

**INFLUENCE OF AFRICAN TRADITIONAL RELIGION AND
SPIRITUALITY IN UNDERSTANDING CHRONIC ILLNESSES AND ITS
IMPLICATIONS FOR SOCIAL WORK PRACTICE: A CASE OF
CHIWESHE COMMUNAL LANDS IN ZIMBABWE**

by

Vincent Mabvurira

THESIS

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Declaration

I declare that this thesis, submitted to the University of Limpopo, for the degree, Doctor of Philosophy in Social Work; **Influence of African Traditional Religion and Spirituality in Understanding Chronic Illnesses and its Implications for Social Work Practice: A Case of Chiweshe Communal Lands in Zimbabwe**, has not been previously submitted by me for a degree at this or any other university; that this is my work in design and in execution, and that all material contained herein has been duly acknowledged.

MABVURIRA VINCENT

DATE

Dedication

To the memory of my parents Obert Chivhaku and Beauty Mhundwa

“I am an African. I owe my being to the hills and the valleys, the mountains and the glades, the rivers, the deserts, the trees, the flowers, the sea and the ever-changing seasons that define the face of my land.....I am an African. I am born of the peoples of the continent of

Africa....” Thabo Mbeki

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Abstract

In many human service professions, religion and spirituality are increasingly recognised as significant sources of clients' strengths that can aid clients' well-being. This Afrocentric study sought to unveil the influence of African traditional religion and spirituality in understanding chronic illnesses in Chiweshe communal lands, Zimbabwe. The aim was achieved through the following objectives: to establish the assumed causes of chronic illnesses in Chiweshe communal lands, to explore how African traditional religion and spirituality promote management of chronic illnesses, to find out the impact of African spirituality on the resilience of people against chronic illnesses, and to establish how African belief systems affect community perceptions and care of people with chronic illnesses. This study was informed by three theories, namely; the Afrocentric theory, strengths perspective and resilience theory.

The study adopted the Afrocentric methodology which is a qualitative approach to studying African phenomenon cognisant of African values. In line with this methodology which respects the canon of *ujamaa* among people of African descent, the study population was comprised of people living with chronic conditions, their families, the elderly, traditional leaders, village health workers and traditional medical practitioners and community home-based care workers from Chiweshe communal lands in Mazowe District of Zimbabwe. Purposive sampling was used to select participants for the study. Data were gathered from eleven people living with chronic illnesses and six families whose members have chronic illnesses and eighteen people (elderly, traditional leaders, traditional medical practitioners and village health workers and community home-based care workers). Data were gathered through one-on-one interviews (for people with chronic illness), family interviews (for families of people with chronic illnesses) and focus group discussions for the other participants. Thematic content analysis was used to analyse data.

African traditional religion was found to be central in understanding chronic illnesses among the study participants. The study participants reported that chronic illnesses are caused by avenging spirits, ancestors calling a person, witchcraft, failure to honour one's ancestors, globalisation and modernisation. A number of strategies were reported to be used to manage chronic illnesses, namely; use herbs, incisions (*nyora*), exorcism (*kupumha*), healing charms (*ndumwa*), rituals, casting away (*kurasira*) and the use of divining bones.

A number of factors in Shona traditional religion were found to promote resilience in chronic illness. These included, among others, the omnipresence of ancestors, having performed rituals such as bringing back ceremony (*kurova guva*), community rituals and the ability of traditional medical practitioners to tap into the spirit world and resolve the negative circumstances surrounding their clients' lives.

In times of need, care was, in most cases, found to be provided by family members, friends, other community members and home-based care workers. The concept of *ubuntu* was reported to have influenced the whole community when it comes to caring for the sick. Close friends (*sahwiras*), totem-based relatives, extended family, and traditional healers played an important role during people's illnesses. Traditional healing methods were also reported to be cheap and linking people to their ancestral spirits. However, ATR was associated with witchcraft and was reported to interfere with allopathic medicine. Members of ATR suffer discrimination from service providers at both government and private hospitals and clinics.

It can thus be safely concluded that African traditional religion and spirituality have significance in understanding chronic illnesses among the Shona people of Chiweshe communal lands. They influence the Shona people's understanding of causes and management of diseases as well as their resilience against chronic illnesses. Social workers

working with people of African descent must appreciate the central role of religion in the lives of African people. Social work practice should, in African communities, be spiritually sensitive. Social work practitioners should understand traditional beliefs and value systems found in African traditional religion. Strengths-based practice, which recognises African traditional belief systems as a source of resilience, should be recognised. It is also important for social workers to recognise African taboos, traditional social safety nets, communitarianism, totemism and African relationships which are broader and more encompassing as compared to the western individualistic ones.

Keywords: African traditional religion, African spirituality, Afrocentric social work, chronic illness, Spiritually sensitive social work, Chiweshe communal lands, Shona, Afrocentricity/ Afrocentrism, Strengths perspective, resilience theory, *Ubuntu*, Traditional medicine, Shona traditional religion, Transpersonal social work, Strengths-based social work.

Abbreviations and acronyms

AIC	African Initiated Churches
AIDS	Acquired Immuno-Deficiency Syndrome
ART	Anti-retroviral Therapy
CDL	Chronic Diseases of Lifestyle
C&HBC	Community and Home Based Care
CSO	Civil Society Organisations
CSWZ	Council of Social Workers (Zimbabwe)
HAART	Highly Active Anti-Retroviral Therapy
HIV	Human Immunodeficiency Virus
HBC	Home Based Care
IASSW	International Association of Schools of Social Work
IFSW	International Federation of Social Workers
IKS	Indigenous Knowledge Systems
IWK	Indigenous Ways of Knowing
JMC	Johanne Masowe Chishanu
NASW	National Association of Social Workers (Zimbabwe)
PLWHA	People Living With HIV and AIDS
UNAIDS	Joint United Nations Programme of HIV/AIDS
UNESCO	United Nations, Educational, Scientific and Cultural Organisation.
USA	United States of America
WHO	World Health Organization
TK	Traditional Knowledge
TM	Traditional Medicine
TMP	Traditional Medical Practitioner

TMPC Traditional Medical Practitioners' Council
VHW Village Health Worker
ZINATHA Zimbabwe National Traditional Healers Association

Glossary of Shona words

<i>Chiremba</i>	-	Doctor
<i>Chirwere cheshuga</i>	-	Diabetes
<i>Chisahwira</i>	-	Friendship / friendship based joking
<i>Hakata</i>	-	Divining bones
<i>Kupumha</i>	-	Exorcise / exorcism
<i>Kurasira</i>	-	Casting away
<i>Kurova guva</i>	-	Bringing back home ceremony
<i>Mudzimu</i> (plural <i>vadzimu</i>)	-	Ancestral/ family spirit (s)
<i>Munyama</i>	-	Misfortune
<i>Muroyi</i> (plural <i>varoyi</i>)	-	A witch (es)
<i>Musikavanhu</i>	-	The creator of people (God)
<i>Mwari</i>	-	God
<i>N'anga</i>	-	Traditional healer/ witchdoctor
<i>Ndumwa</i>	-	Charm
<i>Ngozi</i>	-	Avenging spirit
<i>Nhuta/ Gomarara</i>	-	Cancer
<i>Ninga</i>	-	Sacred cave
<i>Njuzu</i>	-	Mermaid
<i>Nyadenga</i>	-	The great spirit that lives above in heaven (God)
<i>Runyoka</i>	-	Venereal disease
<i>Sahwira</i>	-	Close friend
<i>Samasimba</i>	-	God almighty
<i>Shamhu yaMwari</i>	-	God's punishment
<i>Shavi</i>	-	Wandering spirit

<i>Shuramatongo/ Chakauya</i>	-	AIDS
<i>Svikiro</i>	-	Ethnic spirit
<i>Tateguru</i>	-	Ancestor
<i>Tsviyo / pfari</i>	-	Epilepsy
<i>Unhu / hunhu</i>	-	Good manners
<i>Utachiona</i>	-	Pathogen / virus
<i>Vapenyu</i>	-	The living people
<i>Varikumhepo</i>	-	Those in space (referring to ancestors)

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CHAPTER ONE

GENERAL ORIENTATION OF THE STUDY

1.1 INTRODUCTION

The spiritual domain is an important but relatively unexplained area in most helping professions on the African continent. Despite a split-up with transcendent matters for a protracted period of time, lately, social work academics have developed increasing interest in this area of religion and spirituality. Asher (2001) suggests that the main reason for this sudden surge of interest in spirituality may be that modern African society has demands that, for many, are psychologically and emotionally overwhelming. The other contributory factor is the displacement of African communities from their traditional residential areas with its concomitant erosion of their religious belief systems and spirituality through the mushrooming of congregational clergy of all religions and denominations. These clergy respond to their members' spiritual needs through in a number of ways like counselling and therapeutic care.

The presence of religion and/or spirituality is widespread and is one of the longest-standing phenomena known to humankind (Berry & York, 2011). From a more analytical perspective, it can be argued that religion and spirituality have featured prominently in human history and that in nearly all societies they have played a stupendous and portentous role in human life since the beginning of time. Consequently, they have featured in literature related to mental health (Ameling & Povilonis, 2001; Hill & Pargament, 2003), psychotherapy (Peres, Simao & Nasello, 2007; Breitbart, Gibson,

Pappito & Berg, 2004), nursing and social work (Canda, 1999; Sheridan, 2008; Asher 2001; Berry & York 2011). However, there can be no doubt that the religious and spiritual discourse of social work is well-researched and acknowledged in other countries like the United States (McClain, Rosenfield & Breitbart, 2003; Sheridan, 2008) New Zealand (Phillips, 2010; Baskin, 2002; Beatch & Stewart, 2002; Potahu, 2003) and Canada (Coates et al, 2007). This is, however, still an unexplored area in Zimbabwe. There is vast social work literature in Zimbabwe and much of it focuses on social security, social development, social work education and little is written about social work, religion and spirituality. Sheridan (2002) states that social work services that incorporate spirituality may help clients deal with a sense of alienation, hopelessness, grief and a range of other issues. However, it is noteworthy that it is mostly Christian spirituality that has informed social work practice for decades and it is because of this that this Afrocentric study sought to find pathways for the indigenisation of social work practice through incorporation of African traditional religion (ATR) and spirituality in social work practice in Zimbabwe. This was done by focusing on the influence of African traditional religion and spirituality in understanding chronic illnesses.

1.2 BACKGROUND TO THE STUDY

Most religions such as Christianity, Islam and ATR owe the animation of man to the Supreme Being. For example, the Hebrew Biblical references attribute the existence of man to God, “ ...the Lord God formed man from the dust of the ground and breathed into his nostrils the breath of life, and the man became a living being” (Genesis 2: 7). African traditional religions also suggest that man was created by God. This is evidenced by the African dialectical reverence names of God. Examples are

Musikavanhu (creator of humanity) in Shona, *uNkulunkulu* (Great one) in Ndebele and *Nacilenga* (creator) in Tonga. African traditional religion is at the centre of African ontologies and cosmologies. Africans are a very religious people and their religion is evident in their ways of life such as healing, birth, death, hunting etc. Most scholars on religion such as Chavunduka (2001), Shoko (2007) and Viriri and Mungwini (2009) have converged on the point that religion is the centre of African existence. There is no separation between the spiritual and the material in traditional African life. African religion is the basis and reflection of African people's existence (Viriri & Mungwini, 2009). Given this importance of religion and spirituality to Africans, it is clear that social work practice cannot be complete without including the spiritual dimension (Baskin, 2002).

1.2.1 European Hegemony in African Social Work

The problem with current social work practice in Africa is that following its development in the West, it came to Africa grounded in values and ideologies stemming from Capitalism, Social Darwinism, the protestant ethic and individualism, all of which are un-African. Gray, Kreitzer and Mupedziswa (2014) argue that the situation was worsened by the United Nations which pushed colonial administrators to import social work education and practice to Africa. Thus Western ideas permeated social work institutions despite the ethical conflicts between traditional African cultures and values and the Western Judeo-Christian norms on which social work was based (Gray, Coates & Yellow Bird, 2008). According to Gray *et al* (2014), it was due to these foreign influences that social workers in Africa completely disregarded traditional cultures and support systems based on collective values.

Though African traditional religion plays significant roles in times of war, droughts, death and illness, it has, however, been side-lined by European hegemony. As Makhubele (2011) notes, with the emergence of Western systems of knowledge, indigenous knowledge systems have been regarded as a pagan practice and have been relegated to the lower level. Though social work plays a pivotal role in the health delivery system, less effort has been made, in most African communities, to harmonise it with traditional religion and allopathic medicine in the healing processes. It is, therefore, pertinent for social workers to understand African metaphysics and ontologies. Since social workers in the health sector in Zimbabwe work in hospital settings, community health settings and research organisations, it is imperative that they understand the role played by African traditional religion in the management of chronic diseases and conditions. African traditional orature provides powerful traditional therapeutic and healing properties. Baskin (2002:3), writing in the context of aboriginal New Zealanders, notes that “.....traditional teachings, ceremonies, rituals, stones, water, pipes, herbs, sitting on the earth, fasting, prayer, dreams.... are all part of the journey to spiritual balance and well-being”.

If social work in Africa is to decolonise and indigenise itself, practitioners should have an understanding of African traditional religion. This is mainly because there is no clear separation between the material and the sacred among indigenous African people. As Mbiti (1975:12) argues, “...in traditional African communities, life is religion and religion is life.” An African understanding of illness is critical for effective social work intervention. Social work education in Africa must go beyond Western faiths (Baskin, 2002). However, as Phillips (2010) contends, the idea must not be to displace European

knowledge but to decentralise it in order to make way for other ways of gaining knowledge. Thabede (2005), a key proponent of Afrocentric social work, indicates that practising social workers in Africa should understand the concepts of witchcraft, ancestral worship and other rituals key to traditional African life as well as appreciate the difference between Western and African ontologies. This study was set up against the background of a growing interest of social work scholars in religious and spiritual aspects of social work in some parts of the world and the realisation by the current researcher that such interest is alarmingly limited in Zimbabwe. ATR should not only be seen as backward but its good practices must be embraced for helping professionals to utilise.

1.2.2 The Nexus between Spirituality and Illness in African Communities

People with chronic conditions such as AIDS, cancer, diabetes, and hypertension, face a myriad of challenges in dealing with a number of emotional issues because they feel cast out and abandoned by friends, families and God. They are, sometimes, caught in a spiritual crisis which may lead to spiritual torture. Spirituality is the most powerful source of strength because people who choose to operate in this world do so in some form of faith (Baskin, 2002). It is, therefore, critical for social workers working in the health sector in Zimbabwe to have an appreciation of indigenous African religions. As Viriri and Mungwini (2009) put it, the spiritual beings are very much communal among the living as important participants in shaping everything that may happen. Another critical aspect is the science of causation in relation to illness among Africans. For Africans, everything has a cause, nothing happens without a cause. The important question is: Why must a particular event happen to a particular person at a particular place in a given time and

why that particular person and not the other? Thus, the African understanding of illness goes beyond the germ theory to include the spirit world.

Religion and spirituality are at the centre of social work practice when it comes to chronically ill people. McClain, Rosenfeld and Breitbart (2003) mention that high levels of spirituality in dying patients lead to hopefulness, which result in a more co-operative relationship with treatment teams, improved resolution of long-standing emotional problems and the desire to live longer. Compton, Galaway and Cournoyer (2011) maintain that many people find strength in their lives through their religious and spiritual beliefs and traditions. This usually involves reference to God, Jesus, and Mohammed, a higher power, contact with the universe or infinite. Helping people as they seek meaning and purpose in life often involves exploration of spirituality. Having recognised the importance of religion and spirituality, this study thus explores the role of African traditional religion (ATR) and spirituality in chronic illnesses among the Shona people of Chiweshe communal lands in Zimbabwe.

Critics of African traditional religion argue that Africa is a vast continent with various belief systems that are difficult to harness into one religion. With this in mind, this study focuses on the religion of the Shona people which some scholars have referred to as the Shona traditional religion (Kazembe, 2009; Masaka & Makahamadze, 2013; Shoko, 2011; Shoko & Burck, 2010; Taringa, 2006). Despite the presence of other religions in Zimbabwe, indigenous African religion exists to this day. This is buttressed by Viviri and Mungwini (2009: 179) who note that “.....despite cultural onslaught on Shona metaphysics particularly their belief systems through the spread of western scientific

worldview and the Christian religion, the Shona never lost touch with their traditional metaphysics.”

1.3 OPERATIONAL DEFINITION OF KEY TERMS

1.3.1 Allopathic Medicine

Allopathic medicine refers to the broad category of medical practice that is sometimes called Western medicine, biomedicine, scientific or modern medicine (WHO, 2001).

1.3.2 African Traditional Religion

Many scholars have tried to define the term African traditional religion but to no avail. The difficulty in defining the concept (ATR) ensues from two reasons: (1) it is made up of three concepts (African, traditional and religion) which are difficult to define in their own right; (2) Africa is a vast continent which lacks homogeneity. Despite this lack of a definitive definition, ATR shall, in this study, refer to the indigenous African beliefs and practices.

1.3.3 Chronic Illness

A chronic illness can be defined as a long illness (more than one year) which can be managed but not cured. Examples are cancer, asthma, diabetes, epilepsy. The definition shall include the clinical stage of HIV in this study (Rolland, 1994).

1.3.4 Indigenous Knowledge Systems (IKS)

Indigenous Knowledge Systems as a concept is also known as Traditional Knowledge (TK), ethno-science or Indigenous Ways of Knowing (IWK). IKS refers to the knowledge

systems developed by a community as opposed to the scientific knowledge that is generally referred to as modern knowledge.

1.3.5 Religion

Spirituality is closely linked to religion which Pargament (1997) defines as a multi-dimensional construct which includes both institutional religious expressions such as dogma and ritual, and personal religious expressions such as feelings of spirituality, beliefs about the sacred, and religious practices. Asher (2001) confesses that religion may be understood as a formal set of beliefs, doctrines, laws, practices and assignments of authority which are linked to an explanation of the creation and governance of the universe.

1.3.6 Spirituality

Spirituality is an abstract term that lacks a definitive definition. Defining and operationalizing spirituality depend largely on one of the many theoretical frameworks one uses (Roby & Maisty, 2010). It is often conceptualised by discipline, culture and ideology. Traditionally, the terms spirituality and religion have sometimes been either used interchangeably or confused. Spirituality is the universal aspect of human existence and a search for meaning and purpose, fulfilling relations and connections between other people, a higher power and one-self.

1.3.7 Traditional Medicine

Traditional medicine (TM) refers to diverse health practices , approaches, knowledge and beliefs which incorporate plant, animal and or mineral-based medicines, spiritual

therapies, manual techniques and exercises applied singularly or collectively to maintain people's wellbeing as well as treat, diagnose or prevent illness (WHO, 2002).

1.4 STATEMENT OF THE PROBLEM

Harmful cultural practices in Africa are overemphasised at the expense of helpful ones. Western culture and ideology have indoctrinated Africans into believing that the West provides a universal panacea to most African problems. For centuries social science research in Africa has been informed by Eurocentric methods of inquiry. This has often led to wrong and misdirected treatment for the problems affecting indigenous African people. Eurocentric religious and spiritual hegemony has, for a long time, relegated African religion and spirituality to the margins. Afro-based methods of disease management which are grounded in African belief systems have thus been relegated to the periphery. It is against this backdrop that social work practice in Africa and Zimbabwe in particular has failed to be indigenised. Social work treatment methods which were imported to the continent during the colonial era are still in place decades after Zimbabwean independence.

In Zimbabwe, social workers have pushed Indigenous Knowledge Systems (IKS) in social work practice to the periphery despite calls to indigenise it (Mupedziswa, 1993). They have done so despite the recognition of African belief systems' importance in illness management in the health delivery systems of Zimbabwe (Gelfand, 1975; Kazembe, 2009; Chavunduka, 2001; WHO, 2002). This is despite the fact that there is an increasing attention being paid to the relationship between social work practice, culture and indigeniety in some parts of the world (Hodge & Derezotes, 2008; Baskin, 2002). Makhubele (2011) also notes that in some countries such as South Africa and

Zimbabwe, official propaganda depicts indigenous cultures and methodologies as backward and out of date and simultaneously promotes one national culture at the expense of minority cultures. However, social workers are encouraged to embrace many ways of knowing especially when working with indigenous peoples (Phillips, 2010).

Religion and spirituality play a crucial role in social work practice. Social work practitioners are encouraged to be religiously and spiritually sensitive when executing their duties. A lot has been written by historians, anthropologists, religionists and missiologists about the role of African traditional religion and spirituality among the Shona people of Zimbabwe (Mpofu, 2011; Shizha & Charema, 2012; Shoko & Burck, 2010; Machinga, 2011; Kazembe, 2009, Chavunduka, 1978; Gelfand, Mavis, Drummond & Ndemera, 1985), but little is known about it from a social work perspective. Despite the importance of aspects of religion and spirituality such as resilience and meditation in social work practice, it is an area which is hard-hit by academic amnesia among social work researchers and educators in Zimbabwe. Social work scholars in Zimbabwe have not devoted any effort to researching on religion and spirituality with the exception of the work of Mabvurira and Nyanguru (2013) and Mabvurira and Makhubele (2014).

For most black Africans, it is almost impossible to separate the material from the spiritual. Thus, spiritual issues are critical in the everyday lives of indigenous African people hence neglecting them in social work practice can have detrimental effects on intervention. Furman and Bensin (2006) aver that despite emerging interest in

spirituality, social workers report little preparation for integrating religion and spirituality into practice. This is despite the fact that earlier studies have indicated that social work educators and students, in a number of countries, are willing to include religious and spiritual aspects in their curricula (Canda, 1998; Praglin, 2004; Csiernikn & Adams, 2002).

Many aspects of diversity such as cultural differences have been mentioned in social work education in Zimbabwe but issues which have to do with Indigenous Knowledge Systems, especially African traditional religion, have been left out. Unlike neighbouring South Africa with a comprehensive, Indigenous Knowledge Systems policy, IKS issues in Zimbabwe have not been given serious attention especially by most helping professions. As mentioned earlier, Sheridan (2002) notes that social work services that incorporate religion and spirituality may help clients deal with a sense of alienation, hopelessness, grief and a range of other issues. Social workers have been afraid of speaking about things spiritual with their clients for fear of crossing the line of self-determination. They have consequently neglected a large component of the person-in-the environment (Hunt, 2010). Worse still are issues which have to do with African traditional religion which is facing extinction.

The origin of social work is believed to have been motivated by religious and spiritual beliefs but with the passage of time, the two seem to have drifted apart. Sheridan (2010) declares that spirituality is soulful living and that social work has largely become disconnected from its spiritual roots. Since the early 1980s, there have been calls for a return to the spiritual roots of social work (Canda, 1999; Canda & Furman, 2010; Lembke, 2012; Martin, 2003; Lindasy, 2002; Hodge, 2001), but this has not materialised

in most African countries. Few social work scholars in Southern Africa have researched on religion and spirituality in social work (Thabede, 2005; Bhagwan, 2010a; Bhagwan, 2010b; Ross, 2010; Mabvurira & Nyanguru, 2013; Mabvurira & Makhubele, 2014).

All the three institutions (University of Zimbabwe, Bindura University of Science Education and Women's University in Africa) which are currently offering social work training in Zimbabwe do not offer any course on religion and spirituality in social work practice. Spirituality, as a protective factor for coping with chronic illnesses, has been understudied in Zimbabwe. Available literature is by scholars from developed world and they have written mostly in the context of Christian spirituality. Almost all humanity subscribes to a form of religion and is spiritual to a certain extent. People have always resorted to spirituality when faced with traumatic life events. They always find refuge in spirituality when they cannot explain certain life events. Given that a significant percentage of Zimbabweans are religious, there is, therefore, more to suggest that religion and spirituality are of considerable significance to most people in Zimbabwe. Clients' spirituality, therefore, needs to be given serious attention by policy makers, social work educators and practitioners.

People diagnosed with life-threatening or chronic conditions such as HIV and AIDS and cancer have resorted to faith healing (Kazembe, 2009). Another point of interest is the fact that even some Christians in Zimbabwe turn to indigenous healing practices when faced with strange life circumstances (Chavunduka, 2011; Kazembe, 2009). Furthermore, Viriri and Mungwini (2009) agree that in responding to problems, Shona

people have developed a patch-work of solutions with ideas they draw from modern science, the Christians tradition and their own traditional metaphysics. Given this scenario, there is, therefore, a need for a subterranean understanding of the influence of African traditional religion and spirituality in comprehending chronic illnesses among the Shona people of Zimbabwe. The presumption is that religion and spirituality have been found to provide a protective measure against life-threatening conditions yet little has been explored from a social work perspective among the Shona people who constitute more than 70% of Zimbabwe's population (Kazembe, 2009).

Social work originated from religious movements especially Christian movements and as such a number of scholars such as Edward Richard Canda, Michael Sheridan have developed interest in the role of spirituality in social work practice. However, a research gap exists in identifying the role of African traditional religion and spirituality in chronic illness. An important question to be addressed is whether or not African spirituality has the same effect on chronic illnesses as other forms of spirituality especially among the Shona people of Zimbabwe. The understanding is that though disease is universal, illness is culturally constructed as factors surrounding it vary from society to society.

Sodi (2009) writes that in the mid-1970s, the World Health Organisation (WHO) called for the recognition of Traditional Medicine (TM) through appropriate training and research in an endeavour to facilitate collaboration with primary health care systems. The African Union declared 2001 to 2010 as a decade of African traditional medicine and the World Health Organization recognises the role of traditional medicine in the

health delivery systems of many developing nations. Life in Africa hinges on religion, and African traditional religion and medicine are inseparable. In Africa, the term “indigenous” is synonymous with “African” and “anti-colonial” (Mohale, 2010). Social workers should explore ways of incorporating indigenous spirituality in their practice.

1.5 MOTIVATION FOR THE STUDY

This work was stimulated by the texts of Molefe Kete Asante and Maulana Karenga on Afrocentrism, specifically on aboriginal religions of Africa. The two scholars are African-Americans whose works have immensely contributed to the body of knowledge which is today called Africology or Africanity. Born in America with English names, the two later changed their names to African names. In one of his statements, Asante reiterated that “I find it strange for a black African person to have an English name”. His major argument was that black Africans should not desert their ways of knowing and of doing things. Prior to the coming of the whites, Africans had their ways of treating chronic illnesses and these must be preserved as a heritage for generations to come. They should be improved, researched, tested and retested and health tourists should come down to Africa to learn from our indigenous knowledge. A number of scholars (Emeagwali, 2003; Fernandez, 1994) concede that there is a need to mine the hitherto untapped resource of IKS and use it for Africa’s development. IKS need to be organised as a dialect that is neither cannibalistic nor exploitative but mutually enriching (Bhola, 2007).

The docility and lack of assertiveness among Zimbabwean social workers oriented in Western curricula also motivated the researcher to carry out this study. The social work profession is not well recognised in Zimbabwe especially among the rural folk. The

researcher assumes that it is so because methods currently used in social work are un-African. The assumption is that social workers have denigrated African ways of doing things hence this study seeks to reconcile African traditional religion and social work. The claim by some Zimbabweans that Zimbabwe is a Christian country left the researcher wedged in a spiritual crisis. Being a Christian and a social worker at the same time causes the researcher to still embrace social diversity and acknowledge the existence and subscription of social work clientele to various religions of the world which include African traditional religion(s). The negligence given to spiritual matters by social work academics in Zimbabwe motivated the researcher to want to break the silence. This is also motivated by the understanding that a person consists of the body, the soul and the spirit.

The existence of Centres of Social Work and Spirituality, and Journals dedicated to religion and spirituality in European and American countries has inspired the researcher to seek a platform to herald the importance of African traditional religions in human life. It is the researcher's dream that an institute of religion and social work be established in Africa to propel the study of indigenous religions in relation to social work. The commitment by the government of the Republic of South Africa to Indigenous Knowledge Systems also inspired the researcher. African ways of doing things should be documented for the benefit of posterity and African scientists and researchers should endeavour to improve them amidst European hegemony.

The existence of chronically ill people who resort to African medicine and seek spiritual healing has also motivated the researcher. People with various ailments are seen queuing at healing shrines across Zimbabwe. The shrines may belong to either

traditional healers or Christian prophets. Some modern Christian leaders are also believed to seek assistance from spiritual mediums.

The researcher's family background has also motivated him to carry out this study. His family elders revere their ancestors and always seek solutions to problems from them. In cases of serious illness in the family, they go for a *gata* to seek the causes and possible remedy. They always pray to *Mwari* through ancestors for the protection of the family. This is done amidst criticisms of African traditional religion as a fetish and animistic religion. This perseverance of some Shona people in ATR has forced the researcher to want to know its significance in times of adverse life circumstances such as chronic illness.

The researcher's herbalist aunt also challenged him to carry out this study. She is a specialist in the treatment of cancer and she claims to commune with the ancestors through dreams and the herbs she uses are made known to her by the ancestors through such dreams. The cancerous cells can completely disappear by virtue of her having administered some herbs as instructed by the healing spirit. Allopathic methods of treating cancer like radiotherapy have sometimes failed but the researcher has never seen her failing. She also boasts of the capability to prolong the lives of HIV positive people as long as they consult her in the early stages of the clinical phase of AIDS, an effect found in antiretroviral therapy of Western medicine.

Many African governments, Zimbabwe included, have put measures to standardise African traditional healing, church healing and allopathic healing, and it is the researcher's feeling that social work should not be left behind in this endeavour. Social work is a helping profession which is critical in the management of chronic illnesses,

and understanding the influence African traditional religion in chronic illnesses will improve the profession. This fact is supported by Chavunduka (2001) who argues that there has never been any genuine dialogue between practitioners of African religion and practitioners of other religions in Zimbabwe. Other religions are accused of trying to destroy ATR (Chavunduka, 2001; Nyengele, 2013). Another element was an observation by Mahomoodally (2013) who contends that the documentation of medicinal uses of African plants and traditional systems is becoming a pressing need because of the rapid loss of natural habitats of some of these plants due to anthropogenetic activities and also due to erosion of valuable traditional knowledge. Though this study focuses on ATR, it is not its aim to promote its faith.

1.6 AIM AND OBJECTIVES OF THE STUDY

This study sought to contribute to the limited research on religion, spirituality and social work in Zimbabwe by establishing the influence of African Traditional Religion and African spirituality in understanding chronic illnesses in Chiweshe communal lands. It sought to unveil how ATR influences the assumed causes of chronic illnesses, traditional palliative care methods and how it motivates chronically ill patients. This thesis highlights how traditional African beliefs and practices may be interwoven into Afrocentric social work practice in Zimbabwe for the betterment of human lives. The aim of the study was achieved through the following objectives:

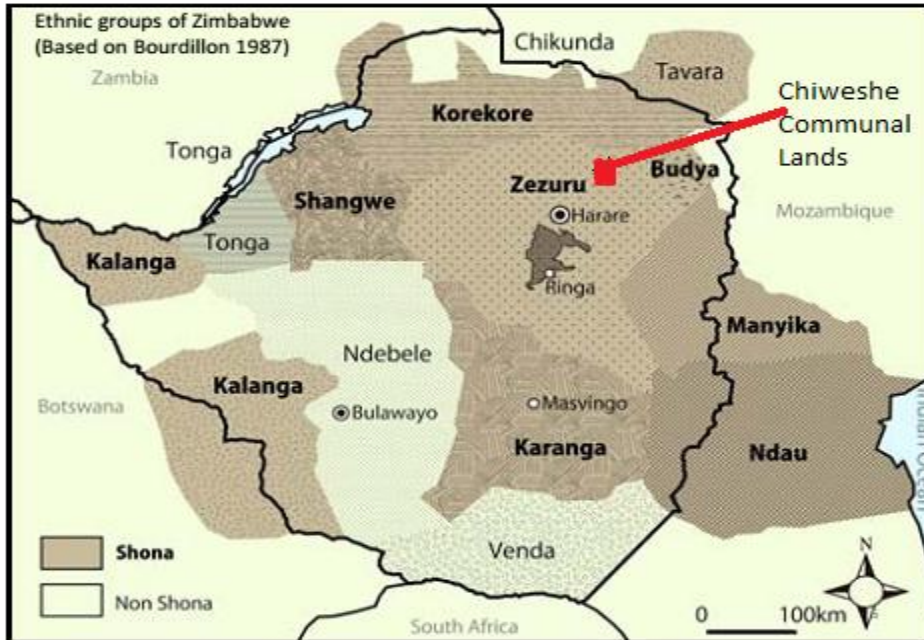
- To find out the assumed causes of chronic illnesses in Chiweshe communal lands;
- To explore how African traditional religion and spirituality promote the management of chronic illnesses;

- To find out the influence of African spirituality on the resilience of people with chronic illnesses;
- To establish how African traditional belief systems affect community perceptions of chronic illnesses;
- To establish how African belief systems affect the care of people with chronic illnesses.

1.7 PROFILE OF THE STUDY AREA

This study was carried out in Chiweshe communal lands in Mazowe District, Mashonaland Central Province in Zimbabwe. Chiweshe is a rural community situated about 80km North East of Harare, Zimbabwe's capital. It is home to rural peasant farmers and as a result of this, it is generally inhabited by low income earners. The area was set up by white settlers as reserves for native Africans who were pushed away from fertile soils in Mazowe district. It is mostly inhabited by Shona people of Zezuru dialect. There are a number of sacred mountains in the area, to mention just a few, Nyota, Ndire, Haa, Bare and Banje. The area is also infested by healing shrines and spirit mediums, where consultations for national issues can be made. There is one major hospital in the area (Howard Hospital) and several clinics.

Figure 1: Ethnic groups of Zimbabwe and location of Chiweshe communal lands



Map adapted from Matsuhira 2011.

Chiweshe communal lands cover an area of about 210 000 acres and are surrounded by Glendale, Concession, Mvurwi, Centenary and Bindura. Religious affiliation in Chiweshe area is quite heterogeneous though majority of the people belong to various Christian denominations. The most prominent spirit medium in Zimbabwe, Mbuya Nehanda, is believed to hail from Mazowe district where Chiweshe communal lands lie. Of interest in Chiweshe area is a mountain, Banje (*Gomo rerushanga*) where some members of an African initiated church called Johanne Masowe Chishanu spent almost seven years. They were supposed to construct a shrine as was instructed by the spirit but they failed as they breached the rubrics. The churches Johanne Masowe Chishanu and Nguwo Tsvuku seem to be a hybridisation of ATR and Christianity and a number of

their rituals are similar to those found in ATR. The headquarters of Nguwo Tsvuku church is found in Chiweshe and the dressing and hairstyles of their prophets resemble that of *n'angas* in ATR.

There are numerous Christian denominations in the area and two mission schools, Howard, of the Salvation Army Church and Langham, of the Anglican Church. There are about five business centres in Chiweshe, namely, Gweshe, Bare, Nzvimbo, Musariri and Chaona. The area is served by a highway road which links Glendale and Centenary.

1.8 SIGNIFICANCE OF THE STUDY

Zimbabwe is still behind regarding critical studies of the religious and spiritual discourse of social work. This gap makes this study important in that it seeks to address some of the issues by providing empirical evidence on the role of ATR and African spirituality in chronic illnesses. This will enable social workers to find ways of incorporating religious and spiritual issues in their practice. This study will, therefore, form the foundation for spirituality and social work research and education in Zimbabwe. Social workers who had taken a course on religion and spirituality were found to have an appreciation of the role of spirituality in social work practice (Heyman, Buchaman, Marlowe & Sealy, 2006).

The Council of Social Workers of Zimbabwe (CSWZ), which acts as a regulatory board for social work practice, and the National Association of Social Workers of Zimbabwe (NASW), which stands as the workers union for social workers, may benefit from the results of this study. Both organisations may benefit from the results of this study as they may decide to strengthen and motivate social workers to understand their clients' spirituality. Social workers have often been found to impose their religion and spirituality

on desperate clients during the helping process. This study, which demonstrates the influence of African traditional religion and African spirituality, may help the CSWZ make it an ethical requirement to respect and strengthen the spiritual resources of a client despite how different they are from those of the social worker or how trivial they may seem.

There are a number of hospice organisations in Zimbabwe which include, among others, The Centre, Island Hospice and the Cancer Society. These organisations deal with terminally ill people or people with life-threatening conditions. Employees of such organisations can get more insight from this study on the role of African traditional religion and spirituality in terminal illnesses. Furthermore, other health professionals such as counsellors and nurses can also benefit from this study. This research project will provide valuable information on the effectiveness of ATR and spirituality as sources of resilience in coping with psychological and social problems among chronically ill patients. Social workers often work with other helping professionals in multidisciplinary contexts in health care delivery systems. These professionals also need to understand the role that religion and spirituality can play in the client's ability to cope with physical and mental illness (Heyman *et al*, 2006).

The Ministry of Health and Child Care stands to benefit immensely from the results of this study. Though the Government of Zimbabwe recognises the role of traditional medicine in its health delivery system, the role of African traditional beliefs and practices in health and healing is not well acknowledged by Western trained doctors. Few of such doctors refer their patients to traditional medical practitioners. By demonstrating the

influence of ATR in understanding chronic diseases, the government may decide to professionalise traditional healing practices.

As a study area, the influence of African traditional religion from a social work perspective is virtually untapped because very little academic work has been carried out on it. To date, there is no book or journal article written by social work academics and researchers in Zimbabwe which interrogates the role of African traditional religion among the Shona people of Zimbabwe. This study, therefore, seeks to offer a social work dimension on the on-going debates on African traditional religion and illness. The results of this study will be significant in this way:

The place of religion and spirituality in social work practice in Zimbabwe will be identified. To achieve this goal, this study analyses the role of religion in social work practice. It also traces the religious and spiritual roots of social work. The assumption is that religion and spirituality are resources lying idle due to neglect by social workers in Zimbabwe. Shona people are a very religious and African traditional religion, consciously or unconsciously, plays a central role in their lives. The study has shown how African traditional religion is embedded in the everyday lives of the Shona people. The argument is that even though African traditional religion and especially Shona traditional religion has faced attack from Christian missionaries, it is still alive to this day.

Ministers of religion will benefit from this study. These are the people who mostly influence the spirituality of people with illness. They pray for them and comfort them in times of trouble. Ministers of religion will work from an informed perspective after this study. Though spirituality is distinct from religion, the two seem to be two sides of the same coin in the sense that they are intertwined and commonly difficult to tell apart.

Ministers of religion can also influence the way religious organisations and their congregants treat people with terminal illnesses such as AIDS. Ministers of religion's attitudes toward PLWHA are very crucial and they need to understand the effects of their actions on such people. If ministers of religion understand the spirituality of PLWHA, then they may help strengthen the spiritual resources of such people.

1.9 ORGANISATION OF THE THESIS

This thesis comprises seven chapters.

Chapter one is the general orientation of the study. This chapter introduces the thesis. It also outlines the research problem, gives definitions of key terms, and the aim and objectives of the study. It further describes the study area and outlines the motivation of carrying out the study.

Chapter two is dedicated to the theoretical framework of the study. The following three theories are described: Afrocentrism, strengths perspective and resilience theory. It also critiques each theory before exploring how it informs social work practice.

Chapter three proffers the religious and spiritual discourse of social work. It traces the historical roots of the profession; puts an argument for religious and spiritually sensitive social work.

Chapter four looks at African traditional world views paying attention to African traditional religion and spirituality. It also narrows down to Shona traditional religion. This chapter also looks at the concept of illness in the African traditional context. It highlights

the assumed causes of illness and treatment methods. It also gives a brief rundown of major chronic diseases and conditions in Zimbabwe.

Chapter five is dedicated to research methodologies that were used in the study. It describes the Afrocentric methodology that was used. The research approach, design, population and sample size are described. All the steps that were taken in data collection and analysis are stated.

Chapter six presents and discusses the research findings.

Chapter seven looks at the summary, conclusions and recommendations.

1.10 SUMMARY

Religion and spirituality strongly influence social work practice though there is little acknowledgement especially from the African continent. The two concepts are almost new to social work scholarship on the African continent. Much of the available literature focuses on western countries and few studies have interrogated the influence of African traditional religion in influencing social work practice. Religion and spirituality have also featured in nursing, psychiatry and psychotherapy. Though African social work has relegated religion and spirituality to the periphery, Africans have been reported to be notoriously religious. Their religion permeates all the facets of their life. The material and the immaterial cannot be easily separated. African live from cradle to the grave is explained through religion.

Most studies on religion and spirituality in social work practice have been focusing on religions like Christianity that are alien to the African continent and not much studies

have been dedicated to interrogate the influence of indigenous religions in understanding chronic illnesses from a social work perspective. Most Africans explain their health issues in the facets of their religions while social work plays a critical role in the health delivery system of a nation. It is therefore of paramount importance to study the influence of African traditional religion and spirituality in understanding chronic illnesses. Given this, the current study sought to understand the influence of African traditional religion and spirituality in understanding chronic illnesses among the Shona people of Chiweshe communal lands in Zimbabwe. Chiweshe communal lands is a rural community located in Mazowe district, Mashonaland Central province, Zimbabwe. Focus was on finding out the assumed causes of chronic illnesses, how African traditional religion promotes the management of chronic conditions and care of the sick as well as resilience of the people in the event of illness. Information from this study will be useful to social work educators and practitioners, the Council of Social Workers of Zimbabwe, Ministry of Health and Child Welfare and members of Chiweshe community in dealing with health matters of social work service users.

CHAPTER TWO

THEORETICAL FRAMEWORKS

2.1 INTRODUCTION

Which theories are needed to understand the multiple dimensions of a person, environment and time involved in human behaviour? This question is critical in research studies related to behavioural sciences and human service professions. It is even more needed in social work as social work as a Discipline seems to lack its own theories. Most social work academics who write on religion and spirituality use a variety of theories from related fields to ground their studies.

Despite the fact that social workers handle various problems, they have not yet developed theories that are specific to the study of religion and spirituality. Almost a century after its inception, social work practice and research continue to borrow from other social sciences Disciplines such as psychology, sociology, anthropology and African studies. For decades, theories have been used as lenses to buttress explanations in social work research. Almost every social researcher rummages around for appropriate theories for their studies. This study is no exception. Four theories were identified as relevant to the study of the influence of African traditional religion and spirituality in the understanding of chronic illnesses; Afrocentrism, strengths perspective and the resilience theory. As Schiele (2000) argues that no one theory is robust enough to explain all human functioning. The four theories were found to play a complementary role in the current study.

A theory provides a footing considering the world, separate from, yet about that world (Silverman, 2011). A wide range of theories influence contemporary social work practice. These three theories provide a framework for critically understanding religion and spirituality in relation to chronic conditions. Apart from illuminating on the basic tenets of the theories, this section also expounds how each theory informs the social work fraternity. The propositions of each theory are outlined and their strengths and weaknesses are also proffered in relation to the study.

2.2 AFROCENTRISM

Though the term Afrocentrism or Afrocentricity emerged from academia, it has been used to refer to anything with an African motif such as clothing, jewellery or furniture. According to Jackson (2003), the term has become a marketplace commodity used to sell almost anything targeted at African-Americans. On the academic front, the term has been adopted by various Disciplines such as history, sociology, anthropology, management, African studies, English, communication as well as social work. It has also been found to be influential in the current study which looks at the interface among African traditional religion, spirituality and social work. The existence of spiritual resources which were/are significant in times of illness, death, hunting and other social events piqued the researcher to look for a pro-African theory in the form of Afrocentricism / Afrocentricity.

Though Molefe Kete Asante is the founder and principal theorist of Afrocentrism and various authors have tried to define the term Afrocentrism. Afrocentricity literally means placing African ideas at the centre of any analysis that involves African culture and behaviours. According to Asante (2003:2) “Afrocentricity is a mode of thought and action

in which the centrality of African interests, values, and perspective predominate”. Olaniyan (1992) views Afrocentrism as an ethnocentric ideology which places emphasis on things African, and attempts to give Africans their rightful place in the world. Asante (2009) further defines Afrocentrism/ Afrocentricity as a paradigm based on the idea that African people should re-assert a sense of agency in order to achieve unity. Karenga (1988:404) also defines Afrocentricity as a quality of perspective or approach which is rooted in the cultural image and human interest of African people.

The basic assumption in Afrocentricity is that Africans must determine their reality and world view. The origins of an Afrocentric world view are found in traditional African history before the advent of European and Arab influence. Afrocentrism is seen as a scholarly theory, paradigm, philosophy and ideology. As a theory, Afrocentrism places African people in the centre of any analysis of African phenomena. This paradigm has originated from African-American scholars who questioned Eurocentrism. From Asante’s point of view, Afrocentrism asks the question *“What would African people do if there were no white people?”* Afrocentrism studies ideas, concepts, events, personalities and political and economic processes from a Black, African perspective. It enthrones the centrality of the African, which is Black, African ideas, values as expressed in the highest form of African culture.

A study interrogating the influence of African traditional religion and spirituality in understanding chronic illnesses, therefore, deserves to have Afrocentrism as one of its theoretical tenets. This study is grounded in an Afrocentric framework. As a theoretical framework, Afrocentricity provides a platform for interpreting characteristics of African life from an African perspective. Afrocentrism questions Eurocentric studies that seek

ungrounded aggrandisement by claiming universal hegemony (Asante, 1990). However, Ince (2009) claims that to subscribe to Afrocentricity does not exclude other theoretical frameworks hence the use of the strengths perspective and the transpersonal theory. Afrocentrism is generally opposed to theories that dislocate Africans to the periphery of human thought and experience (van Wyk, 2014).

Closely related to Afrocentrism are the terms Africanity and Africology. According to Asante (1998), Africanity refers to all the customs, traditions and traits of Africans and the African Diaspora. Africology on the other hand denotes the Afrocentric study of African concepts, issues and behaviours. Africology is the trans-generational and transcontinental study of African people. It is, therefore, important to note that to be African does not necessarily mean one is Afrocentric. Eurocentric ideology masquerades as a universal view in many fields such as philosophy, linguistics, psychology, education and anthropology. According to Asante (1998), Afrocentricity is about taking the globe and turning it over so that we see all the possibilities of a world where Africa is a subject and not an object. Africans who deny their Africanity should be condemned as anti-blacks, un-black blacks, who as a result of their mentacide, have become racist against themselves (Asante, 1998).

According to Williams (1981), Afrocentricity has four values: the Afrocentric cosmology, the Afrocentric axiology, the Afrocentric ontology and the Afrocentric epistemology. The Afrocentric cosmology refers to a world view that is the foundation of African thinking, beliefs, perceptions and values. The Afrocentric axiology is a value system that serves as the foundation for African belief and what Africans are willing to struggle for. The Afrocentric ontology emphasises African collective identity, collective struggle and

collective destiny. Lastly the Afrocentric epistemology stresses the importance of understanding African history, heritage, and culture to acquire the knowledge needed to develop to the fullest potential as a people and achieve liberation.

When the West colonised Africa, there was a total distortion of African values. This is evidenced by Chukwuoko (n.d:31) who reiterates that “.....imperialism bequeathed Africans with two main unforgettable experiences, namely the denial of African identity and the tendentious imposition of Western thoughts and cultural realities and perceptions”. Furthermore Edwards, Makunga, Thwala and Mbele (2009:1) note that “Converging lines of recent evidence from various disciplines such as genetics, linguistics, palaeontology and archaeology all point consistently to Africa as the cradle of civilisation for all humanity, with homo sapiens evolving some one hundred and fifty thousand years ago and gradually emigrating across the Sinai Peninsula some fifty thousand years later”.

2.2.1 Meta-theory of Afrocentric Stance in Social Work

Before social work was established as a formal profession, all countries had their own ways of handling social issues and of protecting and caring for their vulnerable members (Kreitzer, Abukai, Antonia, Mensah & Kwaku, 2009). Avendal (2011) notes that in Ghana for example, social issues were matters of the traditional system, a social institution of extended family members and traditional authorities. The introduction of Christianity, urbanisation and globalisation has contributed to extensive alterations in the traditional social systems and order. Traditional helping processes were affected as people moved to urban centres and life became individualistic as opposed to communal. Due to the spread of Christianity, some traditional ways of managing

diseases have been relegated as evil. Instead of strengthening the traditional support system, colonial powers introduced Western social work to solve the problems which they had created (Avendal, 2011). African traditional religion and other forms of Indigenous Knowledge Systems (IKS) have not been spared by this hegemony. Major ways of knowing and ways of understanding in Africa became shaped by Western philosophy.

The ability to see from several angles is a common weakness of Eurocentric scholarship. Before renaissance, African indigenous knowledge systems and other human civilisations that were condemned as backward and relegated as irrational were and are still viable for human utilisation (Viriri & Mungwini, 2010). Much of what constitutes Africa, both metaphysically and epistemologically, is to a large extent, a product of Eurocentric hegemony.

Before the coming of the whites, Africans were not devoid of spiritual resources. Traditional African societies believed in a higher power. According to Asante (1990), Afrocentricity seeks to convey the need for African people to be relocated historically, economically, socially, politically and philosophically. Asante (2003) argues that “Afrocentricity as a theory of change intends to relocate African people as subjects thus destroying the notion of being objects in the Western project of domination”. Schiele (1996) propounds that, Afrocentricity has three objectives: it seeks to promote an alternative social science paradigm which is more reflective of the cultural and political reality of African people; it seeks to dispel the negative distortions about people of African ancestry by legitimising and disseminating a world-view that goes back thousands of years and that exists in the hearts and minds of people of African descent;

lastly, it seeks to promote a world-view that will facilitate human and societal transformation towards spiritual, moral and humanistic ends and that will provide people of various cultural and ethnic groups with a common understanding.

Afrocentrism acknowledges and underscores the importance of spirituality and non-material aspects of people of African origin. According to Ince (2009), Afrocentricity is based on a unique understanding of African philosophy that concentrates on classical African civilisations as a starting point of any conceptualisation of African people and their history.

Afrocentrism is opposed to theories that dislocate Africans to the periphery of human thought and experience. Afrocentrists believe that Eurocentricity has become an ethnocentric view which elevates the European experience and downgrades all other experiences. According to Asante (2003) “Afrocentricity is not the reverse of Eurocentricity but a particular perspective for analysis which does not seek to occupy all space and time as Eurocentricity has often done”. Afrocentricity aims to see all cultural centres respected.

Given the Afrocentric philosophy, it is necessary to examine all data from the standpoint of Africans as subjects and human agents rather than as objects in the European frame of reference (Asante, 2003). According to Asante (2003), Afrocentricity is not colour-conscious, it is not colour that matters but culture. Colonialism rendered Africans an epitome of barbarism, morons, primitives and sexual perverts among other binary oppositions (Viriri & Mungwini, 2010). It seemed as if whites discovered/ invented Africa against Africans themselves. Africa was forced to imbibe and accept values and cultures of her colonisers. Political subjugation traumatised Africans that many of them lost

confidence in and looked down upon their culture. Western thought dominated by Christianity created hierarchical structure of world religions implying that certain religions were inferior to others. This forced most of them to view and embrace Christianity and Islam as a progressive though they did not completely lose their old cosmology or basic beliefs. As a result of colonialism, Africans have been victimised by cultural denigration which has been manifested in all areas of life which include religion and spirituality (Schiele, 1996).

Afrocentricity opens avenues for understanding the contributions that Africans have made to the world history and to the development of knowledge. One importance of Afrocentrism is that it serves as an alternative approach to understanding and analysing African communities. Asante (2006) argues that many African-American scholars are victims of the hegemonic influences of their teachers and are caught in a stifling bind.

2.2.2 Afrocentrism and Indigenous Belief Systems

An essential element of Afrocentrism is that it recognises the centrality of spirituality in the lives of African people. All aspects, whether animate or inanimate, are considered to be interwoven. In a typical African society, the neediest members of the group are given support through spiritual bonding. The spiritual bonding among Africans predisposes them to helping one another. The individual is thus not complete without others.

There is a need for an African understanding of religion and an understanding of African religion (Awolalu, 1976). Figl (2003) contends that the term religion is Eurocentric and consequently, scholars have a tendency to westernise African religion and spirituality. In African religion, people frequently consult ancestors for advice on daily decisions. This

sense of dependence provides people with comfort and security (Chavunduka, 2001). This advice from ancestors helps people cope with the struggles and stresses in their lives.

Unlike other religions, ATR has no founders or reformers or missionaries who try to propagate it. According to Awolalu (1976:2) it seems as if there were theorists who had never been to Africa but who regarded it as a dark continent where people had no idea of God and where the devil is in his abysmal, grotesque self-dwelt. Before Africans could read and write, there was a “period of ignorance and false certainty” in the study of ATR (Awolalu, 1976). Some scholars and Christian proselytes doubted whether or not the God worshipped in ATR is a real God.

2.2.3 Weakness of Afrocentricity in Academic Discourse Analysis

Afrocentricity is criticised on the grounds that it does not allow for cultural change. Critics of the theory argue that being African today also means being partly European as a result of colonisation and globalisation. Afrocentrism has also been blamed as reverse Eurocentrism. Asante (1988; 1990) argues that Afrocentrism seeks to replace one geopolitical hegemonic centre, which is Europe, with another hegemonic centre, which is Africa. However, Afrocentrism is non-hegemonic and welcomes the existence of a multiplicity of cultural centres. Reinhardt (2011:86) criticises Afrocentrism as a “bad” science, pseudo-science, a parody of science that qualifies as something like science only by a series of institutional framework conditions and formal compliance. Despite its criticisms, Afrocentricity’s growing influence in social work is undeniable (Graham, 1999; Pellebon, 2007). According to Reinhardt (2011), if one criticises Afrocentricity one runs the risk of being labelled racist on the one hand while on the other hand silence means

conceding to the dictates of Afrocentrists. Some critics argue that Afrocentrism tends to make the African centre absolute in that it privileges it over other centres. However, Asante (1990) asserts that the theoretical draft acknowledges centric pluralisms without hierarchy and without seeking hegemony. Proponents of Afrocentrism, however, argue that equal to Afrocentric perspective on the world view are Asiocentric, Americocentric and Eurocentric perspectives. One centrality should, therefore, recognise other centralities. Afrocentricity has been criticised for failure to apply empirical methods to examine its central constructs.

2.2.4 Afrocentric Social Work

Schiele (1997) defines Afrocentric social work as a method of social work practice which is based on traditional African philosophical assumptions that are used to explain and solve human societal problems. Afrocentricity is described as both a social work theory and a perspective though it is popularly used among African- American clients. The primary objective of Afrocentricity is to liberate the research and study of African people from the hegemony of Eurocentric scholarship. According to Williams (1993:2), “an Afrocentric perspective is congruent with the values and ethics promulgated by the social work profession: the right to self-determination; the emphasis on strengths rather than weaknesses; and the appreciation and value of all human experiences”. Schiele (1997) identifies three fundamental assumptions of Afrocentric social work: individual identity is hinged on a collective identity; the spiritual aspect of human is as legitimate as the material aspect; and that the effective approach to knowledge is epistemologically valid. It is implied, in Afrocentric social work, that one cannot affect

one member of the society without affecting others. In Africa, there is no clear separation between an individual and others (*Ubuntu*).

Afrocentric social work believes that if there is more emphasis on spiritual development, there will be less social problems and human misery. Afrocentric social work acknowledges the linear materialistic understanding of reality and also draws heavily on the affective and holistic means of knowing and understanding the world. Afrocentrists do not believe in social science universalism. Ethical social workers use the most current and verifiable knowledge base, resources and skills for competent practice. Afrocentricity has been used as a perspective in social work practice with African-American clients (Graham, 2006; 2007; Miley, O'Melia & DuBois, 2007). Pellebon (2007), writing in the context of America, argues that a non-Afrocentrist, regardless of race or scholarship, is incapable of developing knowledge that accurately represents the African experiences of self-determination.

According to Ross (2010), Afrocentric social work's educational curricula should be respectful and appreciative of African worldviews even if this runs counter to the social workers' value systems. She went on to indicate that the educational curricula should expose students to traditional healers and leaders so that graduates may work in unison with them and include them in their referral systems. African languages are very critical in Afrocentric social work. Thabede (2005) argues that it is important for social workers to be able to communicate through at least one African language. They are supposed to understand its proverbs, idioms and avoidance of taboo topics.

Indigenous theories of help-seeking should be acknowledged in Afrocentric social work. These include family members, the community, traditional leaders and neighbours.

Central to African life is the concept of *Ubuntu* (living through others). Social workers should thus understand traditional social safety nets (Ross, 2010). In Afrocentric social work, social research should also focus on traditional cultural practices. Afrocentric social workers are also encouraged to familiarise themselves with the material cultures of African communities (Thabede, 2005). These include clothing, shelter and food, among other things. Beliefs central to African life should also be recognised. These include the belief in witchcraft, ancestors and the Supreme Being. Social workers should also understand traditional cultural rituals such as circumcision and passage rituals. Afrocentricity will continue to evolve as more information on African people comes to light and as greater demands are placed on African people (Bangura, 2012). Afrocentrists seek advocacy agency in every given place where examination, critique or analysis of African people happens (Asante, 2014).

2.3 STRENGTHS PERSPECTIVE

Traditional methods of social work concentrate on deficit-based approaches by ignoring the strengths and experiences of clients. The underpinning assumption in these theories is that social workers are experts who are to give prescriptions to clients without much of their (clients') participation. In contrast, the strengths perspective gives social work a new twist. In 1989 Weick, Rapp, Sullivan and Kishardt coined the term strengths perspective. The strength perspective is very significant in social work and it was fully developed as a social work theory by Saleebey in 1992 (Saleebey, 2008). According to Goodluck (2002), the strengths perspective is an approach, concept and perspective which has emanated from the understanding that focusing on the problem limits practitioners' ability to see other possibilities for their clients. The strengths perspective

is thus opposed to the deficit/problem-solving model. It tells a much wider story about what people are doing to make things happen and succeed despite the odds, rather than letting things happen as passive by-standers in their own lives. Much of the available literature on the strengths perspective comes from social work and psychology. According to Guo and Tsui (2010), generalist strengths-based practice in social work originated in response to criticisms of the mainstream disease-based psychotherapeutic model and it is based on ecosystem and empowerment theories. The strengths perspective represents a paradigm shift from the problem-based approach. The strengths perspective recognises that for most part of life, people face adversity, become resilient and resourceful and learn new strategies to overcome adversity.

According to Rankin (2006), the strengths perspective constitutes a fascinating and refreshing way to look at clients and their circumstances and is characterised by positive and optimistic view of people confronted with challenges of life. This perspective aligns with building resilience of service users and their families. This perspective requires that individuals, families and communities be seen in the light of their talents, competences, possibilities, visions, values and hope. It requires an accounting of what people know and what they can do. The social worker involved should compile an inventory of resources existing with and around an individual, family or community. The strengths perspective is an ecological perspective that recognises the importance of people's environments and the multiple contexts that influence their lives (Scerra, 2011).

Coping behaviours such as prayer, meditation and spirituality are recognised as important assets in times of the adversities of life. It is also important to recognise that

strengths are culturally defined and strength in one culture may not be strength in another culture (Goodluck, 2002).

According to Grant and Cadell (2009), this perspective recognises the resilience of individuals and focuses on the potentials, strengths, interests, abilities, knowledge and capacities of individuals rather than their limits. Strengths-based perspective rose to prominence as an alternative to the conventional psychoanalytical social work which focused on the deficiencies of social work clientele. Norman (2000) argues that this perspective has changed focus from personal defects to the discovery of strengths, identification of risk factors and protective factors. Strengths-based approach is based on empowerment and ecosystem theories. It holds that all service users have got their strengths (Guo & Tsui, 2010). According to Guo and Tsui (2010), it does not label service users as dysfunctional, defective or ill while at the same time it differs from the empowerment model in that it does not view clients as powerless. The strengths perspective involves systematically examining clients' survival skills, abilities, knowledge, resources and desires that are necessary in the helping process. Central in to the strengths perspective are the assumptions that individuals have the capacity to grow and change, are resilient and possess knowledge about themselves. The strengths perspective assumes that individuals are responsible members in a viable group or community and are experts in their own lives (Nissen, 1998).

Central to the strength perspective are the concepts of strengths, empowerment and resilience, membership, healing and wholeness, dialogue and collaboration (Saleebey, 2001; Rankin, 2006). The social worker who uses this approach should respect client's strengths, engage client motivation, collaborate with the client in therapeutic work and

avoid the victim mind-set. This perspective is based on the premise that all human beings have strengths, capacities and resources. People usually demonstrate resilience rather than pathology in the face of adversity. Healy (2005) identifies five principles of the strength perspective and these are adopting an optimistic mind-set, focusing on client's assets, collaborating with clients, working towards the empowerment of clients and creating a community. Social workers should believe in the strengths of the individual, family or community to take power and responsibility. Social workers who subscribe to the strength perspective resist paternalistic ways of interacting with clients and provide for patients to pursue their agenda as they define it.

The strength perspective also provides that though illness can be harmful, it can also be a source of challenge and opportunity. Redko, Rapp, Elms, Snyder and Carlson (2007) argue that, throughout life, people learn through adversity and challenges and can produce skills and emotional assets that enable them to survive through hardships.

Another concept similar to the strengths perspective is the Interpretive Anthropological Framework (IAF) designed by Hodge 2001. It was designed to understand the personal subjective reality of spirituality in clients' lives and it advocates that:

- an individual's relationship with the Ultimate is a key strength which facilitates coping, defeating loneliness, promoting a sense of mission and purpose, instilling a sense of personal worth and value, and providing hope for the future.
- rituals, inherent in every spiritual tradition have been widely associated with positive outcomes and can serve to ease anxiety and dread, alleviate isolation, promote a sense of security and a sense of being loved and appreciated.

- participation in faith-based communities is also a significant strength which has been associated with increased empowerment, realisation of personal strengths, coping ability, self-confidence, lovability and a sense of belonging.

The strengths perspective is not natural to the world of helping and service (Graybeal, 2001). According to Laursen (2000), rather than focusing on individual and family weaknesses or deficits, the strengths-based social worker collaborates with clients to discover individual and family functioning and strengths. The underlying principle of the strengths perspective is the belief that clients have unique talents, skills and life events in addition to specific unmet needs.

The strengths perspective has the following assumptions:

- people have many strengths and have the capacity to continue to learn , grow and change,
- focus of intervention is on the strengths and aspirations of the client,
- social environment is seen as full of resources,
- service provider collaborates with clients,
- interventions are based on the client's self-determination,
- there is a commitment to empowerment,
- problems are seen as the interaction between individuals, organisations or structure rather than deficits within individuals, organisations or structures.

(Miley, O'Melia & DuBois, 2011; Hammond, 2010).

The strengths perspective is a philosophy and a practice model generated within the field of social work. It is an alternative to viewing clients as pathology units. According to Nissen (1998), one model gaining popularity in the strengths perspective is the Asset

model which focuses on external and internal characteristics of a client that serve as protective factors in adversity. The strengths perspective is against programme models that do not include a search and the role for strengths of the clients.

2.3.1 Strengths-based Practice in Social Work

The strengths perspective emanates from social work values of client's self-determination, empowerment, and inherent worth and dignity. The strengths approach involves systematically examining the client's survival skills, abilities, knowledge, resources and desires that can help in meeting the client's goals. The major focus in strengths-based social work is the collaboration and partnership between the client and the social worker (Rangan & Sekar, 2006). Social workers should enhance the strengths of service users as these have been found to make them resilient in periods of adversity. "The strengths-based approach transforms the professional relationship of social workers and service users from an unequal dyad to an equal collaborative partnership for problem solving" (Guo & Tsui, 2010:237). The strengths-based approach enables social workers to approach clients with a positive attitude. The belief in strengths-based perspective is that without collaboration, it will be difficult to understand all the aspects of the client and his/her family.

2.3.2 Basic Assumptions of Strengths-based Social Work

The following are lexicons of strengths perspective as presented by Saleebey (1992) and (Pulla, 2012).

Capacity for growth and change: The strengths perspective believes that people have the capacity to grow and change.

Knowledge about one's situation: The approach assumes that people have knowledge that is important in defining their situations.

Resilience: According to the strengths perspective, people are resilient. In the context of the strengths perspective, resilience is seen as the opportunity and capacity for individuals to navigate their way through challenging circumstances by means of psychological, social, cultural and physical resources that may help them overcome those trying circumstances and provide them with an opportunity and capacity, individually, and collectively, to meaningfully negotiate life following that adversity:

Membership: The strengths perspective believes that people need to be citizens. In other words, they should be responsible and valued members in a viable group or community

Strengths and interventions: Individuals are experts in their lives and are doing something to better their situations.

The strengths perspective compels social workers to understand and believe that everybody has internal and external assets, competencies and resources. According to Saleebey (2000:127), "we are called to venerate the remarkable abundance of human experience, to acknowledge that every individual, family or community has an array of capacities and skills, talents, gifts, wishes and wisdom that in the end are the bricks and mortar of change". The strengths perspective believes that everyone who struggles learns from the struggle and develops capacities and traits that act as resources in moving forward in life. It holds that people have dreams, hopes and visions though they may be wedged in disease, oppression, poverty and misfortune. Central to the strengths

perspective is the concept of empowerment. A professional utilising the strengths perspective should help individuals, families and communities see and utilise their capacities, see options open to them, understand the barriers they face and improve their quality of life. Social workers are encouraged to collaborate with clients to move clients to their visions and aspirations.

According to Saleeby (2006:10), the strengths perspective is made up of three elements which can be summarised with the acronym CPR.

C- capacities, competence and character

P- promise and possibility

R- resources, resilience and reserves.

According to Saleeby (2000), social workers utilising the strengths perspective should believe the client and believe in the client. They are encouraged to believe the stories brought by clients and should engage them in practice. They are also encouraged to affirm and show interest in the clients' view of things. They should further seriously take the narratives and stories brought by clients to them. These narratives assist in discovering who the client is and the virtues they possess. A social worker utilising the strengths perspective should focus on the dreams, hopes and visions of the clients. They should also make an accounting of the assets, resources, reserves and capacities within the client and the environment. Social workers should believe that there are forces for healing, self-righting and wisdom within or around the person or family. They should, therefore, search for these and employ them in the service of achieving goals on the path to the client's dream. The strengths perspective believes that people's

strengths make them resilient in periods of adversity. According to Guo and Tsui (2010), the new attitude represented by strengths-based practice was welcomed by powerless people in disadvantaged situations such as new immigrants, low income groups and patients with chronic illnesses. The strengths-based model does not label service users as dysfunctional, defective or ill. Programmes that enhance resilience are applied to strengthen strengths-based practice.

However, it is important to note that scholars do not agree with what constitutes a strength. Certain scholars such as Goodluck (2002) mention that the strengths perspective is not yet a theory in social sciences though others such as Waller (2001) recognise it as a theory.

2.4 RESILIENCE THEORY

Resilience is a complicated term used in many areas such as ecology, engineering, psychology and development studies. The concept of resilience originated in the late nineteen seventies as shown by the works of psychiatrists such as Garmezy (1983). Proponents of resilience studies were puzzled by some children raised in conditions of high adversity yet they were coping better than those who were raised under favourable conditions. According to Glover (2009), the concept of resilience dates back to the Second World War when clinicians noted that some evacuated children appeared to suffer more psychological damage than those who stayed at home to face some bombings. Barker (2003:369) defines resilience as a human capacity (individual, group and/or community) to deal with crisis, stressors, and normal experiences in an emotionally and physically healthy way; an effective coping style. Resilience can also be seen as the ability to bounce back from some form of disruption. Windle (1999) defines

resilience as a successful adaptation to life task in the face of social disadvantage or highly adverse conditions. Resilience is a two-dimensional process concerning the exposure to adversity and the positive adjustment outcomes of that adversity. This implies that there should be an impact of a risk factor and the ability of an individual to adapt.

According to Daniel (2011) resilience theory was coined by Holling in 1973 where he denoted that it determines the persistence of relationships within a system and is a measure of the ability of these systems to absorb changes of state variable, driving variables and parameters and still persist. Resilience theory as purported by Gunderson, Holling, Pritchard and Peterson (2002) has its foundation in systems thinking, including complex systems theory, and is essentially about understanding the characteristics of change and the interactions between human and natural systems. Gunderson *et al* (2002) further asserts that, resilience theory aims to understand three fundamental themes. The first considers the characteristics of stability, resilience, and change from one state to another in systems with multiple stable states. The second is cross-scale interactions and the third is one of adaptive change and learning using the heuristic model or metaphor of the adaptive cycle.

Resilience is contextual in many ways as well and must be understood as multi-dimensional and varies across time and circumstances. There are three factors which affect resilience: factors internal to an individual, environmental factors, and a product of the interaction between the person and the environment (Tousignant & Sioui, 2009). Factors internal to the person include internal locus of control, perseverance, emotion

management, optimism, sense of humour, self-efficacy and the ability to solve problems. According to Tousignant and Sioui (2009), individual factors that affect resilience include genes, personality traits and intelligence.

Environmental factors such as the family, peers, religion, the community and social support heavily influence a person's resilience. Resilience is a long process of interaction between a person and his environment, to face adversity and lead to emergence of moral strengths and a sense of optimism (Tousignant & Sioui, 2009). Pienaar (2012) argues that resilience can be seen as having four main determinants: external realities that function as stressors and challenges and which initiate risk and resilience process, external supports that promote resilience, inner strengths that develop over time, interpersonal problem solving skills.

Critical in the study of resilience is the concept of community resilience. The term is used interchangeably with the term cultural resilience. Resilience goes beyond an individual hence the use of the terms family resilience, community resilience and regional resilience. Since life in traditional African societies is communal, it may be necessary to define community resilience. Healy (2006) defines community or cultural resilience as the capacity of a distinct community or cultural system to absorb disturbances and reorganise while undergoing change so as to retain key elements of structure and identity that preserve its distinctiveness. Community resilience may also be defined as "the ongoing and developing capacity of a community to account for its vulnerabilities and develop capabilities that aid that community in (1) preventing , mitigating and withstanding the stress of a health incident (2) recovering in a way that restores the community to a state of self- sufficiency and at least the same level of

health and social functioning after a health incident and (3) using knowledge from a past response to strengthen the community's ability to withstand the next health incident". (Chandra, Acosta, Stern, Uscher-Pines, Williams, Yueng, Garnett & Meredith, 2011:XV).

2.4.1 Resilience in Social Work

The concept of resilience has developed roots in social work although social work research related to it is relatively new. There is a growing interest in recognising spirituality as a source of strength and resilience in social work practice. In a study of African American women in Kansas in the USA, Banerjee and Pyles (2004) found that the women reported that their spirituality helps them manage their difficult situations by reassuring them that their higher power is looking after them. They also argued that spirituality helps to lessen the impact of problems on them, find inner peace, build self-esteem. It also helps to nurture hope despite the challenges of life.

There are many ways in which people's resilience is manifested (Rubin, Malkinson & Witztum, 2012). Resilience may result in an individual bouncing back to a previous normal functioning or not showing any negative effect. Resilience is a process and not a trait. This suggests that people are not born resilient but their resilience develops as they interact with the environment. Agents of socialisation such as the family, the school and the community also promote resilience. According to Pienaar (2012), promoting resilience is critical as it contributes to prevention of negative outcomes for people challenged by stressors such as those posed by HIV and AIDS.

The American Psychological Association (APA) suggests the following ten ways to build resilience:

- maintaining good relationship with close family members, friends and others,
- avoiding seeing crisis and stressful events as unbearable problems,
- accepting circumstances that cannot be changed,
- developing realistic goals and moving towards them,
- taking decisive actions in adverse situations,
- looking for opportunities of self-discovery after a struggle with loss,
- developing self-confidence,
- keeping a long term perspective and considering stressful events in a broader context,
- maintaining a hopeful outlook, expecting good things and visualising what is wished,
- taking care of one's mind, body, exercising regularly and paying attention to one's own needs and feelings.

Resilience is affected by the strength of an individual, their family, community and the culture in which they live. Closely linked to resilience are resilience factors. Those factors are things within a person's environment that assist in developing self-confidence and resilience. These resilience factors provide a cushion or protection against negative and harmful influences (Pienaar, 2012).

2.4.2. Religion and Spirituality as Sources of Resilience

Spirituality is regarded as a source of resilience (Wong & Vinsky, 2008; Cascio, 2012). According to Martin and Martin (2002), spirituality can give people strength to go where there is a threat and it also gives courage and encouragement amidst suffering and

death. Religion can provide a world-view that helps give purpose and meaning to suffering.

Crawford, Brown and Bonham (2006) note that spirituality facilitates resilience in four major ways: by helping build attachment relationships, by opening access to social support, by guiding conduct and moral values and by offering opportunities for personal growth and development. An inverse relationship exists between spirituality and depression among youths. Apart from improving resilience, spirituality has also been found to improve self-confidence and life purpose among youths in stressful situations. Writing in the context of America, Corrigan, McCorkle, Schell and Kidder (2003) argue that research has it that those members of the general population who define themselves as religious and spiritual have less psychological distress, more life satisfaction and greater achievements of life goals.

2.5 JUSTIFICATION OF THEORETICAL FRAMEWORK

Using three theories in a particular study requires validation for their role and consequently, for their relationship. The three theories play a critical complimentary role in this study. Afrocentricity recognises connectedness of the mind, body and spirit and the central importance of spirituality in human life. Healing has been practised in Africa for many decades before imperialism and colonisation (Morekwa, 2004). Afrocentricity seeks to elevate all discourse on African people trans-generationally and trans-continentially from the lowlands of European victimisation and objectification (Asante, 2014).

In traditional African societies, it is believed that when a person is ill, his spirit is affected too. Many African people understand healing to be part of their religion, culture and tradition (Morekwa, 2004). Religion governs the life of a human being. Most Africans believe that healing without the intervention of the Supreme Being is not effective (Morekwa, 2004). *Mwari* (Supreme Being) is an essential element who cannot be overlooked. The *vadzimu* (ancestors) play a critical role in protecting living members from bad spells such as chronic illnesses as well as in the healing processes of those with illness. Morekwa (2004) argues that in African life, there is no barrier between the realm of man (physical, social, cultural, amongst others) and the spirit realm. The spirit realm is part of the existence of man. Africans understand illness as an imbalance between the human world and the spirit world. Ancestors play a critical role in the healing process. Some practitioners are believed to tap into the spirit world during healing processes through a process of spirit possession (see chapter 4).

Strengths-based practitioners are encouraged to look for family traditions, rituals, spiritual and world-views that provide clues about the essential holistic quality of being. Spirituality is an important identifiable individual and family strength. People need to develop inner strength in order to survive. Justification for Afrocentric social work is founded on indigenous African beliefs and practices. Of interest is that despite the changes taking place in many developed countries, in some developing countries social work practice, is slow and sometimes resistant to keep abreast with world trends of embracing Afrocentric world-view in various intervention modalities. Prior to the coming of the white people in the African continent, indigenous African people had their own

way of worshipping God which had assumed the umbrella name African Traditional Religion.

Resilience theory has been included as religion and spirituality have been found to be sources of resilience during life's adverse moments (Crawford *et al*, 2006; Wong & Vinsky, 2008; Cascio, 2012). Life in Africa is very communal and the concept of community resilience necessitated the use of this theory. Africans lean on their religion, the family and the community when they are faced with challenges. Since its inception in the 1970s, the concept of resilience has informed social work practice with various client groups. The resilience theory is closely knitted with the strengths perspective in that most people's strengths are sources of resilience. The strengths perspective also recognises that people are resilient.

2.6 SUMMARY

The contemporary study is informed by three theories namely Afrocentric theory, strengths perspective and the resilience theory. Afrocentrism, founded by Molefe Kete Asante, advocates that African issues should be interpreted from an African perspective. Afrocentrism is a mode of thought and action in which the centrality of African interest, values and perspective. As a theoretical framework Afrocentricity provides a platform for interpreting characteristics of African life from an African perspective. Afrocentric theory is opposed to Eurocentric hegemony of African thought. Life in Africa is centred around religion and traditional religions still play an important role to this day. Afrocentrism recognises the centrality of spirituality in the lives of its people. However Afrocentrism has been criticised for maintaining rigidity and for privileging the African centre over other centres.

The strengths perspective focuses on people's strengths wherein religion and spirituality can be sources of such strengths that people may resort to in times of adversity. This perspective values what people are doing to make things happen and succeed despite life odds. The strengths based theory recognises that rituals inherent in every spiritual tradition have been widely associated with positive outcomes. Participation in religious organisations acts as a significant strength which has been associated with increased empowerment, realisation of personal strength, coping ability and self-confidence. African traditional religion may thus have assets and resources that may be used in difficult times.

Resilience which refers to the capacity of an individual to persist amid challenges has developed roots in social work. The resilience theory seeks to understand how individuals navigate through social and environmental challenges. Environmental factors that promote resilience include the family, religion, cultural practices and many others. In times of adversity, people have been reported to lean on their religion for strengths hence the suitability of the resilience theory in the current study.

The three theories are intertwined in that there are many aspects of African traditional religion promoted by the Afrocentric perspective that act as strengths and sources of resilience among aboriginals. These theories were found to be relevant in that they have been evaluated in relation to their ability to inform a study which looks into the interface between African traditional religion, spirituality and chronic illnesses from a social work perspective.

CHAPTER THREE

INTERFACING RELIGION, SPIRITUALITY AND SOCIAL WORK

3.1 INTRODUCTION

The human tendency to have beliefs, religions and rituals is among the earliest and most powerful features associated with human civilisation and culture (Rubin, Malkinson & Witztum, 2012). This chapter reviews related literature that interfaces religion, spirituality and social work. It traces the historical roots of social work, makes an argument for the importance of religion and spirituality in social work education and practice. It also examines the concepts of resilience and religious coping. It ends by looking at social work education and practice, making an argument that inclusion of traditional belief systems may be one of the methods of strengthening and indigenising social work in Africa.

3.2 CONCEPTUALISING RELIGION AND SPIRITUALITY

Though authorities do not agree on the definitions and dissimilarities of religion and spirituality, this chapter explores at the origins of these two concepts in an endeavour to shed more light on them. This is against the backdrop of the struggle by social work academics to generate acceptable definitions of the two concepts. Though there is debate over the definitions of religion and spirituality, social workers recognise that building on the spiritual strength of the client may enable the clients to improve their coping skills (Heyman, Buchanan, Marlowe & Sealy, 2006). Even if the terms religion and spirituality are often confused and sometimes used interchangeably, a number of

scholars have tried to distinguish between the two. The word religion comes from a Latin word *religio*, which means a bond between humanity and a power greater than human beings (Hill, Pargament, Hood, McCullough, Swyer, Larson & Zinnauer, 2000). The word spirituality also comes from a Latin word *spiritus* which means the breath of life (Hill *et al*, 2000; Rubin, Malkinson, & Witztum, 2012). Lembke (2012:17) also distinguishes between the two concepts by arguing that spirituality consists of a larger sense of being, and loose and informed relationship with the unnamed, while religion is a more formalised set of practices by a community of people who have shared beliefs about a specific being or entity. On another note, religion may be seen as something implying membership to a spiritual organisation with customs, traditions and structure (Kirst-Ashman, 2007). Spirituality encompasses phenomena that cannot be captured in the definition of religion (Gegde & Querney, 2014).

The ability to conceptualise and describe spirituality is limited by language (Lindsay, 2002). Issues of spirituality have widened to include a variety of philosophies of meaning that are not associated with religion *per se* but have included personalised and organised belief systems of incredible variety and degrees of articulation and inarticulation (Rubin *et al*, 2012). Hodge (2001) argues that spirituality is conceptualised as an individual's existential relationship with a perceived transcendence while religion refers to a particular set of beliefs, forms and practices that have been developed by people who share similar experiences of transcendent reality.

Religion and spirituality are strongly based on a personal quest for understanding of questions about life and meaning (Peres, 2007). Most definitions of spirituality encompass the meaning of life, the integration of ultimate values and connectedness

with the transcendent (Gedge & Querney, 2014). According to Kimball (2008), spirituality is a dimension of human experience different from and more expansive than religion and religious observance. Spirituality involves centrally important life orienting beliefs, values and practices that may be expressed in religious and non-religious ways (Canda, 2010). Spirituality may be considered private or it might be shared with others. According to Nash and Stewart, (2005), spirituality is not separate from the material world and is not about personal relationships with a divine presence. It is an aspect embedded within community and people's relationship with all things (Nash & Stewart, 2005). Rice (2002) suggests that making a distinction between religion and spirituality can be distorted and can lead to confusion over meaning. Cheon (2010) argues that the definition of spirituality differs from person to person and across ethnic, gender, class, generational and cultural lines. He further argues that not all people express their spirituality through religion.

British Humanistic Association (2005:2), a principal organisation representing the interests of non-religious people in Britain, postulates that "... there is nothing shameful about spirituality, but nobody has a monopoly on it. We should not allow the term to be kidnapped for the churches and mosques and confined for the use of their clients...."

Spirituality can thus be understood in two main ways; secular and religious (Nash & Stewart, 2005). Cheon (2010) notes that spirituality is not limited to a set of beliefs but the spiritual lives within a person's heart as it is based on foundations of experiences.

"Professional definitions are primarily for professional discourse. They provide a common provisional set of terms and meaning so that we can interact with each other and our clients around the topic of spirituality" (Canda, 2010:5). Religion can be small

scale, relatively informal and very flexible as is common with most traditional religions (Canda, 2010). As Derezotes (2006) notes, the trend for proponents of spirituality to criticise religion and the trend for proponents of religion to criticise spirituality is unhelpful for social workers who must find ways of working across both spirituality and religious diversities. Cheon (2010) posits that religion and spirituality overlap in that both are concerned with the search for meaning. He further mentions that spirituality is expressed in religious forms in many people. He, however, notes that spirituality is broader than religion.

Numerous scales have been developed to measure religion and spirituality. These include among others; the Spiritual Well-Being Scale, Treatment Spirituality/Religiosity Scale, Spiritual Orientation Index, Expression of Spirituality Inventory and the Multidimensional Inventory for Religious/Spiritual Well-Being.

3.3 RELIGIOUS AND SPIRITUAL ROOTS OF SOCIAL WORK

There is a natural integration between religion, spirituality and social work. Social work is historically and philosophically linked to spirituality. The custom of the church strongly teaches that people should care for one another while at the same time social work advocates for the development of the welfare of disadvantaged people in societies. According to Canda (1997), a spiritually sensitive social worker is socially active and lives and acts in harmony with the processes of social change. Eliminating spirituality from social work leaves clients wedged between secular and spiritual outlooks, a dichotomy that stems from the mental health field's attempt to gain legitimacy by allying itself with science (Gotterer, 2001). Spirituality offers social workers skills on a personal

and community level that encourage social and personal transformations. Asher (2001) contends that once social workers begin to consider the role of spirituality and religion in the lives of their profession's beneficiaries, they will begin to have insights into how they can intervene more effectively.

Despite how secular social work practice may try to be, religion and spirituality cannot simply be ignored in social work practice. Social workers should be prepared to identify and address ethical dilemmas resulting from the relationship between their professional and spiritual values (Neagoe, 2013). For many years, social work has been secular and the belief was that religion and spirituality have nothing to offer was dominant. There is, however, a global resurgence of professional interest in religion and spirituality in social work today. According to Spano and Koenig (2007), there has been suspicion and even hostility towards social workers who attempted to incorporate a religious dimension in their practice. Religion and spirituality, which had previously been relegated to the realms of values and private life, have started to regain some of their lost ground in the public and professional spheres (Neagoe, 2013).

The increased number of publications which show the relationship between religion, spirituality and social work indicates that religion and spirituality have made themselves known to social work. Various professional associations in the field of social work have started to produce materials which are designed to assist practitioners in dealing with spiritual matters. Most accepted values of the social work profession may be said to have a corresponding value in the area of Christian ethics. According to Zastrow (1999:317), "social work has its historical roots in religious organisations, social work originated under the inspirations of the Judeo-Christian religious tradition....." This view

is supported by Day (2009) and Dwyer (2010) who note that social work's core values are consistent with Judeo-Christian values. According to Day (2009), social work emerged at the end of the 19th century from religious charity activities. Though social work has spiritual and religious roots, it has drifted away from its religious foundation at some point. Canda (1990) purports that the urge to professionalise and compete with other helping professions led social work away from its spiritual foundation.

According to Martin (2003), the origins of social work can be traced back to the nineteenth century in Britain with the establishment of Charity Society Organisations (CSO). The CSOs reflected religious values and the concept of charity (Lindsay, 2002). The earliest form of welfare for the poor and disadvantaged in American societies was a provision of charity by members of local communities who were primarily organised by religious leaders of local congregations. This relationship, between religion and social work, has also been noted in developing countries. For example, Mugumbate and Chigondo (2013) writing in the context of Zimbabwe note that the link between social work and churches is in the value of helping the poor and those in distress to overcome their challenges.

The spiritual component of social work is evident when one looks at humanity, love and compassionate aspects of the social work profession. Holistic practice in social work has also been found to necessitate the marriage of spirituality and social work. Ife (2002) contends that holistic practice views individuals, families and communities as a complex whole rather than separate disaggregates. Spirituality may have or may not have a sense of community. Catholic spirituality tends to be group-centered while protestant spirituality leans toward individual pietism (Gumz, Wall & Grossman, 2003).

Neagoe (2013) juxtaposes social work principles and Christian values as shown in Table 1 below.

Table 1: Relationship between social work values and Christian values

Social Work Values and Principles	Christian Values	Bible verses to support the Christian values
Human dignity and worth	Creation of human beings after God's own image	Genesis 1:26
Social justice	Jesus' acceptance of the socially excluded	Micah 6:8, Mark 2: 15-17
Service	Serving others despite one's superiority	Matthew 20: 26-28
Integrity	Holiness	1 Peter 1 : 15-17
Competence	Serving God and people within the limits of one's self	Matthew 25: 14-30, Corinthians 12

Data source Neagoe (2013).

Relating social work values to Christian values supported by a Bible verse strengthens the argument that Christianity has played a critical role in the formation of the social work profession. Canda and Furnam (1999) contend that there are spiritual elements embedded in social work values and practice. The inspiration to help others seems to have thus developed as part of religion. The influence of religion on social work has been uneven. Greater appreciation of diversity in religious matters has served as an additional stimulus for practitioners to listen to matters of the spirit in discussions with their clients (Canda, 2005).

According to Canda (1997), spirituality involves understanding the connected aspects of all people. Compassionate helping is a natural way of life and a human birth-right. The renewed interest in spirituality suggests that social work may be rediscovering its soul

(Canda, 1997). Spirituality inspires a sense of mutual responsibility. Canda (1997) also argues that a spiritually sensitive social worker is in harmony with many stages and types of change in human life and cannot be confused by conflicting ideas. “Spiritual sensitivity fosters an ethic of mutual benefit and social justice rather than selfish one sided gain” (Canda, 1997:2).

3.4 INTEGRATION OF RELIGION, SPIRITUALITY AND SOCIAL WORK

The inclusion of religion and spirituality in social work is heavily debated (Wilkinson, 2012). Galanter, Dermatis, Talbort, McMahon and Alexander (2011) aver that spirituality is a vague construct that is not amenable to empirically oriented research and as a result, some practitioners are reluctant to use it. The inclusion of spirituality in social work practice has sometimes been neglected due to its relationship with religious organisations. This position is supported by Kimball (2008:3) who states that “for too long, spiritual development has been conflated with religious formations thus relegating all things spiritual to the domain of faith based practice and significantly inhibiting spiritually sensitive social work practice”.

Social work practice that recognises spirituality has assumed the term “spiritually sensitive social work”. The concept of spiritually sensitive social work has been heavily influenced by Canda and Furnam (1999). Religiously and spiritually sensitive social work has become a necessary component of the 21st century social work practice. Appropriate assessment and intervention practice behaviours that use informed sensitivity on the client’s personal spiritual beliefs and practices have assumed the name spiritual interventions. Interventions based on spirituality include among other things; yoga, meditation, silent prayer, devotional reading and worship ; gratitude

exercises, prayer, visualisations, meditation, guided imaginary, spiritual genograms, yoga, music, spiritual histories, spiritual life maps or prayer with clients (Hodge, 2005; Dwyer, 2010; Jacobs, 2010; Graff, 2007; Young & Koopsen, 2011; Knitter, 2010; Hodge, 2005). Canda and Furman (2010) have identified other spiritual interventions in poetry, music and meditation. Bhagwan (2010b) notes that these spiritual interventions are relevant in areas of HIV/AIDS, substance abuse and family problems. Bhagwan (2010c) also argues that, in the past, social work practitioners were using spiritual interventions without training. According to Canda and Furman (2010) transpersonal social work focuses on helping clients seek self-transcendence, health spiritual experiences working towards personal transformation and establishing harmony between one's self and others.

Spirituality has been found to be at the centre of existence for many people and has consequently been integrated into some social work therapeutic interventions with clients. Social workers and other helping professionals are encouraged to recognise the role of spirituality in their client's lives. Weinstein (2008) notes that the amalgamation of spirituality and social work has implications in the areas of trauma, end-of-life issues, aging, illness, chronic mental illness, the meaning of life, and attempting to answer the age-old question, "Why is this happening?". The seriousness in the interface between religion and social work is seen in the establishment of the Journal of Religion and Social Work, establishment of associations such as the Society for Spirituality and Social Work, Canadian Society for Spirituality and Social Work and conferences like the Convention for Spirituality and Social Work.

In studies by Rice and McAuliffe (2009) and Dwyer (2010), social workers were found to accept spiritually-related intervention strategies with their clients. However, Wilkinson (2012) asserts that social workers need proper training in the areas of religion and spirituality for them to have effective intervention strategies. Canda (1989) maintained that religion touches clients considerably and that people possess spiritual needs that assist in providing an understanding of and purpose for life. According to Asher (2001), all other things considered, more faith and hope result in; fewer hospitalisation days, fewer days in jail or prison, more days in school, more days on the job, fewer suicides, and less spouse, child, and elderly abuse. Canda (1997) further posits that social workers create a living hell for their clients when they cut them off from their souls.

Cascio (2012) states that it is common for people to question the reasons behind events, the purpose of life and that such questions can influence the encounter between social workers and their clients. It is beneficial to create a spiritually conducive atmosphere by telling clients that spiritual topics are acceptable in the helping process (Cascio, 2012). For this reason, it is vital that social work education include content regarding spirituality in order to prepare social workers to provide quality services to clients with different ideological perspectives (Hodge, 2003). Wuest (2009) declares that for social workers to include topics on spirituality in their curriculum, they should first agree on the relevance of the topic to the Discipline.

Social workers who are involved in situations of pain, or crisis need a greater awareness of religious and spiritual issues. Social work clients who are subjected to serious diseases or long term oppression need some way to make sense of their

experiences (Gotterer, 2001). However, the principle of client self-determination remains central. Social workers should never try to impose their own beliefs on clients. Religion can hold negative connotations because it is frequently equated with rigidity and dogmatism as well as perceptions about unequal treatment of women or gender stereotypes (Cascio, 2012). Dalton (2005) indicates that since social workers work with clientele groups with divergent value systems and ideological perspectives, they should have knowledge and appreciation of various spiritual perspectives. A number of social work clients have a belief in a higher power. For example, a study by Baylor University (2006) found that 63% of people not affiliated with religion still believe in a higher power and a third of them sometimes pray.

According to Huguen (1998), many founders of social work as a profession such as Felix Biestek and Mary Richmond were religiously motivated and expressed their faith by means of social work as a vocation and a calling from God to their brothers and sisters in need. Social workers are encouraged to assess a client's religious background and level of interest in using religious resources. Nelson-Becker (2005) argues that social workers need to develop comfort in hearing and discussing client images of God or divine power. It is also critical for "social workers to develop a self-understanding regarding existential issues and spiritual growth and examine their beliefs, motivations, values and activities and consider the impact of these factors upon the client's spirituality" (Canda, 1988:245). A number of advantages have been realised from including religion and spirituality in social work practice among them: certain religious and spiritual practices have been found to improve health by, for example, lowering blood pressure, not smoking or drinking, lowering depression (Wiesman de Mamami,

Tuchman & Duarte, 2010; Newberg & Waldman, 2009). They improve positivity and hope among clients (Rosmarin & Pargament, 2010; Wiesman de Mamami *et al*, 2010). They also improve community and social support for clients (Jacobs, 2010). However, a number of risks have been noted in integrated religion and spirituality in social work practice. These include, among others, the following: (1) certain religious and spiritual practices can increase feelings of blame, anger, and guilt (Jacobs, 2010), (2) they can lead to increased levels of anxiety (Jacobs, 2010), (3) they can also result in the development of unhealthy coping mechanisms such as doubt, escape or delusions (Seaward, 2010; Rosmarin & Pargament, 2010).

3.5 FACTORS AFFECTING SOCIAL WORKERS' RESPECT FOR CLIENTS' BELIEFS

Walsh (2003:337) postulates that "Over the centuries and across cultures, spiritual beliefs and practices have anchored and nourished families and their communities. Families have lit candles and prayed together, meditated and quietly turned to faith for solace, strength and connectedness in their lives. At times of crisis and adversity, spiritual beliefs and practices have fostered recovery from trauma, loss and suffering". According to Heyman *et al* (2006), social workers need to be open and ready to listen and respect clients' belief. In a study by Heyman *et al* (2006), it was found that if spiritual activities are important in a social worker's own life, he/she may have more positive attitudes towards the role of religion and spirituality in social work. Learning of a client's belief system can aid a social worker in helping the client strengthen their ability to cope with various situations which confront them. In some hospitals, assessment the spiritual history of a client is a requirement for all patients (Heyman *et al*, 2006). Heyman *et al* (2006) also found that if agency practice does not embrace the inclusion

of spirituality into practice, social workers may not have positive attitude towards the inclusion of spirituality into social work practice.

Literature on health workers in Britain has begun to stress the importance of recognising the religious and spiritual needs of patients (Gilligan & Furness, 2006). A social worker can gather spiritual information through methods such as *mandala*, a family or spiritual genogram, a timeline or a spiritual history (Cascio, 2012). Before examining spiritual matters with clients, social workers should examine personal unresolved conflicts of a spiritual nature, explore biases, and be cognisant of their own issues in order to minimise projection and counter transference reactions (Cascio, 2012). According to Canda and Furman (2010), spiritually sensitive social work approaches spirituality in a way that respects a full range of spiritual expressions of clients and their communities which includes religious and nonreligious perspectives. Graham, Coholic and Coates (2006) concede that two of the major rationales offered for incorporation of spirituality and religion in social work are professional commitment to both holistic practice and cultural competence. Beres (2004) recommends that social workers reflect upon the ways in which their spirituality influences their practice in order to provide socially just and ethical practice.

3.6 THE DILEMMA OF INCLUDING SPIRITUAL ISSUES IN SOCIAL WORK PRACTICE

Though spirituality appears to open the door to integrity and genuineness in the social workers' relations and ways of working with their clients (Nash & Stewart, 2005), Streets (2008) argues that there are tensions between what social work and spirituality bring in response to human needs. Some clients' religious values clash with the social workers'.

The way in which religious issues are addressed can affect the health and wellbeing of the client, and the integrity of the social work profession. There is no consensus on the usage of religion and spirituality among social workers. Holloway (2007) argues that social workers have developed uncertainty around the appropriateness of intervention strategies available. The religious status of service providers would seem to be less important than the ability to maintain a respectful position towards the belief system of the client (Rubin *et al*, 2012).

Wilkinson (2012:1) identifies the following questions plaguing social work practitioners: is incorporating religion and spirituality in social work ethical? is leaving religion and spirituality out of practice unethical? how far can social workers explore issues of religion and spirituality with their clients? Majority of people in the world consider themselves as being significantly influenced by religion and spirituality. Rituals are central to the lives of people in certain communities and failure to recognise the importance of such rituals will mark the beginnings and endings of new life which can be detrimental to individuals or groups of people affected by particular experiences (Raman, 2007). According to Sheridan (2008), prayer in its many forms, can be a powerful resource for people who find themselves in difficult circumstances. A substantial percentage of social workers in the USA use prayer in their work with clients (Sheridan, 2008; Gilligan & Furness, 2006). Despite this reported use, Sheridan (2008) argues that the way in which prayer is used is one of the most controversial issues in spiritually sensitive social work practice. In a study by Sheridan (2008) among social workers in the USA, it was found that 55,4% had, at some point, privately prayed for

their clients, 33,8% had not covered content on religion and spirituality while 55,9% had attended a workshop or conference in the previous five years that dealt with some aspects of religion and spirituality. Canda (1990) posits that prayer in social work, can be used provided that the client has expressed interest, a spiritually sensitive relationship is well established between the social worker and the client, and the social worker has relevant qualifications.

In a study in Nigeria by Mbonu, Van den Borne and De Vries (2011), respondents stated that it was possible to heal HIV because with God all things are possible. Despite this importance of spiritual issues in the lives of some clients, these researchers argue that the phenomenon of publicly asking HIV positive people to come out into the open in church has added negative implications because the whole church will become aware of the statuses of those involved.

Neagoe (2013) indicates that if religion is to be included as a legitimate component of social work practice, it must be done with great care and sensitivity lest it creates more problems than it solves. Social work practitioners should be aware of areas where religious and professional values clash.

3.7 RELIGION AND SPIRITUALITY IN SOCIAL WORK EDUCATION

The use of spirituality in social work practice is frequently not supported by education and training (Wiedmeyer, 2013). Phillips (2010) notes that without proper training, the response of social workers to the spiritual needs of clients is likely to be ineffective or even detrimental. Wiedmeyer (2013) adds that this may also result in uncertainty for social workers in terms of ethical guidelines. A number of social work academics agree

that the inclusion of spirituality is critical in holistic practice (Dudley & Helfgott, 1990; Coholic, 2003). In a study by Holloway (2007), it was found that practitioners feel underprepared to respond to spirituality due to lack of inclusion of the topic in their training. Heyman, Buchanan, Marlowe and Sealy (2006) found that social workers who had taken a course on spirituality were likely to have positive attitude towards spirituality and religion. Yeo and Miller (2010) mention that social workers are not aware of how to apply spirituality in conceptualisations, assessments and interventions, and this may result in unknowingly violating codes of ethics.

Nelson-Becker (2005) tasks social workers to seek continuing education on religious and spiritual issues so that they are able to enter a common dialogue with clients. This is despite the fact that social work educators have generally shown ambivalence toward the inclusion of religious and spiritual aspects of life in social work curricula. However, the Canadian and USA code of ethics now include religion and spirituality in social work curricula (Canadian Association of Social Workers, 2005; Council of Social Work Education, 2008). Curriculum Policy Statement of the Council of Social Work Education (1992) required that accredited baccalaureate and master's programmes provide content related to spirituality.

Many social work educators agree that it is important for social work students to have an intellectual understanding of spiritual and religious concepts in order to effectively help their clients (Gumz *et al*, 2003). Little has been written about assisting social work students to explore their own spirituality. In a study by Heyman *et al* (2006) among social workers in the USA, it was found that only a third of them had taken a course on

spirituality. This is despite the fact that for many people, religion and spirituality are important in their lives. The first Council of Social Work Education of the United States (1953) recognised the importance of cultural and spiritual influences on the development of the individuals. According to Canda (1989), everyone has spiritual needs and social workers should be able to respond to these needs when working with clients. This can only be achieved when religious and spiritual issues are included in social work education and training.

3.7.1 Teaching and Learning

A number of pedagogical instruments are suggested in the teaching of religion and spirituality. Such instruments include the following: discussions, group work, self-reflection, experimental learning through rituals, meditation, case studies and role plays (Phillips, 2010). A classroom environment with open and non-judgemental dialogue, honesty and sincerity is equally important. However, Dudley and Helfgott (1990) established that some academics expressed inability to teach religion and spirituality by suggesting introduction of specialists or team teaching to ensure diversity of views. In order for students to become competent in addressing issues of spirituality with their clients, they must be equipped and trained in this area (Hunt, 2010).

There is no need for published articles to begin with a statement such as “the concept of religion and spirituality has rarely been addressed in social work. According to Rice (2002), in 2002 there were 50 social work schools offering subjects on spirituality in the United States of America (USA).

3.7.2 Social Work Students and Religion and Spirituality

To have a significant impact on people and situations, social work education and practice should be guided by an understanding of society and its effects on different groups and locations, programmes must be based on knowledge and understanding of specific societal conditions.

In a study by Bhagwan (2010a), South African social work students overwhelmingly supported the inclusion of spirituality in social work education. In another study by Bhagwan (2013), among social work educators in South Africa, 43, 9% were found to have a high level of participation with some involvement in an organised religion in a spiritual group. A significant number, 72% of the respondents reported daily spiritual experiences such as meditation, prayer or reading spiritual texts. Another 50% of the participants indicated that spirituality had never been present in their social work training, 92,4% of the respondents agreed that spirituality is part of diversity and should, therefore, be included in social work education. Also, 80% of the respondents reported that spirituality was not included in their curriculum, while 96% did not offer a course on spirituality.

About 83.1% of the social workers, who participated in the study by Gilligan and Furness (2006) in Britain, indicated that they had gathered information on religion and spirituality about their clients and 90 % of them considered it appropriate while 9.2% reported that they had prayed or meditated with a client.

3.8 RELIGIOUS COPING

Several studies have shown that many people cope with traumatic or stressor events on the basis of their religious beliefs. Peres, Moreira-Almeida, Nasello and Koenig (2007) note that religious coping is also frequent in cases of severe disease. Religious frameworks and practices may have an important influence on how people interpret and cope with traumatic events. According to Peres *et al* (2007), religious coping is not always related to better outcomes. People who wonder whether or not God has abandoned them when faced with adversity, or question God's love for them they are in trouble are found to be associated with negative coping. Asher (2001) contends that the ability to experience faith and hope is a large component of fulfilment and contentment at any particular moment in life. People are better able to get through difficult times if they have faith and hope. No one experiences God in the same way. Some people express their faith emotionally while others do so quietly and contemplatively. Those infected with HIV deal with a number of issues such as social isolation, rejection by friends and family, prolonged periods of illness, fear of what tomorrow will bring, reproductive decisions, guilt, and grieving. Youth living with HIV and AIDS are more likely to wonder whether or not God has abandoned them.

African traditional religion has been seen as a buffer in difficult moments. The Patriot (2014:12) argues that "It is not just any religion that comes to your rescue in times of tribulation, but the religion of your ancestors".

Religion and spirituality are some of the significant means of coping with crises and problems in people's everyday lives. According to Pargament (1997), religious coping

involves drawing on religious beliefs and practices to understand and deal with life stressors. Religious coping can be divided into two categories: positive and negative strategies. Rosmarin, Pargament, Krumrei and Flannelly (2009) note that positive religious coping includes benevolent religious approaches, active religious surrender, seeking spiritual support and spiritual connection while negative strategies include reappraisal of God's power, passive religious deferral and interpersonal religious discontentment. They further indicate that positive religious coping is beneficial to individuals undergoing stressful life events. According to Openshaw and Harr (2005), many clients draw support from their faith group which is useful in that it assists with healing and rebuilding hope. People engulfed by social problems such as ill-health, death and other existential challenges have been found to seek refuge in spirituality.

Rosmarin, Pargament, Krumrei and Flannelly (2009) concede that much of the available literature on religious coping focuses almost exclusively on Christianity, and knowledge about it in other religious populations is scanty. An HIV diagnosis can confer important spiritual impacts. For individuals living with chronic illnesses, spirituality and religion are important as patients face a unique array of existential challenges. It is, therefore, important for healthcare providers to be cognisant of the spiritual component of chronic illness. People reflect on their spirituality after being diagnosed with HIV and AIDS by incorporating their understanding of God as part of their coping repertoire (Tarakeshwar, 2006). Higher levels of spirituality have been associated with less pain and increased energy (Ramer, Johnson, Chan & Barret, 2006). According to Parsons, Cruise, Davenport and Jones (2006), the negative aspects of spirituality such as spiritual struggle and anger at God have been associated with poor medical compliance. Types

of spiritual beliefs and practices determine whether or not spirituality will be a protective or risk factor in the lives of PLWHA. Cicirelli (2002) concludes that religiousness is negatively associated with fear of death. Health care professionals should be able to accommodate spiritual issues in the helping process and where they cannot handle such issues, they can refer clients for clinical and pastoral counselling.

According to Trevino, Pargament, Cotton, Leonard, Hahn, Caprini-Faigin and Tsevat (2010), the following points can be helpful: early assessment of positive religious coping and spiritual struggle in treatment, supporting and encouraging patients utilising religious resources to cope, being open to incorporating religious coping techniques into treatment plans and considering manualised psychological spiritual intervention for patients with HIV. Health policies for many countries focus on improving access to health care and usually, spiritual needs are ignored. Most helping professionals lack the necessary time, skills or even interest to address the spiritual needs of their clients (Bussing and Koenig, 2010). Hill *et al* (2000) contend that spirituality is effective for people who are coping with life's everyday trials. It also assists in alleviating the adverse effects of stress which come from challenges of life. Spiritual concerns such as hope, meaning, inner strength and doubt are relevant in the lives of many clients (Gotterer, 2001).

HIV and AIDS present exceptional existential challenges to people when they are confronted with issues of hope, death, grief, meaning/purpose, and loss. According to Hall (1998), people with HIV/AIDS incorporate spirituality as a way to cope, to help reframe their lives, and to bring a sense of meaning and purpose to their lives in the

face of an often devastating situation. A smaller body of evidence points to the potentially harmful effects of spirituality/religion for persons with HIV and AIDS who may have been ostracised from their religious institutions or their own communities of faith due to lifestyle issues or the stigma/prejudice associated with being HIV positive.

3.9 SPIRITUAL STRUGGLE AMONG SOCIAL WORK CLIENTS

Though spirituality is reported to bring positive results in the lives of many people, it is sometimes be a source of trouble for some clients. Some people may lack a clear picture of the meaning of life. This confusion about the meaning of life has assumed the name spiritual struggle. According to Bryant (2008), spiritual struggle is intra-psychic concern about matters of faith, purpose and meaning in life. Spiritual struggle is an experience with which many students are familiar particularly those who concern themselves with deep reflections of faith, purpose and life meaning (Bryant, 2008). According to Pargament, Murray-Swank, Magyar and Ano (2005), psychological traits that expose an individual to a spiritual struggle include, among other things, spiritual orientations that are not able to adequately address the problems of evil and suffering in life, are insufficiently integrated into an individual's life and are based on insecure religious attachments to an unpredictable or distant God. Chronic spiritual struggles may lead to negative outcomes (Bryant, 2008). In the context of spiritual struggle, crisis does not entail catastrophe but marks a point of transition and signifies a critical developmental opportunity (Bryant, 2008). After a study that assessed spiritual struggles among college students, Bryant (2008) made the following conclusions:

- people identifying with groups that are under-represented or at risk of mal-treatment in society face higher levels of spiritual struggle.
- women report struggling more than men.
- people identifying with non-majority faiths demonstrate greater spiritual struggle than students from majority faiths.
- varying perceptions of God relate to spiritual struggle. Students whose perceptions of God is teacher, divine mystery or universal spirit are more likely to struggle than those who perceive Him as beloved, protector and “part of me”.
- people who are religiously engaged experience fewer struggles than average students.
- struggling relates to low levels of psychological well-being, physical health and self-esteem.

The young adult’s spiritual experiences depend upon their resolution of issues surrounding sexuality, in-group versus inter-group relations and the ability to conform their personal behaviour to spiritual beliefs (Pellebon & Anderson, 2012).

Spiritual struggle includes both reappraisal and discontent. According to Pargament *et al* (2000), religious reappraisals are cognitive efforts to ascribe meaning to stressful events by bringing one’s perceptions of an event which is in line with one’s global meaning system. Wortmann, Park and Edmondson (2011) further mention that some of these reappraisals take a negative tone as in, for example, attributing a stressful event to punishment from God (Punishing God Reappraisal) or work of the devil (Demonic

Reappraisal). Spiritual discontent, on the other hand, involves anger with God's love or wandering whether or not one has been abandoned by God. People facing challenges may feel let down, betrayed and may experience a sense of mistrust. Koenig (2014:1163) notes that "...a patient may feel that their medical condition is a punishment from God or that God has deserted them or that their faith community has abandoned them. Alternatively a patient may be struggling with where he or she is going after death, fearful perhaps of going to hell...." Greater conflict with God or other people over faith predict greater psychological distress particularly if spiritual struggles remain chronic and unresolved (Mahoney & Cano, 2014).

3.10 INDIGENISATION OF SOCIAL WORK PRACTICE: THE PLACE FOR INDIGENOUS BELIEF SYSTEMS

Indigenisation refers to the extent to which social work fits local contexts (Gray, 2005). Opposed to indigenisation are the concepts of universalism and imperialism. Universalism is defined by Gray (2005) as trends in social work to find commonalities across divergent contexts such that it is common to talk about a social work profession with shared goals and values wherever it is shared. Gray and Fook (2004:628) further define universal social work as "a form of social work that transcends national boundaries and which gives social work a global face such that there are commonalities in theory and practice across widely divergent contexts". Imperialism is defined as trends within social work which promote the dominance of Western world-views over diverse local and indigenous cultural perspectives (Gray, 2005). According to Wong (2002), indigenisation challenges universal knowledge and the cultural hegemony of the dominant discourses locally and globally.

There is a quest in the universalism of social work to find an agreement on the universal definition of social work (Gray & Fook, 2004). However, social workers across the globe do not agree on the universalism of social work values. Cossom (1990) argues that in the developing world, social work should free itself from the inbuilt assumptions and cultural biases of first world theories and models of practice and come up with indigenous education and practice. Social work practice must be contextually oriented. Gray and Fook (2004:627) believe that there is room for many types of social work across widely divergent contexts united by shared human rights and social justice goals. Dialogical processes within local contexts are more likely to create indigenous and relevant models of social work practice than imported ones since they directly address the needs of the country, respond to the culture of the people and focus on pertinent social issues (Gray & Fook, 2004).

Colonisation has destroyed much of what was good, just and right in most African cultures. Indigenous modes of helping one another and natural kinship networks were overlooked (Gray, 2002). Menand (2001) argues that any model of philanthropy premised on top down is false.

Cultural competence in social work is a lifelong, on-going process which includes the importance of religion and spirituality in the lives of clients (Wiedmeyer, 2013). Social workers are encouraged to comprehend cultural contexts specific to their clients and how that knowledge is used in the everyday lives of their clients in order for meaning to be known and revealed (Wiedmeyer, 2013). Some authors (Hodge, 2004; Hodge & Bushfield, 2006) have identified spiritual competence as a more focused type of cultural competence. Hodge (2004) notes that spiritual competence has three interrelated

dimensions: (1) an increasing awareness of one's own spiritual world-view including all of its assumptions and biases, (2) developing a non-judgemental understanding of the clients' spiritual world-views and (3) an increasing ability to create and implement strategies that are appropriate, sensitive and relevant to the client's world-view.

More importantly, social workers should be cognisant of the fact that spirituality is culture and as such, they should respect spiritual diversity. However, despite the widely reported importance of spiritually sensitive social work, professionals in the spiritual care teams should not prescribe religion to non-religious clients nor force a spiritual assessment on a client (Koenig, 2014).

3.11 SOCIAL WORK EDUCATION AND PRACTICE IN ZIMBABWE

Development of social work in most African countries has strongly been influenced by and modelled after Western countries (Hall, 1990). According to Kolawole (2005), UNESCO puts a strong challenge to higher education institutions to play a leading role in renewing the entire education system by ensuring that IKSs find their way in the mainstream schools and tertiary education curricular. Calls for mainstreaming IKSs have been reverberated for some time now (Mbeki, 1999, UNESCO, 1994). Development of social work in Zimbabwe has been heavily influenced by its colonial legacy in that it reflects a wholesale transfer from the British experience (Kaseke, 1991, Chogugudza, 2009, Chitereka, 2010). Social work education in Zimbabwe was introduced by the Catholic Jesuit Fathers. However, since independence there has been a gradual shift towards developmental social work which is aimed at addressing poverty and social ills. In Zimbabwe, social work education has been offered by the School of Social Work alone since 1964 until 2010 when more universities started to

train social workers. The School of Social Work is an affiliate college of the University of Zimbabwe. Social work qualifications in Zimbabwe are the Certificates in Social Work, Diploma in Social Work, Honours Degree in Social Work, Master of Social Work. The largest employer of social workers in Zimbabwe has always been the government through its various ministries (Kaseke, 1991, Chogugudza, 2009, Mupedziswa & Ushamba, 2006). Social workers in Zimbabwe specialise mainly in child welfare, medical social work, counselling, rural development, relief work, housing and social amenities.

Social work is a profession perceived by most Zimbabweans as a Western concept (Mamphiswana & Noyoo, 2000). Chogugudza (2009) argues that social work education in Zimbabwe took longer to be appreciated as a formal profession as compared to traditional Disciplines such as psychology, nursing and teaching. Since 2000, Zimbabwe has witnessed a mass exodus of social workers to Western countries such as the United Kingdom, USA and Australia as well as regionally; to South Africa, Botswana and Namibia.

Until 2001, there has not been any legally recognised piece of legislation to govern social work practice in Zimbabwe. Relief came from the Social Workers Act Chapter 27:21 which was passed as a law in 2001. The Act provides for the establishment of a Council of Social Workers of Zimbabwe. The functions of Council, as stipulated in the Act, are as follows:

- to register social workers
- to conduct examinations

- to qualify people for registration
- to define and enforce ethical practice
- to take steps or action to enhance the status and effectiveness of the profession; and, to exercise any other functions incidental to its powers(Refer to Section 4 of the Act).

In 2012, the council developed a code of ethics to be heard for the first time in Zimbabwe. The Social Workers code of Ethics for Zimbabwe has “*Ubuntu*” and “Respect for diversity” as some of its core values for social work practice in Zimbabwe. Before the establishment of the Council of Social Workers, ensuring ethical practice in Zimbabwe depended on the integrity of individual social workers.

3.12 SUMMARY

Religion and spirituality have influenced the development of the social work professions. Though the two concepts are used interchangeably and sometimes confused, they have different meanings. Generally religion refers to an organized form of faith while spirituality refers to the sense of meaning attached to life. A person can join a religious organization but spirituality is experienced at a personal level.

Social work has strong spiritual roots in that it originated from Christian movements in Britain and the United States of America. Christianity has therefore a strong influence on the social work profession. Most social work values are directly related to those found in the Christian religion. Religion and spirituality play a critical role in a person’s life. Most people lean on their religions during life’s turf moments. This religion based

coping has assumed the name religious coping in most helping professions. Whenever people are confronted with problems like illness, they may resort to their religious organisations for assistance. Religious practices like prayer, meditation, singing have an influence on the healing of sick people. Social workers are therefore encouraged to understand the religious and spiritual issues of their clients. They should also try to understand their own spirituality as religious values as these may have a direct influence on the helping process.

The social work curricular should also equip students to be spiritually sensitive. Social work educators should teach content on religion and spirituality to their students. Social work clients may have a number of unanswered existential questions that may negatively impact on the helping process. For example some people may take illness as a punishment from God, some may ask “why me”. It is therefore important for social workers to be spiritually sensitive. Earlier studies have identified a number of barriers that prevent social workers from discussing spiritual matters with their clients, chief among them lack of proper training and uneasiness to discuss spiritual matters.

There is dearth of information pertaining to the nexus between African traditional religion and social work practice. Social work education and practice in Zimbabwe lacks the critical involvement of religious issues. This is despite the fact that including religious and spiritual issues in social work education and practice may be an effort towards indigenising the profession. The next chapter reviews literature related to African traditional world views and the African understanding of illness.

CHAPTER FOUR

SITUATING TRADITIONAL SHONA WORLD VIEW AND TRADITIONAL AFRICAN UNDERSTANDING OF ILLNESS

4.1 INTRODUCTION

Since the beginning of civilisation, religion has shaped human culture and African traditional religion is no exception. African traditional religion is not something that people do at certain times and certain places but it is part of the fabric of living. Cognisant of the fact that Africans have a religious ambivalence, this chapter introduces the concept of African traditional religion before it moves on to Shona traditional religion which is the focus of this study. It further explores the understanding of etiology and etymology of illness among African communities. The concept of *ubuntu* which shapes behaviour and thinking among the *bantu* people of Africa is also examined in relation to the care of the sick.

4.2 AFRICAN TRADITIONAL RELIGION

African traditional religion is a nebulous concept with no founder, scripture or laid down liturgy (Anthony, 2014). According to Ekwunife (1990), ATR are those institutionalised beliefs and practices of indigenous religion of Africa which are the result of traditional Africans' response to their believes, revealing superhuman ultimate and which are rooted, from time immemorial, in the past African religious culture, beliefs and practices

that were transmitted through oral traditional, sacred specialists persons, sacred space, objects and symbols. Awalalu (1976) made a similar observation by arguing that, in the context of ATR, the word traditional means indigenous, that which is aboriginal, or fundamental, handed down from generation to generation, upheld and practised by Africans today.

According to Turaki (1999), African traditional religious system has four fundamental beliefs: the belief in impersonal powers, the belief in spirit beings, the belief in divinities/gods and the belief in the Supreme Being. African religion is still a strong force in the minds and hearts of many people of African origin. African peoples have never believed in an anthropocentric universe. Rather they have always assumed that humanity is surrounded by a realm of spirits in which God is thought to preside over a pantheon of sub-divinities and ancestral spirits (Paris, 1993). Washington (2010) supports the view that Africans believe in a Supreme Being by indicating that the word Zulu (an ethnic group in South Africa), refers to God's people or people of heaven.

From a traditional African belief system, the ultimate dominion over the whole world is in the hands of God. When problems arise, people appeal to ancestors for assistance. These ancestors are spirits of dead relatives who are believed to relay people's petitions to God. Consultation with ancestral spirits is done through spirit mediums. According to Chavunduka (2001), spirit possession is one of the most fascinating aspects of ATR. A spirit can possess a living member of the community and that person becomes the vessel through which the spirit communicates with the living people.

The African world view recognises the centrality of the spiritual feature of all elements of life. Spirituality, in the African context, is taken to mean the transcendent or invisible

substance which connects the entire universe. All of life is filled with a vital life force in dynamic participation (Setiloane, 1986). Africans have a certain emotive sensitivity, an affective rapport with the forces and forms of the universe, a direct and immediate contact with 'the Other.' This vital force is the source of all life and acts in a living way; it creates, gives life, strength and growth (Bujo, 1992). At the heart of African religion is the quest for harmony: harmony between the human being and nature; between the human being and the community; between the human being and the living spirits of ancestors; between the living and the dead; between the visible and the invisible worlds; and most importantly harmony between human beings with God.

4.2.1 African Traditional Cosmologies

Mbiti (1990) notes that Africans believe in a spirit world that is densely populated with spirit beings and spirit dead or the spirits of the ancestors. In ATR, spirits are thought to dwell in certain trees, rocks, rivers, mountains, skies, lakes and many other places (Turaki, 1999). For example, Matikiti (2007) argues that the Karanga people of Zimbabwe believe that Ruvure mountain in Charumbira area is a dwelling place for ancestors-*ninga dzemadzitateguru*. Resident animals such as baboons, lions, leopards and pangolins can also be seen as personifications of spiritual beings. These African divinities cover different areas such as fertility, health and sickness, rainfall, harvest.

Several authors argue that the multiplicity of deities in African religion shows that it is an accommodative religion which can co-exist with other religions (Chavunduka, 2001; Kazembe, 2009; O'Brien & Palmer, 2009). This has necessitated the infiltration of other religions such as Christianity, Islam, Hinduism, Bhuddaism. Africans are thus henotheists- they worship one God yet they do not deny the existence of other gods.

At the highest level of African cosmological thought is a Supreme Being or God. He is the Creator of the world. He is the keeper of life and the source of all power. Awolalu (1976) concurs with this statement when he says that the world of the Africans is theocratic, one ruled and governed by the Supreme Being. Below God are deities who function in the same way as angels in the Jewish or Christian religion (Mbiti, 1969). At the lowest level are ancestral spirits. According to Turaki (1999:4), "these are souls of our forefathers who walked in this world". Ancestors live in the realm of the spirit world. They serve as intermediaries between their families and divinities. They preside spiritually over the affairs of the family.

African traditional religion has its core belief in God as the Supernatural Being, the Great Ancestor and Creator of the universe. The elimination of God from the universal scheme of Africans would thus create a vacuum in African ontology (Omatseye & Emeriewen, 2010). For Africans, religion is an ontological phenomenon which pertains to the question of existence of being (Mbiti, 1990). The principle of causation would be meaningless if the supernatural is removed from African thought. In traditional Africa, life is religion and religion is life (Opoku, 1978).

Though African traditional religion is used to refer to the indigenous religions of Africa, Africa is a vast continent and one may run the risk of generalisation. Paris (1993) corroborates this point by arguing that no continent in the world comprises a higher degree of multiculturalism than Africa. It is the second largest continent after Asia and due to its size (11 668 599sq miles), it is a continent of contrasts. However, despite diversity among indigenous religions of Africa, O'Brien and Palmer (2009:16) have identified the following common themes in African life:

- all things in the universe are part of a whole. There is no sharp distinction between the sacred and the non-sacred
- in most African traditions, there is a Supreme Being: creator, sustainer, provider and controller of all creation
- serving with the creator are a variety of lesser gods and guardian spirits. These lesser gods are constantly involved in human affairs. People communicate with these gods.
- the human condition is imperfect and always will be. Sickness, suffering and death are all fundamental parts of life. Suffering is caused by sins and misdeeds that offend the gods and ancestors or by being out of harmony with society.
- ritual actions may relieve the problems and suffering of human life, either by satisfying the offended gods or by resolving social conflicts. Rituals help to restore people to the traditional values and renew their commitment to spiritual life.
- human society is communal. Ancestors, the living, the living dead and those yet to be born, they all form an important part of the community. The relationships between the worldly and the other worldly help to guide and balance the lives of the community. People need to interact with the spirit world which is all around them.

Despite the importance of religion in the lives of people of African descent, many African languages do not have a word for religion (Paris, 1993; Ray, 2000).

4.2.2 Efforts to Exterminate African Traditional Religion

Westerners tried by all means to destroy African values of togetherness enshrined in the *ubuntu* philosophy in an attempt to erode African identity. They tried to propagate individualism and “independence” (Washington, 2010). For over 100 years, many endeavours were made by Christian missionaries to destroy African religion (Chavunduka, 2001). Despite this partly fulfilled mission, O’Brien and Palmer (2009) contend that to date, ATR remains the largest religion in Sierra Leone, Botswana and Burkina Faso. Western values are thus predicated on the destruction of non-Western values, beliefs and ethos.

The foregoing discussion shows that Westerners did not introduce God to Africa. As noted by Turaki (1999), missionaries did not bring God to Africa but God brought them to Africa. God was known to Africans prior to the coming of missionaries. Daneel (1970) agrees that the pre-Christian belief in a Supreme Being contributed considerably to shaping the destiny of the African people. Awalolu (1976) contends that ATR is not a fossil religion but a heritage of the past which is not and should not be treated as a thing of the past. God is central in African traditional religion. He assumes many names which varied with languages. Examples are *Mwari* in Shona, *Mulungu* in Nyanja, *Modimo* in Tswana and in Sotho, *uNkulunkulu* in Zulu. These are not empty names, they were names of the one and same God, the Creator of the world, Lord Jesus Christ (Turaki, 1999).

Some scholars such as Ray (2000) believe that word religion is new to Africa and does not exist in many vernacular languages. Westerners have used derogatory terms to refer to African spirituality and religions. They have used terms such as animism, fetism,

idolatry, superstition, heathenism, magic, primitive religion and many others. Mbiti (1990) is of the view that such terms are inadequate, derogatory and prejudicial. It is quite myopic to perceive African religious beliefs and practices from the eyes of Christians or modern day religious contexts such as idol worship, fetish, primitive, savage (Omatseye & Emeriewen, 2010; Gunda, 2007). Machingura (2012) argues that in the Pentecostal fold, for example, the spirit possession in ATR is classified under other evil spirits which are not from God but from a satanic source. Despite the introduction of foreign religions in Africa, ART has survived amid stiff competition (Chavunduka, 2001).

Kazembe (2009) notes that early Christian missionaries even tried to destroy African medicine. They regarded it as unscientific and anti-Christian. However, many Christians have continued to participate in African traditional rituals and they consult traditional healers (Chavunduka, 2011; Kazembe, 2009).

4.3 SHONA TRADITIONAL RELIGION

The Shona people are a dominant ethnic group in Zimbabwe. There are a number of dialects under the umbrella name Shona; Manyika found in Eastern Zimbabwe, Korekore found in Northern and North East of Zimbabwe, the Zezuru found in Masvingo province, the Karanga and the Kalanga found in South West of Zimbabwe. Though the Shona have been affected by a tide of globalisation, certain traditions have survived to date. African traditional religion has a strong foothold on contemporary Zimbabweans as an integral part of their everyday lives (Kazembe, 2009). Shona religious thinking pervades the whole of life. Ancestors occupy a central position. According to Chavunduka (2001), ownership of land forms the main link between politics, religion and

spirituality in Zimbabwe. Among the Shona people, illness and death cannot just happen without a spiritual force behind it. As argued by Masaka and Chingombe (2009), even if the cause of death of a relative is uncontested and apparent, the Shona would still want to know it. They believe that science cannot fully account for a plethora of mishaps that trouble humanity.

Among the traditional Shona and Ndebele religions in Zimbabwe, God, or the Supreme Being, is seen as the creator and sustainer of the cosmos in much the same manner as is happening in Christianity. The Shona word for God is *Mwari* and the Ndebele word is *uMlimu* and this God is believed to be active in the everyday lives of people. Traditionally, the Shona and the Ndebele people communicated with God through the *vadzimu* (Shona), or *amadhlozi* (Ndebele). These are the ancestors. According to Moyo (1988), the *vadzimu* are believed to constitute an invisible community within the community of the living, always around their descendants, caring for them and participating in their joys and sorrows.

The Shona traditional religion is sometimes called the *Mwari* religion as hinted by The Patriot (2014:12) which argues that “Zimbabwe had a vibrant Mwari religion that had been in existence since the creation...”. This is against some Eurocentric scholars who believe that the Shona have no religion (Gelfand, 1962). In Gelfand’s words, the Shona admit there is a Creator, an omnipresent spirit whom they call Mwari, *Chikare* or *Musikavanhu* (Gelfand, 1962:37). When praying, the Shona approach lesser spirits who are in communication with senior spirits which include God. Music is an important element in the inducement of spirit possession among the Shona people (Gelfand, 1962; Matsuhira, 2011). Religious influence goes beyond what is termed religion in a

narrow (Western) sense, among the Shona people. This is evident in culture, politics, literature and medicine. Kazembe (2009) notes that among the Shona, the concept of God is similar to the one used in the monotheistic religions such as Christianity, Judaism and Islam. Machingura (2012:85) mentions that “The aspect of being in touch with the spirit world is something linear and centrally important in the Shona worldview before one’s birth, during one’s life, at one’s death and after one’s death”. He further indicates that in the Shona world-view, one can never think of a situation where s/he is not in contact with the spirits. In order to have peace, the “living living” must thus have contact with the “living dead”.

Though Zimbabwe has been invaded by foreign religions, mainly Christianity, many Zimbabweans who become Christians do not resign from the African religion nor do they completely abandon African culture; they maintain dual membership (Chavunduka, 2001;4). This is supported by Thabede (2005) who argues that some Africans have adopted Christian values without completely forsaking their beliefs in the Supreme Being, ancestors of witchcraft.

Shona people do not believe God to have a shape or form, but they see Him as a Spirit who inhabits heaven but is also present on earth. It is believed that a human being cannot argue directly with *Mwari* and the concept of an individual having an intimate relationship with God as in Christianity is not accepted (Bosman, n.d). The traditional Shona religion does not provide for the existence of Satan or demons. Commonly, witches (*varoyi*) are seen as responsible for a lot of evil that takes place in their world. Witches are usually women (Bosman, n.d). Some of the influential spirits among the Shona are *mashavi* (wandering spirits) and *mhondoro* (ethnic spirits). Wandering spirits

are spirits of people who died away from their homes and were not decently buried and the mandatory *kurova guva* ceremony was not done (Shoko, 2007; Masaka & Makahamadze, 2013; Gelfand, 1962). However, according to Masaka and Makahamadze (2013), although *mhondoro* and *mashavi* are important, they are not as important as *vadzimu*. Shona cosmology thus notes the centrality of *vadzimu* in terms of life and death, good health and bad health and other vicissitudes of human life (Masaka & Makahamadze, 2013). The *vadzimu* protects their families or withdraws their protection when offended.

Another important faculty of Shona traditional religion is music which is usually accompanied by dance. Musical performance among the Shona covers rituals, sacrifices, death and funerals, hunting and healing as well as politics. According to Chitando (2002), in desperate moments, the Shona would sing protest songs directly to *Mwari*. Common dances include *mbira*, *shangara*, *dinhe* and *mbakumba* and these originated from different geographical locations in Zimbabwe. The dances are performed in various ceremonies for religious and entertainment purposes.

4.3.1 *Mwari*

At the highest level of Shona cosmological levels is *Mwari*, God the Supreme Being. The Shona believe that the living cannot reason or argue with *Mwari*. There is no personal relationship between the living and the Supreme Being. This *Mwari* is also known as *Musikavanhu* (the Creator of humanity), *Nyadenga* (the Great Spirit that lives in heaven) and *Samasimba* (the Almighty). Prior to the coming of the whites, the Shona people used to hear the voice of *Mwari* at Matopo Hills (Taringa, 2009). It is even believed that the Matopo shrine was central to all the nations including the Israelites

who came to seek blessings from *Mwari* (The Patriot, 2014). For the Shona people, *Mwari* is not a *dues otious* (remote God), but He interacts with his people through ancestors and lesser deities.

4.3.2 *Vadzimu*

The Shona strongly believe in *vadzimu* (ancestors). These are the spirits of deceased relatives that act as guardian spirits for the living members. The Shona thus believe in an afterlife in which those who die are seen as having a different and continuing existence in the spirit world but are still members of the extended family (Swift, 1989). Only an adult who bore children has a capacity to become a *mudzimu* (singular for *vadzimu*). After the death of an adult, the process of *kuro vaguva* (bring home ceremony), is done to bring back the deceased's spirit to protect the family.

Other Shona words for ancestors are *vakatsamira zvuru* (those resting on anthills), *varere muninga dzemakomo* (those who are resting in mountain caves). Ancestors commanded these names because, in traditional Shona society, people are buried near an anthill or in caves. Ancestors are close to human beings and serve as their custodians. Banana (1991:27) argues that for the Shona, "Life is an endless enterprise, death is not death; it is a vehicle from the ontology of visible beings to the ontology of invisible beings. Death is part of life, it is a gateway to eternity, it is a gateway to life in the hereafter". Matikiti (2007) notes that these ancestors could communicate with *Mwari* / God during times of crisis. He gives an example of Chainda, a progenitor of the Charumbira clan who is believed to communicate directly with *Mwari*.

The *vadzimu* are believed to live in invisible communities parallel to the communities of the living. They watch over the living in their everyday lives. This is supported by Taringa (2009:199), who posits that even though they inhabit the world of spirits, they are still present in the human community as guardians of the family traditions, providers of fortune and punishers of those who break accepted mores. They also act as intermediaries between man and God. Despite their protective role, they also have the capacity to become angry and they can cause sickness or other misfortunes. The *vadzimu* take care of the family but can also be offended especially when certain customs, rituals, or traditions are not kept by the living. As Machingura (2012) puts it, failure to communicate with the *vadzimu* is seen as extremely dangerous and disturbing to the social and individual conscience.

According to Masaka and Makahamadze (2013), the place of the *vadzimu* is greatly distorted and misrepresented by the larger part of missionary and anthropological literature in Zimbabwe. Most literature gives the impression that the Shona worship ancestral spirits but in Masaka and Makahamadze (2013:133)'s words "The Shona do not take the *vadzimu* as their *Mwari* but simply as one among a series of necessary stages towards communicating with *Mwari*". The *vadzimu* are thus not an end in themselves but a means to some greater end, which is *Mwari*. Private prayers are directed to family ancestors who judged whether or not they could give direct solace and whether or not such petitions should be forwarded to senior spirits and ultimately to God (Daneel, 1970). Ancestors are seen doing God's work. During rituals, ancestors are invoked to make all healing possible. Ancestors are believed to know more than anyone alive and to have extra-ordinary powers. They can bring good or bad luck if they are

pleased or angered respectively. Names may even be mentioned when people are pleading with the *vadzimu* for protection (Machingura, 2012).

4.3.3 *Mashavi*

The Shona people also believe in a host of other spiritual entities that populate their traditional cosmology. One such type is *mashavi* (alien spirits). These are wandering spirits that are alien to a given family (Machingura, 2012; Chirongoma, 2013). They are spirits of people who died away from their homes and were not accorded decent burials. These spirits roam until they find someone to possess and express their ego. Once the *shavi* spirit identifies its host, it can cause illness which defies treatment (Chirongoma, 2013). Another kind of *mashavi* are *majukwa*. These are spirits of ancestors that no one remembers and honours anymore. Sometimes distinction is made between good and bad wandering spirits (Shoko, 2007b). The good spirits can be responsible for singing, dancing or hunting, no wonder why statements such as “*shavi rekuvhima*” (hunting spirit). The bad spirits are consequently responsible for bad things such as stealing or witchcraft. Of interest to this study, a *shavi* can vest someone with healing powers. The alien spirits are also believed to have the capacity to cause illness as they seek attention.

4.3.4 Witchcraft

The subject of witchcraft creates controversy in many parts of the world. It is bristled with difficulties. This is mainly because some people believe in its existence while others do not. Witchcraft has been an object of anthropological and sociological investigation in Africa since the early decades of the Discipline (Rodlach, 2005). This is so because

many Africans believe that there is always somebody responsible for illnesses that persist over time especially when the sufferers do not respond positively to medication. Since prehistoric times, illness has elicited witchcraft beliefs. According to Foster (1976), one can hardly avoid dealing with witchcraft and related issues when analysing medical beliefs and practices in African communities. Witches (*varoyi*) are believed to be responsible for illness and other misfortunes haunting people. Their powers are passed from generation to generation through spirit possession. They keep and use familiars such as animals, birds, insects or objects to harm people. They travel at night on the back of a hyena or they are believed to fly (Nyabwari, 2014). These are usually people known to the target as they have to know the person's totem for them to be able to mislead the guardian spirits (*vadzimu*) of the person. As Taringa (2009) notes, the Shona people often explain disease and sickness in terms of witchcraft.

From the Christian perspective, witchcraft is a sin and a myth. According to Chavunduka (2001), ATR does not encourage witchcraft but it merely acknowledges the fact that it exists. As Nyabwari (2014) puts it, witchcraft, in all its appellations, is part of the religious component of ATR. In Zimbabwe, witchcraft includes the use of charms, harmful magic and other means or devices which cause illness, misfortune or death. The witch has more power than that of average person. Witchcraft is usually inherited though it can be bought or acquired. According to Nyabwari (2014), people who are unusually old, beautiful or ugly, sometimes physically deformed, excessively successful or poor are often considered witches. In Zimbabwe, witchcraft charges often emanate from quarrels, jealous, envy, cruelty, status competition, hatred towards a successful neighbour and many other issues (Chireshe, Chireshe & Shumba, 2012). Until 2006,

there was a Witchcraft Suppression Act in Zimbabwe which assumed that witchcraft does not exist. Witchcraft is now recognised under the Criminal Law Codification and Reform Act of 2006. Any witchcraft act intended to harm others is criminalised.

4.3.5 *Ngozi*

Ngozi (avenging spirit) is an evil spirit of someone who was murdered and is revenging his murder by attacking the murderer or his family. The *ngozi* can attack the victims in various ways such as causing sickness, death or disaster in the family. The *ngozi* is appeased by first discovering the cause of its anger, followed by the appeasement. *Ngozi* is the most terrifying spirit among the Shona. According to Bosman (n.d), the spirit of a murdered person is believed to become a *ngozi* who would revenge his murder on the murderer or his family. Masaka and Chingombe (2009) suggest that it is important to note that among the Shona people, it is not always the case that the wrongdoer is the one who gets killed or cursed by the avenging spirit but any person who is a blood relative of the wrongdoer is subject to anger of the spirit. The attack of a *ngozi* is fiercer or more savage than the punishment of a mildly angered *mudzimu* (Bosman, n.d). Another type of avenging spirit is *botso* (Chirongoma, 2013; Muchinako, Mabvurira & Chinyenze, 2013; Benyera, 2014) which occurs when a child wrongs a parent and the parent dies without reparations from the child. Its vengeance usually results in some form of mental illness. However, Benyera (2014) argues that this is not common as intra-family disputes are usually resolved amicably.

To silence a *ngozi*, reparations or compensation should be made. Its anger gets worse when its demands are ignored or disregarded as illegitimate (Chirongoma, 2013). In some cases people may get rid of a *ngozi* through a ritual called *kurasira* (casting

away). This takes the form of a scapegoat which is usually a black goat or fowl (Shoko, 2007b). The bad spirit causing the illness is transferred into the animal and is left to wander into the wilderness. If anyone one tampers with it they will catch the illness.

4.3.6 Taboos

Taboos (*zviera*) form part of Shona morality. Taboos are understood to be specific rules that forbid people from performing certain actions, the performance of which may result in the negation of the moral conduct that govern human behaviour (Chemhuru & Masaka, 2010). Breaching of *zviera* is thought to invite misfortunes such as badluck, drought or death (Tatira, 2000). Violation of Shona taboos is thus said to invite an angry reaction from the spirit world. Taboos are understood to be fostering desirable conduct in human behaviours. An example of a Shona taboo is *Ukachera mvura nechirongo chitema tsime rinopwa* which means if you fetch water with a sooty black pot, the well will dry up. Such a taboo was meant to discourage polluting water sources. The taboos play an important role in maintaining human relations, promoting human and environmental health as well as environmental conservation (Chemhuru & Masaka, 2010). There are certain taboos that are relevant in health issues. For example, *ukaseka murwere unirwara* (If you scoff at a sick person you become sick). This taboo prevents Shona people from teasing ill people but would rather assist them in their times of need. It is also believed that breaching certain taboos would result in long term illness.

4.3.7 Totems

The use of totems (*mutupo*) among the Shona is a prehistoric tradition that goes back for centuries. According to Hodza (1979) in Pfukwa (2014), the totem is an animal that a clan takes up and expresses certain values and virtues. Each totem is buttressed by a string of myths and folklore. The *mutupo* serves as a social bond and is an expression of collective identity for a clan or family that carries that totem (Pfukwa, 2014). It is believed by the Shona people that if a person can eat his/her totem animal, misfortunes such as illness will haunt him or his family. Totems are critical in Shona relationships. The assumption is that people who share the same totem are related and they may help one another in times of need. Each totem has a totemic poem (*madetembo*) which is used for praising and respecting the ancestors. Totems are thus used when communicating with one's ancestors during rituals and libations.

4.4 ILLNESS AND TRADITIONAL SHONA BELIEFS

The African view of illness encompasses a wide spectrum – from ancestors, folk beliefs and witchcraft to modern medical science (Mkize, 2003). Among the Shona people, illness is not seen as a purely somatic condition but is rather viewed as a reflection of some spiritual disease on the part of the patient or even another family member. Matolino (2011) purports that the arrival of illness is taken to be symptomatic of an aberration at the spiritual level. Thus the common Shona proverb “*Chiripo chariuraya zizi harifi nemhepo*” which literally means there is something that killed an owl, it cannot die of wind. If illness is believed to be free of witches and sorcery, the blame will be shifted to spiritual agents (Masaka & Chingombe, 2009). Mishaps are thus understood as products of mystical powers. Despite the scientific explanation of the cause of HIV

and AIDS pandemic, for example, the Shona people are keen to know why a given member of their family got infected. According to Masaka and Chingombe (2009), scientific explanation is not enough for the Shona people as it fails to explain why the individual has exposed himself/herself to a disease that he knew was fatal. It is even assumed that the Shona people believe that death is not normal and no one should die (Gelfand, 1962). However, Chirongoma (2013) argues that some Shona people identify natural causes of illness. These are called *zvirwere zvepasi* (diseases from the earth). These are diseases with no identifiable cause. Shoko (2007b), however, argues that these are mild and short illnesses which usually disappear without medication. It is, therefore, rare for the Shona people to attribute chronic illnesses to natural causes.

Shona practices, in respect to illness, cannot be viewed separately from religious beliefs and spirituality. Illness is seen as communicating something that is proceeding from the spiritual world. For example, ancestors are believed to punish someone by blocking chances in life, bringing bad luck or simply causing ill-health (Matalino, 2011). Illness caused by ancestral spirits and alien spirits is not meant to kill the victim but to alert the people on what is supposed to be done. To date, disease or sickness remains a religious problem in Zimbabwe and this means that religion continues to play a significant role in health delivery system. This can be evidenced by multitudes of people who throng Christian churches owned by people believed to have healing powers.

4.4.1 Spiritual Involvement in Illness

According to Gelfand (1964), it is a common belief among the Shona people that spirits have the capacity to cause and end illness. Some illnesses are also attributed to witchcraft, displeased ancestors or *mashave* (wandering spirits). Classification of

illnesses seems to be common among most people of the world and the Shona people are no exception. An anthropologist, Bourdillon (1987), who researched among the Shona people, has distinguished between natural and serious illnesses. Natural illnesses have known causes, for example, flu or fever and some venereal diseases. Of great concern to the Shona people are prolonged serious illnesses. These are assumed to have an invisible cause and a *n'anga* (diviner) should be consulted. In the Shona people's mind set, serious illness is thus caused by spirits, witchcraft or sorcery (Bourdillon, 1987, Chavunduka, 1978, Gelfand, 1964). Bourdillon (1987) notes that Shona people are not only interested in being healed but they further seek the cause of the illness. According to Shona traditional beliefs, every illness has a specific purpose and cause. Mental illness and physical illness may be caused by conflict with other individuals, ancestors, God or witches (Ross, 2010). Aschwanden (1987) writing in the context of Karanga which is one of the Shona ethnic group, argues that Shona people identify three kinds of diseases; diseases sent by God (*zvirwere zvaMwari*), diseases caused by spirits (*zvirwere zvemweya*) and diseases caused by witchcraft (*zvirwere zvevaroyi*). The African theory of illness distinguishes between natural illness and social illness (Gunda, 2007). Natural illness is caused by natural agents such as germs, bacteria and viruses while social illness is caused by social agents such as witches and spirits of various kinds.

Kazembe (2009) notes that the general theory of illness in African traditional systems encompass many things such as illness, disease and life in general in terms of the relations between God, the universe and human beings. Kazembe (2009) also established that people who have been turned away from hospitals as helpless and

dying consult maGombwe. One of his respondents highlighted that what a Gombwe cannot heal, no one can heal.

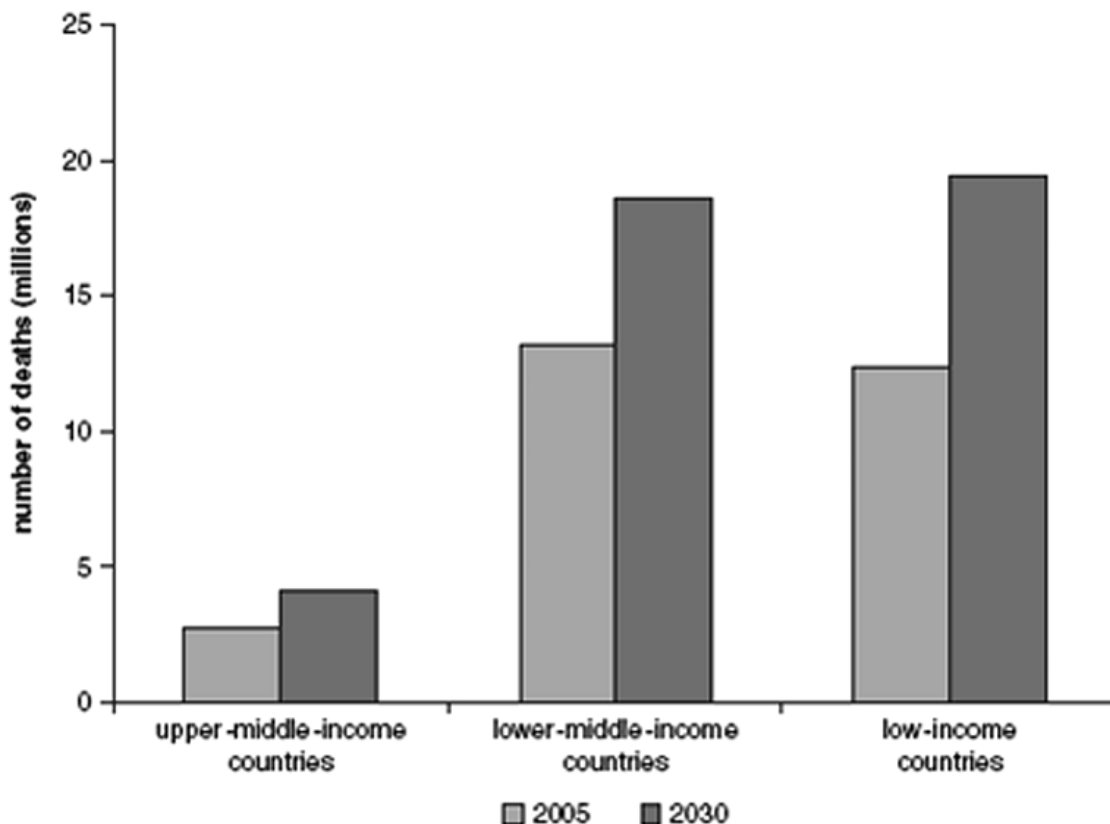
Ancestral reverence perpetuates generational relationships that provide protection, health and balancing of individual, family and cultural dynamics (Edwards, Makunga, Thwela & Mbele, 2009). Many societies and communities believe illness and disease stem from spiritual disharmonies. The belief in the ancestral spirits' power to heal or afflict has a powerful placebo effect that the diviner uses to heal. The spirits of the ancestors are thought to bring illness because sometimes the living may err. These spirits either protect or discipline the living. For a genuine traditionalist Shona, no diagnosis of disease is complete without spiritual diagnosis and treatment.

4.5 THE BURDEN OF CHRONIC DISEASES IN DEVELOPING COUNTRIES

According to Nugent (2008), chronic diseases are increasing in global prevalence and are seriously threatening developing countries' ability to improve the health of their populations. As noted by Townsend (2011), those who seek health care only represent the tip of an iceberg and health professionals only see a small proportion of the symptoms people experience. In poor countries deaths from chronic diseases are exceeding those from communicable diseases. Most governments of developing countries have managed to combat communicable diseases but have neglected chronic conditions (Nugent, 2008). The World Health Organisation has projected an increase in deaths from chronic diseases in low and middle income countries up to 2030. Poor health care is an important feature for the development of chronic conditions in developing countries. Primary health care systems are weak and often ill-equipped to

respond to emerging disease symptoms. Low income populations are the least to get preventive care.

Figure 2: Projected deaths due to non-communicable diseases by country income level, 2005 and 2030



Adapted from Nugent (2008)

4.6 MAJOR CHRONIC CONDITIONS

Chronic conditions may be described as disorders that persist for an extended period of time and affect a person's ability to function normally. In 2010, de Graft Aikins, Unwin, Agyemang, Allotey, Campbell and Arhinful, 2010 projected an increase in deaths resulting from chronic illnesses in Africa within a decade. Africa faces significant challenges of chronic diseases research, practice and policy (de Graft Aikins *et al*,

2010). Many African resource systems are underfunded and struggle to cope with the cumulative burden of chronic and infectious diseases (de Graft Aikins *et al*, 2010). In Africa, chronic illnesses have been associated with a number of factors such as depression, spiritual distress, chronic unhappiness and suicidal ideation (de Graft Aikins *et al*, 2005; Ohaeri, Shokunbi, Akinlade & Dare, 1995; Ellis, 1996; Ebigbo & Oli, 1985). Chronic diseases have been found to cause poverty in families and make demands on the time, emotions and physical capabilities of caregivers (WHO, 1995). According to Commonwealth (2008), Chronic Diseases of Lifestyle (CDL) account for about 60 percent of the global deaths. This was expected to increase by 17 percent in a space of 10 years. Stigma is very common among chronic disease sufferers. Conditions such as cancer, mental illness and epilepsy are highly stigmatised (de Graft Aikins, 2006). De Graft Aikins *et al* (2010) further note that significant a significant number of sick people also suffer from discrimination by community members.

There are several chronic diseases and conditions in Zimbabwe; HIV related illnesses, tuberculosis, cancer, hypertension, epilepsy, stroke, mental illness and cardiovascular conditions. Though the classification of HIV as a chronic condition is contestable, Goldberg and Rickler (2011) have classified it as such.

4.6.1 Mental Illness

Mental illness is one of the chronic illnesses of interest among the Shona people. Muchinako, Mabvurira and Chinyenze (2013) identified a number of assumed causes of mental illness. Chief among them are avenging spirits (*ngozi*), ancestral spirits, sorcery, witchcraft, use of magic charms, love portions and ageing. Muchinako *et al* (2013) further contend that if the afflicted person is not to blame for the cause of the illness,

they get sympathy but if they are to blame, they are ridiculed. In seeking the cause of mental and other illnesses, Shona people do it as a family because there is a belief that a disease affecting one member of the family is likely to affect other members hence the need for the family to collectively approach the problem.

A study by Muchinako *et al* (2013) shows that there is still a continuing belief that the metaphysical sphere influences the cause, treatment and management of mental illness. This is, however, thought to be due to lack of modern psychiatric services in Zimbabwe. Among the Shona people, the mentally ill are viewed as social out-casts, This is attributed to traditional and cultural beliefs. In Zimbabwe, access to modern mental health is centralised and is not accessible to the majority of people especially those who are from rural areas. There are three hospitals that specialise in mental health in Zimbabwe: Ngomahuru in Masvingo province, Ingutsheni in Bulawayo Metropolitan Province and Parirenyatwa in Harare Province. Most people with mental illnesses are likely to resort to traditional herbs as they are the readily available form of medicine. In a study by Wintersteen, Mupedziswa and Wintersteen (1995), it was found that 66% of families with mentally ill members utilised religious counsellors or traditional healers as the first source of help.

4.6.2 Epilepsy

Epilepsy is common in Zimbabwe as it is in other parts of the world. Though WHO puts the global prevalence of epilepsy at 1%, the Epilepsy Support Foundation of Zimbabwe puts the local prevalence estimate at more than 1%. It further asserts that cases of epilepsy may be under-reported due to the prevalence of myths and misconceptions around the condition. Among the Shona people, discrimination of epileptics is rife

(Mugumbate & Mushonga, 2013). People with epilepsy are given names such as *zifaifa* which means dying several times.

4.6.3 Cancer

Cancer or *gomarara* in Shona, can be described as an uncontrollable growth and spread of abnormal cells in the body. It is a leading cause of death in low and middle income countries with a projected 11.5 million people dying of it worldwide in 2030.

4.6.4 Sugar diabetes

Another common chronic disease is diabetes *mellitus* (*chirwere cheshuga*). The Diabetes Research and Wellness Foundation define diabetes as a defect in the body's ability to convert glucose into energy. There are two types of diabetes; Type 1 or insulin dependent diabetes and Type 2 or non-insulin dependent diabetes. With Type 1 diabetes, the body fails to produce enough insulin which is used to process glucose while with Type 2, the body cells are unable to use insulin properly and the unused sugar accumulates in the blood. There is no cure for diabetes but it can be kept under control through various means such as pharmacotherapy and healthy living. In Zimbabwe, diabetes has been reported to be among the top five chronic conditions seen in out-patient clinics (Mufunda, Albin & Hjelm, 2012).

4.7 AFRICAN TRADITIONAL MEDICINE

According to WHO (2001), traditional medicine (TM) embraces ways of protecting and restoring health that existed prior to the arrival of orthodox medicine. WHO (2008) defines traditional medicine as the sum total of knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures that are used to

maintain health as well as prevent, diagnose, improve or treat physical and mental illness. According to Levers (2006), traditional medicine is viewed as holistic as it targets the mind, body and soul of people within their families, communities and religious contexts.

Man and other animals have used herbal remedies and medicine from time immemorial (Pareth, Jadeja & Chanda, 2005). African traditional medicine is the oldest and perhaps the most assorted of all therapeutic systems (Mahomoodally, 2013). WHO (2002) also notes that TM is assuming greater importance in the primary health care of people and communities in the developing world. Sixty percent of the world's population uses herbal medicine for treating their sickness and up to 80% of people living in Africa depend on TM for some aspects of their health care (WHO, 2000). The increased attention to TM can be supported by the following facts; in 2001, Malaysia spent US\$500 million on TM as compared to US\$300 million spent on orthodox medicine (WHO, 2001), 55-60% of Sri Lankans rely on TM and traditional birth attendants (WHO, 2001), about two-thirds of HIV and AIDS patients in developing countries use TM to obtain symptomatic relief, manage opportunistic infections and boost their immune system (UNAIDS, 2003). Richter (2004) notes that the ratio of traditional medical practitioners in sub-Saharan Africa is 1:500 as compared to 1:40 000 for Western medical practitioners.

Traditional medical practitioners include herbalists, traditional healers, diviners and religious healers. Most of these practitioners believe that the ability to diagnose illness is bestowed by God or the practitioner's ancestors on them. Traditional healers have an edge over biomedical doctors in that their healing involves medicine, spiritual, ritual, good luck charms and divination (Mberekó & Mahlatini, 2014). As argued by

Mahomoodally (2013), traditional healers treat the psychological basis of illness before prescribing medicine. Mbereko and Mahlatini (2014) also contend that they make the patient believe in recovery and this helps the patient psychologically. They can interpret bad dreams, something which may be difficult for Western doctors.

Shizha & Charema (2012: 59) posit that “In the African traditional culture, one of the most venerated health components is the significant presence of traditional beliefs and the use of traditional medicine in matters of health and wellbeing involving diviners, midwives and herbalists”. The African Union declared the decade 2001 to 2010 as a decade of African traditional medicine (UNAIDS, 2000). Even though many Africans use traditional medicines, they (the medicines) still remain scientifically unrecognised. TM are more universally located and culturally accepted and respected. In Africa, the healing process does not target the disease but is applied holistically and is a community responsibility (Shizha & Charema, 2012). Shizha and Charema (2008) further declare that community and societal solidarity are the foundation of sustainable social networks and social support provision, and coping strategies required in the healing process.

Mufomadi (2009:33) notes that “Traditional medical science has sustained many Africans for a long time. It is, therefore, not good to dismiss this form of health care” Mufomadi (2009:33) goes on to argue that it is a healing system that is aimed at establishing balance or equilibrium in human beings at several levels; the soul; biological; moral; psychic, subconscious, spirit and physical levels. Shizha and Charema (2012: 62) mention that “western medicine alone cannot detect, prevent, solve or treat the multiple aspects of spiritual, psychosocial and psychological illnesses”.

Basic diagnostic procedures such as divination are used to determine the cause of the illness. According to Mhame, Busia and Kasilo (2010), the traditional medical practitioner's own experiences, added to the accumulated knowledge handed down by the ancestors, allows the practitioner to offer cheap but effective remedies for treating the main ailments.

Diagnosis is central in ATM. According to Mhame *et al* (2010), diagnosis entails a systematic quest for answers to the origins of a particular disease in order to determine who or what has caused the illness and why it has affected a particular person at a particular time. In TM, treatment can either be natural or ritual, or both depending on the cause of the illness. Traditional medicine is a critical component on Indigenous Knowledge Systems (IKS). Indigenous knowledge is inter-generational; it is passed from one generation to the next through cheap means, oral tradition and apprenticeship. Traditionally, Africans have preserved Indigenous Knowledge Systems as a trust for future generations. Most developing countries lack policies that protect indigenous medicines and as such, bio-piracy and bio-prospecting are rife. Lately, some non-Africans attempted to steal IKS from Africa. A number of modern drugs such as quinine and salicylic acid have been developed from indigenous knowledge. However, despite their efficacy, traditional medicines should be used with caution as issues of dosage are not yet clear. As Mposhi, Manyeruke and Hamauswa (2013) state, there is a need for extensive clinical testing of all herbal remedies to ascertain their efficacy and safety as some may be toxic.

4.7.1 Traditional Medicine in Zimbabwe

As noted by Mposhi, Manyeruke & Hamaushe, (2013), 80 percent of Zimbabwean population rely on traditional medicines to cure certain ailments. Other scholars, Shizha and Charema (2012) put the figure at 90%. Health and illness behaviour, and health and medical care systems are integrated into a network of beliefs and values that comprise the Shona society (Shoko, 2011). According to Shoko (2007), among the Karanga group, serious diseases and illness are treated by various forms which involve herbal treatment, extraction of disease causing objects and exorcism of undesirable spirits. The Shona people also use herbs as a preventive measure. Shoko (2007) avers that among the Karanga people, *chifumuro* (exposer) is used. Herbal treatment involves burning some roots or leaves in fire and the patient inhales the smoke to chase away the evil spirit. In some cases, the herbs are mixed with water and the patient is made to drink the herbal solution (Shizha & Charema, 2012). The *chifumuro* is believed to expose the nature of the illness, thus preventing people from attack.

The Shona people also believe in magical objects which are inserted into a human body by witches and sorcerers to cause illness. These usually take the form of insects, feathers, animal skull, worms or metal objects. They are removed by *n'angas* through methods such as *kuruma* (biting), *kukwizira* (rubbing), *kuvhiya* (surgery) or *kupfungaidzira* (blowing smoke) (Shoko, 2007: 502). An interview respondent in Shoko's study indicated that after the object has been extracted, it is displayed for public viewing. Traditional healers work differently with each client. Where illness is attributed to evil spirits or possession, rituals involving dancing, incantations, prayer, inducing of trances and exorcism are performed (Shizha & Charema, 2012).

Traditional medicines are cheaper and accessible for most of the human health care problems currently faced by Zimbabwe. Dhewa (2008) notes that a sick person may be treated and pay later. In some instances, barter trade is acceptable. Mbereko and Mahlatini (2014) found that in Kariba District in Zimbabwe, there were +/- 80 000 people served by two biomedical doctors and around 250 traditional healers. They (Mbereko & Mahlatini) found that low income earners utilise the services of traditional healers more than their high income earning counterparts. Mposhi *et al* (2013:238) postulate that issues of quality, efficacy and efficiency of traditional medicines have been the main cause of poor promotion in Zimbabwe's formal health care system.

For Zimbabweans, the elders and ancestors are key to the continuing access and inheritance of traditional medical knowledge through special dreaming (*kurotswa*) and ritual divination (*kusvikirwa*) where this knowledge is revealed as a gift. Many Zimbabweans who are unable to afford expensive Western medicine, have turned to indigenous healing practices. Despite its criticisms, Abbott (2009) indicates that traditional medicines encompass a large group of healthcare systems, practices and products that are evidence-based and effective.

In Zimbabwe, the use of traditional medicine has endured a number of challenges. It has been associated with witchcraft. For this reason, traditional medical practitioners were prosecuted during the colonial era as they were labelled as witchdoctors. These stereotypes were stimulated by early colonial settlers who tried to destroy TM. Despite the criticism of traditional medicine that it is unscientific, Dhewa (2008) suggests that careful customisation yields many opportunities for innovation and advancement. He

also argues that African traditional healers are equally capable of research, innovation and healing as their allopathic counterparts.

4.7.2 The Legal Status of Traditional Medicine in Zimbabwe

Prior to Zimbabwe's independence, there was no law which recognised traditional medicine. After independence in 1980, Zimbabwe recognised the role played by spirit mediums in the struggle for independence and finally decided to constitutionally recognise traditional practitioners. Pressure from traditional medical practitioners themselves also forced authorities to recognise them. In 1980, the Zimbabwe National Traditional Healers Association (ZINATHA) was formed. ZINATHA seeks to promote traditional medicine and practice, promote research into traditional medicine and methods of healing, promote training in the art of herbal and spiritual healing, supervise the practice of traditional medicine, and prevent abuse and quackery, and promote co-operation with the Ministry of Health to establish better working relations between traditional and allopathic practitioners. ZINATHA has a fluctuating membership of about 55 000 (WHO, 2001).

Two pieces of legislations guide the traditional medical practice in Zimbabwe. These are the Natural Therapists Act and the Traditional Medical Practitioners Act. The Natural Therapists Act Chapter 27:09 regulates the organisation and registration of natural therapists. These include homeopaths, naturopaths and osteopaths. The Traditional Medical Practitioner Council Act of Chapter 27:14 defines traditional medical practice as any act the object of is to treat, analyse, identify or diagnose without the use of operative surgery in illness of the body or mind by traditional medicine. The act recognises ZINATHA as the association for traditional medical practitioners and

provides for the establishment of the Traditional Medical Practitioners' Council. Under this act, it is an offence for a person to practice or masquerade as a traditional medical practitioner.

4.7.3 Traditional Healing Practices

Spiritual healing is recognised by many Zimbabweans. Spiritual traditional leaders and healers go through rigorous training. When herbalists are confronted with a new or strange disease, they seek assistance from the spiritual world and the spirit will lead them to appropriate medicine (Kazembe, 2009). Traditional healers provide a client-centred, personalised health care that is culturally appropriate, holistic and tailor-made to meet the needs and expectations of people. Traditional healers are culturally close to their people. Unlike some western doctors, they treat their patients in the presence of other family members (Mufamadi, 2009). In Africa, the family plays a crucial role during illness. African traditional healing skills are acquired through apprenticeship to an older healer, experience of certain techniques, conditions or by ancestral calling (Ross, 2010). The calling may come in the form of dreams or illnesses. A targeted person may become ill, consult a traditional healer where they are then told about the special calling. The gifting of healing is bestowed by ancestors.

Spirit mediums play an important part in the area of health. They are both religious leaders and as well as health specialists. This strong connection between healing-land and religion is very broad, and it is part of the African theory of illness. This theory attempts to explain illness, relations between ancestors, God and the universe. Traditional healers are believed to have the esoteric knowledge about things beyond the comprehension of ordinary human beings.

Mermaid spirits or water spirits (*njuzu*) are believed to bestow healing powers on their candidates (Chirongoma, 2013; Bernard, n.d; Mujere, 2007). According to Bernard (n.d), spirits of the water are associated with the calling of healers and are seen as the providers of wisdom and knowledge. This procedure usually involves the submersion of the candidate under the water for a certain period after which the person emerges wearing healing regalia.

Bone diviners are one of the common types of diviners in Southern Africa. They use different animal bones that have a symbolic meaning. According to Walter and Jane (2004), the bones are thrown and the position in which they fall is controlled by ancestral spirits. The diviner reads and interprets the bones to uncover the truth and offer advice. Some diviners may even use bones to diagnose a sexually transmitted infection (Mbereko & Mahlatini, 2014).

In a study by Mbereko and Mahlatini (2014), some traditional healers reported that they may be shown a plant in a dream where they are advised about its location and morphology. In most cases, the traditional healer might not even know the plant's name. Such dreams only occur when there is a patient who needs the charm.

Despite the role played by traditional healers in the health delivery systems in most African countries some people such as Christians argue that these healers are involved in giving some people negative charms or responsible for casting evil spells on other people. Bourdillon (1993) also argues that some *n'angas* are motivated by financial gains to do anything. These *n'angas* may produce familiars like *tokolosh* (*zvikwambo*) that may be dangerous to the health and general well-being of the whole community.

Traditional healers have also been criticised for complicating the fight against HIV and AIDS. In a study by Mbereko and Mahlatini (2014), some traditional healer respondents reported that they discourage their patients from using condoms because they believed condoms have AIDS. Generally, practices and instruments used by traditional healers have frequently been blamed by western doctors for exacerbating HIV and AIDS (Mbereko and Mahlatini, 2014). The castigation of traditional healing methods has been fuelled by whites who, upon their settlement in Africa, described TM as primitive, barbaric, ignorant knowledge, superstition and unscientific (Shizha, 2008; Shizha & Charema, 2012).

4.8 UBUNTU (AFRICAN PHILOSOPHY)

African traditional medicine is provided through traditional and cultural philosophy of *Ubuntu*. Though the concept of *ubuntu* has gained tremendous prominence in recent years, it is difficult to define. As noted by Mawere (2012), this difficulty to define *ubuntu* is mainly because the concept is elastic and pragmatic as it is used in almost all the spheres of *Bantu* world-views. Broodryk (2012) defines *ubuntu* as an ancient African world-view which is based on the primary values of intense humanness, caring, sharing, respect, compassion and associated values which ensure happy and qualitative human community life in the spirit of the family. Mkize (2003) further argues that *ubuntu* means qualities such as warmth, empathy, understanding, communication, interaction, participation, reciprocation, harmony, a shared world-view and co-operation. Those who abide by the *ubuntu* ethic are called *abantu* or *vanhu* in Shona.

Bennett and Patrick (2011) posit that *ubuntu* implies a collective personhood in which an individual becomes a person through other people. As a philosophy, it is allergic to any

form of discrimination (Museka & Madondo, 2012). Museka and Madondo (2012) further argue that it is a way of living that contributes positively to the welfare of all members who make up the universe. *Ubuntu* philosophy is important in the study of chronic illnesses in an African setting for two reasons; it is enshrined in traditional African values and belief systems, and it shapes the behaviour and the thinking people of African descent. *Ubuntu* is also seen as an effort to help people in the spirit of service, to show respect to others and to be honest and trustworthy. The concept has originated from the Nguni tribes of South Africa, and it has equivalents among other *Bantu* languages. For example, the word *hunhu* is used among the Shona. Lately, the *ubuntu* philosophy has taken a centre stage in jurisprudence, management, health in Africa and the African diaspora.

The philosophy of *ubuntu* plays a critical role in the care and treatment of people with chronic illness in African communities. Mhame *et al* (2010) postulate that the *ubuntu* philosophy requires traditional medical practitioners to provide health care services for humanitarian reasons first, and not for material gain. Engelbrecht and Kasiram (2012) also argue that in accordance with the principles of *ubuntu*, people with mental illness should be well supported and cared for by their families and the wider community. This is further buttressed by the fact that according to the *ubuntu* philosophy, the community is important and individual needs are secondary to family and community needs. If a person's behaviour is deemed to benefit the community, then one is deemed to be human. As shown by its values, *ubuntu* affects the way people with chronic illness are looked after in African communities. This is supported by the South African White Paper on Welfare which views *ubuntu* as a principle of caring for each other's well-being. The

African expression of *ubuntu* says “Your pain is my pain”. This may suggest that when one is chronically ill, community members may sympathise with that person and may consequently be obliged to help. Under the *ubuntu* philosophy, a person should involve others as brothers and sisters for life and this makes one’s problems lighter (Broodryk, 2006).

Writing on *ubuntu* philosophy, Mbigi (1995:111) talks of the African Collective Fingers Theory which implies that the thumb needs other fingers to work effectively. Under *ubuntu* philosophy, all the people should be treated with dignity and worth, whether they are fit or ill. As noted by Broodryk (2006), sympathy is important in *Ubuntu*, and it is practised when a problem befalls a community member. The communal nature of African ways of dealing with social problems is enshrined in some Shona adages. For example;

Rume rimwe harikombi churu- one man cannot surround an anthill

Kutsva kwendebvu varume vanodzimirana- when men’s beards catch fires,
others assist.

For some Shona people, healing and well-being are a communal endeavour as all members of the community work together towards preserving and securing life, health and wellbeing (Chirongoma, 2013). Among the Shona people, the process of obtaining diagnosis from a traditional healer is not an individual affair. A sick person is usually accompanied by relatives in most cases family elders (Shoko & Burck, 2010). They also have to agree with or refute the results of the diagnosis.

Ubuntu is thus the fountain from which actions and attitudes flow. It is the bedrock of African life that promotes communalism, a spirit of participatory humanism. According to Nyengele (2013), participating in community matters, gives a person a place of belonging, an identity, human dignity and personhood. Interdependence is thus highly valued in African communities than individualism.

4.8.1 Caring for the Sick in African Communities

According to de Graft Aikins (2010), most of the burden of the care of the chronically ill is carried out by their families, households and the community. Communities shape people's interpretations and responses to pain and suffering. In traditional African communities, a person relies on the community when faced with insurmountable problems such as illness. This is shown by Matolino (2011:75) who notes that "In the event of an illness, the community, being one with the individual has the responsibility of taking care of the sick individual and getting rid of the sickness". Mapuranga (2010) states that the idea of doing well to other people as enshrined in the African kernel of *ubuntu* provides a helping hand in the HIV and AIDS prevention and care.

Caring entails giving love and providing for the needs of the person who is in need. Care can be physical, emotional, financial, psychological or any other form (Mapuranga, 2010). Africans recognise the vitality of human life and any action which increases human life is promoted. Mapuranga (2010) argues that discrimination of PLWHA is a problem that violates the African vitality of human life. Usually, the relatives of the sick person engage a spiritual person to find out the causes and remedies of the sickness. Matalino (2011) notes that in the event of mental illness, the person who is afflicted by such a disease would not be sent to some lunatic asylum to be taken care of. Those

close to the person would report the matter to the ancestors so that s/he could be restored to his/her normal state. In African communities, the family plays an important role during one's illness. Among many African communities, it is assumed that an ill person deserves to be treated as a child and therefore, deserves protection (Mufamadi, 2009). Of importance to note is the fact that in African communities, accomplishments of individuals are attributed to the whole family. This also applies to shame and misfortune.

4.8.2 Community and Home- based Care in Zimbabwe

Zimbabwe has a national strategy called National Community Home Based Care Strategy which provides for the care of chronically ill people in their communities. Home-based care has been offered in Zimbabwe for more than two decades for people with chronic illnesses. HOSPAZ (2005) notes that between 70% and 90% of illnesses in Zimbabwe, care takes place at home. Home Based Care (HBC) may be defined as any form of care given to the sick in their homes. HBC is the best way for people to be cared for and to die (Tom & Sadomba, 2013). The current National Community and Home Based Care 2010-2015 policy document notes that the goal of Community and Home Based Care (C&HBC) is to contribute towards an improved quality of life for chronically ill clients and their families through provision of standardised and comprehensive care at community and home level in Zimbabwe (Ministry of Health and Child Welfare and National Aids Council, 2010). HBC has two major strengths; families and communities. Families are the central focus of care and form the basis of HBC team while communities are places where people live and where some community members support their families and their sick individuals. Writing on diabetes, Young and Unachukwu (2012) argues that the relationship that patients have with family members

and colleagues is a very critical factor in improving a patient's sense of wellbeing and leads to more effective management of the disease.

4.8.3 Self-care/ Self-management of Chronic Conditions

There is no agreed definition of disease management. In disease management, care is focused on and integrated across the entire spectrum of the disease and its complications, the prevention, comorbid condition and the relevant aspects of delivery system. Self-management as a component of disease management may be defined as a person's ability to manage the symptoms, treatment, physical, psychological and lifestyle changes inherent in living with a chronic condition (Johnston, Liddy, Lves & Soto, 2008). Self-care encourages patients to be in control of their lives and to be independent. Self-care is an essential component of management of chronic illness among Africans especially where pharmacological treatment is limited. As noted by Harvey (2005), the psychological and spiritual aspects of chronic illnesses are critical in self-care. However, cultural differences should be recognised. Psychological and spiritual elements of self-care include meditation, prayer and traditional spiritual healing.

4.9 PSYCHO-SOCIAL ASPECTS OF CHRONIC CONDITIONS

For many chronic conditions, a number of psycho-social factors are crucial to cope successfully with treatment and maintenance of quality of life. Benzuidenhoudt *et al* (n.d) define psychological effects of a disease as those thoughts, feelings and emotions that affect the mental state and well-being of the infected and affected persons. The psychological effects of illness vary from person to person as people have different coping abilities. According to Charmaz (2000), the diagnosis of chronic illness produces

a crisis which throws people out of ordinary life, order becomes disorder, the controllable becomes uncontrollable, the understandable becomes unfathomable. Chronic illnesses have the potential to induce profound changes in a person's life resulting in the negative effects on their quality of life and well-being (Sprangers, de Regt, Andries *et al*, 2000). Chronic illnesses may result in a variety of stressful outcomes that have negative effects on the psychological adjustment of an individual (Dobbie & Mellor, 2008). Psycho-social aspects of chronic illnesses were also interfere with compliance to medication (DiMatteo, Lepper & Croghan, 2000).

The knowledge that one is infected with an illness, has a significant psychological, social and spiritual consequences. When faced with chronic illnesses, patients are confronted with new situations that challenge their habitual coping strategies. As noted by de Ridder, Geener, Kuijer and van Middendorp (2008), patients with chronic illnesses may have anxiety, depression and other negative emotions.

There are a number of life-threatening conditions that induce psychological problems among people. Chief among them is HIV infection which is a highly stigmatised chronic condition the world over. The diagnosis and experience of HIV is a traumatic life experience in most people. People who are diagnosed with a chronic condition such as HIV, need emotional support to cope with the fact that they have a life-threatening disease. People with chronic illnesses deal with a number of anxieties and stigmas on a daily basis, among them:

- coping with being an outcast within the family, community or work place.
- the stigma surrounding some chronic conditions such as an HIV positive status and the fear of being rejected.

- concerns about dying an ultimately, slow, painful and undignified death.
- anxiety about disclosing HIV positive status to family members, partner(s), and or colleagues.

Learning about HIV positive status is a traumatic event for the concerned person. People learning about a positive result typically react with increased anxiety, depression, anger and distress (Brannon & Feist, 2007).

The infected person may experience decrease in self-esteem as they may no longer have confidence in themselves or what they do. According to Benzuidenhoudt *et al* (n.d), infected people are normally in fear because they have to adjust to a new lifestyle. Persons with HIV and/or AIDS may be caused to see themselves as undesirable by others who view them as contagious (Benzuidenhoudt *et al*, n.d). They also experience isolation as well which is usually caused by loss of support by lovers, family and friends. Another source of stress is the feeling of dependency for emotional and financial support.

The major issue vexing HIV positive people is deciding who should know. In a study by Doyal and Anderson (2008) among HIV positive African women in London, it was found that the women needed some people to know and not others and they were always scared of the responses of people in general. Disclosure need to be properly handled in order to avoid the negative consequences that it may engender. The infected person has to decide who to disclose to, when to disclose and how to disclose. The onus rests on the infected person to disclose his or her status. According to Atibioko and Osinowo (2013), disclosure liberates PLWHA from the burden of shame and secrecy. They, however, posit that even though it is good, disclosure of a positive HIV status is often

difficult and is a potential risk of being stigmatised. Stigma reduces the bearer from being a whole, normal, total being to a tainted and discounted person. Stigmatisation takes place in specific contexts of culture and power (Mbonu *et al*, 2011). According to Greeff *et al* (2008), stigma is significant in Africa where social networks and social values are relatively strong. Mbonu *et al* (2011) notes that anticipated stigmatising societal reactions may also decrease the tendency to disclose zero-status to the immediate social environment.

Mbonu *et al* (2011) further indicate that inadequate knowledge about transmission and about HIV and AIDS can influence how people react to PLWHA. PLWHA are ostracised when they show signs and symptoms of AIDS. According to Mbonu *et al* (2011:213), a person's looks may determine the magnitude of negative reactions he or she receives "if a person with HIV is heavily weighted, people around him/her may not believe that he/she is HIV positive. If a person has appearances widely associated with HIV, people begin to react negatively even if they are wrong about the diagnosis". Another source of stigma is the fact that HIV is associated with promiscuity. A person with HIV or AIDS is frequently an object of blame.

However, Zou, Yamanaka, John, Watt, Ostermann and Thelman (2009) contend that religious beliefs about certain conditions such as HIV can also contribute to fatal attitudes and passive resignation which hinders participation in treatment. The belief that prayer can cure HIV may also challenge adherence to antiretroviral treatment (ART) programme. Wanyama *et al* (2007) found that 6 out of 558 patients in Uganda discontinued their treatment because they believed that their pastors' prayers had cured them of HIV. Zou *et al* (2009) found that shame-related HIV stigma is strongly

associated with religious beliefs such as the belief that HIV is a punishment from God or that PLWHA have not followed the Word of God.

Many patients who are still unfamiliar with HIV and AIDS react to a positive HIV status result with the belief that they have been given a death sentence (Ramamurthy, 2000). Ramamurthy (2000) also notes that even those who cognitively know that HIV/AIDS is chronic are likely to have a strong psychological response that may include dread, despair, fear, guilt, shame or even relief that comes with knowledge.

According to Spies, Afifi, Archibald, Fennema-Notestine and Sareen (2012), mental illness is predominantly high in people living with HIV and AIDS. In the developing world, HIV infected women may face many negative life events than men and this may lead to psychopathology and poor adherence to ART (Spies *et al*, 2012). HIV and AIDS related stigma includes all the adverse attitudes, beliefs and behaviours directed at individuals perceived as HIV infected (Ramamurphy, 2000).

The stigma associated with HIV and AIDS and the resulting discrimination can be as devastating as the illness itself. HIV-related stigma is fuelled by the following factors: HIV is associated with deviant behaviour that is suspected to have caused the positive status, the individual was responsible for it, it is an individual's immoral behaviour that causes HIV, and that HIV and AIDS are contagious and threatening to the community (Letamo, 2011; Wyk, 2007; Ramamurthy, 2000). Stigma is often rooted in social attitudes. According to Wyk (2007:22), AIDS is sometimes seen as a curse from the ancestors and a shame on the family members for not obeying cultural traditions. This has resulted in people burying their HIV deceased relatives in cheap coffins or not even

reclaiming the body from the morgue. Stigmatisation of HIV infection occurs across societies.

Ramamurphy (2000:108) came up with six general dimensions of social stigmas as follows:

- *concealability*: the extent to which a condition is hidden or apparent to others;
- *disruptiveness*: the extent to which it interferes with social interactions and relationships;
- *aesthetics*: the degree to which others react to the condition with dislike or disgust.
- *origin*: the amount of responsibility attributed for causing or maintaining the stigmatised condition;
- *course*: the degree to which the condition is alterable or progressively degenerative;
- *peril*: the degree to which the condition will physically, socially or morally contaminate others.

According to Ngozi, Van de Borne and de Vries (2009), cultural construction of HIV and AIDS based on beliefs about contamination, sexuality and religion plays a crucial role and contributes to the strength of distancing reactions and discrimination in society. People living with HIV and AIDS do not only face medical problems but also social problems associated with the disease. HIV stigma negatively affects seeking HIV testing, seeking care after diagnosis and the quality of care given to AIDS patients. Miller and Rubin (2007) also note that stigma isolates AIDS patients from the community they live in and affects their quality of life. According to Ngozi *et al* (2007), the word

stigma derives from a Greek word *stig'-mah* which refers to a tattoo mark. It denotes marks of humiliation, shame and infamy. Larger social and economic forces also affect HIV related stigma. Ngozi *et al* (2009) further declare that stigma may lead to active discrimination directed towards people who are either perceived to be infected or who associate with them. Rankin, Brennan, Schell, Laviwa and Rankin (2005) and Parker, Aggleton, Attawel, Pulerwitz and Brown (2002) distinguished between internal and external stigma. External stigma refers to the actual experience of stigma while internal stigma refers to the shame associated with HIV/AIDS, and infected people's fear of being discriminated. Ulasi, Preko and Baidoo (2009) note that in some communities, family members of a person who has died of AIDS or lives with HIV are stigmatised. Such family members often they keep it a secret to avoid social rejection.

According to Parker *et al* (2002), early AIDS metaphors such as death, horror, punishment, guilt, shame and others have exacerbated fears which reinforce and legitimising stigmatisation and discrimination. Parker *et al* (2002) note that HIV/AIDS related stigma and discrimination are linked to gender-based stigma. The spread of HIV infection has been linked to female sexual behaviour that is not consistent with gender norms. For example, female sex work is considered a non-normative behaviour and female sex workers are often labelled as vectors who put their clients at risk. Parkers *et al* (2002) also observe that HIV/AIDS related stigma and discrimination interacts with pre-existing stigma and discrimination associated with economic marginalisation. They came up with a vicious circle of stigma and discrimination. In families and communities, HIV/AIDS related stigma, is often manifested in the form of blame, scape-goating and punishment. According to Parker *et al* (2002), communities often gossip about those

perceived to have HIV or AIDS. Extreme cases of stigmatisation may lead to premature death through stigmatisation.

Members of the general population, including relatives of chronically ill people, may find it hard to relate with those who are ill. They may resort to pity, over-protection and sometimes smothering the chronically ill. They may also express intolerance, impatience or frustration with the chronically ill. Another challenge with chronic illnesses which exacerbate their psycho-social effect is that they pose financial challenges to the sufferer and his family especially when a person is no longer able to work or provide income. According to Drummonds (n.d), chronic illness presents immense challenges to a person's sense of self-image and self-worth. Consequently, people with chronic diseases may feel worthless and as a result, isolate themselves. A number of negative emotions have been found to be associated with chronic condition diagnosis and these are; helplessness, frustration, hopelessness, sadness, resentment, anxiety, tension, stress and anger.

Diabetes makes many demands on a person's lifestyle which pose debilitating and life threatening complications with a negative impact on the patient's well-being and social life (Young & Unachukwu, 2012). Anxiety and eating disorders have also been reported in patients with diabetes (Young & Unachukwu, 2012).

The realisation that psychological factors are critical in the treatment of cancer has resulted in the birth of psycho-oncology. The main purpose of psycho-oncology is to investigate psychological factors in the multi-dimensional understanding of malignant diseases which imply psychiatric diagnostics, therapeutic, educational and research in

oncology teams. Psycho-oncology addresses, among other things, psychological reactions to cancer among patients, their family members and their care givers.

4.10 RELIGION, SPIRITUALITY AND CHRONIC ILLNESSES

The spiritual needs of people with chronic conditions are well researched in a number of countries (Moadel, Morgan, Fotone, Grennan, Carter, Laruffa, Skummy & Dutcher, 1999; Hampton, Hollis, Lloyd, Taylor & McMillan, 2007; Yong, Kim & Han, 2008; Bussing, Balzat & Heusser, 2010). Different cultures have developed means of dealing with loss in their own style depending on the traditional beliefs surrounding death and bereavement (Swift, 1989). However, the question in this regard should be whether or not social workers should include spiritual matters when working with chronically ill people. Many patients who are confronted with chronic or fatal conditions rely on spirituality and religion to cope (Bussing & Koenig, 2010). Spirituality and religion are beneficial in that they help in maintaining self-esteem, providing a sense of meaning and giving emotional comfort. They are also gaining attention in health care because they play a vital role in the lives of patients who are recovering from life-threatening illnesses and those who are in palliative or end of life care (Bernard, Maddalena, Njiwaji & Darrel, 2014).

HIV and AIDS are a crisis of enormous spiritual, social, economic and political proportions (UNICEF, 2003). For a long time, spirituality has been associated with illness. It has been found to be beneficial in the treatment of various ailments such as cancer, mental health, and coronary heart diseases (Koenig, Larson & Larson, 2001; Jenkins & Pargament, 1995). Studies have also demonstrated benefits associated with spirituality in AIDS illness (Yi *et al*, 2006; Barney & Buckingham, 2012). Barney &

Buckingham (2012) contend that spirituality is an important coping strategy among patients dealing with HIV and AIDS progression. They note that despite its function, spirituality has also been associated with negative HIV and AIDS outcomes such as stigma and social exclusion. According to Bussing and Koenig (2010), patients' struggle with chronic symptoms can bring feelings of guilt, loss, sadness, loss of self-esteem, loss of role function, questions about meaning of life and communication problems with family and friends. Moadel *et al's* (1999) research in the USA found that 51 percent of cancer patients want help in overcoming fear, 42 percent in finding hope, 40 percent in finding meaning of life and 39 percent in finding spiritual resources.

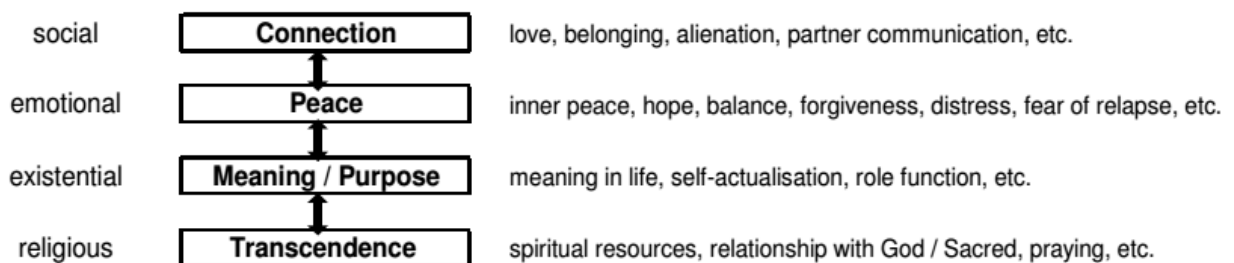
Churches can provide People Living with HIV and AIDs with spiritual counselling, prayers for healing, hope for personal and spiritual salvation, social and material support, personalised care when they are sick and burial after they die (Dilget *et al*, 2007). Zou *et al* (2009), further alludes to the fact that the moral and sexual connotations associated with HIV transmission can also turn the church into a stigmatising atmosphere for PLWHA. This is mainly because HIV positive people are seen to have behaved immorally. Religious beliefs shape individuals' outlook on living with HIV (Zou, *et al* 2007; Ramamurthy, 2000). Faith practices and beliefs can provide a sense of hope and can help people prepare for and accept death. Zou *et al* (2007) argue that people often turn to religion to make sense of and come to terms with being HIV positive. Studies done in the USA by Cotton, Tsevat, Szaflarski, Kudel, Sherman, Feinberg, Leonard and Holmes (2006) have shown that PLWHA use religion to cope with their illness and that being diagnosed HIV positive strengthens people's faith. They also found that an increase in spirituality, after being diagnosed HIV positive, is

correlated with slower disease progression. A sick person may seek closeness with God or may curse God for his situation (Ramamurthy, 2000).

In a South African study by Barney and Buckingham (2012) among patients with advanced AIDS, many of their participants indicated that HIV and AIDS were indicative of God's judgment on sin. In a study by Barney and Buckingham (2012), some respondents also reported believing in ancestors as a significant method of coping with AIDS. Some believed that HIV is an indication that ancestors required veneration or wanted the victim to be a *sangoma*. According to UNICEF (2003), churches have strengths, they have credibility and they are grounded in communities. This offers them opportunities to make a real difference in combating HIV and AIDS. A number of PLWHA receive encouragement from their pastoral staff during HIV counselling as well as from the general congregants.

Bussing and Koenig (2010:21) proposed a spiritual needs model for people with chronic illnesses as follows:

Figure 3: Model of spiritual needs



Model of spiritual needs © Bussing and Koenig (2010:21).

In many African societies, a culture of silence surrounds HIV and AIDS. This is mainly caused by religious association between HIV and immorality. According to UNICEF (2003), in Uganda, imams are including information on HIV and AIDS in religious lectures and sermons.

According to Vance, Brennan, Enah, Smith and Kaur (2011), spirituality and religion can serve as a buffer to the stress of life by allowing people to interpret their life experiences in the context of their beliefs which provide purpose and meaning in life. Generally, chronic disease literature shows the benefits of spirituality and religion in buffering one from stressors of such diseases. In a study by Lorenz, Hays, Shapiro, Cleary, Asch and Wenger (2005) among HIV infected Americans, 80% and 65% reported that their religion and spirituality were important in their lives. Religious participation is also high among those infected persons who did not disclose their HIV status (Vance *et al*, 2011). Vance *et al* (2011) also noted that although religion and spirituality have positive bio-psychosocial outcomes, they can be a source of stress among HIV positive people. Often, the spirituality of people can increase after being diagnosed with HIV (Vance *et al*, 2011). Ignoring spiritual aspects in the management of HIV can contribute to poor health outcomes. Religious and spiritual issues usually emerge during counselling. This is commonly propelled by anger at religious institutions for their particular views on HIV (Vance *et al*, 2011). People with advanced AIDS usually focus on broader spiritual issues which may end of life concerns such as "Will I go to heaven?" (Vance *et al*, 2011). Different groups of people may derive differential benefits from religion and spirituality. Bernard *et al* (2014) state that spirituality gives patients and their families

another opportunity to reconcile with one another, connect, or reconnect with God and seek spiritual, psychological or physical healing.

Siegel and Schrimshaw (2002:91) have identified perceived benefits of spirituality in the lives of PLWHA as follows:

- it evokes comforting emotions and feelings
- it offers strength, empowerment and control
- it eases the emotional burden of the illness
- it offers social support and a sense of belonging
- it offers spiritual support through a personal relationship with God
- it facilitates meaning and acceptance of illness
- it helps preserve health
- it relieves the fear and uncertainty of death
- it facilitates self-acceptance and reduces self-blame.

The comfort of spirituality reduces the distress of life-threatening illnesses. According to Tuck, McCain and Elswick (2001), spirituality and religion are associated with better quality of life, greater social support, and more effective coping among PLWHA. In a study by Peterson, Johnson and Tenzek (2010) among HIV positive women in the USA, the respondents reported that they believed God had a purpose for their lives and that connecting spiritually to God as a higher power provided them with a way to make sense of and make changes to their lives.

In recent years, life expectancy after HIV infection has increased due to Highly Active Antiretroviral Therapy (HAART) but functioning continues to be compromised. This

usually results in reduced quality of life, increased dependency on others and increased mental health outcomes. According to Bernard *et al* (2014), spirituality helps many patients and their families in palliative and end of life care cope with stresses associated with illness and find meaning in the midst of pain and suffering. Bernard *et al* (2014) further argue that spirituality also helps patients with terminal illness, cope with pain suffering, and loss and accept that there is no cure.

4.11 INTERFACING SOCIAL WORK, RELIGION AND SPIRITUALITY IN CHRONIC ILLNESSES

Since its birth, the definitions of social work have changed several times. The International Federation of Social Workers (IFSW) and the International Association of Schools of Social Work (IASSW) General Assembly (2014) revised the definition of social work to “Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion and the empowerment and liberation of people. The principles of social justice, human rights and collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and Indigenous Knowledge Systems, social work engages people and structures to address life challenges and enhance well-being. Cognisant or territorial variances, the IFSW and the IASSW left room for this definition to be amplified at national and regional levels.

The functions of social work seem to, therefore, vary from country to country with a wide variance between the developed and developing worlds. In most developed countries, social work is a well organised and recognised profession while in some developing countries it is in its infancy and seems not to be well acknowledged. Despite definition

issues, social work plays a critical role in health developing systems of most countries mainly as an allied health profession.

Managing chronic illnesses presents a profound challenge to the social work profession. Apart from the patients, their caregivers, other people also require support and empowerment. A long and advanced chronic illness can be highly stressful to both patients and their families. According to Christ and Diwan (2008), the roles of social workers in health care include, among others, (i) assessing the patient and families' psychosocial needs (ii) providing interventions required to address their psychosocial needs and promote their adaptation to illness and disability that may result from it and (iii) developing and implementing effective models of health service delivery. Most social workers in the USA confirmed that spirituality and religion are consistent with professional values. Social work values of client self-determination, service, social justice, dignity and worth of the person, importance of human relationships, integrity and competence work well with spiritually sensitive social work practice (Baskin, 2002).

4.12 SUMMARY

Though Africa is a large continent of diverse cultures, a number of similarities have been identified among the sub-religions of the indigenous African people. Africans are a strictly religious people and as a result of this fact, religion cannot be separated from their everyday lives. African worldviews are different from other worldviews. At the highest level of the African cosmologies is the Supreme Being and there are lesser Gods between him and the living.

Central in most African indigenous religions is the belief in ancestors- spirits of the deceased who are believed to have an oversight on the living. The ancestors have a protective role of the family and also have the capacity to cause misfortunes like illness when angered. Other spirits found in African cosmologies ethnic spirits and wandering spirits. Belief in witchcraft is also another element popular among some African indigenous communities. The witches are believed to have the capacity to cause illness.

Illness has a spiritual explanation among the Shona people of Zimbabwe. Illness is seen as a disequilibrium or imbalance in the spirit world that will be manifesting in the physical. Illness is thus a spiritual disease that also needs spiritual intervention. It is believed among the Shona people that illness can be caused by avenging spirits, wandering spirits, witchcraft, breaching of certain taboos etc.

There are a number of positive aspects of ATR that promote the care, resilience and management of chronic illnesses. There are certain taboos that encouraged the care of sick people. Also of interest is the Ubuntu philosophy whose values of love, caring, respect, mutuality etc ensure that the needy members of the society are taken care of

Africans are an interwoven people characterised by love for one another and communalism. Their traditional way of life is thus opposed to the individualistic nature of western life hence the saying that there are no walls in African communities. The myths and other non-tangible aspects of African life influence the way the sick are viewed. Traditional forms of healing play a critical role in the health delivery systems of most indigenous African communities. Traditional medicine is used to complement western allopathic medicines and a number of governments are promoting it.

There are a number of chronic diseases common in Zimbabwe. These include sugar diabetes, cancer, HIV and AIDS, hypertension etc. These chronic conditions present a number of psycho-social aspects to the sufferers and their families. People suffering from chronic conditions experience the following psychological conditions, anxiety, stress, loneliness as well as physical conditions like pain. Social workers play significant role in the management of these chronic illnesses.

CHAPTER FIVE

RESEARCH METHODOLOGY

5.1 INTRODUCTION

This chapter is dedicated to the methodological framework that was used when exploring the influence of African traditional religion and spirituality in understanding chronic illnesses in Chiweshe communal lands. It outlines all the steps that were followed in this endeavour. It gives justification for the Afrocentric methodology that was used.

5.2 ADOPTING THE AFROCENTRIC METHODOLOGY

For a very long time, African people have been researched on from an European standpoint (Mkabela, 2005). In the predominantly Western oriented academic circles and investigations, African voices are either sidelined or suppressed because African indigenous knowledge and methods are often ignored or not taken seriously (Owusu-Ansah & Mji, 2013). Owusu-Ansah and Mji (2013) further call African researchers to refrain from sticking to research pathways mapped out by Western methodologies. Afrocentrism uses African values, traditions and understanding as a guide for investigating people of African descent. Afrocentrists' major line of argument is that knowledge and science, and its methods of investigation cannot be divorced from a people's history, cultural context and world-view. According to Owusu-Ansah and Mji (2013) it is dangerous to hail any one method of investigation as universal because knowledge has cultural relevance and must be examined from its particular focus.

African knowledge and methods of knowing must drive African research if it is to be meaningful to its people. This study has used the Afrocentric methodology (Asante, 1988; 1990; 1995; Mazama, 2003; Mkabela, 2005; Pellerin, 2012). According to Mkabela (2005:179) "The Afrocentric method is derived from the Afrocentric paradigm which deals with the question of African identity from the perspective of African people, as centred, located, oriented and grounded. Pellerin (2012) argues that an Afrocentric social scientist is charged with the task of creating new research methods that are rooted in the African people's histories, cultures and experiences. Eurocentric research criteria of objectivity, validity and reliability are inadequate and incorrect when researching human experiences in African communities (Reviere, 2001).

According to Mazama (2003), Afrocentricity emerges as a methodology that operates within African ways of knowing, and existence and results in the implementation of principles, methods, concepts and ideas that are derived from our own African experiences. Afrocentric researchers believe that social science researchers should take into consideration the historical, social and contemporary experiences of African people. Afrocentrism is an orientation towards data in which the researcher assumes the right and responsibility to articulate research subjects' reality from the emic perspectives, drawing from their own ideals and values. It is a reaction to the distortions of Eurocentric perspectives of phenomenon in local African environments (Mulemi, 2011). The Afrocentric approach to data collection and analysis supports goals of practical ethnography into prioritising people's felt need for improved well-being rather than theory construction or knowledge production. Afrocentric methodology advocates

for cultural immersion, indigenisation of tools and methods of investigation and the interpretation of research data from an indigenous African perspective.

Eurocentric approaches do not conform to people-centred research envisaged in the canons of Afrocentrism. In Afrocentric methodology, the researcher and the researched have an interactive role in the production of theoretical and applied knowledge (Mulemi, 2011). Owusu (1978) argues that in Afrocentric research, the researcher must have familiarity with the history, language, philosophy and myths of the people being researched. The researcher should identify with subjects to appreciate how they see things and construct reality. According to Cunningham and Durie (1998), understanding of cultural frameworks requires indigenous African people's involvement and control of research. Canons of Afrocentrism underpin Afrocentric methodology. Reveire (2001) identified the following five canons that should guide an Afrocentric research enquiry: *Ukweli* (truth), *Kujitolea* (commitment), *Utulivu* (calmness and peaceful), *Uhaki* (justice) and *Ujamaa* (community). According to Chilisa (2012:191) the canons are derived from seven cardinal African virtues of truth, justice, rightness, propriety, harmony, order and balance and reciprocity. Afrocentric studies are therefore based on indigenous African principles.

Mazama (2003) observes that Afrocentric research should have the following characteristics:

- African experience should guide and inform all inquiries,
- the spiritual component is important and must be given its due place,
- immersion in the subject is necessary,

- wholism is a must,
- intuition is a valid source of information,
- not everything that matters is measurable,
- knowledge generated must be liberating.

Given these characteristics of Afrocentric research methodology, it is the most suitable methodology for examining the role of African traditional religion and spirituality in chronic illness in the rural setting of Chiweshe communal lands. In Afrocentric research, priority is given to African people's customs, beliefs, motifs and values. This is the rubric by which the application of an African methodology operates. Afrocentricity as a research methodology which serves as an empirical method rooted in the entire agency of the African people (Pellerin, 2012). According to Pellerin (2012), utilising an Afrocentric methodology equips the researcher with a detailed foundation for employing culturally correct methods, principles and frameworks in analysing African phenomena. When using the Afrocentric methodology, the issue of cultural location takes precedence over the topic or the data under consideration (Mkabela, 2005). Afrocentric method focuses on the cultural centre for the study of African experiences and interprets research data from an African perspective. According to Mkabela (2005), it is absurd to study indigenous knowledge while staying hooked to external methodologies. An Afrocentric researcher emphasises and identifies with the people being studied in order to understand how they see things. According to Kershaw (1992), the Afrocentric scholar should produce emancipatory knowledge. The knowledge obtained from Afrocentric studies should thus relieve Africans of western knowledge hegemony.

If research is Afrocentric, indigenous African people must be in control of and participate in the entire research process from the beginning to the end (Mkabela, 2005). In Afrocentric approach, research is approached as a negotiated partnership which allows the indigenous communities to define for themselves the degree to which they wish to make themselves available as subjects. Indigenous communities have control over the research process. The Afrocentric paradigm emphasises active involvement of the researched. However, participation alone is not enough to qualify a research activity as Afrocentric (Mkabela, 2005). Afrocentric research allows the researcher to “establish rapport, convene, catalyse, facilitate, adapt, “hand over the stick”, watch, listen, learn and respect” (Mkabela, 2005:184). In Afrocentric research, participants should not be treated as informants but as colleagues and equals. Involvement of local people in all aspects and stages of the research process from the beginning to the end is crucial (Owusu-Ansah & Mji, 2013). The African collective ethic is central to Afrocentric research. According to Mkabela (2005:186), if the ethic is translated into research, it would include:

- an appreciation of the importance of all individuals in the research group
- an understanding that research is part of a very complex (community) whole
- the respect for heritage authority
- the inclusion of elders and cultural committees in the research process
- an understanding of the connectedness of all things (including the spiritual) and a required long term perspective in dealing with research issues.
- researcher must act in an appropriate and respectful manner to maintain the harmony and balance of the community.

As argued by Mkabela, the researcher took the following into consideration;

- the researcher had various population groups as part of the target population as part of appreciation of the invaluable information they could contribute to the study
- the researcher tried by all means possible to respect the cultural heritage of the people of Chiweshe community for example data collection was not done on Fridays as it is a resting day
- the elderly and traditional leaders were included in the study
- the researcher tried by all means to avoid instigating conflict and misunderstanding among the people of Chiweshe during the research process.

One advantage of Afrocentric methodology in the current study is that it fits well as a culturally sensitive research which, according to Tillman (2004), should address (a) specific knowledge, language and world views (b) shared orientation based on cultural, historical and political experiences and (c) specific behaviours that determine cultural distinctiveness.

5.3 RESEARCH APPROACH

According to Mkabela (2005), the principles underlying Afrocentric research are in line with qualitative research in which researchers should actively participate and be involved in the production of knowledge. According to Mkabela (2005), Afrocentric methodology shares the same characteristics with qualitative research method. Both methods assume that people use interpretive schemes which must be understood and that the character of the local context must be articulated. This study is thus qualitative

in nature. Defining qualitative research is difficult but according to Mason (2009) it has the following features:

Is grounded in a philosophical position which is broadly interpretive in the sense that is concerned with how the social world is interpreted, understood, experienced produced to constituted. Is based on methods of data generation which are both flexible and sensitive to the social context in which data are produced. Based on methods of analysis, explanation and argument building which involve understandings of complexity, detail and context.

According to Padgett (2008), qualitative data rely on words especially nouns and adjectives that convey what exist while quantitative data use numbers to describe what exists. Qualitative data capture subtleties of meaning and interpretation that numbers do not convey.

Engel and Schutt (2009) note that data that are treated as qualitative are mostly written or spoken words or observations that do not have a direct numerical interpretation. According to Padgett (2008), qualitative design is best fit when explaining a topic about which little is known especially from an insider perspective and where an in-depth understanding is sought. Qualitative research is also suitable when one is pursuing a topic of sensitivity and emotional depth (Padgett, 2008). Qualitative research gives the researcher an understanding of a particular context within which respondents act and the influence that this context has on their actions. This approach is the most ideal in identifying the role of African spirituality in chronic illnesses in a rural setting.

An in-depth understanding can only be obtained through a qualitative approach. Qualitative approach was the most suitable one to be used because it has allowed the researcher to clarify hypotheses, beliefs, attitudes and motivations of the people under study. According to Padgett (2008), in qualitative research, focus is on flexibility and depth rather than on mathematical probabilities and external validity. The phrase that quantitative design is a mile wide and an inch deep and qualitative design is an inch wide and mile deep holds water (Padgett, 2008). Spirituality and religion are experienced on a deeply personal level, evoking strong emotions, requiring a classroom environment of respect for diverse ideological perspectives. "Through qualitative research we can explore a wide array of dimensions of the social world, including the texture and weave of everyday life, the understandings, experiences and imaginations of our research participants, the ways that social processes, institutions, discourses or relationships work and the significance of the meaning that they generate" (Mason, 2009:1).

Qualitative approach was chosen for a number of reasons which are, among others, the fact that it places people at the centre of research. This is in line with the Afrocentric paradigm which allows a meaningful interaction between the researcher and the researched. There was a need for sufficient interaction with members of Chiweshe community in order to develop knowledge about their religious and spiritual experiences in relation to chronic illness. Participants were thus allowed to tell stories of their experiences in an open-minded manner. Another argument for the use of qualitative approach is its heuristic nature which allows the researcher to expand knowledge of the

phenomenon under investigation. The inductive nature of qualitative approach has made it the most appropriate approach as compared to quantitative approach. Words used by the community members have led to rich sources of data. Qualitative data is usually associated with small samples. It is often linked to the case study orientation, inductive and constructivists approaches of inquiry and is considered to be highly flexible than quantitative approaches.

According to Dahlberg and McCaig (2010), qualitative research is an interpretivist approach that provides a way of identifying in-depth information about a subject especially concerning under-researched areas, sensitive topics or groups that are hard to reach. Chronic conditions are life-threatening and a result a very sensitive topic to research on. This has made qualitative research suitable for the ethical context of the study since it allowed participants to freely express their feelings and explain inconsistencies, conflicting opinions and deep-seated beliefs. There was suspicion and fear that some participants could break down during the interviews but none did so. In spite of the fact that none of the participants broke down, prior arrangements had been made with a social worker for referral.

5.4 RESEARCH DESIGN

Gray *et al* (2007) defines research design as the overall process of using one's imagination as well as the strategy and tactics of science to guide the collection and analysis of data. Research design is a plan for collecting and analysing evidence that will make it possible for the investigator to answer whatever questions he or she has

posed (Flick, 2009:128). This study has used the case study design. Payne and Payne (2011) define a case study as a detailed research enquiry into a single example seen as a social unit in its own right and as a holistic entity. According to Gray (2004:124), “the case study design is ideal when a how and why question is being asked about a contemporary set of events over which the researcher has no control”. A case is a phenomenon or an event chosen, conceptualised and analysed empirically as a manifestation of a broader class of phenomena or events.

According to Porta and Keating (2008:226), a case study is a research strategy based on in-depth empirical investigation of one or a small number of phenomena in order to explore the configuration of each case and to elucidate on a larger class of similar phenomena by developing and evaluating theoretical explanations. Porta and Keating further indicate that case studies usually explore subjects about which little is known. According to Yin (2003), a case study design is used when (i) the focus of the study is to answer how and why questions (ii) one cannot manipulate the behaviour of those involved in the study (iii) one want to uncover contextual conditions because one believes that they are relevant to the phenomenon under study (iv) boundaries are not clear between the phenomenon and the context. According to Yin (1984), there are three types of case study designs namely; descriptive case studies, exploratory case studies and explanatory case studies. Descriptive case studies are set to describe the natural phenomenon which occurs within the data in question. Exploratory case studies are set to explore any phenomenon in the data which serves as a point of interest to the researcher. Lastly, explanatory case studies examine data closely, both at a surface and deep level, in order to explain a phenomenon in the data.

This study has focused on members of Chiweshe communal lands who subscribe to African traditional religion. In a case study, a person can take people, communities, or organisations as subjects of case analysis. Case studies raise the question of how to select the case under study in a way that permits more general conclusions to be drawn from analysing it. Given the researcher's limited resources, Chiweshe area was selected based in proximity and the researcher's familiarity with the area. Another point which was considered was the presence of *masvikiro* (territorial spirits) and *maGombwe* (senior spirits in the hierarchy of Shona spiritual cosmologies) in the area as documented by Kazembe (2009).

Another important question is case delimitation. In this study, Chiweshe communal lands was defined as part of Mazowe District which was never occupied by White commercial farmers for agricultural purposes. The area is made up of three chiefdoms; Chief Chiweshe, Chief Makope and Chief Negomo. However, in the current study, data were collected from Chief Chiweshe's area only.

Case study method has a number of advantages. Firstly, examination of data is often conducted within the situation in which the activity takes place. Secondly, a detailed qualitative account produced in case studies helps to explain the complexities of real life situations which may not be captured by experiments of survey designs.

Case study design has, however, also been criticised on a number of grounds. It is accused of lacking rigour. Thus the case study researcher allows equivocal evidence or biased views to influence the direction of his/her findings or conclusions. They provide very little basis for generalisations since they use a small number of subjects (Zainal, 2007).

5.5 TARGET POPULATION

A study population is a collection of all units of the study from whom the research wishes to make specific analysis and conclusions (Welman, Kruger & Mitchel, 2007). Central to Afrocentric research is the canon of *Ujamaa*- the need for recognition and maintenance of the community. Though this study was on chronic illness, it targeted other members of Chiweshe communal lands in addition to those living with chronic diseases. These included the elderly, traditional medical practitioners, village health workers and community home-based care workers, traditional cultural leaders and family members of people living with chronic illnesses. For the purpose of inclusion and exclusion, an elderly person was defined as any person above 70 years of age and the term traditional medical practitioner was used to refer to herbalists, bonesetters, psychic healers, faith healers, diviners, and spiritists who use indigenous knowledge for developing materials and procedure (Dhewa, 2008). African cultural environment encourages communalism and as such, the researcher-participant separation is discouraged.

Mhame, Busia and Kasilo (2010) argue that satisfactory healing in traditional African communities involves not only recovery from physical symptoms but also from social and psychological re-integration of the patient into his/her community. There was, therefore, a need to include other members of Chiweshe community who were thought would provide rich information on the subject under study. Another reason is that social workers in Zimbabwe are mandated to respect familial and community relations. This is evidenced by the Social Workers Code of Ethics (2012: 1028) which states that all social workers must aspire to “recognise and promote *unhu/ubuntu*, and appreciate that

inherent in each person is dignity and value, and that each person deserves respect. It further stipulates that people exist within a cultural setting and a community and that the individual and community shape, influence and benefit each other. As noted Nelson-Becker (2005), community members may act as cultural brokers by acting as leaders who assist practitioners with understanding the nuances of culturally diverse religions and world views

The ultimate authority in Afrocentric research should be the experiences of the community. With this in mind, this study targeted all the members of Chiweshe communal lands who subscribe to the African traditional religion. Unlike in European settings, in Africa, life is communal. This means that one person's problem becomes a family problem and ultimately a community problem. An important tenet of Afrocentric research is that the inquiry cannot represent the position of a single individual but must be validated by the community which serves as the subject of inquiry (Banks, 1992). According to Mkabela (2005), inclusion of elders and cultural committees is critical in Afrocentric research. Units of inquiry were, therefore, people with chronic diseases who subscribe to ATR and their families, traditional medical practitioners, Village Health Workers (VHW), community home-based care workers, traditional cultural leaders and the elderly in Chiweshe communal lands. People with chronic illnesses were included in the study for their first hand experiences with chronic conditions.

Families of people with chronic illnesses were included for a number of reasons; these are usually the primary care givers who live with the chronically ill people, they take part in managing the illness and they have assumed cause of their relative's illness. According to Liu, Manton and Aragon (2000), sixty-six percent of community dwelling

people who need long term care rely solely on family and friends for help. Another critical aspect is the fact that in traditional African cultures, more emphasis is placed on collective rather than individual interests, and on the achievement of individual fulfilment via group means (Gray & Fook, 2004). Chronic illnesses exert a burden on the patient's family members. Furthermore, families influence the patient's psychological adjustment and management of the illness (Goldberg & Rickler, 2011). The family plays a profound role in the care giving process. The patient's close family members may experience psychological distress, decreased satisfaction in relationships and poor physical health (Glasdam, Timm & Vittrup, 2010).

Among the Shona people, an illness is not a matter to be dealt with exclusively by the patient and his doctor but it is the responsibility of the whole family (Swift, 1989). Family homeostasis is disrupted when a member develops a chronic illness. As noted by Lawrence (2012), chronic illness disrupts the family's self-image and self-esteem. Another aspect highlighted by Lawrence (2012) is that partners of people with chronic illness face dual challenges (1) as the primary provider of support to the ill partner and (2) as a family member who needs support in coping with illness related stress. The partner may feel powerless to see their partner in pain. Having a child with chronic illness has also been found to negatively impact the family. Lawrence (2012) argues that this may result in communication problems between spouses, higher divorce rate, increased relationship conflict, increased role strain and decreased relationship satisfaction. Another critical element cited by Mhame *et al* is that during treatment in traditional medicine the opinion of other family members may be sought regarding the patient's illness.

Traditional leaders wield influence and command much respect in traditional African communities. With adequate support, traditional leaders can facilitate positive change in local communities. They preside over customary law courts and exercise legislative power in many communities. As custodians of culture, traditional leaders have the required influence to alter underlying values and beliefs that are detrimental to community members (SAFAIDS, 2011).

Most traditional medical practitioners are agencies of African traditional religion. According to Green (1994), traditional doctors are religious ritual specialists, family and community therapists, moral and social philosophers, teachers and visionaries. Village health workers are community members trained to offer primary health care at the village level. They have experience of community and home-based care. These were thought to have knowledge of the influence of African traditional religion and spirituality in chronic illnesses.

5.6 SAMPLING METHOD

According to Gray, Williamson, Karp & Dalphin (2007), sampling is the process of selecting a relatively small number of cases from the social whole. Sampling saves time and money and if done properly, it does not stop researchers from making generalisations. Purposive sampling was used to select participants for inclusion in the study. In purposive sampling, population elements are purposely drawn from the population. Padget (2008) echoes that purposive sampling is a deliberate process of selecting respondents based on their ability to provide needed information. In purposive sampling, attention is given to people who can provide the desired information. People with chronic diseases or conditions, who subscribe to ATR, their families and other

members of Chiweshe communal lands were selected for inclusion in the study. Only participants who have been ill for at least two years were selected. These were thought to have enough stories to tell about their illnesses. The study purposely excluded bedridden people on ethical grounds. Purposive sampling enabled the researcher to obtain extensive opinions on the influence of African traditional and religion in understanding chronic illnesses.

5.7 SAMPLING SIZE

A question that often plagues emerging researchers is how large their sample size should be. According to Cohen, Manion and Morrison (2011), there is no clear-cut answer to this question. The correct sample size depends on the purpose of the study, the nature of the population under scrutiny, the level of accuracy required, the number of variables included in the study and whether the research is qualitative or quantitative. In Afrocentric methodologies, the researcher should take care to involve a proportionate sample of African people. This is supported by Pellerin (2012) who posits that an Afrocentric researcher must remain cognisant of the agency of African people and must take care to involve a proportionate sample size. In the current study, eleven people with chronic illnesses participated. The information they provided was augmented by eighteen other members of Chiweshe communal lands who participated in focus group discussions and six families of people with chronic illnesses. The sample size was based on the principle of saturation which states that data collection should stop when no new themes are emerging.

5.8 DATA COLLECTION TECHNIQUES

Tools of measurement used in Afrocentric research must be in harmony with African people's existence. According to Pellerin (2012), applicable tools should not threaten, intrude upon or disrupt the agency of people's lives. There is no one best technique for gathering data. According to Gray *et al* (2007:43), choice of data collection technique depends on: the level of social interaction one needs or wish to observe, the type of information one wants to know, the resources available for research and the relative easy access to individuals, groups or communities. A number of instruments were used to gather data from the participants. These include one-on-one interviews, family interviews and focus group discussions.

5.8.1 Interviews

According to Gray (2004), an interview is a conversation between people in which one person assumes the role of a researcher. In other words, an interview is a face-to-face interaction between the researcher and the respondent. Interviews which allow more direct questions are preferable in a case study design. Interviewing is one of the most frequently used techniques of gathering qualitative and descriptive data that are difficult and time-consuming to unearth. One of the most important sources of case study information is interviewing (Yin, 2008). This method was used to gain an in-depth understanding of the subject under review. "A well conducted interview is a powerful tool for eliciting rich data on people's views, attitudes and the meaning that underpin their lives and behaviours" (Gray, 2004:213). According to Gray (2004:214), interviews are a favoured approach where: there is need to attain highly personalised data, there are opportunities required for probing and a good return rate is important

In this study, the interview questions were created by the researcher for the purpose of gathering data from each participant's demographic information: experiences around spirituality, religion and illness. Data were collected orally from each participant. Conversations during interviews did not follow a uniform question and answer pattern. In order to achieve a reasonable amount of consistency, an interview schedule was used (see Appendix 1 and 1B). In face-to-face interviews, the response rate is usually higher as compared to questionnaires or telephone interviews. They allow for elicitation of more details. According to Gray (2004), face-to-face interviews allow the researcher and the interviewee to create rapport. He further contends that face-to-face interviews help ascertain respondents' reasons for doing something or holding a personal view. The researcher tried to make the conversation as casual as possible. The following disadvantages of interviews have been cited:

- danger of bias due to poorly constructed questions.
- response bias
- inaccuracies due to poor recall
- interviewee can give what the interviewer wants to hear.
- arranging interviews, travelling and establishing rapport are time consuming.
- is generally expensive

According to Gray *et al* (2007), the presence of an interviewer can improve the quality of responses in that if a subject does not understand a question, the interviewer can clarify its meaning. In cases where responses are not clear, interviewers can also seek clarity. Intensive interviewing offers an opportunity to probe extensively for sensitive information from potentially evasive individuals. In the in-depth interviews, the researcher takes

account of each interviewee's individuality in deciding what to ask as well as when and how to ask it (Gray *et al*, 2007).

Recording information usually influence the pace of the interview, the nature of the responses and the quality of the analysis. The researcher recorded the interview proceedings on a tape. Two types of interviews were used to gather data from the respondents. These include one-on-one interviews and family interviews.

5.8.1.1 One-on-one Interviews

One-on-one interviews were used to gather data from the chronically ill people. This method was used to gain an in-depth understanding of the subject under review. The interview questions were created by the researcher for the specific purpose of gathering data on each participant's demographic information: experiences around spirituality and religion. Data were collected orally from each participant while the researcher took notes. All the discussions were in Shona which is the local language in Chiweshe area. Personal interviews are beneficial in that the respondents are motivated to participate. Interviews ensure a high level participation among the respondents as compared to other methods. Another merit of interviews is that it allows the researcher to modify the line of inquiry and follow up interesting responses.

5.8.1.2 Family interviews

Data were also gathered through family interviews. These are families whose members had a chronic disease. Interview questions were directed to the whole family. This data collection method was used by Wintersteen, Mupedziswa and Wintersteen (1995) who were researching on mental illness in Zimbabwe. Families in all their remarkable

diversity are the basic foundation of all human cultures. Crises can make families even stronger. The researcher has ensured that each family member is given an opportunity to share his or her ideas. The researcher chose this data collection tool based on the principle of *ujamaa* which suggest that African people are communal. The understanding was that individual experiences, beliefs and the problems which are caused by the illness are usually shared by the whole family.

The interviews were held at the respondents' homestead during their free time. Among the Shona people, just like in many other African communities, the family plays a very important role during a person's. It is, therefore, critical to understand the family's set or beliefs, cultural expectations and caring practices for people who are chronically ill. In most African cultures, the family is considered as an entity that has existed before one was born and will exist after one has died (Mufamadi, 2009). People with chronic illnesses were excluded from family interviews. As noted by Wintersteen *et al* (1995), this allows participants to be more comfortable and free to talk when the ill members of the family are not around.

5.8.2 Focus Group Discussions

Data were also solicited from the participants through focus group discussions. According to Remenyi, Williams, Money and Swartz (2005), focus group is a research approach of collecting evidence from a highly specialised group of individuals. Gilbert (2012) is of the view that a focus group consists of a small group of individuals numbering from six to ten, who meet together to express their views about a particular topic defined by the researcher. In a focus group discussion, a facilitator or moderator leads and guides the discussion between the participants. According to Silverman

(2011), focus groups allow the researcher to do an in-depth exploration of the participants' views and experiences on a specific subject. The evidence collected using a focus group is usually analysed using qualitative techniques. Focus group method has been selected because it is a useful way of obtaining evidence from experts in an intense and concentrated way. Three group discussions were held with the following groups of people:

- traditional cultural leaders and the elderly
- traditional medical practitioners
- Village Health Workers and home-based care workers

In Afrocentric research, the researcher should have some familiarity with the history, language, philosophy and myths of the people under study. In this study, all the discussions were carried out by the researcher and all proceedings throughout data collection were in Shona which is the local language in Chiweshe communal lands. An advantage of focus group interviews is that they allow a variety of views to emerge while group dynamics can often allow a stimulation of new perspectives (Gray, 2004). Drawbacks of focus groups include sampling bias and expectancy effects. In FDG, participants are usually not representative of any population. Validity of focus group findings is heavily dependent on the authenticity of participants' prior experience and their willingness to be frank (Gray *et al*, 2007). The researcher was the moderator in all the group discussions. Each group consisted of six members. The group size was small enough for all the participants to have opportunities to share their insights, identify themselves as group members, engage in face-to-face interactions, and exchange

thoughts and feelings among themselves. The group size was also large enough to allow diversity of perceptions (Allen-Meares, 1995; Fieldman, 1995).

During the discussions, the researcher started by welcoming the participants in order to make them feel at ease. He then asked them to introduce themselves. The researcher requested permission to audiotape the proceedings. The focus group participants were encouraged to provide as much information as they could. They were also told that they were free to agree, disagree, question and discuss issues with one another while the researcher ensured that all issues that were raised were addressed.

5.9 RESEARCH PROCEDURE

Research participants were identified through contacts with Village Health Workers (VHW) in Chiweshe communal lands. The researcher informed traditional cultural leaders about his visits in their areas. This is in line with Afrocentric research which respects traditional cultural leaders when data is collected in their villages. The researcher made prior visits to respondents and furnished potential respondents with details of the study. Those respondents who were fit enough and accepted to participate in the study were made to read and voluntarily sign informed consent forms. For family interviews, the family heads signed the consent forms on behalf of the families. The researcher had two contacts with chronically ill participants and one contact with all the other participants.

5.10 DATA ANALYSIS

There are many qualitative analysis methods such as conversation analysis, phenomenological analysis, discourse analysis, narrative analysis and many others. In

the current study, thematic analysis was used to analyse the data (Braun & Clarke, 2006). Thematic analysis is a method of identifying, analysing, and reporting patterns (themes) within data (Braun & Clarke, 2008). Thematic analysis has a theoretical freedom in that it is not tied to any particular theory and as such, offers a flexible and useful research tool (Braun & Clarke, 2008). In thematic analysis, a theme captures something important about data in relation to the research question. The researcher's judgement is crucial in determining what a theme is since there is no hard and fast answer to what proportion of data constitutes a theme. It involves the searching across a data set to find repeated patterns of meaning.

5.10.1 Data Analysis Steps

- The first step towards data analysis was familiarisation with the data. Familiarisation started during data analysis when the researcher captured the responses of the study participants. The researcher also read through the data several times and noted down interesting ideas.
- The second step was generating initial codes. Data were organised into groups. The researcher used a highlighter to indicate patterns in the data. Related data were collated into specific codes.
- The third step was searching for meaningful themes. Codes were collated into possible themes. All the data relevant to each particular theme were grouped together.
- The fourth step was reviewing and refining themes. The researcher went through all the themes and ensured that they captured the coded data. Certain themes which were not supported by sufficient codes were removed while others which

were spitted into two or three themes. This stage ended by naming the themes in relation to the aim of the study.

The last step in data analysis was report writing.

5.11 COMMUNITY INVOLVEMENT THROUGHOUT THE RESEARCH PROCESS

In Afrocentric research, the researcher should identify collaboration by allowing the community to participate and provide input during all the stages of the research process (Letiecq & Bailey, 2004). Members of Chiweshe community directly and indirectly participated in the research process. The researcher set up a research committee which comprised of the following people from the community: one school teacher, one member from the Ward Development Committee, one person from local political leadership, one university student, one Village Health Worker and one village head. The team was made up of seven people including the researcher. The school teacher and the university student helped in translating the research instruments into Shona. The village head introduced the research team to the cultural leadership in Chiweshe community. The village health worker was actively involved in organising venues for focus group discussions. Village Health Workers assisted in identifying interview study participants.

5.12 PRESENTATION OF THE RESEARCHER IN THE FIELD

Condemning African culture in its totality results in the absence of genuine interaction between the researcher and the researched. Data were collected in the summer season and many people in Chiweshe area were working in their fields. To identify more with

the people, the researcher dressed simply and all his conversations with the people of Chiweshe were in their vernacular language.

5.13 TRUSTWORTHINESS

In a purely qualitative study, addressing trustworthiness is more relevant than addressing validity and reliability (Sandelowski, 1993; Engelbrecht & Kasiram, 2012). Trustworthiness is closely related to rigour or goodness of qualitative research (Morrow & Smith, 2000; Morrow, 2005). Guba (1981) identified four constructs of trustworthiness in qualitative research: credibility, transferability, dependability and conformability. Credibility is the equivalent of internal validity in quantitative research. Lincoln and Guba (1985) argue that ensuring credibility is one of the most important factors in establishing trustworthiness.

One of the strategies of ensuring credibility is familiarising oneself with the culture of participating organisations. The researcher was well versed with the culture of Chiweshe people. Another strategy is triangulation (Lincoln & Guba, 1985). In the current stage, data was collected through three different methods (triangulation) that is one on-one-interviews, focus group discussions and family interviews. Another strategy is voluntary participation of respondents. Participants should be offered the opportunity to refuse to participate so that only those who are willing, offer data freely. In this study, participants signed a consent form which specified that participation was voluntary and they were free to drop at any stage. Debriefing of superiors is a way of ensuring credibility. The researcher kept the supervisor abreast of all his activities throughout the research process. Transferability is equivalent to external validity in quantitative research. According to Shenton (2004), since the results of a qualitative study are

based on a small sample, it may be difficult to demonstrate that the findings and conclusions are applicable to the other situations.

Dependability is equivalent to reliability. It implies that if the work was repeated in the same context with the same methods and with the same participants, similar results will be obtained. Measuring reliability may be difficult in a qualitative study. However, overlapping methods may be used to counter adversity. Another method of ensuring dependability is clarity on the research process so that future researchers may be able to repeat the work in the same area. Strategies employed to ensure trustworthiness in this study should be treated with caution. Social science researchers do not agree on how to ensure quality in qualitative research. This is supported by Golfe (2006:305) who posit that “Any attempt to establish a consensus on quality criterion for qualitative research is unlikely to succeed for the simple reason that there is no unified theory, methodology or methods that can collectively be described as qualitative research.....”

5.14 ETHICAL CONSIDERATIONS

Throughout history, research has been shaped by ethical issues as these ethical decisions involve one’s morality. Social researchers should understand that research can be harmful to individuals as well as society. Rubin and Babbie (2012) saw an ethic as something associated with morality which deals with matters of right and wrong. Basically, ethics refer to the principles of conduct which are adopted by various professions in an endeavour to protect the dignity and rights of society. Chronic conditions are life-threatening and are associated with grief. Victims may suffer from denial, blame, shame, rejection and denial and some may be suicidal. It is, therefore, of paramount importance to respect applicable research ethics. The pursuit of knowledge

and a concern for the welfare of participants and their social groups should underpin social work research. Bogolub (2010) further contends that social work researchers have an ethical mandate to bring about what is good to research participants. The researcher observed the following ethics:

5.14.1 Informed Consent

De Vaus (2008:85) pointed out that informed consent involves a number of elements as follows:

- the purpose of the study and its basic procedure.
- the identity of the researcher and the sponsor
- the use to which data might be put.

Additionally Gray *et al* (2007), suggest the following:

- a disclaimer stating that participants may decline to answer any questions or withdraw from participation altogether.
- a statement concerning availability of research findings to participants
- name of investigators and their affiliation and organisations sponsoring the research.
- procedure for ensuring confidentiality of data and anonymity of participants.

The researcher fully identified himself with the study participants and the participants were briefed on the nature and purpose of the study. They were requested to fill in some consent forms (Appendix 6 and 6B). Furthermore, participants were informed that

participation was voluntary and that they are free to withdraw at any moment during data collection.

5.14.2 Confidentiality

According to Gray *et al* (2007), if data are confidential, the identities of respondents are known to the researcher but they are kept secret. One way of ensuring confidentiality is by removing identifying information of the respondents from the research instrument. The researcher only asked information that was relevant to the study and such information will only be used for academic purposes. Names of participants or other identification particulars were not sought.

5.14.3 Least Harm

The researcher ensured that the participants were not exposed to both physical and psychological harm. The researcher worked closely with care givers in this endeavour. Two cases which the researcher identified and felt needed further assistance were referred to a social worker for further consideration.

5.14.4 *Utulivu*

The cannon of *utulivu* in Afrocentric research maintains that justice is required for legitimate research (Reviere, 2001). The researcher avoided causing divisions between or within communities but strived to create harmonious relationships between and within groups throughout the research process. During the time of fieldwork, there was no traditional leader (chief Chiweshe) in post following the death of the previous office bearer and the researcher avoided discussing these issues as there were succession wrangles.

5.14.5 *Ubuntu*

Under the canon of *ubuntu*, mutuality between participants and the researcher should be respected. Feelings of tolerance, hospitality and respect for others, their language, opinions and conversations style is highly regarded (Mkabela, 2005). The researcher identified with the people of Chiweshe throughout the data collection by using their local language for communication. Local traditional and political leaders were informed before meeting participants.

5.15 *UBUNTU* AND THE IMPERATIVE TO COMPENSATE

Nama and Swartz (2002) found out that in all research which involve taking up people's time, there is a question of compensation for the respondents. In this study, all the interviewees and focus group participants were compensated for their time with grocery items worth US\$7 each and families were compensated with grocery items worth US\$10.

5.16 LIMITATIONS OF THE STUDY

The researcher used his personal judgement to determine the fitness of interview respondents to participate in the study. Those who were considered too sick to participate were excluded. This was despite the fact that they might have provided valuable information due to their near-death experiences. Another fact is that respondents who professed membership in African traditional religion participated in the study despite their previous membership in other religions. It is possible for people to move from one religion to the other and as a consequence, responses given might have been coloured by experiences in other religions other than African traditional religion.

Some focus group participants were not members of ATR but were giving their views on their experiences of working with members of ATR in their communities. This may act as a limitation in that their responses might have been affected by their own perceptions of ATR.

Chiweshe area is predominantly Zezuru and results of the study should be treated with caution as they might not represent the views of all the Shona people of Zimbabwe. There might be variations across various ethnic groups that constitute the Shona society of Zimbabwe. However, Ranger (1985) argues that language differences among the Shona people are a colonial invention. They share so much horizontal similarities. Chronic conditions are life-threatening and discussing them might stimulate anxiety and inhibition.

The presentation of results does not emphasise statistical details, graphs or tables. The use of tables has the advantage of bringing rich and complex data in one place. However, it was hoped that the narrative approach adopted would best bring out the living experiences of people with chronic illnesses who subscribe to ATR.

5.17 SUMMARY

This qualitative study adopted the Afrocentric methodology. Based on the Afrocentric canon of *ujamaa*, this study targeted all the members of Chiweshe communal lands. Data were however collected from people with chronic illnesses, their families, traditional cultural leaders, traditional medical practitioners and village health workers. Data were collected through three methods: one on one interviews, family interviews

and focus group discussions. The qualitative data gathered were analysed using the thematic content analysis. Study findings are presented in Chapter Six.

CHAPTER SIX

PRESENTATION, INTERPRETATION AND DISCUSSION OF FINDINGS

6.1 INTRODUCTION

This study sought to examine the influence of African traditional religion and spirituality in understanding chronic illness and assess how this may influence social work practice. It has focused on Shona traditional religion among the people of Chiweshe communal lands, a rural area that lies in Mazowe District, Mashonaland Central Province in Zimbabwe. This chapter presents the results obtained from one-on-one interviews with chronically ill people, focus group discussions and family interviews. The study findings are discussed and interpreted in relation to the three theoretical bedrocks of the study which are: Afrocentrism, Strengths perspective and Resilience theory. The findings of the study are presented in two parts. Part A focuses on findings from people with chronic illnesses while Part B focuses in findings from other participants, that is, village health workers and community based care givers, the elderly, traditional cultural leaders, traditional medical practitioners and family members of people suffering from chronic illnesses

PART A: RESPONSES FROM PEOPLE WITH CHRONIC ILLNESSES

This section presents the responses from people with various chronic illnesses who participated in the study. The results are presented qualitatively trying by all means to

capture the voices of the participants in line with the Afrocentric methodology which maintains that the voices of the Africana people should be heard.

6.2 DESCRIPTION OF STUDY PARTICIPANTS

Table 2: Description of study participants

PARTICIPANT	AGE (years)	SEX	LENGTH WITH ILLNESS (Years)	ILLNESS
A	46	Female	7	HIV Positive
B	49	Female	8	Cancer
C	86	Female	13	Painful legs
D	55	Female	7	HIV Positive
E	20	Female	9	Epilepsy
F	42	Female	13	Ulcers
G	55	Male	8	Hypertension
H	41	Male	6	HIV Positive
I	46	Male	10	Cancer
J	50	Male	14	Chronic heart disease
K	38	Male	9	Chronic heart disease

In this Afrocentric study, eleven people with various chronic conditions (see Table 2 above) participated in the study. They were sampled purposively with the help of village health workers. Of the eleven participants, six were females while five were males. The highest age which narrated an illness case was eighty six years while the lowest was twenty years. The mean age was forty eight years. The average number of years in African traditional religion was forty seven years while the mean time frame with a

chronic illness was nine years. All the participants except one were into ATR because it is the religion of their parents and they were raised in it. The fact that the majority of chronically ill participants were born in ATR is in line with an argument by Mbiti (1969) that there is no conversion, by Africans, into ATR. A person is born in ATR and his birth is under the protection and guidance of ancestral spirits. One female participant claimed that she was converted to Shona traditional religion as she had been called by a *svikiro* (ethnic spirit) to undertake a healing assignment. Seven participants were married while four were single, divorced or widowed.

6.3 ASSUMED CAUSES OF CHRONIC ILLNESSES

For some Shona people, there are various causative explanations for chronic conditions. Participants identified a number of supposed causes of chronic illnesses. The general feeling of the participants was that sickness was normal from time to time but it becomes an issue when it does not heal over a reasonable period. Within the purview of the Shona people of Chiweshe, for any other cause beyond the biological cause of illness, explanation for the cause of illness is always sought. The same observation was made by earlier scholars (Gelfand, 1962; Gelfand, 1964; Masaka & Chingombe, 2009; Matolino, 2011). It is worth noting that it was possible for one participant to identify more than one factor that were working together to cause the illness. A number of causes were identified by the participants with chronic illnesses and they are presented below.

Table 3: Causes of illness

PARTICIPANT	CAUSE OF ILLNESS
A	Witchcraft, ethnic spirit
B	Angry ancestors/ neglecting rituals
C	Avenging spirit, familiars, witchcraft
D	Familiars
E	Ancestral call
F	Angry ancestors
G	Familiars, witchcraft
H	Natural – ancestors neglected their role
I	Angry ancestors
J	Ancestral call
K	Familiars

6.3.1 Call by Ancestral Spirits

The Shona people recognise a strong relationship between the living and the living dead. Before the encroachment of foreign religions and to this day in some cases, the deceased members of a family have a significant role in protecting and endangering the lives of the living. The living were/are expected to honour certain requests by their ancestors, failure of which mishaps can confront them. The spirits can also communicate by causing an imbalance like illness in a person's life. It was commonly agreed among the interviewees that if a spirit wants to manifest in a person it may cause chronic illness which can only heal after a person responds to the calling. It is generally believed that a sick person would not respond to medication until s/he goes to a *n'anga* (traditional healer) who will tell her that s/he must welcome the ancestral spirit.

The process of welcoming the ancestral spirit was said to involve a ceremony where traditional home-made alcohol is brewed and certain libations to the ancestors are done. One chronically ill girl (Participant E) reported that she was into ATR because she was told that she was chosen by ancestral spirits to host a healing spirit, so she had no option but to join ATR. She said:

“Ndine basa rokurapa rakaiswa pandiri, tiri kugadzirira kutambira basa racho. Manje manje hurwere hunenge hwapera…….” (I have a healing assignment put on me. We are preparing to welcome the spirit and very soon, the illness will be gone)

She hoped very much that her illness would disappear in no time as preparations were underway to welcome the healing spirit. On the same note, Participant C said:

“Tinoziva kuti kana mweya uchida kugara pamunhu unogona kukonzeresa chirwere chisingaperi” (We know that if a spirit wants to settle on someone, it may cause a long term illness).

Some participants buttressed the call by ancestral spirits by mentioning diseases such as cancer, epilepsy and mental illness which some traditional medical practitioners could successfully cure, and they assumed that some spirits had a hand in their origin. Thus, for the participants, illness may be caused by one’s ancestors seeking attention or some wandering spirits seeking a person to possess. Bosman (n.d) argues that ancestral spirits are believed to cause illness when they want to communicate something to the living. Other scholars, Muchinako *et al* (2013) corroborate with the study participants by arguing that Shona traditions have it that if the ancestors want a

person to become a spirit medium, they make the chosen person mentally ill. That person may seek medical treatment but will not recover until they accept to fulfil the ancestors' wishes. Ancestors occupy a central role in the lives of most indigenous Africans. Though they have a protective factor, it can be seen from the foregoing that they may cause illness if their concerns are not taken into consideration. In line with the proponents of Afrocentrism, most Africans have been influenced by foreign religions to desert their traditional beliefs hence this assumption by some respondents that neglecting the call by ancestors may cause chronic illnesses. Social workers working with African communities should always seek to understand the role played by religion with special reference to ancestors concerning illnesses. They may have to encourage their clients in ATR to perform some rituals in honour of their ancestors rather than discouraging them. However, this may be a delicate endeavour as ATR is diminishing and social workers may be subscribing to other religions other than ATR. Social workers should be culturally competent and should be sensitive to the religious beliefs of all their clients. Where need arise they should encourage their clients to honour their ancestors as failure to do so is believed to cause illness.

6.3.2 Avenging Spirits

Though not present in other religions, one peculiar belief in Shona traditional religion is the belief in avenging spirits (*ngozi*). These spirits are believed to cause misfortunes on their targets. Participants C and E indicated that their illnesses were a result of avenging spirits. However Participants, A, J and K denied the involvement of avenging spirits in their illnesses. The belief in *ngozi* has always been present among the Shona people and is part of the Shona traditional religion. It is therefore critical for social workers to

recognise such beliefs embedded in Shona traditional religion. There is not one type of *ngozi* among the Shona people and the level of rage is not the same. Apart from causing illness, the avenging spirit can cause other misfortunes like losing jobs, road accidents, sudden deaths, divorces etc. The belief in *ngozi* was mentioned in earlier studies (Bosman, n.d; Benyera, 2014, Masaka & Chingombe, 2009; Gelfand, 1962; Chavunduka, 2001, Chavunduka, 2011). These scholars also found that some members of ATR believe that there should be compensation for the avenging spirit hence the Shona saying “*Mushonga wengozi kuripa*” which literally means the solution to an avenging spirit in compensation.

6.3.3 Possession of Some Familiars

Possession of familiars is closely related to witchcraft. However, people may possess them so that they may get rich. These familiars may in turn affect the owners, their children or relatives as part of their condition for services they offer to the owner by causing illness. Chavunduka (2001) argues that people may possess these familiars to get rich but in the long run they may haunt other family members by causing illness. Some of the responses in this regard were:

“Chikwambo chinogona kuda mukadzi, kana muridzi wacho akatadza kuchipa chinokozero matambudziko akasiyana siyana” (A *tokolosh* may need a wife and if it’s not given it causes various troubles)- Participant G.

“Mumusha medu tine vanhu vanobata bata saka kurwara kwerudzi urwu hakushamisi” (In our extended family we have people who possess familiars so illness of this nature are not a surprise) – Participant C.

As seen here participant C attributed her illness to avenging spirits and possession of some familiars by some members of the extended family. Asked to clarify the causes of her illness she indicated that she suspected both. In as much as social workers may have to appreciate the traditional explanations for illness among indigenous African communities, they have to be careful as one illness may have many explanations on the same individual. As in the case with participant, C there is interplay of avenging spirit and familiars owned by a relative. The avenging spirit was thought to open an avenue for enemies to do what they want as they protective factor of ancestors is weakened.

Another participant, D also suspected that her illness was caused by familiars his late father used to possess. She highlighted that upon his father's death, nobody could take over the familiars and they were thrown into the river. This, she said has caused indescribable suffering in their family. She mentioned failure to get jobs by her brothers and her two sisters who were into prostitution in the nearby township. All these problems he attributed to the familiars. Social workers working in African communities must therefore be in a position to discuss issues to do with misfortunes attributed to mystical beliefs among their clients. This is despite the fact that such beliefs maybe against those of the social worker. A client maybe hospitalised but believing that his illness is caused by possession of familiars. Culturally competent medical social workers should be in a position to give a client an opportunity to dispose such things. However in light of the canon of *utulivu*, social workers should be respectful and try by all means to avoid conflicts among their clients. Witchcraft and possession of familiar accusation may cause disharmony among African communities.

6.4 RELIGION BASED WAYS OF MANAGING ILLNESSES

The participants reported a number of activities in an effort to manage their chronic illnesses. The activities ranged from going to traditional medical practitioners, going to hospitals, self- administration of traditional herbs to performing certain rituals. The participants recognised the need to consult the spirit world when need arose. It should be noted that certain illnesses like epilepsy and cancer necessitated some rituals than other illnesses like sugar diabetes or chronic heart diseases. The type of intervention depended on the causative explanation given for the illness. Participant C and E who attributed their illnesses to avenging spirits reported resorting to spiritual healing than for example participant D and G who attributed their illness to witchcraft and natural causes. The element of cultural competence in social work practice ought to be treated with caution as people have different personal preferences and choices despite sharing the same culture or religion. As seen in this case people who share the same religion have different means of addressing the same problem.

6.5 AFRICAN SPIRITUALITY, RESILIENCE AND COPING WITH CHRONIC ILLNESSES

Religion and spirituality are very critical players in promoting resilience during life's adverse circumstances and the Shona traditional religion is no exception. The relationship between Shona traditional religion and resilience in illness has a bearing on medical social work practice in Zimbabwe. Apart from social workers, other helping professionals like nurses, medical doctors or counsellors may also realise this influence. The following section looks at how the various components of Shona traditional religion act as strengths during illness.

6.5.1 Omnipresence of Ancestors

The Shona people of Chiweshe believed that their ancestors are always with them. The ancestors in Shona religion are not remote but always present to protect the living. This means that at any time a member of ATR can communicate with the ancestors seeking their intervention in a particular issue. The omnipresence of ancestors was confirmed by the following quotations;

“Inini vadzimu vangu vaneni nguva dzose, izvozvo zvinondipa simba munguva dzeurwere” (My ancestors are always with me and this gives me strength during illness)- Participant C.

“Vadzimu vangu vaneni nguva dzose uye ndivo vanosvitsa nyaya dzangu kumatenga” (My ancestors are always with me, they are the once who relay my issues to God)- Participant F.

“Chero nguva tinogona kungombera sezvo vari pasi vanesu nguva dzose” (Anytime we can pray as our ancestors are always with us)- Participant D.

The three quotations show that for some Shona, the omnipresence of ancestors gives people strengths and guarantee for protection. They reported that the ancestors always pass their problems to God. Illness may provoke fear of the unknown in some people but the fear may be limited among some people as they are confident that a higher power is protecting them.

This was supported by Masaka and Makahamadze (2013) who argue that the Shona cosmology notes the centrality of *vadzimu* in terms of life and death, good health and

bad health and other vicissitudes of human life. According to Martin and Martin (2002), spirituality can give people strength to go where there is a threat and it also gives courage and encouragement amidst suffering and death. In the same vein, Participant G supported the omnipresence of ancestors by saying:

“Makuva evabereki vangu ari pedyo nemusha wangu. Ndinoziva kuti vakatotichengetedza” (My parents’ graves are close to my homestead, I know they are protecting us).

Among some rural Shona people, burial is done close to the homestead as part of their culture. Some people gain strength and satisfaction by seeing their deceased relatives’ graves. The relatives form the same community with the living and they are a source of strength in difficult moments. The “living dead” are therefore critical in the affairs of the “living living” among the Shona people. This is in line with Pienaar (2012) who purports that culture is a critical component of building resilience. The fact that people will be seeing the graves of their departed parents or grand-parents who are thought to have a protective factor as a *mudzimu* gives the chronically ill people strength and acts as a source of resilience. Also, believing that performing certain rituals will heal a sick person is regarded high among the Shona speaking people and social workers should respect such beliefs during their intervention. In a similar study by Banerjee and Pyles (2004) among African American women, it was found that their spirituality helps them manage their difficult situations by reassuring them that their higher power is looking after them. Ancestral beliefs are therefore assets that may act as a source of resilience for some Africans who believe in them. This was supported by the resilience theory and the strengths perspective in social work which argue that spirituality is a source of resilience

and strength in human life. In line with the Afrocentric social work philosophy, some traditional African beliefs should be considered in social work practice with indigenous African communities. All the beliefs of a person should be taken aboard when providing help. A member of ATR for example may visit a Christian Missionary hospital and social workers should find ways of discussing those beliefs in ATR that may promote resilience of the client like the omnipresence of ancestors.

6.5.2 Shona Rituals

Each religion has rituals that are associated with it from time to time and during special events. There are certain rituals found in Shona religion that were reported to give participants resilience. The process of *kurova guva* (bringing back ceremony) was reported to give people strengths during adverse life circumstances. The process of bringing back home the spirit of a dead person was reported by a number of participants to have positive attributes for the Shona people. When the spirit is brought home, it is believed that it will protect the family. People are not at ease when their deceased relative is not brought back home. The spirit is believed to be wandering at the cemetery and has, therefore, no protective power. They use the term *mudzimu uri musango* which literally means the ancestral spirit is in the wilderness or *musha mutema* which means the homestead is dark when a deceased parent's spirit is not brought home. All the interviewees indicated that the process of *kurova guva* gave them comfort and assurance that they were under protection.

Also the process of communicating with ancestors was supported by Participant G when he said:

“Ndikanyanya kurwadziwa ndinoudza mukoma wangu anouya oreverera kunana mbuya, ndinonzwa kuita zvakanaka, Ndava nemakore akawanda kwazvo ndichingorwara asi midzimu iri kundichengeta” (When I feel more pain I call my brother who comes to say some prayers to the ancestors. I feel relieved. I have been ill for so many years but my ancestors are protecting me).

For some Shona people it can thus be seen that communicating with the spirit world can strengthen a person amid challenges such as illness. Some perform rituals to communicate with the spirit world to intervene in the healing of a sick person. The *vadzimu* are believed to live in invisible communities parallel to the communities of the living. They watch over the living in their everyday lives. This is supported by Taringa (2009:199) who posits that even though they inhabit the world of spirits, they are still present in the human community as guardians of the family traditions, providers of fortune and punishers of those who break accepted mores.

Some territorial spirits were also believed to give people some resilience during illness. It was reported that most people in Chiweshe communal lands are of the *vahera* totem and their territorial spirits used to dwell in some sacred hills such as Nyota, Ndire and Bare. It was also reported that people of Chiweshe sometimes observe certain rituals as a community if problems have affected a number of people in the community. This was reported to be done through the guidance of territorial traditional leaders. Life in traditional African societies is communal. This concept of community resilience was cited by Healy (2006) who defines cultural resilience as the capacity of a distinct community or cultural system to absorb disturbances and re-organise while undergoing

change so as to retain key elements of structure and identity that preserve its distinctiveness. In support of this, Shizha and Charema (2008) contend that community and societal solidarity are the foundation of sustainable social networks and social support provision, and coping strategies required in the healing process.

Of late some members of African traditional religion have not been performing certain rituals due to Christian influence. However for those who still practice such rituals, social workers should be in a position to encourage them as these act as assets during life's difficult moments. Social workers should also seek to understand the meaning given to each ritual and the discomfort associated with neglecting them. Social workers practicing among members of African traditional religions should be in a position to identify spiritual struggles associated with ATR. Due to globalisation it is common to find members of the same family subscribing to different religions and the views and beliefs of members of minority religions should be respected at family level.

6.5.3 Exorcism

The process of exorcising evil spirits was found to be motivating chronically ill people. This process involves seeing or feeling an evil spirit or object taken out of someone. This is confirmed by the following quotation:

“Pana sekuru vari mudunhu medu. Pamba pavo panozara vanhu, unoona mweya yakawanda ichibuda. Kungoona umwe munhu achirapwa zvinokupa chivimbo chekuti newewo watopora” (There is a *n’anga* in our community, a lot of people throng his place and by merely seeing an evil

spirit manifesting in someone you will have confidence that you will be healed)-Participant A.

“N’anga iri mudunhu muno inodzura chaizvo” (a healer in our area extract objects from human bodies)- Participant J.

Thus by seeing evil spirits driven out of others, people get motivated and may have the confidence that they too will be healed. Most of the participants generally confirmed the efficacy of African traditional religion in providing resilience. They argued that traditional methods of healing are spirit-inspired and this gives people hope as their ancestors and God are involved in the whole process.

Exorcism is closely related to witchcraft beliefs among some members of ATR. Social workers must appreciate the causation attached to a particular illness and the healing method that follows it. For example where witches are believed to have inserted an object in a human body it means such object should be extracted by a *n’anga*. It is common for people to complain that they have moving objects in their bodies. Though such problems may have other explanations in the western world, it may be difficult to convince some people who may want to have it exorcised. Some ill people thus believe the healing process is effective when something visible is taken out of them. This may have a placebo effect and ultimately psychological healing.

6.5.4 Belief in Afterlife

Members of African traditional religion believe in afterlife where a dead family person regenerates in the spirit form to become an ancestor. The ancestors will then start looking after their living children and grandchildren. There is thus communion between the “living living” and the “living dead”. The fact that one remains a member of the family even after death was found to motivate some ill people to soldier on during their illness. The assumption was that death was not an issue since it only meant the movement from one ontology to the next. Of interest was Participant C who said:

“Mwanagu nyangwe ndikachirara hangu nemadzibaba angu hapana chakaipa. Ndinoziva kuti ndinonosangana nemadzitateguru angu arere apo. Vazukuru vangu ndinovatenda chaizvo nekumhanyamhanya kwavanoita. Ndinongoti dai vana mbuya vavo vavaonawo mumaguta mavari imomu.....” (My son even if I am to rest with my fathers all is well. I know I will meet my ancestors who are sleeping there. I thank my grandchildren so much for running around. I pray that my ancestor provide for them in urban areas where they are....).

Another interesting response came from participant J who said:

“PachiShona kufa kuenda kune imwe nzvimbo yekuti unenge wokwanisa kuchengeta musha uri mweya. Izvi zvinokushingisa kwete zvekutyisidzirwa neGehena. Riripi Gehena racho. Zvinokonzera kuti munhu atye kufa izvovo....” (In Shona tradition, death means going to another realm where you are able to look after your family in the spirit form

not to be threatened with hell. This gives one, strengths not the promise of hell. Where is the hell? It causes people to fear death).

Belief in afterlife among the Shona people was reported in earlier studies. Banana (1991:27) notes that for the Shona people “Life is an endless enterprise, death is not death; it is a vehicle from the ontology of visible beings to the ontology of invisible things. Death is part of life, it is a gateway to eternity, it’s a gateway to life in the hereafter”. This means that for some Shona people even if an illness does not change for the better, they may be comfortable as they know death to mean migrating to the spirit world. This is against an observation by Cicirelli (2002) who argues that religiousness is negatively associated with fear of death.

Belief in afterlife has a bearing on indigenous social work practice in some African communities. Social workers working in hospice environments may find it easy to practice with members of ATR. Death and dying may easily be accepted by the victim as they are sure they will be migrating to another world where they still remain members of their families. Issues to do with death may not provoke the fear it provokes among Christians as there is no fear of hell among members of ATR. Social workers who are members of end-of-life care teams may find it easy to discuss issues to do with death and inheritance of estates with their clients.

6.5.5 Community Involvement

Though most available literature focuses on individual resilience, the resilience of the whole family may also be influenced by some religious beliefs and practices. Life in traditional African communities is communal and members not only live for themselves

but for the community as a whole. Members of the community intervene in one way or the other when one of them has a problem. Most of the interviewees confirmed that members of their communities were actively involved in helping them during their needy times. This involvement of the community is an asset that gives a person in a precarious situation the assurance that they are not alone in whatever predicament they are facing. This was supported by participant I who indicated that:

“Ndinonzwa kurerukirwa kana ndichiona hama dzakasiyana siyana dzichibatirana nesu paurwere hwehama yedu” (I feel relieved when I see some relatives giving a hand in the illness of our relative) said a family interviewee.

When a person is sick for a long time one’s paternal and maternal relatives all participate in trying to assist the person. This gives the sick person and his/her family strength amid the illness.

“Hurwere hukakura hama dzose dzekwamai nedzekwababa dzinoita muonera pamwe pachivanhu chedu. Izvi zvinopa murwere simba nekuti anenge achiona rudo” (If an illness persists, all relatives from the father and mothers’ sides take part in assisting. This shows that someone is loved and a sick person is motivated)- Participant H.

This supports findings by Matolino (2011) who notes that in the event of an illness in a traditional African community, the community, being one with the individual, has the responsibility of taking care of the sick individual and getting rid of the sickness. Africans, thus, support one another in times of need. On the same note Mapuranga

(2010) notes that Africans recognise the vitality of human life and any action which increases human life is condoned.

The community is thus an important resource in certain African communities that social workers may exploit. The community forms an important support system for individuals in need. Social workers should not only focus on an individual or his family but the extended family or community as whole when looking for ways to assist clients. This is critical for rural social workers working among the Shona people for example. It is not uncommon for people to be accompanied to a hospital by a mere community member and they get motivation from that.

6.6 CARE AND SUPPORT

The participants reported a number of sources of care and support during their illnesses. Support came from children, siblings, spouses, members of the extended family, friends (*sahwiras*), members of the community, traditional medical practitioners, hospitals and clinics, Christian denominations, local NGOs. Participants D, J and K indicated that though they were full members of ATR, members of other religions especially Christianity were free to extend whatever support to them. Their feeling was that it was the same God and they did not have any problem getting assistance from other religions. This may support the observation that ATR is a hospitable religion which accommodates other religions. Social workers working with members of ATR may have to enquire from them whether they are comfortable getting help from members of other religions.

The kind of support reported by the participants was mainly in the form of care, healing, medication, finance, emotional support, reading material, transport and prayers. The interviewees indicated that they could welcome any support as their religion does not have tight rules in terms of who to associate with or materials and foods that they have to use. All the interviewees except participant C reported going to hospitals for medication. Participant C reported that she had lost confidence in hospitals and was now using traditional medicine only. Furthermore all the participants reported visiting various traditional medical practitioners and participating in traditional rituals in a way to manage their illnesses. This suggests that most members of ATR combine allopathic and traditional medicine hence the call for the governments of developing countries to invest in complementary and alternative medicine. Earlier studies by Shizha and Charema (2012) and Mposhi *et al* (2013) have confirmed the use of traditional medicine by a significant number of people in Zimbabwe.

It was also found that though the participants reported getting assistance from relatives and community members, it conflicted a lot with the witchcraft belief as they feared getting help from the witches. Some felt that the witches might claim to be helping but in the process end up increasing their witchcraft. Participant C for example indicated that when her legs become too painful, her relatives take her to a secret place until she recovers. This she said was done to keep her away from people who may be thought to be causing the illness.

PART B: RESPONSES FROM FAMILY INTERVIEWS AND FOCUS GROUP DISCUSSIONS

6.7 DESCRIPTION OF PARTICIPANTS

A total of six families participated in family interviews. Out of these, three had their chronically ill relatives participating in individual interviews (Participants C, E and H) while the remaining three's relatives did not participate. This was done to provide for illnesses such as mental illness where the ill persons could not be interviewed. There were eighteen participants who took part in three different focus group discussions (see 5.8.2). Each focus group discussion had six participants. It is worth mentioning that not all participants of family interviews subscribed to African traditional religion. They only participated in the study because their ill relative confessed membership in ATR.

Of interest among focus group participants was a traditional medical practitioner who claimed to have both traditional religious power and the Christian gifting of prophecy. He claimed that the gift was hereditary as his mother and sister were also prophetesses. He claimed to have both Christianity and traditional guidance which he called "*Ngirozi yesvikiro*" which literally means an angel of a spirit medium. This might support Chavunduka (2001), who argues that there are some people who combine both ATR and Christianity.

All the traditional medical practitioners who participated in the study were members of the Traditional Medical Practitioners Council of Zimbabwe (TMPC). TMPC is a statutory body for traditional medical practitioners and they are required by law to register with this council. Another interesting phenomenon in the study was a couple (VaMarasha and Mbuya Marasha) who were both traditional healers. They reported to have

sometimes collaborated when assisting a patient. Their specialisations and healing were different and they complimented each other.

6.8 CAUSES OF CHRONIC ILLNESSES

6.8.1 Ancestral spirits

Just like some chronically ill interviewees, most family interview and focus group participants reported that some ancestral spirits were responsible for some chronic conditions. This is despite that some family interviewees had indicated that they are members of the Christian religion. Almost all the traditional medical practitioners and the elderly concurred with participants with chronic illnesses that ancestors have the capacity to cause illness. The fact that most people have deserted their traditional religion and neglected the call by ancestors was witnessed in the number of chronic illnesses that were on the rise in their areas. They said this because chronic illnesses were becoming a health concern as compared to the previous years. In support of this, a male focus group discussant stated that:

“Vanhu havachatevedzeri zvinodiwa nemadzinza avo hezvo tava nezvirwere zvakawanda zvinotora nguva refu. Umwe munhu anenge achidanwa nevedzinza rake nekuda kwekuti hapana achazvitevedzera hurwere hahupori. Hurwere hwacho kashoma kuuraya munhu munguva pfupi”, (People no longer follow what is wanted by their ancestors, now you see there are many chronic diseases. Since no one is still following our tradition the illness doesn't heal. The illness rarely kills a person in a short space of time).

The reflexion by the participants that chronic conditions are on the rise in most African countries tally with available literature. In 2010, de Graft Aikins *et al* projected an increase in deaths resulting from chronic illnesses in Africa within a decade. Social workers have critical role to play in this regard as there are scientific and traditional explanations to the rise in chronic conditions. For some Africans, chronic conditions have a spiritual explanation while from a western perspective they may have a scientific explanation. Social workers should seek a balance between the two explanations as assumed causes influence the source of help sought. People who attribute illness to ancestral spirits are likely to seek spiritual intervention compared to those who attribute the illness to other causes. Afrocentric social workers may have to encourage their clients who subscribe to ATR to honour their ancestors and respond to their requests. If the clients disregard these calls, they may suffer from spiritual angst as they will be living contrary to their dogmata.

6.8.2 Avenging spirits

Most of the participants inveterate that avenging spirits (*ngozi*) were the cause of enduring illnesses. The spirits were alleged to affect the responsible persons or their families by causing them myriad mental illnesses and conditions such as epilepsy. This was reiterated by one head of a family during an interview who said:

“Ngozi, ndidzo dziri kukonzera zvirwere izvi. Ngozi dzakaparwa nehama dzedu sekuuraya vanhu ndizvo zvanetsa” (Avenging spirits are the ones causing most of these diseases. Things such as murder which our relatives committed a long time ago are the ones troubling us).

Some traditional medical practitioners concurred that the avenging spirits cause chronic diseases. Some reported that they have efficaciously healed many chronic diseases by telling patients to go and recompense some avenging spirits. The major problem recounted by the participants was locating the relatives of the murdered person in order for compensation to take place. People are now moving to urban areas and a good diviner is required to trace the relatives if there are no longer known to the current generation. The avenging spirit could sometimes manifest themselves through the sick person to narrating their ordeals. This was said to be common in cases of mental illness where a person could say things that showed that s/he was speaking for someone. In such instances, people could ask elders of the family if they know the names mentioned by the person in question. If they do not know them, they may have to consult a *n'anga*. This is despite the fact that these auditory and visual hallucinations are common in most psychotic conditions such as schizophrenia.

However, one family argued that the belief in avenging spirits brings fear and untold suffering on them. One of the members said:

“Zviri pano zvatipedza mafuta. Tinonzi tine ngozi yakaparwa navasekuru vedu. Chekuripisa hatina kana vanhu vacho vakatadzirwa hatitombovazive tichangoperawo hamheno” (We are in dire straits. It is said that there is an avenging spirit haunting us. We have nothing to use for compensation. We don't even know the wronged family, we will all be wiped out).

Thus there were mixed feelings among the participants on the influence of avenging spirits in causing illnesses. Though most believed in it, some felt that

such beliefs had a fear provoking effect. Despite this, spiritually sensitive social workers should always be take into consideration some aboriginal beliefs and practices that are assumed to cause social problems among social work clients. It might be critical for diagnosis in social work to include family members and significant others to get balanced information of the cause of the problem. There are certain feelings like fear and uncertainties that such beliefs like the avenging spirits may invoke in social work clients and it is paramount for social workers to be on the lookout for such things so that they are addressed during sessions.

6.8.3 Punishment from Ancestral Spirits

Though they are applauded for their protective role, ancestors are also understood to have a punitive role on their descendants. A similar observation was made by the people of Chiweshe who concurred that punishment from ancestral spirits could cause illness. Though these beliefs may seem mythical, they must be recognised in Afrocentric and strengths based social work practice. The participants mentioned that angry ancestors could cause illness as a punishment. An elderly woman reported that when ancestors are annoyed, they can cause illness as a way of communicating that they are not amused by the state of affairs. After being requested to elaborate further on circumstances that can anger ancestors, a traditional leader mentioned things such as not performing certain rituals, not appreciating them and not paying the mothers' cow (*mombe yeumai*).

Rituals that were thought to cause illness when neglected included *kurova guva* (bringing back ceremony), not honouring ancestors and not distributing a dead person's estate as he/she ordered. Most of the participants agreed that illness caused by angry

ancestors was easily identified by being long term in nature and could hardly result in death in a short space of time. It was found that in certain circumstances, a person would get into a trance where s/he could manifest and the angry spirit would speak through the person. Illness from angry spirits was also said to occur at the same time with other misfortunes such as loss of a job, road accidents in the family, everything would just go down.

The belief in ancestral spirits is part and parcel of ATR and still holds water to the present day. This is where ATR differs with other religions such as Christianity where God cannot be believed to cause illness. These results are in line with Masaka and Chingombe (2009) who found that suspicions of the work of an enemy or angered ancestors as the causative factors in cases of life- threatening illnesses and deaths are quite common among the Shona people. Social workers working with aboriginal communities in African should see to it that their clients are in harmony with their ancestors and all the necessary rituals to appease the ancestors are performed. Even in cases where clients come to hospitals for treatment, social workers should be at freedom to discuss spiritual issues with the clients especially things that pertain to the illness.

6.8.4 Globalisation

The recent years have seen the world moving into one global village as people of various nationalities interact on a more regular basis. Though there are many advantages associated with the villagisation of the globe, there are also disadvantages associated with that. Globalisation has seen the weakening of some cultures due to hegemonic influence. African countries have more been on the receiving end from their

chiefly western imperialists. Globalisation has thus created problems that are of interest to social work practitioners. These include diseases, juvenile delinquency, alcoholism and many others. Some participants attributed certain chronic illnesses to globalisation and modernisation. For some Shona people, the fact that people from various countries are intermingling and eat alien foods has instigated problems such as cancer, sugar diabetes and hypertension.

VaMarasha, a traditional healer credited the cause of chronic illness to some tablets that people take regularly such as contraceptive pills. He held that such substances, which he regarded as foreign to the body, will have a lethal impact if taken over a long period of time. Another Village Health Worker contended that there were certain foods that were said to be predisposing people to cancer.

“Takanzwa kuti mamwe madrinks ariko mazuvano anokonzera cancer”,
(We have heard that certain drinks sold these days causes cancer), she said.

A community home-based care worker concurred by citing certain skin lotions which she said were claimed to cause skin cancer. Most of the products cited were inexpensive imports as Zimbabwe has revolved to be a dumping ground for most countries due to economic adversities.

A herbalist divulged that chronic conditions are a recent phenomenon as they were not an issue during his youthful days. It can, therefore, be seen that some chronic conditions are believed to be modern diseases. As Zimbabweans interact with people across the globe, they are believed to acquire some of these diseases. A similar

observation was made by Mbereko and Mahlatini (2014) who found that some traditional healers in Kariba, Zimbabwe believe that AIDS was brought by white people in their country. Some of them even believed that it was found in condoms that are promoted as HIV prevention measures. Some Afrocentrists such as Avendal (2011) are of the view that introduction of Christianity, urbanisation and globalisation have extensively contributed to changes in the traditional social systems and order. This has consequently brought a number of problems to Africa. Social workers practising in traditional African settings should always seek to understand the professed influence of modernity and globalisation. Where some clients feel that modern goods and services bring problems to them, social workers should ensure that these are not made available to them or they should seek to explain the advantages and disadvantages of using such products. Thus the educational role of social workers is critical in rural communities as they have to deal with worries brought by novel products.

6.8.5 Witchcraft

Belief in witchcraft is found in almost every traditional African community. The witches have the capacity to cause illness on their targets. Witchcraft is one of the beliefs that have stood the test of time among some Shona people. It was indicated that people in Chiweshe area believe that a person can be bewitched by community members who are often his/her relatives who are jealous of that person's wealth or success in life. Things that result in a person to be bewitched included, among other things, having many cattle, good harvest, having successful children, assuming leadership positions in the community or provoking witches. The participants indicated that some people who are jealous could not be witches themselves but may hire the witches and pay them.

“Kune varoyi vanokonzera urwere hwakasiyana siyana. Ini mwana wangu anorwara nepfungwa zvatisinganzwisisi. Anenge achingorotomaka achiti pane vanhu vanoda kumubaya nebanga. Uku kuroiwa chaiko (There are witches who cause various illnesses. My child is mentally ill and we don’t understand the illness. He utters unfathomable things saying he sees people who want to stab him with a knife. This is nothing other than witchcraft), said a family interview participant.

Witchcraft was supported by an elderly man within a group discussion who said:

“AIDS iriko tose tinoviziva asi varoyi variko uye vava kungatora mukana wekuti kune AIDS. Mazuvano munhu wese angorwara zvava kungonzi iAIDS.....” (AIDS is there, we all know but witches are there as well and they are taking advantage of AIDS. These days all forms of illnesses are regarded as AIDS).

In contrast to this, a village health worker argued that though it is African to believe in witchcraft, this belief sometimes interferes with medication as some people delay going to health care facilities (hospitals and clinics). The witches were believed to suck a person’s blood and the person would become very pale and squeaky. Indications that a person had been bewitched are failure to heal, feeling something moving in one’s body, chronic pain occurring usually at night and sometimes hearing familiars such as owls making noise at one’s homestead at night.

Beliefs in witchcraft have always been there among the Shona people. This corroborates with Nyabwari (2014) and Taringa (2009) who argue that witchcraft is

believed to cause illness among most African communities. Even though early missionaries, who brought Christianity to Africa, tried to suppress witchcraft, most Shona people of various religions hold fast to it. However, length of illness could not solely act as a determinant of witchcraft involvement. It may take a *n'anga* to tell whether a person has been bewitched or not but in cases of strange illness, for example, where pain increases at night, witchcraft beliefs increase. This is mainly because the witches are believed to operate at night. Even in cases of HIV, some people still hold witchcraft beliefs. It can be seen that the Shona people attribute illness to witchcraft when they do not understand the cause and circumstances surrounding the illness. This finding has significant influence on social work practice as social workers have to balance between traditional and scientific explanations of illness. As seen here some respondents attributed HIV to witchcraft while from a scientific explanation it is a virus that is transmitted sexually. Some people may not want to take the responsibility of embarking on risk behaviours that resulted in them acquiring the virus. Such people may delay seeking ART as they believe that they have been bewitched. Witchcraft is dealt with using traditional methods and social workers should ensure that such methods do not interact with antiretroviral therapy. It is therefore important for medical social workers to discuss traditional explanations for illness and ways that are used to manage the illness so that they may discuss these with other health professionals.

6.8.6 Natural Causes

It is rare for the Shona people to attribute illness to natural causes. As argued by Gelfand (1962), even in instances where the cause of illness is flawless, they would still want to know why only that particular person got ill and not others. It can be seen that

within the purview of the Shona people, the biological theory of illness is invalid. This has led some scholars such as Gelfand (1962) and Banana (1991) to hold the belief that in Shona traditional religion a person is not supposed to die. This is because even in cases where death is due to a natural cause, for example, due to advanced age, they would inquire about the cause of death from *n'angas*. For some Shona people, there is a cause behind every effect.

However some respondents attributed some chronic illnesses to natural causes. One family agreed that their relative's illness was natural. When requested to shed more light, they reported that they had been to various *n'angas* who failed to identify the cause of the illness. They also highlighted that their family was clean as they performed all rituals expected of them by their ancestors. Natural causes were cited by a village health worker as:

"Zvimwe zvirwere zvepasi" which literally means some diseases come from the ground meaning they are natural.

However, a *n'anga* refuted this hypothesis by arguing that natural illnesses are very easy to cure as they easily respond to medication. However, Chirongoma (2013) argues that some Shona people identify natural causes of illness. These are called *zvirwere zvepasi* (diseases from the earth). These are diseases with no directly identifiable cause. Shoko (2007b) states that these are mild and short illnesses which usually disappear without medication. It is, therefore, rare for Shona people to attribute chronic illnesses to natural causes. Support for natural or biological cause of illness was minimal. This may support the view that Shona people are notoriously religious and social workers working with them should seek to be spiritually competent. Almost

everything, the good and the bad is explained within the domain of religion and spirituality. Nature therefore has no influence for most members of the ATR. Even natural catastrophes like droughts are given a spiritual explanation. Where health professionals are convinced that an illness is caused by a given pathogen, such explanation to a member of African traditional religion should be thorough as a simple explanation to some of them may not be acceptable. They will be assuming that the spirit world has a hand in one way or the other.

6.8.7 HIV Positive Status

HIV and AIDS have wrecked intolerable harm in most African countries. At some points, the prevalence rates have exceeded 30%. Millions of people have succumbed to AIDS and have died. Though its prevalence is sagging in Zimbabwe, HIV remains a public health concern. Some participants have attributed chronic diseases to an HIV positive status. A number of opportunistic infections take advantage of one's weak immune system and attack a person. There are some chronic conditions that ally themselves to an HIV status.

Most village health workers and home-based care workers cited HIV positive status as a contributing factor to chronic illnesses principally among the young generation. This is confirmed by the following quotations:

“Vanhu vazhinji vane zvirwere zvinenge moyo, cancer, BP vanenge vaine chinwere chemazuvano ichi” (Most people who suffer from diseases such as heart problems, cancer and hypertension are HIV positive).

“Chakauya ndicho chapedza vanhu, tingatsvage muroyi pasina. Imo mumadhorobha menyu umu ndimo matikuvadza” (AIDS is the main killer, we may blame witchcraft. The urban areas are responsible for AIDS).

One family also indicated that their relative’s illness was HIV-related. However, they questioned why others were responding well to ART and their relative was not and a spiritual hand in failure to respond was a possible explanation. . This is what the mother had to say:

“Ko vamwe vanongomwa mapiritsi vachirarama makore akawanda wani. Ko iye mwana wangu ndiye anyanyodii?” (Some HIV positive people respond well to ART and they live long. What is wrong with my daughter?).

Even in cases where people really know the cause of the illness, involvement of the spiritual world may not easily be neglected. Opportunistic infections have increased due to HIV and AIDS. Antiretroviral treatment has prolonged people’s lives hence illness becomes chronic. However, some participants questioned why their relatives fail to respond to treatment while others were responding well. This leaves the spirit world at the centre of every illness. This was supported by Masaka and Chingombe (2009) who contend that for the Shona people, science alone cannot fully account for the plethora of mishaps that trouble humanity, including HIV and AIDS. Masaka and Chingombe (2009) went on to argue that it is unacceptable for the Shona people to accept death as a result of illnesses such as HIV and AIDS, heart attack, high or low blood pressure or stroke. The fact that some participants acknowledge the role of HIV and AIDS in promoting chronic illnesses that come in the form of chronic illnesses is a landmark achievement. However those participants who still want to seek a spiritual explanation where the

chronically ill person is also HIV positive might present challenges to social work intervention in the health system. The skill of interrogation may be used to bring such clients to light.

6.9 TRADITIONAL METHODS OF MANAGING CHRONIC ILLNESSES

Almost every community has developed ways of managing illness and diseases and the Shona people are no exception. The methods used may comprise the use of objects, materials or substances or it can be purely spiritual. A number of techniques were said to be used in managing chronic illnesses. Most of the healing and management was done by traditional medical practitioners. As found by Masaka and Chingombe (2009), the Shona people believe that traditional healers have the esoteric knowledge about things beyond the comprehension of ordinary human beings. Social workers working with African communities should therefore seek to understand the methods that are used by some people to manage chronic conditions as these have a bearing on their practice. Where such methods are effective, social workers should seek to maximise on their use and try to discourage the use of detrimental methods.

6.9.1 Use of Herbs

Humans and animals have used herbs since time immemorial. Plants thus play a critical role in the lives of humans especially their medicinal components. Most of the participants reported that they use herbs such as roots to cure illnesses. Herbs are thus part of the assets that Africans pride in despite being labelled an “uncivilised people”. Knowledge of them and their presence are thus strengths that social workers should take into cognisance. VaMarasha, a focus group discussant was confident that most

chronic conditions can be cured using traditional means. He gave an example of cancer, HIV and mental illness. Apart from his expertise in treating these diseases, he is renowned for snake bites. Some traditional medical practitioners use *nyora* (incisions) to cure some diseases. Sometimes the herbalist can chew leaves or roots of a prescribed tree and administer them on the painful organ. Sometimes s/he mixes various herbs on a trial and error basis as most herbs have no side effects. Patients may sometimes be told to drink the concoctions made from herbs. Most of the herbs are very bitter. An elderly focus group discussant reported that there is a belief that the more the bitterness of the concoction, the more effective it is. The herbs may also be burnt and the sick person is made to breathe the smoke. This may also be done for the whole family to protect other members especially where the illness is believed to be caused by witches.

These results corroborates with Shoko (2007) who found herbs to be common among the Kalanga people, one of the Shona tribes. Herbs have thus been used since time immemorial for the treatment and prevention of diseases. However, the quantity of the medicine remains an issue. As seen in the quotation above, bitter concoctions are believed to be more effective than those that are not. It may be difficult to measure the degree of bitterness that may be sufficient to treat a particular illness. The Shona people also use herbs as a preventive measure. For example, Shoko (2007) notes that among the Karanga people, *chifumuro* (exposer) is used to expose the cause of illness. Herbal treatment involves burning some roots or leaves in the fire and the patient inhales the smoke to chase away the evil spirit. In some cases, the herbs are mixed with water and the patient is made to drink the herbal solution (Shizha & Charema, 2012).

It can be seen that certain artefacts remain influential in the lives of the Shona people despite western influence. It can thus be argued that there are traditional ways of managing illnesses that have existence immemorial and that remain of significance to this day. Despite westernisation, herbs remain of value in managing illnesses among the Shona people. Afrocentric social workers may thus respect herbs as they form the material culture of some Africans. It is important for social workers to encourage traditional medical practitioners to package their herbs in ways acceptable by people. For some time some people in Zimbabwe have been shunning traditional medicine due to unhygienic ways it is packaged and administered and at the same time embracing foreign traditional medicine like the Chinese *Tiens* and the Green World products because they have improved packaging. Social workers may have to educate members of Zimbabwe National Traditional Healers Association on healthy ways of administering herbs. Social workers should not discriminate herbalists as most social work clients use herbs.

6.9.2 Exorcism

Exorcism is commonly used among the people of Chiweshe communal lands. However one challenge that may be faced by social workers in appreciating this method may be the poor recognition of spiritual things in social work practice in Zimbabwe. Since 86 percent of Zimbabweans claim to be Christians, social workers should be encouraged to recognise the beliefs found in other religions, especially minority ones. Exorcism was reported to be used where the healer felt that the illness was caused by evil spirits. It was confirmed by a traditional healer who said:

“Kana hurwere huchikonzerwa nemweya yakaipa ndinopumha nemuswe wemvumba” (If the illness is caused by an evil spirit I drive the spirit out using a dried tail of a beast).

Asked how she does it, she reported that the process involved beating the sick person using a dried animal tail. This method was confirmed by a family interviewee who reported that her *n’anga* beat up the sick person with a dried animal tail to drive out the sickness. The essence of the healing is not in beating the sick person but the evil spirit in him/her so that it goes away. Exorcising was reported to be a common healing method and most participants concurred that it is an effective method. A *n’anga* is usually called to a homestead to drive away evil spirits. The process is usually done at night and the *n’anga* should make sure that the homestead is cleared off of whatever is troubling it. Some traditional leaders had the following to say:

“Pamwe dzimwe nguva unotoona zizi chairo richiuraiwa kana imwe mhuka yamusinganzwisisi. Kana zvadai munotoona hurwere huchidzika”,
(Sometimes you can see a familiar like an owl being killed. After that you see the illness subsiding).

“Vanhu vazhinji kwazvo mudunhu mangu vanouya vachindiudza kuti vari kuda kuchenesa misha yavo.....”(Many people in my territory come to tell me that they want to have their homesteads cleansed.....).

Chireshe *et al* (2012) also confirmed exorcism among the Shona people where a *n’anga* or prophet is summoned to do a cleansing ceremony where evil spirits are believed to be causing misfortunes such as illnesses. The evil spirits hunters are called

tsikamutandas (Chireshe *et al*, 2012). Exorcism is of late prevalent in some Christian churches in Zimbabwe. The belief in exorcism has an important bearing on strength based social work practice. As most Shona people believe that there is a spiritual hand in illness, seeing a spirit being driven away may give them strength that they too will be healed. Where a client is convinced that his/her illness is caused by a spiritual force, social workers should refer such clients to spiritual healers than forcing them to stay in hospitals. Social workers in Zimbabwe should advocate for the inclusion of traditional medical practitioners and other spiritual healers in the health referral system. Dialogue should be initiated between religious boards, traditional medical council and the Ministry of Health and Child Care to see how this can be done.

6.9.3 Healing Charms

Charms are used for various purposes among some African communities. Their use range from enhancing beauty and protection to healing various ailments. A charm is usually medicinal string that is tied on the sick person's neck or waist. It is worn for a prescribed period of time for other illnesses but is usually permanent in the case of chronic illness. All the traditional medical practitioners who participated in the study concurred that removing the charm would result in the illness worsening. The charm may be a string only or a string with a dried herb tied on it. In some cases, it can be a cloth usually black and white or black, white and red (in colours usually used in African traditional religion). The cloth may be kept by the sick person in her/his house. This was echoed by one participant who indicated that:

“Kubvira nakubvira takangokura tichiona vanhu vachiiswa ndumwa kunyanya vaya vanorwara nepfungwa. Izvi zvinonzi zvinobatsira kudzikisa

hurwere". (Ever since we have seen people with charms especially those with mental problems) said an interviewee with chronic illness.

A traditional healer indicated that the strings used are not just strings but they would have been dipped in medicine. She also highlighted that these strings should never be removed unless the healer directs so. However, one family indicated that the use of healing charms was a challenge especially where it has to be worn in the neck because most people would see that a person has a charm. A village health worker also reported that most people were afraid of these charms. This was seen when health staff at clinics and hospitals were hesitant to assist people who have charms on.

"Vanhu vazhinji vanotywa ndumwa kana manesi chaiwo muzvipatara vanotywa kudzibata" (Most people are afraid of these charms even nurses in hospitals are not comfortable touching them), she said.

The use of healing charms, was also identified by Mabvurira and Makhubele (2015) among members of Johanne Masowe Church in Buhera District in Zimbabwe and Seshego township in Polokwane, South Africa. The charms are worn for healing purposes as well as preventive purposes. They are commonly worn by babies to prevent sickness and by adults with chronic problems such as infertility. However, other people who do not understand them may discriminate those who put them assuming that they may be contagious thus bringing misfortunes on them. The mere putting of a charm may act as an asset that can allow some Shona people to persevere amid challenges. Such beliefs may thus act as a source of strength for the Shona people in times of adversity like illnesses. This may be despite the fact that there may be lack of empirical evidence as to the effectiveness of such charms in managing chronic

illnesses. As supported by Thabede (2005) and Ross (2010), social workers working with African communities should respect ornaments and beads that some Africans may put on.

6.9.4 Rituals

Almost every religion has some rituals performed for various reasons. Rituals surround human life from cradle to the grave. When a child is born rituals are performed and when a person dies certain rituals are also performed. What varies from one society to the next is the nature and process of performing the rituals. For some Shona people, rituals are of paramount importance during illness. It was reported that sometimes a ritual could help in cases of illness especially where it is suspected that an illness is caused by unhappy ancestors. The researcher found that under this method, an elder in the family would say a prayer to the ancestors requesting them to intervene in the illness. This method may involve brewing alcohol as an offering to the elders. An elderly participant reported that during the ritual some elderly members of the family can make a petition (*kupopota*) to the ancestors to take away the illness. During such a ritual, the elderly members of the family may also apologise to the ancestors for anything wrong that might have done against them.

The family bull is assumed to represent an ancestor and people may present their petitions to this family bull. Some participants also indicated that they may go to perform rituals in certain sacred places such as mountains with the assistance of spirit mediums.

“Isu vahera vemuno muChiweshe tine makomo edu atinawo atinoenda kunoita chivanhu chedu kana tikaona hurwere hwanyanya”. (We the

Vahera people of Chiweshe, we have our mountains where we go to perform our rituals when troubles by an illness), said a traditional leader

If many members of the same family are affected by illness, spirit mediums were also said to be consulted and they may tell the family to discharge certain rituals. There is a spirit medium who was reported by many participants to be able to diagnose when family spirits were angry.

Rituals are of paramount importance in the lives of many Shona people particularly in times of illness (Shizha & Charema, 2012). They reported that these rituals are common among members of African traditional religion, where illness is attributed to evil spirits or possession. These rituals involve dancing, incantations, prayer, inducing of trances and exorcism. As indicated above, the rituals may be performed in sacred places such as mountains. Shona people assume that ancestors and territorial spirits reside in mountains, rivers, rocks, big trees. Earlier studies have confirmed this belief. For example, Turaki (1999) argues that among some Africans, spirits are thought to dwell in certain trees, rocks, rivers, mountains, skies, lakes and many other places (Turaki, 1999). On the same point, Matikiti (2007) found that among the Karanga people of Zimbabwe, it is believed that Ruvure mountain in Charumbira area is a dwelling place for ancestors.

It is, therefore, possible for some Shona people to go and perform their rituals in these mountains. Rituals have always been applauded in social work practice especially from a strengths perspective. Strengths based social workers argue that coping behaviours such as prayer, meditation and singing should be recognised as important assets. Though Eurocentric religions like Christianity might view traditional African rituals as

satanic, Afrocentric social workers may applaud their importance in managing illness. Spiritually sensitive social workers may thus find it fit to recognise the rituals of traditional African communities. Where for example hospitalised clients insist on the need to perform certain rituals, there may be need for them to be given conducive space in the hospital to do that.

6.9.5 *Kurasira*

The researcher found that *kurasira* (casting away) is another healing method commonly used in Chiweshe communal lands. Under this method, the evil spirit suspected to be causing the illness is removed and put on an animal or bird. The animal is directed to the wilderness to die there. The animal may survive and any person who kills the animal will contract the illness. This was confirmed by an elderly person who adumbrated that:

“Kana munhu ukatora mbudzi dzekurasirwa dzinogara mugomo unopenga” (If you take a scape-goated animal you go mad).

In corroboration of the above, this was echoed:

“Dzimwe nguva mhuka yacho haifi, ndidzo dziya dzamunoona dzichigara mumakomo, dzinogona kuberekana dzotanga kutowanda” (Sometimes the animals do not die, those are the ones you see staying in mountains. They may even multiply), said an elderly man.

The animal is believed to die in the wilderness and this will mark the end of the curse which would have been causing the illness. Scape-goating is usually done on a black goat, chicken or cow. The severity of the problem determines the size of the animal to be used.

People who take these animals for food or for sale are, in most cases, believed to have mental illnesses. If the original illness was caused by an avenging spirit, it means all the curse will come on such a person and he/she has to do all the reparations. The scape-goated animal may be thrown in a flooded river and as the animal is washed away, the illness will disappear from the sufferer. This method corroborates with Shoko (2007b) who found that among the Kalanga people in South West Zimbabwe, members of the group may get rid of a troubling spirit through *kurasira*. This takes the form of a scape-goat which is usually a black goat or fowl (Shoko, 2007b). The bad spirit causing the illness is transferred into the animal and is left to wander into the wilderness. Anyone who tampers with it will catch the illness.

6.9.6 Divining Bones (*Hakata*)

Divination has always been present among most African communities. Various objects are used in the process. Participants in this study revealed that divining bones were identified as one of the healing methods. These are animal bones used by traditional healers and they are interpreted by the diviner to mean something. They may not be real bones but stones, wooden sticks or any other material that the *n'anga* uses. The bones are thrown and the way they appear will be interpreted by the *n'anga*. Divining bones may be used to tell any cause of illness which may range from natural causes, ancestral spirits, avenging spirits or witchcraft. This was confirmed by a traditional healer who said:

“Ndikakanda hakata dzangu ndinobva ndaona chikonzero chechirwere” (If

I throw my divining bones, I will see the cause of illness).

Bone diviners are one of the common types of diviners in Southern Africa. They use different animal bones that have a symbolic meaning. According to Walter and Jane (2004), the bones are thrown and the position in which they fall is controlled by ancestral spirits. The diviner reads and interprets the bones to uncover the truth or develop advice. Bone setting is, therefore, common among most Bantu tribes. However, not all traditional medical practitioners are bone setters.

Bone divination forms part of a branch of psychology that has come to be known as African psychology. In Southern Africa, African psychology is advanced by the Forum for African psychology (South Africa). The social work curriculum for most universities in Zimbabwe require students to undertake foundational courses in psychology. It may be necessary for social work students to be sensitised on this branch of psychology through their foundational courses. Social work practitioners may also have to further their studies in such a way that they understand the psychology behind some African phenomena like bone setting and *kurasira* described under 6.9.5 and 6.9.6

6.10 AFRICAN TRADITIONAL BELIEFS AND THE CARE OF PEOPLE WITH CHRONIC ILLNESSES

All the chronically ill people who participated in the study were not bed-ridden. This meant that they could perform some simple tasks on their own. This, however, did not rule out the issue of care as they would sometimes fail to do certain tasks due to the illness and they needed the support of others. There are a number of attributes of African traditional religion that were reported to be helpful to the ill persons' welfare. As Kreitzer *et al* (2009) notes, before the introduction of westernisation, all countries had their own ways of handling social issues, and protecting and caring for their vulnerable

people. These attributes include relationships, *Ubuntu* philosophy, communitarianism, African taboos and *chisahwira*. These are explained below.

6.10.1 Relationships and the Care for Sick

In times of the need for care, it was found that, in most cases, it came from family members, friends, other community members. For family members providing care to a relative in need was reported to be mandatory as it was a cultural expectation among the Shona people.

The family for participant C agreed that they have no option but to help her as neglecting her may anger her maiden relatives who may refuse to bury her until they are compensated in the event that she dies. One of the family interviewees said:

“Pachivanhu chedu mai vedu vakafa hativavige hama dzavo dzisipo. Saka kana vakaudza vana sekuru vedu kuti hatisi kuvachengeta zvakakanaka tinozoramwirwa zvinhu zvikatiomera” (In our culture, if our mother dies we can't bury her in the absence of her relatives. So if she tells our uncles that we are mistreating her they will refuse to come for her burial and this becomes a tough task for us).

It can be seen that family members are actively involved in the care of the sick. Mufamadi (2009) mentions that in Africa, the family plays an important role during one's illness. Matalino (2011) notes that in the event of mental illness, the individual who was afflicted by such a disease was not sent to some lunatic asylum to be taken care of. Those close to the person will report to the ancestors so that s/he could be restored to health. Families are, thus, critical in times of need. Among the Shona people, the

process of obtaining diagnosis from a traditional healer is not an individual affair. The person is accompanied by relatives and in most cases, by family elders (Shoko & Burck, 2010). They also have to agree with or refute the results of the diagnosis.

Relatives thus play an important role during one's illness. Social workers should understand the traditional African definition of a relative that it goes far beyond the western definition of a relative in which one only talks of those immediate to him. In one way or the other, people are culturally expected to look after their relatives in need. Africans have numerous social support systems that may not be present in western communities. In the process of helping clients social workers may look for members of the extended family who may be in a position to provide help. This goes beyond cases of illness to include even children in need of care who may be assisted by the extended family. When approached by a client, social workers should be able to discuss various traditional social safety nets available for the client and they may also have to network with the client's relatives.

6.10.2 *Ubuntu* Philosophy and the Care for the Sick

Life among indigenous Africans pivots around the *ubuntu* philosophy. The concept of *ubuntu* was also reported to be influencing the whole community when it comes to caring for the sick. This was shown by the following words from the respondents:

“Vanhu vane hunhu vanobatsira chero murwere zvake anenge ari pedyo navo zvisinei nekuti ihama yako kana kuti kwete. Ndinogona kutakura murwere nengoro yangu kuti aende kuchipatara. Pachivanhu chedu tinotarisirwa kubatsirana munguva yedambudziko”. (Good mannered

people assist any sick person near them despite the fact that they may not be related to that person. I may use my scotch-cart to ferry a sick person to hospital. We are expected to assist one another during time of need)- Elderly participant.

“Zvinoratidza kushaya hunhu kana vanhu vachiregerera hama yavo inenge ichirwara. Mudunhu mangu handizvitenderi nekuti handidi vanhu vanofa vakatsamwa vozomuka zvipoko” (It shows lack of manners if people neglect their sick relative. In my area I don’t allow that because I don’t want people who will die angry and become ghosts)- traditional leader.

The concept of *ubuntu* has caring and loving as some of its values. Shona people in Chiweshe communal lands care for the sick as expected in their *ubuntu* philosophy. As shown by the quotations above a person may lose respect and honour for failing to help those in need. *Ubuntu* values of caring, loving and sharing blends very well with social work values and principles. As Shona people will be striving to have *unhu*, they will be assisting those in need. Social workers working with traditional African communities may also be required to exhibit *Ubuntu* values. The concept of *ubuntu* has been reported by many scholars to be playing an important role in the care and treatment of chronic illnesses. Mhame *et al* (2010) postulate that the *ubuntu* philosophy requires traditional medical practitioners to provide health services by putting people first and not for material gain. Engelbrecht and Kasiram (2012) concede that in accordance with the principles of *ubuntu*, people with mental illness should be well supported and cared for by their families and the wider community.

The Council of Social Workers of Zimbabwe has included *Ubuntu* among its ethical principles. Social workers should bear in mind that the *Ubuntu* philosophy guides African life and is not only limited to the caring of the sick. A social worker without *hunhu* may have challenges in practicing in some rural communities in Zimbabwe. The *hunhu* is demonstrated in appearance and behaviours like respecting the elders, loving others, empathy, dressing, tone of voice etc. Social workers should also ensure that other professionals in a multidisciplinary team have *hunhu* as expected by their Shona clients. This implies that nurses for example should respect the elders, dress in a culturally acceptable way while on duty and love and respect their clients. Also social workers trained in urban areas but practicing in rural areas should see to it that their behaviour is in line with those that are culturally expected. A social worker who does not greet elders may not be acceptable in a rural setting.

Furthermore the behaviour that is expected of males and females is different among some African communities. Women for example may not sit on a chair while men are sitting on the ground. During sessions especially in rural settings women might not freely address sitting men whilst standing. The element of professional authority must therefore be treated with caution in certain circumstances as it may violet some traditional African values.

6.10.3 Communitarianism and the Sick

The whole community was said to participate in caring for people with chronic illnesses especially the mentally ill. A family with a mentally ill relative confirmed that sometimes other villagers would bring back their mentally ill relative home or report her whenever she wanted to stray. This, they said, gave them strengths as it showed that other people

in the community understood the problem their family was facing. A traditional cultural leader reported that they always considered disadvantaged members of the community, such as the chronically ill, whenever there was aid from government or from some non-governmental organisations.

“Kana pakauya rubatsiro rwupi zvarwo tinoonawo kuti varwere vatinavo mudunhu medu vawana” (If any form of aid comes we make sure that the sick in our communities get it) he said.

Another traditional cultural leader confirmed that they sometimes team up to work in the fields of chronically ill people. They usually target the elderly in their communities, especially those who are staying alone. Asked how traditional beliefs motivated them to do this he highlighted that it is part of the African philosophy of *ubuntu* to care for one another. This is what he said:

“Pachivanhu chedu tinobatsirana zvisinei nekuti munhu ihama yako yeropa kana haisi. Tikangogarisana hatishayi hukama nekuti mitupo yedu inodyidzana. Vandigere navo ndivana sekuru vangu vana Chiweshe vahera ava. Ndikaita dambudziko vanondibatsira hama dzangu chaidzo dzisati dzasvika.....” (In our culture we assist one another despite the fact that we may not have blood relationships. If we stay in one neighbourhood, relationships will be found because of our totems. If I have a problem they assist me before my real relatives arrive.....).

O’Brien and Palmer (2009:16) confirm the communal nature of African life by arguing that their human society is communal. Ancestors, the living, the living dead and those

yet to be born are all an important part of the community. The relationships between the worldly and the other-worldly help to guide and balance the lives of the community. Community involvement was also supported by Chirongoma (2013), who argues that for some Shona people, healing and well-being are a communal endeavour. All the members of the community work together towards preserving and securing life, health and well-being. The communal nature of traditional African life is an asset that gives people support and strength during difficult moments.

When providing support, social workers should consider the assistance clients may get from other members of the community. The community should therefore be included in the helping process. Social workers should always look into the resources that surround clients and these include other members of the community who may provide emotional and material support. If a person becomes critically ill, it is not uncommon to find community members staying with the person among the Shona people. Where social workers are dealing with anxieties that result from problem situations, they may also have to include other community members who were with the client during the problem situation. For example grief and bereavement counselling in African communities may also include other significant others in the community rather than targeting clients and their immediate families only.

6.10.4 Taboos and the Care for the Sick

Taboos (*zviera*) form part and parcel of Shona morality. Taboos are understood to be specific rules that forbid people from performing certain actions, the performance of which may result in negation of the moral conduct that govern human behaviour (Chemhuru & Masaka, 2010). Breaching of *zviera* is thought to invite misfortunes such

as bad luck, drought or death (Tatira, 2000). Violation of Shona taboos is thus said to invite an angry reaction of the spirit world. Taboos are understood to be fostering desirable conduct in human behaviours. Taboos were found to be influencing the care for the sick in Chiweshe. Sick people without close relatives to take care of them would get assistance from the community because the community fear that if they die in anger, they may become ghosts or rain will not come down. This was reported to be common with the elderly people without close relatives to take care of them. An elderly participant reported that there is a taboo which says:

Ukaseka murwere newe unorwarawo (If you scoff at a sick person you become sick).

Some Shona people are forced to take care of certain disadvantaged individuals due to their beliefs in certain taboos. The taboos play an important role in maintaining human relations, promoting human and environmental health as well as environmental conservation (Chemhuru & Masaka, 2010). There are certain taboos that are relevant in health issues, for example, *ukaseka murwere unorwarawo* (If you scoff at a sick person you become sick). This taboo prevents Shona people from teasing ill persons instead of assisting them in their times of need.

Social workers practicing in indigenous African communities should understand the taboos found in such communities. They ought to understand how these influence the helping process of individuals in need. Despite how funny the taboo may seem, social workers should also respect these taboo.

6.10.5 *Chisahwira* and Care for the Sick

Friendship is very important among the Shona people. Each person and family should have a *sahwira* (very close friend). The friend (*sahwira*) plays a critical role in a number of areas of a person's life.

“Munhu wese anotarisirwa kuva nemasahwira hazvina basa kuti akaipa sei. Chero muroyi chaiye atori nemasahwira akewo.....”. (Every person is expected to have close friends. Even a witch will have his/her close friends), said a family interviewee.

“Sahwira anotaura zvaanoda munhu asingagumbuki. Anogona kuudza munhu kuti une chemazuvano enda kuchipatara unorapwa zvinova zvinhu zvinonetsa vamwewo vanhu zvavo”. *Kana murwere akada kunetsa sekuti achiramba kudya tinodana masahwira kuti auye kuzomupopotera*”. (A close friend can say anything without offending the person. He can tell a person that s/he is HIV positive something which might be difficult for other people. If a sick person for example refuses to eat, the *sahwira* is called to reprimand him)- Village health worker.

This *sahwira* is important during a burial of an individual. A person is taken down the grave by some *sahwiras*. However, these *sahwiras* also play a critical role when one is in need. They provide care, and they are free to tell the truth concerning the illness which might be difficult for the sick person's relatives. An example given by an elderly man was that a *sahwira* can tell a person that he is HIV positive and must go for treatment something which might be difficult for other people.

When told something by a *sahwira*, a person cannot become angry, hence, the importance of every person to have a *sahwira*. In times of need, even a person's parents or other close relatives might need to call his *sahwiras* to say something to correct unwanted behaviour. This is done during the process of *chisahwira*. There are certain things that social workers might need to communicate to their clients, some of which may be unpleasant. It may be of importance for social workers to communicate via the *sahwiras*. However this may sound abnormal to social workers grounded in the western education systems as they may fear breaching confidentiality. It is also believed that people share their secrets with their *sahwiras* hence it might be easy for social workers to take this route. It must also be borne in mind that the *sahwira* is more than a friend in the western world. The friend may be equated to a *shamwari* in Shona culture. A *sahwira* is sometimes as good as the person in need and hardly do Shona people oppose their *sahwiras*. The *chisahwira* develops over a long period of time and trust would have been guaranteed.

Chisahwira has a strong bearing on social work practice. Where social workers intend to influence a client's behaviour, they may use the *sahwiras*. Social workers may also consider communicating to their clients through the *sahwiras*. For example where a client is absconding from counselling session, a social worker may consider telling the *sahwira* to reprimand the client. Where necessary and with the client's consent a social worker may request a client to bring a *sahwira* for sessions so that the client will get support when implementing the intervention strategies. Some ill clients may refuse to take medication as required and social workers may consider telling the friends to communicate with the clients.

6.10.6 Totemism

The Shona belief in totems was found to play a critical role in the care of people with chronic illnesses. It was found that most people under the Chiweshe chiefdom are of the *vahera* totem, the symbol for their totem is an eland. For Shona people, those who share the same totem are related in one way or the other despite lack of traceable consanguinity. Based on shared totems, people could assist one another in times of need such as illness. This was confirmed by one family head who said:

“Kana ndichida kufamba rwendo ndinosiya mwana wangu kune vamwe vana mhofu vatigere navo” (If I want to travel I leave my child with other people of the antelope totem who stay near us).

Totemism was reported by one traditional leader to be very important. He reported that by sharing the same totem and through inter-marriages, you find that any person in your community is a relative. The definition of a relative among the Shona people of Chiweshe is thus broader as compared to the Western individualistic definition which focuses on the nuclear family. Social workers should understand that the network of an individual's significant others is also determined by totem based relationships. A person may respect and assist someone who shares the same totem with her/his mother as she/he finds a close relationship which is totem based. Even in urban areas where some Shona practices and beliefs are shedding off totems are still of importance. Relationships among some Africans thus go beyond traceable relatives as found in western communities. An individual has broad potential traditional social support systems.

Totemism was also reported to link the “living living” and the “living dead”. Totems were reported to be mentioned during family rituals and the healing process to appraise and honour the ancestors. One *n’anga* confirmed this by saying:

“Ndisati ndarapa munhu ndinotanga ndadetemba mutupo wemurwere ndichikumbira vadzimu vake kuti vamusunungure” (Before I treat a person I recite his totemic poem begging his ancestors to relieve).

This was further confirmed by another diviner who said it is difficult to help somebody who does not know his totem. Conversely, a herbalist argued that he treats people without making reference to their totems. The use of totems (*mutupo*) among the Shona is a prehistoric tradition that goes back for centuries. According to Hodza (1979) in Pfukwa (2014), the totem is an animal that a clan takes up expressing certain values and virtues. Each totem is buttressed by a string of myths and folklore. The *mutupo* serves as a social bond and is an expression of collective identity for a clan or family that carries that totem (Pfukwa, 2014). It is believed that when one eats his totem animal, misfortunes such as illness will haunt him or his family. Totems are critical in Shona relationships. The assumption is that people who share the same totem are related and they may help one another in times of need.

Totems thus form part of the Shona mythology. People do not marry someone they share the same totem with as it is considered to be taboo. Some social service providers may assist clients whole heartedly when they discovered that they share the same totem and may run the risk of discriminating those they do not share the same totem with. In as much as social workers should understand the importance attached to totems among some African communities they should also be alert of the bearing

totemism has in their own lives as this may influence social service provision. Totems are an asset that social workers may consider exploiting during the helping process. Social group work sessions for example may have people who share the same totem. Group conflicts may be limited as the members may feel that they are the same people who ought to respect one another.

6.11 COMMUNITY PERCEPTIONS AND WEAKNESSES OF AFRICAN TRADITIONAL RELIGION AND SPIRITUALITY IN THE MANAGEMENT OF CHRONIC ILLNESSES

It was reported that most people in Chiweshe claim to be Christians and they shun ATR. ATR is associated with witchcraft, evil things and possession of familiars. The community's perceptions and attitudes toward ATR and traditional healing methods are presented in this section.

6.11.1 Denigration of African Traditional Religion and Traditional Healing Methods.

People in Chiweshe, especially Christians were reported to look down upon African traditional religion. This is despite the fact that there are some churches in the area that are very close to ATR. A community home-based care worker echoed that:

“Nyangwe zvazvo chitendero chechivanhu chichisvorwa kwazvo munharaunda medu, tine zvimwe zvitendero zvakaita se Nguwo Tsvuku zvakangoda kufanana nechitendero ichi. Vanhu vanonamata nguwo tsvuku vanotyiswa uye hapana munhu anosvika pavanonamatira achibata zvinhu zvavo”. (Though people in our area despise ATR certain religions such as Nguwo Tsvuku are so close to it. People are afraid of them and no one wants to get close to their places of worship and touch their artifacts).

Corroborating the above, one elderly woman said:

“Maonerwo anoitwa chitendero chechiuvanhu nenharaunda haanyatsonzwisisiki, vanhu vanosvora asi vanenge vanotsvaga rubatsiro muchitendero ichochi futi kana vaomerwa”. (We don't understand the perceptions of people towards ATR. People shun it but they resort to it for assistance during their hard times).

Asked to give a comparative analysis of ATR and other religions in relation to the management of chronic illness, some traditional cultural leaders concurred that it was seen by many as backwardness and was associated with witchcraft. A traditional leader pointed out that whenever a TMP got sick in his community, people tended to shun him and could not provide care. This was also confirmed by another traditional healer who argued that most people do not understand traditional medicine as they suspect traditional medical practitioners of witchcraft and they celebrate their illness. Almost all village health workers supported the fact that people were reluctant to assist whenever a TMP needed assistance during times of illness.

Social work seeks to promote human rights and social justice. Social workers challenge discrimination. Social workers working in rural areas should see to it that members of minority religions are not discriminated. There is freedom of worship in Zimbabwe and social workers should ensure that people enjoy the freedom. Most people in Zimbabwe still seek help from traditional practitioners and they should not stop doing so due to disparagement of ATR.

6.11.2 Witchcraft Belief as a Source of Conflict

The investigator gathered that belief in African traditional religion may lead to conflicts in families especially where there is witchcraft accusation among relatives. This was confirmed by traditional leaders, village health workers, the elderly and some traditional medical practitioners. This was said to be the case because most people do not want to acknowledge that they are witches. This was said to be a source of conflict among some family and community members in the study area. One traditional healer had this to say:

“Vanhu vane zvinhu mudzimba umu asi vava kuhwanda nemachechi. Kana tikavabata voti tiri kuvanyebera” (People possess familiars in their houses but they are hiding under churches. If we get to know it they accuse us of accusing them of witchcraft).

One elderly group discussant indicated that members of other religions think that ATR is about witchcraft and familiars.

“Vanhu vanofunga kuti munhu wese anoita zvechivanhu anoroya. Isu tinotovenga huroyi. Izvozvo ndizvo zvinokonzera kuvengana pakati pehama nehama” (People think that everyone in ATR is a witch. We hate witchcraft. This is what causes enmity among related people).

Despite the role played by traditional healers in the health delivery systems of most African countries, some people argue that they are involved in giving some people harmful charms or responsible for casting evil spells on other people. Bourdillon (1993) indicates that some *n’angas* are motivated by financial gains and as such, can do

anything to get money. Witchcraft is a belief that is central among the Shona people. Witches are said to be responsible for causing illness and people may fight over witchcraft accusations. Social workers should play a mediation role where people accuse one another for witchcraft. For social workers to effectively do so, they should familiarise themselves with the beliefs around witchcraft among indigenous people.

6.11.3 Ill-treatment of ATR Members at Hospitals

One focus group discussant indicated that whenever officials at the local hospital discovered that someone had been to a traditional healer, they would shout at him or her. He said:

“Manesi muzvipatara medu akaziva kuti unoita zvechivanhu vanokupopotera zvisingamboiti. Ini ndine mutimwi muhuro asi ndikada kuenda kuchipatara ndinotoubvisa kunyangwe uchifanirwa kugara muhuro nguva dzose....” (If nurses at the local hospital discover that you are into ATR, they will shout at you badly. I have this medicinal string in my neck but I take it off whenever I visit the clinic despite that I should put it all the time....).

The association of ATR with or as witchcraft is well documented (Chavunduka, 2001; Kazembe, 2009). In line with earlier studies, traditional healing methods have been reported to interfere with Western medicines and colonisers of Africa have thus tried by all means to suppress them. Discrimination of members of ATR is likely to happen as most people in Zimbabwe claim to be Christians and ATR is associated with backwardness, witchcraft and satanism.

This suspicion of witchcraft was also reported in geriatric illness. People were reported to be reluctant to assist a very old person who got sick due to the myth that very old people are witches that is prevalent among most Shona communities.

“Munharaunda medu vanhu vakurisa kunyanya vechikadzi vanoonekwa sevaroyi. Takangokurawo zviriko. Vanhu ivava ndivo vatinoona vanonyanya kushaya rubatsiro” (In our community, very old people, especially women, are regarded as witches. We found it like that. These are the people who lack care)-Elderly focus group participant.

One traditional medical practitioner who always dresses in black and white clothes confirmed that most people did not want to sit with him in public places despite the fact that he plays a very crucial role in rain-making for the area. This is what he had to say:

“Ndinoona ndikapinda mukombi vanhu havadi kugara pedyo neni. Hapana anoda kugumwa nehembe dzangu. Asi tisu tinoita minamoto yemvura munharaunda ino” (If I get into a bus no one wants to sit next to me. No one wants to get into contact with my clothes. But we are the people who make prayers for rains in this area).

Discrimination of members of ATR is common. Schiele (1996) argues that political subjugation traumatised Africans to the extent that many of them lost confidence in and looked down upon their culture. Western thought dominated by Christianity has created hierarchical structure of world religions. This implies that certain religions are inferior to others. This has forced most Africans to view and embrace Christianity and Islam as assumed progressive religions. Social workers have a role to play in clarifying some

myths that may be jeopardising the welfare of some people. One such myth given here is that very old people are associated with witchcraft.

6.11.4 Un-scientificness of Indigenous Healing Practices

It was also reported that some medicines and healing practices found in ATR may be dangerous to people's health. It was reported that traditional medicines have no clear dosage and the concepts of under-dose and over-dose are difficult to tell apart.

“Munhu anonzi amwe makwati emuti kuti apore. How many? Ndipo pane dambudziko ipapo” (A person is asked to drink water mixed with tree bucks. How many bucks? That is the problem)-Village health worker.

It was reported that some people were also told to breathe smoke from certain herbs but the time they should breathe them at any given moment is not clear. Some members of ATR were said to delay seeking allopathic medical health services until it was too late for a person to recover. As compared to other religions, village health workers concurred that members of ATR sometimes delay seeking medical attention even though they are apostolic Christian denominations just like ATR. Interpersonal relationships such as witchcraft, possession of familiars are believed to be the causes of illnesses.

This is despite the fact that some traditional medical practitioners highlighted that a number of Christians in their area sought their services. One of them had this to say:

“Vanhu ava vanotivenga masikati asi husiku tinenge tiri tese” (These people hate us during the day but come the evening we are together).

Another chronically ill man indicated that his brother has always forced him to repent to Christianity so that when he dies he goes to heaven. He reported that some church people always say some prayers at their homestead despite the fact that he did not believe in a foreign God.

Traditional healers have also been criticised for complicating the fight against HIV and AIDS. In a study by Mbereko and Mahlatini (2014), some traditional healer respondents reported that they discourage their patients from using condoms because they believed condoms have AIDS. Generally, practices and instruments used by traditional healers have frequently been blamed for exacerbating HIV and AIDS (Mbereko and Mahlatini, 2014). Castigation of traditional healing methods has been fuelled by whites who, upon their settlement in Africa, described TM as primitive, barbaric, ignorant knowledge, superstition and unscientific (Shizha, 2008; Shizha & Charema, 2012). Social workers should fight for the rights of traditional medical practitioners and see to it that any criticism levelled against them is evidence based.

6.12 ASSUMED EFFICACY OF TRADITIONAL HEALING METHODS

Most of the participants applauded traditional healing methods. Even some village health workers and community home-based care workers indicated that they helped in treating certain illnesses as the healers were readily available within the community. One traditional healer argued that traditional healing methods were better than biomedicine in treating chronic illnesses. He gave an example of radiotherapy and amputation in modern cancer treatment which, he said, were painful in that they lead to impairment of someone who was born normal.

Another traditional healer indicated that she can cure diseases such as sugar diabetes, mental illness, can stabilise cancer and HIV and AIDS. However, this was contrasted by another discussant who reported that she refers all cases of HIV and AIDS to clinics and hospitals. All the chronically ill people interviewed were confident that their beliefs have been helping them in stabilising their illnesses.

A family member of a mentally ill girl indicated that a *n'anga* has helped a lot in stabilising his sister's illness. Some traditional medical practitioners appraised traditional medicine for lacking detrimental side effects. To that effect, this was echoed:

“Mishonga yedu haikuvadzi sezvinoita mishonga yemuzvipatara zvamazuvano inonzi ukapfurikidza mwero inokuvadza”. (Our medications do not harm people like Western medicines which are toxic when an overdose is taken).

This was confirmed by a hypertensive interviewee who reported that some drugs she got from the clinic caused her fatigue and fever while indigenous medicine she got from a local herbalist had no such side effects.

Traditional healing methods were also reported to be cheap. Most participants reported that they could go to the nearest TMP at any time to seek assistance. Some traditional healers confirmed that they accepted non-monetary modes of payment such as grain or livestock. This was confirmed by a woman with a chronic disease who said that she uses her chickens to pay her *n'anga*. She said she has always been referred to a hospital in Harare since there are no cancer treating facilities at local hospitals. Another participant indicated that, on several occasions, the hospital has requested her to

purchase some drugs at the local pharmacy as they were always out of stock which came out to be expensive. As such she always resorts to TM which is cheap for her.

Apart from being cheap, services of TMP were reported to be always available. An interviewee boasted of having two specialist herbalist who could treat her hypertension. She argued that their availability has worked to her advantage. It was reported that it was a walking distance to go to most *n'angas* though some people were free to travel long distances to go to a traditional healer of their choice.

Linking people to their ancestral spirits was found to be important. This was said to be crucial as one person's illness was reported to be a sign of imbalance in the spirit world.

A traditional healer said:

“Hurwere hunogona kungodaro iri nzira yekuudzwa kuti pane zvakakanganisika munyika yemweya. Munhu akauya kwandiri ndinobva ndatobatsira mhuri yese nevasipo izvi zvakana nekuti kuchipatara vanongorapa auya chete...” (An illness might be a way of communicating an imbalance in the spirit world. If one person comes to me I automatically help the whole family even those who are not present. This is good and you don't get it in hospitals where they only assist a person who visits them).

Traditional healers dig deep into the causes of illness. This is common in those healers who are possessed by healing spirits. *Mbuya* Marasha indicated that her spirit will not just heal someone and end there. It usually digs into someone's background and unearths the source of the misfortune.

Another advantage reported was that formal schooling is not mandatory for one to become a traditional medical practitioner. As well it was reported that healing can be done in the absence of the sick person, something difficult for most western doctors who may want to examine the patient. VaMarasha indicated that sometimes there may be no need for the sick person to come to his house. S/he can send someone on her behalf. He reported that he is free to give a third person the concoction and inform him/her about how to administer it.

Though it was agreed that most herbalists use specific medicine for specific illnesses, it was reported that with some traditional healers, healing methods differed with what would have come from the spirit world. It was the healing spirit which was said to tell the traditional healer a particular healing method and people with the same illness could get different concoctions.

“Mudzimu wangu ndiwo unondiudza marapiro. Kusiyana siyana kwemarapiro ikoku kunokurudzira vamwe varwere chaizvo. Chero akazofa hake anofa akarerukirwa” (My healing spirit tells me how to cure. The various nature of healing methods may motivate certain clients. Even if someone dies they will do so while motivated)- Traditional healer.

One woman indicated that traditional medicine is very effective in treating opportunistic infections. This is what she said:

“Ini ndakamboita herpes ndikarapwa nemishonga yechivanhu ikapera kuti tsva” (I once had herpes zoster and I was treated successfully through traditional medicine.

This efficacy of traditional healing methods has been reported by a number of scholars (Levers, 2006; WHO, 2002; Richter, 2004; Mahomoodly, 2013; UNAIDS, 2000; Mufomadi, 2009). These results are corroborated by Shoko (2007), who notes that among the Karanga people in Zimbabwe, serious diseases and illnesses are treated by various forms which involve herbal treatment, extraction of disease causing objects and exorcism of undesirable spirits. The efficacy of traditional ways of managing chronic diseases which was reported by the study participants is in line with Abbott (2009) who said despite its criticisms, traditional medicines encompass a large group of healthcare systems, practices and products that are evidence-based and effective.

The affordability of traditional medicines reported by participants was also found by Mhame *et al* (2010), who argue that the traditional medical practitioner's own experiences added to the accumulated knowledge handed down by the ancestors allows the practitioner to offer cheap but effective remedies for treating the main ailments. The results corroborate with Dhewa (2008) who notes that cure before remuneration is considered in African traditional religion and a token or delayed reimbursement is satisfactory. However, though participants in the current study appraised traditional medicine, it must be treated with caution as issues of dosage remain unclear where healers prescribe certain medicines.

Social workers working with indigenous African communities must not discourage their clients from using traditional medicine. It is not uncommon for ill people to request discharge from hospitals so that they can seek traditional healing. Social workers and other service providers in the health delivery system should be in a position to refer clients to good traditional medical practitioners they know. Social workers should

advocate for the inclusion of traditional doctors in referral system in Zimbabwe. Traditional and spiritual healing has yielded positive results for some people in Zimbabwe no wonder why they remain marginalised. The advocacy role of social work should see the full recognition of traditional medicine in Zimbabwe.

6.13 SUMMARY

This chapter presented results obtained from one-on-one interviews, family interviews and focus group discussions. The results were discussed in relation to literature review and the theoretical frameworks of the study. The empirical responses were presented in two parts. The first part (Part A) focused on responses from people with chronic illnesses and Part B focused on responses from the other participants. The potential implications of the results on social work practice were also highlighted.

A number of assumed causes of chronic illnesses were mentioned by the study participants. These include among other, call by ancestral spirits, avenging spirits, witchcraft, natural causes and possession of familiars. Most of the causes are related to the spirit world in the sense that some spirits are involved in one way or the other. It was also found that the healing powers and methods used by traditional healers are inspired by the spirit world. The healing methods include use of herbs, exorcism, casting away, performing certain rituals and use of charms. Some beliefs and practices that promote the resilience and strength of people with chronic illnesses were also presented. There are certain practices in Shona traditional religion that support the care of sick people. These are, among other things, *ubuntu* philosophy, taboos, totemism and the extended family. All these have a bearing on social work practice with indigenous

African clients. The following chapter (chapter seven) gives a summary of key study findings, conclusions and recommendations.

CHAPTER SEVEN

SUMMARY OF THE MAJOR FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

7.1 INTRODUCTION

This study sought to explore the influence of African traditional religion and spirituality in understanding chronic illnesses among Shona people of Chiweshe communal lands in Mazowe district, Zimbabwe. It was informed by the Afrocentric theory, strengths perspective and the resilience theory. It embraced the Afrocentric methodology in which data were collected from eleven people with chronic illnesses, six families with chronically ill members, traditional cultural leaders, traditional medical practitioners, the elderly, village health workers and community home-based care workers. This chapter recaptures the problem statement, aim and objectives of the study. It further demonstrates how each objective has been achieved. Furthermore it gives a summary of key findings of the study, draws conclusions and gives recommendations for social work practice with indigenous communities in Zimbabwe.

7.2 RE-STATEMENT OF THE PROBLEM

Harmful cultural practices in Africa are over-emphasised at the expense of helpful ones. Western culture and ideology have indoctrinated Africans into believing that the West provides a universal panacea to all African problems. For centuries, social science research in Africa has been informed by Eurocentric methods of inquiry. This has often led to wrong and misdirected treatment of problems affecting black African people.

Eurocentric religious and spiritual hegemony has for a long time relegated African religion and spirituality to the margins. Afro-based methods of disease management which are grounded in African belief systems have thus been relegated to the periphery. It is against this perspective that social work practice in Africa and Zimbabwe in particular, has failed to be indigenised. Social work treatment methods which were imported to the continent during the colonial era are still in place decades after the independence of Zimbabwe. In Zimbabwe, social workers have relegated Indigenous Knowledge Systems (IKS) to the periphery despite calls to indigenise social work practice (Mupedziswa, 1993). They have done so despite the recognition of African belief systems' importance in illness management (Gelfand, 1975; Kazembe, 2009; Chavunduka, 2001; WHO, 2002) in the health delivery systems of Zimbabwe. This is despite the fact that there is an increased attention to the relationship between social work practice, culture and indigeniety in some parts of the world (Hodge & Derezotes, 2008; Baskin, 2002). Makhubele (2011) also notes that in some countries, official propaganda depicts indigenous cultures and methodologies as backward and out of date and simultaneously promotes one national culture at the expense of minority cultures. However, social workers are encouraged to embrace many ways of knowing especially when working with indigenous peoples (Phillips, 2010).

Religion and spirituality play a very crucial role in social work practice. Social work practitioners are encouraged to be religiously and spiritually sensitive when they execute their duties. A lot has been written by historians, anthropologists, religious leaders and missiologists about the role of African traditional religion and spirituality among the Shona people of Zimbabwe (Mpofu, 2011; Shizha & Charema, 2012; Shoko

& Burck, 2010; Machinga, 2011; Kazembe, 2009, Chavunduka, 1978; Gelfand, Mavis, Drummond & Ndemera, 1985), but little if any is known about it from a social work perspective. Despite the importance of aspects of religion and spirituality in social work practice, it is an area which is hard hit by academic amnesia among social work researchers and educators in Zimbabwe. Social work scholars in Zimbabwe have not devoted any effort to researching on religion and spirituality with the exception of the work of Mabvurira and Nyanguru (2013) and Mabvurira and Makhubele (2014). For most black Africans, it is almost impossible to separate the material from the spiritual. Thus, spiritual issues are critical in the everyday lives of indigenous African people hence neglecting them in social work practice can have detrimental effects on intervention. Furman and Bensin (2006) argue that despite emerging interest in spirituality, social workers report little preparation for integrating religion and spirituality into practice. This is despite the fact that earlier studies have indicated that social work educators and students, in a number of countries such as USA, Canada and New Zealand are willing to include religious and spiritual aspects in their curricula (Canda, 1998; Praglin, 2004; Csiernikn & Adams, 2002).

Many aspects of diversity such as race, ethnicity and gender have been mentioned in social work education in Zimbabwe but issues which have to do with Indigenous Knowledge Systems, especially with African traditional religion, have been left out. Unlike in the neighbouring South Africa with its comprehensive, Indigenous Knowledge Systems policy, IKS issues in Zimbabwe have not been given attention especially by most helping professions. As mentioned earlier, Sheridan (2002) notes that social work

services that incorporate religion and spirituality may help clients deal with a sense of alienation, hopelessness, grief and a range of other adverse issues. Social workers have been afraid of speaking about spiritual things with their clients for fear of crossing the line of self-determination. They have thus consequently neglected a large component of the person-in-the-environment (Hunt, 2010). They have also disregarded issues which have to do with African traditional religion which is facing extinction.

The origin of social work is believed to have been motivated by religious and spiritual beliefs though with the passage of time, the two seem to have drifted apart. Sheridan (2010) argues that spirituality is soulful living and that social work has largely become disconnected from its spiritual roots. Since the early 1980s, there have been calls for a return to the spiritual roots of social work (Canda, 1999; Canda & Furman, 2010; Lembke, 2012; Martin, 2003; Lindasy, 2002; Hodge, 2001), but this has not materialised in most African countries. Few social work scholars in Southern Africa have researched on religion and spirituality in social work (Thabede, 2005; Bhagwan, 2010a; Bhagwan, 2010b; Ross, 2010).

All the three institutions (University of Zimbabwe, Bindura University of Science Education and Women's University in Africa) currently offering social work training in Zimbabwe, do not offer any course on religion and spirituality in social work practice. Spirituality, as a protective factor for coping with chronic illnesses, has been understudied in Zimbabwe. Most literature which is available is by scholars from the developed world and they have written mostly in the context of Christian spirituality. Almost all humanity subscribes to a form of religion or the other and is spiritual to an

extent. People have always resorted to spirituality when faced with traumatic life events. People always find refuge in spirituality when they cannot explain certain events in life. Given that a significant percentage of Zimbabweans are religious, there is, therefore, much to suggest that religion and spirituality are of considerable significance to most people in Zimbabwe. Clients' spirituality, therefore, needs to be given serious attention by policy makers, social work educators and practitioners.

People diagnosed with life-threatening or chronic conditions such as HIV and AIDS and cancer have resorted to faith healing (Kazembe, 2009). Another point of interest is the fact that even some Christians in Zimbabwe turn to indigenous healing practices when faced with strange life circumstances (Chavunduka, 2011; Kazembe, 2009). Furthermore, Viriri and Mungwini (2009) are of the view that in responding to problems, Shona people have developed a patch work of solutions with ideas they draw from modern science, the Christian tradition and their own traditional metaphysics. Given this scenario, there is, therefore, a need for a subterranean understanding of the influence of African traditional religion and spirituality in comprehending chronic illnesses among the Shona people of Zimbabwe. The presumption is that religion and spirituality have been found to provide a protective measure against life-threatening conditions yet little has been explored from a social work perspective among the Shona people who constitute more than 70% of Zimbabwe's population (Kazembe, 2009).

Social work has originated from religious movements, especially Christian movements. This is the reason why views from different fields have been incorporated in the subject

about the role of spirituality in social work practice. A research gap exists in identifying the role of African traditional religion and spirituality in chronic illness. An important question to be addressed is or not African spirituality has the same effect on chronic illnesses as other forms of spirituality especially among the Shona people of Zimbabwe. The understanding is that though disease is universal, illness is culturally constructed.

Sodi (2009) concedes that around the mid-1970s, the World Health Organisation (WHO) called for the recognition of Traditional Medicine (TM) through appropriate training and research in an endeavour to facilitate collaboration with primary health care systems. The African Union declared 2001 to 2010 to be a decade of African traditional medicine and the World Health Organisation recognises the role of traditional medicine in the health delivery systems of many developing nations. Life in Africa is hinged on religion, and African traditional religion and traditional medicine are inseparable. In Africa, the term “indigenous” is synonymous with “African” and “anti-colonial” (Mohale, 2010). Social workers should explore ways of incorporating indigenous spirituality into practice.

7.3 RE-STATEMENT OF THE AIM AND OBJECTIVES OF THE STUDY

This study sought to examine the influence of African traditional religion and spirituality in understanding chronic illnesses in Chiweshe communal lands. The aim of the study was successfully achieved through the following objectives:

- Objective 1

To find out the assumed causes of chronic illnesses among members of ATR in Chiweshe communal lands. A number of assumed causes of chronic illness have been

identified. They include among others, avenging spirits, angry ancestors, witchcraft, natural causes and globalisation. Most of these causes are explained within the purview of African traditional religion and spirituality.

- Objective 2

To explore how African traditional religion and spirituality promote management of chronic illnesses. Traditional methods of managing chronic illnesses have been explored. These include, among other things, the use of herbs, exorcism, the use of divining bones, and casting away. Most of the healing methods are inspired by African traditional religion as the spirit world is responsible for imparting healing knowledge and power.

- Objective 3

To find out the influence of African spirituality on the resilience of people with chronic diseases. African spirituality and religion have been found to promote resilience during one's illnesses. The belief that one's ancestors are always with him and certain rituals such as bringing back ceremony and the ability of traditional healers to tap into the spirit world gives the sick people strengths as shown in chapter six.

- Objective 4

To establish how traditional African belief systems affect community perceptions of chronic diseases. Traditional African belief systems have been found to negatively influence community perceptions of people with chronic diseases. Members of other religions, mainly Christianity, are afraid of members of African traditional religion because they associate it with witchcraft. At times, members of ATR face discrimination.

- Objective 5

To establish how traditional African belief systems affect the care of people with chronic diseases. Some African taboos, the *ubuntu* philosophy, communitarianism and totemism encourage the good care of the sick in traditional African communities.

7.4 SUMMARY OF MAJOR FINDINGS

Key findings of the study are summarised below.

7.4.1. Assumed Causes of Chronic Illnesses

A number of causes of chronic illnesses show that for the Shona people, the spirit world is involved in the causation of chronic illnesses. The general feeling of the participants was that sickness is normal but it becomes an issue when it does not heal over a reasonable period. It was found that members of African traditional religion in Chiweshe area believed that if a spirit wants to manifest in a family it can do so by causing a chronic illness which can only heal after a person responds to divine calling. Healing was only assumed to occur after the family identified the needs of the manifesting spirit and met them. Avenging spirit, *ngozi*, was believed to have the capacity to cause illness. The spirit from the deceased, avenged person was said to affect the perpetrator or his family. Punishment from ancestral spirits was cited as a cause of illness. It was found that angry ancestors could cause illness as a punishment. From time to time, the Shona people are expected to perform certain rituals to honour their ancestors. Failure to perform such rituals was believed to anger the ancestors who would then withdraw their protective role as they seek attention. Witchcraft was reported to be responsible for the cause of chronic illnesses. It was noted that people in Chiweshe area believe that

somebody can be bewitched by community members, who are usually their relatives or relatives who are jealous of a person's wealth or success in life. Other causes of chronic illnesses reported were globalisation and HIV positive status. Some of the causes are believed to working in combination in causing the illness. Generally the Shona people of Chiweshe communal lands believe that the spirit world is heavily involved in causing chronic illnesses. Earlier studies have confirmed ancestral call (Muchinako *et al*, 2013), avenging spirits (Benyera, 2014), witchcraft (Chavunduka, 2001), possession of familiars (Chavunduka, 2001) and globalisation (Mbereko & Mahlatini, 2014). These findings have a bearing on social work practice with indigenous communities in Africa. Social workers should understand the meaning attached to religion and religious practices and beliefs in some African communities. It can be seen that failure to perform certain rituals is believed to cause certain illnesses. Social workers working with members of ATR should encourage them to follow their religion diligently. Social workers should not impose their religious beliefs on clients despite the backwardness associated with a client's beliefs. Social workers should also seek to understand some of the beliefs in ATR so that they may be in a better position to discuss religious issues with their clients.

7.4.2 Traditional Methods of Managing Chronic Illnesses in Chiweshe Community

A number of techniques were reported to be used in managing chronic illnesses. Most of the healing and management was done by traditional medical practitioners. Participants reported that they use herbs such as roots to cure illnesses. Some traditional medical practitioners reported that they use incisions (*nyora*) to cure some diseases. Another healing method identified was exorcism (*kupumha*). This method was

used where the healer felt that the illness was caused by evil spirits. Another traditional healing method reported was the use of healing charms (*ndumwa*). These are medicinal strings (charms) that are tied on the sick person, usually, around the neck or waist. It was also reported that sometimes a ritual could help in cases of illness especially where it is suspected that an illness is caused by unhappy ancestors. During the ritual, some elderly members of the family can make a petition (*kupopota*) to the ancestors to take away the illness. During such a ritual, the elderly members of the family may also apologise to the ancestors for anything wrong that might have angered them.

Another technique reported was casting away (*kurasira*). Under this technique, the evil spirit suspected of causing the illness is detached from the sick person and placed on an animal or bird. The animal is directed to the wilderness to die there. Divining bones were also identified as a key healing method.

Members of ATR have their spirit inspired methods of managing chronic conditions and they applaud their efficacy. Some of the methods like *kurasira* may seem trivial to people who do not subscribe to ATR. Social workers should therefore guard against demeaning such methods. They should respect whatever the beliefs of the clients are. Most of the healing practices seem mythical to a western trained social worker but despite that, they ought to be valued.

7.4.3 Influence of African Spirituality on the Resilience of People with Chronic Illnesses

A number of factors in African spirituality and Shona traditional religion were found to promote resilience in chronic illness. The fact that the ancestors were always watching over the living and could be communicated with at any time gave people with chronic

illness some strength. The Shona people of Chiweshe believed that their ancestors are always with them. This was reported to be the source of strength during adverse circumstances of life. There are certain rituals that were reported to give participants resilience. The process of *kurova guva* (bringing back ceremony) was reported to give people strength during shocking incidences of life. This process was reported by a number of participants to have positive attributes for the Shona people. When the spirit is brought home, it was believed to protect the family. It was reported that most people in Chiweshe communal lands are of the *vahera* totem and their territorial spirits used to dwell in some sacred hills such as Nyota, Ndire and Bare. It was also reported that that people of Chiweshe sometimes observe certain rituals as a community if problems affected a number of people in that community. Another element cited by participants was the ability of traditional medical practitioners to supernaturally explain other life circumstances of people seeking their services. Some traditional Shona beliefs were found to be a source of resilience even in the event of death. The belief that a person becomes an ancestor upon his death gave people the boldness to face some illness, even death itself.

It was found that to a greater extent, some beliefs and practices in African traditional religion promote resilience during life's adverse moments. Social workers should take such beliefs and practices as assets to use when dealing with their clients. Social workers should also respect some social safety nets that hinges on the African traditional way of life. The resilience strengthening practices and beliefs may also be used in other social work areas like poverty alleviation, community development etc.

7.4.4 African Traditional Beliefs, Community Perceptions and the Care of People with Chronic Illnesses.

There are a number of attributes of African traditional religion that were reported to be helpful to the welfare of ill persons. In times of need, care was found to be provided by family members, friends, spouses, other community members and home-based care workers. Among the Shona people, if someone wrongs her mother and that mother dies without forgiving him or her, the person will be affected by a type of an avenging spirit called *botso*, this belief forces people to take care of their sick relatives. The philosophy of *ubuntu* was reported to be influencing the whole community when it comes to caring for the sick. The concept of *ubuntu* has caring and loving as some of its values. For Shona people in Chiweshe communal lands, people should help the needy, including the sick in their vicinity for them to be considered as having *unhu*.

Certain traditional beliefs were also reported to influence the care for the sick in Chiweshe. A classic example given was the belief in certain taboos. Sick people without close relatives to take care of them, would get assistance from the community because the community feared that if they die with anger, they would become ghosts or rain will not come down. This was reported to be common with the elderly people without close relatives who would take care of them. It is traditionally understood, among some Shona communities, that each person should have a close friend (*sahwira*). This *sahwira* is important during the burial of an individual. A person is taken down the grave by some *sahwiras*. However, these *sahwiras* were found to play a critical role when one is in need and during illness. They provide care, and they are free to tell the truth concerning the illness.

It was reported that most people in Chiweshe claim to be Christians and they shun ATR. ATR is associated with witchcraft, evil things and possession of familiars. However, there are some churches in the area that are very close to ATR. Most people do not understand traditional medicine as they suspect traditional medical practitioners of witchcraft. It was also found that belief in African traditional religion may lead to conflicts in families especially where there is witchcraft accusation among relatives. It was found that some traditional healers may totally discourage their clients from seeking allopathic medicine. Another challenge noted was diminishing membership to ATR. Few people were reported to participate in ATR rituals as they claimed membership in other religion. However, some participants reported that some Christians took part in certain rituals such as rain-making ceremonies and bringing back ceremony. It was also reported that some medicines and healing practices found in ATR may be dangerous to people's health since they lack clarity on dosage. Some members of ATR were said to delay seeking allopathic medical health services.

Social workers should strengthen traditional caring networks found in African communities. Those beliefs and practices that promote human welfare should be encouraged. Examples are *chisahwira*, totemism, communalism etc. Social workers for example may organise people into totem based groups to address social problems. However there are dangers associated with certain methods and practices found in ATR and social workers should sensitise people on these in diplomatic ways. Of more importance social workers should address the challenges faced by members of ATR in public institutions.

7.5 CONCLUSIONS

The ability to see from several angles is a common weakness of Eurocentric scholarship. Before renaissance, African indigenous systems and other human civilisations were condemned as backward but they are still viable for human existence. This study has demonstrated that African traditional religion is of paramount importance to the lives of its subscribers especially when it comes to issues which have to do with long-term illnesses. It shapes and influences understanding of illness. This study makes the following conclusions:

- Religion and spirituality are important in explaining the etiology of chronic illnesses. Without religion and spirituality, it will be difficult for the Shona people to explain long-term diseases and other adverse life events. Though some members of African traditional religion acknowledge the responsibility of natural causes their general feeling is that the spirit world is responsible for causing illnesses. Among the Shona people, illness is not seen as a purely somatic condition but is rather viewed as a reflection of some spiritual disease on the part of the patient or even another family member. The spiritual explanation of illness confirms earlier studies which show that for the Shona people the arrival of illness is taken to be symptomatic of an aberration at the spiritual level. Thus the common Shona proverb "*Chiripo chariuraya zizi harifi nemhepo*" which literally means there is something that killed an owl, it cannot die of wind. If illness is believed to be free of witches and sorcery, the blame will be shifted to spiritual agents (Masaka & Chingombe, 2009; Motolino, 2011).

- Most of the techniques used in managing chronic illnesses among members of ATR in Chiweshe communal lands are spirit inspired. The spirit world plays an important role in imparting knowledge and vesting healing powers that are used in treating chronic illnesses. During the course of treating a sick person, the healers are guided by their ancestors or other invisible hands. Methods of managing chronic illnesses include among others exorcism, casting away, use of divining bones, performing some rituals and many others.
- There are a number of positive aspects of African spirituality and traditional religion that promote resilience of members during chronic illnesses. These include, among others, a belief that ancestors are always with the living, performance of certain rituals like bringing back ceremony and belief in afterlife. The ability of traditional medical practitioners to get into the spirit realm and identify other issues about their clients, gives them an edge over allopathic medical practitioners. This in itself motivates their clients.
- African traditional belief systems have been found to negatively and positively influence community perceptions about people with chronic illnesses. Fellow members of ATR are likely to have a positive attitude towards their sick members as compared to non-members who may discriminate members of ATR. Beliefs in witchcraft promote conflicts among community members. Members of ATR may also be discriminated at health institutions.
- African religion encourages good care of the sick. During illness, beliefs in taboos, totems and the *ubuntu* philosophy encourage good care of the sick.

Communitarianism and *sahwiras* and the extended family systems strengthen the sick during illnesses as they are critical traditional helping systems.

- The assumed causes of illness, methods of managing chronic illnesses, influence of ATR on the resilience and care of people with chronic illnesses have a strong bearing on social work practice with people of African descent. Social workers should seek to understand the beliefs and value systems of indigenous Africans, their myths, taboos and material culture and social capital should be recognised in social work practice.

7.6 RECOMMENDATIONS

Results of this study are of invaluable importance in shaping social work practice with people of African descent and the Shona people in particular. Social workers working with indigenous people should do proper assessment and ascertain the relevance of the suggestions given herein. These recommendations may be relevant to people of African descent who have now subscribed to other religions. This might be the case because some traditional African religious practices may be difficult to completely put down notwithstanding membership to non-African religions. The following recommendations are proffered:

7.6.1 Social Work Education and Practice

Given the importance of religion and spirituality in the lives of the Shona people, they should be given enough coverage in social work education in Zimbabwe. Shona people are the largest ethnic group in Zimbabwe and all social workers trained in Zimbabwe should have a course or component on religion and spirituality in their curriculum. The

content of social work curriculum should include indigenous and foreign religious belief systems. Social work students should be sensitised about theories which influence the understanding of indigenous religions and spirituality such as Afrocentrism, Resilience theory and the Strengths perspective.

7.6.2 Social work ethics

Spiritually sensitive practice should be made an ethical requirement in Zimbabwe. As the Zimbabwean code of ethics is now, it does not mandate social workers to be spiritually competent otherwise they may impose their religious beliefs on clients.

7.6.3 Strengthening Traditional Social Capital

It was seen from this study that traditional social safety nets based on consanguinity and other relations are still vital among the Shona people. It may, therefore, be of importance for social workers working with rural communities to strengthen these ties. Members of the extended family play a critical role in times of need. Social workers working in the medical field may find it helpful to respect traditional family and community social safety nets. People may, for example, assist their needy community members for various reasons that are related to African traditional religion. Fear of an avenging spirit may, for example, force community members to assist sick members without close relatives fearing that when they die angry, their spirits may bring misfortunes to the community.

7.6.3 African Taboos

Taboos have been found to be of significance in shaping human behaviour among the Shona people. Instead of disregarding these taboos as mythology and superstition,

social workers should study and understand them and make use of what is good from them.

7.6.5 *Ubuntu* Sensitivity in Social Work Practice

The concept of *ubuntu* manifests itself in many facets of African life such as care for the sick, orphans, the elderly and other disadvantaged members of the community. *Ubuntu* values of solidarity, compassion, respect and dignity were found to be of importance in the caring and treatment of the chronically ill in Chiweshe communal lands. If the philosophy is still valued in the lives of many *Bantu* people and the African diaspora, then social workers and other helping professionals should find ways of inculcating this philosophy in their practice.

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APPENDIX 1

INTERVIEW GUIDE FOR PEOPLE WITH CHRONIC ILLNESSES

SECTION A : DEMOGRAPHIC INFORMATION

1. Age
2. Gender
3. Marital status
4. Disease or condition
5. Length of illness
6. Time frame in ATR.

SECTION B : RELIGION SPIRITUALITY AND CHRONIC ILLNESS

7. Why are you a member of ATR and not other religions?
8. What do you think is the cause of your illness?
9. How is the spirit world involved in causing this illness?
10. How does your religion and spiritual beliefs help you in managing this illness?
11. What traditional measures do you take to manage your illness?
12. How does this assist in managing your illness?
13. How do your belief systems motivates you in life generally?
14. How do your beliefs in African Traditional Religion and your spirituality give you strength during the ups and downs of your illness?
15. How does African spirituality help you in the most difficult times of your life?
16. What is the community's attitude towards your illness?
17. How do fellow members of ATR assist you in your times of need?
18. Who cares for you when you can't do it for yourself?

THANK YOU VERY MUCH FOR YOUR TIME.

APPENDIX 1B

MIBVUNZO YEVANHU VANORWARA NEZVIRWERE ZVINOTORA NGUVA REFU CHIKAMU CHEKUTANGA: RUZIVO PAMUSORO PEMUPINDURI

1. Makore okuberekwa
2. Murume kana mukadzi
3. Makawana here kana kuwanikwa?
4. Mhando yeurwere
5. Nguva muurwere
6. Nguva muchitendero chechivanhu

CHIKAMU CHECHIPIRI: ZVECHITENDERO, ZVEMWEYA NEURWERE HUNOTORA NGUVA REFU.

7. Nemhaka yei muchinamata muri muchitendero chechivanhu?
8. Zvii zvamunofunga kuti ndizvo zvakakonzera urwere hwenyu?
9. Ko nyika yezvemweya inokwana papi mukukonzera urwere hwenyu?
10. Ko chitendero chenyu nezvemweya zvinokubatsirai sei muurwere hwenyu?
11. Ndezvipi zvechivanhu zvamunoita kuti mubatsirikane muurwere hwenyu?
12. Izvo zvamunoita izvi zvinokubatsirai sei?
13. Chitendero chenyu chinokubatsirai sei muhupenyu hwenyu hwose?
14. Chitendero chenyu chechivanhu chinokubatsirai sei mukukwira nokudzika kweurwere hwenyu?
15. Zvemweya zvinokubatsirai sei pamunonyanyoomerwa nehupenyu?
16. Ko vanhu vemudunhu menyu vanotora sei urwere hwenyu?
17. Ko vamwewo vanhu vanotenda mune zvechivanhu vanokubatsirai sei pamunenge muchinyanyoda rubatsiro?
18. Ndiani anokubatsirai pamunenge musingagoni kuzviitira moga?

NDATENDA KWAZVO NENGUVA YENYU.

APPENDIX 2

QUESTIONS FOR FAMILY INTERVIEWS

1. Number of family members present.....
2. Nature of sickness of relative.....
3. How is the spirit world involved in the causation of this illness?
4. Given that there is freedom of worship in Zimbabwe, why did you choose ATR?
5. How does African traditional religion and spirituality assist when one is chronically ill?
6. How do your ancestors assist when a family member is ill?
7. What benefits do you derive from ATR as a family?
8. What motivates you to assist your sick relative?
9. What rituals do you perform for the betterment of the health of a sick family member?
10. How have your traditional beliefs assisted you in the past concerning your relative's illness.
11. How do fellow members of your religion assist your ill relative?
12. What is the community's perception on the illness of your relative?
13. Would you encourage any sick community member to join ATR? Give reasons.

APPENDIX 2B

MIBVUNZO YEMHURI

1. Huwandu hwevanhu vemumhuri varipo.....
2. Hurwere hwehama yemhuri
3. Nyika yemweya inokwana sei pakukonzera urwere hwehama yenyu?
4. Nemhaka yei makasarudza kunamata muri muchitendero chechivanhu iko kuine zvitendero zvakawanda muZimbabwe?
5. Chitendero chechivanhu uye zvemweya zvinobatsira sei kana munhu achirwara nechirwere chinotora nguva ndefu?
6. Vadzimu venyu vanokubatsirai sei kana umwe wemhuri yenyu awirwa neurwere?
7. Semhuri rwubatsiroi rwamunowana kubva muchitendero chechivanhu?
8. Zvii zvinokusundai kuti mubatsire hama yenyu?
9. Mapira rudzii amunoita kuti hama inenge yarwara ibatsirikane?
10. Ko chitendero chenyu chakakubatsirai sei mumashure maringe neurwere hwehama yenyu?
11. Ko vamwe vamunonamata navo vanobatsira sei hama yenyu inorwara?
12. Ko vamwe vanhu vemudunhu menyu vanoona sei hurwere hwehama yenyu?
13. Mungakurudzira here umwe munhu anorwara munharaunda menyu kuti apinde muchitendero chechivanhu? Ipai zvikonzero.

APPENDIX 3

FOCUS GROUP QUESTIONS FOR TRADITIONAL CULTURAL LEADERS AND THE ELDERLY

My name is Vincent Mabvurira. I am a PhD student at the University of Limpopo and I am researching on the influence of African traditional religion and spirituality in chronic illnesses. I would like to take this opportunity to thank everyone for coming. We are gathered here as traditional cultural leaders and the elderly people to discuss a number of issues pertaining to African Traditional Religion, African spirituality and chronic illnesses. I am kindly requesting each one of you to introduce him/her.

Focus group questions

1. What comments can you make on African traditional religion as one of the religions followed in your area?
2. What relationship if any do you think exists between ATR and chronic diseases?
3. How do African traditional religion and spirituality help when one is chronically ill?
4. How do fellow members of ATR assist when one is chronically ill?
5. How does ATR motivates chronically ill people?
6. Make a comparison of ATR members and members of other religions in terms of caring for the sick in your area.
7. What do you think are the strengths of ATR and spirituality in the management of chronic illnesses?
8. What as well do you think are the weaknesses of ATR and spirituality in the management of chronic illnesses?

APPENDIX 3B

MIBVUNZO YEBOKA REVATUNGAMIRIRI VECHIVANHU NEVAKWEGURI

Zita rangu ndinonzi Vincent Mabvurira. Ndiri kuita zvidzidzo zvekuva muzvinafundo we social work pachikoro chevakuru cheLimpopo. Ndiri kuita tsvagurudzo maringe nehukama huri pakati pechitendero chechivanhu, zvemweya nezvirwere zvinotora nguva refu. Ndinoda kutora mukana uno kukutendai mose nekuuya kwamaita. Takaungana pano sevabungamiriri vechivanhu uye vakweguri kuti tiite hurukuro pamusoro pechitendero chechivanhu, zvemweya neurwere hunotora nguva refu. Ndinokumbira kuti mumwe nemumwe wenyu azvizivise kuboka rose.

Mibvunzo.

1. Ndekupi kutaura kwamungava nako pamusoro pechitendero chechivanhu sechimwe chezvitendero zviri munharaunda menyu.
2. Ndehupi hukama hwamunofungidzira kuti huripo pamusoro pechitendero chechivanhu neurwere hunotora nguva refu?
3. Chitendero chechivanhu nezvemweya zvinobatsira sei kana munhu aine hurwere hunotora nguva refu?
4. Ko vamwe vanhu vanotenda mune zvechivanhu vanobatsira sei kana umwe wavo arwara neurwere hunotora nguva refu?
5. Ko chitendero chechivanhu chinopa sei simba kuvanhu vane hurwere hunotora nguva refu?
6. Mungaenzanise sei vanhu vanotenda muchivanhu nevanotenda kune zvimwewo zvitendero maringe nekuchengetedza vanhu vanorwara.
7. Zvii zvamunofunga kuti zvakanakira chitendero chechivanhu nezvemweya muurwere hunotora nguva refu?
8. Ndehupi hutera hwechitendero chechivanhu nezvemweya muurwere hunotora nguva refu?

APPENDIX 4

FOCUS GROUP QUESTIONS FOR VILLAGE HEALTH WORKERS AND COMMUNITY HOME-BASED CARE WORKERS

My name is Vincent Mabvurira. I am a PhD student at the University of Limpopo and I am researching on the influence of African Traditional religion and spirituality in chronic illnesses. I would like to take this opportunity to thank everyone for coming. We are gathered here as village health workers to discuss a number of issues on African traditional religion, spirituality and chronic illnesses. I am kindly requesting each one of you to introduce him/her.

Focus group questions

1. What roles do you think religiosity and spirituality play in the management of chronic illnesses?
2. From an African traditional point of view what are the causes of various chronic illnesses?
3. What advantages do chronically ill people who subscribe to ATR realise from their religion?
4. What threats are posed by ATR and African spirituality on the management of chronic diseases?
5. How does African traditional belief system affect community perceptions on chronic illnesses?
6. Can you comment on the care of people with chronic illnesses by people who subscribe to ATR.
7. What are the strengths of chronically ill people who subscribe to ATR?
8. What are the weaknesses of chronically ill people who subscribe to ATR?
9. How does African spirituality affect the lives of chronically ill people in general?

APPENDIX 4B

MIBVUNZO YEBOKA RAVANAMBUYA UTANO NEVABATSIRIRI VEVARWERE

Zita rangu ndinonzi Vincent Mabvurira. Ndiri kuita zvidzidzo zvekuva muzvinafundo we social work pachikoro chevakuru cheLimpopo. Ndiri kuita tsvagurudzo maringe nehukama huri pakati pe chitendero chechivanhu, zvemweya nezvirwere zvinotora nguva refu. Ndinoda kutora mukana uno kukutendai mose nekuuya kwamaita. Takaungana pano savana mbuya utano nevebatsiri vevarwere kuti tiite hurukuro pamusoro pechitendero chechivanhu, zvemweya neurwere hunotora nguva refu. Ndinokumbira kuti mumwe nemumwe wenyu azvizivise kuboka rose.

Mibvunzo

1. Ibasa rei ramunofunga kuti rinoitwa nechitendero uye zvemweya muurwere hunotora nguva refu?
2. Mumaonero edu echivanhu emuAfrica zvii zvinokonzera zvirwere zvinotora nguva refu?
3. Ndezvipi zvakanaka zvinowanikwa nevanhu vanorwara vanotenda muchivanhu?
4. Ndeapi matambudziko angasanganikwa nawo nevanhu vanotenda muchivanhu uye mune zvemweya maringe nezvirwere zvinotora nguva refu.
5. Ko chitendero chechivanhu chinoshandura sei maonero evanhu hurwere hunotora nguva refu?
6. Mungataurewo zvisoma pamusoro pemachengeterwo anoitwa vanhu vane hurwere hunotora nguva refu neavo vanonamata chivanhu.
7. Ndezvipi zvakanakira vanhu vanonamata chivanhu vaine hurwere hunotora nguva refu?
8. Ndehupi hutera hwevanhu vane zvirwere zvinotora nguva refu vachitenda muchivanhu?
9. Zvemweya yechivanhu zvinobata sei upenyu hwose hwevanhu vane zvirwere zvinotora nguva refu?

APPENDIX 5

FOCUS GROUP QUESTIONS FOR TRADITIONAL MEDICAL PRACTITIONERS

My name is Vincent Mabvurira. I am a PhD student at the University of Limpopo and I am researching on the influence of African Traditional religion and spirituality in chronic illnesses. I would like to take this opportunity to thank everyone for coming. We are gathered here as traditional medical practitioners to discuss a number of issues on African traditional religion, spirituality and chronic illnesses. I am kindly requesting each one of you to introduce him / herself.

Focus group questions

1. List chronic diseases that you as traditional practitioners can cure.
2. Describe how you cure people completely from chronic illnesses.
3. What roles do you think African spirituality and religiosity play in the treatment of chronic illnesses?
4. From an African traditional point of view what are the causes of various chronic illnesses?
5. What advantages do chronically ill people who subscribe to ATR realise from their religion?
6. What threats are posed by ATR and African spirituality on the management of chronic diseases?
7. How does African traditional belief system affect community perceptions on chronic illnesses?
8. Can you comment on the care of people with chronic illnesses by people who subscribe to ATR.

APPENDIX 5B

MIBVUNZO YEBOKA REVARAPI VECHIVANHU

Zita rangu ndinonzi Vincent Mabvurira. Ndiri kuita zvidzidzo zvekuva muzvinafundo we social work pachikoro chevakuru cheLimpopo. Ndiri kuita tsvagurudzo maringe nehukama huri pakati pe chitendero chechivanhu, zvemweya nezvirwere zvinotora nguva refu. Ndinoda kutora mukana uno kukutendai mose nekuuya kwamaita. Takaungana pano sevarapi vechivanhu kuti tiite hurukuro pamusoro pechitendero chechivanhu, zvemweya neurwere hunotora nguva refu. Ndinokumbira kuti mumwe nemumwe wenyu azvizivise kuboka rose.

Mibvunzo

1. Ndezvipi zvirwere zvinotora nguva refu zvamunogona kurapa muchivanhu?.
2. Munorapa sei urwre hunotora nguva refu?
3. Ibase rei ramunofungidzira kuti rinoitwa nechitendero chechivanhu uye nezvemweya mukurapa zvirwere zvinotora nguva refu?
4. Mumaonero enyu echivanhu, zvii zvinokonzera zvirwere zvinotora nguva refu?
5. Ndezvipi zvakanakira vanhu vanonamata chivanhu vaine hurwere hunotora nguva refu?
6. Ndehupi hutera hwevanhu vane zvirwere zvinotora nguva refu vachitenda muchivanhu?
7. Ko vamwe vanhu vemudunhu menyu vanoona sei hurwere hwemunhu anobata ari muchitendero chechivanhu?
8. Ndekupi kutaura kwamungava nako pamusoro pemachengeterwo anoitwa vanhu vane hurwere hunotora nguva refu neavo vanotenda muchivanhu.

APPENDIX 6: INFORMED CONSENT FORM

UNIVERSITY OF LIMPOPO
Turfloop Campus
Department of Social Work



Department of Social Work
Private Bag x 1106
Sovenga, 0727
SOUTH AFRICA
Tel: +2715 268 2600
Fax: +2715268 2866
Email: vinmabvurira@gmail.com

Dear Respondent

My name is Vincent Mabvurira from the Department of Social Work in the University of Limpopo (Turfloop Campus). I am carrying out a study on the influence of African traditional religion and spirituality in understanding chronic illnesses in Chiweshe communal lands. As part of the research study, I am expected to collect information from identified participants of this study of which you are one of them. I have chosen you to participate in the study because of your involvement in African traditional religion and or knowledge about the relationship between the religion and chronic illnesses. The information that you provide will be kept confidential and your identity will not be provided to anyone. I further reassure the participants that they will be protected from any kind of harm, be it physical, psychological and/or emotional. The session will take approximately two (2) hours. You are requested to be open and be honest as possible as you can in answering questions. You are also requested to give answers freely and

provide information to the best of your abilities. Confidentiality will be preserved at all cost by the researcher. The researcher will be extremely vigilant in respecting your rights to privacy and self-determination.

You have:

- The right to refuse to be interviewed
- The right to refuse to answer any question
- Not be interviewed during mealtimes

Yours faithfully

VINCENT MABVURIRA

Researcher

Signature of respondent Date

APPENDIX 6B : **MVUMO YENYU KUTI NDITAURE NEMI**
UNIVERSITY YE LIMPOPO

Turfloop Campus
Bazi re Social Work



Bazi re Social Work
Private Bag x 1106
Sovenga, 0727
SOUTH AFRICA
Nhare: +2715268 2600
Fakisi: +2715268 2866
Email: vinmabvurira@gmail.com

Anodiwa mupinduri

Ini ndinonzi Vincent Mabvurira, ndinobva kubazi re reSocial work pachikoro chevakuru che University yeLimpopo (paTurfloop). Ndiri kuita tsvagurudzo pamusoro pe hukama huripo pamusoro pechitendero chechivanhu, zvemweya nezvirwere zvinotora nguva refu. Tsvagurudzo iyi iri kuitwa sechikamu chezvidzidzo zvangu zvekuva muzvinafundo we social work. Ndinotarirwa kuita hurukuro nevanhu kuti ndiwane humboo hwandiri kutsvaga nokuda kwaizvozvo imi masarudzwa kuti muve umwe weavo vandichakurukura navo. Zvatichakurukura zvichachengetedzwa zvekuti vamwe vanhu havakwanisi kuzviwana kana kuziva kuti ndiyani akazvitaure. Ndinokuvimbisaiwo kuti hamuzokuvadzwi panyama kana mafungiro. Hurukiro yedu ingangotora maawa maviri. Munokumbirwa kuti musununguke uye muvimbike zvikuru kwavo pakupindura mibvunzo yose. Ini ndichaona zvikuru kwazvo kuti zvamunotaura pano hazvizishambadzwi, uye kuda kwenyu ndiko kuchaitwa.

Mune mvumo :

- Yekuramba kutaura neni
- Yekuramba kupindura imwe mibvunzo
- Yekusabvunzwa panguva yekudya.

Wenyu

VINCENT MABVURIRA

Mutsvagi weruzivo

Siginecha yemubvunzwimusi wa.....