

**CHANGE AND CONTINUITY: PERCEPTIONS
ABOUT CHILDHOOD DISEASES AMONG THE
TUMBUKA OF NORTHERN MALAWI**

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By

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DECLARATION

I hereby certify that this thesis is my own work and has not been submitted for a degree at any other University.

Alister Chaundumuka Munthali

TABLE OF CONTENTS

ABSTRACT	IX
ACKNOWLEDGEMENT	XIII
DEDICATION	XV
ABBREVIATIONS USED IN THIS THESIS	XVI
CHAPTER 1: INTRODUCTION TO THE STUDY	1
INTRODUCTION: THE DELIVERY OF HEALTH SERVICES IN MALAWI	1
MEASURING PROGRESS: IMPROVING SOME BASIC HEALTH STATISTICS	6
THE STUDY AND ITS OBJECTIVES	8
CHAPTER 2: RESEARCH METHODOLOGY	13
INTRODUCTION: LOCATION OF THE RESEARCH SITE AND LOCAL LEADERSHIP	13
GETTING PERMISSION FOR THE STUDY	17
QUANTITATIVE DATA COLLECTION METHODS	19
<i>Administration of a household questionnaire and the problems involved</i>	19
QUALITATIVE RESEARCH METHODS	22
<i>Key-informant interviews</i>	22
<i>In-depth interviews with mothers with children under five and with old men and women (see Appendix 2)</i>	26
<i>Participant-Observation</i>	27
<i>The use of available literature</i>	29
CONCLUDING REMARKS	30
CHAPTER 3: THE DEVELOPMENT OF DOING “ANTHROPOLOGY AT HOME”	32
INTRODUCTION	32
THE DEVELOPMENT OF THE ANTHROPOLOGICAL APPROACH AND THE SUBSEQUENT INVENTION OF DOING ANTHROPOLOGY AT HOME	32
THE “ANTHROPOLOGY AT HOME” DEBATE	34
DOING “ANTHROPOLOGY AT HOME” IN AFRICA	38
SOME PERSONAL EXPERIENCES OF DOING ANTHROPOLOGY AT HOME	42
<i>A search for accommodation: relationships, connections and the role of the Research Assistant</i>	43
<i>Employment of a female research assistant: a confirmation that I was after women?</i>	44
<i>Poor relations with my relatives as a reason for not staying in my home village</i>	44
<i>Asking silly questions?</i>	45
<i>A member of the Criminal Investigation Department (CID)?</i>	48
<i>A physician?</i>	50
<i>Language as an asset and a way of enriching your vocabulary</i>	51
GOING HOME TO DO RESEARCH ON CHILDREN: A BACKGROUND	53

SOME CONCLUDING REMARKS	57
CHAPTER 4: CONTEXTUALISING THE FIELD: KNOWING MORE ABOUT CHISINDE AND THE TUMBUKA	60
INTRODUCTION: A BRIEF HISTORY THE TUMBUKA PEOPLE	60
LOCAL LEADERSHIP	64
SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF THE STUDY AREA: A GENERAL OVERVIEW	66
<i>Housing, water and sanitation</i>	68
<i>Levels of educational attainment</i>	71
<i>Home visits for those who stay away</i>	73
<i>Occupation/sources of cash income</i>	75
<i>Property Ownership</i>	76
STATE AND OTHER INSTITUTIONS IN CHISINDE.....	79
CHILDHOOD DISEASES PREVALENT IN CHISINDE AND SURROUNDING VILLAGES.....	92
<i>Initial actions taken when children were ill</i>	94
CONCLUSION	95
CHAPTER 5: THE AETIOLOGY, PREVENTION AND TREATMENT OF DISEASES IN SUB-SAHARAN AFRICAN SOCIETIES.....	97
INTRODUCTION	97
THE AETIOLOGY OF DISEASE IN AFRICAN SOCIETIES.....	100
<i>Witchcraft and sorcery as causes of illness and misfortune</i>	100
<i>The breaking of societal taboos as a cause of illness</i>	104
<i>Ancestors as a cause of disease and misfortune</i>	105
<i>Natural illnesses and "illnesses caused by God"</i>	108
PREVENTING DISEASES AND MISFORTUNES IN AFRICAN SOCIETIES.....	112
<i>Amulets, incisions and the role of traditional healers</i>	112
<i>The flight of victims and the chasing away of witches</i>	116
<i>Tasting your food to prove your sincerity</i>	117
<i>Membership of African independent churches (AICs)</i>	118
<i>Cultural re-interpretation of pharmaceuticals</i>	120
<i>Biomedical methods of disease control: the case of vaccination in children under five as a disease control measure</i>	121
CONCLUSION	125
CHAPTER 6: UNDERSTANDING HEALTH-SEEKING BEHAVIOUR IN AFRICAN SOCIETIES: A CONCEPTUAL FRAMEWORK	127
INTRODUCTION	127
SOME THERAPEUTIC OPTIONS AVAILABLE IN AFRICAN SOCIETIES	127
<i>Herbalists and diviners</i>	127
<i>The purchase and use of pharmaceuticals from local grocery shops</i>	129
<i>Biomedical health services (health centres and hospitals)</i>	131
FACTORS AFFECTING DECISION-MAKING IN CHOOSING THERAPY IN AFRICAN SOCIETIES.....	134

<i>Theories of causation as guiding principles for the therapy-seeking process...</i>	135
<i>Socio-economic factors influencing choice of therapy</i>	143
<i>Some convenience and efficiency factors influencing choice of therapy</i>	145
<i>The role of world religions and AICs in seeking therapy</i>	146
THE INTERPLAY BETWEEN MICRO- AND MACRO-LEVEL FACTORS IN THERAPEUTIC CHOICES	148
CONCLUSION	154
CHAPTER 7: PREGNANCY-RELATED TABOOS, BIRTH RITUALS AND CHIKHOSO CHAMOTO AMONG UNDER-FIVE CHILDREN	157
INTRODUCTION	157
SEXUAL INTERCOURSE, PREGNANCY AND CHILDREN'S HEALTH	158
SOME RITUALS SURROUNDING CHILDBIRTH: INFERTILITY AND DISPOSAL OF THE UMBILICAL CORD	165
THE TUMBUKA CONCEPTUALISATION OF ABNORMAL BIRTHS: TWINS, BREECH BIRTHS AND <i>MAKHUMBI</i>	170
ENGAGING IN SEXUAL INTERCOURSE AND PUTTING THE HEALTH OF CHILDREN AT RISK: <i>CHIKHOSO CHAMOTO</i> ILLNESS AND STRATEGIES FOR ITS PREVENTION AND TREATMENT	183
PREVENTING <i>CHIKHOSO CHAMOTO</i> IN CHILDREN	186
THE INDIGENOUS CONTAGION THEORY (ICT) AS AN APPROACH TO UNDERSTANDING THE <i>CHIKHOSO CHAMOTO</i> ILLNESS AMONG CHILDREN	190
SEEKING TREATMENT FOR <i>CHIKHOSO CHAMOTO</i> ILLNESS.....	191
IS THERE SANCTIONED EXTRAMARITAL SEXUAL INTERCOURSE IN THE AGE OF HIV/AIDS OR WHEN THE HEALTH OF CHILDREN OR SPOUSES IS AT RISK?.....	193
SOME BIOMEDICAL EXPLANATIONS OF SWELLING AND <i>CHIKHOSO CHAMOTO</i>	200
MANAGING MALNUTRITION – A BIOMEDICAL APPROACH	206
CONCLUSION	209
CHAPTER 8: THE AETIOLOGY, TREATMENT AND PREVENTION OF DIARRHOEA IN CHILDREN UNDER FIVE AMONG THE TUMBUKA ...	211
INTRODUCTION	211
THE AETIOLOGY, TREATMENT AND PREVENTION OF CHILDHOOD DIARRHOEA: A BIOMEDICAL PERSPECTIVE	212
CONTAMINATION OF FOOD OR DRINKING FLUIDS AS A CAUSE OF DIARRHOEA.....	216
SEEKING TREATMENT FOR DIARRHOEA	225
CONCLUSION	231
CHAPTER 9: <i>CHIKOKO</i>, <i>CHITASKA</i> AND <i>THOLA</i> AS MANIFESTATIONS OF MALARIA IN CHILDREN UNDE FIVE	233
INTRODUCTION	233
TUMBUKA TERMINOLOGIES FOR MALARIA.....	236
THE AETIOLOGY AND PREVENTION OF MALARIA	238
SEEKING THERAPY FOR MALARIA	243
SEEKING THERAPY FOR <i>CHIKOKO</i>	256

MANAGING <i>CHITASKA</i>	267
SEEKING THERAPY FOR <i>CHITASKA</i>	269
THE MANAGEMENT OF <i>THOLA</i>	274
SEEKING THERAPY FOR <i>THOLA</i>	276
CONCLUSIONS: LINKING <i>THOLA</i> , <i>CHITASKA</i> , <i>CHIKOKO</i> TO MALARIA: SOME BIOMEDICAL AND SOCIO-ECONOMIC EXPLANATIONS	277
CHAPTER 10: PERCEPTIONS ABOUT CHILDHOOD VACCINATIONS AND VACCINE-PREVENTABLE DISEASES	280
INTRODUCTION	280
A DESCRIPTION OF THE DELIVERY OF VACCINATION SERVICES IN CHISINDE AND SURROUNDING VILLAGES	281
THE EPI SCHEDULES FOR RECEIVING DIFFERENT ANTIGENS AND REASONS WHY CHILDREN CANNOT BE FULLY VACCINATED BY THE AGE OF 12 MONTHS	284
PERCEPTIONS ABOUT VACCINATIONS	289
MANAGING SMALLPOX AMONG THE TUMBUKA	295
<i>Smallpox in a historical perspective</i>	295
<i>Perceptions about smallpox among the Tumbuka</i>	297
MANAGING MEASLES AMONG THE TUMBUKA	301
<i>Introduction: measles as a public health problem</i>	301
<i>Perceptions about aetiology, treatment and prevention of measles among the Tumbuka</i>	302
CONCLUSION	309
CHAPTER 11: SEEKING THERAPY FOR CHILDHOOD AFFLICTIONS CAUSED BY ANCESTRAL SPIRITS AND WITCHCRAFT	313
INTRODUCTION	313
SEEKING THERAPY FOR NATURAL ILLNESSES: CONJUNCTIVITIS AND SIMPLE COUGHS, AND THE (MIS) USE OF ANTIBIOTICS	314
<i>Simple coughs</i>	314
<i>Conjunctivitis</i>	315
ANCESTORS AND CHILDHOOD ILLNESSES AND MISFORTUNES	321
<i>The role of the ancestors in the lives of the Tumbuka and recognising afflictions they cause</i>	321
<i>Seeking therapy for afflictions caused by the ancestors: kinship therapy?</i>	327
WITCHCRAFT	332
CONCLUSION	336
CHAPTER 12: CONCLUSION: CHANGE AND CONTINUITY IN PERCEPTIONS ABOUT CHILDHOOD DISEASES	337
INTRODUCTION	337
CHANGE AND CONTINUITY IN PERCEPTIONS ABOUT THE AETIOLOGY OF DISEASE AND MISFORTUNE	338
CAUSES OF UNDER-FIVE HEALTH CENTRE ATTENDANCE AND UNDER-FIVE MORTALITY	345

REFERENCES	356
APPENDIX 1: HOUSEHOLD QUESTIONNAIRE	395
APPENDIX 2: GUIDELINES WITH KEY INFORMANT INTERVIEWS	403

CHANGE AND CONTINUITY: PERCEPTIONS ABOUT CHILDHOOD DISEASES AMONG THE TUMBUKA OF NORTHERN MALAWI

ABSTRACT

The objectives of this study were to determine what the Tumbuka people of northern Malawi consider to be the most dangerous childhood diseases, to explore their perceptions about the aetiology, prevention and treatment of these diseases, and to determine how such perceptions have changed over the years. The study was done in Chisinde and surrounding villages in western Rumphi District, northern Malawi. Although a household questionnaire was used to collect some quantitative data, the major data collection methods comprised participant observation, in-depth interviews with mothers with children under five and old men and women, and key informant interviews with traditional healers, traditional birth attendants, village headmen, health surveillance assistants and clinical officers.

Informants in this study mentioned *chikhoso chamoto*, diarrhoea, malaria, measles, and conjunctivitis as the most dangerous childhood diseases in the area. Old men and women added that in the past smallpox was also a dangerous disease that affected both children and adults. Apart from measles and smallpox, community-based health workers and those at the local health centre also mentioned the same list of diseases as the most dangerous diseases prevalent among under-five children. Though health workers and informants mentioned the same diseases, the informants' perspectives about the aetiology and prevention of these diseases and the way they sought treatment during childhood illness episodes, in some cases, differed significantly from those of biomedicine. For example, while health workers said that the signs and symptoms presented by a child suffering from "*chikhoso chamoto*" were those of either kwashiorkor or marasmus, both young and elderly informants said that a child could contract this illness through contact with a person who had been involved in sexual intercourse. Biomedically, diarrhoea is caused by the ingestion of pathogenic

agents, which are transmitted through, among other factors, drinking contaminated water and eating contaminated foods. While young men and women subscribed to this biomedical view, at the same time, just like old men and women, they also believed that if a breastfeeding mother has sexual intercourse, sperms will contaminate her breast milk and, once a child feeds on this milk, he or she will develop diarrhoea. They, in addition, associated diarrhoea with the process of teething and other infections, such as malaria and measles. In malaria-endemic areas such as Malawi, the occurrence of convulsions, splenomegaly and anaemia in children under five may be biomedically attributed to malaria. However, most informants in this study perceived these conditions as separate disease entities caused by, among other factors, witchcraft and the infringement of Tumbuka taboos relating to food, sexual intercourse and funerals. Splenomegaly and convulsions were also perceived as hereditary diseases. Such Tumbuka perceptions about the aetiology of childhood diseases also influenced their ideas about prevention and the seeking of therapy during illness episodes.

Apart from measles, other childhood vaccine-preventable diseases (i.e. tetanus, diphtheria, tuberculosis, pertussis and poliomyelitis) were not mentioned, presumably because they are no longer occurring on a significant scale, which is an indication of the success of vaccination programmes. This study reveals that there is no outright rejection of vaccination services in the study area. Some mothers, though, felt pressured to go for vaccination services as they believed that non-vaccinated children were refused biomedical treatment at the local health centres when they fell ill. While young women with children under five mentioned vaccination as a preventative measure against diseases such as measles, they also mentioned other indigenous forms of 'vaccination', which included the adherence to societal taboos, the wearing of amulets, the rubbing of protective medicines into incisions, isolation of children under five (e.g. a newly born child is kept in the house, amongst other things, to protect him or her against people who are ritually considered hot because of sexual intercourse) who are susceptible to disease or those posing a threat to cause disease in

children under five. For example, since diarrhoea is perceived to be caused by, among other things, a child feeding on breast milk contaminated with sperms, informants said that there is a strong need for couples to observe postpartum sexual intercourse. A couple with newly delivered twins is isolated from the village because of the belief that children will swell if they came into contact with them. Local methods of disease prevention seem therefore to depend on what is perceived to be the cause of the illness and the decision to adopt specific preventive measures depends on, among other factors, the diagnosis of the cause and of who is vulnerable.

The therapy-seeking process is a hierarchical movement within and between aetiologies; at the same time, it is not a random process, but an ordered process of choices in response to negative feedback, and subject to a number of factors, such as the aetiology of the disease, distance, social costs, cost of the therapeutic intervention, availability of medicines, etc. The movement between systems (i.e. from traditional medicine to biomedicine and vice-versa) during illness episodes depends on a number of factors, including previous experiences of significant others (i.e. those close to the patient), perceptions about the chances of getting healed, the decisions of the therapy management group, etc. For example, febrile illness in children under five may be treated using herbs or antipyretics bought from the local grocery shops. When the situation worsens (e.g. accompanied by convulsions), a herbalist will be consulted or the child may be taken to the local health centre. The local health centre refers such cases to the district hospital for treatment. Because of the rapidity with which the condition worsens, informants said that sometimes such children are believed to be bewitched, hence while biomedical treatment is sought, at the same time diviners are also consulted. The therapeutic strategies people resort to during illness episodes are appropriate rational decisions, based on prevailing circumstances, knowledge, resources and outcomes. Boundaries between the different therapeutic options are not rigid, as people move from one form of therapy to another and from one mode of classification to another.

Lastly, perceptions about childhood diseases have changed over the years. Old men and women mostly attribute childhood illnesses to the infringement of taboos (e.g. on sexual intercourse), witchcraft and other supernatural forces. While young men and women also subscribe to these perceptions, they have at the same time also appropriated the biomedical disease explanatory models. These biomedical models were learnt at school, acquired during health education sessions conducted by health workers in the communities as well as during under-five clinics, and health education programmes conducted on the national radio station. Younger people, more frequently than older people, thus move within and between aetiological models in the manner described above.

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presented at the Association of Southern African Anthropologists conference held in Windhoek, Namibia and has since been published as a chapter in: LeBeau, D.L. and R. Gordon. (eds). (2002). *Challenges for Anthropology in the 'African Renaissance': A Southern African Contribution*: Windhoek: University of Namibia Press.

This work would not have been possible without the people of Chisinde and other villages where I did my research. In this regard, I would like to thank most sincerely Mr. and Mrs B.P. Gondwe who welcomed me into their house and never seemed to mind my presence. To all my respondents, I say thank you for sharing with me the Tumbuka worldview about childhood diseases. During my research in Chisinde and surrounding villages, a lot of people became my friends and these have now become more than friends – they are my ‘relatives’. Professor Michael Whisson, during his farewell speech to the Anthropology Southern Africa conference in September 2002, said that fieldwork is not just be an academic enterprise, but a way of creating long-lasting relationships. During my fieldwork, I have met some of my informants away from my research site and they have always looked forward to my next visit to the area. Vincent Gondwe and Judith Chavula assisted me in the collection of quantitative data. Without them, more time would have been spent on this exercise.

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DEDICATION

This thesis is dedicated to my wife, Kondwani; my son, Muzipasi; my parents, Mickwell Munthali and Tryness Nyaluhanga; my late uncle (FB), Ackim Munthali and my late grandmother (FM), Leya Nyakhonje who supported me at different times of my pursuit for higher education.

ABBREVIATIONS USED IN THIS THESIS

ADMARC	Agricultural Development and Marketing Corporation
AIC	African Independent Churches
AIDS	Acquired Immune Deficiency Syndrome
AMMA	Amsterdam Masters in Medical Anthropology
BCG	<i>Bacilli Calmente Guerin</i> (Vaccine against tuberculosis)
BZDP	Border Zone Development Project
CCAP	Church of Central Africa Presbyterian
CDSS	Community Day Secondary School
CHAM	Christian Health Association in Malawi
CID	Criminal Investigation Department
CMA	Critical Medical Anthropology
CPAR	Canadian Physicians for Aid and Relief
DALE	Disability Adjusted Life Expectancy
DDT	Dichlorodiphenyltrichloroethane
DHS	Demographic and Health Survey
DPT	Diphtheria, Pertussis, Tetanus (vaccine)
DRC	Democratic Republic of the Congo.
DRF(s)	Drug Revolving Fund(s)
EPI	Expanded Programme on Immunisation
GoM	Government of Malawi
GNP	Gross National Product
GTZ	<i>Gesellschaft für Technische Zusammenarbeit</i> (Germany Technical Cooperation Assistance)
GVH	Group Village Headman
HEPB	Hepatitis B
HIB	Human Immuno Bacteria
HIV	Human Immuno-Virus
HMISU	Health Management Information Services Unit

HSA(s)	Health Surveillance Assistant(s)
ICT	Indigenous Contagion Theory
ITN(s)	Insecticide Treated Net(s)
MCH	Maternal and Child Health
MK	Malawi Kwacha (Malawi currency)
MoH&P	Ministry of Health and Population
MRFC	Malawi Rural Finance Company
MSCE	Malawi School Certificate of Education
NDDF	Northern Division Dark Fired (tobacco)
NIDs	National Immunisation Days
NGO(s)	Non-Governmental Organisation(s)
NRU	Nutrition Rehabilitation Unit
NSO	National Statistical Office
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
PHC	Primary Health Care
PHN	Population, Health and Nutrition
PTA	Parents and Teachers Association
PGVH	principal Group Village Headman
RA	Research Assistant
RCC	Roman Catholic Church
SADC	Southern Africa Development Community
SCF (USA)	Save the Children Federation (United States of America)
SGVH	Senior Group Village Headman
SP	Sulphadoxine-pyrimethamine
STA	Sub-Traditional Authority
STDs	Sexually Transmitted Diseases
TBA(s)	Traditional Birth Attendant
TTV	Tetanus Toxoid Vaccine
UNICEF	United Nations Children's Fund

US\$	United States Dollar
USAID	United States Agency for International Development
VFC	Village Forestry Committee
VH	Village Headman
WHO	World Health Organisation
ZCC	Zion Christian Church

CHAPTER 1

INTRODUCTION TO THE STUDY

Introduction: the delivery of health services in Malawi

Malawi, which shares a boundary with Mozambique in the east, south and southeast; Zambia in the west and Tanzania in the north, was a British Colony from 1891 until it became independent in 1964 (see Figure 1.1). During these years, the missionaries and the colonial government established some health facilities that offered both curative as well as preventive health services. In the early days of the colonial period, the bulk of medical treatment by government was given to the new European inhabitants and very few curative services were provided to Africans (Vaughan, 1991:36). In those early days, public health was mainly restricted to the containment of epidemics; and campaigns were instituted to curb outbreaks of diseases like smallpox, meningitis, sleeping sickness and plague. The missionaries provided more health care services to Africans than the colonial state. It was only after the 1930s and in many places not until the 1960s that "secular medicine reached rural areas in any form other than the great campaigns" (Vaughan, 1991:56) aimed at controlling or preventing epidemics.

With the dawn of independence in 1964, the new Government of Malawi, under the late Dr Kamuzu Banda, took over the administration of the colonial health facilities and services. At that time, in addition to the provision of curative health services, government also accorded priority to the countrywide construction of new health facilities and the overall development and training of human resources to manage the facilities and services of the Ministry of Health. These priorities, as detailed in the first National Health Plan of 1965-1969, were inadequate to bring about the desired long-term improvement in the health of Malawians. This partly explains why the second National Health Plan of 1973-1988, among other things, prioritised the control

of communicable diseases and the creation of a training school for paramedics (Ministry of Health and Population, 1995:12). One way of achieving the control of the major communicable

Figure 1.1 Map of Malawi showing neighbouring countries



(Source: http://icdp.gfz-potsdam.de/html/project/project_images/malawi_karte.html)

diseases was to increase the vaccination coverage for childhood vaccine-preventable diseases. This initiative was clearly spelt out in the MINI Health Plan developed soon after the approval of the second National Health Plan in 1973 (see Mvula and Munthali, 1997). The World Health Organisation established the Expanded Programme on Immunisation (EPI) in 1974, but, in Malawi, the programme was only officially launched in 1979. Though the vaccination coverage was generally low in the early years of the EPI, as of now, Malawi is one of the African countries boasting high coverage rates, ranging from 74 percent for the oral polio vaccine (OPV) to over 83 percent for the other antigens (see UNICEF, 2002).

Malawi's health policy aims at raising the health standard of all Malawians through a sound health care delivery system (Ministry of Health and Population, 1995:11,18). Health care services are structured into six levels, namely health posts, health centres, rural hospitals, district hospitals, central hospitals and specialised hospitals (e.g. leprosy and mental hospitals). The Ministry of Health and Population is by far the largest provider of health services, followed by the Christian Health Association of Malawi (CHAM). CHAM is comprised of health centres and hospitals run by Christian churches. Local authorities, large companies and private clinics also provide some health care services. Of the 503 health facilities available in Malawi in 1999, 40 percent were operated by the Ministry of Health and Population, 16 percent by CHAM and the rest by local authorities, NGOs and private practitioners (Ministry of Health and Population, 1999a:35). Unlike CHAM, which charges user fees for its services, the bulk of health services provided by the government are free of charge. It is only those admitted to "paying wards" in selected government health facilities who pay user fees. A recent study shows that, with regard to utilisation of available therapies, most respondents first sought therapy or assistance from a drug vendor or shop whenever a member of the household fell ill. If this did not succeed they sought therapy from health centres or clinics, CHAM facilities, traditional healers and private clinics, respectively (Chilowa et al, 2001). Some studies have found that the major reasons for using paying services were the availability of drugs and proximity to the

community (Franco et al, 1995 quoted in Tsoka et al, 1997:13).

According to the Ministry of Health and Population, some of the leading causes of under-five outpatient attendance in 1993 were malaria, upper respiratory infections, diarrhoeal diseases, eye diseases and malnutrition (Government of Malawi, 1996). A number of programmes have been established aimed specifically at addressing some of these under-five childhood diseases. For example, over the past five years the United Nations Children's Fund implemented an insecticide treated bed nets (ITNs) programme in five districts namely Mzimba and Nkhata Bay in northern Malawi, Kasungu in the central region, and Mwanza and Mangochi in the southern region (see Figure 1.2). Malawi is a malaria endemic country and pregnant mothers and under-five year old children are the ones who are most vulnerable to this disease. Malaria accounts for more than one third of all hospital visits among children under five and about 40 percent of deaths in children aged less than 2 years old. It is the leading cause of morbidity and mortality in children under five (National Statistical Office, 2001:185). Therefore, the main objective of the UNICEF's ITN programme is to reduce the burden of malaria in pregnant mothers and under-five children through the use of ITNs. An ethnographic study, conducted in the five districts where UNICEF was working, revealed that there are some socio-economic and cultural factors that have affected the implementation of the ITN programme (see Matinga and Munthali, 2001). This, as development sociologist Pieter Streefland and anthropologist Benjamin Paul argue, points to the need to understand the socio-cultural context during the process of implementing public health programmes (Streefland, 1995; Paul, 1995) such as UNICEF's ITN programme, in order to ensure their success.

The Ministry of Health and Population recognises the poor health status of Malawians and attributes this, among other factors, to high levels of poverty, illiteracy, drug shortages in health facilities, inadequate budgetary allocation and poor staffing levels in the Ministry of Health and Population (Ministry of Health and Population, 1995:17-19). The Alma Ata conference, held in the former Soviet Union in 1978,

came up with the primary health care (PHC) concept for addressing the poor and inadequate distribution of health services and the deplorable state of people's health especially in the developing world. The PHC principle is founded on community participation, equity, appropriate technology and inter-sectoral action (see Hardon et al, 1994:39). In 1979, Malawi adopted the primary health care (PHC) approach as a strategy for delivering health care services in the country. The PHC approach started with three pilot districts of Mwanza, Mzimba and Dowa and, by 1989, the whole country was covered (Ministry of Health and Population, 1995:23). Among other initiatives, the PHC approach encourages the participation of communities in the delivery of health services; success depends on the Ministry of Health and Population staff being "aware of and paying due respect to socio-cultural processes in planning and working with the community" (Hardon et al, 1994:39). In Malawi, the PHC approach focuses on three main areas: maternal and child health, water and sanitation and the promotion of the early treatment of common disease conditions (Ministry of Health and Population, 1999b:6). The establishment in Malawi's Ministry of Health and Population of the posts for Health Surveillance Assistants (HSAs), health workers who are resident in the communities (and therefore in constant touch with the members of the communities that they serve) and the formation of village health committees (which work very closely with the HSAs) have contributed to the involvement of communities in making decisions about their health. These HSAs are the people who, in most cases, are responsible for, among other tasks, the delivery of community-based health services which include immunisations, growth monitoring, family planning and contraceptive distribution, malaria prevention and village inspections (for detail on the responsibilities of HSAs, see Kadzandira and Chilowa, 2001; Chilowa and Munthali, 1999:21).

The PHC approach includes the element of treatment of minor ailments and the supply or provision of essential drugs. While the HSAs provide treatment for minor ailments as part of the PHC process, Drug Revolving Funds (DRFs) were introduced in Malawi in 1988 to ensure the availability of essential drugs at community level at

prices that the community can afford. The Population, Health and Nutrition (PHN) Project in the Ministry of Health and Population, and NGOs like Save the Children Federation (USA) and World Vision International, have established DRFs throughout Malawi. The village health committees, whose members are chosen by the community itself, manage and run these DRFs. Supervision of the DRFs is done by the HSAs or in the case of those run by the NGOs, NGO staff. The DRFs keep drugs like Aspirin, Panadol, Bactrim, eye ointment, Fansidar and oral rehydration solutions (ORS). Some of the DRFs concentrate on malaria as part of the national malaria control programme (NMCP).

The committees running DRFs are responsible for the selling of drugs for minor ailments and the purchase of more drugs when they run out of stock (see Foster, 1995). Despite the problems encountered by the DRFs, such as poor medicine procurement systems, limited supply of medicines vis-à-vis disease prevalence, lack of supervision and poor record keeping, it was found that communities appreciate the existence of these DRFs as they are convenient, cheap and they reduce workload at health centres and reduce mortality and morbidity (Tsoka et al, 1997). All these health initiatives at the micro-level form an important component of the PHC process and are contributing towards the improvement of the health of Malawians.

Measuring progress: improving some basic health statistics

While Malawi is one of the countries with the worst health indicators in the world, there have, nevertheless, been improvements in some basic health statistics as documented by UNICEF and the Ministry of Health and Population. According to the 1998 Housing and Population Census, the total population of Malawi is 9.9 million with a growth rate of 2.0 percent per annum (National Statistical Office, 2001:2). This makes Malawi one of the most densely populated countries in Sub-Saharan Africa, with a population density of 99 people per square kilometre. In 1987, the population growth rate was 3.2 percent (National Statistical Office, 1992:2) and the drop in the

rate by 1998 is attributed to the return of Mozambican refugees to Mozambique after peace had returned to that country. The total fertility rate has also dropped from 6.7 in 1992 to 6.3 children born per woman in 2000 (National Statistical Office, 1992; National Statistical Office, 2001:39).

While other health indicators have been improving over the years, the life expectancy rate has been on the decrease since the early 1990s. The life expectancy rate in 2000 was estimated at 40 years (UNICEF, 2002), a drop from 48 in 1992 (United Nations in Malawi and Government of Malawi, 1993:159). The figure for the year 2000 is, however, much higher than the “healthy” life expectancy rate calculated by the World Health Organisation in 1999. Before 1999, life expectancy was calculated based on mortality data only; however this method neglects the fact that people do not live all their lives in perfect health, i.e. it does not take into account years which are spent in disability. The “healthy” life expectancy rate, based on DALE (Disability Adjusted Life Expectancy) for Malawi is 29.4 years (World Health Organisation, 2000). When calculating the life expectancy rate, whether disability is taken into account or not, it is still noticeable that life expectancy has been declining. As is the case with other Sub-Saharan countries whose DALE is less than 40 years, the precipitous drop in overall life expectancy in the region is mostly due to the HIV/AIDS pandemic (WHO, 2000) which is mostly claiming the lives of the economically productive age group of 15-49 years. With over two million Africans killed by HIV/AIDS related diseases in 1999, AIDS is now the leading cause of death in Sub-Saharan Africa, far surpassing the traditional deadly diseases of malaria, tuberculosis, pneumonia and diarrhoeal disease (World Health Organisation, 2000).

Unlike the life expectancy rate, infant and under-five mortality rates have been decreasing. Before and during the colonial period, African women fell pregnant at an early age and bore large numbers of children, many of whom died during infancy (Ransford, 1983:20). Working among the Tumbuka in the early 1900s, Donald Fraser, although he did not give any figures, observed that “when one examines the history of

families, the infant mortality is found to be very great". Fraser attributed the high infant mortality rate to "the lack of knowledge of the simplest laws of hygiene, and of care of children" (Fraser, 1922:140). While the infant mortality rate was at 205 deaths per 1000 live births in 1960, by the year 2000 this figure was down to 117. The under-five mortality rate, which is currently at 188/1000 live births, puts Malawi at number 15 from the bottom in the world, where the bottom refers to the country with the highest mortality rate. In 1960, the under-five mortality rate was at 361 and by 1990, it had dropped to 241 deaths/1000 live births (UNICEF, 2002; National Statistical Office, 2001:98). One of the major reasons for the decrease in the under-five mortality rate is the great increase in vaccination coverage, which has considerably reduced deaths from vaccine-preventable diseases like measles, tuberculosis, tetanus, etc. While the infant and under-five mortality rates are on the decrease, it may not be long before they start increasing again as a result of AIDS. Table 1.1 summarises the basic health indicators for Malawi.

Table 1.1 Basic Health Indicators for Malawi

Population (millions)	9.9
Population density (persons per km ²)	99
Population growth rate (%)	2.0
Total fertility rate (children born per woman)	6.3
Life expectancy (years)	40
Infant mortality rate (per 1000 live births)	117
Under-five mortality rate (per 1000 live births)	188

The study and its objectives

In every culture, there is an inventory of childhood diseases that are considered dangerous, and hence every attempt is made either to prevent them or to seek urgent

therapeutic intervention once they are diagnosed. There are certain diseases which are not seen as any cause for concern or alarm when a child contracts them and therefore, do not call for prompt action. Such diseases include colds, “simple” coughs, certain types of diarrhoeas, etc. During fieldwork, I heard many people referring to some of these diseases, saying things such as: *Kasi chikhoso nacho nimatenda?* (Is a cough also a disease?) Or *Kasi pamoyo pa mino nayo ni matenda?* (Is diarrhoea due to teething also a disease?). What is implied in these statements is that these diseases do not call for immediate action. However, as we shall see later, their persistence and non-response to simple herbal or pharmaceutical remedies may lead mothers to redefine the nature of the illness.

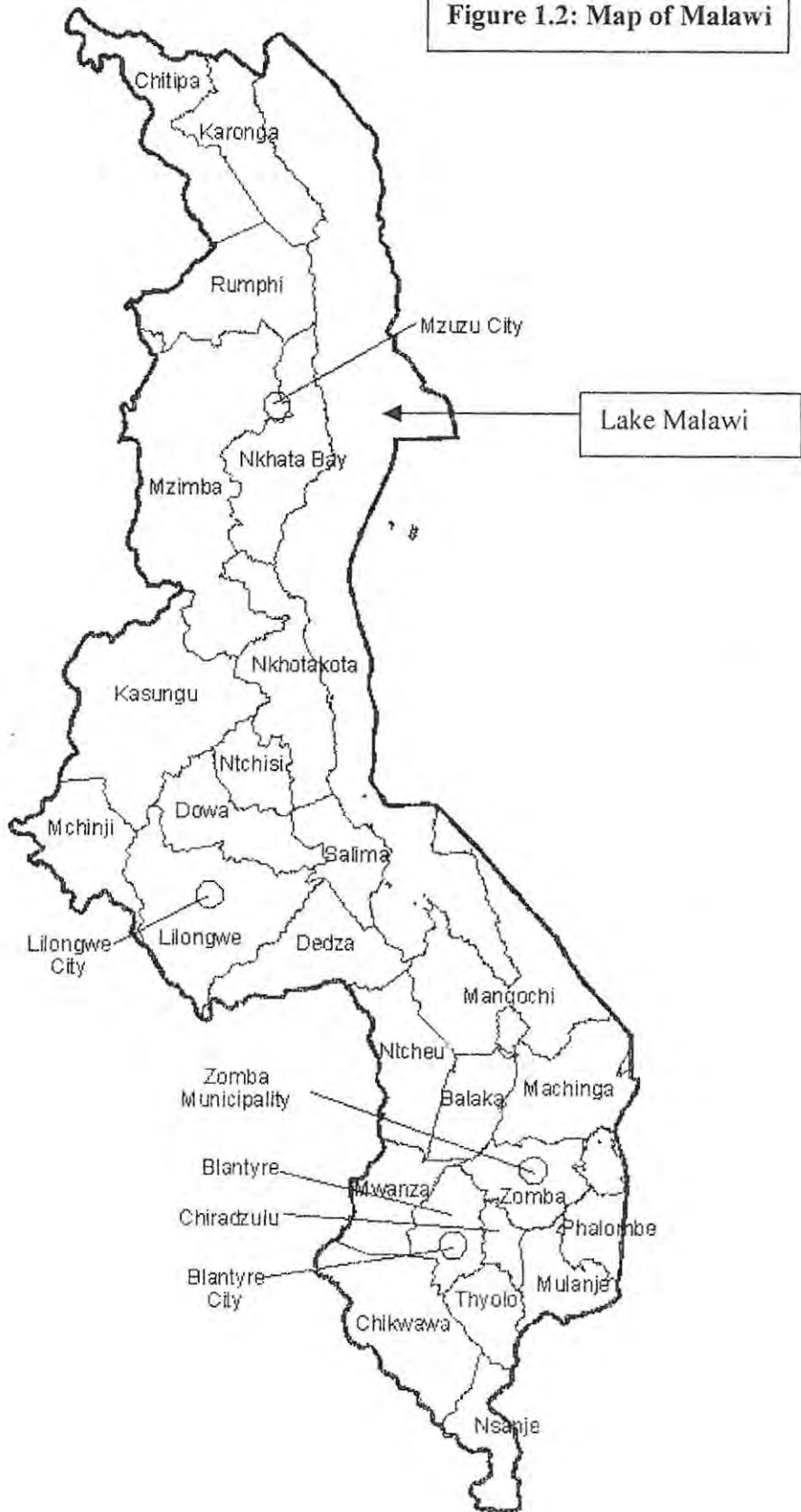
Although this thesis will also discuss such “harmless” types of diseases, the major thrust will be to determine what the Tumbuka people of western Rumphu in northern Malawi consider to be the most dangerous diseases threatening the lives of their children and the reasons why such diseases are so feared. The study will also discuss how the Tumbuka recognise these diseases; their perceptions about aetiology and methods of prevention; and hierarchies or patterns of resort to therapeutic interventions during childhood illness episodes. Due to the dynamic nature of culture, it is likely that the emic perceptions about the aetiology, prevention and treatment of childhood diseases have also changed over the years. The study will examine and document such changes and the different factors that have contributed to these changes. As regards seeking therapy, one of Janzen’s major findings in his study among the Bakongo of Zaire was that friends, relatives, neighbours and associates play an important role in determining therapeutic choices for those who are ill; he has referred to these people, collectively, as the “therapy management group” (Janzen, 1978:4). This study will also explore whether the “therapy management group”, as conceptualised by Janzen, plays any role in the diagnosis, treatment and prevention of childhood diseases amongst the Tumbuka and how the passage of time has affected the role, composition and diversity of such a group.

In exploring which childhood diseases are most feared by the Tumbuka, we take cognisance of the arguments put forward by Douglas and Wildavsky, who assert that the risks to which people in society choose to pay attention are not at all individualistic calculations. Choice is based on shared conventions, expectations and accumulated experience (Douglas and Wildavsky, 1983:8). Like Douglas and Wildavsky, Lupton also contextualises the concept of risk, arguing that “the identification of risk takes place in the specific cultural and historical contexts in which we are located” (Lupton, 1999:13). The lay responses to diseases should be understood within a particular cultural context. For their own reasons, different cultures may place emphasis on different diseases. The Lele of Zaire, while experiencing and suffering from many devastating tropical diseases, only emphasised bronchitis, barrenness and being struck by lightning as dangerous (Douglas and Wildavsky, 1983:6). Though biomedicine may place emphasis on other diseases, the Tumbuka (like the Lele) have their own inventory of childhood diseases that they consider dangerous and for which there exist preventative measures and established patterns of resort to treatment. While this “inventory” indeed exists, in some cases it contains some of the same diseases that biomedicine and its practitioners emphasise. It is the illness explanatory models which may differ considerably.

This study is premised on the hypothesis that theories of disease causation (as will be discussed in detail in Chapter 5) influence, not only people’s behaviour in seeking to protect their children against disease, but also the initial order in which various forms of therapeutic interventions are pursued. Though this hypothesis may hold, however, knowledge does not always translate into what may be termed as “rational” actions, whether in the indigenous or biomedical sense. For example, despite the availability and accessibility of vaccination services and mothers’ knowledge about the usefulness of vaccination, mothers may decide not to take their children for vaccinations because, among other reasons, they have lost trust in “expert systems”. This loss of trust may come about because of their experience of side effects after a child has been vaccinated or a child developing a vaccine-preventable disease even after being

vaccinated against the same disease (see Chilowa and Munthali, 1999). This does not only occur in the realm of biomedicine; in ethno-medicine mothers may, for various reasons, not adopt or engage in what is culturally perceived to be preventative action against certain childhood diseases. Hence, this study will explore factors that may restrict or prevent people from practicing preventive health, despite their knowledge about the aetiology of childhood diseases.

Figure 1.2: Map of Malawi



CHAPTER 2

RESEARCH METHODOLOGY

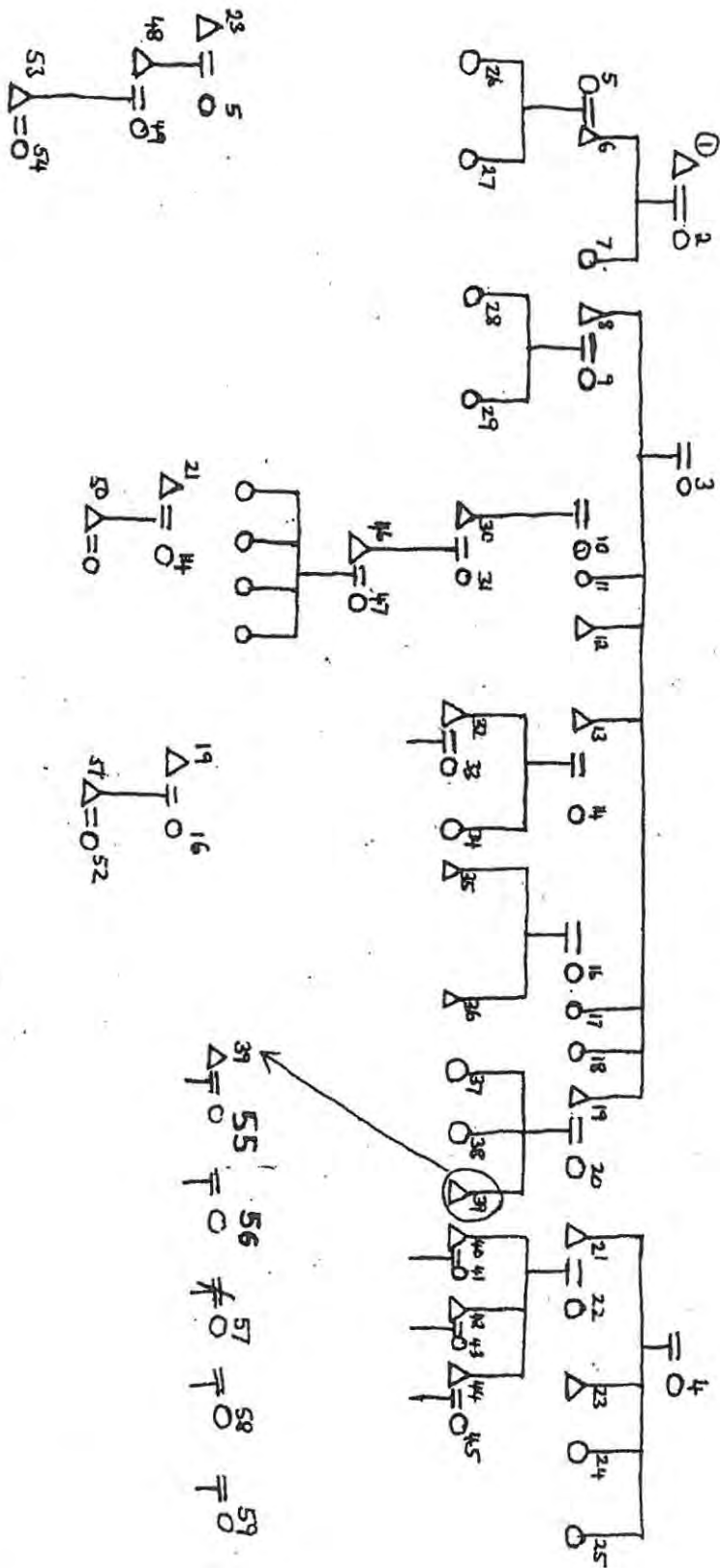
Introduction: location of the research site and local leadership

This study was carried out in three villages, namely Chisinde, Vichimba and Wantulira which fall under Senior Group Village Headman (SGVH) Chisinde in the area of Chief Chikulamayembe. All the area currently covered by the three villages was once under one village headman, Chisinde¹ (see Figure 2.1, map of the study area). Village Headmen Chisinde, Vichimba and Wantulira are all interconnected as they are grandsons of one Chimire Luhanga who lived around 1901 (see Figure 2.2). Chimire Luhanga (1)² had three wives namely Nyakumwenda (2), Nyachaura (3) and Nyagowo (4). Nyachaura had four sons: Yoramu (8), Alick (12), Mateyo (13) and Alufeyo (19). In the history of Chisinde, Mateyo was the first person to be appointed Village Headman Chisinde and this took place in 1938. Though at that time Yoramu was the eldest surviving son of Chimire Luhanga, he refused to be installed as village headman because he was already old and was also in poor health; hence he advised that his younger brother, Mateyo, should be crowned instead. When Mateyo died in 1942 in Johannesburg, South Africa his son Tayileti (32) was too young to assume leadership of the village, so his (Mateyo's) cousin Burton (21), the son of Nyagowo, was chosen to be village headman Chisinde in 1944. Burton died in 1983 after being village headman for 39 years. When he was about to die he chose his cousin, Sanderson Luhanga (39), the son of Alufeyo, to take over the leadership of the village, which he did a few months after the death of Burton.

¹ Among the Tumbuka, the name of the village headman is also the name of the village that he is head of. While Chisinde is the name of the SGVH, it is at the same time the name of the village.

² The numbers in parentheses in this section refer to respective persons in Figure 2.1. The purpose is to show that the three village headmen, namely Chisinde, Vichimba and Wantulira, are related.

FIGURE 2.2. UNDERSTANDING THE RELATIONSHIP BETWEEN CHISIMBE, WANTULIRA AND NCHIMBA VILLAGES



CURRENT VILLAGES HEADMEN

- 32 = VH WANTULIRA
- 39 = SGVH CHISIMBE
- 44 = VH NCHIMBA

1 = CHIMIRE LUHANGA

- 2 = CHIMIRE LUHANGA'S FIRST WIFE, NYAKUMENDA
- 3 = CHIMIRE LUHANGA'S SECOND WIFE, NYACHAUURA
- 4 = CHIMIRE LUHANGA'S THIRD WIFE, NYAGBWO

At almost the same time, the sons of Mateyo Luhanga and Burton Luhanga (the first and second Chisinde respectively) were adults and they started claiming their father's headmanship. There was a lot of in-fighting, and in 1987 a decision was made to split the village into two and the new village (Vichimba) was given to Macford Luhanga (42), the eldest surviving son of Burton Luhanga, the second Chisinde. Macford Luhanga died in 1996, after which his younger brother, Alfred Luhanga (44), took over. Later, Chisinde Village was split further and the new village (Wantulira) was given to Tayileti Luhanga (32), the eldest son of Mateyo Luhanga, the first Chisinde. Whilst a power struggle was the major reason for the split of Chisinde village, the split also worked to the advantage of Village Headman Chisinde, as he rose through the ranks and is now a senior group village headman.

It is apparent therefore that the three village headmen and most of the inhabitants of these villages are related, as they descend from one Chimire Luhanga. Doing research among the Luhangas was also useful because, as we shall see later, they were the most dominant clan when the Balowoka came to settle among the Tumbuka in around 1780, hence it is one of the earliest clans to settle in the area. This research was conducted in the three villages (namely Chisinde, Wantulira and Vichimba) that fall under the area of Senior Group Village Headman Chisinde Luhanga. While the study mostly focussed on these three villages, cases have also been drawn from other villages in the Nkhamanga area (the Tumbuka territory), including my own village (the village where I was born), which is located approximately 16 kilometres east of Chisinde. The reasons for drawing cases from other villages were three-fold. Firstly, while people were narrating their experiences of how they have handled episodes of childhood illnesses or what happened to them when for example, they had twins or breech births, similar cases occurred in other villages close to the time of doing research. Giving birth to twins is a rare occurrence, and while I was doing research a couple in my home village had twins who were two months old at the time, hence this was too good an opportunity to miss. As we shall see in chapter 7, a woman (and her husband) who has delivered twins are considered polluted and dangerous to the health

of people and domesticated animals. The couple, together with the newly born twins, are therefore isolated for a specified period and are only reincorporated into the village after a purification rite. Two couples who had twins during the course of the study were interviewed in order to find out about their recent experiences of being isolated from the rest of the village.

The second reason for interviewing people outside the three villages was that, in some cases, particular types of key informants were not available in the three villages. For example, while herbalists were available in the three villages, no diviner was available. One of the most well known diviners that even people in the Chisinde area have used, is one Nyanundwe, who comes from Kaduku village (about 30 kilometres away from Chisinde), so I had to go to Kaduku to interview her. The Health Surveillance Assistant and Agricultural Field Assistant who are responsible for the area are resident in neighbouring villages, so I had to go to those villages to interview them. Thirdly, since the Tumbuka territory is such a large area, I also interviewed men and women (both young and old) from other villages in order to see if there were any similarities between the issues raised by the men and women in Chisinde and in other villages. This approach helped me to generalise the results as being applicable to the Tumbuka people as a whole.

Getting Permission for the Study

Traditional leaders, namely chiefs (also referred to as Traditional Authorities) and their village headmen, are respected by the community. According to Chief Chikulamayembe, these traditional leaders are the custodians of the Tumbuka culture. They command a lot of authority and this is why, in most cases, they are targets of witchcraft. As far as communities in Malawi are concerned, the most important gatekeeper for studies of this nature is the village headman. Since the research was done in an area belonging to a senior group village headman (SGVH), it was necessary that approval be obtained from him before commencing the study. A

meeting was arranged with SGVH Chisinde during which the objectives of my study were explained to him. He then called his secretary and, in my presence, explained to him my purpose for coming to the area. SGVH Chisinde informed me that if I encountered any problems while doing my work I should let him know. He also advised his secretary to provide any information about the village that I might require. He gave permission to go ahead with the study and in some cases, he was also very helpful in identifying appropriate informants like traditional birth attendants (TBAs), herbalists and *ntchimis* (diviners).

After administering my household questionnaire in Chisinde Village, I moved to Wantulira Village. The village headman for Wantulira does not stay in the village; he stays in Rumphu where he runs businesses, and only visits once in a while. I was advised to contact the chairman of the village committee who acts as village head when the actual village headman is not around. He also told me to go ahead and that I should report to him if I encountered any problems. He added that when the village headman came he would inform him about my research. The village headman's approval was also obtained before doing research in Vichimba village.

Within the first month of my stay in the field, I arranged a visit to Chief Chikulamayembe. The Chisinde area falls under Chief Chikulamayembe, hence it was important for him to know that I was in the area doing research. During the meeting, he encouraged me to go ahead and document the health practices of the Tumbuka people, emphasising that some of the indigenous methods of treatment do indeed work. During our discussion, he mentioned the mystic nature of Tumbuka medicine. He gave an example of a situation where a person has been bitten by a snake and someone a distance away is given some medicine to drink. As soon as he drinks the medicine, the person who has been bitten by the snake starts vomiting and is cured. At the time I visited him I also wanted to make an appointment with him for an interview. As a Tumbuka chief, he is knowledgeable about the history of the Tumbuka people and how they came to settle in the Nkhamanga area.

Informed consent was obtained before interviewing any informant.

Quantitative data collection methods

Administration of a household questionnaire and the problems involved

At the beginning of the study, a census was carried out in two of the three villages comprising the research site, namely Wantulira and Chisinde. The aim of the census was to determine the number of households in the study area. While doing the census, a household questionnaire was also administered to all households in the two villages. By this means, it was determined that there were 83 households in the two villages: 58 in Chisinde Village and 25 in Wantulira.

The household questionnaire (see Appendix 1) was mostly administered to mothers. They were asked to list the names of the members of the household, their sex, age, marital status, occupation, highest level of education attained, whether they could read or write, and if there were any members of the household who did not stay in the village. Those households which had children under five were, among other things, asked whether their children had been sick over the two months preceding the survey, what they had suffered from and the first course of action that they had undertaken to restore the health of the child. The data collected using the household questionnaire assisted in identifying possible informants and I did not need to ask for assistance, for example, to find an old woman or indeed a mother with an under-five child who had suffered from malaria, as their names were all written in the questionnaire. Hence it was easy to follow-up on particular informants. For example, Table 2.1 below shows the household of Mr Sanderson Gondwe. The two children under five belonged to Christina Gondwe; hence she was selected for an in-depth interview, as were her father and mother. Households where there were no children under five were not selected for interviews unless there were old men and women. Old men and women

were interviewed in order to find out what they had considered to be the most dangerous childhood diseases in the past and how they had managed them.

While the household questionnaire was useful in the identification of informants to engage in in-depth interviews, it also provided some other useful data concerning, for example, housing conditions, availability of toilets, sources of water and energy, ownership of property, sources of income, household food security and access to social services like education, market and health centres. In all, 83 household questionnaires were administered.

While the administration of questionnaires is an important way of collecting data, the problem with this approach is that it does not allow for a deeper exploration of issues, and it is a once-off procedure. Hence it is possible for informants to volunteer false information. For example, at the time when household questionnaires were being administered, one household head failed to mention his two sons who were working and staying in Lilongwe. After a few weeks he told me that he was not very clear about the purpose of the research and my stay in the area. He thought that I was a member of the Criminal Investigation Department (CID) and was not sure about what I would do with the information I collected. Had I not stayed in the area for a long period, this information would not have been given.

A brief investigation showed that the demographic characteristics of Vichimba village are not significantly different from those of Wantulira and Chisinde villages. The household questionnaire was therefore not administered in Vichimba, which had approximately 45 households. A decision was therefore made to focus more on observations and in-depth and key informant interviews, which comprised the major qualitative component of the study.

Table 2.1: Demographic Characteristics of members of the household of Mr Sanderson Gondwe³

Personal Identification		Demographic Characteristics					
ID. No.	Q6 Name of Household Members starting with the Head of Household	Q7 Sex	Q8 Age (years)	Q9 Marital Status	Q10 Relationship to Head	Q11 Occupation (if >15 years old)	Q12 Level of Education
1	Sanderson Gondwe	M	70	Married	Head	Farmer	Class B*
2	Tereza Nyakachali	F	64	Married	Wife	Farmer	None
3	Albert Mkandawire	M	3	Single	Grandson	N/A	Under school age
4	Assa Mkandawire	M	8	Single	Grandson	School Pupil	Standard 1*
5	Douglas Mkandawire	M	5	Single	Grandson	School Pupil	Standard 1
6	Nicholas Gondwe	M	12	Single	Grandson	School Pupil	Standard 5
7	Chandulo Mkandawire	M	7/12	Single	Grandson	N/A	Under school age
8	Christina Gondwe	F	32	Divorced	Daughter	Farmer	Form 2*
9	Abraham Gondwe	M	25	Single	Son	Farmer	Standard 8

³ With regard to level of education, in Malawi, a pupil normally spends 8 years in primary school before going to secondary school where he or she spends 4 years before going to the university. The different levels in primary school are divided into standards. Standard 1 is the entry level and one finishes one's primary school education when one reaches Standard 8. When one enters secondary school, one starts in Form 1 and when one reaches Form 4 (equivalent to O-Level) one has finished one's secondary school education. Class B was used during the colonial period and was a grade below Standard 1.

Qualitative research methods

Key-informant interviews

These people were chosen for their supposedly special knowledge, competence and ability to express themselves (de Gabrielle, 1997) in order to gain a deeper understanding of the setting. Because of the nature of this study, key informants included traditional birth attendants, traditional healers (including herbalists and diviners), health surveillance assistants (HSAs), the clinical officers at Mwazisi and Bolero Health Centres, the agricultural field assistant, Chief Chikulamayembe, SGVH Chisinde and other village headmen.

While this study examines childhood diseases, it was important to interview Chief Chikulamayembe because he is the traditional leader of all the Tumbuka people. He has authority over the whole Tumbuka territory. My particular interest was to know the history of the Tumbuka people, the values that the Tumbuka cherish and what distinguishes a Tumbuka person - issues that Chief Chikulamayembe would know about. The SGVH, as a key informant, provided information on the genealogies of his lineage, the presence of health workers in the village, the nearest hospital, school etc. As an old man himself (70 years old) he also provided very useful information on those illnesses that had afflicted children most in the past, what were perceived to be the causes and how these illnesses were managed i.e. treated and prevented.

Another group of key informants who were interviewed were traditional healers. Every adult among the Tumbuka seems to know a traditional cure for at least an ailment or two. For example, most of the women interviewed mentioned *kanufu* as the traditional treatment for *chikoko* (convulsions). This is a well-known "cure". The traditional healers who were interviewed fell mainly into two groups: diviners and herbalists. Herbalists just give out traditional medicines based on what they diagnose to be the problem. They do not divine. Then there are diviners (*ntchimi*) who, apart

from divining and telling people their problems, also give out medicines, depending on the problem divined. These are those whom Friedson calls “the dancing prophets” (Friedson, 1996), essentially diviners, who, once possessed, dance and then divine.

While SGVH Chisinde provided information on the herbalists present in the area, additional information was also obtained from the mothers with children under five. When a mother answered “I go to a traditional healer to the question “when your child suffers from this disease, where do you seek treatment?”, she was then asked “what type of traditional healer (a herbalist or diviner)?” If she said a herbalist, then she/he would be asked the name of the herbalist and where he or she stayed. In this way, five herbalists were identified and interviewed. One of these herbalists was from the neighbouring village of Mulyezi. The people and the SGVH all mentioned that there were no diviners in the area and pointed out that the nearest diviner was at Chitanga on the road to Nyika. One evening, during informal discussions, I learnt that people from the research site and surrounding villages also visited Kaduku where there was a very well known diviner by the name of NyaNundwe. This well-known diviner and three others were visited and interviewed. During the final field trip to Malawi in May 2002, one young diviner had been married and migrated to Lilongwe where her husband was working.

The interviews with these traditional healers were mainly aimed at discovering the common childhood illnesses that mothers brought to their attention, their perceptions about the causes of these diseases and methods of prevention, and how and what they gave for treatment. As was mentioned earlier, there are common indigenous treatments for a range of different illnesses that almost every villager knew. The traditional healers also disclosed treatments that they commonly gave to their clients to me, but they did not tell me the cures for certain other diseases, because they felt that they had to keep them as secrets. If they were to tell everyone, then there would eventually be many traditional healers and they would be out of business. It was necessary to interview these traditional healers because, as Edward Green says:

“... presumably they represent the beliefs of their clients who consult them and they are often better able than their clients to explain such beliefs both because of their specialised knowledge and because of their high status in society.” (Green, 1998:30).

Green further argues that while traditional healers may have a deeper understanding of the causation, modes of prevention and treatment of diseases, their ideas on disease explanatory models do not differ significantly from those of their clients (see Green, 1998:31), a situation that has also been observed among the Tumbuka.

In addition to traditional healers, traditional birth attendants (TBAs), locally known as *wazamba*, were also interviewed. There were three traditional birth attendants (TBAs) in the area, one of whom was a trained and certified TBA. In addition to the three TBAs who were resident in the Chisinde area, one other traditional healer who lived in the Katumbi area was interviewed. This was because she was very famous and people from all over Nkhamanga area (including Chisinde) and the northern part of Mzimba District visited her. On the day I visited this TBA, there was a man from Bwengu in northern Mzimba there who, despite there being a health centre at Bwengu and a government district hospital and a mission hospital at Rumphu, had by-passed all these health facilities, preferring to visit the TBA at Katumbi. Traditional birth attendants play an important role, especially in rural areas of Malawi, where modern health facilities might not be accessible due to distance. During one immunization session it was noted that many women with children under five mentioned that their children had not received BCG and OPV1 (oral polio vaccine, first dose) at birth because the children were born at home. The 2000 Demographic and Health Survey reports that 24.4 percent of deliveries in Malawi are carried out by traditional birth attendants (National Statistical Office, 2001:109). This is a significant percentage, hence the need to appreciate the role of the TBAs. Trained TBAs have weighing scales and they can monitor pregnancy and have been advised to refer complicated

cases to the health centres for delivery. TBAs were asked about different childhood diseases and more specifically they were asked about the beliefs (and taboos) associated with pregnancy and childbirth, especially those that have an effect on the health of the children (those in the womb, as well as after birth). This is mainly because, as we shall see later, the Tumbuka believe that the health and welfare of a child starts at conception, hence the need for pregnant women (and their husbands) to take extra care during pregnancy.

The health surveillance assistants are the community-based health workers and are the lowest rung of the government health service delivery machinery. They are responsible for a number of villages. The HSA who is responsible for Chisinde and surrounding areas is based at Chitanga and reports to the medical assistant at Mwazisi Health Centre. As was mentioned in Chapter 1, HSAs have a series of responsibilities in the communities. Because they are community-based and interact with mothers and children in their day-to-day duties, they are knowledgeable about the most common illnesses that afflict children in their catchment areas. Coincidentally, the HSA responsible for the Chisinde area also came from Chisinde village, but resided at Chitanga because his wife taught at a primary school in that area. Though he was relatively young, his constant interaction with people at home as well as with community members made him aware of the different cultural interpretations of and practices regarding childhood diseases. He provided both the biomedical as well as “Tumbuka” perceptions of childhood diseases with regard to causation, treatment and prevention. As was the case with the traditional healers, he was asked about his own experiences in the community he served, including people’s reactions to vaccinations. The medical assistants at Bolero and Mwazisi Health Centres were particularly helpful, as they examined children whenever mothers brought them to the health centres for treatment. They provided information on the most common childhood illnesses that were brought for their attention at the health centres, biomedical explanations of why such illnesses were common in the area, the recommended course of therapy, and how these diseases could be biomedically prevented.

In-depth interviews with mothers with children under five and with old men and women (see Appendix 2)

While this study aimed to establish the Tumbuka people's perception of childhood illnesses and their ideas about causation, therapy-seeking and prevention of such childhood diseases, it also aimed to determine changes in their perceptions and practices. A discussion of the concept of change and the factors that bring about change calls for a historical re-construction in the almost total absence of written records. In this context, old men and women played a very important role as they remembered the most important diseases that had threatened the lives of children some decades ago, what were perceived to be the causes and their methods of treatment and prevention. Also sought were their views on the way the current generation of mothers manage childhood diseases. In addition to this, old men and women provided information on the perceptions of the changing nature of social organisation among the Tumbuka, for example, marriage and bridewealth, diet and clan organization. While allowing for recall bias, the difficulties in reconstructing the *zero point of culture change* (a term coined by Dr Lucy Mair to designate hypothetical conditions of pre-European equilibrium – see Malinowski, 1945:27) and the fact that change occurs all the time, old people interviewed were able to provide a scenario as it was “then” compared to “now”.

In-depth interviews were also conducted with (young) mothers with children under five. These interviews were aimed at finding out what these mothers considered to be the most important illnesses threatening the lives of their children, what they thought the causes were, their methods of treatment and prevention. For those mothers whose children were sick over the period of two months preceding the interview, the discussion was carried further to include their own personal experiences of how they managed the illness episode.

There were two major methods of identifying informants. As was mentioned earlier, the questionnaire contained all the detailed information on each household in Wantulira and Chisinde villages. Secondly, in Vichimba village, the snowball technique of identifying informants was used. The snowball technique is a method in which you identify one informant and after winning their hearts, you ask them to introduce you to others (Tylor and Bogdan, 1984:24). For example, in Vichimba village I managed to identify one woman with a child under five and after interviewing her, I asked if she could assist me by identifying others who had children under five. In this way, I managed to build up a sizeable cohort of informants. The technique was also used to identify traditional healers, especially herbalists.

Participant-Observation

Participant observation was an important tool for collecting data in this study. Administration of household questionnaires, conducting in-depth interviews and key-informant interviews are, by themselves, not adequate strategies for collecting anthropological data because what people say during such interviews may sometimes differ significantly from what they actually do. It is necessary, therefore, to observe what people do, in addition to interviewing them. In essence, participant observation tends to raise questions that need to be clarified by informants before leaving the field. Hence, it is an important tool for evaluating and cross-checking the data collected using other methods.

Participant observation as a data collection tool involved:

- Visiting traditional healers and observing how they were dispensing medicinal herbs;
- Observing people buying medicines from grocery shops;

- Attending divination ceremonies;
- Attending and participating in funeral and burial ceremonies.
- Participating in rituals aimed at bringing the spirits of the deceased person back to the village; and
- Observing whether children were wearing amulets or not.

A lot of questions arose during these participatory exercises that were subsequently followed up and answered. Some examples may illustrate this situation:

- While shop owners said that they knew the dosage required for the treatment of childhood diseases and other diseases, and that they advised their clients to take the required dosage and sold these medicines in those dosages, hanging around in these shops while sipping a very warm Carlsberg beer revealed that in most cases they do not advise clients on dosage and that they sell according to the amount of money that clients have.
- While members of the Church of Central Africa Presbyterian (CCAP) said that they do not attend divination ceremonies, going to divination ceremonies and asking those present revealed that many members of CCAP, do in fact, attend divination ceremonies.
- When a twin dies, people are not supposed to cry until the other twin comes and starts crying; if this is not done, then the remaining twin will also die. This was confirmed for me at Lunxhwala close to Bolero when a twin died, and people had to wait for the other twin to arrive from Lilongwe before starting to cry. According to informants, if the twin is a child, it is pinched in order to make it start crying.

Without engaging in observation, such data would have been lost.

It is also important to listen very carefully and to be very alert, otherwise one might miss research opportunities in the field. As will be discussed later, language is an important tool that can help one to understand better whatever you are observing. Being a Tumbuka, I could understand what people were saying and then ask for clarification later. Keeping ears and eyes “wide open” is an important requirement during fieldwork; for example, I managed to attend the funeral of Mapopa Chavula because I overheard people talking about it. They said that because of the bad (evil) medicines he had taken while alive, his relatives would not wail at his funeral until they pounded some medicinal herbs put in a mortar. Otherwise, whoever (a relative) wailed before pounding would also die. During the funeral, his relatives were seen pounding in the mortar after which they started crying. While chatting informally at one of the households where local beer was being sold, I also overheard that someone had raped his 10 year-old stepsister and that a case was at that time being heard at the village headman’s house. I managed to attend that hearing because I understood what was being said.

The use of available literature

Ethnographic material on the management of childhood diseases among the Tumbuka is generally lacking. There are, however, some old books which were written by missionaries, most notably by Rev. Cullen Young who arrived at Livingstonia in 1904 and stayed among the Tumbuka for close to forty years before he went back to Britain. Even these books do not contain a lot of relevant material for the present study. Other works on the Tumbuka reviewed included those of Fraser (1922), Vail (1972) and Forster (1989). Though Forster’s book “*Cullen Young: Missionary and Anthropologist*” is relatively recent, he reviewed the works which were published by Rev. Cullen Young. The most recent ethnographic work conducted among the

Tumbuka is that done by Friedson, who was looking at the dancing prophets (diviners) of northern Malawi. It is possible that there might be other ethnographic works on the Tumbuka that I was not aware of during the course of this study. The works of Monica Wilson on the Nyakyusa of southern Tanzania were particularly enlightening as there seem to be a lot of similarities between the Nyakyusa and the Tumbuka. Though Wilson's research was done in the 1930s, her findings are still relevant today in Tumbuka society.

Relevant and other publications of the Government of Malawi have also been reviewed as have been other relevant books on other tribal groups in Malawi. A proper literature survey is presented in Chapter 4 of this thesis and focuses on the aetiology, treatment and prevention of disease in sub-Saharan Africa.

Concluding remarks

This chapter has described the research site and how I gained access to it. It has further discussed the quantitative and qualitative methods of data collection that were used in this study. Participant observation, in-depth interviews and key informant interviews comprised the qualitative component of the study. The household questionnaire was the major data collection tool for the quantitative component and this data was analysed using QUATTRO, a computer software package. Most of the data presented in this thesis was obtained through qualitative research. The sole use of quantitative methods in anthropological studies is discouraged because they do not allow for a deeper exploration of research issues, unlike qualitative studies where researchers or their assistants have the opportunity to "probe" further in order to obtain a better understanding of issues. Each of the data collection methods mentioned above has its own short-falls as well as strengths; however, they can complement each other and, as Hardon et al argue, the use of a mix of different data collection techniques (which is termed triangulation) can yield a high quality of data and reduce chances of bias (Hardon et al, 1994:152). Triangulation is therefore an

important approach, especially within the social sciences where:

“Empirical reality is a reality of competing definitions, attitudes and personal values and research has no option but to recognise this fully and reach beyond the biases that arise from single methodologies” (Ackroyd and Hughes, 1981:137).

Lastly, this study was carried among the Tumbuka people, of whom I am a member. This raises a lot of epistemological issues relating to conducting anthropology at home, which is the subject of the next chapter.

CHAPTER 3

THE DEVELOPMENT OF DOING “ANTHROPOLOGY AT HOME”

“The first means to the proper knowledge of the Savages is to become after a fashion like one of them; and it is by learning their language that we shall become their fellow citizens.” Citizen Joseph-Marie Degerando, a French Philosopher, 1800 AD (Pelto and Pelto, 1973:241).

Introduction

In Chapter 2 we discussed the different research methods that were used during the data collection exercise. The fact that the study was undertaken among the Tumbuka people by me, a member of the Tumbuka, needs to be taken into consideration. In addition, the study took place in a village just 15 kilometres from the village where I was born. This was therefore a case of “doing anthropology at home”. This chapter discusses the development of the anthropological method and the conduct of anthropological research “at home”; the multiple meanings of the concept of “home” and how being away from home during years of schooling and professional work has enabled me to conduct research at “home”. Lastly, some personal experiences of doing anthropological research at home are presented in the context of the wider experiences of other anthropologists who have conducted research in similar surroundings.

The development of the anthropological approach and the subsequent invention of doing anthropology at home

Anthropology, as a theoretically based and systematic study of culture, developed from contact between Europeans and other people whose cultures were radically

different. This contact resulted in a felt need to find an appropriate place for those people in a historical framework and the hypothesised set of stages of the development of human cultures (see Nanda, 1987). In order to do this, evolutionary anthropologists, notably Tylor and Morgan (and later people like Sir James Fraser) obtained ethnographic material from travel accounts to document their perceptions about the development of human culture (Stocking, 1983:72). Though these early anthropologists relied on travellers to give them accounts of the peoples with whom they came into contact with, they were nevertheless also concerned with the quality of data that was brought or sent to them. This is why some guidelines were issued by anthropologists in the early 1870s to guide non-anthropologists in collecting and supplying high quality information for the scientific study of anthropology. Earlier, in the 1840s another anthropologist, James Cowles Prichard, preferred missionaries (rather than naturalists) to collect his data because they stayed in the area for a long time and they learnt the language (Stocking, 1983; Urry, 1984). The attendance, in Britain, of lectures given by Tylor and other anthropologists by people who had careers in colonies (for example missionaries, travellers, administrators etc) led to the production of excellent ethnographic accounts before the development of professional fieldwork (see Stocking, 1983; Evans-Pritchard, 1951).

Evans-Pritchard says that the arrival in the field of anthropology of natural scientists like, among others, Boaz, Haddon, Rivers, Radcliffe-Brown and Malinowski⁴, heralded a new era in the development of anthropology as a discipline. As natural scientists, these people brought with them into anthropology the idea of testing one's hypothesis by one's own observations and not relying on laymen (Evans-Pritchard, 1951). While Boaz, Haddon, Rivers, Seligman and others pioneered the conduct of anthropological fieldwork (see Stocking, 1983; Evans-Pritchard, 1951; Urry, 1984), they spent less time in the field, never learnt the native language and had only superficial dealings with their informants (Evans-Pritchard, 1951:73). These are not

⁴ For example, Boaz was a physicist and geographer while Haddon was a marine zoologist.

favourable conditions for a deeper anthropological enquiry. While Radcliffe-Brown's 1906-1908 study among the Andaman Islanders was an improvement over earlier works by other anthropologists before him in terms of the period of stay and detail, Malinowski is generally considered to be the founder of modern ethnography. He spent the period 1914 to 1918 among the Trobriand Islanders and conducted his fieldwork in the native language (Evans-Pritchard, 1951; Tylor and Bogdan, 1984:3; Urry, 1984). The carrying out of fieldwork and "doing it" in a native language are distinguishing characteristics of anthropology as a discipline that Malinowski has "bequeathed" to his students and others. Conducting fieldwork has become a 2\$!1<1' 3)&85 1 by means of which students of anthropology become professional anthropologists (Razavi, 1992:160; Hayano, 1979).

Since Malinowski, anthropology as a discipline has largely been distinguished by the conduct of fieldwork. While earlier anthropology as a discipline was characterised by anthropologists studying non-western cultures, more and more studies are now also being carried out by western anthropologists in western societies. As early as 1938, Malinowski was one of the anthropologists who encouraged the need to know one's own culture before embarking on a study of a more distant culture (see Malinowski, 1938:vii). "Non-Western" anthropologists, e.g. Kenyatta, began studying their own culture well before "western" anthropologists started their "anthropology at home".

The "anthropology at home" debate

Since the foundation of anthropology as a discipline, the field has been dominated by Western anthropologists. In certain quarters, the development of anthropology has been closely linked with colonialism and the expansion of western influence, with anthropologists providing information on how the West could manipulate and control the non-western world (Lewis, 1973:582) and consolidate the colonial empires (Cole, 1977:352). However Radcliffe-Brown says that:

“A wise anthropologist will not try to tell an [colonial] administrator what he ought to do; it is his special task to provide the scientifically collected and analysed knowledge that the administrator can use if he can” (Radcliffe-Brown, 1950:85).

In the early days of the discipline, Cole suggests that:

“Fieldwork in Europe was not sufficiently traumatic or physically demanding to serve this initiation function” (Cole, 1977:354).

In this context, the field of anthropology has been characterised by fieldwork carried out in far away countries, in cultures which are radically different from that of the anthropologist. And the “civilised” cultures of Europe and North America were therefore not part of the anthropological enterprise.

While the interest in carrying out anthropological studies at home largely started after the Second World War, the actual practice of anthropology at home in Europe and North America really took off in the 1960s (van Ginkel, 1998). Anthropology at home is a call for western anthropologists, who have done the bulk of their anthropological research in exotic cultures, to do research in the west after a century of studying the exotic. The question that anthropologists like Cole (1977) and others have raised is why anthropological research in Europe, for example, became so intense from the 1960s onwards. A number of reasons have been advanced for this “coming home” of anthropology (which some authors have dubbed the partial repatriation of anthropology; see van Ginkel, 1998).

Many countries, which previously served as fieldwork sites for western anthropologists, have put severe restrictions on foreign researchers (Fahim and Hermer, 1980; Messerschmidt, 1981; Mewett, 1989; Jackson, 1987:8), unlike in the past when anthropologists “could carry out research in European colonies with

impunity" (see Cole, 1977:355). Possibly, because of the association of anthropology with colonialism, sometimes anthropologists have been banned by governments or rejected by the intellectuals of the country where they want to do their research (Lewis, 1973; Levi-Strauss, 1966:125). Other anthropologists suggest that the exclusion of outside anthropologists is caused by the fear that they would reveal the new forms of discrimination and the widening gulf between the rulers and the ruled (Brokensha, 1973:592-3). Though it is still possible to gain entry to previous research sites, procedures seem to be tiresome (Mewett, 1989). For example, in post-revolutionary Iran, it is virtually impossible for non-nationals to carry out village level fieldwork, and even local researchers are subject to suspicion, especially if attached to western institutions (Razavi, 1992; see also Goward, 1984). There are also some groups that have chosen not to be studied by western social scientists, preferring to be studied by one of their own (Cassel, 1977a). As regards employment, third world countries prefer the employment of native western-trained anthropologists, who are then encouraged to conduct development-oriented anthropological research (van Ginkel, 1998).

In addition to the above restrictions, political uncertainties and civil wars prevalent in third world countries make it more difficult for western researchers to work in such environments. At a time when countries such as the Democratic Republic of the Congo, the Sudan, Liberia, Sierra Leone, Burundi, Rwanda and other nation states in Africa are riddled by civil wars and political uncertainties, western anthropologists may not want to go and stay for extended periods of time carrying out anthropological research there. Hence, to avoid the bureaucratic processes in third world countries, as well as political uncertainties and civil wars, western anthropologists increasingly decide to do fieldwork in their own countries where there is relative freedom (van Ginkel, 1998) and relative ease of access to one's own society (Jackson, 1987:8). Cole also argues that the transformation of "rural people or isolated tribesmen" into modern citizens makes it more difficult for anthropologists to conduct research in traditional societies (Cole, 1977:355). It was such a modernisation of exotic cultures

and the end of colonialism (and the concomitant association of the profession with colonialism) that constituted some of the premises which led some anthropologists to predict the demise of the field of anthropology in the 1960s (see Lewis, 1973:588). The practice of anthropology at home is, therefore, perceived as a means of revitalising the profession (Messerschmidt, 1981:197-8).

The decrease in funding for anthropological research (Messerschmidt, 1981:196-7; van Ginkel, 1998; Hayano, 1979:99; Jackson 1987:8; Okely, 1987:56), tight academic budgets at universities and other institutions of higher learning (Fahim and Hermer, 1980), the rise in student numbers (van Ginkel, 1998; Jackson, 1987:8), the shortage of jobs in academia (Messerschmidt, 1981; Fahim and Hermer, 1981), the relative ease of access to one's own society (van Ginkel, 1998:251-267), the disappearance of exotic cultures (Hadolt, 1998:314) and the realisation that anthropology is the study of all humankind -and not just exotic peoples (Jackson, 1987) - are some of the factors that have led western anthropologists to start doing research in their own countries.

Other anthropologists, like Messerschmidt, argue that the shortage of jobs in the academic world led to the development of applied anthropology, which in most cases is equated with "doing anthropology at home" (Messerschmidt, 1981; see also van Ginkel, 1998:254). In addition to the scarcity of jobs, "doing anthropology at home" has also been promoted by the fact that western governments and NGOs have also started financing applied and policy research at home into areas such as ethnic minorities, marginal groupings and crime (van Ginkel, 1998; see also Cole, 1977). This change in policy, which made for increased provision of financial resources for doing research at home, also attracted western researchers, which resulted in many western anthropologists staying at home. It was also realised that western anthropologists did not know much about their own culture (Jackson, 1987:8) and when they started doing research in their own "backyards", they discovered that within their own culture they were also able to identify the "other" (see Lofgren,

1987:74; Hadolt, 1987). Anthropologists from western countries (for example, Sweden) that did not have any colonies also conducted their studies in rural areas and marginal communities rather than at the centre of these societies (see Lofgren, 1987:74). The ability to find the exotic and the unfamiliar at home points to the heterogeneity of societies, which can be exploited by anthropologists. There has also been a realisation of the heterogeneity of the concept of home, which may, for example, include the indigenous British as well as immigrants.

For western anthropologists, studying exotic cultures was a way of examining themselves and their society (Diamond, 1964:432), recognising their own peculiarities (van Ginkel, 1998:251; Lewis, 1973) and a voyage of self-discovery mediated through other exotic people (Jackson, 1987:10). The expectation in the 19th century was that the study of contemporary “savage” and “barbaric cultures” could contribute to a better understanding of the early stages of European civilisation (Cole, 1977:352). The factors enumerated above have led western anthropologists to know themselves and their cultures by doing anthropology at home, which as far as the west is concerned, is a relatively new practice. The carrying out of fieldwork at home, especially for the western anthropologist, is a departure from the old tradition that entry into the profession required field experience in another culture, preferably, one quite foreign to one’s own (Messerschmidt, 1981). There are, however, some tricky epistemological issues in doing research at home that will be discussed towards the end of this chapter.

Doing “anthropology at home” in Africa

The study of “primitives” which formed the basis for the development of the field of anthropology was in a way a filling in of gaps of western man’s knowledge about himself (see Lewis, 1973:582; van Ginkel, 1998). This, inevitably, led to the assumption that the study of the non-western world could only be done by a westerner or an outsider (Lewis, 1973). Levi-Strauss argued that allowing natives to study

themselves is *not anthropology*, but *history* or *philology*, because anthropology is the science of culture as seen from outside (1966:126; see also Lewis, 1973; see Diamond, 1964), both geographically as well as epistemologically, and observation of people of one kind by people of another (Hughes, 1974 in Cassel, 1977a:412). In his work, *Ethnographic Atlas*, Murdock states that Europe is not fully represented in his sample because it is the domain of the sociologist and not the anthropologist. As far as Murdock was concerned, anthropologists were not supposed to do fieldwork in Europe: they had to do it elsewhere (Chilungu, 1976). Because of the history of the development of anthropology and its emphasis on the study of the other (where the other means non-western), some African anthropologists, like Chilungu, were at one time advised to major in sociology because anthropology was for outsiders and this meant that, as an African, he could not study Africans (Chilungu, 1976; also see Hayano, 1979:101).

While western anthropologists have been busy doing research in third world countries, anthropologists from the third world countries have all along been doing research in their own countries, and in some cases even in their own cultures. One classic example is that of Jomo Kenyatta, the late former president of Kenya, who was a Kikuyu and did his research among his own people, culminating in the publication of his thesis "*Facing Mount Kenya*" (Kenyatta, 1938). Despite the criticism that Kenyatta received from Leakey at a Malinowski seminar in London in 1935 (Wax, 1976:331-333, Murray-Brown, 1972: 192; Hayano, 1979), Malinowski himself says that:

"Facing Mount Kenya was one of the first competent and instructive contributions to African anthropology by a scholar of pure African origin" (Malinowski, 1938:xii).

Malinowski was one of those who advocated 'anthropology at home', and in a preface to Kenyatta's *Facing Mount Kenya*, he wrote:

“Anthropology begins at home ... we must start by knowing ourselves first, and only then proceed to the more exotic savageries” (Malinowski, 1938:xii).

A year later in 1939, in the preface to Fei’s book *Peasant life in China*, Malinowski wrote:

“If it be true that self-knowledge is the most difficult to gain, then undoubtedly an anthropology of one’s own people is the most arduous, but also the most valuable achievement of a fieldworker” (Malinowski, 1939:xii)

Fei was a Chinese anthropologist who did work among the Chinese. However, even though Malinowski did advocate such types of studies, it was not until the 1960s that western anthropologists seriously started studying western societies.

A number of anthropologists have alluded to differences in emphasis in the training of western and third world anthropologists in western universities. African students in western universities in most cases leave for their respective countries to do fieldwork there, while students from western countries are encouraged to do their fieldwork in cultures other than their own (see Jones, 1970; Fahim, 1977:85). While this is the case, it may also be argued that the choice of the research site can also be the student’s own. For example, while the Medical Anthropology Unit of the University of Amsterdam encourages its international students in the masters in medical anthropology programme to do their research in the Netherlands, students sometimes opt to do research in their home countries. In 1999, I was one of those students, who, for reasons to be explained later, opted to do research at home in Malawi.

Doing anthropology at home in Africa is not a new phenomenon. This has been happening for decades. African anthropologists (as well as other third world anthropologists doing research in their own cultures) have been criticised, mainly

because of “perceived” lack of objectivity in their work. It is claimed that as insiders they cannot critically study their societies (see Hayano, 1979 for Leakey’s criticism of Kenyatta’s work). It was only when Euro-American anthropologists started doing research in their own backyards for reasons stated above that, it was felt that the time was ripe to discuss the problems of doing anthropology at home (Jackson, 1987:10). Following Levi-Strauss earlier arguments, should we say that western anthropologists, by doing anthropology in the west are *not doing anthropology*, but *history* or *philology* (Levi-Strauss, 1966:126)? Or is this only applicable to African and other third world anthropologists? In this context, are western anthropologists being more objective (objectivity being the ideal approach in classical anthropology) than their third world counterparts doing research in their own culture? Sarsby answers these questions succinctly by saying that:

“The fact that [western] anthropologists have sought the unfamiliar at home as well as abroad has meant that many of their problems are the same as those of [non-western] anthropologists doing fieldwork in their societies” (Sarsby, 1984:131).

It can be presumed that this includes the question of objectivity. The irony, however, (as Malinowski puts it) is that, for African anthropologists (unlike their counterparts in the western world) there is the need for them to justify themselves whenever they write about their own society (Malinowski, 1938:xii)

While a lot of African anthropologists have carried out research in their own countries and in their own cultures, what is lacking in their ethnographic works are accounts of their experiences while they were doing fieldwork. In most cases:

“Auto-ethnographers simply go about ethnography as usual in their roles as objective reporters and analyse their data according to their own special interests and theoretical inclinations” (Hayano, 1979:101).

They do not indicate the problems and potential of doing anthropology as native insiders (see also Fahim and Hermer, 1980). This study departs from that norm. It describes and analyses some of the experiences that I went through while doing fieldwork among the Tumbuka of northern Malawi. The sharing of fieldwork experiences also permits comparison and the construction of appropriate generalisations on the conduct of fieldwork "at home".

Some personal experiences of doing anthropology at home

“It is good to talk about fieldwork since one can better understand a text if one knows something about the writer, the experiences upon which the text is based and circumstances of its production” (Crick, 1989:29).

By making a decision to carry out my research at home I was doing what is expected of African anthropologists. The decision to study my own people was arrived at partly because I discovered that I lacked knowledge of my own culture and there is a shortage of ethnographic literature on the Tumbuka of northern Malawi. One of the challenges facing African anthropologists doing research in their own backyards is therefore to detail their fieldwork experiences and in this way to contribute to the debate about doing anthropology at home. In this section I depart from the African tradition of anthropology “at home” by attempting a reflexive approach based on fieldwork experienced among the Tumbuka of northern Malawi. While we spend a lot of time trying to understand the behaviour of our informants, we should also know that our informants also try as much as possible to understand our behaviour. In this section, I seek to contribute to a reflexive anthropology by presenting a few anecdotes which detail how my fellow natives interpreted my stay among them.

A search for accommodation: relationships, connections and the role of the Research Assistant

When I was going into the field in early June 2000, I recruited a graduate research assistant (RA) to assist me in administering the household questionnaire. His home village was very close to where I was going to do my research. The plan was that we were to spend the first night at his home and proceed to the research site the following day to look for accommodation. Chisinde is a very rural area and there are no rest houses and eating houses where one can stay and eat. At Rumphu, we learnt that the RA's uncle was teaching at Bembe Primary School, which is located within the research site. When we arrived at the school the RA's uncle welcomed us into his house. The following day we went to seek permission from the village headman which was granted, as mentioned earlier.

Although I had known the RA for many years, we had never realised that we were so closely related. This knowledge came at an opportune time, because without him I would have taken a long time to establish myself in the field. It also occurred to me that some of the people in the village were distant relatives. These relationships and connections were an advantage for me. There have been a lot of intermarriages among the Tumbuka people of Rumphu, and if someone from the area looks at genealogies, he or she may find that somehow he or she is related to most people. While these relationships were an advantage, at times "relatives" could detain me for a longer period and instead of discussing with them issues concerning my research they could sometimes divert me into discussing issues concerning our families.

Even after my RA left, my hosts assured me that I would be able to stay there as long as I wanted since I was related to them. When I spoke to my mother some time later, she also confirmed the relationship with the RA's uncle.

Employment of a female research assistant: a confirmation that I was after women?

With the assistance of my hosts, I managed to obtain as an assistant a young lady who had just finished her Malawi School Certificate of Education (equivalent to "0" Levels). One day, on returning from work, I was told that she was sick and was sleeping at her relative's house nearby. Her condition was not all that good and I told her to rest and come back to work after she had recovered. When she fell ill, she started complaining to my male research assistant that she had not been sick for some time and wondered why she had fallen sick soon after starting working. Amidst all of this I had no idea what the people in my research site were thinking about the young lady and myself, until one day a young man told me that people were wondering why I was interviewing mostly women. He went on to say that people lived in fear because they thought that I was going to snatch their wives. To my respondents, the employment of the young lady as a research assistant confirmed that I was indeed after women. I assured them that I was in the area for the purpose of research and that I was already married with one son. This was why, in December 2000 when I went back to do more research, my wife and son visited the research area. Though she was in my research site only for 7 hours, my wife's presence assisted in clearing people's misconceptions about my intentions towards the women I interviewed (cf Razavi, 1992: 162). However, though there were these worries among the people, it seemed that this did not affect the way women related to me or the data collection process. Other anthropologists, like Yengoyen, in fact avoided hiring a female assistant or seeking more intimate female companionship for fear of jealousy (see Ardener, 1984:124).

Poor relations with my relatives as a reason for not staying in my home village

During the months of June and July 2000, I visited my home village a few times, during which times I was asked by people (from my own and from neighbouring

villages) why I was staying at Chisinde and not in my own village. I explained to them that I was doing *kafukufuku* (research) in that area, which required me to stay there and not in my home village. No one was satisfied with my explanation. They argued that it was possible for me to stay at home and leave every morning for Chisinde, do my work and then return home in the evening. They suggested that perhaps I did not like staying in my own village and that my relationships with my relatives in my home village were poor. Some people even told me that I did not want to stay in my village because neither my father nor my mother stayed there. My father lived in Blantyre where he was working, while my mother lived in her home village. It was only my aunts and cousins who lived at home. While carrying out research in their own cultures, other native anthropologists have avoided staying away from their home villages because of the fear that they might risk the initiation of potentially damaging rumours about relationships with their parents or relatives (see Nakhleh, 1979:344). My decision to stay away from my village elicited similar reactions and it did not make any sense to the people there. I had similar problems trying to explain my decision to stay in my research site and not in my home village, which was a few kilometres away, to my graduate friends who worked in Lilongwe, the capital city of Malawi. They could not understand why I stayed in my research site and not in my own village.

Asking silly questions?

“The local anthropologist may not be taken seriously by informants if he probes types of behaviour that informants view as commonly shared knowledge, such as marriage customs, or he may be considered intolerably crude in broaching other topics, such as sexual practices. Recognised as a member of the society within which he conducts research, he is subject to the cultural expectation of his informants.” (Fahim and Helmer, 1980:646).

Doing research in one's own home village or culture is also problematic because your informants think that you already know what you are asking. The first research component (namely the administration of the questionnaire) was aimed at determining the socio-economic and demographic characteristics of the villages under study. This component was easy, but the difficult part came when I started asking ethnographic questions. What some people then started to say was that, since I was a Munthali from a village⁵ that was a few kilometres away from my research site, I was expected to know what I was asking them. As far as my informants were concerned, I was asking questions for which I already had the answers. Since I was married and had a child, I was expected to know the rituals surrounding childbirth and other similar events. I explained to them that, since I had spent most of my formative years in town, I did not know "those things". After this, my informants became very open and started telling me whatever I wanted to know.

In my own culture, where I am expected to "know", I have been branded as someone who asks *mafumbo yauchindere* (stupid/silly questions) by a number of people. This was because I was asking questions that they had never expected would come from me. This is one of the challenges that anthropologists have to face when doing anthropology at home. Despite being informed that I was asking silly questions, my questions were answered. The situation would, however, have been different if an "outsider" had raised such questions and as van Ginkel, puts it:

"They are excused for their ... ignorance because they are outsiders" (van Ginkel, 1998:256).

A lot of people practising anthropology at home have experienced this. Another anthropologist, Unni, was branded an illiterate person because, despite being a Nayar,

⁵ See also Nakhleh (1979:346), who did his research among his fellow Israeli Arabs and was asked, "You are the son of Rameh, need I tell you?"

he did not know about Nayar matriliney (Unni, 1979). Branding me as a person who asks silly questions because I was expected to know in a way meant that, like Unni, I was also seen as “illiterate”. This is very interesting, as people use the metaphor of illiteracy to describe an educated person. Another anthropologist who faced a similar situation was Jones, a black American studying his fellow blacks in Denver, USA, who sent his students into a black community to enquire about health practices. One student returned with the information that some women had a craving for a particular type of dirt during pregnancy. Although Jones had grown up in that part of the United States, he was not aware of this fact. Moreover, during his studies, nobody had volunteered this information because it had not occurred to them that he would not already be aware of it since he could readily be identified as both black and southern (Jones, 1970). Nakhleh (1979:346) makes a similar point: some of the information he sought was not easily volunteered on the assumption that as a native he was supposed to know. “Insider” and “outsider” research can therefore complement one another and yield very rich anthropological data.

“He has finally come home because he has been sacked from his place of work”⁶

While people from my village could not understand why I did not stay in my home village, and while some informants felt that I was asking silly questions, my extended stay in my home area was also interpreted differently by other people. Although I had originally planned to stay in my field site, in November 2000 I decided to go and stay in my home village and commute to my research site for four days a week. I then planned to spend the other three days writing field notes and interviewing other informants (in neighbouring villages), as well as doing some observations (attending funerals, rituals, visiting diviners etc). When going to my field site, I used to get lifts

⁶ I work for the Centre for Social Research of the University of Malawi as a Research Fellow. For the past three years, I have been pursuing a PhD programme at Rhodes University in South Africa.

from Bolero trading centre. My niece had a very old bicycle that I also used whenever the need arose. In most cases I walked up to Bolero Trading Centre. When going to funerals or attending ceremonies, I would put on shorts, a t-shirt and a pair of flip-flops; I was not only doing this because I was at home as in town I also wear such attire. (In western societies people wear (black) suits when attending funerals but in the Tumbuka society such an attire is not suitable as members of the community have to assist during the funeral; for example, men dig graves while women cook). On several occasions some people reported to me the discussions others were having concerning me. It appeared that people said that I was deceiving them by saying that I was doing research and that the truth was that I had been sacked from my job and had nowhere to go. For this reason, I had decided to return to my village after an absence of nearly two decades. Such claims arose because of my habit of wearing flip-flops, T-shirts and shorts and using an old bicycle. In the past, the community had been accustomed to seeing me driving a car or being driven in an institutional vehicle. For many people, therefore, my long stay at home and my behaviour suggested that I had lost my job. Others asked where my wife and child were. I thought they were asking in good faith and answered them that both of them were in Blantyre. This was seen as further confirmation that I had indeed been sacked and that my wife had abandoned me.

A member of the Criminal Investigation Department (CID)?

In early December 2000, I went to begin interviewing informants in another village, one of the three villages comprising my research area. On my first day in this village, I sought permission (which was granted) from the village headman, but this coincided with a day when a member of the village was identified as having committed incest. In January 2001, I decided to cycle from my home to my research site, since at the time I did not have sufficient funds for any other form of transport. On the way, I met a man who told me that he had met some people from the third village in my research site who had told him about me and that they were wondering whether I was

not after something else (possibly to find out more about the incest), and were suspicious that I was a member of the CID. He assured them that he knew me very well and that he had stayed with my grandfather in Chililabombwe, Zambia for a very long time. This man did not know me well, but the good relations he had with my grandfather led him to try to clear up the misconceptions that people in my research site had about me. This was not the first time that I was branded as a member of the CID. In my own village, some people were also suspicious about what I was doing in the area and suspected that I was a CID member. They came to this conclusion because of the fact that I was rarely at home, as well as because of the questions I was asking regarding genealogies. When I was asking people in my own village about their genealogies, some were wondering what I was going to do with the data. I told them that I was just interested to know our history. One morning, around 6:30am, I was awoken by one of the members of my village and when I came out of the hut and greeted him, he told me that he was also interested in learning about "our history" and wanted me to tell him what I had learnt from the village headman concerning our genealogies. This was an old man aged about 70 years and I still wonder what his motive was. It was this man who told me that some people in the area thought that I was a member of the CID since I was asking many questions and was never at home (which are seen as identifying of the members of the CID). The person who had told this old man had found me one day interviewing one of the village headmen in the Chisinde area.

Other researchers doing studies in their own countries have also been looked upon as members of intelligence agencies. Thus, Goward reports that Gupta (an Indian researcher) stopped taking notes at public meetings in Uttar Pradesh after suspicions were expressed that she was an intelligence agent (Goward, 1984; see also Razavi, 1992:154). While this role of being a member of the CID or some other intelligence agency was bestowed on me and other anthropologists like Gupta by our informants, it is interesting to note that other anthropologists have felt like tricksters while conducting fieldwork (for example "Bohannan's experience among the Tiv of Nigeria

where she felt like a trickster, as one who seems to be what she is not" (Goward, 1984:107)). Although I made my identity very clear, some people referred to me as a government worker who "has come to know the health problems facing children in our area". These people claimed it was good that the Government had sent a "Tumbuka" person from the area to do the research. Jones's (a black American researcher) informants hinted to him that it was good for black social scientists to do research amongst black people as research done by whites is often inaccurate. According to Jones's black informants, reports written by white researchers tend to be distorted, and hence do not reflect an understanding of the black people (Jones, 1970:251-259); hence a preference for a fellow black researcher.

A physician?

The very nature of my study led some people (especially those I met at NyaNundwe's compound) to think that I was a medical doctor. NyaNundwe, whose divining name Mujovwire means "assist yourselves", is a very well known female diviner who stays at Kaduku in Hewe and is very famous. She has been to most parts of Rumphu and Mzimba Districts and has also visited Zambia many times, "on duty".

When I arrived on that Wednesday morning (7th December 2000), because of the nature of the topic that I brought up, most of the people thought that I was a medical doctor. Word went around the compound⁷ that a medical doctor was on the premises of NyaNundwe. Before I met NyaNundwe, Yilange, a young woman I knew from my home village, passed by and when I greeted her she did not respond. She just looked at me, waved and then went away. I learnt later that she had "eaten a sacrifice", hence she would not talk to anyone unless that person gave her "*mboni*" (*mboni* is in most

⁷ NyaNundwe has a very large compound (it can be called a clinic) where people with serious illness are admitted and in my interviews with some of the patients, I found out that people have been there for periods ranging from one month to 2 years.

cases money - it can also be flour, a piece of cloth or white beads etc - that is paid to someone so that the ancestral spirits which possess him or her should recognise the giver). I then went to see NyaNundwe, and as I was discussing a few issues with her, the mother of Yilange came and told me that she had heard from her daughter that I was around and that she just wanted to greet me. She also told me that people in the compound were spreading the rumour that I was a medical doctor. Although she had tried to dispel the rumour, the local women would not accept it. I informed all the women that I met and interviewed that day that I was not a medical doctor, but just interested in how people seek health care. However, one of the diviners by the name of Cheruzgo insisted that I was not telling them the truth and continued to claim that I was a medical doctor. Cheruzgo told me that next time I visited them I should also bring some medicines for her stomach ulcers. At that time I thought that she was just joking. On my next visit a week later one of the informants I had interviewed the previous week referred to me as "*awa mba dokotala withu awo tikachezganga nawo sabata yamala*" (this is our doctor we chatted with last week). Cheruzgo, together with NyaNundwe, had left for Zambia where they had very urgent business. Before she went to Zambia she told one woman that when I visited again I should leave the medicines for her ulcers with her (friend). Despite the fact that I explained to them that I was not a medical doctor, people would not believe it: they insisted that I was a physician.

Language as an asset and a way of enriching your vocabulary

Sharing a language with informants is an asset because "it facilitates communication, saves time and enables avoiding distortion by interpreters" (van Ginkel, 1998:255). These are some of the advantages of doing research in one's own domestic locality, but as Hastrup argues, "personal credentials and linguistic competence" should not be determinants of whether "an ethnographer works at home or elsewhere" (Hastrup, 1995:152). Perry thought that, being from an English-speaking background and doing research among the English-speaking whites in Australia, he would not have any



language difficulties as was the case when he did his research in Lesotho. This was however not the case because the research he was doing had its own language and he had to learn it over again (Perry, 1989). While I claim that I know the Tumbuka language during the research process I came to realise my own inadequacies in the language. At times I felt like a child learning to speak. Certain phrases and words that were used were strange in the context in which they were used and I had to ask for their meanings. Examples include words such as *loko*⁸ and *kupala moto*⁹. I also learnt new words like *chijulamphinga*¹⁰. My stay at home has enriched my idiomatic vocabulary considerably. My knowledge of the Tumbuka language saved me the problem of learning a language, which in itself is time consuming and not easy in "the absence of an adequate grammar or dictionary" (Goward, 1984:106). Fully understanding and knowing the language enables one to follow discussions and ask questions wherever one needs clarification. This is the major advantage of doing anthropology at home.

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The problems of doing anthropology at home have been raised and discussed by a number of anthropologists. For outsiders, the major problem is to understand and get into the culture or way of life of their subjects, while at the same time having to deal with the issue of language. These are some of the major obstacles to obtaining knowledge. For those doing anthropology at home, the major disadvantage is that

⁸ *Loko* (lock) is an illness in which the patient is not able to eat or swallow anything - even water or porridge. It is believed that witches can lock the oesophagus, preventing food from passing into the stomach. When such a patient eats he or she vomits at the same time.

⁹ *Kupala moto* means getting charcoal embers from someone's fireplace and it is a phrase a man (a go-between) uses when informing the girl's parents of the intention of a certain man to marry their daughter.

¹⁰ *Chijulamphinga* is a sororate.

they are so familiar with the culture that they will take some things for granted. In this context, since I am a Tumbuka studying my fellow Tumbuka people, I am in a way a marginal native in my own culture, as many years of schooling and professional work have alienated me from the culture I thought I knew so well.

*

Going home to do research on children: a background

In 1998-1999, while enrolled for the Amsterdam Masters in Medical Anthropology (AMMA) of the University of Amsterdam, I was interested in determining how illegal immigrants from an African country sought health care in the light of the fact that their illegal status rendered them unable to approach the official health care institutions. Fieldwork was due to start in May 1999, but before that I had already started making contact with illegal immigrants through friends who were also pursuing postgraduate studies at the University of Amsterdam. Before I started developing my research proposal, the birth of my son in January 1999, back home in Malawi, meant that my plans changed. Had I stayed in Amsterdam in order to complete my MA programme, I would not have seen my son until he was 8 months old. It was difficult to wait that long. After discussions with my supervisor, I changed my research topic and decided to conduct research on children in Zomba, southern Malawi. On 7 May 1999, I left the Netherlands for Malawi, where I did my fieldwork.

During the time I was conducting fieldwork for my Masters degree, I learnt of a number of incidents that had taken place after the birth of my son. Some of these were communicated to me while I was in Amsterdam. Our parents (my mother and mother-in-law) wanted our son to wear amulets around his neck and we (I and my wife) did not understand the rationale for doing that. Similarly, when the umbilical cord finally detached itself, a lot of precautions had to be taken in getting rid of it. During the Masters programme, I read that among the Macua of northern Mozambique the

fertility of a woman can be destroyed by “not burying the umbilical cord straight up” (Gerrits, 1997). I therefore wondered whether the reasons for taking precautions when disposing of my son’s umbilical cord were the same as those given by Gerrits. On arrival in Malawi, my wife also informed me that since the birth of our son she had not been allowed to sleep on a bed or in our bedroom: she had been made by our parents to sleep in another bedroom on a mat with our child. The reasons for this were not clear to me. When one day my son suffered from a terrible cough, one of my aunts arrived with an axe and wanted to perform a ritual aimed at curing as well as protecting the child against coughing. Though both my wife and I are Tumbukas, it was difficult for us to understand the relationship between an axe and the child’s cough. (This will be discussed later.) Nobody was able to give me convincing answers to all these questions. These incidents have “estranged me from my own culture, a culture I thought I knew” (see van Ginkel, 1998:258)

Though I am a Tumbuka, my lack of understanding of the Tumbuka culture has been exacerbated by the fact that I have spent very little time in my home village since I left my home to go to boarding school when I was only 16 years old. During the school holidays, I used to visit my father, who at that time was working in Zambia. After secondary school, I went to the University of Malawi in Zomba, southern Malawi, where I spent 6 years doing undergraduate and postgraduate training, after which I started working in Lilongwe in 1991. During this time, a year would pass without my going home or, if I did go home, visits would be very short. The only times I spent more than a day or two at home were when a very close relative passed away and I went to attend the funeral. At such times it was also not easy for unmarried persons to become acquainted with issues surrounding children, childbirth and other related issues.

As an anthropologist, I have also noticed the dearth of ethnographic work done among the Tumbuka of northern Malawi. As pointed out earlier, early missionaries did attempt to document some of the cultural practices of the Tumbuka. This was,

however, before the development of modern anthropology. The most recent ethnographic work among the Tumbuka was done by Friedson (1996) and he studied the “dancing prophets” of northern Malawi. This well-written work reminds me of the period before I went to secondary school, when I used to attend divination ceremonies with my friends. Attendance at these ceremonies was often given as a reason to our unsuspecting parents when, in fact, we wanted to be out of the house at night with our girlfriends.

After discovering that I had very little knowledge of my culture, I thought that I would make up for this by reading some ethnographic material written about the Tumbuka. Such material was, however, very scarce. It is out of these shortcomings and experiences that I embarked on a long journey of re-discovering myself and my identity. I carried out my research in my own culture, amongst my “own people”, and approximately 15 kilometres from my home village. In some instances, I have even drawn some cases from my own village and other surrounding villages.

A number of anthropologists have referred to the fact that native anthropologists studying their own cultures are rarely full insiders. We should also take cognisance of Diamond’s assertion that:

“An Indian or African anthropologist, trained in this western technique, does not behave as an Indian or African when he behaves as an anthropologist” (Diamond, 1980:11).

As in my case, most native researchers stay away from their homes when they are undergoing training and only return after several years to study their own people. This process of “defamiliarisation” with one’s culture allows for a more objective study of one’s own culture. During the time he/she is away, the native anthropologist attains a new status, an occupation, a new residence and a new way of thinking, which, in most cases, is radically different from that of his “fellow natives”. In this context, even if he

goes back to his home, he will view things from a different perspective, and the things which are supposed to be familiar will turn out to be unfamiliar. In my case, the way my fellow natives interpreted my stay at home and the different hardships that I had to endure (for example sleeping on a reed mat for 3 months, sleeping in a leaking house, walking or cycling over long distances, the food I was eating, etc) somehow created a "*homesickness*" in me. Why a homesickness when I was already at "home"? There were moments when I really wanted to return "*home*" to Grahamstown, South Africa, where I had a house and friends. This raises the question of: what is home? In anthropological terms, home is a very relative term: Reis says that it refers to shared experiences and processes of identification and continues by saying that "gender, age and life events are all constituents of at 'homeness' as much as anything else" (Reis, 1998:301).

Being a Tumbuka, my people accepted me as a member of their society: my participation in funeral ceremonies, rituals aimed at bringing the spirits of the deceased home, divination ceremonies, installation of chiefs, etc was never questioned. This is what was expected of me and this was despite the fact that I was asking silly questions. My long absence from home enabled me to look at issues more objectively.

My choice of research topic also brought about the creation of distance between myself and my fellow natives: I was an outsider as regards the world of childhood diseases and how the Tumbuka people perceive and manage these diseases. My interaction with women, traditional healers and biomedical staff at the two health centres in my research site yielded new material everyday (cf van Dongen, 1998). Among the Tumbuka, women are the ones who spend a lot of time with children, and in most cases they are the ones who first notice that the child is sick. Their knowledge about childhood diseases, treatment and prevention is enormous. These women welcomed me into their territory to *teach* me about childhood diseases. When asked about childhood diseases, most men referred me to women, saying that they were the

ones who were more knowledgeable. Since gender is also a constituent of at homeness, in this context I was an outsider, allowing for more distanced research.

Lastly, in this research, I am looking at the changes over time in the management of childhood diseases among the Tumbuka of northern Malawi. In this case I have compared the perceptions of young men and women with those of old men and women. When it comes to examining illnesses that afflicted children 50 years ago and how these were managed, I talked to very old men and women. These old men and women were able to compare what used to happen in the past with what is happening now. By looking at the historical dimension of childhood illness management, and asking old men and women who are knowledgeable, I was in a way also excluding myself from being at home. Although I was doing anthropology at "home", I may not say that I was at "home" as so many things seemed unfamiliar.

Some concluding remarks

Regardless of whether an anthropologist is conducting research in his/her home area or some other exotic culture, it is inevitable that people in the site will come to their own conclusions about his/her role. During the whole research process I was very honest about my intentions: to determine what the Tumbuka people of northern Malawi considered to be the most dangerous illnesses threatening the lives of their children, their perceptions about the aetiology, treatment and prevention of these illnesses and how such perceptions have changed over time. While I, as a "native", was trying to understand my fellow "natives", they were also busy trying to construct their own perceptions about my personal identity. This is why I was labelled as a CID member, a person who asks silly questions, someone who has been sacked and abandoned by his wife and child, etc. Crick had similar experiences while he was doing his fieldwork in Kandy, Sri Lanka. He was an anthropologist doing research on tourism in Kandy and at the same time a Research Fellow at the University of Peradeniya. However, because he was "white" and most of the time was to be found

"hanging around" on the streets as do tourists, people said that he was a tourist, though he loathed being one (Crick, 1989; also see Goward, 1984:113; Hayano, 1979). Among his fellow blacks, Jones was thought to be a Black Panther or connected with the establishment in some way (Jones, 1970:254). People's past experiences may also affect the way they think about an anthropologist. Jones (the same Jones who was thought to be a Black Panther), while working among the Lahu in Thailand, was thought to be a missionary, because most of the Americans who had worked there had been missionaries. It was not easy for him to convince them that he was just an anthropologist (Jones, 1970).

My own people's attempts to construct my identity have at times made me think that perhaps I am no longer a native, no longer part of them! I have been away from my people for so long that all that which seemed familiar had become exotic. In this respect, my experiences resemble what M.N. Srinivas calls being "thrice born". Srinivas says that we are born in one culture, then we go away for training and work and then we come back for research (see Nanda, 1987:16). Despite all the problems I met in my fieldwork, I found that being a native conducting research among my fellow natives was good because it allowed full exploitation of the anthropological method of participant observation. My participation in funerals and other rituals was something that my people expected me to do. My participation in these ceremonies was never questioned and, had I not attended some of these ceremonies, people would have asked why. When they needed financial contributions towards the holding of certain rituals, as a member of the society, I was also approached and I contributed accordingly. When a funeral happened when I was away, I went and condoled with the bereaved family and sometimes I would, following custom, call an elderly person to accompany me. My people did not question why I was interested in attending all these ceremonies. The problem only came when I started asking what they termed *mafumbo yauchindere* (silly questions). While some anthropologists still criticise anthropology at home because of its lack of objectivity, Razavi reminds us that third world anthropologists conducting fieldwork in their own countries and

cultures/societies are, in most cases, not completely insiders (Razavi, 1992). This position allows them to participate actively (being empathetic) in the lives of their own people, a position which can easily be achieved if you are familiar with the local setting. Doing fieldwork at home is a challenge, and in my case it was an important step in discovering my identity.

But as a Tumbuka, who am I? Where are we found? What are the hierarchies and changes in our traditional forms of leadership? These issues, together with the general socio-economic and demographic characteristics of the study area, state and other institutions located within the study area, childhood diseases that children suffered from within the two months preceding the study and how caretakers (mostly mothers) sought treatment will be discussed in the following chapter.

CHAPTER 4

CONTEXTUALISING THE FIELD: KNOWING MORE ABOUT CHISINDE AND THE TUMBUKA

Introduction: A brief history the Tumbuka people

The Tumbuka are a group of people found in the northern region of Malawi, particularly around Rumphi and in some parts of Nkhata Bay and Mzimba Districts. Like the Chewa of central and southern Malawi, the Tumbuka came from Zaire, now the Democratic Republic of the Congo, and settled in northern Malawi between the 14th and 16th century AD (Phiri, 1982). The area the Tumbuka occupied in that period corresponds with the present districts of Mzimba and Rumphi in Malawi, and Lundazi in eastern Zambia (Phiri, 1982).

Around 1780, a group of people known as the Balowoka came to settle among the Tumbuka. They were led by a man called Mulowoka. Mulowoka was not his real name. It was given to him because he led the Balowoka who crossed from the eastern shore to the western shore of Lake Malawi. *Kulowoka* means crossing a body of water and *Balowoka* is a name (formed from the verb *kulowoka*) which was given to this group of people after they crossed the lake; their leader was therefore appropriately named *Mulowoka*, meaning the one who crossed a body of water. The real name of Mulowoka was Kakalala Musaiwila (Kalinga, 1984:139). Historians and missionaries allude to the fact that very little is known about the Tumbuka before the coming of Mulowoka and his entourage (see Vail, 1972). At the time Mulowoka settled among the Tumbuka, the most dominant clan was the Luhanga clan whose very influential leader was Mubila (Vail, 1972; Kalinga, 1984). Other clans included the Botas and the Kumwendas. It is claimed that before the coming of Mulowoka, the Tumbuka were organised in family clans and they did not have any centralised form of chieftainship or tribal aggregation (see Young, 1932:27; Phiri, 1982).

Mulowoka and his entourage were traders and they had come to the Tumbuka country in search of ivory, which was not considered to be of any value by the local inhabitants¹¹. The Tumbuka sold the ivory to him (Mulowoka) in exchange for cloth, beads and conus shells (Kalinga, 1984; Nyirenda, 1931). The Balowoka were very rich people who, after crossing Lake Malawi in dhows, initially settled at Chilumba on the shores of the lake before they moved on to the present Phwezi. Later, as they continued their search for ivory, they settled at Chikwawa. After this, they moved to eastern Zambia, where the land they had journeyed through was divided amongst themselves, with Mulowoka finally going back and settling in Nkhamanga among the Tumbuka. Thereafter, he started distributing clothes and hoes among the local people for free. Many people interpreted the distribution of gifts as aimed at wooing their support. After his return from Zambia, Mulowoka first settled at Mphande, before finally moving to Bolero where the headquarters of his group has subsequently been located. Because of his generosity, the Luhangas gave him a wife, but he did not have any children from that marriage. After this, the Kumwendas also gave him a wife; from this marriage, he had several children. It was also because of his generosity and, the fact that he lived happily with the people, that they decided to elect him chief of the area¹². At the time, the Tumbuka did not object as they did not have a centralized form of government. This chieftainship assumed the name of Chikulamayembe, which is a corruption of the Swahili phrase, *chukuwa majembe*, meaning “pick up or carry the hoes”. It is claimed that this was a command that Mulowoka used to give to his assistants as he journeyed from one place to another in the Nkhamanga area (see Phiri, 1982). The first Chikulamayembe was Khalapamuhanya, son of

¹¹ Nyirenda says that the local inhabitants considered ivory in the same way as bones. They were only interested in the meat (Nyirenda, 1931).

¹² Personal communication with Chief Chikulamayembe, 12th July 2000 at his Bolero Headquarters.

Nyakumwenda¹³ (Mulowoka's wife). Gonapamuhanya was the only son in the family and, when he died, a decision was made to give his chieftainship to his paternal nephew Kamphungu Nkhonjera (see Figure 4.1).

Kamphungu was allegedly exceedingly fierce and, because of his lust for power and because he wanted the chieftainship to belong to the Nkhonjeras, during his reign he allegedly went on a rampage, killing and chasing away members of the Chikulamayembe lineage (his uncle's lineage) and all those who were against him. Dissatisfied with what Kamphungu was doing, his subjects, with the assistance of the Nyirendas, drove him into a hut, surrounded it with thorns and set it on fire. Kamphungu was killed, after which the Chikulamayembe lineage repossessed the kingdom. Pitamkusa Gondwe came to power; he was Chikulamayembe the third (see Figure 4.1). After Pitamkusa Gondwe, there came Bwati Gondwe 1, then Cheyeka Gondwe, Mujuma Gondwe and Bamantha Gondwe, respectively. Nothing important happened when these five Chikulamayembes were in power. After the death of Bamantha, Bwati Gondwe 2 took over and a short while later the Ngoni from South Africa invaded the Nkhamanga Kingdom and captured some people and went with them upwards to Tanzania. After the Ngoni had left, Bwati prophesied as follows:

“When I am dead no other [chief] will last as I have done, there will be a great confusion that will last for a long time. But in a far off day, they will install a young child and he will establish the kingdom” (Nyirenda, 1931).

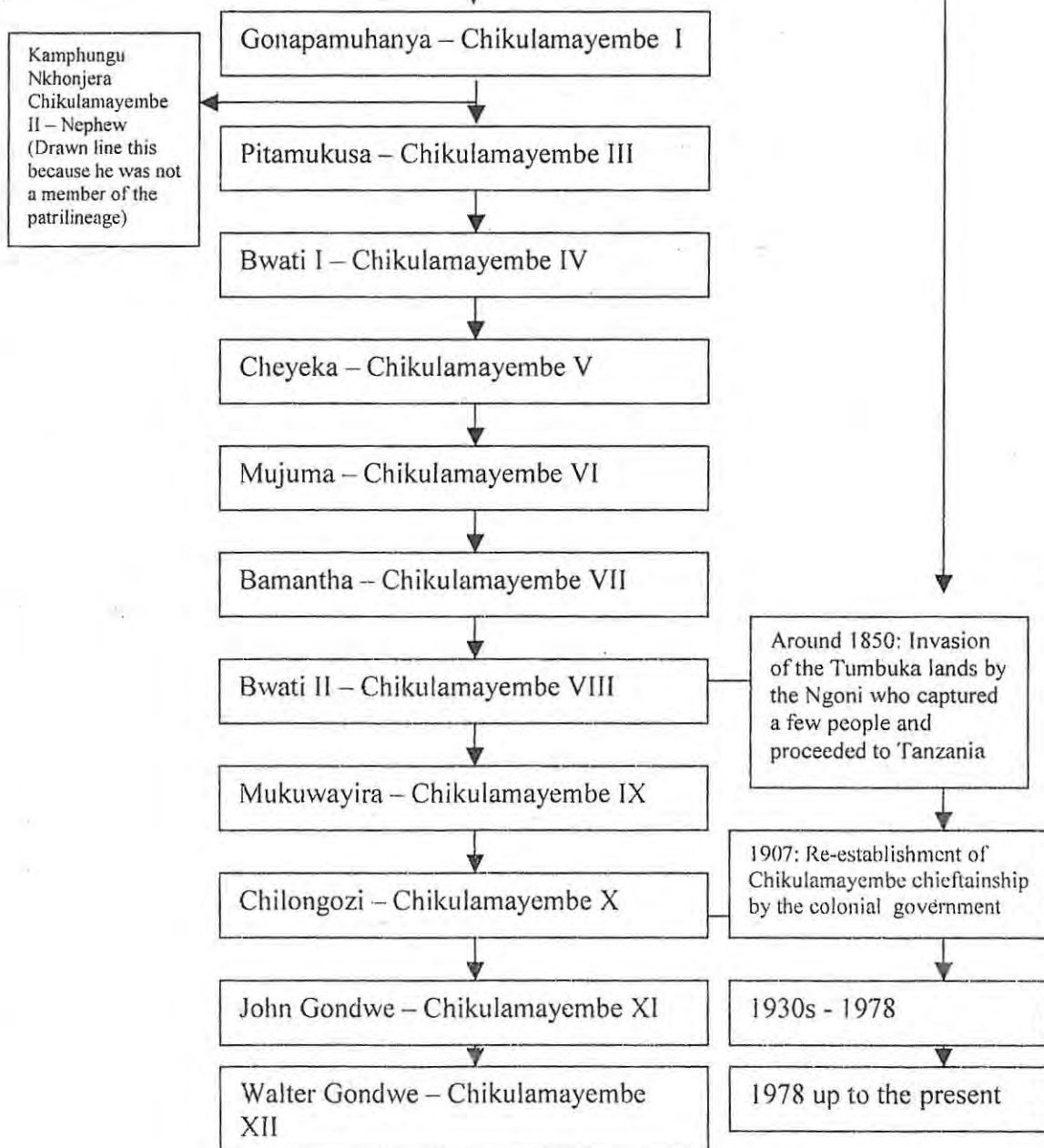
After the death of Bwati Gondwe, Mkuwayira Gondwe took over, but did not last long as the Ngoni came back from Tanzania and there was a lot of fighting before peace returned and the whole area came under the rule of Ngoni chiefs. However the fighting continued until the establishment of colonial rule in 1891, when peace

¹³G;) is an honorific feminine prefix to a surname. NyaKumwenda means the daughter of Mr Kumwenda. In Tumbuka, women are usually known by their maiden surnames with a prefix G;) H

Figure 4.1 Line of succession in the Chikulamayembe Dynasty

Before the coming of Mlowoka there was no centralised leadership. People were organised into small clans. It was a patrilineal society and no bridewealth was paid [before 1780]

The coming of Mulowoka and consolidation of power and subsequent establishment of a centralised patrilineal society [around 1780 and onwards]



returned to the Nkhamanga kingdom; finally in 1907, the Chikulamayembe chieftainship was restored by the colonial government, with Chilongozi Gondwe becoming the chief (see Nyirenda, 1931). The current Chikulamayembe is the twelfth leader in that line.

Although the Balowoka spoke Kiswahili, they later adopted the language and worship of their new people (Fraser, 1922). It was the Ngoni invasion and the earlier settlement of Mulowoka and his entourage that changed the social organisation of the Tumbuka: notably, the establishment of a centralised form of chieftainship, patriliney and virilocal residence and the full payment of bridewealth (Young, 1932; Forster, 1989). The Ngoni were a war-oriented people, and the payment of bridewealth during the marriage ceremony and the subsequent movement of the woman to her husband's home, was a way of retaining sons who were required to fight in their numerous wars. Marrying the sons out would have meant a reduction in the number of warriors, which they did not want (see Philip, 1955).

Local leadership

The Chikulamayembe's area of jurisdiction has, in the past, extended up to Dwangwa in Nkhota Kota, Chisondo near Karonga, Muyombe in Zambia and Nthalire in Chitipa District. Chikulamayembe became a sub-chief in 1932 (see Fig 4.2 for the current area of jurisdiction). As far as hierarchy in traditional leadership among the Tumbuka is concerned, Chikulamayembe is a senior Traditional Authority (Chief). Below him, there are chiefs (TAs), six sub-chiefs (STAs), ten Principal Group Village Headmen (PGVH), seventeen Senior Group Village Headmen (SGVH), 48 Group Village Headmen (GVH) and one hundred and forty-nine village headmen (VH). These figures were true as of June 2000 as new village headmen continue being installed. It is the people in the community who may demand that the village has grown so large that there is a need to split it or the split may come as a result of power struggles, as we saw earlier, in the case of Chisinde. It is not automatic that each TA will have 3

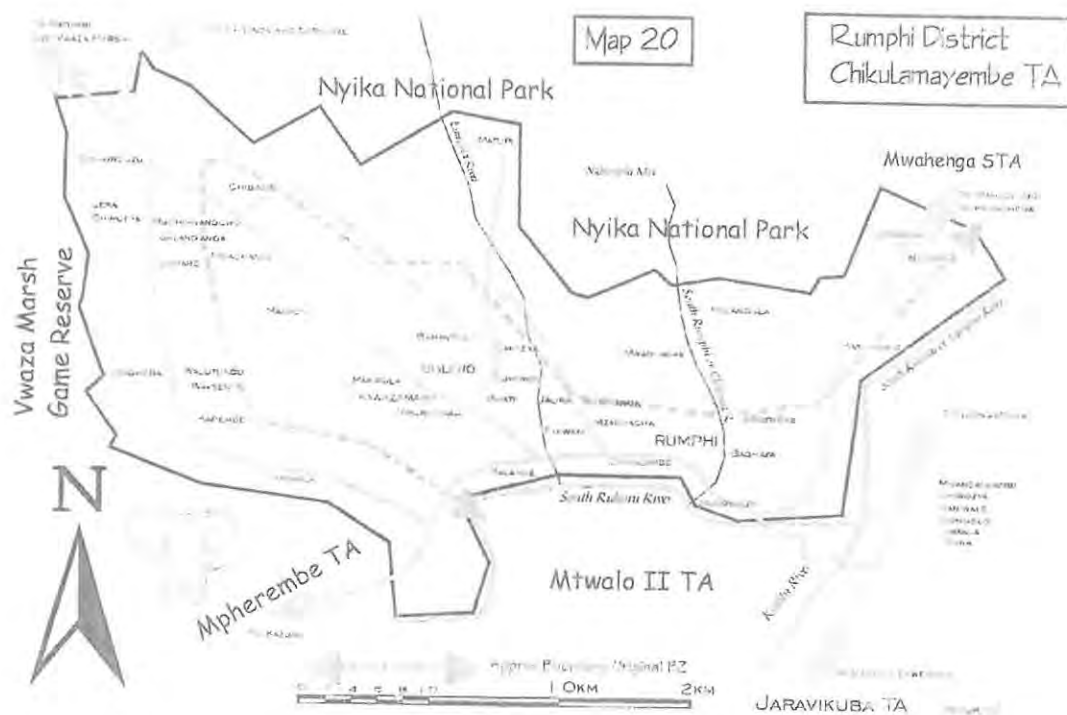


Figure 4.2: Map showing the area under Chief Chikulamayembe (Source: Bannerman, 1997)

STAs and 10 PGVH etc. The numbers of village headmen vary according to the size of the area and population in that particular area. The village headmen form the lowest level of the traditional leaders and each GVH (be it PGVH, SGVH or GVH) has several village headmen under him. The ranks of SGVH and PGVH are not recognised by Government. It is only the ranks of VH, GVH, sub-chief and chief which are recognised. These traditional leaders are paid a monthly allowance through the office of the District Commissioner. A village headman gets MK88, a group village headman MK125 and a chief MK400. Since the ranks of the SGVH and PGVH are not recognised by Government, they get monthly allowances equivalent to what the group village headmen get.

In each of these villages, there is a village committee with a chairman, vice-chairman,

secretary, treasurer and committee members. This village committee is mainly responsible for coordinating development, as well as other activities, for example: mobilising members of their respective villages to participate in self-help community programmes (such as the construction and maintenance of school blocks) and collecting and keeping contributions for particular activities¹⁴.

*

This, in brief, is the history of the Tumbuka people (which has been influenced greatly by the coming of Mulowoka and the Ngoni and the establishment of colonial rule in 1891) and their traditional leadership structure. From this description, it can also be seen that Chisinde, Vichimba and Wantulira villages fall within the area of Chief Chikulamayembe and that, although each of them has a village headman, they all fall under SGVH Chisinde by virtue of his being a group village headman.

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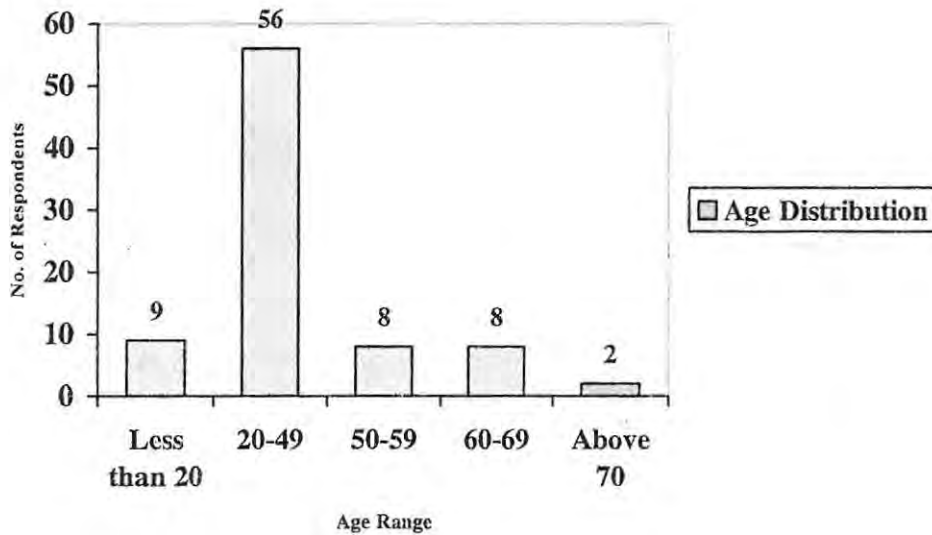
Socio-economic and demographic characteristics of the study area: a general overview

A household questionnaire was administered to all the households in Chisinde and

¹⁴ For example, during the harvesting period members of the village are encouraged to contribute a part of their harvest (say a basketful of maize or some other crop). This is sold and the money realised is used to buy planks for making coffins. This is a form of security because whenever a death occurs in the village, a coffin is provided from these contributions. Villagers realise that death comes at any time, and not only when people have the money to buy a coffin, hence the making of such contributions ensures that, whenever death strikes, a coffin will always be available. Those who do not contribute have to be responsible for themselves when death occurs in their household.

Wantulira villages, with the intention of getting a general socio-economic and demographic picture of the study area. As has already been mentioned in Chapter 2, there were 83 households in these two villages. Figure 4.3 shows that 9 of the respondents were aged below 20 years, 56 between 20 and 49, while 18 were aged 50 and above.

Figure 4.3: Age Distribution of Respondents



Of the 83 respondents, most were married (75, 90.4 percent), 3 (3.6 percent) were divorced and the rest (5, 6.0 percent) were widowed. It can be seen that all the 83 respondents, including 9 aged below 20 years, were all married or had been married previously. Although this questionnaire was mainly administered to female respondents, there were instances when it was not possible to administer it to a female, either because she was not immediately available, or the man was widowed. Of the respondents, 71 (85.5 percent) were female and 12 (14.5 percent) were male. Out of the 362 *de facto* residents in Chisinde and Wantulira villages, 163 (45.0 percent) were married, 182 (50.3 percent) were single and 14 (3.9 percent) were divorced, while the rest (3, 0.9 percent) were widowed. The total number of *de facto* under-five children in these two villages was 65.

In this predominantly patrilineal society, men are the heads of households. Out of the 83 households visited in the two villages, only 6 (7.2 percent) were female-headed and these women were either divorced or widowed. When women are divorced, some go back to their father's homes and have their own houses and separate granaries, while others join their parents, where their fathers are heads of the household. The survey also found that on average, 4.3 persons were living in any one household.

Of the 362 de facto residents of Chisinde and Wantulira, 177 (representing 48.9 percent) were males, while 185 (representing 51.1 percent) were females. This is in line with the 1998 Malawi Housing and Population Census, which found that in Malawi 51 percent of the total population enumerated in that year were females (National Statistical Office, 1998:3).

Housing, water and sanitation

Table 4.1 shows the condition of the houses found in Wantulira and Chisinde villages, which is similar to the trend in Vichimba village and other Tumbuka villages. Most of the houses (56, 67.5 percent) in Wantulira and Chisinde are made from compacted earth. This is followed by houses made of burnt bricks (24; 28.9 percent); walls made by wattle and daub (2, 2.4 percent); only one house had walls made of sun-dried bricks.

The majority of the houses (68, 81.9 percent) in these villages are grass thatched with only 13 (15.7 percent) covered with corrugated iron sheets for roofing. Informants said that these days grass is very rare and to find enough grass to thatch a house properly that it does not leak is a very large and daunting task; so they resort to putting a very huge plastic sheet on the roof followed by a grass thatch. As regards flooring material, most of the houses (68, 81.9 percent) have compacted earth floors, while 15 (18.1 percent) had concrete floors. Some of the houses with corrugated iron roves also had compacted earth floors.

From Table 4.1, it can also be observed that the material used for covering windows varied greatly, including wood (33, 39.8 percent), grass (8, 9.6 percent), glass (12, 14.5 percent), reeds (10, 12.1 percent) and plastic (2, 2.4 percent). There were four houses which had no windows at all. While most people would want to have a house roofed with corrugated iron, and with cemented floors, glass windows and walls built with burnt bricks and cement, abject poverty bars them from having such houses. Most of the houses had 2 or 3 bedrooms. According to elderly informants, the major change was that, while in the past there were *mphalas* and *nthanganenes*, which were separate dwelling huts for adolescent boys and girls, respectively, these days such huts do not exist: adolescent boys and girls reside in their parent's houses; a change people attributed to contact with Europeans.

Table 4.1: Condition of the House/Dwelling Units (n=83)

WALLS OF THE HOUSES	ROOFS OF THE HOUSES	TYPES OF WINDOWS	TYPE OF FLOOR
Poles and Mud (2, 2.4%)	Grass Thatched (68, 81.9%)	Wooden (33, 39.8%)	Cement (15, 18.1%)
Compacted Earth (56, 67.5%)	Tiled Roof (1, 1.2%)	Grass (8, 9.6%)	Mud (68, 81.9%)
Sun Dried Bricks (1, 1.2%)	Iron Sheets (13, 15.7%)	Glass (12, 14.5%)	
Burnt Bricks (24, 28.9%)	Cement Sheets (1, 1.2%)	No Windows (4, 4.8%)	
		Sacks (13, 5.7%)	
		Cloth (1, 1.2%)	
		Reeds (10, 12.1%)	
		Plastic (2, 2.4%)	

All the respondents in both Wantulira and Chisinde said they use firewood for cooking their food. Due to rampant deforestation, women travel long distances in order to find firewood, unlike in the past when forests were just close by. Informants said that due to population pressure, these forests have been cleared for agricultural use, construction of dwelling houses and other uses. Paraffin (77, 93.8 percent) is the major source of energy for lighting. There is no gas station where people can purchase paraffin. The owners of shops purchase paraffin in bulk from a gas station at Rumphi Boma (some 32 kilometres away) and sell it on retail in the village. There were also two other individual business persons who bought paraffin in bulk and sold it to the other villagers from their homes. Other sources of lighting in the houses mentioned included grass and the making of a fire inside the house.

Chisinde and Wantulira villages lie along Ruviri River. This river is seasonal, drying partially during the dry months of August to November each year. In June and July 2000, the water in the river was dirty and stagnant. Despite the proximity of the river to the villages, almost nobody goes to the river to draw water. The river in most cases acts as a source for drinking water for domesticated animals and water for irrigating vegetable gardens. Chisinde is one of the rural areas in Malawi which has benefited from the rural piped water supply projects. The major problem, however, is that water treatment chemicals are in most cases not available for the treatment of water in the storage tanks before it goes to the consumers. In addition to a piped water supply, boreholes and shallow wells are the other sources of water for domestic use during the dry season when water taps run dry. While initially water taps used to run throughout the year, this is not the case these days. A lot of deforestation has occurred in the catchment area of the Ruviri River (the source of piped water) which has greatly diminished the flow of the river, and hence the availability of tap water.

With regard to the disposal of rubbish, although most of the respondents (53, 63.9 percent) said that they throw or dump it in a special pit (*nkhando*), closer observation

revealed that these pits were not specifically dug for waste disposal. Most of the houses in these two villages were made of compacted earth. A lot of soil is dug from the ground for the construction of these houses and moulding of bricks, leaving behind very big pits. These pits (holes) are not meant for rubbish disposal, but they are used in this way in order to fill them up. Twenty-four of the 83 households (28.9 percent) in the two villages said that they just throw rubbish anywhere, especially at the back of their houses. Others said that they burn (3, 3.6 percent) or bury (3, 3.6 percent) the household rubbish. Most of the households (62, 74.7 percent) had toilet facilities, mainly of the traditional type, consisting of a pit covered with logs and then smeared with earth and a small hut erected above the pit, and roofed. Twenty-one households (25.3 percent) did not own a toilet. Twenty (95.2 percent) of these said that they used a neighbour's toilet, only one divorced woman said that she and her children defecated in the bush.

Levels of educational attainment

The educational qualifications of people from Wantulira and Chisinde villages were divided into six categories, namely standards 1 to 5, standards 6 to 8, secondary (Form 1 to 4), university, no formal education and under-school age. Standards 1 to 5 constitute junior primary school; standards 6 to 8 constitute senior primary school; and Form 1 to 4 constitute secondary school. The total number of children under school age was 77 (N=362, i.e. *de facto* residents). One hundred people live away from the village and come home occasionally to visit. Table 4.2 shows that most of the people (245, 86.0 percent)¹⁵ who are fully resident in the villages have not gone beyond standard 8. One hundred and twenty-four people (43.5 percent) have reached senior primary while 111 (38.9 percent) did not go beyond junior primary school. With only a primary school education, it is very difficult to find employment, hence

¹⁵ These percentages are calculated based on the number of people who were fully resident in the village, minus children who were under school age.

most of these people stay at home and try to farm to earn a livelihood. Forty (14.0 percent) of the *de facto* residents have been to secondary school; most of these people also stay in the village, with farming as their major occupation. This is not out of choice, but because jobs are very scarce. None of the university graduates (8) live in the village. Most of the people (52 percent) who live away from the village have been to secondary school or university and of these, 23 (23 percent) are still at school.

Teachers at the primary school said that the presence of men and women in the village, especially those who have finished and passed their Malawi School Certificate of Education (equivalent to O-Level), is generally a disincentive for those pupils in primary school. They said that some pupils who work hard at school, are sometimes discouraged by their parents who say such things as:

“Don’t you see your friends who have finished Form Four and are just staying in the village because of the scarcity of jobs? So even if you go to school, where do you think you will find employment?”

Examples were given of those who are, by village standards, rich and own vehicles, but never went to school. Teachers are considered educated in the village and even they borrow money from the uneducated rich people. With such a situation, it is extremely difficult for some pupils to continue with their education. An example was given of an 18-year old boy who was selected to go to a secondary school, but when his immediate elder brother bought a car, he dropped out of school. He argued that since his brother could buy a car although he had never been to school, he considered going to school to be waste of time. He got married after dropping out of school and started growing tobacco, hoping that one day he would be able to buy a vehicle like his brother.

Table 4.2: Educational Qualifications of the Members of Wantulira and Chisinde (not including those below school-going age).

LEVEL OF EDUCATION	FULL TIME RESIDENTS	THOSE STAYING AWAY
Standards 1 – 5	111(38.9%)	3 (3.0%)
Standards 6 – 8	124 (43.5%)	36 (36%)
Secondary	40(14.0%)	52 (52%)
University	0 (0.0%)	8 (8.0%)
No Education	10 (3.5%)	1 (1%)
Total	276 (99.9%)	100 (100%)

Home visits for those who stay away

As has been noted in the above section, one hundred people stay away from the village. As shown in Table 4.3, there is a variation in the number of times these people visit their home villages. Most of the people who work in towns far away from home only visit their homes once a year. Some people only go home when they hear that someone is sick; hence they go to see patients and give moral support or assist wherever they can. In some cases, they only go to attend the funerals of their relatives. In the group which goes home only once a year, there are also some school pupils who stay in town with relatives and only go home during the long vacation in November of each year. There are others who visit their home villages three times a year. These are mostly students in boarding at secondary schools and they go home during the holidays. Each academic year is divided into three terms and these students go home every holiday, if they can afford it. Those learning at Bolero and Mwazisi Community Day Secondary Schools cannot afford to commute to their schools every day, so they rent a house close to the school or stay with relatives and then over the weekends they visit their parents in order to get some basic necessities.

Table 4.3: Frequency of Visiting Home for Those Who Stay Away

FREQUENCY	NUMBER OF NON-RESIDENTS
Daily	4
Weekly	12
Monthly	12
Three Times a Year	15
Yearly	49
Does Not Come	8
Totals	100

Eight (8) people apparently do not visit their home village at all. They belong to two households whose parents used to live and work in Zambia. The parents only came to live in Malawi in 1996, leaving all their children in Zambia. Since the parents came to Malawi, their children have never visited them. They are still considered members of the village, as it is expected that one day they will return to the village as their parents did. The people who stay away from their villages maintain communication with their relatives back home by visiting them during holidays, by writing letters and by sending remittances. This contact is important because whenever there are problems, be it in town or in the village, there is a need for relatives to know and to assist wherever possible. In cases of death, funds permitting, it is expected that they (those who stay away from home) will be buried in their home village. There is also a history of migrant labour in the area: a considerable number of people have gone to Zambia, Zimbabwe and South Africa to work as migrant labourers in the mines, particularly. These people have always tried to maintain contact though there have been a few exceptions where migrants have severed any form of communication with

their relatives back home.

Occupation/sources of cash income

Most of *de facto* residents (154, 84.6 percent) in the two villages are engaged in farming as a source of food and income. As will be seen later, they are mainly involved in the growing of maize for household consumption, and tobacco as a major source of cash income. Both men and their wives are involved in tobacco farming. In addition to farmers, the two villages also have teachers who teach at the local school, builders, a tailor, business persons, a miller (who runs the maize mill in Wantulira village), forest guards and a forest assistant. There were two elderly people who did not have any occupation; they were described as mad (see Table 4.4).

Table 4.4: Occupation of those fully resident in the village (minus those at school and those under school-age)

OCCUPATION	NUMBER (%)
Farmers	154 (84.6)
Forest Guard	2 (1.1)
Forest Assistant	1 (0.5)
Builders	2 (1.1)
Teachers	8 (4.4)
Tailor	1 (0.5)
Housewives	7 (3.9)
Business Persons	5 (2.7)
Carpenters	1 (0.5)
Miller	1 (0.5)
None	2 (1.1)
TOTAL	182 (100.9)

The major source of cash income in Chisinde is crop sales, especially tobacco, which, as we shall see later, is grown by most people in the village. Since the Ruviri River is nearby, some villagers are involved in the growing of vegetables during both the dry and rainy seasons. In the dry season, the vegetables are irrigated. This is another source of income for these people. As can be seen from Table 4.4, some *de facto* residents are employed or are self-employed. Another important source of cash income for people in this area consists of remittances from relatives working away from home.

While Table 4.4 shows the occupations of the *de facto* residents of Chisinde and Wantulira villages, some people also run small-scale businesses to generate some money. These businesses include the selling of fish, sugarcane, bananas, cassava, paraffin, the hiring out of oxcarts, ploughing and ridging of other people's gardens using cattle, moulding and selling of clay pots and brewing of local beer made from millet, or the distillation of local gin from a mixture of sugar and maize husks. In addition to this, some people do *ganyu* (paid casual labour) in other people's gardens or build houses made from compacted earth for others.

Property Ownership

The possession of property is one of the indicators of being wealthy ("doing well"). Table 4.5 lists the number and percentage of households in Wantulira and Chisinde villages that own specified property. Most households in the area (57; 68.7 percent) own radios. A number of households also own bicycles. Informants said bicycles are very important as they are used as a form of transport in the area. They use them when going to sell produce at the Agricultural Development and Marketing Corporation (ADMARC)¹⁶, when going to the maize mill, health centres and indeed,

¹⁶ ADMARC is a statutory organisation involved in the buying and selling of farm produce.

whenever they are travelling. Those who do not have bicycles can borrow them from relatives or friends whenever they are undertaking a long trip. The maize mill in this area is run on diesel and it is more expensive than mills powered by electricity. Many people, whenever they do not have adequate money, just take a bicycle and cycle to Bolero Trading Centre where there are mills run on electricity.

Table 4.5: Property Ownership

ITEM	NUMBER (PERCENTAGE) OF HOUSEHOLDS POSSESSING THE ITEM
Maize Mill	1 (1.2%)
Sewing Machine	8 (9.6%)
Ox Carts	8 (9.6%)
Plough	12 (14.5%)
Cupboards	12 (14.5%)
Bicycle	36 (43.4%)
Beds	38 (45.8%)
Chairs	42 (50.6%)
Tables	49 (59.0%)
Radio	57 (68.7%)

Although eight (8) people own sewing machines, only one person is a tailor in this area. The rest of the machines are not being utilised. This tailor makes or mends clothes for other people at a fee. Eight (8) out of the 9 households who own cattle have an oxcart. These oxcarts are also used as a form of transport. During the harvesting season, those who have oxcarts carry other people's produce from the farm to the house or from the house to the produce market at a fee. Additionally, oxcarts

are used for carrying patients to health centres, carrying fertiliser from selling agents to houses and carrying firewood from the bush to the village. An ox-drawn cart was also mentioned by a number of people as another source of cash income. Only 38 (45.8 percent) households mentioned that they have beds; though this does not mean that everyone in these households sleeps on a bed.

In addition to property mentioned above, one other criterion for deciding whether a person is doing well or not is the possession of livestock. Table 4.6 shows that most households (66, 79.5 percent) own chickens, followed by pigeons (14, 16.9 percent), goats (13, 15.7 percent) cattle (9, 10.8 percent), ducks (5, 6.0 percent), pigs (5, 6.0 percent) and sheep (4, 4.8 percent), respectively. Pigeons can be sold or eaten as relish. Forty (48.2 percent) households had only one form of livestock, 32 (38.6 percent) had more than one form and 13 (15.7 percent) did not have any livestock. As will be seen later, though these two villages have all these forms of livestock, meat and meat products are consumed very sparingly. It was learnt that chickens are only slaughtered when a visitor comes, at Christmas, and when there is not any other relish. If those who own cattle kill one, it is not for home consumption, but to raise money for other purposes. It is only during funerals that cattle are killed for purposes of consumption, especially if the person who has died had possessed them. The same is applicable to goats, sheep and pigs. Cows are also a good source of milk for the family and milk is also sold to generate income.

Lastly, every household in the village has some land and this is passed on to sons. With the increase in population, the size of land owned by a household decreases. As sons get married, the father divides his land among his sons and most informants said that the land that they have is not adequate to cater for all their needs. The size of the land that one owns depends on one's grandparents. Those whose grandparents were hardworking and managed to clear a lot of forest, own large areas of land, unlike others whose grandparents were lazy or spent time going abroad to Zambia, Zimbabwe and South Africa to work as migrant labourers.

Table 4.6: Possession of Livestock

LIVESTOCK	NUMBER (PERCENTAGE) OF HOUSEHOLDS OWNING LIVESTOCK	TOTAL NUMBER OF LIVESTOCK IN WANTULIRA AND CHISINDE VILLAGES
Cattle	9 (10.8)	-
Sheep	4 (4.8)	19
Ducks	5 (6.0)	28
Pigs	5 (6.0)	36
Goats	13 (15.7)	77
Pigeons	14 (16.9)	154
Chickens	66 (79.5)	459
None	13 (15.7)	0

State and other institutions in Chisinde

This section looks at state and other institutional facilities that are available or accessible to residents of Chisinde.

Education facilities

Bembe Primary School, opened in 1949 by Catholic Missionaries, is located in Chisinde Village and all pupils from Chisinde and surrounding villages go to this school. Primary education in Malawi is provided free of charge since the dawning of multi-party politics in 1994. During the campaign for the 1994 presidential and parliamentary elections, the United Democratic Front (UDF), which was then an

opposition party, promised the electorate the provision of free education. When the UDF won, it immediately instituted free primary education. The charging of school fees in primary school was seen as a deterrent to access to education, especially for the poor. The scrapping of school fees and making the wearing of school uniforms non-compulsory in primary school soon after the United Democratic Front won the elections and took over government in 1994, led to an increase in enrolment of school pupils in primary school (Ministry of Economic Planning and Development et al, 1996). Though these changes led to an increase in enrolment, the mandatory wearing of uniforms was seen as good because, as teachers at the local school argued, school uniforms made it difficult to distinguish whether a pupil came from a poor or a rich family. These days, some pupils drop out of school because they do not have anything to wear. Teachers also bemoaned the fact that free primary education has drastically reduced the quality of education in primary schools as there is a lack of books and of trained teachers, and overcrowding in schools has led to a high pupil/teacher ratio, which is not conducive to learning.

The school enrolment for the 2002 school year was 566 with the distribution of pupils in each class as shown in Table 4.7.

Table 4.7: School enrolment at Bembe Primary School

STANDARD	NUMBER OF BOYS	NUMBER OF GIRLS	TOTAL
1	42	46	88
2	36	42	78
3	40	35	75
4	28	22	50
5	39	25	64
6	25	27	52
7	39	32	71
8	43	45	88
TOTAL	292	274	566

Though it is not very evident from Table 4.7, teachers at the local school said that most of the girls start dropping out of school when they are in Standard 4 or 5, for the following reasons:

- Early marriages;
- Widespread child labour in the area: girls, particularly, are sent to work on tobacco estates in order to contribute towards family income, while boys are usually left to continue with school;
- Poverty: in most cases girls feel ashamed if what they put on is dirty or torn. In lower classes they do not care and they cope with wearing dirty or torn dresses. When they reach standard four they realise that it is shameful or disrespectful to go to school with uncovered breasts; hence they drop out of school if their parents cannot afford to buy them decent clothing.

While school enrolment was quite high in early January 2002, teachers said that between the end of that month and early March 2002 enrolment was very low and out of the 566 school pupils, sometimes only 200 would attend school. Parents explained that, during this period school, pupils could not walk as they were very hungry. Older school-going children were taken by their parents to do *ganyu* (piece work) so that they could contribute to the household's search for food. This resulted in many schools having low enrolment; in fact one of the schools in the Mwazisi area was temporarily closed because of famine in January/February 2002.

While the primary school is located within the village, the nearest secondary school is Mwazisi (approximately 13 kilometres away). It is a community day secondary school (CDSS) that has recently been established. It draws pupils from those villages and primary schools around Mwazisi, including Chisinde.

Agricultural extension services

An agricultural field assistant, based in neighbouring Vitendwe village, stated that his major responsibilities were:

- To teach rural farmers modern methods of farming.
- To advise farmers when to plant, apply fertiliser, etc.
- To promote the formation of farmers' clubs.
- To train members of farmers' clubs on credit procedures and credit repayments as this training is a requirement of lending institutions, such as Malawi Rural Finance Company (MRFC).
- To monitor the activities of farmers' clubs.

As of January 2001, there were fifty-three clubs in his catchment area and most of them were involved in the growing of barley tobacco, with only two growing Northern Division Dark Fired (NDDF) tobacco; one was a poultry club; and the other two were cash clubs. The cash clubs obtained cash loans from MRFC to start small-scale businesses. With such loans, people started businesses like butcheries and the selling of scones, fish, beans and salt. The size of the cash loans given to people depended on the type of business that they wanted to start. Farmers obtained loans for the growing of tobacco from MRFC, ADMARC, Farmer's World and Farmer's Financing Company. These loans were not given in cash; farmers were given farm inputs, such as fertiliser. When they sold their tobacco to the Auction Floors, the money owed to these lending institutions was deducted automatically before clubs got their money.

People join or form clubs because, firstly, they want to share experience and knowledge about growing tobacco for example; and secondly, they want to have access to loans, as lending institutions, such as the MRFC, do not allow individuals (only clubs) to obtain loans from them¹⁷. The formation of farmers' clubs is also advantageous to the agricultural field assistant in that it makes his job much easier as he meets farmers in groups, as opposed to meeting individuals.

Some of the clubs draw membership from both men and women, while others are for women only or exclusively for men. Women may decide to form their own farmers' clubs so that during meetings they can discuss matters more freely. In some cases, within the club, there might be a father in-law, and daughters in-law are supposed to respect their fathers in-law. They are not supposed to talk freely or even eat in their presence; hence the need to form their own clubs. Sometimes they also form different groups because they would like to have some economic freedom. They want to earn money on their own rather than relying on their husbands. While the idea is very appealing, most women however said that their husbands still control the money that they make from such ventures.

Forestry extension services

The Forestry Assistant who is responsible for Chisinde and surrounding villages said that, among other duties, he promotes community-based management of natural

¹⁷ These institutions argue that individuals may not be able to repay the loan as there is nobody who can urge them to work hard. In a club, there are rules that each member has to follow. If an individual fails to repay the loan, it is the responsibility of the other members to make sure that they pay the loan on his behalf. The club finds a way of recovering money from a member who has failed to repay his loan. If the club does not fulfil its obligations of loan repayment, then it may not have a chance of getting another loan the following year. Hence, as far as lending institutions are concerned, they feel that there is security in numbers as well as in groups.

resources. This is an initiative that encourages communities to be responsible for the management of natural resources, especially forests. In communities, there are certain tree species that are protected by law and even if these trees are in your garden, it is illegal to cut them down as they have to be bought from the Department of Forestry. These tree species include *Telecopus angolensis* (*mlombwa*), *Acacia albida* (*nsangu*), *Khaya nyasica* (*mbawa*) and *Ethiopia africanus* (*mkoma*). The species, being protected by law, are either very rare or are in very high demand. For example, *muwawa* is in very high demand for making planks. Any tree on customary land may be used freely, except those that are protected by law.

In order to promote the involvement of communities in the management of forests, village forestry committees (VFCs) have been set up, which, among other things, are responsible for ensuring that people do not cut down trees wantonly and for encouraging people to plant more trees. In the past, the Department of Forestry sold protected tree species and retained all the money from such sales. With the advent of community-based management of natural resources, wherever VFCs exist and are functional, they have taken over the sale of protected tree species. VFCs retain 70 percent of the money, while 30 percent is given to the Department of Forestry. This is to encourage even those villages where VFCs are non-existent to form such committees so that their villages may raise some funds. The money that the committee realises from the sale of trees benefits them directly in their development activities. For example, they may employ someone to mould bricks to build a school for them.

The move taken by Government to protect tree species is an important step. While, up to the 1970s, natural forests were very close to dwelling houses, these areas have since been cleared for agricultural purposes and the building of houses. This has resulted in women travelling longer distances in search for firewood, and herbalists and diviners in search of medicinal tree species.

Health facilities

As was pointed out in Chapter 1, in Malawi, government health care services are provided free of charge, with the exception of the major referral central hospitals of Lilongwe, Queen Elizabeth and Mzuzu, where there exist some fee-paying wards. For Chisinde, the nearest health centre is at Mwazisi (approximately 13 kilometres away). The other health centre is at Bolero, which is approximately 16 kilometres away. Though this health facility is further than the one at Mwazisi, if one has money, it is easier to get there than to Mwazisi because there are many vehicles travelling in that direction. Before the establishment of a health centre at Bolero during the colonial period, and at Mwazisi at the end of the 1970s, serious illnesses were referred to the mission hospital at Livingstonia or the colonial hospital at Mzimba. As we shall see later, people in general complain about government health facilities because, among other things, medicines are usually not available. For example, in May 2002, the health centre at Bolero was closed for about a week because it had run out of medicines.

In addition to the above two health centres, i.e. Mwazisi and Bolero, there is another health centre that opened in 2002 and is located approximately 5 kilometres from Chisinde. It is called the Eva Demaya Centre and is run by a Dutch nurse who has worked in Africa for a long time. In this health facility, two traditional healers are working side by side with biomedically trained people – namely medical assistants and nurses – in the same compound. According to the initiator of the programme, the objective of bringing them together is that she recognises that each of them has something to offer, and if they are in one compound, they can refer patients to one another easily. Patients can also choose whether they would like to have a traditional or western form of treatment. There is also a recognition that a lot of time is wasted moving between traditional and biomedical treatment, hence both forms of treatment are offered in the same premises, at a nominal fee of MK50. The centre started offering traditional medicine on 1st March 2002, while western medicine commenced

on 13th May 2002. There are also plans for the under-five outreach clinic that was run at Ruviri by staff from Bolero Health Centre to move to Eva Demaya Centre (see Figure 4.4).

At community level, government has deployed health surveillance assistants (HSAs) who are community-based and form the lowest cadre of government health workers. As has been mentioned earlier, although the community health worker for Chisinde was based at Chitanga and reporting to the medical assistant at Mwazisi Health Centre, his home village was Chisinde. He said that his responsibilities included:

- Conducting health education sessions for mothers with children under five during static¹⁸ as well as outreach under-five clinics where different aspects of health are taught.
- Vaccinating children against the six childhood diseases, namely tuberculosis, diphtheria, pertussis, measles, poliomyelitis and tetanus; and mothers against neonatal tetanus.
- Monitoring the growth of under-five children and recording their weights on the under-five clinic card.
- Treatment of minor illnesses.
- Conducting village inspections in order to determine the number of people with or without toilets, bathrooms, dish-racks, rubbish pits etc, and creating awareness about the importance of having these facilities. These inspections are also aimed at determining the vaccination status (whether they are fully, partially or not immunised) of children under

¹⁸ Static under-five clinics are those that are conducted at health centres or hospitals.

five and encouraging mothers to have their children vaccinated.

- Monitoring outbreaks of diseases, especially notifiable diseases like measles.

Figure 4.4: Herbalists at the Eva Demaya Centre displaying traditional medicine stored in stoppered bottles



This HSA is also responsible for conducting or operating the under-five outreach clinic at Bembe Primary School.

In addition to state-provided health services, there are herbalists who look for

medicines when children and other people get sick; the most popular herbalist is in Mulyezi village. These give treatment based on signs and symptoms as presented by patients. Most of the herbalists said that a patient usually waits for three days or so and if there are no improvements, then he or she has to try elsewhere. When the patient gets cured, herbalists said that they do not charge him or her, but just ask him to give what he or she can afford. They held the view that if they charge their patients, they may destroy existing relationships, or relationships they are trying to build. One herbalist even said:

“Makuni aya ali kutipa ni chiuta. Titchajirengechi? Kasi tikuchita kuwoda kufuma ku London? Kuti munthu achire chiuta ndiyo akudangirapo”. (The herbs that we use were given to us by God. Why should we charge people? Do we order the herbs from London? While trees are important, it is God who also helps a person to get healed”.

They also held the view that when you charge one another *“ungarya vinandi yayi”* (you cannot gain maximally from the patient). Although the majority of local herbalists do not charge, others charge exorbitantly.

Both trained and untrained traditional birth attendants (*wazamba*) are available in Chisinde. Initially the Ministry of Health and Population initiated the training of TBAs because it recognised that TBAs play an important role, especially in those areas where health facilities are located very far from clients. The aim was therefore to help the under-served population to have a trained person and at the same time reduce the number of maternal deaths by teaching TBAs how to deliver safely and to refer complicated cases to health centres or hospitals. Though this was well intentioned, the Government found that the TBA training programme has had no impact. Though the trained TBAs were told to refer complicated cases to the hospital, it had been found that they still delivered such cases, and maternal deaths were still high. Since there had been no impact, in 2002 Government issued a circular

announcing the ending of the training of TBAs.

Lastly, in Chisinde there are small shops which stock medicines for the treatment of different ailments. It was learnt that most shops are closed down during the rainy season because money is used for other purposes such as buying fertilizer and food. When the crops are sold, these shops are opened again. The shops stock a lot of medicines including Novidar, Conjex, Stearns, Tumbocid, Indocid, Tetracycline, Chloramphenicol, Penicillin, Amoxyline, etc. According to the proprietors of the two of the shops in Chisinde, these medicines are used as follows:

Table 4.8: Uses of Medicines as Described by Shop-owners

Name of Medicine	Use of Medicine (Shop owner A)	Shop owner B
Tumbocid	Stomach upsets	Stomach upsets
Vicks Kingo	Sneezing	N/A ¹⁹
Aspirin	General body pains	N/A
Panadol	Headache, general body pains and when someone is very tired	N/A
Indocid	Rheumatism (<i>Nyamakazi</i>)	Rheumatism
Penicillin	Abscesses (<i>vitufya</i>), coughing (but not <i>chikhoso cha moto</i>) ²⁰	Wounds
Conjex	N/A	Coughing
Tetracycline	N/A	Stomach-ache, wounds and sexually transmitted diseases
Chloramphenicol	N/A	Same as tetracycline but it can also be used for diarrhoea and malaria
Stearns	N/A	Coughing
Bactrim	Same functions as penicillin above, but penicillin is stronger than bactrim	N/A
Novidar	Malaria	N/A
Amoxyline	Coughing	Coughing
Flagyl	Diarrhoea	Diarrhoea

The owners of these shops were not health professionals, but they sold antibiotics over the counter. One of them was a teacher and he owned a shop in order to earn extra money. Medicines, such as antibiotics, are supposed to be sold only on the

¹⁹ N/A means that the medicine was not available in that shop.

²⁰ A child suffering from this illness is very thin (others compared the child's thinness to a stalk of maize), has fever and sometimes also has diarrhoea. When you lift such a child, he is very light and when you hold him by the ribs he cries a lot. In addition to this, some children swell after coming into contact with those who have been involved in sexual intercourse.

production of a doctor's prescription. As we shall see later, one of the reasons why people tend to resort to buying medicines is that the health centres are situated very far away and, even if they take their children there, in most cases medicines are not available. According to the proprietors of these shops, most of the medicines that they stock are purchased in bulk from smugglers who source these medicines from Tanzania. The smugglers cycled to different parts of Rumphi District and other parts of the Northern Region, stopping and selling medicines wherever they find a shop. They also targeted flea markets (*tiwonewone*) which were conducted on particular days in different places. Medicines that the shop proprietors purchased from the smugglers were mainly Tetracycline, Indocid, Amoxycilin, Chloramphenicol and Flagyl. Penicillin, Bactrim, and the rest of the medicines they stock are said to be obtained locally, mostly from health workers who pilfer them from the hospitals and send watchmen, messengers or cleaners to sell them.

In addition to hospitals and smugglers, shop owners also buy medicines in bulk from Chipiku Stores, McConnell and Marketing Services Division²¹. Shop owners are forced to purchase medicines in bulk from smugglers because they sell them at very cheap prices; hence they (shop owners) are able to realise a profit. The companies, which sell drugs wholesale, are only found in Rumphi and to get there the shop-owners have to pay close to MK100.00 for transport. When they come back from Rumphi, they charge their customers very high retail prices, which most of them cannot afford. Hence, for business purposes it is much better, as far as shop-owners are concerned, to buy from smugglers who pedal their cycles from one shop to another, selling medicines at considerably cheaper prices.

²¹ Chipiku Stores, McConnell and Marketing Services Division are chain stores in Malawi, which are involved in the selling of goods at whole sale prices.

Childhood Diseases Prevalent in Chisinde and surrounding villages

The household questionnaire was used to find out the different childhood diseases prevalent in Chisinde and the initial treatment that mothers sought when their children fell ill. For households which had children aged below 5 years, respondents were asked whether these children had been sick during the previous two months. As we said earlier, there were 65 children under five in Chisinde and Wantulira villages, and 53 (81.5 percent) of these had been sick over this period. Table 4.9 below is a list of diseases from which these children suffered.

Table 4.9: Diseases that Children Suffered from Over a Two Month Period

NAME OF DISEASE	NUMBER OF CHILDREN
Measles (<i>chikhoso cha kufuma</i>)	2 (3.8%)
Malaria	18 (34.0%)
Coughing (<i>chikhoso waka</i>)	12 (22.6%)
Diarrhoea (<i>pamoyo</i>)	5 (9.4%)
Otitis media (<i>mphenga</i>)	1 (1.9%)
<i>Chikoko</i>	1 (1.9%)
Conjunctivitis (<i>maso</i>)	3 (5.7%)
<i>Masuku Chende</i>	1 (1.9%)
Stomach-ache (<i>munthumbo</i>)	2 (3.8%)
<i>Chitaska</i>	1 (1.9%)
Headache (<i>mutu</i>)	2 (3.8%)
Fever (<i>thupi kotcha</i>)	4 (7.6%)
Vomiting (<i>bukuzi</i>)	1 (1.9%)
Total Number of Children	53 (100.2%)

Though some of the children may have suffered from two or more diseases over the two months preceding the survey, mothers or caretakers were only asked about the most recent illness episode, and this is what is presented in Table 4.9. Eighteen of the children (34.0 percent) who were sick over this period had suffered from malaria, followed by those who suffered from coughing (12, 22.6 percent), diarrhoea (5, 9.4 percent), fever (4, 7.6 percent), headache (2, 3.8 percent), stomach-ache (2, 3.8

percent), conjunctivitis (3, 5.7 percent), measles (2, 3.8 percent), otitis media (1, 1.9 percent), *chikoko* (1, 1.9 percent)²², *chitaska* (1, 1.9 percent)²³, vomiting (1, 1.9 percent) and *masuku chende* (1, 1.9 percent), respectively. Only one child suffered from *masuku chende*; which is also known as *nkhwezga*²⁴. The parents of this child said that they did not know what the child was suffering from until an old man examined the child, found that the testicles were swollen, and told the father that the child was suffering from *masuku chende*. It can be seen from Table 4.9 that diseases are known by the part of the body they attack, for example *mutu* (head), *munthumbo* (stomache), *maso* (eyes), etc. The Tumbuka, therefore, just like the Chewa of central Malawi, tend to “spatialise disease”, as diseases are generally identified with specific symptoms or parts of the body (see Morris, 1986).

Out of all these diseases, only malaria was referred to using its English name by respondents. All the other diseases were mentioned using Tumbuka names. Due to the fact that some of the diseases were not familiar to people, the medical assistant and health surveillance assistant at Mwazisi and Bolero Health Centres were consulted. It was learnt that *chitaska* is the enlargement of the spleen, which can be caused by, among other factors, infection by malaria parasites. *Chikoko* are convulsions. As we shall see later, in malaria-endemic areas, the occurrence of the two conditions, namely *chitaska* and *chikoko*, especially in children under five, is mostly attributed to malaria.

²² *Chikoko* basically refers to convulsions.

²³ *Chitaska* is splenomegally and this is discussed further in Chapter 9.

²⁴ This is a disease which is characterized by the swelling of the testicles. The testicles are supposed to be on the same level, but when a child suffers from this disease, one of the testicles is at a lower level than the other. The child suffering from this disease cries quite a lot and parents do not know what is wrong.

Initial actions taken when children were ill

Households that had sick children over the two-month period cited above were asked what *initial* action they undertook in order to assist the child, as it is possible that they resorted to more than one type of therapy during the illness episode. In the household questionnaire, we were more interested in the first course of action taken in order to get an overview of what type of therapy is sought for different diseases. The responses to this question can be grouped into 5 categories, namely: taking the child to the health centre, buying drugs from the shops, preparing an oral re-hydration solution, seeking traditional medicine, and finally, taking no action at all. Table 4.10 shows that twenty-nine (54.7 percent) of the 53 households bought drugs from the shops, 16 (30.2 percent) took the children to the health centre, 5 (9.4 percent) used traditional medicine, 2 (3.8 percent) prepared ORS at home and only 1 (1.9 percent) did not take any action when the child fell sick, which the mother attributed to her “laziness”. Mothers, who mentioned ORS, said that they prepared and gave ORS to those children who had suffered from diarrhoea.

Table 4.10: Actions Taken When the Child is Ill

ACTION TAKEN	NUMBER OF HOUSEHOLDS
Bought Drugs from Groceries	29 (54.7%)
Taken to Health Centre	16 (30.2%)
Traditional Medicine	5 (9.4%)
Prepared ORS	2 (3.8%)
No Action Taken	1 (1.9%)
Total	53 (100%)

When a child suffered from coughing, most (9 out of the 12 respondents whose children suffered from this illness) people bought Bactrim or Penicillin from the nearby shops, one took the child to the health centre and another gave the child Conjex tablets. Only one said that she did not do anything. Three informants said that when a child suffered from diarrhoea they prepared an oral rehydration solution while two took their children to the hospital. In the case of malaria, most informants bought Aspirin from the shops (very few bought Fansidar or took their children to the health centre). The treatment of malaria with aspirin does seem strange, but this is followed up later in Chapter 9. Childhood diseases like *chikoko*, *chitaska*, *mphenga* and *masuku chende* were treated using traditional medicine. For the child who suffered from conjunctivitis, the mother said that she bought penicillin capsules from the shop, took out the powder and added water. She applied the mixture directly into the eyes. We can therefore conclude that most people, as an initial action, buy medicines from shops when a child is sick.

Conclusion

This chapter has given some background information on the history of the Tumbuka, their traditional leadership structure, the socio-economic and demographic characteristics of the area under study, health service delivery and the different state and other institutional facilities that are available for or accessible to the people of Chisinde and surrounding villages. The chapter has also discussed diseases that children under five suffered from two months preceding the survey and the initial treatment that mothers sought.

We, thus, have a general idea of the childhood diseases that are prevalent in the research site and of how mothers or caretakers seek treatment. The questionnaire that was used to get this quantitative data was long and it took about one hour to administer. Hence it was not possible to ask respondents further questions regarding the causes and methods of prevention of these diseases or indeed, why they sought

particular treatment for certain diseases. This would have meant keeping the respondents for a long time, which is not advisable. Most of these diseases were also mentioned during in-depth and key informant interviews, when questions regarding the causes, hierarchies of therapy-seeking and the different disease prevention methods were followed up in greater detail. Before examining the Tumbuka's perceptions about the causes, treatment and prevention of different childhood diseases, the next chapter reviews some literature on these aspects of disease in African societies.

CHAPTER 5

THE AETIOLOGY, PREVENTION AND TREATMENT OF DISEASES IN SUB-SAHARAN AFRICAN SOCIETIES

Introduction

While in biomedicine “disease” is perceived as a deviation from the normal values, is accompanied by abnormalities in the structure or function of the body organs or systems (Helman, 1994:103) and, for the most part, is bounded by the physical human body (Friedson, 1996:57), Ngubane reminds us that the term disease, in Zulu, does not apply to somatic symptoms only, but also to various forms of misfortune, states of vulnerability to misfortune and disease (Ngubane, 1977:22). Many African societies interpret the term “disease” in the same way as the Zulus (for example see Read, 1966:11; Ventevogel, 1996:15; Munthali, 2002). The wider meaning of the term disease in African societies can also be understood in the context of the work of traditional healers who are not only involved in the provision of health care, but also in the provision of healing-oriented expertise on social and spiritual issues, which are usually seen as outside the realm of biomedicine. They provide medicines for their clients to prop up failing businesses, acquire a lover or a job, pass examinations, succeed in hunting and farming, etc (cf Yoder, 1981).

This chapter reviews perceptions about the aetiology of diseases, attempts to prevent them and the health care options FOR people in Sub-Saharan Africa. In his classical work in lower Zaire, Janzen has argued that patients are in most cases powerless when it comes to making decisions about therapy choice. It is the therapy management group, essentially comprising relatives, friends, neighbours and other associates, that has the power to make such decisions (Janzen, 1978). In terms of powerlessness during illness episodes and responsibility for therapy choice, it can be argued that an adult patient is just like a sick child because both of them rely on a

network of people. Though, in most cases, the responsibility to look after a sick child lies with the mother, the act of decision-making in most households is in the hands of men²⁵. The household also depends on a network of people when it comes to therapy-seeking (Devisch, 1999) and therapy choice for the sick child.

Health and health care constitute part of a cultural system; hence people's conceptualisation of the aetiology, prevention and treatment of disease differs from one culture to another. Because culture is dynamic, contact with people from other cultures has brought about cultural change and the appropriation of certain elements concerning health and health care from one culture into another. What is observed in most African societies is the

“co-existence of more than one medical system [defined by Glick (1998:23) as a patterned set of ideas and practices having to do with illness] which in a more or less interconnected way seeks to maintain the health status within the community” (Slikkerveer, 1990:14).

In societies where medical pluralism reigns, therapy choice is determined by a host of factors as will be discussed in Chapter 6. LeBeau, in her study in Namibia, argues that one of the most important determinants of therapy choice is the perceived aetiology of that particular illness (LeBeau, 1999:154); and this proposition holds, provided that there is roughly equal access to the diverse health resources available. For example,

²⁵ Matinga and Munthali give an example of a woman whose child suffered from convulsions during a focus group discussion in Nkhata Bay District in northern Malawi. When offered a lift by the researchers to go to the nearest health centre, she refused, saying that she could not go to the hospital without permission from her husband who was not present at the time (Matinga and Munthali, 2001). Though husbands have the control, it will be shown later that in some cases women also fear taking convulsing children to the hospital because experience has shown that they do not survive; hence the resort to traditional medicine.

she says:

“However, there are also African illnesses such as witchcraft, misfortune and social problems which are expressed in terms of exclusively African symptoms such as lizards in the blood; ... and epilepsy which are considered to have a social/spiritual aetiology and are, therefore, best taken to a traditional healer” (LeBeau, 1999:154)²⁶.

In order to better understand how African societies seek treatment (which will be discussed in detail in the next chapter), it would be useful to first examine people's ideas about illness causation and how this subsequently impacts on modes of prevention and determination of therapeutic choices. Anthropologists have argued that the determination of causality concepts helps to understand indigenous practices about treatment and prevention of disease (Green, 1998:12). Working among the Cokwe, Yoder identified three different conceptual categories of medical causality, namely diseases of God, which arise from events in the natural world; diseases caused by sorcery and diseases caused by the displeased ancestors (Yoder, 1981). While this classification of disease aetiology in African societies is helpful, Yoder overlooked those diseases that can be caused by the breaking or infringement of taboos.

The following classification of disease aetiologies in African societies corresponds to that of Ingstad for the Bakwena of Botswana. She says that the Bakwena give five main reasons for sickness, death and misfortune; these are witchcraft/sorcery, ancestors, anger, the breaking of taboos and God's will/natural causes (Ingstad, 1989:249).

²⁶ LeBeau points out later that this is simplifying the choices that people make. As we shall see later, in reality people resort to both traditional as well as western medicines (1999:154)

The aetiology of disease in African societies

Witchcraft and sorcery as causes of illness and misfortune

As African societies modernise, it may be expected that witchcraft beliefs will be considered as archaic and disappear. However, beliefs about witchcraft and cases of witchcraft accusations still flourish in most African societies and evidence shows that such accusations are on the increase (see Comaroff and Comaroff, 1999). Witchcraft and sorcery are perceived as some of the major causes of illness (in both children and adults) and misfortune in this part of the world. In his classical work on witchcraft, Evans-Pritchard says that the Azande perceive witchcraft (*mangu*) as a substance in the body of a witch, inherited through unilinear descent (Evans-Pritchard, 1976). The inherent nature of witchcraft is also a feature in many African societies (see Pradelles de Latour, 1995; Mahvungu, 2000). Among the Sotho of the Green Valley in the South African lowveld, it is believed that children suck witchcraft from their mother's breasts (Niehaus, 2001). While the Ibibio of Nigeria also believe that witches have witchcraft substances in their bodies, they say that these substances are acquired from a practicing witch; and that once a person swallows them, he or she becomes a witch (Offiong, 1991).

Unlike sorcery, the practice of witchcraft does not involve the use of medicines, performance of rituals and casting of spells. The Azande believe that witchcraft may be either a conscious or an unconscious act (Evans-Pritchard, 1976), while other societies consider witchcraft to be a deliberate act intended to harm others (LeBeau, 1999; Niehaus, 2001). The Azande witch either sends *mbisimo mangu* (the soul of witchcraft) to remove or eat the internal organs or soul of the victims, or shoots *ahu mangu* (things of witchcraft) into the bodies of those he/she intends to harm (Evans-Pritchard, 1976:14). Among the Ibibio of Nigeria, it is believed that the soul of the victim is transformed into an animal, and that such a transformation causes a slow and

wasting disease. This animal, upon the decision of the witches, can be killed and eaten, leading to the instant death of the victim (Offiong, 1991).

While these are some of the ways in which witches may cause illness and misfortune, in many African societies witch familiars are frequently used for this purpose. The witch familiars used include baboons, *thikolofe(s)*, hyenas, bush babies, snakes, etc. These are sent by witches to harm people through beating, sucking of blood from the body without leaving any marks (see Hunter, 1979; Niehaus, 2001) and stealing money and other items from the neighbours (see Niehaus, 2001). In some cases, apart from beating, the *thikolofe* can also use charms to cause illness (Hunter, 1979); this is seen as being a very rare occurrence. It is also believed that witches can change themselves into animals and birds and cause harm to people in these altered states. As regards the concept of duality in which the witch changes into a familiar and vice versa, Pradelles de Latour, in his study among the Bangoua of Cameroon, gives an example of a jealous wife who, after changing into an owl, drank the blood of the children of a co-wife, who subsequently grew thin and fell ill (Pradelles de Latour, 1995:603).

While witch familiars can cause misfortune and illness to intended victims, they can also be very demanding, as the following example from the Pondo illustrates:

“An *izulu* [the lightning bird] is said often to turn on its owner, demanding to suck the blood of her relatives. If she refuses it kills her. When a mother is accused of killing her own children it does not mean that she wanted to kill them, but that she had an *izulu*, and she loved her own body better than her children. The children of a woman who has an *izulu* never live; they are just born and die for she gives them to her *izulu*” (Hunter, 1979:282-283).

An *izulu* is also known as *impunchulu* and Holland says this familiar “is said to have a kick so devastating that it causes the victim to cough blood. Those who report this are

often found to be suffering from tuberculosis” (Holland, 2001:135).

In addition to the usage of witch familiars and the sending of what Evans-Pritchard calls the soul of witchcraft, in recent years a new form of witchcraft has emerged in which witches turn their victims (including children) into zombies²⁷ to work in agriculture (Geschiere, 1994; Niehaus, 2001; Comaroff and Comaroff, 1999) and they (the zombies) are also transported to any place where they can help accrue wealth for their owners (Comaroff and Comaroff, 1999:279-303). The use of zombies is believed to be the secret behind the wealth of new entrepreneurs (Geschiere, 1997). One of the most revealing ethnographies on how people are turned into zombies is that written by Wade Davis. In his study on Haiti in the early 1980s, he says that substances which induce a lethargic coma, indistinguishable from death, are administered to the victim. Once this person is buried, the *bokor* (priest) comes to the grave, calls the victim and administers an antidote, and he (the victim) is taken away to distant places to work on plantations, believing that he has been raised from the dead as a zombie (Davis, 1986).

Sorcery medicines can also be used to cause illness and misfortune. These medicines are either added to someone’s food or placed/buried in the path or doorway (Colson, 2000; Niehaus, 2001); sometimes the process is accompanied by an invocation. Passing over these medicines makes the targeted individual sick or to encounter misfortunes. Harmful substances can also be mixed with nail parings, urine, faeces, hair, clothes and footprints, and consequently cause disease and misfortune to befall the person from whom these things were obtained. Because of the fear that these things can fall into the hands of warlocks, in many African societies – e.g. the Kikuyu (Kenyatta, 1938), the Shona (Gelfand, 1964a), and the Chewa (van Breugel, 2001) - people are encouraged to dispose of them properly. In the case of children, the loss of

²⁷ Comaroff and Comaroff define zombies as persons who are thought to have been killed and revived by witchcraft (1999).

soiled diapers is a major cause of concern, as witches can use them to perform their evil work on the child (Ashforth, 2000:106). During the socialisation process, African children are taught to cover their excrement with soil in order to prevent witches from tampering with their faeces and in the process causing illness or misfortune. It can etically be argued that these are in a way good public health practices that are sanctioned by supernatural beliefs.

Witchcraft operates where there is ill-feeling and acts of witchcraft are seen as motivated by hate, envy, greed or jealousy (Evans-Pritchard, 1976; Ashforth, 2000; Niehaus, 2001). It therefore seems rational that witchcraft accusations should be made within a limited locality, e.g. among kin and neighbours (Evans-Pritchard, 1976). Someone who is far away can usually not be affected by acts of witchcraft. Since witchcraft acts within a certain distance, a man who believes that he or a member of his family is (being) bewitched, may leave his area and go elsewhere, so that the witchcraft cannot follow him (Evans-Pritchard, 1976). However, there is need to take cognisance of Colson's views that new and advanced techniques of witchcraft are always emerging (e.g. the use of witchcraft aeroplanes to fly to distant places) and these are regarded:

“as effective over greater distances, reflecting awareness of new technology, increased dispersal of kin and increased geographical mobility” (Colson, 2000:341).

This explains why in some cultures, for example the Ibibio of Nigeria, the death of a person overseas can also be attributed to acts of witchcraft perpetrated from the home country (Offiong, 1991).

There are not really specific diseases that are caused by witches as these differ from one culture to another. One thing which is common, however, is that illnesses caused by witches tend to defy treatment and are generally chronic or severe in nature. The

existence of witchcraft is a practical reality for many Africans as it explains occurrences which are unexplainable in biomedicine. Anti-social behaviour, such as greed, is frowned upon and, as van Breugel argues, witchcraft therefore serves to maintain moral norms and correct anti-social behaviour (van Breugel, 2001). While African societies view witchcraft as threatening their very existence, they are not wholly disturbed because they know that this supernatural force can after all be domesticated (i.e. it can be countered). The different methods used by societies in Sub-Saharan Africa to protect themselves against the ravages of witchcraft will be considered later.

The breaking of societal taboos as a cause of illness

In African societies, it is believed that diseases and misfortunes can result from the infraction or breaking of cultural taboos. Each society requires its members to adhere to the prevailing taboos. The infraction of a taboo does not always result in the suffering of the transgressor (Richards, 1956:34). In some cases, innocent people are the ones who suffer. Children under five neither know nor understand anything about taboos, hence they are always on the receiving end: they suffer because their parents or other adults have breached a taboo. Different societies have set restrictions, for a variety of reasons, on sexual intercourse. The Shona of Zimbabwe consider it a taboo to engage in sexual intercourse while a child is still breastfeeding because it is believed that the man's semen contaminates his wife's milk, and the child becomes sick after feeding on the contaminated breast milk. A Shona child must be weaned immediately if the mother becomes pregnant because pregnancy pollutes the mothers' milk and if breast-feeding continues, the child will develop severe, bloody and intractable diarrhoea (Gelfand, 1964a). Pool (1994:105) also mentions that when a woman becomes pregnant, she has to stop breastfeeding because the child will suffer from *kwashiorkor* or child's illness. Some anthropologists have argued, from an etic point of view that taboos serve the purpose of social control other than causing specific diseases (Alland, 1970:129).

Apart from the above-mentioned taboos related to sexual intercourse, strict adherence to food taboos form another important strategy for the prevention of disease. For example, Matinga and Munthali found that among the Tonga of northern Malawi, it is a taboo for children to eat eggs because it is believed that if they do, they will suffer from a disease called *chakumutu*, which is characterised by convulsions and seizures (Matinga and Munthali, 2001). In fact, in malaria-endemic areas, such as Nkhata Bay in northern Malawi, the occurrence of *chakumutu* is mostly due to malaria. In LeBeau's study in Namibia she found that among the Herero:

“Children are not allowed to eat the tongue of a cow because they will not respect their elders; neither are they allowed to eat the knee of an animal or they will break their leg” (LeBeau, 1999:169).

This discussion shows that each culture has its own set of taboos that have to be adhered to by its members. It is perceived that the failure to uphold these rules may lead to disastrous consequences. In order to prevent illnesses and misfortunes, it is important that strict adherence to the taboos defined by society, is observed.

Ancestors as a cause of disease and misfortune

“Whenever people introduce ancestors as the cause of illness, I see real living persons hiding behind those ancestors” [a *nganga* in Zaire](Janzen, 1978:51).

There is a general belief in African societies that deceased kinsmen take an interest in the affairs of their descendants (Ngubane, 1977; Gelfand, 1964; Quinn 1979; Hammond-Tooke, 1989), by protecting them against the many ills and misfortunes prevailing in this world. In some cultures, the ancestors are seen as bridging the gap between the living human beings and God and they “intercede for their descendants with God to bring good luck and happiness” (Ingstad, 1989:251). In return for the

protection provided by the ancestors, descendants are supposed to offer periodic sacrifices and they should also uphold tradition (for example religious rites, correct burial structures etc), avoid fighting, quarrelling and indeed any involvement in immoral activities (LeBeau, 1999). Unlike witchcraft, the protection that the ancestors offer goes beyond the village locality and operates everywhere, including the urban areas where their descendants live and work (Hammond-Tooke, 1989). Ancestors can be helpful, but at the same time they can also be very demanding and, if their demands are not met, they can cause misfortune or disease (Friedson, 1996:59). While, in some cultures, ancestors are viewed as causing illness directly, in others it is believed that ancestors do not necessarily send the illness, but instead, once offended, they withdraw the protection²⁸ they provide, thereby subjecting their descendants to vulnerability to illness and sorcery/witchcraft (Hammond-Tooke, 1989; Ingstad, 1989). Ancestors, or indeed foreign spirit(s), may cause illness as a way of calling the afflicted to the profession of "*nganga-ship*", a concept that Reis refers to as "wounded healer" in which a person initially suffers before transforming into a healer (Reis, 2000:61-75; see also Gelfand, 1964b). After recovery, he or she commences the profession. The ancestors called him/her to this profession and his/her powers are derived from them and failure to heed the call by the ancestors may aggravate the illness (see Luck, 2002).

When sickness strikes and persists in the family, members of the family, including the patient, may consult a diviner who may indicate that it is the displeased ancestral spirits that have caused the sickness (Bourdillon, 1997; Waite, 1992). They will also advise and give the appropriate type of therapy required for the patient to recover. We shall see later that, among the Tumbuka, there are also other ways of recognising the afflictions caused by the ancestral spirits.

²⁸ Among the Zulu in such circumstances the ancestors are said "to face away from and give their backs to the descendants" (see Ngubane, 1976:339).

In conclusion, it would be useful to discuss cursing as a cause of illness and misfortune, as, in her work among the Nyole people of Uganda, Susan Reynolds-Whyte explores and links this illness causative factor to ancestors²⁹. All senior relatives exercise parental discipline over children, who are supposed to respect and obey their parents and senior relatives who have authority over them “by virtue of their access to ancestors, land and livestock”. If children do not behaving the way they are expected to do, parents can curse them and they will subsequently encounter disease or misfortune. For a curse to take effect, it has to be made by a parent (a senior blood relative) who has been wronged. While a curse is made by a living person, Reynolds-Whyte says that the power behind these curses is the ancestors, as they are the ones who make curses work. These curses do not need to be explicitly uttered for them to take effect; even feelings can effect a curse. For example, when a parent cries after being abused by his or her child, the ancestors see the tears, and then they can effect the punishment (Reynolds-Whyte, 1997:159). This is not the situation among the Tswana who believe that:

“Living people may also, through their [own] feeling of “sorrow in the heart”, cause *dikgaba* [power] on their descendants if they are not treated well (Ingstad, 1989:251);

thereby causing illness or misfortune. Barrenness in women and the high infant mortality rate among the Nyole have been blamed on curses made by the brothers or fathers of the woman because of non-payment or inadequate amounts of bridewealth paid and the unequal distribution of the bridewealth among those entitled to receive it. Reynolds-Whyte gives the example of a woman who lost 12 children because of being cursed over bridewealth and after the curse was removed and the bridewealth distributed appropriately, the thirteenth child survived (Reynolds-Whyte, 1997:166).

²⁹ Though some of her informants linked cursing to God.

The Tumbuka also believe that the non-payment of *chiwanda*³⁰, which is a component of bridewealth, can also cause the ancestors to “hold the womb” of the woman until such time as everything has been corrected.

The belief in ancestors and what they are capable of doing has been so much internalised by peoples of Africa that these beliefs tend to regulate their behaviour. The fear of punishment for socially deviant behaviour is an instrument for forcing people to behave in a socially approved manner as ancestors tend to sanction behaviour that disrupts society or family ties (Bourdillon, 1997). Such interventions by the ancestral spirits are therefore an important tool for encouraging compliance (see Hammond-Tooke, 1989).

Natural illnesses and “illnesses caused by God”

There are certain diseases that children are supposed to suffer from at a particular stage in their development. A well-known example in most cultures is diarrhoea, which children suffer from whenever they are teething or crawling. Diarrhoea, associated with the developmental stages of an infant, is neither blamed on witches or sorcerers, nor is it blamed on the wrath of the ancestors or the infraction of taboos. The onset of this type of diarrhoea and other such diseases are “merely part of the existential reality of the world” (Friedson, 1996:42) or “part of the expected order” (Gillies, 1976:376) and Staiano uses the term “sickness of the world” to refer to

³⁰ Though *Chiwanda* means ancestral spirit, it is also a form of payment that a man’s family gives to his wife’s family as part of bridewealth. It is usually a cow that is slaughtered and all her patrilineal relatives come together and pray that her marriage should be without misfortune. Everyone participates in the consumption of the meat so that no one should have ill feelings or any resentment against the girl who is getting married. These days the *chiwanda* can either be paid as a cow or in the form of money.

natural illnesses (Staiano, 1981).

In her article, which appeared in 1976, titled "*Aspects of Zulu treatment*" and later in her book "*Body and mind in Zulu medicine*" in 1977, Ngubane, while acknowledging the existence of illnesses caused by ancestors (*amathongo*) and sorcerers and witches (*abathakati*) as discussed above, also describes what she calls natural illnesses (*umkhulane*). She says that these diseases "*just happen*" and do not result from personal malice or the fault of the patient. Western-trained physicians understand such diseases, and they respond quickly to treatment (Ngubane, 1976; 1977). Some anthropologists have called these illnesses of God: not that it is God who sends the illnesses, but that *they just happen* and that there is no moral cause (see Feierman, 1981; Friedson, 1996:42). Among the Maasai of Kenya, epidemics and other serious illnesses are perceived as divine (intervention) punishment from God for wrongdoing; Westerlund argues that such illnesses are also "appropriately" referred to as "illnesses of God" (Westerlund, 1989:185). Illnesses, in fact, seem to have a normal course or progress, but if they do not follow what is perceived as a normal course, then supernatural agencies will be suspected.

A number of anthropologists have listed diseases in different cultures which fall into this category, for example: Ngubane says that diseases related to the growth of children, those due to weather changes like diarrhoea; those [believed by the Zulus] acquired through inheritance, for example epilepsy, asthma, etc (Ngubane, 1976:322; 1977), are perceived as natural.

Diseases that people get as a result of changes in place of residence can also be grouped under natural illnesses. If people stay in one area, they eventually get acclimatised to the environment in which they live and they become ill if they go to a new area because they are not adapted to the new environment (Ngubane, 1977:25). It is in this context that Ngubane discusses the concept of *imikhondo* - which are harmful tracks left behind by animals, people etc travelling from or to distant places.

These tracks are contaminants in the natural environment. According to Ngubane, inhalation or coming into contact (touching or stepping over the tracks) with these tracks results in illness or misfortune. All those diseases that people get as a result of stepping over tracks are collectively known as *umeqo* (Ngubane, 1977:24-25).

In a similar vein, before and after Malawi's independence in 1964, many Malawians went/go to Zambia, Zimbabwe and South Africa, where they work(ed) as migrant labourers in the mines. Gelfand explains that:

"Africans from Nyasaland, coming to work in distant countries, deliberately carry in small boxes ticks (tampan) which they allow to bite them at regular intervals". [They] know that as long as they live with these ticks they will not become ill with fever, but if they are far away from them they are liable to have bouts of it. Being afraid, therefore, of losing immunity, they carry with them these ticks which are allowed to bite them at intervals"(Gelfand, 1964a: 131-132).

It was not only when travelling to distant countries that Africans from Malawi carried such ticks with them. Ransford says that even when travelling away from their village to a nearby village, they also carried ticks from their houses which were allowed to bite them, thus reinforcing immunity (Ransford, 1983:181). Gelfand's and Ransford's description of Malawians carrying ticks with them when going abroad for work is an example of ecological adaptation as a disease prevention strategy.

The above examples of natural illnesses show that in addition to witchcraft and sorcery, disease in African cultures can also be attributed to other causes, of which some are naturalistic in origin. It should also be argued that, through missionary teachings and the introduction of education, many Africans have adopted the biomedical causality concepts e.g. that diarrhoea in children under five is caused by poor sanitary conditions. Brian Morris argues, based on his extensive research in

Malawi, that many illnesses are considered “natural”, especially in the initial stages, and that no causative agent is mentioned or sought (Morris, 1985). Similarly, the Ogori of Nigeria have a strictly naturalistic explanation for certain diseases though such explanations may not be scientifically correct, for example, while biomedically malaria is caused by a *Plasmodium* virus and transmitted by mosquitoes, the Ogori perceive this disease as a form of sunstroke (Gillies, 1976).

There is a need to take cognisance of the fact that these natural illnesses are supposed to respond to treatment, be it herbal or modern medicines, i.e. the normal therapeutic regimen the efficacy of which is beyond doubt. If such illnesses persist or the process of healing is slow, the aetiology may shift from natural causation to social/supernatural causation (Westerlund, 1989:194; Chavunduka, 1994).

*

It is also necessary to take note of what Prins calls the “circular passage” (or the notion of circularity) of disease: when a sick person gets rid of his affliction, he unavoidably places someone else at risk of the disease as the disease has to find another victim (Prins, 1992:347). This is similar to the Zulu conceptualisation, which holds that certain diseases:

“can be taken out of a patient and be discarded as a definite material substance; it may hover around in the atmosphere or remain localised until it attaches itself to someone else. In this way what is removed when curing certain forms of disease renders the environment dangerous” (Ngubane, 1977:26).

This creates the need to “strengthen” oneself and one’s family members in order to achieve protection against such environmental dangers.

A causative factor that has not fully been explored in the above discussion relates to

disease as “divine” punishment. This is especially prevalent among the Yoruba and Egoli of Nigeria who believe that diseases can be caused by the displeasure of or the angering the gods. In the case of the Yoruba, it is the god *Shoppana* (Maclean, 1976:304), while among the Egoli (Gillies, 1976:372), it was the goddess *Iya Okeka* (the great mother) or *Iya Osaka* (the rich mother) who were responsible for smallpox epidemics.

The aetiological classifications as described above are not mutually exclusive; as we shall see later, the cause of a particular disease or misfortune may shift from one classification to another, depending on its response to treatment and as determined by the diviners.

Preventing diseases and misfortunes in African societies

While discussing the aetiology of disease and misfortune in the preceding section, mention was made of some of the ways that are used to prevent diseases in African societies, especially in relation to adherence to rules and regulations regarding societal taboos, the upholding of tradition and the propitiation of ancestors. In the case of the Nyole, Reynolds-Whyte (1997) has emphasised the appropriate distribution of bridewealth as a way of preventing childhood illnesses/deaths and other afflictions (for example, barrenness) affecting women. This section discusses other methods of preventing illness and misfortune, and particular attention will be given to the role of traditional healers and traditional medicine, the African independent churches and biomedicine.

Amulets, incisions and the role of traditional healers

In most African societies, children as well as adults wear amulets which, among other functions, are used for protection against witchcraft and other such supernatural powers. These amulets are worn around the neck, the wrist, and waist, or across the

chest, depending on the specifications and instructions given by the traditional healer/faith healer. In Islamic societies, verses from the Koran are written on pieces of paper (see Holy, 1991; Offiong, 1991)³¹ while Christians write the names of angels, saints and verses, especially from Psalms (Offiong, 1991). The papers are folded and used in the production of amulets for protection against witchcraft. In Islamic societies, priests also write on both sides of a wooden slate and this is washed off with water.

“The collected water [from washing the wooden slate] is drunk by villagers to cure illness, and women's infertility, to ensure safety on long travels, an easy childbirth, success in learning at school ... and to safeguard health and general well-being” (Holy, 1991).

Some people drink such water as a general precaution against disease and misfortune (Holy, 1991) while others use it for curative purposes (Stock, 1985).

While Koranic and Biblical verses are used in the production of amulets in some literate societies, in most cases, plant and animal materials and other substances are used. Gelfand describes how these amulets are made; he says they are used to combat the influence of witches, to confer good fortune, to prevent illness etc:

“It [*zango* – the Shona word for an amulet] has a variety of components including a single piece of root which is wrapped in a piece of cloth together with various small objects, such as pieces of skin, stones or feathers. The edges are stitched together firmly round the contents and the finished article is attached to a string. The colour of the cloth varies. It may be red, blue or white and the *zango*, shaped like a ring or

³¹ In Islamic rural Hausaland, these amulets are known as *laya* and they confer protection on children against many diseases (Stock, 1985).

lifebuoy, is worn around the neck or waist by children” (Gelfand, 1964b:112).

People are not supposed to doubt the effectiveness of the amulets (especially those which incorporate verses from the Koran or Bible) because if they do, it means that they doubt the effectiveness of God. Hence, it is not the amulet that protects, but the word of God that brings about the desired results (Holy, 1991). The failure of other forms of amulets to function as expected is explained in terms of the breaking of taboos that the person wearing the amulet is supposed to follow (see Offiong, 1991).

Most authors who have mentioned amulets as preventive measures have been silent on how these amulets work. Davis-Roberts, writing about the Tabwa of Zaire, says that:

It [the amulet] transforms the patient's appearance in the eyes of those who would attack him, making them see him [in a] kindly [way] or with indifference. It also conceals the patient from those who came to harm him and prevents their magical medicines from crossing his path. Finally it also reflects back to the sender whatever misfortune he may project towards the patient (Davis-Roberts, 1992:388).

In addition to making use of amulets, the making of incisions on peoples' skin and rubbing in of medicine is another method of protection against witchcraft (Friedson, 1996; Jolles and Jolles, 2000). Ngubane says that, among the Zulu, the *umgcabo* (incisions) are made on specific parts of the body that are considered most vulnerable and are thought to be points where evil elements enter the body (Ngubane, 1977). The introduction of medicines into the body through incisions is a technique that has been used for many years to disable witches and sorcerers.

Instead of administering medicines through incisions, some witches and sorcerers were made to drink concoctions. Those who vomited were declared innocent of witchcraft while those who did not were declared guilty (Gelfand, 1964:53)³². Audrey Richards discusses the *Bamucapi*, who were witchcraft finders led by a certain Kamwende from Mulanje in Malawi. They detected witches by catching their reflection in a small mirror that they possessed. Once detected, a witch drank *mucapi* medicine³³, after which he would instantly die if he reverted to his evil practices. Unlike the witch finders who existed previously, the work of the *Bamucapi* was syncretic as they sold their medicines in stoppered chemist bottles, their teaching blended the old and the new (Christianity and biomedicine) and they claimed that their powers came from God. It was also claimed at the time that the *mucapi* removed all the witchcraft (Richards, 1935:449; Marwick, 1950:100) by the reform of the witches and protection of their victims. Waite says that *mucapi* was a replacement for the traditional witch-finding substances, such as the poison ordeal that the colonisers had banned (Waite, 1992).

Later, after the *Kamucape* anti-witchcraft movements, there emerged in Rumphu, in northern Malawi, a great prophet named Chikanga, who exerted influence over millions of people in Malawi, Zambia, Tanzania and Zimbabwe in the late 1950s and early 1960s. Like the anti-witchcraft movements of the 1930s and 1940s, he incorporated elements of the Christian faith, sang Christian hymns and prayed during divination ceremonies. Through divination, he detected witches and neutralised their

³² In East and Central Africa, *mwabvi* was the name given to the poison ordeal, which was basically a drink made from the bark of certain trees (for example *Erythrophlaeum guineense*) and given to suspected sorcerers on the order of secular African authorities (see Waite, 1992; van Breugel, 2001:220). In recent times, for example among the Sotho of the South African lowveld, diviners administer medicines to suspected witches so that they will be driven mad if they practice witchcraft again (Niehaus, 2001).

³³ The medicine was also administered through incisions (Marwick, 1950).

powers through incisions into which 'anti-witchcraft medicines' were rubbed. He claimed that he got his powers from God to cleanse Africa of witchcraft (Holland, 2001; Msiska, 1997). Other prophets also arose in different African countries, whose aim was to eradicate witchcraft, such as, Kajiwe among the Mijikenda of Kenya (Holland, 2001). In addition to these "prophets", Evans-Pritchard (1976) also explains in detail the various roles that oracles and diviners play in the lives of the Azande; especially the consultation of the poison oracle who warns them in advance that danger such as witchcraft or sorcery is looming so that appropriate action can be taken to ward off these dangers (Evans-Pritchard, 1976).

Instead of administering protective medicines to people through incisions and by drinking, strong protective medicines can also be buried within the compound, which can turn away the witches (Friedson, 1996). In Zimbabwe, Chavunduka reports that in areas where there are witch scares, people plant pegs soaked in medicine at each corner of the homestead. It is believed that the pegs will prevent the witch from recognizing the homestead at night during her rounds. The homestead that has protective pegs looks like part of the general landscape (Chavunduka, 1978).

There are thus various means to disable witches and to protect both children and adults against acts of witchcraft and sorcery, such as the use of amulets and incisions; the administration of herbal concoctions; the burying of herbal preparations in the compounds, etc.

The flight of victims and the chasing away of witches

A striking example of flight as a way of preventing the effects of witchcraft comes from Evans-Pritchard's classic book on the Azande in which he says that men will usually leave their homesteads before dawn in order to escape witchcraft, because witches are asleep and will not observe their departure. By the time the witches become aware of their departure, the men will be out of range of the witchcraft, since

the Zande believe that witchcraft only acts within a limited distance. If a man is seen leaving, the witches may bewitch him and some misfortune may befall him on his journey (Evans-Pritchard, 1976). People also migrate to other distant places in order to isolate themselves and their families from the powers and influences of witchcraft. The witch also has to define the direction that needs to be followed by the witchcraft substance or familiar. Evans-Pritchard argues that a victim of witchcraft may withdraw to a shelter of grass in the bush so that when the witch dispatches his witchcraft after him, it will search his homestead in vain and return to its owner. Withdrawal to the shelter in the bush is aimed at eluding the ravages of witchcraft (Evans-Pritchard, 1976).

Another common practice in some African countries is to chase the witch away (Kalla, 1999). One of the reasons for this is probably the belief that, since witchcraft works within a certain distance, the witch will not be able to bewitch people in his or her former village because he or she is too far away. In 1999, hundreds of people were chased from their homes in the Limpopo Province, South Africa, because they were accused of witchcraft (Kalla, 1999). In the same province, Niehaus gives an example of a certain Aaron who was accused of keeping a snake that glowed at night and ate the members of his father's second house. After he was chased from the village in 1975, there were no more suspicious deaths (Niehaus, 2001).

As far as many Africans are concerned, leaving at dawn without being seen or without bidding farewell to your hosts, migrating to distant places, hiding in the bush, and chasing witches away constitute important strategies for protection against witchcraft, and therefore, illness and misfortune.

Tasting your food to prove your sincerity

It is a custom in some African cultures that when you offer food or drink to someone, you must first taste it in their presence in order to prove that you are giving such food

or drink in good faith and that you do not have any hidden agendas. Food and drink constitute the most common vehicles for poisoning or sorcery. Having a sip before you offer someone a drink or eating food with your visitors, even if you have already eaten (and you are full) are common practices among Africans. This is done to insure oneself against future accusations of sorcery. Among the Wimbun of Cameroon, when someone offers palm wine, the host drinks before the guests, and this is a precaution against accusations of poisoning (Pool, 1994). Among the Kikuyu, when offering ritual beer to *Mwene-nyaga* (God), the leading elder sips the liquid from the calabashes to prove to *Mwene-nyaga* that the calabash contains nothing harmful. This behaviour comes from a Gikuyu custom, which requires that anyone giving food or drink, should first taste it to prove his or her sincerity (Kenya, 1938).

For those sorcerers who put poison in food or drink, if the intended victims have preventive medicines, they may neither drink nor take the food because their hands would shake too much; the glass or plate would break or they would vomit if they ate or drank poisoned food/drink (Caplan, 1997:160). These methods are therefore used for protection against poisoning through food or drink.

Membership of African independent churches (AICs)

The emergence of the African Independent Churches in the 19th century, which syncretise traditional African religion with European Christianity, marked a new era in the history of healing and prevention of disease in sub-Saharan Africa. The incorporation and popularisation of the healing power of the Holy Spirit, support and acceptance of indigenous customs, and a caring church community (which replaces the weakening extended family system) are some of the factors that have attracted a lot of African followers into these independent churches (Kiernan, 1996; Bourdillon, 1997), although some of Ashworth's informants in Soweto, Johannesburg, alleged that the Zion Christian Church drew a large membership for the church because of its use of *muthi* (medicine) made from human body parts (Ashworth, 2000). Like the

diviners in traditional African religion, the priests divine, but with the help of the Holy Spirit (Ashworth, 2000; Daneel, 1970). The major difference is that the priests of the AICs rely on the Holy Spirit, while diviners rely on ancestors or other spirits (Daneel, 1970). In addition to divination and healing, these independent churches are also involved in the prevention of disease and misfortune (including those perpetrated by acts of witchcraft and evil spirits), which are not a mainline concern of western Christian churches³⁴. In Nigeria, the African independent churches like Christ Army, Mount Zion, and the Apostolic Faith are, among other things, involved in “rescuing people from witch attacks and other malevolents”. Charms, whose powers are derived from the Holy Spirit, are prescribed for the purposes of warding off or exorcising diseases caused by witchcraft and evil forces. These charms can be obtained locally and manufactured from materials from sacred forests. They can also be obtained by mail order from Europe and the United States of America (see Messenger, 1970; Offiong, 1991). In the case of Rev. Samuel Mutendi’s Zionist Christian Church in Zimbabwe, the wearing of sanctified cloth around the neck shielded people against the evil spirits (Daneel, 1970). In South Africa, the Zion Christian Church fortifies houses against witchcraft (see Niehaus, 2001:3) and administers individual protective medicines (Ashworth, 2000).

Van Dijk says that members of the Pentecostalist movements in Malawi perceive prayers as:

“a method of putting in place spiritually protective walls against witchcraft”
(van Dijk, 2001:103).

³⁴ The Roman Catholic and Anglican liturgies include services of exorcism to drive away evil spirits, but they are performed only under very strict conditions, for example, under the Bishop’s authority.

Like diviners, priests in Pentecostal churches such as the Miracle Power of God in Blantyre, are able to identify those who practice witchcraft and those who have been affected by it (van Dijk, 2001). The large number of followers that the African Independent Churches have, would seem to be largely because of their propensity to incorporate traditional beliefs as explained above. Making Christianity indigenous rarely goes beyond the practices recorded in the Acts of the Apostles.

Cultural re-interpretation of pharmaceuticals

Van der Geest argues that the pharmaceuticalisation of health and health care is a worldwide phenomenon which is particularly pronounced in the developing world. He claims that pharmaceuticals tend to undergo a process of cultural reinterpretation to fit indigenous conceptualisations of medicines, health and health care (van der Geest, 1998). The (mis)use of pharmaceuticals in the developing world to prevent diseases is a well-known phenomenon. The general lack or scarcity of medicines in the public health service and the advice that patients get when they visit hospital facilities about purchasing biomedical medicines is one of the factors that have led a lot of people to go directly to the source of drugs without bothering to go to the government health institutions first (Reynolds-Whyte, 1998). Some western medicines have been appropriated into indigenous African medical systems; and because of their specific attributes, these medicines are being used to treat or prevent "African illnesses". In South Africa, the pharmaceutical "*doepa*", because of its offensive strong smell, has been indigenised and is very widely being used to ward off evil spirits. This, as Cocks and Dold argue, is because "traditionally strong smelling substances have been used for such protection" (Cocks and Dold, 2000:1510). Among the Hausa of Nigeria, wounds are associated symbolically with the colour red and hence red coloured antibiotics are selected for the treatment of wounds (reported in Cocks and Dold, 2000).

In some cases, successful experiences with antibiotics during illness episodes have led

people to consume them periodically in order to prevent further illness - see Wolf-Gould et al for the misuse of Chloramphenicol to prevent typhoid attacks (Wolf-Gould et al, 1991). The use of pharmaceuticals for the prevention of diseases has been reported elsewhere in Africa, for example in Ghana (van der Geest, 1998; see also Radyowijati and Haak, 2002) and in Ivory Coast (Alland, 1970). The reinterpretation of western pharmaceuticals is not a new phenomena in the developing world. As early as 1895, people demanded “missionary medicine” to make them stronger (see Vaughan, 1991:60).

The use of antibiotics has been incorporated into African folk medicine and they are (mis)used for a variety of conditions, including the prevention of diseases. While such a reinterpretation and use of pharmaceuticals may be dangerous and diverges from biomedical rationality, they are not irrational actions when examined within the rationality of the context in which they are used. This rationality builds on the comparison between traditional medicine (for example colour and taste) and western medicines, as the example of *doepa* above illustrates. Traditional medicine may associate specific physical characteristics with particular medical properties, because of parallels between the physical characteristics of the medicine and the nature of the illness e.g. red medicines for blood diseases.

Biomedical methods of disease control: the case of vaccination in children under five as a disease control measure

The discourse on the prevention of disease in African societies, which centres primarily on the different strategies discussed above, is not a complete treatise as it leaves out the different biomedical methods of disease prevention that have been introduced in these communities, and which have been appropriated. While there are a number of biomedical methods of preventing diseases, for example cleanliness, a balanced diet, use of insecticide-treated mosquito bed-nets etc, this section will mainly look at the prevention of childhood diseases using vaccinations, as this is an

important method, particularly in children under five. It is now approximately 28 years since the World Health Organisation (WHO) launched the Expanded Programme on Immunisation (EPI); however, this was introduced in various countries in the developing world at different times, and as Wright points out, “with the intent of taking vaccines of demonstrable value from developed (countries) to developing countries” (see Wright, 1995:609). Though some new vaccines have been introduced, initially only vaccines against diphtheria, pertussis, tuberculosis, measles, poliomyelitis and tetanus were included in the EPI programme (Wright, 1995; Hall et al, 1990). These diseases posed a great public health problem, especially in the developing world: e.g. globally, vaccine preventable diseases were estimated to cause over 3.2 million deaths and 246,000 cases of paralytic poliomyelitis in 1987 (Wright, 1995:610).

While vaccination coverage rates in Africa in the early years of the Expanded Programme for Immunisation were low (see Wright, 1995), some countries have made considerable progress and have since achieved high coverage rates. For example, an evaluation of the EPI programme in Malawi in 1980 showed that the percentage of fully immunised children ranged from 20 per cent to 39 per cent (see Chilowa and Munthali, 1999). In Sierra Leone, vaccination coverage rates for the different antigens in 1975 were less than 15 percent (Amin et al, 1992:852). It was not only in Africa that EPI coverage rates were low. In the Philippines, the EPI coverage for children aged under 3 years was 25 percent (Auer and Tanner, 1990:1265). Table 5.1 shows the vaccination coverage rates for different antigens in Africa in 1994.

Table 5.1: Percentage of Children vaccinated in Africa by the age of 12 months in 1994 (Source: Wright, 1995:609-616)

NAME OF ANTIGEN	PERCENTAGE OF CHILDREN IMMUNISED BY THE AGE OF 12 MONTHS
BCG (Vaccine against tuberculosis)	68

DPT 3 (Vaccine against diphtheria, pertussis and Tetanus)	52
POLIO 3 (Poliomyelitis vaccine)	51
MEASLES (Measles vaccine)	51

It can be seen from Table 5.1 that the coverage rates for 1994 were much higher than those in the 1970s and 1980s. This is probably due to the intensive health education campaigns regarding the importance of vaccinations and the subsequent experiences of mothers regarding the reduction in incidence of vaccine-preventable diseases. Table 5.2 shows the vaccination coverage rates for the Southern African Development Community (SADC) countries in 1999 for children aged one year. With the exception of Angola and the Democratic Republic of the Congo (DRC), other countries in the SADC have much higher vaccination coverage rates compared to the situation in 1994. Angola and the DRC have low vaccination coverage rates probably because of the civil war raging in those countries, which makes accessibility and delivery of vaccination services to the target population problematic. Vaccination coverage in other war torn countries (outside the SADC) like Somalia, Ethiopia, Sierra Leone and the Sudan is also reportedly low (see Table 5.3). In Sierra Leone, the impact of the war is apparent: vaccination coverage for DPT, Polio and BCG in the early 1990s were at more than 70 percent, while that of measles was at 62 percent (Amin et al, 1992). In 1999, as can be seen from Table 5.3, the coverage rates for DPT and BCG had been considerably reduced.

Table 5.2: Percentage of One Year-Old Children Who Received BCG, DPT, OPV and Measles Vaccines in 1999 in SADC Countries (Source: UNICEF, 2002)

SADC COUNTRIES	ROUTINE EPI % VACCINES FINANCED BY GOVERNMENT	PERCENTAGE OF ONE YEAR-OLDS IMMUNISED IN 1999			
		BCG	DPT	OPV	Measles
Angola	0	52	22	46	46
Botswana	100	97	90	92	86
DRC	0	30	25	21	15
Lesotho	25	95	85	82	77
Malawi	2	84	84	74	83
Mauritius	100	86	85	85	79
Mozambique	10	84	61	56	57
Namibia	100	80	72	72	66
Seychelles	0	99	99	99	99
South Africa	100	97	76	72	82
Swaziland	100	97	99	97	82
Tanzania	10	87	76	74	72
Zambia	0	94	84	85	90
Zimbabwe	100	88	81	81	79

Table 5.3: Percentage of One Year Old Children Who Received BCG, DPT, OPV and Measles Vaccines in 1999 in Some War Torn Countries outside SADC (Source: UNICEF, 2002)

NAME OF COUNTRY	ROUTINE EPI % VACCINES FINANCED BY GOVERNMENT	PERCENTAGE OF ONE YEAR-OLDS IMMUNISED IN 1999			
		BCG	DPT	OPV	Measles
Ethiopia	18	46	21	35	27
Sudan	25	65	50	50	50
Somali	0	39	18	18	26
Sierra Leone	0	73	46	61	62

While some of these coverage rates are impressive, there is still a need to improve on them and sustain the high rates. One of the major challenges of the EPI as Wright (1995) and others have pointed out is the funding of EPI activities. In the SADC, out

of 14 countries, it is only in South Africa, Namibia, Swaziland, Mauritius, Botswana and Zimbabwe that the Government fully funds the purchase of vaccines used during routine EPI activities. In other countries, either the vaccines are wholly financed by external agencies such as UNICEF (for example in Zambia and Angola) or host countries contribute a percentage to the total cost of the vaccines. Though there are developments in which poor countries are being urged to contribute incrementally towards the purchase of vaccines and eventually to completely take over, UNICEF has categorised countries according to GNP/capita and total population size. Those countries that have been placed in Band A require continued external support, otherwise EPI programmes would collapse (see Chilowa and Munthali, 1999). In addition to increases in vaccination coverage as an indication of the success of EPI, the other indicator is the reported decrease in the prevalence of vaccine preventable diseases, as reported in some studies (Amin et al, 1992; Chilowa and Munthali, 1999).

Despite the successes of the EPI programmes, it is important to note that there has been some resistance to vaccination. The reasons for such resistance include: children developing vaccine preventable diseases even after being vaccinated against them; beliefs that vaccines are meant for family planning and not disease prevention; and the belief that only God has the power to protect people against diseases (see Chilowa and Munthali, 1999; Nichter, 1995; Streefland and Egers, 1997). Some of these concerns are not new as they were also raised during the colonial period with regard to vaccination against smallpox (see Vaughan, 1991; Chilowa and Munthali, 1999). The concerns of the target population need to be addressed in order to increase social demand for these vaccines, as such demand is one of the most important factors affecting sustainability of high vaccination coverage rates.

Conclusion

This chapter has in general discussed the aetiology and prevention of disease in sub-Saharan African countries. What is apparent from this literature review is the

“difficulty” of disentangling illness causality factors and prevention methods which are only applicable to children from those applicable to adults. Witchcraft, the wrath of the ancestors, the breaking of societal taboos and natural causes can all be responsible for illness causation in both children and adults, and methods of prevention are also similar. As regards ancestors and taboos, children under five are in general victims as they may not be able to displease ancestors or even break taboos.

It cannot be denied that African societies have changed considerably over the years since contact with people from other parts of the world. The interaction has generally led to the introduction of western scientific ideas about not only the causation and prevention of disease, but the treatment of disease as well. As shall be seen in Chapter 6, during illness episodes, a range of therapeutic alternatives are available to which people can resort: they may choose to self-medicate with herbal concoctions or western pharmaceuticals; consult traditional healers (herbalists, diviners and other experts in indigenous healing strategies); or they may go to biomedical health facilities such as dispensaries, clinics and hospitals (see Feierman, 1985; Awusabu-Asale and Anarfi, 1997). Biomedical health facilities may be private or may belong to the State. There are also the *malamai* (Islamic scholars) who practice medicine based on the use of Koranic texts (Last, 1992) and the healing power of Allah (Stock, 1985). In addition to these options, in Africa today there also exist African Independent Churches e.g. the Zion Christian Church (ZCC), which also offer healing services to their members. Given all these therapeutic options, what, therefore influences choice of therapeutic assistance during illness episodes?

CHAPTER 6

UNDERSTANDING HEALTH-SEEKING BEHAVIOUR IN AFRICAN SOCIETIES: A CONCEPTUAL FRAMEWORK

Introduction

The major concern in this chapter is to develop a conceptual framework for understanding the decision-making processes regarding therapeutic choice. Our hypothesis is that, while theories of disease causation (as discussed in the last chapter) and other micro-level factors such as age, educational attainment, distance to health facilities, availability of medicines, etc play a role in people's choice of therapy, there is also a need to recognize that these factors do not operate in isolation, as there are wider macro-level factors (such as overall government policies, national health education campaigns, allocation of resources, etc) that have an impact on what occurs at the micro-level. In addition to this, the choice of therapy consists of, not random, but ordered processes that are dependent on prevailing situational contexts, as will be illustrated in this chapter, as well as in the ethnographic case studies of childhood diseases among the Tumbuka.

Some therapeutic options available in African societies

Herbalists and diviners

In African societies, there exist different forms of traditional healing. First, there are herbalists, whose healing prowess is founded on their knowledge of the medicinal functions of particular plant and animal species (Ingstad, 1989). These people may practice traditional healing as a part-time profession. The term "herbalist" is, however, a misnomer, as it implies that the "practitioners" only make use of herbal pharmacopoeia. Chavunduka has criticised the use of this term, citing as the reason

their “use of other ingredients, as well as animals, insects and birds” (Chavunduka, 1994:8). Unlike diviners or spiritual healers, herbalists are not guided by any spirit either in their administration of therapeutic regimens, or in their choice of plant and animal species, but they acquire medicinal knowledge through informal learning from a close family member, or the inheritance of a father’s or other relative’s trade (see Du Toit, 1985a; Offiong, 1999). Herbalists administer their medicines based on symptomatology and when this fails or is insufficient, people try to identify (e.g. through divination) the cause of the symptoms (see Reynolds-Whyte, 1998).

Unlike herbalists, diviners are called to the profession through a dream or (often serious) illness, after which they undergo apprenticeship as diviners (Ulin, 1979; see also Yoder, 1981; Reis, 2000). Reynolds claims that diviners may draw their powers from ancestral, family or foreign spirits (Reynolds, 1996). Diviners are usually involved in dealing with those illnesses that are generally severe in nature. One of the challenges facing illness episodes in African societies is to determine the agent responsible for the illness. Without knowing the responsible agent, even if therapy is sought and administered, the patient may not get well, because the root cause of the illness has not been addressed. After determining the cause of illness, diviners may then recommend the appropriate therapeutic course to be taken.

The nostrums used by traditional healers to cure illness consist of concoctions of plants (leaves, roots or barks), stems, bulbs, fruits, flowers and animal parts. Sometimes the power of these medicines can be released by invocation. The patient can take these medicines through the mouth, apply them as lotions on the skin, rub them as powder into skin cuts, through inhalation or as enemas, etc (see Ransford, 1983). While traditional healers may administer herbal concoctions that are effective in the treatment of disease (see Morris, 1986; 1985), in some cases, as Yoder argues, they tend to associate some characteristics of the indigenous medicine either with some aspect of the illness, or with a desired action by the patient. He gives the following example of this association in the treatment of epilepsy:

“A certain type of beetle is used in the medical preparations for epilepsy (*cikonya*), for just as this beetle curls up and plays dead when frightened, so should the epileptic curl in upon himself and stop flailing about.” (Yoder, 1981:239).

As we will see in the case studies of childhood illnesses among the Tumbuka, such associations do not only occur in therapeutic processes, but also in theories of causation and prevention of illness. While herbalists and diviners can be consulted during illness episodes, people in both rural and urban areas also possess a wealth of medical knowledge about medicinal plants, and they are often able to treat themselves and members of their families. Every adult person has some knowledge of herbal remedies (or western medicines, as we shall see below) that they can use to cure certain diseases. Hence, for minor illnesses, they are more liable to self-medicate, without necessarily consulting other therapeutic alternatives (see Alland, 1970; Morris, 1985; and Westerlund, 1989).

In conclusion, it is important to note that while people might indeed choose traditional healers for therapy, in some cases it is traditional healers who at the end of the day may advise patients to seek care from the hospital, for various reasons: either because they have failed, or because the disease requires hospital treatment, or they fear the police if the patient dies in their compound (see Frankenberg and Leeson, 1978). At the same time, while people might choose biomedical health care, sometimes health professionals may well advise them to try traditional medicine.

The purchase and use of pharmaceuticals from local grocery shops

Apart from using herbal remedies, people also use (western) pharmaceuticals as a way of self-medication. These pharmaceuticals can be obtained from licenced pharmacies, medical institutions such as hospitals and health centres, shopkeepers,

roadside stalls and hawkers (Radyowijati and Haak, 2002). One of the reasons why people go to (formal and informal) pharmacies is the general shortage of medicines in public hospitals and health centres. In most cases, registered pharmacies are situated very far from rural villages, and, as a consequence, people resort to the informal sector for access to western medicines. The informal sector is in general within reach, available 24 hours a day, and medicines are even sold one tablet at a time, which registered pharmacies may not do (van der Geest, 1985; Reeler, 1996). The services offered by the grocery shops are generally quick, the social distance between the provider and the client is reduced, and it is less stressful as traders are usually acquaintances (Wolf-Gould et al, 1991; Reeler, 1996). In addition, customers also buy what they want without being questioned further (Reeler, 1996; Wolf-Gould et al, 1991; Cocks and Dold, 2000). Radyowijati and Haak have also further argued that self-medication with antibiotics is influenced by factors such as “lack of access to appropriate health care, poverty and stigma associated with having certain illnesses” (Radyowijati and Haak, 2002) such as sexually transmitted diseases. Although it may be argued that there is no privacy if one is known by the shopkeeper, privacy is maintained in the sense that the client will just buy the medicine without revealing what he or she will use it for.

Despite the fact that the informal traders do not have any formal training in pharmacy, they stock a wide variety of pharmaceuticals (Wolf-Gould et al, 1991), and as has been shown in Chapter 4, these medicines include antipyretics, antibiotics and anti-malarials (see van der Geest, 1985). Although in the western world some of these medicines are supposed to be obtained by prescription only, in developing countries they are purchased over-the-counter in the informal sector. One problem with the widespread misuse of pharmaceuticals (and especially of buying a few tablets at a time) is the development of resistant strains of micro-organisms (Radyowijati and Haak, 2002; van der Geest, 1985). A number of such cases have been reported in the developing world; for example, the development of Chloroquine-resistant parasites

(see Molyneux, 1988; also Abdulla, 2001) may, among other factors, have been promoted by the misuse of Chloroquine.

In certain circumstances, while western-trained medical personnel may be available, the widespread use of medicines suggests that people seem to have placed more confidence in western *medicines* than in western or western-trained *doctors* (Hardon, 1987). While there are disadvantages surrounding the sale of drugs by the informal sector, van der Geest has argued that the informal sector for drug distribution in developing countries “meets community needs and that realistic reforms should not aim at its liquidation” (van der Geest, 1985). While community needs, such as healing and protection against diseases, may not actually be met (as the consumption of wrong medicines cannot cure a person), what actually is met in this context is the community’s need for easy access to (cheap) medicines that would otherwise be very expensive in formal pharmacies and are not usually available in government health facilities.

Biomedical health services (health centres and hospitals)

Biomedical health services were introduced in Africa by missionaries and colonial administrators. Initially, missionaries and their missions delivered more health care services to African communities than did the colonial governments. They established hospitals, trained African medical personnel and dealt with chronic illness and epidemics until the period between the 1930s and 1960s when colonial (or independent) government medical services reached rural areas (Vaughan, 1991). While the introduction of biomedicine in African societies has led to the curbing of many indigenous African illnesses, colonial incursion has also been blamed for the introduction of measles and whooping cough and the exacerbation of the spread of smallpox as a result of the movement of people as porters, labour migrants, soldiers, etc (Ranger, 1992). Missionaries and colonial administrators denounced the magico-religious character of African medical systems, and consequently the Witchcraft

Suppression Acts, which were passed by some colonial states, banned witch-finding and witchcraft (Waite, 1992). Missionary medicine, in a way, was perceived as a tool to convert or draw the African patient to the love of God. Long-term periods of hospitalisation afforded the missionaries opportunities for evangelism; and Vaughan claims that some patients were coerced to stay in hospital even after getting cured, in order to win their souls (Vaughan, 1991). In some cases, after demonstrating the superiority of European medicines, children wearing amulets were denied biomedical treatment (Ranger, 1992) as a way of coercing parents to accept Christianity and abandon the traditional forms of religion and way of looking at disease.

After independence, the new African leadership inherited the colonial health delivery machinery and expanded it in the rural areas. It is this machinery that is recognised and supported by African governments, though in some countries such as Zimbabwe and Ghana, there have also been attempts to professionalise and integrate traditional medicine (see Chavunduka, 1994 and Ventevogel, 1996 respectively) with western medicine. Although independent African states have inherited the colonial and missionary medical systems and these services have contributed significantly to the containment of disease, it has been found that there are a lot of problems being faced by public health systems. The delivery of public biomedical health care services is severely hampered by, among other factors, lack of funds, poor quality of patient care, nurses' negative attitudes, shortage of vital drugs and limited availability of specialised care (LeBeau, 1999:124). Poor or inadequate transportation and physical accessibility problems (especially where there are no all-weather roads) greatly limits people's access to health care services (Ademuwagun, 1979; Kloos, 1990). In addition to public health services, there are also private clinics that offer health services at a fee. However, the major deterrent to the use of these private clinics is cost.

The healing powers of the African independent churches (AICs)

“... the Zionist Churches recruit large numbers as a result of their prophetic healing activities” (Daneel, 1970:12).

Although they were not necessarily a component of the initial African traditional healing culture, the 19th century saw the establishment of the African Independent Churches, as explained earlier in Chapter 5. These churches are popular among Africans because they have incorporated elements of African traditional forms of healing into the church. It has been argued that the large numbers of people who, for example, thronged Prophet Kimbangu’s meetings in the Congo were presumably there because of the healing of the sick rather than the gospel (Daneel, 1970:16; see also Pemberton, 1993; Peltzer, 1999 and Maxwell, 1995 for other AICs). As Ingstad points out, the prophets (*maprofiti*) base their healing practices on concepts of sickness and misfortune that are traditional to a large extent (Ingstad, 1989; see also Maxwell, 1995). Though some healers in the Zion African Church in South Africa may use herbal remedies, in most cases, they heal by laying hands on the patient, washing with or drinking blessed (holy) water, through prayer and sacrifices (Peltzer, 1999; Du Toit, 1985). The prophets draw their source of revelation from the Holy Spirit (Chavunduka, 1994) and the power of God (Peltzer, 1999). For those who use herbal remedies, there might be a need to activate them by religious rituals and faith (Du Toit, 1985):

Although there are reports that other AICs use herbal medicines, Daneel reminds us that the use of medicines (for example in the Reverend Samuel Mutendi’s Zionist Church in Zimbabwe) is not allowed, and visits to the hospital for medication are considered “as a lapse in the spiritual life (*kuheduka*), a form of infidelity” (Daneel, 1970:53). Healing is therefore an important element in these AICs.

*

Before the coming of missionaries and colonial administrators, African peoples in addition to self-medication with herbs, also relied on consulting herbalists and diviners during illness episodes. Nowadays there exist a multiplicity of therapeutic options which comprise, not only:

“multiple choices of therapy, but also multiple categories of healers, multiple conceptions of disease and illness” (Slikkerveer, 1990:14).

The therapeutic options available (as discussed above) include herbalists, diviners, purchasing of medicines from local shops, biomedical health facilities, African independent churches etc. Figure 6.1 below illustrates that these therapeutic options have been divided into three categories, namely: AICs; indigenous medicine, which comprises herbalists, diviners and self-medication with herbs; and biomedicine, which comprises of self-medication with pharmaceuticals, visiting local health centres and hospitals. In such pluralistic medical systems, patterns of resort, which Young defines as “the paths people make as they pick and choose their ways from one sector of the medical system to another, in pursuit of diagnosis, cures, and other medical services”, can either be simultaneous or sequential (Young, 1983), as will be discussed later. While this thesis looks at the aetiology and prevention of disease, another of its major concerns is to understand the therapy-seeking process during childhood illness episodes; this calls for the development of a conceptual framework that may help us to understand the cultural and other factors that may influence therapeutic choice.

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Factors affecting decision-making in choosing therapy in African societies

As will be discussed in this section and as can be seen in Figure 1 below, there are a

number of factors that influence choice of therapy in African societies. Some studies, which have correlated variables such as age, sex, literacy and wealth with patterns of health care, have shown that people:

“who are more acculturated to western standards (younger, wealthier and more highly educated) will be more likely to use western medical facilities [at least as a first resort] than will individuals who are less acculturated ... i.e. older, poorer and less well educated” (Mathews, 1998:125).

Mathews argues that although such correlational studies are important, they are nevertheless not very useful in explaining *why* people choose western medical facilities (Mathews, 1998:125). Some studies have shown that educated people also believe in the existence of African illnesses (see definition of African illnesses below), for which they also consult traditional healers (Azevedo et al, 1991). The professional, after all, is also a kinsman and, though educated and acculturated to western standards (i.e. with a belief in the efficacy of western medicine), the persistence of illness may nevertheless pressure him/her to accept the decision-making process of the therapy management group, i.e. friends, relatives, neighbours, etc (Janzen, 1978). Janzen reaches this conclusion with reference to a professional health worker in Zaire, who, after the consumption of antibiotics did not cure him, had to succumb to the decision-making process of the therapy management group. Often educated people may use traditional healers as a last resort, especially where physicians have failed to cure the illness (Dennis and Harrison, 1979). In addition to the demographic factors, i.e. age, educational level, socio-economic status, etc, there also exist other factors that influence decisions regarding therapy choice.

Theories of causation as guiding principles for the therapy-seeking process

As has been said earlier, missionaries and the colonial administration introduced biomedicine in African societies. This task was later (especially after World War II)

also taken up by the World Health Organisation and international aid agencies, such as USAID. At that time, emphasis was placed on indigenous beliefs and practices (Morsy, 1990) and it was held that with health education and the demonstration of the effectiveness of biomedical therapeutic and preventative interventions, Africans would abandon their indigenous approach to disease (see Fraser, 1923; see also Vaughan, 1991) and embrace the biomedical model. The abandonment of health-related cultural beliefs and practices (so it was argued) would reduce the public health problems in African societies (see Onoge, 1975). However, from the discussion on the aetiology and prevention of disease in African societies in the previous chapter, it is apparent that witchcraft and sorcery, displeased ancestral spirits and the infringement of societal taboos are still considered as important causes of disease and misfortune. Foster and Anderson have argued that these health and illness beliefs:

“are part of the innermost being of every people and cannot be cast aside lightly” (Foster and Anderson, 1978:226).

Independent African governments, together with international aid agencies, have played an important role in the eradication of epidemic diseases as well as the improvement of water and sanitation in the developing world. While this is the case, it should be pointed out that these public health campaigns have at times not been as successful as intended because of “what development specialists have called *cultural obstacles*” (Joralemon, 1999:10). Because they are considered as cultural experts, anthropologists have been employed by governments and international aid agencies:

“to analyse what happens when innovations are presented to recipient peoples, and by evaluating projects that have been completed, ... to work out guidelines for future planning and programme implementation” (Foster, 1969:13).

This applied work done by anthropologists has included studying how the existing

beliefs and practices may affect the implementation of public health programmes. In this context, the major task of the anthropologist is to identify cultural obstacles to biomedical health care. Such a perception is biased as it assumes that “biomedical health care” is inherently superior and that alternatives are obstacles to health. One of the reasons why public health programmes in African communities have sometimes foundered is that at times such programmes have been or are viewed by recipient peoples as in conflict with their existing cultural beliefs and practices. It may suffice to give a few examples in which conflicts between biomedicine and indigenous beliefs, or what Joralemon (1999) calls cultural obstacles, have negatively affected the implementation of public health programmes in African societies.

As we have seen, witchcraft and sorcery are still considered important causes of illness in African societies and some of the ingredients used in the process of preparing sorcery medicines include clothes, nail pairings and the faecal matter of the targeted individual. This is why in many African societies, through the process of socialisation, people learn for example to dispose of faecal matter properly, out of fear that witches might tamper with them (faeces) and consequently cause illness or misfortune (see Kenyatta, 1938; Gelfand, 1964; Ashforth, 2000; see also Munthali, 2002). A study carried out among the Zulu of South Africa in the 1960s found that, while home gardening and compost pit programmes were fairly successful, a pit latrines project was less successful. This was because the Zulus believed that someone would bewitch them through their faeces if they defecated in one place, preferring instead to defecate in the bush, as long as it was hidden from public view (Kark and Kark, 1963, quoted in Foster and Anderson, 1978). Although biomedically the disposal of faecal matter in pit latrines is one way of controlling vector born diseases, such as diarrhoea, cultural beliefs in witchcraft, sorcery and such other supernatural forces may work against the success of such programmes.

In malaria prevention programmes, some studies have shown that pregnant mothers in some cases are reluctant to take Chloroquine tablets because their bitter taste is

associated with traditional medicines that are used to induce abortions (Foster, 1995) and that in some places, such as KwaZulu-Natal, some of the anti-malaria drugs, such as quinine, were in fact believed to cause malaria (Brain, 1990). In situations like these, it is highly unlikely that the target group of people will adopt such health programmes.

We also saw earlier that, although biomedicine promotes breastfeeding when the mother is pregnant, this is not allowed in some African cultures, because of the fear that it might cause the child to suffer from diarrhoea (see Gelfand, 1964; Munthali, 2001). While eggs are one of the foods commonly found in rural areas in Africa, children and pregnant mothers are sometimes prohibited from eating them. For example, among the Tonga of Nkhata Bay District in northern Malawi, children are not allowed to eat eggs because of the belief that they may suffer from convulsions as a result (Matinga and Munthali, 2001; see also Munthali, 1999; 2001). Msukwa has also reported that in Kasungu District in central Malawi, children are also prohibited from eating eggs because they believe that they may suffer from epilepsy (Msukwa, 1981:12). Such beliefs tend to rob children of an important source of protein. Hospital personnel, who are agents of biomedicine, generally promote the idea that children under five should eat eggs, which is in contrast with the indigenous beliefs.

It is not only in Africa that culture has been seen as an obstacle to the implementation of public health programmes. Joralemon gives an example of Wellin's study in Peru where it was found that, although biomedically the boiling of water is important to prevent waterborne diseases, people did not boil water because of their belief in the hot/cold conceptualisation of disease. Boiled water was perceived to be potentially harmful and hence Wellin's informants believed that it had to be drunk only to counter illnesses perceived to be caused by exposure to what were conceptualised as cold forces (Joralemon, 1999).

What is apparent in these examples is the existence of conflicts between indigenous

ways of thinking and biomedical explanatory models. An emphasis on such conflicts characterises what Foster and Anderson refer to as the *adversary model* (Foster and Anderson, 1978:226). This model, as can be seen from the above examples, and as we shall see later when dealing with the Tumbuka 'disease worldview', is still relevant to medical anthropological studies today, but it has been criticised because it fails to explain medical modernisation. McCay says that:

“a new perspective emphasises the pragmatism of the consumer, the adaptability of the traditional practitioner, and a certain flexibility whereby health beliefs, interwoven with other dimensions of life, are retained, while health behaviours change radically.” (McCay, 1980:147).

Behavioural change, including changing health behaviour and beliefs, is a long-term process. While initially people might reject innovations in preventive health and therapeutics, they may, with time, eventually accept such innovations, depending on a number of factors, including the demonstration of the efficacy of the new biomedical measures being introduced.

It cannot be denied that sociocultural factors play an important role in the way people seek treatment and disease prevention measures. Anthropologists have argued that peoples' health-seeking behaviour (to a large extent) depends upon their understanding and interpretation of the causes of their illness (Awusabo-Anarfi, 1997). To give an example: since childhood convulsions among the Tonga are attributed to the consumption of eggs, such children may not be brought to the hospital for treatment; traditional medicine is preferred instead. As discussed earlier, a number of disease-causing factors are recognised in African societies. Based on these theories of causation, some scholars have classified diseases into those that can be cured by recourse to traditional medicine (African illnesses) and those that can be

cured by using European medicines (western diseases)³⁵ (LeBeau, 1999). In terms of causality, “African” illnesses are those that people perceive to be caused by sorcery, witchcraft, curses, the breaking of societal taboos and the wrath of the ancestors. All these at one level relate to bad relationships. As Morris points out, the use of herbal medicines in such circumstances is deemed unnecessary or secondary because the most urgent thing is “the ritual procedures that seek the underlying aetiology of a disease or misfortune” (Morris, 1985:34; also see Ashforth, 2000). It is important that, in such circumstances, diviners should, for example, “detect these illnesses and counteract the power of witchcraft and remove objects sent into the body” (Yoder, 1981:241). In the case of diseases caused by displeased ancestors, while (herbal/medicinal) cures are important, they may not be adequate on their own as there is a need for the restoration of a balance in supernatural relations, and this is best achieved through sacrifice (Du Toit, 1985; Ashforth, 2000). It can be seen therefore that, with such a dichotomisation, biomedicine may not be perceived as the sole or appropriate treatment option for illnesses that Africans perceive as being caused by witchcraft, displeased ancestors and the infringement of taboos. As Awusabu-Asale and Anarfi argue:

“There is a belief that western medicine can provide neither an explanation nor a cure for certain diseases: therefore people suffering from a disease whose origin has been attributed to supernatural causes, may seek explanation and possible cure for the disease at fetish shrines, diviners, or spiritualists” (Awusabu-Asale and Anarfi, 1997).

³⁵ Feierman calls the latter hospital illnesses (Feierman, 1981). The Bushmen classify diseases into Bushmen diseases that are caused by witchcraft, and European diseases which are new organic ailments such as tuberculosis (Westerlund, 1989). In some countries, for example Botswana, a distinction is made between European illnesses and Tswana illnesses. Tswana illnesses were known to Tswana people and their doctors before the arrival of Europeans, while European diseases are of more recent origin and outside the scope of traditional medical knowledge (Ulin, 1979:244).

Such diseases are generally perceived as 'African' in nature, and therefore, as requiring indigenous African therapeutic interventions and preventative approaches. For those diseases believed to be caused by ancestral spirits, once thus determined, people may avoid seeking biomedical health care as they fear that this would further provoke the ancestors and consequently the condition would worsen (Friedson, 1996).

It is not only in African societies that such cognitive dichotomies exist. For example, in India, natural diarrhoea (*bedhi*) is perceived as caused by an excess of heat in the body, which in turn is caused by eating foods classified as hot according to the Ayurvedic system and hence seeking biomedical treatment is considered an appropriate option. However, another form of diarrhoea known as *dosham* is perceived to be caused by ritual pollution, and it commonly occurs when a mother feeds her infant after seeing a woman who has suffered a miscarriage (Foster, 1978, quoting Lozoff et al, 1975). This type of diarrhoea cannot be treated at the hospital.

While this dichotomisation of diseases into African and Western diseases is helpful in understanding therapy-seeking processes in African societies, we will argue later that this approach distorts the true picture of how therapy is sought. In some cases, patients simultaneously use both traditional as well as western medicine in what LeBeau calls "double consumption" (LeBeau, 1999:155). For example, in the case of sorcery, Yoder argues that herbal or biomedical drugs are taken to relieve the physical symptoms, while the traditional healer addresses the ultimate cause by "extracting sorcery instruments from the body" (Yoder, 1981; see also Alland, 1970).

While the cognitive approach (which, among other things, encompasses the African/Western illnesses divide) in medical anthropology studies is useful, it however does not address the concept of change, and while the African/Western disease dichotomy exists at a classificatory level, in actual practice there is no such rigidity in people's behaviour. As we have argued, the non-response of an illness to

therapy demands a shift in the perceived cause of the illness, regardless of whether the illness is initially considered African or western. Approaches in medical anthropology which place emphasis on “cultural determinism and its micro-analytic focus” have been criticised because they tend to neglect global forces which are influential in producing and shaping illness and its perception (see Morsy, 1990:30).

What is observed in many studies is that minor illnesses such as colds, coughs, headaches, etc are treated in the home, either using herbal concoctions or medicines bought from nearby shops. When these illnesses do not respond to such therapies, people go to the hospital or traditional healer (Morris, 1985; Morris, 1986; Chavunduka, 1994), depending on what is perceived to be the aetiology of the illness (LeBeau, 1999) and their previous experience of the efficacy of various healing systems (Heap and Ramphela, 1991; LeBeau, 1999). Like Morris (1985) and Chavunduka (1994), LeBeau’s study in Namibia has also shown that:

“[For] the most universally recognised symptoms patients first go to western health care, unless the illness has a social/spiritual aetiology or western medicine has been unsuccessful” (LeBeau, 1999:145).

The seeking of therapy at government health facilities and its subsequent failure, as Feierman argues, is a form of diagnosis. The hospital’s failure to cure an illness is on the part of the patient a reassurance or a confirmation that the illness is sorcery-induced; hence a decision is made to pursue other forms of therapy (Feierman, 1981). Cases abound in which patients have been secretly taken out of the hospital to seek traditional medicine upon advice from medical personnel (see Offiong, 1999). As Frankenberg and Leeson found in Lusaka, “the *ng’anga’s* patients tend to be a population of survivors: the patient and the illness have survived western medicine” (Frankenberg and Leeson, 1976:253) for a relatively long time.

The initial choice of treatment may also depend on where people themselves perceive the probability of cure to be high (Mathews, 1998). For those illnesses that are considered “African”, it does not make much sense to seek treatment in modern hospitals because, as far as Africans are concerned, the probability of cure there is either non-existent or low. As we shall also see later, even some aspects of what are referred to as African illnesses need to be treated by western medicines in order for a cure to be effected, as traditional medicines alone might be viewed as inadequate. The classification of illnesses into western and African is therefore not watertight as people move from one form of therapy to another in search of a cure. This dichotomisation into African and western diseases has been criticised because it tends to bypass the herbal aspect of traditional healing (see Morris, 1985). The active ingredients contained in some herbal cures/medicines are very effective in the cure of some diseases. All those diseases that people suffer from as part of the natural order (namely natural illnesses) can be classified as western diseases. These diseases can effectively be treated using herbal or European medicines found in hospitals and clinics (see Morris, 1985; Yoder, 1981). The herbal medicines that are used to cure these natural illnesses (*umkhulane*) are believed to be potent in themselves and effective, hence there is no need for a ritual (Ngubane, 1977). However, if the disease persists after receiving treatment, then it can be reclassified as originating from witchcraft or such other supernatural forces; hence they become reclassified as African illnesses. This is in line with Feierman’s findings that, with regard to therapeutic action, the passage of time is an important factor, as “cultural interpretation of illness changes as the illness itself changes through time” (Feierman, 1985:77). Hence, the duality of African/western illnesses is not all that exclusive as reclassification may occur in the course of seeking treatment.

Socio-economic factors influencing choice of therapy

Apart from theories of causation, another factor that researchers have identified as influencing therapeutic choice is the cost of the therapeutic intervention. The

penetration of capitalism and the cash economy at the micro village level has led to the formation of socio-economic classes. Health has increasingly become a commodity and only those who can afford medical care can get it (Onoge, 1975). If the cost of treatment is high, people will try to avoid that form of therapy and only resort to that alternative when everything else has failed. Unlike in other countries where state health services are largely free of charge, such as in Malawi (see Chilowa and Munthali, 1999), in most African countries user fees have been introduced as cost sharing measures in accordance with the Bamako Initiative³⁶. While people may desire to consult health centres during childhood illness episodes, the cost may be a deterrent factor and some scholars have argued that this constitutes one of the factors that leads people to seek treatment from traditional healers who are sometimes seen as cheaper (Offiong, 1999). A number of researchers have argued that the introduction of user fees bars the poor from “appropriate” care since they cannot afford to pay (Devisch, 1999). In Zambia, it was noted that one of the reasons for the decline in national hospital attendance rates was the introduction of user fees in state-delivered health services (Chabot, 1998). The choice of therapeutic alternatives based on cost, and only resorting to the most expensive alternative when everything else has failed, is what Young refers to as “cost-ordering” (in Mathews, 1998).

However, researchers have also demonstrated that traditional medicine is not necessarily all that cheap either. Heap and Ramphele have shown that, as much as people may desire to utilise traditional medicine (e.g. because they are suffering from what is perceived as an African illness), the cost of pursuing such a therapy is sometimes prohibitive (Heap and Ramphele, 1991; see also Ashforth, 2000). In addition to the cost of the therapeutic intervention, there are other costs involved, e.g. the cost of food, transportation and the loss of agricultural working time (Kloos,

³⁶ This was a recommendation put forward in 1987 by the African Ministers of Health that recognized the poor quality of health services provided by governments, and that in order to improve this, there was a need, among other things, for people to pay something to help government provide better services (see Shaw and Griffin, 1995).

1990). From this, it can be seen that, if for example the cost of transportation together with the cost of treatment is seen as too high, one may choose to buy medicines from the local shops instead.

The cost of therapeutic intervention need not be measured in monetary terms alone. Foster and Anderson talk about social costs, and they state that these refer to “the restructuring of personal relationships, customary exchange patterns, and friendship ties that often accompany innovation” (Foster and Anderson, 1978:247). They give examples of cases in which, though a need was recognised to get biomedical health care, a decision was made to consult an indigenous healer, either because the healer was a relative or the person who made the decision had the supreme authority in the household; hence behaving or acting otherwise would have produced discord within the family (Foster and Anderson, 1978).

While cost may indeed determine therapeutic choice, it is evidently not the only factor, as people may also seek therapy where the probability of cure is very high, regardless of cost.

Some convenience and efficiency factors influencing choice of therapy

Recourse to traditional medicine and other forms of therapy may also be as a result of the unavailability of or distance to biomedical health facilities, low staffing levels, unavailability of appropriate or essential medicines at these facilities, and the poor treatment of patients by health workers³⁷ (see LeBeau, 1999; Hjortsberg, nd). Long queues (resulting in long waiting times) at state-run health facilities also force people

³⁷ Dennis and Harrison quote a traditional healer who told them that “western medical practitioners get angry too easily and are too impatient. They do not understand the villager; then the villager gets angry and does not cooperate. Thus the western medical practitioners do not gain his confidence and the villager returns to his *zo* (meaning medicine man)” (Dennis and Harrison, 1979:82).

to resort to other means of therapy. Hjortsberg, based on a study done in Zambia, has argued that such problems, which are inherent in the public health care system, generally call for people to shop around for a cure (Hjortsberg, nd). In their study in Lusaka, Frankenberg and Leeson found that some of the *ng'angas* (traditional healers) were being consulted because they were near, their service was private, and available without queuing (Frankenberg and Leeson, 1976). Though researchers have argued that better utilization of modern health facilities can best be achieved by increasing the quality of services provided (Kloos, 1990), quality is not the only consideration as resorting to other forms of therapy can also be influenced by other factors, including the cultural definition of the illness and what is perceived to be the most efficacious therapy.

While distance might be important, it may not be the deciding factor in therapy seeking, as the availability of high quality services (in whatever way this is defined by the communities) at the clinics may offset or mute the variable of distance (Devisch, 1999; see also Csete, 1993). Cases have been documented where therapy-seekers bypass a nearby hospital or clinic for a traditional healer miles away (Offiong, 1999). This is in line with what Senah wrote about Ghana, saying that though biomedical health services might be available, the "prevailing social and cultural values render biomedicine an inappropriate option for many illnesses" (Senah, 1995:110).

The role of world religions and AICs in seeking therapy

While people are indeed free to choose a therapy depending on the factors explained above, in some cases religious organisations may attempt to restrict the choices that people are able to make during illness episodes. In the case of African Independent Churches, such as the Zionists, Du Toit argues that:

“Decision-making during illness episodes is taken away from the members as Zionists are expected to behave alike and follow the guiding precepts of their leaders” (Du Toit, 1985).

Cummergen argues that Zionists (e.g. the Zulu Zionists) reject the use of modern medicines. Other Zionists (e.g. those in Swaziland), although they reject the use of modern medicines, are less strict and are known to use herbs, poultices and soap during healing (Cummergen, 2000). “Mainline” Christianity only allows for the consumption of herbal and western medicines, and various forms of spiritual healing by prayer, laying on of hands, anointing with oil, and even confession as a therapeutic process. Herbal concoctions where invocation, or what Feierman calls “the spoken formula” is involved, are usually not allowed by the church (Feierman, 1981). The singing and dancing, which is connected to the ancestor-based religion, is forbidden by most church edicts (see Spring, 1985). Although mainline Christianity disavows certain aspects of traditional medicine, some studies have shown that in reality, Christians turn to ‘traditional’ medicines when biomedicine is seen to fail (Spring, 1985). Ranger adds that, while individuals may be Christians, in instances of serious illness, it is a person’s *jamaa* (kinsmen) who determine how he/she should be treated, regardless of his/her Christian stance (Ranger, 1992:270). The rebuke of Christians who turn to traditional medicines by their fellow Christians attracts the response that it is not their (i.e. the patients’) responsibility to determine that treatment options to pursue as the decision is made not by them, but by their relatives (Ranger, 1992:271).

In Islamised areas, such as Hausaland in Nigeria, the use of pre-Islamic medicine is condemned because it centres around spirits and spirit worship (which are considered as *sihr* (magic), hence *haram* and reprehensible in Islam)³⁸, which contradicts basic principles of Islam. The invocation of supernatural beings, such as spirits, to effect a cure infringes on the fundamental belief in Islam which requires that prayer can only

³⁸ See Abdalla, 1985.

be made to Allah and to him alone (Abdalla, 1985). While one's religion may indeed influence the type of therapy one might resort to during illness episodes, serious illness may equally result in people being pressurised to accept the decisions made by their relatives, or simply to try anything which might bring healing or relief.

The interplay between micro- and macro-level factors in therapeutic choices

From the above discussion, it is apparent that there exist micro-level factors that affect the therapy-seeking decision-making process at household and community levels. These micro-level factors include the prevailing cultural beliefs and practices regarding health and illness, socio-economic status, availability of medicines in the local health facilities, distance to the health facilities, demographic characteristics of the clients, such as age, educational level, etc. While these factors play an important role in the decision-making process, we should also recognise the interplay between these micro-level factors and the wider macro-level factors.

In order to illustrate this interplay, we will consider the different national health and welfare programmes that have been established in some developing countries to control specific diseases. For example, in Malawi, the National Malaria Control Programme (Matinga and Munthali, 2001), the National Control of Diarrhoeal Diseases (CDC) Programme (National Statistical Office, 2001), and the National Expanded Programme on Immunisation (EPI) Programme (Chilowa and Munthali, 1999) were established in order to control malaria, diarrhoea and vaccine-preventable diseases, respectively. The establishment of these programmes and the work that they do illustrates the linkages between micro-level and macro-level processes. These national programmes are involved in the mass media campaigns aimed at creating awareness about the activities in which they are involved. They run programmes on the national radio station on the use of ORS in diarrhoeal disease control, the importance of using mosquito nets and the early treatment of febrile illness as a strategy to control malaria, the importance of vaccinating children against diseases

such as measles, tuberculosis, pertussis etc. Apart from the radio, community based health workers are also involved in educating members of the community about some of these issues, as we saw earlier.

Some studies in medical anthropology have focussed on knowledge of vaccine-preventable diseases and the different antigens (see Chilowa and Munthali, 1999; Streefland et al, 1999, Vaahtera et al, 2000), insecticide treated nets (see Matinga and Munthali, 2001), and the aetiology, prevention and treatment (e.g. with ORS) of diarrhoeal diseases in children under five, etc. As Pelto et al (1990) have argued, when anthropologists look at issues such as knowledge about different aspects of health and welfare, they are looking at evidence of the impact of the macro-level processes at the household and community level, i.e. at the micro-level. They have also further argued that one of the aims of anthropological research is to communicate micro-level understandings and cultural concepts to policy-makers. Though development programmes have mostly utilised top-down approaches, more recently, micro-level ethnographic research has been utilised to inform and improve macro-level policy formulation (Pelto et al, 1990). While this thesis has been written for academic purposes, its findings will also be shared and discussed with the Ministry of Health and Population in Malawi to determine how they can be used in national health education campaigns.

Though some factors, such as the availability of medicines or vaccines and knowledge about certain health issues are identified at the micro-level, they do originate from macro-level processes. For example, existing government policies and the allocation of resources by the central government have an impact on the delivery of health services at the micro-level. The availability of medicines, vaccines and other requisites at a local health facility is largely determined by three related factors: firstly, the allocation of resources to the health sector; secondly, the ability of the government to purchase these items on the world market where prices are set and

controlled by western corporations; and thirdly, the ability of the government to get medicines delivered to rural areas.

The delivery of vaccination services illustrates this point well. As we showed earlier, most of the countries in the SADC require continued external donor funding to run their routine vaccination programmes, without which the EPI programmes would collapse. In Malawi, the government only funded two percent of the vaccines required for the routine vaccination programme in 1999 (see UNICEF, 2002). The rest was funded by donor agencies, such as UNICEF. One of the reasons for the failure of the state to adequately fund health programmes is the lack of funds. This is also manifest in the training of health workers. While in the past, community-based health workers were given an eight week training programme (see Chilowa and Munthali, 1999), the current situation is that, once recruited, they are given on-the-job training, which might not be adequate. In recent years, the Malawi College of Health Sciences, which trains health workers such as nurses, health assistants³⁹ and clinical officers etc, has been closed intermittently because of a lack of funds. This affects the staffing levels (which are already low) in public health facilities.

It therefore seems that there is a clear correlation between the socio-economic status of a country and the health status of its citizens. It has been found that a country's per capita gross national product (GNP) correlates well with the national mortality rate and life expectancy: the higher the GNP, the lower the mortality rate and the higher the life expectancy rate (Elling, 1981). From this discussion, it can be seen that factors relating to the wider political economy constitute some of the most important determinants of people's health and welfare.

Figure 6.1 gives a pictorial representation of a conceptual framework for understanding the therapy-seeking process, the interplay between macro and micro-

³⁹ Health Assistants supervise community based Health Surveillance Assistants.

level factors, and the interrelationships between aetiology, prevention and the therapy-seeking processes. What is apparent in this framework is the complex nature of therapy seeking and the situational variables that accompany such processes. The dictum, *prevention is better than cure*, is well known. As far as public health is concerned, knowledge of risks to life and health is important as this dictates a strategy for prevention and medical care (Obermeyer, 2000). Risk, as Lupton (1999) and Douglas and Wildavsky (1983) have argued, is however a socio-cultural construct, and each culture has devised its own strategies for managing risks. Although what is considered risky to human health varies cross-culturally, the Health Belief Model explains how individual perceptions about risk influence variations in risk behaviour. This model argues that individuals will adopt preventative measures against particular risks if they see themselves as susceptible to health threats perceived to have serious consequences (see Figure 1). Furthermore, the benefits of taking the preventative action should be seen as outweighing the perceived costs (Bloor, 1995; Brown, 1999) of not taking such preventative action. For example, postpartum sexual intercourse is prohibited in many African societies because it is believed that having sexual intercourse during this period will result into the contamination of breast milk and the child may develop intractable diarrhoea after feeding on this contaminated milk (see Gelfand, 1964). As far as these societies are concerned, postpartum sexual intercourse is a health risk to the suckling child, hence it is better to adhere to postpartum sexual taboos. Witchcraft, displeasing the ancestors and the infringement of taboos (as the above example shows) are all considered risks to human health and as we discussed earlier, strategies (the use of amulets, incisions, propitiation of ancestral spirits, etc) have been developed to counter these risks (see Figure 6.1).

In addition to these cultural methods of managing risk, there are also biomedical methods, e.g. good sanitation and hygienic practices and vaccinations. Initially, while there was resistance to smallpox vaccinations, with time people started appreciating their effectiveness in protecting people against the disease. Some recent studies have shown that mothers generally appreciate that vaccinations protect their children

against vaccine-preventable diseases (Chilowa and Munthali, 1999). The fact that there are vaccination coverage rates of more than 90 percent of the targeted children (see UNICEF, 2002) would seem to indicate that mothers take their children for vaccination because they know that unvaccinated children are vulnerable to contracting vaccine-preventable diseases. As Streefland et al argue, the perceived risk of a child getting a vaccine-preventable disease contributes to the acceptance of vaccinations (Streefland et al, 1999). While a lot of mothers take their children to immunisation sites for vaccinations, there are others who do not. A number of studies in the Social Science and Immunisation Project⁴⁰ showed that mothers might sometimes not have their children vaccinated because they believe that vaccinations are in fact what makes their children sick (see Streefland et al, 1999; Chilowa and Munthali, 1999). The perception that vaccinations are a risk to the health of children may thus lead to non-compliance with vaccination regimes (see Streefland et al, 1999). Some mothers in developed countries, such as the United Kingdom, also claim to have experienced their children becoming sick after being vaccinated, and such mothers have subsequently stopped taking their children for vaccinations (see Rogers and Pilgrim, 1995).

While people may know or believe the benefits and effectiveness of adopting preventive actions, action may not take place. As Brown argues, and as shall be seen later when discussing childhood diseases among the Tumbuka, this may be due to barriers (such as that it is inconvenient, expensive, unpleasant, painful or upsetting (Brown, 1999), distance etc) relating to a treatment or preventive measure. These characteristics may lead a person away from taking the desired action. While prevention measures are supposed to work, sometimes they do not, for reasons such as that the preventive medicine was not compatible with the child; the vaccines had expired, etc. In cases where mothers do not adopt the (biomedical) preventative

⁴⁰ This project put emphasis on the social and cultural dimensions of immunisation in different countries, namely the Philippines, the Netherlands, India, Bangladesh, Malawi, Ethiopia and the United States. The project was headed by Prof. Pieter Streefland of the University of Amsterdam.

measures, a disease may develop, and therapy will have to be sought in order to prevent further incapacitation or death. During these illness episodes, mothers will resort to different therapeutic options, depending on factors which have been discussed above, and as shown in Figure 6.1, from which it can also be seen that therapy options are broadly divided into traditional medicine and western medicine, and that this division is based on aetiology. At each stage of health-seeking, the outcome will either be positive, i.e. the sick person will be cured, or the outcome will be negative, i.e. the patient will die or his condition will not respond to treatment. If the person is not cured, recourse will be had to other therapeutic options.

As will be discussed in more detail in the subsequent ethnographic chapters, therapy-seeking can be seen as an hierarchical movement within and between aetiologies; at the same time, it is not a random process, but an ordered path of choices responding to negative feedback, and subject to a number of factors as discussed above. For example, febrile illness in under-five children may be treated using herbs or antipyretics bought from the local grocery shops. When the situation worsens (e.g. accompanied by convulsions), a herbalist will be consulted or the child may be taken to the local health centre. The local health centre refers such cases to the district hospital for treatment. Because of the rapidity with which the condition worsens, informants said that sometimes such children are believed to be bewitched hence while biomedical treatment is sought, at the same time diviners are also consulted. The movement between systems (i.e. from traditional medicine to biomedicine and vice versa) during illness episodes depends on a number of factors, including previous experiences of significant others (i.e. those close to the patient), perceptions about the chances of getting healed, the decisions of the therapy management group, and other factors as detailed in Figure 6.1. Patients will move from one option to another and back again, depending on response to treatment, and one leaves this cycle after being cured or when dead. The therapy option that one starts with depends on a number of factors as explained earlier in this chapter, and at times as we have argued, people can simultaneously resort to more than one therapy option. As will be shown in this

thesis, the therapeutic strategies people resort to during illness episodes are appropriate rational decisions, based on prevailing circumstances, knowledge, resources and outcomes. As Crandon-Malamud argues, boundaries between the different therapeutic options are not rigid, as people move from one form of therapy to another (Crandon-Malamud, 1991) and one mode of classification to another.

Conclusion

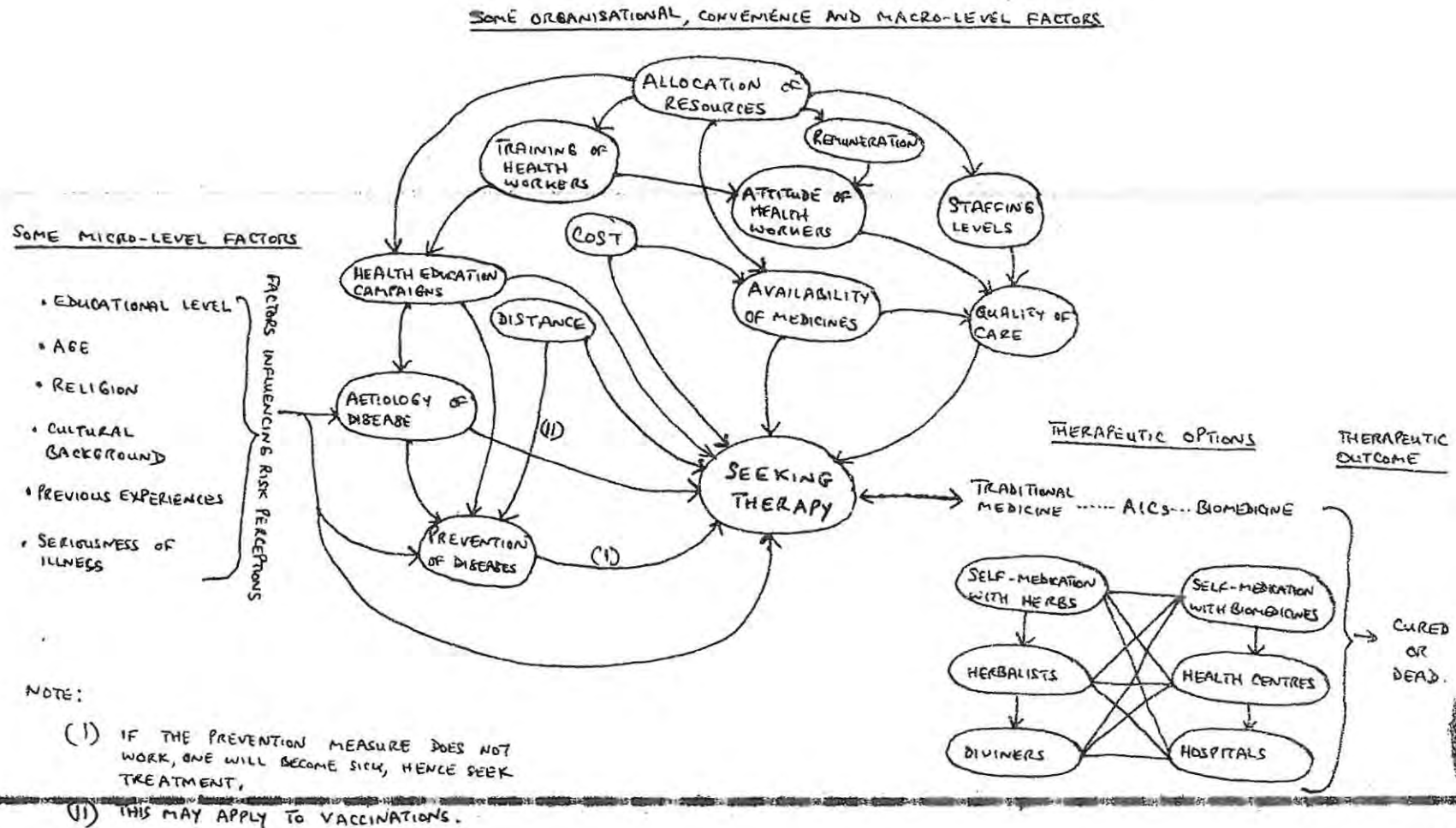
African societies have changed considerably over the years since gaining contact with people from other parts of the world. That interaction has generally led to the introduction of western scientific ideas about the causation, treatment and prevention of disease. Because of these interactions, what we see in African societies (and as we shall see among the Tumbuka in subsequent chapters) is that therapy-seeking is not a straightforward matter. Existing cultural beliefs and practices, among other micro-level factors, are important determinants of the health-seeking process in African societies. With time, and contact with people from other cultures, cultural change is inevitable. Diffusion, conquest and trade have been some of the major vehicles for the introduction of biomedicine in African societies. This has not led to the abandonment of African indigenous beliefs and practices about health and health care.

As we have argued, what we see in African societies is the proliferation of what has been referred to as medical pluralism and that this pluralism embodies a calculated movement between aetiologies. While this thesis examines micro-level determinants of health-seeking behaviours in contemporary Africa, which is characterised by global interdependence and dominated by capitalism, it also argues that macro-level factors impact at the micro-level, which impact should be a fundamental aspect of any local-level study of health-related issues and behaviour.

A number of general studies have been done among the Tumbuka, including that done by Friedson, who amongst other things, studied the role of music and drumming in

Tumbuka healing (Friedson, 1996). This thesis differs from previous studies done among the Tumbuka and elsewhere in Africa, in that it brings out new empirical ethnographic data about people's perceptions of the aetiology and prevention of childhood diseases, how they seek treatment, and the different factors that determine therapy choice during childhood illness episodes. The following chapters also demonstrate that while cultural factors and other micro-level factors are important, health and disease at the micro-level are also affected by the wider macro-level processes and that our understanding of that interaction is central to our understanding of Tumbuka health-seeking strategies for themselves and (for the purpose of this thesis) for their children.

FIGURE 6.1 : A FRAMEWORK FOR UNDERSTANDING THERAPY-SEEKING PROCESSES



CHAPTER 7

PREGNANCY-RELATED TABOOS, BIRTH RITUALS AND *CHIKHOSO* *CHAMOTO* AMONG UNDER-FIVE CHILDREN

Introduction

Among the Tumbuka, as is the case with many ethnic groups in Sub-Saharan Africa, taboos on sexual intercourse exist that, emically, are aimed at the protection of children, spouses, and elderly men and women against specific illnesses (see Pool, 1994; Gelfand, 1964; Evans-Pritchard, 1976, for similar taboos in other societies), the prevention of the worsening of epidemics, and the prevention of misfortunes, for example during hunting episodes (see Read, 1966; Kenyatta, 1938, for similar beliefs elsewhere). While taboos on sexual intercourse have been instituted aimed at preventing misfortune and illness, an “outsider” would expect that the existence of such taboos would also restrict acts of sexual intercourse (with the wrong person and at the wrong time) and instil marital fidelity, especially in these times of the HIV/AIDS pandemic. This chapter examines how, according to the Tumbuka, the infringement of taboos on extramarital and other forms of sexual intercourse may affect the health of children, and that of their parents. It also discusses rituals surrounding the birth of children, for example:

- The seclusion of the child after birth and its subsequent incorporation into the wider community.
- The disposal of the umbilical cord and why a lot of care is exercised in this regard.
- Prenatal and postnatal sexual taboos, with particular emphasis being placed on effects the breach of these taboos has on the health of children.

As will be explained later, all these practices have implications, directly or indirectly, on the health and welfare of the child; the Tumbuka take a lot of precautions in order to safeguard the health of their children.

Sexual intercourse, pregnancy and children's health

While sexual intercourse is necessary for procreation, the Tumbuka believe that if not handled properly, it may also be a threat to the health of the people, especially children. Like the Zulus (see Krige, 1965), the Tumbuka hold the idea that it is important that a lot of care should be exercised during pregnancy as the health and well-being of a child begins at this stage. Every precaution is therefore taken to ensure a successful pregnancy and delivery. Firstly, the Tumbuka believe that sexual intercourse with and marriage to a patrilineal relative should be avoided in order to prevent, among other things, the woman from bearing a crippled child. During fieldwork, an example was given of an uncle (father's brother) who made his niece pregnant, who then delivered a crippled child.

When a woman gets pregnant, informants said that she should continue having sexual intercourse until she is approximately seven months pregnant (for similar findings among the Tumbuka see also Mkandawire, 1998). The act of sexual intercourse during this period is necessary as it nourishes the child and *mwana akubabika nankhongono* (the child is born healthy and strong). It is held by the Tumbuka that if a couple stops having sexual intercourse soon after conception, the baby will be born very weak, with very low birth weight, and in some cases the woman may even have a still birth. One community-based health worker compared having sexual intercourse during this period to a maize plant, and said that:

“For a maize plant to grow well, there is need to apply fertiliser at different stages, otherwise it may not grow well; likewise, there is a need for a pregnant

woman to continue having sexual intercourse in order to ensure that the foetus grows or develops healthily”.

The belief that the father’s sperm feeds the foetus during the development of the pregnancy, seems to be widespread (for example see Chakanza, 1998, for the Chewa of Malawi and Gaussett, 2001, for the Tonga of Zambia).

Among the Tumbuka, the husband is not allowed to have sexual intercourse with other women when his wife is pregnant. Informants explained that when a man has sexual intercourse with other women, and then returns home and has sexual intercourse with his wife, the “blood” of the other women mixes with the blood of his wife in her body. Blood in this context is used as a metaphor to refer to sexual fluids. When a woman has sexual intercourse with other men, and she comes back and has intercourse with her husband, the blood from different men mixes in her womb. Informants said that extramarital sexual intercourse when a woman is pregnant is discouraged because it may lead to a very difficult labour and she and the child may even die in the process. The Chewa of central Malawi (see Chakanza, 1998) and the Nyakyusa of southern Tanzania (Wilson, 1957) hold similar beliefs. The Tumbuka say that the “blood” from different men ‘fight’ within the woman’s body, and therefore she cannot deliver properly until she mentions all the men with whom she has had sexual intercourse. The Chewa (Chakanza, nd) and the Nyakyusa (Wilson, 1957) and the Bemba (Richards, 1956), like the Tumbuka, also believe that a woman will only deliver smoothly after mentioning the names of all her sexual partners (Chakanza, nd). While the mentioning of men she had sex with is a “cure” for difficult labour, women said that this is a very embarrassing situation. This is why some traditional birth attendants said that nowadays they give specific medicines to women so that they can deliver smoothly, even though they have had sexual intercourse with many men. Confession, as Chakanza argues, lessens the consequences of infidelity (Chakanza, 1998). While among the Tumbuka, the Chewa and the Nyakyusa extramarital sexual intercourse can lead to difficult labour, this

belief does not exist among the Ngoni of neighbouring Mzimba District (see Read, 1959). Etically, it can be argued that limiting sexual intercourse at this stage is important because it prevents sexually transmitted infections, which may also affect the child in the womb.

One TBA trainer at Rumphu District Hospital said that if a woman swells or has convulsions during pregnancy, the Tumbuka also believe that she has had sexual intercourse with many men; hence it is advisable for her not to deliver at the hospital, but with the help of a traditional birth attendant. In such circumstances, TBAs administer some medicines, after which the pregnant woman is taken to and immersed in a fast flowing river *kuti wanalume wasukike* (so that the men with whom she had sexual intercourse with can be washed away). When such a ritual is performed, it is believed that the woman will deliver without any problems. Such a case happened in April 2002 at Mwazisi, and the health workers went to take the woman away from the river, after being alerted as to what was happening. While this is the emic explanation of convulsions in pregnant women, the TBA trainer said that, biomedically, such presentations constitute what is known as pre-eclampsia, i.e. a disorder that occurs only during pregnancy, is characterized by high blood pressure, swelling and protein in the urine, occurs in the late second or third trimesters (middle to late pregnancy) and is one of the leading global cause of maternal and infant illness and death (<http://www.preeclampsia.org/about.asp>).

In addition to avoiding extramarital sexual intercourse and sexual intercourse after the seventh month of pregnancy, the Tumbuka also believe that, during the course of pregnancy, a woman should adhere to certain food taboos, otherwise the health of the child may be adversely affected. For example, a pregnant woman should avoid eating certain foods such as *delele* (okra) and *bwankha* (*Clarias gariepinus*)⁴¹ because they

⁴¹ Mud fish.

are slippery/slimy; otherwise the pregnancy might *slip* (*kuteremuka*), leading to premature delivery. This is why in Tumbuka there is a saying which goes:

“*Nthumbo yila yateremuka*” (meaning, the pregnancy has *slipped*).

One TBA and her assistant said that a woman who is taking *chimika* medicines is not allowed to eat *bwankha* and okra. The word *chimika* is derived from the verb *kumika* or *mika* meaning to stop, and in this context it refers to getting pregnant and the cessation of the menstrual flow. When a newly married woman does not get pregnant, traditional healers are consulted who may administer some herbal medicines to make the woman pregnant. These medicines are referred to as *mankhwala yachimika*, meaning medicines which will stop the menstrual flow⁴². The Katumbi-based TBA said that when a woman takes *mankhwala yachimika* while at the same time she eats *bwankha* or okra, during sexual intercourse the man’s sperms will just *slip* (*slide*) away (in the same way as okra and *bwankha*) from the vagina, and hence the woman will not get pregnant. Such a woman should also not eat fresh ‘bloody’ meat as she would continue menstruating while pregnant, and consequently she might even lose the pregnancy. It is therefore necessary for pregnant women to dry meat first before eating it. As will be explained later, pregnant women are also not supposed to eat eggs otherwise the child will suffer from convulsions at birth.

Most informants said that okra is also prohibited during pregnancy because, in most cases, soda is added when it (the okra) is being cooked. It is believed that soda spoils the eyes of the child, hence he or she will not see properly once he or she is born. The

⁴² While herbal medicines are used to cure infertility, the efficacy of the cure depends on the cause of the infertility. The Tumbuka, like the Zulus (Ngubane, 1981) also believe that if bridewealth is not settled properly, the ancestors can hold the woman’s womb until bridewealth is settled. Where it is suspected that the husband is infertile, his wife is advised to have extramarital sexual intercourse in order to get pregnant. These are some of the ways in which the Tumbuka deal with infertility (see Munthali, nd).

consumption of anything bitter, such as pepper, is also prohibited for the same reason (see Munthali, 1999, for similar beliefs among the Yao of southern Malawi). Pregnant women are also not supposed to eat anything which is hot. Any foods or beverages (for example *sima* and tea) need to be cooled first. According to informants, this is because if they are taken while hot, they land on the foetus and will therefore burn it, and at birth the baby will be born with scars (some blackish spots). Furthermore, when a pregnant woman sees a snake, she should call someone else to kill it. If she makes the mistake of killing the snake herself, then, it is believed, the baby will crawl like a snake when he or she reaches the stage of crawling. Women with such children are reminded that they killed a snake when they were pregnant. A pregnant woman is also not supposed to laugh at crippled people because she might deliver a crippled child as well. When a pregnant woman is coming out of the house, she is not supposed to stand in the doorway, otherwise the baby will behave in a similar way during delivery (see Krige, 1965 for similar beliefs among the Zulus).

Though it did not come out of this study, Mkandawire says that among the Tumbuka a pregnant woman is not supposed:

“to wear any bangles, watches, necklaces or anything that is tied around her body because of the belief that these may cause the umbilical cord to coil around its [the child’s] neck, resulting in strangulation in utero” (Mkandawire, 1998).

Krige describes a number of things that a pregnant Zulu woman is supposed to observe or follow for fear of resemblances that may occur in her children. Though Krige’s book was first published in 1936, some of these things are still observable among the Tumbuka to this day; they still believe that whatever the woman does during the period she is pregnant, *pala anachikozgo chiheni* (when she has a “bad resemblance”), the child will do also. This is why the elderly men and women said that it was necessary to follow the above restrictions strictly.

We have stated earlier that a woman can continue having sexual intercourse with her husband up to seven months of pregnancy and he can ejaculate sperms into the vagina, as had been the case previously. The Tumbuka have the view that after the seventh month of pregnancy, the child in the womb turns around and the head faces the delivery canal, preparing for delivery. The TBAs, the TBA trainer and elderly women said that having sexual intercourse at this stage is considered dangerous because the man's penis *yingavotola luwombo lwa mwana* (can pierce the child's fontanel), resulting in the death of the child. This is one of the explanations that the Tumbuka give for stillbirths (also see Mkandawire, 1998). Unlike the Tumbuka, the Yao of southern Malawi believe that for the first delivery, sexual intercourse between the pregnant woman and her spouse should continue until she is about to deliver. This is done in order to dilate the birth canal, and hence facilitate a smooth delivery (Mkandawire, 1998).

After the seventh month of pregnancy, it is believed that when a man ejaculates, the sperms land on the foetus, and it (the child) may be born with sperms covering his or her body. This is generally perceived to be shameful, and it also explains why sexual intercourse should stop when the woman is seventh months pregnant. Informants said that it is very disgraceful and disgusting for a child to be born with sperms covering his or her body as the mother is laughed at by women attending to her during delivery, mocking her that she liked sexual intercourse so much (*akawa nanjala yikulu* or *nimulyezi*). According to elderly women and TBAs such a child (born with sperms covering his or her body) will be very weak and might even die soon after birth. To avoid this, the couple may have sexual intercourse, but they have to perform *coitus interruptus* or (as some young men and women said) they can use condoms. While this is the emic interpretation, Bennett and Brown suggest that the creamy substance which covers the body of the newborn baby is most likely *vermix caseosa*, which functions to protect the foetus from amniotic fluid and against friction against itself (Bennett and Brown, 1996, quoted in Mkandawire, 1998).

As far as deliveries are concerned, TBAs continue to play an important role in rural areas of Malawi such as Chisinde. In addition to deliveries, they also help pregnant women to counteract the powers of witchcraft. The TBAs said that in witches, out of jealousy, may use the umbilical cord to tie the child in the mother's womb. In such cases, hospital personnel are not in a position to know that the witches have tied the child. It is believed that when such a woman (with a tied child) goes to deliver at the hospital, either the child will die at birth or the mother will die in the process of giving birth. In this context, TBAs and traditional healers play an important role because they are able to untie the child so that the woman delivers properly. There are also some pregnant women who run away from the health centres as the time to deliver approaches. One TBA stationed at Katumbi said that some women attend antenatal clinics conducted at health centres. Sometimes when these pregnant women are about to deliver, they are told by the health centre staff that they will be referred to the district hospital because their case cannot be handled at health centre level. The TBA said that, upon being told this, some women fear that when they go to the district hospital *wamuwatumbula* (they will have to undergo a caesarean operation). Because mothers have heard that some TBAs help (to deliver) even those who were told by health centre staff to go for a caesarean operation, they may decide to visit such TBAs. In some cases, even after nine months women might not deliver. They may start wondering why they are not delivering. Thinking that they have been bewitched, they also abandon hospital care and go to the TBAs for assistance. One TBA said that she had had many cases of this nature. Though the maternal death rates at one of the TBAs was reportedly quite high, the above-mentioned factors led many women to continue delivering at this TBA.

Some women said that they were forced to continue delivering at the TBAs because of the bad behaviour and attitude of the health workers, especially to those who started attending antenatal clinics late or who never practiced child spacing. This can be illustrated by quoting from Mkandawire's study. Her informants said that

whenever they (informants) make a noise during delivery, nurses sometimes say the following:

“Was I around when you were conceiving? Just shut up and push”.

“Did you scream as loudly when you were making this baby? If you do not shut up I will just leave you to deliver on your own because I have better things to do than stand here and hear you screaming” (see Mkandawire, 1998).

Such attitudes on the part of the nursing personnel discourage some women from delivering at the health centres, despite the fact that the health centre might be nearer.

What we see therefore is that, as far as the Tumbuka are concerned, a lot of care needs to be exercised during pregnancy in order to safeguard the health of the child and that of its mother. This is done by adhering to the regulations on taboos as set by society. Further, there is also a need to monitor the pregnancy to ensure that witchcraft is not involved. All these things are done in order to ensure the health of the child.

Some rituals surrounding childbirth: infertility and disposal of the umbilical cord

A newly born child has a ‘long navel’, which is what remains of the umbilical cord after it has been cut. Soon after delivery, Tumbuka women tie a string around the waist of the child together with the umbilical cord. This is done because they fear that the cord may fall between the legs of the child and when this happens, such a child will not be able to reproduce in future (see Mkandawire, 1998, for similar findings). While the Tumbuka fear the falling of the umbilical cord between the legs of the newly born child, the Nyakyusa make sure that the child’s cord does not fall between

its mother's legs; for if it happens it is believed that the child will be sterile (Wilson, 1957).

The falling of the remains of the umbilical cord between the legs of the child at birth is believed to be one of the causes of infertility in the Tumbuka society. In the Chisinde area, one thirty year old woman was reported to have been married and divorced three times because she could not bear children. One of the reasons people gave was that her father and mother had been careless and it was very possible that the umbilical cord had fallen between her legs.

From the day the woman delivers, she is not supposed to engage in sexual intercourse until after the child is weaned. After delivery, she is also not allowed to cook for a period of one month, because, during this time, she is considered to be *wakubinkha* (unclean) as she continues discharging the *lochia*, which may last between 2 and 4 weeks. If she cooks food for the household, those who eat that food will be defiled (*wakazuzgika*), because the food has been cooked by someone who is "unclean". Her dirtiness is transferred to the food she has cooked through physical contact. The woman who has just delivered and her husband must sleep on different beds or mats because the woman is still unclean. Like a woman who has just delivered, a menstruating woman is also not allowed to cook and she should also sleep separately from her husband. One herbalist said that it is not only the Tumbuka who perceive menstruating women as unclean. He cited Leviticus 15, which, among other things, says that menstruating women are unclean, hence sexual intercourse with them and indeed contact with anything with which they have had contact with, should be avoided.

After delivery, the child is kept in the house until the umbilical cord falls off. The newly born child is also kept in the house (as we shall see later) in order to protect it against those people who are considered 'hot', because of acts of sexual intercourse. Mkandawire has also argued that newly born babies are kept indoors because it is

believed that they are not strong enough and may inhale air from outside that may cause them to fall sick and die (Mkandawire, 1998). Among the Lele of Zaire, it is believed that new-born babies will be killed if they came into contact with anyone coming fresh from sexual intercourse, and in order to protect these vulnerable babies, Douglas says that:

“Yellow raffia fronds were hung at the entrance of the compound to warn all responsible persons that a ... new born baby was within” (Douglas, 1966:152).

Among the Tumbuka, during this time, flowers of pumpkins are picked and some liquid is squeezed out (from the fresh pumpkin leaves) onto the navel of the child or a maize cob is burnt and its ashes put on the navel. In some cases, the ashes from the maize cob are mixed with Vaseline ointment and the mixture is smeared on the navel. This helps the umbilical cord to fall off within 3 to 5 days so that the child can come out of the house. The Ngoni of Malawi also use a maize cob to hasten the falling of the umbilical cord. Unlike the Tumbuka, the Ngoni squeeze the juice of a small bitter thorn apple into the ashes of a maize cob. This is mixed in castor oil and the mixture applied to the baby's navel (Read, 1959). In addition to ashes, some people apply dirt from a pounding stick, cow dung and other traditional medicines to the navel (see Government of Malawi, 1993). However, the application of such material is discouraged in biomedicine as the baby's navel can be a point of entry for many infections, such as tetanus. This is why some mothers said that health workers at the local health centre castigated mothers whose children had such material on their navels.

Once the remains of the umbilical cord fall off, arrangements are made to bring the child out of the house. The leaves of a tree called *muzuwula* are picked and crushed in a mortar and these are put in a winnowing basket. Some water is poured into the basket and the woman is told to go out of the house with the child. As she goes out,

she stands in the doorway facing outside. Another woman, also standing in the doorway, lifts the basket above the child and mother, and the filtrate from the basket falls on the child, and bathing him in the process. When they are outside, the mother again goes back into the house and as she passes through the door, the filtrate falls on the child and the bathing ritual is repeated. When the child has been bathed in this way, every person can touch it, even if that person is 'hot'. They also take the bark of *muzuwula* and twist it into a string that is put around the neck or waist of the child. The bark of *muzuwula* is also immersed in water and the concoction used to cook porridge, which the child also takes in the doorway. Elderly woman explained that this ritual takes place in the doorway because a diverse group of people enter through the door, including those who are hot, and this ritual tends to render them harmless as soon as they enter through the door. The ritual is necessary because it prevents the child from suffering from *chikhoso chamoto* type of illness, as we shall see later.

The umbilical cord has to be disposed of properly because it is feared that when it is just thrown away anyhow people may find it and use it to make some dangerous medicines, which can harm the child and its mother. The most frequently mentioned example given by informants was that the fallen umbilical cord may be used as *chizimba* to mystically multiply one's crop yield even if one has a small garden. The umbilical cord is compared to the woman's womb and since it is from a woman *uyo akwandana* (who reproduces), it implies that the crop yields will also be large. According to some elderly women and TBAs, the correct procedure for disposing of the umbilical cord is as follows:

A hole is dug at the base of a tree and the part of the umbilical cord that faced away from the child's navel is put into the ground. The hole is then covered. What is left above the soil is the part of the umbilical cord that was attached to the child's body. If one makes the mistake of covering the whole umbilical cord with soil, this will harm the mother, because she will not be able to conceive and give birth again.

Informants, mainly old women and traditional birth attendants, said that it is important to know the place where the fallen umbilical cord is (partially) buried, because when the woman fails to conceive again, a traditional healer will have to make *chimika* medicines (these will have to be thrown or placed where the umbilical cord was buried), which will make that woman conceive again.

The fallen umbilical cord is compared with the womb of the woman, and burying it would imply burying the woman's womb, thereby causing that woman to be 'infertile'. Some elderly women said that it is a requirement that two or more people should be involved when getting rid of the umbilical cord so that they remind each other of the proper way of doing this work. If only one woman does it, she might make some mistakes, and cause misfortune to the mother.

Both men and women also said that should the baby die within one month of birth, it should be buried in a very shallow grave and the funeral should only be attended by women. In this study, women did not explain why such a child should be buried in a shallow grave. However, this belief also exists among the Chewa of central and southern Malawi and Chakanza explains that at this tender age the child is regarded:

“As part of the mother (*chiwalo chamayi*) and therefore burying it in such a deep grave would be the same as burying the womb of its mother, thus making it impossible for her to have another child” (Chakanza, 1998:31).

While informants said that such funerals are attended by women only, I (together with other men) attended the funeral of a three week old baby in May 2002. During this funeral, it was noted that the men only dug the grave, while the women were responsible for all other activities related to burial (for example, putting the coffin in the grave and covering it with soil). When the burial was over and before people left the graveyard, it was also observed that an elderly woman led the bereaved young

woman to her baby's grave and some milk was squeezed from her breast onto the grave of her child. Elderly men and women explained that the act of squeezing out the mother's milk onto the grave is important because it signifies that "the dead child has gone with or taken away its milk"; hence the woman will not experience any pain arising from too much milk accumulating in her breasts. These elderly people also explained that during the funerals of such little babies, the mother is still discharging *lochia* at the time, hence she is unclean. This explains why most of the burial activities are done by women as it is feared that men would swell up if they participated in such a burial.

The Tumbuka Conceptualisation of abnormal births: twins, breech births and *makhumbi*

Thus far, our discussion has centred on the Tumbuka's perceptions about pregnancy and some rituals surrounding birth. The ritual conducted in the doorway strengthens the child so that he or she should not be affected by people who are considered "hot". Rituals of strengthening newly born babies in order to protect them against disease and misfortunes are done in many African societies. For example, while among the Tumbuka the strengthening ritual is done to protect children against "hot" persons, among the Zulu the ritual is aimed, among other things, at protecting children against *izinyamazane*⁴³(Krige, 1965:66). While these strengthening rituals serve an important purpose as far as the Tumbuka and the Zulus are concerned, it should be noted that among the Tumbuka, as we shall see later in this chapter, when children are born, they will either be accepted into society or isolated (together with their parents), depending on the way in which they are delivered. In line with the biomedical conceptualisation, the Tumbuka also know that a woman is supposed to carry her child for nine months, after which she should deliver. If it is a 'normal' birth, then

⁴³ *Izinyamazane* are diseases which the child may have contracted while in the womb, as a result of its mother having walked over the tracks of harmful animals (Krige, 1965).

there are no problems and people are generally very happy. However, if the birth is not normal, according to Tumbuka beliefs, then people start to wonder. For example, if, during delivery, a hand comes out first as if the baby is requesting something, they ask “*mwana akulombachi?*” meaning, “what is he requesting?” If it is a breech birth, they ask “*mwana ababika wakifulika chifukwa vichi?*” meaning, “why has the child been born with legs coming out first?” If it is twins then they say “why twins?” According to informants, the Tumbuka seem not to like the idea of human beings giving birth to more than one baby at a time, as is the case with dogs and other animals, and they explicitly make the association between animals and multiple births. Multiple and breech births are regarded as abnormal births, and as the Nyakyusa say:

“Kyala [God] made us to have one child so when we have twins it is just like an illness” (Wilson, 1957:168).

Among the Tumbuka, it is possible to recognise twins and even those who were born by breech births because they are given special names. In the case of twins, the first to be born is called *Muleza*, which means “twin” while the other is called *Nyuma*, meaning “later” or “after”. Those born by breech births are given the name *Mavunika*. If one hears these names, he knows that the person bearing that name was not born in a normal way, as conceptualised by the Tumbuka. While the Tumbuka are generally not happy with twins, Read says that among the Ngoni, the birth of twins is celebrated and they kill a beast to give the mother meat and broth to increase the flow of milk (Read, 1959). Reynolds-Whyte, who has done extensive fieldwork among the Nyole of eastern Uganda, states that among these people, children are valued so much that when twins are born they celebrate and (they) say:

“Give us births. Give us male and female, let us deliver two by two that we may always hold twin ceremonies here” (Reynolds-Whyte, 1997:55).

While these people celebrate, the Tumbuka do not as the couple with twins is considered dangerous to people, as well as domesticated animals, and hence they are isolated from the rest of the community. The Nyakyusa also hold the same beliefs (Wilson, 1957). Unlike the Tumbuka and the Nyakyusa, Krige says that among the Zulu, one of the twins was killed at birth by placing a lump of earth in his throat in order to prevent death in the family (Krige, 1965).

Abnormal births among the Tumbuka are known as *makhumbi*, of which there are three major types, namely: *makhumbi yawamuleza* (twins), *makhumbi yamavunika* (breech births) and *makhumbi yachiwulira*. After a woman delivers, it may be some months before *andasawule* (i.e. before she resumes her menstrual cycle). During this period, the couple is not supposed to engage in sexual intercourse until the child is weaned. As will be explained later, the postpartum sexual taboos have to be observed in order to protect the child against diarrhoea and *chikhoso chamoto*. When a woman resumes her menstrual cycle [after delivery], she is supposed to show her menstrual blood to the traditional birth attendants or indeed any other elder. If she gets pregnant before she resumes her menstrual cycle, the Tumbuka consider it to be an abnormal birth known as *makhumbi yachiwulira* – an abnormal birth that carries a heavy sanction. As Zulu says, among the Tumbuka this situation is generally regarded as “appalling and disgraceful” (Zulu, 2001:474).

If the wife has had an abnormal birth, the couple is considered dangerous and is isolated from the rest of the community. In the past, a temporary shelter was erected away from the village where the couple stayed until the isolation period was over. These days, while a shelter might be erected, some people just turn their kitchen into a temporary shelter, as the following photograph shows (see Figure 7.1).

Figure 7.1 Photograph showing the hut where a couple with twins stays before reincorporation into society

Main House



This kitchen was turned into a temporary shelter for the couple with twins. In the past, the shelter was built very far in the bush.

The length of the isolation period depends on the type of abnormal birth and it ranges from one month to more than two years. During this period, their other children are taken care of by other members of the family. The Nyakyusa, who live in southern Tanzania on the border with Malawi, like the Tumbuka, also consider multiple and breech births as dangerous and also isolate the couple from the rest of the community. The difference is that, among the Tumbuka those with abnormal births have to take care of themselves, while among the Nyakyusa, the mother is taken care of by her own mother, while the man is taken care of by his daughter or son (see Wilson, 1957) and husband and wife live in separate temporary huts.

The temporary shelter, where the couple with *makhumbi* stays, is supposed to be erected downwind of the village, because when it is erected upwind, the Tumbuka fear that the smoke from the fire that the couple is using to cook their food will blow towards the village. The smoke from such fires is considered polluted and when it blows towards the village it makes people (especially children) as well as domesticated animals "swell" (as it will be explained below), and consequently it might kill a lot of people. Those with *makhumbi yachiwulira* will stay in that hut until the woman delivers and resumes her menstrual cycle, which may take a minimum of two years. The chances of a woman cheating, pretending that she had resumed her menstrual cycle before she became pregnant, are very slim as she would have to show the traditional birth attendants (*wazamba*) that she had resumed her menstrual cycle, as explained earlier. Without such a demonstration, it would be assumed that she had not started menstruating, and hence she (and her husband) would have to be isolated. The traditional birth attendants play an important role in ascertaining whether the birth is normal or not. If it is abnormal, they will inform the rest of the community; and the newly born baby together with its parents will have to be isolated. Unlike the Tumbuka women, the Bariba women give birth alone and the duty of ascertaining normal and abnormal births is made particularly difficult (Sargent, 1985) in their case, especially with regard to breech births.

One informant, Nyachirambo, gave the example of her son, Lumbani, who had *makhumbi yachiwulira* in the early 1990s. She said that Lumbani, together with his wife, was isolated and during that period they cooked on their own until the wife had delivered and started her menstrual cycle and a ritual had been conducted to reincorporate the couple and the newly born child into the community. Even their own child (who was breastfeeding at the time) was taken away from them and he never went to his parent's hut or ate food with them during the period of their isolation. For the other types of abnormal births, namely, twins and *mavunika* (breech births), their polluted state is not so feared because it is not the wish of the couple but God's wish; hence they are only isolated for a period of one month i.e. until the cessation of the flow of the afterbirth. *Makhumbi yachiwulira* is so feared because it involves sexual intercourse with a woman who is considered unclean and at a time when the couple is supposed to adhere to postpartum taboos on sexual intercourse. It can etically be argued that the heavy sanction imposed upon a couple with *makhumbi yachiwulira* is a way of enforcing postpartum sexual taboos, and at the same time a good cultural method of spacing children.

The Tumbuka, like the Nyakyusa (see Wilson, 1957), believe that any contact with the couple who are in the state of *makhumbi* would result into "swelling" (*kutupa*) of the people as well as of domesticated animals. This can be perceived as an example of contagious magic in which the swelling of the pregnant woman is mystically transferred to the people with whom she comes into contact or to people who come into contact with anything she has touched. The contagion is transferred to her husband as well. For the Nyakyusa, in addition to swelling, people also develop diarrhoea when they come into contact with those who have had an abnormal birth (Wilson, 1957). A couple in this condition has to be isolated from the rest of the community (as has been explained above) because it is feared that *wangakazuzga wanthu pamuzi* (they can defile people in the village). When women in the state of *makhumbi* cook food, whoever eats that food swells. While adults swell when they come into contact with a couple in the state of *makhumbi*, informants stressed that the

swelling is more pronounced in children.

There is a need to note a shift in the interpretation of swelling in children. While almost all old men and women attributed swelling to *makhumbi* (and sexual intercourse as will be explained later), some of the young informants said that these days when children swell they think that it is possibly because of lack of food (malnutrition) as the problem of *makhumbi yachiwulira* is on the decrease because of family planning methods, such as the use of condoms. A 36 year-old male informant recalled that the last case of *makhumbi yachiwulira* occurred in Chisinde in the early 1990s, while twins and the *mavunika* type of *makhumbi* occurred in 1997. It is also felt that the cases of *makhumbi yachiwulira* are very rare because the sanction lasts a long time, and it is very painful.

Should a couple that has suffered *makhumbi* take with them some plates when they go to the temporary shelter, those plates will have to be destroyed and thrown away because they have been defiled (*zakazuzgika*) and hence are unclean. If they do not do so and others use the same plates, then those people will “swell”. When people have cooked food that they would like to share with those in the shelter, they are supposed to meet half way and they give them food on leaves (e.g. leaves of bananas). When a couple has *makhumbi*, they are both supposed to put on only a limited range of clothing. They have to choose those clothes that they are prepared to throw away when the period of isolation is over.

There are certain instances in which a couple, even though they are in the state of *makhumbi*, do not refrain from interacting with others. In such cases, some of the people (they interact with) may decide to have herbal baths⁴⁴ in order to protect themselves and their children against swelling. One informant added that this is as if

⁴⁴ They could not reveal the type of herb that they use.

one has “vaccinated” oneself and one’s family against being affected by those in the state of *makhumbi*. When one has protected oneself and one’s family in this way, it is the couple with *makhumbi* (and their children) who will suffer from swelling if they (deliberately) come into contact with members of the (protected) household. This can be compared to what Davis-Roberts calls “sending back to the sender whatever misfortune he [the witch] may project towards [the intended victim]” (Davis-Roberts, 1992:388).

When the period of staying in the temporary shelter is over, informants said that a ritual is conducted to reincorporate the couple and the children into the village. A herbalist takes the bark of the *uteta* tree and soaks it in water after which the mixture is boiled. The water is poured into four potsherds, and everyone invited washes his hands and feet. Boys, girls, men and women use their own potsherd when washing, which is why they have four potsherds. However, there are variations in the preparation of these purification medicines. While some use four potsherds, others only use two: one for males and the other for females. Some of the medicine that was cooked is put in a winnowing basket. A goat or chicken (if available) is killed and some blood is mixed with the medicine. A woman feeds only her fellow women, while the man feeds only his fellow men. The goat or chicken killed during such a ritual is taken away by the herbalist who prepares the medicines. As we shall see later, herbalists who prepare such medicines are not paid in cash. Instead they take away the clothes, the blankets, the bed sheets, plates, pails and the goat or chicken which is killed during such a ritual. In the evening, the couple uses a broom to sprinkle some medicines in all the houses where they used to visit. If the child is a girl, it is the mother who does this; when the child is a boy the father will do it.

But why is *uteta* used in this purification ritual? One statement made by a traditional healer based at the Eva Demaya Centre regarding the use of *uteta* during this ritual was:

“Chitechi chinjire pa chitechi chinyakhe ndipo vikukolererana”.

What this Tumbuka statement means is that something which is soft (*chitechi*) should be used to treat another thing which is also considered or perceived to be soft. The *uteta* tree is very soft, even when it is dry. After delivery the mother is very weak (*akuwevya nkhongono*) and therefore both the child and mother are considered “soft”. Traditional healers said that *uteta* is used in this ritual because the tree, the mother and her child are all considered soft. Traditional healers at the Eva Demaya Centre also added that, for the same reason, *uteta* is also used in the ritual conducted to bring the baby out of the house after the fall of the umbilical cord. The Tumbuka words *chitechi* and *chiteta* both mean “that which is soft”. The name *uteta* is therefore derived from the word *chiteta*; hence from the name of the tree one can sometimes suggest its use.

All restrictions regarding taboos associated with *makhumbi* have to be followed, as failure may result in the destruction of life, as the following example shows:

Mr Chiukepo Gondwe and the death of his two children

Mr Chiukepo Gondwe had lived and worked in Zimbabwe for a long time. He returned to Chisinde in 1971. At the time, he had two children, both of whom died later. When he returned to Chisinde, his wife was pregnant, but she was breastfeeding (as will be seen later, a pregnant woman is not supposed to breastfeed), which was perceived to be what killed the younger (the one who was breastfeeding) of the two children that they brought from Zimbabwe. The elder one died because his mother was cooking for him.

It was alleged that Chiukepo Gondwe’s wife got pregnant before resuming her menstrual cycle after delivery. As has been explained earlier, such a woman and her husband are supposed to be isolated and they should not cook for anyone. Some of

Chiukepo Gondwe's relatives claimed that the elder child died because he ate food prepared by his mother, who was unclean and was supposed to have *makhumbi yachiwulira*. Because Mr Chiukepo Gondwe had lived in Zimbabwe for some time, working as a migrant labourer before returning to Chisinde in 1971, he did not know much of the customs pertaining to *makhumbi* and sexual intercourse. The death of his two children was seen to prove this point; although, during a discussion with him, he did not attribute the death of his children to his "non-compliance".

While it is now close to 10 years since the last case of *makhumbi yachiwulira* happened in Chisinde and about 5 years since the other types of *makhumbi*, SGVH Chisinde and most people indicated that should it happen today that a couple has *makhumbi* (of whatever type), a temporary shelter will be erected for them away from the village, as has always been done among the Tumbuka. There have been some modifications to this practice. While in the past there was a lot of bush and uncultivated land, this is no longer the case; hence what happens is that a shelter is erected very close to the village or even next to your own hut, as can be seen from the following case, which happened in Mkupa Village in August 2000, where a kitchen was turned into a "temporary shelter".

Interview with Sekanawo: a father of twins

When Sekanawo's wife was 8 months pregnant, health workers at the local health centre told him that his wife was expecting twins. He visited two diviners who had told him that it was not twins, but that the child was not properly positioned in the womb. Though the diviners told him this, he however believed what the hospital workers told him. When the time to deliver was near, his wife left for Rumphu District Hospital with her mother (Sekanawo's mother in-law). After staying in the hospital for two days, she gave birth to twins on 21st August, 2000. This was at a time when Sekanawo was selling tobacco at the Mzuzu Auction Floors. On 22nd August, 2000, as he

was going to Mzuzu, he passed through the hospital and gave his wife transport money to be used when returning home. The wife and twins were discharged from the hospital on 23rd August, 2000, on the same day he was coming back from Mzuzu, but the wife and the twins reached home first. When Sekanawo got home in the evening his aunts, NyaChaura and NyaZgambo (wives of his mother's brother), were at his house and they forbade him to enter his house because [he was told] he had *makhumbi*. He argued that there was no need for him not to enter his house as having twins was not a sin, but a gift from God. Instead of a temporary shelter being erected for him, there was a kitchen and he found that some of the walls had been covered with grass, and there was a sack at the door. He was instructed to move into the kitchen and not to enter his house again until a ritual had been conducted to cleanse him and his wife. Whenever he wanted something from his house, he was advised to send someone else. He, together with his wife and the twins, slept on a sack and used their own plates; they did not eat with anybody else and had a jug for drawing water. They were supposed to put on one set of clothes that were washed at night only. Though he was given these instructions, he said that this was such a busy time and he could not stick to the rules as he used to go to Mzuzu now and again. He had bank books in his main dwelling house, and hence he could not do without going into the main house to collect them. He also used to enter his house (though he was told not to) to change clothes. He said that he was instructed to put on one set of clothes because of the fear that if he put on different sets of clothes, the one who would come to conduct the ritual, would take all those clothes as well. If he used all his clothes then the herbalist would collect everything.

The movements of Sekanawo and his wife were also very restricted. They were not allowed to eat using other people's plates because it was argued that there are some people who used protective medicines; and when one used their plates, they would start swelling, or the wife would not start menstruating

early. A temporary shelter was not erected for them because they had a kitchen. At first they were told that they could only move out of the kitchen once the woman started menstruating again. He, however, told them that he was just too busy and he wanted to move into his house as soon as possible. So the herbalist agreed and he prepared some medicines for them as described below.

On the day the ritual of reincorporating them into the society was carried out, a herbalist prepared some medicines; but Sekanawo and his wife did not know the composition of these medicines. The herbalist crushed the medicines (consisting of barks and roots), boiled them and then poured them into two potsherds. One potsherd was for females and the other for males. Everyone came and washed their hands and feet. Part of the medicine that was cooked was poured into a winnowing basket, together with some beer. The husband drank some of this and held the mixture in his mouth and then spat it out. The second time he drank the mixture he swallowed it, and then the others followed suit. The people who took part in this ritual were those who attended to Sekanawo's wife while in hospital, and neighbours. This ritual marked the end of the isolation period.

Then the herbalist told Sekanawo and his wife to get all the things that they had used during the isolation period. The couple gave the herbalist a blanket, bed sheets, shoes, clothes (the wife had used one dress and the husband one shirt and one pair of trousers) and the jug for drawing water.

Though Sekanawo did not know the plant or herb that the herbalist used to prepare the medicines used in this ritual, it can safely be assumed that the herbalist used *uteta*, a plant that many other informants mentioned as the one used in such circumstances. Most informants said that the herbalists who prepare *makhumbi* medicines are not 'paid' in cash, hence, as was the case with Sekanawo, they take away those things that

the couple was using during the isolation period as a 'form of payment'. In general, contact with a couple in the state of *makhumbi* is prohibited, but those people who have also undergone this process (i.e. those who have had twins themselves) can interact with them without swelling. This explains why Sekanawo's aunts, NyaChaula and NyaZgambo interacted with him as they had also given birth to twins.

While in Sekanawo's case, his kitchen was turned into a temporary shelter, there have been some cases where the person's own house was turned into a temporary shelter and, after the period of isolation, the house was destroyed and a new one built as the other house was considered defiled, and hence they could not continue to live there. Sekanawo's case shows that the isolation of people with *makhumbi* is still being practised among the Tumbuka. As far as the Tumbuka are concerned, a couple with *makhumbi* has to live in isolation, mainly because of children. Elderly men and women may easily avoid a house belonging to a couple with *makhumbi*. Children do not know anything and may therefore easily wander and interact with those who are in the state of *makhumbi*, resulting in 'swelling'. In order to protect children against this, such couples have to be isolated.

The Tumbuka also recognise that abnormal births are very rare occurrences. Biomedically, 96 percent of births are predicted to be vertex presentations, with less than 4 percent as breech births (Sargent, 1985). The delivery of twins is also a rare occurrence. Anything that deviates from what the Tumbuka perceive as a normal birth is, therefore, considered dangerous to the health and welfare of society at large and hence it has to be isolated. Such occurrences tend to destroy or disturb the established structures within society, as can be discerned from such statements as "why twins?", "why breech births?" etc. Twins and breech births are not considered very polluting, hence the mother, father and the newly born are isolated for only a very short period, as it has not been done deliberately; it is considered to be God's wish. However, the Tumbuka consider *makhumbi yachiwulira* to be a deliberate action, a breach of postpartum sexual taboos. As has been explained earlier, postpartum sexual

intercourse is prohibited and two major reasons were given locally: to protect children from contracting diseases like *chikhoso chamoto* and diarrhoea, and secondly, to prevent *makhumbi yachiwulira*. If a couple has *makhumbi yachiwulira*, it is proof that they have been having sexual intercourse at a time when the woman was still unclean; after delivery she had not started menstruating and hence she had not 'bathed'. This flouting of societal rules is seen as deliberate, and hence they are removed from the community and treated in some ways as social lepers, as explained earlier. Their removal from the community is because any contact with them is considered dangerous to the health of the people (especially children) and domesticated animals (see also Wilson, 1957, for similar beliefs among the Nyakyusa). The punishment meted out to such people lasts a long time so that others may learn that flouting societal rules is wrong and punishable. While these explanations were given by the Tumbuka people, it can also be argued that postpartum sexual taboos are also useful as they encourage the spacing of children, which is beneficial both to the mother as well as the children⁴⁵.

Engaging in sexual intercourse and putting the health of children at risk: *chikhoso chamoto* illness and strategies for its prevention and treatment

As we have discussed above, as soon as a child is born, he is kept in the house until the umbilical cord falls off and a ritual is performed to protect him against people engaged in sexual intercourse. In addition to the fear of *makhumbi yachiwulira*, postpartum sexual intercourse is also prohibited because the Tumbuka believe that sexual intercourse can cause *chikhoso chamoto* in children, as well as in old men and women. A child suffering from this illness is very thin (others compared the child's

⁴⁵ Lepowsky also says that postpartum sex taboos were observed in Papua New Guinea on Vanatinai Island. No sex was allowed for a period of three years and this dropped to two years between 1978 and 1987. These taboos were observed because it was feared that the child would sicken and die. She contends that this helped the cultural ideal of child spacing (Lepowsky, 1990).

thinness to a stalk of maize), has fever and sometimes also has diarrhoea. Such a child is very light and cries a lot when held by the ribs. While some children waste after coming into contact with those who have been involved in sexual intercourse, others however swell depending on their "blood". From this, it can be seen that, in children, *chikhoso chamoto* illness is presented either by severe wasting or swelling especially of the hands and feet. In some cases these symptoms are accompanied by coughing. *Chikhoso* means 'cough', *cha* means 'of' and *moto* means 'fire'. The name *chikhoso chamoto* therefore literally means a 'cough of fire' and is derived from the fact that 'fire' is one way in which the child contracts this illness. The Tumbuka believe that when a person who has been involved in sexual intercourse touches the fire where the child's porridge is cooked, he or she pollutes the fireplace, thereby affecting the child's health. While informants said that the name, *chikhoso chamoto* is derived from the 'fire', some people also argued that the act of sexual intercourse generates a lot of heat, hence the 'fire' in the 'cough of fire' denotes sexual heat.

It is believed that those people who are involved in sexual intercourse can cause *chikhoso chamoto* in children and old people (who are not sexually active). People leading a normal sexual life are considered (potentially) hot (*wamoto*) and they can be dangerous (causing disease and misfortune) to the elderly and children who are considered cold (*wakuzizima*). While among the Tumbuka both physical contact and fire can lead to sexual pollution, among the Bemba it is mediated only by contact with fire (Richards, 1956; Douglas, 1966). Among the Chewa of central Malawi, *chikhoso chamoto* is known as *tsempho* or *mdulo*. Like the Tumbuka, the Chewa say that *tsempho* is characterised by severe wasting or the child's body might swell, and this is related to promiscuous sexual relationships or to the indulgence in sexual intercourse by spouses during prohibited periods (see Morris, 1986; Chakanza, nd; Marwick, 1965).

Young and old men and women said that if any person, after having had sexual intercourse, goes back home and lifts a child, shares with him cups for drinking water

or plates, feeds the child or touches the fireplace where the child's porridge is being cooked, that child will suffer from *chikhoso chamoto*. There are others in the village who may want to light a cigarette and may, therefore, go to someone's fireplace to do so. In some villages, this is not allowed because they say that they do not know what that person had been doing and he or she may have had sexual intercourse; hence he would pollute the fireplace, thus causing *chikhoso chamoto* in children and the elderly. Parents who have a small child are not supposed to have sexual intercourse until it is weaned, for fear of making it ill. Viyezgo, a 26 year-old informant from Chisinde Village, who got married in April, 2000 (two months before I commenced my fieldwork), admitted that at the time he was having sexual intercourse with his wife; hence they were not allowed to touch or hold small children otherwise those children would have developed *chikhoso chamoto*. They were not even allowed to touch the fireplace belonging to Viyezgo's parents otherwise they (Viyezgo's parents) would have suffered from *chikhoso chamoto*. When the parents cooked relish, they were forbidden to touch the pot, fearing that the parents would suffer from *chikhoso chamoto*. He said that these are the instructions that he got from the TBA and he (and his wife) stuck to them, otherwise, the TBA would have reprimanded and reminded them that their actions would make their parents and children suffer from *chikhoso chamoto*. Among the Tumbuka, as a man prepares to get married, he has to build a house where he and his wife will live once they are married. Although interaction with the man's parents cannot be avoided, there are *invisible boundaries* that the newly married couple cannot cross (for example, touching their parent's fireplace), for fear of making them sick. All the old men and women explained that *chikhoso chamoto* is due to sexual intercourse. While young men and women subscribed to this idea, they also said that this condition might also be due to malnutrition. Health workers said that the signs and symptoms presented by a child suffering from *chikhoso chamoto* are those of a malnourished child suffering from either marasmus (severe wasting) or kwashiorkor (swelling); hence biomedically this illness can be prevented by giving the child a balanced diet as we shall discuss below.

The onset of *chikhoso chamoto* in children can also be explained in terms of the humoral theory (or the hot-cold theory of disease), which has its origins in Hippocratic and Galenic medicine. This theory postulates that health can be maintained or lost by the effect of heat or cold on the body. The coldness or hotness in this context does not necessarily refer to the actual temperature, but to symbolic powers (Helman, 1994; see also Foster and Anderson, 1976). While sexual intercourse according to the Tumbuka makes the couple dirty, and dirtiness is a threat to the health of children, informants also said that sexual acts make those involved “hot”. The Tumbuka consider children and the aged to be cold while people within the childbearing age are considered “hot” or potentially “hot” as they may be involved in sexual intercourse any time. Any contact between a hot person and the child would make the child fall sick. Contact therefore has to be avoided in order to ensure the good health of the child. In order to treat these diseases which have been caused by contact with those who are hot, water and other medicines that are considered cold are used, for example (as explained earlier) the use of ashes in the preparation of amulets and pouring water (mixed with herbs) over a hot axe, as will be discussed later.

Preventing *chikhoso chamoto* in children

One of the things that mothers do to protect a child against *chikhoso chamoto* is to make a separate fire that should be used for cooking the child’s porridge. People engaging in sexual intercourse are not supposed to touch this fire as they can harm the child. This fire is made away from the other fires used to cook the household’s food. It is the mother who cooks the child’s porridge as she is expected to observe postpartum sexual taboos at this stage, and hence she is not seen as a threat to her child’s health. The making of a separate fire where a child’s porridge is prepared with the intention of protecting the child against “hot persons” seems to be widespread: for example it is also practised among the Yao (Munthali, 1999; Munthali, 2002) and the Bemba (Richards, 1956:30).

In addition to making a separate fire, some protective medicines can also be put on the hearth or the fireplace to protect children against *chikhoso chamoto*. Informants did not reveal the names of these medicines, but they explained that a hole is dug in the fireplace, and the medicine is put in this hole, which is then covered. A fire is made on top of this (former) hole. Some of this medicine is used to prepare a herbal bath for the child. When this has been done, mothers do not care whether someone who has had sexual intercourse touches the fire, as the child will not be affected. In some cases, these protective medicines work in a such a way that the one who had had sexual intercourse (and would have harmed the child when he or she touched the fireplace where the child's porridge is cooked) is the one who suffers from *chikhoso chamoto* (i.e. if person A has sexual intercourse and touches the hearth belonging to person B, who has a child C, and person B had buried protective medicines on the hearth where she prepares porridge for child C, instead of child C getting *chikhoso chamoto*, it is A who will get this illness). It is claimed that when such people develop the cough, they are not easily cured. They may then decide to consult diviners who will reveal to them the reasons they are suffering from *chikhoso chamoto*.

In addition to the above methods of preventing "*chikhoso chamoto*", herbalists and some elderly women said that ashes are mixed with other ingredients and the mixture is put on a black piece of cloth. The cloth is sewn and attached to a string which the child wears around the neck. As has been explained, *chikhoso chamoto* is caused by "hotness" (arising from acts of sexual intercourse) and this is perceived as synonymous with fire, and the touching (by those who are impure because of engagement in sexual intercourse) of the fire where the child's food is prepared, hence some elderly women said that the use of ashes in the preparation of these protective amulets is to counteract the effects of fire, i.e. to act as a cooling agent. Once an amulet is worn, either it is not taken off the child until it snaps on its own or it is removed when a child reaches weaning age and is kept for another child. Informants said that there are certain instances where the child wears amulets to

protect him or her against *chikhoso chamoto* and other diseases, but the child still suffers from the disease the amulet is supposed to protect against. Informants said that this is possible because some medicines expire (*yakusukuluka*), and hence lose their protective strength. In these circumstances, they have to prepare a new amulet. The use of amulets as a protective measure against childhood illnesses caused by sexual intercourse and other related factors is widespread in Malawi (for example see Chakanza, nd; Chakanza, 1998, for the Chewa and Yao; and Munthali, 1999; Munthali, 2002 for the Yao).

While it was observed that many children under five were wearing amulets, mothers said that there are comparatively fewer children wearing amulets these days. One of the reasons is that when children are sick, they are taken to the health centre for treatment. Informants said that when doctors see children wearing amulets they shout at the mothers, telling them that it is the amulets that cause disease in the children. Some health workers even take away those amulets from the necks or waists of children and throw them away. As far as the Tumbuka are concerned, most women said that amulets are looked upon as an indigenous form of immunisation; old men and women particularly would love to see the continuation of these practices.

In earlier times, when a man had had sexual intercourse with another woman, fearing that his children would become sick on contact, he would consult the elders and tell them what he had done. The elders plucked off some leaves from certain tree species (not mentioned by informants) and gave them to the young man, who then rubbed them between his palms. When he got home, he could lift the small child and it would not suffer from *chikhoso chamoto*. This was one way of hiding what he had done from his wife, because they would quarrel if she found out. Some young women interviewed said that even these days a man who has had sexual intercourse with other women, sometimes gets some herbal medicines consisting of leaves, and rubs these on the ribs of the child so that he should not be affected with his father's pollution. A study done among the Yao of Zomba in southern Malawi showed that, in

the past, a man who had committed adultery did not go straight to his house. He stood a few metres away from his house and called someone to whom he declared that he had committed adultery, hence he could not go to his house for fear of making his children ill. It was only after herbalists had administered medicines that he was able to go home and interact with his children (Munthali, 1999; 2002).

Women, in most cases, blamed the men if a child suffered from any disease believed to be caused by acts of sexual intercourse. When asked if women do not engage in sexual intercourse outside marriage, most women said that they do not do so because they want to protect the life of their child. One elderly man said that women are very clever. They have sexual intercourse, but when they come back, they treat the child with herbs without the knowledge of the husband. They do this very easily since they are the ones who look after children. Fwasani, a 30-year old man, said that women have extramarital affairs, but that they do so very secretly because they fear that once it is known that they are engaged in sexual intercourse with other men, they will be divorced. While men say this, many young women I interviewed said that, although many men are monogamously married, it is a known secret that they have concubines as 'they cannot stay with one woman'. There is therefore an element of mistrust between men and women.

Old men and women alleged that there is a very high incidence of *chikhoso chamoto* (i.e. children either wasting or swelling) and other diseases in children under five because young men and women do not stick to the cultural rules regarding sexual intercourse. In addition, they also alleged that the intermarriages between the patrilineal Tumbuka and matrilineal ethnic groups, especially those from the central and southern regions of Malawi, have led to the breakdown of Tumbuka customs, leading to non-compliance with societal rules.

The indigenous contagion theory (ICT) as an approach to understanding the *chikhoso chamoto* illness among children

As we have seen, children suffer from *chikhoso chamoto* because they come into contact with someone who has had sexual intercourse; they may “swell” because of coming into contact with someone who is in the state of *makhumbi*; and (as we shall see) they may develop diarrhoea because they have been breastfed on milk contaminated by sperms or because the mother is pregnant. Though the Tumbuka may administer some medicines to ensure that these children remain in good health, (as has been explained) those who are considered unclean are also isolated from other people including children, since they are considered to be contagious until the necessary rituals have been conducted to purify them (see Green, 1998:13). Among the Tumbuka, after delivery the baby has to be kept in the house, not because it is impure, but because it has to be protected from those people who are considered “hot”. Its food has to be cooked on a separate fire and such a fire is not supposed to be tampered with by anybody who is considered hot, for fear of polluting it, and hence causing illness to the child. The same thing applies to those people in the state of *makhumbi*: they have to be isolated and stay away from the village because they are considered to be pollutants and any contact with others would make them swell.

These results conform to what Green calls the indigenous contagion theory (ICT). He says that people become ill because of impersonal exposure. The ICT is based on the fact that people become ill as a result of contact with or contamination by, a substance or essence considered dangerous because it is unclean or impure (Green, 1998); hence Green says:

“The isolation, avoidance or social marginalisation of people in polluted states serves to quarantine those who, in fact, could be a health threat to others because of their contagiousness” (Green, 1998).

A couple with *makhumbi* and those engaged in sexual intercourse are considered a threat to the health of others, including children, because of their perceived contagiousness. For a couple with *makhumbi* and the newly born child, physical boundaries are set in place to prevent contact with others; for example, persons of childbearing age are forbidden to enter a house where a newly delivered mother and her child are, because they are considered potentially hot and hence can harm the child; and those with *makhumbi* are housed in a temporary shelter away from the rest of the community members. As Hammond-Tooke argues, such ritual prohibitions and taboos as those described in this chapter act as boundaries that protect the health of the population at large. The crossing of these boundaries, namely the breach of these ritual prohibitions, causes illness (see Hammond-Tooke, 1981). These beliefs in dangerous contagion, as Douglas argues, function to maintain the ideal order of society and to uphold certain moral values (Douglas, 1966).

Seeking treatment for *chikhoso chamoto* illness

Both young and old men and women said that it was a waste of time to seek biomedical treatment for a child suffering from *chikhoso chamoto*. Once it is determined that a child is suffering from *chikhoso chamoto* (for example, through the recognition of signs and symptoms or through divination), parents generally resort to traditional medicine. The following case illustrates how *chikhoso chamoto* is treated in young children:

Khumbolane had two wives and lived in Chisinde Village. In 1998, before marrying his second wife, he used to visit and have sexual intercourse with her. After this, he would return home and again have sex with his wife, hold his children and share food and cups for drinking water with them. His daughter, who was at that time three years old, developed a cough and her health deteriorated very badly. She became very thin. Khumbolane bought drugs from grocery shops to treat her, but her condition just worsened. The

elders informed him that his daughter's health was deteriorating because of his infidelity. He admitted that he was indeed having sexual intercourse with another woman and the elders dug up the roots of and plucked off leaves from the *muzuwula* tree and these were put in a cup. Some water was added. The elders then heated an axe in the fire until it was red hot and Khumbolane held this axe above the head of his daughter. He took the leaves and roots from the cup and squeezed them above the body of the child, making sure that the extract fell on the hot axe and then onto the head of the child. After this treatment, the condition of the child changed completely for the better the following day and he never bought any drugs from the shops again.

Instead of squeezing some liquid out of the concoction made using *muzuwula*, there is another way in which the therapeutic regimen is prepared and administered. The *muzuwula* is put on a plate and some water is added. The axe is put in the fire until it is red hot. The plate with *muzuwula* is then held above the head of the child. The person who is alleged to have made the child suffer from *chikhoso chamoto* is called and he or she takes the hot axe from the fire and immerses it in the *muzuwula* concoction placed above the head of the child, after which the child is healed. There are circumstances when the person who is being accused of having had sexual intercourse refuses to acknowledge that he is the guilty party, or they may not know exactly who caused the *chikhoso chamoto*. In such circumstances of uncertainty, everyone in the family who is sexually active is invited to participate in this treatment ritual. Those invited take turns in immersing the hot axe in the plate of *muzuwula*. We saw earlier that *chikhoso chamoto* is caused by sexual intercourse-related heat; hence the immersion of the hot axe in the plate symbolises the putting out or cooling the 'fire'. An axe is used to cut many things and its use in this ritual signifies that it will "cut down" (*kudumula*) the *chikoso chamoto* as well. Informants further said that if you administer modern medicines, the *chikhoso chamoto* comes back. Although adults may also suffer from *chikhoso chamoto*, children are the ones who are most

vulnerable, and on contact, are easily affected by those people who have engaged in sexual intercourse.

When it is known that the child is suffering from *chikhoso chamoto*, the elders start looking for herbal medicines. In most cases, it is the responsibility of the grandmother (the child's paternal grandmother) to look for treatment for her grandchild. Some of this medicine is used to prepare porridge for the child, while some is used to prepare a herbal bath. Leaves are soaked in water, taken out and squeezed over a child's head, as described above. All the people interviewed said that biomedicine cannot cure this type of illness; they have to seek recourse to traditional medicine. This is shown by Khumbolane's child in the above example. In general, from the Tumbuka perspective, traditional medicine for the treatment of *chikhoso chamoto* works but, if it happens that the medicine has not worked, then it implies that the medicines are just not compatible with the child; hence they have to look for other cures.

Is there sanctioned extramarital sexual intercourse in the age of HIV/AIDS or when the health of children or spouses is at risk?

The advent of the HIV/AIDS pandemic in the early 1980s and the subsequent diagnosis of the first case of AIDS at Lilongwe Central Hospital in 1985 led the Government of Malawi and local and international organisations to conduct research to determine the different factors that might enhance the transmission of HIV/AIDS in Malawian communities. Wife inheritance and the engaging of younger brothers and/or outsiders to assist those who cannot make their wives pregnant still persists (see Munthali, 2001) and these are some of the factors that are enhancing the transmission of HIV/AIDS among the Tumbuka.

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Among the Tumbuka children are important because, in the absence of a formal social security system, children are the ones who help or provide for their parents in their old age. Children also change the status of their parents. For example, a woman will still be considered a girl until she has a child. Because of the value that is placed on children, couples will do all they can in order to have children who can carry on the name of the patrilineage. If a woman does not show any signs of pregnancy several months after getting married, aunts and grandparents intervene. Among the Tumbuka, there are several ways of helping a couple who do not have children to be able to do so. When the woman does not get pregnant she and her husband are advised to try extra-marital sexual relations, preference being given to men from the husband's lineage. In establishing these outside sexual relations, the aunt (the husband's father's sister) or grandmother plays an important role. She (the aunt) will discuss the issue with the man in the absence of the wife and advise him that it is possible that his wife is not getting pregnant because she is infertile. Hence, it would be advisable for him to try other women for the sake of having children. The man starts having sexual intercourse with another woman without the knowledge of his wife and when it happens that such a woman gets pregnant, the conclusion might be reached that it is the wife, rather than himself, who is infertile.

While the husband does this, the aunt also discusses the issue with the woman and consequently advises her that since her husband is failing to make her pregnant, it would be useful for her to try other means of getting pregnant. While women and their husbands might be able to arrange all this on their own, the aunt in most cases plays a role in making such arrangements. Informants said that while these arrangements are being made, women in general live in fear because if their husbands find out they could be divorced on grounds of infidelity. The women are advised to look within the husband's family and in most cases it is the younger brother (or patrilineal cross cousin) who assists his elder brother in "fathering" children and a number of cases were given in which the younger brothers played a role as the following case shows:

The story of Ndafwachi and his younger brother, Saulosi

Before they got married in the early 1980s, NyaUkandawire, got pregnant while still at her parent's home and mentioned Ndafwachi as the one responsible for her pregnancy. They got married and she moved to live with her husband. Even at that time (close to 20 years ago) people suspected that it was not Ndafwachi who had made Nyaukandawire pregnant, but someone else. After she delivered, a number of years passed without her becoming pregnant again. Saulosi, the younger brother of Ndafwachi, was approached by his aunt and requested to have sexual intercourse with his sister-in-law, so that she could become pregnant. She became pregnant, and her child resembled Saulosi. Once as Saulosi was coming out of his brother's bedroom, his brother found him and they quarrelled and nearly fought. After this, Saulosi stopped having sexual relations with his sister in-law. NyaUkandawire, then, turned to a Mr Banda, (who was not a relative, but a friend of Ndafwachi) and got her last child from him. It is alleged that Mr Banda died of HIV/AIDS related illnesses in 1999.

As this case of Ndafwachi and his younger brother, Saulosi, shows, when the wife is made pregnant by another man there is a possibility that the child will resemble the biological father. During fieldwork, people talked about two cases in which children resembled the men who were "hired". Later on the "hired" men sued, claiming custody of their children, which was not granted. Though these cases happen, a number of informants said that there is a way of ensuring that the child should resemble either the wife or the husband (and not the biological father). The wife is instructed that when the husband comes out of the bathroom, she should drink the water that is left behind in the basin. In this way, the foetus will be nourished by that water and when he/she is born he will take after either the mother or the father. When I suggested that this may be possible in rural areas but may not be applicable in major

towns where most people use showers (hence the wife may not find any water in the bathroom), one old man explained that in such cases the wife would drink the water that the husband uses when washing his hands before and after eating *sima*. After having sexual intercourse, the wife is supposed to wake up at night to cook *sima* for her husband (some young women said that this practice still continues, but instead of waking up at night and cooking, they cook in the evening and put it in a food container so that the husband can eat the food at night after sexual intercourse). After eating, the husband washes his hands, then the wife takes the water to pour it outside, but before she does so she drinks some of it and the husband does not suspect anything at all. According to informants, this would ensure that the child resembles either its mother or father. In addition, an elderly woman said that in order to ensure that the child takes after one of them, she should just stare at her husband a great deal during the course of her pregnancy.

The role of the aunt and younger brother in this context is important because the intervention of outsiders (those outside the family lineage) is not encouraged as they may publicise such incidents, which would be embarrassing. Younger brothers and their sisters-in-law are sworn to secrecy, because, once the husband knows what has happened he may commit suicide or divorce the woman on the grounds of sexual immorality. While priority is given to younger brothers to assist their elder brothers in fathering children, there have been instances where someone who is not related has been called in to assist. One well-known case is that of Mr Zondani Luhanga and the wife of Mr Zikani Msowoya. It is believed that Mr Msowoya is infertile and that his first two children were fathered by Mr Luhanga. While Mr Msowoya knew what was happening, he did not want to say anything, but at one time, due to public pressure, he started accusing Mr Luhanga of having children with his wife. Angered by this, Mr Luhanga sued Mr Msowoya, claiming custody of his children, who even resembled him. This is why it is very discouraging to have someone outside the lineage to assist in such an exercise.

After extra-marital sexual intercourse, if the woman does not get pregnant, then it is adequate proof that she is infertile. In order to ascertain this, they choose a man who already has children and if the woman fails to conceive after having sexual intercourse with such a man, it confirms that the woman is infertile. If both the man and the wife have children after having extra-marital sexual intercourse, then the conclusion is drawn that “*ndopa zawo ndizo zapambana waka*” (their blood is just not compatible). If the husband fails to make other women pregnant, then it is concluded that he has a problem. According to the Tumbuka culture, polygyny is allowed and infertility on the part of the woman is just one reason.

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It would be counterproductive for the younger brother or whoever has been “hired” to use a condom, while the purpose is to make a woman pregnant. Likewise, if a man fails to make his wife pregnant, it also does not make sense for him to use a condom, when his aim is to show the world that he is fertile. In a population of just above 10 million people (National Statistical Office, 2001) and an HIV/AIDS prevalence rate of 14 percent in the 25-49 year age group (Strategic Planning Unit and National AIDS Control Programme, 1999:2), HIV/AIDS continues to claim the lives of many economically productive young men and women in Malawi, leaving behind the elderly and orphans. While this scourge rages on, there is evidence that people still engage in sexual intercourse without the using condoms, despite the high knowledge levels about HIV/AIDS and how it is transmitted (Munthali, 2002).

One would expect that, with the existence of sexual taboos among the Tumbuka, which discourage extramarital sexual intercourse, people would stick to their partners, and that such beliefs would help arrest the transmission of HIV/AIDS in Tumbuka society. The belief that engagement in sexual intercourse when the wife is pregnant could:

- kill the woman;
- cause difficulties in labour;
- make the child suffer from *chikhoso chamoto* at birth;
- make a spouse suffer from *chikhoso chamoto* if one of them engages in extramarital sexual intercourse; etc

might be expected to make spouses faithful to one another.

While traditional medicines and the fulfilment of marriage payments, especially *chiwanda*, may lead to conception, one of the ways of overcoming infertility still being utilised by the Tumbuka is the engagement of the assistance of a younger brother/cousin or an outsider as we have discussed earlier. In such circumstances it seems that the Tumbuka sanction extramarital sexual intercourse for purposes of conception and begetting children. In a way, infertility puts faithfulness or fidelity in marriage to the test. ‘Outside assistance’ would imply that in the case of the woman, blood from her husband as well as from another man would mix in her body, that she will have a difficult labour and that both her husband and child would suffer from *chikhoso chamoto*. The question that I raised with my informants was why the health of the husband, the woman and child (children being the most vulnerable) should be compromised by encouraging spouses to have outside sexual relationships in cases where the wife does not conceive, as this seems to contradict the very foundations of the Tumbuka ideologies regarding sexual intercourse and child health. Many young and old men and women said that engaging in extra-marital sexual intercourse in this context is “approved” and that in such circumstances some preventive medicines have to be taken in order to protect the spouse and child from harm. The emphasis was that these medicines should be taken without the knowledge of a spouse as they (the medicines and the threat of *chikhoso chamoto*) may be a cause of tension in the house once the partner finds out. While extra-marital sexual relationships go on, the couple in most cases also takes *mankhwala yachimika* (medicines to make the woman pregnant) and when the wife becomes pregnant, the husband is unlikely to suspect

anything as the explanation might be that the *mankhwala yachimika* have proved effective. While the Tumbuka perceive extra-marital sexual intercourse to be bad, it is worse not to have children and hence this is a situation where the lesser evil is tolerated.

It can be envisaged, therefore, that while society does not approve of sexual promiscuity, in some instances, it is society itself that encourages people to be involved in 'disorderly' sex. Postpartum sexual intercourse and extra-marital sexual intercourse are prohibited for, among other reasons, to prevent childhood diseases, but within the same society there exist traditional medicines that people can take after extra-marital sex so as not affect the health of their spouses and children, even if they come into contact or share cups/plates with them. It can be argued, therefore, that the existence of these preventive medicines against *chikhoso chamoto* and diarrhoea is one of the factors that would encourage people to engage in extra-marital sexual intercourse. The preventive medicine gives them the potential assurance that, even if they engage in sexual intercourse, the health of their spouses and children will not be compromised. Secondly, experience has taught some of the young men and women that some beliefs or taboos about sexual intercourse are not correct; hence some of them may not follow such sexual taboos. This is not evidently about socially sanctioned extra-marital sexual intercourse, but about the lack or falling away of such sanctions.

While from the emic perspective, the restrictions on sexual relations when the wife is pregnant serve to prevent spouses and the children in the womb from developing *chikhoso chamoto*, it can also be argued that such restrictions may also serve to prevent the transmission of HIV/AIDS, as well as other STDs. In addition to this, the Tumbuka recognise that sexual promiscuity can lead to the disruption of society, hence these sexual taboos help to keep society together and also reinforce the importance of fidelity in marriage (Green, 1998).

Some biomedical explanations of swelling and *chikhoso chamoto*

While emically, the swelling of children is seen as a result of contact with those in the state of *makhumbi* and the wasting (as well as swelling) of children is attributed to contact with those who are hot, in biomedicine “swelling” (kwashiorkor) and becoming very thin (marasmus) are signs of malnutrition. Kwashiorkor is a Ghanaian word meaning a disease that the young child develops when displaced from the mother by another pregnancy. The condition is characterised by general swelling of the body and protrusion of the belly, together with sparseness and reddish colouring of the hair” (Ransford, 1983:23). Ransford further says that kwashiorkor affects infants weaned from the breast and not yet able to cope with an adult diet. As we have explained earlier, a child of a couple who are in the state of *makhumbi yachiwulira* is taken away from them (the couple) and it is the grandmother who takes over the responsibility. As we will see later, weaning foods for such children are very low in nutrition and so they contract malnutrition-related illnesses. Some of the young mothers, while accepting the indigenous explanations, said that swelling and wasting can also be as a result of lack of food in the child’s body. In order to understand the problem of malnutrition in the area, let us examine the crops that people grow and their eating patterns.

Maize is the staple food crop. While some of it is eaten while still green (on the cob), or roasted when dry, most of the maize, once harvested, is stored in a granary. When required, some of it is taken out, shelled, degrained and pounded.

The pounded maize is taken to the maize mill to be ground into fine flour and this is used to prepare *sima*, a stiff porridge. All the respondents (except one) said that they grew maize in the 1999-2000 growing season (refer to Figure 7.2). Other major crops that are grown in this area are: pumpkins, potatoes, pulses, tobacco and groundnuts. Pumpkins are eaten, but they are also an important source of relish (the leaves are cooked and eaten with *sima*). Tobacco is the major source of cash income and 72.3

percent of the households in Chisinde and Wantulira villages grew it in the 1999-2000 season.

The survey also revealed that most of the people produced enough food to eat during the 1999/2000 growing season (Table 7.1). Eleven (11) out of 83 households that did not produce enough to eat, purchased the necessary food from the Agricultural Development and Marketing Corporation (ADMARC), while others did work for food i.e. they were paid in kind, with food (4) or had food transfers from their relatives. Most of the people who ran out of food before the next harvest, bought maize. Other types of food that were bought included cassava, beans, rice and sugar.

Sima made from maize flour is eaten at lunch and supper everyday. *Sima* can be eaten with different types of relish, which include vegetables⁴⁶, meat, poultry and its products, fish and beans. For children, porridge made from maize flour is prepared in the morning, and whenever the child cries, indicating that he is hungry.

⁴⁶ There are different types of vegetables that people eat in this area and these include Chinese cabbage, mustard, rape, bean leaves, potato leaves, pumpkin leaves and lettuce.

Figure 7.2: Crops Grown by People in Wantulira and Chisinde Villages

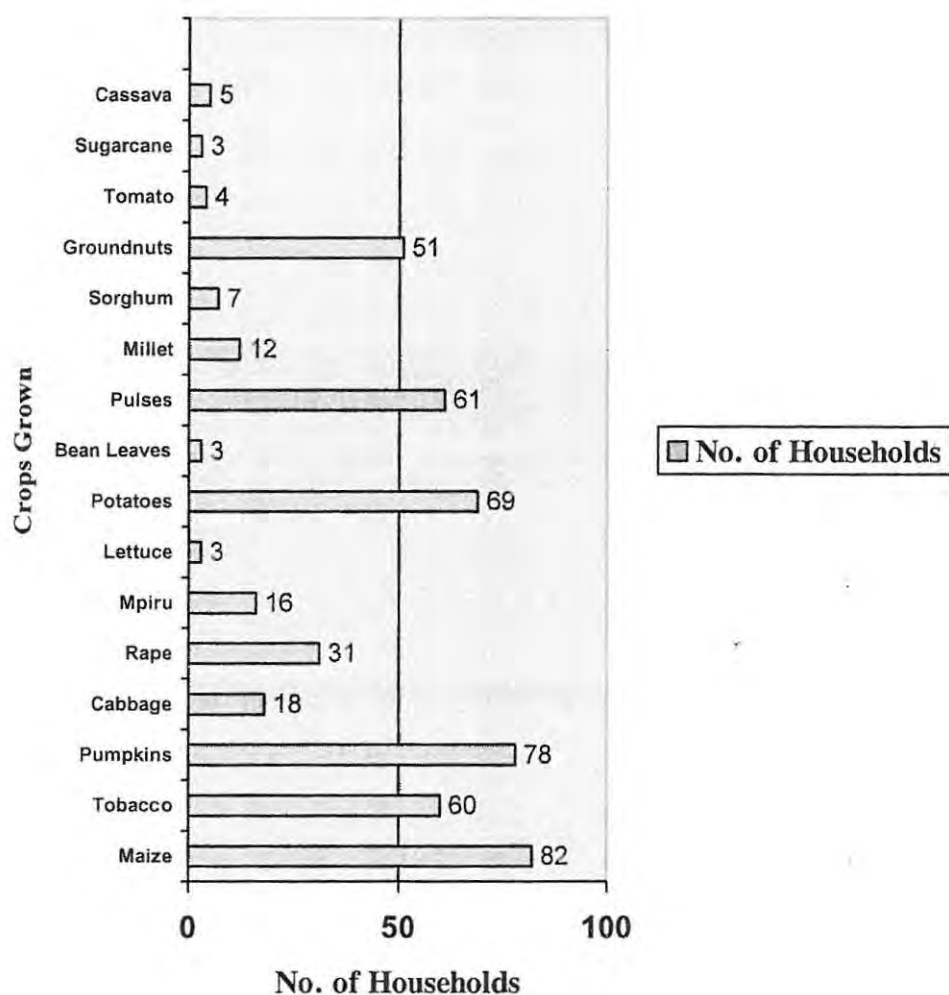


Table 7.1: No. of Households that Ran out of Food/Had Enough Food in 1999/2000

No. of Households	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
With Food	79	72	72	76	81	83	83	82	82	82	82	81
Without Food	4	11	11	7	2	0	0	1	1	1	1	2
Total	83	83	83	83	83	83	83	83	83	83	83	83

Table 7.2: Frequency of Eating Certain Foods

NAME OF FOOD	NUMBER OF TIMES EATEN					
	Daily	Weekly	Fortnightly	Monthly	Yearly	Not eaten
Bean Leaves	4	0	0	0	-	-
Beans	31	40	9	3	-	-
Bwaka ⁴⁷	0	1	0	0	-	-
Carrots	0	0	0	0	0	83
Cassava	28	28	11	12	-	-
Chinese	68	3	4	2	-	-
Citrus Fruits	41	25	4	7	4	-
Coffee	0	0	0	1	-	-
Cooking Oil	30	13	14	9	0	-
Fish	7	48	14	13	-	-
Fresh Milk	7	11	5	14	0	-
Groundnuts	71	11	0	1	0	-
Gruel	23	27	16	14	-	-
Guava	22	26	9	9	6	-
Lettuce	1	1	1	2	-	-
Meat	0	11	26	34	8	-
Meat Fat	2	12	4	13	0	-
Mpiru	66	3	0	0	-	-
Nyungu ⁴⁸	80	3	0	0	0	0
Paw paw	10	18	17	16	-	-
Potato	56	15	4	6	-	-
Poultry	0	11	18	35	6	-
Powdered Milk	0	8	9	7	0	-
Pumpkins	75	3	3	0	-	-
Rape	18	2	4		-	-
Sugarcane	62	12	5	2	-	-
Tea	33	19	12	10	2	-
Tomatoes	79	2	2	0	0	-
Wild Fruits	49	18	7	2	1	-

⁴⁷ *Bwaka* is potato leaves that are cooked and eaten as relish with *sima*.

⁴⁸ *Nyungu* is pumpkin leaves that are also cooked and eaten as relish.

Table 7.3: Possession of Livestock

Livestock	Number of Households Owning Livestock	of Total Number of Livestock in Wantulira and Chisinde Villages
Cattle	9	-
Sheep	4	19
Goats	13	77
Pigs	5	36
Chickens	66	459
Pigeons	14	154
Ducks	5	28

From Table 7.2 it can be seen that in most cases *sima* is eaten with vegetables as relish. The most frequently eaten types of vegetables are pumpkin leaves (*nyungu*), Chinese cabbage and mustard (*mpiru*). It is very clear from the table that meat and poultry (and their products) are very sparingly eaten in this area. Most of those people interviewed said that meat is indeed eaten very rarely. They slaughter a chicken when a visitor comes or at Christmas. Others said that they slaughter a chicken only when there is no any other relish available⁴⁹. Friedson, in his study among the Tumbuka, also mentioned that eating meat is a luxury and that chicken is usually eaten only on occasions such as the visit of a relative or of a person of importance (Friedson,

⁴⁹ In an earlier study, Cassel (1977) stated that, among the Zulu, 95 percent of the families had poultry and eggs were relatively plentiful at certain seasons of the year. Eggs were infrequently eaten, however. It was considered uneconomical to eat an egg that would later hatch and become a chicken; egg-eating was generally considered as a sign of greed and eggs were also thought by some people to make girls licentious (Cassel, 1977).

1996:89). Meat is also generally eaten during the installation of chiefs, at funerals and funeral-related ceremonies (for example, when bringing the spirits of the dead back from the graveyard).

From the data presented, it can be envisaged that there is a general lack of good protein-rich foods in the diet of most people. Those children who have been weaned and have not yet started eating *sima*, are, in most cases, given porridge made from maize flour. It is therefore not surprising that, as a number of other studies have shown (see Ministry of Economic Planning and Development et al, 1996; National Statistical Office, 2001; Msukwa, 1981), malnutrition in children under five is a serious problem in most rural areas in Malawi, including Chisinde. The existence of food taboos also tends to exacerbate the problem of malnutrition. For example, we shall see later in chapter 8 that children are not supposed to eat eggs or in some cases *bwankha* (*Clarias garepinus* – a type of fish that has no scales) because of the belief that eating these foods will result in their suffering from convulsions. From Table 7.3, it can be observed that chickens are owned by 66 households (which represents close to 80 percent of the total number of households in Wantulira and Chisinde villages) and this implies a relative abundance of eggs. Secondly, in the nearby Ruviri stream (see Figure 6.1) *bwankha* is the most common type of fish that is found. The prohibition on the consumption of these commonly found sources of proteins in the village compounds the problem of malnutrition.

While only 11 households out of 83 did not produce enough food for themselves in the 1999-2000 growing season, most informants said that over the years a lot more people have not been able to produce enough food and they attributed this to population pressure (hence small gardens), climatic conditions (droughts or too much rain) and non-use of fertiliser (because they cannot afford it), etc. Following arguments put forward by Susan George in her book “*How the other half dies: the real reasons for world hunger*” (George, 1986), it can also be argued that widespread malnutrition in Chisinde and other areas in Malawi is due to the fact that large areas

of fertile land have been set aside for the growing of tobacco, which is the major cash crop driving Malawi's economy. While it can be argued that money realised from tobacco can be used to buy food, most of the informants said that this never happens, because when one has the money there are a lot of things on which to spend it. In most cases, at the time tobacco is being sold at the Auction Floors, food is not a problem and a priority, as sales occur soon after people have harvested maize from their gardens. The money is therefore spent on other things and by the time the household runs out of food in January or February, the money from tobacco sales would already have been spent. The production of the local staple is therefore compromised by the growing of tobacco, which is a macro level factor.

Managing malnutrition – a biomedical approach

In order to address the problem of malnutrition, the Government of Malawi introduced supplementary feeding programmes in which handouts of foods like *likuni phala* (a weaning food) were distributed to mothers with children under five attending under-five clinics. This also lured many mothers to attend under-five clinics and have their children vaccinated. The discontinuation of the programme, possibly due to financial constraints, resulted in some mothers not taking their children for vaccinations (see Chilowa and Munthali, 1999). The most that health workers at health centre level do, when malnourished children come to the health centre for treatment, is to advise mothers to give children a balanced diet. Since meat is expensive, they ask mothers the type of food that is available in the home and, if foods like beans, groundnuts, etc are available, then the mothers are advised on how to feed the child accordingly. Those who are severely malnourished are referred to Rumphi District Hospital where the Nutrition Rehabilitation Unit (NRU), which has community health nurses, takes over the control of the feeding of the child. Even the agricultural field assistant, a community-based agricultural worker, said that at the time (January 2001) most people in the area had food, but that they did not know good feeding practices, and hence malnutrition resulted.

According to the Maternal and Child Health coordinator for Rumphu District, the major functions of the NRU are to:

- Prevent the re-occurrence of malnutrition in children under five;
- Treat malnourished children by giving them food; and
- Educate mothers on how to feed their children properly by using locally available foods.

Once children are admitted to the NRU, their mothers are taught various things, including how to rear chickens; how to grow vegetables; and how to prepare foods which are nourishing, for example by adding groundnut flour to vegetables. Children, who are malnourished, but at the same time are suffering from other illnesses, are admitted to the paediatric ward, but they still get their food from the NRU. The intensive programme that goes on in the NRU usually results in a child improving within two weeks of admission and, once they are discharged, parents are encouraged to continue feeding the children in the same way. In a study done among the Yao, it was found that mothers also had the belief that the swelling or wasting of children could be due to sexually related factors. Informants in this study said that when such children are admitted to a hospital ward and are given a balanced diet, they get well, not because of the change in diet, but because the hospital is like a prison and the mother cannot therefore engage in sexual intercourse. However, when the child is discharged from hospital, it gets sick again, because the mother resumes having sexual intercourse, which affects the health of the child (Munthali, 1999; 2002). Biomedically, it can be argued that such children get sick again because the mothers do not continue to give them a balanced diet as advised by hospital staff, but the local people attribute it to the resumption of sexual intercourse by the parents after the child is discharged from the hospital.

The major problem, according to the health workers, is that there seems to be a lack of knowledge about malnutrition. Kwashiorkor (characterised by oedema of the hands and legs, peeling of the skin, and the child being miserable, among other symptoms) and marasmus (characterised by severe wasting, a child looks old) are culturally perceived (as discussed in this chapter) as due to abnormal births and sexual intercourse-related factors. While there seems to be a shift in aetiology as young women start attributing swelling and wasting to malnutrition, it seems that there is still a lot that needs to be done in order to change the situation. The MCH coordinator at Rumphu gave the example of a rich family who even owned a vehicle and had plenty of food at home. When their child got sick and they went to the hospital, health workers told them that their child was marasmic. The mother refused to accept such a diagnosis saying:

“We have a lot of food at home, hence my child cannot be malnourished”.

While most of the families may indeed have adequate food, malnutrition in children under five occurs in some households for several reasons. Firstly, in the rural areas of Malawi including Chisinde, all children eat from one plate and older children therefore tend to eat more than their other siblings. As we mentioned in the previous chapter, if a woman becomes pregnant while still breastfeeding, she has to stop breastfeeding immediately in order to protect the [born] child from suffering from diarrhoea and other diseases. When the child is weaned in this way, he or she feeds on porridge made from white maize flour or *sima* with vegetables, with nothing else added. The weaning foods are therefore not all that rich in protein and hence the child may well suffer from kwashiorkor. The Tumbuka do not look at it this way; they link malnutrition-related signs and symptoms to sexual relations and the mother's pregnancy. While the wasting and swelling of children can be interpreted biomedically as malnutrition-related conditions, Morris argues that the wasting of children can also be due to tuberculosis if accompanied by a persistent cough (Morris,

1986).

Conclusion

This chapter has described what mothers perceive to be the causes of malnutrition related illnesses in children under five, how they seek treatment and the different methods that they use in order to prevent these illnesses. While old men and women see sexual intercourse and related factors as the major causes of the swelling and wasting of children and young men and women, by and large, still accept these indigenous illness explanatory models, these young men and women, through knowledge acquired at school and their constant interaction with the community-based health workers, are also increasingly accepting the biomedical explanatory models.

As we have argued in this chapter, although the institution of taboos on extra-marital and postpartum sexual intercourse aims at protecting children, the elderly, and spouses against *chikhoso chamoto*, prevention of difficult labour and the occurrence of *makhumbi yachiwulira* etc, it can also be etically argued that these taboos have some latent functions, for example the spacing of children which is beneficial to the health of both the mother as well as the child. Health workers attributed the occurrence of malnutrition in children under five, as mainly due to lack of knowledge of preparing balanced diets and the early weaning of children, mainly due to the mother getting pregnant or engaging in sexual intercourse. Following Murdock's thesis (1980), it can also be argued that the occurrence of malnutrition in Chisinde and surrounding villages is so widespread that the breaking or infringement of taboos on sexual intercourse could coincide with the onset of malnutrition signs and symptoms.

In addition to the swelling and wasting of children, diarrhoea was also mentioned frequently by mothers as one of the diseases that the Tumbuka attribute to sexual

intercourse and related factors. The next chapter discusses how sexual intercourse is perceived to cause diarrhoea, how treatment is sought and the different methods that mothers use to prevent diarrhoea.

CHAPTER 8

THE AETIOLOGY, TREATMENT AND PREVENTION OF DIARRHOEA IN CHILDREN UNDER FIVE AMONG THE TUMBUKA

Introduction

As we have seen in the last chapter, sexual intercourse is prohibited from the time a woman is seven months pregnant, unless the couple practices *coitus interruptus* or uses condoms. The use of condoms is a relatively recent phenomena among the Tumbuka. As we stated earlier, these condoms have been introduced as a preventive measure against AIDS and STDs and as a family planning method. In this context the use of condoms is a new adaptation of a traditional method.

After a woman has delivered, the prohibition on sexual intercourse continues in order to protect the child against *chikhoso chamoto*, as well as preventing the couple from contracting *makhumbi yachiwulira*. In addition, the Tumbuka also believe that breastfeeding a child while a woman is pregnant, or a woman having sexual intercourse while breastfeeding, may cause a child to suffer from diarrhoea. During interviews with young and old women and key informants, diarrhoea was indeed mentioned as one of those diseases that threaten the lives of children under five in Chisinde and surrounding villages.

This chapter discusses Tumbuka perceptions about the causes of diarrhoea, its signs and symptoms, the dynamics of therapy-seeking when children suffer from this illness, and how they attempt to prevent the illness. The chapter also discusses diarrhoea as a public health problem in Malawi, as well as the biomedical explanatory models for diarrhoeal diseases.

The aetiology, treatment and prevention of childhood diarrhoea: a biomedical perspective

According to Chetley, diarrhoeal diseases are one of the major contributors to malnutrition, poor health and inadequate development of children in the developing world (see Chetley, 1987), accounting for approximately 40 percent of all deaths of children under the age of 5 years (Pitts et al, 1996:1223). Diarrhoea, characterised by the frequent passing of watery stools, either accompanied by blood or not, is caused by pathogenic agents such as viruses, bacteria and protozoa (Saloojee, 2001). A child is said to have a diarrhoeal episode if he or she experiences 3 to 4 such stools within 24 hours (see Iyun, 2000). While in developed countries diarrhoea is mostly due to other causes, such as inborn errors of metabolism, allergies, systemic disease and hormone secreting tumours, etc, in the developing world the majority of diarrhoeal cases are attributed to infection with pathogenic agents (Curtis, 1998:44), particularly the rotaviruses, *Shigella species* and enterotoxigenic and enteropathogenic *Escherichia coli* (Saloojee, 2001; also Kendal, 1990). The transmission of these diarrhoea-causing pathogenic agents is mostly through the faecal-oral route by drinking contaminated water, eating contaminated food, or they can spread from one person to another through contact. Flies constitute one of the most important vectors for the transfer diarrhoea-causing micro-organisms from excreta to foods or food utensils. In addition to flies, human and animal feet treading on faeces may bring micro-organisms that cause diarrhoea to the domestic vicinity. Children under five can therefore develop diarrhoea through the ingestion of contaminated earth or any other materials found in the home. Once ingested, the pathogens will infect the intestines of the host. While most of these pathogenic agents of diarrhoeal disease are killed by the acidic and cytotoxic secretions of the stomach, a number of them survive and colonise the intestinal lining where they multiply, causing damage to the villi. The invasion of the intestinal tract by the pathogens and the subsequent production of toxins by these agents provokes the secretion of abnormal quantities of water from the

gut lining, leading to the emission of frequent liquid stools, characteristic of diarrhoea (Curtis, 1998).

In biomedicine, there is a need to follow good hygienic and sanitation measures in order to arrest the spread of micro-organisms that cause diarrhoea. These rules include the use of clean latrines for the disposal of human excreta, the washing of hands after visiting the toilet and before eating, proper cleaning of eating utensils and use of clean water for drinking and cooking. At the global level, the International Drinking Water and Sanitation Decade of 1981-1990 was an initiative on the part the WHO and UNICEF to extend water supply and sanitation services to the poor populations of the world (WHO and UNICEF, 2000). The major aim of this initiative, was among other things, to prevent diarrhoeal disease through the widespread provision of clean water (Curtis, 1998:54). Evidence has shown that adequate sanitation measures, a safe water supply and hygiene education reduces diarrhoeal related morbidity and mortality by 65 percent and 26 percent, respectively (WHO and UNICEF, 2000).

Studies have also shown that breastfeeding is one of the most important methods of preventing diarrhoeal-related morbidity and mortality in infants (Saloojee, 2001), because of the better nutrition and supply of maternal antibodies to the infant. Exclusive breast feeding also prevents the use of feeding bottles, which may be contaminated with pathogenic agents (Curtis, 1998:59).

In addition to the three factors mentioned above, namely the improvement of the water supply and sanitation, promotion of personal hygiene and breastfeeding, the World Health Organisation also recommends the improvement of weaning practices (see Kendall, 1990). Diarrhoea is also very closely associated with infections like measles. It has been found out that the measles vaccination that a child gets at the age of 9 months prevents up to 25 percent of diarrhoea cases associated with death in children under five (Saloojee, 2001:344).

For the treatment of diarrhoea, it is important that fluids, which are lost during a diarrhoea episode, be replaced. The discovery of oral rehydration therapy constituted a major leap forward in the treatment of diarrhoeal diseases, as it prevents severe dehydration. Unlike intravenous rehydration, which is very expensive, is confined to use in hospital and is administered only by hospital personnel (see Ueli, 1993), oral re-hydration therapy is cheap, can be prepared at home by a lay person and is generally the appropriate treatment of almost all cases of diarrhoea. This illness is in most cases self-limited (i.e. it can stop on its own) and does not require treatment with antibiotics. Bloody diarrhoea should be treated by using *Nalidixic acid* (see Saloojee, 2001).

In Malawi, as is the case with other countries in the developing world, diarrhoea is one of the major causes of morbidity and mortality in children under five. In 1996, it was the third leading cause of under-five outpatient attendance at hospitals in Malawi, after malaria and upper respiratory infections, and it accounted for 7.4 percent of under-five health facility admissions. In the same year, it was the 6th leading cause of mortality among in-patients under five, after pulmonary tuberculosis, other causes, uncomplicated malaria, pneumonia and anaemia (Ministry of Health and Population – HMISU, 1999). The Demographic and Health Survey for 2000 showed that 18 percent of the children suffered from diarrhoea in the two weeks preceding the survey, a drop from 22 percent in 1992, which was attributed to some improvements in access to safe drinking water during the 1990s (National Statistical Office, 2001:119). Between January and December 2001, of the 180 children under five who died at Rumphu District Hospital, 44 (24.4 percent) of deaths were due to diarrhoea or diarrhoeal related illnesses⁵⁰. Repeated episodes of diarrhoea may lead to

⁵⁰ The data, upon which these figures and percentages are based, is for 10 months only. Records of the number of children under five who died at Rumphu District Hospital in February and August 2001 were missing from the records office.

malnutrition, which is why it is argued that, although public health programmes for the control of diarrhoeal diseases focus on case management, emphasising the use of ORT to prevent dehydration, there is also a need to make nutritional management a critical component of the ORT interventions (Bentley et al, 1988).

Recognising that diarrhoea is a huge public health problem in Malawi, with children under five estimated to experience approximately 6 diarrhoeal episodes⁵¹ annually (see Government of Malawi, 1994; Ministry of Economic Planning and Development, 1996:39), early in 1981 the Government of Malawi launched the National Control of Diarrhoeal Diseases (CDD) Programme which focuses on reducing morbidity and mortality due to diarrhoeal diseases, especially in children under five. In Malawi, just as in Zimbabwe (see Pitts et al, 1996), the National Control of Diarrhoeal Diseases programme attempts to control diarrhoeal diseases through the provision of safe water, intensification of immunisation campaigns to control measles-related diarrhoea, promotion of hygiene and sanitation measures and the use of ORT. The use of ORT has been promoted since the mid-1980s (National Statistical Office, 1992). While initially government also encouraged the preparation of salt/sugar solutions as a way of managing diarrhoea, in 1993 this was discouraged as it became clear that giving the children an incorrect mixture of sugar and salt could aggravate the situation (Ministry of Economic Planning and Development et al, 1996). The Ministry of Health and Population, through the HSAs, also teaches mothers different aspects of diarrhoea: its causes, signs and symptoms, methods of prevention and that ORT should be given to children with diarrhoea to replace lost fluids. Such health education campaigns and the advertisements on the radio have led many mothers (more than 90 percent) to know more about ORT.

⁵¹ The World Health Organisation says that every child has 5 episodes each year and 800,000 children die each year from diarrhoea and malnutrition (see van Reewijk, 2001).

While this section has provided the biomedical view of diarrhoeal disease, there also exist indigenous perceptions about diarrhoea. Since diarrhoea was mentioned by many old and young women as a dangerous childhood disease, the following sections deal with the way the Tumbuka perceive diarrhoea.

Contamination of food or drinking fluids as a cause of diarrhoea

In Tumbuka, diarrhoea is known as *pamoyo* or *kujulika munthumbu*, which literally means 'opening the bowels'. This disease is attributed to a number of factors. One of the reasons why sexual intercourse is prohibited when a child is breastfeeding is that the Tumbuka believe that, once the man releases his sperms into the vagina, these sperms move around the woman's body and finally reach the breasts; thereby contaminating the breast milk. Once the child feeds on the contaminated milk, he or she will suffer from diarrhoea. As we saw in Chapter 5, the belief that the man's semen contaminates breast milk, is widespread in Africa. Although Gelfand does not specify the disease the child may suffer from, he says that the Shona believe that children become sick after feeding on the contaminated breast milk (Gelfand, 1964). The fear that the child will become sick, or indeed, in the case of the Tumbuka, that it will suffer from diarrhoea among other diseases, is one of the reasons why sexual intercourse is not allowed when a woman is breastfeeding.

Engaging in sexual intercourse while the mother is breastfeeding is also not advisable as chances are that the woman might get pregnant. The Tumbuka hold the view that when a breastfeeding mother gets pregnant, the pregnancy is a threat to the health of the child. Some informants said that, while hospital personnel encourage pregnant women to continue breastfeeding, the Tumbuka do not allow such a thing. The child is weaned immediately and taken away from its parents. Being a patrilocal society where the wife leaves her home to stay with the family of her husband, when a woman becomes pregnant while she is still breastfeeding, her mother-in-law (the child's grandmother) takes away the child because it is feared that it will become sick

if it continues staying with its parents. The child has to be taken away so that its parents can be free to have sexual intercourse (*kuti wenecho wasangwenge*) without making the child ill. This belief also exists among the Shona of Zimbabwe (see Gelfand, 1964) and the Wimbun of Cameroon (Pool, 1994). A Shona child must be weaned immediately if the mother becomes pregnant because pregnancy pollutes the mother's milk and if breast-feeding continues, the child will develop severe bloody and intractable diarrhoea (Gelfand, 1964; Pitts et al, 1996; see Munthali, 1999, for the Yao beliefs about diarrhoea in children under five). Pool (1994), who did his research among the Wimbun, also mentions that when a woman becomes pregnant she has to stop breastfeeding because the child will suffer from *kwashiorkor* or child's illness. The Binis of Bendel State in Nigeria forbid a nursing mother to engage in sexual intercourse because if she does her baby will suck semen from the breast and become ill (Weiss, 1988). Biologically, it is also desirable for a child to be weaned before another comes, for the sake of the mother's health as well as that of children. It can be seen therefore that by associating diarrhoea and *kwashiorkor* with pregnancy, the Tumbuka people are dealing with empirical realities, even though they cannot explain them in biological terms.

As has been discussed in the previous chapter, a couple should observe postpartum taboos on sexual intercourse. A child becoming ill with *chikhoso chamoto* or a wife becoming pregnant while still breastfeeding are indications that the postpartum taboo has not been adhered to. One day I was interviewing a 28-year old woman, Sekani NyaGondwe, who held a 15-month old child on her lap. This child (who was Sekani's niece) was pale and very thin; and Sekani explained that the child's mother became pregnant while she was still breastfeeding. When it was known that the mother was pregnant, it was too late, as the child had already been breastfed on the contaminated milk and had developed diarrhoea. The child was taken away from its mother and the grandmother took over the care of the child. While this woman explained the child's condition in terms of sexual intercourse related factors, biomedically the child's symptoms indicated that he (the child) was suffering from marasmus, a nutritional

disorder in which a child lacks adequate access to the necessary range of groups of food. As this case of a 15 month old child shows, once a woman has another child or is pregnant, care for the older child decreases, and grandparents, as explained earlier, are given the responsibility of caring for the child. Breast milk provides adequate nutrition for these children; hence early weaning and especially weaning at a time when the child is not ready to take solid foods may subsequently result in malnutrition.

Informants (TBAs and elderly women) said that, when a woman is pregnant, the body changes as it prepares for the child in the womb: even the breast and breast milk change. They said that milk from such a pregnant woman is not white: it is a bit yellowish in colour (called *chikenyani* in Tumbuka). Therefore, there is not any “food” for the already born child in the mother’s breasts, and if he continues breastfeeding he develops diarrhoea as he feeds on bad milk. The watery stools that the child defecates are pus-like in colour and texture (*chimbuzi chikuwa chamafiramafira*). When a breastfeeding mother is pregnant, most of my informants said that it is necessary to tell the elders so that they could look for appropriate medication for the child. While the Tumbuka explain the development of diarrhoea in a child who breastfeeds from a pregnant mother in terms of *physiological* changes taking place in the body of the woman, the Luo of Kenya interpret it differently. They say that once conception has taken place, the growing foetus will be jealous of the breastfeeding child, and as a result it will poison the mother’s breast milk, thereby causing diarrhoea in the breastfeeding child (Barasa, 1999).

As has been indicated earlier, in the past, sexual intercourse between the husband and wife was not permitted until the child was weaned. This was done in order to prevent diseases like diarrhoea. When the elders saw that the child had reached weaning age, they informed the couple that it was time for them to resume sexual intercourse. If at any time before the child was weaned, a spouse suggested sexual intercourse to their partner, they were advised to report such incidents to the elders. In the past, for a

couple to resume sexual intercourse after the birth of a child, a traditional birth attendant (TBA) had to visit the couple's house and advise them accordingly. It is claimed that women never agreed to have sexual intercourse when the children were very young because they feared that this might kill them. They only resumed sexual intercourse after the child was weaned, which could take two to three years. This was in a way beneficial as it allowed for child-spacing.

These days the situation has changed. Elderly men and women alleged that young men and women start having sexual intercourse when the child is still very young. According to them, this explains why so many children these days have poor health. We see is that, as Zulu argues for the Tumbuka, elders in general use the child's health status as a yardstick to determine whether its parents are observing postpartum sexual abstinence or not (see Zulu, 2001). In this vein, the occurrence of *makhumbi yachiwulira* (as explained earlier), the onset of diarrhoea and *chikhoso chamoto* (as discussed in Chapter 7) in children are indications of the breach of postpartum sexual intercourse taboos. One 85-year old woman said that these days when young men and women are advised on how to take care of their children, they become very angry, saying:

"Kasi vyamunyumba mwane ukuvimanya ndiwe? Chifukwa vichi ukulawiska ivyo vikuchitika mu nyumba mwane?" (Are you the one who knows what is happening in my house? Why do you monitor what is happening in my house?)

Such statements are held to show a lack of respect for the elderly and for Tumbuka customs. Old men and women attributed the many deaths and illnesses striking children and young men and women to the abandonment of traditional Tumbuka customs. One old woman put it succinctly as follows:

Mwawana wasono mukupulika chala. Dango lamuziwizgo mukulondezga chala. Mukufwa ngati ni nkhuku zachigodola chifukwa dango mukulikola yayi. Mwaluska nakudelera ivyo wapapi winu wakumuphalirani. (You young men and women, you do not understand. You do not follow the Tumbuka customary rules. You die like Newcastle stricken chickens because of failure to follow these rules. You do not follow what elders tell you”.

In general the Tumbuka believe that when a woman is breastfeeding, she is not supposed to have sexual intercourse, otherwise the child will develop diarrhoea. This taboo thus needs to be observed. One of the traditional birth attendants said that sexual intercourse between the wife and the husband is not strictly forbidden and said that

“Kuzgala wangazgala kweni ndopa mwanalume angathiliranga mwenemumu yayi”.

This means that the husband and his wife can have sexual intercourse, but that the man should not release the blood (semen) into the vagina. What this suggests is that couples practice *coitus interruptus* at a time when the child is still breastfeeding. One 26-year old young man affirmed that sexual intercourse is forbidden when the child is still breastfeeding, but that a couple can have sexual intercourse as long as they use condoms in order to prevent contaminating the breast milk with sperm. While condoms have recently been introduced as a means of preventing sexually transmitted diseases, in this context they have been adapted as a means to prevent childhood diseases such as diarrhoea. Another young man said that when he had his first child he and his wife were advised by the TBA that they could have sexual intercourse, but that the sperm should not be released into the vagina, and he admitted following this rule, i.e. *coitus interruptus*.

Among the Luo, Barasa discusses the concept of *chira*, which is “a form of punishment from the supernatural for any member of the society who breaks the norms. Barasa gives committing adultery by either parent as an example of *chira*-induced diarrhoea in children.

When a parent having a breastfeeding baby commits adultery, then goes back home and carries the baby before bathing, the child will be attacked by *chira*. It is believed that the parent from his or her adulterous activity carries with him or her harmful powers which can be washed by bathing before breastfeeding [the] child” (Barasa, 1999:48).

From the above description of the Tumbuka beliefs about sexual intercourse, pregnancy and diarrhoea and the example of *chira*-induced diarrhoea among the Luo, it can be seen that it is held that the rules set down by society need to be adhered to in order to protect the children against diseases such as diarrhoea.

Old and young women also believed that contamination of breast milk causes diarrhoea in breast feeding children. In addition to this, young women also attributed diarrhoea to other causes, such as:

- The drinking of unclean or contaminated water (*maji yaheni*) especially during the rainy season;
- The eating of food that has gone bad (*chakurya chakusasa*) or food that has been contaminated by flies because it was not covered; and
- The non-availability of toilets, which forces people to defecate anywhere, with flies contaminating food.

These young women said that they either learnt this at school or during the health education sessions conducted during under-five clinics. The old men and women attributed diarrhoea to breastfeeding while the mother is pregnant and similar explanations; none of them mentioned that diarrhoea can also be caused by poor sanitation and unhygienic practices. They never associated diarrhoea with the consumption of contaminated food, food that has gone bad or with contaminated water sources.

There are also other causes of diarrhoea in children. Many young women said that any type of food that a child takes can cause diarrhoea *pala chakurya chila chapambana nayo* (i.e. if that food is not compatible with the child). The onset of diarrhoea is therefore a sign that the stomach has rejected the food that the child has eaten. This belief also exists elsewhere in Africa, for example in Benin, where van Reeuwijk says that it is believed food can cause one to have diarrhoea because “it did not fit” a person’s stomach. In addition to this, van Reeuwijk’s informants said that, if one eats too much food, the stomach may therefore not contain all the food and that is when one gets diarrhoea (van Reeuwijk, 2000).

One woman, who was once a health volunteer, said that, in the past, people had not been allowed to live or cultivate very close to the source of a piped water supply. These days there are a lot of people living in that area and others have since opened up large tobacco farms up-river, which has resulted in contamination of the water. She explained that this might be the cause of widespread diarrhoea in Chisinde, particularly because of the intermittent shortage of water treatment chemicals. Some women said that diarrhoea can be attributed to the non-availability of toilets, especially for children who defecate anywhere, with flies contaminating food.

As we will see in Chapter 9, both old and young women said that they have observed that the onset of diarrhoea is sometimes a symptom of diseases and they explicitly mentioned malaria and measles. Finally, mothers (both old and young) mentioned that

diarrhoea in children may also be caused by teething which is a widespread diarrhoea causative explanation in most African cultures, for example in Benin (van Reeuwijk, 2000), in Kenya (Barasa, 1999), in Nigeria (Ueli, 1993; Feyisetan et al, 1997), Malawi (Munthali, 1999), and in Burkina Faso (Curtis, 1999). Apart from teething, other childhood milestones that are associated with diarrhoea that have been reported in other parts of Africa include crawling, walking and talking (Weiss, 1988; Curtis, 1998). None of these researchers have explained why it is thought that a child should develop diarrhoea at these stages in life.

How then do children get diarrhoea when they are teething? It may be argued, etically, that teething coincides with crawling as at this stage the child moves around and as he explores his world, he picks things up (including soil) and puts them in his mouth. Some mothers even said that they do not stop their children from eating soil as it is believed that it helps the proper development of the fontanelle. As discussed above, earth (soil) is a good route or medium for the faecal-oral transmission of diarrhoea-causing pathogens. This might explain why children might get diarrhoea at this stage in their lives. One informant said that, at this stage of development, the gums of the child itch quite a lot (just before the teeth come out) hence, the picking up of objects and chewing on them serves to scratch the gums.

Green says that the perceptions about the aetiology of diarrhoea discussed above generally exist in most countries in southern Africa. He adds that also prevalent in this part of the world is the concept of the internal snake as a causal factor. *Nyoka* is an invisible force that inhabits the stomach of the sufferer. If dirt or any impurity is introduced into the stomach, the *nyoka* reacts with displeasure by causing diarrhoea in order to clean the stomach (Green, 1997). Although Green's findings about the *nyoka* are not replicated among the Tumbuka, similar results were obtained by Barasa. He found that the Luo generally believe that every person is born with worms in his or her stomach, and that these worms help, among other things, to digest food. However, if this food does not *rhyme* (sic) [is not compatible] with these worms then diarrhoea

will ensue (Barasa, 1999; see Geissler, 1998, for a detailed description of the worm concept among the Luo).

It can be seen from the above discussion that diarrhoea is mostly perceived to be caused by some form of contamination, whether it is in the indigenous or biomedical explanatory models. Diarrhoea was perceived by informants as a way of *kuchapa muthupi* (cleansing the body) of the contaminants that are introduced orally. Hence, most mothers held the view that diarrhoea can be prevented by following good hygienic and sanitation measures such as:

- giving the child well cooked food;
- washing hands after visiting the toilet;
- making use of rubbish pits when disposing of rubbish;
- owning and making use of toilets;
- drinking boiled water;
- covering food and drinking water to avoid contamination by flies; and
- keeping the mother's breasts always clean.

These measures were mentioned by young women who further explained that food should be well cooked and drinking water boiled in order to kill *tuvilombo* (micro-organisms). One young woman said that mothers should closely observe their children and ensure that they do not eat soil. It can be seen that young Tumbuka women, mainly through health education programmes on the radio, in primary school and during the intensive health education campaigns conducted by the health

surveillance assistants, understand the biomedical way diarrhoea is transmitted and how it can be prevented.

Both young women and old women said that diarrhoea due to teething cannot be prevented as every child has to suffer from this type of diarrhoea. When a child suffers from bloody diarrhoea, the anus may also be eaten away, leaving behind a large hole. In Tumbuka this is called *chigwewu*. Many people did not know the cause of this type of diarrhoea, but some suggested that during the rainy season if a child sits on moist ground then the moisture can eat the anus away⁵². As can be deduced from the above discussion, there are different types of diarrhoea, namely: mere diarrhoea (*pamoyo waka*), bloody diarrhoea (*pamoyo pandopa*), diarrhoea due to teething and diarrhoea due to a child breastfeeding on “contaminated” breast milk. Many mothers said that diarrhoea caused by teething is characterised by soapy or whitish (foamy) stools (*zikuwa waka mphovu pera*), which are very different from the yellowish stools in diarrhoeal episodes caused by other factors.

Seeking treatment for diarrhoea

As far as treatment is concerned, most of the young women who were interviewed said that whenever their children suffer from diarrhoea they either go to the hospital for treatment, where they are given oral rehydration solution (ORS), or they purchase these ORS packets from the nearby shops. Young women said that they heard about ORS mostly from the local radio station and the community health workers. According to the 1992 Demographic and Health Survey, knowledge about ORS is widespread in Malawi, at 90 percent of the women who had had births in the five years preceding the survey (National Statistical Office, 1992:95). Shop-owners in Chisinde said that there is a very high demand for ORS and they have to make sure that they always have it in stock. The 2000 Demographic and Health Survey reported

⁵² For similar information see Matinga and Munthali, 2001.

that 62 percent of those children under five who suffered from diarrhoea were treated with ORS (National Statistical Office, 2001:120), while an earlier study found that 78 percent were either given ORS packets or gruel (Ministry of Economic Planning and Development et al, 1996). The decrease has not been explained.

Young women said that, in some cases, the solution is prepared by the health centre personnel and given to the child. In most cases the mothers are given the ORS packets so that they can prepare the solution at home. All the young mothers said that they knew how to prepare this solution. They stated that it is prepared as follows:

Containers are properly cleaned. Water is boiled and then allowed to cool. Three clean Coca Cola (a bottle having the capacity of just over 300 millilitres) bottles are filled with this boiled water (equivalent to one litre) and poured into a large container. The contents of the ORS packet are emptied into this container and stirred until everything has dissolved. This is then frequently given to the child to drink.

As we saw earlier ORT is cheap and can be prepared easily in the home by a lay person. The problem with ORT that was observed during fieldwork was that mothers still administered ORT even more than 24 hours after preparation. The rule is that, once the solution is prepared, it has to be administered within 24 hours; after that whatever remains should be thrown away and a new solution prepared. A solution kept overnight should be thrown away because in many rural homes people do not have proper facilities for storage, and hence the solution may become contaminated. However, due to financial constraints most mothers continued to use the solution after the stipulated 24 hours, with doubtful efficacy. HSAs said that mothers are also advised simply to give clean boiled water if ORT is not available.

While mothers can indeed purchase ORT from the shops or get it free from the health centre at Mwazisi, the dynamics of therapy seeking during diarrhoeal episodes is very

much linked to what Edward Green calls *multilevel causal explanation* (Green, 1998). Initially mothers might think that diarrhoea is caused by, for example, the ingestion of contaminated water or food, and hence they will administer ORS. If the diarrhoea persists, people's perception about the aetiology might change. They may start thinking that the diarrhoea has been caused by teething, or contact with someone who has recently had sexual intercourse. As one woman put it:

“My child suffered from diarrhoea. I bought ORS from the shop and gave it to the child. However, the child continued suffering. I started wondering what might be the cause of this diarrhoea. Later, when the teeth cut, I realised that the diarrhoea was due to teething”.

Although the Tumbuka have clear classifications of diarrhoea, if the episode lasts for more than 3 or 4 days (regardless of its signs and symptoms), it is a major cause for concern, and the aetiology tends to shift. The taxonomy given above is therefore not exclusive, as the aetiology may shift in the course of therapy-seeking.

At all these levels people tend to seek treatment. If it is determined that the diarrhoea is due to the child suckling on contaminated breast milk then even if one obtains medicines, the child may get better for a while, but the diarrhoea will come back. The Tumbuka, therefore, believe that it is important to determine the cause of that diarrhoeal episode and “treat the cause”. These findings are similar to those of Ashford (who did his work in Soweto in Johannesburg) whose informants said that, while antibiotics can cure illness, it is necessary to cure the cause as well (Ashford, 2000). In this context, when it is determined that the contamination of breast milk is as a result of sexual intercourse or pregnancy, then the child has to be weaned immediately, or if the mother is pregnant, then the child has to be taken away from the parents and raised by the grandmother, as explained above. The administration of medicines while the child continues breastfeeding is a waste of time and resources as the child will not be cured.

This study also found that in addition to the use of ORS, there is also a very widespread use of antibiotics in the treatment of diarrhoea. Most women reported that they purchased medicines such as Chloramphenicol, Flagyl, Bactrim and Penicillin from the nearby shops in order to treat childhood diarrhoea. There is a widespread belief that antibiotics are “general players” (as one shop owner described it), and hence that they can be used in the treatment of all diseases. One of the women said that she specifically asks for penicillin tablets, because this medicine was perceived as very strong and equated to injections. The widespread use of antibiotics in the treatment of childhood diarrhoea has also been reported elsewhere, for example in Benin (van Reeuwijk, 2000). Although this is the situation, studies have shown that the use of antibiotics is ineffective in the treatment of diarrhoeal episodes, hence expensive and a waste of money and resources, and may even prolong diarrhoeal episodes (see Chetley, 1987; Hardon, 1987). In addition, the giving of antibiotics to children suffering from diarrhoea should also be discouraged as it could result in the development of resistance. The medical assistants at Bolero and Mwazisi Health Centres also mentioned that diarrhoeal illnesses which are caused by viruses do not respond to antibiotics, and that it is a waste of resources to use them in diarrhoeal episodes. They added that bloody diarrhoea is caused by bacteria and in such circumstances it is useful to use antibiotics, and that one of the most widely used antibiotics in the treatment of bloody diarrhoea is Nalidixic Acid. They also pointed out that in viral diarrhoea, it is important to replace lost fluids by using ORS and that in such circumstances, it is important to address the cause of diarrhoea. If the diarrhoea is due to uncleanliness in the home, the mother should be advised accordingly. When it is due to other diseases such as measles, malaria or acute *otitis media* (ear infection), these diseases need to be treated.

Chetley has argued that the use of antibiotics in the treatment of diarrhoea has to be avoided, as it may divert the attention of mothers from the essential task of replacing water and electrolytes and secondly because the widespread use of antibiotics has led

to the development of resistance to these medicines (Chetley, 1987). The use of Chloramphenicol in the treatment of childhood diseases is not recommended except in life-threatening situations as it causes anaemia and other life-threatening blood disorders (Chetley, 1987:4; Hardon, 1987:277-292). While shop owners in Chisinde play an important role in the provision of health care to people, the advice that they give to their clients, for example recommending the use of Chloramphenicol in the treatment of paediatric diarrhoeal diseases, may be detrimental to the health of their clients. This is partly the reason why some scholars have suggested that, due to the role the shop owners play in health care, there is a need for them to be given some basic training on drugs or medicines (see Snow et al, 1992).

In the case of children, informants said that diarrhoea can sometimes be caused by teething. The general consensus among both young and old women was that it was not advisable to give the child any treatment for diarrhoea caused by teething, because one might just hurt the child. They said that, even if you give the child any medication, the diarrhoea will not stop until the teeth come through. This form of diarrhoea does not require any medication. There are others who look for traditional medicine when a child has diarrhoea as a result of teething, but most women said that it is just a waste of time because the diarrhoea will not stop until the teeth come through; in Tumbuka they say "*kasi mino nayo yanamunkhwala?*" meaning "does teething diarrhoea also have medication?". These findings are similar to those of Mull and Mull in their study in Pakistan, where they also found that diarrhoea can be caused by teething and that such diarrhoea is not normally a cause for concern; on the contrary, it was believed that it was actually harmful to try and stop it, because, if one did so, the trapped heat might cause soreness in the eyes and fever (Mull and Mull, 1988). While Barasa reports that the Luo also consider teething diarrhoea as normal and therefore not to require any medication (Barasa, 1999), he however quotes Maina (1987), who says that among the Akamba of Kenya, teething diarrhoea is also treated. The Akamba cut the edges of a child's gums and apply indigenous herbs. This operation is aimed at forcing the teeth out more quickly, thereby removing the cause

of teething diarrhoea (see Barasa, 1999). Instead of performing an operation the way the Akamba do, the Swazi just rub some traditional medicine on the gums in order to make the teeth grow faster (see Weiss, 1988).

It has been discussed above that a child can also suffer from diarrhoea when he breastfeeds while the mother is pregnant or while the mother is having sexual intercourse. The young women stated that if such a child is given ORS the condition improves; he becomes rehydrated, but the child may still be weak. Hence they may buy *Flagyl* from the shops and give it to the child to drink. This was perceived by the young women to work, but they also pointed out that it will not work for long because, if the child continues breastfeeding while the mother is pregnant then he will develop diarrhoea again. The best “medicine” in these circumstances (according to informants) is to wean the child as is recommended culturally.

The elderly women never mentioned ORS as treatment for diarrhoea. ORS was only mentioned by the young women and men; the young men were not able to describe how ORS is prepared, saying that women were in a better position to know because they were the ones who prepared it. Elderly men and women said that they use traditional medicine to treat childhood diarrhoeal episodes.

While mothers with children under five gave ORS to their children whenever they suffered from diarrhoea, traditional medicines were also used. The bark of tree species such as *muzguzgu* and *chikuyu* (the fig tree) or the roots of *chilowe* and *chitimbe* are crushed and soaked in water. The mixture can either be boiled or not, and the concoction is given to the child to drink. Traditional healers said that the traditional medicines that are used to treat or stop diarrhoeal episodes in both adults and children *yanandi yakuwa na nkhanya ndipo yakuwawirapo*, meaning that ‘many such medicines have an astringent taste and are a bit bitter’. The ‘astringent’ medicine is important as it *ties* or *binds* (*kukaka* = coagulating) the supposedly loose and

watery material in the stomach making it to harden in the process and it also seals any ulcers that might be in the stomach. This medicine, (it is claimed) stops the diarrhoea.

As far as treatment of diarrhoea in children under five is concerned, young women said that they purchase ORT from the nearby grocery shops. In some cases they may buy antibiotics such as Chloramphenicol. If they do not have money, they resort to traditional medicine (as described above), or they may go to the health centre where ORS is given free of charge. The major drawback is the long distance between Chisinde and Mwazisi Health Centre; hence this option is only used when the situation worsens.

Conclusion

While almost all the old men and women attributed diarrhoea to teething and children suckling on contaminated or bad milk, most young men and women, although accepting such indigenous explanatory models, also attributed diarrhoea to unhygienic practices in the home and to other biomedical explanatory models. There has therefore been an aetiological shift from spiritually polluted fluids, to biologically contaminated liquids and solids (bad milk, to bad water etc). As far as the Tumbuka are concerned, it is important to determine the cause of the diarrhoeal episode in children under five. For example, the use of antibiotics such as Chloramphenicol to treat childhood diarrhoea caused by feeding on breast milk contaminated by semen, is perceived not to be really helpful. The best treatment comprises the weaning of the child, using condoms or practising coitus *interruptus* and sticking to postpartum taboos as discussed above. Diarrhoea that is perceived to be caused by teething, does not require any treatment. Informants said that it stops on its own. Such a perception is detrimental to the health of the child as it may subsequently lead to severe dehydration and death.

It has been established that diarrhoea is essentially a disease which is very much associated with poverty and its resultant malnutrition, poor sanitation, poor housing and overcrowding, lack of garbage disposal, poor and contaminated water sources and general vulnerability to infections (Helman, 1994; UNICEF et al, 1993; Weiss, 1988). Helman has added that the control of diarrhoeal diseases will only be achieved when socio-economic issues have been addressed (Helman 1994:367). In Chisinde, there is a need to improve the water and sanitation situations if diarrhoea is to be contained. Though there is piped water, the major problem is that this water is not, in most cases, treated with chemicals. As has been mentioned, diarrhoea can also be a sign of other diseases such as measles or malaria. In such cases, it is important to treat the measles or malaria. Mothers also mentioned malaria as another disease which afflicts children in this area. The next chapter discusses the Tumbuka's perceptions about malaria in children under five, how they seek treatment and the different prevention measures that they use in order to protect children.

CHAPTER 9

CHIKOKO, CHITASKA AND THOLA AS MANIFESTATIONS OF MALARIA IN CHILDREN UNDE FIVE

“A good malaria fighter must learn to think like a mosquito,” suggestion on how to counter the disease, made by Sir Malcolm Watson, the British malaria authority commenting on the difficulties in fighting disease in the wider Kwazulu-Natal area” (Brain, 1990:20).

Introduction

As the scientific world continues the search for a vaccine for malaria, the disease continues to kill millions of people every year. Recent estimates are that malaria kills up to 2.7 million persons annually, and that 90 percent of these deaths occur in Africa, where most of the victims are children under the age of 5 years. It is estimated that 300 million episodes of clinical malaria occur each year in the African region, but the actual figure could be much higher than this (Samba, 2001:iii; see also Greenwood, 1999) as in most cases the incidence of acute illness is difficult to measure because of “the imprecision in clinical diagnosis and lack of microscopic confirmation” (Breman and Campbell, 1988:613; see also Greenwood, 1999). Attempts to control malaria over the past seven decades have included the spraying of people’s homes with dichlorodiphenyltrichloroethane (DDT), the taking of malarial prophylactics, the destruction of breeding grounds for mosquitoes and more recently the use of insecticide-treated bed-nets (ITNs). The use of DDT led to the eradication of malaria in Europe and North America, but its use was discontinued, mainly because of its non-biodegradability and its lethal effects on other forms of life, for example the American bald eagle (see Duguid, 2002; Murdock, 2001). There have been calls for DDT to be reintroduced in developing countries because of its low price and its effectiveness in killing mosquitoes. While some of these countries are still

considering reintroducing DDT, other countries have already reintroduced its use in malaria control programmes, for example South Africa reintroduced it in 2000 after experiencing a very high prevalence and incidence of malaria (Duguid, 2001).

In addition to these initiatives, the World Health Organisation encourages the early diagnosis of malaria and timely seeking of appropriate treatment as one way of controlling the transmission of the disease (see Breman and Campbell, 1988). Due to the absence of laboratory equipment in most of the health facilities in rural areas in developing countries, such as Malawi, it is unlikely that malaria cases will be diagnosed early. This explains why most countries in the developing world give malaria treatment on presentation of fever or a history of repeated episodes of fever (see Baume et al, 2000), which is certainly a cheaper and quicker approach. Early diagnosis and treatment is advantageous as it reduces morbidity, as well as sources of new malarial infections (see Espino and Manderson, 2000).

Biomedically, malaria is caused by a virus that is transmitted by a mosquito. The word malaria is derived from the Italian *mala aria* which means bad air, as previously it was thought that the foul air emanating from swamps caused the fever (see Watkins, 2001). Severe malaria in malaria-endemic areas is characterised, by among other symptoms, splenomegaly and convulsions. Such biomedical conceptualisations have, however, not been universally accepted. People have their own perceptions about malaria and its accompanying signs and symptoms, which shape their decisions on prevention and therapy-seeking (see Brain, 1990; Agyepong, 1992; Foster, 1995; Baume et al, 2000). For example, Brain claims that during the 1929-1933 malaria epidemic in Natal and Zululand, people were influenced by the traditional healers to refuse to take quinine, claiming that the government wanted to kill them, that quinine would cause impotence and sterility, and that in fact quinine caused malaria (Brain, 1990). In Zimbabwe, a study conducted in the 1990s found that, although most people agreed that their houses should be sprayed, some refused because of cultural and religious reasons, although the authors do not specify these reasons (Vundule and

Mharakurwa, 1996). The bitterness of chloroquine and its subsequent association with the bitter traditional abortifacients, the lack of money to purchase anti-malarial drugs (see Foster, 1995), and the claim that Fansidar worsens the condition of patients suffering from malaria (Matinga and Munthali, 2001) are some of the factors that have negatively impacted on the malaria control programmes in Malawi.

With 43 percent of all outpatient cases and 19 percent of under-five mortality being due to malaria in the year 2000 (National Statistical Office, 2001:185), Malawi is one of those countries that faces a huge malaria problem. In 1984 and as a direct response to the problem, Malawi established the National Malaria Control Programme (NMCP), which is under the Ministry of Health and Population. The agency is involved in the extension of people's awareness of malaria as a public health problem, promotion of timely treatment of malaria, and the institution of effective malaria prevention measures. Prevention efforts have included the use of insecticide-treated nets, taking of anti-malarial tablets and prompt treatment of malaria in order to prevent severe illness or death (see Matinga and Munthali, 2001).

Despite the fact that Malawi is a malaria-endemic country, a recent national survey revealed that the utilisation of insecticide treated bed-nets is very low, at 6 percent of the households surveyed (National Statistical Office, 2001). Several reasons have been given for non-use of bed-nets in Malawi; these include "feeling like you are in a grave" or "feeling like you are suffocating" when you sleep in a mosquito net, lack of knowledge about the use of mosquito nets and where you can get them, not liking white coloured nets (most people sleep on mats, hence the nets get dirty very easily and this may affect the re-treatment rates as they would feel embarrassed to take the net for re-treatment), and the lack of money (see Matinga and Munthali, 2001). UNICEF Malawi, Canadian Physicians for Aid and Relief (CPAR), the Population, Health and Nutrition (PHN) project in the Ministry of Health and Population and other agencies run the ITN projects in various parts of Malawi, and it is in these parts that a higher percentage of people use nets and a higher percentage of people know

about the nets. The percentage is higher, presumably because of the intensive awareness campaigns in these areas, and because ITN committees (composed of friends and relatives) within the village have been set up, and are the ones who are responsible for selling the nets within the village.

While a number of ethnographic studies have been carried out in Malawi on people's perceptions about malaria (see Bisika, 1997; Matinga and Munthali, 2001), the review of these studies reveals a dearth of ethnographic material on malaria among the Tumbuka, especially in children under five. Friedson's recent work among the Tumbuka looked at dancing as a form of therapy. In his work titled *The dancing prophets: musical experience in Tumbuka healing*, he mentioned in passing that malaria is a well-known disease among the Tumbuka (Friedson, 1996). His emphasis was on mental healing, hence he did not give a full picture of how the Tumbuka perceive malaria and its signs and symptoms.

During the in-depth interviews I conducted in the area of SGVH Chisinde and surrounding villages, malaria was the most illness commonly mentioned illness by informants as threatening the lives of children under five. This chapter explores the Tumbuka's conceptualisation of malaria in children under five: its signs and symptoms, local terminologies, the aetiology, patterns of therapy-seeking and modes of prevention. In malaria-endemic areas, severe malaria is sometimes characterised by convulsions, the enlargement of the spleen (splenomegaly) and anaemia. While these signs and symptoms may be biomedically linked to malaria, it will be shown in this chapter that the Tumbuka look at these as separate disease entities.

Tumbuka terminologies for malaria

The Tumbuka term for malaria is *phungu* and this term was mostly mentioned by old men and women in the study area. They said that a child who has *phungu* vomits yellowish stuff (*kubokola nyongo*), shivers quite a lot (*kunjenjemera chomene*) and

has very high fever (*kotcha thupi*), despite the fact that the child feels cold at the same time. *Phungu*, according to informants, is caused by changes in habitation, for example, if the child stays with its family in the urban areas and they then go to their home village in the rural areas, the child would suffer from *phungu* since he has been exposed to a new environment where he drinks *maji ya chilendo* (strange water). A number of cases were cited in which Malawian migrants working in the mines in Zambia and Zimbabwe had their children suffering from *phungu* upon returning to their rural Malawian homes. While they acknowledged that even adults suffered from *phungu*, they emphasised that children were the ones who were most vulnerable. In order to prevent *phungu*, they carried water from the urban areas which they mixed with water from the local sources (which were in most cases rivers); such a mixture was then given to the child to drink. Old men and women said that whenever they did this, children never suffered from *phungu*.

In a UNICEF-commissioned ethnographic study on malaria, Matinga and Munthali reported that the term *phungu* is also used in Mzimba and Nkhata Bay districts where Tumbuka is spoken (Matinga and Munthali, 2001). While old men and women referred to malaria as *phungu*, most young men and women neither knew nor used this term. They referred to malaria as “malaria” in Tumbuka, as well as in English. Young men and women said that this is the word that they have always used. If someone were to ask the elderly for the Tumbuka term for malaria they would answer that it is *phungu* - otherwise the term “malaria” is commonly used in the area and everyone understands it. Even the health workers said that the term they use is malaria. In 2002 some posters, which showed that malaria is *phungu* in Tumbuka, had been distributed and posted at the local health centre; possibly from now onwards and with publicity, people will start using the word *phungu* instead of malaria.

During the in-depth interviews, mothers mentioned the disease malaria by its English name and at the same time attributed fever (*kotcha thupi*) to malaria. All the young women interviewed were able to mention the signs and symptoms of malaria namely

kotcha thupi (high body temperature), *kubokola nyongo* (vomiting yellow stuff) and *kunjenjemera* (shivering), the same symptoms as elders mentioned for *phungu*. It was also learnt that whenever a child has fever, most women conclude that the child has malaria (for similar findings among the Baganda, see Launiala and Raijas-Walch, 1999). This perception is not correct because, while fever is indeed one of the major symptoms of malaria, there are also other diseases or illnesses that are characterised by the presence of fever, for example measles. As will be clarified later, such potential misconceptions affect the way mothers and caretakers of children seek therapy whenever their children have developed a fever.

The aetiology and prevention of malaria

The history of malaria is replete with a number of theories about its aetiology, the earliest of which was the miasmatic theory. This theory postulated that swamp air contained chemicals which had been freed from rotting wood. This air was what was responsible for causing malaria (Ransford, 1983). It was because of this theory that double storey buildings were preferred during the early days of the colonial period as it was believed that miasma did not rise above ground level (Ransford, 1983) and that the miasma was thought to spread horizontally (King and King, 1994). Ransford and Friedson claim that Africans were the ones who first recognised the link between mosquitoes and malaria (Ransford, 1983; Friedson, 1996) and in the West it was only known later through the pioneering works of Patrick Mason, Ronald Ross, Grassi and others around the 1890s.

Biomedically, malaria is caused by a virus that is transmitted by an infected female anopheles mosquito. Young women said that malaria is caused by mosquitoes (*nyimbu*). While most young women recognised that malaria is caused by mosquitoes, they also said that there are other causes of 'malaria', for example the exposure of the child to very cold weather (*kuzizima chomene*) and the consumption of very cold foods. Among other informants, a young woman from Chikupizga village said:

“My child suffered from malaria because she was exposed to very cold weather and at one time before she got ill she took very cold *sima* (*sima yizizimu chomene*) at her grandmother’s house.”

Informants said that the consumption of cold foods and exposure of the child to very cold weather make the child feel cold and start shivering, consequently he or she will develop fever. Shivering and fever are perceived to be symptoms of malaria (according to informants) and this is why they conclude that cold weather and eating very cold foods can also cause “malaria”. From such an explanatory model one would expect that there should be a very high incidence and prevalence of malaria in June and July when Malawi has a winter season, however, most mothers said that while indeed there are a lot of children suffering from malaria during winter, most of the cases of malaria occur in the rainy season, but they could not link the high prevalence of malaria with the high population of mosquitoes in the rainy season⁵³.

While cold weather is seen as one of the causes of malaria among the Tumbuka, in southern Ghana, in addition to coldness (for example running barefoot in the rain), malaria is also thought to be caused by exposure to external heat, most commonly the heat of the sun. Other sources believed to play a role in causing “*asra*” (the local term for malaria) in southern Ghana included heat from burning charcoal, heat from cooking or working near fire (Agyepong, 1992). Such types of “hotness” were never mentioned in my study as causes of fever. While Agyepong cites physical heat as a cause of fever, my informants mentioned “ritual heat”, which arises from acts of sexual intercourse, as being responsible for the development of fever in children under five and the aged. Children under five and the aged are normally classified as

⁵³ This failure complements the findings of Ramakrishna, who found that because local beliefs attribute malaria to dust, mosquitoes and sun/heat, the Yoruba therefore consider peak malaria prevalence to be in the hot dry season (Ramakrishna et al, 1989). See some similar findings in Zambia (Green, 1998).

“cold” and when they come in contact with anybody who is “hot” they may become sick. As discussed in Chapter 7, a child develops *chikhoso chamoto* when he or she comes into contact with a person involved in sexual intercourse; which subsequently leads to a rise in body temperature, thereby causing ‘malaria’.

“When boys and girls have attained puberty, *wakupanga nhowa za wulewi* (they engage in sexual intercourse), which leads to outbreaks of ‘coughing’ (*chikhoso*). In the olden days, boys were not supposed to touch the fireplace because they feared that they might cause children and elderly people like us to suffer from *chikhoso chamoto*. In those days, people used to follow taboos and that is why the incidence and prevalence of disease were low” (a 90 year old woman).

While the Tumbuka believe that the exposure of children to those engaged in sexual intercourse can cause fever, etically it can be argued that attempts to restrict sexual intercourse by the implementation of this taboo are helpful as it may control teenage pregnancy, space children and check the transmission of sexually transmitted diseases, including HIV/AIDS. *Chikhoso chamoto* per se is not seen as fever, but it is accompanied by fever; because fever is synonymous with malaria, people conclude that sexual intercourse can also cause malaria. Such views are held not only by old men and women; even young men and women have been socialised to internalise such indigenous disease explanatory models, and the following was put forward by a twenty-six year old man from Chisinde Village:

“A child can suffer from malaria if it is very cold, but it can also suffer from malaria if the husband has sex with his wife while the child is still breastfeeding. Sexual intercourse at this stage is permissible, but you need to use a condom otherwise, if you do not use one after ejaculation, “*ndopa zikwenda*” in the body of the woman and will spoil breast milk.”

The Tumbuka word *ndopa* in English is blood and it is most often used by the Tumbuka to refer to sperms/semens. "*Ndopa zikwenda*" therefore means that the sperms once ejaculated into the vagina move around the body and that eventually they contaminate breast milk. The use of condoms is a recent phenomenon among the Tumbuka. While the use of condoms came about mainly as a preventive measure against sexually transmitted diseases and HIV/AIDS, as well as being a family planning method, it can be deduced from the above statement that, among the Tumbuka, condoms may also play a role in the prevention of fever among children, as they prevent the contamination of the breast milk by sperms. As we have already seen in Chapter 7, having sexual intercourse while the child is still breast-feeding is prohibited (postpartum sexual taboos) as this results in a child developing diarrhoea and fever. Fever and diarrhoea are some of the symptoms of malaria. As far as the Tumbuka are concerned, in order to prevent fever among children, boys and girls should not engage in sexual intercourse and parents of a breast-feeding child should use condoms or totally refrain from sexual intercourse to protect their children from "fever". Malaria is also seen as being caused by exposing children to those who are engaged in sexual intercourse, and informants said that this is the reason why people prepare amulets for children to wear around their waist in order to protect them against "*chikhoso cha moto*" (as explained earlier). Those who believed that cold weather and the consumption of cold foods can cause malaria said that children should be properly clothed (warm clothing etc) when it is very cold and that they should never be given cold foods.

Those who said that malaria is caused by mosquitoes were mostly young men and women. None of the old men and women ever said that malaria can be caused by mosquitoes. The young women mentioned a number of ways in which they can prevent malaria, such as the draining away of all stagnant water around the home, cutting grass short and destroying tins and old and broken pots that might contain stagnant water as these may act as breeding places for mosquitoes. Only a few women mentioned the use of bed-nets as a measure for preventing malaria, but they were

quick to point out that the major deterrent to the use of bed-nets is that they are very expensive and, since most people in the area are very poor, they cannot afford to buy them. Most of these young women have been educated up to senior primary school level and were taught at school that malaria is caused by mosquitoes. In addition, health workers also conduct health education sessions during under-five clinics. It has been argued that the anopheles mosquito, which causes malaria, mainly feeds at night, hence the use of ITNs is considered an effective malaria prevention measure. It seems that the local population is not aware of this as some studies have shown that some people would buy nets, not so much to prevent malaria as to have a peaceful sleep (Matinga and Munthali, 2001).

Some traditional methods are also utilised to chase away mosquitoes from houses, the most common being the use of a herb called *kanufu*. This herb is very strong smelling; people use it to beat the walls of their houses just before they go to sleep and some herbs are left in the room, producing a very strong smell, which chases the mosquitoes away. The use of strong smelling substances to chase mosquitoes seems to be very widespread as Matinga and Munthali cite their use in several districts in Malawi (see Matinga and Munthali, 2001).

There were only a few mothers who said that they do not know how to prevent malaria, while a few others also said that it is not possible to prevent malaria:

“There is no way of preventing malaria. Even if you take care of your children properly they will still suffer from this disease” (a young female informant from Chisinde village).

While very few women said that malaria can be prevented, the preventive measures which were mentioned were based on what is perceived to be the cause of the fever: for example, the use of bed-nets in order to prevent mosquito bites, which can lead to

malaria, and also abstention from sexual intercourse, especially when vulnerable babies are still suckling.

Seeking therapy for malaria

The study reveals that the younger Tumbuka people of northern Malawi believe that when a child has fever (*kotcha thupi*), it is in fact most likely that the child is suffering from malaria. Fever is indeed one of the major symptoms of malaria, but the problem with this indigenous classification is that fever can also be caused by other diseases as well. In sub-Saharan Africa, where malaria is endemic, it has been estimated that 40 percent of all fevers are due to malaria (see McCombie, 1996), and in rural Africa (including Malawi), where laboratory facilities for the analysis of blood specimens to determine the presence of *Plasmodium* species are often non-existent, health personnel have been advised to give presumptive malaria treatment whenever fever or a history of fever is reported (see Baume et al, 2000). Biomedically, the presumptive treatment approach is good as “it is unlikely to encourage the development of parasite resistance, while at the same time preventing the rapid, adverse effects of malaria in young children” (Glik et al, 1989:422).

Since a child suffering from malaria has very high fever, most mothers said that the first thing they do is tepid sponging, i.e. they soak a piece of cloth in cold water and cover the child with it in order to bring down the body temperature. Others, however, were against this, arguing that if you do that then your child will also suffer from pneumonia (*chilaso*), and instead of only needing therapy for malaria, you also have to look for treatment for pneumonia. Hence they discouraged the use of such a method for bringing down body temperature.

Most of the informants in this study said that whenever a child has malaria, the first thing that they do is to purchase medicines from nearby shops and most of them said that they buy antipyretics like aspirin and panadol. This finding is similar to most of

the studies carried out in Ghana (see Agyepong, 1992), in Kenya (Snow et al, 1992; Mwenesi et al, 1995), in Uganda (Kengeya-Kayondo et al, 1994), in Zambia (Baume et al, 2000) and elsewhere (for example Espino et al, 2000, for the Philippines). Informants said that they know that the child has malaria because it has a fever, and aspirin, as far as they are concerned, is the right treatment for fever (and malaria). Though the pills in the nearby shops cost less, informants said that sometimes they do not have the money to buy these pills. Because of their inability to buy medicines from shops and the non-availability of medicines that are provided free of charge in government owned health facilities, such people most often resort to the use of traditional medicines.

If the fever does not abate and the condition becomes serious, that is when they go to the health centre at Mwazisi for treatment. Despite the fact that antipyretics are widely consumed or used as a treatment for childhood fevers/malaria, these are not the biomedically correct therapies for malaria. The perception that antipyretics are suitable treatment for malaria is one of the factors that delays the seeking of appropriate care whenever children have fever or malaria. The consumption of analgesics when a child has malaria will relieve the pain and indeed lower body temperature for a while, so that parents think that the child has recovered. After a few days, when the child again develops a fever, they may once more administer the antipyretics. The problem with this is that the *Plasmodium falciparum* virus, which is responsible for the most severe and dangerous form of malaria, can develop and cause death within two days. This explains why it is important to administer appropriate treatment whenever a child has malaria.

In Malawi's Ministry of Health and Population, the first drug of choice for the treatment of malaria is Fansidar and despite the availability of Fansidar in the nearby shops, there were very few mothers who said that they bought it for the treatment of childhood malaria. Earlier, the first drug of choice was Chloroquine, but this was abandoned in 1993 by the Ministry of Health and Population because malaria

parasites had developed resistance against this drug. Chloroquine was otherwise very effective and cheap as well. One of the women said that most mothers do not want to buy Fansidar because they fear that they may overdose the child as they are informed at the under-five clinics that the safest way to treat children suffering from malaria is to take them to the health centre for treatment. Others feared to administer Fansidar to their children because they said that it worsens the condition of the child. They said that it is not only the children's condition which may worsen after taking Fansidar but also in adults', but that the situation is generally worse with children. Through discussions with young women who had children under five, it was found out that mothers do not follow the prescribed dosages of Fansidar, as the following case illustrates:

"My child suffered from malaria in May 2001 and I took him to Mwazisi Health Centre for treatment. He was given three tablets of Fansidar and 10 tablets of aspirin. I did not use all these tablets at once. I just gave the child one tablet of Fansidar and then kept the rest and a month later, when he suffered from malaria again, that is when I gave him the rest of the medicines", (Justina Kaluwa, July 2001).

Most informants mentioned two major reasons for under-dosing: firstly to reduce the effects of the drug; and secondly, if they bought the Fansidar from the shops, they possibly only bought one tablet because they could not afford to buy the full dosage. In their study in Zimbabwe, Vundule and Mharakurwa (1996) also found that the lack of money to purchase a full set of tablets was one of the reasons for not completing the dosage. Agyepong worked in Ghana and although he does not explain why, he also mentions that, when Chloroquine is used, the dosage is sub-therapeutic (Agyepong, 1992).

While people said that they do not administer Fansidar to their children because of dosage-related problems or that Fansidar makes children sicker, it can also be argued,

that Fansidar is much more expensive than analgesics/antipyretics, and hence people would prefer to purchase cheaper drugs such as antipyretics (Table 9.1).

Table 9.1: Prices of some pharmaceuticals sold in local shops

Name of Drug	Use	Price (Malawi Kwacha)
Panado	Pain killer	3.00/two tablets
Aspirin	Pain killer	1.50/two tablets
Parapain	Pain Killer	8.60/three tablets
Fansidar	Malaria	3.00/tablet
Novidar	Malaria	31.70/three tablets

From Table 9.1 it can be seen that antipyretics are cheap and because aspirin is the cheapest, most people said that they buy it during episodes of febrile illness. Novidar and Fansidar are the correct treatment for malaria. In formal pharmacies, Fansidar is very expensive and costs around MK100.00 for three tablets. Fansidar is much cheaper in the grocery shops found in Chisinde and surrounding areas because it is alleged that shop owners buy it very cheaply from workers in government health facilities. Novidar SP is packed in Malawi by a local pharmaceutical company and it is not available in government health facilities. It is only sold in established wholesalers and hence it cannot be sold cheaply like Fansidar. Money in rural areas is a major problem. Richardson (in Foster, 1995) documents the collapse of a drug sales scheme that was selling Chloroquine at a very low price because people could not find cash to purchase Chloroquine, despite the presence in the area of a malaria epidemic. In the end the drugs were given away free of charge as otherwise they would have reached their expiry date.

People's observation that Fansidar worsens the condition of the child or indeed an adult suffering from malaria, may be correct because, biomedically, according to

health workers, Fansidar only starts working after twenty-four hours, and hence the condition of the child may get worse in the interval before the drug starts working. Such a situation may indeed bar people from getting the "biomedically" right treatment for malaria. The right treatment for malaria consists of Fansidar and an antipyretic. The delay in seeking appropriate care is also based on people's own interpretation of the cause of the fever. If it is perceived that the child's fever, has been caused by exposure to people engaged in sexual intercourse, then the Tumbuka generally believe that going to the hospital with such a child is just a waste of time and money, as western medicines cannot effectively cure this type of fever. They may arrive at the conclusion that the fever was caused by exposing the child to those engaged in sexual intercourse if they find that after the administration of western medicines the child does not get better and the fever just continues, or they may consult a diviner if they find that their child is not getting cured. The unavailability of drugs at government-run health facilities, distance to the health centres and traditional beliefs in general thus promote the concept of self-medication. Foster adds that "economic barriers and cost of seeking care especially where a fee is required" may also lead people to self-medicate (Foster, 1995:32). In Malawi, this argument would be applicable mainly to the private medical practitioner, to the paying wards at government referral hospitals and the CHAM facilities, because health services are largely provided free of charge by government, despite the Bamako Initiative (see Chapter 1). It can be envisaged from this discussion that people's own experiences (for example the condition of the patient becoming worse after taking Fansidar) and traditional beliefs will often impact negatively on the efforts by the Ministry of Health and Population to control malaria.

Another factor that delays the seeking of appropriate treatment for malaria is the long distance (approximately 13 kilometres) from Chisinde to Mwazisi Health Centre. Vehicles rarely go in that direction, except on market days. The other health centre, at Bolero Trading Centre, is 16 kilometres away and one has to pay MK60.00 in order to get there. This is a lot of money, which most people in this rural area cannot afford. In

addition, although the mothers might want to take their children to the health centres, there were claims that the health centres in most cases do not have the required medicines and hence they just give aspirins for all illnesses, while the shops closer to home stock all sorts of medicines, which can be bought easily. Some people say why should they spend time and money going to the health centre while medicines can easily be found within their vicinity? While the government provides services free of charge, the drugs that are dispensed can also be easily obtained over the counter (see Snow et al, 1992). My study did not examine the health-seeking behaviour of those people living close to the health centre. Other studies have documented that the most common response to fever is to take the child to the health centre, especially when it is near (for example see Baume et al, 2000).

In Chisinde, most mothers said that whenever children suffer from fever/malaria, they prefer to buy medicines from the nearby shops because the hospital is very far, and that, even if they go there, the medicines are not always available. One woman described finding medicines at the health centre as a form of lottery: you can either find the medicines there or not and you do not know when you will find the medicines available at the health centre. Since most medicines are not available, most mothers claimed that the health workers instead give out Aspirin for every illness that is presented. This is expressed in the following statement:

“Everyone who goes to the health centre at Mwazisi is given Aspirin tablets even if that person is very sick. *Kasi dada liliko pilisi lakuchizga nthenda yili yose?* (Do you think that there is a pill which can cure all the diseases?) (an old informant, Wantulira Village).

The lack of medicines in the health centres is a chronic problem in Malawi. During the in-depth interviews with mothers, health workers were being accused of selling medicines to the shop owners, and this was given as the major reason for the unavailability of medicines at the health centres. Another factor that determines

choice of therapy is the people's own perception of what has caused the "malaria". For example, if they think that the malaria has been caused by (*moto*) exposure of the child to those engaged in sexual intercourse, instead of going to the hospital for treatment, they first look for traditional medicine, which is prepared as follows:

"An axe is put on the fire. A winnowing basket (*chihengo*) is put above the head of the ill child. A piece of charcoal is then placed in the basket. When the axe is red hot it is removed using an old rug, and held just above the winnowing basket. A medicinal concoction is poured on the axe and then the liquid falls on the charcoal in the basket and eventually it trickles through the basket onto the body of the child. After this, another type of medicine is prepared, which is given to the child to drink⁵⁴."

If this sort of treatment does not work, then the child is taken to the hospital for treatment. *Plasmodium falciparum* malaria can progress from mild illness to severe disease and death in as little as two days; hence it is important for caregivers of children to seek appropriate treatment promptly. Because of the rapidity with which the disease develops and worsens, there have been a lot of witchcraft accusations, as can be seen in the following case study:

On 2nd January 2001, a five-year old child was buried at Chiwapasi village. He had gone to attend a church gathering (*ungano*) of the African International Church at Jumbi (some 10 kilometres away) when he fell ill, and as soon as he came back home he slept. The parents thought that the child was very tired after walking to and from Jumbi. The father, who worked and stayed at

⁵⁴ Those people engaged in sexual intercourse pose a threat to the health and safety of children. As explained earlier, if they touch a fireplace where the child's food is being cooked, then the child will become sick. The placing of the axe in the fire and the use of charcoal tends to symbolise this relationship. The axe is said to "cut" the illness.

Rumphi Boma (some 15 kilometres away), also came home that afternoon, and finding that his son was asleep, he did not bother to wake him up. After spending some time at his home he left for Rumphi. The mother, finding that her son had fever, gave him some aspirin tablets. The condition of the child got worse and after two days the mother decided to take the child to Rumphi District Hospital for treatment. The child was vomiting and had severe diarrhoea. On returning from the hospital after receiving treatment, she met her husband and told him that the child was not well. The husband then decided that they should consult a traditional healer. The diviner told the parents that their child was bewitched by someone residing close to them in their village. He did not mention the name but just said that this “witch” was bald-headed, had a cattle byre, a pigsty and kept pigeons. Though the diviner did not mention any names, the parents of the child knew that the description fitted someone from their village. The diviner then gave them some medicine, which was later given to the child and his condition improved tremendously and he later “recovered”. After two days the child fell sick again and a message was sent to the father. The child complained of stomach ache and was vomiting. The father, seeing the condition of the child, told his wife to put the child on her back and they left for Bolero Health Centre. Before they left, the child developed convulsions and when they arrived at the health centre the clinical officer told them that their child had already died of severe malaria.

Previously this person had also been accused of witchcraft and the case was still outstanding: the man had been called by the village headman and told publicly that he was the one who had bewitched and killed a Mr Chipeta, but he had denied responsibility. The village headman therefore said that since he refused to confess, some members of the village (including the “witch”) should consult a diviner so that it could be confirmed whether he was guilty or not. The “accused person” said that he could not consult a diviner because he was a church elder in the Church of Central African Presbyterian (CCAP), and according to its doctrines, the church does not

allow its members to do that. The case was then taken to Chief Chikulamayembe. The death happened in September 2000 and by January 2001 the Chief had not done anything. The people were therefore further angered by the death of the child (as described in the above case) and they finally agreed that since nothing was forthcoming from the Chief, they would deal with the matter on their own. They carried sticks, petrol and pestles and went to see their Principal Group Village Headman and told him that they were going to kill Mr Chigwere as he had not been punished; that through witchcraft, he (Mr Chigwere) was going to kill most people in the village. The Chief intervened and called Mr Chigwere; this time he agreed to go to a diviner, despite the fact that he was a senior member of the CCAP. The members of the village had bought petrol and if he had refused they had threatened that they were going to kill him. The diviner confirmed that Mr Chigwere was the guilty party, but demanded payment of MK12000 (equivalent to US\$160) to visit the village and neutralise Chigwere's witchcraft. By May 2002, during my last field trip, members of the village had not yet found the money.

It can be deduced from this case study that the Tumbuka may also attribute fever to witchcraft; witchcraft can also be a cause of fever in addition to the other causes mentioned previously. As far as febrile illness is concerned, households firstly do self-medication (either with medicines they purchase from shops or from the stocks that they keep in their homes) and, if the condition does not improve, they go to the health centre. They may use traditional medicines, depending on the cause of the fever, or if they do not have the money to buy medicines from the shops or if treatment from the health centre fails. The situation is complex as circumstances such as those described above may require consultation with traditional healers or diviners.

Tumbuka Perceptions about Convulsions (*chikoko*)

In Tumbuka convulsions are known as *chikoko*. Most of the informants said that they do not know the cause of *chikoko*, but that what they observe is that just before an

attack of this illness, the child will run a very high fever, start “*kuchenuka*” (delirium/hallucinations) and then the convulsions would follow. They said that although the child has very high fever, at the same time, he or she feels very cold and shivers. Some women said that, traditionally, a child can also suffer from *chikoko* if some indigenous practices have been ignored. For example, if a woman with a child suffering from *chikoko* passes behind (at the back of [*kumuwongo*]) a pregnant woman, it is believed that the newborn baby will suffer from *chikoko* at birth. This can be explained in terms of the notion of sympathetic magic in which the *chikoko* that the other child is suffering from is mystically transferred to the child or foetus in the womb. While this might be the emic explanation, among the Tumbuka it is generally considered disrespectful to pass behind someone’s back. Some elderly women and TBAs said that engaging in sexual intercourse and touching a child afterwards, is as if you have “startled” (*kuchenuska*) or frightened the child, and this results in the development of convulsions (fits). Among the Mijikenda of Kenya, convulsions are attributed to “a figurative ‘animal or bird’, which gets into a child if it is frightened, thus inducing the fits. Sometimes the animal or bird is said to be in the child’s mother. The child is supposedly frightened when it sees the animal/bird in its mother’s eyes” (Mwenesi et al, 1995:1295).

The Tumbuka also believe that children will also suffer from convulsions if they eat eggs. This belief also occurs among the Tonga of Nkhata Bay District and the Ngoni of Mzimba District (see Matinga and Munthali, 2001). Some informants explained that the consumption of eggs by children is forbidden, because once children taste eggs, they will find them very sweet, will always want to eat eggs, and chickens will not be able to multiply. Others felt that elders were just selfish and that they did not want children to eat eggs⁵⁵. In the past, girls especially, were prohibited from eating eggs. According to the Tumbuka tradition, visitors know that they are warmly

⁵⁵ Though some people have now started giving eggs to their children, this belief about children not eating eggs is still very strong among the Tumbuka.

welcomed if their host kills a chicken for them. Hence, there is a need for chickens to reproduce. If children and girls are allowed to eat eggs, then they might demand them at any time. The task of welcoming visitors is a woman's responsibility; hence it is important that she keeps chickens. The girls were forbidden to eat eggs so that when they get married they will be able to keep chickens, and therefore welcome visitors appropriately. Some healers also said that eggs are sometimes used as *chizimba* in the preparation of preventive medicines for *chikoko*. Eating eggs would therefore neutralise the preventive medicine, thus making the children vulnerable to *chikoko* again.

There were very few young women who said that *chikoko* was a result of malaria attacking the brain. These women said that they had learnt this at the antenatal clinics or from their friends. Mothers, in general, consider *chikoko* to be a very dangerous illness because, if proper treatment is not sought, then the child will die or may go mad.

Therefore, depending on the cause, the Tumbuka identify several types of *chikoko*, namely:

- That which comes from God.
- That caused by exposure of the child to those engaged in sexual intercourse.
- That which is inherited. Ramakrishna et al (1989) claim that this belief also exists among the Yoruba of Nigeria, who attribute *ile tutu cum giri* (convulsions) to heredity, among other factors.
- That which comes from the breaking of food taboos (for pregnant women and children).

- That which is caused by witchcraft.

There are several ways in which people know that *chikoko* has been caused by witchcraft. For example, there are specific medicines which are used for the treatment of *chikoko*; and one of the old women, who used to practice traditional healing before her old age, said that if it happens that a child suffering from *chikoko* does not become healed after the administration of the appropriate types of medicines, then it is concluded that the *chikoko* is caused by witchcraft. If the medicines fail to work, people may consult diviners to find out who or what has caused the *chikoko*. Therefore, the failure of medicines to work may lead to a shift in the perceived aetiology of *chikoko*.

Many women said that they did not know how *chikoko* could be prevented. However, those who mentioned the breaking of taboos as a cause of *chikoko* said that it is important that taboos should be followed strictly, for example, that children should not eat eggs; and that in public, pregnant women should make sure that they sit in a place where no one can pass behind their backs.

There are a number of indigenous methods that are used to prevent *chikoko*. According to informants, one method involves the making of incisions on the child's body and then rubbing some medicines into these cuts. Blood is perceived to be the vehicle for the transportation of these protective medicines to all parts of the body. The following are some elaborate methods of preventing *chikoko* that were given:

(a) The use of “*mchembo wa munjiri*” (the lair of a warthog)

In the past, when a child suffered from *chikoko*, the first thing that mothers did was to look for traditional medicines. Once the child recovered from *chikoko*, they went with him or her to *mchembo wamunjiri* (to the lair of a warthog), where some herbal medicines were prepared. Some of these medicines were used to bathe the child while

others were given to him to drink in a potsherd (*chande*). Afterwards, all the objects used during the ritual, for example the *chande* (calabash), pots (*miphika*), cooking sticks (*muthiko*) etc, were not brought back to the village, but were left in the bush. The child was shaven clean and the hair was also thrown in the bush. After all this, the mother or guardian was told by the herbalist to put the child on her back and go home. They were not allowed to look back as it was believed that doing so would make the child suffer from *chikoko* again. If this ritual was followed properly, the child never suffered from *chikoko* again. However, in the event that the instructions were not followed correctly, the child would never be cured and when he grew up, the convulsions would turn into *vizilisi* (epilepsy) and sometimes he or she could even go mad. This ritual is still conducted up to this day.

(b) The use of amulets⁵⁶

Some medicine is taken and put on a piece of cloth and this is sewn into a small bag. A thread or string is then taken and inserted into the small bag and the child wears this around the neck. Charcoal is then put in the doorway. The wife stands inside the house while the husband stands outside. The woman takes the child and gives it to the husband who is standing outside and then the husband gives the child back to the wife. The charcoal is then picked up from the doorway, and swung around the head of the child and thrown away while saying:

“Vilute kutali muthupi mwamwana wane yayi. Fya ukawe kutali” (You should go very far and not in the body of my child), (said a traditional healer).

This traditional healer further explained that charcoal is used in this preventive ritual for *chikoko* because charcoal is black in colour and *chikoko* is like wind (*mphepo*),

⁵⁶ The use of amulets and charms as a means of preventing convulsions has also been reported among the Mijikenda and the Luo of Kenya (see Mwenesi et al, 1995).

which moves or travels from place to place looking for its victims. The healer further said that charcoal, since it is black, covers the child with a form of “darkness” so that *chikoko* could not see or recognise him.

Asked how the small bag works, traditional healers explained that the strength of the medicine is inside the cloth, which produces a smell; when the wind is blowing, the smell of the medicine is inhaled by the child and goes into the body. This amulet may snap on its own or when the child grows it is taken off its neck and kept for another child. While Zimbabwe (name of a herbalist) prepares amulets in this manner, some people said that they prepare amulets from *ndau* and the tooth of a *munjiri* (warthog) and, as explained above, the child wears this around the neck.

What we see therefore is that the warthog or something connected with it (for example its lair) is used in the prevention of convulsions. Traditional healers said that a warthog behaves in the same way that a child suffering from *chikoko* (convulsions) does. If a warthog is attacked, it will convulse, grind its teeth, turn its eyes revealing the white part and when the attack is over, it defecates (or even urinates). As we shall see below this is exactly how a child with *chikoko* behaves. Therefore, the use of a warthog (or anything connected with it) as a preventive measure for *chikoko* works based on what Sir James Fraser calls the *Law of Similarity* (Fraser, 1993:12-37). *Ndau* is a very strong smelling grass and when it is worn it chases the *chikoko* away.

Seeking therapy for *chikoko*

Most of the people in the area said that whenever a child suffers from *chikoko*, the first thing that they do is to consult traditional healers or old men and women for treatment. There was only one traditional healer who said that since a child with *chikoko* has very high fever, the first thing that she does is to soak a clean cloth in water and cover the child with, it in order to bring down the body temperature. This is done before giving the child traditional medicine.

Most of the elderly women said that, in the past, medicines (for all illnesses) were administered on a “*chande*” (calabash) and not on a plate as is the case nowadays. They never used plates because these plates were to be used again by the child, and because they feared that if he used the same plate he would suffer from *chikoko* again, they said that it was better to use *chande*. The *chande* was preferred because, at the end of the treatment period, it was broken into small pieces and thrown away as reuse could result in the illness not coming out of the body. These days some people go to the hospital whenever their children suffer from *chikoko*, because they do not know the different tree species that their forefathers used for the treatment of *chikoko* as they claim that they (forefathers) hid the names of these tree species.

One traditional healer said that she gives the child’s guardians some roots⁵⁷ which are put in a clay pot (*kabuzi*), which, after adding water, is put on the fire to boil. The water is then used to prepare porridge for the child. When boiling the medicine, one old woman said that the lid has to be taken off/removed because they want the disease (*chikoko*) to “evaporate” from the child’s body just as water evaporates from the pot when boiling. If the lid is left on the pot while the medicine is being cooked, the implication is that the disease will not come out of the child’s body. This applies, for all types of medicines whenever they are being boiled.

The traditional treatments for *chikoko* mostly consist of strong smelling plants, of which *kanufu* is the most popular. Traditional healers said that strong smelling substances are used because it is believed that the smell chases away (*kutchimbizga*) the *chikoko*. When these strong smelling plant species are administered, the major indicator that the child has been cured is when he or she defecates and urinates (just as a warthog does, as described in the above). If he does not, then there is a way of forcing the child to do so. A piece of Lifebuoy soap is chopped into a narrow, long

⁵⁷ She could not reveal the names of the trees from which she gets the roots.

and roundish shape; this is pushed in and out of the anus of the child suffering from *chikoko* repeatedly, forcing the child to defecate. When this happens, mothers are assured that the child will be fine. Leaves from these strong smelling plants are rubbed between the palms and then put very close to the nose of the child so that he can inhale some of the smell, after this the leaves are rubbed all over the child's body including the head. These strong smelling plants are also used for the treatment of convulsions in Kasungu, Nkhata Bay and Mzimba Districts (see Matinga and Munthali, 2001).

If the child does not recover after he has been given the strong smelling traditional medicine, he or she is then taken to the local health centre for treatment. Some young women said that some elders within the village tend to get worried and even start crying when a child suffering from *chikoko* is taken to the hospital, claiming that the treatment that they receive at the hospital (which in most cases consists of an injection) actually worsens the condition of the child, eventually killing him. As explained earlier, children suffering from *chikoko* are first treated using traditional medicine. Such children are only brought to the health centre very late and the chances of survival are very low. These children are given an injection and when they die, people generally attribute the death to the injection, and not to the fact that the child was brought to the health centre too late.

Some traditional healers said that some of the traditional treatment for *chikoko* may not work because the child may possibly be suffering from epilepsy (*vizilisi*) and not *chikoko*, as some people might think. Hence instead of looking for treatment for *vizilisi* they look for treatment for *chikoko* and the child will not be cured⁵⁸. These traditional healers said that a child with epilepsy produces a lot of foam at the mouth,

⁵⁸ In some areas like Kasungu District in central Malawi, *khunyu* is the local term used for both febrile convulsions and epilepsy, but people differentiate between the two, in that convulsions are accompanied by fever while epileptic attacks are associated with foaming at the mouth and there is no fever (Matinga and Munthali, 2001).

while the one with *chikoko* has fever. One of the diviners said that epilepsy can only be caused by witchcraft. What happens is that the witches make the child eat witchcraft substances while asleep at night. These substances remain in the body of the child and they move around its body. When the witchcraft substances get to the heart, that is when the child falls down and starts convulsing. In adults, the picture is different as, before an attack of epilepsy, they see a very big and tall person (a giant) chasing them, and when they get tired of running they fall down, with a lot of foam at the mouth and convulsing. With this illness it is not held to be advisable to go to the hospital for treatment as the patient will not be cured. In such circumstances traditional healers claimed that traditional medicine as the best option.

These results are similar to the findings of the study conducted among the Luo of western Kenya and the Mijikenda of coastal Kenya which affirm that modern health facilities are the last resort when a child has fits (Mwenesi et al, 1995). While among the Luo “roots are dried and crushed and the child made to sniff the powder to induce sneezing in order to get the worms out of the head” (op. cit.:1275), among the Tumbuka, as we have seen, fresh and very strong smelling leaves are used in order to chase away the “*chikoko*”. In most cases, especially when the child has convulsions, the chances of survival for these children are very slim, because the caretakers only go to the health centre when the disease is already in its very advanced stages. In such cases a quinine injection is usually given. People do not perceive that the delay in seeking appropriate care when children suffer from convulsions is detrimental to the children’s health; hence when children die after being given an injection⁵⁹ of quinine, they tend to accuse the hospitals of killing their children and do not admit that they only went to the health centre when it was too late.

⁵⁹ In their study on the Kenyan coast near Kilifi, Mwenesi et al (1995:238) also reported that informants felt that “it is the injection which kills the child” (see also Baume et al, 2000; Foster, 1995).

Mothers are very observant and in general they also share information. Experience has taught them that children suffering from convulsions do not survive when they go to the hospital for treatment and this is why some mothers even cry when their children have to go to the health centres whenever they suffer from convulsions because they anticipate that they will not be cured as there are no medicines at the health centres for this illness. Despite the health education which is given during the under-five clinics, most people do not link (convulsions) *chikoko* and malaria. Such people claim that a child with malaria is cured by Fansidar while most of the children with convulsions do not survive. There were a few women who said that convulsions are linked to malaria and such women said that as soon as a child has convulsions they rush to the health centre for treatment; however even these women first of all administer some herbal medicines before they rush to the hospital for biomedical treatment. For such women “the use of traditional medicine supplements rather than replaces modern health care” (Baume et al, 2000:1498). As explained earlier traditional medicine is looked on as relieving the symptoms, but not necessarily curing. One of the women said that whenever her child suffers from *chikoko* she goes to the local grocery shops and buys quinine because she was told at the under-five clinic that *chikoko* is actually severe malaria (*malaria yakulu*) and that the best treatment for such cases is quinine.

The few women who recognise that convulsions are linked to malaria and their positive experiences at the health centres may well act as agents of change in society, bringing about a change to an allopathic view of convulsions on the part of their fellow villagers, as exemplified in the following case of Talumba, the daughter of Mr Chifwenge Gondwe of Chisinde Village:

Mr Chifwenge Gondwe’s Experience with *Chikoko*

Wiwemi, the wife of Mr Chifwenge Gondwe, went to Mwazisi Health Centre with her daughter Talumba, who had developed fever. At the health centre,

Talumba was given aspirin which she was to take in the morning, at midday and in the evening. After receiving treatment, as Viwemi and her daughter, were going home in the company of two elderly women, Talumba had an attack of *chikoko* and fell unconscious. Viwemi then started crying because she thought that her child had died. The two elderly women knew what was happening; they took the child away from her and one of them carried the child on her back. When they finally got home the elders took some traditional medicine as explained above and administered it to the child. According to Mr Gondwe, the condition of the child got worse. Around 4:00pm the same day he, together with his wife and child, boarded an ADMARC truck and went to Bolero Health Centre, where the child was diagnosed as having severe (cerebral) malaria. The child was given bactrim, Fansidar and aspirin. Around 1:00am the child regained consciousness and started eating. In the morning the doctors advised him to go and buy milk and use it when preparing porridge for the child. The child recovered and was discharged after spending two days in the ward.

Mr Gondwe says that, since this experience, he always advises his friends that when a child suffers from *chikoko* they should go to the hospital for treatment or, if they cannot afford to, then they should just buy aspirin and Fansidar and administer it to the child with such symptoms. While at the hospital, Mr Gondwe was asked whether, when the child had developed high fever, they had soaked a piece of cloth in cold water and pressed it over the body of the child in order to bring down its body temperature. He told them that this was not done because people believe that the child will also suffer from *chilaso* (pneumonia) and instead of treating the child only for *chikoko*, they would have had to treat it for pneumonia as well. In this case it can be seen that there is some tension: while Mr Gondwe believes in a biomedical way, in the link between *chikoko* and malaria, at the same time he believes in the traditional way about the link between a cold cloth and pneumonia. He claims that covering the child with a wet cloth would have made the child's condition worse.

As has been said earlier, the delay in seeking appropriate care can cause malaria to develop into severe malaria and death within two days, especially if it is *Plasmodium falciparum* malaria. Because of its rapid development, there are a lot of accusations of witchcraft among the Tumbuka, as they say “*mwana aluta uli? Mayilo akawa makola waka akaseweranga*” (how can a child die? Yesterday he was fine and was playing”).

The Death of Fwasani Gondwe

Fwasani, a two-year old child, had a very slight fever on the evening of 7th December 2000 and his mother bought aspirin and gave it to him. The child started feeling better and the following morning he even went with his father to the garden nearby. Around lunch hour, the father went away and when he came back late that afternoon he found that the child was on his mother’s back and she explained that although she had given him some aspirin tablets, his condition was not all that good. The husband told her to bathe the child so that they could take him to the hospital for treatment before the condition worsened. However, as the child was being bathed he had an attack of *chikoko* and fell unconscious. They went to the health centre at Bolero on foot where he was given an injection of quinine, but the condition did not improve. The clinical officer informed the parents that the child had severe malaria. He had called for an ambulance to take them to Rumphi District Hospital, where further dosages of quinine were to be administered. Around 9:00pm he found that the condition of the child was worsening and the ambulance had not arrived. Fwasani’s father left the ward and went to Mwachimba Village and consulted Maria, a well-known diviner in the area. He found her sleeping outside her house and after explaining things to her, she told him that she was sleeping outside deliberately because in a dream she had seen a man coming to her with a very sick child. She explained to him that taking that child to the hospital was just a waste of time and that it was really up to him to make a

decision whether to continue keeping the child in the hospital or to bring the child to her as she was prepared to assist him. He managed to get some medicines from her that night and when he got back to the health centre he found that the ambulance had come and had taken his wife and child to Rumphhi District Hospital. Because it is approximately 15 kilometres away, he decided to go home and sleep and then leave for Rumphhi the following day. When he got there the following morning around 10:00 am, he found that Fwasani's condition had not improved, and that since coming to the hospital the child had not received any attention. Later a nurse came and said that the child was anaemic and needed a blood transfusion and the father donated the blood. At the same time he was told that he must go and buy quinine from Banja La Mtsogolo (a private clinic which, apart from family planning services, also provides health care services) as the district hospital did not have quinine at that time. He went and bought the quinine. As the process of transfusing blood started, the child passed away. On their way from Rumphhi in a car, the dead child urinated and this puzzled the parents greatly. Does a dead child urinate? This was the eighth child in this family to die soon after being weaned.

This story was narrated to those of us who had gathered at the home of Mr Tinkhani Gondwe (Fwasani's father) to help him mourn the death of his son. When I went to the health centre to discuss some issues with the clinical officer he told me that a Mr Tinkhani Gondwe had come to the health centre the previous day with a child suffering from severe malaria. After giving the child a dose of quinine he had told him that he would call an ambulance so that they could go to Rumphhi District Hospital for further treatment (as was also narrated by Mr Gondwe during the funeral). Later on when the clinical officer had come to monitor the situation of the child, he had found Mr Gondwe with a razor blade in his hands about to make incisions on the body of the sick child to administer some traditional medicines. After explaining to him that the quinine that the child had been given was adequate, Mr

Gondwe abandoned his plans. It is not known whether after the clinical officer had left, he had gone ahead and administered the traditional medicine.

Mr Gondwe could not understand the death of his child and this is the case with most of the deaths caused by *chikoko*. On the previous day, 8th December 2000, he was with his son in the garden and later that afternoon the child had fever again and subsequently suffered from *chikoko*. As the clinical officer was injecting quinine into the child, Mr Gondwe claimed that he had been very observant and that the medicine had squirted and did not enter into the body of the child. This, together with the facts that the child was not attended to on arrival at Rumphu District Hospital around 10:00 pm the previous night; the child urinated after already being pronounced dead and that this was his eighth child to die etc were just too much for him. Biomedically, while malaria and the delay in seeking therapy may be offered as explanations for the death of Fwasani Gondwe, his father and other people in the village could not understand such a series of events. As far as they are concerned, the possibility of witchcraft afforded an adequate explanation for all these occurrences (see Evans-Pritchard, 1937 and Marwick, 1965).

Mr Tinkhani Gondwe's uncle, a Mr Wongani Gondwe, did not attend the funeral. Mr Tinkhani Gondwe was accusing his uncle of being responsible for the death of his son. None of the sons of Wongani attended the funeral either. This was not the first time that Wongani had been accused of witchcraft. Earlier on in the year he (together with others in the village) was accused of killing one Chidongo Gondwe.

The death of Mr Chidongo Gondwe

It is alleged that Chidongo Gondwe, who died on 22nd October 2000, was bewitched using a type of witchcraft called "*loko*". "*Loko*" is the name given to a disease, as well as to a type of witchcraft in which witches "lock" the oesophagus and hence the patient cannot eat porridge or even drink water; if

this happens then he can't eat *sima*, which is the main staple food for the Tumbuka. If someone delays in looking for medicine for this illness then the condition worsens. A person who has been bewitched in this way just loses weight and becomes very thin. When he wants to eat or tries to eat, the food does not pass beyond his neck and he just vomits. It is adults who suffer from this disease and most people said they have never seen a child suffer from *loko*.

It is alleged that before he became sick, Pyera went to Chidongo's house and invited him to join them as they were drinking locally brewed beer (*masese*), but Chidongo had refused saying that he did not want beer that day. At Pyera's insistence, Chidongo had agreed and went with him. When they got to the place where the beer was, there were two straws for drinking beer and Pyera offered one to Chidongo. After Chidongo had drunk using the straw, Pyera removed the straw, broke it and threw it away, saying that from that time onwards they would use the other straw. When Chidongo saw that the straw that he used had been broken, he asked Pyera why he had done that, suspecting that there was some harmful medicine in the straw. After this incident, Chidongo started telling people what happened and that if he was going to die then it was Pyera who had killed him. Soon after this, he became very sick and many traditional healers were visited. Chidongo's caretakers even went to Rumphi District hospital where after consultations with a traditional healer, he abandoned his bed in the ward and went to the traditional healer. When the traditional healer failed, he went back to the hospital and this time the medical personnel did not give him any attention as they were very angry that he had left their care. He then went back to one traditional healer near Rumphi. He finally died on his way back from the traditional healer on 22 October 2000. People started pointing fingers at Pyera and Wongani as the ones who had killed Chidongo. Chidongo was a village headman, and before he became ill,

people like Pyera and Wongani were heard saying why can Chidongo be a village headman and not them and they said that *awonenge* "he would see".

Hospital personnel did not give attention to Chidongo during his second visit because he had run away to seek medical treatment from the traditional healers. His caretakers attributed the lack of attention by the medical personnel as an indication of the further ramifications or ravages of witchcraft. They claimed that witchcraft was responsible for the creation of the medical personnel's animosity towards Chidongo. When Fwasani died there were also accusations that Wongani had killed him. When the death of Chidongo, Mr Tinkhani Gondwe (Fwasani's father) was chosen as acting village headman (replacing Chidongo) and it seemed that this did not please people like Wongani. Tinkhani Gondwe's health was not all that good and he lived in fear and said that he would be the next person to be bewitched by Wongani.

There is a need to examine more closely the relationships between the persons accused of witchcraft in this context and the accusers, as these may provide an indication of the tensions involved (Marwick, 1970:280-295; see also Niehaus, 2001:83-84). Around the mid-1990s, the parent village that Chidongo came from had grown so big that a decision was made to split the village into two. Chidongo, a 65-year old man at the time, was chosen to head the new village. He was not the most senior member of his patrilineage. There were others like Wongani who were older, and hence felt that they should have been made the village headman. However, Wongani and his brother, Temweka, were both in their mid 80s and it was felt that it was better to choose someone younger and more energetic to head the new village. The illness and subsequent death of Chidongo was blamed on Wongani (and Pyera), whose relationship with Chidongo was already strained due to the issue of village headmanship. Particularly after Wongani was overheard saying something like "How can a younger person be chosen to be the village headman while those of us who are older have not? He will see!" Such statements and the antagonistic relations that existed between Chidongo and Wongani were seen as adequate proof that Wongani

(in collaboration with Pyera) was the one who had bewitched Chidongo. Since Mr Tinkhani Gondwe (Fwasani's father) was expected to take over as village headman after the death of Chidongo, it was believed that Wongani and others were not happy as they wanted to take over the village headmanship. The death of Fwasani had led to witchcraft accusations and yet biomedically Fwasani is said to have died of severe malaria. Fighting over land and headmanship are common occurrences among the Tumbuka. These findings are in line with Marwick's theory of "witchcraft as a social strain gauge" (Marwick, 1970:280-295). He contends that "the distribution of witchcraft accusations, between persons standing in various relationships reveals tension points in the social structure" (Niehaus, 2001:83; Marwick, 1970:286).

Despite the fact that traditional forms of treatment for *chikoko* are widely used, there are others who feel that it is a waste of time to use these forms of treatment; they have learnt this from experience and they simply take their children to the health centre for treatment. According to medical assistants interviewed, while convulsions in children under five can also be due to other diseases or infections, in malaria endemic areas like Chisinde, convulsions are mostly due to malaria infections. These convulsions affect the brain so, to avoid brain damage, children are put to sleep using sedatives such as paraldehyde, varium or diaspum. Paraldehyde is preferred because it acts within one or two minutes unlike varium or diaspum, which are slow acting. Apart from being sedatives, these drugs are also very good anti-convulsants. It is only after this and when it is determined that the convulsions are due to malaria that the first dose of quinine is given and after that the child is referred to Rumphi District Hospital for further treatment.

Managing *chitaska*

Chitaska is basically the enlargement of the spleen (*kapamba*) due to infection and in biomedicine this condition is known as splenomegaly. The Tumbuka regard *chitaska*

as a separate illness and think that it only attacks children. According to informants, a child suffering from *chitaska* has a swelling on the left side of his or her stomach.

“When one side of the child’s stomach is swollen and it is hard then we know that the child is suffering from *chitaska*,” (an old woman, Chisinde Village).

“When a child has *chitaska*, the stomach is swollen on one side”, (another old woman, Wantulira Village).

According to informants, a child suffering from *chitaska* cries quite a lot, has a very high fever and the illness in general causes a lot of discomfort to the child. Most of the people interviewed knew that *chitaska* was the enlargement of the spleen (*kapamba*), but they could not explain what caused this condition. They only noticed that their children were suffering from the disease. Most young women also said that they were not able to “diagnose” that a child has *chitaska*, and that this is mainly done by elderly people (especially women), who then advise them to look for traditional treatment.

While most women said that they did not know the cause of *chitaska*, some elderly women, traditional birth attendants and traditional healers said that the breaking or infringement of taboos, especially food taboos, is one of the major causes of *chitaska*. For example, pregnant women are forbidden to eat pumpkins, which have a hard outer covering (*majungu ya chitangalala or phuzu*), otherwise the child will develop *chitaska* at birth. *Chitaska* is perceived to be oval or roundish in shape and this is equated to the shape of the pumpkin. In public or in a crowd, a pregnant woman is supposed to sit in an isolated place so that she can monitor what is happening around her. Otherwise, if a woman with a child suffering from *chitaska* passes behind her back, then she will deliver a child who will suffer from *chitaska* at birth. Some women said that this disease is inherited, and that if a woman suffered from *chitaska* when she was a child, then all her children would also suffer from the illness. These

informants said that such a belief makes it very difficult for this disease to be prevented, i.e. how do they prevent a disease that is inherited? How can a pregnant woman always ensure that she positions herself in a such a way that no one passes behind her back? Such beliefs are very difficult to follow; hence the difficulty in preventing *chitaska*.

Seeking therapy for *chitaska*

Most informants (mostly women) said that the first course of action that they took when a child suffered from *chitaska* was to consult traditional healers (or any person in the know) for treatment, and that if this treatment failed they went to the hospital for treatment. Mothers also gave examples of their experience with episodes of *chitaska* in their children, and how they sought treatment, as below:

The Case of Maggie Msowoya

At the time of the interview in December 2000, Mrs Msowoya said that her child, Maggie, was three years old, and that in 1998 when she was one year old she had suffered from *chitaska* and had run a very high fever. She went to Mwazisi health centre where the child was given some aspirin tablets, but her condition worsened. She was advised to consult Nyauhango, a herbalist. After Nyauhango examined the child, Mrs Msowoya was told that Maggie was suffering from *chitaska* as the left hand side of the stomach was swollen and hard. The child was groaning a lot because of pain. Nyauhango dug some roots and made some cuts on the enlarged part. Some of the medicine was used to bathe the child. After this treatment, Mrs Msowoya and her daughter left for Nkhata Bay, where they stayed for some time. Maggie's condition worsened there. She went to the mission hospital, where the child was given an injection. Since the child was suffering from *chitaska*, one hospital worker showed her a lady who stayed close to the hospital, who knew the traditional

medicines for *chitaska*. When she consulted the woman, she was given some roots from which she prepared a concoction, which was given to Maggie to drink. After some time, she went back to the traditional healer with the child and the healer made some cuts on both sides of the stomach. Maggie recovered and never suffered from *chitaska* again.

Mrs Msowoya did not specify the traditional medicine that the traditional healer gave her. She also stated that Nyauhango knew the right treatment for *chitaska*. When she (Mrs Msowoya) was asked why her child was not cured with the medicine that she got from Nyauhango, she explained that Maggie only took this medicine three times before they (Mrs Msowoya and Maggie) left for Nkhata Bay. She insisted that there is need for taking such medicines several times before a child can be cured. Mrs Msowoya believed that Maggie was healed because the medicine that she got in Nkhata Bay was “compatible with Maggie’s blood” and because she took the medicine a number of times, unlike the medicines that she got from Nyauhango. One other conclusion that can be made from Maggie’s case is that, while mothers may sometimes want to consult the hospital for their child’s illness, the hospital personnel sometimes advise the mothers to try traditional medicine, possibly this happens because of their (hospital personnel’s) own experience with the disease as well. In their study, Matinga and Munthali also report on some community health workers who advocated the use of traditional medicines in the treatment of splenomegaly, in preference to biomedicine (Matinga and Munthali, 2001).

The use of a lizard was commonly mentioned as treatment for *chitaska*. Nyauzumala said that when her child suffered from *chitaska*, a traditional healer advised her to bring a new clay pot and a cock since the child who was sick was a boy. The healer cut some roots into small pieces and these were put into the new clay pot. Then one of the claws or toes of the cock was cut off and put in the pot. This medicine was then given to the child to drink in the form of porridge. Instead of preparing porridge, some healers mix some medicinal powder, the blood of the chicken and the blood of a

lizard (*mutondoli*) and then they make some cuts around the navel into which this mixture is rubbed. Others dissect the lizard, dip the dissected part into a medicinal powder and then rub it onto the bleeding small cuts around the stomach.

The stomach of a child with *chitaska* is distended and so that it always looks as if *walya kale* (he has already eaten) and his stomach is full. The stomach is like this because of the enlargement of the spleen. Some traditional healers said that the stomach of a lizard always looks full and at no time would someone find a lizard's stomach "not full". Thus, as we saw earlier, *like things treat like things*. This is why the stomach of a lizard is dissected and rubbed onto the cuts made on the child's body. Having received this type of treatment the children are believed to recover without any problems at all. Some elderly women and traditional healers said that this treatment ritual is conducted at the rubbish dump so that, just like rubbish, the illness that the child is suffering from should be left there as well.

While a few women linked convulsions to malaria, none of the informants linked splenomegaly to malaria. Women said that they seek traditional medicines whenever their children suffer from splenomegaly because they believe that there is no appropriate treatment for this illness at the health centres. They make this conclusion because when they go to the hospital and they get treatment, the spleen does not return to its normal size immediately. They expect that it should not take long before the enlargement disappears. Biomedically, the spleen reduces in size very slowly and the Tumbuka would rather see a rapid reduction in size and a return to normal size. They draw the conclusion that there are no effective medicines for the treatment of splenomegaly at the health facilities. The distension of the child's stomach in areas where malaria is very prevalent is due to the enlargement of the spleen as a result of infection by malarial parasites (see Maurel, 1994:27; Welcome [Pty] Limited, 1975). Lepowsky, in her study of childhood illnesses on Vanatinai Island in Papua New Guinea, mentions that children may be struck by an illness called *roro* if they eat animal protein foods and some greens and fruits. She contends that *roro* is basically

an enlarged spleen, which is a symptom of malaria (Lepownsky, 1990). Among the Tumbuka, *roro* is *chitaska* and Lepownsky's findings in Vanatinai about the aetiology of splenomegaly were not replicated in this study, but among the Tumbuka, splenomegaly is treated using traditional medicines in Papua New Guinea.

While traditional medicines for *thola*, *chikoko* or *chitaska* may be administered, sometimes, even if they are the right herbal concoctions from an emic perspective, the children may not get well. One of the most common explanations obtained from mothers was that the child's blood was not compatible with the medicines (*munkhwala undayane na ndopa za mwana yayi*), as illustrated in the following case:

Justina Kaluwa said that her son, Joe, suffered from *chitaska* and she went with him to a traditional healer. The healer told her to bring a chicken and a live lizard. She managed to bring a chicken, but failed to catch the lizard and asked the healer to help her, which the healer did. The child was undressed and small cuts were made, a pair down the middle of the navel, another pair just above the navel, two pairs on each side of the navel. Then the toe of a chicken was cut off and its blood smeared onto the cuts; while this was being done the healer was preparing the medicine (powder) which was to be rubbed onto the cuts. The live lizard was then dissected and a part was dipped into the powder, which was then rubbed into the cuts made around the navel.

As for the choice of the chicken she said that this depends on the sex of the child and since her child was a boy she took a cock. The cock in this case was taken as *chizimba*, as was the live lizard. The child recovered after this treatment. She also said that her first-born child had also had the same disease and a similar process had been followed; since the child was a girl a hen was used instead. The only significant difference was that instead of using a live lizard, the traditional healer had used the fluid of a plant known as *chinthembwe*, which was then used to smear the medicine onto the cuts, after

which the child recovered. Joel, her youngest son, was initially given the same treatment as her first-born daughter, but Joel did not recover, which was why in the second treatment a lizard was used.

The traditional healer explained to her that the "*chinthembwe*" treatment failed to work because the child's blood was "not compatible" with the treatment. The case of Justina Kaluwa illustrates that while one medicine may cure one person, the same medicine may not cure another person, even though they are suffering from the same illness; thus seemingly supporting the concept of "medicines being compatible with blood". Similar findings have been reported in Ghana where upon failure of treatment it is said:

"There is someone with whose blood the does not agree. There is someone with whose blood the drug agrees. Sometimes a drug works for one person but not the other because it disagrees with their blood. In that case take another medicine ... " (an informant in Agyepong, 1992:135).

Agyepong's findings in Ghana and the above case of Justina Kaluwa show that "blood compatibility" with medicines is an important component of the healing process. "Incompatibility" is determined when one does not recover after receiving treatment.

In addition to the incompatibility of the blood with the medicines, one of the old women said that these days there are a lot of false medicine men who are after money as they also have to survive and hence they will administer incorrect medicines that do not work. Another diviner said that sometimes people do not really differentiate between convulsions and epilepsy, as both of them are characterised by seizures (convulsions). So instead of giving treatment for convulsions, they give treatment for epilepsy and the child will not recover in such circumstances.

An old woman, Nyachimayi, said that, in the past when a child suffered from *chitaska*, they used to make small cuts (*simbo*) on both sides of the stomach and some medicine was rubbed into the cuts.⁶⁰ Some of the medicine was given to the child to drink and if the condition of the child did not improve, then they knew that it was witchcraft. Some people who practice witchcraft sometimes just want to confuse others and they mystically pull the child's intestines to one side of the stomach so that people will think that the child has *chitaska*, whereas the child had actually been bewitched. So when the right treatment of *chitaska* failed then they started looking for *mankhwala ya wulowe* (medicines that cure diseases caused by witchcraft) and children used to get better. Others used to get traditional healers to divine and find out who and what caused the *chitaska*. In addition, some people who practise witchcraft sometimes plant a roundish thing in the child's stomach so that people should think that it is *chitaska*, while it actually is not. The witches deliberately cause *chitaska*-like symptoms in order to mislead those responsible for seeking therapy.

The management of *thola*

Thola is a disease that attacks children and is generally considered to be very dangerous. The child suffering from this disease is generally pale, particularly his eyes, tongue and palms. In addition to this, the child defecates pus or mucus (whitish stuff) stools, grows very thin and is generally weak (according to one teacher at Bembe Primary School). When you lick the palms of such a child they taste salty. After seeing all these signs and symptoms, people know that the child is suffering from *thola*.

All informants said that the aetiological factors for *thola* are related to funerals. The Tumbuka believe that the following can cause *thola*:

⁶⁰ She did not reveal the name of the medicines used.

- (a) When a mother with a child under five enters a house in which there is a dead body.
- (b) When a mother (with a child on her back) uses the same path when going to the graveyard as those carrying the coffin.
- (c) When coming back from the funeral one goes straight home without washing his or her hands at the river and once he or she gets home, holds or feeds the child.
- (d) When a mother of a child under five touches a dead body and later on goes back home and breastfeeds her child.

According to informants causes, (a) and (b) come about because the dead body emits a smell that pollutes the room and pathway respectively. When a woman, or indeed any caretaker of a child, has done any of the above things and then goes home and breastfeeds the child, that child will suffer from *thola*. This is because the dead body is generally considered cold (*chinthu chizizimu*) and after touching the corpse people are supposed to wash their hands with some traditional medicine, for example, with *kanufu* and other such strong-smelling medicines.

If one does not wash one's hands, and then eats with or holds the child, then that child will suffer from *thola*. The Tumbuka believe that a dead person emits bad air and if you touch a corpse and then touch a child, it means that you have directly transferred *thola* to the child. It is only children aged below the age of five years who can suffer from this illness. Grown-ups or adults cannot suffer from this disease because "*mathupi yawo ngakukhola*" i.e. their bodies are strong, while the bodies of children are weak, hence their vulnerability to illnesses like *thola*. While these were the explanations for contracting *thola*, some elderly men and women said that the

aetiological factors for *thola* are generally linked to funerals because a child suffering from *thola* looks like a dead person in appearance.

Other methods of preventing *thola* include not using the same path as those carrying the coffin when going to the graveyard and a mother should walk in the bushes or walk ahead of those people carrying the coffin. Alternatively, she should squeeze a few drops of the milk from her breast onto the path that is being used by those carrying the coffin. This ensures that even if the child breastfeeds from the mother, he or she will not suffer from *thola*. The other way of preventing *thola* is to take some soil from the path that is being used by those carrying the coffin and to rub it against the feet of the child.

A long time ago boys and girls were not allowed to see a dead body (corpse) and they were kept in the house until after the burial. The reasoning was that they should be protected against diseases such as *thola*. Even those who had small children were not allowed to see corpses because of the fear of *thola*.

There is a variation in the interpretation of the illness *thola*. The HSA, who is a community-based health worker, said that *thola* is basically anaemia. Some of the informants said that if you go to the hospital with a child (with signs and symptoms of *thola* as described above) you will be informed that the child is anaemic. While some accepted this biomedical explanatory model, they also said that not all cases of *thola* are anaemia. Some are *thola*. The HSA also came from Chisinde and he was able to give biomedical as well as traditional explanations for illnesses such as *thola*.

Seeking therapy for *thola*

People still use traditional treatments for *thola*, but the diagnosis from the local hospital is that such a child is anaemic, which according to the Tumbuka, is not always correct. Both old and young informants strongly felt that a child suffering

from *thola* should not be taken to the hospital because they felt that health workers do not know this illness. It is the grandparents who seek for treatment for *thola*. Traditional healers could not reveal the treatment that they give for *thola*. The health workers said that *thola* is prevalent in this area because of the high prevalence of malaria.

Conclusions: linking *thola*, *chitaska*, *chikoko* to malaria: some biomedical and socio-economic explanations

In the first six months of its life, the child's haemoglobin is less attractive to malarial parasites than that found in older persons and the diet of breast milk is not particularly favourable for the multiplication of *Plasmodium falciparum* parasites. These factors, together with the antibodies inherited from the immune mother, offer protection for the child against malaria. The introduction of other foods into the child's diet, new haemoglobin filling the blood cells and the depression of inherited antibodies after six months make children particularly vulnerable to malaria attacks (Molyneux, 1988:33-34). Once the plasmodia are injected into the body, they multiply into thousands (or even millions) and these parasites grow within the red blood cells, causing the bursting of the infected cells. Unlike the *Plasmodium vivax*, which destroys young red blood cells only, *Plasmodium falciparum* destroys both young and old red blood cells; hence *Plasmodium falciparum* is associated with very high levels of parasitaemia (see Welcome [Pty] Limited, 1975). Anaemia (*thola*) results from the destruction of these red blood cells by malaria parasites. The destruction of the red blood cells causes them to stick together, forming small clots which block capillaries leading to areas of defective oxygenation (a condition known as ischaemia) in many tissues. The spleen, which acts as a blood filter, overworks in order to remove the destroyed cells from the blood. Repeated exposure to malaria and thus a regular and heavy workload for the spleen results in enlargement and hardening, which is especially palpable in children (Maurel, 1994). The clogging of the arteries that lead to the brain, kidneys, heart, lungs, bone marrow, etc seriously affects the functioning of these organs (see Maurel,

1994; Molyneux, 1988). Convulsions (*chikoko*) develop as a result of the clumping of the parasitised red blood cells in the capillaries of the brain (Welcome Pty Limited, 1975:8). Convulsions, anaemia and splenomegaly (*chitaska*) can be as a result of other infections, but in areas where malaria is endemic, this disease is responsible for most of these signs and symptoms.

Malaria, therefore, poses a great threat to the health of children under five. It is thus imperative that diagnosis should be done promptly and appropriate treatment sought, otherwise severe illness and death may result. The general lack of laboratory equipment, especially in rural areas of Malawi, has prompted the Government of Malawi (as well as other countries where malaria is endemic) to give presumptive treatment on presentation of fever or a history of repeated fever. While people's own interpretation of malaria and its symptoms may affect the way they seek therapy and attempt to prevent the disease, the socio-economic environment in which the health workers perform their duties needs to be put into perspective. The case of the death of Fwasani Gondwe is one of the many cases of children under five who have died because of financial constraints on the part of government. While the parents took Fwasani to the hospital too late, if the ambulance had arrived in good time and if quinine had been available at Rumphi District Hospital, the child could possibly have been saved. By 10:00am the following morning the child had not received any attention since his arrival 10:00pm the previous night, and then the father was asked to go to Banja La Mutsogolo to buy quinine.

This chapter has shown that while some mothers link malaria with convulsions, they do not link splenomegaly and anaemia with malaria and their ways of seeking therapy do not include the provision of anti-malarial tablets. It has also shown how the Tumbuka perceive malaria and its signs and symptoms, and how their economic deprivation together with their experience of clinics and hospitals, shape their therapy-seeking behaviour, as well as the preventive measures they take.

Thus far we have discussed the Tumbuka's perceptions of malnutrition-related illnesses, diarrhoea and malaria and their signs and symptoms. While these illnesses were mentioned by mothers as threatening the lives of children under five, other diseases which were mentioned frequently were vaccine-preventable diseases, namely measles and smallpox. Smallpox was only mentioned by the elderly men and women. The next chapter therefore discusses the Tumbuka's perceptions about vaccine-preventable diseases and how these impact on the uptake of vaccination services.

CHAPTER 10

PERCEPTIONS ABOUT CHILDHOOD VACCINATIONS AND VACCINE- PREVENTABLE DISEASES

Introduction

Vaccination, which is one of the ways of conferring resistance to disease, has been practiced in Malawi by biomedical practitioners since the arrival of the missionaries and colonial administrators. In the early days of missionary work and colonial rule, vaccinations were mainly given against smallpox. This continued after Malawi became independent in 1964. The Expanded Programme on Immunization (EPI), initiated by the World Health Organisation in 1974, was officially launched in Malawi only in 1979 by President Dr Kamuzu Banda. Until 2001, the programme targeted six childhood diseases, namely measles, tuberculosis, whooping cough, diphtheria, poliomyelitis and tetanus. A new vaccine DPT-Hepb+Hib has since been introduced in Malawi, which, as we shall see, in addition to protecting children against diphtheria, pertussis and tetanus, also protects them against jaundice, meningitis and pneumonia. This new vaccine has since replaced DPT. The main objective of the EPI in Malawi is to reduce childhood morbidity and mortality from childhood vaccine-preventable diseases (see Chilowa and Munthali, 1999; Vaahtera et al, 2000).

During fieldwork, out of the above mentioned vaccine-preventable diseases, only measles was frequently mentioned by both old and young mothers as one of the most dangerous diseases that currently threaten the health of children in the area. Old men and women said that, in the past, in addition to measles, smallpox was one of the diseases that people feared and that it had attacked both adults and children.

This chapter discusses the delivery of vaccination services in Chisinde and surrounding villages, and mothers' perceptions about these vaccination services. It also considers two examples of vaccine-preventable diseases, namely measles and smallpox, focussing on how mothers recognise these diseases, their perceptions about the aetiology and methods of prevention of these diseases, and how they go about seeking therapy whenever children suffer from them. Though smallpox has been eradicated, it is nevertheless important to document, through the use of oral history, how the Tumbuka managed the disease, as early missionaries, such as Fraser, did not write much on the disease (see Fraser, 1922).

A description of the delivery of vaccination services in Chisinde and surrounding villages

It is necessary to have an idea of how vaccination services are delivered in Chisinde and the surrounding villages, and the role that HSAs play in this work. In Malawi, the Expanded Programme on Immunisation (EPI) is responsible for coordinating the immunisation activities. The EPI falls under the Directorate of Preventive Health Services of the Ministry of Health and Population. At the national level, the EPI Programme Manager and his staff are only involved in immunisation activities, but the Ministry of Health and Population staff at district and health centre level⁶¹, in addition to the provision of vaccination services, are also involved in other activities (Chilowa and Munthali, 1999). For example, the health surveillance assistant (HSA) responsible for the Chisinde area said that, while he vaccinates children, he is also responsible for other activities like family planning, the distribution of condoms, the monitoring and reporting of the outbreaks of disease to higher authorities, growth monitoring of children under the age of five years, conducting health education sessions, treatment of minor illnesses, and inspection of villages to see if they have

⁶¹ Initially there were also regional offices of the Ministry of Health and Population, but these have since been abolished under the decentralisation programme.

toilets, bathrooms, dish racks, kitchens and if they do not, to advise them accordingly. At one time he was even coordinating the construction of SAN-PLAT latrines, a project funded by the GTZ-sponsored Border Zone Development Project (BZDP). This is why in some quarters the HSA has been dubbed the “super health worker”, responsible for doing everything at community level (see Kadzandira and Chilowa, 2001). Although such a load of responsibilities in turn affects his work output, as Wright has argued, the provision of vaccination services is generally perceived as a vehicle through which nutrition, ORS, breastfeeding and distribution of essential drugs are promoted (Wright, 1995).

As far as vaccination services are concerned, there is a need to distinguish between outreach and static vaccination services⁶². Static vaccination services are provided at the hospitals, health centres and dispensaries. In the case of Chisinde and surrounding villages, they are offered at Mwazisi Health Centre. Outreach clinics are held away from the health centre and may be conducted in classrooms, churches, health posts, or even under the shade of a tree. The major purpose of establishing outreach clinics is to bring the vaccination services as close as possible to the clients of these services so that distance should not be the reason for the non-immunisation of children. During outreach clinics, the HSAs carry the vaccines in a cooler box packed with ice cubes to keep the vaccines cold and they travel to a place away from the health centre to vaccinate children and their mothers. As soon as this is over, they return to the health centre and put the remaining vaccines in the refrigerators. It is of utmost importance that vaccines should be kept within the recommended temperature ranges as exposure to temperatures outside this range may destroy the vaccines.

There is an outreach clinic at Chisinde, which is conducted once a month in a classroom, and the responsible HSA carries vaccines from Mwazisi Health Centre as

⁶² The Ministry of Health and Population uses the word ‘static’ to refer to those services offered at the health centres, dispensaries and hospitals. The term ‘fixed’ may however be more appropriate in this context.

Chisinde falls in its catchment area. The major complaint was that his catchment area, which consists of seven villages is large and is in a very hilly area. He has a bicycle, but in most cases he pushes it because of the hilly terrain. He suggested that in such terrain, the Government should provide motorcycles. The use of bicycles in such terrain affects the HSAs' work output in that, instead of visiting villages in their catchment area several times a month, they may only go to each village once a month. This, for example, affects the campaigns to mobilise people for vaccination services.

The vaccines are delivered to the health centre at Mwazisi by a vehicle from the District Health Office in Rumphi, which in turn gets them from the EPI central stores in Lilongwe. At Mwazisi Health Centre, the vaccines are kept in the paraffin run refrigerator: TTV, DPT and BCG have to be kept in the refrigerator at between 4 and 8 degrees Celsius. They are not supposed to be frozen as this may destroy their potency. Measles and polio vaccines are kept in the deep freezer at temperatures below zero. During the visits to the health centres at Mwazisi and Bolero, it was observed that the vaccines were being kept at the recommended temperatures and a record of temperature readings was also kept on the fridge. Because of the incapacity to keep large stocks of vaccines, the health centres have to order new stock (by filling in a form shown in Table 9.1 below) from the District Health Office whenever they are running out. While community health nurses may also vaccinate children, the bulk of this task is left to the Health Surveillance Assistants. Vaccines are only taken from the fridge when required during the vaccination sessions.

Table 9.1 Monthly Vaccine Report and Order Form

Health Facility Month Year:

Type of vaccines	Stock at beginning of the month (vials) (a)	Amount received during the month (vials) (b)	Total (a+b) (c)	Amount used (d)	Balance at the end of the month (c-d) (vials)	Amount being ordered
POLIO						
MEASLES						
DPT- HEPB + HIB						
BCG						
TTV						
VITAMIN A (CAPS)						

The EPI Schedules for receiving different antigens and reasons why children cannot be fully vaccinated by the age of 12 months

In the EPI programme in Malawi, there are currently four vaccines, namely DPT-Hep+Hib, which protects children against diphtheria, pertussis (whooping cough), tetanus, jaundice, meningitis and pneumonia; BCG against tuberculosis; OPV (oral polio vaccine) against poliomyelitis; and the measles vaccine. These vaccines are

supposed to be administered to children whenever they reach specific ages as shown in Table 9.2.

Table 9.2: Vaccination schedule (see Vaahtera et al, 2000)

Name of vaccine	BCG	DPT1- Hepb+Hib	DPT2- Hepb+Hib	DPT3- Hepb+Hib	OPV1	OPV2	OPV3	Measles
Scheduled Age for Vaccination	At birth	6 weeks	10 weeks	14 weeks	6 weeks	10 weeks	14 weeks	9 Months

From Table 9.2, it can be seen that children are supposed to be fully vaccinated before they reach the age of one year. It is desirable that this vaccination schedule should be followed religiously because those aged below 12 months are the ones who are most vulnerable to these diseases. The recent Demographic and Health Survey conducted in Malawi in 2000 reveals that 70 percent of the children aged between 12 and 23 months were fully vaccinated, but of these only 54 percent were vaccinated before the age of 12 months (National Statistical Office, 2001:115). As is normally the case with large-scale quantitative studies, important as these figures are, unfortunately, they do not tell us much about why only 54 percent were fully vaccinated before the age of 12 months.

In the current study, checking under-five cards revealed that there were many children who had not completed the vaccination schedule in time. This can be due to a number of reasons and, according to informants, these were principally due to service delivery factors, as well as to client-related factors. HSAs attached to Mwazisi Health Centre said that in the year 2000, the health centre did not receive a steady or regular supply of vaccines and, that between May and June 2000, they did not have any vaccines at all. During that period neither 'static' nor outreach immunisation sessions were conducted, including the outreach clinic at Chisinde. The refrigerators at Mwazisi

Health Centre are run on paraffin, and at one time the health centre ran out of paraffin, and they had to transfer the vaccines for safe-keeping to Bolero Health Centre, which has refrigerators run on electricity. During this time mothers who came to the health centre were sent away without their children being vaccinated. The HSAs pointed out that in such circumstances it is highly unlikely that children can complete the vaccination schedule in the recommended time period. This shortage of vaccines is not an isolated event in Malawi (see Chilowa and Munthali, 1999). In June 2000, there was a countrywide shortage of the BCG vaccine, which is used to prevent tuberculosis. At that time, since Malawi depends on the largesse of the donors to run its EPI programmes, the Ministry of Health and Population held discussions with UNICEF on how the problems relating to the acquisition of vaccines could be solved. As the incidence of tuberculosis is on the increase in Malawi due to the HIV/AIDS pandemic, the shortage of the BCG vaccine placed newborn babies at risk and this caused a lot of concern (see www.idsociety.org).

The transfer of staff before appropriate arrangements have been made to replace them may also contribute to the disruption of the delivery of vaccination services in the area. For example, in 1999 the Health Surveillance Assistant who was stationed at Chisinde and was responsible for running the outreach clinic there was transferred to Rumphi District Health Office. Her transfer led to the temporary closure of the outreach clinic at Chisinde, which caters for Chisinde as well as surrounding villages. At the time, there was no one who was prepared to take over the running of the outreach clinic at Chisinde. According to the mothers, Mwazisi Health Centre was situated a long way away and some of them did not visit the health centre for vaccinations until the outreach clinic at Chisinde was reopened in October 2000. As was mentioned earlier outreach clinics bring vaccination services closer to the people. Long distances to where the immunisation sessions are conducted may, therefore, lead to non-completion of the vaccination schedule on time.

There are also other limiting factors in addition to the above service-delivery factors. Though most pregnant women go to the health centre for delivery, in this rural area traditional birth attendants (TBAs) still play a role in the delivery process. The Demographic and Health Survey of 2000 reports that in the Northern Region of Malawi where Rumphu is situated, 36.6 percent of the deliveries occurred at home (National Statistical Office, 2001:109). Though the report does not say explicitly who assists in these home deliveries, it can be safely assumed that most of these deliveries are done by the traditional birth attendants. TBAs in the Chisinde area mentioned that because the health centres are far away, they still assist people to deliver babies. Inspection of under-five cards during immunization sessions revealed that a good number of children did not receive the BCG and OPV0 (OPV Zero) vaccines which are given at birth, because children were born at home/TBA (see Vaahtera et al, 2000, for similar findings in Mangochi, southern Malawi).

Two other frequently mentioned reasons why mothers said their children were not vaccinated at the correct age were that they (mothers) went away to attend a funeral, or that the mother was sick at the same time. When they were asked whether the father could bring the child for vaccinations whenever they (mothers) were sick, mothers said that it is not their responsibility:

“It has never happened and when you go with the child to the health centre for vaccination *kabonda kakukhumba bere* (the child wants to be breastfed),” (one woman said at Bolero Health Centre).

Breastfeeding is something that the fathers cannot provide. Taking children to the health centre for vaccination services is generally perceived to be the responsibility of women. Chilowa and Munthali also found that in Ntchisi and Chitipa Districts, men did not take their children for vaccinations (Chilowa and Munthali, 1999:51). In my study, some health workers had the view that men should also be taught about the importance of vaccinations so that when their wives are ill, are away or are busy with

some household chores, they could take their children for vaccinations. This would ensure that children are vaccinated according to the vaccination schedule. While the attendance of funerals prevented mothers from going with their children for vaccinations, some community health workers also said that vaccination sessions have at times been cancelled because of the death of a staff member, because all staff members had to attend the funeral.

Other reasons that were mentioned by mothers for not having their children vaccinated at the correct age included:

- When a child is sick, some mothers do not take them for vaccinations because of the fear that once vaccinated, the condition of the child will worsen.
- One woman said that the child had diarrhoea and he had soiled all his clothes. She could not put the child in nappies only because she feared that her friends would laugh at her.
- During the rainy season some women said that their husbands sometimes prevent them from going for vaccinations as they want them to go to the garden and work. During the season of harvesting tobacco, mothers are also prevented because their husbands would like them to first harvest the tobacco.

HSA's mentioned cases in which husbands followed their wives to health centres where they had gone with a child for vaccinations and beat them up within the health centre premises. The reason for beating their wives was that previously, after the child had been vaccinated, it had developed an abscess and the man had told his wife not to take the child for vaccinations again. Abscesses seemed to cause a lot of concern. Some mothers said that they have observed that some HSA's always produce abscesses whenever they vaccinate children. When they go with their children for vaccination, they first of all find out who the vaccinator is: if he is the one who

produces abscesses then the mothers just return home without their children being vaccinated.

Though the HSAs affiliated to the health centres at Bolero and Mwazisi did not say so, reports that were submitted to the Maternal and Child Health (MCH) Coordinator at Rumphu District Hospital indicated that between January and March 2002, the turnout of mothers at under-five clinics was very low. This was attributed to two reasons: firstly, this is the rainy season and people are busy in their gardens; secondly, during this period there was widespread famine not only in Chisinde and surrounding villages, but also in the entire country. Heavy rainfall can also prevent HSAs from going to conduct outreach clinics in their catchment areas. In some cases for those outreach clinics which are very far away, nurses from Rumphu District Hospital travel by vehicle. If these nurses depart late from Rumphu, it means that they also reach the outreach clinic very late and most mothers, thinking that the vaccinators have not come (as they sometimes do not), would have left the outreach clinic for their homes. While the target of the Ministry of Health and Population is that children should be fully vaccinated by the time they reach 12 months of age, the factors discussed above make this objective very difficult to achieve.

Perceptions about vaccinations

In Tumbuka, immunisation is known as *katemera*. The term *katemera*, however, does not only apply to the biomedical vaccinations that children and women receive at the health centres and other such places. Most of my informants also referred to the indigenous methods of disease prevention as "*katemera*". In order to differentiate the indigenous methods from the biomedical vaccinations, informants talked of "*katemera wachifipa*", meaning 'black or African vaccinations', which encompassed the utilisation of amulets, incisions, etc, among other methods (see Samuelsen, 2001, for similar findings in Burkina Faso). These "African vaccinations" are not only used

against what the Tumbuka perceive to be African illnesses⁶³, but also against attacks by wild animals; for example, the case of a man vaccinating people against lion bites in Mombasa (see Vaughan, 1991:59). While acknowledging the existence and use of African forms of vaccinations, this chapter mainly deals with biomedical vaccinations as given at the health centres and the associated outreach clinics. Mention will be made of whooping cough, which informants said cannot be adequately prevented by biomedical vaccinations; hence it is necessary to have recourse to African forms of vaccinations.

All mothers with children under five said that they had heard about immunisation. The major sources of information about immunisation are the radio and health workers (especially the HSAs). Both mothers and the vaccinators said that before children are vaccinated, mothers gather in a group and the health workers teach them about different aspects of health, including vaccinations and vaccine-preventable diseases. In most cases, it is the HSA who is responsible for conducting these health education sessions. During such sessions as well as from radio programmes, mothers said that they had been told that immunisation is good as it protects children against diseases and that pregnant mothers have to be vaccinated against tetanus as well.

There is no outright rejection of vaccination services in the area. Many mothers go with their children for vaccination because they understand the value of vaccinations. Although there are no members in Chisinde and the surrounding villages, within the catchment area of Mwazisi Health Centre, there also exist members of the Jehovah's Witnesses (*Mboni za Yehova*), Zion and the Apostolic Churches, who do not accept vaccinations. The HSAs also cited a group of people who had previously lived in Nyika, but when the area was declared a national park, they were resettled within the catchment area of Mwazisi Health Centre. The HSAs alleged that these people initially refused to have their children vaccinated saying:

⁶³ See a definition of African illnesses as given in Chapter 5 (Literature review).

“Naumo tikakulira ivi vikawako yayi” (meaning we grew up without these vaccinations).

After intensive health education campaigns, these people have now started accepting vaccinations.

While routine vaccinations are well received by the people, a lot of fear is expressed regarding the national vaccination campaigns and the national immunisation days (NIDs). On NIDs all those who are below 15 years of age are vaccinated, regardless of their immunisation status, i.e. whether they are fully, partially or not immunised⁶⁴. Before 1999, target groups received polio vaccinations during the NIDs, but with the big reduction in polio cases, the campaign has since shifted to measles. The HSAs said that the people are acquainted with routine vaccinations given to children under five and pregnant women. They are surprised that even “grown-up” children such as those attending school, should have to receive vaccinations. It was learnt from the HSA that people fear such mass campaigns and say that they may be because there are a lot of people now, and that this is one way in which the Government of Malawi would like to slow down population growth. They claim that the vaccinations that children receive during the NIDs destroy their reproductive capacity. Regardless of such feelings, most people still go with their children for vaccinations. The 1999 NIDs coincided with the parliamentary and presidential elections in Malawi and mothers, according to the HSAs at Mwazisi Health Centre, thought that as the population in the northern region was already low, the government was ensuring that children do not reproduce by giving them vaccinations, thus ensuring that a president does not come from the north. Such reasoning is based on the fact that during the

⁶⁴ A child is said to be fully-immunised when he has received one dose of BCG, three doses of DPT-Hepb+Hiv, three doses of OPV and one dose of the measles vaccine. OPV stands for the Oral Polio Vaccine.

elections of 1994 and 1999 Malawians voted for the president along ethnic lines (see Nichter, 1995, for similar results in India).

The HSA responsible for the area said that there are very few people who do not bring their children for vaccinations. According to the HSA, those who do not come do not understand why vaccinations are important and further stated the need to educate such people. Some mothers of children under five said that they were aware of other mothers who did not want their children to be vaccinated. Mothers who refuse vaccinations learnt a lesson when their children become ill and they had to go to the hospital for treatment. Mothers (with children under five) said that it seems it is government policy that children under five who do not have a vaccination card should not be given treatment. This is what leads some mothers to have their children immunized as they fear that if they are not vaccinated, they will not receive treatment at the health centre whenever they fall sick. Others feel that vaccinations are what make their children sick; hence, though they may not want to take their children for these vaccinations, they are forced to go out of fear that the children will not receive treatment if they do fall sick. It seems that the provision of medical treatment is therefore perceived as a bait to draw those mothers who would otherwise not have their children vaccinated. These findings are similar to those of Chilowa and Munthali who, in their study in Ntchisi and Chitipa Districts, found that mothers in certain circumstances see themselves as forced to take their children to be vaccinated (Chilowa and Munthali, 1999). In Nichter's study in India, some women expressed the same sentiments: they said that "if they did not accept vaccinations, they might be offered poor government health service should they require it" (Nichter, 1990:202). This is what Nichter calls passive acceptance of vaccinations, which means:

"... acceptance of vaccinations by a public which yields to the recommendations and social pressure, if not prodding, of health workers and community leaders" (Nichter, 1995:617).

While this was the perception of many mothers in this study, health workers agreed that indeed, when a child has not been vaccinated, the mother is told to go and have her child vaccinated before she gets any treatment. When mothers are told in this way they interpret it as a punishment for not having the child vaccinated. By referring such children for vaccination, health workers are ensuring that every child is vaccinated; and they take advantage of every contact they make with a child. In private clinics, because they are after money, the unvaccinated child may receive treatment.

Vaccination promotion regimes aim at educating the mothers so that once they are in the know, they will be able to make informed decisions, and go to the vaccination centres to have their children vaccinated, based on their understanding of the importance of vaccination. While mothers are being educated during the vaccination sessions and through other channels such as the radio, at the same time such regimes can be labelled coercive because they 'force' mothers to have their children vaccinated, or otherwise they will not receive treatment when they are sick. Apart from treatment, which is perceived by mothers as a form of bait to draw them to vaccination services, the Government of Malawi's Ministry of Health and Population in the past used to provide *likuni phala* (a weaning food) to mothers of children under five as part of its supplementary feeding programme for children under five. While the Ministry of Health and Population was doing this as a strategy to reduce malnutrition in children under five, mothers also perceived it as a bait to draw them and their children to vaccination sessions (see Chilowa and Munthali, 1999:37).

As far as measles and other childhood vaccine-preventable diseases are concerned, none of the mothers ever mentioned the use of traditional methods for the prevention of these diseases. The only vaccine-preventable disease that was mentioned as preventable by the utilisation of traditional methods was whooping cough. Both old and young women felt that whooping cough cannot be entirely prevented by biomedical vaccination; this needs to be complemented by indigenous prevention techniques. In this context, they said that children should wear traditional amulets as a

preventative against whooping cough. Many children in the village were observed wearing amulets around their necks as a form of protection. Old men and women particularly attributed the onset of whooping cough in children to acts of sexual promiscuity or immorality and that is why it requires indigenous forms of vaccination and not that which is given at the health centres.

It was also learnt that relatively few children wear the protective amulets these days. This is because, according to informants, whenever children wearing amulets are sick and are brought to the health centre for treatment, the doctors shout at the parents and say that such beliefs are what result in children becoming ill. Some mothers claimed that some health workers even go to the extent of removing the amulets from the necks of the children saying they are ineffective and hence are just a burden for the children. Young mothers are at a loss: on the one hand they do not want to offend their grandparents by ceasing to put the amulets around the necks of their children; and on the other hand, they face the wrath of the health workers when they go with their children for vaccinations or for treatment. This is why, according to one of the informants, when a child falls ill, the mother might decide to seek therapy from the health centre first and after that “the grandmother can prepare amulets for the child” and in this way they are able to beat the “system”. Amulets were not mentioned as preventive measures for measles.

Despite these reservations, it can be seen that vaccination has been accepted by the Tumbuka as a childhood disease prevention strategy. All the factors relating to service delivery need to be addressed by government and its partners, and awareness campaigns need to be intensified, directed particularly at men, so that they should also understand the importance of vaccinations.

Managing smallpox among the Tumbuka

Smallpox in a historical perspective

Smallpox, a disease characterised by very high fever, severe multiple skin eruptions and pustules and mostly clustering on the face and limbs (see Arnold, 1993), was caused by a virus that was either airborne or spread by direct contact with the patient, and has occurred throughout history in epidemics. It was also spread by contact with clothes, bed linen and feeding utensils (Ransford, 1983:203). The disease first appeared in China and the Far East at least 2000 years ago, after which it spread to the rest of the world⁶⁵ through the movement of armies and populations (Parish, 1968). It was estimated that a third of those who suffered from smallpox died and so, in places like India children could not be incorporated and be counted as members of the family until they had had smallpox and survived (see Arnold, 1993).

Variolation developed as a preventive measure against smallpox. Variolation was defined as a process of inoculating a person with the virus from mild cases of smallpox. A person who was inoculated in this manner contracted a mild form of smallpox and so developed immunity (Parish, 1968:7). This method of preventing smallpox was practised for many years in both Europe and the United States of America, as early as the 18th century. It is argued that the practice of variolation was borrowed from Asia where it had been practised for many centuries (Anderson, 1990), before spreading to Africa and the western world. The process of variolation has taken many forms. In China, scabs from smallpox pustules were blown into the nose through a tube, a process they referred to as “*sowing smallpox on a lucky day*”; in India, Brahmin priests inoculated, into parallel scratches in the skin, cotton infected with smallpox matter that had first been stored for a year; in ancient Persia, prepared scabs were swallowed; and children were wrapped in the cloth of smallpox patients

⁶⁵ See www.tulane.edu/~dmsander/Tutorials/Pox/Pox1.html

(Parish, 1968:8).

The use of variolous matter that had been stored for a year was important:

“ ... for in artificially introducing the disease in a more attenuated form that it had been acquired naturally, the inoculators were likely to reproduce the disease not in its full severity but still in sufficient strength to have a prophylactic effect” (see Arnold, 1993).

While the process of variolation was in a way useful, sometimes the person so inoculated became seriously ill and possibly died, and the chances of spreading the disease through contact were higher as often the need to isolate those who were artificially inoculated was overlooked (Parish, 1968; Dawson, 1992).

Some scholars have suggested that the concept of variolation in Africa was not learnt from the Europeans, as it was common in West Africa by the late 17th century (see Maier, 1979; Samuelson, 2001). The replacement of variolation by the Jennerian technique of vaccination and the massive campaigns that followed resulted into the eradication of smallpox all over the globe, the last known case to be diagnosed being that of Ali Maow Maalin, a hospital cook near Mogadishu in Somalia on 26th October, 1977 (Ransford, 1983:209). While in other areas in Africa smallpox is said to have been introduced by the Europeans, among the Tumbuka of northern Malawi, smallpox existed long before any white man appeared (Fraser, 1922). Fraser further states that there were outbreaks of the disease just before the coming of the Ngoni in the 19th century. During that epidemic many people died and many villages were left almost empty. There are suggestions that the disease was carried into the country by an Arab slave wagon, as happened in other parts of central Africa (Fraser, 1922).

In Malawi, during and prior to the colonial period, the use of variolation was widespread. During the colonial period, local people were employed by the colonial

government as vaccinators and had the very difficult task of convincing people that smallpox vaccinations were better than the indigenous method of variolation (Vaughan, 1991:43). There were massive widespread attempts to evade the colonial state smallpox vaccinators because people felt that the vaccines themselves were what actually caused smallpox (Chilowa and Munthali, 1999); injection sites on the body became swollen (see Chilowa and Munthali, 1999); and after being vaccinated, people felt a lot of pain and could not hoe their fields for some time (Vaughan, 1991). In other countries, the availability of variolation (which was perceived as effective against smallpox) religious objections and the disapproval of the leading role of the state prompted resistance against the Jennerian form of smallpox vaccination (see Streefland et al, 1999). As time went on, however, people started believing in the efficacy of vaccines, especially when they noticed the decrease in the incidence and prevalence of smallpox (Chilowa and Munthali, 1999). The last case of smallpox was reported in Malawi in 1971 (King and King, 1992:58).

Perceptions about smallpox among the Tumbuka

One of the things that this study examines is what old men and women (those aged over 60 years old) perceived to be the most dangerous childhood diseases in the past, and what the young men and women today perceive to be the most dangerous childhood diseases. Old men and women said that in the past, before its eradication, smallpox used to be seen as a dangerous disease to both children and adults. None of the young men and women ever mentioned smallpox, possibly because they have never experienced the disease. Old men and women said that smallpox was caused by the wind blowing; they said that *nthomba ni mutunga/mphepo*, meaning smallpox is like wind. Like the Tumbuka, the Bambara of Mali also believe that smallpox comes with the wind and in their case, they explain further that this is so because it is only wind which “has a widespread contact with the body as to be able to cause so diffuse an eruption” (Imperato et al, 1979a:15). In other African cultures smallpox was seen as a signal of the displeasure of the (smallpox) gods (Maclean, 1976), a belief not

documented among the Chewa or Tumbuka of Malawi. Cultures influenced by Islamic teachings believed that smallpox was caused by a bad *genii* (Imperato et al, 1979a). As far as old men and women can remember, such causal explanations were absent among the Tumbuka.

According to informants, there was a widespread belief among the Tumbuka that outbreaks of smallpox were aggravated by acts of sexual promiscuity. This is why during smallpox epidemics, the village headman used to call all his subjects and tell them that, since there was an outbreak of smallpox in the village, everyone was urged to abstain from sexual intercourse until such time as the outbreak was over. If the epidemic continued, it was assumed that there were some people in the village who were not complying. Hence all young girls were called and forced to confess to their sexual behaviour. The purpose of such an action was to make everyone understand that, for the epidemic to go away, there was a need to abstain from sex. These findings are similar to those of Chilowa and Munthali, who found that among the Chewa of central Malawi, in the district of Ntchisi, abstinence from sexual intercourse during the period of the smallpox epidemic was a pre-requisite for the end of the epidemic (Chilowa and Munthali, 1999).

Contact was a major means for the transmission of smallpox. Therefore, etically, it can be envisaged that the prohibition or curbing of sexual promiscuity during epidemic times made a lot of sense as smallpox was a contagious disease. The Tumbuka's' attempts to prevent the disease involved those people who had smallpox being isolated from the community, with temporary shelters being erected away from the village, for fear of transmitting the disease to others in the village (see Chilowa and Munthali, 1999, for similar findings among the Chewa of central Malawi; Munthali, 1999, for the Yao of southern Malawi). People who suffered from smallpox were only allowed to come back into the village once they were healed. The temporary huts were erected downwind of the village. This was because of the belief that smallpox was transmitted or caused by wind. The isolation or quarantine of

people suffering from smallpox has been reported in many cultures in Africa. For example, in the small city of Kumasi in Ghana, entry was denied to those who had smallpox, and those who were discovered after entry, were isolated and put into quarantine in remote villages. Moreover in Kumasi, prisoners were not taken if they had smallpox (Maier, 1979). While most scholars have written that smallpox sufferers were isolated, Gelfand said that among the Shona of Zimbabwe, such patients were not isolated and once the outbreak started, it spread rapidly from one house to another and from one village to the next, "the unfortunate victims merely curling up and dying in their own huts (Gelfand, 1964:131-132).

My informants claimed that a person could only suffer from smallpox once, and this was why, in most cases, those who took care of persons suffering from smallpox were those who had themselves suffered from smallpox. This is similar to what used to be practised elsewhere in Africa. For example, among the Yoruba of Nigeria, smallpox was represented as a deity, and only persons who had survived an attack of the disease could belong to the cult; and only they were permitted to come into contact with anyone suffering from smallpox (Ajose, 1957). There were times when children suffered from smallpox and their mothers, who had never suffered from the disease, had to go and take care of "what was theirs". Old women said that mothers had no choice as they had to take care of their children. This was despite the fact that they knew that it was dangerous to do so; for them it was an obligation to take care of their children in such difficult and dangerous circumstances, as no one else would have done that for them.

During the whole period of illness, patients (whether children or adults) suffering from smallpox never slept on mats. They slept on banana leaves because they are slippery (slimy) and, hence they could not stick to the body of the smallpox victim. Mats made from reeds or bamboos could stick to the body of the person suffering from smallpox and the victim experienced a lot of pain in the process of separating his or her body from the mat (see Munthali, 1999, for similar findings among the

Yao). Though informants gave this reason, it can, however, also be suggested that sleeping on the banana leaves was much cheaper as the leaves (unlike the infected mats) could later just be thrown away or burnt.

As regards treatment, the pustules were pierced using big thorns, after which the body of the smallpox victim was rubbed with okra until the whole body became reddish. Okra was used, not as a form of treatment, but just to wash the pustules. They never went to the hospital because the hospitals were too far away in Mzimba and Livingstonia. An old woman mentioned that in the 1940s she, together with two other family members, had suffered from smallpox. Temporary huts were built for them outside the village as was usually the case and they used to be visited by doctors working for the colonial government. Out of all the old men and women who were interviewed, this was the only informant who mentioned that doctors from the colonial government were treating those suffering from smallpox.

When a smallpox epidemic was over, the Tumbuka used to perform a ceremony known as *kupyera chikungu*. In this ceremony all the fires from all the fireplaces in the village, including smouldering logs, broken pots etc, were swept clean and the rubbish thrown away at a road junction, after which they went back to their houses without looking back. They feared that if they looked back they would suffer from smallpox again. A new fire was made at the chief's house by rubbing together some sticks since there were no matches at the time. Everyone in the village came to get the fire from the new fire made at the chief's house. It was believed that when someone passed or jumped over what was thrown away during the *kupyera chikungu* ceremony, he or she would get smallpox. This raises what Prins calls the circular passage of disease, i.e. that although the village got rid of smallpox, the act of throwing away supposedly infected rubbish at the road junction also placed others at risk of contracting the disease (see Prins, 1992; Ngubane, 1977). While Prins and Ngubane apply this to individuals, in Tumbuka context, the notion of circularity can also be applied to the whole village, as the ritual of *kupyera chikungu* was a

communal and not an individual event. The ritual of *kupyera chikungu* was not only performed during smallpox epidemics. It was also done after the mourning period for dead chiefs. Although Fraser also describes this ritual very ably (Fraser, 1922), he does not relate it to the ending of outbreaks of smallpox. It may be deduced that the deaths of chiefs and smallpox epidemics posed serious threats to the Tumbuka, and that the major function of the ceremony was to prevent further attacks of the disease, as well as death in their communities.

We thus see that smallpox attacked both adults and children; during fieldwork only adults mentioned this disease. The discovery of the Jennerian form of vaccination marked a new era in the fight against smallpox and this initiative eventually led to the eradication of smallpox in the 1970s.

Managing measles among the Tumbuka

Introduction: measles as a public health problem

Measles is a respiratory disease caused by a virus and transmitted from one person to another by infected droplets from the mouth, nose and throat of an infected person (King County, nd). Its signs and symptoms include a rash, high fever, cough, running nose and watery eyes. According to the Centre for Diseases Control (CDC) in the United States of America, measles is more severe in malnourished children (CDC, nd) and its complications include diarrhoea, middle ear infections, pneumonia, dehydration, stomatitis and encephalitis (CDC, nd; www.babybag.com/articles/cdc_meas.htm). The signs and symptoms of measles generally begin 10 to 12 days after contact with an infected person. Since the disease is contagious one week before and one week after the rash begins, it is during this period that measles is mostly transmitted.

In the mid-1980s, it was estimated that about 2.1 million children in the world under the age of five years were dying each year from measles (Jeena and Coovada, 2001). In 1998, there were an estimated 30 million cases of measles worldwide and about 900,000 deaths (WHO, nd). It can be argued that this precipitous drop in measles-related fatality cases has largely been due to the EPI, which has managed to vaccinate large numbers of children. Although the virus causing measles was first isolated in 1954 by John Enders, the first measles vaccine was only licenced in the United States of America in 1963 (CDC, nd).

In Malawi, measles has also been one of the major diseases causing mortality and morbidity in children under five (Ministry of Health and Population, 1995). The World Health Organisation estimates that in the 1980s there were 4,000 to 10,000 cases reported each year in Malawi and special wards for measles patients were established (WHO, Regional Office for Africa, 2000). With the decline in poliomyelitis cases, in 1998 the Ministry of Health and Population in Malawi started an intensive campaign to reduce measles morbidity and mortality. By 2000, measles deaths had been reduced to zero and the measles wards which existed in many hospitals in Malawi had also been closed.

Perceptions about aetiology, treatment and prevention of measles among the Tumbuka

Measles or Chicken Pox? The Case of Josephine

Tiyowoyechi had a six-year old daughter, Josephine, who was in Standard One. When she was three years old, she suffered from *chikhoso chakufuma* (see below). Tiyowoyechi explained that rashes came out all over Josephine's body. The rashes were not small, but big vesicles. She was on her way to the health centre at Mwazisi when she was advised by her grandmother that it was not really necessary for her to go there because there was a traditional way of

treating the disease. She was then told to give the child *nkham*, okra and soil from demolished (old) houses (see explanations below). Okra was mixed with *nkham* and soil and some water was added. After stirring properly, this was given to the child to drink and the child got well. Tiyowoyechi did not go to the hospital after that. The purpose of giving this concoction was for the measles rashes to appear, which was necessary for healing to take place.

In Tumbuka, measles is known as *chikhoso chakufuma*. *Chikhoso* is a cough, while *chakufuma* means “that which comes out”. *Chikhoso chakufuma* therefore means the cough that comes out and in this context “coming out” refers to the rashes that characterise measles. Health workers also use the term *chikhoso chakufuma* to refer to measles. Measles is also seen as a “type of cough” as it is accompanied by a cough. The use of *chakufuma* is necessary as it distinguishes measles from the other types of coughs. During the first two months of my fieldwork, whenever mothers mentioned *chikhoso chakufuma* without further questions, I literally translated it to mean measles until Josephine’s mother mentioned that the rashes that appeared on her daughter were “big ones”. After enquiries from health workers, it was learnt that a child who has “big rashes” is not suffering from measles, but chicken pox which was very prevalent in the area at the time i.e. in 2000.

The Tumbuka term *chikhoso chakufuma* is also used for chicken pox. In terms of terminology, it would seem that it is difficult (if not impossible) to differentiate chicken pox from measles as both of them are referred to as *chikhoso chakufuma* in Tumbuka. Biomedically, the best way of distinguishing chicken pox from measles is, through symptomatology. After Josephine’s case, whenever a mother mentioned ‘measles’ as one of the most dangerous childhood diseases, and that one of her children had suffered from this disease, I was able to probe further, asking particularly the size of the spots. If they were big, I would conclude that it was not measles per se, but chicken pox. According to clinicians, chicken pox is a generalised rash with bigger vesicles which have pus or fluid inside. This rash covers the whole

body from skull to foot. For measles, the spots are very small, generalised and they also come out behind the ear. Unlike chicken pox, measles is a notifiable disease; hence whenever HSAs notice that there is a case of measles, they have to report it immediately. In most cases, measles presents as an outbreak. In addition to small rashes, a child with measles is known by the redness of the eyes. The child also has a cough. The development of pneumonia can be a complication of measles. From the discussion with women it seemed that measles was just one type of *chikhoso chakufuma*. Tumbuka women refer to both measles and chicken pox as *chikhoso chakufuma*; and will only differentiate between the two if asked about the size of the spots.

Both old and young mothers were able to recognise the signs and symptoms of measles: mainly the rash, very high body temperature (according to informants) and coughing. Some felt that the disease was caused by the inhalation of contaminated air, especially when a mother goes to crowded places with her child. In such places, if there is one child suffering from measles, a healthy child can contract the disease if he or she inhales contaminated air. Most mothers also felt that measles can be contracted through contact. As explained earlier, these are in fact also the biomedical ways in which measles is transmitted. Unlike the Bambara of Mali who believe that the ultimate cause of measles is witchcraft (the immediate cause being wind) (see Imperato et al, 1979b), the Tumbuka do not generally associate measles with witchcraft, or indeed with any spiritual causal agent.

When it is recognised that a child is suffering from measles, he or she should be given a mixture of *nkhama* and *dolomu* because it is believed that this facilitates the appearance of rash. *Dolomu* is a type of okra and because it is slippery (slimy), its purpose is to clean or wash the lining of the alimentary canal. *Nkhama*⁶⁶ is considered

⁶⁶ *Nkhama* is a red powder that is made by collecting reddish material that floats on water and burning it.

to be a cool substance and when drunk it cools one inside, thus forcing the rash to come out instead of developing inside. A little bit of *nkham*a is added to *dolomu* and given to the child to drink. Some of this mixture is also put in the nose and ears of the child. It is put in the ears to prevent a child from becoming deaf, and in the eyes to protect them from being spoiled by the rash. Some informants suggested that some of this mixture is rubbed on the child's skin. If this medicinal preparation is not given, mothers said that the child's body temperature will continue rise until the rash appears. If the child is not given appropriate care, he or she may die once the measles attacks the heart.

When it is recognised that the child is suffering from measles, it is not bathed until such time as mothers are convinced that all the spots have 'appeared'. If the child is bathed, then the spots might not all appear and even the ones which had appeared might disappear back into the body, and the child might even die. This is why some people objected to the rubbing of the indigenous medication for measles on the skin of the child as this would prevent the rash from appearing. It is the traditional medicine that facilitates the appearance of the rash and the bathing would lead to the disappearance of the rash. The use of *nkham*a (known as ngama among the Yao) and okra to facilitate the appearance of measles has also been reported in other cultures in Malawi (see Munthali, 1999; Chilowa and Munthali, 1999). In Ntchisi District, Central Malawi, it has also been reported that mothers also rub *Coca Cola* on the skin of children suffering from measles to facilitate the appearance of the rash (see Chilowa and Munthali, 1999).

The major concern for the mothers of children under five is that whenever their children suffer from measles, spots should be "*smoked out*" from the body by the use of traditional medicines as described above and that bathing should not be done as it inhibits the appearance of the spots. While the avoidance of bathing and the use of medicines can bring out the rash, some informants said that on their own these medicines may not be all that useful. There is need for harmony in the home because

it is alleged that quarrelling, fighting and ill-feelings may impede the appearance of the rash, a characteristic qualifying the use of many traditional medicines in Africa (see Bujis, 1995). The avoidance of the bathing of children suffering from measles seems to be widespread in Africa. For example, the Bambara of Mali only re-institute the bathing of measles-stricken children when the rash begins to fade (Imperato et al, 1979b; see also Munthali, 1999, for similar beliefs among the Yao of southern Malawi). This is in contrast to biomedical conceptualisations, which encourage the bathing of children suffering from measles (see also Chilowa and Munthali, 1999).

Before the spots appear, the child may only have fever and a cough. Some mothers said that, in order to treat the fever they buy either Panadol or Aspirin from the nearby shops and that they also buy *Bactrim* for the treatment of the cough. It is when these are administered that the spots sometimes appear and they, then, know that it was measles, which made the child to have a high fever. As far as measles is concerned, informants said that they use both indigenous and biomedical treatment. This is because they felt that hospitals do not have the medicines which are able to speed up the appearance of the measles rashes. Others felt that the indigenous treatment for measles is adequate, and that it is only when such treatment fails that they take the child to the health centre for treatment. One young mother said that people trust the traditional way of treating measles, because sometimes when they go to the hospital for treatment they are only given one tablet of *Aspirin*, and they know that measles cannot be cured by *Aspirin*. The Luo of Kenya believe that modern medicines hasten the death of children suffering from measles as the injections that they give make the disease hide in the stomach, with fatal consequences. Like the Tumbuka, the Luo also recommend that herbal medicines should be given to such children in order to speed up the appearance of skin rashes (Kawango, 1995:87).

Hence, when children suffer from measles, the disease is first of all treated in the home, using traditional forms of treatment, which facilitate the appearance of the spots, while at the same time the accompanying coughs and fevers are treated with

western medicines purchased from the nearby shops. The traditional treatment that is given is aimed at bringing out the rash; hence it is perceived by the Tumbuka women as inadequate to treat both the fever and the cough. For the fever and the cough, the initial treatment consists of purchasing medicines from the shops. It is only when measles cases worsen that children are brought to the health centre for treatment. Health workers said that measles is a viral infection, that as such does not have any cure, and that symptomatic treatment is the approach used by the health centres. As has been said above, a child who is suffering from measles is not supposed to be bathed until all the spots have come out, and this has implications for seeking therapy at the health centres. After rubbing the *nkhama* on the child's body, the child is also not supposed to be bathed. The practice of not bathing the child suffering from measles contradicts the health centre's messages that there is no harm in bathing such children. *Nkhama* is a red substance, and once rubbed over the child's body, it is unlikely that such a child will be brought before a clinician, for fear of being reprimanded. One health worker, who comes from the area and has grown up in this cultural setting, confirmed that when the *nkhama* is rubbed on the child's body, such cases are not brought to the attention of clinicians. Therefore, the promotion of bathing children suffering from measles by health workers and the long distance to the health centre at Mwazisi are only some of the factors that deter women from seeking therapy at the health centres when their children suffer from measles. Some women said that when a child suffers from measles he or she may not be bathed for a period lasting five days. Though the Tumbuka do not see "any problem" inherent in such a practice, the health workers say that this makes the child vulnerable to other infections.

There are a number of ways in which children can be protected against measles. While *nkhama* is used to enhance the emergence of the rash, it can also be used for the prevention of measles. When there is an outbreak of measles in the surrounding villages, some informants said that the child can drink *nkhama* and that, in their opinion, this works, although at the same time they know that it does not give life

long protection, as the child may suffer from measles again at a later stage in his or her life. In cultures where it is believed that measles is caused by spiritually related factors, amulets are worn as preventive measures (Imperato et al, 1979b). In some quarters it has been reported that measles cannot be prevented. Every child has to suffer from this illness at one stage (Munthali, 1999).

All the young mothers with children under the age of five years said that measles can also be prevented by vaccinating children against the disease. Only a few mentioned that the measles vaccine is given at the age of nine months. Most mothers complained that experience has shown that, though children may be vaccinated against measles, such children will still suffer from measles. Similar findings have been reported in India, where mothers said that vaccination does not work for measles, as children still experience measles even though they are vaccinated (Nichter, 1995). From these findings it can be seen that mothers perceive the measles vaccination as necessary, but not a sufficient condition for the prevention of measles. As Nichter has argued, "vaccinations may be directly or indirectly associated with local illness categories that are much broader than the biomedically defined diseases for which the vaccine was intended" (Nichter, 1990:208). *Chikhoso chakufuma* is a broader term which the Tumbuka people use to refer to measles, chicken pox and other children's rashes. Hence it can be seen that when informants said that children still suffer from measles even if they are vaccinated, this is because the local Tumbuka term uses the word for measles to include illness episodes that are not clinically measles (see Nichter, 1990, for similar findings on Mindoro Islands, Philippines, and Brown, 1983, in Cameroon).

Mothers gave a number of reasons why children may still suffer from measles even after being vaccinated:

- that the vaccine may not be all that effective;

- suspicion that the health workers may sometimes be diluting the vaccines; and
- that the dosage that was being given was inadequate.

What needs to be clarified in such circumstances is that the measles vaccine does not in fact confer life long protection against measles. Children who have been vaccinated against measles may still suffer from the disease at a later stage, but they suffer from milder attacks while those who are not vaccinated suffer from more virulent attacks. Only very few mothers were able to say that for vaccinated children “*chikhoso chikwiza nankhongono yayi*” (they do not suffer from serious forms of the disease). This is the message that the health workers need to bring to the clients of the vaccination programmes, because otherwise they (clients/mothers) may not bring their children for vaccination.

Measles is also recognised by the Tumbukas as a contagious disease; hence some mothers felt that it is important that a child suffering from measles should not come into contact with other children. If one wants to visit, a person should just leave his or her children at home. Though at the health centre they are advised that the child should be isolated from others whenever he or she has measles, most informants said that this is very difficult in practice, which is why in most cases when there is one case of measles in a household, the other children under five in that household will also suffer from the disease.

Conclusion

There are two major indicators of the success of national vaccination programmes: firstly, the sustained reduction in the incidence and prevalence of the programme’s target diseases; and secondly, whether over a specified time period, there is an observable increase in the percentage of the target population vaccinated. At a global

level, the reduction in the incidence and prevalence of smallpox and its eventual eradication in the late 1970s is a success story for the vaccination programmes. Over the years there has also been a steep decline in the incidence and prevalence of childhood vaccine-preventable diseases (see Greenough and Streefland, 1998). The 2002 UNICEF report on the State of the World's Children says that globally there have been massive reductions in the number of cases of measles over the previous decade, and that, given commitment on the part of different countries in the world, poliomyelitis may become the second disease to be totally eradicated by the year 2005 (UNICEF, 2002).

In Africa, vaccination has played an important role in the containment of some of the worst childhood diseases, and this has principally been because of the great increase in vaccination coverage rates over time. In sub-Saharan Africa, apart from countries where civil war is raging, which has subsequently caused or contributed to the disruption of the delivery of vaccination services (for example in Ethiopia, see Streefland et al, 1999), other countries have achieved high coverage rates (see Chapter 5). Malawi is one of those countries with high vaccination coverage rates, and according to the year 2000 Demographic and Health Survey, 92.4 percent of the children aged 12-23 months received BCG, 84.2 percent DPT3, 79.8 percent OPV3 and 83.2 percent measles (National Statistical Office, 2001:115). These figures show a marked decline from the 1992 Demographic and Health Survey when vaccination coverage for children aged 12-23 months were 97.0 percent, 88.1 percent, 88.6 percent and 85.8 percent respectively (National Statistical Office, 1992:86).

Though the 2000 Demographic and Health Survey mentions this reduction in vaccination coverage, it does not provide detail on why there has been a downward trend in vaccination coverage. It would seem that the decline is due to service delivery related factors especially transport, availability of vaccines and paraffin (where fridges run on paraffin) and the overburdening of the HSAs. The analysis of these factors reveals that service delivery is mostly affected by the lack of money to

provide these services, which in turn is affected by allocation of resources *vis a vis* the priorities of the Government of Malawi. While Malawi and other countries in sub-Saharan Africa have achieved high coverage rates, Greenough questions how such high rates will be sustained (Greenough, 1995). Malawi, as is the case with many countries in the region, depends on the support of the donor agencies (especially UNICEF) to run its vaccination programmes. In 1999, though the Government of Malawi pledged that it would contribute approximately 10 percent of the estimated cost of routine vaccines (Chilowa and Munthali, 1999), that pledge was not fulfilled as it only managed to contribute 2 percent in that year (UNICEF, 2002). The non-availability of vaccines and of paraffin in the health centres can be attributed to the failure of personnel in the higher echelons of the Ministry of Health and Population to ensure that they (vaccines and paraffin) are available at all times. This calls for proper coordination between the Ministry of Health and Population and the donor agencies (especially UNICEF), who have pledged to support vaccination programmes in countries which have been grouped in Band A; Malawi being one of them.

While this study was done at the micro-level, we find that in Chisinde macro-factors affect the way vaccination services are delivered at the local or micro-level. As has been mentioned earlier, mothers in Chisinde accept vaccinations; although in some cases they feel coerced to do so by their fear that medical treatment will be denied to those children who have not been vaccinated. Government, through the health education sessions conducted during the vaccination sessions, radio programmes on the Malawi Broadcasting Corporation (the national radio station) and the annual countrywide mass immunisation campaigns, has managed to teach the people of Chisinde and other villages about the need for children to be vaccinated against the six childhood communicable diseases. The bringing of vaccination services nearer to clients through the establishment of the outreach clinics and the employment of community based health workers (who as in the case of Chisinde may come from the same cultural background) are all attempts by Government to improve the health of people. Now that Government has created the social demand for these vaccinations, it

is imperative that vaccines are available at the health centres at all times and, where refrigerators are run on paraffin, that this should also be made available. The use of appropriate forms of transportation should be made available especially in those areas where the terrain is hilly as the use of bicycles may impede the work of the community-based health workers.

It has been mentioned in this chapter that measles is one of the diseases that the Tumbuka do not attribute to witchcraft. In previous chapters, it was mentioned that childhood illnesses such as convulsions, splenomegaly, diarrhoea, etc can, among other factors, be caused by witchcraft. The non-response of diseases to biomedical treatment is one of the indications that witchcraft is involved as we saw earlier in the literature review. In addition to witchcraft, diseases caused by the ancestors are also perceived by the Tumbuka as not amenable to biomedical treatment. The next chapter therefore discusses some examples of childhood diseases and afflictions caused by witchcraft and the ancestors and how the Tumbuka manage them.

CHAPTER 11

SEEKING THERAPY FOR CHILDHOOD AFFLICTIONS CAUSED BY ANCESTRAL SPIRITS AND WITCHCRAFT

Introduction

As in other cultures, the Tumbuka classify illnesses according to aetiology (see Ingstad, 1989; Yoder, 1981; Westerlund, 1989). Firstly, there are those diseases that the Tumbuka call *matenda yakwiza waka* (diseases which just come) or *matenda yachiuta* (diseases from God). Friedson, who did his research among the Tumbuka in the mid 1980s, says that such diseases are “merely part of the existential reality of the world” (Friedson, 1996:42). These, as we have discussed in our literature review, constitute what are referred to as natural illnesses; examples of such illnesses in the previous chapters include teething diarrhoea, measles, malaria, etc. Secondly, there are those diseases that children get as a result of the infringement of taboos as discussed in detail in chapters 7 and 8. Examples of these illnesses include chikhoso chamoto, childhood diarrhoea caused by suckling on contaminated breast milk, convulsions in children under five, etc. Then there are illnesses caused by witchcraft and the displeasure of the ancestors. While such disease classifications based on aetiology occur, as we saw earlier, these classifications are not really exclusive as ideas or perceptions about aetiology may change or shift based on, among other factors, the illness’s response to treatment.

This chapter discusses some examples of childhood afflictions caused by the ancestors and witchcraft and the different ways in which the Tumbuka treat or prevent these diseases. It would be useful first to discuss or recapitulate, using conjunctivitis and simple coughs as examples, how treatment for illnesses which are perceived as natural is sought.

Seeking therapy for natural illnesses: conjunctivitis and simple coughs, and the (mis) use of antibiotics

Simple coughs

The local term for a cough is *chikhoso* and according to informants, the Tumbuka recognise different types of coughs. These are: *chikhoso waka*, *chikhoso chakakotokoto* and *chikhoso chakufuma*. In Chapter 7, we discussed *chikhoso chamoto* and we said that this is caused by the exposure of children to people engaged in sexual intercourse. In Chapter 10, we discussed *chikhoso chakufuma*, which is basically a cough accompanied by a rash (measles). Apart from these two types of coughs, the Tumbuka also have mere coughs (*chikhoso chawaka*). According to informants, simple coughs are not really a cause for concern.

Both young and old women said that simple coughs are caused by the inhalation of dust, and this is particularly prevalent during the dry season when it is very windy. A few women added that some tobacco farmers store their harvested tobacco in their homes in order to protect it from being stolen. They said that the smell of tobacco makes the children and adults to start sneezing which later develops into a cough. A child with a cough is mainly recognised by frequent coughing.

The first thing that they do whenever a child suffers from a simple cough is that they purchase medicines from the nearby grocery shops. The medicines purchased include conjex, bactrim and stearns. In some cases however people do not have enough money for these drugs; hence the resort to traditional medicine. One of the most common trees used for the treatment of simple coughs is *muyokayoka*. The bark of this tree is soaked in water and boiled and the concoction is given to the child to drink. Informants said that this traditional medicine is very bitter and it is advisable that it should only be given to children above the age of three years. In addition to

muyokayoka, some people also use the leaves of bluegum trees, which are soaked in water and the concoction given to the child to drink.

Informants said that it is very difficult to prevent coughs. A person cannot dictate the type of weather (e.g. windy weather produces a lot of dust which can lead to children developing coughs) that is required on a particular day, as this is beyond human control.

Conjunctivitis

Conjunctivitis was mentioned by both young and old mothers as one of the diseases threatening the lives of children in Chisinde and surrounding villages. Informants who mentioned this disease said that they recognise a child suffering from conjunctivitis as he or she has red eyes and *vinthu vituwa vikufunkha mu maso* (whitish stuff comes out of the eyes). Mothers mentioned a number of ways in which a child could get this illness, which were:

- Wind and flies transferring the disease from an infected child to a healthy one;
- Sand entering and getting stuck in the child's eyes; and
- Not bathing the child frequently.

According to the mothers, transmission of conjunctivitis from an infected child to a healthy one, takes place particularly in crowded places, for example maize mills and hospitals. We saw in the previous chapter that most of the mothers said that, through their own experience, they have also observed that whenever a child has measles, he or she also develops red eyes. Hence, as far as they were concerned, measles is one of the diseases that can also make a child develop conjunctivitis.

As regards prevention, most informants said that children should not be exposed to dusty weather conditions, as such conditions encourage the transmission of conjunctivitis and, that infected children should be isolated from the healthy ones to prevent the transmission of the disease. While many young women said that the disease can be prevented by avoiding exposing the children to windy weather, they at the same time felt that it was impossible to prevent the disease because you cannot avoid going to maize mills or health centres, where there is a lot of overcrowding and hence it is easy for the disease to spread. At household level, mothers also mentioned the difficulties of isolating infected children. If one child has conjunctivitis, then all the other children in the household will contract the illness.

All the women interviewed said that when a child suffers from conjunctivitis, they take him to the hospital where doctors put some ointments (contained in tubes) into the eyes. In the past, however, these eye ointments for the treatment of conjunctivitis were also available in the village; hence there was no need for mothers to visit health centres when their children suffered from conjunctivitis. A woman, who used to be a village health volunteer, said that soon after receiving her training as a volunteer in 1990, she was given a number of medicines, including eye-ointments, which she kept at home and administered to people (including children) whenever they became ill, with relatively minor ailments. This is no longer the case since she stopped working as a village health volunteer in 1997.

While mothers go for biomedical treatment, they also consult herbalists for conjunctivitis. Herbalists give them some leaves which are shredded and put in a funnel made of leaves obtained from mango trees. Water is poured into the funnel and the child's head is tilted upwards so that the filtrate from the funnel goes straight into the eyes. Despite the fact that herbalists know the tree species they use for the treatment of conjunctivitis, they could not reveal their names. Some women said that they use *maope* (a type of okra) to clean the eyes of the child suffering from

conjunctivitis. Mothers said that they use traditional medicines because the hospital is very far, and even when they go there they are in most cases informed that there are no medicines.

In addition to obtaining treatment from the hospital and herbalists, women said that they also buy penicillin from the shops. Penicillin tablets are ground and mixed with Vaseline ointment and this mixture is put in the eyes of the child. When penicillin is in the form of a capsule, they open it, take out the powder and put this in the eyes of the child. Mothers with children under five said that when they mix penicillin and Vaseline ointment, they tend to see this as similar to the eye ointments which are dispensed from tubes. One of the shop owners in the area confirmed that people in the village indeed bought antibiotics for the treatment of conjunctivitis. According to the shop owner, these antibiotics were either dissolved in water and the solution put into the eyes or, as the mothers said, they mixed the antibiotic with Vaseline and put it into the eyes, as described earlier.

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While mothers would like to take their children to the health centre for treatment (e.g. for conjunctivitis), they said that these health centres are located very far away; what demoralises them most is the fact that, even if they walk long distances to these facilities, in most cases they are informed that there are no medicines and they have to return to their homes without receiving any medication. As was pointed out in Chapter 4, although the services provided by the Ministry of Health in Malawi are generally free of charge, medicines are not always available (see also Bush and Hardon, 1990). This forces people to resort to self-medication with either indigenous medicine or medicines bought from the local grocery shops.

In addition to these factors, informants said that some health workers had joined the wrong profession: since they are very rough with their patients, it would have been

much better if some of them had joined the army. In addition to the pilferage of drugs, health workers were also accused of favouring their friends and relatives and those people who are very influential in the area. Other people are seen as being at a disadvantage. Due to my closeness to the health workers, there were a number of occasions when people requested me to accompany them to the health centre in the hope that they might get better treatment. Others just asked me to go to the health centre and get some medicines for them. With such a situation prevailing, informants said that they would rather resort to purchasing medicines from the shops; as one young woman put it:

“Masitolo ndiyo nivipatala vithu madazi yano” (the shops are our hospitals these days).

While these factors deter people from seeking treatment at the health centres, we also need to recognise that some people may not want to consult biomedically trained personnel at the health centres because of their own interpretation of the disease. For example, if they perceive that the diarrhoea that the child is suffering from is as a result of teething they might feel that there is no need to go to the hospital, as teething diarrhoea does not require any biomedical treatment at all.

Because of the factors mentioned above there is widespread use of antibiotics in Chisinde and surrounding areas. A lot of people said that they take antibiotics because they are strong and that, through their own experience and the experience of others, they believe that they will get better when they take antibiotics. Some health workers reported that they have seen people throwing away aspirin tablets because of the perception that Aspirin is not strong enough for the disease that the child is suffering from. Some HSAs said that Bactrim, Panadol and Fansidar are bigger in size than aspirin, and that hence these tablets are perceived as stronger and more effective than aspirin. Although aspirin and penicillin are the same size, the colour and odour of penicillin makes people perceive that it is much stronger than aspirin.

The major problem with the use of antibiotics is that, though details on dosage may be supplied by the health workers, smugglers or written on containers/wrappers of these medicines, caretakers of children may not have enough money to purchase enough medicines to meet the required dosage. Shop owners pointed out that they were in business and therefore could not afford to give away medicines free of charge to those who could not afford a full dosage. If they did that, their business would not survive. Shop owners, therefore, sell medicines according to the amount of money the client has. Hence, as one woman said, people are forced to buy only one tablet and when they find more money, they can go and buy some more medicines. These findings are similar to those of van der Geest's study in Nten, Cameroon, where he found that medicines are sold in very small quantities, sometimes only one or two tablets at a time (van der Geest, 1985). Such a practice is not only found in Africa, but also in other developing countries, for example, the Philippines where Lansang et al found that, for financial reasons, people could not buy the required number of capsules or tablets (see Lansang et al, 1990). While the purchase of one tablet at a time makes medicines accessible to the members of the community, the major problem with this is that if one does not take the entire antibiotic course for the specific illness, it does not work and one builds up immunity to the antibiotic. Therefore, buying one tablet at a time does more harm than good, and is also a waste of money.

One of the shop owners said that in the rainy season people do not have money. The hospitals are situated very far away at Bolero and Mwazisi, and one needs transport to get there. Whenever they find some money they would rather purchase some medicines from the shops than going to the hospital because, even if they go there, they will not find any medication. People only go to the hospital if the condition is serious.

According to shop owners, the demand for specific medicines varies seasonally. During the rainy season, coughing and diarrhoea are very prevalent among both

children and adults. Whenever people come to buy medicines, one shop owner asks them why they would like to buy that medicine. There are some who come and ask for specific medicines while others ask what type of medicine they should buy for a specific childhood illness. For coughing, people usually ask for penicillin or bactrim, while for diarrhoea they ask for Thanzi ORS, chloramphenicol or flagyl.

Shop owners in general know that it is illegal to sell antibiotics over the counter. One shop owner said that he does not sell antibiotics to strangers because he may never know the motive of that stranger. He only sells these medicines to those people that he knows. He does not sell these medicines to strangers because they may report him to the “authorities” and he might be arrested. He said that one day a car stopped in front of his shop and a man came in and asked him if he had penicillin. Though he had these medicines he told the man that he did not sell such medicines.

At one time as I was drinking a beer at one of the shops I started enquiring from the owner whether he had any antibiotics. He agreed that he had tetracycline, bactrim, and Indocid. When I enquired further he said that he was just joking, he did not have them in stock. A few minutes later, an old lady came in and asked for Indocid. He looked at me and then gave the old lady one tablet of Indocid. The following day he hid the tins containing the antibiotics and said that two men had come later and started asking for antibiotics. He did not know these people hence he had decided to hide the tins.

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Although there is a widespread misuse of pharmaceuticals and there are shortfalls in the delivery of government health services, the Tumbuka expect that diseases, which are considered natural, such as conjunctivitis, simple coughs, teething diarrhoea etc will respond to treatment. These diseases will be classified as natural as long as they

respond to treatment, whether biomedical or indigenous. If a disease does not respond to treatment, then other causes will be suspected and divining is one way of determining the cause of illnesses refractory to treatment. We have discussed extensively in chapters 7 and 8 some of the childhood diseases that are caused by the breach of sexual, food and other such taboos. In the following sections, some Tumbuka perceptions of childhood illnesses which are caused by witchcraft and displeased ancestors will be discussed.

Ancestors and childhood illnesses and misfortunes

The role of the ancestors in the lives of the Tumbuka and recognising afflictions they cause

As we saw in our literature review in Chapter 5, the belief that the ancestors influence the lives of their descendants is widespread in Africa. The case below shows that, among the Tumbuka, ancestors can even kill if someone does not do things in accordance with the norms of the society.

Mr Lekani Luhanga retired from the civil service in the mid 1990s after working for thirty years. Instead of going back to his home village (as expected), he settled at Rumphi Boma with his family. Rumphi is about 20 kilometres east of his home village. One diviner claimed that Mr Luhanga's father, who died in the early 1960s appeared to her and requested her in a dream to ask his son (Lekani Luhanga) why after retiring he had decided to settle at Rumphi and not in his home village. In addition, in that dream the deceased father's spirit warned that if his son did not move away from Rumphi and settle in his home village, "he should not be surprised if anything befell him or his family".

When Mr Luhanga was informed about the diviner's dream, he said that his daughter, Towera, was at school in Chitipa District and that he would leave Rumphu and settle in his home village when his daughter came back from school. Towera had a two-year old son, whom she had left with her parents, when she went back to school after delivery. The child was, therefore, being taken care of by its grandparents. One day, as the grandson was playing in the yard, he fell into a very big pot full of water head first and died instantly. During the funeral, which was conducted in Mr Luhanga's home village, the diviner and some elders in his village explained to him that the ancestors (his father) had killed the child by throwing him into a pot full of water. He was also informed that if he continued to live in Rumphu, more misfortunes would follow. (Initially, when he was told about the ancestor's wishes, he had neglected them. He had spent a lot of time in the urban areas where he worked and did not really believe in or pay much attention to the work of the ancestors)⁶⁷. He was, however, so terrified after experiencing the death of his grandson that, fearing further afflictions, he immediately left Rumphu and settled in his home village. Since then he has not had any misfortunes in his household.

Although it has been argued and there is evidence that the Tumbuka people were once a matrilineal group and that it was the Ngoni invasions and domination of and massive interaction with the Tumbuka that changed the Tumbuka to a patrilineal society, as of now the Tumbuka are a strongly patrilineal society. Inheritance is from the father to the son. When people leave their home villages to work elsewhere, be it abroad or otherwise, they still communicate with their relatives back home and, as we saw in Chapter 4, it is not uncommon for migrant workers to send home remittances. When people living away from their home villages die, it is desirable, funds

⁶⁷ This was the diviner's interpretation of why Mr Luhanga neglected what the ancestors were demanding.

permitting, that they should be buried in their home village together with their ancestors. A number of funerals occurred in Chisinde and surrounding villages at the time I was doing fieldwork. Though some deaths occurred away from the village (in some cases as far as Blantyre, approximately 800 kilometres away), the dead bodies were, nevertheless, brought to the area for burial. When someone retires, it is required that he should return to his village and settle in the land of his ancestors. Building a “home” away from someone’s home village is, therefore, something that is reprehensible and punishable by the ancestors. In the western world and among those Tumbukas who have embraced the western ideals, the death of Mr Luhanga’s grandson in the above case may be interpreted as an accident. As far as most Tumbuka are concerned, accidents and deaths (although not in every case) are just some of the many misfortunes that the ancestors can inflict upon their descendants. It can be seen from this example that the occurrence of misfortunes and attributing them to ancestors is a way of coercing people to abide by what society expects of them.

Mizimu is the Tumbuka term for the ancestors (*muzimu* is the singular). Whenever the Tumbuka refer to the ancestors they normally use the plural word “*mizimu*”. The Tumbuka conceptualise *mizimu* as dead parents or grandparents; and this is why the phrase, *wasekulu withu*, meaning “our grandparents”, is also used to designate or to refer to ancestors. It is believed that when someone dies, the body is buried, but the spirit departs from the body. The Tumbuka also believe that ancestors are “second” to God and they pray to God through them. Such a belief is widespread as the Chewa of Central Malawi also perceive ancestors to be the intercessors between living human beings and the almighty God (van Breugel, 2001:77).

Not everyone qualifies to be an ancestor and death is not the only qualification for to become one. The prerequisite for becoming an ancestor is that he or she should, at the time of his death, have a child. Even though one may be advanced in years and even married, if one has no children, he or she cannot become an ancestor. The reasoning is that, though they are dead, ancestors continue playing an important role

in the lives of their descendants. My informants said that if someone at the time of his death does not have children, as far as the Tumbuka are concerned, there is no need for his spirit to come back to the village and trouble people: “who is there for his spirit to come and see? Who is there for his spirit to protect and punish when he or she has done something wrong? The Tumbuka say that it is better for the spirits of such people not to come back as they have no role to play and no one to look after. In order to ensure that the spirits of those who did not have children do not come back after death, a piece of charcoal is rubbed on the anus of the dead man and the process is accompanied by an invocation, saying:

“*Kuno undalekeko kako yayi. Sono ungakawerangaso yayi*”. (You have not left anything in this world. Do not come back).

The Tumbuka fear that such a person’s spirit can come and trouble people in the village; hence the ritual is carried out to ensure that the spirit does not come back. Informants could not explain why they rub the charcoal on the anus, but they stated that charcoal is used because it is black in colour; hence it would make that person’s spirit unable to see and at the same time it would make him forget the relatives he had left behind.

As is the case with many cultures in Africa (for example see Gelfand, 1964; Ngubane, 1977; Hammond-Tooke, 1989; LeBeau, 1999), the Tumbuka also believe that ancestors have a role to play in the lives of their descendants. The ancestral spirits protect their descendants against misfortunes like accidents, deaths, illnesses etc, irrespective of where they are on this earth. This is why the Tumbuka say that “*mizimu ni mphepo*”, meaning that ‘ancestors are wind’, because they are also found everywhere where their descendants are. Most informants said that whenever there are no deaths or illnesses in the village, it is believed that it is because of the protection that is afforded by the ancestors.

Though ancestors can be helpful and protective, they can also be angered by the acts of their descendants, and in turn subject them to a host of misfortunes. There are a number of factors that can make the ancestors angry. The graveyard where the ancestors are buried is supposed to be well cared for. Once every year the bush in and around the graveyard is supposed to be cleared, and during this event beer is brewed and sacrificed to the ancestors. The people sing funeral songs and pray to the ancestors that they should give them good things, especially protecting them from the many misfortunes prevailing in this world. If their descendants do not clear the bushes in and around the graveyard, and do not periodically offer sacrifices and pray to the ancestors, then the ancestors will become angry. In addition to this, fighting and quarrelling amongst kinsmen, including chasing one another from the land (of their ancestors) are also things that are reprehensible in the eyes of the ancestors. The Tumbuka say that the ancestors are happy when they see that their descendants are happy and living peacefully. Descendants are also supposed to uphold tradition as this is what the ancestors desire. The death of the grandson of Mr Luhanga indeed illustrates what can happen if traditional values are not adhered to.

These results confirm Friedson's work among the Tumbuka, who found that failure to obey the wishes of the ancestors, infringement of some taboos and non-fulfilment of certain obligatory rituals were factors that made the ancestors angry (Friedson, 1996:59). It is believed that once the ancestors are angered, they can punish their descendants. There are no specific misfortunes that can be attributed to ancestors. Informants stated that accidents and deaths (like the case illustrated above), illnesses, dismissal from work, being caught by lions, barrenness, etc can all be caused by the ancestors. Some cases were cited in which people lost their jobs, but came back to their home villages and after propitiation of the ancestors, they were either reinstated or they got another job immediately. It is necessary to recognise the changing nature of the misfortunes that the ancestors can cause. Old men and women said that in the past it was common for children and adults to be killed by wild animals, especially lions, but that these days (owing to the scarcity of lions) car accidents, being killed

during the collapse of mines, dismissal from work, etc may also be attributed to ancestors. The bushes and forests that used to exist around people's homes have long since been cleared for agriculture, the construction of houses, roads and other infrastructure, and lions have moved away, and therefore no longer pose a threat to human beings or to domesticated animals.

One of the issues raised by informants was that in most cases ancestors do not punish those who have done something wrong. Innocent people are mostly the ones who suffer. The view was expressed that if punishment befell those who had done wrong, people would have stopped "sinning". For example, as we saw earlier, infertility in women is sometimes attributed to the ancestors' anger over the non-payment of bridewealth by the husband; the death of the grandson of Mr Lekani Luhanga was attributed to his grandfather's decision to settle away from his village, etc. Though this is the situation, it was also noted, however, that in some cases the guilty themselves experienced the punishments. It can, hence, be envisaged that misfortunes caused by the ancestors can afflict both the innocent as well as the offenders. Children under five are particularly on the receiving end, as it is unlikely that they are able to offend their ancestors. According to one of the diviners, ancestors make children suffer or experience misfortunes, mostly because they want to attract the attention of their parents who would then act speedily so that the child can be healed.

While ancestors provide protection [against misfortunes] for their descendants, they also expect them to uphold tradition and to propitiate them from time to time. Once it is known through dreams and divination that the ancestors are demanding some form of propitiation or redress for something wrong, as far as the Tumbuka are concerned, it is necessary to do whatever they demand, otherwise illness, death or other misfortune may occur. Not all misfortunes and diseases, nor indeed any particular misfortunes or diseases, are specifically attributed to the ancestors. In addition to dreams and divination, the Tumbuka also recognise afflictions caused by ancestors through the sighting of certain species of snakes and grasshoppers.

Informants said that there are certain snake species, such as *zuvi*, which are very commonly seen around the home. If such snakes enter someone's house, he or she will not be surprised, because in most cases they are looking for food, such as chicken eggs. There are other snakes, however, such as *chitumbi*, which are rarely seen around the home. If such a snake is seen in someone's yard or house, it is a sign that something is amiss. Such snakes may even enter a house, curl up in a corner and cause no harm to anyone. People ask why such a rare snake has entered the house. Even if such a snake is killed, another one may come again the following day and coil up in the same manner. This is a warning that something is wrong in the family, which needs immediate redress. In addition to the snake, my informants said that there is a grasshopper known as Mazombwe which is brownish in colour (similar to the colour of soil). It is a rare type of grasshopper and when people see such a grasshopper flapping its wings, it is an indication that there will be a death in the family. If it does not flap its wings, it is an indication that the ancestors are not happy with something in the village. Fraser has also mentioned that the Tumbuka perceive the sight or presence of certain snake species as a sign of the presence of ancestors. He specifically mentions the blindworm, a snake with a saw-like backbone, and the puff adder. He says that some snakes, even if they enter the house, are not killed or chased away, as it is a sign that a well-intentioned spirit has come to live among them (Fraser, 1922).

Seeking therapy for afflictions caused by the ancestors: kinship therapy?

Informants said that illness (and misfortunes) caused by ancestors cannot be healed by biomedicine. The following two cases illustrate how treatment is sought in such cases.

Case One

One day as Khwima, a 4-year old boy, was coming out of his mother's house,

a snake bit him on his leg. His mother took him to the hospital several times and when they saw that there was no improvement, the services of a herbalist were sought. There was still no improvement. When they consulted a diviner, they were told that the ancestors had sent the snake to bite the child as they were displeased because of the quarrelling and fighting that was so prevalent between Khwima's mother and his uncle (Khwima's father's younger brother). In addition, they were also using very foul language against one another. The diviner then called those who were fighting and their relatives, and they set the matter right by addressing the ancestral spirits and requesting them to heal the child. Before the ceremony of talking with the spirits, the child was unable to walk, whereas after the ceremony, he woke up and limped away to his mother's house. No more medicines were necessary after this.

Case Two

Alice was Fumbani Gondwe's second born child. Soon after birth she was given the name of *Walyenge*, which means 'let them eat' by her maternal grandparents. Soon after being given that name the child started crying, and cried quite a lot and continuously for three days. The parents decided to consult a diviner, who informed them that the child was crying because she was refusing the name that was given to her. It was also revealed to them that the [late] father's maternal grandmother was the one who made the child cry because she had wanted the child to be named after her. Arrangements were made and the kinsfolk gathered together and talked to the spirits, informing them that the child's name was no longer *Walyenge* but Alice (the name of the father's maternal grandmother). The daughter stopped crying right at that moment. She is now nine years old, and since then she has never been sick again.

The above cases involved children aged less than 5 years old. In case one, when the

boy developed the wound, his mother (a widow) first went to the hospital for treatment. When the wound started swelling and worsening, herbalists were consulted and their treatment failed as well. In order for them to recognise that the wounds were caused by the ancestors, diviners were consulted. The worsening of the state of the wounds and their seeming incurability forced the therapy seekers to resort to consulting diviners.

One of the diviners said that the non-response to what is perceived to be the correct medication for wounds can also be attributed to what he referred to as the "*plastic type of witchcraft*". He said that this type of witchcraft, which has its origins in Zaire (now the Democratic Republic of the Congo), involves the witch magically placing a plastic paper on the wound. This plastic paper is invisible to the ordinary human being. When medicines are put on the wound, the imperviousness of the plastic paper prevents the medicine from reaching the wound. While hospital personnel and herbalists may think that they are treating and dressing the wound, the medication does not reach its target area. This necessitates the consultation of diviners, who are known to have the ability to identify the agents responsible for the affliction.

Though the above-mentioned therapy-seeking behaviour is for wounds (Case One), the same procedure is followed for other illnesses (both adult, as well as childhood illnesses) that are attributed to ancestors. Informants said that for illnesses that are attributed to the ancestors, it is not possible to effect a cure with medication or therapy sought from modern health facilities or herbalists. Because initially they think that it is an ordinary or natural illness, people first seek treatment from hospitals and herbalists (see also Friedson, 1996, for similar findings), which may prove unsuccessful. What most people said was that there is "no medication" as such for illnesses caused by the ancestors. When it is recognised that it is the ancestors who are responsible for the misfortune, the correct form of therapy is for the kin to come together and "talk to the ancestors", which in Tumbuka is referred to as "*kuyowoyera*". While beer is normally involved in ceremonies to placate the

ancestors, in illness episodes attributed to ancestors, it is the ancestors themselves who dictate what should be used when talking to them. Substances that are perceived by the Tumbuka to be “white” are used when talking to the ancestors. These include maize flour, silver Malawian money, namely MK0.05, MK0.10 and MK0.20 and white beads. The white substances are used because it is perceived that the ancestors are also white: white in the sense that they do not have any blemish or sin. Ancestors are also compared to wind, which is also perceived by the Tumbuka to be “white”.

In this ritual what the ancestors demand as *mboni*⁶⁸ is put on a plate and covered by another plate. In this gathering of kin, it is the eldest surviving man/woman of the patrilineal lineage who has the responsibility of talking to the ancestors and in his or her speech he basically says that if it is the spirits who have caused the illness or indeed any misfortune because something has gone terribly wrong, they should forgive them and cure the one suffering, and further that the ancestors should give them protection against the many misfortunes prevailing in this world. According to informants, when this ritual is over there is basically no need for further medication as this “talking” on its own, which involves kin, is adequate therapy. If relatives have been constantly quarrelling or fighting and the ancestors inflict illness upon someone, then those quarrelling have to end the hostilities against one another for a cure to be effected. Whatever is used when talking to the ancestors is supposed to be kept in the house, be it money, cloth or beads. When one would like to use it, he or she tells the ancestors, otherwise calamity may follow. If a piece of cloth was used in this ritual, after keeping it in the house for some time, one may want to give it to a child to wear. Before this is done, the ancestors need to be told that the cloth will be given to a child; and that if the child wears it, it also means that it is the ancestors who have put on it as well.

⁶⁸ As explained earlier, *mboni* is in most cases money - it can also be flour, a piece of cloth or white beads etc - that is paid to someone so that the ancestral spirits that possess him or her should recognise the giver.

In case number two, the child was not sick at all, but she was just crying continuously for three days. She had no fever and therefore the parents could not take her to the hospital. Parents were at a loss to explain why the child was crying, hence they decided to consult a diviner who subsequently told them that the crying of the child was a sign that the name that the child had been given was not acceptable. The name *Walyenge* is given to a child whose hope of survival is very slim. If a number of children have died while still young, the parents may not have much hope that the next child will survive. It is assumed that children are being eaten by witches, which is why they are given the name *Walyenge*, which means “let them eat”, as the parents do not hold out any hope for the survival of the child (see Mkandawire, 1968). This name was rejected because one of the child’s ancestors demanded that the child should be named after her. Hence, after talking to her spirit and giving the relevant name to the child, the child stopped crying immediately. Such a case confirms the fact that, in the minds of the Tumbuka, misfortunes caused by the ancestors may not need any medication at all, but rather what has been referred to as kinship therapy (see Janzen, 1978:11) or relational therapy (Reynolds-Whyte, 1998:322).

In a study done among the Tumbuka in the mid-1980s, Friedson gives an example of a boy whose illness did not respond to treatment from either the local healer or the mission hospital. After his parents had divorced, the father refused to allow his son to stay in his village⁶⁹, and he went to live with his mother which, according to Tumbuka custom, is unacceptable. Upon consultation with a diviner, it was found that the dead paternal grandfather was the spirit who had inflicted the boy with the illness, because the boy’s father had not allowed him to stay in his village. The spirit further said that if the father did not relent, the child would die (see Friedson, 1996:59). Friedson also gives the example of Mulaula. In the mid 1980s, Mulaula, a well-known diviner among the Tumbuka, became ill. He tried to cure himself, but failed, and in the end he

⁶⁹ Being a patrilineal society, children belong to the husband and his kin and after divorce, the children are supposed to stay in their father’s village. In this case the father refused.

went to the hospital to seek therapy. After this visit to the hospital, the ancestors appeared to him and told him that he was just wasting his time, as he would not be healed unless he erected the cement tombs for his grandparents, which they had demanded earlier. The illness that Mulaula suffered from incapacitated him so much that he could not continue divining. It was, however, reported later on that after erecting the required tombstone he was cured and resumed his practice (Friedson, 1996:60-64).

It can be concluded that just talking with the spirits may not be adequate. The act of talking should either be accompanied by the fulfillment of the demands of the ancestors or their descendants should correct what went wrong. The death of Mr Luhanga's grandson would have been averted if Mr Luhanga had decided to settle in his home village after retiring, and not in Rumphu; Khwima was healed because those who were quarrelling and fighting stopped; and *Walyenge* stopped crying when her name was changed to Alice in accordance with the demands of the ancestors.

Witchcraft

While the non-response of disease to known and effective treatment is one way of knowing that the illness is not natural, there are also other ways of determining whether the illness is due to witchcraft or not. If an illness does not respond to treatment, a diviner may be consulted who will determine the cause of the illness. The Tumbuka also believe that the sudden onset of illness is an indication that the person has been bewitched. It is believed that illness should progress slowly: from a mild beginning to a serious condition. Any departure from this norm is therefore perceived as unnatural. This is why, as we saw in Chapter 9, the progression of malaria caused by *Plasmodium* species, which may result into death or serious illness within 48 hours, is in most cases attributed to witchcraft (see the case of Fwasani). If one quarrels with another person and is told that "*Uwonenge*" (meaning "You will see"), and if the person (or his/her child) to whom these words are directed, all of a sudden

becomes sick, it is suspected that the one who said these words has bewitched him or her. This is why, among the Tumbuka, one has to be very careful of what one says or does because you might be labelled a witch.

While these are the ways in which the Tumbuka recognise diseases caused by witchcraft, there are other diseases that are traditionally thought by the Tumbuka to be due to witchcraft, for example *chilaso* (pneumonia), as can be seen from the following example:

In April 2002, Malani, a two-year old boy, got sick and his mother took him to Bolero Health Centre where, upon examination, they were told that the child was suffering from pneumonia. Malani was given an injection and the parents were told to return to the hospital after two days for further treatment and observation. However, when they got home, the husband told the wife that in most cases pneumonia does not respond to biomedical treatment because it is [perceived to be] caused by witchcraft. A decision was therefore made to consult Thumbiko, a well-known diviner, who confirmed that the child was indeed suffering from pneumonia. Thumbiko told Malani's parents that the pneumonia that the child was suffering from was as a result of being bewitched. He also advised Malani's parents that in such circumstances biomedical treatment was not helpful. Thumbiko then gave them treatment and the mother stayed with the child at Thumbiko's place for close to one week after which he was discharged.

The diagnosis of pneumonia led the parents to consult a diviner as this illness is perceived by many Tumbuka as not responsive to biomedicine in most cases. While the failure of the health centres to treat certain illnesses may indicate that the illness is caused by witchcraft or such other agencies, the diagnosis of certain illnesses by health centre staff may also lead people to consult diviners or traditional healers. Both young and old men and women indicated that pneumonia is usually caused by

witchcraft, hence there is a need to use traditional medicine in such circumstances. Informants were also asked about other childhood diseases that can be attributed to witchcraft. They stated that *mufwiti akupanga nthenda yili yose nanga yingawa* AIDS, meaning that a “witch (*mufwiti*) can make a person to suffer from any type of disease, even AIDS”. One diviner said that witches take a reed and make a hole through it. They cover one end of the reed with a *phula* (birdlime) and they put some medicines in the reed, after which they fill it with water. The reed is then made to stand against the wall. After some time the *phula* will give way and start letting water trickle very slowly from the reed. Once the water starts trickling from the reed, then the bewitched person will also develop severe and intractable diarrhoea, and become very thin. People will think that the person is suffering from AIDS, whereas he has been bewitched. When preparing medicines to make a person look as if he or she is suffering from AIDS, one of the ingredients is some part of a chameleon, because “it has been observed that when a dog eats a chameleon it becomes very thin”, hence it is believed that when a chameleon is used then the targeted person will also emaciated. The attribution of HIV/AIDS related signs and symptoms to witchcraft is one of the factors that promotes the transmission of AIDS among the Tumbuka, as some young men have inherited their brothers’ wives because of the belief that they did not die of AIDS, but of witchcraft causes (see Munthali, 2002, for more details). The linking of AIDS related signs and symptoms to witchcraft is not unique to the Tumbuka; some recent studies in Zambia (Yamba, 1997) and in South Africa (Ashforth, 2002) also demonstrate that some people in these countries attribute AIDS related signs and symptoms to witchcraft.

Like other cultures in Africa, in Tumbuka witch beliefs there also exist witch familiars, which are used in the causation of misfortunes and illnesses. While informants said that hyenas and other animals might be used as witch familiars, they particularly talked about a witch familiar called *kanandirye*. One diviner said that *kanandirye* is a living thing that witches manufacture by putting *vizimba* medicines mixed with chicken in a horn. When prepared like this, the *kanandirye* becomes a

living thing, but it cannot be seen by a normal human being. It is claimed that this witch familiar clucks like a chicken. People will hear it clucking, but when they look for it, they cannot see it. It is also said that the *kanandirye* will even enter into a conversation with the owner (the witch). The *kanandirye* only feeds on human blood. It sucks blood from people (including children) without the victims knowing or seeing it. The only thing they realise is that they waste away and turn pale, signalling the loss of blood. It communicates with its owner whenever it wants to eat (a blood meal) and if the owner does not give it food it tells him or her that if he or she does not give him food then it will turn on him. Whenever the *kanandirye* demands food, the owner directs it to go and eat someone and in most cases it will feed on someone who belongs to the same family. When the owner dies, the *kanandirye* eats anyhow and does not follow the rules.

Anaemia in many people, including children under five, is sometimes attributed to the blood being drained by the *kanandirye*. Informants said that when a child is anaemic they go to the hospital for a blood transfusion or they might be given iron tablets. These only work for a while because the *kanandirye* will continue sucking blood from those persons. Hence diviners said that in such circumstances there is the need for the biomedical staff to work very closely with the diviners. They argued that in their case it is not possible to transfuse blood into a child, hence the hospital should be consulted in order to deal with this component of the illness. After the blood transfusion or administration of iron tablets, it is necessary to find out what is causing the anaemic condition. The diviners will in such circumstances administer indigenous medicines to deal with the witch familiar.

Diviners admitted that there are certain things that they cannot do like the transfusion of blood into someone who is anaemic, or the rehydration of the body through intravenous means. At the same time they said that hospital personnel cannot deal with issues of witchcraft, for example in cases where the *kanandirye* is sucking blood from its victims. In such circumstances, as we argued in the case of diarrhoea caused

by the infringement of taboos, treatment has to be given at several levels. The taking of iron tablets or transfusion of blood in the case of anaemia caused by the *kanandirye* is not adequate as it is necessary to deal with the supernatural cause of the illness as well.

Conclusion

The existence of ancestors and their continued role in the lives of their descendants is a reality for most Tumbuka people. Their existence is manifested in the many misfortunes that are attributed to them by the Tumbuka people, and is revealed through the processes of divination, dreaming and the sighting of certain snake and grasshopper species. What is apparent from this chapter is the ancestor's desire to see their descendants living peacefully. Fighting and quarrelling amongst relatives is deplored by the ancestors. Ancestors also desire the continuation of what are described as the Tumbuka customs, for example, that men should not abandon the land of their ancestors and build a home elsewhere. In addition descendants are not supposed to abandon their obligations to their ancestors. Because of the belief and experience of what the ancestors can do, most Tumbuka would rather not anger the ancestors. The belief in ancestors coerces people to behave in the manner approved by the ancestors. Such a belief is therefore a tool for social control.

While illnesses caused by witchcraft need to be identified by diviners, they can sometimes be known by the rapidity with which they progress from simple illness to serious illness and death. There are other diseases like pneumonia that the Tumbuka generally believe are caused by witchcraft. While such diseases can be cured by diviners, we should take note that, in some cases there is need for collaboration between diviners and biomedical practitioners as each might be required to address different aspects of the illness episode.

CHAPTER 12

CONCLUSION: CHANGE AND CONTINUITY IN PERCEPTIONS ABOUT CHILDHOOD DISEASES

Introduction

The major objectives of this study were, firstly, to find out what the Tumbuka people of northern Malawi consider to be the most dangerous childhood diseases in the area, how these diseases are recognised and the steps or measures that mothers or caretakers of children take in order to treat or prevent these diseases. Secondly, the study also aimed to determine differences in perceptions about childhood diseases between old and young women. According to informants, the Tumbuka consider *chikhoso chamoto*, diarrhoea, malaria, measles and conjunctivitis as the major threats to the health of children under five. In addition to these diseases, elderly informants mentioned that, before its eradication, smallpox was one of the most dangerous diseases that affected both adults and children. In Chapter 11, we saw that children under five, just like adults, are vulnerable to illnesses and misfortunes caused by acts of witchcraft and the displeasure of the ancestors. Witchcraft and ancestors, as informants said, can be responsible for all forms of illnesses and misfortunes, and it is through divination processes and non-responsiveness or refractoriness to therapeutic interventions that such types of diseases are determined. Dreaming is also a conduit through which the ancestors can communicate to their descendants about the different ancestor-related afflictions affecting them (descendants). While divination can play an important role in identifying diseases caused by witchcraft, there are certain diseases among the Tumbuka that are generally perceived or recognised to be caused by witchcraft (for example, pneumonia) and as we saw in the last chapter, the diagnosis of pneumonia in the hospital environment may lead caretakers of children to consult diviners.

While the above-mentioned diseases were perceived by the Tumbuka as threatening the lives of children under five, there was also a need to find out from the clinical officers at Mwazisi and Bolero Health Centres what they also considered to be dangerous childhood diseases prevalent in their catchment areas. What health workers may consider as dangerous diseases may not necessarily be considered as dangerous by the local population. As we said in Chapter 1, this mainly stems from the arguments put forward by Douglas and Wildavsky, who have stated that risk is a cultural and a collective construct (see Douglas and Wildavsky, 1983:6-7) and therefore the health risks that people fear in one culture may not necessarily be the same risks that people in other cultures may fear. For example, the diseases that the Tumbuka mothers mentioned in this study have largely disappeared in affluent western countries; and hence children under five in these developed countries suffer from other diseases. In this chapter, we examine a list of dangerous childhood diseases as mentioned by health workers and then compare this to the inventory of diseases that mothers mentioned in order to determine where they (health workers and women) converge and diverge. However before undertaking this comparison, there is a need to summarise the major findings about the Tumbuka's perceptions about the aetiology, treatment and prevention of childhood diseases, and how this has changed over time.

Change and continuity in perceptions about the aetiology of disease and misfortune

The coming of missionaries and colonial administrators introduced biomedicine to the Tumbuka people, who had initially relied on indigenous medicine. The establishment of the mission station at Livingstonia in Rumphi District towards the end of the 1800s, which provided western education and western medicine to the African population, marked the beginning of change in the Tumbuka 'disease worldview'. It was generally hoped by the missionaries and colonists that the exposure of Africans

to western education and western medicine would eventually lead to the abandonment of indigenous beliefs and practices regarding peoples' health (see Fraser, 1923; see also Vaughan, 1991), especially if the effectiveness of the biomedical interventions could be demonstrated. However, as this study demonstrates, while the Tumbuka subscribe to the idea of natural causation of disease and the *effectiveness* of biomedicine, witchcraft, the infringement of food, sexual and other taboos, the displeasure of the ancestors, etc, are still perceived as important causes of illness and misfortune among the Tumbuka. The consultation of diviners in order to find out the cause of illness and misfortune and the propitiation of the ancestral spirits are still being done today. Unlike other cultures where herbal or medicinal cures are mixed with the restoration of a balance in supernatural relations in order to treat those diseases believed to be caused by ancestors (e.g. see du Toit, 1985), the Tumbuka believe that biomedicine or medicinal herbal concoctions are not necessary: what is required in such a context is setting of the matters right with the ancestors.

Therefore we need to note the changes or shifts in perceptions about the aetiology of illness among the Tumbuka. Most of the old men and women who participated in this study attributed illness in children under five to the supernatural and other similar forces. While young mothers with children under five also subscribed to such notions, they also held biomedical disease explanatory models. For example, in the case of diarrhoea, both old and young women attributed diarrhoea in children under five to teething, to sexual intercourse when the child is breastfeeding or to breastfeeding while the mother is pregnant. However, young women added that diarrhoea can also be due to poor sanitation and hygiene measures such as eating without washing one's hands, a child eating food contaminated by flies, drinking contaminated water etc. Most of these young women have gone as far as senior primary school where they claimed that they learnt about biomedical disease explanatory models. In addition the Ministry of Health and Population in Malawi runs a number of programmes on the national radio station, aimed at educating the Malawian population on health and population issues. Most people (approximately 70 percent of the households in

Chisinde and Wantulira villages, see Chapter 4) in the study area owned radios, and a number of women mentioned that they heard about certain health issues on the radio.

Of notable importance was the adoption by the Ministry of Health and Population of primary health care as an approach or a strategy for the delivery of health care services in Malawi. In this approach, the Ministry has, among other things, deployed HSAs, who are health workers based at the community level. Among other duties, as discussed in Chapters 1 and 4, these HSAs are involved in monitoring disease outbreaks and educating mothers on health including the aetiology and prevention of childhood diseases. These health education sessions are conducted in the communities where they live, as well as during both static and outreach immunisation clinics. We have seen that these community health workers play an important role in educating mothers about health issues, as they (HSAs) were frequently mentioned by informants as sources of information on health.

The adoption of biomedical disease explanatory models can also be influenced by friends and relatives and their own experience with biomedicine regimes. In Chapter 9, the example of Talumba, who had suffered from convulsions, was given. When Talumba's condition did not improve after the old women had administered strong-smelling herbal medicines, her father took her to the health centre, where she was diagnosed as suffering from cerebral malaria. The child was admitted for two days, after which she was discharged. Talumba's father said that this experience had made him believe that biomedical treatment was effective in the treatment of convulsions. From that time onwards, he said that he advised his friends that whenever their children suffered from convulsions, they should not spend time administering strong-smelling medicines; instead they should either go to the health centre for treatment or purchase Fansidar and Panadol from the local grocery shops and give it to their children.

We see that in the case of Chisinde and the surrounding villages, there exist a number of factors that have influenced a shift in perceptions about aetiology, treatment and prevention of childhood diseases to biomedical explanatory models, namely:

- The existence or availability of community based health workers who are blitzing the community with a lot of information on health;
- The programmes on health broadcast on the local radio station;
- Some level of schooling; and
- Experiences of the powers of biomedicine by people like Talumba's father who later advise their friends and therefore act as agents of change.

Apart from these factors, it can also be argued that conversion to Christianity has to some extent brought a shift to a more biomedical view of illness. Most Eurocentric churches do not allow their members to consult diviners. This study has shown that in times of serious illness, even staunch members of these churches resort to the consultation of diviners, e.g. all those who were involved in witchcraft accusations as described in Chapter 9, were members of these Eurocentric churches.

While these factors are indeed agents of change and have contributed greatly towards the adoption (by young men and women) of biomedical ways of explaining disease, we still find that these young men and women sometimes also attribute disease to the supernatural and other such forces. Grandparents were frequently mentioned as sources of information on indigenous perceptions about childhood diseases. The socialisation process also moulds young men and women and thus helps them internalise the indigenous beliefs about disease and misfortune. Murdock has argued that the existence of very high morbidity and a comparatively brief life expectancy among the indigenous peoples of the world assures that, by chance alone, the breach

of a taboo will frequently be accompanied by some illness. Mystical retribution, which Murdock explains as the onset of illness as a consequence of the violation of some taboos or moral injunction (rather than the mediation of some offended or punitive supernatural being), is commonly seen as a cause of illness in African societies (Murdock, 1980). Using Murdock's thesis, we can therefore also argue that diseases, such as diarrhoea, are so common among the Tumbuka people in rural Malawi, that the mother's involvement in sexual intercourse while still breastfeeding or, breastfeeding while she is pregnant, may coincide with the onset of diarrhoea or *chikhoso chamoto* in children. Such coincidences tend to reinforce indigenous beliefs about disease and misfortune.

As we saw in previous chapters, during illness episodes, people in Chisinde and surrounding villages may choose to buy medicines from the local grocery shops, consult herbalists and diviners or go to either Bolero or Mwazisi Health Centres for treatment. In addition to these services, there is also a private clinic at Bolero Trading Centre where those with money can go and get treatment. The Eva Demaya Centre⁷⁰, which opened at Ruviri early in 2002, is another option for people of this area. From the data presented in this thesis, it can be seen that there are a number of factors that affect the type of therapy that mothers or caretakers resort to whenever their children become sick. These factors include the cost of treatment, distance to the health facility, the attitude of health personnel (for example behaving like soldiers and being rude to patients etc), the perceived cause of illness, past experiences in dealing with the illness, and the availability of medicines at the health facility, among others.

We need to point out that these factors do influence one another; for example, while distance matters, the perceived cause of illness and past experiences of dealing with the illness may influence choice of therapy. Though the health centres at Bolero and

⁷⁰ A newly opened health centre located at Ruviri. It offers both traditional and western medicines.

Mwazisi were nearer, in some cases, people from Chisinde and the surrounding villages visited the diviner at Kaduku because of the belief that some supernatural force was responsible for the illness. As far as hierarchy of resort to therapeutic treatment is concerned, it seemed that, during illness episodes, people in most cases first self-medicated with traditional medicines or with western medicines bought from the local grocery shops or medicines left from the previous illness episode. When this failed they either went to the health centre or the herbalist. It seemed that people first self-medicate, consult herbalists or visit the local health centre because initially most illnesses are thought to be natural.

If the treatment they obtained from the herbalist or health centre failed, they then consulted diviners in order to determine the cause of illness. While this is the trend in therapy seeking, we also find among the Tumbuka what LeBeau calls *double consumption* (LeBeau, 1999). During illness episodes, in some cases the Tumbuka resort to both traditional as well as western medicine, because of the perception that these tend to reinforce one another. In the case of measles, the Tumbuka give traditional medicine in order to facilitate the appearance of the rash, while at the same time they either go to the hospital or buy medicines from the shops to treat the cough, diarrhoea and conjunctivitis which accompany this disease. In addition, as one diviner was quoted as saying in the previous chapter, witchcraft can be responsible for many disease symptoms, such as anaemia and severe dehydration. In order to treat these symptoms, there is a need for a blood transfusion or intravenous rehydration, processes that can only be done in a hospital environment. In such cases, it is important that the diviner should take care of the “witchcraft” because it is believed that even if blood transfusion or intravenous rehydration is done, the patient may continue to suffer from these as long as the basic supernatural cause has not been addressed. This is also what we saw in the case of childhood diarrhoea caused by contamination of breast milk by semen. Informants said that ORS or medicines given at the health centre may work, but that this should be accompanied by weaning the child or stopping engaging in sexual intercourse, otherwise the child will continue

suffering from diarrhoea.

It can also be concluded from the evidence and discussion in this thesis that, although the dichotomy between African and western diseases is useful, disease classification based on aetiology may shift, depending on the response to therapy. The Tumbuka generally believe that illnesses should be responsive to treatment, be it indigenous or biomedical. The refractoriness of illnesses to what is perceived as effective treatment by the Tumbuka may lead to witchcraft accusations; or to thoughts that the illness has been caused by displeased ancestors; these are issues that can only be dealt with in a traditional way. In most cases, diviners therefore dealt with illnesses that had lasted for longer than they normally should have. This is in line with the findings of Frankenberg and Leeson in Lusaka, who said that illnesses that are brought to the *ng'anga* (diviners) are those that have lasted for a long time (see Frankenberg and Leeson, 1976) despite seeking therapy from different sources. Witchcraft therefore tends to explain occurrences that cannot be otherwise explained, and the consultation of diviners can therefore be considered as a source of hope for illness episodes that have defied what is perceived as effective treatment.

While this is the case, we also need to note that there are exceptions to this rule. There are certain illnesses, such as pneumonia that the Tumbuka generally perceive as being caused by witchcraft. Hence, as soon as it is diagnosed, either biomedically or otherwise, recourse is had to traditional medicine as the case of Malani in Chapter 11 shows. The Tumbuka also believe that an illness should follow a normal course namely from mild illness to very serious illness and death. The sudden onset of serious illness or the rapid progression from mild to serious illness and death (as we saw in the case of *Plasmodium falciparum* malaria, for example, the case of Fwasani and the child from Chiwapasi Village as described in Chapter 9) invites accusations of witchcraft. Seeking therapy for childhood diseases is therefore a complicated process and there are many factors that play a role in this search.

In conclusion it would be useful to look at the causes of the attendance of children under five at Bolero and Mwazisi Health Centres and under-five mortality, and what the health workers consider as the most dangerous diseases in Chisinde and the surrounding areas.

Causes of under-five health centre attendance and under-five mortality

Though diviners in Tumbukaland do not generally keep records, they said, that in most cases, they dealt with illnesses and misfortunes which are believed to be caused by witchcraft. While this was the case, people also consulted them for other forms of illnesses. While it was possible to determine the types of illnesses that diviners dealt with, it was impossible to determine the number of children under five who were treated by the diviners over a period of one year, due to the absence of records.

However, health centres at Mwazisi and Bolero kept records on the number of both children under five as well as adults, and the diseases that they suffered from, according to biomedical diagnosis. The outpatients departments (OPD) of all health facilities carry out a surveillance of 32 specific diseases. Although re-attendances are also recorded, specific attention is given to first visits to these OPDs (Ministry of Health and Population-HMISU, 1999:4). Table 12.1 shows the number of illness episodes in children under five who passed through the OPD at Mwazisi Health Centre. The data for September, October and December 2001 was not available from the records at Mwazisi, and it was claimed that someone from the district hospital had come and borrowed the report forms and never returned them. When this official at Rumphí District Hospital was contacted, he said that he had returned the forms to Mwazisi Health Centre.

Despite the absence of data for these three months, it can be seen that malaria is the most common cause of outpatient attendance among children under five in the catchment area of Mwazisi Health Centre. This is followed by other respiratory

infections, scabies, other diarrhoeal diseases, eye diseases and pneumonia. Pneumonia and scabies were not mentioned frequently by informants. Though malnutrition-related illnesses were frequently mentioned by informants, there were only 29 cases of malnutrition at Mwazisi Health Centre in the year 2001. One reason for this is possibly that, such cases are generally interpreted as caused by sexual intercourse and other related factors, hence most malnutrition-related illnesses are therefore not brought to the health centres for treatment. People would rather resort to indigenous medicine. While measles was also mentioned frequently by women, there were only eight suspected cases of measles at Mwazisi Health Centre in 2001. We mentioned in Chapter 10 that in some cases people use traditional medicine in the treatment of measles in children. This indigenous treatment involves the rubbing of a red medicinal substance on the body of a child suffering from measles in order to facilitate the appearance of the rash. Mothers fear that when they go to the health centre with a child upon whom reddish material has been rubbed, the health workers may shout at them; hence very few cases might pass through the OPDs. While this is a possible explanation for a low declaration figure for measles, health workers also said that in the recent past there have been a lot of outbreaks of rashes in children under five that have mimicked the measles rash, hence some of the measles cases mentioned by mothers may not necessarily have been clinical measles cases.

It can also be seen from Table 12.1 that the highest prevalence or incidence of malaria occurred between January and April, which is the rainy season. The incidence and prevalence of malaria is high during this season because of the relative abundance of breeding grounds for mosquitoes.

While Chisinde is in the catchment area of Mwazisi Health Centre, it was mentioned earlier that in some cases people from this area also went to Bolero Health Centre for treatment. Table 12.2 shows the causes of outpatient attendances among children under five at Bolero Health Centre. It can be seen that the leading causes of outpatient

attendances at Bolero and Mwazisi health centres are similar, with malaria as the leading cause.

Fig 12.1: Outpatient Monthly Return – Mwazisi Health Centre (First Visit) – 2001 (Source: Health Centre Records)

DIAGNOSTIC CATEGORY	JAN	FEB	MA R	AP R	MA Y	JUN	JUL	AU G	SEP	OCT	NOV	DEC	TOTA L
Malaria	371	603	356	478	385	174	250	163	-	-	165	-	2945
Other upper respiratory infection	157	123	98	133	116	84	44	67	-	-	66	-	888
Scabies	12	5	10	13	8	6	3	6	-	-	12	-	349
Other diarrhoeal diseases	21	24	20	15	14	9	13	14	-	-	33	-	274
Eye diseases	6	13	21	65	18	18	16	11	-	-	6	-	174
Pneumonia	9	19	18	14	11	7	4	19	-	-	10	-	111
Common cold	5	1	3	1	1	22	12	0	-	-	8	-	53
Worm infestation	6	10	2	4	6	0	1	3	-	-	5	-	37
Ear diseases	5	5	5	3	3	4	3	1	-	-	1	-	30
Malnutrition	6	3	1	3	2	4	3	4	-	-	3	-	29
Bloody diarrhoea	3	2	2	0	2	2	2	4	-	-	10	-	27
Other lower respiratory infection	2	0	3	4	0	0	0	4	-	-	0	-	13
Asthma	2	2	2	0	3	1	0	0	-	-	2	-	12
Measles (suspect)	1	3	0	2	1	1	0	0	-	-	0	-	8

Fig 12.2: Outpatient Monthly Return – Bolero Health Centre (First Visit) – 2001 (Source: Health Centre Records)

DIAGNOSTIC CATEGORY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Malaria	375	580	635	625	610	336	615	357	475	925	370	485	6388
Other upper respiratory infection	186	136	247	515	616	246	265	410	430	488	254	280	4073
Other diarrhoeal diseases	38	61	35	210	44	22	32	41	56	67	60	56	722
Pneumonia	18	60	6	61	102	96	120	65	60	11	58	20	677
Eye diseases	14	32	4	27	36	29	31	18	54	7	32	60	344
Scabies	25	46	3	20	28	32	34	3	34	6	63	48	342
Common cold	20	14	-	-	160	60	-	-	38	10	28	6	336
Ear diseases	22	22	2	8	8	15	15	4	41	3	18	14	172
Worm infestation	26	46	0	6	3	6	2	3	26	0	15	10	143
Malnutrition	18	14	2	2	3	1	0	0	1	2	18	12	73
Bloody diarrhoea	6	0	0	0	0	0	0	0	0	4	10	20	40
Asthma	3	10	-	-	0	3	-	-	0	4	3	10	33
Other lower respiratory infection	6	0	0	0	10	7	0	0	0	0	3	1	27
Measles (suspect)	0	0	0	0	2	0	0	0	0	0	0	0	2

At the national level, as of 1996, the ten leading causes of under-five outpatient attendance were as follows:

Table 12.3 Causes of under-five outpatient attendance 1996 (source, Ministry of Health and Population – HMISU, 1999:23)

DIAGNOSIS	NUMBER OF FIRST VISITS TO THE HEALTH FACILITY
Malaria	2628539
Upper respiratory infection	998137
Other diarrhoeal diseases	639016
Diseases of the eye	436299
Pneumonia	374407
Other lower respiratory infection	313043
Other conditions of the skin	278576
Malnutrition	254851
Abdominal complaints	247547
Ill defined/other diagnosis	212902

From Table 12.3 it can be seen that these causes of under-five OPD attendance are not very different from the situation in Chisinde and surrounding villages. While Mwazisi and Bolero health centres have admission facilities, no serious or life-threatening cases are kept at these health centres as they are all referred to Rumphi District Hospital for specialist care. It was therefore difficult to obtain under-five mortality data at the health centres. Table 12.4 shows the causes of under-five mortality at Rumphi District Hospital in 2001. In that year, 180 children aged under five years died, and from Table 12.4 it can be seen that the five leading causes of under-five

mortality in 2001 were malaria, pneumonia, gastroenteritis, malnutrition-related illnesses and anaemia.

Table 12.4 Leading causes of under-five mortality at Rumphi District Hospital – 2001 (Source: Hospital Records)

Diagnostic Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Malaria	8	-	5	5	6	5	3	-	2	9	8	7	58
Pneumonia	3	-	1	10	6	6	1	-	0	10	9	9	55
Gastroenteritis	3	-	4	2	2	1	2	-	4	7	19	6	50
Malnutrition related illnesses	3	-	3	6	4	1	0	-	0	6	7	7	37
Anaemia	6	-	3	6	4	2	0	-	0	1	2	3	27
Severe Dehydration	1	-	0	0	2	0	0	-	1	2	2	1	9
Meningitis	1	-	0	1	2	2	0	-	1	1	1	0	9
Tuberculosis	1	-	1	1	0	0	0	-	0	1	0	0	4
Wounds	0	-	0	0	0	0	0	-	1	0	1	0	2
Abscesses	0	-	0	0	0	0	0	-	0	0	0	1	1
Bee Sting	0	-	0	0	0	0	0	-	0	0	0	1	1
Total No. of Deaths	17	-	8	22	18	12	4	-	8	28	40	23	180

What is apparent from these tables is the absence of vaccine-preventable diseases, such as poliomyelitis, tuberculosis, pertussis, etc. Health workers said that vaccine-preventable diseases no longer pose a threat to the health of children under five because of the success of the vaccination programmes, which have led to the elimination of some diseases, such as poliomyelitis. The last case of poliomyelitis was diagnosed in Malawi in 1997 (see Chilowa and Munthali, 1999). Because of the success of vaccination programmes, as we noted Chapter 10, Malawi closed the special measles wards which had been established in many hospitals in Malawi to cater for those suffering from measles. While vaccine-preventable diseases are on the decrease, the Ministry of Health and Population, with support from donor agencies like UNICEF, still accords high priority to the provision of vaccination services because it recognises the risk of not doing so.

Health workers also mentioned that over the years there has been an increase in the incidence of tuberculosis. Tuberculosis is an opportunistic infection closely associated with HIV infection and in Malawi an estimated 70 percent of people who were reported with tuberculosis were evidently also HIV infected (Kumwenda, 2001). Reported TB cases have risen from 5,000 in 1985 to 24,000 in 2000 (Kumwenda, 2001 and Glynn et al, 1997:74). These trends in HIV and TB infections have put a severe strain on the government's health budget because close to 80 percent of people admitted to hospital wards suffer from HIV/AIDS-related problems compared to 20 percent in 1990 (see Kumwenda, 2001). There is a need for the government to ensure that the BCG vaccine is always available in order to protect children against tuberculosis.

Health workers considered the diseases described above as dangerous to children, and that a lot of care taken in order to prevent the development of serious illness and death. Though vaccine-preventable diseases were not all that prevalent, health workers stressed the need to continue vaccinating children as they are still vulnerable to these vaccine-preventable diseases.

In this study, informants were asked what they considered to be the most dangerous diseases affecting children in the Chisinde area and surrounding villages. As we have seen in the previous chapters, such diseases included malaria, *chikhoso chamoto*, diarrhoea, measles and conjunctivitis. Though splenomegaly and convulsions in children under five can also be due to other infections, it has been argued that in malaria-endemic areas, such as Chisinde, these conditions are mainly due to malaria. *Chikhoso chamoto* mainly refers to malnutrition-related illnesses and this may be accompanied by coughs and other conditions. Measles was the only vaccine-preventable disease that mothers mentioned as threatening the health of children in Chisinde. None of the other vaccine-preventable diseases were mentioned, presumably because they are no longer occurring on a significant scale among the children under five. Old men and women also mentioned smallpox as a disease that affected children a long time ago, but that these days it is no longer seen as a threat. Though mothers perceive that there is an element of coercion in vaccination programmes, most mothers said that children who were not vaccinated were at risk of contracting vaccine-preventable diseases. Because of the recognition of this risk most mothers chose to have their children vaccinated. From this it can be envisaged that as far as health risks in children are concerned, the diseases that the Tumbuka say are dangerous are the same diseases as those that have been listed in Tables 12.1 and 12.2, except that worm infestations, epilepsy, scabies, pneumonia and asthma were very rarely mentioned. The major difference was in the interpretation of these diseases. While there were other causative factors, it seemed that one of the most common cause of illness in children under five was seen as the wrong type of sexual intercourse. Extramarital sexual intercourse, sexual intercourse after seven months of pregnancy and postpartum sexual intercourse are believed to be detrimental to the health of children. Perceiving sexual intercourse as a risk factor to children's health, the Tumbuka use different strategies which are perceived to prevent and treat illnesses arising from sexual intercourse and other related factors.

References

Published sources:

Abdalla, I.H. (1985). The Ulama of Sokoto in the nineteenth century. In: du Toit, B.M. and Abdalla, I.H. *African healing strategies*. Owerri: Trado-Medic Books.

Abdulla, S., C. Goodman, P. Coleman, G. Mubyazi, N. Kitumbih and T. Odorosobo. (2000). *Changing the first line drug for the treatment of malaria in Tanzania*. Report compiled for the Ministry of Health, Tanzania.

Ackroyd, S. and J.A. Hughes. (1981). *Data collection in context*. London: Longman.

Ademuwagun, Z.A. (1979). The relevance of Yoruba medicine men in public health practice in Nigeria. In: Ademuwagun, Z.A., J.A.A. Ayoade, I.E. Harrison and D.M. Warren (eds.). *African therapeutic systems*. Massachusetts: Crossroads Press.

Agyepong, I.A. (1992). Malaria: ethnomedical perceptions and practice in an Adangbe farming community and implications for control. *Social Science and Medicine* 35:131-137.

Ajose, O.A. (1957). Preventive medicine and superstitions in Nigeria. *Africa* 27: 268-274.

Alland, A. (1970). *Adaptation in cultural evolution: an approach to medical anthropology*. New York & London: Columbia University Press.

Alland, A. (1975). Adaptation. *Annual Review of Anthropology* 4:59-73.

Alubo, S.O. (1987). Drugging the Nigerian people: pills, profits, and underdevelopment in Nigeria. *Studies in Third World Societies* 34:84-114.

Amin, R., R.H. Hull, S.A.T.P. Horton, C. Kamara and J. Chowdhury. (1992). Immunisation coverage, infant morbidity and infant mortality in Freetown, Sierra Leone. *Social Science and Medicine* 37(7):851-856.

Anderson, R. (1990). Chiropractors for and against vaccines. *Medical Anthropology* 12:169-186.

Ardener, S. (1984). Gender orientation in fieldwork. In: Ellen, R.F. (ed). *Ethnographic research: a guide to general conduct*. London: Academic Press.

Arnold, D. (1993). *Colonising the body: state medicine and epidemic disease in nineteenth century India*. Berkeley: University of California Press.

Ashforth, A. (2000). *Madumo: a man bewitched*. Capetown: David Philips.

Ashforth, A. (2002). An epidemic of witchcraft? The implication of AIDS for the post-apartheid state. *African Studies* 61(1):121-143.

Auer, C. and M. Tanner. (1990). Childhood vaccination in a squatter area of Manila: coverage and providers. *Social Science and Medicine* 31(11):1265-1270.

Azevedo, M.J., G.S. Prater and D.N. Lantum. (1991). Culture, biomedicine and child mortality in Cameroon. *Social Science and Medicine* 32(12): 1341-1349.

Baer, H.A., M. Singer and J.H. Johnsen. (1986). Introduction: toward a critical medical anthropology. *Social Science and Medicine* 23(2):95-98.

Baume, C., D. Helitzer, and S.P. Kachur. (2000). Patterns of care for childhood malaria in Zambia. *Social Science and Medicine* 25:277-292.

Bentley, M.E., G.H. Pelto, W. Strauus, D. Schumann, C. Adegbola, E. de la Pena, G. Oni, K. Brown and S.Huffmann. (1988). Rapid ethnographic assessment: applications in a diarrhoeal programme. *Social Science and Medicine* 27(1):106-116.

Bennett, R.V. and L.K. Brown. (1996). *Myles textbook for midwives*. Edinburgh: Churchill Livingstone.

Bloor, M. (1995). A user's guide to contrasting theories of HIV-related risk behaviour. In: Gabe, J. (ed). *Medicine, health and risk: sociological approaches*. Oxford: Blackwell Publications Limited.

Boston, J. (1971). Medicines and fetishes in Igala. *Africa* XLI(3):200-7

Bourdillon, M.F.C. (1997). *Where are the ancestors: changing culture in Zimbabwe*. Harare: University of Zimbabwe Publications.

Brain, J.B. (1990). "But only we black men die": the 1929-1933 malaria epidemics in Natal and Zululand. *Contree: Journal of South African Urban and Regional History* 27:18-25.

Breman, J.G. and C.C. Campbell. (1988). Combating severe malaria in African children. *Bulletin of the World Health Organisation* 66(5):611-620.

Brokensha, D. (1973). Comment on anthropology and colonialism. *Current Anthropology* 14(5): 592-593.

Brown, J.E. (1983). Low immunisation coverage in Yaounde, Cameroon: finding the problems. *Medical Anthropology* 7(2):9-18.

Brown, K.M. (1999). Health belief model. Community and Family Health, University of South Florida (www.hsf.usf.edu/~kmbrown/health_belief_model_overview.htm).

Bujis, G. (1995). Indigenous healing: some aspects of the work of diviners and herbalists in Southern Africa. In: Allais, C. (ed). *Sociology of health and illness*. Johannesburg, Lexicon Publishers.

Caplan, P. (1997). *African voices, African lives: personal narratives from a Swahili village*. London: Routledge.

Cassel, J. (1977a). The relationship of observer to observed in peer group research. *Human Organisation* 36(4):412-416.

Cassel, J. (1977b). Social and cultural implications of food and food habits. In: D. Landy. *Culture, disease and healing: studies in medical anthropology*. New York: Macmillan Publishing.

CDC. (nd). *Measles* (www.cdc.gov/nip/publications/pink/meas.pdf).

Chabot, J. (1998). How to improve quality of care in Africa: are health reforms the beginning of an answer. In: Streefland, P. (ed.). *Problems and potential in international health: transdisciplinary perspectives*. Amsterdam: Het Spinhuis.

Chakanza, J.C. (nd). Sex and sexuality: a cultural perspective. *The Lamp* Volume 19.

Chakanza, J.C. (1998). Traditional birth rituals in Malawi. *The Lamp* 14:27-34.

Chavunduka, G. (1978). *Traditional healers and the Shona patient*. Gwelo: Mambo Press.

Chavunduka, G. (1994). *Traditional medicine in modern Zimbabwe*. Harare: University of Zimbabwe Publications.

Chetley, A. (1987). *Antibiotics: the wrong drugs for diarrhoea*. Amsterdam: Health Action International.

Chilowa, W. and A. Munthali. 1999. *Immunisation in Malawi: quality of care, social demand and sustainability of vaccination services*. Amsterdam: Het Spinhuis.

Chilungu, S.W. (1976). Issues in the ethics of research method: an interpretation of the Anglo-American perspective. *Current Anthropology* 17(3):457-481.

Cocks, M. and A. Dold. 2000. The role of "African Chemists" in the health care system of the Eastern Cape province of South Africa. *Social Science and Medicine* 51(10): 1505-1515.

Cole, J.W. (1977). Anthropology comes part-way home: community studies in Europe. *Annual Review of Anthropology* 6:349-378.

Colson, E. (2000). The father as a witch. *Africa* 70(3): 333-358.

Coreil, J. (1990). The evolution of anthropology in international health. In: Coreil, J. and J.D. Mull (eds). *Anthropology and primary health care*. Boulder: Westview Press.

Comaroff, J. and J. Comaroff. (1999). Occult economies and the violence of abstraction: notes from the South African postcolony. *American Ethnologist* 26(2):279-303.

Crandon-Mallamud, L. (1991). *From the fat of our souls : social change, political process, and medical pluralism in Bolivia*. Berkeley: University of California Press

Crick, M. (1989). Shifting identities in the research process: an essay in personal anthropology. In: Perry, J. (ed). *Doing fieldwork: eight personal accounts of social research*. Geelong: Deakin University Press.

Cummergen, P. (2000). Zionism and politics in Swaziland. *Journal of Religion in Africa* XXX(3):370-385.

Daneel, M.L. (1970). *Zionism and faith-healing in Rhodesia: aspects of independent churches*. The Hague and Paris: Mouton.

Davis-Roberts, C. (1992). "Kutambuwa ugonjuwa: concepts of illness and transformation and the Tabwa of Zaire." In: Feierman, S. and J. Janzen. (eds). *The social basis of health and healing in Africa*. Berkeley: University of California Press.

Davis, W. (1986). *The serpent and the rainbow: an astonishing journey into the secret society of Haitian voodoo, zombies and magic*. London: William Collins Sons and Co. Ltd.

Dawson, M.H. (1992). "Socioeconomic change and disease: smallpox in colonial Kenya, 1880-1920". In: Feierman, S. and J. Janzen. (ed). *The social basis of health and healing in Africa*. Berkeley: University of California Press.

de Gabriele, J. (1997). Researching traditional religion in Malawi: some reflection on fieldwork. *Religion in Malawi*: Zomba: Department of Theology and Religious Studies.

Dennis, R.E. and I.E. Harrison. (1979). Traditional healers in Liberia: a review of literature with implications for further research. In: Ademuwagun, Z.A., J.A.A. Ayoade, I.E. Harrison and D.M. Warren (eds.). *African therapeutic systems*. Massachusetts: Crossroads Press.

Devisch, R. (1999). Therapy choice, utilization and satisfaction by low budget health seekers in suburban and rural Bantu Africa. *African Anthropology* VI(2):141-197.

Diamond, S. (1964). A revolutionary discipline. *Current Anthropology* 5:432-437.

Diamond, S. (1980). *Anthropology, ancestors and heirs*. The Hague: Mouton.

Douglas, M. (1963). *The Lele of the Kasai*. London: Oxford University Press.

Douglas, M. (1966). *Purity and danger: an analysis of concepts of pollution and taboo*. London and New York: Routledge.

Douglas, M. and A. Wildavsky. (1983). *Risk and culture*. Berkeley: University of California Press.

Duguid, S. (2002). *SA's necessary evil*. Mail and Guardian, July 5-11, Pages 24-25.

du Toit, B.M. (1985). Religion, ritual, and healing among black South Africans. In: du Toit, B.M. and I.H. Abdalla. *African healing strategies*. Owerri: Trado-Medic Books.

du Toit, B.M. (1985). The isangoma: an adaptive agent among urban Zulu. In: du Toit, B.M. and I.H. Abdalla. *African healing strategies*. Owerri: Trado-Medic Books.

Ellen, R.F. (ed). (1984). *Ethnographic research: a guide to general conduct*. London: Academic Press.

Elling, R.H. (1981). The capitalist world-system and international health. *International Journal of Health Services* 11(1):21-51.

Ember, C.R. and M. Ember. (1993). *Anthropology*. New Jersey: Prentice-Hall

Espino, F. and Manderson, L. (2000). Treatment seeking for malaria in Morong, Bataan, The Philippines. *Social Science and Medicine* 50:1309-1316.

Espino, F., L. Manderson, C. Acuin, F. Domingo and E. Ventura. (1997). Perceptions of malaria in a low endemic area in the Philippines. *Acta Tropica* 63:221-239.

Evans-Pritchard, E.E. (1937). *Witchcraft, oracles and magic among the Azande* Oxford : Clarendon Press, 1937.

Evans-Pritchard, E.E. (1951). *Social anthropology*. London: Cohen and West.

Evans-Pritchard, E.E. (1976). *Witchcraft, Oracles and Magic among the Azande*. Oxford: Clarendon Press (abridged version).

Fahim, H. and K. Helmer. (1980). Indigenous anthropology in non-Western countries: a further elaboration. *Current Anthropology* 21(5):644-663.

Fahim, H.M. (1976). Remarks on foreign/indigenous anthropology, with reference to the study of Nubians in Egypt and Sudan. *Human Organisation* 36:80-86.

Fahim, H.M. (1977). Foreign and indigenous anthropology: the perspectives of an Egyptian anthropologist. *Human Organisation* 36(1):80-86.

Fainzang, S. (1998). Anthropology at home via anthropology abroad: the problematic heritage. *Anthropology & Medicine* 5(3):269-278.

Feierman, S. (1981). Therapy as a system in action in north-eastern Tanzania. *Social Science and Medicine* 15B: 353-360.

Feierman, S. (1985). Struggles for control: the social roots of health and healing in modern Africa. *African Studies Review* 28(2/3): 73-147.

Feyisetan, B.J., A. Asa and J.A.Ebigbola. (1997). *Mothers' management of childhood diseases in Yorubaland: the influence of cultural beliefs*. *Health Transition Review* 7:221-234.

Fink, H. (1991). *Religion, disease and healing in Ghana: a case study of the traditional Dormaa medicine*: Munchen: Trichster.

Fleming, C.J.W. (1974). The law of obligations in northern Malawi part 1: contract. *Society of Malawi Journal* XXVI(2):24-32.

Fleming, C.J.W. (1977). Crime and punishment in northern Malawi. *Society of Malawi Journal* XXX(1): 6-14.

Fleming, C.J.W. (1977). The law of obligations in northern Malawi part 2: the law of wrongs. *Society of Malawi Journal* 28(1):6-19

Forster, P. (1989). *T. Cullen Young: missionary and anthropologist*. Hull: Hull University Press.

Foster S. (1995). Treatment of malaria outside the formal health services. *Journal of Tropical Medicine and Hygiene* 98:29-34.

Foster, G.M. (1969). *Applied anthropology*. Boston: Little, Brown and Company.

Foster, G.M. and B.G. Anderson. (1978). *Medical anthropology*. New York: John Wiley and Sons

Franco, L.M., A. Ntonya, and N.B. Rhodes. (1995). *Community financing experience and options: a study to provide baseline information for the Ministry of Health decision-making*. Lilongwe: Ministry of Health and Population.

Frankenberg, R. and J. Leeson. (1976). Disease, illness and sickness: social aspects of the choice of healer in a Lusaka suburb. In: Loudon, J.B. (ed). *Social anthropology and medicine*. London: Academic Press.

Fraser, D. (1922). *Winning a primitive people: sixteen years' work among the warlike tribes of the Ngoni and the Senga and Tumbuka peoples of Central Africa*. London: Seeley Service & Co. Limited.

Fraser, D. (1923). *African idylls: portraits and impressions of life on a Central African mission station*. London: Seeley Service.

Frazer, J. (1993). *The golden bough: a study in magic and religion*. Hertfordshire: Wordsworth Editions Limited.

Friedson, S. (1996). *Dancing prophets: musical experience in Tumbuka healing*. Chicago: University of Chicago Press.

Gausset, Q. (2001). AIDS and cultural practices in Africa: the case of the Tonga (Zambia). *Social Science and Medicine* 52:509-518.

Geissler, P.W. (1998). 'Worms are our life', part 1: understanding of worms and the body among the Luo of western Kenya. *Anthropology and Medicine* 5(1): 63-79.

Gelfand, M. (1964a). *Medicine and custom in Africa*. Edinburgh and London: E. & S. Livingstone.

Gelfand, M. (1964b). *Witch doctor: traditional medicine man of Rhodesia*. London: Harvill Press.

George, S. (1986). *How the other half dies: the real reasons for world hunger*. London: Penguin Books.

Gerrits, T. (1997). Social and cultural aspects of infertility in Mozambique. *Patient Education and Counselling* 31:39-48.

Geschiere, P. (with C. Fisiy). (1994). Domesticating personal violence: witchcraft, courts and confessions in Cameroon. *Africa* 64(3):323-341.

Geschiere, P. (1997). *The modernity of witchcraft: politics and the occult in postcolonial Africa*. Charlottesville: University Press of Virginia

Gillies, E. (1976). Causal criteria in African classifications of disease. In: Loudon, J.B. (ed). *Social anthropology and medicine*. London: Academic Press.

Glick, L.B. (1998). Medicine as an ethnographic category: the Gimi of the new Guinea Highlands. In: van der Geest, S. and A. Rienks (eds.). *The art of medical anthropology*. Amsterdam: Het Spinhuis.

Glik, D.C., W.B. Ward and A. Gordon. (1989). Malaria treatment practices among mothers in Guinea. *Journal of Health and Social Behaviour* 30:421-435.

Gluckman, M. (1966). *Custom and conflict in Africa*. Oxford: Basil Blackwell.

Glynn, J.R., D.K. Warndorff, P.E.M. Fine, G.K. Msiska, M.M. Munthali and J.M. Ponnighaus. (1997). The impact of HIV on morbidity and mortality from tuberculosis in sub-Saharan Africa: a study in rural Malawi and review of literature. In: Awusabo-Asare, K., Ties Boerma, J. and Zaba, Basia. (eds). Evidence of the socio-demographic impact of AIDS in Africa. *Health Transition Review*. Supplement 2. 7:75-88.

Goward, N. (1984). The fieldwork experience. In: Ellen, E.F. (ed). *Ethnographic research: a guide to general conduct*. London: Academic Press.

Green, E.C. (1997). Purity, pollution and the invisible snake in Southern Africa. *Medical Anthropology* 17:83-100.

Green, E.C. (1998). *Indigenous theories of contagious disease*. Walnut Creek: Altamira Press.

Greenough, P. and P. Streefland. (1998). Social science and immunisation: new possibilities and projects. *Social Science Research Council* 52(1):1-15.

Greenwood, B.M. (1999). Malaria mortality and morbidity in Africa. *Bulletin of the World Health Organisation* 77:617-618.

Haak, J. and A. Hardon. 1988. Indigenised pharmaceuticals in developing countries. Widely used, widely neglected. *Lancet*, 10 September , pp 620-621.

Hadolt, B. (1998). Locating difference: a medical anthropology "at home". *Anthropology & Medicine* 5(3): 311-323.

Hahn, R.A. (1995). *Sickness and healing: an anthropological perspective*. New Haven: Yale University Press.

Hall, A.J., B.M. Greenwood and H. Whittle. (1990). Modern vaccines: practice in developing countries. *Lancet* 335(8692):774-7.

Hammond-Tooke, D. (1989). *Rituals and medicines: indigenous healing in Africa*. Johannesburg: AD. Donker (Pty) Ltd.

Hammond-Tooke, W.D. (1981). *Patrolling the herms: social structure, cosmology and pollution concepts in Southern Africa* (18th Raymond Dart Lecture). Johannesburg: Witwatersrand University Press.

Hardon, A.P. (1987). The use of modern pharmaceuticals in a Filipino village: doctor's prescription and self medication. *Social Science and Medicine* 35(3):277-292.

Hardon, A.P., P. Boonmongkon, P. Streefland, M.L. tan, S. van der Geest, A. van Staa and C. Varkevisser. (1994). *Applied health manual: anthropology of health and health care*. Den Haag: CIP – Data Koninklijke Bibliotheek.

Hastrup, K. (1995). *A passage to anthropology: between experience and theory*. London and New York: Routledge.

Hayano, D.M. (1979). Auto-ethnography: paradigms, problems and prospects. *Human Organisation* 38:99-104.

Heap, M. and M. Ramphela. (1991). The quest for wholeness: health care strategies among the residents of council-built hostels in Capetown. *Social Science and Medicine* 32(2):117-126.

Helman, C.G. (1994). *Culture, health and illness*. 3rd ed. Oxford: Butterworth Heinemann.

Holland, H. (2001). *African magic: traditional ideas that heal the continent*. London: penguin Press.

Holy, L. (1991). *Religion and custom in a Muslim society": the Berti of Sudan*. Cambridge: Cambridge University Press.

Hughes, E.C. (1974). Who studies whom? Plenary address of 33rd Annual Meeting of the Society of Applied Anthropology. *Human Organisation* 33(4):327-334.

Hunter, M. (1979). *Reaction to conquest: effects of contact with Europeans on the Pondo of South Africa*. Capetown: David Philip.

Imperato, P.J. and D.A. Traore. (1979a). Traditional beliefs about smallpox and its treatment in the Republic of Mali. In: Ademuwagun, Z.A., J.A.A. Ayoade; I.E. Harrison, and D.M. Warren (eds.). *African therapeutic systems*. Massachusetts: Crossroads Press.

Imperato, P.J. and D.A. Traore. (1979b). Traditional beliefs about measles and its treatment among the Bambara of Mali. In: Ademuwagun, Z.A., J.A.A. Ayoade; I.E. Harrison, and D.M. Warren (eds.). *African therapeutic systems*. Massachusetts:

Crossroads Press.

Ingstad, B. (1989). Healer, witch, prophet or modern health worker? The changing role of ngaka ya Setswana. In: Jacobson-Widding, A and D. Westerlund. (eds.). *Culture, experience and pluralism: essays on African illness and healing*. Uppsala: University of Uppsala.

Iyun, B.F. and E.A. Oke. (2000). Ecological and cultural barriers to treatment of childhood diarrhoea in riverine areas of Ondo State, Nigeria. *Social Science and Medicine* 50:953-964.

Jackson, A. (1987). Reflections on ethnography at home and the ASA. In: Jackson, A. (ed). *Anthropology at home*. London & New York: Tavistock Publications.

Janzen, J.M. (1978). *The quest for therapy: medical pluralism in lower Zaire*. Berkeley: University of California Press.

Jeena, P.M. and H.M. Coovada. (2001). Vaccine preventable infectious diseases. In: Kibel, M.A. and L.A. Wagstaff (eds). *Child health for all: a manual for southern Africa*. Capetown: Oxford University Press.

Johnson, T.M. and C.F. Sargent (eds). (1990). *Medical anthropology: a handbook of theory and method*. New York: Greenwood Press.

Jolles, F. and S. Jolles. (1999). Zulu ritual immunisation in perspective. *Africa* 70(2): 229-248.

Jones, D.J. (1970). Towards a native anthropology. *Human Organisation* 29:251-259.

Joralemon, D. (1999). *Exploring medical anthropology*. Boston: Allyn and Bacon.

Kalinga, O.J. (1984). The Balowoka and the establishment of states west of Lake Malawi. In: Salim, A.I. (ed). *State formation in Eastern Africa*. Nairobi: Heinemann Educational Books.

Kalla, J. (1999). "De-witching South Africa". In: *True Love*. January 1999.

Kark, S.L. and E. Kark. (1962). *A practice of social medicine: a South African team's experiences in different African communities*. Edinburgh and London: E. & S. Livingstone.

Kawango, E.A. (1995). Ethnomedical remedies and therapies in maternal and child health among the Luo. In: Sindiga, I., C. Nyaigotti-Chacha and M.P. Kanunah. (eds). *Traditional medicine in Africa*. Nairobi: East African Educational Publishers Limited.

Kendall, C. (1990). Public health and the domestic domain: lessons from anthropological research on diarrhoea diseases: In: Coreil, J. and J.D. Mull (eds). *Anthropology and primary health care*. Boulder: Westview Press.

Kengeya-Kayondo, J.F., J.A. Seeley, E. Kajura-Bajenja, E. Kabunga, E. Mubiru, F. Sembeja and D.W. Mulder. (1994). Recognition, treatment seeking behaviour and perception of cause of malaria among rural women in Uganda. *Acta Tropica* 58:267-273.

Kenyatta, J. (1938). *Facing Mount Kenya: the traditional life of the Gikuyu*. London: Heinemann.

Kiernan, J. (1996). The Zionist Congregation over time: continuity and change in social composition and structure. *African Studies* 55(2):69-88.

King, M. and E. King. (1992). *The story of medicine and disease in Malawi: the 130 years since Livingstone*. Blantyre: Montfort Press.

King County. (nd). *Communicable disease fact sheet – measles (Rubeola) –* (www.metrokc.gov/health/prevcont/meas.htm)

Kleimann, A. (1980). *Patients and healers in the context of culture: an exploration of the borderland between anthropology, medicine and psychiatry*. Berkeley: University of California Press.

Kloos, H. (1990). Utilisation of selected hospitals, health centres and health stations in central, southern and western Ethiopia. *Social Science and Medicine* 31(2):101-114.

Krige, E.J. (1965). *The social system of the Zulus*. Pietermaritzburg: Shuter and Shooter.

Kumwenda, (2001). The problem of HIV/AIDS in Malawi: how big is it? *Daily Times*, May 9, 2001.

Last, M. (1992). The importance of knowing about not knowing: observations from Hausaland. In: Feierman, S. and J.M. Janzen. (eds.). *The social basis of health and healing in Africa*. Berkeley: University of California Press.

Lansang, M.A., R. Lucas-Aquino, T.E. Tupasi, V.S. Mina, L.S. Salazar, N. Juban, T.T. Limjoco, E. Lennore and M. Calvin. (1989). Purchase of antibiotics without prescription in Manila, The Philippines: inappropriate choices and doses. *Journal of Clinical Epidemiology* 43:61-67.

Launiala, A. and H. Raijas-Walch. (1999). Biomedical and local concepts of malaria among the Baganda in Uganda. *Suomen Antropologi* 4:142-153.

Lepowsky, M. (1990). Sorcery and penicillin: treating illness on a Papua New Guinea Island. *Social Science and Medicine* 30(10):1049-1063.

Levi-Strauss, C. (1966). Anthropology: its achievements and future. *Current Anthropology* 7(2):124-127.

Lewis, B.A. (1972). *The Murle: red chiefs and black commoners*. Oxford: Clarendon Press.

Lewis, D. (1973). Anthropology and colonialism. *Current Anthropology* 14(5):581-602.

Lofgren, O. (1987). Deconstructing Swedishness: culture and class in modern Sweden. In: Jackson, A. (ed). *Anthropology at home*. London & New York: Tavistock Publications.

Lozoff, B., K.R. Kamath, and R.A. Feldman. (1975). Infection and disease in South Indian Families: beliefs about childhood diarrhoea. *Human Organisation* 34: 353-358.

Lupton, D. (1999). *Risk*. London: Routledge.

Luck, K. (2002). Conflict between the living and the dead: the patrilineage verses the individual in the training of indigenous healers. In: LeBeau, D.L. and R. Gordon (eds). *Challenges for anthropology in the African Renaissance: a Southern African contribution*. Windhoek: University of Namibia Press.

McCay, B. (1980). Medical anthropology, George M. Foster and Barbara G. Anderson. New York: John Wiley and Sons. *American Anthropologist* 82(1):145-147. (Book Review)

McElroy, A. and P. Townsend. (1998). The ecology of health and disease. In: van der Geest, S. and A. Rienks (eds). *The art of medical anthropology*. Het Spinhuis: Amsterdam.

McElroy, A. and P. Townsend. (1985). *Medical anthropology in ecological perspective*. Boulder and London: Westview Press.

Maclean, U. (1976). Some aspects of sickness behaviour among the Yoruba. In: Loudon, J.B. (ed). *Social anthropology and medicine*. London: Academic Press.

Maeir, D. (1987). "Nineteenth century Asante medical practices". In: *Comparative Studies in Society and History*. London: Frank Cass and Co.

Maina, B. (1978). *Beliefs and practices concerning treatment of measles and acute diarrhoea among the Kamba*. Nairobi: Kenya Medical Research Centre.

Malinowski, B. (1938). Introduction. In: Kenyatta, J. *Facing Mount Kenya: the traditional life of the Gikuyu*. London: Heinemann.

Malinowski, B. (1945). *The dynamics of cultural change: an enquiry into race relations in Africa*. Greenwood Press: Connecticut.

Malinowski, B. (1939). Preface. In: Fei, H-T. *Peasant life in China: a field study of country life in the Yangtze Valley*. Dutton: New York.

Manners, R.A. and D. Kaplan. (1968). *Theory in anthropology: a source book*. Chicago: Aldine

Marwick, M. (1965). *Sorcery in its social settings: a study of the Northern Rhodesian Chewa*. Manchester: Manchester University Press.

Marwick, M. (1970). Witchcraft as a social strain-gauge. In: Marwick, M. (ed). *Witchcraft and sorcery: selected readings*. Harmondsworth: Penguin.

Marwick, M. (1950). The Bwanali-Mpulumutsi anti-witchcraft movement. *Africa* 20:100-112.

Mathews, H.F. Illness classification and treatment choice: making decisions in the medical domain. In: van der Geest, S. and A. Rienks (eds.). *The art of medical anthropology*. Amsterdam: Het Spinhuis.

Maurel, M. (1994). *Malaria*. South Africa: Southern Book Publishers.

McCombie, S.C. (1996). Treatment seeking for malaria: a review of recent research. *Social Science and Medicine* 43:933-945.

Messenger, J.C. (1970). Reinterpretations of Christian and indigenous beliefs in a Nigerian nativist church. In: Middleton, J. (ed). *Black Africa: its people and their cultures today*. London: Macmillan Company.

Messerschmidt, D.A. (1981). On indigenous anthropology: some observations. *Current Anthropology* 22(2):197-198.

Mewett, P.G. (1989). Making a research topic: a continuous process. In: Perry, J. (ed). *Doing fieldwork: eight personal accounts of social research*. Geelong: Deakin University Press.

Mkandawire, A.H.C. (1968). *Mazgu yakuzizika m'Chitumbuka*. London: Oxford University Press.

Molyneux, M. (1988). Malaria in Malawi. *Society of Malawi Journal* 41(2):35-36.

Morgan, L.M. (1998). Dependency theory in the political economy of health: an anthropological critique. In: van der Geest, S. and A. Rienks (eds). *The art of medical anthropology: readings*. Amsterdam: Het Spinhuis.

Morris, B. (1985). Chewa conceptions of disease – symptoms and aetiologies. *Society of Malawi Journal* 38:14-43.

Morris, B. (1986). Herbalism and divination in southern Malawi. *Social Science and Medicine* 23:367-377.

Morsy, S.A. (1981). Towards a political economy of health: a critical note on the medical anthropology of the Middle East. *Social Science and Medicine* 15B:159-163.

Morsy, S. (1990). Political economy in medical anthropology. In: Johnson, T.M. and C.F. Sargent (eds). *Medical anthropology: a handbook of theory and method*. New York: Greenwood Press.

Msiska, S.K. (1997). *Golden buttons: Christianity and traditional religion among the Tumbuka*. Blantyre: Christian Literature Association in Malawi.

Msukwa, L.A.H. (1981). *Meeting the basic health needs of rural Malawi: an alternative strategy*. Swansea: Centre for Development Studies, University College of Swansea.

Mull, D. and D.S. Mull. (1988). Mothers' concepts of childhood diarrhoea in rural Pakistan: what ORT program planners should know. *Social Science and Medicine* 27(1):53-67.

Munthali, A.C. (2001). Management of childhood diseases among the Tumbuka of northern Malawi. *Society of Malawi Journal* 54(2):43-65

Munthali, A.C. (2001). Doing fieldwork at home: some personal experiences among the Tumbuka of northern Malawi. *The African Anthropologist* VIII(2): 114-136.

Munthali, A.C. (2002a). The prevention of disease in Africa: bio- and ethno-medical approaches. In: LeBeau, D.L. and R. Gordon (eds). *Challenges for anthropology in the African Renaissance: a Southern African contribution*. Windhoek: University of Namibia Press.

Munthali, A.C. (2002b). After Delivery: Attempts to Protect Children from *Tsempho* in a Rural Malawian Village. *Society of Malawi Journal* 55 (1): 24-37

Murdock, G.M. (1980). *Theories of illness: a world survey*. Pittsburgh: University of Pittsburgh Press.

Murdock, D. (2001). DDT: key to third world's winning war on malaria. *Human Events* 57(18):1-2.

Murray-Brown, J. (1972). *Kenya*. London: George Allen & Unwin Ltd.

Mwenesi, H., Harpham, T., and R.W. Snow. Child malaria treatment practices among mothers in Kenya. *Social Science and Medicine* 40(9):1271-1277.

Mwenesi, H.A., Harpham, T., Marsh, K., and R.W. Snow. (1995). Perceptions of severe childhood malaria among the Mijikenda and Luo residents of coastal Kenya. *Journal of Biosocial Science* 27:235-244.

Nakhleh, K. (1979). On being a native anthropologist. In: Huizer, G. and B. Mannheim. (eds). *The politics of anthropology: from colonialism and sexism toward a view from below*. The Hague: Houton.

Nanda, S. (1987). *Cultural anthropology*. 3rd ed. Belmont: Wadsworth Publishing.

Ngubane, H. (1976). *Aspects of Zulu treatment*. In: Loudon, J.B. (ed). *Social anthropology and medicine*. London: Academic Press.

Ngubane, H. (1977). *Body and mind in Zulu medicine: an ethnography of health and disease in Nyuswa-Zulu thought and practice*. London, New York and San Francisco: Academic Press.

Ngubane, H. (1981). Marriage, affinity and the ancestral realm: Zulu marriage in female perspective. In: E.J. Krige and J.L. Comaroff. *Essays on African marriage in southern Africa*. Capetown: Juta ad Company.

Nichter, M. (1990). Vaccinations in South Asia: false expectations and commanding metaphors. In: Coreil, J. and J.D. Mull (eds). *Anthropology and primary health care*. Boulder: Westview Press.

Nichter, M. (1995). Vaccination in the third world: a consideration of community demand. *Social Science and Medicine* 41(5):617-632

Niehaus, I. (2001). *Witchcraft, power and politics: exploring the occult in the South African lowveld*. Capetown: David Philips.

Nyirenda, S. (1931). History of the Tumbuka-Henga people. *Bantu Studies* 5:1-76.

Obermeyer, C.M. (2000). Risk, uncertainty, and agency: culture and safe motherhood in Morocco. *Medical Anthropology* 19: 173-201.

Offiong, D.A. (1991). *Witchcraft, sorcery, magic, and social order among the Ibibio of Nigeria*. Enugu, Nigeria : Fourth Dimension Publishers.

Offiong, D.A. (1999). Traditional healers in the Nigerian health care delivery system and the debate over integrating traditional and scientific medicine. *Anthropological Quarterly* 72(3):118-130.

Okely, J. (1987). Fieldwork up the M1: policy and political aspects. In: Jackson, A. (ed). *Anthropology at home*. London & New York: Tavistock Publications.

Onoge, O.F. (1975). Capitalism and public health: a neglected theme in the medical anthropology of Africa. In: Ingman, S.R. and A.E. Thomas (eds). *Topias and utopias in health: policy studies*. The Hague: Mouton Publishers.

Parish, H.J. (1968). *Victory with vaccines: the story of immunisation*. Edinburgh and London: E. & S. Livingstone.

Parsons, T. (1952). *The social system*. London: Tavistock Publications Limited.

Paul, B. (1955). *Health, culture and community*. New York: Russell Sage Foundation.

Pauw, B.A. (1981). Basic concepts: culture and people. In Myburgh, A.C. (ed). *Anthropology for Southern Africa*. Pretoria: J.L. van Schaik.

Pelto, P.J. and G.H. Pelto. (1973). Ethnography: the fieldwork enterprise. In: Honigmann, J.J. (ed). *Handbook of social and cultural anthropology*. Chicago: Rand McNally and Company.

Pelto, P.J., M.B. Bentley and G.H. Pelto. (1990). Applied anthropological research methods: diarrhoea studies as an example. In: Coreil, J. and J.D. Mull (eds). *Anthropology and primary health care*. Boulder: Westview Press.

Peltzer, K. (1999). Faith healing for mental and social disorders in the Northern Province (South Africa). *Journal of Religion in Africa*.

Pemberton, J. (1993). The history of Simon Kimbangu, prophet, by writers Ntinanyani and Nzangu, 1921: an introduction and annotated translation. *Journal of Religion in Africa* XXIII (3):194-231.

Perry, J. (1989). *Doing fieldwork: eight personal accounts of social research*. Geelong: Deakin University Press.

Philip, K.D. (1955). *Onani Angoni*. Blantyre: Macmillan Malawi.

Phiri, D.D. 1982. *From Nguni to Ngoni: a history of the Ngoni exodus from Zululand and Swaziland to Malawi, Tanzania and Zambia*. Blantyre: Popular Publications.

Pitts, M., J. McMaster, T. Hartman and D. Mausezahl. (1996). Lay beliefs about diarrhoeal diseases: their role in health education in a developing country. *Social Science and Medicine* 43(8):1223-1228.

Pool, R. (1994). *Dialogue and interpretation of illness: conversations in a Cameroon village*. Oxford: Berg.

Pradelles de Latour, C.H. (1995). Witchcraft and the avoidance of physical violence in Cameroon. *Journal of the Royal Anthropological Institute* 1(3): 599-609.

Prins, G. (1992). A modern history of Lozi therapeutics. In: Feierman, S. and J.M. Janzen. (eds.). *The social basis of health and healing in Africa*. Berkeley: University of California Press.

Quinn, F. (1979). "How traditional Dahomian society interpreted smallpox." In: Ademuwagun, Z.A., J.A.A. Ayoade; I.E. Harrison, and D.M. Warren (eds). *African therapeutic systems*. Massachusetts: Crossroads Press.

Radcliffe-Brown, A.R. (1950). Introduction. In: Radcliffe-Brown and D. Forde (eds). *African systems of kinship and marriage*. London: Oxford University Press.

Radyowojati, A. and H. Haak. (2002). *Determinants of antimicrobial use in the developing world*. Child Health Research Project Special Report, February 2002.

Ramakrishna, J., W.R. Brieger and J.D. Adeniyi. (1989). Treatment of malaria and febrile convulsions: an educational diagnosis of Yoruba beliefs. *International Quarterly of Health Education* 8(4):305-319.

Ranger, T.O. (1992). Godly medicine: the ambiguities of medical mission in south-eastern Tanzania, 1900-1945. In: Feierman, S. and J.M. Janzen. (eds.). *The social basis of health and healing in Africa*. Berkeley: University of California Press.

Ransford, O. (1983). "*Bid the sickness cease*": disease in the history of Black Africa. London: John Murray.

Razavi, S. (1992). Fieldwork in a familiar setting: the role of politics at the national, community and household levels. In: Devereux, S. and J. Hoddinott (eds). *Fieldwork in developing countries*. New York: Harvester Wheatsheaf.

Read, M. (1959). *Children of their fathers*. London: Methuen and Company.

Read, M. (1966). *Culture, health and disease. Social and cultural influences on health programmes in developing countries*. London: Tavistock Publications.

Redmayne, A. (1970). *Chikanga: an African diviner with an international reputation*. In: Douglas, M. (ed). *Witchcraft confessions and accusations*: London: Tavistock Publications.

Reeler, A.V. (1996). *Money and friendship: modes of empowerment in Thai health care*. Amsterdam: Het Spinhuis.

Reis, R. (1998). Resonating to pain: introspection as a tool in medical anthropology. *Anthropology and Medicine* 5(3):295-310.

Reis, R. (2000). The "wounded healer" as ideology: the work of ngoma in Swaziland. In: van Dijk, R., R. Reis and M. Spierenburg. (ed). *The quest for fruition through ngoma: the political aspects of healing in Southern Africa*. Capetown: David Philip.

Reynolds, P. (1996). *Traditional healers and childhood in Zimbabwe*. Ohio: Ohio University Press.

Reynolds-Whyte, S. (1997). *Questioning misfortune: the pragmatics of uncertainty in eastern Uganda*. Cambridge: Cambridge University Press.

Reynolds-Whyte, S. (1998). Pharmaceuticals as folk medicine: transformations in the social relations of health care in Uganda. In: van der Geest, S. and A. Rienks. (eds.). *The art of medical anthropology*. Amsterdam: Het Spinhuis.

Richards, A. (1935). A modern movement of witch finders. *Africa* 8(4):448-461.

Richards, A. (1956). *Chisungu: a girl's initiation ceremony among the Bemba of Northern Rhodesia*. London: Oxford University Press.

Saloojee, H. (2001). Diarrhoeal disease: In: Kibel, M.A. and L.A. Wagstaff (eds). *Child health for all: a manual for Southern Africa*. Capetown: Oxford University Press.

Samba, E. (2001). Preface: The malaria burden and Africa. *The American Journal of Tropical Medicine and Hygiene* 64: ii (Supplement).

Samuelsen, H. Infusions of health: the popularity of vaccinations among Bissa in Burkina Faso. *Anthropology and Medicine* 8(2/3):163-175.

Sargent, C. (1985). Witches, merchants and midwives: domains of power among urban Baliba women. In: du Toit, B.M. and I.H. Abdalla. (eds). *African healing strategies*. Owerri: Trado Medic Books.

Sarsby, J. (1984). Special problems of fieldwork in familiar settings. In Ellen, E.F. (ed). *Ethnographic research: a guide to general conduct*. London: Academic Press.

Senah, K.O. (1995). Ethnomedicine in the context of health care delivery in Ghana. In: Gallagher, E.B. and J. Subedi. (eds.). *Global perspectives on health care*. New Jersey: Prentice Hall.

Senior, M. with B. Viveash. (1997). *Health and Illness*. London: Macmillan.

Shaw, R.P. and C.C. Griffin. *Financing Health Care in Sub-Saharan Africa*. Washington, D.C.: The World Bank, 1995

Sindiga, I., C. Nyaigotti-Chacha & M.P. Kanunah. (ed). (1995). *Traditional medicine in Africa*. Nairobi: East African Educational Publishers.

Singer, M. (1989). The coming of age of critical medical anthropology. *Social Science and Medicine* 28(11):1193-1203.

Slikkerveer, L. Jan. (1990). *Plural medical societies in the horn of Africa: the legacy of "Sheikh" hypocrites*. London and New York: Kegan Paul International.

Snow, R.W., N. Peshu, D. Foster, H. Mwenesi and K. Marsh. (1992). The role of shops in the treatment and prevention of childhood malaria on the coast of Kenya. *Transactions of the Royal Society of Tropical Medicine and Hygiene* 86:237-239.

Spring, A. (1985). Health care systems in north-east Zambia. In: du Toit, B.M. and I.H. Abdalla (eds.). *African healing strategies*. Owerri: Trado-Medic Books.

Staiano, K.V. (1981). Alternative therapeutic systems in Belize: a semiotic framework. *Social Science and Medicine* 15B(3): 317-332.

Stock, R. (1985). Islamic medicine in rural Hausaland: In: du Toit, B.M. and I.H. Abdalla (eds.). *African healing strategies*. Owerri: Trado-Medic Books.

Stocking, G.W. (1983). The ethnographer's magic: fieldwork in British anthropology from Tylor to Malinowski. In: Stocking, G.W. (ed). *Observers observed: essays on ethnographic fieldwork*. Wisconsin: University of Wisconsin Press.

Streefland, P.H. (1995). Enhancing coverage and sustainability of vaccination programmes: an explanatory framework with special reference to India. *Social Science and Medicine* 41(5):647-656.

Streefland, P., M.R. Chowdhury and P. Ramoz-Jimenez. (1999). Patterns of vaccination acceptance. *Social Science and Medicine* 49:1705-1716.

Tarimo, D.S., D.P. Urassa and G.I. Msamanga. (1998). Caretaker's perceptions of clinical manifestations of childhood malaria in holo-endemic rural communities in Tanzania. *East African Medical Journal* 75(2):93-96.

Tsete, J. (1993). Health seeking behaviour of Rwandan women. *Social Science and Medicine* 37(11):1285-1292.

Tsey, K. (1997). Traditional medicine in contemporary Ghana: a public policy analysis. *Social Science and Medicine* 45(7):1065-1074.

Taylor, S.J. and Bogdan, R. (1984). *Introduction to qualitative research methods*. New York: Wiley.

Ueli, B. (1993). Oral rehydration therapy: qualitative studies of balance between pragmatism and scientific rigour in managing diarrhoea. *Social Science and Medicine* 36(4):525-531.

Ulin, P.R. (1979). The traditional healer of Botswana in a changing society. In: Ademuwagun, Z.A., J.A.A. Ayoade; I.E. Harrison, and D.M. Warren (eds.). *African therapeutic systems*. Massachusetts: Crossroads Press.

UNICEF. (2002). *The state of the world's children 2002*.

www.unicef.org/sowc02.summary.

Unni, K.R. (1979). On tracks and tracts in my fieldwork rural Kerala. In: Srinivas, M.N., A.M. Shah and E.A. Ramaswamy (ed). *The fieldworker and the field: problems and challenges in sociological investigation*. Delhi: Oxford University Press.

Urry, J. (1984). A history of field methods. In: Ellen, R.F. (ed). *Ethnographic research: a guide to general conduct*. London: Academic Press.

Vaahtera, M., T. Kulmala, K. Maleta, T. Cullinan, M.L. Salin and P. Ashorn. (2000). Childhood immunisations in rural Malawi: the time of administration and predictors of non-compliance. *Annals of Tropical Paediatrics* 20:305-312.

Vail, H.L. (1972). Suggestions towards a reinterpreted Tumbuka history. In: Pachai, B. (ed). *The early history of Malawi*. London: Longman.

van Breugel, J.W.M. (2001). *Chewa traditional religion*. Blantyre: Christian Literature Association in Malawi.

van der Geest, S. (1981). Under-the-counter medicines in developing countries. *Pharmacy International* 2(12):280-283.

van der Geest, S and A. Hardon. 1990. Self-medication in developing countries. *Journal of Administrative Pharmacy* 7(4):199-204.

van der Geest, S. (1998). Use and misuse of pharmaceuticals: anthropological comments. In: Streefland, P. (ed). *Problems and potential in international health: transdisciplinary perspectives*. Amsterdam: Het Spinhuis.

van der Geest, S. (1985). The intertwining of formal and informal medicine distribution in south Cameroon. *Canadian Journal of African Studies* 19:1569-1587.

van der Geest, S. (1987). Theoretical orientations and medical anthropology. *The Journal of Research and Education in Indian Medicine* VI(3-4):23-34.

Van der Geest, S. (1987). Unequal access to pharmaceuticals in Southern Cameroon: the context of a problem. *Studies in Third World Societies* 34:141-168.

van Dongen, E. (1998). Strangers on terra cognata: authors of the other in a mental hospital. *Anthropology and Medicine* 5(3)279-294.

van Gennep, A. (1977). *The rites of passage*. London: Routledge and Kegan Paul.

van Ginkel, R. (1998). The repatriation of anthropology: some observations on endo-ethnography. *Anthropology and Medicine* 5(3): 251-268.

van Dijk, R. (2001). Witchcraft and scepticism by proxy: Pentecostalism and laughter in urban Malawi. In: Moore, H.L. and T. Sanders (eds). *Magical interpretations, material realities: modernity, witchcraft and the occult in post-colonial Africa*. London and New York: Routledge.

Vaughan, M. (1991). *Curing their ills: colonial power and African illness*. Cambridge: Polity Press.

Ventevogel, P. (1996). *Whiteman's things: training and detrainning healers in Ghana*. Het Spinhuis: Amsterdam.

Viljoen, R.S. (1995). *Debating and debunking some myths surrounding the decline of the Overberg Khoikhoi with reference to the smallpox epidemics of 1755 and 1767*. Grahamstown: SN.

Vundule, C. and S. Mharakurwa. (1996). Knowledge, practices, and perceptions in rural communities of Zimbabwe. *Bulletin of World Health Organisation* 74(1):55-60.

Waite, G. (1992). Public health in precolonial east Africa: In: Feierman, S. and J.M. Janzen. (eds.). *The social basis of health and healing in Africa*. Berkeley: University of California Press.

Watkin, S. (2001). Malaria and mosquito. *New Internationalist* 336:7

Wax, M. (1976). Introduction. *Human Organisation* 35(4):331-333.

Way Harley, G. (1970). *Native African medicine: with special reference to its practice in the Mano tribe of Liberia*. London: Frank Cass and Co. Ltd.

Weiss, M.G. (1988). Cultural models of diarrhoeal illness: a conceptual framework and review. *Social Science and Medicine* 27:5-16.

Welcome (PTY) Limited. (1975). *The facts about malaria in Southern Africa*. Spartan, Isando: Welcome (PTY) Limited, Southern Africa.

Westerlund, D. (1989). Pluralism and change: a comparative and historical approach to African disease aetiologies. In: Jacobson-Widding, A and D. Westerlund. (eds.). *Culture, experience and pluralism: essays on African illness and healing*. Uppsala: University of Uppsala.

WHO. (2000). *WHO issues new healthy life expectancy rankings: Japan number one in new 'healthy life' system*. Washington and Geneva: WHO (Press Release 2000).

WHO-Regional Office for Africa. (2000). Malawi closes measles wards. *Vaccine Preventable Diseases Bulletin*. September 2000 Issue.

WHO and UNICEF. (2000). *Global water supply and sanitation assessment 2000 report*. New York: WHO/UNICEF.

Wilson, M. (1957). *Rituals of kinship among the Nyakyusa*. London: Oxford University Press.

Wolfers, I. (1988). Traditional practitioners and western pharmaceuticals in Sri Lanka. In: van der Geest, S. and S. Reynolds-Whyte (eds). *The context of medicines in developing countries: studies in pharmaceutical anthropology*. Dordrecht: Kluwer Academic.

Wolf-Gould, C.S., N. Taylor, S.M. Horwitz and M. Barry. (1991). Misinformation about medications in rural Ghana. *Social Science and Medicine* 33(1):83-89.

Wright, P.F. (1995). Global immunisation – a medical perspective. *Social Science and Medicine* 41:609-616.

Yamba, C.B. (1997). Cosmologies in turmoil: witch-finding and AIDS in Chiawa, Zambia. *Africa* 67(2):200-223.

Yoder, P.S. (1981). Knowledge of illness and medicine among the Cokwe of Zaire. *Social Science and Medicine* 15B:237-245.

Young, A. (1983). The relevance of traditional medical cultures to modern primary health care. *Social Science and Medicine* 17(16):1205-1211.

Young, T.C. (1932). *Notes on the history of the Tumbuka-Kamanga peoples in the northern province of Nyasaland*. London: Cass.

Zulu, E. (2001). Ethnic variations in observance and rationale for postpartum sexual abstinence in Malawi. *Demography* 38(4):467-479.

Unpublished sources

Bannerman, J.H. (1997). *Border Zone Development project: Nyika-Vwaza border zone identification and description*. Mzuzu: Office of the Regional Administrator and GTZ.

Barasa, K.W. (1999). *Perceptions of diarrhoea in children under five years of age among the Luo of Bondo Division in western Kenya*. Nairobi: University of Nairobi. (MA Thesis).

Bisika, T.J. (1996). *Malaria Case Management in Children in Malawi: The Case of Namasalima. A Report of the Rapid Ethnographic Study*. Draft Report May, 1996.

Chilowa, W.R., J.M. Kadzandira and S. Devereux. (2001). *Social policy in Southern Africa: the case of Malawi*. Zomba: Centre for social Research.

Curtis, V. (1998). *The dangers of dirt: household hygiene and health*. Wageningen: Grafisch Service Centrum (PhD Thesis - University of Wageningen, The Netherlands)

Government of Malawi. (1993). *Situation and analysis of poverty in Malawi*. Lilongwe: Government of Malawi.

Government of Malawi. (1994). *Basic health statistics 1994 report 18*. Lilongwe: Karora Printing and Publishing House Limited.

Government of Malawi – HIMSU. (1999). *Basic health statistic 1996 report 20*. Lilongwe: Capital Printing Press.

Kadzandira, J.M. and W.R. Chilowa. (2001). *The role of health surveillance assistants (HSAs) in the delivery of health services and immunisation in Malawi*. Zomba: Centre for Social Research.

LeBeau, D.L. (1999). *Seeking health: the hierarchy of resort in utilization patterns of traditional and western medicine in multi-cultural Katutula, Namibia*. Grahamstown: Rhodes University (Unpublished PhD Thesis)

Mastwijk, S. 1999. *'Insecurity is our only security': a case study into the situations of insecurity and their cultural understandings of the Tumbuka in Kabenga, Malawi*. Wageningen: Wageningen Agricultural University (Unpublished MA Thesis).

Matinga, P.U. and A. Munthali. (2001). *An ethnographic study on malaria in five selected districts in Malawi* (Final report submitted to UNICEF Malawi, Lilongwe).

Mavhungu, K.N. (2000). *Witchcraft beliefs, practices and institutions in Venda, Northern Province: beyond social strain gauge and modernity explanations*. (Paper presented at the AASA conference, University of Namibia, Windhoek, May 2000).

Ministry of Economic Planning and Development, National Statistical Office and Centre for Social Research. 1996. *Malawi social indicators survey 1995*. Lilongwe: United Nations Children's Fund.

Ministry of Health and Population. (1995). *Health policy framework*. Lilongwe: MoH&P.

Ministry of Health and Population. (1996). *Basic health statistics*. Lilongwe: Ministry of Health and Population.

Ministry of Health and Population. (1999a). *To the year 2020: a vision for the health sector in Malawi*. Lilongwe: MoH&P.

Ministry of Health and Population. (1999b). *Malawi national health plan 1999-2004*. Lilongwe: Capital Printing Press.

Ministry of Health and Population - HMISU. (1999). *Basic health statistics 1996 report 20*. Lilongwe: Capital Printing Press.

Mkandawire, L. (1998). *Child bearing practices of Malawian women: a response to maternal and infant mortality*. Syracuse: Syracuse University (BSc in Nursing Honours Thesis)

Munthali, A. (2000). *The prevention of disease in Africa: ethno- and biomedical approaches*. Paper presented at the Association of Anthropology in Southern Africa conference, University of Namibia, Windhoek, May 2000.

Munthali, A. (2001). *Coping with the impacts of the HIV/AIDS pandemic: some lessons from Malawi*. (Draft submitted to UNRISD for review for publication, September 2001).

Munthali, A. (1999). *Changing modes in childhood diseases prevention in a rural village in Malawi*. Amsterdam: University of Amsterdam (MA Thesis).

Mvula, P. and A. Munthali. (1997). *Managing external health resources in the health sector in Malawi*. London: London School of Hygiene and Tropical Medicine.

National Statistical Office. (1992). *Demographic and health survey: a preliminary report*. Zomba: National Statistical Office.

National Statistical Office. (1998). *Population and housing census: report on preliminary results*. Zomba: National Statistical Office.

National Statistical Office. (2000). *Demographic and health survey: a preliminary report*. Zomba: National Statistical Office.

Strategic Planning Unit and national AIDS Control Programme. (1999). *Malawi's national response to HIV/AIDS for 2000-2004: combating HIV/AIDS with renewed hope and vigour in the new millennium*. Lilongwe: SPU and NACP.

Stroeftland, P.H. and I. Egers. (1997). *How vaccination practice developed in the Netherlands*. Paper presented at the workshop on immunisation and the State, Delhi, 16-16 January, 1997).

Tsoka, M.G., A. Kazembe and J. Chipala. (1997). *Drug revolving funds: a healthy strategy – lessons from the present for the future DRF management*. Draft Report for the PHN Project of the Ministry of Health and Population.

United Nations and Government of Malawi. (1993). *Situation analysis of poverty in Malawi*. Lilongwe: UN and GoM.

van Reeuwijk, M. (2000). *Children in Tcheti: their ideas and practices concerning dirt, hygiene and disease transmission – diarrhoea and other gastro-intestinal diseases*. Amsterdam: University of Amsterdam (Unpublished MA Thesis).

Websites quoted

www.babybag/articles/cdc_meas.htm

www.idsociety.org

www.tulane.edu/~dmsander/Tutorials/Pox/Pox.html

www.encyclopadia.com

www.who.int/inf-new/child3.htm

www.metrokc.gov/health/prevcont/measles.htm

www.cdc.gov/nip/publications/pink/meas.pdf

APPENDIX 1: HOUSEHOLD QUESTIONNAIRE

Identification

Name of Interviewer	
Date and Time of Interview	
Date and Time Checked by Researcher	

Q1. May I know your name?

Q2. How old are you?

Q3. Sex of Respondent 1=Male, 2=Female

Q4. Who is the head of this household?

Q5. Sex of head of household 1=Male, 2=Female

Q6. Including yourself, how many people live in this household?

(For each of the persons counted above, please provide me with their particulars as in the chart on the next page).

PERSONAL IDENTIFICATION		DEMOGRAPHIC CHARACTERISTICS						
ID. No.	Q7 Name of member of household living here starting with the Head of Household	Q8 Sex of member of Household	Q9 Age of member of household	Q10 Marital status of member of household	Q11 Relation to Head of Household	Q12 Occupation if older than 15 years	Q13 Highest education level attained	Q14 If no education, can he or she read and/or write
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								

Are there any members of the household who live or work away from home?

NAME	Q15 DATE OF BIRTH	Q16 RELATIONSHIP TO HEAD OF HOUSEHOLD	Q17 SEX	Q18 LEVEL OF EDUCATION	Q19 OCCUPATION	Q20 HOW OFTEN ARE THEY HOME	Q21 MARITAL STATUS

CHILDREN AGED BELOW FIVE YEARS	Health seeking during an illness episode			
	Q22 Did this child (name) suffer from any illness the past two months	Q23 If yes, what was the illness	Q24 What was the initial action taken when it was discovered?	Q24 If no action was taken, why?
1				
2				
3				
4				
5				
6				

QUALITY OF MAIN HOUSE

For each of the following features of the main house, state their major condition:

Q25. Walls

- 1 Poles and mud walls
- 2 Compacted earth walls
- 3 Sun-dried brick walls
- 4 Burnt brick walls

Q26 Roof

- 1 Grass thatched roof
- 2 Tiled roof
- 3 Iron sheet roof
- 4 Cement sheet roof

Q27 Floor

- 1 Cement floor

2 Mud floor

Q28 Windows

- 1 Wooden windows
- 2 Grass windows
- 3 Glass windows
- 4 No windows
- 5 Other

TOILET OWNERSHIP

Q29 Does the household own a toilet

- 1 Yes
- 2 No

Q30 If yes, what kind of toilet facility does your household use?

- 1 VIP Latrine
- 2 Latrine with san plat
- 3 Traditional latrine
- 4 Other

Q31 If no to question 29, where do household members usually defecate?

- 1 Bush
- 2 Neighbour's toilet

SOURCE OF WATER, ENERGY AND WASTE DISPOSAL

Q32 What is the household's major source of water for domestic use?

- 1 River
- 2 Protected well
- 3 Unprotected well
- 4 Borehole
- 5 Piped water supply
- 6 Other specify

Q33 How do you dispose of your rubbish?

- 1 Burn
- 2 Dumped in a special place (pit)
- 3 Thrown anywhere
- 4 Buried
- 5 Other specify

Q34 What is the main source of energy for lightning?

- 1 Paraffin
- 2 Candles
- 3 Wood
- 4 Grass
- 5 Other specify

Q35 What is the main source of energy for cooking?

- 1 Collected firewood
- 2 Purchased firewood
- 3 Made charcoal
- 4 Purchased charcoal
- 5 Paraffin
- 6 Crop residues
- 7 Manure
- 8 Other specify

SOME ECONOMIC CHARACTERISTICS

Does this household own any of the following?

Q36 Property items (Circle those owned)

- 1 Bicycle
- 2 Plough/Ridger
- 3 Sewing machine
- 4 Ox-Cart
- 5 Beds
- 6 Radio
- 7 Cupboards
- 8 Tables
- 9 Chairs
- 10 Other Specify

Q37 Livestock owned (Circle those owned and specify number)

- 1 Cattle
 - Oxen*
 - Bulls*
 - Heifers*
 - Tollies*
- 2 Sheep
- 3 Goats
- 4 Pigs
- 5 Chicken
- 6 Pigeons
- 7 Ducks
- 8 Other specify

INCOME SOURCES

Q38 What is the first major source of cash income for this household (Tick one)

- 1 Crop sales
- 2 Livestock sales
- 3 Small business
- 4 Income transfers
- 5 Salaried farm employment
- 6 Salaried non-farm employment
- 7 Ganyu on the farm
- 8 Other ganyu

- 9 Pension
- 10 Other specify

Q39 What are the other sources of cash income for this household? (Tick one)

- 1 Crop sales
- 2 Livestock sales
- 3 Small business
- 4 Income transfers
- 5 Salaried farm employment
- 6 Salaried non-farm employment
- 7 Ganyu on the farm
- 8 Other ganyu
- 9 Pension
- 10 Other specify

HOUSEHOLD FOOD PRODUCTION AND CONSUMPTION

Q40 What crops did you grow last year?

- 1 Maize
- 2 Vegetables
 - Pumpkin leaves*
 - Cabbage*
 - Rape*
 - Potatoes*
- 3 Pulses
- 4 Millet
- 5 Potatoes
- 6 Sorghum
- 7 Cotton
- 8 Groundnut
- 9 Other specify

Q41 Did you produce adequate food to meet your household food requirements throughout last year until this year's harvest (not food that you bought)?

- 1 Yes
- 2 No

(If yes, go to Q46)

Q42 For how many months did you run out of food?

Q43 During which months did your household run out of food?

- 1 January
- 2 February
- 3 March
- 4 April
- 5 May
- 6 June
- 7 July
- 8 August

9 September
10 October
11 November
12 December

Q44 What did you do to meet your household food requirements?

- 1 Purchase from ADMARC
- 2 Purchase from local market
- 3 Food transfers from relatives
- 4 Food transfers from NGO/Government
- 5 Ganyu labour for food
- 6 Begging
- 7 Credit from money lenders
- 8 bartering beer for food
- 9 Other specify

Q45 When you run out of food what food did you buy?

- 1
- 2
- 3
- 4

Q44 How many meals per day do you have now? Record and get some detailed information especially for children.

Q45 How many meals per day do you usually get during the food shortage months?

Q46 Given a checklist of the food items on the following page, ascertain those consumed and their frequency of consumption during the stated period of time.

Food item	Frequency			
	Daily	Weekly	Fortnightly	Monthly
A. PROTEIN FOODS				
Meat and its products				
Poultry and its products				
Fish				
Beans and other pulses				
Others specify				
B. VEGETABLES				
Dark green leaves (specify)				
Pumpkin leaves				
Tubers				
Carrots				
Tomatoes				
Other specify				
C. FRUITS				
Citrus fruits				
Guavas				
Wild fruits				
Papaya				
Other specify				
D. OILS, FATS AND MINERALS				
Cooking oil				
Meat fat				
Groundnut				
Milk (powdered)				
Milk (fresh)				
Other specify				
E. CARBOHYDRATES				
Cereals (purchased)				
Cereals (cultivated)				
Cassava				
Potatoes				
Sugarcane				
Pumpkins				
Other specify				
F. BEVERAGES				
Gruel				
Coffee				
Tea				
Other specify				

ACCESS TO AND USE OF FACILITIES

For each of the following facilities, state their distance from your household, the means you usually go to them and whether any member of your household uses them.

FACILITY	DISTANCE	MEANS OF GETTING THERE	DID YOU USE IT IN THE PAST TWO MONTHS
Produce market (e.g. ADMARC)			
Local market			
Primary school			
Secondary school			
Health facility <i>i. Outreach clinic</i> <i>ii. Health Post</i> <i>iii. Health Centre</i> <i>iv. Dispensary</i> <i>v. District Hospital</i> <i>vi. Mission Hospital</i>			
Bus stage			
Water for domestic use			
Firewood			
Trading centre			
Postal Agency/Office			
Church			

Options: 1=Foot, 2=Bicycle, 3=Oxcart, 4=Motor vehicle/Bus, 5=Other specify

THIS IS THE END. THANK YOU VERY MUCH FOR YOUR COOPERATION.

APPENDIX 2: GUIDELINES WITH KEY INFORMANT INTERVIEWS

I. Becoming a traditional healer and duties and responsibilities (for traditional healers only)

- Description of how he or she became a healer and for how long he or she has practiced.
- The type of work he is involved in (treatment, divination, disease prevention et cetera).
- Major health and other related problems brought to his attention.

II. The Traditional healers' and other peoples' personal experiences

- Age of youngest child or member of household.
- Was this child ill over the past two months? If yes what did he or she suffer from?
- Cause, signs and symptoms of this illness.
- Initial treatment and subsequent treatments if the initial one did not work.
- If the initial treatment did not work, any explanations?
- Could this illness have been prevented? If yes how? Explore both biomedical and indigenous illness prevention measures.

III. Diseases threatening under-five children in the area

- Names of diseases threatening and prevalent among under-five children in the area.
- Characteristics of children particularly vulnerable to these diseases (probe for age, seasonality, taboos etc).
- Causes of these diseases.
- Initial treatment for each disease mentioned and reasons for choosing that form of treatment.
- What happens when the initial treatment does not work?

IV. Prevention of under-five children

- How can diseases mentioned in Part III be prevented?
- Description of how preventive measures work?
- Can these measures fail to work?
- If they can fail, what might be the possible explanations?
- Are there groups of diseases that cannot be prevented? Probe.
- Any views about biomedical immunisations and how these differ or are similar to indigenous forms of immunisation?

V. Relationship with other traditional healers and the Ministry of Health and Population (mostly for traditional healers)

- Possible explanations of why treatment may sometimes fail to work as expected.
- Does he or she refer patients to other people/institutions?
- If yes, for which types of illness and at what point?
- Does he or she get referrals from other people or institutions?
- If yes for what type of illnesses?
- What problems does he or she face in his or her work? Is there anything that can be done to improve what he does?

(Apart from the questions that were specifically for traditional healers, the above guidelines were also used during the in-depth interview with mothers with under-five children and elderly women).

