

# **Euthanasia and the experiences of the Shona People of Zimbabwe**

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**Fainos Mangena**

**Department of Religious Studies, Classics and Philosophy**

**University of Zimbabwe**

**Zimbabwe**

**[fainosmangena@gmail.com](mailto:fainosmangena@gmail.com)**

**and**

**Ezra Chitando**

**Department of Religious Studies, Classics and Philosophy**

**University of Zimbabwe**

**Zimbabwe**

**[Chitsa21@yahoo.com](mailto:Chitsa21@yahoo.com)**

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**[thoughtandpractice@gmail.com](mailto:thoughtandpractice@gmail.com)**

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## Abstract

In this paper, we critically reflect on the concept of Euthanasia as understood in the West and in Africa, and especially in sub-Saharan Africa. From the Western block, we rely on the contributions of Ronald Otremba and James Rachels. In our view, Otremba represents the Traditional Western view of euthanasia, which holds that life is sacrosanct and therefore ought not to be taken away for whatever reasons. Otremba's defense of passive euthanasia over active euthanasia stems from this understanding. Rachels, on the other hand, does not see any morally significant difference between active and passive euthanasia, for the simple reason that the result is the same - death. Next, as we examine the African view of euthanasia with special reference to Munyaradzi Mawere's interpretation of the Shona position on it, we want to ascertain whether or not there is something that can be called African euthanasia, and if not, whether or not the understanding of euthanasia in Africa has Western roots.

## Key words

Euthanasia, active euthanasia, passive euthanasia, consent, pre-colonial Shona society

## Introduction

Incisive research into the concept of euthanasia is very scarce in Zimbabwe: only Munyaradzi Mawere's article titled "The Shona Conception of Euthanasia: A Quest to Depart from Zimbabwe Tradition" (2009) has delved into this subject at considerable depth. It is our submission that although Mawere has done a sterling job as the first Zimbabwean to discuss the morality of euthanasia from the perspective of the Shona<sup>1</sup> people of Zimbabwe, it is not clear whether the idea of euthanasia that he is referring to has African roots, or it is simply an application of the Western concept of euthanasia to the Shona context.

In this paper, we interrogate Mawere's discussion on euthanasia and expose its deficiencies. We set out by defining the term *euthanasia*, focusing on the decision-making processes involved in its administration, as well as on its practical aspects. We then explore the merits and de-merits of the traditional Western view of euthanasia, focusing on the contributions of

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<sup>1</sup>The Shona people constitute the largest ethnic group in Zimbabwe, and the Shona language has six different dialects, namely, *Karanga*, *Korekore*, *Kalanga*, *Manyika*, *ZezeruandNdau* (See Mangena 2012, 63-64).

Ronald Otremba and James Rachels. Next, we reflect on the Shona people's perceptions of euthanasia as interpreted by Mawere (2009, 101-115). In this regard, we are guided by the following questions:

- Are the requirements for the definition of euthanasia by the West - which Mawere seems to be endorsing without critical thought - cast in stone?
- Could there be a distinctively African type of euthanasia which does not need to satisfy the criteria for euthanasia as defined by the West?

As we seek to answer the questions above, we cite several cases in Shona society which, in our view, have some striking similarities with the Western conception of euthanasia. We seek to determine whether or not these cases point to the idea of euthanasia as understood in the West, or if they point to an idea of euthanasia that is rooted in Africa.

### **Euthanasia: Definitions and Distinctions**

*The Daily News* of July 5, 2013 carried a story on its second page titled: "Family advised to turn-off Mandela's life support". According to this story, doctors treating Nelson Mandela said he was in a "permanent vegetative state", and advised his family to turn-off his life support machine (*The Daily News*, 2013, 2). The story further claimed that "Rather than prolonging his suffering, the Mandela family is exploring this option as a very real probability" (2013, 2).

This story and many others have re-ignited the long-standing debate on whether the practice of euthanasia - which it alludes to - is conceivable in Africa. We would not be surprised if Zimbabweans and South Africans who read that story were to be shocked by the move by these South African doctors, and also by the fact that the Mandela family seemed to be buying into this idea, given that in Africa, it is not every day that one hears about euthanasia being administered in hospitals. For many contemporary Africans, the very thought of euthanasia is unacceptable, as they are convinced that their culture prioritizes and protects life in all circumstances. At best, the idea of euthanasia largely remains foreign. With regard to the Mandela case, prominent Zimbabwean sociologist, Claude Mararike, remarks:

Harbouring such feelings, as the Mandela family did, is tantamount to *kuroya* (practicing witchcraft). The mere thought of entertaining the idea of allowing doctors to turn-off Mandela's life support machine (passive euthanasia) by the Mandela family is in itself a failure to appreciate how the African values life (Mararike 2013).

Mararike (2013) argues that African,s particularly the Shona people of Zimbabwe, consider *kuroya* as one of the worst evils on earth, and that it is as good as murder itself. Mararike (2013) also believes that Africans value life because they are afraid of the menacing *ngozi* (avenging spirits) which may come back to haunt them in the long run (cf. Mawere 2009, 106; Mangena2012, 70). However, as we shall see later in this paper, this is not to suggest that as Africans we do not have cases that have striking similarities with the Western concept of euthanasia. In the meantime, we will sample the definitions of euthanasia available, and outline and explain the decision-making processes involved in its administration.

According to Campbell and Collinson (1988, 121), an act of euthanasia involves at least two people. Campbell and Collinson argue that when defining euthanasia, one must consider the rationality and morality of any decisions taken by the one who is to die (the patient) or his or her family representative (the significant other), inasmuch as one must also consider the rationality and morality of the decisions taken by the one who will administer the act of euthanasia (the physician), and the setting in which it will be administered (Campbell and Collinson 1988, 121).

Yet what is even more critical in the definition of euthanasia is the issue of considering the rationality and morality of any decisions to be made by the patient or his or her family representative, as these point to the importance attached to patient autonomy in all discourses involving the practice of euthanasia. So, what is euthanasia? Etymologically, the term *euthanasia* has Greek roots, with *eu* meaning “well” or “good”, and *thanatos* meaning death. Thus *euthanasia* literally means “good death” (Mackinnon 1998, 24; Kuhse 1991). Closely related to this definition is the one by *the Concise Oxford Dictionary*, which defines *euthanasia* as gentle and easy death, and the bringing about of this in cases of incurable and painful disease(*The Oxford English Dictionary* 1989, 444). Both definitions require further interrogation.

With regard to the first definition, it is important to note that while the term itself implies that there can be a good death, in itself, it does not tell us when or under what conditions death is good, that is, is good death one that comes suddenly or after some time to think about and prepare for it? Is it one that takes place at home and in familiar surroundings or one that occurs in a medical facility? Is it one that we know is coming and over which we have control or one that comes upon us without notice? (Mackinnon 1998, 124-125).

The problem with the second definition is that it does not tell us whether or not *euthanasia* is the same as *murder*. All sorts of murders might be procured in ways which are “gentle and easy” without there being the slightest temptation to call them acts of euthanasia. The distinction between euthanasia and murder is clarified by Phillipa Foot (1978, 34), who asserts that “it is the qualification that the killing must be done for the sake of the one who is to die that will distinguish euthanasia from straightforward death.” By extension, it is the imperative that the death satisfies the four criteria cited above that will also distinguish euthanasia from straightforward death.

We have no doubt that the questions raised above regarding the first definition of euthanasia have no easy answers. We also have no doubt that the issue of the distinction between euthanasia and murder is critical if we are to adequately understand the concept of euthanasia.

Nevertheless, we do not intend to spend considerable time discussing these questions and raising alarm on the issue of the distinction between euthanasia and murder. Instead, we are keen to find out if the concept of euthanasia is present in indigenous African thought. However, before we do this, it is critical to outline and reflect on the decision-making processes involved in the administration of euthanasia. These decision-making processes, which also serve as sub-types of euthanasia, are *Voluntary*, *involuntary* and *non-voluntary* euthanasia. It is at this level that ethical issues on euthanasia arise. *Voluntary euthanasia* occurs when the person whose life is at stake makes a decision about what is to be done (Mackinnon 1998, 128). In short, the person whose life is at stake is the one who requests to die because of his or her unbearable condition. *Involuntary euthanasia* takes place when the physician, upon careful moral assessment, decides to end the patient’s life - especially if recovery is not reasonably expected. This decision can be taken even if the patient clearly expresses a wish to live (Campbell and Collinson 1988, 23).

Those who initiate the death of a person normally appeal to the principle of mercy which establishes two important duties, namely, “the duty not to cause further pain and suffering” and “the duty to end pain and suffering already occurring” (McDonald 1981, 160). *Non-voluntary euthanasia* is administered in cases where people cannot make informed consent probably because they are very young children (newborns), severely brain damaged or they are adults in a vegetative state. In such cases, neither consent nor the lack of it can be said to be a factor (Campbell and Collinson 1988, 123).

At the level of implementation, two things happen: *Either* the physician decides to end the life of the patient actively, that is, by administering a lethal injection, prescribing an overdose of sleeping tablets or other means on grounds of mercy, *or* the physician may simply decide to do nothing to prevent death from occurring (May 1994).

Having defined euthanasia, we shall next consider the contributions of two Western moral philosophers on this issue, namely, Otremba (1995) and Rachels (cited in Mappes and Zembaty 1997).

### Western Conceptions of Euthanasia

The distinction between active and passive euthanasia is crucial in Western Medical Ethics. The idea is that it is permissible, at least in some cases, to withhold treatment to allow a patient to die, but never permissible to take any direct action designed to kill the patient (Otremba cited in Mappes and Zembaty 1997, 61). This doctrine seems to be acceptable to most medical doctors in the West. For example, it is endorsed in a statement by the House of Delegates of the American Medical Association as follows:

The intentional termination of the life of one human being by another - mercy killing - is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association. The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family (AMA extract, in Mappes and Zembaty 1997, 61).

Ronald Otremba is one of the defenders of the traditional Western view of euthanasia, which holds that passive euthanasia is morally permissible while active euthanasia is not. In defending this claim, Otremba (1995, 22) dismisses active Euthanasia for two reasons. *First*, it violates the principle that life itself is intrinsically valuable. This value is independent of one's physical or mental state of health, and is based on the principle that God is the sole creator of life and has sovereign authority over life and death. *Second*, Otremba argues that although the principle of autonomy states that the individual has a right to self-determination, this principle is not absolute, as it is subject to a higher authority or good.

However, in his response to the Traditional Western view of euthanasia in general and to Otremba in particular, James Rachels begins by giving an example which seeks to illustrate that there is no moral difference between active and passive euthanasia. He begins his argument thus:

A patient who is dying of incurable cancer of the throat is in terrible pain, which can no longer be alleviated. He is certain to die within a few days, even if present treatment is continued but he does not want to go on living for those days since the pain is incurable. So he asks the doctor for an end to it and his family joins in this respect (Rachels quoted in Mappes and Zembaty 1997, 62).

Rachels calls on us to suppose the doctor agrees to withhold treatment, as the conventional doctrine says he may. The justification for doing this would be that the patient is in terrible agony, and since he or she is going to die anyway, it would be wrong to prolong his or her suffering needlessly. But now notice this: if one simply withholds treatment, it may take the patient longer to die, and so he or she may suffer more than he or she would if more direct action were taken and a lethal injection given. For Rachels, this fact provides a strong reason for thinking that once the initial decision not to prolong his or her agony has been made, active euthanasia is actually preferable to passive euthanasia, rather than the reverse (Rachels quoted in Mappes and Zembaty 1997, 62).

Rachels proffers a further illustration to support his view that there is no morally significant difference between active and passive euthanasia:

In the first example, Smith stands to gain a large inheritance if anything should happen to his six year old cousin. One evening while the child is taking his bath, Smith sneaks into the bathroom and drowns the child and then arranges things so that it will look like an accident. In the second, Jones also stands to gain if anything happens to his six year old cousin. Like Smith, Jones sneaks in planning to drown the child in his bath. However, just as he enters the bathroom, Jones sees the child slip and hit his head, and fall face down in the water. Jones is delighted; he stands by, ready to push the child's head back under if it is necessary, but it is not necessary. With only a little thrashing about the child drowns all by himself, "accidentally," as Jones watches and does nothing (Rachels quoted in Mappes and Zembaty 1997, 63).

Rachels argues that Smith killed the child, while Jones "merely" let the child die: that is the only difference between them. Did either man behave better, from a moral point of view? If the difference between killing and letting die were in itself a morally important matter, one should say that Jones' behavior was less reprehensible than Smith's (Rachels cited in Mappes and Zembaty 1997, 63). Rachels argues that the cases of euthanasia with which doctors are concerned are not like this at all: they do not involve personal gain or the destruction of normally healthy children. Instead, doctors are concerned only with cases in which the patient's life is of no further use to him or her, or in which his or her life has become or will soon become a terrible burden. However, for Rachels, the point is the same in these cases: the

bare difference between killing and letting die does not, in itself, make a moral difference (Rachels cited in Mappes and Zembaty 1997, 64).

### **Euthanasia and the Shona Experience**

Having outlined the two extreme views in the Western conception of euthanasia as represented by Otremba and Rachels, we now turn to euthanasia and the African experience. We are very careful not to use the phrase “the African view of euthanasia”, for this would imply that we have something called “African euthanasia” which is different from “euthanasia in Africa”, and yet this is the subject of our investigation. The designation “African euthanasia” means euthanasia that originates from Africa, while the designation “euthanasia in Africa” refers to euthanasia that is found in Africa but has Western origins. As we reflect on euthanasia and the African experience, we begin our discussion by re-visiting Munyaradzi Mawere’s position on euthanasia, especially among the Shona people of Zimbabwe.

#### **Munyaradzi Mawere on Euthanasia among the Shona**

In an article titled “The Shona Conception of Euthanasia: A Quest to Depart from Zimbabwe Tradition”, Munyaradzi Mawere (2009, 101-116) asserts that the Shona people are against the idea of euthanasia, and that their opposition to it is cultural, and is captured in Shona proverbs (*tsumo*), idioms (*madimikira*) and folktales (*ngano*) (Mawere 2009, 105). He also thinks that the Western view of euthanasia is basically the same as the Shona one (Mawere 2009, 105). For instance, he quotes Thomas Aquinas who argues that “everything naturally loves itself and, every part as such belongs to whole which translates to the point that every man is part of the community” (Mawere 2009, 105).

Mawere also quotes McDonald (1998, 159) who postulates that by having his or her life terminated, the patient injures himself or herself and the community to which he or she belongs. For the Shona, choosing death in whatever circumstances is considered harmful, destructive and a loss not only to the bearer of the life, but also to family, friends and the community to which the one whose life is terminated is a member (Mawere 2009, 105). Mawere cites a proverb which points to the fact that the Shona people are against euthanasia: “*Murwere haa rerwi nebonde*” (“A sick person cannot be nursed by a sleeping mat”). For Mawere, nursing a sick person by means of a sleeping mat is like applying passive euthanasia



to him or her (Mawere 2009, 106). Thus according to Mawere, the Shona people are not only against active euthanasia, but passive euthanasia as well.

In addition, Mawere believes that in Shona culture, people involved in all forms of killing including euthanasia risk being haunted by *ngozi* (avenging spirits) of the people they will have killed (Mawere 2009, 106). With reference to the mode of operation of *ngozi*, Mangena (2012, 70) reports that *ngozi* may strike viciously by not only targeting the perpetrator of the crime, but also his kinsmen. Mangena shares this position with Emmanuel Ribeiro (cited in Mawere 2009, 106), who notes that the avenging spirit can cause a series of inexplicable deaths, diseases and other inexplicable misfortunes on the murderer and his or her family.

Furthermore, Mawere remarks that the other Shona proverb which shows that euthanasia is not tolerated in Shona culture is “*Usarasa chirimumaoko nekuombera* (“Do not lose what is already in your hands by clapping”). He thinks that this proverb can be applied to life itself - that a patient should be contented with the life he or she has, as no one knows what the future holds or whether there is another life beyond the grave. Mawere cites a scholar by the name J.G. Williams, whose slippery slope argument on euthanasia is comparable to the attitude of the Shona people as he observes that “if a person who is apparently hopelessly ill may be allowed to take his own life, then he may be permitted to deputize others to do it for him should he no longer be able to act ... This may incline other people to act on behalf of other patients who have not authorized them to exercise their judgment.”

Having reflected on the position of the Shona people on euthanasia which, for Mawere, stipulates that euthanasia is always wrong, Mawere recommends a moderate view of euthanasia. According to this latter view, euthanasia is not a fundamental right for anyone, but rather a *prima facie* obligation, so that each case ought to be treated as special in its own right. This means that the moral rightness or wrongness of euthanasia is determined by the circumstances that surround each case (Mawere 2009, 109). In short, Mawere believes that there are cases in Shona society that should warrant euthanasia and others that should not. He gives the example of the defective newborns, that is, children born with blindness, deafness and extremely low intelligent quotient that must have all their needs taken care of by others. He thinks that life is meaningless to such children, and that they should be allowed to forego such lives: “Though some would say that the prospective lives of many defective newborns are modestly pleasant ... justice will be done if such lives are terminated” (Mawere 2009, 110).

Mawere gives another example of a thirty year old man who is critically injured in a car accident, resulting in the amputation of his hands and legs; he has become blind and his face is deformed; his body is continually bleeding and he is not sleeping at night because of unbearable pain, and he has lost a bit of his sanity as a result. For Mawere, this case will warrant euthanasia, as any fair-minded person would judge that this kind of life is not worth living (Mawere 2009, 111).

It is clear that throughout his reflections, Mawere is not asking: “Does euthanasia exist in Shona society?” Instead, he is asking: “What are the moral issues surrounding the administration of euthanasia in Shona society?” To him the question of whether or not euthanasia exists in Shona society is not that important. In contrast to Mawere, We consider this to be a pertinent question which we are trying to address. What do we make of Mawere’s assertion that the Shona have a dismissive approach to the question of euthanasia? What do we make of his moderate view?

In our opinion, it is misleading for Mawere to suggest that euthanasia is always unacceptable in Shona society even before he establishes whether or not it existed in that society, and if it did, whether or not it continues to exist in it today: Mawere should have undertaken thorough research before making such a claim. In fact, our research findings, which are based on oral literature, indicate that in pre-colonial Shona society, certain cases of “euthanasia” were sanctioned. However, we are not sure whether these were explicit cases of euthanasia as defined by Campbell and Collinson (1988), Foot(1978), Otremba (1995) and Rachels (cited in Mappes and Zembaty 1997). This is why we are putting quotation marks around the word euthanasia - to show that it is a contestable concept. Nevertheless, we think that the present generation of the Shona people may still believe in euthanasia because it is not alien to their culture. Below we outline and examine these cases.

### **Cases of “Euthanasia” in Pre-colonial Shona Society?**

As we explore the idea of euthanasia beyond the confines of Europe and America, it is important not to lose sight of the fact that we are dealing with concepts that vary from culture to culture. For instance, we have noted that in the context of the West, euthanasia has been defined within the framework of four critical aspects, namely, the Physician, the Patient, the Significant Other and the Clinical setting. We have also seen that in the context of the West, the concept of informed or proxy consent on the part of the patient is of critical importance.

Other cultures may consider different sets of issues to be pivotal in determining whether or not to facilitate “euthanasia”.

It seems that without either informed or proxy consent, it would be difficult to say an act of euthanasia has taken place - a view supported by scholars such as Campbell and Collinson (1988), Foot (1978), Otremba (1995) and Rachels (cited in Mappes and Zembaty 1997). While this is the case with regard to the Western conception of euthanasia, we are of the opinion that the Shona experience is somewhat different. Indeed, Africa is awash with cases that somehow point to euthanasia, but do not satisfy each of the four aspects we mentioned above, namely, the physician, the patient, the significant other, and the clinical setting. Our task is to determine whether or not these are cases of euthanasia in the African sense, and, more specifically, in the Shona sense. Below we examine some of the cases in pre-colonial Shona society, where oral literature attests to the fact that the idea of killing to alleviate suffering was in existence. In a wide ranging interview with Sekuru Jimitias Karevo (82) of Harare but who is originally from Matepatepa in Bindura, we learnt that cases of killing for the benefit of the sick or the terminally ill were common in pre-colonial Shona society.

Karevo begins by citing a case in which an elderly person, preferably a man, would get into the room of a terminally ill person as if to assess his or her condition, and strangle him or her to death, after which he would close his or her eyes and mouth (Karevo 2013). Upon leaving the room, he would pronounce the person dead to those waiting to enter the room. This was done out of the realization that the terminally ill person had endured much pain, and that there was need to “help” him or her to rest.

Mararike (2013) also cites a number of cases in Shona society in which killings were administered to alleviate suffering or to fix a social problem. He begins by citing a case involving people who were suffering from leprosy:

*Munguvadzekare, vanhu vane maperembudzi vaiswakumusasa kunze kwemusha kutivasasangana nevanhu vasina, ndikokwavaipirwa chikafu asivaizongopedzisira vafavariikoko nokuti vanga vasingarapwi sezvo kwakanga kusinamushonga wemaperembudzi.*

(In pre-colonial Zimbabwe, people afflicted with leprosy were isolated so that they would not come in contact with the rest of the group and they would normally die as there was no cure for the disease).

Mararike (2013) further notes that such killings were not only applied to the terminally ill, as certain circumstances, including famine and war, also forced society to administer them:

During times of famine, families would choose to starve to death those who were advanced in age in order to save children. In times of war, families would run away from their enemies but because of the extended nature of most traditional families, it was difficult to run away as a group so it was a common practice to run away leaving behind those who were advanced in age and they would die as a result of fatigue or attack by enemies (Mararike 2013).

We found out that in other instances, some Shona communities would perform a ritual that involved the setting up of a *riva* (mystical trap) at a hidden place on a mountain. As long as the trap remained active, they would live on. However, when they became too old, they would ask their *vazukuru* (nephews) to go and trigger the trap: only then would they die.

Are the cases above similar to euthanasia as understood by Western scholars such as Campbell and Collinson (1988), Otremba (1995) and Rachels (cited in Mappes and Zembaty 1997)? Is the concept of euthanasia as presented by these scholars cross-cultural?

With regard to the first case recounted by Karevo above, it would appear that it is close to active euthanasia or mercy killing, since it satisfies one criterion of the Western definition of euthanasia, namely, that “a killing is done for the sake of the one who is to die” (Foot 1978, 34). However, this is not the case since no Physician was involved in this act of killing, the killing was not done in a clinical setting, and no consent was obtained from either the patient or his or her representative. With regard to the second and third cases recounted by Mararike above, it would also appear that the same criterion of Western-type euthanasia is satisfied but the others are not.

As for the case of the mystical trap cited above, one can argue that the four criteria for the definition of euthanasia presented by Campbell and Collinson (1988), Foot (1978), Otremba (1995) and Rachels (cited in Mappes and Zembaty 1997) are not satisfied because there is no physician, patient or the patient’s proxy involved in this ritual. Besides, the environment is not even remotely clinical, as no one is sick. However, the fifth criterion, that is, consent, is satisfied since the man who is choosing to have his *riva* triggered by his or her *muzukuru* in order to die is doing it out of freewill. The criterion of euthanasia which requires that it be a killing done for the sake of the one who is to die is also satisfied.

Thus in our view, all the cases cited above, notwithstanding the fact that they do not satisfy all the criteria for the Western concept of euthanasia, point to euthanasia in the African sense. This is only so if the definition of euthanasia is restricted to “an act of killing that is done for the sake of the one who is to die” (Foot 1978, 34). This would mean that the definition of

euthanasia in Africa is very broad, encompassing killings that have nothing to do with terminal illness.

### **Conclusion**

We have explored the concept of euthanasia, tracing it from its Western roots, and showing how it is understood in the Shona society of Zimbabwe. We have noted that there are cases in Shona society that bear striking resemblance with euthanasia as defined by Western scholars. However, we have observed that this resemblance alone cannot justify categorizing these as cases of euthanasia, at least going by the Western criteria for the definition of euthanasia that stipulate that an act of euthanasia requires the presence of a physician, a patient, a significant other, a clinical setting, and informed or proxy consent on the part of the patient. In our attempt to describe the cases that we found in Shona society as euthanasia, we only utilized the criterion which states that euthanasia is an act of killing that is done for the sake of the one who is to die. We then inferred that the concept of euthanasia in Shona society was broader in scope than the Western conception of it.

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