Changing Modes of Childhood Illness Prevention in Rural Malawi

By

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Alister Chaundumuka Munthali BSc MSc (Miw)
University of Amsterdam, The Netherlands
August 1999
Dedication

Dedicated to Muzipasi Munthali
Abbreviations

<table>
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<tr>
<th>Acronym</th>
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<tr>
<td>AIDS</td>
<td>Acquired ImmunoDeficiency Syndrome</td>
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<td>AZC</td>
<td>African Zion Church</td>
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<td>CSR</td>
<td>Centre for Social Research</td>
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<td>DANIDA</td>
<td>Danish International Development Agency</td>
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<td>DHO</td>
<td>District Health Office(r)</td>
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<td>DRC</td>
<td>Democratic Republic of the Congo</td>
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<td>EPI</td>
<td>Expanded Programme on Immunization</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HSA</td>
<td>Health Surveillance Assistant</td>
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<tr>
<td>KIT</td>
<td>Koninklijk Instituut voor de Tropen</td>
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<td>MoH&amp;P</td>
<td>Ministry of Health and Population</td>
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<td>MSIS</td>
<td>Malawi Social Indicators Survey</td>
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<td>NHSRC</td>
<td>National Health Sciences Research Committee</td>
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<td>NSO</td>
<td>National Statistical Office</td>
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<td>ORS</td>
<td>Oral Rehydration Solution</td>
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<td>SSI</td>
<td>Social Science and Immunization (Project)</td>
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<td>TA</td>
<td>Traditional Authority</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<tr>
<td>UMCA</td>
<td>Universities Mission to Central Africa</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>UvA</td>
<td>Universiteit van Amsterdam</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<td>ZCH</td>
<td>Zomba Central Hospital</td>
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Glossary of local terms used in the text

Chilowero:
   a house where a child is kept in seclusion soon after birth.

Chinyera or kanyera:
   an illness that a man suffers from after having sexual intercourse with a newly delivered mother.

Likambako:
   medicine that a child bathes in or is tied around its neck or waist to protect it against becoming ill as a result of pollution arising from sexual intercourse.

Chikuku: measles
Therere: okra
Chigwada: cassava leaves
Ngama: red ochre
Kutuluka: coming out of the house
Kumutengera mwana ku mphasa or kutenga mwana kumphasa
   This is the first ritual sexual intercourse the couple engages in after the birth of a child.

Maula: divination
Mphinjiri: amulets
Njilizi: amulets
“How can he when he does not even speak our tongue? But he says that our customs are bad; and our own brothers who have taken up his religion also say our customs are bad. How do you think we can fight when our own brothers have turned against us? The whiteman is very clever. He came quietly and peaceably with his religion. We were amused at his foolishness and allowed him to stay. Now he has won our brothers, and our clan can no longer act like one. He has put a knife on the things that held us together and we have fallen apart”.

Chinua Achebe 1959:176 (The italicised words are my own emphasis and they portray a functionalistic perspective of a culture as developed by Bronislaw Malinowski and A.R. Radcliffe-Brown, the two well known anthropologists of the functional and structural functionalist schools respectively)

“Man who lives in a world of hazards is compelled to seek for security. He has sought to attain it in two ways. One of them began with an attempt to propitiate the powers which environ him and determine his destiny .... The other course is to invent the arts and by their means turn the powers of nature to account ...." 

John Dewey 1923:3 in his book *The Quest for Certainty*. 

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CHAPTER 1

INTRODUCTION: CONTEXT OF THE STUDY

Introduction:

One of the most interesting issues that Pool (1994) discusses is the concept of relevance. Pool went to conduct his anthropological fieldwork among the Wimbum of Cameroon on kwashiokor. His topic of research was very relevant to the scientific community and at the same time very appealing to the funders of his study who, it can be presumed, also wanted to understand the socio-cultural construction of kwashiokor for purposes of better implementation of public health programmes. However, when he arrived in Cameroon and started his fieldwork he found that he was drawn away from his earlier research ideas by what he says was relevant to the community where he was doing his research (Pool 1994). He found himself busy trying to decipher the meanings of certain local terminologies and creating some kind of order by placing them within an indigenous aetiology or medical system. This was what was relevant to the Wimbum of Cameroon among whom Pool did his research. How, then, do we define the concept of relevance? And to whom should “whatever” be relevant?

Relevance, as can be constructed from Pool’s thesis, is a socio-cultural construct and what is relevant for one society may not necessarily be relevant for another. This is more so when we are looking at the western “scientific” way of thinking and looking at the world and the indigenous cosmology of most societies especially in the developing world. Among other factors, the socialization and enculturation processes in different societies tend to define what is relevant for that particular society and why. This is what might be referred to as the emic explanations of relevance. For example, Douglas and Wildavisky in their book “Risk and culture: an essay on the selection of technical and environmental dangers” give an example of the Lele people of Zaire (now the Democratic Republic of the Congo (DRC)) who suffered devastating tropical ills which included fever, gastroenteritis, leprosy, ulcers, barrenness and pneumonia. The two authorities posit that in this world of disease, the Lele focussed mainly on bronchitis,
being struck by lightning and the affliction of barrenness (Douglas and Wildavsky 1983:7-8). For their own reasons, the Lele chose these risks as the most important and relevant for them and as can be envisaged, these risks are very different from what a biomedical person and indeed someone who has embraced “western civilization” may call relevant.

Bearing in mind that cultures are not static, it is, therefore, appropriate to say that relevance is a dynamic entity. What was relevant for the Lele at the time Douglas was conducting her fieldwork in Zaire in the middle of this century may no longer be relevant now. A lot of changes may have taken place, most probably as a result of contact with other cultures over the years.

In the following pages, particular attention will be paid to the dynamic nature of the concept of relevance in a small rural Yao village in Zomba district of southern Malawi. I will especially look at how mothers of different generations perceive the concept of relevance especially with regard to childhood afflictions? Specifically the following questions will be investigated: what were the most important risks or dangers affecting children in those days, how have these changed over time, how were they coping with these risks and how does the perception of risk and danger impact on the public health programmes in contemporary Malawi?

The biomedical approach to the prevention of childhood diseases in Malawi

Vaccination: a biomedical initiative

During the colonial era, the British initiated the formation of a Public Health Department which was among other functions responsible for the prevention of smallpox. According to Vaughan, “smallpox police” who were Malawians were employed and were responsible for the administration of the smallpox vaccines (Vaughan 1992:43). These “policemen” had the very difficult task of persuading the (local) populace that vaccination was important because this exercise was associated with iatrogenic effects which were more pronounced in children. It was, therefore, a common practice for
people to hide their children during the vaccination exercise (Chilowa and Munthali 1998). Smallpox epidemics brought about social change in that people started accepting vaccination as a way of preventing smallpox after they observed that it was only those people who were not vaccinated that were badly hit by the disease.

With the eradication of smallpox in the early 1970s, international agencies and national states have intensified their fight against childhood diseases. The Expanded Programmes for Immunization (EPI) have been established in a number of developing countries under the initiation and umbrella leadership of the World Health Organization. Despite the fact that vaccinations for selected diseases were being offered from 1973 and that immunization was included in the national health policy around the same period, the EPI was launched in Malawi in 1979. Six diseases have since been included in the programme namely diphtheria, measles, pertussis, poliomyelitis, tetanus and tuberculosis.

Since the launching of the EPI in Malawi in 1979, a number of evaluations have been conducted to determine the impact of the programme (MoH & P 1984, MoH & P 1991, MoH & P 1991, NSO 1992, NSO 1996 and Roe 1990). In most cases the success of the national vaccination programs have been measured by looking at the immunization coverage rates. Official Malawian records indicate that vaccination coverage is very high, standing at more than 80 percent. When considering children aged below five years and individual antigens, this official statement is correct and is supported by the many evaluations stated above including the Malawi Social Indicators Survey (Chilowa et al 1996) and the more comprehensive transnational Social Science and Immunization study (Chilowa and Munthali 1998). Most of these studies have, however, been largely quantitative with a programmatic approach and aimed at determining the immunization coverage rates alone.

In order to depart from the earlier evaluations and other studies conducted in Malawi, one of the objectives of the Social Science and Immunization study conducted by the Centre for Social Research under the directorship of the Royal Tropical Institute, Amsterdam, was therefore to investigate the social and cultural factors which affect
differences in vaccination coverage from the perspectives of both the health care providers and the community (Munthali 1996). The results of this study are described elsewhere (Chilowa and Munthali 1998). One of the major findings was that good relations between the vaccinators and the mothers at the micro level are important for the building and maintenance of the clients’ trust in expert systems. While the delivery of the services have largely been promotional in nature, cases were identified when a prescriptive approach has been utilized. Forms of “carrot and stick” policy included the refusal to provide treatment for those children who are not immunized whereby the vaccination card acted as an entry ticket for children to receive therapeutic care. Members of the African Zion Church (AZC) were found to refuse to vaccinate their children because of the belief that they have in the protective power of God. The existence of such pockets of resistance threaten the endeavours of the international community in their fight against childhood infectious diseases.

With the assistance of the bilateral as well as multilateral donor agencies, Malawi has achieved a vaccination coverage which is a rarity in the developing world. Because of vaccination, smallpox has been eradicated all over the world. Over the past five years, Malawi has had only two cases of poliomyelitis in 1997 (WHO/UNICEF). Diphtheria and pertussis are very rare. Of major concern is measles. Over the years, sporadic measles epidemics have been reported in several districts in Malawi though some of these were just imagined epidemics. For example a measles epidemic in Ntchisi district was reported on the local radio station at a time when fieldwork for the Social Science and Immunization study was being conducted in August 1997 but during this time only two children died out of the five who were affected. The international community is now preparing to rid the world of measles and Malawi will have national immunization days in 1999 aimed at the eradication of this disease.

Answering the question of relevance

While we document the successes of the immunization programmes and the great promises that these programmes hold especially against vaccine preventable diseases, it can be argued that we have missed a cultural dimension or perspective of illnesses,
and emic explanations of how they are prevented and in turn how these perceptions and practices have hindered or facilitated the success of the vaccination as well as other public health programmes in Malawi. The vaccination programme has almost exclusively been informed by the biomedical perspective and it is not clear whether the local Malawian population especially mothers and the indigenous institutions they turn to (consult) also consider the diseases on which the EPI focuses or is founded on to be the most important for them. This research has, therefore, been a departure from other studies conducted in Malawi because the objective was to investigate what the mothers themselves consider or perceive to be the most important dangers or risks threatening the lives of their children and also explore how they endeavour to prevent or ward off these pressing perils. In this attempt to scrutinize the emic perspectives of relevance regarding risk and vulnerability, it is important to mention that as it was hypothesized in my research proposal it was not surprising to find that some mothers (especially the young ones) also mentioned some of the vaccine preventable diseases as important dangers or risks to the lives of their children and that they prevent these illnesses by going to the clinics for vaccinations. It can be presumed that this is largely because vaccination has been internalized and has thus become part of the culture of disease (illness) prevention in (some) Malawian societies.

Theoretical orientations

“Illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place”.

(Susan Sontag 1991:3)

As Sontag has rightly put it, illness is indeed the night side of life, a citizenship that is not welcome at all and people try as much as possible to avoid this distressing status. Apart from being distressing, the other reason people try to avoid using the illness passport is that it is a step closer to death as Stonard Lungu, one famous local musician in Malawi sang saying “uthenga wa imfa ndi matenda” which means that illness is the harbinger of
death. Bauman says that fighting death is meaningless but fighting the causes of death turns into the meaning of life and he adds that the ultimate cause of death is birth because it is only those people who live that die (Bauman 1992). The causes of death are many and among these are diseases and accidents. Though van Dongen says that hope is a lie but good to live with (van Dongen 1998), man’s hope lies in the fact that death can be avoided or postponed (though not indefinitely) as a number of strategies have evolved in different cultures all over the globe for the prevention of illness and other causes of death. It is, therefore, no wonder that throughout our lives we struggle to protect ourselves from diseases which are subsequent causes of death. And it is through these strategies that our entry into what Sontag calls the kingdom of the sick is checked.

As has been mentioned in earlier on the thrust of this study is to look at how mothers or women of different generations try to prevent what they consider to be the most important dangers or risks threatening the lives of their children. The warding off of dangers or risks that threaten the lives of children is particularly important because children are greatly valued. Gerrits, who studied infertility among the Macua of neighbouring Mozambique found that families value children so much and even those who have only one child foresee problems because when they die their only child will be left without a network of brothers and sisters who can support him or her when needed (Gerrits 1997:39-48). Whyte, who has done extensive fieldwork among the Nyole of eastern Uganda stated that among these people children are valued so much that when twins are born they have to 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” (Whyte 1997:55).

While modern and enlightened couples may look at childbearing as a consumption activity (i.e. that it is very expensive), most people in sub-Saharan Africa, Malawi included, look at childbearing as an investment activity and a sign of wealth, hence their resistance to family planning initiatives. In addition to children bringing pleasure to the home as has been pointed out by Gerrits (1997:39-48), children are also valued largely because of the unavailability of social security systems that parents can fall back on in times of economic
as well as social turbulence. Whether childbearing is a consumption or investment activity, parents spend a lot of time protecting their children from the many dangers and risks in existence in this perilous world. It is important to note that the terms child bearing as a consumption or investment activity have been borrowed from W. Penn Handwerker who uses them in his article "Employment and Fertility Transition on Antigua, WI: Education, Employment, and the Moral Economy of Childbearing". Summarily, what he says is that women who view childbearing as an investment activity should have many children while those who view childbearing as a consumption activity should have few. He uses these terms in the context of what he calls the resource access theory (Penn Handwerker 1993:41-52).

**Historical reconstruction and its limitations**

In order to get a better understanding of perceptions about risk and vulnerability, a historical approach has been utilized. Berridge and Strong say that,

> "The historical perspective is necessary because it provides a chronological approach, a sense of continuity as well as change, and an ability to interweave different levels of interpretation in its analysis of medical and public health issues and events" (Berridge & Strong 1991:137).

A study such as this, which is concerned with generational differences in the perception of danger/risk and the different strategies that have evolved for the prevention or warding off of these dangers requires theoretical perspectives that address the concept of culture change (i.e. looking at historical issues) while at the same time incorporating a functional (structural) perspective.

In his book, *The dynamics of social change: an inquiry into race relations in Africa*, Malinowski (1945) has defined culture change as a process by which the existing social order of a society, that is its social, cultural and material civilization is transformed from one type to another. He has attributed cultural change to what he calls *independent evolution* in which change is brought about by internal factors and forces and to the
**doctrine of diffusion** which comes about due to culture contact (Malinowski 1945:1). One of the most important questions that he raises is:

"The most important problem of culture change can thus be formulated: the natives are changing and moving towards ......? The definition of the blank or X is the all important element in the problem (1945:61)."

While it is acknowledged that the culture of the people of Mtwiche village (where this fieldwork was conducted) is changing due to the many forces of deculturation in existence, it is important to reconstruct what was there at the beginning and what the current situation is. Due to possible recall bias, it will not be possible to reconstruct the real "zero point" of culture change, a term coined by Dr Lucy Mair to designate conditions of pre-European tribal equilibrium (Malinowski 1945:27). But if we are to try and account for the degree and causes of change it is a worthwhile exercise to try to look at issues or conditions at the starting point through the invocation of the memories of very old informants who are assumed to be knowledgeable in such matters; not withstanding recall bias as mentioned above.

In addition to Malinowski's theory of culture change, there are also a number of theoretical orientations that have informed the approach used in this study. The first is the structural functionalist approach as developed by A.R. Radcliffe-Brown who was inspired by the French sociologist Emile Durkheim. Structural functionalists view social and cultural phenomena as functionally interconnected and basic to the structural maintenance of society (Hardon et al 1994:17, Hendry 1999:9-10, Radcliffe-Brown 1957 and Nanda 1987:57). What this implies is that all elements of society or culture (including the observance of taboos, ritual performances, sorcery, witchcraft, divinations etc) have a purpose and that purpose is to tie together the various elements of that society or culture into a cohesive whole. Hardon et al (1994:17) have criticized the structural functionalist approach because of its failure to explain conflict and change in society. Paul, in his theory of system and system change has, however, placed functionalism in a changing environment and says:
"The habits of people in a given community are not separate items in a series but elements of a cultural system. The elements are not equally integrated, however, some are central to the system, others peripheral. Hence some cultural elements can be altered or replaced with little effort, others only by applying great force", (in Wellin 1998:10-22).

What Paul is positing is that medical systems (both bio and ethno) are not static: they are liable to be disturbed and therefore change, especially when new health related elements are introduced. The responses of a given socio-cultural system and the typological changes that may take place as a result of the introduction of new (medical) elements are some of the things that are examined in this research. The discourse on function and functionalism inherently discusses consequences and this becomes clearer at a later stage when consequences of breaking of taboos and non-adherence to indigenous beliefs and practices are discussed.

Another theoretical orientation that has informed me is the cognitive symbolic approach. This is basically because the study is looking at the meanings and interpretation of some concepts like risk, danger, vulnerability, prevention as well as some illness terms that came up during this study. Thirdly, this study will also examine how the social constructionist approach (developed by sociologists) which looks at (bio)medical knowledge as a social construct (Vaughan 1994:4-8, Lupton 1994:11-13 and Wright and Treacher 1982:1-22) can be used to explain the construction of lay (indigenous) knowledge in a rural Malawian village.

Objectives of the study

Overall objective

To describe how mothers in a selected Malawian village try to prevent what they feel are the most important dangers or risks threatening the lives of their children.
Specific objectives

1. To determine the meaning and interpretation of the terms risk, danger, uncertainty and vulnerability as used by mothers and traditional healers in connection with children.

2. To find out what mothers and the various institutions they resort to consider to be the most important risks or dangers that threaten the lives of their children and why.

3. To determine the different institutions that play a role in the identification and prevention of risk/dangers and what type of dangers they are specialized at.

4. To determine factors that predispose or make children vulnerable (when, how, why and which children) to these most important risks or dangers.

5. To determine how mothers try to prevent the so-called important childhood risks or dangers.

6. To determine how their perception of risk and vulnerability as well as past experiences influence their behaviour regarding prevention.

7. To examine how people's perception of risk and vulnerability and their practices of preventive health behaviour influence (specifically do they facilitate or impede) vaccination as well as other health programs.

The discourse on risk: a changing scenario?

The following chapters will describe what the mothers consider to be the most important dangers and which children are particularly vulnerable and why. Briefly, from the interviews that were carried out, the impression was that in general mothers fear most illnesses (some forms of diarrhoea, swelling, wasting) caused by pollution arising from sexual intercourse. Extra precaution is taken to protect children from such pollution. The other dangers included measles, diarrhoea and "malnutrition". Despite the fact that there
were differences in the explanatory models for these illnesses, it seemed that both the young and old women converged on these to be the most important illnesses. The care for children in Mtwiche village seems to start from the moment a woman is pregnant. There are certain foods that she is not supposed to eat because doing so would result into a child becoming ill after it is born. In addition to foods, there are also certain activities that she is not supposed to perform and these are aptly described in chapter 3.

There was only one illness, namely smallpox, that the young women never mentioned and this is understandable because the disease has since been eradicated. The young mothers also mentioned illnesses like malaria and poliomyelitis which were never mentioned by the elderly women. The question, regarding these two illnesses is whether they are emerging illnesses (have they emerged recently) or is it a question of relevance again, i.e. that these illnesses were there but attention was never paid to them because they were not considered important (or is it that they were not known or understood or recognized?)? These questions or illnesses will be discussed in the context of culture/social change.

Such findings do illustrate the need to contextualize relevancy. While biomedicine has placed (as described earlier) a lot of emphasis on vaccine preventable diseases and diarrhoea, for example the people of Mtwiche village look at illnesses arising from sexual pollution as the most relevant for them. The introduction and implementation of public health programmes (immunization programmes included) in a rural village like Mtwiche would call for the adjustment of these programmes to take into consideration of the social cultural environment in which they are implemented (Streefland 1997). It has to be acknowledged that the introduction of public health programmes especially in the developing world is an exercise in culture change hence the importance of knowing what is relevant for the target population. A celebrated Malariologist who worked on the Panama Canal project has been quoted by Paul in his book Health, culture and community as saying:

“If you want to control mosquitoes, you must learn to think like a mosquito”, (Paul 1955:1).
What this statement means is that there is need for ascertaining the existing habits, how these are linked to one another, what functions they perform and what they mean to those who practice them before the introduction of any public health programmes (Paul 1955).
CHAPTER 2

METHODOLOGICAL ISSUES

Introduction:

This study was qualitative in nature and focused on the micro level namely at the village level. Since very little similar work had previously been carried out and that research was done in one village and over a very short period of six weeks, the study was, therefore, exploratory (Harden et al 1994:116-117). This research should be looked at as a pilot study requiring a follow-up detailed ethnographic enquiry with a cross-cultural approach in order to better understand the people's reactions to public health programs in contemporary Malawi. The study was also comparative because the perceptions of very old grandparents (over 60 years old) are being compared to those of young (some of them teenagers) mothers (less than 30 years old). The traditional birth attendants' and traditional healers' perceptions of risk and vulnerability have also been described to determine how such knowledge contributes to the construction of (indigenous) preventive health measures.

The study area

The study was carried out in Mtwiche village in the area of Traditional Authority Malemia in Zomba District in southern Malawi. The village is run by a village headman with the assistance of a number of aides. It has a population of about 3,000 people. Most people in this area are Muslims. While most people in Malawi are Christians, a considerable percentage of the population are Muslims and they are mainly found in the lakeshore districts of Nkhota Kota, Salima, Mangochi, Balaka, Machinga and Zomba. Christianity only came to Malawi around the 1860s with the coming of the Universities' Mission to Central Africa (UMCA) from Britain. Later on other missionaries including Dr. David Livingstone and Dr. Robert Laws followed. The coming of the missionaries in the 1860s and the subsequent declaration of Nyasaland as a British Protectorate in 1891 happened
at a later stage. Before then, there were Arab slave traders who came from East Africa (Zanzibar in particular) and Asia and were involved in the purchasing and selling slaves. These Arab slave traders are the ones who introduced Islam in this part of Malawi and this was way before Christianity came to Malawi. It was in 1891 when the missionaries led a successful fight against the abolition of slavery in Malawi but they were not successful in converting people (who by then were already Muslims) to Christianity. This explains why people in the districts mentioned and in this context why the people of Mtwiche village are Muslims.

People living in this area are mostly of the Yao tribe and they speak a language called Chiyao. They have a matrilineal system of descent with a matrilocal residence rule whereby the husband goes to live with the wife’s family. With the system of matrilineal descent the ties between a woman and her brother are very strong. Children are the official heirs of the woman’s brothers’ property.

The main food crop is maize and some also sell some of it to generate some income. Others, however, also grow rice mainly for sale.

The nearest hospital is Domasi Rural Hospital which lies about 5 kilometers away. However, there is also an under-five clinic where children receive vaccinations.

Why Mtwiche village?

As it has been explained earlier on the study was aimed at describing the intergenerational differences in the perception of risks or dangers that threaten the lives of children in rural Malawi. The rural area was chosen because of the assumption that most people in the urban areas have been largely influenced by what might be referred to as the modernization process. Since my family was in Zomba and also due to very limited financial resources allocated for fieldwork, I had to choose a rural village which was closer to urban Zomba. This was mainly to cut down expenses on transport and other costs.
The nearest hospital/health centre to Zomba (urban) is Domasi Rural Hospital which is approximately 16 kilometres away. In order to choose the village I had to consult with the Health Surveillance Assistants at the rural hospital. I specifically requested a village which was not very far from the hospital, had a minimum of two TBAs, two traditional healers and most importantly one which had low coverage. Though low coverage may be explained by mothers not going because of poor quality of care, one other explanation is that people do not perceive vaccine preventable diseases as the most important dangers threatening their lives. It is different from other villages because it is the only village which was closer to the hospital that satisfied all the conditions.

Getting permission

Because of very limited time which was allocated for fieldwork, a number of short cuts were made in this study especially with regard to obtaining clearance to conduct the study. As far as Malawi is concerned, the most important institution that gives ethical clearance for studies of this nature is the National Health Sciences Research Committee whose secretariat is at the Ministry of Health and Population headquarters in Lilongwe. This committee meets only once in every three months three months and their next meeting was scheduled for July 1999 hence I would have wasted a lot of time if I were to wait until they meet. This would have implied that the production of this manuscript would have been delayed by approximately two months. Because of the urgency of the matter, provisional approval was obtained from the Chairperson of the NHSRC.

I informed the District Health Office (DHO) a two weeks after I had started my research who said that they did not have any problems. The most important gatekeeper is the village headman and I contacted him before I started fieldwork. Unfortunately this was at a time when people were very busy harvesting rice and other crops and it was a bit difficult to meet the headman because he was very busy. The wife of the village headman informed me that it was a bit difficult to meet him. She, therefore, advised me to tell her why I was looking for the chief so that she could in turn brief him later that evening. I explained to her that I was a student at the University of Amsterdam and at the same time I was working at the Centre for Social Research, an institution of the University of Malawi,
as a Researcher. The intention of coming to the village was to learn what mothers of
different generations consider to be the most important dangers to children and how they
cope or negotiate with these dangers. The following day I was informed by the Chief's
wife that he had approved my research and that I could go ahead.

Sampling

When researching issues that have to do with intergenerational changes in the perception
of risk and risk negotiations (coping mechanisms), it is imperative that mothers of different
generations should be interviewed. In this study young mothers aged below 30 and
grandmothers aged above 60 years were interviewed. Due to problems that were
foreseen in trying to identify old mothers (as I was new to the place), the snowball method
of sampling was utilized. The wife of the village headman was herself an old mother of
8 children. Her first born was born in 1956. She was, therefore, my first informant. After
that I asked her if she knew one or two other grandparents of her age or older so that I
could also interview them. Those that she told me were subsequently interviewed and
also asked to identify further one or two other grandparents. In this way a total of 15 old
women were interviewed.

Recognizing that it is children aged less than one year old who are most vulnerable to
infection and it is those women who have very young children who may recall better the
experiences that they have had with their children, assistance was sought initially from old
women to identify one or two young women with children less than 12 months old. These
young women were in turn asked if they knew other women of their age who had children
aged less than one year. In this way 15 young women aged between 18n and 30 years
were interviewed. Recognizing also that appearances may be deceiving, these young
ladies were always asked their age before proceeding. A number of scheduled interviews
were cancelled after knowing that the woman did not meet the criterion.

In addition to this, two traditional healers, two traditional birth attendants and the village
headman were interviewed. Two focus group discussions were conducted, one with old
women and the other with young women.
Data collection methods

In order to increase the validity and reliability of the data collected, a triangulation approach to anthropological research was employed. This means that a number of different data collection methods were used and different groups of people (sources of information) were interviewed. The data collection methods which were used included the use of available literature, in-depth (individual) interviews and focus group discussions with mothers and key informant interviews with the village headman, traditional birth attendants and traditional healers. Particular attention was paid to how mothers of different generations perceive risks their children face and what they do about it.

A number of observations were also made and these were particularly aimed at seeing whether children were wearing amulets and whether they had any incisions on the exposed parts of their bodies. Observation as a technique was necessary because it helped to raise important questions which were subsequently clarified with relevant informants. A further observation was made when one of the traditional healers was divining and giving out medicines.

Data analysis

Data analysis was a continuous process. All the interviews were tape recorded and were transcribed on the same day of the interview. As fieldwork progressed, major emerging themes were identified and these included: the most important dangers to children, how these dangers are caused, which children are particularly vulnerable and why, the prevention of dangers and inter-generational differences in the perception of childhood dangers. All data collected was therefore grouped into these major themes.

Experiences during the research process: a concluding remark

Reading through this manuscript one would conclude that the research process went on smoothly without hassles. The first problem I encountered was that of language. In
Mt维奇 village they speak *Chiyao* since they are Yaos. Most people also speak *Chichewa*, a language which is spoken and/or understood by most people in Malawi. However there were two old women who did not know Chichewa and because it was not possible to communicate with them properly the interview had to be cut short and other old women were identified.

Secondly, this study was conducted at a time when Malawians were approaching the second presidential and parliamentary elections which were due on 25th June 1999. Early in my fieldwork the President was addressing a political campaign rally in Mt维奇 village and everyone went to attend this rally resulting into postponement of my appointments. On another two separate occasions the appointments also had to be cancelled because a prospective member of parliament (MP) was conducting campaign meetings.

Lastly there was the issue of payments. There were a few young ladies who refused to be interviewed saying that they did not see what they could immediately gain from being interviewed. They said that they were expecting to be paid and if they were not paid, they had better things to do other than spending an hour or so answering my questions.

Despite such “minor” problems, I managed to collect data upon which this dissertation is based.
CHAPTER 3

PREGNANCY, FOOD TABOOS AND THE PREVENTION OF CHILDHOOD ILLNESSES

"Mazirawa akukoma mukanwo mwanu koma kwa mwana n dadoipa" (These eggs are tasting nice in your mouth but they are not good for the child when (s)he is born).

an old informant, Mtwide village

Defining taboos

The English word taboo is derived from the Polynesian word “tabu” which means to forbid or forbidden and as far as Polynesians are concerned the word can be applied to any form of prohibition. Early voyagers to the South Seas including Captain Cook adopted the word to refer to prohibitions of a special kind (Radcliffe-Brown 1952:133-135 and Hendry 1999:35-37). Being cultural constructs, taboos are behavioral codes that regulate or guide how people in a particular society should conduct themselves in certain circumstances. There is a general belief that the infraction of taboos results into a person having misfortunes or illness. It should, however, be noted that once a taboo is broken, it is not always the one who has transgressed or breached the taboo who suffers: the sufferers may be the spouse, the children or the community at large. As Richards says:

"It is important to notice that the punishment falls on the innocent and not on the guilty. The adulterous woman who touches her hearthstone causes her husband to fall ill of the chest if he accidentally comes near the fire (Richards 1956:34).

It is, especially, important to point out that the children are the ones who in most cases suffer as a result of the infringement of taboos by the elderly since they do not know anything of these restrictions. In order to prevent children from becoming ill it is, therefore, important for those in the know to avoid breaking taboos. Because in the world of science
it is difficult to establish the link between cause and effect as far as taboos are concerned, Goudsblom has called people’s practice of imposing taboos on each other a *delicacy of feeling, a fallacy* (Goudsblom 1986).

In later chapters, other taboos existing in the Yao community where this study was conducted will be described. In this chapter, however, emphasis will be placed on food taboos especially for pregnant women.

**Food taboos**

A number of food taboos have been imposed on pregnant women with the aim of protecting the child to be born from contracting specific illnesses. It was not possible to obtain further explanations of how these food taboos/restrictions cause illness. Even the old mothers who are assumed knowledgeable in such matters just said that these are the beliefs and values that their parents taught them hence they have stuck to them and they have over the years tried to hand this tradition down to the younger generation: this passing on of knowledge from one generation to another is one of the factors that characterizes a culture (Nanda 1987).

*Okra and cassava leaves*

Cassava leaves are collected by women both in the rural and urban areas and cooked as relish. In urban areas, especially, people may buy these leaves from the market. Okra, like cassava is also a vegetable and its most important characteristic is that it is very slippery and a person needs to be taught how to eat this vegetable. In most cases when preparing these two vegetables, soda is added. A pregnant woman is not supposed to eat these two vegetables because if she does a child will be born with okra-like coating its whole body and when this happens a child will defecate greenish or blackish stuff. The elders will, therefore, know that despite the fact that the pregnant woman was told not to eat okra and *chigwada*, she ate after all not heeding the warning. Such a child suffers from an illness called *chinyera* right at birth.
While the people of this village perceive this as a problem, the views of some health workers was that the defecation of greenish or blackish material after the birth of a child is a normal thing and this stuff is what is called meconium. In medical terms it is material that collects in the intestines of a fetus and forms the first stool of a newborn. It is a thick and sticky consistency, is usually greenish to black and is composed of secretions of the intestinal glands, some amniotic fluid and intrauterine debris, such as bile pigment, fatty acids, epithelial cells, mucus, lanugo and blood (Anderson & Anderson 1994:645). In fact the passing out of meconium is a good sign as it shows that the child's bowel is not blocked. However, the passage of meconium into the amniotic fluid while the foetus is still in the womb indicates some degree of distress which caused the relaxation of the anal sphincter and defecation. This meconium stained liquor is graded I (slight) to III (severe) and it indicates a corresponding degree of distress.

**Roast maize (chimanga chokazinga) and eggs**

In Malawian villages dry maize is roasted and eaten as a "snack". In Mtwiche village a pregnant woman is not supposed to eat roasted maize in order to protect a child from suffering from stomachache after it is born. Others said that the child may also have diarrhoea. People know that a child is suffering from stomachache because it cries so much. In this way they know that when the mother was pregnant she was eating roasted maize. When it is noticed that the child is crying because of stomachache,

"some maize is roasted after which water is added and the mixture is boiled. They take the extract and rub it on the body of the child. It is believed that the child stops crying right away", or

"Maize, millet, sorghum, pigeon peas, beans and some other seeds are boiled in water together with an unbroken egg. To all this, salt is added and the extract is then given to the child to drink and stomachache stops".

While the crying of the child may "indeed" signify that the mother ate roasted dry maize, it may also be argued that crying of a child at this age is quite normal and it is the only
way it can communicate to the parents or the mother in particular that something is wrong and it needs some attention. For example, a child will cry when it is hungry, when the nappies are wet and indeed when it is sick. The crying of the child may also be due to "colic pains" which are a commonly occurring complaint to newborn babies all over the globe. These colic pains are experienced by children aged between one and four months.

Pregnant women are also not supposed to eat eggs because the child can also suffer from stomachache. Eggs are also bad for the pregnant woman because when the child is born (s)he will defecate yellowish material similar to the egg yolk and the child also cries quite a lot. When the elders notice this, they prepare some medicine for the child as follows:

"A hole is made on one side of the egg and this is boiled in water where some medicine has been added. The concoction is then given to the child to drink."

After this the child ceases defecating the egg-yolk like stuff and also stops crying. In other cultures eggs are also heavily tabooed. But unlike the Yao where it is only pregnant women who are not allowed to eat eggs, the Samburu of Kenya consider any form of excrement as most unclean, hence eggs are regarded as hen's excrement and therefore avoided (Read 1966:32). Among the Tumbuka of Rumphi, children are the ones who are not allowed to eat eggs because there is a belief that if they do, they will suffer from an illness called njiri which is characterized by convulsions and seizures (Munthali 1999b). Women are advised not to eat raw eggs in the western culture because of Salmonella risk to the unborn child.

The other food stuff that is also tabooed because of the fear that the child would suffer from stomachache once it is born is crab (nkhano). When a pregnant woman eats crab, the child would also suffer from what is referred to as chiulo.
**Pepper**

The eyes of the newly born child will swell which can later lead to blindness. This is because when the expectant mother eats pepper it goes straight to the eyes of the child and when a child is born, (s)he may not see. According to a biomedical perspective, such a suffering of the child can be due to gonococcal neonatorum which is caused by gonorrhoea.

**Offals (of any bird or animal)**

A pregnant woman is not supposed to eat any offals of any animal because it is believed that when she does the child will not get out of the chilowero quickly. This is because when the child is born the umbilical cord does not drop off easily hence it is forced to stay there for a period of up to two weeks or more. Biomedically, umbilical cords may become infected resulting in failure of the cord to drop off and this is due to inadequate hygiene. The cord needs to be cleaned. In those days a child could stay in the chilowero for two or three days but these days the child may be there for up to 2 weeks basically because nowadays couples do not follow traditional beliefs and values for example that of not eating offals when the woman is pregnant. Women are being recently advised not to eat too much liver (which previously had been recommended as a vitamin A source) as an excess of this vitamin is damaging to the unborn child.

**Tomatoes**

The child develops tiny abscesses which are very similar in appearance to tomatoes. When these small abscesses are pressed they release watery fluids. As far as treatment is concerned, a piece of tomato is squeezed into these small abscesses and they disappear in no time at all. Though they tried to explain the symptoms and signs, it was however not all that clear as to what this infection could be; though it could be what in biomedicine are called “milky spots”.

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**Mkute (Food remains)**

Mkute is usually a term that is given to food which has been kept overnight. The interviewees said that a child is not supposed to eat these food remains because (s)he would feel very cold and will fall ill as (s)he is eating contaminated food.

**Ducks, turkey, pork or indeed any meat which may be allergic**

Women said that there are certain meats which when eaten may produce allergies and these include ducks, turkey, pork etc. A pregnant woman is not supposed to eat these because they fear that if they do the child may also have allergies once (s)he is born.

**Bananas**

A child does not breathe properly because the nostrils are blocked because they are full of mucus. In contrast with this tradition, a pregnant woman is, however, supposed to eat a lot of foods which are rich in calcium such as bananas in order to prevent cramps. Foods rich in calcium are also for healthy teeth, nails and hair.

**Other taboos or prohibitions**

In addition to the above taboos, there are also some other taboos that are or were being practised among the Yao of this village. For example, a pregnant woman is not supposed to drink water while standing. What is required is that she should be seated whenever she drinks water. It is not advisable to stand because after a child is born (s)he tends to choke every time (s)he feeds (mwana amakhalira kusamwa kokhakokha) and this is not good for the child.

When a pregnant woman wants to get out of the house she should just do so. If, however, as she is getting out of the house she decides to stand in the doorway and then later get out of the house, what will happen is that during delivery the baby as it is coming out will just stop and the woman will be in great pain trying to get the baby out of the birth
canal. When she is walking from one place to another, she should not stop on the way and go back to wherever she was coming from because if she does that during delivery the baby will also stop as it is coming out and go back into the uterus. This is very painful for the mother. A pregnant woman is also not supposed to wear a waist belt because when the baby is born it will be having a rope or string tying its whole body. Elders say that whatever you do while you are pregnant, a child will undergo the same things. A child may be born with the umbilical cord surrounding its neck or its foot and this is mainly due to excessive activity of the child while still in the womb prior to delivery and this can also lead to foetal distress (even death of the foetus - still born). Excessive activity may be due to an unstable lie or polyhydramnions (excessive amniotic fluid) which means that the baby can move around too freely and therefore the cord gets caught around the neck or limb. Hickey, who did her research among the Chewa/Ngoni of Mchinji reported of a pregnant woman who was feeling unwell and she said that the hospital did not help at all. Hence she consulted a traditional healer who after examining her found that the baby was all tied up in strings by some jealous people through magic. The traditional healer then gave her some herbs to help untie the string and the pain stopped (Hickey 1999:47).

Any experience for the young generation?

All the old women interviewed agreed that during their time it was indeed a taboo for a pregnant woman to eat eggs, roasted maize, crabs, pork, turkey, et cetera. This area is predominantly Muslim and pork is heavily tabooed as is the case with all other Muslim societies. Hence, though it is claimed that pork produces allergies, they already do not eat pork. In those days young women and men were very obedient and once they were told something they could stick to it. Failure to stick to these taboos is revealed through the observation of the child after it is born. For example, the crying of the child signifies that the mother ate eggs or roasted maize or crabs as explained above. What this implies is that even if the woman cheats or hides when eating these tabooed foods, the elders will find out when the child is born through the already pre-defined signs and symptoms. This indicates that the elders put in place a system of checks and balances and according to informants it was not easy to cheat because in the end the woman was caught and asked to confirm what she ate or did. There have been reports of women having obstructed
labour because of committing adultery while pregnant and have been asked to reveal this on their delivery beds in order to speed up the delivery process.

Most of my young informants were aware of these food taboos and they said that they learnt them from their mothers and grandmothers. Some said that despite the fact that they knew that they are not supposed to eat certain foods, they went ahead and ate and then after the child was born it had problems as illustrated above.

“When I was pregnant, I used to eat bananas and eggs. After I delivered, my child was not breathing properly because there was a lot of mucus in its nose and at the same time she was also defecating yellowish stuff similar to the egg yolk. My parents told me that it was because I did not observe the food taboos as I was advised”, said a young informant.

This young informant added that because of her experience with her child becoming ill after she did not observe the food taboos, during her next pregnancy she would adhere to these taboos in order to ensure the good health of her child after delivery. This view was shared by a number of other young informants that were interviewed formally and informally.

Such experiences by the young generation of mothers has forced some of them to resort to the old beliefs of tabooing certain foods in order to protect the child after birth. Others, however, said that as much as their parents advise them not to eat certain foods when they are pregnant they do not accept this advice. They retort that these are old beliefs (ndi zakale) which are no longer valid. It is increasingly difficult to state the point in time when these changes occurred because while some people claimed to have changed, the others said that they still adhere to the age old beliefs. During fieldwork, for example observed that there were many children wearing amulets around their necks. Therefore, the change that is taking place can be labelled as a gradual process.
Biomedicine - a force towards change?

While personal experiences with consequences of breaching food taboos and the general desire not to disappoint parents are contributing towards the continued practice and observance of food taboos as defined earlier, it is important to mention that most young women and even the old women said that nowadays most young women when pregnant do not observe these taboos. One of the most important forces that is being held responsible for processes of detribalization or deculturation is the interaction with the Ministry of Health and Population staff at health centres and hospitals. The health workers teach the young women especially during the antenatal clinics that they should be eating a balanced diet in order for them to remain in good health and the child to be born in good health as well. Included in balanced diet, the health workers stress, should be eggs, vegetables (including cassava leaves and okra), meat (offals included), fruits (even bananas) et cetera.

It is, therefore, apparent that while the biomedical perspective promotes the consumption of certain foods in order to ensure the good health of the mother and the developing foetus and thereafter that of the baby, this very much contradicts the local beliefs and values which taboos some of the very foods being promoted by the health personnel. All these forms of food taboos are, indeed, excluding much needed nutrients from the diet of the mother. A war of words and ideologies, therefore, ensues between the grandparents and the young mothers. This is basically as a result of the two contesting models that are in existence in the village: the grandparents who still stick to the traditional values of for example tabooing certain foods and the younger mothers who largely hold on to the biomedical perspective.

The failure of some people of Mtweche village to abandon their food taboos as defined above stems from the fact that such measures contravene or contradict the indigenous values and beliefs in which people have invested time and resources and around which they have based their lives and hence such values and beliefs constitute their cosmology or world view.
Concluding remarks

The anthropological discourse on food taboos are especially important in public health as many scholars including Lepowsky and Heggenhougen et al have pointed out the existence of a synergistic relationship between malnutrition and infectious diseases (Lepowsky 1987:71-92 & Heggenhougen and Clements 1990) for example that malnutrition increases children's vulnerability to measles. In Malawian rural societies, for example in Mtwiche village, which are already ravaged by malnutrition, the observance of food taboos for whatever explanations as detailed above tends to exacerbate the already fragile situation of vulnerability to infectious diseases. Therefore, the promotion of good and balanced nutrition as a means of reducing or preventing malnutrition contradicts the food taboos existing in Mtwiche village and such biomedical measures are liable not to succeed. The identification of cultural traits such as food taboos is, therefore, an important step towards the designing of strategies aimed to institute a civilizing process aimed at re-orienting or detribalizing such trends in society.
CHAPTER 3

ILLNESS AND POLLUTION FROM SEXUAL INTERCOURSE

Introduction:

Sexual relations are one of the most important dangers to children in Mtwiche village. Grandparents were quick to point out that most of the illnesses that children suffer from are as a result of pollution arising from defined sexual relations.

Seclusion of the child after birth

When a child is born, it is first of all kept in seclusion for a certain period which may range from three days to seven days. The house where a baby is kept soon after birth is called chilowero. While in some cultures as Ngubane and Read put it, the fear of pollution from a woman who has just given birth is the underlying reason for the seclusion (Ngubane 1977:77-79; 88-90 and Read 1966:69), amongst the Yao of southern Malawi where this fieldwork was conducted the reason is different: the child has to be protected against the perils of this world and the pollution that they fear is not from the woman who has given birth but from other people who are classified as “hot” (otentha). Among the Zulu for example, a woman is not supposed to leave the house in the first three days after she delivers but after that she has to cover herself with a blanket when she is going out. After ten days when she goes out of the house she can go out without a blanket but should smear red ochre on the exposed parts of her body to protect herself from the dangers to which she is exposed (Ngubane 1977:78). This is very different from what is practised among the Yao as the woman can go out of the house without being subjected to any rituals: she is not exposed to any danger at all. She is, however, dangerous to men when she has sexual intercourse with them or when she eats with them on the same plate or when she adds salt to the food she has cooked.

According to most of my informants, there are two reasons why a child is kept in the
chilowero in its first few days. Firstly, it is to allow the umbilical cord to dry and fall off. And once it falls off the elders take it and bury it in a secret place and nobody is supposed to know this place. The reason is that they fear that once a witch knows where it is buried, they may take it out and use it to make harmful magic. They did not specify what the witches may do with it. Gerrits (1997), however, cites the example of Genoveva a lady from the Macua, who traditional healers said suffered from infertility because the umbilical cord was not disposed of or handled in a culturally appropriate way. And she was bewitched hence making her infertile.

It is not only in African countries where the placenta has to be buried. It is a source of potent danger to the new born baby. In a certain Muslim village in India all placentae are interred in the household midden pit on the outskirts of the village, for a placenta is not a thing to be buried inside. It must be hidden so it cannot be unearthed by a barren woman who wishing to conceive uses it for her own magic, but harms the baby in the process (Jeffrey & Jeffrey 1993:7-31).

The second reason why a child is kept in seclusion is that at birth both the child and mother are classified as cold (ozizira) and it is feared that when the child goes out without proper ritual ceremonies, it will meet those people who are classified as hot (amoto) and when this happens (mwana amasupuka) the child will cry quite a lot and sometimes may even die especially if touched or handled by these hot people. Restrictions have also been placed on who enters the chilowero to see the child: only those people who are classified as cold are supposed to enter - young men and women because they are potentially hot, are prohibited.

The hot and cold dichotomy as applied to persons of sexual maturity and the exclusion of such persons from important ceremonies such as birth rituals has also been discussed by early anthropologists like Audrey Richards who did her research among the Bemba of neighboring Zambia. She says that sexual relations make a couple hot and in this state such a couple is very dangerous especially to babies and young children who are vulnerable to so many dangers (Richards 1956:30). In addition to Richards, Foster has also utilized the hot/cold dichotomy in explaining the etiology of illness in "primitive"
societies (Foster 1998:141-150). According to Foster, illnesses can be due to excessive heat or cold entering the body and treatment logically follows attempts to restore the proper balance through hot and cold foods and herbs et cetera. In this context, sexual relations make a couple hot and this will make a child sick as it is considered cold. Therefore, in order to protect the child against this hotness, they administer hot medicines (see later explanations on preparation of likambako). Such illness explanations fall under what Foster calls the naturalistic medical systems.

**Getting out of the house (kutuluka)**

At the end of the seclusion period a ceremony called *kutuluka* which literally means “coming out of the chilowero” is conducted. Before bringing out the baby, it has to be bathed and sometimes incisions are made on its skin and amulets worn around the neck and waist (both the *mphinjiri* and the herbal baths comprise of what is referred to as likambako). The house is smeared and *mphinjiri* worn around the neck or waist. Read also mentions this ceremony and calls it “coming out of the house” (1966:69) but unfortunately she is silent about the purpose of this bathing marking the end of the seclusion period. What is the purpose of this ritual bath?

Before being taken out of the house the child has to be bathed in water where traditional medicine has been added and this medicine can be obtained from traditional healers or herbalists. There are, however, some individuals who know these medicines and they prepare them on their own without making any consultations. In the olden days, amulets were prepared and put around the waist or neck of the newly born baby. These days there are also some people who are still doing this. The assumption was that men cannot be trusted: they can have sexual intercourse with other women while the child is very young and it was/is believed that such acts can make the child ill. The bathing of the child using water where traditional medicine has been added and the wearing of amulets were, therefore, aimed at protecting the child against pollution brought about by husbands indulging in sexual intercourse with other women. When this ritual is not followed then as soon as the child meets those people who are hot the child becomes sick and sometimes even dies.
While people have acquired this knowledge through the socialization process, some do not follow these rules seriously, with hidden agendas. For example, one informant said that sometimes there might be some jealous relatives who, despite their awareness that hot persons or those who have just had sexual intercourse are not supposed to go and see the child for fear of making the child sick or even die, they may go to the chilowero where a newly born child is thereby causing misfortunes to the child. In order to prevent such scenarios, as soon as a child is born, it is kept in the chilowero until proper birth rituals have been conducted. Before bringing out the child only those people who are classified as ozizira are allowed to enter. In the chilowero there is always fire burning. On the day the child will get out, they take out a piece of burning wood and use it to light a fire outside the chilowero. They then, rub castor oil on the child’s body.

The restrictions imposed on who is supposed to enter the chilowero imply that people in this society generally recognize that hot people are dangerous to the newly born babies hence all those people who are potentially hot (young men and women inclusive) are not permitted to enter into the chilowero. Sometimes, however, despite the fact that a child has been bathed in traditional medicine and amulets have been put around the waist and the neck, the child may still fall sick or be affected by pollution arising from those people who have indulged in sexual intercourse. Since likambako is given to a child to protect it against such type of pollution, the couple or their parents have to go back to the traditional healer or whoever was responsible for the preparation of this protective medicine and explain to him that despite the fact that a child was given preventive medicine nevertheless (s)he has become sick. The person responsible has to look for some stronger medicine which will afford protection against those who are “hot”.

Exposure to pollution as defined above may result in the child suffering from diarrhoea or fever. While children may suffer from these illnesses from natural causes or man-made poor sanitation/hygiene, all the old informants including some young women said that divination processes play an important role in determining the cause of the child’s illness. It is through these processes that people know that someone in their midst has touched the child after having sexual intercourse.
In this context, I would like to cite an example which illustrates that the situation has changed quite a lot. I had made an appointment to interview one informant the following day but when I arrived I was informed that she had left at dawn for Zomba Central Hospital (ZCH) where she was escorting her young sister who had developed labour pains during the night. The sister was discharged the same day and the following day I went to have an interview with my informant. During the course of the interview she said that her sister who had delivered the previous day was sitting outside a nearby house with her baby and she also invited me to go and hold the baby. I reminded her that custom has it that a child comes out of the chilowero after two to three days that is after the umbilical cord had fallen. One question that came instantly into my mind was: why had the baby come out of the house when the umbilical cord had not fallen as is usually the custom? She told me was that things have changed quite a lot nowadays. **Likambako** was administered on the same day the child arrived home from the hospital and could therefore be handled by even those who were/are hot; hence it was very safe for me to go and hold the baby; regardless of whether I was in the hot condition or not.

**Limitations of likambako**

While the administration of likambako has evolved as a way of preventing childhood illnesses (hence ensuring security) which come about because of pollution arising from indulgence in sexual intercourse, it has to be pointed out that it has its own limitations. There are two types of likambako: likambako laling’ono and likambako lalikulu. Very few people know how to prepare and administer likambako lalikulu.

**Likambako lalikulu**

When the child is to be taken out of the chilowero, a couple belonging to the same clan as the mother of the child to be brought out is requested to have sexual intercourse in their house. The couple is given some medicine (*mphinjiri*) which is put on the mat or bed where they will have sexual intercourse. In the morning after the intercourse they wash their hands in a pot (nowadays it can be a basin) of water. This water is used to bath the child on the day it is coming out and the medicine which was on the bed when they were
having sexual intercourse is used to make *mphinjiri* which is tied around the neck and/or waist. After this ceremony the child can now come out and they are no longer afraid of anything and the child can be touched by anyone without fear. The medicine for the preparation of this type of *likambako* is put on the bed where sexual intercourse is performed in order to make it hot.

One traditional healer I interviewed had a different version of *likambako lalikulu*. He said that he has been administering *likambako lalikulu* for sometime and he has not had any complaints from anyone so far. He said that as soon as a child is born and while still in the *chilowero*, he makes incisions on its skin into which is rubbed some medicinal powder. A child is then given a herbal bath. After this even if someone wants to harm the child (for example by touching it after sexual intercourse), nothing will happen to it.

**Likambako laling’ono**

This is prepared simply by taking the herbs and bathing the child without giving the medicine to a couple who will have sexual intercourse.

It is believed that *likambako laling’ono* is not all that strong because after this a child can still be affected (i.e. become sick) by those people who are “hot”. People still administer this because there are others who do not know *likambako lalikulu*. Once *likambako lalikulu* is administered, the child is fully protected and nothing can affect him/her. *Likambako laling’ono* has therefore some limitations because it can fail to work.

The use of amulets as a strategy for the prevention of illness afflicting children is widespread in sub-Saharan Africa. The Dormaa of Ghana (Fink 1989:302), the Tabwa of Zaire (Davis-Roberts 1992:376-93), the Berti of the Sudan (Holy 1991:30-31), the Shona of Zimbabwe (Chavunduka 1978:35-36 & Gelfand 1964), the Nyole of Eastern Uganda (Whyte 1997:132-52) and the Digo of Kenya (Read 1966:31) are some of the tribes in Sub-Saharan Africa that utilize amulets for the prevention or treatment of childhood illnesses.
The use of amulets is still widespread in Malawi too as it has been expressed in the excerpt of the song by Billy Kaunda, one of the most popular local contemporary musicians:

Wona asalire e kumuchekera timpli ee (When a child cries you make incisions on its body)
Asa'atsamu/e e kumumveka njilisi ee (When it yawns you make it wear njilisi)
Asakhosomole ee kumusokera timphini ee (When it coughs, you sew chithumwa)
Thisatenthe ee kutenga kukaombeza kumanhwala (When its body is hot, you go to a diviner)

Amuna anga mandiopsya nditupita kwa amayi (My husband you have intimidated me, I am going to my mother)
Ndapi/ira mokwanila ndikawauza akandimvera (I have persevered for long, they will understand my problems)
Zoterezi kwathu kulibe pefi ndifile opemphera (We do not practice these things because at home we are christians).
Mutzarditenga mukazasintha tsalani muzisanduka ... (You will get me back when you change, stay and continue practising witchcraft).


The above song is indeed a testimony of the continued utilization of amulets, consultation of traditional healers as well as the practice of witchcraft. In this song the wife is leaving the husband because the husband likes traditional medicines and divinations so much. She does not believe in this because at her home they are christians. We can, therefore, safely say that the coming of Christianity has to some extent tried to detribalize the societies in Malawi by telling them to stop practices based on traditional beliefs.

All the women interviewed mentioned that most young couples do not like their children to wear amulets around their necks as well as their waists. Hence what happens is that most of the likambako that is administered is the bathing of the child. This is especially the case with those children born in towns like Lilongwe, Blantyre, Zomba. Some of these children who are born in town do not even put on amulets but they grow very well without becoming sick. Asked why this is the case, my old informants said that it is God’s will.

Declaration of adultery as a way of protecting children against being ill

Extra-marital sexual intercourse is generally considered dangerous to the child. The informants said that it is not possible for a woman to engage in sexual intercourse soon after delivery because at that time she considers herself dirty (unclean) and polluted.
Engaging in sexual intercourse with the husband would imply that she does not love him because this is considered very harmful to the man.

After the birth of a child, the husband and wife are not supposed to have sexual intercourse. According to my informants the period varies between six months and twelve months.

A long time ago when a man has committed adultery and yet he knows that he has a small child at home, it was not possible for him to go to his house directly. He was supposed to stand a few metres away from his house and call someone especially his in-laws and declare to them that he has committed adultery. He was announcing his misbehaviour for the good of the health of the child. Failure to pronounce this would result into a child being affected by the sexual intercourse he had. This is what is referred to in local language as tsempho. As soon as this is announced the man is taken to another house where he is kept while consultations go on with the traditional healers or such other knowledgeable persons in order to find some medicines to protect the child against being affected by the promiscuous father. The search for medicines is usually the responsibility of the parents of the woman. The administration of these medicines differs and it largely depends on the rules given by the medicine man. Various informants said that the medicine once obtained

i. is mixed and/or cooked with food and given to a child and some is used for bathing the child.

ii. is used to bath the child at a road junction where the man stood when he was announcing his infidelity.

iii. Others light a fire and they throw some medicines in that fire. The man is told to hold the child and together they should warm themselves beside this doctored fire.

Such rites as are performed by the members of the Yao society to purify the father who
is in a polluted state may be referred to as purification rites. As can be envisaged from the above discussion, it can be concluded that most of the blame for a child becoming ill was placed on the promiscuous father and all these attempts to look for protective medicine were/are aimed at protecting the child from pollution arising from the sexual intercourse performed by the father with other women. When asked if the mother would ever be blamed, most women gave varied answers: some said that a woman with a young child cannot engage in sexual intercourse because she knows that by so doing she is placing her child at risk of getting ill, while others said that young children cannot be affected because these young women when they engage in sexual intercourse (adultery) always have the child with them. Men have sexual intercourse with other women when the child is away with its mother hence it is proper that they should stand away from their houses until proper rituals have been conducted to prevent the child from being affected by such type of pollution. One old woman, however, said that it is a bit problematic for a mother to have sexual intercourse with other men because it is a shameful act as the child is still very young. However, when it happens that she has sexual intercourse, the child will have diarrhoea. Chilivumbo (1972:67-79), who did his research in Blantyre, Mulanje, Zomba, and Lilongwe has reported that after sexual intercourse a woman becomes taboo. Any baby she touches contracts illness and may die. If she adds salt to relish or cooks any food, those who eat it contract mdulo, a blood vomiting illness.

A number of old women spoke of personal experiences with regard to husbands having sexual intercourse with other women. They said that if a man has sex with other women and comes back to his house in those days when he holds the child, it cried quite a lot and in the end the child could even die. A number of cases were cited during the interviews in which children died in the hands of men or on their laps and when this happened people knew that the man had sexual intercourse with other women. The old women especially said that it is very easy to differentiate the normal crying of a child and that caused by a father in a polluted state. As soon as the child starts crying they know that the father has had sex with other women hence they quickly take the child away from him and start looking for medicine which is used to bath the child.

Audrey Richards has also reported that among the Bemba, the father who is impure
through illicit intercourse kills his child with fire (*ukumuipaya umuliro*) so that the baby starts to waste away and then dies (1956:34).

**Hospital admission as a way of preventing childhood illness?**

When a child swells or loses weight, of course at the hospital they say that it is malnutrition. In some cases they recommend that when the mother goes home she should start giving the child a balanced diet. If the condition is very bad, the health worker may decide to admit the child in the hospital. During the admission period the child is given a balanced diet (*zakudya za magulu*) and after a few days the condition of the child starts improving and in the end it gets better. The indigenous belief is that the child is in this condition because the couple started having sexual intercourse before the time for *kumutenga mwana ku mphasa* was reached.

While people in this village acknowledge that giving the child a balanced diet is indeed helpful, some of my informants disputed this fact saying that indeed the child gets better not because of being given a balanced diet at the hospital but because the hospital is like a prison and hence the woman, since she has to stay with the child at the hospital, does not have time to engage in sexual intercourse which is the underlying cause of the illness of the child. They claim that when a child is discharged, it will become sick again if the couple engages in sexual intercourse again. Giving balanced diet without addressing the root cause of the illness does not mean anything at all.

**The dangers associated with a newly delivered mother**

Old women interviewed said that after the birth of a child, the husband and wife are not supposed to have sexual intercourse for a period of 12 months. This period is, however, not all that strict as mothers mentioned periods ranging from 6 to 12 months. This postpartum sexual abstinence is for the good of the husband as well as the child. It is believed that having sexual intercourse with a newly delivered mother would result in a man becoming sick; the man would suffer from an illness called *chinyera*. It is a bit difficult to translate this illness into English as this would create misrepresentations because it is
a culture bound syndrome. Chinyera can also be referred to as a folk illness. Rubel (quoted by Helman 1994) has defined folk illnesses as

" Syndromes from which members of a particular group claim to suffer and for which their culture provides an aetiology, a diagnosis, preventive measures and regimens of healing", (in Helman 1994:97).

Chinyera is a very unique disorder recognized, I presume, mainly by the people of Mtwiche village and possibly other surrounding villages. As far as the biomedical system is concerned, it is not able to diagnose what a patient suffering from chinyera is really suffering from.

A number of men and women I talked to in Mtwiche village confirmed that when a man suffering from chinyera goes to the hospital, after careful examination he is informed that they cannot find anything wrong with him. One traditional healer interviewed said that sometimes if it is a Malawian medical doctor who is making the diagnosis and cannot find anything and yet the person looks very sickly he will advise him to try “mankhwala achikuda” (African medicine). The signs and symptoms of a man suffering from chinyera include feeling very cold and always either basking in the sun or warming himself to the fire, the fingers become long and very thin, has very pale and straight hair, palms become very pale signifying loss of blood, and in some cases a black person becomes very light. It is not only fingers which become long and thin but also the person himself. He does not walk upright because the upper part of the genitals (just above where pubic hair is) is very painful. If proper care is not given to the man he may die. In those days this illness was very rare because people were following strictly the beliefs and values of society. These days you find many thin men with very long fingers and the health workers say it is AIDS. There is a general belief in this society that not all such cases are AIDS: some are chinyera and this illness results from having intercourse with a newly delivered mother. Divination is a process through which people know that the man is suffering from chinyera. A diviner is in a position to say that the man is suffering from chinyera because he started having sexual intercourse with the wife when the child was still very young.
When it has been established that a man is suffering from *chinyera*, a traditional healer will prepare the medicine as follows:

"Some medicine is put in a reed and this is blown into the anus after which black things come out of the anus".

It is these black things that were causing a lot of pain to the man. After this treatment the man's condition improves greatly.

In those days it was a taboo for a couple to sleep on the same mat after the wife delivers as this was considered to be very tempting. One of the informants said,

"*Mphaka ndi khoswe sungamangirethumba limodzi*" meaning you cannot put a cat and a rat in the same bag as a rat is bound to be eaten.

What she meant was that after the birth of a child a couple is not supposed to sleep on the same mat let alone in the same (bed)room because if this happens it may not be possible for the couple to avoid having sexual intercourse. In order to protect the man, in some cases the wife and husband used to sleep in separate houses until such a time comes that they could resume sexual intercourse. After delivery a lot of "bad things" (*zinthu zoipa*) remain in the vagina and it is better for some time to pass before she can be engaged in sexual intercourse again.

Nowadays things have changed quite a lot. Young couples resume sexual intercourse six weeks after delivery. They claim that since children are born at the hospital, the hospital staff tend to evacuate (*amapopa*) the vagina thus removing all the bad or dangerous things which can harm a man i.e. cause him to suffer from *chinyera*. While this is the emic explanation, etically it can be argued that indeed evacuation is possible and is performed if the placenta or part of it is retained. If evacuation is not done then the womb would not involute (contract) and consequently there would be a postpartum haemorrhage. The retained material can also cause infection.
If parents ask the young women why they are resuming sex so soon and they try to advise them to refrain from doing so, the young women get very irritated and ask them:

"Kodi mukufuna kuthetsa banja langa?" (Do you want me to be divorced?).

What these young mothers mean is that if they do not have sexual intercourse with their husbands while still having a small child the husband may decide to leave or even divorce them for other women where he can be taken care of.

While most old women said that if a newly delivered mother has sexual intercourse with a man, nothing can happen to the baby, it was interesting to note that some women said that sexual intercourse when the baby is breast feeding is bad as semen from the man tends to pollute breast milk. The child, therefore, sucks milk which has been contaminated with semen hence it will become sick: it will suffer from diarrhoea, "malnutrition" and coughing. This conceptualization by the Yao of Mtwiche village, southern Malawi regarding the pollution of breast milk by a man's semen is indeed similar to those beliefs held by other African tribes like the Shona of Zimbabwe, the Azande of Sudan and the Wimbum of Cameroon (Gelfand 1964:117, Evans Pritchard 1976:27 and Pool 1994:105-107 respectively). While Evans-Pritchard is silent on what would happen if a child breast feeds while the mother is having sexual intercourse, Pool has said that the child would suffer from kwashiorkor (1994:105) while Gelfand mentions intractable diarrhoea (1964:117). In this study both were found: the child would swell or become very thin and will also have diarrhoea. Swelling and becoming very thin are both signs of malnutrition. Most old women said that there are so many children nowadays who look malnourished because modern and young couples start having sexual intercourse before the time for kumutengera mwana kumphasa is reached. Evans-Pritchard adds that while illness among the Azande is almost always attributed to witchcraft, there were indeed certain circumstances when this was not the case for example when it was known that a taboo has been breached. He says:

".... When a child becomes sick, and it is known that its father and mother have had sexual relations before it is weaned, the cause of death is already indicated
by the breach of a ritual prohibition and the question of witchcraft does not arise", (Evans-Pritchard 1976:27).

Recognizing that sexual intercourse after a woman delivers is dangerous both to the man and the child and wanting to ward off this danger, the elders found it necessary to advise young couples to refrain from having sex until a number of months pass, as elaborated above.

All the old women who were interviewed said that the situation has changed quite a lot these days. Postpartum sexual abstinence as defined by the elderly is not being adhered to. The result is that there are so many "malnourished" children at the hospitals these days who are characterized by swelling as well as being very thin. At the hospital they say that these children are malnourished i.e. it is lack of food. While to some extent this might be true, there is a general belief that the condition of these children is as a result of not sticking to the taboos. For example, some mothers said that sometimes after a man has sexual intercourse with other women, they come home and share eating utensils or cups for drinking water with the children or they eat on the same plate with the children. This is what leads to children looking as if they are malnourished and the children may also develop diarrhoea.

A newly-delivered mother is not supposed to put salt in the relish that will be eaten by others. If she does this then the children will be swollen as if they are malnourished. The elders and the husband will suffer from toothache. The husband would also suffer from toothache if he eats on the same plate as the wife who has just delivered. When such things happen even if you try to obtain treatment from the hospital, it does not work. Almost the same thing happens when the woman while she is still in the chilowero eats together with children. She is supposed to eat alone and using separate utensils. This should also be observed when the woman is menstruating. Otherwise children would suffer from toothache frequently. The old women interviewed said that in those days people used to grow very old while having full sets of teeth and they were even able to eat roasted dry maize. These days most young men and women including children suffer from toothache because of failure to observe these taboos.
Few old informants said that another change that has taken place is the introduction of bars. These days when a woman delivers she may decide to leave the baby with her mother or grandmother and others even decide to throw their children away into the latrine (of course this is very rare). After this, they then go and drink and dance in bars where they have sex with other men. This new “fire” is what makes the child sick (moto wanyuwanivu ndi umene umabweretsa matenda kwa mwana). After having sexual intercourse with other men in bars, this same woman comes home and adds salt to the food which is then eaten by people in the household thereby causing the men, children and old people to become sick. Children may have swollen cheeks, legs and they cough very often. In those days bars were not there and people used to follow rules and regulations as set down by society. Nowadays morality has completely broken down causing all these problems.

**Kutenga mwana ku mphasa**

This is the time when the couple has to resume sexual intercourse after the birth of a child. This period varied from six months to 12 months and all the elderly women said that this postpartum period has greatly been reduced by modern couples. None of the young women interviewed, however, admitted that these days young women have sexual intercourse six weeks after delivery. They said that they follow what their elders tell them namely that they should not have sexual intercourse for a minimum period of six months after delivery. Evidence showed otherwise. Therefore, were these young women just telling me what, as a researcher, I wanted to hear? The same issue has been raised by Pool in his research on HIV/AIDS and behavioural change (Pool 1996:302-221). Recognizing the intimacy of sexual issues and the secrecy that surrounds this especially in African societies, one point that can be raised at this juncture is the legitimacy of the answers that these young women were giving as far as the issue of postpartum sexual abstinence was concerned. Borrowing a term from Professor James Scott of the *Weapons of the Weak* fame, I would look at this as a *hidden transcript* since it is something that these young women say “offstage” and it contradicts what the practice is (Scott 1990:1-16). For example, one of the elderly women interviewed gave an example of her younger sister who despite the advice that was being given by the parents became
pregnant again a few months after she delivered another child. This showed that there are some young women and men who do not take heed of what the elders say.

In those days after delivery and before the couple could resume sexual intercourse, it was the elders who decided this for them. They could not resume sexual intercourse by their own volition. The elders would say:

"Munyumba muja akhalitsa tiyeni tiwalamule ayambe kugonera limodzi mwamuna angalowe pa thengo". (This translates as: In that house they have stayed for long without having sexual intercourse. Why don’t we allow them to start having sexual intercourse otherwise the man will start having sex with other women”.

When the child is about six months old or older, a ceremony called kutenga mwana ku mphasa is conducted. During this ceremony, the couple has the first sexual intercourse after the birth of the child in its presence. After this ritual the likambako which is used to bathe the child everyday is thrown away while the one tied around the neck and waist is taken off the baby. The traditional healers differ in their prescription of likambako. Others take it away when the child is old enough, some leave it until it snaps or gets cut on its own; while others take the one around the neck and put it around the waist and the one which was around the waist is put around the neck. At this time the child is taken to be a grown up and even if the parents are promiscuous, nothing can happen to it. It has been recognized that when a child is not given likambako (s) he dies hence it is important for him/her to wear this especially when getting out of the chilowero. However, nowadays modern couples do not follow this and such behaviour is what is leading to children suffer from diarrhoea, malnutrition and having pale hair (as is being claimed by the older generation).

Sexual intercourse and “doctors”

The Malawi Social Indicators Survey has revealed that 46.9% of all births in Zomba district are done in the hospital, 40.9% in the home, 6.7% TBAs while 5.5% in a Health Centre. From this it can be seen that over 50% of all deliveries are performed by people
trained in biomedicine (Chilowa 1996:14-16). Since Mtwiche village is in Zomba, it can be presumed that this statistics is also applicable to this village.

In the case of Mtwiche village most deliveries are taking place at Domasi Rural Hospital which lies about five kilometres away. The administration of likambako to the newly born children is still being practised. However, the problem being raised now by most old and young women is that contradictory to traditional beliefs which advocate that a newly born child should not be handled by those people who are “hot”, in the hospital deliveries are carried out by the medical doctors and nurses who (it is presumed) sometimes have sex in their houses before coming to the hospital for deliveries. And in such “hot” conditions they assist the delivery of children and then nothing happens to the baby. This has provoked a lot of thought especially from the younger generation of mothers who have failed to trace the link between cause and effect namely between exposure of babies to hot conditions (e.g. doctors) and the onset of illness in children. This has led some of the young men women not to follow what their elders are saying regarding traditional values and beliefs. Some of the elders especially blamed children’s illnesses on the doctors/nurses having been hot during the time the child was being delivered.

The conflicting views of malnutrition

While the original intention was to write a separate chapter on malnutrition, this would have meant that there will be a lot of repetition. Because of its great association with sexual relations, it would be better to deal with it in this chapter.

In the absence of anthropometric techniques and such other methods, it becomes increasingly difficult to recognize widespread moderate childhood malnutrition. The observance of clinical signs is a certain method of recognizing those children who are severely malnourished. There are two major forms of malnutrition namely marasmus which is accompanied by severe wasting and kwashiorkor which is characterised by swelling and skin and hair changes.

The State of the World's Children report by UNICEF (1998) has pointed out that despite
years of research, the reasons why some children develop kwashiorkor and why others
develop marasmus still remains a mystery. What is clear, however, is that if left untreated,
children with either condition are at high risk of dying from severe malnutrition. While this
is a very clear biomedical view, the socio-cultural concept of “malnutrition” is very
different. Do different cultures across the globe look at “malnutrition” (in whatever way
they define associated conditions) as resulting from lack of nutrients?

The young mothers who mentioned that malnutrition is one of the most important dangers
said that it can be caused by either lack of food in the body or when the child suffers from
diarrhoea and does not receive any treatment at all. They added that malnutrition can be
prevented by giving a child a balanced diet and when the child develops diarrhoea,
treatment should be sought timely. When a child suffers from malnutrition they go to the
hospital where they diagnose that the child is suffering from malnutrition. When the
condition is very severe, it is admitted and while in the hospital it is given a balanced diet.
But if the condition is moderate, the parents are advised to start giving the child a
balanced diet. This, however, is in great contradiction with the traditional values and
beliefs which say that the conditions of malnutrition arise because of infringement of
sexual taboos (as explained earlier).

Concluding remarks

A number of rituals as explained above are performed as soon as a child is born. In this
section I have tried to give what Audrey Richards (1956:112-115) calls the “expressed
purposes of rituals” which she defines as the explanations by the performers of the rite
themselves regarding what they try to achieve by their ritual behaviour. The observation
of food taboos by pregnant women, the administration of likambako, declaration of
adultery by men especially and hospitalization et cetera are specifically aimed at
protecting babies against becoming ill. These are the expressed purposes but other
anthropologists like Marvin Harris have called these the emic perspectives or explanations
(1980:32). And building on the work of Bronislaw Malinowski, it would be proper to say
that the function of these rites (preventive though they may be) is in general to promote
the social cohesion of the group.
Additionally, what should be mentioned is the pragmatic approach that people have towards these preventive rituals: these are based on the argument that people administer *likambako* in order to protect children against becoming ill or being affected by those in the hot condition. This is something that they believe and it works.

Birth rituals in general have of course many of the features in common to the rites of passage in the sense in which van Gennep uses the term. These rites consist of rites of separation, rites of transition and lastly rites of incorporation (van Gennep 1977). Applying van Gennep’s theory to birth rituals it can be seen that there is a ritual of separation of the child (and the mother) as soon as it is born for the reasons espoused above. The brief period when the *likambako* is administered comprise the rite of transition and it is only after this that the child can be incorporated into society (this is the rite of incorporation). The *likambako*, therefore, removes the fear and dangers associated with sexual relations and it offers safety and security for the mother. As far as children are concerned the Yao mothers are obsessed with one fear (that of sexual relations polluting the child) and this is the most important feared risk that mothers are very much preoccupied with. And strategies have, as outlined above, evolved to offset such fears.
Despite the great global advances that have been made in the prevention of measles through the availability of the measles vaccine which is administered to children when they are aged nine months, the disease continues to be one of the most feared diseases amongst people in Malawi and other African countries. The World Health Organization says that measles is one of the major causes of death amongst African children. During years of epidemics measles can contribute or be responsible for up to 50% of all deaths of children aged between 1 and 4 years (Nyasulu & Munthali 1998). The disease is highly infectious and spreads easily from one child to another if they are not immunized. It is transmitted through respiratory droplets from infected persons even before a rash is seen. It has a deleterious effect on the nutritional status of the child more serious than any other common childhood infection. Therefore, immunization is the most effective public health measure available to improve the health of children. The signs and symptoms of measles include very high fever, red (fiery) eyes, coughing, sores in the mouth, diarrhoea and rashes on the skin. Complications include pneumonia, middle ear infections and bronchitis (Shealy 1998:446).

Because of high standard of health care and nutrition standards, measles is less a threat to children in the industrialized world. However, it can be “exported” to the developing world, putting the children in the poor countries at risk (UNICEF 1998).

The immunization coverage rate for measles nationally has been estimated at 70 per cent. In its 1998 Progress of Nations report, UNICEF stated that a high immunization drop out rate (i.e. the percentage of infants who begin but do not complete the full course of six vaccinations in their first year) spotlights problems in a health system. Taking the
BCG vaccination, given shortly after birth, as the starting point, and measles, administered at nine months, as the last vaccine that a baby receives, it is possible to chart a country's success or failure in immunization. In Malawi UNICEF estimates that the drop out rate between TB and measles immunizations is 29 per cent (UNICEF 1998). These are the children whose fundamental human right to health care has been denied, so proclaims UNICEF.

The causes of measles

Most of my informants said that they do not know the cause of measles. Some said that this illness is caused by God himself.

The treatment of measles

Once a child has measles their main concern was that the rashes should come out as quickly as possible. In order to hasten the appearance of these rashes, traditional medicine was used: a white stone known as "Cheka" was put in a pot of water where salt was added and this mixture was boiled after which it was given to the child to drink. It is claimed that after this it did not take long for the rashes to appear. In addition to this, a child was given "ngama" to drink. Their other preoccupation as far as measles is concerned was that it should never inflict the heart because if that happened then the child would die. In order to prevent this they used to draw a line on the chest of the child using "ngama". In addition to the fear that measles may inflict the heart, the people were also concerned that it should not invade the eyes because if it did so, the child could no longer be able to see. Because of this they used to rub some of the "ngama" on the eye rashes.

The use of traditional medicine to enhance or speed up the coming out of measles rashes has also been reported in Ntchisi and Chitipa districts where they use okra. During the Social Science and Immunization project it was also interesting to note that in Ntchisi district they, in addition to okra, also use Coca-Cola in order to hasten the appearance of rashes (Chilowa & Munthali 1998). Half of the Coca-Cola is rubbed on the child's body
while the rest is given to the child to drink. While Coca-Cola is a soft drink, the Chewa of Ntchisi have taken this as medicine to bring out the measles rash. This constitutes what in anthropology is referred to as "cultural reinterpretation".

Traditional medicine was available to treat children suffering from measles and this sometimes was very effective. Almost all the old women agreed that even though medicines were available for the treatment of measles, such medicines would not work (effectively) if there is a lot of sexual intercourse or activity in the village (Pamudzi pakakhala moto wambiri chikuku chimakhala ndi mphamvu).

They also said that it is not advisable to bathe a child suffering from measles because if you do so the rashes will disappear into the stomach and this is very dangerous because the child will die. This is, however, very different from what is happening now because the hospital recommends that a child suffering from measles should be properly bathed. The rashes may also go into the stomach if someone who has had sexual intercourse comes to see the child who has measles. Sometimes what happens is that they hide a child suffering from measles. When a visitor comes, they may be chatting at a distance while the child is in the house. They hide the child because they are not certain of whether the visitor had sexual intercourse (otentha) or not before coming to the house. This was a strategy aimed at the prevention of further deterioration of the child's condition.

The prevention of measles

Some old women said that traditional medicine was available for the prevention of measles. One of the informants, said that this disease even affects the elders. She gave an example of her sister who died of measles. She said,

"In those days there were traditional healers who through making incisions on the skin were protecting people against measles. There was this traditional healer who said that those who had suffered from measles need not receive these incisions. My sister cheated him saying that she had already suffered from measles. At a later stage she suffered from measles and died. All the others who had received
preventive medicine were okay. A person can only suffer from measles once. However, if it happens that (s)he suffers again then it is believed that it is through witchcraft”.

The problem, however, was that if someone knows such preventive medicine (s)he may decide not to give your child this medicine and hence your child would suffer quite a lot. Considering that measles is a very dangerous disease, the demand for preventive medicine is very high and even though in those days there were some traditional healers who knew preventive medicine, they could not meet that demand. The hospital these days is managing the fight against measles.

When there is an outbreak of measles in the village, they used to beat a drum and inform everyone in the village about this outbreak. The message was that couples should abstain from sexual intercourse until such a time when the outbreak was gone. (This could sometimes take three to 6 months). It was in fact the elders who again announced that the outbreak is over and people can resume sexual intercourse. All the elderly women who were interviewed said that in those days people were very much united and during such incidents everyone was very cooperative and indeed did not have sexual intercourse. A fresh branch of a tree was put in the road leading into the village to warn people that there is a measles outbreak in the village. When people see these tree branches they could then take the necessary precautions. When the outbreak is over, it is the elders who decide and rule that couples can now start having sexual intercourse. Couples cannot decide independently to start having sexual intercourse without the ruling from the elders. The elders were, therefore, very powerful indeed. It is proper to suggest that, in general, these elders probably just wanted to maintain such a hegemony.

When the rules about sexual abstinence are not followed, many children could then be afflicted and they would end up dying. These days these rules are no longer holding and the old women said that young people do not care any more. When they are told that there is an outbreak of measles in the village, they try to question why they should behave like they are in prison in their own houses by not having sexual intercourse with their spouses? The cooperation and unity that was once there is no longer available, things
have fallen apart and the centre cannot hold anymore (Achebe 1959)

The signs of measles as said above include fever, diarrhoea and rashes. One of my informants said that when these signs show the elders know that this is measles and then people in the village are warned about this and then if they follow this then measles outbreaks cannot come. Those who have just had sex are not allowed to see a child suffering from measles as this would exacerbate the condition. This is what used to happen in those days when people acted in unison. This does not happen now. The notion of individualism has now been adopted by most people and this is exemplified by everyone cooking on his own.

In order to protect the child against measles a sick child is isolated from healthy ones in order to limit the transmission of the disease.

Some said that it is a bit problematic to try to prevent measles as every child has to suffer from this illness at one time or the other. Most of the women interviewed said that they look at measles as a necessary step in the growth of the child. They only feel that the child is theirs after it has suffered from measles and survived. The suffering from measles can therefore be looked at as a rite de passage, a concept that was coined by the Frenchman Van Gennep to signify a change in status. The suffering and survival constitute what van Gennep calls the rite of aggregation (Mair 1965:233-237). After suffering from measles and surviving, a child can no longer suffer from measles again, hence it constitutes an important step in life, an achievement of the new status.

Measles: a changing scenario?

While sexual abstinence was one of the secondary methods of preventing measles, these days (they do not call on people not to have sexual intercourse anymore) the major method is through vaccinating children at the Under Five Clinics when children are aged nine months. Some said that the only problem with vaccination is that even though a child can be vaccinated against measles, (s)he will still suffer from the disease. Biomedically this is correct because most children when vaccinated may suffer from mild forms of
measles when there is an outbreak. Young mothers find it particularly hard to follow the age-old beliefs of refraining from sexual intercourse when the child has measles because when they go to the hospital, an institution which was not there during the time of their grandparents, the children are treated by doctors and nurses who have come from their houses and it is very probable that they had sexual intercourse before they came to the hospital for duties. When such doctors, who they presume had sexual intercourse handle or touch the baby during the process of treatment, their babies get healed. So where is the logic of refraining from sexual intercourse when children are afflicted with measles?

The issues of blame and responsibility, however abound, when the child dies. The mother is particularly blamed for her activities. Most young mothers, said that their children were vaccinated and they grow without suffering from measles. These days the young women said that they go to the hospital for treatment when their children suffer from measles. The parents, however, insist that they should go for traditional medicines but they said that these do not assist at all; hence their reliance on the hospital. Some women said that they only resort to traditional medicine when the hospital has failed to cure the child of measles. It is the staff at the hospital who are in a position to diagnose that a child is suffering from measles. Some of the young ladies are not in a position to do that. Old women, however, know the signs and symptoms of measles and are able to inform the young mothers.

Old women also advocated that a child suffering from measles should not be bathed for reasons explained above. At the hospital, however, they advise that the child should be bathed which conflicts with the traditional beliefs and values. A compromise seem to have been reached as the young women said that these days instead of bathing the child, the hospital recommends that a clean piece of cloth should be dipped in water, all the water should be squeezed out of the cloth and this should be used to clean the child’s body. One informant said that when bathing a child suffering from measles you need to use hot/warm water because if you use cold water the condition may worsen.
Concluding remarks

What is clear from the above discussion is that both the young and old women agree that indeed measles is a very dangerous illness, however, the point of departure is the explanatory models for this illness. In the past the elders exerted a lot of social control over the young people and over the years this power has slowly been eroded. Now they cannot exert any control at all. If there is any power left in them it is very limited. The new generation has largely adopted the biomedical illness explanatory models.
CHAPTER 5

THE CAUSES, TREATMENT AND PREVENTION OF DIARRHOEA

Defining diarrhoea: a biomedical perspective

Diarrhoea is a disease which commonly attacks children aged between 6 months and 2 years of age and is characterised by the frequent passing out of loose or watery stools (three or more times a day). This is caused by viruses and bacteria and spread by among others the utilization of dirty hands, dirty cooking pots and feeding pots (including infant feeding bottles) and the consumption of dirty and contaminated water. This disease is dangerous because it can lead to death and malnutrition. Death is as a result of the loss of large quantities of water and essential salts from the body i.e. dehydration. Diarrhoea causes malnutrition and makes it worse because food is lost from the body and also because a person suffering from diarrhoea is usually not hungry. Diarrhoea is worse and more common in children with malnutrition (WHO nd).

It has been established that diarrhoea is essentially a disease which is very much associated with poverty with its resultant malnutrition, poor sanitation, housing and overcrowding, garbage disposal, poor and contaminated water sources and the general vulnerability to infections (Helman 1994:9-10 & 365-367, UNICEF et al 1993:43-50 & Weiss 1988:5-16). Helman has added that the control of diarrhoeal diseases shall only be achieved when socio-economic issues have been addressed (Helman 1994:367). The safest and most inexpensive way of preventing and treating diarrhoeal diseases which is currently available is through the use of oral rehydration salts (ORS) which are available in different outlets including hospitals, groceries and shops. Despite the availability of ORS (in some cases free of charge), a number of problems have cropped up since the introduction of this treatment in different countries and these include non-acceptability by the indigenous populations and the wrong or inappropriate way of dissolving ORS (Helman 1994, Mull and Mull 1988:53-67 and Weiss 1988:5-16).
In Malawi diarrhoea remains one of the major causes of morbidity and mortality amongst children (NSO 1992:93-97). And ORS is the most used treatment for diarrhoea and the 1998 Progress of Nations report by UNICEF (1998) estimates that for the period 1990 - 1997 ORS use has been pegged at 78% a great improvement from 43% for the period 1987-1994 (UNICEF http://www.unicef.org/trans/trans05.htm).

Causes of diarrhoea: an ethnomedical view

In local language diarrhoea is known as “kutsegula m’nimba” which literally means opening the bowels. Both the old and young women said that they easily know that the child is having diarrhoea by observing the frequency at which the child passes the watery or loose stools which is not very different from the biomedical perspective. All those women who were interviewed and mentioned diarrhoea to be an important danger for children said that this is so because a child loses a lot of water and in the process it becomes very weak. If treatment is not sought on time the child might even die therefore diarrhoea is very dangerous.

Two old women from those interviewed said that diarrhoea is indeed one of those most important dangers affecting children but the rest mentioned diarrhoea as a sign of something else. They attach diarrhoea to a taxonomy of a number of illnesses. Some said that this illness comes about as a result of growing up i.e. it is a rite de passage (van Gennep) and every child has to pass through this status especially when teething. This view was also shared by some young women interviewed as well as the traditional healers and traditional birth attendants. It is, therefore, not possible to prevent it as it is an important step in the life of a child. In addition to teething, other childhood milestones that are associated with diarrhoea that have been reported in other parts of Africa include crawling, walking and talking (Weiss 1988:5-16, Curtis 1998:99-112). Others said that a child may develop diarrhoea when it is suffering from measles as well as headache. This, of course, is in line with the biomedical perspective which states that a child suffering from measles will also suffer from diarrhoea.

However, most of the old women interviewed and as has been explained in Chapter 3,
attributed diarrhoea to pollution arising from sexual intercourse. Diarrhoea is one of the symptoms manifested in children whose parents especially the father have sexual intercourse with other women and then they come back to the household where they share eating utensils with the children or having sexual intercourse with the wife before the period as defined by society is over. In his review of cultural models of diarrhoeal diseases, Weiss has also reported such an association between diarrhoea and parental sexual infidelity and gives an example of the Binis of the Bendel State in Nigeria where a nursing mother is forbidden to engage in sexual intercourse because if she does her baby will suck semen from her breasts and become ill (Weiss 1988:5-16). Very few of the young women in Mtwiche village shared this idea.

As has been said above, it is believed that some diarrhoeal cases in children are caused by teething while others are due to pollution caused by sexual intercourse committed by parents. The difference between these two cases is that a child suffering from diarrhoea caused by sexual pollution becomes very weak compared to that caused by teething. Some of the informants said that it is possible to suffer from diarrhoea caused by natural causes. It was also expressed that people tend to wonder that despite the fact that the government has given them piped water, diarrhoeal cases are on the increase these days. In those days they used to drink water from rivers but diarrhoeal cases were very few. The child may also have diarrhoea because may be (s)he has headache or measles or malaria.

Most of the young women interviewed attributed diarrhoea to general uncleanliness in the home, not boiling drinking water and not covering foods as well as drinking water. What was most interesting was that none of the old women ever mentioned that diarrhea is caused by uncleanliness or drinking unboiled water. They mainly attributed it to pollution arising from sexual intercourse. Some, however, said that they do not know the cause of diarrhoea they just realize that a child is suffering from diarrhoea.

Because of the great diversity in the aetiological factors for childhood diarrhoea, old women and very few young women said that before giving any form of treatment, it is very important to determine the cause. In order to do this they go to "maula" (divinations)
where they are told whether the diarrhoea is caused by ancestors, sexual pollution, witchcraft or is indeed due to natural causes. Unlike in other cultures like in Burkina Faso (based on an AMMA lecture the social character of African medicine by Sylvie Fainzang of GERMES/INSERM, France) where diviners only divine, the traditional healers interviewed in Mtwiache village did both namely, divining, as well as giving out medicinal herbs. Both traditional healers interviewed said that their main area of specialization are those illnesses which are caused by witchcraft (matsenga) though they also assist those people who have illnesses of natural origin or those arising from sexual pollution. Those suffering from illnesses for example diarrhoea caused by ancestors are advised to go and consult those traditional healers who are specialists in this area.

When my informants were asked to explain how ancestors and the breach of, for example, sexual taboos make a child suffer from diarrhoea, the explanation they offered was that it is a belief that has been passed onto them over the generations and it has been found to work. Pool’s work among the Wimbum in Cameroon is one of those studies that has attempted to shed some light on this mystery. Some of his informants said that it is not possible for ancestors to cause illness; they attributed the illnesses to the work of the living persons who masquerade as ancestors. Pool (1994) also adds that since it is old men as heads of clans who are supposedly in constant touch with the so called ancestors, it is presumed that old people are the ones who are witches hence responsible for meting out punishments through the infliction of illnesses like kwashiorkor, diarrhoea and death on those who break the traditional norms.

**Treatment of Diarrhoea**

Traditional medicine was available for the treatment of diarrhoea and some old parents said that this used to work in those days not nowadays. Even if you give your child the traditional medicine that was given to children in those days it does not work at all. Amulets sometimes are also put around the necks or waists of those children suffering from diarrhoea as a way of treatment. Young mothers said that since a child loses a lot of water when suffering from diarrhoea, it has to be given water frequently in order to replace the water which is lost.
Diarrhoea, which is caused by teething does not give a lot of worries to the parents. One mother said that they buy medicine from the pharmacies and rub it on the gums and diarrhoea does not continue. While in Swaziland it has been reported that parents rub traditional medicine on the gums to make the teeth grow faster (Weiss 1988:5-16), my informants said that they usually do not do anything because such type of diarrhoea is considered normal.

All those young mothers who mentioned that diarrhoea is one of the most important dangers for children said that at the hospital they are advised to boil some water, add salt and sugar and then give the mixture to the child to drink frequently and if the condition does not improve they are supposed to rush to the hospital. Only one mother explained that when they are making sugar/salt solution at home, they take three tea spoons (or three fanta bottle tops) full of salt and another three teaspoons (or bottle tops) of sugar and dissolve it in three fanta bottles (equivalent to one litre) of water. At the hospital they give them a packet of UNICEF (this is what ORS is known as in the villages since it is distributed by UNICEF) from which they prepare a solution on their own when they get home. These young mothers were therefore asked how they prepare these solutions after being given a packet of ORS. It was interesting to note that all of them said that they take three fanta bottles full of (boiled) water (which is approximately one litre - the recommended volume of water) and pour them in a bigger bottle to which is added all the contents of the packet and this mixture is stirred. And this mixture is then given to the child to drink frequently. Some of them said that when they do not find any ORS at the hospital they are advised by the health workers to prepare a salt/sugar solution at their home. Asked about the effectiveness of this solution the mothers said that when it fits the child its condition will improve. In addition to ORS and salt/sugar solution prepared locally, some mothers added that they also give the child rice water and locally made gruel (thobwa). One said that breastfeeding should continue. Most of them said that as far as diarrhoea is concerned they do not go to the traditional healers for treatment. Others visit the traditional healers when the hospital has failed.

Even though divination systems play an important role in determining the help seeking behaviour as regards diarrhoea, self medication may start and then they may go to the
hospital believing that if it is of natural origin it will be treated and will stop. If this treatment, however, fails they may then reclassify the illness and attribute it to supernatural origin or witchcraft. Reclassification is not only for diarrhoea: it applies to many illnesses. Though sorcery or witchcraft is an important possible cause of illnesses in village life in Malawi, it was very infrequently mentioned as a cause of diarrhoea in Mtwiche village. Witchcraft as a cause of illness was mentioned by both young and old women.

One young woman mentioned that a child will have diarrhoea if while pregnant the mother eats eggs and roasted maize (ref to Chapter 3). Some young mothers said that they find it a bit problematic to give the child traditional medicine because at the hospital once they know then they will be very angry at you.

### Prevention of diarrhea

All the old women said that it is not possible to prevent diarrhoea and in the old days they just realized that a child is suffering from diarrhoea. It is not possible to prevent diarrhoea before the child suffers from this illness. You only take action when the child suffers from the disease. The young mothers interviewed, however, said that it is very possible to prevent diarrhoea and they mentioned the use of clean plates, cups and pots, covering drinking water and food to prevent contamination by flies which are responsible for the transmission of diarrheal microbes, covering dirt, making use of pit latrines for the disposal of waste and making use of pit latrines and keeping them clean always.
CHAPTER 6

CONCLUSION: RISK AND VULNERABILITY IN THE CONTEXT OF SOCIAL CHANGE

"The practices of these peoples (Africans) in relation to disease are not a medley of disconnected customs, but are inspired by definite ideas concerning the causation of disease ....", (Good 1994:38 quoting W.H.R. Rivers 1924).

Introduction:

An attempt has been made in the previous chapters to describe what the mothers of different generations consider to be the most important dangers threatening the lives of their children. "Most important" in this context does not mean the most common but what they fear most. Though many anthropologists including Foster and Anderson have argued that traditional peoples are not the best candidates for preventive health because the concept of prevention does not exist in their cosmology (Foster & Anderson 1978:232-233), in the previous chapters an attempt has been made to show that amongst the Yao people of Mtwiche village in Zomba, prevention is part and parcel of their cosmology.

Paul (1977) quoting the work of Polgar (1963) talks about the fallacy of empty vessels which means that the subject populations do not have established health customs and are empty vessels waiting to be filled with whatever health programme is being advocated (Paul 1977:233-236). From the previous chapters it has aptly been demonstrated that the people of Mtwiche village are not empty vessels as far as preventive as well as other aspects of health care are concerned. They know what they are doing!

In this chapter attention will be paid to the discourse on risk and vulnerability in the context of social (culture) change.
Disappearing epidemics and the emergence of new risks/dangers

Both the young and old women mentioned "malnutrition" (for the old women was it really malnutrition or an illness caused by sexual relations?), measles and diarrhoea as the most important dangers/risks. The major difference, however, was that illness explanatory models were in most cases different, young mothers preferring to give biomedical explanations.

Smallpox: an epidemic that has disappeared

Smallpox was the only disease that was mentioned by the old women as a disease which was very dangerous to people including children in those old days. What the mothers said was that when a person suffers from smallpox, (s)he was isolated from the others and a hut was built for him in the bush and near a stream where (s)he was nursed until such a time when (s)he was healed. This quarantine practice was enforced in order to prevent the further transmission of the disease to other people. Variolation, defined by Streefland & Egers as the inoculation of a healthy person with tissue taken from the pustules of an infected individual (Streefland & Egers 1997:6), was also practised as a way of protecting people against smallpox in Mtwiche village.

As is the case with the Yao of Mtwiche village, the use of variolation was also widespread in other parts of sub-Saharan Africa. Fink has described this process as "smallpox purchasing" since the material that was required could only be purchased from individuals suffering from smallpox (Fink 1989:302). The other tribes in this part of Africa that practised variolation included the Kikuyu of Kenya (Sindiga et al 1995:132), the Thonga of South Africa (Way Harley 1970:225-6) and the Nyamwezi of western Tanzania (Read 1966:31-2).

The process of variolation as defined by Streefland and Egers and others resulted into those so inoculated contracting mild forms of smallpox and in the process develop immunity.
The old women said that fearing that the skin would stick to the mat and hence cause a lot of pain to the patient, it was advisable that such patients should not sleep on mats but on banana leaves which are slippery. Such practices have also been reported by Chilowa and Munthali who did fieldwork among the Chewa of Ntchisi (1998). Thanks to the development of the smallpox vaccine, the disease has since been eradicated. It is in this context that the young women never mentioned smallpox because all of them have never experienced this illness.

*Malaria and poliomyelitis: emerging illnesses?*

There were certain diseases, however, that were only mentioned by the young women namely malaria (*malungo*) and poliomyelitis. These two diseases were never mentioned by the old women. While probably they existed in those days it seems the old women were not interested in them.

Briefly what the mothers said was that malaria is caused by mosquitoes and its signs and symptoms include feeling very cold, having very high fever as well as vomiting. One woman said that a child can also suffer from malaria if it feels very cold as a result of lack of warm clothing. Another woman said that this disease is dangerous because it may also attack the brain and then the child faints and may become mentally retarded. As far as treatment is concerned they said that they buy medicines such as aspirin from the shops and when this fails they go to the hospital for treatment. The child should also be well covered in order to protect it from cold weather. Sometimes they also consult traditional healers if the situation at the hospital does not improve. It was also mentioned that malaria can be prevented by making use of mosquito coils and mosquito nets.

As for polio, they said that they do not know the cause of this disease but they only realize that a child gets paralyzed and fails to walk after being very sick for a very long time. When a child develops polio they go to the hospital for treatment. All the young women who mentioned this disease as the most dangerous said this is so because it is a disabling disease and a child cannot function on its own: it always needs assistance. They, however, added that this disease can be prevented by having the children
vaccinated.

**Children as innocent sufferers**

The protection of children against becoming ill is the responsibility of their parents. At such a tender age, these creatures (children) cannot be in a position to look after themselves. Hence, mothers (especially) struggle in order to make sure that their children are in good health. Those interviewed in Mtwiche village admitted that everyone who is born is at one time or the other liable to become ill (of natural causes?). As has been explained above a number of strategies have evolved in order to protect children against risks.

Lupton (1993) has said that the concept of risk has a forensic property for it works backwards in explaining ill fortune as well as forwards in predicting future retribution. Among the Yao a number of dangers to children have been defined for example the food taboos for pregnant women, fear of sexual pollution, measles, diarrhoea and “malnutrition”. For modern couples measles is a preventable disease and if a child suffers from this disease, then people will know that the child was not vaccinated and the blame goes to the mother (parents?). They also know that malnutrition can be prevented by giving the child a balanced diet. The suffering of a child from malnutrition is indeed a sign that the child is not being fed properly. As far as the old women are concerned, malnutrition and some forms of diarrhoea are signs that sexual taboos have been broken. These examples support Lupton’s thesis regarding the forensic nature of risks. It can also be envisaged that knowledge of dangers or risks (and sometimes having personal experiences) may force people to adopt preventative measures. Since children do not know anything we can label them as innocent sufferers especially where afflictions or illnesses can be preventable. This view concerns or is applicable to both biomedical as well ethnomedical perspectives. While this is a widely held view namely that education causes awareness and then awareness may lead to change in behaviour, this is not always the case. Gringer, quoting the work of Simms and Bauman, says that there is a history of consistent failed connections between education and awareness and awareness and behaviour (Gringer 1995). This is especially the case where two or more
theories about risk and risk aversion contradict. For example, biomedicine promotes the consumption of a balanced diet for pregnant mothers and this includes eating eggs, offals, vegetables like okra and cassava leaves et cetera. But some of these foods, despite the fact that they are the ones which are mostly found in the village are heavily tabooed for purposes of protecting the health of the child after it is born. Because of health promotion through education, some young women have indeed started eating some of these foods and there is still a great figure of those who still do not eat despite the education (hence awareness) they receive. So as Gringer says, despite the fact that education does produce awareness, awareness may not directly lead to changes in behaviour because of differences in agendas (of the biomedical and ethnomedical perspectives).

**Personalistic versus naturalistic medical systems**

One of the most important contributions to the field of medical anthropology made by Foster is the dichotomous classification of entire ethnomedical systems into personalistic and naturalistic systems. He has defined a personalistic medical system as:

"One in which disease is explained as due to the purposeful intervention of an agent who may be human (a witch or sorcerer), non-human (a ghost, ancestor, an evil spirit) or supernatural (a deity or other very powerful being).

In contrast, a naturalistic system,

"Explains illness in impersonal, systemic terms and disease is thought to stem, not from the machinations of an angry being, but rather from such natural forces or conditions as cold, heat, wind, dampness and above all, by an upset in the balance of the basic body elements," (Foster 1998:141-150 & Foster and Anderson 1978).

It can be envisaged from the discussion earlier on that indeed Foster’s classification of medical systems into personalistic as well as naturalistic is applicable to the way the Yao
of Mtwiche village conceptualize or explain childhood illnesses. The hotness arising out
of sexual intercourse, germs and other (micro)organisms causing for example malaria can
be grouped under naturalistic systems while witchcraft and ancestors are personalistic.
While to a large extent I concur with Foster’s classification and that indeed illnesses
arising from sexual intercourse can be grouped under naturalistic systems because they
disturb the child’s body equilibria, I wish to argue that at the same time this hot/cold
dichotomy can be personalistic. This is especially so when people even if they know that
they have had sexual intercourse and they are not supposed to go and see the child (for
fear of making him sick), they still go and see the child with possibly hidden intentions.
This is what Foster says is the purposeful intervention of an agent.

Illness as a social construct

The perceptions of the young women were very close or even similar to those of
biomedicine, the perceptions of old women were very different. It is increasingly difficult
to relate for example sexual intercourse and falling sick of the child. What the old women
said was that indeed children fall sick if the parents have sexual intercourse with others
or if the parents resume having sexual intercourse before the ceremony of *kutenga
mwana kumphasa* is conducted. For those who have embraced the western world view,
it is a bit difficult for them to establish or understand the link between cause and effect.
People in this area have defined sexual and other taboos, the infraction of which results
into the child becoming ill. Testimonies were obtained from those who were interviewed
and they confirmed that children indeed sicken and sometimes even die after exposure
to sexual pollution. Whether these illnesses are from other causes, people of this area
have that experience and attribute some of the illnesses to pollution. Other sociologists
like Chilivumbo have also explained that some people are perceived to be dangerous
because they can tell you that “You have seen the sun rising and you will not see it
setting” and the person to whom this is addressed gets sick and then dies before sun set
(Chilivumbo 1972). What can be concluded from this discussion is that indeed illness (and
medical knowledge) is a social construct.
Conclusion: a dialectic approach to the study of risk and vulnerability

This study has examined what mothers of different generations consider to be the most important dangers or risks to children and what mothers do in order to prevent these risks. It has looked at the crucial concept of relevance. It has also been looking at culture or social change. An attempt has been made to describe the indigenous customs and beliefs which were being practiced a long time ago, whether these are still being practiced and what changes have taken place et cetera.

Talking of culture change, Malinowski has stated that there are three phases of culture contact. Applying this to change in Mtwiche village I would say that at first there was a reservoir of indigenous customs, beliefs and institutions and this culture complex was relatively stable and to borrow a term from Wilson & Wilson (1945) the cultural system was in equilibrium. During this period the most important risks or dangers to children were smallpox, measles, diarrhoea and other illnesses arising from sexual pollution. As explained above, culturally specific methods evolved as a response to these risks. Cultures are not static they change but in the case of primitive cultures the change was very slow. The coming of Islam in this area and later on the introduction of schools by the colonial government fueled the process of "cultural revolutionalization". I would define cultural revolutionalization as rapid change in the cultural system. Those mothers interviewed indeed said that young men and women who have been to school do not value the traditional customs and beliefs. This is largely because they look at themselves as educated and hence cannot follow their own traditional values. As a result of these cultural contacts, the original cultural system which prevailed in Mtwiche village was disturbed from an original condition of equilibrium. The study has also shown that the introduction of new traits in the cultural system may result into their rejection or assimilation or a compromise of these new traits.

McLeish has defined dialectism as the study of how opposites can be identical and how they become identical (McLeish 1969:9). In this study we have seen that the views of the old women contradict with those promoted by the medical personnel. Such a contradiction, according to Marxism is a basis for change (McLeish 1969:7). Without
contradiction there can be no change. Through processes of deculturation which includes education, religion (Islam) and the introduction of the cash nexus, it is apparent that the old cultural system is in the process of crumbling as can be envisaged in the young women's perceptions of risk which are very different from the old women. One old man said that while the introduction of money has been helpful, it has also brought disadvantages. For example, traditional medicine upon which people relied in those days is no longer working these days. This is so because there are so many fake traditional healers who because of the love of money demand huge payments even before the patient is healed. In those good days it was the patient who was giving the traditional healer a token of thanks for getting healed and it was not that much.

Lastly this study has shown that risk and risk aversion is indeed a socio-cultural construct (Douglas 1983): what may be relevant for one society may not be relevant for another society. Risks also differ according to age groups: sexual pollution for example is very dangerous to newly born children and grown ups have their own risks. While public health experts have defined certain risks, there also exist lay definitions of risks.

As has been exemplified in the previous chapters, I would also tend to agree with Deborah Lupton who said that:

"Risk definitions may therefore be hegemonic conceptual tools that can serve to maintain the power structure of society......(Lupton 1993)."

By saying that young people are not adhering to traditional values, are the elderly men and women not bemoaning the erosion of those powers that they once had over the young people? By calling for young people to go back and start following traditional values and beliefs, do they not simply want those powers back?
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