INTERNATIONAL JOURNAL OF INNOVATIVE RESEARCH & DEVELOPMENT

ISSN 2278 – 0211 (Online)

'So Long as We Survive': Communities, Health and Culture in Zimbabwe

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Abstract:
Bone-throwing oracles, herb-dispensing healers, prophets in the open, prophets and apostles in mega-churches, spiritual fathers, nurses and nurse aids as well as doctors all seem to be in service of a general population seeking health services. Their methods and scope may vary but the desired end is healing and health. Physical and spiritual wellness are a thriving industry in Africa. Yet health and formal health systems often assume western connotations, neglecting the cultural and social milieu in which the ailing are situated. In addition, anthropologists, sociologists and experts from various other fields within the social sciences have explored the dynamism and richness of cultures in African communities. These have been highlighted in Zimbabwe from colonial times to the post-independence era. While offering rich analyses and discussions, the studies have tended to obfuscate the conflicts and complementarities between health and culture when viewed both in traditional, religious and 'modern' times. In the process, perspectives in medical anthropology and sociology often stay rooted in binaries defined either as rural or urban. This paper bridges this divide by revealing that realities of health and culture are not divided along rural/urban or traditional/modern lines. Instead, using a multi-sited ethnography, the paper details how the relationship between culture and health is fluid despite setting. Urbanites and rural folk embrace various approaches to health medication in Bulawayo and Lupane and depending on the nature of the problem, place value on one approach over another. However, when considered in whole, none of the approaches is deemed superior.

Keywords: *Health policy, Zimbabwe, health and culture, traditional health, medical ethnography*

1. Introduction

The study eschewed the binary which often characterises studies of Zimbabwe as a dual economy and society composed of rural and urban communities. Instead, in adopting a fluid perspective, the approach employed in the study resonates well with Marcus (1998) cited in Brockmann (2011) who indicates that meaning is always situated; the study seeks to go beyond a 'place-focused' towards a 'multi-locale' approach'. Communities in this study while domiciled in different settings, are construed as fluid, moving from one setting and site to another and not permanently bound. Indeed, making a distinction loosely attached to spatial fixedness ignores the active migration of Zimbabweans both within the country(Muzvidziwa, 1997; Ranga, 2003) and between other countries(Crush & Tevera, 2010; Crush, et al., 2012). As will be discussed later in the paper, those seeking healing need not be situated in one place either as they move from place to place or from one locale to another in search of healing. Hence, a person who may have otherwise been identified as rural-based may seek assistance in an urban setting and vice versa. Defining such mobile persons based on their place of residence limits the extent to which they may be understood. The argument is simply that in as much as there is no distinction of specific ailments based on locality, there also need not be a distinction of a disease-bearer. For example, there is no rural or urban HIV. Indeed, the distinction is deemed unnecessary when one considers that mobility means that populations are involved in movement of diseases and pathogens (Sambisa & Stokes, 2006; Barnett & Walker, 2008). If all segments play a part in spread and velocity of disease, then there need not be distinction based on where they are situated at a given point in time.

The concept of fluid households is therefore appropriate and is borrowed from Young & Ansell (2003)'s study of families, migration and HIV/AIDS in southern Africa. It is a useful concept because it captures the mobility of persons, households and communities between places. Zimbabwe has a long history of migration, mobility and displacement (Hammar, 2008; Hammar & Rodgers, 2008; Magaramombe, 2010; Muzondidya, 2010; Mutopo, 2011) which has contributed to fluid families. Whereas the traditional nuclear family unit was situated within a homestead, families are now dispersed both within and beyond Zimbabwe largely in search of employment. Yet, ties with home remain relevant and indeed necessary (Ndlovu, 2010)for those who have moved from traditional rural homesteads, opting for other rural, peri-urban, local urban and transnational locations. The dynamic nature of human mobility in contemporary Zimbabwe has meant that people do indeed move from rural locales to other rural locales if economic prospects are better. This mobility is evident in some of the academic research on artisanal miners (Mabhena, 2012; Mawowa, 2013) as well as in Zimbabwean migrants who move into rural south african settings where they are absorbed into the commercial

agricultural sector as labourers (Bolt, 2015). In addition, movement transpires in health, in sickness and even in death (). Given this kaleidoscopic portrayal of Zimbabwean society, it is evident that a segment of the population is mobile, therefore making for fluid households. This article eschews the use of household as a term to describe a family unit. The reasoning lies in the fact that household as it is employed in microeconomics is inadequate as a descriptive term among African families (Miles, 1993). Although the use of households as units of analysis has been rejected in this paper, it is observed to be quite useful in others. For example, in what is now a classical critique of the use of terms such as household, Guyer (1981) discusses the evolution and eventual shift from the use of non-culturally sensitive language to language which more appropriately captures the realities of african clan systems and lineages. Household in the western sense is therefore used measuredly.

2. Health and Culture

The focus of the study was on health and culture in Zimbabwe using select cases from Bulawayo and Nkayi. Although the interplay between health and other aspects of human interest such as health service effectiveness, health delivery and health-sector expertise could have been useful as study areas, health and culture was deemed germane due to the dynamic nature of Zimbabwe's mobile population. In addition, through the process of enculturation, individuals learn how to view the world, experience it ,and behave nit. Allhuman societiesexperienceillness and each culture has devised its own ways of dealing with it. Medical Systems are integral parts of the socio cultural systems in which they exist (Sussman, 2004, p.37).

The diversity among and between cultures is therefore very central to the way health is understood and dealt with. Among some groups, it may merely be a scientifically recognizable challenge which can be resolved through identifying pathogens and vectors. In other groups, it may translate into a physical and/or spiritual matter which is redeemable through consulting oracles and gods. The contrasting understandings and solutions mean that methods of treatment ad even localized strategies for prevention and care will differ. It is in this light that the study was conducted. The following sections outline the diversity of health and culture on the African continent and details the health system in Zimbabwe.

Health and healthcare tend to be construed in western frames. Presented in the simplest of terms, this means that a positivist conception of medicine and health is often adopted. Yet, across the African continent, health and healing are not understood in purely scientific terms. This is due -in part- to the extent of urbanisation on the continent. According to United Nations (2018), Africa is the least urbanized continent with 43% living in urban areas and 90% of the world's rural population situated in Africa and Asia alone. Residing in urban settings alone is not a sufficient factor accounting for limited penetration of western notions of health and wellness. Social aspects also play a role. In Nigeria for example, Chukwuneke, et al. (2012) observe the underutilization of health care services at the primary level because most people do not accept the western model of heath care system provided for them. It is only in instances of serious health complications that recourse in western health systems is resorted to. The complexity of health systems and healthcare are not only evident to end-users or clients but equally play out among service-providers(Chukwuneke, et al., 2014).

In Kenya, attitudes and uses of medicine are diverse as some ethnic groups tend to defer to their indigenous knowledge for recourse while other groups blend the use of western and traditional medicines. Among the Swahili of Lamu, two causes of illness are identified and these are (i) spiritual imbalance caused by personal transgression or an attack by harmful forces directed by an envious person, and (ii) the functioning of a person's body 'in conjunction with personal attributes that are fixed at birth and determine moral character, behavior, and predisposition to ailments' (Gearhart & Abdulrehman, 2014). Consistent with the multifaceted conception of the causes of illness is a multipronged, specialist approach to treatment which involves actors adept at addressing physical, spiritual or psychological conditions. This approach is at odds with western notions of illness causation, diagnosis and remedy. The contrast here is such that the Swahili of Lamu recognize causes which are not merely physical but may be derived from supernatural factors while western epistemes are rooted in scientifically-determinable causation. An equally eclectic approach is employed by the Luo who have various perspectives on illness. In an earlier study, Johns, et al. (1990) recognize that illness identification among the Luo is different from western marking of illness. Not all Luo disease concepts translate directly into physiological concepts with challenges relating to non-equivalence (chiri) and complex overlapping concepts (kuom, yaro). Moreover, young, primary school-age children within this group demonstrate an ability to engage in self-medication, in addition to their embracing of a 'pluralistic medical practice' which incorporates both western and traditional forms of medicine (Geissler, et al., 2000). With African populations sharing similar patterns and characteristics, it is plausible to assume that the attitudes, perceptions and conceptions of health are broadly similar. A major criticism with the studies cited above is that they are largely constrained by situatedness. In other words, they rely on fixed spatial zones as sites of enquiry and this reliance tends to lead to binaries of rural and urban, local and foreign and so forth. While useful as descriptive terms, such binaries tend to be of limited analytic value since many populations particularly within the African continent are very mobile and tend to easily traverse across porous borders. To then make mention of urban and rural in such fluid dynamic contexts risks persisting with a theme whose usefulness is now obsolete.

Culture need not be understood to mean traditions alone. With the proliferation of subcultures, a more nuanced understanding of what culture entails is necessary. It can be defined as consisting of the values held by members of a group, the languages theyspeak, the symbols they revere, the norms they follow, and the material goods they create, from tools to clothing (Giddens, et al., 2017). Such values, languages, symbols and so forth are not spatially confined but traverse various spaces and contexts. In addition to traditions, a key part of the cultures across Africa is religion. Major religious forms include animism, African traditional religions, Christianity and Islam. A discussion of these religions and how they relate with belief systems is beyond the scope of this paper. Due to resource limitations, the focus will be on traditional

and Christian religions. What we wish to draw out is that religion plays a central pat in shaping how communities and people engage with health. This will be revealed in detail in the findings and discussion of the paper. For now, a brief layout of Christian religious formations, their growth and size in contemporary Africa suffices.

3. Health in Zimbabwe: A Systematic Perspective

The formal, state-instituted health system in Zimbabwe comprises of state-run health facilities as well as private healthcare entities. Initially run under the aegis of the developmental policy 'Equity in Health' in the 1980s, the system has since adopted a new policy in the name of 'the National Health Strategic Plan 1997-2007'. Although improvements have been made in the number of service points and number of workers available, existing health worker distribution patterns are not conducive to realizing the objectives at national level (Mudyarabikwa & Mbengwa, 2006). Improvements were recognized in the formal health sector, but little has been done to track changes in other non-formal areas. Discussing the three-tiered health system in Zimbabwe -which includes traditional healers, prophets from "Churches of the Spirit," and western style hospitals and clinics for health and healing-, Machinga (2011)reveals how some groups within Zimbabwe resort to traditional healers for assistance with medical challenges. The western system is relied upon but there is conviction that some complications are not merely physical but spiritual. In this context, people resort to traditional healers or churches of the spirit. The behavioral patterns of health users in Zimbabwe are complex with putatively important primary care routines being skipped even by pregnant women (Mathole, et al., 2004).

Although Machinga (2011) affords attention to the use of traditional medicine as a form of recourse, religion plays an equally pivotal role in the multi-tiered structure. The salience of religion is evident in psychiatry where mental illness and psychiatric conditions are not solely attended to in formal health institutions but often believed to be spiritual matters(Mandizadza & Chidarikire, 2016). The diagnosis also affects the treatment methods chosen which in the main become spiritual rituals. Religion must owever not be wholly understood as a positive effect in relation to alleviating the plight of the ill. Instead, in some instances, religion does not serve as a relief to those who are afflicted. Their healing or recovery can be scuppered by some religiously-founded positions on health. Such putatively negative effects are common of very conservative apostolic faith groups which form part of the collective of African Independent Churches of the first generation. Among these, ultra-conservative Apostolic groups (e.g., Johanne Marange, Johanne Masowe Sabbath (ye Sabata), Madhidha), because of their emphases on faith healing and strict adherence to church beliefs and practices, tend to undermine modern health-seeking or use of modern health services (CCORE, 2011). The approach has also filtered to more contemporary religious groupings in the form of the charismatic movement which has swept over much of contemporary urban Africa. With a focus on wealth and healing as central aspects to manifest deliverance, the charismatic movement has deployed doctrinal scripts to justify the centrality of faith as a remedy ahead of contemporary medicine. This dovetails with what one scholar have dubbed 'economies of hope' (Wariboko, 2017) which are neither immoral nor completely sanctified. It is in this context that some congregants are either exposed to hazardous and potentially-fatal practices. The media is awash with dubious practices of some religious leaders within the charismatic movement across Africa who have encouraged their members to engage in harmful practices[1]. While the examples to cite are numerous the point to note here is that religious practices within certain sects tend to have negative influences on people and their health. In addition, the religious influences of sects in Zimbabwe are not peculiar to that country alone but also manifest in many other parts of the continent.

4. Methodology

The study upon which this paper is derived was constructed on a qualitative research design. Relying on a multi-sited short-term ethnography in Bulawayo and Lupane, the study traces the experiences of twelve (12) individuals as they seek out health services in both traditional and conventional platforms. The participants were identified through a non-random sampling frame, an approach which constrains the generalizability of findings in the paper. Despite this limitation, the convenience sampling approach was deemed useful and appropriate given the fact that a specific type of participant was sought after, and therefore could not be easily identified using a random sampling approach. For instance, the criteria for participants was that: (i) they be adults, (ii) be familiar with conventional and alternative health systems and (iii) must have used at least one health service system in the past year within the study.Getting participants fitting this description from the population would have been challenging using a random technique. However, a convenience approach enables better representation of participants meeting such qualities. This is because convenience sampling 'involves purposive or deliberate selection of particular units of the universe for constituting a sample which represents the universe' (Kothari, 2004). As a result, participants meeting the specified criteria are targeted and engaged in the research. The data instruments employed included participant observations and interviews.

The analysis of data was conducted thematically. At the heart of the study were aspects of health access, health cost and cultural orientation. Resultantly, for participants both in rural and urban areas, these issues are discussed as themes. The following section lays out the issues in detail as identified during the short-term ethnography. But before delving into the findings, it is important to make a clear distinction between traditional ethnographic work and a more conventional approach identified as short-term ethnography. The clearest distinction between traditional forms of ethnography and short-term theoretically driven ethnography is the duration which either process takes. In the former, the expectation is that a study which spans over a long period is conducted while in the latter, a shorter time span lapse. The duration can be as short as two days but this presents some methodological challenges as has been revealed in a study

[1]www.thesoutherndaily.co.za/index.php/2015/12/16/snake-pastor-bitten-by-his-own-snake-dies/ ; www.pmnewsnigeria.com/2018/09/14/6-dead-as-prophet-makes-congregants-drink-jik-in-church/

employing short-term ethnography of young people in the United Kingdom (Brockmann, 2011) as well as in virtual reality games (Miller, 2007). An additional distinction to be made relates to the fact that short-term ethnography relies on a 'sharply focused dialog between research and theory' (Pink & Morgan, 2013) while also allowing the researcher to take a more deliberate and interventional approach to that of long-term participant observation and being theoretically engaged. Other qualities include the intensity of research encounter, a focus on the detail, the ethnographic-theoretical dialogue as well as other traces of ethnographic encounters such as audiovisuals. While short-term ethnography may be easily dismissed as a fad, the changes within ethnography as a discipline and field of enquiry are steeped in history. With changes in perspectives on the world such as world systems, so too has ethnography evolved in terms of scale and scope (Marcus, 1995). Prior to this turn, ethnography had always been rooted in a historical imagination, framed by various cultures and contexts (Comaroff & Comaroff, 1992). As a result, it is evident that although short-term ethnography is yet another new approach, it is only part of the evolution of ethnography as a methodological approach, discipline and field of enquiry.

5. Findings

This section presents the findings for the combined study sites. The twelve participants had diverse socioeconomic backgrounds, from different ethnic groups and subscribed to different religious convictions. The gender split was four (4) women and eight men (8). The distribution by religion is presented in Table 1 below.

Religion	Number of Participants
African/traditional	3
Christianity	7
Islam	1
Other	1

Table 1: Frequency and Distribution of Participants by Religious Conviction

Table 1 above shows the frequency and distribution of participants in the study according to self-identified religious conviction. The religion marked 'other' was identified by one participant who in elaborating, indicated that they were not committed to one specific religion. Although self-identifying with one religion, we detail later in the findings, the diversity of methods relied upon in seeking health service.

The two 'sites' have a variety of formal health institutions whose size ranges from national referral centres (which is the largest in Zimbabwe) to rural health centres. Bulawayo alone has more than twenty-four facilities in both the public and private sector. These include prominent ones such as United Bulawayo Hospitals, Mpilo Hospital, Mater Dei Hospital as well as smaller clinics situated within and around residential neighbourhoods in both affluent and less-affluent areas. Some of the clinics include Tshabalala Clinic, Luveve Clinic, North End Clinic and Princess Margaret Clinic. In Nkayi, there are at least sixteen formal health institutions which comprise of district hospitals as well as rural health centres. These are inclusive of public health facilities as well as mission-run health institutions. Again, the size of facilities varies with the district hospitals being the apex and rural health centres forming the base. Among the facilities are Ngwaladi District Hospital, Sebumane Clinic, Dakamela Rural Hospital and Nesigwe Rural Health Centre.

The study sought to identify the different health systems which the participants employ when ill. The key finding here was that participants resort to a mix of methods and systems in search of physical relief. Not only are these systems sometimes at odds with one another from a doctrinal perspective, they vary in terms of the diagnostic prescriptions they make.To ascertain the different responses to conditions and ailments, the study classified complications into three levels comprising of minor, moderate and major. Minor ailments are those which were deemed to be routine ailments common in households such as headaches, colds, flu, stomach aches and so forth. Moderate complications are those which were deemed to be infrequent in occurrence, require some form of expert knowledge and unless left unattended for very lengthy periods are non-fatal. Among the complications which form a part of this type are migraines, early-stage cancers, injuries to the body, persistent coughs, head injuries and so forth. The third type of ailment/complication which the study classified was major. Major complications occur infrequently but have potentially fatal consequences if left unattended immediately. Among these complications include snake bites, exposure to poisonous substances, chronic ailments, late-stage cancers, involvement in high-impact accidents and so forth.

Type of Ailment/Condition	Primary Relief Sought	Length of Travel
Minor	None =42%; Formal health = 25%; Spiritual = 17%; Traditional = 17%	Local facilities/oracles/shrines = 75%; Distant facilities/oracles/shrines = 25%
Moderate	None = 0%; Formal health = 50%; Spiritual = 33%; Traditional = 17%	Local facilities/oracles/shrines =60% Distant facilities/oracles/shrines =40%
Major	None = 0%; Formal health = 75%; Spiritual =17%; Traditional = 8%	Local facilities/oracles/shrines =40%; Distant facilities/oracles/shrines =60%

Table 2: Ailment Complications, Relief Sought, and Distance Covered for Treatment

The findings reveal that most participants were not prompted to seek relief when faced with minor complications. However, as the severity of the complication increased, the sources of relief also increased such that not seeking attention was not an option. Moreover, while people increased their useof various systems, there were shifts in terms of method

resorted to the most. For example, although participants initially increased in resorting to traditional remedies over moderate complications, the usage declined on major complications.

In addition to identifying the methods of relief sought, the study also sought to ascertain the mobility of participants to seek relief. To identify mobility in the interviews, participants were asked where they sought relief when faced with complications of various kinds as classified into minor, moderate and major. Again, the tendency was to rely upon local solutions first and this reliance diminished as the complications discussed became more significant. Hence in major complications, most people resorted to distant facilities. An interesting aspect in this regard was the reliance upon health facilities outside of Zimbabwe noted by some participants. While not personally involved, two participants indicated that they were familiar with other people who had sought for treatment in countries as far afield as India. The researcher also learnt of the experiences of other people from participants, experiences which resulted in the people migrating temporarily to rural areas for healthcare. This was common for those people who sought relief through spiritual or ritualistic medicine.

6. Discussion

Although the findings point towards a diverse reliance on various tiers of the health delivery system, what is not readily evident is why. In addition, the gender dimension is not readily evident. The discussion section places the findings within a richer academic setting. Relying on fluid households as a concept, the study recognizes that meaning is always situated and in so doing manages to go beyond a 'place-focused' towards a 'multi-locale' approach' (Brockmann, 2011).Using this lens, the paper now turns to revealing why participants behave the way they do and how -through gender- these dynamics play out.

To understand the reasons why people, resort to multiple methods of the health three-tier system in Zimbabwe, it is important to recognise the role of economy as well as culture. The economy constrains people from seeking formal healthcare due to limited finances as well as exorbitant medication. Moreover, health facilities face intermittent drug shortages which make them an unreliable platform for some people. On the other hand, religious and spiritual healing require few material resources and due to informality, resorts to flexible methods of payment. Hence whereas formal health demands that a person seeking service must make payment in the form of money or cash, informal platforms can negotiate the mode of payment to include something more readily accessible to the patient. This is especially pertinent in Zimbabwe at the time of the study given the liquidity challenges which meant that acquiring cash was very difficult. In terms of culture, participants demonstrate a level of fluidity which breaches rigid cultural boundaries. It is difficult to identify a modern versus rationalist or traditionalist versus Christian/Muslim culture. Although this cannot be generalised onto the whole Zimbabwean population due to the methodological premises of the study, the diverse approach to religion has been identified elsewhere[2], giving credence to the position that fluid cultures may be a wide phenomenon. Religious syncretism and cultural diversity are not to be viewed as negative qualities but ways of embracing various positions. Although people may identify with a given religion or identity, they do tend to become involved with others without necessarily moving away from what they consider to be a main identity. In this vein, it is possible to identify as Shona/Ndebele but equally embrace western identities or Christian/Muslim/Judaic values.

There is gendered lens which must be interrogated before drawing conclusions. To start off, in the context of Zimbabwe, gender is a categorical variable and therefore less susceptible to fluidity. One is either a man or a woman, either playing specific culturally-defined roles or expected to do so. This position applies equally well in the health service arena where caregiving and support are deemed women's jobs (Muzvidziwa, 1997). Moreover, within some sects, women's public roles are defined, and their bodies controlled such that the choice over what remedial action to seek and whom to approach is determined by men (CCORE, 2011). The apostolic sects are the most prominent in this regard but are complemented by emergent charismatic churches which deploy more subtle means to get their systems of control in place. These are also consistent with the traditional system of patriarchy which deprives women of agency in some social fields and establishes rigid controls over their gendered roles. From this perspective, the role of cultural controls needs to be considered in reading the uptake and lack thereof of western medicine. The decision on what to take, when and where may not always be a personal one but one which involves a family, a group within a religious or traditional set-up or a much larger collective. The cultural controls may be enforced to varying degree depending on one's location, but, in broad terms are manifest in urban, peri-urban and rural areas. It is for this reason that distinguishing sites was unnecessary. Whether one is in urban or rural areas, the flow of culture continues. It may be witnessed and appreciated with difference from one place to another but is however recognised in all spaces. This is the fluidity of culture and it plays a clear role in shaping behaviours around health. Accepting and embracing certain systems and forms of knowledge is not a given in a multicultural setup.

7. Conclusion

The study sought to discuss the dynamics which play out in the arena of health using culture as the main point of reference. Employing fluid households as a conceptual lens, the study has revealed that spatial zones are at once merged and obliterated as people in different parts of the country seek relief or remedy to their afflictions. The same fluidity with which people demonstrate in moving from one spatial zone to another is demonstrated as people are equally fluid in their movement from one health system to another. Self-identification with a given religion does not mean that people do not seek recourse in other methods. Depending on the nature of the problem and the complication thereof, participants place value on one approach over another. These values may shift depending on how complicated a matter is. Hence while some

[2]www.relzim.org/major-religions-zimbabwe/ ; www.bulawayo24.com/index-id-news-sc-religion-byo-119741.html

may resort to religious remedy for moderate complications, the numbers dwindle when major complications are at play. However, when considered in whole, none of the approaches is deemed superior. That is, religion, tradition and modern scientific systems all have a role to play in establishing health among people. Relying on the conception of culture as consisting of the values held by members of a group, the languages they
speak, the symbols they revere, the norms they follow, and the material goods they create, from tools to clothing (Giddens, et al., 2017), the paper has argued that religion and traditional societal beliefs play a role in shaping how health is understood and embraced.

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