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Disability and Rehabilitation: Beliefs and Attitudes Among Rural Disabled People in a Community Based Rehabilitation Scheme in Zimbabwe

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ABSTRACT

This study aimed to examine beliefs about and attitudes to disability and rehabilitation amongst rural people on a Red Cross Community Based Rehabilitation programme in Gutu District, Masvingo Province, Zimbabwe. A small sample was used, and 56 per cent of respondents blamed traditional causal agents for disability in the family (witchcraft and spirits), 33 per cent blamed God and only a small minority blamed natural causes. Thirty six per cent sought traditional help first and 64 per cent medical help with 62 per cent seeking both at some stage. There was no correlation, however, between expressed belief in a causal agent and the type of help sought (traditional or medical), or whether that help was valued. It was also found that the Red Cross Community Based Rehabilitation programme, whilst being valued for its practical assistance, had almost no impact on people's beliefs about causal agents.

Introduction

The number of people with disabilities worldwide is estimated by the World Health Organisation (WHO) to be in the region of 10 per cent. In Zimbabwe, the only extensive data on the incidence of disability is provided by the National Disability Survey of Zimbabwe conducted in 1981 as part of the programme for the International Year of Disabled Persons. The Survey estimates that 276 300 people in Zimbabwe have disabilities, that is approximately 4 per cent of the population have moderate to severe disability. This figure is likely to be an underestimate in the light of the WHO findings, and because of the methodology and implementation of the survey itself. Nevertheless it serves to reinforce the assumption that a substantial number of

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Zimbabweans are disabled, despite the fact that so few ever receive institutional attention.

The impracticability and expense of providing institutional care for all with moderate to severe disability, and a growing recognition of the inappropriateness of such care, has led to the development of a new approach to rehabilitation in the community. Many countries around the world are developing community based rehabilitation (CBR) strategies, in conjuction with the WHO, ILO, UNICEF and other international aid agencies.

In Zimbabwe CBR is being developed both by the Government, with WHO and ILO assistance, and by the voluntary sector. The central thrust of the programme of the Ministry of Health is the training of rehabilitation assistants to work at district hospitals and provide a referral chain, as needed, from community or village level workers through to central hospitals and national rehabilitation centres. As much rehabilitation as possible is to take place in the home, at local clinics or at district hospital level.

At the same time NGOs, such as the Zimbabwe Red Cross, Cheshire Foundation, Zimcare Trust, Jairos Jiri Association and the National Council of Disabled Persons of Zimbabwe (NCDPZ), have begun to develop various CBR and outreach programmes in different parts of the country, working, where possible, in conjuction with rehabilitation assistants and community rehabilitation workers. These initiatives, unfortunately, have not all been successful — the Cheshire Foundation Mobile Unit, for example, has ceased to operate. However, overall considerable progress has been made since independence in 1980, and although nation-wide coverage is patchy, there are well established CBR programmes in several areas of the country.

There is not a great deal of data available on the detailed working and problems of CBR programmes worldwide, although more information is beginning to circulate from different countries. In Zimbabwe itself, there are evaluations of the various programmes, for example, Red Cross (1984) and Cheshire Foundation (1984), but there is little background data, beyond the anecdotal, on underlying factors such as values and attitudes to disability and rehabilitation amongst the rural population. Studies such as those by Brand (1984), Nyathi (1984), Dube (1986) and Chigarasa (1987) have either focussed on a specific type of disability (Brand on paraplegia), or on barriers to employment in urban settings (Nyathi, Dube and Chigarasa). Whilst providing useful insights into attitudes to disability, these studies do not attempt to examine those attitudes and beliefs in a rural setting, or in relation to rural CBR programmes. Likewise, the evaluations of CBR programmes themselves do not concentrate specifically on underlying issues of beliefs, values and attitudes to disability and rehabilitation, although these may have a significant effect on the success of the programme.

The study reported here aimed to examine beliefs about and attitudes to disability in the context of the Gutu District Red Cross CBR programme which

was started in 1985. The aim was to gather data on people's beliefs and attitudes; to assess whether uptake of medical and CBR services was significantly affected by expressed beliefs and attitudes; and to measure conversely what impact, if any, the CBR programme itself had had on beliefs and attitudes.

Methodology and limitations

The research excercise discussed in this paper was carried out in November 1986 by the authors, who were taken and introduced to respondents in their homes by the local Red Cross Co-ordinators. A verbal questionnaire was the research instrument, and it was administered individually to the disabled person or to a close relative. The population sampled consisted of people who were on the Red Cross Rehabilitation Programme in Gutu District, Masvingo Province. All three areas of Gutu District were sampled, and forty respondents in some 31 families were interviewed, including disabled people themselves and/or relatives of disabled people. Systematic random sampling was not possible as the researchers were dependent on the Red Cross Coordinators, but prior to the study they had made it known to the Red Cross personnel that they wished to interview a cross-section of people on the programme, concentrating on those who had been in the programme for a year. The sample included people with differing types of disabilities and differing socio-economic backgrounds.

From the outset it must be acknowledged that a major weakness of this study lies in the small size of the sample and in the method of sample selection. The study was not based on a systematic random sample, but one drawn up and contacted by the Red Cross personnel as noted above. Both these factors may have introduced biases favouring the Red Cross.

A further problem was that one of the researchers did not speak adequate Shona, and this may have contributed to possible errors through the misinterpretation of responses. However, it was felt that this factor was relatively well controlled, and that the impact on the findings presented was minor. Where there was doubt as to the exactness of interpretation, a recording of incomplete data was made.

The time factor was a further limitation, and the main reason why the sample size is so small. However, it was considered more important to sample widely in the area rather than to take a larger sample of the more accessible population, as this would also bias the study — in this case to those with easier access to services and amenities in general.

There were also difficulties linked specifically to the research instrument itself, and it was unfortunate that a full pretest was not possible in the time available. In particular, the questionnaire was found to be too long — leading to some sections being scantily addressed; one or two questions could have

been clearer; and some were found to be redundant or unduly repetitive.

Presentation of the results

Introduction

The research team were interested primarily in whether beliefs about the cause of disability influenced the type of help sought, and whether community based rehabilitation, in this case the Red Cross programme, had itself had an impact on people's expressed beliefs. Two working hypotheses underlay the research:

a) that 'negative' beliefs about disability impede successful rehabilitation as measured by uptake of services, and integration into the family and community life;
b) that CBR as a rehabilitation strategy changes people's beliefs about and attitudes to disability.

The research team examined what help had first been sought by respondents, traditional or medical treatment, and whether or not this had been helpful. Subsequent treatment was also examined and assessed. Treatment sought was analysed with respect to beliefs regarding the causality of the disability, both initial belief and present belief; and with respect to religion. The effect of the Red Cross CBR programme on beliefs was specifically examined and the respondents' assessment of its usefulness to them.

It should be noted that a total of 40 respondents were interviewed, of whom 17 were disabled, and 23 were relatives of the disabled. The study included 31 different families, with 6 cases of a disabled person and a relative both being interviewed, and 3 cases where 2 relatives of the same disabled person were interviewed.

Beliefs about causality

1. Christianity and Traditional Beliefs about Cause of Disability

The researchers wished to examine whether belief in Christianity tended to preclude traditional beliefs in witchcraft and spirits as causal agents of disability. In addition they wished to assess whether a rejection of traditional beliefs in favour of Christianity was followed by a belief in natural causes, or by a switch from belief in traditional supernatural causes to belief in Christian supernatural causes (God). They hypothesised that respondents believing in traditional religion would be more likely to believe in witchcraft and spirits, bad spirits (*ngozi*) and ancestral spirits (*vadzimu*), causing disability, than would Christian respondents.

However, it was impossible to make a strong statistical comparison. Of the 32 respondents replying fully to questions in this regard, 26 expressed some form of Christian belief while only six were non-christians. Nevertheless, it is of interest to note that of the Christians 10 initially blamed witchcraft, 2 were

ancestral spirits, eight God and only two initially blamed natural causes for disability in the family. For 4 Christian respondents full data on initial beliefs was not obtained. Thus of Christian respondents 12 (46%) attributed disability to the traditional causes of witchcraft and ancestral spirits, and 10 (38%) to God or natural causes. The result are summarised in Table 1.

It can be seen that of the five respondents who indicated that they were not Christians, two blamed witchcraft and one initially blamed ancestral spirits. Of the remaining two, one initially blamed natural causes but later blamed God, and the other blamed God throughout; and in both cases this seemed to have led the respondents to reject Christianity. Thus a belief in the power of God to cause disability did not necessarily mean acceptance of that God. These two respondents believed in the existence and power of God, but rejected Christianity for themselves. Only three out of six non-Christians blamed traditional causes, witchcraft and ancestral spirits for disability. There was an almost equal likelihood amongst non-Christians and Christians that disablement would be attributed to witchcraft and/or ancestral spirits.

2. Initial beliefs and help first sought

Analysis of first belief regarding causal agent, and the type of help first sought gave the results found in Table 2. Those believing in witchcraft were as likely to seek medical as traditional help first, although those believing in God as the causal agent were more likely to seek medical help initially. However, the numbers here are too small to make wide generalisations, and can merely be said to indicate a possible trend. Further data on possible linkage between belief in causal agent and treatment sought would need to be obtained.

3. Change of belief regarding different types of disability

An attempt was made to assess whether respondents' initial beliefs about the cause of disability had changed, and in particular what effect the Red Cross programme might have had on their beliefs. Of the 33 respondents giving full data on this question, 28 (85%) indicated no change of belief, and in only 5 cases (15%) was a change of belief clearly expressed. One respondent's belief had changed from blaming God to blaming witchcraft, but no reason was given; one blamed God now instead of witchcraft because the respondent had now become a Christian; one blamed ancestral spirits instead of witchcraft, no reason was given; and two who had initially blamed natural causes now blamed God, also no reason was given.

Most important in this study was the finding that the Red Cross programme appeared to have had almost no influence on people's beliefs about the cause of disability. In only two instances did respondents acknowledge that the Red Cross programme had influenced their beliefs at all. In one of these, a relative of a woman with an impaired leg said that the Red Cross had led her to believe that witchcraft was not the cause of the disability, but that it was caused by

God; and in the second case, the mother of a baby with cerebral palsy said that she still believed that witchcraft was the cause, but the Red Cross had influenced her to consider the possibility of natural causes.

Overall for all disability types, and summarising initial and current beliefs, witchcraft is cited by respondents as the causal agent 32 times, God 20 times, natural causes 11, ancestral spirits twice, and there were seven instances of respondents saying that they did not know. It is clear that witchcraft is the predominant agent believed to cause disability amongst this sample of respondents, with God the second most important perceived cause. Interestingly, no-one cited evil spirits (*ngozi*), although this was given as one possible option on the questionnaire, and ancestral spirits (*vadzimu*) were only cited by two respondents. Thus, in this sample, there was very little evidence of an association of spirits of any sort with the disability in the family.

However, an interesting chance finding was that a few respondents, while giving one answer to the cause of disability in the family, had very different ideas on the causes of disability in general. For example, one respondent said that his daughter's polio was a natural disease, and that his own arthritis was the natural result of ageing. Yet he said that disabilities in general could be caused by witchcraft, bad spirits (*ngozi*), ancestral spirits (*vadzimu*) and as a punishment, such as for adultery, and that other people believed that spirits (unspecified) had caused his own arthritis. It may be a possibility that respondents felt there was a particularly severe stigma attached to evil spirits or to ancestral spirits causing disability, and that for this reason they may have been reluctant to attribute these agents to their own case.

Treatment and Assistance

1. Assistance from Red Cross and other agencies

Assistance provided by the Red Cross was analysed, with assistance being categorised into seven types: aids and appliances, clothes and blankets, medical help/referral, general advice, physiotherapy, money, and help seeking education or work.

In 8 cases more than one type of assistance was given, and in 6 cases only one type. There were also 5 respondents new to the programme who were not yet sure what type of help they would receive. Therefore the 54 instances of help were for 25 disabled people, and there was 1 disabled man who, although he had been on the programme for a year, said he had as yet received no help.

Of the 25 assisted people, 18 respondents reported that the Red Cross had met their expectations, and in 7 cases had failed to do so. Several gave very positive replies. Of those who said that the Red Cross had not met their expectations, 6 indicated that their expectations had 'not yet' been met and one said 'I don't know'.

When asked about alternative sources of help, very few respondents

indicated that they had had any access to alternative help. Four respondents indicated that referrals to hospitals, and one that the school, had been of assistance, but there were no other positive responses. Despite the fact that many respondents (30) indicated they were Christians, and at least 21 had sought traditional help at some stage, none of them indicated either church or *n'anga* (traditional healer) spontaneously as sources of help. This could be interpreted as an artefact of the respondents' assessment of what was of interest to the research team, but direct questions on this issue did corroborate the above finding that little help was derived from these sources.

2. Traditional and medical help

Respondents were asked what type of help they had initially and subsequently sought in the categories of traditional and medical treatment, and whether these were helpful. It was discovered that more people sought medical help first than sought traditional help (18 to 10), and that medical help was assessed much more positively than was traditional help. Fifteen out of 28 respondents' attempts to get medical help were considered useful, compared with only two of 20 recorded attempts to seek traditional help. In these 2 cases the *n'anga* was considered helpful in identifying that polio had been caused by witchcraft in one case, and, in the other, the case of a child with severe burns on the foot and leg, the *n'anga* was reported to have helped by revealing who had caused the child to be lifted from a hut and put in a fire in the middle of the night. Both recorded instances of help refer to explanations of the agent reputed to have caused disablement, rather than to practical assistance in alleviating the disease, injury or disability.

Although the finding of this study is that medical treatment was clearly valued more highly amongst this sample than was traditional treatment, it must be recognised that a bias could have occured through respondents identifying the researchers as having a westernised background, and being linked to the Red Cross, and therefore being more likely to favour medical over traditional treatment. Nevertheless, if this reflects a perception that the Red Cross is linked with medical help and respondents wanted to maintain the link with the Red Cross, this in itself reinforces the researchers' perception that respondents valued medical treatment over traditional treatment with respect to disabling conditions in the study. It should be noted that just over half of the respondents had sought both medical and traditional help at some stage.

3. Religion and type of help sought

Help sought was analysed with respect to religion, on the working assumption that Christians might be more likely to seek medical help than traditional help, and disbelieve traditional ideas about the cause of disablement. The results tended to support this assumption.

It was found that Christians were more than twice as likely to seek medical help first rather than traditional help (6 to 7), but 15 out of 25 Christians for whom full data was available sought both types of help at some stage, and one sought only traditional help. Nine respondents sought medical help only.

In this sample there were only 3 non-Christians giving full data on this issue, so meaningful comparisons cannot be made. Nevertheless it is clear that of the Christian respondents a significant number sought traditional help as well as medical assistance, a finding in keeping with the results of the analysis of causal belief about disability and religion, wherein traditional beliefs were not found to be incompatible with Christian religion.

Conclusion and comments

From the results of this study it is clear that there was a tendency for respondents to hold apparently contradictory views and beliefs, and to take action seemingly in conflict with these beliefs. Someone could be a self-professed Christian who believed witchcraft had caused his/her disablement, and might proceed to seek and value medical treatment rather than traditional help. Most respondents in the study were Christians, but a non-Christian could nevertheless blame God, and visit a *n'anga* as well as seeking medical help.

Medical services were said to be valued more highly than traditional services, irrespective of beliefs regarding causality of disablement, or of religion. However, a possible bias could have arisen here because of the researchers' personal identity and their perceived link with the Red Cross. This result must therefore be treated cautiously. At least half of the respondents said that both types of treatment had been sought at some stage.

One very striking result was that the Red Cross programme itself appeared to have had a negligible impact on beliefs held, even though the great majority of respondents felt the programme had been helpful to them in a variety of material and rehabilitative ways. Their response to the programme was pragmatic and goal oriented, but this did not involve any clear awareness regarding causes of disability.

The implication of these findings for rehabilitation is that it may be irrelevant what beliefs people hold regarding causal agents of disability, provided that they have access to appropriate rehabilitation services. It appears that they will take up and use these services effectively either in conjuction with traditional services, or to their exclusion, regardless of belief of causality. It is erroneous to assume that people hold a consistent world view, or that they will necessarily reject the offer of practical assistance because it clashes with expressed beliefs. Further, it did not appear that 'negative' beliefs of causality led to serious stigmatisation, rejection and neglect of people with disabilities in this sample.

However, regarding the prevention of impairment in the first place a good practical understanding of health issues and health risks would seem essential. This was not the focus of the present study, but it may be concluded that an approach such as that of the Red Cross programme in itself is insufficient to address this issue effectively.

The conclusions of this study can only be tentative because of the small size of the survey, and it would be useful to have further data from families with no disabled member, and from those with a disabled member but no link with rehabilitation schemes. This would facilitate testing of the research teams' present conclusions that expressed beliefs have little impact on uptake of appropriate rehabilitation services, and that attitudes to disabled people in rural areas may not be so negative as is often assumed. Belief in the traditional agents of witchcraft or punishment by God do not necessarily impede successful rehabilitation and integration, although their implications for long term primary health and disease and disability prevention measures were not investigated. The services provided by the Red Cross, whilst much needed, popular and useful, do very little to change underlying beliefs about disability.

Table 1: First Beliefs in Causality of Disability and Religious Beliefs

Religious Beliefs	Agency				Total
	God	Witchcraft	Ancestral spirits	Natural causes	
Christian	8	10	2	2	22
Non-Christian	1	2	1	1	5
Total	9	12	3	3	27[a]

a: There were 13 cases with insufficient responses.

Table 2: Help First Sought and Initial Belief Regarding Cause of Disability

Help first Sought	Agency			Total
	Witchcraft	God	Natural	
Traditional	6	1	1	8
Medical	7	6	1	14
Prayer	0	1	0	1
Total	13	8	2	23

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