



Midlands State University

Faculty of Arts

Department Of Development Studies

TOPIC: Indigenous Knowledge Systems employed in child health care in  
Manicaland: Case of Mutare.

BY

CAROLINE T. MUZVIDZWA

R131425A

THIS PROJECT IS SUBMITTED IN PARTIAL FULFILMENT OF THE  
REQUIREMENTS OF BACHELOR OF ARTS IN DEVELOPMENT STUDIES; HONOURS  
DEGREE AT MIDLANDS STATE UNIVERSITY.

ZVISHAVANE; ZIMBABWE

## APPROVAL FORM

The undersigned certify that the supervised student Caroline Tafadzwa Muzvidzwa R131425A's dissertation entitled: **Indigenous Knowledge Systems employed in child health care in Manicaland: Case of Mutare**, submitted in partial fulfilment of the requirements of the Bachelor of Arts Honours Degree in Development Studies.

.....

...../...../.....

**Supervisor: Mr Sillah**

**Date**

.....

...../...../.....

**Chairperson: Mr. Munhande**

**Date**

**DECLARATION**

I Caroline T Muzvidzwa R131425A do hereby declare that the work contained in this dissertation is entirely a product of my own original work with some quotations and references attributed from other sources. I hereby declare that this work has never been previously submitted in partial fulfilment of the Bachelor of Arts Honours Degree in Development Studies at Midlands State University

.....

**Caroline Muzvidzwa**

...../...../.....

**Date**

## **DEDICATION**

This dissertation is dedicated to Paula Muzvidzwa

**RELEASE FORM**

**NAME OF STUDENT:** MUZVIDZWA CAROLINE T

**DISSERTATION TITLE:** Indigenous Knowledge Systems employed in child health care in Manicaland. Case of Mutare

**DEGREE TITLE:** Bachelor of Arts in Development Studies Honours Degree

**YEAR THIS DEGREE GRANTED:** 2016

Permission is hereby granted to the Midlands State University Library to produce single copies of this dissertation and to lend or sell such copies for private, scholarly or scientific research purpose only. The author reserves no other publication rights; neither the dissertation nor extensive extracts from it may be printed or otherwise reproduced without the author's written permission.

**SIGNED** .....

**PERMAMENT ADDRESS:** 4500 Hobhouse 11  
Mutare

## **AKNOWLEDGEMENTS**

First I would like to thank the relevant authorities at the Midlands State University institution who gave me the knowledge and necessary direction in creating a platform to expand my academic works. My profound appreciation goes to the Faculty of Arts and the Development Studies Department for the detailed knowledge provided since the beginning of the programme. Special thanks to my supervisor Mr Sillar, for his dedicated time, effort, support and advice in helping me conduct this study. Acknowledgement goes to my targeted population for exploring the necessary information contributing towards the research study. Special dedication goes to my mum for providing the love, inspirational support as well as the financial help to make the study possible. Lastly I would like to thank God Almighty for taking me this far as well as the unwavering support from my friends.

## **ACRONYMS**

AIKS	-African Indigenous Knowledge System
CHE	-Child Health Epidemiologic
CSF	-Child Survival Foundation
DHS	-Demographic Health Survey
ESAP	-Economic Structural Adjustment Program
GHO	-Global Health Observatory
IKS	-Indigenous Knowledge System
MD	-Millennium Declaration
MDG	-Millennium Development Goals
MHCWZ	-Ministry of Health Child Welfare of Zimbabwe
MICS	-Multiple Indicator Cluster Survey
NEPAD	-New Partnership for Africa's Development
ORT	-Oral Rehydration Therapy
NGO's	-Non Governmental Organisations
PHC	-Primary Health Care
SDG	-Sustainable Development Goals
STD's	-Sexually Transmitted Diseases
UNDP	-United Nations Development Program
UNICEF	-United Nations Children Fund
WHR	-World Health Report
WHO	-World Health Organisation
ZDHS	-Zimbabwe Demographic Health Survey
ZNFP	-Zimbabwe National Family Planning
ZMNSS	-Zimbabwe Micronutrient and Nutrition Surveillance Survey

## **ABSTRACT**

*This study aims to research on the use of Indigenous Knowledge Systems employed in child health care with a case study of Mutare so as to reduce child mortality. The study also discusses the leading causes of child mortality in Mutare and the factors that contribute to increased child mortality like religious beliefs and cultures that do not support visiting clinics and hospitals. It looks at how effective are these IKS in addressing child mortality which is an issue of concern in development because children are significant for sustainable development.. This was made possible through conducting interviews as well as observatory study for key findings as to what methods are used by IKS experts in dealing with different child related diseases which result in mortality. Measures to counter weaknesses surrounding IKS will be discussed so as to mainstream IKS as a medical route to child health care to deal with the problem of child mortality in Mutare.*



## TABLE OF CONTENTS

1.0 INTRODUCTION.....	2
1.1 BACKGROUND TO THE STUDY.....	3
1.2 STATEMENT OF THE PROBLEM.....	3
1.3 RESEARCH OBJECTIVES.....	4
1.4 RESEARCH QUESTIONS.....	4
1.5 SIGNIFICANCE OF STUDY.....	5
1.6 THEORATICAL FRAMEWORK.....	6
1.7 CONCEPTUALFRAMEWORK.....	7
1.8 RESEARCH METHODOLOGY.....	8
1.9 LITERATURE REVIEW.....	10
1.10CHAPTERSUMMARY.....	16
2.0 CHAPTER ONE.....	17
2.1 CHILD MORTALITY TRENDS IN ZIMBABWE.....	17
2.2 KILLERS OF CHILD MORTALITY.....	23
2.3 FACTORS LEADING TO CHILD MORTALITY.....	28
2.4 CHAPTER SUMMARY.....	36
3.0 CHAPTER TWO.....	37
3.1 IKS AND CHILD CARE IN MUTARE.....	37
3.2 CHAPTER SUMMARY.....	45
4.0 CHAPTER 3.....	46
4.1 MAINSTREAMING IKS AS A MEDICAL ROUTE.....	46
4.2 WHAT CAN BE DONE TO COUNTER IKS WEAKNESS.....	51
4.3 CHAPTER SUMMARY.....	53
5.0 CONCLUSION.....	54

## **1.0 INTRODUCTION**

The writer provided background information to the study, problem stating, theoretical and conceptual framework which gave detailed information of the study. In the process, the research aims, objectives and questions were also presented to inform the vision of the research and targets within the general aim. Further, a literature review was offered to present the results of previous research in relation to the study and in the process the study was justified as it informed the potential beneficiaries of the research. Skills and methods of conducting the research were also described in detail and in the end the chapter explored the possible limitations that the research will face together with the ethical considerations in relation to the study.

### **1.1 BACKGROUND TO THE STUDY**

Indigenous knowledge systems have been used for about thousand years in Africa. Indigenous knowledge system have been used to promote sustainable development and the people has highly relied on it for protecting their children against diseases before the coming of artificial medicine that is said to be more effective on child health care. It is important to note that IKS on health care marked a shift as a result of colonialism when missionaries and Europeans brought in cosmopolitan medicine and discouraged the use of traditional medicines. Indigenous knowledge system which is traditional medicine is the oldest form of health care system that was used by grandmothers and mothers in protecting their children against various diseases. In Zimbabwe the use of IKS has been sidelined after independence when the government constituted maternity wings at all major hospitals and provided drugs and well trained midwifery but still some people do not visit these hospitals because of the distance they have to travel and some are culturally tied that they do not favour artificial medicines like the apostolic churches and some traditionally grounded communities. Zimbabwe has been characterised by detrimental socio-economic service provision

which led to a number of rural population to depend on traditional health care and in some cases hospital professionals has encouraged people to use traditional methods to prevent diseases in promoting child health.

IKS has been used in the country over a long period though through the existence of colonisation it is said to have faced criticisms and with the existence of modernisation and globalisation many grandmother are staying in towns and are no longer well versed with the IKS knowledge used to protect children against various diseases and this has resulted in few people using IKS and some using the wrong methods. Child mortality has then remained a cause for concern in the country as some children are dying because of the lack of proper knowledge on the use of IKS knowledge system and because of poverty some rural community elders practice some indigenous knowledge methods which are risky at times to the child health. It can be noted that IKS have been opted by most people because of the increase in underutilization of health care systems in public health sectors as highlighted by the Ministry of Health and Child Welfare of Zimbabwe. According to Chimhete many people have been forced to seek traditional care due to high staff turnover, high hospital cost and shortage of essential drugs resulting in a new pattern of health seeking behaviour were people have optimized traditional (IKS) care to health care in reducing child mortality.

The study enhances development largely since Zimbabwe has signed the Millennium Declaration which consist of the Millennium Development Goal number 4 that seeks to reduce the number of child mortality by 2015 though it has been a failure in meeting the requirements and now it has engaged in the Sustainable Development Goals with the same aim of reducing child mortality .This makes the protection and proper care of children crucial as a country cannot be marked developed if it has high levels of child mortality. The MDGs have required countries to reduce child mortality by 75% in 2015 but this has been a challenge to Zimbabwe since it fails to meet its target of reducing

the number of under five mortality by at least 75 percent from 102 deaths per 1 000 live birth to 27 per 1000 live births by the end of 2015 hence there is need to address the issue. It is important to note that as indicated by the Multiple Indicator Cluster Survey 2014 an estimate of 75 children die per 1 000 live birth. However in 2000 102 deaths per 1 000 live birth were recorded but in 2009 it decreased to 91 per 1000 live birth and in 2012, 75 deaths were recorded. The Zimbabwe National Family Planning (ZNFPC) noted that one in at least 15 children die before turning 5 years and according to D.Maromo the Manicaland Communications Officer one newly born baby dies in every 20 live birth. Therefore from the above statistics the research hereby is crucial so as to address how IKS can be a cause or how effective can it be in dealing with children health.

## **1.2 STATEMENT OF THE PROBLEM**

Child mortality has affected development especially in developing countries .Child mortality has been fuelled by factors like poverty , ignorant mothers on proper care and failure to use indigenous knowledge systems properly because of modernization were most grandmothers has shifted to urban areas are no longer able to cure diseases using IKS appropriately among others. Child mortality in Zimbabwe has increased following the economic meltdown experienced in the country as NGO's capacity to provide drugs has declined. However the research addressed the issue of child mortality using traditional methods and assess its effectiveness in promoting child health care as seeking the western medicine has proven to be expensive and at times shortage of drugs has turned off people to depend on these western medicines in Mutare hence they have engaged in Indigenous Knowledge system which are easy and cheap.

## **1.3 RESEARCH AIM AND OBJECTIVE**

This research made an assessment on the effectiveness of indigenous knowledge systems employed in Mutare child health care issues in relation to the increases in child mortality. Much attention was

be placed on how these IKS can help mitigate the effects of child mortality and how they are contributing to reduce child mortality in the Province. The main objectives were:

1. To make an assessment on the IKS knowledge employed by societies in Mutare with regard to child health care focusing on children under 5years.
2. To what extend are they contributing to the child health care and how effective are they to the children living in Mutare.
3. To discuss some of the effects that these IKS have on child health focusing in Mutare.

#### **1.4 RESEARCH QUESTIONS**

1. How effective are IKS employed on child health care in Mutare?
2. What are the major effects of these IKS knowledge on the health of children in Mutare?
3. How best can we educate the communities in Mutare on the effects that these IKS have on child health protection?

#### **1.5 SIGNIFICANCE OF THE STUDY**

This study was important considering the fact that there is high child mortality and some cultures still believe in the use of IKS in protecting the children despite the effects that such practices will have on the child because of ignorance. The research also explained IKS in relation to some diseases that do not require medical attention and hence the society has to make use of the IKS like the healing of the fontanel is said not to be properly cured at hospitals. The study addressed child mortality newly as it focused on the different IKS practices done by societies in an effort to protect them as because of poverty, acquiring medical attention is difficult and embracing traditional methods of protecting and preventing mortality to the child is crucial. The study had an academic significant as the researcher focused on a new research study with more of exploratory study being conducted in addressing child health with Indigenous Knowledge systems in practice in Mutare. The study also focused on a new angle of addressing child mortality through the use of IKS hence it

is relevant to the communities and health ministries and the target group which are children who important for future development hence there is need to address issues surrounding them. The study will also help the society to understand the importance of proper IKS system in a bid to reduce child mortality in the society.

## **1.6 THEORITICAL FRAMEWORK**

This chapter focused on the theory that shaped the researchers study. The research looked on the Sociocultural theory of Lev. S.Vygotsky .The theory explained how individuals mental functioning is related to culture, history and institutions surrounding them in development. It focuses on sociocultural perspectives on the roles that participation and culture enhance in development. According to this theory development or child development can be derived to the culture that one is in and specific structures and processes revealed to them by individuals like the use of IKS in some cultures is considered the best health care practice. The Sociocultural theory suggests that social interactions need to be understood as part of the cultural setting and not separately in order to understand the contribution of interaction to cognitive development and thinking. This theory can support IKS as culturally Zimbabweans believe in the use of traditional medicine in fighting diseases hence the use of IKS on child health care is relevant. IKS is considered the best methods in the child development as it shapes a child development within the social setting in child health care. Vygotsky theory places a greater role of language, social interaction and society in child development as to how the society addresses problems faced by children in their health. The theory supports the use of IKS as it places emphasis on society and culture beliefs as IKS are linked to a certain cultures and beliefs.

## **1.7 CONCEPTUAL FRAMEWORK**

Child health care is the care and treatment offered to a child against diseases that might affect her physically, socially, psychologically and the social well being of the child, It involve taking care of the child against diseases and protecting her from such through vaccines, baby check up before and after birth , immunizations, use of medicines to fight against infections. Failure to provide proper health care to the child will result in child mortality.

Child mortality is the death of children and infants under the age of 5 because of the failure to protect and prevent some diseases like diarrhoea, HIV/AIDS, malaria among other leading causes of under 5 mortality. According to the UNICEF definition, child mortality is the probability of dying between birth and 5 years of age expressed per 1000 live birth

Indigenous knowledge systems is the local knowledge that is unique to a given culture and acquired by a local people through accumulation of experience and intimate understanding of environment .It is the basis for local level decision making in health care, agriculture ,natural resources and other activities in rural communities according to ( Warren 1991). IKS are dynamic and continually influenced by internal creativity and experimentation as well as contract with external systems (Flavier et al 1999).The concept of Indigenous knowledge system is important on child health care as it offer preventive medicine against child related diseases that might led to child mortality. IKS should promoted because many cultures still depend on cultural knowledge because of poverty that hinders them the possibility of visiting hospitals.IKS and child health care is important as it allow the communities to prevent diseases and they offer a psychosocial care which can be accommodated by everyone and still remain a fact that we cannot live without cultural knowledge. However it is important to note that IKS can be changed as time moves and it can be preserved

## **1.8 RESEARCH METHODOLOGY**

The methodological approach for the study was based on primary and secondary data collection so as to have detailed information and because some societies could not expose their practices directly because of fear

### **a. Research approach**

The researcher used qualitative design approach because the researcher wanted to have a full understanding of how communities make use of Indigenous knowledge systems in dealing with children health. There is need for public participation therefore qualitative approach was used in the study through the use of interviews, indepth questions and snowballing as to know households with the targeted population. Qualitative approach is important as it seeks to understand situations surrounding the study area as it aim at producing factual description based on face to face knowledge of the targeted individuals as well as social groups in their natural settings (McMillan and Schumacher 2006). Therefore it is relevant to the study as the researcher was able to understanding IKS in relation to the cultural an beliefs of people in Mutare.

### **b. Research design**

The researcher used the exploratory research design so as to understand the practices more as the study require a thorough understanding. This design helped the researcher to get quality information in identifying IKS methods through observations and quality information that address the issue in line with child health. Expert survey were used by the researcher and they will helped in getting information from experts like the caregivers and elderly who use these IKS in child health care.

### **c. Population and sampling**

The researcher population targeted the elderly, mothers with young children, health officials, and community and care givers. The researcher focused more in Sakubva resident area



because most of the targeted population resides in the area like the elderly ( aged between 45-55) are found. The location also consist of a large population with young mothers and a lot of children some staying with their grandparents and it is accessible to the researcher. The researcher used snowballing sampling to have the targeted respondents and this helped her in reaching the right population she was targeting. The researcher population targeted 15 people, 5 were the elderly, 5 mothers with children, 1 health official and 4 community and caregivers.

**d. Data collection**

There was use of face to face interviews to get a clear understanding of the practices used by the targeted individuals. Interviews helped the researcher to have a room for open dialogue with the elderly mothers with the young children for better understanding. Observations were also used by the researcher to get a clear understanding to how the targeted respondents ensured child health protection by using indigenous knowledge systems in Mutare.

**e. Data analysis**

Qualitative data analysis techniques were used by the researcher so as to analyse data from the interviews and in-depth questions. The use of transcription themes in analysing data as to the effectiveness of these IKS in child health care and find out how many people support the use of these traditional were used.

**f. Ethical consideration**

In carrying out the research it was difficult to get all information as some societies failed to expose all the methods they used because of privacy attached to some medicines they use and fear as to why the research was carried out. It is important therefore to refer back to Nachmias and Nachmias (1992), which express that whenever a research involve human participants some considerations always stand as a guide; that is, any human costs

involved, privacy and confidentiality together with minimised risks for the progress of the study. Thus the author prioritized the rights of participants both as individuals and as collectivises, if that is the case therefore the information gathered cannot be used for non-research purposes. Personal details of respondents are not provided in this document. It is noted with appreciation that respondents participated on voluntary basis and no financial hand outs were given to the respondents. Informed consent will be used by the researcher seeking permission from the targeted population.

## **1.8 LITERATURE REVIEW**

The chapter serves to highlight some existing literature about indigenous knowledge systems in relation to child health in fighting against reducing child mortality. The aim of this chapter therefore seeks to review what some scholars and countries do in protecting children against diseases through the use of traditional knowledge. However much research has been not been done internally

knowledge ,ecological knowledge and indigenous ecological knowledge .This therefore shows that to come up with a single definition of IKS is difficult as they can be defined according to communities and cultures. According to Wilkson and Gumbo etal (2005) IKS is as set of knowledge that embrace cultural, social, traditional ,scientific ,legal, philosophical and governance system of a particular community in relation to how they address problems. The knowledge is shared by people of the same ethnic group of the same language therefore it is specific to localities as noted by Dondola (2005). It is important to note that IKS in this research is therefore a combination of different knowledge practice skills, cultural beliefs that are used to promote child health in curbing the levels of child mortality. Mapara (2009:14)

gives a geographical definition of IKS as a body of knowledge of the indigenous people of particular geographical area that has survived on for a very long time.

S in sustainable development that it was identified as one of the flagship programmes of the New Partnership for Africa's Development (NEPAD) Southern African Biosciences Network (SANBio) Initiative. The Initiative is establishing biosciences networks of centres of excellence involved in research and development in the region. The holistic nature of IKS and its interface with the other flagship areas (biotechnology & biodiversity & technology) was recognized as an important tool for addressing the diverse challenges facing the region including public health care issues

In South Africa, an indigenous African potato (*Hypoxis*) that is a medicinal plant growing in KwaZulu-Natal Province among the Zulu people is traditionally used to treat chronic viral and bacterial diseases. Traditional healers have been using it to treat cancer of the bladder and prostate, and sexually transmitted diseases (STDs). Studies done on the plant have shown that it contains two substances called sterols and sterolins that are essential dietary fats or lipids. The plant has helped many people to recover quicker from chronic and other diseases. It is a partly poisonous root, but with the right preparation and dosage, it is an approved immuno booster to assist the body's natural defence system. The University of Stellenbosch (South Africa), for instance, has conducted extensive research on this traditional medicinal plant and has developed easy to take tablets. There are indications that although the potato is not a sufficient treatment on its own, it could be extremely helpful when combined with other forms of treatment. Studies in the same university on HIV care revealed that the plant had shown the ability to increase CD4 counts (the amount of white blood cells in the

body);stabilise the patient; increase the weight of patients; and decrease the amount of HIV in the body ( Klerk, 2004).

Malaria is another dreadful disease killing millions of people, especially children, in many parts of Africa. The Tugen people in Kenya, who are part of the Kalenjin ethnic group living in the Rift Valley Province, believe in natural and non-natural causes of illness. Some of the Tugen, for example, believe that malaria is caused by Cheko che makiyo (fresh unboiled milk), dirty water, and ikwek(vegetables), such as Solanum nigram and Gynadropis gynadra. Tugen aetiological beliefs on malaria are logically valid, especially within the ecological context in which they live. The kipsaketinik (herbalist) generally prescribes and dispenses aqueous medicines prepared from roots, leaves,bark, and other plant or animal part.

According to the Tugen indigenous diagnoses, esse (malaria) is the result of excess bile in the body. The bile has to be expelled before healing can take place. Thus purgation is regarded as the key treatment regimen for malaria. On the basis of this knowledge,different forms of herbal medications are prescribed according to the severity of the illness (Aman,2000).In Tanzania, indigenous people are actively involved in a malaria control research project in Mtwara and other areas of the country. They assist in identifying the type of trees whose leaves, barks or roots are used as medicine to cure malaria. They also identify plant species that are repellent to mosquitoes (mosquitoes are vectors of malaria parasites). This is based on the acknowledgement that many indigenous groups have excellent knowledge of cures and treatments for some of the most common diseases that afflict them, and should be involved in studies regarding these diseases (Sarfi (2005).

Pneumonia is very common, associated with exposure to cold air, and treated with cupping in the home. Tuberculosis or *samba nkersa* (*samba* means lungs, *nkersa* means cancer) is recognized as a more serious and severe illness, treated by isolation due to communicability. There is no stigma or taboo associated with asthma. People are aware that one can die from asthma. Although it is occasionally seen among children, it is more common among the elderly. Children are also thought to grow out of their symptoms. The etiology of asthma is unclear. Some think it is contagious to some extent because it is associated with tuberculosis (TB) that is known to be communicable. Asthma is dealt with by changing residence and moving away from a climate or environment; this makes it worse. It can also be prevented, according to the healers, by avoiding dust and pollen that make it worse (dust, pollen). It is treated by using a special honey called *tazma mar*, also used for other types of cough. The healing secrets of the *medihanit awakge* are passed down from generation to the next (ZIRCIK, 2002).

Traditional medicine plays an important role in public medical and health care in Africa because most people cannot afford Western medical services. In most rural and urban areas of Eastern and Southern Africa, traditional medicine vendors are a common scene in the marketplace where they are traditional healers and pharmacists. They are the local population's main medical resource. They are known to possess a special connection to plants, and for their knowledge of sacred artefacts used to invoke their healing power. Their knowledge comes from experience, from trial and error with plant remedies, from methods passed down from generation to generation. Thus, for example, the Maasai in East Africa use vine to deaden pain; the bark of the baobab tree that is boiled down to a broth to relieve back pain. Since the baobab tree is held sacred,

only the needed portion of the bark is cut. Moreover, the leaves and barks of certain trees are used to stimulate gastric juice secretion in the treatment of digestive disorders. In addition, building on local traditional medicinal knowledge, a tea made of dried stem barks of ‘*Strychnos myrtoides*’, is used by the Zigua, Ndorobo and Maasai in East Africa to enhance the action of chloroquine against resistant parasite in the treatment of malaria ( Kindamba, 2002).

## **1.8 CHAPTER SUMMARY**

This chapter has laid the foundation of the study. The research was prompted by the fact that most rural children still under as a result of under 5 mortality diseases despite the existence of indigenous knowledge systems as people tend to favour modern methods

## **2.0 CHAPTER 1**

### **PROBLEM OF CHILD MORTALITY IN ZIMBABWE WITH A SPECIAL CASE OF MUTARE**

#### **Introduction**

The issue of child mortality in Zimbabwe has affected development largely and addressing it remains difficult. Child mortality has affected development over years and the issue has led the international community to creating the Millennium Development goals which seek to eradicate child mortality by 2015 as goal number 4. However it is sad to note that this has not been a success especially in developing countries and according to the Global Health Observatory ,the under 5 mortality globally average annual rate of reduction has accelerated from 1,8 between 1990-2000 to 3,9 from 2000-2015 making it a failure to meet the MDG4 goal. Internationally states has therefore developed a new framework of Sustainable Development Goals which also target to end preventable death of newborns and children under 5 years by at least 25 death per 1000 live birth. The problem of child mortality has raised concern in Zimbabwe and it has been influenced by factors like economic meltdown, social instabilities, religious beliefs, shifts in medical technology, the high prevalence of HIV/AIDS among other issues. This chapter therefore seeks to explain the trend surrounding child mortality in Zimbabwe, killers of under 5 and the factors driving to child mortality.

#### **2.1 Child Mortality Trends in Zimbabwe**

The Trend of child mortality in Zimbabwe is characterised by various factors that marked some shifts in the number of death over the past years. Factors like the shift in

the use of medicines from traditional to western medicines, harsh weather patterns influencing diseases, economic meltdown and social instability, the prevalence of HIV/AIDS , different cultures and beliefs among others has marked the levels and trends of child mortality in Zimbabwe as the country failed to protect children against diseases. The researcher trend of child mortality will focus more on from the attainment of independence in 1980 when the government managed to fund the health sector marking a good record during the 1980-95 period to 2015. Tracing child mortality in Zimbabwe is however difficult and little known.

Child mortality has been an issue over decades but with the coming of Independence in Zimbabwe its levels declined. According to Hill et al 1997, the under 5 rate have halved from 1960 to 1990 reaching a level of 80 per 1000 in 1990. Soon after independence the health sector improved as the government of Zimbabwe engaged in the health for all program. Mortality levels declined during this period as the country has adopted the Primary Health Care program as well as immunisation programs that seeks to reduce diseases affecting children through disease prevention programs. The government managed to build over 240 new health centres, decentralised hospitals and scarp maternal fees through the free health policy. Therefore it is important to note that child mortality levels declined during the 1980 -1990 period as new interventions through protecting children were promoted by the government of Zimbabwe. According to Kembo(2009),increased effectiveness of the programmes for equitable distribution of health facilities aimed at removing the discrepancies between rural and urban areas reduced the number of child death in the country.

Zimbabwe had a supported Expanded Program in Immunization and community level child monitoring and surveillance through health workers. This ensures the prevention and protection of newborn children against diseases and child health services were



accessed at a single visit promoting access of drugs to the community. Such initiatives declined childhood mortality rates and the period 1983-1988 recorded an under 5 mortality rate of 75 per 1 000 birth compared to 104 per 1 000 recorded during 1978-1982. The period between 1980 and 1990 had a decline in child mortality levels as access to health facilities has improved and it decreased by 50% during this time. Zimbabwe has established the Child Survival Foundation in 1983 to support in promoting child health and remained committed to the Primary Health Care that helped in reducing the level of child mortality.

The trend of child mortality between 1990 and 2014 according to the MIMS (2009), report noted that the under five mortality rose from 55 deaths per 1000 live births in 1990 to 94 per 1 000 in 2009. This was because of the situation that the country experienced during the 2008 period and the rising of HIV/AIDS levels. However the MIMS (2014) estimates had a strong downward trend in the number of deaths recorded during the 2010 and 2014 period maybe because of the availability of drugs as the economy had improved.

The Health system during the 2010 and 2014 period has improved as the country receive drugs outside and the government had improved health infrastructures making hospitals and clinics available in all areas to reduce distance needed to reach big health centres. The availability of medicine in the country and improved skilled birth attendance according to MIMS 2014 analysis has improved the health system and reduced the number of child death in Zimbabwe with an estimate of 75 deaths per 1000 live births. Other factors that contributed to the decrease in child mortality levels during this period was the increase in post natal care coverage which increased from 11,7% in 2009 to 85% in 2014 according to the DHS 2010/11 and WHO (2011). Full immunisation doubled during this period and exclusive breastfeeding improved as a

result of awareness campaigns held by the Ministry of Child Health and Welfare together with Health related NGOs in the country.

The period 1990 to 2008 marked an increase in child mortality levels in the country. This was characterised by different factors like the social and economic conditions, droughts, the HIV/AIDS prevalence and other disease outbreaks the country experienced during this period. Since the 1990 the country's economy declined and this affected children development largely as will be highlighted with the factors below.

### **Economic and social conditions**

It is also noted that the imposition of the Economic Structural Adjustment Program during 1991 and 1995 affected the health system largely as it led to changes in the health policies. The right to health was not consolidated despite the success of decentralisation of hospitals and funding the health sector has received. It is reported that by 2000 the health per capita funding has declined to \$8,55 from \$23,6 which has been recommended by the Commission of review in the health sector in 1997. This eroded drastically and stood at US 0,19 in 2008 leading to the collapse of the health sector and child mortality levels increased. Economic challenges affected child care in the country during this period.

The agricultural based economy declined and this marked increased poverty especially during the 1992 period and a lot of children died as a result of malnutrition. The situation was worsened by the imposition of sanction in the country under the Structural Adjustment Program and the country's health situation crippled rapidly as accessing drugs was difficult. The economic situation of the country worsened from 2005 to 2008 leading to many trained health officials during the period migrated in

search of better pastures and at some clinics patients had no one to attend them affecting the public health system. In the period maternal mortality increased threefold from 283 deaths per 1000 live birth in 1994 to 960 deaths per 100 000 live birth in 2010/11 and an approximate of 10-12 women die from pregnancy related complications. The economic situation during the period led to hyper inflation that hinder the society to access medicines and this had a profound effect on child survival as the health delivery structure has been strained.

According to the World Health Report 2009, the Zimbabwean government expenditure on health was affected by the economic decline as it did not change from 7,3% in 2000 to 8,9% in 2006. Clemens and Moss (2005) estimated that the purchasing power for the average Zimbabwean in 2005 was at the same level as of 1953 indicating the stress that the country went through during the period and this fall according to them has an impact on health in general and mortality of children. They estimated that the economic situation led to death of about 3,900 infants between 2000 and 2005 and this amounts to 11% deaths under one of children born each year in the early 2000s. In response to poor and worsening health indicators, Zimbabwe joined 189 nations in the MDG s so as to reduce child mortality.

### **HIV/AIDS**

During the period 1990 and 2000 HIV/AIDS was recorder the most killer of children in Zimbabwe. This virus was further influenced by the economic hardship the country experienced making it difficult for the country to prevent the mother to child transmission and import ARVs from developed countries because of the trade barriers as a result of the imposed sanctions.HIV/AIDS was recorded the most killer because doctors and other health practitioners as well as the community at large were not aware of the relevant drug and antibiotics to treat it. Lack of medicines also led to

child mortality during the period as a result of the government lack of adequate budget as well as the restrictions it had from the developed countries that had the ARVs. About a third of the infected mothers would pass the virus to their babies because there was no PMTCT intervention and some were not aware of the importance of being tested when pregnant either because of ignorance. According to Muller F et al ( 2005) in the period 1980-2005 among the 10 million children born in Zimbabwe a cumulative of 504,000 were infected and as of 2010 about 120 000 children between 0-14 were living with HIV/AIDS. According to the World Health Organisation, HIV/AIDS infection has undermined the MDG4 goal of reducing child mortality by two thirds between 1990 and 2015. The Joint United Nations Program for HIV/AIDS noted that in 1990 HIV/AIDS infection accounted for more than 20% of the total risk of dying before the age of 5. Zimbabwe has the highest estimate of HIV prevalence of 13.7% which led to the Zimbabwe child to poor health outcomes.

### **Disease Outbreak**

The trend of child mortality is also explained by the prevalence of other diseases like diarrhoea, cholera and HIV/AIDS which has affected children during the 1990-2008. Diarrhoea affected child mortality during this period and according to the Zimbabwe Micronutrient and Nutrition Surveillance Survey of 2008, 20% of children under 5 has suffered from diarrhoea. The disease was serious considering the social and economic hardship faced by the people in Zimbabwe which makes it difficult for some households to access salt for the ORT treatment. Most death was recorded as trained nurses and doctors have migrated to other countries leaving the country with untrained personnel and the lack of medicines in the country because of the poor economy.

It is also important to note that child mortality in Zimbabwe has declined since 2009 as a result of an improved economy with the UNICEF providing vaccines at an

affordable rate making vaccines available at clinics and hospitals. Child mortality has also decreased following the work of NGOs related to child health through their awareness campaigns and health initiatives like the Immunisation for all programs. Because of awareness campaigns the community at large has understood the importance of seeking medical health and immunising children against diseases. According to Dr Madzima, the country's economic downturn for the past 15 years had an effect on child death but because of these new interventions the rate has declined.

## **2.2 KILLERS OF UNDER 5**

Child mortality for children under the age of 5 in Zimbabwe has five leading causes which are the neonatal diseases which comprise of preterm birth complications, birth asphyxia and sepsis contributing 29% of under 5 death. According to the 2010 Global Systematic Analysis of National Causes of Child mortality report around 10,758 newborns die each year in Zimbabwe because of preterm delivery (37%), failure to breath (27%) and infection (19%). The other contributors are HIV/AIDS which is recorded as the most leading cause with 21%, measles contributing 8%, diarrhoea constitute 9% and pneumonia which has 13%, according to the Child Health Epidemiologic (2010). These killers are also contributing to the increased child mortality levels in Mutare though according to research diarrhoea is said to be the leading cause in the district.

### **Neonatal Causes**

It is noted that one of the major killers of children in the country is the neonatal causes accounting 44% mortality rate according to WHO(2002) .Neonatal causes affect the newly born child during the first seven days of life and most death are recorded during this period. Zimbabwe is recorded as the fourth highest country with

preterm birth complications leading to death of children according to WHO (2002). According to the Zimbabwe Demographic and Health Survey (2010), preterm complication are the leading causes with 37%, followed by asphyxia with 27% and other infections contributing 19%. It is important to note that lack of health staff at clinics can lead to birth complication and in some cases some gave birth on their own and lose a lot of blood resulting in complications that will be exposed to the child which are the neonatal causes.

### **HIV/AIDS**

HIV/AIDS is one of the most killer of children under 5 years in Zimbabwe since 1990. Children contract the virus during birth and as at times parents fail to get tested during pregnancy because of ignorance, religious beliefs and cultures that do not allow them to visit clinics and hospitals. Children has died because of HIV/AIDS in societies of Mutare as their parents do not go for testing during pregnancy ,this affects the parent to mother transmission prevention process in curbing HIV rate in the country. Such is caused by lack of education and at times religious beliefs that do not allow seeking medical attention. HIV/AIDS in children under five years is transmitted from the mother to the child during pregnancy, childbirth or during the breastfeeding period. According to the ZDHS (2009), about 700 children younger than 18 months had HIV. However it is imperative to note the issue of HIV had to be addressed at taken seriously by the community at large because it cannot be treated by IKS and traditional medicines. There is need to engage the community in awareness campaigns but at times gender disparities may affect this as some women are not allowed to move out of the household hence at times men will not advice their wives about such campaigns.

## **Pneumonia**

Pneumonia is a third killer disease of children under 5 years in Zimbabwe contributing 14 % of the child deaths. According to the Statistics from the Family Health Department in the Ministry of Health and Child Care pneumonia is one of the commonest cause of child death among children below five years. The disease affects children in the rural areas mostly because of failure to access pneumonia antibiotics as those in urban areas might have access to these antibiotics resulting in mortality. Pneumonia is caused by a failure of a child to regulate required temperature needed in the body. Lack of clean energy sources in some areas like the charcoal which is used to warm the temperature of the child can lead to pneumonia. Failure to adapt to the IKS systems of warming maize stock also led to pneumonia hence there is need to adopt to such practices as it helps in instances like poverty where it is difficult to buy pneumonia antibiotics. In an effort to regulate the child temperature lack of education by mothers and caregivers also led to increased child mortality as in some areas the use of wood, charcoal led to pneumonia.

This disease has affected children in Mutare as well .The area being a mining town has a lot of dust particles and the large population in areas like Sakubva and Natview with poor road network which are dusty has led to a lot of children to suffer from pneumonia. According to WHO (2009), pneumonia is a respiratory infection which also results from dust particles and it is a single largest infectious cause of death in children. Children in Mutare are dying from pneumonia because of ignorance by some families to seek medical attention and other has religious and cultural beliefs of seeking holy water and oil. However it is crucial to note that pneumonia has led to

child mortality in Mutare and there is need to engage IKS in addressing such diseases with an effort to reduce child mortality.

### **Diarrhoea**

Another killer of children under 5 years is diarrhoea in Zimbabwe and has affected Mutare largely. According to the Zimbabwe Micronutrient and Nutrition Surveillance survey of 2008, 20 percent of children under 5 had suffered from diarrhoea in 2009 and about 80% of diarrhoea deaths are caused by poor hygiene, inadequate sanitation and lack of safe drinking water. Diarrhoea has led to death of infants and toddlers in Mutare because of problems of unclean water from polluted rivers like the Sakubva River especially those staying in Garikai and Hobhouse, raw sewage is also a major contributor to the increased diarrhoea cases as most children will crawl and play in the sewage as it flow along the streets because of burst pipes. Therefore such factors trigger the prevalence of diarrhoea in Mutare.

### **Malaria**

Another killer of children under the age of 5 is malaria. According to the WHO (2002), malaria is responsible for 10% of child mortality in developing countries and in Zimbabwe lives have been lost as a result of the pandemic. Malaria has affected child development in Mutare especially those living in swampy areas like Sakubva and Musha Mukadzi where waste is disposed everywhere and creating a breeding sites for mosquito's. Some families cannot afford mosquito nets to cover and prevent their children from these mosquitos because of poverty or ignorance risking their babies to malaria. Frequent migration in Mutare because of the need for second hand clothes, malaria in Mutare is prevalent as Mozambique is a malaria infested area therefore chances of contaminating the disease to mothers who visit there are high. It is



important also to note that ,according to the Health and Child Welfare Deputy Minister Douglas Mombeshora,an increase in malaria cases was reported in the country and Mutare was one of the affected areas with a total of 22 480 cases reported in 2013 and it is one of the killer diseases of children below five years.

### **Measles**

Measles is the fifth cause of death in children under 5 years of age in the country. It accounts for 1% of childhood mortality its cases increase because of lack of vaccination. According to MIMS (2009) by November an estimate of 200 cases of measles were reported across the country and a significant proportion are those from the Johanne Marange and Masowe religion who forbid medical treatment and in line with the National Immunisation Day of 200, 31% of the unvaccinated children were tied to religious beliefs which poses risk of the diseases to kill a number of children.

Measles(rubella) has affected a lot of children in Mutare as there is a high proportion of the Marange and Masowe sects who do not allow children to visit clinic for vaccination. According to the article posted by Samuel Kadangure in the Manica Post of 16 October 2015, Dr Parirenyatwa noted that children have to be vaccinated by the rubella vaccine to fight against measles. It is reported that most people in Mutare deny medical treatment in favour of holy water and prayers because of ignorance and religious beliefs making measles a threat to the lives of children under 5 years.

### **Cholera**

Outbreaks of cholera have led to increased child deaths in the country and in 2008 and 2009 a serious outbreak was recorded which killed a lot of people and children included. Cholera is contributing to child mortality in the country and Mutare largely

as a result of poor water supplies and sanitation. This has been addressed by the Water and Sanitation Program being run in the country so as to improve water and sanitation to reduce the number of cholera cases. Failure by the council to collect garbage in the city and the use of unclean water because of shortage of water supplies has led to cholera outbreaks especially in areas like Hobhouse where the society used one open water source during the 2010-2013 period. It can also be noted that the unrepaired sewerage systems is affected human health especially during the rainy season when they overflow in streets and some children will come and play in the dirty sewage water. Such led to risks of cholera that will affect the child. Poverty and ignorance has intensified cholera cases in the area, as some households will not afford to buy the purification tablets in a bid to protect their children from diseases.

### **Malnutrition**

Malnutrition in Zimbabwe has also led to child mortality and as noted by the 2010/11 Demographic health survey that the high prevalence of chronic malnutrition and stunting in children under 5 was as result of malnutrition. Malnutrition is a underlying cause of child mortality as it affected 56% of children between 6-23 months of age. Malnutrition contributes to half of children deaths and there is need to harness this problems as it is affecting child development largely.

## **2.3 FACTORS LEADING TO CHILD MORTALITY**

### **Lack of medicines**

The poor availability of medicine is one factor leading to child mortality in Zimbabwe and Mutare at large. Lack of medicine like vaccines, ARVs and other antibiotics which are important for child development has led to increased mortality in Mutare.

This lack of medicine is traced from the period when the country had the structural adjustment programs and the trading system was banned, this marked the failure of the country to acquire drugs in clinics and hospitals. The failure of the government to budget more on health medicines contributes to the lack of medicine at clinics and hospitals because of economic meltdown in the country. Poor availability of medicine especially in rural hospitals affects children and eventually led to increased child mortality. This is influenced also by the poor access to health care because of the distance the mothers had to travel to reach a hospital with medicines as major clinics in towns are the ones with medicines at times.

### **Poverty**

Poverty has affected the children livelihood and development in Mutare and the country as a whole. Poverty led to malnutrition which is another killer of children under the age of 5 years. This is because most families in Mutare has shifted to the three meal per day to one meal and this affects the baby being breast feed since the mother should eat enough food for proper breast feeding. In such cases most mothers are breastfeeding their babies for less than 6 months which is the proper feeding period. Having one meal is affecting the child health as it won't be balanced hence resulting in increased cases of malnutrition and kwashiorkor thus when the child is attacked by other diseases he/she will not be able to fight the diseases resulting in death. Therefore poverty affects the body building system of the child and it led to child mortality in Mutare.

Poverty is a major contributory factor to child mortality in Mutare as it hinders the capacity of some families to seek medical attention as they lack funds to buy some

drugs. This inability to seek health care will led to death as diseases like pneumonia and HIV require drugs, therefore failure to access it will be risk to the child health. It is also important to note that poverty within the institutional organisation in relation to child health also led to child mortality as the failure to acquire relevant drugs needed by the community, efficient maternity wings for the pregnant women as at times clinic will report that they have no beds and pregnant women will resort to home delivery. Poverty in hospitals and clinics led to child mortality as at times some hospitals in Zimbabwe lack the adequate newborn care corner which provides optimum child care with a resuscitation mask, bag and suction bag which helped the child in breathing reducing child mortality and saving life of the newborns. At times because of shortage of drugs at hospitals families do not visit the hospitals with the belief that there won't be drugs.

Poor water and sanitation especially in areas like Sakubva, Destiny and Garikai in Mutare has led to increased child mortality as this will result in high cases of diarrhoea .Pneumonia cases also increase because of poor ventilation in some houses as others use bricks as windows in Garikai area of Mutare. Poor ventilation will affect the child respiratory system as breathing normally under such conditions will be difficult.

Poor diet is also a result of poverty and it lead to malnutrition and diseases like kwashiorkor .Poor diet in Mutare is as a result of poor yields because of droughts and floods .Such affects family's capacity to provide a balanced diet to their children. According to WHO (2002), 35 percent of children under 5 years are stunted in Zimbabwe as a result of malnutrition (MIMS 2009).

### **Lack of education of mothers and caregivers**

Education of mothers is crucial in proper child care and protection in an effort of protecting them from the killers of the under 5 mostly. Lack of education of mothers and caregivers is a contributing factor to child mortality especially in Mutare where the large population of the girl child is uneducated because of religious beliefs to those in the Marange and Masowe sects. Early marriages in Sakubva and other high density suburbs have result in most young mothers to be uneducated as they leave school to marriages because of pregnancies at times.

Lack of education result in improper care of the child , poor diet will be given to the baby as the mother lacks the knowledge of which food is appropriate for the child and is it a balanced diet. Such result in malnutrition and it affect the child proper development as the child will be stunted because of poor diet. Therefore education of the mother and a caregiver is crucial in proper care of the child as in cases when the child suffer from diarrhoea the mother might not be able to prepare the Oral Rehydration Therapy (ORT) for the child.

Children with uneducated mother are at risk of acquiring and suffering from diseases unlike those with educated mothers. This is because uneducated mother in some cases will fail to read notices and listen to adverts encouraging immunisation of children against diseases therefore they will not visit the hospitals and clinics. Uneducated mothers at times has a belief that whatever disease a child suffer from is spiritually connected therefore they don't believe in seeking medical attention in an effort to cure diseases. This has led to death of several children as some treatment does not require the holy water but require medical one. Children with uneducated mothers are at risk

of suffering from disease as the mothers will not be able to read and follow prescriptions well.

Lack of education result in poor living conditions that affect the child as mothers and caregivers do not know how to protect children well in a conducive environment with proper ventilation, free from sewage, proper water and sanitation among other good conditions. Uneducated mother expose their children to whatever condition and at times they leave the child playing in sewages as they are unaware that it will result in diarrhoea.

Failure to keep in mind past exposure by an uneducated mothers or caregiver makes a child at risk of death. Because the mother will not recognise symptoms of a certain disease the child suffered from other the other child suffered from which require medical attention. This will put the child at risk as the mother will not find means to treat the child in fight with a certain disease. For example measles and diarrhoea symptoms that need one to seek attention as fast as possible in protection of the child. Lack of education of mothers and caregivers is a major factor leading to the increased number of child mortality in Mutare.

### **Religious Practices**

Religious factors are leading to child mortality in Mutare largely. This is because the district has a large population of the Johanne Marange and Masowe apostolic member who does not support the use of medicines in curing diseases. A lot of people in Mutare are held within this religious belief that holy water and anointing oil are the essential, medicines in healing diseases. This has led to a number of the Marange

children dying as they are not immunised and vaccinated in fighting of diseases. Another thing to put into consideration is the marriage system in the church which hinders the girl child to further her education as she will be married. These early marriages in these churches result in lack of education of such children as mothers to protect their children for proper development. Hence religious beliefs that hinder children visiting the hospitals are increasing child mortality across the country and Mutare at large as diseases like HIV/AIDS require only medical attention. HIV/AIDS pandemic might affect children tied to such religion since the mothers during pregnancy do not visit the hospital therefore she won't be tested and preventing the mother to child virus will be difficult as most of their births are done home. Religious practices led to failure to diagnose dysfunctions from as early as birth because of negligence which will result in death of children. It is also important to note that such religious practices are undermining immunisation programs like the Reach Every District programme. According to the UNDP (2011) refusal of medical treatment on the basis of religion has a strong bearing on child mortality in Zimbabwe as they do not allow their children to be immunised or seek modern treatment.

### **Poor Nutrition Practices**

Poor nutrition practices to the child will result in child mortality. This is because children need a balanced diet with nutritional contents that helps them fight diseases and allow them to grow strong. Poor nutrition result as a failure to adhere to the require breastfeeding period of 6 months. Breast feeding is important for children as it is healthy therefore mothers should ensure exclusive breast feeding as it enhances the life development of a child because it has high nutrient content needed by the baby for body building and fighting against some diseases. Poor nutrition practices can be seen

when a mother does not clean the child's milk bottle or the child utensils well. This might lead to diarrhoea and as the child will be eating from unclean utensils. The poor nutrition practices are linked to the lack of education of mothers since they lack the knowledge on the proper nutrition practices that should be followed in child care. Poverty also led to poor nutrition practices as in some cases mothers will not be able to have the appropriate mixed food to feed the baby and they will just give the child what will be available without considering what effect it might have to the child because of her digestive system.

### **Energy Sources**

Energy sources also led to child mortality in the country. The absence of clean energy sources like electricity has led to most children suffer from respiratory infections. This is caused by the inhaling of smoke from wood, charcoal that will be used within their households. Such energy sources affect the child breathing function properly and at times children might suffer from asthma and other respiratory challenges. Therefore unclean energy sources also led to child mortality.

### **Failure to use IKS properly**

Although the use of Indigenous Knowledge System it is important in addressing child death in the country. The failure to use it appropriately has led to a number of children losing their lives at the hands of traditional healers or elders. The use of IKS requires closer attention and understanding of the necessary measures that should be taken. For example when one is cleaning a child fontanel there is need to make sure if you are using a napkin the napkin is clean and you reach the correct position. Good hygienic measures should be taken into consideration and the amount of salt and oil used



should be correct as well. The failure to use IKS has led to a lot of children dying especially in rural areas of Mutare and the Marange area who do not seek medical healing. It is important therefore to note that the failure to use IKS appropriately will lead to child mortality.

### **Teenage pregnancy and marriages**

Teen marriages have also contributed to child mortality in Mutare. This is because of religious beliefs or as a result of early pregnancies. Young children are becoming mothers when they lack the knowledge on proper care of a child and the environment that a child should live in. Lack of maturity to be responsible for a child is also affecting children health for instance in Mutare a lot of young mothers do not value the importance of keeping the child warm and at times she will wrap the child in a towel only or use the baby carrier only . This is not advised by health officials as it will expose the child to cold and the child will suffer from pneumonia or flu. Teenage marriages result in a child being exposed to difficult conditions and some do not know the importance of immunising their children and this is influenced by fear of what other peers will say when they see her with a child. Teenage marriage expose a child to risk of malnutrition as some mothers will not breastfeed their children properly because of shame and ignorance at times. Lack of exclusive breast feeding to the child will make the baby weak. Young mothers do not seek medical attention during pregnancy and some because their parents would have sent them to their husbands houses were they are not welcomed at times, birth option will be difficult and they have home birth at times were they lost a lot of blood. Some even abort the child before delivery.

### **Systematic delivery weakness within the health sector**

Weak systems in the health system have led to child mortality in Mutare. This is experienced when the clinic or hospital fail to provide pregnant mothers with adequate waiting room thus at times they use staff houses waiting for delivery is reached and it may result in some complications as at times the nurse will delay to reach the patient.. According to UNDP (2011), lack of responsiveness among the health officers also result in death of children as some nurses tend to ignore patients when they call for assistance resulting in other mothers giving birth on their own. Another issues affecting children is that of strikes within the health system. Pregnant mothers or sick children are not attended to when the health staff are on strike and few cases has been recorded of children dying at hospitals as they have no one attending them. This undermines child development and at force community to engage in IKS practices as seeking medical attention will prove worthless.

### **Poor Government Budget**

Poor budgeting is also a factor leading to child mortality as little budget allocation has been set for the health sector resulting in inadequate drugs and health supplies required. According to ZDHS(2009) the state investment in health between 2000-2010 varied from 4,2% of the state budget in 2001 to 15,3% in 2009 which marked the decline in the health system services and a lot of mortality rates were recorded during the period. There is need for the government to invest more in the health sector as it is an important tool for development. Poor government budget affects health system of the country leading to increases mortality as there will be no medicines and vaccines required for child development. It is important to note that the state annual budgetary allowance is said to be \$9 per capita instead of \$34-\$40 according to the Quagadougou Declaration. According to the data compiled by the Community

Working Group in 2015 the country's budget was only 6,3 percent of the 4,1 billion annual budget on health. Therefore, there is a need for the government to budget more in the health sector to reduce child mortality as a poor budget is affecting child development.

### **Health services user fees**

It can be noted that the imposition of the health user fee by the government has somehow led to child mortality in Zimbabwe. This is because most people in rural communities are poor, hence they fail to pay for the maternity fee and registration fee whenever they seek medical attention. In some cases, most households do not want to pay the fee, and this has forced them to rely on traditional methods in healing diseases, but at times it has led to a number of children losing their lives.

## **2.4 Chapter Summary**

This chapter explained the problem of child mortality in Zimbabwe through exploring the major killers of children under five years and the contributing factors to such, with a special case of Mutare. The child mortality trends were also given to show how the issue of child mortality has been over the past years to date.

### **3.0 CHAPTER 2**

#### **3.1 IKS AND CHILD CARE IN MUTARE**

##### **Introduction**

This chapter seeks to explore some key findings on child care using IKS. It explains how IKS help in reducing child mortality in line with the leading causes of child death. It is therefore going to explain how the elders and mothers address child diseases with the use of Indigenous Knowledge Systems in Mutare. The writer will address the leading cause of child mortality first and then look at other diseases and how IKS help in combating such diseases. However it is important to note that these IKS should be addressed carefully as they risk child health if conducted by someone who is not aware of how it should be done. Failure to use these IKS well will result in rather increased child mortality but according to the study many in Mutare has relied on IKS following the failure of clinics to provide necessary medication and appropriate care because of lack of resources at clinics.

##### **Neonatal Birth**

In addressing neonatal birth elders and mothers make use of their Indigenous Knowledge system from birth and care of the child during the first 72 hours. It is important to note that IKS can be used to address this most killer disease that accounts for 42% of child mortality in the country as well as in Mutare. Pregnant mothers are induced by using hot water , the mother drink a lot of hot water as the inducer before birth. In addressing neonatal causes, grandmothers help the pregnant mother during birth by conducting safe birth methods as they use a sewing thread or a sack thread with a measurement of about 10-20cm to tie the mothers umbilical cord before cutting it. The thread will be tied twice with care at the umbilical cord and measure again 5cm before cutting the cord so as to reduce chances of the blood to flow back into the

mothers system as it will result in some health complications. In cutting the umbilical cord the grandmothers use sugarcane skin blade....in the absence of a razor blade, others make use of the “*jekacheka*” fibre in cutting the umbilical cord. The use of a sugar cane skin blade. is usually done in cases when a mother had delivery pains on the road and at times reaching a shop to buy a razor blade will not be essential and in some poor households where they cannot afford to buy a razor blade. In cutting the umbilical cord some make use a snail shell especially during the rainy season and some believe in putting the mother’s milk on the child naval so that it fall according to the mothers days of menstruation period. Such practices in home births are usually used and a lot of children especially those tied to religious belief that they are denied hospitalisation have been used and a lot of children have survived.

After child birth , as scientifically proven a child has to cry, however in cases that the child did not cry under IKS practices the grandmothers check what is known as “*chindimbo*” connected to the voice box which hinders the ability of a child to cry. The *chindimbo* will then be cut by the sugar cane blade and the child will eventually cry, but there is need for proper cutting as failure to cut the exact size will led to some complications on the child. If the child is said to be having what is called “*buka or berevere*” when the child will be scared a lot, the use of raw eggs will be applied all over her body. Some communities believe in throwing the child up in the sky or letting the mother jump from a high position with the baby on her back. Tying the child naval around her waist also reduce the chances of a child being afraid. Such beliefs are to make sure the child is not too afraid.

Under post natal care, if the child is born weak, IKS knowledge makes use of heated mealie meal and spread it on a sheet or any piece of cloth and put the child on it. The child will lie on the cloth to make her strong and if one had visited the hospital in such

instances when the child is weak, he/she will be put in glasses where they have the required heat. It can be seen therefore that IKS system are cheap if they are properly handled. If the mealie meal is heated too much the child might be burnt. The child eyes are made open by the use of water mixed with ashes which will be rubbed on the eye lids. This is believed to make the child see and some put mother's milk in the child eyes. Shaping the child's head is done every morning using heated oil and hands. In IKS belief the child first hair cut and umbilical cord is tied on the child waste to prevent her from diseases for a week. These are some of the antenatal delivery and post natal care methods used in IKS by grandmothers and caregivers in Mutare in addressing the neonatal birth complications and care of a child leading to child mortality.

### **Pneumonia**

Pneumonia is an infection of the lungs. It is treatable and preventable. IKS practices are also used in fighting pneumonia which also led to increased child mortality levels. Traditionally this is addressed by using banana ashes or *mushaba* tree ashes and they lay the child on the ashes. The ashes will be placed under a blanket at an average temperature for the child to feel warm by the mother or elders. It is also important to note that, in the absence of banana ashes or *mushaba* leaves ashes the elders in Mutare also makes use of maize mealie meal to keep the baby warm by heating it and spreading it under the child blanket. In line with addressing pneumonia virus the child clothes are not allowed to be hanged outside on the washing line until the naval falls as it is believed to cause some infections.

## **Diarrhoea**

Diarrhoea is the condition of having at least three loose or liquid bowel movements each day which lasts a few days and can last for few days and can result in dehydration due to fluid loss. Diarrhoea is a leading killer of children under the age of 5 years in Mutare. The Indigenous Knowledge system therefore seeks to address this and reduce the child mortality levels. Diarrhoea is controlled by making use of flour in preparing child porridge. This is meant to stop the child from vomiting and helping her ease her stomach by losing all the food she had taken. Other communities use a wet piece of soap by putting it on the child's anus to help release. This is done to clean the child's stomach so that whatever virus in the stomach will come out and the child will feel better, however the use of soap needs close attention as if not properly handled the child might suffer worse and according to medical practitioners the use of soap has complications on human development.

Cooking sorghum porridge also helps in reducing diarrhoea especially in rural areas and it is cheaper than buying medication. Diarrhoea can be reduced too by giving a child warm cooking oil for drinking. These are some of the IKS methods used to prevent diarrhoea as a cause of child mortality in Mutare. The use of *tsangamidzi* was also recommended by some elders in Mutare in dealing with diarrhoea, the mother or any caregiver will chew the *tsangamidzi* and give it to the child. Others grind it and stir the particles in water then give the child. It is also believed that the use of the soil eaten by goats and cattle called *gowa* is also important for healing diarrhoea. The soil will be put in water so that the child will drink it and to those grown up they will eat the soil directly. This soil is believed to cure diarrhoea and stomach pains.

In reacting to diarrhoea, IKS practices also believe in the use of a hoe. The metal part of a hoe is burnt on fire and the mother will put the milk on the heated metal in a container and add water then give the child to drink. According to this belief the diarrhoea will be gone in a matter of 24 hours vividly suggests its effectiveness. However, this methods makes a child susceptible to diseases like tetanus At times if the metal has rust it will eventually affect the child's health. Some also believe in the use of goat milk, the child will drink goat milk in healing diarrhoea. The use of traditional beans plant roots (*munyemba*) also helps in fighting diarrhoea cases in Mutare. The *munyemba* roots are boiled in water and the child will drink when it is warm, such is mostly practiced during the rainy season where the *munyemba* is mostly available. It can be noted that there are various ways and beliefs used by people traditionally in healing diarrhoea which is a cause of child mortality and if these are properly practiced the rate of child mortality will be cut through the use of these Indigenous Knowledge system as they are cheap and affordable.

### **Measles**

The outbreak of measles resulting in child mortality can be prevented traditionally with Indigenous Knowledge practices. Measles known as *gwirikwiti* affect a number of children under 5 years and it can be spread by contamination or staying in the same room with someone affected. However, as this killer disease mostly affect the Marange and Masowe children who do not seek medical attention traditionally this can be healed. Measles according to IKS knowledge can be healed by applying wet ashes on the affected areas of the child. The use of ashes is believed to be very effective in reaction to measles outbreaks and most use it because it is cheaper than buying vaccines at hospitals and clinics.



It is also noted that when a child has measles he should not be given salty foods as the salt will worsen the condition. The child should not take a bath during the period as the ashes will not work and the parents of the child are not advised to have sexual intercourse as this is believed to worsen the condition of the child. Some societies also believe that when a child has measles she should eat okra as they believe it reduce the disease in some way. The use of the *muroro* tree is said to help again in the fight against measles in Mutare. It is also believed that the use of python oil (*mafuta eshato*) is essential in treating measles by applying it on the affected area.

### **Cholera**

In addressing cholera outbreaks using Indigenous Knowledge Systems the elders in Mutare encourage the use of blackjack (*nhungumira*). The blackjack is boiled and the child will drink the water and this will help the child. Some communities use a herb known as *bunganyunyu*, to cure the disease. Others encourage mothers to give the child rice without cooking oil as it is believed that cooking oil will cause the child to suffer more. However in poor household, the rice will be expensive for them and cannot afford it, thus they will use the blackjack which is cheap and accessible especially in the rainy season. It is also important to note that the use of *gowa* and a metal tool is also essential in cholera healing as the use of a metal like a hoe or axe is said to be effective within a day. It can be noted that IKS practices and methods used in cholera treatment can be used in diarrhoea treatment as well.

### **Malaria**

Malaria as one of the causes of under 5 deaths has been addressed by some societies in Mutare by using IKS practices. However most of the communities and elders subscribe to medical attention when a child has malaria but some has said they use

salty water as treatment for malaria. They believe that warm salty water will treat malaria and this is mostly used by societies tied to religious beliefs that they cannot seek medical treatment. The water will be given to a child and it will help the child vomit the green substance believed to be infection of the malaria virus. Others in Mutare also believe in the use of chilli in treating malaria to the children around 3-5 years. The chilli will be taken as pills, and they use the small ones that can be swallowed. The child will be given about 4-5 and drink them with water. These are the IKS practices that the elders in Mutare use in treating malaria and they engage in them because they are cheap and affordable

IKS can be used in protecting the child against various diseases and these can be explained below

### **Fontanelle ( *Nhova* )**

Traditionally it is believed that a child health might be affected by what is known as *nhova* and most grandmothers encourage mothers to seek treatment in addressing this as it has led to a death of several children, According to Health Practitioners there is nothing like *nhova*. The correct term is dehydration and there is need to give the child adequate foods that contain liquids. These grandmothers' traditional beliefs are in contrary with medical practices as they suggest that the practice may kill children because fontanelle is a critical death cause in children. It is now important to discuss various practices and method of treatment used by the elders and caregivers in Mutare to treat fontanelle related diseases.

The grandmothers and child care givers as well as traditional healers use a tree known as a the blood wood(*mubvamaropa*) fruits. These blood wood fruits will be burnt and the ashes are applied on the mother's nipples and the child will eat when she/he is

breastfeeding. It is believed that the ashes will help the child as the *nhova* will disappear. However it was said that it is important for the bloodwood fruits to be fetched by someone who knows well the fruits to avoid complications during treatment process. Others use the jatropha fruits known as (*zvipfuta*) in treating *nhova*. These jatropha will be burnt and the ashes are mixed with cooking oil. The ashes will then be placed in the child mouth on the *nhova* which is at the ceiling (the upper top of the mouth) of the mouth or at the mother's nipples.

It is also noted that when treating *nhova* on a child who has teeth there is use of a napkin .A new napkin has to be used for hygienic purpose in cleaning the *nhova* of the child mouth. The napkin will be thrown away after use in line with their belief that it has to be done that way. In poor households the use of a used napkin is allowed but it has to be clean but chances that some will bring unclean napkins are high and because the elder or traditional healer will only want money or a tokens of appreciation at the end the napkin will be used putting the child at risk of other health problems like diarrhoea.

*Nhova* treatment also includes the use of cooking oil and salt. The cooking oil and salt will be mixed and a hen's feather used to clean (*kwesha nhova*) and the child will vomit and she will be fine. Although there is need to use the appropriate oil and soil as failure o provide necessary ingredients will result in other complication on the child health. The feather should be clean as well for hygienic purposes. It is therefore crucial to note that in treating *nhova* there is need for promoting good hygienic measure and it should be properly done to avoid consequences of deaths or wounds in the mouth. *Kukwesha nhova* require a very good understanding on the exact procedures with the age one is treating as a child who is above 2 years will eat the ashes from the bloodwood and jatropha fruits.

### **Nhongorongongo (green substance found on the child stomach)**

There is a sickness which is called *nhongorongongo* which is said to be prevalent on children and this affects the child development. This occurs in the child abdomen and it will expose the green colour on the child stomach. This *nhongorongongo* can be treated by using milk, coke cooking oil and *tsangamidzi*. These are mixed together, boiled and give the child to drink after 2 days. There is need for effective preparation of this medicine and make sure the child drink it after 2 days as failure to make good procedures will put the child at risk of other diseases. Some use water from a tree called *gowa*. The water will be given to the child to drink in fighting the *nhongorongongo*. The use of aloe vera (*gavakava*) is also encouraged by elders in Mutare in treating *nhongorongongo*. The aloe vera leaves will be boiled and give the child to drink the water. These methods are mostly used in Mutare and during time when a child has this diseases it is advised that the child clothes will not be put outside on the washing line especially where there is direct sunshine as it will make the child suffer more. It can be noted that these were some of the IKS practices that have been explained by the people in Mutare with regards to treatment of *nhongorongongo* and it can be seen that these practices need an expert in using these methods as if not properly handled will affect the child more.

### **Buka/Berevere**

Traditionally there is what is believed as *buka /berevere* which is a situation when a child is too frightened that at times it is believed to result in death and physically impaired. In dealing with convulsion people in Mutare use eggs and king onions, this is grinded and rubbed on the child body. The use of cooking oil and onions can be

used by households who can afford it but poor households use tree leaves of a tree known as *munyazvirombo*.

### **3.2 Chapter Summary**

This chapter focused on key findings on the use of IKS in Mutare under child health care was explained. Different methods were outlined as to how the elderly and traditional experts help in fighting the leading causes of child mortality using Indigenous knowledge systems. The effectiveness of the use of IKS was highlighted as most tend to rely on these systems. Complications surrounding some methods used were also highlighted during the explanation of the key findings on IKS and child health care in Mutare.

#### **4.0 CHAPTER 3**

### **HARNESSING THE POWER OF IKS FOR BETTER CHILD CARE IN MUTARE**

#### **Introduction**

This chapter seeks to explain the strength of using IKS in child care in the case of Mutare following the methods and practices explained in chapter 2. IKS are relevant and important mechanisms in promoting development in the country largely and it is therefore in the context of reducing child mortality levels that this development can be explained. There is need to harness IKS for better child care as they are cheap, affordable, readily available and effective in combating diseases as they have been neglected with the coming of western medicine though their contribution is greatly appreciated. These IKS has to be harnessed as they can offer solutions to health issues and child mortality cases as in Mutare and they are also valuable resources used in herbal medicine production. IKS can be harnessed following the economic challenges that people experienced in the country resulting in high levels of poverty leading to a number of people relying on the cheap methods of treatment. IKS should be harnessed because they are important ingredients to child development as they can be accessed by anyone though this cannot be a success without compliments from the Ministry of Health and Child Welfare. IKS should be harnessed as well following the fact that a lot of people has trusted and believed IKS s the appropriate way of having treatment.

#### **4.1 IKS as a mainstream medical route for medical care**

Looking at how IKS have helped a lot of communities and households in treating various diseases taking into consideration high levels of poverty in these communities because of economic challenges mostly, it is therefore valid to consider

mainstreaming IKS as a medical route in the country. Mainstreaming according to this context means ensuring that the use of IKS has been popularised and a lot of people are aware on what IKS are and how can they be used as a medical care route effectively.

Communities should know much about IKS and this can be achieved only if people know much of them and it is in this discussion where some ways to mainstream IKS can be discussed to give an insight on communities to understand these traditional ways of healing various diseases as a medical route to reduce mortality levels in the country. IKS has to be mainstreamed considering the fact that a lot of people are not aware about these especially those in urban areas, hence there is need to mainstream IKS for use in instances of poverty and shortage of drugs. It was reported that traditional methods of curing various disease saved lives of many especially the under 5 children. Therefore people have to be aware of the IKS systems that can be employed in treating various diseases especially to the poor communities and those who live far from clinics and hospitals.

It is therefore important to note that IKS have been discouraged by lot especially health officials, however their role in child care can be greatly considered especially to rural communities. IKS has to be mainstreamed as a medical route through the ways like, creating an effective policy framework on the use of IKS, incentivising elders and grandmothers offering IKS treatment to children, awareness programs, medical officials should complement the efforts of IKS, include traditional healers as part of the health care team among other issues.. IKS should be mainstreamed as noted by Abbott (2009) that traditional medicines has to be ,mainstreamed as they encompass a large group of health care systems ,practices and products that are evidence based and effective.

IKS has to be mainstreamed through engaging medical health officials and traditional leaders, grandmothers who use IKS to treat different diseases together. Health officials has to complement efforts of IKS in promoting health care in children through offering support and encouraging community to resort to traditional methods as a medical route. The government has to support the use of IKS through the Ministry of Child and Health by setting a policy specifically focusing on the use of IKS. This will avoid situations where people die because they lack funds to purchase drugs at hospitals. The policy will ensure efficiency in the use of these IKS systems as according to a report by the Zimbabwean Parliamentary Health Committee in 2010, about 80% of the people use traditional medicine (Nkatazo 2010).It is important to note that the Parliamentary Health Committee members in 2010 alluded to Zimbabwean government to set up statutory instruments that would ensure traditional medicines becomes a part of Zimbabwe health care system (Nkatazo, 2010) as the promotion and integration of these IKS will help mainstream health care system importantly because IKS encompasses a large group of health care systems, practices and products that are evidence-based and effective (Abbott, 2009). In setting a policy that supports the use of IKS it can be noted that the country can produce its own medicine and reduce chances of shortage of drugs that will lead to mortality of people. Therefore the country has to set a policy that is specific on promotion of IKS on health care ensuring it as a medical route.

In line with awareness campaigns there is also need to conduct meetings that alarm people about relying on IKS and having faith on them as they can yield positive result if properly handled as a medical route. The meetings should target young mothers and grandmothers who offer IKS practices to the children and mothers are included for



them to rely on IKS. This is so because it was reported that a lot of health officials criticise the efforts of IKS and people will there by lack trust in the methods that elders use. However when health professionals encourage people to resort to traditional methods especially in curing diseases like diarrhoea , it can be seen that a lot of people will have trust on these methods.

Indigenous Knowledge systems also have to be mainstreamed through engaging various awareness campaigns. Such campaigns should incorporate the elders, health officials and the community at large so as to train people on the appropriate use of IKS systems within households. These awareness campaigns should incorporate health professionals to show that they complement the efforts of IKS and this allow a lot of community members to attend especially those who do not trust these traditional ways in treating various diseases. The health officials will also have to encourage the community to rely and use IKS methods whenever necessary especially when an emergency arises to avoid death of people and children at large. It is also important for the health experts and IKS specialist to give a clear understanding to the people on how the traditional methods should be used properly to avoid complications. Therefore these awareness campaigns will give room for people to understand that IKS are important and should be embraced when fighting mothers, the elderly and the IKS and medical experts so that these young mother will have a clear understanding on the use of IKS as lack of knowledge has led to increased child mortality in the country. Such meetings and awareness campaigns help in informing and educating the community to adopt to the use of IKS. It is also important to note that during these meetings the elders and other IKS experts should train others on the effective methods on using traditional ways and the health officials should also train the community on the proper hygienic ways and appropriate methods that do not result in complications.

It is also important to note that IKS has to be known by young mothers considering early pregnancies experienced in the country. These young mothers has to be informed and encouraged to visit elders to seek treatment especially with children to reduce mortality as most children from young mother are dying either as a result of ignorance on proper care and lack of funds to access medicines at hospitals. It is therefore important to ensure that these mothers are well trained and informed to adopt IKS as a medical route. To make sure young mothers are informed and aware of IKS there is need to enhance IKS as a curriculum in schools. Through the policy that support the use of IKS effectively, the Ministry of Education will therefore include indigenous Knowledge systems as a curriculum in schools so as to allow students to know about these systems from a tender age and this will promote awareness .Therefore it is important to consider the study of IKS in schools offering various methods that are used in different cultures so as to educate students on these systems that are crucial to development.

Indigenous knowledge experts including the elderly, grandmothers and traditional healers should be educated on proper treatment and care of patients to avoid complications making it face a lot of criticisms. There is need therefore to educate these specialists on proper care and handling of patients and when dealing with children there is need to educate them on complications that children will suffer from other ways they use in curing diseases that is harmful and affect the child. These IKS experts should be educated through trainings targeting them only where they will be trained effectively on how to ensure IKS is taken as a medical route with fewer complications and doubt from many people.

There is also need to in cooperate IKS specialists in the modern health facilities. Traditional healers and the elderly should work together with the nurses and doctors

at clinics. This is to ensure information is shared between health officials and traditional healers as well as the elderly on how different diseases can be treated without any harm surrounding them. In instances when the health officials cannot treat a certain disease there is need to complement efforts of each other to reduce mortality. It is important to note that according to (Hoff 1997), traditional healers (TH) can serve as primary health workers and provide advice were necessary, hence the fact that they should work together can be a success. According to Hoff this will help in information exchange and sustainability for improved livelihood of people. It is believed also that traditional healers can help treat several ailments effectively and they can save lives. Traditional practitioners and health officials should work together to reduce instances where the traditional healers will work for money charging a huge amount to cure diseases as they will result in lack of efficiency and effectiveness.

Clinics and hospitals should recommend the use of IKS rather than discouraging and fighting it as most discourage the use of IKS which later impact negatively on how the community perceive these systems. Therefore if clinics and hospitals recommend the use of IKS these traditional methods can be comprehended and it can be mainstreamed. According to WHO (2002) misperception that IKS are for the poor and uneducated has to be removed as 85% of African people rely on these traditional ways hence the use of IKS will be improved in the country.

#### **4.2 What can be done to counter the weakness of IKS**

It can be noted that IKS though they play a central role in promoting health care in the country ensuring sustainable development and dealing with the MDG 4 goal, it is encompassed with several challenges that at times it cannot yield successful results. Therefore there is need to address the weaknesses surrounding IKS in line with health issues so as it can be mainstreamed and harnessed as a medical route. The weakness

can be countered through making information pertaining IKS readily available and is understood by many, removing the perception that the IKS are related to witchcraft, educating and training people about IKS to avoid complications, misperceptions that IKS is for the poor and uneducated should be removed ,improving resilience on the use of IKS among other issues.

Information and literature about IKS should be made available as the IKS are said to lack disinformation and the information is distorted and only available to grandmothers and traditional healers. The weakness of disinformation is considered as one of the major challenges the IKS has as a lot of people lack information about what these IKS encompasses of and how can they be used in fighting diseases. Therefore there is need to make sure information is readily available and is written in all languages for everyone to understand. Since IKS are grounded within one's particular society, information about IKS should be in line with different community beliefs and to those who are illiterate awareness campaigns were they are taught and trained about these systems should be properly carried out targeting everyone to avoid instances were other households, man will deny their wives to visit elders and other IKS experts because they lack information about them. It is therefore important to make information readily available to avoid disinformation surrounding IKS.

IKS has to be universalised as they are mostly used in rural areas; this makes it more of rural people when they can be used by everyone. Urban communities have to be aware of IKS systems and it should be enhanced in these communities as well. Modernity has resulted in lack of knowledge about IKS as most grandmothers do not have anyone to teach about IKS system as most families are living in urban areas with a urban life which only believe in modern drugs henceforth the use of IKS is poorly

appreciated. Therefore there is need to universalise IKS and deal with lack of knowledge as it one of the weakness of Indigenous knowledge system.

Resilience on the use of IKS should be improved among communities. This resilience can be promoted through inclusive participation in the community with the elders of the community and every member in the community. These community engagements should have medical specialist as well as traditional healers and IKS experts. The training should be enhanced to promoting resilience on the use of IKS within communities as it has been contradicted as a result of modern health services and delivery where people favour medical treatment more to IKS. However there is need to improve community resilience on the use of IKS.

There is need also to encourage people on the relevance of using Indigenous Knowledge Systems following criticisms surrounding them as a result of globalization and the coming in of western medicine. It is noted that with the coming in of western medicine the use of traditional, local medicines has lost its value as most discourage the use of IKS as not effective and efficient. But it can be noted that IKS have been and still is effective and efficient in promoting the health system of the people especially in areas where hospitals are far away and in times of economic meltdown with shortage of medicines in clinic, IKS was a success. However it's therefore important to encourage communities through campaigns and trainings on the relevance of Indigenous knowledge systems despite the existence of modern medicines.

Another issue to counter weakness of IKS is through engaging modern doctors and IKS experts through acknowledging areas of strength and weakness of both. Through acknowledging weakness of each there will be fewer cases of complications related to

the use of IKS. It is important for elders and traditional healers to encourage people visit the doctor when they fail.

### **4.3 Chapter Summary**

The chapter focused on harnessing the power of IKS for better child care in Mutare through mainstreaming IKS as a medical route as most has sidelined them in health care systems. Ways to engage these IKS has been discussed like awareness campaigns, educating and training communities' among others to ensure IKS is harnessed and become a medical route. In this chapter measures that can be employed to counter weaknesses surrounding IKS has been explained also.

## **5.0 CONCLUSION**

This project focused on the IKS employed on child health care in Mutare. It looked at how the elders and other IKS experts make use of these IKS to protect children against the killer diseases. In the introduction the research methodology that the researcher used like questioners, interviews were explained with the relevant targeted population. The problem statement which is the increase of child mortality despite the availability of modern medicines was addressed as the research seeks to address child mortality by encouraging communities to rely on IKS. Communities were to have an understanding on the effectiveness of IKS on child care on the research objectives. The introduction gave an overview of what the research was to focus on through research objectives, questions and significance of the study which is child development as they are future leaders hence there is no development without a child wellbeing for sustainability to be reached.

The project also looked on the killers of children under five years with special attention to Mutare. These killer diseases were discussed and factor that also led to child mortality were explained as well like poverty, lack of education and others discussed in the research. The problems surrounding child mortality was explaining following the killers as well as factors that lead to child mortality in Mutare. Key findings on the methods used by elders and other IKS experts in child health care were explained focusing on different cultures and belief among the people in Mutare.

The last chapter of the project focused on harnessing IKS as a medical route and measures to counter its weaknesses were also explained so as to make IKS cab be a medical route for medical care.

## **REFERENCE LIST**

Aman, R.(2000) Indigenous Food Plants Programme: Using Locally Available Edible Species to Enhance Community Health, Provide Income and Conserve Biodiversity, National Museum of Kenya

Anand, G. (2005) Traditional Societies In East Africa Use Wild Plants For Different Purposes And Means To Survive.

Bronfenbrenner, U. (1979). *The Ecology of Human Development*. Cambridge. Harvard.University Press.

Clemens and Moss .T(2005) Costs and Causes of Zimbabwe Crisis .CDG Notes. Washington. Centre for Global Development.

De Klerk, P. (2004) A Potato, A Traditional Medicinal Plant Used To Treat Chronic Viral And Bacterial Diseases And Some Forms Of Cancer, Is Now Recognized By Physicians To Boost The Immune System Of HIV-Infected People

Harkness, S. & Super, C. M. (2008). Themes and Variations: Ethnotheories in Western Cultures. In Rubin, K. (Ed.). *Parental beliefs, parenting and child development in crosscultural perspective*. New York. Psychology Press.

Hoff W.(1997).Traditional Health Practitioners as Primary Health Care Workers. Tropical Doctor.;27(Suppl. 1):52–55. [[PubMed](#)]



Kembo J.(2005).Social and Economic Factors Influencing Under five mortality in Zimbabwe during 1996-2005. School of Health Systems and Public Health.University of Pretoria

Kindamba, M (2003) Medicinal Use Of Plants To Alleviate Health Problems Of Both Human And Livestock In East Africa.

Mapara. J(2009) Indigenous Knowledge Systems in Zimbabwe .Juxataposng Post Colonial Theory.The Journal of Pan African Studies.

Marecik, N. (2002) Traditional Societies In East Africa Use Wild Plants For Different Purposes And Means To Survive.

Myers, R. (1995). Twelve who survive: Strengthening Programmes of Early Childhood Development In the Third World. 2nd edition. Ypsilanti, Michigan: High / Scope Press.

Saifa, O.A (2004) Like Affects Like” Is An Indigenous Principle To Determine The Effectiveness Of Plants In The Treatment Of Diseases.

UNDP (2011). Keeping the Promise. United To Achieve the Millennium Development Goals. The Saturday Herald 12 March 2011.Zimbabwe

WHO (World Health Organization). 2002. Fact Sheet No. 271. June WHO, Geneva.

WHO(2012). Born To Soon ,The Global Action Report on Preterm Birth

WHO(2011).International Statistical classification of diseases and related health problems.10<sup>th</sup> revision.

Zimbabwe Demographic and Health Surveys,1994,2005/6 and 2010/11

Zimbabwe Demographic and Health Survey Country report (2000,2007). Harare. Central Statistics Office

[www.herald.co.zw/malaria](http://www.herald.co.zw/malaria) claims 10 lives in Mutare.13 February 2013

## **Research Tools**

### **Questionnaire for IKS experts**

Hi, my name is Caroline Muzvidzwa. I am a fourth year student at the Midlands State University. In partial fulfilment of the requirements of a B.A Honors Degree in Development Studies, I am carrying out an academic research on Indigenous Knowledge Systems employed in child Health care in Manicaland. Case of Mutare. Your kind participation and contribution as well as your experiences and opinion could be of great value to this research.

Instruction: Please put a tick in the space provided next to answer

#### **I. BASIC LOCATION INFORMATION**

- a) Full Name.....
- b) Age range  
18-25yrs [ ] 30-35yrs [ ] 40-45yrs [ ] 45-55yrs [ ]  
Other [ ]  
(Specify)
- c) Community where one lives?  
Hobhouse [ ] Chikanga [ ]  
Sakubva [ ] Garikai [ ]  
Other [ ]  
(Specify)  
.....  
.....
- d) Religion  
Christianity [ ] Moslems [ ] Other [ ]
- e) Do you have access to clinics and hospitals nearby? **YES** [ ] **NO** [ ]
- f) Are these clinics offering good services to child health care issues? **YES**[ ] **NO** [ ]
- g) Do you use IKS ? **YES** [ ] **NO** [ ]

#### **II. SAFETY OF THE CHILD**

- a) Do you feel safe by engaging in the use of IKS in child health care? **YES** [ ] **NO**[ ]

**If NOT, (Tick all that applies):**

Problems with the child [ ]

Hygienic issues with the care giver [ ]

Scared of risks that might affect the child [ ]                      Other                      [ ]

(Specify):

.....  
.....  
.....

- b) Have you relied on IKS and was it helpful to you in child health care issues?  
**YES [ ] NO [ ]**

**If YES, (Tick all that applies) – As a result of:**

Religious Beliefs [ ]

Shortage of drugs at hospitals [ ]

Poverty [ ]

Other [ ]

(Specify):

.....  
.....

- c) If you have health problems with your child where do you go with the child?  
**(Tick all that applies):**

Hospital or clinic [ ]                      IKS experts [ ]

*(Specify and support your choice):*

.....  
.....  
.....

- d) Are children safe with the IKS systems employed to them in the community?  
**YES [ ] NO [ ]**

**If NOT (Tick all that applies):**

Children are dying because of such practices [ ]

Children are vulnerable to other diseases [ ]

Other [ ]

(Specify):

.....  
.....  
.....

## Interview Guide for Organisations

Hi, my name is Caroline Muzvidzwa. I am a fourth year student at the Midlands State University. In partial fulfilment of the requirements of a B.A Honors Degree in Development Studies, I am carrying out an academic research on the *“Indigenous Knowledge Systems employed in child health care in Manicaland.Case of Mutare.”* Your kind participation and contribution as well as your experiences and opinion on the subject could be of great value to this research.

1. Could you explain some IKS systems that are employed in this community in child health care?
2. What would you say are the major effects surrounding these Indigenous Knowledge System to children health?
3. How many households have relied on IKS in child health care?
4. To what extent has IKS contributed to child health care reducing child mortality levels in Mutare?
5. What kind of IKS practices have you used to protect children against the leading causes of child mortality?
6. How effective are these IKS in protecting children against such diseases in the area?
7. How can IKS risks and negative effects be addressed to ensure a lot of people rely on IKS as a route to child health care?