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A moral compass that slipped: Indigenous knowledge systems and rural development in Zimbabwe

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Abstract: While African indigenous knowledge systems (IKS) remain one of the most valuable resources owned by rural people they have also been the least mobilized for sustainable development. Current development research and practice have witnessed a striking invisibility of IKS. The study adopted reflexive ethnography and utilised key informant interviews, informal or “irregular” focus group discussions, documentary evidence and individuals’ experiences in three purposively selected rural villages in Chivi district, southern Zimbabwe. Using examples from health, the study concludes that there has been a steady disaffection of IKS and practices as solutions to development woes. Besides exogenous factors, communities and individuals partly contribute to their own marginalisation and exclusion from mainstream development discourse. Rural people’s ways of learning, storing and transmitting knowledge have partly contributed to their own decimation as “knowledgeable” people often “ring fenced” their expertise or died without transferring it to next generations.

Subjects: Social Sciences; Development Studies; Cultural Studies

Keywords: assets; indigenous knowledge; rural development; rural people

1. Introduction

Indigenous knowledge systems (IKS) in emerging economies in general and rural Africa in particular have historically been considered one of the most valuable assets rural people own but also the least

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PUBLIC INTEREST STATEMENT

This study recognizes the historical tensions between indigenous knowledge systems (IKS) and western sciences in various aspects of rural development, particularly health. Based on data collected using qualitative methodology from three selected rural villages in southern Zimbabwe, it was found that most of the IKS in rural areas have ceased functioning as a guide for addressing challenges associated with people’s livelihoods particularly in health. IKS have been reduced to a *blank signpost*—that is, they are no longer capable of providing moral guidelines against the current development challenges. The marginalization and exclusion of IKS from mainstream development discourse and practice is a recalcitrant problem that can be attributed to both exogenous and endogenous factors. The erosion of IKS poses a serious threat to rural development efforts.

mobilized for developing rural communities. Indigenous knowledge (IK) or “rural people’s knowledge” include beliefs, rituals and perceptions, ways of learning, local technology, stocks of knowledge and the practices of acquiring and transmitting it (Chambers, 1991, p. 83). IKS have many dimensions; linguistics, medicine, clinical psychology, botany, zoology, ethology, ecology, climate, agriculture, animal husbandry, and craft skills. IK, also known as traditional knowledge refers to the large body of knowledge and skills that has been developed outside the formal education system and that enables communities to survive in their specific environments (Lanzano, 2013; Mapara, 2009; Renn, 2012; Sillitoe, 1998). IKS include rural people’s beliefs, African Traditional Religions (ATRs) practices and customs. IK is an integral part of the poor’s strategies for survival. Within communities, it is the basis for decision-making in food security, human and animal health, education and natural resource management. While the scope of this paper attempts to capture most of the IKS dimensions, it specifically examines how the processes of marginalisation of IK particularly relating to health, have influenced their effectiveness in the management of health issues. However, rural people’s assets and knowledge have lost importance and no longer function as economic pillars for rural and national development. Avenues for the preservation of traditional knowledge are fading and are at risk of being lost altogether. Loss of traditional knowledge will result in a decline of indigenous identity and a severe reduction in the recognition and understanding of an invaluable sustainable knowledge system (Human Rights & Equal Opportunity Commission, 2009, p. 221).

Indigenous peoples have a longstanding relationship with land, forests, rivers and the air. In this sense, indigeneity can be conceptualized as a state of fusion between indigenous peoples and their accustomed environments (Durie, 2004). The relationship between people and the environment also forms an important foundation for the organization of IK, the categorization of life experiences, and the shaping of attitudes and patterns of thinking. The inter-linkages between people and environment also vary by gender. For instance, as Bock (2006, p. 299) puts it; “rural women’s lives and livelihoods are tied to the quality of the environment as well as by their access to natural resources.” Because human identity is regarded as an extension of the environment, there is an element of inseparability between people and the natural world. Thus the importance of IK and its value towards keeping the environment for securing herbal and medicinal plants for poor communities is critical for rural development.

In addition participation in various debates ranging from national and local politics, religious and cultural topics enriched the data collection exercise. Besides exogenous factors, this paper also explores how the indigenous at community and individual levels continue to contribute to their own marginalisation and exclusion and their respective interfaces with outsiders. The marginalisation and disempowerment can be attributed to various factors including growth and spread of Christianity, and the adoption of colonial western science and culture (Chiwanza, Musingafi, & Mupa, 2013). The transmission of IK and practices is at risk in many regions of the world (Sachs, 2006). The postcolonial state has not been helpful either. For instance, witchcraft and sorcery although historically recognised among the Shona cosmology, remain legally suppressed. This has consequently constrained the functions of bodies such as the Zimbabwe National Traditional Healers’ Association (ZINATHA) resulting in the exclusion of IKS from the mainstream development policies and practice. Although local people’s truths, voices and visions have been largely dismissed (Russell-Mundine, 2012), the role of IK as an enabling agent for rural development has been well documented (Ellen & Harris, 2000; Kaya, 2007).

The relevance of IKS is reflected in the UN Draft Declaration on the Rights of indigenous peoples Article 14. It focuses on the right to “revitalise, use, develop and transmit histories, language, philosophies and other intellectual pursuits to future generations.” Article 24 provides the right to “traditional medicines (TM) and health practices” as well as the protection of “vital medicinal plants, animals and minerals.” Heritage rights are about both the maintenance and the development of culture and resources. The WHO *Declaration on the Health and Survival of Indigenous Peoples’* definition of health states that “Indigenous Peoples” concept of health and survival is both a collective and individual inter-generational continuum that encompasses a holistic perspective. It incorporates four distinct shared dimensions of life. These refer to the spiritual, intellectual, physical, and

emotional realms. Linking these four fundamental dimensions, health and survival manifests itself on multiple levels where the past, present and future co-exist simultaneously (Durie, 2004, p. 1139).

2. The interface between IKS and western science

The interface between IKS and western science continues to generate a lot of contests and tensions. According to Durie (2004), contests about the relative validity of science or IK are usually conducted on the assumption that one is inherently more relevant than the other. Hardly ever does such a polarized debate generate wisdom and seldom does it lead to the generation of new knowledge or fresh insights. Instead, positions become more entrenched as proponents defend their ideological positions. In practice, however, it is not unusual for scientists or indigenous peoples to live comfortably with the contradictions of different bodies of knowledge. Many scientists subscribe to religious beliefs that cannot be explained by science, and many indigenous people use scientific principles and methods in everyday life while at the same time holding firm to indigenous values (Durie, 2004, p. 1140). For example, a medical doctor while trained in biomedicine can still believe in witchcraft and sorcery and vice versa a traditional or spiritual healer may still visit a health clinic for ailments believed to be beyond his or her capacity. However, no academics, practitioners or state have attempted to fuse or integrate the two. A unidirectional and educative approach continues to epitomise exchanges between biomedical and traditional practitioners (World Health Organization, 1990). For instance, the complementarity between the professional western family planning practices and the knowledge associated with reproductive health practices among the indigenous communities have not been adequately explored. Although there are some positive exceptions (see Abdool Karim & Abdool Karim, 1993; Friedman, 1998 as cited in Wreford, 2008), most biomedical professionals' unwillingness to understand and incorporate the medical premises of the traditional healers into biomedical interventions has been historically problematic. Another challenge is the lack of intellectual appreciation and respect from biomedical professionals for traditional healers (King, 2000, p. 23). Durie's (2004) two case studies on the Maori of New Zealand demonstrate how incorporating indigenous beliefs into research protocols and measurements have the ability to enhance health research and better understanding of health and illness.

When it comes to the sub-Saharan African region, it has been estimated that one traditional healer interacts with every five hundred persons, compared to one Western doctor per four thousand people. This means that for many people living in sub-Saharan Africa, TM within the informal health-care sector is the only available healthcare option (Acosta & Karlsson, 2008). Despite the advances in the management of HIV and AIDS associated with the development of newer classes of antiretroviral drugs and their increased availability, most patients in Zimbabwe still use traditional herbs as supplements. The biological and pharmacological properties and therapeutic claims made on medicinal plants elsewhere in Zimbabwe have already been documented. According to a study by Maroyi (2013), 89.2% the plant species had biological and pharmacological properties.

3. Rethinking symbolic capital and power

Practices of IKS and their interface with health are shaped by deep-seated and reproducible cultural dispositions or mindsets nurtured within the society (Ojha, 2007). Habitus constitutes "a set of durable, transposable dispositions" which regulates mental activity to the point where individuals are often unconsciously aware of their influence (Bourdieu, 1994, p. 72). The habitus is thus not wholly structured, though it still remains strongly influenced by historical, social and cultural contexts. To illustrate the importance of this concept, one might think of how the Shona are more capable of mobilising their own deeply held beliefs on different diseases affecting both people and animals. Social capital exists as a set of lasting social relations, networks and contacts (O'Brien & O'Fathaigh, 2004).

The roots of symbolic capital can be almost anywhere, its central criterion is that actors perceive and recognize its existence. In Bourdieu's conception of symbolic power it is important to pay attention to those authorities in whose hands the symbolic capital is concentrated. This suggests that actors have little choice as they structurally accept the rules of the games and play the game without

questioning the rules. In reflexive sociology, this amounts to “symbolic violence” which is exercised upon a social agent with his or her complicity (Bourdieu & Wacquant, 1996, pp. 167–168).

Power is fundamentally about having the capacity and legitimacy to influence others, and the perception of this position to others, enabling the power holder to call on the obedience of others (Lukes, 2005; cited in McAreavey, 2012). As Guzzini (2013) added, power is agential and inter-subjective. This is a powerful dimension of power which is about being able to influence the interests and desires of the victims without their being aware of its effects; power is tied to agency (McAreavey, 2012, p. 50). Community members may be blithely unaware that their aspirations are being manipulated subjected to mild coercion and their autonomy or capabilities obstructed (McAreavey, 2012, p. 50). According to Long (2015), the notion of “interface” entails that these social relationships and value commitments are forever on the move. Interface was seen as a site for conflict, incompatibility and negotiation. The power of different actors remains in continual shift due to ongoing strategic manoeuvres, contestations and negotiations over meanings, values and intentionality. Thus power inevitably generates resistance, accommodation and strategic compliance as regular components of the politics of everyday life (Long, 2015, p. 43).

4. Methodology

This study was designed to examine the extent to which most of the IKS in rural areas in Zimbabwe have lost importance as a guide for addressing people’s livelihood challenges particularly in health. It also sought to explore the factors influencing the marginalisation and exclusion of IKS from main-stream development process.

The study was guided by the social constructivist paradigm (Creswell, 2013; Ravn, 1991; von Glaserfeld, 1991) and followed a reflexive methodology (Gergen & Gergen, 1991; Steier, 1991). Reflexivity refers to the ways in which the products of research are affected by the personal and the process of doing research (Davies, 1998; Hennum, 2014). Reflexivity focuses on the ways in which beliefs, and political ideologies interfaces the research process. It can be a most powerful tool for assisting the researcher to explore their assumptions, biases and value judgements (Russell-Mundine, 2012). This approach is similar to the anthropological emic-etic perspectives (Headland, Pike, & Harris, 1990; Kottak, 2006; Xia, 2011) which recognize the complementarity of locals’ observations, categories, explanations, and interpretations and those of the researcher. This provides for a deep understanding of the people studied. Qualitative data were collected using informal interviews and individuals’ experiences in the three neighbouring rural villages in Chivi district, southern Zimbabwe. The selection of the three villages and interview participants was both convenient and purposive. Firstly, the researcher’s familiarity with the target population and previous research contacts facilitated accessibility and availability of respondents. Secondly, key informants were chosen on the basis of their willingness to provide the information by virtue of knowledge or experience. Individuals or groups of individuals that were identified and selected were proficient and well-informed about phenomenon of interest (Cresswell & Plano Clark, 2011). Such key informants included village health officers and nurses at the local clinic. Thirdly, informal focus group discussion participants were selected using the convenient sampling technique. With this technique participants were selected simply as they just happen to be situated near to where the researcher was conducting the data collection (Etikan, Musa, & Alkassim, 2016). Discussions among men at a funeral sitting around a night fire were not formally structured but often produced credible and quality insights on issues.

This was done through interviewing key informants and participating in informal “focus” group discussions, while attending social gatherings like funerals in the villages. In addition participation in various debates ranging from national and local politics, religious and cultural topics enriched the data collection exercise. However this excluded the women’s perspectives as the researcher interacted more with men than women. I attempted to fill in this gap by interviewing key female informants particularly on issues relating to reproductive health and child birth practices. Participants’ perceptions and explanations varied by age. For instance, the older generations were able to explain

the loss of IK and attributing contributing factors to external factors while the young generation criticised the older generation's failure to transmit IK to succeeding generation was key. Young generation included men and women between approximately 30 and below 50 years and older generation composed of relatively much older people mostly those who have retired from full-time employment and in their early 60s and above. Key informants on traditional healing and medicine were drawn from the older generation. I also reflected on my previous research in the area (Maunganidze, 2000), and lived experiences as a resident through observations and recollections. Reflexivity provided me the opportunity to study my own experiences and those of others (Davies, 1998). Positioning and standpoint have been considered central elements to framing relations between researchers and informants. Reflexive research aims to give voice to silent and otherwise oppressed groups. Through informal discussions the locals freely expressed concerns relating to the loss of IK and consequently its persistent exclusion from mainstream development programmes. Most villagers have historically associated me and similar researchers as advocates for development. This effectively enhanced cooperation between researcher and participants.

5. Results and discussion

5.1. Defining traditional medicine and healing

The study found out that traditional healing or medicine has been the dominant aspect of IK. The term TM has been variously conceptualized and largely applied under different terminologies. Although the concepts suffer from a lack of precision, at the global level, TM is known to include diverse health practices and approaches, knowledge and benefits that incorporate plants, animals and other mineral-based medicines, spiritual therapies, manual techniques and exercise applied singularly or in combination for the maintenance of wellbeing as well as to treat, diagnose or prevent illness (WHO, 2002). Traditional healing works hand in hand with TM. Healing is dialectically connected to afflictions. [Affliction] is the dislocation of self and context; healing is the objectification and restructuring of such dislocation. Central to this process is the rendering of disorder in terms of metaphors of opposition between the impaired subject and an intrusive, external agent (Comaroff, 1980, p. 644). Thus TM and healing are intricately interwoven.

Thus, a traditional healer is any person who is endowed with the knowledge and skills to maintain the health needs of the people of the community using divination, medicinal herbs, symbolic rituals and psychotherapy. The traditional healers prescribe medicines that are prepared using animal parts, herbs, water, alcohol, roots, leaves and bark of trees available in their community. Every elder both male and female was expected to know some TM. As one key informant expressed:

Not everyone is a traditional healer but one cannot fail to treat ailments such as wounds or headache. You only consult a traditional healer when illness persists.

The above observation has crucial implications for the importance of the loss of IK and its transmission to the younger generations. Knowledge about TM practices has not been transmitted to the succeeding generations. Rural people's ways of learning, storing and transmitting knowledge have partly contributed to their own decimation as "knowledgeable" people often "ring fenced" their expertise or died without transferring it to next generations. Both the old and younger generations concurred that local people have contributed to the loss of IK. In addition, the meaning of TM or healing is not universal even at local level. Participants' views and lived experiences confirm the multiple realities and uncertainties associated with traditional healing. The presence of uncertainty implies the recognition that unexpected situations will arise and that they will continue to do so time and again. From a social constructionist perspective, one of the very relevant sources of uncertainty is the heterogeneous character of human beings. Due to the way people perceive, (re)produce and enact practices, individuals with responsibilities are encouraged to become involved in such processes and serve to mould expectations particularly in situations where expectations are disapproved or appear to conflict with one another. In a sense, uncertainty provides a problem of co-operation and organized contexts must maintain some means of handling expectations and

unforeseen situations (Sjostrand, Sandberg, & Tyrstrup, 2001, p. 8). Under uncertainty, however, unexpected events must be dealt with as and when they arise and dealt with in ways, shapes and forms that are highly improvisational. Individual understandings of reality promote differences in expectations and ambitions, making it difficult to mobilize coordinated responses. For instance, the keepers of IK were not certain about how transfer of knowledge and expertise would affect their power in the community while for the potential successors and other actors questioned the predictability and sustainability of IK in the management of health. For example, the challenges of involving traditional healers in HIV and AIDS care in Southern Africa have been documented (Mills et al., 2006). There is also uncertainty surrounding the collective protection and preservation of IK.

5.2. TM and public health

Both traditional and spiritual healing are systems of IK that are based on the universal values and truth. African traditional medical practices are embedded in African cosmology (Levers, 2006). The use of local knowledge for the treatment and possible prevention of diseases is not new in African cosmology. For many people living in sub-Saharan Africa, TM within the informal healthcare sector is the only option available (Acosta & Karlsson, 2008). The knowledge of and uses of specific plants and animals for medicinal purposes (often referred to as indigenous or “TM”) is an important component of African Indigenous knowledge systems (AIKS) (Kaya, 2007, p. 3). In Zimbabwe and among the Shona people, traditional herbal medicines have historically been used as primary treatment for main diseases and ailments such as cancer, and HIV-related problems like nausea, depression and insomnia. For most of the poor people, traditional healers are often the first and last line of defence against the most contagious and debilitating diseases that plague their lives (Madamombe, 2006). However, the emergence of western science has exposed TM to much scrutiny. TMs is widely used by many Africans living with HIV, but not sufficiently documented (MacPhail et al., 2002; Sebit et al., 2000; Zachariah et al., 2002). For instance, traditional herbal medicines like the African potato (*Hypoxis hemerocallidea*), *Sutherlandia*, commonly known as cancer bush (Bepe et al., 2011; Mills, Cooper, Seely, & Kanfer, 2005), and others such as *Acacia karroo* (Hayne Tree) known in this study area as *Muvunga* whose roots extract is drunk as convulsions remedy and also treatment of STD infections; gonorrhoea and syphilis (Chigora, Masocha, & Mutenheri, 2007; Maroyi, 2013). Studies by Yu et al. (1995) and Seely, Mills, Wu, Verma, and Guyatt (2005) elsewhere found out that consumption of Chinese green-tea was associated with lower risk of stomach cancer.

The pattern of seeking TM has changed over the years. This is partly due to the establishment of more rural clinics and village care systems in post colonial Zimbabwe. Although some patients and their families often consulted traditional healers even after hospitalization, the trend has changed over the years. IK has lost its guiding function. As one local clinic nurse confirmed:

In the past we often referred patients to traditional healers we knew. We used to have local experts for countless ailments but now this is declining. Most have moved to urban areas or crossed borders for greener pastures.

However, the introduction of free health care in public hospitals and clinics in post-colonial period was not the only contributing factor to the reduced number of locals seeking assistance from traditional healers. The sudden disappearance of traditional ceremonies such as appeasing the spirits of the dead (*kupira vadzimu*) reduced the symbiotic connection between the dead and living. In the three villages under investigation key informants' views and my own lived experiences corroborate that spirit mediums were believed to possess divine or mystical powers to detect the causes of illness, or death and also prescribe the nature of treatment. The practice of appeasing the spirits of the dead also acted as a moral cord that bound the family members and communities together. It was also believed to protect family members from unnatural death. When spiritually possessed a spirit medium would diagnose cause of disease and prescribe “medication”. This was also evidenced during the government initiated land resettlement programme in the early 1980s and later the 2002 fast track land resettlement programme. The close connection between the dead and living was demonstrated when many villagers in this study were reluctant to relocate under the programme.

There are many possible explanations for this; firstly, individuals argued that they did not want to leave their relatives' graves unattended. Secondly, migration tended to disrupt networks which have historically protected individuals and acted as survival mechanisms.

Although human agency is critical, when it comes to TM, culture becomes prominent and influences people's perspective on what belongs to "our culture" and "the other's culture" and where they seek healthcare (Wreford, 2005). When it comes to choosing TM prior to Western medicine, it is not only lack of or poor healthcare and people's financial resources, but culture that influences the choice (Bourdieu, 1998). Some interviewees pointed out that it was important for them to consult both a traditional healer and the local clinic when they fell ill, even if they believed that only the professional nurse or doctor could treat them. For a broken leg, for instance, the patients still went to a traditional healer for good luck and reassurance. This used to be the case but now the reverse is true.

Many people particularly the older generation choose TM only because they are more familiar with the culture. However the absence of active involvement of traditional herbalists and healers in the design and administration of public health programmes has contributed to the erosion of IK. Consistent with reflexive sociology, the blame for the loss of IK cannot be placed on particular group. Reflecting on villagers "lived experiences and my own interaction with them, it is observed that IK appears to have lost importance in the public space, although at individual level villagers still trusted it. Actors make their choice based on this trust" (Bourdieu & Wacquant, 1996). Both traditional and "faith healers" are usually highly respected within the community, which in some ways can be seen as a form of authoritarianism (Acosta & Karlsson, 2008). An individual might not be able to choose his healthcare treatment; an older family member, often male, usually makes the decision instead. Over the years, urbanization, globalisation, forced migration and emergence of new religious values have profoundly affected the TM. Unlike in other parts of Southern Africa (Kaya, 2007) where there were increasing efforts to identify effective means of preserving and protecting IKS for future generations, promoting their broader adoption, and protecting them from unauthorized appropriation and commercialization, there is no evidence of such efforts in this study. In this study some interviewees and focus group participants concurred that IK has been subdued and threatened by the growth of new forms of faith healing practices most popular with the younger generation. The globalised panic accompanying the emergence of charismatic faith based or "prophetic" denominations has not spared the rural communities. Since TM was believed to be superstitious and unchristian, faith healers were becoming more popular with most locals. This has provided opportunities for individuals to freely balance between personal health and protection of cultural or religious values. For instance, children may seek help from clinics while at school without the knowledge of elders.

5.3. Indigenous knowledge, asset building and rural development

IK serves local development when its structure and content are integrated into the various main-stream development programmes. IK is part of community assets or capitals. Capital refers here to the resources the people or communities possess. It revolves around people and has the power to trigger incentives for community participation and contribute to empowerment. The link between community capitals and rural development is illustrated under the community capitals framework, which is an expansion of the systems approach to poverty reduction, effective natural resources management and social equity (Flora & Flora, 2013). Therefore, focusing on existing or readily available resources or capitals is central for sustainable development. The study also sought to find out how local resources such as trees and plants which have been traditionally used for medicinal purposes have been conserved. There has been over-exploitation of plants without strategies to manage and conserve them. It was found out there has not been any deliberate systematic stock-take or profiling of such medicinal or herbal trees or plants. This has not happened despite studies elsewhere in Zimbabwe (Maroyi, 2013), that have shown such plants being the most affordable and easily accessible source of treatment in the primary healthcare system of resource poor communities. In addition, the "experts" were no longer available. The keepers of IK have since disappeared. There has not been any deliberate initiative to conserve the "knowledge". Most of them have either died without transmitting the knowledge to future generations or had lost the "divine" or "spiritual"

powers. The potential successors were not certain about the effects of acquiring such knowledge. However, in some cases the younger generation were reluctant to have such powers bequeathed to them as one informant indicated:

My grandfather specialised in all forms of reptile bites including snakes. He would often wake me up in the night to accompany him into nearby forest to dig out some tree roots. He had the ability to identify the type of reptile that would have bitten you by just seeing out blood from the affected part. After his death no one was prepared to become the “heir” to this “expertise”.

Better community health welfare can be realised through the interdependence, interaction and synergy among these assets. Investing in IKS “capital,” offers opportunities for building or strengthening one or more capitals. For instance, new innovative ways of resource conservation should be complemented by already available traditional practices. The marginalisation of IKS in development practice leads to an imbalance among capitals resulting in “decapitalization” (Mary, Guitierrez-Montes, & Fernandez-Baca, 2013). Decapitalization relates to the loss of building potential capitals or assets. This often occurs when a community places too much weight on one aspect at the expense of innovation. IKS has the power to improve wealth creation and to contribute to sustainable socio-economic development. One of the challenges Africa and Zimbabwe in particular faces, is the inability to transform its IKS into asset-building. As Sherraden, Curley, and Grinstein-Weiss (2003) argued, through increases in tangible and financial assets, asset building is one policy option that could address the needs of many rural areas through benefiting both individual households and whole communities. The concept of asset or capacity building was developed by Sherraden (1988). Any capacity building policy would seek to influence and improve many aspects of individual and household welfare including knowledge, resources, and functioning skills (Sherraden et al., 2003; cited in Grinstein-Weiss, Curley, & Charles, 2007, p. 27). It is therefore critical to recognise the role played by community capital in promoting rural development. Thus IK as part of community capital should function as a moral compass that guides both individuals and communities in addressing development challenges. In this study, local peoples’ religion in particular has not been appropriated and deployed to steer rural development.

5.4. IKS: The illusion of community capital

IKs are said to be a product of a dynamic system, a collective good integrated in the physical and social environment of communities (Viergever, 1999). The presumption is that IK is collectively owned, processed and transferred to the next generations as part of social capital. When IK loses value or popularity or credence as a moral “sign post”, it is the habitus that is eroded. Habitus develops through the internalization of the objective structures of the environment in the form of practices. Habitus forms a durable generative principle that guides the actor in his or her choices between alternatives that are present in a certain conjuncture (Siisiäinen, 2000). For examples, rain making ceremony and related rituals used to be followed religiously by the communities. Elders would predict with average precision when it could rain. Even during the war of liberation in Zimbabwe spirit mediums would foretell danger and regularly consulted. Every wild animal had meaning to the ruralites. Bourdieu’s idea is that economic, cultural, and social capital becomes meaningful and socially effective only through the process of symbolic translation. This paper agrees with other scholars elsewhere (Bock & Shorthall, 2006; Bush, 1996; Campbell, 2000; Everingham, 2006) that do not regard communities as unitary and harmonious and knowledge as collectively owned. The individual is a part of all creation and the idea that the world or creation exists for the purpose of human domination and exploitation is absent from indigenous world-views (Duran & Duran, 1995, pp. 14–15).

Power relations are reconstructed and perpetuated through various IK interactions. For instance, it is not coincidental that women’s knowledge in animal health which is key to mainstream development and property ownership has been persistently subdued. IKS has not been institutionalized as community capital but “a network of ‘parochial capital’ serving to dominate, rather than empower the local patch” (Amin & Thrift, 1995; cited in Everingham, 2006, p. 243). IK is exploited by individuals

for their own investment. For example, certain skills and expertise in public health management, consulting spirits and performing rituals were considered a preserve of male elders in order to protect interests of males. Women were only involved in food procurement and preparation for men's consumption. Thus the gendered dimensions of the erosion of IK need to be addressed to ensure sustainable and inclusive rural development. In this study the implications are far reaching. For instance, the only two long serving village based paramedical or community health officers were both females. As a result any programmes on personal and public health had predominantly focused on family planning, and reproductive health at the expense of killer diseases such as prostate cancer.

The problem arises when this symbolic power or violence is involved in the politics of universal values and universal truth because behind the universal values lurk the specific interests of certain groups. There are no universal values and trust, but dominant values. For instance, there are myths and "half" truths circumscribing *runyoka* (protective medicine used to ensure that anyone who defiles with one's wife can suffer from untreatable ailments) and *ruzhowa* (thicket of bushes, usually thorn bushes; planted as a fence round a field or home). This functions in the same manner as *runyoka* but has much stronger effect because it ensures that the culprit can be caught in action. These other forms of male created sorceries, did not only sustain patriarchy but violently commoditized the female body and sex beyond the reproductive health discourse. However not all "science" was male dominated. Other researches elsewhere show women as experts in "family planning" planning and management of medicinal plants (Chambers, 1991; Kaya, 2007; Maroyi, 2013). However this has since disappeared. For example, to date, the only *kuwuchika* expert (traditional village based gynaecologist) left in the village, though still doing it secretly has been constantly associated with witchcraft and often effectively ostracized. This same old man, was for many years known to have *rukwa* (magical powers to protect one's property against thieves and poachers). Trespassers would often be caught in the act. From interviews conducted most people still believe there are people who can give criminals *muti* (protective medicine or magical or mystical powers) to avoid prosecution, if prosecuted to escape conviction, if convicted to avoid custodial sentence at all costs. There is a case of a local "expert" in treating snake bites whom everyone turned against including his own immediate family members accusing him of owning the same snakes. Unlike Christianity, which was more liberal or tolerant, the purging of "so called" witches or wizards by freedom fighters in the late 1970s discouraged such practices. However traditional healing or medication remained a reasonable option for the communities particularly at a time when access to hospitals was limited due to shortage of drugs during the war. These and other undocumented acts of sorcery and witchcraft show how IKS which traditionally guided and protected communities have slipped into wrong hands. It is critical to recognise that vast stocks of IKS evolved in the rural areas separately from the western sciences in urban areas. The recent contact between the two and the rising commercialisation or commoditization of IKS, have transformed IKS from a communal/collective to an individual capability/possession. This has also adversely affected the process of conserving and transferring the IK to next generations.

6. Conclusion and recommendations

The study sought to address the loss of indigenous health knowledge in rural Zimbabwe and how the local people in their interactions with the outside world have contributed to this loss. One of the key findings is that current development research and practice have witnessed a striking invisibility of indigenous and traditional knowledge. "Rural" or "local" knowledge has been excluded from mainstream development. The study results show a weak deliberative interface between rural people's knowledge and western scientific knowledge in both the personal and public health domains of rural livelihoods. The study concludes that there has been a steady disaffection of IKS and practices as today's solutions to development woes. It is further argued that the origins of constraints and blind-spots circumscribing indigenous knowledge's struggle for recognition as a strategic partner at both policy development and implementation levels are both endogenous and exogenous. Although factors that have influenced the loss of IK were institutional, structural and personal, rural people's ways of learning, conserving and transmitting knowledge have significantly contributed to the erosion of this indigenous knowledge. This is partly due to the "people's knowledge" being often "ring

fenced” and expertise consequently dying with their founders. As a result, IK has ceased to play its traditional role as a moral compass for both the survival and maintenance of rural livelihoods. Forms of experiments and innovations have been obscured by professionals’ preoccupation in western based health research, extension and communication leading to the erosion of indigenous knowledge. IKS have been reduced to a *blank signpost*—that is, they are no longer capable of providing moral guidelines against current development challenges. There is need to intensify collaborate research among health professionals, IK “experts”, government institutions, communities and researchers to ensure that IK is integrated in rural development programmes. Rural development is, above all, constructed by actors operating at grassroots level and should therefore be inclusive enough to benefit rural communities.

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