

Healing Practices in Johane Masowe Chishanu Church: Toward Afrocentric Social Work with African Initiated Church Communities

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ABSTRACT The social work scholarship in Zimbabwe and South Africa has neglected issues to do with religion and spirituality. This study focused on an African initiated church called Johane Masowe Chishanu (JMC) in Zimbabwe where it originated and in South Africa where it is visibly growing. The study sought to examine the healing practices in Johane Masowe Chishanu Church. Data was collected from the church's prophets (N=15), assistants to prophets (N=6) and chronically ill people (N=9) who sought assistance from the church, through interviews from a community in Buhera District in Zimbabwe and Seshego Township in Limpopo Province, South Africa. It was found that assumed causes of illness among the members of Johane Masowe Chishanu Church include among others, avenging spirits, witchcraft and punishment. Methods employed to heal illnesses include stones, leaves of the hissing tree, burying the problem, singing and pointing to the east.

INTRODUCTION

For a very protracted time frame, social work practice in Africa has been informed by studies done in the developed world some years back. In spite of the fact that South Africa is straddling between developed and developing nations, the social work research is still dominated by the Eurocentric worldview and professional imperialism. This is worse in Zimbabwe where the profession has remained colonized way after the country's political independence. This scenario is even worse in issues related to religion, spirituality and social work that have suffered total negligence and specifically, the development of Afrocentric approaches in those issues for developmental purposes. This state of existence may have serious ramifications for religious minorities in Africa. Social workers are encouraged to keep challenging themselves to expand their understanding, compassion and justice activism to ever widening circles of at one time

unacknowledged and marginalized groups (Canda 2005).

What is humorous is that despite the changes taking place in the developed countries, social work in some developing countries is slow and sometimes resistant to keeping abreast with world trends of embracing Afrocentric worldviews in various intervention modalities. Prior to the impending of the White people in the African continent, the aboriginals had their own way of worshiping God, which had assumed the umbrella name African Traditional Religion (ATR). Upon the arrival of the White people, they propagated Christianity in African communities and planted churches all over Africa. Whoever practiced ATR was ridiculed and branded heathens and uncivilized, and many were converted and disregarded their identities and African values such as Ubuntu, togetherness, and coexistence, amongst others. This saw a sharp waning in the membership and relevance of African traditional religion. However, this is not to suggest that the African traditional religion has become extinct. It has survived alongside other religions mainly Christianity and Islam. Justification for Afrocentric social work is founded on indigenous African beliefs and practices but the point of departure is that the method is also very applicable in certain African Initiated Church communities like Johane Masowe. Similarly, though not the focus of this article,

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Zion Christian Church (ZCC) is an African Initiated Church (AIC) with Afrocentric worldviews in their approach to healing and community services. Amongst other visibly cherished values espoused by ZCC akin to JMC are free spiritual services, togetherness, and communalism just to name a few. With the movement of time into colonial period, some Africans started to plant their churches, which assumed the name African Initiated Churches. In Zimbabwe the movement was mainly apostolic in nature. The earliest were Johane Marange Apostolic Church and Johane Masowe Church (JMC). Their members are named *mapostori* in local vernacular.

Johane Masowe Chishanu has been selected in this study for a number of reasons. It looks like a hybrid of Christianity and ATR, it has a very significant membership in Zimbabwe (Dodo 2012; Mabvurira and Makhubele 2014) and growing tremendously in South Africa. Prominent in JMC is the presence of numerous prophets who claim to be gifted with healing powers. This also pushed the researchers to interrogate the role of the church in managing chronic illnesses. Chronic conditions are a problem in most societies including Zimbabwe and South Africa. The problem is compounded by two irreconcilable etiological explanations—the biomedical causes based on Western explanations and spiritual causes based on traditional African understanding of illness. In most African nations, people haunted by illness, thus, seek treatment from allopathic medical practitioners, African traditional healers and faith healers. It is therefore of paramount importance to assess the role of the church in the treatment of chronic illnesses focusing on JMC and probably for the first time in history from an Afrocentric point of view.

The role of AIC in national development in Zimbabwe and South Africa is not well documented and specifically on the prevention, management and treatment of chronic illnesses. This gives the impression that they are not doing anything or researchers have neglected them or might also suggest that their activities are antithetical to development and national progression. The major challenge that faces AIC of apostolic and Zionist nature in Zimbabwe and South Africa is blackmailing. This dates back to the colonial period where they created enmity with the colonial governments because they encouraged their members to oppose White rule. For example, they did not seek medical attention

from Western styled hospitals nor sent their children to school and discouraged their members from working for Whites. Members have thus distanced themselves from modernity even way after independence. Despite improper document, JMC plays a number of roles in development for example, Dodo et al. (2014) argue that “There is an African initiated church called Johane Masowe Chishanu, which has prescribed, developed and nurtured some of the best peace-making, peace building and peacekeeping mechanisms for both social and political systems”. Dodo et al. (2014) also argue that JMC is one of the few AIC that have remained on their original agenda.

Background to Johane Masowe Chishanu

Johane Masowe Chishanu (JMC) was founded in 1931 in Southern Rhodesia, now Zimbabwe (Dodo 2012). According to Griffith and Savage (2006), the Johane Masowe religious group was inspired by Shonhiwa Masedza who changed his name to Johanne Masowe (John of the wilderness). His mandate was to preach to Africans (John the Baptist of Africa). According to Dillon-Malone (1978), he was to Africa as Jesus was to the Whites. Members do not read the Bible, but worship on open space and do not collect money during services. Mukonyora (1998) argues that they receive the word of God live and direct from the Holy Spirit. However, some scholars (Engelke 2007; Dodo 2012) argue that Shoniwa Masedza saw the Bible as a tool for colonial subjugation. They wear white robes and worship on Fridays (Chishanu). The church heavily relies on prophecy, as Dodo et al. (2014) put it “the church believes in prophecy where people are told of their future, their plans, their imminent feelings and downfalls”. Church services are characterized by Holy Spirit inspired songs that have the capacity to cleanse people of misfortunes and drive away evil spirits. The church is based on the pronouncements that were given to Shonhiwa Masedza by the Holy Spirit. It has no overall or national leadership, the affairs of each assembly (*sowe*) are managed by a board called *dare*. Each prophet is believed to bear the power of a given angel. For example, a person can be inspired by angel Michael in the Hebrew Bible. Anyone is welcome to seek help from the church for free despite non-membership.

According to Dodo (2014), Johane Masowe managed to establish his apostolic church interests in nine countries within southern Africa, namely, Zimbabwe, Botswana, South Africa, Angola, Tanzania, Mozambique, Malawi and Zambia with over half a million followers before his death in 1973. The church has also over the years been guided by the earliest ‘pronouncements’ (*tsananguro*) as defined by Dodo, which are equivalent to the Mosaic Ten Commandments. The church has over the period been led by basically three leaders, namely, Shonhiwa Masedza (1931-1936), the biblical Emmanuel (Mudyiwa Dzangare) (1936-1944) and the self-appointed ‘Big Five’ who have continually changed since 1965. These are Phillip (Chigwada), James (Dzivaguru), Michael now corrupted to Micho, Daswes (Mapira) and Edward Gomo (Wimbo) and later in the 1980s, Madzibaba Israel based at Harare Coca Cola grounds, Lawrence Katsiru based in Marondera, Edward Manyara of Warren Park, Mathias of Domboshava and Gibson Chinhewere of Chiweshe (Dodo 2014).

The church is also prominent for its prophets, dreamers and visionaries, also called ‘*vaporofiti*, *varoti* and *varatidzwi*’, who complement each other’s role during the church service. To stimulate the above, there are also ‘*vaimbi*’ and ‘*vaimbiri*’ men and women who are good at singing spiritual choruses, which then inspire and drive all the prophets into spiritual trances. Therefore, it is strongly believed that everyone within the church has an equally important functionality.

METHODOLOGY

Research Design and Approach

In order to obtain an understanding from the perspective of the prophets, assistant prophets from JMC and members who are chronically ill, a triangulation was appropriate as an exploratory, descriptive and contextual design was ideal to provide rich information from participants’ perceptions and experiences within their natural setting without influencing them in any way (Babbie and Mouton 2001). In other words, the study was qualitative in nature, thus providing a better insight into the perceptions on the causes and treatment of chronic illnesses and to generate possibilities for future research (Babbie and Mouton 2001; Terre Blanche et al. 2006). Indi-

vidual interviews were used to gain a detailed picture of a participant’s beliefs about, or perceptions or accounts of a particular subject (De Vos et al. 2010) and in this case, healing practices in JMC. Contextual design has developed within the information systems design practice of the high technology industry. Contextual design is a popular human-centered design method from the field of information systems design (Beyer and Holtzblatt 1998). Contextual design practitioners herewith as social science researchers’ conduct focused field observations, validate or adjust their interpretations in discussion with participants (Notess 2005). People’s behavior becomes meaningful and understandable when placed in the context of their lives. Without a context, there is little possibility of exploring the meaning of an experience (De Vos et al. 2010). The meaning of creations, words, actions, and experiences can only be ascertained in relation to the context in which they occur (Terre Blanche et al. 2006). The principle of understanding in context has a strong influence in the development of qualitative methodologies. The rationale for this methodology was also rooted in the attempt to discover valuable, practical and appropriate information regarding the healing practices from JMC and the significance of this body of knowledge in relation to social and public health and risks.

Population and Sampling

Purposive and snowball sampling were used in this study. Discussants and interviewees were selected purposively, while others were recruited through snowball sampling. The rationale for purposeful and snowball samples was to target individuals who could provide information to understand the phenomenon of healing practices in the context of JMC. The study population was, therefore, limited to the prophets, assistant prophets and members who are chronically ill in Buhera District in Zimbabwe and Seshego Township in Limpopo Province. Purposive sampling was appropriate to select unique cases that were especially informative for the study (Neuman 2006). Snowball is aimed at approaching a single case that is involved in the phenomenon to be investigated in order to gain information on other similar persons (De Vos et al. 2010). The senior prophets were approached in each community and households who belonged to JMC who

eventually referred the research team to other producers. The hope was that each participant would refer the research team to the one he or she has worked with on healing practices or have knowledge about healing practices conducted in the church. This qualitative study was ultimately concerned with information richness and not representativeness (Julie et al. 2004). It targeted members of Johane Masowe Chishanu who participate in spiritual healing processes. These were mainly the prophets and *vasondosi* (assistants to prophets). Fifteen prophets, six *vasondosi* and nine chronically ill people from a community in Buhera district in Zimbabwe and Seshego Township in Limpopo province, South Africa participated in the study. Thematic analysis was used to analyze the qualitative data.

Data Collection and Analysis

Structured individual interviews (face-to-face) were conducted with selected persons who were prophets, assistant prophets and people who were chronically ill, and each referred the researchers to the next participants. This method was selected as it provided an opportunity to minimize variations in the questions posed to the participants and to make sure that all relevant topics are covered (De Vos et al. 2010). Participants were visited at their homes and appointments were secured with each one of them. Informed consent of participants was obtained prior to data collection. Though the participants consented, they were not requested to sign a consent form after one prophet from Zimbabwe indicated that it was against the pronouncements of *Baba Johane* to sign something pertaining to the church, to tape record church activities or take photos of church proceedings. Structured individual interviews, which had mainly open-ended questions based on the underlying objectives of the study, guided the interview process. The researchers jotted down notes with the permission of the participants. For the research team to verify and maintain accuracy, they were guided by the viewpoint that qualitative data analysis involves bringing order, structure and meaning to the mass of information collected (De Vos et al. 2010). Data was analyzed thematically. Thematic analysis is a search for themes that emerge as being important to the description of the phenomenon (Daly et al. 1997). The process involves the identification of themes through cautious reading and rereading of the data (Rice and Ezzy 1999). It is a form of

pattern recognition within the data, where emerging themes become the categories for analysis.

In support of that, Terre Blanche et al. (2006) outline these steps as follows. Step 1 is the familiarization and immersion (getting to know the data and engaging the data from the tape recorder, field notes and interview transcripts). In Step 2, the inducing themes (working with themes that are easily noticeable). These themes emanate from the data relating to the research aim. Step 3 entails coding (breaking up the relevant data in understandable means). Step 4 is elaboration (getting fresh view of the data by exploring themes more closely), and Step 5 is interpretation and checking the data (the researcher provides clarification and assessment of the data). Due to the sensitive nature of the subject, discussants and interviewees were assured that all information provided would be treated confidentially. Subsequent discussion therefore used pseudonyms to protect their identity. An issue focused approach was adopted in analyzing the qualitative data. This is an approach that describes what has been learned from all informants about a particular situation (Weiss 1994). Data was coded according to concepts and categories used in the study, and from these, excerpt files were compiled that collected material from interviews that dealt with the same issue. Excerpts are presented using the "preservationist approach", that is, material is presented in the original speech so as to reproduce the words recorded on tape as accurately as possible (Weiss 1994).

Ethical Considerations

Permission to conduct the study was obtained from University of Limpopo Turfloop Research and Ethics Committee. For religious reasons, the participants were not requested to sign consent forms however, a covering letter explaining the purpose of the study and assuring the participants of anonymity and confidentiality was included. Participants were also informed that participation in the study was completely voluntary and that they could withdraw from the study at any stage.

FINDINGS OF THE STUDY

Demographics

A total of thirty people participated in the study. Of these, nine were male prophets, while

six were female prophets, all the six *vasondosi* were male. The ages of the prophets ranged from twenty-one to sixty-two years with a mean age of thirty-four years. The ages of the *vasondosi* ranged from twelve to twenty-two years. The average number of years in the office of a prophet was ten. Concerning the chronically ill, three were male while six were female, one had a chronic heart problem, three had cancer, one had sugar diabetes, one mental illness while three confirmed HIV positive status. Findings are presented thematically as follows.

Perceptions on the Causes of Illness

Six prophets indicated that chronic illnesses are caused by evil spirits. These spirits were thought to be caused by bad spirits (*mweya yetsvina*) that haunt the Black people. “*Mweya yekumadokero*” (a Western spirit) reiterated a female prophet. In JMC, the east represents good things while the west represents bad things. Another prophet also highlighted that such illnesses are caused by living people by saying “*Mamwe mabasa evapenyu*” (Some are the deeds of living people). Asked how a living person can cause conditions like high blood pressure, most of the prophets indicated that the living can stir *mhapo* (winds) to cause an illness or they can pray (*kureverera*) to the ancestors of the targeted person calling on the name of the disease they want to haunt him. All the prophets indicated that the *kureverera* is usually done by a close relative for it to work effectively. “*Tse dingwe ke meoya ya badimo*” (Some are ancestral spirits) reiterated a female prophet. She went on to argue that when parents die possessing familiars (*zvinhu*), those familiars can start haunting surviving children if not properly disposed. The familiars were thought to just cause misfortune and long suffering in the form of chronic diseases. “*Lelapa ka moka le swanetse go ntsha setshila*” (the whole family can be (wiped) cleansed) indicated an assistant prophet.

Four people with chronic conditions cited witchcraft as the cause of their illnesses. They indicated that Black people are jealous of one another and they bewitch those who become successful. “I sent my children to school and now am enjoying my sweat and people are jealousy” highlighted a female sufferer of high blood pressure. “*Ini ndakanzwa kuti mumusha medu mune ngozi, sekuru vangu vakauraya munhu*

uye ngozi yacho haina kuripwa” (I heard that there is an avenging spirit in our family, our great grandfather killed someone and the spirit was not appeased) indicated a woman with a mental problem.

Perceptions on Treatment of Illness

The prophets highlighted that they have been given power by God to relieve the Black race (*ndudzi yevatema*) of its problems so that it can be prosperous like other races. However, they admitted that they have different assignments (*mbiya*). They specialize in entrepreneurial activities (*mbiya yemabasa*), evil spirits (*mweya yemadzinza*), fertility issues (*kuuchika*), and financial prosperity. They also indicated that though they have areas of specialty, they could cut across different problems. Various materials are used for healing purposes and they have assumed the name *muteuro* (prayers). Various healing methods were presented as follows.

Nhombo: These are small stones that are given to people with problems. The stones are collected from rivers or streams or anywhere where there is running water. The stones are used for bathing (by putting them in bathing water). The number of stones should be dividable by three to represent the holy trinity (*mitumbi mitatu*), which is the anchor of JMC. The bathing can be of the whole body or the face as directed by the prophet. The bathing should be done a number of days, as prescribed by the prophet. The number of days as well should be dividable by three. The number of days for using the stones can go up to twenty-one days. The prophet should also indicate how the stones are to be disposed after use. Disposal methods indicated include returning them to the prophet, keeping them in a given place or throwing them in a given direction saying things that the sufferer wants to happen. The stones should never be mixed with bath soap or allowed to fall to the ground. “*Kana rikadonha harichashandi, unotangidza patsva*” (If it falls to the ground it becomes useless and you have to start again), said a *musondosi*. “*Tinokurudzira vanhu kusungiria miteuro pamucheka muchena*” (We encourage people to keep the *muteuro* tied in a white cloth), he went on.

Kutsipika (Burying): Under this method, the sufferer is usually asked to buy a clay pot (*mbiya*) and certain materials like a red or white

cloth or as prescribed by the prophet. In certain circumstances the nature of problem is written on the cloth. These are put in the pot, which is buried in the bush upside down where no one can come across it. By burying the pot, it is believed that the problem has been buried and it will not come again unless the pot is turned up by someone. Sometimes the Holy Spirit might direct the prophet to go and bury the pot at a given place, usually in the mountains. In that case, the sufferer has to give the prophet bus fare.

Mucheka Mutsvuku (Red Belt): The sufferer may be asked to put on a red belt inside his clothes for a prescribed period. The red belt usually with a white cross on it is believed to chase away ancestral spirits that may be haunting the sufferer. “*Mucheka uyu unogona kungochengetwa mumba chaimo*” (The cloth can be kept in a safe place in someone’s house) said an assistant prophet. “*Meoya ye mebe ga e rate go bona seaparo se se hubedu*” (Evil spirits avoid anointed red cloth) said another assistant prophet.

Leaves of the Hissing Tree: The hissing tree is a wild tree common in some parts of Zimbabwe known as *Muhacha* or *Muchakata* in Shona and *Umkhuna* in Ndebele. Its fruit (*hacha*) is food to both human beings and some animals and birds. The leaves are used in various ways in JMC. They can be boiled in water and sufferers are requested to drink the water or someone may be asked to keep them in a safe place in his/her house. They are believed to provide a protective measure in people’s houses. It is believed that when Johanne Masedza had an encounter with God in Mhondoro Area, the Mihacha tree helped him sing the Great Hossana Song. One assistant prophet indicated that sometimes the hissing tree can be used to make a very small cross that someone can hang around the neck like a jewelry. This is believed to have a protective factor. “*Dzimwe nguva tinochererera hoko yemuhacha pamusha sekureva kunenge kwaita mweya*” (Sometimes we bury some pegs of the hissing tree at someone’s homestead as directed by the spirit) indicated a prophet. “*Ga gona selo se sempe se se ka go hlagelago ge o berekisa matlakala a*” (Nothing bad will come your way if you have these leaves) said a chronically ill man.

Makate: The *makate* involves pouring a prescribed number of full pots of water. This is done

to drive away evil spirits causing misfortunes to an individual. The *makate* method is usually used in conjunction with other methods. Someone may pour the water before given *nhombo* or leaves of the hissing tree.

Songs: Sometimes the spirit may request special songs or a song to be sung for a particular person. The respondents indicated that each song has a purpose. Types of songs stated are *mavhesi etsitsi* (choruses for mercy) and *mavhesi ehondo* (choruses for battles). They highlighted that choruses for mercy are used when a person is in trouble and requires the Lord’s mercy while those for battles are used when there is a stubborn spirit inflicting pain on a person. Sometimes a prophet can be told to sing a particular new song for a sick person.

“*Ndinogona kunzwa rwiyo rwuchiimbwa kumakore ndiri pakati pekunamatira munhu*” (I can hear a song being sung in the clouds during my session with a person) said a prophet. “*Meoya ye mengwe ye mebe e ka e ponagatsa mo gare ga lebaka*” (Some evil spirits can even manifest during the process) highlighted a chronically ill woman. Of interest was the response from a male prophet who said “*Dikosa tsa semoya di bohlokwa kerereng ya rena, ga re opele fela ka ge re swanetse go opela go swana le dikereke tse dingwe*” (Spirit inspired songs are important in our church, we don’t just sing for the sake of singing like other churches).

Pointing to the East: Sometimes the prophet may just request the sufferer to point to the east for a prescribed number of times. The sufferer may say out his/her request to God while in the process of pointing. This can be loud or silent as directed by the spirit. One prophet said, “*Ka mo go Johane Masowe re tla tswelela bohlabela*” (In Johane Masowe, Christ will appear from the east).

Choto: The prophet may request the sick person to have *choto* at his/her homestead. Under the *choto*, members of the church will spend a night praying at a person’s homestead. “*Tinobva tadyara minamoto mamusha iwowo*” (we then plant certain prayers at that given homestead).

The prophets indicated that whenever a certain activity is prescribed to an individual he or she should try to follow it without fail. “*Munhu akasaita zvinenge zvataurwa nemweya anodyiwa netsanagudzo*” (If a person doesn’t do what the spirit says, he/she will fall victim) said a

prophet. In the same regard a chronically ill man said “*Ke fetsa nako ya go lekana masome pedi tee ke le lesokeng gore ke be kaone*” (I spent twenty-one days in the wilderness for me to get better).

Experiences of People with Chronic Illnesses

Out of the eight people with chronic illnesses, seven were confident that the healing practices work. This is evidenced by some of the following statements they made.

“*Ndakaona shanduko kubva pandakatan-ga kushandirwa namadzimai ivava*”

I saw an improvement when I started getting assistance from this female prophet

“*Ukasangana nemuporofita ari kuita zve-pachishanu chaizvo unoyambuka*”

If you meet a prophet who is following the pronouncements of Johane Masowe Chishanu, you overcome the suffering.

“*Mo kerekeng ya rena batho ba bantsi ba thusitswe.*”

At our shrine, a lot of people have been assisted.

Only one man doubted the healing methods. He indicated that he has been getting assistance for more than two years without any improvement.

The chronically ill members heightened that one advantage with JMC is that when one finds one prophet to be ineffective he/she can freely look for another one. “*Dimpho tsa baporofeta di a fapana. O swanetse o itote, gore o hwetse moporofeta yo a nago le mpho ya go rarrola bothata bja gago*” (The assignments of the prophets differ, so you must be careful to look for a prophet who is gifted to solve your problem), indicated one lady. “*Dzimwe nguva muporofita anogona kukuudza kuti uende kune rimwe sowe kunobatsirwa ikoko*” (sometimes a prophet may refer you to another assembly) said one old woman with a heart problem.

The respondents confirmed that healing practices do not focus on the current problem but the prophets may tap into someone’s past and future. “*Vaporofita vanoona vanokupa nhoroo yekwaunoba nekwaauri kuenda, kana kusvika musi werufu chaiwo. Muporofita anoona chaizvo anogona futi kukuudza kuti hausi kuzokunda*” (An accurate prophet can tell you your background and your future even to the day you will die. Some prophets can also

tell you that you will not overcome this problem) said one lady.

When asked whether they can recommend people to the prophets all the respondents indicated that they would. The major reason cited was the presence of witchcraft and evil spirits that haunt people in their everyday lives that need exorcism. The major challenges cited concerning JMC is the rise of false prophets who are cheating people and lack of confidentiality during healing sermons. “*Kana muporofita paine zvaaona anongozviti bvuu pane vane. Vaporofita vanobvumidzwa kumisa chipi zvacho chinenge chichiikita kana paine zvavaratidzwa*” (If a prophet sees something on you, he says it publicly. A prophet is allowed to stop anything that can be going on when he sees something in the spirit), said one man.

DISCUSSION

Causes of illness cited by members of JMC are in line with the traditional African understanding of illnesses. The causes cited include evil spirits, witchcraft, possession of familiars and avenging spirits. None of the respondents cited any biological explanation for the existence of illness. As noted by Ross (2010) in African traditional beliefs, every illness has a specific purpose and cause. Mental illness and physical illness may be caused by conflict with other individuals, ancestors, God or witches. Health and illness behavior and health and medical care systems are integrated into a network of beliefs and values that comprise the Shona society (Shoko 2011) and are evident amongst Africa people in general. In African culture, a network of beliefs and values provide exposition of health and illnesses. According to Machinga (2011), it is a common belief among the Shona people and other cultural groups as found in South Africa and Africa at large, that spirits have the capacity to cause and end illnesses. Some illnesses are also attributed to witchcraft, displeased ancestors or *mashave* (wandering spirits). An anthropologist who researched among the Shona people, Bourdillon (1987) distinguished between natural and serious illnesses. Natural illnesses have known to cause for example, flu or fever and some venereal diseases. Of great concern to the African people are prolonged serious illnesses. These are assumed to have an invisible cause and a *n’anga* (diviner) should be consult-

ed. In the African person's mindset, serious illness is thus caused by spirits, witchcraft or sorcery (Chavunduka 2011). It is also noted that the Africans are not only interested in being healed but they further seek the cause of the illness. Aschwanden (1987) writing in the context of Karanga, one of the Shona ethnic group argues that the Shona distinguishes between three kinds of diseases, that is, diseases sent by God (*zvirwere zvaMwari*), diseases caused by spirits (*zvirwere zveuweya*) and diseases caused by witchcraft (*zvirwere zvevaroyi*).

Healing methods used in JMC include the use of material objects like water, leaves, clothes, and clay pots. This is also similar to what is found in traditional African religions. According to Shoko (2007), among the Karanga, serious diseases and illnesses are treated by various forms involving herbal treatment, extraction of disease causing objects and exorcism of undesirable spirits. The African people also use herbs as preventive measures against possible infections by illnesses, for example Shoko (2007) notes that among the Karanga people, *chifumuro* (exposer) is used. The *chifumuro* is believed to expose the nature of the illness thus preventing people from attack.

The African also believe in magical objects, which are inserted by witches and sorcerers to cause illness. These usually take the form of insects, feathers, animal skin, worms or metal objects. These are removed by *n'angas* through methods such as *kuruma* (biting), *kukwizira* (rubbing), *kuvhiya* (surgery) or *kupfungaidzira* (blowing smoke) (Shoko 2007: 502). An interview respondent in Shoko's study indicated that when the object is extracted, it is displayed for public viewing (Shoko 2007).

The fact that most chronically ill respondents were confident with the healing practices in JMC confirms the importance of spiritual healing in human life. Religion and spirituality may also act as a source of resilience for members of JMC. The fact that prophets are able to narrate or foretell life events also gives members the confidence that they can effectively cure illnesses. Several studies have shown that many people cope with traumatic or stressor events on the basis of their religious beliefs (Wong and Vinsky 2008; Cascio 2012; Pienaar et al. 2012). Peres et al. (2007) notes that religious coping is also frequent in cases of severe diseases. Religious frameworks and practices may have an impor-

tant influence on how people interpret and cope with traumatic events.

IMPLICATIONS FOR PRACTICE

JMC beliefs and healing practices are very conducive for Afrocentric social work practice. Schiele (1997) defined Afrocentric social work as a method of social work practice based on traditional African philosophical assumptions that are used to explain and solve human societal problems. Afro-centricity is described as both a social work theory and a perspective, though it is popularly used among African American clients. The primary objective of Afro-centricity is to liberate the research and study of African people from the hegemony of Eurocentric scholarship. Schiele (1997) identified three fundamental assumptions of Afrocentric social work, these include, individual identity is hinged on a collective identity, the spiritual aspect of human is as legitimate as the material aspect, and that the effective approach to knowledge is epistemologically valid. It is implied in Afrocentric social work that one cannot affect one member of the society without affecting others. In Africa there is no clear separation between an individual and others. It is also believed that spiritual development is a major objective of Afrocentric social work. Afrocentric social work believes that if there is more emphasis on spiritual development, there will be less social problems and human misery. Afrocentric social work acknowledges the linear materialistic understanding of reality and also draws heavily on the affective and holistic means of knowing and understanding the world. Afro-centrists do not believe in social science universalism. Ethical social workers use the most current and verifiable knowledge base, resources and skills for competent practice.

According to Ross (2010), Afrocentric social work educational curricula should be respectful and appreciate African worldviews even if this runs counter to Western social workers' value systems. She went on to argue that the educational curricula should expose students to spiritual healers and leaders so that graduates may work in unison with them and include them in their referral systems. African languages are very critical in Afrocentric social work. Thabede (2005) argues that it is important for social workers to be able to communicate at least

through one African language. They are supposed to understand its proverbs, idioms and avoidance of taboo topics. In JMC, for example, all men are referred to as *madzibaba* while women are referred to as *madzimai* despite one's age. These two words literally refer to fathers and mothers, respectively. Also another thing, a person is called by his or her first name, the concept of respect falls away.

Indigenous theories of help seeking should be acknowledged in Afrocentric social work. These include the family members, the community, traditional leaders and neighbors. Central to African life is the concept of Ubuntu (living through others). Social workers should thus understand traditional social safety nets (Ross 2010). In Afrocentric social work, social research should also focus on traditional cultural practices. Afrocentric social workers are also encouraged to familiarize with the material cultures of African communities (Thabede 2005). These include religious practices, clothing, shelter and food among other things. In this regard, social workers should familiarize themselves with artifacts used by members of JMC. The greeting methods used by JMC members should also be understood by social workers working with these communities.

Beliefs central to JMC should also be recognized. These include the belief in witchcraft, ancestors and the Supreme Being. Social workers should also understand church rituals and their meanings, the value of certain songs, the dos and don'ts in the church especially at the sowe where services are conducted. As Canda (2005) notes, prophecy arises from a deeply felt moral, value and ethical commitment. Members of JMC believe that each person has an angel assigned to him or her and one should not disappoint such an angel. Social workers working with members of African initiated churches are therefore encouraged to respect their beliefs and values. As Canda (2005) puts it, social workers should become more familiar with the way people experience God, angels and helping spirits in recovery and resilience. Social workers should find constructive ways of correcting anomalies when working with these groups. One such method will be to engage their leadership mainly the prophets in decision-making. Another critical element in JMC is the respect for the sowe as a sacred place. One cannot put on shoes or wear prohibited colors like black. It is therefore criti-

cal for anyone working with this community to respect this. Labeling and referring minority religious groups as "cults" should be reduced to the minimum. Non-judgmental attitude, acceptance and self-determination should take precedence. Since members of JMC constitute a significant percentage in Zimbabwe and other southern African countries, it is high time that social workers should commit resources to researching these church communities and come up with an amicable ways of partnering with them in addressing social issues. However, this can be difficult as they have variations among themselves and they do not have national leadership (Dodo et al. 2014).

CONCLUSION

This study sought to explore the healing practices in Johane Masowe Chishanu in relation to chronic illnesses. Etiological explanations for illnesses given by interviewees were found to be similar to those found in African traditional religion. It has been found that members of JMC are highly spiritual and they believe that their healing practices are effective. They use various material objects in their healing practices.

RECOMMENDATIONS

It is there recommended that social workers in Zimbabwe and South Africa can employ Afrocentric social work when working with these communities. The principles of non-judgmental, acceptance and self-determination should be highly respected. Social workers should seek to understand some of the main beliefs in JMC. Social workers should also expand research on the range of spiritual perspectives in Africa.

REFERENCES

- Aschwanden H 1987. *Symbols of Death*. Gweru: Mambo Press.
- Babbie E, Mouton J 2001. *The Practice of Social Research*. Cape Town: Oxford University Press.
- Beyer H, Holtzblatt K 1998. *Contextual Design: Defining Customer-centered Systems*. San Francisco: Morgan Kaufmann.
- Bourdillon M 1987. *The Shona People*. Gweru: Mambo Press.
- Canda ER 2005. The future of spirituality in Social work: The farther reaches of human nature. *Advances in Social Work*, 6(1): 97-108.

- Chavunduka G 2001. *Dialogue among Civilizations: The African Religion in Zimbabwe Today*. Crossover Communication. Occasional Paper Number 1, 2001.
- Daly J, Kellehear A, Gliksman M 1997. *The Public Health Researcher: A Methodological Approach*. Melbourne: Oxford University Press.
- De Vos AS, Strydom H, Fouche CB, Delpoit CSL 2010. *Research at Grass Roots: For the Social Sciences and Human Service Professions*. Pretoria: Van Schaik.
- Dillon-Malone CM 1978. *The Korsten Basket Makers: The Study of Masowe Apostles*, Manchester: Manchester University Press.
- Dodo O 2012. *Understanding Apostolic Church Beliefs*. Germany: Lambert Academic Publishing.
- Dodo O 2014. *Seven Days of Apostolicism: Reflecting on Social Roles*. Bindura: University Press.
- Dodo O, Banda RG, Dodo G 2014. African initiated churches, pivotal in peace building: A case of Johane Masowe Chishanu. *Journal of Religion and Society*, 16(2014): 1-12.
- Engelke M 2007. *A Problem of Presence: Beyond Scripture in an African Church*. Berkeley CA: University of California Press.
- Griffith RM, Savage DB 2006. *Women and Religion in the African Diaspora: Knowledge, Power and Performance*. Baltimore, Johns Hopkins University Press.
- Julie H, Daniels P, Adonis T 2004. Service learning in nursing: Integrating student learning and community-based service experiences through reflective practice. *Health SA Gesondheid*, 10(4): 41-54.
- Mabvurira V, Makhubele JC 2014. Eurocentric spiritual hegemony, an impediment to the incorporation of African spirituality in social work practice in Zimbabwe. *Theologia Viatorum: Journal of Theology and Religion in Africa*, 38(1): 78-95.
- Machinga M 2011. Religion, health and healing in the traditional Shona culture of Zimbabwe. *Practical Matters* 4: 1-8.
- Mukonyora I 1998. Dramatization of life and death by Johane Masowe. *Zambesia*, XXV: 191-207.
- Neuman WL 2006. *Social Research Methods: Qualitative and Quantitative Approaches*. Toronto: Pearson.
- Notess M 2005. *Using Contextual Design for Digital Library Field Studies "Studying Digital Library Users in The Wild"* - JCDL 2005 Workshop, USA: Indiana University.
- Peres JFP, Moreira-Almeida A, Nasello AG, Koenig HG 2007. Spirituality and resilience in trauma victims. *Journal of Religion and Health* 46(3): 343-350.
- Pienaar A, Swanepoel Z, van Rensburg Heunis C 2012. A qualitative exploration of resilience in adolescent AIDS orphans living in residential care facility. *SAHARA. Journal of Social Aspects of HIV/AIDS*, 8(3): 128-137.
- Rice P, Ezzy D 1999. *Qualitative Research Methods: A Health Focus*. Melbourne, Australia: Oxford University Press.
- Ross E 2010. Inaugural lecture: African spirituality, ethics and traditional healing- implications for indigenous African Social Work education and practice. *South African Journal of Bioethics and Law*, 3(1): 44-51.
- Schiele JH 1997. Afrocentricity: An emerging paradigm in social work practice. *Journal of Social Work*, 4(2): 284-294.
- Shoko T 2011 Shona traditional religion and medical practices: Methodological approaches to religious phenomena. *Africa Development*, XXXVI(2): 277-292.
- Shoko T 2007. Karanga traditional medicine and healing. *African Journal of Traditional and Comparative and Alternative Medicines*, 4(4): 501-509.
- Terre Blanche M, Durrheim K, Painter D 2006. *Research in Practice: Applied Methods for the Social Sciences*. Cape Town: UCT Press.
- Thabede D 2005. *Casework: An Afrocentric Perspective*. PhD Social Work Thesis, Unpublished. South Africa: Stellenbosch University.
- Wong YR, Vinsky J 2008. Speaking from the margins: A critical reflection on the "Spiritual-but-not-religious" discourse in social work. *British Journal of Social Work*, 39(7): 1343-1359.
- Weiss R 1994. *Learning from Strangers: The Art and Method of Qualitative Interview Studies*. New York: The Free Press.