

Clubfoot in Malawi: local theories of causation

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SUMMARY This paper examines local theories of the causation of clubfoot expressed by the guardians of children undergoing treatment at clinics run by the Malawi National Clubfoot Programme (MNCP). Core data was collected and analysed using qualitative methodologies of critical medical anthropology. Sixty detailed case studies were completed, each based on an extended open-ended interview with patient guardians. Five main theories of causation were put forward: God; the devil; witchcraft or curses; biological reasons; and inherited condition. Each was elaborated in a variety of ways. There is growing international recognition of the importance of examining the relationship between culture and disability. This study is the first attempt to do so for clubfoot in Malawi. It provides a platform on which to build future qualitative research that can be harnessed by the MNCP and similar initiatives to develop their knowledge base and service provision, both in Malawi and the wider African context.

Introduction

Idiopathic clubfoot (congenital *Talipes equinovarus*) is a condition in which the child is born with the hindfoot adducted, flexed and inverted and the forefoot abducted and pronated in relation to the hindfoot. Neglected clubfoot results in significant impairment in body structure and function and may result in activity limitations and participation restrictions. For health-care professionals, clubfoot is, biomedically, a clearly defined physical impairment. In contrast, for the guardians of children presenting with the condition, it is rarely clearly defined. Physical disability in Malawi, as

elsewhere, harbours social and cultural implications that can readily influence the perception of a condition and its associated treatment-seeking behaviour.

In 2009, we undertook the first detailed anthropological study of clubfoot in Malawi, examining perceptions of, and treatment-seeking behaviour for, congenital *T. equinovarus*. The aim of the research was twofold:

- first, to determine new empirical data on the perspectives of clubfoot and its treatment in Malawi, amongst patients and their guardians
- secondly, to make recommendations to develop the services of the Malawi National Clubfoot Programme (MNCP) through the qualitative analysis of patient and guardian perspectives of clubfoot

This paper focuses on one component of the wider research project. It examines the local theories of the causation of clubfoot expressed by the guardians of children undergoing treatment at MNCP clinics.

Methods

The core data collection was carried out in Malawi over five weeks (June–July 2009). The research was based at Beit Trust Cure International Hospital in Blantyre, from where the MNCP is coordinated. Eight other MNCP clinics (Nkhota-Kota, Mzuzu, Lilongwe, Mwanza, Mulanje, Balaka, Dedza and Rumphu) were included in the research and each was visited at least once. Due to time and budgetary constraints, all 26 MNCP clinics could not be included in the research. The nine selected were chosen specifically to render a substantial body of rich and diverse data: they were located in different areas of the country, employed different clinical set-ups, had been established at various stages of the MNCP's development and encompassed a range of patient demographics.

A total of 60 case studies was completed. A case study comprised a consent form signed by the patient's guardian, a transcription of their extended interview, a summary of the patient's medical history and a set of documentary photographs (to confirm the nature and severity of the condition). In all cases, the guardian was a parent or close familial relation of the patient.

Core data was elicited using informal (or soft) open-ended interview techniques in the vernacular. A broad spectrum of interview questions was designed by the research team. These were reviewed and refined during the research period in light of themes arising during the course of the interviews. The direction and content of each interview was determined by the guardians and focused on the issues they self-identified as priorities. Dominant themes were identified in the case studies. This involved the systematic sorting of the data, labelling ideas and phenomena as they appeared and reappeared. The apparent trends in perceptions, causation and local explanatory models that emerged were critically analysed.

Permission for the research was granted by the College of Medicine Research and Ethics Committee of the University of Malawi and informed consent was obtained from all guardians participating in the study.

Results

Five main theories of causation were put forward by the guardians: God; the devil; witchcraft or curses; biological reasons; and an inherited condition. When discussing ideas about the causation of clubfoot, most guardians preceded their remarks with 'not sure' or 'could not be certain', before suggesting a range of possible explanations. The majority of guardians emphasized their belief in, or preference for, one particular channel of causation. These results are presented in Table 1. Thirteen guardians could not offer any theory of causation or preferred not to discuss the causes of the condition.

Discussion

Five main theories of causation associated with clubfoot were identified and each comprised a number of sub-factors.

Eight guardians gave biological explanations. Taking too much medication, taking both local medicine (*mankhwala a chikuda*) and biomedicine (*mankhwala a chizungu*) and, specifically, 'taking pills' during pregnancy were thought to cause physical harm to the unborn child. The use of the contraceptive pill was perceived to be particularly risky. The poor nutritional state of the expectant mother was also linked to problems in the child's correct physical development, as was illness during pregnancy, especially malaria and other fevers. One mother believed that clubfoot was caused by a sexually transmitted disease. Five guardians attributed the presentation of clubfoot to insufficient room in the womb. They believed that the baby was unable to move or stretch properly, that the fetus was positioned incorrectly and that proper growth was prevented through lack of space. A mother of twins thought the second twin had developed clubfoot because the first twin 'had too much of the space and the second one was crushed'. Damage previously caused to the womb, through miscarriage or abortion, was also thought to contribute to the likelihood of the child being born with an impairment. One father concluded that 'the tendency men have in this country to beat their wives when they are pregnant, could cause problems to her body and, maybe, one result is clubfoot'.

Four guardians suggested that clubfoot was inherited. This was a persistent idea shared by those who had more than one

case of clubfoot in their family. A mother in Mzuzu explained that 'it is somehow in my husband's family, that is why two of my children have it', whilst another in Lilongwe claimed 'the baby is just a counterfeit, a copy of the old man (paternal grandfather) who passed away, the baby now has his condition'. A mother in Lilongwe whose seventh child was born with unilateral clubfoot thought it resulted from contact with her dying husband. She concluded that pregnant women should not attend to people who are ill and that the impairment was a direct result of her nursing her husband and, worse, touching his coffin whilst she was carrying the child.

The most cited theory attributed the occurrence of clubfoot to God. This was elaborated in a variety of ways. We were often told that it was the Will of God (*chifunilo cha Mulungu*) that the child was born with clubfoot. In some cases the guardian suggested it was 'God's choice' that the child was born with clubfoot and, in others, that 'it was just God', meaning there was no explicit reason 'but it is just the way it is'. Guardians interpreted it as 'coming from God' in both positive and negative lights. Several guardians said their child was 'a gift from God', whilst others claimed the presentation of clubfoot was 'a punishment from God'. A mother in Nkhota-Kota, who had converted to Islam in order to marry, explained 'to some it is a punishment and to some it is not. At first, I thought it was a punishment for me but now I see it is not and I am repenting my feelings'. A number of guardians concluded that the condition was a 'test from God', but that God could also redeem the situation through treatment. A mother in Blantyre explained 'the impairment is a test of my faith. I will stand with the problem of the child. I believe the same God will give me a way out'.

Two guardians, who regarded the presentation of clubfoot as a test, thought it was a test not from God but from the devil (*mdyerekezi* or *mdyabulosi*) or Satan (*satana*).¹ A grandmother in Lilongwe said that 'you cannot run away from the devil, he follows us, to take away our faith. He tests us through physical challenge. Coming for treatment helps to prove faith, it proves to him that we care for the child'. A mother in Lilongwe whose fifth child had been born with clubfoot, but who had been able to seek treatment only intermittently due to transport difficulties, concluded, 'the devil caused the problem. It is temptation from the devil. I did not do anything to result in this. But the treatment is taking longer because the devil is strong in fighting against it. Some were born without clubfoot, this one was born with it, so the devil is working against the girl. I don't know why against this child, but it is the devil'. This mother, a practising Catholic, was supported by her Church, which, she explained, had encouraged her 'to surrender herself to God because of the clubfoot'.

Seven guardians attributed the presentation of clubfoot to witchcraft or curses: a further four cited God or curses, but could not distinguish which. A mother in Blantyre explained that clubfoot in her child was the direct result of a curse (*tembelero*) that a neighbouring family had put on her after a quarrel. Another guardian claimed that relatives had placed the curse on his son because they had felt envy (*nsanje*) for his comparative wealth, pastures and cattle. Witchcraft is conceived as an ever-present threat in Malawi and arouses a state of permanent suspicion.² In another case, rather than a curse being given as the cause of the impairment, the presentation of clubfoot was seen as a physical

Table 1 Causes for clubfoot given by patient's guardians

Cause given	No. of guardians
God	22
Biological	8
Witchcraft / curses	7
God or curses (did not know which)	4
Inherited	4
Devil	2
Do not know	13
Total	60

sign that the child was himself a witch. The guardian recalled how 'people in the village said he was supposed to be a witch because he was born with this problem. They said that when he grows up he will be the most terrible amongst witches in this area'. The existence of child witches is debated across Malawi (as elsewhere in Africa):³ they are seen to be powerful, dangerous and, by some, to be increasing in number.⁴

The theories of causation presented by our research in Malawi are similar to the explanatory models reported by Konde-Lule *et al.* in Uganda, where, in addition, certain ethnic groups believed that neglected spirits (both ancestral and roaming spirits) could cause clubfoot by weakening the bones of a baby.⁵

Although the majority of published research dealing with clubfoot is clinically orientated and addresses the condition and its treatment from a biomedical angle, there is scant material on the social and cultural aspects of clubfoot. What qualitative work there is has focused mainly on barriers to clubfoot treatment adherence.⁶ The Ugandan Sustainable Clubfoot Care Project (USCCP) has made some efforts 'to study knowledge, attitudes, beliefs and practices' about clubfoot across different regions in Uganda.⁵ The main difference between the Ugandan project and our research lies in the respective pools of interlocutors. Unlike the Ugandan study that had a broader research agenda of understanding clubfoot in the wider community, this research focused specifically upon the perceptions of guardians with children undergoing treatment at MNCP clinics. The key findings and recommendations of both projects show close parallels.

Conclusion

This research demonstrates that local theories of causation associated with clubfoot are widespread and deep-rooted in Malawi. There are marked differences between the perceptions of clubfoot expressed by the guardians of patients undergoing treatment in the MNCP and the biomedical framework of health-care professionals. If service provision is to achieve the maximum positive impact and if neglected clubfoot is to be eradicated from Malawi, the ideas and perceptions of the intended beneficiaries must be meaningfully integrated into health-care programming. The MNCP is responding effectively to this need by seeking ways to engage sustainably with the guardians of its patients. Exploring local theories of causation is important because such perspectives influence treatment-seeking behaviour, notions of compliance and the social presentation of physical disability. (These closely related aspects are discussed further

in a subsequent paper.) We contend that failure to appreciate socio-cultural perceptions of specific disabilities, such as clubfoot, can severely hamper the success of treatment programmes.

Against an international backdrop that advocates examining the relationship between culture and disability, there is a pressing need to better address disability in Africa.^{7,8} As the first applied anthropological study of clubfoot in Malawi, this should be seen as a platform on which to build future qualitative research that can be harnessed by the MNCP, and similar initiatives, in order to develop their knowledge base and service provision, both in Malawi and the wider African context.

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