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How to cite this thesis
THE ATTITUDE OF THE TSONGA COMMUNITY TOWARDS THE
CEREBRAL PALSYED AND THE ORTHOPAEDICALLY HANDICAPPED CHILD

by

BUSISIWE HELEN BALOYI

DISSERTATION

Submitted in fulfilment of the requirements for the degree of
MASTER OF EDUCATION
in
SOCIO-PEDAGOGICS

at the

RAND AFRIKAANS UNIVERSITY

SUPERVISOR: PROF. C.S. ENGELBRECHT

MAY 1989
"Heaven's Special Child"

(Dedicated to parents of Handicapped Children)

A meeting was held quite far from earth
It's time again for another birth,
Said the Angels to the Lord above,
This special Child will need much love.

Her progress may seem very slow
Accomplishments she may not know,
And she'll require extra care
From the folks she meets down there.

She may not run or laugh or play
Her thoughts may seem quite far away
In many ways she won't adapt
And she'll be known as handicapped.

So let's be careful where she's sent
We want her life to be content
Please Lord find the parents who
Will do a special job for you.

They will not realise right away
The leading role they're asked to play,
But with this child sent from God
Comes stronger faith and richer love.

And soon they'll know the privilege given
In caring for the gift from heaven,
Their precious charge, so meek and mild
Is "Heaven's Very Special Child".

Author Unknown
ORTHOPAEDIC HANDICAP

NORMAL LEG
ACKNOWLEDGEMENTS

I wish to express my gratitude to:

1. Professor C.S. Engelbrecht, to whom I am indebted for his expert guidance. I have attained more knowledge through him. I also wish to express a special word of thanks to his family for the hospitality I have received. He was always prepared to sacrifice his time.

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7. My dear children Sipho Bornellee and Nomsa (Jacqueline) for their encouragement in my work. Grow so that you can serve the Lord through service to handicapped people.

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9. God my Heavenly Father/Ellohim/Elshadai, who gave me life and strength to write this dissertation.
Psalm 103:1

"Bless the Lord, oh my Soul, and all that is within me
bless His holy name."

* In all that you do, give thanks to the Lord. (English)

* In alles dass Du tust, danke dem Herren. (German)

* Alles wat jy doen, doen dit uit dankbaarheid aan God. (Afrikaans)

* Εἰς ὅλα δίνετε ἐνθαλείσ οτό Θεό (Θεος). (Eis ola dinete enkaristies ston Theo. (Theos). (Greek)
Chapter One constitutes the heart of this study which entails the statement of the problem, prevailing attitudes and beliefs in the Tsonga community, attitudes and feelings of parents whose children are handicapped. This chapter also gives the aim, delimitation, method and plan of the study.

Chapter Two elucidates what cerebral palsy and orthopaedic handicap are. It is a thought provoking and interesting chapter since it gives definitions, occurrence and causes of cerebral palsy and orthopaedic handicaps. Types of cerebral palsy such as spasticity, athetosis, rigidity, tremor and mixed type are clearly indicated. This also applies to orthopaedic handicap, where handicapism like poliomyelitis, dwarfism, tuberculosis of the spine, amputation of a limb or limbs, spina bifida, muscular dystrophy, scoliosis, osteogenesis, rachitis, kwashiorkor and congenital deformities are discussed in detail. Cerebral palsy and orthopaedic handicap occur during four different stages, i.e. pre-natal, para-natal, neo-natal and post-natal stages.

Chapter Three gives the traditional attitudes of the Tsonga community towards cerebral palsied and orthopaedically handicapped children. The chapter first elucidates terms which also constitute the heart of this dissertation. It highlights the treatment of handicapped children by the ancient Greeks, Romans, Hebrews, and also the Sothos, Zulus and Tsongas.
The traditional Tsonga life, customs and beliefs are discussed in detail, e.g. how the Tsonga people live(d), family life amongst the Tsonga, marriage (lobola), religion, witchcraft, the traditional initiation school and formal education. The Tsonga people have various amazing beliefs on the causes of handicaps, witchcraft and taboos being the major causes of cerebral palsy and orthopaedic handicaps, according to the existing ideology.

Chapter Four entails the empirical component of the study. Different groups were interviewed i.e. interview Schedule "A": Parents of the cerebral palsied and the orthopaedically handicapped children; Interview Schedule "B": Parents of children who are not cerebral palsied and orthopaedically handicapped, and Interview Schedule "C": Professional Group: the doctor; social worker; teacher; orthotist; speech therapist; physiotherapist and the nursing staff. Problems encountered during the interview and other limitations conclude the chapter.

Chapter Five gives interview analysis and data accumulated. The attitudes of the respective groups are validated in this chapter (especially on parenting). Professional workers are also seen to be playing a crucial role in the life arena of a handicapped child.

In Chapter Six, findings, conclusions and recommendations by the researcher are given. Findings pertaining to the parents of handicapped children, parents of the non-handicapped children and the professional workers in particular are given. Recommendations following the study are as follows: the need for more institutional care, recommendations concerning community change, specific training of parents and profes-
sional workers concerned with the handicapped child. Goals for cerebral palsied and orthopaedically handicapped children are given. All in all, guidance and counselling is strongly needed and regarded as a master key, according to the present researcher, in order to unlock myth ideologies and uproot negative attitudes.
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CHAPTER I

STATEMENT OF THE PROBLEM, AIM, DELIMITATION, METHOD AND THE PLAN OF THE STUDY.

"They destroyed crippled children in a cruel way, by leaving them to die in a deep cleft or ravine in the Taygetus Mountains. Sometimes such children were simply left beside the road or a wood, or they were drowned in a lake or a river."

(the attitude of the early Greeks)

* * * *

"If the handicap did not seriously affect the child's ability to work and move about freely, he was allowed to live; if the handicap was of more serious nature he was destroyed as the attitude was that he could be a burden to others."

(the attitude of the early Romans)

* * * *

"Although they did not cast off or kill the crippled, they regarded them as inferior. Care of the cripple was also coupled with care of the poor, widows and orphans."

(the attitude of the early Hebrews)

1.1 INTRODUCTION

The above-mentioned thought-provoking quotations taken from Frampton and Rowell (1955) depict the attitude of three different communities of the past concerning their attitude towards and treatment of the physically handicapped children in their midst. The quotations reveal the community as a chief architecture in
the life arena of the physically handicapped children, such as the cerebral palsied and orthopaedically handicapped children.

The title of this study gives rise to the notion of posing some relevant and fundamental questions, such as:

What is cerebral palsy? What is an orthopaedic handicap?

What are the causes/aetiology of cerebral palsy and orthopaedic handicaps? What is the attitude of the present community at large towards the cerebral palsied and the orthopaedically handicapped children? Are the cerebral palsied and the orthopaedically handicapped children accepted as part and parcel of the present community? Is there any community without these children?

Some even more existential and deeply underlying questions are: What happens if one personally has a relative or, even nearer to the heart, a child who is cerebral palsied or orthopaedically handicapped? Is his/her presence, as is often implied, a punishment from God or a curse? The above questions posed are the "mainstream" of the present study or form the basis of this study.

1.2 STATEMENT OF THE PROBLEM

The devotion of the present writer, in working among the physically handicapped children, provoked the notion to undertake the study. A study of this kind is relevant in a community set-up (such as the Tsonga) where the occurrence of a physical handicap in a family, traditionally was seen as a trial or visitation by the gods or the forefathers' spirits. (This was, in fact, often considered to be an open revelation of some secret indiscretion or misconduct of the parents.) The study is also especially relevant in a community where physically handicapped children in the olden days were killed after birth, often by means of pulling the umbilical cord or by leaving them to their own fate or own devices. This study is also relevant in a community,
like the Tsonga, where ritual ceremonial needs had to be gone through in order to atone the parents of a handicapped child and the child with the gods and forefathers.

Such beliefs, attitudes and customs that have been passed on through the years from generation to generation and have become engraved in the culture, are often very hard to change and to obliterate. Often major community guidance and counselling programmes have to be undertaken. It often is a matter of "educating" the community. This places the present study within the socio-pedagogic cadre.

It is the privilege of this study to take place in Gazankulu, which is a self-governing state; and which, because of its control over education and health services, can adapt community guidance and counselling specifically to the needs of the community. Such community guidance and counselling can consequently be very crucial to change the present attitudes.

The researcher has reason to presume that the present Tsonga community already has a much more lenient and accepting attitude towards the handicapped in its midst than the communities in earlier days. But the researcher would like to investigate this presumption empirically in order to find out, how deep and widespread the traditional attitude (fragmented traditional attitude) still prevails. This could be done by conducting interviews with the present parents of cerebral palsied and orthopaedically handicapped children, parents of normal children, professional workers, including doctors, social workers, physiotherapists, nurses and teachers and then comparing the information with accounts given by old people.
1.2.1 PREVAILING ATTITUDES AND BELIEFS IN THE COMMUNITY

From her daily contact with physically handicapped children and from her experiences with parents of handicapped children and with the community at large, the researcher has the feeling that, in spite of the presumed greater leniency and acceptance, all in all, the cerebral palsied and the orthopaedically handicapped children are not yet totally accepted by the community. Presently, the writer still comes across the following attitudes in her daily work and in a sense these constitute the heart and nucleus of this study:

* The present writer is of the opinion that many people in the Tsonga community are still "swimming in the deep sea of preconceived dominating ideologies, the sea of myth and conception" with a resulting rejection of cerebral palsied and the orthopaedically handicapped children. Many people are still rooted within this illusory ideology.

* It would appear from the writer's observations that most of the people in the community still regard a cerebral palsied or an orthopaedically handicapped child as a burden to the family involved. A demonstration of the people's rootedness in this subfusc and subconscious attitude is the fact that cerebral palsied and orthopaedically handicapped children are often taken to the hospital by their parents after realization of the handicaps, and that the parents then often disappear indefinitely and are nowhere to be found again. Eventually the social worker brings the rejected child to the school for the handicapped children in order for it to receive formal education. Many a child stays for 16 years without hearing from or knowing its parents. Such an attitude of the parents ravels the child's whole life arena, and raises the question what all this means to the child. The child is living in
a world of confusion, full of sorrows and this poses many unanswered question to the people working with the child.

* Myths are also still prevailing within people's minds about the causes of such handicaps. In this regard witchcraft seems to be regarded by many people in the Tsonga community as the cause of such handicaps. This is a glaring contrast to the views of authors such as Pohl (1950:15) and Davis (1980:5) who maintain that premature birth is one of the main causes of cerebral palsy (handicaps).

* As far as premature birth is concerned, there is a prevailing Tsonga community belief that the mother of such a prematurely born baby was bewitched and transformed during some night and had sexual intercourse with a gorilla, whose sperms interfered with the foetus and which hence resulted in an early birth. Many members of the community are convincedly rooted within this illusory ideology.

* Another observation of the present writer which provoked this study among the Tsonga is her notion that certain prevalent religious beliefs influence the attitudes of the community. Many defects, such as spina byfida or a cleft palate are, for instance, believed to be the result of "divine wrath" or the "will of the father" (cf. also Gottlieb, 1972:20). Linked up with this belief is the often posed question in the community: "What is wrong with the father?" According to the present writer this is an invalid question. There is nothing wrong with the Father. The true fact is that something has gone wrong with the foetus during the first trimester of pregnancy at the pre-natal stage.

* The dominating misconception in the community (according to the experience of the writer) is that cerebral palsied and
Orthopaedically handicapped children are a curse in the family. The writer heard it said about the mother of a new-born handicapped child:

"Hm, yes, that crippled child is a good lesson to her, God wanted to close her mouth. What a discipline! She was too proud and selfish. This is a very good discipline which will cause her chronic pain."

People regard a handicapped child as a punishment for the bad personality of the parents. This links up with another thorny problem, namely that people who do not have such problems often laugh at the families with a handicapped child.

* The present writer is also aware of the prevailing taboo that pregnant women are not allowed to look at a handicapped person or child, for fear that they will also give birth to such a child or even worse. Physically handicapped children are also often suspected to be the result of attempted abortion.

1.2.2 ATTITUDES AND FEELINGS OF PARENTS WHOSE CHILDREN ARE HANDICAPPED.

The second mainspring for undertaking this study cuts to the very heart and nucleus of the study and is based on parental attitudes. Community emanates from the reproduction of children by parents. According to Kimpton (1977:137),

"a parent is a primary helper, monitor, co-ordinator, observer, record keeper and decision maker for his or her child."

Kimpton (1977:137) strongly emphasises that the parent is the "principal monitor". Whenever one talks about the cerebral palsied or orthopaedically handicapped child, one must realize that the parent is "an engine" or "key holder" in the life arena of such a handicapped child.
A most crucial question for the present study to pose in this respect is: What is the attitude of the parents of the handicapped children in the Tsonga community?

According to the present writer's observations in her contact with parents, there are parents who are clouded with confusion in the Tsonga society. Their crisis gives birth to an attitude of rejection. Their feelings and behaviour constitute a "key stone" in this study. According to the notion of the present study, it is normal that everybody desires a normal child, this also includes the Tsonga community.

"The capacity to produce a normal child, a healthy baby is psychologically and culturally important. Consequently, when an abnormal child is born, parents perceive themselves as inadequate, failure, and regard the events as both a personal and cultural tragedy" (Gottlieb, 1972:18).

The proposition "cultural tragedy" conceals the true essence or meaning of what a cerebral palsied or orthopaedically handicapped is in the family involved. This leads to the question why the child is referred to as a tragedy. What has constituted this tragedy?

Biklem and Bogdam (1976) in their chapter on "Attitude of Parents" say that, in raising a child parents harbour a complicated set of expectations and dreams which usually represent the way they themselves have experienced or hoped to experience life.

The behaviour of parents of a handicapped child derives from many factors. These include cultural and social-class attitudes to children in general, to handicapped people and to teachers, doctors, social workers, occupational therapists, physiotherapists and others. But to a major degree, their behaviour derives from their feelings about their handicapped child.
There are different feelings of the parents in general. According to Bleck and Nagel (1974:216), different feelings of bereavement may come to the fore as potentialities. These include the following:

- anger
- grief
- adjustment
- feelings of shock
- feelings of guilt, which are probably less common
- feelings of embarrassment, which are social reactions to what the parents think other people are feeling.

The different feelings of the parents constitute a major part of the problem of the present study.

These feelings can be experienced so severely as to lead to suicide by parents. To verify this experience, there is the case of the Tsonga woman, the mother of a handicapped girl, who committed suicide at Giyani. It is evident that parents of the handicapped children are fighting a big battle in their minds, often with nobody to guide and counsel them. Parents need timeous and continuous counselling to help them handle their feelings and the resulting attitudes.

In this regard the above feelings give rise to certain categories of parental attitude. The Department of Education and Training, in their publication, Psychological-Pedagogical Aspects (1975:113) quoted Sommers, who distinguishes 5 different categories of parental attitude, viz:

- Acceptance of the child and his handicap
- Open rejection of the child
- Disguised rejection of the child
- Ignorance of the handicap
- Overprotection
At the school for the handicapped, the following parental attitudes have been observed: wrong addresses are given by parents; when school closes, teachers who escort children to the station often find that the parents do not meet the handicapped child at the station. Some parents find it all too easy to bring the child to the special school 'BUT' too hard to meet the child at the station. From her own experience, the writer knows how extremely hard it is to work with a child whose family has rejected him.

1.3 AIM OF THE STUDY

The present study aims at exploring the feelings of the different members of the community towards physically handicapped children, and in doing so:

- to find ways for changing the different attitudes of the community. It is the highest hope of this study that it will illustrate some of the social dimensions by which the cerebral palsied and orthopaedically handicapped children could be rehumanized and to extirpate some of the dominating ideologies that dehumanize the physically handicapped children;
- to contribute towards encouraging the acceptance of the disabled;
- to ligate and meliorate the fragmented parental attitudes;
- to highlight the crucial role played by the school in encouraging excellence;
- to discourage divorce caused by the birth of the handicapped child in the family;
- to discourage witchcraft and taboos;
- to advocate the introduction of guidance and counselling as a key service at the special school which is presently 'NOT' in existence;
- to show that every life has its purpose;

- to point out that cerebral palsyed and orthopaedically handicapped children are not a curse in the family and are not a punishment from God;

- to assist parents of handicapped children and to discourage their negative attitudes regarding the status of the handicapped child and their rejection of him;

- to stress that parents who accept the child should be encouraged;

- to show that the three Rogerian qualities, namely
  
  (i) Empathy  
  (ii) Unconditional positive regard  
  (iii) Congruence  

  are most desirable in any community, especially as far as the handicapped are concerned;

- to enlighten the community on the aetiology of cerebral palsy and orthopaedic handicaps;

- to encourage the community to accept cerebral palsyed and orthopaedically handicapped children;

- to make the community realise the handicapped child and his magnitude of talents;

- to encourage the community to serve. Jesus served. In support of this purpose, Colossians 3:23 can be quoted:

  "What ever you do, work with all your heart, as though you are working for the Lord and not for men."
1.4 DELIMITATIONS

In order to keep this study within a manageable scope, the following delimitations had to be accepted:

- Only the Tsonga community is involved in this study. It does not include any other black communities within the broader South African perspective, such as Venda, Sotho or Zulu communities.

- Only the orthopaedically handicapped and the cerebral palsied children are involved in this study. It excludes the other handicaps, such as the visually handicapped and the aurally handicapped (deaf) children.

- Not all members of the community are included in the study. It involves four groups:
  
  (i) old people, because of their knowledge of the traditional customs;
  
  (ii) professionals, such as social workers and orthotists, who are often involved with the handicapped children concerned;
  
  (iii) parents of handicapped children because of their close relationship with these children; and
  
  (iv) parents of non-handicapped children, to contrast the views of the former groups with.

1.5 METHOD OF STUDY

This is a two-pronged study. The following two aspects are the major tools for the study:

1. Literature study to serve as a theoretical background for the research.

2. Empirical study to obtain recent and relevant information.
1.6 PLAN OF THE STUDY

In this chapter an indication was given of the nature of the problem, the aims of the study, the delimitation of the study, and the proposed method.

The further plan of the study is based on the following aspects:

Chapter 2: An exposition on what cerebral palsy and orthopaedic handicaps are. Discussions based on occurrence and causes of the two phenomena, i.e. orthopaedic handicap and cerebral palsy are also given.

Chapter 3: A discussion of the traditional life style of the Tsonga community.

Chapter 4: A report on the conduct of the empirical study.

Chapter 5: An analysis of data accumulated.

Chapter 6: Findings, conclusions and recommendations stemming from the research are given.
CHAPTER 2

CEREBRAL PALSYED AND ORTHOPAEDICALLY HANDICAPPED (CRIPPLED)
CHILDREN: DEFINITIONS, OCCURRENCE AND CAUSES.

2.1 INTRODUCTION

In order to obtain a true perception of the problem, it is necessary to describe the two physical conditions concerned, i.e. cerebral palsy and orthopaedic handicaps in some detail. The elucidation of the two phenomena in this chapter is based on giving definitions, stating the occurrence and reflecting on the causes/aetiology of the cerebral palsy and orthopaedical handicaps respectively and similarities between cerebral palsy and orthopaedical handicaps.

2.2 CEREBRAL PALSY

2.2.1 A broad description of cerebral palsy

Historically speaking, according to the literature reviewed, there was no differentiation made before in the classification of children suffering from the different forms of orthopaedic crippleness. They were all classified under the same category and they attended the same school. The condition existed, unnamed for many years. In the nineteenth century something good happened in England. In the year 1861 W.J. Little (1861:378-380), an English neurologist, defined the difference between cerebral palsy and orthopaedical handicaps:

"The outward signs of crippling in the cerebral palsied were the result of brain damage. Orthopaedic crippleness on the other hand, is caused by a defective bone or muscular system. Cerebral Palsy is not the result
of a defective bone or muscular system, but is the result of damage to certain parts of the brain which causes motor dysfunction (unco-ordinated muscular control)" (Department of Education and Training, 1975a:18).

According to McDonald and Chance (1964:7), and in line with the above-mentioned definition by Little, cerebral palsy condition was known as Little's Disease. Another commonly used label was "spastic". These names tended to give people the idea that all cerebral palsy individuals were the same.

Phelps (1974:7) puts it in this way, the word "cerebral" refers to the "brain" and the word "palsy" depicts a "lack of muscular control". Cerebral palsy, therefore, is not a disease but a permanent brain lesion. Perlstein (MacDonald and Chance, 1974) points out that lesions in different parts of the brain, produce different symptoms or motor disfunctions. Bleck and Nagel (1975:37) say "cerebral" means "brain" and "palsy" means "paralysis" i.e. cerebral palsy means brain paralysis.

Brain-injury can originate before birth (pre-natal stage); during birth (i.e. intra-natal/para-natal stage); immediately after birth (i.e. at the neo-natal stage) or even later after birth (i.e. in the post-natal stage). Furthermore, this condition is characterized by various degrees of paralysis, inco-ordination, weakness, or any other motor dysfunction or disorder caused by injury to the brain. The symptoms range from mild to profound, depending on how bad the injury is. This is why some can walk, though handicapped, while others are wheelchair bound patients who cannot walk. The following symptoms are also often associated with cerebral
palsy (brain damaged): learning disabilities, speech problems, visual disorders, hearing impairments and other problems that could be encountered.

2.2.2 Types of cerebral palsy

There are different types of cerebral palsy that are often distinguished. The types most often mentioned are:

2.2.2.1 Spasticity (Spastic)
2.2.2.2 Athetosis (athetoid)
2.2.2.3 Ataxia (ataxic)
2.2.2.4 Rigidity
2.2.2.5 Tremor
2.2.2.6 Mixed type (usually spasticity with athetosis)

The above-mentioned types of motor disabilities are defined by Davis (1980:1-5) and also Pohl (1950:5) as follows:

2.2.2.1 Spasticity (spastic)

Spasticity (spastic) is a condition caused by damage to the motor area of the cortex which controls voluntary and planned movements. The clinical image is mainly one of stiffness. It usually results in hemiplegia either on the left or right side of the body, depending respectively on whether the right or left hemisphere of the brain has been affected.

Pohl (1950:56) substantiates that the effect occurs on the opposite side in relation to the damaged part of the brain. Voluntary control, especially control involving fine movement is possible, but patients are clumsy, because the contraction
of the muscles blocks any planned movement. When the arms are raised above the head, then, the arm on the affected side is usually found to be shorter than the other normal arm. This method of "arms raising" can be used as a test when diagnosing a mild or severe case of spasticity. It could be tested by a physiotherapist, a teacher, a doctor or an occupational therapist.

In addition, according to the observation of the present writer, the affected limbs are usually much thinner than the other unaffected side. The affected limbs can be straightened when pulled. The muscles are very weak. These children can walk, but the affected hand is not dominant in any hand participation. Like a pocket knife, the affected arm can be pulled straight but returns to its original position when released. It is difficult for the patient to use the affected limb. The teeth have been observed to be large, especially the incisors, with the result that the lips are open. The gums appear swollen. Most of them have visual problems, e.g. strabismus eyes. The eyes are normally big in size. By merely looking, one would suspect or realise that something has gone wrong with a particular child.

Davis (1980:5) says that about 50% of all cerebral palsied individuals manifest spastic motor movements. Pohl (1950:13) says it is present in approximately 66 percent, and Kirk of New Jersey University (Pohl, 1950:13) says it is approximately 45.9 percent.
2.2.2.2 Athetosis (Athetoids)

Athetosis is a condition caused by damage to the area of the basal ganglia which control the body. It is clearly elaborated by Pohl (1950:7-9) that athetosis is a condition characterised by regular and repeated involuntary action. Muscle contraction is not rhythmical and follows no definite pattern. Twisting or contortion of the facial muscles is usual, with involuntary movements of the face. One could conclude that the patient "is crying and laughing at the same time". This is caused by involuntary movement of the
face. It is not easy for the patient to control his saliva. This condition usually influences the movement of the whole body, but is sometimes limited to the one side. The action of sitting and walking becomes difficult. When the child walks, he appears intoxicated (drunken) and cannot walk fast. In this condition, whatever he does, is difficult for him, for example, eating, drinking, writing, talking, etc. He needs to be assisted in drinking and eating. Sometimes a patient eats like an animal with his mouth to the plate and no use of the hands. The patient is unable to direct food straight to the mouth. In drinking, the cup shakes until it falls. In some cases communication becomes impossible. Only with sleep, which induces complete relaxation, does the movement decrease and usually stop.

Furthermore, athetosis varies, in some cases the muscles are very tense. This type of athetosis, which is characterised by tension, is known as tension athetosis. When the tension is severe, the patient is wholly incapable of making any movement. During emotional stress athetosis is aggravated. In other words the gravity of the illness increases. In some cases there is a hearing loss. McDonald and Chance (1964:35-36) emphasize that athetoids also have hearing loss in higher frequencies.

According to David (1980:5) about 25 per cent of cerebral palsy is classified as athetosis. According to Kirk (1962:355-358) it is approximately 23.7 per cent and according to Pohl (1950:8) it is approximately 19 per cent.
2.2.2.3 Ataxia (Ataxic)

According to Davis (1980:4) ataxia is classified according to the type of motor disability by awkwardness of fine and gross motor movements and a lack of co-ordination i.e. the movement required for balance, posture and orientation in space. Thus, the characteristic picture of a person suffering from ataxia is a disturbance in the equilibrium or balance. Furthermore, it is not possible to diagnose this condition before the child begins to walk. Such a child or person needs to be supported whenever he walks. According to Cash
(1980:3-4), there is difficulty in maintaining posture. Movements may be strong, but jerky and unco-ordinated. Such patients normally have a deep voice.

Pohl (1950:13) reports that about 8 per cent of cerebral palsied individuals are classified as atoxic. According to a table based on a study in New Jersey, Kirk (1962:356-358) says this figure is 10.8 per cent.

2.2.2.4 Rigidity

Literature reports that rigidity is a rare type of cerebral palsy, characterised by continuous muscle tension and stiffness, leading to clumsiness. Sometimes rigid behaviour is considered to be a symptom of mental retardation or neurological impairment. Pohl (1950:10-11) substantiates that generally all four limbs are affected, the simultaneous contractions of both the agonist and antagonist muscles prevents people with rigidity from making anything but very slow movements.

This is a most severe form of handicap. As the four limbs are affected, it is very hard for the patient to carry out any action. For example, it is hard for a patient to walk, write, eat, drink, etc. The patient always lies on the floor or bed due to the complicated condition. One such case was known to the present researcher. She was severely affected. She could not defend herself from any danger including reptiles. She was found twice with a snake inside her dress on her thighs. In this regard a patient cannot defend him/herself from any danger.

Pohl (1950:13) says that, only 4 per cent make up the rigidity
type of cerebral palseid patients. According to a table based on a study in New Jersey University, Kirk (1962:356-358) gives it at being 12.6 per cent.

2.2.2.5 Tremor

Cerebral palsy of the tremor type is characterised by involuntary vibrating movement, generally regular and rhythmical. Rhythmical movement is the main feature of this condition. The damage to the brain is in the basal ganglia (as in the case of athetosis).

Tremor differs from athetosis in the sense that the movements are rhythmical whereas with athetosis there is no pattern. This is the main difference between tremor and athetosis. One must clearly differentiate between the two phenomena.

Pohl (1950:12) says that tremor interferes with walking, standing, climbing stairs and making use of the hands. In this regard, it is also difficult for the patient to write. Most of the children suffering this tremor condition, employ typewriters for they are unable to write and for movement wheelchairs are mainly used. Emotional excitement aggravates the condition and increases the vibrating movement. In this condition, therapy consists mainly of relaxation exercises. There is a regular and rhythmical movement of the eyes. The speech is rhythmical and staccato too. The patient is like an old person.

Approximately 2 per cent according to Pohl (1950:13) make up this type. Kirk (1962:355-358) says it is 1.96 per cent.
2.2.2.6 Mixed type

Gearheart (1980:4) feels that the mixed form of cerebral palsy cannot be considered to be a separate form of cerebral palsy. Generally it is a mixture of athetosis and spasticity. According to Pohl (1950:13) only 1 per cent of cerebral palsy is of the mixed form and Kirk (1962:355-358) says it is 3.4 per cent.

2.2.3 The typographical classification of cerebral palsy

A typographical classification denotes the part of the body which has been affected due to brain injury. Cerebral palsy includes the following classification:

2.2.3.1 Monoplegia: One limb affected. It could be left or right arm or left or right leg.

2.2.3.2 Hemiplegia: When one side of the body is affected i.e. left side (arm and leg) or right side (arm and leg).

2.2.3.3 Triplegia: When three limbs are affected, it could be both legs and one arm, it usually takes place in spastic condition and polio case.

2.2.3.4 Paraplegia: Only both legs or both arms affected.

2.2.3.5 Quadriplegia: When all four limbs are affected. All four limbs are equally affected.

2.2.3.6 Diplegia: When all four limbs are affected, but two sides affected to a different degree.

2.2.3.7 Bilateral Hemiplegia: The whole child is affected, the upper limbs more severely than the lower limbs.

Gearheart (1980), Denhoff (1976) and also McDonald and Chance (1964:38) emphasized that hemiplegia is the most common, with monoplegia, triplegia and double hemiplegia quite uncom-
2.2.4 Occurrence and causes of cerebral palsy

It is vital to understand the occurrence and causes of cerebral palsy in order to erase people's illusions about the handicap. A crucial question to pose is, When does brain damage take place? It appears that it can take place during the following four stages:

2.2.4.1 Pre-natal stage (before birth)
2.2.4.2 Para-natal stage (during birth)
2.2.4.3 Neo-natal stage (immediately after birth)
2.2.4.4 Post-natal stage (any time after birth)

In answer to the question what the main causes/aetiology of cerebral palsy are, Pohl (1950:15) summarises the main causes of brain injury in the following list: heredity, malformation or maldevelopment of the brain, disease or injury of the mother, premature birth, deprivation of oxygen (anoxia), mechanical injury of the brain at birth, hemorrhage of the brain and blood incompatibility between mother and child (Rh-factor), infection of the foetus.

The occurrence and causes are further explained as follows:
2.2.4.1 Pre-natal (before birth)

The pre-natal stage is the first stage in which cerebral damage can take place. The causes/aetiology during this stage are as follows:

2.2.4.1.1 Anoxia
2.2.4.1.2 Irradiation
2.2.4.1.3 Smoking in pregnancy
2.2.4.1.4 Virus infection
2.2.4.1.5 Prematurity
2.2.4.1.6 Medication
2.2.4.1.7 Hemorrhage
2.2.4.1.8 Maldevelopment of the brain
2.2.4.1.9 Hereditary or genetic factors
2.2.4.1.10 Rh factor
2.2.4.1.11 Kernicterus

2.2.4.1.1 Anoxia

Anoxia means a lack of oxygen. It is one of the major causes of brain injury in the pre-natal stage. The placenta is very important at this stage. The amount of oxygen the foetus receives depends on the oxygen content of the blood of the mother. Pohl (1950) substantiates that if the placenta is underdeveloped, or hemorrhaged, or has any other abnormality, the free flow of blood from the mother can be decreased. This can be caused by the taking of drugs, and also by allergies and shock. Moreover, anoxia can also occur at birth. Anoxia is one of the most serious causes of cerebral palsy.
2.2.4.1.2 Irradiation

Keats, Russ and Soboloff (1958:33) have indicated that X-ray therapeutic irradiation of the lower abdominal area of the pregnant female, particularly in the first trimester of pregnancy may produce cerebral damage to the developing foetus. The first three months of pregnancy are the most dangerous stage in cerebral palsy development. Furthermore, it may happen that X-rays are taken of a woman when the doctor or the woman is not aware that she is pregnant. In some cases the pregnant woman is aware and the doctor is not aware. It is important that women in the community should be given guidance to enlighten them on causes of cerebral palsy. Sometimes X-ray could be taken during the first month of pregnancy, more especially when the mother is not sure of her pregnancy. McDonald and Chance (1964:21) emphasize and warn that over-exposure to X-ray which might occur on examination of the mother to determine the foetal position may result in damage to its brain tissue and cells. Few women are aware of this fact, especially in the Tsonga community. Some members of the community cannot read or write and are unable to take any advice or attain knowledge on the aetiology of cerebral palsy.

2.2.4.1.3 Smoking in pregnancy

According to Swann (1981) the smoking of cigarettes or tobacco results in a variety of potentially harmful chemicals getting into the serum of the smoker. These include carbon monoxide, thiocyanates and nicotine. In the case of the father, it will affect the sperm and in the case of the mother, the products will cross the placenta and affect the foetus. Smoking also causes miscarriage according to Swann (1981).
In contrast, there are only isolated suggestions that congenital malformation (congenital amputees) are associated with smoking in either parent e.g. these children are born without arm or arms, hand or hands, legs which develop up to the knee or ankle, and arm or arms which develop as far as the elbow. But the possibility is far from resolved according to Swann (1981).

2.2.4.1.4 Virus infection

During the pregnancy, the mother is often unaware that infection can be more dangerous to the foetus than to herself. D.E.T. (1975a:34) quotes Perlstein (1975) saying that the most dangerous infection is German measles (rubella). When a mother contracts this disease during the first trimester of pregnancy, the child is affected in approximately 10% of cases. The disease may also affect sight, hearing and the heart of the child. In other words, mothers should protect themselves, especially while they are pregnant, against getting German measles, in order to prevent giving birth to a handicapped child. Unfortunately, the Tsonga people are not aware of the dangers of viral infections.

2.2.4.1.5 Prematurity

Prematurity is when a baby is born before its time. The normal date of delivery is the ninth month of pregnancy. At this stage, the skull of the premature child is very thin and fragile, which is conducive to brain-injury. Thus, a child born prematurely is much more susceptible to any kind of injury. Pohl (1950:15) states that the blood vessels of the brain are under-developed in a premature child, which may cause rupture and hemorrhage. The premature children
are very weak and can be affected by any disease which can easily affect the brain. The premature child needs special attention.

Some people in the Tsonga community believe that the mother of a premature baby was bewitched and transformed during the night and had sexual intercourse with a gorilla, whose sperms disturbed the foetus and hence resulted in an early birth. Nevertheless, the child was kept in a clay vessel to keep it warm. The fat of a slaughtered pig was kept, to smear the child in order that it should grow fast and prevent some diseases from occurring.

According to D.E.T. (1975a:35) Illingworth states that 33 $\frac{1}{3}$ per cent of all cerebral palsied children are born prematurely. Moreover, the incidence of cerebral palsy is higher among premature infants than among those carried to full term. Cross (1957) reported that 7,6% of normal live births were prematurely born, as compared with 18,12 per cent of malformed live births.

2.2.4.1.6 Medication

Medication taken during the first three months (trimester) of pregnancy, in other words any medicine taken without the doctor's prescription during pregnancy, could damage the growing foetus. A child can be born without limbs. In the Tsonga community there are herbalists. A woman was given medicine by her mother-in-law, during the first trimester of pregnancy, and gave birth to a child without feet. The herbal medicine may damage some developing cells of the foetus. In some instances it causes brain damage and results in cerebral palsy.
2.2.4.1.7 Hemorrhage

Hemorrhage causes cerebral palsy, according to Keats (1961:16). Hemorrhage in the brain can be caused by protracted anoxia which damages the blood-vessels. This can seriously injure the cells of the brain. Hemorrhage of the foetal brain can also be caused by trauma (injury). The brain is divided into various parts and each has a special function. If hemorrhage/bursting of blood vessels takes place in the motor-area, it results in a motor dysfunction. If hemorrhage takes place in the visual area, it results in blindness and if the auditory part hemorrhages, it results in deafness.

2.2.4.1.8 Maldevelopment of the brain

Strauss and Kephart (D.E.T., 1975a:37) observed that, once maldevelopment of the brain occurs, it cannot be curbed. The major reason is that the deformed group of cells cannot function properly. Possibly an atrophy of certain brain-cell-areas may also occur in this situation, and this results in malfunctioning (McDonald and Chance, 1962:20).

2.2.4.1.9 Hereditary or genetic factors

Illingworth (1958) cites Philipp (1949) describing a family in which there were six cases of paraplegia; Woods (1956) finding that in twenty-six cases of paraplegia, four siblings and one cousin were affected; Yannet (1944) found that in the family of eighty-six patients with cerebral palsy (seventy-two were spastic and fourteen athetoid children), none of 260 siblings had cerebral palsy, but sixteen were mentally defective. Yannet (1949) also found that five of seven children with paraplegia, and two of sixty-five with quadra-
plegia had affected siblings or relatives. Pohl (1950) in his series of 144 cases of cerebral palsy described twins siblings with cerebral palsy. Fuldner (1955) found seven affected siblings or relatives in 204 cases of cerebral palsy. Wells and Shy (1957) described a syndrome of progressive familial athetosis with cutaneous telangiectasia. Eastman and De Leon (1955) found children with cerebral palsy presented a higher incidence of other congenital malformations such as extradigits and cleft palate than did the control. The high incidence of prematurity in cerebral palsy would partially explain these observations.

2.2.4.1.10 Rh Factor

The Rh incompatibility refers to incompatibility of the blood of the mother with that of the child-in-utero. Previously, it had been estimated that from five to ten per cent of cerebral palsy is caused by the incompatibility of the blood. According to Dr Landsteiner, every person belongs to one of the following four blood groups: 0, A, AB, or B. In addition the red blood cells carry Rh antigen.

In this regard, if a woman who is Rh negative carries a baby who is Rh positive, it can happen that anti-Rh positive antibodies develop in the mother's blood which have a destructive effect on the blood of the child. Therefore, these children are born with a dangerous condition called erythroblastosis. The child may recover fully, or develop cerebral palsy or be stillborn. The question is, which type of cerebral palsy? Incompatibility of blood causes athetoids. It is important to test the mother's blood to find out if she is Rh negative, and appropriate steps must be taken to avoid damage to the infant.
Kernicterus

In most cases kernicterus is caused by the incompatibility of the blood of the mother and the child. In this case a set of symptoms with poisonous cells occurs simultaneously. The areas of the damaged brain are yellow in colour. Kernicterus usually causes the malfunctioning of the cerebellum and the basal ganglia are affected. Therefore, this type of brain injury causes athetosis. In this situation, there is relationship between Rh factor and kernicterus. In other words, the treatments are the same.

Para-natal stage (during birth)

Causes/aetiology during the para-natal stage (during birth) are as follows:

2.2.4.2.1 Anoxia
2.2.4.2.2 Breech birth
2.2.4.2.3 Drugs
2.2.4.2.4 Too quick delivery
2.2.4.2.5 Delayed birth
2.2.4.2.6 Caesarean Section
2.2.4.2.7 Delivery instruments

2.2.4.2.1 Anoxia

At this stage (during birth), cerebral palsy may be caused by anoxia, this is through lack of oxygen being transported between the mother and the child. Anoxia can occur through disturbance of the child's respiratory system i.e. lungs. Furthermore, brain cells are especially sensitive to the movement of oxygen to the brain which is a crucial part in life. McDonald and Chance (1964), substantiate that
during the birth process the veins and sinuses on the surface of the brain are sometimes torn and cells in the cerebral cortex are damaged by the hemorrhaging.

2.2.4.2.2 Breech birth

At times a normal Vertex delivery (head first) does not occur. These buttocks-first deliveries are known as breech deliveries. Anoxia is fairly common in breech deliveries. The Tsonga women would say that a breech birth child will be a hooligan, and regard it as a taboo, even if the child is not physically handicapped. They strongly regard such a child as inferior. In the past, such children were killed. Today they are not allowed to enter a room where an ill person is. It is believed that a breeched birth person could cause the condition of the patient to deteriorate.

2.2.4.2.3 Drugs

Another cause of cerebral palsy at this stage (para-natal) can be drugs given to the mother when she is in labour.

McDonald and Chance (1964:22):

"the excessive use of medication to produce maternal anaesthesia or analgesia during labour can conceivably result in suppression of the infant's respiratory centre."

This is a hazardous journey, from the mother's womb to this world.

2.2.4.2.4 Too quick delivery

There are many crucial conditions which result in brain damage. If the delivery is very quick, there is little time for adaptations between the pressure in the uterus
and atmospheric pressure. At this stage blood can escape from cerebral blood vessels which can cause brain injury and result in handicaps. This exposition is contrasted with Tsonga illusions. It is believed by the Tsonga women that if the delivery is too quick, it reveals that the mother had sexual intercourse at a very early stage before her menstrual stage.

2.2.4.2.5 Delayed birth

Delayed birth causes brain damage. Keats (1970:20) states that,

"the duration of labour becomes an increasingly important factor in producing trauma with cerebral hemorrhage."

The Tsonga's belief is that the delayed birth is caused by the weakness of the mother, the right word for them is "laziness" or that she had always eaten cold porridge during pregnancy. Another reason they postulate is that somebody has made "a knot" for late delivery, so that the woman will die in the pangs of giving birth, that is why a pregnant woman will never tell people when she is giving birth. It is her secret which only the clinic or hospital, and her closest relatives know. Some even keep this from their mothers-in-law. According to them, this is done to avoid complications during delivery.

2.2.4.2.6 Caesarean Section

Caesarean Section may also present problems during this stage. The caesarean operation disturbs the circulatory system between the foetus and the mother. The Tsongas had a strong belief that a woman who went to the hospital for
delivery was a coward. In some rural areas they still hold this view, but today most of them give birth at the nearest clinics.

2.2.4.2.7 Delivery instruments

Another problem encountered at birth is the use of instruments in affecting delivery. This normally happens if the techniques used by the doctor were not so well-developed, but today the instruments used are well-developed (D.E.T., 1975, Psychological Medical aspects).

2.2.4.3 Neo-natal stage (immediately after birth)

McDonald and Chance (1964) highlight that the child's problems do not end with his delivery (para-natal stage). The child has to adjust to the marked differences between intra-uterine and atmospheric pressures. The period immediately following birth also has hazards.

"Anything which interferes with the establishment of the infant's respiratory function is a potential cause of cerebral palsy. Excessive use of medication to produce maternal anaesthesia or analgesia during labour can conceivably result in a suppression of the infant's respiratory centre. If plugs of mucus are present in the infant's respiratory tract, they obstruct the flow of air and prevent the lungs from expanding. If for any reason the child's breathing mechanism cannot provide an adequate supply of oxygen for his body tissues severe damage to brain tissue may occur" (McDonald and Chance, 1964:23).

These illuminate that problems do not end with delivery,
problems continue immediately after the birth of the child. Therefore, children must be thoroughly checked immediately after their birth. Anoxia is the most ominous danger threatening the new born baby.

2.2.4.4 Post-natal stage (Later/any time after birth)

It is crucial to highlight that brain damage can occur later to the child who was born normal, survived the hazards of birth, and ran the gauntlet of the neonatal period. The present study brings in and emphasizes the philosophy that "We don't know what the future holds for us." Thus, accidents can happen and dangerous diseases occur.

Causes/aetiology during this stage (Post-natal) are as follows:

2.2.4.4.1 Accidents or traumatic injuries
2.2.4.4.2 Infections and high-fever conditions
2.2.4.4.3 Toxic factors
2.2.4.4.4 Vascular accidents
2.2.4.4.5 Cerebral Anoxia
2.2.4.4.6 Brain tumors
2.2.4.4.7 Games

2.2.4.4.1 Accidents or traumatic injuries

This is accidental traumatic lesion of the brain due to head wounds and skull fracture. These can occur during automobile accidents and contact sports. Many people become cerebrally palsied through motor accidents, where brain hemorrhage caused the damage. These injuries can also result from blows to the head or a fall from a tree or a fall from a great height. These can result in death.
2.2.4.4.2 Infections and high-fever conditions

Cerebral infections are quite common in children. The following occur: Encephalitis and meningitis and brain abscess are frequent causes of cerebral palsy. Encephalitis is inflammation of different parts of the brain and meningitis is inflammation of the meninges i.e. the membranes in the brain that separate its different parts. Furthermore, meningitis causes not only cerebral palsy, but also blindness and deafness. This is a dangerous infection. High-fever conditions cause cerebral palsy. Many black people, including the Tsonga community, are not aware of these conditions and some blame witchcraft.

2.2.4.4.3 Toxic factors

Russ and Soboloff (1958), state that toxic causes are very common. In this condition, any substance digested, inhaled or injected into the infant which is toxic can cause changes in the brain. These must be included among the causative factors of cerebral palsy.

2.2.4.4.4 Vascular accidents

These conditions cause cerebral palsy and are seen more frequently in adults than in children. In children the so-called "stroke" may occur in those cases of congenital aneurysm of the brain.

2.2.4.4.5 Cerebral anoxia

This is caused by insufficient oxygenation of the brain due to carbon monoxide poisoning, and high altitude anoxia are causes of cerebral palsy in the post-natal period.
2.2.4.4.6 Brain tumors

At this stage, brain tumors are not common in children. In reality, it is not the tumour that causes the damage to the brain. It is the effect on the brain. Now, the question is how the effect takes place during operation. If part of the brain is touched during operation, it could cause cerebral palsy. Therefore, the residual sequelae of the surgical interdention and the tumor may produce the syndrome known as cerebral palsy.

2.2.4.4.7 Games

Games like boxing, rugby or soccer can cause brain damage and cripple the participant who is injured.

2.3 ORTHOPAEDIC HANDICAP

2.3.1 What is meant by an orthopaedic handicap/crippleness/lameness

"The expression "physically handicapped children" in Schedule 1 to the Educational Services Act, 1967 (Act 41 of 1967), as amended, means children with chronically disturbed function or chronic abnormalities (congenital or acquired) of any of the following systems of the body" (D.E.T., 1975a:114).

This condition (orthopaedic handicap) differs from cerebral palsy. Part of the brain is not damaged. Brain-injury is the main feature in differentiation of the two phenomena. In orthopaedic handicap, there is nothing wrong with the brain but the body is physically deformed. Furthermore,
the crucial fact is that the orthopaedically handicapped children usually are normal mentally. Most of them are very good in a learning situation with a very high IQ.

2.3.2 Types of orthopaedic handicaps

2.3.2.1 Poliomyelitis
2.3.2.2 Dwarfism
2.3.2.3 Tuberculosis of the spine
2.3.2.4 Amputation of a limb or limbs
2.3.2.5 Spina bifida
2.3.2.6 Muscular dystrophy
2.3.2.7 Scoliosis
2.3.2.8 Osteogenesis
2.3.2.9 Rachitis (Rickets or osteomalacia) and kwashiorkor
2.3.2.10 Congenital deformities viz clubfoot, congenital amputees, extra digits and congenital dislocation of the hip.

2.3.2.1 Poliomyelitis

Poliomyelitis is an infectious disease epidemic and endemic throughout the world. It is caused by one of three types of ultra-microscopic virus i.e. Brunhilde (type 1), Lansing (type 2) and Leon (type 3). It is transmitted by droplet infection and by oral ingestion, the latter probably being the more important mode of transmission in developing countries. The incubation period varies from three to thirty days, while seven to fourteen days is the most common interval between infection and the clinical illness. The paralysis is made worse by injections or exercise in the prodromal phase, any or all of the limbs and trunk may be affected. The respiratory or swallowing muscles may also be affected,
and may require urgent treatment to save the patient's life, e.g. where the trunk and four limbs were paralysed the limbs may recover while the trunk remains partially or totally paralyzed (Huckstep, 1982:119-165).

FIGURE 2.3: A CASE OF POLIOMYELITIS

2.3.2.2 Dwarfism

Dwarfism means a very small person, especially one afflicted with dwarfism.
2.3.2.3 Tuberculosis of the spine

This disease is the most important cause of pressure on the spinal cord. When any part of the spinal cord is subjected to external pressure, the tissues of the spinal cord and thus the nerves will be destroyed. The nerves and muscles below the point of pressure, will be paralysed. When the pressure point is in the lower part of the spinal cord, the legs will be paralysed (paraplegia).
2.3.2.4 Amputation of a limb or limbs

Accidents could lead to limb amputation. Cancer could also lead to amputation in order to save the person's life. Infection could result in loss of a limb if gangrene sets in.

FIGURE 2.6: A CASE OF THE AMPUTATION OF A LIMB
2.3.2.5 Spina bifida

Spina bifida means an opening in the spinal column. It is a birth defect. It is a chronic condition characterized by defective closure of the bone encasement (spinal column). This defect normally occurs during the first two months of pregnancy and the split or opening can be situated anywhere along the spinal column, even along the neck or skull. There are three forms of spina bifida, viz.

1. Spina bifida occulta (occulta = hidden or concealed)
2. Meningocele
3. Meningomyelocele

1. Spina bifida occulta: Occulta means hidden or concealed. It is a condition with an opening in the spinal column without any protrusion of the spinal cord or meninges. The cord may be normal or only slightly abnormal, and it may be duplicated and it may have an enlarged central channel. In this condition, the skin of the back may be normal over the opening, or there may be a depression. A fatty tumour, or a bunch of hair, or a maldevelopment of a blood vessel may be present (D.E.T. 1975:10, Physiological Medical Aspects).

2. Meningocele: In this condition a protrusion of the spinal membrane in the form of a sac or blister is found. The spinal cord lies safely in the column.

3. Meningomyelocele: This is a most severe form of spina bifida. The protrusion contains not only the dura and nerve roots but also the whole spinal cord. If the sac is well-covered with skin and the child has no motor sensory or sphincter (it is the muscle that closes bowel opening or anus) abnormality, it is diagnosed as a meningo-
In this condition, the sac is removed by the doctor, and in most cases it is usually done during the first year after birth. In other words, meningomyelecele is a bluish sac with uneven depressions and very often with an open sore over the visible nerve. This is terrible! In this way, if the defect is high up in the lumbar region of the spinal column, the movement of the lower part of the trunk and legs is expected to be impaired and the sphincter-control will be abnormal. When the defect is lower down, we probably find both paralysis and loss of sphincter control (D.E.T., 1975a: 101). Further, the condition of some of these children is so severe that there are doctors who feel that nothing should be done to prolong their lives.

Another problem, children may not have any feeling in the lower limbs. In this regard, the child may suffer severe burns in hot water or fire without feeling any pain. This is the most severe form of spina bifida, where the patient has no control over excretory functions and has to be nursed for his whole life. An aggravating aspect is the smell produced, and such children are always lonely, more especially at the adolescent stage.

FIGURE 2.7: A CASE OF SPINA BIFIDA

![Figure 2.7: A Case of Spina Bifida](image)
2.3.2.6 Muscular dystrophy

Muscular dystrophy is a progressive illness attacking the voluntary muscles of arms and legs. The muscles may seem healthy to some people without experience in this special field. The muscles become weaker and weaker and if they are not exercised they deteriorate rapidly. This condition leads a patient to be wheel-chair bound. In this regard it is crucial to keep children with muscular dystrophy as active as possible.

Normally, such children are of normal intelligence. The child seems healthy but the muscles weaken. The small muscles of the fingers are usually the last to be affected and deterioration happens symmetrically on both sides of the body. Literature says that the cause is unknown, but it seems as if a hereditary factor may be involved. Furthermore, literature postulates that boys are affected five to six times more frequently than girls.

2.3.2.7 Scoliosis

This is another type of defect. It has been discussed that tuberculosis of the bone may result in a deformed spine. Another cause of scoliosis is poliomyelitis. There are many children with poliomyelitis but no scoliosis. In this condition, if there is paralysis of the muscles on the one side of the spine, the muscle-tone or tension of the muscles on the other side results in the spine being pulled sideways. The sitting position is too difficult for the patient. Many children with scoliosis are wheel-chair bound.
2.3.2.8 Richitis and kwashiorkor

The two conditions are grouped together because both are connected with what is eaten, and a balanced diet is needed in the body. Richitis (rickets or osteomalacia) is a disease found among underfed children. The first sign of richitis is seen at the age of one or two years where the child is adept at walking or toddling, during the crawling stage it is not clear. In this condition, the child is expected to have a retarded growth, thickened epiphyses, mostly at
the wrist, deformed head, long bones, spine and ribs. The child is always prone to fractures. They are prone to other diseases such as bronchitis and early childhood illnesses.

Kwashiorkor is a condition of malnutrition and has more or less the same results as rachitis. It is only cured by a balanced diet.

2.3.2.9 Osteogenesis

The patient looks like a dwarf. Osteogenesis is an inherited condition of imperfect bone formation. In this condition, the bones are abnormally brittle and subject to fracture. Therefore, such children have a weakly developed structure. They are normally short, the face is thin and long with big eyes. These are the main features of this condition, which is characterized by fragile bones.

FIGURE 2.9: A CASE OF OSTEOGENESIS

![Figure 2.9: A CASE OF OSTEOGENESIS](CARTILAGE BONE (GLASS-BONE))
2.3.2.10 Congenital conditions (birth defects)

The following are examples of congenital conditions (birth defects) viz.: clubfoot; congenital amputees; extra digits and congenital dislocation of the hip.

Clubfoot: According to Fishbein (1975) the term "talipes" is used for all deformities of the feet. The term is used to depict a condition where the foot is turned. The foot may turn inward (talipes varus) or outward (talipes valgus) or it may be in a position in which a child will walk on his toes (talipes equinus). The child walks like a horse because a horse walks on one toe. Sometimes the toes may be turned up in such a way that the child is forced to walk on his heel (talipes calcaneus). Therefore, any combination of these deformities may occur but 75% of all clubfeet according to Fishbein are turned inward and on the toes (talipes equinovarus).

FIGURE 2.10: CASES OF CLUBFOOT

LEFT AND RIGHT FOOT WITH CONGENITAL TALIPES EQUINOVARUS
Congenital amputees: This is a mysterious condition. The children are born without one or both arms or legs or with an arm or arms that have developed only as far as the elbow or palms of the hands, or with leg or legs that developed only as far as the knees or at the lower part of the limb, or with a foot, or hand or hands without toes or fingers.
Extra digits: The child is born with extra fingers and toes. It can easily be rectified by doctors through operation. The removal of the extra digit can be done immediately after birth but it is advisable to wait until the digits are large in size. The most crucial fact is that surgery must not be delayed.
 Congenital dislocation of the hip: The main features of this condition are a shortened leg, a tilted pelvis, atrophy, depression of the buttock and the characteristic limp. The abnormalities can be the result of developmental defect that the hip socket is too shallow with the result that the hip dislocates during, or soon after birth. What is the cause then? If the child is wrongly positioned in the uterus, a maldeveloped hip may result. It is necessary for the condition to be corrected as soon as possible.

2.3.3 Occurrence and causes

Orthopaedically handicapped/lame individuals differ from cerebral palsied individuals. There are three stages in which orthopaedic handicap takes place. They are as follows:
2.3.3.1 Pre-natal stage (before birth)

This is a first stage (before birth) in which crippleness can take place. What are the causes? The following aspects are the causes of crippleness:

2.3.3.1.1 Hereditary factors
2.3.3.1.2 Drugs
2.3.3.1.3 Position of the child in the uterus
2.3.3.1.4 X-ray
2.3.3.1.5 Unknown causes

2.3.3.2 Para-natal stage (during birth)

Here, crippling does not take place as it does in cerebral palsy. Congenital dislocation of the hip is caused by the difficulties of the mother during delivery. It is sometimes difficult for the child to make its way out. Dislocation of the hip is the main example at the para-natal stage.

2.3.3.3 Post-natal stage (after birth)

One cannot predict what the future holds for us in terms of physical disabilities. At this stage, the following aspects can take place:

2.3.3.3.1 Virus infection: Poliomyelitis.
2.3.3.3.2 Accidents with vehicles

Every day there are accidents with vehicles on the road. It is a centre of death, crippling, blindness and deafness. The accidents verify the philosophy that "We don't know what the future holds for us!" Nobody knows what will happen during the forthcoming seconds, minutes, days, weeks, months and years. There is a terrible and horrible slaughter on the roads, which leads to death and maiming. Nunan (1983:2) says: "Frightening figures released by the department of statistics show that over 10 000 people are seriously injured in road accidents each year. They are all left with permanent disabilities and they swell the ranks of our handicapped population whose needs in today's world continue to expand and increase essential needs such as residential care, special schooling, ongoing medical treatment and post-school employment."

2.3.3.3.3 Accidents with firearms

Firearms (rifles, revolvers, etc.) are very dangerous if they are not kept safe in the family. Therefore, to avoid accidents, they must always be kept out of reach of children. Adults should avoid threatening each other with firearms.

2.3.3.3.4 Falls

Falling can be dangerous, and lead to trauma. Falling may result in death and in severe cases the spinal cord may be injured and handicaps or paralysis may occur depending on the position of the fall.
2.3.3.3.5 Fire

Fires can be dangerous if uncontrolled. Burns can cause permanent disablement. There are many children who have lost some of their limbs through burns, not only the limbs, but also their sexual parts.

2.3.3.3.6 Stoves

Children can be badly crippled or disfigured if they play near an unsupervised stove and pull over a pot of boiling water or food like porridge.

2.3.3.3.7 Games

For the physical health, games are important, but games like soccer, boxing, rugby, basket ball or netball can lead to serious injuries and paralysis.

2.3.3.3.8 Anger

Parents and teachers should control anger. Anger urges the teacher or parent to employ corporal punishment. There are children who became crippled through severe beating. The head is part of the body which should be strictly respected. In our Institution we have children victimised by their fathers who became cripples.

2.3.3.3.9 Fighting

Fighting or violence in the family or in the community or anywhere can cause serious injury, especially if weapons are used (sticks, knives, firearms, etc.). We have an inmate
at the Institution whose husband beat her with an 'umbrella'. She has spastic hemiplegia on the left side. This was a result of fighting.

Incidence of crippling, according to Weinberg (1960), in the United States, it has recently been estimated that 1.5 per cent of over 850,000 children under the age of twenty-one years, and approximately 4 per cent or 4½ million adults are orthopaedically handicapped.

The number of cripples in South Africa has been estimated as 80,000 in a population of over 13 million. This is only an arbitrary figure but does indicate, to some degree, the extent of this problem (Weinberg, 1960).

In conclusion, one phenomenon stressed by European, American and South African authorities i.e. Humphrey; Dybwad & Grobler respectively, is the fact that physical handicaps are more acceptable than the cerebral palsied patients (Weinberg, 1960).

2.4 SYNTHESIS

In this chapter cerebral palsy and orthopaedic handicaps were defined and the occurrence and medical causes of these conditions were discussed. The next chapter is devoted to the attitudes of the Tsonga community towards these phenomena and where and when they occur according to the Tsonga beliefs.
CHAPTER 3

TRADITIONAL ATTITUDES OF THE TSONGA COMMUNITY TOWARDS CEREBRAL PALSIED AND ORTHOPAEDICALLY HANDICAPPED CHILDREN

3.1 INTRODUCTION

This chapter is an effort to reflect on the attitudes that have traditionally prevailed among the Tsonga people as a community towards cerebral palsied and orthopaedically handicapped children. It begins by defining certain key concepts which constitute the heart and nucleus of this dissertation. Furthermore, it elucidates the cultural background and the historical attitude of the Tsonga community towards physically handicapped children, generalising it to a broader perspective, for example, by also referring to the cultures of other indigenous communities, such as the Sothos, Zulus, Xhosas and Vendas. It also examines the customs of earlier European cultures, such as the ancient Greeks, Romans and Hebrews. The main thrust of the chapter is based on religious aspects and customs, crises, values, norms and beliefs among the traditional Tsonga people.

3.2 ELUCIDATION OF TERMS

Two key concepts that need classification are: attitude and community. It is also necessary to give more information on the Tsonga people.

3.2.1 What is an attitude?

The pronouncements of a number of authorities can throw light on what an attitude is. Morris (1973:85) defines an attitude as a state of mind or feelings with regard to
some matter. It is an indication of a mood or condition, or manner of carrying oneself.

Warren (1934:24) regards attitude as
"a set, or readiness to respond in a definite way to social stimuli of a general or specific character".

Gouws, Louw, Meyer and Plug (1979:124) state that an attitude is
"n Relatief stabiele en blywende aangeleerde geneigdheid om op 'n bepaalde wyse teenoor sekere persone, voorwerpe, instellings of sake op te tree of te reageer. Dit dui verder op 'n voortdurende psigiese en/of neurale toestand van gereedheid om op sekere voorwerpe of klasse voorwerpe op 'n positiewe of negatiewe wyse te reageer. Houdings impliseer 'n neiging om te klassifiseer en te kategoriseer en bevat gevolglik kognitiewe, affektiewe en gedragskomponente."

Chaplin (1968:44) considers an attitude as
"a relatively stable and enduring predisposition to behave or react in a certain way toward persons, objects, institutions, or issues. Looked at from a slightly different point of view, attitudes are tendencies to respond to people, institutions or events either positively or negatively. Attitudes typically imply a tendency to classify or categorize. Thus one with a favourable attitude toward the Democratic Party is likely to react favourably to all Democrats, disregarding their unique characteristics as individuals. Similarly, if the individual holds the attitude that "All Jews are aggressive" he will respond to Jewish people as if they were aggressive, whether or not they are in fact aggressive."
The sources of attitudes are cultural, familial, and personal. That is, we tend to assume the attitudes which prevail in the culture in which we grew up. A large segment of these are passed on from generation to generation within the family structure. But some of our attitudes are also developed as adults on the basis of our own experience. Social psychologists believe that important sources of adult attitudes are propaganda and suggestion from authority, business, educational institutions, and other agencies which seek to influence conduct."

From these definitions it would appear that the following aspects regarding attitudes are important to the present study:

- it is a state of mind of feelings regarding a certain matter (in this case the children suffering from cerebral palsy and orthopaedical handicaps)

- it indicates a readiness to respond in a definite way (either positive or negative)

- it is relatively stable and enduring (attitudes toward cerebral palsied or orthopaedically handicapped children will therefore not change easily)

- it is acquired or learned, often passed on from generation to generation within a family, community structure or cultural milieu in which a person grows up, but it may also be developed on the basis of a person's own experience

- it is seldom "neutral", but rather reveals the tendency
to react either positively or negatively towards the object (in this case cerebral palsied or orthopaedically handicapped children)

it shows the inclination to classify or categorise (in other words, seeing "all cerebral palsied or orthopaedically handicapped children as" such or such).

3.2.2 What is a community?

Morris (1973:270) defines a community as a group of people living in the same government. Whilst in the Encyclopaedia Britannica Micropaedia III (1973–1974:47) community is defined as "a group of people with common characteristics and interests living together in a certain environment and affecting one another in various ways."

Warren (1934:52) defines community as

"a group of individuals of the same species living in close proximity."

Gouws, Louw, Meyer and Plug (1979:99) state that a community is

"n groep persone wat dieselfde belange of doelstellings het."

Fowler and Fowler (1982:190) on the other hand see it as an

"organized political, municipal, or social body; body of people living in same locality; body of people having religion, profession, etc., in common; ... body of nations unified by common interests."
In addition to the common use of the word "community" in a more geographical sense, Swel (1982), according to Jaff (1988:13) also refers to
"Communities stressing areas of common life";
the distinguishing features here being the actual absence of any geographical boundaries; the emphasis being rather on commonality (e.g. religious or cultural affiliation).

According to Soma (1978:5) Ross also distinguishes between a "geographical community", that is people living within a specific geographic area and a "functional community", referring to a group of people who share some common interest in function, such as welfare.

In this dissertation, the writer has taken the Tsonga Community to be a geographic as well as a functional/commonal community, in the sense that (1) they live within the definite boundaries of the Gazankulu Government and (2) they share a common history, a common culture, common interests, common beliefs and a common way of life. Vygotskii (1982: 68), the psychologist and one of the cultural architects in cognitive theory, postulates that the differences in our history are a source of the differences in our cultures. People are what they are today as a result of their culture and their history. Buck-Morss (1980:103) supports the implications of Vygotskian thinking for genetic epistemology.

3.2.3 Who are Tsonga?

The Shangaan/Tsonga are a people of mixed extraction who originated when Soshangana, a Zulu chieftain, who fled before Shaka, subjected and inducted various Tsonga tribes of Mozam-
Some of these tribes later migrated to the Eastern Transvaal and currently live mainly in Gazankulu. The name Shangaan is often used for the whole group, although various Tsonga, especially those who were not subjected by Soshangana, object to it. The whole group, however, speaks Tsonga. There are at present about a million Shangaan/Tsonga people living in South Africa and more or less 2 million in total, including those who live in Mozambique and Southern Zambesia (Wêreldsprektrum, 1982:98).

The traditional occupation of the Shangaan/Tsonga is stock-raising, agriculture, hunting and fishing. It is verified by the Wêreldsprektrum (1982:99) that

"Shangaan/Tsonga beoefen tradisioneel 'n groter verskeidenheid van ekonomiese bedrywighede as die meeste ander swart volke, naamlik akkerbou, veeteelt, jag en visvang."

The social organization consists of clans or kinships with a common forefather and the relationships are assigned mainly according to their patrilineal descent.

In the olden days, the different Tsonga tribes were ruled by independent chiefs, but after the subjection by Soshangana a centralized authority system with a paramount chief was introduced.

The traditional religion is based mainly on the worship of the forefathers. Witch doctors and witchcraft also play an important role in the traditional life-style. The Shangaan/Tsonga have a fine feeling for arts and crafts, and in modern times the men have become especially known as a result of their tribal dances at the mines (Wêreldsprektrum, 1982:98).
This study has taken place among the Tsonga people under the Gazankulu Government, one of the self-governing homelands in South Africa. The Gazankulu Government is divided into four districts namely, Ritavi; Mhala; Malamulele and Giyani. The research specifically took place in the Ritavi district where a school for the handicapped has been established. This is the only school of its kind in Gazankulu.
"In France, history records that Francis I (1494-1547) had a woman of Aveyron put to death because she had given birth to a deformed or crippled child."

This thought-provoking quotation by the Department of Education and Training (1975b:16) paints a grim picture of what a handicapped person was often treated like in early history.

The quotation reveals how a particular culture had its own ways of dealing with handicapped children (i.e. destroying and maltreating them). The exposition of the attitudes of the different cultures in the past will help to verify the fact that the disabled were very often not accepted. Such an expose (albeit brief) can serve as a norm against which the attitude of the Tsonga can be compared and understood. The three ancient cultures that come up for discussion are the ancient Greeks, the ancient Romans and the ancient Hebrews.

3.3.1 The attitude of the ancient Greeks towards handicapped children.

Historically speaking, much of what is known as formal education in the modern Western world, originated in and emanated from Greece. According to often quoted history, the Greeks (αν Ελληνες) had a highly-developed culture and assumed a more humane attitude towards the disabled than most of their neighbours. However, in contradiction to this, according to the Department of Education and Training (1975b:3) quoting Rowell and Frampton, the ancient Spartans destroyed...
their disabled children in a cruel way, leaving them to
die in the deep clefts or ravines in the Taygetus Mountains.
Sometimes such children were simply left beside the roads
or in a wood, or they were drowned in a lake or a river.

The Greeks (very rightly) admired "a healthy mind in a healthy
body". It is, however, unrealistic to expect that all people
or members of a society should be healthy. A disabled child
is a human being none the less, and also a living, feeling
creature. He is not merely an object. In this respect,
it is still difficult to understand why the disabled were
so cruelly cast out by the Greeks, who were otherwise so
highly developed culturally, educationally and morally,
and from whom so much of the modern Western world emanated.

3.3.2 The attitude of the ancient Romans towards handicapped
children.

The Romans also had their own way of destroying and treating
handicapped children. According to the Roman Law of Twelve
Tables, the head of the family was allowed to decide the
fate of his handicapped child. According to them, the serious-
ness of the defect was taken into consideration. Frampton
and Rowell (1955:12) state that, if the handicaps did not
severely affect the person's ability to work and move about
freely, he was allowed to live. If the handicap was of
a serious nature, he was destroyed, because the attitude
was that he would be a burden to others. The custom of
destroying disabled children was discontinued when they
became more enlightened. People with deformities were subse-
quently often used for entertainment at the courts of kings.
Dwarfs were often sold as slaves (Frampton and Rowell,1955:12).
3.3.3 The attitude of the ancient Hebrews towards handicapped children.

The Hebrews had a different attitude towards handicapped children from the Romans and Greeks. People differ and cultures are different. According to literature, the Hebrew laws presented a sharp contrast to the cruel practices of the Greeks and Romans. Frampton and Rowell (1955:13) state that the Hebrew Law contained specific instructions that the disabled were not to be destroyed, for example, the Bible (II Samuel 19:30) relates that although the son of Jonathan, Mephiboseth was lame on his feet, he was honoured by King David and he did eat continually at the king's table.

From this it is obvious that a handicapped person was valued differently in Israel. In contrast to the Romans who used a handicapped person for entertainment at the courts of kings, in Israel Mephisboseth, who was lame, was honoured by King David and ate continually at the king's table.

Frampton and Rowell (1955:13) report that, although the Hebrews did not cast off or kill the disabled, they often also regarded them as inferior.

The question that could be posed in the light of the brief exposition is whether the handicapped were earnestly loved, understood and accepted by the different cultures and communities. According to the above attitudes, it appears that in the majority of cases the communities mentioned had "no room" for loving, understanding and accepting these unfortunate children. In this regard, proper guidance and counselling could have limited or even precluded the cruel treatment of these handicapped children. These cultures undoubtedly lost great potential or "treasure" in plagueing or even
ending the lives of the handicapped, the "treasure" being the gifts that the handicapped children undoubtedly could have had (albeit undiscovered) and the contributions they could have made.

This historical overview of attitudes towards the handicapped challenges any new generation to improve on the previous attitudes.

3.4 TRADITIONAL TSONGA LIFE, CUSTOMS AND BELIEFS.

Before the attitudes of the traditional Tsonga people can be understood, it seems to make sense first to give a brief background of how they lived and still live, what their customs were and are, and what they believed then and now. In this account the present writer relies very strongly on her own observations and on what has been told her by the older people.

3.4.1 How the Tsonga people live(d)

The Tsonga economy is self-sufficient, in other words it is an economy which has no external market factor of note. The family is basically self-sufficient in satisfying its needs. The economic system is individualistic, but it was not individualistic before. There was unity amongst the Tsonga. It is a great joy and good opportunity for men and women to work their lands, even at a relatively old age. They enjoy watching the growth of the crops. But the individual who is successful in his economy is not necessarily always happy, because of the danger of being suspected of having killed or bewitched other people to help him (especially during some nightly activities).
The economy among the Tsonga people is varied, consisting of agriculture, pastoralism (stock-breeding), hunting, fishing and gathering.

3.4.1.1 Agriculture

With their subsistence economy in agriculture the Tsonga people depend very heavily on nature, especially on rain. There are, however, no rain-making rites that are performed among the Tsonga (as with the Modjadji of the Pedi people).

Both men and women share in the agricultural activities. The men usually clear the new fields, but the breaking of soil is done by both men and women. Today, however, women can also be seen clearing new fields, sometimes assisted by men. Changes are rapidly taking place. There are for example, women nowadays within the Tsonga community, who even earn a living in the building and construction industry.

Be that as it may, the introduction of the plough in agriculture is mostly still done by the men. The rest of the agricultural activities are all primarily done by women. In the Tsonga culture women are the main providers of food. Each married woman is entitled to her own land (masimu).

The women grow crops that can be stored for later use. Traditionally, the oldest and most important crop was sorghum (nwahuva), but maize (mavele) has gradually become very popular (even more popular than sorghum). The reason is that maize needs no protection against birds. This popularity is also supported by Junod (1962:9) that "Their king is the maize", "This cereal is indeed the most widely cultivated in Tsongaland". The Tsonga cultivate a variety of pumpkins.
(makwembe). They also plant water-melons (makhalavatla), gourds (marhanga) and ladles (mariwa). As far as legumes are concerned, the Tsonga people love growing njugo beans (tindluwa) and cow-peas (tinyawa). Peanuts (timanga) are also becoming an increasingly important crop. The Tsonga also plant sugar cane (mimova).

All crops mentioned are grown on the women's land and are harvested for the use of the whole household. For the tilling and weeding of the crops they have a system called "tsimu", where people are invited to help in the fields. In the preparation of "tsimu", a goat is slaughtered, chickens' heads and feet are prepared as well as porridge and beer (if possible) for the people to eat and drink. All the helpers arrive between five and six o'clock in the morning. The whole family and the helpers go to the field. After they have finished tilling and hoeing, they all enjoy what has been prepared to eat. This "tsimu" method is also applied at harvest time to bring in the crops.

There are certain taboos which regulate the entering into the field, for example (agricultural taboos):

- during her menstruation period a woman is not allowed to enter because she is "hot" and "unholy";
- if a woman has been involved in sexual intercourse the previous day, she is also regarded as "unholy" and "hot";
- in all agricultural activities, eating of the first fruits of any ripe product is prohibited, therefore it should be taken to the sacred place to be given to the ancestors. Very little is, however, given to the ancestors, e.g. 3 cobs of mealies.

There are some additional taboos given by Junod (1962:28-
- Girls are not allowed to walk amongst the pumpkins to pluck their fruit or to pick their leaves without certain precautions.
- Sometimes no one is allowed to till the soil.
- To cut roots while they are still "soft" is taboo, it would cause strong winds and hail.
- It is forbidden to whistle in the fields after having sown or until the mealies are grown. This would call the "baloyi" and endanger the harvest.
- The women must not cross other peoples' gardens. If however she does this, they will call her on the day they begin to sow, and she will have to sow the first seed; thus she will prevent all the seeds from "burning".
- Culturally, it was formerly considered a taboo to plant foreign kinds, such as bananas, oranges, etc. They were regarded as inviting misfortune on yourself (tihlolela).

In contrast to the women with their longer-lasting crops, men usually cultivated in their gardens (ntanga) only those crops and vegetables which could be used fresh and directly from the garden, such as cabbages, pumpkins, water-melons, fresh maize, sugar cane, spinach, bananas, mangoes and tobacco.

The agricultural year ends with the harvest. Everyone harvests his own fields and keeps, as far as possible, his product separately in his own house (xitlati).

3.4.1.2 Stock-breeding

The Tsonga people are agriculturalists as well as pastoralists. "Cattle are the Black man's bank" (Van der. Waal, n.d.:38). Their herds of livestock, including cattle (tihomu), goats
(timbuti) and donkeys (tidonki), are an indication of their wealth and have social value. These herded animals, however, often have even more religious value because these are used as offerings and sacrifices during ancestral worship. This applies especially to the goats. Sheep (tinyimpfu) are not as common as goats.

3.4.1.3 Gathering

The products obtained through gathering are of great importance among the Tsonga people. Such products include edible wild fruits and medicine. The problem, however, is that most of these gathered food stuffs cannot be preserved for long, but there are certain fruits and insects which can be preserved for some time, such as locusts (tinjhiya), mopani worms (matomana) and termites (manjhenjhe). These are often used as garnish to eat together with porridge (Van der Waal, n.d.:20). Gathering is largely an activity of women and children (boys and girls). Gathering is the daily activity of women. Sometimes women spend a whole day in gathering. Herdboys are always gathering wherever they are while herding.

3.4.1.4 Hunting

Although hunting was undoubtedly more developed in remote times than now (Junod,1962:52), there is still some hunting activity among the men and even the boys. Bows and arrows are used for bird hunting and assegais for game. Boys learn to hunt while herding the cattle and small stock.
3.4.1.5 Fishing

"Laasgenoemde is 'n seldsame verskynsel onder die swart volke van Suider-Afrika, die Zoeloes het trouens neerhalend na die Tsongas verwys as "viseters". Vis word met behulp van 'n hoek en lyn, fuike of gevlegte mandjies in die riviere gevang" (Wereldspektrum 1982:99).

The Tsongas call these baskets "mitavani". The Sothos also say that they don't eat a "snake" fish as the Tsonga people do, when eating fish. Boys learn fishing while herding goats and cattle. Even girls try fishing, while they are gathering food, e.g. locust, mopani, wild fruit and vegetables.

3.4.1.6 Wage earning

Many Tsonga people are employed as migrant labourers outside Gazankulu where they work for wages, that they call "mali yo rindzo muti" (money to support the home) or "mali ya mukhuhlwani" (flu money) (Van der Waal, n.d:11). This already started around the 1840's, when they were employed in mines at Kimberly and on the Witwatersrand. Presently they are employed all over South Africa. Nowadays women are quite often employed by the building constructers together with men.
3.4.1.7 The typical Tsonga kraal

An important feature of this dissertation is to point out the whole true picture of the Tsonga people:
LAYOUT OF THE KRAAL:

A. Boys' hut
B. Hut of 2nd wife
C. Girls' hut
D. Hut of head wife
E. Hut of 3rd wife
F. Hut of 4th wife
G. Hut of 5th wife
H. Hut of 6th wife
I. Hut of 7th wife
J. Hut of 8th wife
K. Hut of kraal head
L. Cooking hut
M. Grain and cooking hut
N. Sacrificial hut
O. Goat hut
P. Storage hut
Q. Chicken-pen
R. Granary
S. Cattle kraal
T. Cooking screen
Ua. Ceremonial tree and place of sacrifice
Ub. Grave and place of sacrifice
Uc. Fire place and place of sacrifice, "Xitiko"
V. Men's meeting place
W. Main entrance
X. Sub-exit
Xa. Exit to saltworks
Xb. Exit to ironsmelting
Y. Inner court
Z. Rubbish dumps
3.4.2 Family life amongst the Tsonga

The family has always played (and still plays) an important role in the transmission of customs, beliefs, traditions (and hence also attitudes) of the Tsonga people.

3.4.2.1 Family structure

One of the main features of the family is the transmission of culture from generation to generation. By culture is meant that complex whole which includes knowledge, beliefs, art, morals, law, customs and any other capabilities acquired by man as a member of society. Each individual person is born into a complex culture that will strongly influence how he will live and behave for the rest of his life. Culture can be referred to as a product of human thought.

The Tsonga family structure consists of a father, a mother (mothers) and their children. In most cases the grandparents also have a role to play.

3.4.2.2 The role of the father

The father is the head of the family. He keeps order in the family. Even if the family is a big polygamous family, he controls the whole family. He has every right to discipline his family and give orders according to his will. He has many tasks to fulfil. His responsibilities include the following:

* He fixes the houses and the kraals.
* His task is to plough and break the soil, while the rest of the family cultivate the crop.
* His duty is to see them all in the field working. He
makes sure that everybody participates.

* His special task is to make a separate fire place which is different from the fire place made by his wives. Only sons and grandsons are allowed to sit with the father. The fire place is called "bandlha" in Tsonga, which means a thinking place. It is also where discipline is given. Supper is mostly given to them at the "bandlha". If they have slaughtered a cow, the father and his sons are to cook the head and its brains at the "bandlha". (It is custom that a cow's head and its brain should be eaten by men only for it gives them reasoning power. No female is allowed to eat the head.)

* If a child or any member of the family is ill, the father calls a meeting to curse whoever has tried to bewitch the child. Furthermore, if there is a sick person in the family, he calls a meeting to announce that if there is somebody bewitching the patient, it is advisable that such a person should stop it. He tells them not to kill the sick one, but rather to kill him, or if they desire, whether it is a cow or a goat. This is announced in a harsh way or manner! The day after the meeting the father then slaughters mentioned cow or goat. According to Tsonga belief, the patient recovers the very same day.

* The father is regarded as the stem of the family, and very rightly so.

* It is the father's task to give food to any passer-by whoever is hungry. It is believed that a human being is "God" as created by God "Munhu i Xikwembu". If ever there are visitors, he sees to it that all the members of his family greet them to show love and respect.

* The father controls the whole family - even his married sons. It sometimes happens, for example, among the children
that a younger brother does not respect the elder brother. In such a situation, the father observes the stubbornness of his son, whether this troublesome son is married or not. The younger brothers of the troublesome brother are told to tie him very tightly. His older brother then beats him with a shambok to discipline him. The younger brothers are also free to discipline their disrespectful brother. He is thoroughly beaten until he cries out and asks for forgiveness. If his wife should cry for him, they are entitled to shambok her too. After this severe discipline he will humble himself to all his brothers. The troublesome brother has no power to fight because he is being beaten up by all the brothers. If he does not have any other brothers, his uncles or any close relatives are free to discipline him.

* The father also has a special task to control his daughters-in-law. All daughters-in-law should dish his food every day. Even if he has as many as five daughters-in-law, they all still have to dish him food. If there is food uneaten, no woman is allowed to eat it. The boys or any passers-by are, however, permitted to do so.

- The father also has to check if the mother-in-law (his wife) is regularly given food to eat.

- It is his task to know everything concerning his daughters-in-law. If ever there is a fight among them, he may even use a whip to frighten them so that they stop quarrelling. But according to Tsonga custom, a father-in-law is not allowed to use his hand for disciplinary purposes. This is a strong taboo, and the violation thereof can be a serious case. Should this happen, the daughter-in-law is expected to prepare beer for her reconciliation with the father-in-law and with the ancestors. The father-in-law introduces
the purpose of such a reconciliatory meeting to the ancestors. According to his feeling a cow or goat for reconciliation is slaughtered. This is done to prove that the father-in-law and the ancestors have forgiven her. In this situation, the father is highly respected for his disciplinary task.

3.4.2.3 The role of the mother

According to the Tsonga custom, the mother is called "Xiaka muti" which means one who has built up the family. The mother is the one "who bites the father's ear". She is a watchdog for the father. The father should then observe quietly to check on what he has been told by the mother. She never shouts, she observes quietly. If the mother is the father's first wife, she is the one who is supposed to enjoy drinking beer with the husband, so that she can "bite the father's ear" (or gossip) about family matters with him. The other wives (co-wives) "nkatikulombe" are not allowed to drink with them.

All matters are reported to her and she relates the problems to the father. No one (neither male nor female) is allowed to report any problem encountered, directly to the father. According to Tsonga custom this symbolises respect in the family, and the mother is grateful for the recognition she enjoys. The person with the problem is called to a meeting before the father and the mother. Then advice is given to him or her. Sometimes the father's sister is also asked by the father and the mother to give advice to a person involved. This is done because the aunt, according to the Tsonga people is regarded as a father, since she is the father's sister. More especially when the son wants to
marry, he will inform the aunt that "I have lifted my eyes and am attracted by someone else". Henceforth the aunt acts on his behalf and gives the message to the father and the mother. She is also the one who will send lobola from the bridegroom to the bride's family.

The mother is the one who decides what to plough for, she knows what crop is suitable for the soil. Furthermore, she has to check at the fields (masimu) of her daughters-in-law whether there are weeds to be cleared. She instructs them when or whether to organise a "tsimu", where people are invited to help in the field.

Her duty is also to supervise how food is prepared at the cooking place. It is her task to see to it that all the females in the family engage in grinding corn. She must also encourage respect in the family.

Furthermore, the task of the mother is to discipline girls and her daughters-in-law. There are some matters in which the mother does not communicate directly with her own daughter, but sends her husband's sister (the aunt) to speak to her daughter, e.g. to tell her that she should never give her body to the boys, in other words that she is not allowed to have sexual intercourse before marriage. This should be done when the first menstruation occurs. Thereafter such a girl is initiated into the society of adulthood in her own family.

Further functions of the mother are:
- to assist the daughter-in-law in giving birth; and
- to wake all the children up every day;
- to check if her daughters and the daughters-in-law are
3.4.2.4 The role of the grandfather

In the Tsonga culture the grandfather is regarded as the "root" of the family. He is the "wisdom" of the family. He is concerned about his son who is the father of the family. He observes whether the father fulfils his functions in the family; if not, he reminds and advises him. His main task is to help solve problems in the family. The grandfather is a judge in the family's affairs. He solves all the problems which the father and the mother have failed to solve. That is why he is often regarded as the "main root" of the family and the "senior judge". Furthermore, he helps the chief of the tribe to judge cases at the court.

The grandfather also has the task of observing the health of everybody in the family. It is his responsibility to collect herbs from the witchdoctor so that the family can be protected from the witchcraft of the nightwitches.

The grandfather often has to fill the role of mediator. He is often asked to function as a messenger in the community, especially when cattle have destroyed or damaged another family's crops. If an apology has been extended by an old man, it is highly appreciated. If people have fought or were engaged in some form of hostility, the wronged person is often advised to contact the old man to carry a message of reconciliation and forgiveness between the two people involved. If, for example, the husband has wronged his wife or the wife has wronged her husband, to show respect, the woman can send such a message of forgiveness to her
husband or vice versa. An apology brought by an old man is held in high esteem, even if the matter is of a serious nature. According to the Tsonga people such an apology is a real apology, and one is almost forced to accept this apology. The grandfather's task, therefore, is to bring peace in the family and by implication also in the community.

Furthermore, if one of his grandchildren is involved in marriage, the old man is the appropriate one to speak to the ancestors and show them the "lobola" (money).

Because of his wisdom and experience it is the privilege of the grandfather to advise his children (the father) and his grandchildren and also to help and give advice during the initiation school. He is also expected to relate stories to his grandchildren and thus keep the flame of folklore burning.

Other tasks (if he still can) include:
- to plough and plant vegetables;
- to help the family in fixing the cattle kraal;
- to look after the cattle with his grandchildren.

How, then, is this old man supported? According to custom his children are obliged to support him. Previously a favourite activity for the Tsonga grandfather was smoking "dagga". The old man had to wake up early in the morning (at 5 am) and smoke dagga and recite poems of praise to his forefathers every morning.
3.4.2.5 The role of the grandmother

The Tsonga grandmother is also called the "root" of the family. In a certain sense, her functions are similar to those of the grandfather. She is a "watch-dog" in the family, when the adults and younger members of the family have gone out for agricultural, pastoral and gathering functions. Each grandchild is supposed to bring her some of the food remnants, such as mopani worms, locusts or wild fruit.

The grandchildren learn from her how to use cow's dung, and how to decorate the grandmother's hut.

She is the person responsible for burying a still-born baby. Even if the child died immediately after birth, she is still responsible for burying such a child. In such cases, the grandfather is not allowed to come near. She is the "wise one" whose responsibility it is to protect the children from fire. Her task is to talk with ancestors. If a child is ill, she has to carry out certain rituals. Also if a son of the family goes out to work elsewhere, she carries out certain rituals, to protect her descendent at work. When he comes back, she takes him to the sacred place with all his goods and money he has earned. Everything is shown to the ancestors at the sacred place, to welcome him back and to thank them for their protection of him at work.

3.4.2.6 The role of girls

The tasks of the young Tsonga girls are manifold and include the following:
- to learn to sweep and keep the yard clean and to smear the hut-floor using cow's dung;
- to fetch water and to collect wood;
- to cook and to grind mealies and sorghum for porridge and beer;
- to catch locusts and collect mopani worms and other edible foods suitable to be eaten with porridge.

3.4.2.7 The role of the boys

Amongst the Tsonga, boys are believed to be there to herd cattle and goats. The younger boys herd the calves. The boys are also expected to help in food gathering, such as gathering locusts and mopani worms while herding the cattle and goats. They also try hunting and fishing from this stage. According to Junod (1962a:61) "Boys spend their time in the following occupations: herding the goats, stalking, catching game, learning the science of the veld". Junod (1962a:61) continues to explain that, as he grows up, the Tsonga boy leaves the flock of goats and is entrusted with the care of the big cattle, oxen and cows. He becomes proud, and tyrannises his younger brothers. He calls himself "hosi" which means their "chief".

3.4.3 Marriage amongst the Tsonga

Marriage is a social approach, a sexual and economic union between a woman and a man. This union is presumed to be more or less permanent by the couples and others. This union also assumes reciprocal rights and obligations between spouses and their future children. Then, marriage establishes both an affinal and consanguineous relationship (Morris,1973:801).

According to the Tsonga people marriage does not mean that
couples must have marriage certificates and (Western-type) wedding ceremonies. Lobola is the prerequisite of marriage among the Tsonga people. People (especially Westerners) are inclined to think of marriage as involving one man and one woman at a time (monogamy), but most black societies in the world allow men to marry more than one woman at a time (polygamy). The Tsonga people very often engage in polygamous marriages. Men have married from two to twenty wives, or even more. It is a most important aspect which causes a man to feel great and obtain a high status. The purpose of polygamous marriage amongst the Tsonga people is because women are great contributors to the economy. A poor man can not marry more than one wife and such a person was mocked in the past. Polyandry, i.e. marriage in which "one woman" may marry "many men" does not occur among the Tsonga.

In polygamous marriages among the Tsonga people today there are between two and ten wives. However, today it is not as highly prized as earlier because of economy, but polygamy is still commonly practised. There are, for example, young men less than twenty-five years old who have two or three wives. Junod (1962a:282-283) verifies that polygamy is uniformly practised all through the tribe. This is not to say that every man has many wives.

There are two types of polygamous marriage:
1. Sororal polygamy
2. Non-sororal polygamy

1. Sororal polygamy: If one man marries two or more sisters this is called sororal polygamy. According to the Tsonga people, it is believed that sisters who grew up together
are more likely to get along well and co-operate as co-wives than co-wives who are not sisters.

2. Non-sororal polygamy: If one man marries co-wives who are not sisters, such marriage is non-sororal polygamy. Non-sororal co-wives have separate living quarters. Sororal co-wives (sisters) may live together. In such a marriage, the husband must share his personal goods equally among his wives. In matters of sex, wives have equal rights, normally they require the husband to spend a week with each wife in succession, or the husband stays with a pregnant wife for seven or eight months. Failure to do so leads to adultery. This is a serious problem among the Tsonga people, because love is not equal. Wives are not equally ranked. The first wife has a special prestige and she is granted the status of chief wife and her house is the house of the father. The junior wives regard her as a "mother". All matters are reported to her and she reports these matters to the father (husband). But generally, younger wives are favoured because they are more attractive and the senior wife may be compensated for her loss of physical attractiveness by increasing prestige.

In the polygamous families jealousy also exists among the children and the emotional ties are deeper with the mother than the father. The children are not equally loved by the father. In the polygamous families there are 25 to 100 members of the family. For example, the present writer is from a polygamous family where the father married six wives, had 54 children, and there are more children on the way.
Who should marry, according to the Tsonga people.

Among Tsonga people there are four types of marriages which can be distinguished, namely:
- arranged marriage
- cousin marriage
- exogamy/exogamous marriage
- levirate and sororal marriage

3.4.3.1 Lobola ("lovola")

The original meaning and the consequences of the lobola, is to consider it as a compensation given by one group to another group, in order to restore the equilibrium between the various collective units composing the clan (Junod, 1962a: 278). According to Junod (1962a:277), there are two kinds of lobola, i.e.

1. The lobola which a boy obtains from his sister's marriage, and which he employs with the consent of the family to buy a wife for himself. This is the true old-fashioned way for him to contract a marriage;

2. The acquired lobola won by a boy who has worked for it, and who has started a herd for himself (tisungulela ntlambi). This second kind of lobola became much easier to procure under the new conditions, especially when a stay of a year or two in Johannesburg was long enough to save the necessary sum of money.

3.4.3.1.1 Advantages of the lobola custom

According to the present writer, lobola is strongly emphasized amongst the Tsonga people for many reasons. Marriage in which the husband paid lobola is regarded as a real marriage
and without lobola marriage is not recognised. According to Junod (1962a:279) in the primitive collective stage of society the custom has certainly great advantages:

1. It strengthens the family, i.e. the patriarchal family, the right of the father.  
2. It marks the difference between a legitimate and an illegitimate marriage and, in this sense, takes the place of an official marriage register.  
3. It puts hindrances in the way of dissolving the matrimonial union, as a wife cannot definitely leave her husband without her group returning the lobola. Therefore, it obliges the married pair to have a certain regard one for the other."

3.4.4 Religion

"Religion is a belief in the existence of a Superhuman controlling power, especially of God or gods, usually expressed in worship or something compared to religious faith as a controlling influence on a parent's life" (Hawkins, 1981:591).

The attitudes of the Tsonga towards handicapped children cannot be appreciated or even understood without an understanding of the Tsonga people's religious life.

3.4.4.1 Traditional religion and interpretations

In the Tsonga community there are two main religions dominating, namely the first group who call themselves Christians and who worship God, called JAWHEW/ELSHADAI/ELLOHIM in Hebrew and Theos (Θεός) in Greek. The second group communicates with God through Jesus Christ (Ιησους Χριστος). The second group worships their forefathers (gods) which means that
there is more than one person to be worshipped. In this (second) group witchcraft is the dominating ideology and is very important according to their belief.

However, there are some people who worship both, i.e. God (the Heavenly God and the Father of Jesus Christ) as well as the gods (the forefathers). This is a dual relationship.

3.4.4.2 How the Tsonga people value God

The Tsonga word for God is Xikwembu. Xikwembu is a supernatural being. They use the name Xikwembu in different expressions such as "Xikwembu xi kona!" for example and which means "Really God is living!" This is an expression of amazement and is often used after a narrow escape from any danger, for example a car accident or after a recovery from a serious disease, and so on.

It is clear that to the Christian Tsonga, God is the personification of all the moral characteristics to be desired by God, for example, purity, cleanliness, forgiveness, charity, love, respect, or faithfulness. According to them Xikwembu has created the world and all animal and plant life upon it, and afterwards Xikwembu created man. Xikwembu has a Son "Yesu" (Jesus). Xikwembu and Yesu have the same characteristics. In connection with the creation, Xikwembu is also known as People Creator.

Xikwembu is also closely associated with the elements of nature, wind, rain, hail, death and lightning. Rain is a gift of God. There are no rituals connected with Him in any way. He does not normally appear in dreams or in any other way except the experience of His healing, grace,
love, blessings and so on. Nobody has ever met God. He is the giver of life and the disposer of death, according to the Christian view. Many Tsonga people accept the fact that the God of the Bible does exist, but most of them do not worship Him by praying and going to church. The majority praise the forefathers and also mention the unknown God (unknown God is God Himself).

There is a preconceived ideology which exists among the Tsonga people. Many believe that the God of the Bible is not for "ordinary" black people, but He is God of the "white people" and for the educated or high status people. Although He is not seen as the God for the illiterate people, whatever they achieve in life, the living God (Xikwembu) is more often than not mentioned. To some people God is of very little importance to man in his relation to this world. Not all people have the same faith. Christians believe in life after death.

3.4.4.3 Ancestor worship

Ancestrolatry among the Tsonga, according to Junod (1962b:373-374), stems from the idea that every human being becomes a Xikwembu (god) after death. There are consequently many categories of these. The two great categories of gods are those on the father's side and those on the mother's side. In other words, each family has two sets of gods. They are equal in dignity. There are also the gods of assegai (Swikwembu swa matlhari), that is those who have been killed in battle.

The Tsonga word for these gods/ancestors/forefathers is Swikwembu. They are invariably called in the plural form.
(They are also called in plural form in the Bible.) The ancestor worship of the Tsonga people (like so many other indigenous people) is based on the belief that the living and the dead can mutually influence one another. The basis of all rites are therefore connected with the ancestors' spirits. They have to be respected, to be honoured and obeyed. They have to be thanked for their blessings and have to be fed through sacrifices.

According to the ancestor worshippers, the ancestors have power over life and death, over sickness and health, over poverty and prosperity, and over fortunes and misfortunes, including all handicaps such as physical or orthopaedic handicaps, blindness and deafness. The Tsonga people believe that there is nothing impossible for the ancestors' spirits. The main desire of the ancestors is to be remembered by their descendents. If their descendents are faithful, they reward the living through good health for themselves and their progeny and for their live-stock, and through rain and good harvests. If, however, they are forgotten, they may withdraw their protection and bring disaster, disease, ill-health, drought and poor harvests, or even death.

Not all the spirits of all dead persons are worshipped, though, and not all dead persons are considered to become esteemed gods (Swikwembu). In families, there are forefathers who are worshipped. It depends on the choice of the individual family, and particularly the head of the family who decides whom to worship, i.e. Xikwembu or Swikwembu. When a child dies, the Tsonga cry bitterly and very often say that the forefather (gods) have made a mistake to take away the innocent soul. The Tsonga also believe that a person's parents are his "gods". The parents are the people who protect
and who give life to the individual. If there is a grudge between the child and his parents, the Tsonga maintain that there can and will be no prosperity at all in life.

3.4.4.4 Method of communication with the ancestors' spirits

According to "traditional" Tsonga belief the ancestors' spirits cannot speak directly to the living, but there are various ways in which they can communicate their messages:

A first channel of communication between the ancestors' spirits and their living descendants is through dreams. The ancestors express their desires through visiting their descendants in their dreams. Not all dreams of a person are necessarily important; but rather those that he remembers. When a person dreams directly and repeatedly of a certain ancestor he knows that there must be something troubling that ancestor's spirit. Sometimes the ancestors even speak explicitly in the dreams and thus directly state their desires. Usually, after such dreams, the Tsonga people rely on their diviners to interpret their dreams and also to instruct them concerning the form of sacrifice necessary to appease the ancestors.

The ancestors' spirits can also express their desires through certain "signs", for example, through fighting, poverty, disease, death, or even the birth of a crippled child. Once again diviners are approached to interpret such signs and to indicate the desired mode of appeasement or reconciliation. The reconciliation depends on the demand of the ancestor(s). If the ancestor(s) is (are) very angry or upset, they may demand a cow, or else it could be a goat or a hen, usually black or white in colour, for the ancestors can often be
very explicit in their demand of colour as well. Sometimes the ancestors may demand a cow or goat (slaughtered) and sometimes unslaughtered. According to the custom and belief, reconciliation should be done at the sacred place. There are different sacred places (Magandzelo) in the Tsonga people's cultural life including:

1. the sacred tree (mainly the marula tree) (See figure 3.2 Ua)
2. the sacred fire place (circle) (See figure 3.2 Ub); and
3. a place near the grove of the ancestors or on the grave of the ancestor(s) (See figure 3.2 Uc).

All the sacrifices are required to take place at the three sacred places mentioned. The following are examples of the type of sacrifices which take place at the sacred fire place, sacred tree and on or near the grave.

The drum performance usually takes place in the ancestors' worship. Junod (1962b:483) says that the "tambourines" or "tom-toms" are performed in order to balance the worship. "Tom-toms" are sounds produced by the drum. According to the researcher, the sounds produced are "tlangu-tlangu, tlangu-tlangu, tlangu-tlangu! tla-tla-tlangu, tla-tla-tlangu, tla-tla-tlangu! thangu-thangu, tlangu-tlangu, tlangu-thangu!"

After a father has heard from the diviner what the ancestors demand from his "children", he is required to make beer and to slaughter a goat or a cow. When the preparations are completed, the father summons all the relatives to the
sacred place, for rituals, where the ancestors are, i.e. around the tree, fire place or at the grave of the particular ancestor. Then the father slaughters a cow or goat at the sacred place, so that the blood is shed on the sacred place. The father then drinks a little beer from a small kalabash and spits the rest out over the grave or tree or fire place, whereafter a kalabash full of beer is poured on the sacred place. The father relates the problem to the particular ancestor concerned, so that he or she can relate the problem to the other ancestors and talk about the purpose of the meeting. This consists first of saying the praising-poem of the particular ancestor, thereafter telling the ancestor about the purpose of the meeting and then, telling the ancestor about all difficulties and circumstances. This ritual is gone through while the others are clapping hands, (more or less four times to each sentence). All the intestines of the sacrificial animal are buried at the grave/tree/fire place. The dung of the cow or goat is smeared on the person involved, who is troubled by the ancestor. Alternatively the dung is first mixed with blood before smearing, or the troubled person is smeared with the blood alone over the whole body. The rest of the blood is poured onto the sacred place. The whole cow or goat is subsequently cooked, and the people gathered have a feast, drinking, dancing, singing and eating the meat. It is compulsory that the whole cow and the beer should be finished on the same day. Bones as well as the horns are not allowed to be thrown away. The father and the person involved have to collect all the bones and the horns and place them at the sacred place. These are said to be given back to the ancestor again.

If the food is not finished by the end of the day, a hole is dug at the sacred place and everything is buried in it,
The cooked meat, the porridge and the beer. This is done so that the ancestor can also enjoy the meal. Nobody is allowed to take any food or drink (meat and beer) out of the yard, otherwise the ancestor will be displeased again.

A person smeared with dung or blood must wait until the medicine man comes to cleanse him/her. He or she is not permitted to wash even if the waiting takes a few days. This is a final cleansing act which completes the whole ceremony. Other sacrifices and thanksgiving ceremonies are also common.

The place of sacrifice depends on the reason for the sacrifice. For instance, it can (and very often does) take place in the cattle kraal. The nature of the sacrifice depends on the circumstances. Beer is nearly always the medium of sacrifice and may be accompanied by a cow or goat or vegetables or any crop. If vegetables (or any other crop) are ready they are not supposed (or even allowed) to be eaten without taking the first few to the sacred place to thank the ancestors. After the sacrifice, they are allowed to be eaten.

The ancestors' spirits are believed to be very sensitive. Whatever the living descendants do, the ancestors wish to be informed. In this respect there is a parallel in Christianity. Whatever Christians feel or do, they tell to God or Jesus in their prayers. The Holy Spirit is very sensitive too.
3.4.5 Witchcraft

Witchcraft to the Tsonga people represents all that is evil and destructive. It is regarded as a very bad practice within the society. Witchcraft is feared more than anything else. It is believed in by almost all people of all classes among the Tsonga, the uneducated as well as the educated. There are only very few who do not believe in witchcraft. Witchcraft may well be the strongest, most dominating ideology among the Tsonga people.

The Tsonga people know who the recognized wizards and witches are in their community and with confidence will (secretly) point them out to others who do not know the witch. Some witches boast and publicly tell the one with whom they are quarrelling that they are going to cast a spell on him. It sometimes in fact does happen that the person who is threatened with death does get sick and even die. Before he dies the victim often calls the family members to confess the name of the wizard or witch. Among the Tsonga people there are witches who have been burnt because of their witchcraft. The chief often dismisses them from his village.

The witches are permitted to take part in all the normal activities in the community. When they do participate in the activities of any group, their presence often, however, causes an immediate change in the atmosphere.

The Tsonga people distinguish between "witchcraft of the night" and "witchcraft of the day". "The witches of the day" use medicine in their witchcraft, especially poison and herbs. The "witches of the night" do evil without the application of medicine.
It is believed that night-witches are born with supernatural powers and have inherited witchcraft. They do evil things, often activated by jealousy or hatred. It is, for example, believed that if a male witch has proposed to a female and she rejects him, he can cast a spell over her so that she becomes insane or barren or remains unmarried for the rest of her life. The night-witches use evil to harm others for the sake of their own benefit or pleasure. According to Junod (1962b:509-510)

"a. the baloyi (witches) are in the first place thieves.

b. the great crime of the baloyi is that of killing.

They are murderers, and all the more to be feared as they act unconsciously, without being seen or known."

It is believed that it is possible for the child of the night-witch at birth to be thrown against a wall without incurring any harm. It is believed that it will either land softly against the wall like a cat or rat or on its hands and feet. This proves that the child will someday also be a witch. It is believed that this is done by the families involved in witchcraft, after the birth of a child, to find out whether he or she will one day be able to help the father or the mother in their nightly tasks.

Most night witches are women, a status which is usually transmitted unilineally from mother to daughter. To support this, Junod (1962b:506) says that

"this dreadful power (baloyi/witchcraft) is sucked in at their mother's breast when they are still infants, but it must be strengthened by special medicines in order to be really efficient."
Some inherit witchcraft from both father and mother. It is strongly believed that when a female night witch marries, she will teach her husband also to become a witch, resulting in the whole family being involved in witchcraft. In other words the child is believed to be born with the innate ability to be a witch and possessing all the innate qualities of becoming a witch, but the child has also still to be taught how to use these abilities. They are believed to be instructed in a very intensive training programme (which lasts throughout childhood), in the secrets of night-witchery.

Night-witches sometimes use a cat, a baboon or a dog. They are believed to be able to fly by night and to transfer themselves to far-away places to practise their witchcraft there and to harm others. They are believed to be able to enter a person's house, where he is sleeping, without his knowledge and then use their witchcraft to manipulate him.

Furthermore, according to Junod (1962b:509)

"These baloyi/witches know each other, they form a kind of a secret society within the tribe."

3.4.6 Education amongst the Tsonga

Jeff (1988:iv) quotes Collins that "Education is that mode of living most conducive to the liberation of the individual. Liberation occurs when the individual becomes aware that the world is many - as well as one."

Education amongst the Tsonga people is encountered both in traditional education and in modern education. This means that they have two types of schools, viz.
i. the traditional initiation school
ii. the formal school (under the control of the Gazankulu Department of Education)

3.4.6.1 The traditional initiation school

According to custom the traditional initiation school has certain aims. It is upheld even to this day because it aims
- to teach their culture;
- to encourage taboos;
- to teach respect for the elders;
- to teach co-operation and compassion;
- to teach loyalty;
- to teach humility and dignity.

The initiation school for boys differs from the school for girls. The proceedings during the initiation of the young people into the adult world are given here in some detail, because it does give a certain insight into the social, religious and cultural world of reasoning and feelings of the Tsonga which all in all has a definite bearing on his attitudes towards life in general and towards handicaps in particular.

A. The initiation "school" for boys

According to the Tsonga people, the initiation school for boys is called "endzilweni" which means "at the fire". It is also called "ngoma" according to Junod (1962a:82):

"'Ngoma' is the shield of buffalo's hide! It is the crocodile which bites! The candidates must accept all the hardship of initiation. They are taught to
The initiation rites for boys are always held in mid-winter so that the boys can learn suffering through cold. The boys are put through a severe test and death does occasionally occur. In essence there is no difference between "endzilweni" and "ngoma", because suffering is being experienced at this school.

The erection of the initiation school is a secret among the old men. The village chief is informed by the organizers of their intention to conduct the initiation school. But in previous times, according to Junod (1962b:75),

"... this school was the business of the chief and has been arranged by the council of the headmen (tinduna) over which he presides."

According to Junod they built the lodge outside the village in a remote place, not too far away however, because the women had to bring food each day for all the inmates of the "place of mysteries".

Today the old men select a special witch doctor who is very good at circumcision, they call him a special doctor. He is paid from the affiliation fees. In former days this fee was R1 and it was called "R1 for a razor blade". Nowadays it can cost up to R60 "for a razor blade".

The preparations for the school last up to a week. The old men involved are not allowed to go home during this time. The household is not supposed to know anything about their disappearance. However, they are suspected of being at the initiation school. This is a crucial secret. This
is done to prevent the night-witches or witchcraft.

The father takes his son to the sacred place in the kraal before they leave, so that they can speak/communicate with the ancestors to protect the child. Further, the father looks for a "Mudzabi" i.e. a circumcised boy who went to this school the previous year. He could be called the boys' prefect. Each boy is then taken by his prefect or helper to the initiation school and this helper or guard will look after this boy for the duration of the school. Boys from the age of 10 years are allowed to attend the initiation school. Each boy is undressed by the person who brought him and is then circumcised by the special witch doctor by means of a razor blade to cut the foreskin off. The problem of bleeding is handled according to the knowledge of herbalist and the old people who erected the school.

The task of the old men is to comfort the boys and if a boy cries, they start singing to produce a very big noise "so that people in the village cannot hear his cries". The boys are not all circumcised on the same day since they do not all arrive on the same day. They stay naked throughout the whole period (in the midwinter season). They are smeared all over their bodies with ashes mixed with soil or chalk.

Before the initiation school starts, special women are selected to cook for the pupils at the school. These women should be faithful people, who will be holy for the pupils who go to the "fire" or "ngomeni" according to Junod. They must in other words not be involved in sexual intercourse throughout the whole period of initiation until the last day. (The period used to be 4 to 6 months in earlier days, but nowadays it only lasts six weeks because of the compulsion
of formal education in South Africa.) These women should be faithful for that period. If this taboo is broken, some of the boys are bound to die.

The porridge for the boys is cooked by these women, not at home, but at a special place selected for this purpose. Each family bring its share of mealiemeal to this spot. The porridge is cooked very hard. No meat or vegetables are prepared for the boys. They are allowed to eat porridge only.

There are special girls selected to take the porridge to the initiation school every day. These girls are not allowed to put on tops, they wear "Nwandhindhani" only (a traditional cloth, that covers from the waist to the knees). On their arrival, they stop at a distance and kneel, shouting "Ho tshwa!" (we are burning). The helpers (prefects) reply "Burn your private parts" and then come with their lashes in their hands, giving the girls a few lashes before collecting the food. The initiates eat like dogs with their mouths only without using hands or arms, with their hands behind their backs. According to Junod (1962a:82):

"They must eat as fast as possible. They sometimes vomit right on the table."

During this initiation period, the boys are taught to hunt, day and night. Only the helpers (prefects) and other circumcised men are allowed to eat the meat of the hunt. If they meet any female or uncircumcised male in the bush or veld, they beat him or her severely and no one reports them, because they have been seen naked. Even old women are beaten severely.
During the absence of the initiate from their homes, members of their families are not allowed to cut their hair or beards. They are also not allowed to work on soil or the renewal of huts, using cow's dung. These taboos are lifted when the children are back from the initiation school.

The trials

There are six main trials according to Junod (1962a:82) i.e. blows, cold, thirst, unsavoury food, punishment and death:

1. Blows: They are severely beaten by the shepherds (prefects).

2. Cold: The boys lie naked in their shed. June to August are the coldest of the South African winter months. They suffer bitterly from cold. They must always lie on their backs. Shepherds keep watch during the night and beat them if they lie on their sides. No blankets are allowed, only light grass covers.

3. Thirst: It is absolutely forbidden to drink a drop of water during the whole initiation, and this taboo is said to be very painful.

4. Unsavoury food: Parents must bring plenty of porridge. All the food is placed on the reed tables, and must be eaten by the boys without any seasoning. If the porridge is not well cooked, the mother is charged to kill goats and fowls, and is thus made to obey.

5. Punishment: They are punished severely by suffering all forms of punishment. Blows are punishment for minor offences.
6. Death: The circumcised must also be prepared to die if their wounds do not heal properly and if the medicine is not successful. Many of them die. It is absolutely forbidden to mourn over them. The mother must not cry. The corpse is buried in a wet place, in a grave dug with sticks, as it would make people suspicious if the shepherds were to go to the village and fetch a spade for this work.

Towards the end of the initiation period, a day before the celebration, all families involved bring porridge and meat or any staple food available in winter or any delicacy according to their custom. Bread, coffee or tea is not allowed. On this day they sing, dance and eat the food prepared for them. This is done throughout the night. In the early hours of the day they are taken to the river to bath (between 4 and 5 a.m.) and on this day all the circumcised men of the village will go to the river to assist in some traditional aspects. At dawn all the initiation huts are set alight by these men. Thereafter the initiates are bathed by these men, all ash on the body is washed away. Thereafter they are smeared with "tsumana", a red mixture of pigs oil or vaseline, they are all red in colour and clothed in red and white and beads which are "X" in shape.

From there, they all gather at the same place, each family brings a chicken and a loaf of bread per son. The same girls who brought food to the initiation school are the specific people to bring chicken and bread to this spot. Then they celebrate.
Each leader then takes his boy back to his home. It is a great day in each family. Each family prepares delicious food including meat, porridge and beer to feast with. All the relatives are invited to come and rejoice with the family. When the boy and his helper approach home, the people start rejoicing by singing, dancing and express joy the traditional Tsonga way. Thereafter they are taken to the sacred place where they communicate with their ancestors.

The ancestors are worshipped for their faithfulness in protecting their grandson. They perform all that has been taught them on ancestor worship.

The initiated boys start to live a new life, they will separate themselves from their previous friends who did not go to the initiation school. They are well-disciplined. Those who were not disciplined before or were troublesome, are well-disciplined at the initiation school. Among the Tsonga people initiation school is not compulsory, but among the Xhosas it is compulsory. They disregard circumcision which has taken place in hospital, and the person is not regarded as a real man, even children of highly educated people e.g. lawyers, doctors, principals, etc. are compelled to attend this type of school. If not circumcised traditionally, they are strictly excluded from all matters to be solved by men. Girls should never marry a man who is uncircumcised or circumcised in hospital.

Finally, loyalty, respect, co-operation, humility, love, helpfulness and dignity are expected from the people who have been to the initiation school.
For interest's sake, according to Junod (1962a:73-74), a French anthropologist, Mr. A. van Gennep some years ago published a book on *Les Rites de Passage* (Paris Nourry 1909) which throws a great deal of light on these mysterious customs. For more details see *Zidjie*, a South African novel which Junod had published in 1910 (Foyer Solidariste, Saint-Blaise, Switzerland) where a more elaborate description is found.

B. The initiation "school" for girls

During her first menstruation period, a girl is taken to the sacred place to inform the ancestors that she has matured. The ancestors are asked to protect and to prepare her for a bright future. An old woman is sent to the girl's father to inform him about the maturity of his daughter. Thereafter, the old women, including her aunts (the father's sisters) meet with her and tell her not to have sexual intercourse with boys before marriage. This is taboo that has to be observed very meticulously.

The initiation of the girl takes place at her home or at her aunt's or uncle's home (unlike the boys whose school is erected outside of the village). The girl's initiation (similar to the boys) also takes place in winter time, following her menarche, sometimes between June and August. The girl's parents gather food to be used during this period. A girl who was initiated the previous year is elected to be the girl's bodyguard or prefect (mudzabiti). She will cook for the girl, and a hut is selected in the family for this purpose. A girl's hut is a first preference.

The girls are not told when the "school" will start, because some of them flee. Before they start with the initiation,
the girl is taken to the sacred place where the ancestors are believed to be. An old woman (preferably the grandmother) tells the ancestors about the initiation school. She asks them to protect the girl from witches and witch doctors who could try to bring upon her evil spirits. On the evening of this day, women are invited to a meeting to "undress the girl". This is done while singing and dancing. Men are not allowed to come near.

Throughout the duration of the initiation "school", the girl has to stay naked and has to stay inside a hut. She is smeared with ashes. Ashes are also used for toilet routine purpose. Ashes are believed to prevent germs and a bed smell. This is cleaned in the evening. She can go outside for toiletry. Junod (1962a:177) states that "the nubile girls are imprisoned in the hut."

Porridge is prepared in a hut by her helper. Whatever she wants, the helper is told. She sleeps on a floor made of cow's dung and is not allowed to sleep on the traditional floor mat (Sangu). Everyday, usually between 4 and 5 a.m., she has to go to the river to wash herself before the people wake-up. People often hear them screaming at the river, since the water is very cold. She meets with other girls from the different families who are also undergoing their initiation "school".

Every evening after supper, women come to sing and dance while mocking her and laughing at her. She is taught how to dance and she has to dance for them to show respect, while she is naked. According to Junod (1962b:176-182), "They are teased, pinched, scratched by the adoptive mothers or by other women; they must also listen to
the licentious songs which are sung to them. Though they are trembling from cold, being still wet, they are not allowed to come near the fire."

It is the task of her "body guard" as well as the women who come every day to teach her the laws and customs of the tribe, including respect (especially respect for her future husband), co-operation, if her future husband should marry a second wife, respect for her mother- and father-in-law, her parents, siblings and the community at large. She is also taught that she should not have sexual intercourse while menstruating, because then she is not "holy". She learns that she should take 10 days without her husband otherwise her husband could become seriously ill or even die. This is a strict taboo according to the Tsonga people. During this time she is also taught about humility, co-operation, hard work, cleanliness, compassion, patience and love for others.

Towards the end of the initiation "school", preparations for beer, meat and other food are made. On the last night, women frighten a girl with "tingoma". What precisely happens during the last night, however, is a big secret, nobody will ever be told. All the Tsonga women who have been to the initiation school keep this secret. The mother of the present writer is one who, in her youth, attended the initiation school, "but" she never told the present writer what happened on the last night. Even a blood sister or grandmother will not tell anybody what happens on this last night. This is amazing that Tsonga women can keep such a secret! It is self-evident that nobody is allowed to enter the hut where the girl is, except the women or girls who have undergone an initiation "school". If one does, it is believed,
she will go insane.

Junod (1962a:177) writes the following concerning the initiation "school" for girls:

"It is said that a man who sees a girl during this month becomes blind!"

The preparation for the last day is more or less the same as for the last day of the boys at the initiation school. In the morning the initiate is taken to the river for the last time. They remove all the ashes and smear her with "tsumana". She is red in colour because of "tsumana" and pig's oil or vaseline. There they dress her smartly in the traditional Tsonga wear. All the relatives are invited to enjoy the feast. The girl is first taken to the sacred place to thank the ancestors for their faithfulness and protection. Thereafter, the family members and relatives bring gifts to her, e.g. shawls, clothes, money, and then the celebration takes place.

3.4.6.2 Formal education

Formal education is effectively taking place in Gazankulu among the Tsonga people. Many people are more interested in formal education than in initiation school although some girls and boys attend initiation school during the school holidays but they are still interested in formal education. Presently, Gazankulu has 8 pre-primary schools; 5 lower primary schools; 30 higher primary schools; 41 junior secondary schools; 71 senior secondary schools; 1 technicon; 3 training colleges and 2 schools for the handicapped crippled and for the deaf (information received from Mr Soundy, the chief educational planner).
3.5 BELIEFS ON THE CAUSES OF HANDICAPS

There are many aspects of handicapism which the Tsonga people strongly believe in. These are mainly based on the causes of handicaps. On the other hand, Stubblefield (1964), some studies by Lenski (1963), Mosland Sarason and Gladwin (1958) support the idea that no community must ever be blamed in relation to what they believe. The present writer agrees with the above notion in the sense that some think their culture is more civilized than the culture of others. No culture is superior to another culture. All cultures are equal. Bowles, Gintis and Bourdeu (1976) support this notion. There is no community which is perfect. All varying cultures should be respected.

Now, to understand the Tsonga community, one must understand their culture. According to Tylor, culture is that complex whole which includes knowledge, beliefs, art, morals, law, custom and any other capabilities acquired by man as a member of society. Each one of us is born of a complex culture that will strongly influence how we live and behave for the rest of our lives. Culture is shared. For any action or thought to be considered cultural, it must be generally shared by some group of individuals, for instance, we share certain values, beliefs and behaviour with our families and friends.

3.5.1 What are these beliefs?

The following are the most prominent beliefs on the causes of handicapped children according to the Tsonga people.

1. Uncooked liver: Although the marriage between relatives
(for instance cousins) is permissible amongst the Tsonga, there is a belief that the couple can have handicapped children, unless they uphold the age old tradition of eating the uncooked liver of the slaughtered cow or goat prepared for the wedding feast. The "eating of the uncooked liver" is a ritual that is performed during the marriage where bride and bridegroom must eat the liver in the presence of the grandparents and some other old people, who have been invited to the wedding feast to witness the fulfilment of the tradition. This custom is still fully in existence today.

2. Laughing at the handicapped: Another belief that still strongly prevails amongst the Tsonga is that if a person laughs at or ridicules a handicapped child (or even his family), such a person will also have a handicapped child. In his book, Vuthachi bya Vatsonga (The wisdom of the Tsonga people) the Chief Minister of Gazankulu, the Right Honourable Prof. dr Hudson W.E. Ntsan'wisi quoted a special proverb, relating to this belief: "Never laugh at a handicap, one can laugh at a handicap while still in her/his mother's womb" (Hleka Vulema wa ha ri endzeni ka khwiri ra mana wa wena) (1973:30).

3. Looking at the handicapped person: Pregnant women were not allowed to look at the handicapped disabled person for fear that they would produce a similar child or one even worse. They were not allowed to go where the crippled child or person was. Even today some people strongly hold this belief. That is why handicapped children were hidden away; and even today some people still hide them away. Furthermore, they were not allowed to talk about them, e.g. the mentioning of their names.
These superstitions gave birth to "FEAR", and that is why many people cannot work among the disabled children for fear that they will produce a similar child. Gottlieb (1972) says that in previous eras they were regarded with awe, as if they possessed magical powers. While Luther and Calvin described them as "filled with Satan".

4. Divorced man: If a man has divorced his first wife and marries another woman, the custom is that the new wife is not allowed to use the property of the first wife. There are some specific things she must "NEVER" use, e.g. bed, used by the previous wife, or anything used by the previous wife. The bed and sleeping mat and bed linen are the most dangerous things. In other words, this new wife should never have sexual intercourse on the previous wife's bed, sleeping mat or bed linen. If this happens, her first born will be a cripple. Even if the child is not a first born, but any child conceived on these specific things will be a cripple.

5. Witchcraft: Many people believed in witchcraft and even today it is strongly believed in. In current times this is verified by people who burn the Zanghoma or witch doctors. Not only is witchcraft strongly believed by the illiterate, but also by educated people with degrees, e.g. some nurses, teachers, social workers, Christian pastors, and so on. They believe in witchcraft. That is why the witch doctors boast or promote themselves by revealing the names or influential positions of the educated people who visit them by night. It is believed that somebody who hates or is jealous of the family has bewitched the child in the mother's womb. OR that the mother who gave birth to the child had tried to
bewitch other pregnant women and “had” failed, and thus had herself given birth to a handicapped child.

6. Many boyfriends: This is a most important aspect in the Tsonga community because a Tsonga girl is not allowed to love before the age of 25. In this regard she should be promised to one only. If she breaks many promises, when she gets married, her first born will be a cripple. This is called "madambi" in Tsonga. According to the custom the parents usually propose a match for their own son. They are the people who choose for their son. When the son comes back from work he will find a wife chosen by his parents. The two are, therefore, forced to love each other, even though this is not the partner of their own choice. If the father has wronged somebody, then he has to pay the damage through his daughter to cancel the debt. This has to be confirmed in the court. If there was a great hunger in the family, girls were sold to the well-to-do families so that they could get food to eat. But, because of many changes, what holds today may not hold tomorrow. The procedure has changed today, but some people still practise this custom.

7. Abortion: It was suspected that crippled children were the result of attempted abortion. This gives rise to the feeling of punishment, and also results from the sense of social isolation which parents of the disabled children experience in our Tsonga community. For instance, Stubblefield (1962) in conversation with a minister, the mother of a handicapped son stated that she could not understand why God was punishing her. When the minister questioned why she felt this way, the mother reported having attempted an abortion during the pregnancy
because she did not want any more children.

8. To make a knot: It is believed that a handicapped child is born if somebody who is angry with the pregnant woman or has a grudge against her goes to a witchdoctor to curse her while making a knot in a rope or piece of cloth.

9. Walking stick of the husband: The walking stick of the husband is not allowed to be kept at the second wife's house, otherwise she will give birth to a handicapped child, he should preferably leave it outside the hut.

10. Sitting position: When a woman is expecting a baby, she should sit properly to prevent a handicapped child.

11. Mouth rinsing by the first wife: If the first wife does not like the second wife, she does the following things: The second wife goes to the river to fetch some water. When she comes back, she leaves a clay pot at the cooking place. During the absence of the second wife, the first wife washes out or rinses her mouth and spits out the water into the clay pot fetched by the second wife. This is done secretly. Therefore, the second wife will have a crippled child. Furthermore, this water would be used for cooking in the family by the second wife. The fact is that, the first wife wishes to harm the other woman.

12. Taboos: Tsonga people believe in taboos. If a handicapped child is born in the family it is regarded as a bad omen. The woman feels rejected. She is viewed with
3.5.2 The results of these beliefs

It is a crucial question to pose, why people have such beliefs? According to Tenza (1983), it is obvious that any unpleasant birth in the form of a disabled child either mentally or physically, does not generate the usual excitement. The husband and wife are horrified, the problem is whether the rest of the family will accept the child. If it is a girl, who is going to marry her and bring a dowry? If it is a boy, how will the family name continue, as he may not be able to work to get a bride?

According to Gottlieb (1972:30) the presence of the child made a certain mother say the following words:

"How often did I cry in my heart that it would be better if my child died! ... I would have welcomed death ... and would still welcome it, for then I would finally be safe."

The birth of the handicapped child forced this mother to desire that death should take the child back home since the family is suffering because of the new child. He is a burden in the family. In this regard she feels desperate at the prospect of caring for her disabled child at home; she imagines a whole life filled with sadness and difficulties both for the family and the child himself. For herself, she lacks confidence and, not knowing what the future holds, frightens her and her child.

According to Irwin (1972), many agree that it is not death, but illness and injuries that destroy. The value of a life
That is to be shunned, an existence in which the child will never be able to experience and enjoy what life has to offer is a "half life". In other words, a disabled person is not regarded as a whole. According to this view, handicapped people are not seen as complete.

Cooper and Henderson (1963:26): "but the whole point is that if you have got a sick person in the house it's a sick house. I don't care what anybody says, and it would give her no chance whatsoever of having a normal life."

Gottlieb (1972:35) says of a family with a handicapped child that, their marriage was suffering, their social activities were disrupted, the other children were socially embarrassed, the child's behaviour was poor or unmanageable, the child had no contact with the other children, and that he seemed unhappy in the home.

But on the other hand, in generalisation or individualisation, another notion says, a disabled person is firstly a person and secondly a disabled person. This form of generalisation ignores the personality of the disabled person, it ignores the fact that his life is determined by various factors which form part of the society in which he lives. The life of the disabled person is admittedly affected by his disability but also by the kind of environment from which he comes.

What then, is the effect that the birth of a handicapped child has on the religious faith of parents? Not only does the birth of a disabled child affect their religious faith, but their religious faith also affects the parents' own response to this event.
Let us consider two groups. Both groups of parents have the same problem with religion. The group which believes in the forefathers (gods) blames these dead bodies. They believe that the birth of the disabled child is a punishment from their ancestors. On the other hand, the Christian parents interpret a handicapped child as a sign of God's disfavour. For example Kimpton (1977) according to Murray (1959), said that one mother of a handicapped child contended that having a child who will remain disabled for his entire life, places parents, at least in their feeling, outside the province of God's mercy and justice. It creates a crisis in the parents' religious beliefs, if they are still able to believe that there is a God.

Furthermore, Stubblefield (1964) says that a survey of 220 Protestant and Catholic clergyman disclosed that 15 per cent of these ministers believed that having a handicapped child had caused doubt about the goodness of God in the parents known to them, and 13 per cent had observed reactions of guilt. Failure to resolve this conflict, they noted, often resulted in attitudes of chronic bitterness, resentment or apathy.

Another dimension of the theological crisis is the belief that the handicapped condition is the punishment of God. It is believed that the cause is the problem of sin and guilt. This has been proved or verified by many researchers like Kimpton (1977). In some instances, such a belief represents man's persistent need to affix responsibility, and to believe that God "visits" the sins of the fathers upon the sons. In this regard, such Christians have concentrated on the book of Exodus 20:5 and 6, which says:

"You shall not bow down to them or serve them; For I the
LORD your God am a jealous God, visiting the iniquity of the fathers upon the children to the third and the fourth generation of those who hate me, but showing steadfast love to thousands of those who love me and keep my Commandments."

Such Christians forget that we are living within the period of grace through our LORD and Saviour Christ Jesus. There is a difference between the Covenant of the first generation and the Covenant of the new generation. The Covenant of this generation is the Covenant of GRACE.

3.5.2 The evidence of two old Tsonga persons

According to Mvhexani Munghani, born in 1910, an old Tsonga man of 78 years who was interviewed at Mandlhakazi on the 11th April 1986, in olden times when people were primitive, the prevailing law was the survival of the fittest. Therefore, the chain of living was very hard. This clearly indicates that only the strong and fit, who excelled in hunting and fighting survived. The chances of living in that era were limited, because there were many constraints. How then did the disabled survive? Could the handicapped individual take part in hunting? In other words, it is possible that they had no room for them because of their physical deformities. Tribes were slaves of migration, as life was rooted in hunting. These migrating tribes were often at war with one another. During war the disabled had little chance of survival. They could neither hunt (therefore depended on others for food) nor flee (therefore depended on others for protection) with the result that the handicapped were left behind to be killed by the enemies because they were unable to defend themselves. Furthermore, Mvhexani said
that some severely disabled were killed at an early stage. This was a secret agreement of the grandmothers and the elderly people (female neighbours). According to him it was not easy to understand and accept the disabled.

According to Nwa-Mbhanyele Mabunda, a Tsonga woman approximately 72 years of age, who was interviewed on the 12th April 1986 at Nkowa-Nkowa township, house no. 648, there were two methods by which handicapped children were treated.

If the child was severely handicapped, he/she was to be destroyed immediately after birth. This was done in a severe form. The child was given boiled water or oil (pig's oil) to drink while the mother went to the river to fetch water or went to the bush to collect firewood. The child was destroyed in different ways, some pulled the umbilical cord immediately after birth. Some did not destroy the child even if the child was severely handicapped. The second method of treating a handicapped person, according to her, was, if the child was not severely handicapped he/she was free to live but was regarded as an inferior in the community.

According to this community, it was their belief that a disabled child was born, because of marriage which took place between related families without the two parties eating uncooked liver of a slaughtered goat or cow prepared for the marriage feast e.g. cousins, the uncle's daughter. Even today this belief still exists.

It was believed that this birth predicted a period of starvation and drought. Eventually the disabled were accepted in the Tsonga community, whether severely or not severely handicapped. But they were not accepted as "whole". Now, the question is, what made them accept the disabled? They
were allowed to live for the following reasons: There was a certain man by the name of Mugovo, his first born was disabled and was immediately destroyed after birth. The same thing happened to his second and third children. The wife fell pregnant for the fourth time, and a handicapped child was born. It was believed that the continuous birth of the handicapped was a message from the forefathers. Therefore, the chief brought a new law in which was stated that the life of the handicapped was legal among the Tsonga people, whether severely handicapped or not. The grandmothers were involved/in charge of the life of the handicapped as there were no clinics before, so they had to assist the daughter-in-law when giving birth, i.e. para-natal stage. Males e.g. grandfathers, and the father of the child and the mother were not concerned with the child. The grandmother had to decide the fate of the child.

According to the Tsonga Community it was a message from the forefathers to discontinue destroying innocent souls. The question is, why did this continuously happen? The naturalist, Pestalozzi (1916:51) postulates that "nature punishes man" because he has tried so many times to destroy the disabled by giving him ever more disabled children. The Community focused on Mugovo's son (cripple), who had grown up like any other child. It is said that he was highly gifted in art, such as claywork and the like.

Nwa-Mbhanyele strongly emphasised that the disabled were allowed to live in a Tsonga Community, "BUT" were prohibited from attending any feast and partaking in the ancestral worship because they were regarded as "unholy" before their forefathers. During the ancestors' worship the first thing asked by relatives was, Why was the handicapped born to
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their family? They slaughtered a cow or goat to reconcile the forefathers, and asked them not to curse them again. The cow for the rituals was given to the forefathers as a covenant so that a handicapped child would never be born into their family again. If the cow died, it was quickly replaced by another cow.

According to Nwa-Mbhanyele, in Tsonga history twins were regarded as a handicap. They regarded a woman as a goat. The best solution for them was to destroy one of the two children. It was a serious embarrassment. This woman was restricted, she was not allowed to sit on any mat used by the family because she would make others bear twins as a goat does. In destroying the twin children, old women were involved in the plot. According to the Tsonga community, it was imperative that one of the twins was killed.

3.6 A SHORT INSIGHT INTO THE BELIEFS OF THREE OTHER BLACK ETHNIC GROUPS

In conclusion, it seems sensible to give a short insight into the beliefs of three other black ethnic groups as far as handicaps are concerned, namely the Xhosa, the Zulu and the Sothos.

3.6.1 The Xhosas

According to Bukelwa Ndlovu interviewed on the 6th August 1986 at the University of the Witwatersrand, the handicapped child among the Xhosas, was seen as a visitation from God or the ancestors, especially if he was male. Rituals were made to cleanse the family. All the members would gather in one kraal for the offering. The meal would be eaten
and finished in one day. It would be mixed with bitter leaves and cow's dung. Nobody was allowed to take any of this food out of the family, and bones and horns were burnt near the cattle kraal. Furthermore, during slaughtering, the ox had to give a loud shrill cry, so that the people would know that their offering had been accepted by the ancestors.

Thus, the handicapped child would be accepted by the whole family. They would protect him from injury and harm and he would be respected by all.

The fate of these people was decided by the success of this ritual, if it failed, the ancestors were considered to be unforgiving and unaccepting of the disabled child. Depending on the degree of handicap, sometimes the child was left to die, or if he grew up he was given all the inferior jobs, like looking after children and feeding chickens. Pregnant women were not allowed to look at these children, for fear that they would produce the same child or even worse.

3.6.2 The Zulus

According to the history of the Zulu Paramount Chief Shaka, the handicapped were destroyed in a cruel way for the sake of military tactics. Shaka was war-inclined, he wanted only strong men in his tribe, therefore he had no room for disabled people. Baloyi (1983:46-60) from his book Xaka stresses that Shaka was war-inclined.
3.6.3 The Sothos

According to their historical attitude, the handicapped child was destroyed immediately after birth. It was a secret of the grandmothers. The term used was "Mafelela ndoni" which means "something ended in the hut". According to them, the birth of a handicapped child has many causes. According to them if anyone laughed at a cripple, that particular person would be given a cripple by their forefather "badimo" or God "Modimo". The Tsonga people and the Sothos have the same idea about this aspect.

According to the Sothos, a cripple is related to an albino. If anyone laughs at an albino, that particular person is given an albino too. If the albinos are killed after birth, God "Modimo" or gods "badimo" (badimo - plural for "gods" and Modimo - God for singular) will continue giving the woman an albino child until it is allowed to live, then only, will she give birth to a normal child.

Another cause, according to them, is if one hated a handicapped, this hatred gave birth to a crippled child. They had many beliefs on causes of a handicap. Their belief was that a handicap was regarded as a sign of witchcraft, that the mother had been defeated by the other pregnant wizards. In other words, the mother had tried to bewitch other pregnant women (wizards) and failed hence resulting in her giving birth to a crippled child.

Furthermore, according to them a handicap was caused by a specific disease which usually attacked children. In this situation if the mother or any family member cried during this attack, the child became handicapped due to
this cry. The child became a victim of a spastic type of handicap, more especially hemiplegia (i.e. if the left upper and lower limbs are affected or the right upper and lower limbs. Monoplegia is if one limb is affected, and is not usual). The Tsonga people also had a strong belief on this view. It exists even today.

Pregnant women were not allowed to look at the handicapped people for fear that they would produce a similar child or one even worse, a crippled figure or shadow could affect the child in the mother's womb or uterus. Moreover, pregnant women were always reminded that they were not allowed to walk on small trees for fear that they would produce a dwarf. Among the Sotho people there are more dwarfs than in the Tsonga community. This can be verified. Near Tzaneen in the Northern Transvaal (where this study is taking place) before the racial segregation took place among the blacks in South Africa, they had a special area where they formed a sort of clan. The area was called Magomu-gomu. Today they are scattered among the Tsonga people at Ritavi. These Sotho people (dwarfs) marry each other and have families.

Additional evidence of this fact was seen on the 15th September 1987. The three special schools, i.e. schools for the handicapped, i.e. cerebral palsied and the orthopaedically handicapped children from Gazankulu (Tsongas); Lebowa (Sothos) and Venda (Vhendas) underwent orthopaedic classification. On this day, the present writer personally saw that among the three groups, i.e. Tsongas, Sothos and Vhendas, there were no dwarfs among the Tsonga and Venda children, and only the Sotho group had a few dwarfs. Furthermore, deformities and disabilities are prevalent among the Sothos.
According to the Sothos, one should never wear any clothes previously worn by a handicapped person.

Another taboo according to them, is when a man has married two wives. He should be very careful about his clothes. He should buy double of everything, in other words, the property of the first wife should be strictly kept in her own house and the property of the second wife should be strictly kept in her own house. He should never leave his shirt or underwear or trousers or any clothing in the house of a first wife if it does not belong to the first house. The belief is that, she will produce a handicapped child if this happens. This applies to the second wife too.

Both wives normally stay in the same yard. If it should happen that the second wife leaves the first house/wife and stays in her own yard with a husband, after the completion of the house, according to their culture, they should perform rituals to protect their house against the witches. The witch doctor is invited to conduct the task. Therefore, the husband should "erect" the yard or stand with a first wife though the yard is for the second wife. In other words, the husband should have sexual intercourse with a first wife in the second wife's house, otherwise the first wife is never allowed to visit the second wife and if she visits she will die or give birth to a crippled child. Furthermore, if the husband dies in the second wife's house, they should make a hole at the back of the second wife's house so that the corpse can be taken out through this hole to the graveyard. The door is not to be used to take the corpse through.

If a man has divorced his wife, when he remarries he should make sure that he buys everything new. If the linen and
of the divorced wife is used, their first child will be a cripple.

According to the history of the Sotho people, twin children are regarded as handicapped and a taboo in their culture. One Sotho woman explained to the present writer that she once laughed at a woman who had twins, and then she herself produced twins, unfortunately they were still born.

3.7 CONCLUSION

In the light of the insights gathered in Chapters 2 and 3, it was possible to conduct an own empirical survey among the Tsonga people. The course of this investigation is reported in the next chapters.
CHAPTER 4

THE EMPIRICAL COMPONENT OF THE STUDY

4.1 INTRODUCTION

In the light of literature study (as a theoretical background) relevant to the phenomenon of cerebral palsy and orthopaedical handicaps, it was considered crucial for the researcher to find out empirically what the present attitude of the Tsonga people is, towards the cerebral palsied and the orthopaedically handi­
capped.

This was done, as Soma (1978:27) puts it, through

"Systematic investigation intended to add to available know­ledge in a form that is communicable and verifiable."

The researcher expected to obtain various answers from different groups according to class, religion and background in the Tsonga community. Instead of employing other data-gathering techniques, such as questionnaire, psychometric testing or systematic observ­ation, the researcher decided rather to use interviews as a means of obtaining the required information.

The interview as a data-gathering technique is most appropriate in research where attitudes are concerned, especially when indivi­dualized questioning and in depth probing is required. Although it is very time-consuming it has the advantage that the researcher can obtain a 100% response (as opposed to the posted questionnaire where response-returns can often be very low).

In this regard, the researcher was well aware of the fact that only a limited number of respondents would be able to be handled,
and that the interviews would have to be conducted with great
discretion and responsibility. The researcher therefore decided
not to utilize other field workers in the investigation, but
rather to conduct all the interviews herself in person.

Three sets of interview schedules were structured to conduct
this empirical study, i.e. interview Schedule A, B and C. To
keep the scope of the empirical research within manageable limits,
20 interviewees were involved in each interview set, i.e. 20
x 3 = 60 interviewees, were included, all in all, in the research.

The three sets involved the following three groups:

Interview 'A': Parents of cerebral palsied and orthopaedically
handicapped (crippled) children.

Interview 'B': Parents of children who are not cerebral palsied
and orthopaedically handicapped (crippled) children.

Interview 'C': Professional group; doctors; social workers;
teachers; orthotists; speech therapists; physio-
therapists and the nursing staff.

These three groups were specifically chosen for the interview
research because each group plays a different, but vital role
in the life world of the disabled child:

a. The parents were included, because they are nearest to the
child, and have a certain attitude towards "bone of their
own bones and flesh of their own flesh".

b. The parents of non-handicapped children were included, because
in a sense they reflect the attitude of the community at
large.

c. The professional workers were included, because they were
expected to have an enlightened and "educated" view of the
problem.
There is, therefore, a "triangular" relationship between parents, the community and the professional group, each forming a cornerstone in the life arena of a disabled child.

The three interview sets were structured in such a way as to probe the real attitude of the three groups as representatives of certain sectors within the community.

4.2 COMPILED INTERVIEW SCHEDULES

The researcher compiled three different interview schedules. Interview schedule 'A' comprises 40 questions; interview schedule 'B' contains 33 questions and interview schedule 'C' entails 31 questions.

In order to put each interview into perspective, it was necessary to obtain certain biographical data. All three interview schedules consist of structured as well as open-ended questions. The literature study contributed a great deal towards the compilation of the items contained in the three interview schedules, as data-gathering research instruments.

4.2.1 INTERVIEW SCHEDULE 'A' : PARENTS OF THE CEREBRAL PALSYED AND THE ORTHOPAEDICALLY HANDICAPPED (CRIPPLED) CHILDREN

In general it can be maintained without fear of contradiction that the parents are the most crucial and significant people in the life circle of any child, whether he is handicapped or not. Therefore, the researcher regards the parent as an "engine"
driving force in the life of his/her child. This is true for
a normal child and even more so in the case of a handicapped
child. It was therefore crucial and illuminating to obtain cer-
tain biographical data from this group of respondents. It is
the parent who knows the history of his/her own child. The inter-
view schedule was carefully structured to obtain the relevant
information, for example, the following introductory questions
were asked:

1. Gender
2. How old are you?
3. What is the child's name?
4. What is the child's gender?
5. What .......... age?
6. Apart from ..........., how many children do you have?
7. Which church do you belong to?
8. Where do you live, in a rural or an urban area?

The above eight questions were introductory and "warming up"
questions, as it were. Accordingly, there is a difference between
question 1 to 8 and the subsequent questions. Question 9, for
instance, asks the respondent, according to his/her view, where
a handicapped crippled individual fits in the community. This
type of question needs explanation as opposed to questions 1
to 8, which need one word to answer only, e.g. urban or rural.
In response to question 9 a variety of answers could be obtained,
for example:

- They fit in nowhere, because they are not normal;
- They are an embarrassment in the community;
- The community only pretends when claiming that it accepts
  the disabled;
- They always need help and patience, et cetera.
In the light of the literature study and also from the researcher's personal experience (living among the Tsonga people and teaching at a school for handicapped children for ten years), the following specific information seemed to be relevant and questions were asked to elicit the information:

* the parents' view on the attitude of the community, past and present, toward handicapped children (questions 9, 10 and 11);

* the parents' feelings towards their child and his/her physical condition (questions 12, 13 and 19);

* the parents' view of the causes and development of physical handicaps (questions 14, 15 and 16);

* the parents' beliefs about the causes and the physical condition of their child (questions 17, 18 and 25);

* the parents' possible experience of embarrassment concerning their child's condition (questions 20, 21 and 26);

* how the child's condition influences the parents' interpersonal relationships (questions 22, 23 and 24); and

* the parents' views on the child's education (questions 27 to 40).

4.2.2 INTERVIEW 'B': PARENTS OF CHILDREN WHO ARE NOT CEREBRAL PALSYED AND ORTHOPAEDICALLY HANDICAPPED (CRIPPLES)

The parents of children who are not cerebral palsied and orthopaedically handicapped also play an important role in the life of the handicapped child. In a certain sense they represent the community at large and, besides, according to Tsonga custom,
a child is not a child for his biological parents only, but also
for all other grown-ups (parents) in the community. Therefore,
an interview schedule was also compiled for this group of respon-
dents.

This interview schedule differs in certain respects from the
one compiled for the parents of the handicapped children. The
questions are structured in such a way that they probe the atti-
tude of this group, to find out to what extent the community
at large is sharing the problem with the parents of the handi-
capped (crippled) children.

The interview schedule starts with introductory questions which
are more or less the same as in interview schedule 'A', but as
the questions continue, they differ. The examples are as follows:

1. Gender
2. How old are you?
3. How many children do you have?
4. Which church do you belong to?
5. Where do you live, in a rural or an urban area?
6. Do you know any cerebral palsied or orthopaedically
   handicapped person in your community, and what is your
   attitude towards him or her?
7. Do you know what the historical attitude of the Tsonga
   community was towards the cerebral palsied and the ortho-
   paedically handicapped children?

This is one of the crucial questions. In comparison
to group 'A', more truthful answers were expected to
this question. Parents would be emotionally not free
to give truthful answers, particularly to this question.
It would not be easy for a parent to report that handi-
capped children were killed in days gone by. Group
"B" could easily report that disabled were killed in the past. This question was asked of the individual interviewees to find out how knowledgable the community is or how ignorant they are. This would in a certain sense reveal the interest of the community in the life of a handicapped child.

In the light of literature study and also from the researcher's personal experience, the following specific information seemed to be very significant in order to reach the aim of the study. Therefore, questions were asked to probe and verify or falsify the researcher's impressions:

* the causes of cerebral palsy and orthopaedic handicaps according to the existing ideologies of their culture (questions 10, 11 and 12);

* disadvantages and advantages of the handicapped people in the community, according to the view of non-handicapped children's parents (question 13);

* the community's (parents of the non-handicapped children) experience or belief in sin, chronic pain, curse, embarrassment and blame in the family involved (questions 14, 15, 19, 21 and 22);

* feelings of this group, if it should happen in their family that they have a handicapped child, would they be able to love, respect, understand and accept the child as a whole (questions 16, 17, 18, 20, 23, 24, 25 and 30);

* whether formal education can play a decisive role in the rehabilitation of handicapped children (questions 26 and 27); and

* the view of the parents with non-handicapped children, whether there is a need that the community should be educated (in-
formed) on the following topics:

i. The causes of cerebral palsy and physical handicaps.

ii. How to prevent handicaps.

iii. The management of the handicapped, and so on (questions 28, 29, 32 and 33).

4.2.3 INTERVIEW SCHEDULE 'C': PROFESSIONAL GROUP: THE DOCTOR; SOCIAL WORKER; TEACHER; ORTHOTIST; SPEECH THERAPIST; PHYSIOTHERAPIST AND THE NURSING STAFF.

In another sense than was stated in 4.2.1, the professional workers are the most important group in the life arena of a handicapped (crippled) child. Children spend more time with professional workers than even with their own parents. These professionals are working as a group to improve the quality of life of these children. Their respective goals are supposed to be concordant and also united for the total development of the child.

Kerr (1975:134) states that

"Whether we be teachers, therapists, doctors or parents, we aim to educate our children mentally, emotionally and physically ... An integrated, co-ordinated plan between school and therapy departments is the only sound basis for success".

The researcher agrees with Kerr that the professional group can contribute greatly towards such a "sound basis".

In the interview schedule set, introductory questions differ slightly from the first two interview sets. Some of the questions are as follows:

1. Gender

2. Which church do you belong to?
3. What are your qualifications i.e. formal training covering this special field?

4. When did you start working among the handicapped (crippled) children, i.e. experience?

5. Would you rather work with normal children?

6. i. Why are you employed among the handicapped (crippled) children?

   ii. What has motivated you in working with handicapped children?

7. Do you find it easy to work with a handicapped child or is it difficult?

In the light of the writer's personal experience and seeing that this group has broad experience in working within the life circle of the handicapped children, the following specific questions were posed to reach the goal of this study:

* whether the professional workers feel encouraged or discouraged in working with a handicapped child (questions 9, 10 and 12);

* the professional workers' personal views on whether handicapped children are an embarrassment, curse, punishment or even a special gift (question 15);

* the professional workers' probable reaction or feelings if they should beget a handicapped child themselves, or even if they themselves should become handicapped (questions 22 and 23);

* the professional workers' view of the parental attitude towards the professional workers (questions 16, 17, 18 and 19) including their attitude towards their children;

* the professional workers' disadvantages and advantages in working with handicapped children (questions 20 and 21);
* the professional workers' experience of the attitude of the community towards the handicapped individuals making use of percentage estimations of acceptance and rejection within the community (questions 12, 13 and 14);

* the professional workers' views about the causes, development and prevention of cerebral palsy and physical handicaps (questions 24 and 25);

* the professional workers' view whether it is possible to improve the different attitudes of the community towards the handicapped through educating or informing them (questions 26, 27, 28, 29 and 30); and

* whether, if it should happen in their families that they have a handicapped child, they would be able to love, respect, understand and accept the child as a whole or whether they would experience a chronic pain (question 31).

4.3 LOCALIZATION OF RESPONDENTS

As has been stated before, the respondents in this investigation fall into three groups, i.e.

- parents of handicapped children;
- parents of non-handicapped children; and
- professional workers.

The localization of these respondents differed from group to group.

4.3.1 LOCALIZATION OF THE PARENTS OF HANDICAPPED CHILDREN

The researcher, as a teacher at a special school for handicapped children had access to the names and addresses of the parents of handicapped children. From this list a group of 20 couples (parents) was eventually selected, taking due account of factors
such as availability, distance of living address from the school and willingness to co-operate (as it appeared that a considerable number of parents were not willing to co-operate).

4.3.2 LOCALIZATION OF THE PARENTS OF NON-HANDICAPPED CHILDREN

Seeing that there was no list of addresses available of parents whose children are not handicapped, the researcher had to rely on the willingness of people in the community to co-operate as respondents. The researcher, however, tried to reach urban as well as rural areas. In this respect the researcher continued until she had reached 20 couples.

4.3.3 LOCALIZATION OF THE PROFESSIONAL GROUP

In order to obtain information from professional workers, the researcher decided to involve the team of professionals attached to the special school for handicapped children. Some other professionals not directly attached to the school were, however, also involved. This group eventually included 2 doctors; 2 social workers; 1 ortholist; 1 physiotherapist; 2 speech therapists; 3 nurses; 7 teachers and 2 house mothers.

4.4 CONDUCT OF THE INTERVIEWS

Seeing that many of the parents (of handicapped as well as non-handicapped children) do not have telephones at home, it was not always possible to make appointments beforehand. Where it was possible to make an appointment, it was done, otherwise the researcher simply had to approach parents at home or at work during lunch time. It was easier to contact the professional workers by means of the telephone and to make appointments.
As far as duration is concerned, the interviews with the parents took the longest time (from 40 minutes up to one hour, depending on the parents' understanding of the questions). The professional group responded very fast and easily understood the questions posed.

Because of much distrust and suspicion among the respondents, the researcher thought it wise not to use a tape recorder. The responses were noted directly onto the interview schedule as the conversation was proceeding.

4.5 PROBLEMS ENCOUNTERED DURING THE INTERVIEWS AND OTHER LIMITATIONS

As can be expected from any investigation of this sensitive kind of research, certain problems were encountered. Hayman and Sheatsley, quoted by Shipman (1981:3) endorse this phenomenon. They maintain that "Questions about sensitive areas of human experience are difficult to word neutrally. Even if this is accomplished the results are probably invalid within a short period as the words summing up these results will have changed."

Certain problems were encountered during the interview sessions. Some of these problems were general, while others pertained to certain groups more specifically.

4.5.1 GENERAL PROBLEMS

- It was difficult to interview the less educated people (illiterates). For them an interview is a mysterious project. This was more so in the current research because it was about such a contentious area as the cerebral palsied (crippled) and the orthopaedically handicapped children. It was regarded as an embarrassing subject. The information obtained in the
appears to be reliable and valid.

- In some situations, when the researcher posed a question to the interviewees, they countered with "why" questions, like "Why do you ask me this?". Being interviewed was obviously a foreign experience to many of them.

- Some interviewees could not easily comprehend the questions posed. Thus, repetition had to take place, which was time-consuming.

- Some interviewees initially had problems in trusting the researcher. They suspected her of being a private investigator or police informer. In most cases the obstacle could be removed, however, in the course of the interview. In one case, while the researcher was busy with the interview, the interviewees were called and cautioned by a friend (or relative) to stop the interview: "You will stand before the court, the policemen will arrest you!!" Thus, the researcher had to discontinue the particular interview, and locate other respondents instead.

- The study was expensive, since the researcher had to phone for interviews and make arrangements, which some of them did not comply with, and invariably new arrangements had to be made.

- Many people did not have a telephone, to contact them for an appointment.

- Some disturbances took place during some interviews, e.g. children making a noise by crying or running up and down; visitors; or knocks at the door.

- Some respondents complained that the questions were difficult.
4.5.2 SPECIFIC PROBLEMS ENCOUNTERED WITH PARENTS OF HANDICAPPED CHILDREN (GROUP 'A')

- Parents were possibly not always honest or open to give truthful information.

- The researcher experienced doubts.

- Some parents were not accountable enough to keep the appointment confirmed, and new arrangements had to be made.

- Some parents dodged the researcher and consequently others had to be located.

- It was not always easy to reach these families, since some of these parents stay quite far from the school.

- Parents often wished to relate the crisis period and history of the child, which was not part of the interview.

4.5.3 SPECIFIC PROBLEMS ENCOUNTERED WITH PARENTS OF NON-HANDICAPPED CHILDREN (GROUP 'B')

The researcher had considerable trouble to locate parents who were willing to co-operate.

- Some people who were approached resisted, ignored the researcher and were not interested in being of assistance. Typical comments were: "No, you want to attain knowledge through us. You want to get an increase in salary from us."

- Some people could not appreciate the nature of an interview project. They wanted to be paid. The researcher was asked: "How much are you going to pay me?"

- Some interviewees were bold and the researcher was told at
- Some of the people who did participate were probably not interested very much, e.g. they did not communicate freely or look at the researcher's face.

- Some interviewees wished to discuss their private affairs with the researcher and the researcher quite often had to redirect them explicitly to the interview schedule.

4.5.4 SPECIFIC PROBLEMS ENCOUNTERED WITH THE PROFESSIONAL WORKERS (GROUP 'C')

- It was not always easy to interview the professionals. Many of the professional workers are overworked and failed to keep appointments. New interviews had to be arranged.

- This is a group which gave many excuses not to be interviewed. Much indirect resistance had to be overcome at first.

4.6 EDITING, RUBRICATION AND SYNTHESISING OF THE DATA OBTAINED

After the completion of all the interviews, the data obtained was edited, rubricated and synthesised. The results are given in Chapter 5.
5.1 INTRODUCTION

After having gathered the information from the three different groups, as has been set out in Chapter 4, the data was categorized and aggregated. The results are given in the following paragraphs.

5.2 AN OVERVIEW OF THREE GROUPS OF RESPONDENTS

The three sets of interview schedules have accumulated different answers since the interview schedules entail different questions in each set. Thus, the researcher expected different answers from each set.

For the sake of the background a short overview is given of some of the most important biographical data concerning the three groups (such as gender and religion).

5.2.1 Gender

In all three sets of interviews respondents were asked to indicate whether they were male or female. The results are given in table 5.1.

TABLE 5.1: THE GENDER OF THE THREE GROUPS OF RESPONDENTS
From table 5.1 it appears that 30% of the respondents were male and 70% were female. The distribution was more or less the same in all three groups.

5.2.2 Religious affiliation

Seeing that religion plays such a major role in the attitudes of people it was important to find out the religious affiliation of the respondents. These are reflected in table 5.2.

### TABLE 5.2: RELIGIOUS AFFILIATION OF THE RESPONDENTS

<table>
<thead>
<tr>
<th>RELIGION</th>
<th>GROUP A</th>
<th></th>
<th>GROUP B</th>
<th></th>
<th>GROUP C</th>
<th></th>
<th>TOTAL</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NO</td>
<td>%</td>
<td>NO</td>
<td>%</td>
<td>NO</td>
<td>%</td>
<td>NO</td>
<td>%</td>
</tr>
<tr>
<td>Evangelical Presbyterian</td>
<td>5</td>
<td>25</td>
<td>8</td>
<td>40</td>
<td>8</td>
<td>40</td>
<td>21</td>
<td>35.0</td>
</tr>
<tr>
<td>Apostolic Faith Mission</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>25</td>
<td>6</td>
<td>30</td>
<td>11</td>
<td>28.3</td>
</tr>
<tr>
<td>Zion Christian Church</td>
<td>6</td>
<td>30</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>7</td>
<td>11.7</td>
</tr>
<tr>
<td>Roman Catholic Church</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>10</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
<td>Pentecostal Church</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>10</td>
<td>4</td>
<td>6.7</td>
</tr>
<tr>
<td>Emmanuel Assembly of God</td>
<td>2</td>
<td>10</td>
<td>3</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>8.3</td>
</tr>
<tr>
<td>Dutch Reformed Church</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>3.3</td>
</tr>
<tr>
<td>TOTAL CHRISTIAN</td>
<td>14</td>
<td>70</td>
<td>18</td>
<td>90</td>
<td>20</td>
<td>100</td>
<td>52</td>
<td>86.7</td>
</tr>
<tr>
<td>NON-CHRISTIAN</td>
<td>6</td>
<td>30</td>
<td>2</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td>13.3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>20</td>
<td>100</td>
<td>20</td>
<td>100</td>
<td>20</td>
<td>100</td>
<td>60</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Of all the interviewees in this research 30.7% are Christians and 13.3% are non-Christians. Whereas all the professional workers (Group C) were Christians, among the parents of the handicapped children (Group A) the research reflects 70% Christians and 30% of non-Christians, although many of them became discouraged in christianity after the birth of a handicapped child. The churches with the highest representation in the total group were the Evangelical Presbyterian Church (35.0%) and the Apostolic Faith Mission Church (28.3%). This was also the case with the professional workers and the parents of non-handicapped children as separate groups. Among the parents of handicapped children the Zion Christian Church had the highest percentage (30%).

5.2.3 Areas in which respondents live

Table 5.3 reflects the areas in which the respondents live.

<table>
<thead>
<tr>
<th>AREA</th>
<th>GROUP A</th>
<th>GROUP B</th>
<th>GROUP C</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NO</td>
<td>%</td>
<td>NO</td>
<td>%</td>
</tr>
<tr>
<td>RURAL</td>
<td>14</td>
<td>70</td>
<td>13</td>
<td>65</td>
</tr>
<tr>
<td>URBAN</td>
<td>6</td>
<td>30</td>
<td>7</td>
<td>35</td>
</tr>
<tr>
<td>TOTAL</td>
<td>20</td>
<td>100</td>
<td>20</td>
<td>100</td>
</tr>
</tbody>
</table>

From the table it appears that the majority (65%) of all the respondents live in urban areas. This applies especially to the professional workers where 80% live in urban areas. As far as the parents (Group A and B) are concerned, however, the majority live in rural areas (70% and 65% respectively).
5.3 THE ATTITUDE OF THE RESPECTIVE GROUPS (ESPECIALLY ON PARENTING)

The researcher reflects first on the attitude of the parents of the cerebral palsied and the orthopaedically handicapped children. According to the view of the researcher, this study regards parents as a "mainstream" or "an engine" in the life arena of a handicapped (crippled) child. This is one of the crucial reasons why parents were the first group to be interviewed. According to Kimpton (1977:15)

"A parent is a primary helper; monitor; co-ordinator; observer; record keeper and decision maker for his/her child."

In other words, the role played by the parents is far more crucial than the other members of the family. This leads one to the fact that if the parents reject the child, the family members will probably also reject him, and if they accept the child, the whole family will hopefully also love, accept, understand and respect the child as a whole.

Kimpton (1977) strongly emphasizes that the parent is a "principal monitor". According to the view of the researcher, even the professional group, working with a handicapped child i.e. the teacher; doctor; social worker; housemother; physiotherapist and speech therapist; nursing staff, see a parent as a "mainstream" or "an engine". In this regard, whenever we talk about the cripple or handicapped children, parent is "an engine" or the "keyholder" in the life arena of a handicapped child.
5.4 THE ATTITUDE OF THE PARENTS OF HANDICAPPED CHILDREN
(INTERVIEW "A")

To understand the different attitudes of the parents towards their handicapped child, Yacoob (1983:50) says:

"It is necessary for us to look at these attitudes very carefully and examine as scientifically as possible how they arise. It is not enough simply to criticise people for holding negative attitudes. On close investigation, one would recognise that all these attitudes arise out of society, they arise out of certain factors which exist in the society."

The researcher agrees with what Yacoob says, because the attitude of the Tsonga people arises out of the factors which exist in this society. The question is then, do the Tsonga parents of the handicapped children have similar attitudes towards their handicapped children? According to the Department of Education and Training (1975c:113) Sommers distinguishes 5 different categories of parental attitude:

1. Acceptance of the child and his handicaps.
2. Open rejection of the child.
3. Disguised rejection.
4. Ignorance of the handicap.
5. Over-protection of the child.

The researcher believes that feelings are the same everywhere in all communities.

When studying the attitude of parents towards their handicapped children, the researcher has found that they vary from one family to the next and from one parent to the next.
5.4.1 Historical and present attitude of the community

It is important for parents to know what the traditional attitude of the Tsonga people was towards handicapped children, because this can influence their own (present) attitude. In response to the question what they considered the historical attitude of the Tsonga people was, the parents reported that as far as they knew the historical attitude of the Tsonga people was one of open rejection, because 80% of the interviewees reported that handicapped (crippled) babies were destroyed or killed and 20% said, they were kept out of the village or hidden in a hut. Thus, the question arises as to what the present attitude of the Tsonga community towards the handicapped (crippled) child is. In answering this question, 80% of the respondents indicated that the community still rejects the child and 20% pointed out that people pretend to love and accept the disabled. In other words (according to the parents) there is still no real acceptance in the community of a handicapped child.

5.4.2 Causes of cerebral palsy or orthopaedic handicaps

The parents of handicapped children were asked to indicate what they themselves believe to be the causes of cerebral palsy and orthopaedic handicaps and what they thought the community believed in this regard. The responses are categorized and summarized in table 5.4.

TABLE 5.4: THE CAUSES OF CEREBRAL PALSY (CRIPPLENESS) OR HANDICAPS ACCORDING TO THE INDIVIDUAL PARENT
Thirty percent of the parents themselves believe that the handicaps are caused by taboos and another 30% believe that it is caused by witchcraft. The table indicates that most of the Tsonga people do not know the real causes of cerebral palsy and orthopaedic handicaps.

The next question then was, what are the causes of handicaps according to the existing ideology of the Tsonga people. Forty percent of the parents of handicapped children were of the opinion that the community believes it to be caused by witches and 60% thought that the community believes that this condition is caused by witchcraft as well as taboo. It is thus clear that these two causes are regarded as primary causes.

<table>
<thead>
<tr>
<th>CAUSES</th>
<th>ACCORDING TO PARENTS</th>
<th>ACCORDING TO COMMUNITY (AS SEEN BY PARENT)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NO</td>
<td>%</td>
</tr>
<tr>
<td>Clinics</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>White people (e.g. high rate of polio-myelitis in Gazankulu)</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Taboos</td>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>Nature (because cripples were there before)</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Witchcraft</td>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>Witchcraft as well as taboos</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>20</td>
<td>100</td>
</tr>
</tbody>
</table>
5.4.3 Primary reactions

The parents were also asked to give their first feelings after being told about the handicaps of the child. It appears that the primary reaction of all the parents (100%) was negative, one way or the other. The various feelings include:

- Feelings of embarrassment
- Plan to commit suicide as they felt they were not willing to live or not worthy of living
- Miserable
- Disbelief
- Shocked, and racked with many questions
- Fear for suspect of witchcraft, i.e. people would consider the mother as a wizard
- Guilt feelings
- Continuous anger and many other feelings
- Wish the LORD to take the child back (death).

It is clear, then, that of all the parents interviewed, no one could easily accept the child at first. It takes time to accept a handicapped child. This is a stage in which different attitudes emanate. This is a crisis period for the parent.

In comparison with the above feelings of the Tsonga people, Bleck and Nagel (1964:216) also give different feelings of bereavement from the parents of a handicapped child. Their list include:

1. Anger
2. Grief
3. Adjust, which takes time
4. Feeling of shock
5. Feeling of guilt, which is probably less common
6. Feelings of embarrassment, which is a social reaction to what the parents think other people are feeling.

Bleck and Nagel (1964:216) continue by indicating what behaviour such feelings can cause:

"1.1 The anger of bereavement may cause aggressive behaviour towards those who are trying to help the parents. This behaviour includes neighbours; relatives; friends; doctors, etc.

1.2 The grief may cause depression.

1.3 The adjustment may come fairly quickly and through often stable is not always so in face of blames that arise later.

1.4 These sense of shock may cause disbelief and a succession of consultations at other clinics in the search for better news.

1.5 Guilt is frequently written about but it is not felt by all parents. It is a complex with undertones, for example, of punishment. It can produce depression.

1.6 Embarrassment can lead to withdrawal from social contacts and consequent social isolation."

(Highlighting by the present writer)

According to the notion of the present researcher, it is natural that everybody desires a normal child. This notion includes the Tsonga people. This is supported by many writers, for example, Gottlieb (1972:18) who says that

"The capacity to produce a normal child a healthy baby is psychologically and culturally important."

According to Gottlieb (1972:30) many parents manifest

"behaviours such as, hysteria, weeping, vomiting, diarrhea
and numbness after discovering that their child is somehow handicapped.

Bearing in mind all that has been said about the feelings of the parents in this regard, such parents can not be condemned for their negative attitude. Parents of a handicapped child may well be lost in a maze of anger; witchcraft; taboos; grief; feeling of embarrassment and so on.

5.4.4 The child: a curse or a punishment?

Seeing that the parents have different feelings and many beliefs start germinating, the parents were asked whether they considered their child a curse. One hundred percent (100%) of the parents interviewed believe that their handicapped child is a curse and a punishment. Between 65% and 75% believe it is a curse or a punishment of God and between 25% and 35% believe it is a curse from their forefathers. Regardless of whether they believe in God or in the forefathers, the parents therefore somehow seem to believe in what is written in the Bible, i.e. Exodus 20:5:

"... And when I punish people for their Sin, the punishment continues upon the children, grandchildren, and great-grandchildren of those who hate me."

In objection of this belief, the researcher argues that today we are living in a period of grace, this is a generation of grace through the death of Jesus Christ. Psalm 103:8-10 says,

"8. The Lord is merciful and gracious, slow to anger and abounding in steadfast love.
9. He will not always chide, nor will he keep his anger for ever.
10. He does not deal with us according to our Sins,
Hebrews 10:17 says

"I will never again remember their Sins and lawless deeds."

The Lord, unlike people who bear grudges towards other, does not hold grudges. The argument highlights that there is a big fight/battle in the mind of the human being. This reveals that a handicapped child is not easily accepted in the community.

The idea of regarding a disabled child as a blessing never exists. Blessings are highly valued but according to the parents a cripple is not accepted except with a feeling of pity and shame. Some parents are so confused that 50% blame God; witchcraft; the clinics; taboos and so on, but 50% of them don't place the blame on anybody.

5.4.5 Present feelings

Parents were asked what their present feelings are concerning their disabled child. It appears that chronic pain exists among the parents. Parents are confronted with a serious problem; 85% of the parents experience a chronic pain where there is no peace, and 15% of them have mixed feelings.

5.4.6 Talking about the child

Parents were asked whether they often/never talked about their disabled child. The responses reveal that 70% of the parents always talk about the child with (i) friends, (ii) relatives and (iii) siblings, relating the problems experienced. According to the researcher, this links up with the above-mentioned chronic pain feelings. On the
other hand, 30% of parents do not talk about the child, due to the fact that experience has taught them that many people continuously ask questions about the child's history, and that it is tiring and boring to keep on relating the same story. Many parents even complain that such questions about the child are poison to them.

5.4.7 Taking the child to places

From the responses of parents it appears that they never take their handicapped child to town, a party, a picnic, etc., but that 70% of them do take the child to church, and that the other 30% don't take their handicapped children anywhere.

5.4.8 The attitude of the relatives, friends, siblings and the multi-professional group working with the disabled children.

In response to a question in this regard, it appears that the parents have experienced the following attitudes from 40% of the parents regard the professional workers as the best group for their children, because they tolerate working with the handicapped. On the other hand, many parents feel that although friends, relatives and siblings often pretend to accept the disabled children, they do not totally accept them.

5.4.9 Different attitudes of fathers and mothers

Some families are incomplete and have problems of their own. In families in which there is a mother and a father there are often other problems. This research shows that
only 25% of the fathers accept the child, whereas 65% of the mothers accept the child and have a good relationship with the child but feel "chronic pain". The other 35% of the mothers have a bad attitude towards their own child.

5.4.10 Influence of the child's birth on marital relationships

The question was asked whether the birth of the child has affected the love of husband and wife. According to the research 70% of marriages are affected, only 30% of marriages are not affected by the handicapped (crippled) child.

5.4.11 Problems caused by the handicapped child

From the responses of the parents it appears that they also experience problems caused by the handicapped child, one half (50%) of the parents experience normal problems caused by the handicapped child, and the other 50% experience abnormal problems. The various problems include:

- The child is rebellious towards its siblings and parents. It is always problematic in the family.

- The child always expects special attention (mi ni khoma kahle).

- The child instructs the family to handle him with respect and is never satisfied (mi ni hlonipha).

- Many parents complain about theft.

There are also problems which force the parents to be short-tempered with a child e.g. stubbornness; theft; disloyal; slowness, etc.

Some specific instances mentioned were:

- one broke the father's arm
According to the researcher such children are very difficult to co-operate with. In other words parents never experience peace in their relationship with such children. They are faced with difficult problems, i.e. the child's handicaps and behaviour.

5.4.12 Feelings about the progress of their child

It appears that parents do feel motivated by the achievements of their child, and many have hopes and high expectations at times, but all the parents are also often discouraged by the poor progress of the child.

5.4.13 Residing place for the child during school terms

The researcher has found that all parents interviewed prefer their children to stay at the school for the handicapped rather than to stay at home and attend a day school. This is a debatable and questionable notion. Why do all parents prefer the child to stay at the school for the handicapped? Is it not an indication of not totally accepting their handicapped child? It is not a question of getting rid of the child as Cooper and Henderson (1963:160) put it:

"... the whole point is that, if you have got a sick person in the house, it's a sick house."

5.4.14 Parents' visits at school

A next question that arose in this regard is, how often would the parent visit the child at school. The information obtained is reflected in table 5.5.
### TABLE 5.5: PARENTS' PREPAREDNESS TO VISIT THEIR CHILD AT SCHOOL

<table>
<thead>
<tr>
<th>DURATION</th>
<th>NO</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every weekend</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Fortnightly</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>Once a month</td>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>Twice a year</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Once a year</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>20</td>
<td>100</td>
</tr>
</tbody>
</table>

It appears that 75% \((20+25+30)\) are prepared to visit their child at least once every month. There was no parent who was not prepared to visit his/her child at all.

5.4.15 Other matters concerning school attendance

One hundred percent \((100\%)\) of the parents believe that formal education is a key or hope in the life cycle of a handicapped child. They are all concerned that formal education should totally involve the child's life.

* In the school situation, 90% of the parents do not accept a bad report from a child from the multi-professionals working with it, 10% accept what a child reports.

* Ninety-five percent \((95\%)\) of the parents are satisfied with the way the special school treats their children, and there are only 5% who are partly satisfied.

5.4.16 The need for community guidance, counselling and education

All parents considered forming a parent's group for rehabilitation of their children and to share new ideas with others.
They all support a notion that the community needs guidance and counselling regarding handicaps. To open the door to acceptance, love, respect and understanding. Why specifically guidance and counselling? This suggestion strongly directs the researcher to support Aurthur Jones (1970:7) who maintains that

"Guidance is the help given by one person to another in making choices and adjustments in solving problems. Guidance aims to aid the recipient to grow in his independence and ability to be responsible for himself. It is a service that is universal not confined to the school or family. It is found in all spheres of life; in homes; in business and industries; in government; in social life; in hospitals and in prisons; indeed it is present wherever there are people who can help."

Guidance and counselling are the best therapy to remedy chronic pains experienced, myths, such as witchcraft and taboos, all the misconceptions of the community that a handicapped child can be guided towards a normal life. All parents wish that their children should be treated as a normal human being.

5.4.17 Conclusion

The researcher wishes to conclude this part with a number of suggestions for the parents which are summarised by Ayrault (1974:27) in her book You can raise your handicapped child Twelve suggestions for the parents in raising a handicapped child:

1. Accept; love; and respect your child.
2. Give your child a feeling of physical and emotional security.
3. Help your child reach its maximum level of physical and emotional development.

4. Encourage your child to be self-dependent and to accept what responsibility he is able to assume.

5. Give your child the gift of emotional security by responding to him with patience and understanding from earliest childhood.

6. Be consistent in all areas of development, discipline, feeding, home-bound treatment, etc.

7. Minimize the development of fears, frustrations, and other negative emotional attitudes.

8. Refrain from punishing your child beyond his physical and mental capabilities.

9. Recognise that your child's wishes, opinions and ideas are evidence of growth.

10. Show a genuine interest in your child's accomplishment, however small they may be.

11. Praise your child for what he accomplishes.

12. Encourage your child to accept himself as he is rather than as he wishes he were.

On the other hand Rogers (1969) would suggest empathy; unconditional positive regard and congruence. The researcher discourages the prejudice that a handicapped is a curse and punishment from God or forefathers.
5.5 ATTITUDE OF THE PARENTS OF THE CHILDREN WHO ARE NOT CEREBRAL PALSIDED (CRIPPLED) AND ORTHOPAEDICALLY HANDICAPPED (CRIPPLED) (INTERVIEW "B")

A handicapped person is also a member of the community. Other than his/her parents, there are also other members of the community who are not friends or relatives of a family with a disabled child. All these people are aware of the fact that there are physically handicapped people in the community, in other words they are part of the community i.e. blacks; whites; Indians and Coloureds. Disablement, is a state with which most people are not intimately acquainted; it takes on the characteristics of a mystery with its unfamiliarity. According to the researcher, man admires that which is normal in life; this is a natural fact.

As has been pointed out in the previous chapter, a group of 20 parents of non-handicapped children were interviewed to obtain an indication of the attitudes of the Tsonga community in general. The responses of this group are reported in the following paragraphs.

To verify that a handicapped person is an integral part of each community, 100% of this group (in response to a question) confirmed that they all have relatives who are handicapped and all reported a feeling of pity towards their relatives who are handicapped. In this regard, pity-feeling poses a real danger and is most influential in the life of a handicapped person. It is a "poison" because it limits development in self-confidence. It encourages frustration, isolation, regret that he/she had been born; etc. According to the researcher, pity-feeling is one of the features of disguised rejection. To discourage this, one should firstly
Goldenson, Dunham and Dunham (1978:15) quote Biklem and Bogdan:

1. Firstly, there is a tendency to presume sadness on the part of the person with disability.

2. Second, there is the penchant to pity.

3. Third, people without disabilities sometimes focus so intensely on the disability as to make it impossible to recognize that the person with disability is also simply another person with many of the emotions, needs and interest as other people. This attitude is reflected in the perennial question, "It must be hard to get around in a wheelchair?"

4. Fourth, people with disabilities are often treated as children, 'are so frequently nicknamed Benny-Bernard, Helly-Hellen, Marry-Marriam'.

5. Fifth, is avoidance. Having a disability often means being avoided, given the cold shoulder and stared at from a distance, e.g. "Sorry I have to go now."

6. Sixth, we all grow up amidst a rampage of handicapist humor. It must take a psychological toll. "There was a dwarf with a sawed-off cane ...".

Goldenson; Dunham and Dunham gave more than six examples stated above. Thus, it is clear that there are different attitudes towards a handicapped child/person in all people irrespective of colour or class, in all communities.
5.5.1 The historical and present attitude of the community

In response to the question about the historical attitude of the Tsonga community towards handicapped people, 90% of this group, reported that the cerebral palsied (cripples) were destroyed in the past, and 10% reported that they were hidden away and regarded as inferior. As far as the present attitude of the Tsonga community is concerned, 70% of the group feel that the handicapped are rejected; 20% feel that they are partly accepted; and 10% feel that they are generally accepted. According to their individual feelings, they are all uncomfortable about the historical attitude of the Tsonga community towards handicapped people.

5.5.2 Causes of cerebral palsy and orthopaedic handicaps

The parents of non-handicapped children were asked to indicate what they themselves believed to be the causes of cerebral palsy and orthopaedic handicaps. The parents sometimes gave more than one cause, with the result that the total in table 5.6 is 57 (and not 20, as would have been expected).

TABLE 5.6: THE CAUSES OF HANDICAPS ACCORDING TO THE PARENTS OF THE NON-HANDICAPPED CHILDREN.

<table>
<thead>
<tr>
<th>CAUSES</th>
<th>NO</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taboos</td>
<td>21</td>
<td>36,8</td>
</tr>
<tr>
<td>Witchcraft</td>
<td>8</td>
<td>14,0</td>
</tr>
<tr>
<td>Infection and trial of abortion</td>
<td>4</td>
<td>7,0</td>
</tr>
<tr>
<td>God</td>
<td>6</td>
<td>10,5</td>
</tr>
<tr>
<td>Drugs</td>
<td>4</td>
<td>7,0</td>
</tr>
<tr>
<td>Accidents</td>
<td>1</td>
<td>1,8</td>
</tr>
<tr>
<td>Smoking</td>
<td>4</td>
<td>7.0</td>
</tr>
<tr>
<td>---------</td>
<td>---</td>
<td>-----</td>
</tr>
<tr>
<td>Herbals</td>
<td>4</td>
<td>7.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Incest (The father having had sexual intercourse with his daughter)</th>
<th>5</th>
<th>8.8</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>57</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

According to this group, the major causes of handicaps as reflected by the existing ideologies of the Tsonga culture are **taboos and/or witchcraft** (50.8%). These two myths are the most misguided ideologies within the minds of the Tsonga people. Other causes include God; incest; infections; trial of abortion; drugs; smoking; herbals; accidents.

5.5.3 Have the parents sinned?

Some Tsonga people are rooted within the different ideologies as regards handicapped (crippled) individuals. 40% of this group believe that parents had **sinned** and 60% said that parents had not sinned for having a handicapped child.

The researcher disagrees with the notion that parents have sinned. To support this argument, according to the Bible, John 9:1-13 says:

1. As he passed by, he saw a man blind from birth.
2. And his disciples asked him, "Rabbi, who sinned, this man or his parents, that he was born blind?"
3. Jesus replied, "It was not this man sinned, or his parents, but that the works of God might be made manifest in him."
5.5.4 Reaction should parents have a disabled child in future

The researcher posed hypothetic but thought-provoking questions to this group interalia: "If in the future such a child is born in the family, would you be able to love, respect, accept and understand the child?"

* Fifty percent (50%) of the group indicated that they would be prepared to love, respect, accept and understand their child but 50% said they would have no room for a handicapped child in their families.

* Seventy percent (70%) would experience a chronic pain in their lives including the family as a whole and 30% would experience mixed feelings toward a handicapped child. According to the researcher, there are different attitudes in the community with many negative and very few positive attitudes towards the handicapped, while nobody knows what the future holds for him/her. One should remember some have had accidents; diseases e.g. polio infection, and so on.

5.5.5 Reasons for parents rejecting a disabled child

In answer to the question why they thought parents reject their handicapped child(ren), this group gave a number of reasons why they thought parents reject their children. These reasons are given in table 5.7.

<table>
<thead>
<tr>
<th>REASONS</th>
<th>NO</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling of inferiority</td>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>Embarrassment</td>
<td>8</td>
<td>40</td>
</tr>
<tr>
<td>It causes fight in the family</td>
<td>6</td>
<td>30</td>
</tr>
</tbody>
</table>

TOTAL 20 100
It appears that many parents reject the child because he is regarded as an embarrassment (40%), or because of feelings of inferiority (30%) and because it causes fight in the family (30%). A handicapped (crippled) child from a family who rejects him/her has a chronic pain which causes him to feel insecure; he may even pray for death. The researcher has experienced this from the disabled.

5.5.6 Reasons for parents acceptance of a disabled child

In contrast to the previous question, this group was also asked why they thought some parents do accept their handicapped child(ren). Their answers appear in Table 5.8.

<table>
<thead>
<tr>
<th>REASONS</th>
<th>NO</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cripples were there before</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>so not a taboo</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less serious handicaps</td>
<td>8</td>
<td>40</td>
</tr>
<tr>
<td>Intelligent at school</td>
<td>7</td>
<td>35</td>
</tr>
<tr>
<td>Regarded as a gift</td>
<td>2</td>
<td>10</td>
</tr>
</tbody>
</table>

| TOTAL                          | 20 | 100 |

It appears, the main reasons why some parents do accept the child are because the handicap is less serious (40%) or because the child does well at school (35%), although about 85% of this group were of the opinion that all parents of a handicapped child experience a chronic pain, whether they accept the child or not.
5.5.7 Other matters: concerning the acceptability of the handicapped child in the community

From the responses to other questions concerning the acceptability of the child in the community the following information was obtained:

* According to the researcher, those who accept, strong motivation is needed and those who reject also need a strong motivation to realize a handicapped in the community.

One interviewee said that she had heard members of a certain family saying that "it would be better to poison or to institutionalise the child so as not to see it again" and that the mother of this particular handicapped eventually committed suicide because of the handicapped child.

* Fifty percent (50%) of this group viewed a handicapped as an outcast in the Tsonga community because a handicapped is mocked by people; not respected by people; many parents always complain about this handicapped child; they usually ask, why the Lord forsook and outcast them in such a way? The other 50% do not view it as an outcast.

* Since a handicapped person is part of the community, 60% felt they could work among the handicapped children and 40% would work as a last choice or never work with them.

* Sixty-five percent (65%) are prepared to talk about a handicapped child or person. In this regard it depends on whether the talk is good or bad. As far as sharing a room with a handicapped person is concerned, 60% could share and 40% could not share a room because it would
cause horrible dreams (according to their belief).

* Sixty-five percent (65%) could walk in the street with a handicapped child without embarrassment, whilst 35% of the group could not walk with him because it would be an embarrassment. To indicate that a handicapped is an embarrassment, usually children insult each other by referring the other party as one of the cripples they know in the community. For example, "Go away, with your small fingers like those of the dwarf!".

* Thirty-five percent (35%) of them never talk about a cripple for fear that they may happen to have one in the future. According to them it is taboo to talk about the cripple (disable). It was a strong taboo in the past e.g. 1960.

5.5.8 Views about formal education to handicapped children
Some questions were also asked concerning the formal education of handicapped children. The groups are as follows:

* One hundred percent (100%) of them agreed with the suggestion that the handicapped children should receive formal education and agreed that formal education could play a crucial role in the rehabilitation of a handicapped child. According to Rogers (1969:22).

"Education is concerned with development toward the fully functioning person."

* There are disabled persons who are highly gifted in learning situations. According to this group 90% had recognized that some handicapped persons in the community had talents, while 10% had never realized that. Vaughan (1971:39)
expresses that Dr Winthrop Phelps, an American neurologist and a pioneer in this field, holds the same view as Keats that:

"Today we know that many cerebral palsied have normal or higher than normal intelligence, and can be physi­cally improved."

To support this notion, the researcher has found that some handicapped pupils are bright in learning situations. Today we have examples like Risiva who started his schooling at the school for the handicapped. He is presently completing his degree in medicine at the University of the Witwatersrand. Furthermore, some medical students who are presently at Medunsa (Medical School) are products of the same school for the handicapped.

Another example is quoted by the Department of Education and Training (1975:28) that

"Earl Carlson is a great man, because though seriously affected by cerebral palsy (athetosis type) he has a brilliant intellect and has achieved great academic success."

Earl Carlson was the medical doctor and also the writer Born That Way. According to the notion of the researcher a handicapped is not a curse or punishment in the family or society. A handicapped person should be regarded as a human being good and worthy of living.

5.5.9 Disadvantages of a handicapped person

The groups of parents of non-handicapped children was also asked what they considered the disadvantages of a handicapped person. The following disadvantages were mentioned:

- The handicapped person always needs special care (for
- His/her handicaps encourage him to be more lazy and he/she looks for pity feeling
- It causes embarrassment
- It causes divorce and destroys families
- It frustrates the child
- He/she is regarded as an inferior
- Some handicapped children blame their parents
- It causes a chronic pain to the parents
- Some handicapped persons are stubborn; rebellious and curse parents or people working with them.

To add on these disadvantages, according to Baloyi (1986:36) on the 16th April 1986, discussion was held with 30 Tsonga women. The purpose of discussion was to confront the question "What is your attitude towards a disabled child?" It was disconcerting to find that many answered, "It is a curse and punishment to have a handicapped child." The following reasons were given:

1. The husband will reject the child and even confirm that the child does not belong to him because he himself is not a handicapped (crippled) person.
2. The in-laws will always mock the mother. They will pass remarks that there has been no "cripple" in the family before, where does this "cripple" come from?
3. The neighbours, friends, relatives and the community as a whole will laugh at her because many regard it as a taboo.
4. The poor mother is regarded as a witch, it is a belief that the mother has tried to bewitch other pregnant women during her pregnancy and she has failed, thus she has borne a handicapped child.
5. The rejection of the child will overwhelm the mother.
with problems. The child will become a burden to her and the other members of the family.

6. The husband will always be restless at home and his attitude affects their love and the family as a whole. The husband may sometimes reject the food cooked by his wife. The poor mother will always be threatened, life becomes too hard for her. The worst part of it is that the mother is unable to work because she has to devote her time to look after her handicapped child.

7. Because of the attitude of the family and the community, the mother is somehow tempted to ask if God will take the child's life.

8. If the child is noisy, the neighbours will be affected. The family will be "chan" by the neighbours, the neighbours will always criticise this family.

9. The mother will fear another pregnancy and will be tempted to abort the foetus.

10. The family will be poverty-stricken, because the mother cannot get out to work. If they don't have enough linen to change the bed clothes, a bad odour will result i.e. economic factor.

11. The husband who drinks will condemn the child and the mother. Usually the father blames the wife for the child's handicapped condition, i.e. her fault."

According to the above information it is not easy to accept a handicapped child. Goldenson, Dunham and Dunham (1978:14) "It is realized that in terms of personal relations, if you are labelled "handicapped", therefore, handicapism is your biggest burden. It is a no win situation."

In other words, if one is a handicapped individual, you are not simply an ordinary person according to the disadvan-
tages listed. This is a difficult situation. Goldenson, Dunham and Dunham (1978:14) maintain that
"The assumption is often made that disablement is a
continuing tragedy."

The word "tragedy" has nothing good within its meaning. At this stage a question is posed, "is a handicapped person accepted?" The researcher wonders if people are not tolerating or pretending to accept them.

5.5.10 Advantages of a handicapped person

To counterbalance the previous question Group "B" was also asked whether a handicapped person has any advantages. The following responses were obtained.

- Some are more intelligent than a normal child, some schools for the handicapped have products who are medical doctors, teachers and lawyers.
- Most of them have special talents in art and craft and music.
- They help parents with pensions they receive from the Government.
- They are capable to nurse/to look after the children or family during the absence of the adult members of the family.
- They can be trained in knitting; typing; clerical work etc. and get employed in the community.
- They can herd domestic animals and help in all the inferior jobs.

All in all, according to this group, a handicapped person has few advantages and many disadvantages.
5.5.11 Strong need of educating and informing the Community

This group supports the notion of the researcher that, there is a strong need that the community should be educated and informed in the following topics:

- The causes of cerebral palsy (crippleness)
- How to prevent handicaps
- The management of the handicapped person
- At what stage in the child's development cerebral palsy (crippleness) or physical disabilities take place, etc.

This education of the community could solve some problems probed during the interview questionnaires, where the researcher found only 30% of the interviewees said that handicapism takes place at any time and 70% have no knowledge of when it occurs; 90% of them know nothing about its prevention.

5.5.12 Community contribution to the life of a handicapped person

The interviewees were asked what they as members of the community do for the handicapped individuals. Eighty percent (80%) give Christmas donations (Xikhwama xa Khisimusi) and 20% say that there is nothing they can do for them. In this regard it is interviewed to note that the Tsonga people donated the following amount through Radio Tsonga:

- 1986 donated R10 000
- 1987 donated R19 629
- 1988 donated R49 000

R78 629

This amount was donated to the school for the handicapped via Radio Tsonga in Gazankulu.
5.5.13 Conclusion

The researcher wishes to give the following verses to the handicapped and the people (community members) who donate (Xikhwama xa Khisimusi) during the Christmas period. 1 Corinthians 15:58

"So, my dear brothers, since future victory is sure be strong and steady, always abounding in the Lord's work, for you know that nothing you do for the Lord is ever wasted as it would be if there were no resurrection."

The handicapped should not nurture worries. God cares for them. Matthew 6:25-28

"25. Don't worry about things - food, drink, and clothes. For you already have life and body - and they are far more important than what to eat and wear.

26. Look at the birds! They don't worry about what to eat - they don't need to sow or reap or store up food - for your heavenly Father feeds them. And you are far more valuable to him than they are.

27. Will all your worries add a single moment to your life.

28. And why worry ...? Look at the field lilies! They don't worry about theirs."
5.6 THE ATTITUDE OF THE PROFESSIONAL GROUP: THE DOCTOR; SOCIAL WORKER; TEACHER; ORTHOTIST; SPEECH THERAPIST; PHYSIOTHERAPIST AND THE NURSING STAFF.

(INTERVIEW "C")

The group of professional workers is also important in the life experience of a handicapped child. The eyes of the handicapped children, the parents and the other members of society are focussed on the professional workers. The parents and children expect miracles to be worked by the professional workers. Sick people or patients expect healing from the doctor. Professional workers are human beings with different feelings and attitudes towards the disabled patients. Therefore, some are good and some are bad. They are not superhuman. Bleck and Nagel (1964:219) say a bit about the feeling and behaviour of the professional advisors:

"Nurses; social workers; teachers; therapists and doctors are faced with a handicapped child as are adults ... social workers and doctors can feel revulsion at the abnormal and having these feelings show them in recommending the parents to put the child into a home. When this is not what the parents would choose ... Doctors may reveal their sense of inadequacy at caring for the child by brusque dismissal of the child and parents. Doctors may also reveal their sense of inadequacy by objecting to their parents "shopping around" for a further opinion."

This quotation reveals that one should not always expect good from the professional group, one should never take things/situations for granted in life. According to what they have experienced, the views of the two psychologists, Rogers and Freud differ, Rogers says man is naturally good,
whilst Freud says *man in the light of the killings in World Wars I and II can often be bad. In life things are not always good. It is natural that one often encounters good as well as bad situations.

5.6.1 Formal training covering this special field

To place the group of professionals in true perspective they were asked about their formal training in the special field of handicaps. Eighty percent (80%) of the interviewees of this group have received formal training covering this special field. The professional group had 3 - 15 years of experience in working among the handicapped people.

5.6.2 Their aims, problems and consolations in working with handicapped children

* In working among the handicapped, 80% of the professional group prefer to work with handicapped children and 20% wish to work with normal children because the handicapped are rebellious and expect more from them.

* The aim and objectives of this group in working with handicapped children are (reasons):
  - To help as a member in the community
  - For interest sake
  - As a calling (or vocation)
  - Discovered their suffering
  - To help them to realise that there are some members in the community who care for them, love, respect and understand their handicaps.
  - Many members of the community dislike and fear the handicapped people and are not prepared to work among them.
They have relatives who are handicapped. Realization of their talents was also a prime motive.

This group has devoted themselves to work for handicapped children in the community. It appears that, therefore, 55% find it easy and 45% find it difficult to work with a handicapped child.

* Although it is not easy to work with a handicapped child, 75% of the professional workers prefer to work among the handicapped children for the rest of their lives and 25% of them have doubts. They sometimes feel discouraged by working with handicapped persons. The main obstacles are the misconduct; some handicapped children are sometimes rebellious to the helpers; some have no respect, but most of them do have; because they are not given corporal punishment it sometimes encourages the child to have chances from time to time. On the other hand some have hope when working with a handicapped child. What gives them this hope? The following reasons are given:

- It helps them to trace their talents
- It is rewarding to help their people
- The positive result they produce
- To attain more knowledge in this field
- The realization that even they as normal persons could be a handicapped in the future
- Feeling rewarded when the child improves and becomes functional
- The chance of improving people's standard of living and attaining a better lifestyle
- Their teaching method is interesting
- To know them better: the more one knows them, the
more one loves them and develops a new attitude towards the disabled people.

Some of the handicapped children have positive attitudes towards the professional workers.

If all professional workers and the community at large, could have these expectations there would be a sunny future for the handicapped in the Tsonga community.

5.6.3 Prediction of the future of the handicapped child

Seventy percent (70%) of the professional workers predicted bright futures in the lives of handicapped children through assistance availability. For example:
- If the community accepted them
- If they were trained to live normal lives
- If there were facilities
- If they were given the right opportunities

The researcher suggests that, if a handicapped child accepts himself and his handicaps a bright future can be expected for him.

Thirty percent (30%) of the interviewees said it could be bright if the handicapped were cared for in after care centres or institutions because after their discharge from the special school, life becomes dull for them in the community. The researcher strongly agrees with this notion because she has met many handicapped people who had showed promise of a bright future at the school for the handicapped but after discharge the researcher found that they had not reached full potential. The essential problem at this stage is that most of the handicapped are not happy at home but happy
at school. Most of them are never at ease, they are employed in the community but after a short period of time, more problems arise. They are never satisfied with their employers and their co-workers.

5.6.4 The personal attitude of the professional workers

The professional workers were asked a number of questions covering their own attitude towards the handicapped child, and also what they considered the attitude of the Tsonga community towards handicapism to be. Their responses are given below:

* According to their responses 65% of the professional workers have a positive attitude towards handicapped children. To verify this, parents reported that professional workers are the best equipped people in the community to handle their children. However, 35% of the professional workers have some mixed feelings. This is not unusual because mixed feelings very often occur in normal life, even with non-handicapped children, when a child is wrong the teacher feels bad and when the child is good, another attitude develops. He feels proud and encouraged (rewarded) in working with the child.

* Professional workers usually have close relationships with the parents. The best group is the one which knows the parents in the community. According to the experience of the professional workers, parents who accept their handicapped child range from 20% - 30% and who reject them range from 70% - 80%. In general, according to them, Tsonga people who accept the handicapped in their midst range from 10% - 30% and those who reject them
range from 70% - 90%.

* In many cases (according to the professional workers) the handicapped (crippled) child is considered a curse or an embarrassment in the family. In this group, 50% considered handicapism as a curse and embarrassment, whilst 50% negate this.

* In this group of the professional workers, 85% do not regard the handicapped child as a punishment but 15% do regard the child as a punishment. Such a child is not regarded as a gift from God. According to the view of the researcher, a handicapped individual is not a curse, an embarrassment or punishment. Handicapped people are human beings who are worthy of living.

* Concerning the knowledge of the professional group based on the traditional Tsonga view towards the handicapped, it became apparent that the Tsonga community considers the handicapped child as
- a curse bestowed upon unfaithful parents;
- an embarrassment;
- not an easy person to be accepted;
- the result of witchcraft and taboos;
- a punishment from God and the forefathers.

To support this belief, Goldenson, Dunham and Dunham (1974:14) say:

"There are also religious beliefs that illness or disability is a punishment from God, and families influenced by these beliefs are tormented with the idea that the disability is the direct result of someone's sinning."
The researcher disagrees with the above notion. The Bible says that God does not reward us according to our iniquities (Psalm 103:10-12).

According to this group, parents of a disabled child never endure peace, they experience a chronic pain. It is revealed by their attitude. The negative attitude gives rise to poor relationships between the parents and the professional workers. According to the responses from this group, very few parents have good relationships with the professional workers. For example, some parents withhold the child's history. It was reported that parents are good when in need of help, with which they are seldom satisfied. Parents expect a change or improvement of a miraculous nature. Another example is that if the child is not admitted to the special school, the parents' attitude changes or if the child is admitted, they leave everything in the hands of a social worker or school. The child is titled "munhu wa wena" meaning "your person". In other words it is not their child anymore. They call it the Government's child and are often unwilling to participate in the child's life. For the non-progressive disabilities blame is laid on the professional workers e.g. social worker, doctor, teacher, physiotherapist, orthotist, nursing staff and the speech therapist. It should however be kept in mind that even at the school for the normal pupils, there is often a poor relationship between the home and the school.

The professional workers maintain that some parents are never satisfied and sometimes their demands are impossible to meet e.g. in learning situations, they expect high marks though the mental capacity of the child does not
reach the particular standard. Some pupils fail to be promoted to the next standard (e.g. from Std II to Std III). Some children have to repeat the same standard for three years and when such a child is discharged from the school to the handwork section, a strong negative attitude arises within the parents towards the school. Some parents can never accept that their child is a failure.

* The professional group reported that, many parents are not interested in what the child learns. According to them, the parents who are interested range from 10% to 20% and 80% to 90% are not interested. From 10% to 30% of the parents visit their children regularly at school.

In view of the above responses it would appear that very few parents truly accept a handicapped child.

* Eighty percent (80%) of the professional group encountered problems which were caused by the parents of the handicapped child. The problems are as follows:

- Open rejection of a child at school by the parents.
- During school holidays parents do not meet their children at the stations.
- Parents expect more from the professional group – complaining all the time.
- Parents neglect the child's instructions given by the professional workers, e.g. they don't supervise the child to wear appliances which help them in body functioning.
- Some parents easily accept a bad report given by a child about the professional workers, resulting in negative attitudes that arise.
- Wrong addresses are given by some parents to break
communication and, they are nowhere to be found.
- Some parents do not show parental love (disguised rejection).
- There is a poor contact between the parents and the professional workers.
- The professional group has to deal with impatient parents or relatives of the child concerned.
- Most of them fail to visit the child at school and are also not interested in the child's work. Most of them never give their child pocket money.
- The social worker is sometimes reported to the Government because the child is not admitted to the special school, (the social worker is blamed) although it is certified by the doctor that the child is not educable.
- Some parents always defend their children.
- Some parents overprotect a child (very few parents).
- Some have disguised rejection and it is not easy to work with such parents.

In the light of the myriad problems the professional workers have reported, the question is why many are still interested in working with the handicapped? In this regard, 40% of the professional group indicate that they prefer to work with a non-handicapped child, 25% prefer working with a minor-handicapped child and 35% prefer working with both.

* In answering the question about the causes of cerebral palsy, the following causes were given by the professional workers: virus infection; meningitis; prematurity; genetic; non-progressing defect of the brain; traumatic birth; difficulties during birth; bleeding during pregnancy; nature and kernicterus.
It is clear that this group has a better knowledge on the causes of handicaps than group "A" and "B".

In contrast to their own views, it was reported by all (100%) the professional workers that according to the existing ideologies of the Tsonga people, witchcraft and taboos are considered to be the causes of cerebral palsy or handicaps.

In response to the question whether the professional workers know how to prevent cerebral palsy or handicaps, 65% do not know how to prevent it, 35% at least know how to prevent it e.g. medical check up; girls who are crippled should be given contraceptives; antenatal clinic; take only the doctor's prescription when pregnant and genetic counselling. Dr Graig, Department of Orthopaedic Surgery, University of the Witwatersrand (1983:3) encourages prevention.

"Prevention can be classified either as primary, secondary or tertiary. For instance, Poliomyelitis vaccine given to a child correctly will prevent the illness (handicaps)."

The researcher agrees with Dr Graig because prevention could limit the number of handicapped people in all communities.

5.6.5 Formal education

The professional workers support the notion of the researcher that the handicapped children should receive formal education. Their education should take place in a special way with special facilities and special teachers. In such schools, according to Gearheart (1980:15)

"A variety of specialised equipment, such as modified typewriters, pencil holders, page turners, special desks and braces, may be required. Cerebral palsied
What is "special education"? According to the Department of Education and Training (1975:56)

"Special education includes such education of special nature, such medical, dental and therapeutic treatment (including the performance of operations). Provision of artificial medical aids, care in a hospital and in a school hostel; transport and escort and the provision of such other services as, in the opinion of the minister, are necessary to meet the needs of a handicapped child."

Reasons for formal education structured under special education according to the views of the professional workers:

- To be accepted in the community.
- Through formal education handicapped individuals can face the future to become independent people, not to depend on others.
- To get suitable jobs in accordance with their disabilities.
- To live a normal life in the community and care for themselves.
- Formal education will encourage emancipation, it will develop self-confidence and self-acceptance, to understand that nobody is to be blamed for his/her handicaps.
- To discourage handicaps and encourage him firstly as a person and then as a handicap. To avoid self-pity. Boom (1969:48) says "self-pity creates darkness, and can even create sickness. It is a very respectable sin, logical and convincing." Many handicapped children yield to self-pity.
- To realize that they are also part of the community and
should play their part/role.

- To develop a competitive spirit in life and classroom situations.
- To realize that they should learn as normal pupils do since they are using the same syllabus.
- To encourage their artistic abilities so that they become more creative in arts and crafts. According to Cruickshank (1971:249-250)

"It is the task of the teacher to encourage this special talent. The goals of art are: To develop visual perception; to develop motor control; to aid in the teaching of writing; to reading and maths; to establish spartial relationships and to help the child in socialization with the group."

These are the reasons why the handicapped children should receive formal education.

Presently Gazankulu is faced with a serious problem, there are insufficient schools for the handicapped children. At present there is only one special school in existence and the second one will be officially opened in July 1989 (school for the deaf).

5.6.6 Reactions should professional workers themselves have a handicapped child in future.

The question was asked, what the attitude of this group "C" i.e. professional workers would be if one of them happened to have a handicapped child in the family. Would this particular individual be able to love, understand, accept and respect the child? In this regard, 65% reported that they would experience a chronic pain, 15% would have mixed feelings and 20% would accept the child for the following reasons:
- The special experience attained in this field by them would encourage the individual to accept the child.
- They would be able to improve the handicaps of the child.
- Guidance and counselling could help in acceptance of the child.

5.7 SYNTHESIS

In this chapter the responses of three groups of interviewees were given, i.e. parents of the handicapped children; parents of the non-handicapped children and the professional workers. Findings, conclusions and recommendations emanating from these responses are given in the next chapter.
CHAPTER 6

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS FROM THE RESEARCH: “EVERY LIFE HAS ITS PURPOSE”.

6.1 MAJOR FINDINGS FROM THE RESEARCH

From the results of the empirical research, as reported in Chapter 5, the findings of this investigation can be summarized as follows:

6.1.1 General findings

From the responses of all three groups of interviewees concerning the handicapped child, it is clear that:

- Everybody desires a normal child.
- Handicapped children were destroyed in the past.
- Handicapism is regarded as an embarrassment.
- It causes chronic pain to the parents.
- A handicapped individual needs special care for the rest of his life.
- People have a feeling of pity and shame towards the disabled, which indicates that the handicapped child is not always fully accepted.
- Many people have no light on the cause or aetiology of handicaps.
- Many people have no light on its prevention.
- Handicapped children should receive formal education.
From the responses of the parents of handicapped children, it appears that:

- Parents blame various persons or forces, including God, the ancestors, witchcraft, maternity clinics, white people and contravention of taboos for their handicapped children.

- All the parents (100%) believe that a handicapped child is a curse and punishment: 75% see it as a curse and punishment from God and 25% say it is a curse from the forefathers.

- Due to all the problems encountered, not a single parent interviewed regarded his/her handicapped child as a blessing.

- The majority of parents (85%) experience chronic pain and 15% have mixed feelings towards their handicapped children.

- Most of the parents do not like talking about their handicapped children.

- The handicapped child needs special attention.

- Many complained about the lack of respect that they experience from their handicapped children.

- Some of the handicapped children are reported to be rebellious towards their parents as well as towards their siblings.

- All parents harbour a wish that one day a miracle will cause their child to become normal.

6.1.3 Findings pertaining to the parents of non-handicapped children.

Parents of non-handicapped children reported the following facts:

- Handicapsim is a "poison"; it limits development in self-confidence; it generates frustration, isolation and regrets.
- Some of this group believe that parents of the disabled children have sinned.
- Some of them would not accept, love, understand or respect a handicapped child if it were born into their families.
- Half of this group believe a handicapped person to be an outcast in the Tsonga community.
- Handicapism causes divorce and unrest in the family.

6.1.4 Findings pertaining to the professional workers in particular.

From their responses concerning the disabled child, it appears that the professional workers
- have discovered the rejection (open and disguised rejection), suffering and need of the handicapped children;
- wish to help in the community;
- recognize the potentials of the handicapped and desire to reveal and realize them;
- find it not easy to work with handicapped children and that a lot of patience is required;
- feel that the more one works with handicapped children, the more one understands, loves, respects and accepts them;
- are encouraged by good behaviour and that bad behaviour of the children discourages their devotion;
- are dissatisfied with the attitude of the parents towards their handicapped children;
- regret the poor relationship that often exists between parents and professional workers.
6.2 CONCLUSIONS FROM THE RESEARCH

From the above-mentioned findings the following conclusions can be drawn:

- Handicapped individuals need help from the community.
- It is not easy to accept, understand, respect and love a handicapped person.
- Handicapped persons are acceptable and are not accepted as they should be.
- There is still very much ignorance about the causes and prevention of handicapism before, during or after birth.
- The community needs to be educated in this specific area.
- Handicapped children need special education.
- Handicapped children are not easy to work with.
- People are not inclined to talk about handicapped children; they are regarded as an embarrassment.
- Many people still believe in witchcraft and taboos as causes of handicaps.

This indicates a strong and defined need for guidance, counselling, information and education in this specific area so that people will be led to respect, love, understand and accept handicapped individuals in the community.

6.3 RECOMMENDATIONS EMANATING FROM THE RESEARCH

In the light of the above-mentioned findings and conclusions, the question which arises is the following: What can be done, not only to change the destiny of these children, but also the attitude of the community towards them?

The researcher strongly believes in the aspect of changeability. The world is not static; it is dynamic. Feelings and attitudes
are not always the same. To support the notion of the researcher, Hjelle and Ziegler (1981:55) say that, according to Rogers (1969), in the concept changeability, the personologists see a commitment towards continuous personal growth. People are described as forever growing; unfolding their potentialities, and thus changing in the process. According to Hjelle and Ziegler (1981:55), it is not only Rogers who believes in changeability, but also Maslow, who holds the same view as Rogers. According to Maslow's theory, people have the capacity to decide what kind of persons they wish to become, as they grow in various directions. Personality changes necessarily take place. Thus, the recommendations of the researcher could contribute towards improving the attitudes of the Tsonga people, regarding the respect, love, understanding and acceptance of handicapped people in the community.

6.3.1 Recommendation concerning the need for more institutional care.

According to the view of the researcher, there is an urgent need to improve the care structure of the disabled children in the Tsonga community.

* More institutions should be established throughout Gazankulu for the daily care, training and education of handicapped children. This could relieve the long waiting list presently experienced at the only school for the handicapped children in the country (Gazankulu).

* These institutions can also serve as resource centres to educate parents and other people in the community concerning the care and prevention of cerebral palsy and orthopaedical handicaps.
6.3.2 Recommendations concerning community change.

There is a strong need for a change in the attitude of the Tsonga community at large (and parents in particular) concerning the cerebral palsied and orthopaedically handicapped persons in the community and an education towards accepting these disabled individuals as good and trustworthy human beings, worthy of living.

* According to the desire of the researcher, this should be done by specially trained counsellors within a specially designed and concerted community guidance and counselling programme.

* The strongest need for information and training is in aspects such as

  - the causes of cerebral palsy and orthopaedic handicapism;
  - the possible stage(s) at which the mentioned handicaps set in;
  - how to prevent these handicaps;
  - how to extirpate the different myth ideologies concerning these handicaps; and
  - the care of the handicapped child.

* According to the researcher this training (guidance and counselling) should preferably be conducted at the envisaged schools or institutions for handicapped children, but until such time that these schools have been established, it should be done at community centres or churches.

* Such training (guidance and counselling) should best be introduced as group training, including as many parents as possible. Group training, according to authors such
as Brington, Baker, Clark and Ambrosa (1982) and Christensen, Johnson, Phillips and Glasgow (1980), seems to be more effective than individual training, because parents and other participants can provide each other with
- companionship,
- support,
- encouragement in programming efforts, and
- useful information.

* The aim of suggested guidance and counselling, according to the researcher, is:
  - to increase the behavioural knowledge and teaching skills of parents and other participants;
  - to improve the participants' handling of their handicapped children by methods of play skill teaching, and
  - to aid them in their management of behaviour problems.

* As far as duration is concerned, the researcher suggests that this activity should continue until there are enough schools and care centres for handicapped children. Furthermore, this programme can train the parents in home management of these children who as yet have not found a regular placement in a special school.

* Apart from community institutions, what else can be done to motivate people towards loving, accepting, respecting and understanding the disabled children or individuals in the Tsonga community. These concepts could be promoted through the following media:

1. **Radio and television** can be most effective, according to the views of the researcher in reaching illiterate people, who are unable to read or write. Radio and television could help in:
- discouraging superstitions and any other myths;
- revealing the causes of cerebral palsy or crippleness;
- a demonstration of at what stages of development cerebral palsy or handicaps set in; and
- showing how to prevent them.

2. **Newspapers and periodicals** can also be used to educate the Tsonga community, specifically those who are literate, but who are still indoctrinated with **wrong ideologies of taboos and witchcraft.**

3. The (ordinary) schools (for non-handicapped children) can introduce the care of the handicapped as part of their curriculum.

4. The church, by means of spiritual encouragement, can also uproot preconceived ideologies and this will help the community at large and parents in particular to **love, accept, respect and understand** the handicapped within their midst.

6.3.3 **Recommendations concerning specific training of parents and professional workers concerned with the handicapped child.**

The resultant question then is: "Who is able to provide parents and professional workers with the 'key to acceptance'?"

* According to the view of the researcher, the **Counsellor** should guide the parents i.e. opening the doors of **understanding**, **loving**, **respecting** and **feeling** for the handicapped. The views of the researcher are in accordance with many other writers. Sherman, Frenkel and Newman (1986) and Morrissey, (1976), for example, say that **acceptance** including **tolerance; approval; loving; respecting** and **feelings** for others. Furthermore, according to Prout and Douglas (1986) **acceptance** is essential
for the success of family care and other community placements. The researcher agrees whole-heartedly with Prout and Douglas.

* Professional workers, i.e. the doctors; social workers; physiotherapists; speech therapists; occupational therapists; teachers; the nursing staff and parents play an important role in the life of handicapped children. According to the view of the researcher, they should maintain the well-known Rogerian qualities, viz. congruence; unconditional positive regard and empathy. This applies especially to the professional workers, but parents should also strive towards these qualities.

1. **Congruence**

Belkin (1981:109-110) views congruence in terms of genuineness, which simply means that the counsellor must be himself in his relationship with his clients; that he avoids presenting a facade or "acting out the role" of the therapist. Moreover, Stefflre and Steward (1970:8-9) agree with Rogers who maintains that the counsellor's being should be authentic or real, in the sense that what the counsellor is experiencing internally should be consistent with the messages that he is communicating to the client externally. This allows the counsellor to be aware of and honest about the kinds of feelings the client is eliciting. Counsellors could contribute greatly towards parents' also attaining such congruence.

2. **Empathetic understanding**

According to Stefflre and Steward (1970:8-9), the counsellor must experience empathetic understanding of the client's (child's) internal frame of reference, recognising, however, that no one can ever fully understand what an individual is experiencing intern-
This was initially emphasized by Rogers, who stated that the counsellor must develop a highly accurate understanding of the client's internal frame of reference, by putting himself in the client's boots. Although the counsellor can never become the client, the counsellor must try to understand the client's situation. This also applies to the parents in particular.

3. Unconditional positive regard

Belkin (1981:109-110) says that unconditional positive regard occurs when the counsellor accepts the client and all of his experience without judgement; without evaluation; and without any conditions. Stefflre and Steward (1970:8-9) state that this genuine acceptance of all aspects of the client's self experience is central to the client-centred counsellor. Such unconditional positive regard for an individual means respecting the person, regardless of the different values the counsellor might place on certain behaviours. In other words, a handicapped person should be accepted as he/she is, regardless of his/her handicaps. To maintain such feelings for a person, counsellors must be non-valuative and accept the client as an individual. Rogers believes that, when this condition is provided, the client will start to believe in himself as a person of worth, one who is capable of growth. This aspect equalizes with the aspect of "holism". Parents need the support of professional workers to attain such an uncondition- al, positive and holistic regard of their child(ren).

* Furthermore, the researcher recommends that teachers at the special schools should qualify in guidance and counselling in order to acquire all the necessary techniques to guide and counsel their pupils in the school situation, even in life as a whole.
This would help teachers to handle all pupils, regardless of what the concerned parents' attitudes towards their child may be, i.e.

i. Acceptance of the child and his handicaps.

ii. Open rejection of the child.

iii. Disguised rejection of the child.

iv. Ignorance of the child's handicaps.

v. Over protection.

(Sommers, in Department of Education and Training, 1975d:113).

6.4 GOALS FOR CEREBRAL PALSYED AND ORTHOPAEDICALLY HANDICAPPED CHILDREN

Handicapped individuals (even children) also think about their handicaps, more especially the individuals who are experiencing the following attitudes:

i. Open rejection

ii. Disguised rejection

iii. Ignorance of him as a child and his handicaps.

In this regard, according to the view of the researcher, teachers or professional workers and the parents should talk to the bigger children, or even ten-year-olds, about their handicaps, especially after such children's realization of their self-concept or body-image. The following aspects are, for example, crucial to discuss with the handicapped children:

- that they have to live with their handicaps;
- that no one is to be blamed for their being handicapped;
- that they must make the best of their condition and always try to improve themselves;
- that being handicapped is not a punishment, curse or embarrassment;
- that they have certain abilities to compensate for their disabilities, certain abilities that they have which normal people
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- that they must stress the positive in life and never concentrate on the negative;
- that they are human beings, good and worthy of living;
- that they should try to avoid the many internal "whys" in their minds;
- that "every life has its purpose", God created them with a purpose.

* Adolescent handicapped should also be encouraged to join in a group work and to talk about their handicaps.

* Moreover, it is recommended by the researcher that the teacher of disabled children should be encouraged to obtain the Diploma in Special Education (D.S.E.) which is being offered through the Department of Education and Training (D.E.T.) or through the University of South Africa (UNISA). These are geared toward a better understanding of the handicapped child.

* More specifically it is recommended that professional workers and parents, who are the "keyholders" in the life arena/cycle of the handicapped, should encourage the following aspects in handicapped children.

1. **Self-discipline**

All people desire self-discipline in a normal life and society. Handicapped children should be encouraged to reach high standards of self-discipline. In this regard, the child has to accept himself and his handicap.
2. **Self-confidence**

Cerebral palsied and the orthopaedically handicapped children usually feel inferior and self-conscious on account of their handicaps. More especially with the adolescent group where they start judging or criticising themselves because of their disabilities. If an individual accepts a challenge and succeeds, there is an improvement in the individual's physical condition. This attitude helps the individual to overcome his/her self-consciousness and he/she will stop meditating so much over their handicaps.

3. **Integration into society**

Handicapped people are part of all communities. Therefore, parents and professional workers should encourage handicapped children to learn to live with others, in order to develop normal personalities. In this regard, it is crucial that cerebral palsied and orthopaedically handicapped children be given a chance to play with others in the community. Handicapped people do not live in an isolated world community, but live among normal people with normal life-styles. According to Vygotskii, the child's intellectual development or cognitive learning takes place through playing (i.e. integration in the community). His sense of humour should be developed and his knowledge and capabilities extend his experience otherwise he may yield to "self-pity". This attitude is regarded as a "poison" in the life-arena of the disabled, according to the view of the researcher. In this way the handicapped can be saved from the crippling effects of fear, anxiety, regret and self-consciousness.
4. **Motivation**

The aspect of motivation should play a crucial role in the life of a handicapped child. The child should be motivated to explore and expose himself to different aspects of life and to attain more knowledge which will enable him to overcome his handicaps.

5. **Perseverance**

Perseverance leads to success. The researcher believes that handicapped children should be encouraged to persevere in life, in order to achieve success.

6. **Love**

Handicapped children should be encouraged to love their friends, professional workers, house-mothers and their parents (some of the children are from the families which reject them). They are to love as the Lord has commanded us to love one another as He has loved us.

7. **Respect**

Some handicapped children do not have respect and are rebellious towards the professional workers, parents, siblings and their peer groups. Thus, respect must be emphasized.
6.5 CONCLUSION

The researcher wishes to conclude this study with some closing remarks. According to S.A. Cerebral Journal, Volume 25, Number 1, March 1981, page 3, the year 1981 was proclaimed the year of Disabled Persons, and had the following objectives:

"a. Helping disabled persons in their physical and psychological adjustment to society.

b. Promoting all national and international efforts to provide disabled persons with proper assistance, training, care and guidance to make available opportunities for suitable work, and to ensure their full integration in society.

c. Encouraging study and research projects designed to facilitate the practical participation of disabled persons in building and transporting systems.

d. Educating and informing the public of the rights of the disabled person to participate in and contribute to various aspects of economic, social and political life; and

e. Promoting effective measures for the prevention of disability and for the rehabilitation of disabled persons."

The Christian Medical Commission (1988:1) gives some words of encouragement:

"Whatever caring group of individuals, Church or other organization you belong to, you can promote the participation and integration of people with disabilities by the force of your own example."
Rev. Harold Wilke, Founder/Director of the "Healing Community" in White Plains, New York (1988:9), suggests the following targets and dimensions for the different people in the community:

"Target the parent: 'Don't limit the possibilities.'
Target the physicians: 'The human body has many ways of coping.'
Target the school: 'Place these children in normal schools.'
Target the church: 'Disability comes not from SIN!'

'Preaching must be that of FAITH and HOPE and LOVE.'

Target the psychologists: 'The human spirit is far more resilient than we know!'"
ADDENDUM A.

INTERVIEW A

PARENTS OF THE CEREBRAL PALSIED (CRIPPLED) AND THE ORTHOPEADIC HANDICAPPED (CRIPPLED) CHILDREN

1. Gender

2. How old are you?

3. What is the child's name?

4. What is the child's gender?

5. What is ................. age?

6. Apart from ................ how many children do you have?

7. Which church do you belong to?

8. Where do you live, in a rural or an urban area?

9. According to your view, where does the handicapped (crippled) individual fit in your Community?

10. What do you know about the attitude of the Tsonga Community towards handicapped (crippled) people in the past?

11. What is the attitude of the present community of Tsonga people towards the disabled (crippled)?

12. What were your expectations of ......................... before his/her birth, OR what type of the child did you expect?

13. What was your first feeling or attitude after being told about the handicaps of .........................
14. As a parent of a handicapped (crippled) child, what do you consider the causes of handicaps according to your belief?

15. What are the causes of handicaps (crippleness) according to the existing ideology in your culture?

16. According to the belief in your culture at what stage does a handicap develop?

17. i. Do you think your handicapped (crippled) child is a curse in your family by your forefathers?

ii. or a curse by God?

iii. Do you blame somebody in particular that you have a handicapped (crippled) child?

18. i. Do you view your child as a punishment from God?

ii. or your forefathers?

iii. Do you view your child as a special blessing from God?

iv. Or as a special blessing from your forefathers?

19. i. As a parent of a handicapped (lame) child in your Community, do you endure peace in your life in this connection?

ii. Is it painful to think of your child's handicap (chronic pain)?

20. Do you ever talk about.......................... with your
i. Friends
ii. relatives
iii. his/her siblings
21. i. Do you ever walk with your child in the street?

ii. Do you ever take him/her to a party, church, town, etc?

22. According to you view, what is the attitude of the following persons in your Community:

i. the relatives
ii. the friends
iii. siblings
iv. the multi-professional group working with a handicapped child?

23. i. To the mother: What is the attitude of the father towards?

ii. To the father: What is the attitude of the mother towards?

24. i. To the mother: Did the birth or presence of the child affect your LOVE for your husband?

ii. To the father: Did the birth or presence of the child affect your LOVE for your wife?

25. Do you believe that every life has its purpose?

26. i. Have you ever encountered serious problems concerning?

ii. Have you ever wished that God or forefathers would take the life of?
EDUCATIONAL INTERVIEW

27. Do the achievements of................. motivate or discourage your love, understanding, respect and acceptance of your child as a whole?

28. Do you wish that your child should stay (live) with you at home or would you rather leave him/her at a school that cater specifically for such children?

29. If ............... were admitted to such a special school, how often would you like to see or visit him/her?

30. Do you accept a bad report from................about the multi-professionals working with a child e.g. the principal, teacher, housemother, nurse, doctor, physiotherapist, speech therapist or anybody working with your child?

31. Do you think formal education is the key or hope which could make your child be accepted as a human being worthy of living in any community or is there any other possibility?

32. In educating your child are you concerned that it should cover his/her life in totality?

33. i. Are you satisfied with the way the special school treats your child?
   
   ii. Have you ever considered forming a parent's group for rehabilitation of your child and for the new opinions which help share the load of parents of handicapped children?

34. Does the community (including parents) need guidance and counselling regarding handicaps?

35. Do you think there is a need that the community should be educated (informed) on the following aspects:
   i. The causes of the cerebral palsy or handicaps (crippleness)?
   ii. When does cerebral palsy or handicaps take place?
   iii. How to prevent cerebral palsy or handicaps?
   iv. How to extirpate the different myth ideologies?
   v. The care of a handicapped child and so on?
Where should this take place?
1. Through radio/television
2. Newspapers/periodicals
3. Special meeting/trainig sessions
4. At school as part of the curriculum

36. Some parents do not meet their child at the station but bring the child back to school quite readily.
Why is this so? What could be the reason?

37. Are there problems which sometimes force you to be short tempered with...................•...? What are the problems?

38. Do you wish.....................to be treated as a normal human being?

39. What do you think the possibilities are to have another crippled child in the future?

40. Have you ever considered that a handicapped person could be a TALENTED human being?
ADDENDUM B

INTERVIEW B

PARENTS OF THE CHILDREN WHO ARE NOT CEREBRAL PALSIED (CRIPPLED) AND ORTHOPEDIC HANDICAPPED (CRIPPLED)

1. Gender

2. How old are you?

3. How many children do you have?

4. Which church do you belong to?

5. Where do you live, in a rural or an urban area?

6. i. Do you know any Cerebral Palsied or handicapped person in your community?

   ii. What feelings does he/she provoke in you?

7. i. Do you have a relative who is a handicapped (crippled)?

   ii. What is your attitude towards him or her?

8. Do you know what the historical attitude of the Tsonga Community was, towards the cerebral palsied or handicapped child?

9. Are you comfortable or uncomfortable about the historical attitude of the Tsonga Community towards the Cerebral Palsied (crippled) children?

10. i. What are the causes of Cerebral Palsy or crippleness according to your belief?
10. ii. What are the causes of cerebral Palsy or crippleness according to the existing ideologies of your culture?

11. At what stage in the child's development does cerebral palsy or crippleness or physical deformities take place?

12. Do you know how to prevent handicaps/cerebral palsy/physical deformities?

13. i. According to your view what are his disadvantages in the family or community?

ii. According to your view what are the advantages of a handicapped/crippled individual in the family or in the community?

14. i. Do you think the parents of a handicapped/crippled child have sinned?

ii. Do you think a handicapped person is a curse in the family?

iii. Do you think a handicapped person is an embarrassment in the family?

15. Do you blame somebody that we have handicapped individuals in our community?

16. i. If it should happen in your family that you have a handicapped (crippled) child, would you be able to LOVE; RESPECT; UNDERSTAND and ACCEPT the child as a whole?

ii. Do you think you would have peace of mind in this connection or would it cause you pain?

17. Do you know what the future holds for you?
18. i. According to your opinion why are some of the handicapped (crippled) children rejected by their parents?

ii. Why are some of them accepted by their parents?

iii. How do you view the life of the disabled (crippled) child from a family who rejects him/her?

19. Do you think some of the parents (parents of a handicapped) endure peace or do they all experience a chromic pain in their lives?

20. According to your view, what is the attitude of the Tsonga people towards handicapped (crippled) children?

21. Do you view a handicapped (crippled) person as an outcast in society?

22. Can you work among handicapped/crippled children?

23. Do you ever talk about handicapped/crippled individuals in your family?

24. If you had a choice, would you prefer a minor or a severely or a non-handicapped child in your family?

25. i. Would you be prepared to share a table/eat with a handicapped person?

ii. Would you be prepared to share a room with him/her?

iii. Would you be prepared to be seen openly in the street with a handicapped person without embarrassment?
EDUCATIONAL INTERVIEW

26. i. Do you think handicapped (crippled) children should receive formal education?

ii. Do you think formal education can play a crucial role in the rehabilitation of a handicapped (crippled) child?

27. Do you think that there are enough institutions for the education of our handicapped (crippled) children in the society?

28. Do you think there is a need that the community should be educated (informed) on the following topics:

i. The causes of Cerebral Palsy/crippleness/disabilities
ii. How to prevent handicaps
iii. The management of the handicapped and so on.

29. Do you think it is possible to improve the different attitudes of the Tsonga Community?

ii. How to improve the different attitudes?

Where should this take place?
1. Through radio/television
2. Newspapers / periodicals
3. Special meetings / training sessions
4. At school as part of the curriculum

30. If you were a parent of a Cerebral Palsied/crippled, how often would you like to see him if he was at the residential school?

31. Have you ever realized the TALENTS of the handicapped or crippled child?

32. Have you ever met a highly educated handicapped person in the society?

33. As a member of the community what do you think you could do for the handicapped/disabled individuals?
PROFESSIONAL GROUP: THE DOCTOR; TEACHER; ORTHOTIST; SPEECH THERAPIST; PHYSIOTHERAPIST AND THE NURSING STAFF

1. Gender

2. Which church do you belong to?

3. What are your qualification i.e. formal training covering this special field?

4. When did you start working among the handicapped (crippled) children i.e. experience?

5. Would you rather work with a normal children?

6. i. Why are you employed among the handicapped (crippled) children?

   ii. What has motivated you in working with handicapped (crippled) children?

7. Do you find it easy to work with a handicapped (crippled) child, or it is difficult?

8. Would you prefer to work among the handicapped (crippled) children for the rest of your life?

9. i. Do you ever feel discouraged in working with a handicapped (crippled) child?

   ii. If so, what are the main obstacles?

10. i. Do you have the courage to work with a handicapped (crippled) child?

    ii. What gives you courage?
11. In general, what do you predict or speculate is the future of a handicapped (crippled) child. (i. bright or ii. dull future)?

12. Which attitude do you have towards the cerebral palsied (crippled) individuals?

13. i. According to your experience what is the attitude of the parents of a handicapped (crippled) child towards their child?

ii. According to your experience could you estimate the percentage of parents manifesting the different attitudes (i.e. who accept or reject)?

14. i. According to your view, what percentage of the Tsonga community accepts the crippled child and his handicaps?

ii. According to your view what percentage of the Tsonga community rejects the crippled child and his handicaps?

15. i. In many circles the handicapped (crippled) child is considered a curse or embarrassment in the family? what is your view?

ii. In your view, is a crippled child a punishment in the family?

iii. Is a crippled child a special gift in the family?

iv. According to your knowledge what is the traditional Tsonga view towards the handicapped (crippled)?
16. Do you think a parent of a handicapped (crippled) child endures peace or experiences pain in their lives because of the presence of the crippled child in the family?

17. From your own dealings with parents, how do you experience the relationship between the parents and the professional workers?

18. What would you estimate is the percentage of parents of crippled children who are interested in what the child learns at school?

i. What would you estimate is the percentage of parents of crippled children who are not interested in what the child learns at school?

ii. What would you say is the percentage of parents of crippled children who regularly visit the children at school?

iii. Would you estimate is the percentage of parents who do not visit the child at school?

19. Have you encountered any problems that were caused by the parents of a handicapped (crippled) child?

i. What type of problems have you encountered in this connection as a professional worker?

20. What are the disadvantages of working with a handicapped (crippled) child?
4 -

ii. What are the advantages of working with a handicapped (crippled) child? (as far as your career is concerned)

21. If you had a choice would you prefer working with a minor or a severely or a non-handicapped (crippled) child?

22. i. Do you have a relative who is handicapped (crippled)?

ii. If so, what is your attitude towards him/her?

23. i. Have you ever considered that you could also become a crippled person during some periods of your life?

ii. Do you know what the future holds for you or for us?

24. i. According to your knowledge, what do you consider the causes of Cerebral Palsy (crippledness)

ii. As far as you know, what are the causes of Cerebral Palsy or handicaps according to the existing ideology of the Tsonga people?

25. Do you know how to prevent the birth of a handicapped (crippled) child?

26. Do you think it is possible to improve different attitudes of the Community towards the handicapped (crippled) individuals?

27. According to your view, do you think there is a need that the Community should be educated (informed) on the following aspects:
The causes of Cerebral Palsy or handicaps

When do the handicaps or cerebral palsy take place?

How to prevent cerebral palsy or handicaps

How to extirpate the different myth ideologies on the birth of a handicapped child.

The management of a handicapped child.

Where should this take place?

1. Through radio / television
2. Newspapers / periodicals
3. Special meetings / training sessions
4. At school as part of the curriculum

28. According to your view, does the community (including parents of the handicapped/crippled children) need guidance and counselling to highlight the fact that a handicapped individual is a human being in his/her own rights and worthy of living?

29. i. Do you think that handicapped (crippled) children should receive formal education?

ii. What role do you think formal education can play in rehabilitation of our handicapped (crippled) children in the society?

30. Do you think that there are enough institutions that cater for the education of our handicapped (crippled) children in the society?

31. i. If it should happen in your family that you have a handicapped (crippled) child, would you be able to LOVE; RESPECT; UNDERSTAND and ACCEPT the child as a whole?

ii. Do you think you would endure peace or experience a chronic pain?
Abasia: The scientific term for lack of co-ordination in walking.

Anoxia: Lack of oxygen (in the brain) or an indication of a negative situation, or reduction of oxygen in the body tissues below physiological levels.

Anthropologists: The scientific study of the origin and the physical, social and cultural development and behaviour of man.

Aphasia: Inability to understand words and to use speech in writing, a breakdown in symbolisation, OR defect or loss of the power of expression by speech, writing or signs, or of comprehending spoken or written language due to injuries or disease of the brain centres.

Ataxia: Irregularity of muscular action or failure of muscular co-ordination.

Athetosis: Athetos (not fixed) + eidos (form) - a derangement marked by ceaseless occurrence of slow, sinuous, writhing movement, especially severe in the hands and performed involuntarily.

Bandhla: The practice of males of the Tsonga communities of making their own fire around which they sit, drink and converse. Females are excluded.

Basal ganglia: ganglion (Pl. ganglia) is a knot or knot-line mass, the basal ganglia are masses of grey matter situated in the cerebral hemisphere together with the thalamus. It comprises the corpus stratum.

Bilateral Hemiplegia: The whole child is affected but the upper limbs are more severe than the lower limbs.

Breech Presentation: In obstetrics a breech presentation means that part of the body of an infant which
presents itself in the birth process. In a breech presentation the buttocks appear first. The Vertex presentation is the normal way of giving birth, it is when the head presents itself first.

Caesarian Section: An incision through the abdominal and uterine walls for the delivery of an infant. This is done when birth through the normal passages is impossible or dangerous.

Diplegia: When all four limbs are affected, but two sides are affected to a different degree.

Ellohim: God in Hebrew.

Elshadai: God in Hebrew.

Encephalitis: Inflammation of the brain — which causes drowsiness and slowing down of mental and physical faculties (often called "sleeping sickness").

Foetus: The unborn, while still growing and developing in the uterus (womb) before 8 weeks is called an embryo.

Hemiplegia: When one side of the body is affected i.e. left side (arm and leg) or right side (arm and leg).

Iyesous kristos: [Ἰησοῦς Κριστός] Jesus Christ.

Jahweh: Jehovah.

Kernicterus: (Ger. nuclear jaundice) A condition with severe neural symptoms, associated with high levels of bilirubin in the blood. It is characterised by deep yellow staining of the basal nuclei, globus pallidus, putamen, and caudate nucleus.

Lobola: A marriage payment made by the family of the bridegroom to the family of the bride.

Magandzelo: Sacred places e.g. sacred tree, sacred fire place, near the grave or on the grave where the ancestor is worshipped.
Magomu-gomu : A dwarf person.
Makhalavatla : Watermelon.
Makwembe : Pumpkins (plural) and (singular) kwembe, pumpkin.
Manjhenjhe : Termites.
Mariwa : Ladles.
Marhanga : Gourds.
Masimu : Land to plough crops.
Matomana : Mopani worms.
Mimova : Sugar cane.
Monoplegia : The condition where one limb is affected or paralysed. It could be left or right arm or left or right leg.
Monogamy : Marriage involving one man and one woman only.
Mudzhabi : A circumcised boy or girl who went to the initiation school the previous year, they are also called prefects or helpers to the initiation school.
Mukhuhlwani : Flu
Muscular dystrophy : Disease affecting muscles. In most cases, diseases affecting the muscles result from damage to nerves which control the feeling and motion of the muscles.
Nkatikulobye : co-wives.
Non-sororal polygamy : If one man marries co-wives who are not sisters, such marriage is non-sororal polygamy.
N’wandhindhani or Xibelani : Female traditional wear in the Tsonga community.
Ntanga/Xirhapa : Garden.
Occupational therapist : One who uses therapy to encourage the handicapped to use whatever parts of the body are usable.
Orthopaedic : Παίς (child). That branch of surgery which is specially concerned with preserva-
tion and restoration of the function of the skeletal system, its articulations and associated structures — or the correction of the malformation of the body.

Orthotist: (In Greek = Orthoter = orthoté) A restorer or preserver, or a person skilled in orthotics and practising its application in individual cases.

Osteogenesis: An inherited condition usually transmitted as an autosomal dominant trait, in which the bones are abnormally brittle and subject to fractures. Usually the child is born with deformities.

Paraplegic: Condition where the lower limbs are both affected or paralysed.

Physiotherapist: Physical therapist (physio = physis nature = a combining form denoting relationship to nature, as in physionomy, or to physiology, as in physiochemistry.

Polyandry: Marriage in which one woman may marry "many men".

Polygamy: A marriage in which one man has married from two to twenty wives or even more.

Quadriplegia: Paralysis of all four limbs, tetraplegia.

Rh factor: This concerns the blood type as classified by Landstein, which is today the international classification, namely types 0, A, B. The Rh stands for Rhesus, or species of monkey which was used in the first experiments. The Rh factor is important in connection with the incompatibility of blood between the mother and the child-in-utero. If this is not eliminated, brain damage might occur.

Rubella: German Measles.

Spastic: The nature of, or characterized by, spasms, or a state of hypertonicity, or increase over the normal tone of a muscle, with heightened deep
tendon reflexes.

Speech therapist: A person skilled in speech correction.

Spina bifida: An inborn defect where the spinal cord and nerves of the spinal column are not protected by the necessary bone.

Sororal polygamy: If one man marries two or more sisters, this is called sororal polygamy.

Taboos: A prohibition excluding something from use, approach or mention because of its sacred and inviolable nature. A ban or inhibition attached to something by social custom or emotional aversion.

Talipes: The term used to describe a condition where the foot is turned.

Talipes calcaneus: Deformities of a foot, the toes are turned up in such a way that the child is forced to walk on his heel.

Talipes equinus: Deformities of a foot, it may be in a position which will force the child to walk on his toes.

Talipes equinovarus: Deformities of a foot, when clubfeet are turned inward and on the toes.

Talipes Valgus: Deformities of a foot turned outward.

Talipes varus: Deformities of a foot which is turned inward.

Theos: Ὁς - God

Tihlolela: Inviting misfortune upon yourself.

Tindluwa: Njugo beans.

Tinyawa: Cow peas.

Tsimu: Where people are invited to help in the field.

Tremor: An involuntary trembling or quivering.

Triplegia: When three limbs are affected, it could be both legs and one arm, it usually takes place in a spastic condition.

Xiaka muti: One who sustains the family.
Xitlati : Store house.

Yesu : Jesus (Christ)
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