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Childbirth Was Never Meant to Be an Individual Project: Kusungirwa, Collective Care, and the Clinical Implications of Postpartum Depression Among Shona Women in Zimbabwe

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***Abstract*: Postpartum depression (PPD) is estimated to affect one in three mothers in Zimbabwe, yet primary health care practitioners do not routinely screen for it, and culturally responsive clinical approaches are not used. Purpose: This paper explores the hypothesis that the Shona indigenous postpartum practice of "Kusungirwa," where a new mother returns to her maternal home to receive structured care from female kin, is a community-based psychosocial intervention, and factors that protect against depression are directly translatable to contemporary psychological theory. This paper engages in a critical theory synthesis of Bowlby's (1969) attachment theory and Berry's (1997) acculturation theory and a review of empirical and ethnographic literature on postpartum practices and PPD in Zimbabwe. Results/Discussion: The interpersonal, nutritional, and labour-saving components of "Kusungirwa" work to address the exact neurobiological and psychological factors that render postpartum women vulnerable to depression. Two recurrent clinical traps pathologising collective care and offering unstructured individual psychotherapy in the absence of support are explored and reframed in a cultural humility framework (Hook et al., 2013; Tervalon & Murray-García, 1998). Conclusions: Practice, community, and policy recommendations are provided, including culturally sensitive screening, engagement of traditional birth attendants in referrals, and the need for routine postpartum screening in Zimbabwean primary health care. The loss of "Kusungirwa" through urbanisation, economic hardship, and migration is not only cultural, but a tangible public mental health threat, and its deliberate recreation is a clinical and moral obligation.**

***Keywords*: postpartum depression, Shona culture, Zimbabwe, Kusungirwa, cultural humility, attachment theory, acculturation, perinatal mental health, indigenous healing.**

1. Introduction

For the Shona people of Zimbabwe, childbirth was never an intimate affair. It was a social crisis, a time for the family to reorient around the weakest member: the mother. The tradition of "Kusungirwa", in which a pregnant woman, for her first child, goes to the home of her mother for the last months of pregnancy, and stays there for the birth and after, under the care of her female relatives, was not a ritual. It was a therapeutic practice, performed inter-generationally with skill and loving care long before the language of mental health was invented to describe its effects.

That tradition is eroding. The effects of urbanisation, economic change, migration, and modernity have steadily eroded the extended family structures on which "Kusungirwa" thrives. Instead, Zimbabwean mothers are increasingly giving birth and recovering in environments that lack the elements their nervous systems evolved to receive sustained relationships, rest, collective feeding, and the absence of household responsibilities. The consequence is measurable. Epidemiological research at urban clinics in Harare and Mbare consistently reports that a third of Zimbabwean mothers (33-34%) suffer from postpartum depression (January et al., 2017; Nduna & Mthombeni, 2017). But there is no postpartum screening in most of the primary care clinics across Zimbabwe, no referral pathway, and no national guideline for perinatal psychological assessment (She Corresponds Africa, 2024).

This paper advances three interrelated arguments. First, the essential components of "Kusungirwa" proximity, burden-reduction, multigenerational continuity in the knowledge of care, and collective sustenance are structurally identical to the conditions contemporary psychological theory ascribes to be necessary for recovery from the experiences of childbirth. Second, the therapeutic encounter with Shona postpartum women is compromised by the twin errors of pathologising the collective and employing individually oriented therapeutic approaches to what are structural and relational traumas. Third, that a culturally humble, tradition-informed approach to clinical assessment and treatment is not only ethically preferable but also more effective. The paper is an example of practice-based integrative review: it draws on empirical, ethnographic, and theoretical evidence to make culturally sensitive clinical recommendations for Shona women in the postpartum period in Zimbabwean primary care and diaspora settings.

A reflexivity statement is required before proceeding. The author is a Zimbabwean Shona woman and Clinical Psychologist, raised in the cultural context discussed in this

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paper. Closeness to this topic is both epistemologically productive, the ability to name practices, idioms, and practices of relatedness with specificity rather than geneticisation. and methodologically risky, in the sense of risking over-generalisation from personal knowledge, failure to account for inter-group differences, or unintentional romanticisation of practices that, in certain family contexts, may feel coercive rather than supportive. Both possibilities are held in mind here. The point is not that Kusungirwa is always experienced as positive, but that its underlying structure, when it is operating optimally, is consistently aligned with the evidence for what is protective against PPD, and that its erosion is a public mental health concern requiring clinical and social intervention.

2. Cultural Context: Kusungirwa and the Architecture of Postpartum Care

Accurate names are needed to talk about Shona postnatal practices. Three related terms are used in the literature and in communities and conflating them blurs distinctions. "Kusungira" refers to the action of the family: the receiving, organising and maintaining of care for the new mother. “Kusungirwa” refers to the receiving of mother it is the mother's experience. “Masungiro” refers to the practice in its entirety: the event, the time and the rituals and responsibilities that make up the postpartum care in the maternal home. In this paper, "Kusungirwa" is used as the preferred term to describe the new mother's psychological and clinical experience, while "Masungiro" is used to describe the socio-cultural practice.

In ethnographic and historical literature, "Masungiro" was a practice centred in the mother's house where a first-time mother (muroora) returned to her mother (Amai) in the latter stages of pregnancy and stayed on through the postpartum period (Chirongoma et al., 2021; Mushambe, 2025). The primary caregiver is usually the mother's Amai, whose role here is domestic and nutritional: she manages the organisation of the household to support the mother's recovery. The father's sister - "tete" - has a ritual authority, offering advice on cultural matters, facilitating negotiations between the husband's and wife's kin, and communicating generational knowledge of infant care and maternal wellbeing. Ambuya (grandmother) may also be involved, depending on family composition and proximity, but is subordinate to Amai. This distinction is important for health care: the conflation of all female kin as "grandmother" misrepresents the social ecology and may misdirect health care providers on the importance of women's presence and lack thereof in the postpartum woman's life.

The content of "Kusungirwa" has been amply described. The postpartum woman is excused from muroora being the household and service work expected from a daughter-in-law in the marital home. She is given herbal concoctions believed to aid her recovery and breastfeeding (Mushambe, 2025). She is kept company: she is not alone. The baby is cared for at night by female relatives so that she can rest. Guests are controlled. Meals are cooked for her. Housework and domestic decisions are made for her. The period of planned, systematic care usually lasts for a few weeks and is recognised, within the community, as the correct way for mothers to recover and for babies to bond. Its lack is recognised and, in healthy communities, remedied.

The legacy of "ananyamukuta" traditional Shona midwives is pertinent. Historian Mushambe (2025) chronicles these practitioners as midwives in maternal health care in the period from 1880 to 1970, possessing both technical expertise in the birthing process and recovery, and having an authoritative position in the community postpartum support structure. Their increasing marginalisation with the medicalisation of birth is not only a loss of traditional knowledge but also a structural loss of the postpartum support system that "Kusungirwa" relied on.

Within-group differences need to be recognised. Masungiro is not universally practised in Zimbabwe. Women in the capital city of Harare's high-density suburbs give birth and recover without being cared for in their natal homes, either because they are too far away to return or because urban households and domestic arrangements do not provide the domestic and social space for it (Dodzo & Mhloyi, 2017). Christian families may practise weaker forms of the practice, or none. Women in the diaspora may not have access to Kusungirwa. In rural communities, where the practice is more robust, out-migration of men and economic hardship have also eroded the practice (Kaiyo-Utete et al., 2023). A provider working with Shona women after childbirth should not assume Masungiro as a constant background variable, but as a variable that needs to be asked about: Was Kusungirwa practised? To what degree? What was there, and what wasn't? What did the mother expect, and what did she get?

3. Theoretical Framework

A. Attachment Theory and the Postpartum Nervous System

Attachment theory (Bowlby, 1969) at its heart describes the ways in which humans regulate emotion and arousal through responsive relational contact. This theory was designed to explain infant behaviour, but it applies to mothers as well. Her hormones are in super-flux post-birth: oestrogen and progesterone levels, high throughout pregnancy, plummet, directly impacting serotonin and dopamine levels. Her body is actively healing. She is tired and increasingly sleep-deprived. She is also expected to establish and maintain primary attachment with her newborn baby while she herself has diminished regulatory capacity. Attachment theory suggests this is exactly the situation in which a secure base and safe haven are most necessary: a steady relational presence that communicates safety, deactivates threat detection, and allows the nervous system to relax from hypervigilance and repair (Bowlby, 1969).

"Kusungirwa" offers this. The elimination of muroora obligations removes a significant source of performance threat. The continued presence of amai and tete provides relational continuity and co-regulation. The screening of visitors relieves the unpredictability of social events. Infant night care enables night sleep. From an attachment perspective, the birth household becomes a structured secure base and not in metaphorical terms, but in a real sense, providing exactly what a dysregulated postnatal nervous system needs for recovery. The fact that Shona grandmothers and aunts were doing what

Western neuroscience would later recognise as the only thing that should be done is no coincidence. It demonstrates the knowledge of a people who knew, from centuries of experience, what the mind and body of a new mother needed to survive.

B. Berry's Acculturation Theory and the Cost of Cultural Dislocation

Berry's (1997) theory of acculturation offers an additional lens to explore PPD in urban and diaspora communities of Shona women. Berry views acculturation as the psychological and behavioural adaptation to contact with a different culture. Acculturative stress refers specifically to the particular form of mental health stress brought on by this process: the sustained stress of living between cultural systems, resolving cultural identity conflicts and living in an environment that fails to align with culturally formed expectations.

For the Shona woman who has a child in the city of Harare in South Africa, or in the diaspora, the loss of Kusungirwa is not the loss of a custom. It is the absence of the entire relational and material environment that her nervous system has been conditioned by cultural learning and experience to anticipate in her state of heightened vulnerability. She enters the postpartum period with a sub-conscious expectation of the presence of amai, of management of her environment, of collective infant holding. Instead, she enters a nuclear family, probably without extended family, in a context of economic constraint, in which she is expected to return to functional competence in a few days. Berry's model suggests this discrepancy between cultural expectation and cultural reality is a particular pathway to poor mental health and in the face of postpartum depression, a gaping hole (Berry, 1997).

The intersection of these two frameworks generates a coherent clinical account of Shona PPD: it is not merely a biological event, not merely a psychological vulnerability, but a predictable consequence of placing a woman whose regulatory system was shaped for community in conditions of structural isolation. This framing has direct implications for both assessment and intervention, which are explored in the following section.

4. Clinical Implications

A. Culturally Grounded Assessment

The Edinburgh Postnatal Depression Scale (EPDS), translated to Shona by Chibanda et al. (2010a), offers a baseline screening assessment but the scale should not be administered uncontextualised for risk of false negatives and misalliance. The translation of symptoms of postpartum depression in Shona women will often not be expressed using the language of depression. The most common idiom is “kufungisisa” literally, thinking too much which in the clinical literature has been recognised as a culturally specific idiom for internalised distress, including rumination, anxiety and dysphoria (Chibanda et al., 2010a). Other idioms are "ndinorwadziwa" (I am hurting) and "ndakaneta" (I am tired) with the latter signifying a type of fatigue that is generally communicated by the patient as qualitatively different from normal tiredness and not relieved by sleep. Patients presenting in this way will not be heard by a clinician who is listening only for symptoms that align with the DSM.

Thus, culturally sensitive postpartum screening in the Shona cultural context starts with "kufungisisa" as a valid presenting symptom, and goes on from there to map the relational ecology: Who was at the baby's birth? Who was present and absent? Has “kusungirwa” been practised and how? Is Amai accessible? Has tete been involved? What muroora has the mother been doing? What is the relationship of the family to the extended family? These relational mapping questions are not "contextual" to the clinical picture they are the clinical picture. The answers determine whether the presenting distress is a primarily biological process, structural trauma, acculturative loss, or, more likely, a combination of all three, and treatment needs to be tailored accordingly.

The therapeutic relationship is sensitive to sequencing. Shona social norms are rooted in respect, controlled self-disclosure and a preference for indirectness in the expression of distress (Chireshe & Chireshe, 2010; Cultural Atlas, n.d.). A clinician who jumps straight to symptom questioning without first establishing a sense of belonging through cultural recognition, naming of tradition, and an attitude of curiosity rather than efficiency risks inviting shame and silence, which underpin underreporting. Therapeutic alliances must be formed before testing can be accurate [MOU4.1]

B. Clinical Pitfall One: Diagnosing Collective Care

Clinicians who have been trained in Western models of mental health which favour autonomy (of the individual), differentiation (of the self), and differentiation (of the family) are especially vulnerable to pathologising Shona collective care arrangements. When a mother who has given birth reports Amai is living at home, tete is making decisions, infant care is being shared among several female family members, the clinician trained in object relations, family systems or other Western models of psychology may be tempted to reach for the terms enmeshment, excessive involvement, boundary violation. This response is a clinical error.

The collective care structure, where it is healthy, is not a symptom. It is a safety measure and something Western mothers cannot afford. The clinician's role is not to evaluate whether it should exist, but how it is working: Is the mother's autonomy honoured? Is the collective holding her or watching her? Is she held or controlled? Are there some relationships in the collective that are experienced as troubling? These are the clinical questions. Tervalon and Murray-García (1998) suggest cultural humility necessitates a stance toward redressing power differentials in the clinical relationship and in this case, the clinician should work against the epistemic authority of Western psychological approaches that pathologise what is, by a different and equally robust standard, a protective practice.

Hook et al. (2013) conceptualise cultural humility as another-focused interpersonal orientation that is open and curious, and non-superior about a client's culture. In this context, this means coming to the description of collective care with a question: What does this mean to you? How does it feel to have Amai here? What does it mean to you to have tete there? The

responses to these questions will be far more clinically informative than any preconceived notion, from either end of the spectrum, about what it means.

C. Clinical Pitfall Two: Individual Therapy for a Structural Wound

The second pitfall relates to the therapy itself. Zimbabwean postpartum depression exists in the context of other disorders. It is consistently accompanied by poverty, food insecurity, intimate partner violence and HIV. Chibanda et al.'s (2010b) landmark study in Harare found 54% of women with HIV were depressed after childbirth. January et al.'s (2017) scoping review shows poverty and absence of social support as the strongest predictors of PPD in Zimbabwean women. A woman who presents with "kufungisisa" but has no food security, no "Kusungirwa", no support from extended family and no rest is not, primarily, presenting with a cognitive bias. She is presenting with an appropriate assessment of a dangerous situation in the context of structural disadvantage.

To provide cognitive reframing in the context of this presentation without naming the structure, without advocating for support, and without validating her distress is not therapeutic. It is erasure. The clinical imperative is first to name the structure: to hold, explicitly, that she feels a loss because of the absence of "Kusungirwa", that her postpartum conditions are inadequate, and that her distress is appropriate to the lack of support, rather than being a disorder in her. And the lost object is rightly grieved: it should not be avoided. Only then, from a position of recognition, can the task of crafting alternatives proceed.

This is not to say that effective treatments are not to be used. Chibanda and colleagues' Friendship Bench model for Zimbabwe shows the success of adapted problem-solving therapy and trained community health workers in primary care (Chibanda et al., 2010a). It's fit with community-based help-seeking and its deployment of lay staff with a cultural fit to the community make it an excellent choice for postpartum care. But even the community-based Friendship Bench is delivered most effectively within a framework that acknowledges the loss and seeks to replace, in practical ways and to some extent, the benefits offered by Kusungirwa.

D. Clinical Supervision: Holding Culture in Supervision

Good clinical practice with clients of diverse cultures does not come from training. It needs reflective supervision in which the clinician's own cultural assumptions and their views about autonomy, family, illness, and help-seeking are probed just as the client's distress is. Therefore, for clinicians working with Shona post-partum women, supervision should be explicitly devoted to examining the two pitfalls above. A supervisor who does not explicitly name or challenge pathologisation of collective care activities by a supervisee or who accepts individual therapy as reflective and normative treatment for structural distress is complicit in the clinical error.

Three features should be part of supervision. First, routine cultural case consultation: a regular supervisory time for the clinician to present cases of Shona postpartum women for cultural formulation consultation, not just diagnostic or technical consultation. Second, reflective self-disclosure practice: supervisees should be encouraged to reflect on their cultural biases prior to and following sessions, especially regarding their expectations of the client's family structure and which responses (positive and negative) were evoked by the client's family structure. Third, structural case advocacy: supervisees should be encouraged, in supervision, to advocate for clients whose clinical needs require more than therapeutic treatment, whether it be collaboration with social services, family negotiations, or communication with community health workers. Hook et al.'s (2013) model of cultural humility describes ongoing self-critique and institutional accountability as two key elements of culturally humble practice; this is nurtured (or stymied) in the supervisory relationship. This model of supervision should be core to training clinicians to practice perinatal care in Zimbabwe.

5. Systems-Level Recommendations

Clinician competency is a starting point. Zimbabwe's burden of postpartum depression (PPD) is one in three mothers and has no established screening, which calls for a multi-level approach.

At the primary health level, routine postpartum screening using the Shona version of the EPDS should be made universal, part of any postnatal care. Screening without referral is not enough; development of culturally relevant postpartum protocols for mental health, developed in partnership with traditional birth attendants (ananyamukuta), community health workers and women who have experienced PPD, is urgently needed. January et al. (2017) cite lack of such protocols as a key driver in the treatment gap.

On the ground, traditional birth attendants should be embedded in perinatal referral pathways, rather than seen as marginal or informal service providers. Mushambe's (2025) account of ananyamukuta reveals a complex body of knowledge that was not replaced when it was marginalised it was lost, leaving a gap that biomedical services have failed to fill. Their re-integration would need formal training in psychosocial screening, referral arrangements and payment but they are trusted by the community and speak their language in a way that cannot be replicated by biomedical services.

At the system level, Zimbabwe needs a perinatal mental health strategy that puts PPD on the public health agenda instead of individualising the experience. The finding of Kaiyo-Utete et al. (2023) that antenatal depression is independently associated with adverse birth outcomes also supports the need for early intervention the consequences of untreated perinatal mental illness are far beyond the mother's health they impact on infant development, mother-infant bonding, and family functioning over the following years. [MOU5.1]

Finally, training of clinicians should address the multicultural aspects of Shona postpartum care. Models of cultural competence which treat cultural knowledge as something to be learned are unhelpful. Tervalon and Murray-García (1998) and Hook et al. (2013) suggest that cultural humility is the better model of clinical practice: a lifelong

commitment to self-critique and self-evaluation, to learning from others as peers rather than "experts", and to the recognition of the client's cultural framework as a central clinical asset. In Shona postpartum communities, this means enough knowledge of “Masungiro” to pose questions, but enough curiosity to be taught the answers by the woman who knows.

6. Equity Impact

The primary beneficiaries of this approach are Shona postpartum women, especially urban, peri-urban and diaspora women, who currently receive care that is not sensitive to the structural causes of their distress, or to the cultural supports that might support it. Culturally sensitive assessment, universal screening for postpartum depression, and referral programs engaging traditional birth attendants will narrow the gap in care for this group. Secondary beneficiaries are clinicians who will have a more theoretically coherent understanding of postpartum phenomena that do not align with DSM-style symptom mapping, and health systems which will save the down-stream costs of perinatal mental illness on infant and family development.

This approach carries particular risks of harm for two populations, which need mitigation. First, women for whom "Kusungirwa" was not a protective experience those who have experienced natal-home care practices as coercive, surveillance-like or instrumentally controlling may be harmed if the framework is applied naively and collective care is assumed to be always therapeutic. The prevention strategy is to include in the assessment protocol an exploration of the mother’s experience: whether she felt supported or managed, surveilled or cared for, and whether particular relationships in the collective were supportive or problematic. The therapeutic project is always to follow the woman, not the cultural script. Second, there is a risk that institutionalisation of this framework without adequate resourcing and support places a burden of culturally responsive care on already under-resourced community health workers and traditional birth attendants without adequate training, payment and support. Mitigation requires that inclusion of traditional birth attendants in referral networks be matched by formal recognition, support and compensation, and long-term supervision arrangements not just goodwill and cultural fit.

7. Conclusion

It is still common in clinical circles that traditional practices must be "validated" by Western science before they are considered as potential therapeutic supports. This paper has made the case that the opposite is true: that the Shona practice of "Kusungirwa", is a highly sophisticated, evidence-based postpartum intervention strategy and that the science we employ to understand PPD attachment theory, acculturation theory, the neurobiology of the postpartum period is largely playing catch-up to what Shona communities knew from generations of observation. The grandmothers were not behind. The field is.

There are clear clinical and public health consequences of this argument. Postpartum screening must be done. Culturally sensitive screening must be used in lieu of Western symptom language. Collective care arrangements must be appreciated, not pathologised as individualism. Indigenous birth attendants must be included. And the causes of poverty, food insecurity, the disintegration of extended families that make PPD a common occurrence in the lives of Zimbabwean women must be placed in the medical room, not dismissed as social determinants of health.

The loss of "Masungiro" is not only culturally significant. It is a recognised public mental health hazard. Its deliberate revival for urban families, for diaspora families, with community health services is not only therapeutic but also restorative. Bearing children was never meant to be an individual endeavour. The proof, across fields and across ages, is in the pudding.

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