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FACULTY OF HUMANITIES AND SOCIAL SCIENCES

School of Social Science: Culture Cluster

**The life histories of traditional birth attendants  
in the context of changing reproductive health practices  
in uMzimkhulu, KwaZulu-Natal**

by

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## **Declaration**

I, Yonela Scina, declare that in this work all citations, references and borrowed ideas have been appropriately acknowledged. I hereby confirm that an external editor was used to proofread and correct spelling and grammar errors.

**Supervisor: Professor Maheshvari Naidu**



Signed .....

**21/08/17**

Date .....

## **Dedication**

I dedicate my dissertation work to my mother, Thembakazi Scina, my sister, Chulumanco Bhengu and my sons, Ludumo and Liyema Dlamini.

“Those who complete the course will do so only because they do not, as fatigue sets in, convince themselves that the road ahead is still too long, the inclines too steep, the loneliness impossible to bear and the prize itself of doubtful value.” – Thabo Mbeki

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## **Abstract**

This is a study of the life histories of Traditional Birth Attendants (TBAs) based in uMzimkhulu in the province of KwaZulu-Natal in South Africa. The study sought to explore the life histories of the TBAs, their practices, rituals and attitudes. It further investigates the attitudes of women who make use of their services and those who prefer not to. TBAs fall into the cultural realm of traditional medicine and offer traditional medicine and rituals to pregnant women. uMzimkhulu is small town in a rural area where the use of traditional medicine is popular, regardless of free access to western health care facilities. Culture still plays an important role in this community, and for successful pregnancies, many women in the community seek the services of TBAs. This study has found that traditional medicine plays a 'silent role' in the health care system as many pregnant women continue to seek traditional sources of health care; in the case of uMzimkhulu, many of the participants preferred to use medicines prepared by TBAs during their pregnancies.

The study adopted a qualitative research design. The research techniques included in-depth interviews and participant observation techniques. Interactions with the TBAs took place at their homes which allowed the researcher first-hand experience of the relationship between TBAs and the women that seek their services. Other interactions took place in the homes of the participating women and at the Rietvlei hospital where the health care practitioners work.

Three theoretical perspectives were adopted in this study: African feminist theory, social identity theory and the social capital theory. The life histories of the TBAs contributed to a rich understanding of reproductive health care from the perspective of TBAs, their attitudes and experiences. Furthermore, a better understanding was gained of the practices they offer and the cultural meanings attached by those who seek the services of TBAs. This study has demonstrated the important role culture plays in the lives of the participants. Cultural background influenced many decisions made by the pregnant participants with regard to their health seeking behaviour. Despite efforts of the western hegemonic health care system practitioners to discourage women from using alternative traditional medicines, many continue to use these with the view that western medicine does not fully protect their pregnancies.

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## **List of Acronyms**

ANC	Antenatal care
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
IUD	intrauterine deaths
MDG	Millennium Development Goal
MSL	meconium stained liquor
SBA	Skilled Birth Attendant
SIT	Social Identity Theory
SSA	Sub-Saharan Africa
STD	Sexually transmitted disease
TBA	Traditional Birth Attendant
THP	Traditional Health Practitioner
WHO	World Health Organisation

## Zulu-English Translations

<i>abalozi</i>	whistling
<i>abathakathi</i>	witches
<i>abathandazeli</i>	faith healers
<i>abelungu</i>	white people
<i>amadlozi</i>	ancestral spirits
<i>amafutha enja</i>	
<i>yolwandle</i>	oil from a seal
<i>amakhosi</i>	ancestors
<i>amaqaba</i>	uneducated individuals
<i>amarhewu</i>	traditional South African non-alcoholic drink made from fermented mealie pap
<i>amathambo</i>	throwing of bones
<i>amathwasa</i>	an <i>ithwasa</i> is an ‘initiate’
<i>bhula</i>	consult
<i>doek</i>	head cloth
<i>ibhayi elibovu</i>	red cloth worn around waist as a skirt and a red head cloth
<i>idlozi</i>	ancestors
<i>idrop</i>	sexually transmitted disease
<i>ifindo</i>	contraceptive, direct translation means a tightly tied knot
<i>imbelekisani</i>	traditional tonic used for making the birthing process quick
<i>imimoya emibi</i>	evil spirits
<i>impepho</i>	incense
<i>intambo</i>	string from traditional healer with powers of protection
<i>intambo</i>	
<i>yasesinqeni</i>	string with protective powers
<i>inyanga</i>	herbalists
<i>ipinifa</i>	traditional dress mostly worn by women in traditional rural areas
<i>ipleyti</i>	a cultural illness in infants where the navel is believed to be ‘raw’ and painful from the inside
<i>isgodlo</i>	consultation room

<i>isigidi</i>	mercury
<i>isihlambezo</i>	preventative health tonic during pregnancy
<i>isipatsholo</i>	sexually transmitted disease
<i>isithunywa</i>	ancestral messenger
<i>isiwasho</i>	holy water
<i>izangoma</i>	diviners
<i>makoti</i>	wife
<i>malume</i>	
<i>omdala</i>	eldest uncle
<i>muthi</i>	medicine
<i>nhlampfurha</i>	castor oil
<i>sangoma</i>	traditional
<i>ubizo</i>	calling
<i>uchatho</i>	enema
<i>ugcusulu</i>	sexually transmitted disease
<i>ukuhlola</i>	consultation/reading with sangoma
<i>ukumisela</i>	process of assisting women fall pregnant through traditional methods and practices
<i>ukurhesha</i>	being exposed to and being attacked by evil spirits
<i>ukuthwasa</i>	process of becoming a practising sangoma
<i>ukuxukuza</i>	a form of traditional antenatal care involving abdominal examination of the pregnant woman
<i>ukuzalisa</i>	assistance of pregnant women with the birthing process
<i>umegqo</i>	see <i>umbhulelo</i>
<i>umoya</i>	gastroenteritis
<i>umsamo</i>	upper part of the rondavel (round hut) which is known to be the cradle of the ancestors for many African families.
<i>umthandazeli</i>	faith healer
<i>ushibhoshi</i>	Jeyes Fluid (powerful household cleaner and disinfectant)
<i>xirhakarhani</i>	an indigenous analgesic

# CHAPTER ONE: Introduction and literature review

## 1.1 Background and outline of the research problem

Reproductive health is a priority public health concern as significant numbers of women die each year due to complications during childbearing and reproduction. Of the Millennium Development Goals of the United Nations set in the year 2000, Goals Four and Five address child and maternal mortality ratios. According to Rowen, Prata and Passano (2009) and Crowe et al. (2012), over half a million women die of maternal causes such as obstructed labour and haemorrhage, septicæmia and hypertension every year. The major obstacle in preventing these deaths is the lack of primary health care facilities and qualified personnel in many developing countries. Traditional Birth Attendants (TBAs) are often consulted in such countries as part of an alternative health care system by pregnant women.

Traditional birth attendants (TBAs) are usually women based within communities that assist pregnant woman during the pregnancy and birthing process. Their duties include preparing decoctions to be ingested by pregnant mothers as well as assisting with rituals that are intended for protecting the unborn baby and mother from any bad or evil spirits that are potentially dangerous. According to Kayombo (2013, 2), “traditionally, the role of TBAs on reproductive health starts immediately after a woman becomes pregnant”. Some TBAs are traditional healers, they have ancestral spirits (*amadlozi*) that guide them by showing them visions and herbal medicines to use when assisting pregnant women. Some women prefer TBAs over health care systems due to cultural embedded beliefs. According to Imogie, Agwubike and Aluko (2002, 95), “the reasons given by childbearing mothers regarding preference for TBAs over orthodox medicare include, among others, it is cheap (relatively inexpensive) both the practitioners and the medication; easily and readily accessible/available near the grassroots; they use familiar language; they are regarded as more efficacious, thus more confidence in them; they use natural herbs and there is mutual trust because of their assumed respect for tradition and custom of the people”. However, TBAs have no formal training; they use traditional methods and practices to attend to pregnant women. Flomo-Jones (2004) claimed that 98% of these deaths occur in developing countries where a women's lifetime risk of dying from pregnancy related complications is almost four times higher than that of her counterparts in developed countries.

Several studies such as Roost et al. (2004), Waldmann (1992) and Rodgers (1979) have stated that maternal mortality is, despite the efforts of safe motherhood programmes, still a common problem, mainly in low-income countries. The connection between infant mortality and poor, underdeveloped countries is thus one that cannot go unnoticed. Rodgers (1979) conducted one of the earliest studies focusing on mortality. He analysed 56 countries to determine the effects of income and inequality on mortality. His findings showed that income was the most consistent indicator of infant mortality. Rodgers (1979) and Waldmann (1992) argued that other factors such as access to health and social services also play a role in maternal mortality. Child and maternal deaths in any country are a reflection of the country's overall health care status and system. Further international studies (for example, Kale and Costa 2009, Jafarey et al. 2009, Abe and Omo-Aghoj 2008 and Bhatia 1993) have suggested that there are more maternal and child deaths in underdeveloped countries compared to developed countries due to lack of quality resources. Developed countries possess far more efficient and quality health care and are therefore able to achieve better results.

Tinker (1998) argued that pregnancy is not a disease and pregnancy related mortality is almost always preventable. Yet more than half a million women die each year due to pregnancy related complications; 95% of these come from the developing world. The absence of primary health care leads to maternal and infant mortality. Antenatal care in a medical setting with skilled health care workers improves maternal health. Societies where there is a lack of or no access to health care facilities and skilled health care workers show high numbers of maternal and infant mortality. Crowe et al. (2012, 2) argued that “despite concerted effort to increase ‘Skilled Birth Attendants’ (SBA) to be in attendance, in the short to medium term, many women in the developing world will continue to give birth without the supervision of a SBA”, thus leading to complications and deaths that can be prevented.

Even though underdeveloped countries have little or no access to health care facilities, TBAs are widely used as an alternative health care system. Melhado (2012) argued that in low resource settings such as in Bangladesh fewer than 20% of pregnant women are attended to by a skilled provider. A study conducted by Lech and Mngadi (2005) revealed that as many as 38% of deliveries are attended to by TBAs and grandmothers and lastly a study conducted by Nyanzi, Manneh and Walraven (2007) found that TBAs were an integral part of the primary health care system. TBAs are used widely in African rural areas amongst rural (and even peri-urban African women) due to the lack of access to primary health care facilities. Among peri-

urban African women, there is also pressure to use TBAs from the women's (traditional) parents.

Taking into consideration internal and global studies, according to Kruske and Barclay (2004), approximately half of all births in developing countries are attended to by TBAs and as many as 95% of women are attended by TBAs. Roost et al. (2004, 1372) found that “in Guatemala, 80% of all childbearing women are attended by traditional birth attendants”. It is important to note that before the establishment of primary health care, several TBAs were already practising in many traditional and underdeveloped societies. Imogie et al. (2002) stated that apart from their main role of assisting in childbirth, traditional birth attendants also attend to issues including family planning, nutritional requirements, recommendations for screening of high-risk mothers as well as fertility/infertility treatment including determination of ailments or abnormalities relating to reproductive organs and reproduction. Before so-called ‘western’ bio-medical health care methods were introduced, traditional societies used their own traditional health care systems. Bisika (2008) and Bergstrom and Goodburn (2001) argued that in sub-Saharan Africa, in many African communities, TBAs are highly respected; they perform important cultural rituals and provide essential social support to women during childbirth. In all cases, their beliefs and practices are influenced by local customs and sometimes by religious inclinations and adherence. Ngomane and Mulaudzi (2012) indicated that TBAs know how to reduce labour pains “by massaging the back of the pregnant woman and teaching them how to pant”. They added that “in severe situations, hot compresses around the abdomen and massaging the body with *nhlampfurha* (castor oil) are used in addition to *xirhakarhani* (an indigenous analgesic) which is boiled and given to the labouring woman to drink”. However, these practices have been shaken by the hegemonic western medical ideas and practices. These and other practices used by TBAs are based on traditional expertise that has been used for centuries. In the context of Africa and South Africa, African traditional health care is used as an alternative health care system. Choguya (2013, 1) stated that “African traditional health care is grounded in thousands of years of knowledge and has sustained life, on its own or in concert with western medicine”.

In South Africa, however, since 1994 comprehensive reproductive health policies have been introduced by the department of health to establish partnerships to plan, process and review HIV/AIDS policy, focusing on the prevention of new HIV infections and treatment AIDS related opportunistic infections and free health services for pregnant women and children under

the age of six. Since the introduction of these policies a noticeable increase in the number of healthcare facilities which include free consultation and medication can be identified. As opposed to some of the underdeveloped African countries, antenatal care has drastically improved in South Africa with clinics being built in rural areas and where clinics haven't been built mobile clinics visit the communities. This is not the case for all communities, some women still need to travel to neighbouring communities for clinic visits during pregnancy, and this presents a challenge as travelling costs from homes to the clinics tend to hinder the attendance of the women. Due to this development in South Africa, unlike countries where health care infrastructure is still underdeveloped, the attendance of TBAs is based more on the choice of the woman rather than the lack of health care facilities.

However, in recent years, especially in the South African peri-urban context, the value of TBAs including their knowledge and practices have been increasingly questioned. The acceptance of Western medical thought in many modern cities in Africa has led to the view that traditional African ways are backward and unscientific (Selepe and Thomas 2000). TBAs have, over the years, had to conform to western methods and practices. They have had to discard some of their practices and learn new methods deemed safer by those who view the western health care system as superior and more efficient. The culture and practices of the TBAs are being forcefully modified to fit in with 'safer' and scientific practices that will ensure the safety of the mother and child. This has contributed to the idea, held by those who are relatively educated and part of the rapidly globalised world, that what TBAs do is founded in superstition, and may be harmful to the mother and baby (Maglacas and Simons, 1986). However, minimal literature is voicing the cultural knowledge and practices used by TBAs when assisting pregnant women.

Abbott, Faan and Coenen (2008, 239) stated that "the term globalization describes the increased mobility of goods, services, labour, technology and capital throughout the world". This process of globalisation has had a positive effect on the health care system as developments through modern medicine have reduced a number of illnesses. As early as the 18<sup>th</sup> century, modern medicine had already started growing its roots in colonised countries, imposing its methods on native people that had their own traditional health care systems. Western medical discourse was priority for colonisers who were taking advantage of introducing and imposing their ideologies on native people and their cultures. TBAs encounter challenges fitting into the broader reproductive health care because they use traditional methods that are considered less

effective and unsafe compared to ‘western methods’. It can be said that the services they offer as TBAs, are ‘outside’ the globalised processes of the mobility of both policy and seemingly technologically advanced reproductive health care of bio-medically controlled so-called western health care.

However, in an attempt to protect their unborn babies, mothers are weighing their reproductive health care options, choosing a health care system that they believe will best suit them, and at the same time protect and enhance the development of their unborn babies. TBAs offer traditional methods and rituals to pregnant women, but some women feel that these methods and rituals are not safe as TBAs do not have any formal training. Roost et al. (2004) and Selepe and Thomas (2000) concurred that TBAs have no formal training and appear to be associated with perinatal and maternal mortality. Some of these concerns involve the decoctions that the TBAs routinely offer to pregnant women.

Relatively little research has been done on these decoctions. Studies by Varga and Veale (1997) and Steenkamp (2003) have shown that there are ingredients that are included in some of the decoctions that are potentially a medical threat to the mother and foetus. According to Varga and Veale (1997, 914), “many plants are used as components of the *isihlambezo* decoction ... additional materials occasionally added to *isihlambezo* include fish heads, lizard or snake skin, dried hyrax urine, mercury, clay and sand”. TBAs also frequently examine the vagina often using bare hands and apply herbal medicines to the vulva or vagina to ensure health of the growing foetus and safe delivery. Some of these practices might cause genital infections including pelvic sepsis which is one of the major causes of infertility, menstrual disorders and ectopic pregnancies. There are thus two streams of thinking in South Africa, among African communities and pregnant women in the African communities, who are familiar with TBAs: one that TBAs possess indigenous knowledge and special local skills that can assist pregnant women, and another, that TBAs pose a potential medical threat and harm to pregnant women and their unborn babies. This split perspective is in turn contrasted with a changing and broader health care system that is dominated by ‘western’ biomedical discourse and practice.

This exploratory study works through the life histories of several TBAs and probed if they felt that their traditionally based expertise was being included within a broader reproductive health framework, or whether they felt African peri-urban women’s responses were compelling them to change and adapt their (traditional) practices. Collecting the life histories of TBAs enabled generation of information that is based on the lives and actual experiences of TBAs. Generating



the life histories of TBAs revealed critical insights around some of the practices and rituals offered by TBAs to pregnant women. Life history collection also allowed TBAs to describe how their traditional practices have had to change over the past decade due to globalisation and how they have been responding to women that appear resistant to their traditional practices. Gathering TBA life histories can potentially and critically reveal possible conflict between their traditional approaches to reproductive health and the so-called western methods practised by doctors and nurses in health care facilities, and TBAs feel African women perceive them.

## **1.2 Motivation for study**

The personal motivation for this intellectual study arose when I was pregnant and female family members advised that I consult a TBA to assist with the management of my pregnancy. The TBA offered me a mixture of boiled herbs that she had put in a 500ml used Smirnoff (alcohol) bottle. She explained that the mixture had all the vitamins needed for the baby's growth and she also gave me a thin red string to tie around my waist; the string was going to protect the baby from evil spirits and witchcraft. I took the decoction and string but had no intention of ingesting the decoction because I did not know what ingredients were included in it and whether it was safe for me or my baby. Thereafter, a spark of interest arose as I started reading about TBAs and found that there was very limited literature on their traditional expertise especially in the South African context.

## **1.3 Research problems and objectives: Key questions**

- 1) What was the background and motivation for the woman becoming a TBA?
- 2) What are the traditionally based practices/rituals that TBAs offer to the African women that consult them?
- 3) What traditional practices have TBAs changed or have been forced to change in the last decade?
- 4) How do the TBAs respond to the peri-urban African women who appear to be resistant to their traditional practices or show low adherence to their advice?

5) What do the TBAs think are the areas of possible conflict between their traditional approaches to reproductive health and the so-called western methods practised in clinics and hospitals?

#### **1.4 Research problems and objectives: Broader issues**

Western and traditional health care systems are rapidly changing within the processes of globalisation. Western health care ideas have become hegemonic and dominate all parts of the world. Development has brought about changes in all spheres of life including health care. Western health care has become the primary source of health care in most parts of the world; western health care practices are trusted and are viewed as safe when compared to the traditional health care system. The argument is that western health care is 'scientific', verifiable and consistent. Before the 'western' health care system became popular and dominant among many African communities, traditional health care was widely used and accepted, especially in African traditional and indigenous societies. However, regardless of the assistance that they offer, TBAs have become less popular with the development of the third world countries. The broader issue that this study was concerned with was the encroaching hegemony of the biomedical reproductive health discourse and praxis, which is appearing to marginalise and 'push underground' African traditional reproductive health care.

#### **1.5 Study challenges**

Gaining access to the representative body for the TBAs proved to be a great challenge. The person said to be the manager of the organisation ignored every attempt to meet with her. After two months of ignored calls and emails, she eventually agreed to a meeting but refused to give me a letter allowing me to interview TBAs. She explained that I needed to speak to the traditional leaders in the Harry Gwala district for access to interview TBAs. Upon further investigation, I found that the correct person to contact was based at the Department of Health in the Pietermaritzburg office.

All the interviews took place in the homes of the TBAs. This proved to be a challenge as they were very busy people. Most interviews were not completed as a result of TBA commitments.

Many of the TBAs were sangomas<sup>1</sup> and their scope of work was vast with people arriving for *ukuhlola* (reading) and other personal issues. We would start interviews, but at times not finish them because the TBA was rushing somewhere for an emergency or people from another area would fetch them to perform rituals in their homes. Sometimes interviews needed to be cancelled if people in need arrived. This caused the interview sessions to extend beyond the initial planned period.

The homes of the TBAs were based in the rural areas of uMzimkhulu, a small town in KwaZulu-Natal (see Appendix 6 for a map). Transport at times proved to be a challenge as it is scarce in these areas; there is one taxi going to town in the morning which returns only in the afternoon. Mostly I had to hire cars or make alternative transport plans. Upon arrival, I would have to find directions to the TBAs' houses as rural areas do not have street names or numbers. Another danger in rural areas was the risk of being bitten by dogs as most homes do not have proper fencing. The homes of the TBAs were based in some of the most rural of areas, Sarah for example lives in an area that is on top of a small mountain, there is no electricity, taps with running water, schools or clinics. The people in this community have to travel to neighboring communities to access these amenities. Road infrastructure is poor and as a direct result cars drop off community members at the bottom of the mountain and villagers make their way to the village on foot, on rainy days it becomes difficult to travel as the terrain is poor. Majority of the other homesteads were also in communities that were underdeveloped with lacking infrastructure.

## **1.6 Survey of existing research**

Maternal mortality continues to be one of the biggest challenges faced by the health care sector in all parts of the world. Zureick-Brown et al. (2013) concurred that maternal mortality and HIV/AIDS are two of the leading causes of death among women of reproductive age worldwide. The situation however is worse in underdeveloped countries. African countries form a large group of the underdeveloped countries that contribute to the global estimates of maternal deaths. This study however will focus on the South African context. A study conducted by Ezugwu et al. (2009) indicated that Nigeria constitutes 1.2% of the world's

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<sup>1</sup> Sangoma – traditional healer, a term commonly used in South African English, and hence used in this research without italics, and not in its Zulu form (*isangoma* - singular or *izangoma* - plural)

population but contributes 10% of the global estimates of maternal deaths. Nikiema, Beninguisse and Haggerty (2009) argued that pregnancy is potentially risky for all women worldwide; however, the lifetime risk for African women is heightened by the conjunction of a high fertility rate, poor nutritional status and vulnerable health conditions. Underdeveloped countries have poor health care systems, and in such instances, alternative health care systems are used. One of these alternatives is traditional health care. Neba (2011, 136) stated that “the traditional health system has the following components: Diviners Divination and healing are often practised by the same person, who has the power to deal with the spiritual realm. They look for disturbing events in the past, which can cause misfortune if left untreated. Herbalism: Common ailments, such as headaches or coughs are considered to be diseases with natural causes”. TBAs form part of the traditional health care system and they assist women who are unable to use the western reproductive health care system and those that choose to be assisted by them. TBAs are often the first choice for some women because they are based within communities and they share the same culture and language. A study carried out by Imogie et al. (2002) revealed that ‘rural dwellers’ prefer to use services of the TBAs as they believe that TBAs can play more meaningful roles in family planning, fertility, infertility treatment and maternal and child care services. Titaley et al. (2010) concurred, adding that “being part of the community, speaking the local language, living in the community and sharing the same culture meant that traditional birth attendants have developed the feeling of trust in the community”. Additionally, in many indigenous communities, health is about relationships that are formed over time.

Traditional birth assistants have no formal training and are also, in some instances considered to cause harm to the mother and infant. However, studies have been conducted to learn more about TBAs and the services that they offer. Scholars such as Falle et al. (2009), Abodunrin et al. (2010) and Fronczak et al. (2007) have advocated for TBAs as they feel that with proper training in birthing practices, they can make a huge difference in reducing maternal mortality.

A number of medical studies have been conducted on TBAs and their contribution to health care in South Africa and Sub-Saharan Africa. Two such studies include Bulterys et al. (2002) *Role of traditional birth attendants in preventing perinatal transmission of HIV* and Nahlen (2000) *Rolling back malaria in pregnancy* which report that in some areas where birth attendants have become an integral part of the health care system, they have become increasingly involved in providing cost effective services. Nyanzi et al. (2007) reported that

TBAs contribute “to the gum that holds society together”. TBAs can thus be considered important for social cohesion and welfare; they are not merely health practitioners. Imogie et al. (2002) reported that TBAs play meaningful roles in family planning, screening of high-risk pregnant mothers, fertility/infertility treatment and maternal and child care services. These studies have contributed to and clarified the importance and role of the TBA in the health care context, more so in underdeveloped countries. However, there is still a gap in the literature regarding studies that focus on traditional based expertise of TBAs and whether they are being included within the broader reproductive health framework.

Antenatal care (ANC) is believed to guarantee healthier pregnancies and uneventful deliveries. Mametja (2009, 1) claimed that “early entry to antenatal care (ANC) is important for the early detection and treatment of adverse pregnancy related outcomes”. Women who do not attend ANC services have a higher risk of poor pregnancy outcomes. In countries and communities where there is a shortage of primary health care facilities, alternative health care systems are used. TBAs form part of a health care system that assists women before, during and after pregnancy. Despite their effort and time in assisting pregnant women, TBAs do not have formal obstetrics training; everything that they do is based on years of experience and intergenerational knowledge that has been passed on from one generation to the next through networks within the communities. However, their traditional expertise is often rejected by bio-medically trained personnel and they are considered unsafe and a threat to the well-being of both the foetus and the mother.

As they do not have any formal obstetrics training, TBAs have often been associated with perinatal and maternal mortality. Selepe and Thomas (2000, 21) and Roost et al. (2004) have noted some of the most common complications that TBAs are unable to treat: obstructed labour and haemorrhage, septicaemia and hypertension/acclampsia. Studies conducted by Kayombo (2013), Leroy and Garenne (1991) and Amin and Khan (1989) have described poor management of pregnancy and child delivery by TBAs who frequently examine the vagina, often using bare hands to apply herbal medicines to ensure health of the growing foetus and safe delivery. However, this practice could cause genital infections including pelvic sepsis which is one of the major causes of infertility, menstrual disorders and ectopic pregnancies.

Maternal mortality in Africa has been influenced by socio-cultural beliefs. Authors that have focused on this topic include Marchie and Anyanwu (2009) and Okolocha (2001) who argued that besides the health care services, there are socio-cultural factors that contribute to maternal

mortality such as female genital mutilation which could lead to prolonged and obstructed labour, due to adhesions. Some cultures prescribe food restrictions for pregnant women; the belief is that certain foods will have a negative impact on the child as they grow older. Okolocha et al. (1998) added that in sub-Saharan Africa, the problem stems not only from inadequate health services, but is also the result of the interplay of many antecedent factors that could be social, cultural, economic and logistic, coupled with very high fertility. The Edo tribe in Nigeria believe that if a woman eats eggs during her pregnancy the child will grow up to become a thief. Okolocha (2001) described how pregnant women are not allowed to drink milk to prevent the baby from being a weakling or developing a tendency to steal later in life.

As the 'western' hegemonic bio-medical health care system continues to grow, the traditional health care system continues to be viewed as risky. TBAs have, over the years, had to sometimes change their cultural practices to conform to so-called western or bio-medical health care as this is regarded as safer and more appropriate. Many TBAs have had to undergo training as their methods and practices are regarded as harmful. Saravanan (2008, 2) claimed that "since the 1970s the training of TBAs has been one of the primary single interventions encouraged by World Health Organisation (WHO) to address maternal mortality". Ngomane and Mulaudzi (2012, 2) argued that "in ancient times indigenous practices were the major source of survival in Africa, America, Asia and Australia. Together with many other traditional health practices, the care of pregnant women formed part of the centre of these practices". The processes of globalisation have had an impact on the attitude of people regarding traditional health care. Ngomane and Mulaudzi (2012, 2) argued that "the impact of colonization was major and resulted in indigenous communities feeling condemned if they continued with their indigenous practices in public, because they were regarded as committing a sin". The promotion of the 'western methods' of reproductive health such as contraception, prevention of sexually transmitted diseases (STDs) through the usage of condoms and Prevention of Mother to Child Transmission through testing and the usage of medication left traditional societies feeling somewhat outdated and backward. They were made to feel that their methods of healing are not safe and do not work. Women are now questioning practices that are used by TBAs and which are now labelled as unsafe. With such views, TBAs face the challenge of having to possibly alter their practices to accommodate the 'modern woman'. This is a key point of interest for this study.

This study is important as it explores literature focusing on practices and rituals that are used by TBAs, and further probes whether their traditionally based expertise is being included within the broader reproductive health framework. Little is known about the actual practices and rituals used by the TBAs; it is unclear what kind of training they might need to ensure the safety of mother and baby. Therefore, the purpose of this study was to gather baseline data on the beliefs and practices of TBAs. Such literature is important as it can contribute to improving the health care system: by working together, understanding and respecting practices, both health care systems can reduce the number of maternal deaths and complications. The main goal is to reduce maternal mortality and to achieve this goal, all health care systems need to collaborate when assisting pregnant women. Potential collaboration between the two health care systems will mean more knowledge of the other, resulting in possible solutions to current challenges. Scholars such as Melhado (2012), Gill et al. (2011), Maglacas and Simons (1986) and Joseph and Kelsey (2011) have advocated that TBAs need to be trained to be able to take on and assist in complicated pregnancies and birthing. Life histories are helpful in generating information to clarify and elaborate the practices of TBAs.

Zureick-Brown et al. (2013) stated that maternal mortality and HIV/AIDS are two of the leading causes of death among women of reproductive age worldwide. Maternal mortality continues to be one of the biggest challenges of the health care sector in all parts of the world. The situation, however, is worse in underdeveloped countries, and African countries form a large group of the underdeveloped countries that contribute to the global estimates of maternal deaths. This study will focus on the South African perspective of maternal health, specifically the traditionally based expertise of TBAs when assisting pregnant women.

Underdeveloped countries have poor health care systems due to a lack of financial resources and infrastructure. Studies conducted by, for example, O'Donnell (2007), have concluded that people in developing countries are more likely to have less access to health care than those that are in developed countries and that within countries, the poor have less access to health services. In such countries, alternative health care methods are used to meet the demand of people in need of medical care.

Antenatal care (ANC) is believed to guarantee healthier pregnancies and uneventful deliveries (Mametja 2009). Biomedically trained personnel often regard the practices of TBAs as unsafe. Biomedical health care is a model of illness that generally ignores the social and psychological factors and focuses on biological factors to understand a person's illness). It is important to

note that before the establishment of the western biomedical health care, several TBAs were already practising in many traditional and underdeveloped countries.

Following the growing international interest in training TBAs, Kamal (1998) has reviewed the reasons for the continual existence of TBAs, the various extended roles of TBAs, as well as the current international interests in training TBAs. Kamal (1998) has noted that TBAs continue to practise despite various attempts by countries such as Egypt, Lebanon and Syria to ban them. This can be attributed to factors such as: insufficient basic health care services in developing countries, inability of the poor masses to meet the financial requirements of the modern and trained health personnel, migration of professional health care personnel to urban areas, and the lack of transportation and other communication networks from rural to urban areas. Kamal (1998) noted that about 60% of urban and 80% of rural babies in developing countries are delivered by TBAs; they thus appear to play a vital role due to their being easily accessible. Imogie et al. (2002) revealed that 'rural dwellers' prefer to use services of TBAs for family planning, fertility, infertility treatment and maternal and child care services. Titaley et al. (2010) highlighted the feeling of trust for TBAs in communities. In many indigenous communities, health is about relationships that are formed over time. Scholars such as Bisika (2008) and Bergstrom and Goodburn (2001) argued that in Sub-Saharan Africa, in many African communities, TBAs are highly respected; they perform important cultural rituals and provide essential social support to women during childbirth. With regard to international interest and responses in training TBAs, Leedam (1985) studied the training and utilisation programmes of TBAs in over 70 countries over the past three decades and found that despite these countries' effort to train TBAs, there has been little training due to inefficient planning and supervision of the work of TBAs. He discovered that many TBAs that were left unsupervised tended to slip back into their old practices. Kamal (1998) suggested this can be very risky for mothers.

Byrne and Morgan (2011) conducted a study to describe the mechanisms by which TBAs can be integrated with the skilled or formal health care practitioners to increase the number of skilled birth attendants. The authors also aimed at investigating the components by which a successful integration of this sort can be achieved. Byrne and Morgan conducted this study in response to the requirements for fulfilling Millennium Development Goal (MDG) 5, of reducing maternal mortality by 75% by the year 2015. The study was also a reaction to the results of the 40 years of the Safe Mother Programme, whereby it was discovered that most



communities prefer Traditional Birth Attendants (TBAs) to Skilled Birth Attendants (SBAs) (Byrne and Morgan, 2011). Such preferences or attitudes are not likely to lead towards the achievement of MDG 5 as stated above. Hence, Byrne and Morgan's (2001) study aimed to devise strategies of utilising the strengths of TBAs and increasing the number of skilled birth attendants through integrating TBAs into the modernised health care system. The methods used by the authors is a systematic review of the interventions that link TBAs and formal health care workers, measurement of the outcomes of skilled birth attendants, referrals, and facility deliveries. The mechanisms for the integration were training and supervision of the selected TBAs: making them work collaboratively with formal health workers, training them in the use of modern health care facilities, enhancing communication system between TBAs and SBAs, and clearly defining the roles of TBAs. Other complementary activities for the integration included a specific selection of TBAs, community participation, accessibility changes and improved affordability. Thirty-three articles were found to meet the criteria of describing the integration of TBAs into the formal health care system. It was found that with regular training and supervision, more and more TBAs were integrated into formal health care systems. The rate of integration was dependent on the quality and regularity of the supervision, the scope of the training and availability of the formal health personnel. The authors thus concluded that integrating TBAs into modern health care practices increased the number of skilled birth attendants. The integration, which is done through training and supervision, requires sufficient formal health personnel and regular supervision. The authors also realised that the most impact was experienced when TBAs were integrated into formal health care practices via complementary actions that overcame the barriers of contact among TBAs, SBAs, and women.

Based on evaluating the extent to which the aim of Millennium Development Goal 5 (that is, reduction of maternal mortality) will be met, Crowe et al. (2012) carried out a study to estimate the absolute number that were not attended to by Skilled Birth Attendants (SBA) between 2011 and 2015 in South Asia and Sub-Saharan Africa. This study aimed at assessing the reality of the assumption that by 2015, maternal mortality will be reduced by 75% through increased skilled birth attendance and that by 2015, 90% of deliveries will be attended to by SBA (cited in Crowe et al. 2012). The study also sought to inform policy makers of the extent to which the achievement of the aim of MDG 5 is dependent on policies directed towards those women that give birth unattended by SBAs. The authors estimated the recent trends in births attended to by SBAs in each country of South Asia and Sub-Saharan Africa (SSA). They then used these trends as the basis to estimate and project future changes in skilled birth attendance. The authors

collected the estimates of the number of SBA births both in rural and urban settings in these two sets of countries (except in Senegal, Mayotte, Seychelles and Tanzania, where the authors reported unavailability of data), the forecast for future birth rate, as well as future estimates of the rural and urban population between 2011 and 2015. This data enabled them to estimate the number of births in these countries that would not be attended to by SBAs between 2011 and 2015. The authors found that an estimate of 130 and 180 million non-SBA attended births between 2011 and 2015 in both South Asia and SSA. Of these births, 90% occur in rural areas. The authors also found that though there are more non-SBA attended births per year in South Asia presently, the projection is that these two regions will experience approximately the same number of non-SBA attended births. The conclusion is that over the next five years, there will be a considerable increase in the number of non-SBA attended births in both South Asia and SSA, despite the future prospect of improvements in SBA. The authors suggest that since most rural people – due to a variety of reasons – prefer TBAs to SBAs, policy efforts at reducing maternal mortality in these developing countries should be followed by complementary efforts and interventions to improve the safety of non-SBA deliveries.

According to Ching-Cheng Chen et al. (2011), continuing to train TBAs has an impact on the knowledge of birth delivery and performance. The authors conducted research to investigate the effectiveness of continuing to train TBAs on their reproductive knowledge and performance in Mzuzu Central Hospital in the northern region of Malawi. The authors conducted the study on 81 participants that had received continuous training from 2004 to 2006, and a structured questionnaire was used to assess their reproductive knowledge. The authors found that after undergoing training courses, TBAs improved greatly in terms of their reproductive knowledge. They developed more confidence in advising pregnant women on hygiene, family planning, and child care. Pregnant women were also found to develop more confidence in seeking the services of the trained TBAs. The conclusion was that continuing training courses had a positive impact in maintaining the reproductive knowledge, skills, and performance of TBAs.

Many studies reveal that women prefer TBAs to professional health practitioners, mostly due to financial, transportation and communication limitations. According to Shiferaw et al. (2013), Ethiopia remains one of the top six developing countries in the world with a high rate of maternal deaths. These authors explored and reported the reasons why women in a certain area of Ethiopia still preferred to go to TBAs instead of professional health workers. Even when key challenges of transportation and availability of obstetric services were addressed, most

women still preferred to seek the services of TBAs. The authors conducted a cross-sectional household survey among 15-49-year-old women. This method was combined with in-depth interviews and focus group discussions. The authors found that though the majority of the women (about 71%) received antenatal care and advice from professional health practitioners, very few (about 16%) deliveries were assisted by the professional health practitioners. A significant number of women (about 78%) were assisted by TBAs. Further inquiries by the authors found that 42% of the women reported that seeking the attention of professional health care was not necessary, while 36% reported that it was not customary. Only 22% complained of the cost. From the group discussions, the authors found that women reject the services of professional health workers because they perceive TBAs to be culturally acceptable and more competent. Women's previous negative experiences with professional health facilities, as well as ignorance on the importance of skilled attendance at delivery also contributed to women favouring TBAs. The authors concluded that if proper utilisation of health facilities is to be achieved, attention should be given to the crucial role of communication between proper health care providers and their clients. Also, a more client-centredness and cultural sensitivity is important in the provision of health care.

The issue of maternal deaths continues to be of great concern, even though some measures have been undertaken to curb this. These measures include the increase of professional health workers and health facilities as well as increasing the extent of community-based services in developing countries. But there is still uncertainty as to which interventions are best. Although the annual maternal mortality has declined from 526 300 in 1980 to 342 900 in 2008, only a few developing countries (23) were on course for meeting Millennium Development Goal 5, of reducing maternal mortality by 75% in the year 2015. Montagu et al. (2011) conducted a study using delivery data from demographic and health surveys in 48 developing countries of Sub-Saharan Africa (SSA), Southeast Asia and South Asia between 2003 and 2011. The authors adopted the method of stratifying the reported delivery locations by wealth quintile for each of the countries under study and then created weighted regional summaries. They found that in the three regions under study, more than 70% of women from the lowest two wealth quintiles gave birth at home. In SSA, 54.1% of the richest women used public health facilities for delivery, as compared with only 17.7% of the poorest women who used such facilities. In the poorest quintile of the SSA, 56% of the home births were not attended, while 41% were attended by TBAs. In the wealthiest quintile, 40% of the home births were unattended while 33% were attended to by TBAs. The authors discovered that cost was the main reason for the

poorest women not delivering in facilities; only a few complained of lack of access. Overall, main reasons given by both the poorest and the wealthiest woman for choosing to deliver at home was that delivering at a facility was deemed not necessary by the household decision maker. The authors' conclusion was that most women in developing countries deliver at home. They suggested that due to such preferences for home delivery, and the future prediction for higher number of home deliveries, efforts to reduce maternal death should give priority to interventions that can make home delivery safer.

According to Pfeiffer and Mwaipopo (2013), the Tanzanian Government promotes TBAs because of their important roles in conducting antenatal and neonatal health counselling and initiating timely referral for women. The TBA's role in Tanzania officially excludes conducting delivery. Yet, it was discovered that many women still report to TBAs for delivery and many TBAs still carry out delivery services. It is in this context that Pfeiffer and Mwaipopo (2013) explored the health-seeking attitudes and experiences of women regarding their antenatal and postnatal health care as well as learned about the traditional practices of TBAs, and how these practices could be incorporated into the modern biomedical health system. By conducting both qualitative and quantitative interviews with over 270 individuals, the authors found that in the urban areas, there was significant improvement regarding pregnancy and delivery-related health-seeking of services from the skilled health workers. The findings were different in the rural areas, where there was an inadequate skilled health care workforce as well as poorly equipped health facilities. The authors discovered that there were more deliveries at facilities in urban areas while most pregnant women in the rural areas delivered at home with the help of a relative or TBA. The conclusion reached by the authors was that the focus should not on strengthening the traditional health care sector but rather on strengthening the skilled health system in order to improve and guarantee delivery by the skilled health personnel. The authors also suggested that government try to bridge the rift between traditional health sector and formal health sector through encouraging community-based enlightenment and education conducted by well-trained health professionals.

A study by Flomo-Jones (2004) has investigated the practices of TBAs during prepartum, labour and postpartum periods of women in the Abaqulusi district of KwaZulu-Natal. The author interviewed 48 trained TBAs, aged between 20 to 70, as well as 48 mothers were attended to by these TBAs. Of these mothers, 50% were between the age of 15 and 24, a situation which points to a high risk linked to TBAs' practices. The author found that TBAs

attend to women during pregnancy, during delivery and during the postpartum periods (period ranging from one hour to six weeks after delivery). In terms of the practices of TBAs, all the interviewed TBAs examined mothers using their hands with either gloves or plastic bags. They educated the mothers on the importance of good nutrition, child spacing, and follow-up care. The TBAs delivered babies on the floor, on a blanket and in a lithotomy position. Before delivery, the TBAs examined the mothers. After delivery, they measured the umbilical cords, tied it with string and then cut it. They also cleaned the baby thoroughly, wrapped it and placed it near the mother. They delivered the placenta before washing the mother and put her to bed. During the postpartum period, the TBAs paid regular visits to the mother, during which they examined the umbilical cord, bathed the baby, educated the mother on breastfeeding, caring for the breasts and eating a balanced diet to ensure proper flow of breast milk. The authors also found that the women perceived the TBAs as caring, loving and more accessible at any time. The conclusion by the author was that the work of TBAs was indispensable, especially in the rural areas of South Africa, and hence the TBAs and their work need to be supported by the health professionals.

A continual investment in the training programmes of TBAs by policy makers and funders will largely be motivated by the positive outcomes of the already trained TBAs. Some scholars have studied the extent to which TBA training programmes have been relevant in developing countries, in terms of increasing skilled based knowledge of delivery practices. A study by Saravanan et al. (2011) has assessed the extent to which a TBA training programme in India has been successful in disseminating knowledge and skills of birthing practices. The authors compared the post training birthing practices of 24 trained TBAs with those of 14 untrained TBAs. They also compared the birthing practices and experiences of women that were assisted by trained TBAs with those of women assisted by untrained TBAs. The authors found that incorporating local and evidence-based knowledge was important for improving TBA training. They also recommended raising community awareness with regard to public health measures of maternal health and childbirth.

The literature reviewed above shows links between access to skilled health workers and maternal mortality. Lack of or poor access to skilled health care personnel has been mostly positively correlated with an increasing maternal mortality rate in low and middle-income countries. If maternal mortality is to be reduced, policies should enhance improved access to skilled birth attendants. Some scholars have suggested ways of achieving this aim: improved

access to skilled health care personnel. According to Rosskam et al. (2012), increasing access to health workers skilled in midwifery is crucial for alleviating the problem of maternal mortality in developing countries. By sharing case stories of skilled health care workers, as well as innovations from Nigeria, Sri Lanka, and Bangladesh, these scholars studied the strategies that should be adopted to increase access to skilled midwives. They found that in Nigeria, the National Health Care Development Agency has established the Midwives Service Schemes (MSS) for midwifery training, an initiative that has helped to reduce maternal mortality. The government of Sri Lanka encourages public health midwives to work in remote areas to address the problem of limited availability of skilled midwives in rural areas. Having discovered that 90% of births in Bangladesh are at home, the government has started a strategy of admitting home birth assistants and other TBAs into an entry programme to train them in the skills of professional midwifery. Overall, the authors found that three factors were crucial for scaling up skilled health care workers: recruiting more midwives, retaining skilled health workers as well as continual motivation of the public health care workers, including midwives.

In terms of HIV/AIDS, TBAs have often been regarded as unprofessional and of being responsible for higher risks of mother-child infections. Some scholars have therefore investigated the extent to which TBAs are equipped to prevent or reduce the risk of spreading HIV infection during delivery. According to Peltzer and Henda (2006), TBAs can be used more and their knowledge of preventing infection risks can be enhanced through the support and supervision of the western health sector. Peltzer and Henda (2006) studied a training programme for TBAs in a rural area in the Eastern Cape, South Africa, with the aim of evaluating the effectiveness of this training programming on HIV/AIDS prevention and safe delivery by TBAs. The authors carried out a pre-post training evaluation of 50 TBAs in two rural primary health clinics. The authors found that after the training, the TBAs increased their knowledge of risk management and this resulted in a significant improvement in TBAs handling of the risks during pregnancy. The HIV risk practices during pregnancy and delivery were found to be significantly reduced. The training was also found to lead to more TBA involvement in managing HIV and other sexually transmitted infections (STI) risks. Some of these management practices included counselling about risk reduction, assessment of the risk, distribution of condoms, community education and home-based care. The training also resulted in more TBAs carrying out more complex pre-natal check-ups such as examining the position

of the foetus in the uterus and checking the pulse of mother and baby. Fewer TBAs were found to conduct abnormal and complicated deliveries after the training programme. The authors' conclusion was that training was essential to improve TBAs' knowledge of managing risks involved in pregnancy. They, therefore, recommended that more skilled support and equipment be provided for such TBAs to carry out more basic obstetric duties.

One of the many causes of maternal mortality is Postpartum Haemorrhage (PPH) (Prata et al. 2011). Thus, it appears that to reduce the rate of maternal mortality, steps need to be taken to curb and control PPH. According to Prata et al. (2011), training TBAs on the application of misoprostol was effective in improving their knowledge of PPH management. They evaluated the extent to which TBAs improved in their knowledge of PPH management after undergoing training on the use of misoprostol and blood collection delivery mat methods. Their large study (77 337 home births) in rural Bangladesh aimed to determine how the trained TBAs were able to correctly and safely apply the two interventions mentioned for reducing PPH. TBA knowledge and skills of managing PPH were significantly improved with training, which resulted in more effective management of PPH and less mortality in the studied areas. The authors thus recommended strengthening such programmes in settings not covered by skilled birth attendants.

Other scholars who have considered the causes of postpartum deaths in low-income countries include Wall et al. (2010) in order to develop preventive measures. Conditions such as pre-eclampsia/eclampsia, obstructed labour, and low birth weight increase the risk of intrauterine hypoxia, which causes most intrapartum-related neonatal deaths, are prevalent in low and middle-income countries. This is because women in these countries lack quality access to health facilities, resulting in most of them delivering at home, without a skilled birth attendant. Interventions include prevention and management of pre-eclampsia, monitoring progress of labour with access to emergency obstetric care, and assisting non-breathing new-born babies through stimulation and bag-mask ventilation. However, the authors recognised that in Sub-Saharan Africa, few hospitals are equipped with these facilities and few professionals are available to carry out this function. They therefore suggested this region adopt a community-based approach of increasing skilled birth attendants.

Some scholars have assessed the effectiveness of the strategy employed by the World Health Organisation (WHO) in curbing the issue of maternal mortality in developing countries. The strategy, as observed by Prata et al. (2011), involves training and deployment of skilled birth

attendants into communities and improving emergency obstetric health care facilities in hospitals. This strategy was hoped to be effective in reducing maternal mortality in developing countries. However, studies of where women in most developing countries go for child delivery services as well as the mortality rate in those countries have proved this strategy to be minimally effective. According to Prata et al. (2011), though upgrading obstetric care facilities makes sense, it does not address the issues and safe delivery needs of about 45 million women in some developing regions of the world where women are most likely to deliver at home, without the intervention of a trained birth attendant. Prata et al. (2011) studied deliveries in 28 countries in four major developing regions of the world. The authors observed that despite that these countries only constituting 34% of the regions' population, 69% of maternal deaths in the regions occur in these 28 countries. The authors also noticed that over the last 15-20 years, documenting of the birth in these regions shows no positive indication of an increased flow of mothers towards skilled birth attendants for deliveries and hence, one can assume that there is a likelihood of no significant change in the near future. Following such assumptions, the authors, therefore, suggested that to reduce maternal mortality in these regions, governments should devise and implement a cost-effective, complementary strategy that will ensure the availability of health workers at homes where deliveries take place. One such strategy, as suggested by the authors, is to train community-based traditional birth attendants in modern technologies such as misoprostol, family planning skills and postpartum care. Such development, the authors recommend, will help to increase the chance of women from low economic quintiles benefiting from the global safe motherhood efforts.

In ancient times, indigenous beliefs and practices formed a major part of the belief system and survival of people in Africa, Asia, America and Australia (Ngomane and Malaudzi, 2012). Some of these beliefs and practices affected the lifestyle and practices of women during pregnancy. However, with the advent of civilisation, some of these traditional beliefs are fading especially in regions like America, where westernisation has taken the lead. But traces of these beliefs can still be found in other regions. An example is the Bohlabeledo district of Limpopo Province in South Africa where it was noted that only 2.9% of pregnant women in the district visit antenatal clinics before 20 weeks while 58.3% only visit the antenatal services during their second and third trimester (Ngomane and Malaudzi, 2012). Bohlabeledo district is also recorded to have up to 180 deaths per 100 000 deliveries, presumably due to the beliefs in this society. Researchers have therefore explored the indigenous beliefs behind the reluctance of women to make use of antenatal clinics in areas such as Bohlabeledo. According to Ngomane and Malaudzi



(2012), an understanding of the indigenous beliefs of clients regarding their health issues is important in ensuring better health care provision for women. The authors explored the indigenous beliefs and practices of pregnant women that caused them to delay visiting antenatal clinics in the Bohlabelo district. Women shared their indigenous beliefs and practices during unstructured interviews. The targeted participants were pregnant women who were visiting antenatal clinics for the first time. The authors found that there were many traditional beliefs preventing women from making use of the benefits of antenatal clinics. These included the women's fear of being bewitched when they visited the clinics. To protect themselves from being bewitched and to protect their children, the women often used traditional herbs they believed would protect their children from harm. Some said that they trusted the knowledge of TBAs, preferring their care and expertise to the harsh treatment they often received from trained midwives in the clinics who were disdainful of their traditional beliefs and practices. Therefore, to increase visits to antenatal clinics, the authors recommended that indigenous beliefs and practices be incorporated into the modern midwifery curriculum.

A big challenge today, especially in the developing regions, is how to cope with, or prevent the transmission of HIV/AIDs. Infected women can transmit the disease to their offspring. Considering that most women in the developing regions lean towards TBAs, it is pertinent to explore the extent of TBAs' knowledge and expertise in preventing mother-child transmission of HIV/AIDs. According to Madhivanan et al. (2010), there is very little research done in India concerning HIV awareness and the practices of traditional birth attendants in the region. Considering that most women in this region deliver with the aid of a TBA, the authors explored the attitudes and knowledge among rural TBAs in the rural areas of Mysore, India in order to examine how TBAs could be involved in the prevention-of-mother-child transmission (PMTCT) of HIV. Using a survey with over 400 TBAs (of between 26-80 years of age) in 144 Indian villages, they explored knowledge and practices around birthing and prevention of mother-child transmission of HIV. They found that only 51 of the 417 TBAs reported having heard about HIV/AIDs. Of these, only 36 (72%) correctly reported that they were aware that the virus could be passed from mother to child. The majority of the TBAs were found not to have provided antenatal care to their clients. While half reported that they referred their clients to the hospital in cases of excessive bleeding before delivery, 53 found such referral only necessary if the excessive bleeding took place after delivery. Some of the TBAs who reported being aware of HIV said they refrained from attending to those women whom they suspected had been infected; others reported rubbing oil on their palms prior to delivery services; some

reported taking herbal medicines prior to the birthing practices; while others said they wore gloves. The authors concluded that most TBAs in India did not have basic knowledge of HIV/AIDs and safe delivery practices. Most lacked basic knowledge regarding the risk and prevention of mother-to-child transmission. Observing that there was a shortage of skilled birth attendance in rural areas of India, the authors recommended that more research be carried out to determine whether TBAs should be trained and be incorporated into the prevention-of-mother-to-child-transmission (PMTCT) and maternal child health programme in India.

Both pregnant women and TBAs have traditional beliefs concerning birthing practices which can affect delivery services. A study by Keri, Kaye and Sibylle (2010) sought to assess the current beliefs, attitudes, knowledge and practices of TBAs in Uganda regarding referral of complicated issues (such as obstructed labours and fistula cases) during delivery services. They found that though some TBAs, especially those who had some previous training were willing to refer complicated issues during labours to health facilities, there were other more serious problems including reports of abuse by medical doctors, nurses, as well as the perception of fistula disease as a disease caused by hospitals. Many of the TBAs are said to have reported that medical health practitioners were sometimes abusive to the pregnant women. This caused some pregnant women to refuse being referred, even when their delivery issues become complicated. Other TBAs were also found to suggest that fistula diseases were caused by some practices, such as the use of metal forceps to pull out babies as well as delayed operations by doctors in the hospitals. The authors recommended training of TBAs in order to standardise their knowledge of the need for timely referrals. Such training should also increase the TBAs' knowledge about the cause and prevention of obstetric fistula. Further recommendations by the authors are that such training should involve collaboration between biomedical and traditional health personnel and that there should be increased infrastructure to prevent the mistreatment of pregnant women by medical personnel.

One way of achieving safe childhood is to train TBAs on neonatal mortality control. According to Gill et al. (2011, 1), "neonatal deaths now account for greater than 40% of deaths of children under 5, with about 75% occurring during the first week of life". Their study in a rural village in Zambia aimed to determine if training TBAs to manage common perinatal conditions could be effective in reducing infant mortality in poor communities, especially those that have limited access to modern health care facilities. The research was done in the form of an intervention in the work of the TBAs. The first part involved training of the TBAs in a modified version of

neonatal resuscitation protocol and administration of a single dose amoxicillin which was accompanied by referral of the infants to health care. The second intervention involved control birth attendants who continued with their existing standard of care using clean delivery kits and observing basic obstetric skills. The authors found that the number of infants' deaths at day 28 after birth was 45% lower among live-born infants delivered by TBAs of the first intervention than those of control birth attendants. However, though infant deaths caused by infection occurred at similar rates among the two groups, deaths caused by asphyxia were greatly reduced among infants delivered by the intervention group of birth attendants. Training traditional birth attendants on the management of common neonatal conditions (such as neonatal resuscitation protocol) shows significant effects, by reducing neonatal mortality rate in rural settings of Africa. They also found training TBAs to administer a single dose of amoxicillin before referring sick infants to hospitals proved helpful. They suggested that such an approach has the potential to be applied also in settings with dispersed rural populations.

In addition to studying the traditional beliefs of pregnant women and TBAs regarding delivery services, other researchers have explored the perceptions and views of mothers and birth attendants regarding certain government policies. Rishworth et al. (2011) examined government policies regarding TBAs in Ghana and the views of mothers and birth attendants towards such policies. They explored the views and experiences of mothers, TBAs and skilled birth attendants towards the recent government's policy in the western region of Ghana which restricts TBAs' role to referrals, forbidding them from carrying out any other delivery services. The study aimed to explore the intersection between global safe motherhood discourse and the socio-cultural and political environment of the Upper West Region of Ghana. The authors found from interviews and discussions that most mothers thought that traditional birth attendants were preferable to skilled birth attendants in conducting deliveries in the rural community mostly because they were more easily accessible. According to the authors, this preference of TBAs to SBAs is an indication that government's strict adherence to the directives and guidelines of the World Health Organisation will not have positive outcomes. The findings further suggest that the government policy forbidding TBAs from delivery services will only worsen and threaten the relation between traditional birth attendants and skilled birth attendants in the region. Such a policy is an indication of government's inability to comprehend the local realities in the region, especially the reality of poor accessibility to health workers. The suggestion by the authors is that to fulfil Millennium Development Goal 5 in Ghana, the government needs to ensure adequate and even distribution of health facilities

and health staff. A training programme for TBAs would also be important so as to ensure adequate provision of health care services to mothers in the region.

According to Abrahams et al. (2001), understanding the causes of late antenatal care attendance is of crucial importance in dealing with the issues of maternal mortality. Abrahams et al. (2001) studied the health care-seeking practices of pregnant women as well as the role of midwives in a peri-urban area of Cape Town, South Africa. Most of the participants were Coloured women ranging between the ages of 17 to 40. The participants were interviewed about their knowledge of their bodies during the pregnancy period; the symptoms and illnesses they experienced during pregnancy; the causes and severity of those illnesses; those involved in their decision to seek antenatal care services (including place and timing); their experiences of the antenatal interventions; their assessment of the appropriateness and the need for these interventions; as well as their traditional health practices. The authors found that antenatal care attendance by the women was influenced by many factors. Some of the women went to the hospital simply to do a pregnancy test and then booked for antenatal services. Others booked for antenatal care services (some earlier and some later) because of their perceived need for such services. For example, some booked earlier because a previous child had Downs syndrome. Some of the women travelled a long distance to book in Cape Town simply because the nurses in their home town were too rough with pregnant women during delivery. Some did not book for antenatal care in hospitals due to economic and transportation barriers. Above all, most women had to weigh the expected benefits over anticipated costs before making decisions to seek antenatal care. According to the authors, the findings showed that enlightening women on the need for antenatal care is crucial. Such enlightenment would change their perceptions concerning the quality of health care.

According to a study by Goodburn et al. (2000), trained TBAs are more likely to carry out more hygienic delivery services compared to those who are untrained. The hygienic discrepancy was measured by the postpartum infection of deliveries conducted by both categories of attendants. The study, an analysis of 800 deliveries, took place in Bangladesh, and data on postpartum morbidity was gathered prospectively after two and six weeks. Hygienic practices of the TBAs were considered such as hand washing with soap, clean cord care, and cleaning of the surface. They found that 45% of the deliveries conducted by trained TBAs observed hygienic practices with only 19.3% of untrained TBAs following these practices. However, they found no difference regarding cases of postpartum infection when deliveries conducted by both

categories were compared. The implication of this, according to the authors' logistic regression, is that TBA training for hygienic delivery had no independent effect on postpartum infection. Rather, other factors such as previous infection and insertion of the hands into the vagina were found to have significant effects on postpartum infections. The conclusion reached by the authors is that training TBA training may not be an effective way of preventing postpartum infection. Rather than giving attention to TBA training as a whole, more attention should be given to the individual components of the training.

The emergence of globalisation and transition to a technological age, coupled with the prevalent strategy of training TBAs to perform skilled delivery services, has posed some questions as to the future of traditional birth attendants. Some scholars have examined the history and evidence of the effectiveness of TBA training in order to assess how TBAs have become skilled birth attendants, as well as to predict the future of those who still remain at the level of TBAs. Sibley and Sipe (2006) studied the history of TBA training as well as the future of traditional birth attendants in an environment that lays considerable emphasis on transition to skilled birth attendance. The authors conducted a meta-analysis of sixty studies that deal with the effectiveness of TBA training. They found that most of the studies highlighted the effectiveness of TBA training, as the training caused moderate to large improvements in intrapartum and postpartum care practices, increases in women's use of antenatal care and emergency obstetric care, as well as a reduction in maternal mortality due to complications such as asphyxia and pneumonia. The authors concluded that in places where there is a high mortality rate and weak health system, TBAs' participation in some key evidence-based-interventions can contribute towards achieving the aim of the Millennium Development Goal of reducing infant mortality.

## **1.7 Conclusion**

In ancient time indigenous practices formed a major part of the belief systems and survival of people in Africa, native people survived through traditional practices and medicine which was and still is part of the culture in indigenous societies. However, the introduction of western medicine has changed this trend as it discredits any merits of traditional medicine, as a result traditional practices are slowly fading away. Even though traces of traditional practices and beliefs can still be found in some communities, western ideology and practices have encroached on traditional beliefs and practices. The literature in the chapter has discussed in

great length maternal mortality and the causes. Some of the causes that have been mentioned in the literature is lack of access to health care facilities and medical personnel, unskilled birth attendants and use of traditional medicines that have not been scientifically tested. Traditional birth attendants continue to assist women in traditional communities, however, their skill and knowledge are constantly being challenged.

## **1.8 Structure of dissertation**

### *Chapter 1: Introduction and literature review*

Chapter One has provided the background of the dissertation, the history of traditional birth attendants and the practices they offer to women. The chapter describes the research problem and questions, theoretical framework, and provides a summary of the chapters. The chapter also presents a literature review to validate, evaluate and argue the findings of the present study. The literature covers international, national and provincial studies that have focused on TBAs and the role that they play within their communities to support and analyse responses and to better understand cultural groups and their conceptualisation and meanings attached to pregnancy and the health seeking behaviour of pregnant women. The chapter discusses the background of TBAs and the role that they have played in reproductive health care in developing countries, the traditionally based practices and rituals they offer and the worldview of the women that they offer them to. The chapter discusses traditional practices that have had to change in the last decade as a result of the encroaching western health care system that regards their traditionally based knowledge and practices as backward and unsafe. The chapter explores the responses of TBAs when assisting peri-urban African women who appear to be resistant to their traditional based knowledge and practices or show low adherence. Finally, the chapter mentions areas of possible conflict between the traditionally based approaches to reproductive health care and the so-called western approaches practised in clinics and hospitals.

### *Chapter 2: Research methodology*

Chapter Two describes the research design and methodology of this study. The chapter outlines in detail the process and use of life histories which were used to gather a range of data. The chapter explains the analysis, coding and interpretation of the data, as well as the process of choosing the population of the sample. The ethical considerations and challenges faced by the researcher during the research will be discussed, including the process of gaining permission into gated communities and the importance of following protocols.

*Chapter 3: Journey to becoming traditional birth attendants*

Chapter Three presents a thick description of the background of the participating TBAs. It provides insight into their motivation for becoming TBAs and their journeys to start and become practising TBAs. The chapter demonstrates the journey through *ubizo* explaining what led them to realise that they were called to become traditional healers, the training they received and how they were influenced to go back to their communities to assist and heal people, especially pregnant women. The chapter gives a thick description of the lives of TBAs, their life experiences as traditional healers and how they see and feel about their journeys and selection by the ancestors to become healers. The chapter works through the life stories of the TBAs and considers their role in society which has broken gender roles through the taking on of previously male-dominated roles such as leading rituals, communicating with the ancestors, assisting during the birthing process and conflict resolution among families.

*Chapter 4: Traditional practices offered by traditional birth attendants to pregnant women*

Chapter Four discusses the traditional practices that the TBAs have learned through their various training methods. The chapter gives a thick description of the practices and their efficacy during pregnancy and how they are contributing to the lives of women who believe in them and those that attend TBAs. The chapter describes the health seeking behaviour of women during pregnancy and their reasons for selecting the health care systems they used when pregnant. It also focuses on the reasons why some women still prefer the assistance of TBAs as opposed to health care facilities with trained medical personnel that are considered 'safe'. The encroachment into traditional medicine by western medicine has meant that the practices, and knowledge of the TBAs has had to change so to meet the 'safe' standards of the western scientific practices. The chapter considers these changing practices that are required of TBAs.

*Chapter 5: Traditional birth attendants' responses to the attitudes and views of peri-urban women regarding their services*

Chapter Five discusses the responses of TBAs towards peri-urban African women who appear to be resistant to their traditional based practices or show low adherence to their advice. The chapter also looks into the perceptions of and attitudes of 15 African (five rural, five peri-urban, five urban) women towards the practices and rituals that TBAs offer, their preferences for the health care systems they select during their pregnancies and the driving force behind those preferences.

*Chapter 6: Conflict between the traditional and western approaches to reproductive health*

Chapter Six discusses the areas of possible conflict between the traditional approaches to reproductive health and the so-called western methods practised in clinics and hospitals. The chapter discusses the attitudes of both TBAs and medical personnel towards each other and their practices. It considers the opinions of the TBAs as their traditionally based practices are seen as backward and unsafe and as they are forcefully being introduced to new systems regarded as scientifically proven to be safer than those of the TBAs. The chapter also discusses the possible solutions that TBAs and medical personnel feel may address the challenges within the reproductive health care system. Discussions around the inclusion of TBAs within the reproductive health care systems are also included.

*Chapter 7: Conclusion and recommendations*

The final chapter offers a summary of the findings of the present study and notes important contributions of this research. The chapter also offers suggestions for further research on TBAs and the contribution of their practices in reproductive health care in South Africa which may have an influence on policy formulation and the development of the reproductive health care system in the country.



## **CHAPTER TWO: Research methodology**

### **2.1 Introduction**

This chapter describes the research methodology undertaken in the present study. “The purpose of research is to discover answers to questions through the application of systematic procedures” Berg (2001, 6). This research sought to study the life histories of TBAs, to probe if they feel that their traditionally based expertise is being included within a broader reproductive health framework, or whether they feel African peri-urban women’s responses to them is compelling them to change and adapt their (traditional) practices when working with the pregnant women. Qualitative research methods were chosen to allow the researcher to observe and study things within their natural setting. The research took place in the homes of the TBAs and in Rietvlei Hospital (gynaecology clinic) in uMzimkhulu, KwaZulu-Natal.

Qualitative research methods enabled first-hand observation and put the subject or participant at the centre of the research, giving the participants the power to voice their opinions and share their experiences. The participants also had the power to provide data in their own words rather than participating in data collection where they are used merely for data extraction to become part of another statistic.

Sampling methods are very important for any research. Sampling is important because of the significant impact it has on the quality of the research findings. For this study, snowball sampling was used to select the required number of participants. The sample consisted of ten TBAs, five health care practitioners and fifteen African women that had previously consulted TBAs. The data collected throughout the research was firstly translated from isiXhosa and isiZulu to English and later transcribed for easier interpretation. To support the interpretation of this study, both published and unpublished literature was also used.

The chapter consists of six sections. The first describes the population of the study and how the sample was chosen; section two describes the instruments used to collect the data; section three deals with data analysis and how the data was handled and processed; section four discusses some of the ethical considerations used to protect the rights of the participants; section five describes the challenges and limitations that were faced during the research; and the final section summarises and concludes the chapter.

“Qualitative research methods is an umbrella concept which covers a wide range of techniques and philosophies, thus it is not easy to define” (Hennink, Bailey and Hutter 2011, 8). Qualitative research examines people’s lived experiences. This can be achieved through the use of research methods such as in-depth interviews, focus group discussions, observations, content analysis, visual methods, and life histories or biographies. Berg (2001, 7) claimed that “qualitative researchers are most interested in how humans arrange themselves and their settings and how inhabitants of these settings make sense of their surroundings through symbols, rituals, social structures, and social roles”. Sharan (2002, 3) argued that “the key to understanding qualitative research ties with the idea that meaning is socially constructed by individuals in interaction with the world”. In qualitative research, the researcher studies every aspect within its natural setting. Mack et al. (2005, 132) stated that “the strength of qualitative research is its ability to provide complex textual descriptions of how people experience a given research issue. It provides information about the ‘human’ side of an issue – that is, the often contradictory behaviours, beliefs, opinions, emotions, and relationships of individuals”. Qualitative research methods are suitable for this study as they consider the viewpoints of the participants, they allow the participants to voice their opinions thereby offering a clear perspective on their stories. The participants are viewed as part of an explicit component of knowledge rather than as a mere source of data. Life histories were the main method for gathering data for this study and they entail the participants telling their life stories.

Life history as a method of qualitative research is used mostly in anthropological research, as it is a methodology that allows the researcher to develop a representation of the participant’s life according to the participant him/herself. Gathering life histories allows the researcher to get a holistic understanding of the participants therefore making it possible to draw a conclusion on the lived experiences of the participants. Goodson and Gill (2011, 34) argued that “life history research ought to honour and respect the narrative of the life storyteller first and foremost and, at the same time, be open to opportunities for dialogic encounter and collaborative interpretation between the researcher/listener and the teller”.

## **2.2 Population of the study and how the sample was selected**

Sampling is a method that is used by researchers to minimise to a small section the population size that they wish to study to estimate characteristics of the whole population. It is almost impossible to study an entire community as the researcher will be met with many challenges

such as time, data collection, data management and financial limitations. In agreement, Coyne (1997, 623) stated that “in qualitative research sample selection has a profound effect on the ultimate quality of the research”. Sampling methods are divided into two sections which consist of probability sampling and non-probability sampling. This study will be guided by non-probability sampling where participants are selected from the population in a non-random manner. Simply put, this means that non-probability sampling does not give all the individuals within the population an equal or fair chance of being selected to participate in the research. The three most common non-probability sampling methods include purposive sampling, quota sampling, and snowball sampling. In this study, snowball sampling was used to select the participants. Snowball sampling is used when the desired sample characteristics are rare; TBAs are rare because they are mostly based in rural communities where they offer specialised services to pregnant women. For this study, the selection of the participants involved TBAs based within rural communities in the small town of uMzimkhulu in KwaZulu-Natal.

The research population for this study consisted of ten TBAs. In addition, a sample was selected of 15 African women that had visited TBAs as well as five health care professionals consisting of three professional nurses and two medical doctors. Snowball sampling was used because the TBA community is not known to many people beyond their own communities. Snowball sampling requires the researcher to identify someone that meets the criteria for inclusion in their study. The researcher first approached a TBA within the rural community of uMzimkhulu and then asked that TBA to recommend other TBAs from neighbouring communities. Snowball sampling was especially suitable for this study as it gave the researcher the opportunity to reach more TBAs which would have proved inaccessible and hard to find if another sampling method had been employed. Similarly, snowball sampling was used to identify the fifteen (five urban, five peri-urban and five rural) African women. Lastly, a sample of health care practitioners that work specifically at the Rietvlei antenatal care (ANC) clinic were selected to share some of their experiences when assisting pregnant women who had consulted TBAs during the interview sessions of the present research.

The researcher chose uMzimkhulu as a research site for two reasons. Firstly, uMzimkhulu is an underdeveloped small town in KwaZulu-Natal that is struggling with poverty and disparities in health care. There is a shortage of health care facilities and health care practitioners and people have to travel far for medical assistance. Secondly, cultural practices in uMzimkhulu promote the use of TBAs during pregnancy.

### **2.3 Instruments used in the study**

According to Helitzer-Allen, Makhambera and Wangel (1994, 75) “qualitative research methods such as in-depth interviews, focus group discussions and participant observation are increasingly being used in reproductive health research”. These methods are becoming increasingly popular in the reproductive research field because of their ability to elicit information from participants on social norms, behaviours, beliefs and attitudes. The purpose of this study was to gather the life histories of TBAs, therefore, the use of in-depth interviews and life history interviews was especially suitable in that the participants were given an opportunity to tell their life stories, beliefs and attitudes towards reproductive health care through the guidance of such research instruments. Fisher (1991, 22) stated that “a life history is the collection and organization of materials that represent the ‘essence’ of an individual’s life, or the underlying aspects that organize and direct the activities of that individual”. In addition anthropologists Crapanzano (1984) and Zeitlyna (2008) state that life histories are data collection strategies that detail an individual’s life lifelines displaying events in their lives in chronological order while noting the importance and meanings of those events. According to Allen et al. (1994, 75), “the in-depth interview has evolved from anthropology, and is a compromise between unstructured and semi-structured interviewing techniques. It is more like a conversation than an interview in that it requires the skills of probing and following leads”. In-depth interviews thus allow researchers to dig in deep and probe meaning into some of the details that participants mention during the research process. Seidman (2013, 9) stated that “at the root of in-depth interviewing is an interest in understanding the lived experiences”. Understanding the life histories of the participants was the main purpose for this study and in-depth interviews were used to collect the data. Through the interview sessions, the researcher was able to communicate and interact with participants on a personal level which enabled the development of a good rapport. Simply put, rapport is a close relationship in which the people involved have feelings of mutual understanding and good communication. Keegan (2009, 107) argued that “rapport is a prerequisite of good qualitative research”. Building rapport is very important in research as it has an influence on the quality of data that a researcher can elicit from the participants.

Interviews were scheduled at times suitable to participants. All participants had other commitments such as work, community meetings and other family related matters. Scheduling appointments proved to be a problem, especially with the health care professionals due to long working hours with very little free time. Participants were encouraged to choose a setting where

they would feel comfortable for the interviews. The interviews were conducted in the homes of the TBAs and Rietvlei Hospital. The 15 African women that participated in the study were interviewed during their consultation visits to the TBAs; further interviews were scheduled with these women elsewhere to encourage speaking freely about emotions and attitudes to the practices and rituals offered by the TBAs. These interviews took about an hour each. Ten life history interviews were conducted with the TBAs who constituted the primary sample community. These interviews took between one to three hours and were conducted in the homes of the TBAs. Interviews with the health care practitioners were conducted at Rietvlei Hospital Doctors Quarters rooms and the nurses' homes and the interviews took approximately 45 minutes each.

The aforementioned interviewing techniques allowed the researcher the privilege of gathering rich data and the development of a personal relationship with the participants. For the participants, the interview was an opportunity to share feelings, attitudes and ideas. Before each interview, participants gave permission to record and take pictures as requested. In accordance with research ethical protocol, all the information and pictures gathered during the interview were stored on a flash disc kept in a secure place. A diary containing written notes was also stored in a secure place to protect the anonymity of the participants. A tape recorder proved to be a great advantage for recording the interviews, allowing the researcher to listen carefully and go back to points that were not clear. The tape recorder complemented the diary notes, serving as the primary data source.

For this study, three sample communities consisting of TBAs, African women and health care professionals were interviewed. Each group was asked questions guided by an interview guide (see Appendices 1, 2 and 3). All participants were provided with a copy of the interview questions prior to the interviews. If participants wandered off the topic it was easy to direct them back to the questions. All the interview questions were translated to the preferred language of the participants, either isiXhosa or isiZulu. The interviews were conducted in the language of preference of the participants.

## **2.4 Data analysis**

Data analysis involves a collection of methods and procedures whereby the data that has been collected is converted to create meaning about the people and situation that were being investigated. According to Merriam (2009, 176), "data analysis is the process of making sense

out of data”. The bulk of the information that was collected during this research was recorded on a tape recorder and analysed using content and narrative analysis and which was based on a full transcription of the audio tapes. Merriam (2009, 176) argued that “making sense out of data involves consolidating, reducing, and interpreting what people have said and what the researcher has seen and read, it is the process of making meaning”. The researcher listened to the stories again and again and later transcribed. The researcher further read all the transcribed data in parallel and then analysed, interpreted and sieved through this in light of the theories that guided the study. Nvivo 10, software created to assist researchers in the process of data management and analysis, was selected as a tool for analysing life histories as it allowed the researcher to examine and make sense of the data. Nvivo 10 enabled the researcher to code and analyse life history transcripts, to link the transcripts and coded sections to sound files. Bazeley and Jackson (2013, 2) stated that using the software “releases some of the time used to simply manage data and allows an increased focus on the ways of examining the meaning of what is recorded”. Nvivo software was selected for the data analysis of this study because of the system’s ability and capacity for recording, sorting, matching and linking data.

## **2.5 Ethical considerations**

Hennink et al. (2011, 64) stated that “qualitative research methods are applied to get to know perceptions, beliefs and feelings of people”. Even when strong bonds have been established, it is still important to treat the participants with respect and to safeguard their interests. This is an important aspect within this research field due to the fact that the researcher is dealing with private and often sensitive life issues. Hennink et al. (2011, 64) argued that “the closeness and sometimes intimacy in the relationships between the researcher and participants demands that we carefully consider the ethical principles of doing no harm”. This can be achieved through keeping the acquired information in a safe and secure place and creating pseudonyms for participants.

Green and Thorogood (2004, 58) argued that “consent implies that the participant is capable of making a rational judgment about whether to participate, and that their agreement should be voluntary”. Informed consent was requested and acquired from all the participants to partake in the study. They were made aware through the consent form that they read and signed that their participation in the study was voluntary and that they could withdraw from the study at any given time (see Appendices 4 and 5 for informed consent forms in English and Zulu

respectively). Also, all interviews were conducted in locations that were chosen by the participants.

When the data collection process was complete, all the acquired data was kept in a safe place. Files were created and saved in a protected location on the researcher's laptop computer. Pseudonyms were used for all participants so as to protect their identities. All the information that the participants wished not to be included in the study was excluded. When the data had been compiled, all the recorded tapes were destroyed.

## **2.6 Challenges faced during the research**

For this research, TBAs in the uMzimkhulu area in KwaZulu-Natal had to be approached. However, to approach the TBAs the researcher had to gain access to the TBA community through their association known as NUPAATHPSA. There is little information on this organisation, even via google. It was a challenge to find the relevant people. It took over three months to receive responses from a particular person at NUPAATHPSA association who then referred the researcher to her manager, who to date has not responded to any communication. The researcher was also required to obtain a gatekeeper letter from the KwaZulu-Natal provincial Department of Health (see Appendices 7 and 8 for approval of research proposal from Department of Health and Rietvlei Hospital respectively). The Department of Health stated that they needed an ethical clearance letter from the university (see Appendix 9) before they could provide the researcher with a gatekeeper letter. This proved challenging as the policy of the university stipulated that they would only grant ethical clearance once the department of health had provided a gatekeeper letter.

## **2.7 Conceptual framework**

The theoretical framework is the lens through which the data for this research was assessed. For a study that assesses the life histories of traditional birth attendants in the context of changing reproductive health, useful lenses included African feminist theory, social capital theory and social identity theory. The African feminist theory is useful because the study has focused on issues that are exclusive to female roles in traditional society. Not only is giving birth an exclusively female activity, most traditional birth assistants are also females. Their

roles in modern society are likely to be affected by issues of gender and feminist theory enables a critical view of this.

Social identity theory is useful as the role of traditional birth assistant has been greatly affected by modernisation and alternative modern birth practices and new discourses on reproductive health. Finally, social capital theory enables an expatiation of how the collectivity of those involved as traditional birth attendants from a traditional African perspective work together to build their own social identity and support each other in their profession. Before discussing African feminist theory in particular, the theory of feminism needs a brief introduction.

### ***2.7.1 Feminist theory***

Central to modern feminist thought is the idea that women have been oppressed by structures within society. Questions of inequality between the sexes could be linked to one of the following: class, race, religion, sexual preference or work preference (Hooks 2000). Grant (2013) asserted that orthodoxy has been created by the way feminism has been studied and this orthodoxy implies that there is no one feminist theory but a multifaceted set of theories.

Feminist theory is divided according to its attachment to one or another of several male theories whose terms it has attempted to appropriate and whose male-biased assumptions it has tended to mitigate. While this hyphenation model has led to many interesting discussions of “liberal feminism”, “Marxism feminism”, “psychoanalytical feminism”, “existentialist feminism”, it has left us with a feminist theory that understands itself to be “a kind of bandage to the basically misogynist canon of Western political and social philosophy” (Grant 2013, 1).

In addition to the multiple versions of feminist theories, there is also a discrepancy between their primary formulations and what has emerged to be popularly known as the African feminist theory. Central to the focus of the feminist’s cause is the fight against patriarchy. The MsAfropolitan website defines patriarchy as “the psychological and political system that values the male higher than the female”. It entails a sense that an individual is offered less space in society based on their female gender. History indicates that women, irrespective of their racial/ethnic/class group have always been disadvantaged compared to men of the same racial/ethnic/class group (MsAfropolitan 2012). The next sub-section addresses the notion of African feminism.

### ***2.7.2 African feminism***



There are some marked differences between feminism as such and what is being referred to as African feminism. Peterson (1984) noted an obvious and very important area of difference between Western feminism and African feminism as follows:

Whereas Western feminists discuss the relative importance of feminist versus class emancipation, the African discussion is between feminist emancipation versus the fight against neo-colonialism, particularly in its cultural aspect. ... the opinion which is implicit in the choice of subject of the first generation of modern African writers has had a profound influence on attitudes to women and the possibility of a feminist school of writing. (35-36)

The contention is between the fight for female equality which is very western, or the fight against Western cultural imperialism which seems to be a more urgent African problem. While not sufficiently discussed according to Peterson (1984), it is of significant value to the current study which discusses an element of the traditional African society that has over the years been undermined by the modernisation movement. The life histories of traditional birth attendants need to be considered in the context of changing reproductive health practices in Africa. Imperialism has undermined valuable traditional health practices like those of traditional birth attendants in the changing reproductive health scene in South Africa.

Relevant to the current study is the idea that African feminism is a battle against neo-colonialism and its modernist undermining of traditional practices such as those provided by TBAs in favour of modern medical approaches to reproductive health.

Theoretically, there are varieties of African feminisms rather than one overarching 'African feminism' (Morrell 2016; Aronson 2003; Hooks 2000; Grant 1993). The advantage of the lack of agreement among African feminist is that it allows deep reflection on a variety of issues, respects differences whilst recognising a common ground. Many women refer to themselves as both African feminists and Black feminists. African feminist thought has an added commitment to analyses in African contexts. Thus, African feminists here refers to feminists of African heritage both in Africa and in the diaspora. 'African women' refers to women of African heritage who are rural, urban and of all social classes who are either resident in Africa or anywhere else in the world.

The MsAfropolitan website (MsAfropolitan 2012) supports the 20<sup>th</sup> century development within African feminists towards collaborating with each other in this interconnecting world.

African feminist need to focus on more than eliminating the arrogance of imperialism that Western feminism has imposed on African narratives (Oyewumi 2002). The MsAfropolitan website (2012) noted that trends in the last decade towards working together while respecting contextual issues form a formidable force. African feminists should not be simply reactive towards the negative recognitions of Western feminists, but should also take advantage of their resourceful work. It also calls upon Western feminists to be aware of their privileged positions so that together, the ideals of feminism can be realised.

The MsAfropolitan website (2012) has identified some important issues of feminist concerns to include patriarchy, tradition, under-development, sexuality among others. It notes:

African feminists pay attention to the ways that patriarchy uses law, tradition, force, ritual, customs, education, language, labour to keep women governed by men in both public and private life. African feminism sees that African men and women could have mutually beneficial, transformative and progressive relationships in the private and public spheres if our relationships were non-patriarchal and egalitarian. Nevertheless, African feminists consider it their responsibility to strive for such an equal society. Expecting that men will someday redistribute privilege and power to create a better, more harmonious prospect for future generations is considered illusive.

African feminists have resisted the popular Western criticism of African traditions, or of seeing African history as marked by male dominance (MsAfropolitan 2012). Issues of household, marriage customs, production methods or sexual freedoms have been discussed as harbouring patriarchal traditions in African societies, and have made distinctions between male and female in ways that disadvantage the female. Feminist scholars are divided about this aspect of the gender debate. Some scholars hold that some African traditions embody the complementarity of gender roles (Oyewumi 2002). Others claim that African women have been silenced for too long regarding the crimes of traditional patriarchy that are abusive and dehumanising such as polygamy, widow abuse, genital cutting, witch-hunting and women's lack of access to property and power in traditional society (MsAfropolitan 2012).

Political misrepresentation of some gender issues has been concealed by the imperialist Western post-colonial approaches to African gender debates as noted by Disch (2016) and Appiah (1993). Contemporary approaches to gender discourses have included an analysis of three approaches: 'Vamps' (cultural representation) with 'Visibility' (historical representation

and ‘Voice’ (political representation) which allows an emphasis on the interdisciplinarity of feminist exploration and representation.

African feminist thought doesn’t seek to abandon tradition, as tradition also harbours precious cultural memories and a rich legacy of knowledge and spirituality (MsAfropolitan 2012). Ver Beek (2000) has noted that spirituality is integral to African people’s understanding of the world and their place in it, while also affecting decisions about development. Lunn (2009) indicated that spirituality has been largely ignored in development policies and practices. Tradition needs to adapt to the times rather than stagnate. If some traditional practices are enhanced and developed they can enrich society, as customs and culture should do. Sisonke Msimang, an African feminist has incorporating lobola (bride price) in her wedding ceremony in a completely feminist way! This is a good example of how to maintain cultural pride whilst simultaneously preserving a commitment to evolution and harmony.

### ***2.7.3 Social identity theory***

Social identity is the portion of an individual’s self-concept<sup>2</sup> derived from perceived membership in a relevant social group (Hogg, Terry and White 1995). Stets and Burke (2002, 225) have defined a social group as “a set of individuals who hold a common social identification and view themselves as members of the same social category”. Social identity Theory (SIT) was originally formulated in the 1970s and 1980s in the field of psychology by Henri Tajfel and John Turner who used it to make a distinction between personal and social identity (Brown 2000, 746). The theory introduced the concept of social identity as a means of explaining intergroup behaviour, given that it is an identity that is derived from group membership. It is a theory which considers one’s personal identity to be socially constructed by the society that one lives in or the group that one belongs to (Hogg et al. 1995).

SIT has had some success in explaining intergroup phenomena. Turner et al. (1987) noted that much of social identity theory deals with intergroup relations that is how people come to see whether or not they are members in a group. Brown (2000) noted that the theory is useful in addressing the psychological problem of the relationship between the individual and the group. It explains the emergence of collective phenomena from individual cognition. Hence, one’s identity is not independent of and prior to society. The society or social group forms the identity

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<sup>2</sup> Self-concept or self-identity is a collection of beliefs about oneself that includes elements such as gender roles and sexuality, racial identity and many others. Generally, self-concept is made up of one’s overall self-worth.

of the individual. SIT proposes that people strive to achieve or maintain a positive social identity. When this is achieved, it boosts the self-esteem of the individual. Once one's social identity has been strong enough to favourably distinguish one from those outside the social group, it is considered a positive identity (Brown 2000). On the other hand, if membership of a group elicits a negative or unsatisfactory identity, people may seek to leave the group or find means of achieving more positive distinctiveness for it.

Brown (2000) highlighted different strategies for such adjustments with favourable conditions for making such adjustments. In other words, the different social categories that people find themselves in, or choose to belong to, define them as members of that group. The different groups that one finds oneself in, defines one's identity by virtue of one's membership. Some of the categories that can define one's social identity, which Appiah (1994) referred to as collective social identities, include: religion, ethnicity, race, sexuality. Brown (2000) added categories like nationality, political affiliation, sports team, race. It is clear from the focus of this study that TBAs as a social group qualify as a social category that can define one's social identity. Appiah (1994) noted that despite the heterogeneity of the list of social categories above, each of the collective identities matter to their members who bear the group identity. They also matter to others who want to recognise them. However, they matter to the group members and to outsiders in different ways.

Appiah (1994) cited a relevant example to this study which relates feminist theory to social identity theory. Using the example of gender and sexuality, he argued that they are both grounded in the human body; both are differently experienced at different places and time. Nevertheless, everywhere, gender identity proposes norms of behaviour, dress and character. Despite these abstract similarities, he noted that gender and sexuality are in many ways quite distinct categorisations. Thus, while it is quite rare to recognise a man as being a woman (gender), a straight person can very easily be mistaken to be gay. He also identified the reality of class consciousness as a popular aspect of collective identity perpetuated by social identity. The thrust of the feminist debate as related to social identity is that while one may be acceptable in one society as part of a social group according to, for example, gender roles, this is not always accepted by others, as discussed under African feminism.

Each of these categories that give one a sense of belonging provide an identity unique to the group. One can be defined with characteristics of the group. These characteristics become self-defining for the individual (Hogg et al. 1995). They also become a means of recognition by

those who are not members of the group. Thus, social identity is one's awareness that one belongs to a certain distinctive group (Stets and Burke 2000) as well as a means for others to recognise that person as a member of that group. Appiah (1994) argued that there is such a thing as a personal identity by which each individual seeks to be recognised, despite membership to different collective groups. This personal identity is formed as one's different collective identities dialogue with each other and gives one a place in society. He argued that "we make up selves from a tool kit of options made available by our culture and society" (Appiah 1994, 155). Although we make choices, we do not have control of the options from which we choose.

Government policies and education can be used to further emphasise positive values in social groupings that are valuable to individual development and nation building (Appiah 1994, 159). The argument is that if a specific social group is being unfairly discriminated against by factors of modernisation, or any other factors, then policies should be implemented to protect the autonomy and identity of this group. Not doing so would be allowing this group to experience identities negatively and unfairly. Nevertheless, as Appiah (1994, 161) suggested, "one form of healing... that those who have these identities participate in is learning to see these collective identities not as sources of limitation and insults but as a valuable part of what they centrally are". Without such deliberate efforts, it is unlikely that people will be willing to be identified as traditional birth attendants if they are continuously misrecognised.

The ethics of authenticity require us to express what we centrally are; social groups demand recognition in social life as women, black traditional birth attendants and so forth. In other words, cultural work must be done to undo negative, discriminating and stereotypical recognitions that insult and restrict members of a social group from expressing themselves freely. The scripts must be re-written. The real or authentic self is the identity that the individual wants to express. Being recognised as such by others implies a social acknowledgement of one's collective identity.

One of the benefits of being a member of a group that determines one's social identity is that the group provides the individual with certain capabilities or traits of the group. Some of these characteristics can be referred to as social capital which is discussed below.

#### ***2.7.4 Social capital theory***

The idea of social capital embodies two phenomena: firstly, that there are resources involved and secondly, that these resources are gathered and useful within a social group or environment. Bourdieu (2011) describes social capital as the

Aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition – or in other words, to membership in a group – which provides each of its members with the backing of the collectivity – owned capital, a ‘credential which entitles them to credit, in the various senses of the word. This relationship may exist only in the practical state, in material and/or symbolic exchanges which help to maintain them. They may also be socially instituted and guaranteed by the application of common name (the name of a family, a class, or a tribe or of a school, a party, etc.) and by a whole set of instituting acts designed simultaneously to form and inform those who undergo them; in this case, they are more or less really enacted and so maintained and reinforced, in exchanges. (86)

The use of the term social capital in this study aligns more with Kreuter and Lezin’s (2002) delimitation of its definition and use as the connection between social capital and community based health promotion. This use is relevant to the study, given its applicability for the understanding community based health promotion practices of TBAs. Bridging social capital is a means of appreciating its close ties to the notion of organisational collaboration that is central to the understanding of community-based health promotion programmes. The above definitions of social capital imply a social group with a common purpose that is trained or educated in some form to acquire their social capital.

Portes (2014) gave a critical definition of social capital as participation in associations and general trust in others. He described it as an unqualified social good. For this study, the social group under consideration is the TBAs and their social capital is derived from the kind of training and socialisation that they have and which allows them to continue to survive as a traditional practice in the modern era. Kreuter and Lezin (2002, 227) asserted that people are always in groups forming alliances and coalitions that are inherently valuable. The emphasis is on the use of collaboration and participation by members of a group towards achieving a common good. These principles are identified as being critical for community health promotion strategies. TBAs are part of a community health practice which requires such a unit.

Kreuter and Lezin (2002) believed that individual health behaviours are strongly influenced by infrastructure, policies, and social norms that can affect health actions positively or negatively. This is because what is considered valuable within these structures is more likely to be an acceptable practice. Such practices can also be enforced through policies. This is more in the context of modernisation which undermines even positive traditional practices in a way that can jeopardise the social capital of practitioners like the TBAs.

## **2.8 Conclusion**

In this chapter, a detailed description of qualitative research has been presented. The chapter also clarified how qualitative research methods were an efficient tool for data collection. The chapter analysed and discussed extensively the different tools that were used to collect data. The following chapter considers the background and history of TBAs.

## CHAPTER THREE: Journey to becoming traditional birth attendants

### 3.1 Introduction

This chapter discusses the background and the history of traditional birth attendants. The chapter draws mainly on the social identity theoretical perspective of those involved as TBAs. This is because the chapter focuses on factors that affect the social identity of TBAs. The African feminist theoretical perspective was also useful here as most of those practising as TBAs are female and those requiring their services are also female. The chapter discusses findings that are mainly related to the history of the traditional birth assistance as a practice. It considers findings on how the practitioners come to be identified as TBAs as well as findings related to the physical and spiritual implications and the gender roles among TBA practitioners. The chapter, through the use of life histories, presents the background and history of the TBAs, describing their journeys through apprenticeship and the calling process to become *izangoma* (traditional healers). The use of life histories was beneficial in the study as it gave the TBAs an opportunity to share and give a thick description of their lives, lived experiences, practices, rituals, and attitudes. Pseudonyms were used to protect the identity of the participants.

According to Bergström, and Goodburn (2001, 56), “throughout history, traditional birth attendants (TBAs) have been the main human resource for women during childbirth. Their role varies across cultures and at different times, but even today, they attend the majority of deliveries in rural areas of developing countries”. TBAs play an important role in African rural communities, especially for those with minimal access to primary health care facilities. To better understand TBAs, it is important to gain insight into their background. What is immediately obvious from the literature is the impact of modernisation on the identity of the majority African rural women who are practising TBAs. They are seen as rural African women who provide services because the urban areas are being catered for by modern medicine in clinics and hospitals.

TBAs are considered very knowledgeable and in some communities are preferred over clinics and hospital. This can be attributed to the fact that TBAs do not charge consultation fees and are based within the communities, they speak the native language and understand the cultural dynamics within the communities that they live in. Tamuno, Omale-Ohonsi and Fadare (2010, 1) added that the “majority of the traditional herbal medicines used in Africa are provided by practitioners who live within the communities, have been trusted over time and are often



willing to assist the patients with their knowledge and skills, sometimes at minimal costs to the patients”. This is a strong indication of the social capital of TBAs in traditional African societies. This social capital is also highly recognised in these societies, making it possible for the TBAs to live authentic lifestyles in their careers (Appiah 1994).

### **3.2 Background and history of the TBAs**

Abby, Pinky, and Victrice are examples of practising TBAs that have learned to perform practices and rituals through an apprenticeship with TBAs that were family members. In many traditional communities, social capital is a form of developing and maintaining traditions, practices, and rituals that have been used for generations in an attempt to preserve them. The social identity of these TBAs whose social capital was constructed and sustained in the family represents an interesting sense of social identity for these TBAs that finds positive recognition in the family nucleus before the ravages of modernisation (Hogg et al. 1995; Brown 2000). This makes the sense of belonging easy and thus further enhancing their positive social identity and building the self-esteem of the young TBAs (Brown 2000).

Abby was born in 1976 in uMzimkhulu and lived with her grandmother who was a practising TBA, Abby’s grandmother had observed and learned to become a practicing TBA from her mother. It seems that practicing as a TBA was a generational occurrence as knowledge was being passed down from one generation to the next. Even though she does not have a clear memory, she was aware that there was four generations worth of reproductive knowledge within her family. Through observation Abby would learn a few of the practices that her grandmother offered to pregnant women. Abby’s grandmother also wanted to pass on her knowledge and skills to Abby, so that she too would be able to assist women with reproductive health care. This is an indication that not only did these family members socialise future TBAs, they were also trained, capacitated and thus able to gain some social capital for the TBA through a social constructionist means of learning as they were observing and being cumulatively introduced to different practices that characterise the duties of TBAs. When preparing concoctions for pregnant women, Abby’s grandmother would call Abby to observe, explaining that she too would be preparing them soon. Abby explained that her grandmother spent a lot of time teaching and explaining things that she was still not sure about. Her grandmother also invited Abby along when she went to assist women with the birthing process. Abby would observe, assist where she could and sometimes even participate in the process.

At first, it was small things such as assisting the women with breathing, making sure that they were lying in the right position, patting and rubbing their bellies to ease the contraction pains. Gradually her grandmother would ask her to prepare the woman for the birthing process, and after a while, Abby ended up being the one who was the most active during the birthing process with her grandmother assisting her. The indication is that as new TBAs receive training, their social capital is developed as well as their confidence and ability. This illustrates a strategy for adjustment offered to new members by the group (Brown 2000).

During her first pregnancy, Abby encountered complications and her child was born prematurely. She was all alone at the homestead when the baby arrived and had no time or means to inform anyone. She explained that she used her experience and training to deliver her own baby. Though it was difficult, because she was trained, she knew exactly what to do to deliver her baby safely.

*“Clinics and hospitals were very far in those days, we had to travel very long distances to get to the nearest clinic. If you missed the 7 o’clock bus in the morning, you would have to wait until the following day. For me, when my contractions started it was already one in the afternoon and there were very few families with cars back then, even if there were many, though, I would not have afforded a special to the nearest hospital because my family survived only on my grandmother with the TBA practices.” – Abby*

Underdeveloped countries have little or no access to health care facilities. O’Donnell (2007, 2820) argued that “a large body of evidence confirms that many people in the developing world go without health care from which they could benefit greatly. The poor in developing countries are even less likely than the better off to receive effective health care”. In many developing countries, rural dwellers often experience barriers that inhibit their access to medical assistance. For rural dwellers, to be able to access health care, they need the financial means to travel and pay for the services. O’Donnell (2007, 2821) added that “access to health care can be defined in a variety of ways. In its most narrow sense, it refers to geographic availability”.

*“Yoooh! Yoyo [a nickname from my childhood that most elders in my community still call me by]... I will never forget that day, I can only imagine what could have happened if I had no prior training or experience... I still shake when I think of that day, I am grateful that my grandmother capacitated me with all the skill I possess today. Even though I have the experience of assisting women to bring life to this world, I still think that I was lucky that I was*

*able to do everything correctly, I thank God and my ancestors every day because I know that if something had gone wrong both of us would have died because I was all alone when everything happened.” – Abby*

Flegg (1982), Rodgers (1979) and Waldmann (1992) conducted some of the earliest studies focusing on the relationship between poverty and access to health care facilities. Moreover, these studies found that countries with unequal income distribution have higher rates of infant mortality. Even though Abby was able to deliver her new-born successfully, she is still part of a greater group of women who are unable to receive medical assistance due to poor infrastructure and poverty. She is like many other women in developing countries who are still faced with the challenge of accessing health care facilities and medically trained personnel.

The African feminism perspective has shown that the focus of feminist advocacy in Africa differs from the West. While feminism versus class emancipation occupies Western feminists, African feminists still have issues of neo-colonialism, poverty and lack of resources in rural areas to deal with. The question is why African governments do not empower structures that are already in place within these rural areas to be more efficient in assisting those who cannot make it to the clinics or hospitals either due to distance, transport or lack of fund. TBAs are identified and recognised as alternatives that are readily available in the communities. They are also not expensive and are from within a trusted homogenous community.

Like Abby, Pinky was trained by her grandmother. Everything that she knows and has been practising for the past forty years is what she learned through an apprenticeship with her grandmother. Pinky's grandmother was the only person in their family that practiced as a TBA, according to Pinky, her grandmother was trained by a neighbour who lived three houses away from their house. Pinky is the second born of three children. She explained that their mother was an alcoholic who would at times not come home. Pinky's grandmother invited the children to stay with her because she was always home and felt she would be able to take better care of them. Pinky's grandmother was trained as a TBA, even though she was not a *sangoma* or *umthandazeli*. Pinky remembers seeing heavily pregnant women visiting her grandmother's house on a regular basis. She explained that at times she would see children sent to come and get her grandmother to assist pregnant women who were giving birth in their homes. Pinky started assisting her grandmother with the collection of herbs and roots on mountains and river banks when she was ten years old, learning their uses. Her grandmother played a meaningful

role in her life, not only as a mother figure but as a teacher and mentor that had great influence in nurturing the woman and TBA that she is today.

*“Every time we went to collect amakhambi (roots and herbs) she would explain the use and usefulness of each root and herb. At times she would test me to see if I pay attention... she would ask me to pick and explain what the use and usefulness of each herb is. She would explain to me that it is important to know the names of herbs and how to prepare them so that we can be able to assist other people who need the assistance.” – Pinky*

Victrice is 55 years old; she has been practising as a TBA for the past 30 years. A number of people within her community assisted her in her journey to becoming a practising TBA. Victrice’s uncle was a traditional healer who was also knowledgeable in practices and medicines that were used to assist pregnant women. In her family, her uncle was the only person who practices as a TBA, other family members were not interested in learning through *malume omdala* (uncle). When Victrice fell pregnant she decided to seek assistance from her uncle, who prepared *isishlambezo* and offered *ukuxukuza* to pregnant women. *Malume omdala* as Victrice referred to him, introduced her to the world of healing. It was during her pregnancy that she got to spend time with *Malume omdala* and came to understand his practices. She took this time to ask questions about things that interested her about ancestors, pregnancy, medicines and rituals. *Malume omdala* assisted Victrice with her delivery as she was unable to get to the hospital in time to give birth.

*“It was the most stressful time, I was unable to get transport in time to get to the hospital. I felt it in the morning, but thought the baby was just moving and maybe bumped me really hard inside, but I was wrong. I started feeling this pain, it was a different type of pain, a pain I had never experienced before. Before I knew it, malume was in our kitchen door asking where I was and how I was doing. I have no recollection of who called him or when I had never been in that type of pain in my life before. You know, in our culture it is taboo for a man to see a woman who is not their wife naked. Now, in my case, malume was not only going to see my naked body but my private parts as well. I was not comfortable, but the baby was coming and I needed assistance from an experienced birth attendant.” – Victrice*

Victrice shared that after the birth of her first child she went back to *malume* to learn about practices he offered to pregnant women. She explained that she also wanted to learn something new that would not only benefit herself but the community as well. *Malume* was excited to

learn of my interest as his own children had no interest in anything associated with traditional healing. *“I am now, because of malume’s teachings”*.

Being a TBA requires a set of skills that has to be learned over time. Some of the skills that are required to become a recognised and practising TBA are learned through apprenticeship and community networks. Some individuals are called to become *izangoma* (diviners), *izinyanga* (herbalists) and *abathandazeli* (faith healers) who learn the skills, practices, and rituals of becoming a TBA through initiation school. However, other individuals learn the practices and rituals through an apprenticeship with family members, older women in the community or by self-education. TBAs thrive in communities that uphold social capital. A gender related challenge is the cultural taboo of having a man as a birth assistant. The feeling of discomfort by the respondent indicates a red flag that needs attention. It reflects that certain patriarchal suppressive practices that have not yet found expressions of dissatisfaction in the traditional practice by African feminists.

Social capital can be defined as naturally occurring relationships among persons within the community which promote or assist the acquisition of skills and traits valued in the marketplace. Furthermore, social capital features social organisations, such as trust norms, and networks that can improve the efficiency of society by facilitating coordinated acts. The process of apprenticeship that exists amongst TBAs is a form of social capital, as it involves the teaching and training of ordinary community members to become practising TBAs. The process involves empowering individuals within the community with knowledge that will benefit members of the community. It is a process of sustaining the culture and cultural practices that are an important aspect of each traditional community. All the participants in this study became practising TBAs through apprenticeship and networking, explaining that other TBAs played meaningful roles assisting and teaching them about practices, rituals, and herbs. They even used time at meetings and workshops as an opportunity for teaching each other about practices, rituals, and medicines.

### **3.3 “... *Ubizo*, the calling”**

A certain level of understanding of the traditional cosmology on illness and healing is required to understand the practices and meanings of the attached beliefs and causation in South Africa. Even some South Africans lack this in-depth understanding; only those who form part of the practices and those who train traditional healers have a deeper understanding. Hammond-

Tooke (1989) explained that healing practices form part of a wider cultural conceptual framework marked by a strong relationship between healing and a belief in which disease and illness causation are closely related. Many African beliefs are linked to a magical and mystical understanding. Beliefs around health and the causation of illness are linked to magical and mystical rituals that are used by witches; ancestors also fall within this magical world as mystical rituals are required to appease them when healing or solving problems that are believed to be the result of evil and harmful works of witches. The African feminist approach allows an understanding of the spiritual as inextricably linked to the traditions of the people. Lunn (2009) argued that not paying attention to these factors can and has seriously undermined development attempts and its sustainability. It is also popularly believed that modernisation has seriously undermined some of the traditional practices that do not align with the Western view of development and thus has affected the social identity and social capital of those involved in practices like the TBA through *ubizo*.

*“A person has to have ubizo, not anyone can become a sangoma.” – Sarah*

Sarah, Primrose, Dolly, Prudence, Angela and Juliet are trained sangomas; it is through initiation school they were taught to become practising TBAs. Initiation school involves intensive training on healing people as well as on becoming a TBA. These women went to different initiation schools, but all agreed that even though each initiation school has its own rules and ways of teaching practices and rituals, there is not a significant difference in the teachings. Each woman, however, had a different path leading to initiation school.

*“You can never run away from the calling. When the ancestors call, you have to answer or you will endure a life filled with misery, misfortune, illness and sometimes even death...” – Sarah*

Ancestors are bestowed with power and authority and are regarded as an important and functional part of the living world. African ancestors communicate with the living by occupying the body of a sangoma and are believed to have great influence in the way of life of their kinsmen. “Ancestor worship is founded on the belief that the dead live on and are capable of influencing the lives of those who are still living” (Bogopa 2010, 1). Sarah, Primrose, Prudence, Dolly, Angela and Juliet all answered their calling from the ancestors and are now practising sangomas. They all expressed the importance of the ancestors and their importance to the black African community, explaining that when people die, they go to another world, they are not dead. They are able to see beyond what we see in this world hence they are able to

communicate through traditional healers to show us things that we are unable to see with our eyes and knowledge. The participants explained that the ancestors are part of who we are; they protect and guide us at all times.

*“You see my daughter, the ancestors are very powerful and need to be respected and obeyed. I learned that the hard way... I did not want to become a sangoma and I tried, by all means, to ignore my calling because I was scared and did not like the way sangomas live... what happened in my life during that period is something that I can say is out of a television story. I would misplace money and even when I opened a bank account I would still lose money and the bank would never have an explanation for me... I would lose jobs and lose clothes, but I continued to ignore the dreams and signs to become a sangoma. After a while, I started to get ill and people in our community started talking and passing comments that if I continued ignoring idlozi this way I was going to die. After almost dying I decided to go and consult a sangoma who explained to me that my ancestors were angry with me for ignoring their request for such a long time.” – Sarah*

As we sat on the grass mat in Sarah’s rondavel (traditional round house) drinking *amarhewu* (a traditional South African non-alcoholic drink made from fermented mealie pap), Sarah explained that the calling can reveal itself through illness, visions, and prophetic dreams. She explained that the only way to relieve yourself from the dreams is if you answer your calling and train to become a sangoma through a process known as *ukuthwasa*. If you ignore the calling, bad luck and other misfortunes can ruin your life. Latif (2010, 42) argued that “traditional healers cannot simply choose to become healers as a mere career decision. In African culture, it is believed that it requires a certain ‘calling’, which qualifies an individual to become a traditional health practitioner”. In our conversation, Sarah explained that she has seen people ignoring their calling and living very miserable lives. Some have had very bad luck and others get so sick that death was inevitable. Sarah explained that she believed it is the way the ancestors force you to become a sangoma because no one enjoys being ill. Campbell (1998), cited in Latif (2010, 61), argued that “it is believed that the reason the ‘calling’ is by means of an illness, is to coax the individual to go through a tedious training programme”. A study of the Tale community carried out by Calhoun (1980, 305) found that “the authority of living persons is partial and subject to challenge; that of ancestors is pervasive and absolute. Ancestral authority is the key to the working of the Tale kinship system and the reproductive capacity of the society”.

*“Ancestors can block everything in your life such as (employment, marriage, and having children) and much more other fundamental needs that are important to us here in this world.”*

– Sarah

Sarah explained that she began having dreams of old men and women who were unknown to her asking her to join them. For almost five months she tried to ignore the dreams and did not tell her grandmother who she lived with at the time until she started seeing them during the day, telling her not to ignore them and to follow them or something very bad would happen to her. In these dreams, Sarah would be shown a homestead where she would find a woman that would train her to become a sangoma. Sarah says that these incidences became so frequent that they would even occur while she was in the classroom, she says she would see the women and men in her dream physically come up to her by her chair and tell her to stop what she was doing and go with them because she was needed. At times, Sarah says she would smell *impepho* (incense) in the classroom and subsequently pass out. Upon waking, her teacher would ask what had happened and she would explain; Sarah claimed this happened at least three times. She was at the tender age of 16 when she accepted her calling, she had try to run from it, but she eventually could not run any longer.

Sarah explained that:

*“Ndandivele ndive sekunuka ndingati ukutsi liqhamkaphi iphunga lale mpepho, ngoba ndikeskolweni futsi ngaphakatsi eklasini, ndandati kanjalo ke ukutsi seyiyaqal lentfo.”*

*“All of a sudden I would smell it... I would smell the incense, however, I did not know where the smell was coming from because I was in school, inside the classroom. That is how I would know that it was starting.”*

Unlike Sarah, Primrose’s ancestors only came to her in a dream once and she immediately submitted. This was because her parents were practising sangomas; when she told them about her dream they immediately shared with her the meaning of her dream and what was now expected of her. Primrose had a dream about the ocean, it looked beautiful and peaceful she explained that she started playing around in the sand until she came across a pile of what seemed to be seashells and old looking bones. All of a sudden she heard a familiar sangoma song and drums beating from far and when she looked up there was a group of sangomas dancing and singing. When she looked closer she saw her grandfather, who waved to her and called her to join them. She explained that she was happy to see her grandfather; however, she



was not willing to join him since he was dancing with people she did not know. She immediately tried to run away and go home; however, the peaceful ocean became so violent that powerful waves blocked her way as she tried to run away. At this point in her life, Primrose was getting ready to marry the love of her life, however, plans had to be put on hold as she was still undergoing training. She explained that she was 24 when she accepted her calling to become a sangoma.

*“Even before the dream happened, I was able to see things before they happened ... things such as death and birth. I would see someone I do not know walking down the road, but know all of their problems in life and know the exact person who can help them solve their problem. My grandmother would always say that Nginenhloko emhlophe meaning I might have the calling and the ancestors are with me. It was uncomfortable at times because nothing hurts more than knowing that someone is going to die, but not be able to help them.” – Primrose*

Unlike the other sangomas who participated in this research, Dolly did not attend an initiation school; she was trained directly by her ancestors. Dolly explained that she was called and trained in a dam not very far from her house and remained in that dam for a period of three weeks. When she emerged from the dam after the three week period she was already dressed in the traditional clothes of a sangoma. Dolly thought it was a dream; the whole time she was in the dam she did not realise that everything that was happening was real and not a dream. It was only when she emerged from the dam that she realised that everything that she thought was a dream was actually real. Dolly shared that other people found her experience difficult to believe because of the impracticality of remaining under water for so long without dying. Dolly could not recall her age when she was called to become a sangoma, all she can remember is that she was a newlywed bride. She explained that at the time she and her husband were in the process of starting a family. They had to put their plans of starting a family on hold as she was focusing on her new duties as a sangoma.

*“People who were not there do not understand my situation, it will even be hard for you to believe me. The day I was called to the river was very stressful for my family. In our culture, if someone is called to a river or drowns, there should be an offering of some sort in the form of chickens, goat or cow. These animals are supposed to be thrown in the river as an offering to inkanyamba or amadlozi that are holding you hostage in the river; the belief is that when this offering happens whatever is holding you down will release you and take the offering instead. However, in my situation none of the animals were thrown into the river because the chickens*

*flew away and the cow almost killed people in a violent stampede trying to run away. Apparently, an old woman advised my family to leave and told them that I will come out when the time was right. In the midst of everything Dolly shared that apparently a sangoma from the community came to the dam and asked permission from Dolly's family to ask for the right of passage and protection for Dolly while she was still in the dam. The sangoma explained to the family that Dolly will return, but for now, she is needed in that dam.” – Dolly*

Prudence was born in 1971 and has been practising as a TBA for 18 years now. Prudence has two special gifts: *idlozi* (ancestors) and she has been trained as a sangoma; she also has the gift of *isithunywa* where she is able to see and communicate with heavenly beings. Through *isithunywa* she is able to pray for people and treat them through roots and holy water that she has personally prayed over. She explained that if you are not a sangoma it is difficult to explain and differentiate the two. Her explanation to me was that she is able to communicate with the ancestors and has the ability to pray for and heal people.

*“I have two gifts, I have been to initiation school to learn to become a sangoma and I also have isithunywa which was also nurtured at the same initiation school I attended. When isithunywa takes over I see izingelosi ezincane (baby angels) that just surround me and when this happens I am able to see beyond this world, I am able to see everything about your life because they tell me everything and the reason for you coming to visit me, once that is established they proceed to tell me the best way to assist you, be it through prayer, holy water or even roots and herbs. Prayer works, through it I have been able to assist so many people who have consulted me... People who had given up on life, people who were sick and never ever thought that they would ever overcome their illness. Can you believe that I have even consulted with white people? Yes, they have also come for assistance, especially the ones with cancer.” – Prudence*

Anne was born in 1951 and she was the youngest of ten siblings. Anne's family was very poor, her father left to look for a job in the mines of Johannesburg and never returned home. During her teenage years Anne realised that she had a gift of praying for and healing people. Her healing methods included praying for people and using *isiwasho* (holy water). Through her healing, Anne has prayed for and assisted women who were unable to conceive. She gained popularity after assisting a woman who had been declared barren and was divorced by her husband.

Traditional healing has become very prominent in public discourse as traditional healers are operating in parallel with biomedicine. McCall (1995, 258) argued that “A theory of ancestors must encompass a much broader range of experience. I contend that to understand the meaning of ancestors we must discard the boundaries of ‘cult’ and ‘religion’, which have traditionally defined the field of inquiry”. To better understand ancestors, we cannot define them in isolation from the spiritual and mystical realm. Ancestors are bestowed with mystical powers and authority that need to be respected in the world of the living.

Nevertheless, from a feminist perspective, the idea of being persuaded to answer the *ubizo* is something that feminist theorists might oppose. Traditional practices have been made unattractive by modernisation practices; one of the research participants noted that she did not want to answer the call because she did not like the lifestyle of sangomas. Moreover, the social identity theory (SIT) perspective indicates that if membership of a group like the TBA or sangoma elicits a negative or unsatisfactory identity, people may seek to leave the group or find means of achieving more positive distinctiveness for it (Brown 2000; Appiah 1994). Implicit notions of perceived paternalism and its fight against compulsive traditions are among the main reasons why *ubizo* culture might be unpopular. However, the spiritual dimension to it retains its sanctity as discussed further in the following section under the process of *ukuthwasa*.

### **3.4 The process of *ukuthwasa***

“Ukuthwasa is a spiritual journey that is specifically designed by the ancestors for those who are endowed with the gift of healing by their ancestors” (Mila 2009, 1). Even though *ukuthwasa* and being chosen by the ancestors is perceived as a gift, no one actually seems to want this gift bestowed upon them. *Ukuthwasa* remains a phenomenon which has gained a global following over the years due to the discourse of spirituality. It is a spiritual journey that not only involves the individuals who have been chosen by the ancestors, but also the family members of those individuals.

#### **3.4.1 Personal sacrifice for *ukuthwasa***

*Ukuthwasa* is not generally welcomed as it means that one has to give up one’s life and dreams to do what one has been called to do by the ancestors. It is a difficult and exhausting training process that is usually met with resistance. The participants in this research shared that they had met their calling with resistance. Families of some performed certain rituals as a way of

asking the ancestors to leave them and choose other older individuals; however, the rituals did not work and the participants eventually became sangomas.

*“No one wants to become a sangoma, no one wants this life. I cried and cried, I asked my father to help me get free from my ancestors. He tried, we performed all kinds of rituals that people told us about... After every ritual, it would be quiet for a while, but they would come back again. What I do not like about this life is that you have to give up your dreams and aspirations for them. You give your life up for the ancestors because what they want they get... Your life is controlled by them. My dream was to become a teacher one day, but I had to leave school in Form One. Every time I opened a book they would get angry, even though I couldn't see them I would feel it. My eyes would water up and I wouldn't be able to see anything after that. I guess the ones that chose me were amaqaba, I guess maybe that felt that school would distract me from what they wanted me to do. – Juliet*

*“I tried to avoid them, my grandmother took me to mthandazeli who was supposed to pray for and heal me. We heard about him from a woman who had claimed that she too had ubizo but never became a sangoma because this mthandazeli chased her ancestors away... The mthandazeli was my last hope, I would pray every minute of the day to have God take this away from me. He charged us a cow to perform the cleansing and said they would never bother me again, he gave me water that I was supposed to use when bathing, he said the water would drive them away. It was all a lie, they remained and instead they came more frequent and I got sick. My grandmother told me to stop running or I was going to die. I did not want them, I did not want to share my body, why would they choose me anyways? I was the youngest at home...” – Angela*

*“What I do not like is that they are intimidating, whether you want to become isangoma or not is none of their business.... They want you to carry out their wishes, when I was sick all the doctors and nurses did not know what was wrong with me. One time, I was taken to a Catholic hospital where I was attended to by an old nurse who advised me to go see a sangoma because there was simply no diagnosis for my illness and I was only getting worse. A few days later my family took me to a sangoma in a nearby community, I will never forget that man because he confirmed my greatest fear. He told me that I needed to go to initiation school and start training and that nothing will heal me. Ukuthwasa is the only cure for my illness...” – Prudence*

This gift takes away freedom from an individual and is often met with resistance. The above responses confirm the assertions by Booii (2004, 3) that “the diagnosis of *ukuthwasa* is often resisted, and the sick person and the relatives can consult several *amagqira* to have it confirmed or negated. It is resisted because the training and treatment is long, demanding and expensive.” The above findings contribute to the financial, psychological and autonomy constraints on the individual and the family, when viewed from the African feminist perspective.

The African feminist advocates for the emancipation of women from oppressive cultures that would constrain their autonomy such as those expressed in the foregoing responses on women’s experiences in their call to operating under *ukuthwasa* (Peterson 1984). The diagnosis of *ukuthwasa* needs to be accepted by all those that it will affect as it is not an individual journey; even though it is the chosen individual who has to go through the training process, the family also play a supporting role and have to participate in some of the rituals that will be performed during and after the process of *ukuthwasa*.

The mysticism that shrouds the lives of those who have the calling to become sangomas is also manifested in a sickness known as *ukuthwasa*. *Ukuthwasa* can be defined as a culture bound syndrome. This means that it is not easy for an outsider to understand and grasp the concept of *ukuthwasa*; it is even difficult for people in the same cultural system to understand this phenomenon as it is only sangomas themselves that have a deep understanding of the process. While the concept can be regarded as social capital for those who are sangomas, there is also a stigma manifested in the negative recognition that society generally attaches to the social identity of these women. Hence, despite their positive contribution to society in their services as TBAs, they do not enjoy the experience of being called, neither are they always favourably recognised by the community except when their services are required.

Mlisa (2009, 7) has noted that “in Western terms, afflictions such as palpitations or auditory and visual hallucinations that are often experienced during *ukuthwasa* would be diagnosed as pathological conditions associated with mental disturbances. In *ukuthwasa*, such afflictions are viewed as normal characteristics and as emic signs of *ukuthwasa*”. There are negative implications on the social capital of the women as *ukuthwasa* affects the kind of self-concept or social identity that they derive from the experience (Hogg et al. 1995). In other words, it is only considered culturally normal for a select few who are deeply aware of these experiences. Hallucinations, pathology and mental disturbances are not generally positive social recognitions.

### 3.4.2 *The role of sickness in ukuthwasa*

Helman (2007) argued that anthropologists have pointed out that any society's health care system cannot be studied in isolation from other aspects of that society, especially its social and religious organisation. Culture is a pattern of learned beliefs, values and behaviour that are shared within a group; it includes language, styles of communication, practices, customs and views on roles and relationships.

*"I was sick, no one knew what was wrong with me ... the last doctor that I saw told me that I needed to go to Embizweni (a psychiatric hospital in uMzimkhulu) so that the doctors there can check and see if my brain was good because what I was explaining was not anything that happened to someone who is not sick in the head. I got scared because I did not want to be told that I have a mental problem. After accepting my calling I was normal and everything in my life went back to how it was, I was no longer sick and have not been ever since I answered my calling. I also do not have a mental problem it was just the ancestors, they wanted me to answer my calling, but I was delaying. The doctors were wrong because they had no deeper understand of what was happening to me. Everything made sense to me when the traditional healer that was training me explained everything to me from his perspective. I do not blame doctors for not having this type of knowledge because they are different to us and have been taught about illnesses in a different way to us."* – Juliet

*"No one could tell me what was wrong with me, we went to different doctors and hospitals. We could not speak English and depended on the nurses that were assisting the doctors... After a conversation that we could not understand, the nurse asked my grandmother if I was in school and whether I was a slow learner or not ... my grandmother asked the nurse what that had to do with anything, the nurse explained that the doctor thinks that there might be something wrong with my brain. I still think even today that maybe we should not have wasted so much money and time because the white doctors have no understanding of our culture as black people. They will tell you what is wrong with you according to what they have learned at school ... I doubt that they are taught about ithongo or what it means if one is called to become isangoma."* – Angela

Ancestors are believed to have a great influence on health and healing. The ancestors use sickness to force those who are called to respond to the call. These sicknesses defy any kind of medical or Western medical treatment and disappear as soon as the individual accepts and answers the *ubizo*. Here is a social capital that is understood and shared amongst those who are

called to serve. These sangomas are also then used to heal other members of the society, in addition to their roles as TBAs.

### ***3.4.3 The initiation process***

The initiation process can be understood from the theoretical perspective of the social identity theory. Turner et al. (1987) related that much of SIT deals with intergroup relations (or how people come to see whether they are members in a group). Prudence and Angela shared that they had to take two white home grown chickens to the house of the healer that was going to train them, Prudence explained that these chickens were an offering to the healer who was going to be the trainer. All the participants shared that the first three months were the hardest, and noted that they had to wear red clothing. Gcabashe (2009) noted that the first three months are known as the red phase; the initiate is only allowed to wear red clothing and must also smear on red ochre.

Brown (2000) noted the role of social identity practices, in underscoring the physiological problems of relationships between individuals and the group as important in assisting group members to maintain a positive social identity. Individuals in the group are distinguished from those outside the social group by these practices. After the initial three-month period, Juliet shared that a ceremony is held to wash off the red and the initiate moves to the next level which is white.

*“It is difficult, the first three months were the hardest for me to adapt to... the new life because it becomes a total shock to the body (umzimba uyethuka). What I did not like was the fact that I could not wear shoes, sit on a chair or sleep in a bed.” – Prudence*

*“People look at and treat you differently, even people that you were close to change their attitude towards you. I don’t know if they change because they now see you as being different to them or they change because they feel compassion for what you are going through. For me, it was extremely hard because I was very close with my grandmother and I could not see her as often as I wanted to... Even she changed and treated me differently, she would keep telling me to respect idlozi (the ancestors).” – Angela*

During the second phase initiates wear only white and smear the whole body with *umcako omhlophe* (white mineral lime also used as paint in the rural areas). *“The white phase simply means that there is progress ... when you are at the initiation school you want everything to*

*happen fast so that you can leave and go back to a familiar place.*” – Angela. White is worn until the training is complete. During the white phase, the *ithwasa* (initiate) is taught a particular method of *ukuhlola*. According to Gcabashe (2009), during the white phase *amathwasa* (initiates) are taught *ukuhlola* through *amathambo* (throwing of bones), *amakhosi*, *isthunywa*, *idlozi*, *amadhege* or whatever method the *idlozi* chooses. The initiates continue with activities that exercise and strengthen their sixth sense.

*“They would hide things in and around the initiation school and part of your test as ithwasa would be to find where those things have been hidden. This would tell the healer who is training you how strong or weak you are. It was always an anxious moment for me because I did not want to be known as the one with the weak idlozi.”* – Juliet

During the white phase, the initiates are also taught to identify medicines, their usefulness and diseases. The participants shared that the exercises and learning processes were strenuous and stressful. To ascertain the progress of the initiates, the trainer will bring patients that the initiates are supposed to *bhula* (consult), through this they become familiar with communicating with their ancestors and understanding the language of the ancestors. The initiation process can be understood as means of developing social capital amongst the initiates (Bourdieu 2011). A sense of belonging is created through the process. This is crucial, given the negative recognition some of the respondents reported experiencing from those who are not sangomas and given how no one wants to become a sangoma and how others treat one differently because of ‘the calling’.

#### ***3.4.4 Communication link between the ancestors***

Buhrmann (1986) argued that sangomas are the mediators between the ancestors and their living kin. An important aspect of ancestral beliefs is the role of the sangoma or traditional healer. They play a central role in the health and spiritual well-being of the community through the interconnectedness of the communication with the ancestors. Sangomas are interpreters through which ancestors and the living communicate. African ancestors communicate with the living by possessing the sangoma and passing on messages. They can also appear to a family member in dreams, but only a sangoma can decipher the meaning.

*“I have no explanation for what happens to me when the ancestors take over my body. I do not have a recollection of anything that happens during that time because my mind and soul disappear to a place I do not know. I am unable to explain anything that is uttered through my*



*lips at that time because I am not the one who is talking, the ancestors are. At times the ancestors alert me about a patient even before they arrive. They tell me about the patient's life history and their reason for coming to see me, this allows me the opportunity to prepare myself for the visit because I even know the time that they will be coming.” – Prudence*

*“They whistle when they talk to me ... My ancestors communicate through abalozi, which is whistling. I understand everything that they say through whistling, it is like a code language that we use and it works well for me. Sometimes the patient will hear the whistle, but is unable to make sense of the message. I am able to diagnose and provide a remedy for the patient through the whistling communication from my ancestors.” – Juliet*

After their trial diagnoses, Prudence, Angela and Juliet shared that they had to go to the different traditional healers who were going to train and assist them with their *ukuthwasa* initiation journey.

### **3.4.5 “Communities of both the living and the dead”**

“Ancestors are vested with mystical powers and authority. They retain a functional role in the world of the living, specifically in the life of their kinsmen, indeed, African kins-groups are often described as communities of both the living and the dead.” (Kopytoff 2012, 314)

Collectively, the participants acknowledged the belief and presence of the ancestors. When people die, it is believed they start a new life in another world. The world that they go to is different in that it blesses all those that have been called to it with higher powers and knowledge to assist those who remain here in our world. Even though we are in different worlds, the ancestors continue to guide and protect us; they empower us with the knowledge to assist each other through a holistic approach to life. In the everyday life of the African child, ancestors play a meaningful role whether one believes in them or not.

*“They have all the knowledge that we lack. They are seers to many hidden things in this world... Their knowledge surpasses everything that we think we know. They know about each and every person whether they knew them on a personal level or not, that is why we sangomas seem to know so much that is happening around us and in other people's lives. They tell us what is happening, they tell us how to assist people to solve problems in ways that we as normal human beings would not have been able to think of. I personally see their existence as an important part of our culture and belief system as black people.” – Sarah*

When confronted with challenges in life it is a common practice for the living to communicate with the dead. Burning incense and calling clan names as an introduction to the communication process is one of the most common ways in which the living reach out to the ancestors. Others will go directly to the graveside of the people who have passed on to talk to them and share their difficulties. The TBAs shared that everything that they do is based on communication with the ancestors. According to Kopytoff (1971, 130), “the dead members of the lineage, as a collectivity, are appealed to in times of crisis (such as a serious sickness or a series of misfortunes) and, more regularly, on such occasions as the marriages of women of the lineage, the breaking of sexual taboos affecting these women, and the coming-out ceremony for infants.”

*“You see Yonela, as black people we believe that our lives are overseen by our ancestors, they are there all the time whether we feel their presence or not. I’m sure you know even from your own experience that when things are not going well there is a need to consult the ancestors and find out why things are the way they are in your life. In my lifetime I have been able to assist many people understand why things have been happening the way they have been in their lives. The ancestors help me to uncover and see beyond what I know.” – Primrose*

*“How can they communicate when they are dead is a question I am often asked by people who do not believe in ancestors or my role as a practising sangoma. People think that because they are dead they are unable to communicate. They communicate beyond our understanding and are the glue that binds many African communities. Some people have even said to me that this whole ancestor worship and belief is nonsense and is backward. However, I always tell them that there is so much knowledge brought by the dead to our own lives.” – Dolly*

*“There are many instances where the ancestors have assisted people to overcome challenges in their lives. Through the guidance and knowledge of the ancestors I have been able to assist women who have been unable to have children, people who have been unemployed, families solve long standing feuds, and illnesses that are not known to the western practitioners. The ancestors are true communicators who are true to their people. They continue to look after us just as they did when they were still living on this earth. Beyond the grave is where my knowledge and assistance comes from.” – Juliet*

The TBAs shared that the ancestors are involved in our everyday lives. Those who believe in ancestors believe that they benefit greatly from communicating with them. Bae and Van der

Merwe (2008, 1300) maintained that “the concept of ancestral involvement in everyday life is more than a story or a myth”. Although, notions of modernisation are called upon for the rejection of ancestral practices as being backward and traditional, these practices are important to millions in many areas in the world (Oyewumi 2002). Ancestors can be defined as the living dead who hold influence over their living descendants (Bae and Van der Merwe 2008, 1300). Those that remain in this world are still very much connected to those that have died; communication does not only end when people die. Through rituals, communication between the living and the dead continues and the relationship grows. It is the social capital of the sangomas that allows this relationship and communication to thrive.

The living kin gain protection, blessings, explanations and guidance from those that have died. According to Bae and Van der Merwe (2008, 1300), “the living descendants are believed to gain protection and blessings in return for their veneration of the ancestors. They further stated that “the ritual practices associated with ancestor worship are heavily reliant upon the premise that the dead are able to return to the living and have an influence on the lives of the living” (1321).

### ***3.4.6 Women and basic health in the developing world***

In many third world countries TBAs play a significant part in the health care system through their role of assisting women during and after pregnancy. They play a vital role in basic health care, support, advice and even assisting with the birthing process. In many African patriarchal communities, the social system denotes women as subordinate to men, and women are restricted from performing or partaking in many important aspects or decision making within communities. Epstein (2007, 7) argued that “the denigration and segregation of women is a major mechanism in reinforcing male bonds, protecting the institutions that favour them, and providing the basic work required for societies to function”. For women to participate in or lead rituals is taboo in many communities as women are considered ritually unclean. Some communities see them as inferior and unworthy of communicating with the ancestors or of leading rituals.

In the absence of an older male in the family, a younger male member is selected to communicate with the ancestors and perform rituals even when older female family members are present. The occurrence of menstruation in both religious and traditional societies is

considered unclean and the discharge, according to Agyekum (2002), weakens the woman and possibly those around her during that time. An international survey of literature by scholars such as Agyekum (2002), Das (2008), Umeora and Egwuatu (2008); Cicurel and Sharraby (2007) demonstrated the belief that menstruation makes women spiritually unclean.

TBAs have broken these socially constructed prohibitions which are at the forefront of pregnancy and birth. Pregnancy and childbirth are interwoven in the spiritual realm and are considered one of life's most important events. Today women are actively involved in these spiritual events and this changes the manner in which many communities operate and define the role of women. The TBAs are part of the most important spiritual practice of bringing life into this world, communicating with the ancestors for the rite of passage to pregnancy and childbearing. TBAs are mediators that negotiate pregnancy with the ancestors, they ask for protection and guidance of the pregnant women throughout the duration of the pregnancy. The importance of TBAs in many communities is becoming evident; we see women who have defied gender roles and being marked as subordinate within communities by taking on previously dominated practices which were and in some communities still restricted to the male gender. This supports the views of some African feminists like Oyewumi (2002) that the Western perception of feminist roles are different from those in Africa.

*“The ancestors do not care whether you are male or female, when they need to use you they use you. I have been a practising sangoma for as long as I can remember and I do not recall a single day where my call or plea to the ancestors was not heard because of my gender.” – Primrose*

*“Gender is not important to the ancestors, otherwise no woman would be a sangoma. I think that men here in the land of the living feel that they have to undermine us as women because they know how strong we are. I respect men, but at times I feel that the rules and practices in our societies are for their benefit. They want to be seen as honourable and superior at all times. I feel that even though they uphold a certain status in our communities, women are the ones that make the communities function the way they do. A woman is compassionate and quick to understand that is why you find that as a TBA I take the pain and joy of another woman at heart because I have lived some of their experience. The fact that I can heal, diagnose and assist many people proves how powerful a woman I am.” – Dolly*

*“Women are considered unclean and impure, especially during their menstruation cycle. In many homes you find that any rituals being performed are led by men because they are believed to be purer and superior to women. You find that there are restricted areas such as isibaya (kraal) where women are prohibited from entering especially if they are having their period. Women are not allowed to touch or come in close contact with traditional medicines especially during their periods because it is believed that they kill off the usefulness of the medicine. There are many negative connotations that are associated with being a woman in traditional societies, however, the ancestors see beyond these social constructions when selecting an individual that will carry out their work. As a practising sangoma I am able to lead instead of being led, I possess more knowledge and I am listened to. People come to me when they need assistance, they know that I will be able to assist and solve their problem because I have the knowhow, regardless of the fact that I am a woman.” – Angela*

Nyanzi, Manneh and Walraven (2007) described TBAs as mothers to the village because of the service that they offer to the community. Nyanzi et al. (2007, 46) added that “TBAs provide general health care and support to their communities – over and beyond the sphere of reproductive health. Not only do they attend to women and/ or their babies during the antenatal, delivery and postnatal periods, but they are also often the first point of call for other community members when ill-health is suspected”. This description of TBAs reinforces the life stories of the participants in this study. In some instances, while I was at their homes for interviews their phones would ring constantly – women calling and seeking advice and others booking consultations. On one particular visit to Angela’s house, a woman whose foetus had not moved in days came to consult. She was in tears when she arrived, but Angela calmed her down and took her to *isgodlo* (her consultation room) to further investigate the matter. As I waited outside another woman who was having problems with her in-laws came to see Angela; she wanted to seek Angela’s advice as she was regarded as a knowledgeable woman who assisted families resolve conflicts. Drew (1995, 5) claimed that “female consciousness stems from women’s nurturing role in the socially-defined sexual division of labour and refers to women’s awareness of themselves as producers and nurturers of life.”

Ancestors empower women to become more than mere members of the community, especially in patriarchal societies as they hold power and knowledge that makes them more than women; rather they are seen as individuals who can help and partake in traditional practices that were traditionally led by men. Even though considered to be of a lesser standing in society, women

who are chosen to become traditional healers are associated with power and knowledge. It is through networks that these women continue to empower themselves.

*“You cannot know everything, sometimes you need the knowledge and assistance of other people, when I am consulting a patient and they present symptoms I have no knowledge of I always contact another TBA for assistance. We need to assist each other in our line of work, it is through this practice that we grow. I believe that it is important for women to assist each other in these communities that we live in because we are already considered to be inferior” – Juliet*

This is evidence of the social capital that these TBAs enjoy on the basis of their roles in society. They share ideas and learn from each other in order to attend to the needs of the community. It is a positive expression of the social identity that they also enjoy in the midst of general negative perceptions described earlier. The researcher, however, found that even though women are empowered and alleviated from certain social constructs of societies because of their ability to break social norms and take the roles which were previously restricted to men only, they continued to suffer some form of oppression through not being able to fully own their bodies. According to feminist theory, women should own their bodies. However, the research participants described how they would have preferred not to be sangomas; they did not want to accept their calling because of the hardships of initiation school and because it meant giving up their life dreams and professions to become practising sangomas. Angela shared that she was not happy about sharing her body; she felt that it was not fair because she did not want to become a practising sangoma. She was forced to become a sangoma because running away from her calling made her sick. She shared that it was difficult because she had no knowledge of what happened to her when the ancestors possessed her body to communicate their messages.

### **3.5 Conclusion**

Traditional birth attendants play an important and meaningful role in assisting women before, during and after pregnancy in rural communities. They live within the communities that they operate in and have a personal understanding of the language, cultural practices and beliefs systems; hence they are first preference to many women in cultural communities. This chapter, through the use of life histories, has presented the background and histories of several TBAs, describing their individual journeys to become practising TBAs through apprenticeship and

*ukuthwasa*. Through the life histories, the chapter has revealed the importance of TBAs in the developing world where there is a lack of proper infrastructure; even though they have little or no formal training, their presence in many communities is recognised and respected by those who believe in and prefer the assistance of TBAs. In the following chapter, the practices offered by the TBAs are discussed.

## **CHAPTER FOUR: Traditional practices offered by traditional birth attendants to pregnant women**

### **4.1 Introduction**

Pregnancy and birth can be considered as part of culture, health and illness; even though pregnancy is not an illness it remains embedded in a highly visible social matrix rooted in rituals and a spiritual realm of beliefs. Various cultures globally have health related practices and beliefs regarding pregnancy and childbirth which are one of life's most important events. In some communities, women prefer the assistance of TBAs for the cultural beliefs and practices they offer. Despite making use of primary health care facilities, the need to consult a TBA remains a priority as western health care methods do not address all their concerns. "An understanding of the indigenous beliefs and practices of clients regarding health issues is imperative in ensuring the quality of care and positive health outcomes for both the client and the service provider" (Ngomane and Mulaudzi 2012, 30). Hence, this chapter is concerned with the social capital that TBAs enjoy as delineated by Bourdieu (2011). As a social and cultural institution, TBAs are deeply embedded within the community of uMzimkhulu, and are still regarded as a fundamental part of the health care system. Lefèber and Voorhoever (1997) acknowledged the social identity of TBAs: "The work of the TBAs is adapted and strictly bound to the social and cultural matrix to which they belong, their practices and beliefs being in accordance with the needs of the local community". The current chapter is longer than other chapters due to the richness and abundance of the life history data.

### **4.2 Cultural practices and rituals offered by the TBAs to women in the community of uMzimkhulu**

Steenkamp (2003, 97) argued that "traditional remedies are part of the cultural and religious life of the African people". The research participants offered a variety of services to women and explained that all the services were influenced and guided by their cultural beliefs and practices. This is clear evidence of the relationship between the TBAs and their local communities; as was discussed earlier, the relationship of collaboration exists among TBAs for the purpose of more efficient provision of services where one might need the expertise of another (Bourdieu 2011). The aim of these services is to protect the unborn infant from any form of negative influence. The main practices that the participants offer to women include



*ukumisela* (process of assisting women to fall pregnant), *ukuxukuza* (a form of traditional antenatal care), preparing *isihlambezo*, *imbelekisani*, *ukuzalisa*, (traditional tonics) traditional forms of contraceptives, treating sexually transmitted diseases and preparing a concoction for infants that is consumed after birth for conditions known as *ipleyti* and *umoya*. This not only defines the social identity of TBAs and their roles in the local communities, but also highlights the social capital through which they collaborate with each other and remain continuously relevant.

#### **4.2.1 Infertility and the role of women in childbirth**

*Ukumisela* is a process of assisting women that are unable to fall pregnant to become fertile and able to conceive. The participating TBAs shared that they see on a regular basis many women who are unable to conceive. They explained that in their communities, women are under pressure to fall pregnant so as to grow the lineages they are married into. From a social capital perspective, it can be asserted that as long as a need continues to be pressing in a society that requires the expertise of TBAs, their services continue to be relevant (Bourdieu 2011). As long as there continues to be a problem that they collectively have the capacity to resolve for members of their local communities, their credentials are intact. As long as there are women who have reproductive health challenges, the practical and symbolic exchange which justifies their presence is continuously relevant (Bourdieu 2011).

The value of TBAs to women in the uMzinkhulu community is anchored on the assertion that infertility is a global reproductive health issue that affects many individuals and couples. In many African communities, a great deal of importance is attached to parenthood. Married women are especially expected to conceive and are defined by their fertility; women unable to conceive are often ridiculed, called by hurtful names that distinguish them from other fertile women and are regarded as lesser women. The success of TBA interventions for women without children means that their social capital as TBAs saves these women from negative recognition in their local communities. This deals with apparent misrecognition of infertile women by society, and in the process creates a positive social identity for TBAs who help families, especially married women to have children through their training and practices (Bourdieu 2011). Their cultural practices remain continuously relevant for the well-being of modern women.

A study carried out by Ademola in 1982 found that among the Ekiti of south-western Nigeria, infertile women were treated as outcasts; after they died, their bodies were buried on the

outskirts of the town with those of people who were mentally ill. “A woman’s infertility may lead to rejection by her partner, social ostracism, and loss of access to land or other productive resources” (Dimka and Dein 2013). In some communities, infertility may even lead to divorce and conflict within families. It is a common trend in most societies to blame women for failed conception. An infertile person does not only experience a personal deprivation but lets down the whole clan (Sewpaul, 1999). This means that the capacity of TBAs to assist with fertility is a critical social resource that continues to ensure their relevance and positive social identity in their local communities as they provide an unqualified social good (Portes 2014).

#### ***4.2.2 Spiritual and the supernatural beliefs about childbirth***

Although pregnancy and childbirth are a biological phenomenon, in many cultures and religions the birth experience is a socially constructed process. Pregnancy is highly associated with a supernatural and higher power; it is believed in many communities that a higher power has authority and control over the pregnancy. All the participating TBAs believed that pregnancy does not just happen; it is the ancestors that decide when they want to bless a family with children. When a family is unable to conceive, the ancestors are asked through rituals to bless the family with a child. Sarah, Primrose, Anne, Dolly and Juliet shared that they offer the service of *ukumisela* to women who are unable to conceive. The social capital of TBAs here is based on their group forming alliances and coalitions that are inherently valuable in their collaborations towards achieving a common good (Kreuter and Lezin 2002). They promote health of pregnant women in a traditional community.

These positive contributions by the TBAs enhance their positive collective identity or social identity. An identity based on their contribution to the well-being of community members elicits healing properties against the negative social recognitions that the factors of modernisation have imposed on them (MsAfropolitan 2012; Appiah 1994). Through mediation and intercession with the ancestors which they believe to be a higher power, they are able to assist families and women become fertile and pregnant. Pregnancy and childbirth to them are spiritual journeys guided by the ancestors. This is in line with the views of Ver Beek (2000): spirituality is integral to African people’s understanding of the world and their place in it. TBAs believe that a pregnancy can be seen as a gift from the ancestors if the child is born without deformities; a child with deformities is regarded as a punishment to the woman or family. Complications during pregnancy are often attributed to the woman’s behaviour, sometimes complications are seen as the result of one acting against customs.

The value of an African feminist perspective in the cultural practices of sangomas was illustrated by one of the respondents, Sarah, who explained that when a woman comes for consultation because she is unable to conceive, as a sangoma she will need to communicate with the ancestors and find out from them why they have blocked that particular woman from conceiving. Through this communication the sangoma will find out the reasons behind the woman's infertility and ways of assisting the woman. Clearly, a Western feminist would respond to the dilemma differently based on their lack of appreciation for the role of the ancestors in the life of African women (MsAfropolitan 2012).

Sarah explained that pregnancy is not only something that affects women; it can bring all family members together. Although only the woman goes through physical changes, the worldview of certain African cultures demands the support of the family for a successful pregnancy, and each family member has an important role to play during such times. Helman (2007, 75) lent credence to this argument adding that "although pregnancy and childbirth are female events, both physically and socially, most men are deeply involved in the birth of their children. In many cultures this emotional involvement is recognized by a series of rituals that men must carry out during their wives' pregnancy, birth and post-partum period". This aligns with Oyewumi's (2002) assertion about the difference between the African and the Western conception of family with regard to the gender debate priorities as she emphasised some level of complementarity of gender roles.

#### ***4.2.3 Sorceries and witchcraft practices***

MsAfropolitan (2012) identified witch hunting as one of the distinguishing characteristics of the issues that concerns African feminists which Western feminist would not understand, and about which African feminist have been silent for too long. Primrose explained that in many African communities, sorcery is a daily reality and it is strongly believed that infertility can be caused by a witch that curses a woman or the family that she has married into. She explained that in her line of work she has seen many women that have been cursed or blocked from having children. A study carried out in Mozambique by Chapman (2006) found that vulnerability to reproductive threats are frequently expressed as fear of witchcraft or sorcery (*'feitigo'*). Chapman further states that the belief in *feitigo* is universal among Shona speakers regardless of class and social station. Bourdillon (1991, cited in Chapman 2006, 496) argued that all types of misfortune, from falling in the path to losing employment, becoming sick, losing a child, or dying were attributed to sorcery. "Pregnancy is a 'delicate' time when women have 'lots of

problems', some of which are particularly unpredictable and could lead to the death of the mother or child. Women and their babies were said to be vulnerable to 'evil' sent by another person (directed sorcery), particularly a neighbour or a girlfriend of the child's father, who might have a grudge or be jealous, or to 'spells' which a woman might step over in the environment (non-directed sorcery)" (Abrahams, Jewkes and Mvo 2002, 83).

The TBAs described the following as sources of infertility in some women in traditional societies. *Umeggo* (also known as *umbhulelo*) is a form of sorcery that is performed by witches and other evil people whereby they put magic *muthi* (medicine) on the ground for a specific person; when the targeted person steps over it, it can cause fatalities, illnesses, infertility or whatever else the witch wished. Unresolved family matters that may have angered the ancestors, lengthy usage of contraceptives and an unclean womb are all possible causes of infertility. The capacity of the TBAs to resolve these kinds of spiritually related challenges that affect women is an important contribution to the challenges that African feminists would have only approached through rhetoric. This marks another indication of the social capital that the TBAs exercise for the benefit of their local communities (Bourdieu 2011).

#### ***4.2.4 Family cleansing***

Sarah explained that there are many factors that may influence infertility in African women; some of the women that she had assisted had been bewitched through *umeggo*, by love rivals, and family politics. She explained that there are many ways of dealing with the different types of problems. If the issue is related to unresolved family matters, she needs to go to the home of the woman to communicate with the family and find ways to solve the matter. She explained that in many cases the family needs to slaughter a chicken or two, sometimes even a goat, depending on the severity of the offense. Sarah explained that she has to dress up in *ibhayi elibovu* (red cloth around her waist worn as a skirt and a red doek), what she usually wears when she is going to communicate with the ancestors. Before talking to the ancestors she needs to burn incense as a way of appeasing them and then asks an elder member of the family to call out the clan names and ask the ancestors to forgive the offense of the family and to bless them with a child. All the homes she had visited to perform this practice were then able to conceive within a couple of months. Through this practice we see that infertility, pregnancy and childbirth bring together efforts from all immediate family members.

In many traditional communities the interconnectedness of health, family and culture does not go unnoticed. Family structures play a meaningful role in assuming primary responsibility in

maintaining family health (Zhou 2010; Eggenberger, Grassley and Restrepo 2006; Choudbry 1997).

*“You see my child, being a sangoma means that you can help people who suffer from many unexplained illnesses and challenges. I have assisted many women that were unable to conceive, what I have found sometimes is that when the makoti (wife) does not get along with her mother in-law she may be in trouble. Did you know that your mother in-law can make you infertile if she does not like you? Knowing that a child is a very important aspect of marriage in the black community, not having any children will make your husband to love you less, sometimes even want to divorce you. So your mother in-law can do all of this just to make your husband leave you to find another wife that will be able to give him children. As a trained sangoma, I have healed and helped many women in such situations to fall pregnant.” – Sarah*

She continued that if she finds that the person has *umegqo* she will give that woman herbs and roots to ingest, to steam, and to use through induced vomiting in the mornings. She will also give the woman a string to wear around her waist which will protect the mother and the foetus as soon as she conceives. Once the woman has fallen pregnant, Sarah described an old method used was to apply medicines to the vagina to ensure the protection and development of the foetus. At times, a TBA would make small incisions with a razor on the pubic area of the woman to apply medicines that will be absorbed into the blood for better protection of the woman and foetus. This method, according to Sarah, was an effective way of preventing or curing *umegqo*.

Sarah described a range of treatments to assist women to conceive. Initially she prescribes boiled herbs to use for two months. After this, the woman should be clean and fertile enough to fall pregnant, but she must return to continue with the treatment. Children who have been born as a result of *ukumisela* are often given names such as Celiwe (asked for), Nomiselo/Miselwa (named after the practice of *ukumisela*) and Sicelo (asked from the gods). Sarah explained that children are often given names as a result of a situation or something significant to the family.

*“Umegqo is a very common way of bewitching someone, many women have walked over spells that are meant to make them infertile. Umegqo is a very serious type of sorcery that needs an experienced healer to treat. I have seen many women who have been cursed through umegqo*

*either to prevent them from getting pregnant or to cause harm or even death if the woman is already pregnant.” – Sarah*

*“What we understand in our culture as black people is that pregnancy is a very vulnerable period. Falling pregnant may even be a difficult period for some women and there are many causes for such. There are biological, natural and cultural causes for infertility in all communities, however, what I have found is that the cultural causes outweigh the biological. What you have to understand is that pregnancy is only ever appreciated by the immediate family members while others pretend to be happy. Therefore, a pregnant woman and the family have to make sure that the woman and foetus is protected at all times... I have seen women who have been blocked to fall pregnant so that their marriages can fail, this can be done by jealous love rivals or at times even the in-laws if they do not like that particular bride. I have assisted a woman whose unclean sanitary towels were stolen by her mother in-law for the pure purposes of blocking her from ever having children so that her husband would leave her for another woman who was the desired choice of the mother in-law.” – Primrose*

*“Sometimes it is the people close to you that do not wish you well. I find that it is very rare where someone is bewitched by someone they have no close relation to. Intsila yomuntu yonakalisa okuningi (a person’s grime can literally kill them if it falls in the wrong hands) especially underwear and period blood. Witches are able to take dirty underwear and sanitary pads to block a woman from ever falling pregnant. I have seen many strange things in my time I tell you, women’s underwear and sanitary towels in the nests of impundulu (mythological creature in the folklore of the tribes of South Africa), you see the ancestors show you exactly where something is or who is doing it to you.” – Dolly*

Since witchcraft was so ingrained in the belief system of the study population, it can be considered part of their value system and culture. It can be argued that as long as a practice remains accepted by people, and as much as people believe in witchcraft and other curses that affect women’s reproductive health, it will be difficult to discontinue the practice or belief. This is despite the advent of modernisation and the negative attitudes to some African traditional practices. It is part of the people’s culture (Geertz cited in Jones 2003) as a system of significant symbols that guide the behaviour of those who share it. He added that culture is the source, rather than the result of human interaction. Hence, the changing reproductive health practices noted from this study in a society that is becoming more and more modern are continuously influenced by cultural beliefs like witchcraft which affects the family and fertility.

Thus, although medical science may be used in this society, people usually revert to the ritual practices of sangomas when they are stuck regarding reproductive health challenges. This further endorses the value of a feminist theory that is African and capable of understanding this mythical reality.

#### ***4.2.5 Repair against the damages of Western medical practices***

The practices of the TBAs have generated certain findings that collaborate contemporary research on some of the implications of prolonged contraceptive use by women. This social capital of the TBAs is valuable as it indicates how their cultural practices can help ameliorate the negative impacts of Western medicine (Bourdieu 2011). Western approaches are not necessarily always best and should learn from the African perspectives for the welfare of women as a whole (MsAfropolitan 2012).

The TBAs explained that they believed that another cause for such high infertility rates in their communities is the introduction of western contraceptives. As a precautionary measure, many women in all parts of the world are using contraceptives to prevent unwanted and unplanned pregnancies. Health departments all over the world are working tirelessly to encourage women of childbearing age to use contraceptives for family planning purposes, for women who feel that they are not ready for pregnancy and most importantly to allow women to plan and have control of their lives. However, traditional communities feel that contraceptives are doing more harm than good. The TBAs see contraceptives as an unnatural violation of nature which disturbs the natural manner in which the body is meant to function; for this reason, they feel that the use of contraceptives confuses the body and fills it with chemicals that disturb the normal function of the natural chemicals within our bodies. Animasahun et al. (2013) lent credence to this argument by stating that “many people in Nigeria believe that the use of exogenous hormones will eventually disrupt the body’s natural functions, and lead to infertility”. This study also found that 50% of the participants thought that previous use of oral contraceptives (OCP) and intra-uterine contraceptive devices (IUCD) leads to infertility. This might inform the studies that have suggested that various African families and indeed various other third world countries do not want to use contraceptives for fear of becoming infertile (Gerrits 1997). In support, Animasahun et al. (2013) argued that contraceptives are believed to be a major risk factor for infertility.

*“I have assisted numerous women that have been using contraceptives for lengthy periods of time. I do not encourage the use of chemicals to prevent pregnancy because I feel that those*

*chemicals disturb the natural chemicals in women's bodies. I know that prevention is an important aspect in the lives of women and as part of family planning, I usually advise my patients to use natural methods because I know that they are also very effective. When I assist a woman who is unable to conceive I usually ask them if they have previously used contraceptives so that I know how to start assisting the woman. It is not easy for one to fall pregnant while there are still some chemicals in the body, they can kill or make the foetus abnormal. I have to clean the woman's body and uterus for a whole two months if they have previously been using contraceptives. If I could, I would ask the government to encourage women to use the old traditional contraceptive methods or natural herbs that will not introduce harmful chemicals in the bodies of women.*" – Dolly

*"They can be a real problem when you want to conceive and they take a long time to be cleared from the body. The woman needs to be patient after taking contraceptives, especially after a long time because it will take time to also clear them out of the body. I have assisted many women who used contraceptives and had become infertile as a result. You see Yoyo, the thing is they are harmful to the body and to the foetus if you fall pregnant while the chemical is still in your body. The baby will become sick if the mother is not clean."* – Juliet

*"I have helped so many women, I have even seen the nurses from the hospital. They keep telling women not to come to us for assistance, but they also come and consult us. Infertility is a very painful thing for any woman to go through, and African communities have our own way of dealing with and treating infertility. Having an education and working at a hospital does not change the fact that you are black and have to follow certain treatments available to women for treating infertility. In our community there are certain illnesses that the doctors are unable to see or treat that only traditional doctors can heal. What I am saying is that as traditional healers we assist a number of women who are unable to conceive through traditional medicine and rituals. The last nurse that I assisted used my medicine for a month and fell pregnant with twins. I can honestly say that even though the doctors and nurses do not trust our medicines and practices, however, we make a big difference in the lives of the people in the communities that we live in."* – Sarah

Sarah, Primrose, Anne, Dolly and Juliet treated infertility through a process known as *ukumisela*. The fact that the different TBAs share the same set of knowledge and diagnoses is a clear indication of valuable social capital that they share. The TBAs use different herbs and roots for making decoctions to treat infertility, however *ugobho* (*Gunnera perpensa*) seemed



to be a common ingredient; even those who did not use *ugobho* said they had heard of the benefits offered by the root. *Ugobho*, as it is popularly known among the Zulu and Bhaca<sup>3</sup> traditional healers, is a medical plant that grows near rivers or marshy areas and is used for a number of ailments in traditional medicine. Simelane (2010) argued that *ugobho* has long been used by traditional healers to induce labour, expel the placenta after birth, to relieve menstrual pains and to stimulate milk production. There was consensus amongst the TBAs on the usefulness of *ugobho*, and they explained that it is a very popular plant to use in reproductive health in South Africa. Despite going to different initiation schools, they had all learned the importance and usefulness of *ugobho*.

An important issue within African feminist concerns is the clash of cultures wherein the modernisation tendencies of the nurses and hospitals undermine the practices of the TBAs, yet some nurses go to TBAs for assistance. This resonates the ideas of Oyewumi (2002) about the attitudes of the Western feminist's paternalistic approach to African affairs. The dangers of medical contraceptives seemed evident to all the TBA practitioners. Although TBAs receive some training, the nurses and doctors do not recognise this because it is not a Western type qualification. This affirms again the view of MsAfropolitan (2010) about the need for collaboration between the traditional and the modern, the African and the Western for the purpose of a better world. The availability of healthier contraceptive approaches could indeed prevent many fertility related challenges. Valuable knowledge that could have been gained from the TBAs regarding health care in general is continuously undermined in the modern society.

Sarah, who is Bhaca speaking, explained in the following paragraph that TBAs offer a range of services to women who are unable to conceive or those that have recurring miscarriages. She further explained that she used *ugobho* to treat the abovementioned and that it is a medicinal plant that she trusts for its cleaning effects.

*"Here what I do is to clean out the woman's body and womb to prepare it for pregnancy. I use ugobho mixed with other herbs for this process, it is a root that I boil in water. Ugobho is an excellent herb for cleaning out the womb and keeping it clean. To make the womb fertile I use impila which is also a root. I buy this root from the chemist, and it makes the womb fertile."*

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<sup>3</sup> Bhaca people or amaBhaca are an ethnic group in South Africa, mainly found in the small towns of the former Transkei homeland (Mount Frere, uMzimkhulu) and surrounding areas - a region that the amaBhaca call *kwaBhaca*, or "place of the Bhaca".

*People that have used the impila concoction usually take less than three months to fall pregnant.” – Juliet*

Dolly is one of the TBAs that does not use *ugobho* in her concoctions; for *ukumisela* she uses three different ingredients interchangeably which are *impila*, *iboza* and the African potato. All these ingredients are roots that she boils.

*“Even though I have not used it personally, I hear that ugobho is an excellent medicine. I do not use it because my ancestors have never suggested that I use it. All the medicines that I use have been pointed out to me by my ancestors. You see, whenever they want to introduce me to a new type of medicine they do it in the form of a dream... maybe they are still going to suggest it, I do not know.” – Dolly*

#### **4.2.6 Sexually transmitted disease and infertility**

The social capital of the TBAs also serves to inform society members and sensitise them about how sexually transmitted diseases are related to infertility. In recent times, the TBAs explained they have been seeing many cases where women complain about infertility when they are suffering from sexually transmitted diseases (STDs). The TBAs explained that a love rival can cause you harm by bewitching someone with an abnormal discharge that will eat away at reproductive body parts and make one infertile through a process traditionally known as *ukubhajwa*. They also explained that some women get STDs traditionally known as *idrop*, *ugcusulu*, *isipatsholo* (gonorrhoea and chlamydia) through unprotected sex and unfaithful partners. The TBAs explained that if a person stays too long without seeking help for an STD, they may end up infertile and sometimes the process is irreversible. Gonorrhoea and chlamydia are the main causes of infertility in the third world (Gerrits 1997, Odile 1983). Dolly explained that *ugculu* causes great damage to the womb of a woman.

*“Ugculu rots the inside of the womb, it also kills off very important vital veins and blisters on the inside and outside of the womb can also be identified. If a woman happens to fall pregnant while they have ugcusulu, the foetus will also be affected and sometimes can even die.” – Dolly*

Angela and Juliet were the only TBAs that shared their knowledge for treating *isipatsholo*, *ugcusulu* and *idrop* (these are traditional names for gonorrhoea and chlamydia that are used interchangeably amongst the TBAs). Angela explained that she uses *fesh* as one of her ingredients for curing *isipatsholo/ugcusulu/idrop*. While she does not know how to spell, read

or write, she knows her ingredients as she knows herself. Upon further investigation at one of the chemists in uMzimkhulu, I found that *fesh* is actually citrus soda, though the TBAs have named it after Eno and the freshen laxative because of the resemblance and characteristics when mixed with water. “My patients ought to take a spoon of this mixture every day, I swear by this medicine. It works very well and has cured all the people that have come to me for assistance.”

Angela explained that *“to cure ispatsholo (gonorrhoea and chlamydia) I use a powder known as fesh that I buy from the chemist. Fesh comes in a small plastic container, it is a powder. I use a cup of water and a tablespoon of the fesh powder. When you add the powder to water it bubbles, just like when you see Eno. I then boil ikhubalo elikhala amahlwili, you see this root turns red when you cook it, it becomes red like blood and the actual root looks like blood clots when I have strained it. Once I am satisfied with the colour of the boiling roots, I add the fesh water that I have prepared and continue to boil for another hour or so and then put it aside to cool down. I have to dispose of ikhubalo ulikhala amahlwili in a safe place as jumping or over it may cause harm.”*

It is worth noting that the social capital of the TBAs gives them considerable insight that warrants an assertion that the pedestal that has been given to formal education should not work against the acknowledgement of the insights and wisdom that social groups like the TBAs gain in the course of their services to the community. They know their roots as they know themselves, despite not being able to read or write. They can diagnose and cure diseases that are likely to lead to infertility even when doctors in the hospitals fail. Nevertheless, they are already finding ways of combining what they know with what they are embracing from medical sciences. They use *fesh* and demonstrate some level of precaution in their practices. The collaboration could have more beneficial effects if they were not rivals with modern medical health practitioners. There are indications that hospitals do refer some patients to the TBAs, but there is also a poor sense of recognition of their value and worth.

There is a sense of professionalism and ethics in the TBAs evident in their relationship with their patients and in the way they respect their limits and collaborate with/use the expertise of available medical science resources in the hospitals and clinics nearby. Some TBAs explained that they do not like to deal with STDs because they feel that they are tricky to diagnose; they send their patients to get tested at the community health care facilities. They explained that people consult them for the treatment of STDs because the nurses and doctors judge them and

gossip about them. One of the TBAs explained that on one occasion a woman who had come to consult her for STD related issues said she would rather stay at home and die from her STD than go and get shouted at by the nurses at the clinic. Despite this, the TBAs explained that they always encourage women to look after their bodies, to go to the clinic for regular check-ups as they do not have the machines that are used by the clinics to detect STDs and HIV. This is an indication of the value of the social capital that the TBAs have and how that gains them positive recognition among some patients who prefer being assisted by them on STD matters rather than by the staff at hospitals who do not treat them with respect. Their capacity for such collaborative and respectful intergroup behaviour can be attributed to a strong sense of social identity (Hogg et al. 1995).

#### ***4.2.7 Women emancipation and empowerment and informal education***

Some of the TBA practices have feminist characteristics as they embody certain emancipatory practices from a cultural dimension as noted by Peterson (1984). This empowerment is achieved by ensuring the overall well-being of the woman through the cultural healing practices of the TBAs and through educating the women on valuable reproductive health skills. This practice addresses not only women's equality, but ensures their overall well-being (Oyewumi 2002). The TBAs support women with advice and via collaboration with medical tests and clinic cards.

On one of my visits to Sarah's house I asked to sit in on one of her consultations. The first thing that she did was to ask for the visiting woman's clinic card to check if she was visiting the clinic as she should. After this she explained to the woman the importance of looking after herself and the foetus by eating healthily, getting enough sleep, drinking plenty of water and taking both *isihlambezo*, vitamins and ARVs if she was HIV positive. She explained that as TBAs, they have to look at a pregnant woman as a whole and not simply as a woman with a child growing inside her. After the visit, the TBA explained that she could not write but was taught to read. Even though she cannot make sense of the long English words she could check dates on the clinic card. She explained that she did not want her patients to know that she was illiterate because it was important to be able to check the clinic cards. Sarah also shared that she did not assist women who did not attend the clinic; she only agrees to assist them when they bring their clinic cards along to the consultation. Abdominal

*“Women should help other women, we are not called the mothers of the community for no reason. A woman needs to understand that they are an important part of society, their role*

*cannot be taken away by anyone, therefore teaching each other ways and means to look after ourselves is something that will empower us and make us a strong union. I always tell the women that come for consultation that they only have one body and womb and need to take good care of themselves, anyone that will come to them and give them snuff tobacco to insert in their vaginas for pleasurable sex is out to destroy them and their future. I always tell them that if they feel that they have an illness they should always come to me or go to the clinic, sometimes if they are scared (because the nurses shout at them) I accompany them. If we do not look after ourselves and our future mothers, who will?” – Juliet*

*“Umuntu wesifazane kumele azinakekele noma engazithwele (a woman should always look after and take care of her body, even when they are not pregnant). I always encourage the women I see to know what is happening in and with their bodies, even when I am not consulting, I gather all the girls from this community and teach them the importance of looking after their bodies and saying no to boys who will destroy their lives and leave them with children and incurable diseases.” – Primrose*

#### **4.2.8 Antenatal care**

TBAs play an important feminist role in the education, via an oral tradition, of women and the youth to empower them in terms of antenatal care. The TBAs highlighted the importance of receiving antenatal care (ANC) during pregnancy, stating that it gives the pregnant woman an opportunity to learn to look after herself and her baby. Appropriate antenatal care is important in identifying and mitigating risk factors in pregnancy and to learn about medical, nutritional and educational interventions that are available; however, millions of women in developing countries do not receive antenatal care (Magadi, Modise and Rodrigues 2000, Alexander and Korenbrot 1995, Simkhada et al 2007, Pell et al. 2013, Agus and Ploriuchi 2012).

Many women in developing countries are attended to by traditional birth attendants who are regarded as low skilled individuals (Ebuehi and Akintujoye 2012, Montagu et al. 2011, Falle et al. 2009, Eijk et al. 2006 and Bergstrom and Goodburn 2001). Assessment and care during pregnancy is very important for both woman and unborn infant. TBAs do not only offer medicines, they also offer a practice known as *ukuxukuza* (a form of traditional antenatal care) during pregnancy – they track the health of both the foetus and mother, work out the gestational age of the foetus and offer nutritional and educational interventions that will contribute to the healthy development and growth of the foetus.

*Ukuxukuza* involves a process of massaging the belly of the pregnant woman in order to feel the foetus, using their hands to locate the head and buttocks to feel if the foetus is lying in a position aligned with its gestational age. Engelbrecht et al. (2012) explained that the word *ukuxukuza* literally means shaking the stomach, and is a general term used by the community to refer to abdominal examination of the pregnant woman. Sarah, Primrose, Abby, Juliet and Angela and Victrice all offered *ukuxukuza* to pregnant women. They explained that *ukuxukuza* is an important practice used also by nurses at the clinic and is part of the ANC guidelines they have been taught. Mchunu and Bhengu (2004, 41) summarised the importance and roles of TBAs: “The influence and acceptability of these females, known as Traditional Birth Attendants continue to exist amongst people in remote rural areas and even when formal health services are available. Pregnant women in rural communities worldwide still rely on TBAs for advice throughout their pregnancies. Such advice includes dietary information, sexual activities and medication to be taken during pregnancy.”

#### **4.2.9 The consultation process**

On one of my visits to Sarah’s house I was fortunate to arrive at the same time as a woman who was coming for a consultation. With the permission of both Sarah and the consulting woman I was allowed to observe the consultation. When I arrived, Sarah was wearing *ipinifa* (a traditional dress mostly worn by women in traditional rural areas), however, she went and changed for the consultation with the woman. She took off her shoes, changed her *doek* (head cloth) from the black one she was wearing to a red one and put on *ibhayi elibomvu* (red cloth around her waist). She asked us to follow her to her consultation room and to take off our shoes before we entered. What I noticed was that there were no chairs, but only grass mats and Sarah asked me to sit where I would be able to see clearly. I noticed that it was not the woman’s first consultation as Sarah did not have to explain to her what she needed to do and where to sit.

Sarah took an enamel plate which was next to her fireplace and put *impepho* (incense) into it and burned it. While the incense was burning, Sarah knelt facing *umsamo* (upper part of the rondavel (round hut) which is known to be the cradle of the ancestors for many African families). While burning the incense, Sarah started sneezing and every time she sneezed we would have to reply with “*Makhosi*”. Sarah called out her clan names and asked for her ancestors to be present and helpful as she was about to carry out the important task of assisting the woman who she was about to consult. Sarah moved to the woman who was sleeping flat on her back and started touching the woman’s stomach, explaining that she was feeling the

position of the foetus. Sarah applied the contents of a brown bottle from one of the pots that near the fireplace to the woman's belly. She estimated the gestational age of the foetus and the estimated month of birth which was uMfumfu (October). She told the woman that everything felt normal to her, but she advised the woman to visit the clinic where they could see the baby via a scan in case of any abnormalities or complications. Finally, she gave the woman a bottle of *isihlambezo* that the woman fetches every month and some of the oil that was in the brown bottle.

*“For ukuxukuza I burn incense which I use to appease the ancestors when asking for their assistance and guidance when working on a pregnant woman. To massage the belly I use Vaseline and entressdruppels, the belief is that entressdruppels protect the foetus from evil spirits. The smell repels any form of sorcery and keeps the foetus and mother protected.” – Primrose*

*“I use an oil known known as amafutha enja yolwandle (seal oil) which I buy from the chemist. This oil is very significant in protecting the foetus and mother during pregnancy. While applying this oil I put my hands around the belly of the pregnant woman so as to massage it and move the belly around. Moving the foetus around helps and prepares the foetus for birth... You see, my child, if the foetus does not move it gets stuck to the mother which creates a great challenge when the woman has to give birth because it becomes extremely difficult for her. Ukuxukuza is very useful.” – Sarah*

*“I boil the incense and leave it to cool down, when it is cool enough I pour it into an empty Vaseline container and mix it with some Vaseline. I rub it on the pregnant mother's stomach thoroughly while moving the foetus. Whatever is left over I give to mother to continue rubbing at home. This mixture is important for keeping evil spirits away.” – Abby*

Abby shared how she used a toilet roll to listen to the heartbeat of the foetus. “I use the toilet paper cardboard support centre to listen to the heartbeat of the foetus. I listen for the heartbeat during the process of *ukuxukuza*, I place it on the belly of the woman and move it around until I can hear the heartbeat”.

The consultation process experience displays the social capital of the TBAs, their knowledge base, how they collaborate, how they are educated and how they educate their clients. TBAs are trusted within communities for their knowledge in attending births and the decoctions that they prepare for expecting mothers. These decoctions assist mothers with the delivery process.

It is believed that the decoctions assist to clean the foetus and the womb and they make the birth process easy and quick for the pregnant woman. Expecting mothers within traditional communities believe that for a good pregnancy without complications, they have to use decoctions that are prepared by the TBAs. This belief is rooted deep within cultural practices, and due to easy access and interaction, many women find TBAs more caring about than midwives, as evidenced in a study conducted by Titaley et al. (2010): “Traditional birth attendants are more patient. They gently touch your stomach and do not easily feel upset. This attitude is different from midwives. Sometimes after the physical examination, the midwife leaves if she thinks it is not the time for delivery yet. In contrast, the traditional birth attendant will wait patiently and accompany the woman all along”. Ngomane and Mulaudzi (2012) concurred adding that “indigenous practices and beliefs influence and underpin the behaviour of women during pregnancy”. These assertions of the social capital of TBAs confirm the views of Kreuter and Lezin (2002) that social capital is valuable when it is connected to community based health promotion.

#### ***4.2.10 Ensuring an easy and safe delivery***

TBAs do more than simply deliver babies. As part of the local community they are acquainted with the women and their families with whom they share the cultural ideas about how the birth has to be prepared for and performed. They know the local medicines and rituals which are used before, during and after delivery. The work of the TBAs is adapted and strictly bound to their social and cultural matrix, their practices and beliefs being in accordance with the needs of the local community (Lefeber and Voorhoever 1997). Besides sharing a social identity as TBAs, the cultural norms that TBAs share with members of the community indicate another social unit of shared values. At a cultural level, the TBAs share a social identity with the women of the community whom they assist. This contributes to the closer ties between the community woman and the TBAs, unlike the relationship they have with nurses in the clinics who do not demonstrate strict cultural ethics and sensitivities. The research participants who offered *isihlambezo* to pregnant women shared that it was important during pregnancy as it has all the essential and natural vitamins, minerals and sugars needed for the development of the foetus. *Isihlambezo* is also ingested to make the birthing process easy and quick.

Varga and Veale (1997, 14) defined *isihlambezo* as “an herbal decoction used by many Zulu women in South Africa as a preventative health tonic during pregnancy”. The common ingredients that the TBAs use to prepare *isihlambezo* are *umsilawengwe* (*Gnidia kraussiana*),



*ugobho* (*Gunnera perpensa*), *ntsukumbili* (*Senecio serratuloides* DC), *ibhuma* (*Typha capensis*) and *iboza* (*Tetradenia riparia*). The TBAs explained that the ingredients have important nutrients and act as a preventative measure to illnesses that may attack the foetus after birth. *Umsilawengwe*, for example, was said to be a good asthma medicine, The TBAs explained that they include medicines in *isihlambezo* that will protect the foetus from bad spirits and physical illness. They explained that mothers who do not consume *isihlambezo* during pregnancy have babies that are often prone to illnesses.

*“I buy umsilawengwe from the chemist. The trick with this root is that it needs to be prepared by someone who is very experienced, it can be a toxic root if not prepared well. It needs to be cooked for a lengthy period of time to get it right, after cooking it needs to be sieved so well that not even a single fragment is left behind. This roots helps with the development of the foetus and it also prevents chest complications such asthma when the foetus is born.” – Primrose*

*“For preparing isihlambezo, I only use ugobho because I am close to the river, this [ugobho] root is easily accessible to me. It grows in marshy and wet areas and close to or by the river banks. I wake up extremely early on days where I will have a patient come for consultation. I do this because I want to be ready by the time the patient comes, I usually prefer that the patients also come in the morning, I find it easier to work in the mornings rather than midday or in the afternoon. Ugobho is the only ingredient that I use when preparing isihlambezo, I know no other way... I only prepare it the way I was taught. I tell my patients to only take one spoon in the morning, not more and not less. My grandmother always told me of the positive properties that ugobho possesses. My grandmother used to say that ugobho has many useful traits and is in true essence a root worth using when assisting pregnant women.” – Abby*

*“It is good for the mother’s womb, it makes it a warm place for the foetus ... if prepared well it also prevents miscarriages. Also, it contains important nutrients that are essential for the development of the foetus. Even when a woman is having difficulty in labour, I prepare ugobho so that the baby will come without struggle. Over the years I have noted that infants that were ingesting ugobho during pregnancy are different to the others. What I have noticed is that the infants always look chubby and beautiful, they are never underweight and rarely have complications. I know this because I follow up on my clients ... I am always impressed with the result.” – Sarah*

Prudence explained that there are many herbs that can be used when preparing *isihlambezo*. “*If you have been thoroughly trained, it is easy to prepare fertility concoctions. Fertility ingredients are in abundance, it is the choice of the TBA which herbs and roots they select when preparing isihlambezo. I boil ugobho and ibhuma and leave them to cool overnight. I have never used any other ingredients but these, they always help the people that I prepare them for. These plants can be dangerous and need someone who is thoroughly trained when it comes to preparing and measuring them.*” – Prudence

Dolly prepares *isihlambezo* using *ugobho* and sometimes *umsilawengwe*. She explained that she uses these roots interchangeably, however, prefers to use *ugobho* because it is safer. “*Umsilawengwe is a good medicine, but I am scared of using because I heard that it killed a school teacher who used it as an enema. Even before he died from it I had always heard from other people that you need to be extremely careful when using it to make medicine for a patient especially pregnant women.*” The value of lessons being learnt in the course of their practice as TBAs is an indication that there is openness to continuous learning on the part of the TBAs. The positive social capital is motivated by the desire to better serve the community; this is different to the modernist capitalists’ motive of profit maximisation. TBAs appear to value a positive social identity and social recognition more than self-enrichment.

Anne does not use *muthi*, she prays for people and provides them with *isiwasho*. Anne encourages her clients to bring candles; she prays over the candles which differ in colour according to the problem being experienced. The women light the candles during the prayer session to conceive or for the protection of her foetus. In addition to the work with candles, Anne prescribes *isiwasho*. “*There are many ways of using isiwasho, you can bath with it, induce vomit, and use it through the use of the uchatho (enema) which is inserted in the lower bowel way of the rectum*”. Juliet uses three ingredients when preparing *isihlambezo*. She uses *ugobho* but it is difficult to find in her area and she therefore often has to use other ingredients. She therefore also uses *intsukumbili* and *ibhuma* which give similar results. She boils these roots, leaves them to cool and then pours them into empty two litre bottles that the women take home.

The intrinsic connection of the African traditional lifestyle with the spiritual is evident here. The social identity of a typical African woman is inherently spiritual. In their activities and approaches to childbirth, the TBAs recognise and respect the social capital of the women they work with. This affects how popular they are among traditional women in relation to childbirth.

This also supports the popular view amongst African feminist theories like Ver Beek (2000) and Lunn (2009). Ver Beek (2000) emphasised how integrated the spiritual is to the African's understanding of the world and their positioning within it. Lunn (2009) illustrated how the spiritual is being continuously undermined through policies. This desensitisation of people through political structures by the modern structures of society is obvious in the reporting of the detached attitudes of nurses and doctors in modern hospitals in their treatment and relationships with pregnant women. The undermining of the spiritual can be assumed to have contributed to the undermining of the practices that are tied to the spiritual. It appears the Western medical practitioners do not really acknowledge the value of the TBAs until they are confronted with medical conditions that defy medical science.

Victrice also prepares *isihlambezo* using *untsukumbili*; she explained that this herb can be used for many other health related medicines. At times Victrice also uses *iboza*, a root with all the properties needed for the development of the foetus. Angela uses the African potato and *impila* when preparing *isihlambezo*. She explained that the African potato is rich in nutrients for both the mother and the foetus. The TBAs explained that it is important to encourage the mother to eat healthy foods that will benefit the foetus. They explained that they encourage pregnant women to eat foods such as eggs, fruits, meat, vegetables and drink lots of water. Even though each culture has its own belief system and way of doing things, healthy nutrition should be part of every women's diet during pregnancy, explained the TBAs.

The practices of the TBAs have not always been perfect. Primrose, Sarah, Anne and Dolly explained that in the past, due to lack of understanding, some TBAs prevented mothers from eating nutritious foods because of cultural beliefs. Sarah specifically remembered that her grandmother would advise women against eating eggs as the belief then was that eggs during pregnancy would cause the child to grow up to be a thief. If a mother drank too much water, it was believed this would cause the foetus to grow a big head making the birthing process difficult. The TBAs advise their clients to consume fruits during pregnancy; they do, however, warn against eating fruits such as pineapple, papaya (especially when still green) as well as aloe vera during early pregnancy as these fruits are said to cause miscarriages in early pregnancy. Erusand and Tesha (1979) claimed that some taboos in the past maybe today be interpreted differently: women may have been discouraged to consume nutritious foods during pregnancy.

*“I encourage all my patients to follow and attend to their food cravings. My grandmother used to say that food cravings are the body’s way of telling the pregnant woman which foods and nutrients are urgently needed by the body to function well and prevent certain deficiencies during the pregnancy. She always used to say that the body is like a very clever machine that communicates with those who listen.” – Pinky*

The indication here is that contrary to popular belief that cultural practices can be dogmatic and promoted at the expense of the welfare and well-being of the people they are supposed to help. The evidence from these women indicates that there is indeed progression in their social capital as TBAs. They are continuously paying attention to their clients and learning lessons that are bound to impact positively on their services to the women. The change in attitude and knowledge about nutrition and cravings of pregnant women is a good example. This accrues them positive social recognition within a modern society that tries very hard to undermine their value.

*Imbelekisani* is a concoction that is prepared for pregnant women to ingest in the final month of pregnancy. This concoction is believed to make the birthing process a quick and easy one. However, most of the TBAs explained that they were not comfortable with preparing *imbelekisani* because it is toxic, especially when prepared by someone who does not have the required expertise and experience. Primrose explained that *imbelekisani* is not something that she usually prepares or promotes. It is risky and can have an adverse effect on the foetus which they are always trying to avoid as TBAs. The only time Primrose prepares this concoction is to prevent a woman having to go to hospital for a C-section. If prepared correctly *imbelekisani* appears to work very well. Pinky shared the same sentiments: *“Imbelekisani is a very difficult concoction to prepare, I need to be assisted by my husband when preparing it... it is one of the most intimidating concoctions because you can actually kill a foetus if mixed and prepared by someone who does not have the required experience. As much as I have been helping women for more than forty years, I feel that imbelekisani is one of the hardest concoctions to get right. Ugobho is good for removing and cleaning the womb, I use an extra dose of what I usually use when preparing isihlambezo”*. Angela also did not advise the use of *imbelekisani* as it is regarded as a very dangerous concoction that can result in the death or miscarriage of the foetus. She explained that some women are cursed by witches or evil people to have very long birthing processes and some even die during the birthing process. She explained that she only prepares *imbelekisani* in a life or death situation. Due to the toxicity of *imbelekisani*, Pinky refused to

share how she prepares this concoction. All that she shared was that the main ingredient is *ugobho* and that she doubles the dosage and adds other herbs that she buys at the chemist. Pinky regarded this concoction as dangerous and not to be prepared by people who have little knowledge of traditional medicines. The emphasis for the need for expert knowledge further endorses the social capital of the TBAs. It implies that they do not only hear from the ancestors, they also commit themselves to improving knowledge of their trade or calling. Their specialised activities are not open to anyone except those identified and trained through the different approaches discussed earlier, in line with the prescriptions of how social identity is formed (Stets and Burke 2002; Brown 2000).

TBAs assist with the births of a substantial proportion of the world's new-borns. Though the birthing process was previously the main practice offered by TBAs, many now only ever offer this when it is an emergency and when women are far from clinics and hospitals. Due to maternal mortality and potential adverse events that occur during the birthing process, TBAs now prefer to send pregnant women to hospitals to be attended to by medical personnel who are highly trained. This is understandably an acknowledgement of the advances and efficiency of medical science.

The collaborative efforts between the TBAs and the medical centres or clinics is commendable, especially since most of this comes from the TBAs. Pinky explained that she did not encourage women to give birth at home. "I make sure that the mother knows her possible due month. It is very important that women give birth in the hospital with the assistance of a medically trained doctor or midwife ... in case of emergencies such as excessive bleeding and other emergencies that we as TBAs are not trained on". Pinky explained that before the introduction of ambulances and development of poor communities, through building of hospitals, clinics and proper infrastructure, it was normal for women to give birth at home. She explained that giving birth at home was at times a very long procedure. The TBA would spend almost the entire day at the pregnant woman's home and at times even the night. Pinky explained that when it was almost time for the delivery of the infant, she would spend the whole week praying and burning incense to appease her ancestors while asking for their guidance for when she was to assist the woman give birth. She shared that each family had cultural rituals to perform before the baby's arrival. As a TBA, she shared she would encourage and support the family.

*"When the contractions have started, but are still further apart I would usually take the woman for a walk around their yard. This would really help as it made the birthing process an easy*

*one for the woman and myself. While she is walking around I made her drink half a cup of isihlambezo which I prepared specifically for the purposes of giving birth and I had to keep examining her through the vagina to see how far or close the baby is. Before the birthing process starts the woman had to use the enema so that when she gives birth there would no faeces, if the child came in contact with the faeces in any way she or he would have no appeal and people would not like the child.” – Pinky*

Pinky explained that she would ask that the pregnant woman to lie down on a grass mat in an upright position looking at the roof of the house. She would help the woman with breathing techniques to alleviate the pain and sometimes pressed a warm cloth on the belly to relax the muscles. She explained that she would gently pat the belly of the pregnant woman and massage it with herbs mixed with castor oil to reduce the pain. A study carried out by Ngomane and Mulaudzi (2012) indicated that TBAs know how to reduce labour pains by massaging the back of the pregnant woman and teaching her how to pant. They added that if pain was severe, hot compresses around the abdomen were used and the body was massaged with *nhlampfurha* (castor oil) and the labouring woman was given a preparation of *xirhakarhani* (an indigenous analgesic) to drink.

*“Breathing is very important at this time, as an experienced TBA, you must make sure that you teach the woman when and how to breath. Breathing can help to bring calmness to the woman and she can concentrate on pushing the baby out of her body. I have to communicate with the woman very well, I refrain from shouting even when I can see that the woman is not following my instructions because shouting will cause her stress.” – Pinky*

When there are complications during birth, traditional healers see this as a sign that the ancestors are unhappy or angry; this can be due to many reasons such as infidelity on the part of the woman, pregnancy out of wedlock, teenage pregnancy or falling pregnant by a relative. This can manifest as a breech birth and during such situations there is an urgent need to burn incense and call upon the ancestral spirits. This is another illustration of strong ties with the supernatural. One might ask why some of these challenges do not occur in hospitals; one response is that the modern medical health system is foreign and thus not necessarily under the protection or control of the ancestors. In addition, some cultural practices do not have simple and straightforward explanations.

Pinky explained that when the ancestors are unhappy, the most common sign is for things to not go well during the birthing process: a woman is in labour for many hours. When the baby is in a breech position, as a traditional healer she immediately sees this as a sign that the ancestors are angry about something. She burns incense, calls out clan names and pleads with the ancestors to calm down and have sympathy.

*“I have to watch and make sure that the woman is pushing at the precise time, at this point as a TBA, you need to be sure that the woman can hear you clearly and can understand what you are communicating to her. When the baby is born, I have to check and see if they are breathing before I can do anything else. If and when I am satisfied with the baby’s health I will continue to ask the assistance of a family member to cut the umbilical cord. My grandmother taught us to always cut the cord by measuring it from the belly of the baby to the knee, where it touches the knee or I have to measure it to the head of the infant and ask a member of the family to cut it and leave it to me to tie it. My grandmother always used to say that cutting the cord any closer may kill or cause the infant to be infertile when they grow older. I have to explain to the family to leave the umbilical cord alone until it falls off, the family then decides what they do with it after it falls. After the baby has been delivered I have to bath and dress the infant and give them to a family member who will look after them while I take the placenta out of the mother and help her to clean up.” – Sarah*

*“As soon as the placenta is out I have to give it to a member of the family to do with it what their culture and rituals require them to. Families are different, in some families I am not allowed to clean after the delivery it is the duty of the mother to clean up. I have to ask before I start the whole process whether they will clean or I will. As a TBA it is your responsibility to teach first time mother’s breastfeeding techniques and other common methods of looking after a child. I always tell the new mother the importance of breastfeeding and explain to them that the yellow to orange milk substance that comes out in the first couple of days as it is the most vital for the infant as it makes them less susceptible to illnesses. Lastly, I have to prepare a concoction to clean out the woman’s womb and another to help her heal. I use ugobho and other herbs that I buy from the chemist to prepare these concoctions. My general advice after the birthing process is for the woman to abstain from sexual intercourse for at least six months, the purpose of abstaining is to allow the body to heal and to avoid conceiving again as she is still extremely fertile.” – Primrose*

The majority of participants in this study explained that part of their role as TBAs is to encourage women to use contraceptives after birth so that they do not conceive immediately. They shared that they always encourage the women and their husband to sleep in separate rooms so as to avoid being tempted. They did however feel there was no need to sleep in separate rooms because of the availability of western contraceptives today even though they did not agree with the invasion and harm these cause to the body of the woman. Some advocated the use of condoms as opposed to injections and pills. Of all the TBAs that participated, only one offered traditional contraceptives.

Primrose explained that after the birth she always encouraged her patients to go to the clinic for assistance with contraceptives. She added that some of her patients prefer getting natural contraceptives from her because they believe that the ones from the clinic have chemicals that may at a later stage harm their uterus or make them infertile. Primrose explained that she uses a root called *ifindo* (direct translation is a tightly tied knot). She buys this root from the *muthi* market at Durban Station, she boils the *ifindo* root for an hour or two and then leaves it to cool down. She instructs the women to drink a spoon of this concoction in the morning. All the participant TBAs explained that they always encourage women with practices of safe sex through the usage of condoms and to test for HIV and STDs on a regular basis.

Some of the TBAs encourage the women they see during pregnancy to bring the infants once they are born so that the TBAs can check up on them. In the first three months, the infant needs to be well looked after. The navel/umbilicus of the infant takes a long time to heal. In the African culture it is believed that if it does not heal, it will cause many problems for the infant. *Ipleyti* and *umoya* (gastroenteritis) are some of the problems linked to the umbilicus. The TBAs explained that it is important to ingest *isihlambezo* during pregnancy to ensure that the umbilicus will heal fast after birth. They explained that some of the herbs in *isihlambezo* are aimed specifically at healing the umbilicus. Most of the participants prepare *ipleyti* and *umoya* concoctions. Those that prepare these concoctions shared that they use *icubudwana* (*ledebouria revolute*), *untsukumbili* (*senecio serratuloides*) and *mathunga* (*Eucomis outumnalis*) for *ipleyti*. For *umoya* they shared that they boil *itshongwe* (wild ginger), *nukani* (*octea bullata*), *isihlungu samakula* (potassium permanganate) and *ialam*. They explained that a teaspoon in the morning and at night should help the infant heal.



*“What you will see is that when the child is ingesting these concoctions for umoya or ipleyti they will pass out green stringy faeces. When you see this you know that the concoction is cleaning out the infant.” – Juliet*

Part of the duty of the TBAs is to ensure that women behave according to and respect cultural practices during their pregnancy. According to Juliet, “In our culture, there are certain restrictions that women ought to adhere to for a safe pregnancy that is safeguarded and acceptable, we have to sit the women down and educate them on these so that they do partake in things that will in the end put their pregnancy or themselves in danger”. Naidu and Nqila (2013, 130) stated that “taboos are prohibitions or restrictions imposed on certain actions or words by social custom. Taboos also serve to set persons or objects apart as sacred, prohibited, or accursed”. There are numerous taboos for women in the Bhaca community. According to Angela, pregnant women are not allowed to peep through windows or doors or stand in the doorway because the baby will do the same when it is time to give birth. Either one is inside or outside the house, or the baby will also only peep through, but refuse to come out. Women are not allowed to wear clothing with ties; this will also tie their birthing process and make it last longer. A long birthing process is tiring and can be a threat to both baby and mother. Pregnant women are also not allowed to walk at night because there are many bad spirits that may attack her and her foetus. When a woman is pregnant she is extremely weak and vulnerable to evil spirits and evil doers. Most evil happens in the dark and *ukurhesha* (being exposed to and being attacked by evil spirits) also happens at night. If, for an emergency, a pregnant woman must walk at night, she ought to take the soil on the ground that she is walking on and rub it on her belly, especially if she does not have *intambo* (string from traditional healer with powers of protection) or any other form of protection against evil spirits. It is believed that witches and evil spirits are capable of stealing the pregnancy or interfering with it (Echezona-Johnson 2016).

*“It is important to have some form of protection during pregnancy because at this time women are extremely weak and can easily become exposed to evil spirits. As a TBA you have to make sure that you protect your client and the baby that is growing inside of them, some of us are sangomas, others abathandazeli, but we each have a way of making sure that the foetus and mother are protected because pregnancy is an extremely weak moment for the foetus. Witches target this time because they know how of this weakness.” – Anne*

A pregnant Bhaca woman must not sit on rocks. A rock will cause the foetus to sit inside the stomach even when it is supposed to come out, explained Juliet. Rocks should be avoided for a successful birthing process. When waiting for an ambulance to take a woman whose labour process has started, we make that woman carry a rock on her back as it makes the baby stay inside until the ambulance comes. That is how we prevent home births while we wait for help.

*“You see Yoyo, in our culture, pregnant women and rocks should never meet. I always tell my patients not sit on or eat rocks, it does not matter how tired they are, rocks will make the baby to stay inside... It becomes a big problem for the person assisting the woman to give birth.” – Juliet*

Sleeping too much during the day will make the birthing process long and tiring because the foetus gets accustomed to the sleeping patterns of their mother. Sleeping all the time makes a lazy foetus that will make the birthing process a long and tiring one, putting both the lives of the foetus and mother at risk. Sometimes if a woman is sleeping all the time, a TBA will predict that the baby will be a boy; boys tend to be lazier than girls. TBAs always encourage women to be active during pregnancy; she should clean, collect wood and go to the river. This helps the woman to keep fit and prepares the foetus and the body for the big day, explained Victrice.

There are quite a number of practices that indicate that the social capital of the TBAs has accumulated over time. There is evidence of progression or advancement in their knowledge or the resources they share for the advancement of their careers or vocations as TBAs. Some of the information that they share, like the strong likelihood of falling pregnant shortly after the delivery, has been confirmed as true by certain scholars. Some of their practices have, however, not been verified by medical sciences.

#### **4.3 Traditional practices that TBAs have had to change or have been forced to change in the last decade**

While TBAs play a meaningful role in many traditional communities, their practices and knowledge remain questionable as they do not have formal training. The western hegemonic health care system regards methods and practices used by THPs (Traditional Health Practitioners) as backward, unsafe and unscientific. In countries where medical pluralism exists, traditional practices and medicine have become susceptible to the influence of the

hegemonic western health care system. Traditional medicine in many traditional communities is generally regarded as less efficient and more risky when compared to western medicine.

From an African feminist perspective, Peterson (1984, 35) noted that the “whereas Western feminists discuss the relative importance of feminist versus class emancipation, African discussion is between feminist emancipation versus neo-colonialism, particularly in its cultural aspect”. Wang (2011) lent credence to this argument by stating that “western medicine, taking a scientific approach in looking at efficacy, demands an efficacy with standardized and systematic scientific protocols”.

Traditional medicine is not considered scientific in nature and therefore does not meet the standards for efficacy demanded by western hegemonic medicine standards. TBAs follow and practice traditional medicine, which many in the dominant health care system want eliminated as TBAs are associated with maternal mortality due to lack of skill, equipment and qualification. TBAs may lack certain skills and facilities, like when they need to deal with excessive bleeding, but this kind of recognition negatively affects the confidence of the TBAs in their practices. Previous discussion has shown that they both collaborate with modern health care facilities in their referrals of patients and that they are afraid of doing something wrong, feeling they are ‘under the spotlight’. They do not want any casualties on their hands and prefer to take advantage of the benefits of the western medical system. Nurses and doctors also sometimes refer patients to the TBAs when they find themselves unable to explain the causes of disease but on the whole, the social identity of TBAs is not held in high esteem by the nurses and doctors.

In many third world countries, TBAs are believed to be adding to the crisis of maternal mortality because of their practices and rituals (Crowe et al. 2012; Selepe and Thomas 2000; Roost et al. 2004). As TBAs do not have formal obstetrics training, they are unable to deal with some of the complications that arise during childbirth. Maine and Rosenfield (1999) argued that in developing countries, complications of pregnancy and childbirth are still the leading cause of death and disability among women of reproductive age.

In attempts to achieve “safe motherhood”, the idea of training TBAs has been discussed on an international level so as to decrease maternal mortality rates. Falle et al. (2009) argued that the role of TBAs in improving maternal health has been heavily debated, especially in the context of a renewed focus on Millennium Development Goals (MDGs). TBAs have over the years

had to change some of their practices so as to make them safer and cleaner for mother and infant and to reduce maternal mortality. The participants in the study shared that they have had to change the way in which they offer services to women and infants during and after pregnancy.

In the following paragraph, Victrice shared that as TBAs, they have over the years had to change their practices to accommodate the changing health care framework. She explained that many factors have influenced changes in their practices, adding that the safety of the foetus and mother have become a primary concern. TBAs have had to attend workshops so that they can be educated on improved methods when assisting pregnant women. She continued that HIV/AIDS has also had an influence on their practices; TBAs have had to learn about and understand this disease not only to protect themselves, but also to educate pregnant woman on how to take better care of themselves during and after pregnancy. As TBAs, they are also now required to have certificates for when they are going to collect herbs and roots.

The TBAs stated that they are no longer allowed to assist women during the birthing process unless it is an emergency and the women are far from health care facilities. TBAs have been urged to stop assisting women as they do not have the necessary skills for a safe motherhood initiative such as cleaner and safer methods during the birthing process, recognising complications of labour and make appropriate referrals until they are trained on safer modern methods (Melhado 2012; Mobeen 2010; Jokhio, Winter and Chen 2005; Goodburn et al. 2000; Mathur 1979). The TBAs shared that even though they no longer often provide a birthing service to women unless in the case of an emergency, they have had to change their methods to make the process cleaner and safe for everyone involved.

TBAs are not only regarded in a negative light; positive impacts have also been noted that have not only protected lives, but also enhanced their social capital as TBAs. Before their workshops and training, the TBAs shared that they used herbs which were proven to be harmful to the mother and infant, they did not use gloves and would keep one razor to use for many procedures with different individuals. In the following paragraph, Sarah explained that when she used to assist women with birthing she would never wear gloves because she thought that her hands were clean. She thought gloves were only worn for protection against HIV. When she first knew about the HIV virus, she would wear plastic bags and ask someone to tie them around her arms as a preventive measure but she had little knowledge of the seriousness of the disease and how easy it was for the disease to be transferred through blood and vaginal fluids. She

explained that the plastic would tear at times and only in recent years has she learned how serious HIV/AIDS is. At the workshop there was a slogan “one pair of gloves per patient” and gloves were described as an important source of hygiene.

The “one pair of gloves per patient” slogan struck many of the TBAs and they explained that they had not previously known the importance of using gloves when assisting their patients. Sarah, Primrose, Pinky and Juliet shared that they would use their bare hands when touching and applying herbs to the vaginas of the women. Sarah claimed she would even make incisions on the pubic areas to apply herbs and muthi for protecting the foetus and mother during pregnancy. WHO’s Gender, Sexuality and Vaginal Practices (2006), (Brown and Brown 2000) and (Bagnol and Mariano 2008) study has revealed the following (often dangerous) vaginal practices: ingesting herbal medicines and aphrodisiacs (intended to affect the vagina); inserting substances into the vagina; washing, smoking, steaming (fogging) or smearing the vulva with a range of substances; making small incisions on the pubic area, on the clitoris and around the labia and rubbing herbal medicines into the incisions – ‘cutting for love’. The TBAs stated they were unaware that inserting and rubbing herbs in and outside the lips of the vagina could lead to infertility or even complications during the pregnancy. It was through the workshops that TBAs learned of these dangers.

Assisting women during the birthing process is a very personal and intimate process. In the 1970s and ’80s the TBAs shared that they did not know the importance of cleanliness: “*yes we washed our hands and bathed the infant and mother after birth, but we did not adhere to cleanliness and safe methods,*” stated Sarah. “*If soap was available we would use and if it was not available we would just wash our hands with water and continue with our job, there were no gloves or antiseptic detergents such as Dettol; back then all we had was water and our herbs. We used herbs and roots as antiseptics and for many years thought that they were best and a natural source.*” The TBAs also explained that they would use the same razor on different patients. Sarah explained that she would wash her razor after assisting each patient and then would use it again, not realising it could cause any harm. At the workshops she learned that even when a person is not infected with the HIV virus, other diseases could still be transmitted.

*“I would keep one razor for a very long time, I thought that after washing it, it was clean again. I did not know that there were diseases back then that could be transmitted from one person to*

*the next. We lacked education and sometimes I really wonder if I ever played a role in the infection of an innocent individual.”*

*“At the workshops we were taught that we cannot use the same razor on different people, once we have used a razor we need to dispose of it and take a new one especially if we will be working with a different patient.” – Primrose*

The TBAs explained that they have become advocates that encourage women to give birth at health care facilities. They stressed to their clients the importance of knowing the estimated due date of the baby, explained the importance of giving birth in a health care facility and described some of the complications that may arise from giving birth at home. The TBAs have in a way become gatekeepers for calling the ambulance when a woman is in labour. They explained that while waiting for the ambulance, they assist women with breathing techniques, calming them and at times even escorting them to the hospital for support. In the following paragraph, Sarah explained that she no longer offers the birthing process to women; instead, she has made it her personal duty to be responsible for calling the ambulance. She further explained that she encouraged all the women that consult her to give birth in health care facilities where there are trained medical personnel with lifesaving machinery.

*“Mina angisazalisi, kulama workshop esiwahambayo bayasichazela ukuthi kubalulekile ukuthi umuntu azalele esibhedlela lapho kukhona odokotela, amanesi Kanye nemishini eyakhelwe ukusiza nokusindisa impilo yomuntu makukhona imkinga evelayo. Engikwenzayo manje umuntu uma elunywa ukushayela iamulance ucingo ngisho ukuthi iphuthume izolanda umuntu odinga usizo kungekenakali.” – Sarah*

*“I have resulted in calling the ambulance, I am also one of the TBAs that refuse to assist women give birth at home unless in the case of an emergency. Even in the case of an emergency I still have to call the ambulance to come and get the patient immediately after they give birth in case of any bleeding that can follow as a result of the birth. The infant also needs to be assessed by trained personnel in case they also need emergency medical assistance. Usibonda wendawo (the chief) has also availed his resources to us such as the telephone or van should an ambulance delay. When I do not have airtime to call the ambulance I use the phone at the chief’s house, and I find that sometimes when I make the call at the chief’s house, the ambulance comes quicker than most times - maybe it is in my mind [as she laughed it off].” – Pinky*

*“I call the ambulance, I don’t want anyone dying in my hands... As much as we assist the community, not everyone appreciates what we do, when someone dies while you are assisting them through the birthing process, you become the talk of the village with some even offering explanations that you are a witch and will use the woman and child for evil experiments as imikhovu. I find that it is a safer option for a woman to give birth in a health care facility with trained health care professionals who know what to do when an emergency occurs.” – Primrose*

The advantage of giving the responsibility to the health institutions also lies in the TBAs being able to protect themselves from negative accusations of witchcraft if someone dies. The change therefore, does not come only from outsiders forcing them not to continue with their services, but is a reflection of the changes in people’s mentalities as a whole. Expertise is expected of them without mistake or compromise. Therefore, they have been forced to change practices by several factors related to the modern society. The workshops form an important bridge in knowledge which allows them to see and learn about the dangers themselves. On the one hand, it gives them an exit route and a relief from some of the pressures from communities in the unfortunate situation of loss of lives. They also learn other things in the workshops that keep their services relevant, even though the responsibility of actually assisting in the birth process is gradually changing.

*“Our practices now including counselling on HIV/AIDS and TB, when a patient comes for ukuxukuza I have to use that time to explain to them the importance of knowing their HIV status during pregnancy. I have to explain to them that if they do not know their status they are putting the life of their infant and themselves at risk. If the patient is already positive I have to encourage them to take their ARVs and go to the clinic for regular check-ups,” explained Pinky. “This is something new to us as TBAs because previously all we needed to advise on was health care, nutrition and behavior during pregnancy. We are used to assisting patients with diseases where the ancestors lead and guide the diagnosis, however, HIV is different because the ancestors are unable to diagnose it. We have to encourage each person to go to the clinic and test because some traditional healers end up diagnosing patients with lies and leading them astray.”* Scholars such as Raistler and Chon (2010), Homsy et al. (2004) and King et al. (2004) have argued that the training of TBAs can result in reducing the number of new HIV infections if they have the proper support systems. A critical observation here is that modernisation has also brought with it a new disease that the ancestors are not familiar with. Thus, there is a necessary shift in responsibility of who is to attend to HIV patients. It affects

the roles of the TBA in reproductive health since HIV is so closely tied to the reproductive health system.

At the workshops, the TBAs learned the importance of nature conservation and plant preservation. The national policy on traditional medicine and regulation of herbal medicine of 2005 was passed preventing people from picking plants and herbs without formal documentation. The TBAs explained that without a certificate that allows them to collect plants, they must buy these at the local chemists or at Durban station because collecting herbs and roots without a certificate is a criminal offense. Having to produce certificates and a limit to what can be collected is something new and restricting. Some shared that, at times, when they see important roots and plants while walking, they steal and hide them. They explained that the information that they receive on conserving plants has taught them the importance of taking care of nature and saving plants for future generations.

*“Things have changed, we never used to have certificates to collect the medicines that we use for healing people. Even now Yoyo, I am not allowed to collect the roots and herbs from across the road (as she pointed me to a green marshy area where she explained that many important plants that she used for her medicine grew) if I do not have this certificate. If anyone from the municipality, nature conservation company or even the police see me collecting roots and herbs, I have to produce a certificate as proof that I am truly indeed a registered THP with a practising number. If you do not have this certificate you can get into serious trouble.” – Juliet*

*“You see, even when you travel to a different city or town and you are carrying plants you must take your certificate with you in case the police stop you and find the plants. A taxi I was travelling in to Pietermaritzburg was once stopped and the police did a thorough check on our bags, upon finding mine they asked if I had the correct papers for travelling with these medicines and fortunately for me I had my certificate with me.” – Primrose*

Over the years, the TBAs explained that they have had to be trained thoroughly on the types of herbs they use. The TBAs explained that it is through the workshops that they have learned to distinguish harmful plants from the beneficial ones, which ingredients to leave out and which to include when preparing decoctions, especially for pregnant women. The TBAs explained that *isigidi* (mercury) is an ingredient that they would sometimes include in *isihlambezo* and *imbelekisani*, however, they learned through the workshops that *isigidi* and *ushibhoshi* (Jeyes Fluid) are very dangerous elements which can have devastating effects on the development of



the foetus. The TBAs explained that they share information with each other and educate each other; even though they do not all attend the workshops, those that do, come back and share what they have learned at the workshops. Here is another indication of how these TBAs share their social capital and how they continue to negotiate their new social identity. Moreover, it can be observed that their certification has the advantage of enhancing their social identity within the broader and wider community.

The TBAs also shared that through the workshops they have learned to measure their ingredients properly when making decoctions such as *isihlambezo*, *imbelekisani* and those for treatment of infants and STDs.

*“We have learned many safe ways of making medicines for our patients through these workshops. These workshops encompass everything from HIV to even the most basic practices that we thought were safe. I have learned how to measure my ingredients accordingly without adding too much or too little of the ingredient. I was one of the TBAs that included isigidi in my decoctions, however, after the workshops I made sure that nothing that I prepared included that ingredient anymore.” – Abby*

*“I used isigidi in many of my decoctions, however, after the information that we received at the workshops I have since excluded it as part of my ingredients. I find that the workshops are very informative and educational.” – Victrice*

#### **4.3.1 Incorporation into the modern health sector**

In line with the proposition of African feminists like Peterson (1984), Oyewumi (2002) and others, TBAs feel a sense of empowerment from policy practices that incorporate their practices into modern society. They related how they now have rights to write referral letters for patients to go to hospital: “this has given us power and made us realise that we are an important aspect within the health care sector and that our work is also regarded as important” (Dolly). Even though the TBAs felt they still needed more training, they explained they were already changing their practices to become safer. The TBAs saw this as a change in perspective on the practices that they offer; they felt that they were slowly being integrated into the broader health care framework with their practice and medicines also becoming known and accepted even if only by a few people within the western health care system.

*“I feel like I am part of something bigger now. Referring patients to clinics and hospitals makes me really feel like I am making a real change within my community. I think that this initiative will assist in mending the relationship between THPs and western medical personnel.” – Angela*

*“I am now able to refer my patients to the clinic which is something that has never happened in the past. It is not only just a piece of paper, it is a way of saying that as TBAs we also play an important part in the current health care issues. There is a belief that we can make a difference in the health care system and I also believe that, having a patient who has been seen by myself being accepted by a nurse or a doctor means that there is a potential for collaboration between them and us. We have different health care systems because they deal with only the physical and we deal with the physical and psychosocial, therefore I strongly believe that we can collaborate and work as a collective.” – Primrose*

Though some TBAs are benefitting from the municipal traditional healer workshops, some felt that these were a waste of their time and regarded the workshops as a money-making scheme for the facilitators and the municipality. They felt that if the workshops were an initiative from the government, they should not have to pay for the certificates. Some of the TBAs explained that they only just survived on the money from consultations and medicines and they were mostly the breadwinners in their families. They explained that they understood the need to train THPs to make traditional medicine safer for all; however, they did not have the means to pay for the certificates after the workshops.

#### **4.3.2 Suspicion of brain drain**

With such radical changes, a sense of suspicion was noted amongst some of the TBAs. Some felt that the workshops were a system of ‘brain draining’ the TBAs to share all their knowledge of traditional medicine for the benefit of *abelungu* (white people). The TBAs were even wary of my research when I first started talking to them. Some thought that I was an undercover agent, working for a private company that wanted to steal their practices for making profit and to steal their medicines giving them big names. They explained that they are tired of being interviewed about traditional medicine only to hear what they had shared confidentially later on radio shows without any acknowledgement. Some of the TBAs felt that the certificates are a limiting factor created to ‘deter them’ and enrich the white superiors.

*“I do not trust anyone that comes to interview me especially if they ask me about my traditional medicine practice. This is not a business for me, yes I earn money from it, but it is something that I was called to do. It buys bread and butter for my children, therefore I cannot just give away my knowledge to people who will go and make medicines to people with all the resources to make my medicine and advertise it on the radio and television without my acknowledgement or incentive.” – Sarah*

*“It gets tiring after a while, before we would get excited especially if we were being interviewed by the government officials because we always thought that they would bring change in our lives as THPs, however, we would never hear from them again. What always bothered me is the fact that we would give them the ingredients we use when preparing decoctions in confidence only to find that they want to do experiments on them to find out the usefulness of herbs and roots that we use. I think that they basically do their research through us.” – Prudence*

The reactions of these THPs is not unrealistic. As far as the ideas of modernisation and dependency theories of the modern day capitalist systems are concerned, the more developed countries always drain the resources of the less developed to their own advantage. It is not only a matter of the West plundering Africa, but also a question of the upper class or urban areas plundering the resources of the peripheral societies. This is experienced as stealing their social capital, as expressed by some of the respondents. This undermining of the social identity of these THPs and their social capital by the holders of power is one of the areas of concerns of African feminist theories as expressed by Peterson (1984) and Oyewumi (2002). Care is required to protect the well-being and source of livelihood of these THPs while policies try to support them and to better the overall health care industries. It must also be acknowledged that medical science took a long time to get to where it is today and it has also made mistakes in the past.

#### **4.4 Conclusion**

In the African community, TBAs play a meaningful role as a source of social and cultural support during pregnancy. They understand the cultural practices and belief systems followed by the women that consult them and offer a holistic approach to reproductive health care. Even though they do not have formal obstetrics training, their role in society remains an important one as they are still preferred over western health care methods. TBAs offer practices that are

guided by and based in cultural belief systems that are safeguarded by higher ancestral powers that are considered important in the worldview of many African communities. All the practices that they offer to pregnant women are learned through social networks and are guided by ancestors. These cultural practices and beliefs play a vital role in the beliefs and lives of the pregnant women as they offer assistance and guidance that other forms of health care are unable to.

## **CHAPTER FIVE: Traditional birth attendants' response to the attitudes and views of peri-urban women regarding their services**

### **5.1 Introduction**

This chapter begins by discussing traditional birth attendants' responses to African women who appear to be resistant to their traditional practices. The chapter works through the life histories of the TBAs to gain insight into their responses. The chapter also considers the understanding and meaning of pregnancy and the health seeking behaviour of the 15 research participants during their pregnancies.

Health seeking behaviour among pregnant women is often guided by cultural beliefs and practices. Even though pregnancy is viewed as a biological phenomenon by the western hegemonic health care system, traditional health care methods view it as a natural phenomenon that is interconnected with the spiritual world. Pregnancy is viewed as a biological phenomenon in western healthcare as they only focus on the development of the fetus. Their practices neglect the pregnant woman who is often viewed as an incubator for what is growing inside of her. This is the opposite for traditional healthcare systems as they offer a holistic approach to pregnancy, the pregnant woman is not isolated to the pregnancy. According to Hoban (2007, 425), "there are two dominant and divergent paradigms that inform the discourse on childbirth. The biomedical treats pregnancy and childbirth as an illness, requiring technological management by skilled professionals in formal medical facilities. In contrast, where medical pluralism exists, pregnancy, childbirth and the post-parturition period are seen as natural".

### **5.2 The perceptions and attitudes of African women towards the practices and rituals offered by TBAs**

Consideration of health seeking behaviour among the participants illustrated the complexity of the health care system in the community of uMzimkhulu. In such communities, the treatment, cause of illness and the healing system are clearly interconnected. Several common themes emerged from the data analysis and provided insight into women's choices of health care systems during pregnancy. These themes are described in this chapter. The data reflects considerable diversity in the health seeking behaviour of the women during pregnancy. Women's health seeking autonomy may be influenced by many factors such as cultural beliefs, education, work status and religion. Similarly, choosing to give birth at home is influenced by

personal preferences, family belief systems and structures, health related issues, social and cultural norms. In patriarchal societies, however, women do not have the choice or control over the type of health care system they will use during their pregnancy and childbirth. Giving birth at home is associated with risk factors that may lead to death; however, many women still prefer home deliveries over health care facilities. During pregnancy, women are faced with deciding on a health care system that will best suit both their needs and belief systems. Behaving according to cultural beliefs during pregnancy is important and in every community and culture, there are certain rituals and practices important for the protection of the mother and foetus. With changing times, medical pluralisms have come to exist with the western hegemonic health care system retaining dominance. Women have, over the years, had to choose either one or both health care systems.

For Thandeka, Thuli, Thandiswa, Thandah and Thobeka (pseudonyms for some of the participants in this research), traditional views, practices and beliefs have prevailed. These women reside in the rural areas of uMzimkhulu. They have never left uMzimkhulu or lived in bigger cities and have worked as domestic workers for teachers and nurses in the small town. The most educated dropped out of school in grade nine and none seemed to regard education as important. Their communities still believe strongly in the importance of TBAs and the practices that they offer to women in general, but most importantly during pregnancy. All five had been assisted by TBAs with all their pregnancies and two of the five women had given birth at home with the assistance of a TBA. For them, visiting a TBA was more important than their monthly visits to the clinic and they all believed that TBAs played a meaningful role during pregnancies. The TBA practices are interwoven with their own beliefs and practices making the women feel comfortable to communicate their concerns with the TBAs without the fear of being judged.

The worldview of this rural community involves cultural beliefs and practices during pregnancy; these practices are believed to play an important role in protecting the mother and foetus for the duration of the pregnancy, and they also play a role in the development of the foetus. During their pregnancies, the participants shared that they visited TBAs for protection against evil spirits. Thobeka explained that she visited a TBA for all three of her pregnancies for the sole purpose of protecting her foetus from *abathakathi* and *imimoya emibi* (witches and evil spirits). Her TBA gave her an *intambo yasesinqeni* (string with protective powers) to wear around her waist. She was also provided with *amafutha enja yolwandle* (seal oil) to apply to

her belly every day especially on days when she would be going to family or community gatherings. The belief in this community is that pregnancy is a very vulnerable period for women making them susceptible to evil spirits and easy targets for witches. In this community, a pregnant woman ought to limit attending weddings, funerals or parties as it is believed that some people have evil and negative energies that may taint or even harm the foetus. This understanding of the TBAs amongst the community members is an example of the influence and impact of social identity. Believing in TBAs enabled women to collectively share their ideas and even to maintain their traditional health related identities.

Thuli shared that she too made use of the services of a TBA with her two pregnancies. The TBA provided her with *isiwasho* (water that has been prayed over) to drink, bath and breathe in the steam. Thandiswa explained that she did not attend the clinic during her first pregnancy because she believed that the services of the TBA were more important. To protect her foetus, she was given *intambo* to wear around her waist and Vaseline mixed with *impepho*, to apply to her belly every day. These are important practices in this community; if a woman does not follow these practices, it is believed that she may lose her foetus which is not strong enough to fight off bad spirits. The TBAs explained that during the pregnancy *umfati omitsi kufuneka aqine angatsambi* (meaning a pregnant woman should be strong and not weak). Being strong, according to the TBAs, depends on the use of medicine to protect against evil spirits. Some of the women in this study did seek some form of antenatal care but it seemed of little importance to them. This was a worrying trend as ANC can help with finding problems and can even save the lives of both the woman and foetus. ANC improves the survival and health of babies, reducing the number stillbirths and neonatal deaths and indirectly by providing an entry point for health contacts with the woman at a key point in the continuum of care (Kisuule et al. 2013; Titaley et al. 2010; Lincetto et al. 2010; Raatikainen, Heiskanen and Heinonen 2007). Some women visited the clinic in the second trimester only when they were worried. They had no understanding of the importance of participating in ANC in the first trimester of pregnancy. Some shared that they feared having blood tests and taking an HIV test; this appeared to keep many away from the clinics. They seemed to prefer TBAs as they could then avoid these tests. This finding means that maternal education is important during pregnancy. Authors such as Elmusharaf, Byrn and O'Donovan (2015) and Bender and McCann (2000) recommended integrational learning during pregnancy as they believed it would improve appropriate selected health behaviours. Caldwell (1979) argued that higher levels of maternal education result in a reduced sense of fatalism in the face of children's ill health. In addition, the women expressed

that they found being assisted by male nurses and doctors very worrying and this made them uncomfortable. In the African culture, it is taboo for a man who is not your husband or boyfriend to touch or see your private parts. The body is a sacred and personal possession; only those trusted are allowed to see and touch one's body or this can feel like a violation. Generally, the genital and pelvic examination leads to the greatest sense of vulnerability.

*“Kunzima ukuba nqunu ngisho phambi kwabomama laba ababelethisayo, ngiye ngibone kunzima kakhulu uma sekuzomele ngikhulule ngibuye ngithintwe umuntu wesilisa engingamazi. Umzimba awukhululeki kanti kwamina ke angikhululeki, ikona engiye ngibone ukuthi kuyangixosha emtholampilo loku.*

*“I find it extremely uncomfortable undressing and being touched in my private parts by a TBA, it becomes an even greater challenge being assisted by a male nurse or doctor because it feels like a violation of my body.” – Ammy*

### **5.2.1 Concoctions during pregnancy**

Few studies have focused on the specific ingredients and preparation of *isihlambezo*. Concoctions during pregnancy are believed to play a vital role as a preventative health tonic providing the foetus with important vitamins and calcium. The research participants all believed that women who do not ingest *isihlambezo* during pregnancy become prone to complications during the birthing process. The participants also believed that the foetus does not develop well without *isihlambezo*. One of the participants shared that her cousin who had not taken *isihlambezo* during pregnancy experienced a very long and strenuous labour process and gave birth to a weak infant. Studies carried out by Adams et al. (2009) and Band et al. (2007) found that women use complementary and alternative medicine for relief of stress and pregnancy related complications, as prevention of labour and for the general health benefits during pregnancy. Makoae (2000, 36) added that “herbal medicines serve different purposes such as treating abdominal pain, preventing abortions, ensuring safe pregnancy, keeping the foetus slim, making the pregnant women strong, enlarging the birth canal and enhancing stronger contractions during labour”.

*“Kumele ngisisebenzise isihlambezo uma ngikhulelwe, sibalulekile ngoba sisiza mina kanye nengane. Ngiye ngizwe umehluko umangisebenzisa isihlambezo emzimbeni wami angibi naso isibhocobhoco nokukhathala kanti futhi nesisu ngiye ngizwe silula singangesindi nengane ngiye ngizwe idlala ngaphakathi esiswini.*



*“I have to use isihlambezo during pregnancy because I find it to be most helpful to me and the baby growing inside me. I always feel a difference when I start using isihlambezo as my whole body feels different, I do not get tired as often and the foetus moves around making me aware that they are well and healthy.” – Thanda*

*“Isihlambezo sixebula umtwana anganamatheli esiswini. Ukunamathela kwengane esiswini kwenza ukuthi kube nzima uma usuyoteta. Mina ngibona kubalulekile ukuthi ngisebenzise Isihlambezo ukuze ngingabi nazo izinkinga umasengiyozala.*

*“Isihlambezo prevents the foetus from sticking to the womb of the pregnant woman. If the foetus is stuck onto the womb it makes the birthing process difficult for the woman. I use it so that I do not encounter problems during the birthing process.” – Thobeka*

*“Isihlambezo siyikhambi, senziwa ngamakhambi wesintu, mina ngiye ngibone kungcono uma ngisebenzisa imithi yemvelo kunamaphilisi wasemtholampilo engingazi ukuthi akhandwa kanjani. Angazi kungani emitholampilo bengasisebenzisi isihlambezo ngoba phela thina abantu abasisebenzisayo siyawuzwa umehluko owenzekayo kithi. Mina sangisiza Isihlambezo ingane yami ingadlali, kodwa ngathi sengiqala ukusebenzisa Isihlambezo ngezwa isidlala.*

*“Isihlambezo is a natural concoction prepared using natural traditional medicines. I find that I prefer the use of isihlambezo as opposed to the pills that I get from the clinic because I have no idea how they have been made. I do not understand why the staff at the clinic have a problem with isihlambezo because as an individual who uses it, I find that it makes a big difference. Isihlambezo helped me when my foetus was not moving, but it started moving as soon as I started on isihlambezo.” – Thandiswa*

A study carried out by Adams et al. (2009) found that most users of alternative and traditional medicine regarded these medicines as more natural, safe, or having at least of equal efficacy when compared with medical prescriptions for pregnancy. The respondents in this study voiced the same opinion, sharing that it is in fact the pills from the clinic that they do not trust as they do not know how they have been prepared. It emerged that the participants feared the idea of going to hospital. Thandeka, Thuli and Thandiswa specifically expressed their fear of being taken to theatre for a caesarean section. They expressed that all the practices that the TBAs offer are natural including the birthing process; hence they are the preference.

### **5.3 Giving birth at home and TBAs' approach to handling delivery challenges**

Thuli explained that the TBAs have their own methods of making pregnant women feel safe and to handle complications. When Thuli's child refused to come out during the birthing process, her TBA spoke to her ancestors and the child was delivered safely: "This situation would have been handled by taking me to theatre if I was at a health care facility; they like theatre those people". The findings established that for some of these women, giving birth at home was a common cultural practice which they felt was important; something bad could happen to them if they birthed their babies in a foreign place such as a health care facility. Birthing at home allowed these women to observe cultural practices before, during and after birth which they would not be able to perform in any other environment. The women felt that giving birth at home surrounded by their families and ancestors made the birthing process special and blessed by those that have passed on as they are called upon to guide and protect the entire procedure.

It is important to note that people from traditional societies are more spiritually inclined and their understanding of difficulties is intrinsically spiritual. This explains why spiritual approaches are required to handle birth difficulties; confronted by the same challenges, the hospital staff opt for a caesarean operation. The African feminists would advocate for the respect of women's values; these are unique to rural woman and include cultural beliefs. Cultural practices are not always brutish and backward as modernist or imperialist views would suggest. They are alternative approaches. Medical science with all its sophistication continues to grow; errors occur in both traditional practices and modern medicine (Peterson 1984; MsAfropolitan 2012).

Giving birth at home enables the participants to keep their placentas. Placentas are in an important part of the birthing process as they have been the home of the foetus for nine months. In the research community, the belief is that the placenta is an important symbol that needs to be buried in the cow kraal so as to lay claim for the child who is now officially part of the home. The participants shared that giving birth at the hospital deprives them of this opportunity as they do not know what happens to their placentas. One of the participants felt that the youth of today can be considered as a lost generation because cultural practices have been forgotten; an example is the throwing away of placentas. She further claimed that the ancestors are not happy with the manner in which the practices have changed to adapt to modern practices.

A study carried out by Dwivedi (1997) found that the western model of health care did not sit well with traditional local customs and rituals. Findings established that participants preferred natural births in the comfort of their own homes referred to as a natural setting. Coxon (2013) argued that women associate different risks with different settings for birth. Women who prefer home births are usually described as being concerned about risks imposed on 'natural' birth in a hospital and by separation from their families.

*“Ngike ngizwe isitori ezisabisayo ngabantu abaya e theatre beyohlinzwa, abanye bakhala ngobuhlungu, abanye bathi kuyazwakala uma usikwa noma usuthungwa abanye bajova kaningi emgogodlo futhi kanti abanye bathi odokotela bake bakhohle izinto ngaphakathi kwabo kumele baphinde bayosikwa futhi.”*

*“I have heard many frightening stories from people who had been to theatre for a caesarean. People have shared that they could feel as they were being cut, others explained complained about the number of injections that they got in the backs, while others complained of hospital instruments being left inside their stomachs.” – Thandeka*

*“Ngikhetha ukuya komama ababelethisayo ngoba banginika umgcansi wami khona uzokwembelwa esibayeni, kuyisiko kithi ukuthi umgcantsi wembelwe. Loku kwakwenziwa obabomkhulu nathi silandela ezinyaweni zabo.”*

*“I choose TBAs because they give me my placenta, it is important in my culture to bury the cord at home. It is a practice that my ancestors do and we are following in those footsteps.” – Thobeka*

Duru (2015) claimed that a human being is a product of his experience, beliefs system, and religion. The implication is that it is impossible to detach people from their cultural practices that are entrenched in belief systems that have persisted over centuries. TBAs are part of people's culture. The participants shared their appreciation for the depth of cultural knowledge of TBAs and expressed that the TBAs were culturally sensitive to their needs, as opposed to the nurses who often shouted at them. Any attempt to break away from the culture or which does not respect culture can be perceived as a threat, imperialistic and paternalistic. This is one possible perception highlighted by respondents of how TBAs and women from the rural societies view the clinics and health care practitioners in the hospitals.

*Ukuxukuza* is an ancient practice that has been practised in traditional communities for many years. The participants shared that they believed that *ukuxukuza* was an important practice during pregnancy as the TBA is able to feel the position of the foetus. With dry hands, the TBAs feel for the head and buttocks of the foetus in an attempt to establish the position of the foetus and estimate the month of delivery. The participants appreciated how the TBAs handled and communicated with them about the changes occurring in their bodies. “The TBAs were tender, friendly and patient,” explained one of the participants. Thus participants felt closer and more comfortable with the practices of the TBAs as opposed to the nurses at the hospital who were described as impatient, rude and unfriendly.

*“Ngixukuza kumama obelethisaya, ngikhetha yena kunoma ngiye esibhedlela noma emtholampilo. Unesineke futhi wenza kube lula ukuthi ngikhulume naye ngibuye ngibuze imibuzo ngoba ukhululekile kanti emtholampilo sifika onesi bengenaso isikhathi kanti futhi abakhululekile kunzima ngisho ukubuza imibuzo.”*

*“I have my exam done by a TBA, I choose a TBA instead of a clinic because they are very patient with us pregnant women and that makes communication easier with them. I find it easy to talk to the TBA even when I have a personal question that I would find intimidating to ask if it were a nurse or doctor because of their attitude.” – Thuli*

Effective communication between the health care provider and patient is central to the success and effectiveness of a functional health care system. It also creates a bond between the provider and the patient building trust which in turn makes the ability to gather information from the patient easy. When patients feel comfortable with a health care provider they find it easier to talk to them, making the diagnosis process for the provider easier and in most cases more accurate (Fong Ha and Longnecker, 2010; O’Daniel and Rosenstien, 2008; Dingley et al., 2008).

The participants preferred the assistance of TBAs as opposed to medically trained personnel because of the different kinds of communication. They found that communicating with a TBA was easier because TBAs made the participants feel comfortable and made the communication process easier. The presence of TBAs was experienced as calming in contrast to that of nurses and doctors. It emerged that the participants felt closer to TBAs as they were respected members of the community who understood their language and cultural practices. Imogie, Agwubike and Aluko (2002, 98) found that the participating pregnant women in their study

preferred the assistance of TBAs because they were “near to the grassroots; they use familiar language; they are rated/regarded as more efficacious, thus more confidence in them”.

Similarly, a study by Sialubanje et al. (2015) found that women preferred the services of the TBA as opposed to health care facilities as women found TBAs trustworthy and easily accessible as they are based within their communities. In the following paragraph Thandeka explain that she did not like going to the clinic because of the attitudes of the nurses and doctors. She explained that the women get treated as if they are not human or as if their presence is an annoyance to the providers. Their attitude towards us as patients makes it difficult for us to describe our problems and illnesses because we fear they may shout at us or mock us. She explained that during her pregnancy she contracted an STI and decided to go to the clinic for assistance. When she told the nurse about her condition, she asked Thandeka why she was having unprotected sex with multiple partners. This reply made Thandeka angry and she decided that she would never go back to the clinic, but would continue with the services offered by the TBAs who were very understanding, treated their patients with respect, and advised in a way that felt as if one was talking to one’s best friend.

Okafor et al. (2014, 45) claimed that “traditional birth attendants receive a remarkable level of patronage from pregnant women as they are perceived to be more compassionate than orthodox health workers and provide other services deeply rooted in culture which are not available in the orthodox health centres”.

Thuli explained that she did not see the importance of going to the clinic because she got *isihlambezo* and *ukuxukuza* from the TBAs and what she appreciated about the TBAs is that they did not take blood as with the ANC tests carried out at the clinics. She also explained that the nurses at the clinic gossip about them and call them names, especially the ones that are renting rooms within the community.

*“Ukuba bekuya nagmi mina ngabe angiyi emtholampilo, ngabe nje ngiziyela kubo bona labomama ababelethisayo. Angisiboni mina nesidingo sokuthi ngiye emtholampilo ngoba ngiyaxukuza ngibuye ngithole nesihlambezo komama, ngiyabathanda futhi bona ngoba abalidonsi negazi. Okunye okungixoshayo emtholampilo walapha ukuthi akuve ezikhuluma nomphakathi izinkinga zethu labo nesi.” – Thuli*

It emerged that the participants felt that nurses regarded themselves as educated individuals who were better than the rest of the community. They expected to be treated differently to the

rest of the community and as a result, have become unapproachable people who are representatives of the western health care system. This imperialist attitude from hospital staff elicits resistance from the local community members who need medical assistance for their pregnancies. It also creates an atmosphere of distrust.

The data shows that it is a daunting process for community members to attend clinics and to feel comfortable enough to disclose their illnesses to the nurses. In the following paragraph, Thuli explained that the nurses in their community claimed they were better than others because they had an education. They forgot they were representatives of the clinics and they made it difficult for community members to attend the clinics and confide in them. Thuli felt that to the nurses and doctors, all that was important was the number of patients seen in a day and not the quality of service. Thuli described how one day she went home not sure how she was she was supposed to take her pregnancy vitamins; when she asked the nurses she was told to read and she would know. Attitudes and behaviours of maternal health care providers influence health care seeking and quality of care see (Mannava et al., 2015). The participants shared that when the nurses asked them if they used alternative medicines, none would admit to using alternative medicines, fearing the nurses' attitudes. A study carried out by Band et al. (2007, 125) showed that women were afraid of sharing with nurses or doctors that they were using alternative medicines and women felt that "admitting to seeing a traditional healer would negatively impact their antenatal care".

*"Ngoba befundile bavele babone ukuthi izulu nomhlaba konke kungokwabo, okuseqinisweni nje ukuthi amanesi azibona engcono kunathi, siyawesaba futhi siyawenqena ngoba aziphakamisile kanti futhi nendlela abasipathangayo thina zigulani ayigculisi. Kwenye inkathi ugoduka ungazi ukuthi isigulo sakho yini ngoba abanandaba nokuthi uchazekile kahle noma cha, kubona okubalulekile ukuthi benyuse amanani wabantu abababonayo ngosuku noma ngabe labobantu abagculisekanga ngosizo abalutholile. Kwenye inkathi ngathi ngibuza ukuthi amaphilisi wokukhulelwa ngiwadle kanjani wangitshela ukuthi angifunde ukufunda ngoba kubhaliwe ukuthi adliwa kanjani."* – Thuli

*"Because the nurses are educated they think that they are better than everyone else, this makes us see them in a different light as educated people who we are unable to relate with. I also have a problem with the manner in which they treat us as patients, sometimes you go home not even sure what illness you have because some do not even bother to explain the disease to you. I think the most important thing to them is to increase the number of patients that they see and*

*not the quality of work that they offer to their patients. One time I asked how to take my pregnancy vitamins and the nurse who was assisting me said I should learn to read because the packet states how many pills should be taken in a day.” – Thuli*

*“Siyasaba ukusho uma sisebenzisa imithi yesintu ngoba siyazi ukuthi sizothethiswa futhi nendlela esizophatheka ngayo ingashintsha. Uma uke wavuma ukusebenzisa imithi uthethiswa ungena egunjini okuhlolwa kulona uze ube uyaphuma futhi, noma ke sebekuhlola futhi konke okungahambikahle ngawe ngabe ushukela ukhuphukile or iCD4 count yakho nayo yenyukile noma iBP konke kuye kuthiwe ingoba usebenzisa imithi yesintu. Ingako siye sikhethe ukuthi singasho uma besibuza.”*

*“We are scared of admitting to alternative health care systems because we will receive poor attitude and assistance from the hospital staff. They shout at you from the minute you enter the consultation room until you leave... whether your diabetes, CD4 count or BP is not as it is supposed to be it is because you use traditional medicine.” – Thandiswa*

Inherent in the attitudes of the nursing staff was a bias and prejudice about the cause of sickness, and often they did not actually conduct tests to ascertain causes. This is not good health care. Participants felt comfortable in the presence of the TBAs who were respected and trusted members of the community; the TBAs lived in the same communities and understood the language and cultural beliefs of the participants and this created trust and a special bond. The women explained that they felt safe with and could trust the TBAs. For these women, respecting their cultural practices during their pregnancies meant fulfilment of their cultural beliefs and a feeling that their pregnancies were protected by the ancestors. Culture is an important part of one’s social identity which must be recognised and respected to ensure a person’s autonomy and dignity. Vilifying the cultural practices of these pregnant women prevents these women from trusting western medical help, despite its potentials.

Health seeking for these women is influenced by their families, communities and the belief systems that they were brought up with. Family members encourage pregnant women to seek the assistance of the TBAs. Families have an effect on health seeking behaviour; in the worldview of the families of these women, the services offered by TBAs were fundamental and culturally acceptable. Musoke et al. (2014) and Al-Mandhari et al. (2009) carried out studies which showed the influence that family members had on the health seeking choices of their loved ones. Usually it is the elders within the families that have the greatest influence on

the type of health care service participants chose during pregnancy. The participants explained that the elders have the knowledge and right to advise them on health care systems that they feel will best suit them and their pregnancies. In the following paragraph, Thandiswa explained that in their home, all pregnant women were encouraged to seek the services of TBAs. Their first visit is always to a TBA rather than the clinic as clinics do not offer, for example, the protection of the foetus from evil spirits.

TBAs are part of their communities and they are familiar with the beliefs and practices within the community. Even though western medicine has become hegemonic and is generally considered to be a safer option, some women still prefer traditional medicine as it is culturally relevant to them. According to Meissner (2009, 4), “the modern health care system has several shortcomings. Apart from a general shortage of personnel, there are wide geographical discrepancies in the access to health care facilities. Furthermore, modern services are often not affordable and/or culturally irrelevant and ill-suited to handle the range of illnesses occurring in the African population”.

*“Sonke ekhaya umasizithwele siyaye siqale komama ababelethisayo ngaphambi kokuthi siye emtholampilo. Umthetho nje wasekhaya uthi uma sikhulelwe siqala ngesintu kuqala sigcine ngabelungu, kuningi esikutholayo kubabelethisi besintu esingakutholi emtholampilo. Labo mama bahlala nathi lana emakhya futhi bayayiqonda imithetho kanye nenkolelo zethu, abayibukeli phantsi inkolo yethu ngoba vele nabo basebenza ngayo. Ugogo uyaye asiqugquzele ukuthi sihambe bona ababelethisi laba khona sizokwazi nokuthi sithole izinto ezizosivikela zibuye zivikele nezingane zethu kulabantu abangasifiseli abanye abantu okuhle.”*  
– Thandiswa

Thanda explained that in her community there is a saying “*isala kutshelwa sibona ngomopho*” meaning those who do not listen and who do not want to be told are seen by injuries. She explained that it was important to listen to the elders, especially with regard to health and during pregnancy which is a vulnerable period. She believed that if one did not listen to one’s elders, one could be cursed with the ancestors turning their backs on one.

*“Kubalulekile ukulalela abantu abadala ngoba sebeyihambile lendlela kanti futhi nolwazi lwabo lunzulu lundlula olwethu ikakhulukazi uma besiyala ngezinto ezphathelene nempilo Kanye nokuzithwala ngoba kubayisikhathi esinzima lesi empilweni yowesifazane. Angifuni mina ukungalaleli abantu abadala uma bengitshela futhi bengibonisa ngesimo engibhekene*



*naso ngoba uma sekungahambi kahle ngiyobuye ngiye kubona futhi bangitshela ukuthi babengiyalile ngangalalela. Kunesisho ngakithi esithi isala kutshelwa sibona ngomopho. Ngikholelwa ukuthi uma ungabalaleli abadala uba nebadi kanti namadlozi ayakuflathela.” – Thanda*

The five participants were at the time of the interviews unemployed and depended on the government child support grant. They all lived in big families where their child support money contributed to school fees and monthly groceries and very little was left for care of their children. It costs a taxi fare to get to the nearest clinic and they felt it would be easier if the clinic was within walking distance. It emerged that the participants preferred the TBAs not only for cultural reasons (easy communication and traditional practices attracted women to the TBAs) but also for economic reasons (even if clinic services were free it still cost money to travel there). They also had to buy food as the lines at the clinics were long and it usually took all day until they were seen by the nurses. Even though they had to pay the TBAs with something after the consultation, they usually did not have to travel far and they also felt the TBAs were very understanding and allowed them to pay whatever they could afford and would at times consult for free.

*“Thina asinawo umtholampilo lapha esgodini sethu, kumele sigibele izimoto siye emtholampilo okwesinye isigodi. Inkinga ebuye ibekhona ukuthi asinayo imali yokugibela umasesiya kulomtholampilo ngoba siziphilela ngemali yeqolo efana nokuthi ayikho ngoba ekhaya sibaningi futhi akekho umuntu osebenzayo sonke sithola lemali sithenge ukudla, sikhokhele izimoto ezihambisa izingane esikolweni sibuye sithenge izimpahla zezingane. Ingako sibuye singayi emtholampilo ngoba kukude kanti futhi asinayo imali yokugibela siyekhona.”*

*“We do not have a clinic in our area we have to go to a neighbouring area to access a health care facility. The problem we face is that we do not have enough transport money sometimes, I come from a big family and all of us depend on the child grant support money which is not enough to cover everything within the household. We use this money to buy food, pay transport money for the children to get to school and buy clothes for the children. Having to pay R40 just to get to a health care facility makes it difficult on us and that is why we end up using alternative health care services.” – Thuli*

*“Kumele ngilinde kuze kuphume imali yeqolo ukuze ngikwazi ukuya emtholampilo kwaBhala, okanye ngihambe ngiyiboleka imali. Ingako ngibuye ngingayi emtholampilo ngoba kumele kubekhona imali engibuye ngingazi ukuthi ngizayikhokha ngani... ngiyaye ngikhethe ukuthi ngiye komama ababelethisayo ngoba nabo bayasisiza phela ayikho into abangayenzi umasikhulelwe ngisho noma ngabe unesifo socansi bayakwazi ukuthi bakusize. Mina ke futhi ngikholelwa ukusizwa yibaona kunoma ngiye emtholampilo.”*

*“I have to wait for the child grant support or borrow money from neighbours to be able to go to the health care facility kwBhala. This is the reason why I sometimes do not attend my monthly clinic visits during pregnancy because at times I do not know where the money will come from. I attend the TBAs instead because they are also able to assist pregnant people with their knowledge even if you have an STD they are able to assist. In any case I personally prefer the assistance of a TBA during my pregnancies.” – Thanda*

Sibusie, Yolanda, Londeka, Lungelwa and Ammy reside in the small village town of uMzimkhulu. They were born and raised in the surrounding rural areas of uMzimkhulu and moved to the village in their high school years. All these women had matriculated and were currently working at some of the retail shops as cashiers or packers. They all understood the importance of ANC during the first trimester. Their understanding was that as soon as they tested positive for pregnancy, they had to seek assistance from a health care facility or any other form of alternative health care system to check on the development of the foetus as well as to avoid complications. When asked how they came to understand the importance of ANC during the early stages of pregnancy, they explained that they learned through reading, life orientation classes at school, the radio and general knowledge of knowing that pregnancy is an important period that needs to be guided by some form of medical care.

The participants admitted to medical pluralism during their pregnancies; they held onto their cultural beliefs as well as participated in ANC. Medical pluralism involves the use of more than one medical system. Chhaya (2009) stated that the complex interplay between patient centeredness and empowerment, health economics, failure of the biomedical approach and many other factors has resulted in an increasing prevalence of medical pluralism. The participants shared that they used both conventional and alternative medicine during their pregnancies; however, thoughts differed as to which system was the first preference and the reasons for the preferences. Ammy explained that they use parallel health care systems as they did not know which one works best: they take calcium to assist in the development in the bones

of the foetus and *isihlambezo* to assist the foetus to move around and not stick to the womb. The herbs in traditional medicine were important to them; however, they felt that traditional medicine left a gap that needed to be filled by western medicine.

The women explained that they felt that as much as traditional medicine was an important aspect within the health care system, it had shortcomings. They felt that traditional medicine lacked what they thought were very important aspects such as the treatment of infections after the birthing process, bleeding, high blood pressure and diabetes. Also, the participants shared that even though the traditional birth attendants in their areas consulted with and assisted children when they are sick, they did not offer services such as immunisation. For these reasons, some of the participants felt that using both the traditional and western health care systems was necessary.

*“Sishaya ngapha nangapha asazi okuphi okusebenza ukudlula okunye. Icalcium ngapha ukuze siqinise amathambo engane kanye nesihlambezo ngapha ukuze ingane inganamatheli esiswini.”*

*“We use both health care systems because we do not know which one works best.” – Sibusie*

Makoae (2010) used data from several studies conducted in Lesotho to show that women do not consider the traditional health care and modern health care system as mutually exclusive. If encouraged, they will participate in ANC in health care facilities, but once back in the village they seek advice and care from the TBAs. This behaviour is largely due to the cultural and bio-social context of the birth process. The participants shared that they believed that the clinic medication was important because it assisted with the healthy development of the foetus: *“we still believe that the natural herbs and roots included in isihlambezo also play an important role in the development and the prevention of the foetus sticking to the womb and not being free to move and stretch.” – Thandeka*

Sbusie, Yolanda and Londeka all expressed their dissatisfaction with the conventional health care system for its inability to protect them from evil spirits and for not conforming with their cultural views; however, they understood the importance of health care facilities during pregnancy too. It emerged that the women preferred both health care systems as both played a vital role in the protection and development of the foetus and mother. Chhaya (2009) argued that the reality in South Africa is that health care is provided by both western and traditional health care providers with a great reliance on traditional medicine especially in rural

communities. The participants were aware of the potential risks and harms associated with traditional medicine, but felt that traditional medicine was part of their culture and essential for uneventful pregnancies guided by the ancestors.

The choice of health care seemed to be motivated by friends, families and work colleagues. People who had previously been pregnant seemed to have a bigger impression on the decisions taken by the women in their health seeking journey during pregnancy. In every society, social networks such as family, friends and peers influence the health-seeking behaviours of people around them. Social influences play a significant role in the health-seeking process; once diagnosed, patients source information from people around them to make decisions. This significant influence depends on the relationship between patients and social networks or the level of trust, support and sense of comfort (Low, Tong and Low, 2015).

*“My mother explained to me that it is important to attend both the clinic and TBAs. She said that both would complement each other because I had shared with her that I was not sure about attending a TBA in my second pregnancy. She persuaded me by stating that attending the TBAs offered women protection from evil spirits and witches which the medicines from the clinic are not able to. As I wanted to protect my child in the best possible way I decided to attend the TBA.” – Ammy*

The participants visited the TBAs because they felt that they would make a big difference during their pregnancies. Even though the service and pills from the clinic assisted in the development and growth of the foetus, some of the participants still felt a sense of cultural obligation during their pregnancies. Protection against sorcery and other forms of evil spirits was a common cause for women to seek the assistance of TBAs. A study by Dako-Gyeke et al. (2013) found that many women feel this spiritual susceptibility. They believe spiritual attacks manifest first in the supernatural and then in the physical. Consequently, miscarriage and other maternity complications can be physical manifestations of such spiritual attacks. The belief among the participants was that witchcraft was something real and pregnant women are considered to be particularly vulnerable to evil spirits. The views of the women, however, differed as to the motives behind visiting TBAs during pregnancy; some of the women wanted the ‘full package’ including *isihlambezo*, *imbelekisani*, protection against evil spirits and *ukuxukuza* while others only required the TBAs to assist them with the protection of their unborn babies during pregnancy. Those who only required the TBAs to assist during birth

believed that the medication from the health care facilities was enough and they would not use alternative complementary medicine as they felt that it may not be safe.

*“I believe that the medication that we are given at the clinic is enough to assist with the development of my baby. Where the clinic fails is assisting me to protect my baby from evil spirits and witches. I have to find other methods that will keep me baby protected until birth.”*

– Lungelwa

*“I was dating a married man whose wife was failing to give him children, I don't know whether she was barren or what was happening with her, you know these educated people do not want to fall pregnant. Anyways, when she heard I was pregnant with her husband's child she called and threatened to kill me and the baby and to stay away from her husband. How can I stay away from him when we were having a child together is what I asked her. She told me that she did not care what I did as long as I kept my distance from her husband... After a couple of weeks I started having these constant dreams that I was having a miscarriage or I would dream of a woman that I did not know forcing me to drink something from a dirty cup. A friend of mine suggested that I seek the assistance of a TBA to assist me protect myself and my baby. The TBA assisted me with a string that I had to wear around my waist, muthi that I had to sprinkle all around the room that I slept in and medicine to apply on my belly every day until I gave birth. After this I never had the dreams again and my baby was born without any complications, I tell this story to anyone who doubts the power of the TBAs and the practices that they offer.”* – Yolanda

The use of traditional medicine among other participants was motivated by the opinion that herbs and roots were natural. The belief was that natural medicine was better than the pills from the clinic because they may have chemicals that may affect the growth and development of the foetus. Other factors that pushed some of the participants away from the health care facilities were the injections and blood tests; the women claimed they were afraid to go to health care facilities during pregnancy as HIV testing and counselling was now compulsory. Londeka, Lungelwa and Ammy shared that they did not go to the clinic until they were five months pregnant because they were scared of being tested for HIV and diabetes, even though they understood the importance of ANC in the first trimester and of being tested. In support of this, a study by Okafor et al. (2014) found that the main reason for non-attendance of ANC is that women don't like taking drugs or injections.

*“I couldn’t bring myself to go to the facility because I was scared to get tested for HIV and diabetes. I have seen people who are sick from these diseases and I do not want to have them, I do not even want to test to know if I have them as I feel that knowing will kill me even more. I know it is important to get tested when you are pregnant so that you can protect and prevent your child from contracting the illness, however I was just scared. I ended up attending the health care facility when I was five months pregnant and the only reason why I attended was that my mother forced me to go so that I will be able to protect the baby otherwise I do not know when I would have gone. I tested negative and promised myself to have my partner come and test and to also use condoms so as to minimise my chances of becoming infected.” – Londeka*

*“I just did not want to go, I was scared because if I found out I was positive I do not know what I would have done with my life. What I feared the most was the fact that I knew that my husband loved women, I was always fighting off different women to leave him alone, also he had impregnated a girl that was known to have multiple sexual partners. We were pregnant at the same time and that scared me because I was sure that she had this illness. In the previous weeks before I had to visit the clinic for my third ANC visit he had developed a rash on his thighs that just would not go away and that scared me because I had no idea why he was developing this rash, prior to that he had had endless flu symptoms, cold sores and stomach bugs that drained him and made him feel very weak. One time I had to take a week away from work to look after him... I just did not want to find out whether I was positive or negative. Knowing the importance of testing so as to keep my baby safe I eventually told him that we needed to go to the clinic and get tested, at first he declined however agreed a couple of days later. We both tested positive for HIV, however the nurses encouraged me to not give up on life and I was soon started on treatment.” – Ammy*

*“I know the importance of attending ANC during pregnancy hence I have attended in both my pregnancies. Even though I understand the importance of attending ANC a friend of mine at work made me realise how important it was as I was afraid to go at three months because of the compulsory HIV test. The friend shared with me how the nurses assisted her in understanding her body and keeping her body healthy after she had tested positive for HIV. She explained that testing in the early stages is important as it allows you the opportunity to have control over your health. Even though I was scared, it was this reason that pushed me to go to the clinic.” – Lungelwa*

Through social networks, the participants had come to understand the importance of ANC throughout the pregnancy so as to detect and sometimes prevent early signs of complications and at times even death. The detection of complications is what seemed to encourage these women to consult doctors and health care facilities. Londeka explained that pregnancy is stressful not knowing how one's baby is developing and growing; it is also an important period for the mother to make sure she is well as she the 'oven' assisting the development of the foetus. The participants shared that the clinics did not have ultrasound scanners so they were unable to actually see their foetuses, so they would have to save to go to a general practitioner in the town for a scan. Some of the women were fortunate enough to be taken for an ultrasound scan at the Rietvlei Hospital.

It was clear that the research participants understood the importance of ANC during pregnancy and they clearly believed it was important for pregnant women to participate in the conventional or orthodox health care system. Some of the participants preferred attending both for the added benefits that each lack; some seemed sceptical of using medicine from the TBAs, however felt they benefitted from their protective practices. Health care facilities were generally believed to be important though some of the women were afraid of needles and of testing for HIV and other chronic diseases.

Pamella, Ondella, Nelie, Zukiswa and Zingi were born in the rural areas around uMzimkhulu, but moved to big cities in South Africa when they were young for education at multiracial schools. uMzimkhulu is still home to them, although they only come back for rituals or family gatherings and hardly ever during school holidays. They expressed that living in big cities and adapting to a modern lifestyle has not changed the fact that they are black and that there are certain practices and rituals they need to perform at certain stages of life. Pregnancy to these women symbolised an important transition into a woman's life involving intricate emotions and physical changes. The women understood that pregnancy was a time when a woman ought to seek out a health care system that would best meet their required needs. While they come from rural areas and understand the need to follow traditions and practices, they felt that some of the practices were not suitable for them. The main priority for these women was to protect and seek appropriate health care which would offer the desired developmental outcomes for the pregnancy.

Pamella and Ondela work for some of the biggest corporates in South Africa while Nelie, Zukie and Zingie work within the health care system. Their views of pregnancy were strongly

influenced by western health care and they felt part of the western health care system. These women believed that pregnancy was a period where a woman needed to take care of the growing foetus and her body by eating healthily, taking vitamins and exercising. Their belief in evil spirits and witches was limited by their more modern worldview. They felt the best way to protect the foetus was to keep healthy and take vitamins. They did not follow the practices of the TBAs of using traditional medicine to repel evil spirits and witches. Rather, they believed these practices were not safe and would threaten the well-being of their foetus and their own health.

#### **5.4 TBAs' educational or training qualifications**

This study and others has established that the views of these women towards TBAs were based on the fact that TBAs had no formal training and that their practices and medicines were not scientifically approved and therefore threatened both their lives and their unborn babies (Vyagusa, Mubyazi and Masatu 2013; Roost et al. 2004; Bergstrom and Goodburn 2001; Selepe and Thomas 2000). The women complained about the potential exposure to uncleanliness from TBAs during their pregnancies which could lead to infection or even death. According to Whitaker (2012), some experts believe women are putting themselves at serious risk by relying on TBAs, who cannot handle obstetric complications such as haemorrhage, eclampsia and obstructed labour, conditions that account for three-quarters of maternal deaths. Furthermore, untrained TBAs often use unsafe delivery procedures. Practices such as jumping on the stomachs of pregnant women and pulling at their perineum have cost many women and babies their lives.

Similarly, Leedam (1985) claimed that the practices of traditional birth attendants can endanger lives. Even though the participants felt that TBAs might have knowledge in traditional healing methods and preparing traditional medicine, this knowledge was limited. Amounts and ingredients vary for *isihlambezo* and *imbelekisani*. Nelie who is a qualified nurse shared that she had heard a colleague talk about two cases where pregnant women in the Mount Frere area were rushed to hospital complaining of stomach aches; it was later found that they had ingested some form of poison which had resulted in the death of their babies. Upon further investigation, it was found that these women had been taking *isihlambezo* bought from a traditional healer based in town.



*“I would not feel safe being attended to by a traditional birth attendant. I do not hold anything against them, my only concern is that of the health and safety of my baby. I do not trust the practices that they offer and more especially the concoctions that they offer to pregnant women. I would not want to ingest anything that has not been tested and proven to be safe enough to be ingested by human beings and will not cause any adverse events. Pregnancy is a fragile period and women need to understand this and protect themselves. You cannot go around ingesting medicines that you know nothing about.” – Ondella.*

*“Over the years, the argument has been that traditional healers in general use practices that put their clients at risk. If I seek medical assistance it is because I need to be assisted and healed, I cannot go to be assisted and come out worse than I was. As a black person I understand the role that traditional healers play in our communities, especially when passing messages from the ancestors to us and so forth; however, I feel that they need some training to be able to heal and treat people’s illnesses and not pose a threat to harm them in the process. I would not want to put my pregnancy at risk by attending the services of a practitioner that has not been through school and received thorough training. Pregnancy is a vulnerable period where even specialists sometimes diagnose or miss something and complications still occur. Personally, I would not risk the health of my child by attending a traditional birth attendant.” – Zukiswa*

*“The issue with the traditional birth attendants is that they have no formal training. When you are pregnant you need to do your research and find out as much as you can how to best protect your foetus and the best way to ensure healthy development. This is my first pregnancy and to be honest with you, traditional birth attendants are not even an option for me right now. I had a big argument with my mother because she was telling me that I needed to seek the assistance of traditional birth attendants or my baby would present complications during and after the birthing process. When I explained that I would not attend a TBA or even ingest isihlambezo because I felt that these were unsafe practices for me personally, she shouted at me and said that I better pray that the baby does not present with complications. She continued to add that living in a city and having a fancy job does not change the fact that I am a black person who is still very much susceptible to witches and evil spirits, especially since I was working away from home and people back home in the rural areas were already jealous about that. I told her that I would pray that God protects and guides my pregnancy from evil spirits and witches.” – Zingie*

Some of the practices that the participants felt were unacceptable during childbirth included: giving birth on a dirty surface; lack of hand-washing by the birth attendant; guarding the perineum with the foot; frequent vaginal examinations; and traditional methods commonly used to stop bleeding, such as pressure on the abdomen with hand, knee, stool, or other objects, and methods to hasten delivery of the infant or to expel the placenta, and the use of non-sterilised razors which led to fear of infections and possibly death.

A study by Goodburn, Gazi and Chowdhury (1995) found that traditional birth attendants would tie a tight knot around the abdomen above the uterus, which was believed to prevent the baby from rising up again into the abdomen; some would even stand on the abdomen. This practice is believed to be dangerous resulting in many complications such as decreased oxygen supply to the foetus which may lead to brain damage. The participants felt that traditional birth attendants increased threats that could arise during their pregnancies and they felt that TBAs were unaware of some of the complications that could arise during pregnancy as a result of cross contamination. The importance of glove usage was the main issue raised by the participants as they felt that viruses and other various diseases were passed on if gloves were not used properly. Nelie felt that every health care practitioner should always wear gloves as a precautionary measure to protect not only the patient but the health care practitioner as well. The participants had heard of TBAs who would conduct vaginal examinations without the use of gloves and felt that this was a serious health hazard.

Studies conducted by Vyagusa et al. (2013) and Ganle (2015) suggested that traditional birth attendants did not have adequate knowledge in the use of protective gear while assisting pregnant women. The studies found that some traditional birth attendants did not wear gloves when conducting vaginal examinations or during the birthing process and some used the same pair of gloves for different deliveries. This can lead to infections and the transmission of HIV. Vyagusa et al. (2013) argued that TBAs lack knowledge about HIV and the possible risk of infections when assisting with childbirth and other bodily examinations without protective gear.

*“Umhhh, my general view is that traditional healers in general do not practice or follow safe health care methods. I hear that throughout the pregnancy they smear some herbs and oils to protect the woman and foetus from bad spirits. My first concern is that the herbs that they use may be harmful and cause complications or even the death of the foetus. Secondly, are they using gloves when they apply these herbs and oils, what if I develop an infection? ... As far as*

*I am concerned, nothing should be applied to the vagina as it may cause complications unless it is something that has been tested and proven to be safe. I personally would not allow anyone to apply anything inside my vagina especially something that I do not have much knowledge of.” – Nelie*

*“I read that when you are pregnant your immune system runs lower than usual, therefore, you are fragile to most infections. I do not know what is included in the concoctions that they give to pregnant women, all I know is some of the traditional birth attendants are said to include harmful ingredients that cause complications during the birthing process and are also harmful to the development of the foetus. A mother’s protective instinct kicks in the minute she learns of her pregnancy, and the minute I was told that I was pregnant, I read up on the best health care system that would protect and assist in the development of my foetus.” – Zukiswa*

*“What I know is that the practices used by traditional birth attendants are not safe ... it has been proven that they have contributed to HIV infections through the use of unsterilised razor blades and other practices where multiple people are assisted with one razor to make incisions on their bodies. Not only is this practice unhygienic, it also poses as a threat for harmful incurable diseases. I have never trusted traditional healers because some of them have fake qualifications and operate by scamming people for money. My greatest problem is that they do not have universal practices or medicines, each does as they have learned or have been taught by their ancestors. Pregnancy is an extremely vulnerable period to be taking risks with practitioners that either do not know what they are doing or have no formal training and experience.” – Pamela*

*“My mother told me that when my aunt was giving birth she was assisted by a traditional birth attendant. Her birthing process was taking longer than usual and they were starting to worry as she looked like she was about to give up. Eventually the baby made some slight movement down and the TBA who was assisting her took iqhiya [doek] and tied it around the upper part of the abdomen so as to push the baby down. As that did not help the TBA apparently asked for a log that was to be placed in the same region as the doek so as to prevent the baby from pushing backwards instead of coming out... After burning incense and pleading with the ancestors the foetus was birthed successfully. My main concern is that so much could have gone wrong, the log and doek could have punctured vital organs inside the mother and damaged the foetus somehow. I would not allow anyone to put logs or tie my abdomen with*

*anything as it may make it difficult for me to breath. With proper training I feel that these are some harmful practices that could be prevented.” – Zingie*

*“I have heard of people dying while being assisted by the traditional birth attendants. I understand that they have no formal training and in case of emergencies do not have a clue of what to do to assist the dying woman. My biggest concern is that they are unable to deal with and treat complications such as bleeding and infections which are life threatening. What happens if I bleed or develop an infection after birth, how will they assist me? The ancestors cannot stop my bleeding nor can they treat my infected new born right after birth.” – Ondella*

### **5.5 The role of family members in the choice of health care alternatives**

The findings of the present research established that the families of the women encouraged them to use traditional birth attendants. The families expressed the importance of traditional birth attendants as black people who believed in the power of bewitchment; the families refused to understand that these women did not believe in the services provided by traditional birth attendants and as a result opted for western health care during their pregnancies. This illustrates the families’ emphasis on social identity and cultural solidarity during pregnancy and birth. The families did not approve and felt that these women were losing touch of who they were, their practices and cultural belief systems.

Some of the participants claimed that certain family members stopped talking to them because they refused to go to traditional birth attendants. The participants felt that the older women refused to understand that times had changed and there was access to alternative and safer health care systems. The health care systems into which they were born did not give them the opportunity to be assisted by trained personnel and it thus appeared that this type of health care was a cultural practice, when in fact it was simply a lack of safer health care options. The participants explained they had no confidence in the traditional birth attendants used by their parents; they had been exposed to more education and safer options and health care facilities were now even free. The women felt that in ten years’ time, traditional birth attendants may have no clients because women today are empowered with knowledge to make safe health seeking choices during pregnancy. They believed that education played an important role in guiding a woman to choose a safe health care system during pregnancy. One of the participants explained that in as much as she is a black person and believed in the power of the ancestors and ritual practices, she had decided to attend a clinic for her physical protection.

A study conducted by Wanjira et al. (2011) argued that there was a significant association between mother's level of education and delivery practices they choose. Younger mothers were more likely to use skilled attendants during delivery than their elder counterparts. Mathole et al. (2004) also found that women, especially younger women, preferred to visit the clinic often mainly to be reassured that the baby was growing well and was in the correct position. The study findings established that the medical system as a social construction has been affected by modern life and changes in lifestyle. The manner in which these women view health and illness has shifted from a traditional worldview to more modernised and efficient perspectives. Orami (2005) claimed that a paradigm shift has been taking place regarding the way in which traditional societies view illness and healing.

*“My mother made it clear that since I did not want to listen to them as elders I would have bad luck and that the ancestors would turn their backs on me. She explained to me that pregnancy and culture were intertwined therefore, all the cultural practices needed to be carried out for a complication free pregnancy. She said my refusal to continue with the practices of the family would leave me ousted by the ancestors and blamed my refusal on my education qualifications. What hurt the most was when she said to me I should not tell her about any complications that I may face during my pregnancy as I have refused to listen to the older generation in the family.” – Nelie*

The women believed in monthly visits to the health care facilities to ensure all was well. The biggest fear amongst the women was that if they stayed away from the health care facilities they might miss the opportunity to discover life threatening and dangerous complications at an early stage in their pregnancies. Mathole et al. (2004) found that women expressed concern about long times between visits to the health care facilities as this could make it difficult for the health care workers to know how to care for them should complications arise. The participants also expressed that the ultrasound scan attracted them to the health care facilities as doctors would be able to pick up abnormalities with scans. These participants felt that because of their employment and status within their communities, they had to make use of ‘appropriate’ health care systems. All five participants explained that they could afford gynaecologists and bought their own vitamins from pharmacies. They felt safe in the hands of specialists and felt that in the event of complications they would be well looked after. Thassri et al. (2000) argued that socio-economic status, age, and locus control are factors that consistently influence pregnant women’s information and health seeking behaviour. Nelson

(1983) suggested that hospital births are also influenced by socio-economic status. Coxon (2013, 53) argued that women who prefer hospital births are thought to be concerned about risks and uncertainties of 'natural' birth preferring to 'stay in control' and seeing hospital medical technology as a means of reducing risk by securing a clinically clean and safe birth with access to anaesthetic pain relief during labour.

The findings also established that the participants felt that African culture can be limiting, especially during pregnancy. Their concerns were mainly regarding nutrition and some of the foods that many African women are supposed to avoid during their pregnancies. These are very important nutritional foods that assist with the development and growth of the foetus and not eating these foods may lead to malnutrition and complications. These women believed that during pregnancy, a woman should be guided by a professional regarding what to eat.

*"I have heard that TBAs restrict some of the foods that you eat during pregnancy, and apparently it is nutritious foods too such as fruits, vegetables and meat. In this day and age women have access to so much information from the clinics, gynaecologists and even our phones through google. We can research and see which foods are suitable and which ones need to be avoided during our pregnancies, I personally feel that TBAs need to attend some form of basic training to cover important aspects so that they can be able to assist their patients." – Nelie*

The women in this research preferred to visit health care facilities on a monthly basis. Health care facilities during the first trimester were considered important for blood tests and check-ups. Zukiswa, who is a trained health care professional, stressed the importance of ANC, especially in the first trimester, for detecting rhesus negative blood, HIV and other sexually transmitted diseases. TBAs are unable to detect these complications and women may only access health care treatment too late when there is little that can be done to assist them and their babies.

Zukiswa felt that some of what the TBAs offered would do more harm than good. She gave examples of the concoctions and their effects, especially on HIV positive pregnant women. Ultrasound scans were seen as important allowing the women to take important decisions regarding possible defects of their babies. These women explained that they preferred the services of the western health care system due to its accuracy and efficiency. They felt that

women who did not use clinics and hospitals gambled not only with their lives, but also with those of their unborn babies.

The findings of this study also established that family planning was a priority for modern women as it gave them the power to plan and space out their pregnancies. Family planning allowed them to limit the number of children with many preferring a maximum of two children due to the high cost of living. The participants explained that they were unaware of any contraceptive methods that were offered by TBAs. They also would not consume any contraceptives offered by them as they did not feel that the medicines would be safe.

*“If the products that are dispensed by TBAs had been tested and approved maybe I would not have an issue with using their medicines or even attending them when in need of medical assistance. I do not know what medicines they use or where they get them from, all I know is the fake traditional healers that sell poisonous medicine to people are ruining the whole health care system for those that know and have been trained on the use of and preparation of their medicine. My personal issue is that there is no formal training or common ingredients that guide the process of making medicines.” – Nelie*

### **5.6 TBAs’ response to peri-urban African women who are resistant to their traditional practices**

The TBAs explained that they did not have influence or control over the health care methods that people chose. They assisted those people who trusted in their knowledge and practices to the best of their abilities. One of the TBAs noted that even though people look down upon it now, traditional medicine has been around for centuries assisting and treating people all over the African continent. Even without scientific proof and formal training, the TBAs felt they had been assisting women within their communities for many years. All the participating TBAs felt that fewer women were coming for advice and medical assistance. They all agreed that the younger women showed less confidence in them as health care providers. One of the TBAs explained that education has played a key role in discouraging African people to consult traditional healers as it teaches people that traditional medicine is a form of medicine that is unscientific and potentially poses threats to a patient’s well-being. The TBAs felt that white people have little understanding of the traditional health care system and see it as a threat to their profit-making western health care system. Western health care methods have changed the mind-set of black people who have stopped believing in what is theirs and in what is natural to

the body. What seemed to distress the TBAs was the fact that the medicines that doctors promote as safe are made from the same herbs that TBAs use. Chemicals and other forms of unnatural ingredients that pollute the body are also found in these medicines however. Dwivedi (1997) found the TBAs did not feel valued in current modernised attitudes.

Illiteracy and lack of training on how to manage complications during childbirth have affected TBAs. Some of the practices that TBAs offer have been banned in the community of uMzimkhulu in an effort to protect the lives of women and their babies during childbirth. Many third and first world countries, for example Malawi, have banned TBAs from assisting women. Sarelin (2014) stated that in Malawi the government has made out-of-facility births with traditional birth attendants (TBAs) illegal and banned TBAs from practising. In other countries, institutionalising birth has been one of the methods to reduce maternal mortality. Institutional births are controlled by policy makers and those in power who force women to give birth in clinics or hospitals where they will be attended to by trained western health care personnel such as nurses, doctors and midwives. This type of system has seen women neglecting their own cultural beliefs and health care systems to adopt modern and western health care systems.

Fahy (2008) argued that childbirth becomes institutionalised according to the natural or medical boundaries placed around the experience. The findings in this study have established that births are becoming institutionalised to become more medical and less natural. Women are considered to get the best medical treatment with lower mortality rates from institutions. This policy takes away the power and the decision-making process from women and their families to seek health care systems that they feel are best for them during their pregnancies. What is considered a socially acceptable, safe and normal way to handle birth today has been influenced by the homogenous western health care system, which has excluded other health care systems which are considered unsafe and socially unacceptable. This type of system dictates to women where, how and under whose care to give birth, undermining their views, choices, cultural practices and values in the process. While the policy may be thought to be in the best interest of women, it has also taken the choice and freedom from women and their families to give birth in settings where they feel most secure and comfortable. The policy of institutional delivery has been the cornerstone of actions aimed at monitoring and achieving Millennium Development Goal 5 to improve maternal health and reduce mortality.

Efforts to increase institutional births have been implemented worldwide within different cultural and health systems (Melberg et al. 2016; Koblinsky 2006; Campbell and Graham



2006). The TBAs explained that power has been taken away from them to carry out their practices and rituals. They felt that they had been side-lined and excluded from the health care system by those in power. They felt that what was theirs and African was being eroded so as to establish and forcefully introduce a new and foreign health care system which side-lines and views African practices as unsafe and harmful and adding to maternal mortality. The findings established that the TBAs felt robbed because they have had to change and adapt to ‘safer’ methods within their health care practices; however, those that train them have not taken the time to be trained and taught some African practices by the TBAs. It is not only in African countries where TBAs have had to undergo training to make their practices safer. Davis-Floyd (2007) described how TBA training courses and other forms of exposure to biomedicine have resulted in fundamental alterations in practice for many traditional midwives in Mexico.

*“We have had to change and do away with our practices and have been banned from offering certain services to our patients. We have been banned from assisting women during the birthing process because apparently what we do is considered unsafe and potentially deadly to those that we assist. We are losing our way of doing things, these health care systems that they are introducing are eroding our cultures, our beliefs and our own way of doing things. What I see is that black people are losing who and what they are, the practices and rituals performed during birth are not done for fun as they have an important role in the manner in which we grow up and understand ourselves as people. As you see now, our people are so lost they are losing who they are and adapting other people’s cultures because even before birth their culture and practices are being transformed. As a TBA, I feel that our practice is becoming irrelevant because we no longer offer what we know and understand, we now have to incorporate other cultures in our practices as a bid to make what we do ‘safer’ for those who consult us.” – Sarah*

*“We have lost! What we offered has been taken away from us and we will never get it back because of the government policies and the continuous development of the world. We have to do things in hiding now because some of our practices have been banned, but when a patient comes and you can see as a health practitioner that they are in need you cannot let them go without assisting them. We have lost our authenticity as traditional healers and our own people are looking down us because they have been told and taught that what we do is unsafe and should be escaped.” – Primrose*

The TBAs explained that women have been influenced by such policies to stop trusting them and their practices during pregnancies. The findings established that TBAs felt that their practices and knowledge were considered less valuable than the western methods due to their lack of education and modern skills training. They felt that black women have been brainwashed to believe that their cultural practices and rituals were unsafe compared to western practices. The TBAs felt that these policies were taking away their culture and belief systems and were forcing them to conform to a new way of doing things which takes away the authenticity of their cultural beliefs and practices. They felt that in years to come they will become 'extinct' even though they feel they play an important role in reproductive health within their communities. They feel the services they offer to women within their communities are important, but they have no control over their practices and services as women are being told through radio, television and health care facilities that the practices offered by TBAs are unsafe and women should refrain from seeking assistance from TBAs and traditional healers in general.

*“Women have been led to believe that there is only one type of health care system that best and safe during pregnancy. It is not a lie that we are not trained or have the needed education to attend to the complications of birth, however, we have an understanding and set of skills that we have been using over time and they have for the past centuries been working well. I must admit that woman and infants die during and after the birthing process and we sometimes do not have control over the complications that may occur during birth, but the same happens in the health care institutions with trained health care personnel. What makes people trust health care facilities are all the machineries that get tied onto women during and after birth, however complications may arise wherever a woman may choose to give birth.” – Angela*

The encroachment by the hegemonic western health care system of the reproductive health has left women undervalued and with little control over their own traditional health care system. The western health care system has taken over the territory of traditional healers and has demeaned centuries of knowledge and practices that traditional healers use when assisting pregnant women. Davis-Floyd (2007, 707) stated that for past millennia, midwives have served women in childbirth. In pre-modern times, midwives were usually the only birth attendants. With the Industrial Revolution and the arrival of modernism, male physicians either replaced midwives or superseded them in the modernist medical hierarchy, leaving midwives with plenty of women to attend but with relatively little autonomy.

The TBAs explained that their practices have been in existence for centuries, however, the western hegemonic system has taken that away by replacing their knowledge and experience with practices that they feel are safer. Health care practitioners are all under pressure to “do birth according to medical standards” as one midwife put it. But this will in many cases mean using interventions and/or transporting the woman to the hospital, despite the midwife’s alternative judgment. The TBAs explained that when they offer their services to pregnant women during the birthing process they have to adopt skills from the western health care system as opposed to their own. This made them feel they have been forced to neglect what is theirs to adapt to a foreign health care system. They explained they feel under pressure when assisting women as they feel that they have to exceed their expectations so as to be considered skilled. All the participating TBAs explained that they were not happy with the erosion of their knowledge and practices through being forced to adapt to foreign knowledge and practices.

According to Davis-Floyd (2007, 707), “as the new millennium dawns on a growing worldwide biomedical hegemony over birth, midwives, the daughters of time and tradition, find themselves negotiating their identities, searching for appropriate roles, and seeking new rationales for their continued existence”. The TBAs explained that they feel that they no longer have cultural practices in place for assisting pregnant women during pregnancy because all their practices are considered unsafe and some have even been banned. One of the TBAs said that they feel that they need to explain themselves and negotiate their cultural beliefs, views and practices with people from other countries that feel that their traditional practices are unsafe and should be done away with.

The TBAs explained that they have their own ways of doing things. *“I have had to go inside a hospital setting and burn incense and seek the forgiveness and guidance of the ancestors because a patient of mine was presenting symptoms that the doctors and nurses were not familiar with, also the baby was not coming even though the woman was already dilated. The woman refused to go to theatre as she feared for her life, after my services the woman gave birth to a healthy baby boy. My point here is, for black people, unlike white people have a different cultural dimension that they will never understand.”* – Sarah. There needs to be treatment of both the physical and spiritual in health care; a patient is not just a physical being “the healing of a patient must include more than the biology and chemistry of their physical body” (Ross 2009). In the following paragraphs the TBAs share their feelings with regard to

the attitudes of the peri-urban women that consult them and who appear to be resistant to their traditional practices.

*“There is very little that we can do as THPs to change people’s opinion, views and understanding about our healing methods. Over the years our own black people have lost the confidence that they used to have in us. It hurts to meet someone who is in need of assistance, but does not believe in my healing methods and practices. You find that some women are threatened by their families to come and seek assistance from us during their pregnancies, some even confess and share that the only reason why they are seeking our assistance is because of their families and not their choices. I have helped many people in my life time, people who looked down upon me and my practices, people who will question me and asked them if I knew what I was doing while I was assisting them. Others ask me to meet them in private place so that they are not seen and judged by people for being seen with a THP. Doctors, nurses and other people with very big positions have come to me for assistance. We live that type of life now as THPs, a life of helping people in hiding. If someone comes to me for assistance, I help them the best I know how and I am very confident in my practices and rituals. I am unable to force anyone to use my medicines or believe in my healing practices. Many people doubt what we as THPs offer and practice, but I truly appreciate all those that do not look down upon.” – Sarah*

*“If someone comes to me for assistance I help them, what they do with the medicines or the advice that I give to them is honestly up to them. I am unable to force anyone to take my medicine, however, I always encourage pregnant women to go the clinic to get medication that will assist with the development of the foetus, even if they neglect my medicines, but they must use the medication from the clinic. What I like about myself is that I do not care what people think, do or say about my practice. However, I do advise young women to use traditional medicines during pregnancy because they protect the foetus from harmful spirits. I think our people think that because we live in much more modern times that witchcraft has disappeared, witches are still there and are not going anywhere. We are black people and we believe in sorcery, even if you are saved or believe in another form of power... at the back of your mind you know that such things exist and that we are the only people that can help to overcome such challenges. I usually tell them that it is in their best interest to ingest these concoctions if they want to protect themselves and their babies.” – Primrose*

*“Many men and women come to me for assistance and through conversations I have gathered that they feel at ease when consulting me for assistance because they are Christians. Many people are Christian now, people believe in the power of God and heavenly presence. Over the years, there seems to be a growth in the number of people that come for consultation. Some have shared that they prefer the services of umthandazeli because there is no muthi or ancestors involved. People these days seem to have very little belief in ancestors, their works and contributions in their lives. I always explain to them that I too work with them, the difference with my ancestors is that they heal through prayer as opposed to muthi.” – Anne*

*“I let them be, I understand that as human beings we have different belief systems and practices, however it amazes me that black people are abandoning their way of life because someone has come with Christianity and said that what black people practice is wrong according to their bible. I am a traditional healer, but I am also Christian who believes in God and goes to church on a regular basis. I believe that what I have and am is a gift from God, my healing powers are also from God so that I can be able to assist and heal his people. That said, I believe that as human beings we have to respect each other and understand that times have changed and will continue to change. If people feel comfortable going to a medical doctor, it is their choice. Some hide when they come to see us, they do not want to be seen as some people in the communities that we live in feel that attending TBAs is a backward and uneducated decision.” – Abby*

*“What I have come to notice is that over the years the trust and confidence that pregnant women have no longer exists. In this day and age the educated women think that our practices are no longer important and that they are unsafe. When they do come for assistance, however, end up doubting my advice and show low adherence I let them be. As TBAs, we have come to understand that our practices are becoming outdated as women now prefer the services of medical doctors. Even the trained doctors can only do so much to make sure that patients adhere to their medicines, however, it is always up to the patient what they decide to do with their health and well-being. All I can do is encourage a patient to take my medicine and the medicine that they get from the clinic. Modern women do not usually attend THPs, they prefer the assistance of medical doctors. I understand their fears as we are said to lack knowledge and safe practices, but they should know that our traditional medicines are useful and have helped a lot of people. I respect their choice, every individual should follow a health care system that they feel comfortable with.” – Dolly*

*“We know and trust the medicines that we offer because we have been preparing them the same way for many years. The same people that have a problem with the medicines and practices that we offer are the same people that were birthed by us, same people that we prepared isihlambezo for when they were still in the bellies of their mothers. It makes me sad to see our own people abandoning our practices because other races tell and educated them on the dangers that are associated with our practices and health care system. All health care systems are a threat to a patient in many ways, it all depends on the skill of the practitioner assisting a patient. What I agree on is that we need assistance in measuring our ingredients when preparing medicines for pregnant women. We know the ingredients and we know where to find them, however the government needs to assist us with the measuring.” – Juliet*

The findings of the study established that the TBAs felt that modernisation, education and the introduction of the western health care system have had an impact on the manner in which black people receive and utilise their services. This has also affected how women identify with pregnancy and labour. Davis-Floyd (2007, 706) claimed that “in modernizing societies traditional systems of healing, including midwifery, have become increasingly regarded by members of the growing middle and upper classes as premodern vestiges of a more backward time that must necessarily vanish as modernization/bio medicalization progresses”. One of the TBAs explained that as traditional healers, they are based in communities to assist black people overcome challenges and illness in their lives. *“Western health care alone does not solve some of the challenges of a black child, one can live in the suburbs and live the life of a white person however, their roots call them back when their ancestors need them back. We will remain in these communities and not go anywhere because we play a very important role,”* explained Sarah.

The TBAs explained that pregnancy is more spiritual than people think. It is a particularly vulnerable time where a woman needs more than physical examination; therefore it is important to provide a pregnant woman with both physical and spiritual needs. This correlates with Appiah (1994) who argued that gender and sexuality are grounded in the human body. Both gender and sexuality can be understood within the framework of spirituality which the participants value during their pregnancy. According to Primrose, *“women are ashamed of coming to us for assistance, especially the educated ones. They feel that the services that we offer to them are dangerous to them and their babies.”* The healing of a patient must include more than the biology and chemistry of their physical body; by necessity, it must include the

mental, emotional and spiritual aspects. Because of these challenges, the development of an integral health care system that is rooted in appropriate regulation and supported by rigorous scientific evidence is the direction that many models of integrative health care are moving towards in the 21st century (Ross, 2009).

*“What seems to bother some women about the type of health care that we provide is that we have no formal training. What we offer is something that has been taught to us by our ancestors through various other people such as sangomas or by themselves in rivers and dams. We have no universal guide or reference, what we do depends on the type of calling that you have and how the ancestors wish for you to help people. We are taught different styles and ways of treating and preparing medicines. It is no lie that people do die in the hands of traditional healers, however, they also die in the hands of the so called trained professionals (doctors and nurses). I personally feel that as the years have gone by, pregnancies have also become much more complicated. I cannot pinpoint the cause, but I feel that health in general has become much more complicated. Assisting a pregnant woman now is not the same as it was twenty years ago. Many women die now as opposed to the olden days.” – Juliet*

A combination of higher maternal age, an ethnically diverse population, rising caesarean rates and increasing levels of obesity and chronic disease, such as diabetes, mean that more pregnancies are medically complex, and demand for tertiary-level, critical and intensive care in maternity services is increasing (Coxon 2013, 53). Dolly, corroborated with this: *“We do not have training like the nurses and doctors at the health care facility have.”*

## **5.7 Conclusion**

Health seeking behaviour has changed over the years due to the influence of globalisation which has influenced medicine and has seen the dominance of the western hegemonic health care system. Traditional practices have had to undergo changes over the years to meet the ‘safe’ scientific standards of the western health care system. As a result of globalisation, health care as a whole has undergone changes to become safer and meet ‘safer’ standards. Western health care looks down and demeans other health care systems as less, backward and unsafe as those who practice and offer it do not hold the training required. The encroachment of western medicine in developing countries has led many to see traditional health care as unsafe and practised by those without education qualifications or the skills required to carry out health care practices and rituals. Some African women have also taken the worldview of traditional medicine as less and backward when compared to the western health care system; many hold

the view that traditional medicine will cause harm to them and their unborn babies during pregnancy and potentially cause complications or even death. The notion of cultural practices and beliefs has been broken down. The services of TBAs are often deemed unsafe and backward as some black women no longer feel the need to fulfil their cultural obligations during pregnancy. However, some women still hold strong attachments and beliefs in their culture and the practices that the TBAs offer during pregnancy; observing these cultural practices is still part of their worldview. These women prefer the practices of the TBAs over western health care which they feel does not have a holistic approach to their pregnancies. Some women believe that both health care systems will have a positive contribution to their pregnancies and therefore use both health care systems to gain benefits from both.



## **CHAPTER SIX: Conflict between the traditional and western approaches to reproductive health**

### **6.1 Introduction**

This section discusses the views of TBAs about the areas of possible conflict between their traditional approaches to reproductive health and the so-called western methods practised in clinics and hospitals. Prior to the introduction of the now hegemonic western medicine practices, traditional medicine was dominant and was the main source of health care within traditional societies. The arrival of the Europeans and process of modernisation marked a turning point not only in standards of living but in the health care system as well. This type of hegemonic change and development requires traditional society to become westernised and adapt to a new culture and way of life. This chapter examines the possible areas of conflict between the traditional approaches to reproductive health care and the western methods of clinics and hospitals. In-depth interviews were conducted with the health care personnel at the Rietvlei Hospital in uMzimkhulu and their views and attitudes towards traditional medicine are presented as part of the findings of the chapter.

The definition of traditional medicine remains problematic. The World Health Organisation (WHO) noted that it is difficult to define the broad range of characteristics and elements of traditional medicine, but that a working definition is essential (Waldram 2008; Ritcher 2003). This medical system is often defined under the banner of ethno-medicine and includes ritual and religious healing which involves the use of herbs, plant and animal medicines, spiritual therapies which may be applied individually or concurrently to maintain the well-being, as well as to diagnose, treat and to prevent illness. Traditional medicine and traditional healing provide patients with practices and treatments that are indigenous to the culture and are historically operated predominantly outside western health care facilities and systems as well as beyond the practices and curriculum of the dominant health care system (Suswardany et al. 2015). Traditional medicine offers a holistic approach when treating patients and the beliefs are that illness is the result of supernatural phenomena.

In Africa, traditional medicine has been operating for centuries and was the only source of medical care for traditional communities (Davis 2012; Abdullahi 2011; Romeo-Daza 2002). However, western hegemonic medicine has become dominant and is alienating other forms of medicine which are now regarded as primitive, backward and unscientific. Those who hold a

different view and believe in other forms of alternative medicine are considered uneducated and backward as alternative medicine is considered unsafe and less effective than western medicine. Scholars like Oyewumi (2002) and Peterson (1984) noted that the problem of cultural dominance known as neo-colonialism is a more urgent concern for African feminist than the fight over class which occupies the attention of Western feminists. While some modern medical practices are highly researched and have been scientifically proven, the approach has also been made popular by modernisation. The services of TBAs are currently only valuable in rural areas where clinics and hospitals are not easily accessible or where community members cannot afford the travelling costs or medical bills. Government policies have also favoured western over traditional medicine.

## **6.2 Areas of possible conflict between traditional birth attendants and medical personnel**

The introduction of modern western medicine in many traditional societies has resulted in competing discourses on the use and efficacy of traditional medicine. The cultural landscape of the traditional health care system in South Africa has been overpowered by colonial powers and structures; traditional healers and their patients have had to shift to follow and adapt to the much-praised western health care system (Ritcher 2003). Traditional medicine is being forcefully replaced by western medicine in many societies forcing traditional and native people to abandon their preferred health care systems. Possible conflicts between TBAs and medical doctors are caused by the different belief systems and practices.

### ***6.2.1 Dominance of western belief systems over traditional belief systems in health care practices***

There is evidence of modernisation in the way TBAs are considered in modern society. What is western is considered modern and acceptable, while what is local and traditional is considered backward and unacceptable (Oyewumi 2002). TBAs claim that medical personnel treat them poorly and rank them lower because they have not attended university or have received formal training and education. They feel that anything that they do when assisting patients is looked down upon and judged and that they are seen as assisting only for financial or material gain. One of the TBAs said it makes them feel less like health practitioners when patients are told by other health care professionals that what traditional healers offer is dangerous. This undermines and damages the social identity of THPs because it is a negative

recognition or a misrecognition (Appiah 1994). The negative identity created by such social recognition can cause members of the social group to exit the group. Brown (2002) noted that based on SIT, when people who are unable to maintain a positive social identity, they lose their self-esteem. Such a negative or unsatisfactory identity causes people to leave the group or find means of achieving more positive distinctiveness for it.

Authoritative knowledge is an ongoing social process that both builds and reflects power relationships within a community of practice simply as the knowledge that is attached to persons in authority positions as, for example, the doctor in childbirth (Wenger 1991). Western health care and birthing practices have been influenced by authoritative knowledge, giving western medical personnel the power to be the decision and policy makers. Those who hold alternative views are seen as backward and less educated. Authoritative knowledge has introduced technocratisation and the introduction of machines to assist with the process of birthing. The technocratic model has dominated the birthing process in the developed countries and has infiltrated the developing world, creating a conflict of interest for pregnant women when selecting a health care system.

What seems to upset THPs most about western health care personnel is that they have turned their own people against them. While this may be true in some cases, many African people still believe in and have confidence in the practices that THPs offer. Western medicine, many of the TBAs agreed, seems to offer relief of symptoms faster than traditional medicine; however, it lacks the holistic approach offered by traditional medicine. The efficacy of traditional medicine has often been appraised by scientific standards of the hegemonic western health care system that shares no similar beliefs, practices nor traits (Summerton 2006). The prevailing idea among those who favour and believe in the dominance of the western health care system is that it is the only form of medicine that can cure and assist people; it is also considered to be safer and more effective in the relief of symptoms than other alternative health care systems.

The participating TBAs explained that the foundations of their health care system have been shaken by the introduction of other forms of health care systems, but mostly the western health care system. This has not only eroded some of their beliefs, but has also taken away their identity, beliefs and practices. Weakening of their social identity results in weakening the entire social group (Brown 2000; Appiah 1994) and undermining their social capital as well (Bourdieu 2011; Kreuter and Lezin 2002). They shared that their main struggle was that they were being pressured into abandoning their wealth of knowledge to adapt to new and 'safer'

methods of healing and assisting patients. In the case of reproductive health care, the TBAs felt that they no longer had the right to assist patients due to various new policies. The restriction of rights is tantamount to the restriction of the social capital as well as restriction of the role of TBAs. This, according to the ideas of Bourdieu (2011), implies the destruction of their social capital. It makes their potential resources worthless and thus undermines their source of social identity.

### ***6.2.2 The politicisation of knowledge: Formal versus informal knowledge of health care professionals***

Bourdieu and Passeron (1990 cited in Davis-Floyd and Sargent 1997) stated that formal schooling succeeds in obtaining from the dominated classes a recognition of legitimate knowledge and know-how (for example in law, medicine, technology, entertainment or art). One could add that legitimising modern science as knowledge and undermining traditional knowledge and wisdom is a misrecognition of local traditional knowledge and practices (Oyewumi 2002; Appiah 1994) and hence is undermining to groups like the TBAs. This also has implication for the social identity assertion that one's identity is not independent of and prior to the society (Brown 2000). Therefore, if the most dominant voice in society, which is the voice of policy or of the majority, considers a group like the TBAs as insignificant, the entire society will in time accept the social construction.

Davis-Floyd and Sargent (1997) have described how, in the formal medical field, Paul Starr has explained the historical transformation of authoritative knowledge in America. He pointed out that well into the twentieth century, medical care was provided by a multi-stranded, pluralistic system within which the knowledge held by the barber, surgeons, homeopaths, folk healers of various kinds, midwives, and other empirically based practitioners was considered authoritative by different parts of the population. The TBAs in this research saw the western medical system as authoritative and as governing not only their own modern health care system but others too, becoming the cultural authority that needs to be followed and adhered to by other cultures as well.

### ***6.2.3 The supremacy of western education over the informal training of TBAs***

As the TBAs do not possess formal training or education and are considered to come from an inferior cultural paradigm, their practices seem to not have a strong hold when compared to the dominant health care system. Bourdieu and Passeron (1990 cited in Davis-Floyd and Sargent

1997) stated that the process whereby the authority of any particular knowledge system and the power relations supporting it and benefiting from it come to be perceived not as socially constructed, relative, and often coercive but as natural, legitimate and in the best interest of all parties, is termed misrecognition. As discovered in this research, Makoe (2000, 57) explained that training TBAs is not easy because they have never been exposed to basic education and the majority are illiterate and learned their skills by observation, practice and the guidance of ancestors. It is further asserted that they may have difficulty understanding things which they cannot see or touch. The argument, therefore, is that the curriculum of TBAs should be simple with the intention to improve their practices, not to make them professional midwives. This does not only underestimate their social capital, but is prejudiced to undermine their social identity.

The participating TBAs described how they have often been told that their practices are based on superstition while the practices of western health care are based on scientific facts. They shared that their practices have been banned and constrained by policies whereas the western health care system is believed to be legitimate, safer and the best health care for all. In the following paragraphs the TBAs explained how they were constantly reminded that they did not have formal training and that their practices were not safe especially for pregnant women.

*“Basitshela njalo ukuthi lokhu esisuke sikwena umaselapha abantu kubeka izimpilo zabo engcupheni ikakhulukazi abesifazane abazithwele. Sikuzwa yonke indawo lokhu, ema rayidweni kanye nalama workshop esibuye siwahanjiswe ngenkani, sithathwa njenga nonompilo abangasizi kodwa abenza izinto zibe zimbi ngaphezu kwalokho esikuficile, kokunye abanye baye bathi siyababulala nabantu ngemithi yesintu ngoba asikwazi ukuti sebenzisa nokuyithaka ngendlela eyenza ukuthi ingabi yingozi kulabo esisuke siyenzela bona. Ngiyaye ngizibuze njalo ukuthi sibabulala kanjani abantu ngoba phela kade saqala sisiza abantu kusukela emandulo. Engikucabangayo ukuthi yonke inhlobo yezempilo inako ehlulekayo kuko, ukuphila nokushona komutu akuyona intando yami njenga nesangoma name ngisizwa abaphantsi kanye noNkulunkulu ukuthi ngisize ngibuye ngelaphe. Uma sekufike isikhathi somuntu name akukho engingakwenza ngisho nabo odokotela kukhona lapho ababuye bahluleke khona. Ukube izibedlela nemitholampilo zisebenza ngalendle abasho ngayo odokotela nonesi ngabe abantu abashoni khona. Ngoba abantu bashona kukhona odokotela abafundile kanye nalobuxhakaxhaka kwemishini ekuyiyo abaye bayincome bathi thina njengabelaphi bendabuko asinayo.” – Juliet*

*“They tell us all the time that our practices are not recognised as safe to offer to pregnant women. We hear it from the radios and the workshops that we go to, we are regarded as health care professionals that add to the deterioration and at times even the death of those that we assist. How can we be responsible for killing people when our methods and practices have been in existence since the beginning of time? I think every health care system has certain limitations, whether someone lives or dies is not up to a health care professional, it is up to the greater powers that oversee and guide everything that happens. People die even in the western health care system that is regarded to be safe for patients, it is not up to even the doctors with their authority, formal education and machines to save a life that is no longer supposed to be in this world.” – Juliet*

*“Indabuko yethu, ezempilo kanye nendlela esiphila ngayo ihlezi imataniswa naleyo yabelungu kanti ke asifani, banendlela yabo yokwenza izinto kanti nathi sineyethu. Uhulumeni wethu uzama ngayo yonke indlela ukuthi siphile njengabelungu nokuthi sithathe indlela yabo yokuphila, thina bantu abamnyama sinendlela yethu yokwenza izinto kanti ke ayifani neyabelungu, uhulumeni kumanje usenze imithetho esehlukanisa namasiko wethu ingane isaphuma esiswini sikamawayo. Sinendlela yethu esenza ngayo izinto uma ingane izalwa kodwa akusenzeki manje ngoba uhulumeni sewenza kwangabi kemthethweni ukuzalela ekhaya kanti ke futhi akasasivumeli ukuthi sense amasiko ezinganeni kanye nonina ngoba kuthiwa kuyingozi ezimpilweni zabo. Angicabangi ukuthi abantu abayizifundiswa bayazithemba izinto esizenzayo thina singabelaphi besintu ngoba bafundiswa ukuthi konke okwethu akulungile.” – Prudence*

*“Our tradition, health care system and way of life are seen as less when compared to the western health care system. Our governments are trying by all means to have us change and adapt to the western way of life. Our children are separated from who they are at birth, we are no longer able to perform our practices and bring our own children to this world the way that our cultures require us to because our cultures are seen as unsafe and as contributing to the death of patients. I do not think that people with formal education have trust in us or our practices as they are taught all the time how unsafe our practices are when compared to the western health care system.” – Prudence*

*“Ukushintsha kwesikhathi sokwenze ukuthi abantu bethu abamnyama bangakwethembi ukuza kithi kanye nokusebenzisa imithi yethu uma bengaphilile. Ntsuku zonke sitshewa ukuthi umuntu uma engaphilile akaye emtholampilo, ilapho ezothola usizo langempela, thina belaphi*

*bendabuko sithathwa njengabantu abasiza abantu ngoba sifuna imali kanye nemfuyo yabo, uyaye uzwe abanye abantu bethi abelaphi bendabuko bathatha konke abakutholayo bakuhlanganise bese bathi umuthi ozokwelapha abantu lowo. Imithi kanye nokwelapha abantu abakhulelwe yinto engasavunyelwe ukuthi thina siyenze ngoba kuthiwa siyababulala futhi sibeka izimpilo zabo kanye nezezingane zabo. Abantu bakithi batshelwa mihla yonke ukuthi bangezi kithi uma bedinga usizo ngoba bazogula kambe kushone izingane zabo”. – Primrose*

*“As a result of the changing times, people now regard us as health care professionals who do not now what they are doing, we are regarded as crooks who mix any and everything to make medicines that end up harming our patients. The practices that we offer to pregnant women are no longer regarded as important as women are advised by health care professionals that what we offer as traditional healers are outside the traditional health care framework and women should avoid us if they want to keep their pregnancies complication free.” – Primrose*

In South Africa, traditional medicine is mostly practised by sangomas who are guided by the ancestors throughout their healing processes. Traditional medicine takes into account the whole body and treats it in a holistic manner; illness is viewed as an imbalance in the body which needs to be restored, in many instances, and the illness does not always have a simple biological explanation and involves the spiritual world. Unlike traditional medicine, western medicine considers only a specific part of the body which has the disease. It considers the disease as biological with symptoms which need to be treated by prescribed medication which is targeted towards specific symptoms.

According to Eisenberg (1997), the dysfunctional consequences of the Cartesian dichotomy have been enhanced by the power of biomedical technology. Patients suffer “illnesses”, however, doctors diagnose and treat “diseases”. *Illnesses* are experiences of discontinuities in states of being and perceived role performances. *Diseases*, in the scientific paradigm of modern medicine, are abnormalities in the function and/or structure of body organs and systems. Traditional healers now also sometimes re-define illness as disease; because they share symbols and metaphors consonant with lay beliefs, their healing rituals are more responsive to the psychosocial context of illness. These findings are in accordance with the way in which the two health care systems treat and view pregnancy.

Western medicine views pregnancy as involving a woman and foetus as separate entities. McLean and Petersen (1996) stated that the medical model of pregnancy encourages the

physician to view the foetus and the mother as two separate patients, and to see pregnancy as inherently a conflict of interests between the two. However, traditional medicine and childbirth recognise the impact of the mind and spirit, as well as the physical body, on the experience of pregnancy and birth. Physical health, values and beliefs, relationships, emotional well-being, and spirituality all affect pregnancy and birth. In turn, the experiences of pregnancy and birth influence body, mind, and spirit. Ancestors in traditional medicine are believed to be members of clans that have passed on and are part of another world where they are invested with mystical powers that assist their kin. Ancestors are the guiding forces for health care as they are regarded as higher powers who hold true knowledge that guide and assist those that heal people.

Hippocrates of Kos was a Greek physician and is often referred to as the father of medicine. He changed the course of Greek medicine with his certainty that disease was not caused by gods or spirits but was the result of natural action. He based his medical practice on observations and on the study of the human body. He held the belief that illness had a physical and a rational explanation. He rejected the views of his time that considered illness as caused by superstitions and by possession of evil spirits and disfavour of the gods. He also believed that the body must be treated as a whole and not merely as a series of parts. The holistic healing philosophy of Greek medicine states that man is essentially a product of nature, or the natural environment. Health is living in harmony with nature, and disease results when this harmony and balance are upset. Hippocrates believed in the natural healing process of rest, a good diet, fresh air and cleanliness.

It was Hippocrates who finally freed medicine from the shackles of magic, superstition, and the supernatural. Healing is restoring this lost harmony and integration. The father of western medicine held similar views to that of the traditional healers in taking a holistic approach to healing even though he differed in understanding the causes of illness. He believed that rest and good diet were the main natural healing processes of the body and argued that antibiotics were not natural and could potentially cause an imbalance within the body. Traditional Greek herbal medicine echoes this sentiment. The writings of Hippocrates and Galen clearly show that they gave priority to the nutritive, tonic approach over therapeutic intervention.

It was only when medicine began to lose track of the traditional holistic and vitalistic priorities of Greek medicine in supporting and building the natural resistance of the organism that doctors began to look for stronger and stronger drugs and radical intervention. The father of western medicine ensured that a holistic approach was maintained when assisting patients; this practice,



however, changed as modern methods were introduced and the philosophy of a holistic approach to medicine has mostly been eradicated in western medicine today.

#### ***6.2.4 The role of machines in the health care system***

The TBAs felt that reproductive health care had conformed to become westernised. Birth is now often viewed almost as an unnatural process and human touch had been minimised by the complicated machinery used in hospitals and clinics. Franklin (2014); Davis-Floyd and Davis (1996) and Farber (2011) argued that machinery has replaced the hands of the midwives, causing a transition from a natural to an unnatural state during childbirth. The TBAs expressed that the transition from traditional to medical and modern practices started when policies were put into place to prevent the natural birthing process.

The process of medicalisation of the birthing process and the introduction of technology has been claimed to make birthing safer and more successful than more natural birth processes. Davis-Floyd and Davis (1996) introduced the concept of the medicalisation of the birthing process, expressing the commonly held belief that with medical and technological advances, childbirth will be more successful and safer. The TBAs shared that through workshops and networks it has been communicated to them that their practices are unsafe and that they lack the skill needed to make birthing safe for women. They shared that they are told that in the hospitals there are machines and means of making the birthing process and entire pregnancy safe. Davis-Floyd (1992, 1994) discussed these machines as symbols of our culture's "supervaluation" of machines over bodies, technology over nature. She analysed obstetrical procedures, diagnostic and otherwise, as rituals that not only convey cultural core values to birthing women, but also enhance the courage of birth practitioners by deconstructing birth into identifiable and (seemingly) controllable segments, then reconstructing it as a mechanistic process. She found that these ritual procedures enhance courage not only for obstetricians and nurses, but also for the women themselves: being hooked up to some of the highest technologies society has invented gives many American women the feeling that they are being well taken care of and that they are safe. A reassuring cultural order is imposed on the otherwise frightening and potentially out-of-control chaos of nature.

What the TBAs expressed is that black women have been encultured to the western methods and health care system and now they feel safer in health care facilities as opposed to being with traditional healers. They feel that the machines at the hospital provide safer health care outcomes as opposed to a spiritually based health care system. While this is true, some women

still prefer the natural and spiritually based practices of the TBAs; they feel that the technology offered at the hospitals is unnatural and may be harmful in the process of birthing. Even though some women feel safer in the presence of technology and medically trained personnel, for some women this process is concerning as it takes away from them the natural state of birthing and rather increases their anxieties. Davis-Floyd and Arvidson (1997) argued that not all women are reassured by the technocratisation of birth. There are some women in the United States who supervalued nature and their natural bodies over science and technology, who regard the technological deconstruction of birth as harmful and dangerous, who desire to experience the whole of birth – its rhythms, its juiciness, its intense sexuality, fluidity, ecstasy, and pain.

*“Ukuzala kanye nokuzalisa into ebalulekile kithi bantu kanti futhi edinga abantu ukuthi babambisane. Isandla kanye nobukhona bomuntu kubalulekile ngesikhathi kukhona ozalayo ngoba kusuke kuzalwa umuntu ezokwandisa umndeni ngakho ke kubalulekile ukuthi amukelwe kahle abantu bomndeni ukuze azizwe amkelekile naye. Esikubonayo manje ukuthi abantu besifazane sebegqugquzelwa ukuthi bazale emitholampilo kanye nasezibedlela lapho umfazi ozithwele ezithola esegunjini nabantu angabazi kanti duthi nalabo abasuke bezomsiza uma ebeletha usuke engabazi. Manje uthola ukuthi ukuxhumana komuntu nalowo osuke eyozala sekuyimvela kancani ngenxa yemishini eseyisetshenziswa emitholampilo kanye nasezibhedlela, obekwenziwa abantu sokwenziwa yimishini manje, abanye omama abasuke beyoteta esibedlela bayayisaba lemishini kanye nemimese esetshenziwayo. Bayaye bathi lemishini ekhona emitholampilo iyona eyenza kuphephe ukuzalela esibhedlela. Noma ikhona imishini kodwa omama bayaqhubeka bayashona, engikwaziyo ukuthi ukuzala kuyinto ebucayi umuntu ozalayo usuke ephakathi kokufa nokuphila akukhathaleki ukuthi usuke ekuphi ezaliswa ubani, yingako kubalulekile ukuthi umfazi azalele lapho ezwa khona ukuthi ukhululekile.” – Sarah*

*“Birthing is a special practice that comprises human interaction to give the woman giving birth a sense of love and warmth during the process, however, what we see now is that women are no longer offered the opportunity to give birth in the presence and safety of their homes and in the company of those that they love; they have to give birth in isolated rooms with strangers that carry out the birthing process. There is less human interaction and more machinery involved, they say that those machines make the birthing process easier and safer; however, you still hear of women that have died in hospitals during or after giving birth. Birthing is a natural, but complicated process that needs a woman to be in the company of the people that she loves and an environment where she feels safe. The new health care system has*

*taken that opportunity away from the woman and replaced it with lonely hospital rooms where some women end up dying in the presence of strangers.” – Sarah*

The role of machines presents a complicated sets of arguments for and against the function and social capital of TBAs. The arguments show some elements of bias for and against the use of machines. Some of the points raised require more research to deduce conclusions. The point is that each approach, both traditional and western, has its own unique advantages and disadvantages. None can be discarded outright, but the negative practices identified in each can be eliminated for the sake of ensuring safety of both the pregnant women and their babies.

### **6.3 Complications that have been attended to by medical personnel at Rietvlei Hospital**

There are said to be many complications that are associated with the practices and concoctions that the TBAs offer to pregnant women. The medical staff at the Rietvlei Hospital shared some of the complications they have seen among women during labour. Scholars such as Hogan et al. (2010), Ronsmans and Graham (2006), Jokhio et al. (2005), Yayla (2005), Bale, Stoll and Lucas (2003), Thaddeus and Mainne (1994), AbouZahr and Royston (1991) and Flegg (1982) have argued that too many women in developing countries die each year from pregnancy related causes. While this remains a challenge in the underdeveloped countries, they also suffer a shortage of skilled birth attendants and as a result, women use alternative health care systems with the assistance of TBAs who are regarded as unskilled and uneducated (Adegoke et al. 2012; Ahmed 2011; Prata et al. 2011; Baral et al. 2010; Scheffler et al. 2008; Paxton et al. 2006; Gerein, Green and Pearson 2006; Carlough and McCall 2005; Knippenberg 2005; Hangoro and McPake 2005). South Africa is one of the countries that suffers a shortage of trained and skilled birth attendants; while this is the case, cultural beliefs and practices also influence the health seeking behavior of pregnant women (Msoka et al. 2015 and Morris et al. 2014).

Even though health care facilities have become easily accessible in some traditional communities, some pregnant women still prefer the assistance and services of TBAs as they offer traditional and cultural practices that are not offered by the hegemonic western health care system. This reasoning has many medical personnel worried as they feel that pregnant women should only be assisted by them in health care facilities so as to prevent complications during and after childbirth (Phaladi-Digamela 2014). The medical personnel at Rietvlei Hospital explained that they believed that most of the complications that women and infants

suffer during pregnancy and the birthing process are as a result of the concoctions that are ingested during pregnancy.

While several studies report that the use of traditional medicine during pregnancy is high in South Africa, minimal research has been conducted on the potential benefits or harm of the ingredients used in the concoctions. Mkize (2015) argued that little is known about the chemistry, mode of action, or even the safety of most of the plants used in making traditional remedies used in pregnancy. While a few studies have reported that traditional medicine use during pregnancy may have negative outcomes (Mabina, Pitsoe and Moodley 1997; Mkize 2015), none have focused on any positive traits that may be offered by the herbal tonics prepared by TBAs. Mbwangi (2011), Mkize (2015), Usta et al. (1995), Varga and Veale (1997) and Houlihon and Knuppel (1995) have found that some of the outcomes associated with the ingestion of *isihlambezo* during pregnancy are foetal distress and meconium aspiration syndrome (MAS) which is the leading cause of morbidity and mortality in newborn infants.

The abovementioned complications were also reported by the doctors and nurses at the Rietvlei Hospital. Furthermore, Mabina et al. (1997) shared that conditions such as childhood malnutrition, congenital malformations, tumours, and acute renal failure have been linked to toxic or carcinogenic constituents present in herbal medicines taken during pregnancy. The contrasting reports between the views of the TBAs and those of these medical care practitioners on the roles and values of concoctions for pregnant women from TBAs does not allow for a collaborated report of what the issues. One has the impression that the two approaches to medical health of pregnant woman and their babies are more focused on supremacy of one approach over the other, than on an interest in the well-being of pregnant women and their babies. The impression is that each approach is struggling for recognition and supremacy. The medical personnel at the Rietvlei Hospital shared that the most common complication they have noticed among women who ingested traditional concoctions during pregnancy is abnormal labour. Dr Green defined abnormal labour as labour that progresses very quickly. He felt that people who ingest traditional concoctions present abnormal contractions. He explained that the severity of the contractions has an impact on the foetus especially with regard to the amount of oxygen reaching the foetus. He explained that some of the complications associated with the usage of *isihlambezo* are brain damage, mortality and disability.

### ***6.3.1 A relationship between traditional medicine and caesarean operations***

Caesarean sections were only performed in the case of an emergency according to this research. The medical personnel have a monitoring and evaluation sheet recording the number of caesarean sections they perform. Dr Green explained that a C-section should be the last resort as they are considered as a kind of complication themselves. Van Dille et al. (2007, 1) claimed that “increasing caesarean sections rates (CSR) are a major public health concern and the prevention of the first caesarean section, which often leads to repeat operations, is an important issue”. The doctor participant in this research explained that women who take traditional tonics during pregnancy have a potential of increasing their caesarean sections and mortality rates: “We avoid caesarean sections because of the associated complications: anaesthetics complications include low blood pressure, high spinal which affect the nerves to the heart and lungs and can even go to the brain”.

Failed spinal blocks sometimes mean a woman needs to be put under general anaesthetic which can cause complications for the foetus and the possibility of patients reacting to the anaesthetics. There are also surgical complications involved with the possibility of bleeding, infections and bladder/bowel injury. The doctor also shared that one of the negative effects of a caesarean section was that they limit the number of children that a woman can have and uterine ruptures are likely because of the scar left behind. It is for the above reasons that medical personnel consider caesarean sections as the last option. Van Dille et al. (2007, 1) claimed that reducing the number of first caesarean sections is a most important issue.

*“Esijwayele ukukubona njenga nodokotela balapha kulesisibedlela ukuthi omama abeza bezobeletha babonakala ngezimpawu ezithize uma eseqala ukuzala. Labo abasebenzisa imithi yesintu baye bathande ukwehluka kunalabo aba ngayi sebenzisanga, kuyaye kujwayele ukuthi badinage ukunakekelwa ukudlula labo ebebengayisebenzisi imithi yesintu. Angikubeke nje ngisho ukuthi bagcina beumthwalo ngoba isikhathi esiningi bagcina e theatre beyosikwa ngoba kubonakala ukuthi ingane isincisheka i oxygen ngenxa yokusikwa okuba ngamandla.”*  
– Dr Green

*“What we usually see as doctors at this hospital is that pregnant women who have been ingesting isihlambezo have a tendency of presenting with strange labour symptoms as opposed to women who have not been ingesting isihlambezo. Women who ingest isihlambezo during pregnancy usually have an increased ratio of suffering from complications and usually require more attention than those who do not ingest isihlambezo, it becomes a challenge for us medical*

*personnel as they end up requiring intense medical attention and sometimes even have to go to theatre for a caesarean if we find that the foetus is in distress.” – Dr Green*

*“Inking enkulu esibhekene nayo njenga nabodokotela kanye nama nesi ukuthi sizama ngazo zonke indlela ukuthi omama aba belethayo bazibelethele bangayi ukuyo hlinzwa, uhulumeni uyasikhuthaza njenga nodokotela ukuthi sizame ukugwema ukuthi omama bazale ngomthungo, kodwa siye sibone ukuthi labo abasebenzisa imithi yesintu baye bagcine sebezinkinga ezibeka izimpilo zabo kanye nezabantwana babo engozini kanye nasekufeni. Asazi ukuthi yini le ethkwa izinyanga uma benza isihlambezo eye yenze ukuthi omama abazithwele bagcine sebebhekana nalezizi zinkinga ababhekana nazo uma sebebeletha.” – Dr Red*

*“The challenge that we are currently facing as doctors and nurses is that we ought to try and avoid performing caesarean sections as they are potentially dangerous when compared to natural birth. However, those who use traditional tonics almost always have to be operated on as a result of perinatal asphyxia which is a process where the foetus is not receiving enough oxygen as a result of severe contractions. As medical personnel we have no idea what traditional healers include in the tonics that they prepare for pregnant women that cause such complications during childbirth.” – Dr Red*

The medical personnel at the Rietvlei Hospital shared that they have noticed a trend in women who ingest *isihlambezo* during pregnancy of passing meconium stained liquor. Meconium is the earliest stool of an infant. Unlike later faeces, meconium is composed of materials ingested during the time the infant spends in the uterus: intestinal epithelial cells, lanugo, mucus, amniotic fluid, bile, and water. Meconium is normally retained in the infant’s bowel until after birth, but sometimes it is expelled into the amniotic fluid (also called ‘amniotic liquor’) prior to birth or during labour and delivery. The stained amniotic fluid (called ‘meconium liquor’ or ‘meconium stained liquor’) is recognised by medical staff as a sign of foetal distress. The medical personnel shared that this is very common among women who ingest *isihlambezo* during pregnancy.

Dr Red explained that women do not always admit to using *isihlambezo*, but they have noted and know the common complications that are encountered by women who have ingested *isihlambezo* through pregnancy. Dr Red explained that when she first started working in rural hospitals she experienced meconium stained liquor (MSL) passed during labour; when she asked her consultant why so many women in the area were experiencing this, she was told that

they are not sure what the cause is, however, have noted that women who have admitted to ingesting *isihlambezo* during pregnancy often have this complication. Pregnancies complicated with meconium-stained liquor are regarded as at risk (Wong, Chow and Ho 2002; De Souza 1975; van Bogaert and Msira 2008). Evidence from studies indicates that the passage of meconium may be related to foetal maturity.

*“Ukuqala kwami ukusebenzela ezibedela zasemakhaya ngaqala ukuqaphela ukuthi baningi omamam ababelethayo ababa meconium liquor, kuyenzeka vele ukuthi omama babe nayo leyonking uma bezala into vele esihlezi siyi lindele njenga no nesi kanye no dokotela. Kodwa kwangixaka ukuthi kungani kwenzeka kangaka lapho engangisebenzela khona. Kumhlangno wasekuseni lapho esiye sikhulume ngezinkinga esibhekene nazo emsebenzini, ngaye ngathatha ithuba ngabuza kwabanye odokotela ukuthi kwenziwa yini ukuthi libe phezulu kangaka izinga lomama abathi mabezala kubese kuvela inking ye meconium liquor. Odokotela baye baphendula bathi abazi nabo, kodwa baye baqaphele ukuthi kwenzeka kakhulu komama abasebenzisa isihlambezo ngenkathi bekhulelwe. Lokhu kwenza ngifise ukuqonda ukuthi ngempela yini ekuthakwa ngayo isihlambezo eyenza ukuthi kube sekubela izinkinga ezingaka ngenkathi amama esebeletha.” – Dr Red*

*“When I first started working at this hospital for my community services I noticed that the number of women who presented with meconium liquor was more than usual, in the first couple of weeks of my gynaecology and obstetrics rotation I literally lost count of the number of women who presented with this complication during their process. Meconium liquor is something that we face on a regular basis as medical personnel, however, the rates at this hospital had me worried. I then decided to ask some of the doctors during our regular morning meetings where we discuss challenges and success that we face in our day to day experiences with patients at the hospital. I asked why there were so many women who were presenting these complications, all the doctors explained that they are not sure of the direct cause, however, it was a very common symptom amongst women who ingest isihlambezo during pregnancy.” – Dr Red*

There may be other nutritional or lifestyle factors that contribute to the complications experienced by many women at Rietvlei, apart from traditional medication. The hospital information contradicts with some of the assertions of the TBAs who believed that women who took the traditional medication as advised had easy and safe deliveries. It is also possible that the situation in the community in question has arisen due to the mistake of one particular TBA. This cannot therefore be used to generalise about the practices of TBAs.

Medical pluralism is an occurrence that exists in many culturally integrated societies. South Africa is one of the most diverse countries in the world and is home to many diverse cultures. It becomes difficult to define and treat a disease using the biomedical approach alone, as culture plays a large role in shaping health-related values and health seeking behaviours. During pregnancy, women feel the need to use health care systems that they feel will best protect them and their babies, while also promoting safe development for their foetus.

The nurses claimed to understand the dynamics that are involved within the health care system; they understood there are traditional practices and rituals for pregnant women. However, they worried about the ingredients in tonics given to women. Although they did not know details of the potential toxicity, they had noted a trend of complications among women who ingest *isihlambezo* (Veale et al. 1999; Varga and Veale 2002; Ngomane and Mulaudzi 2012; Brookes 2004).

The lack of scientific evaluation of the efficacy or safety of these medicines has resulted in condemnation of their use during pregnancy by health professionals in South Africa. The medical personnel felt that thorough scientific research into the ingredients of *isihlambezo* would be useful, although this could be challenging as they vary with different traditional healers.

*“Singabantu abamnyama ngako ke siyazi ukuthi sinezinkolelo zethu ezingahambisani nemithetho yasemitholampilo. Siyazi nathi njenga nabahlengikazi ukuthi isihlambezo into esetshenziswayo, siyazi futhi ukuthi sisetshenziselwani, inking esiba nayo ukuthi isihlambezo asiphekwa ngendlela eyodwa, futhi asazi nokuthi kufakwani uma senziwa. Esikwaziyo ukuthi sidala izinkinga kumama kanye nengane ikakhulukazi ngenkathi sekumele umama azale, siyayye sibe nenkiya nkiya uma ingane sekubonakala ukuthi incisheke umoya sekumele umama aphuthunyiswe etheter kuze kuyosheshiselwa ukuthi kuphume ingane. Abantu abasebenzisa isihlambezo babonakala ngokuba nezinkinga ezivuka esithubeni kodwa umuntu ube hamba umtholampilo singaboni lutho olungahle lube yingozi.” – Nurse Brown*

*“Before I am a nurse I am a black woman who was raised in the rural areas of uMzimkhulu. I understand our practices and also understand the reasons behind women ingesting tonics during their pregnancies. I understand the need to ingest isihlambezo during pregnancy, and if I am being honest before I attended nursing school I shared the sentiments that ingesting isihlambezo and imbelekisani during pregnancy were something that women had to do, it was*



*a cultural practice that needed to be followed so as to prevent unwanted complications during pregnancy. It was only when I started learning and practicing that I got to understand the effects of isihlambezo on the woman and mostly foetus. What worries us as nurses and doctors is that we do not know what is included when preparing isihlambezo and we feel that there should be thorough research conducted to find the toxins that cause the complications that we end up facing in the labour wards. We see all the complications associated with the ingestion of tonics during pregnancy and even though some women deny using these tonics the complications tell a different story.” – Nurse Brown*

*“Mina ngake ngasisebenzisa isihlambezo ngikhulelwe ingane yami yokuqala, umakhulu wam wayezenza ezithengisela nabanye omama emphakathini. Mina angibanga nalutho ngenkathi sengiyozala konke kwahamba kahle. Ngiyazi kodwa ukuthi bakhona abantu abaphtheke kabi uma sebeyozala ngenxa yesihlambezo, kusuke sokuyinkinga enkulu ngoba umama kanye nengane basuke sebephakathi kokufa nokuphila, kwenye inkathi sekumele ukuthi ayosikwa umama ukuze sitakule ingane le esuke ingasawutholi kahle umoya.” – Nurse Blue*

*“When I was pregnant with my firstborn I used isihlambezo, I started using it from the second trimester. My grandmother prepared it for me and I did not experience any complications during the birthing process. I know from experience that some women experience complications during the birthing process as a result of ingesting isihlambezo. The complications are quite severe and sometimes result in the death of mother and foetus, in most cases though we end up having to take women for emergency caesarean sections so as to get the foetus that is no longer getting enough oxygen as a result of severe contractions.” – Nurse Blue*

The findings of this study established that IUDs (intrauterine deaths) are more common among mothers who ingest *isihlambezo* during pregnancy. What seemed to bother the nurses was that the pregnant women denied taking traditional medicine as they were scared of being shouted at by the medical personnel; however, denying the use of *isihlambezo* during pregnancy can make it difficult for nurses and doctors to assist. *“We have found that pregnant women lie about using traditional medicine because they are scared of us, they are scared that we will shout at them as we tell them all the time not to use traditional medicine during pregnancy. They are not lying, we do shout at them, but we do that because we are trying to prevent them from using medicines that are harmful to them and the developmental growth of their babies.”* – Nurse Pink. These findings are consistent with studies carried out by Ngomane and Mulaudzi

(2012), Davis-Floyd (2000) and Mkize (2015) in which participants stated that they could not go to hospital for care because they were afraid of hospital nurses who yelled at them and scolded them.

A study carried out by Sibomana (2010) linked the death of a foetus to the use of herbal medicine that was ingested by the mother the day before. Similarly, a study carried out by Mbwanji (2011) found that staff had observed maternal mortality and other severe complications which they linked to the usage of herbal remedies during pregnancies.

Rolanda and Sally (2006) found that occasionally staff observed uterus rupture or even death that could be linked to the use of traditional medicine. Several other studies (Mkize 2015; Mbwanji 2011; Sulaiman, Mchsin and Chatterjee 2001; Mabina et al. 1997; Morris and Mdlalose 1991) have also found the use of herbal medicine in pregnancy to be associated with congenital malformations, intrauterine growth restriction, decreased foetal survival rates, low birth weight, foetal distress, foetal hypoxia and premature delivery as a result of uterine hyper stimulation which may lead to perinatal mortality.

The nurses explained that the use of herbal medicine was very challenging as they have no way of preventing pregnant women from ingesting them. Nurse Pink was concerned that women continued using traditional medicine even though they were educated each time they visited ANC clinics on the possible complications that may result from the use of traditional medicine. She explained that they noticed that women who visited ANC clinics every month and maintained healthy non-eventful pregnancies would at times experience complications during the birthing process. She explained that for a while this puzzled them until they found that women were taking herbal traditional tonics during pregnancy and some would even carry them to the hospital to continue taking them until the baby arrived.

*“Omama abazithwele abavamile ukukhuluma iqiniso uma sibabuza ukuthi bayawusebenzisa yini umuthi wesintu ngenkathi bezithwele. Baye bengasho ngoba phela besaba ukuthi sizobathethisa, ngempela ke vele siyabathethisa ngoba sisuke sesikhathele ukukhuluma into eyodwa siphindaphinda. Siyaye sithethe futhi ngoba sibona ukuthi babeka impilo yabo kanye neyengane esuke ikhula ngaphakathi engcupheni yokulimala noma ukufa. Esiye sikuqaphele nje ukuthi ingane iyalimala ngempela ngenkathi iphuziswa lemithi okungekho owaziyo ukuthi ithekwa ngani, siyaye sibone nama intrauterine deaths amaningi futhi komama abasuke*

*bephikile ukuthi bayayisebenzisa imithi yesintu baze bazovuma ngoba sebebona ukuthi kunenkinga ingane aysiphilile kahle noma seyiyashona.” – Nurse Pink*

*“Pregnant women never admit to the use of traditional medicine as they know that we tend to shout at them. I know that it must be frustrating for them to keep hearing that their traditional methods and medicines which they believe in and have been raised to understand as important and should be fulfilled during pregnancy, however, we also need to make sure that they are healthy during pregnancy and that there is an elimination of complications and noneventful births. I agree that we shout at them, however, it comes from a good place... We shout because we do not want maternal mortality, nothing is as painful as seeing a mother go home without her child or at times even both. What breaks our hearts is to see intrauterine deaths in mothers who were healthy and attended ANC visits throughout their pregnancies.” – Nurse Pink*

*“Kuleliveki elidlule kukhona intombazane egoduke ingamuphethe umntwana wayo. Lentombazani kade ihamba ikloniki lalapha kanti futhi beyiza zinyanga zonke singaboni lutho olungase lube yingozi kuyena kanye nakwi ngane, kodwa kuthe lapho eseyobeletha khona kwabakhona izinkinga esingakwazanga ukuzichaza ngenxa yokuthi ubelihamba ikloniki futhi simhlola nathi singatholi lutho olungase lwenze kube nezinkinga uma esebeletha. Indlela awayelunywa ngayo yayiphikisana nokuthi ingane seyiyaphuma. Kwaze kwabonakala ukuthi ingane seyisenkingeni umoya ayisawutholi kahle ngoba umama wayo wayesikwa kunganqamuki. Kwamele sibize udokotela ongazange athathe isikhathi eside ukufika, kodwa wafika ingane seyishonele ngaphakathi kumawayo. Omunye wonesi abasafunda wabona yone lentombazani iphuza okwakuse bhodloleni sathi sesibuza ukuthi ngabe kwakuyini yathi intombazani beyiphuza imbelekisani ukwenzela ukuthi isheshe itete.” – Nurse Blue*

*“Just last week a mother went home without her daughter. The woman had been coming to our clinic for the past eight months and had not presented with any complications during her pregnancy however, had an eventful birthing process. Her contractions had started when she was brought into the hospital, but had not dilated by then... her contractions were so severe and the foetus was in distress, we had to call a doctor so that she could be rushed to theatre, what worried one of the training nurses was that she was seen drinking muthi that was in a bottle that she had hid under her pillow. She was in excruciating pain while waiting for the doctor and nothing we did was helping because her contractions were severe and came one after, but no sign of the baby... by the time she was taken to theatre it was too late as her*

*daughter had unfortunately died. When asked what she was drinking earlier she explained that it was imbelekisani which was supposed to make the child come faster.” – Nurse Blue*

The nurses at the Rietvlei Hospital shared that they feared that the TBAs were not aware of the complications that some women suffer as a result of their traditional tonics. They wondered if TBAs monitored the women that took their tonics; one of the nurses shared that health care professionals have to follow up on their patients to check on their condition and well-being, and she wondered if the TBAs checked up on their patients for feedback on the birthing process. The nurses shared that it didn't seem that pregnant women were told about the side effects that they could encounter as a result of ingesting *isihlambezo* and other traditional tonics during pregnancy.

Another nurse thought that traditional healers might not be aware of the challenges that the nurses and doctors faced during the birthing processes of women who had ingested traditional tonics during pregnancy. One nurse speculated it would be difficult for the government to monitor and regulate traditional tonics and traditional healers did not receive monitored and regulated training. The nurses explained that they always get different answers when asking how the pregnant women measure traditional tonics and whether they mix these tonics with the medicines they receive from the clinics. Nurse Pink explained that she did not think that traditional tonics were bad; however, she felt that the traditional healers were not educated in measuring their ingredients to make them safe. She feared that many of the complications that they were seeing at the hospitals were a result of wrong measurements more than using toxic ingredients. Studies such as those by Mkize (2015), Azrina (2008) and Varga and Veale (1997) have suggested that the health impact of herbal medicine is highly dependent on amount, concentration and gestation age. Herbs may contain chemical compounds which may be teratogenic and exposure of the embryo to teratogens during the first trimester of pregnancy may cause congenital anomalies because this is a critical time for organ development.

*“Iyakhathaza indaba yokucabanga ngalezihlambezo ezisetshenziswa omama abakhulelwe ngenxa yokuthi asazi ukuthi kufakwani. Inking enkulu ukuthi basho izinto ezingafani omama bezingane uma ubabuza ukuthi sikalwa kanjani uma sizophuzwa isihlambezo sabo, njalo uzozwa izimpendulo ezingafani abanye bathi baphuza ispoon esisodwa, abanye ezimbili kanti abanye baphuza uhafu wenkomishi. Kuyaye kusiphazamise lokhu ngoba kumele uma kusetshenziswa umuthi owodwa kumele ukalwe ngendlela efanayo, noma umuntu engaya*

*phesheya uma efuna umuthi okhona lana eningizimu ne Africa uzofica ukalwa ngendlela efanayo.” - Nurse Pink*

*“It worries us as nurses to think about as we obviously do not know what is included in the tonics. The biggest problem that we have is the fact that these tonics are prepared by different people with different skills and methods, when you ask the women who ingest these tonics how they measure them you get a different answer all the time... some will tell you that they take a spoon, others two some even take half a cup. You just never know how they are actually supposed to take these tonics and how much. Western medicine for example will have the same dosage intake for medicine, if you go to another country you will find similar dosage measurements.” – Nurse Pink*

*“There is very little education that we can do when the patients come to hospital with a complication, we do try and educate while they are still pregnant, however, most women do not listen they only realise the severity of the complications only when they are going through them.” – Dr Green*

Some women would rather die and lose their babies than not ingest traditional tonics during pregnancy, the nurses explained. Some women confessed only after the complications that they were indeed using traditional tonics during their pregnancies, and some shared with us they would never use traditional tonics again after the pain and other life threatening complications experienced during the birthing process. The nurses felt that intervention from the government and policy makers was needed urgently as they felt that the use of traditional tonics impacted negatively on the health outcomes of pregnant women and increased their mortality rates.

*“Siyaye sibacele oSr ukuthi basikhulumele nabo omama abasuke beza kuma ANC clinics ngezinkinga okungenzeka zibavelele uma beqhubeka besenzisa imithi yesintu ngenkathi bezithwele. Kodwa ke omama abafuni ukulalela bayaqhubeka basebenzise imithi yabo banga kunaki ukubexwayisa kwethu njenga nonompilo, bafika kithina ngoba sekonakele sebevelwe yizinkinga, angeke ke kuthi umuntu efika esezinhlungwini kanye nempilo yakhe isengcupheni. Kanti futhi awukwazi ukuthi utshele umuntu ukuthi bekungamele ukwenze ukuthi ngoba esbhekene nenkinga kumele nje ubasize wena kuphela. Asinayo indlela esingenza ngayo njenga no nesi kanye nodokotela esingavimba ngayo ukuthi omama bangayisebenzisi imithi yesintu, uhulumeni kuphela ongagwema loku uma befuna ukuthi kusinde izimpilo zomama kanye nezingane abazithwele.” – Dr Red*

*“We do ask the sisters and nurses at the clinics to educate and discuss with pregnant women the issues involved when one ingests traditional tonics during pregnancies, however, women refuse to listen and continue despite the warnings that they receive. They come to us when there is already a complication and it doesn’t help much to tell someone you should not have done that, you just have to help them. We have no control over the situation, some women do listen, but others do not... The government needs to intervene and quickly if they want to see a change in maternal mortality rates in this country.” – Dr Red*

Collaboration between the hospitals and the TBAs needs to be a policy imperative. It is clear that traditional women will always follow the advice of TBAs although they are unlikely to admit this to the nurses. It seems the nurses also need to change their attitudes to gain the trust of the pregnant women they work with. It could be that some of the traditional concoctions are safe on their own, but dangerous if combined with medication from the hospitals. It appeared there had been much finger-pointing rather than a concerted and combined effort to find out what the problem is. A medical system that is not only different, but hostile and antagonistic to the culture of the people is not ideal, if the well-being of the people of that culture is a serious consideration.

#### **6.4 Inclusion of TBAs within the broader health care system is best for everyone**

The inclusion of TBAs within the broader reproductive health care framework could improve the health care system in South Africa according to some of the medical personnel at the Rietvlei Hospital. The doctors felt that collaborating with TBAs would make a much more efficient health care system that would provide holistic health care services to patients. “Traditional health care is another health care system just like ours,” explained one of the doctors, “it is unfortunate that the general impression among people is that it is backward and unsafe, as Africans we have also been brainwashed to believe that like everything else that belongs to us is backward and needs to be altered to meet the standards of other culture who regard and rate us in lower standards”. The findings established that training TBAs is one of the solutions that the medical personnel at the Rietvlei hospital think the government should try if they are serious about reducing maternal mortality rates and meeting the Millennium Development Goals. Scholars such as Gill et al. (2011), Sibley and Sipe (2006), Goodburn et al. (2000) and Greenwood et al. (1990) have argued that TBAs should be identified and trained to improve pregnancy outcomes and potentially lower the maternal mortality rate.

Developing countries are among those that experience the highest maternal mortality rates in the world, due to poor infrastructure, poor health care facilities, shortage of medically trained personnel and cultural beliefs practices and preferences that influence the health seeking behaviour of pregnant women. To combat maternal mortality rates, countries such as Pakistan, Bangladesh, Gautemala, South Sudan, Ghana and Nigeria have taken a decision to train and capacitate TBAs so as to decrease maternal mortality rates. Studies by Haarsager (2008) Roplogle (2007), Hakeem et al. (2005), Smith et al. (2000), Paul and Rumsey (2002) and Akpala (1994) have focused on the training of TBAs and found that training TBAs improved the health care system as cleaner and safer birthing processes were introduced and complications more easily identified.

*“Ukuthi ababelethisi besintu bafakwe kwezempilo ngibona kuyikona okuzoba ngcono, mina ngibona kuyisixazululo kuzozonke lezinkinga esibhekene nazo thina bodokotela nonesi. Uhulumeni ulindele ukuthi sikwazi ukwenza ama target abasenzela wona wokuthi sinciphise ukushona komama kanye neingane, kodwa ukufundisa omama abazithwele kanye nokuyekisa ababelethisi umsebenzi wabo akusona isixazululo kunaloko kuyabhebhethekisa lolubishi esibhekene nalo. Ukufaka ababelethisi besintu kwezempilo kuzokwenza kube lula ukuthi bakwazi ukuqeqeshwa ngendlela efanele ukuthi basebenzise imithi efanele kanye nezindlela ezingcono zokusiza omama abazithwele.” – Dr Green*

*“To include traditional health care workers within the broader health care framework is better, I personally see this as a solution to many to the challenges that we are currently facing as medically trained personnel. The government expects us to meet certain requirements especially in maternal health as they want to reduce the mortality rates, however, educating pregnant women and restricting TBAs to perform certain practices is honestly not solving the problem. Including TBAs within the health care framework might help as TBAs could be offered training and guidance to better assist pregnant woman.” – Dr Green*

*“Amazwe asakhula njenga naleli lethu ezempilo kesakude ukuthi zifike ezingeni eliseqophelweni lokuthi sikwazi ukusindisa izimpilo njengoba uhulumeni kanye ne WHO befuna ukuthi senze. Kuningi esisabhekene nako okuyizingqinamba kithi, intuthuko, amakliniki emphakathini, kanye nabasebenzi bezempilo abalingana nenani labantu abadinga usizo. Ukuthi kususwe ababelethisi besintu kwezempilo akulona isu lokwenza izinto zibe ngcono, ngibona kungcono ukuthi bafakwe kwezempilo ngaleyondlela sizokwazi ukusindisa izimpilo zabomama kanye nezingane zabo. Kunamazwe asebakile ababelethisi besintu kwezempilo*

*baphinda babaqeqesha futhi kanti futhi imiphumela yabo mihle ngoba ababelethisi sebeqeqeshiwe bayazi ukuthi yini ekungamele bayenze. Ngibona kungcono ukuthi iSouth Africa nayo yenze njalo.” – Dr Red*

*“In developing countries health care as a whole still has a long way to go before we can have the kind of impact that the government and World Health Organisation are expecting. We are still faced with poor infrastructure, limited number of clinics and trained health care personnel and as a result people are taking advantage of the situation by providing naïve patients with bogus health care and medicines. Cutting out traditional healers is not the answer, I feel that including them in mainstream health care we can save more lives that way. There are countries that have budgeted and trained traditional healers and are seeing better health care outcomes. South Africa should do the same, especially since it is such a multicultural and diverse country.” – Dr. Red*

Including traditional healers into the mainstream health care system would allow researchers along with health care personnel to get an in-depth understanding and knowledge into the practices that are offered by the traditional birth attendants. It could help with planning and would assist those training them to know where the greatest weaknesses are. Including traditional healers into the mainstream health care system would also provide insight into the traditional tonics prepared for pregnant women. It would give medical personnel the opportunity to train TBAs in how to treat minor ailments that do not need immediate hospital attention and to recognise complications that need immediate medical care. Testing the ingredients is one of the important issues according to hospital staff so that TBAs can be taught to exclude the toxic ingredients from their traditional medicines.

*“Abanye ababelethisi besintu bayawazi umsebenzi wabo, bayazi nokuthi imithi yabo yenziwa kanjani ukuze ingacini isiba yingozi. Kudala omama bethu bekhulelwe yithina babesebenzisa zona izihlambezo lezi kodwa kwakuba kancani kubekhona lezinkinga esezibakhona manje. Inkinga enkulu ngesikhathi esiphila kusona ukuthi abantu sekulula ukuthi bazenze izinyanga bathengisele abantu imithi eyingozi. Ayikho indlela yokuthi siabgade abantu abazenza izangoma, kodwa ukuthi bafakwe kwezempilo ukuze bathole ukuqeqeshwa yikona mhlawumbe okungenza ukuthi kuisombululele lenkinga esibhekene nayo okwamnaje.” Dr. Green*

*“Some of the traditional healers know their work and understand the contents of the ingredients that are supposed to go into the tonics and have been in use for as long as any of*



*us can remember... Some of our parents used these tonics when they were pregnant with us and did not endure any complications. The problem these days is that everyone is becoming a traditional healer and are putting the lives of many women and babies at risk. There is no way of monitoring and tracking traditional healers, however, including them in the mainstream health care and creating new policies can maybe try to solve the problem.” – Dr. Green*

The findings established that the medical personnel felt that TBAs are slowly being integrated into the mainstream health care system because they are able to refer patients to hospitals and clinics. The medical personnel shared that some of the TBAs wait with their patients at casualty until they have been attended to. This has changed the attitude of medical personnel towards TBAs; previously they have been known to abandon patients and have no follow-up processes in place for patients. The doctors explained that the TBAs were an important means of improving reproductive health care systems within South Africa; banning and excluding them would only make matters worse because many women believed in their practices and some even preferred them over western medicine. According to Makoae (2000), TBAs are an important resource for primary health care in many developing countries. Training programmes to upgrade and improve TBA skills are common and are encouraged by the World Health Organisation. While the medical personnel appreciated the input of some of the TBAs in rushing patients to the hospitals, they did feel that they believed that hospitals could assist women regardless of the complications and often only brought patients in advanced adverse circumstances into health care facilities. Many examples were given by the nurses and doctors of the events they have had to deal with as a result of TBAs sending patients with advanced complications. The findings established that many of the IUDs they have faced were a result of women who had come to the hospital too late due to the assistance of TBAs. The medical personnel explained that sometimes patients would be handed over to them by a TBA along with traditional medicines and enemas, completely dehydrated as a result of induced vomiting which is part of the practices of some TBAs during pregnancy.

*“Abanye omama bafikiswa kuthina sebenezinkinga eziphuthumayo okuba yinkinga kakhulu ukuthi asibe sisazi nathi ukuthi sathathe ini siyihlanganise nani ngoba sisuke singazi ukuthi baze babe kule simo abakusona bekusuke kwahlanganiswa ini nani ngobani. Uyaye uthole ukuthi abanye balabomama abazithwele bafikiswa sebe sesimweni esibucayi, kodwa bebehlalisiwe kubabelethisi besintu ngethemba lokuthi bazobelethela ekhaya bese bephuthunyiswa esibhedlela sebetetile. Okusenyanisweni ukuthi kuyaye kube nezinkinga ezivelayo uma umuntu*

*ezala ezidingisa umtholampilo noma isibhedlela ukusindisa impilo kamama kanye nengane.”*

*– Nurse Brown*

*“Some women are handed over to us with adverse complications and the problem is that we do not even know where to start because we do not know what has been done to the woman. You find that some of the women that are handed over to us have serious complications that need immediate medical attention, but were kept by the TBA with the hopes that they would be able to treat the complication and birth a healthy baby. Truth of the matter is that once there is a complication both the lives of the mother and foetus are in danger.” – Nurse Brown*

*“Yebo, ababelethisi besintu bayabaletha omama ababelethayo kithi uma sebeqala ukusikwa, kodwa ngesinye isikhathi basinikeza bona sebenezinkinga eziphinda phindene ngoba baqale bazame ukuthi benze ezabo izinto zokuzama ukusiza abafazi uma bezala. Asikwazi abakwenzayo uma bezalisa abantu, kodwa siye sithole ukuthi isikhathi esiningi basinikeza amapatient asebeke bazama ukuthi bazizalisele noma esebeqale babaphuzisa imithi babachathisa, baye bathi ukuchatha kubalulekile ngoba uma umama esezala akufuneki ukuthi kuphume kanye netoilet ithinte ingane ngoba kuthiwa yenza ukuthi umtwana abe noqathu angathandeki. Asazi ke ukuthi kufakwani kulemithi abachatha ngayo ngoba ufika abanye omama sebekhala ngokuthi kuyashisa ngaphathi ezinqeni kanye nasemathunjini.” – Nurse Blue*

*“Yes, TBAs do refer patients to us, but at times they hand them over with double the complications. We do not have knowledge of the practices and manner in which births are carried out by the TBAs, however, we often find that the women that they hand over to us have used the enema in an attempt to remove stools which is considered to be bad luck, we do not know what goes into the enema as some women have complained that their rectums are burning and are painful.” – Nurse Blue*

*“Ababelethisi besintu benza umsebenzi omuhle kakhulu ngokuthumela omama abazithwele kithi, ngibona kungcono ukuthi omama abakhulelwe bathunyelwe emithola mpilo umasebeqala ukusikwa. Ngisho loku ngenxa yokuthi maningi ama complications abakhona uma umuntu ebeletha, kuyaye kubengcono ukuthi athi eqala umuntu abe esemtholampilo ukuze akwazi ukuthola usizo oluzom lungela ukuthi asinde yena kanye nomtwana. Kueminyanga edlulile esengiyi sebenze lapha sesibone omama abazithelwe belethwa esibedlela sekukade icomplication iqalile, abanye bafika bene Cephalopelvic Disproportion (CPD) eyenzeka uma*

*ungane inkulu kunendawo okumele iphume kuyona, kona akuvamile ukuthi kwenzeke loku, kodwa ke uma umama elunywa kodwa ingane ingaphumi kuyaye kuthiwe inking yiyona iCDP.”*  
– Nurse Pink

*“TBAs are doing a wonderful job of referring patients to us, however, I feel that pregnant women should be taken to health care facilities immediately when their birthing process starts. This is because there are so many complications that can arise and need to be treated with machines and medicines that are only treatable and manageable within the health care facilities by trained health care personnel. Over the years there have been a number of women who have been brought in hours later than they should have that have presented with Cephalopelvic Disproportion (CPD occurs when a baby's head or body is too large to fit through the mother's pelvis.). CPD is rare, however, many cases of “failure to progress” during labour are given a diagnosis of CPD.”* – Nurse Pink

The medical personnel shared that while the efforts of the TBAs were making a difference and contributing the reproductive health care system, some were however still not willing to assist patients by escorting them to nearby hospitals as soon as the birthing process started. They still want to assist and only when complications are beyond their scope of knowledge will they rush the women to hospital for medical assistance. Training is important as such incidences could be avoided, explained one of the nurses. Teaching TBAs to identify complications and offering them resources to take women to hospitals or at least call ambulances that will be able to provide some medical assistance until the woman arrives at the hospital are important aspects of reproductive health that should be taken into consideration by those who formulate policies and plans.

*“Once we received a patient that was 2cm dilated, however, was getting three strong contractions in ten minutes. It did not make sense to us at all, we knew there was a problem and we had to rush the woman to theatre. After the ordeal we asked the woman what happened and she explained that as soon as she felt some pains she was taken to a TBA who was supposed to assist her, upon her arrival she was made to drink some muthi which was said to help her with pains and make the birthing process easier. She explained that she remained in the care of the TBA for a couple of hours, but the baby wouldn't come... The father of the child finally insisted that they rush her to hospital as he was not happy with the medicine that the TBA insisted that she drink after every hour. We explained to her that there was no way she was*

*going to give birth at home as her condition needed medical technology that TBAs do not possess.” – Nurse Pink*

*“At times it is not even the fault of the TBAs, but the issue of transport. Ambulances are available but are unable to cover the whole of uMzimkhulu as it is such a big area. Some women end up having to take public transport and those that have money hire cars within their communities. We have had an experience of women being attended to that had uterine ruptures before they even arrive at the hospital.” – Nurse Blue*

## **6.5 Conclusion**

Prior to the introduction of the western health care system, traditional medicine was dominant in all traditional societies and was the source of health care within many African traditional societies. The introduction of western medicine has brought about competing discourse on the efficacy of traditional medicine. The general view was that traditional medicine was forcefully being replaced by the western health care system, with possible conflicts between TBAs and medical personnel being caused by the different belief and practice systems. It appeared that TBAs felt that their practices and knowledge were regarded as lower and more backward by those who held the view that western medicine was a safer alternative. A great challenge that the TBAs believed to be unfair was that their practices were being appraised by the scientific standards of the hegemonic health care system. TBAs, who are generally known for their lack of formal education, are forever being judged by their competitors who are regarded as knowledgeable and skilled. The medical personnel at the Rietvlei hospital shared their experiences of the complications they had to deal with which they assumed to be as a result of the practices and medicines offered by the TBAs. A number of studies described similar complications to those the health care personnel at the hospital had experienced and attributed these complications to the tonics that women ingested during pregnancy which are mainly *imbelekisani* and *isihlambezo*. The general view was that TBAs should be trained and included within the broader reproductive health care framework as the medical personnel felt that then it would be easier to train and monitor the ingredients that were included when preparing traditional tonics during pregnancy.

## **CHAPTER SEVEN: Conclusion and recommendations**

### **7.1 Introduction**

This chapter is a summary of the central findings and arguments. It draws conclusions and recommendations that are based on the analysis of the results of the study, looking at the life histories of traditional birth attendants in the context of changing reproductive health practices in uMzimkhulu, KwaZulu-Natal. This exploratory study sought to work through the life histories of TBAs and probe whether they felt that their traditionally based expertise was being included within a broader reproductive health framework, or whether African peri-urban women's responses to them were compelling them to change and adapt their (traditional) practices when working with pregnant women. The discussions in this study outlined the traditionally based practices and rituals that TBAs offer to African women and some of the practices they have had to change over the past decade as a result of globalisation and pressure from the western scientifically based health care system in an attempt to provide 'safer' practices and rituals. The life histories showed TBAs' responses to peri-urban women who appear to be resistant to their traditional based expertise or those that show low adherence and what the TBAs thought were the areas of possible conflict between their traditionally based expertise and approach to reproductive health and the so-called western methods practised in clinics and hospitals.

### **7.2 Summary of the findings**

Most of the TBAs that participated in the study were trained sangomas who underwent intensive long-term training at various training schools. The participants suffered mysterious diseases, unexplainable bad luck and repetitive dreams which were later diagnosed by other sangomas as symptoms of an illness known to the South African black communities as *ubizo* which they were advised to cure through intensive training known as *ukuthwasa*. New identities for these women have been constructed as gender roles within patriarchal communities previously restricted women from leading roles during cultural practices and rituals, especially those that need communication with ancestors as that was solely a male role. The findings established that TBAs play an important role in their communities as they offer traditional based expertise that many women sought during their pregnancies. Within their communities, they are highly respected and are often the first choice as they offer traditional expertise and

are considered an important part in the worldview of the women who seek their advice. Ancestors are seen as important beings that have a significant role in the lives of the TBAs and the women that consult them; the ancestors are seen as mystical beings who have authority over the lives of those that live in this world. Pregnant women visited TBAs for protection during their pregnancies through the ritual practices that the TBAs offered. As some of the TBAs were trained sangomas they were also able to see any harmful threats to their pregnancies. The women in the study felt comfortable in the presence of the TBAs and preferred their services to the medical personnel in health care facilities. The findings established that TBAs were not only consulted for their expertise as caregivers and health practitioners, they were consulted for family planning and conflict resolution. The participating women expressed that the TBAs were the 'glue' that held their communities together. Many of the participants viewed them as community counselors they could confide in and who would find resolutions that would be accepted and followed by family members.

Pregnancy and birth are embedded in highly visible social matrix rooted in rituals and a spiritual realm of beliefs. The findings established that cultural practices during pregnancy played a meaningful role in the lives of the participants. The TBAs offered a wide range of rituals and cultural expertise not offered in western health care facilities. All the participants regarded pregnancy as one of life's most important events that needs utmost care. It was established that the 15 peri-urban women that participated in the study differed in their views of 'safe' methods and practices and their choice of a health care system during pregnancy. Practices offered by the TBAs were seen as pivotal by women that resided within the rural communities that TBAs operated in while those that did not reside in rural communities found them to be harmful and a risk to their pregnancies. The main aim of the TBA services were to offer protection to the foetus and pregnant mother from harmful and evil spirits that may be directed by jealous love competitors or even witches. Birth was seen as growth within the family, especially if the child was a boy as that meant a continuation and growth of that particular family; not all family members were happy about this. All the women that resided in the rural areas believed in the power of witchcraft and believed that the TBAs were able to protect and block such events from happening. Besides the protection against harmful spirits during pregnancy, TBAs assisted women who were unable to conceive and those with STDs.

Health seeking behaviour was often guided by the cultural beliefs of the participants; however, some mentioned that their families played a role in their selection of a health care system during

their pregnancies. Grannies and mothers especially offered advice on the benefits of the health care systems that they felt were best during pregnancy. Health seeking behaviour was also found to be influenced by the level of education of the pregnant woman. Some scholars even aligned levels of high education with the choice of 'safer' health seeking methods. Educated women preferred the assistance of western medical personnel, regarding this as the safer option. Modern women have lost confidence in TBAs due to their lack of education and training. In African communities, undermining the advice of your elders is regarded as disrespectful and can result in bad luck and rejection by the ancestors. It was established that the TBAs were able to assist women that were unable to conceive. Infertility according to TBAs was a common problem amongst the women they see. Infertility is a particularly important issue in African culture as a great deal of importance is attached to parenthood, especially for those who are married. The TBAs offered a practice known as *ukumisela* for infertile women. The practice involved 'cleaning' the women and seeking guidance and assistance from the ancestors as infertility can be caused by the anger or disapproval of the ancestors. Throughout pregnancy, the women participants in this research visited the TBAs for a practice known as *ukuxukuza* where the TBAs feel for the head and buttocks of the foetus is an attempt to establish the position of the foetus and to estimate the month of delivery. The TBAs also applied traditional medicine to the bellies of the pregnant women to protect the foetus against harmful spirits. *Isihlambezo* is one of the most popular of the medicines that the TBAs offered, with some of the participants believing that *isihlambezo* was a necessity during pregnancy as it assisted with the development of the foetus and made the birthing process easy and uneventful. *Ukuzalisa* is a practice that the TBAs only offer now in cases of emergency.

Medical pluralism exists in the community of uMzimkhulu with many women still attached to their cultural beliefs as well as the benefits of western health care. The use of both health care systems enabled women to fulfil both their cultural and medical needs. The importance of traditional medicine during pregnancy was highlighted as some of the women feared witchcraft as a threat to their pregnancies; the use of western health care provided them with the additional practices that traditional medicine lacks such as ultrasound scans and pregnancy vitamins. Mistreatment in the hands of medical personnel was one of the reasons for some of the women seeking alternative health care where they felt they would be treated with respect and dignity. TBAs were found to be the opposite as they were part of the community, understood the cultural practices of the participants and treated the women with respect and dignity

Unemployment was a reason given by some of the participants for not using health care facilities as they did not have the funds for transport.

With the encroachment of the western medical system, many traditional practices have had to change and adapt to new safer practices as prescribed by the scientific standards of the western health care system. The TBAs have attended workshops that sought to train them on safer practices and harmful medicines and as a result, they have had to change the ingredients of their tonics. Attending the workshops is the responsibility of the participants as they have to cover their own travelling fees and many felt they could not afford this. A practising TBA is now much more like her western counterpart as she needs to obtain certificates with practice numbers. This was something new to the TBAs as healing has never been associated with a piece of paper that needs renewal after a certain time. Practices offered by the TBAs during pregnancy were considered unsafe as TBAs are regarded as lacking education and skill to attend to complications; as a result policies have restricted TBAs from assisting women with the birthing process. The findings established that even though TBAs are no longer allowed to assist women during the birthing process, they do often assist in emergency situations where ambulances take a long time to arrive or when women do not have the money to hire cars.

The scope of TBAs has been extended over the years; they have been trained to counsel HIV positive women and encourage them to take their antiretroviral drugs. Health promotion is not something new to the TBAs but an in-depth scientific understanding of a specific illness is. TBAs are no longer allowed to collect certain medicinal plants which are endangered. Some of the TBAs do not have a clear understanding of the nature conservation act and see it as a deliberate attempt by the western health care system to restrict their practices. Even before the introduction of the workshops, TBAs have long known some of the symptoms of STDs, and some did not treat but rather referred patients to health care facilities. The scope of the TBAs has broadened and they are now able to refer patients to the hospitals. Medical personnel felt that some patients were brought in with escalated complications, but it is still useful when a patient is brought in as they are able to treat the complications and stabilise the patients for further medical treatment.

As the hegemonic western health care system continues to grow and education becomes increasingly accessible, the attitudes of some people towards traditional medicine have changed. Those who are educated mostly hold the view that traditional health care practices are not safe and have not been scientifically proven. Even though health seeking behaviour has



often been guided by cultural beliefs, this is no longer the situation for some women as the findings established that some women have lost confidence in traditional health care practices during their pregnancies. The complications that arise during the birthing process that TBAs are not able to treat, the traditional tonics that are ingested during pregnancy that are said to cause complications during the birthing process and the underdevelopment of the foetus were part of the reasons why some women preferred western health care services during their pregnancies as opposed to TBAs. Some women only visited TBAs for medicines that they could apply onto their bodies to protect and chase harmful and evils spirits away from their unborn babies, but did not ingest any traditional tonics as they feared their effects.

Findings have established that there are two dominant and divergent paradigms that inform the discourse on childbirth. The biomedical treats pregnancy and childbirth as an illness, requiring technological management by skilled professionals in formal medical facilities. In contrast, where medical pluralism exists, pregnancy, childbirth and the post-parturition period are seen as natural. The encroachment of the traditional health care system has shifted birth from a natural state to a technologically based state with the idea that machines are assumed to make the birthing process safer. Some scholars, however, have refuted that machines make birthing safer and easier and have instead argued that machines add to the complications and rise of caesarean sections which are regarded as a one of modern medicine's last resorts due to the complications that can occur. The technocratisation model has eliminated the human touch which the TBAs feel is an important aspect of birth and in welcoming the unborn baby. Some of the participants preferred giving birth at home in the presence of their families and loved ones where they could practise their traditional rituals. However, the natural state of birthing has become associated with the possibility of complications. The technocratisation of birth has taken the power of the women to decide on health care systems that they feel are better suited for them and their cultural practices. Some have argued that the female body is considered as merely a machine that can be plugged into other machines that do the labour for the women as opposed to the woman's body doing the birthing. Some of the participants felt that the machines neglected them and were too focused on foetal monitoring; they expressed their dissatisfaction with this development preferring TBAs who focused on both the woman and the foetus.

Participants from the rural areas feared health care facilities and they expressed their fear of nurses and the technology. All the rural participants expressed their fear of needles and the blood tests that are conducted for HIV and STDs and they feared receiving their HIV results.

This finding established that these women feared ANC and clinics because of the compulsory HIV test. TBAs have encountered women who do not want to visit health care facilities because they fear testing for HIV and other diseases; it emerged that some TBAs who assist women with STDs encourage women to get tested for HIV at the health care facilities. Family planning is one of the popular practices that the TBAs offer, even though there was no consensus among the TBAs on the type of family planning, they all concluded that family planning was an important aspect within reproductive health care. Some of the TBAs felt that family planning options offered at the health care facilities are filled with chemicals that in turn poison the body and cause infertility among women, while other TBAs preferred that women use family planning options from health care facilities as they feel that they are more effective.

Few studies have focused on the specific elements of *isihlambezo*; this study contributes to filling this gap and details various herbs and other ingredients used in the preparation of *isihlambezo*. The findings established that some women doubted the usefulness and safety of the concoctions that are prepared by the TBAs while some felt that they were safe and a necessity during pregnancy. Some scholars and the medical personnel at the Rietvlei Hospital have associated the ingestion of traditional tonics during pregnancy with complications that are present during pregnancy and the birthing process. The findings established that most of the complications that arise during the birthing process are severe and often increase the number of caesarean sections and IUDs. Users of alternative medicines such as traditional tonics found they had been prepared with natural herbs and were good supplements. Some women in this study preferred traditional tonics to vitamin pills which they assumed contained chemicals that could threaten the development of the foetus. The study established that some women carry their traditional tonics to the hospital and continue taking them while waiting for their babies to be born. The medical personnel explained that they often came across bottles filled with traditional tonics in the maternity wards; however, they were never told what the medicine was as the women were afraid of being shouted at.

The study found that the TBAs felt undervalued and with little control over their own traditional health care system as they are being forced to adapt to new practices that are in line with the modern health care standards which neglect their own knowledge and regard their practices as unsafe. It worried the TBAs that their knowledge and practices are being eradicated by a foreign health care system that seeks to dominate and force people of different cultures to follow one health care system. The TBAs explain that the western health care system does not offer a

holistic approach to health care and excludes the cultural understanding and causation of meaning that is attached to illnesses and therefore does not meet the needs of some cultures. Even though the TBAs still see patients, they do not have autonomy in healing their patients as they have been banned from offering certain practices to pregnant women and patients in general. The TBAs explained that the western health care system practices and methods have infiltrated into and eradicated their own systems. When they offer services to women now, either they are referring patients for 'safer' treatment at health care facilities or they are using modern health care practices and abandoning their own in the process. Even though they had learned many useful practices from the workshops that they attended, some of the TBAs felt undermined as nurses and doctors had no interest in learning and understanding their practices.

The findings established that some women no longer have confidence in the services that the TBAs offered and that women are becoming resistant to their advice. The findings of the study established that the TBAs felt that modernisation, education and the introduction of the western health care system have all had an impact on the manner in which black people receive and utilise their services. This finding worried the TBAs as some expressed their dissatisfaction in the manner in which reproductive health care is evolving. TBAs have an understanding of pregnancy which is different to that of the western health care system as they view pregnancy as a spiritual rather than physically based experience. It was established that women are particularly vulnerable during pregnancy where they can experience witchcraft, harmful and evil spirits. The study established that physical examinations were an important aspect of pregnancy, however, a holistic approach which also focuses on the spiritual aspect is important.

The study established that training TBAs on safer reproductive health care knowledge and practices was one way to address the spike in complication rates and maternal mortality. The medical personnel at the Rietvlei Hospital suggested that TBAs be included within the broader reproductive health care framework for the improvement of maternal mortality rates. The view was that including TBAs would allow western health care practitioners an insight into the practices and medicines used by TBAs when assisting pregnant women. The doctors recommended more research to gain insight into the ingredients of the traditional tonics so that the toxic ones can be excluded and a standardised method could possibly be rolled out for all TBAs.

### 7.3 Contributions of the study

This study has made the following contributions in the area of traditional birth attendants and reproductive health care in South Africa.

The study has covered a broad range of cultural practices that are used by the TBAs when assisting pregnant women during their pregnancies. It has given insight into the medicine that the TBAs in uMzimkhulu use when preparing their traditional concoctions, namely *isihlambezo*, *imbelekisani*, STD medication and the medicines that are rubbed on the bellies of pregnant women. Gaining insight into these ingredients is a first step to allowing researchers to conduct comprehensive research on the ingredients so as to eliminate the toxic elements and possibly standardise safe ingredients to be used by all TBAs within South Africa which could potentially reduce the number of complications that the medical personnel see during the birthing process. Gaining insight into the ingredients could also mean that there will be an improvement in the development and growth of the foetus, decreasing the number of babies that are born with low birth weight. A comprehensive study of the ingredients may also disclose traditional ingredients that are beneficial during pregnancy.

The study can assist the government, western health care system and facilitators to review their contributions and support in the practices that TBAs offer. The study establishes the strengths and weaknesses of the TBAs within the health care system which can highlight areas where possible training, assistance and support could be offered. Throughout the study the TBAs expressed their frustration regarding the manner in which the western health care system has taken over their health care system and has left them with less autonomy over the practices they offer to pregnant women. Training of TBAs has covered issues such as the use of gloves, recognising complications and referring pregnant women that are presenting with complications to hospitals. However, TBAs and traditional health care practitioners in general need assistance with the inclusion and measurements of ingredients when preparing traditional medicines.

The study has provided information on maternal health as well as cultural aspects that are the basis for the TBAs' practice, knowledge and skills. The study has offered an insight into the practices that are offered by TBAs and the role they are playing in the rural communities of uMzimkhulu. It gives insight into the traditional practices that are still entrenched within these rural communities and highlights the history and knowledge that the TBA practices and knowledge are based on.

#### **7.4 Recommendations for further research**

Including THPs/TBAs within the broader reproductive health care framework could assist in reaching out to a great number of women as many studies suggest that many women visit TBAs in traditional rural areas, especially in South Africa. Having TBAs included within the health care system may allow a bridge for educating and accessing a greater portion of the female population that does not have an understanding on the importance of ANC visits during pregnancy.

Training TBAs has been found in other countries to have contributed positively to reproductive health. In a country such as South Africa with diverse cultural and medical cultures, it seems wrong to expect people to follow the western health care system and neglect their own traditional systems. Training TBAs who share the culture and language and reside within the communities may have a better influence on adherence to ANC. People often relate to and understand TBAs from within their communities better than outsiders who do not understand the way of life of African or traditional rural people. TBAs may shift the attitudes of women about ANC and visiting health care facilities during their pregnancies. As found in the study, TBAs do have an influence on the attitudes of pregnant women during pregnancies and they encouraged them to participate in ANC, test for HIV and take their vitamins.

Understanding of cultural practices and beliefs of patients is an important aspect that needs to be understood and respected by all health care practitioners. Women in the study felt comfortable being assisted by TBAs who were respectful and did not undermine their culture. When people feel looked down upon, they feel uncomfortable and go to a place where they will feel understood. It is challenging for women to be told that their cultural practices are backward and harmful; this can create a break in the relationship which in turn makes it difficult for women to adhere to western health care methods.

Change in the attitude of medical health care personnel is an important factor if women are expected to participate in ANC services. The attitudes of health care providers are an important aspect in health as they influence adherence to medicines and health care as a whole. Many of the pregnant women in this study reported preferring alternative health care systems as they receive better treatment from TBAs and midwives than the grumpy and moody nurses at health care facilities.

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## Appendices

### Appendix 1: Interview questions / medical personnel

#### In-depth interviews for western health care practitioners

1. Do you know of the practices performed by TBAs? If you know of some practices, according to your medical knowledge are the practices that you know of safe for pregnant women?
2. Have you assisted women who are using both western and traditional health care? What have been your findings in such situations?
3. Have you assisted women using *isihlambezo*? Are there any implications that you have come across as a result of this traditional decoctions?
4. What advice do you give to pregnant women that are consulting TBAs?
5. Do you feel that practices used by TBAs should be included within the reproductive health care framework?
6. As a medical practitioner what is your attitude towards TBAs?

## **Appendix 2: Interview questions / women who consulted TBAs**

### In-depth interviews for women that have consulted TBAs

1. What was your experience in consulting a TBA?
2. What are some of the practices that the TBA performed on you?
3. Are you compliant with the practices of the TBAs
4. Do you adhere to the medicines that you are given by the TBAs?
5. Do you know the ingredients that are included when preparing the decoctions that you are currently ingesting?
6. Do you benefit from the practices used by the TBAs?
7. Do you feel that your health and the health of your unborn baby are in safe hands when consulting the TBAs?
8. What encouraged you to consult a TBA?
9. Between the traditional and western health care system which one do you prefer and why?
10. Do you feel that the practices used by the TBAs are still relevant in the newly developed communities?

### **Appendix 3: Interview questions / Traditional birth attendants**

1. What was the background and motivation for the woman becoming a TBA?
2. What are the traditionally based practices/rituals that TBAs offer to the African women that consult them?
3. What traditional practices have TBAs changed or have been forced to change in the last decade?
4. How do the TBAs respond to the peri-urban African women who appear to be resistant to their traditional practices or show low adherence to their advice?
5. What do the TBAs think are the areas of possible conflict between their traditional approaches to reproductive health and the so called western methods practiced in clinics and hospitals?

#### **Appendix 4: Informed consent form (English)**

My name is Yonela Scina and I am currently enrolled for a Doctor of Philosophy degree in Anthropology at the University of KwaZulu-Natal My Student registration number is: 207514930

I am conducting a study focusing on the experiences of Traditional Birth Attendants (TBAs) and their experiences in the reproductive health care system. This study will work through the life histories of TBAs and probe if they feel that their traditionally based expertise are being included within a broader reproductive health framework, or whether they feel African urban women's responses to them is compelling them to change and adapt their (traditional) practices when working with the pregnant women.

You have been chosen as a possible participant in the study. Participation in this study is voluntary, and you may, at any stage, withdraw from this interview or choose not to answer any of the questions that you may not be comfortable with. For the purpose of this research study, your comments will be anonymous unless you request that your personal information be revealed and used. I will make all possible efforts to preserve confidentiality including using pseudonyms and arranging a secure place for data storage. Information gathered through this study may be published in academic journals and presented orally. But here too your confidentiality will be maintained.

Please note that there will be no form of compensation.

Should you agree to take part in this study you will be required to take part in an in-depth interview which will allow you to express your feelings regarding the topic at hand. Interviews will be between 30 and 45 minutes. Should there be a need for another schedule your permission will be requested. With your permission all interviews will be tape recorded and transcribed.

Would you like to continue with the interview? YES                      NO

If you have answered 'YES' above please fill in the agreement and consent section below which we will both sign and keep a copy of.

My Name/Signature: Yonela Scina \_\_\_\_\_

Participant Name/Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Appendix 5: Informed consent form (isiZulu)

Isivumelwano sokuzibandakanya kucwaningo

Igama lami ngingu Yonela Scina, ngingumfundi waseNyuvesi yaKwa-Natal, Ngifundela iziqu zobudokotela kwi-Anthropology. Inombolo yami yesikole ithi 207514930.

Ngenza ucwaningo olubheka kabanzi ukuthi ababelethisi besintu basebenza kanjani emphakathini waseMzimkhulu. Lolucwaningo luzobuka imvelaphi yababelethisi besintu, lubukisise ukuthi basebenza kanjani kanye nokuthi bazibona besabalulekile emphakathini noma abantu sebekhetha ukuya kodokotela nasezibedlela uma bedinga usizo ngenkathi bezithwele.

Ukhethe ukuba ube ingxenye yalolucwaningo. Ukuzibandakanya kwakho kumahhala, unгахoxisa noma inini ekuzibandakanyeni kulolucwaningo futhi ungakhetha ukuthi ungayiphenduli eminye yemibuzo esizokubuza yona uma ungazizwa kahle ngokuyiphendula. Ngizokwenza konke okusemandleni ukuvikela imininingwane yakho ngokusebenzisa igama elingelona elakho nokuthola indawo ephiphile engizobeka khona yonke imininingwane yalolucwaningo. Ulwazi oluzotholakala ngalolucwaningo lungase lusetshenziswe kwimibhalo, noma kunjalo imininingwane yakho angeke idalulwe.

Ngicela uqaphele ukuthi asikho isinxephezelo esizotholakala ngokuzibandakanya kulolucwaningo.

Uma uzibandakanya kulolucwaningo uzocelwa ukuba ube yenxenye yabantu abazophendula imibuzo, lemimuzo yenziwe ngendlela ekunika ithuba lokuthi ukhulume ngendlela ozizwa ngayo. Lemibuzo izothatha isikhathi esilingana 30 kuya ku45 wemizuzu. Ngemvumo yakho yonke imibuzo ozoyiphendula izoqoshwa futhi ibhalwe phansi.

Ungathanda ukuqhubeka nemibuzo? YEBO \_\_\_\_\_ CHA \_\_\_\_\_

Uma uphendule ngo 'YEBO' la ngaphezulu ngicela ugwalise lesisivumelwano esizosisayina sobabili bese siyasigcina.

Igama lami: \_\_\_\_\_ Usuku: \_\_\_\_\_

Igama lakho: \_\_\_\_\_ Usuku: \_\_\_\_\_

## Appendix 6: Map of uMzimkhulu





## Appendix 7: Approval of Research Proposal from Department of Health



**health**

Department:  
Health  
PROVINCE OF KWAZULU-NATAL

330 Langalibalele street,  
Private Bag X9051 PMB, 3200  
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DIRECTORATE:

Health Research & Knowledge  
Management (HKRM)

Reference: HRKM372/15  
KZ\_2015RP57\_716

05 January 2016

Dear Ms Y Scina  
(University of KwaZulu-Natal)

**Subject: Approval of a Research Proposal**

1. The research proposal titled 'The life histories of Traditional Birth Attendants in the context of a changing Reproductive Health Practice in KwaZulu-Natal, UMzimkhulu' was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

The proposal is hereby **approved** for research to be undertaken at Rietvlei Hospital.

2. You are requested to take note of the following:
  - a. Make the necessary arrangement with the identified facility before commencing with your research project.
  - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to [hrkm@kznhealth.gov.za](mailto:hrkm@kznhealth.gov.za)

For any additional information please contact Ms G Khumalo on 033-395 3189.

Yours Sincerely

**Dr E Lutge**

Chairperson, Health Research Committee

Date: 05/01/16.

Fighting Disease, Fighting Poverty, Giving Hope

## Appendix 8: Approval of Research Proposal from Rietvlei Hospital



health

Department:  
Health  
PROVINCE OF KWAZULU-NATAL

RIETVLEI DISTRICT HOSPITAL

Office of the CEO

P/Bag x501, Stafford's Post,  
Via Port Shepstone, 4886  
Tel: 039-2605200, Fax: 039-2600019  
Email: nonhlanhla.keswa@kznhealth.gov.za  
www.kznhealth.gov.za

TO	YONELA SCINA
FROM	MRS. N A KESWA: RIETVLEI HOSPITAL
DATE	14 AUGUST 2015

### RE: PERMISSION TO CONDUCT RESEARCH AT RIETVLEI HOSPITAL

The CEO is pleased to inform you that you are permitted to conduct your research as per request application.

Please note the following:

This letter does not in any way represent Ethics Approval that should be obtained from an accredited Ethics Committee.

Should you wish to publish your findings, kindly ensure that you apply for approval from the provincial Health Research Ethics Committee in KZN Department of Health to Dr. Lutge ([Elizabeth.lutge@kznhealth.gov.za](mailto:Elizabeth.lutge@kznhealth.gov.za))

The hospital will not provide any resource for this study.

You are requested to provide feedback on your findings to the CEO / Medical Manger's office.

Kind Regards

Mrs. N A Keswa  
Hospital CEO

uMnyango Wezempilo. Departement van Gesondheid

*Fighting Disease, Fighting Poverty, Giving Hope*

## Appendix 9: Ethical clearance from university



25 November 2015

Ms Yonela Scina 207514930  
School of Social Sciences  
Howard College Campus

Dear Ms Scina

Protocol reference number: HSS/1366/015D

New project title: The life histories of traditional Birth Attendants in the context of a changing Reproduction Health Practices in Kwazulu-Natal, Umzimkhulu

### Approval notification – Amendment Application

This letter serves to notify you that your application for an amendment dated 25 November 2015 has now been granted Full Approval.

#### • Change in Title

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study must be reviewed and approved through an amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

Best wishes for the successful completion of your research protocol.

Yours faithfully

Dr Shenuka Singh (Chair)

/pm

Supervisor: Dr M Naidu  
Academic Leader Research: Sabine Marschall  
School Administrator: Ms N Radebe

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Humanities & Social Sciences Research Ethics Committee

Dr Shenuka Singh (Chair)

Westville Campus, Govan Mbeki Building

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Website: [www.ukzn.ac.za](http://www.ukzn.ac.za)



Founding Campuses: ■ Edgewood ■ Howard College ■ Medical School ■ Pietermaritzburg ■ Westville