THE CONSTRUCTION OF RISK IN CHILDBIRTH IN RURAL ZIMBABWE

THE CONSTRUCTION OF RISK IN CHILDBIRTH IN RURAL ZIMBABWE: The Case of Traditional Midwifery

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ABSTRACT

This thesis is based on a study that was conducted in the Manicaland Province of Zimbabwe during the period 1996-1997. The main objective of the study was to identify factors in traditional midwifery that facilitate the vulnerability of both the birthing woman and the traditional birth attendant (TBA) to risks in childbirth. Traditional birth attendants in Zimbabwe, though for a long time a shunned and ridiculed cadre, have always been the custodians of maternal health in the rural areas. TBAs have traditionally relied on intuition and hands-on-experience in their day-to-day practice.

With the government's adoption of the upgrading programme for TBAs as a Primary Health Care initiative to reduce infant and maternal mortality, TBAs in Zimbabwe have since incorporated some of the modern obstetric methods into their own traditional practices. There is yet another group of TBAs, who regardless of the training programme, have continued dependence on their experiential and intuitive knowledge for delivery of health. Traditional Birth Attendants, as well as the rural women with whom they share an explanatory model of birthing, were consulted in this study in order to get an emic understanding of risk construction, which in turn would inform intervention strategies. It was hoped that the fusion of these conceptual categories (indigenous with biomedical), would contribute to a body of knowledge which would be a foundation for culturally compelling interventions to reduce risks in traditional birthing practices. As this study unfolded, it became apparent that not only was the

women's preference for the TBA determined by cultural forces, but that there were a myriad of additional, contextual forces at play. Macro-processes affecting TBA practices are noted, and issues analyzed from the broader perspective of critical medical anthropology (CMA).

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DESCRIPTION OF SHONA TERMS

Mbuya Nyamukuta	Traditional Birth Attendant
Sunikwa kusunama	a Shona term from the variation term which means improperly positioned.
Makombora	a traditional feast hosted in favour of the TBA in appreciation of her services
Kugadzira nzira	ensuring the vaginal opening is wide enough to allow the passage of the baby
nzira	vaginal opening
zambia	a piece of cloth which most women use as a pinafore
feso	a botanical plant used in the preparation of the vaginal canal and also during vaginal examination.
tewu	a botanical plant whose bark is used for tying the cord (also known as *mutsawawa, mutimumwe, mushayamhanda, or garara)*
mhandatsva	a first birther
mudzimu	a Shona spirit
choumai	afterbirth
ndongorongo	lumps of blood that appear on the baby's navel at birth
sokorodzi	goiter
kureva	a confession required of birthing women, especially first birthers during a difficult delivery
sadza	dish prepared from maize-meal
zvakandouyawo zvega	(in this context) something happening without use of logic
chisi	a day in a week set aside for rest

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Clinic/Care
CMA	Critical Medical Anthropology
CSO	Central Statistics Office
CSW	Commercial Sex Worker
ESAP	Economic Structural Adjustment Programme
FGDs	Focus Group Discussions
HIV	Human Immune deficiency Virus
IDRC	International Development Research Center
IMF	International Monetary Fund
KAPB	Knowledge, Attitudes, Practices, and Beliefs
LBW	Low Birth Weight
MOHCW	Ministry of Health and Child Welfare
NGO	Non-Governmental Organization
TBAs	Traditional Birth Attendants
VHW	Village Health Worker
WHO	World Health Organization
PHC	Primary Health Care
ZDHS	Zimbabwe Demographic and Health Survey
ZINATHA	Zimbabwe National Traditional Healers Association

CHAPTER ONE

INTRODUCTION

1.1. Why a Study of Traditional Midwifery

Traditional midwifery[1] one of the oldest yet so popular "professions", is increasingly drawing the attention of those involved in health development planning. There is growing realization and recognition of indigenous health care services' complementary role in improving the health of those populations where these systems exist alongside conventional medical systems.

NOTES

[1] Throughout this thesis the notion "traditional midwifery" is used to refer to the practice of traditional birth attendants (TBAs). While I acknowledge the fact that TBAs do not have the same academic qualifications and licensing as their conventional counterparts, I prefer not to use this as criteria for drawing a line between the practices. The practices of TBAs in Zimbabwe are construed both in the professional and popular sectors as "traditional" dwifery. It is the "traditional" aspect that distinguishes the practice from modern obstetrics, and it is not only about semantics, but also about the culture's perception and interpretation of the services provided by the TBAs.

It is, however, unfortunate to note that cross-culturally, traditional practitioners have been accorded a very inferior position, an attitude emanating from a misconception and misinterpretation of indigenous healing processes. Traditional midwifery and its practitioners have received the same misinformed, negative treatment, not only from the dominant biomedical systems, but also those whose agenda it is to devalue alternative kinds of knowing.

In Zimbabwe, while considerable attention has been paid to the biomedical aspects of birthing, more is yet to be done in the area of traditional midwifery. A survey conducted by the Ministry of Health in 1985 shows that a higher proportion of women in the rural areas consult TBAs[2] for assistance in delivery, and that more than 75% of the nation's babies are delivered by TBAs (Ministry of Health Reports 1985).

NOTES

[2]. In this thesis the terms Traditional Birth Attendant (TBA) and *mbuya nyamukuta* are used interchangeably to denote any elderly woman in the community assisting with childbirth. The female pronoun is used as most TBAs are female.

This scenario poses very challenging questions: what is it about TBA assisted deliveries that Zimbabwean women find attractive, or conversely, what is wrong with our hospital services? Also central to my inquiry is the issue of the AIDS epidemic, which is currently a priority problem in Zimbabwe. I wanted to find out how much both the birthing women[3] and their attendants perceived themselves to be at risk of contracting the deadly virus, and the extent to which the epidemic has altered the meaning of traditional midwifery in Shona culture.

NOTES

[3]. In cognizance of the fact that pregnancy is not construed as a health disorder in traditional Shona society, I refer to women in this study not as patients, but as clients or birthing women.

I describe in this thesis birthing processes among the Shona, one of the dominant ethnic groups in Zimbabwe.[4] I allowed myself to enter into this research with as much of an open mind as possible, so as to examine the social construction of birthing in Shona culture. I realized that I had a lot of research advantages; for instance, I was not a foreigner to the language of my respondents with whom I shared the same cultural background. I was, however, quick to realize that these strengths could easily contaminate my process of inquiry, especially if I took it for granted that I knew a lot about this subject already.

NOTES

4. Black Africans are about 98% of Zimbabwe's indigenous population. The Shona comprise 71% of the population, while the second largest ethnic group, the Ndebele, constitutes 16%. The remaining 11% is comprised of other ethnic groups such as whites, mixed (coloured), and Asian groups.

The truth, as it later turned out, was that even I, who shared the same cultural background with the participants in this study, had limited knowledge on how birth is actually construed among the Shona. For me it was one thing to be well conversant with the everyday language (Shona), it was another knowing the codes used by the TBAs in their day-to-day practice. Gaining some insight from Agar's conceptualization of ethnography as a "decoding process" (Agar 1983:68), I came to an understanding that a lot was encoded in what appeared to the naive eye as "the order of the day." I was constantly reminded of Max Weber's description of "man as an animal suspended in webs of significance he himself has spun," and Geertz's conceptualization of culture as these webs (Geertz 1983:38).

Given all of culture's intricacies, the encoded behaviors and beliefs therein, the manipulation of these into the construction of a shared body of knowledge would altogether require, as Geertz correctly puts it, "an analysis of culture which is not an experimental science in search of law, but an interpretive one in search of meaning" (ibid.) This thesis is primarily about seeking meaning to issues in birthing in traditional Shona society.

The data collection methods employed in this study made

it possible for me to get an emic understanding of birthing in my own culture, without imposing my own limited, outsider (etic) perspective. The amount of time that I spent on this study allowed me to get involved more closely with my participants, as well as to appreciate some of the concerns they had about birthing. One question that kept on lingering in my mind had to do with why women were so motivated to consult the traditional birth attendant. Did all the women who consulted the TBA prefer this service? Did they have a choice regarding where they should go for delivery, or are they experiencing the same dilemma which Spittal has called "choiceless choices" (Spittal 1995). This question was provoked by Sesia's study among the Oaxacan rural communities, where she observed that "women (coming for maternal care) come here on their own when they need to", to quote the title of her paper (Sesia 1996).

I came to realize that to fully understand these issues and this problem, one would have to examine, not only how a group of people construe a given concept, but also what options are available at any given point in time, and what forces are at play to determine the health care seeking behavior of those individuals. It became imperative that while an ethnographic approach be adopted in soliciting

information and conceptualizing the problem, a broader perspective be employed for analysis of issues at stake and for further framing the problem. Such an approach would have to take into consideration the encompassing socio-economic, political, and environmental forces, and the linkages of these to the micro-processes and the way they impact on human behavior.

This thesis advances the macro-analytical perspective, critical medical anthropology (CMA), to understand the concerns and dilemmas of birthing women in Zimbabwean rural society, as well as the TBAs who assist them in delivery. The origin and application of CMA, as well as issues in its application are discussed.

1.2 The Perspective of Critical Medical Anthropology (CMA)

CMA is a growing theoretical body in medical anthropology which understands health issues within the context of encompassing macro-forces, which in turn have an impact on individual behavior. The approach is, therefore, an extension of the political-economy of health approach, rooted in the theories of Marx and Engels (Singer et al. 1992).

One of the criticisms that has been leveled against this approach is that it does not effectively demonstrate the linkage between macro political-economic and historical forces to micro-processes. In this thesis, I counter this critique by demonstrating how issues occurring at the macro level in Zimbabwe have had an impact on childbearing practices in the country's rural areas. The approach is also appropriate for issues in indigenous birthing systems as it addresses the concept of *power* among actors in the health care system, and how the hegemony of biomedicine contributes to the denigration of less powerful, less legitimate ways of knowing.

1.3 Objectives of the Study

1.3.1 General Objective

The general objective of the study was to identify factors in the practices of Traditional Birth Attendants (TBAs) that make both the birthing woman and the TBA vulnerable to risk[5] in childbirth, in order to generate recommendations to reduce vulnerability in culturally appropriate ways.

NOTES

[5] The concept of risk, while laden with epidemiological connotations, is increasingly becoming part of everyday discourse as a social construct. The concept is used therefore in this thesis primarily in qualitative terms.

1.3.2 Specific Objectives

The specific objectives of the study were to:

i determine the TBAs and birthing women's knowledge of, as well as attitudes, practices and beliefs with regards to the following:

HIV/AIDS

Traditional birthing practices

Impact of AIDS on traditional birthing practices

ii find out what the TBAs and the rural women perceive as risk in childbirth, and the extent to which they perceive themselves to be vulnerable to risks in childbirth

iii describe factors influencing women's choices regarding childbirth

iv identify macro- and micro-forces within which choices regarding childbirth are made

v make recommendations to reduce vulnerability to risk in childbirth

1.4 Thesis layout

The preceding section aims to justify a study of traditional midwifery by highlighting some of the challenges women encounter in their reproductive life. In the following chapter, I describe the area in which this study was conducted. An understanding of the infrastructural limitations as they are experienced by the TBAs and the rural women is crucial for appreciating the dilemmas women face in deciding where to give birth. I describe in the same chapter the data collection methods employed in this study, as well as the methods used to analyze these data. Ethical issues, as well as challenges encountered in conducting this study, are presented. In chapter three, I "unpack" traditional midwifery. The upgrading programme for TBAs, along with its limitations and strengths, is discussed here as a bridge between conventional and indigenous practices.

The fourth chapter sets the broader context within which the TBA operates. The economic reforms and their impact on TBAs and the health care delivery system are noted. The challenges of HIV/AIDS is the subject of the fifth chapter. I start by giving the reader a general idea of the AIDS situation in Zimbabwe. I then discuss the impact of the

epidemic on traditional birthing practices, specifically discussing both the TBA and the women's perception of HIV related risks in childbirth, in order to provide an informed discussion on the women's motivations to deliver at home. I shift my focus from discussing HIV/AIDS risks to discussing more generally pregnancy related risk factors and how these are construed by the Shona. This risk construction, as in the case of HIV/AIDS, provides some insight into the underlying reasons for "high-risk" women's compliance or lack thereof, with modern obstetrical services.

Chapter six applies the perspective of CMA by discussing the different ways in which "power is expressed in the social relations within the health care system" (Singer et al. 1992:62). I use the notion of legitimate versus illegitimate ways of knowing (Sargent and Bascope 1996) to demonstrate the ways in which different conceptual categories are created, as well as the consequences of such conflicting models on health delivery. I introduce in the same chapter some primary data on the construction of birthing in Shona culture, based on a "mock delivery" that I observed. The challenges and dilemmas the TBA goes through are made transparent, calling for an understanding of what the TBA is receiving in return for her services, as a token of appreciation, as well as a morale

raising strategy. I also discuss the traditional role of women and how this influences women's choices in childbirth.

The seventh chapter is basically building on the issues discussed in earlier chapters on risk construction. I focus more on the conceptual differences between what biomedicine defines as risk vis-a-vis the TBA and her clients' construction of the same. I summarize the findings of this study in the final chapter.

CHAPTER TWO

METHODOLOGY

2.1 Description of study area

Zimbabwe is a landlocked country sharing borders with Mozambique in the East, Zambia in the North, South Africa in the South, and Botswana in the West (see figure 1). The country is made up of four major cities, with Harare being the capital. There are eight administrative provinces in the country and these are further subdivided into districts. The 1992 Population census estimated the total population to be 10.4 million, with a population growth rate of 1.78% (CSO 1992).

FIGURE 1. MAP OF ZIMBABWE

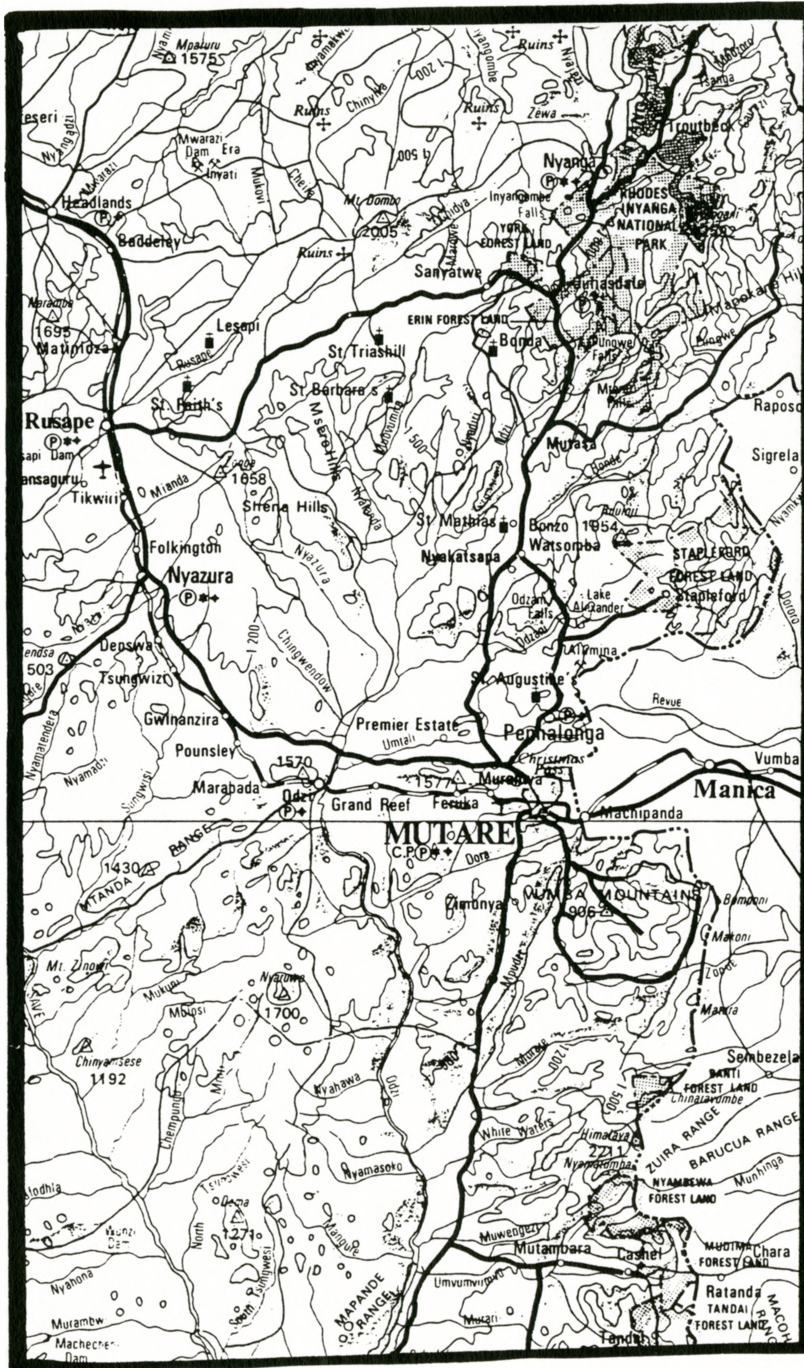
This study was conducted in the Manicaland province, in two districts namely Mutasa and Mutare (see figure 2). A total of six health centers; Zongoro, Tsonzo, Mwoyoweshumba, Rowa, Mushunje, and Muromo, were selected using the criteria of availability of up to date records on TBA practices at the clinics. In addition, two referral centers, Marange and Bonda hospitals, were also included for baseline data collection. Mutare district has an estimated population of 168,400, while Mutasa has 120,000 people and most of these are of the Shona/Manyika ethnic group. The 1992 census projections show that the male-female ratio in the Manicaland Province is such that females outnumber males and the greater percentage of the population resides in the rural areas, of which Mutasa and Mutare rural are a part (CSO 1992).

Health centers are scattered and in some areas patients have to walk an average of ten kilometers to the nearest health center. The clinics are usually staffed with one State Certified/Registered nurse, a member of the Environmental Health Team, and a few other volunteer staff. There is low provision for tarmac roads in the districts and public transport is mostly facilitated by gravel roads. Electricity

is available at a few isolated Rural Service Centers, otherwise lighting is provided through diesel generators, solar systems or kerosene lamps. This infrastructural base has had a great impact on the health care seeking behavior of the rural populations, and will be discussed in the following sections.

FIGURE 2

LOCATION OF MUTASA AND MUTARE



2.2 Data Collection Methods

2.2.1 Focus Group Discussions

Given the subject matter of this study, as well as the cultural context within which the study was conducted, ethnographic methods of data collection were the most appropriate. Focus group discussions were conducted with eight groups of TBAs. Four groups comprised those TBAs who had received formal training under the Ministry of Health's upgrading programme. The other four groups comprised those TBAs who had not yet been formerly trained, but were quite instrumental in providing maternal care to women in the communities they served. This categorization was found necessary in order to compare TBAs opinions on different aspects of traditional midwifery.

Each focus group discussion opened with a prayer, song and dance, followed by the chanting of slogans. Usually slogans are thematic, and in this instance the message behind the slogans was that of safe motherhood. FGDs solicited information related to the TBAs practical birthing experience, and also their concerns with regards to practicing within the context of unavailable resources, as well as in the context of

threatening health problems such as HIV/AIDS.

It was also necessary to ascertain the role of the training programme in alleviating the problem of HIV/AIDS through raised awareness on safe methods of delivery. FGDs had an average of 8 participants each, and were particularly homogeneous in terms of sex, age, literacy level, as well as social status. A discussion guide with trajectory questions was prepared and pretested at one health center, Mwoyoweshumba in Mutasa district (see Appendix 1). The tool was later revised to include questions which would capture some of the issues raised by the pretest group and also to remove any ambiguities. The discussions were recorded on cassette, with informed consent from the participants. These were later transcribed. Participants were informed of the purposes of the study and how data collected were going to be utilized and disseminated. Confidentiality was also assured to the participants.

2.2.2 Key Informant Interviews

Registers for TBAs that are kept at the health centers were consulted for identification of this category of respondents. TBAs are required to report deliveries to the

clinic within 24 hours so as to ensure appropriate care is rendered to the mother and the child. It is at this time when a record is made of the name of the TBA, her status regarding training as well as an update of the number of deliveries she would have assisted until then. Key informant interviews were conducted with five TBAs who had assisted the highest number of recorded deliveries. Three informants were obtained from the catchment area serviced by Bonda hospital, while the other two were from Marange communal lands. All interviews were conducted at the respective centers. Key informants were notified of the exercise in advance, and would all turn up at the clinic on the set date. The time spent on the interviews ranged from 1-$1^{1}/_{2}$ hours, and in most cases had to be moderated in order to allow the participation of other informants. Informants had a lot of experiences to share, and because of this each key informant was interviewed twice (on separate occasions). Key informants declined to have their names published in this thesis, for fear that their grievances would interfere with the existing good relationship between them and the health personnel.

2.2.3 Narratives

Narratives were used here as a data collection method to elicit events in childbirth from the TBA and their clients. Narratives are about story telling, where the story is guided by a "plot", which in turn shapes people's understanding of "how things have come to pass and how our actions and the actions of others have helped shape our history" (Mattingly 1994:77). In this study TBAs told stories of how they had started practicing, the challenges they have experienced along the way, the constraints currently being encountered, as well as the anticipated future of the practice in relation to present circumstances. Rural women also volunteered narratives on childbirth. These embodied experiences provided deeper insight into what women perceived as "risk", and also provided clues to women's motivations to utilize TBA services.

2.2.4 The "Mock-Delivery"

Efforts to conduct participant observation on birthing practices where TBAs were present were futile (see 2.4). Instead, a mock TBA assisted delivery was set up for observation in order to complement other ethnographic methods

of inquiry. On one of the field days a trip was made to a village located approximately five kilometers from the health center, in order to meet with one of the well known TBAs in the area to discuss the possibilities of conducting a "mock-delivery." The name and location of the TBA were obtained from the registers kept at the clinic. The main purpose of this particular exercise was to observe TBA practices that placed the parturient at risk of a negative pregnancy outcome, and this was explained to the TBA. Also the TBA was encouraged to enact a real life situation, and was told that this would give the researcher a better understanding of the problems that they encounter during a delivery, and that through concerted efforts with the TBAs, problems in childbirth could be addressed. As such, the TBA was advised not to perform in a way which she thought would be considered correct by the researcher. The date and time for the mock delivery were arranged. There was also consensus that this exercise would take place at the TBAs place of residence, in a room where she normally performed deliveries.

On the day of the exercise, a young woman in her late twenties, assumed the role of parturient. The latter was also accompanied by two elderly women, whose main role was to encourage the parturient, and not necessarily to assist the

TBA with the delivery. Notes on the set-up of the room, the number of people present and their roles, equipment used by the TBA as well as utterances made were taken as the "mock delivery" progressed. The findings from the "mock delivery" are discussed in chapter six. Of the methods that were used to collect data in this study, this is the only instance when an exercise was conducted away from the health center.

2.2.5 Informal Interviews

Informal interviews were conducted with nurses from three of the bigger health centers in the study area: Marange, Bonda and Tsonzo rural hospitals. Marange and Bonda are referral centers. It was anticipated that information regarding women's compliance with the referral system could best be volunteered by personnel working in the relevant settings.

Interviews were conducted during preliminary visits to the study area. It was at these visits that I introduced myself to the health personnel, explained to them the purpose of my study, and requested their collaboration on the project. In all cases I introduced myself to the nurses as an employee with a local research institute (the Blair Research Institute), conducting some research for a Masters programme,

in that order. It was mainly my status as an employee at this Institute that gained me access to the hospital records at the hospitals. The Blair Research Institute is the research wing of the Ministry of Health in Zimbabwe, and its activities are well known to most people working in the area of health.

As I went through the hospital records, questions evolved and these constituted the basis for my informal interviews with the nurses. Information that came up during these interviews include population of trained TBAs, nurses' relationship with the TBAs, as well as nurses' understanding of the challenges faced by the TBAs in their practice. As there was no structure to the interviews, each subsequent interview built on the experiences from the previous interview. Notes on the interviews, as well as relevant information from records, were taken with the consent of the nurse.

2.2.6 The Questionnaire

In addition to ethnographic methods, a questionnaire was administered to women coming to the Ante-natal Clinic at four health centers; namely Muromo clinic, Tsonzo rural hospital, Rowa clinic and Marange hospital (see Appendix 2). The

questionnaire which had both open ended and closed questions which solicited information on the users' knowledge of, as well as attitudes, practices and beliefs (KAPB) with regards to traditional midwifery child spacing methods, was pretested at Mwoyoweshumba clinic. Women coming for ANC at the clinic were asked to participate in the interviews, where the interviewees' reaction to specific questions were noted. Questions which the women were not comfortable answering, as well as ambiguous questions, were rephrased. Some questions such as on family planning methods were sensitive, and required the researchers tact in asking.

The revised version of the questionnaire had 34 (mostly quantitative) questions, and was used to collect data on women's KAPB presented in this thesis. The visits to the clinics were planned ahead of time with the assistance of the health personnel. In rural Zimbabwe, there is day in the week when everybody in a given community is expected to rest from working in the fields. On this "holy" day, or *chisi*, women do not necessarily take a day off, but rather they use the time to make visits to the clinic. Ante-natal care as well as immunization services are mostly provided on these days. The questionnaire exercise was therefore arranged in such a way that it coincided with this day.

On the day of the interviews, I got to the clinic long before the women did, so as to get a representative sample of women coming for ANC. The length of the interview was determined by a number of factors. Some of the questions required recall, for instance questions on the number of TBA assisted deliveries and whether women consulted the same TBA for all the TBA assisted deliveries. Some open ended questions required detail and probing. An example would be question number 13 which solicited information on TBA procedure (appendix 2). Yet other questions took more time as respondents gave multiple responses. Due to these factors, at least seven respondents had been interviewed by the end of each day. A total of 36 respondents were interviewed from the five health centers.

2.3 Data Analysis

Since most of the data collected were ethnographic, qualitative means of data analysis were employed. Data generated from the focus group discussions were analyzed following Willms and Johnson's content analysis model (1996). Subsets of the data were read and words/phrases describing what the participants were saying were written in margins

beside the paragraphs. These words/phrases were then listed on a blank sheet of paper. The same subsets were reread. Using a different colored pen, the key quotations, jot questions, interpretations and insights were highlighted in the margins. A list of these emergent themes and issues was written down on a blank sheet of paper. The two lists were then combined to produce a first draft of a coding scheme. Key informant interviews, as well as the open ended questions from the questionnaire were also analyzed using this model. A statistical package, SPSS/PC+, was used for analysis of the closed questions in the questionnaire.

2.4 Ethical Considerations and Limitations of the Study

- Issues discussed in this study were of a sensitive nature, especially where they had to do with the sexual behavior of the respondents. This, together with the fact that there was a noticeable age difference between the respondents and the interviewer, made it difficult to solicit some information related to sexual practices.
- The interviews with the women, the key informant interviews as well as the FGDs were conducted at the clinics. This created a bias where respondents indicated

being satisfied with their relationship with health personnel.

- Delivery is a matter of life or death. TBAs were reluctant to answer questions on mortality for fear of interrogation.
- Respondents for the questionnaire exercise were difficult to obtain. Due to constraints of transportation in the rural areas, most women did not have time to participate in the interviews after the clinic. Also, most women felt disinclined to participate in another involving exercise after a lengthy consultation with the nurse. It was considered ethically incorrect to interview women upon arrival at the clinic, as patients are served on a first-come-first-served basis.
- The mock-delivery was conducted after vain efforts to observe a real delivery. There were a number of reasons for this. Firstly, TBAs only attend to (or so I was made to understand) emergency cases. It was not practical for the TBAs or the nurses to inform me in time to be there. Also for non-emergency cases, TBAs do not keep booking records for them to know when to expect a client. The second reason was that, for most women, the idea of having someone strange in the delivery room was

unacceptable. In most cases this has to do with suspicions of sorcery.

Some TBAs thought I was getting too involved and feared that I might betray them by reporting certain flaws to the health personnel. They feared that these nurses would interrogate them. Although TBAs did not report any confrontation with the nurses on any matter, their fear for interrogation was based on past experience. TBAs recalled the days during the colonial era when their activities were mistaken for witchcraft. During this time, the colonial administration would harass them for this. Evidence of this has been documented by Chavunduka (1983) who notes that during the colonial era, traditional healers and birthing practitioners were labeled as witches because of their perceived "evil" practices. They would be beaten or killed, with ostracism being the mildest form of punishment. Most TBAs relive these traumatic days and this has had an impact on how they relate with any one wishing to know more about their practice.

CHAPTER THREE

"UNPACKING" TRADITIONAL MIDWIFERY

3.1 Who is a TBA - The Primary Health Care Perspective

The World Health Organization (WHO) defines a traditional birth attendant (TBA) as:

> a person who assists the mother during childbirth and initially acquired her skills by delivering babies herself, or through apprenticeship to other traditional birth attendants. (WHO 1992:5).

The main role of the TBA is to assist women from the same community as herself, or her family unit, during neo-natal delivery as well as post-natal stages. In some cases, the TBA, locally known as *mbuya nyamukuta,* is also a herbalist or spiritualist, but usually these enterprises are independent of the birthing process. It should be made very clear here that birthing in traditional Shona society is perceived of as a natural process, requiring no technocratization, and no consultation of the spirits as is the case in indigenous healing practices. A herbalist also does not prequalify one to be a traditional birth attendant. A TBA is a neutral figure in the community, whose reputation and expertise in childbirth is earned through the years.

TBAs are mostly menopausal women who have also mothered their own children, and therefore share the same embodied experience as their clients. In this thesis I use the terms embodied experience, intuition and hands-on experience to refer to the different knowledge systems within which TBAs operate. Embodied experience is derived from either the TBA's or the birthing woman's lived experience of birthing. The notion has been defined as "subjective knowledge derived from a woman's perceptions of her body and its natural processes as these change throughout pregnancy" (Browner and Press 1996:142). Hands-on-experience is that which the TBAs obtained through informal apprenticeship and was refined over the years through continued application of informally acquired skills. Intuition is defined by the American Heritage Dictionary as an inner knowing, an inner voice; the faculty of knowing or sensing without the use of rationale processes: immediate cognition. TBAs also rely on this body of knowledge in making decisions associated with delivery.

Until the introduction of the upgrading programme for TBAs in 1981, this cadre had primarily depended on these processes in their delivery of maternal health. Some background to this upgrading programme will place the TBA practices in context.

3.2 The TBA Upgrading Programme

The concept of "upgrading" as opposed to "training", has been used to refer to the TBAs acquisition of new skills in their practice. This is in recognition TBAs informally acquired skills. Upgrading of TBAs in Zimbabwe was deemed necessary in order to provide health services as widely as possible within the current economic constraints, particularly the constraints of shortage of formally trained personnel, a situation borne out of the present economic situation in Zimbabwe.

It has become a challenge for the Ministry of Health to recognize other alternative systems of health care, and to harness all human resources that could make a difference to the health care delivery system. It is just as well that the Alma Ata declaration (1978) recommended that governments should give high priority to the "full" utilization of human resources by, among other things, *collaborating* with traditional birth attendants wherever possible (italics mine). Collaboration with, as opposed to integrating the TBAs into the health care system is most appropriate in order to ensure the preservation of the traditional aspects of childbirth.

According to Zimbabwe's Ministry of Health policy on the

delivery of health services, the TBA should conform to three specific criteria in order to be eligible for training. The TBA should be *acceptable* to the community, *accessible* to the expectant mother and *affordable* by the family concerned (Ministry of Health Reports 1985). That makes it possible for the Primary Health Care (PHC) team to co-ordinate and monitor the TBA's activities to ensure delivery of good quality care. In the context of PHC, the TBA services become much broader, going even beyond childbirth to include other non-birthing issues of importance to maternal health, such as hygiene, and food and nutrition. In short, the TBAs are an important avenue through which health education messages can be delivered to the community at the grass-roots level.

Contemporary midwives (i.e. the State Certified Midwives), have been assisting in ensuring that the TBAs' practices are safer for the TBA, the mother as well as the fetus in utero. It should be appreciated that TBAs are quite instrumental in providing services to women, particularly those in the rural and peri-urban areas. Furthermore, for the low income populace, in this age of economic instability, less costly yet more accessible services have become more attractive.

The programme thus offers a cost-beneficial alternative

to providing effective and acceptable maternal health care. It is estimated that with adequate and not too extensive training, the TBA can go a long way in alleviating the suffering of the rural women folk, as well as reducing the unacceptably high maternal and infant mortality rates, which currently are 120 per 100,000 live births and 70 per 1,000 live births respectively (Taylor et al. 1983).

3.2.1 Syllabus of the Upgrading Programme

The programme was introduced in line with the principles of primary health care to improve TBAs management of pregnancy and delivery which in turn would have an impact on maternal and child health. Specifically, TBAs are introduced to basic obstetric procedures, as well as general child health care. Most importantly, they are trained to identify biomedical risk factors, and the appropriate action to take in such situations. Except for emergency cases, TBAs are expected to refer all complicated cases to the nearest health care unit. In this study, TBAs demonstrated competency in identifying (biomedically determined) high risk factors, and yet referral problems were noted by many as being a big challenge due to infrastructural and other concomitant factors.

One of the main areas that the upgrading programme focuses on is the use of a simple delivery kit containing the following:

gloves, cord ties, surgical blades,

cotton wool, candle and matches,

4 small pieces of cloth to clean baby's face,

2 clean pieces of cloth for baby wrapping,

clean plastic and clean cloth to cover the mattress/mat

The challenges that TBAs are faced with in procuring this amount of accessories are discussed in the following sections.

It is worth noting, however, that the upgrading programme has its merits in that it recognizes that the traditional birth attendants are usually semi/illiterate, requiring appropriate training strategies. The communication techniques that have been used include group discussions, role play, song and dance. Choice of communication skills is crucial if the correct message is to be put across more effectively. Song and dance was a very common feature of the focus group discussions in this study. Messages taught during the training sessions are captured in song, hence making it easy for the TBAs to remember the message.

The TBA programme is also significant since it embraces issues of greater priority such as AIDS awareness. Traditional

midwifery involves a lot of blood handling, placing the TBA and her client at risk of HIV infection. Issues on the study population's knowledge, attitudes, practices and beliefs are addressed in depth in the fifth chapter. Although findings of this study show that knowledge about HIV/AIDS is scant among the TBAs, the upgrading programme will do its part in curbing the spread of the virus.

There was evidence in this study, however, that the upgrading programme had altered the way in which TBAs perceived their role in the community. Because some practitioners have received training and some have not, the question on who deserves the title *mbuya nyamukuta* has become a contentious issue. It became necessary to investigate the nature and origins, as well as the consequences of such contentions, and how these are handled by the TBAs themselves.

3.3 Perceptions of *Nyamukuta* of Themselves

I describe here the events leading to the observation of this contention in order to demonstrate how failure to clarify concepts can result in misinterpretations with long term adverse consequences. It all started when one day I made a visit to one village with the intention of meeting some of the TBA practitioners. I wanted to make myself known in the area

and also to arrange for a meeting with the TBAs for the focus group discussions (FGDs). The nurse who could have accompanied me was detained at the last minute; there is usually only one certified nurse at a rural health center. I had obtained the blessing of the village headman and was expecting little resistance from the community. As I went about from door to door in search of *mbuya nyamukuta*, I was astonished by the small number of women who came forward. It just did not tally with the records kept at the clinic. I began sensing some misunderstandings and decided to ask differently. Rather than ask to see *mbuya nyamukuta*, I asked for "any woman in the area who assists in delivery". They turned up in dozens.

I used this encounter to frame one of my trajectory questions for the FGDs, in case no one brought it up. What later emerged during the FGDs was that only those who had received formal training and had been awarded certificates and honorary badges deserved the title *nyamukuta*. The rest were "just practicing women". I found this division not only unbefitting, but laden with serious implications on the practice of traditional midwifery. Those who had not yet undergone training felt disinclined from using modern methods of delivery because they did not have the relevant

"credentials". It was disturbing to note that even where TBAs could have transcended the conceptual differences between biomedical obstetrics and their own indigenous knowledge (which is a much more difficult task), a small issue like "titles" could be a hindrance in achieving this task.

These attitudes in TBAs can be attributed to the upgrading programme. Before the introduction of the programme, these practitioners were all alike referred to as *mbuya nyamukuta*. Some clarification on the meaning of the different titles is therefore necessary in order to ensure best possible services from this important cadre. As this issue can be attributed to the upgrading programme, it makes sense that the trainers of TBAs take upon themselves the responsibility to correct this misunderstanding. It therefore became necessary in this study to ascertain the health personnel's perception of the role of the TBA, as well as the nature of the relationship between the two cadres. This would determine the nature of strategy the health personnel adopt to correct situations such as that of titles among the TBAs. Informal interviews conducted with the rural health personnel solicited this information. This is discussed in the following section.

3.4 Perceptions Of Health Personnel Of TBAs

Conventional medical practitioners are known for shunning and ridiculing traditional health care practices. This is a major threat to the relationship of the cadres in the two sectors of health care and may have negative effects on the acceptability of modern methods of delivery by the TBAs. Asked how they thought about their relationship with the nurses, TBAs in all groups indicated that the relationship was sound. The hospital personnel's views with regards to traditional birth attendants and their practices was also solicited from three different health care workers.

3.4.1 The Informal Interviews

1st interview: This was held with Sister A[6], at Tsonzo rural hospital. The hospital whose catchment area services 7,698 people, has a total of 64 trained TBAs. While most TBAs in this area have received training on modern methods of delivery, in this area they have been instructed to limit their activities to attending to emergencies, and to refer all other cases to the hospital. The women usually come to the hospital in the company of the TBA, and in most cases it is the TBA who arranges transportation to the clinic.

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6 Real names are omitted to protect the identity of these respondents. However, the institutions are real.

The hospital staff at the time of the visit were in the process of training TBAs of the Apostolic Faith sect[7]. The nurse noted that initially they had problems getting these particular TBAs into the system, and they had to go through the "chain of command", i.e. prophets, prophetesses, local leaders and other figures in the sect in order to win the participation of the TBAs. The Apostolic Faith TBAs are trained mainly to equip them with skills so that they can continue to attend to members of their sect. The nurse also indicated that untrained TBAs are difficult to identify because they fear being interrogated and hence they tend to hide.

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[7] The Apostolic Faith is a popular religious sect in Zimbabwe. There are several sub-sects, and each has its own founder. In the area where this study was conducted, the dominant sub-sect is one that was founded by a Johanne Masowe. Followers of this religious sect resist any form of medication, as they believe in the healing powers of "holy" water. Any diseased member of the sect is expected to recover upon the consumption of the water, which is often accompanied by prayers from the "ordained" members of the sect. Visits to the hospital are not only unnecessary, but are interpreted as a lack of recognition of the power of the "saints", and anyone who utilizes health services becomes defiled.

2nd interview: This was conducted with Sister B at Bonda Mission Hospital. This is a referral center, with a missionary background. It was interesting to find out whether a religious background would have any influence on the clinic staff's relationship with the TBAs.

The nurse indicated that the relationship between the two cadres was sound. According to the nurse, the major setback encountered by the TBAs' in their practice was that of old age. This factor hindered such activities as reporting deliveries to the hospital. The nurse reported that whenever a mother is attended to by a TBA, the latter was expected to bring her client to the hospital within 24 hours of the delivery. The mothers are actually encouraged to come in the company of the TBAs, but in most cases, mothers end up reporting to the clinic on their own. Due to old age, the TBAs find it difficult to walk the long distances to the clinic.

It was also noted that most mothers booked in at the hospital well in advance; to the nurse, this was an indication that mothers preferred hospital deliveries to TBAs.

Another interesting issue that was brought up by this nurse was that of birth certificates. She noted that women or TBAs who were resentful to reporting deliveries to the clinic

ended up doing so in order to obtain health cards which are a requirement if the child is to get a birth certificate. The nurse further noted that this enabled them to provide appropriate post-natal and post-partum care to the child and the mother.

3rd interview: Mr. C, a nurse at Marange hospital noted that there are about 70 trained TBAs in the catchment area and these are predominantly members of the apostolic faiths. Marange is also the hometown of Johanne Marange, the founder of this religious sect. Over 80% of the population in this area belong to this sect.

The same economic constraints described earlier in this thesis were echoed here. There is a short supply of basic equipment such as surgical blades and methylated spirit. The nurse noted that because methylated spirit was expensive at rural outlets, TBAs teamed up to buy a bottle of methylated spirit which they would then share to cut on cost. The nurse also noted that because the catchment area had a very high population of Apostolic Faiths, the majority of the women from this sect were against the idea of delivering at the clinic. It is reported that at one time, one woman (from the Apostolic Faith sect), had to find another TBA after her regular

practitioner had been "defiled" by new methods acquired during training.

It was also noted that the nurse who was in charge of the training programme at Marange hospital discontinued training of TBAs because of low incentive. The nurse, who held qualifications as a general nurse, was then receiving a salary of a TBA trainer, which is much less.

Discussion:

The most striking feature of these interviews was the consistency of the nurses' sensitivity to the needs and dilemmas of the TBAs. Unlike in other settings (e.g. the *dai* of India) where there is lack of respect for traditional birth attendants by the modern health personnel (Chawla 1994), in Zimbabwe the relationship between these two cadre is sound. Nurses demonstrated an awareness of the constraints that TBAs encounter in the referral process, such as the elderly TBAs' inability to walk the long distance to the clinic, as well as religious barriers to utilizing modern health care services. This is important as it makes it possible for the nurses to make informed decisions on how to address these constraints. Also, the reported sound dialogue between the TBAs and the nurses provides good basis for addressing misconceptions

inherent in the practice of the TBA, such as the issue of titles mentioned above.

In order to fully appreciate the role of TBAs in the health care system, along with the challenges they are facing in their delivery of maternal care, a contextual analysis of prevailing forces is imperative. The following chapter sets the context for TBA practices by describing the political economy of the country.

CHAPTER FOUR

THE CONTEXT

4.1 Zimbabwe's Health Care Delivery System

Having elevated the TBA to a position of prominence in the health care system, it becomes necessary to explore the economic context within which this cadre operates. Zimbabwe's crippled economy has had negative consequences not only on the quality of the population's day-to-day living, but also on the quality of health care provided. To place this problem in perspective, let me walk the reader through some of the historical events that contributed to the present economy.

Zimbabwe became a new nation state in 1980. At that time, the health care system was characterized by gross inequities in the distribution of health care services. For instance, all the major hospitals were in the bigger cities, whereas the rural areas, where more than 60% of the population resides, were serviced by a few isolated, poorly staffed health centers. Zimbabwe's colonial past accounts for much of the disparities that are inherent in the health care

system. At independence, however, Zimbabwe undertook vigorous steps to remedy these deficiencies. Equity was declared the guiding principle of the health care system. Implementation of this policy has been mixed because of severe constraints imposed by the pattern of health care left by the colonial administration. The "sophisticated" health care system was designed to provide colonials with health care equivalent to what they would have in their home country[8] (Taylor et al. 1993:243).

The nation enjoyed a short-lived stable economy. Soon after, there followed severe economic challenges. Analysts have labeled the 1980s as "the lost decade of development" and Zimbabwe is no exception. Notable factors precipitated problems in the economy: a prolonged drought, the international recession, external military destabilization, as well as the accelerating prevalence of HIV/AIDS.

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[8]. CMA alleges that biomedicine promotes the hegemony of bourgeoisie society. At the same time, the biomedicalization of anthropology has only contributed to a resolution of conflict that benefits the dominant classes (Singer et al. 1992:79).

The imposition of the economic-structural adjustment programme (ESAP) by the International Monetary Fund (IMF) and the World Bank considerably crippled the economy. Cuts in public expenditure resulted in severe drug shortages in health facilities and poor working conditions for medical personnel. This has led to an exodus of doctors and nurses in search for greener pastures in neighboring countries such as South Africa and Botswana. As a local newspaper correctly puts it:

> the decline in allocation of resources on health and the flight of skills from the Ministry because of subsequent poor working conditions have adversely affected the health delivery system which is trying to cope with an increase in disease (Herald 1997).

These events have mainly been attributed to a reduced per capita expenditure on health in line with the ESAP policies. It is reported that since the launch of ESAP, per capita expenditure decreased by 40 percent, leading to poor salaries, high staff turnover, drug shortages, and reduced number of hospital beds (Herald 1997). Yet the workload in hospitals continues to rise due to the HIV/AIDS pandemic. It is estimated that up to 70 percent of patients in hospitals suffer from HIV/AIDS related diseases, and yet the workload cannot be reduced.

The government is therefore overstretched as it tries to

cope with a growing population which is not proportional to its resources. The "flight of skills" from the public service and other associated events has meant that the populace relies more on alternative medical systems, of which traditional midwifery is no exception. As such, these economic transformations have marked a new turn in traditional midwifery. It therefore becomes imperative to investigate the impact of these events on the practice of the TBA, in order to appreciate the dilemmas in which the TBA finds herself in.

4.2 Impact of Economy on Traditional Midwifery

Data generated from the focus group discussions (FGDs) held with the TBAs show that the government initiated-training programme for TBAs can no longer be run as efficiently as before. This is due to shortages of skilled personnel who could have continued the training at selected health centers. Also, due to public sector expenditure cuts, even the simple delivery kit that the TBAs are required to keep in order to curtail the spread of HIV/AIDS and other risks, cannot be replenished, as resources have become scarce. Clearly, the list of items required to complete a safe delivery is quite detailed (see page 22), and in most cases is beyond the means

of the economically disadvantaged TBAs.

With the government's downsizing policy, another challenge is that there are not enough staff to continue the distribution of this equipment. Although some TBAs collect their regular supplies from the local health center, a majority of the TBAs, who are mostly aged women, can hardly make it to the clinic, and would therefore have to rely on the village health worker (VHW) for provision of these supplies. The VHW, who are usually women, have to use bicycles to perform their errands, as they cover vast areas and travel long distances. Bicycle maintenance and replacement has become a big problem in itself.

These constraints may appear to be trivial, but they can result in adverse consequences, such as failure to replenish the delivery kit, resulting in the TBA using whatever is at her disposal at that point in time (e.g., use of reeds or unsterilized razor blades for cutting the cord, thereby increasing the vulnerability to contracting HIV as well as tetanus infection). TBAs continue to operate within the constraints of limited resources; their clients' decisions are also guided by these prevailing forces. The following chapter explores the problem of AIDS in Zimbabwe, its impact on traditional midwifery, the response of the TBAs and birthing

women to the epidemic, along with the factors influencing these world views.

CHAPTER FIVE

THE CHALLENGES OF HIV/AIDS

5.1 The General Outlook

In Zimbabwe, AIDS has reached pandemic proportions, with 500 people reportedly dying every week due to AIDS related illnesses (Zimbabwe Press Release Statement 1997). According to the World Health Organization (WHO) estimates of 1991, of the 3 million women who are infected with HIV, 2.5. million are from sub-Saharan Africa. Most of these women are within the child-bearing age group. It is estimated that by the year 2,000, women will account for half of the HIV positive population (Norr et al. 1991:250). Heterosexual transmission in sub-Saharan Africa accounts for 70-80% of the cases (d'Cruz-Grote 1996).

The reality of HIV/AIDS incidence and prevalence shows how this should be a priority concern for policy makers working in the area of health development in Zimbabwe. Something has to be done in order to ensure that the picture predicted for the year 2,000 is averted. All groups at risk

of contracting or transmitting HIV, as well as the behaviors that place them at risk, should be identified in order to come up with realistic and sustainable interventions.
Theoretically, some models to reduce HIV have had many shortcomings. The epidemiologic model, for instance, has advanced the "high risk group" approach in its analysis of the extent of the problem. The earlier identified groups include commercial sex workers, long distance truck drivers and migrant workers (e.g. Wilson et al. 1990). This approach is reductionistic, as there is growing evidence that the epidemic has continued to spread beyond the earlier identified groups; for instance, women in so-called monogamous marriages are dying, yet these women are not classified as a high risk group.

This ethnographic study solicited knowledge, attitudes, practices and beliefs of TBAs and birthing women with regards to HIV/AIDS. Data generated from FGDs as well as key informant interviews is used here to present the TBA's explanatory model of AIDS in childbirth, in order to get an understanding of how much the TBAs know of HIV/AIDS, how much they perceive themselves to be at risk, and what precautions they are taking to ensure they do not contract the virus.

5.2 HIV/AIDS and Birthing: The TBA's Explanatory Model

> *... what would you do if it were you ... She knocks at your door in the middle of the night, the waters have broken, the woman is in such pain she could give birth any second, she is looking right into your eyes begging for help, I know I am supposed to refer the case to the clinic because, say, "she has BP"* [9]*, but the only fellow who owns a vehicle around here has gone to town ... I do not have gloves its been long ever since the clinic supplied us with any ... what am I supposed to do?*
> (Key informant:Marange)

What is one supposed to do in such a situation? This was the dilemma. This response would come up during interviews with TBA key informants, as well as at FGDs that were conducted with the TBAs. What prompted the response was the question whether the TBAs were or were not aware of the AIDS situation; there was concern that HIV transmission could occur through unsafe birthing practices. It was at this juncture that I decided to begin my research; I was interested in what they already knew, identify the gaps, and reflect on mechanisms to fill in those gaps. Hence, participants opinions with regards to the problem were solicited.

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[9] Lay language denoting high blood pressure

All the groups that participated in the FGDs had TBAs who had heard about AIDS, citing the clinic as their major source for information. Thus, while the upgrading programme mentioned earlier touches on HIV/AIDS issues in its syllabus, the clinic has played a prominent role in disseminating information on AIDS. These statements, complement the remarks made by the nurses during the informal interviews to show that there is a harmonious relationship between the TBAs and the clinic staff which facilitates dialogue on health issues. TBAs who had not yet had the opportunity to go for training, also have access to this information. On the same note, there was not any significant difference between the two categories (trained and untrained) with regards to knowledge of issues that were covered during the discussions, including knowledge of HIV/AIDS.

The few TBAs who had not yet heard about the subject portrayed an eagerness to know more about the disease. Sexual intercourse was reported to be the major mode through which HIV is transmitted. Misconceptions in knowledge, beliefs and attitudes were noted. For instance, one respondent noted that the virus is spread "through death" while another noted that "aspirin" can be used as cure for HIV/AIDS. Use of unsterilized razor blades was noted as another way in which

the virus is transmitted. One group felt that at their age, they were no longer at risk of contracting the virus.

Most groups expressed the fear that since they handle blood in their practice, and they do not have an adequate supply of gloves, they are at high risk of contracting HIV. One group also portrayed an awareness that there is no cure for AIDS.

The most interesting observation on the subject of HIV/AIDS was the TBAs' commitment towards serving their communities. Most groups reiterated the concern for saving human life through assistance in delivery, more than a fear of contracting HIV. TBAs also indicated that it was difficult for them to tell whether a client was HIV positive or not. Finding it improper to ask, they would go ahead and perform a delivery in spite of the possible sero-status of the client.

On being asked what they thought the future held for traditional midwifery, all except two groups thought that it was promising in spite of the odds. This was mainly due to the fact that rural women, even those who were aware of the challenges of the AIDS epidemic, continued consulting TBAs. The motivations for consulting the TBA are discussed in the following chapter. The other two groups thought because of the AIDS epidemic, there is no future in traditional

midwifery. Yet other TBAs felt that their clientele was decreasing due to modern child spacing methods which made it possible for small family sizes.

TBAs therefore have different opinions with regards to their practice. There is a general expression of fear (of contracting the HIV virus), concern (over the fate of birthing women needing TBA assistance), and uncertainty of the direction of traditional midwifery. The main factors compounding these concerns include inadequate knowledge on HIV/AIDS, the humanitarian attitude towards childbirth, and the prevailing economic conditions which have affected the practice of TBAs considerably.

5.3 Birthing and HIV/AIDS: The Women's Perspective

All the women who participated in the questionnaire exercise had heard about AIDS (see Appendix 2 for questionnaire). This is predictable, since previous studies have made similar findings. For instance, findings from the Zimbabwe Demographic Health Survey of 1994 show that all but a fraction of Zimbabwean women and men have heard of AIDS. However, there is evidence from the same survey that men generally have greater knowledge of AIDS related information

than women. These disparities in levels of awareness have long term adverse consequences on the health of women, particularly those in the childbearing age-group, as these factors determine the choices that are made.

In this instance, the radio was noted as the most common source of information on AIDS by the women. The next most popular source of information was health personnel. Social gatherings were also noted as another source of information on HIV/AIDS. Most respondents knew more than one symptom of AIDS, the most commonly reported being loss of weight. Other symptoms that were known by the respondents were chronic diarrhoea, thinning of hair, persistent cough, and lymphadenopathy. Respondents also knew more than one mode of HIV transmission, the most common being sexual intercourse, which was also noted as the most common mode of HIV transmission by the TBAs. Other reported modes were use of unsterilized instruments and blood contact. The most commonly known methods of preventing HIV infection were condom use and fidelity. HIV/AIDS was noted as a priority problem by most (32) of the respondents.

A high proportion of the respondents (21) differed with the fact that TBAs could transmit HIV through their practices. Those who maintained this stance noted that traditional

midwifery was a noble practice, with no intention to cause harm to the beneficiaries. Some also noted that TBAs could not transmit HIV because they were getting trained and also they were taking precautions during their practice, such as using gloves and new razor blades. Knowledge of HIV/AIDS among this population is therefore scant. The discussions also showed how there are serious misunderstandings among these women with regards to the association between HIV/AIDS and birthing. The other reason why women differed with the view that TBAs' could transmit HIV through unsafe methods was because of the stigma surrounding HIV/AIDS. Heterosexual intercourse is the major mode of HIV transmission in Zimbabwe, and therefore most of the women thought this implied that their TBAs were sleeping around. Most women took this as an insult, to think that even with the overwhelming help they are receiving from the TBAs, the government may be still blaming them for HIV transmission.

The women were also convinced that this is not the case. TBAs are mostly menopausal women who because they and their husbands are not that sexually active, are not at risk for HIV sexual transmission. Even when efforts were made to redirect the discussion to talking about birthing practices as a means by which HIV could be transmitted, women in this study were

protective of the practices of TBAs.

On whether there was any future in traditional midwifery, 72% of the respondents thought the future of the practice was bright, mainly because a lot of women were still consulting the TBAs. Those who did not see any future in the practice cited threats such as the AIDS epidemic.

The issue of HIV/AIDS is, therefore, a broad theme in reproductive health. I will return to this issue in the following sections, and look at what HIV has done to this culture's birthing practices. Meanwhile I will proceed to describe the factors that motivate women to utilize TBA services.

5.4 Motivations To Deliver At Home

Having established women's knowledge of HIV/AIDS, and given the finding that most were aware of the problem, the next question was: why then, in light of all these risks, do women continue to consult the TBA? As previously noted, there is a group of women who strongly believe that TBAs are not part of the HIV/AIDS problem. These women would still continue consulting TBAs. There are yet others who are well aware of the risks in traditional midwifery, yet in spite of

this, continue to consult the TBA. Several reasons were cited by the women as to why they prefer to be attended to by the TBA.

The idea that the TBA was nearer and more accessible and convenient in times of emergencies was noted as one reason for consulting the TBA. Other reasons that were cited were that the TBA, in contrast to the health centers, is more affordable because she does not demand any payment. Reasons cited for preference of modern health care facilities were that they offer better services and the staff is more knowledgeable (Table 1).

Table 1
WOMEN'S PREFERENCE OF PLACE OF DELIVERY AND REASONS FOR THEIR PREFERENCE

Reasons for preference	**Preferred place of delivery**	
	TBA	**Clinic**
better service	2	13
more knowledgeable	---	15
nearer	5	---
cheaper	1	---
Total	8(22.2%)	28(77.8%)

More women (77.8%) indicated that, if given a choice, they would utilize hospital services. Reasons cited for this were knowledgeability of clinic personnel and better service. The

few women who preferred the TBA's service cited geographic proximity of the TBA and affordability of TBA services. Based on these observations, it can be argued that in this study, women's choices of place of delivery are restricted due to poverty and infrastructural factors, and that, if these were absent, utilization of hospital services would be higher. TBAs are mostly (though not exclusively) preferred for convenience purposes.

Although user fees are subsidised for the low income groups, the fee is beyond the means of most women.[10] Distance to the clinic and lack of clinic fees are common prohibiting factors in the use of modern health care facilities.

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[10] Loewenson notes that fee charging prejudices those in need of access to care (Loewenson 1991). In 1980 Zimbabwe introduced a free health care for those earning below Z$150, and at that time, clinic attendance trebled especially in rural areas. Clinic attendance dropped with rising nominal wages, depriving the low income groups of this benefit.

This same observation was made in Mexico, where women are at risk of infection because their consultation of the TBA is largely due to lack of "geographical, economic and cultural access" to medical services (Camey et al. 1996).

Another factor that hinders women's consultation of the clinic is poverty. The majority of women who participated in this study cited peasantry as their source of income. Peasant women predominantly, who depend on agricultural produce for a living, cannot afford "decent" clothing for the baby. For most of them this is an embarrassing experience hence, they consult the TBA who is not concerned about such matters.

In an informal discussion with women at a rural hospital in Zimbabwe, there was an expression of discontentment over the opening of mother's baggage by the health personnel. The women further indicated that the nurses would do this in order to see what the mother had prepared for the baby. Most women are not too comfortable with this, hence another reason for delivering at home even when they perceive themselves to be at risk.

Based on findings from a study she conducted in India, Kumar (1995) notes that in this culture women did not prepare clothing for the baby as this would be interpreted as a bad omen (Personal communication). This belief is also found in

traditional Shona society, although it may not be as strong as in the Indian culture. Some of the women in this study did actually prepare what they could for the baby, but made certain that no one else except very close members of the household knew about this. However, for the majority of the rural women who participated in this study, it was not so much about cultural beliefs around the baby's clothing, than that of incapacity to provide for the baby.

In the event that a birthing woman has to travel to a health center, she is often accompanied by her relatives. Travelling costs are usually beyond the means of most families. Failure to comply is also compounded by the woman's fear to leave her children unattended and also concern over loss of working days. In a society where birthing is not construed as a health disorder and work is a mark of a woman's virtue, a day lost at a hospital is worth a lot. Thus women would prefer giving birth at home where they can get back to work as soon as they want to.

Some women (28%)noted that they consulted the TBA because that was what their husbands could afford. Most of these women rely on their husbands for payment of clinic fees. A woman's choice of place of delivery is therefore restricted due to lack of financial resources.

The other reason that was cited by the women as to why they consulted the TBA was that it allowed for interpersonal relationships during birthing. This was seen to be a significant component of the birthing process. There is a shared feeling that birthing is not something that you go through alone, and relatives are viewed as a source of comfort and reassurance. In the mock delivery reported in the subsequent sections, Tsitsi's circle of relatives were present to support and empathize. Among the Shona, birthing is seen as a societal concern, involving the whole network of an individual's friends and relatives. The significance of this empathetic relationship has also been noted in "most of Latin America, especially in the rural areas" (Cominsky 1986: 83). He notes that:

> *Traditional birth attendants and the woman's kinfolk provide emotional and physical support ... Thus birth is seen not only as a biological process, but as a social, emotional, and spiritual one, culturally defined and patterned* (Cominsky 1986:84).

Where interpersonal relationships are overlooked, the consequences can be far reaching. For instance, one woman noted that:

> *At the hospital there is time for the husbands only, then time for anybody else, and they don't just come in, they have to wait until it is time ... and they don't get in all at the same time, which would be more uplifting if*

they did, the rules require that there be two visitors per patient at any one time. My mother in-law once missed her bus, by the time she got to the hospital the visiting time was over ... she was really upset (Rural woman, Mutasa).

This woman went on to tell how her in-laws insisted she deliver her next baby at home where there are no regulations. Kleinman (1980) notes the strength of family-patient interactions in the therapeutic process, arguing that it is within a familial context that significant health related decisions are made and actions taken. The same can be said of the role of the family in Shona birthing practices.

Birthing is a very intimate moment, and the birthing woman would rather have her attendant feel the same way. Birthing women emphasize that there less empathy generated in hospital compared to a home situation. Practically, it is not feasible for the nurse to entertain the birthing woman as much as she would like to, given the nurse-patient ratio at the clinic. Women in this study realized these constraints, while also reiterating how it motivated the women to deliver at home, where the TBA is attending to one client at any given point in time. The one-to-one relationship of the TBA and the birthing woman is considered nurturing and empathetic.

In the mock delivery described in this thesis, the

birthing woman demonstrated behaviors which would not be easily accommodated if they were to occur under hospital conditions. A TBA will tolerate the birthing woman's continual cry for help, her request that the TBA be holding her legs all the time, and her desire to have a relative by her in case she needs her. One woman who had given birth in a hospital situation noted:

> *You know how in the labor ward you have your own chime above your head? The nurses had told me that I could sound the chime whenever I needed their attention, but I tell you, they never come* (rural woman:Mutasa).

This perceived lack of empathy dissuades women from utilizing modern health care facilities. Women also feel restricted in what they say and do within an institutional setting. Code discusses what she terms "rhetorical space" which she defines as:

> *discursive realms that exist as fictional and shifting locations whose ideological imperatives structure and limit what kinds of utterances can be voiced within them with reasonable expectation of being heard, understood or taken seriously* (Code 1995:ix).

I find the situation in the labour ward that I describe above to be one of these "discursive realms".

Mothers' shelters could also be an example of such "rhetorical spaces" where authoritative knowledge is created

by the act of silencing. These facilities are a primary health care strategy for safe motherhood. Women in waiting, particularly those at high risk, are expected to utilize these facilities for closer monitoring by the hospital personnel. While this strategy has been useful in reducing chances of a woman dying from pregnancy related complications, several studies have shown that these institutions are another avenue in which the authoritative knowledge of biomedicine is expressed. Sargent and Bascope (1996) note the limited ability of women in these institutions to participate in decision making, as doing so is interpreted as challenging the hospital personnel. There is a lack of interaction through silencing, which most women find unacceptable, and hence another reason for low utilization of such institutions. Ireland (1996) also notes that these are the same realms where distinctions are made between true or false, legitimate or illegitimate, and similar distinctions which construct and perpetuate different realities.

It is important to note that although these realms do exist and authoritative knowledge is created in the process, most women do not feel coerced to comply with this authority. Also, these realms provide the foundation for conflicting "clinical realities" (Kleinman 1980), which can only be

resolved through dialogue and the negotiation of models. Yanagisako and Delaney (1995) note that although institutions and "cultural domains" of meaning influence ideas and practices, people do not necessarily organize their everyday actions according to those divisions. Rather, people think and "act at the intersections of discourse".

"Acting at the intersection of discourse" has been useful in understanding other ways of knowing, particularly how indigenous forms of knowing inform biomedicine. Hence, in order to increase compliance of high risk women in utilizing "rhetoric spaces", there is a need for a merging of models and a transcendence of conceptual categories (Willms et al. 1995).

Women also note that in the hospital, nurses had very little time to reassure the birthing woman. There was also an expression of discontentment and disapproval over such procedures as induction or epidurals, designed to lessen pain in, and speed up child birth. This is seen by some of the women as unnecessary control over the woman's body and only a complicated alternative to "just holding the woman as she gives birth". Reassurance during child birth is a very important measure for the reduction of potential risk of poor pregnancy outcome.

One TBA noted how they have had to prepare food for their

clients to enable them to gather the strength to push. It was noted that even when the client felt disinclined to eat (most women in this state are too anxious to eat), the gesture was reassuring. This kind of exchange may not be possible in an hospital situation.

Religious background is another factor that influences a woman's choice of place of delivery. Members of the Apostolic Faith are known for shunning hospital services and most women from this sect prefer having their deliveries assisted at home by a TBA from the sect. There are interesting differences in birthing practices of TBAs of the Apostolic Faith sect and those of other TBAs. In case of complications, Apostolic Faith TBAs do not refer cases to the hospital. Rather, they make the woman drink water which would have been prayed for. It is believed the delivery will be less difficult after this. Clients who consult the clinic become "defiled", and can no longer be attended to by a TBA from the sect.

5.5 Risk Perception as a Determinant of Compliance

Most studies on childbirth have shown that compliance rates vary according to the risk factor considered. Much depends on the woman's perception of risk. Most women,

drawing on their "embodied experience", find that it is not always the case that when a Risk Factor is present, a difficult delivery follows (Risk Factor being the biomedically identified positive predictive value that makes a negative pregnancy outcome possible) (Durjadin 1995). For instance, a multipara may argue that although once she had a still birth, she has continued to consult a TBA and all the deliveries were successful. For that woman, previous still births cease to be a risk factor, and because of the strong community spirit in these settings, this is also taken seriously by the other women. In Zimbabwe, older women who were once diagnosed as "at risk" and latter delivered successfully at home, would boast and show off to the younger women who have no experience with child birth. This has a strong negative impact on these younger women's perception of risk in the long term.

For other women, the presence of one risk factor may not be perceived of as very risky compared to when one has multiple risk factors. For instance, grand multiparity[11] on its own may

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[11] King et al (1991) note that the concept of multi-parity was first introduced in 1936, and that there is still no universally accepted definition of the term.

not concern the parturient, compared to the combination of this factor with other factors such as previous still births, prolonged labour and others. Also, some risks are perceived to be more grave than others.

Women who have had previous Caesarian deliveries are more likely to comply with the referral system compared to a primipara, yet both are high risk cases in the biomedical sense. Thus Kaufert and O'neill (1993) would remark that it is a question of "how much risk is acceptable to you."

Browner and Press (1996:149) also notes in their study with American women that these draw on their embodied experience when they choose not to incorporate specific prenatal biomedical recommendations. Drawing on a narrative from one informant who was reluctant to quit smoking because she had given birth to a nine-pound baby despite the fact that she was a smoker, Browner and Press conclude that such women are likely to use such experiences as a rationale for rejecting clinical recommendations and to act independently. A similar narrative was shared by one woman in this study. She noted that all her seven children had been delivered by a

TBA, and in all cases these were breech babies. The woman, who was overwhelmed as she told her story, noted that her TBA had successfully turned all her breech babies. A woman with such an experience is less likely to perceive a breech as a complication requiring referral to the clinic.

In most cultures the family plays an influential role in making decisions in childbirth. In some cases this is detrimental to the woman's health as she can not make her own independent decisions. For instance in Zimbabwe, women giving birth for the first time have to do so at home, to allow closer monitoring by the kin, while grand multiparas often exceed safe parity due to pressure from in-laws to produce more children. Cultural values therefore can deprive a woman of the opportunity to make choices to the best of her interests, thus placing her at risk of a poor pregnancy outcome.

It is interesting to note how the concept of grand multiparity has been construed in different settings. Western authors have noted a grand multiparity of more than four children (>4) (e.g. Lennox 1984:126), while authors from the Southern countries' health care systems (e.g. Taylor et al. 1993; Mbizvo et al. 1997) note more than five (>5) and more than seven (>7) respectively for the same indicator.

Focus group discussions conducted with TBAs in Zimbabwe also show a great deal of variation in how TBAs construe multi-parity. Some TBAs defined a multipara as one who has had more than nine children (>9), yet others noted one ought to have exceeded the seventh mark (>7), to be at high risk.

As noted earlier, there is still no universally accepted definition of this risk factor. This discrepancy could also be explained by the value attached to family size in different settings. In patrilineal societies, where having more children is a quality of virtue, as represented by the TBAs and the rural women, it would make sense that a woman is not perceived to be at risk until she has given birth to nine children. Four children would be considered a very modest and unacceptable number. Such world views need be taken into account when designing policies pertaining to culturally constructed practices such as birthing. Policy makers should not only consider the biomedical perspective, but other socio-cultural factors that determine birthing preferences.

Among the Shona, restrictions imposed by cultural beliefs are yet again evident during the post-natal period. During the first six weeks following the delivery, the woman's sexual life is regulated. A woman is required to spent at least two weeks indoors i.e., until the baby's cord breaks and a naming

ceremony has been performed where the name of the baby is announced. After this the woman continues to observe sexual regulations for four more weeks (six weeks in all). She is not supposed to engage in sexual intercourse, not necessarily for fear of pollution, as is common in other cultures, for instance traditional Hindu society (Thompson 1985) and Botswana (Ingstad 1990). In the Shona culture it is generally believed that after delivery a woman's back "breaks" and becomes too weak for intercourse. The longest period a woman would have to stay without engaging in intercourse was six months.

These proscriptions come with a lot of implications. The seclusion of women during the first two weeks following the delivery, though noteworthy in that the woman is not stressed by household chores and has more time to breastfeed and attend to the baby, often means that babies who need immediate professional care may not receive it. Examples would be babies with low birth weight (LBW), prematures and those who need to be assessed and treated, such as babies born to mothers who are infected with Hepatitis B virus.

The six weeks to six months abstinence period also has implications on HIV/AIDS prevention. Traditionally, (before the advent of HIV/AIDS), this was a respected practice, and it

was sanctioned for the husband to "roam around" and have sexual intercourse with other women while his wife's back was "strong" enough for intercourse. Prohibition of sexual intercourse during this period was also due to the belief among the Shona that semen spoils the breast milk which in turn affects the baby's health. It is believed that if the baby suckles the concoction this may place it at risk of diarrhoea, severe weight loss, or even death. In this day of HIV/AIDS, such practices make both the woman and the man susceptible to infection with the HIV virus, as the man has had to look for alternative sexual partners during the time when his wife is observing sexual regulations. Thus cultural practices and beliefs can contribute to the spread of HIV. While this may the case, it is worth noting that HIV/AIDS has also had a negative impact on some of the Shona cultural practices. I discuss these issues in the next chapter, where I highlight the cultural construction of birthing among the Shona, along with the impact of the AIDS epidemic on these practices.

CHAPTER SIX

THE CULTURAL CONSTRUCTION OF CHILDBIRTH

6.1 "Legitimate" versus "Illegitimate" Knowledge

In its analysis of how power relations affect "bourgeios medicine", critical medical anthropology (CMA) addresses the question of how power is expressed in the social relations of various groups and actors that comprise the health care system (Singer et al. 1992). In this thesis I am interested in the interaction between medical personnel (the intermediate level) and the birthing women together with their social network systems and the TBA (the individual level). The constitution of authoritative knowledge in obstetrics, for example, reflects power relationships within a community practice (Davis-Floyd 1993). I discuss how birthing women organize their thinking and perception of risk, and the belief systems from which these behaviours are derived, vis-a-vis the biomedicalization of obstetrics.

Relative to biomedicine, anthropologists have documented the disadvantaged position of ethno medicine (Good 1994;

Kleinman 1995) and ethno-obstetrics (Jordan 1992; Davis and Davis-Floyd 1993). They posit that there is an "inner knowing" (intuition) and an "embodiment of knowledge" in midwifery, which is a form of authoritative knowledge for homebirthers and their midwives. Yet this form of knowledge has been granted no authority in the realm of biomedicine. They acknowledge as well that in particular health care domains, several knowledge systems exist, some of which carry more weight than others "either because they explain the state of the world better for the purposes at hand ... or because they are associated with a stronger power base (structural superiority), and usually both" (Davis-Floyd 1996:113).

In obstetrics, the biomedical model has gained ascendence and legitimacy, thereby devaluing and dismissing other kinds of knowing. Jordan (1993), notes that those who espouse alternative knowledge systems are seen as backward, ignorant and naive, or worse, simply as trouble-makers. TBAs are seen in this light, as they hold different physiological and anatomical concepts about reproduction. Training programmes for TBAs adopted by most countries in the South attempt to alter some of those traditional beliefs that expose women to greater risk. What complicates this process is that while the public health system introduces a new way of obstetric care,

TBAs continue to believe in the strength of their own authoritative knowledge, a system of knowledge shared by the women they assist as well as other members of the communities to which they belong.

TBAs who participated in the focus group discussions had a lot of interesting stories to share when they were asked how and when they first started practicing. In all of the eight groups, participants indicated that they learned this practice from their mothers when they were very young. They would accompany their mothers on calls and would assist with small tasks such as fetching water; in the process, they gained experience. Some had also learned from their paternal grandmothers.

Most TBAs made reference to intuition as their source of knowledge in the practice of traditional birthing. One common phrase that was used by the participants was *zvakandouyawo zvega* (it just happened). This is the main evidence of the application of intuitive knowledge in the practice of these TBAs. Some of those who used this phrase related how they had been led into the practice by their *mudzimu*, a Shona spirit. Most TBAs had difficulties explaining what the actual source was, always reverting back to the idea that "it just happens".

One woman shared that she and a friend had acquired skills of being a TBA by practicing on each other. This woman noted that she was in Zambia at the time and the health centers there were inaccessible. This woman and her friend would assist each other in delivery when the need arose. Another woman reported being intimidated into practicing at a very early age, and shared this poignant narrative:

> *I was only 13 and was the eldest of six children. My mother was expecting her seventh child, and I was the only one in the room who was old enough to assist ... I remember my mother getting ready to give birth ... she threw a mat on the floor, gathered all the equipment that she would use after delivery ... including a string which she made out of "garara"* (see description of terms)*, which she was going to use for tying the baby's cord. She lay on her back and as she pushed, she ordered me to stay close so I could receive the baby... I was ashamed and scared at the same time, ashamed to see my mother 'uncovered', and scared at the experience. The most scary part was when I saw a black-like thing coming out of my mother...I was about to run for my life but my mother reassured me to stay and help. Little did I know that the 'black-like' thing was my younger sister's head. That was actually the beginning of my career as a midwife.*

This 65+ year old woman started practicing at age 13; in total she has 52 years of hands-on experience. Experiences such as this demonstrate the "legitimacy" of traditional midwifery. In spite of this, trained and untrained TBAs expressed interest in learning modern methods of midwifery.

The fact that the training manual has pooled the experiences of the TBAs and included these in the syllabus, is quite commendable since the TBAs have a wealth of experience to share. It would be of concern if this experiential knowledge was replaced and forgotten.

6.2 A Typical Birthing-Room: "The Mock-Delivery"

In order to gain a deeper understanding of how the Shona TBAs construe birthing, a mock delivery was organized and observed. I felt I needed to add some face validity to what information I had obtained from the TBAs and mothers at the ante-natal clinic (ANC). Therefore, I observed a mock delivery within a naturalistic setting. I describe here what transpired during the mock delivery:

Tsitsi, a first birther, and an emergency case that could not make it to the health center due to distance, was made to sit on a neatly hand-crafted mat so that she could deliver in a squatting position. A pestle (duri), was placed behind her so she would not fall backwards when pushing. To assist Tsitsi in gathering strength for pushing, she was made to pull hard on a string suspended

from the roof of the hut. Two other women were in this hut where the delivery was taking place, and when Tsitsi began to push, these women chided and encouraged. The more outspoken of the women joked about how Tsitsi's mother had exhibited the same type of "cowardice" during her first delivery, adding insultingly that it ran in the family. There was also a vessel with cold water in the room, and one of the women frequently dipped a face cloth in this vessel and gently wiped away the sweat from Tsitsi's face. Meanwhile, the TBA continued monitoring the birthing woman. She noticed that the woman was developing into prolonged labor. The other women noticed the same thing. One of the women started demanding that Tsitsi make a confession ***(kureva)****. This "confession" involves the girl revealing her sexual history, confession which is perceived to speed up the delivery, as it is believed this would basically be the underlying cause for the delay. The woman warned Tsitsi of a negative pregnancy outcome if she failed to comply. Eventually Tsitsi confesses that at one time a boyfriend had fondled her breasts. This was an acceptable confession, and the women required that Tsitsi make an*

apology. She did. The midwife then reached for a wooden spoon and stuck the rear end of the spoon into Tsitsi's mouth. Tsitsi jerked (for real, as such an act would obviously illicit such a reaction). Momentarily the "nyamukuta" shouted "the head is showing!" and prepared herself to receive the child. This time Tsitsi pulled real hard on the suspended string. Without gloves, the "nyamukuta" received the baby; at this time, the women ululated. The "nyamukuta" proceeded to cut the cord using a razor blade and tied the cord. The baby (a doll made out of small pieces of cloth) was cuddled and shaken to illicit a cry. The baby was then wrapped up in a small piece of cloth torn from the "nyamukuta's" "Zambia", a piece of cloth used by most Shona women to wrap around the waist, as Tsitsi had no receiver for the baby. As the "nyamukuta" still had to clean the mother, the baby was handed over to one of the women who joked about the baby's features, remonstrating who the baby resembled. As she did so, she realized that the baby had "ndongorongo" (see description of terms), and informed the other women. The "nyamukuta" then went on to describe how she would dispose of the placenta

(throwing it in the toilet or burying it underground). After the placenta had been disposed and both the mother and child were clean, the "nyamukuta" offered tea to her visitors, to Tsitsi (specifically to keep her warm), and to the other women in appreciation of their presence.

This mock delivery reflects a typical *nyamukuta* assisted delivery. A typical birthing process in traditional Shona society involves a woman believing that time has come for her to be delivered, and that she is capable of going through this process without any biomedical intervention. In other words, she has confidence in her body's natural ability to birth and is prepared for a natural delivery. When a TBA is consulted, she begins to monitor the birthing woman. Some of the pre-delivery tasks include *kugadzira nzira*. This process involves widening of the birth canal (most common for first birthers) to guard against any possible complications resulting from vaginal tears. A botanical substance locally known as *feso* is normally used to this end. This practice is not unique to the Shona of Zimbabwe. The Maya in rural Mexico, as well as the Hispanics, use warm olive oil for this purpose (Sargent and Bascope 1996; Buss 1980).

It is also during this time that a bond is created

between the TBA and her client. By the time of the delivery, a decision has already been reached where the delivery should take place. Hence, although TBAs are encouraged to refer all complications to the clinic and to attend only to emergencies, some of the emergencies are pre-determined. When a decision has been made on where to deliver, the woman either presents at the TBA's homestead, or the TBA is called to attend to the client at the latter's home.

The squatting or half-sitting position described in the mock delivery is the most commonly recommended posture. Most TBAs find it more comfortable as it helps the woman to bear down more naturally. The World Health Organization (WHO) recommends that women adopt any comfortable position during labor (Bhardwaj 1993). Alternative positions are the dorsal and the lateral positions, but these are not as common in Shona culture as the half-sitting position. Bhardwaj (1993) notes that the lying down position was mainly adopted by obstetricians for their own convenience, and that there is no scientific basis for adopting this position.

In this study, TBAs describe how they determine where to cut the cord. The remaining cord should be three times longer than the middle finger. The cord is cut and tied using either a string or bark from an indigenous plant called *garara*. The

plant is known by other women as *mutimumwe, mushayamhanda, mutsawawa* or *tewu*. TBAs did not know of any medicinal properties of the plant, other than the fact that it is widely used since it grows naturally and is readily available.

One other important issue that emerged during the mock delivery was the presence of Tsitsi's relatives and their contribution to the whole delivery process. The TBA emphasized the need for empathy in such a situation, comparing this to hospital rules which are quite stringent regarding company in the labor ward.

Asked how they handle high risk cases, TBAs noted that it depends on the risk factor being considered. In the event of a breech they are advised to cover the woman with a blanket and refer to the clinic as swiftly as possible. In this study however, TBAs highlighted the transport problems that they encounter in the referral process, and admitted to turning the baby (external version) even when it is long past the safe time to do so. Modern obstetrics recommend attempting external version before 36 months of pregnancy, and any attempt of the same procedure after this places the parturient at high risk (Chi et al. 1986).

There are more operational challenges that the TBA face. In Tsitsi's case, the TBA had to perform the delivery without

any gloves. All the participants in this study were concerned about this. The biggest worry for TBAs was that they frequently come in direct contact with blood, and as such, are at great risk of contracting the HIV virus. Risks of contracting HIV during a delivery have also been documented by McKeown (1992). She notes that in modern obstetrics, although the occupational risk of acquiring HIV infection "even from a needlestick injury involving an HIV patient" is estimated at 0.25%, the spillage of maternal fluid on hands and other parts of the body can cause infection, especially where the skin is broken.

What was most compelling about this issue was the TBA's concern to save life more than protect herself against infection. TBAs challenged me repeatedly with the question: "what would you do if you were the TBA?" I came to appreciate their dilemma and discovered that the humanitarian aspect of birthing was the overriding feature of the TBA's work. Alternatively, TBAs have had to use regular plastic bags as gloves. Although this may protect the TBA, it places the birthing woman at risk of infection. On the same issue of equipment, TBAs note that they often use new surgical razor blades to cut the cord. In cases where these are not available, alternative means are resorted to, such as the use

of reeds or a sharp knife. This often results in the baby contracting tetanus.

Drying of the navel is usually achieved through the use of methylated spirit. One group of TBAs note that in the event that this is not available at the health center, they would have to obtain it from a shopping outlet where it is usually very expensive. At such times, they team up with other TBAs to buy a bottle of methylated spirit, to cut on cost. Where this was both unaffordable and unavailable, alternative means of drying up the navel are resorted to. These include expressing breast-milk on the navel, or applying cowdung which is burnt before application. Ashes were also mentioned as a navel drying substance. The placenta, known locally as *choumai,* is carefully disposed of, either by throwing this in the toilet, or burying it underground. The TBA sees to it that both the mother and the child are clean and warm after the delivery. As evidenced in the mock delivery, there is a tradition of sharing and caring among the Shona people. Most TBAs offer food to their guests.

TBAs say that there are occasions when they have to reside for a few days at their client's home. Alternatively TBAs keep the client at her home until the whole delivery process is over and post-natal care has been done. When the

delivery process is complete, the TBA stays with the client for a few more days, usually one week, or until the cord breaks. The TBA is then sent away ceremoniously. The client's in-laws prepare a special dish called *makombora,* which is comprised of chicken and *sadza;* the meal is served specifically for the TBA, even though it is eaten co-operately.[12] A few gifts in the form of soap, sugar, tea-leaves, baby oil, or laundry soap are presented to the *nyamukuta*. Normally, these are items that the woman cannot afford at the time of delivery and are provided by the *nyamukuta* herself.

Thereafter, the woman is in the hands of her relatives or in-laws, who continue to ensure that all cultural obligations around childbirth are observed. These regulations include abstaining from intercourse, as described in the previous chapter. I now turn on to discussing the implications of these behaviors as they are practiced today.

NOTES

[12] Generally a meal comprising chicken is the celebration meal among the Shona.

6.3 Effects of the Epidemic on Cultural Birthing Practices

While much can be said about the contribution of cultural practices to the spread of HIV/AIDS in rural Zimbabwe, a lot can also be said of AIDS' negative impact on the traditional birthing practices. Most TBAs note that it was difficult for most men to control their sexual passions during this period, and that during their reproductive years, though not openly socially sanctioned, it was known that a man would seek alternative sexual partners during the period of abstinence. This cannot be condoned anymore, as this places the woman at high risk. However, there is evidence that most men continue to patronize prostitutes during such times as when the wife is not available for sex. For instance a study conducted in the Rusitu district of Zimbabwe shows that men in this area justified their patronage of prostitutes on the grounds that when they are at home, their wives are frequently unavailable for sex due to pregnancy, post-partum abstinence or migration. They also note that what is most worrying about this is that during these encounters, condoms are rarely used. (Gregson et al. 1996). Women are also unavailable for sex during the breast-feeding period. The discussion on child-spacing methods provided more insight on how the AIDS epidemic has

disrupted cultural obligations in this area. As noted earlier, the role of the TBA goes beyond assisting women in delivery to include pre-natal and post-natal care. The TBA is instrumental in educating younger women on child-spacing methods, as they are advised to do this during the upgrading programmes. An interesting observation that was made during this study was that in most cases, TBAs, who are mostly post-meno-pausal and are no longer using contraceptives, would impart to their clients knowledge about folk methods of child-spacing they themselves used during their reproductive years. Prolonged breast-feeding was noted by most TBAs as a very effective method of child-spacing. As noted earlier, sexual relations are prohibited during this period for fear of negative health consequences on the baby. In this day of HIV/AIDS, these strong traditional beliefs and practices are being challenged. Prolonged breast-feeding, as would be the case with abstinence, only makes the man vulnerable as he engages in extra marital relations during this period. The women are also placed in a big dilemma. Their choices are as follows:

i) "let the man go", save your child, but rest assured he will bring HIV/AIDS

ii) succumb to sex and risk your baby's life

Most women would rather "let the man go", hoping that he will be responsible enough (e.g. by using a condom), but are generally prepared to pay the cost for the love of their children. Some TBAs abhorred the use of condoms, which most referred to as rubbers or tubes, noting that these "modern things" only take away the whole essence of sex in Shona culture as a procreative activity. In traditional Shona society, most women noted that "the idea behind sex is so that children be born so the lineage is extended and we also have someone to leave our inheritance. Condoms, whether used for HIV prevention or child spacing, jeopardizes this purpose of sexual intercourse. They are also disgusting".

There is a shared concern among the TBAs that HIV/AIDS has disrupted some of the traditional beliefs and practices around childbirth.

Asked what they would recommend for child-spacing in place of condoms or other modern methods, TBAs mentioned the methods which they themselves used. The most commonly cited folk method of child-spacing was one that was referred to by the TBAs as *kusungira*. This involves a woman tying a piece of cloth around her waist. Usually knots are made on this piece of cloth to signify the number of years one intended to stay without conceiving. For instance, if a gap of four years

between children was required, then four knots are made on the cloth. Some of the women interviewed in this study admitted to using this method even in modern times, and for most who have used it, it has been very effective.

TBAs would recommend that such and other traditional methods of child-spacing be used instead of the "disgusting" condom. The adverse consequences of this world view on AIDS prevention efforts cannot be over emphasized. However most TBAs bemoan the days when it was possible to abstain from sex, breast-feed for longer periods and perform other culturally sanctioned obligations around sexual intercourse and childbirth without anticipating infection with a virus.

Women's choices with regards to childbirth are therefore largely determined and constrained by their disadvantaged position in society. Their biggest dilemma comes when they have to perform cultural obligations in order to ensure the security of their marital position. Most of the women who participated in this study are married women (83%) and these noted the challenges they face in their reproductive life as they succumb to the pressure of culture. In the following section I examine the factors that perpetuate this unprivileged position of women. A contextual analysis of women's issues is a prerequisite for ensuring effectiveness of

interventions to improve women's health.

6.4 Traditional Roles of Women in Shona Culture

Many behaviours that place people at risk for health problems are the result of complex patterns of behaviour which frequently involve not only that individual but his/her entire network of social relationships and value systems (Norr et al. 1991). Childbirth is one such problem, and should be understood as a societal problem for any intervention to be effective. The health of women, particularly reproductive health, often occurs in the context of unequal distribution of power and is also related to their socio-economic status.

Townsend and McElroy (1992) and Baer (1996) propose the medical-ecological model which is more in touch with women's lives than the biomedical model. This model complements the perspective of CMA in addressing health issues from a broader perspective, only more emphasis is placed on environmental issues. These note that health is not only measured in terms of morbidity and mortality, but that it is a function of a group's interaction with its environment (ibid.)

Studies on reproductive health show that in most cases women's autonomy in health matters is often constrained. Most

women, especially in agricultural economies, continue to till the land, fetch firewood, water the garden, collect water and other related activities until the onset of uterine contractions(Townsend and McElroy 1992). From the perspective of modern obstetrics, activities such as these are healthy and should be continued, unless the woman has an incapacitating problem, such as anaemia.
Anaemia in pregnant women causes incapacity from tiredness, lassitude, breathlessness, and decreased ability to work (Shulman et al. 1996).

While exercise is necessary during pregnancy, this should be distinguished from hard labour forced on the women due to cultural requirements. Rural Zimbabwean women work long hours in the fields as this is the major source of income for many. Also, productive work in Zimbabwe is a mark of a woman's virtue, so much so that when bed-rest is recommended during a threatening pregnancy, compliance is likely to be low, as a woman sleeping while others are working is seen as lazy. The detrimental effects of these world views on the health of women cannot be over emphasized. Most worrying in such situations is the woman's inability to take decisions that protect her health and interests. Factors that compound this incapacity in women is the subject of the next section.

6.4.1 Economic Deprivation

The structure of employment that was inherited from the colonial period has perpetuated the feminization of poverty in rural Africa (Schoepf 1993:1402). This is a strong factor in attitudes towards illness and disease. This has had far reaching consequences on the health of women. The relational nature of these factors and their consequences is worth mentioning. Poverty in women is facilitated by low literacy levels which in turn jeopardizes job opportunities, leading to financial insecurity, overreliance on men and consequently failure to make decisions regarding their health.

In most settings women have limited access to knowledge. In Zimbabwean traditional society, illiteracy in women is quite rampant, and much has to do with the notion of the "boy-child preference" common in most patrilineal societies. The justification for this preference is that the boy-child continues the family line, and that it is wiser to invest in him, than to educate a girl-child who will eventually marry and move out of the family circle. An educated and prosperous girl-child, so the argument goes, brings pride to another family on marriage, an undesirable outcome not only to the parents but the clan as a whole. As a result, literacy in

these societies is heavily biased towards males (Zimbabwe Demographic and Health Survey (ZDHS) 1994).

In addition to the above determinants, there is the traditional role of the woman. In African traditional culture, "socialized female characteristics" (Amaro 1995:442) are disempowering as they inhibit the woman's ability to make safe and informed choices regarding her reproductive health. Sexual intercourse between married individuals in Zimbabwean context as in most patrilineal societies, is supposed to result in children who elevate the status of the man in society, as well as ensure the security of the woman's marital status. In most parts of the world, the status of a woman depends on her ability to have children, and that her reproductive capacity is often seen as the possession of her husband or her family (Batterink et al. 1994). Thus in most cases, women are under severe pressure to conceive, as failure to produce children is a disgrace and can lead to rejection.

In most patrilineal societies, it is not just about bearing children, but producing children of the "right sex" (boy children). Apart from the fact that children are invested in as a guarantee for future social security, most women have had to exceed the safe number of children in search for this right sex. Most women who die of haemorrhage in delivery are

grand multiparas.

While for most couples protected sex, or more specifically, use of condoms, takes away the whole meaning of intercourse as a gratifying and functional activity, failure to use the device increases a woman's reproductive risks. In this study, this is compounded by the negative attitude of TBAs towards condom use. It is most worrying for pregnant women, particularly because pregnancy accelerates HIV progression and vertical transmission of HIV from mother to foetus is reportedly highest in Africa (Mackie 1993).

Discussion:

For most women, therefore, sexual behaviour occurs in the context of unequal power. These traditional/cultural practices and beliefs are useful for understanding the conditions affecting women's reproductive health, and the context within which they have to make decisions related to their health.

In summary, women's choices are restricted due to their socially constituted low status in society, also their disadvantaged financial positions which make them more dependent on men. Lack of initiative, which is mainly due to inability to make decisions, along with a sense of insecurity

within a marital relationship, further compound the dilemma of women. These factors compromise a woman's health, particularly her reproductive life.

It is also essential to make a distinction between certain practices, so as to avoid falling into the trap of ethnocentrism. I suggested elsewhere a distinction between exercise during pregnancy and hard labour. I should also add that submissiveness for instance, should not always be taken to mean insubordination. When TBAs in this study advise women (especially young women), on good marital relations, submission is often part of the lesson. In traditional Shona society, submission is expected to be reciprocated by respect. It is only when the other party abuses their power that the system fails. There is a need, therefore, to be culturally sensitive to these issues before any recommendation to better the situation is arrived at.

6.5 Incentive for Being a TBA - The TBA's Perspective

The TBA shares in these challenges which the woman goes through in her reproductive life. It became necessary, in light of the complexity of these factors, whether TBAs thought their services should be paid for, and how. The TBAs were

given the opportunity to share their views with regards to the issue of remuneration. Some indicated that regardless of the formal training, they do not get paid for their services. They were asked whether they were receiving anything from their clients in appreciation of their services. All the groups indicated that they were not receiving anything in the form of gifts from their clients. One group noted that traditionally, it was the responsibility of the husband to perform the *makombora* ritual, discussed in the previous section, in honor of the TBA. While the other groups did not mention specifically the role of the husband, the idea of a feast hosted in favour of the TBA was mentioned in all the other groups. However, the most common items that the clients would give their TBAs as mentioned earlier, were soap, sugar and cooking oil.

The TBAs reiterated that nowadays, their clients were not doing anything at all regarding gifts or payment. Most groups concurred that they did not demand any payment and that this was more of a charity service than an income generating activity. All but one group noted that the main reason why the mothers were not giving them anything in appreciation was more because of their low income status than apathy. The other group maintained that it was sheer apathy on the part of their

clients.

TBAs noted that it is they instead, who provided for the needs of their clients. Most of the women, it was noted, came to the point of delivery without having prepared for the baby, that even when the TBA received the baby, she had to tear off part of her *zambia*, in order to wrap up the baby and keep it warm, as was clearly enacted in Tsitsi's case. It was also noted that it is the TBA who prepares food for her client, using her own resources. Another group also noted that because it is due to financial need that their clients do not give, most end up avoiding the TBA because of shame. Poverty among the rural women place them in difficult situations and dilemmas with regards to birthing.

The TBAs felt that the issue of incentives was a major drawback to their practice and thought it was the responsibility of the Ministry of Health to organize something for them in the form of a small allowance. The World Health Organization (WHO) suggests that decisions to pay the TBA should take into account the existing relationship between the TBA and her clientele, and ensure that such interactions are not disrupted (WHO 1992).

6.6 Incentives for the TBA: The Women's Perspective

It was interesting to find out how women who benefitted from the TBAs' services reciprocated. Reports made by the women contradicted the scenario painted by the TBAs during the FGDs. Most mothers indicated that they always gave their TBAs something as a token of appreciation. The most commonly reported gifts were sugar, cooking oil and mealie-meal. Some would also give money, and the amount ranged from ZWE$5-$20. Most mothers noted that the TBAs did not demand payment in any way. Respondents who had not given gifts to the TBAs, had not done so because those TBAs were their relatives and they did not feel obliged. No respondent in this category reported having failed to offer a gift due to a lack of resources as hinted by most TBAs.

Respondents' opinion on TBAs standards were solicited to find out whether there are any areas that needed improvement. Nineteen (54%) of the respondents thought that the TBAs needed to improve. Some of the explanations that were given were that the TBA should do away with traditional methods of delivery, and also that they should not attempt to assist complicated cases. Those who indicated otherwise thought TBAs were adults who knew what they were doing and that they were

doing a lot to assist the rural women.

Discussion:

The World Health Organization (WHO) notes that any formal training programme initiated through the modern health care system will open up the issue of remuneration among the trainees (WHO 1992). TBAs in this study, particularly those who have received formal training from the Ministry of Health, felt that they had acquired a new status and that their services should now be paid in cash than in kind. For some TBAs it was not so much about the acquisition of new skills that they thought they should be paid. Rather this had to do with the difficulties they encounter as they try to procure equipment to perform a safe delivery in this day of HIV/AIDS. Also the TBAs understand the contextual forces affecting women's decisions in childbirth, and are inclined to assist in spite of their own disadvantaged economic status.

TBAs reiterated that, much as they may want to continue assisting in childbirth at no charge, as has always been the norm, the high cost of living was making this impossible. Thus TBAs felt that, although they do receive some incentive from the birthing women in kind, and since most of these women are from a low income background, the Ministry of Health

should consider a small allowance to defer expenses. Given the current economic and health challenges in the country, this concern is justified, and some form of assistance should be considered to ensure TBAs continue to render this vital service.

Having explored the challenges that TBAs and birthing women encounter in the birthing process, I now discuss the conceptualization of risk in indigenous birthing practices, vis-a-vis the biomedical definition. My central argument is that risk is a social construct and as such, there is a Shona way of thinking about risk in childbirth. These cultural interpretations are necessary for understanding choices in childbirth, and provide an entree point for interventions to reduce risk in birthing women.

CHAPTER SEVEN

RISK CONSTRUCTION

7.1 Biomedical Risks vs Cultural Interpretations

High-risk monitoring has been used as the standard approach to reducing maternal mortality and morbidity from pregnancy-related problems. A high risk pregnancy has been defined as one in which "physiologic, psychologic, and environmental factors exist in the mother or fetus that imply a threat to either's health" (Schmitz and Reif 1994:176). In recent years, anthropologists have come to an understanding that birth is not simply a biological act, but a social construct (Davis-Floyd and Davis 1996:111). It is estimated that 30% of all pregnancies are high-risk (Chi et al. 1983), and early identification of risk is essential to prevent and reduce poor outcomes. Women should be encouraged to start a series of visits to health facilities early in pregnancy, in order to identify complications or indicators of potential risk.

A majority of available risk assessment instruments focus

on biomedical risk factors, hence overlooking the assessment of psycho-social and environmental stressors noted by the women and their effects on pregnancy outcome. In order to achieve the primary health care philosophy of health for all by the year 2,000, and to ensure a significant reduction in maternal morbidity and mortality, women's health should be understood from a holistic perspective. Bridget Jordan is cited by different authors as advocating for a dialogic, bio-social approach to childbirth, one which would accommodate both biomedical and indigenous systems (e.g. Davis-Floyd and Davis 1996; Browner and Press 1996).

It is understood that the training programme for the TBAs in Zimbabwe also addresses issues such as identifying complications and encourages the referral of such cases. TBAs were asked to name what they considered to be complications and how they dealt with them. Both groups (trained and untrained), demonstrated competency in detecting complications and how to handle them. The following were considered as complications by the TBAs:

Caesarian section (operation) cases, high risk hospital record card, transverse section, known in vernacular as *sunikwa*. first pregnancy (*mhandatsva)*

fits, goiter

short stature

one with twins

7th + pregnancy (See Appendix 3 for a model of biomedical high risk factors for comparison with TBAs knowledge).

Women's knowledge of TBAs' practices were solicited to determine whether the women themselves understood the concept of risk. It was encouraging to note from the women's reports that the TBAs have put into practice such crucial strategies as risk monitoring to reduce maternal mortality.

When respondents were asked whether they knew what the TBA looked for during an examination, the most commonly reported observation was vaginal dilation (*nzira*) (see Table 2).

Table 2
WOMEN'S KNOWLEDGE OF EXAMINATIONS UNDERTAKEN BY THE TBA
N=36

Examination	Frequency	Percent
Position of baby	9	25.0
Nzira	14	38.9
Medical record of mother	1	2.8
Other (listen to fetal heartbeat)	12	33.3

Respondents also noted that TBAs also examined to see whether the baby was well positioned. Other respondents observed that the TBA was more concerned with personal hygiene and the medical record of the mother. Respondents reported that most TBAs would check with the woman's health card in order to see whether there would be any likelihood of complications, in which case they would have to refer the birthing woman to the health center. However, some of the respondents indicated that if given a choice, they would prefer being attended to at the clinic. Reasons given for this preference were that health personnel were more knowledgeable (as presented above), and that the hospital offers better services.

While TBAs were aware of the high risk factors in pregnancy, they admitted to attempting to assist some of the cases. As discussed earlier, some of the reasons why TBAs assisted complicated cases include infrastructural and operational constraints. For instance, most TBAs noted poor road network systems and inadequate transportation as reasons why they do not refer cases to the clinic. Few people in the rural areas own vehicles. Alternatives to automobiles would be wheelbarrows or bicycles. Use of these at night is not practical, considering that there is no lighting on the roads.

Even when transport is available, most of the roads in the rural areas are poorly maintained gravel roads which makes it more difficult to transport a woman in labour to the clinic. Most women noted that these conditions speed up labour, and a woman in advanced labour is likely to give birth on the way to the hospital without any assistance, which places her at greater risk.

For those women who make it to the clinic, more problems await. Most health centres' lighting is provided on a limited basis by a diesel generator. These are not always functioning, although non-governmental organizations (NGOs)have played a significant role in ameliorating the problem.

PLAN International is an example of such an organization which has embarked on a programme to provide solar systems to rural health centres in the Manicaland province of Zimbabwe where this study took place. This programme has not been without setbacks. Gross poverty among the rural folk has bred crime, and most of the solar equipment at the health centres has either been vandalized or stolen. Women who utilize clinic facilities need to be prepared for these conditions, and in most cases they have had to bring their own equipment (e.g. candles, kerosene lamps, for the lighting). In addition

to problems in lighting, the water supply systems to most health centres is often also inadequate. Women would have to be accompanied by a relative who would assist in fetching water for use during the delivery and after. Hence, social support is crucial in birthing, and lack of it can result in negative pregnancy outcome, as noted by Mbizvo (1997), Taylor (1993), and others.

In this study, TBAs volunteered what they construed as a high risk pregnancy, demonstrating that practically, there are conceptual differences between what is defined by biomedicine as high risk, vis-a-vis the TBAs perception of what constitutes risk. In this section, I talk about these differences as they are construed among the Shona, as well the long term health consequences of such world views.

Primiparity: In most non-western societies, age at marriage is much lower compared to the West. This is the norm in those settings, and in particular settings (e.g. Sierra Leone), rituals are performed to initiate girls and prepare them for marriage at very young ages (Jambai and MacCormark 1996). However, the skeletal development of these young girls is not yet completed; their pelvis' are still too narrow, often making the first delivery difficult or even life

threatening. The complications of primiparity include obstructed labor due to the disproportion of the pelvis to the baby's head (cephalo-fetal disproportion). This disproportion can also result in uterine rupture, leading to trauma in the young mother, and in extreme cases, post-partum depression. Primiparas are also at high risk for producing pre-term babies who are usually low birth-weights (ibid.)

In order to facilitate a less difficult first delivery, TBAs in most cultures assist in applying some slippery substance to the birth canal to help the baby to slip out. As noted earlier, in Zimbabwe, this process called *kugadzira nzira,* meaning preparing the birth canal, is most common in first birthers, and is said to commence around the seventh month of pregnancy. A herbal substance (*feso*) is used to this end. It is believed that these measures reduce the risks of vaginal tears and other associated disabilities resulting from a difficult delivery.

There are a lot of risks associated with this procedure. Most notably it does not determine the size of the pelvis, hence women with a well prepared birth canal but a small pelvis have often been the victims of such cultural practices. There is an added risk; when an obstructed labour occurs to a first-birther among the Shona, a certain cultural procedure

has to be performed before the delivery can be completed.

The Shona construction of this high risk factor contradicts the biomedical perspective where prolonged labour (i.e. more than 18 hours) is usually due to feto-pelvic disproportion or malpresentation of the fetus (Duarte and Yano 1992). The longer the labour, the greater the risk of death. In a study conducted in Zaire, for women in labour more than 48 hours, the risk was more than 400 times greater than for women who laboured 12 hours or less (Smith et al. 1984). **Prolonged labour** results in uterine rupture which increases the risk of death more than 100 fold. In this case, women would require immediate resuscitation before an intervention to deliver the baby is possible.

On the contrary, the Shona believe that if a first birther is experiencing problems during delivery, then she must have been sexually irresponsible at one point in her sexual life. This has to be confessed (*kureva*) to all those attending to the delivery before any action is effected to assist the complication, as is demonstrated in Tsitsi's case. In other words, delivery among the Shona should be completed without any difficulty. This act has often resulted in strained relationships, especially when it is a girl confessing to her in-laws. Apart from this common social

outcome, there are a lot of other risks facilitated by the delay in making a confession. Some of these negative outcomes include vaginal tears as well as death of the baby and mother at birth due to fatigue. Nonetheless, TBAs denied any experience of the latter outcome.

For these and other reasons, it is then justified that first birthers should give birth under their paternal kin's care. Cross-culturally, the relationship between mother-in-law and daughter-in-law is one that does not permit sound dialogue especially on such sensitive matters as birthing. Most girls feel distanced from their mothers-in-law, and this makes it difficult for them to communicate any complications to them. There are constraints in getting the mother-in-law to do vaginal examinations on her daughter in law. Some mothers-in-law have demonstrated apathy by leaving things undone until the last minute. This is also attributed to the fact that the mother-in-law may not necessarily feel as committed to her daughter-in-law whom, in her opinion, is another person's responsibility, as she would with her own daughter.

Obstructed labour: In case of an obstructed labor, TBAs in Zimbabwe, as well as the women they assist, admit to

attempting turning the baby (External Version) to facilitate a normal presentation. This is relatively safe before 36 weeks of pregnancy, but after this, the risk of damaging both mother and baby is high, and TBAs are advised to refer the woman at once. However, due to constraints in referring cases, TBAs continue to attempt turning even after the 36 weeks. TBAs are well aware of the negative consequences, but given the circumstances, as well as for humanitarian reasons, they have no option but to take the risk.

Grand-multiparity: In Zimbabwe the most common pregnancy related complication resulting in maternal death is excessive bleeding, or *haemorrhage* (Mbizvo et al. 1997). This is common in grand-multiparas. Epidemiologically, maternal mortality risk takes a U-shaped curve and rises again with high parity (Jambai and MacCormarck 1996). These describe how the placenta attaches to different places in the uterus with every new pregnancy. After many pregnancies, these new areas ("good places") high in the uterus, get used up. This means that the only place left available is the lower uterus. When the placenta attaches low in the uterus it does not attach so firmly, increasing the risk of excessive bleeding, or it may block the birth canal. A grand multipara is also at greatest

risk for anaemia, gestational diabetes and hypertension (Hughes and Morrison 1994). The value attached to child-bearing in traditional Shona society places the woman at high risk as she exceeds safe parity.

In Zimbabwe, women losing blood through haemorrhage would need supplementary blood, and donors are usually identified from the woman's social network (i.e. friends or relatives). With the AIDS epidemic, most people are reluctant to give or receive blood, which is another challenge as this exposes the woman to risk of death from shortage of blood. The challenge remains; for the woman and her kin, the social benefits of child-bearing out-weigh the risks.

Visits to ante-natal care clinics (ANC) are yet another marker that determines the outcome of a pregnancy. A study conducted in Nigeria shows that women who did not receive ANC are at greater risk than those that did (Lennox 1984). Socio-economic variables such as illiteracy, low economic status, poor nutrition all combine to contribute to risks in pregnancy.

When TBAs were asked what risk factor it was that bothered them the most, the response was interesting. No reference was made to the biomedical risk factors. Rather, the TBA mentioned what is known in the vernacular as

ndongorongo. TBAs noted that this is a usual condition, and is "satisfactorily" handled by the TBAs themselves. On delivery, a baby has lumps of blood on the navel. TBAs indicated that this has to be eliminated soon after the baby is born. Asked what the cause of this *ndongorongo* could be, TBAs had different explanations and suspicions. Some noted that it is a fairly new phenomenon, and that this, as well as other newly emerging diseases such as HIV/AIDS are being brought about due to a mixture of blood/tribes (cf Willms et al. 1996). *Ndongorongo* is also interpreted as a bad omen to the family, and failure to identify and eliminate it at birth brings a lot of misfortunes to the family. The baby itself also falls prey to these misfortune, which manifest in the form of severe illness.

Modern midwives note that this is a normal condition. Normally, when a baby has just been born, blood collects at different places on the cord and around the navel area. This, according to the nurses, is what is interpreted as *ndongorongo* by the TBAs.

Previous studies show that more than 50% of birthing women die outside a health facility in Zimbabwe (i.e. traveling, at home, and at the TBAs) (Mbizvo et al. 1996). Participants were asked whether they had ever encountered any

deaths in their practice. All groups denied having ever lost a client. They noted that it had happened elsewhere, but not to them. This contradicts findings such as those of the study cited above, and this also makes it difficult to quantify maternal mortality rates in the rural areas. TBAs probably thought that they were being interrogated on this question.

Having noted these divergent world views in what constitute risk in childbirth, I now turn to discussing other concomitant factors that aggravate the risk of birthing women.

7.2 Cultural and Psychosocial Forces

As noted earlier, a lot of emphasis has been placed on biomedical risk assessment. A holistic approach to understanding risk would consider psychosocial and cultural forces as important determinants in decision making and risk-taking where the behaviour is perceived as risky by the birthing woman. Psychosocial risk markers include socio-economic conditions; namely income, education of women, nutrition and housing (Taylor et al. 1993:244). Other psychosocial factors that are associated with pregnancy or neo-natal complications but not usually part of risk assessment, are life stress, low levels of social support and

negative attitudes about pregnancy and self (Schmitz and Reif 1994).

Maternal life stress is associated with poor neo-natal outcomes both directly and indirectly through its effects on risk taking behaviours. This can be linked to nutritional habits. Among low-income groups, where food is scarce and has to be shared sparingly when available, women always make sacrifices to either receive the last portion or even go without to ensure the males and the children have had enough.

In Zimbabwe, low birth weight (LBW) among the rural population is estimated at 10-11% compared to 5.1% in hospital delivered women. This suggests that those women who delivered at home were poor and malnourished (Taylor et al. 1993:246). Nichter notes that among the Havik women in India, refusal to take meals is quite common after quarrels, and is a means of expressing conflicting and distress within the food idiom. In this same culture, females eat together after males are served (Nichter 1981). This compares well with eating regulations in Zimbabwean traditional society. Women in this study noted that, especially where they were residing with their in-laws, they ensured that the husband's kin were well served first. Such behaviours have negative impact on pregnancy outcome.

The occurrence of thyroid problems in pregnant women due

to iodine deficiency, for instance, is a function of poor nutritional habits. In Zimbabwe, goiter (*sokorodzi*) is a common risk factor and is known to the TBAs. This problem is quite common among members of the *Mai Chaza* religious sect, and is therefore a high risk factor particularly in members of this sect. The evidence for the relationship between nutritional habits and high risk pregnancies has been documented (e.g.Taylor et al. 1993), although a focus on the nutritional habits of specific groups (like the *Mai Chaza* noted above and their influence on pregnancy outcome) could be an area for future research.

The issue of whether a pregnant woman should eat more food than usual during pregnancy is also a contentious issue in Shona society. Most women indicated that a pregnant woman should eat less because eating more adds to the weight of the baby, making it difficult for the woman to push during delivery. Although eating less may actually result in a small baby, it is noted that this is often dangerous because very small babies are weak and easily die (Gordon 1980).

Food taboos during pregnancy in rural Zimbabwe are quite strong. Foods that were commonly cited during the FGDs as taboo included paw-paws, honey, chillies and black fruits. It is believed that if a woman eats too many paw-paws, then the

baby is all messed up at birth. It is believed that this mucous-like substance covering the baby is a result of the paw-paw. Too much honey intake is believed to make the baby salivate a lot when it is born. Dark fruits are believed to contribute to the colour pigment of the baby; in other words the baby is born very dark.

Food taboos in pregnancy can have negative consequences on the health of the mother and the child. Prohibition in the intake of most of these foods results in the woman being denied of their nutritional value. TBAs can play an important role in educating women on food habits during pregnancy.

The foregoing discussion shows how risk is construed in different categories, and the consequences of these conceptualizations. It is important to identify these conceptual differences in order to negotiate models targeted at reducing risk in childbirth. While these cultural interpretations of risk are crucial for understanding the birthing practices of TBAs as well as the health seeking behavior of birthing women, they should not be understood in isolation. Given the disempowered position in which culture has placed women in, an analysis of psycho-social life stressors help complete the picture of what constitutes risk in the life of a birthing woman in rural Zimbabwe.

CHAPTER EIGHT

CONCLUSION

Zimbabwe is one country with an unacceptably high maternal mortality rate. There is an array of factors that place women's health at risk, and in recent times, this has been exercabated by the advent of HIV/AIDS. In Zimbabwe, TBAs deliver most of the nation's babies, yet are not adequately protected from risk of HIV infection during a delivery. While sero-positive birthing women place the TBA at high risk of contracting the HIV virus, they themselves are also vulnerable to HIV infection when the TBA has been infected and continues to perform deliveries. For most rural women, these are painful facts which requires one to adopt a sensitive approach in dealing with these issues.

An understanding of the different ways in which risk in childbirth is construed within specific cultural contexts is paramount to the designing of culturally sensitive, culturally appropriate and *culturally compelling* interventions (Willms et al. 1996:3). In this study, both the TBAs and their clients were interviewed in order to get an "insider perspective" (Spradley 1980) of what constitutes risk in childbirth. There

are substantial differences in what biomedicine defines as high risk vis-a-vis the indigenous system's construction of the same. The biomedical perspective has been criticized for being linear, thereby overlooking the encompassing forces within which women make decisions regarding their reproductive health. While the World Health Organization (WHO) initiated programme to upgrade the skills of TBAs has been well embraced by this cadre in Zimbabwe, there are noticeable conceptual differences in what the TBAs are taught during the courses and what they actually practice on the ground. In any traditional setting, decisions in childbirth are deeply rooted in culture, its members drawing on complex belief systems to justify their behavior. In traditional Shona society, women continue to consult TBAs because they share the same belief system around childbirth. Women also draw on their embodied experience as one motivation for consulting the TBA. In this culture, birthing is construed as a natural process, and does not require any intervention of technology. TBAs would argue that they have a wealth of experience which they attained even prior to the introduction of technology, and that technology has redefined the meaning of birthing as a medical problem.

This thesis has advanced the holistic perspective,

critical medical anthropology (CMA) to explore the possible risk-enhancing factors in traditional birthing practices, as well as the extent to which the affected population perceive themselves to be at risk. The macro forces within which the TBA provides her services, and the linkages of these to the micro-processes have been presented in this thesis to demonstrate the complexity of the environment in which women are giving birth.

Women's compliance with health care facilities is not only influenced by what they believe in, but it is also about **acceptability and affordability of, as well as accessibility** to resources. In Zimbabwe, lack of access to modern health care facilities mainly due to poor physical infrastructure often leaves the birthing woman with no choice but to consult the more accessible TBA. When women cannot afford "decent" clothing for the baby, when they cannot afford to pay even the subsidized clinic/hospital fees, the only option available is to consult the TBA. Women who resist the control of technology over their bodies, whose explanatory models and perception of risk in childbirth differs with that of biomedicine, who feel restricted in what they say or do because there is a "more authoritative" body of knowledge that can explain their condition better, who feel lonely

because there is no one to empathize, often opt to deliver in a more acceptable environment, the home.

TBAs share these same dilemmas with their clients. The relationship between the TBA and her clients is a delicate one, for in most cases the final word and decision that determines the outcome of the pregnancy lies with the TBA. Some TBAs in this study express concern that, because of the high prevalence of HIV, they are most at risk and may not be taking clients in future. But for the majority of the rural populace, traditional midwifery will move with the tide.

Recommendations

- A lot of information was generated through focus group discussions (FGDs) and other qualitative methods of data collection employed in this study. TBAs had an unusual opportunity of sharing their concerns in a group, and most were stunned to note that they were not alone in the dilemmas that they are facing. Any sustainable intervention to reduce risks for TBAs will require their full participation. It is recommended that there be regular meetings/workshops with the TBAs where they can voice their concerns with regards to their practices. In most cases, the reason why people do not talk is not

because they do not have anything to say, but that they do not know how and where to say it. These meetings will go a long way in empowering TBAs. The meetings need not always be held at the health center. Occasional meetings could be conducted in the community.

- Women who are informed of their sero-status should receive counseling on how to communicate this information to the TBA. TBAs have the right to make informed decisions regarding assistance in childbirth.
- A Ministry of Health and Child Welfare (MOHCW)initiated national body for Traditional Birth Attendants might be a useful vehicle as it will improve dialogue between the TBAs and the biomedical practitioners, as well as their indigenous counterparts, particularly the Traditional Healers. Lessons can be drawn from such an organization like the Zimbabwe National Traditional Healers Association (ZINATHA). This is an organized body for traditional healers with a strong advocate as its president. A lot of work has been done on traditional healing in Zimbabwe partly because of the conducive machinery that is in place and also because of the advocacy role of the high ranking members of the association. The same could be done for TBAs.

- The TBA and her clients are at high risk of contracting HIV through unsafe methods of delivery. TBAs in this study made a strong request that their midwifery kits be replenished more often. The kits could be replenished at the regular meetings/workshops with the TBAs.
- In this study, there was evidence of discrimination against untrained TBAs (by the trained TBAs), and this has resulted in low self-esteem on the part of the untrained TBAs. Such issues could be addressed at the meetings with TBAs. Also, as much as possible, the meetings should be attended by any woman in the community who assists with delivery.
- As there are a host of factors associated with risk in childbirth, a multi-sectoral approach to addressing the issue is recommended. The regular meetings/workshops proposed here could also be attended by representatives from different departments, such as Transport, Rural Development, Energy and Water Resources, Women's Affairs, Education, and other relevant parties (including non-governmental organizations NGOs) that could make a difference to the health of women in the rural areas.

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APPENDIX 1
FOCUS GROUP PROBES FOR TBAs

How does one become a midwife?

At what age can one become a midwife?

How are skills obtained - what are these skills?

How do you perceive of your role in the community?

Are any examinations done during the perinatal period, and what exactly is looked for?

Explain in detail how you prepare for a delivery - (take note of risky practices)

Is it ceremonious - what rituals are carried out - (take note of risky practices)

What precautions are taken during a delivery?

What type of equipment is used?

Is number of clients going up or down?

Has AIDS affected the practice in any way? Explain

Who is at risk and how are they at risk?

How is your relationship with the professional sector?

How are complicated cases dealt with - which cases are referred to hospital - which cases are dealt with - (take note of risks (HIV))

Views on training - are new skills acceptable - which of the old methods are still being used and why. Which of the new skills have not been adopted and why?

How do you see the future of traditional midwifery?

Anything else to say?

****

APPENDIX 2

KNOWLEDGE, ATTITUDES, PRACTISES, AND BELIEFS OF MOTHERS WITH REGARDS TO ISSUES IN TRADITIONAL MIDWIFERY

Quest.#:________ Village:________ District:______

Date:________ Time taken:___________

1. Age
   1.15-24
   2.25-34
   3.35-44
   4.45-54
   5.55-64
   6.64-74
   7.above 74

2. Religion
   1.Apostolic Faith
   2.Roman Catholic
   3.Anglican
   4.Methodist
   5.Other _____________

3. Source of income
   1.Peasantry
   2.Husband
   3.Other ____________

4. Marital Status
   1.Married
   2.Single
   3.Divorced
   4.Widowed

5. No. of children
   1.<three
   2.three
   3.four
   4.five
   5.six
   6.>six

6. Have you ever been assisted by a TBA in delivery
   1.Yes
   2.No

7. Of your children, how many were delivered by a TBA

1. One
2. Two
3. Three
4. Four
5. Five
6. Six
7. >Six
8. None

8. If more than one, was it the same TBA

1. Yes
2. No

9. (If any) Why did you choose a TBA
(If none) Why would one choose a TBA

1. cheaper (affordability)
2. nearer (accessibility)
3. more knowledgeable
4. religion
5. Other (specify)

10. (If non) Given a choice, which would you prefer

1. TBA
2. Clinic nurse.

11. Explain your response

____

____

12. When you visit the TBA, what does she look for and why

1. Position of baby
2. Listens to foetal heart
3. *Nzira*
4. Medical record of mother
5. Other ________________________________

13. Explain in detail the process that you go through when you visit the TBA

____

____

14. What do you give your TBA in return for her services

1. Gifts (Specify what)
2. Money (Specify amount)

15. What traditional methods of family planning are you aware of

1. Abstinence

2.Prolonged breastfeeding
3.Withdrawal
4.Tying twisted cord around the waist (*kusungira*)
5.Other ______________________________

16. Which of these are still being practiced
____

17. Which are the modern methods of family planning that you know
1.The pill
2.Condom
3.Injectables
4.Diaphragm
5.Loop
6.Billing
7.Other

18. What method are you using and why
____
____

19.Are you aware of AIDS 1.Yes
2.No

20.Where do you get information on AIDS
1.Health personnel
2.Radio
3.Social gatherings
4.Books
5.Other ______________________________

21.What are the symptoms of AIDS
1.Loss of weight
2.Diarrhoea
3.Coughing
4.Lymph nodes
5.Thinning of hair
6.Headache
7.Other______________________________

22. Explain how AIDS is transmitted
1.Sexual intercourse
2.Contact with blood
3.Use of unsterilized instruments
4.Coughing
5.Other

23. How can AIDS be prevented
1. Condom use
2. Avoid multiple sexual partners
3. Avoid contact with blood
4. Other

24. Do you think AIDS is a big problem in your area
1. Yes
2. No

25. Do you think TBAs are capable of transmitting AIDS
1. Yes
2. No

26. Explain ______________________________

27. Are there any areas where you think the TBAs should improve
1. Yes
2. No

28. Explain ______________________________

29. What is your husband's attitude towards traditional midwifery
1. Supportive
2. Not supportive
3. Don't know

30. What is his preference
1. TBA
2. Clinic staff
3. Neutral
4. Don't know

31. Why that preference ______________________________
____

32. What do you see as the future of traditional midwifery
____
____

33. How far are you from the clinic ______km

34. Anything to say ______________________________
____

****Thank you very much for your time. ****

APPENDIX 3
QUESTIONNAIRE DATA

Respondents' Background Information

N=36

	Value Label	Frequency	Percentage
Age of respondent	15-24	12	33.3
	25-34	11	30.6
	35-44	10	27.8
	45-54	3	8.3
Marital Status	Married	30	83.3
	Single	2	5.6
	Divorced	3	8.3
	Widowed	1	2.8
Religion	Apost. Faith	6	16.7
	Catholic	4	27.8
	Anglican	8	22.2
	Methodist	7	19.4
	Other (non, traditional)	11	30.6
Source of Income	Peasantry	18	50.0
	Husband	9	25.0
	Other (projects, remittances)	9	25.0
Distance from clinic	<5km	22	61.1
	5-10km	10	27.8
	>10km	3	11.1
No.of children per respondent	<3	16	44.4
	3-6	14	38.9
	>6	6	16.7

KAPB of Respondents with Regards to Traditional Midwifery

Ever assisted by a TBA	Yes	29	80.6
	No	7	19.4
Number of children delivered by TBA	1	18	50.0
	2-3	7	19.4
	4-5	3	8.4
	>6	1	2.8
	None	7	19.4
Whether assisted by same TBA	Yes	9	25.0
	No	2	5.6
	Not Applicable	25	69.4
Whether TBA was trained or not	Yes	10	27.8
	No	15	41.7
	Don't know	2	5.6
	Not applicable	9	25.0
Reasons for choosing TBA	Cheaper	8	22.2
	Nearer	13	36.1
	Knowledgeable	2	5.6
	Religion	1	2.8
	Other(relative in-law pressure)	12	33.3
Preference when given a choice	TBA	8	22.2
	Clinic nurse	28	77.8
Examinations done by TBA	Pos. of baby	9	25.0
	Nzira	14	38.9
	Med. record	1	2.8
	Other (listen fetal heartbeat)	12	33.3
Gifts given to	Gifts (kind)	20	55.6
TBA	Cash	3	8.3
	Both	8	22.2
	Nothing	5	13.9

AIDS Related Information

Ever heard about AIDS	Yes	36	100.0
Source of info. on AIDS	Clinic	13	36.1
	Radio	20	55.6
	Social gatherings	3	8.3
Symptoms of AIDS	Weight loss	27	75.0
	-	9	Missing
	Diarrhoea	16	44.4
	-	20	Missing
	Coughing	13	36.1
	-	23	Missing
	Lymph nodes	7	19.4
	-	29	Missing
	Thinning hair	18	50.0
	-	18	Missing
Modes of HIV transmission	Intercourse	32	88.9
	Unsterilized equipment	2	5.6
	Other (coughing handshakes)	2	5.6
AIDS Prevention	Condom use	17	47.2
	Avoid multiple sex partners	13	36.1
	Avoid contact with blood	2	5.6
	Other (cover mouth when coughing)	4	11.1
Whether AIDS is a problem in area	Yes	32	88.9
	No	4	11.1

Perceptions on AIDS and Traditional Midwifery

Whether TBAs can transmit HIV	Yes	12	33.3
	No	21	58.3
	Don't know	3	8.3
Should TBAs improve	Yes	19	52.8
	No	17	47.2
Husband's attitude toward TBA practice	Supportive	18	50.0
	Not supportive	12	33.3
	Don't know	6	16.7
Husband's preference	TBA	6	16.7
	Clinic staff	22	61.1
	Neutral	8	22.2
Future of trad. midwifery	Bright	26	72.2
	Not bright	7	19.4
	Don't know	3	8.3

Information on Child-Spacing

Folk methods of child-spacing	Withdrawal	3	8.3
	Kusungira	17	47.2
	Other (abstain Pbreastfeeding)	16	44.5
Folk methods still being practiced	withdrawal	3	8.3
	kusungira	10	27.8
	other (prolonged breastfeeding abstinence)	23	63.9
Modern methods of child-spacing	Pill	34	97.1
		2	Missing
	Condom use	17	47.2
		19	Missing
	Injectables	23	63.9
		13	Missing
	Loop	1	2.8
		35	Missing

****

APPENDIX 4
BIOMEDICAL HIGH RISK FACTORS

Historical
Primipara >150cm
Para 5+
Previous long labor
Last baby peri-natal death
Previous post-partum haemorrhage
Previous retained placenta

Present pregnancy
Breech
Multiple pregnancy
Antepartum haemorrhage
Anaemia
Pre-eclampsia
Previous Caesar
Transverse lie
Chronic lung or heart disease

Delivery Outcome
Post-partum haemorrhage
Puerperal sepsis
Retained placenta
Major operative delivery (vacuum extractors, Caesar)
Breech
Twins
Still birth
Neonatal death
Maternal death
Minor Operative delivery (By Babona (1974) cited by Lennox (1984)
AND
Age < 19
Age >35
Primigravida
Rural residence
With <3 ante-natal visits
Pregnancy for 42 weeks (Source:Chi et al. 1986)

****