Indigenous beliefs and practices that influence the delayed attendance of antenatal clinics by women in the Bohlabelo district in Limpopo, South Africa

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A B S T R A C T

Objective: to explore and describe the indigenous beliefs and practices that influence the attendance of antenatal clinics by women in the Bohlabelo district in Limpopo, South Africa

Research design and methods: a qualitative design was used to enable participants to share their beliefs and practices in their own words. Purposive sampling was used.

Setting: women who were attending antenatal clinics for the first time were targeted. Data were collected via unstructured in-depth interviews. Twelve women were interviewed.

Findings: the findings were grouped into six main categories: pregnancy is a honour; pregnancy needs to be preserved; the unborn infant is protected; the knowledge that clients have; trust in indigenous perinatal practices; and perceptions regarding clinic or hospital services. It became clear that the indigenous beliefs and practices of pregnant women have an influence on their attendance of antenatal clinics. For example, factors such as fear of bewitchment cause delayed attendance of antenatal clinics. Women use herbs to preserve and protect their unborn infants from harm. They also trust the knowledge of traditional birth attendants, and prefer their care and expertise to the harsh treatment that they receive from midwives in hospitals and clinics who look down on their indigenous beliefs and practices.

Conclusions: it is recommended that indigenous beliefs and practices should be incorporated into the midwifery curriculum, so that the health sector is able to meet the needs of all members of the community.

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Introduction and background

An understanding of the indigenous beliefs and practices of clients regarding health issues is imperative in ensuring the quality of care and positive health outcomes for both the client and the service provider. This study aimed to explore the indigenous beliefs and practices of pregnant women that influence their delayed attendance of antenatal care institutions.

Maternity services, like other primary health-care services, are rendered free of charge in all primary health-care facilities in the Bohlabelo district in Limpopo, South Africa (Owen, 1995). Nonetheless, antenatal services are not fully utilised by pregnant clients, as confirmed by the district maternal health data, collected and analysed for more than 10 years. It is cause for concern that only 47% of women attend antenatal services during their second and third trimesters. There are 180 deaths per 100,000 live births in the district. The Saving Mothers Report (Department of Health, 2005–2007) indicates that only 63.2% of pregnant women in South Africa attend antenatal services. However, this report shows a significant improvement from a previous report (Department of Health, 1999–2001) which stated that only 47% of women attend antenatal clinics.

This phenomenon concurs with several studies conducted in other parts of Africa. For example, a study conducted in Zimbabwe by Tsu (1994) indicated that the majority of women reported to clinics during the third trimester of pregnancy, which resulted in negative birth outcomes. A similar enquiry by the national Department of Health also confirms this phenomenon (Department of Health, 1999–2001), and outlines similar causes of maternal deaths. As a result, the World Health Organization (1996) recommended four focused antenatal visits to enhance the quality of care, rather than the quantity of care, aimed at reducing maternal and child morbidity and mortality.

Papen (2008) argues that pregnancy represents a highly constructed social world that has been designed for women to adhere to. However, the cultural aspects of pregnancy are often neglected. Indigenous beliefs and practices take shape around the cultural traits that are passed from one generation to the next. These
practices are deeply rooted and embedded in these societies, and therefore they become part of the people's lifestyle. They are innate to such an extent that it is difficult to try to change these beliefs and practices, as people have adhered to them throughout their entire lives. Belief systems play a major role in the health-care-seeking behaviour of individuals (Shaikh and Hatcher, 2005). It is therefore important that these belief systems be incorporated into the strategies that are formulated to improve maternal care. The National Health Aboriginal Association of Canada emphasises that important that these belief systems be incorporated into the behaviour of individuals (Shaikh and Hatcher, 2005). It is therefore practices, as people have adhered to them throughout their entire practices are deeply rooted and embedded in these societies, and relevant knowledge of the social and ritual practices of the people that they serve (National Health Aboriginal Association, 2004).

In a study on cultural practices and social support for pregnant women in a northern New Mexico community, Williams (2001) found that the understanding of cultural beliefs and practices resulting from ethnicity facilitate adaptation and change by the community in support of pregnancy, thus contributing to increased motivation in attending antenatal services. Indigenous practices and beliefs influence and underpin the behaviour of women during pregnancy and childbirth. In addition, religion also has an impact on childbirth, thus leading women to believe that they have to follow and practice their religious rituals in order to preserve their pregnant state and give birth to healthy infants.

In ancient times, indigenous practices constituted the major source of survival in Africa, America, Asia and Australia. Together with many other traditional health practices, the care of pregnant women formed part of the centre of these practices. This, however, was affected by exploration and the invasion of traditional practices by modern civilisation. The impact of this colonisation was major and resulted in indigenous communities feeling condemned if they continued with their indigenous practices in public, because they were regarded as committing a sin. The above arguments are confirmed by Mulaudzi (2001), who affirms that despite condemnation of traditional health practices and the introduction and promotion of modern Western medicine, traditional medicine is not fading away in Africa. Instead, practitioners are eager to rediscover their sociocultural identity and regard traditional medicine as a treasure.

The report of the Department of health (1998) stated that 350,000 traditional healers were providing health-care services in South Africa, but their areas of speciality were not highlighted. Therefore, there is a need for the health system to learn more about the indigenous treatment modalities of indigenous communities, so that the system can create a platform for the integration of services between Western and indigenous health interventions. Such a move will facilitate collaboration between the health sector and traditional healers, particularly as traditional health practices have been legalised in South Africa. Traditional health practitioners and traditional birth attendants are allowed to practice legally under the Traditional Health Practitioners Act 22 of 2007 (Tshabalala-Msimang, 2008). It is therefore imperative that midwives understand the indigenous beliefs and practices that influence the attendance of antenatal clinics.

Mulaudzi (2003) indicated that, due to poverty and the inaccessibility of health facilities, 80% of Africans depend on traditional health practitioners for medical care. This phenomenon may be witnessed in the Bohlabelo district, in that pregnant women consult traditional health practitioners during their first trimester to strengthen their pregnancy and to obtain medicines that will protect them from danger when they meet sexually active people. The same trend is experienced in India where, despite governmental efforts to improve maternal health-care services, women do not use the antenatal services as envisaged (Guedelma, 1994).

In their study of cultural birth practices in Zambia, Mainmbolwa et al. (2003) concentrated on exploring the reasons why women choose to give birth at home. It was found that they had traditional birth attendants who attended childbirths at their own homes. However, their perceptions and beliefs have never been studied to put together a strategy for health providers to access indigenous communities and gain knowledge of their traditional practices and beliefs.

As is the case in many rural areas of Limpopo, Bohlabelo district is facing a challenge with antenatal clients who are not accessing antenatal services within the first 20 weeks of gestation. They progress normally and take care of their pregnancy themselves at home until the third trimester. They only go to a health facility to book a bed on which they will give birth when the time is due. This practice is in conflict with the practices of Western health professional midwives, who condemn them without knowledge of the beliefs and practices in their home environment. The purpose of this study was therefore to explore and describe indigenous beliefs and practices that influence the delayed attendance of antenatal clinics by women in the Bohlabelo district in Limpopo.

Research design and methods

A qualitative descriptive exploratory design was followed within the context of the Bohlabelo district in Limpopo. A qualitative approach is described as a systemic, interactive, subjective approach, used to describe life experiences and give meaning to them (Burns and Grove, 2005). A qualitative approach was chosen for this study, which enabled participants to share and express their feelings and experiences pertaining to their indigenous beliefs and practices with regard to antenatal care (Ritchie and Lewis, 2003).

Data collection method

Purposive sampling was used in this study, and the participants were selected in terms of their status of being pregnant and reporting for their first antenatal visit. Twelve participants were interviewed. The participants were from the health centre and clinics in the Bushbuckridge region. The researcher did not experience major problems in gaining entry to the setting and recruiting participants, as she had been working in the area. In-depth interviews were held with the participants. Face-to-face interaction was preferred to ensure the flexibility of the interview process and to enhance free interaction between the researcher and the participants (Ritchie and Lewis, 2003). An in-depth, unstructured interview method was used. The researcher posed the first question and asked the same follow-up questions to all participants. She then asked further follow-up questions based on the themes generated during the conversation (Ritchie and Lewis, 2003). The opening question was, ‘What are the indigenous beliefs and practices that you are expected to conform to from the time you realise that you are pregnant so to ensure a healthy infant?’

Techniques such as probing, clarifying, reflecting and paraphrasing were used during the interviews to encourage participants to express themselves freely and to enhance in-depth descriptions of the required phenomena. For example, phrases such as ‘Tell me more’, ‘Oh! I see’, ‘Oh!’, ‘Yes, and what else?’ were used to facilitate the flow of conversation (De Vos et al., 2002; Creswell, 2009). ‘Double-checking’ questions were also asked in order to confirm what participants really wanted to say and to clarify meaning. A tape recorder was used to record conversations. In addition, observations were made and field notes were taken by the researcher as the interview was in progress (Brink et al., 2006). To facilitate smooth flowing of the interview, the researcher practiced good communication skills by achieving a balance between talking and listening. The researcher also picked up verbal and non-verbal cues from participants’ demeanour and took
cognisance when participants were bored, tired, angry or embarrassed (Denzin and Lincoln, 2000).

Measures to ensure trustworthiness

The researcher complied with measures to ensure the trustworthiness of data, for example by ensuring credibility, transferability, conformability and dependability (Polit and Beck, 2008).

Credibility

Credibility was achieved by ensuring that the participants recruited were knowledgeable about the phenomenon. The researcher used purposive sampling to interview women who were coming to receive antenatal care for the first time, as their information would be based on accurate reasons for beliefs and practices that delayed them in attending antenatal clinics. A tape recorder was used to capture the data and information shared during the interview. The process helped to ensure that the data was recorded correctly and that no information was missed. The participants’ own words were used to ensure correct representation of their voices. Data triangulation was done by combining different methods of data collection, namely unstructured interviews and observation. Prolonged engagement was achieved by the researcher’s continuous commitment to data collection and analysis. Member checking was undertaken for the clarification and confirmation of data with the participants (De Vos et al., 2002).

Transferability

Transferability refers to the extent to which the findings can be applied to other settings (Polit and Beck, 2008). To ensure transferability, information on descriptions of the settings, inclusion and exclusion criteria were provided to allow the reader to visualise the context and type of settings in which the findings or the methods may be applicable.

Dependability

Dependability refers to the reliability of data over time and the conditions under which it was obtained (Polit and Beck, 2008). Different ethnic groups in different geographical areas were used to participate in the study. The use of an independent co-coder helped to ensure the consistency of findings.

Confirmability

Confirmability refers to a mechanism of ensuring that the data represent the information that the participants provided (Polit and Beck, 2008). In this case, confirmability was ensured by the checking of facts and by follow-up questions, which were used to check if the researcher understood exactly what the participant had said and what it meant. The researcher kept records of main decisions and events during the field work in the form of dates, venues and the mode of entry into the field. An independent co-coder was involved in data analysis to strengthen conformability (Lincoln and Guba, 1985).

Ethical considerations

The rights of participants were respected by obtaining their informed consent before starting the study. They were made aware of their right to decline to answer questions or to withdraw from the study if they wished, and no intimidation took place (Babbie and Mouton, 2004). The participants’ right to respect and human dignity was upheld, in that their privacy and confidentiality were totally protected by using a consultation room as a private place for interviews. The researcher complied with the participants’ right to justice by treating all participants equally and not making any false promises. Care was taken to ensure that the participants were protected from harm and discomfort (Burns and Grove, 2005).

Method of data analysis

Data analysis commenced simultaneously with the interviews, as reflective remarks (e.g. thoughts and insights) were documented in field notes. Insights and ideas related to transcripts of the notes or to the codes were used to assist the researcher in evaluating her ideas, and to bring about a clear understanding of the description and exploration of the phenomena. The data were also used to write a narrative analysis of the study under the sub-heading themes, as shown in Table 1 (Henning et al., 2004).

Findings

Five major categories were identified from which subcategories were developed. The themes that emerged from the subcategories were also presented. The main categories were: pregnancy is a honour; pregnancy needs to be preserved; the unborn infant is protected; the knowledge that clients have; trust in indigenous perinatal practices; and perceptions regarding clinic or hospital services. The findings were categorised and are shown in Table 1.

Pregnancy is a honour

The first category that emerged strongly is that falling pregnant is seen as a honour. Pregnancy is regarded as a sacred event that brings joy to the entire family. Table 1 shows the subcategories and themes as verbalised by the participants.

The news is kept confidential until the ancestors and relatives have been informed. The good news is also shared with the in-laws. This is evident from statements such as:

I reported my pregnancy to my mother-in-law. She advised me to go and tell my husband’s aunt. When I reported my pregnancy... she looked at the moon and she smiled.

Table 1

Pregnancy is a honour.

<table>
<thead>
<tr>
<th>Subcategories</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-laws</td>
<td>• Brings joy to the in-laws</td>
</tr>
<tr>
<td></td>
<td>‘I reported my pregnancy... she looked up at the moon and she smiled.’</td>
</tr>
<tr>
<td></td>
<td>‘I reported the pregnancy to my mother-in-law who advised me to report it to my husband’s aunt.’</td>
</tr>
<tr>
<td></td>
<td>‘She looked at the moon and she smiled.’</td>
</tr>
<tr>
<td></td>
<td>‘I felt that my in-laws were very supportive. They all volunteered to be part of the process.’</td>
</tr>
<tr>
<td></td>
<td>‘My aunt-in-law also advised me not to hesitate in coming to see her if I happened to have abdominal cramps.’</td>
</tr>
<tr>
<td>Own family</td>
<td>• Ancestors are informed about the pregnancy</td>
</tr>
<tr>
<td></td>
<td>‘A sacrificial animal (mhamba) is slaughtered to the ancestors to open the way to a safe motherhood.’</td>
</tr>
<tr>
<td></td>
<td>‘When I am about to deliver I will go home to my mother to deliver and to be cared for during the postnatal period.’</td>
</tr>
<tr>
<td>Pregnant woman</td>
<td>• Acceptance</td>
</tr>
<tr>
<td></td>
<td>‘I have seven children and have no husband of my own, but nonetheless I will take care of this child. Maybe it will be a girl; I only have one at the moment.’</td>
</tr>
</tbody>
</table>
Pregnancy brings joy to the family. In the African culture, children are regarded as equalling wealth, especially male children. Therefore, a woman falling pregnant constitutes an achievement. The woman considers herself as someone who has reached one of the milestones expected by the family and by society at large. The woman is awarded respect, power and status in the community. In other ethnic groups in South Africa, such as the Xhavenda, the woman’s name changes immediately after the birth of her first child and the mother is then referred to as the mother of her daughter or son. For example, if the name of the child is ‘Mpho’, she will be called ‘Mother of Mpho’. The same is practiced amongst the Shona in Zimbabwe. For example, Miti (1999) the author of the book, ‘The Prodigal Husband’, referred to the characters as the Mother of Isaka and the Father of Isaka. This practice poses a problem to women suffering from infertility problems or who are barren. However, the practice of keeping the news of a pregnancy confidential causes a delay in the first attendance of an antenatal clinic.

Another theme that strongly surfaced was the support that pregnant women receive from their in-laws. They stated that their in-laws got actively involved in caring for them and ensuring preservation of the pregnancy. They actually felt honoured by the news and regarded pregnancy as a significant, confidential family event. Amongst Africans, a woman’s ability to bear children is respected and regarded as an achievement by the man’s family. The following statement was made:

I felt that my in-laws were very supportive. They all volunteered to be part of the process. My aunt-in-law also advised me not to hesitate in coming to see her if I happened to have abdominal cramps.

The statement on support given by family members was also confirmed by Draper (2002), who stated that women value the support of family members. This is even more evident from the fact that in-laws usually accompany their daughter-in-law to hospital to give birth. The in-laws feel fulfilled when their daughter-in-law falls pregnant, because they feel that their son is fertile and is increasing the number of family members. Furthermore, the family feels that their lobola (price paid for the bride) has reaped rewards in that their family is growing. Lobola comes in the form of money or cows, which are paid by the bridegroom’s family to the bride’s family as a token of appreciation. It is a tradition amongst the majority of ethnic groups in South Africa, other parts of Africa and India. The practice is a symbol of cementing the union between the two families and an agreement that, from that moment onwards, the wife belongs to the groom’s family (Nwoke, 2009).

The participants stated that their husbands also felt proud of their pregnancy. A study by Draper (2002) found that men expressed their willingness to be involved in pregnancy care and childbirth, because it shaped their fatherhood and gained them respect in the family and in the community as a whole:

My husband was overjoyed. He could not keep the news to himself. He wanted to be involved in everything, including accompanying my sister-in-law who was delegated to go and inform my family, which was a task that fell outside his boundaries.

However, despite the joy that pregnancy brings to the family, it is considered taboo to share the news with friends and distant relatives. Pregnancy is kept secret from friends and outsiders. They only find out about the pregnancy when it becomes obvious. These findings are corroborated by Mathole et al. (2004), who indicated that women in Zimbabwe felt that pregnancy had to be kept secret during its early stages for fear of witchcraft. It is believed that the first three months of pregnancy are crucial and sensitive, as this constitutes the period when the fetus is being formed in the uterus. The pregnancy is protected from evil spirits who may be inflicted by jealous people and who would bewitch the pregnant mother to give birth to a malformed infant or to suffer a miscarriage.

The findings of a study conducted in Tanzania on the utilisation of maternal health services also indicated that the majority of women delayed their first visit to an antenatal clinic. The same findings were echoed in a study conducted in Nigeria where the median time for first antenatal clinic attendance was 23.7 weeks (Mpembeni et al., 2007).

Beliefs of witchcraft are a contributing factor to the delay in first attendance of an antenatal clinic (Mathole et al., 2004). Women are expected to attend an antenatal clinic in their eighth week of pregnancy. However, studies indicate that they only start visiting a clinic at 26–27 weeks of gestation. Chapman (2003) indicates that women in Mozambique maintain that delaying antenatal care protects the unborn fetus from human and spiritual harm.

### Pregnancy needs to be preserved (Table 2)

In this category, the findings indicated that pregnancy needed to be preserved physically and spiritually with herbs. It is believed that having contact with other women at the clinic may subject women to evil spirits who could harm the fetus. The pregnancy needs to be strengthened with herbs to prevent malformation of the fetus and a miscarriage, which could be inflicted by jealous people. It is therefore very important for women to start attending the antenatal clinic after three months of gestation. The participants stated that they relied on the elders in the family to guide them in the types of preservation methods to be used and, where necessary, they consulted traditional birth attendants who ordered treatments for them. This is corroborated by the following statements:

Ritlangi [some type of runner grass] was cooked and tied around my waist to strengthen my pregnancy.

The ancestors were informed about my pregnancy in the form of rituals.

Mfundulo is the name of the herb that I was given to drink daily to strengthen the pregnancy.

### Table 2

<table>
<thead>
<tr>
<th>Subcategories</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical preservation</td>
<td>• Herbs are given to preserve the pregnancy.</td>
</tr>
<tr>
<td></td>
<td>‘Ritlangi [a type of runner grass] was cooked and I had to drink the water from the concoction.’</td>
</tr>
<tr>
<td></td>
<td>‘The boiled grass is tied around the waist to strengthen my pregnancy.’</td>
</tr>
<tr>
<td></td>
<td>‘My aunt-in-law gave me a herbal drink to take for abdominal discomfort.’</td>
</tr>
<tr>
<td></td>
<td>‘The thread around my waist is to protect my pregnancy from aborting or premature birth (Hiketa).’</td>
</tr>
<tr>
<td></td>
<td>‘This grass tied around my abdomen will help me to observe if the pregnancy is growing.’</td>
</tr>
<tr>
<td>Spiritual preservation</td>
<td>• Divine protection is sought.</td>
</tr>
<tr>
<td></td>
<td>‘The ancestors must know about my pregnancy.’</td>
</tr>
<tr>
<td>Herbal protection</td>
<td>• The use of herbal medicine.</td>
</tr>
<tr>
<td></td>
<td>‘Mfundulo is the name of the herb I was given to strengthen the pregnancy.’</td>
</tr>
<tr>
<td></td>
<td>‘In preparation for labour, Mbheshwana [name of a herb] will be boiled to enhance labour and prevent fetal distress.’</td>
</tr>
</tbody>
</table>
The above findings are supported by Kearney et al. (2003), who stated that, based on the fact that pregnancy is seen as a pivotal period, pregnant women commit themselves to informing their ancestors, who will offer them protection. They also consult traditional birth attendants who will assist them in identifying their health needs. This is consistent with the findings of a study conducted in Zambia by Maimbolwa et al. (2003), that traditional birth attendants advise pregnant women to use traditional medicines as a way of preserving pregnancy.

The unborn infant is protected (Table 3)

All participants emphasised that it was important to protect the unborn child from all harmful influences. For example, a woman is discouraged to continue having sexual relations with her husband, as it is believed that the sperm may contaminate the fetus. The mothers are also advised not to eat the wrong types of food or take any medicines that are not recommended by traditional birth attendants, so as to avoid coming to any harm:

- **Sex is prohibited during pregnancy.**

  My mother-in-law makes me sleep with her in her bedroom to ensure that I abstain from sexual intercourse, thus protecting the baby from harm. My husband can only come back to me once the baby has been born.

- **I have been advised to drink boiled herbs (Mbita) for the preservation and protection of my unborn baby, so that I may have a safe pregnancy and labour.**

The generic term for Mbita is clay pot and the botanical name is *Sclerocarya caffra*.

These statements illustrate how women are committed to protecting their unborn infants in collaboration with their in-laws. However, modern midwives tend to teach women conflicting ideas based on biomedical aspects and knowledge, as they do not understand indigenous practices and the needs of women. In modern medicine, sexual intercourse is not prohibited during the first and second trimester (Williams, 2002). It is necessary for midwives to learn specific skills from traditional birth attendants and elderly women, rather than viewing modern medicine as superior to indigenous knowledge. A lack of understanding of cultural beliefs and practices results in a lack of support from the health system, thus contributing to delayed attendance of antenatal clinics.

Pregnant women view the herbs that are administered to them during pregnancy as healthy, nutritious and providing a safe environment for the fetus in the uterus (Davies-Floyd, 2000).

Knowledge of traditional birth attendants (Table 4)

Table 4

<table>
<thead>
<tr>
<th>Themes</th>
<th>Subcategories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex is prohibited during pregnancy.</td>
<td>From contamination by the father</td>
</tr>
<tr>
<td>‘My husband can only come back to me when the baby is born.’</td>
<td></td>
</tr>
<tr>
<td>‘My mother-in-law makes me sleep with her in her room to ensure that we abstain from sexual intercourse.’</td>
<td></td>
</tr>
<tr>
<td>Prevent complications during pregnancy.</td>
<td>From mother’s behaviour</td>
</tr>
<tr>
<td>‘I am advised not to drink water while standing because I will have too much water during labour.’</td>
<td></td>
</tr>
<tr>
<td>‘I have to drink Mbita [boiled herbs] so that I have a safe pregnancy and labour.’</td>
<td></td>
</tr>
<tr>
<td>Women can choose between home and clinic delivery.</td>
<td>From faulty obstetric practices</td>
</tr>
<tr>
<td>‘I want to deliver in hospital.’</td>
<td></td>
</tr>
<tr>
<td>‘I want the hospital because my cousin was assisted by an operation when the baby was lying transversely.’</td>
<td></td>
</tr>
<tr>
<td>Restrictions in hospital delivery.</td>
<td></td>
</tr>
<tr>
<td>‘The kneeling position is not allowed in hospital but at home I can use it.’</td>
<td></td>
</tr>
<tr>
<td>‘Hospital care is good but the nurses want us to breathe like a dog, which is almost impossible during strong labour.’</td>
<td></td>
</tr>
</tbody>
</table>

The majority of participants stated that they relied on traditional birth attendants for management and care during their pregnancy, based on the attendants’ expert knowledge and skills in pregnancy care. However, some cited a lack of accessibility to health centres and clinics as a rationale for seeking assistance from traditional birth attendants. They indicated that a lack of money for transport to visit primary health-care facilities is often a deterrent in making use of these facilities, as these are situated far from their villages. Although primary health care is free, women still have to pay for transport to visit these health centres and clinics in some areas.

Both groups of women agreed that traditional birth attendants were knowledgeable in what they did. The knowledge is based on an apprenticeship, as the skills are learned through years of practice and by shadowing their elders. Participants maintained that although some of the traditional birth attendants could not read or write, they had a sound knowledge of methods of determining the gestational age and growth of the fetus, prevention of obstruction of labour, prevention of abortion or miscarriage, management of labour after a pregnancy had threatened to abort, and prevention of illness during pregnancy:

- It is amazing. They help us to calculate the gestational age of the fetus. If you cannot read, you are advised to use traditional methods for calculation, such as the position of the moon and engraving marks on a tree.

- Nurses keep on asking you questions about the dates, which is sometimes confusing. I found these methods easy.

- With my previous pregnancy I was told to put stones in a calabash every time when the moon sets. I couldn’t tell when I would have the baby, but I knew that in the ninth month when the moon sets, I have to prepare myself for delivery.

- They gave me Ritlangi [a type of runner grass] to tie around my waist. It helped me to know whether the baby was growing well or not.

The participants said that the traditional birth attendants gave them advice and taught them how to deal with issues such as calculating the gestational age; for example, by keeping track of the gestation by carving a mark on a tree near home. At the end of each month, they carved marks on the same tree in order to help them estimate their due date. For growth of the infant in the uterus, they wore a woven thread of grass around their waist. If the woven grass remained loose around the abdomen, they consulted a traditional healer who would consult the ancestors by using bones to find the cause of intra-uterine growth retardation.

This shows that Ritlangi is used like a tape measure to estimate fetal growth. The beauty of nature, such as the time that the moon sets each month, is used to estimate the infant’s due date. A study conducted in Zambia by Maimbolwa et al. (2003), that traditional birth attendants advise pregnant women to use traditional medicines as a way of preserving pregnancy...
Knowledge of traditional birth attendants.

<table>
<thead>
<tr>
<th>Subcategories</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gestational period</td>
<td>‘I cannot tell when I will have the baby, but in the ninth month when the moon sets.’ ‘The Ritlangi grass around my waist will help me to calculate how far my pregnancy is.’</td>
</tr>
<tr>
<td>Prevention of obstruction of labour</td>
<td>‘When it is time to give birth, I will untie the knots in the grass belt around my waist and scatter the leaves of herbs all over my yard so as to have an easy and fast delivery.’ ‘Xirheti or Xiveve [name of the herb] is boiled to drink to accelerate labour.’</td>
</tr>
<tr>
<td>Prevention of abortion</td>
<td>‘After I was sure that I was pregnant, a grass thread (Ritlangi) was made to prevent abortion.’ ‘The same grass is boiled to ensure a safe pregnancy.’ ‘A herbal medicine, Mpundulo, was given by a midwife for me to drink to prevent abortion.’</td>
</tr>
<tr>
<td>Management of labour after pregnancy threatened to abort</td>
<td>‘When the pregnancy threatens to abort, roots are tied into small sheaths and boiled. The water is given to the woman to drink.’ ‘Roots of Nenbeneneme [name of a tree] are put into a tin, which is buried upside down to prevent abortion’ ‘At term, the tin is dug out and normal labour can proceed.’</td>
</tr>
<tr>
<td>Prevention of illness during pregnancy</td>
<td>‘The little knots tied along the ring of grass are a herb, Ndzenga [name of a tree] to help me not to be sick during pregnancy.’</td>
</tr>
<tr>
<td>Management of after pains</td>
<td>‘If the woman has continuous abdominal pains after birth, Matlula roots are boiled and given to her to drink.’</td>
</tr>
<tr>
<td>Prevention of childbirth before arrival at hospital</td>
<td>‘When I delivered my first child, my mother-in-law made me carry a stone so that I did not deliver on the way to hospital.’</td>
</tr>
<tr>
<td>Induction of labour</td>
<td>‘When the time comes I will drink Mhheswana to start fast labour and prevent fetal distress.’</td>
</tr>
<tr>
<td>Management of pain during labour</td>
<td>‘Roots of Xirhakarhani are boiled and the water is drunk to relieve excessive labour pains.’ ‘Xirhommeboho leaves are mixed with Dinda to accelerate labour and prevent severe pain.’</td>
</tr>
<tr>
<td>Management of prolonged labour</td>
<td>‘In case my labour takes long, Dinda will be boiled for me to drink to enhance fast labour.’</td>
</tr>
<tr>
<td>Management of abnormal fetal position in uterus</td>
<td>‘If the fetus presents with a hand, I flex the hand back into the uterus so that the head should come first. ‘I do (ku hlambela) internal versions when the fetus is lying normally.’</td>
</tr>
<tr>
<td>Assessment of fetal well-being</td>
<td>‘When the fetus moves, then I know it is well.’ ‘The grass thread around my waist will become tighter and tighter and this shows that the fetus is well and growing.’</td>
</tr>
<tr>
<td>Management of retained placenta</td>
<td>‘If the placenta is retained, Dinda is boiled and drunk to induce contractions.’ ‘If placenta birth is delayed, Rihlanga [two slender river canes] are used to pull it out manually.’</td>
</tr>
<tr>
<td>Management of infant born with membranes</td>
<td>‘When the baby is born with membranes, the traditional midwife puts castor oil (nhlapfhhurha) on the heels of the baby and gently removes the membranes.’</td>
</tr>
<tr>
<td>Care of premature infant</td>
<td>‘If the baby is born before time, it is anointed with castor oil (nhlapfhhurha) every day and wrapped with leaves (castor leaves) and put into a clay pot. A fire is kept burning to warm the room.’ ‘When the baby is premature, it is breast fed regularly until it grows to a normal-size baby.’ ‘The preterm baby is touched only by its mother.’</td>
</tr>
<tr>
<td>Management of prolonged labour</td>
<td>‘Performance of traditional episiotomy.’ ‘If the perineum is too rigid, a bottle is broken to cut the tight muscle of the perineum and afterwards the woman must sit with her legs tightly together, after bathing with salt and water, until the wound is healed.’</td>
</tr>
</tbody>
</table>

Conducted in India by Choudhry (1997) indicated that traditional birth attendants are considered knowledgeable and skilful in maternal care. They provide comprehensive input towards the management of pregnancy and birth. They monitor women during pregnancy and, where necessary, they refer and accompany pregnant woman to a hospital and give them support during childbirth. The practice of supporting women during childbirth is now practiced world-wide and has been termed the ‘Doula system’. ‘Doula’ is the Greek word for woman servant. Today it has come to mean a woman who specialises in helping families through the childbearing year (Hofmeyr et al., 1991).

Participants also regarded traditional birth attendants as competent practitioners, as they were able to prevent complications such as obstructed labour.
women know that labour pains can be reduced by massaging the back and by panting. In a severe situation, hot compresses around the abdomen and massaging of the body with Nhlampfurha (castor oil) are used. In addition, Xirhakarhani (an indigenous analgesic) is boiled and given to the labouring woman to drink.

Knowledge of how to prevent abortion or premature labour is seen in the following statement:

When the pregnancy threatens to abort, roots are tied into a small sheath and boiled. The water is given to the woman to drink. It is stored in a tin which is buried upside down to prevent abortion. When the pregnancy reaches term, the tin is dug out and normal labour can proceed.

When I delivered my first child, my mother in-law made me carry a stone so that I did not deliver on the way to hospital.

Indigenous healers have expertise in rendering holistic preventive, primitive, curative and rehabilitative health care and are respected by all. It is therefore evident that even if pregnant women can go to a clinic for antenatal care, they start by visiting traditional birth attendants, even before eight weeks of pregnancy, to ensure a healthy pregnancy before they start with modern antenatal care services (Mulaudzi, 2003).

Perceptions regarding clinic or hospital services (Table 5)

The participants indicated that they were sometimes reluctant to visit clinics due to the attitude of the nurses:

Hospital care is good, but nurses shout and scold us and we are afraid to suggest what is comfortable for us.

These findings are consistent with a study conducted by Davis-Floyd (2000) among women in developing countries, in which participants stated that they could not go to hospital for care because they were afraid of hospital nurses who yelled at them and scolded them. Another study also indicated that women view nursing care in midwifery settings as substandard compared with childbirth at home under the supervision of traditional birth attendants. The participants cited that nurses prefer to assist women with money. They also indicated that they are not allowed to bring their spouses or relatives along for support.

Pretorius and Greeff (2004) confirmed that unbooked antenatal clients from indigenous communities were afraid of being scolded by the nurses and resorted to consulting traditional birth attendants for care, even if their condition warranted modern medical intervention. On the basis of the findings of this study, it is clear that women are afraid of being scolded and shouted at for late bookings. The number of complications that resulted in perinatal mortality increased due to a lack of understanding of women's belief systems and their rationale for delayed attendance of antenatal care facilities. However, knowledge of the beliefs and practices of indigenous health-care methods may assist midwives with proper planning of their antenatal care methods.

Some of the participants indicated that they preferred to give birth at home where their views were respected. The also stated that the home environment was more comfortable than the hospital, as they received care and support from family members. They furthermore stated that, in hospitals, there were routines that were not consistent with their views. The routines followed were sometimes too restrictive. Participants stated:

The nurses make us breathe like a dog when giving birth and this is impossible when you are in pain.

The kneeling position is not allowed in hospital and nurses give you instructions and won’t listen to you.

If you air your views or your opinion, they laugh at you and ridicule you.

They make you feel small and useless.

You are often tied to the bed in such a way that you can’t even move.

The nurses give you instructions and will not listen to you.

In her study of perceptions and the constraints of pregnancy related to referrals in rural India, Gupta and Gupta (2000) found that unsympathetic midwifery and nursing staff and the negative experiences that pregnant clients suffered in health facilities, such as long waiting times without attendance and a lack of psychological support, caused the family to take pregnant women back home, so that traditional birth attendants could assist them in a comfortable home environment where they would not be refused water and food during labour. An understanding of cultural beliefs and practices by health workers motivates clients to attend primary health-care facilities for antenatal care, as clients feel secure in the care of service providers who understand and accept them the way they are, taking into consideration their cultural heritage as a whole. Participants indicated that their rationale for going to clinics and hospitals is often motivated by fear of complications and maternal death, and complications that could cause them to lose their infants:

I came to the clinic to put my name on their books, in case I have a difficult delivery.

My sister was saved by the hospital as the baby was delivered by an operation.

I have seven children. I can deliver at home but I am afraid as I have been told that I may die due to bleeding.

Davis-Floyd (2000) stated that, in Egypt, the high rates of maternal mortality are associated with hospital births caused by complications after a caesarean section, and that women who give birth at home under the care of traditional birth attendants enjoy the best care and have fewer complications.

Table 5

Perceptions regarding clinic or hospital services.

<table>
<thead>
<tr>
<th>Subcategories</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitudes of nurses</td>
<td>‘Hospital care is good but the nurses shout and scold us and we are afraid to suggest what is comfortable for us.’ ‘The nurses make us breathe like a dog when giving birth and this is impossible when you are in pain.’</td>
</tr>
<tr>
<td>Restricted choices</td>
<td>‘The kneeling position is not allowed in the hospital.’ ‘The nurses give you their instructions and will not listen to you.’</td>
</tr>
<tr>
<td>Motivation to use hospital or clinic services</td>
<td>● Clinic and hospital childbirth is motivated by fear of complications. ‘I came to the clinic to put my name on their books in case I have a difficult delivery.’ ‘My sister was saved by the hospital—she was delivered by operation.’ ‘I have seven children and I am afraid to deliver this one at home.’</td>
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trust their birth attendants because they know them, as they are from the same community and some are even related. Kildea (2006) confirmed the fact that indigenous communities trust their traditional birth attendants, because when she was born, her mother could not produce sufficient milk until her father took her mother to a traditional healer in Zimbabwe, where herbal tea was boiled for her mother to drink and she then produced more than enough milk to even share with another mother who did not have sufficient milk.

A study conducted by Choudhry (1997) found that the outcome of giving birth by Indian women was not satisfactory when conducted by Western midwives, because they did not trust them. Western people did not respect Indian cultural beliefs.

### Conclusion

The findings indicate that pregnancy is regarded as an honour by the family. However, it is also a sacred event that must be kept secret for fear of bewitchment, the rationale being that evil spirits may be inflicted on the pregnant woman, thus causing malformation of the fetus. It is within this belief system that women prefer to stay at home during the first trimester of pregnancy. The in-laws feel fulfilled when their daughter-in-law falls pregnant, because they see that their son is fertile and is increasing the number of family members. The family members also feel that their lobola was not paid in vain as they have reaped rewards and their family is growing. The findings also indicate that men feel joy and pride when their wives are pregnant, as it establishes their fatherhood and gains them respect in the family and the community as a whole.

The fact that indigenous communities honour a woman’s pregnancy period is a call for the health sector to learn what pregnancy means to the community, and what the community expects from the health sector during antenatal care visits.

Herbs are used to preserve and protect the infant from harm. This study found that unborn infants are protected by restricting the mother’s intake of other foods, by the mother abstaining from sexual intercourse and by her avoiding walking across roads. The modern midwifery profession also supports this phenomenon by restricting consumption of alcohol and smoking. The indigenous communities do not allow pregnant women to eat eggs, in order to prevent complications during pregnancy. Meanwhile, modern medicine emphasises preservation of pregnancy by eating a well-balanced diet. Emphasis is given to a diet high in protein, vegetables and fruits, while avoiding tobacco and alcohol, and wearing loose outfits to enhance comfort.

At least four antenatal visits are recommended by the World Health Organization to preserve pregnancy. The perinatal education programme also continues to equip midwives for the management of pregnancy and labour, in order to ensure the safety of both mother and child. It is therefore a matter of urgency for the Department of Health to include traditional birth attendants in antenatal care training so that safe motherhood is ensured.

Like the Korean mother-in-law who takes control of care of the newborn baby (Schneiderman, 1996), the Bohlabela mother-in-law removes the pregnant daughter-in-law from her husband’s bedroom to protect the infant from being contaminated by the father (i.e. making them abstain from sexual intercourse). In the same way, modern medicine encourages pregnant couples to use condoms during sexual intercourse to prevent sexually transmitted infections. Dialogue is also needed in this regard between health professionals and traditional birth attendants to make them aware of each other’s measures of protecting the unborn infant.

The participants showed trust in the methods used by traditional birth attendants. They admired their skills and knowledge, as well as their compassion and commitment in rendering care. Clients trust their birth attendants because they know them, they are from the same community and some are related. The strengthened relationship of trust can also be seen in the system of using a doula as a supportive mechanism in childbirth.

Women feel comfortable in the presence of familiar faces of people they trust, rather than in an unfamiliar environment. The belief that traditional birth attendants are knowledgeable and have expertise in rendering care encourages women to have faith and to put their trust in what their carers advise them to do during pregnancy. It is therefore evident that positive belief systems, trust and good interpersonal relations can facilitate positive birth outcomes in the community. These findings call for modern midwives to build a relationship of trust with the community in order to enhance satisfactory birth outcomes.

The negative attitude of midwives was cited as one of the factors that influenced delayed and non-attendance of antenatal clinics. It became clear that the participants felt comfortable with traditional birth attendants, based on the respect that these attendants show, which, in turn, is based on them being knowledgeable, committed, compassionate and caring.

### Recommendations

These findings call for dialogue between the community and the health sector. The similarities and differences between the two must be identified for them to reach consensus on issues pertaining to improved antenatal attendance. This will create a feeling of empowerment and awareness in the community, which will assist members of the community to utilise their resources and antenatal care services optimally.

There is a need for modern midwives to devise strategies to build a relationship of trust with the community in order to enhance satisfactory outcomes. The Department of Health needs to strengthen community involvement and active participation in issues pertaining to antenatal care. There is a need for capacity building amongst both health-care practitioners on the one hand, and traditional birth attendants and community members on the other hand, to equip both sides with the skills required to enable them to appreciate the similarities and differences in their respective practices, which will facilitate co-operation between them. The efforts will assist them to review their antenatal management skills to prevent maternal mortality and morbidity.

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**Table 6**

<table>
<thead>
<tr>
<th>Confidence shown by a pregnant woman</th>
<th>Confidence shown by a traditional midwife</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘I do not know the name of the medicine she gave me. I know she will not poison me.’</td>
<td>‘I assist many women with abnormal pregnancies and I deliver them without problems.’</td>
</tr>
<tr>
<td>‘I do not know the name of the medicine she gave me. I know she was trying to help and that she would not poison me.’</td>
<td>‘It is good that you nurses want to know about the treasures of traditional herbs because Europeans are twisting you.’</td>
</tr>
</tbody>
</table>

**Trust in indigenous perinatal practices (Table 6)**

Good interpersonal relations can facilitate a positive outcome in giving birth in the community. A client shows confidence and trust in traditional birth attendants in the following statement:

I trust the traditional birth attendants. I was not born in a hospital myself, but there is nothing wrong with me. I don’t know the name of the herbs that she gave me. I know she was trying to help and that she would not poison me.

Clients trust their birth attendants because they know them, as they are from the same community and some are even related. Kildea (2006) confirmed the fact that indigenous communities trust their traditional birth attendants, because when she was born, her mother could not produce sufficient milk until her father took her mother to a traditional healer in Zimbabwe, where herbal tea was boiled for her mother to drink and she then produced more than enough milk to even share with another mother who did not have sufficient milk.

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South African midwives should assume the role of a change agent in such a way that they become the first to embrace and understand indigenous treatment modalities in order to facilitate positive acceptance of these practices by the health sector as a whole. The importance of prompt referral to the next level of care must be emphasised with regard to both sectors.

The efforts by the South African Government’s national health sector to legalise traditional health practices call for more attention to be paid to skills development. The Department of Health should devise a strategy for orientating modern health providers to indigenous practices in order to strengthen cohesion. The midwifery and nursing profession in South Africa. Managers should avail a budget for skills development. The Department of Health should devise a strategy for orientating modern health providers to indigenous practices in order to strengthen cohesion. The midwifery and nursing profession in South Africa. Managers should avail a budget for skills development. The Department of Health should devise a strategy for orientating modern health providers to indigenous practices in order to strengthen cohesion. The midwifery and nursing profession in South Africa. Managers should avail a budget for skills development. The Department of Health should devise a strategy for orientating modern health providers to indigenous practices in order to strengthen cohesion. The midwifery and nursing profession in South Africa. Managers should avail a budget for skills development. The Department of Health should devise a strategy for orientating modern health providers to indigenous practices in order to strengthen cohesion.


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