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USE OF TRADITIONAL AND COMPLEMENTARY HEALTH PRACTICES IN PRENATAL, DELIVERY AND POSTNATAL CARE IN THE CONTEXT OF HIV TRANSMISSION FROM MOTHER TO CHILD (PMTCT) IN THE EASTERN CAPE, SOUTH AFRICA

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Abstract

The aim of this study was as part of a baseline assessment in PMTCT in the traditional health sector: a) to determine the views of women who have used the services of traditional practitioners before, during and/or after pregnancy, and b) to conduct formative research with traditional health practitioners (THPs), i.e. herbalists, diviners and traditional birth attendants (TBAs) on HIV, pregnancy care, delivery and infant care. The sample included a) 181 postnatal care clients with a child less than 12 months interviewed at postnatal clinic visits from 20 primary care clinics in the Kouga Local Service Area (LSA), Cacadu district, Eastern Cape, and b) 54 traditional birth attendants (TBAs) and 47 herbalists and/or diviners were interviewed from Kouga LSA. Results showed that THP (in particular TBAs and to a certain extent herbalists/diviners) play a significant role in pregnancy and postnatal care, and also with the assistance of delivery. Certain HIV risk practices were reported on the practice of TBAs. THPs also seem to have some role in infant feeding and family planning. THPs should be trained in optimising their services in pregnancy and postnatal care, and preparation for health facility delivery. In addition, they should be trained on HIV risk practices, HIV/AIDS, HIV prevention including PMTCT, infant feeding and family planning.

Key words: Traditional medicine, traditional practices, complementary medicine, prenatal care, postnatal care, delivery, infant care, HIV, PMTCT, Eastern Cape, South Africa

Introduction

Abrahams *et al.* (2002) studied indigenous healing practices and self-medication among pregnant women in Cape Town, and found that the majority of Xhosa speaking women follow indigenous health practices for both themselves and their babies because of the need to “strengthen” the womb against witchcraft or sorcery, to prevent childhood illnesses, and to treat symptoms they perceive that biomedical services would not be able to treat. Self-medication with non-prescribed drugs, herbs and Dutch remedies was common among Afrikaans speaking women. Herbs and Dutch remedies were mainly used to treat indigenous illness (*baarwind*) while over-the-counter drugs were used to treat minor ailments associated with pregnancy. In pregnancy, herbs or minerals are often used as a tonic to clean the womb, to ease delivery, to induce labour, and to protect the child from evil and have a healthy child (Henda and Peltzer, 2005; Van der Kooi and Theobald, 2006; Varga and Veale, 1997).

According to Nolte (1998) Traditional Birth Attendants (TBAs) can be characterized in South Africa as a middle aged or elderly lady with no formal training, who acquired her skills through experience and attends to women during pregnancy, labour and the postnatal period in different ways. This may include advice or instructions

as to what to eat, what not to eat, the giving of herbal remedies for pain, sickness or discomfort; abdominal massages, offering comfort to mothers, giving them a sense of security. They also assist with the delivery of the baby and advise and assist the new mother on how to care for the baby after it is born (Department of Health, 2004). A number of authors have indicated the importance of traditional birth attendants in the delivery of health care to the mother and child in South Africa (Nolte, 1998; Jepson and MacDonald, 1988; Selepe and Thomas, 2000; Troskie, 1997). Little is known about the role of traditional healers (herbalists or diviners) in obstetric care. Oyebola (1980) interviewed a group of 106 Yoruba traditional healers who practice midwifery and found that these herbalists are indispensable to delivery services in Nigeria.

Bulterys *et al.* (2002) noted that traditional (or "trained") birth attendants could play a critical role by reaching pregnant women not currently receiving formal antenatal care and by assisting with delivery of primary services designed to prevent HIV transmission. Trained birth attendants could oversee the provision of nevirapine to women infected with HIV who give birth at home and to their newborn infants. Traditional birth attendants could also counsel women and their partners on how to reduce the risk of HIV being transmitted to the child, focusing particularly on the postpartum period. A different view is held by Berge (2003) arguing that the TBAs cannot be expected to carry out HIV/AIDS prevention and treatment activities (to administer HIV tests or deliver antiretroviral drugs to women giving birth at home) because of their lack of resources and skills. In developed countries one can argue this but in developing countries this argument is questionable. WHO (2004) notes that TBAs have the potential for improving maternal and newborn health at community level. The role of TBAs in caring for pregnant women and conducting deliveries is acknowledged, but generally TBAs are not trained to deal with complications.

The aim of this study was as part of a baseline assessment in PMTCT in the traditional health sector: a) to determine the views of women who have used the services of traditional practitioners before, during and/or after pregnancy, and b) to conduct formative research with traditional health practitioners (THPs) *i.e.* herbalists, diviners and traditional birth attendants (TBAs) on HIV, pregnancy care, delivery and infant care.

Method

Sample and procedure (postnatal clients)

The sample included 181 postnatal care clients with a child less than 12 months old chosen from consecutive postnatal clinic visits at convenience from 20 primary care clinics in the Kouga Local Service Area (LSA), Cacadu district, Eastern Cape. Half (50.7%) of the participants were between 18-25 years old, 39.9% 26-35 years and 9.4% 36 years and older; 27.5% had less than Grade 8 education, 60.1% between Grade 8-11, and 12.3% Grade 12 education. The racial background was 69.6% Xhosa, 29.0% Coloured, and 1.4% other. Most (76.3%) indicated that they were single and 23.7% married or co-habiting; 52.2% were living in their parent's house, 42% in their own house and 5.8% in the house of the in-laws. Most (74.6%) indicated that they were unemployed, 23.2% employed and 2.2% self-employed at the time of the survey interview. Nine in ten women indicated that their family income was less than R3000 per month, 1% R3000 and more and 9%, no income.

Mothers with an infant from 0-6 months were 37.8% and from 7-12 months were 62.2%.

Postnatal clients were interviewed with a semi-structured questionnaire by a trained external researcher after informed consent was obtained and the client was exiting the primary care facility. All clients approached agreed to participate in the study.

A semi-structured questionnaire for THP clients included biographic and health care information, information on the last delivery, contacts/relationship with TBAs, THP, HIV and AIDS, antenatal care, obstetric care, post-partum care, and counselling on safe infant feeding for HIV exposed newborn babies.

Sample and procedure (traditional health practitioners)

The sample included 54 TBAs from Kouga LSA, 27 from Kouga municipality, 12 from Koukamma and 15 from Sundays river municipalities. Except for one, all TBAs were older than 45 years; two in three (68.5%) were Coloured and 31.5% Xhosa by racial or ethnic background; 49% had either no formal education or up to Grade 4 education. 24.5% had Grade 6-7, and 26% had more than Grade 7 formal education. The 54 TBAs interviewed fall into the categories of (1) traditional birth attendants only (85%) and (2) TBA and herbalist or diviner (15%). Two of the TBAs were registered with the Traditional Health Practitioners Council, while 52 were not. Most TBAs received their training as a TBA from their mother ($n=26$), followed by grandmother ($n=16$), other relative ($n=10$) and self-trained ($n=2$). In addition, 47 herbalists and/or diviners were interviewed from Kouga LSA, 17 from Kouga municipality, 12 from Koukamma and 18 from Sundays river municipalities, using a similar procedure as above; 46

were Xhosa and 1 Coloured, 17 Male and 30 female, 25 (53.2%) were registered with the traditional healer's council; 70% saw less than 10 patients a month.

TBAs and herbalists and/or diviners were recruited from existing lists of the traditional health practitioner coordinating office in Cacadu District, through key informants in 20 primary care clinics in Kouga LSA and community members. They interviewed with a structured questionnaire after informed consent had been obtained by a trained researcher at their homes or surgeries. The interview schedule and questionnaire were translated and administered in IsiXhosa and Afrikaans by two trained HSRC researchers.

A semi-structured questionnaire was used for herbalists/diviners and it covered sections on biographic information, practice characteristics, HIV attitudes, risk perceptions and practices, referral, family planning, pregnancy and infant care.

The HSRC research ethics committee and the Eastern Cape Department of Health approved the study protocol.

Results

Results are divided into findings from interviews with (1) postnatal clients and (2) traditional health practitioners.

Postnatal clients

Eighty-three (45.9%) of the clients reported that they had never consulted a traditional health practitioner (THP); 36% had consulted a THP (including a traditional birth attendant=TBA) with their last pregnancy (more than half of them 51.9%) more than once. The traditional birth attendance was only 5% in this sample, while 34% utilized THPs or TBAs for postnatal care. The place of consultation with the THP or TBA was mainly at the surgery or home or the THP or TBA (Table 1).

Table 1: Contact with TBA/THP with last child

	N	%	Number of contacts with TBA	N (%)	Place of contact	N
Contact with TBA/THP during pregnancy	65	35.9	1 2 ≥3	21 (32.3) 20 (30.8) 24 (21.1)	Client's house TBA's house	2 74
Contact with TBA during delivery	9	5.0	1 2 3	8 (72.5) 2 (15.0) 1 (12.5)	Client's house TBA's house	3 6
Contact with TBA/THP post delivery	61	33.7	1 2 ≥3	32 (54.9) 13 (23.6) 10 (18.2)	Client's house TBA's house	7 49

The most frequent reason for consultation with a THP/TBA during pregnancy was (1) check baby's position, followed by (2) rubbing stomach (for wind), (3) checking the baby, (4) getting medicine (for wind). Only 14 (16.7%) got advice from the TBA about preparing for delivery about risk signs during pregnancy, frequent exercise, not standing especially at doors (because the child would do the same in delivery), to be aware of labour pains, call TBA/ambulance when labour pains/begins and prepare baby cloth.

After delivery the most frequent postnatal traditional care was (1) (physical) check up, followed by (2) "got protection belt" (for baby), (3) infant feeding advice, (4) referral to health facility for postnatal care, (5) baby bath and cleaning the cord, (6) advice on nutrition of the mother, (7) family planning and (8) medicines for various ailments for the mother and infant (Table 2).

Table 2: Details of TBA/THP contact during pregnancy and after delivery with the last child (multiple response possible)

<i>During pregnancy</i>	N
Check baby's position	38
Did TBA or THP give any herbs during pregnancy#	38
Rubbed stomach (for wind)	33
TBA gave advice on HIV and AIDS	31
To check the baby	21
Got (bottle) medicine (for wind)	16
Other medicine (stomach, skin, delivery)	4
Got protection belt	3
Got advice to prepare for delivery##	14
<i>After delivery</i>	
Check up (physical)	25
Got protection belt (for baby)	17
Give advice on what you can feed the child after delivery	17
Give herbs or other medication to the baby after delivery	11
Give mother herbs or other medication after delivery	10
Advice post partum check up at public health service	8
Baby bath, clean cord	7
Advice about baby care	7
Advice about nutrition (yourself)	7
Advice on family planning	7
Rubbed stomach	2
Other (Phlegm, chest problem, gastro, fever)	5

Heal the wind; For easy delivery; Giving rubbing medicine; Help the baby with fits; Rubbing thing; Stomach problems; Stomach wind; Swelling, rubbing and prevention; To dry water in the body; To heal that wind; To heal the abdominal pain;

##About any risk during pregnancy and to prepare babies clothes; Be aware of labour pains; Buy baby clothes and call TBA when on labour pains; Delivery pains, breaking of water, look for the moon when is full; Giving medicine for rubbing If she got pains she must call ambulance; Medicine to drink; Not standing especially at doors, because the child would do the same in delivery; Rubbing staff for colds delivery; She phoned the ambulance and advised her to get ready; The babies situation after rubbing; To do the exercise frequently; To report when in labour pains; To report when in labour pains to have baby cloths.

Attitude about taking traditional medicine

Most postnatal clients (64, 86.5%) did not tell their obstetric care provider if they were taking traditional medicine, one in five (19.5%) think that telling their obstetric provider about having used traditional medicine would affect the care (negatively) given by the obstetric care provider, and nine (12.3%) believed that traditional herbs can hurt unborn baby.

The treatment of infant with traditional and complementary medicine included in order of frequency (1) gripe water (for the wind) (24.3%), (2) pharmaceutical agent (over-the-counter drug) (13.8%), (3) rooibos tea (9.9%), (4) galactagogue (a *galactagogue* is any substance that stimulates lactation, hence it increases milk production) (8.8%), and (5) traditional medicines given to the infant (8.3%).

Home delivery

Most women gave birth at health facility (93.4%) and their babies were delivered by nurses (48.6%) and doctors (38.3%). From 11 mothers who had delivered their last baby with the TBA all said that their TBA washed her hands before assisting in the delivery, and 8 used a new razor blade but 4 had not used gloves, 3 had used herbs for cleaning the umbilical cord, and only 2 asked about nevirapine (administration) (n=2).

Traditional health practitioners TBAs

Most TBAs reported to be involved in pregnancy care (88.9%), prenatal check-ups (75.9%), conducting a postpartum visit (76.9%), assess the baby's position in the uterus (75.9%), family planning (90.7%) and only a few took the mother's (9.3%) pulse, checked the mother if she had taken nevirapine (18.5%), and conducted abnormal or complicated deliveries (3.7%).

HIV/AIDS knowledge

Most had good HIV transmission knowledge (more than 80% correct responses), while only 56% knew that the transmission of HIV from mother to child can be prevented, 46% knew that there was no cure for AIDS and only 44% knew that they can contract HIV when assisting during delivery (Table 3).

Table 3: HIV/AIDS knowledge

	N (Correct response)	%
A person can get HIV by using a cup or plate that has been used by a person with HIV/AIDS (False)	45	86.5
Having sex with more than one partner can increase a person's chance of being infected with HIV (True)	52	96.3
People can protect themselves from HIV by using a condom correctly every time they have sex (True)	52	96.3
You can get HIV through contact with infected blood (True)	50	92.6
HIV can be transmitted from mother to child through breastfeeding (True)	44	81.5
Transmission of HIV from mother to child can be prevented (True)	30	55.6
Needles and razors can transmit HIV (True)	45	83.3
There is no cure for HIV, the virus that causes AIDS (True)	25	46.3
A TBA can contract HIV when assisting during a delivery (True)	24	44.4

Infection control

TBAs were asked about infection control practices. Although 64.8% reported using their bare (but washed) hands during delivery; 79.6% reported the use of gloves; 70.4% reported cutting the umbilical cord with a new razor blade or with sterilised scissors (75.9%) (Table 4).

Table 4: Infection control

	N	%
During delivery do you use bare hands (washed before)? (in the past 3 months) (risk)	35	64.8
During delivery do you use bare hands (not washed before)? (in the past 3 months) (risk)	0	
During delivery do you use gloves (unused)? (in the past 3 months) (low risk)	43	79.6
Do you cut the umbilical cord with a new razor blade (in the past 3 months) (low risk)	38	70.4
Do you cut the umbilical cord with a used razor blade (in the past 3 months) (risk)	0	
Do you cut the umbilical cord with scissors (not sterilised) (in the past 3 months) (risk)	2	3.7
Do you cut the umbilical cord with scissors (sterilized) (in the past 3 months) (low risk)	41	75.9
Do you cut the umbilical cord with reed or dry wood from mountain (not sterilised) (in the past 3 months) (risk)	1	1.9
Do you cut the umbilical cord with reed or dry wood from mountain (sterilised) (in the past 3 months) (low risk)	2	3.7

Herbalists and/or diviners (n=47)

Almost one in two of the herbalists and/or diviners (48.9%) indicated that pregnant women consult them during their pregnancy, with 85% saying they would come more than once during pregnancy. Reasons for such consultations included:

- The woman is past the due date for delivery;
- Lack of foetal movement;
- Abdominal pain, constipation, heart burn;
- Body pain, stomach-ache, back-ache;
- Swollen legs;
- Morning sickness;
- STIs;
- High blood pressure;
- “Uterus full of wind” or “Dirty uterus”;
- Problems with foetal position;
- False labour.

The reported THP treatments prior to delivery varied from rubbing, medicines for bathing or ingestion to referral to TBAs or the clinic. Reported post-partum care included checking of mother and infant; advice on breastfeeding; medicines for baby protection or for ingestion and referrals to the clinic.

Limitations of the study

This study uses a convenient sample and was by self-report. Postnatal clients may not have felt free to answer questions on traditional health practices being interviewed in a health care facility. So findings cannot be generalised to the study area.

Discussion

The study found that THP (in particular TBAs and to a certain extent herbalists/diviners) play a significant role in pregnancy and postnatal care, and also with the assistance of delivery. Certain HIV risk practices were reported on the practice of TBAs. THPs also seem to have some role in infant feeding and family planning. In this study 83 (45.9%) of the clients reported that they had never consulted a traditional health practitioner (THP); 36% had consulted a THP (including a traditional birth attendant=TBA) with their last pregnancy (more half of them 51.9%) more than once. In a similar study among postnatal women in Lusaka, Zambia, 21% reported using a traditional healers during the current pregnancy, and Bland *et al.* (2004) found that 26% of the mothers had consulted a traditional healer at some point in the first 12 weeks of life. Abrahams *et al.* (2002) found also among the majority of Xhosa speaking women that they follow indigenous healing practices for both themselves and their babies because of the need to “strengthen” the womb against witchcraft, to prevent childhood illnesses and to treat other symptoms. Other studies also found the use of herbs/home remedy such as *Isicakathi*, *Isihlambezo* (*Agapanthus* sp. L’Herit), which is a plant used by the expectant mother from the period she is six months pregnant until the baby is born. Pharmacological analysis suggests the possibility of both therapeutic and harmful consequences (Dlisani and Bhat, 1999).

The treatment of infants in this study with traditional and complementary medicine included in order of frequency (1) gripe water, (2) pharmaceutical agent (over-the-counter drug), (3) rooibos tea, (4) galactagogue, and (5) traditional medicines. A similar wide distribution including herbs and gripe water (the latter contains sodium bicarbonate and alcohol and is used to relief ‘colic’ or ‘wind’ or perceived abdominal pain) was found in a study on the use of non-prescribed medication in the first three months among the Zulus in rural South Africa (Bland *et al.*, 2004) and other studies (Abrahams *et al.*, 2002; De Wet, 1998; Cocks and Dold, 2000; Cocks and Moller, 2002). It is possible that the perceived benefits of Gripe water may be partially caused by the relaxation and sleep-inducing effects of the alcohol (Bland *et al.*, 2004).

Whilst the administration of non-prescribed medications may not cause any clinical problems, they may be dangerous, may interfere with appropriate health-seeking behaviour and preclude compliance with breastfeeding as

recommended by the World Health Organisation (Bland *et al.*, 2004; Mabina *et al.*, 1997; Varga and Veale, 1997). Traditional healers are highly valued providers who are often consulted for the procurement of traditional preparations for infant use (Sibeko *et al.*, 2005; Varga and Veale, 1997).

In this study most postnatal clients (86.5%) did not tell their obstetric care provider if they were taking traditional medicine, one in five (19.5%) thought that telling their obstetric provider about having used traditional medicine would affect the care given by the obstetric care provider, and 88% of the women did not believe that traditional medicines can hurt an unborn baby. Banda *et al.* (2007) found among the Lusaka sample that 64% stated that if they sought care from a traditional healer, they would not share this information with their obstetric provider; 54% believed that admitting to a visit to a traditional healer would result in worse medical care; and 61% said that traditional herbs can hurt unborn baby. Women may be unwilling to discuss with their obstetric care provider the use of traditional and complementary medicine, since it could be considered unacceptable. Health care providers need to take into consideration the use of traditional and complementary medicines of their obstetric patients.

Most TBAs reported to be involved in pregnancy care, prenatal check-ups, conducting a postpartum visit, family planning, but only a few checked the mother if she had taken nevirapine. TBAs had good HIV transmission knowledge (more than 80% correct responses), but only 56% knew that the transmission of HIV from mother to child can be prevented, 46% knew that there was no cure for AIDS and only 44% knew that they can contract HIV when assisting during delivery. Almost half of the herbalists and/or diviners (48.9%) indicated that pregnant women consult them during their pregnancy; 85% said that the pregnant women would consult them more than once during pregnancy. It is revealing that herbalists and/or diviners play such an important role in antenatal care, and further research should be conducted on this.

Although some health care providers remain suspicious of traditional remedies, most agree that traditional healers can play an important complementary role in health care provision (Bodeker *et al.*, 2006; Baggaley *et al.*, 1996; Burnett *et al.*, 1999; Bulterys *et al.*, 2002). Use of traditional medicines on infants and consultation with traditional healers seem to be common. The importance of recognizing and directly addressing the use of traditional medicines is reiterated in this study. Health programmes that neglect this matter may be missing important opportunities to provide education and minimize drug interactions. Health care providers must open lines of communication with traditional healers and with mothers to maximize PMTCT programme success. Given the use of traditional medicines, incorporation of traditional healers into health initiatives could be an effective strategy for meeting selective health needs (Bodeker *et al.*, 2006; Ndulo *et al.*, 2001; Nations and Souza, 1997).

THPs should be trained in optimising their services in pregnancy and postnatal care, and preparation for health facility delivery. In addition, they should be trained on HIV risk practices, HIV/AIDS, HIV prevention including PMTCT), infant feeding and family planning (Peltzer and Henda, 2006).

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