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EDITORIAL

USE OF TRADITIONAL MEDICINES IN PREGNANCY

Traditional medicine among African communities has been practised since antiquity. It was an integral part of the culture, belief and health care systems. These aspects of society were largely designed to maintain a robust, healthy and cohesive ecosystem desirable for prosperity and wellbeing. Among the cohorts that heavily relied on African traditional medicine were expectant and lactating mothers. Traditional healthcare among child bearing women started before conception, through pregnancy, postpartum period and continued into care of the new-born. For instance, there existed fertility remedies for both women and men to ensure continuity of the family line. This healthcare continuum was characteristic of African traditional set ups with emphasis on preventive care. Typical sources of drugs and remedies consisted of herbals, animal derived products and soils. The preparations utilized included decoctions, concoctions, ashes, rubs and inhalations.

Traditional medicine uptake depends on the cultural socialization of the individual. In ancient society, younger women depended on elderly members of the extended family for medical advice during pregnancy. Nevertheless, in subsequent pregnancies they learned the art of self-medication. In case of complicated cases, the attention of traditional medical practitioners was sought as appropriate. This ethnomedical proficiency was mastered with experience and was thus preserved for transmission to future generations. This chain of events was of course broken by the advent of allopathic medicine which heralded the demise of cultures, traditional practices, biodiversity and traditional medicinal products.

Modern health care systems promote comprehensive antenatal care involving use of allopathic medicine to improve women’s experiences during pregnancy and delivery. Despite these programs, pregnant women still consume traditional medicines away from the attention of health care providers. They opt for these products due to perceived benefits under the influence of cultural and religious practices. Elderly family members play a key role in promotion of traditional medicines by narrating personal experiences, success stories of other users and even warn of adverse outcomes in cases of dissent. Religion on the other hand encourages use of herbals because they are natural products with fewer side effects and are likely to provide a ‘back to Eden’ experience. Close to delivery, pregnant women are motivated to take traditional medicines to prevent prolonged labour, induce labour and avoid caesarean delivery. Interestingly, there are traditional beliefs at play in some cases. To this end, spousal sexual infidelity is believed to affect the health of the mother and/or child and may have fatal outcomes. In some communities, the woman is advised to consume crossroads soil (*rirongo*, among the Abagusii of south-western Kenya) for protection. Traditional medicines may also be preferred due to availability, accessibility and cost-effectiveness. In most cases the herbs used are readily available at low or no cost which augurs well with the users who commonly belong to the bottom of the economic pyramid. Some women, however, intentionally avoid conventional medicines due to previous unpleasant experiences such as nausea, vomiting and dizziness.

Majority of women using traditional remedies do not disclose this to healthcare providers for fear of unfavourable consequences. They are likely to be judged, scolded or neglected for seeking healthcare from unorthodox sources. These women desire to benefit from the modern healthcare system while concomitantly using traditional medicine for its benefits, hence the silence. It is therefore necessary for the attending doctors to inquire about herbal use during antenatal clinics. This will enable them to educate their clients on safe use of herbals in order to preclude habitual consumption which may cause adverse outcomes. For this purpose, contemporary healthcare systems need to offer culturally competent care that upholds diversity of cultural factors and offers a conducive environment for constructive interaction between healthcare providers and expectant mothers.

Several studies in diverse regions have reported widespread consumption of herbs among pregnant women. The most commonly consumed herbs include ginger, cranberry, valerian, raspberry, chamomile, pumpkin, bitter leaf, bitter kola, neem, lemon, black seed, mustard oil, prune, garlic, peppermint, turmeric, aloe, okra and herbal teas. A myriad of reasons have been cited for this health seeking behaviour including suppression of nausea and vomiting as well as promotion of foetal development and wellbeing. Untoward effects such as premature labour, miscarriage, foetal malformations, teratogenicity, emmenagogue and abortion have been reported. There are safety concerns due to the herbal ingredients, interactions with conventional medicines as well as microbial and heavy metal contamination.

In the current issue of the journal, Ibanda *et al.* have elucidated the prevalence and factors associated with herbalism among pregnant women in Kawempe National Referral Hospital, Uganda. The authors' findings corroborate those of similar studies in Africa. Such results should inform policy and practice changes that will positively impact on antenatal care experiences of pregnant women. Furthermore, a suitable pharmacovigilance program on traditional medicines is required for proper documentation of adverse effects and interventions.

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