Attitudes of women towards traditional midwives — a survey in the Kgalagadi (Kalahari) region

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Abstract **Two hundred and forty-nine women of childbearing age from 20 villages in the Kgalagadi (Kalahari) desert region, who had borne a child, were asked about their attitudes towards institutional and non-institutional deliveries. Two hundred and two (81,6%) women preferred to give birth at home. One hundred and seventeen (46,9%) attended antenatal clinics at health facilities but virtually none of these attended postnatal clinics. Forty-one per cent of the women who prefer to give birth at home do so because at home they receive African 'muti' and an abdominal massage; 22,5% deliver at home because they feel it is safer and more convenient. Most African women and communities are reluctant to entrust the sluicing of their placenta and other products of conception to strangers such as nurses. Ninety per cent of respondents suggested that traditional midwives and health personnel should work together to improve community maternal health services.**

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Nearly all countries, developed and developing, have traditional midwives (TMs) or birth attendants.[1] In developed countries, however, very few TMs still practise. Over two-thirds of births in the world, however, are conducted by TMs. Most of these people are not trained in modern medicine but are experienced in traditional birth systems.[2] In developing countries TMs practise mostly in rural areas. They serve the poor and illiterate. About 30% of all births in Botswana are non-institutional births.[2] In Botswana's neighbouring countries the situation is even worse: Zimbabwe 50%, Zambia and Malawi about 60% each. In nearly all African countries women give birth at home.[3] In Botswana most TMs are related to the parturient, either mother, sister or another close relative. In most other African countries, TMs are professionals hired for a fee. In Benin the personal history of the TM is important. A woman whose own children have died or who has never had children does not qualify as a TM.[2] In Kenya TMs are usually important women in the community. They are wise, mature people with economic and political power. They therefore exert considerable influence on local health practices.[2] In all cases however TMs undergo an apprenticeship. Preferred candidates are postmenopausal women who have borne many children. TMs almost always live in the communities in which they practise. They speak the vernacular and understand and adhere to the local system of health beliefs and practice.

There are three main types of community served by TMs.[4] The first is the isolated and remote community located far from road networks and health facilities, the second the rural community with access to roads and health facilities. In such communities TMs usually work together with scientific medical personnel. Women usually attend antenatal clinics at health facilities but prefer to deliver at home. The third type of community is the urban/peri-urban community which, despite having a central system of service, still prefers traditional birth attendants. In the majority of African countries most traditional birth attendants are women. Nigeria and Ghana, however, have male traditional birth attendants. In a survey of 263 registered TMs in Ghana, 48% were men. They delivered more babies annually than female TMs.[5] Many TMs in Ghana are also herbalists. In the Bendel province of Nigeria, a woman must also be present during deliveries.[6]

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Community profile

The Kgalagadi region is located in the south-west corner of Botswana. Its area of 110 110 km^2 constitutes about 19,5% of Botwana's total land mass. The terrain is generally flat and featureless. Poor vegetation cover and deep structureless sands up to 120 m in depth are typical of the region. The climate ranges from dry to semi-dry with very low humidity levels. Temperatures are very high in summer and very low in winter, and there are up to 40 frosty days annually. Very little rain falls in Kgalagadi and no surface water is available. Ground water, though salty, constitutes 100% of the water for domestic and animal consumption. There is no industry and more than 50% of the population is economically inactive. The population projection for 1991 was 36 391 with an annual growth rate of 3,4%. There is no public transport in the region, as most of the roads are sandy and difficult to drive on. There are 45 villages and 7 major settlements. The Kgalagadi region has one referral primary hospital, 6 clinics with maternity services and 20 health posts. Ten of the health posts are manned by enrolled nurses without midwifery qualifications, the rest are manned by family welfare educators (community health workers). Every village is within walking distance of a health facility. Most clinics have waiting shelters for parturients who live far away from the clinic.

Materials and methods

Twenty villages were randomly selected from the 45 villages in the region. A randomised house-to-house questionnaire survey was carried out. All women aged 15 - 49 years in each household, who had been pregnant or had borne a child, were requested to answer the questionnaire. In households where some members were absent repeat visits were made until everyone had been interviewed. The survey was carried out by the researcher and a field assistant.

Results

One hundred and thirty-seven (55%) of the respondents were single mothers, 47 (18,8%) were married, 20 (8%) were separated, 15 (6%) were divorced and the rest, 30 (12%), had a common-law husband. The majority of those interviewed were unemployed. One hundred and forty-seven (59,2%) were illiterate, 71 (28,6%) had had a primary education and 30 (12%) had had a secondary education. Tables I and II below show the parity and

age distribution of the respondents. Only 117 (46,9%), less than half the respondents, attended antenatal clinics. Those who did not attend claimed that there was no health facility near their villages. Two hundred and two (81,6%) of the respondents preferred to give birth at home. They gave three major reasons: (*i*) 74 (36,7%) deliver at home because of a lack of health facilities near their villages; (*ii*) 45 (22,5%) preferred delivery at home to ensure that the products of conception did not fall into witches' hands; (*iii*) 83 (41%) preferred delivery at home because of the African 'muti' and abdominal massage they receive.

Two hundred and twenty-four (90%) of the respondents agreed that traditional birth attendants and health personnel should work together. Six potential respondents were unable to be interviewed because after three visits they were still unavailable. In most cases a second visit identified missing respondents. In 10 cases the respondents were available during the third visit. Twenty-three households were revisited altogether.

TABLE I.
Parity of women interviewed and percentage of total

Parity	No. of women	% of total
0*	7	2,8
1	24	9,6
2	30	12,0
3	65	26,0
4	54	21,7
5	37	14,9
> 5	32	12,9

* Postpartum deaths.

TABLE II.
Age distribution of women interviewed and percentage of total

Age group	No. of women	% of total
15 - 19	21	8,3
20 - 25	33	13,3
26 - 30	42	16,9
31 -35	43	17,3
36 - 40	59	23,7
> 40	51	20,5

Discussion

Despite the progress made by the Botswana government in the provision of primary health care services nearer to every village in Kgalagadi, a lot more needs to be done with regard to maternal health services. In Kgalagadi there is a health facility within 8 km of each village. Despite this most women still prefer to deliver at home, and claim that there are no health facilities. More delivery shelters have been constructed at all clinics to cater for those mothers whose villages are far away from good road networks. Mothers can remain at the clinics until delivery. Botswana is not an exception. A survey in Kenya revealed that modern antenatal care is available to 84% of women. Of these, only 26% went to hospital for delivery.[7] In Ghana the situation is as bleak; a survey there showed that 92% of pregnant women received antenatal care but only 33% delivered at a health facility.[5] In Benin a 1977 survey showed that 51% of 203 female villagers preferred to give birth at home.[2]

Most Africans believe in witchcraft and the sluicing of the placenta and other products of conception is controversial. African custom does not allow strangers to sluice postnatal products. Only close relatives should sluice products of conception to prevent them from falling into the wrong hands or even protect them from scavengers. Scavengers should not be permitted to eat human placentas. Childbirth in all cultures is surrounded by a diverse array of rituals such as the disposal of the placenta.

If the ritual is performed properly, it lends protection against witchcraft. In Cameroon, for example, one reason why women prefer to be delivered by TMs in spite of sufficient modern maternity units is to guarantee appropriate disposal of the placenta.[8] In health facilities it is the duty of nurses to do the sluicing. Nurses are strangers who may sell these products to other strangers, including witches.

The prescription of African herbs or 'muti' postpartum is viewed as essential by most of the respondents. The same applies to abdominal massages which TMs prescribe and perform. One of the first concerns of the TM is timely expulsion of the placenta. The most common way of ensuring this is through abdominal massage which may prevent haemorrhage.[9] In Ethiopia, the TM shakes the woman up and down and then helps her maintain a sitting position until the placenta is expelled. It is believed that if she lies down, the placenta will go to the brain and cause death.[10] Regular warm baths are also encouraged. Some other cultures have other postnatal practices such as binding of the parturient's abdomen to aid involution of the uterus; this is practised in Malawi.[11] In Nigeria an abdominal massage with very hot water containing herbs is performed for 40 days postpartum.[12] Some other environmental stressors make hospital experiences unpleasant. These include lack of communication, biomedical routines and technical interventions, specific hospital customs and expected patient behaviour, isolation from family and friends and conflict of attitudes and beliefs between health workers and parturients.[2]

The parity of the parturient might also play a role. Some women do not want to leave other children alone without adequate care especially if the health facility is far away.[1] To 'entice' more Africans to deliver in health facilities attitudes of health workers have to change. Instead of just advising mothers about stomach press-ups and giving out exercise posters, health workers must demonstrate these activities or do them together with the parturient. Furthermore the after-products of conception could be given to relatives for 'proper' disposal within or without the health facility. TMs might also be encouraged to visit their patients in the health facility; this would increase co-operation and co-ordination between the two services. TMs are essential to the success of any maternal health services in Africa. They are in most cases the first and nearest contact with women in the villages. They are therefore the best primary health care service in the village. An increase in the number of waiting shelters is also essential and a relative or two should be allowed to accompany the parturient. Feeding will naturally become a problem, especially in remote areas where there is no industry. TMs as primary health care providers need information on risks in pregnancy and delivery. They should be encouraged to communicate as equals with health personnel. Most important of all, they should be recognised as part of the maternal health services.

Conclusion

The majority of women in the remote area of the Kgalagadi region still prefer home deliveries for a number of personal reasons. Health personnel have to change a few of their rules and attitudes and meet traditional midwives half way. In addition, both TMs and health personnel have to co-operate more and co-ordinate their activities better to improve this essential service.

TMs are a key element in the success of primary health care. They should therefore be recognised.

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