The Zulu traditional birth attendant

An evaluation of her attitudes and techniques and their implications for health education

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Summary

Some of the important practices of Zulu traditional birth attendants in their care of pregnant women are summarized. This information is valuable in constructing the format/content of appropriate antenatal health education for women from rural areas. The target group for antenatal health education should include the opinion-formers of the community.

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Obstetricians working among rural communities in Africa are often confronted by behaviour unfavourable to health among the women using the health facilities that they service. The frustrated doctor may respond to this behaviour with anger and even ridicule unless he is initiated into some of the cultural insights of the people as regards pregnancy and labour. This article documents insights gained during 2 years of contact with a group of 5 Zulu traditional birth attendants (TBAs), who live in the magisterial district of Vulamehlo, which is 80 km south of Durban.

Material and methods

A questionnaire based on one used in Ghana[1] was constructed by the authors with suitable modifications. The TBAs met with the authors for a morning (from 08h30 to 13h00) every fortnight during 1980, and less regularly during 1981. The questionnaire was administered by two of the authors (C.L.M. and M.C.M.) and a consensus of views was recorded.

Results

Antenatal care

There is no tradition among Zulu TBAs which involves physi-

cal examination of the pregnant women. They understand their role during this phase of pregnancy to be that of a health educator, and their advice includes the following:

Dietary taboos. They advise against the use of meat or milk from the family herd, or the eating of eggs. Alcoholic beverages are strictly forbidden to pregnant women.

Isihlambezo. This is a herbal infusion which varies in its constituents from place to place. It is used to prevent oedema and to ensure that the baby is clean at birth and not covered with vernix (a shameful thing suggesting inadequate continence in the husband during the pregnancy).

Intercourse during pregnancy. This group of TBAs advise the use of coitus interruptus from the seventh month of pregnancy.

Work. They advise women to be as active as possible, especially in early pregnancy. There is no tradition that heavy manual labour may be harmful to the pregnancy.

The expected date of delivery. Calculations are made using the lunar cycle. Delivery is expected during the 4 weeks following the completion of the ninth lunar cycle (36 weeks' gestation).

Illnesses in pregnancy. This group of TBAs had no understanding of the causes or treatment of antepartum haemorrhage, oedema and convulsions, weakness and dyspnoea or vomiting in pregnancy. Their advice regarding these problems often meant the loss of valuable time while traditional treatments were tried.

The early diagnosis of pregnancy. No attempt is made to palpate the abdomen of a woman who has amenorrhoea. The diagnosis of pregnancy is made on inspection of the breasts (pigmentary changes are recognized), the abdomen and the back of the knee (ill-defined changes in the popliteal fossa). This usually means that pregnancy is diagnosed at 4-6 months. Attendance at an antenatal clinic is often delayed a further month or two because of very uncertain ideas about the function of the antenatal clinics.

Labour

The TBAs assist women in labour, and are usually called late in the first stage.

Labour may be diagnosed by the appearance of a blood-stained show together with frequency of micturition and lower abdominal and back pain. The latter may be accompanied by groaning.

The TBAs do not recognize early rupture of membranes, either as a sign of early labour or as a potentially harmful event.

The selection of mothers for delivery. This group of TBAs refused to attempt to deliver women who admitted to a previous caesarean section or prolonged labour. They did not, however, take a history of previous deliveries, nor did they take into account previous perinatal deaths. They defined prolonged labour in a primigravida as lasting over 24 hours, and in a multigravida as lasting over 12 hours.

The first stage of labour. Women are encouraged to remain ambulant and continue household tasks until the onset of the second stage. There is no tradition of monitoring fetal and maternal well-being or the progress of labour in the first stage, the TBA being called only when there are signs that the woman is approaching the second stage or if labour is prolonged.

The second stage of labour is diagnosed by the urge to bear down, accompanied by strong contractions and rupture of membranes. Pelvic examinations are not carried out. The second stage is conducted in the kneeling position. The TBAs monitor the progress of labour in the late first and second stages by palpating the level of the presenting part abdominally. They are able to recognize failure of descent and can differentiate between a transverse and a longitudinal lie.

Difficulties in labour. The causes of poor progress in labour could be *umeqo* (a poor relationship with the ancestors), a tight perineum, a contracted pelvis or placenta praevia. Usually, *prolonged labour* is first treated with *imbelekisane*. This is an infusion made of various roots and herbs, or out of the bladder or uterus of a monkey, which the labouring mother is given to drink. When strips of sensitized rat uterus were exposed to a sample of this substance it was repeatedly shown to produce tonic contractions (Fig. 1).

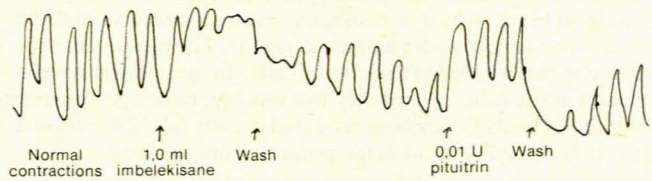

Fig. 1. The effect of *imbelekisane* on strips of sensitized rat uterus.

The TBAs recognized the association between prolonged labour and the birth of a baby in poor condition, but they are unable to detect *fetal distress.* They have difficulty in detecting *meconium* because deliveries are commonly conducted on a dung floor in a poorly lit room. *Retained placenta* is treated by having the mother kneel and blow into an empty bottle. If that fails, she may be given a large volume of water to drink, after which vomiting is induced. One of the TBAs claimed that she had performed a manual removal of a retained placenta. *Postpartum haemorrhage* is not clearly recognized as a serious complication. These TBAs made little serious attempt to estimate blood loss, and considered that if the loss was excessive it was because the 'mother had too much blood in her'.

The care of the neonate

The dangers of hypothermia are recognized. A fire is usually made in the hut in which the birth is taking place to ensure the baby's arrival into a warm environment. The baby is bathed in warm water, smeared with Vaseline and wrapped in a warm blanket. The asphyxiated baby is treated by milking the cord towards the baby, and splashing cold water onto the abdominal skin.

Normally the TBAs wait until the cord has stopped pulsating, when it is cut with a razor blade, pair of scissors or the sharp edge of a reed. They do not tie the cord. The cord stump is treated with various traditional remedies to help it dry out quickly.

Colostrum is regarded with the revulsion commonly accorded to pus, and babies are therefore not put to the breast for 12-24 hours while the colostrum is expressed and thrown away. The baby is given a mixture of sugar and water during this time to clear its bowel of meconium. Enemas are used very commonly in the first week of life, if the baby does not pass a stool or if he is crying and restless with colic.

Jaundice, tachypnoea and repeated vomiting are recognized as dangerous complications in the neonatal period. Tachypnoea is treated with traditional medicine. If that produces no improvement the baby is referred to the nearest clinic or hospital. Jaundiced and vomiting neonatal infants are usually referred immediately.

Postnatal care

The TBA normally visits any woman she has delivered during the traditional lying-in period of 8 days. She bathes the baby, gives him an enema when she considers this necessary, and offers advice about breast-feeding. Perineal tears are washed regularly with a solution of salt or Dettol in water. The mother is then instructed to kneel so that her heels press the wound edges

together. An infusion called *ugobho* is given to the mother to aid in the involution and healing of the uterus.

Social status and payment

All the TBAs in this group of women were postmenopausal. They were either widows or married to husbands unable to work because of ill-health. They had gained acceptance by the community as being women of courage and compassion who could be relied upon to stay with a woman in labour. The experience they gained in this way led to their being called in to assist whenever a woman in the valley where they live was experiencing a difficult labour. Rewards for services rendered usually take the form of a gift such as a chicken, or some produce from the land.

Discussion

In rural Zulu society the attitudes and practices surrounding childbirth are largely governed by those of the older women who participate in the supervision of delivery. Attempts at providing health education for young women are certain to fail unless health education takes these attitudes and practices into account. It is also important to be aware of traditional practices when attempting to make hospital and clinic delivery more acceptable to illiterate rural women.

Useful practices

A number of these practices are useful and should be encouraged. Such encouragement can act as a bridge for more effective communication if used well by a health educator. Useful practices discussed above include the following:

Coitus interruptus. Naeye and Ross[2] have recently shown that the use of condoms during the third trimester of pregnancy greatly reduces the incidence of chorio-amnionitis and its complications. These include premature rupture of the membranes, premature labour, an increased incidence of abruptio placentae and an increased perinatal mortality rate. The TBA's advice that coitus interruptus be practised in the third trimester is therefore good.

Positions during labour. There is now considerable evidence that the maintenance of an upright position in the first stage of labour is associated with less pain and more efficient uterine action, and hence a shorter labour.[3] Our experience with the kneeling position in the second stage of labour shows that the adoption of this position also shortens the second stage and reduces pain. Encouraging mothers to be up and about during the first stage of labour and providing them with suitable diversions between checkings is elementary psychoprophylaxis which every hospital, including rural units, should use. Midwives and doctors working in rural areas should be taught to conduct deliveries in the squatting position so that this can be offered to women who prefer it as a matter of routine.

Information about the **duration of pregnancy** as estimated by illiterate rural women using the lunar calendar can be extremely accurate. Semiliterate women should be encouraged to use this method of estimating the period of gestation, and staff working among rural communities *must* take the trouble to learn how to interpret it. This can be important in preventing their concluding that 'all these women are ignorant and stupid'.

Neutral practices

Some practices of the TBAs can be classified as being of doubtful value, but probably not harmful. The use of *isihlambezo* and *ugobho* probably falls under this heading, although more samples of the latter should be analysed in order to ensure that they are pharmacologically inert.

Harmful practices

Other practices are harmful and direct health education is necessary to change them. They include the following:

Dietary taboos. There are culturally acceptable ways of circumventing the taboos which adversely affect the protein intake of pregnant women. These should be discussed frankly during antenatal health education.

Heavy manual labour. Many rural women eat only 1 or 2 meals a day and are obliged to carry heavy loads long distances and to work long hours tilling the fields while pregnant. Hard physical work undertaken with a restricted protein intake is associated with an increased incidence of intra-uterine growth retardation and perinatal death, especially when there is associated ketonuria.[4] Direct education on the need for regular meals and the avoidance of heavy work is required.

Other necessary advice. The TBAs must be advised about conditions such as antepartum haemorrhage, premature labour, pyrexia and convulsions in pregnancy which demand urgent referral to the nearest health centre or hospital. The role of the antenatal clinic in offering an early diagnostic service and preventive care must be elucidated, as must the significance and dangers of pre-labour rupture of the membranes and the appropriate action required. The need for adequate fetal and maternal monitoring in the first stage of labour and the trained midwife's role in this must be explained, as well as the significance of prolonged labour and the dangers inherent in the use of *imbelekisane*. The advantages of immediate and exclusive breast-feeding and the importance of colostrum must be stressed, and the dangers of giving enemas to young children and neonatal infants explained.

Target groups

Antenatal health education is traditionally delivered to groups of pregnant women alone. In rural society these young women are not the opinion-formers, and it is unrealistic to expect them to change patterns of behaviour against the opinion of the older women. It is necessary to make a deliberate attempt to invite these older women, especially those who are recognized traditional midwives, to participate in health education classes. It is even more effective if they can participate in the development of appropriate health education material and act as voluntary assistants to the trained midwife in carrying the message into the community.

Conclusion

The TBAs interviewed were eager to learn and to assist in the delivery of better care to their people. When we approached them in the right way we did not find them resistant to new ideas and to change. The information they have given has been valuable in designing the structure and content more appropriate to health education for women from rural areas. It has also encouraged us to reach out to the older women of the community, who are the opinion-formers, in order to bring about the necessary changes.

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