CHAPTER 2

Literature review

2.1 INTRODUCTION

Chapter 1 discussed the background to the problem, formulated the problem statement, outlined the purpose and significance of the study, and the research methodology.

This chapter describes the literature review, which was directed by the central concepts in the study. The literature review was narrowed down to the concepts of cultural behaviour during pregnancy in different cultures, as well as transcultural nursing in general.

The literature was studied in order to determine the necessity of investigating the beliefs and practices of Sotho antenatal women as well as the role played by such beliefs in health care behaviour. Previous research conducted into beliefs and practices of different cultural groups in pregnancy was also reviewed. In addition, literature on pregnancy and antenatal care clinic attendance as viewed by different cultural groups, different worldviews, prescriptive and restrictive beliefs of pregnant women in various cultures, and the theory of cultural care diversity and universality were reviewed.

2.2 CULTURE

Culture influences the practices and beliefs of people in general. In this case culture also has a bearing in the beliefs and practices of Sotho antenatal women.

According to Leininger (1997:13), *culture* implies an integrated pattern of behaviour that includes the thoughts, communications and actions, customs, beliefs and values, as well as institutions of racial and religious customs and socioeconomic groups. Giger and Davidhizar (1995:13) describe culture as a patterned behavioural response that develops over time as a result of learning through social and religious structures and intellectual and artistic manifestations. They add that it is also

the result of acquired mechanisms that have innate influences on behaviour but are primarily affected by internal and external environmental stimuli.

According to Clark (1996:27), *culture* has certain identifiable characteristics, which are common to all cultures. *Cultural universals* are areas of culture that are addressed by all cultures, such as family, marriage, parenting roles, education, health, work and modes of communication. Although the above areas are commonalities in each culture, such areas are not exactly alike in each culture. Leininger (1997:13) points out universality and diversity in culture.

2.2.1 Characteristics of culture

Culture has the following characteristics:

(1) Universality

According to Clark (1996:276), *culture* is a phenomenon that involves all people. Leininger (1997:38) defines *cultural universality* as the commonalities or similar cultural meanings, patterns, values and symbols and life-ways within and among cultures.

(2) Uniqueness

All cultures are unique and although similarities may occur among cultures, no cultures are the same (Clark 1996:276).

(3) Stability

Clark (1996:275) describes *stability* as another characteristic of culture. *Cultural stability* means that although culture is not static, and changes over time, there are aspects of culture that do not change at all, and these provide the basis for resistance to change. Culture is lasting and is transferred from generation to generation.

(4) Changeability

Culture changes over time. Superficial aspects of a culture change more easily than deeply held beliefs and values (Clark 1996:276). According to Mellish (1998:24), cultural change is the process of change in any aspect of culture that entails modifications in behaviour, customs and traditions.

(5) Subliminality

Cultural expressions are often expressed through behaviours and symbols of conscious awareness (Clark 1996:276).

(6) Variability

The degree to which an individual adheres to cultural beliefs, values and customs is affected by many factors. Such factors are depicted in the sunrise model, and include level of education, language, and economic factors (Clark 1996:275-276; Leininger 1997:37).

2.3 FACTORS CONTRIBUTING TO CULTURALLY CONGRUENT CARE

The barriers to cultural congruent care interfere with nurses' and midwives' ability to promote the health of people from other cultural groups. Nurses should therefore recognise the existence of cultural diversity among clients and use a knowledge of these diversities to develop culturally sensitive and congruent care in designing interventions which advocate holistic care of clients (Clark 1996:278; Leininger 1997:32-40).

2.3.1 Cultural sensitivity

Clark (1996:278) describes *cultural sensitivity* as awareness on the part of caregivers of the significance of cultural factors in health and illness. This signifies that people are unique and need to be respected as unique individuals. *Culturally sensitive* nurses do not expect individuals to conform to the majority culture nor do they expect all members of a culture to behave in exactly the same way.

2.3.2 Cultural relativism

Another characteristic of a culturally effective nurse or midwife is cultural relativism (Clark 1996:278).

Cultural relativism is the ability to view beliefs and behaviours in the context of a culture in which they originated. It implies that culture and the phenomena surrounding it should be viewed from an emic rather than an etic perspective.

In this study, the emic views of Sotho antental women who experience their culture is sought. The researcher sought the emic perspective of the Sotho women (see chapter 3). Clark (1996:278) and Morse (1992:1-2) point out that the etic perspective, on the other hand, is the outsider's point of view, who witnesses a phenomenon without clearly understanding its origin.

2.4 BARRIERS TO CULTURALLY CONGRUENT CARE

The researcher deemed it necessary to examine barriers to culturally congruent care because if the results of this study are implemented, some of the problems that appear below may be combated. Literature on the responses of nurses and midwives to clients from other cultures was reviewed to emphasise the significance of a study on the beliefs and practices of Sotho antenatal women as a cultural group, because according to Clark (1996:276), nurses frequently encounter clients whose culture differs from their own, and the response of nurses to these differences may either be positive or negative. Clark (1996:276-278) describes various potentially negative and positive responses of nurses and midwives to clients from other cultures.

According to Clark (1996:276-277), the following are the negative responses that nurses can display towards clients of different cultures. In this study, negative responses are referred to as barriers to culturally congruent care.

2.4.1 Ethnocentrism

Ethnocentrism is a belief that one's own values, beliefs and customs are superior to those of others. If nurses are *ethnocentric*, they may ridicule or belittle the beliefs and behaviours of clients in such a way that it may be impossible for them to accept or work with such clients. In this study, midwives who do not understand the use of amulets to ward off evil spirits during antenatal care may ridicule the practice without trying to understand the basis for it (Clark 1996:276; Mellish 1998:27).

2.4.2 Cultural blindness

Clark (1996:276) describes *cultural blindness* as one of the nurse's negative responses to clients. C*ulturally blind* nurses behave as if differences do not exist between their culture and that of the client. For example, cultural blindness occurs when a community health nurse who counsels clients on nutrition ignores the client's cultural food preferences Clark (1996:276). The above is also true in as far as midwifery care is concerned because in different cultural groups food taboos as well as food preferences exist.

2.4.3 Cultural shock

According to Clark (1996:276), cultural shock occurs when a nurse *suddenly* becomes aware of the differences between her cultural background and that of a client. The nurse may regard the client's beliefs, values and ways of life as *alien* and become *shocked* by the aspects of such an alien culture. C*ultural shock* occurs in response to behaviours approved of in one culture and disapproved of in the nurse's own culture. If a certain behaviour is regarded as taboo in the nurse's culture and accepted by members of another culture, the greater the shock to the nurse. Clark gives the example of a community health nurse who may be shocked by the dirty house during a community visit. The same *cultural shock* may occur when a midwife encounters a client who uses a snakeskin as a means of warding off bad spirits, or uses animal claws as a pendant during pregnancy. Mellish (1998:27) states that cultural shock occurs in cultural groups when one culture is suddenly introduced to another.

2.4.4 Cultural conflict

Clark (1996:277) maintains that *cultural conflict* may also impede a nurse's ability to respond adequately to the needs of clients from other cultures. In *cultural conflict*, nurses are aware of the differences between their culture and that of a client and feel threatened by the differences. In this case, the nurses' reaction may be to ridicule the client's beliefs in order to put their beliefs and practices as superior. This behaviour is different from that of ethnocentric nurses, who truly believe that their culture is superior. Nurses in cultural conflict only need to preserve their own self-esteem and label others as *crazy* when they are aware of their behaviour. Mellish (1998:27) states that cultural conflict occurs when two cultures are actually involved in a conflict.

The above should sensitise midwives to their own behaviour when they become aware of their clients' behaviours and feel threatened by them. In this study, the above negative responses may be overcome by *cultural accommodation* as indicated in Leininger's Sunrise Model (see figure 2.1).

2.4.5 Stereotyping

Clark (1996:277) defines *stereotyping* as attributing a cultural pattern to all members of a particular culture on the basis of prior attitudes and interactions. Stereotyping is detrimental to nurse/client relationships in the sense that the clients are not regarded as individuals, but as copies of their cultural group. It is therefore important to acknowledge the fact that the findings in this study will serve as guidelines for the care of Sotho antenatal women and not as rigid rules, because not all Sotho antenatal women may uphold the same beliefs and practices, especially those living in urban areas. At the same time, Clark (1996:277) states that stereotyping needs to be distinguished from generalisation in the sense that generalisations are expectations based on knowledge of behaviours and beliefs common to a particular cultural group. A stereotype, on the other hand, is an assumption that a member of a particular group will always act in accordance with that particular group's cultural perspective.

Figure 2.1 ?????

According to Clark (1996:277), nurses need to be familiar with the various dimensions of their clients' cultures and the influence of culture on health and health care behaviour, but at the same time, must also consider the uniqueness of each individual, family or group. Therefore the degree to which the client conforms to cultural norms and values must be ascertained.

The above negative responses or barriers to culturally congruent care might lead to other negative attitudes by nurses (Clark 1996:277).

The following are attitudes and behaviours that may be precipitated by barriers to cultural congruent care.

(1) **Racism**. Racism is a belief that people can be classified on the basis of biophysical traits, which, in turn, determine people's mental abilities, ethical and physical capabilities. Racism therefore results in some people being regarded as intrinsically superior or inferior.

The implication for nursing is that nurses should not rate people according to their race or attribute people's abilities to classes regarded as superior or inferior, socially. The above reaction of nurses may interfere with the nurses when dealing with clients (Clark 1996:277).

(2) **Prejudice**. Prejudice refers to a set of attitudes unfavourable to a group of people, based on preconceptions rather than facts. Both racism and prejudice may result in discrimination (Clark 1996:277).

Midwives should therefore refrain from developing unfavourable attitudes to clients, hence in this study, each individual antenatal woman should be treated according to facts, not preconceived ideas.

(3) **Discrimination**. Clark (1996:277) describes discrimination as differential treatment of an individual or group based on unfavourable attitudes towards a group. Therefore nurses or midwives who treat patients on the basis of their superiority and inferiority are engaging in discriminatory practices.

(4) Cultural imposition. Cultural imposition is the expectation that everyone should conform to certain norms (Clark 1996:277). In this study, expected norms may be set practices which midwives may expect antenatal women to adhere to according to Western expectations, such as exercise during pregnancy, adhering to particular types of diet, or clothes to be worn by pregnant women as described by Bennet and Brown (1998) and Nolte (1998), for example. Nurses and midwives can therefore forget that individual clients have their own practices regarding the above issues. Mellish (1998:23) contends that if nurses try to impose their ideas, no matter how scientific, they will fail in their task.

2.5 SOTHO CULTURE

As discussed earlier, it is important for midwives to understand the characteristics of culture to be aware that commonalities in each culture might not be viewed the same (see section 2.2.1). For example, in Western culture, a family might be viewed as the immediate members of the family (i.e. mother, father and children) whereas in non-Western cultures, family means immediate family members including members of the extended family and *significant others*. Nurses should acknowledge diversities among cultures and bear them in mind when rendering culturally congruent care to individual clients. In this study, the beliefs and practices of Sotho antenatal women form the *unique* characteristics of the Sotho women that need to be studied.

The researcher therefore found it necessary to discuss the Sotho culture with regard to how they view family, as well as their culture in midwifery practices.

In Sotho culture, children are born at their mother's house. The Sotho (Basotho) view this as very important because in Sotho culture, an expectant mother is attended to by people to whom she is related by blood. After the birth, the new mother remains in seclusion for some time, the end of which is marked by a special ceremony. Prior to the return to her husband, a ritual of purification is performed on the new mother.

As the children grow, they are given a necklace of charms which they wear all the time. The children may be named after their paternal grandfather or grandmother, depending on their sex. A boy retains his name until he is circumcised, when he chooses another name.

2.6 CULTURAL VALUES AND WAYS OF LIFE

Cultural values and ways of life are an element of the culture-care diversity and universality theory. These are discussed in relation to assessment of a woman during antenatal care. According to Leininger (1997:34), midwives need to know about diverse cultures and to use this knowledge to guide their teaching, clinical practice and consultation as well as research work.

The implication of the above for midwifery is that during antenatal assessment, the midwife should investigate the woman's beliefs and values that affect her way of life. Not investigating them could lead to problems in care. Kroll (1996:27) states that during pregnancy and childbirth, cultural insensitivity and misunderstandings can result in distress for the woman.

According to Novak and Broom (1995:33), assessment in pregnancy should include the following cultural phenomena:

- Ethnic/racial identity (how do the pregnant woman and her family identify themselves)
- Language(s) spoken at home and with outsiders
- Place of birth
- Religion
- Ethnic affiliation (are persons or family, family friends and associates from the same ethnic group?)
- Dietary habits and food preferences, including restrictions and prescriptions
- Ethnic health care practices (folk healing etc)

The above phenomena are assessed in order to understand the woman with regard to care expressions that should be delivered by a midwife. This should be done because not all women in antenatal care may accept certain procedures done by nurses. According to Lew (1991:149), Cambodian women are extremely modest and many of them were raped during the Khmer rouge rule, and for this reason these women might not accept pelvic examinations because they can be psychologically stressful. While Dobson (1991:135) asserts that a female interviewer is most suitable for interviewing Punjabi mothers.

Dobson (1991:135), Lew (1991:149) and Novak and Broom (1995:36) maintain that women need individualised assessment in pregnancy. In this regard, Giger and Davidhizar (1990:202; 1995:7-9) developed an assessment model in transcultural nursing assessment. Callister (2001:212) asserts that cultural assessment includes people's beliefs, values and health-related behaviour.

2.7 WORLD-VIEWS IN CULTURAL RESEARCH

The researcher reviewed literature on different world-views in relation to pregnancy and beliefs and practices during pregnancy in different cultures.

2.7.1 Magical-religious health paradigm

In the magical-religious health paradigm, supernatural forces are dominant. In this paradigm, the fate of the world and people living in it depends on the actions of gods or other supernatural forces. The implication for nursing is that some people believe that happenings are predetermined and cannot be altered. This paradigm also indicates that individuals believe that what is not humanly possible may still occur. According to Andrews and Boyle (1995:22), midwives should understand the individual's attitude and behaviour that may result from belief in supernatural influences. Novak and Broom (1995:136) also assert that midwives should understand the variations in the mother's attitude and behaviour that may result from cultural influences.

Leféber (1994:15) refers to West's (1981) findings that pregnant Sotho women avoided walking in the streets at night because of fear of witches and bad influences from the supernatural world. In her study of traditional birth attendants in South Africa, Nolte (1998:59) stated that traditional birth attendants prescribe medicine for mother and baby to keep evil spirits away.

Spector (1991:128-129) states that another traditional approach to illness centres on religion. Illness in this approach is viewed as a punishment for breaking a religious code. One example of a religious practice is the "blessing of the throats" on Saint Blaisé Day to prevent sore throat and choking. Another example is the Virgin of Guadalupe, the patron saint of Mexico, who is pictured on medals that people wear or in pictures hung in the home to protect the people from evil and to ask for her blessing and prayers.

Hammond-Took (1989:83) states that the logic behind beliefs in witchcraft and sorcery is based on the assumption that there's no such thing as chance, events on earth do not happen by chance. In this paradigm, it is believed that misfortune of being ill may befall a person who has wronged the ancestors or God.

2.7.2 Scientific or biomedical health paradigm

In the scientific or biomedical health paradigm, life is controlled by physical and biochemical processes that can be studied objectively. Determinism, mechanism, reductionism and objective materialism characterise the scientific paradigm (Andrews & Boyle 1995:23-24). In the biochemical paradigm, pregnancy is viewed as a physiological process that necessitates continuous medical observation and care. According to Nolte (1998:83), a pregnant woman in Western culture needs to attend antenatal clinic early in her pregnancy. The biomedical health paradigm conveys the understanding that certain physiological changes occur in pregnancy and there's a cause for such changes and effects that the changes bring about in a woman. This is not necessarily the case and understanding of all women visiting the antenatal clinic, although it might be the ruling paradigm, even for midwives of African origin.

2.7.3 Holistic health paradigm

In the holistic view, the forces of nature must be kept in natural balance. Human life is an aspect of nature. If human life is disturbed, imbalance occurs, and this results in disease (Andrews & Boyle 1995:27).

According to May and Mahlmeister (1994:171), many cultures uphold the notion of maintaining balance in the woman's physical, emotional and spiritual being during pregnancy. A pregnant woman, therefore, has to avoid certain types of thoughts, emotions or interactions that may cause imbalance within her body. Ntoane (1988:21) points out that, according to the Batswana, having unbalanced emotions or temper in pregnancy causes misfortune.

The holistic health paradigm coincides with Florence Nightingale's view that emphasises nursing's control of the environment so that patients should heal naturally (Andrews & Boyle 2003:78)

According to Andrews and Boyle (2003:78), illness is the outward expression of disharmony. This disharmony may result from seasonal changes, emotional imbalances or any pattern of events. That is why the woman's feelings about pregnancy are explored during the first antenatal visit. This is done in order to determine the pregnant woman's emotional stability and whether or not both the woman and the husband have accepted the pregnancy positively. The family support system is also determined, as well as the cultural background and the socio-economic status of the woman. Coping mechanisms and patterns of interaction are also identified to determine whether the woman is holistically ready for the pregnancy, which would contribute to her wellbeing as an individual (Bobak & Jensen 1991: 238).

Buchanan (1987:52) asserts that the client may be subjected to stressors at any time, and the nurse has to use collaborative decisions to assess with the client the sources of such stress. In this study, this assessment is done to maintain balance in the pregnant woman and to provide holistic care.

2.8 CULTURAL BELIEFS AND PRACTICES OF SOTHOS RELATING TO HEALTH AND ILLNESS IN GENERAL

The Sothos have certain cultural beliefs and practices that relate to health in general. The researcher found it important to report on these because they have a bearing on the antenatal beliefs and practices of the Basotho.

According to Hammond-Took (1989:79), the Sothos prevent illness caused by witchcraft and sorcery by using medicines to protect their homes. In addition, they make extensive use of urine and sea water to sprinkle around a homestead to weaken harmful medicines and powers. Witches are believed to have *fisa* (ritual heat) and cooling urine, in particular, will immediately kill their familiars if poured over them.

In addition to the general protection of the homesteads, personal charms are used against witchcraft and sorcery. Another important aspect is that if illness is diagnosed as sent by an ancestor, no other medicines are used except the medicines of the home. The use of these medicines is always combined with ritual killings, or libations of beer or snuff.

2.9 THE NAME *BASOTHO* AND HOW IT FITS INTO THE STUDY OF THE BELIEFS AND PRACTICES OF SOTHO ANTENATAL WOMEN

In this section, the researcher discusses aspects from the literature pertaining to the historical background of the name **Basotho.** The name **Basotho** is important to report on in this section because women in this study are from the Basotho clan. In order to understand the beliefs and practices of Sotho antenatal women, it is important to understand the name and origin of this clan.

2.9.1 The name *Basotho*

According to Tsiu (2001:11) (cited by Ellenberger (1912:34), the historical establishment of the Basotho and their clan system dates back to the eighteenth century. According to Ellenberger (1912:34) (cited in Tsiu 2001:11), the Basotho name was derived from the name "*Abashuntu*" a derivative of the name "*uku shunta*" meaning "to make a knot". The then Bapeli, who were the very first people to be called "*Abashuntu*", used to wear a breech cloth with three ends, one of which passed between the legs and joined the other two in a knot behind. In the researcher's experience, this mode of dress is called "*tshea*". This designation, though bestowed in derision, was adopted with pride by the Bapeli, and later by other tribes similarly clothed and was the origin of the present term "*Basotho*".

2.9.2 Historical establishment

The first inhabitants of Lesotho were the people of three small clans from the banks of the Tugela, namely the Maphetla, the Mapolane and the Baphuthi (Tsiu 2001:11). These tribes were troubled by the Amahlubi and decided to cross the Drakensburg Mountains about the year 1600 on their way to Lesotho. The other Basotho tribes, including the Baphuthing, Makgolokwe, Basia, Batlokwa, Bafokeng, Bakwena, Bahlakoana, Dihoja, Bataung and others, all lived undisturbed until the time of the Difaqane in 1822.

According to Lye (1967:107-131), the Southern Sotho and Tswana had segmented following the invasion by the Zulu king Shaka. The Southern Sotho, under the leadership of Moshoeshoe, gathered as a nation on a larger scale. These were Basotho from various tribes. Moshoeshoe founded what we today know as the Basotho. According to Tsiu (2001:11), this term is used today

to refer to the Basotho, who may be referred to as Basotho of Qwa-Qwa, Lesotho, Bloemfontein or anywhere in South Africa.

2.10 PREGNANCY

2.10.1 Medical perspective of pregnancy

According to *Mosby's Medical and Nursing Dictionary* (1986:914), pregnancy is the gestational period, comprising the growth and development within a woman of a new individual from the day of conception to birth. Pregnancy lasts approximately 266 days (38 weeks); clinically, it is said to last for 280 days (40 weeks).

According to Nel (1995:21), the following signs and symptoms are a diagnosis of pregnancy:

- amenorrhoea
- morning sickness
- urinary frequency
- breast enlargement and tenderness

Other symptoms of pregnancy include

- desire for food that did not previously enjoy preference
- increased growth of the hair
- increased vaginal discharge

2.10.2 Diagnosis of pregnancy in different cultures

Chalmers (1988:13) states that amongst the Zulus, pregnancy is recognised by the cessation of menstruation, enlargement and pigmentation of breasts, presence of colostrum, appearance of food cravings and chloasma.

According to Sparks (1990:155), both trained and untrained traditional birth attendants diagnose pregnancy in the first trimester by noting the enlargement of breasts as well as changes in eating habits.

According to Okafar (2000:189), in Eastern Nigeria and most parts of rural Nigeria, pregnancy and childbirth are considered family events to be guided by experienced mentors in the family and are thus not left in the hands of young and inexperienced couples alone.

2.10.3 Perception of pregnancy as a normal state or an abnormal state of development according to different world-views

The beliefs and practices of pregnant women in different cultures, to a great extent, determine such women's view of pregnancy. According to Isenalumbe (1990:192), the justification for home delivery is that pregnancy and childbirth are normal physiologic processes, while May and Mahlmeister (1994:170) state that in Western countries, pregnancy is viewed as a condition that necessitates medical observation.

Kuckelman Cobb (1995:359) states that women in Portugal see pregnancy as a natural event that doesn't really necessitate medical intervention. This is confirmed by Cannon (1995:108-109), who states that normally a traditional birth attendant will only see a woman if she comes to her with antepartum haemorrhage after a fall, walking too far or carrying heavy loads. This confirms that pregnancy is seen as a natural event.

Lew (1991:48) points out that child-bearing is not an illness according to the Southeast Asians, therefore the concept of seeking health- related advice during this period is strange to them. Nompanda (1999:10) states that Pondos do not view pregnancy as an illness but there's a value placed on children and women should stay healthy all the time during pregnancy and have a safe delivery.

From the above, it is clear that pregnancy is viewed differently by different cultures as natural or "not that natural" and that pregnancy is conceptualised and defined, as well as lived in these broad terms.

As indicated, pregnancy is regarded as a condition that necessitates continuous medical observation in Western terms (see section 2.3.1). According Bennet and Brown (1998:24), antenatal women attend the clinic as early as the twelfth week of pregnancy or as soon as pregnancy has been confirmed. The reason for this is early detection of abnormalities. On the other hand, with the advent of increased cultural sensitivity and human rights, some women choose to go to the clinic late in pregnancy as long as they remain healthy.

2.10.4 The Sotho perspective on pregnancy

In Sesotho an expectant mother is attended to by people to whom she is related by blood. According to the Basotho, pregnancy is an important rite of passage and the Basotho attach a great importance to the birth of the child. The child is born at the mother's home and is named after the paternal parents (from the researcher's experience).

2.11 ANTENATAL CARE

2.11.1 History of antenatal care in South Africa

According to Sellers (1993:xv-xvii), midwifery in South Africa started in 1652 after the Dutch East India Company established a refreshment station at the Cape. At that time regulations stated that midwives had to be examined and licensed. However, there were still midwives who were untrained, but these were rural old women who attended to rural women at the Cape. This occurred because there were not enough sworn midwives for all the people who required their services.

At the beginning of the nineteenth century, a Doctor Leishing proposed that a midwifery school be established, but this was not established until 1810. In 1867 Sister Henrietta Stockdale was trained as a midwife. Sister Stockdale became the head of a midwifery school although she herself was not formally trained. The first regulations for the certification of midwives were gazetted on 31 July 1892. Registration was voluntary, but males who were not doctors were excluded.

2.11.2 The history of antenatal care in other countries

According to Maloni, Cheng, Liebl and Maier (1996:48), in the early 1800's prenatal care was surrounded by myth, cultural tradition and taboo. Several factors led to the development of the current model for prenatal care delivery, such as convulsions and pre-eclampsia in pregnancy. The first prenatal clinic was established in Dublin in 1943. Women who registered for delivery were examined physically and those with symptoms of pre-eclampsia were treated. This resulted in a decreased rate of pre-eclampsia and maternal death. Nurses played a key role in the development of prenatal care because they conducted deliveries which mostly occurred at home. They also conducted home visits and taught women about childbirth and infant care.

As can be deduced, the cultural view on the normality and naturalness of pregnancy could influence the perception of the necessity of routine prenatal care as well as the gestational period at which a woman can attend clinic.

2.11.3 Factors influencing midwifery experiences in antenatal care

Several factors influence antenatal care as discussed below.

2.11.3.1 The education and training of midwives

The education and training of midwives is influenced by Western medical thought. This has led to the view that traditional African ways are backward and unscientific (Selepe & Debera 2000:96-101). Thorne (1993:1931-1941) points out that the Western biomedicine is rapidly superseding other health belief systems.

The training of midwives has therefore contributed to underrating alternative practices other than the biomedical view. For this reason, the researcher decided to conduct this study.

2.11.3.2 Inadequate formal education and training of midwives

Most midwifery books used in South Africa uphold eurocentric rather than afrocentric values. This results in a lack of understanding of the cultural values upheld by African maternity clients,

including Sotho antenatal women. The South African Nursing Council rules and regulations for the training of midwives R2488 together with the guidelines do not as yet include multicultural aspects of midwifery care, but still focus on European values.

2.11.3.3 Uncertainty about the role of the midwife in the care of Sotho women during the antenatal period

Midwives in South Africa are still uncertain about their role in the care of Sotho antenatal patients. This was evidenced by their lack of understanding of the practices of these women in pregnancy. For example, when such women come to the clinic with certain ointments prescribed by their custom, this elicits feelings of rejection on the part of the midwives. This therefore makes it difficult for midwives to care for the women through a lack of understanding.

The beliefs and practices of a particular group influence the health practices of the group. It is therefore sometimes difficult to care for people whose culture is not known to the person providing care.

2.12 THE SOTHO PERSPECTIVE ON ANTENATAL CARE

Most of the women at Bolata adhere to certain cultural beliefs and practices during pregnancy. The researcher observed this every time on antenatal clinic days and in the village. The fact that the Sotho antenatal women still adhere to cultural beliefs and practices calls for midwives to understand these beliefs and practices. At the clinic in Bolata, some midwives negated such practices that are so important to the Sotho antenatal women observing them. Most of the women in this clinic used to wear strings on their waists and applied ointment, which to them was an important symbol that denoted significant beliefs in the antenatal period. They also used herbs, protected themselves from bad spirits, and wore clothing prescribed by culture. Practices like these accompanied the avoidance of certain acts regarded as taboo in the Basotho culture.

Leféber (1994:17) reports taboos imposed on Sotho, Zulu and Xhosa women in South Africa, such as going on certain pathways believed to harbour bad spirits, sleeping during daylight, which is believed to cause delayed labour, and plaiting hair, which is believed to form a knot.

Chalmers (1988:12-19) states that coitus in pregnancy is generally accepted in South Africa in the early months to strengthen the embryo, but among the Basotho and Pondo it is restricted in the last few months of pregnancy.

2.13 TRADITIONAL MEDICINES USED DURING ANTENATAL CARE

The researcher reviewed literature on the beliefs and practices of certain cultures globally and found the following on the use of herbs and traditional medicine:

- Use of herbs by Mexican women to remain healthy during pregnancy (Cosminsky 1977:10).
- Malawi women were given medicine for three months to widen the maternal passage (Nolte 1998:63).

2.14 ROLE OF TRADITIONAL BIRTH ATTENDANTS DURING PREGNANCY/ANTENATAL CARE

Antenatal care by traditional birth attendants is a significant aspect because it clearly delineates the beliefs and practices of pregnant women from traditional African orientation.

According to Sparks (1990:155), prenatal care from traditional birth attendants in Zimbabwe is attended by primigravidas as well as multigravidas. However, formalised prenatal care is provided to primigravidas at seven months when the pregnant woman leaves her husband's village and returns to her parents' home. A ceremony called *masungiro* is held at the pregnant woman's home. After *masungiro*, a pregnant woman visits a family member who is a traditional birth attendant for formal care during pregnancy. The woman is given a special drink to open and widen the pelvis for birth. The traditional birth attendant also widens the woman's introitus manually until her whole hand can be inserted into the vagina.

Sparks (1990:155) states further that in the ninth month, abdominal palpation is done to diagnose twin pregnancy and external version is also done for a transverse lie, though the latter procedure is dangerous and trained midwives have been told not to do it. After all the above procedures have been done, the pregnant woman has to discuss any grievances and bad deeds she has done with

the *ambuya* (traditional birth attendant) and then "morally cleansed, she may anticipate an easy delivery" (Sparks 1990:155-156). Literature on the advice or instructions of traditional birth attendants to pregnant women was also reviewed because this has a bearing on the beliefs and practices of such women.

Sparks (1990:155) discusses the advice or instructions given by traditional birth attendants on nutrition, rest and exercise (except for normal chores), sexual intercourse, and the importance of purity so that the ancestors should protect the birth.

In Bophuthatswana, traditional birth attendants advise women during pregnancy (Ntoane 1988:21). See table 2.1 on the differences between trained and untrained traditional midwives' instructions to pregnant women. These differences may influence antenatal women to either adhere to harmful practices and reject the safe practices of trained traditional birth attendants .

The differences and similarities that appear below might influence antenatal women's practices because trained traditional birth attendants encourage harmless or safe practices while the opposite usually occurs with untrained traditional birth attendants.

Table 2.1 Differences between trained and untrained traditional midwives

TRAINED TRADITIONAL BIRTH ATTENDANT	UNTRAINED TRADITIONAL BIRTH ATTENDANT
Emphasis on proper nutrition	Avoidance of eggs but proper nutrition
Avoidance of sleep during day	Avoidance of sleep during day time
Exercise	Exercise not emphasised
Referral of high risk cases to clinic	Referral to clinic not emphasised
Prenatal teaching is important	Prenatal teaching is less important
Prenatal clinic visit advocated	Prenatal visits not stressed
Do not perform external version	Perform external version
Give few traditional drugs	Frequent use of traditional drugs
Able to identify high risk patient	Less able to identify high risk patients
Attempt good hygiene	Good hygiene poorly understood

(Ntoane 1988:21)

Kuckelman Cobb (1995:358) found variations from culture to culture in the degree to which a lay midwife is involved in prenatal care. Kuckelman Cobb (1995:358) cited the following examples in the use of lay midwives in prenatal care:

- The *dai* (traditional midwife in India) is called during the prenatal period only if there is a complication, otherwise she comes only when labour begins.
- Prenatal visits in the Mayan Indian community to obtain a reproductive history, family attitudes and relationships, identifying a delivery helper at home, providing an abdominal massage, checking the position of the baby and giving advice on the use of vitamins.

According to Lang and Elkin (1997:151), in rural Guatemala traditional midwives visit the pregnant women pre-natally. These visits are not regularly scheduled and often begin late in pregnancy. During these visits traditional midwives perform abdominal examinations and attempt to do external version if the foetus is in a transverse position. Various dietary recommendations are also offered.

Miller, Imam, Timouri and Wijnker (1995:153) state that the trained traditional birth attendants visit each pregnant woman on two to five occasions before delivery, giving advice on immunisation, nutrition and hygiene. Prenatal evaluation included questions about bleeding, fever, headache, foetal position, oedema, anaemia and conditions of the breasts.

A literature review on methodological issues revealed that qualitative research is the method of choice for an insider's perspective on cultural beliefs and practices.

2.15 EMPIRICAL LITERATURE REVIEW

2.15.1 Methods used in literature review

A computer literature search was done in Unisa OASIS and assistance was sought from the library staff for books and interlibrary loans.

The following information was reviewed.

2.15.2 Cultural assessment in antenatal care

According to Bobak et al (1995:17) and Novak and Broom (1995:147), midwives need to be familiar with each woman as an individual and not stereotype such a woman, because although a woman may belong to a certain cultural group, she might not uphold some of the practices in the cultural group. Therefore validation of each woman's cultural beliefs, if any, is useful. When equipped with this knowledge, the midwife has to support and nurture those beliefs that promote physical and emotional adaptation to pregnancy and carefully explore the harmful beliefs with the patient and re-educate the patient in order to modify such practices. The need for examining each woman's beliefs system in this study is that exploring them will help in antenatal teaching of such women.

2.15.3 Communication (with the focus on touch)

To be able to communicate effectively with antenatal women, midwives/*accoucheurs* should be aware of racial, cultural and social factors that make people what they are and affect how they behave. Midwives should assess the use of touch as a means of communication because some women may be distressed by an action such as stroking the hair of a Southeast Asian woman (Dickason, Silverman & Kaplan 1998:35). According to Lew (1991:149), Cambodian women are extremely modest and many of them were raped during the Khmer Rouge rule so these women might not accept pelvic examinations because these can be psychologically stressful.

2.15.4 Space in antenatal care

According to Dickason et al (1998:36) and Giger and Davidhizar (1990:199-202), the culture in which people live determines their views of personal space. In this regard Dicakson et al (1998:35) assert that the loss of control over personal boundaries is frequently mentioned by Southeast Asian women as a negative aspect of maternity care in the United States, while Vietnamese women often prefer a female friend to be present during delivery.

Midwifery implications, then, are that care expressions, patterns and practices, such as getting closer to a woman on assessment, especially by a male nurse, are not acceptable in other cultures. This affects holistic health care in as far as the sunrise model in culture care theory is

concerned. It is very important for midwives to understand the above variations in some ethnic groups in order to give culturally congruent maternity care.

2.16 BELIEFS AND PRACTICES DURING THE ANTENATAL PERIOD

There are two major categories of beliefs which influence pregnant women's practices, namely prescriptive and restrictive beliefs.

2.16.1 Prescriptive beliefs

In a study conducted in South Africa Leféber (1994:15) refers to West (1981) who found that the Sotho tribe was seen to be taking certain precautions in order to protect the mother and foetus against witches and bad influences from the supernatural world. Practices like walking in the street at night are also avoided by pregnant Sotho women.

In her study of traditional birth attendants in South Africa, Nolte (1998:59) found that traditional birth attendants prescribe medicine for mother and baby to keep evil spirits away.

The link between Leféber (1994:15) and Nolte (1998:59) indicates an understanding that certain actions are prescribed by culture. The following aspects relating to the prescriptive practices of pregnant women in different cultures were encountered in the literature.

2.16.1.1 Rest and activity

Bobak and Jensen (1993:292) state that cultural groups encourage women to be active in pregnancy but not to engage in strenuous exercise to ensure that the baby is healthy but not too large. According to Clark (1996:32), exercise is suggested as a remedy for illness in Asian cultures. Clark (1996:32) also states that Indians remain active during pregnancy to aid the baby's circulation.

Bobak and Jensen (1993:292) and Clark (1996:32) confirm that activity is important during pregnancy. Some cultures prescribe how active a woman should be during pregnancy. Bobak and Jensen (1993:292) point out that Filipino women may be cautioned that any activity is dangerous

and inactivity constitutes a protection for mother and child. These references show the necessity that rest and activity as prescribed by each culture should be investigated (in this case Sotho antenatal women).

In Western culture, exercise is a common prescription because Bennet and Brown (1998:651-652) point out that exercising the abdominal muscles antenatally will ensure a speedy return of both the pelvic floor muscles and the abdominal muscles to their normal tone post-natally, effective pushing in labour and the lessening of backache in pregnancy.

According to Cosminsky (1977:17), massages can be done at various times during pregnancy because they are beneficial to the woman and promote relaxation. Nolte (1998:63) also found that massages to the abdomen and back are done by traditional birth attendants. Cosminsky (1977:17) and Nolte (1998:63) confirm that a form of exercise in pregnancy is prescribed in African cultures, as well as relaxation methods.

2.16.1.2 Sexual activity

According to Bobak and Jensen (1993: 292), some cultures view sexual relations as normal during pregnancy. Chalmers (1988:13) states that coitus is generally accepted and encouraged in the early months to strengthen the embryo, but amongst the Basotho and Pondo it is restricted during the last few months of pregnancy. It is therefore evident that coitus is permitted and even prescribed earlier in pregnancy. It is therefore important that Sotho antenatal women's views be investigated in this regard.

2.16.1.3 Use of herbs and traditional medicine

According to Cosminsky (1977:10), herbs and teas are often administered to Mexican women to remain healthy. In a study in Malawi, women were given traditional medicine for three months, which was believed to widen the maternal passage. Nolte (1998:63) found that traditional birth attendants gave the following medication to pregnant women: herbs to facilitate quick delivery, *muti* enema to empty the lower bowel, herbs to facilitate bleeding post-natally because retained blood will make the mother ill. The question of the practice of Sotho women remains.

Both Cominsky (1977:10) and Nolte (1998:63) confirm the use of herbs in pregnancy by women from different cultures. This reinforces that some antenatal women take remedies and prescribed herbs to stay healthy (Nompanda 1999:10).

2.16.1.4 Antenatal clinic attendance

It is necessary to report on clinic attendance whether in Western medical terms or as visits to traditional birth attendants because this has a bearing on the practices of antenatal women. In her study on women and health care in Africa, Gullaime (1991:182-183) found that women's choice of health care for themselves and their children varies according to whether they seek prenatal care, postnatal care or treatment for illness or for infertility. Gullaime found women's responses varied, and one third of the women chose traditional care alone. In this category, women selected home remedies when they felt sick.

According to Gullaime (1991:182-183), 61 percent of women in their childbearing years go to a hospital or maternity home and such women attend prenatal consultations; 35 percent of pregnant women remain at home to be looked after by the family, and 19 percent of all women, however, receive no prenatal care, because the health care centres are too far away, too expensive and too inhabitual.

The arguments presented by the Gullaime (1991:182-183) indicates that there are various differences and commonalities among the communities a midwife is faced with in her day to day delivery of service. Rice (2000:22-34) maintains that it is important to ask individual women in midwifery care about their wishes and needs concerning traditional practices. In the implications for birthing services, Rice (2000:22-34) asserts that due to modernisation and Westernisation, traditional childbearing practices are displaced by Western procedures, but this has not happened in the Hmong society despite living in a Westernised country like Australia. This is an indication that because some women still adhere to traditional, cultural practices during pregnancy, they might not prefer to attend the antenatal clinic.

2.16.2 Restrictive beliefs

Leféber (1994:17) cites Chalmers' (1988) report that some taboos were imposed on pregnant Sotho, Zulu and Xhosa women in South Africa. Taboos on the following activities were reported:

- Moving on certain pathways that may harbour evil spirits or wizards, witches or wild animals. The argument is that this may harm the baby.
- Plaiting hair may form a knot in the umbilical cord.
- Sleeping during daylight may delay the birth of the baby, during delivery.
- Peeping through windows and doors may cause the foetal head to protrude, but not proceed through the vaginal canal.
- Sexual intercourse during the last trimester may result in a sperm- coated baby at birth.

Ntoane (1988:21) in her study of traditional birth attendants in Bophuthatswana discussed the following taboos in table 2.2.

Table 2.2 Taboos and consequences of their transgression

TABOO	CONSEQUENCES OF TRANSGRESSION
Plaited hair during pregnancy	Cord winds around the neck
Sleep during day time	Baby will be asleep on day of delivery
Eating standing	Lie will change
Eating tendons	Delays labour, blocks delivery path
Eating uncrushed egg	Labour obstruction
Drinking water whilst standing	Baby will have a long head
Having temper during pregnancy	Misfortune: still-birth

(Ntoane 1988:21)

2.16.3 Food restrictions

Food restrictions in some cultures during pregnancy were also encountered in the literature review. According to Dickason et al (1998:229), culture has an impact on what people eat, especially prenatally. Nolte (1998:126) points out that the diet of a pregnant woman should be balanced. The intake of proteins must be double during pregnancy because 5 grams to 6 grams of proteins are deposited daily, therefore it is imperative for such proteins to be replaced.

According to Andrews and Boyle (1995:103), in some cultures, eating rabbit, goat, pork or crab can cause unwanted physical characteristics to an unborn baby. According to the researcher's experience with Sotho antenatal women, they believe that eggs should not be taken in pregnancy because they harden the amniotic membranes. Therefore, it is important that such beliefs be investigated so that proper dietary replacement can be done. Educating pregnant women about alternative foods that contain proteins should be done. Leininger (1988:16) states that "patterns of eating, food procurement and food use by diverse cultures in their unique ecological context are major areas of study to help nurses understand the meanings of wellness, illness and disease".

Leininger's statement needs careful consideration because even if people stay in one geographical area, their eating patterns are determined by the area in which they live as well as influences from people of other cultures who live around them, such as the moving of rural Black people into urban suburbs in South Africa.

According to Leininger (1989:22), the way clients comply with diet or use of food recommended by health care workers in pregnancy may also be affected by the hot/cold theory. According to Andrews and Boyle (1995:103), hot foods are avoided because they are believed to cause overexcitement, inflammatory reactions, sweating and fatigue.

The above references are a confirmation that it is significant to explore the food practices of different cultural groups (in this case, Sotho antenatal women).

2.17 CONCLUSION

Literature on culture, world-views, pregnancy, antenatal care and beliefs in antenatal care attendance, and the role of traditional birth attendants was reviewed and discussed.

Chapter 3 deals with the research methodology and design.