CULTURAL PRACTICES REGARDING ANTENATAL CARE AMONG ZULU WOMEN IN A SELECTED AREA IN GAUTENG

by

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submitted in fulfilment of the requirements

for the degree of

MASTER OF ARTS

in the

Department of Advanced Nursing Sciences

at the

UNIVERSITY OF SOUTH AFRICA

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FEBRUARY 2002
DECLARATION

I declare that "CULTURAL PRACTICES REGARDING ANTENATAL CARE AMONG ZULU WOMEN IN A SELECTED AREA IN GAUTENG" is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

SIGNATURE
NB Ngubeni

DATE
30 July 2002
Acknowledgements

I wish to express my sincere gratitude to God the Almighty for being with me this far and to many people whose support and assistance have made the completion of this study possible.

In particular I would like to thank the following people and organisations:

♦ Professor SW Booyens, my supervisor, for her wise counsel, support, encouragement, guidance and special kindness.
♦ Mrs JE Tjallinks, my joint supervisor, for her guidance.
♦ Dr DM van der Wal, for his expert knowledge on the data analysis chapter.
♦ My husband, for his support and endurance.
♦ My four children, Mthokozisi in particular for his warmth, understanding, offers of assistance and loving.
♦ The Medical Officer of Health, Dr MAR Selahle, for allowing me to conduct the study in his clinic.
♦ Informants, for their time and honesty and for their genuine interest, because without them this dissertation would not have been possible.
♦ Mr Sam Kekana, for his willingness to help, understanding, and going out of his way to search for books at the Unisa library.
♦ The midwives at the antenatal clinic for their kind cooperation.
♦ Phili Sidziya, a friend, for her willingness to help.
♦ Mr and Mrs Velaphi and Cynthia Mabuza, and Sylvia Magagula, my fellow Christians who dedicated themselves wholeheartedly to typing my study. May God bless and keep them.
CULTURAL PRACTICES REGARDING ANTENATAL CARE AMONG ZULU WOMEN IN A SELECTED AREA IN GAUTENG

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Summary

The registered midwives are engaged in continuous health education lessons in antenatal visits, discouraging antenatal clients from using harmful traditional and cultural practices in an attempt to preserve pregnancy to term. Despite the registered midwives’ efforts, the clients continue to use harmful cultural methods, which are life-threatening to both the mother and the foetus in utero. The prenatal clients perceive the registered midwives as not being sensitive to their culture.

The results of this study revealed that health education in antenatal clinics should be collaborative: that is, the people who have influence over the clients’ pregnancy, like the mother-in-law, the traditional practitioners, clients and their family members, should be involved by the midwives during the preparation of pregnancy lessons and health education lessons on how to preserve pregnancy to term according to scientifically proven methods.

KEY TERMS:

Attitude, beliefs, mother-in-law, instill guilt, midwives, pregnant women, traditional birth attendant, traditional chemist, traditional medication, traditional healer, traditional practices, transcultural, wizards.
Dedication

Dedicated to my late parents,

Gedion and Lillian Spengane,

for I am what I am today because of them
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CHAPTER 1

Cultural practices regarding prenatal care among Zulu women in a selected area in Gauteng

1.1 INTRODUCTION

This study is about cultural and traditional practices of pregnant Zulu women with the aim of preserving their pregnancy to term. The focus of the study was on cultural practices regarding prenatal care among Zulu women in a selected area in Gauteng.

Health care is both an art and a science. The "healing arts" side of health care involves a holistic health process which focuses on the person as a whole without segmenting the person into diseases or healthy organ systems (Valentine 1989:1). In the field of nursing, professional caring is viewed as "those cognitive and culturally learned action behaviors, techniques, processes, and patterns that enable (or help) an individual, family or community to improve or maintain a favorably healthy condition or way" (Leininger 1981:7). Though there can be caring without curing, there can be "no curing without caring"
(Leininger 1981:6). If curing or healing is inhibited by a lack of caring, then it is important to understand the caring phenomenon from a holistic approach.

"Caring" from a holistic perspective entails a 'Gestalt' approach: that is, caring for a patient or client in "totality", including the cultural point of view. Thus experience shows that caring which excludes cultural sensitivity is perceived by the recipient as incompetent.

1.2 BACKGROUND TO THE PROBLEM

The researcher, who was employed in one of the satellite clinics of the East Rand in the Gauteng Province in 1986 as a registered midwife in the "X" prenatal clinic, was alarmed by the high number of pregnant mothers defaulting on their prenatal visits. No fewer than 75,0% of previously seen prenatal clients just did not turn up for their prescribed return visits at the clinic. An interview with the midwife in charge of the prenatal clinic revealed that out of twenty prenatal clients seen in one day on their first visit, only about seven clients return for the next visit (Personal Interview with Midwife 2001).

The researcher herself encountered the following incidents at the clinic:

✧ Two situations involving cultural dependency

Mrs "A" was a pregnant Zulu client with a previous Caesarean section for cephalo-pelvic disproportion (disproportion between the size of the foetal head and the size of the mother's pelvis). During her prenatal visit she was informed that because she had a previous Caesarean scar, the delivery would be better monitored in a hospital, because of the need for specialised technical equipment to monitor both the mother and the foetus, equipment which the clinic did not have. It was further explained to the client that she should attend the prescribed prenatal visits at the clinic, but for the delivery itself she would be referred to a neighbouring hospital with a referral letter with her pregnancy details. She was also reassured, in order to allay her anxiety, by taking her to a well-baby clinic and showing her other mothers who had had a problem like hers, and had delivered successfully in the hospital and were now bringing their babies to a well-baby clinic. According to the South African Rules and Regulations, R2488, as amended (SANC 1990),
a midwife must give the client return dates, which are weekly during the last trimester of pregnancy. That was the last time the client was seen in the prenatal clinic. When defaulters were being traced, she was nowhere to be found. At the time of the delivery she was brought into the clinic by her family members with foetal asphyxia, draining meconium-stained liquor, which indicated foetal distress. She was transferred to hospital by ambulance. She ended up with foetal death, postpartum haemorrhage and postpartum bladder atony, due to previous adhesions. The report from her family members was that an ancestral ceremony had been performed so that the ancestors would render her delivery safe at home, for if she were to deliver in hospital, as she had been told at the clinic, the hospital would obviously operate on her again, thus rendering her physically weak as a woman.

In a second example, a primigravid pregnant Zulu prenatal client attended a health education session where the registered midwife discouraged the ingestion of traditional medication during pregnancy and further explained its dreadful effects on the mother and its teratogenic effects on the foetus. Despite all the health education given during prenatal visits, the culture of the Zulus recommends strict adherence to the mother-in-law's instructions in order to preserve pregnancy to term. The client continued to consume traditional medication. This was evidenced by the fact that she was admitted to the clinic with very strong contractions and the cervix was already two centimeters dilated. She ended up with maternal and foetal distress.

Even though this client at first denied having used traditional medication, she eventually admitted to using it, stating that it was imperative for her to abide by her mother-in-law's orders. These experiences and many others resulted in the researcher's embarking on this study.

1.3 AIM OF THE STUDY

The aim of the study was to explore the nature of the cultural practices of Zulu pregnant urbanised clients in their attempts to preserve pregnancy to term.
1.4 PURPOSE OF THE STUDY

Following the background of the study and the nature of the background, the purpose of the study was to investigate and discover the perception of cultural practices regarding prenatal care among Zulu women in a selected area in Gauteng.

1.5 RESEARCH QUESTION

The question put to interviewees was: "Would you please explain in detail how you traditionally preserve pregnancy to term?"

1.6 RESEARCH OBJECTIVES

The following research objectives were formulated to guide the researcher. In this study the researcher aimed at:

- exploring the cultural practices of Zulu women during pregnancy
- developing guidelines for midwives who care for Zulu pregnant women
- developing guidelines for midwifery curricula regarding prenatal care for Zulu women

1.7 IMPORTANCE OF THE STUDY

There is a need to increase awareness of, and knowledge about this phenomenon. It is hoped that the study will help midwives and other healthcare professionals to acknowledge and understand Zulu women's cultural practices regarding prenatal care.

The study aimed to address the need to pay attention and to be sensitive to the cultural practices of diverse cultures. It is important for healthcare practitioners to anticipate which type of cultural care to render to prenatal clients from diverse cultures. This study's findings could be important in identifying what impact knowledge of cultural practices during prenatal care could have on the healthcare sector as well as nursing education. Guidelines for healthcare practitioners could then be identified that could make a
contribution to competent cultural care during pregnancy.

In view of the fact that all clients should receive competent cultural care, this study’s findings could be of significance and could be utilised in the planning and implementation of nursing care plans as well as nursing curricula.

1.8 SIGNIFICANCE OF THE STUDY

The contribution that the proposed research could make to the body of nursing knowledge is to bridge the gap between the pregnant clients’ cultural practices and their perception of competent care because:

- Their cultural and traditional practices to preserve pregnancy to term would have been explored and acknowledged.
- Maternal and foetal complications and deaths caused by traditional practices of pregnant Zulu clients would be minimised.
- Thus the goal of the World Health Organization (WHO), which is “Health for All”, would be attained.

1.9 RESEARCH METHOD

This study has used a qualitative research approach, in that it attempts to capture the human experience within the context of those who experienced it (Polit & Hungler 1995:16). Qualitative research includes the systematic collection and analysis of subjective data (Parse, Coyne & Smith 1985:3; Polit & Hungler 1995:15). It takes into account human beings’ participation in a situation by using the raw data of informants in written and oral descriptions (Parse et al 1985:16). The researcher chose a qualitative research approach because it was the most appropriate design for answering the aim and purpose of the study, as the research question and objectives indicate.
1.9.1 Research approach and design

As indicated above, the researcher used the qualitative approach for this study. The phenomena under study were cultural practices regarding prenatal care among Zulu women in a selected area in Gauteng. The design was descriptive.

1.9.2 Population and sample

The population for the study was a number of pregnant primigravid clients visiting an prenatal clinic in Gauteng. Polit and Hungler (1995:230) describe the accessible population as those that conform to the eligibility criteria, such as those described in paragraph 3.5.1.2 who were accessible to the researcher for the study. A sample refers to the subset of units of elements (humans) that compose the population (Polit & Hungler 1995:230). In this study the elements were named informants. Field and Morse (1990:138) describe an informant as the one from whom the majority of the information is obtained. A non-probability, purposive sampling design was used to select informants that were information-rich for the study. Those informants met the eligibility criteria listed in paragraph 3.5.1.1. The informants were contacted and agreed to participate in the research (before the focus group interviews) with informed consent (Streubert & Carpenter 1999:58).

The size of the sample was determined when saturation of information occurred and when there was no further need to increase the number of informants. This means that repetition and confirmation of previously collected data occurred and no new insights were being generated from new data (Streubert & Carpenter 1999:22-23; Tesch 1990:95).

✦ The target population

The informants were selected according to the following criteria. They had to be

- South African Zulu women
- residing at the East Rand for two years or more
- primigravid, with 36 weeks' gestation period
1.9.3 Data collection approach

The data for this research was gathered through conducting focus group interviews as well as personal interviews.

- Focus group interviews

Focus group interviews were used for this study. Bosch (1987), in Morrison and People (1999:62), defines the focus group technique as a "qualitative research technique used to obtain data about feelings and opinions of small groups of participants about a given problem, experience, service or other phenomenon". Morgan (1996), in Griffin and Sullivan (2000:19), describes a focus group as a research technique that collects data through group interactions on a topic determined by the researcher.

The focus group interviews provided the informants the opportunity to explain their cultural practices during the prenatal period. The focus groups were conducted in a comfortable environment (Streubert & Carpenter 1999:23). Reflexivity, bracketing and intuiting were continuously reviewed to prepare the researcher for overriding a biased approach (Abbott & Sapsford 1998:150; Polit & Hungler 1995:636). A broad open-ended question was used to start the interview. Subsequent probing questions followed, depending on the response to the broad research question (Polit & Hungler 1995:271-272).

For the purpose of gathering more information, particularly the "taboo" based data which the informants were not comfortable discussing in a focus group, personal interviews at the informant's homes were agreed upon. The information gathered from the focus group interview was used as the point of departure for conducting the personal interviews. Probing and reflecting was used during the interviews to obtain more in-depth information.

1.9.4 Data analysis

Data analysis started soon after the first focus group interview (Tesch 1990:92). The researcher used reflexitivity, bracketing and intuiting to exclude preconceptions of the phenomenon in order to enter the world of the informant with an open mind.
A detailed discussion of the process of data analysis is presented in chapter 4 of this study. Polit and Hungler (1995:251) and Burns and Grove (1997:532) describe content analysis, which was used to analyse the data of this study. The unit of content to be analysed must first be selected, followed by the development of a category system for classifying the units of content. Quantification of categories was employed for data analysis, as described by Burns and Grove (1997:532) and Polit and Hungler (1995:251).

1.9.5 Trustworthiness

The goal of the qualitative study is to accurately represent the informants' knowledge regarding cultural practices during the prenatal period. Guba (1981) and Lincoln and Guba (1984) suggest four criteria to support trustworthiness. These criteria are credibility, dependability, conformability, and transferability. These criteria and strategies were implemented in the study to establish trustworthiness (Polit & Hungler 1995:362-363; Streubert & Carpenter 1999:28-29).

1.10 DEFINITIONS

In order to facilitate communication and to ensure that the key terms are interpreted in the same context by the researcher and the reader, the researcher has defined the terms as they were used in the study.

Culture

Helman (1996:2) argues that culture is a set of guidelines (explicit and implicit) which individuals inherit as members of a particular society, and which tell them how to view the world, how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces or gods, and to the natural environment. It also provides them with the way of transmitting these guidelines to the next generation – by the use of symbols, language, art and rituals. To some extent, culture can be seen as an inherited 'lens', through which the individual perceives and understands the world, and learns how to live within it. Growing up within any society is a form of enculturation, whereby the individual slowly acquires the cultural 'lens' of that society (Helman 1996:3). Andrews and Boyle
(1999:3) define culture as follows. "Culture represents the way of perceiving, behaving, and evaluating the world. It provides a blueprint or guide for determining people's values, beliefs, and practices, including those pertaining to health and illness. In this study, "culture" will be used specifically to depict the cultural practices of the Zulu pregnant women who reside in an urban area, not in KwaZulu-Natal. Therefore the context of the term "culture" as used in this study revolves around an urban influence, rather than being rurally rooted.

✦  Prenatal care

The aim of prenatal care is to ensure the optimum physical, psychological and emotional well-being of the woman, her unborn child and her family, by offering support and guidance, so enabling participation in the planning and delivery of her care and the nurturing of parent-child relationships (Bennet & Brown 1996:100).

✦  The selected area

The study was conducted in an urban area. The prenatal clinic where the study was conducted is situated at the East Rand in Gauteng. The informants who participated in the study were Zulu pregnant women living in the East Rand, which is an urban area.

✦  Practice

A practice is a frequent or systematic repetition, a repeated exercise. The word is also used to indicate an action that is common or habitual or done regularly, like a ceremony or observance (Concise Oxford Dictionary 1976:867).

✦  Zulu woman

A Zulu woman is a bride who has undergone a series of aggregation rites, by means of which she is gradually incorporated into the new kraal; this is not complete until about a month after the wedding (Krige 1965:147-148).
1.11 ETHICAL CONSIDERATIONS

Ethical considerations were implemented to prevent ethical dilemmas. Permission from the Medical Officer of Health of the clinic was obtained (see annexure B). Care was taken to ensure the rights of the informants. The three ethical principles of the Belmont Report, namely beneficence, respect for human dignity, and justice were followed in the study (Polit & Hungler 1995:119-126). Ethical issues pertinent to this study were consent, confidentiality and publication of the findings. These considerations are discussed in detail in paragraph 3.10 of chapter 3.

Principles of ethics in research were adhered to: written permission was requested and obtained from the authority concerned (see annexure A and annexure B). Full explanation of the purpose of the research was given to the informants in order to obtain consent. They were also assured of freedom from harm and freedom from exploitation and their right to full disclosure was maintained (Polit & Hungler 1995:134-149). Full disclosure means that the researcher has fully described the nature of the study, the informants' right to refuse participation, the researcher's responsibilities, and the likely risks and benefits that may be incurred (Polit & Hungler 1995:137). The right to self-determination was also explained, namely that informants had freedom from coercion of any type (Burns & Grove 1997:776; Polit & Hungler 1995:137).

1.12 LIMITATIONS OF THE STUDY

Limitations applicable to this study are the researcher's bias; participant effect; data collection and analysis. These aspects are discussed in detail in paragraph 5.8.

1.13 OUTLINE OF THE STUDY

This dissertation consists of five chapters, set out as follows:
Chapter 1

This chapter provides an introduction to the study, giving the background to the problem statement, research question, purpose of the study, objectives, significance of the study, research methodology, terminology and outline of the research report.

Chapter 2

This chapter provides the literature review of works on Zulu women and their cultural practices regarding prenatal care. Pregnancy from the Zulu cultural perspective and from the medical perspective is discussed. The topic of health and illness from the traditional perspective, and where pregnancy belongs as far as the Zulus are concerned, is also presented. The chapter covers

- world-view
- culture
- Zulu culture
- prenatal care
- competent cultural care
- research studies regarding the topic

Chapter 3

Chapter 3 follows with an overview of the methodology used in the study. It describes the research design, population, sampling, data collection and data analysis used in the study. Ethical considerations and measures to provide trustworthiness are also discussed.

Chapter 4

In this chapter methods of data presentation and comments of the informants are portrayed, followed by a discussion.
Chapter 5

This chapter offers conclusions, a discussion of the strengths and limitations of the research findings, and provides recommendations concerning the research presented and future research.

1.14 CONCLUSION

In this chapter the background and context of the study were described. The importance of the study and the aim, purpose, research question and objectives were explained. Relevant concepts were defined, and an outline of the study provided. A literature review follows in the second chapter.
CHAPTER 2

Literature review

2.1 INTRODUCTION

Chapter 1 provided an orientation to this study by discussing the background to the problem, the problem statement, purpose of the study, research question and objectives, importance and significance of the study, research methodology, terminology and the outline of the study. The literature review contained in this chapter is mainly centred on the cultural practices regarding prenatal care of Zulu women in an urban area in Gauteng. National and international literature were cited.

2.2 CULTURE

Helman (1996:2) argues that culture is a set of guidelines (explicit and implicit) which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces or gods, and to the natural environment. It also provides them with the way of transmitting these guidelines to the next generation – by the use of symbols,
language, art and ritual. To some extent, culture can be seen as an inherited ‘lens’, through which the individual perceives and understands the world he or she inhabits, and learns how to live within it. Growing up within any society is a form of enculturation, whereby the individual slowly acquires the cultural ‘lens’ of that society (Helman 1996:3). Andrews and Boyle (1999:3) define culture as follows: “Culture represents ways of perceiving, behaving, and evaluating the world. It provides a blueprint or guide for determining people’s values, beliefs, and practices including those pertaining to health and illness”.

2.2.1 Zulu culture

In this study the culture of the Zulus was ‘displaced’ because the study was conducted with informants who were Zulus who did not reside in KwaZulu-Natal but in the East Rand in Gauteng where there was an urban influence on their cultural practices. Their beliefs and practices regarding health and illness are discussed elsewhere.

The researcher also held an interview with midwives of the “X” clinic, which has not been included in this study by request of the midwives involved. The interview was held to add to the researcher’s information regarding the study, particularly from the professionals’ point of view.

It was discovered that some Zulus, even if urbanised or educated, abide by some rural traditional practices during pregnancy. Isihlambezo was quoted as an example; even registered midwives consume isihlambezo during pregnancy.

In the Zulu culture, the birth of a child is important, not only as the advent of the individual into the society, but as marking a further stage in the lives of its parents. The first child is especially important, for no marriage is considered complete before a child has been born (Krige 1965:61). To a woman, therefore, childlessness is the greatest of all misfortunes, for not only will she be taunted and jeered at by her more fortunate sisters, but she may even be divorced on that account, though it is more usual for her people to send a sister to raise seed to her (Krige 1965:61). Such a step will, however, not be taken until the woman herself and her family have done all in their power to promote conception. It is
believed that the woman may have been bewitched, or she may be the victim of an angry or spiteful ancestor, for reproduction of the species is regarded as the work of the ancestors (Krige 1965:61).

The cultural practices of the Zulu women during pregnancy are discussed elsewhere.

2.3 WORLD-VIEW

Craffert (1996:1) argues that world-views are part of other systems with which they are in dialectical interaction. Together with at least social institutions and structures and certain customs and conventions, a world-view contributes to a cultural system. Being in a dialectical interaction with social institutions, world-views shape, but are in part shaped themselves by, the institutions. Being a mental construct, a world-view influences social institutions and is affected by changes in institutions and the environment. One such institution is the healthcare system (Craffert 1996:1). A world-view itself consists of at least world-view elements (such as views on the self, the other, nature and time) and the fibres which keep these elements together — referred to as an ethos (consisting of categories such as causality, real and unreal). These aspects interact so that, for example, views of the self are determined by views on causality (Craffert 1996:1).

A group's world-view reflects a group's total configuration of beliefs and practices and permeates every aspect of life within the culture of that group. Members of a culture share a world-view without necessarily recognising that they do. For the purpose of this study, only the world-view as it relates to health and illness will be discussed (Boyle & Andrews 1989:23).

2.3.1 Magico-religious world-view

In the magico-religious paradigm the world is an arena in which supernatural forces dominate. The fate of the world and those in it, including humans, depends on the acts of God or gods, or other supernatural forces for good or evil. In some cases the human individual is at the mercy of such forces regardless of behaviour.
2.3.2 Biomedical health paradigm

Craffert (1996:1) argues that central to biomedicine is the notion that, in the words of Worsley (1982:321), "the body ... is like a machine in which the parts sometimes break down ... Treatment then consists of the repair or replacement of parts (surgery), or in destroying the noxious causal agents ... with the aid of 'magic bullets', notably chemical drugs, administered by highly trained experts who monopolize the knowledge and practice of medicine".

According to this world-view, life is controlled by a series of physical and biochemical processes that can be studied and manipulated by humans. The biomedical paradigm is characterised by several specific forms of symbolic thought processes. The first is determinism, which states that a cause-and-effect relationship exists for all natural phenomena. The second relates life to the structure and function of machines; according to this theory, it is possible to control life processes through mechanical and other engineered intervention methods. The third form is reductionism, according to which all life can be reduced or divided into smaller parts; study of the unique characteristics of these isolated parts is thought to reveal aspects or properties of the whole (Boyle & Andrews 1989:28).

2.3.3 Holistic health paradigm

In the holistic paradigm the force of nature itself must be kept in "natural balance" or "harmony". Human life is only one aspect of nature and a part of the general order of the cosmos. Everything in the universe has a place and a role to perform according to natural laws that maintain order. Disturbing these laws creates imbalance, chaos, and disease.

Zulus share the magico-religious health paradigm. A person's health is a gift from God or the supernatural. The individual is at the mercy of supernatural forces in the form of the ancestors who may cast spells of good or evil on the individual. In other words, when the ancestors are neglected they respond by bestowing misfortune or illness on individuals. Health is a gift and illness is an entity separate from self, which is caused by an agent that is external to the body but which is capable of invading the body and causing illness or

2.4 PREGNANCY

Pregnancy is the normal condition when a woman's womb contains a growing child (foetus) within it, to be born after a normal gestational period of 40 weeks.

2.4.1 The medical/Western perspective of pregnancy

Pregnancy is a biological human condition, a physiological process that could produce a positive outcome if successfully managed by professional health personnel. Sellers (1997a:133) argues that pregnancy is a time of not only physiological change, but also of psycho-social adjustment. Emotions, thoughts and behaviours go through an array of changes, starting even before pregnancy itself, when conception is merely planned, and continuing until well after the baby is born. Many changes have implications for one's whole life. For this reason, pregnancy must be viewed as a long-term process affecting not only the woman, but the whole family. How the woman and her family perceive and adjust to these experiences is, in turn, affected by the social, cultural and religious environment in which the family unit is embedded (Sellers 1997a:133). The midwife must constantly be on the alert for idiosyncratic reactions occurring in women resulting from the psychological, social, cultural, or religious background from which the individual pregnant woman emerges (Sellers 1997a:133).

2.4.2 Pregnancy (the Zulu perspective)

Krige (1965:62) states that for the Zulus pregnancy is a time of great concern, not only for the health and successful confinement of the mother, but more for the future welfare of the child, who is easily affected by anything the mother may do, and stands in great danger of being harmed by wizards. Gumede (1978:824) argues that various taboos come into force to guide the pregnant Zulu woman and her foetus through pregnancy. Brindley (1985:100) states that the Zulus believe that the ancestors mould the foetus. The ancestral shades are influential in ensuring fertility and in bringing about conception (Brindley 1985:100).
Pregnancy is a cultural and often spiritual experience for women, an event that is rich with cultural meanings and practices (Lamp 1998:14). As this study deals specifically with the clients in the prenatal period in order to assist health care practitioners to render competent cultural care, it is important to review the relevant cultural practices of the Zulus.

2.5 CULTURAL BELIEFS AND PRACTICES OF ZULUS RELATING TO HEALTH AND ILLNESS IN GENERAL

✦ Cause of illness

Wizards (abathakathi)

Krige (1965:320) argues that, just as the doctor is the protector of society because he cures sickness, averts evil omens and 'smells out' evil doers, the umthakathi or wizard is the enemy of society. He is the man or woman who uses the powers of the universe, which he has learnt to employ by means of magic, for anti-social ends. The umthakathi uses his power for evil and acts against the welfare of society; he injures people's health, destroys life, prevents rain, causes lightning, makes the cows become dry and is the cause of all manner of misfortune (Krige 1965:321). Once he has been discovered, he is shown no mercy, but is got rid of as soon as possible (Krige 1965:321).

The umthakathi works in secret and is able to carry out his evil practices by virtue of the medicines he uses. Abathakathi (wizards') nostrums contain all manner of ingredients such as snips from the tongue, lip, nose, eyebrow, eyelid, heart, caul, private parts, hair, finger and toe nails, human placenta, baboon's tail and eyebrows, dog's brain and excrement, urine and anything that has been thrown off from the body (Krige 1965:321). As parts of the human body form most powerful medicines, there is a whole class of abathakathi called izinswelaboya who seize parts to carry out their works of harm and poisoning. All these are used to attain their evil ends (Krige 1965:321).
Figure 2.1

Pregnant Zulu woman
How the wizard effects his evil purposes

The most deadly of all medicines to any man or woman are those made up of parts of his or her own body such as fingernails, hair or excreta. For this reason Zulus are very careful that no one is near when they go to relieve themselves. If an enemy is able to produce someone's excreta, he will mix them with certain medicines and deposit them in a hole in the hearth where fire is made (Krige 1965:321). Then when fire is made, the man whose excreta are so buried will have a burning sensation; he will cry out with pain and will very soon die, unless a doctor finds out what is the matter and treats him against it. The same may be done with urine; another common practice of abathakathi is to watch to see where their enemy passes water and then to cut through the wet earth with a medication knife (Krige 1965:321). The person whose urine has been treated this way will not be able to pass water again. The bladder will "burst open and fill the stomach" until he dies. Urine may also be used to make a woman sterile, and Callaway mentions a case where a man bewitched a woman in this way by taking earth saturated with her urine, wrapping it up together with poisonous plants and placing it in little bags of skin. These he buried under the fireplace of his own hut (Krige 1965:321). An umthakathi may kill you by using your footprint. He will collect soil from your footprint in a snail shell and mix it with medicine, or cook it. Then your foot will swell up, and the swelling will go to the rest of the body, causing severe pain. Another method is for the wizard to use as an emetic an infusion of leaves of a small bush, mixed with a little earth from the footprints of the person he wishes to kill. He vomits the whole into a snake hole, calling out the name of the person. After he does this the victim will very quickly feel the effects (Krige 1965:322).

An important class of abathakathi medicine is that which is buried along paths or in the kraal for the purpose of causing fatal disease in those who come into contact with it. If imbo (said to be a certain plant) is planted in the kraal, the moment it takes root all the people in the kraal will get bad headaches and cough blood and die (Krige 1965:322). Death is often caused by putting medicine on the road, and this may be done in various ways. One method is to smear a stick or coin with medicine mixed with the insila (dirt) of an enemy, and to throw this away on the road, calling out the name of the person you wish to injure (Krige 1965:322). Then, when the person passes along that way or picks up the coin, he will become ill and die. If no name is called out, anyone who passes there will be
killed. The umthakathi may also take a thread from the back of the mamba, its gall and its fat, and mix these with certain amakhubalo (medicinal roots). This medicine he lays across the path with two sticks to hold the thread in place, and calls out the name of the person he wishes to bewitch. When this person comes along the road and touches the thread, it will immediately turn into a real mamba and bite him so that he dies immediately. In this case, unless the name is called, nothing happens. All these medicines that are placed along pathways to injure are known as umbulelo (Krige 1965:322). A very powerful umbulelo consists of the placenta of a woman and a horse, mixed with human fat, umdlebe (a poisonous brush), umopo (a certain sea-animal), ifelakhona (a certain mollusc), and one or two other ingredients.

A common means of killing people is to put medicine in their food. Tigers' whiskers thrown into a persons' food will, when swallowed, cause a gradual death. Another way of harming people is for the wizard to place poison on his finger. This he has only to point at a person to cause him to die on the spot, or to contract one of the illnesses recognised as caused by abathakathi, such as gout, tape-worm, or ophthalmia (Krige 1965:322). Very often wizards administer their medicines by mixing them with the snuff of people they wish to kill. It is also possible to harm people by spurting medicine (chints'a or khafula). Medicine is chewed and spurted out, while the wizard calls his enemy by name and gives him imaginary stabs with an assegai smeared with the same mixture. This will cause the death of the person whose name has been called (Krige 1965:323).

To make a person sleepy or of a weak disposition, an umthakathi administers medicine of hyena skin. To cause excessive menstrual flow, he gives the person some of the menstrual discharge of a female baboon (Krige 1965:323). The compound of tiger flesh and eyes of the land-and-sea-crab is used to cause the eyes of the victim to protrude and drop out. A man can bewitch bulls not to drop when stabbed by chewing a certain medicine, breathing it on his hand and then rubbing the side of the beast (where it will be stabbed) with his hand (Krige 1965:323). He can also cause the flesh of a slaughtered bullock not to get cooked by chewing the medicine and breathing it on the pot in which the meat is being cooked (Krige 1965:323).
One of the worst crimes committed by evil-doers is the prevention of rain, which they withhold by putting pegs dipped in medicine in the ground and tying knots in the grass on the mountains, and then sprinkling them with medicine. In the old days, if there was no rain, the king would send round messengers to look for such pegs or knots, and if any were found, the owner of the nearest kraal would be fined or killed (Krige 1965:323).

_Abathakathi_ cause lightning to strike a kraal by securing some of the grass above the entrance of one of its huts (which gets soiled from the bodies of persons going in and out) and some ashes from the common ash-heap; or they may use the footprints of a man, together with rubbish from the road leading to his home (Krige 1965:324). These they burn in the veld with the fat and feathers of the “bird of heaven”. The smoke then goes up to heaven, the sky becomes overcast, it begins to thunder, and the lightning runs along the road on which the person has walked, reaches his home and strikes him (Krige 1965:324).

**Medicine and treatment**

Krige (1965:327) argues that, since the direct cause of illness is very often the black arts and machinations of a wizard, it is essential that the Zulu doctor combat these by counter-magic. We find, therefore, that medicine and magic go hand-in-hand in the treatment of disease. Nor is the use of magic confined to dealings against _abathakathi_; it is seen in almost every kind of medical treatment. Even when the ancestors are causing illness, recourse is often had to “baring” such disease, and the use of sympathetic magic in the curing of sickness is extensive (Krige 1965:327).

The Zulus use large numbers of herbs, barks, and roots that have real medicinal value, but in addition to these, the doctor uses medicines concocted of the most diverse ingredients, including baked insects, dried reptiles, “dung of lions in powders and the fat of water-spirits, ... the shrivelled flesh of the white man, and the hardened menses of the baboon,” asbestos flint, washing-soda, skins and bones of every conceivable animal (Krige 1965:327).
There are certain preparations and fortifications in Black society for which flesh or fat of a human being is essential. Human fat costs more in the native medicinal market than any other medicine, and that of a European, is in the words of an informant, "simply pure gold" (Krige 1965:328).

**Classes of medicine**

Though we find such diverse ingredients in the concoctions of the Zulu doctor, there are certain classes of medicines distinguished by a generic name according to the use for which they are intended.

**Black and White medicines**

Black and white medicines are always used together. "Black medicine" (*umuthi omnyama*) is a generic name for all medicines that are administered with the intention of charming away evil, as, for instance, after lightning has struck a beast in or near the kraal, or for removing anything that causes dislike, as, for example, when a youth is rejected in love or when a man wishes to obtain the favour of a chief. In the preparation of this medicine, which acts as an emetic, leaves or roots or both are bruised, powdered, and mixed with water; then this is churned, and where there is much froth it is drunk in a kneeling position outside the kraal. The best time to take an emetic is in the morning, and a feather may be used to assist the vomiting. On the first time of using such a "Black medicine", the mixture is taken where aloes are abundant. A fire of aloes is kindled and the contents of the stomach ejected to quench the fire, for it is thought that the badness must be consumed. On subsequent occasions the medicine is rejected on pathways, so that others may walk over and take away the *insila* (filth) that is the cause of the offence. The body is also washed with medicine (Krige 1965:328). The taking of "Black medicine" is always accompanied by certain obligations of abstinence (*ukuzila*) as, for example, from leaving the kraal, from eating certain foods, or from seeing certain persons. From these restrictions one is released by the *ukuphothuka* process which consists in rubbing, anointing, or washing the body in water or grease medicated with charms, after which follows the administration of *umuthi omhlophe*, or "White medicines", which release one from or clear away the effect of the "Black medicines". White medicine is churned in the
same way as "Black medicine", and while this is done, the spirits are praised and success is asked for (Krige 1965:329). Then, when the froth subsides, then the contents of the pot are drunk. The rejection of white medicine takes place in the cattle-pen, since white medicine is a "blessing" (Krige 1965:329).

Amakhambi

*Amakhambi* is the name applied to green vegetables, medicines, the leaves or roots of which are used as common household remedies, well known to most Zulu mothers (Krige 1965:329).

Imbiza

*Imbiza* is a large number of herbs used as boiled decoctions for scrofula, chest complaints and as blood-purifying processes generally. These are called *izimbiza* and are, in contrast to *amakhambi*, prepared by a doctor (Krige 1965:329).

IsiChonco

*IsiChonco* is the name for infusions made by pouring cold or lukewarm water upon medical leaves, pounded roots, etc (Krige 1965:329).

AmaKhubalo

*AmaKhubalo* are native wood-medicine, such as roots or barks (never leaves), bulbs or animal powders. These are used for self-fortification and protection from evil and are nibbled or chewed. They are often worn round the neck and nibbled at when necessary (Krige 1965:329).

Intelezi

*Intelezi* is the generic name for all medicinal charms, the object of which is to counteract evil by rendering its causes innocuous, as when a poison of an *umthakathi* or lashes of
lightning are rendered harmless by the doctor. *Intelezi* is generally administered by being sprinkled (*chela*) on people or about the kraal or huts, but sometimes it is also *chintsad* or spurted out of the mouth (Krige 1965:329).

**UmFingo**

*UmFingo* is medicine that has the same object as *intelezi* but, instead of being sprinkled, it is carried about on the person as a charm for rendering unsuccessful the evil works of any enemy or wizard.

**UmSizi**

*UmSizi* is the name given to any medicine that is burnt and ground up into a black powder; but the term is applied more particularly to medicine used to produce certain sexual diseases, or kidney disease, dysentery, bleeding from the bladder or stomach, known by the same name. These *umSizi* disease is contracted only by men and sometimes culminates in insanity. A man suspecting his wife of adultery gets from a doctor some *umSizi* (made by mixing flesh of various animals with leaves) and this he eats. This, upon intercourse with his wife, leaves in her a mysterious power of conveying disease to the adulterer upon subsequent connection with her. The husband and wife suffer no harm, but the adulterer must be doctored again to be set right. A man who has killed another contracts potentially the same disease and must purify himself before entering a kraal (Krige 1965:329).

**UmKhando**

*UmKhando* is a class of medicinal charm, mostly stones, quartz, etc, but sometimes roots, used for gaining influence or supremacy over others and taking away their power. It is taken for purifying when one has killed another and in this case it must be taken only in one way, by *ncinda’ing* or *khafula’ing*. To *incinda* medicine, the tips of the fingers are dipped into the medicine and conveyed to the mouth. When *ncinda*ing medicine to gain ascendancy over another in love or in other matters, it is usual after sucking the forefinger to point it at the person. An *umthakathi* is able to kill people in this way (Krige 1965:330).
**Isibethelo**

*Isibethelelo* is the name of any love medicine used for “fixing” a girl to you against all-comers (Krige 1965:330).

**Umbulelo**

*Umbulelo* is a class of injurious medicine put along paths or in a kraal by an *umthakathi* for the purpose of causing fatal disease in those who come into contact with them (Krige 1965:331).

Though each doctor to a certain extent has his own special medicines and methods of treating patients, there are certain general methods of treatment for any common ailments, some of which are surprisingly simple and scientific despite the Zulu maxim (Krige 1965:331). “As many symptoms, so many diseases”. To re-set a broken arm, a hole is dug and partly filled with pliant clay. The whole arm with hand open and fingers curved inwards is inserted, and the rest of the clay filled in and beaten closely down. Then several men steadily raise the body perpendicularly to the arm and draw it out by main force. Fractured or dislocated limbs are bound up with the aid of dried hide or bark which secures them well when set (Krige 1965:331). For sprains, ointments are used, while for ringworm a paste of the nights or the milky juice of the euphorbia is rubbed on the affected part. Poultices of bruised herbs are used for tumours, glandular swellings, or wounds, and they are applied warm or cold. In the case of wounds, a few drops of the extract obtained by steeping bruised *ubuhlungwana* leaves in cold water are first poured into the wound and then a paste of the leaf is plastered over it and bound on like a poultice (Krige 1965:331). This prevents inflammations and ensures healing. For boils, the leaves of the *umhlankosi* tree are crushed and applied to draw out the matter (Krige 1965:331).

Lotions are commonly used to pour on affected parts of the body, and for pouring such medicines into the nose, eyes and ears, a small reed about two inches long is used. A good cure for headaches is to pour a certain decoctions into the nose, while in the case of sore eyes juice of the crushed leaves of *Berkheya* sp. is poured in the eyes. Tumours in the ears are similarly cured by pouring in lotions. Another common treatment is an
enema which is injected by means of a reed in case of children, a horn in the case of grown-ups (Krige 1965:331). This treatment, which is always administered by a member of one’s own sex, except in the case of mother and child, is used for abdominal pains, dysentery and diarrhoea, the two later being considered as identical by the Zulus, who call it *uHudo* (Krige 1965:332).

**Incisions, cupping and snuffing**

Many medicines are administered by means of incisions, especially in the case of local pains, when powders are rubbed into incisions on the affected parts. In the case of paralysis, we find a combination of the *ncinda*ing medicine. As this disease is thought to be caused by an *umthakathi*, who uses for this purpose a certain tree, the cure is effected by the use of the bark of the same tree (Krige 1965:332). The patient is made to stand in the sun, while the doctor makes incisions in the ground all along the shadow and so right along the whole affected side, but in this case the bark is boiled in water and the patient dips his fingers into the hot concoction, and sucks from the finger tips the liquid thought to cure the patient.

A favourite treatment among the Zulus is cupping. Incisions are made on the skin with a sharpened iron and the blood drawn by suction through a horn. Then, very often, ashes of medicinal roots are rubbed into the cuts. Many medicines are snuffed or inhaled, especially in the case of headaches and neuralgia. For headaches, the powdered bark of the *umkhwangu* tree is used as a snuff. Sometimes leaves of a creeper are simply rubbed in the hands and the scent inhaled (Krige 1965:332).

**The vapour bath**

In cases of rheumatism, scrofula, and insanity, the treatment known as *iPhungula* (a sort of vapour bath) is administered. Medicine is boiled in a large pot, over which the patient is made to sit on a stool of some kind, closely covered by grass mats or blankets, until he becomes thoroughly steamed out, the steam being maintained by putting two or three large red-hot stones into the water. The patient is afterward sprinkled over the bare body with the same or other similar decoctions while it is still boiling hot; but this is not supposed to
pain him at all, because the sprinkler is made of the leafy stalks of the umGunya, iCimamilo, uMmgwanyola and other herbs that have the property of rendering boiling water painless. Though the theory of the vapour bath is not understood by the Zulu doctor, he is said to experience good results by this practice (Krige 1965:333). In the case of scrofula, the vapour bath treatment is followed by medicines of the roots of bitter herbs, taken morning and evening. Scrofula is, however, treated domestically rather than professionally. A somewhat similar treatment, used in the case of paralysis in the legs, is that of digging a hole in the ground and heating it by kindling a fire in it. After the ashes have been withdrawn the patient enters, is covered up, and allowed to perspire for some time. This process is called, "to straighten out a person" (Krige 1965:333).

Barring disease

A common practice, especially in disease caused by the spirits, is to “bar” the illness. The doctor takes medicine which he mixes with the blood of the sick man, and this he carries to an ant-heap which the ants will repair when broken. Here he makes a hole, deposits the mixture, closes the hole with a stone, and departs without looking back. If, however, the disease was caused by a wizard, the doctor may decide to bila, that is, to return the disease to the originator, thereby causing him to be ill. In this case, when barring the disease, the doctor will put with the other medicines one special medicine which has the power of rendering the wizard powerless, and of sending him the disease. For this reason it is customary for a wizard to take great care to doctor himself with strengthening and other medicines before trying to harm others by sending diseases to them (Krige 1965:333). There seems to be an idea of “barring” also in the belief that, for illnesses like mumps, the treatment is not complete till the patient has walked backward to an ant-bear hole into which he shouts, “mumps, mumps, leave me, leave me”. Another method of “barring” a disease is to scarify the patient over the most painful spot, and to put this blood in the mouth of a frog, which is then abandoned in some faraway spot. In cases of venereal disease, a live frog may be placed against the afflicted parts and then thrown into a stream (Krige 1965:334).
Sympathetic magic in the treatment of disease

In the treatment of many diseases, sympathetic magic plays an important part, and in many cases the medicines administered have in reality no curative value at all. For spasms and the twitching of flesh, twitching animals are used. Medicines used from iMfinyezi, a small beetle which curls up when touched, and sea-animals which act similarly, together with plants which when touched fold up their leaves, is taken internally and rubbed into the body through holes in the skin (Krige 1965:334).

If blood comes out of the body through the nose or mouth, it is necessary to take the bark of trees which have juice like blood, for example, the uMdlebe and uGazi trees, and parts of an animal which has much blood or which bleeds readily. These are mixed together with blood of an animal like a goat, which destroys the poisonous properties of the other ingredients. To cure fear and nervousness, the heart, eyes, fat and flesh of the lion, elephant and other powerful animals are mixed with the bark of many trees (Krige 1965:334). To this is added the blood of a cow or sheep, and the whole is burnt into a powder which is taken internally. In all these diseases it is necessary to use medicines for vomiting and for enemata while the other medicine is being used. Sympathetic magic is also seen in the remedy for snake-bite: the head and bile of the snake are eaten with certain plants. There are certain herbs, too, which are used for so many diverse complaints that their use cannot be considered as based on real medicinal effect (Krige 1965:334). The climbing plant called Thwalabombo is used as an emetic to make a young man “nice” when courting; it is drunk with goats’ milk as cure for sexual impotency; it is sprinkled about the yard by a kraal owner to drive away the black art of the umthakathi; a girl menstruating for the first time drinks it with ujiba (kaffir corn) as a tonic; housewives use it as a soothing draught for chest troubles. Medicine and magic thus goes hand in hand, and the doctor must be well versed in all forms of magic, not only to effect his own cures, but to counteract the magic of the wizard, which is so important a function of the Black doctor (Krige 1965:335).

The aim of the following discussion is to depict that the cultural background and beliefs, norms and the value system of the Zulus influence how the Zulu pregnant women preserve their pregnancy to term. This, in turn, will influence their perception of the registered
midwife’s culturally competent care pertaining to pregnancy when they attend the prenatal clinic. The registered midwives will be against practices like self-medication with *isihlambezo* owing to its oxytoxic effect which may cause a ruptured uterus.

**2.6 PRENATAL CARE**

Following is a discussion of prenatal care from a Zulu perspective.

**2.6.1 Traditional prenatal care**

The following discussion is about Zulu prenatal care as practised by the traditional healers, traditional birth attendant, elderly women, medication taken during pregnancy and the diet of a pregnant mother.

**2.6.2 Traditional medicines used during pregnancy**

Traditional treatment comprises a variety of procedures and methods that are used in various combinations to treat disease. The choice of which procedures or methods to use in a treatment depends on the diagnosis.

**Traditional medicines**

Traditional medicine formulas are prepared from various natural substances (animal, mineral and vegetable) by a traditional healer. Traditional medicine remedies may be in one of the following forms: powder, poultice, ointment or herbal, and can be given either locally or systematically.

**Herbal remedies**

Herbal remedies are formulas of traditional medicine which may be constituted from one or several plants. Generally, the amount of herbal medicine made up is sufficient for one course of treatment, and is used until it is finished. If the entire amount is not used, the remainder should be thrown out. Herbal medicine solutions should be refrigerated if possible.
Figure 2.2
A herbalist
 Routes of administration

Chalmers (1990a:10) and Felhaber (1999:35) state that the routes by which traditional remedies may be administered include oral (by mouth), dermal (on the skin), nasal (in the nose), vaginal (in the vagina), and auricular (in the ear).

 Dosages

Dosages of traditional medicine are determined according to age and perceived strength of the patient (Felhaber 1999:35).

 Blood cleansing

Blood cleansing is done to detoxify the body of blood-borne toxins for example, when pregnant women complain of minor disorders during pregnancy: cramps, dizziness, fatigue and morning sickness. The Zulu believe that in those minor disorders the blood becomes impure, hence the detoxification done by traditional healers. It is often performed after illness to rid the body of any remainder of the disease (Felhaber 1999:35). It is also done to open the blood vessels and improve the blood circulation (Felhaber 1999:35).

 Charms

Charms are used mainly for luck, protection, affecting the behaviour of other people and driving away bad spirits (Felhaber 1999:35). During pregnancy the mother and the foetus in utero are believed to be vulnerable to evil spirits, which is why charms are used by Zulu traditional healers to protect the mother and foetus from the wizards and to drive the evil spirits away. Charms are used for good luck during the whole process of pregnancy till delivery (Felhaber 1999:35).

 Cuts (incisions)

Cuts are made to introduce medicine directly and immediately into the blood stream. They have a similar effect to a hypodermic injection; it is the African mode of injection. They are
used mainly to protect the mother and the foetus from all the invading evil spirits and harmful effects of wizards (Felhaber 1999:35).

♦  **Emetics**

Emetics are used to facilitate the body's natural expectoration process. They are used for cleansing purposes in cases of chest problems (for example, wheezing, tight chest) and for problems with the gastrointestinal tract (for example, to cleanse it of poisons, excess mucus or bile, foreign bodies, slime and dirt). They are used for biliousness-related problems (Felhaber 1999:36). Pregnant mothers very often complain of nausea; the traditional healer will prescribe traditionally prepared emetics from herbs boiled to make an oral infusion taken as one spoon daily to prevent nausea. Abdominal cramps are perceived by the Zulus as excess bile; the same treatment as for nausea is prescribed for bile excretion through defecation (Felhaber 1999:36).

♦  **Enemas**

Enemas are a cleansing method used to expel foreign bodies from the lower section of the gastrointestinal tract. They are used for health problems such as backache, constipation, womb complications, illnesses of the urogenital system (for example, kidney problems), infertility, certain types of sexually transmitted disease, and for aphrodisiac purposes in both men and women (Felhaber 1999:37). Pregnant mothers often complain of constipation due to the relaxation of the smooth muscle by progestogen, thus peristalsis is hindered. Boiled herbs are given to the pregnant mothers by traditional healers in solution by enema to relieve constipation whenever necessary (Felhaber 1999:36).

♦  **Intelezi**

*Intelezi* is a mixture of different medicinal plants that is used for a variety of purposes, including use as a charm. It is an all-purpose medicine for going out, protection, warding off evil spirits, steaming and bathing (invigoration of the body). It has a broad-spectrum activity for luck and protection, and is considered to be a very strong medicine (Felhaber 1999:36). Wizards and evil spirits will never harm a pregnant mother using *intelezi*
(Felhaber 1999:36).

**Ncinda**

*Ncinda* is a method of administering small amounts of herbal medicine that is performed ritually under the supervision of a healer. *Ncinda* is used for serious or obstinate cases of diseases which are believed to be caused by unnatural causes, such as wizards who want to harm the pregnant mother (Felhaber 1999:36). It is used to get immediate results, and to ward off bad luck (Felhaber 1999:36).

**Snuff**

Snuff is an example of a traditional medicine that is used in powdered form. It can consist of on single herb (in most cases) or of a mixture of two or more herbs. It is used for illnesses such as headaches reported by pregnant mothers, sinusitis, clearing of excess mucus in the head, and opening of the blood vessels in the head (Felhaber 1999:38).

**Steaming**

Steaming serves as topical application of the medicine through skin pores to penetrate, stimulate, invigorate or relax (sedate) and to heal the body. It is more efficient than bathing because of the hotter temperature. It is used for the same purposes as bathing. It relieves pregnant mothers from oedema and fatigue (Felhaber 1999:38).

**Piercing (African acupuncture)**

African acupuncture is a method of pain management used mainly to treat pain in areas with no wounds or open sores. A porcupine quill is commonly used as a needle. The area that has pain is pierced with the quill and medicine (usually in powdered form) is applied. This procedure may also involve applying pressure, followed by medicine, on the painful area (Felhaber 1999:38). It is commonly used to relieve oedema of the lower limbs of pregnant mothers (Felhaber 1999:37).
2.6.3 Emotional support given by the traditional healer to the Zulu pregnant women

**Prayer to ancestors**

Prayer functions at the psychosocial level where it reinforces treatment in the cases of cultural rites and *amathwasa*. Prayer to ancestors is pursued in cases of ancestral instructions (*inhlombe*), asking for help in dealing with ancestor-related diseases or illnesses, or requests for protection of a pregnant mother and her baby and luck during pregnancy and delivery. *Inhlombe* is a ceremony of variable duration (usually one to four days) that is performed by *sangomas* when initiating a student traditional doctor or when graduating as a traditional doctor. It may also be performed for other purposes such as thanking ancestors for protecting the pregnant mother (Felhaber 1999:3).

**Reassurance**

Reassurance is a technique that is used during counselling to promote and instill confidence in the pregnant mother about a healer's competency. Reassurance is used to encourage compliance with medicine-taking and to help speed up recovery of a pregnant mother (Felhaber 1999:37).

**Rest**

Rest is encouraged during treatment so that the patient's body can be relieved of stress, circulation may be improved and recovery may be helped. It is believed that rest gives medicine a chance to get into the circulation and work efficiently (Felhaber 1999:37).

**Sacrifice to ancestors**

Sacrifice to ancestors is used at the psychosocial level to reinforce treatment in a variety of different situations. It may be done to cure illnesses believed to be caused by ancestors, to request protection during pregnancy and delivery of a pregnant mother from evil spirits, luck or help from the ancestors (Felhaber 1999:38).
Smoke inhalation

Smoke inhalation is used for rapid entry of medicine into the bloodstream and the quick effect of the medicine on the brain, for instance to relieve pregnant mothers from headaches. It is also used at the psychosocial level for protection, driving away evil spirits, communicating with the ancestors, strengthening, luck (mkhokha) and for removing evil spirits which harm the mother and baby in utero (Felhaber 1999:38).

2.6.4 The role of the traditional birth attendant during pregnancy

The prenatal care done by the Zulu traditional birth attendant is to massage the abdomen of a pregnant woman. The traditional birth attendant puts her arms around the pregnant woman from behind and jerks the uterus from side to side. This is supposed to alter the position of the foetus which, it is believed, will otherwise lie in one place, causing pressure symptoms which might deform it, or cause untoward symptoms in the mother, such as vague aches and pains and debility (Lefeber 1994:6; Nolte 1998b:62).

The traditional birth attendants also tie medicated strings around the pregnant woman's waist in order to keep pregnancy till term. Furthermore they prescribe medicine to keep the evil spirits away (Nolte 1998b:63), for example:

- smearing traditional ointment under the pregnant woman's feet
- burning herbs and asking the pregnant woman to inhale the smoke of burnt herbs

The Zulu traditional birth attendants teach the pregnant mothers the following:

- Heavy blood loss during delivery should be seen as a form of purification (AbouZahr, Vlassof & Kumar 1996:452).
- Prolonged labour is a sign that the pregnant woman was unfaithful to her husband (AbouZahr et al 1996:452).
- Some early warning signs of possible complications, such as swelling of the feet and hands, are regarded as part and parcel of pregnancy (AbouZahr et al 1996:452).
A pregnant woman must not attend any healthcare service, for pregnancy is not a disease, and so there is no need for prenatal health services for pregnancy which is a normal and common condition (Abou Zahr et al 1996:451).

Failure of pregnancy in the form of miscarriage and still-birth is widely perceived to be caused by sorcery/witchcraft, consequently the state of pregnancy itself is regarded as a state of vulnerability to the actions of jealous others. Thus it is not revealed or is deliberately concealed from everybody but the most immediate family (Jewkes & Wood 1998:1050).

2.6.5 The role of the elderly women in pregnancy

The husband’s grandmother instructs the umakoti (bride) that it is essential for sexual intercourse to take place during the early months of pregnancy to strengthen the embryo (Brindley 1985:101).

The grandmother will tell the umakoti to sit straight or the embryo will not position itself correctly. She must refrain from poking her head in and out of the hut door lest her baby emerge and retract during delivery (Brindley 1985:101).

The old women teach the pregnant woman the taboos on activities during pregnancy like the following:

- Plaiting hair may form a knot in the umbilical cord of the baby in utero (Lefeber 1994:19).
- Sleeping during the day may make the baby behave in the same way on its delivery day (Lefeber 1994:19).
- Moving on certain pathways that may harbour the evil spirits of wizards, witches or wild animals may harm the baby (Lefeber 1994:19).
Figure 2.3
A traditional birth attendant
2.6.6 Traditional medicine taken during pregnancy

It is a cultural practice of some pregnant Zulu women to use the herbal infusion *isihlambezo*, prepared by a traditional healer. The dose may vary from one spoonful weekly to a cupful four times a day (Lefebre 1994:15). Herbal medicine is made from the roots, barks or leaves of locally available plants (Lefebre 1994:15). Again herbal medicine/traditional medicine employed in treatment consist of stems, bulbs, fruits, flowers and seeds, used fresh or dried, whole or in powdered form (Chalmers 1990a:10).

**Indications of using herbal/traditional medicine during pregnancy**

“*A large number of herbal medicines serve the purpose of correcting either constipation or diarrhoea, conditions with which the people are very concerned*” (Lefebre 1994:15). A “dirty stomach”, the phrase used to describe the condition of not having had a bowel movement and also to explain diarrhoea, is of particular concern for pregnant women, as the gastrointestinal tract and uterus are believed to be connecting organs (Lefebre 1994:15). This is a belief that the ‘way’ should be cleansed so that the baby will be free from infections and this is done by prescribing medicine which has supposedly both a diuretic and a laxative action (Lefebre 1994:15).

Traditional herbal medications such as *imbelekiisane* are ingested during pregnancy to prepare for sound foetal growth, to prevent oedema or to prevent the presence of vernix on the newborn (Chalmers 1993:65). These herbal mixtures have been found, when tested within a Western research framework, to have oxytocic properties, that is power to stimulate uterine contractions (Chalmers 1993:65). According to Myles (1993:399), these oxytocic effects of the herbal mixtures often result in a ruptured uterus.

There are as many formulas of herbal medication as there are *inyangas* (herbalists), for example, *isinwazi* (*Rhoicissus cuneifolia*). Roots are boiled with parts of *uxamu* (crocodile). The pregnant woman must take a cupful of this mixture daily till delivery in order to hasten the whole process of birth (Gumede 1978:824).
Muti (enema) is given regularly to pregnant women to empty the lower bowel to avoid obstructed labour (Nolte 1998b:63). Herbs are given to the pregnant mother orally in order to promote postnatal bleeding, because retained blood is regarded as impure and will cause the mother to be ill (Nolte 1998b:63).

Herbal medication is given to the pregnant mother for the purpose of getting rid of meconium (the first intestinal discharges of a newly-born baby) (Nolte 1998b:63). Herbal medication is given to the pregnant mother topically, vaginally and orally to keep the evil spirits away (Nolte 1998b:63).

These traditional medicines are believed to serve different purposes, such as treating abdominal pain, preventing abortion, ensuring a safe pregnancy, keeping the foetus slim, making the pregnant woman strong, enlarging the birth canal, inducing stronger contractions during labour, ensuring a strong child, preventing maternal oedema and to facilitate placental delivery (Lefeber 1994:15).

Myles (1993:399) states that the toxic effect of some herbal medications result in ruptured uteruses. The herbal infusion isihlambezo is taken orally, a cupful daily till delivery, by a pregnant women to ensure that the baby in utero is clean at birth and not covered with vernix caseosa. (Vernix caseosa is a white sticky substance present on the baby’s skin at birth. It is absorbed within a few hours and is in fact thought to have a protective function.) (Myles 1996:506). Traditionally, vernix caseosa, often seen as sperm, on a baby is regarded as a shameful thing, suggesting the result of intercourse during pregnancy (Lefeber 1994:16).
Figure 2.4

Traditional medication
2.7 WESTERN PRENATAL CARE

The Western method of prenatal care refers to the scientifically proven methods of care given to the pregnant woman and the foetus by professionally trained health personnel to ensure that the woman reaches term physically and emotionally prepared for the delivery. Care is rendered in totality, that is, taking into account the cultural perspective of the client. To achieve this objective, training of the midwives is imperative. In contradiction of the Zulu culture’s beliefs regarding diet, for example, diet is used to help recuperation of the patient and to ensure that the patient gets enough energy and strength. Advice may be given where necessary as to which foods to take or to avoid while a particular medication is being used, so as to prevent food-medicine interactions (Felhaber 1999:35). A pregnant mother complaining of general body tiredness is, for instance, encouraged to consume lots of starchy foods for energy.

2.8 TRAINING MIDWIVES IN SOUTH AFRICA

The training of the midwives should include the approach that an important focus of ethnomedical studies is the accommodation of indigenous (non-Western) therapeutic systems in societies characterised by urbanisation and modernisation. Training should emphasise that health care decision-making should lie with the users of the health care, clients or patients, rather than only with the healers (Varga & Veala 1997:912).

Reconciliation of differences between medical systems and traditional systems is through what can be referred to as “cultural reinterpretation” (Varga & Veale 1997:912). In this process, newly introduced elements are interpreted and used according to preexisting cultural rules. Regarding medical pluralism in Africa, cultural, reinterpretation is to be described in connection with reproductive health practices and use of Western health medicines, pharmaceuticals, and other products in traditional medical practices (Varga & Veale 1997:913).

Midwives should be trained to critically evaluate the persistent usage of traditional systems alongside Western medicine as adaptive mechanisms or stabilising factors in the face of social change. Particularly among newly urbanised individuals, utilisation of traditional
medicine in conjunction with biomedicine is seen as ameliorating the stress of acculturation, a means of maintaining group identity and cultural cohesion, and as an affordable health care alternative (Varga & Veale 1997:913).

Training of midwives should include:

2.8.1 Move towards transcultural nursing

According to Leininger (1980:12-36), transcultural nursing is a formal area of study and practice that focuses on a comparative analysis of cultures and subcultures with respect to diverse health-illness caring beliefs, values and practices, which has the goal of generating scientific and humanistic culture-specific or culture-universal therapeutic nursing care practices. The focus of transcultural nursing health care delivery to the consumer is within his or her own cultural context (Leininger 1981:366).

The nursing profession has a responsibility towards the community to deliver holistic and individualistic care, and nurses should therefore take into account the cultural differences between people. During history taking, for example, a nurse using the transcultural approach will not undermine the patient’s subjective history which may include, among other things, her perceptions about health and illness, what she views as an appropriate form of treatment, and what she understands to be the cause or causes of her illness. All this information will equip the nurse with cultural information to enable her to deliver care according to the patient’s cultural point of view. In other words, a nurse using the transcultural approach will be sensitive to the patient’s values and beliefs or the effect of those of her profession upon the patient. Having said this, one question remains. How can nurses acquire the knowledge and skill to render transcultural care? This question will be answered by the second recommendation.

2.8.2 Inclusion of transcultural nursing in the nursing curricula

It is imperative that nurse educators prepare students to look at culture as an integral component of professional nursing practice. This would be accomplished by the deliberate integration of cultural content into nursing curricula.
Factors related to the inclusion of cultural content

- The manner in which cultural diversity is handled within any given curriculum depends on the values and beliefs of the nursing philosophy and the conceptual framework. Nurse educators must therefore examine their institutional philosophy to determine whether they reflect a commitment to providing a safe, effective care to clients from diverse cultural groups. In other words, the philosophical base will determine the institution's commitment to teaching cultural content (Nolte 1998a:3-9).

- The other factor related to the inclusion of cultural content is the way in which the curriculum is organised and whether it is integrated or non-integrated (Nolte 1998a:3-9).

An integrated curriculum usually organises content in a broad and conceptual manner. If culture is viewed as a broad construct, cultural content can be integrated with ease into nursing courses. The South African Nursing Council supports this approach (Nolte 1998a:3-9).

Horizontal and vertical threads

The vertical strands of the conceptual framework support the concept of progressive learning and are content oriented. The horizontal strands are process oriented and more consistently reinforced throughout the programme. Thus, the identification of culture as a horizontal and/or vertical thread will influence how the content is developed in the curriculum.

Curriculum orientations

Approaches to learning following the medical model severely limit the amount of content on cultural diversity. Epidemiology can be addressed, but the human experience of culture is not the focus of the curriculum. On the other hand, a holistic model provides direction for the inclusion of a diverse content.
2.8.3 Curricula approaches for teaching cultural content

The specific cultural content will depend on all the abovementioned factors. There are various approaches for including culturally diverse content, namely concept, unit, course and multidisciplinary approaches. The concept approach requires the identification of major concepts that are taught at the basic level and then reinforced throughout the various semesters. One disadvantage is that there will be a fragmented presentation and, as a result key content will not be covered.

✦ The unit approach

In this approach the faculty is responsible for teaching a unit or several units related to culture. The unit approach has these advantages: it does not require major curriculum revisions; students can explicitly identify the culture content; guest speakers can be invited to offer specific content; and the content can be monitored with ease (Khanyile 1998:128).

✦ The course approach

This is the offering of a required or elective course pertaining to culture and health care. The course is usually one semester in duration. The distinctive advantage of this approach is that the cultural content can be explored in depth. The pitfall is that, if it is designed as an elective, it may not reach all students (Khanyile 1998:128).

2.8.4 Teaching strategies for cultural content

Numerous strategies can be employed to foster student learning about culture and health care. These include lectures, seminars, role-playing, role modelling and clinical conferences. Other teaching methods include the following:

✦ Resources

Articles pertaining to culture and health care are common in nursing and nonnursing journals and textbooks. Reference lists should be distributed to students. There are
specific exercises in the literature that can be used by students to make them more culturally sensitive (Khanyile 1998:129).

 Headquarters, field studies and projects

It is recommended that all students complete a report, field study or project associated with culture and health care. Topics could include folk health practices, specific health care beliefs, and selected health care problems of a particular cultural group. This will help a student to learn a specific topic in depth and also how to communicate and share with peers (Khanyile 1998:129).

 Guest speakers

The use of experts in the delivery of culturally sensitive care is an effective teaching strategy. Nurses with experience in delivering care to various cultural groups can share their experience with students.

2.9 EXPLANATION OF HOW THE ABOVE FITS IN WITH THIS STUDY

As we have moved into the new millennium, the year 2000 holds many challenges. Various health and social trends will demand our attention. We will respond to these needs by taking into account our clients' cultural heritage, recognising their diversity and rendering culturally sensitive care. In order to render holistic quality maternal health care to the community it is the responsibility of the health care system to provide the necessary health education to, among others, pregnant Zulu women and their families.

The parting of ways between African and modern medical ideas lies very deep; very near humankind's experience with plants and other substances. Once the traditional African has decided that similarity forms a basis for arguing towards causality, and the man in the white coat insists that causality should first be proven experimentally before any further deductions can be made, what possibility is there for reconciling them?
2.10 URBANISATION

Cities are places of cultural diversity and cultural expression. People rely on their cultural values and norms in their interaction with others. Their cultural identity should be respected before addressing their cultural accommodation. Pregnant Zulu women with a ruraly oriented culture face difficulty in acclimatising to Western practices during pregnancy. It rests with the health care professionals to acquaint themselves with their clients' acculturation process, to have cultural sensitivity and help cultural accommodation in order to render prenatal care holistically.

2.11 RESEARCH STUDIES ALREADY DONE ON THIS TOPIC IN OTHER CULTURES, NATIONALLY AND INTERNATIONALLY

Mokoae (2000) conducted a study in the year 2000 in Lesotho. The study was based on the cultural practices of Lesotho women during pregnancy. The cultural practice investigated was the use of traditional birth attendants (TBA) during pregnancy, delivery and puerperium. The study was quantitative. A total number of 60 TBAs participated in the study. The findings depicted that:

- TBAs did not monitor the foetal heart, which was of concern.
- Herbs were used during prenatal care.
- Traditional beliefs and taboos were identified by TBAs.
- Conditions such as haemorrhage, multiparous and nulliparous women and absence of foetal movements were referred to the local clinic.
- There was a need for cultural care preservation.
- There was a need for cultural care accommodation or negotiation.
- There was a need for cultural care repatterning.

Recommendations were a need for the health care professionals to train the TBAs.

Another study was conducted by Nompondana (1999) at the Flagstaff district in the Eastern Cape. The purpose of the study was to identify the ways in which the TBAs managed pregnancy and its complications. The study was quantitative. The subjects
comprised one hospital with its residential clinics and 50 traditional birth attendants. They were all Xhosas. The findings revealed that the TBAs were giving medicines that were not tested. The recommendation was that training of the TBAs would promote collaboration of the TBAs with professional health care workers and so medicines that they used could be tested. Recommendations for future study were:

- The implementation of a training programme for TBAs should be put into place and TBAs' programmes should be evaluated.
- The study should be repeated on a wider scale in order to get more ideas on the development of training for TBAs.

A study was conducted in Switzerland by AbouZahr et al (1996) at Chicago, Illinois in the United States of America. The focus of the study was women's health from a blood perspective, including reproduction as well as other health concerns, especially tropical diseases endemic to developing countries. The study was qualitative, using focus group interviews. Women's knowledge, attitudes, practices, perceptions of pregnancy, illness and pregnancy-related complications were explored, to determine why the use of formal health services tended to be low during pregnancy and delivery. The results of such studies were illuminating, showing clearly the extent to which maternal complications were not recognised as serious by women themselves or by their families and birth attendants (Bhatia 1982). For example, heavy blood loss after delivery was interpreted as a form of purification (Lefebre 1994). Other complications such as prolonged labour were sometimes interpreted as a sign that a women had been unfaithful during pregnancy (Chalmers 1993) and some early warning signs of possible complications, such as swelling of the feet and hands, were so common that they were not taken seriously by communities (Thomas, Ashley & Bernard 1991). The conclusion drawn from these early studies was that if sufficient information and education were provided, women would be persuaded to use the health services (notably prenatal care) set up for them in maternal child health and family planning clinics.

2.12 CONCLUSION

In this chapter the literature review which was done for this study included, inter alia, the
concept of culture, the different world-views regarding health care and the cultural practices of the Zulus regarding pregnancy and prenatal care. In the next chapter the methodology utilised for this research is depicted.
CHAPTER 3

Research methodology

3.1 INTRODUCTION

In this chapter the qualitative research paradigm underlying this study is discussed. The discussion is structured around the research design, population, sampling technique, the research instrument used, trustworthiness and the ethical aspects involved.

3.2 APPROACH USED

For this particular study a qualitative approach was used. Qualitative methods are used where there is little known about the phenomena. Qualitative research is a systematic, interactive, subjective approach used to describe life experiences and give them meaning (Burns & Grove 1997:27). Polit and Hungler (1995:712) define the qualitative research as the investigation of phenomena, typically in an in-depth and holistic fashion, through the collection of rich narrative materials using flexible research design. A qualitative research approach attempts to capture the human experience within the context of those who experience it (Polit & Hungler 1995:16). Researchers who use qualitative research adopt
a person-centered and holistic perspective to understand the human experience, without focusing on specific concepts. The original context of the experience is unique, and rich knowledge and insight can be generated in depth to present a lively picture of the informants' reality and social context. These events and circumstances are important and valuable to the researcher (Holloway & Wheeler 1996:2-3; Polit & Hungler 1995:16; Talbot 1995:414-415). Regarding the generation of knowledge, qualitative research is characterised as developmental and dynamic, and does not use formal, structured instruments (Holloway & Wheeler 1996:6; Polit & Hungler 1995:16). It involves the systematic collection and analysis of subjective narrative data in an organised and intuitive fashion to identify the characteristics and the significance of human experiences (Parse et al 1985:3; Polit & Hungler 1995:15). Qualitative researchers are concerned with the 'emic' perspective to explore the ideas and perceptions of the informants. The researcher tries to examine from the informants' point of view to interpret their worlds. Therefore, the researcher becomes involved and immersed to become familiar with, and keep an open mind about, the phenomenon. The immersion of the researcher helps to provide dense descriptions from the narrative data gathered from the informants and to interpret and portray their experience to generate empathetic and experiential understanding. However, immersion cannot be obtained without a trusting researcher-informant relationship. The relationship is built up through basic interviewing and interpersonal skills (Holloway & Wheeler 1996:3-8).

Three phases were used in the research process, as illustrated in Figure 3.1 (see page 52). The first phase was the conceptual one, where a research question and objectives were formulated with the purpose of study. Then a literature review was done to sensitise the researcher to concepts and to gain familiarity with the content of the literature. Thereafter the researcher performed bracketing to clear any preconceived ideas about the phenomenon.

The second phase was the design and planning of the study. The researcher was the instrument used to collect the data from informants, thus a nonprobability sampling design and purposive sampling were used.
**PHASE 1**

- Background
- Research question and objectives
- Literature review
- Reflexivity bracketing intuiting

**PHASE 2**

- Research design
- Data collection instrument
- Sampling
- Trustworthiness
- Ethical consideration

**PHASE 3**

- Data collection process
  - Stage 1
    - Focus groups
  - Stage 2
    - Individual interviews
  - Data analysis/interpretation

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*Figure 3.1*

*Phase of the research process*

(Applied from Polit & Hunger 1995:31-37)
The third phase included the empirical research that involved the collection, analysis and interpretation of data. The data collection was divided into two stages, namely the focus group interview followed by an unstructured interview with each of the participants. Field notes were made during the interviews. Data analysis started as soon as the data from the focus groups had been read. After the interpretation and the research had been completed, the researcher again reviewed the literature and studied the findings in relation to the existing literature, as shown in Figure 3.1.

The phases in figure 3.1 are interrelated. Each subsequent phase could not be implemented without the previous phase. During each phase reflexivity, bracketing, and intuiting were done, with the implementation of strategies of trustworthiness to prevent bias in the study.

3.3 CONCEPTUAL PHASE

The conceptual phase included thoughts, readings and questionings of the researcher about the phenomenon under study.

3.3.1 Background to the problem

This study is about cultural practices of Zulu pregnant women regarding prenatal care. The focus of the study was on cultural practices regarding prenatal care among Zulu women in a selected area in Gauteng.

3.3.1.1 Background to the study and problem statement

The researcher, who was employed in one of the satellite clinics of the East Rand in the Gauteng Province in 1986 as a registered midwife in the "X" prenatal clinic, was alarmed by the high rate of pregnant women who were defaulting on their prenatal visits. As stated in Chapter 1, 75.0% of previously seen prenatal clients failed to return for their prescribed return visits to the clinic. An interview with a professional nurse in charge of the prenatal clinic revealed that, out of twenty prenatal clients seen in one visit, about seven returned for a follow-up visit. Two situations involving cultural dependency are described in
Chapter 1. These two experiences prompted the researcher to become interested in the phenomenon and the need to investigate the cultural practices of Zulu women during pregnancy.

3.3.2 Research question and objectives

The exposure to the background and experiences discussed above led to the research question of the phenomenon under investigation.

- What were the cultural practices used by Zulu women during prenatal care in an urban area?

The research objectives were formulated and the researcher aimed at:

- exploring the cultural practices of Zulu women during pregnancy
- developing guidelines for midwives who care for Zulu pregnant women
- developing guidelines for midwifery curricula regarding prenatal care for Zulu women

3.3.3 Literature study

According to Talbot (1995:430) there are different views regarding the time at which the literature study should be conducted in a qualitative study (whether before or after the study). According to various literature sources, this aspect of when the literature study should be conducted is related to the purpose of the study (Chenitz & Swason (1986) and Marshall & Rossman (1989), cited in Van der Wal 1992:51). Researchers who feel that the review should be done prior to the raw data collection support this by saying that the literature review justifies the study and puts it into context. Those who hold the opposing view recommend waiting until the findings are completed and then examining the findings in relation to the literature (Burns (1989), cited in Talbot 1995:430).

In this study, the researcher conducted a literature review before submitting the proposal which was a prerequisite prior the commencement of the study. The aim was to obtain
background knowledge about the phenomenon under study. Thereafter, a more detailed review was undertaken to orientate the researcher about the concepts and cultural practices of Zulu pregnant women during the prenatal period. This data was used to construct and adapt the conceptual phase, and to formulate the criteria for the study. The literature study sensitised the researcher to the content of the literature. After the research findings had been analysed and interpreted the researcher again reviewed the literature and situated the findings in relation to the existing knowledge in the literature about the phenomenon under investigation (Talbot 1995:430).

3.3.4 Reflectivity

A qualitative researcher is part of, and not divorced from, the phenomenon under study, and must constantly take his or her position as main research tool into account (Holloway & Wheeler 1996: 13). Because the researcher is the main research tool who hears, feels, sees and interprets words of informants, this may create bias and subjectivity. Therefore the researcher should be reflective and aware of personal assumptions, in order to increase objectivity. Abbott and Sapsford (1998:150) describe the importance of reflectivity, or reflexivity, throughout the researchers' research project. The three reasons for reflexivity are:

- to help the researcher with self-monitoring, to spot when something is going wrong and to correct it
- to help with analysis of the data and finding the way through the mass of data
- to aid self-justification and demonstrating that others should believe in the researcher's interpretations

3.3.5 The researcher's process of bracketing

Qualitative researchers use bracketing to improve the rigour of the research. It is the process of identifying and holding in abeyance any preconceived beliefs and opinions about the phenomenon under study (Polit & Hungler 1995:636). Fetterman (1989), cited in Holloway and Wheeler (1996:6), states that the researcher should enter the project with an open mind but not an empty head. Newman (1997:334) also mentions that the
researcher should take measures to guard against the influence of prior beliefs or assumptions. Therefore in this study bracketing was done continuously and prior to the raw data collection. This ensured that the researcher questioned her own assumptions and set them aside, with the purpose of acting like a stranger regarding the phenomenon (Holloway & Wheeler 1996:5). Bracketing made it possible for the researcher to focus on the informants' experience and to shape the data collection process according to it (Crotty 1996:20). The reason for bracketing was to reduce bias or preconceived ideas, which could have been introduced by two aspects:

- the literature study the researcher undertook prior to the raw data collection
- the researcher's personal experience of the cultural practices of Zulu women during pregnancy

Bracketing was achieved in the following way:

- Mullaney (1997:162) explains that during bracketing it is necessary to make assumptions, beliefs and biases explicit and to expose them. Abbott and Sapsford (1998:151) recommend that the researcher should write an autobiography about her or his own life and values. This researcher therefore wrote a narrative description about personal experiences of the cultural practices of Zulu pregnant mothers. This was to express the researcher's experiences and set them aside, which would help her to maintain an open, objective approach when interviewing the informants and analysing the findings.

3.3.6 Intuiting

Intuiting occurs when the researcher remains open to the meaning attributed to the phenomenon by those who have experienced it (Polit & Hungler 1995:198). It requires concentration and complete absorption from the researcher to focus on the phenomenon under study (Massey 1995:56). The researcher was continuously aware of the need to keep an open mind, looking at how informants explained their cultural practices during the prenatal period.
3.4 RESEARCH DESIGN

The design and planning phase described how the researcher chose the methodology to address the research question and objectives. Careful planning in this phase was done for the actual collection of data in Phase Three. The research and sampling designs were planned to ensure rigour and trustworthiness in the research (Polit & Hungler 1995:32).

The purpose of this study was to explore prenatal practices regarding prenatal care, as well as to collect data regarding the cultural practices of pregnant Zulu clients, a descriptive design was considered to be the most appropriate method. A descriptive design was used to identify the phenomenon of interest, identify variables within the phenomenon, and develop conceptual and operational definitions of variables (Burns & Grove 1997:779).

A nonexperimental research design using an exploratory, descriptive (Wilson 1993:227) and contextual qualitative approach was undertaken (Mouton & Marais 1990:43-44; 49-50). This design was chosen because it provides data in the present and tells what people are thinking, doing, anticipating, feeling, perceiving and planning in their natural environment: that is, the emphasis is on the natural world of humans (Polit & Hungler 1993:178). A discussion of the exploratory, descriptive and contextual research approach follows.

 Exploration approach

An exploratory study begins with the phenomenon of interest with the aim of exploring the dimensions of the phenomenon, about which little information was found. It provides insight about the phenomenon (Brink 1996:11). Exploratory research focuses on the 'what' question, and everything about the topic is potentially important. Thus, the researcher must be creative, open minded and flexible in exploring all sources of information (Neuman 2000:21). It provides the 'facts' of new data (Mouton & Marais 1990).

The researcher explored the literature throughout the study to gain information regarding the phenomenon. The researcher approached the research with an open mind, without
preconceived ideas and with the aim of increasing knowledge and providing new data regarding the phenomenon in the context.

**Contextual**

According to Burns and Grove (1997:777), contextual research depicts the body, the world, and the concerns unique to each person within which that person can be understood. Mouton and Marais (1990:50) argue that the aim of contextual research is to set the phenomenon, event or group within the context of the unique setting of its domain.

This study is contextually bound to the unique time, space and value context of the specific prenatal clinic where the research was conducted. It is site-specific and can only be a prenatal setting in the context of the specific prenatal clinic (Mouton & Marais 1990:50).

### 3.4.1 The population

Burns and Grove (1997:790) and Polit and Hungler (1995:710) state that the population is an entire set of individuals or objects having some common characteristics. For this study, the population was the entire population of Zulu pregnant women residing in the East Rand in Gauteng Province, to which the researcher would like to generalise the results of the study (Polit & Hungler 1995:716).

#### 3.4.1.1 Target population

The target population was composed of all the Zulu primigravid women with a 36 weeks' gestation period in one month at the East Rand in the Gauteng Province attending the prenatal visits at the "X" clinic.

### 3.5 SAMPLING

Burns and Grove (1997:279) and Polit and Hungler (1995:794) state that sampling refers to selecting groups of people, events, behaviours, or other elements, or portion of the population to represent the entire population.
3.5.1 Sampling method

Purposive sampling was used, since the researcher was interested in only Zulu pregnant mothers. Informants were selected according to the following criteria:

3.5.1.1 Selection criteria

- The informants had to be pregnant women involved in the cultural practices of Zulu pregnant women.
- For purposes of homogeneity the informants had to be:
  — primigravid
  — with a 36 weeks' gestation period
  — Zulus and able to speak Zulu
  — South African by birth
  — attending the prenatal visits at the "X" clinic
  — and to have lived in the East Rand for two years or more

Burns and Grove (1997:783) and Polit and Hungler (1995:703) argue that homogeneity refers to the degree to which objects are similar or a form of equivalence, such as limiting subjects to only one level of an extraneous variable to reduce its impact on the study findings.

3.5.1.2 Sample size

Out of 120 Zulu pregnant mothers who were attending the prenatal clinic, only 12 informants met the criteria for inclusion in the sample. After discussions with the informants at the prenatal clinic 12 of them agreed to participate in the study.

3.6 DATA GATHERING

3.6.1 Focus group

The focus group interview was used for this study. Bosch (1987) in Morrison and People
(1999:62) defines focus group as "a qualitative research technique used to obtain data about feelings and opinions of small groups of participants about a given problem, experience, service or other phenomenon". Morgan (1996) in Griffin and Sullivan (2000:19) describes a focus group research technique that collects data through group interactions on a topic determined by the researcher.

3.6.1.1 Reasons for the use of the focus group technique

The researcher used a focus group technique to gather data because in focus groups the researcher observes, probes, asks questions to facilitate the discussions and, as a result, has access to the experiences and feelings of the informants as she observes their nonverbal cues (Polit & Hungler 1995:736). The focus group interview was an appropriate tool to generate more information that was used in subsequent data collection procedures. An interview guide was later developed using the information obtained from the focus group interview.

3.6.1.2 The purpose of the focus group interview

The aim of the focus group interview was to ascertain the traditional methods used by the Zulu pregnant clients to preserve pregnancy to term. In addition to that, the researcher's aim was to simultaneously, but indirectly or in a subtle way, ascertain the informants' perception of culturally competent care pertaining to pregnancy.

3.6.1.3 The environment in which the focus group interview was conducted

To ascertain the cultural practices used by the Zulu pregnant clients during the prenatal period, the focus group interview was conducted in an empty ward within the clinic which was large enough to accommodate all participants seated in an oval configuration so that each could maintain eye contact with all others in the room (Morrison & People 1999:63).

- The environment was nonthreatening and comfortable
- Sequential numbering of informants facilitated note taking and transcription of audiotapes: informants wore tags with letters of the alphabet in sequence order.
• The focus group interview was scheduled for two hours.
• The telephone was taken off the hook to ensure that there would be no distraction.
• All the clinic workers were made aware of the interview and in addition a "NO DISTURBANCE PLEASE" sign was put on the ward door.
• The ward was well ventilated and well lit.
• Each informant was provided with a comfortable seat.
• Glasses and jugs of water were available.
• A high-quality tape recorder with an extension was tested beforehand.
• The tape recorder was strategically placed between the researcher and the informants so that the discussion could be clearly recorded and thus facilitate transcription.

3.6.1.4 Focus group interview technique

✦ Group composition

Homogeneous groups were used; informants were all 36 weeks' primigravid Zulu women residing in the East Rand attending prenatal visits at the "X" clinic. The purpose of the focus group interviews is to produce self-disclosure. The homogeneity of the group reduced the perceived risk to informants.

✦ Group size

Each group consisted of four participants. Smaller groups were preferred, to maximise the group dynamics in each group and to allow each participant the chance to participate. They also tended to generate more intense discussions, with more information being made available about the point of view of each participant. Smaller groups also allowed the researcher to observe nonverbal cues during the discussion session. Since the study required the informants to delve deeply into their experiences and feelings, smaller groups were appropriate.
Number of groups

The number of group sessions was determined by the saturation point, as has been mentioned above. After the informants were seated according to the criteria, consent forms were issued for them to sign.

Purpose statement of the focus groups

A central statement was posed by the researcher to the informants as: **Explain the cultural practices used during the prenatal period.** To promote logical sequence of thought, traditional methods were subdivided into headings. A heading would be exhausted before proceeding to the following one.

- Traditional medication taken during pregnancy.
- Types of food abstained from during pregnancy.
- Traditional preparation for labour.
- The role of the elderly people during pregnancy particularly the mother-in-law.
- The role of traditional healers during pregnancy.
- The role of traditional birth attendants during pregnancy.

Discussion session

- The researcher welcomed the informants and thanked them for their participation.
- The researcher promoted a relaxed, nonthreatening atmosphere by using an ice-breaker.
- A brief overview of the objectives and instructions regarding the process of the interview was given by the researcher.
- The researcher carefully explained that note taking by the assistant and tape recording was for the benefit of the researcher and would not be used in any way to harm the informants (Griffin & Sullivan 2000:30).
- Clarification of responses was sought and questions were reframed to obtain meaningful responses.
The researcher remained neutral and nonjudgmental throughout the focus group interview (Morrison & People 1999:64).

The interview was tape-recorded and the assistant took notes during the process.

Verbal and nonverbal and body language cues were identified and appropriately acted upon.

The researcher repeated several times that everyone's voice needed to be heard (Griffin & Sullivan 2000:18).

When saturation was reached, the researcher summarised the highlights of the discussion, thus seeking verification from informants. Saturation is the process of collecting data in a qualitative study to the point at which a sense of closure is attained because new data yield only redundant information (Polit & Hungler 1995:714). The researcher was satisfied when the last focus group interview session yielded similar responses to those in the first and second group sessions.

Informants were reminded that follow-up focus group interviews would be held if any information was not clear.

The researcher closed by expressing appreciation of the informant's participation.

Debriefing session

At the end of the discussion each informant was given a chance to explore her feelings during and after the group discussion. The researcher helped to allay anxiety or guilt feelings. Thereafter the informants were thanked for their participation.

To gather more data and to encourage more self-disclosure, as some discussions were taboo, the informants were asked to continue to participate through one-to-one interviews at their homes. They agreed to participate as they said their home environment was more relaxed, nontthreatening and provided privacy for taboo discussions. Following is a discussion of interviews held at informants' homes.

3.7 INDIVIDUAL INTERVIEWS

Data from the primigravid Zulu prenatal clients were gathered by means of interviews. According to Burns and Grove (1997:784) interviews are structured or unstructured verbal
communication between the researcher and the informants, during which data is obtained for a study. Polit and Hungler (1995:705) describe an interview as a method of data collection in which one person (an interviewer) asks questions of another person (a respondent); interviews are conducted either face-to-face or by telephone.

3.7.1 Motivation for the use of interviews

For the purposes of this study interviews were done to ascertain the aspects not found clear in the focus group.

- The researcher was able to clarify responses informants did not understand (LoBiondo-Wood & Haber 1990:357; Polit & Hungler 1993:205).
- Pregnancy and traditional beliefs and practices are personal. Personal interviews promoted the likelihood that responses would be spontaneous and self-revealing, which aided insight into the study (Polit & Hungler 1993:231-232; Wilson 1993:225).

3.7.2 Aim of the interviews

The aim of the personal interviews was to discover data on the clients’ experiences at the clinic while attending prenatal visits. Additionally, the researcher aimed to simultaneously but subtly elicit the clients’ perception of culturally competent care during pregnancy.

3.7.3 Environment in which the interview was conducted

All interviews were conducted at the informants’ homes during the day when children were at school and the adults at work or out to seek employment; this provided privacy and no interruptions. The researcher kept to the prearranged time and date of each interview (Burns & Grove 1997:309). One hour was planned for each interview. At each home of the informant, the researcher ensured that prior to the interview the following aspects were given careful consideration:
Using a high-quality tape recorder and tape which was tested before each interview.

Having a supply of working pretested high-quality batteries for the tape recorder as some of the informants resided at informal settlements with no electricity.

Having an extension cord in case the plug was not within easy reach of the tape recorder for those informants who had electricity in their houses.

Placing the tape recorder strategically between the researcher and the informants so that the dialogue could be clearly recorded.

3.7.4 Interview schedule

During the personal interviews the researcher had an outline of topics in the form of open-ended questions which she intended to investigate, which she used for probing. As the interview progressed, both the interviewer and the informant were free to deviate from the prepared agenda and to introduce thoughts or observations that were particularly relevant to their personal perspective (Wilson 1993:223). However, although the researcher spent various amounts of time interviewing each informant, she endeavored to ensure that at the end of the interview all the predetermined questions had been covered in some sequence or form, with each informant (Wilson 1993:223).

3.7.5 Interview technique

Only consenting informants were interviewed.

The informant was greeted and thanked for her willingness to participate.

To put an informant at ease an ice-breaker was used so that she would feel comfortable in expressing her honest opinions (Polit & Hungler 1995:346). 

During interviews, the researcher made every effort to be flexible, adopting either a passive or active role as the situation demanded.

All interviews were audio-tape recorded and that was communicated to the informant before the interview commenced.

The researcher did not maintain eye contact as it is not accepted in the Zulu culture, but the researcher observed the informant to identify verbal and nonverbal body language cues and acted appropriately.
• Informants were probed with no pressure applied.
• At the closure of the interview, the informant was thanked for participating till the end of the interview and also reminded that follow-up interviews would be made if any aspects were unclear (Van der Wal 1992:115, 118, 199).

3.8 DATA ANALYSIS

Data analysis refers to the systematic organisation and synthesis of research data (Polit & Hungler 1995.699). Burns and Grove (1997:778) refer to data analysis as conducted to reduce, organise, and give meaning to data.

Data analysis started soon after the researcher conducted the first focus group. The researcher used reflexivity, bracketing and intuiting (as described in paragraph 3.3.6) to exclude all preconceptions of the phenomenon and entered the world of the informant who was interviewed (Tesch 1990:92). After the focus group interviews and personal interviews the researcher replayed the tape and listened to the tone of the voice, responses and content of the informants. Then the researcher read and typed the interview and transcribed the interview words, because it was not possible to analyse the raw data without typing it. Nonverbal responses, for example laughter and change of voice, were included in the interview transcription. After the transcription the tape was replayed and correlated with transcription for accuracy (Field & Morse 1990:97-99; Streubert & Carpenter 1995:45).

The researcher used contemplative dwelling on material during the data analysis. This was the undistracted listening to, reading and rereading of the descriptions to uncover the meaning of the experiences. It freed the researcher to be open to both tacit and explicit messages in the data (Streubert & Carpenter 1995:45-46; Parse et al 1985:19).

Parse et al (1985:4) state that the informants move to the language of science during the analysis process. According to Giorgi (1975) cited in Tesch (1990:93), the data is searched for ‘themes’ and then transformed into a professional/abstract language. These meaning units are clustered together to tie essential nonredundant themes together into a description statement. This description is on a ‘specific’ level of the experience and is
then developed to a 'general' level by leaving out the particulars. This process is called the 'identification' of the fundamental structure.

In this study, meaning units were extracted from the original focus group interview and unstructured interviews. Similar meaning units were clustered together. These meaning units form different subcategories, which ultimately fit into certain categories. All the categories were then finally organised and themes emerged from these categories.

3.8.1 Discussion of data analysis procedure

In qualitative data analysis the researcher needs to use intuition and inductive analytical reasoning during and after display of data. There are basically three strategies to analyse the data:

- Reduction allows the researcher to deduce inherent meanings from the voluminous narrative data.
- Data display is the organising of the data in tables, graphs and matrices.
- Conclusion drawing and verification is the process of attaching meaning to the findings (Massey 1995:97).

The analysis of qualitative data is challenging because there are no systematic rules to guide the analysis and interpretation of data and much time and work are required from the researcher to read, reread, organise and analyse the data. Patton (1990), cited in Talbot (1995:481), states: "Because each qualitative study is unique, the analytical approach used will be unique. Because qualitative inquiry depends, at every stage, on skills, training, insights, and capabilities of the researcher, qualitative analysis ultimately depends on the analytical intellect and style of the analyst". Tesch (1990:77) identifies 26 different data analysis procedures, which have different analytical focuses. The grouping of the analysis is mainly in two types, namely: structural analysis and interpretation analysis (Tesch 1990:99). The researcher used Tesch's (1990) interpretational qualitative analysis method. Tesch (1990:115-123) describes the 'de-contextualising' and 're-contextualising' in descriptive/interpretive analyses. The following steps, graphically shown in Figure 3.2, describe how the researcher analysed the data (see page 68).
Figure 3.2
Data analysis steps
(Applied from Tesch 1990:115-123)
3.8.1.1 Segmenting

The data focus group interviews with different informants were the raw unassimilated data. Intuitive statements, sentences and paragraphs of the experience were embedded in the context of the typed and transcribed document. The researcher identified smaller parts in the interview through dwelling on them in order to unfold the informant's experiences. Significant statements and phrases regarding the cultural practices of the Zulu pregnant woman were extracted. These are called meaning units. The 'de-contextualising' of the data meant that several segments or meaning units in the data, which contained ideas or pieces of information, were identified. The relevant portion or meaning unit applicable to the experiences was extracted from its context (Tesch 1990:115-118). The researcher typed the focus group interview and transcribed the interview on the computer. Thereafter two columns were created with the original verbatim data. The data was copied and pasted into the next column and then carefully read. The meaning units were extracted twice manually by underlining the meaning units on printouts. After the second extraction both were compared and this was finally processed on the computer, by deleting the nonrelevant data in the second column.

3.8.1.2 Developing an organising system

Sentences and paragraphs of the focus group interviews and transcribed dialogue had two contexts. First they were part of the initial description or interview conducted and belong to the original context from which they were extracted. Secondly, they belong to the 'pool of meanings' The 'pool of meanings' are groups constructed so that the segments could be sorted into those groups. This is then the same as an organising system (Tesch 1990:118).

Two basic ways can be utilised to establish an organising system. Firstly, a theoretical framework or research questions can guide the creation of an organising system. Secondly, it can be created from the data itself (Tesch 1990:119). In this study there was not an exact theoretical framework of research questions which could be utilised to establish an organising system. The meaning units from the data with the prior literature review allowed the researcher to create an organising system. First, the researcher
worked with one informant's scripts. From this the researcher made a list of a tentative
organising system of each. Thereafter the first informant's organising systems were
compared and integrated. The subsequent scripts for each informant were separately
done and then finally integrated into categories and subcategories as they emerged during
the progress of the study.

The tentative system become refined as the analysis process continued with other
narrative essays and interviews. The meaning units were clustered together to form
subcategories and ultimately the categories. After the researcher was satisfied with the
organising system of the data, it was applied to the rest of the data collection (Tesch
1990:118-121).

As described, the researcher ordered the data of the informant in two columns. These
were the original text and the meaning unit. Subsequent columns were added alongside
for the formulated statements. This helped the researcher with the creation of the
organising system.

Through this method the researcher was then able to determine saturation of data. When
the pool of meanings was saturated with meaning units, and no organising systems could
be derived from further data, no more informants were approached.

3.8.1.3 Sorting data (coding)

When the organising system is done properly, it is easier to sort the data into relevant
segments. Mnemonic codes were utilised to tag text segments of organising systems or
categories into the coding process and a final column was added to the columns described
above. The researcher finally had each informant's analysed narrative essay and
unstructured interview in four columns. These columns respectively contained the original
text; meaning unit; formulated statements/organising systems; and the codes. The codes
which the researcher attached to the meaning units and organising system were the
categories of the themes. After coding, the researcher used 'recontextualising' to
assemble all meanings that belonged in one category in one place. A category with its
subcategories dealt with one concept and represented one 'pool of meaning' and finally
became part of a theme (Tesch 1990:121-123).

The researcher first united each informant’s codes and categories. New folders and files were created for this uniting of data. This was then the first time the meaning units, subcategories and categories were extracted from their original setting. All the relevant data, for example, ‘uncertainty’, of the one informant, was united together as a category. After each informant’s meaning units, subcategories and categories were united, they were integrated with all the other informants’ relevant data. The document consisted then of the central theme with categories and subcategories of all the informants’ coded meaning units.

3.9 TRUSTWORTHINESS

Trustworthiness establishes the validity and reliability of qualitative research (Talbot 1995:428). The research demonstrated trustworthiness when the cultural practices of informants were accurately represented (Streubert & Carpenter 1995:162-163). But Munhill and Oiler (1986), cited in Holloway and Wheeler (1996:162-163), argue that in qualitative research, objective experiences potentially exist together in the research data. Therefore the qualitative researcher must show rigour and establish trustworthiness with the decision trail in the study.

According to Maykut and Morehouse (1994:64), the term ‘trustworthiness’ is used by Lincoln and Guba (1985) to evaluate the quality of their data in their findings. The four criteria of credibility, dependability, conformability and transferability increase the trustworthiness of qualitative research. Applicability, consistency and neutrality are also included where applicable.

Credibility

Field and Morse (1990:118) state that the researcher should demonstrate the credibility of the findings. Lincoln and Guba (1985) used activities which increased the probability of the findings which were produced (Streubert & Carpenter 1995:25). Credibility in essence refers to the truth of how the informants know and experience the phenomenon
(Talbot 1995:529). Holloway and Wheeler (1996:164) explain that "researchers must ensure that those participating in research are identified and described accurately".

← Prolonged engagement

Activities such as a prolonged engagement with the informants increased the credibility (Polit & Hungler 1995:362; Streubert & Carpenter 1995:25). The researcher worked at one of the clinics where the Zulu pregnant women attended the prenatal clinic. This reflects the researcher's prolonged engagement with the informants of the phenomenon under investigation. Enough time was spent with the informants to develop a trust relationship with them during the interviews and member checks (Holloway & Wheeler 1996:164).

← Reflexivity

According to Koch (1994), credibility is enhanced when the researcher describes and interprets the experience as researcher (Holloway & Wheeler 1996:164). Refexivity, bracketing and intuiting were a major concern in the whole research project, and being as open as possible, to establish rigour and prevent bias. The researcher described her personal experience related to the phenomenon through bracketing and the analysis of her experience made the researcher aware of possible biases and preconceived ideas. Each phase of the research process was thus carefully approached, using bracketing (laying aside what is known) and intuiting (looking at the phenomenon) to avoid bias and approach the phenomenon with an open mind.

← Peer and informants' debriefing

Polit and Hungler (1995:362) maintain that peer informants' debriefing increases credibility. Peer debriefing by the evaluation of the designated supervisor provided an external check to ensure rigour in the study. Informants' debriefing or member checks involved the researcher's returning to the informant, checking with her the findings on her cultural practices during pregnancy to confirm them as true (Holloway & Wheeler 1996:164; Mertens 1998:182; Polit & Hungler 1995:362). The researcher also did member
checks with the informants' feedback. They checked the categories which emerged from the data and after the themes were finalised the researcher went back to them and discussed the interpretations and conclusions with them.

Table 3.1: Trustworthiness strategies

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>CRITERIA</th>
<th>APPLICATION BY RESEARCHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credibility</td>
<td>Reflexivity</td>
<td>Bracketing and intuiting in each phase of the research process.</td>
</tr>
<tr>
<td></td>
<td>Prolonged engagement</td>
<td>Involved with the phenomenon since 1986. Trusting relationship with informants.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Involved for two years with literature review and interviews.</td>
</tr>
<tr>
<td></td>
<td>Peer debriefing</td>
<td>Research data analysis and findings examined by supervisors.</td>
</tr>
<tr>
<td></td>
<td>Informants debriefing</td>
<td>Member checked with informants and discussed the themes which emerged. Finally discussed the categories with informants.</td>
</tr>
<tr>
<td></td>
<td>Authority of researcher and</td>
<td>Involvement with the phenomenon since 1998. Psychiatric nurse and tutor qualifications for seven years. Pre-exercise increased</td>
</tr>
<tr>
<td></td>
<td>referential adequacy</td>
<td>the interview, analysis skills and interpretations of findings.</td>
</tr>
<tr>
<td></td>
<td>Interview technique</td>
<td>Conducting the research project's interview competently.</td>
</tr>
<tr>
<td></td>
<td>Structural coherence</td>
<td>Recorded and transcribed the interviews. Translation of Zulu interviews into English. Examinined by supervisors forenso</td>
</tr>
<tr>
<td></td>
<td></td>
<td>dependability and conformability. Edited by a professional editor.</td>
</tr>
<tr>
<td>Transferability</td>
<td>Purposeful sample</td>
<td>Sampling was purposeful; experts with knowledge and experience of Zulu language and cultures.</td>
</tr>
<tr>
<td></td>
<td>Dense description</td>
<td>Data provided about informants, research context and setting was adequate.</td>
</tr>
<tr>
<td>Dependability</td>
<td>Stepwise replication</td>
<td>Data was coded and again recoded after two weeks. Member checks of codes, themes, categories and subcategories. After the third recoding, two supervisors compared and examined it.</td>
</tr>
<tr>
<td>Conformability</td>
<td>Inquiry audit</td>
<td>The two supervisors of the research audited the research process. The audit trial and the research process are described in</td>
</tr>
<tr>
<td></td>
<td>Dependability occurs with</td>
<td>The researcher achieved credibility as described in paragraph 3.9.1 (see above application).</td>
</tr>
<tr>
<td></td>
<td>credibility</td>
<td>The researcher achieved credibility as described in paragraph 3.9.1 (see above application).</td>
</tr>
<tr>
<td></td>
<td>Audit trial</td>
<td>Researcher audited all the phases of the research process under the supervision of one Master's, one Doctoral prepared</td>
</tr>
<tr>
<td></td>
<td></td>
<td>colleagues. The inquiry trial contributed to the dependability as well as the conformability.</td>
</tr>
<tr>
<td></td>
<td>Conformability occurs with:</td>
<td>The research project established rigour with the decision trial and proved conformability as described in paragraphs 3.9.1, 3.9.2 and 3.9.3 (see above application).</td>
</tr>
<tr>
<td></td>
<td>credibility</td>
<td>Conclusions and interpretation derived directly from the data.</td>
</tr>
<tr>
<td></td>
<td>transferability</td>
<td></td>
</tr>
<tr>
<td></td>
<td>dependability</td>
<td></td>
</tr>
</tbody>
</table>
3.10 ETHICAL CONSIDERATIONS

Ethical considerations were an important aspect in this study. Due to the sensitive nature of the study, possible risks were continuously examined to increase sensitivity to the informants and not to expose them to risk. The researcher followed the three ethical principles of the Belmont Report, namely beneficence, respect for human dignity, and justice (Polit & Hungler 1995:119).

3.10.1 The principle of beneficence

With this principle the researcher always kept the rule of “Do no harm” in mind. This is also the most fundamental ethical principle in any research.

✦ Freedom from harm

Although physical harm in this project was not to be considered, the psychological consequences of participation in the study needed attention and sensitivity. The wounds of the nurse tutors’ experiences could be re-opened and the researcher assured the informants of her honesty and was sensitive to the emotions of informants. She told them if they felt that it hurt them emotionally, they were welcome to withdraw from the interview (Polit & Hungler 1995:120).

✦ Freedom from exploitation

During qualitative research, the psychological distance between the researcher and informant decreases and this increases the risk of exploitation. The researcher took special precautions not to betray the informants’ confidence, with any personal information that could be linked to them in the data presentation and discussion (Polit & Hungler 1995:120). She also assured them that the tapes and written narrative scripts would be safely stored and later destroyed after the research (Rubin & Rubin 1995:94).
 Benefit from research

The researcher considered the risk/benefit ratio, kept risks minimal by approaching the informants individually, and explained the aim and purpose of the study. These benefits include the description and understanding of experience during change with the aim of contributing in guidelines to be considered on change at the workplace (Polit & Hungler 1995:120).

3.10.2 The principle of respect for human dignity

This is the second principle of the Belmont Report and includes the right to self-determination and full disclosure.

 The right to self-determination

Self-determination means that the informants have the right to decide if they want to participate or not. The researcher approached informants purposefully and no remuneration was offered to them to participate. They voluntarily decided to participate in the study and had the opportunity to withdraw. Written informed consent and an agreement were obtained from the informants prior to the interview, accompanied by a covering letter (see annexures C and D). The individuals who refused to participate were not threatened or intimidated. Permission was asked to record the interview (Polit & Hungler 1995:122).

 The right to full disclosure

Full disclosure means that the study's nature was fully explained to the informants. Self-determination is dependent on full disclosure. The researcher's aim and purpose were discussed with the informants who agreed to participate and were included in the covering letter and agreement (see annexure C). The nature of the study, time, commitment and involvement of the informants were explained. The preliminary findings were shared with the informants during member checks to increase trustworthiness. Informants were invited to comment on the researcher's interpretation of the data analysis (Polit & Hungler
3.10.3 The principle of justice

This principle includes the right to fair treatment and the right to privacy.

✦ The right to fair treatment

Fair treatment entails the fact that selection of informants was based on the requirements of the research question. It entails nonprejudicial treatment of individuals who withdraw or refuse to participate. The sampling method was purposive with the purpose of selecting people with a certain experience. Informants were heterogeneous regarding their language and age (Polit & Hungler 1995:124).

✦ The right to privacy

Anonymity occurs when the researcher cannot link information with informants, thus anonymity is not possible in a qualitative study. During the interviews informants were assured of privacy. The promise of confidentiality was guaranteed: information would not be publicly reported in such a way that the informant's identity could be exposed. Confidentiality was ensured verbally and in the written agreement. The following steps were used to implement confidentiality:

- The agreement and recorded tapes were kept in a locked cabinet.
- No names were attached to the tapes and computer files.
- There was a pledge of confidentiality by the researcher (see annexure C).
- Interviews were not published and only meaning units that were applicable were utilised in the data presentation.
- With the presentation, the verbal quotes were attached with a code (Polit & Hungler 1995:125-126).
3.11 CONCLUSION

In this chapter the discussion centred around the qualitative research paradigm. Each of the research methodologies implemented was fully described.

A nonexperimental research design using an exploratory, descriptive and contextual qualitative approach was undertaken. Data was collected by means of focus groups and interviews. Trustworthiness of the data obtained was evaluated according to four criteria, namely: credibility, dependability, conformability and transferability. Finally, the ethical consideration of the study was discussed.

The following chapter (Chapter 4) discusses data analysis.
CHAPTER 4

Data analysis

4.1 INTRODUCTION

Burns and Grove (1997:778) and Polit and Hungler (1995:699) argue that data analysis is conducted to reduce, organise, and give meaning to data. In this chapter the data analysis is based on themes, categories and subcategories. This chapter presents data analysis and interpretation of the findings. Polit and Hungler (1995:585) and Burns and Grove (1997:565) state that, in qualitative studies, interpretation and analysis of data occur virtually simultaneously. That is, the researcher interprets the data as he or she categorises it, develops a thematic analysis, and integrates the themes into a unified whole. Such themes and categories are presented in this chapter as these emerged from the data.

4.2 SUMMARY OF THE STRUCTURE OF THE DATA

The analysis of the data resulted in the emergence of six themes and 27 categories with about 102 data units. The major themes and categories are exhibited in data display 4.1.
DATA DISPLAY 4.1
SUMMARY OF THE STRUCTURE OF THE DATA

Theme 1: Magico-religious world-view
Theme 2: Traditional medication taken during pregnancy by Zulu women
   Category 2.1: Motivation for taking traditional medication
   Category 2.2: Oral medication: *isihlameziso*
   Category 2.3: Oral medication: *Umchamo wemfene*
   Category 2.4: Inhalation: *impepho*
   Category 2.5: Grains from traditional herbs
Theme 3: Types of food abstained from during pregnancy by Zulu women
   Category 3.1: Yellow foods
   Category 3.2: Green leafy vegetables
   Category 3.3: Potatoes
   Category 3.4: Milk
Theme 4: Traditional preparation for labour:
   Category 4.1: *Ukukhukhla*
   Category 4.2: Castor oil
   Category 4.3: Peeping through a window or door
   Category 4.4: Record solution
   Category 4.5: Sleeping during the day while pregnant
   Category 4.6: Sex avoidance
   Category 4.7: Pain
Theme 5: Minor disorders during pregnancy:
   Category 5.1: Dizzy spells
   Category 5.2: Nausea and vomiting - morning sickness
   Category 5.3: Heartburn
   Category 5.4: Backache
   Category 5.5: Headaches
   Category 5.6: Cramps
   Category 5.7: Constipation
Theme 6: Some changes brought about by pregnancy
   Category 6.1: Role change
   Category 6.2: Body changes
   Category 6.3: Social vulnerability
   Category 6.4: Stress

The term "indicator", often used as a subheading within categories, merely indicates the data units that provide evidence of that specific category where there is more than one subcategory within a category.

4.3 PRESENTATION OF THEMES AND CATEGORIES

A description of the magico-religious world-view follows:
4.3.1 Magico-religious world-view

Data display 4.2 exhibits data pertaining to the magico-religious world-view. This world-view, as indicated previously, is an arena in which supernatural forces dominate. The fate of the world and those in it, including humans, depends on the act of God or gods, other supernatural forces or good or evil spirits. The human individual is at the mercy of such behaviour.

All the themes and categories following must be read, interpreted and understood in terms of this world-view. The reader will only fully understand the experience of the pregnant Zulu woman in these terms.

---

DATA DISPLAY 4.2
THEME 1: MAGICO-RELIGIOUS WORLD-VIEW

- Isihlambezo cleans the baby in utero from any harmful evil spirits, which may affect the baby (Data 4.2).
- It is known as all-purpose because it caters for all ill health problems related to pregnancy like tiredness, oedema of the feet and backache (Data 4.2).
- It is the normal routine without any argument that you routinely obey your mother-in-law and all the elders of the family. For they all say if anything goes wrong to the baby because I did not follow the traditional medicine routine intake, I will take the blame (Data 4.2).
- All our grandparents as "Blacks" including the registered midwives grandparents consumed traditional medication during pregnancy, never attended prenatal clinics, delivered babies at home and all went well.
- If a breech baby is delivered alive, he will bring bad luck or misfortune to the family because he came out with buttocks first instead of the head. He will also have misfortunes in his whole life. I do not want to carry that blame for the rest of my life.
- I guess we have to abide by the registered midwives' restraints as far as this practice is concerned because what if complications occur during this procedure and my baby dies in utero, probably I die also.

4.3.2 Traditional medication taken during pregnancy by Zulu women

Data display 4.3 is about traditional medication taken during pregnancy by Zulu women.

4.3.2.1 Motivation for taking traditional medication

A description of the clients’ views on their indications for taking traditional medication and
how the registered midwives discourage them from using traditional medication during pregnancy is presented in category 2.1 below.

DATA DISPLAY 4.3
THEME 2: TRADITIONAL MEDICATION TAKEN DURING PREGNANCY BY ZULU WOMEN
CATEGORY 2.1: MOTIVATION FOR TAKING TRADITIONAL MEDICATION

- To make the baby grow well in the womb (Data 4.3).
- To prevent any illness from both the baby and the mother.
- The registered midwives discourage us from consuming any traditional medication, saying it may poison both the baby in utero and myself because it is not scientifically tested and proven for oral consumption and safety. I am customarily forced to obey my mother-in-law who instruct me to take traditional medication it is for that reason that I end up taking it as the whole family will blame me should the baby die in utero during delivery. They will say it is due to my disobedience of not taking traditional medication.
- As I have already mentioned that every "Black" person's grandparent consumed traditional medication during pregnancy. Here we are as "Blacks" we were not killed by that practice. Based on that arguments, we will continue the practice even though the practice result in bad relationship between us and registered midwives.
- Isihlambezo cleans the baby in utero from any harmful evil spirits, which may affect the baby (Data 4.3).
- It is known as all purpose because it caters for all ill health problems related to pregnancy like tiredness, oedema of the feet and backache (Data 4.3).
- It is the normal routine without any argument that you routinely obey your mother-in-law and all the elders of the family. For they all say if anything goes wrong to the baby because I did not follow the traditional medicine routine intake, I will take the blame (Data 4.3).

Lefeber (1994:24) argues that, to prevent complications during pregnancy, a traditional healer prepares isihlambezo for the pregnant mothers. A belief that a pregnant Zulu mother will not have prolonged labour when taking isihlambezo till term has a psychological effect which keeps the women positive and strong, thus preserving pregnancy to term.

A magico-religious paradigm is presented here by the fact that Zulu pregnant mothers take traditional medication to clear the baby in utero from any evil spirits which may harm the baby (Boyle & Andrews 1989:99; Nolte 1998b:63). Varga and Veale (1997:911) argue that the most often cited reason for use of herbal medicines was protection from evil spirits, as an alternative to failed modern treatment, and a belief that herbal remedies were more effective than Western prenatal care. Krige (1965:63) states that isihlambezo renders delivery successful.
The value system, belief system and norm for the Zulu nation is that a healthy baby in utero will be either a healthy daughter who will enrich her parents through ilobolo (dowry) when getting married or a son who will bring forth healthy children leading to a healthy generation. Hence the name of that particular family will not perish, but will last for ever from generation to generation, which is the pride of the Zulu nation.

Data display 4.4 comprises traditional oral medication taken during pregnancy by Zulu women.

4.3.2.2 Oral medication: isihlambezo

A description of sources where isihlambezo is purchased by Zulu women during pregnancy is discussed in category 2.2 below.

DATA DISPLAY 4.4
THEME 2: TRADITIONAL MEDICATION TAKEN DURING PREGNANCY BY ZULU WOMEN
CATEGORY 2.2: ORAL MEDICATION ISIHLMABEZO

- Isihlambezo is taken a cupful daily until delivery (Data 4.4).
- I buy isihlambezo from any of the following sources.
  - A traditional herbal chemist (Data 4.4).
  - I buy it from inyanga herbalist.
  - Isangoma
  - Traditional birth attendants

Isihlambezo is one of the various types of traditional medications taken by the Zulu pregnant mothers as a cupful daily until delivery (Nolte 1998b:63). Isihlambezo is a herbal decoction used by many Zulu women in South Africa as a preventative health tonic during pregnancy (Varga & Veale 1997:911). Krige (1965:63) states that isihlambezo is an infusion of certain plants, such as uhlahalahla, covered up in a pot from which the woman drinks a spoonful now and then. It is said to render the birth successful, with rapid delivery. Chalmers (1993:65) states that traditional herbal medications such as isihlambezo and imbeleksana are imbibed during pregnancy. Reasons for their ingestion are to prepare the way for an easy labour; to ensure sound foetal growth or to prevent oedema. These herbal mixtures, depending on the particular 'recipe' followed by each different traditional healer, have been found, when tested within Western research.
frameworks, to have oxytocic properties (Chalmers 1993:65).

Whether isihlambezo is obtained from a traditional herbal chemist or from an inyanga, isangoma or from a traditional birth attendant, it serves the same purpose of supposedly enhancing pregnancy to term.

Gumedze (1978:824) states that isihlambezo is given to the pregnant woman so that her confinement should be quick, easy and effortless. He further states that there are many formulas, for example isihlambezo may be a mixture of various herbs—isinwazi (Rhoicissus cuneifola); ugobo (Gunera perpensa); impila (callilepis laureola DC); or isibhara (Vernonia natalensis). Roots are mixed and boiled with part of umbola, uxamu or iguana. A decoction is made and taken orally daily. A participating traditional female doctor from the Kranskop area provided this formula. She specialises in confinements only and learnt the skill from her mother. The following was provided by a male inyanga: isinwazi (Rhoicissus cuneifolia); iklolo; icishamililo (Pentanisia variabilis); umdubu (Combretum); umphombo (Haemanthus natalensis). The roots are boiled with the head of a fish to make a decoction. Gumedze (1978:824) conducted a study of isihlambezo taken by pregnant Zulu women. Five specimens were examined in the Department of Pharmacology at the medical school in Durban. The effects of isihlambezo were tested against an isolated rat uterus. One specimen stimulated uterine activity, one had an antiprostaglandine effect, one an anti-oxytocic effect and two were inactive.

Data display 4.5 is a continuation of oral traditional medication taken during pregnancy by Zulu women.

4.3.2.3 Oral medication: “umchamo wemfene” (baboon’s urine)

Indications for taking orally umchamo wemfene and its ill effects on the pregnant women is discussed in category 2.3 below.
DATA DISPLAY 4.5
THEME 2: TRADITIONAL MEDICATION TAKEN DURING PREGNANCY BY ZULU WOMEN
CATEGORY 2.3: ORAL MEDICATION UMCHAMO WEMFENE

- A herbalist says, it is the real baboon’s urine, but he can not disclose how he gets hold of the baboon. We also buy it where we buy isihlambezo. It is specifically taken to precipitate labour when time for delivery comes (Data 4.5). An inyanga prepares it.
- Registered midwives discourage all oral traditionally prepared medication saying it will harm the baby and myself.

Umchamo wemfene the herbalist confirmed to be real baboon urine but he is not supposed to tell how he obtained the urine from a baboon. Like isihlambezo, umchamo wemfene enhances the chances of carrying pregnancy to term and assists problem-free delivery. Since isihlambezo and umchamo wemfene are taken for the same indications, the choice lies with an individual as to which one to take.

Data display 4.6 is a continuation of traditional medicine taken during pregnancy by Zulu women.

4.3.2.4 Inhalation “impepho” (aromatic yellow everlasting plant with tiny flowers)

DATA DISPLAY 4.6
THEME 2: TRADITIONAL MEDICINE TAKEN DURING PREGNANCY BY ZULU WOMAN
CATEGORY 2.4: INHALATION IMPEPHO

- Regarding inhalation we burn impepho and inhale its smoke.
- I silently mention all the ancestors on my husband’s side and plead with them to protect me and my baby in utero from evil spirits and witchcraft while inhaling smoke from burnt impepho (Data 4.6).

It is a belief of the Zulus that the ancestors will have mercy on the individual concerned and they will grant a wish if invoked over a burnt impepho (Brindley 1985:100). Felhaber (1999:38) argues that smoke inhalation is used for rapid entry of medicine into the bloodstream and the quick effect of the medicine on the brain. It is also used at the psychological level for protection, driving away evil spirits, communicating with the ancestors, headache treatment, strengthening, luck (mkhokha) and for removing a problem immediately from frightened people. Mkhokha is used here in the context of business; it
is incense that draws people to the business premises. Brindley (1985:100) describes *impepho* as aromatic yellow everlasting plants with tiny flowers (*helichrysum miconiaefolium*).

Data display 4.7 concerns grains of traditional herbs used as a cultural practice by Zulu pregnant women.

### 4.3.2.5 Grains of traditional herbs

Indications, the purpose of usage of grains of traditional herbs and the reaction of the midwives towards this cultural practice are presented in category 2.5 below.

#### DATA DISPLAY 4.7

**THEME 2: TRADITIONAL MEDICATION**  
**CATEGORY 2.5: GRAINS OF TRADITIONAL HERBS**

- **Methods and purpose of usage of grains of traditional herbs**
  - Grains of traditional herbs are poured on a cloth-thread by an *inyanga*, hidden inside a knot and I tie that thread around my waist direct on my body and then I put on my clothes.
  - I remove that thread only when I am having a bath, otherwise, I have to have it on until delivery (Data 4.7).
  - It protects us (mother and baby in utero) from evil spirits and witches.
- **Reaction of the midwives in the prenatal clinic when seeing knots on threads during abdominal palpation**
  - They would ask, "am I allowed to touch?" when you say yes, they will continue with palpation and there will be no harm.
  - The midwives do not mind anything which you do not drink or eat, topical applications, threads of traditional medication around the waist, they just ask "Am I allowed to touch?" when they do abdominal palpation. When you allow them they continue with abdominal palpation. But anything taken in by mouth they say it goes to the baby.

Boyle and Andrews (1989:100-101) state that African beliefs may involve wearing special articles of clothing to ensure safety of mother and baby. Nolte (1998:63) explains that the traditional birth attendants tie strings around pregnant women's waists, to keep pregnancy till term. Nobody except the *inyanga* has ever seen what is inside the thread knot as nobody is allowed to open the knot, according to the *inyanga*’s strict instructions.
4.3.3 Types of food abstained from during pregnancy

Data display 4.8 indicates that Zulu women abstain from certain types of food during pregnancy.

4.3.3.1 Yellow foods

Indications for not consuming yellow foods and examples of those yellow foods are discussed in category 3.1 below.

DATA DISPLAY 4.8
THEME 3: TYPES OF FOOD ABSTAINED FROM DURING PREGNANCY
BY A ZULU WOMAN
CATEGORY 3.1: YELLOW FOODS

- Indicator
- Yellow foods, drinks and fruits, if taken during pregnancy will cause the baby to have jaundice which I am told usually kills the baby (Data 4.8).
- Examples of yellow foods
- Pumpkin, carrots, paw-paw, oranges, eggs, naarties, pineapple, orange juice, cheese and mangoes.
- Supplements for yellow foods
- Well, I am not working, I can never afford food supplements. There is no choice of food you have to eat only what is available (Data 4.8).
- I see the registered midwives as accommodating because they advise us accordingly (for example) as I do not consume eggs based on my cultural way of life, midwives give an option of beans to supplement the eggs.
- Midwives do give options as far as nutrition is concerned.

Yellow foods such as egg yolk contain vitamin A which keeps the skin and mucous membranes healthy. Eggs are a first-class protein which builds and restores women's body tissues.

A well-balanced diet during pregnancy is important on three accounts: the health of the woman herself, the health of her developing foetus and the alleviation of minor disorders of pregnancy (Myles 1996:115). When the pregnant mother is not well nourished she will suffer from deficiency diseases like scurvy and the foetus will not develop well, and this may end in intra-uterine growth retardation (Chalmers 1993:65). Felhaber (1999:11) states that it is important to eat correctly to prevent malnutrition. The food we eat must
provide energy, and it must help to build, repair and protect our bodies. To do this, we must eat a combination of foods every day. Eggs and cheese help to build the body. Carrots, mangoes, oranges and paw-paws are foods that protect the body and help prevent the body from getting sick (Felhaber 1999:11).

Vitamin C, obtained from oranges and naartjies, helps with the absorption of iron. Egg yolk also contains iron which helps with the formation of red blood cells. Lack of iron in the body results in anaemia. Myles (1996:346) addresses the following effects of anaemia to the mother and the foetus:

✦ **Mother**

- reduced enjoyment of pregnancy and motherhood due to fatigue
- predisposition to infection caused by cell-mediated immunity
- predisposition to postpartum haemorrhage (severe loss of blood after delivery of baby)
- potential threat to life

✦ **Foetus**

- increased risk of intra-uterine hypoxia and growth retardation
- higher risk of prenatal morbidity and mortality (Myles 1996:346)

The Vitamin C in yellow fruits (oranges and naartjies) also keeps blood vessel walls healthy. Severe deficiency of vitamin C causes scurvy (Stevenson 2001:14).

Data display 4.9 discusses aspects relating to green leafy vegetables.

### 4.3.3.2 Green leafy vegetables

Reasons for not consuming dark-green leafy vegetables, and the convictions of pregnant women on the subject are described in category 3.2.
DATA DISPLAY 4.9
THEME 3: TYPES OF FOODS ABSTAINED FROM DURING PREGNANCY BY ZULU WOMEN
CATEGORY 3.2: GREEN LEAFY VEGETABLES

- **Indicator**
  - Spinach, lettuce, cabbage, turnip, when eaten during pregnancy will cause the unborn baby to have ugly big dark-green patches on the face and all over the body (Data 4.9).
- **Effects of dark-green leafy vegetables: convictions**
  - Those ugly patches will remain for life, and I promise you, I saw a woman who used to eat green leafy vegetables while pregnant, she ended up with a patchy daughter. (Data 4.9).
  - There can never be big ugly dark-green patches all over the body and face and you tell me they are birth marks and it coincides with the fact that the mother was consuming dark-green vegetables during pregnancy (Data 4.9).

Dark-green leafy vegetables keep the individual's skin and mucous membranes healthy. If an individual does not consume dark-green leafy vegetables, skin- and mucous-related diseases will prevail (Stevenson 2001:14).

Data display 4.10 depicts potatoes as one of the foods abstained from during pregnancy by Zulu women.

### 4.3.3.4 Potatoes

Indications of Zulu pregnant women abstaining from consuming potatoes are given in category 3.3.

DATA DISPLAY 4.10
THEME 3: TYPES OF FOOD ABSTAINED FROM DURING PREGNANCY BY ZULU WOMEN
CATEGORY 3.3: POTATOES

- I was told by my family's elderly women that I am not supposed to consume potatoes while I am pregnant, for my baby will be born with discharging eyes (Data 4.10).

Potatoes contain carbohydrates. Carbohydrates are essential to provide the mother and foetus with heat and energy (Myles 1996:116). The mother needs energy to do exercises to promote blood circulation. She also needs energy to carry pregnancy to term and also during delivery. Lack of energy may hinder the mother from carrying pregnancy to term
and pushing the baby out during delivery. Low intake of carbohydrates will also result in an undernourished woman and foetus, which could lead to susceptibility to infections.

The nutritional status and the nutritional intake of the mother during pregnancy have a profound effect on the growth of the foetus. If the mother’s intake of nutrients is not sufficient, this can lead to “foetal malnutrition” (Poleman & Capra 1984:134). Stillborn, low birth weight, premature and congenitally defective infants are more frequently born to mothers who have had an inadequate diet prior to and during pregnancy (Poleman & Capra 1984:134). An adequate supply of nutrients during pregnancy also helps to assure an adequate supply of good quality breast milk during lactation (Poleman & Capra 1984:134).

* Specific nutrient needs during pregnancy

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**Protein**

Protein promotes growth of the foetus, placenta and accessory tissues (uterus, breast, red blood cells) and production of breast milk (Beischer, MacKay & Colditz 1997:85).

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**Fats**

Fats are important sources of energy. They provide the fat-soluble vitamins (A, D, E and K), and are essential components of cell membranes and the central nervous system (Beischer et al 1997:85).

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**Vitamins and minerals**

Vitamins and minerals are needed during pregnancy for calcification of the foetal skeleton and formation of teeth (Poleman & Capra 1984:134).

Data display 4.11 is a discussion of milk consumption from a Zulu perspective.
4.3.3.5 Milk

As stated, behaviour restrictions of Zulu pregnant mothers by the elders of the family encompass dietary restrictions. These include meat, milk and alcohol (Chalmers 1993:65). Traditionally, dietary limitations have also been imposed to prevent too large a baby and hence a difficult delivery.

Restrictions of as much as a third to a half of the mother's normal intake have been reported (Chalmers 1993:65).

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**DATA DISPLAY 4.11**
**THEME 3: TYPES OF FOODS ABSTAINED FROM DURING PREGNANCY BY ZULU WOMEN**  
**CATEGORY 3.4: MILK**

- As an umakoti (daughter-in-law) I will not consume milk or any milk products until my father-in-law grants me to consume milk by conducting a ceremonial feast of a slaughtered goat. Presently the ceremony has not yet been conducted for it is done after delivery of a first born baby. I may never consume milk even in a cup of tea, not to mention porridge (Data 4.11).

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Milk is protein. Protein intake provides for the growth of new tissues in an unborn baby; protein also repairs the pregnant mother's worn-out tissues (Myles 1996:115). Dietary deficiency of calcium, which is found in milk and is important for formation of healthy bones may lead to a baby suffering from rickets (Myles 1996:382).

A Zulu perspective of traditional preparation for labour is discussed in data display 4.11.

4.3.4 Traditional preparation for labour

4.3.4.1 "Ukuhlukuhla" (rubbing of a pregnant mother's abdomen by a traditional birth attendant using a traditional cream)

The purpose of ukuhlukuhla, duration, and the consequences of failure to abide by that cultural practice, are described in category 4.1 below.
DATA DISPLAY 4.11
THEME 4: TRADITIONAL PREPARATION FOR LABOUR
CATEGORY 4.1: "UKUHLUKHLA" (RUBBING OF A PREGNANT MOTHER'S ABDOMEN BY A TRADITIONAL BIRTH ATTENDANT USING A TRADITIONAL CREAM)

- **Purpose of ukuhlukhlala**
  - To relax abdominal muscles so as to facilitate delivery when delivery time comes.
  - To correct the presenting part of the baby in utero (for example) if the baby's head is facing up and the buttocks are presenting abdominally, a traditional birth attendant will bring the head down and the buttocks of the baby up by a twisting motion (Data 4.11).
  - It is done once a week till delivery (Data 4.11).
  - Even our mothers while they were pregnant, their grannies monitored their pregnancy at home till we were born. Here we are normal and alive. There were no midwives when we were born. We can do the same without the help of the midwives.
  - The baby I'm pregnant with is a family baby. I have to do rubbing as my family instructs me to do to preserve this pregnancy to term.
  - If anything goes wrong during delivery (for example) if due to obeying the midwives instructions of not having external version by a traditional birth attendant, I then deliver a breech baby who may probably die during delivery. I will be blamed by the whole family for failing to abide by their instructions. That is why we turn a deaf ear to the registered midwives who strongly discourage this practice and this strains our relationship with the registered midwives.

Nolte (1998b:62) states that a traditional birth attendant does the following:

- massages the abdomen to correct abnormal presentations and positions
- gives health education, for instance regarding what to do during delivery, nutrition, rest
- gives no prenatal care
- monitors foetal movement by abdominal palpation
- does external versions by twisting the head upwards abdominally.

Western medicine allows only a obstetrician to do external version for it needs highly specialised skill; if performed by a non-specialist it could be fatal to both the pregnant woman and the baby in utero.

Castor oil usage from the Zulu perspective is discussed in data display 4.12.
4.3.4.2 Castor oil

Indication of castor oil consumption by Zulu pregnant women is described in category 4.2.

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DATA DISPLAY 4.12
THEME 4: TRADITIONAL PREPARATION FOR LABOUR
CATEGORY 4.2: CASTOR OIL

- We drink a tablespoon of castor oil once a week until delivery.

**Purpose of castor oil intake.**
- We drink castor oil to clear the baby's passages of stools so that the baby is born without the obstruction of the passages by the stools (Data 4.12).
- A baby born while the stools are coming from the mother due to bearing down will not be liked by people, he/she is a bad luck baby (Data 4.12). Even on admission for labour the very midwives give you an enema for the very reason that we drink castor oil for (that is to evacuate the bowel before delivery).
- There is a strained relationship between us and the registered midwives because even though they discourage this practice, saying it may result in abortion, we will not stop it because they also give us enema to hasten delivery in the clinic.

Castor oil consumption is self-induction, which results in early labour. The baby may be born prematurely, which could be fatal (Myles 1996:564). Nolte (1998:63) argues that the traditional birth attendants give *muthi* (enema) or laxatives to empty the lower bowel.

Data display 4.3 discusses the Zulu belief pertaining to peeping through the window of door during pregnancy.

4.3.4.3 Peeping through the window or door

Consequences of peeping through the window or door while a Zulu woman is pregnant are explained in category 4.3.

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DATA DISPLAY 4.13
THEME 4: TRADITIONAL PREPARATION FOR LABOUR
CATEGORY 4.3: PEEPING THROUGH THE WINDOW OR DOOR

- You do not peep through the window or door because even during delivery, the baby will peep through then goes back to the uterus (Data 4.13).
Boyle and Andrews (1989:98-102) describe cultural variations and cultural beliefs about activity and pregnancy. Pregnant mothers adhere to these beliefs and practices to avoid being blamed by their in-laws should anything abnormal happen to their babies. To quote a few beliefs:

- Do not reach over your head, or the cord will wrap around the baby’s neck.
- Do not have your picture taken, because it might cause still-birth (Boyle and Andrews 1989:101).

Data display 4.14 pertains to traditional preparation for labour using a solution from a gramophone record.

4.3.4.4 Solution from gramophone record

The dosage and the indications of the intake of a solution from a gramophone record by the Zulu pregnant women are discussed in category 4.4

DATA DISPLAY 4.14
THEME 4: TRADITIONAL PREPARATION FOR LABOUR
CATEGORY 4.4: SOLUTION FROM GRAMOPHONE RECORD

- **Indicator**
  - The *inyanga* boils pieces of a big gramophone record in water and makes a solution from that (Data 4.14).
- **Dosage**
  - We drink a teaspoon full of boiled record solution daily till delivery (Data 4.14).
- **Indication**
  - Do you see how fast the record spins on the record player when music is played? It will be like that during delivery (Data 4.14).
- **Reasons for preparing fast delivery**
  - Have you not heard of mother or baby dying from fatigue due to spending hours and hours when for some reason the baby fails to come out? I surely do not want that to happen neither to my baby nor myself (Data 4.14).
  - Even the midwives themselves give you a “drip” with medication added into it to make the cervix dilate when they are not satisfied with the process and duration of cervix dilatation. Now why do they blame us for taking our traditional methods to achieve the same purpose.
A telephonic enquiry from a midwife who resides in KwaZulu-Natal confirmed the use of a gramophone record-solution in KwaZulu-Natal.

The pharmacological action of the solution is to cause a rapid spread of the excitation wave over the uterus during labour, and strong contractions occur, resulting in a precipitated labour (lasting less than four hours).

Data display 4.15 describes beliefs about sleeping during the day while pregnant from a Zulu perspective.

4.3.4.5 Sleeping during daytime while pregnant

Sleeping during the day while pregnant from a Zulu perspective is discussed in data display 4.15.

DATA DISPLAY 4.15
THEME 4: TRADITIONAL PREPARATIONS FOR LABOUR
CATEGORY 4.5: SLEEPING DURING DAYTIME WHILE PREGNANT

- **Indicators**
- A pregnant Zulu mother is not supposed to sleep or rest during the day.
- **Reasons for not sleeping during the day**
  - The baby will rest and sleep during delivery until the baby dies in the utero, if a pregnant mother rests or sleeps during the day (Data 4.15).
  - A pregnant mother has to be active so that during delivery the baby can actively come out fast and alive.
  - The midwives encourage activity and physical exercise during pregnancy but they also encourage rest and sleep, they say it is a biological need.

Boyle and Andrews (1989:101) state that the belief is that a pregnant woman has to keep active to ensure a small baby and easy delivery. It is a Zulu belief that if the woman sleeps during the day, the baby will sleep during the day as well, meaning that when grown up he or she will be lazy.

Rest should not only be a cessation of activity, but there should be definite periods set aside for rest. The pregnant woman should rest with her feet up. This aids return of blood to the heart, resolution of oedema and fluid in the legs, reduction in the incidence and
severity of pre-eclampsia, improvement or prevention of varicose veins, improvement in the blood flow of the uterus and probably in a reduction of prematurely terminated pregnancy (Beischer et al:80-81).

Data display 4.16 describes sex avoidance as a means of traditional preparation for labour in a Zulu belief system.

4.3.4.6 Sex avoidance

Instructions relating to sex avoidance and its repercussions are discussed in category 4.6.

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**DATA DISPLAY 4.16**
**THEME 4: TRADITIONAL PREPARATION FOR LABOUR**
**CATEGORY 4.6: SEX AVOIDANCE**

- **Indicators:**
  - My mother-in-law informed me that a month before delivery, I have to sleep in her bedroom in order to make sure that that I do not have sexual intercourse with my husband.

- **Indications for sex avoidance**
  - If I have sex during the last month of delivery I am told my baby will be born with male sperm covering the baby, which disgraces a mother [in] that she does not have self-control over sexual activity and the baby will be disliked by everybody during his/her whole life span on earth (Data 4.16).
  - Registered midwives say having sex does not affect the baby in utero. It is also a myth that the baby will be born with sperms covering the baby, so I will take their word for it.

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Boyle and Andrews (1989:101) state that it is a cultural belief that it is necessary to avoid sexual intercourse, or harm will come to you or your baby. Sexual intercourse is prohibited during the last trimester of pregnancy or the baby will be covered with vernix caseosa (the fatty substance covering the skin of a newborn baby) which is believed to be sperm, and is also believed to be shameful, suggesting the results of intercourse during pregnancy (Lefeber 1994:16).

Because of the sexual intercourse restriction and the beliefs surrounding it, the husbands of the pregnant women have extramarital affairs which may result in sexual disease. (Meyer-Weitz, Reddy, Weits, Borne & Kok 1999:45).
Bennett and Brown (1996:116) argue that sometimes couples fear that sexual intercourse in pregnancy may harm the baby. It is absolutely safe and normal unless special conditions pertain. If the woman is nauseated in early pregnancy she may feel disinclined to have intercourse but the couple can be encouraged to find other ways of being loving. Libido varies throughout pregnancy and if during the middle trimester the abdomen is large, couples sometimes have to adopt different positions (Bennett & Brown 1996:116).

The concept of pain from a Zulu perspective, pertaining to traditional preparation for labour, is discussed in data display 4.17.

4.3.4.7 Pain

Pain endurance during labour as perceived by the Zulus is described in category 4.7.

DATA DISPLAY 4.17
THEME 4: TRADITIONAL PREPARATION FOR LABOUR
CATEGORY 4.7: PAIN

- My own biological mother, my aunts and grandmother told me on my wedding day that, culturally, labour pain cannot be expressed, whether verbally or nonverbally, otherwise I would be disgracing my family by displaying cowardice (Data 4:17).

Fouche and Heyns (1998:73) argue that, traditionally, the mother was expected to be quiet and stoical during delivery. The expression of pain was regarded as a cowardly expression that could bring shame to the family. Helman (1996:179) describes the concept of pain from a physiological perspective as "a type of signalling device for drawing attention to tissue damage or to physiological malfunction".

Pain arises when nerves or nerve endings are affected by a noxious stimulus, either from within the body or from outside it. Because of this biological role, it is sometimes assumed that pain is culture-free in the sense of being a universal biological reaction to a specific type of stimulus, such as a sharp object or extremes of hot or cold (Helman 1996:179). The concept of 'culture' is defined by Helman (1996:2) as 'that complex whole which includes knowledge, beliefs, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society. Growing up within any society is a form of
enculturation, whereby the individual slowly acquires the cultural 'lens' of that society.

Pregnant mothers are reassured during pregnancy that labour pains will be alleviated by tying tight cords around the abdomen. It is thought that pain and problems in labour will be due to the presence of evil spirits. Witchcraft, with magic charms, portions and incantations, will be used to drive away the bad influences (Sellers 1997a:417). Fisher (1987:37) conducted a study which suggested that the childbirth pain experience is basically common to all races. Pain is a highly personal experience, dependent not only on neurological pathways, but also on cultural learning and the meaning of the situation in the light of past experience or "conditioning". (Boyle and Andrews 1989:284; Fisher 1987:37). Helman (1996:180) argues that, in order for the next person to know whether a person is in pain, the next person is dependent on the sufferer signalling that fact, either verbally or nonverbally. When that happens, the private experience and perception of pain become a social, public event; private pain becomes public pain. Under some circumstances, however, the pain may remain private: there may be no outward clue or sign that the person is experiencing pain, even when it is very severe. This behaviour is common among societies that value stoicism and fortitude (Helman 1996:18).

Data display 4.18 is a discussion of the minor disorders of pregnancy.

4.3.5 Minor disorders of pregnancy

The minor disorders of pregnancy are common to all pregnancies regardless of race or culture. All the subcategories under this theme are also listed in Western textbooks on pregnancy.

4.3.5.1 Dizzy spells

The indications of dizzy spells during pregnancy are discussed in category 5.1.
Dizzy spells and/or fainting in pregnancy can be worrying to the pregnant woman and her family. When this condition arises early in pregnancy, it is probably caused by progesterone-induced general vasodilation of pregnancy, which has not yet been counterbalanced by the increase in the blood volume (Sellers 1997a:247). Fainting may occur when the woman has been standing for a while, especially in a hot, confined or crowded place. Tight clothing, over-exertion, lack of sleep, excitement and shock may also be contributing factors. Fainting may occur in late pregnancy, as a result of pressure on the aorta and/or on the inferior vena cava by the enlarged uterus (the supine hypotensive syndrome) (Sellers 1997a:247).

4.3.5.2 Nausea and vomiting — morning sickness

Treatment of nausea and vomiting from a Zulu perspective.

• When I am nauseous, to avoid vomiting, my mother-in-law advised me to chew intelezi (aloë kraussii).
• This plant is not poisonous, it grows in the garden, a small bite of its green leaves is enough to counteract nausea.
• It has a bitter taste, but it is tolerable (Data 4.19).
• We actually try by all means that the midwives should never know the traditional medication we take for all minor disorders of pregnancy because should they know they will really give it to you.
Morning sickness occurs early in pregnancy and disappears approximately at 14 weeks. Some women merely develop a dislike for certain foodstuffs; some are nauseous in the morning, whereas others are nauseous throughout the day. The cause of nausea is not known.

Theoretical possibilities are:

- the increased levels of human chorionic gonadotrophin during early pregnancy (Nolte 1998b:123)
- changes in carbohydrate metabolism, which may cause a decrease in blood glucose levels in early pregnancy
- emotional factors (Nolte 1998b:123). The pregnant woman will be emotionally labile throughout her pregnancy, owing to hormonal fluctuations and increased anxiety (Nolte 1998b:73). If vomiting becomes severe, the mother may lose weight and become dehydrated and ketonic (ketones in urine testing occur as a result of starvation or maternal distress when all available energy has been utilised) (Myles1996:173). This condition is called hyperemesis gravidarum (Myles 1996:119). The condition warrants hospitalisation. All treatment for morning sickness is not always effective, but the following measures usually alleviate the symptoms:
  - Avoid food that causes nausea, for example spicy or fatty foods.
  - Eat a rusk or toast before rising.
  - Take smaller meals more often (Nolte 1998b:123).

Traditional theories as to the causes of nausea and vomiting include too much gall, liver problems, allergy to eating certain types of foods or idlišo (poisoned foods) (Felhaber1999:65). Traditional treatment is as follows:

- *ilabatheke* (hypoxis latifolia) bulb [½ teaspoon, powdered]. Pour half a litre of boiling water on to the herb, cool and strain. Dosage: Drink ¼ cup every four hours until finished (Felhaber 1999:66).
- *ilabatheke* treats nausea and vomiting during pregnancy (Felhaber 1999:66).
Data display 4.20 is a discussion on heartburn during pregnancy.

4.3.5.3 Heartburn

Reasons for suffering from heartburn during pregnancy according to the Zulus.

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DATA DISPLAY 4.20
THEME 5: MINOR DISORDERS OF PREGNANCY
CATEGORY 5.3: HEARTBURN

- I am troubled by heartburn because the baby has very long hair, hence the burning sensation on my chest (Data 4.20).

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Oesophageal reflux – heartburn or waterbrush – occurs in over 60.0% of pregnant women and is the reflux or regurgitation of the gastric juice into the oesophagus, or into the mouth, when it is commonly known as “waterbrush”. It is due to the relaxation effect of progesterone, causing incompetence of the cardiac sphincter, combined with the pressure on the stomach from the enlarging uterus (Sellers 1997a:253). It usually occurs in the second and third trimesters of pregnancy, and is experienced as discomfort, burning or pain in the epigastrium. The acidic gastric juice causes irritation of the lower oesophagus and oesophagitis (inflammation of the oesophagus) may occur (Sellers 1997a:253). The condition is worse at night when the woman is recumbent and it may prevent restful sleep.

Incompetence of the pyloric sphincter can result in the bile being present in the gastric juice (Sellers 1997a:253).

Traditional theories as to the causes of heartburn include too much gall (bile), misuse of alcohol, and eating only one type of food (lack of variety in the diet) (Felhaber 1999:72). Traditional treatment is as follows:

- * uma/momnandi* root [½ teaspoon, powdered]. Pour one litre of boiling water onto the herb, let stand for half an hour, strain and bottle. Dosage: drink ¼ cup three times a day until finished (Felhaber 1999:72).
- * uma/momnanci* treats heartburn during pregnancy (Felhaber 1999:72).
Data display 4.21 is a discussion of backache during pregnancy.

### 4.3.5.4 Backache

Backache as a minor ailment during pregnancy is described in category 5.4.

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**DATA DISPLAY 4.21**
**THEME 5: MINOR DISORDERS OF PREGNANCY**
**CATEGORY 5.4: BACKACHE**

- It is a common saying by birth attendants and elderly woman that whenever one experiences backaches during pregnancy, rest and sleep cause muscle relaxation and thus backaches are alleviated.
- Sometimes my mother-in-law reassured me by saying, backaches are one of the minor disorders of pregnancy, after delivery I will be fine.
- If backache persists regardless of rest, a herbalist treats it by oral traditional medication.
- To prove that you are a strong woman, you have to bear the pain and stop complaining and reporting every minor disorder, that was an advice from my biological mother (Data 4.21).

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Nolte (1998:124) states that many pregnant women experience backache because of the effects of progesterone on the ligaments of the pelvis as well as the changes in the posture. Progesterone and relaxing encourage relaxation of ligaments and muscles, reaching maximum effect during the last weeks of pregnancy (Myles 1996:100). This is likely to be the cause of backaches. Posture may alter to compensate for a change in the centre of gravity, particularly if abdominal muscle tone is poor. The gravid uterus (pregnant uterus) pulls the body forward, the woman leans backwards in order to balance and she tends to exaggerate the normal lumber curve, hence the backache.

The traditional treatment of backache is as follows:

- **Umsenge** (Cussonia spicata) leaves or root bark [one teaspoon, powdered]. Boil the herb in one and half litres of water for half an hour, cool, strain and bottle. Dosage: drink half a cup four times a day (Felhaber 1999:152).
- **Umathunga** (Eucomis autumnalis) bulb with:
  - **Igibilisa** (Bowiea volubilis) bulb [one teaspoon of each, powdered]. The powdered herbs are left overnight in three and half litres of water. The
mixture is then boiled the next day for 5 minutes, then strained and cooled to lukewarm temperature. Usage: the strained lukewarm liquid is used as an enema (Felhaber 1999:152).

In Western treatments enemas are nowadays prohibited during pregnancy as they may induce labour. Instead, prevention of backache is encouraged by maintaining correct posture (maintaining an anatomical position which avoids exaggerating the lumbar curvature) (lordosis) (Sellers 1997a:256). To prevent backache the woman should wear comfortable shoes and avoid excessively high heels. The pregnant woman should be taught exercises that will strengthen her back muscles, especially pelvic tilts, pelvic cradle posture and relaxation (Nolte 1998b:124).

Data display 4.22 discusses headaches during pregnancy.

4.3.5.5 Headaches

Treatment for headache during pregnancy from a Zulu perspective.

DATA DISPLAY 4.22
THEME 5: MINOR DISORDERS OF PREGNANCY
CATEGORY 5.5: HEADACHES

- I do suffer from mild headaches, although not always.
- I usually drink lots of water, and eventually the headache subsides.
- I sometimes just take a nap, and that always helps.
- If the headache persists I simply take two Panado tablets and that always helps.

Sellers (1997a:251) argues that headaches are a fairly common complaint in early pregnancy and are probably due to the effects of oestrogen and progesterone on the circulatory system, and in particular on the intracranial vascular system. They are very similar to "premenstrual tension" headaches and they usually disappear after the first trimester, although occasionally the condition may persist throughout pregnancy (Sellers 1997a:251).
Traditional treatment of headaches is described by Felhaber (1999:93) as follows:

- *Ishongwe* (Xysmalobium unduletum) root [powdered]. Put a little of the powder in the nostrils as snuff (sniffing the powder up into the nostrils).

- *Indodemnyama* (Diospyros galpinii or Diospyros villosa) root. Burn and inhale the smoke of the root. Ancestral headache is treated by performing cultural rites following consultation with elders or a traditional doctor (Felhaber 1999:93). If the headache does not respond to the traditional treatment it is then regarded as an ancestral headache. To perform cultural rites, a goat is slaughtered, and African beer prepared.

- *Umhlonyane* (artemisia afra) burnt and inhaled during the goat ceremony while calling all the ancestors to heal the headache (Brindley 1985:100). Krige (1965:296) says that the gall of a slaughtered goat is poured on the body of the sick person. It is sprinkled, beginning at the end of the forefingers, extending up each arm, the forehead, down the body and then on each leg. This is so that the *amaThongo* (ancestors) may lick the patient and make her well (Krige 1965:296).

Medical treatment of headaches during pregnancy:

The woman should be reassured that, like morning sickness, the headaches will pass off after the first trimester and that she should rest if they are troublesome.

If they persist, then she should see a doctor, who may prescribe a mild analgesic. The teratogenic effect of medication must be kept in mind. The doctor will then exclude raised blood pressure and proteinuria (Sellers 1997a:251).

Data display 4.23 as a discussion of cramps during pregnancy.

### 4.3.5.6 Cramps

Problems related to cramps during pregnancy are discussed in category 5.6.
DATA DISPLAY 4.23
THEME 5: MINOR DISORDERS OF PREGNANCY
CATEGORY 5.6: CRAMPS

- I am troubled by terrible cramps on the calves of my legs, especially at night and when I wake up early in the morning (Data 4.23).
- During the early months of my pregnancy, I never had these cramps but now on the last months, the cramps are a problem.

Nolte (1998:124) states that cramps are painful muscular spasms of the gastrocnemius muscles. These spasms usually occur during the later months of pregnancy. The possible causes are:

- pressure of the enlarging uterus on the nerves of the lower extremities
- exhaustion
- excess or deficiency of calcium in the diet (Nolte 1998b:124)

Traditionally, “piercing” (African acupuncture) is a method of pain management used mainly to treat pain in areas with no wounds or open sores. A porcupine quill is commonly used as a needle. The part of the body that has pain is pierced with the quill and medicine (usually in powdered form) is applied. This procedure may also involve applying pressure, followed by medicine, on painful areas (Felhaber 1999:38).

Medically, cramps are treated by supplementing the woman's calcium intake, if it is inadequate. Antacids containing aluminium hydroxide can be taken, because this substance reduces the effect of phosphor of calcium, thus decreasing the possibility of cramps (Nolte 1998b:124).

Data display 4.24 is a discussion of constipation during pregnancy.

4.3.5.7 Constipation

Complications of constipation are discussed in category 5.7.
DATA DISPLAY 4.24
THEME 5: MINOR DISORDERS OF PREGNANCY
CATEGORY 5.7: CONSTIPATION

- I become constipated every now and again and it causes lots of discomfort.
- I have even developed piles from straining due to constipation (Data 4.24).

Traditional theories as to causes of constipation include *kokwana* (parasites) and eating food that is too refined (lacks fibre) (Felhaber 1999:70). Traditional treatment of constipation is as follows:

*Umnungwane* (Zanthoxylium capense) leaves with *ubuhlololo* (Achyropsis avicularis) root [$\frac{1}{4}$ teaspoon of each in 2 litres of water, powdered]. Boil the herbs in 2 litres of water for half an hour, cool, strain and bottle. Dosage: Drink half a cup three times a day until finished (Felhaber 1999:71).

Medically, Myles (1996:119) states that, with regard to constipation, progesterone causes relaxation of all smooth muscles resulting in delayed peristalsis (Myles 1996:119).

Data display 4.26 is a discussion of some changes during pregnancy.

4.3.6 Some changes brought about by pregnancy

Some changes brought about by pregnancy are described in data display 4.25.

4.3.6.1 Role change

Social changes brought about by pregnancy are discussed in category 6.1.
DATA DISPLAY 4.25
THEME 6: SOME CHANGES BROUGHT ABOUT BY PREGNANCY
CATEGORY 6.1: ROLE CHANGE

- As far as chores are concerned there is no role change for I have to continue to do laundry, cooking and cleaning the house for if I stop doing all that to have more time to rest, my mother-in-law told me that even the baby will rest and not come out during delivery (Data 4.26).
- As far as decision making is concerned, my mother-in-law chooses for me traditional birth attendant to consult the type of traditional medicine to take during pregnancy to enhance pregnancy to term, as I am presently taking isihlambezo, and where to get that isihlambezo from.
- In fact my entire way of life is directed by my mother-in-law during pregnancy, for example what to eat and what not to eat, what to wear, when to go out and where to go (with the purpose of avoiding evil spirits at certain places and at certain times of the day).
- My role as a married woman as far as conjugal rights are concerned is also dictated by my mother-in-law. Presently I am sleeping in my mother-in-law's bedroom till delivery.

Chalmers (1993:65) states that traditionally coitus during the early months of pregnancy is encouraged, to strengthen the baby, but is frowned upon during the last trimester, when it is believed to result in a vernix (sperm) coated baby at birth. Fear of bewitchment leads to additional taboos being imposed during pregnancy. Pregnant Zulu women are advised to avoid certain pathways that may harbour evil spirits of wizards, witches or wild animals, all of which harm the baby (Chalmers 1993: 65). At least, women should wear protective wrist and ankle bracelets to prevent these spirits from entering the body (Chalmers 1993:65). Additional restraints during pregnancy encompass dietary activity. These include avoiding food stuffs such as eggs, meat, milk and alcohol which may cause abortion or result in delayed or obstructed labour (Chalmers 1993:65). Eating or drinking while standing is also prohibited lest the baby change its position in utero or develop a long head (Chalmers 1993:65).

Pregnancy is a time of great concern, not only for the health and successful confinement of the mother, but far more for the future welfare of the child, who is easily affected by anything the mother may do, and stands in great danger of being harmed by wizards (Kringe 1965:62). The Zulus say that during the first and second months after conception a woman is troubled with incessant dreams, ukuphupha. Should she at this time dream of a green or black snake or a buffalo she will have a male child, but if she dreams of a
puffadder or that she is crossing a full river she will have a female child (Krige 1965:62). Once she is pregnant, the woman will cover from sight her breasts and abdomen by means of a skin *ingcayi*, which is afterwards used to carry the infant on the back, when it is called *imbeleko* (Krige 1965:62). While she is pregnant, a woman must be very careful indeed, for there are all manner of dangers in the world around her that will harm her unborn child unless proper precautions are taken. To safeguard her child from evil influences the woman must be treated by a doctor, who will give her special medicine (Krige 1965:62). This medicine is continued until two or three months after birth, when the child will be strong enough to resist these influences. A pregnant woman is constantly in fear of hurtful *imikhondo* (tracks of obnoxious animals, such as the eland, etc.), which cause sinking of the fontanelle (as from spurious hydrocephalus) in children whose mothers pass over them while pregnant. During her pregnancy the mother therefore has to arm herself continually, and especially when going far from the kraal, with the *umkhondo* plant, a small spreading weed with tiny leaves and yellow flowers, which she ties round the ankle so as to counteract the enemy at the very first point of attack (Krige 1965:63). There are many practices that are said to render the birth successful. During the later months of her pregnancy a woman will keep an infusion of certain plants, such as *uhlakahla*, covered up in a pot from which she drinks a spoonful now and then. This medicine (*isihlambezo*) renders the birth successful, with rapid delivery. It must not be looked upon by anyone, lest the child takes the likeness of that person — the reflection in the water being presumably swallowed by the woman in the drinking and transferred to the child (Krige 1965:63). To make the birth an easy one, the pancreas of cattle (*nyikwe*) is sometimes eaten. A pregnant woman must take care not to stand when eating, lest the child stand in the womb and consequently cause trouble by being born feet first. She must also not peep at the door, for if she does, her child may also only just peep and then go back into the womb (Krige 1965:64). Not only has the woman to be careful to avoid dangers awaiting her child and herself, but even her husband is thought to be more vulnerable than usual, and the Zulus have a belief that a man must not go into water when his wife is pregnant, for he will quickly be carried away by it (Krige 1965:64).

Data display 4.26 explains body changes during pregnancy.
4.3.6.2 Body changes

Some of the effects of progestogen during pregnancy are highlighted in category 6.2.

DATA DISPLAY 4.26
THEME 6: SOME CHANGES BROUGHT ABOUT BY PREGNANCY
CATEGORY 6.2: BODY CHANGES

- What I observe is that my nipples are more dark in colour. My breasts are tender. Nobody ever told me of such changes (Data 4.26).
- I have darkish patches on my face, I don't know why.
- I am becoming more roundish and fat.

During pregnancy, the duct and alveolar system of the breasts enlarge with increased pigmentation under the influence of oestrogen and progesterone (Sellers 1997a:249). Breast tingling and tenderness is one of the earliest symptoms of pregnancy. Later in pregnancy there is an increased vascularity, together with a general enlargement of the breasts and the woman may experience tenderness and discomfort (Sellers 1997a:249). Nolte (1998:68) states that, during pregnancy, some areas such as the nipples, linea nigra, umbilicus and vulva show increased pigmentation. An irregular brown colouration, cloasma (melasma gravidarum) often appears on the face, especially over the forehead, nose, cheeks and sometimes the neck. This is caused by the increase of the hormone melanotrophin during pregnancy (Nolte 1998b:68). Traditionally there is no treatment for skin changes during pregnancy.

Data display 4.27 is a discussion of social vulnerability during pregnancy from a Zulu perspective.

4.3.6.3 Social vulnerability

Instructions from the mother-in-law of a Zulu pregnant woman regarding vulnerability.
Helman (1996:30) argues that all cultures share beliefs about the vulnerability of the mother and the foetus during pregnancy. Cultural concepts of the physiology of pregnancy are often evoked after the child is born, in order to explain post hoc any unwanted outcomes of pregnancy such as a deformed, ailing or retarded child (Helman 1996:30). Culturally, it is believed that the mother’s behaviour, her diet, physical activity, state of mind, moral behaviour, use of drink, drugs or tobacco, can directly harm the physiology of reproduction, and cause damage to the unborn child (Helman 1996:30). The pregnant woman is in a state of social vulnerability and ambiguity. She is in a state of transition between two social roles, that of wife and that of mother. In this marginal state, she is somehow in an ambiguous and ‘abnormal’ state, dangerous both to herself and to others (Helman 1996:30).

The pregnant woman will be emotionally labile throughout her pregnancy, owing to hormonal fluctuations and increased anxiety. Hormonal fluctuations are due to endocrinal changes during pregnancy (Nolte 1998b:71-73). The pregnant woman may be tearful without good cause, yet experience joyful moments later (Nolte 1998b:73).

Data display 4.28 is a discussion of stress during pregnancy.

**4.3.6.4 Stress**

Stressors during pregnancy are described in category 6.4.
• I am stressed by the fear of the unknown as I do not know if the baby I am carrying is normal or abnormal or if pregnancy will last till term.
• I am stressed by the fact that as this is my first baby, will I cope during delivery, because some women die during delivery, or the baby die during delivery (Data 4.28).
• I am also stressed by the fact that as I sleep in my mother-in-law's bedroom, is my husband faithful or is he collecting HIV outside? This scares me to death. I, however, ask him to use condoms in case he is tempted outside.

Chalmers (1993:65) argues that the reasons for taking traditional herbal medication during pregnancy like isihlambezo and imbeleksane are:

• to prepare the way for early labour
• to ensure sound foetal growth
• to prevent oedema or the presence of vernix on the newborn (Chalmers 1993:65)

♦ Culture

Guilt which leads to stress

The pregnant Zulu woman consumes traditional medication (isihlambezo) carrying out the orders of her mother-in-law. She does this even if she is unwilling to take it, because she will be blamed for whatever goes wrong with the foetus or labour. The pregnant woman becomes guilt-laden, for she consumes the isihlambezo fearing that it may cause adverse effects to her or the baby in utero or during delivery.

♦ Factors causing stress: social, emotional and cultural

Social

Among other things a pregnant woman may experience poverty or financial difficulties. Problems could include alcoholism, drug abuse or criminal activities of her partner or
family members. There could be death or chronic illness among family members (Sellers 1997b:983).

Marital discord or sexual problems may be associated with the pregnancy. The thought of caring for additional dependent family member could be stressful, especially if this is an unwanted pregnancy. The fact that the pregnant woman's life is controlled by either her mother-in-law or the elderly members of the family, who prescribe what she should eat, and where and when she may go out, could be very stressful. This is all the more so because culturally she can neither debate nor argue the issues: “hers not to reason why: hers but to do or die”.

**Emotional**

Even if the traditional practices end up in intra-uterine death, for example, a gramophone solution having a teratogenic effect on the baby in utero, the Zulu pregnant woman, because of cultural restraints, cannot say “Look what you did!” to her mother-in-law. Her lot is to suffer the loss in silence, and naturally the stress may lead to emotional turmoil.

**Cultural**

Helman (1996:302) argues that social support, at all stages of life, is very important in protecting the woman against stress. However, a pregnant Zulu woman’s husband, mother-in-law, and elderly members of the family all give her orders to abide by, whether she likes it or not, and this could cause great stress. These people, who are supposed to give her social support and help her cope with stress, instead become a source of stress. A culture which imposes submission regardless of one's feelings can be very stressful.

### 4.4 INTERPRETATION OF FINDINGS

Only the problematic findings were interpreted: that is, problems that were harmful to the mother and baby in utero.
4.4.1 Interpretation of findings of Theme 2: Category 2.1

Motivation for taking traditional medication.

Source of the problem:

- Zulu pregnant mothers are forced by their mothers-in-law to consume traditional medication during pregnancy. Guilt is also instilled in them.
- Pregnant mothers perceive the registered midwives as neglecting the culture of clients in the prenatal visits.

Informant:

*It is the normal routine without any argument that you routinely obey your mother-in-law and all the elders of the family. For they all say if anything goes wrong to the baby because I did not follow the traditional medicine intake, I will take the blame.*

Informant:

*I perceive the registered midwives as focusing on Western medication only. I wish I could teach them about traditional medication.*

Informant:

*I perceive registered midwives as having been brainwashed by Western education.*

✦ Effects of the problem

These herbal mixtures, depending on the particular "recipe" followed by each different traditional healer, have been found, when tested within Western research frameworks, to have oxytocic properties (Chalmers 1993:65). Krige (1965:63) states that isihlamba zo renders delivery successful.

✦ Relationship between registered midwives and prenatal client is strained

✦ Solution to the problem

The informants resolved to continue with the traditional medication consumption during
4.4.2 Interpretation of findings of Theme 3: Categories 3.2 and 3.4

Food abstained from during pregnancy by Zulu women: Yellow foods, green leafy vegetables, potatoes, milk.

Source of the problem

Zulu pregnant mothers, due to cultural restraints, do not consume a well balanced diet.

Informants:

Registered midwives are very dominating, dictators, channelling, authoritative as regards food abstained from during pregnancy based on traditional practices, and this strains our relationship with registered midwives.

Effect of the problem

When the pregnant mother is not well nourished, she will suffer from deficiency diseases like scurvy and the foetus will not develop well, and this may end in intra-uterine growth retardation (Chalmers 1993:65).

Registered midwives' competent care is questioned by pregnant mothers

Informant:

I see the midwives as accommodating because they advise us accordingly (for example) as I do not consume eggs based on my cultural way of life, the registered midwives give an option of beans to supplement the eggs. Registered midwives do give options as far as nutrition is concerned.

4.4.3 Interpretation of the findings of Theme 4: Category 4.1

Traditional preparation for labour ukuhlukuhla (rubbing of a pregnant mother's abdomen by a traditional birth attendant using a traditional cream) for the following reason:
To correct breech presentation by performing external version.

Source of the problem

External version should be performed by obstetricians only, because it may lead to knotting of the umbilical cord, placental separation, premature rupture of the membrane, pre-term labour. All these are life-threatening to the mother and the foetus in utero (Myles 1996:420).

Competent care of the registered midwives is questioned by pregnant mothers during their prenatal visits.

Solution to the problem

Informant:

*I guess I we have to abide by the registered midwives restraints as far as this procedure is concerned, because what if complications occur during this procedure and my baby dies in utero, probably I also die.*

4.4.4 Interpretation of the findings of Theme 4: Category 4.6

Sex avoidance

Source of the problem

Indication for sex avoidance:

Informant:

*If I have sex during the last month of delivery I am told my baby will be born with the male sperms covering the baby, which disgraces a mother [showing] that she does not have self-control over sexual activity and the baby will be disliked by everybody during his / her life span on earth.*
Solution to the problem

Informant:

Registered midwives say having sex does not affect the baby in utero. They say it is also a myth that the baby will be born with male sperms covering the baby. So I will take their word for it.

Traditionally, dietary limitations have been imposed to prevent too large a baby and hence difficult labours. Given the higher incidence of cephalo-pelvic disproportion amongst African women, drastic limitations of dietary intake reflect understanding of this birth difficulty (Chalmers 1993:65).

4.5 CONCLUSION

In this chapter data analysis with content analysis as a point of departure was described. Unit content was selected and analysed and described as themes. The category system was used to classify the units of content. Each category was subdivided into a subcategory. Thematic analyses were unified into a whole. Findings were interpreted based on sources of problems, effects of problems and solutions to the problems based on the informants' perspective.

In the following chapter, the researcher will reveal her own impressions gathered during the discussions of the findings and thereafter she will make recommendations about possible solutions to the problems. The limitations of the study will also be discussed in the next chapter.
CHAPTER 5

Summary of findings, conclusions, implications, recommendations and limitations of the study

5.1 INTRODUCTION

In the previous chapter, data was analysed and findings interpreted based on the source of the problem and solutions to the problem as identified by informants in the study.

In this chapter, the study and its findings are summarised. Conclusions are drawn and recommendations are made on the basis of those conclusions. The limitations of the study are discussed.

5.2 SUMMARY OF THE STUDY

The purpose of the study was to explore the cultural practices regarding antenatal care
among Zulu women in a selected area in Gauteng. Zulu pregnant clients use traditional and cultural practices to preserve pregnancy to term. Some of these practices are harmful to both the mother and the foetus in utero. Health education is conducted in antenatal clinics to discourage harmful traditional cultural practices for preserving pregnancy to term, and the complications which are life-threatening to both the mother and the foetus are highlighted, but regardless of this, the Zulu pregnant mothers continue using traditional practices to preserve pregnancy to term. To explore the traditional and cultural practices, a literature review was conducted.

The researcher established a theoretical framework for the study by conducting a literature review. The literature review focused on some cultural and traditional methods used by Zulu pregnant women to preserve pregnancy to term. A brief overview of the world-view of the Zulus was given. A description of health and illness and the perception of pregnancy by the Zulus was discussed.

Through focus group and individual interviews, the following perspectives were established:

- possible solutions to problems caused by traditional practices of preserving pregnancy to term as identified by Zulu pregnant women

Data was analysed. The researcher analysed the contents of the focus group interviews and individual interviews’ narrative to determine themes and patterns. An effort to arrive at a holistic understanding of phenomena was made by categorising and coding of data. Data was interpreted, while analysed. Solutions as perceived by informants were established.

5.3 SUMMARY OF FINDINGS

Findings were summarised according to the sources of the problems identified, their effect on the midwife-patient relationship, and the solutions that the informants identified as the most appropriate to each problem.
These findings were:

- Zulu pregnant mothers are forced to consume traditional medication by their mothers-in-law and guilt is instilled in pregnant mothers.
- Zulu pregnant women, due to cultural restraints, do not consume a well-balanced diet.
- Pregnant mothers perceive registered midwives as authoritative. They feel their culture is not respected during prenatal visits.
- Traditional preparation for labour, ukuhlukuhla, consists of rubbing of the abdomen of a pregnant mother by a traditional birth attendant using a traditional cream to correct breech presentation by performing external version. Prenatal clients see no problem in this dangerous practice, saying it is an ancient practice and there is nothing wrong with it.

5.4 CONCLUSIONS

Based on the findings, the following conclusions have been drawn:

✦ Violation of human rights

Zulu pregnant women have no freedom of choice as to how they intend preserving pregnancy to term. Culturally they have to abide by instructions and orders from their mothers-in-law who enforce adherence to traditional practices by imposing threats and guilt on pregnant women. If they did not adhere to traditional ways, and if the baby died in utero or during delivery, the women would carry the blame for the rest of their lives.

✦ Lack of client empowerment

Zulu pregnant women will always be victims of deficiency diseases, intra-uterine growth retardation, malnutrition, and anaemia because they are not allowed to consume a well-balanced diet as culturally they have to avoid certain foods during pregnancy.
Lack of knowledge

Zulu pregnant mothers with breech presentations are victims of placental separation, premature rupture of membranes, cord prolapse, premature labour, and maternal and foetal death due to external version performed by traditional birth attendants, twisting the head of the baby upwards abdominally.

5.5 IMPLICATIONS

How can registered midwives display cultural sensitivity in prenatal clinics as far as consumption of traditional medication by Zulu pregnant mothers is concerned?

Informants in the study all expressed a willingness to consume traditional medication during pregnancy as instructed by their mothers-in-law with the intention of preserving pregnancy to term.

Informants stated that they were threatened that if they did not abide by the orders, should something go wrong, they would be blamed for not carrying out orders.

A collaborative approach in prenatal clinics regarding health education would be more effective, in which family members who are influential during pregnancy like the mother-in-law and the traditional practitioners would participate actively during health education sessions. The registered midwives, while showing cultural respect, should calmly explain and display the consequences of the traditional medication consumption during pregnancy.

Midwives should have training in the practices and beliefs, as they could be ethnocentric and use stereotypes due to lack of knowledge themselves. The researcher only reported on certain aspects, and many important aspects were omitted.
How can registered midwives encourage and enforce the benefits of consuming a well-balanced diet during pregnancy while simultaneously being sensitive to cultural limitations of Zulu pregnant mothers?

A research project should be undertaken on the wide range of traditional foods that would include all food constituents. A list of choices of food which could replace foods which are culturally not allowed to be consumed during pregnancy should be offered. Pregnant women and their families should be the ones who actively participate in such a project to encourage their ownership of the research and findings.

How can registered midwives successfully discourage pregnant mothers with breech presentation from having external version performed by traditional birth attendants?

The probability of cord prolapse and winding of the cord around the neck should be explained to prenatal clients, as well as all other consequences which might occur to both the foetus and the mother. For example, this condition could be fatal if not handled as an obstetric emergency by a skilled health professional.

5.6 RECOMMENDATIONS

Based on the conclusions, the implications of the conclusions, the implications, and the findings of this research, the following recommendations are made, regarding:

Lack of knowledge and skill

It has been found that traditional birth attendants and traditional healers influence family members if a pregnant Zulu woman, and particularly the mother-in-law and husband, lack knowledge and skill in the management of the woman during pregnancy. It is recommended that a training programme be initiated. Lessons should include information on:
• preparation for a planned pregnancy: physically, emotionally and socially
• indications and importance of attending prenatal care rendered by professionally trained health personnel
• minor disorders of pregnancy
• teratogenic effects of some medication
• avoiding self-medication during pregnancy
• preparation for labour
• importance of communication between the pregnant women, her family members, TBAs and traditional healers

In addition to the lack of appropriate knowledge and skill in the family, the following barriers exist to quality of care for pregnant women (AbouZahr et al 1996:451-464).

✧ Further barriers to quality of care for women

Further barriers to high quality of health care may be grouped into three main types: barriers regarding information, access and utilisation.

• Lack of knowledge of the midwives. The midwife should constantly be alert for idiosyncratic reactions occurring in women resulting from cultural background from which each individual pregnant woman emerges. Delivery of culturally appropriate health care in prenatal clinics demands that midwives develop proper attitudes, knowledge, communication and interpersonal skills. It would appear therefore that experiential learning is an appropriate approach in addressing this problem. Cultural awareness programmes are a necessity for the midwives in order for them to be sensitive to the cultural needs of the prenatal women.

• Information barriers prevent women from recognising illness and knowing how to prevent it and treat it appropriately.

For instance, pregnant Zulu women perceive vaginal bleeding during pregnancy as caused by evil spirits and this prevents them from recognising the signs of a complication and seeking medical help to treat it appropriately.
• **Access barriers** prevent women from seeking appropriate care. For instance, the instillation of guilt feelings by the mother-in-law (such as telling the pregnant woman that she will be blamed if the baby dies in utero due to failure to abide by cultural practices during pregnancy) creates a barrier which prevents women from seeking appropriate care.

• **Utilisation barriers** prevent women from receiving adequate care at health services or from using these services effectively. For instance, TBAs and traditional healers form a barrier which prevents pregnant Zulu women from utilising prenatal clinics.

> **Recommendation regarding information barriers**

The efforts of health care providers to ensure that women receive appropriate care during pregnancy have long been hampered by the fact that women do not perceive pregnancy to be a disease and do not, therefore, see the necessity for health care for what is, after all, a normal and common condition. Of course they are right; pregnancy is not a disease but a normal physiological process (AbouZahr et al 1996:451-452).

Much of the early work in worldwide maternal health focused on removing information barriers by informing women in rural communities about the complications of pregnancy. Knowledge, attitude, and practice studies were undertaken, using focus groups and other methods to elucidate women’s perceptions of pregnancy, illness, and pregnancy-related complications, to determine why the use of formal health services tended to be low during pregnancy and delivery. The results of such studies were illuminating, showing clearly the extent to which maternal complications were not recognised as serious by women themselves or by their families and birth attendants (AbouZahr et al 1996:452). Some early warning signs of possible complications, such as swelling of the feet and hands, were so common that they were not taken seriously by communities. The conclusion drawn from these early studies was that if sufficient information and education were provided, women could be persuaded to use the health services (notably prenatal care) set up for them (AbouZahr et al 1996:452). Women’s perceptions of what quality of health care entails
do not always coincide with technical definitions of quality. Women may express a preference for a treatment or intervention that is inappropriate or unnecessary. A study in Pakistan, for example, found that women preferred to use the services of birth attendants who speeded delivery by using oxytoxics to increase contractions (AbouZahr et al 1996:453).

One of the limitations of efforts to provide information to women has been registered midwives' focus on the individual woman, taking little account of the familial, social, and cultural environment within which she lives. Several studies have observed the (lack of) power of the women for decision-making, but few efforts have been made to alter that environment by communicating with families and influential family members (AbouZahr et al 1996:453). Studies such as these demonstrate the need not only to inform women and their families about danger signs and symptoms, but also to provide them with the information and skill they need to make informed decisions about when to seek health care and from whom.

**Recommendation regarding access barriers**

Access to health care is determined by physical and logistical factors, including the proximity of health services to where women live and the availability of transportation. The existence of a facility within easy physical access is by itself no guarantee that it will be used.

A household survey carried out in Burkina Faso found that women had difficulty in using an available service because of inconvenient opening hours of the clinics, organisational problems, and poor communication with the staff (AbouZahr et al 1996:455). The way the health system was organised made women reluctant to go for prenatal or delivery care. Services adhered to a fixed and rigid timetable and imposed a variety of stipulations concerning who could accompany or visit the woman, choice of birthing positions, and certain postpartum cultural practices (AbouZahr et al 1996:455).

The researcher recommends that consulting only the first "X" number of first visit of
prenatal women by the midwives in the prenatal clinic to cease because the rest may end up defaulting prenatal care, the ones who are beyond the stipulated “X” of first visit only to be seen.

**Recommendation regarding utilisation barriers**

Lack of cultural sensitivity by registered midwives may lead to a barrier of utilisation of prenatal clinics.

The provider-client relationship is of the utmost importance to women’s health-seeking behaviour. There is considerable evidence that positive interactions between patients and health providers lead to patient confidence and compliance with prescribed treatment (AbouZahr et al 1996:456). Women may be unaccustomed to receiving health care in unfamiliar surroundings, and to taking instruction from health professionals. The main health providers in their own families, in clinics women are faced with a “top-down” situation in which they are told what to do, while dialogue is discouraged. Rather than being provided with options should a treatment fail, they are told to return again to the health facility. Thus the possibility of effective action is taken out of the hands of the women, and they are left powerless in an area where they once had considerable autonomy (AbouZahr et al 1996:457).

During health education sessions, midwives should not impose, for example, what to eat to the prenatal women because it sounds authoritative, the approach should be more of a discussion where the prenatal women’s views are also discussed in an understanding, relaxed atmosphere for the benefit of the prenatal woman and her baby in utero.

**5.7 FURTHER RESEARCH TO BE UNDERTAKEN**

- More research should be undertaken to increase health professionals’ knowledge about transcultural nursing. This should focus on identifying the needs and gaps in the system and skills of the service care providers/nurse educators.
- It is imperative that nurse educators prepare students to look at culture as an
integral component of professional nursing practice. This would be accomplished by the deliberate integration of cultural content into nursing curricula.

- The implementation of a training programme for traditional birth attendants (TBAs) should be done and evaluated.
- As the study was done with selected informants at only one prenatal clinic, it is recommended that this study be repeated on a wider scale in order to get more ideas on the development of a training programme for traditional birth attendants.

5.8 LIMITATIONS OF THE STUDY

During the focus group interview the informants were asked to describe their experiences with the registered midwives in the prenatal clinic during visits, as they were women who used traditional practices to preserve pregnancy to term. The informants wondered why the researcher asked for that information from them; as the researcher was also “Black” with a Zulu surname, they supposed that she would know their experiences. When the researcher asked for information on Zulu cultural practices, they also wondered why as they assumed the researcher would know, despite full disclosure of her own position given by the researcher to the informants before commencing with the interviews.

The informants were not comfortable discussing aspects like “sex during pregnancy”; this was a taboo subject, private, personal and confidential. The informants were not willing to discuss such a subject.

5.9 CONCLUSION

Delivery of culturally appropriate health care in prenatal clinics demands that the registered midwives develop proper attitudes, knowledge, communication, interpersonal skills and cultural sensitivity. It would appear therefore that in service training and continued education, the auditing of communication skills in this area would be an appropriate approach for addressing this problem. Registered midwives should engage in cultural awareness programmes. Auditing according to explicit criteria should be used to set clear standards, measure performance and compare practices among registered
midwives. Actions to resolve discrepancies should be identified. Health education lessons should be collaborative discussions involving traditional practitioners and family members of pregnant mothers, particularly husbands and mothers-in-law.

5.10 FINAL CONCLUSION

This study was an attempt to highlight the problems which exist in health care provision regarding the prenatal care of pregnant Zulu women, specifically because of negation/unawareness of the many cultural influences and practices framing this period of health-sensitivity in a Zulu woman's life. It is therefore hoped that it will contribute to the necessary awareness among health professionals, so that the barriers which were detected could be overcome, resulting in a more co-operative relationship between these women and the registered professional midwives attending to them, as well as better pregnancy outcomes.
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Annexure A

Application for permission to conduct research
03 July 2000

The Medical Officer of Health
Municipality Health Department
98 Kempton Avenue
PO Box 522
BENONI
1520

Dear Sir/Madam

I hereby request your permission to conduct a study at your clinic during the year 2000. I am registered with Unisa for a Master’s degree programme. The topic of my research is Cultural practices regarding antenatal care among Zulu women in a selected area in Gauteng. What triggered my interest in the study is the fact that despite health education lessons given by the registered midwives in the antenatal clinic, the pregnant mothers continue to suffer complications from the effects of traditional practices they use to preserve pregnancy to term.

The reason for choosing your clinic for conducting the study is based on the fact that I have previous experience of the clinic as I was employed in it as a registered midwife in 1986. My target population will be the Zulu primigravid 36 weeks gestational period mothers residing at the East Rand for a duration of two years and above. I will interview these antenatal clients.

The results of my study will be published and the clinic will benefit from the results of the study.

Thanking you for your kind cooperation.

Yours faithfully

[Signature]

NB NGUBENI
Annexure B

Letter of approval
Health Department
98 Kempton Avenue
P O Box 522, Benoni 1500
Tel: (011) 741-6420
Tel: (011) 741-6415
Fax: (011) 741-4211

Enquiries: Mrs Z. Habange
Reference: 1/13/77 (2M/bn)

4 September 2000

N.B. Ngubeni
P.O. Box 229
DAVEYTON
1507

Dear Mrs Ngubeni

Your letter dated 1st August 2000 refers.

Permission has been granted to you to collect data for your research in M.A. (Cur) Degree at Daveyton and Phillip Moyo Memorial Health Centre Midwifery Section.

I hope that your study findings and recommendation will be of benefit to Benoni.

I wish you luck with your studies.

[Signature]

Dr M.A.R. Selebele
Medical Officer of Health

PRIVATE BAG X014, BENONI, 1500, TEL: 011-741-6420 http://www.benoni.org.za
Annexure C

Informed consent form
Information consent form

UNIVERSITY OF SOUTH AFRICA

INFORMED CONSENT FORM

RESEARCH TITLE: CULTURAL PRACTICES REGARDING ANTENATAL CARE AMONG ZULU WOMEN IN A SELECTED AREA IN GAUTENG

COURSE: MASTER'S DEGREE MIDWIFERY

RESEARCHER: NB NGUBENI (TEL NO: 0732067685)

The purpose of this study is to explore the cultural practices regarding antenatal care among Zulu women in a selected area in Gauteng. Focus group discussions will be conducted. Each session will last for approximately two hours. During these sessions each informant will be required to describe cultural practices regarding antenatal care among Zulu women. These discussions will be tape-recorded, and the cassette will be destroyed immediately after data has been analysed. There may be no direct benefits to you as a participant of this study, but there may be changes in the registered midwife-client relationship following the completion of the study.

THIS IS TO CERTIFY THAT I, ........................................... (print name) hereby agree to participate as an informant in the above mentioned study, I understand that there will be no health risks to me resulting from participation in the research.

I hereby give permission to engage in focus group discussion and individual interviews and for those discussions to be tape-recorded. I understand that, at the completion of the research, the tapes will be erased. I understand that the information may be published, but my name will not be associated with the research.

I understand that I am free to deny any answer to specific questions during discussion session. I also understand that I am free to withdraw my consent and terminate my participation at any time, without coercion.

I have been given the opportunity to ask whatever questions I desire and all such questions will be answered to my satisfaction.

.......................... .......................... .......................... .......................... 
PARTICIPANT WITNESS RESEARCHER DATE
Annexure D

Data collection tool:
Focus group questions
Data collection tool: Focus group questions

These will be used for general discussion.

First session

Researcher: “I would like each one of you, to please explain in detail your cultural practices as pregnant Zulu women during pregnancy (prenatal period).

Informants: Each takes turns in discussing their cultural practices during the prenatal period.

Researcher: Takes down notes with the tape-recorder turned on.

Researcher: Probes and reflects.

Informants: Engage in discussion.

Researcher: Observes nonverbal cues, takes down notes and makes summaries.

Duration: One hour.

Break: 30 Minutes (refreshments served).

Second session

Researcher: After the break the researcher proceeds from general to specific questions, namely:

- Traditional medication taken during pregnancy
- Types of food abstained from during pregnancy
- Traditional preparation for labour
- The role of the elderly people during pregnancy, particularly the mother-in-law
- The role of traditional healers during pregnancy
- The role of traditional birth attendants during pregnancy

Informants: Engage in discussion.

Researcher: Takes down notes, observes nonverbal cues and reacts appropriately.

Informants: Continue to engage in discussion.

Researcher: Makes summaries.

Duration: One hour.

Break: 30 Minutes (refreshments served).
Annexure E

An interview
Annexure E

Researcher: Nkosikazi U "X" ngicela ungichazele kabanzi ngosikiko-mpilo lwakhonjengo Mzulu ngesikhathi uzethwele.

Informant: Usho ukuthini?

Researcher: Njengoba usuzezinyangeni exintathu zokugcina, ngokwesi Zulu wenzani njengoba uzethwele nje?


Researcher: Ngicela uchaze lezizinhla zombili ozivezile – okokuqala.

Umamezala wakho ukutshela ukuthi wenza?

Okwesibili.

Ush’ukuthini uma uthi ubusa impilo yakho?

Uzwakala sengathi kuyakuucasula lokhu ...

Informant: Ungeke wacasuka uma utshelwa ukuthi udleni, ungadlini, imithi yesintu okufanele uyiphuze, Uhambe nini, ulale kuphi ebusuku nobani.

Researcher: Uzwakala sengathi ucasulwa yilokubuswa...! Kodwa masixoxe ngephuzu ngalinye siqale ngokudla.

Informant: Kufuneka ngingadli imifino ngoba ingane yami izoba nomabala amnyama emzimbeni. Abahlengikazi ekiliniki bathi ngidle imifino khona mina nengane yami sizophila kahle.

Researcher: Kuyinto enzima kuwe ukuthi ubenezinhla ezimbili ongazi ukunthi ukhethe kuphi.


Okufika kungisanganise du ukuthi, uma kungahambanga kahle, noma siphuphume isisu nomi ishone ingane uma ngibeletha, kuyoba yicala lami lelo ngoba ngingenzanga engikutshelwa wumamezala.


Uzwa kanjani ngokuthi "Qha" uma ungayithandi into?
Informant: Angivunyelewe ukuzakalisa imizwa yami. Siselapho nje ngicela siiyikele le ngxoxo, siyoqhubeka ngelinye ilanga.

Researcher: Kusho ukuthini kukuphatha kambi ke lokhu ...!

Ngiyabonga isikhathi sakho. Khona uzokwehlisa umoya, ngicela udonse umoya kakhulu ucabange nje kushela ngokuphafumula kwakho nangosuku olwaluluhle kuwe njengosuku lwakho lomgcagco. Uma kukuhle kuwe siyohlangana futhi sichasiselane ngalamaphuzu owavezile.
Researcher: Mrs "X" would you please explain in detail your cultural practices (as a Zulu woman) during the prenatal period.

Informant: What do you mean?

Researcher: As you are in your last three months of pregnancy now, what do you do based on your culture, relating to your pregnancy.

Informant: Whaau! Basically, it is not what I do, it is what I am told to do by my mother-in-law. She literally rules my life now.

Researcher: Would you like to explain the two issues you have just raised.

Firstly, what is it that your mother-in-law tells you to do?

Secondly, what do you mean when you say, she literally rules your life?

You sound angry ...!

Informant: Would you not be angry when somebody tells you what to eat, what not to eat, what traditional medication to take, when to go out, to crown it all even where to sleep at night and with whom.

Researcher: You feel controlled ...! But let us talk with one issue at a time, starting with diet.

Informant: I must not eat green leafy vegetables for my baby will have dark patches all over his/her body. The nurses at the prenatal clinic on the other hand says I have to eat green leafy vegetables, it is good for myself and my baby in utero.

Researcher: It must be very hard for you to be torn in between two poles.

Informant: I must also drink isihlambezo so that my pregnancy goes smooth with no problems and to have a quick delivery with no complications and a healthy baby. I don't even know what the isihlambezo solution is made up of, nobody is prepared to tell me. In fact, I am not allowed to ask anything because it is disrespectful to question an adult.

What really drives me crazy is that if I do not abide by, and I happen not to carry this pregnancy till term or the baby dies during delivery, I am regarded as a cause of that for not obeying all the instructions of my mother-in-law.

Researcher: This must be very devastating for you. It is very painful to have somebody instilling guilt n you.

How do you feel about saying "no" to the instructions which you do not agree with?
Informant:  I am not allowed to voice my feelings. Just on that note let us please stop here, we will continue some other day.

Researcher:  It must be stressful for you.

Thank you for your time. To relax you, please take deep breaths, concentrate on nothing else but your breathing and think of a day with good memories like your wedding day. Then we will set a date to continue with the interview to clarify some aspects which you mentioned, with your permission.
Annexure F

A traditional chemist
A traditional Chemist
Annexure G

Plants illustration

Plants used by traditional care givers to generate traditional medication
(Felhaber 1999:193-221)
Pterocelastrus rostratus
Pittosporum viridiflorum
Siphonochilus aethiopicus
Aloe ferox
Pentanisia prunelloides
Chironia baccifera
Eucomis autumnalis
Cussonia spicata
Dioscorea sylvatica
Artemisia afra
Hypoxis sp.
Glycyrrhiza glabra
Scilla natalensis
Eucalyptus globulus
Elephantorrhiza elephantina
Mentha longifolia
Scabiosa columbaria
Ocotea bullata
Acorus calamus
Warburgia salutaris
Carpobrotus edulis/
Carpobrotus acinaciformis
Sideroxylon inerme
Scilla nervosa
Zanthoxylum capense
Corhichonia decumbens
Aloe maculata
Dicoma anomala
Euclea natalensis
Tulbaghia violacea
Gunnera perpensa
Cotyledon orbiculata