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Self-delay for Timely Antenatal Care, Rituals and Heavy-Handed in-laws: Cultural Practices Killing Pregnant Women in Zambia- Lundazi district

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Abstract

This study examined socio-cultural practices surrounding maternal deaths in Lundazi district – Zambia. The practices stealthily affect antenatal care received by antenatal women with subsequent maternal complications and deaths. Four Focus Group Discussions involving 40 members of Small Motherhood Action Groups (SMAGs) were conducted in March 2018.This study found that pregnant women in Lundazi district- Zambia delay to initiate antenatal care until 6th or 7th month of their pregnancy. The reasons given include fear of witchcraft stealing the human embryo for magic. Pregnant women are delayed further as they seek traditional medicines from Traditional Healers for pregnancy protection. Other pregnant women cannot attend antenatal care consistently because their mothers-in-law want them to do what is considered beneficial for a woman traditionally- do house chores or join the team going to the maize field. Late antenatal initiation is a crisis. It is an emergency in waiting for which some pregnant women never recover.

Key words: *Culture, antenatal, maternal deaths.*

Introduction

The social integrity of a society is judged by whether or not it supports women to reach the highest level of attainment in all spheres of life including women's health. Graça Machel, widow of late President Nelson Mandela, rightly remarked when she said, maternal health is not a 'women's issue'. It is a demonstration of the integrity of communities and societies[1]. Indisputably, society has a responsibility to ensure that all women should safely journey through pregnancy and childbirth[2].

This can only play out big if a society is adjusted to its profound obligation of making the life of women predictable, transparent, dignified and immeasurably fulfilling.

A larger-than-life societal profile is a fitting signature that allows women soar higher in their long arduous obstetric journey. This journey gets potentially clear when society unchains contradictory binding social-cultural uncertainties and grave dangers that shackle women to the margins of death during pregnancy, labour or after childbirth. If society's handling of women's affairs especially her maternity sojourn is antagonistic, unsteady, veiled, insensitive and in reverse then throngs of precious women would bow out of life as if it were a pandemic.

It is no longer acceptable to allow great numbers of women to die in what must be recognized as a pandemic[3]. But maternal deaths can be stopped. Maternal deaths can be prevented. The ever-flowing tap of horror can be closed permanently. The pen of shame that writes down daily statistics for maternal deaths: its ink can dry up. There is evidence to support up to 75% reduction in maternal deaths within few years[4]. This demands enduring commitment, sacrifice, self-denial and a change of societal attitude if a decisive upend of maternal deaths is to be achieved.

A walk away attitude, a bystander outlook or a heavy-handed patriarchal cultural dynasty is a fertile soil for maternal deaths. Such an attitude pushes society's gaze away from what should be central. This is a fragile constituency of catastrophe to women, children and society. It is startling to learn that in the world, approximately 810 women die every day from pregnancy- or childbirth -related complications [5].

This means that worldwide, nearly 34 women die every hour, 5,600 every week, 24,300 every month, 291,600 every year, 2,916,000 every ten years and 8,748,000 die every generation- thirty years due to complications during pregnancy, childbirth or after childbirth. Statistics indicate that globally, half a million girls and women die each year as a result of pregnancy or child birth[6]. The World Health Organization observe that in sub-Saharan Africa (the area of the continent of Africa that lies south of the Sahara Desert) women face a 1-in-13 chance of dying while pregnant or in childbirth, as compared to a 1-in-4,100 chance in industrialized countries[7].

Maternal death is defined as "the death of a woman while pregnant, during child birth or after child birth within 42 days of termination of pregnancy[8]. In simpler terms this definition means death of a woman during pregnancy, child birth, after delivery or termination of pregnancy within 42days.

In Zambia, notable progress has been pulled off in reducing the Maternal Mortality Ratio (MMR) from 591 deaths per 100,000 live births in 2007 to 398 deaths per 100,000 live births in 2014[9]. However, the significant milestone achieved fell short of reaching the Millenium Development Goal target of 162 deaths per 100,000 live births at the close of 2015[10]

In Zambia, the direct causes of maternal mortality are post-partum haemorrhage (34%), sepsis (13%)[11], obstructed labour (8%), pregnancy hypertensive disorders – eclampsia (5%)[11], and abortion complications (4%)[28]. Indirect causes include malaria (11%), HIV (10%) and others (17%)[11]. Between 2010 and 2018, Lundazi district in Zambia, contributed a proportionately large number of women dying during or after childbirth.

Lundazi district is located approximately 725 kilometres from Zambia's capital city- Lusaka. The district lies in the Eastern part of Zambia. It borders with Malawi to the east. The larger proportion of the district's population lives in villages where they grow maize, groundnuts, tobacco, cotton, rice, beans and rear cattle and goats. The flourishing rice and beans business in Lundazi are a huge attraction to people from other provinces. Before it was broken down to three districts, Lundazi had an area size of 14,029 km[2] with a total population of 410,444 served by 56 health facilities. Two of these are first level hospitals- Lundazi District Hospital and Lumezi Mission Hospital.

In 2011 alone, Lundazi district lost 27 pregnant women[12]. Medical experts conducted an analysis of the deaths using their biomedical model. Their analysis fell short of social analysis to facilitate a rewarding understanding of how women understand and treat pregnancy, and how this ultimately affects labour, childbirth and after childbirth. The identified gap therefore triggered this study in 2018. The objective was to examine socio-cultural practices contributing to maternal deaths in Lundazi district.

Lauderdale[13] observed that culture plays a major role in the way a woman perceives and prepares for her birthing experience. This is because each culture has its own values, beliefs and practices related to pregnancy and birth. But as the proverb goes 'if an insect bites you, it comes from inside your clothes' sometimes culture can be a 'grinding enemy'[14] biting the pregnant woman to death amid a supportive health care environment.

Materials and Methods

The study used a qualitative descriptive approach. Each Focus Group Discussion session performed consisted of 10 participants[15].

To ensure Trustworthiness, a total of 4 Focus Group Discussion sessions were conducted with an admixture of gender and age. The study ensured credibility, dependability and transferability of data through audio recording of the discussion, summarizing of points discussed, requesting for clarifications, re-playing of the taped discussion before participants for cross-checking of information.

Participants recruited for the study were members of Small Motherhood Action Groups (SMAGs). SMAGs are community-based volunteer groups that aim to reduce critical delays that occur at household level with regard to decision-making about seeking life-saving maternal health care at health facilities[16]. Naturally, 80% of the SMAGs were females with a mean age of 38 years. 90% of the female participants were former Traditional Birth Attendants. These SMAG members, accustomed to seeing and handling pregnancies and deliveries in their communities were perfectly attuned to the subject under study. Participants were selected conveniently. Focus Group

Discussion sessions were held at health facilities.

Focus Group Discussions were conducted during the month of March, 2018. Each session was conducted in a private spacious room taking 60minutes. At the end of the session, participants were served with refreshments. At the beginning of the Focus Group Discussion, participants were given a thorough explanation of the purpose of the study, consent, and audio-taping. After obtaining consent from individual participants, bio-statistical characteristics of the focus group participants were collected. Questions from the Focus Group Discussion guide were read in English by the researcher. Translation into Tumbuka was done by the interpreter. Participants' responses were translated from Tumbuka into English by the interpreter. The responses were written down and later typed and stored as a soft copy.

Results

Question. What does a woman do traditionally when she gets pregnant?

The purpose of this question was to gain an understanding of possible harmful cultural practices affecting pregnant women. Participants gave varying responses. The first response was that in the village, the moment a woman missed her menses and realized she was pregnant; automatically she changed the way she dressed. She began to wear oversize clothes to mask her belly by attempting to make herself look bigger. The reason given for wearing drowning clothes was chiefly to conceal her pregnancy from prying eyes.

Wearing unfittingly oversize clothes assisted the pregnant woman to deflect undue attention from her wicked relatives, neighbours and her known and unknown enemies from doing harm to her and her pregnancy. Participants emphasized that the concept of pregnancy in the village was highly secretive. On this subject no one was to be trusted not even the mother in-law [17]. It could be discussed in low tones at dusk or late in the night for fear of unwarranted listeners else they catch the slightest confirmation and the pregnant woman's life especially her pregnancy gets imperilled.

On emphasizing the secrecy of pregnancy, one participant compared the way people hide their underwear to the way a pregnant woman should hide her pregnancy during the early months. Participants explained that if the pregnant woman became excited and shared her pregnancy story with everyone in the village, she was attracting dark forces of jealous, envy, malice and revenge upon herself. For her carelessness, she could pay the bitter price of a miscarriage, magically missing pregnancy, could suffer a complicated delivery or deliver chunks of a dead foetus or literally die herself.

*In the village, the moment a woman knows that she is pregnant; she begins to wear oversize clothes to hide her pregnancy. She does so in the fear of emotionally detached relatives, envious neighbours, sworn enemies and pretenders who can use juju (magic) to steal her pregnancy, dissolve her pregnancy, make her abort or complicate her delivery (*Focus Group Discussion 1, Participant 3).

Participants explained that for fear of registering a bad pregnancy outcome from the traditional point of view, majority of pregnant women could start attending antenatal care during the 6th or 7th month of their pregnancy when it was impossible to conceal the pregnancy. Even then, pregnant women would refrain themselves from going to overcrowded places, eating in public places or visiting the neighbour for fear of witchcraft because 'anything that could potentially prevent the birth of the child creates immense fear and suscipicion'[17] Participants narrated that for pregnant women, starting antenatal care at 6th or 7th month was tragic. One participant using a proverb in local language stated, *balimi bayowoya kuti ulimi nikuyambilira nanthumbo nicimoza. Pala mzimai wacelwa nikuti ningozi. Niimfa*! *(*Focus Group Discussion 4, Participant F*)*. farmers emphasize early preparations and so it is with pregnancy. The moment the woman realized she was pregnant; she was under obligation to access antenatal care without further delay. If she delays then its disaster. It's death! Participants also emphasized that with pregnancy it is 'Ready, Set, Go!' for antenatal care.

Early and consistent antenatal care assisted the pregnant woman to walk a strongly predictable pregnancy journey to delivery. Late antenatal booking on the other hand was crowded with so many unresolved issues bordering on the health of both the mother and the baby.

Participants stated that starting antenatal care very late, pregnant women missed life-saving opportunities to receive life-saving health care

advice from health workers, missed opportunities to be thoroughly examined and tested for life-threatening conditions, and also missed opportunities for close monitoring with subsequent negative pregnancy outcome. Women who start antenatal care late than the first trimester have poorer pregnancy outcomes[18]. Ordinarily, the pregnant woman got trapped in the tight grip of death.

When a woman delays to start antenatal care early, she misses an opportunity to receive life-saving advice from health workers early, misses an opportunity to be examined and tested early for conditions which can affect her own life or that of her child (Focus Group Discussion 1, Participant G*)*.

The second response participants gave over traditional practices that endanger the lives of pregnant women was that the moment a woman got pregnant, family members took her first to a Traditional Healer for pregnancy confirmation and pregnancy fortification. To such families, only the Traditional Healer could confirm and fortify a pregnancy against magic and evil spirits. Participants narrated that the Traditional Healer could not only examine the woman but could proceed to book her for three to four months at his residence for rituals. The woman would only be released in the 7th or 8th month of her pregnancy to start antenatal care.

In some families, the moment it is known that a woman is pregnant, they immediately take her to a Traditional Healer for confirmation and fortification of pregnancy before going to a health facility (Focus Group Discussion 2, Participant A).

Participants explained that pregnant women who spent much time at the Traditional Healer instead of starting antenatal care early usually met their choice with death. Participants were however quick to report that following aggressive awareness campaigns to Traditional Healers in maternal health care, the practice was on the decline.

The third response from participants was that in the village, some pregnant women became victims of maternal deaths because of matriarchal authority of their mother in-law. Participants recounted that the mother in-law in the family held a special place of power and authority. She had the first and the last word. Her word was final in the management of her daughter in-law's pregnancy. Consistent attendance of antenatal care was frowned upon and heavily censured. The daughter in-law, though heavily pregnant, was expected to attend field work, do house chores and attend to any other assignment deemed fit by her mother in-law. Regular attendance of antenatal care was looked upon as a sign of laziness and a window of escape from work and an opportunity to meet boyfriends.

The pregnant woman was expected to be strong when pregnant, strong during childbirth and strong after childbirth. Participants explained that the mother in-law, in driving her point home to the daughter in-law, could cite an example of herself that when heavily pregnant she could still go to the field, come back late while carrying a bundle of firewood, look for relish, cook for the family, draw water, wash clothes for her husband, bathe the children and finally warm water for the husband to bathe.

In other families, a woman is not allowed to start antenatal care early or to visit the clinic regularly because she is labelled as lazy by her mother in-law. Her mother in-law lashes out at the daughter in-law accusing her that she was using pregnancy care at the clinic as a way to escape work. Therefore, some women are forced not to start pregnancy care early or continue as required. (Focus Group Discussion 4, Participant F).

Participants explained that the matronizing behaviour from the mother in-law reduced the daughter in-law to a mere pregnancy-carrying-machine that obeyed even when her healthy was in jeopardy. Mothers in-law significantly influence how pregnant women access health services.[19]

Discussion

Reducing maternal deaths is a global community's top priority. This study found that indigenous people's life ways can be a strong opposing hurricane to the provision of quality life-saving antenatal care to pregnant women with resultant adverse pregnancy outcome.

Modern health facilities can sprout everywhere with pride, costly high-tech equipment procured and shipped, specialized human resource recruited, drugs and testing reagents made available for quality antenatal care services but as a long as cultural determinants of antenatal care are not addressed, indigenous people will remain fastened to their negative cradle of

tradition which affect the life of a pregnant woman.

Socio-cultural beliefs and practices encircling maternal health and maternal deaths in the rural parts of Africa are so deep-rooted and tend to manifest in pregnant women's behaviours[20].

This study found that one of the prominent reasons why pregnant women in Lundazi delay to start antenatal care in line with the 2016 World Health Organization Antenatal Guidelines[21] is related to cultural secrecy. Traditionally, a pregnant woman was expected to hide her pregnancy and keep her pregnancy story in her own corner until 6th to 7th month of her pregnancy.

One participant during the Focus Group Discussion said unspeculatively on why pregnant women fear to make their pregnancies public through accessing antenatal care during the first and second trimester.

*In our culture, it is widely believed that human embryos of between 1 month to five months are on high demand in the world of witchcraft. The embryos are used for magic and juju to enable people win in their pursuits of life. Every woman is aware of a hunt for human embryos. So, a pregnant woman hides her pregnancy until 6th or the 7th month before starting antenatal care (*Focus Group Discussion 1, Participant C*).*

These findings are consistent with the findings of a study conducted in Malawi titled *Understanding barriers preventing pregnant women from starting antenatal clinic in the first trimester of pregnancy in Ntcheu District-Malawi*[22]. This study found that hiding of the pregnancy during the first or second trimester was a measure by pregnant women to avoid witchery activities on their pregnancies and this affected antenatal attendances for the first and second and sometimes the third expected antenatal contacts. The findings of this study further tally with the findings of a study conducted in Tanzania in which participants reported of late initiation of antenatal care fearing witchcraft if they enrolled on care early[23]. However, literature is replete with information that antenatal care initiated during the terminal stages of pregnancy is already an emergency.

It is a crisis in waiting for the pregnant woman and her pregnancy as late attendance of antenatal results in the potential for complications during pregnancy, delivery and puerperium[24]. Pregnant women who start antenatal care late risk developing serious danger signs for severe maternal complications such as vaginal bleeding, acute abdominal pain, severe headache, blurred vision[25,26].

This study found that some pregnant women in Lundazi prefer to seek care from sources other than a health facility the moment they realize they are pregnant. The sources highlighted in this study are Traditional Healers. Traditional Healers are community gate keepers who command respect and reverence from the members of a rural community.

Their services are desperately sought after by both rural and urban dwellers for reproductive health-related conditions including a pregnancy. One participant during the Focus Group Discussion explained:

*In some families, pregnant women strongly believe that they cannot begin their pregnancy journey without a blessing of the Traditional Healer. They seek out the Healer for protection against witchcraft. The challenge comes in when the Traditional Healer, in the name of performing ritualistic protection, detains the pregnant woman for months on end (*Focus Group Discussion 3, Participant B*).*

Findings of this study are consistent with the findings of a study conducted in South Africa. In this qualitative study involving 20 pregnant women, participants reported that they had sought the services of a Traditional Healer for various reasons[27]. Commenting on why pregnant women sought the Traditional Healer scholars wrote: it means no miscarriage, better foetal growth and guaranteed stability of health[28].

This study found that mothers in-laws in Lundazi can either be a positive influence to a pregnant woman supporting her to sail through her maternity excursion or can chip away at a pregnant woman's opportunities to receive essential interventions at the most crucial time. Participants reported that through mothers' in-law's dictatorial role, pregnant women were hemmed in and placed in an environment where they had limited choices. For peace' sake, they acceded to all the terms set forth by their mothers in-laws even when they felt unwell. In one of the Focus Group Discussion, one participant elaborated:

Some pregnant women have died because their unfeeling mothers' in-laws were unsupportive,

*reckless, too demanding and authoritative. They force their young daughters' in-laws to go and work and miss antenatal care or insist that she goes to the field even when she is feeling unwell (*Group Discussion 1, Participant F*).*

Findings in this study are consistent with the findings conducted in Nepal titled- *The role of mothers-in-law in antenatal care decision-making in Nepal: a qualitative study,* scholars found that tradition placed senior women to occupy top position in a hierarchical family network, exercising unlimited authority and power over daughters in-laws[29]. In this position, they sometimes influenced their daughter's in-law positively to seek antenatal care early. But mostly their influence was to the contrary[29] observe that this nonchalant behaviour comes from the perception that antenatal care is a waste of time mainly because they lacked ANC experience but their negative influence came at an extreme cost of maternal complications and deaths.

Negative socio-cultural beliefs and practices among pregnant women in Lundazi district of Zambia are real. Pregnant women delay to start antenatal care within the first trimester because they are afraid of losing their pregnancies through witchcraft. Other pregnant women rush to seek traditional medicine from the Traditional Healer for pregnancy protection and therefore delay to start ANC.

In order for effective health promotion messages in Lundazi, health workers should target Traditional Healers, and senior citizens.

Recommendation

The study recommends that health workers to step up health promotion messages targeting senior citizens and Traditional Healers in order to break down negative cultural beliefs and practices. Chiefs and Head men to be fully engaged for change of practices that disadvantage women especially during pregnancy, labour and childbirth.

Conclusion

Tables

Table1. Demographic characteristics of participants

Participants' Characteristics	***Demographics***
Gender	
Male	*8(20%)*
Female	*32(80%)*
Mean age in years for all participants	*38*
Educational Levels	
Primary not completed, n(%)	
Primary completed, n(%)	*22(55%)*
Junior not completed n(%)	*5(12.5%)*
Junior completed n(%)	*5(12.5%)*
Senior not completed(%)	*4(10%)*
Senior completed(%)	*3(7.5%)*
	1(2.5%)
Marital Status	
Single	2(5%)
Married	32(80%)
Widowed	6(15%)

Author's Contribution

JT was responsible for the study conception and design. JT and PM were responsible for data collection, analysis and drafting the manuscript.

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