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THE CULTURAL BELIEFS AND PRACTICES AMONGST URBAN ANTENATAL BOTSWANA WOMEN

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A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, in partial fulfillment for the degree, Master of Science in Nursing (Midwifery)

Supervisor: Dr P. McInerney

Johannesburg, March 1999

A nation without its own culture

is a lost nation .....

- Sir Seretse Khama

The First President of the Republic of Botswana

DECLARATION

I, Reginah Lionjanga, hereby declare that this research report is my own work. It is submitted for the degree of Master of Science (Nursing) in the University of the Witwatersrand, Johannesburg. It has not been submitted or presented before for any degree at any other University.

RWng

REGINAH LIONJANGA

02/09/1999

Date

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I would like to convey my sincere gratitude to my research supervisor, Ms Pat McInerney and co-supervisor, Mrs Barbara Lester, for their constructive criticism and help.

Special thanks go to the antenatal women in the city of Francistown who willingly participated in this study. My gratitude also goes to the Ministry of Health, Botswana and the World Health Organisation (WHO) for their sponsorship, Mrs Beverley Noble for diligently typing this project and my statistician, Mr Themba Mhoto for assisting me with data analysis.

Lastly I wish to express my deepest gratitude to my husband Duncan Tshwanelo and daughter Miranda Nasosoa for providing me with support and encouragement throughout my studies. To all of you, I say thank you once more.

DEDICATION

To my husband,

My daughter,

My late parents.

I love you all.

ABSTRACT

The purpose of this non-experimental descriptive study was to identify the cultural beliefs and practices surrounding pregnancy. The study aims at collecting data which will function as baseline information on cultural beliefs and practices surrounding pregnancy. The study was conducted in the city of Francistown, the second largest to the capital of Botswana situated in the north-east. A structured interview guide with both open and close-ended questions was used to collect data from 230 pregnant women who were 18 years of age and above and who were willing to participate. The data was processed on computer and a statistical software package known as Statistical Package for Social Sciences (SPSS) was used. The study revealed that pregnant women used a combination of care givers which either included a modern midwife and an elderly woman at church or a modern midwife and a traditional midwife. This is done in order to follow the traditional and cultural beliefs surrounding pregnancy and childbirth. The majority (92.2%) of the antenatal women in this study had primary and secondary education but still follow their cultural beliefs and practices, thus education does not appear to influence cultural beliefs and practices. The most common reasons cited for adhering to the beliefs and practices were that defiance was a taboo punishable by the ancestors. This study has highlighted the cultural beliefs and practices related to pregnancy. Further in-depth investigation into the impact of these cultural beliefs and practices is needed as it is imperative to determine their impact on pregnancy and its outcome. The limitation of

the study was that data was only collected in one city and therefore the results cannot be generalised to the entire population.

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CHAPTER ONE

1.0 INTRODUCTION

All cultures recognise pregnancy as a special transition period that may have particular customs, beliefs and rituals that dictate activity and behavior during pregnancy. Foods to eat, activities to avoid and care and behavior during pregnancy and childbirth may all be culturally prescribed. These cultural beliefs and practices influence the woman's experience and shape mothering behavior.

During pregnancy and childbirth, women belong to a group of highly vulnerable members of society. They are particularly vulnerable in developing countries characterised by poor sanitation, a high prevalence of communicable diseases and periodic drought conditions which affect both food and water supplies (Anderson & Stangard, 1986). Where such characteristics exist, especially in Africa, one is least likely to find a centrally organised system of maternity care. The pregnant women tend to seek assistance from the local healers since the healers are accessible and they both share the same cultural heritage. Thus culture constitutes a fundamental part of the life of each individual and the community at large.

1.1 STATEMENT OF THE PROBLEM

Globally, much research has been done concerning the cultural practices and beliefs related to pregnancy, but in Botswana, very little has been done. In the researcher's experience as a midwife working in the maternal and child health and family planning unit, she observed that women who used to come to the clinic for their routine ante-natal care perceived health from a different world view-point than the health care providers. It is these perceptions that would influence the outcome of pregnancy because pregnancy is almost universally associated with culturally based ceremonies and rituals, hence the researcher's interest in determining the cultural beliefs and practices related to pregnancy.

According to the safe motherhood initiative launched in 1987, there is an enormous gap between mortality rates in the developed and the developing worlds. In Botswana alone, some 200 women die each year while between 2,000 and 3,000 are significantly handicapped by pregnancy-related causes which are preventable. Of all the health statistics recorded by the World Health Organisation (WHO), maternal mortality has the largest discrepancy between the developed and developing countries (Safe Motherhood Initiative, 1994). Thus, the concept of cultural practices can not be overruled as it is supported by literature that in all cultures, certain beliefs exist surrounding what facilitates a good pregnancy and its outcome, as well as negative sanctions that may contribute to high mortality rates (Choudhry, 1997). The cultural context in which pregnancy occurs provides norms that influence attitudes, values and

interpretation of personal and interpersonal experiences. The cultural beliefs and practices influence the woman's experience and shape mothering behavior.

1.2 PURPOSE OF THE STUDY

The purpose of this study is to identify the cultural beliefs and practices amongst urban antenatal Botswana women in Francistown city. Francistown city is gradually growing, resulting in an increase in the mobility of people who bring with them a variety of cultural backgrounds. Many of these women attend an antenatal clinic which is based on a Western medical approach. In addition, they also visit a traditional birth attendant in order to follow the traditional and cultural beliefs surrounding pregnancy and childbirth. This poses a challenge to the nursing profession when attempting to provide individualised care. In order to meet individualised needs that consider culture, nurses need to be culture sensitive.

An appreciation of cultural meanings sensitizes the health care provider and helps ensure provision of appropriate care, particularly when the care depends on what the client thinks is important. According to Leininger (1991) without the inclusion of cultural factors, care provided is only partial or incomplete.

1.3 SIGNIFICANCE OF THE STUDY

To the researcher's knowledge, little research has been done concerning the cultural practices and beliefs related to pregnancy in Botswana. This is an exploratory

descriptive study to document the cultural beliefs and practices surrounding pregnancy. The findings will reflect how the beliefs and practices impact on pregnancy. Knowledge of such information could assist the health care providers in becoming aware and sensitive to enable them to recognise the cultural backgrounds of their clients and thus render culture sensitive care. The information could also assist the nursing schools in including the component of culture in the curricula so that nursing students are sensitised throughout their training.

1.4 RESEARCH QUESTION

What are the cultural beliefs and practices amongst urban antepartum Botswana women in Francistown city?

1.5 RESEARCH OBJECTIVES

The objectives of the study are to:

- identity the cultural beliefs and practices related to pregnancy,
- determine the advantages of cultural practices related to pregnancy,
- determine the disadvantages that may be related to the antepartum cultural practices.

1.6 OPERATIONAL DEFINITIONS

Cultural practices and beliefs: refers to the sum of norms, taboos and values related to pregnancy regardless of their benefits or harm.

Antepartum/antenatal women: refers to all pregnant women, eighteen years and above coming to the clinic for their routine care irrespective of the period of gestation or ethnicity.

Elderly women at church: refers to respectable women in church who have got divine powers to foresee problems surrounding pregnancy and can help sustain it through prayer and giving of holy water.

1.7 ASSUMPTIONS

The following assumptions were held throughout the study:

- there are cultural practices and beliefs related to pregnancy,
- the cultural beliefs and practices related to pregnancy suggest specific practices associated with pregnancy,
- the cultural beliefs and practices influence normative behavior in pregnancy,
- those who agreed to be interviewed were honest when giving their views.

1.8 LIMITATIONS

- The interview guide was written in English but the interview conducted in Setswana. The results were translated back into English, therefore some useful meaning could have been lost.
- Data collection was limited to one city and therefore results can not be generalised to the entire population.

1.9 CONCLUSION

In this chapter, an overview of the research study is presented. The research problem is identified and outlined. The research questions, assumptions, limitations and research objectives were also presented.

CHAPTER TWO

LITERATURE REVIEW

2.0 INTRODUCTION

The literature reveals that much has been written about practices and beliefs related to pregnancy, labour and the postnatal period. For the purpose of this study, only those cultural issues pertaining to pregnancy will be discussed. The literature review tended to highlight the following aspects:

- The definition of culture.
- Cultural values, beliefs and norms.
- The role of culture.
- The types of culture including ethnicity.
- Health care system and culture including ethocentricism.
- Cultural values and beliefs in pregnancy.

2.1 THE DEFINITION OF CULTURE

Even though the concept of culture has been defined by many authors, the meaning remains basically the same. In 1871, Sir Edward Tylor, a British anthropologist (cited

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LITERATURE REVIEW

2.0 INTRODUCTION

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2.1 THE DEFINITION OF CULTURE

Even though the concept of culture has been defined by many authors, the meaning remains basically the same. In 1871, Sir Edward Tylor, a British anthropologist (cited

in Boyle & Andrews, 1989:11), gave the first definition of culture as being used today:

> *"That complex whole which includes knowledge, belief, art, morals, law, custom and other capabilities and habits acquired by man as a member of society."*

McKenzie and Crowcroft from London (1994:286) define culture as:

> *"A social construct which is characterised by behavior and attitudes of a social group determined by upbringing and choice, culture is constantly changing and notoriously difficult to measure."*

Leininger, an American pioneer of transcultural nursing (1991:47) defines culture as:

> *"The learned, shared and transmitted values, beliefs, norms and lifeways of a particular group that guide their thinking, decisions, and actions in a patterned way."*

May and Mahlmeister, American Associate Professors of Nursing (1990:263) define culture as:

"A system of goals, beliefs, attitudes and roles that change but tend towards stability, that are shared by a distinct human group and that are transmitted by that group and learned by succeeding generations."

Mcgee (1992) states that culture has got two elements: - the manifest dimension, that is, those aspects about people that can be observed, such as the things they make, how they cook and how they behave; the tacit element which is rarely explicit and only traceable through the manifestation of a culture. These include values, attitudes and beliefs.

From the above definitions, it is clear that culture is a universal phenomenon that forms the basis or foundation of human existence. As such, culture should be viewed and analysed as a whole. However, within this whole, there are parts which are inter-related and inter-dependent. The components of culture as already mentioned, such as beliefs, norms, values, morals, roles, attitudes, inter alia, perform separate functions but nevertheless mesh to form an operating whole.

2.2 CULTURAL VALUES, BELIEFS AND NORMS

Values refer to the desirable or undesirable state of affairs and are a universal feature of all cultures whilst norms are the rules by which human behaviour is governed (Boyle & Andrews, 1989:13). Norms often provide direction for living up to values and set limits within which persons may seek alternative ways of achieving their

goals. Beliefs develop from the shared experiences of a group within a society and these are expressed symbolically. Values and norms are learned in childhood along with the suitable behaviours that reflect them.

Values serve many functions, some of which include influencing one's perceptions, directing a person's responses towards one another, reflecting a person's identity and forming a basis for self-evaluation, giving meaning to life (Potter & Perry cited in Boyle & Andrews, 1989). Thus values, reflect the personality of a culture which is distinctive to a particular society and is shared by its members.

According to Surgitharjah (1994:741) each culture values its tradition, beliefs and customs. The tradition, beliefs and customs offer a sense of identity, security and cohesion amongst the group. Cultural identity and pride are important indicators of the strength of cultural values and life experiences of any cultural group. Cultural practices provide the strength for meeting daily stresses and problems and influence one's actions and decisions whilst cultural identity is an integral component of cultural pride which stimulates one to seek one's roots.

Within some cultures, individuals are expected to adopt and comply with society's prescribed rules that relate to the norm. Actions and decisions considered to be right in one culture may not be acceptable to another. Besides being a way of life, culture relates to morality beliefs, norms and the accepted behavior which is passed on to the younger generation (Perry, 1988 as cited in Abdullah, 1995). For instance, according

to Muslim culture, the act of circumcision rituals of young boys is the norm and the rationale for the ritual is that it is considered a process of purification.

Morgan (1996) compared African-American rural and urban antenatal women. The study found that there was less use of professional prenatal care by rural women. The reason given was that professional prenatal care provided does not reflect culturally congruent care that draws upon generic cultural care values, beliefs and practices of the women. Prenatal care is often given by maternity nurses, clinical nurses, specialist and certified nurse midwives who lack knowledge about cultural factors in prenatal care.

Gr not, Spitzer, Aroian, Ravid, Tamir and Noam (1996) in support of the above found that rural Israeli women are reluctant to use urban health care. The study revealed that the reluctance is related to differences between traditional beliefs about pregnancy and delivery. They found that women in rural areas view pregnancy as a normal state that does not require any medical attention. These women chose to deliver at home with support from female family members, neighbours, traditional attendants or lay midwives. These rural women also tend to attribute pregnancy outcomes to factors beyond the purview of medical science, such as good and evil spirits, food and weather. In contrast, pregnancy practices in the urban area reflected a biomedical and technological approach including close monitoring and intervention throughout pregnancy.

2.3 ROLE OF CULTURE

According to Henkle and Kennerly (1990), culture reflects the background and experiences of a specific group of individuals. It is influenced by tradition and customs learned throughout life. As a result of its influence on all aspects of daily life, it provides a frame of reference through which changes in environment are appraised and coping responses developed within the context of an individual's feelings. The culture of a given society is distinctive and always specific to it, encompassing all the knowledge, beliefs, customs and skills acquired by members of the society.

Abdullah (1995) states that culture provides a guide for determining the values, beliefs and practices within society. Culture determines how individuals accommodate themselves within their culture in society because it is also related to how people live.

All human interactions are influenced by the beliefs and practices specific to the culture of its participants. According to Leininger (1991) people would not exist if they were not alike or different from each other, that is, it is the cultural heritage that makes humans distinct from each other. Human differences and similarities have existed since time immemorial and they will continue to do so because culture, like society, is not static, it is dynamic and changes with time.

Furthermore, every human being, irrespective of role status, was reared in a culturally specific environment, socialised on values, attitudes and beliefs. In addition, each

individual's behaviour is conducted in a manner prescribed by the socialisation process (Mcgee, 1994). One's identity lies in that socialisation process. By acting out what has been learned in the process validates one's identity.

In support of the above, the maternal and child health and family planning statistical report (1995) states that in Botswana, the national antenatal attendance has declined from 74% in 1994 to 69% in 1995. The physical accessibility of health facilities for antenatal care does not appear to be a factor in determining the use of the services. Recent statistics have shown that almost 100% of Gaborone (capital city of Botswana) residents, live within a radius of 8 kilometers from a heath facility. The same publication states that the role of traditional birth attendants (T.B.A) cannot be ignored because they are viewed as important providers of care in their communities. In addition, the T.B.A's and their clients have common cultural values.
Anderson and Staugard (1986) also found that the traditional healers apply a holistic view of health embracing spiritual, emotional, social and cultural factors.

Some modern health workers would refer to the traditional beliefs and customs as being "irrational". Such attitudes demonstrate ignorance and arrogance on behalf of the modern health worker. Without studying, understanding and respecting the conceptions and traditional beliefs of the community, relevant messages on health promotion and disease prevention will never be addressed.

2.4 TYPES OF CULTURE

Culture will be discussed under two categories namely:

- The dominant/minority culture including ethnicity.
- The health care systems culture including ethnocentrism.

2.4.1 Dominant/Minority Culture

According to Mcgee (1992), culture may be described as either dominant or a minority. A dominant culture is one that has or assumes it has authority to act as a guardian of the controlling value systems and has a monopoly on the rewards available. A minority culture is one that possesses certain traits that are held in low esteem by the dominant culture. These traits may be gender, race, ethnicity or profession. The term minority has nothing to do with numbers. According to Boyle and Andrews (1989:12), all cultures are equal, those that are labeled "dominant' are simply different from those that are labeled "minority", not more advanced or better. Ethnicity refers to cultural practices and outlooks that distinguish a given community or people (Giddens, 1992). The ethnic distinctions are commonly associated with marked inequalities of wealth and power. Mcgee (1992) further stated that ethnic minority is used to indicate people who do not belong to or identify with the dominant culture.

Choudhry (1997) states that cultural practices continue to influence many Indian immigrant women to whom Western practices are unknown or unacceptable. Once these women encounter people who are not familiar with their customs and beliefs, they may start to doubt their beliefs. The author observed that working class women have been particularly quick to change their ways as influenced by the Western health care professionals. The Indian immigrant women come from an authoritarian, restrictive, socio-economic environment compared with North American society that is liberal and individualistic. The immigrants live in two cultures and attempt to balance values of their cultural heritage with those of the host community but are often pressurised to maintain their original identity.

Sharts-Hopko (1995) supports Choudhry by stating that when people migrate to a new culture, they experience stress. They must adjust to a new language, way of life, differing social values and behavioural norms. The person's social role becomes ambiguous and status generally decreases.

2.4.2 Health Care Systems and Culture Including Ethnocentrism

Nurses as members of the health care team belong to a culture with its own set of values, attitudes and practices. Nurses are immersed in a value system of rational, analytic and biomedical principles which are reflected in their attitudes and behaviors (Boyle & Andrews, 1989). Nurses enter the health care profession with their own unique concepts of health. During the socialization process into nursing, neophytes

are expected to shed their old values and thought and develop behaviour patterns that are in line with their new culture. Nurses are therefore socialised to believe that modern medicine as taught and practised in Western civilization is the answer to all of humanity's health needs, hence, the term ethnocentrism.

Giddens (1992:251) states that ethnocentrism is a suspicion of outsiders combined with a tendency to evaluate the cultures of others in terms of one's own culture. By virtue, all cultures have been ethnocentric to a lesser or greater degree. Outsiders are thought of as strangers and morally or mentally inferior. Therefore, in ethnocentrism, there is an intense identification with the familiar and devaluation of the foreign beliefs and behaviors that are unfamiliar. Further still, people who are different from one's cultural group are treated with suspicion and often hostility.

Mcgee (1994:5) states that the idea that culture is influential to nursing is not a new one. The idea dates back to the times of Florence Nightingale (1894) when she wrote, "it is a truism to say that the women who teach in India must know the language, the religions, superstitions and customs of the women to be taught in India. It ought to be a truism to say the very same for England." This statement reflects the cultural aspect of care, a statement made 105 years ago!

After the 1979 Alma Ata Conference of Primary Health Care, WHO recommended that governments use traditional healers and traditional birth attendants as part of the strategy for providing primary health care for all (Ebbey-Tessendorf & Cunningham,

1997:20). However, this does not amount to a blind endorsement of all aspects of traditional medicine but encourages and supports countries in their efforts to find safe and effective remedies and practices for use.

In view of the above statement, the government of Botswana formulated its own national health policy based on the principles of primary health care. The health policy was officially adopted in 1995. According to the National Health Policy, the traditional health system is still an integral part of the Setswana cultural values and traditional beliefs, and as such, many Batswana still consult with traditional medical practitioners. To this end, the Ministry of Health adopted a policy of engendering good working relationships between scientific medical practice and traditional practice. The Ministry therefore organises fora where major health problems are discussed by modern and traditional health practitioners resulting in a healthy flow of information (Botswana National Health Policy, 1995).

In support of the above, Chipfakacha (1994) states that in most African countries, traditional medicine forms the basis of care. This is because traditional healers provide culturally familiar ways of explaining the cause of ill-health and its relationship to the people's social and supernatural worlds. There is no cultural difference between the traditional healer and his patient. Living in the same community and speaking the same language makes the traditional healer acceptable and accessible. Chipfakacha (1994) further illustrated that the countries that have adopted the concept of primary health care can only make it a reality by incorporating

traditional healers into the modern health care system. Traditional healers are respected by their communities; they are viewed as leaders who can encourage community participation.

Papo (1996) stated that in South Africa, primary health care is the main focus of the national health care system. Ethnic identities and cultural background of individuals strongly influence their health care attitudes, values and practices. These concepts may result in barriers for achieving the goals and objectives of the national health care system. In order to overcome these cultural barriers, Madeleine Leininger, an American nurse and anthropologist suggested that nurses need an approach that will enable them to identify their cultural differences from patients. In addition, they also need to gain an understanding of the similarities and difference between people (Leininger, 1991:1997).

Abdullah (1995) states that the nursing profession is entrusted by society with a challenging role of maintaining the health of individuals by providing individualised client care, within the context of a whole person. This can only be achieved by considering such factors as culture, beliefs and traditions. Without the inclusion of culture, health personnel are only providing partial or incomplete health care because health care is influenced by the beliefs of providers and consumers. According to Miller (1995), if health care beliefs become value-laden, they are held tenaciously. When these beliefs originate from an unfamiliar health culture, they are called superstition and are labeled false.

Burk, Wieser and Keegan (1995) support Abdullah by stating that the holistic approach is significant in nursing and requires that three distinct cultures be considered in the provider-client process. These are: the culture of the client, the culture of the nurse and the culture of the health care system in which the interaction occurs. Nurses must first be cognisant of their own personal and professional cultures before they can begin to understand the cultural beliefs and behaviors of their clients. Thus, a blending of the three cultures provides the basis for achieving culturally sensitive care. Cultural sensitivity is a basic tenet of holistic nursing care which is based on respect of the beliefs, attitudes and cultural lifestyles of clients. Culturally sensitive care is flexible and accessible to clients. It recognises that cultural heritage provides patterns for group references while allowing individual variance in beliefs and behaviours.

Papo (1996) further stated that society is gradually changing, resulting in an increase in the mobility of people who bring with them their different cultural backgrounds. All these changes have introduced new beliefs and values that further contribute to the complexity of knowledge nurses must acquire to meet the needs of the individual clients.

Therefore, by incorporating knowledge about cultural influences and values of clients into nursing practice, care is most likely to be effective and appropriate, particularly when the care depends on what the client thinks is important and that to which she

will agree. Understanding the cultural differences in human behaviour and the influences of the cultural environment on clients' perspectives is essential to the nurses' ability to individualize nursing care without stereotyping clients or allowing nurses to be ethnocentric (Henkle & Kennerly, 1990). Once cultural biases exist, clients will be viewed as strangers because they behave, act and speak in ways that are different from the care providers.

Bastein (1990) supports the above by stating that in Bolivia, workshops for both traditional and modern practitioners were held in which information was shared about illnesses that were perceived in cultural, biological and social terms. Because of the importance of culture in any society, doctors and nurses were given cross-cultural training in which special attention was given to the beliefs and practices of traditional medicine through role playing. The workshop allowed the traditional and modern practitioners to compare and link their experiences of illness and to focus on joint strategies for improving health. The workshop was geared towards reconciling the modern and traditional practitioners so as to bring about harmony in management.

It is as important for the health care provider to be aware of the client's culturally based health beliefs and behaviours as it is to know the client's family history, medical history, current symptoms and physiologic status. Understanding and respecting diverse cultural beliefs, attitudes and lifestyles, while at the same time appreciating individual variances within each culture, forms the basis of holistic care that is acceptable and effective.

2.5 CULTURAL VALUES AND BELIEFS IN PREGNANCY

According to Spector (1995) pregnancy, childbirth and disease are not just private experiences but they also have an intrinsic social dimension. The health conditions in which they take place are often determined as much by cultural practices as by biological and environmental factors. For example, food taboos during pregnancy can have serious consequences for the health of the pregnant woman and the unborn baby. In order to reduce such consequences, nurses must be able to influence behaviours, cultural attitudes and lifestyles.

Globally, no known culture would treat pregnancy with indifference or neglect. Instead, cultural beliefs about and values associated with pregnancy touch all aspects of social life in any culture. Such beliefs and values lend perspectives to the meaning of pregnancy and its outcome to the women (Mattson, 1995). With rare exception, all cultures have prescribed behaviours, customs or rituals for ensuring a safe and successful pregnancy outcome and often there are negative sanctions in place that may be difficult to ignore.

Mattson and Lew (1992) state that South East Asian refugees in America have little or no knowledge of anatomy, physiology, germ theory and hygiene, prenatal care or family planning. Pregnancy is not considered an illness, so the concept of seeking health-related advice during this period is strange to the refugees, except for asking for assistance from elders and family members.

The cultural context in which childbirth occurs provides norms that influence attitudes, values and interpretations of personal and interpersonal experiences. The experience of pregnancy can not be described adequately or comprehensively by quantitative means alone. Rather, pregnancy is a phenomenon endowed by the woman with meaning and subjective significance (Callister, 1995).

2.5.1 Nutrition and Diet

Choi (1995) states that all societies pattern behaviour of individuals involved in the process of reproduction. Beliefs concerning appropriate behaviour in pregnancy are characteristic of all cultures. Regulations resulting from these beliefs include nutrition during pregnancy and the type of help given to the woman. Generally, culture appears to pattern attitudes and affect thought processes about all aspects of pregnancy and childbirth. For example, traditional foods are still frequently adhered to by many pregnant women. Some of these foods are believed to have specific beneficial effects. Dietary restrictions both in terms of quantity and quality, are also practised. Nourishing food is also recommended and women are advised to satisfy their cravings for specific types of food (Chalmers, 1993).

Abdussalam and Kaferstein (1996) state that the primary function of food is to provide nourishment. Nevertheless, in every society there are dietary customs which play socio-culture and symbolic roles that go far beyond the nourishment of the body. The nutrients do not automatically become food, until they are so defined and are culturally accepted as fit for human consumption. For instance, many folk beliefs

require pregnant women to avoid eating meat and eggs or in some societies even to abstain from fruit and vegetables. Scientifically, these are the foods pregnant women need. According to May and Mahlmeister (1990), most cultures encourage the pregnant woman to maintain a diet that is generally considered a normal one for that culture.

Choudhry (1997) stated that most Indian women believe that hot foods are harmful and that cold foods are beneficial to the pregnant women. Because pregnancy generates a state of hotness, it is thought desirable to attain balance by eating cold food. Consequently, cold foods are recommended during early pregnancy to avoid miscarriage whilst hot foods are encouraged during the last stages of pregnancy to facilitate expulsion of the foetus.

When educating clients and families about negative aspects of folk beliefs and practices, care must be taken to present information in a respectful and non-judgmental way to avoid humiliation and alienation.

2.5.2 Physical Activity

Most cultures encourage a pregnant woman to maintain normal activities but to exclude strenuous work. Normal activity is advocated to "loosen the muscles" and "help keep the baby small" so that labour will be easy. Norms for sexual activity during pregnancy are variable ranging from no contact during the first three months to

strict prohibitions throughout pregnancy. Many of these practices which appear neutral to modern health workers may indeed have greater positive influence within a specific culture. A pregnant woman should therefore be viewed in totality within her cultural context.

2.5.3 Neonatal Preference

Khanna (1997) found that in a North Indian village of Shahargaon, the preference for sons is prevalent and daughters are disfavoured resulting in speculation over the sex of an unborn child. Instead of practising sex-selective abortion, daughters were neglected in terms of resource allocation and occasionally female infanticide was practised. According to Raman (1988) and Walia (1982) as cited in Choudhry (1997) women in various parts of India fast and ingest herbal medicines in the hope of having a son. The birth of a son is usually celebrated with gift giving whereas the birth of a daughter is subdued. Most Indian women grieve when they are not pregnant with a son.

Pregnancy therefore, presents a unique opportunity to influence a woman's health promotion and illness prevention behaviours. Health related behaviours of the pregnant woman affect not only her own well-being but the health and future of her unborn child.

2.6 CONCLUSION

In this chapter, factors such as definition of culture, role of culture, cultural beliefs, values and norms, the health care system and lture and the cultural beliefs and values as related to pregnancy were presented.

From the related readings, it is stated that each culture usually has a set of beliefs about the meaning of health and health maintenance and about correct behaviour for preventing illness. Furthermore, there are cultural differences and similarities that exist in every culture and it is therefore wrong to assume that all persons from a specific culture have the same cultural background. The literary reviews presented have provided guidelines for conducting the present research.

CHAPTER THREE

METHODOLOGY

This chapter describes the study methods including the design, setting, population, sample and ethical considerations. The data collection instrument is described and its validity and reliability are discussed.

3.0 STUDY DESIGN

The study design was a non-experimental descriptive survey. Descriptive studies describe attitudes, opinions and behaviours as they exist in the population (Wilson, 1993). Surveys are non-experimental because there is no manipulation of the variables. Some of the advantages of surveys are that they are flexible and have a broad scope since they focus on a wide range of topics (Polit & Hungler, 1993). According to Wilson (1993) some of the disadvantages of surveys are that there is a tendency of data obtained to be relatively superficial and there is a possibility that preconceived questions are irrelevant or confusing to the respondents and therefore yield meaningless data.

The aim of the research was to collect data which will function as baseline information on cultural beliefs and practices surrounding pregnancy.

3.1 SETTING FOR THE STUDY

The study was conducted in the city of Francistown, Botswana, the second largest to the capital Gaborone. It is situated in north-eastern Botswana. The researcher chose this city because it is growing rapidly and experiencing an influx of people who bring along with them their different cultural backgrounds resulting in the city becoming multicultural (see Annexure A).

The health care system within Botswana is based on the principle of primary health care as contained in the Alma Ata declaration of 1978. The central components of the primary health care strategy are equity, intersectoral collaboration, community participation, appropriateness, affordability and accessibility.

The city is served by one national referral hospital and ten clinics (see Annexure B). Services at the referral hospital include: in-patient care for more complicated health needs, preventive, curative and rehabilitative services; specialist services for serious and complicated health problems including specialist clinical services. The services at the clinics include maternal and child health, family planning, preventative, diagnostic and treatment of common diseases; simple laboratory tests; case finding and follow-up.

For the purpose of this study, all the ten clinics offering antenatal services will be utilised. The distance between the clinics is about three to five kilometers thus rendering them geographically accessible to the clients.

3.2 POPULATION

The study population comprised all pregnant women coming to the clinics for their routine antenatal care regardless of the gestational period and ethnicity. The clinic preliminary record review revealed that on average, ten pregnant women attend each clinic on a daily basis for routine antenatal care. A total of approximately 2000 women are seen in the ten clinics per month.

3.3 SAMPLING METHOD

In consultation with a statistician, a sample size of 200 pregnant women was considered to be representative of the population. Thus, a minimum of 200 respondents was to be sampled in a three week period in all the ten clinics. At the end of this three week period, 230 antenatal women had been interviewed.

Because the number of patients on a daily basis was small, all the ten clinics were used so that the target population was reached. Every pregnant woman, 18 years and above, who was in the clinic at the time that the researcher was conducting the interview, and who met the inclusion criteria formed part of the sample.

3.4 RESEARCH INSTRUMENT

A structured interview schedule with both open and close-ended questions was used as the tool for data collection (see Annexure C). The researcher conducted all the interviews herself. A structured interview schedule allows for the collection of personal data. The subjects are asked to respond to the same questions in the same order and are given the same set of options for their responses (Polit & Hungler, 1993). Open-ended questions allow subjects to respond to questions in their own words whilst close-ended questions are fixed alternatives that do not allow the respondents to express their opinions. According to Wilson (1993) some of the advantages of an interview schedule are that they allow the researcher to collect data from people who are illiterate. Furthermore, they are usually more effective in getting at people's complex feelings or perceptions. Some of the disadvantages are that some object to being forced to choose from alternatives that do not reflect their opinions and that respondents may be self-conscious about being recorded on tape, or about notes being taken about their responses, thus they may decide to withhold some information.

The above method was chosen because in a face-to-face situation there would be a higher response rate. This method of data collection also allows opportunity for clarification and probing of questions.

3.4.1 Structuring of the Questions

The interview schedule was structured in such a way as to gather information in the following areas:

- demographic data,
- beliefs related to health care,
- cultural practices and beliefs related to care during pregnancy,
- cultural practices and beliefs related to food or substances eaten during pregnancy.

3.5 PREPARATION FOR DATA PROCESSING

A draft form of the interview schedule was submitted to the statistician at the Human Science Research Council in Pretoria in order for data to be processed on the computer. Data was therefore coded to enhance processing.

3.6 PILOT STUDY

A pilot study was conducted on five pregnant women in one of the city clinics. These women were interviewed to determine whether the tool was:

- free flowing and meaningful,

- clear and free from ambiguities,
- easy to administer,
- eliciting the correct type of responses to the questions being asked.

A pilot study is a small scale version done in preparation for a major study (Polit & Hungler, 1993).

Once the pilot study was completed, minimal changes were made. For example, in question 8, "use of sonar" was deleted because sonars are not routinely done and few women have heard of or have had one.

3.7 DATA COLLECTION

Data was collected in July 1998 over a three week period. Data was collected from Monday to Friday of each week. Each clinic was visited daily until the required sample of 20 per clinic was reached.

The information letter was read to the respondents before commencement of the interview to obtain their verbal consent (see Annexure D).

The participants were informed that anonymity would be ensured by not using names. The respondents were made aware that their willingness to participate in the study was voluntary and that they were free to withdraw from the interview at any time if they so wished. The respondents were also informed that their participation or non-

participation in the study would not influence the type of care to be rendered and that responses would be kept confidential. The interview lasted 20 minutes (see Annexure C).

3.8 DATA ANALYSIS

The data was processed on computer and a statistical software package known as the Statistical Package for Social Sciences (SPSS) was used. This package provides a wide variety of analytic capabilities such as advanced statistical techniques.

3.9 VALIDITY

The tool was presented to midwifery experts for purposes of detecting ambiguity of the wording, inappropriate and or inadequate response categories and any other flaws in the interview schedule. The tool was considered to have face and content validity.

3.10 RELIABILITY

In order to enhance reliability, the structured interview schedule was used with the researcher conducting the interview.

3.11 ETHICAL CONSIDERATION

In order to proceed with the study, permission was obtained from the following:

- The City Council authorities in Francistown to conduct the study in the clinics. This included the city clerk and matron in charge of the clinics (See Annexure E, Reference Number FCC/47).
- The participants through their verbal consent.
- The Committee for Research on Human Subjects of the University of the Witwatersrand (see Annexure F, Protocol Number M980527).
- Persons in charge of the clinics.

3.12 CONCLUSION

In this chapter, the study methods and procedures have been discussed. The method of choosing a sample and the relevant data collection procedures have been described. Statistical methods of data analysis have been identified and described.

CHAPTER FOUR

FINDINGS AND DISCUSSION OF FINDINGS

In this chapter, the research findings and discussion are presented. The chapter will be divided into two sections: - Section A and B. Section A will show the demographic profile of the respondents. It reveals the cultural beliefs and practices related to pregnancy. Section B will show the association of demographic data in relation to beliefs relating to health care.

4.0 SECTION A

In this study, 230 women were interviewed about the cultural beliefs and practices relating to pregnancy. The findings below show the results.

4.1 DEMOGRAPHIC PROFILE

4.1.1 Age of the Respondents

Table 4.1: Age of respondents (n = 230)

AGE GROUP	N	%
18-25	117	50.9
26-33	65	28.3
34-41	44	19.1
42-49	4	1.7
Total	**230**	**100.0**

The above data shows that the majority of the respondents (50.9%) are in the age group 18-25 years. A further 28.3% are in the age group 26-33 years. Thus 79.2% of the sample were aged between 18-33 years. Abdullah (1995) stated that the young are taught about the many rules acceptable within their culture and these rules may be regarded as tools to carry throughout life. They in turn are expected to carry out their beliefs and traditions within their culture.

4.1.2 Marital Status of Respondents

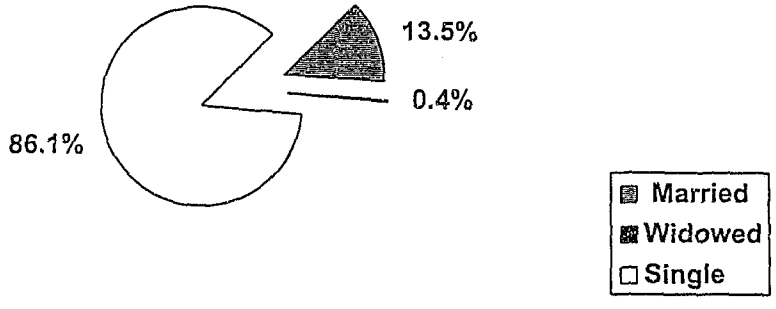


Figure 4.1: Marital status of respondents (n = 230)

At the time of the interview, the majority of the respondents (86.1%) were single. Marital status may have had an influence on the cultural background of women because after marriage, the women may be expected to adopt the cultural beliefs and practices of her spouse's family. Further analysis, however revealed that there was no relationship between culture and marital status. The increasing number of single

parent families seems to suggest a decline in marriage (Haralambos & Holborn, 1992).

4.1.3 Level of Education

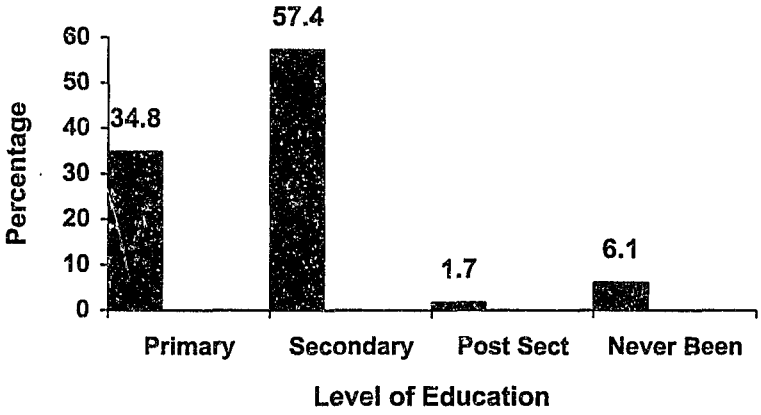


Figure 4.2: Level of education of respondents (n = 230)

According to Botswana education system, primary education is formal education from grade one to seven; secondary education is from form one to five and post-secondary is either technikon or university. The majority (92.2%) of the respondents had attained either primary or secondary education. Mechanic as cited in Boyle and Andrews (1989) stated that attitudes towards health and illness are related to educational level. Choudhry (1997) concurs with Boyle and Andrews (1989) by stating that the influence of education has persuaded many Indian women to seek medical intervention during pregnancy. In this study however, further analysis revealed there was no relationship between level of education and the cultural beliefs.

4.1.4 Religious Affiliation

Table 4.2: Religious affiliation of respondents (n = 230)

	N	%
Spiritual	183	79.6
Catholic	6	2.6
Protestant	20	8.7
None	21	9.13
Total	**230**	**100.0**

The study showed that 79.6% of the respondents belonged to the spiritual healing churches. These churches, inter alia, include the Zion Christian Church (ZCC), International Pentecostal Congregation Church (IPCC), Spiritual Healing church, St. John's, St. Annah, Eloyi and Seven Apostolic Church. Cavender (1991) stated that these Spiritual Healing Churches are characterised by inspiration and revelation by the Holy Spirit as exhibited in the divine prophecy, speaking in tongues, faith healing through laying of hands and prayer and consecrated water. It is then followed by 8.7% who belonged to the Protestant Churches which include the Seventh Day Adventist Church (SDA), UCCSA, Anglican, Methodist and Lutheran Churches. . Miller (1995) states that religious affiliation influences the way in which people respond to signs and symptoms of illness.

4.1.5 Nationality

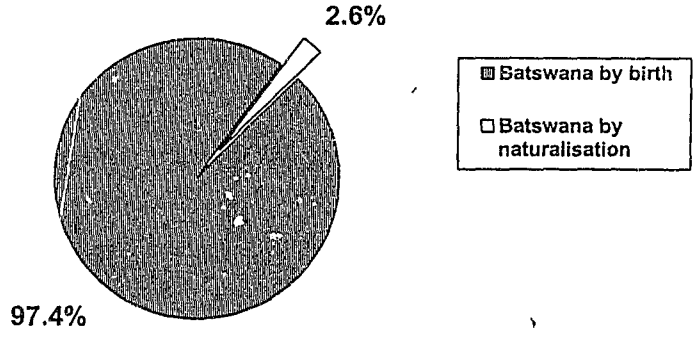


Figure 4.3: Nationality of respondents (n = 230)

The majority of the respondents (97.4%) were Batswana by birth and comprised of different ethnic groups.

4.2 HEALTH BELIEFS RELATING TO HEALTH CARE

4.2.1 Importance of Tetanus Vaccine

Table 4.3: Distribution of respondents' opinions about the importance of tetanus vaccine (n = 230)

	n	%
Very important	197	85.7
Less important	31	13.5
I do not know	2	0.8
TOTAL	230	100.0

More than three-quarters of the respondents (85.7%) stated that tetanus toxoid vaccines were important. The reasons given were that the vaccine was a "soldier" that protected the mother and her unborn baby by "fighting" against diseases and infections. This medically meant boosting one's immunity. Those who thought it was less important stated that in their experience, they had never had any tetanus vaccine and had never experienced any problems with their pregnancies. The two respondents who did not know whether tetanus vaccine was important stated that they have never heard about the vaccine because nurses have never told them what it was and how it worked.

Tetanus toxoid in obstetrical and midwifery practice in a developing country is important. This is because many women deliver at home where the walls of the dwelling are plastered with cow dung which exposes them to the risk of *Clostridium tetani*.

4.2.2 Importance of Screening Tests

Table 4.4: Respondents' views on the importance of screening tests (n = 230)

	n	%
Yes	222	96.5
No	7	3.0
I do not know	2	0.9
TOTAL	**230**	**100.0**

Almost all of the respondents (96.5%) stated that the screening tests such as blood tests were important. The reasons given were that the blood tests aided in early

detection of diseases and infections so that proper treatment can be timeously given. "Weak blood" which is referred to as anaemia medically, was cited as an example. Seven respondents did not view the screening tests as important. Of the seven, three stated that from their experience, they have never had their bloods tested but have never had problems, four felt they were exposed to unnecessary pain. Those who did not know stated that they have never been told why these tests were being done.

These findings are in contrast to Mattson's (1995) study done in South East Asia. To South East Asians, withdrawing blood equates to a withdrawal of the soul, thus blood withdrawing is foreign to them. The South East Asians do not trust the Western medicine or treatments that are prescribed for them. They rarely seek preventative care.

4.2.3 Importance of Repeat Antenatal Appointments

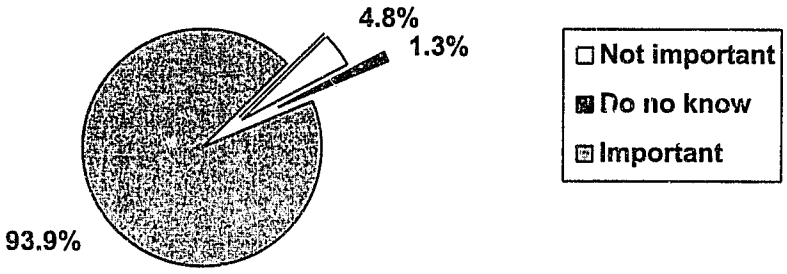


Figure 4.4: Respondents' perceptions of whether repeat antenatal appointments are important (n = 230)

Almost all of the respondents (93.9%) stated that repeat antenatal appointments were important. The following reasons were given:

- early detection in case the baby is lying "across" the abdomen or is lying with the "legs" down so that proper management and referral can be made timeously. Medically the above may be interpreted to mean a transverse lie and a breech presentation respectively,
- there were also certain conditions which the women may not be aware about but would be detected at the clinic. High blood pressure was cited as an example. The above referred to asymptomatic conditions.

Those who did not view repeat antenatal appointments as important gave the following reasons:

- women should only come to the clinic when they were not well because most of the time they were not complaining,
- the massaging (abdominal palpation) that was done in the clinic by the nurses was not thoroughly done.

Those who did not know whether repeat antenatal appointments were important could not give reasons to substantiate themselves.

According to the Health Systems Development Unit (1996), the traditional role of women is to care for the children and the home. Therefore, their days are spent doing household chores such as collecting fire wood, fetching water, cooking and doing the laundry. These tasks on their own are time-consuming and when prioritizing daily activities, extra commitments such as antenatal care, from which benefits are not immediately apparent, have to be put aside. The same publication states that the benefits of attending antenatal care are not always clear. It further states that demands made on women within the family, are such that many of them do not have any extra time to attend to their own needs.

4.3 CULTURAL BELIEFS AND PRACTICES RELATING TO HEALTH CARE

4.3.1 Where Do You Go First When You Realize You Are Pregnant?

Table 4.5: Respondents' views on where to go first when they realize they are pregnant (n = 230)

	n	%
Clinic	210	91.3
Traditional midwife	13	5.7
Other	7	3.0
TOTAL	**230**	**100.0**

Almost all (91.3%) of the respondents who chose the clinic first when they realized they were pregnant gave the following reasons:

- nurses were able to confirm pregnancy,
- nurses were able to "identify" or "detect" any problems with the pregnancy such as when the baby's legs are down instead of the head (breech instead of cephalic),
- the nurses also issued a health card which was a "passport" for them to be used in any health facility within the country.

The 5.7% who chose the traditional midwives gave the following reasons:

- they too were able to confirm pregnancy,
- the traditional midwives were also known to the woman and this facilitated the interpersonal relationships,
- in addition, the traditional midwives gave them traditional medicine which protected the pregnancy by driving away evil spirits and repelled witchcraft from jealous people.

The 3.0% who chose elderly women at church stated that:

- the elderly women at church could also diagnose pregnancy,
- the elderly women at church gave them holy water to help protect the pregnancy.

Choudhry (1995) stated that in India, pregnancy and childbirth is not considered an illness, so the concept of seeking health-related advice during this period is strange, except for asking for assistance from the elders, herbalists and family members. The

Western health practices often seem to be frightening and intrusive, partly because of the dichotomous practices seen with Western medicine and the lack of understanding of diagnostic procedures. Additionally, because Indians have a strong belief in fate, many do not seek medical treatment because they perceive their predicament as something that must be endured rather than something that can be alleviated. Mattson and Lew (1992) concur with Choudhry by observing the same attitudes amongst South East Asian women. Burk, Wiser and Keegan (1995) state that Mexican-American women are primarily responsible for maintaining the health of the family. These women incorporate traditional medicine in their home care. When the illness is considered serious, other family members are often consulted before seeking outside health services.

4.3.2 Traditional Rituals Carried Out When One Falls Pregnant

Table 4.6 The use of traditional rituals when one falls pregnant (n = 230)

	n	%
Yes	140	60.9
No	90	39.1
TOTAL	**230**	**100.0**

Those who responded positively to this question described some of the rituals as follows:

- being given some traditional medicine to drink so as to induce vomiting and an enema to cleanse the body so that the baby grows in a clean environment,
- being given holy water to drink so as to drive away evil spirits. Holy waist, neck, hand and feet bands are also used to drive away evil spirits,

- to drink one's early morning urine as it is considered to make one's body "strong" and to be able to withstand witchcraft,
- being given pounded placenta of a donkey mixed with food or water so that labour progresses quickly and without problems because donkeys are known to have quick labours.

Similar rituals have been described in the Health Systems Development Unit (1996). Traditionally, pregnant women are considered to be vulnerable to witchcraft as the physical and psychological changes make the woman weak. Generally, this period of change is considered to be potentially dangerous. As pregnancy is viewed as a sign of success, others might become jealous. The jealous people within close proximity are most likely to bewitch the baby or the mother in order to harm them. Thus, rituals are to protect the woman against the various dangers of pregnancy. The approach chosen for protection depends on the family to which the woman belongs.

4.3.3 Cultural Beliefs and Practices During the First Three Months of Pregnancy

The beliefs and practices adhered to during pregnancy and the consequences if they are violated are presented in tables 4.7 - 4.9. The tables show that beliefs and practices change according to the period of gestation.

Table 4.7: Beliefs and practices, and the consequences if they are violated during the first three months of pregnancy (n = 230)

BELIEF OR PRACTICE	CONSEQUENCES IF VIOLATED
• The woman should be faithful to the father of the baby (she should not take another sexual partner).	The pregnancy will be lost. The pregnant woman will be a weakling.
• The pregnant woman should be a loving, warm-hearted person especially towards cripples.	The woman can give birth to a crippled baby.

From the above table, it is evident that even culturally, women are advised to be faithful to their partners. This practice is medically beneficial in this era of HIV/AIDS to help prevent the spread of the disease.

Table 4.8 Cultural Beliefs and Practices During the Fourth to Eighth Month of Pregnancy

BELIEF OR PRACTICE	CONSEQUENCES IF VIOLATED
• Sexual intercourse with the father of the baby is permitted.	The "father's dirt" (semen) will make the foetus grow.
• The woman should not wear a belt.	The umbilical cord will strangulate the baby by wrapping around the baby's body.
• She should not sit on top of a mortar.	The baby will be born with a flat nose.
• The woman is not supposed to drink water whilst in the standing position.	The baby will easily choke during feeds.
• The woman is not supposed to jump over potholes.	The baby tends to have a sunken fontanelle.

BELIEF OR PRACTICE	CONSEQUENCES IF VIOLATED
• The pregnant woman is not supposed to be lazy or sleep during the day.	The woman will sleep during labour. The child will be sleepy at birth.
• The woman should not let a stubborn person walk behind her.	Labour will be slow or difficult. The baby will also be stubborn.
• The woman should not overwork herself.	The baby will be tired at birth.
• She is not supposed to bath at night.	Labour will start at night and it will be difficult to get help.
• The woman is not supposed to view a corpse.	The baby will be born blind.
• She is not supposed to listen to the radio.	The child will cry a lot and not sleep.
• The pregnant woman is not supposed to stand at the door for a long time.	Labour will be prolonged. The baby will also "stand" at the perineum during delivery.
• She is not supposed to lie on her back.	The foetus will kick her in the heart and the woman can die of heart failure.
• The woman is not supposed to sit on the ground but use a mat or a chair.	People can pick up sand from where she sat and bewitch her resulting in loss of the pregnancy.
• The pregnant woman should not sit with her legs crossed.	Labour will be obstructed.
• The woman should not jump over pieces of wood.	The baby will be born with rickets or a clubfoot.
• She should not hold onto something when standing, e.g. a chair.	Labour will be slow and difficult.
• The pregnant woman should not walk with her arms behind her back or fold her arms.	She may have a miscarriage or a still birth.
• The woman should not return to the house in case she has forgotten something.	The baby will go "backwards" leading to prolonged labour.
• The pregnant woman should not look at the mirror.	The baby will have a squint.
• The pregnant woman should not cross where a snake has passed.	The baby will crawl like a snake.

BELIEF OR PRACTICE	CONSEQUENCES IF VIOLATED
• The woman is not supposed to enter a social gathering and shake hands with people.	The people might be jealous of her and cast evil spirits leading to loss of the pregnancy.
• The pregnant woman is not supposed to go out a lot (visiting).	She can meet with or pass by people who have committed abortions and she can lose the pregnancy.

Because of the importance attached to pregnancy and childbirth, many cultural beliefs and practices have a bearing on its outcome. Various traditional beliefs and practices are intended to protect both the mother and her unborn child from adversity. However, some beliefs and practices can damage the health of both the mother and child in various ways. For instance, in cases of premature labour, the woman is medically advised to refrain from sexual intercourse as it may lead to the pregnancy being lost. On the contrary, women are culturally advised to have sexual intercourse during the course of pregnancy in order to aid in the growth of the foetus.

Table 4.9 Cultural Practices and Beliefs During the Last Month of Pregnancy

BELIEF OR PRACTICE	CONSEQUENCES IF VIOLATED
• Sexual intercourse even with the father of the baby, is prohibited.	The baby will be born covered with the "male dirt" (semen) and the nurses will be angry because the baby will be dirty.

From the above table, it is evident that during the last trimester, sexual intercourse is prohibited. Yet medically, as in cases of postmaturity, sexual intercourse is advised. Research has found that seminal fluid contains prostaglandins. The prostraglandins

act by ripening the cervix and are used before induction with oxytocin (Ruiz, 1998). Thus the cultural practices during the first and last trimesters tend to contradict each other.

But, there are those practices which are medically beneficial and should be encouraged. For instance, culturally, the pregnant woman is not supposed to sleep on her back. Medically, pregnant women are not advised to sleep in the dorsal position because of the supine hypotensive syndrome.

From the above, it can be seen that culture is essentially a design for living, a way of life adopted by a particular group of people Boyle and Andrews (1989) stated that all cultures recognise pregnancy as a special transition period and many have particular customs and beliefs that dictate activity and behaviours during pregnancy. They further argued that the cultural experiences of father-becoming and mother-becoming are disrupted by the emphasis of Western medicine on obstetric technology. Many of the traditional cultural beliefs, values and practices related to pregnancy and child birth, are viewed by nurses as old-fashioned or old wives tales. This may be explained by the fact that nurses are socialised to believe that their belief system is superior.

4.3.4 The Benefits of the Cultural Beliefs and Practices Related to Pregnancy

Table 4.10: Responses to the benefits of cultural beliefs and practices (n = 230)

	n	%
Yes	206	89.6
No	15	6.3
I don't know	9	3.9
TOTAL	**230**	**100.0**

Of the 206 (89.6%) respondents who stated that there were some benefits to the cultural beliefs and practices related to pregnancy, the following reasons were given:

- following the instructions would ensure that no problem would be experienced with the pregnancy, moreover, violation of the beliefs and practices would be punishable by the ancestors,
- they are sure there must be some benefits issuing from the cultural beliefs and practices as they believe that the tribal/community/group/family elders would not deceive them.

Of those who did not see the benefits of cultural beliefs and practices, the following reasons were given:

- since they did not believe there were any benefits, nothing could happen to them,
- from their experience, they had defied culture but never had any problems.

Burk, Wieser and Keegan (1995) stated that Mexican-American women believe that they have little control over the outcome of pregnancy except through avoidance of activities or foods that are considered taboo. If they are avoided, pregnancy will proceed to term without any problems.

4.3.5 The Person Preferred to be Seen During Pregnancy

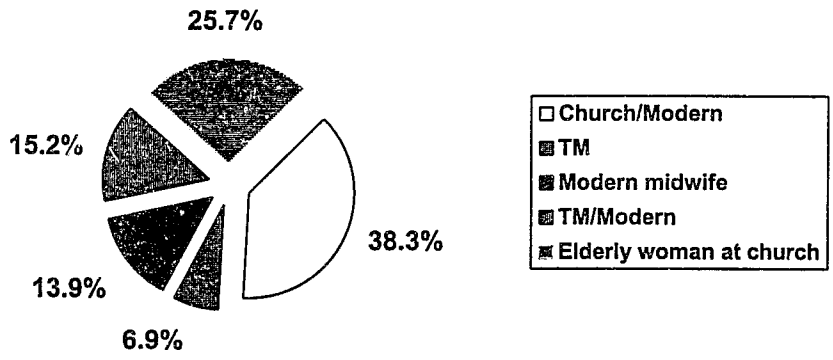


Figure 4.5: Responses according to the person preferred

The pregnant women in this study used a combination of care givers which either included a modern midwife and an elderly woman at church or a traditional midwife and modern midwife. The reasons given for preferring to use a combination of care givers were that their services complemented each other because:

- at church, they are given holy water to help "strengthen" the pregnancy. This helps drive away evil spirits and furthermore these women did thorough massaging (abdominal palpation),
- the traditional midwife gave traditional medicine to ward off witches and also did a thorough palpation,
- the modern midwife as an expert in her field can treat ailments.

Leininger (1991) in support of the above, states that the professional antenatal care provided does not reflect culturally congruent care that draws upon generic cultural care values, beliefs and practices of the women. This is because many of the health care professionals lack knowledge about transcultural factors in prenatal care. Chipfakacha (1994) states that people's beliefs and patterns of behaviours are grounded by cultural beliefs. He further states that lay people activate their health care by deciding when and whom to consult, whether or not to comply, when to switch between treatment alternatives, whether care is effective and whether they are satisfied with its quality.

4.3.6 Whether the Clinic Nurses are Culture Sensitive

Table 4.11: Responses of whether nurses are culture sensitive (n = 230)

	n	%
Yes	12	5.2
No	209	90.9
N/A	9	3.9
TOTAL	**230**	**100.0**

The majority of the respondents (90.9%) stated that the clinic nurses were not culture sensitive and the following reason was given:

- the nurses did not want to touch the bands worn on the neck, hands, feet and waist. The nurses did not want to touch the bands because they did not want to be bewitched. Furthermore, they did not want to touch the bands because they were afraid they would go blind. However, the reasons given by the

women could be interpreted as culture sensitivity. Nurses may be demonstrating a respect of the cultural practices of the women.

In support of the above, Leininger as cited in Mcgee (1992) argued that the folk system needs to be incorporated into professional approaches to care which might then be aimed at assisting the individual in maintaining their existing health status and lifestyle.

4.3.7 Satisfaction with the Courtesy Received in the Clinic

Table 4.12: Responses to the courtesy received in the clinic (n = 230)

	n	%
Yes	32	13.9
No	198	86.1
TOTAL	**230**	**100.0**

Of the 32 (13.9%) respondents who stated that they were satisfied with the courtesy received at the clinic, the reasons given were:

- the nurses were supportive,
- the nurses were welcoming,
- they always greeted the women whenever the women entered the consulting rooms.

The majority (86.1%) of the respondents who were not satisfied with the courtesy received at the clinic gave the following reasons:

- nurses were unapproachable, for instance, if a woman wanted some clarification on something, it seemed the nurses were always in a hurry, they did not have time to attend to individuals,
- the nurses were arrogant,
- the nurses had time for "rich people" and not ordinary people.

According to Mcgee (1992) the code of professional conduct requires that the nurse recognise and respect the uniqueness and dignity of each client.

4.3.8 Specific Foods to be Eaten During Pregnancy

Table 4.13: Responses to specific foods to be eaten during pregnancy (n = 230)

	n	%
Yes	198	86.1
No	32	13.9
TOTAL	**230**	**100.0**

The data showed that of the respondents (86.1%) who stated that there were foods which they believed must be eaten during pregnancy, the following reason was given:

- the food eaten should be culturally acceptable because it will help to make the baby grow and keep the pregnant woman healthy.

Those who said there were no specific foods to be eaten during pregnancy gave the following reason:

- food to be eaten during pregnancy should not be culture bound but based on what the pregnant women can afford and tolerate since most pregnant women have a craving for certain foods such as clay and mud.

Choudhry (1997) reporting on a study done in India says that most cultures have prescribed foods to be eaten during pregnancy. If the food practices are not adhered to, the pregnancy might be affected. Choudhry further stated that pica such as mud, raw clay and baked clay have no traditional significance.

4.3.9 Foods or Substances Not to be Taken During Pregnancy

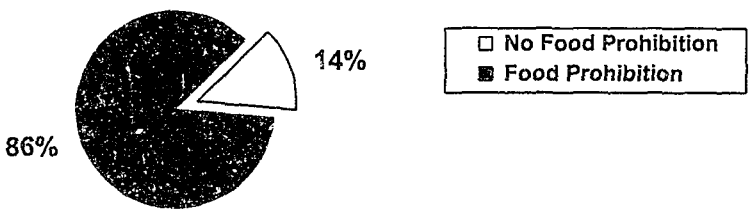


Figure 4.6: Respondents' beliefs on foods not to be eaten during pregnancy

(n = 230)

The majority of respondents (86%) stated that there were foods or substances which they believed should not be eaten during pregnancy.

Of the 230 pregnant women interviewed about foods or substances not to be eaten during pregnancy, 198 (86%) gave reasons why certain foods should be avoided. Their views are presented in Table 4.14:

Table 4.14: Reasons given for food avoidance during pregnancy (n = 230)

FOODS TO BE AVOIDED	REASONS GIVEN
• Eggs.	Prolonged labour. The egg white will block the birth canal. The baby will be born without hair. The foetus will grow big leading to operations.
• Dried meat (biltong).	The baby will be born malnourished.
• Fish.	The baby will have a scaly skin.
• Liver, pancreas.	Causes discoloration of the baby's teeth. The woman will expel a lot of clots after delivery. The woman will also bleed a lot during delivery.
• Tripe.	Leads to prolonged labour.
• Colon or kidney.	A baby boy will have a long penis and a baby girl will have big labias. The umbilical cord will take long to dry up.
• Meat from hoofed animals.	The baby will be delivered as breech.
• Meat from a cow that died whilst giving birth.	The baby will have delayed milestones (crawling, standing, walking). The mother will have a difficult delivery; pregnancy can be lost.
• Meat from crawling animals and wild animals.	The baby will be born with a clubfoot. The baby may adopt the habit of that animal.
• Oily foods.	The baby will be covered in fat (vernix) at birth.
• Sweet foods.	It predisposes the baby to body rash, baby will drool saliva.

FOODS TO BE AVOIDED	REASONS GIVEN
• Water melon.	The membranes will rupture prematurely and liquor will drain for a long time. The woman will urinate excessively during labour. The woman will also shiver throughout delivery.
• Left over foods or cold foods.	Stools will come out first during labour. Labour pains will be delayed.
• Pumpkin.	The baby tends to have colic.
• Samp or bread.	The baby tends to be constipated.
• Chicken feet.	The baby will grow long nails and tends to scratch a lot.
• Bean leaves.	The foetus will grow too much hair and the hair will cut the woman during labour.
• Hot tea or coffee.	The foetus will be burned leading to discoloration in some parts of the body, e.g. the buttocks.
• Sour milk.	The child will vomit often.
• Alcohol.	The baby will be drunk at birth and not cry. Alcohol is even discouraged in Western medicine because it leads to growth retardation.

Dietary taboos and restrictions can lead to nutritional deficiencies. Traditions such as these remain deeply rooted in the women despite their level of education (Nyinah, 1997).

4.3.10 Foods the Women are Encouraged to Eat During Pregnancy

Table 4.15: Respondents' views according to foods encouraged (n = 230)

	n	%
Yes	213	92.6
No	17	7.4
TOTAL	**230**	**100.0**

Almost all of the respondents (92.6%) stated that there were foods that they were encouraged to eat. These foods included the culturally accepted foods such as sorghum, wild fruits and warm foods which were believed to keep the pregnant woman and her unborn baby healthy. Others stated that they were only told what they were not supposed to eat but never told what they were supposed to eat.

4.3.11 Beliefs Regarding the Consequences of Food Eaten

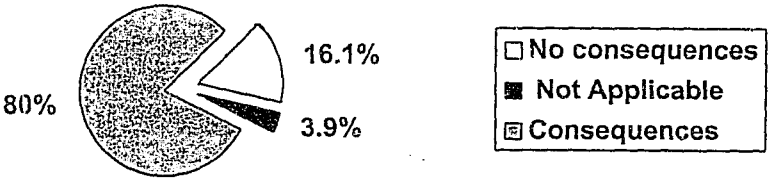


Figure 4.7: Respondents' views according to the consequences of food eaten (n = 230)

More than three-quarters of the respondents believed that the food eaten during pregnancy can affect the woman or her unborn baby. The reasons given were that:

- even though they had not witnessed anything pertaining to the consequences, they did not want to take chances and it was a taboo to defy culture,

- they had heard of women who had given birth to cripples, had difficult labours and ended up with operations. The respondents who stated that there were no consequences stated that from their experience, they have eaten the forbidden foods previously but did not have any problems with the pregnancy. According to them, an event will happen if one has faith in it but otherwise if one does not believe, the event will never happen. Thus the majority of women in the study believed that there are consequences if the food eaten is not culture-bound hence their adherence to the cultural practices and beliefs.

4.4 SECTION B

In this section, the researcher has cross tabulated the demographic variables with the beliefs relating to health care. Three variables were considered to be significant and are highlighted in the table. The statistical test used was the contingency coefficient whose value is determined by the number of rows and columns in the table. The closer the value is to zero, the stronger the relationship. The results are presented in table 4.16:

Table 4.16: Cross-tabulation of the beliefs relating to care and demographic variables

	P value		
	Marital status	**Education**	**Religion**
• How important is tetanus toxoid vaccine to you?	.886	.258	*0.097
• How important are screening tests?	.493	.288	*0.050
• How important are repeat visits?	.396	.244	*0.037

* Denotes there is an association between the variables crossed because of the P values that are closer to zero. Marital status and education have got no significance when crossed with the above variables. Education too was cross-tabulated with the cultural beliefs and practices relating to pregnancy but no relationship was established. Despite their education, individuals still adhere to their cultural heritage. Choi (1995) states that pregnant educated women have richer life experiences because they have been exposed to more information regarding germ theory, foetal development and thus set higher standards for themselves as mothers. Because of these standards, they may have evaluated their cultural heritage as less satisfying and thus change.

Religion reflected an association with the beliefs relating to health care. Miller (1995) stated that religious affiliations influence the way in which people respond to signs and symptoms of illness. Many religions prescribe rituals associated with

health protection. Some of the rituals may influence the way people choose to prevent illness, for example, the use of holy water. In support of the above, Spector (1995) states that religion strongly affects the way that people choose to prevent obstetrical problems. She further states that most women believe that the obstetrical problems are prevented by the adherence to religious codes, morals and practices and they view these problems as a punishment for breaking a religious code.

4.5 CONCLUSION

In this chapter, the cultural beliefs and practices of 230 antenatal women in Francistown city have been presented. The study findings reflected that though the majority (92.2%) of the respondents had been to school, this did not influence their cultural belief. The study has also revealed that pregnant women use both the medical and traditional approaches of care because they believed the services compliment each other. From the respondents' perspectives, providers of care are not culture sensitive. Yet, from the respondents' responses, the nurses may have been culture sensitive. The nurses should therefore be respectful and non-judgmental in their interactions with clients so as to avoid humiliation and alienation. The study results have also reflected food taboos which the women adhered to. Yet, the food prohibited such as eggs, liver and intestines were beneficial for the health of the pregnant woman and her unborn child.

From the study, religion has been seen to be an important cultural value. It affects the way people choose to prevent illness and plays a strong role in rituals that are associated with prevention. It is therefore important to determine the extent to which religious beliefs and attitudes impact on pregnancy and its outcome.

CHAPTER FIVE

SUMMARY, RECOMMENDATIONS AND CONCLUSIONS

5.0 SUMMARY

In this chapter, a summary of the study and its findings, the limitations and recommendations for further research, nursing education and clinical practice (midwifery) will be discussed.

The purpose of the study was to identify the cultural beliefs and practices amongst urban antenatal Botswana women. The study was conducted in the ten (10) maternal and child health clinics in Francistown city, Botswana over a three week period. The research design undertaken was a descriptive survey using a structured interview schedule. The interview schedule made use of both open- and close-ended questions. The population for the study comprised of pregnant women 18 years and above who came to the clinic for their routine antenatal care regardless of ethnicity or period of gestation. The sample size was 230 pregnant women. The study therefore sought to answer the following question:

"What are the cultural beliefs and practices amongst urban antenatal Botswana women in Francistown city?"

5.1 RESEARCH OBJECTIVES

The objectives of the study were to:

- identify the cultural beliefs and practices related to pregnancy,
- determine the advantages of cultural practices related to pregnancy,
- determine the disadvantages that may be related to the antepartum cultural practices and beliefs.

5.2 SUMMARY OF FINDINGS

The findings revealed that pregnant women visit a traditional midwife and an elderly woman at church in order to follow the traditional and cultural beliefs surrounding pregnancy and child birth. The reasons given were that their services complemented each other. For instance, whilst the clinic or modern midwife diagnosed and treated illnesses, the traditional midwife or elderly woman at church gave traditional medicine or holy water respectively to protect the pregnancy.

In this study, the majority of the respondents (92.2%) had been to school but still follow their culture. Thus education does not appear to influence cultural beliefs and practices while a relationship between religion and culture was found.

The study found that 60.9% of the respondents stated there were rituals done to help protect the pregnancy from witchcraft. This is because pregnancy is viewed as a

success and people might be jealous and therefore try to harm the pregnancy. It was also found that some of these beliefs and practices could be beneficial and therefore can be emphasised. For example, culturally, a pregnant woman is not supposed to sleep in the dorsal position because the foetus might kick the woman in the heart causing heart failure. Medically too, the dorsal position is discouraged during pregnancy because of supine hypotensive syndrome.

The findings reflected that cultural beliefs and practices included an adherence to food taboos. The respondents stated that if the forbidden food was eaten, the consequences could render the life of the mother and baby at risk. Yet, this study found that most of the food stuffs forbidden were medically beneficial to the pregnancy for a healthy mother and foetus. For instance, eggs, liver, intestines, are all a taboo during pregnancy yet they are a source of protein necessary for growth of the unborn baby.

The study showed that the respondents expected the clinic nurses to be welcoming, to greet the clients as they come into the clinic to display a friendly attitude (good interpersonal relations) and be able to answer questions without any excuses. The respondents stated that whenever clarification on certain issues were needed, nurses seemed to be in a hurry. The respondents further stated that the nurses sometimes shouted at them for having done something wrong, for example, missing an appointment.

5.3 LIMITATIONS OF THE STUDY

- The interview guide was written in English but the interview was conducted in Setswana. The results were translated back into English, therefore some meaningful meanings could have been lost.
- Data was collected in one city only and therefore results can not be generalised to the entire population.

5.4 RECOMMENDATIONS

The following recommendations can be made:

5.4.1 For Further Research

- A comparative study between urban and rural women should be undertaken. This would provide information on practices and beliefs from both perspective.
- Further investigation into the impact of cultural beliefs and practices on pregnancy needs to be undertaken.
- The elderly women should be interviewed to determine what it is that they do in their caring that pregnant women want to consult with them.
- Professional nurse care givers should be studied to determine how much they know about transcultural nursing practices.

- The same study should be conducted at national level so that the results can be generalised.

5.4.2 For Education

- During curriculum development, the concept of transcultural caring should be included so that nurses are sensitized during training. The curriculum should focus on comparative transcultural nursing care, values and practices that include both western and traditional culture. The achievements of culturally sensitive care requires the development of a knowledge base in nursing. The knowledge base should incorporate an awareness of the nurses' own culture, preferences and prejudices alongside specific information about local ethnic groups.
- The culture of nursing institutions have to change in terms of the value placed on particular behaviours and policies which inadvertently discriminate against members of ethnic minority groups.
- Educational programmes must reflect the values, knowledge and experiences that are expected of the learners in order that they become competent and professional carers.
- Nurse educators need to learn how to effectively transmit transcultural knowledge about diverse and similar cultures without incorporating their personal views and biases.

5.4.3 For Clinical Practice

- Clients and nurses should be encouraged to narrate their experiences from interactions or relationships with each other over time. New view points can be discovered about themselves in a different environmental cultural context. The narratives provide a means to discover different or new perspectives about people and to develop different approaches to human caring practices.
- The employing authority should offer opportunities for the ward sisters to undertake courses on transcultural nursing.
- Since some of the practices can be harmful, care must be taken to present the information in a respectful, non-judgmental way to avoid humiliation and alienation.
- The clinical nurses should be culture sensitive so that they are able to render comprehensive quality care. Nurses need to be flexible, respect cultural differences and avoid unfavorable cultural imposition that may stifle the development, survival and growth of a culture.
- Nurses need to design and deliver antenatal care creatively so that it combines strengths from each culture.
- Nurses need to be aware of cultural differences that exist among clients. They should also be supportive of cultural influences that affect an individual's perinatal experience.

5.5 CONCLUSION

This study has highlighted the cultural beliefs and practices related to pregnancy amongst urban antenatal women in Francistown city, Botswana. Two hundred and thirty (230) antenatal women 18 years and above were interviewed. The study shows that the majority of the respondents (92.2%) had been to school but still follow their cultural beliefs and practices. Education therefore, does not appear to influence cultural beliefs and practices. The findings show that the beliefs and practices related to pregnancy are adhered to and to violate them was a taboo punishable by the ancestors. The findings also revealed that nurses were not perceived as culture sensitive by the respondents. Yet, according to the responses given by the respondents, nurses were not perceived as culture sensitive by the respondents. However, examples given to illustrate this assertion indicate that the nureses' behaviour may well have been demonstrating a cultural sensitivity which was not interpreted as such by the respondents. It was also found that the respondents expected the clinic nurses to be welcoming, to display a friendly attitude and greet the clients as they come into the clinic.

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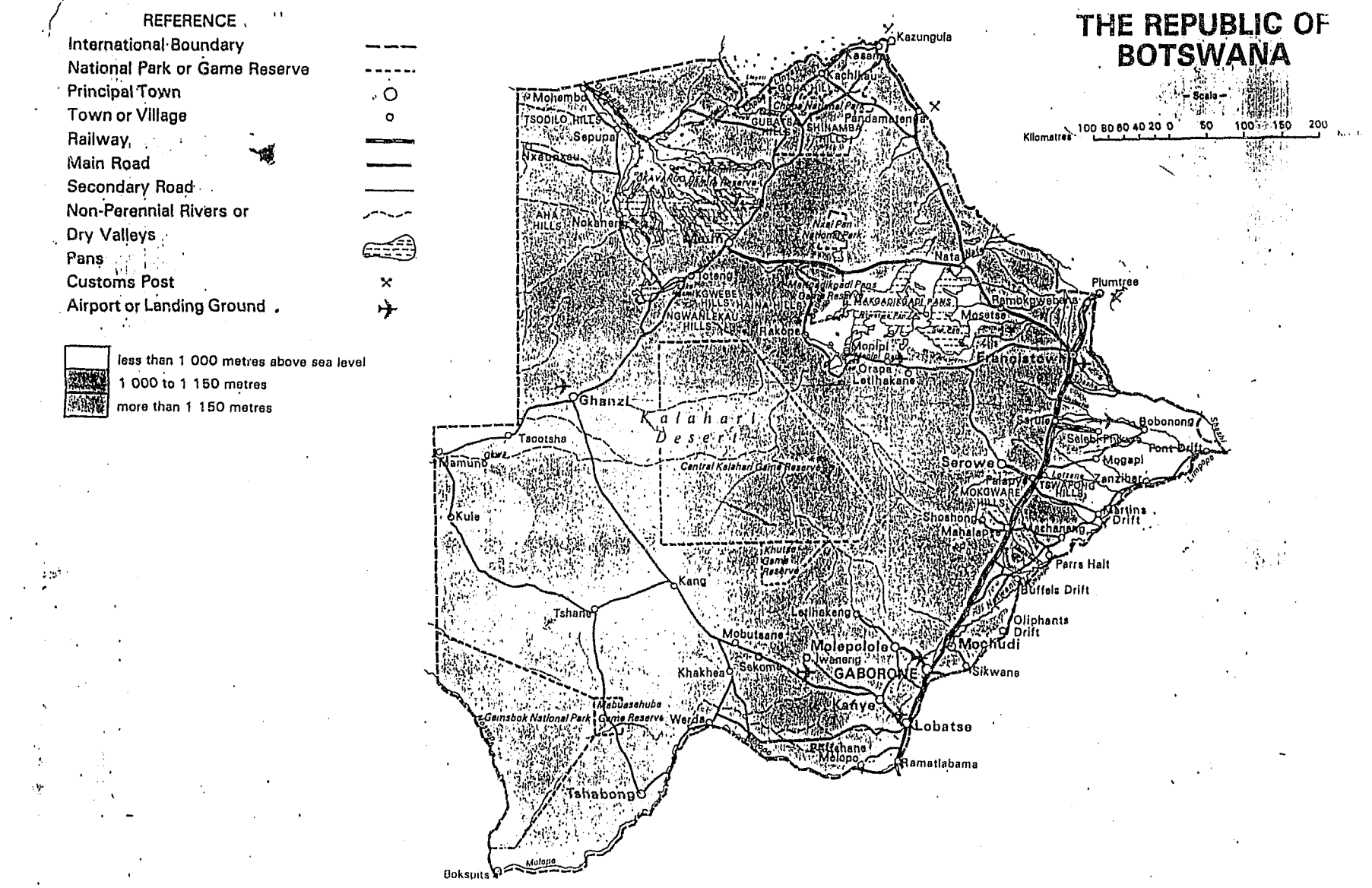
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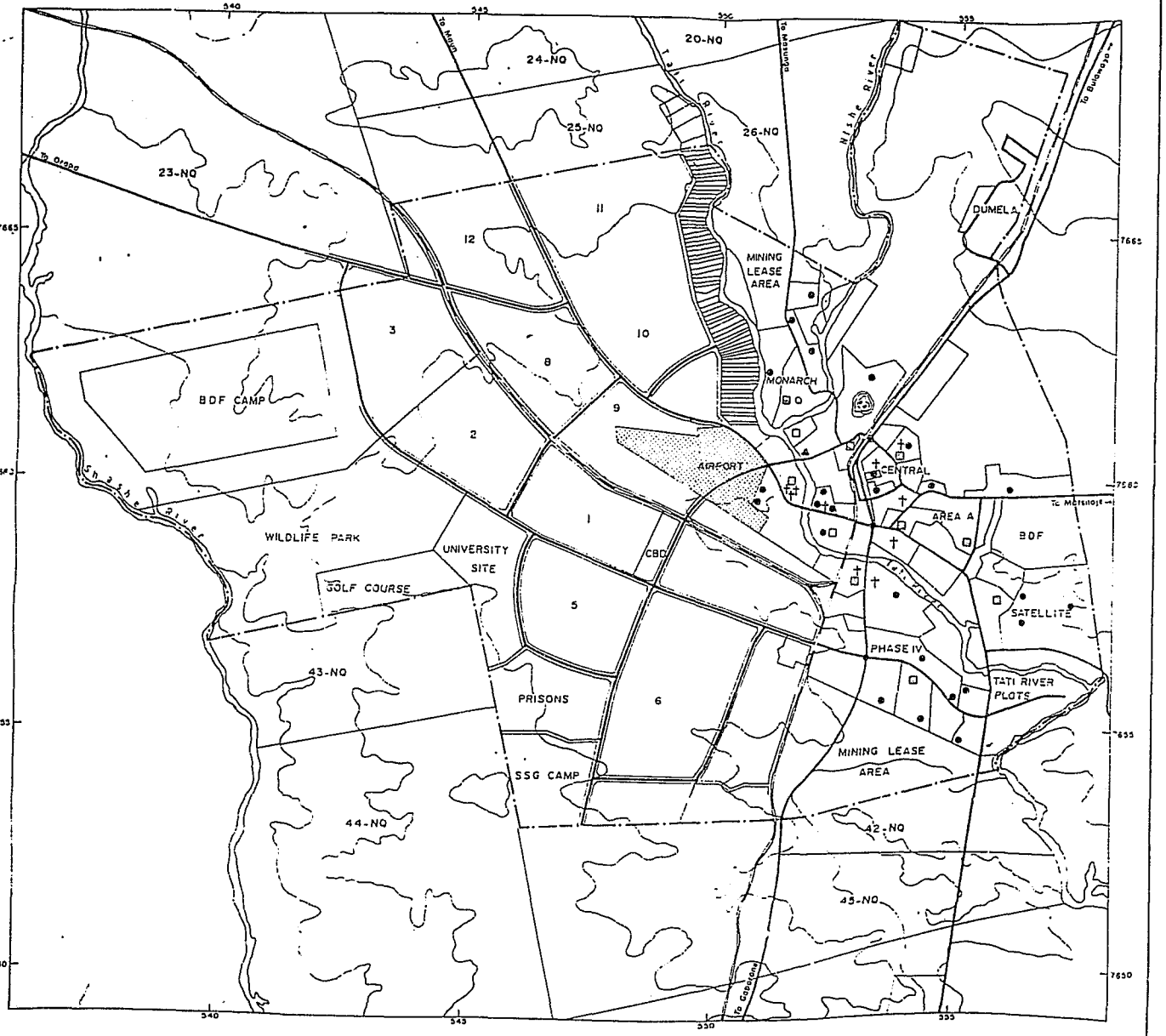
ANNEXURE A

THE REPUBLIC OF BOTSWANA



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ANNEXURE B



MAP 6

CITY OF FRANCISTOWN DEVELOPMENT PLAN

EXISTING CIVIC AND COMMUNITY FACILITIES

LEGEND

- EDUCATIONAL INSTITUTIONS
- HEALTH INSTITUTIONS
- STADIUM
- CHURCHES
- CIVIL AVIATION

N

0 1 2 3 4 KM

ANNEXURE C

INTERVIEW GUIDE

SECTION A

Demographic Data

1. **Age in Years**
   - 18 - 25 ☐
   - 26 - 33 ☐
   - 34 - 41 ☐
   - 42 - 49 ☐

2. **Marital Status:**
   - Single ☐
   - Married ☐
   - Widowed ☐
   - Separated ☐
   - Divorced ☐
   - Other ☐

3. **Level of Education:**
   - Primary ☐
   - Secondary ☐
   - Post Secondary ☐
   - University ☐
   - Never been to School ☐
   - Other ☐

4. **Religious Affiliation:**
   - Z.C.C. ☐
   - Spiritual Healing Church ☐
   - Catholic ☐
   - Other ☐

5. **Nationality:** Motswana by birth ☐

Motswana by naturalization ☐

6. **Tribe:** _____

SECTION B

Beliefs Relating to Health Care

7. **How important is tetanus toxoid vaccine to you?**

Less important ☐

Somewhat important ☐

Very important ☐

Please explain: _____

_____

8. **Are the screening tests such as bloods important to you?**

Yes ☐

No ☐

Please explain: _____

_____

9. **Are repeat antenatal appointments important to you?**

Yes ☐

No ☐

Please explain: _____

_____

Cultural practices and beliefs relating to care during pregnancy

10. **Where first do you go when you realise you are pregnant?**

Clinic ☐

Traditional midwife ☐

Other ☐

If other, specify who _____

11. **Why do you choose the person above?**

_____

_____

12. **Are there any traditional rituals to be done when one falls pregnant?**

Yes ☐

No ☐

Please explain: _____

_____

13. **What are the beliefs and practices**

i) **When you first hear that you are pregnant?**

_____

_____

ii) **During pregnancy?**

_____

_____

iii) **In the last month of your pregnancy?**

_____

_____

14. **Are there any benefits of the above practices?**

Yes ☐

No ☐

Please explain: _____

_____

15. **Who do you prefer to see during pregnancy?**

Traditional midwife ☐

Modern midwife ☐

Other ☐

If other, specify who _____

_____

Explain why: _____

_____

16. **Are the nurses in the clinic willing to accept your culture?**

Yes ☐

No ☐

Please explain: _____

_____

17. **Are you satisfied with the courtesy you receive in the clinic?**

Yes ☐

No ☐

Please explain: _____

_____

Cultural practices or beliefs relating to food or substances eaten during pregnancy

18. **Are there any foods or substances which you believe must be eaten during pregnancy?**

Yes ☐

No ☐

Please explain: _____

_____

19. **Are there any foods or substances which you believe must not be eaten during pregnancy?**

Yes ☐

No ☐

Please explain: _____

_____

20. **Are there any foods or substances which you are encouraged to eat?**

Yes ☐

No ☐

Please explain: _____

_____

21. **Do you believe the food or substances you are not supposed to eat has an impact on yourself or the baby?**

Yes ☐

No ☐

Please explain: _____

_____

ANNEXURE D

INFORMATION LETTER

My name is Reginah Lionjanga, a year II Master of Science in Nursing student at the University of the Witwatersrand. I am conducting research on cultural practices of antenatal women as partial fulfillment of the Masters degree. The study is aimed at sensitizing and educating the healthcare providers to be aware of the cultural practices related to pregnancy so as to improve the quality of care. I am requesting your participation. Your participation is voluntary. The interview will last for 20-30 minutes and if you feel like withdrawing from the interview, you are free to do so. Your participation or non-participation in the study will not influence the type of care to be rendered. Your name will not appear in the interview guide and responses will be kept confidential.

ANNEXURE E

ATTENTION: Ms Reginah Lionjanga

FRANCISTOWN CITY COUNCIL

FRANCISTOWN

PRIVATE BAG 40 FRANCISTOWN BOTSWANA

ALL CORRESPONDENCE TO BE ADDRESSED TO THE TOWN CLERK

TELEPHONE: (267) 211050 FAX: (267) 212427

REF: FCC/47

22rd April 1998

Reginah Lionjanga
c/o Mrs. A. Makgekgenene

Dear Sir

RE: GRANT OF A RESEARCH PERMIT - YOURSELF

Your request for a research permit refers.

We are pleased to inform you that you have been granted permission to conduct research entitled "The Cultural Beliefs and Practices Amongst Urban Antenatal Women in Botswana" with the City Council Clinics.

Although permission is granted you will be expected to stop briefly at the Health Department Head Quarters to introduce yourself before the start of the project. You will also be expected to work in close liason with both the Council Health Managers and the Senior Nursing Sisters Incharge of the Catchment areas. Lastly, copies of papers written as a result of the study should be made available to this Council for use in future planning expansion and improvement of health services.

Looking forward to seeing you.

Yours faithfully

K. Kebabonye
for/City Clerk

ANNEXURE F

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

COMMITTEE FOR RESEARCH ON HUMAN SUBJECTS (MEDICAL)
Ref: R14/49 Lionjanga

CLEARANCE CERTIFICATE PROTOCOL NUMBER M980527

PROJECT The Cultural Beliefs And Practices Amongst Urban Antenatal Botswana Women In Francistown City

INVESTIGATORS Ms R Lionjanga

DEPARTMENT Dept of Nursing Education, Ministry of Health Botswana

DATE CONSIDERED 980529

DECISION OF THE COMMITTEE *

Approved unconditionally

DATE 980623 CHAIRMAN ..... (Professor P E Cleaton-Jones)

* Guidelines for written "informed consent" attached where applicable.

c c Supervisor: Miss P McInerney
Dept of Dept of Nursing Education, Wits University

Works2\lainC015\HumEth97.wdb\M 980527

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and ONE COPY returned to the Secretary at Room 10001, 10th Floor, Senate House, University.

I/we fully understand the conditions under which I am/we ~~are~~ authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee.

DATE 11/08/1998 SIGNATURE .....

PROTOCOL NO.: M 980527

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Author Lionjanga R
Name of thesis The Cultural Belief And Practices Amongst Urban Antenatal Botswana Women Lionjanga R 1999

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