

When KNOWLEDGE is not POWER

The integration of Traditional midwifery into the Health system:  
*The case study of a Traditional Midwife among the Toka of Zambia.*



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## ABSTRACT

Health is one of the major problems facing most developing countries like Zambia. Poor economies, low funding, shortage of staff, epidemics like AIDS, coupled with poor and sometimes inaccessible facilities make the provision of health difficult. The 1978 Alma Ata conference's call for health for all seemed a far cry for such countries. But the conference was aware of this problem and thus, its recommendation for the utilization of traditional practitioners in an integrated health system. One of such integration is that of Traditional midwifery with the health system. Under this system, observations and questions arise; does the traditional midwife lack any form of knowledge that can be exchanged between the two systems of medicine? What does the traditional midwife know? Is it knowledge from the point of view of the traditional midwife herself, from her clients or indeed from the biomedical professionals? Thus, the focus of this thesis is knowledge. Traditional midwifery is analyzed from a point of view of knowledge; how it is perceived, recognized and/or utilized, in such an integrated system.

The analytical frame work in this thesis consists of situated knowledge, Epistemology discrimination and Feminist critique on development theories. Qualitative methods were the main methods used to collect primary data during the field work in Kabuyu, Zambia.

In this thesis, I argue that what the traditional midwife practices is knowledge. Based on the local experiences and traditions, this knowledge may be different from what is commonly called "western" knowledge. However, this difference should not be the basis of discriminating it from the world body of knowledge. I suggest communication between the different kinds of knowledge systems under the integrated program for any meaningful development to take place.

Key words: Knowledge, midwifery, traditional, integrated situatedness.

## CHAPTER I.

### 1.0 Introduction

The famous Alma-Ata international conference of Primary Health Care (PHC) in 1978 set in motion the collaboration between practitioners of biomedicine and traditional medicine. The background of this move was the goal of the World Health Organisation (WHO) to provide “Health for All” by the year 2000. This goal seemed unlikely in most third world countries where states could not meet this demand. Most Third world countries had shortage of manpower, facilities, and the rural communities had little or no access to these facilities(Vansintejan 1988) . Thus, the conference recommended the recognition and incorporation of indigenous practitioners. The indigenous practitioners were recognised as a workforce that could be utilised as community health workers to help with the problem at hand as well as to represent a linkage of the traditional culture and the biomedical establishment (Fleming, 1994). Since the Alma-Ata conference there has been a continuing interest in the potential benefits of what could be obtained in the collaboration between practitioners of biomedicine and traditional medicine in the third world countries. However, the emphasis and success of this collaboration has been with the traditional midwifery than any other aspect of traditional medical practitioners (Boerma, 1990).

### 1.2 Traditional Midwifery and The Alma Ata Declaration (1978)

It has been estimated that 60-80% of the world’s babies are delivered by traditional midwives. This is happening mainly in third world countries where 88% of the worlds babies are born (Fleming, 1994). WHO therefore recognised the traditional midwife as a significant workforce in the field of maternity care and thus, declared that:

Traditional medical practitioners and birth attendants are found in most societies. They are a part of the local community, culture, and traditions, and continue to have high social standing in many places, exerting considerable influence on local health practices...It is

therefore well worthwhile exploring the possibilities of engaging them in primary health care and of training them accordingly :Alma-Ata,1978. (Fleming 1994:p.143)

Therefore, throughout the 1970s and 1980s WHO encouraged countries to initiate training programs for the traditional midwives and to formally or informally use them. Thus by 1985, 52 countries had running training programme for traditional midwives and Zambia is one of them. (Fleming, 1994)

### 1.3 Problem Statement

Zambia like most low income countries has a health system that is facing an increasing challenge especially in maternal and child care. In 1996 a survey carried out by the Ministry of Health to assess safe motherhood needs in the health system revealed many short comings in policy issues, quality of service delivery and manpower. The report also revealed that the quality of antenatal, delivery and postnatal care were perceived as poor by the community, thus most women preferred to deliver at home. In fact statistics show that 46% of Zambian women use the traditional midwife during birth. (Maimbolwa, 2004)

The collaboration of the two sectors of medicine (the traditional and the modern) was a good encouragement and initiative by WHO. It was a positive step to take for most countries like Zambia, whose health systems cannot meet their goals. But my observation is that training was only recommended for the traditional midwife (into modern health care) and not for all involved like the medical practitioners (into the traditional aspect of health care). What kind of collaboration is this? Does it mean that even if the traditional midwives are recognised as midwives in their communities, they lack knowledge? Or perhaps what is Knowledge? Or perhaps whatever the traditional midwife practices may not be perceived as knowledge by their counterparts (the medical personnel,) in their trade?

#### 1.4 Focus of Study

Therefore, my thesis in general terms is about what constitutes knowledge. The term knowledge can mean different things by different people in different situations in today's world. However, generally in the world the term Knowledge has come to represent something universal, what is commonly called western knowledge that is purported to assume universal dominance. (Engelstad et al, 2005). Crush (2003) states that "knowledge is power" but he elaborates further that "power is also knowledge because power decides what is knowledge and what is not knowledge" (p.5). For me then the question is: What is knowledge and what is not knowledge, who decides? I will use traditional midwifery to explore the question of knowledge.

For this reason I decided to write about knowledge using the experiences of traditional midwifery as an indigenous knowledge system that is widely practiced in the third world. It is also one of the indigenous knowledge that has attracted international attention and is currently working in collaboration with western science. I chose to look at it through the experiences of one traditional midwife of the Toka people of Southern Zambia, Kabuyu in Chief Musokotwane's area near Livingstone. I chose to write about knowledge in the field of traditional midwifery because it is a knowledge system that is under scrutiny in the world health system today. In addition, in traditional Zambia, midwifery is a domain of women in which women are respected for their role(Stefaniszn 1964).

#### 1.5 Hypothesis:

Sidelining or ignoring certain knowledge systems can certainly lead to a loss of useful knowledge, especially at local level such that we could be talking of endangered knowledge or knowledge extinction. This poses a lot of danger especially for poor countries like Zambia, whose health system cannot manage to address most of its health issues. This is especially so in reproductive health of which the traditional midwife seems to possess a useful set of knowledge relevant in the local context.

To guide the discussion of the thesis the following research questions have been framed:

1. Does the traditional midwife know and is traditional midwifery knowledge? Alcott et al (1993) in the theory of epistemic discrimination argue there is discrimination in epistemology. They explain that epistemic discrimination is as a result of contemporary epistemological theories that have developed definitions of knowledge, constructed as universal and homogenous, and stipulating requirements for justification that other systems of knowledge cannot meet thus, are not considered as knowledge. They point out that the discrimination is more on the propositional knowledge against practical knowledge and men's knowledge against women's. (pp,238) Could this be the case with traditional midwifery? Alcott's theory also points to a possibility of gendered knowledge, thus, is it by coincidence that only women are midwives among the Toka.
2. If she knows is her knowledge acknowledged by those in the same field, or by the general populace? How are her practices perceived? Feminist critics argue that the neoclassical school in development theory identifies indigenous institutions and attitudes as a contributing factor in hampering development in the Africa and thus exclude their knowledge in development.(Parpart 2000). Could this be the case with traditional midwifery?
3. Can different knowledge producers and different ways of producing knowledge communicate or be porous allowing for exchange and understanding? Engelstad et al (2005) point to the fact that all knowledge is partial knowledge and that it is situated in particular contexts. They argue that Situatedness is a prerequisite for connecting the different contexts in which all knowledge is produced (p.11). Has alternative or different experiences and ways of knowing been taken in to account when integrating two different systems in the case of traditional and modern midwifery?

## 1.6 Research Design

This thesis is based on both primary and secondary data. Primary data was collected through interviews, conversations and participatory observation in field work in Chief Musokotwane's area of kabuyu between June and August 2005. I got attached to one Midwife with whom I already know and I became guest to her home and village for three weeks but I returned there through out my three months of research for follow-ups and clarifications. During my stay I sampled the population by "purposeful selection" Maxwell(2005) and "progressive contextualization"(Vayda 1983) in which I followed specific activities of other members of the community by being a member of my contact's family.

Secondary data was collected consisting of both qualitative and quantitative data. This included health, social, cultural as well as statistical data. These were obtained mainly from Kabuyu health centre as well as the Ministry of Health and the central statistic office. A library research was also conducted. I visited the University of Zambia Library in August 2004 in which I researched on local literature. Due to lack of wide material on my topic in Zambia, In January, 2006, I extended my research to the Nordic Africa Institute in Sweden where a wide range of literature on this topic was made available to me. In addition, the Tromsø University Library was also a source of relevant materials.

## 1.7 Thesis Outline

The thesis has Chapter I as the Introduction which includes the theme, research questions, main hypothesis and research design. Chapter II looks at methods of study covering research instruments, sampling, experience and the validity and reliability of data. Chapter III is theories and Literature reviews. The back ground is in chapter IV. Chapter V, VI and VII is empirical data, while Chapter VIII and XI as data analysis. Chapter X has the conclusion.

## **CHAPTER II:**

### 2.0 Method of the Study.

Blaikie defines research methods as procedures used to collect and analyze information about reality.(Blaikie 2000) In this chapter, I will discuss the research methods that I employed, why and where I employed them. I will also discuss the ethical consideration I took in the study; my experiences in the field as regards to the challenges I faced and lessons I learnt; and the reliability and validity of the data presented.

### 2.1 Ethical issues

Since my study involved human beings, I considered Maxwell's question on negotiating relationship between the researcher and the community. He asks "what ethical issues can such relationships raise?(Maxwell 2005) Thus, I considered the following ethical points: that the informant must have agreed to give the information on their free will; that the risk of the informer must be as low as possible and assessed in relation to the generation of new knowledge; that the informant should be able to withdraw from participation if they felt like. In regards to the first guideline, I first asked for permission to conduct the research from the authorities and persons involved before the research started i.e. The headman of the village, the midwife and the health centre concerned. I approached a traditional midwife whom I already knew and explained my purpose of research and study to her. I asked her to be my main informant. She accepted and introduced me to the headman of the village and the health centre who both accepted to let me conduct this research. I then made it clear that they were at liberty to decide the information that they wanted to give me and not vice versa. It was entirely up to them to give me what kind of information and when they felt comfortable. This can be seen in the choice exercised concerning my research. They expressed reluctance to give out information on traditional medicine for fear of companies making profits from their knowledge. Apparently it has come to their knowledge that some profit making companies are making use of

traditional knowledge on plants for their own benefits. However, they decided to limit my study to the practices of the traditional midwifery (a decision that I have respected) because, they hoped my findings may help bio-medics understand their traditions better. This is because there have been collaborations between the traditional midwife and the health care centre in the village.

On the second guideline, I have omitted certain information that maybe of risk to the informants especially in line with the laws of the country. With the third guideline, I also made it clear that the informants could withdraw whenever they felt like even though this never happened.

### 2.3. Methods

The data provided in this thesis is based both on primary and secondary data, which is mainly qualitative with some aspects of quantitative. The research was divided into two sections. One section relates to the fieldwork and the other to Library research. In developing this study, the main techniques used were interviews, conversations and participatory observation. The primary data was collected from the local people while the secondary data was collected from the health centre, the ministry of health and the libraries.

#### 2.3.1 Sampling

Maxwell (2005, p86) describes sampling as an essential part of research methods. To sample entails making a selection of a part from a larger whole. In this case, selecting the people in the whole village from which to collect my data and the area in the whole country.

I conducted my field research work in Kabuyu, chief Musokotwane located in what is called Shungu area. I chose this area because it is not only a place I already know, but also its proximity to my base Livingstone. This would enable me to go back and make

consultations and verification of data as I planned to do. Shungu area is one place that I have conducted research in before. In 2000, as an undergraduate, I conducted a research on the history of traditional midwives in Zambia. Chief Sekute, in the Shungu area was one of the places that I visited. My initial research introduced me mainly to the training of traditional midwifery by the ministry of health. But it also indicated to me on how much alive traditional aspects of the traditional midwifery were in Zambia and the idea of this research was born.

However, I noted how invisible this tradition can be, as it is confined to the seclusion of the home premises making it not so visible to the public eye. For this reason, I decided to do my research based on an area and a midwife that I already knew in order to be accepted and gain an insight of the situation that might be difficult to get into under other circumstances.

Thus, the selection of my main informant was not random either, but was what Maxwell (2005, p.89) calls “purposeful selection”. The vicinity I visited has three midwives. I chose this particular midwife because I was already acquainted to her. She is a distant relative whom I have known for six years. Given the time frame for my field work as well as practical and economic reasons, I needed to find someone who was not only a capable representative of a midwife in this society, but one with whom it would not take lots of time and resources to break the ice in the initial stages of acquaintance. The other people that I interviewed came by way of progressive contextualization which I will explain later in this chapter.

### 2.3.2 Autobiography

I used autobiography in developing this study because I have used experience to explore the topic. Smith et al (Smith 2001) explain that experience is the very process through which a person becomes a certain kind of subject, owing to certain identities in the social realm(p.25) Autobiography is a method then, that not only renders a voice to the researched “object” and but make it into “Subject”. (p.25). It is appropriate here as

autobiographical subjects know themselves as subjects of particular kinds of experience attached to their “social status” and “identities”(p.25); in this case the traditional midwife not in her right as a person but as a midwife. Therefore, I decided to keep some parts of the data in the very words of the main informant. I will also use quotations. Some of the main parts of her narrations will also be provided in the text.

### 2.3.3 Participatory Observation

I chose participant observation for three reasons. Maxwell (2005, p110) points to participant observation as a method that can provide more complete data about specific situations and events than any other method. He also points to the fact that in participant observation the observer is generally much less of an influence on participants’ behaviour if done in natural settings (p.109). However I also chose the method because of the society I was dealing with. The Toka’s way of education or of transmitting knowledge from one end to another is based on “*kulanga aku chita*”, meaning “seeing and doing”. Socialisation into the society at all levels is based on this principal. You have to be part of the group to learn. Therefore, I considered taking something that would be more natural for my informants and participant observation suited with this arrangement.

Thus, I got attached to one Midwife, within Kabuyu with whom I already know and I became guest to her home and village for three weeks (30<sup>th</sup> June-21<sup>st</sup> July, 2005), but I returned on day trips through out my three months of fieldwork research (July –August, 2005). I participated and observed the daily activities of her life in the village and also made conversations and asked questions where necessary.

I also got involved with the women and young people of the house hold and through them, with their neighbours, making the total of women to 15 and that of young people to 8. These form the main clients of the midwife and as such they complimented the information I got directly from her. I participated in their daily activities in the village such as drawing water, cooking, fetching firewood, grooming sessions, and story telling by the kitchen fire after the days work. In this way large parts of my primary data was

gathered as I soon discovered that the women's working places, like the water well were great information centres. I was able to gathered data in a way that Vayda (1983) describes as progressive contextualization, which involves focusing on "*significant human activities or people-environment interactions and the explanations of these, by the placement within progressively wider or dense context*". (p.65)

The conversations in such activities gave me the opportunity to conduct in-depth interviews in the most natural settings, in a relaxed way and in most cases on topics that they (interviewees) had initiated. In this way I got an insight into the practical issues and challenges involved in maternal and reproductive health, since much of the conversations at these forums centred on their (women and young people's) reproductive health and those of their children: problems, solutions, failures, illusion, realities, choices and reasons. This made me see the correlation between what the informants said and what they actually did; what the midwife said and what practically happened. In fact this revealed attitudes and information that I would probably could have never discovered by merely participating and observing my main informant, the midwife. I should also add that I think, the fact that I went on this research with my children created a positive relationship between me and my informants, as we shared experiences and they came to accept me not only as a person or a researcher, but as a woman.

#### 2.3.4 Interviews

Maxwell (2005,p.110) states that interviews enables a researcher to collect "rich" data that is both detailed and varied enough to provide a revealing picture of what is going on. He also states that structured and unstructured interviews are methods that can led to reliable data. Therefore, interviews formed a part of my methods for data collection. Both structured and unstructured interviews were carried out sometimes concurrently with participant observation as mentioned above or otherwise.

I chose to use unstructured interviews with the midwife and the people in the village. I

preferred it because it went well with participant observation as I used them concurrently. I asked questions as situations provided themselves and also I directed questions to what I really wanted to be discussed when opportunities or the atmosphere was conducive. The kind of information I wanted from them also needed conversation like kind of interviews.

In addition, I also took the people concerned in to consideration. I did not want to use questionnaires as most of the people in this area cannot read or write. And then I did not want to read out questions to them as it would create a distance between me and them. I know from experience in the area that the only time these people are treated with questions on paper is when they are at the police station, at the hospital or dealing with Agriculture officials, population office and such government officials, who in most cases are people of an authority and power that they may not have. Therefore, they associate paper, pen, questions and even tape recorders and cameras to people who are not a part of them. I felt this impression was going to disturb a comfortable and relaxed rapport.

However, I used structured interviews for people in offices and government workers (July-August, 2005). This method is straight to the point and much more direct in getting information. Being direct also meant not wasting so much time as most of them had to allocate time for me from their work. Such interviews I carried out at the health centre in Kabuyu and at the ministry of health in Livingstone. I wanted information about the statistics in relation to health in Zambia in general and in Kabuyu in particular. I was also looking for information on what kind of services were offered in the field of reproductive and social health, which in one way or another involved the traditional midwifery as a traditional institution.

### 2.3.5 Library Research

My Library research began on August 22<sup>nd</sup>, 2005. Much of my secondary data was derived from the Library research. Secondary sources provided me with a back ground from which to work from. Even if there were not so much written materials on Zambian

traditional midwifery, I consulted related topics on the subject that were quiet informing to this study.

I consulted the Livingstone Museum Library on 22<sup>nd</sup> August, which had some archival materials on the Toka as a people but had completely nothing on the topic of traditional midwifery. This made me to travel to Lusaka on 25<sup>th</sup> August 2005 and consulted the University of Zambia Library, which is one of the largest Libraries in the country. I was able to access a few materials on Traditional midwifery in general. Then I went to the Ministry of Health in Lusaka, from 27<sup>th</sup> -31<sup>st</sup> August, 2005, where I consulted documents on the Traditional midwifery, and found quiet a number of government reports, especially on government policies on primary health in the country. I spent the last month of my field work in September 2005, putting my field work notes together.

The lack of a wide range of written materials on the topic, in my country meant that I had to continue with my library research when I came back to Norway in October 2005. I continued with my Library research at the University of Tromso library which provided me with some books. However, my Library research only paid off at the Nordic African Institute Library in Sweden where I travelled in January, 2006 in search of appropriate materials. The Library provided me with the much needed literature that I could not get in my country and also from University of Tromso Library; materials that I feel have informed my study greatly on traditional midwifery in Africa in general, and Zambia in particular.

### 2.3.6 Quasi Statistics

Even if my main method is qualitative data, I have also used some quantitative data. Maxwell (2005, p.113) observes that conclusions of qualitative data have implicit quantitative component, which he refers to as “quasi statistics”. I used this method to enable me assess the amount of evidence of numerical results that could be readily drawn from the collection of data. This was done to assess the already existing conclusions on issues like statistics that indicate the percentage of babies delivered by the traditional

midwife and the percentages of women consulting the health centre or the traditional midwife. In this was I was able to deduce a picture of figures that related to this particular village in Kabuyu and Zambia in general.

#### 2.4 Challenges and Limitations

Time was a limiting factor in my field research. Three months was not enough to do all this vast research work. The other limiting factor was the topic itself. Not many people were willing to talk to me about this topic. In Zambia traditional midwifery is connected to sexuality and sex is a taboo topic. It is not discussed anyhow. Even professional people like Librarians and university lecturers looked a bit taken aback when I told them what I was looking for. This made me think that perhaps I was doing a wrong research area. It also limited the number of people that I was able to talk to especially men and boys or couples, since as a woman I could not easily talk to this category of population according to the tradition of the area. This has also affected my sample of the general populace. I could easily sample women and girls and that is all I will have in my data on the general populace.

The question of trust was another issue. The issues that the women discussed were mainly personal and it was done within a circle of friends, therefore it took a bit of time before some of them could trust me with their talk. In fact most of the opening up came at the time that I was winding up my research. This experience taught me how much time matters in conducting research especially one that deals with people. Warming up to the occasion, gaining trust and confidence can take a bit of time.

I also had problems in the area of medicine which I was also interested in. Although unlike herbalist, midwives medicines are not a secret, it is difficult to include this in my thesis considering what is going on around the world today regarding patents. Before I started my research I had a meeting with the midwife and the local Headman (the representative of the Chief of the tribe) referred to the patents and said that he was worried of what this kind of information will be used for in Europe. He indicated that his

worry was not that people would know about the tribe's medicines, but the possibility of someone making profit from their knowledge. It is for this reason that my area of research on traditional medicines used in traditional midwifery will not be included in this thesis.

Another challenge I knew I was going to face was to write what I had got in the field in to English. Each evening when going through my notes with my main informant, I encountered words and meanings that I knew I was never going to be able to translate or find equivalents, while still keeping the original sense and meaning. This made me feel a great sense of loss and helplessness to the effects of the weakness of translation. Before this research, I took language for granted, but not anymore. I have realised how weak a point can sound if the translation fails to find an equivalent word to carry the meaning and sense of the point. This dilutes the intended message and may not carry the intended effect with it. In addition, the whole process of writing this thesis poses a great challenge to me. Coming from a society that is more "oral" than "textual", will defiantly affect my writing, not to mention the problem of writing in a foreign language.

However, my main set back more than anything else, was the death of my father who died just a month after I had reported back to school from my fieldwork. I had to go back home to attend the funeral, but also to sort out some family issues since my parents together with my husband took care of my children in my absence. It was particularly difficult considering that my youngest child (who is two years old now), was in the total care of my parents. Thus I was away from school for the whole first semester of my second academic year. I missed out quiet a lot, particularly on the thesis seminars organised by the programme and also on supervision from my supervisor. All the same despite everything, I was able to come up with something to begin from, even though I know my performance has been affected a great deal.

## 2.5 Validity and Reliability of the data.

Maxwell (2005, p.105) notes that validity is relative to be assessed in relation to the purposes and circumstances of the research. Various factors can affect the reliability and validity of data collected such as gender, time constraints and sampling. However, I chose to use methods that would rather strengthen than weaken my data. For instance I used autobiography because I wanted to make use of experience as a method. Smith et al (2001), state that experience is the primary kind of evidence, as it makes the narrator a “uniquely qualified authority” (27).

On sampling I used purposeful selection which enabled me to gain access and an insight of the situation under study which could have otherwise been difficult. Participant observation coupled with in-depth interviews also provided a more natural and conducive way of getting an understanding of this society as it is a method that is also employed in the society’s day to day running of affairs. In addition, progressive contextualization gave me an opportunity to link words with action. I was able to see the relationship between what my informants said and what they actually chose to do. The conversations and interviews on the practices in reproductive health allowed me to focus on “why” and “if” type of questions since I was present and saw my informants make choices or give advise on who to consult, when and for what kind of problem. Such situations made me not just make assumptions about certain actions and choices, but gave me a chance to get first hand information from the people concerned. Furthermore, quasi statistics made it possible for me to assess the amount of evidence of numerical results that could be readily drawn from the collection of data. All the same the validity and reliability of this data has been affected by time limit, the topic itself being a taboo, trust from my informants, and interpretation from the local language to English.

## 2.6 Summary

This thesis is based on both primary and secondary data. The main focus is on primary qualitative data based on the traditional midwife’s experience and supplemented by other people connected or concerned with her practice such as her clients and the health centre. The methods used include autobiography, participant observation, in-depth interviews,

structured interviews, conversations in group discussions and social situations. I participated in the daily activities of the midwife, the women and young people such as fetching water and telling stories by the fireplace, to get an insight of traditional midwifery. The reliability and validity of my data has been affected by such factors as time limit, the topic itself, trust and interpretation. However, I tried to use methods that would rather strengthen the reliability and validity of data than weaken it like participant observation, purposeful selection, autobiography, progressive contextualization and quasi statistics. Despite the existence of weakening factors in my investigation, I believe that the data collected can provide information about the reality of the status of traditional midwifery among the Toka, the health centre at kabuyu, as well as that of the women and young people in their everyday experiences in reproductive health in their area.

## CHAPTER III

### 3.0 Literature Review and Theories

The term knowledge can mean different things to different people in different situations in the world today. However, as Crush (1983) states, the term as we generally know it today is a modern innovation that has evolved over centuries to represent something universal (p.12). This has created a situation that has called for the acknowledgment of other kinds of knowing. The main purpose of this chapter is to give an understanding of theories and definitions in relation to the general term of knowledge and to specific terms of knowledge such as situated knowledge, indigenous knowledge and feminist epistemology and critiques, important to this thesis. Traditional midwifery which provides the theoretical focus as a kind of knowledge will also be introduced by way of literature reviews that have informed this thesis on the topic.

### 3.1 Knowledge as a Term: Epistemology verses metaphysics

Lehrer (1990) points out that there has been a lot of disagreement about what knowledge is. The main disagreement has been in philosophical inquiry between epistemology, the theory of knowledge and metaphysics, and the theory of reality. The argument has been that the epistemologists have asked what is it that we know, while the metaphysician has asked what is real to account for how we know. He explains that depending on methodological and substantiated presuppositions of the philosopher, sometimes epistemology has won and other times metaphysics has won. (p1). Taking this into consideration, I have used a definition of knowledge that takes into account the two philosophies of epistemology and metaphysics for the purpose of this study.

Thus, I will use Berger et al (1966)'s definition, who defines knowledge as the certainty that phenomena are real. Reality is defined as a quality appertaining to phenomena that we recognize as having a being independent of our own volition. However, he points out

that what is real in one society may not be real in another. Thus, he explains that knowledge and reality are justified by the fact of their social relativity. This, he says, means there is not only a variety of knowledge in human society but also the processes by which any body of knowledge comes to be socially established as reality. Therefore knowledge arises in the relationship between human thought and social context, bringing about the relativity of specific historically and socially located viewpoints. ((Berger 1966). Thus, one of my research questions (p.4 of this thesis) is does the traditional midwife know?

### 3.2. Traditional Knowledge

Mammo, (1990), explains that a tradition is some thing past down from generation to generation, eventually becoming the customs and traditions of a given society. He states that Indigenous knowledge comprises of such traditional practices that have proved to sustain local needs. (175). According to Sillitoe (Sillitoe 2002), Indigenous knowledge relates to knowledge held more or less collectively by a population, informing understanding of the world. It may pertain to any domain, is community based, embedded in and conditioned by local traditions and is culturally informed. He explains that it is mainly transmitted orally and through experience. Repetitive practice characterizes its learning between generations (p.9). This thesis will deal with the question of knowledge in its exploration of traditional midwifery, one of a domain in indigenous knowledge systems. If there are a variety of knowledge is traditional midwifery knowledge and does the midwife know? This definition gives possibility that traditional midwifery maybe knowledge and if so then the traditional midwife probably knows.

### 3.4 Situated knowledge.

Berger et al (1966), points to the fact that knowledge is brought about by the relationship between human thought and social context which has specific located viewpoints that are historically and socially relative. The theory of situated knowledge takes this kind of contextualization as a point of departure in discussing knowledge. Engelstad et al (2005)

writing on this concept state that it has become apparent that all aspects of the production of knowledge are situated and there is no such thing as universal knowledge(p.1) They argue that the acceptance of knowledge's situatedness is a prerequisite for connecting the different contexts in which all knowledge is produced. The concept opens a space for communicating between different knowledge producers and ways of knowing. It serves to break down the boundaries within the scientific production of knowledge, not only within the physical, natural, social, cultural and human science but also the boundaries between scientific and non-scientific knowledge production. The concept's aim is to make the boundaries porous, allowing for communication and understanding between knowledges which can only be achieved with respect and trust in the relations between knowledge producers and knowledge. (p.11) they point to the fact that the relationship between different knowers is crucial in situatedness. This point will be looked at in relation to my third research question, which is on the ability of the integration to exchange of ideas between the two different knowers (the western and the traditional medicine)

### 3.5 Feminist epistemologies:

Feminist critiques in knowledge theories take the step further from contextualization of knowledge to specifications such as gender, race ethnicity, and class. Feminist (Engelstad et al p.6-7) demand the inclusion of minorities especially that of women, their perspectives and lives in research analysis in all the sciences involved with knowledge production.

In the same line of thought Alcoff et al (1993) talks of the theory of epistemic discrimination. They explain that epistemic discrimination is as a result of contemporary epistemological theories that have developed definitions of knowledge, constructed as universal and homogenous, and stipulating requirements for justification that other systems of knowledge cannot meet thus, are not considered as knowledge. They point out that the discrimination is more on the propositional knowledge against practical

knowledge and men's knowledge against women's. (pp217). In this case does the traditional midwife know, or is her knowledge one of those knowledge systems that are discriminated against?

Alcoff et al (1993) further argue that human beings have different point of views and we could be talking of a "gender specific point of view" which is not only structured by neurophysiologic but also social and cultural factors. This is to say that there are some gender-specific "subjective facts" that are not accessible to subjects who are not of that gender. The argument is that the focus of epistemology on propositional forms of knowing has excluded many important sites of knowing like practical forms and experiential knowledge of which gender is a part. ((pp.217). Thus, is it by coincidence that midwives among the Toka are women? Aren't women diverse and internally different-representing complex positions and interests? My thesis will focus not only on what is called "unscientific" knowledge, but knowledge that is exclusively women's such that points raised in the feminist epistemological critique like "point of view" will be considered.

### 3.6. Feminist critique in development

Feminist critique in development echo similar sentiments. They argue that neoclassical school in development theory identifies indigenous institutions and attitudes as a contributing factor in hampering development in Africa. Mean while women in the south are largely responsible for maintaining cultural traditions and more so use indigenous institutions and practices as part of their survival strategies. Therefore, by assuming that these institutions and attitudes constrain development, then these theorists of development place women's way of knowing outside the concept of development.(Parpart 2000). Thus, the second question which tries to find out how traditional midwifery is perceived by those in the same field (that is medicine) or indeed by the general populace will be analysed using this theory. This will be looked at in terms of integration which in this case is a developmental aspect in the health system. This

offers a better forum in which to analyse how traditional knowledge is perceived in the light of development.

### 3.6.1 The term integration.

Lugina (2001) defines integration in this field of midwifery as a tool to weave together all issues that will enhance quality care (p.56). Boerma (1990) states that it is the “collaboration between practitioners of biomedicine and traditional medicine” as recognised by WHO at the Alma-Ata conference in 1978 (p.347). This term is relevant to this study as it is a concept within which the traditional midwife is supposed to be operating in.

### 3.6.2 The term midwife

According to WHO a midwife is one that gives supervision, care and advice to women during pregnancy, labour and postpartum<sup>1</sup> period, to conduct deliveries and to care for the newborn. Important tasks are health counselling and education not only to women but also to the family and community. The work should involve antenatal education, preparation for parenthood, gynaecology, family planning and childcare. (Arvidson, 1988, p.9). This is a term that will be widely used in this thesis as the focus is midwifery.

## 3.7 Literature Review

Since the Alma-Ata conference in 1978, there has been an increase in literature surveys on the characteristics, attitudes and practices of traditional midwifery intended to inform policy action on midwifery integration. Therefore, even if survey of literature shows that little has been researched on the institution of traditional midwifery in Zambia, this topic seems to be attracting a lot of attention the world over as health organisations in different countries, especially those with low income economies, have considered co-operation between modern and traditional midwifery. Thus, this section will not only

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<sup>1</sup> After birth

survey literature on traditional midwifery in Zambia but will include those on other countries that have informed this thesis. I will look at literatures that look at traditional midwifery in particular, the integration of traditional midwives into the health systems and midwifery in general terms.

### 3.7.1 Traditional Midwifery a *tabula rasa*<sup>2</sup>?

The following publications, makes important contributions to the field of traditional midwifery in that they are an attempt to informing policy makers what problems midwifery is facing today. They argue for co-operation between traditional and modern midwifery in the countries of study but with different views on how to integrate.

Anderson describes traditional midwifery in Botswana as possessing a rich culture that informs childbirth in the local aspect and is considered important at community level. To show this she explores the common practices in this kind of midwifery and the relationship the midwife has with the community. However, she bemoans the ignorance or non consideration of this aspect by modern medicine under the integrated system of health in Botswana. (Anderson 1988). Even if Anderson writes about Botswana, her work is informative to this study since she shows not only the practices of the traditional midwife, but also the relationship that exists with modern medicine. This could mean non porous or exchange or meaningful communication between the two systems; modern and traditional in the integrated programme.

On the other hand Maimbolwa (Maimbolwa 2004), writes about midwifery in Zambia and the challenges that it faces. She echoes the worries of the Alma-Ata conference on how difficult the declaration on health for all is to achieve in the field of midwifery in countries like Zambia with poor economies. Her concern mainly is how well to equip and improve modern midwifery. She does acknowledge the importance of traditional midwifery to maternal health in Zambia. However, she points to the need for the training

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<sup>2</sup> Meaning empty like terra nulis; something presumed empty and to be filled in with knowledge as explained by Hoppers, C., Ed. (2002). Indigenous knowledge and the integration of knowledge systems, towards a philosophy of articulation. Claremont, New Africa Books. P.53

in the field of traditional midwifery which she explains is based on “superstitions and myth reflecting a lack of basic knowledge of the physiology of the birth process” (p.11).

Echoing the same sentiments is Isenalumbe ((Isenalumbe 1990). Writing on the integration of traditional birth attendant<sup>3</sup> with the modern health care in Zaire, he observes that even if traditional midwives are an essential part of maternal health they require some “professionalism” which they can get by training from the health personnel (p.197). Fleming (Fleming 1994) also is another author that share these views. Covering a general world view on the integration of traditional midwifery she states that “traditional and cultural practices of unschooled, indigenous attendants<sup>4</sup> have been alleged to compound, or even create problems” in maternal health (P.143). She observes that this has prompted WHO to call for skilled personnel to be present at every birth, leading to the acceleration of the training of traditional birth attendants. Needless to say that Maimbolwa(p.8) points to the fact that, a traditional midwife, with or without training is not recognised as “skilled” (Maimbolwa 2004). She explains that the difference between a skilled attendant and a midwife in the Zambian medical context is that a skilled attendant focuses on delivery care while a midwife’s scope of practice covers sexual and reproductive health in a life perspective (p.8). Maimbolwa’s classification however, does not at all include the traditional midwife. Maimbolwa, Isenalumbe and Fleming advocate for hospital deliveries and the training of traditional midwives to ensure safe child birth and motherhood.

These literatures then reflect on how traditional midwifery is perceived by those in the same field i.e., maternal and child health. The reflection indicates that the traditional midwife lacks knowledge and thus, must be trained for her manpower to be effective because whatever she seems to know is mere superstition and compounds the problems in maternal health. Nevertheless, I think the most important point to note is that even if the traditional midwife can be trained she is still considered as “unskilled”. I should also point out that in the literatures above the traditional midwife is referred to as a traditional

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<sup>3</sup> The term Traditional Birth attendant or TBA in short refers to traditional midwife

<sup>4</sup> Meaning traditional midwives.

birth attendant, a term that may express the scope of what a traditional midwife is perceived to practically be in some medical circles.

### 3.7.2 Techno medicals unjustified in midwifery?

There is literature that is concerned with natural and home births as compared to institutionalised high technology birth as in hospitals or clinics, common in modern midwifery. Even if this literature does not address the issues of traditional midwifery per se, the issues it raises reflect on traditional midwifery as it falls in the category of homebirth on most principals, especially the practices. Therefore, such literatures have informed this thesis and they will be reviewed in this section.

Davis-Floyd (Davis-Floyd 2001), explores institutionalised birth<sup>5</sup> that is subjected to high technology associated with western medical system; what he calls a techno medical model(p.8). He questions the necessity of public health programs like safe motherhood initiatives, for being influenced by techno medical perspectives. Advocating for natural birth he argues that in the last 20 years it has become clear that most of the routine obstetrical procedures in hospitals, have no scientific evidence to justify them (p.1). He explains that the main problem is not the technology in itself but the approach. He argues that the techno medical model unnecessarily depends on machines that may be a hindrance and not a solution to a safe birth. He however stress on the nature of techno medical model to have a non holistic approach as the main problem. He says in techno medical model everything is separated; birth is separated from nature, from home and family, from body and spirit, from mother and baby and from the human touch of mother and midwife relationship, when machines take centre stage. He urges for an emphasis on natural birth such as viewing the body as an energy system and recognising subjective knowledge such as intuition into the medical field. (p.13).

These views are supported by Gaskin (Gaskin 1978) and Langer (Langer 1998). Gaskin

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<sup>5</sup> Birth that takes place in hospitals or clinics.

likens a labouring woman to elemental forces such as gravity and earthquakes in what she calls the spiritual energy of birth. She also recommends the use of intuition. (pp.282.). On the other hand Langer notes that the social support (that a home environment may provide), improves the birth process a lot and eliminates the common problems of the techno medical model approach such as episiotomy, forceps and cesarean section.(p.1058)

These literatures gives researched support to some common beliefs and practices that the traditional midwife has been relying on for centuries such as intuition, social support and natural forces such that it can be assumed that probably the traditional midwife knows. The literature also shows that there are different views about the practices of birth.

### 3.7.3 In search of appropriate birth care

Arvidson (1998) explores the trend of midwifery in Zambia. She elaborates how Zambia after 1964 conformed to the western medical delivery system which meant changes from home births to institutional birth with the intention of providing a safer child birth. She however observes that for a meaningful transition to take place there is need to address medical issues based on their local appropriateness and applied accordingly. She argues that in order to engage patients in health promoting measures, health workers also need to understand lay beliefs and attitudes. She notes that there is evidence that hospital based delivery care in Zambia is at odds with traditional values associated with childbirth, noting that, childbirth as a social event has been undermined and the fragmentation of the health services have imposed a culturally insensitive approach on the trained midwife. Maimbolwa (2004) agrees with this observation when she states that her training as a midwife did not include anything about the traditional practices such that as a qualified midwife later, she did not know how to deal with certain situations that confronted her when dealing with her clients.

These observations reveals to this study that while the training of traditional midwifery is

the main issue in the integration program to improve childbirth that of the health professionals on the aspects of traditional midwifery has been left out. Staugård (Ed, 1998) puts it clearly when she asks are “women (i.e. including traditional midwives) in health development, partners or recipients?” (47)

Lugina (2001) writes about childbirth in Tanzania and the problems facing institutionalised birth. She notes that even if birth is the climax of childbirth, it is not the end. She states that the problems of institutionalised birth in a “shorter stay”<sup>6</sup> model introduced to most developing countries, has created problems in the aftermath of birth where women’s postpartum problems are not adequately addressed by the health system. This is due to lack of capacity to follow up. She attributes this problem to models of care in the health system that started in developed countries and transferred to low income countries with limited evaluation for applicability. She notes that the model of hospital deliveries and shorter stay was introduced to low income countries where no specific plans were made for follow up, leading to decreased access of professional help to women and children once outside the hospital. She also notes that the education of midwives in low income countries is not adequate such that they lack knowledge and skills especially in postpartum care. She observes that there is a gap in what the nurses learn and what is applicable in practise causing a lot of suffering for both mothers and children.

#### 3.7.4 My theoretical argument

In view of the concepts and perspectives presented here my argument is that the public health programs like primary health care programme that include the traditional midwife to improve health are a good initiative. However, there seems to be a problem in accepting the situatedness of all forms of knowledge. This can lead to what Alcoff et al (1993) call epistemology discrimination that makes some knowers to discriminate other knowers by not recognising kinds of knowledge that are different from theirs thus,

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<sup>6</sup> The institutionalized birth with a short stay model refers to a system of birthing at the hospital but where stay after the birth is restricted to a short time in order to cut expenses in medical care. Lugina (2001:17)

limiting the exploration and the utilisation of the available knowledge. This theory is supported by feminist critiques in development that argue that women's ways of knowing are placed outside the concept of development. This can undermine good intended programs such as the safe motherhood initiative as David-Floyd (2001) points out or indeed the integrated system in medicine that the Alma-Ata conference proposed. Admittedly, not one system is perfect but, dialogue and an exchange of notes between the systems can lead to a different but strong kind of knowledge as envisaged by the theory of situatedness. (Engelstad et al, 2005)

### 3.7.5 Summary

The definitions and reviews have shown a picture of what is going on in the world of knowledge in general and in the integration of a two kinds of systems; Modern and traditional midwifery. This chapter has shown the arguments existing in the philosophical worlds about what constitutes knowledge. Lehrer(Lehrer 1990) reveals the arguments between metaphysics and epistemology in what constitutes knowledge. However, Berger et al (Berger 1966), offer an insight to knowledge by showing that the two arguments need not be there because both have something to offer in to what constitutes knowledge. They provide a definition that becomes a stepping stone for this chapter to explore different concepts about knowledge in the literatures such as situated knowledge, feminist epistemology and critiques on development that has a bearing on knowledge production and utilisation.

The analysis of these concepts gives precedent to review literatures that have dealt on the meeting of two different systems; indigenous and modern. The literature concentrates more on the meeting of modern midwifery with traditional midwifery which is the main topic of this thesis. The literature gives information on different aspects of traditional midwifery. On one side, issues like superstition, unskilled, unschooled, compounding maternal health problems and an urgent need for training in modern technologies are revealed about traditional midwifery. On the other side, issues like an available human resource and relevance to safe motherhood and community needs are revealed.

In addition, other literatures even if not directly talking about traditional midwifery, show that science and technology which is supported by modern midwifery may not be the only solution to maternal health. David-Floyd without necessarily condemning technology in itself identifies it as a possible contributing factor to the problems of maternal health. Arguing for more natural practices in birth such as allowing it to have a home atmosphere, link to family, the spirit with the body, instincts, mother and midwife, mother and child contacts in what he calls a holistic model. These views are supported by Langer; 1998 (on family support); Gaskin; 1978 (on spirituality and instincts).

## **CHAPTER IV: Background**

This chapter gives the background of Zambia. It describes the general overview of Zambia as a country, its political, geographical, economical, education and health background. It gives the wider overview from which, the integration of bio and traditional midwife in discussion operates from.

### **4.1 Zambia**

The Republic of Zambia is a landlocked country in Central Africa, south of the Congo and north of Zimbabwe. Formerly Northern Rhodesia, the country is named after the Zambezi River. Around 2,000 years ago, the hunter-gatherer occupants of Zambia, (called Bushmen) began to be displaced or absorbed by migrating tribes called the Bantu. The major waves of Bantu-speaking immigrants begun in the 12th century. By the late 19<sup>th</sup> century most of the immigrating tribes had settled in the areas in which they are found today(Langworthy 1972).

In 1888, Cecil Rhodes, spearheading British commercial and political interests in Central Africa, obtained mineral rights concession from local chiefs. In the same year, Northern Rhodesia (Zambia) was proclaimed to be within the British sphere of influence and by 1924 the administration of the country was transferred to the British Colonial Office as a protectorate. It was not until 1964, that Zambia became independent from British rule(Hall 1967)

### **4.2 The History of Traditional midwifery In Zambia**

Traditional midwifery has always played on important role in the Zambian societies. This skill was confined to women only. In most societies it was a job done by elderly women who had gained a lot of experience by being assistants to midwives for a long time.

Midwifery was a profession; not every woman could be called upon to deliver a baby. Her role was not limited only to giving assistance at birth(Stefaniszn 1964). In most Zambian languages, the name Midwife is suggestive of her other roles other than childbirth. For example, among the Tumbuka people she is called *Azamba* -head of female knowledge; among the Bemba, she was called *Nachimbusa* –head of the instructional aids (Mbusa) for female education (Corbeil 1982); among the Chewa she was called *Namukungwi* – meaning (female) teacher.

Even with the introduction of western medicine and modern maternal health care, the traditional midwife is still widely consulted at deferent levels and degrees through out the country. Some women prefer to seek the assistance of traditional midwives for various reasons.(Maimbolwa 2004)

#### 4.3 Zambia Today

Zambia is a democracy and has a multiparty system of politics which was reintroduced in 1990 after being banned in 1973 in favour of a one party participatory democracy. The major population of 10 million consists mainly of the local people, covering 753,000 square kilometres with a growth rate of 2, 9 per cent per annum. 5.2 million Of the population are women with a total fertility rate of 5.9 children per woman. (Johansson et al, 1997) Women of reproductive age make up 23 per cent of the population. Zambia was until two decades ago one of the most prosperous countries in sub-Sahara Africa, but now it is not only ranked as one of the least developed countries in the world, with 85% of the population living in poverty, but in 2000 it was recognized as one of the heavily Indebted Poor Countries (HIPC) in the region (Carmody, 2004, p.143)

#### 4.4 Education System In Zambia

Before contact with Europeans the Zambian people had evolved their own indigenous education systems that answered their own needs as individuals and as communities. Mwanakatwe (1974) states that this kind of education was highly life cantered and

practical, embodying religion, morality, social continuity and designed according to the nature of the environment and gender needs. Thus, boys and girls were trained differently according to their needs and became experts in different things. It is for this reason that in Zambian traditional society only women were trained and could become experts in midwifery while men could be trained and become experts in things like hunting. Most of the learning was done informally but holistically (Carmody, 2004).

The first schools were introduced to Zambia in 1800s by early Christian missionaries from Europe. The creation of schools went side by side with their evangelization work. After Independence, the Zambian government took over the running of most schools in the country. Education was seen as the key factor to modernization and thus, there was massive expansion of schools, colleges and a University just after Independence. In 1965 the government proclaimed a universal primary schooling for all and abolition of school fees. Thus between 1964 and 1990 enrolments in primary schools increased fourfold and by 1990, the total literate rate was 73%. However by the end the 1970s, the education system started experiencing problems. There were a lot of school dropouts and an increasing number of unemployment. This led the nation to start questioning the relevance of the curriculum. Carmody (2004 p.89) states that;

The Zambia primary school was culturally alien in a double sense, namely, as a structured environment of learning which specifically focused on the target of learning knowledge of the curricula, and through the curricula contents which were widely based on western-Europe knowledge”.

The curricula has mainly been condemned for being highly “bookish” and not practical as it emphasizes more on academics and less on practical issues like culture, morals and crafts. Thus from the 1970s to date, the government has tried to reform the education system with attention to the diversification of the curricula and adaptation to the local environment and needs. However apart from the curricular a number of contributing factors like the poor economy and lack of facilities, the school drop out, unemployment and in the last decade the HIV/AIDS situation are still a problem for the education system in Zambia today .

#### 4.5 The Health care System

In the pre-colonial period, the health system of the local people depended on traditional medicine linked to the local indigenous religion. Traditional medicine has been practiced for centuries and is still widely used. Traditional midwifery is a branch of traditional medicine. However, after the introduction of Christianity and colonialism, traditional medicine was attacked mostly from the Christian and developmental point of view that it was a heathen activity and associated to witchcraft and backwardness. Therefore, during this period, medicine was practiced, but not so openly or freely for fear of victimization. However, after Zambia's Independence people felt free to practice the trade.(Maimbolwa 2004)

However, the break through for traditional medicine was in the 1970s when the developments of primary health care in Zambia, recognized people in traditional medicine such as the herbalists, the spiritual healers and the traditional midwives. After the Alma-Ata declaration a closer collaboration was established in which a traditional medicine unit at the ministry of health was created. The training of traditional birth attendants into modern practices was also established. (Maimbolwa, 2004)

Nevertheless, modern medicine has been playing a prominent role in the provision of health care services since its introduction by missionaries in the 1900s. Today the Government is the largest provider of health care in the country. There are about 14.5 health care centres per 100 000 population. However, the services have been deteriorating over the years. Key health indicators show a situation that has been worsening over the past decade. For example the infant mortality rate is one of the highest in the region with one in every five children dying before reaching his/her fifth birthday. In the 2000 World Health Report of WHO's member states overall health system attainment and performance, Zambia was ranked at 174 among the 191 member states. (Hjortsberg 2004)

HIV/AIDS epidemic is the main challenge of the health care in Zambia today. 16% of people aged between 15-49 is infected with HIV. In urban centres the level exceeds 30%.

An effort to curb the spread of the disease is one of the main focuses of the health sector. Prevention of transmission from mother to child, voluntary counselling and testing are some of the efforts put in place by the Ministry of health to curb the disease (Maimbolwa, 2004)

Lack of human resource is also another major challenge to the health sector in Zambia. The national coverage of nurses is one nurse per 6 000 inhabitants. For trained medical doctors it is one per 16000 inhabitants. During the period 1977-1995 the density of medical doctors declined by 50 percent. Other challenges include poor facilities, low funding, and epidemics such as Malaria and Tuberculosis (T.B) (Hjortsberg, 2004.).

Nevertheless, several reforms have been implemented by the government to improve the situation. For instance the Primary Health Care (PHC) Policy introduced in the 1980, which introduced rural health care centres in rural areas. The Kabuyu Health Centre is one such rural health centres. The PHC's main aim is to allow local people to have access to health and to participate in improving their quality of life and health. (Moua, 1994, p.). The traditional midwives form part of the PHC. Under this program they have been successfully incorporated into the existing health care system by the provision of training under the Ministry of Health. (Moua, 994). However, according to WHO, in spite of undergoing a lot of reforms Zambia's health system is still performing poorly. (Hjortsberg, 2004, p.26).

#### 4.6 The Ethic Groups

Zambia has 73 ethnic groups. All groups of people that arrived and settled in Zambia before the colonization of the country by the British Empire in the 1800s are called indigenous Zambians. Only seven of these make up the major groups. Other groups, especially those that are small fall in the shadow of bigger groups due to their size. These groups fall in the category of minorities and in most cases marginalized in terms of languages and history. Their languages are not recognized as official languages by the

government and their histories too, do not form or are not mentioned in the main history of the nation. The Toka of Southern Zambia, which this thesis will discuss, is one such group.

*Fig. 1 Map of Africa showing the location of Zambia(Book 2006).*



#### 4.7 Summary

In this chapter I have shown Zambia in the wider context through its history, geography, politics, population, economy, education and health. The poor economy, lack of human resource and epidemics such as HIV/AIDs are the main challenged for the health system in the country, while for the education system the curricula can be added to the above list of challenges.

## **Chapter V Empirical Data 1**

This chapter deals with empirical data on the traditional midwife to address the question, does the traditional midwife know? It is however divided into two parts. The first part gives the initial empirical data of my research. It highlights the Toka as a group giving the context within which the research is taking place and a background from which the traditional midwife in discussion operates from. The second part forms the second part of my empirical data. It introduces the traditional midwife; who she is what she knows and how she transmits what she knows, both as an education and a service for which her role is suppose to serve

### **Part A**

#### **5.1 The Toka**

The history of the origin of the Toka is not well known. They are said to have originally be known as Tonga but the invading groups from the west of Zambia were unable to pronounce “Tonga” properly, pronouncing it “Toka”, a term that is still applied today. They occupy an area which Mubitana (1977) calls “Shungu” (the local term for the Victoria Falls), which is an area that surrounds Livingstone town of Southern Zambia. Shungu is occupied by three chiefdoms<sup>7</sup> namely Mukuni of the Leya in the east, Sekute of the Subiya in the west and Musokotwane of the Toka in the North. Therefore my research is directed at the Toka of Zambia who occupy the northern part of Shungu in Chief Musokotwane’s area.

Fig.2 Map of Zambia showing Shungu area(Book 2006)

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<sup>7</sup> An area whose leader is a chief



Shungu

## 5.2 The Toka Economic Structure

The Toka practise a mixed economy. Their main economic activities are agriculture and animal husbandry which is influenced mainly by climatic conditions. The Shungu area lies in the driest rain belt in Zambia, averaging 30 inches per annum, thus droughts are frequent making agriculture difficult. Maize, beans and groundnuts are grown as subsistence as well as cash crops. Of all the homesteads I visited all had gardens were they grew these crops.

Despite the poor rainfalls and hence poor produce, many people grow a little more than what they need in order to sell the surplus. Although not on a very large scale all the households that I visited indicated that they sell some of their crops to Livingstone town 15 kilometres away. This is so even when they are unable to produce enough for their own consumption due to erratic rainfalls as the case was when I visited the area (in 2005). The explanation to this was that the life to day in Zambia demanded cash than ever before. Basic needs such as health and education are not free. This forces many families to sell what ever they produce in the year depending on the demand for cash regardless of the surplus of food. Thus, food shortages and hunger are common in the area, especially in the rainy season when most crops are not yet ready for consumption.

Apart from the unfavourable climate, land also poses a major challenge to the Toka's main economy. There is not only a shortage of land but the land available is poor and not suitable for agriculture. This has not always been the case. The colonisation of the area by the British led to the alienation of the well watered and fertile land to European settlers. Native Reserves were created by the colonial government where the Toka were forced to live, the greater parts of which were unsuitable for agriculture. (Mubitana, 1977:21)

Today 42 years after Zambia's independence the pressure on land has not eased out. I observed that young people are facing a dilemma. It is difficult to find land for cultivation apart from the one, one can inherit from relatives. But this arrangement is not sustainable and has led many young people to migrate to towns in search of jobs and a living.

The Tokas also rear cattle which is a symbol of wealth. They provide financial security as they can be sold when a need of cash arises in the family. However, stock-rearing has also been facing problems. There has been a cattle disease called food and mouth disease (*denkete in the local language*), which has affected the southern part of Zambia for the past ten years. Because of the disease a lot of cattle have died rendering most families poor. This has been made worse with the privatization policies that were introduced in Zambia in 1992. Services such as veterinary services which the government had previously provided for free were now to be paid for. Most peasant farmers in the area are unable to meet such expenses.

### 5.3 Political, Social and Religious Organisation of the Toka

There are three levels of political, social and religious<sup>8</sup> organisation among the Toka. The highest one is the Chiefdom and is led by a chief. The chief exerts authority over a wide range of units that comprises several units of villages that Mubitana calls the neighbourhood. (Mubitana, 1977). The chief presides over political, judiciary and

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<sup>8</sup> Politics, social and religion issues are not easily distinctively separated. They run side by side and in most cases intertwined

religious issues for the whole group. Thus Chief Musokotwane presides over the Musokotwane area comprising of several neighbourhoods.

The second largest unit is the neighbourhood. It comprises of several villages led by a leader from the chief's lineage. On behalf of the chief, the leader presides over the people of the neighbourhood. People of the same neighbourhood share the same social and economical amenities such as water and land. The government uses such neighbourhoods to provide social amenities for its citizens. Kabuyu is one such neighbourhood and the government has provided it with a health centre and a school.

The village is the lowest unit and it consists mainly of family members. Among the Toka family consists of a male head with his wife or wives<sup>9</sup>, his children and his relatives' children and one or more other families which acknowledge the ritual, social and political authority of the family head. Such a unit that comprises of ten or more adult males is recognised as Munzi (village) and the head of the unit is called sibuku (headman) who is the chief's representative. The villages are formed voluntarily and are made up of people with strong kinship ties or clans. (Mubitana, 1977, p.30).

## 5.5 The Clan

The Clan (*Mukowa*) is the widest kinship unit that extends beyond political boundaries. The main feature of the clan is that clan members uphold rules of exogamy such that there are rules from which clan one can or cannot marry from. The clan system also identifies membership of same lineages. A clan is identified by a name (Totem) that is associated with nature, especially animals. Members of the same clan recognise and

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<sup>9</sup> Polygamy is not a strange practice among the Toka. Men, with the consent of their wives and family can marry more than one wife. The women explained to me that it is normally rich men that manage to marry more wives, because men are supposed to be providers of their families. However, there are also exceptional cases. This practice is a complicated subject that needs to be well studied before one can make clear conclusions. This is because the information I got indicated that even wives made proposals for their husbands' second wives. A second wife can even live with her husband in the first wife's village where she is accepted, not only by the first wife, but also by her family and community. Men can marry as many wives as they can manage.

identify with each other as relatives. Villages are to a large extent are organised on clan relationships. (Mubitana, 1977p.48)

## 5.6 The Family

The smallest unit is the family<sup>10</sup>. When a man marries he moves to his wife's natal village until the couple have one or two children. Then they move to the man's natal village to settle permanently<sup>11</sup>. (Mubitana, 1977, p.49). One of the reasons for this arrangement ensures that the young bride is attended to by the traditional midwife in her natal village with whom she is familiar with. By the time she may have two children; she would be familiar enough with her husband's village and people and maybe ready to be delivered by their midwife. Nonetheless, she is free to return to her natal village in the subsequent pregnancies if she feels comfortable to deliver there. This arrangement is a common practise in Kabuyu.

The Toka believe in the existence of a supreme being, *Leza* (God) who is identified with the creation (Cilenga). *Leza* is recognised as a spirit and has no gender. "He"<sup>12</sup> is thought to be far removed from the living people and he is rarely addressed to directly. Communication between the people and *Leza* is by the ancestral spirits (*Mizimu*), of those members of the clan or family that have died. The communication is through the living family heads or those of special and high position in society. The dead are concerned about the living and intercede on their behalf to God. In this way the dead and the living have a continual interaction. (Mubitana, 1977, p.54).

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<sup>10</sup> A family consists of extended family members such as nephews, nieces, grandparents etc.

<sup>11</sup> Mubitana (1977) explains that the phenomenon is new. Originally the Toka were matrilineal and a man moved to his wife's village upon marriage, where the children identified themselves to their mother's clan. This changed with the introduction of colonization and Christianity that brought about a patriarch kind of system; where children were to be addressed by their fathers' names called surnames. However, children are still practically considered to belong to women. The women informed that generally, women decided how many children they were going to have, since to a woman children meant power and security. The more children one had, the more she was respected in society and the more secure she would be in her husband's village in case of divorce or death. Children have the right to inherit their fathers' clans land, thus a woman could have reason and a claim to stay in her former/late husband's village if she had children. This is crucial considering the land scarcity in the area.

<sup>12</sup> Here I use "He" in the same way God is referred to in Christianity because I have failed to find an equivalent of non gender in the English language.

However, today this link between the ancestors' spirits and the people is not so visible. Most people in kabuyu are Christians and they believe in one supreme God whom they still call Leza. Belief in the ancestral spirits is regarded as heathen. A number of churches can be found in kabuyu such as the church of Christ, the Catholic and the church of God. All the people I interviewed indicated that they were Christians. Nevertheless, people still consult and communicate with their ancestors' spirits during special occasions such as in illness, childbirth, death, famine etc. Family heads, traditional doctors, traditional midwives, neighbourhood or village heads, and the chief are the only ones entrusted in carrying out rituals that involve the consultation of the ancestral spirits, as they hold positions that are considered as important or special in the community.

#### 5.7 Preparation for life in Toka society.

The socialization of the young into the society is a responsibility of the adults of the village. After the age of seven or there about, children are socialized separately according to gender. Boys as the providers of the home while girls as caregivers and home managers. Women in general and the traditional midwife in particular as custodians of culture and tradition are very important persons in the socializing of the young. This is because they take up the greater part of socializing. Before the children are seven, they provide most of the teaching to both girls and boys around the kitchen fires. After the age of seven, this teaching is concentrated on girls while the boys are taught by men. However, in the teen years, before and during marriage, the traditional midwife in particular takes up the task of guidance to both sexes. From this time on she provides lifetime guidance to adulthood, spirituality, marriage, childbirth, parenthood and death. She assumes the role of a community primary service provider in a very wide context. The position of the traditional midwife is very vital since she deals with the continuity and survival of the society. This is a difficult task considering that Zambia's child mortality rate is very high at 1 in every 5 births dying before the age of five. (Hjortsberg 2004)

## Part 2

### 5.2 Nene, The traditional midwife

*“The absence of experience is the presence of limited knowledge” Nene, July 2005*

The midwife among the Toka is called “Nene” or “bachembele”. “Nene” is a Toka word which means “old one” and “Bachembele” means old woman. Age in Toka society is respected and gives special position in society, because experience is recognized as the best way of acquiring knowledge. To be recognized as old means to be recognized as knowledgeable and wise. Sobonfue.E. Some (Some 1999) explains that the elderly people’s proximity and kinship to the world of ancestors also gives them a special and unique position in African societies.(p.67-68) Hence a midwife among the Toka is an elderly but energetic woman with knowledge of the Toka society before, now and after. For this reason I call my informant “Nene” not as her name but as her position and the relationship she has with those she serves in her society. This Chapter therefore explores who Nene is and what she knows in her position as a midwife to address the research question; does the traditional midwife know?

For the Toka, midwifery is not restricted to child birth but it involves everything that connects to bringing children in to the world and the insurance that these children will grow up, to bring in the world their own children. To introduce this knowledge I start by presenting The story of Life which forms the cornerstone of the knowledge of midwifery in the Toka context. I present the story as exactly as it was told (translated from Toka) by Nene in order to retain its content as much as possible, taking into account translation limitations. Then I proceed to explore the main aspects of this system of knowledge namely: conception, pregnancy, birth and maternal and childcare from Nene’s point of view.

#### 5.2.1 The Story of the beginning of Life:

*“Knowledge of the beginning of life is the foundation up on which our midwifery is built”*

Nene, 2005.

It is evening around Nene's kitchen fire. The younger children, the teenage girls and the mothers from the homestead and their neighbours are gathered around the fire to chat about the daily happenings of the day but most importantly to tell fairy tales. It is a common practice. Fairytales are used both for entertainment and educational purpose. Social, moral and historical lessons are taught from the stories. Nene does not always tell stories. The women and the elder children normally do that, after which the children are asked in turns, to tell some stories they had previously heard. But today, Nene says she has a story to tell; the story of the beginning of life. The Audience has heard it before, but they still sit quietly and listen because it is said, a story and the lesson learnt is different or new on each occasion told.

"In the beginning there was God", Nene starts. A young boy chips in "he was always there". Others murmur "Keep quiet". "He is right, God was always there". Nene continues. "But he was lonely. He needed company. So he created the clouds to make the sky, then the moon, and the sun. But still He thought that was not good enough. So he decided to create the earth which he could decorate as he pleased. He made earth shaped like a basket (*Liselo*) in which he could fill in things. With his *Liselo* He went to the sky, give me some of your water, and the sky gave; then he went to the sun, give me fire, and the sun gave; then he went to the moon, give me some of your energy and the moon gave; mixing them together he created earth filed with water, fire and energy to make it fertile. He let some of the water flow on the earth to make rivers and sowed seeds to make plants and trees that grew from the belly of the earth. Then he created animals to roam the earth as they wished".

"God was spirit (*Muzimu*) without body. So the earth felt lonely. She asked God to create someone like her to keep her company. But God said, you need two companions for you who can complement each other in their roles; Man and woman, otherwise, one creature will soon be tired and lonely and ask me to make yet another being. To accomplish this God told the Earth to give the materials to make her companions. So the earth gave fire which is love in human's heart. To make woman a little more fire was added to the

woman's heart so that she could be as nurturing as earth. The earth also gave water to go to the woman's stomach (womb), to protect and nurture that which will grow in there like the way the earth nurtures the plants with the water from her belly. The earth also gave rivers to become woman's basket (genital) to collect seed, and mountains to become her breasts. The woman looked so beautiful like the earth, so the moon said: she is too beautiful. To remind her of what her beauty cost the earth, my energy will strike her every complete moon".

"To make man, earth gave him rivers filled with fish, so many we cannot count them, so that man could multiply. But how? So earth gave man a root from the tree which became man's tool (genital), facing down like roots do. With that he could plant his seeds. However, man and woman had no blood. Earth convinced the animals that roamed the earth to give some of their blood to make humans. With the blood God completed his work. God was happy with what he had made, but He also wanted man and woman to be his companions, but not in the same way they were going to be with earth. Man and woman were going to be earth's companion in body. Since God had no body, man and woman could only be his companion in spirit. So God decided to give man and woman a part of himself; spirit. So he let his shadow fall on them to give them life and with a deep sigh breathed air (*Moya*) or soul into them and so man and woman became beings.

"Now God gave earth her companions. He said to her; in body man belongs to you and when he dies he will return to you and the blood in him will dry; but in spirit, man belongs to me and when he dies the spirit will return to me to become spirits (*Mizimu*). While he lives he shall not be separated. He is body, blood and spirit. And when he dies, he shall not die for ever for he shall live in his seed, therefore, you earth will never be lonely again.

"Earth was so pleased with her companions. She took them on a tour, introducing them to things on earth. Earth explained to man and woman; you shall eat the plants as you wish but not the animals. The blood that runs in you also runs in them; consider them as your relatives. Just like you are related to me so they are. Each one of you has an animal whose blood is exactly like you, look out for such animals and do not eat them. To know each other and to be recognized you shall be called by the same name as the animal; (*Mukowa*) or totem. In that way all your relatives will be called by that name so that you

may know them and not let your seeds mix (have sexual intercourse). Because if they do God will be angry with you and the seeds will bear weak fruit as punishment, and you and your clan will not last but die”. And so this is how we came to have clan names. My ancestor’s blood was related to *Mudenda* (the elephant) and so they became known as such. How about you chelo what is your clan name?” She asks all the children their clan names one by one.(Kabuyu, July 19,2005)

### **What is the meaning of the story?**

Interview with Nene (Kabuyu, July19,2005)

Nene: This story has many lessons. It teaches the importance of giving and contributing to creation. But it is mainly meant for the young adults. It is important that they learn about their bodies and their intended purpose. It is also important for the children to know how the human beings came into being and the importance of clan names. The story is also good for the women, because if they are to become good midwives they have to understand the way God created a human being because everything starts from there. But today, I told this story mainly for the teenage girls. I know that one of them is having a relationship with a boy of the same clan (Mukowa). Her mother complained to me. She is afraid; the two might decide to have sex. This cannot be allowed. It is “incest”<sup>13</sup> because people of the same clan are related. It can even be worse if she conceived from such a relationship because God will punish us with a “weak” child. We don’t want that. Obviously a marriage cannot be allowed between such people but if they have sex they will pollute the clan and the village. It is my duty, to make sure the girl knows what she is getting into. I use the story to tell her that it is okay to fall in love but not with one’s relative. I know the message has been understood. If she continues I can then talk to her directly and with the boy concerned. The story is to tell her that it is not me who made the rules but I found them and I know that they are true. Earth has forbidden it. Incest brings “weak” children in the clan.

Q: What does “Weak” mean?

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<sup>13</sup> Incest in Toka has a broad meaning. It involves not all those with whom you share the same totem, and this can be quite broad.

Nene: This weakness can be either mentally, physically or both. Physically a child can have diseases that are difficult to cure or easily get sick. Most diseases like fits (some kind of epilepsy), madness, and suicide are due to weak blood and they run in families. To avoid them, there is need for strong clean blood. But if you marry within the family, you make the weak blood strong and the disease comes back. The weakness can also be mental. In this case the children can be stupid. To produce good and healthy children marriages must not be between related couples and totems are one way of preventing this from happening. We the adults must make this very clear to the young ones otherwise, the whole village will be polluted with “weak” people and in this way a village cannot survive. It can die either of disease or stupidity. Therefore, it is taboo (*Chilatondwa*) to have sex with a relative.

The story of life is the axis on which traditional midwifery revolves and can best be understood from. It forms a good start from where to explore this topic.

### 5.2.2 Who is Nene?

Nene was born Lovina Muulu in chief Musokotwane’s area. She does not know exactly when she was born. She has had seven years of primary education. She got married in 1965, a time she says, when girls used to get married soon after puberty. She got married soon after puberty. Upon marriage, her husband moved from his village to join her in her natal village where they have been living up to date. At the time of my visit, her house hold was made up of her husband and herself; two married daughters (one had come home 2 months earlier to give birth, and the other on a visit), 4 children (under 14) who are nephews and nieces, and 7 orphaned grand children<sup>14</sup>. Her two elderly sons with their wives and children live nearby on Nene’s family land. It is their piece of land which they have inherited from their mother, but which will be inherited by their sons and not daughters due to the change from matrilineal to patrilineal system in the recent years.

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<sup>14</sup>A common household in this area is made up of extended family. I saw and was also informed by the health centre that in recent years orphaned children and terminally ill relatives from the city are a common feature in most households. The family is the social support in case of illness, unemployment, divorce or any social/economic problems.

She has had 10 children, five of whom have since died. Seven of her children she delivered with the help of a traditional midwife in the village, who is still alive but too old to practise. It is from her that she learnt her practise by participant observation. she still consults the old midwife in her practise. One child she delivered at a hospital when she went to visit her husband in Livingstone town, 15km away, where he was working at the time. Two of her children she delivered on her own. On the first occasion, she says it was in the rainy season and everyone was away working in the fields. Her labour started suddenly and by the time the midwife arrived, she had already delivered. On another occasion, she was on her way from visiting her in-laws when the labour started and she delivered alone. She says this has contributed to her clients' trust of her ability as a midwife.

She has been practising as a junior midwife since the birth of her fifth child who is now 33 years old. During this time she worked under the supervision of her predecessor. However, she has been practising as a full time traditional midwife of her village for eight years. She does not know the number of the babies she has delivered as there are no records. The young woman form what she calls, junior midwives whom she delegates to help her in low risk cases. The high risk cases are first births and women who have a history of difficult births. These, she attends to herself.

### 5.2.3 Who is a midwife among the Toka?

*“How can you give meaningful support to a person who is in a position that you have never experienced?”* Nene, July 2005.

The position of midwife among the Toka is given by the community. “This is because you are entrusted to deal with life”, Nene states. The community chooses you, you do not choose yourself”, she adds. The choice is made by looking for certain qualities in the likely woman.

“She is suppose to be one who knows the Toka traditions and culture very well and of good moral standing. This is because the task entrusted on her is not just delivering babies but ensuring that the Toka as a group survives in terms of a people as well as in terms of culture. She is the keeper of tradition and a teacher of that tradition. This is what

makes her moral standing crucial. She is also suppose to be a woman who has born children of her own and in her menopause period. This ensures that she has the experience needed in the profession”, Nene explains.

However, training in the art of midwifery is open. Each birthing session is a training forum for all women in the same age<sup>15</sup> group as the woman who is giving birth. The women present are both students and social support to both Nene and the birthing woman. Nevertheless, the birthing session is open only to women who have themselves given birth before. Men and those who have never given birth before are excluded. “How can you give meaningful support to a person who is in a position that you have never experienced?”, Nene explains the reason for this rule. She says that in order to understand and give meaningful support to a woman in labour one needs to have undergone the experience before.

To add to the training given at birthing sessions, the women are given assignments to take care of the sick or help their peers and families in child rearing. In this way, they gain experience. The community notices those that are particularly good and by consulting them regularly, they indicate their choice of who should be their midwife. However, one does not become a full time midwife until they reach menopause. When they are under this age, they operate as junior midwives under the supervision of the senior midwife. To be chosen as a midwife is considers as “an honour, to oneself and to one’s family”, states Nene.

For the services offered, the traditional midwife is normally paid in kind. “Traditionally after attending to a birth I am considered “blinded” by the process. To rectify this, the family of the woman gives me a token of food staffs that are suppose to “open” my eyes”, Nene explains. The food comprises of peanuts, fish, “*bondwe*” (a kind of spinach), eggs, ox liver and some wild fruits like “*mahuluhulu*” (Monkey oranges), *Monsomonso* (tamarind). Any one of these foods stuffs is given.

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<sup>15</sup> In the Toka society, those born within the same age range form a peer group that identifies with each other. Such groups are used as classes to give general lessons in life according to the needs and development of the group. People in each peer group identify with and offer social support to each other. The peer group system is based on the society’s rules on age, respect, taboos and authority. Members of the same peer group are not strictly bound to observe these societal rules within their group.

#### 5.2.4 Nene on Conception.

*“It is the only time that we can behave like God: create another human being”*. Nene, July 2005.

On Conception Nene explained that for the Toka the process to become human begins at conception. It is believed that conception takes place when man places his water filled with the countless fish(seed), given to him at creation, into woman's basket (Liselo) that is designed like earth to nature growth. However, for the Toka, sex and conception are sacred. She says “It is the only time that we can behave like God: create another human being,” just like God had done at the beginning of the world. It is viewed as a process in which the couple is in communication with the spirit world. For it is believed that a child already existed as a spirit (Muzimu) in the world of spirits before conception. However, the transformation of the spirit into humanity takes place in the long process of sex, conception and birth. For this transformation to occur, God and the spirits in the spirit world have to agree to this action, thus the couple is involved in an action that is spiritual. The spirits concerned in this process are the couples' ancestors transformed into spirits by way of death. She explains, "Death and birth are the same way- they are routes of transformation from spirit to human and from human to spirit". Thus, the rituals performed at funerals are also performed at conception. For example the fire ritual which is performed especially in when there difficulties for the couple to conceive. A small fire is kept burning in the hut in which conception is taking place. She explains that "the fire symbolizes fertility and continuity of life as it was given to earth at creation for that purpose. This fire ritual is also performed as part of funerals rites. When a person dies, a fire is kept burning until the end of the funeral rituals, to represent continuity of life and not the end".

Nene is consulted on and about conception. She advises the couple on sexual behaviour that will ensure conception. In case of infertility, she administers medication in cases that are not complicated. She assesses the situation and advises when to involve other people like the herbalist or the hospital.

### 5.2.5 Pregnancy in Nene's practice

*“To be entrusted with the task of nurturing life in one's body marks the difference between man and woman”* Nene, July 2005

Nene explains that a pregnancy is both a happy and an apprehension period. A pregnant woman is considered to be in a privileged position of bringing another being into the world, making it a happy situation. However, being pregnant is also viewed as dangerous situation as the woman can be vulnerable to jealousy human beings as well as bad spirits that would not be happy to see the woman achieve the intended goal and thus terminate the pregnancy. Another reason is the presence of the baby itself in the womb of the woman. This is considered dangerous because the baby's blood is looked upon as foreign blood in the body of the woman. She clarifies that, “a baby being a mixture of the mother's blood and the father's blood makes it a different being from the woman carrying it. Blood being connected to totemism and ancestors means that by being pregnant, a woman carries foreign blood which belongs to ancestors that are not her own”.

However, she emphasised that a woman is considered particularly vulnerable in the first months of pregnancy. For this reason, in the first few months, the couple informs no one about the pregnancy except the midwife and very close family members. The midwife has a crucial role to play at this point to ensure the pregnancy is carried to full term. She talks to the couple about the situation they are in and advises on what to do. To ensure that the baby survives the couple is told on what is happening to the child. They are taught on the physical being of the baby in the womb such as the stages of pregnancy in relation to their expected behaviour. She points out that in the first three to four months the unborn child is said to be in a stage of animal (the totem); it is in this stage that abortion is allowed to take place. In the second stage; four to six months it is considered to be in a godly state because it is believed that at this stage the child has no sex, like God. This stage is crucial because the child cannot be aborted and is said to be in a state in which it is present both in the spirit world and the human world just like God is. It is said to be aware and an active participant in the world outside the womb. Thus, the

parents are told not to show hatred or to be quarrelsome during the time of pregnancy because, the placenta that is likened to a root sucks in all that is happening outside the womb and brings it to the baby. She says, "a quarrelsome couple is believed would produce a quarrelsome child". The mother in particular is told not to get angry because this would affect the well being of the child. To show love to each other is encouraged, to ensure a happy baby. Lack of love is believed to make the child wither away and can lead to death in the womb. However, if the child survives it would grow in to a miserable human being still yearning for love denied to it in the womb. Sex is encouraged as it is seen as one way of expressing this love. Society at large is also expected to support a pregnant mother from getting angry or worried. Quarrelling with a pregnant woman is a taboo.

Other taboos concern what the woman eats. Nene ensures that the woman observes these taboos. Foods that would make the child fat and big such as eggs, fatty meat are not allowed because "big babies are difficult to deliver", she says. What is encouraged is foods that will make the child strong but not necessarily fat like vegetables and fruits. Eating of soil from certain types of anthills is also encouraged as a means of cleansing the stomach of diseases and also making the woman's blood strong. " A pregnant woman needs a disease free stomach and a lot of strong blood for the child to survive", she explains. The midwife also gives abdomen and back massages to the pregnant woman. This process is said to increase blood, relax both the mother and the child and also as a way of getting to know each other between the child, the mother and the midwife. This process is also used to predict any abnormalities in the pregnancy such as twins, breach or even illness.

Nene says in the last stage of pregnancy- six to nine months- the child takes on human nature. She explains, " at this stage the child acquires sex and physical characteristics with which it will be recognized at birth" .This period is dedicated to preparation for birth. Nene prepares the couple for this, especially the pregnant woman. One or two months before birth, the pregnant woman is taught how to prepare the birth canal by

stretching it. "First, two fingers are introducing into the canal, then more until the fist is able to go in", she says. The woman does this every morning until birth. The process is believed to strengthen and widen the birth canal. Herbs are also used to make the birth canal stretch. A month before birth, the couple is forbidden from having sex. "The same is required me and my partner"<sup>16</sup>, she says. She explains that avoiding sex is supposed to allow the couple as well as the midwife to meditate upon the coming event of birth. It is taken in the same way as fasting or a form of prayerfulness, because the advent of birth is considered to be very important.

During this period, the woman and Nene spend a lot of time together. They are said to be introducing each other's spirits which will need to work together during birth. Most importantly, Nene prepares the woman for the actual birth. There is a belief about the energy of the moon which was given at the time of creation which affects the woman every circle of the moon resulting into menstrual period. Nene explains,

"The moon energy is stored in the woman's body when pregnant or during her menopause. Both the midwife and the pregnant woman have this energy. The energy is good energy to be used in child birth. I train pregnant women how to channel this energy for birth, so that birth would be easy, quick and enjoyable".

#### 5.2.6 Nene's role in Child Birth.

*"Birth is like death: it is a transformation from one state of being into another"*. Nene, July 2005

On her role in birth Nene had the following to say:-

"On the onset of labour, I am informed. With the help of other female members of the family and the village (especially her peers), I prepare the house in which birth is to take

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<sup>16</sup> My observation was that the population within which Nene operates is small since it is at village level (see p. 36 of thesis), so the numbers of births are not that much in a year (even if I was not given statistics and it was difficult to tell by the number of mothers present in the village since some delivered in their natal villages while some, who were not present came from their husbands villages to deliver in Nene's village as their natal village). Besides that, the women also explained to me that the junior midwives do help Nene such that she does not operate alone. Risks cases such as first births and women with history of having difficult labour were mainly reserved for Nene to attend to, while on non risks cases, Nene delegated the operation to the junior midwives.

place with fresh cow-dung or wet clay. This gets rid of insects. This layer is then covered by dry cow-dung or clay to absorb any liquids such as blood or water. A rug is spread where the birth will take place. A fire is lit in the house. Only those who have given birth before are welcome to give support to the mother and myself. I also bring my equipment. This is a medicine calabash and a cooking stick. The medicine is used to moisture the birth canal and make it slippery. The cooking stick is used in the case of a retained placenta. It is used to make the woman vomit and then in the process force the placenta out.

“When the time comes to give birth she squats with the mortar as support on her back. Or she can be on her knees and her hands holding the mortar. Sometimes the mortar is not used. The female friends and relatives give her the support at the back instead of the mortar. The squatting position makes the baby come out fast. The birth is natural and I normally do not intervene. I just give encouragement to the pregnant woman especially in terms of bringing the moon energy to be active”.

”I only intervene in case of complications such as breech or the retention of the placenta. In case of breech, I use medicines and try physically to change the position of the baby by messaging or manually turning it. But, there are no strict rules as to what can be done in such a situation. In most cases, I rely on intuition. It is something one learns from experience. If the problem persists I call the herbalist or refer the to the health centre”.

“When the baby is born, water is splashed on it to make it cry after which it is kept warm and given to the mother. The birth is incomplete until the placenta is delivered and the cord cut. Delivering of the placenta is my most sacred job because it signifies the end of life in the womb for the child. The child moves from the spirit world to the earthly world. So it is a very scared moment.”

“I bury the placenta in the hut of birth to mark the end of the pregnancy and a start of a new life. It also marks the connection between the child and the land of birth. The placenta which has fed and protected the baby in the womb is replaced by the mother’s

breast. The mother and child are then confined for at least one month. This is done to avoid diseases and also to make the mother and child recover from the birth and get to know each other”.

“During confinement period, I sometimes personally help the woman and the child to recover by giving them hot messaging baths. And sometimes I instruct and supervise a close family member or neighbour to this chore. I make the mother sit in water baths containing herbs to heal the birth canal. I also instruct her to eat food that will help her produce more milk such as *munkoyo*<sup>17</sup>. This is the time to make the baby fat. The mother is not allowed to do any chores. Her duty is just to feed the child and rest. From now on the mother and child are considered as one and they are not allowed to be separated. My duty is to help the mother and child recover, as well as to train the mother in breast feeding and taking care of the newly born. I also encourage other family members to get involved in the new being and the mother. During the confinement period only close family members can see the child. The confinement period ends with the shaving of both the mother and baby’s hair and a welcome by the family members and friends. This is the occasion when all members of the village are welcome to come and see the child”.

“But my work does not end here. I continue to make visits to the mother and child. I monitor the growth of the child and train the parents on child care. The main things I teach the new parents are: how to treat common illnesses in children by introducing them to herbs, the importance of breast feeding and child spacing”.

#### 5.2.7 Breast feeding and child spacing; Nene duty

*“The child has a right to the breast and mother must feed it on demand, anytime any where ...”* Nene, July, 2005.

Breast feeding and child spacing are considered paramount to the child’s survival in Toka tradition. Since the midwife’s aim is to ensure the continuity of life, her duty includes the insurance of the child’s survival. Thus, she monitors and councils the couple to ensure

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<sup>17</sup> A fermented drink

that the child is breast fed at least for two years before it is weaned and the thought of having another child can be entertained. Nene says that in the first six to eight months of the child's life it is traditionally demanded that "The child has a right to the breast and mother must feed it on demand, anytime any where". The mother is encouraged to give the child the breast not only when the child is hungry, but also as comfort when the child is in pain, afraid or angry. Nene explains that the breast replaces the placenta's offer of food and security in the womb. She states that breast milk is essential to the child's growth and helps complete the transformation of the baby from spirit to human being. Nene also teaches the mother on how to detect any temperature changes in the child, to detect fever by using the breast. She says that the mother is encouraged to notice any temperature changes in the mouth of the baby when it feeds. Breast feeding is also regarded as a child support and is believed to prevent infant mortality.

Weaning starts after 8 months. Nene encourages the mother to introduce low pace weaning from this age until the child is about two years old. In this system the mother is encouraged to leave the child in the care of other members of the family like elder siblings and grandparents, prolonging the time in between breast feeding. Nene explains that this system introduces the child to other foods stuff and other people in the family other than just the mother. When a child shows independence by being able to walk, show good interest in other food and able to play with other children, she recommends complete weaning. This is about or around two years. Weaning is only done upon Nene's approval or satisfaction after observation of the child's development However; it is not done any how. Nene's recommendation is during the dry cold months between March and August. The explanation she gives is that, the area in which the Toka live experiences shortage of food in the hot rainy season (October- January). This is the time when most staple foods are being cultivated. However in the cold dry season there is plenty of food. Another reason she gives is the presence of water borne diseases such as diarrhoea and malaria which are common in the hot, rainy season are less common in this period.

Nene also teaches the couples to use breast feeding to delay pregnancy. She explains that exclusive breast feeding makes the “womb reject the seed from the man”. This system is used in the first six to eight months (for some women it can go up to even a year), after which traditional medicines are used in combination to breast feeding. Early conception is considered a threat to both the lives of the unborn child and the breast feeding one. Nene says that a pregnant mother produces unnourished milk which can lead the breast feeding child to suffer from a dangerous disease called “*Masoto*<sup>18</sup>” which normally leads to death. If early conception<sup>19</sup> takes place there are normally two options taken: if the one breast feeding is too young to be weaned, abortion is considered to save the live of the one already born. If the child is considered strong enough, it is weaned so that the mother’s body can be free to concentrate on the unborn child. In this case Nene normally assumes responsibility by helping the mother take care of the prematurely weaned child, or encourages other family members like the grandparents to take up this role which she monitors.

Nene explains that child spacing is only encouraged to avoid infant mortality and not to keep families small. She encourages women to produce as many children as they can because children are considered as security in old age. The big number of children ensures that the burden of looking after aged parents is spread over the children and it does not become unbearable.

Since 2000, Nene has also been involved in the reproductive programs of the Kabuyu Health centre. She says she has been to the training sessions of traditional midwifery at the health centre. She states that there are a number of new things she has learnt from the Health centre such as hygiene and using sterile equipment. However, she points out that “I went for the training not because I don’t know anything in child birth. But because I want to be recognised by the clinic by obtaining a certificate”. She further explains that “the health centre is discouraging women from being attended by those without a

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<sup>18</sup> It is a disease in which a child losses lot of weight and it is connected to the unnourished milk which the mother produces because of being pregnant.

<sup>19</sup> Early conception is the conceiving while the child is not yet ready to be weaned according to Nene’s judgement

certificate”. She also mentions that she is encouraging her trainee midwives to go and take the course at the clinic. Otherwise, she says, they will be considered as “untrained” and unrecognised by the health centre.

In addition, Nene says she has been involved in the family planning programs of the health centre. Her role is to support and encourage mothers to take the pill called microgynon. However, during my visit, this microgynon was withdrawn from circulation by the health centre and replaced with a new pill called Oralcon-f. However, she complained that she had no information about the family planning pills and the changes.

“Many mothers have been taking it for years. I am afraid for the young mothers. I don’t trust these pills. I have always been suspicious.... These days we have a lot of complications. Then there is the problem of some nursing mothers not producing enough milk when they are on the pill. You can try all you know but the problem does not go away. I ask myself, what is wrong? Then some women develop heavy bleeding, I can not deal with that. I do not know what to do. They have to go to the clinic. However, the pill is good because it is readily made and available unlike traditional medicine which we have to prepare from Scratch. It is just the information that we do not have about the pills, so it is difficult to determine how good and reliable it is for our mothers. One moment they say it is good, another moment they say it is bad”. She lamented.

She has also been involved in the HIV/AIDS home based program. This program has been incorporated into her already existing role of taking care of the sick in their homes. She visits and helps them in their daily chores which they are unable to perform. She performs this role in conjunction with other women in the village.

## Summary

This chapter divided in two parts has in the first part, highlighted the Toka as a group, the context from which this research takes place. The historical background, the economy, social, political and religious aspects of the Toka has been explored, but most importantly placing the traditional midwife’s position in a wider context. The second part has introduced Nene, the traditional midwife among the Toka as a focus. This part has explored what she does in her practice and how she transmits it as an education as well as a service to the community. It has also shown her collaborative work with the health centre at Kabuyu.

## **CHAPTER VII Empirical Data 2**

6.0 Is Nene acknowledged as knowledgeable by those in the same field or by the general populace? How are her practices perceived?

Having looked at the Toka in general and the midwife in particular in the previous chapter, this chapter will focus on other people that are involved directly or indirectly with the midwife in her service. The chapter will take a look at the women, the young people and the clinic that in one way or another make use of the traditional midwife. Addressing the question; Is the midwife acknowledged as knowledgeable by those in the same field, or by the general populace? The chapter will see why, when and how they utilize the midwife. It will also explore how these people or institutions view the services of the traditional midwife.

6.1 Making choices in reproductive health: The young women and Nene.

This section deals only with data collected from interaction and interviews with the young women who form the main clients of Nene. Being in the reproductive age, they form the largest client for Nene in maternal health. A total of 15 women were interviewed. They were in the age range of 20-35 years old. In this group all women were mothers and no one had less than 2 children or more than 6 children. The mothers are provided with maternal health care by both the traditional system of midwifery through Nene and by the Health centre. Dual systems where a mother consults the clinic as well as the traditional midwife are also common but the purposes vary. To find out what kind of relationship the women had with the traditional midwife I asked question based on the dual system nature of their maternal health services; the clinic and the traditional midwife. The questions addressed in this section is when, why and how do you make choices between the hospital and Nene?

Table 1. Young women's choices

	Traditional midwife Only	Health Centre Only	Both Traditional and Health centre
Antenatal care	2	0	13
Childbirth	8	2	5
After Birth care	15	0	0
Breast feeding	15	0	0
Child Spacing <sup>20</sup>	15	0	0
Family Planning <sup>21</sup>	1	14	0

This data represents in numbers where and for what purpose the women chose to have their maternal health problems attended to.

### 7.1.2 Why?

Those who used the dual system in antenatal sited that the two (Nene and the health care) supplement each other. One woman stated that “we receive medication such as ant malaria tablets and iron tablets from the clinic which we can not get from Nene. But we get the physical and psychological preparation from Nene that the health centre does not offer”. Those that used Nene only attributed this to their age<sup>22</sup>. (All of these were above 30) They said those who were engaged at the clinic where younger than them hence they felt uncomfortable.

On birth, the most common reasons given to use Nene and not the health centre were; limitations of the centre to offer some services such as social support, birth without episiotomy, unrestricted position for birth, short tolerable labour, and more time for observation and support after birth. Those that had used both sited chance and choose for giving birth either with Nene's help or the health centre. “I only use what is available at available at the time. The health centre closes at 16:30hrs. If labour

<sup>20</sup> Child spacing is and family planning are understood differently by the locals. Child spacing is associated with the cultural sexual taboos and observations that are said to promote child health such as no sex in the first 1 or 2 months after birth, no sex after outside marriage while the child is breastfeeding and no pregnancy before the child is ready to be weaned. The aim of child spacing is not to limit the size of the family, but to ensure the survival of the children.

<sup>21</sup> family planning is not directly associated with the promotion of child health as in the sense above but is as a way to limit the size of the family, such that it is only considered seriously after one has had a lot of children and common after at least after 4 children.

<sup>22</sup> Refer to Peer group explanation on p. 46, ref. number15 of this thesis

comes before closing time I go to the health centre, if it is late I go to Nene”. Another said that she used the health centre because she had development a complication and was referred to the health centre. But in her normal births, she has delivered with the help of Nene. Nevertheless all of them despite where birth took place depended on the services of the midwife for the seclusion period after birth because this was not offered at the health centre.

In addition all the women depended on the traditional system of the midwife on advise and support for breast feeding, weaning and child spacing. This included sex education for both partners that demanded such things as abstinence in the first few months after delivery, no sex outside marriage while the baby was breastfeeding (it is believed the this could affect the child even leading to death if this happened)<sup>23</sup> and no pregnancy before the child was ready for weaning (a pregnancy before the child was weaned was believed to be dangerous to the child’s health). Exclusive breastfeeding is the main way of preventing pregnancy in the first 6 to 8 months. However after 8 months most women seek the program for family planning offered by the health centre, like the pill and injections to prevention of pregnancy. This is attributed to the readily availability of the pill compared to the traditional midwifery’s traditional medicine. One that depended on the traditional way on the prevention of pregnancy gave religious reasons. “I am catholic, and my faith does not encourage the pill, so I use traditional methods from Nene”, she said.

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<sup>23</sup> When a child is breast feeding it is considered a part of the matrimony such that any offence to the marriage such as adultery, quarrel, fight or divorce is treated in consideration to the breastfeeding child before all else. When the child is weaned then such cases are then analyzed on the effects of the marriage based on the couple.

*Fig. 3 Mother toilet training baby.*



*A young mother toilet training her 3 months old baby by supporting him with her feet. In Toka tradition children are already toilet trained for bowel movement by the age of 4-6 months.*

## 7.2 The young people and Nene people.

This is the second part of the general populace that has a relationship with Nene; the young people. This part looks at data provided by the young people through interviews and interaction. In all 8 teenage girls aged between 14 and 16 were interviewed. The questions addresses what kind of relationship they had with Nene and what kind of issues they consider important that Nene could or did addresses in their lives?

The teenagers treat Nene as their friend. Traditionally she is considered as their peer and they share with her taboo topics such as reproductive health related issues, freely<sup>24</sup>. The list below shows the issues discussed with the midwife that the young people identified as important. They are listed according to importance.

*Table 2. List made by the Teenagers*

1.	Menstrual related problems such as hygiene and antidotes for ailments during menstrual period
2	Sex
3	Marriage. Possible partners, when and how.
4	Morals, culture and tradition.

<sup>24</sup> Refer to some elderly people's relationship with the young on p.40 of this thesis and to peer group explanation on p. 46 of this thesis, ref. number 15

I have put morals, culture and tradition separately as it was identified even if in all the other three issues it was somehow present in one way or another.

The teenagers considered their relationship with Nene as important. “Menstruation, sex and marriage partners we discuss with Nene and not our parents”, was the explanation. It is not culturally allowed to discuss such topics with ones parents. The teenagers also indicated that the school system does not address these topics directly. They expressed a need for the position of Nene to continue because of its necessity in addressing the issues they considered important. “If it is not there, who would guide us in reproductive issues”? one asked. They all agreed to the importance of Nene’s position and expressed interest to be the future Nene in future. However, most of them thought that it was not possible to learn all that Nene knows because they do not have as much time to spend at home with Nene since they were all students at the local school. The said that the only meaningful time they have to learn from Nene was by her Kitchen fire in the evenings. Some of them even expresses a desire to move out from Kabuyu to further their education. (the school at Kabuyu only gives up to 9 years of education). This, they indicated would prematurely terminate their socialization with Nene. This socialization, they said was necessary for not only for becoming Nene in future, but also for their own development as adults. They mentioned that reproductive health and sex education was very important in their development as responsible adults.

7.3 The Health Centre and Nene. What kind of relationship exists between the two systems of reproductive health providers in Kabuyu?

The health centre at Kabuyu is another part of the community that deals with the Nene. The health centre has one nurse and one Environmental Health practitioner who performs the duty of a clinical officer. The nearest doctor is 15 km away in Livingstone. To explore my research of how other people in the same field as Nene perceive Nene’s practices, a structured interview was conducted with the health personnel. The questions asked were what was the health centre coverage in terms of population, what kind of

reproductive health services did the health centre provide to women in reproductive age (who are also Nene's clients); what kind of relationship existed between the health centre and their co-reproductive health provider: Nene?

*Table 3. Kabuyu health centre profile (2005)*

Staff	Total population coverage	Women in child bearing age	Total number of expected pregnancies	Children under five years old
2	5062	1114	168	1012

### 7.3.2 Reproductive Health Programs at kabuyu Health Centre

The clinic opens from 08:00hrs to 16:30hrs. It provides ante natal care where the foetus growth and the health of the mother are monitored. Iron tablets are also given to all expectant mothers. Maternity services are also provided where mothers are assisted during birth. This is based on hospital deliveries and shorter hospital stay model to reduce costs. Home-follow ups cannot be applied because of shortage of staff. Thus, after a normal delivery, a woman is discharged within three hours. Complicated cases are referred to Livingstone general hospital 15 kilometres away. Birth control services are also offered. The clinic has three main methods of birth control; the pill, the injection called Depo-Provera and condoms. For children, an under five year's clinic is held monthly to check their growth and to give immunizations against some diseases like measles, polio and tuberculoses.

In the case of the youth or young people, the health centre indicated that they had no specific programs for them. The need for a reproductive education program was recognised by the health centre. However, it was stated that the health centre has no

capacity nor trained personnel to run such a program. No plans have yet been put up for a program in this line.

### 7.3.3 The health centre and Nene; collaborators in reproductive health?

Shortage of staff (the clinic has only two members of staff) and the country's policy on health for all has made the clinic to identify people in the community with whom to work with in the area of maternal and child health. A program designed by the Ministry of Health of Zambia which incorporates traditional midwifery in the running of primary health care runs at Kabuyu health centre. Nene and a number of other women volunteers have been identified by the clinic and are being trained under this program as trained traditional birth attendants<sup>25</sup>. This programme has been reinforced by a new program called the Safe Motherhood Initiative introduced after 1987. Under this program mothers are encouraged to have hospital deliveries and are discouraged from having home deliveries under traditional midwives that have not been trained by the health centre.

The main course under this program is to train the women in modern practices of midwifery. The emphasis is on hygiene and recognition of complicated cases to refer to a health centre. Cultural taboos especially on food and sex for pregnant women are discouraged. Physical monitoring of labour and keeping records of statistics are encouraged.

The kabuyu health centre has also included other aspects in the training of Traditional birth attendants. Recognizing the closeness of the traditional midwife to the community and to women in particular, they have given Nene another responsibility: that of providing support in family planning program. Her social standing in society and her already existing roles makes her an appropriate support for the mothers. The health centre has one main contraceptive in pill form micro gynone. The instructions on how to take the pill are supplemented with arrows to show how to take the pill making it easy for those that cannot read to follow the instructions.

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<sup>25</sup> This is how the traditional midwife is known after being trained under the ministry of health's training program

Another program that the clinic has involved Nene and women of her position in the area is the home based care for HIV/AIDS patients. The number of AIDS patients is not exactly known but it is very high. The health personnel attribute this to the common practise in Zambia where people who are terminally ill are taken to the village. The family as the traditional social security provides the support of looking after them. In addition, most people prefer to die in their birth place. This practise has meant that there are a lot of terminally ill people in Kabuyu brought from the cities. However, it has been difficult for the health care system to cope with long term illnesses that are common in AIDS patients with its limited staff and facilities. The community has been identified as a resource; hence the home based care system is encouraged. Nene is thus in charge of her village in the home based care. The clinic asks her to monitor those that are on long term drugs such as T.B or Anti- Retro Viral (ARVs), drugs. Her responsibility includes offering them support in terms of encouragement and reminders to take their drugs as per clinical instructions. This is considered important because most patients, not understanding the way the drugs work, stop taking medication when they feel better, making their situations worse.

In addition, Nene with the help of the young women have incorporated her traditional duty of visiting the sick in the village into the program, such that it is not only HIV/AIDS patients that are on her list of responsibility, but all that are seriously ill. The program offers moral and social support to those that are ill and their families. Under the supervision of Nene, the women identify ill people and what kind of social support they need. The support offered ranges from encouragement, performing challenging tasks in the family of the sick such as drawing water, getting fire wood or taking care of the children; to assistance to get to the medical centre in terms of transport or calling the attention of the clinic to reach the ill. In this way the clinic has been able to reach those that are far from it and also has been assisted to take care of ill people in ways that the health system is not able to.

#### 7.3.4 Summary

This chapter has focused on other people that are involved directly or indirectly with the midwife in her service. The chapter has looked at the women, the young people and the clinic that in one way or another make use of the traditional midwife. Addressing the question; Is the midwife acknowledged as knowledgeable by those in the same field, or by the general populace? The chapter has presented data on why, how and when these people and institution utilize the traditional midwife, providing an insight in which the young women see her as a complimenting the services of the health centre which cannot address all their health problems; while the teenagers acknowledge her as the sole provider of the reproductive health issues in the community; and the health centre recognise her labour as necessary considering their shortage of manpower to address the health problems in Kabuyu.

## **Chapter VIII Data Analysis**

### **Part I**

#### 8.0 Does the Traditional midwife know?

This section will address the research question: Does the traditional midwife know? to explore forms of knowing in the Toka traditional midwifery. The section is divided into two particular fields of knowing. These are theoretical and the physical forms of knowing.

#### 8.1 Nene's Theoretical Knowledge

Traditional midwifery is associated with a lot of “beliefs” and “myths”. However, in the Toka society, the so called “beliefs” and “myths” are a reality. In fact knowledge in the Toka terms does not separate belief or myth from practical. It is all and one thing because, what becomes practical originates and makes sense from the “belief” or “myth”. To have no such background is equal to have no knowledge at all. The data analyzed herein will be questions that address the explanation and sense of the “beliefs” and “myths” associated with traditional midwifery.

Knowledge of the Toka cosmology and interpretation forms the back bone of traditional midwifery. It encompasses all that traditional midwifery among the Toka is all about i.e. morals, traditions and humanity or life in Toka terms. This is illustrated in the story of life from which all that the midwife does makes sense and has an explanation and meaning. For instance the ability of man to transform himself from spirit to body and vice versa through reproduction and death explains the sense of life and death that this midwifery deals with. This transformation is a reality in Toka midwifery.

Berger et al (1966) in his definition of knowledge points out that what is real in one society may not be real in another. They explain that knowledge and reality are justified by the fact of their social relativity, and that knowledge arises in the relationship between

human thought and social context bringing about the relativity of specific historically and socially located viewpoints. Thus, human knowledge is explained as becoming available to a society priori to individual experience. (pp.13)

Given this back ground Nene's world view point makes sense. It is given as it was experienced. For instance when she explains the totemism to the children she says "my ancestors' blood was related to Mudenda and so they became known as such." (this thesis p.42). It is the priori experience that explains what she knows. She also mentions the act of incest as a bad result for the society which may have "weak" children that will fail to ensure the continuity of life. This knowledge also is based on the experience of society and is passed on to the young as knowledge.

However this thesis is concerned more about contextualized knowledge. Nene's story of life brings out what Berger et al (1966) call the "socially located view points". For Nene, the physiology of a woman's body is exactly as that of the earth. The more she knows and understands the earth's physiology, then the more she knows woman. Such a viewpoint might not make sense to other people in different societies and maybe regarded as myths, but for Nene and the Toka society, they are real and therefore they are part of the society's body of knowledge. Having such knowledge, women of Nene's status are regarded as knowledgeable in the Toka society and are entrusted to transmit the society's world view points to the young to ensure its survival and continuity. That aside, the term Nene is in it self is acknowledgement of knowledge in the Toka society. For age (which means more of experience than the number) is also equivalent to knowledge. Thus, in Toka society the traditional midwife does know.

Nevertheless, what the traditional midwife knows in Toka Society need not be recognized as knowledge only by the Toka society. Situated knowledge theory argues that all forms of knowledge are situated and as such no one knowledge need be elevated as universal knowledge. Recognizing other society's and minority groups such as women, working class or indigenous people's knowledge will open space for communication between different kinds of knowledges and their producers thus, offering a better understanding of

reality(Engelstad 2005). Dalmiya and Alcoff's theory of epistemic discrimination puts it better(Alcoff 1993). They state that contemporary epistemological theories have developed definitions of knowledge stipulating justifications that other systems of knowledge cannot meet hence, are not considered as knowledge (p.217). Therefore, the Toka way of knowing should not be limited and excluded as "myth" or "belief" just because they do not meet the so called "justification" (which Alcoff et al say is to be propositional.), to be recognized as knowledge systems. If they represent the reality of their society, so then they should be considered as knowledge.

#### 8.1.1 Nene's practical knowledge

Traditional midwifery also uses concrete or practical knowledge which as explained earlier stems from the theoretical knowledge. The questions being addressed are: does the Traditional midwife know? If she does, what does she know, and how; is it by coincidence that only women are midwives among the Toka? To address these questions I will analyze data that is presented in what I call the practical knowledge of this field. Addressing the question "what is knowledge" Lehrer (1992) says "the first condition of knowledge is that of truth" (p.9). To help me answer the questions in this section, I will analyze Nene's practical knowledge to see if it meets the condition of knowledge i.e. Truth.

Nene mentions the importance of the energy of the moon at birth (P. 50 of this thesis).Although from a Christian point of view, Gaskin (Gaskin 1978) also talks about spiritual energy based on observations made on 780 birthings. She says "we have found that there are laws as constant as the laws of physics, electricity or astronomy, whose influence on the progress of birthing cannot be ignored" (pp.282) She describes a pregnant woman as an elemental force in the same sense as hurricanes, gravity or thunderstorms. She further states that a midwife should know and understand the energy of childbirth as "not to know is to be like a physicist who doesn't understand about gravity". (p.282)

Nene claims that a well supported labour can be pleasurable. Maimbolwa in her randomized control trial, (Maimbolwa 2004) noted that mothers who were given social support during labour said they had “enjoyed their birth experience”(p.6) This view is echoed by Langer (Langer 1998). She noted that women that were socially supported by a “Doula”<sup>26</sup> during labour in a clinical trial showed satisfaction, self esteem and their perception of the reproductive experience improved. (p.1057)

Intuition is another form of knowledge that Nene recognizes and uses. Writing on intuition, Davis-Floyd et al (Davis-Floyd 1997) defines it as “the act or faculty of knowing without the use of rational process...” (p.317) He makes observations of intuition based on data he collected from twenty two white middleclass American midwives who acknowledged intuition in their practices. He notes that within the midwifery community, intuition does count as knowledge. (p.336). Nene points out that intuition is not something taught but learnt through experience (p.53 of this thesis). Alcott’s theory of epistemic discrimination identifies experiential knowing as one of the knowledges that is being discriminated. They argue that such kind of knowledge should not be discriminated just because it does not meet the criteria of propositional form of knowledge.(Alcott 1993)

Nene states that only those who have given birth before are allowed to give support to a birthing mother. She questions, “How can one give meaningful support to a person who is in a position that they have never experienced?” (P.46 of this thesis) Gaskin, (Gaskin 1978) expresses similar sentiments. She says that a woman, who has had a child naturally, tends to be in a better position to support a labouring woman (p.284). Alcott et al (1993) in their theory of epistemic discrimination support this view by illustrating it in a concept they call experiential knowledge. They describe it as “Knowing what it is like to be an organism “x” experiencing “e”...” which is based on personal experience such that to grasp “e” one needs to be “x”. This is what they call the “point of view” that is

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<sup>26</sup> Doula is a word referring to an experienced woman in child birth that provides support to women in before, during and after child birth. Langer, 1998, p.1057

only accessible to those who occupy that kind of view. Thus, we could be talking of some gender-specific subjective facts that are not accessible to subjects who are not of that gender or indeed who have never experienced the subject (p.217). Thus, with this analysis, I assume that it is not by coincidence that only women are accepted as midwives by the Toka and only those who have had children themselves. Such that the knowledge that they poses is exclusively women's. Hence to exclude such kind of subjective knowledge from the body of knowledge is epistemic discrimination.

Nene indicates that support for the mother does not end with birth. Support is also extended to breastfeeding as breast feeding in Toka tradition is considered as very important in child health. She states that breast feeding is good food for the child, but it is good for many other things like attachment and security (p.50 of this thesis). Grant (1998) in his research in Mexico on support during labour and in breast feeding makes the following findings:

”support in the immediate post partum period increases breast feeding by ameliorating the mother's emotional status..., helps mother child bonding and reduces anxiety and depression in the first weeks post partum”(p.1057)

Nene also claims that child spacing is good for child survival, such that it is taboo to conceive early in the Toka tradition. It is known in medical circles that the health of women and children deteriorate in close birth intervals. In fact infants born less than twenty four months after the previous child have a greater risk of dying before the age of five(Johansson et al 1997).

The data analysis here indicates that what Nene knows is the truth going by the findings of other people in the field of midwifery and obstetrics. Space limitation of this thesis does not allow me to explore other things that can be proved as knowledge using the criteria of truth. Thus fulfilling Lehrer's condition of knowing knowledge, Nene's know how is identified as knowledge, answering my research question that she does know.

## 8.2 Summary

Divided into two sections, this chapter has tried to find out if Nene knows by exploring her theoretical practices as well as her practical practices. Using the Berger's (1966) definition of knowledge, the chapter has demonstrated that what are commonly referred to as "beliefs" and "superstitions" in other societies are actually real in Toka society and thus qualify as knowledge. At the same time, using situated knowledge theory it has been shown how this knowledge should be recognised by other societies other than just the Toka. The second section on the practical knowledge of traditional midwifery, Lehrer (1990)'s way of testing knowledge has been used to check if what Nene knows is knowledge. Thus, Nene's practices have been compared to studies and research in different parts of the world that demonstrate most of her practices to be true.

## **Chapter XI: Second part of data analysis**

9.0 Is the Traditional midwife recognised as knowledgeable by those in the same field (i.e. reproductive health)?

Having shown that Nene possesses knowledge, this part addresses the research questions: Is traditional midwifery recognized as knowledge by those in the same field; can different knowledge producers and different ways of producing knowledge communicate and allow for exchange and complimenting each other? The part will analyze data collected from the Kabuyu health centre.

Feminist critiques in development (Parpart 2000) argue that some development theories identify indigenous institutions and attitudes as a contributing factor in hampering development in Africa. What is the case in the integration of traditional midwife which is a relatively new development? I will use this theory to see how Nene's knowing is viewed in this development.

Data indicates that Nene's system of knowing has been identified as a threat to the development of safe motherhood in the programme initiated at the clinic. The fact that the program for safe motherhood initiative's main campaign is that of mothers to have hospital deliveries and not home deliveries indicates this. In addition, those who wish to be delivered at home are discouraged from being delivered by the traditional midwives that have not been trained by the health centre. This shows that the traditional midwife's way of knowing is not part of what is known as safe motherhood. To ensure that those that stay at home also have a safe motherhood, the training of traditional midwives in modern practices takes centre stage. Under this program it is the traditional midwife (the problem to a safe motherhood) that needs training and not the health personnel. The training has a number of positive aspects to birth such as hygiene and the keeping of records. However, the idea of replacing one system by another points to the fact that the replaced system is a problem, thus needs replacement. Traditional midwifery has its own

system of giving birth, some of which have been identified by research as helpful in labour such as squatting or kneeling while the modern system of lying on one's back has shown not to be helpful (Arvidson, 1998, p.44). Regardless of such evidence, the midwives are discouraged to use their system which has been identified as a threat to maternal and child health.

Noticeably are the discouragements on cultural taboos such as food and sex in traditional midwifery. Nene explained that the foods excluded are those that make the child too big and thus difficult to deliver. However, my research could establish anything on this. Another aspect is sexual taboos. Pregnant women and their partners are discouraged to have sex just before birth and a few months after birth. Before birth, it is explained as spiritual in the same way people fast in a state of prayerfulness for serious matters. Birth is regarded as a very serious matter and a state of prayerfulness is demanded by the midwife. Whether this is positive or not my research could not find an answer. However, sex taboo after a birth has some revelations. In traditional midwifery it is taboo for a couple to engage in sex at least three months after a birth. This is discouraged in the training of traditional midwives by bio-medics, stating that the couple should be left to decide what to do. On the contrary, Lugina(2001) states that studies have established that sex in the first 6-8 weeks after birth is not appealing to women because during this period the walls of the vagina are thinner, there can be vagina dryness and sexual arousal is physiologically reduced. She also adds that emotional liability after birth can affect sexual interest and enjoyment. (p.11&60).

Furthermore, the midwives are discouraged from depending on nature, but are encouraged to intervene during birth. This is against traditional midwifery that largely encourages natural birth and only calls for intervention in complicated circumstances. David-Floyd (2001) demonstrates that natural birth is a safe way to deliver. She points out that the very nature of intervention can harm birth (p.5)

This data demonstrate that the traditional midwifery has been identified as hampering development in reproductive health. This is well put by Fleming (1994) when she states “traditional and cultural practices of unschooled, indigenous attendants<sup>27</sup> have been alleged to compound, or even create problems” (P.143) in maternal health hence, the justification to train them. The training will introduce modern practises and prohibit them to observe what is called “superstitions and myth” (Maimbolwa (2004:p.11), which she claims displays their lack of knowledge.

Feminist critiques in development (Parpart 2000) state that by assuming that these institutions and attitudes constrain development, then neoclassical theorists of development place women’s way of knowing outside the concept of development. Using this theory I will analyse data to see if Nene’s way of knowing has been placed outside the development of integration at kabuyu health centre.

The fact that some ways of knowing have been identified as hampering development in midwifery even when studies show the contrary as demonstrated above, shows that it has been placed outside the development of the integration in midwifery. However, data further indicates that not only has the ways of knowing of traditional midwife been placed outside the development of the integration of midwife, but the traditional midwife herself has been placed outside the concept of development. The fact that the very aspect of training traditional midwives has been taken over from her by the clinic, demonstrates this. The clinic is not working together with Nene to train the upcoming midwives in the community but even identifies those trained outside the clinic program as “untrained” and not recommended for women to consult as they are identified as dangerous to maternal health. Furthermore, her position has been reduced to birth attendant. Under the training program, the traditional midwife is no longer a midwife but a “trained traditional birth attendant (TBA), the terminology that is now accepted in the integration programme.

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<sup>27</sup> Meaning traditional midwives.

This is not surprising because data indicates that the knowledge that the ministry of health is passing on to traditional midwifery in the training program is mainly limited to birth. The knowledge of birthing is the main part that is being highlighted in this training leaving out things like prenatal care, post natal care, sexual and reproductive health that traditional midwifery deals with. In fact even if the traditional midwife has been identified as an ally in primary health by WHO, the traditional midwife is recognized as “unskilled” birth attendant, even after being trained as a TBA.(Maimbolwa, 2004,p.8) This shows that what the traditional midwifery knows is being discriminated against in what Alcott et al (1993)’s theory can be called epistemic discrimination which excludes other forms of knowing that are not accepted by the universal homogenous definition of knowledge(pp.217) and is being placed outside the concept of development in midwifery.

9.2 Are the two different ways of producing knowledge communicating and allowing for exchange and complimenting each other in the integration program?

The theory of situated knowledge argues that for meaningful development to take place it should be accepted that all knowledge systems are situated because it is a prerequisite before different ways of producing knowledge can communicate and allow for exchange and complimenting each other. The data in this section indicates that there is not a meaningful exchange or communication between the modern knowledge and the traditional knowledge despite their cooperation. Communications seems to come from one end-the ministry of health-and only what the ministry decides is to be communicated to the traditional midwife. The training program of traditional midwives to “trained” birth attendants is limited to passing what knowledge the health system thinks the traditional midwife needs to know and not vice versa. The health system knows very little about traditional midwifery or it has decided to ignore it all together. This is expressed by Maimbolwa a trained midwife in the Ministry of health:

“My experience at Zambezi hospital was totally different from what I had learnt during my midwifery education...I asked myself, why did labouring women...not come to deliver at the maternity units? ...This (traditional midwifery system), perplexed me because during my training, I had not been taught this aspect of midwifery care and did not know how to cope with labouring women’s family network...The traditional

medicine issue was not even addressed at the midwifery school. Hence these issues put me in an awkward position, as I did not know how to handle the situation” (Maimbolwa, 2004, p.3)

Lack of knowledge exchange can also be sited in the family planning programs. In the family planning program Nene has only been trained as a support, such that even if she knows so much about child spacing in the traditional aspect, in the pill aspect she has not so much knowledge. During my interview Nene stated that she was ignorant, but suspicious on some negative effects of the family planning medication on the women, even if she appreciated its availability. Johansson et al (1997) state that Zambia, since the 1970s has been a site for clinical and introductory trial of contraceptive method currently available on the market (p.46). Such information is not communicated to Nene as a support person for the program. Changes and withdrawal of contraceptives are not properly explained<sup>28</sup>. This leaves Nene in a state of ignorance on contraceptives. In the same way, the health system does not get a feed back from Nene about the effects of the contraceptives. She has observations about the possibility of the contraceptives to affect the milk production in breast feeding mothers, abnormalities in reproductive health such as excessive bleeding during birth and prevalence of oedema in pregnant mothers which she has no forum to present to the health system. In addition, data demonstrates that Nene’s system of reproductive health involves both partners to a large extent. On the other hand the ministry’s approach is toward women only excluding men (Arvidson, 1998, p.47). Arvidson notes that for this reason there is a tendency of men in Zambia refusing their wives to take contraceptives. Yet the Ministry of Health fails or ignores the traditional approach in which Nene involves both partners and thus, men cooperate even in difficult demands such as sexual taboos concerning birth.

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<sup>28</sup> During my visit the pill given to women by the clinic for many years called Microgynon was suddenly withdrawn and replaced by Oralcon-f. I was informed by some women that when they had gone to collect Microgynon, were told it had been stopped because it was not good and they were asked to start taking Oralcon-f. The health centre confirmed to me that they had been instructed by the authorities within the ministry of health to withdraw Microgynon and introduce Oralcon-f. The health personnel gave me no reason for this change. Nene as a support person in the family planning program was not informed about this development.

Thus, data makes it clear that the partnership between the health centre and Nene is not one with meaningful exchange of knowledge. She is involved as labour since the health has not got enough to cover its obligations. Data shows that the health centre is desperately in need of staff as it has only two staff for a population of 5000. This data correlates closely with Hjortsberg (2004) who says that for every trained nurse there are 6000 inhabitants. This means that Nene remains an ally for the health centre as long as there is shortage of personnel and facilities in the ministry of health and not as a recognized knowledgeable partner worth of exchanging notes with.

## **Part II data analysis.**

### 9.3 The Present and the future for traditional midwifery

This section will address the research question: Traditional midwifery being traditional is it recognized as knowledge by the general populace? In this case the young women who form the present nursery for training of traditional midwifery and the teenage girls who form the future nursery; and both of which form the main clientele of Nene.

9.3.1: Is Nene's knowledge acknowledged by the young women? The present situation of traditional midwifery.

Feminist critique in development theory (Parpart 2000) argues that some development theories identify indigenous institutions and attitudes as a contributing factor in hampering development in Africa. What is the case in the integration of traditional midwife which is a new development? I will use this theory to see how Nene's knowing is viewed by the young women under this development.

Data shows that under the development of an integrated system in reproductive health, the women choose to utilise both systems. The interesting point is that they acknowledge both systems weaknesses and strengthens and make choices based on that. For instance,

all of the women I talked to chose to use Nene in the postpartum<sup>29</sup> which include breastfeeding and child spacing. This kind of care is the weakest for the health care as they do not provide for it. Writing on Tanzania, Lugina (2001) observes that modern midwives have inadequate knowledge and skill in postpartum care which is attributed to the nature of their training (p.58). This could be true about Kabuyu health centre where the postpartum care is non-existent.

Another strong part that the women recognise in Nene is the actual giving of birth. More than half of the women I interviewed choose to give birth with Nene's assistance. The reasons they gave such as the free birthing position, no episiotomy and the social support provided by Nene have been shown to ease labour. Maimbolwa (2004) in her randomised trial demonstrated this fact. (p.41). Meanwhile, the modern delivering system which is also practiced at Kabuyu Health centre does not have provision for these practices.

However, the strong part of the Health centre services such as the family planning programs is highly utilized as compared to the traditional midwifery that is not so strong in this area. The strength of the health centre lies in the readily available medication in form of the pill and injection.

Meanwhile the antenatal care gives a better picture of how the women make use of the strengths and weaknesses of both systems. 13 out of 15 the mothers interviewed, utilise both systems at the same time. The reasons given were that the two systems (Nene and the health care), supplement each other. They receive medication such as ant malaria tablets and iron tablets from the clinic which they can not get from Nene. Yet they receive the physical and psychological preparation from Nene that the health centre does not offer.

Thus, the data demonstrates that Nene's knowledge is recognised by the general populace in this case the women. However, this data further demonstrates that they have only acknowledged the strong features of traditional midwifery such that it is no wonder then

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<sup>29</sup> Following birth

that 60-80% of the world's babies are delivered by traditional midwives (Fleming, 1994) and 46% of Zambian women still prefer to use the traditional midwife (Maimbolwa, 2004). This data further indicates a real integration of the two systems by the women's choices in a way perhaps that even the Alma Alta conference could not have foreseen.

9.3.2 Is Nene's knowledge acknowledged by the young people? A look at the future of traditional midwifery.

This section also addresses the question is traditional midwifery acknowledged by the general populace, in this case the young people? The section will analyze data collected from interviews and conversations with the young people.

The theory used in this section is situated knowledge. Engelstad et al (2005) argues that for any meaning full development to take place knowledge production should be situated in a particular context since all knowledge production is situated. This they argue, gives room for the exchange of knowledge between different knowledge systems.

Data demonstrates that the young people are exposed to two different kinds of knowledge; traditional knowledge from Nene and academic knowledge from the school system. Data further shows that the young people do acknowledge and seek Nene's knowledge in reproductive health and culture, but the pursuit of academic knowledge which is only begotten in schools, hinders their hope to be the future Nines. The school system does not only exclude the traditional knowledge but it also removes them from the context in which they could learn Nene's trade if they are to become future traditional midwives. This demonstrates that the two knowledge systems to which the teenagers are being socialised in have boundaries between them with doubted communication. Carmody (2004) notes that the educational system in Zambia is highly academic or "bookish", while the traditional way is highly practical.

The effects of lack of exchange and communication between the two different ways of knowing have already started showing its weaknesses in the socialisation of young

people. Carmody (2004, p.131) notes that the advent of HIV/AIDS has confronted the education system in Zambia. It has been acknowledged that there is a strong linear relationship between the level of education and HIV infection, rising from 8.0% with a maximum education of 4 years to 33% for those with 14 years of education or more. It must be observed that in rural areas like Kabuyu, the higher the education one wants to get the more likely one is to move away from the community since the local school only provides 9 years of education. Thus, most teenagers move away from the traditional midwife and her education which comprises of sex education. Those who do not go further with education remain in their community but their chances of staying permanently there are slim, considering that Kabuyu has land problems that cannot sustain the people.

Even if there is no clear evidence that the absence of the traditional midwife plays a role in the increase of HIV infections in young people, the possibilities are high. Arvidson (1998) states that HIV is most prevalent in urban settings than rural settings. (p.19). She explains that urbanisation and the transition from traditional to modern culture has given rise to new patterns of sexual behaviour in adolescents, including unprotected premarital sex, often leading to induced abortions, STDs and HIV infections. She states that adolescents themselves express concern about lack of information and understanding about their own sexuality (p.48)

The problem has been compounded by what Arvidson (1998) calls a lack of training in health workers on how to deal with adolescents. She notes that reproductive health in Zambia focuses on women in programmes like maternal and child health or the safe motherhood initiative, which cater only for women and exclude adolescents. (p47). Kabuyu health centre is no exception. Data indicates that not only is there a limited number of staff but the available staff have no training in this area. Arvidson (1998) attributes teenage pregnancies which account for 20% of all births in Zambia, to this problem. (p.21). She concludes by stating that reproductive health programs introduced in sub-Saharan Africa have failed to understand reproduction in a social context. (p.48)

This data shows that young people acknowledge Nene's knowledge. However, there is a problem in that knowledge systems to which these young people are exposed to are not situated in their context and thus, there is a lack of communication between the two systems. This poses a danger on Nene's knowledge as the continuity of her knowledge is hampered by modern system of learning which has no room for it. This problem is exacerbated by the fact that the modern system of education removes her nursery from her reach, since a greater part of this education is not made available in the local community. In addition, the very future of the young people and the Toka society is at stake. Even if the integrated system in the ministry of health intends to reduce infant mortality rate so that more children can be able to reach their fifth birthday, this is as far as the system can go. The system seems not to have a provision to ensure that these very children survive into adulthood, as the danger of death arises yet again when they become sexually active. This is unlike traditional midwifery that does not only promote the growth of infants, but also of adolescents and young people into adulthood, marriage, birth and parenting, to ensure the continuity of the Toka society.

### 9.3.3 Summary

The chapter has also explored the way Nene's knowledge is perceived by other people such as those in her field (the health centre), the general populace that comprised of her main clientele; the young women and the teenagers. Using the Feminist critiques theory on development, data on the study of women indicates that they recognised Nene as knowledgeable. But their recognition is selective to those aspects that they experience as the strong parts of Nene's knowledge such as the physical and psychological part of antenatal care, childbirth, postpartum care, breast feeding and child spacing. To fill up their other reproductive health care needs, they turn to the health centre. And this is in the medical part of antenatal care and birth control pills popularly known as family planning.

On the teenagers, this chapter has shown that the teenagers recognise Nene's knowledge in reproductive health and cultural knowledge that concerns them. They showed interest in becoming the future Nene, but they expressed concern over their pursuit of another

kind of knowledge in the education system of the country. Using the theory of situated knowledge the study demonstrated that Nene's knowledge and the education systems knowledge that are being used to socialise the teenagers do not communicate and there is no exchange of ideas such that the teenagers are left with a fragmented kind of knowledge. This has led to problems in their sexual and reproductive well being.

The health centre's perception of Nene's knowledge is studied using the theory of feminist critiques in development. Thus, the study finds that even if Nene's labour is appreciated by the health centre in areas that it cannot address such as homebirths, postpartum care, support in family planning programs and home based care for AIDs patients; the health centre identifies Nene's ways of knowing as dangerous to the development of a safe child birth and are placed outside the concept of this development. Thus, in order to tap Nene's labour a training program in modern midwifery has been established for her and women have been advised not to be attended by anyone who is not trained by the health centre, showing that Nene's knowledge is not recognised

## CHAPTER X: CONCLUSION

### 10. Summary of research topic

This thesis uses concepts and theories on Knowledge and development to explore traditional midwifery as a knowledge system. It is addressed within a framework of a program whose aim has been to merge two different knowledge systems- bio medical and traditional medicine- in an integrated program that has a goal to find a way to provide health for all. The program called the integration of traditional midwife with the health system offers a forum to explore two knowledge systems put together for a common cause. However, this arrangement also offers a conducive environment that brews up questions on how different knowledge systems can be perceived. In order to examine what and how knowledge is perceived especially if it is different from what is known as “universal” or “western” knowledge a research at Kabuyu in Chief Musokotwane’s area among Toka people of Southern Zambia was carried out. The focus was the experiences of one traditional midwife with the people and institution around her. The thesis has been guided by the following research questions:

- 1 Does the traditional midwife know and is traditional midwifery knowledge? Is it by coincidence that only women are midwives among the Toka?
- 2 If she knows is her knowledge acknowledged by those in the same field, or by the general populace? How are her practices perceived?
- 3 Has alternative or different experiences and ways of knowing been taken in to account when integrating two different systems in the case of traditional and modern midwifery?

#### 10.1 Summary of the main findings

This study found out that traditional midwife among the Toka holds two kinds of knowledge that are a part of each other: the theoretical knowledge that comprises mainly of what is commonly referred to as "superstition" and "beliefs"; and also the practical knowledge that is mainly applied physically. In the theoretical part the study uses Berger et al (1966) definition of knowledge in which he explains "socially located view points" to demonstrate that the so called "superstitions" and "beliefs", are a recognised knowledge among the Toka. Nevertheless, conforming to Situated knowledge and epistememic discrimination theories, that denounces the assumption of a "universal" knowledge and the recognition of other kinds of knowledge respectively, this study justifies the recognition of this kind of knowledge by other groups of people and not only by the Toka or women.

On the practical aspect of traditional midwifery, the study used Lehrer (1992)'s condition of recognising knowledge and that is "truth" (p.9). Therefore what Nene claims to be true in her knowledge such as the moon energy, intuition, social support given by women only and child spacing. Using other research studies conducted on these aspects, to test Nene's claim, this study finds that her claims are true on the practical aspect of traditional midwife are true. This truth is based on the findings of other researchers on some of what Nene's practices.

This study also found out how Nene's knowledge is perceived by other people such as those in her field (the health centre), the general populace that comprised of her main clientele; the young women and the teenagers. Research on the women indicates that they recognised Nene's as knowledgeable. But their recognition is selective to those aspects that they experience as the strong parts of Nene's knowledge such as the physical psychological parts of antenatal care, childbirth, postpartum care, breast feeding and child spacing. To fill up their other reproductive health care needs, they turn to the health centre. And this is in the medical part of antenatal care and birth control pills popularly known as family planning.

On the teenagers, the study has found that the teenagers recognise Nene's knowledge in reproductive health and cultural knowledge that concerns them. They showed interest in becoming the future Nene, but they expressed concern over their pursuit of another kind of knowledge in the education system of the country. Using the theory of situated knowledge the study demonstrated that Nene's knowledge and the education systems knowledge that are being used to socialise the teenagers do not communicate and there is no exchange of ideas such that the teenagers are left with a fragmented kind of knowledge. This might have led to problems in their sexual and reproductive well being. This is demonstrated by studies by authors like Carmody and He on young people's problems in Zambia such as HIV and teenage pregnancies.

The health centre's perception of Nene's knowledge is studied using the theory of feminist critiques in development. This theory claims that some developmental theories identify indigenous systems as hampering development therefore; indigenous people's ways of knowing are placed outside the concept of development. With this theory, this study finds that even if Nene's labour is appreciated by the health centre in areas that they cannot address such as homebirths, postpartum care, support in family planning programs and home based care for AIDs patients; the health centre identified Nene's ways of knowing as dangerous to the development of a safe child birth and were placed outside the concept of this development. Thus, in order to tap Nene's labour a training program in modern midwifery has been established for her and women have been advised not to be attended by any one who is not trained by the health centre.

## 10.2 Answers to my research questions

In view of the above findings the answers to my research questions are

- 1 The midwife does know and traditional midwifery is a knowledge system that is exclusively women's knowledge among the Toka as it is mainly based on experiential kind of knowing.

- 2 Women consider the traditional midwife knowledgeable in certain areas of reproductive health such as physical and psychological antenatal care, child birth, postpartum care, breast feeding and child spacing. The teenagers also acknowledge the traditional midwife's knowledge in reproductive, sex and cultural education. On the other hand the medical professions regard the traditional midwife's knowledge as dangerous to safe child birth and thus recommend her training into modern midwifery in order for them to use her labour.
  
- 3 In the integrated system, knowledge is not situated such that modern midwifery is taken as the "universal" knowledge. Thus, there is no exchange and communication between the traditional midwifery and bio medics. Boundaries exist.

### 10.3 Points to note.

In regards to the findings of this study, my point is that the study has disputed the saying that "Knowledge is power" (Crush 2003), and demonstrated that sometimes knowledge is not power. However, this study has proved Crush (2003)'s argument that power decides what knowledge is and what not knowledge (p.5) is. For even if Nene does know and her main clientele (women and teenagers) do recognise her knowledge, the policy makers do not. In the integrated system, it is her manpower capacity that is recognised and acknowledged, not her knowledge.

Another point is that, this study has shown that Alma- Ata conference (1978)'s dream of "health for all", by integrating traditional medicine with bio medics has seen a suppression of an indigenous way of knowing; which is the traditional midwifery. Although the idea is good the approach has not been, at least among the Toka of Zambia. The traditional midwife has been transformed from the respected knowledgeable position

that she holds in her society as a midwife, and reduced to un-knowledgeable position of birth attendant in the integrated system.

#### 10.4 Concluding remarks

To situate knowledge will mean to accept other societies and minorities such as indigenous people, lower class people and women's knowledge. This will end discrimination of knowledge on the basis of their producers. It will instead enrich policy, planning and development with knowledge that will address issues at local level.

Taking traditional midwifery as an example, indigenous knowledge does hold a kind of knowledge that is rich and relevant to the local community. To sideline such kind of knowledge will certainly endanger some useful knowledge systems. For poor countries like Zambia and places like Kabuyu, such a loss can be tantamount to further underdevelopment, and a creation of yet new and more challenging problems ( as has been the case with HIV and teenage pregnancies).

In search of a safe child birth care, Zambia has conformed to the change from home to institutionalised birth. But ignoring local knowledge, policy makers have pushed for a complete transformation to ensure safe motherhood. However, the country's economy and training system has failed to meet the demands of its people. As this study demonstrates, this transformation does not provide a complete answer to local peoples' needs. The revelations of the midwife's main clientele (women and teenagers), provide a picture of what and how an integrated system can become meaningful to the local people. It shows that no one knowledge system can provide for all their needs. But that communication and exchange of knowledge can lead to a new but much better knowledge system.

#### 10.5 Suggestions.

I would like to point out that the theory of situated knowledge, much as it is important in

issues as the one discussed in this thesis, needs to be reinforced by what I will call “situated problems”. Meaning that problems should be analysed based on the local situation. This is because as much as people in general do face similar problems the world over, to solve them, the problems have to be situated in particular contexts to provide a realistic solution to particular people and then, can the situated knowledge be applied.

Furthermore, it has been suggested before that planning of health should consider the cultural norms of local people such as language, the way they view illness and other such cultural aspects(Kleinman 1980; Gaski 1997). However, this is not enough. Local knowledge should also be identified, explored and where it applies put to use for any sustainable development to take place. As Mammo (Mammo 1990) points out, development efforts that are applied by scrapping the old systems and introducing completely new ones without any appropriate continuity from the past, have contributed to Africa’s poverty and underdevelopment. (p.181)

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**Conversation with Nene, on reproductive health. Kabuyu, Zambia. 15<sup>th</sup> July 2005**

My question (Q): How do you know that the pill (microgynon) is the correct type for each woman?

Nene: Nobody knows until you feel bad after taking them. The nurse says I should advise such women to stop taking the pill and refer them to the clinic.

Q: But now Bina Bombo says it (microgynon) has been banned because it is bad, what are you going to do?

Nene: I have to find out tomorrow at the clinic. But I am worried. How can they say that it is not good? Many mothers have been taking it for years. I am afraid for the young mothers. I don't trust these pills. I have always been suspicious. These days we have a lot of complications. There is the problem of nursing mothers milk drying. You can try all you know but the problem does not go away. I ask myself, what is wrong?

Q: But does the milk really dry up?

Nene: Not completely, but the production is less and the child is always crying and hungry. I have seen it in many women. When they stop taking the pill, the milk is okay. Then some women develop heavy bleeding, I can not deal with that. I do not know what to do. They have to go to the clinic. All the same, the pill is good because it is readily made and available unlike traditional medicine which we have to prepare from Scratch. It is just the information that we do not have about the pills, so it is difficult to determine how good and reliable it is for our mothers. One moment they say it is good, another moment they say it is bad.

Q: Has any medicine been cancelled in this way before?

Lovina: Oh yes. In my time...around the 1970s Depo- Provera was introduced and then cancelled.

Q: What was the reason?

Lovina: We were just informed that it was bad. But you should have seen the way they campaigned at the beginning to make us take it. They said "no need to swallow pills everyday, just one jab and you do not have to worry for the next three months". Then after a while it was banned.

Q: Do you mean it was stopped? I used it in 1996.

Lovina: Yes, I was also surprised to see it reintroduced. Now they say it is okay again. Don't ask me about these pills and medicines I do not have answers, all I have is worries for you young ones.

Q: But apart from the pills from the clinic, how can mothers prevent pregnancy?

Nene: Exclusive breast feeding up to 6 or 8 months depending on the "back" (fertility) of a woman. When the baby breast feeds a lot, the "Stomach", (womb) rejects the "seed" (sperm). But when the baby grows and is eating other food, you need to combine breast feeding with medicine. We use this medicine with food until the child is able to walk and eat on its own, then you can wean the child and prepare to have another one. If you do not want to have a child so soon, you can prolong breast feeding or use stronger medicine. But now, there are pills from the clinic which women can take. But there some like Bina Celo, she is catholic and she follows my instruction on breast feeding. She does not take the pill. Others just want to try different things and they try the traditional medicine and also the pills. For some, it is the fear of milk drying up that makes them come for traditional medicine

Q: But is spacing children good?

Lovina: Very good. It makes the child to grow well. It is taboo to conceive before the child can walk and feed itself. If a mother does that, the baby will be sick, because the milk will become bad milk.

Q: How does it become bad?

Lovina: When a mother conceives, she stops producing good milk because of the other one growing inside, so the child will suffer from "Masoto". This is a bad disease especially if they child cannot eat a lot on its own. In most cases the child dies. The one in the womb can also be affected, because the mother's body cannot provide for it properly. In this case I normally try to avoid this by emphasizing to the parents not to conceive before the child is able to eat lots of food and walk. This age is about 2 years. But for some children it comes early or late. During this time the mother feeds on foods that increases the production of milk like "Munkoyo" (a fermented but non alcoholic drink) and fermented porridge. She also has to drink lots of milk if they have cattle. The traditional medicine to stop pregnancy is administered through the fermented porridge. Nowadays, couples have a choice whether to use pills or my medicine. They know how

important it is have good space in between. I counsel the couple during pregnancy and when the child is born about this.

Q: What happens if a mother conceives in the prohibited period?

Nene: If the born child is in good health and can eat well, I recommend weaning the child so that the mother's body can concentrate on the unborn child. The weaned child is put under good diet which I personally monitor in conjunction with the couple and their parents if there are nearby. In this situation the mother needs a lot of support or else we could lose both children. But if the born child is too small to be weaned, abortion can be we considered

Q: So you consider breastfeeding very important?

Nene: Yes, it is not only good for spacing children and as good food for the child, but it is good for many other things. At birth the child is more of a spirit and less a human being. Breast feeding makes the child to develop well into more of a human being. In the womb the child has been connected to the mother by the umbilical cord and comforted by the placenta, but when it is born, it is detached from these things leaving the child un attached and afraid. The breast then takes the place of the umbilical cord and connects it to the mother and the child feels safe. So our tradition demands that a mother should give the breast to the child not only when it is hungry but even when it is in pain, afraid, tired or any other discomfort. The breast will make the child to relax because that is its attachment to reassurance of protection which the umbilical cord and the placenta had provided in the womb. The breast is also important to detect illness in the child. When a mother feeds the child frequently, she becomes aware of the child's normal temperature in the mouth. So when the child's temperature rises it is easy to tell from the breast. Breast milk is also good when the child is ill, because in most cases even when the child has lost appetite for food breast milk will be the last thing it will reject. So our tradition the child has a right to the breast and mother should feed on demand, any time any where in the first 6-8 months of life.

Q: In normal circumstances how do you wean the child?

Nene: If the child is big and strong, able to eat a lot of food on its own. By this I mean when a child begins to demand and show its own interest in food the family is eating; not when he is forced to eat. Then we can consider weaning. I instruct the mother to put

restrictions a bit by bit depending on the child's growth. This is the road to weaning, but not the actual weaning. After the child is walking and playing, then the mother can allow a lot of time in between feeds. The child should be encouraged to be with other children and left in the care of other adults like grand parents, aunties elder siblings etc. for longer hours. This makes it easy to wean the child. Some children just lose interest in the breast on their own if this method is used properly and consistently. This is not the same for all children. Normally sickish children will delay to walk and may not want to engage in play, so in such cases weaning is delayed. Again by tradition I do not allow weaning a child in the rainy season. This is because, the food is scarce in the village, and it is still in the ground (cultivated). Another reason is that there are lots of diseases during this period. The rain and the heat brings in bad air full of disease, especially diarrhea and Malaria. Children easily succumb to these diseases. The traditional calendar for weaning is in the dry, cold season. There is plenty of food during this time and the cold makes people eat a lot, so the child will have a variety of food to eat from and the cold will make it have an urge to eat. This is good because by the time the next rainy season comes in, the children are already weaned and are strong from the lots of food they had been eating and so they can survive the semi-hunger that is common in this part of the country in the rainy season.

Q: Do you counsel the couples also on how many children they should have?

Nene: Yes, but I am not like the hospital who teaches them on having a small family. I tell them the truth. They should have as many children as they can, for if they have a small number of children, it is either that the children will be over burdened to take care of them in old age or they (parents), will suffer of lack of no one to take care of them. This they can see for them selves here in the village. When you grow old, no one will take care of you, but your children. If you have one or two, how will they share the burden of looking after you considering that they too will be having families of their own, plus their parents in law? If the children are six or ten, there is a big difference, the burden becomes light and they are only too glad to care of you.

## Appendix 1

### Interview Guide

#### 1. Nene

##### Questions asked

1. Age, marital status, religion, number of children, family life, educational background
2. How did you become a midwife?
3. What is traditional midwifery?
4. How many pregnancies do you attend to per year?
5. Who are your clients?
6. How are you rewarded?
7. Do you train others in your trade?
8. What kind of cooperation do you have with the Health centre

The main Topics were **Conception, Pregnancy, Birth, after birth care, and collaboration** with the health system in the area.

#### 2. The young women

##### Questions asked

1. Age, marital status, religion, number of children.
2. Who decides the number of children you will have? Yourself? Your husband? You and your husband? Your family/clan? And why?
3. What kind of relationship do you have with Nene/ with health centre?
4. Who helps you during birth and where do you normally give birth? At home or at health centre?
5. How do you decide who is to help you in child deliver and where you deliver?
6. Do you use birth control methods? If yes what kind. If not why?
7. What kind of relationship do you have with the health centre?
8. What services do you appreciate from Nene/health centre

The main topics were **pregnancy, birth, after birth care, breastfeeding, birth control**

#### 3. The Teenagers

##### Questions asked

1. Age, educational background
2. Do think it is necessary for you to receive sex education/ reproductive health care and education?
3. Do you receive any kind of sex education, reproductive health?
4. If answer to 2 is yes, where, how and by who?
5. If answer to 2 is No, why?
6. What kind of relationship do you have with Nene?

7. Is Nene's trade necessary to you? State why.
8. Can you be a future Nene?

Main topics were **sex education, culture and tradition, reproductive health, general education, the future.**

#### **4. The Health centre personnel**

Questions asked

1. Position at the health centre
2. Coverage area of the health centre
3. Population in the coverage area
4. Population of women, children under five years and Teenagers?
5. Any specific services for family and reproductive health?
6. Any specific programs for children and the youth?
7. Services the health centre offers to the community
8. Is the health centre involved in the training of traditional midwives in the local area?
9. If yes to 8. What kind of training is offered? What is the subject matter in your course?
10. If answer is No to 8. State reasons. Any plans for such a program in future.
11. What kind of relationship exists between the health centre and Nene?