© Kamla-Raj 2014
Ethno Med, 8(2): 147-156 (2014)
PRINT: ISSN 0973-5070 ONLINE: 2456-6772
DOI: 10.31901/24566322.2014/08.02.05

Understanding African Indigenous Approaches to Reproductive Health: Beliefs around Traditional Medicine[1]

Maheshvari Naidu

School of Social Sciences, University of KwaZulu-Natal

KEYWORDS Pregnant. Hegemonic. African. Women. Narratives

ABSTRACT Illness and health is more often than not, embedded in a matrix of cultural beliefs and is often more than about simply *'being ill'* or *'being healthy'*. The cause of the 'ill health' may also be located in social and spiritual realms, so that ethnomedical aetiology may include witchcraft and sorcery, and 'attack' by familiars or malevolent spirits. In many communities, constructed understandings of the body and health, for oneself, as well as that of the unborn child, extend back inter-generationally, and point to wider understandings of the (cosmological) world and how the individual is 'located' within this world. Likewise, with many categories of peri-urban and rural African communities, there is an entrenched belief that a pregnant woman and her unborn foetus can be protected from harm, and reproductive health can be promoted by turning to traditional health practices. This paper examines one particular traditional practice; that of offering a decoction known generically as *isihlambezo* in *isi*Zulu*,* meant to aid in the delivery of a healthy baby. The paper works through qualitative data gathered from a sample group of pregnant women and traditional healers (*sangomas*), and probes the popularly constructed meaning of the decoction or *isihlambezo*. The narratives of the *isi*Zulu participants around *isihlambezo,* in turn reveal that a complex web of beliefs cohere around understandings of reproductive health and the well-being of the unborn child. These narratives additionally problematise what appears as the hegemonic positioning of the western biomedical discourse which appears to 'push' the faith and reliance on indigenous herbal remedies underground, thus rendering its use somewhat invisible against the more visibly championed western reproductive health care and prenatal medicines.

INTRODUCTION

'Traditional' health practice has, in the last decade, been 'mainstreamed' within South Africa in 2004, by the active promulgation of the 'Traditional Health Practitioners Act, No. 35'. However, this, in some respects lies in legislature and policy, and may still not impact on health care models, constructions of patient and constructions of 'health' itself. This paper is an exploratory inquiry and focuses on popular and indigenous constructions of reproductive health and some of the antenatal health needs of pregnant women. By working through the qualitative narratives of pregnant *isi*Zulu women and *isi*Zulu women who have had children and their use of antenatal indigenous herbal medicine, the paper reveals the tension and dichotomised positioning between western allopathic approaches and those considered traditional and indigenous. The paper positions these 'insider' emic narratives alongside that of what the traditional healers have to say about the decoction *(isihlambezo)* that they offer to the women.

While drawing the necessary attention to the untested and contested background to some of the (potentially dangerous) pharmaceutical properties of the herbal infusion known generically as *isihlambezo*, the paper highlights that equally urgent, is the acknowledgement on the part of the 'orthodox' medical practitioners, of the popularity and relatively wide spread use of traditional medicines such as *isihlambezo,* and of the importance of the examination of women's popular construction of reproductive health care. The paper argues that the hegemonic narrative of the western biomedical discourse appears to further impel the reliance on indigenous herbal remedies *underground*, thus rendering its use invisible against the more visibly positioned and championed western reproductive health care and prenatal medicines.

METHODOLOGICAL APPROACH

A qualitative approach was used with narratives gathered from an identified core sample of women who were either pregnant or women who had had children. Initial sampling was nonrandomised, where approximately 4-6 *isi*Zulu women were selectively identified. The snowball method was thereafter used, with the initial participants referring the interviewer to other potential participants who were familiar with *isihlambezo*. A relative saturation point was reached with the initial core sample of 15 female

participants. A second sample of an additional 15 women were later included as themes from the initial sample group emerged. Follow up questions based on the initial data were constructed and posed to the second group of women.

Simple exclusion criteria were used when sampling the women. The women had to be:

- Between 18- 42 years old;
- From the *isi*Zulu speaking cultural linguistic group;
- To either be pregnant at the time of interview, or have had children (or both);
- To have either used *isihlambezo* during the prenatal period of one or more pregnancies;

The first set of narratives were collected over three months March to May 2013 by two *isi*Zulu speaking research assistants, working in two different densely populated urban areas of Umlazi and Kwa Mashu in the KwaZulu Natal (KZN) province. The research assistants were in their mid-twenties. Both of these University students had experience with qualitative research work. Research assistants were used as they were proficient with the local language and indicated that they were familiar with a few potential participants across the age groups. It was also believed that the *isi*Zulu participants would be more comfortable sharing their experiences with them. The second set of data with the second sample of 15 women was collected from January to March 2014. The same two research assistants were used as they were familiar with the nature of the research and the fluidly structured interview schedule. Additionally, they helped identify 8 women from the group of 15, who were fully conversant and comfortable in English (as the researcher did not speak *isi*Zulu) and who were prepared to meet personally with the researcher for more in depth interviews.

The age range (for both the first as well as the second sample) was chosen as this sampling was assumed to be representative of the childbearing age of most women. Of course girls younger than 18 can and do fall pregnant. However, ethical considerations mean that women younger than this age would need parental consent to participant in such a study. To approach these young mothers, in the absence of parental/guardian consent was thus deemed to be unethical. The researcher also did not want the parents approached for fear that the participants would be influenced by how they felt the parents would want them to answer the questions. The interviews led by the research assistants lasted approximately 30-45 minutes, and were conducted at a place that was comfortable to the women. The responses were recorded and later transcribed. None of the women's names were used out of respect for preserving their anonymity.

Interview questions with the women attempted to probe wide health and reproductive histories, the women's awareness and knowledge of their (reproductive) bodies, pregnancy and childbirth, experiences around hospital-based health care and their health-seeking behaviour during pregnancy, both within a hospital context as well as from so called traditional sources and medicines. The interviews with the researcher on many occasions lasted over an hour. Two interviews with two participants lasted approximately two hours each and indexed instances when the women felt that the interviews created a vital space where they could share their experiences. In all the interviews, the researcher took care in ensuring that cue was taken from the participants themselves, as to the actual duration of the interviews.

A sample of 8 *sangomas* or traditional African healers and herbalists known to administer to pregnant women were also interviewed by the research assistants in *isi*Zulu. These interviews (given the busy schedules of the practicing *sangomas*) lasted approximately 30 minutes and were conducted at the place of practice of the traditional healers (which was sometimes their own homes). The criteria for selecting the *sangomas* or traditional healers, was simple. They were selected on the basis of having consulted with pregnant women who had sought their assistance in assembling a decoction/mixture that could be taken to promote their health, as well as that of their unborn child.

Narrative analysis was used to analyse the responses from the women and the *sangomas*. Once the transcribed material was ready, it was read over several times to gain familiarity with the empirical data against my archival and textual research. The researcher then began coding the responses into thematic clusters. The data was in turn cast against an interpretivist analytic. An interpretivist approach does not assume there to be a dominant singular truth claim and the paper thus worked from the understanding that so called 'truth' and truth claims are relative and multiple. The understanding was that the

women's narratives revealed an epistemic of privilege (see Harding 2004) and were capable of revealing an insider and emic perspective based on their lived experiences. The paper worked from the premise that their particular claims of health and bodily health practices thus deserved to be written into 'discourse' and open to both inclusion and critique.

'Indigenous' Constructions of Illness and (Reproductive) Health

Van Wyk (2004) points out that illness or ill health is the experience of impairment or distress, and likewise culturally defined and constructed. The cause of the 'ill health' may also be located in social and spiritual realms, so that ethnomedical aetiology in many so called traditional communities may include witchcraft and sorcery, soul loss, and spirit intrusion. Thus beliefs about health, as well as what makes people ill, are influenced by the 'culture' and religio-cultural matrix that one is embedded in. Corporeality and understanding of the body, and how and what constitutes the body also has certain implications in respect of a group's collective understanding and construction of sickness.

Adams et al.'s (2005) ethnography of 38 Tibetan women examined women's beliefs and behaviours surrounding pregnancy and childbirth and found that the fear of attacks by spirits and demons precluded a woman travelling at night to a health centre or clinic. Chapman's (2006) in-depth ethnographic study of 83 women in Mozambique in Southern Africa (during pregnancy and after childbirth) reveals the extreme structural and cognitive gaps between the biomedical constructs of risk and the social threat perception of childbearing women. In the context of sub-Saharan African women, it is recognized that most African patients often attribute illness to a spiritual or social causative reason rather than a (purely) physiological or biological cause. Ethnographic studies (Abrahams et al. 2004) focusing more specifically on the health-seeking behaviour of childbearing women in South Africa likewise draw our gaze to belief patterns that include sorcery and witchcraft as concerns that weigh as heavily as infectious diseases, that might risk the health of the unborn child (and in some instances that of the pregnant mother as well). Anthropologists working with illness and health are cognisant of this and emphasise the whole body, 'mind' and 'soul' (variably conceived and understood within various societies) in attempting to cohere and articulate an ethnomedical approach to illness and healing. *Isihlambezo* is one example of a traditional medicinal drink commonly taken by women during pregnancy to stave off fears (and the perceived realties) of ill health around pregnancy.

Isihlambezo

South African social anthropologist, Varga, and the South African pharmacologist Veale (1997: 911) define *isihlambezo* as a,

"[H]erbal decoction used by many Zulu women in South Africa as a preventative health tonic during pregnancy".

A somewhat fuller definition is given within a pharmacology study (Kaido et al. 1997: 185);

[The] traditional herbal remedies used during pregnancy and childbirth are known collectively as isihlambezo. Isihlambezo is taken as an antenatal tonic during the last trimester of pregnancy in the belief that it promotes a favourable course of pregnancy and facilitates a quick and uncomplicated labour. Many different plants can be used as isihlambezo ingredients and the recipes vary depending on factors such as the traditional healer consulted, the general state of health of the woman, the geographical area or the tribal (sic) community.

Isihlambezo is referred to as a decoction. A decoction refers to extracting the mineral salts of plants from hard materials such as roots, bark and wood which require boiling and are then steeped for a number of hours. As Lust (2008) explains, the 'tea' is then boiled down and becomes concentrated. Water is then added before drinking.

While references from literary sources are important for the social anthropologists, just as vital, and in some instances *even more important*, are the understandings and definitions from our respondents, who draw from their lived experiences. The Abrahams et al.'s (2002: 80) study on the health-seeking practices of Xhosa women in the Cape which appeared in *African Journal of Reproductive Health,* made the vital point that even though the traditional practitioners (now formally referred to under the rubric of 'indigenous healers'), are regarded as the main repositories of indigenous knowledge, "it is the lay 'practitioners' of the popular sector [who]

also deserve attention". This lay practitioner, as the researcher understands it, is the woman who consumes the traditional 'product'. One contends that it is here "that ill-health is first recognised, health care activities initiated and sets of beliefs about health maintenance are held and acted upon" (Abrahams et al. 2002). The 'location' of this recognition and practice lies then with the women, their understandings of the mixture and of the traditional healers who offer it to them. It is to their narratives that we turn. The paper offers two initial narratives from two *sangomas* or traditional healers who administer the decoction or *isihlambezo*. This is followed by a thematic analysis of some of the discursive issues that surface from what the larger sample of women share about their experiences with *isihlambezo*.

Narratives of *Isihlambezo*

Narrative One: MaLungile is a 42 year old *sangoma*. She says she believes in *uNkulunkulu* (God).

MaLungile shares,

Isihlambezo is a mixture given to pregnant women to help them with the birth process to make it easier and painless. I usually give it to pregnant women when they are 7 months along their pregnancy, and I used it myself when I was pregnant. To make isihlambezo I mix some brown sugar with an egg, water and shake it altogether. I then add the special herbs and things the ancestors reveal to me, and I pray over it asking for God's power to make it work. I then give it to my clients.

My clients are always impressed with my mixture; they say it works wonders. They never feel any labour pains after drinking it. Most of them give natural birth. It is only sold by us traditional healers, you can never find it where they sell western medicine. Another thing is that it has to be used immediately after it's been prepared. At pharmacies they keep things for a very long time, that's why they can't sell isihlambezo.

All healing power comes from God and the ancestors. A pregnant woman is supposed to follow certain things. She is not supposed to go out at night or attend funerals, as this attracts unfamiliar spirits which may harm the unborn baby. She is supposed to stay indoors and never leave the house without notifying and gaining permission from the ancestors. Nobody should touch her belly except for her husband because some people use serious muti [medicine] which can bring imikhango (bad spirits) to the baby. One way to protect the mother and unborn child is to take isihlambezo.

Narrative Two: MaNkosi has been a practicing *sangoma* (traditional healer) for twenty years. MaNkosi says that she believes in *amadlozi* (ancestors) and *uNkulunkulu* (God).

MaNkosi shares,

Isihlambezo is a traditional medicine given to pregnant women so that they can easily give birth when they are due. It is made up of traditional herbs. People like us, sangomas and izinyanga (traditional doctors) who supply it, know what goes in and what it is made up of. It is a mystery from the ancestors; different healers use different ingredients to make isihlambezo. Benza ngendlela okhokhomkhulu babo ababakhombisa ngayo. We make it according to how our ancestors show us.

Hhayike, umbhedo ke lowo. Lezinto zakhiwa abantu abakhonjiswe ngesambulo amadlozi ukuthi bazakhe kanjani, akwenzeki nje neze ukuba bashaye eceleni, bahleze bekwenza ngendlela ngaso sonke isikhathi. Mina nje zonke izingane zami ngaziphuzisa isihlambezo kade zikhulelwe, zateta kahle nje iziqomqomu zezingane eziphile saka. Ayikho lento emakhemise, angani lamakhemise enu awafuni sidayiselwe isihlambezo, nodokotela benu abasifuni baloku bethi: "isihlambezo, klifi klifi, nywe nywe nywe!"

It's nonsense [to say that people should be worried about what goes into the mixture]. These things are made by us sangomas... we have a revelation from the ancestors on how to make them. We never go wrong and we always use the correct method. I have even been giving isihlambezo to my own daughters during their pregnancy and they all gave birth to healthy children. You will never find this thing in pharmacies because your pharmacists don't want to supply isihlambezo and your doctors also don't want it. They are always complaining saying isihlambezo; this and that!

Bazinike labo? Inkinga yegenge ukuthi ayazi kodwa ayizikhohliwe ingosiyazi abakhulu! Into eyenza ukuthi thina zalukazi sibe nombono ohlukile ingoba siyasazi isihlambezo, sisisebenzisile kakhulu futhi sasizakala. Laba

baphuphuthekiswe odokotela nje sebeloku belandelana nezinto zasentshonalanga abangazazi!

What do those young women know… the ones who choose to not use isihlambezo? The problem with them is that they think they know everything whereas they know nothing. The older women have a different opinion because they know isihlambezo… they have used it and it has worked for them. The younger women have been deceived by western doctors and they are busy following western things that they do not even know. Kuphi khona? Bazini abasentshonalanga konje? What do the westerners know? Abazi lutho labo! These western doctors ... even our African doctors who study the western medicine, they know nothing!

Traditional medicines are very powerful, the power comes from God and the ancestors. Being a healer for us Africans, is a supernatural gift. With this gift we can protect the mother and her unborn child.

The strong belief in the efficacy of *isihlambezo* is echoed in the understanding of many of the women interviewed, who were had taken the decoction made up by traditional healers like MaLungile and Makhosi. While two women[1] from the group of 30 indicated strong negative feelings regarding *isihlambezo,* the rest were largely women who shared the beliefs of the traditional healers.

Understanding the Embeddedness of Traditional Medicines

In peeling back the meanings embedded in the transcriptions with the sample group of women with experiences of *isihlambezo*, what becomes discernible is a strongly emergent pattern to the manner in which the answers from the respondents were framed. Given this, four 'stock' responses are elicited and presented below. These contain the sustained pattern for the rest of the sample group;

Respondent 1: It's a birth-inducing drink that is used by black people.

Respondent 2: Its medicine that is used during pregnancy to help keep the baby healthy at all times.

Respondent 3: It is traditional medicine for pregnant women.

Respondent 4: It is a traditional birth-inducing medicine that is made by traditional doctors and other people with knowledge of herbs and healing.

There is particular rationale behind the manner in which I have ordered the responses. They move from a short descriptive definition, that both describes what it 'is' (birth-inducing) and includes 'who' drinks it (Black people, that is, Black women), in the context of reproductive health, that is, referencing 'women' and 'women in the *Black* community'; to a slightly longer response, that while still descriptive, labels and 'names' the mixture as '*medicine'* and its perceived health impact on the foetus and child; through entire antenatal and post-birth periods.

The third response from the third participant is short but brings in powerful intergenerational and cultural continuity by naming the herbal drink '*traditional'* medicine. The fourth response includes the descriptive elements of the earlier responses, but widens the definitional nexus and obliges us to consider the vital inclusions of the 'traditional healer or doctor' and indigenous knowledge systems as a whole and the interconnected (lay) system. In doing so it alludes to a particular traditionally-based, wider reproductive health care schema that includes the traditional practitioner (*isangoma*) and patient (pregnant women) as well as her family assisting her in accessing the medicines.

Thus the *sangomas* or traditional healers positioned their decoctions as deriving their power and efficacy from God and the ancestors, which they claimed *they* were able to access. They also positioned their decoctions as powerful and 'traditional' against that of western medicine. This is echoed by the women who claimed to have used the mixture and who indexed their faith in the decoction for the protection the 'traditional medicine' offered, for both the physical as well 'spiritual' well-being of the child. One has thus to keep this ontological frame in mind when 'listening' to the answers from the women. This is because their health-seeking behaviours and practices in the context of their pregnancy, is in turn constructed within such an ontological and cosmological scaffold. This tiered understanding in turn appeared to be (as shared by the women), largely ignored by what they termed as 'the western doctors'.

A 32 year old waitress and mother of one shared with the interviewer the belief that;

Isihlambezo is used to give birth with less pain and to protect the child against harmful

spirits... And yes I have used it before...during my last pregnancy trimester. For three months every morning and afternoon...

While a younger 20 year old graphic design student told us that she believes the mixture is used to:

[P]rotect both the baby and its mother from any harm during pregnancy. Also some people are very cruel, they are witches and would do harm to you and even try to kill your child before it is born. Using isihlambezo, protects you from all this. It covers the baby from all sorts of sorcery and bad luck...It is used to help to ease pains and to aid a smooth delivery... It also protects the baby from infection and mother from any harm... Let's say you are pregnant and your partner has another girlfriend who does not have a child. That girlfriend could easily go to a sangoma and ask for muti to kill that child... but not if you used isihlambezo...

These women's' responses, as with the rest of the group, clearly indicate a high level of faith in the efficacy of *isihlambezo*. More importantly, they measured this efficacy in 'health' and 'wellness' indices of *both* physical 'protection' in terms of infection etc., as well as a kind of cosmological protection. While the former would be recognised by health practitioners within western health care systems, the latter would be deemed irrational and irrelevant to the wellbeing of mother and child. Yet it was Vaughn and colleagues (Vaughn et al. 2009: 64) who point out that "culturally diverse patient populations" need medical educators to learn and become familiar with new methods of cultural assessment and treatment in order to be effective. They add that "medical educators also need teaching and learning approaches and philosophies that consider health attributions, beliefs, and practices of patients" (ibid). However, the narratives from the women revealed that this was not their perception or their experience with the medical community. They felt instead that their gynaecologists and general physicians understood "*nothing*" about traditional medicines. They claimed that even *"Black doctors ignore our roots and only give us White medicine*!"

When asked if their gynaecologist had advised them to use *isihlambezo*, the responses were emphatic as illustrated below:

No he had warned me about it but I thought 'what the 'hell'. He was one of the doctors I had consulted about my inability to fall pregnant and he had not helped me. So I didn't listen, I wanted to do everything that the traditional healer had recommended, said a 34 year mother of two, who was an occupational nurse by profession.

This sentiment was echoed by a 19 year old participant, a young mother, who had used it a month before the birth of her twins. She told us that her gynaecologist

…was against it. I still can't believe I wasted so much money on his fees for nothing, well except for scans. Had I known better I wouldn't have wasted time and money with gynaecological visits every month, I would have just invested on prayer and isihlambezo...

Another 38 year-old mother of three showed *both* her scorn for what she perceived as Western medicine, *and* the faith she had in both her mother, and that of what she saw as traditional medicine by claiming that her gynaecologist

…warned me about it. He told me of all the dangers of using it. But I had to decide between my mum and him and seeing that mum had had all 6 of us I trusted her and not the Doctor

Van Rensburg (2009:157) based at the Faculty of Health Sciences, University of the Witwatersrand claimed that, not too long ago, South African policy-makers had helped create what he termed "a multi-cultural and multi-cosmological (sic) context" for health and health care delivery. He pointed out that this has taken place against the background of the significant change in political and social spaces, post-democracy, which included a renewed emphasis on the signification and identification of 'African roots'. However, this is perhaps an over-simplification and certainly does not accord well with the phenomenological experiences of many women in the context of reproductive health and healthcare delivery.

All cultural groups have disease theory systems which include 'attributional concepts' which are situational and grounded conceptual schemes used to explain the causality of illness. Three commonly held paradigms of disease across many cultures are natural, personal and emotional (see Beiser 2003; also Vaughn et al. 2009: 66). Writing over two decades ago, in the Journal of *Social Science and Medicine* , Varga and Veale's paper (1997: 911) probed, as they put it; the potential impact of urbanization and access to Western clinic-based care on the popularity and utilization patterns of *isihlambe-*

zo, as well as the potential maternal-foetal health effects of its use. The findings from this small sample of women reveal that the popularity and use of *isihlambezo* with *isi*Zulu women has not faltered. Their 1997 study also revealed that many of the herbs and wooden bark had highly toxic properties and they called for further pharmacological studies.

One woman told us that;

It's good for pregnant women but definitely not babies. I heard some babies are born with abnormalities because of it. For women it's really good because they feel no pain. Although this was not her personal experience, she claimed that she knew of such an instance. Another woman from the 15 interviewed, shared her painful experience with a stillborn baby that she attributed to her use of the brewed decoction; *against the wishes of her physician*. These experiences are not meant to either validate or even (given the small percentage, 2 women out of 15) negate the pharmacological and toxicology studies such as that of Varga and Veale (1997). However, even one antenatal complication (and worse yet, a tragic death of a child) is cause for deep concern.

The point one needs to stress, is that as long as the women and their particular (culturally constructed) health-seeking preferences and behaviours remain 1) under- researched within the social sciences; and 2) ignored by the Western bio-medical discourse and health care models within the natural and medical sciences; the women will continue to turn clandestinely to traditional remedies in defiance of their physicians' directives. And more critically, *both* the potentially rich medicinal and potentially dangerous toxic qualities of *isihlambezo* will remain invisible and largely marginalised and under-studied. Perhaps this is wonderfully illustrated in one women's answer to the question regarding whether *isihlambezo* was widely available in pharmacies. She chuckled out a loud response:

Hahaha! No what black medicine is sold in pharmacies? White people would never allow for such things to be sold because they know that they would be out of business. If people use isihlambezo then they will just go to their community clinics and not gynaecologists.

Or another response: *No they* [the pharmacies] *don't sell it, only traditional healers sell it and the people from the Zion church because they also believe in ancestors*. These kind of responses showed that the women see their health in the context of their implicit belief in ancestors and the 'help' of their 'transcendental kin' (see Naidu 2012).

It was Okonofua (2002: 8) who claimed that it is clear is that "traditional medicines are important in reproductive health service delivery in Africa". Okonofua who works from the ethnographic location of Cameroon, points out, that there has, however, been "little substantive research to document the effectiveness of traditional medicine for reproductive health care and to identify ways to integrate it with the orthodox system of care" (ibid.).

Critical scholarship in journals such as *African Journal of Reproductive Health* and *Indilinga* to name a few, in supporting African scholarship against the hegemony of 'Western' constructions of knowledge forged in the global North, and paternalistically offered to us in the South, demand also an internal critique of non-western knowledge systems. Thus it is not about a myopic or naive acceptance of all things non-western and traditional either. Just as critical feminist theory has the courage to contest masculine sexual constructions that are injurious to African women, likewise critical social science scholarship focusing on medicine and health approaches are also intent on critique and interrogation. The point I am making is that a *carte blanch* acceptance of the majority of the women's positive experiences with *isihlambezo* is just as reckless perhaps as a wholesale epistemological dismissal and restriction of its use. While the former ignores the broad spectrum of herbs (from the toxically harmful to the potentially helpful) etc. that go into the decoction generically referred to as *isihlambezo,* the latter ignores both the women's (and the family's) faith in the medication, as well as actual benefits perceived and experienced by the women taking the traditional product.

Much of the interest in many aspects of health and healing in the context of indigenous knowledge in the medical literature has focused in the past, on the potential for harm caused by traditional practices (see Morris and Mdlalose 1991; Kaido et al. 1997). Social scientists such as Varga and Veale (1997) writing the journal *Social Science and Medicine* are perhaps among the few exceptions who recognise that health-seeking practices of patients within a diverse multi-cultural society like South Africa, are nec-

essarily complex and deeply layered by intersectional socio-political and cultural realities. The narrow discriminatory attitude is a kind of epistemic violence that has in turn contributed to the view that much of the health- seeking behaviour of women turning to indigenous medicines is steeped in traditional religion and superstition (!). Once such behaviour is relegated to the 'lower' order of belief and superstition in this manner, medical care, practices and practitioners will neglect to ask about the health preferences of the pregnant women that consult with them, *much less listen to the women*.

Vaughn et al. (2009: 64) note that compared to 'Western' populations, African patients may be more likely to attribute illness to a spiritual or social cause rather than a physiological or scientific cause. They go on to say that "African patients are more likely to expect health practitioners to provide an experiential and a spiritual reason why they have been afflicted with illness" (Vaughn et al. 2009: 64). From what the women in this study communicated, such a whole-body explanation for their ill health from their physicians and gynaecologists, was palpably absent, causing them to turn to traditionally-crafted understandings that 'fit; their understanding of the world and of their bodies, and of the safety of their unborn child. Likewise the Abrahams et al.'s (2002: 79) study with Xhosa-speaking women from the Cape revealed that the majority of the women followed indigenous healing practices for themselves and their babies because of the need to 'strengthen' the womb against sorcery, to prevent childhood illnesses. Like the Zulu women in this study, these were all symptoms that they perceived biomedical services would not be able to treat.

Moreover, the Xhosa women, like the *isi*Zulu women in this study, could not broach any of these concerns with their antenatal health-care practitioners in the hospitals they visited as they worked through a different explanatory model from that of the health practitioner. However, this is not simply a case that the (trained) doctor knows best. Critical theory obliges us to question the very construction of medical knowledge (see Naidu 2012) and the treatment and medical regimes that go along with such hegemonic constructions of patient health. This is perhaps especially so in reproductive health. The narratives of the women around their health-seeking behaviours regarding antenatal childcare and their use of *isihlambezo* thus underpins the urgency of moving away from a normative medical system; to a more flexible medical system" related to the expectations of the population established with its participation" (see Abrahams et al. 2002: 80; Beninguisse and Brouwere 2004; Dahlberg and Trygger 2009). As some scholars working from a social science perspective have pointed out, approaches to medical care "need to effectively understand and manage" culture, and ethnicity "to enhance patient's medical adherence" (Vaughn et al. 2009: 66-67).

The Harrison and Montgomery (2001: 311) study asserted over a decade ago that reproductive health had become a priority public health concern, adding that this was true even though "less attention has been paid to women's own reproductive health priorities". Perhaps in some respects, little has changed a decade later.

CONCLUSION

It is of course not new, that the biomedical discourse has 'muscled out' indigenous knowledge around illness and health, and no less so in the context of reproductive and antenatal health. However, the women's narratives show that in practice, for many women, their trust is still vested in indigenous approaches. Their clandestine use of *isihlambezo* is done *without* the knowledge of their gynaecologists. In the presence of what they experience as the admonishing and judgemental attitude of their physicians, they thus turn to their own cultural frameworks and resort to traditional medicines. However, both the women and their doctors are caught in the proverbial 'hamsters wheel'. Both are moving on the wheel and neither will catch up to the other, each existing in their own (epistemological) space. Herein lies the inherent danger.

Findings from this study reveal that a responsible approach to reproductive health thus also needs to factor in patients' cultural beliefs about their health and what exactly makes good health. This does not mean that the physician starts indiscriminately to prescribe *isihlambezo* to the women. Rather, it means that: 1) on the one hand, the health practitioner respects and includes the women's religio-cultural faith in indigenous medicine like *isihlambezo,* so the women are comfortable talking to their doctors about their use without fear of judgement and 2) on the other

hand there is reciprocal faith in the doctor's cautioning about where and how the decoction is obtained.

Such a climate then becomes conducive for mutual discussion of the potential danger in *some* of the herbs used in *isihlambezo.* More importantly such a climate creates the space for more pharmacological studies regarding which of the large numbers of herbs going into *isihlambezo,* can safely be advised for use by the women, thus acknowledging the immense potential of *isihlambezo*. It is such a move towards '*medicine'* that fits a bio-psycho-social (and spiritual!) model of health-care that will make cognitive sense to the pregnant women. In essence this asks for an emphatic dismantling of the hegemonic narrative of the western biomedical discourse which has thrust faith and reliance on indigenous herbal remedies *underground*, rendering its use invisible against the more visibly positioned Western reproductive health care and prenatal medicines.

NOTES

1 An earlier version of this paper appears in Naidu M 2013. Constructing Patient and Patient Healthcare: Indigenous Knowledge and the use of *Isihlambezo. Indilinga: African Journal of Indigenous Knowledge Systems,* 12(2): 252-262). This version of the paper is expanded to include new follow up data from a sample community of indigenous healers or *sangomas* for their perspectives on the traditional mixtures that they administer, as well as additional interview material from a further sample of women and their views on the decoctions that they are offered.

2 These two women were both University graduates, which perhaps explained their scepticism and their informed concerns over the potential dangers in the traditional decoction. Zenani was a 33 year old mother of 3 children. She informed us that she used *isihlambezo* when she was pregnant with her first child and nearly lost him. She shares; I couldn't feel the labour pains so the child came out when I was on my way to town. I felt something coming out of my body and I never thought it was a child. Then I saw a red spot on my skirt and realised that I was bleeding. I asked the taxi driver to drop me at the nearest hospital and the nurses told me that the baby's head was already out. That *isihlambezo* thing is really dangerous because the people who make it do not know the correct measurements, it can really kill you. The doctors hate it. The problem with *sangomas* is that they always claim to know everything. The older mothers are superstitious so they will always believe in power of *isihlambezo,* but younger women will reject it because they have been exposed to science.

Jabu was a 22 year old 3rd year Community Development Student at the University of KwaZulu-Natal (UKZN). She had a three year old son and told us that she had been raised with Christian beliefs. Jabu shares; *Isihlambezo* is a traditional *muti* (medicine) given to a pregnant woman in order to ease the birth process and make her feel less labour pains. It is sold by *sangomas*. It is only available from traditional healers; pharmacies don't sell it since it is an illegal herb! That thing kills! Doctors do not recommend it because they think that the herbs used in preparing the mixture can be harmful to the unborn baby. I would never recommend it to anyone-*isihlambezo* has never been tested in a laboratory. Young women do not use it because they know it's dangerous. Our mothers and grandparents believed in it because they were not educated or exposed to the western methods. Those who believe in traditional medicine say that traditional healers have powers from ancestors and gods. Let's be logical; *sangomas* don't have machines such as ultrasound and are not exposed to science, so we cannot expect them to be able to give a concoction to help with the baby that they have never seen, they do not even know how the foetus develops.

These two narratives reveal that *isihlambezo* is not necessarily accepted by all categories of African women. However, the point is that a relatively high number of women do take the decoction, more especially the peri-urban or rural women, and women who take the mixture on the advice of their parents. Given the relatively high recourse to this traditional mixture, and the fact that there is open hostility to the decoction from the (western) medical fraternity to its potential ill or fatal effects, it becomes critically imperative that social science studies probe how *isihlambezo* comes to be discursively and differently positioned by the reproductive health care practitioners, and the women themselves.

REFERENCES

Abrahams N, Jewkes R, Mvo Z 2002. Indigenous healing practices and self-medication amongst pregnant women in Cape Town, South Africa. *African Journal of Reproductive Health*, 6(2): 79-86.

Adams V, Miller S, Chertow J, Craig S, Samen A, Varner M 2005. Having a "safe delivery": Conflicting views from Tibet. *Health Care for Women International*, 26: 821-851.

Beiser M 2003. Why should researchers care about culture? *Canadian Journal of Psychiatry,* 48(3): 154-160.

Beninguisse G, Brouwere VD 2004. Tradition and modernity in Cameroon: The confrontation between social demand and biomedical logics of health services. *African Journal of Reproductive Health*, 8(3): 152-175.

Chapman R 2006. Chikotsa – secrets, silence, and hiding: Social risk and reproductive vulnerability in central Mozambique. *Medical Anthropology Quarterly*, 20(4): 487-515.

Dahlberg AC, Trygger SB 2009. Indigenous medicine and primary health care: The importance of lay knowledge and use of medicinal plants in rural South Africa. *Human Ecology*, 37(1): 79-94.

du Toit BM 1971. *Isangoma*: An adaptive agent among Urban Zulu. *Anthropological Quarterly*, 44(2): 51-65.

Harding S (Ed.) 2004. *The Feminist Standpoint Theory Reader: Intellectual and Political Controversies*. London: Routledge.

Harrison A, Montgomery E 2001. Life histories, reproductive histories: Rural South African women's narratives of fertility, reproductive health and illness. *Journal of Southern African Studies*, 27(2): 311-328.

Kaido KL, Veale DJH, Havlik I, Rama DBK 1997. Preliminary screening of plants used in South Africa as traditional herbal remedies during pregnancy and labour. *Ethnopharmacology*, 55(1):185-191.

Lust J (Ed.) 2008. *The Herb Book.* Boston: Barnes and Noble.

Morris G and Mdlalose BE 1991. The use of *Isihlambezo* in the Upper Tugela Region. *SA Family Practice*, 1(1): 169-173.

Naidu M 2012. Performing illness and health: The humanistic value of cancer narratives. *Journal of Anthropology Association Southern Africa*, 35(3 and 4): 71-80.

Naidu M 2013. Attending to the patient: Bioethics and medical literature. *International Journal of Dharma,* 38(1): 7-26.

Okonofua F 2002. Traditional medicine and reproductive health in Africa. *African Journal of Reproductive Health*, 6(2): 7-12.

Van Wyk IWC 2004. African witchcraft in theological perspective. *Theological Studies*, 60(4): 1201-1228.

Varga CA, Veale DJ 1997. *Isihlambezo*: Utilization patterns and potential health effects of pregnancy-related traditional herbal medicine. *Social Science and Medicine*, 44(7): 911-24.

Vaughn LM, Jacquez F, Baker RC 2009. Cultural health attributions, beliefs, and practices: Effects on healthcare and medical education. *The Open Medical Education Journal,* 2(1): 64-74.