

Customs and practices during pregnancy, childbirth, and the postpartum period in the Kilimanjaro area, Tanzania

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Abstract

Introduction: Here, we report the traditions, customs, and beliefs of rural women during pregnancy, childbirth, and the postpartum period in rural Tanzania, and discuss how they compromise between traditional and modern perceptions of maternity care and experiences.

Methods: A focus group interview with nine women who have children under 5 years old was conducted by a midwife researcher (one of the authors) in Rombo, a village in the Kilimanjaro region, in Tanzania, in December 2009. The interview was translated from the local language into English and transcribed. The data were assessed by describing and categorizing as pregnancy, childbirth, after childbirth, and feeding of the baby.

Results: The women recognized the importance of institutional delivery, but also appreciated cultural practices related to childbirth. Goats, bananas, local beer made from bananas, and kanga (Tanzanian pareu or wraparound skirt) were important items not only for pregnancy and childbirth, but also for daily life in the study area. They integrated medical approaches by health professionals and traditional approaches by the family in childbirth.

Conclusions: A transition gap regarding the modern and traditional practices was not clearly observed as in urban areas in the present study area, but it is possible that the same conditions will arise in this area in future. It is necessary to take traditional customs and practices into consideration to improve women's satisfaction regarding childbirth and delivery.

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Introduction

There are inequalities in safe delivery rate, obstetric outcomes, and childbirth experiences among women of different cultures and ethnicities due to socioeconomic differences in their physical and social environments^{1,2}. On the other hand, several factors that have previously attracted little attention as predictors of childbirth satisfaction are now being recognized as important, including self-control ability and self-efficacy³. Not only evidence-based care, but also women's awareness regarding their health and a relationship of mutual trust between women and healthcare personnel were determined as factors that enrich childbirth

experiences⁴. Several studies have also indicated that preference regarding place of childbirth and/or childbirth attendant are determined not only by physical accessibility and affordability of health care services, but also by whether women feel that their social and cultural needs regarding delivery are being appreciated⁵⁻⁸. These studies from different settings suggest that in improving women's health, including their perceived satisfaction regarding childbirth and delivery, it is important to take into consideration not only physical and technical issues but also various socioeconomic and cultural factors.

Tanzania is one of the world's poorest countries,

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with 75% of its population living in rural areas where basic transport infrastructure is still lacking, and health care facilities are often located far from local communities. This makes it extremely difficult for pregnant women and for those with complications associated with childbirth, such as severe hemorrhage, obstructed labor, pregnancy-induced hypertension, sepsis, and abortion complications, to gain access to skilled health care⁹⁾. The maternal mortality ratio (MMR) in Tanzania is currently as high as 454 per 100000 live births¹⁰⁾. On the other hand, a recent study regarding women's perception of pregnancy and childbirth demonstrated that women have a high level of awareness and a strong preference for giving birth at a health facility rather than at home¹¹⁾. In addition, women and their partners demonstrated higher levels of confidence in doctors and nurses than traditional birth attendants (TBAs) with regard to childbirth assistance¹²⁾. However, although women recognize the importance of institutional delivery, sociocultural factors and other factors related to family and community can sometimes form complex barriers to visiting health care facilities for maternity care^{13,14)}.

Improvement of maternity care services has had an impact on the transition from traditional beliefs and customs to modern attitudes and behaviors. In suburban Dar es Salaam, Tanzania, there is some transition between tradition and modern style among young people, although they have weak family and community relationships and adopt more informal relationships in the present transition period^{15,16)}. The generation gap is one barrier to early sexual debut and engaging in high-risk behaviors¹⁷⁾. Total women's health should be recognized from various viewpoints, but several steps are still required to achieve this goal.

We have conducted studies regarding women's health literacy in underserved and disadvantaged conditions, including HIV-positive breastfeeding women in rural Tanzania. Here, we report the traditions, customs, and beliefs of rural women regarding pregnancy, childbirth, and the postpartum period (after childbirth and feeding of the baby), and discuss how they compromise between tradition and modern perceptions of maternity care and experiences in rural Tanzania, with an understanding of cultural factors that can influence women's health as part of a study on women's health literacy.

Methods

A focus group interview with nine women who have children under 5 years old was conducted by a midwife researcher (one the authors) in Rombo, which is a village in the Kilimanjaro region of Tanzania, in December 2009. The nurse in charge of the health center in the study area recruited interviewees in the catchment area and they agreed to participate in the interview. The interview guide was established based on the authors' experience as reproductive health professionals, including research work performed in Tanzania. The guide consisted of questions regarding traditions, customs, and beliefs regarding pregnancy, childbirth, and the postpartum period, and how interviewees practice and recognize these traditions, customs, and beliefs. The interview was performed in the local language, Chaga, for about 60 minutes, and the interview was transcribed and translated from Chaga into English. Notes were taken during the interview by the nurse and one of the authors, because the interviewees did not permit recording on tape and/or electronic transcription. Immediately after the interview, the authors reviewed and complemented the results from their notes. The data were analyzed by describing and categorizing as pregnancy, childbirth, after childbirth, and feeding of the baby. The data were also categorized into tradition (a belief, custom, or way of doing something that has existed for a long time passed on from generation to generation in the study area), custom (an accepted way of behaving, acting, or doing things in a community), and belief (a strong feeling that something exists or is true). Custom and belief were considered not only in the traditional context, but also in the recent and/or modern context.

The present study was approved by the Ethics Committees of the Nagasaki University Graduate School of Biomedical Sciences (approval number: 09072354) and National Institute of Medical Research in Tanzania (NIMR). Prior to the interview, all interviewees gave oral informed consent to participation in the study after explanation about its objectives, confidentiality, and ethical considerations, and receiving assurance regarding the voluntary nature of participation.

Results

Women who participated in the interview were aged between 21 and 37 years old. All interviewees were married. One of the interviewees had a grandchild. None of the interviewees spoke or understood English

to a level suitable for participating in the interview.

Table 1 shows the traditions, customs, and beliefs related to pregnancy, childbirth, and the postpartum period mentioned by the interviewees, which were classified according to pregnancy, childbirth, and the postpartum period, and categorized into traditions, customs, and beliefs. Traditional customs were more likely to be observed in the postpartum period, while beliefs were more likely mentioned in the period of pregnancy and childbirth. Goats, bananas, local beer made from bananas, and kanga (Tanzanian pareu or wraparound skirt) were important items for pregnancy and childbirth.

In addition to the traditions, customs, and beliefs mentioned in Table 1, the interviewees' discussions related to pregnancy, childbirth, and childcare are described as follows. The male roles and functions in decision making were normally essential in the study area, although the mother-in-law and the woman's own mother played roles in decision making regarding childbirth and care for the baby. Some interviewees mentioned that they followed their mother-in-law's suggestions, but that they sometimes felt forced to do so, and therefore could not refuse to follow these suggestions.

In general, interviewees recognized the importance

Table 1. Traditions, customs, and beliefs related to pregnancy, childbirth, and the postpartum period (after childbirth and feeding of the baby) in rural Tanzania

Pregnancy	If a pregnant woman eats eggs during pregnancy, she will give birth to a baby without hair or with "malnutrition" hair, which is brown and thin. (T, B)
	If a pregnant woman eats avocado during pregnancy, the embryo will have stomach pain. (T, B) the amniotic fluid will become turbid. (T, B) she will have prolonged labor. (T, B) she will have fetal asphyxia. (T, B)
	If a pregnant woman ties a kanga (Tanzanian pareu) across the neck, she will have a loop in the umbilical cord. (T, B)
	If a pregnant woman eats offal during pregnancy, she will give birth with malformation. (T, B) her baby will be bald. (T, B)
	If a pregnant woman eats intestine during pregnancy, the baby will have hernia of the umbilical cord. (T, B)
	If a pregnant woman has extramarital sexual intercourse, she will have an abortion because of shame. (T, B)
	If a pregnant woman has sexual intercourse before the expected date of birth, she will deliver an albino baby.
Childbirth	When the labor process makes rapid progress (before arriving at a health facility) on the way to health facilities, the woman will not give birth if she ties a knot in the edge of her kanga. When the labor process is normal, women do not tie a knot in the edge of kanga because the baby will not be able to drop. (T, B)
After childbirth	If postpartum women cook and/or eat offal, the umbilical cord of the baby will not fall off. (T, B)
	For 6–7 days after childbirth (until the baby's umbilical cord has fallen off), the baby should not be shown to and/or held by strangers who are not family members, because it is necessary to avoid exposing the newborn to the "bad eyes" of strangers. (T, C)
	Until the baby's umbilical cord has fallen off, the umbilical cord should not be touched by anyone. (T, C) the umbilical cord should not be cleaned (washed) by anyone. (T, C)
	Postpartum women live in their mother-in-law's house for 6 months after delivery to avoid frequent pregnancy, because the baby will die and/or become weak if the mother gets pregnant during the first 6 months of life (the baby cannot be sufficiently fed by the mother). (T, C)
	When a baby is born, a goat is killed by the family (a male goat for a male baby, and a female or male goat for a female baby). A piece of skin is cut from the ear of the goat, and a cross is drawn with blood from the goat skin on the forehead of the baby by family members. If the baby is born at a health facility (out of the home), this ceremony is performed before the baby enters the house. Offal and intestines of the killed goat are left at the base of a banana tree, which stands in the direction of Mt. Kilimanjaro. Local beer is prepared using bananas, and is served to relatives and neighbors. (T, C)
Breastfeeding and feeding of the baby	If the postpartum mother goes to her parents' house when she has a marital dispute with her husband (she stops giving breast milk to the baby, because the baby should remain with the father and grandparents on the father's side), the family should kill a goat and serve to relatives and neighbors when the mother resumes breastfeeding of the baby. (T, C)
	If the mother does not have enough breast milk, the baby is given boiled cows milk and/or "local butter," which is prepared from cow's milk (leave boiled cow's milk for 2 days in an opaque container with a volumetric flask shape, then shake for 1 h. The top clear layer is called "local butter"). (T, C)
	If the postpartum woman does not breastfeed, people in the community and family members will believe that the woman is HIV-positive. (B)
	After 3 months of age, the mother usually starts giving the baby grilled mashed banana with boiled cow's milk or local butter. (T, C)

English expressions included technical term were used as free translation from Chaga to English.

T: Tradition. A belief, custom or way of doing something that has existed for a long time and is passed on from generation to generation in the study area.

C: Custom. An accepted way of behaving, acting or doing things in a community.

B: Belief. A strong feeling that something exists or is true.

of institutional delivery and childbirth with skilled birth attendants, because most women indicated that they had gone to a health facility for childbirth if they estimated having sufficient time to reach the facility. However, they had stayed at home and sought someone to help with delivery if they estimated having no time to reach such a facility before giving birth. Usually the mother-in-law decides when to go to the health facility. The mother-in-law or community TBAs usually assisted in childbirth at home. Outsiders were excluded from entering the place where women were giving birth.

On the other hand, women who deliver their babies within the community are generally thought of as “healthy women” in the study area. In addition, women sometimes prefer to deliver at home, because institutional delivery precludes celebration in accordance with traditional cultural norms by family members and relatives, for example, killing and serving a goat for purification and exorcism at childbirth. Some women dislike the concept of giving birth at a health care facility, because giving birth is a private event and they prefer not to share the space and time with others. Women in the study area recognized that quality care was not “materialistic” care, but that processed in accordance with cultural norms within the community and family.

Delivering a baby boy is recognized as the duty of a daughter-in-law both in the study area and within families. Women who do not have a baby boy and have only baby girls feel shame and are under pressure to have a baby boy. The ideal number of children reported by the interviewees was from 2 to 6 taking into consideration economic reasons from child rearing to the provision of sufficient education. However, family members and relatives often pressure women to have more children. Women who cannot have children are sent back to their parents’ home in some cases.

According to the interviewees, women usually marry at the age of 18 years old. Women who are more than 30 years old who are unmarried and have no children are regarded as incompetent women by both the community and family, and male siblings will criticize their unmarried female siblings.

The interviewees indicated that it is important to be free and independent. They prefer having an independent life plan from their husband/partner. The interviewees indicated that their expectations for the future were that their children would become well educated, they would live in a good house with

electricity, and they would live close to their children when they establish a family after marriage.

Discussion

The women included in the present study recognized the importance of institutional delivery, but also engaged in cultural and family practices related to childbirth. A previous study in rural Tanzania also indicated that women stated the importance and better quality of care associated with institutional delivery compared to home births, but family support in an institution was essential during labor¹⁸. Recent efforts to promote institutional delivery and childbirth with the assistance of skilled birth attendants may have contributed to women’s preference for institutional delivery as a modern perception, but they also appreciated and preserved cultural practices as a traditional perception regarding childbirth, integrating both medical and cultural approaches in childbirth.

Traditional customs were more likely observed as ceremonies and/or practices in the postpartum period, while beliefs were more likely to be mentioned as traditional taboos and/or recommendations in the period of pregnancy and childbirth. There is a traditionally negative impression against women who do not breastfeed as women who have abandoned the role of mother¹⁹. On the other hand, with the increasing burden of discrimination and stigma regarding HIV/AIDS over the past two decades, postpartum women do not breastfeed for whatever reason are often thought to be HIV-positive by people in the community. HIV-positive women who do not breastfeed may face the double burden of stigma regarding HIV infection and not performing the role of being a mother in the study area. Most of the customs and beliefs mentioned in this study were passed down from generation to generation as traditions in the study area. However, such traditions also influenced the interpretation of recent and/or modern phenomena, such as HIV infection.

Family support may be able to humanize the care environment during childbirth even in institutional delivery in the context of the study area, because women sometimes prefer to comply with traditional customs, such as killing a goat and serving it for purification and exorcism at childbirth. On the other hand, as mentioned in the present study, women who are not married and/or do not have children are not appreciated by their family and society in a male-dominant culture. In addition, women preferred an

independent livelihood from their husband/partner. These statements suggested that women may expect to make their own choices, although this is difficult to realize in a male-dominant culture, and women prefer more freedom from gender inequity and to have greater satisfaction in their life. At the same time, women's expectations of their children were high in comparison to their expectations of their husband/partner, and women may put their hopes on their children. It may be necessary to consider whether there are gaps between preferences and satisfaction of women regarding customs and practices related to childbirth. It is important to consider family role and support in the quality of reproductive health care.

In the present study, use of herbal medicine during pregnancy and the postpartum period was not mentioned by women, although they appreciated traditional items, such as goats, bananas, and local beer. However, a study performed in Tanga district, Tanzania, indicated that oral herbal medicine was commonly used during pregnancy and childbirth²⁰. Goat is the most popular meat and banana is a staple food in the Kilimanjaro area. In the study area, grilled goat meat and local beer made from bananas are served at all ceremonies and celebrations. Goats, bananas, local beer made from bananas, and kanga were important items not only for pregnancy and childbirth, but also for daily life. According to observations by the authors, in general, rural women prefer receiving kanga as gifts on any occasion, including Christmas and at ceremonies, in the study area. Kanga is also used to wrap and carry the baby. If women can feel comfortable controlling their progress of labor using kanga, such as making and untying knots, this can have a psychological effect and mitigate stress and unnecessary pressure on women despite the lack of a biological effect.

The present study had several limitations. First, the sample size in this study was small, and these findings do not represent Tanzania as a whole, but correspond only to a limited area. The second limitation is that the range and depth of the results and analysis were limited because data came from only one focus group interview with nine women for 1 hour. Third, the interview was not recorded on tape, and only notes were taken that were translated from Chaga to English. Although the interviewer asked the interviewees regarding background information at the beginning of interview, the translator and note-taker could not fully catch up with the interview process.

Therefore, the details of the interviewees' background information, such as individual age, educational status, age at first childbirth, etc., were not noted and there was no word-for-word description of the interview contents in the present study. In addition, some significant aspects discussed by the interviewees may have been missed in the process of translation, because there is sometimes no appropriate translation between Chaga and English for some practices and concepts that were difficult to explain in the English context. However, the authors and the nurse who conducted and participated in the interview complemented and assessed the description after the interview. The fourth limitation was that we could not obtain rich data regarding how women compromise between traditional and modern perceptions of maternity care and experiences, although the interviewer attempted to extract information regarding this point. This may have been due to a lack of clear transition of generations in the study area, and language limitations also represented a barrier to obtaining effective data, as mentioned above.

Although there were several limitations, we concluded that reproductive women currently perform traditional customs and practices in the study area. On the other hand, the concept of institutional childbirth was widely recognized by the women, but some felt compelled to follow their mother-in-law's suggestions to follow traditional customs and practices in the study area, which was a typical remote and rural village. The generation gap regarding the practice of modern and traditional customs in the suburban area of Dar es Salaam^{15,16} was not confirmed in the present study area, but it is possible that the same conditions will be faced in this area in future. It is important to have an understanding of the transition process of integration on traditional and modern customs and practices in childbirth, because health professionals should have the capacity to provide flexible care based on contemporary background and needs of women although health professionals' customs and practices in their own pregnancy and childbirth are different from those of the target population.

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