Common Knowledge Newsletter

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TRADITIONAL MIDWIFERY GATHERING MARCH 20-22 1998 A WORLD FIRST EVENT

THE THEME: TRADITIONAL MIDWIFERY PAST, PRESENT, AND BEYOND THE YEAR 2000.

The first integrated, international gathering of traditional birth attendants took place in the Ntshamathe (Sha-ma-tay) village in Umzingwane (Oom-zin-gwa-nay) District - Matebeleland (Ma-ta-bay-lay-land) South Province in Zimbabwe. The Ministry of Health and Child Welfare showed their enthusiastic support by co-hosting the conference with Common Knowledge and The Traditional and Medical Clinic.

The Aims of The Gathering

Aims of Common Knowledge

- Learn about the traditional knowledge of the local women
- Support cultural diversity
- Introduce modern trained midwives from other countries to traditional knowledge and practices
- To meet in a village where traditional women live

Aims of Zimbabwe Clinic

- Bring together women from different tribal groups to share their knowledge
- Bring the modern trained midwives of Zimbabwe to meet with some of the traditional midwives
- Look at the realities and problems facing both the Ïtraditional

The Zimbabwe Traditional and Medical Clinic

The History

Wintergreen, founder and trustee of Common Knowledge Trust, met Dr Barbara Sibanda, founder and director of The Zimbabwe Traditional and Medical Clinic, several years ago with the idea of bringing together traditional midwives and modern trained midwives from other countries. Her hope of keeping alive the common traditional knowledge which is so often hidden by the impact of modern ways, was met by rejoicing from Barbara whose life's work has been similar.

Wintergreen, Josh (Barbara's husband and supporterDr Barbara Sibanda

Barbara, the organisational wonder, brought together traditional midwives, Government officials and modern, medically-trained Zimbabwe midwives .More than 120 people came to the village to rejoice, learn and share. It is very difficult to organize such an event without financial support and we all had to sacrifice to bring this event to reality.

Barbara, a dynamic and highly respected woman, opened The Traditional and Medical Clinic in 1981. She went on to open the King's Maternity Clinic, a small private clinic in Bulawayo which provides a warm and friendly environment for over 300 women a year who give birth to their babies. She also opened a rural village clinic where The Gathering met.

Why was this Gathering Different?

Birth conferences throughout the world are usually only accessible to highly-educated or middle class care providers. They are often held in 4-star hotels. While the theme often relates to natural childbirth or the future of birth practices or traditional midwifery, there is little representation from the traditional women who birth babies in their communities and who still attend the majority of the world's births. Like midwives everywhere they have their stories, their knowledge, their fears and their problems. We felt strongly that it was time they had their own forum, instead of always being at the receiving end of the latest governmental or medical whim or trend.

Personal messages from the traditional midwives of Ntshamate

"Thank you, we gained knowledge from you, as much as you gained from us. What you started with us must not die as you leave, it must go on."

"Thank you for the love that was shown and to Chief Sigola in Ntshamate. What pleases us most is the spirits of this country - to bless us as traditional midwives and see us as Common Knowledge beyond the year 2000. Extend our thanks to the ladies who sent gifts. Send back our love and thanks and share the knowledge from the conference."

"Thank you for the love you have brought and the education and bringing us together. We would like to see this be something to pass through generations and that will be talked about as part of history."

Dr Barbara Sibanda's interview before The Gathering:

" In short what I am trying to say is this Common Knowledge, since it was formed, was an organisation that was silent, but working to co-ordinate people in different countries, talking to people, and getting the organisers organised. So now we're going to have a situation whereby it's now going to change to an organisation that will be known by many others all over the world through this particular conference. Why I'm saying that is because here in Zimbabwe we have already involved the government. The Ministry of Health is already interested in the work that Common Knowledge is doing and what medical and traditional birth is doing. This is why they've come to co-host the conference together with us. This is one score for an organisation such as Common Knowledge. Getting the government involved is not an easy matter. But I have convinced the government that it will benefit not only us but people all over the world. The second important thing is that what we have achieved is bringing in different cultures from different countries to come and interact in a conference. That interaction in itself is bringing people together for the common good of promoting traditional midwifery. Now, having different cultures coming together is also friendship among the participants. The participants will start knowing each other, and then maybe get to a stage whereby we can say now we are an organisation, so we trust and understand that we are really a welfare organisation, as we call it in our country. We are a non-profit organisation and now we must start getting funds for actual projects that we are doing as Common Knowledge. For instance, we have the kit about the bodywork which we want to distribute. That needs a bit of money to be put in. We also need a data collection centre at the conference so we can collect all the information from all these countries which are participating, and the information to be printed into a book by Common Knowledge. So these are some of the things I'm looking at. I'm looking at after this conference, people all over the world will know that this is really serious business. We are not that organisation we started as. We are now actually going into the world and the world recognises the work we are doing. So that is an important part of it; that interaction that we are now trying to do.

Common Knowledge a vital link from past through present to the future

Our future now as Common Knowledge is that we shall be asked maybe by other countries, to co-host other conferences. Maybe in your country, maybe in other participant's countries. Zimbabwe is just a stepping stone to make Common Knowledge be known all over the world. Which is why I'm happy the government has given us its support. One way or another, the next thing is that some are going to despise us. I have gone through that myself with this clinic. In1981-1982 no-one wanted to know me.That woman- how can she talk like that- how can she think doctors and healers can work together?"

Dr. Parienyatwa's Speech

"**T**raditional birth attendants(Gogo) have been with us conducting deliveries since time immemorial. In Sub-Saharan Africa and Zimbabwe in particular, traditional birth attendants still deliver a significant number of women, particularly in rural areas.

Dr. Parienyatwa, Deputy Minister of Health, receiving a flower from Jenny, of Common Knowledge. The Government of Zimbabwe officially recognizes their multi-tribal health practices. The modern health system is hampered by lack of funding, as it is in many of the "restructured" countries. The Government is seeking to balance the realities facing their particular country.

Upgrading the knowledge, attitudes and practices of traditional birth attendants has been found to reduce both maternal and infant morbidity and mortality nationally. The reduction of neonatal tetanus cases to almost zero is clear evidence of the importance and effectiveness of the traditional birth attendants training programme. I believe TBAs should be included, and include themselves in the wide concept of reproductive health.

My Ministry has been in the forefront in communicating, identifying and upgrading skills and knowledge of this important group which fulfils the needs of women when there is a gap in caring and will continue doing so.

It will be noted that women have informed choice about where to deliver, and figures indicate that traditional birth attendants deliver an average of 14% of the birthing population {In this region, ed.}. Home deliveries, if properly conducted, are an advantage to the women because of the family's support. Women who delivered at home are encouraged to go for post-natal care at clinics.

Your conference's theme "**Traditional midwifery, past, present and beyond the year 2000** " is challenging. It is my hope that the deliberations will go a long way in promoting safe motherhood and preventing child and maternal morbidity and mortality.

It is noted that the two and half day programme touches on all aspects of pregnancy and childbirth. Of interest in your programme is that you have a discussion on the role of men during pregnancy, birth and after. I hope your discussion will focus on those issues which men should provide in order to promote good health and well being for their women and the newborn.

This conference is an historical event in Zimbabwe and in the southern region, in the sense that it has drawn all key players to participate and share ideas and experiences. I have noted that the overseas traditional birth attendants and medical midwives, traditional birth attendants from the southern region and the technical midwives are present at this conference. I hope the experiences that will be shared will go a long way in promoting safe motherhood and childbirth. This is in line with this year's world health day theme "Safe motherhood - a right to life in Africa." It is like your conference is commemorating this day.

Ladies and Gentlemen, I also hope that all the information captured at this important conference will form a basis of our data bank in the region and worldwide."

Dr Theo Harvey, the medical doctor who has worked with Dr Sibanda for over 15 years. In his welcoming address he highlighted the need for health care workers and the traditional midwives to work together to cope with the scarce resources, poverty, inaccessibility of services and longdistances between health care facilities.

Thoughts from Common Knowledge

Wintergreen : "Regardless of the colour of our skin, religion, personal belief, ethnic background, social status, or where we live, all women have babies out the same hole and men put their seed in the same way. So, we have "common knowledge" together. Since time immemorial people have been ingenius and developed cultures. The knowledge that gets passed on within a cultural group is also "common knowledge." Modern medical information is anothr form of "common knowledge" but one which often disregards cultural knowledge."

More than 120 people attended The Gathering. More than 60 were Traditional Midwives from around Zimbabwe, including some from Zambia, and also some Traditional Healers. There were also Community Health Workers, District Nursing Officers, Hospital Midwives, and Midwife Trainers. We were thrilled to have in attendance so many Government officials, including Ms Hagar Mapondera, Public Health officer for the World Health Organization and Ms Omah Dube, the Traditional Birth Attendant Programme Co-ordinator. It was heartening to have in attendance and participation so many of the key figures involved in the liaison work between government programmes and the Traditiona lMidwives as they were able to experience and share directly in the exchange of knowledge, and witness how valuable this forum was for the expression of both common ground and major differences.

For Zimbabweans, this event was unique and turned out to be so exciting that national TV and national newspapers gave it prominent exposure. When we do this again, it will be supported by both the Minister of Health and WHO.

Among the Traditional Midwives were some older midwives who practise in the traditional ways, younger midwives who had participated in the Traditional Birth Attendant Training Programmes, and others from a particular church or faith who considered themselves Spiritual Midwives and used prayer and faith as a means of securing the best outcomes. All were assumed by the Ministry of Health to play major roles in counselling, family planning, and caring for the mother and child throughout pregnancy, birth and post-partum.

The Traditional Birth Attendant Programme coordinator, Mrs. Omah Dube.

More than 120 people attended the Gathering. Traditional midwives, international midwives, technical midwives, trainers, Government representatives

The first day of the conference was largely taken up with speeches by the invited guests and organisers mentioned earlier.The international delegates were introduced and given the opportunity to present information about themselves and their practice in midwifery in their particular countries. There were representatives from Australia, Denmark, USA, Canada, New Zealand and Sweden. Some worked in hospitals, some at home, some were registered and some traditional (working from a non-medical basis).This fairly official day was interspersed at every available opportunity with song and dance by the traditional midwives, healers and invited dancers, and anyone else who wanted to join in. This included people from the village who came for this big event. It was a grand opening and an uplifting start to the Gathering.

The second day we had the opportunity to share information in smaller groups. The topics all related to traditional practice and were asked to be looked at in the light of the **THEME** of the conference:

TRADITIONAL MIDWIFERY PAST, PRESENT, AND BEYOND THE YEAR 2000.

The workshops that day were:

* **THE ROLE OF THE TRADITIONAL BIRTH ATTENDANT**
* **PRACTICES BEFORE AND DURING PREGNANCY**
* **COMPLICATED PREGNANCIES AND DELIVERIES**
* **PRACTICES AFTER DELIVERY**
* **TRADITIONAL ROLE OF MEN BEFORE PREGNANCY, DURING PREGNANCY AND AFTER DELIVERY**
* **CARE OF THE NEWBORN**
* **RITUALS BEFORE, DURING , AND AFTER DELIVERY**

The reports from these small conferences were shared with everyone during the afternoon and following morning, with too little time left for the lively questions and answers which followed. Small groups were planned so that the traditional women would feel more comfortable. Generally, there is a belief that these women will feel inhibited in a large group that has a large Government or professional representation. However, we found that even in the small groups, the technical midwives often ran the discussion. This was more apparent in the groups which dealt with those areas of pregnancy , birth and newborn care which is seen of as "medical". In the future we will stay in a large group because we found that reading reports, translating them in 3 languages was a very big chore. Keeping people together seems to be the best option.

Pregnancy

The traditional midwife now is expected to advise expectant mothers to book in at the local clinic for ante-natal screening.The traditional midwife attends the birth, but will probably see the woman from time to time in the village to ask how she is doing.

The mother can choose which midwife she would like to have at her birth, and two traditional midwives usually work together.The traditional midwife checks the woman's home and general living conditions.She also speaks to the father about his forthcoming role, advising and counselling where necessary.

She advises the woman on diet, herbs (inkuzane or ruredzo) or soap to make the birth canal slippery towards term.The midwife also assesses fetal movements and the general well-being of the mother, and advises her on diet, health and parenthood and to have regular visits to the clinic. She is expected now to also counsel the woman on family planning.

For heartburn, the mother is given very little to drink. For cramps the traditional midwife massages the muscles. For hip pain, ground donkey bone is used as a rub.

Birth:

The birthplace may be anywhere in the home.The midwife will help prepare the room by warming it if necessary, sprinkling water to settle dust, and cleaning soot off the roof with a dry branch.

The midwife is usually called when the labour is well advanced, but women can call her earlier.

She will make some porridge for nourishment, and force the mother to eat if she is weak. She now listens to the fetal heart wth a toilet cardboard tube, and asks the mother if the baby is moving and okay.

Traditionally the midwives lift the mother's buttocks and perform internal podalic version for breech babies.This practice is now discouraged if the baby is known to be breech beforehand, and clinic referral is required.

Early rupture of the membranes is traditionally interpreted as the washing of the baby and the birth canal, and not considered a problem. Cord prolapse is rarely if ever seen and traditional midwives are encouraged to refer to the clinic if they recognise it.

Some traditional midwives pray for the mother.

Herbs are sometimes used to stimulate and precipitate the labour. Dried donkey's placenta is a natural form of oxytocin. (We were told that it is used as a labour stimulant and can cause the labour to be overly strong; some women take it before presenting at clinics and hospitals for their birth. Others stressed that it was only used to control post partum haemorrhage.) Dried fish is also used to stimulate and initiate labour and also for turning transverse babies.

Some midwives do vaginal examinations but it is not encouraged because of the high incidence of AIDS and lack of sterile gloves. Traditional midwives are encouraged to use empty plastic bags (sugar bags) in the absence of gloves.

When the signs of second stage are apparent (bulging anus and the mother says she is bearing down) the

Some of the midwives from Umzingwane Village. Inside their rural clinic.. Our first meeting.

woman is encouraged to lie on her back with a mealie mortar under her head for support. Women used to squat but it ís not encouraged any more. There are often 10-20 people in the room.

A slippery plant extract from a tree is boiled and used on the hands to stretch and massage the perineum, and also traditionally used to extract baby animals having difficulty birthing.

Traditionally, if the baby was stuck by the head or breech, then the perineum would be torn and both hands used like forceps.

If the baby doesn't breathe right away then cold water is sprinkled on the baby's face, or it is fanned to ensure it gets enough air, or the feet are flicked.

If the midwife has been supplied with a sterile kit from the local clinic, she will use the cotton ties, razor blade and spirits on the cord. Otherwise boiled salted water will be used.

The mother is encouraged to kneel to birth the placenta, and wait for nature to take its course. She will blow into a bottle if it doesn't come straight away. The cord is tied but not cut until the placenta is out. For a retained placenta, in some traditions, the cord is tied around the mother's thigh to stop the placenta going to the heart when she breathes in - she could die. She is asked to keep blowing into the bottle.(I wonder if this could be referring to concealed haemorrhage and the cord shortening if the uterus fills with blood? Ed.) The throat may also be irritated or tickled to encourage coughing, or salt water drunk to induce vomiting, or the vagina smoked with specific herbs to force the placenta out.

Certain barks and donkey's placenta are traditional remedies for excessive bleeding, as is throwing a rock into the house to frighten the mother into stopping bleeding; but traditional midwives are now being strongly encouraged to transfer complications. Traditional midwives and those from other countries suggested giving the mother plenty of fluids and rubbing the mother's nipples or feeding the baby to stimulate contractions.

(**Cont page 6**)

Birth (cont from page 5)

If the membranes are still caught inside then they are wrapped around some mat straw and pulled out.The placenta is turned inside out, to ensure that the woman has a different sex baby next time.

Traditionally, a hole is dug in the corner of the kitchen (near where the mother sits if it is a girl baby, and near where the father sits if it is a boy baby) where no-one will step, and the placenta is buried there. This is to remind the child to always come back home.

With the WHO training of traditional midwives, disposing of the placenta via a plastic bag into the toilet is being held up as the safe hygienic approach. One of the traditional healers felt that the breaking of this deeply symbolic tradition was the cause of communication breakdown between today's youth and their families and communities.

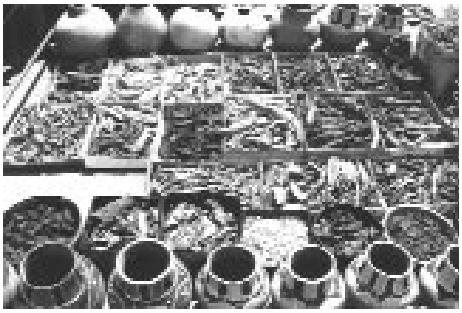
Midwives of the future?

For small and medium tears, sitz baths are prepared using the bark of the marrula tree. This causes the vaginal muscles to contract. The bark is boiled, cooled overnight and then used in a cold sitz bath. Traditional midwives are now encouraged to refer women to the local clinic for suturing large tears.

The traditional midwife visits the mother every day for a month and helps bath the baby, cook porridge, care for the baby, and help heal tears with sitz baths.

Traditional midwives are now encouraged to refer the mother and baby to the local clinic soon after the birth for weighing and assessment. This happens within the first few days or week after the birth. The local village community worker is also informed.

TREATING INFERTILITY TRADITIONALLY



Local herb market in Bulawayo

- Traditionally midwives and healers use herbs.
- Skills involving repositioning of the uterus in order to conceive are time honored and highly valued.
- Some spiritual traditional midwives from particular churches help women conceive. If they are not conceiving, it is often thought to be caused by bad spirits. They use prayer to secure a good outcome, and continue to pray and counsel and give holy water after the woman has conceived.

SOME WOMEN SEE ONLY TRADITIONAL MIDWIVES FOR CARE FOR INFERTILITY.

The reasons for this may be cultural or community isolation, or belonging to a specific religious group.

THE TRADITIONAL ROLE OF MEN (BEFORE, DURING AND AFTER PREGNANCY)

Past

The male's only role was to get the woman pregnant.

There was discussion of when to have the child, and complaint from the in-laws if there was no child within 1-2 years.

Medication would be given to the father before intercourse so as not to interfere with the growth of the baby.

Future

It was generally hoped that in the future the men would play a more supportive role in ensuring the woman's health.

It was also hoped that there would be more choices available in how to deal with infertility. Some couples may choose to accept not having children.

Some of the traditional midwives from the many areas of Zimbabwe. Everyone was eager to have their picture taken, proud to be a part of history!

Traditional Practices Before Pregnancy

The past : before menses

There is pulling on the labia minora with the bark of a certain tree or sticky milky substance on fingers.

The young girl faces a certain tree, talks to the tree, and asks the tree for the type of breasts she wants, shaping them to her particular desire.

Girls wear a string around their waist.

Changes are observed in the pubic area.

At menses:

The girl breaks the string around her waist, puts it across the doorway and the mother puts it on for three days to regulate the menses.

An auntie observes how many days bleeding occurs. If more than five days, the girl goes to a many- coloured rock and points to the colours three times, in order to make sure she only bleeds for three days.

The girl goes to an aunt or an old lady past menopause and silently receives a gift of porridge which she pricks three times in order to regulate menses.

Sadza (porridge) is cooked in a traditional plate which is then turned upside down. Three mounds of sadza are put on top. The first two the girl doesn't finish and throws on the floor. The third mound she doesn't finish, and pats into a flat cake on the floor. Without turning back, she goes to a room where her auntie is waiting to teach her about womanhood.

The girl is taken to an isolated place, counselled and talked to by older women, and examined to see if she is a virgin. If not, they return to the village in disgrace bearing only half a cup of water, or an incomplete leaf, or torn blanket. The virgin's cup would be full, the leaf complete or blanket whole.

Older women would examine the child to see if she had a big enough pelvis, and they would check on her menses.

Almost all cultures represented were very concerned about the menses only lasting three days, otherwise there is concern about the health of the woman.

In the present

Cultures are more mixed, urban schoolteachers replace aunties. There is education about the importance of virginity, how to handle menstruation, and anatomy. This is complemented by the mother's knowledge at home and by friends. The girls are also educated on STDs, signs of pregnancy and gender issues.

It is felt that children no longer effectively communicate with their parents, and girls tend to have longer periods, and dysmenorrhoea with pain relief needed.

In a few cases, some girls confront their fathers with staining on their pants and then they are referred to the mother.

There is a big gap between past and present practices, so now the church and kitchen tea associations provide much guidance and education. Also there is media education.

There is also a lot of divorce going on, and the opinion of one woman working in the field is that it is because of the short labia minora

In the future

Relationships between traditional midwives and trainers should become stronger. They need to work more hand- in- hand with one another and learn from each other.

It is necessary to look at practices and strengthen successes and eliminate failures.

Wintergreen isn't pregnant. But how else are we to learn without touching and laughing?

Traditional Practices during Pregnancy

The past:

The couple are together for seven months and then apart for two in order to prepare the birth canal. The abstinence was also to avoid sexually transmittable diseases from outside the marriage.

The diet was okra and other slippery foods and the mother was advised not to eat too much otherwise the baby would be too big. No chilli otherwise the baby's eyes would be red.

The present:

Sex continues but recommended to use condoms to avoid the risk of acquiring sexually transmittable diseases.

The media is now a source of information on safe-sex practices.

Clubs, churches and associations also take an active role in education through pregnancy.

There are no longer pelvic assessments or podalic version (turning breech babies)done.

The future:

Refer complicated pregnancies as early as possible to the clinics.

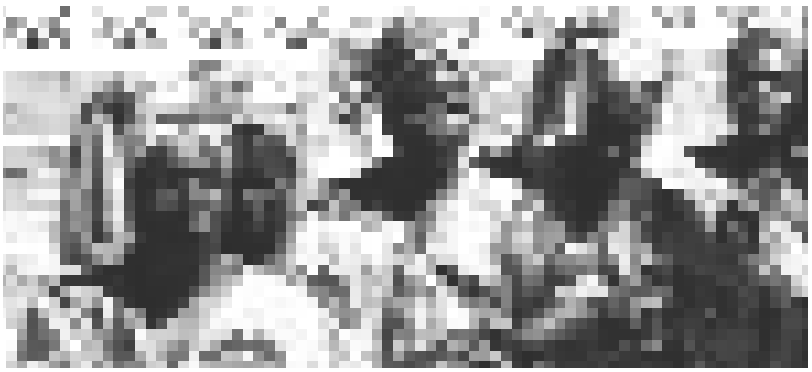
Upgrade the knowledge of all midwives, both technical and traditional.

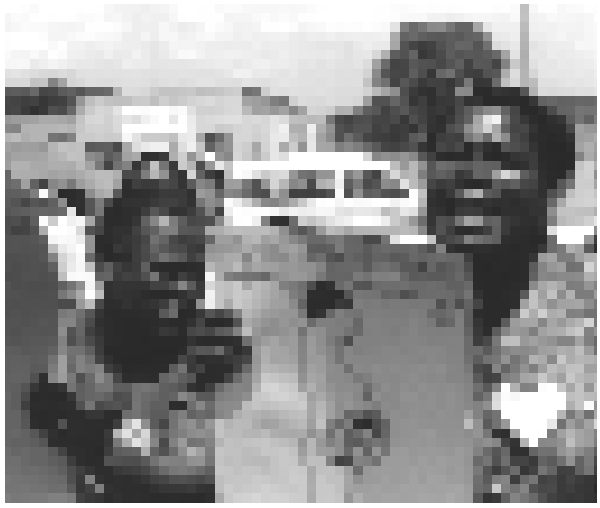
Traditional midwives are the backbone of provisional health care and need to have phones installed on all their homesteads.

Joint meetings need to be encouraged to promote healthy practice and relations between traditional and conventional practitioners.

THEY SAY: **"A PICTURE SPEAKS A THOUSAND WORDS".**

OUR PICTURES SPEAK of OUR PAST, PRESENT AND FUTURE





WE CAME IN ALL AGES!

and we learned...

Sai Moyo, our spiritual guide, traditional healer and kind gentleman

POST PARTUM DEPRESSION a presentation by Mrs A. Ndlovu

Mrrs. Ndlovu stressed the leading role traditional midwives have in helping prevent and deal with depression. She can be a catalyst in preventing post partum depression. It has been shown by research that traditional midwives are preferred because of the social support. She understands the woman more as an individual and can acknowledge when the woman is communicating to her through unusual behaviour.

Family planning plays an important role. Traditional midwives should be encouraged to have a thorough understanding and knowledge of family planning practices and methods as the mother has a lot of faith in the midwife. Too many children can cause a lot of mental stress. There is less stress if the children are well spaced and the woman is given a chance to relax psychologically.

Traditional family planning methods include the mother tying a cord around her waist to remind her husband that she is not available for sex. Also taking herbs, or burying a bottle of herbs outside the bedroom. Also abstaining from sex until the baby's first teeth are through. (This can be a long or depressing wait says one midwife.)

So the modern concept is to encourage the use of condoms pre and post natally, to prevent STDs and conception. The advantages definitely outweigh the disadvantages. Breastfeeding is also a good way to prevent early conception, except that very depressed women don't usually want to breastfeed. It is a challenge to promote good parenting skills.

Gender bias is also a contributing factor to post partum depression. Husbands need to find out why their wives aren't behaving in the usual way, instead of just calling them lazy. Signs are weeping, lack of self-care, forgetting to feed the baby,orbecoming mute .Depression can also be due to malaria, repeated sepsis, or a long and difficult labour with subsequent rejection of the baby .It is believed that depression can also be related to something going wrong with an ancestral spirit.

TRADITIONAL PRACTICES AFTER DELIVERY

Past

The mother is kept indoors until the cord has dried up.
She is given special food and sitz baths.
The baby is sometimes bathed on day 2, and only warm water fed to the baby until the cord dries.
Traditionally ashes, cow dung and breastmilk are applied to the cord.
The baby is wrapped in dirty linen until the cord drops off, and baby's clothes never aired outside the home (to prevent tetanus.)
Baby and mother and father are kept indoors for up to one month.
No intercourse for at least six months.(for spacing children).
For irritable , uncomfortable babies, sometimes a herb called Maqoqana is smoked in the fire

Present

The baby is wrapped in warm linen.
Breastfeeding is immediately encouraged.
Nappies are now aired outside the house.
The cord is dried fast with spirits.
The mother is encouraged to eat warm foods(porridge and tea).
If the delivery is normal, the mother is referred to the clinic for weighing and to obtain a care-card.
The mother rests for two weeks, but if no help is available then she starts cooking straight away.
She will bathe and have marulla sitz baths twice daily.

Future

Traditional midwives would prefer to have scales to weigh the baby at home.
It would be optimal for the mother to have two weeks resting time, and no sex for at least 6 months. (Current family planning education is encouraging women to have sex earlier with contraception, to encourage husbands to be monogamous and so lessen the incidence of AIDS.) One of the traditional midwives suggested the very practical traditional solution of having sex between the thighs. This seemed like a very sensible and simple compromise. (Ed.}
Meths and sterile gloves need to be always available.

Abnormalities

Traditionally, babies with cleft palates or spina bifida were smothered.
Traditionally, the second baby of a set of twins was killed as twins were considered taboo.
At present, parents would go to court or jail if the baby was killed, but still don't know what to do with them (the babies).

SOME OF THE REALITIES IN ZIMBABWE

The Minister of Health and Child Welfare is working with WHO. For 3 years there has been a programme established to train the TBAs as front- line community health workers in the rural areas. They would like to see the useful practices maintained and the harmful ones let go. Exactly which practices no one really knows.Perhaps we will get an opportunity to talk abou these issues and address them through the development of the College of Traditioinal Midwifery which The Traditional and Medical Clinic is committed to opening in affiliation with Common Knowledge.

For example, WHO is encouraging TBAs to bring women in if they have problems. There is also a system in place so that women with medically defined problems can be assisted through the medical system. TBAs are not encouraged to help these women, who have clinic cards with a red star which indicates that they may be a problem. There are some mixed realities that we all recognize. Are medically defined problems exactly the problems that TBAs have difficulty with? Are there skills which TBAs have that can deal with some of these problems? To bring women into the clinic when there is an emergency is difficult, due to distance and lack of transport, and is that the best time to move a woman? Clinics are not always technically capable of handling difficulties either. The college will investigate the range and abilities of the traditional skills and the Ministry is eager to learn more about these things.

The medical services in Zimbabwe compared to the very modern countries, is very modest and always struggling. The Government of Zimbabwe recognizes all forms of traditional healing and healers. Problems exist in the hospital birthing situation as well and there is great interest in bringing the traditonal and modern more together.

There were many cultural rituals and ceremonies that are being altered by modernization and urbanization. We felt that these issues needed to be addressed. For example, for sanitation reasons the afterbirth is no longer buried in a traditional way, which is connected to having young people tied to their place of birth. Now that the afterbirth is being disposed of in a modern way, there are those who believe that children no longer feel connected to their place of birth. These are very real issues that effect the culture profoundly.

Where would we be without midwives? Why, we'd just be women helping each other to have our babies and sitting on the wall.

There are many cultural rituals and ceremonies that are being altered by modernization and urbanization

There were other examples that came up at the Gathering. WHO is encouraging women to be delivered on their back, when this trend has changed in developed countries where this idea was developed. The Minister of Health would like TBAs to wear gloves, yet they aren't available. Can we work together to understand policies and the realism of policies?

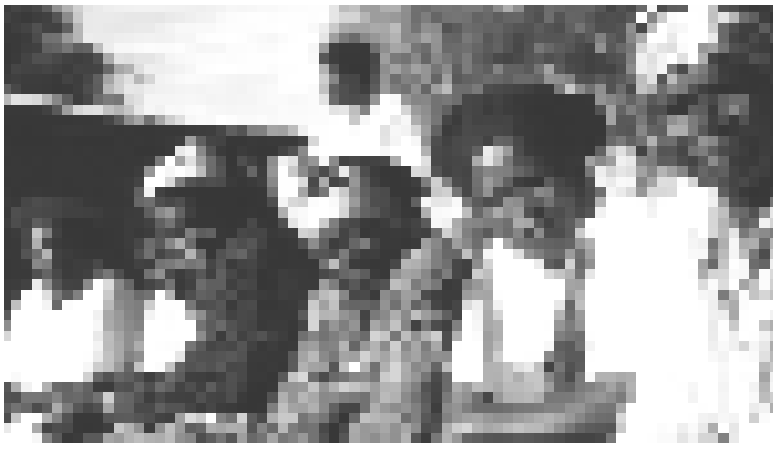
The TBAs would like a phone in each home to call for transportation if necessary, but this financially is not likely. They would like one vehicle per village to act as transport, but once again this is not financially possible. They are being taught to use a toilet paper tube to listen to the heart beat. They want to get modern equipment. Is this necessary, practical, or something they could build there? These are all questions which they are eager to address. They would like the kits WHO has provided to be filled up and blankets to be available.

SO WHERE DO WE GO FROM HERE?

The Zimbabwe Traditional and Medical Clinic, through their Board of Directors, is organizing the college of Traditional Midwives.

Any support that you give should go directly to the Traditional College

We are planning on another gathering in Zimbabwe in 2 years time and the Minister of Health and hopefully WHO will help with the funding. We hope to have more gatherings in other countries, in other villages in the future. Common Knowledge is about our lives and our knowledge. It is about the reality that regardless of skin colour, religion, belief or culture, we all have babies out the same hole and men put that gift of life into us the same way. We share common knowledge. We also acknowledge the ingenuity of humans to come together to develop cultures, and the knowledge we pass down is our unique cultural common knowledge.



COMMON KNOWLEDGE AND THE ZIMBABWE TRADITIONAL AND MEDICAL CLINIC COLLEGE OF TRADITIONAL MIDWIVES

The Zimbabwe government supports traditional knowledge and traditional practice. You have the opportunity to preserve and pass on this knowledge and grow your skills with dignity.

***K**eep the focus on traditional midwifery (tribal differences, village differences, religious differences) so that we can explore the whole scope of what has been traditional practices as compared with modern medical practices. Try to get a clear picture of what is traditional and what is modern.

***S**tart by assuming that everyone is doing their best and would like the most positive outcome.

***A** strong foundation of respect between all people who attend should be cultivated.

***I**nvite traditional midwives to contribute to the overall organization and running of the college.

***I**nvite the older traditional midwives to share their knowledge, experience and ensure their participation.

***R**ecord stories and information and specific traditional practices so that they are not lost.

***W**ork on cultivating understanding of what is "traditional" and what has been introduced through contact with medically trained midwives. Remember that medical opinion changes faster than traditional knowledge. For example, it was the medical profession that had women lie on their backs so that the doctor could have a better view of the woman's bottom. For 2 generations in most modern countries all women birthed on their backs. Now in most of these countries women are staying upright. There are many reasons for this. It is believed that "traditionally" most women birthed upright. And medically, they have discovered that there is an increase in cord prolapse, bleeding, difficult births, more pain when women are lying on their backs.

***I**nvite guest speakers from different countries (very different traditions) and also from the medical profession to learn about what they are doing. This way you can look at different options and talk about them.

***T**reat everyone in the college equally. The college needs to be a safe place for traditional practitioners.

SOME QUESTIONS:

These questions are not in any order of significance. They are questions that popped into our heads as we thought about the college and Common Knowledge.

Please remember that in countries where the medical profession is very developed, for almost 2 generations there has been little cultural health knowledge available to people. Recently, there has been an increased interest in natural birth and the revitalizing of knowledge and skills that come from cultural knowledge.

Questions upon Questions.... and there are many more!

? What problems were happening in the past in all aspects: puberty, menstruation, infertility, pregnancy, birth, babies, nursing,child spacing, childhood disorders, wellness of mothers, etc.
? What problems are happening today. And what do you think are the causes.
? What things have improved and why.
? What did traditional midwives do. What were the expectations of your role. How has that changed from one generation to the next.
? How are medically trained midwives different from traditional midwives.
? How did you learn. How do you keep on learning. How is learning different between generations.
? How did you become a midwife. ***(THIS WILL BE THE TOPIC OF OUR NEXT NEWSLETTER, SO SEND IN YOUR STORY, IN YOUR OWN LANGUAGE, TO THE TRADITIONAL CLINIC IN BULAWAYO)***
? What traditional skills do you feel are being lost. Why are they being lost. How is that affecting families and communities.
? Do you use ceremonies and rituals in your practice. Do they vary from area to area or individual to individual or cultural group to cultural group.
? Do you have access to enough information for learning more skills.
? Do you know which of the modern medical skills you feel make for safer childbirth.
? What practices and situations do you feel comfortable with.
? Modern medical practices outline what they consider to be "high risk." Are those the same things that you consider to be a problem. Which ones and why.
? Are there other things you consider a problem that the medical model doesn't talk about.
? What frightens you. How do you deal with fear.
? Do you have the opportunity to talk together about the births you attend and any problems that you have encountered.

And MORE!

? Do you ever send anybody to another traditional midwife because you don't feel comfortable.

? Is there a change from the past as to which family members are at the births, both at home and at the clinics or hospitals. Who supports the mother in pregnancy and birth.

? Do you believe that their training makes them better than traditional midwives.

? Have you ever been involved with hospitall births.

? Does the technology of modern medicine frighten you. Make you wish you it was available to you. Do you dislike it.

? In learning skills do you want to blend traditional and modern ways. How and what. Or do you believe that modern and traditional are or should be separate.

? Do you enjoy telling each other the stories of the births you go to. Do you feel the stories are important.

? If you refer a woman in birth to a clinic for a complication, what skills do you use while transporting.

? Do traditional midwives go to the clinic/hospital with the mother for support and assistance and to find out what happens.

? Do you feel as educated or respected as a medically trained midwife.

? Traditionally men have not been involved in birth. Is that changing. How.

? Do you know much about what medically trained midwives do.

These are some of the questions that we talk about. We hope that you will find them interesting. What are your questions?

The unsung heros behind the scenes

Others whose untiring work must be recognized

GOALS AND OBJECTIVES

1. To promote the understanding and tolerance of diversified health issues/systems in relation to the individual, families, groups, societies and cultures: local ly, nationally and globally.
2. To promote the conservation of diversified health knowledge.
3. To educate people in the diversified health knowledge known by cuturally divesified groups.
4. To promote "Common Knowledge" approaches in regards to the health of iindIviduals, families and cultural groups.
5. To provide liason to explore opportunites for traditional peoples to communicate their needs/concerns in regards to the use of the modern medical model and the impact thereof.
6. To promote the legitimatization of diversified health systems as independent systems without the need to legalize them through the governmental system or the allopathic health system.

MEMBERSHIP FORM

When you become a member of Common Knowledge, you will receive our Newsletter. Each Newsletter will have a Theme. The next one: How did you become a midwife, traditional birth attendant or traditional healer? **We would also welcome any stories you would like to share. We are always seeking funds to cover the costs of "The Gatherings" and monetary donations would be greatly appreciated.**

Send your stories in by 31 May 1999

IN AFRICA: $50Zim 1 YEAR { } $75Zim 2 YEARS { } $150Zim 4 YEARS { }
OVERSEAS: $10US 1 YEAR { } $15US 2 YEARS { } $30US 4 YEARS { }

YES, I WOULD LIKE TO MAKE A DONATION. PLEASE SPECIFY THE AMOUNT { }

PLEASE PRINT

NAME.....

ADDRESS.....

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Tel/Fax/Email .....

The small group from overseas, both medical and non-medical midwives. They do both hospital and home.

Payment: Cheque or Money Order.
Do not send cash

Amount enclosed:

.....$ US / $ Zim

Sister Jefferies, the medical midwife for King's Maternity Clinic, Bulawayo