The Challenges Associated with Traditional Prenatal Care Practices among Pregnant Women in Rural Zimbabwe

Florah Nokuthula Takavarasha[1], Nicole Chatindo[2], Taruvinga Muzingili[3*], James Dominic Shalom Sithole[4]

[1]Department of Social Work, Zimbabwe Ezekiel Guti University, Harare, Zimbabwe.

[2]Department of Social Work, Women's University in Africa.

[3]Acknowledge Education Department of Social Work, Melbourne, Victoria, Australia.

[4]Women's University in Africa, Department of Social Work, Harare Campus, Harare Province, Zimbabwe.

[*]Corresponding author

DOI: https://dx.doi.org/10.47772/IJRISS.2025.907000006

Received: 12 May 2025; Accepted: 20 May 2025; Published: 26 July 2025

ABSTRACT

This study investigates the challenges associated with traditional prenatal care practices among pregnant women in rural Zimbabwe. Traditional birth attendants (TBAs) remain central to maternal care in these communities due to cultural familiarity, accessibility, and affordability. However, their services are often provided without formal training, resources, or integration into the national healthcare system. The study aimed to explore how these practices influence maternal health outcomes and identify gaps hindering safe pregnancy and childbirth. A qualitative research approach was used, employing an interpretive phenomenological design. Data were collected through semi-structured and key informant interviews with 15 pregnant women and 5 TBAs. Findings revealed several challenges, including limited clinical knowledge among TBAs, inadequate medical resources, risk of complications during high-risk pregnancies, stigma from health workers, and poor coordination with formal healthcare services. These factors contribute to delays in care, preventable complications, and emotional distress among pregnant women. The study concludes that while traditional care is culturally valued, its isolation from formal systems poses risks. Practical integration—through TBA training, clear referral systems, and cultural sensitivity among health workers—is essential to improve maternal outcomes and align community practices with national health goals.

Keywords: Traditional Prenatal Care, Maternal Health, Zimbabwe, Traditional Birth Attendants, Health Belief Model, Rural Healthcare, Policy Integration.

INTRODUCTION

The Sustainable Development Goals (SDGs) provide a global framework for addressing critical health challenges. SDG 3 explicitly aims to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030. Despite these ambitious targets, maternal health remains a critical concern in many low- and middle-income countries, particularly within Sub-Saharan Africa (Chipunza & Nhamo, 2023; Musiwa et al., 2024; Musona et al., 2024). In these regions, systemic challenges such as limited access to formal healthcare, economic barriers, and cultural preferences impede progress. Zimbabwe, like many of its regional counterparts, faces persistent maternal health challenges, particularly in rural areas where most of the population relies on traditional prenatal care practices. The use of traditional medicine and the involvement of traditional birth attendants (TBAs) remain widespread in rural Zimbabwe (Zinyemba, 2022). These practices are deeply rooted in cultural and spiritual beliefs and are often more accessible and affordable than formal healthcare services (Musona et al., 2024). However, the reliance on traditional practices, particularly when unregulated or used in isolation from modern healthcare systems, may contribute to poor maternal outcomes.

The gap between traditional practices and formal maternal healthcare creates a complex landscape that challenges the implementation of national policies aimed at improving maternal and neonatal health.

This study aims to critically explore the challenges of traditional prenatal care practices among pregnant women in rural Zimbabwe. It examines how these practices interact with formal health systems and influence maternal health outcomes. The study also considers how these insights may inform more culturally responsive health policies and programming to improve maternal healthcare delivery without undermining traditional knowledge systems.

LITERATURE REVIEW

Traditional prenatal care practices remain a significant component of maternal health strategies in many parts of the world, particularly in regions where formal healthcare systems are underdeveloped, inaccessible, or culturally misaligned. These practices often arise from centuries-old indigenous knowledge systems and continue to be trusted sources of care, especially in rural and marginalized communities. However, their impact on maternal outcomes varies widely depending on the extent to which they are integrated with formal healthcare systems. In Eastern Europe, particularly in rural Romania, traditional herbal remedies are used among expectant mothers. Păduraru et al. (2019) found that many of these remedies are administered without clear dosage guidelines or scientific validation, posing risks to maternal and foetal health. The unregulated status of traditional midwives, combined with inconsistent access to formal healthcare, exacerbates these risks. This situation bears resemblance to rural Zimbabwe, where TBAs operate without formal training or oversight, often leading to complications during childbirth (Choguya, 2014). In Western Europe, although traditional prenatal care is rare due to widespread access to healthcare, challenges persist regarding the cultural sensitivity of maternal services. Sharma et al. (2020) highlight that some immigrant and minority groups prefer traditional methods, which are frequently misunderstood or dismissed by formal providers, leading to mistrust and lower utilization of services.

In the Middle East, religious and cultural beliefs strongly influence traditional prenatal care. Al-Krenawi et al. (2011), in their study of rural Jordan, observed that pregnant women often delay seeking formal care due to reliance on spiritual healers and religious rituals. Such delays increase the likelihood of complications during pregnancy and delivery. Similarly, in rural Iran, Kheirabadi and Maracy (2010) reported that the absence of structured collaboration between traditional and biomedical practitioners often results in conflicting advice and fragmented care. These challenges are mirrored in Zimbabwe, where women may consult both TBAs and clinic-based providers yet receive inconsistent guidance that complicates maternal care planning (Zinyemba, 2022). In North America, among Indigenous communities in Canada, traditional prenatal care is not only a health practice but also a means of cultural preservation. Browne et al. (2016) noted that geographic isolation and historical marginalization contribute to ongoing disparities in maternal health. While traditional care may offer psychosocial benefits, it can delay necessary medical interventions. Zimbabwean women in rural regions face similar barriers, including geographical isolation, economic hardship, and a preference for culturally resonant care, all contributing to delayed engagement with formal health services (Zinyemba, 2022).

In South America, particularly in rural Peru and Bolivia, traditional prenatal care plays a significant role in maternal health. Mathez-Stiefel et al (2012) found that using coca leaves to alleviate pregnancy symptoms is common, though often unsupported by scientific research. When misused, such remedies can pose risks to maternal and foetal well-being. This is comparable to the Zimbabwean context, where pregnant women consume herbal preparations intended to induce labour or protect against spiritual harm. However, the lack of dosage control can lead to adverse outcomes (Musona et al., 2024). In North Africa, cultural and religious practices significantly influence maternal health behaviours. In Egypt, Chamberlain (2004) highlighted that reliance on spiritual healers and home-based care often results in delays in accessing emergency obstetric services. The lack of scientific oversight and regulation of these practices creates a parallel health system that is largely unaccountable. Zimbabwe shares this challenge, as traditional practices operate independently of national health regulations, often leading to unmonitored and unsafe maternal care practices (Maoza et al., 2019).

In West Africa, rural communities in Nigeria demonstrate a high preference for TBAs due to trust, familiarity, and accessibility. Okafor et al. (2016) identified the lack of formal training and government regulation as key risks associated with traditional prenatal care. Women often seek TBAs even when formal facilities are available, leading to delayed interventions during complications. Zimbabwe's rural populations demonstrate similar trust-based preferences for TBAs, often choosing them over clinic-based services despite the known risks (Mlambo, 2021).

In Central Africa, particularly in the Democratic Republic of Congo, traditional prenatal care remains the primary option in many rural areas. Esther et al. (2017) found that the absence of integration between traditional and formal providers leads to fragmented maternal care. Pregnant women often navigate both systems simultaneously, but without coordination, the risk of miscommunication and conflicting treatments increases. This lack of system integration is also evident in Zimbabwe, where TBAs are sidelined in health policy and excluded from formal maternal health planning (Mudonhi et al., 2022). In East Africa, the challenges of traditional prenatal care are amplified by geographical isolation and limited formal health infrastructure. In Tanzania, Mahiti et al. (2015) emphasized the need for greater oversight of TBAs and the herbal remedies they administer. Despite government efforts to promote facility-based deliveries, many women rely on traditional methods. Zimbabwe faces similar difficulties, with women often using traditional remedies secretly due to the stigma attached to such practices in the formal healthcare system (Mudonhi & Nunu, 2022). In Southern Africa, Malawi presents a context very similar to Zimbabwe.

Zimbabwean Context

In Zimbabwe, the reliance on traditional health care remains widespread, particularly in rural communities where formal healthcare infrastructure is limited and poverty is rampant (Muzingili, 2017; Taruvinga & Simbarashe, 2015). Traditional medicine often induces labour, promotes foetal development, or offers spiritual protection (Musona, 2024). These practices are not only culturally normative but are also seen as necessary due to the inaccessibility or unaffordability of formal maternal healthcare services. Pregnant women in rural areas frequently consult traditional birth attendants (TBAs), who provide care based on indigenous knowledge and spiritual guidance (Zinyemba, 2022). These TBAs are often regarded as more empathetic and attuned to the community's cultural needs than formal health workers. The reasons for the continued reliance on traditional practices are multifaceted. Cost, distance to health facilities, and negative experiences with formal healthcare workers all contribute to the preference for traditional methods (Muzingili & Chidyausiku, 2017). In many rural parts of Zimbabwe, health centres are understaffed, poorly equipped, and far from villages. Women may have to walk long distances or pay for transportation they cannot afford, which deters them from seeking formal healthcare (Chidyausiku et al., 2025). Apart from the value given in traditional practices (Zinyemba, 2022), rural Zimbabwe is characterised by persistent poverty and marginalisation from development programmes (Muzingili & Taruvinga, 2025; Muzingili, 2017).

Religious and spiritual beliefs also play a significant role (Muzingili & Gombarume, 2018). Many women believe that pregnancy is not merely a biological process but a spiritual journey that requires rituals, cleansing, and the protection of the unborn child from evil influences. TBAs and traditional healers are seen as the custodians of such knowledge (Zinyemba, 2022). As a result, their services are not only preferred but often perceived as essential. Women sometimes use herbal remedies in secret due to fear of judgment from formal health providers, which compromises the safety and effectiveness of clinical care interventions. Despite government efforts to improve maternal health outcomes, including the introduction of Maternal Waiting Homes (MWHs) and campaigns promoting facility-based deliveries, the uptake of such interventions remains low in many rural areas (Chipunza & Nhamo, 2023). These findings underscore the need to understand and address the cultural and structural determinants of maternal health behaviour.

The lack of formal recognition and integration of traditional care into the national healthcare system further complicates the situation. TBAs are not formally trained, regulated, or included in maternal health policies, despite their widespread use. This exclusion creates a fragmented care system where traditional and formal providers operate in isolation, reducing collaboration and shared learning opportunities. Mlambo (2021) emphasizes that marginalizing TBAs limits their potential contribution to safe maternal care and denies the health system a valuable resource that could be leveraged through appropriate training and supervision. The

current maternal health policy landscape in Zimbabwe does not adequately account for the realities of rural women who rely on traditional care (Musona et al., 2024). Without efforts to integrate TBAs into the formal healthcare system, provide them with basic training, and regulate the use of traditional remedies, maternal health outcomes are unlikely to improve significantly.

METHODOLOGY

The study adopted a qualitative research approach to explore the lived experiences and perspectives of pregnant women and traditional birth attendants in Goromonzi Rural District, Zimbabwe. This approach was chosen for its ability to capture the depth and complexity of human experiences, particularly in understanding traditional prenatal care practices shaped by cultural beliefs and social contexts. By focusing on how participants interpret and engage with these practices, the study aimed to generate insights that reflect the realities of maternal care within rural Zimbabwean communities.

An interpretive phenomenological design guided the research process. This design was appropriate for examining how individuals make sense of their prenatal care experiences, allowing for a detailed exploration of subjective meanings and cultural significance. The phenomenological lens enabled the researchers to understand not only what traditional practices are used, but also why they are valued and how they influence maternal health decisions.

The study was conducted in Goromonzi, a rural district characterized by limited access to formal health facilities, inadequate infrastructure, and a strong presence of indigenous knowledge systems. In this setting, traditional prenatal care practices are not only common but often serve as the primary maternal support system due to economic and logistical barriers to formal services.

Participants included fifteen pregnant women selected through convenience sampling, and five traditional birth attendants identified through purposive sampling. These participants were chosen based on their direct engagement with traditional prenatal care, making them suitable for providing rich, experience-based data. Data collection involved semi-structured interviews with pregnant women and key informant interviews with traditional birth attendants. These interviews allowed for a flexible, yet focused exploration of beliefs, practices, challenges, and experiences related to traditional maternal care.

The data were analysed using Interpretative Phenomenological Analysis, which involved immersing in the data, identifying recurring themes, and interpreting their significance in relation to the study's objectives. Trustworthiness was ensured through strategies such as participant rapport building, triangulation, member checking, and peer debriefing. Ethical considerations were addressed through informed consent, confidentiality, and respect for cultural norms throughout the research process.

FINDINGS

Following the presentations of drivers, the third objective was to assess the challenges associated with the use of traditional prenatal practices among pregnant women in rural areas as presented below:

Limited Knowledge and Skills

Traditional birth attendants (TBAs) and community-based support groups often lack formal training in modern prenatal care, leading to gaps in the care they provide. While they may have extensive experience with childbirth, they may not be aware of recent advancements in maternal health or how to manage complex medical conditions during pregnancy. For example, they might not recognize early signs of hypertension or gestational diabetes, which could lead to serious complications if untreated. Additionally, their knowledge of how to use modern medical equipment, such as blood pressure monitors or fetal heart rate monitors, is often limited. This lack of knowledge and skills can result in delayed interventions or reliance on outdated methods that may not be effective for all pregnancies. Commenting on the lack of formal training, one TBA acknowledged that:

> *"I've been helping women deliver for many years, but I don't know how to use the machines at the clinic. They talk about things like blood pressure and sugar levels, but I don't have the tools to check these things. I rely on what I've learned from experience, but sometimes I worry that it's not enough."*

This TBA's reflection highlights the limitations of relying solely on traditional knowledge in the absence of formal training. Despite her extensive experience, the inability to use modern medical tools creates a gap in her care, especially when it comes to monitoring conditions like hypertension or diabetes. Her concern about the adequacy of her skills illustrates a tension between traditional practices and modern medical expectations, revealing the vulnerability of both the caregiver and the women she serves. In line with the above observation, health professionals acknowledged some glaring gaps in traditional prenatal practice, with one nurse noting that:

> *"The TBAs don't always recognize the danger signs in pregnancy. We've seen women come in too late with conditions like preeclampsia because the TBA didn't know what to look for. It's frustrating because by the time they reach us, the situation is much worse."*

This nurse's frustration underscores the critical knowledge gap between TBAs and formal healthcare providers. The delay in recognizing and addressing complications like preeclampsia poses serious risks to maternal health. The nurse's statement highlights the consequences of this gap, emphasizing how the lack of early detection often results in escalated emergencies, which could have been prevented with timely medical intervention.

Despite acknowledging the importance of TBAs in prenatal services, some pregnant mothers were aware of limitations associated with traditional practice. One pregnant person retorted that:

> *"I trust my TBA because she has been delivering babies for as long as I can remember. But sometimes she doesn't know what's happening, like when I had swelling in my legs. She told me it was normal, but later the nurse said it could have been a sign of high blood pressure."*

This woman's experience reflects the trust placed in TBAs due to their experience, yet it also reveals the potential dangers of relying exclusively on traditional knowledge. The TBA's dismissal of the swelling as "normal" highlights the limitations of her understanding in recognizing serious medical conditions. The disconnect between traditional and modern advice creates uncertainty for the woman, who may not fully realize the potential risks until it's too late. This was further confirmed by another pregnant woman who acknowledged that:

> *"My TBA doesn't have the equipment to check my baby's health like the nurses do. She helps me with herbs and advice, but I feel nervous about not knowing if something's wrong. I wish she could do more, but I still prefer her because she understands me better than the clinic nurses."*

This woman's statement reveals a conflict between her emotional comfort with the TBA and her awareness of the limitations in the care provided. While she values personal support and cultural understanding from the TBA, the absence of modern prenatal monitoring creates a sense of unease. This tension highlights the balancing act women face between trusting traditional methods and recognizing the need for advanced medical care.

Inadequate Resources

Traditional prenatal care providers, particularly TBAs, often work with limited resources. They may lack access to basic medical supplies such as gloves, antiseptics, or sterile instruments, which are essential for safe prenatal and delivery care. In rural areas like Goromonzi, this resource gap is further widened by poor infrastructure, making it difficult for TBAs to access necessary medical supplies or refer patients to formal healthcare facilities. Consequently, pregnant women may not receive timely or adequate care during

emergencies, such as excessive bleeding or infections. This scarcity of resources not only hampers the quality of care but also increases the risk of complications for both mothers and babies. One TBA noted that:

> *"I don't have gloves or proper tools. I do what I can with what I have, but sometimes I feel scared, especially during difficult deliveries. Without the right supplies, I can only do so much."*

The TBA's statement reflects the stark reality of resource limitations in traditional care. Operating without basic medical supplies like gloves or sterile instruments not only compromises the safety of the delivery but also increases the emotional burden on the TBA. Her sense of fear during complex deliveries underscores the risks both she and the women she helps are exposed to, revealing the fragility of care in resource-poor settings. One nurse commented on this with regard to lack of resources in rural areas noting that:

> *"It's not just the TBAs who lack resources. Even at the clinic, we sometimes run out of basic things like antiseptics or clean instruments. When pregnant women come in with infections or complications, we don't always have what we need to help them right away."*

This nurse's account highlights that the resource gap is not confined to traditional care providers but extends to formal healthcare facilities as well. The lack of essential medical supplies affects the ability to provide timely and effective care, particularly in emergencies. The shared struggle between TBAs and clinics to access resources reveals a broader systemic issue in rural healthcare, where inadequate infrastructure jeopardizes both traditional and modern care.

The challenge resources also reflect unprivileged economic status of women in rural areas, who sometimes choose TBAs due to capacity challenges. One pregnant woman noted that:

> *"When I went to the TBA, she didn't have clean instruments, but I trusted her to help me. I didn't have money to go to the clinic, and she told me it would be okay. But I got an infection after birth, and now I wish I had gone to the clinic."*

This woman's experience underscores the direct consequences of inadequate resources in traditional care settings. While her trust in the TBA was strong, the lack of sterile instruments led to a preventable infection that could have been avoided with better resourcing. Her regret reflects the difficult trade-offs women face between affordability, accessibility, and safety when choosing between traditional and formal healthcare. To show the complexities of relying on TBAs, one woman narrated the following:

> *"The TBA helped me when I was bleeding after birth, but she didn't have any medicine to stop it. She tried everything, but I had to wait for hours to get to the hospital. I was scared I wouldn't make it."*

This woman's experience during a postpartum hemorrhage highlights the life-threatening risks posed by inadequate resources in traditional care. The TBA's inability to provide medical intervention during a critical emergency left the woman vulnerable, relying on delayed transportation to a hospital. The fear and uncertainty she experienced emphasize the urgent need for better emergency resources and referral systems in rural areas to prevent such dangerous delays in care.

Risk of Complications

Traditional prenatal care methods, while culturally significant, may increase the risk of complications during pregnancy and childbirth. For instance, TBAs may not have the skills to handle high-risk situations like Breech presentations or prolonged labor, which can lead to life-threatening conditions such as postpartum hemorrhage or fetal distress. Inadequate prenatal monitoring can also lead to undetected issues, such as preeclampsia or anemia, which require medical intervention. Without access to emergency obstetric care, these complications can quickly escalate, putting both the mother and child at risk. This is particularly concerning in rural areas where referral systems to hospitals may be weak or non-existent. One TBA noted that:

> *"I can manage normal births, but when something goes wrong, I don't always know what to do. When the labor is too long or the baby is in a bad position, I feel helpless without the right tools or training."*

The TBA's admission reflects the limitations of traditional care when faced with complex or high-risk deliveries. Her feeling of helplessness during difficult situations highlights the insufficient training and resources available to handle complications. This vulnerability not only impacts TBA's confidence but also puts the lives of mothers and babies at risk, underscoring the pressing need for better support and education for traditional caregivers. Commenting on women arriving with complications, one nurse noted that:

> *"We often see women who have been in labor for too long with the TBA. By the time they come to us, they're exhausted, and the baby is in distress. It's heartbreaking because we could have helped them sooner if they had come to the clinic earlier."*

The nurse's frustration points to the delayed transfer of women from TBAs to formal healthcare facilities, often resulting in avoidable complications. The prolonged labor and fetal distress seen by the nurse reflect the limitations of traditional care in managing complex cases. The emotional toll of seeing worsened conditions that could have been prevented adds to the tension between traditional and modern healthcare systems, where timely collaboration could improve outcomes. The issue of birth complication was further acknowledged with one pregnant woman noting that:

> *"I was worried when my labor didn't start on time. The TBA said to wait, but I was scared something was wrong. I wanted to go to the clinic, but she said it would be okay. I ended up going anyway, and the nurses said I needed to be induced."*

This woman's experience reveals the conflict between her trust in the TBA and her fear of potential complications. The TBA's reassurance was comforting, but her instincts led her to seek medical intervention at the clinic, where her condition was managed appropriately. This tension between traditional advice and modern medical interventions highlights the uncertainty many pregnant women feel when navigating between the two systems of care. Using lived experiences with birth complications, one woman narrated that:

> *"During my last birth, the baby was in a bad position, and the TBA couldn't help. I was rushed to the hospital, but we almost didn't make it in time. Now I'm scared to have another baby because I don't know what could happen next time."*

This woman's near-death experience during childbirth underscores the serious risks posed by complications that traditional birth attendants are unequipped to handle. The delayed transfer to the hospital heightened her fear and anxiety about future pregnancies, revealing the psychological burden that complications can leave on women. Her lingering fear highlights the need for better risk management and emergency care options for rural women reliant on traditional methods.

Stigma and Discrimination

Pregnant women who rely on traditional prenatal care methods may face stigma and discrimination from formal healthcare providers and even members of their community. Healthcare workers, especially those in modern medical facilities, may view TBAs as unqualified or outdated in their practices, leading to tension or mistrust between the two systems of care. Women who choose to use TBAs might also feel judged by family members who have embraced modern medical care, causing additional emotional stress during pregnancy. This stigma can discourage women from seeking necessary care from formal health providers, particularly in cases where complications arise, thereby increasing the risk of poor maternal outcomes. One TBA commented on being viewed as outdated by noting that:

> *"Some of the nurses treat us like we don't know anything. They don't respect the work we do, even though we've been helping women give birth long before the clinics were built. It makes it hard to work together."*

This TBA's frustration reflects the stigma she experiences from healthcare professionals who view traditional methods as outdated or inferior. The lack of respect for her knowledge and contributions creates a barrier to collaboration with formal healthcare providers. This tension not only undermines the TBA's confidence but also hinders the potential for integrating traditional and modern care practices for the benefit of pregnant women. The above observations confirm the following narration from one nurse:

> *"The women come to us after seeing the TBAs, and sometimes they've been given bad advice. We try to help them, but they don't always trust what we say. They think the TBA knows better, and it's hard to change their minds."*

This nurse's account highlights the distrust that can arise between women who seek traditional care and formal healthcare providers. The nurse's perception of the TBA's advice as "bad" reveals a disconnect in understanding and communication between the two care systems. The difficulty in gaining the trust of women who have relied on traditional methods amplifies the challenge of providing effective care, especially when conflicting advice causes confusion or resistance to medical interventions.

Findings further showed that pregnant woman on feeling judged for using TBAs from other members of community and health professionals. One pregnant woman noted that:

> *"When I told the nurse I was seeing a TBA, she looked at me like I was doing something wrong. I felt ashamed, even though I trust my TBA more. It's hard when you feel like you have to choose between what you believe in and what the nurses think is best."*

This woman's experience of feeling judged for using traditional care reflects the internal conflict many pregnant women face when navigating between cultural beliefs and formal healthcare expectations. The nurse's reaction made her feel ashamed, illustrating the stigma associated with traditional practices in the eyes of some healthcare workers. This emotional strain highlights the psychological burden placed on women who feel torn between their cultural values and the perceived authority of modern medicine. Commenting on family pressure to use modern care, one pregnant woman further noted that:

> *"My mother-in-law doesn't believe in going to the clinic. She says the TBA is enough, but I feel like I should go to the clinic just to be safe. It's hard when your family thinks you're wrong for wanting something different."*

This woman's account illustrates the familial and social pressures that can shape prenatal care decisions. Her desire to seek formal healthcare for safety reasons conflicts with her mother-in-law's strong belief in traditional methods, creating emotional tension. This struggle between respecting family expectations and pursuing her own sense of safety reflects the broader challenge many women face in balancing cultural values with modern healthcare options.

Lack of Integration with Formal Healthcare Services

One of the key challenges is the lack of integration between traditional prenatal care and formal healthcare services. Pregnant women often receive fragmented care due to the disconnect between TBAs and modern healthcare providers. For example, a woman might receive advice from a TBA that contradicts the guidance given by a nurse or doctor, leading to confusion and potentially harmful practices. Also, TBAs may not have established referral pathways to hospitals, meaning women in distress are not transferred to higher-level care in a timely manner. This lack of coordination can result in missed opportunities for early interventions that could prevent complications during pregnancy and childbirth. Commenting on the lack of referral systems, one TBA noted that:

> *"When a woman is in trouble, I try to send her to the clinic, but the process is slow. We don't have a clear way to get them there quickly, and sometimes it's hard to know who to call. I feel helpless when time is running out."*

The TBA's reflection reveals the logistical challenges of referring women to formal healthcare services during emergencies. The absence of a clear and efficient referral system leaves both the TBA and the pregnant woman vulnerable, particularly in life-threatening situations. This feeling of helplessness underscores the urgent need for better integration and communication channels between traditional and formal healthcare providers to improve maternal outcomes. With regards to this, health professionals acknowledged the existence of fragmented coordination, with one nurse noting:

> *"We don't always know what the TBAs are advising the women. They come to us with different ideas about what's safe during pregnancy, and it can be confusing for them. If we worked more closely with the TBAs, we could give better care, but right now, it feels like we're working against each other."*

This nurse's statement highlights the fragmented nature of care between traditional and formal systems, where inconsistent advice leads to confusion for pregnant women. The lack of collaboration between TBAs and healthcare workers creates a divide that undermines the quality and coherence of prenatal care. The nurse's desire for greater integration suggests that bridging this gap could lead to more effective and synchronized care, ultimately benefiting the women involved. Related to above, one pregnant woman noted conflicting health advise that include:

> *"The TBA tells me to rest more, but the nurse says I need to walk every day. I don't know who to listen to. I feel stuck between two people I trust, but they're telling me different things."*

This woman's experience of receiving conflicting advice from her TBA and nurse illustrates how the lack of integration between traditional and formal care systems can create confusion and stress. Her trust in both caregivers makes it difficult for her to know which guidance to follow, leaving her feeling uncertain and conflicted. This situation highlights the need for clearer communication and coordination between the two systems to provide consistent and supportive care. However, the findings showed that TBAs services have become popular due to accessibility of formal healthcare services. One pregnant woman noted that:

> *"I wanted to go to the clinic when I started feeling pain, but the TBA said it wasn't necessary. By the time we got to the hospital, it was too late, and I lost the baby. I wish there was a way for them to work together so we could know what to do sooner."*

This woman's tragic experience of losing her baby due to delayed access to formal healthcare underscores the life-threatening consequences of the disconnect between traditional and modern care systems. The TBA's advice to delay going to the clinic, combined with the absence of a clear referral process, resulted in a preventable loss. Her reflection on the need for better collaboration between the two systems highlights the critical importance of integrated care pathways to ensure timely and effective interventions during pregnancy.

DISCUSSION

The challenges identified in this study—ranging from limited knowledge and inadequate resources to systemic fragmentation and cultural tensions—do not operate in isolation but interactively produce a complex maternal health landscape in rural Zimbabwe. These dynamics carry significant implications, not merely as isolated outcomes but as embedded consequences of the intersecting realities that shape the prenatal care experience.

The limited medical knowledge and diagnostic skills among TBAs, while not unique to Zimbabwe, have implications that are intensified by the country's healthcare ecology. As observed in similar contexts like rural Romania (Păduraru et al., 2019), the absence of formal training constrains TBAs' ability to detect high-risk conditions. However, in Zimbabwe, this challenge is not buffered by a robust referral system or institutional support. Instead, it creates a persistent clinical vacuum**,** where critical maternal conditions remain undiagnosed until they become life-threatening. This leads to delayed health-seeking behaviour, as women may continue relying on TBAs until complications escalate beyond the point of effective intervention. The consequence is not only heightened maternal and neonatal morbidity but also the normalization of crisis-level interventions as

ISSN No. 2454-6186 | DOI: 10.47772/IJRISS | Volume IX Issue VII July 2025

routine, further eroding trust in formal health systems that are perceived to intervene only during emergencies rather than throughout prenatal care.

These knowledge gaps are compounded by resource insufficiencies that affect both TBAs and formal health facilities. While under-resourcing is a common theme in many low- and middle-income countries, the dual deprivation in Zimbabwe—where neither TBAs nor clinics are adequately equipped—produces a mutual dependence on insufficient systems**.** This leads to a paradox: women often seek out TBAs for their cultural alignment and accessibility, only to find that even basic safety measures, such as sterile instruments or emergency transport, are unavailable. The consequence is a form of structural entrapment**,** where women's choices are constrained not by preference alone but by the absence of viable, safe alternatives. This entrapment fosters a cycle of preventable complications, as seen in the narratives of infections following home deliveries or life-threatening delays in accessing emergency obstetric care.

The inability of TBAs to manage complications such as breech births or prolonged labour—highlighted in both this study and others like those in Nigeria (Okafor et al., 2016)—has implications that extend beyond the clinical sphere. In Zimbabwe, such scenarios often result in psychosocial trauma**,** where women not only endure physical risks but also long-standing emotional distress and fear surrounding childbirth. The consequence is a growing sense of fatalism among some women, who come to expect danger as an inevitable part of pregnancy. This internalization of risk alters reproductive choices, with some women delaying or avoiding future pregnancies due to fear, which in turn affects community demographics and household dynamics in rural areas where fertility is culturally significant.

The conflicting advice and lack of coordinated care between TBAs and formal providers reflect a deeper institutional failure to bridge indigenous and biomedical systems. While this fragmentation has been observed elsewhere—such as in Iran (Kheirabadi & Maracy, 2010)—its implications in the Zimbabwean context are sharpened by the near-total absence of integration mechanisms. The result is cognitive dissonance for pregnant women**,** who must navigate contradictory guidance about diet, rest, or labour onset. This confusion does not merely lead to poor adherence to medical advice; it also engenders distrust in both systems**,** weakening the perceived credibility of health information and undermining the overall effectiveness of maternal health initiatives. Moreover, the stigma associated with traditional care**,** as reported by both TBAs and pregnant women, produces a hidden layer of vulnerability. Women who opt for traditional care often conceal their choices when interacting with formal health providers, leading to incomplete disclosure of health practices. This has clinical implications, as health workers are unable to make fully informed decisions without knowing about herbal remedies or rituals that may affect pregnancy outcomes. The social consequence is a form of cultural silencing**,** where women feel compelled to suppress their beliefs and practices in medical settings, leading to disengagement, emotional stress, and missed opportunities for culturally aligned care interventions.

The exclusion of TBAs from formal health policy further entrenches these problems. Unlike in some West African or Canadian Indigenous contexts where TBAs are at least partially recognized (Browne et al., 2016), in Zimbabwe, their marginalization not only limits their access to training and resources but also sends a powerful symbolic message about the legitimacy of community knowledge. The implication is a deepening institutional divide**,** where TBAs and clinic staff operate not as collaborators but as competitors. This rivalry reduces the likelihood of timely referrals, as TBAs may delay or avoid transferring women to clinics for fear of criticism or disrespect. The systemic effect is a breakdown in continuum of care**,** where transitions between home- and facility-based services are not only inefficient but also emotionally fraught for both caregivers and patients.

Finally, the economic constraints faced by rural women—a recurring theme across findings—intersect with cultural preferences to reinforce the use of traditional care. While affordability is a practical driver, the implication is more than financial. It reflects a broader structural disenfranchisement**,** where women are compelled to make health decisions within the narrow confines of poverty, distance, and social expectation. This economic marginalization not only perpetuates reliance on under-resourced traditional services but also limits women's ability to advocate for their health needs within either care system. The broader consequence is a reproduction of health inequities**,** where the poorest women shoulder the greatest maternal risks, not because of ignorance or cultural resistance, but because of systemic exclusion from safe, reliable, and respectful

maternal care. In totality, these findings illustrate that the challenges associated with traditional prenatal care in rural Zimbabwe are not isolated technical deficits but deeply embedded in structural, cultural, and institutional contexts. The implications are therefore expansive: delayed medical interventions, psychosocial stress, health system fragmentation, and the perpetuation of maternal and neonatal risks across generations. These consequences are not merely outcomes but reflections of a health system that has yet to reconcile its biomedical ambitions with the lived realities of the communities it serves.

CONCLUSION AND RECOMMENDATIONS

The study concludes that while traditional prenatal care remains a culturally significant and accessible option for many pregnant women in rural Zimbabwe, it presents serious challenges when not integrated with formal healthcare systems. The findings reveal that traditional birth attendants (TBAs), although trusted and experienced, often lack formal training and essential resources, limiting their ability to manage high-risk pregnancies and medical emergencies. This gap in knowledge and capacity contributes to delays in seeking appropriate care, increasing the risk of complications and maternal mortality. Additionally, both TBAs and rural clinics operate under severe resource constraints, further compounding the challenges faced by women during pregnancy and childbirth. The lack of collaboration and mutual respect between traditional and formal care providers creates confusion, stigma, and fragmented care experiences for pregnant women, who are often caught between two systems offering differing advice and levels of support.

To address these challenges, it is recommended that TBAs be trained in basic obstetric care, including the identification of danger signs and appropriate referral procedures. A community-based training program led by local clinics could build capacity while preserving cultural relevance. Establishing formal referral pathways between TBAs and health facilities is essential to ensure timely care. Clinics should also designate liaison officers to maintain regular communication with TBAs. Resource-sharing agreements between TBAs and local clinics could improve access to sterile supplies and emergency kits. Finally, healthcare workers should receive cultural sensitivity training to reduce stigma and promote collaborative care, enabling women to navigate both systems with confidence and safety.

REFERENCES

1. Al-Krenawi, A., Graham, J. R., & Al Gharaibeh, F. (2011). A comparison study of psychological, family function marital and life satisfactions of polygamous and monogamous women in Jordan. Community Mental Health Journal, 47(5), 594–602.
2. Browne, A. J., Varcoe, C., Lavoie, J., Smye, V., Wong, S. T., Krause, M., ... & Fridkin, A. (2016). Enhancing health care equity with Indigenous populations: evidence-based strategies from an ethnographic study. BMC health services research, 16, 1-17.
3. Chamberlain, G. (2004). Historical perspectives on health: Childbirth in ancient Egypt. The journal of the Royal Society for the Promotion of Health, 124(6), 284-286.
4. Chidyausiku, W., & Muzingili, T. (2017). Community reaction to corporate social responsibility programmes in Zimbabwe. African Research Review, 11(3), 60-70.
5. Chidyausiku, W., Chihambakwe, W & Muzingili, T. (2025). Electoral Authoritarianism and Election Rigging in Relation to Human Rights Violations: The Role of Revolutionary Political Parties in Four SADC Countries (Zimbabwe, DRC, Tanzania, and Mozambique). International Journal of Research and Innovation in Social Science, 9(2), 4152-4161. https://dx.doi.org/10.47772/IJRISS.2025.9020324
6. Chipunza, T., & Nhamo, S. (2023). Health and healthcare delivery in Zimbabwe: past and present. In Post-Independence Development in Africa: Decolonisation and Transformation Prospects (pp. 171-194). Cham: Springer International Publishing.
7. Choguya, N. Z. (2014). Traditional birth attendants and policy ambivalence in Zimbabwe. Journal of Anthropology, 2014(1), 750240.
8. Esther, K., Kleph, K., Mariette, K., Sylvie, Y., Andre, W., Niclette, L., Michel, K., Baptiste, K. and Oscar, L. (2017) Plants Used by Pregnant Women at Kipushi City in Democratic Republic of Congo: Prevalence and Indications. Open Access Library Journal, **4**, 1-8.

9. Mahiti, G. R., Kiwara, A. D., Mbekenga, C. K., Hurtig, A. K., & Goicolea, I. (2015). "We have been working overnight without sleeping": traditional birth attendants' practices and perceptions of post-partum care services in rural Tanzania. BMC pregnancy and childbirth, 15, 1-12.
10. Mathez-Stiefel, SL., Vandebroek, I. & Rist, S. Can Andean medicine coexist with biomedical healthcare? A comparison of two rural communities in Peru and Bolivia. J Ethnobiology Ethnomedicine **8**, 26 (2012).
11. Mawoza, T., Nhachi, C., & Magwali, T. (2019). Prevalence of traditional medicine use during pregnancy, at labour and for postpartum care in a rural area in Zimbabwe. Clinics in mother and child health, 16(2), 321.
12. Mudonhi N, Nunu WN. Traditional Medicine Utilisation Among Pregnant Women in Sub-saharan African Countries: A Systematic Review of Literature. INQUIRY. 2022;59.
13. Musiwa, A. S., Sinha, V., Hanley, J., & Ruiz-Casares, M. (2024). Antenatal care coverage and early childhood mortality in Zimbabwe: new interpretations from nationally representative household surveys. Health Promotion International, 39(3), daae039.
14. Musona, T., Mangombe, K., & Muchabveyo, B. (2024). Prevalence and determinants of antenatal care service utilisation among pregnant youths (15-35) years in Harare: A cross-sectional analysis of the 2015 Zimbabwe demographic and health survey. The Dyke, 17(2), 1-21.
15. Muingili, T. (2017). Community Participation in Formal Social Security Programmes in Zimbabwe: A Case of Harmonised Social Cash Transfers (HSCT) In Epworth District. Retrieved from: https://journals.eduindex.org/index.php/ijss/article/view/6506
16. Muzingili, T., & Chidyausiku, W. (2015). The rural participation complexity rainbow: Challenges of community involvement in corporate social responsibility programmes in Zimbabwe. International Journal for Social Studies, 2(01), 120-132.
17. Muzingili, T., & Gombarume, M. (2018). The discourse less discussed: spirituality and health issues in Zimbabwe. Journal of Pan African Studies, 11(3), 84-104.
18. Muzingili, T., & Taruvinga, R. (2025). Glittering Hope: Evaluating the bicycles for educational empowerment (BEEP) programme as panacea to inclusive education in Zimbabwe. Social Sciences & Humanities Open, 11, 101314.
19. Păduraru, D. N., Coman, F. L. O. R. E. N. T. I. N. A., Ozon, E. A., Gherghiceanu, F., Andronic, O., Ion, D. A. N. I. E. L., ... & Bolocan, A. L. E. X. A. N. D. R. A. (2019). The use of nutritional supplement in romanian patients–attitudes and beliefs. Farmacia, 67(6).
20. Sharma, E., Howard, N., & Duclos, D. (2020). Navigating new lives: a scoping review and thematic synthesis of forced migrant women's perinatal experiences. Journal of Migration and Health, 1, Kheirabadi, G. R., & Maracy, M. R. (2010). Perinatal depression in a cohort study on Iranian women. Journal of research in medical sciences: the official journal of Isfahan University of Medical Sciences, 15(1), 41.
21. Taruvinga, M., & Simbarashe, G. C. (2015). Elderly and rural health Care in Zimbabwe: exploration on available health care systems and challenges faced in accessing health services. Retrieved from: https://www.researchgate.net/publication/381916584_Elderly_and_rural_health_Care_in_Zimbabwe_exploration_on_available_health_care_systems_and_challenges_faced_in_accessing_health_services
22. Zinyemba, L. (2022). The Role of Traditional and Spiritual Birth Attendants in Maternal Health Care amongst Tonga Women of Binga: A Livelihood Strategy or Maternal Health Service? In Tonga Livelihoods in Rural Zimbabwe (pp. 131-144). Routledge.