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Cultural Factors Exacerbating the Tragedy of Poor Maternal Health in Zambia

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Abstract

Maternal mortality is all but eliminated in today's developed nations. Advanced technology has developed to provide for the safety and comfort of the mother throughout all stages of pregnancy—prenatal, birthing, and post-partum—yet this technology is not available or even heard of by women in developing nations. Around the world, 800 women die every day from complications in pregnancy and childbirth that are preventable. Most of these deaths occur in sub-Saharan Africa, where the tragic conditions women suffer through are largely ignored. Physical factors such as a shortage of health care workers, geographic barriers, and inadequate funding are often cited as the main issues contributing to poor maternal health in Africa. Although these physical problems appear to have concrete solutions, cultural conflicts force the perpetuation of this tragedy in maternal health conditions. However, little research exists on these more subtle factors. Focusing on Zambia, this paper provides an in-depth analysis of the cultural view of women as well beliefs and practices surrounding pregnancy and childbirth. In a postcolonial society that mixes traditionalism and modernism, Zambian women remain oppressed with little independence. Furthermore, data provided by Zambia's Ministry of Health shows that the concepts of spirituality and witchcraft continue to wield great influence over the people's perception of complications in childbirth. These beliefs surrounding maternal health are passed on to younger generations through traditional birth attendants. Although traditional birth attendants are highly valued members of a community, they are often looked down upon by health care professionals because they lack the medical background necessary to aid a woman undergoing a complicated delivery. This paper provides evidence that these cultural factors must be addressed in order to improve maternal health.

Keywords: Mortality, Health, Africa

1. Cultural Factors Exacerbating the Tragedy of Maternal Health in Africa

The threat of injury and death during pregnancy and childbirth is all but eliminated in today's developed nations. Advanced technology in the area of maternal health care ensures the safety and relative comfort of the mother throughout all stages of maternity—prenatal, childbirth, and postpartum. Despite these miraculous advancements, this technology is not available or even heard of by women in developing regions. According to the World Health Organization, 800 women die every day of causes related to pregnancy and childbirth that are completely preventable.[16] Regions of sub-Saharan Africa exhibit the worst maternal health conditions in the world, even when compared to nations of similar economic status. Maternal mortality or maternal death is defined as the death of a woman due to causes related to or aggravated by pregnancy. The maternal mortality ratio (MMR), or the number of maternal deaths per 100,000 live births, is the most commonly used indicator of the quality of a nation's maternal health care. In 2010, the African country of Chad had the highest MMR in the world at 1,100.[16] Other nations in sub-Saharan Africa display similar figures that are extremely high, especially in comparison to the MMR of 21 seen in the United States. These already high statistics, underestimated due to the underreporting of data in Africa, ignore

maternal morbidity—conditions that affect a woman's health beyond what is expected, resulting in short-term as well as chronic suffering. Data regarding maternal morbidity poses even more problems in collection. However, estimates show it to be several times higher than maternal mortality. Common causes of both maternal mortality and maternal morbidity include obstructed labor, infection, high blood pressure, hemorrhaging, and obstetric fistulas. These conditions are generally preventable or curable with assistance and attention of a health care professional in an adequately supplied health facility. Nevertheless, only 45% of women in sub-Saharan Africa are attended by a health professional during birth.[16] The maternal health conditions that women in sub-Saharan Africa suffer through are horrific, yet little has been done to effectively address this issue. Included in the WHO Millennium Development Goals (MDG) was the initiative to reduce maternal mortality across the globe by 75% by 2015. Although some progress has been made in select areas, it is nearly impossible to accomplish this goal in the next three years, as shown by the absence of progress in Zambia.[9]

With an MMR of 440, Zambia is not the worst African nation to be a pregnant woman. However, with an average annual decrease of less than 0.4% in the past two decades, the lack of improvement in Zambia's maternal health is disturbing.[16] Liberated from British colonial control in 1964, 99.5% of the population belongs to African ethnicities, such as the Bemba, Tonga (Toka), and Lozi peoples, Zambia consists of a unique amalgamation of traditional and modern cultures.[1] Although many meanings exist, in this context, culture will be applied as the expression of the philosophies, behaviors, customs, and traditions of a group of people. Like all people across the globe, Zambians retain specific beliefs and practices regarding pregnancy and childbirth. While many of these traditions do not harm the health of the mother, others can increase the risk of maternal mortality and morbidity. Furthermore, health care facilities in Zambia often reflect a system of Westernized medicine that lacks sympathy for traditional African values and clashes with traditional childbirth practices, decreasing the comfort of the mother and the likelihood that she will utilize a health facility. While culture is essential to the individuality of a nation's people, this research aims to determine whether Zambian maternity culture is actually detrimental to the health of the mother and interfering with attempts to advance maternal health in this region.

This paper is the result of an extensive literature review of various public health journals and global databases. Only sources published within the past decade that also fell after the declaration of the WHO MDG 5 to reduce maternal health were considered. The exception to this being a study done by Nsemukila et. al. published in 1998 as this study was the only research found that displayed in-depth evidence for the existence of important and widespread Zambian beliefs regarding pregnancy. Through analysis of cultural factors pertaining to pregnancy and childbirth, Zambia provides evidence for the necessity of addressing the culture surrounding pregnancy in order to improve maternal health in sub-Saharan Africa.

2. Contributing Factors to Zambia's Current State of Maternal Health Care

Most of the literature regarding maternal health in Zambia focuses on the physical barriers contributing to this problem, such as a shortage of health care workers, geographic obstacles, and inadequate funding in both health care facilities and individual families. In 2005, Zambia's Ministry of Health reported that the country had only 50% of the health care force necessary to provide rudimentary health services, resulting in a doctor to patient ratio of one doctor to 14,500 people.[4] With half of the health care professionals needed to provide a broad range of health care, those specializing in maternal health care are even fewer. This shortage can be attributed to several factors, including immigration of native Zambian doctors to other countries for higher salaries.[4] Doctors that stay in Zambia are usually concentrated in urban areas, forcing rural women to walk long distances to reach a health care facility. The long distances to a health care facility discourage many women from deciding to go to and reaching a health care facility because of the difficulty of walking during labor.[2] In a study done by Stekelenburg et al., 50% of the women interviewed had to walk two hours or more in order to reach a health facility, illustrating the distances that must be overcome by these women in labor.[13] Additional factors that discourage women for delivering in a health facility include the inability to pay medical fees for delivery services at a hospital or health clinic.[13] The combination of all of these variables creates potentially disastrous situations for expectant mothers-to-be, but it appears that these problems should have simple solutions rooted in the implementation of effective health care policy. Despite this seemingly obvious answer, the lack of progress in maternal health care in Zambia in the past two decades implies that there must be a more subtle impediment preventing significant advances in maternal health care in this region.

3. Women in Zambia

Many traditional African groups in Zambia, such as the Bemba, are matrilineal in structure, meaning that authority passes through the mother's line. In the pre-1960 era, this meant that a man would permanently move to his wife's village to establish his family, and that his wife's brother would have ultimate authority over the man's children.[15] The earlier introduction of Christianity as well as a transition into a postcolonial society after receiving independence from Britain in 1964 relaxed some of these standards of permanently living in the wife's natal village and introduced patriarchal elements into the African family.[15] However, children remain primarily the responsibility of the woman and her family. By staying within the wife's family, a woman is able to utilize the services of a traditional birth attendant (TBA) that she has likely known since childhood. Given that Zambian culture is largely gerontic, expressing great respect for the elders of a community, women and girls are greatly influenced by the older women in a village, which contributes to the carrying of traditional female knowledge via oral custom.[11]

Girls undergo extensive initiation rites at the onset of puberty that deal with sexual and reproductive health education, emphasizing the pleasure of the male in sexual relations.[14] Thus, young girls are introduced to the concept of male domination at an early age. Instruction of this initiation into womanhood is performed again by an elder woman in the community. However, the mother of the girl is excluded from the proceedings as these sexual topics are considered inappropriate for a mother to discuss with her daughter.[14] Combined with the secrecy that shrouds the exact proceedings of these rites, the lack of discussion on these issues between mother and daughter at an early age creates a barrier to open communication in the future with regards to sensitive sexual topics. For example, unsafe abortions result in a large fraction of maternal deaths.[16] A study done by Hadley and Tuba concluded that young mothers are reluctant to share the status of an unwanted pregnancy with family members, and this unwillingness to communicate vital health information extends into health facility settings.[3] Although abortion is legal in Zambia with the written consent of two physicians, young girls seek illegal, unsafe abortions more often due to embarrassment or shame over the unwanted pregnancy.[17]

Although advancements in the area of women's rights have been made, women in Zambia continue to be oppressed. Girls usually receive less formal education and exhibit lower literacy rates than boys.[1] Literacy has been observed as proportional to delivery in a health care facility as literate women are more likely to deliver in a health facility.[12] The augmented education of girls delays marriage, which can postpone pregnancy. However, the traditional practice of early marriages for girls is also thought to be common.[10] Although the legal age of marriage for women is eighteen, under customary law girls can be married much earlier, sometimes at the onset of puberty, with parental consent. Although many Zambians discourage this practice, early marriages still occur for reasons including collection of a dowry for a family experiencing economic difficulties and avoidance of problems resulting from promiscuity, such as HIV/AIDS infections and single parenthood.[10] While early marriage is used as a tool to avoid certain problems, it also creates new problems. The decision to use contraception and family planning lies with the husband. Because men often fear the sexual freedom that contraception provides for women, girls married at a young age often become pregnant early due to the absence of preventative measures.[10] A young age at pregnancy intensifies the risks associated with maternal health as a young girl's body is simply not ready for childbirth.[17]

Men generally hold the power in decision making, especially in husband-wife relations. Traditionally, women are responsible for home maintenance, subsistence farming, and childcare although some differences are seen in the roles of urban and rural women.[14] Throughout Zambian culture, the male is empowered while the female is left to defer to the decisions of the male. This has serious consequences in the area of maternal health. Pregnancy is considered solely a woman's issue. Manandhar et al. led focus groups discussions in which the male leaders of a Zambian tribe admitted "they knew nothing about pregnancy and childbirth, or any other details of women's reproductive health".[8] Little is done to increase the knowledge of men in this area as the man is excluded from most of the maternal proceedings, including delivery.[10] However, the final decision on whether or not to deliver in a health facility or seek emergency care in case of complications is often left in the hands of the man, who has little familiarity or involvement with childbirth.[10] Research shows that women who make their own decisions are more likely to deliver in a health setting than those who do not.[12] The disparity between the male as the primary decision maker and his immersion in the undertakings of the pregnancy delays the reaction time in seeking help for complications arising in delivery and, in some cases, inhibits delivery in a health facility entirely.

4. Beliefs and Practices about Pregnancy and Childbirth

A mix of Christian and indigenous philosophies pervades Zambian culture. Christianity—introduced in the nineteenth century—did not gain popularity until the mid-twentieth century.[14] Although Western religious practices have become widespread throughout the nation, Christianity simultaneously coexists with the deep spirituality of African tribes.[14] The merging of these two belief systems has resulted in the belief in the Christian God as well as the spirit realm of the ancestors, leaving room for the acceptance in the existence of witchcraft in the modern era. In the African sense, witchcraft is a negative association with bad or misfortunate events that can't be explained in other ways. Contrary to the intuitive idea that modernization eliminates belief in witchcraft, some say that witchcraft is "resurgent—in politics, culture, and even religion—as a means of coping with modernity or, more specifically, globalization".[14] Regardless of the size or persistence of this so-called resurgence, belief in witchcraft still exists today and is often applied to pregnancy and labor in Zambia.

In 1998, Nsemukila et al., funded by Zambia's Ministry of Health, conducted a year-long study that resulted in a comprehensive overview of the determinant factors of poor maternal health in this region. After identifying the expected external factors, the many beliefs surrounding the maternal period were summarized.[10] Several more recent studies have been conducted on a smaller scale, showing that no changes in these beliefs have yet occurred. Despite the necessity of addressing some traditional beliefs and practices surrounding pregnancy, the results of these studies have not had significant effects in reducing maternal mortality.

Most traditional beliefs regarding pregnancy are centered on the pregnant woman's conduct. While some of these beliefs harm the health of the mother, many can be beneficial to the health of the child and mother, such as not smoking or drinking alcohol and limiting heavy lifting. Beliefs about pregnancy, delivery, and the postpartum period can be divided into three categories: nutritional, behavioral, and sexual.

The nutritional beliefs in Zambia can have mixed effects on the health of the mother, trending toward more adverse results. A balanced prenatal diet is essential to provide a platform of good health for both the mother and child and can prevent future complications. However, limitations imposed on Zambian mothers restrict some essential nutrients. For example, it is believed that chicken and eggs should be avoided because the child will have no hair, and fish cause bleeding during pregnancy. Other beliefs during pregnancy include the idea that hot drinks will burn the baby and stillbirths occur when a woman consumes meat from an animal that died on its own. During delivery, cold drinks are thought to stop or slow down labor while, after labor, the woman is restricted from cooking or even eating with others for a period of time for fear of injuring her child as well as giving others a sickness.[10] These beliefs show a clear lack of the knowledge of basic female anatomy and physiology that is important for a pregnant mother to possess, in order to fully understand and adapt to the changes occurring in her body.

Behavioral beliefs vary widely. Pure superstitions exist, like the avoidance of knots in clothing or necklaces by the mother and the father during pregnancy so that the child will not be born with the umbilical cord wrapped around the neck.[10] Other behavioral taboos could have greater consequences on the health of the mother. Zambian women often deliver in seclusion or with the accompaniment of a few select women at home.[7] Several factors contribute to the preference of a secretive home delivery. In general, pregnancy due dates and the start of labor are not announced to the village for fear of witchcraft harming the child. Likewise, women deliver with few people present in the room to avoid supernatural harm to the child.[10] All men, including the father, are excluded from the site of delivery. This taboo has numerous adverse implications. As described above, the omission of the presence of the husband during birthing limits his interaction and involvement so that he is less informed or delayed when he makes the decision on whether or not to seek professional help. Furthermore, this taboo also prevents many women from seeking out a health facility. The breaking of traditional values and discomfort associated with a male attendant discourages many women from considering delivery in a hospital. Research shows that women who are not bothered by male attendants are more likely to utilize the services offered by a health professional, regardless of gender.[2] Communication and trust are essential in getting mothers competent and timely help during a complicated delivery. The sum of these traditional beliefs shows that this vital communication and trust between woman, man, and health provider does not exist in Zambian culture. Without these things, the reaction to get help for complicated labor is slowed or even completely stopped as either the people that could get the mother help do not know she needs it or the mother is not comfortable in trusting those that could help her.

Similar to behavioral beliefs, the category of sexually-related beliefs contains principles that could drastically affect health. Throughout pregnancy, there are strict regulations on when a couple can and cannot engage in sexual relations. Likewise, after the child is born, sexual relations are prohibited to protect the child that is breastfeeding from the mother.[10] This encourages men to seek sexual gratification outside of marriage, which could result in an increased spread of the HIV/AIDS epidemic that has already devastated the nation. In regards to maternal health,

beliefs about obstructed labor are perhaps the most saddening as well as devastating. While witchcraft is often blamed for birthing complications or birth defects in the child, obstructed labor is considered a punishment for extramarital affairs.[7] This so-called punishment enacted on the mother is the result of infidelity of the woman or—astoundingly—the man, meaning that traditional Africans believe that the woman will be punished for the man's transgressions. It is believed that the woman will die if she meets the partner of her husband during delivery.[10] This further illustrates the double standard that exists between the genders in Zambian. For the same supposed familial crime, the woman will die while the man suffers no personal effects. In reality, obstructed labor is the result of physiological malfunctions. Although some women are left alone to struggle with this ordeal on their own, a woman undergoing obstructed labor will be given traditional herbs as medicine if she confesses to her extramarital relations.[7] However, the medicinal effects of these herbs have been little studied and are unknown as to whether they are helpful or harmful. There is little documentation of the procedure followed if a woman does not confess. Obstructed labor is one of the leading causes of maternal mortality and morbidity.[16] Left untreated, obstructed labor can continue for days. In cases of prolonged obstructed labor, the child is stillborn. If the mother survives, she is not left unscathed. On top of many other health problems, obstructed labor can result in an obstetric fistula—a hole that arises between the vagina and the anus or bladder that causes uncontrollable leakage of urine and feces. Obstetric fistulas are widespread throughout sub-Saharan Africa and cause social ostracism and abandonment as well as chronic health problems.[16] Obstructed labor is a grave concern. In order to eliminate maternal mortality and morbidity due to obstructed labor, a drastic reversal in cultural beliefs is necessary. By educating individuals on the true reasons for obstructed labor and highlighting the medical help available, women can get the professional assistance in a complicated delivery. Through eradication of the unfounded traditional explanation of obstructed labor, a woman can receive sympathy and acceptance during obstructed labor, rather than the stigmas associated with extramarital affairs. Elimination of the blameful, negative beliefs about obstructed labor has the potential to inspire cohesion among women in a village and, hopefully, the beginnings of a transformation in gender norms.

5. Traditional Birth Attendants

The traditional birth attendant (TBA), also called a midwife by some, plays a key role in Zambian culture. Traditional birth attendants are elderly women in the community that have much life experience and have given birth before. Although young women may desire and train to be TBAs, they maintain a junior status until menopause.[11] Not only do TBAs assist in childbirth, they are also heavily involved in the upbringing and education of children through oral tradition. TBAs are very respected, honored, and valued members of a community. In an interview during a study done on the Toka people of Zambia, one TBA explained that "the community chooses you, you do not choose yourself" and that this is so "because you are entrusted to deal with life".[11] Training of a TBA involves observation and learning of traditional practices from a predecessor with emphasis on the spirituality of childbirth.[11] All of this evidence shows that traditional birth attendants exert a large influence over maternal health.

In contrast to their positive role within the community, TBAs have no formal medical training. When complications arise during pregnancy, a traditionally, culturally accepted explanation such as those outlined earlier is given.[11] In some cases, a TBA will advise a couple to refer to the hospital, but this is extra time that delays the immediate care a woman needs. Additionally, the physical interference of an untrained TBA can have disastrous consequences. This is demonstrated by the personal anecdote of the Cameroonian Prudence in the book *Half the Sky*. After undergoing obstructed labor, the TBA attending Prudence attempted to force the baby out by jumping up and down on her stomach. This response ruptured Prudence's uterus and, combined with inefficient hospital service, ultimately caused her death.[5] This horrific example does not imply that all TBAs would resort to such extreme and uneducated measures. However, this type of harmful "treatment" does exist and contributes to the tenuous relationship between TBAs and health professionals. While TBAs have a vast knowledge of the local people and their beliefs, they are often looked down on or discounted by health professionals as hindrances to delivery. Health professionals will go so far as to counsel patients to avoid TBAs and their dangerous practices.[11] In a health setting, advice or information about a particular case given by a TBA is often ignored, resulting in poor case management and initial misdiagnoses.[3] Attempts to rectify the barrier between these different health providers have been made. Generally, these attempts take the one-sided form of training programs for TBAs.[11] While basic medical training is an obvious asset for a TBA to possess, these training programs are ineffectual in that the flow of knowledge is one way and incomplete. Modern practices are forced onto the TBA whereas health professionals take away little from the interaction. While TBAs embody compassionate and skilled individuals, they are also generally from poor socioeconomic conditions and exhibit low literacy levels.[6] Thus, Westernized programs reliant on literacy and

scientific comprehension fail to adequately educate this population, causing low attendance levels, additional tension between health professionals and TBAs, and ultimately a poor quality of care of pregnant women.

6. Solutions and Conclusions

6.1 Education

Education is a global sign of development, indicative of a higher quality of life. Increasing education is not a new or innovative answer. It is seen as a solution to many of the problems associated with developing nations like Zambia, including maternal health. As mentioned earlier, age at marriage and first pregnancy increase as education increases. Given time for their bodies to develop, the health risks associated with childbirth are lowered.[17] Additionally, educated mothers choose to deliver in hospital more often.[2] In the same study by Gabrysch and Campbell, the education of the father was also positively correlated with health facility use during delivery (2009). Education leads to greater autonomy of the individual. While some argue that this escalates the promiscuity of youth as they abandon traditional values, the overall effect of increased education indubitably improves maternal health through increased utilization of quality health practices and behaviors. Education specific to maternal health for both the mother and father would also greatly benefit Zambian parents. With a high attendance rates, prenatal clinics provide an optimal environment for maternal education programs. In other countries, information given to women at prenatal clinics about possible complications in pregnancy increased use of health facilities.[2] Along with an upsurge in his knowledge about pregnancy, including the father in this type of maternal education ensures greater involvement and better decision-making throughout pregnancy. By initiating small shifts like active participation of the male in prenatal activities, the cultural exclusion of males can begin to be reversed, converting pregnancy and maternal mortality from solely a woman's issue into a priority for everyone.

7. Working Together

The results of intersectoral group discussions about Zambian maternal health, analyzed by Manandhar et. al. in 2008, show that the basis for improving this issue can be summed up in two words: communication and partnership. The concept is simple. All groups invested in maternal health—policy makers, health professionals, TBAs, and the very people themselves—need to make a concerted effort to develop relationships among all. Despite the innocent simplicity of this solution, the details of carrying out this plan remain elusive. Evidence shows that a smaller scale of relationship building yields better dialogue and understanding. In the same study by Manandhar et. al., provincial intersectoral debates, rather than national, had a greater attendance rate over a period of one year (2008). Furthermore, the semi-structured discussions at the national level exhibited a tendency to veer away from the topic of maternal health and delve more into research practices. In addressing such personal topics, especially with a cultural context, it is vital to maintain an intimate connection to the affected people and the ultimate goal. This is easier to maintain at smaller, more local levels. In order to involve local women and address the cultural aspects surrounding maternal health, a grassroots movement that fosters communication between groups would dispel any misconceptions between groups as well as allow women to assert their independence.

An avenue to carry out such discussions could be the creation of differing levels of meetings throughout the year. For example, monthly workshops led by a community's TBA and health professionals if present would provide women with a resource to learn about healthy behavior for women. Such workshops need not be limited to solely pregnancy-related health. Depending on the success of the initial workshop for women, these monthly health conferences could be expanded to include a session for young girls. These sessions could range from general health behaviors to activities promoting girls' empowerment. In such a safe and trusted environment, local girls and women would be able to come together as a community to learn about health and create a feeling of solidarity. Additionally, monthly community workshops could be followed by semiannual or annual conferences held for leaders in maternal health—doctors, TBAs, policy makers—in each region. In a workshop of this sort, equal time would be allotted to each specific group of leaders for presentation of their view, followed by small group conversations of an assorted group of individuals. By fostering conversation about the current maternal health concerns, these conferences would result in a trickle-up, rather than a trickle-down effect, in which the needs and results of each local community is brought before the larger group to influence change in maternal health. Clearly, the implementation of intersectoral communication programs and discussion groups needs to be explored. Based on

the successful camaraderie developed in the research done by Manandhar et. al., this route provides hope for future development (2008).

8. Traditional Birth Attendant Involvement

Traditional birth attendants represent an untapped and undervalued resource that is essential if the solutions described above are to be successful. TBAs are the largest maternal health resource available to women in Zambia, and they are available to a woman from childhood. Responsible for many aspects of the informal education of girls, TBAs also pass on the maternity beliefs described above through oral tradition. Thus, TBAs must be heavily involved if these issues are to be changed. As stated earlier, the medical training programs for TBAs are largely ineffectual due to the Westernized approach of these programs. A transformation of training programs and even perhaps health clinics themselves are necessary to overcome the lack of progress resulting from current TBA training programs. The ultimate goal of health professionals and TBAs are the same—a healthy mother and a healthy newborn. By developing an environment of peer equality among TBAs and health professionals, knowledge can easily be exchanged between groups. In developing this partnership, a solid foundation for a system of comprehensive maternal health care can be established. If these partnerships are developed adequately enough, Zambians can consider a somewhat radical shift from the typical, impersonal Western hospital to community health centers in which health professionals and TBAs can work under one roof. A health clinic of this sort could also become the home of the community workshops described above. This would also enable local women to become more involved in their own health care and gain familiarity with the procedures and facilities available during pregnancy. Because of the strong sense of community and respect for traditional values that pervades Zambian culture, this type of solution has the potential to greatly enhance the accessibility, trustworthiness, and quality of maternal health care.

9. Conclusion

At the end of the day, the debate is not whether or not maternal health needs to be addressed. That maternal mortality is a tragic loss in both its preventability and the sheer loss of life is agreed upon by all. The debate is how best to fix it. While many factors come into play in determining the quality of maternal health and health care a woman has, these things cannot be effectively developed without considering culture. Not all Zambian beliefs surrounding pregnancy are harmful, and the continuation of these benign beliefs helps to maintain the individuality of indigenous people in the face of growing globalization. However, several aspects of Zambian culture must be altered in order to improve maternal health. The predominantly inferior status of women must be transformed, even if only gradually, so that maternal health can be placed where it belongs—at the forefront of topics for advancement by developing nations and in the hands of the mother-to-be. Among women, a change in traditional beliefs and practices is necessary as well. This change needs to be promoted and initiated by respected TBAs in conjunction with health professionals. By adhering to modern medical standards for appropriate practices and explanations of pregnancy and delivery, Zambian women will decrease their chances of dying in childbirth. The cultural factors present in Zambia show that maternal mortality must be combatted through a cultural viewpoint in order to save the lives of mothers across all of sub-Saharan Africa.

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