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Original Research Article

A qualitative exploration of traditional medicine use in maternal health: experiences of healthcare providers in selected health care facilities in Zambia

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ABSTRACT

Background: Traditional medicine (TM) remains widely used by women in Zambia, especially during pregnancy and childbirth. Over the past years, researchers have tried to address the safe integration of TM in maternal health. Use of traditional medicine remains a dilemma to the Health Care Workers (HCWs) who have limited or no knowledge on the effects. This study explored the experiences of healthcare workers regarding use of traditional medicine among women during maternal healthcare.
Methods: A phenomenological design was conducted in Lusaka, Solwezi and Kaoma districts of Zambia between November 2020 and February 2021. In-depth interview (IDI) guide was used to collect data. A total of 80 HCWs participated in the study, of which majority (n=62) were Front line HCWs working in the Maternal health units and the remainder were Policy makers and programme coordinators serving at district, provincial and national level (n=18). Thematic analysis was used to identify key themes.
Results: HCWs reported mixed experiences. While some acknowledged the cultural significance of traditional practices, many raised concerns about their harmful effects, particularly during labor and delivery.
Conclusions: The study was observed a multifaceted mixture of cultural, personal and systemic constraints regarding use of traditional medicines in general. These findings confirm presence of a complex, tension-filled terrain shaped by systemic gaps, cultural beliefs and professional vulnerabilities spread across rural urban contexts in this population.

Keywords: Experiences, Labour and child birth, Traditional medicine

INTRODUCTION

Globally, traditional medicine (TM) remains an essential part of healthcare for many communities, particularly in low- and middle-income countries. In most parts of the world, TM is used in parallel with modern medicine but this often comes with considerable difficulties, making the users not to disclose any information to HCWs.[1] The use of TM during child birth remains a dilemma to the Health Care Workers who have limited knowledge on the effects of TM during the process of child birth.[2]

In Zambia, despite efforts to strengthen facility-based maternal care and the implementation of good maternal health policies. Many women continue to use TM and consult traditional birth attendants (TBAs) during the

process of childbirth.[3] This behaviour is driven by a confluence of factors such as strong cultural norms that favour traditional remedies, geographic and economic barriers to accessing health facilities.[2] Women operate within a dual healthcare system, alternating or combining biomedical and traditional practices.[4] A key issue is the lack of disclosure, as many women fear judgment, stigma or reduced quality of care from HCWs.[5] HCWs' encounter not only the women but also the complications that sometimes arise from the use of unregulated TM. Beyond the clinical challenges, the emotional and psychological toll of dealing with TM related complications is profound.[2,4]

Healthcare workers are trained to ensure safe motherhood, yet they often feel powerless when faced with maternal deaths resulting from TM use. The responsibility of explaining these deaths to hospital authorities, the community and grieving families places additional strain on HCWs.[5] Good maternal health outcomes call for comprehensive public education and integrating culturally sensitive counselling into maternal healthcare services to encourage open discussions, helping women make informed decisions while improving patient-provider trust.

Despite the critical role HCWs' play in the provision of maternal health services their experiences and voices are rarely cantered in practice, research and policy discourse.[6] This study sought to explore the lived experiences of healthcare workers in Zambia as they provide maternal care in settings where TM is widely used.

METHODS

Study design

A phenomenological design was conducted to investigate lived experiences of HCWs managing maternal cases involving suspected TM use during childbirth.

Study setting

The study was conducted in Lusaka, Solwezi and Kaoma Districts of Zambia, some regions with high levels of TM use and notable maternal health challenges.

Sample size and sampling strategy

The sample size was determined based on thematic saturation. Purposive sampling was used to recruit participants based on their experience and involvement in maternal care services.

Data collection and participants

Data were collected using semi-structured in-depth interviews, conducted in English. IDI guide was used to collect data between 2020 and 2021 from health care workers. A total of 80 healthcare workers participated in the study, 62 were front line HCW working in the labour ward and antenatal care unit (n=62) and 18 were Policy makers and programme coordinators serving at district, provincial and national level (n=18).

Data analysis

Thematic analysis was used to analyze the data. The transcriptions were then imported into NVivo 12 qualitative data analysis software to facilitate systematic coding and organization.

To ensure the credibility and trustworthiness of the analysis, the research team engaged in regular peer debriefings, maintained an audit trail of analytical decisions and applied member checking with some participants to verify the interpretations of their responses.

Ethical consideration

Ethics clearance was obtained from the University of Zambia Biomedical Research Ethics Committee (UNZABREC) Reference number 632-2019. Written permission was obtained from the National research authority (NHRA) and the Ministry of Health (MoH). An informed written consent was obtained from all participants.

RESULTS

Results were drawn from a total of 80 participants, including 62 front line health workers and 18 maternal health policy makers and program officers from the district, province and women national level as seen in the table below

Characteristics of respondents

Table 1 shows the basic characteristics of respondents. It presents the age category, sex and education level and occupation of respondents. Analysis of interviews with HCWs, policy makers and program coordinators (PM&PC) revealed six major as included the Table 2.

Invisibility and concealment of traditional medicine use

Non-disclosure of use

Participants described how women often hide information on use of traditional medicine, making it difficult for HCWs to intervene effectively. This concealment compromises clinical decision-making and jeopardizes maternal outcomes.

History taking from these patients was observed as a challenge and health care workers used different questioning and probing skill to collect the focused history. The process of history taking require patience at the same time the health worker needs to make a fast

decision so that the necessary interventions are put in place to assist the patient. Many patients only disclose after complications arise. "*They won't tell you unless you ask indirectly… some won't admit it until there's a problem. others have to die with a no…….*". (IDI, HCW,7).

Disclosure was more common among younger women in pain, but older women and family members remained secretive. HCWs resorted to tactful questioning or even searching bags to identify potential risks. "*Mostly young women, especially underage, disclose when in severe pain… the older ones don't.*" (IDI, HCW,5).

Even though they were no policies on how the HCWs could find out on whether the women were in possession of traditional medicine, health care workers had devised their own strategies. "*I search them and confiscate the herbs… no policy supports this, but it has worked for me, I don't like problems.*" (IDI, HCW,6)

However, policy makers and program managers indicated that at times the HCWs would force women to accept even when they may have not used and this has a bearing on the HCW patient relationship and rapport building.

"*Staff usually interrogate women on TM use and they usually link any maternal complication to the use of traditional medicine. Our policies are clear on the provision of non-judgmental non-discriminatory, culturally sensitive and respectful maternal health care*" (IDI, PM &PC 1).

Trafficking and currier of traditional medicines

HCW felt TM hold cultural and traditional significance. Families currier the herbs during visiting hour and women will pack and hide the herbs in bags and in coloured flasks and drinking bottles.

"*Women are clever, herbs are hidden in home-prepared food and drinks, others pretend to be taking a walk and meet someone who hands them medicine imagine sometimes even through windows.*" (IDI, HCW,2).

Some hidden sources within the environment

Traditional medicines being not a formal or sanctioned part of hospital care is often secretly provided to expectant mothers by some hospital staff and patients within the labour ward and maternity waiting homes.

Women within the labour ward exchange a lot of notes around maternal health issues and they share most of these traditional preparations and some experiences.

"*It is very worrying that there are no safe places for the expectant women, herbs are illegally secured in the hospital spaces*" (IDI, HCW,15)

Health system constraints and disjointed care

Antenatal care versus Labour and postnatal care

The structure of maternal services contributed to information gaps and undermined continuity of care. HCWs frequently encountered women for the first time during labor, with no prior records or referrals. The disjoint between antenatal and labor services created missed opportunities for early education and identification of traditional medicine use.

"*I think we have a challenge our model does not have room for the labour ward staff to know the patients and so we have designed a model we are calling midwifery models of care under the Zambia midwifery care project, antenatal and labour ward will be one department so that midwives interact with the expectant women antenatally as well as in labour*" (IDI, PM &PC 4).

Incompatible and interoperability systems

Effective interoperability can improve patient outcomes, streamline care and inform healthcare decisions. Interoperability is key to efficient healthcare delivery. In Zambia, healthcare systems face challenges integrating data across facilities.

"*Some women come with no referral letter from the facility that was attending to them some no record from the antenatal clinic.*" (IDI, HCW,8). "*We have SMART care a comprehensive healthcare solution that offers a range of services and products, including Electronic Health Records management system it is being used in some healthcare facilities, enhancing patient care and streamlining services, the roll out has been slow and currently its coverage in rural areas is low due to connectivity issues, what I can say is the system is not yet interoperable.*" (IDI, PM &PC3)

Absence of policies and clinical guidelines

Lack of standard operating procedures and treatment protocols

HCWs reported an absence of standardized protocols, training or national guidance on handling TM use in maternal care. "*Handling women with herbal medicine use is trial and error… we need a toolkit to guide practice at different levels.*" (IDI, HCW,6).

Lack of a legal framework

The absence of a legal environment leaves practitioners filed with fear as they navigate cases with uncertainty, inconsistency and anxiety.

HCWs' do not know the legal implication of certain actions of great concern. "*We're not even sure of the laws around TM use, health is a right, but we also need a*

system to accommodate and regulate these practices." (KII, HCW,9)

Trust erosion and conflict with patients, families and communities

Mistrust from the patient

Many HCWs shared experiences of strained relationships due to mistrust. Questioning TM use often triggered patient hostility, resistance and sometimes escalating to conflict. These tensions escalate when HCWs dismiss patients' traditional practices, leading to resistance and hostility.

"*Once you correct or you question women become rebellious and in most cases nurses are the primary enemies because they spend most of the time with the patients as opposed to the other HCWs.*" (IDI, HCW,10).

Conflict with patients, families and communities

The HCWs do not tolerate the use of TM and any preparations that are not subjected to scientific tests or not validated by scientific articles and documented evidence. Women misinterpret these teachings and they feel blamed.

"*Once they report you to traditional leaders, they will not only transfer you but chase you out of the community.*" (IDI, HCW,11)

Conflict at work places

Mostly following an eventuality, the health workers tend to blame one another and this largely contributes to misunderstandings.

"*Even when the woman used herbs… supervisors don't want to hear it. We're made to write endless reports.*" (IDI, HCW,5)

Burden of adverse outcomes and emergency presentations

Emergency

HCWs frequently witnessed complications such as uterine rupture, postpartum haemorrhage and precipitate labor in some women who had taken herbal preparations. HCWs are subjected to investigations and punitive actions despite acting in emergencies.

"*After visiting hours, contractions change dramatically… it's usually after they've been given something. They traffic different types of herbs… we only dance to the consequences.*" (IDI, HCW,13). "*Sometimes we see the effects too late… when the woman is weak, leaving us with little time to intervene, we try to resuscitate but the prognosis is poor, more especially when herbs are taken in the ward, it will be like the patient is progressing well then abruptly after taking the herbs the condition changes...it is difficult to explain this*." (KII, HCW,10)

Work overload

Complications resulting from TM use demand for more intensive monitoring, interventions and longer patient stays which will result to HCW work overload.

"*Patients who have used TM increase our work overload their labour progression is unpredictable and instead of the normal way of checking on the patient they need regular check-ups.*" (IDI, HCW,14)

Psychosocial distress and professional risk for HCWs

Fear to lose employment

HCWs are made to write reports on what transpired despite knowing fully well that the woman took herbal medicine to induce labour hence causing complications.

"*The most gruesome interrogation is one that happens following a maternal death the investigation process is very bad, the supervisors always look for health worker related factors unlike the patient related factors.*" (IDI, HCW,7).

Fear to face the community

Fear to face the community can be a significant experience for healthcare workers (HCWs).

This fear might stem from past experiences of hostility or conflict, concerns about being blamed or judged and uncertainty about how to address community concerns.

"*In this community, they will be pointing fingers, this is the HCW who neglected and mistreated our relative.*" (IDI, HCW,14).

"*We are working on the system for sure if you compare a death in a general ward usually were relatives are allowed, they will actually go to the community and give an account of the efforts that were made by the HCWs, so we are trying to see how we can accommodate the presence of a family member during delivery without compromising on the privacy.*" (IDI, PM &PC8)

Emotional toll following a maternal death

The emotional toll on healthcare workers following a maternal death with suspected herbal medicine use is really a serious problem.

HCWs may experience grief and guilt, feeling responsible or wondering what could've been done differently to preserve the life of the maternity woman.

"*I was filled with guilt and self-blame… now I have anxiety, depression and post-traumatic stress disorder (PTSD).*" (IDI, HCW,6).

"*Breaking the news to the family… it's heavy mmmm, I can say it's difficult. The baby is alive but no mother. It's traumatic.*" (IDI, HCW,1).

Table 1: Summary of demographic characteristics of participants.

Age category (years)		25-34		35-44		45-54		Above 55		Total
Front line health care workers (HCWs) (n=62)										
Sex		Female	Male	Female	Male	Female	Male	Female	Male	
		16	6	23	2	10	3	2	0	62
Clinical officer		2	1	3	1	2	1	0	0	10
Nurse midwife		14	4	19	0	7	2	2	0	48
Doctor		0	1	1	1	1	0	0	0	4
Educational level	Diploma	9	5	19	1	6	3	2	0	45
	Degree	6	1	2	1	2	0	0	0	12
	Masters	1	0	1	0	2	0	0	0	4
	PhD	0	0	0	0	0	0	0	0	0
Policy makers and program coordinators (n=18)										
Sex		Female	Male	Female	Male	Female	Male	Female	Male	
		0	0	2	1	4	2	7	2	18
Nurse midwife		0	0	2	1	2	1	5	0	11
Doctor		0	0	0	0	2	1	2	2	7
Educational level	Diploma	0	0	0	0	0	0	0	0	0
	Degree	0	0	1	0	1	1	3	0	6
	Masters	0	0	1	1	3	1	3	2	11
	PhD	0	0	0	0	0	0	1	0	1

Table 2: Summary of the themes.

Themes	Sub- themes
Invisibility and concealment of traditional medicine use	Non-disclosure of use
	Trafficking of traditional medicines
	Some hidden sources within the environment
Health system constraints and disjointed care	Antenatal care versus labour and postnatal care
	Incompatible system
Absence of policies and clinical guidelines	Lack of standard operating procedures and treatment protocols
	Lack of a legal framework
Trust erosion and conflict	Mistrust from the patient
	Conflict with families and communities
	Conflict at work places
Burden of adverse outcomes	Emergency
	Work overload
Psychosocial distress and fear among HCWs	Fear to lose employment
	Fear to face the community
	Emotional toll

DISCUSSION

This study reports critical insights of the lived experiences of healthcare workers and their navigation of the interface between biomedical maternity care and traditional medicine use in selected health facilities of Zambia. The findings confirm complex, tension-filled terrain shaped by systemic gaps, cultural beliefs and professional vulnerabilities. The current study showed hidden threats for the HCWs as they managed women suspected of TM use during the process of child birth. Concealment of TM due to cultural Influence, made it difficult for the HCWs to get information. This study affirmed that HCWs relied on their basic knowledge supplemented by practical experience, yet encountered difficulties getting information from patients for clinical decision making. Similar to this study, revealed that women's use of TM is often hidden, making clinical

assessment difficult.[7,8] The tactic of disguising herbs in porridge or tea, as reported by this study, reflects a coping strategy used by women who wish to reconcile cultural fidelity with biomedical compliance.

The study revealed that health care workers cited fragmented maternal health services as a major challenge they experienced. HCWs indicated that antenatal, antepartum and postnatal care is disconnected between healthcare providers within and across most health facilities. The absence of an electronic interoperable database made it difficult for providers to coordinate care across facilities. Studies have noted that fragmented care undermines maternal health strategies.[1,5]

The HCWs highlighted that lack of legal and clinical Frameworks to address TM issues in maternal health was a challenge revealed that Traditional Birth Attendants have historically assisted many women during childbirth throughout the continent, but integration of TM and conventional maternal healthcare raises complex legal and policy questions.[7] This finding is in line with a Zambian study by 6 that pointed at ensuring safety and efficacy of traditional practices, regulation of practitioners and how to reconcile statutory laws with customary practices. Constitutional and Statutory Provisions of Zambia's Constitution enshrines the right to healthcare as a directive principle of state policy, but it does not address TM. HCWs in the current study gave an account of the absence of a standalone statute that regulates TM practice. In Zambia's plural legal system, customary law coexists with statutory law, especially in personal and family matters. While there is no formal "customary medical law," customary norms strongly influence attitudes toward pregnancy and childbirth.

A healer's legitimacy comes from community acknowledgment of their knowledge and lineage, a principle even recognized in Nigerian law 9 and resonant in Zambia's context.

One of the most troubling findings is the erosion of trust and open conflict between HCWs and patients, families and communities. Similar accounts have emerged from other countries and commonly noted in rural areas, where biomedical providers face resistance or backlash when challenging traditional norms.[2,3]

Further this study highlighted that the HCWs bore the weight of death and systemic blame. Perhaps the most emotionally charged narratives were those involving maternal deaths.[10] The psychological toll, compounded by punitive investigations and lack of counselling, leads to professional burnout.[4] The Participants in the current study feared job losses or transfers reinforced by a culture of defensiveness rather than reflection or systemic learning. These findings call for institutional reforms that protect HCWs while promoting maternal safety.

The study was conducted only in three provinces on a small sample and the qualitative design method, limits generalizability to other regions with differing cultural practices.

Despite the limitation, the findings provide insights for designing targeted interventions to improve maternal health outcomes while respecting cultural contexts.

CONCLUSION

Healthcare workers in Zambia operate within a delicate ecosystem of cultural beliefs, biomedical mandates and systemic constraints. Their testimonies expose the unspoken burdens and professional risks of navigating TM use in maternal care. While respecting cultural practices, urgent reforms are needed to support HCWs.

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