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“Midwives in Niger : an uncomfortable position between social behaviours and health care constraints.”

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Summary

[1069]

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Abstract

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Maternal mortality rates are very high in developing countries. In Niamey, the capital of Niger, maternal mortality rate is 280/100,000, in spite of a high concentration of health services and of health personnel. Several studies demonstrated that the efficiency of maternal health services was low, both because the quality and the quantity of work were insufficient. The usual response to the poor performances of health services in developing countries is mainly technical. If improvement of the training of health personnel and re-organization of health services are necessary, they are not sufficient. A good effectiveness of care cannot be achieved without a mutual confident relationship between providers and patients. Focus group discussions were held in Niamey with women users of maternal health services, with student midwives and experienced midwives. Sources of complaints between providers and patients appeared to be numerous. However, they are centered around two themes, delivery techniques and cultural requirements, which correspond to two types of constraints : technical constraints and social representations and practices of the population. A description of traditional practices and beliefs related to delivery

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were obtained through discussion groups with old women and traditional birth attendants (TBAs). Both women and midwives are lied up by the same social rules (e.g. linguistic taboos, respect and shame) but technical constraints force midwives to violate those rules, making the application of their technical skills very difficult. Thus, the mutual relationship between users and providers is source of dissatisfaction, which often degenerates into an open confrontation. Midwives must learn how to implement obstetrical techniques within specific cultural environments.

Key words. midwives, developing countries, user provider relationship, dissatisfaction, cultural constraints, traditional delivery

INTRODUCTION

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In spite of a fast growing number of health personnel and of health services, maternal mortality remains a major public health problem in developing countries. The magnitude of the problem in the world was compared to the crash of an airplane, full of 250 pregnant or just delivered women, every 4 hr [1]. The World Health Organisation's estimates of maternal mortality rates (MMR) for sub-Saharan Africa range from 270 maternal deaths per 100,000 thousands live births in Southern Africa to 760/100,000 in West Africa [2]. In comparison, the rate in North America is 12/100,000 [2]. A survey carried out in 9 countries under the supervision of WHO, showed that 88-98% of maternal deaths could have been avoided by appropriate care [1]. The determinants of maternal mortality can- be classified into four main groups : direct medical causes (e.g. toxemia, hemorrhage, infections) : reproductive behaviour (e.g. age at first marriage, parity, child spacing) ; socio-economic factors (e.g. GNP., literacy rate, social status of women) ; health care delivery (e.g. coverage, shortages of essential drugs, lack of qualified personnel, efficacy of health services). Safe Motherhood programs have essentially focused on reproductive behaviour (family planning programs) and on the delivery of health services (training of Traditional Birth Attendants (TBA), of midwives and of obstetricians). Because of their position in the health system,

midwives play a key role : they are the persons initially responsible for antenatal care, for delivery services, for postnatal care, for family planning and for supervision of obstetrical teams at the peripheral levels.

The second International Conference on Safe Motherhood held in Niamey in 1989 aimed at raising concerns of governments and funders about the importance of the problem, thus leading to actions that should make maternal mortality and morbidity rates decrease. The workshops and training programs that have been organized in Niger for midwives ever since do not seem to have produced the expected results : an improvement of maternal health services and, as a result, a decrease of maternal and infant mortality and morbidity rates [3,4].

In order to better understand the reasons for the relative failure of those programs, anthropological studies were carried out among the population of women and midwives.

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MATERNAL HEALTH IN NIAMEY

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In Niger, estimations of maternal mortality rates range from 700/100,000 nationwide to 280/100,000 in Niamey, the capital [3-5]. This difference can be attributed to several factors ('Urban privilege") [6, 7], of which greater accessibility to health care is probably the most important. Pregnant women of Niamey have free access to an extensive framework of public health facilities [11 Maternal and Child Health clinics (antenatal care, immunization), 7 maternity wards (delivery services) and 2 referral hospitals], which they use extensively : 95.3% of pregnant women have at least one antenatal consultation during their pregnancy, 76.8% have at least 3, 71.2% deliver in maternity wards [8]. In addition, the concentration of midwives. nurses and doctors is very high : although Niamey's population (400,000 inhabitants) is only 5.5% of the nation population, half of the nation's health personnel is concentrated in the capital [8,9]. The high MMR in Niamey (although it is much lower than in the rest of the country) calls into question the efficiency of health services. A quantitative ap-

proach, used at first to evaluate the quality of work of health personnel, in particular of midwives, showed major deficiencies in knowledge, attitudes and practices. An analysis of the reasons for this situation revealed major weaknesses in the supervision and the management of human resources within the Ministry of Health as well as in the basic and post-basic training of health personnel [4,8,9]. The usual strategy to improve such a situation is based on administrative decisions and on an inflation of training programs (workshops, refresher courses, etc.), reinforcing the idea that managerial problems are mainly technical. The acquisition of new and/or improved technical skills is certainly a necessity. The mastering of such skills is indispensable to health personnel at all the levels of the system but it is not enough : their efficiency depends also on their willingness to apply their skills. We present here the synthesis of several qualitative surveys designed to study the interaction between midwives and pregnant women.

OPINIONS OF WOMEN CONCERNING OBSTETRICAL CARE IN NIAMEY

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Five focus group discussions composed of 12 women each, conducted by two female Nigerian sociologists, were held in Niamey in different national languages [10]. The inclusion factor was a previous utilization of Niamey obstetrical services (MCH clinics and maternity wards). Groups were designed to gather women from different ethnic origins, different socio-economic status and different ages. Most women were unhappy with the obstetrical services but grievances concerned mostly delivery services. No woman complained about the competence of the personnel. The only grievance with antenatal care was the poor quality of reception in MCH clinics. The diversity of grievances concerning delivery services can be grouped into two themes : delivery practices and attitude of the midwives and of the personnel in general. Delivery, as it is practiced in maternity wards, makes many women uncomfortable, and is therefore a major source of friction. During labor, women usually refuse to push, even when mid-

wives insist. They identify categories of personnel by the color of their blouses. This allows them to ascertain that midwives arc rarely present during labor and delivery, which are often monitored and performed by student midwives or by cleaning staff. The progression of labor is rarely monitored by physical examinations. Even when multiparae warn the staff that delivery is imminent, they arc rarely listened to. In spite of the fact that midwives are themselves less than conscientious, apparently they do not hesitate to insult their patients/pregnant women when they do not comply. This is especially true when' patients/pregnant women prefer squatting during/ labor and delivery, rather than lying in the lithotomic position on the delivery table. When the woman insists, she is compelled by the personnel (midwives and cleaning staff), to clean the floor herself immediately after delivery. The absence of an appropriate disposal measure to hide the blood losses of delivery are also a major concern to women.

TRADITIONAL DELIVERY

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Discussion groups, conducted under the supervision of the authors by two highly trained female Nigerian surveyors were held with older women and traditional birth attendants (TBA) from the Zarma ethnic group which constitutes 62% of Niamey's population.

The primipare is required to deliver in her parents’ house, leading many urban women, most of whom had their pregnancy followed up in MCH centers [8], to deliver in rural areas, where access to health services is difficult.

In all cases, at the onset of labor, the woman is isolated in a room of her house with the TBA and/or her mother. She squats, the older woman sitting behind her and holding her tightly around the waist/ During contractions, the attendant massages her abdomen. The squatting position is chosen because women believe "it prevents the foetus from drinking the amniotic fluid. If it were to do so, it would lead to vomiting and respiratory difficulties, and would entail a high risk of neonatal death". During labor, woman must not push for that would give her after-pains. The fear of after-pains is very great. In rural ar-

eas, women try to prevent it by depositing, after delivery, ashes at the intersection of the paths leading to the village, in order to protect themselves from the bush 'evil spirits' [11]. Underlying the fear of after-pains is probably a feeling of shame. During labor and delivery a woman must neither shout nor [1071] cry ; urine loss and defecation are also considered shameful. A nickname will even be given lo the child of a mother who would not have complied with these "taboos'.

Table 1.
“Matrix of conflicts” between midwives and women

	Delivery position	Delivery process	Anatomic words	Blood	Safety
Midwives	Lithotomic position	Women must push	Must use taboo words	Physiologic loss	Biomedical
Women users	Squalling	Women are afraid of pushing	Are ashamed of taboo words	Attraction of evil spirits	Psychological and symbolical

A prolonged labor has a social meaning : it is often attributed to a bad temper in the woman. After expulsion of the placenta, the cord is cut. The placenta and the blood losses are then buried with the maternal side of the placenta facing the sky, either in the house itself or in the ground of the latrines, so that "evjl spirits are not attracted to the family by the smell of blood'1. After delivery, the woman and her child will be confined at home for 40 days, primarily to avoid 'evil spirits' smelling the blood loss. Even the word 'meat' cannot be uttered in the woman's room. The death of the woman during the confinement period is attributed lo her fear after seeing an 'evil spirit'.

MIDWIVES, BETWEEN MEDICAL TRAINING AND SOCIAL PRACTICES

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Two surveys were carried out among midwives by the authors to better understand their social identity, to identify the problems they face in their day-to-day practice, and to learn their interpretation of those difficulties [12]. Focus group discussions were held with experienced midwives and with student mid-wives. Both midwives and their young counterparts complain a great deal about pregnant women's attitudes and tended to consider them responsible for the poor quality of maternal services. They accused women of being 'stupid' and of refusing to comply. Paradoxically, midwives brought up the same themes as pregnant women, but had a quite different perspective. Their complaints were centered around two main themes : technical and social considerations (Table 1).

The fact that many women prefer squatting during labor and delivery, preventing midwives from performing physical examinations and also yielding the risk that body fluids will spread on the

floor, and the fact that women refuse to push, even when the midwife insists, are the two main causes of friction. Midwives are well acquainted with traditional delivery practices and related beliefs, but cannot or do not want to take them into account.

In many situations, midwives feel socially uncomfortable with pregnant women. Their occupation compels them to use terms related to sexuality (e.g vagina), that are culturally forbidden (linguistic taboos), to all but those belonging to specific 'inferior casts" [13]. They also face great relational difficulties when pregnant women are older than them. In that case, they claim they feel in a "situation where they are delivering their mother".

All 382 students of the training school for health personnel (midwives, nurses, laboratory technicians and social workers) were surveyed by questionnaires and interviews. This survey aimed at identi-

fying their socio-economic status * and at studying the sociological representations they have of their profession and of the patient. The majority of student midwives belong to the middle or the upper class : 45% have a high socio-economic status, 36% a medium socioeconomic status. Most grew up in an urban environment (74%). Those rates are respectively 21.1%, 29.1% and 43.1% in the general population of women in Niamey [14].

In one part of the questionnaire, student midwives were requested to write down the three first words that came to their mind when words associated with their profession were proposed. The three words midwives think best identify their profession are 'suffering', 'blouse' and either 'sadness', 'resistance' or 'pregnant woman'. The expression 'pregnant woman' calls to their mind 'blood test', 'suffering' and 'pregnancy'. The word 'child' is given by only 5% of school midwives, and ranks always third. Delivery is experienced as a 'natural' but difficult and painful event. Expressions referring to the technological side of their profession are nearly always absent. The only one that was mentioned did not refer directly to the 'state of pregnancy' (e.g. blood test).

DISCUSSION

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To our knowledge, no study concerning the interrelationship between midwives and pregnant women in sub-Saharan Africa have been published. However, during the last International Conference on Safe Motherhood, held in Niamey in 1989, many participants acknowledged that midwives had fallen in [1072] public esteem throughout Africa and that a malaise existed within the profession (Prual A., personal communication).

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* The socio-economic status of parents was computed as a score of several weighted indicators : type of housing, ownership of a house (weighted to the type of housing), ownership of means of transportation (car, motorcycle, bicycle), type of access to water (running water at home, community running water in the yard, wells, water carrier), access to electric power (at home, in the yard, no access). Four socio-economic classes were defined : upper class, middle class, low class, poor.

The analyses of the poor quality of maternal services in developing countries usually focus on the technical aspects, assuming that the practice of health personnel will mainly be determined by their knowledge and by the availability of appropriate support, but not by their social identity. The acquisition and the mastering of a knowledge does not necessarily mean it will be brought into play in the interaction with the patient (15,16). The provider-patient relationship must rely on a reciprocal respect and confidence for care to be effective. The existence of a relational problem between patients and health care providers has already been pointed out by Sauerborn *el al.* in Burkina Faso : *"Apart from "implementation failure' there may be an underlying conceptual discrepancy between providers and users"* [17]. The comparison of the discourses of midwives, patients, rural women and TBA's allows us to analyse this 'conceptual discrepancy'. The relationship between midwives and pregnant women is felt by both groups as dissatisfactory and often degenerates into frictions. The observation of those frictions lets us hypothezise that this situation originates in the existence of a 'matrix of conflicts', which is not conceptualized by the social actors. It is centered around two types of constraints, the technical constraints and the social representations and practices of the population (Table 1) [18]. The themes, as expressed by midwives and by women, are identical but from a different perspective. The only problem that they did not seem to share concerned blood disposal, which is so important to pregnant women. The significance of 'blood' has two different forms : the risk (of 'attracting evil spirits') for pregnant women, and only the physiological loss for midwives.

Women interpret and experience pregnancy and delivery through a social meaning, whereas the role of midwives and their social status is defined in relation to their technical knowledge. In order to deal with technical constraints, they have to reject many social rules (e.g. age classes ; taboos concerning sexuality), that they must nonetheless apply outside health services. They are also compelled to make women deliver according to health services rules (e.g. lithotomic position). This situation pushes them in a very awkward position *vis-à-vis* the population. This is most likely responsible for the 'aggressivity' and the 'lack of respect' that many pregnant women complained about. The focus group discussions held with midwives and student midwives showed that they knew of the social representations of pregnancy and

delivery, as well as of the traditional procedures for delivery. Most of them even seemed to adhere to the social representations, although often with a certain degree of shyness and shame, but not to the procedures.

In Zarma and Hausa ethnic groups, that constitute the majority of the population of Niger, relationships are regulated by moral canons (shame, respect and joking relationships) that are mainly expressed within parents and relations, or in coded social relationships (e.g. between peoples from different ethnic groups ; between peoples with different patronyms) [19]. Those canons are obviously shared by the midwives. During their training, they learn a scientific discourse whereby the patient * is viewed mainly as the support of a medical intervention. Patients are not identified in their social framework. Therefore, moral canons are not applied any longer and patients 'lose' their social identity. In this process, they 'lose' also their right to be respected and to be taken care of.

Surprisingly enough, no user of health services complained about the technical aspect of the quality of care. Pregnant women may have no means to measure the efficacy of health services. However, the discussion groups showed that, if they knew of some risks of pregnancy and delivery, they had a symbolic interpretation of those risks, which midwives seemed to share to a certain extent. This might also explain why they do not monitor adequately pregnancies and deliveries, medical assistance being out of place. The profession of midwife in sub-Saharan Africa will find its place only when patients are socially recognized and when the risk will have a medical meaning both for patients and midwives.

These surveys have demonstrated that technical training, however good it may be, is not sufficient to solve the problem of maternal mortality in sub-Saharan Africa. If usual public health measures (revision and adaptation of basic and post basic training programs, improvement of the supervision, of the management of human resources, etc.) are indispensable to improve maternal health, they will not be sufficient if cultural beliefs and practices of both the providers of care and the 'clients' arc not taken into account. This has already been acknowl-

* The word 'patient' is used here in a broad sense : anyone seeking a health intervention.

edged by the *International Conference of Midwives,* WHO and UNICEF during the PreCongress Workshop on 'Midwifery Education-Action for Safe Motherhood' (Kobe, Japan, October 1990). One of the recommendations stipulates that "Midwifery education programmes [...] be reviewed to improve midwifery practice by giving priority to providing a community based education which is founded on the identified needs and perceptions of the community and the community's perception of the midwife. [...]". Several actions could be easily undertaken at different levels. The core curriculum of schools of midwifery, as well as workshops and continued education seminars, should include anthropological courses that would deal with representations and practices of pregnancy and delivery in traditional settings. In addition, a code of ethics could be built upon [1073] indigenous sets of social behaviours. In this way, midwives would learn how to conciliate medical care constraints and populations' habitus. Based on a better knowledge and analysis of each other's practices, a dialogue must be initiated between providers and clients. On the health services' side, this can be obtained by having student midwives, midwives, medical students and medical doctors do qualitative surveys under the supervision of qualified social scientists, on different types *of* population : pregnant women, TBA's, old women, etc. [19]. On the population's side, the creation of groups of users of maternal health services, which can even be promoted by the health services themselves, would give both the population and the providers of care, an opportunity to have a constructive dialogue [21].

By doing so, they would be able to integrate and bring social and professional identities into line, thus improving maternal health services' performances.

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