



*Traditional Midwifery between Tradition and Modern Expectations: Case of some Traditional Midwives in Adjelhoc, a Tuareg Community, East-Northern Mali*



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*Spring 2011*



# **DEDICATION**

To my family

## **AKNOWLEDGEMENTS**

Many thanks to you Trond Waage, my supervisor, for the guidance you provided. You gave me fruitful comments enabling me to elaborate this thesis. I appreciated a lot the efforts you have put, your availability and also your encouragements throughout this writing process.

I would like also to thank Lisbet Holtedahl, Peter I. Crawford, and Bjørn Arntsen for their great contribution to this work and all the staff of Visual Cultural Studies for teaching me during these two years at the University of Tromsø. I am also grateful to Gary Kildea for his precious contribution in editing my film and giving feedback on my thesis.

I am indebted to Tatta and her family, Mohamed El Moctar, Wada, Daha, Rahmata, Modibo, briefly, to all the people living in Adjelhoc for providing me with information enabling me to write this thesis. Without your contribution, this work would not have been possible. I cannot thank you enough.

I am indebted to the Norwegian State through Lånekassen and the Sami Centre for providing financial support to my study at the University of Tromsø.

Thanks to my classmates for giving me feedbacks on my project, and to Rachel Issa Djesa, Toril Hanson Toril, Mohamed Ag Erless, Medecin du Monde in Kidal, DDRK for giving me various kinds of support for my project.

Special thanks to my family for giving me encouragement and social support during my whole life.

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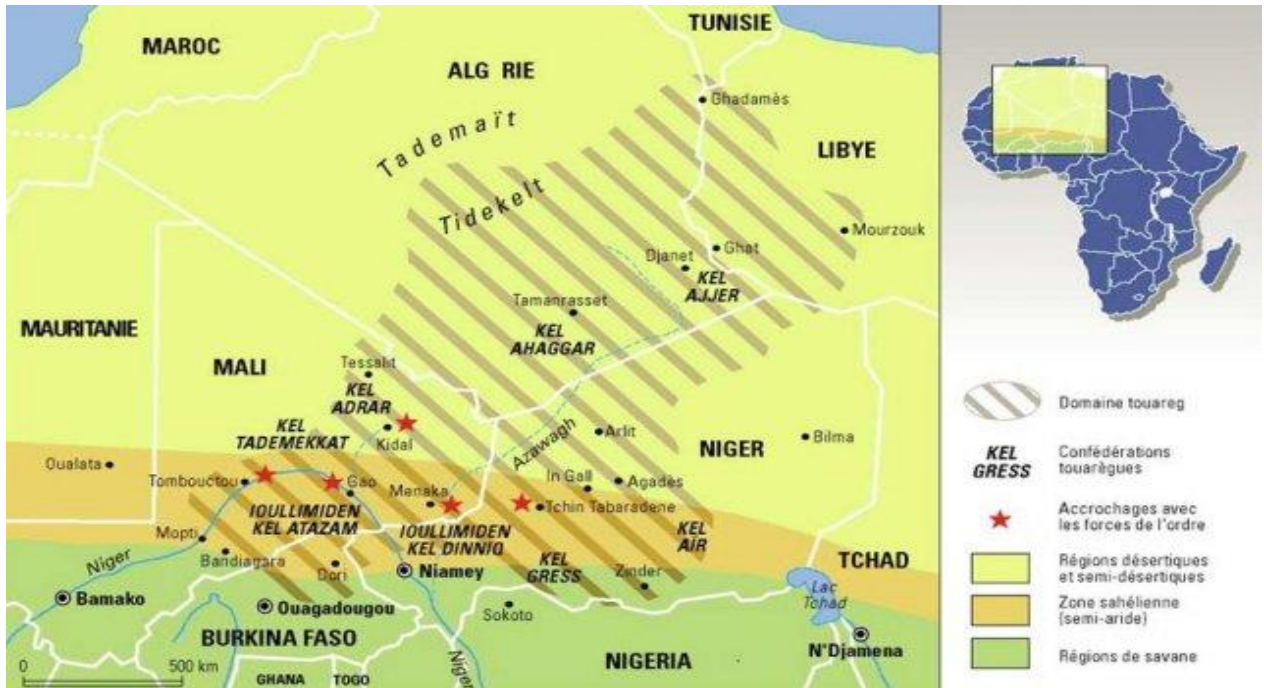
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## Map 1: Territories where Tuareg communities live



<http://www.monde-diplomatique.fr/cartes/touaregs1995>

## Map 2: Republic of Mali



Source: [http://www.lib.utexas.edu/maps/africa/mali\\_pol94.jpg](http://www.lib.utexas.edu/maps/africa/mali_pol94.jpg)

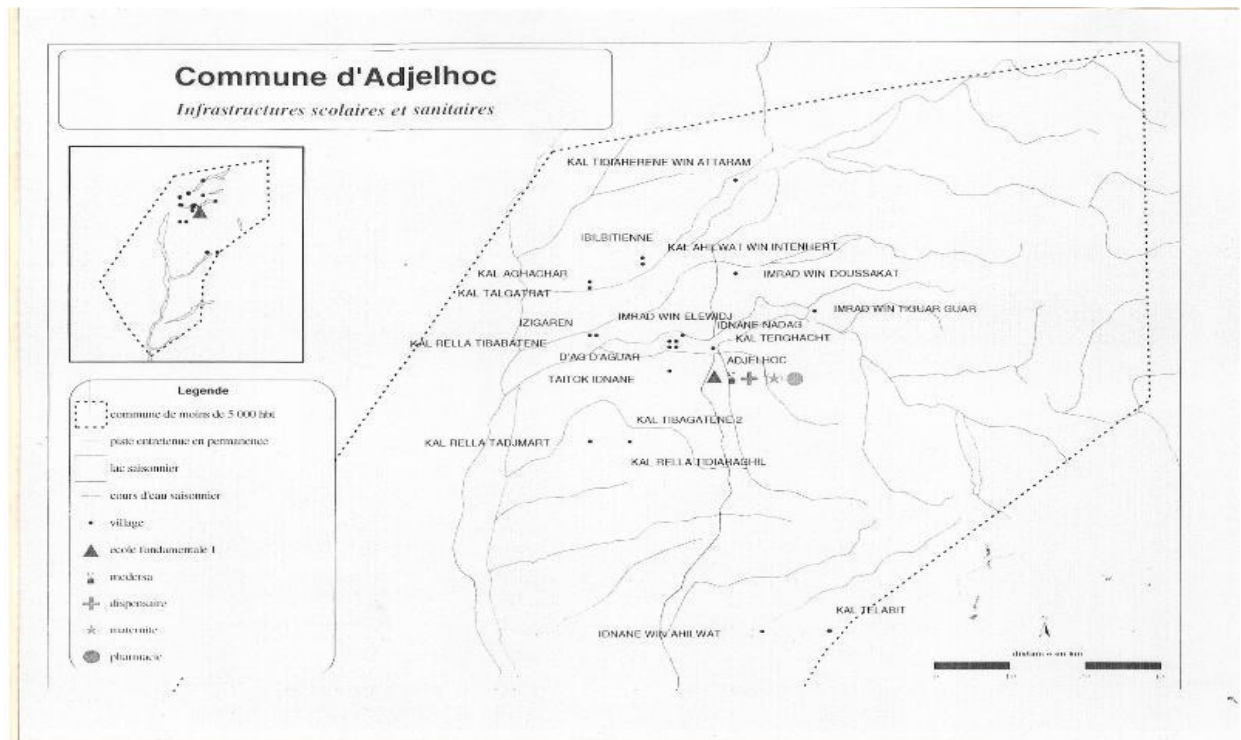


### Map 3: Region of Kidal



Source: [http://sahara-eliki.org/images/carte\\_kidal.jpg](http://sahara-eliki.org/images/carte_kidal.jpg)

### Map 4: Commune of Adjelhoc



Source: Direction Nationale des Collectivités territoriales du Mali

## **GLOSSARY**

**DDRK:** Developpement Durable de la Region de Kidal

**HIPC:** Heavily Indebted Poor Countries

**NGO:** Non Governmental Organization

**PSA:** Poste de Santé Avancé

**TM:** Traditional Midwife

**WHO:** World Health Organization

## **ABSTRACT**

This dissertation deals with traditional midwifery in transition in Adjelhoc, a Tuareg community in the Kidal region of east-northern Mali. It aims to approach the dynamism there between pregnant women, traditional midwives, the health centre, and DDRK<sup>1</sup> (Développement Durable de la Région de Kidal) in dealing with issues of pregnancy and childbirth. In doing so, I intend to demonstrate some of the social transformations taking place in this rural area of Adjelhoc.

In Adjelhoc, women, in most cases, prefer to stay at home throughout their entire pregnancy and to get help in childbirth only from traditional midwives, even if they live near a community health centre which could provide them with modern care. Women perceive the health centre as an environment in which they feel insecure, especially when it comes to certain common procedures used during pregnancy and in delivery. To lessen the gap between the community and the local health workers, DDRK is currently supporting six traditional midwives in Adjelhoc in acquiring modern skills and equipment. Collaborating with DDRK these traditional midwives have been given a new task as middle-persons between the community and professional health workers of bringing women to the health centre both for antenatal visits and for childbirth. The integration of traditional midwives into the local health system is seen as beneficial for health workers through the improvement of rates of utilization of obstetric services at the health centre. However, traditional midwives, who have always been highly respected because of their knowledge and the vital assistance they offer the community are now having their status threatened due to the reluctance of local women to visit the health centre (especially in earlier stages of their pregnancy). Traditional midwives find themselves in an ambiguous position between the professional health sector (health centre and DDRK) and the community.

In the field, Tatta, one of the six traditional midwives in Adjelhoc was my main informant. Applying techniques of participant observation, I used a video camera as a

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<sup>1</sup> DDRK in English means Sustainable Development of Kidal Region (my own translation). This NGO is funded by Luxembourg Cooperation in Mali and intervene in different domains among them the health sector.

main tool in recording some of the social realities in the lives of Tatta and other actors involved in traditional midwifery in the community.

**Key words:** Traditional midwives, pregnancy, childbirth, knowledge, health centre, training equipment, health centre, NGO.

## CHAPTER I: INTRODUCTION

This thesis deals with traditional midwifery in the Kidal region in the east-north of Mali. It aims to describe the social interactions of some traditional midwives within their community, their relation to DDRK as well as to the local health workers. Doing this, I intend to explore the process of transition of traditional midwifery in this Tuareg community. The discussion at hand in this thesis is based on fieldwork done in Adjelhoc from April to July 2010. In this work I use the term '*traditional*' to qualify the type of midwives I refer to in order to make clear the difference between them and the modern midwives who have formal education and belong to hospital settings. This is to warn the reader to not be confused in discovering throughout the work that the so called '*traditional*' midwives I refer to, also use some '*modern*' equipment and techniques.

Tuareg people or Kel Tamasheq (reference to their language denotes people who speak that language) are a Berber (or of that origin) population (Rasmussen 1992; Randall 1993). They now find themselves occupying large tracts of southern Algeria, northern Mali and Niger, with smaller pockets in Libya, Burkina Faso, northern Nigeria and Mauritania (Keenan 2003: 1). According to Rasmussen (1992: 352) other terms used to refer to Tuareg people include "*People of the veil*" (a reference to the men's face-veil), and "*People of the Tent-posts*" (a reference to traditional pastoral nomadism). In Mali, we find them mostly in the three northern regions of the country that are Tombouctou, Gao, and Kidal.

Adjelhoc a rural commune is located in the *cercle*<sup>2</sup> of Tessalit in the Kidal region. The majority of the population consists of Tuareg people who have lived with Arabic people for many generations (before the independence of Mali in 1960). However, other people live in the area and are mostly military personnel and civil servants coming from the southern regions of the country. This Tuareg community is in transition between nomadism and settlement. In the commune, there is only one sedentarized village named Adjelhoc (where people started to settle from the beginning of 1940s) and different

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<sup>2</sup> Name of administrative Division under Region

nomadic units or “*fractions*”<sup>3</sup>. Some of these nomadic units can be considered actually as semi-nomadic: villages like In-Amzel ‘*Secteur*’ and Maratt ‘*secteur*’ and the like; places that I had the chance to visit during my fieldwork. In the aforementioned localities, many Tuareg families have built their own houses (adobe mud houses) and made them their permanent homes.

The main economical activity of the people living in the commune is cattle farming (goats, sheep and camels) whilst others are traders. The majority of traders are Arab people.

In Adjelhoc, there is an institution providing preventive and curative health services to the population called a Community Health Centre according to the ministerial decree N°94/MSSPA-MATS-MP (August 1994). That decree says that the Community Health Care Centre is a first level organisation delivering the Minimum Health-Care Package<sup>4</sup>. Adjelhoc’s health centre is provided by the State but its services have been improved by DDRK. This NGO has provided the health centre with some equipment like an ultrasound unit, microscopes etc., as well as a medical doctor.

In Mali, traditional midwifery is still practiced in many communities especially in rural areas. According to the Malian Demographic and Health Survey (2006: 115), in the regions of Kidal and Tombouctou the rate of home births is the highest in the country: respectively 80% (Kidal) and 75% (Tombouctou). This survey also shows that among mothers preferring home birth, 89 % don’t have any contact with a health centre during their entire period of pregnancy. The above statistics, aim to contextualize the discussion

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<sup>3</sup> Fraction is a regrouping of camps whose size is less in terms of population in order to be considered as village in Mali

<sup>4</sup> The services of the Minimum Health Care Package are :

- Manage the implementation of socio-sanitary measures within populations;
- Provide with curative services such as routine care for patients, screening and treatment of locally endemic sub routine clinical exploration;
- Ensure the availability of essential drugs;
- To develop preventive health care activities (Maternal and infant Health / Family Planning / Immunization, Health Education);
- Initiate and develop promotional activities (hygiene – cleaning up, Community Development, Information Education Communication); and
- Promote community participation in managing community health centers and taking care of individual and the community health problems.

and to demonstrate that traditional midwifery is common even if people live near a health centre as in Adjelhoc.

In this Tuareg community (Adjelhoc), expectant mothers prefer to give birth at home with help from traditional midwives. They are highly desirable as birth attendants because of their skills but also because of their relationship (friend, kin or relative) with the mother or the mother's family. Furthermore, the community claims that a traditional midwife should have particularly good morals; a person who doesn't easily fall out with the woman in labour, a person who can keep a secret (regarding her work) and the like. These social virtues referring to the traditional midwife are highly recommended. In addition to that, the community is firmly attached to certain cultural values when it comes to intimacy. A female's body, especially her intimate parts are seen as "*taboo*" (a term borrowed from health workers) for foreigners to observe or to touch. A salient example of this attitude is the fact that the Tuareg women in this community always give birth with their clothes ("*tungu*") on. See Ag Erless in his work "*la grossesse et le suivi de l'accouchement chez les Touaregs Kel-Adagh*"<sup>5</sup> (Ag Erless 2010). The "*tungu*" is a kind of veil that women wear as ordinary clothes in their daily life and which covers their entire body, from the head to ankle. .

According to the World Health Organization (WHO), a traditional midwife is "*a person who assists the mother during childbirth and who initially acquired her skills by delivering babies herself or through apprenticeship to other traditional birth attendants*" (Titaley and al. 2010: 6). I refer to that definition not only to mention how traditional midwives acquire their knowledge, but to talk about the awareness of the WHO of their skills. And birth attendance is as one activity among several others that a traditional midwife performs in a community like Adjelhoc; roles such as traditional healer and counsellor.

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<sup>5</sup> My own translation: pregnancy and the follow-up of delivery to the Tuareg Kel-Adagh

## 1.1 - Why do traditional midwives still hold a strong position?

This question does not only concern Adjelhoc, but many localities in the world where traditional birth attendance is practiced. In many works dealing with traditional midwifery such as Titaley and al. 2010; Replogle 2007; Lefèber and H. Voorhoever 1997; Selepe and Thomas 2000; Lech and Mngadi 2005; Nicholas and al. 1976 the traditional midwife is seen as benefiting from her '*position*' within the community. She is a person who shares daily life with the childbearing women as well as possessing special skills to do with pregnancy and giving birth. Assuring this traditional role in her community enables her to remain at the centre of this particular process, the dispensing of advices to women. A comparison of traditional midwives to health workers, as stressed by Lefèber and Voorhoever (1997: 1178), is adapted and strictly bound to the social and cultural matrix to which the community belongs; their practices and beliefs are in accordance with the needs of the local population.

Doing my field research in Adjelhoc, I noticed that women do not doubt the efficiency of services offered by local health workers. However, they do complain about the way they are treated by health workers. At the community health centre in Adjelhoc, there is a nurse, a young woman, who is in charge of follow-up examinations of pregnant women and of delivery services. But, when complications occur, the male medical doctor is called to deal with the situation. To examine women for gynaecological infection and to assess the development of a normal pregnancy, the health workers need to access the intimate parts of women including making a vaginal examination. Among the Tuareg, this is a serious situation to deal with. Women reproach health workers for not strictly maintaining professional confidentiality. In addition, women complain about certain techniques used at the health centre including that of laying the woman on a table during antenatal visits as well as for delivery. In their eyes this is just unacceptable. In Ag Erless's work (2010: 316) in Kidal, a similar case is well described by a health worker point of view.

*“Les techniques qu'on utilise en milieu hospitalier elles n'y sont pas habituées et ce sont les techniques qu'elles n'aiment pas. Nous aussi, on ne peut pas exercer nos*



*activités sans ça. On ne peut pas donner l'ordonnance à une femme dont on n'a pas fait le TV [Toucher Vaginal], qu'on n'a pas fait différent tralalas. [...] Parce que ce sont des gens qui n'aiment pas être déshabillés devant quelqu'un. A l'école, nous avons appris à déshabiller les femmes, c'est ce qu'on doit faire. Mais ici, on ne le fait pas, à cause de leur mentalité. [...] ...elles refusent le fait de dévoiler leur sexe<sup>6</sup>. M. Sow, modern midwife.*

This quotation situates the perception of many Tuareg women about the way that modern medicine attends to pregnancy and delivery.

Referring to Tatta (my main informant), she doesn't have any such 'intimacy' problem with the women she works with because they trust her, they are confident in her presence. But she did mention that in the past, even she has had a few difficulties in gaining access to the private parts of women's body. On the other hand, traditional midwives are very well reputed in this locality due to their knowledge of traditional remedies. I observed that for the most part the community turns first to traditional remedies (plants or animal products) to treat maladies. The health centre is seen more as a last resort in the trajectory of a person's seeking help in the case of illness.

## **1.2 - Tatta (walet Anoufleye), my main informant**

Tatta is a middle-aged person; approximately 46 years old. She is a Tuareg woman, married and living in her house in the role of spouse, mother, grandmother, and sister-in-law. She is a tall woman, approximately 1m80, a stout person of a dark skin colour. Within her household, she is particularly attached to her granddaughter of six months, spending a lot of time taking care of her. In Adjelhoc, Tatta's family has a shop located at a corner of the courtyard of the house. One can buy there various items such as candy, sugar, oil, rice, cigarettes, biscuits, and so on. Tatta's husband usually keeps the shop; but sometimes Tatta replaces him if he is not around. In front of the shop, there is a shaded

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<sup>6</sup> "The techniques we use in hospital settings, they [Tuareg women] are unfamiliar to them and dislike them. We too, we cannot do our work without them. We cannot deliver any prescription to a woman without performing the vaginal examination and others. These people do not like to take off their clothes before anyone. We have learnt at school that woman should be undressed, that is what we should do. But here, we do not do it because of their mentality. They refuse to uncover their sex" (from my own translation.)

area used as a gathering place for everybody. At any time of the day, one can find tea to drink. Almost every afternoon, Tatta if she is not busy working inside, will meet her friends under the shade to discuss a wide range of topics. Many times, I saw people coming to visit her (in her house). When she conversed with other women there - or, for that matter, in any social situation where I had the opportunity to observe her - she tended to dominate the discussion. She also enjoyed telling funny stories and making others laugh. When she talks, she has a particular way of making gestures with her hands. This is characteristic of her style in many social situations.

She is an intelligent woman. I was impressed by her command of French (speaking) although she didn't complete her first year at elementary school. According to her, she learnt French by herself. She, like other Tuareg women, also works at producing goods for sale. She fashions various types of leather carpets and tents. And she also makes necklaces for sale. She used to be a member of some associations in the village. She once represented an association that promoted training in Gao organized by an NGO. She has various other experiences of working with NGOs. She showed me three different certificates she'd been awarded for having attended certain training programmes organized by a variety of NGOs.

### **1.2.1 – Tatta, a Traditional midwife**

Since she was young, Tatta had observed her mother performing deliveries. Thus she inherited most of her skills and even now, she claims to use the same techniques taught to her by her mother. But before starting to assist women in childbirth, she practiced her skills with animals whenever they had difficulties in giving birth. Working with animals enabled her to learn a lot about the process of birthing in practical way. The first delivery she actually took part in occurred when she was pregnant herself for the first time. This happened in 1980 when she went to visit one of her close relatives. The woman wanted to give birth in strictly intimate surroundings and asked Tatta if she could attend. She was reluctant out of fear but her relative insisted. According to Tatta, as she was attending the delivery, the woman giving birth was the one who had to instruct her as to what she should do. This experience is quite common in this Tuareg community. Other traditional

midwives told me of having the same experience; either due to their nomadic lifestyle whereby other, more qualified, persons are just not around and/or because of concerns around intimacy. Moving on from that experience Tatta began performing deliveries regularly and became well known in the village because of her skills and also for her outstanding moral character. She said that people were confident with her because she could keep the secrets of her work and also because of her natural ability to comfort people. According to her, she enjoys doing this work not for monetary reward, but for God's blessings. She helps at births without asking for payment (neither cash nor gifts). She is often shown gratitude, though, and in various ways. For example, some people give her name to their baby (if it is a girl) as was the case with the delivery I filmed during my fieldwork.

As with many Tuareg women, Tatta owns some special knowledge of traditional medicines. Many of the remedies that she uses to treat women and children are made from plants whilst others are made from the dung and urine of animals. For example, she uses "*ahidjar*" (acacia nilotica) and "*cacadour*" (ginger) for making a decoction for the treatment of a person who feels "*ulh*" (palpitations, nausea, or heart infection). She also treats other maladies such as "*bandagari*" (an illness of hot), eye infections, "*adakan na ehf*" (severe headache) as well as vomiting and diarrhoea illnesses in children.

When a child suffers severe malaria (*tennede ta badanate*), she makes a plant remedy from "*tadhant*" (*boscia senegalensis*) and "*techaqq*" (*salvadora persica*) and then bathes the child three times<sup>7</sup> followed by a massage.

When it comes to pregnant women, one complaint she is called upon to treat is "*inezad*" (malpresentation of the foetus). Her remedy for such cases includes the massaging of the woman's abdomen in order to replace the foetus. She also treats "*amagras*" (an illness provoked by change of diet), and "*tahafinit*" (malaria or 'dirtiness' in the abdomen of a person).

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<sup>7</sup> Three times is a required number for Tuareg traditional healer to assess the efficiency of treatment.

She uses camel's dung and urine as medicine to treat different illnesses affecting both children and adults. According to her, you mix camel urine with water, bathe the sick child with it and then give a little in water to drink to counteract stomach-aches. Goat's urine is also used to treat stomach-aches in woman as well as infertility in women. She prepares a concoction by mixing it with water and boiling it before administering it as a drink to the patient.

Attending at childbirth and the practice of traditional medicine are part of Tatta's repertoire of highly valued knowledge. Such knowledge is not unique to her; it is shared with other Tuareg women of a certain age and/or experience. And as such Tatta is a particularly well known and well trusted personage in Adjelhoc

- **Tatta, a Trained Traditional midwife**

As she has remarked herself, Tatta already knew a great many things about pregnancy and childbirth - and was renowned for this expertise - long before she was in touch with Médecin du Monde<sup>8</sup> and later, with DDRK. Indeed, it was due to her knowledge and reputation that she was recruited by these NGOs to collaborate with them. Working with them, however, enabled her to improve her work especially around hygienic aspects. In the past Tatta said that she performed the deliveries in a very "*rudimentary*" way. She would use a kitchen knife or other sharp objects to cut the umbilical cord; the delivery areas were not properly cleaned. She would also use unclean clothes as towels to clean the baby and mother.

Tatta and the five other traditional midwives have, since 2005, been going through different training sessions in Adjelhoc organized by Médecin du Monde. The training aimed at upgrading their skills in managing the whole process from pregnancy to delivery. According to Tatta, training has enabled her to learn different symptoms pointing to dangers for pregnant women and how to refer such cases to the health centre. Médecin du Monde has also provided them with various materials and equipment such as latex gloves, lamps, bleach, soaps, puromycin, plastic sheets, new (sterile) blades, mats,

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<sup>8</sup> Médecin du Monde is an International NGO financed by the Cooperation Belgium in Mali.

fabrics, buckets as well as bags for carrying it all. In addition to the equipment, Médecin du Monde had granted traditional midwives a cash payment each year (10 000 F CFA<sup>9</sup>). From 2009, Médecin du Monde ended its activities in the village and has been replaced by DDRK. But DDRK really only started its activities with traditional midwives in 2010.

Through these different courses, Tatta and the five others have gained new and unique knowledge within their community. That puts them into a specially qualified category and distinguishes them from other traditional midwives (who have not had the chance to learn modern skills with the NGOs).

### **1.2.2 - DDRK introduces a new strategy**

Working with DDRK, Tatta and others have been assigned a new role of doing midwifery activities. They have been given the task of campaigning to expectant mothers to go to health centre for obstetric services. Sensitizing women as task did not exist when traditional midwives were working with Médecin du Monde. This new approach has been initiated by DDRK in accordance to the new policy adopted by the World Health Organization. This new policy from WHO has been again adopted by the Malian State<sup>10</sup>. I got this information about the State from the Malian Regional Health Institution in Kidal. In Replogle's work, we learn that the WHO changed attitude towards training traditional midwives in its safe motherhood programme due to the lack of concrete result (Replogle 2007: 177). From 1990s this international Institution and other major health policymakers shifted the funding away from traditional midwives training. This position of WHO of training traditional midwives is clearly stated in its World Health Report 2005 that *"the strategy is now increasingly seen as failure. It will have taken more than 20 years to realize this, and the money spent would perhaps, in the end, have been better used to train professional midwives"* (ibid: 177). According to the WHO's new approach the delivery should happen at the health centre and be performed by health workers.

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<sup>9</sup> 16 Euros.

<sup>10</sup> Mali is member of the World Health Organization for many decades. This international Organization is also an important financial partner of the Malian State when it comes to health sector.

Thus, DDRK in its approach working with traditional midwives, instructed them that they can attend birth by themselves, but their main role now is to encourage women to frequent health centre especially for antenatal visits and childbirth services (see the film “*Tatta, a Tuareg Traditional Midwife*”). DDRK wants traditional midwives to be actors bringing the expectants mothers closer to health centre in order to lessen the gap between the community and the health centre.

From 2010 DDRK improved the working condition of traditional midwives. In addition to the initial annual payment (10 000 FCFA) and the delivery kit (equipment), DDRK introduced the strategy of bonus payments. The bonus is paid to the first three traditional midwives sending the most expectant mothers to the health centre both for antenatal visits and later for the birth itself. However, the deliveries that traditional midwives perform by themselves are also factored in to an assessment of their eligibility for the bonus. Thus the best performing traditional midwife for a given year would get 30 000 FCFA<sup>11</sup>, the second one 20 000 FCFA<sup>12</sup> and the one in third place would get 10 000 FCFA.

### **1.3 - Some research questions**

Approaching traditional midwifery in Adjelhoc in this thesis, some research questions have been framed.

- What does it mean being a traditional midwife culturally and socially in Adjelhoc for the local community, DDRK, the health workers and the midwives themselves?
- Traditional midwifery in Adjelhoc is in transition. Tatta and others have learnt new skills and the use of modern equipment in performing deliveries. To what extent does this new status affect their social role related to their traditional midwifery?
- What changes do the introduction of a money economy into the traditional midwifery *‘field’* imply?

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<sup>11</sup> 46 Euros

<sup>12</sup> 31 Euros

- Traditional midwives attended a variety of training sessions and yet remain rooted in their own empirical knowledge. How valuable is the knowledge system of traditional midwives in the face of modern medicine's knowledge system?

#### **1.4 - Approaching traditional midwifery through theories**

To guide the discourse of this thesis, theories from various different authors have been utilized. To approach the transition (traditional midwives' social, traditional and economic changes) Barth's work (1981) on "*models of social organization*" is an interesting theoretical tool. His work is relevant because it enables one to understand which status is relevant in any social situation where different types of social persons are gathered. Barth argues, referring to '*social person*' that an understanding of '*status-set*' is required about actors before the establishment of any act of reciprocity. I will refer to '*status-set*' to make more comprehensible the reasons for traditional midwives being generally better reputed and trusted than health workers.

Adjelhoc is a community where actors belonging to different social '*fields*' meet with the objective of saving the lives of mothers and newborns. These different actors are traditional midwives, pregnant women, the health centre, and DDRK. In approaching interaction within and between social fields in this thesis I refer to the work of Grønhaug (1975) on "*Macro factors in local life: social organization in Antalya, southern Turkey*". Grønhaug's work offers important theoretical tools to analyze the dynamism and the relationships between micro and macro levels within the community given that each social field has its scale (in space). While traditional midwives and pregnant women are rooted in their Tuareg cultural values where family bonds, respectability and reputation are key, the health workers are connected to the State (and bureaucracy) possessing modern knowledge received at medical school enabling them to offer modern obstetric services to the community. DDRK a fourth field is connected to universal/international rules and norms for providing support to the community through traditional midwives and the health centre.

Dealing with pregnancy and delivery in any community presupposes that the practitioner possesses some knowledge. In Adjelhoc, traditional midwives acquired their knowledge

through taking part in deliveries over a long period. They possess empirical knowledge that enables them to take care of women in their community. In approaching the knowledge system in traditional midwifery in this work, the concept of ‘*authoritative knowledge*’ of Brigitte Jordan (1997) is used. Her work “*authoritative knowledge and its construction*” has the merit of contributing to the growth of anthropology about childbirth as a ‘*cultural system*’. Traditional midwives’ knowledge as authoritative knowledge is challenged by health workers. According to Jordan (1997: 58), authoritative knowledge “*is the knowledge that within a community is considered legitimate, consequential, official, worthy of discussion, and appropriate for justifying particular actions by people engaged in accomplishing the task at hand*”. Jordan’s point of view is used to illustrate a clash between traditional midwives and health workers.

## **1.5 - Film as part of the thesis**

My film “*Tatta: A Tuareg Traditional Midwife*” is a portrait of a Tuareg woman named Tatta Walet Anoufleye. It mainly explores the daily life of Tatta in her community and in different social situations. The film and the text both deal with the practice of traditional midwifery in this community but in different ways. While the film focuses on Tatta and her quotidian activities, the text tries to set out the transformation taking place in the practice of traditional midwifery in the community and the dynamism between different actors dealing with pregnancy and childbirth.

Through the film, I tried to show visually different aspects such as:

- How the daily life of a traditional midwife like Tatta looks in Adjelhoc.
- How a Tuareg woman gives birth in her own community helped by a traditional midwife and which kind of persons are normally allowed to attend the delivery.
- How body language, facial expression and hand gestures are vital to the expression of the ideas and knowledge of people like traditional midwives whose practice stems from empirical know-how.
- What the environment in which the different activities of Tatta actually looks like.



- How the community generally, as seen through a series of interviews and observed conversations, values the work of traditional midwives in the community.

Within its 33 minutes, the film gives a chance to its viewers to learn many things about the lives and worldview of the people of this milieu that the text cannot do in such short time.

## **1.6 - Thesis outline**

This dissertation is structured in six chapters. While the first chapter sets out the context of the work as an introduction, the second chapter deals with the methodology. In the second chapter I explain the approach that I used while doing participant observation in the field. At times I video recorded ongoing interactions as a means of obtaining fruitful data to have at hand for the writing of this thesis.

In chapter Three, the setting of Adjelhoc is described with an emphasis on the people living there. In this part, we learn some more general information about the lives of the Tuareg people whether in Kidal or elsewhere. Approaching traditional midwifery through various anthropological theories chapter four analyzes the point of view of Barth talking about '*status*' and '*status-set*', Grønhaug working on '*social fields*' interaction, and Jordan dealing with the '*knowledge system*'.

In the chapter five I analyze some empirical material on the activities of traditional midwives, their relationship with pregnant women, and with health and DDRK workers in the community. In chapter six, by way of conclusion, some findings are explored.

## CHAPTER II: METHODOLOGICAL FRAMEWORK

In the field, I was doing qualitative research using the technique of participant observation in order to gain as complete an understanding as possible of different social interactions and representations about traditional midwifery in Adjelhoc (Davies 2008: 77). The video camera was used as main tool to record interviews, social interactions with my main informant and other persons involved in the study. Sometimes, I used the service of a female interpreter since I didn't speak the local language. In the field, I had a notebook and my mobile phone for field notes and to record some interviews.

### 2.1 - Starting point

My first ideas as to my main fieldwork started during some seminars we had had at the University. When I was searching on the internet, I found a research proposal<sup>13</sup> entitled *"Illness and Health among the Kel Tamasheq in Northern Mali"*. I was immediately attracted by this proposal not because it was on Kel Tamasheq but rather the subject involving health issues caught my interest. My preliminary idea was to think of a research topic similar to that. This led me to contact by email different persons who were involved in that research in Mali in order to get some more information about their findings. Among those who responded, I got to know Mohamed El Moctar a young Tuareg man, a native of Tombouctou. He is a medical doctor and was working at the Community Health Centre in Adjelhoc. Later on, after many exchanges by emails and phone, he became my contact person for my fieldwork.

The decision to work on traditional midwifery was made during the seminars in the classroom. In my initial project ideas, traditional midwives were identified as a kind of gateway to gain access to the community given their vital social role. This became clear from the information I got from El Moctar. Taking these suggestions into account I finally decided to actually narrow the focus of my research to traditional midwifery. I then informed El Moctar about that and about my interest in possible informants since

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<sup>13</sup> The research outline was elaborated by the Institute for Islamic and Middle Eastern Studies, University of Bern in Swiss. The three persons who answered me could not give me more information about whether the research has been carry out or not.

some traditional midwives were already in touch with the health centre through the DDRK. Later on, I received his final acceptance and a positive answer from some traditional midwives who showed an interest in being part of my project.

## **2.2 – Why Adjelhoc as a field location?**

The whole region of Kidal was totally unknown to me. I intended to do my field research in Tombouctou (one of the three regions in the northern Mali) where I spent some months (08) in 2006. When I asked El Moctar about the locality where he was working as a possible area for my research, he showed a positive attitude towards the whole project. That was an asset, it seemed to me, that I ought to seize since the information I got from him whilst developing my project paper, had been so fruitful. However, one of my concerns was the security situation<sup>14</sup> in the Kidal region and I told him so. He assured me that Adjelhoc was quiet and was not involved in the recent (2009) rebellion and conflict (the localities in the region involved were Tinzawatene, Tin-Essako, etc.). After being thus reassured, I decided to choose Adjelhoc. So, it was largely his presence in the locality that influenced my choice of Adjelhoc.

## **2.3 - Motivation of doing field research**

My motivation developed from what El Moctar had described to me. Medical doctors working at the health centre faced difficulties getting women interested in using modern health services in the locality. He told me that body intimacy concerns, was one reason local women avoided frequenting the health centre. This stimulated my interest in doing field research on these realities through traditional midwifery.

And, as a matter of personal interest, Kidal was a locality I hadn't visited before. It was a discovery for me. As a Malian who was keen to get to know the whole country in order to grasp the cultural contrasts between different localities, I looked forward to getting such an opportunity.

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<sup>14</sup> Region of Kidal has known different episodes of rebellions from 2006 till now. In addition to this rebellion, the locality is troubled by Islamists who abducted people mainly white people.

## **2.4 - Access to the field**

First, as I have said, I got access to it through El Moctar. I didn't know him (in person) before getting to Adjelhoc. Both of us were young which made things quite easy between us. He offered me a place to stay in his house during my research period which I accepted. The fact of living in his house facilitated my integration. I got to know easily people who used to come to visit him and realized that some of them had already received information about me and about my research topic.

As mentioned above, El Moctar had already informed some traditional midwives. Among them were Tatta and Rahmata. Tatta lives in Adjelhoc village but the second one, Rahmata is living in In-Amzel Secteur, a Tuareg camp about 12 kms from the village. El Moctar and I went to visit these two women for the initial contact. This gave me the opportunity to get to know them and to explain my research idea. But in the overall facilitation of my work with the informants, especially with Tatta, I benefited from the contribution of Wada. She is an aged woman, a native of Adjelhoc, who knows virtually everyone in the village. She works at the health centre as the pharmacy keeper. I got initial access into the field through El Moctar but Wada was the one who helped me be more readily accepted in my work with Tatta. She has known Tatta since they were little and in the film we can observe something of their close joking relationship. At one point Wada joked with Tatta as having been "*born under date palm tree*".

## **2.5 - Choosing informant**

The preliminary choice of possible informants had been made by El Moctar. But before he took it further, I told him that it would be great for me if he could seek out well reputed and communicative individuals. I also suggested to him that the traditional midwife should be a person with whom I could interact in French and also the kind of person with whom it is easy to be in touch. Based on these criteria, El Moctar had chosen Rahmata and Tata before I arrived in Adjelhoc. But in the field, I didn't work to the same extent with both of them. I did more work with Tatta than with Rahmata. The reasons are explained below.

## **2.6 – Starting up my fieldwork**

The first time El Moctar and I visited Tatta in her house, we found her resting under a shade just a few steps from the main entrance of her house. El Moctar introduced us and the ensuing discussion took place in Tamasheq which I could not understand. When we left Tatta's house, while going back home, El Moctar reported to me that Tatta didn't show any interest in being involved in the project. He said that Tatta became sceptical learning that the research project would require the presence of me, as a man, with her in her house, in the street and the like. Tatta also suggested to come with Wada visiting her in her house or making an appointment to see her at the health centre. Tatta's response disappointed El Moctar. From this initial contact, he said we should look for another one since they were 6 traditional midwives in the village working with the health centre.

Contrary to Tatta, Rahmata did show some enthusiasm for being part of the project when we went to visit her. The discussion was in Tamasheq with El Moctar but I could see her facial expressions indicating as much. She was smiling and was not embarrassed at all. She replied to me (in Tamasheq) to come to her at any time I wanted. And before deciding on another traditional midwife in Adjelhoc as an informant, I spent some days with Rahmata living in her house, observing what she normally does in her daily life. She was a divorced woman and lived with her mother, children, and grand-children. At that moment, Rahmata was looking after some pregnant women at the time however none of them was expecting to give birth in the coming four months. This became tricky for me since the process around birth-giving itself was a key element in my fieldwork.

Some weeks following my arrival in Adjelhoc, DDRK's workers organized a meeting with all six traditional midwives in Adjelhoc. That gave me the opportunity to see all of them. Their participation at the meeting, the way they interacted with DDRK's personnel either to answer or to pose questions had been significant for me in the choice of the ideal informant. At the meeting, the way Tatta participated made me see that the first choice made by El Moctar remained of interest. She was the most active discussant with DDRK's personnel at the meeting.

Finally in my efforts to settle on a main informant, I sought advice from Wada. She knew very well all six of the traditional midwives. When I discussed my project with her she offered the thought that Tatta might be the only one who could really help me. Afterwards, with Wada's involvement, I tried negotiations for the participation of Tatta in my research project.

## **2.7 - Negotiation with Tatta**

The first time Wada and I went to Tatta's house, she was not at all embarrassed like she was in my previous visit with El Moctar. Wada and Tatta first took a while discussing between themselves in Tamasheq and finally Wada let me know that Tatta had agreed to participate in the project. Tatta's reluctance was due to the gender issue of working with a man foreign to the culture. She needed to be reassured by a woman like Wada who knows the community as well as she did herself. Later, Tatta asked me (in French) for more details about the purpose of my research and how it would proceed. This gave me the opportunity to explain my project and my expectations of her involvement in it. I made three such visits to Tatta's house with Wada and later I began to frequent the house alone. Later on, I got to know her two older sons and became friends with them. Being thus in touch with them, my integration into Tatta's family became a lot easier.

## **2.8 - Doing participant observation without the video camera**

Having spent some time both with Tatta and Rahmata observing their daily activities, I noticed something different about them in terms of social interactions. Tatta interacted with more people than did Rahmata. With Tatta, I also had realistic chances to film a delivery since some of the pregnant women she was looking after were expecting to give birth soon. In addition, Tatta lived in the village near the health centre; she had more contact with health workers than did Rahmata (she lived 12 kms from the health centre). Thus, information and observation regarding social interaction that I could gain from following Tatta seemed richer for my research than would be possible with Rahmata. For these reason, I decided to go ahead and work with Tatta as my main informant.

Observing Tatta in her house one day, I took my note book and started to write in it. Seeing me doing this, she then stopped the discussion she was having and began observing me. She reacted as if perhaps I could actually understand what she was talking about with her sister-in-law. She didn't actually ask me what it was that I was writing but by the way she looked at me I could tell that she was seriously wondering about my attitude to her. I noticed such a reaction in her twice. After this, I decided to stop using my notebook altogether when I was with her and began using my mobile phone for taking notes. Using this method I no longer noticed any such influence on the ongoing events before me.

## **2.9 - Use of video camera in the field**

Before starting to film in Tatta's house, I recorded with my camera a training session which she attended with other traditional midwives from Adjelhoc and Tessalit (a town located 90 kms further north). The training (see chapter five) was organized by DDRK in Adjelhoc. But even before that day, Tatta knew that filming would be part of my project. When I decided that I wanted to use the video camera with her I explained the reasons and showed her how the different items of equipment worked. She didn't offer any suggestions or objections and told me that: *"if it will help you to improve your work, it is a pleasure for me to be in your film"*.

However, as the research process went along, I did notice that, at times she was getting a little irritated by my daily presence. Sometimes she expressed her feelings, saying things like *"tomorrow I will be busy, I'd prefer you not to come"* or *"I will have some guests here tomorrow and I will have to take care of them"* or *"I am rather tired, it is enough now"*. After some weeks, I travelled to Kidal (the regional city) for a while. During my visit there I bought a book (Ag Erless's book on pregnancy and delivery in Kidal) which contained various photos of Tuareg traditional birth attendants and newborns. The title of the book was also written in *'Tifinagh'* (Tamasheq's written form) that Tatta could read. I also had another book that I had brought from Bamako and which also contained some photos of traditional midwives and some illustrations of childbirth. When I came to visit her with these documents, after having been away, she seemed quite impressed by them.

She was already familiar with some of the images from one of the books because she had already seen them at a training session. I could deduce her attitude about them from the way she discussed them with her sister-in-law and with other women. I told her that I had to write a document something like these books and, as well, to make a film about her and her life-experience as a traditional midwife. As it happened, these documents helped me a lot to explain the nature of my project and my everyday work with Tatta.

## **2.10 - Some challenges with Tatta**

In working with Tatta, there was always a gender issue. Local gender roles placed limits on my working with her in the community. In her house, things were fine. But, if she wanted to go out, it was a difficult for me to follow her. One morning she said that: *“I am going to a marabout’s house to treat his kid’s eyes; men from here are too bad, they will not accept you to film. I don’t want to be mistreated”*. When I discussed this attitude with Wada, she told me that Tatta was uncomfortable because some people could misinterpret my presence with her saying that she was not serious or that she was unfaithful. So, I was not able to follow her around in the village, into different social arenas, as much as I wanted to.

## **2.11 - Filming a delivery**

I have a Tuareg fellow student who helped me to translate my video footage after fieldwork. When she saw the scene showing the delivery that I filmed, she asked me: *“how did you manage to film that?”* Reflexivity (Davies, 2008) as an approach to fieldwork can sometimes help one to make the right choices. First I decided to choose Tatta as a main informant because I noticed I had a realistic chance of filming a delivery with her. Working with Tatta has been a huge advantage because I was often in her house. Because of this I met Daha, a woman who came to look for Tatta to help with a delivery. She is a long-time friend of Tatta. In the morning on this day, I was with Wada in Tatta’s house when Daha showed up with the information. Afterwards, Wada called to



me *“Diallo<sup>15</sup>, get ready there is a woman in labour over there they came to look for Tatta to attend the birth”*. I asked her *“Do you think they will allow me to film?”*. She said *“Just take your video camera and go along with them”*. I went to see Daha and I asked if her family would allow me to film Tatta performing delivery. She looked at me and then said: *“Okay, you can come but you will wait until we call you”*. This meant that I could not join them before the coming out of the new-born-baby. After waiting for almost two hours, I heard a voice saying *“Diallo you can come”*. It was Tatta who spoke. So I started the filming from the cutting of the umbilical cord and the delivery of placenta. Some days later, Daha told me that they accepted me to film because they thought it would help Tatta to improve her work. In addition, the respectful attitude that I had demonstrated to Tatta plus the fact that other women understood the nature of my project all played a part in my favour; in having me be accepted.

## **2.12 - Ethical aspects**

In the field, the responsibility of the researcher in respect of those being studied is to protect their physical, social and psychological welfare and to honour their dignity and privacy (Spradley 1980: 21). Working with traditional midwives in Adjelhoc, I had to take into account these considerations and also to be sure that they didn't accept me only because a health worker was my contact person. I informed them in a knowledgeable way so they could understand the research topic and the purpose of having them as objects of study. This is a concern of Davies (2008: 55) talking about informed consent. As she has said, participants in the research have to be informed and knowledgeable about the theoretical debates and terminologies in which the research questions are grounded. I didn't speak the local language so I worked with an interpreter so that the persons involved in the research could understand in their own language the nature of my research proposal. I was working in an area where people could misinterpret my presence with women. My task as researcher was to protect their dignity and honour living in their community by accepting whatever they suggested that I do.

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<sup>15</sup> In the field, people called me Diallo, my family name. This is quite regular in Mali that people call you by the family name instead of the first name. This has nothing to do with the joking relationship between ethnic groups people use to have in the country.

The filming of a delivery scene in a Tuareg community in Kidal by a man was very challenging. This was a special ethical concern to deal with. To get final acceptance of my use of the images for research purpose, I watched all my footage with Tatta. This was also a way for me to involve her in the editing process. She gave her final acceptance but suggested that I did not include one specific clip in the final film. That clip shows a situation that occurred in a family which she visited with me and where family members refused to be filmed. I respected her decision and did not, of course, use it in the film.

## **CHAPTER III: ADJELHOC AND THE PEOPLE LIVING THERE**

Aguelhoc (in Tamasheq) or Adjelhoc (administratively) is a rural commune in the Kidal region in the east-northern part of Mali. The commune is situated in the north of the Tilemesi Valley and in the sandstone massif of the Adrar des Ifoghas (Kidal). It lies 430 km north of Gao and 150 km south of the Algerian border. The area of the commune is approximately 22.000 km<sup>2</sup> and has about 11.000 inhabitants.

The commune is structured in nineteen nomadic units<sup>16</sup> and one sedentarized village named Adjelhoc. Administratively, the commune is divided into ten “*Secteur Administratifs*” (Administrative Sectors) among them Adjelhoc, In-Amzel, Taghlit, Tassigdimt, Tagharabat, Telabit, In-Akafel. Each Administrative Sector is led by a ‘*Chef Secteur*’ (Sector Chief) who is elected during communal elections.

### **3.1 - History of the village Adjelhoc**

Historically, the name Adjelhoc means, in Tamasheq, a place where the plateau runs aground in to the valley. The history of the village is linked to the French colonization which started in the area in the 1940s. French colonists came from Algeria and set up a military post in Adjelhoc. The soldiers were recruited among the local Tuareg population but French colonists remained the military chiefs. The military post was established in order to secure the Trans Sahara Road which crosses Adjelhoc from the Niger River in Gao to the Mediterranean in Alger. This road was built for the transportation of merchandise. With the establishment of the military post, the Arab traders from Algeria started to visit the place with a variety of goods such as tea, fabric and tobacco. Later on, some of these Arab traders started to establish themselves in the locality and built small adobe mud houses for dwellings and stores for their selling activities. Afterwards, some

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<sup>16</sup> Some important nomad unit/fraction based on their size of population are Taghlit, Tassidjimt, Ukinik, Telabit, In Akafel, Tamuscat, Matalmen, Marat, Tagharabat, Soran, Laway laway, Aslagh, Inamzil, In Tefouq and Sawané.

Tuareg people, known for their nomadism, started to build mud houses in a process of sedentarization. So after the French colonists, Arab traders were the first to be established in the area and only later, Tuareg people.

### **3.2 - People living in the area**

The present population is composed of 95% Tuareg people with most of the rest being of Arab people. In addition, there are a few people living there who come from Gao (430 kms from Adjelhoc further down) and the some others are from the southern parts of the country. Among these are civil servants such as military personnel, school teachers, health workers etc. In Adjelhoc I also encountered some Tuareg people whose fathers were French colonists or Malian military (from other areas in Mali). Islam is the principal religion and this is well noticeable in their daily life. In whatever they do, they make reference to Islam. This religious tendency bestows strong authority to marabouts<sup>17</sup>. They are highly respected persons in this community because of their knowledge of the Koran. The maraboutic families are mostly Arab descendants. They are called “*Dagh Ichaïgh*” or “*Cheickh*” or the “*Kounta*”.

The severe drought that occurred in 1973-74, considerably affected their traditional economic relationship which was based on cattle farming (Ag Erless 2010; Keenan 2003). That situation constrained many Tuareg people in the area to move to Algeria and Libya. During my field research, I noticed that many young men engaged in temporary migration to Algeria searching for wage labour. Some decide to settle there for longer periods. Commonly, young men returning from Algeria have accumulated some wealth and accordingly they enjoy a certain social prestige. They also tend to wear the kind of clothes that are difficult to obtain in the local economy.

The local market is mostly supplied with goods from Algeria and because of the proximity of this country and with the marriage bonds many people in Adjelhoc have

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<sup>17</sup> The marabouts are the people who possess the knowledge of the Koran. They are respected and even feared sometimes because of their knowledge. In Adjelhoc people resort to them for getting the religious benediction or blessing (Al Baraka) (Rasmussen 2000) and for treatments as well especially when they think that the illness is caused by devil or witch. Their treatment is based on the Koran and provide with the amulets and the other.

relatives there. Tatta is an example of that. She had two of her married daughters who lived in Algeria. I noticed that even for the treatment of severe illnesses people preferred to go there instead of coming to Bamako. The reasons for that are that they're likely to have relatives there and that they expect better and/or cheaper health care facilities there.

In many nomadic units, people have started to build adobe mud houses as part of sedentarization patterns. Some local residents told me that this fact is also motivated by economic issues and climate change too. The mud house resists the wind better than the tent and also protects more against the sun in the heat of day during the dry season. But the fact of building a house doesn't necessarily stop the wandering life. It is only this lifestyle that enables them to fully exploit nature as pasture for their animals in the desert. During my field research I noticed that in In-Amzel and Maratt many houses were left behind whilst the owners were away herding their animals. But these people would come back and occupy them during the rainy period. On the other hand, there were usually some families still in residence there even though most of the men had left with animals. The mud houses are situated in a rather scattered way. People do this so that they do not have to share with others the grassy areas as pasture for the flock in the rainy season. There is no river or other watercourses in the area. They live in very vast and arid territory. They have large diameter wells mostly built by International NGOs from which they fetch water for cattle and for household consumption. However, during the rainy season the different ponds in the area are replenished with rainwater. The rainy season is an important period for them. It represents a time for rest and for social gatherings because there is abundance of pasture and of water for animals. During this time they commonly pay visits to relatives and organise other social events such as marriages.

### **3.3 - Infrastructure**

In a village one could find a mixture of modern houses, adobe mud houses and tents. Some modern houses look the same as those in big cities such as Bamako (the capital). Many houses are built like store rooms with a living room attached and an enclosed courtyard. People usually use the rooms to rest during the day, protected from the sun's heat. At night, they often sleep outside in the courtyard.

In Adjehoc, there is a water tower which provides running water. They also have a large diesel generator providing electricity<sup>18</sup> to the village. The subscribers to these electricity and water services pay their bills monthly. There is a Community Radio Station which broadcasts from 08h to 12h. The programming includes public information announcements and messages from the various NGOs as well as representatives of Malian State. In the village, there is a fundamental school (for 9 years of study) which was inaugurated in 1965-66 and then broadened in 1997; there is also an "Institut de Formation des Maîtres" (IFM)<sup>19</sup> a high school which started in 2007. It receives students from various parts of the country. In addition to these infrastructural institutions, there are also military posts for security of the area and its population and also a Community Health Centre (see below) and the nursery (located at a military post). The commune is further supported by nine NGOs which are financial partners participating in various sectors such as schooling, water supply, healthcare, microfinance and so on. My particular interest here is, of course, one of these NGOs named DDRK and its work with traditional midwives.

### **3.4 - Pregnancy and delivery are women's 'world'**

In my discussions with men in the field, I found that many of them were surprised to learn of my project on traditional midwifery. Some remarked that I should go and talk to women because it doesn't concern men. Their reaction was not because it was taboo for them, but rather that the topic was not of interest to them. One day, Tatta's husband, talking to someone about me, said "*he came from Bamako to learn women's work*". On another day, an old man with whom I conversed commented, with irony in his voice "*How can you leave Bamako and come all the way to Adjehoc just to learn how traditional midwives perform deliveries?*" Ethnographically, these reactions are interesting since they reveal how some issues in the community are gender grounded. Later on I discovered that the fact of childbirth being such an engendered topic in the community was a matter for discussion by married couples. When the Tuareg woman

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<sup>18</sup> The electricity was not available the entire day. It started from 12h to 14h30 and late in the afternoon from 18h30 22h30

<sup>19</sup> Teachers' Training Institute is a high school where students attend three years of study for becoming teachers at the fundamental schools in Mali.

gets pregnant she first informs her husband. Throughout the whole period of pregnancy, the husband is very much involved. But his contribution is essentially to do with financial aspects like purchasing medicine, if needed, or when complications occur. It's his job to assure that fees and to provide the animal that is to be slaughtered on the day the woman gives birth and then on the baby's name-giving-day. Apart from such financial aspects, it is the woman, with help from her female relatives and friends, who deals with her pregnancy and delivery.

In general, especially in the case of first-time-mothers the husband prefers to send his wife to her mother. The general community attitude was that first-time-mothers needed quite a lot of care and that only their own mothers could ensure that. The particular delivery that I filmed in the field was such a case. The woman who gave birth had left Bamako, a modern city where she lives with her husband, for Adjelhoc to deliver the child in her mother's house. In addition to all the care that the first-time-mother may expect from her mother, the Tuareg community also seeks to avoid any negative effects of '*tar ha*' (a certain desire or longing). Daha told me in reference to the woman who gave birth that she had been sent to her mother to make sure that she would not be suffering from '*tar ha*'. '*Tar ha*' is a cultural phenomenon highly feared in the Tuareg community. According to the community, a pregnant woman who has '*tar ha*' cannot easily give birth. Even if she does manage to deliver that woman will still feel bad until her particular desire has been satisfied. In Adjelhoc, every Tuareg woman has some experience of '*tar ha*', either personally or in respect of a relative or friend.

In addition to childbirth, traditional medicine is also engendered in the Tuareg community. Women resort to women seeking remedies for several illnesses but especially for gynaecological ones (Rasmussen 1998; Randall 1993; Ag Erless 2010; Bernus 1989). The marabouts are consulted in general when the community feels that the illness is caused by a devil (*alshanan*) or a witch (*tikrikawan*) (Bernus 1989: 195). But the services offered by marabouts are very expensive such that many families cannot afford them. These payments are made in general with animals such as cows, camels, sheep and goats (Diakit  1993: 204).

### 3.4 - Women in Adjelhoc

The Tuareg community has been a matrilineal society in the past and this successoral regime is still in practice in some communities like the Hoggar in south of Algeria, and in Intililt (in the Gourma) and Gossi in Mali (Ag Erless 2010: 92). According to Murphy (1966: 1262), the high status of the Tuareg woman is linked to their traditional matrilineality.

In Adjelhoc, the woman is the main manager of the tent, or the house. In the family women attend to household chores, take care of children (bathe and feed them) and wash clothes. They also look after small animals, fetch water from the well and transport it either on donkeys or by carrying it on their head. As housewives, they also have to take care of guests. According to Mariama a Tuareg woman living in In-Amzel Sector *“The woman is the main manager of the family. She takes care of the children, small animals and guests. These tasks involve only the woman without any contribution of her husband. We fetch firewood and water unless you have children to help you with that. We also send the children off to school. Now women from the rural areas are no longer lazy. They prefer to work and to gain profit from their work.”* With the husband away with the cattle looking for pasture, the woman’s position has become more and more strengthened. As Talila said, *“Sometimes we replace our husbands when they leave with animals. It may happen that your husband leaves the camp for 5 months and you will be alone taking care of everything.”*

To supplement the household income, women do various remunerable activities. They work with animal skins, at tanning leather or making carpets and tents for sale. They make mats, necklaces and knit cushions to earn money. During periods of abundant milk they sell dairy products such as butter and cheese. The animals themselves are sold only in case of extreme necessity like health care fees or purchases of essential clothing. Animals are kept as marks of social prestige and to welcome the guests<sup>20</sup>. When a foreign guest comes to the house an animal is usually slaughtered (commonly a goat) as a sign of

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<sup>20</sup> They slaughter a goat to welcome a guess. I had even been welcomed by the meat of goat they slaughtered for me.



welcome and esteem. The money earned through remunerable activities is used mainly for supplementing the food supply. I also noticed that in Adjelhoc some Tuareg women (married and unmarried) ran their own small shops wherein they sold clothes, cosmetic products and the like.

I noticed something of a difference between Tatta and the other women (Rahmata, Mariama and Talila) in In-Amzel when it came to the workload around the house. This was connected with the various facilities and services available in the village that Tatta could benefit herself. In particular, she had running water in her house. In this arid environment, having such facility attenuates the burden of housework considerably. Tatta also benefited from having a maid to help around the house. Nevertheless, all of those women took part, more or less equally, in the aforementioned economic activities as well as in the taking care of household guests.

Rasmussen in her work, carried out in a Tuareg community in Niger, mentions that women gain much prestige and security from assuming mother-in-law status (1991: 103). This was not quite evident in Tatta's case from my observations of her as mother-in-law in her own house. She had an on-going conflictual relationship with her daughter-in-law. Tatta often complained about her, finding her to be incompetent when it came to household chores. She would say: *"I am not satisfied with this lady...; I am not sure if she will stay in this house for a long time."* This kind of relationship was interesting for me not because it entailed conflict but because it enabled me to understand more about Tatta as Tuareg woman. Coming from the south (Sikasso Region), I had in mind (like many other people from the south) a *'stereotype'* that Tuareg women in general are *'lazy'*. However, I was very impressed at how hard working Tatta and many other women were in their daily activities. For instance, I saw Tuareg women pounding millet in ways I could hardly imagine before coming to the area. That *'lazy woman'* stereotype completely disappeared after the first week of my work.

In the Tuareg community, a woman is also known to enjoy high social status and jural independence (Rasmussen 1991: 102). In Adjelhoc a Tuareg woman occupies the place of *'first Lady'* in the house. One of these aspects of a Tuareg woman's power is explained

in Keenan's work (2004: 125): "*woman power certainly seems to have played a decisive role in the preservation of monogamy*". During my field research I did not observe any polygamous families in the community either. I also noticed that Tuareg women in this community are more "*free*" in their house compared to those in the part of Mali (Sikasso) that I'm a native of. I had been working with Tatta for two weeks before I actually introduced myself to her husband. I was concerned about that situation since I had in mind that I should be first accepted by Tatta's husband. If I had to conduct the same research in Sikasso, I would certainly have to be accepted by the husband first. When I explained my embarrassment to Wada, she replied that "*if Tatta accepts you, you have nothing to do with her husband*". Throughout my whole period of research with Tatta I didn't ask for any permission from her husband of being in their house. I was particularly impressed by such a social reality in the field.

One day a woman came to look for Tatta regarding a conflict in her house with her mother-in-law (see the film *Tatta a Tuareg Traditional Midwife*). The woman complained about her mother-in-law because she was controlling her in her own house. She had left the home (for some days) and finally came to Tatta to express her rage. "*I have said to Ghayeya [her husband] to treat me normally... I cannot accept that Mouma [her mother-in-law] controls me in my house...*" In Adjelhoc, like other Tuareg communities, divorce is quite frequent and, referring to Rasmussen (1991: 111), upon divorce, the Tuareg woman does not automatically experience a lowering of her status, which depends on her conduct between marriages.

In this community, women are linked through competitive statuses (according to their age and experiences) as tent makers, animal keepers, necklace makers, carpet makers, traditional healers, traditional midwives, mothers, spouses, etc. as shared role inventory among women. These statuses are available for all women who grow up as a '*social person*' in this Tuareg community.

## CHAPTER IV: THEORETICAL FRAMEWORK

This chapter deals with anthropological theories I make use of in my discussion. Doing this, I refer to Barth in his work “*analytical dimensions in the comparison of social organization*” (1981) to approach the ‘*status*’ of the Tuareg traditional midwives at hand in this work. The concept of ‘*status set*’ as an element involving traditional midwifery in this Tuareg community is also approached in Barth’s perspectives. Traditional midwives from this local community interact with other professional health sector workers coming from outside (DDRK and health centre). To complete Barth’s perspective I make use the concept of ‘*social field*’ from Grønhaug (1975) in his work on “*macro factors in local life: social organization in Antalya, southern Turkey*”. His work, I believe will help to understand how the traditional midwifery is articulated between different actors present in Adjelhoc. Having examined the dynamics between actors referring to the issue at hand in Grønhaug’s perspective how the knowledge of traditional midwives dealing with pregnancy and delivery can be approached as a field of knowledge or a ‘*knowledge system*’. These thoughts lead me to refer to Jordan (1997) in her work on “*authoritative knowledge and its construction*”.

### 4.1 – Traditional midwives in their community

To help at birth is common knowledge or shared experience for Tuareg woman. In Adjelhoc, before the NGOs (Médecin du Monde and later DDRK) arrived, the status of being traditional midwife was not restricted. It was inclusive. Any woman possessing the knowledge and respect of the community could do the work of traditional midwife. The aim of discussing these aspects is to show in an anthropological discourse how this status altered, from common knowledge to a restricted practice contingent upon community legitimacy; in this community in Adjelhoc, the pregnant woman or her family always decides who will attend the delivery. My main concern referring to traditional midwifery in this context is to talk in Barthian terms about “*the events through which statuses, relations, and groups are made manifest have their form determined by the actors’ codifications of tasks and occasions*” (Barth 1981: 121). In 2005, Médecin du Monde came to Adjelhoc to improve the health care system. They selected in collaboration with

the community six traditional midwives. The selected six got the chance to upgrade their skills through different training sessions organized by the NGOs. In addition, they received material such as a delivery kit to improve their work in birth attendance. They were also given monetary payment. This attempt of the community and Médecin du Monde at organizing the work of traditional midwives in Adjelhoc can be illustrated here in Barth's terms as "*an agreed definition of the situation*". He adds that "*through such understanding, social statuses are mobilized and activity ordered in the manner we can describe as social organization*". These six traditional midwives working with NGOs have gained new legitimacy through their gained competences (compared to others) with their work within a system of organization in their community. And they have been made different than other women in the society in a kind of hierarchy dealing with traditional midwifery.

In Adjelhoc, giving birth is a family matter which entails intimacy concerns with women. Hence, health workers struggle when it comes to making expectant mothers interested in obstetric services offered at the health centre. Women acknowledged the efficiency of services provided by health centre (they resort to it in case of complication) but they felt insecure in being in health centre environment. In Barth's terms, the relevance of status in the social situation can be understood through "*a definition of the situation thus implies the mobilization, as relevant and acceptable, of a set of articulating statuses*" (Barth 1981: 122). A labouring mother, in each community, has her own expectations about where and who should attend the delivery. In this community, giving birth is women's affair. The traditional midwife should have good morals, be an aged person, be a person who has given birth herself, and have a status that refers to a sum of "*multiplex capacities vis-à-vis alters with comprehensive previous information*" (Barth 1981: 136). This previous information (laying women on table, and touching or seeing women's intimate parts) referred to the health centre reveals a shame attitude that women in this community have even for those who have never visited the health centre. Some women only referred to the information they received from relatives or friends when describing how people are treated by health workers. This is Barth's concern (Ibid: 127) saying that "*a single polluting status in a cluster has a contagion effect on the person as a whole*".

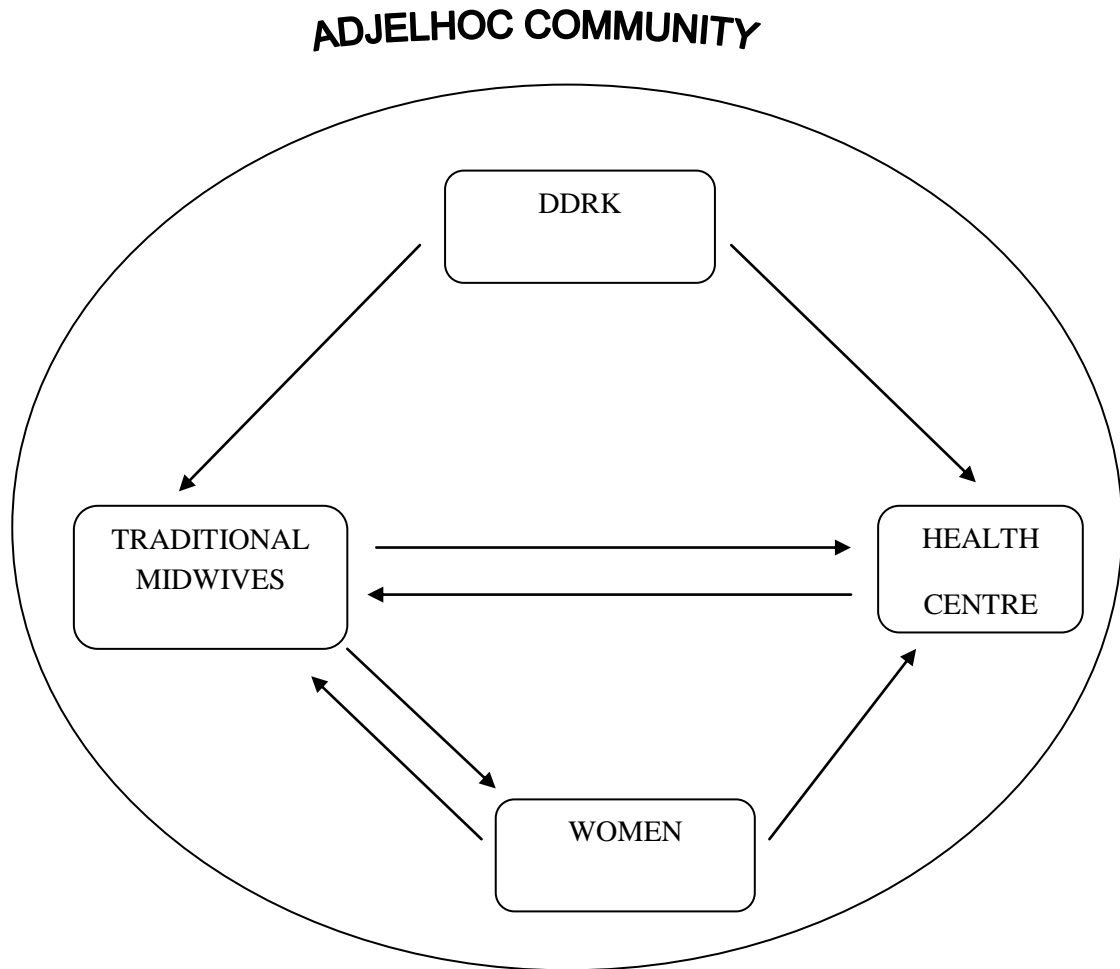
I noticed also that the atmosphere at the delivery place is like an ‘ordinary’ social gathering for different women around the labouring mother. The midwife and the family of the woman in labour talk about their daily life and their experience of child birth like “*who the baby looks like*” said a woman or “*I know Zahara will hate me forever because of the pain I created in her*” said Tata and everybody laughed at the same time; or the labouring woman saying “*let me have a rest I am tired*”, and the like. These statements tell the comfort that the woman in labour and her family can benefit from traditional midwifery. Her work is done in an environment where people have control over it. Such a climate might be difficult to get at a hospital. And in contrast to the hospital setting, the labouring mother and her family know that the dignity of the labouring woman will be protected. As Barth said, we need to understand the nature of the interconnection between statuses which are combined in such status sets so as to be able to construct rules governing the combinability of statuses in a generative model. In such interconnection between traditional midwife and pregnant woman, we have the fact of being both of them being women, sharing the same intimacy, concern, and belonging to the same cultural values. Tatta is mother, grandmother, mother, spouse, and an aged person in her community. In addition, her reputation of being a trusted person gives more legitimacy to her skills as traditional midwife in the community. Such combinability of statuses is important to understand the nature of the interpersonal relationship involving birth attendance.

## **4.2 - Different social fields in Adjelhoc**

Tatta and others are known in their community for providing support to friends and relatives at birth. Providing services to women in the community is a part of their social life. This traditional role was played and assumed by them in a whole traditional system of solidarity within the community. Recently, while collaborating with Médecin du Monde and later DDRK, they became involved in a relationship that exposes them to a new field with a broad scale while working in their local community. They learned new things when it came to pregnancy and delivery and used some modern equipment in their work. DDRK also established the contact between them and the local health centre. Dealing with pregnancy and delivery relates traditional midwives to a broad scale that is

mediated by national and international rules referring to maternal and infant health care. I am here trying to identify different actors as '*fields*' interacting in the community with the aim of discovering the dynamics between them. Referring to Grønhaug (1975: 3), a '*field*' of social organization is constituted by a series of interrelated elements of multiple individuals' interaction and communication. He adds that any organizational field has a characteristic interaction pattern (ibid: 3). In Adjelhoc we identify actors belonging to different social fields. And they play also different role when it comes to provide supports to pregnant women (and newborns). In an attempt to describing these fields, first we have traditional midwives who belong to the community and the pregnant women receiving different supports from others at the second level; at the third level, there is the community health centre providing modern health services in the community and related to the Malian State, and at the last level, DDRK providing with different kind of supports (material, money) in the community through health centre and traditional midwives and is related to the national and international rules. The interaction between the four fields is portrayed by the below figure.

**Figure 1:** Flow of interaction/information between different social fields concerning providing with services in Adjelhoc.



The arrows indicate the flow of interaction from an actor to another within the community, symbolized by a big circle. The arrows show that women and traditional midwives interact with one another. But this interaction between the women and the health centre is only in one direction. Women make contact with health centre after being motivated by traditional midwives; because of a communication barrier, health workers cannot go directly to women. The arrows also show the mutual interaction between traditional midwives and the health centre working as partners through the contribution of DDRK. At the top, the flow of the information comes from DDRK and afterwards goes to the health centre and to traditional midwives. This interaction is one directional.

Doing his research in Antalya, Grønhaug was occupied by trying to discover in social fields. He argues that *“the important thing must then be to try to follow the social relations of persons and groups, as an effort to discover some of the interaction content and the range of activities and relation”* (Ibid: 5). Each identified field in Adjelhoc has its relation and does specific activities with distinctive codes and goals. But these fields meet sometimes when it comes to provisions of improved services in the community in order to save the lives of mothers and newborns. Approaching the dynamics between different actors, I refer to Grønhaug (1975: 3) when he says that *“the problem is to identify fields of social interconnections that display the most significant patterns as seen from the view point of the production of social person”*. In this thesis I have identified the management of pregnancy and delivery as the field of *‘social of interconnection’*. This field is portrayed in this work by the Tuareg women who get pregnant and then give birth. This interconnection of the pregnant women and the baby’s wellbeing is one aspect to understand in order to describe the individuals’ choices that occur as elements of social-organizational interconnections and to investigate the actors’ own values and goals that are culturally defined (Grønhaug 1975: 2). In this sketch, the role of DDRK is extremely important. It provides money and equipment, and also establishes contact between the local women and the health centre through traditional midwives.

Working with Médecin du Monde and DDRK enabled traditional midwives to upgrade their skills and also to move from attending birth in *‘traditional’* state to an *‘improved’* state. That transformation is visible in the community because a category of traditional midwives has been more legitimized in the community when it comes to knowledge which was shared. The material and money these women are currently getting from DDRK are aspects improving their work but also strengthening their new status in their community. So, achieving the knowledge in DDRK’s field, the traditional midwives’ position in the local field is strengthened.

The health centre, representing the Malian State in this sketch assures the national health policy of Primary Health Care (mentioned above). The support it gets from DDRK enables it to improve its services. The ultrasound equipment, the microscope, the revitalization of the building of the health centre, the medical doctor, etc. are aspects of



that improvement. DDRK, working in Adjelhoc is trying to apply the new approach of World Health Organization according to which birthing should be performed by health workers in a health centre.

Health workers have modern knowledge and equipment for taking care of expectant mothers; but for the community, the body of women dealing with pregnancy and childbirth is something else. It entails emotion, feelings, how to become a respected woman, a good mother, shame, respect, sex, and the like. In this dynamism, traditional midwives have been identified as suitable actors for bringing expectant mothers to the health centre and spreading health information in the locality. Their contribution to that has been fruitful. I noticed in the community that many women did not know the kind of services they could get at the health centre before collaborating with traditional midwives. That was even acknowledged by health workers and the members of the community health association referring to the rate of antenatal visits and deliveries. Within this transformation, the gap between the community and the health centre has lessened. The modern equipment that traditional midwives use when attending births helps them to provide improved services to expectant mothers in their houses. But in this process, we find out the work of the traditional midwives in transition puts them between pride and uncertainty. They gain a better reputation with the delivery kit and the money but their task of bribing women closer to the health centre threatens their statuses in the community. I observed working with Tatta in the field that she still does her work as she did in the past. DDRK workers told them to go to women but Tatta preferred to stay in her house and wait that pregnant women come to her. She said *“I am too tired to run after them because they are not able to understand anything”*. She felt that women were not listening to her about going to health centre and noticed that her respectability was under threat due to the reluctance of local women to be brought at the health centre.

### **4.3 - Traditional midwives’ knowledge as authoritative knowledge**

Having portrayed the status of traditional midwives and their work as partner of the health centre an issue that may arise is that the value of traditional midwives’ knowledge of working with modern equipment and with health workers. Though traditional

midwives accept the use of modern skills when performing delivery, they remain convinced that they know something that health workers do not know. They have been working with pregnancy and delivery for many years, like Tatta who had 25 years experience before attending training from Médecin du Monde and later DDRK. She inherited her knowledge from her mother but also through different experiences doing her work. Tatta and the others tended to believe in the superiority of their own system as being the right one (Anderson and Staugård 1986: 15) about an illness that Tuareg pregnant woman faced but the health workers ignored. Traditional midwives called it *'inezad'*. (Refer to the film *'Tatta A Tuareg Traditional Midwife'* to see visually how traditional midwives advocate their knowledge with health workers).

Brigitte Jordan in her work *'Authoritative knowledge and its construction'* (1997) stresses that the label *'authoritative'* while referring to knowledge, is intended to draw attention to its status within a particular social group and to the work it does in maintaining the group's definition of morality and rationality (1997: 58). Among these Tuareg women this *'morality'* refers to the dress code giving birth, not being on a table, being with relatives, not crying, etc. and the *'rationality'*, refers to the shared experience or knowledge that traditional midwives possess. She also mentions that by authoritative knowledge *"I specifically do not mean the knowledge of people in authority position"* like health workers and traditional midwives. These statements are taken here to illustrate the discussion on *'inezad'* in traditional midwives' understanding referring to their knowledge since authoritative knowledge is about accountability in a community of practice in Jordan's term. The setting of the discussion I refer to is the training session where there were traditional midwives and professional health workers.

For traditional midwives *'inezad'* is an illness that occurs during the pregnancy. It is provoked by activity when the pregnant woman does some hard activities or carries a weighty object like a tent. It is also provoked by inactivity when pregnant woman spend many times lying down in the same place. Traditional midwives said that the foetus will move to another place which they called *'emazey'*. According to Ichainasse (traditional midwife) showing a side of her body she says that: *"you find the foetus here and then you move it like that to here"*. A pregnant woman who has *'inezad'* will have a hip that hurts.

Every traditional midwife attending the training had experienced that at least once in her life. Traditional midwives shared this knowledge about their work and said that that illness does not involve modern medicine because health workers do not have any knowledge about it. During my stay in Adjelhoc working with Tatta, she showed me a pregnant woman who had *'inezad'* that she treated. Some months before I came in Adjelhoc, she told me that she treated another woman who had *'inezad'*. She said that the woman had been to the health centre but she did not receive satisfactory treatment there. To treat the case, Tatta does some massages on the abdomen and with some physical manoeuvres repositions the foetus.

For health workers, what traditional midwives called *'inezad'* does not exist. They claim that the foetus stays only at one place in the womb. They also add that the whole evolution of the foetus takes place in the womb. They admitted that foetus may be in different positions or abnormally presented such as a breech, a transverse lie or an occiput posterior presentation, and the like. To deal with the malpresentation of foetus, they perform some physical manoeuvres to reposition the foetus. But they rejected the explanation that the foetus moves from the womb to somewhere else.

Analytically, we discover that the two systems of knowledge (traditional and modern) explain the situation in its own way. The modern knowledge referred to different names (the breech, the transverse lie, the occiput posterior, etc) describing the position of the foetus and tells the techniques they use to deal with the case. The traditional knowledge, with gesture and other body languages, explains the situation and also how it attends to. But both systems of knowledge agreed they perform some physical manoeuvres to deal with the case. To understand the dynamism of the clash between the two knowledge systems, Jordan argues that *"the central observation is that for any particular domain several knowledge systems exist, some of which, by consensus, come to carry more weight than others, either because they explain the state of the world better for the purpose at hand (efficacy) or because they associated with a stronger power base (structural superiority), and usual both"* (1997: P56).

At the training, *'inezad'* was not the only element creating a clash between the two knowledge systems, but the most important one ethnographically. I took this example to discuss the authoritative knowledge from Jordan because *'inezad'* knowledge is the one that counts for traditional midwives. Health workers tried to convince them with different names of malpresentation of the foetus, but traditional midwives remained true to their thesis according to which the foetus moves from the womb to *'emazey'*. In addition, there was *'tar ha'* (see above), a well known cultural phenomenon in Tuareg community that modern medicine fails to understand.

## CHAPTER V: DESCRIPTION AND ANALYSES

In this chapter, I am analyzing my field material. The setting of the discussion is some social situations I observed and also some discussion I have had with actors in different social arenas.

### 5.1 - Delivery in Tuareg community

The delivery I attended took place about 2kms from the health centre in the village. When we arrived at the courtyard where the delivery would take place, my first feeling was where are the people? I first saw cows, goats, sheep, and camels (their cries drew my attention). Afterwards, Tatta and other women went in to the tent where the labouring woman (Zahara) was laying, together with her mother, sister, sister-in-law, her aunt, and some kids. I stayed outside in the courtyard with the man who drove the car. That man was a brother of Zahara (the labouring woman). I was waiting until they called me to film, but I was sceptical. I asked that man: *“do you think they will call me to film the delivery?”* he said *“sure, they will call you; maybe the baby is not yet born”*. His answer comforted me waiting. My attention was focused on the tent and I could hear the voices of many people talking. Several time they said different names of God *“lahilaha illalahou”, “allahou akbar”, ’bissimilah rahmane rahim’, ’soub hanalaye’*, and the like. These names were said in the delivery tent for praying to God that the labour would be quick and also for acknowledging the power of God because they said that *“all depends on God’s will”*. In this community, the labouring woman is not allowed to cry. This is shameful for women; she rather says the names of God as an expression of the pains she may feel. Not crying while giving birth is also a sign of bravery for Tuareg women.

Tatta had been chosen to attend the delivery not only because of her skills but also her relationship to the family of Zahara. Tatta told me she knew Zahara since she had been a baby. Tatta also knows all the members of the family. According to Daha, when Zahara’s labour started, Zahara’s father recommended Tatta. This delivery was not the first one Tatta had performed in the family. Her relation to the family was based on previous

information that family had for being a confident person, a person who had good morals, and also a person who did not easily fall out with labouring women.

In the tent, after being called, I found the delivery place much like an “ordinary” gathering place. Nothing was surprising to them. Women were sitting around Zahara. She had her clothes on and also they were using a big blanket. No intimate part of her body was nude (see the film *Tatta A Tuareg Traditional Midwife*). Being a man, I was not allowed to attend the coming out of the baby, Daha told me. So, I attended the cutting of the umbilical cord and the delivery of the placenta. When I was filming, Zahara said “*he [me] is filming only me. Tell him to move the camera on me*”. Her mother and other said that “*your intimates parts are protected you should not care; and this man [me] has nothing to do with you, he is only filming Tatta and the baby*”. Their reaction referring to privacy of their intimate parts, tells that they are strongly concerned about it especially in presence of strangers like a man.

Among the women attending the delivery, I noticed they played different roles in providing support to Zahara. But Tatta and Zahara’s mother, Fourie, occupied the main roles. Tatta was responsible in assisting Zahara so that she could deliver in the safest condition and Fourie was the manager of social supports provided to her daughter. Tatta talked to her about what she needed and afterwards Fourie managed that support by telling others what to do (bringing the thread, the towels, and how or when to help Zahara keeping a position). Fourie’s role was divided between tenderness, affection, and admonishment. Her tender attitude was expressed with things like, “*even if the baby is beautiful, I prefer my daughter*” while trying to comfort her daughter; and her admonishment attitude could be seen through “*what an incompetent daughter...*” telling to her daughter to be brave like other women. The others were observing and waiting for Tatta or Fourie to tell them to do something.

Of the women present in the delivery tent, many had given birth themselves. All of them had some knowledge about giving birth. However, this knowledge was not equally shared; for instance, Tatta’s knowledge was the one that counted the most among them. Jordan (1997: 58) says that “*authoritative knowledge is an interactionally grounded*

*notion.*” How was this authoritative knowledge distributed within different participants in the delivery tent? In the tent I noticed that the authoritative knowledge was hierarchical. It went from Tatta to Zahara. She had no previous information about giving birth herself. In that hierarchy, Zahara, her knowledge about her body had no value. Like the labouring woman in Jordan’s work in a high-technology birth setting, the previous knowledge of the woman in labour of her body had no value compared to the physician’s knowledge which was technology-dependant knowledge (see Jordan 1997). Zahara said she was thirsty and asked to have water. Her mother told someone to bring water but Tatta replied by saying no, adding that water was not good for her at that moment. A woman said that she should drink water and referred to her own experience when she had drunk water in labour but Tatta rejected her view and told Fourie to bring porridge instead. Zahara said she did not want any porridge but Tatta instructed her to drink it, adding that it would help her deliver the placenta. Zahara complained that her back hurt and she needed to rest her mother admonished her to be patient and bear the pain because it was God’s will. She was in semi-sitting position and she asked to lie down on her back because she could not bear pain in her legs, but Tatta told her to keep that position until she delivered the placenta. Afterwards, Daha brought a scarf and asked Tatta to tie Zahara’s abdomen with it and instructed Tatta to use her toes to press on Zahara’s abdomen. Tatta first rejected Daha’s idea saying that *“I don’t use that old technique anymore”* before acquiescing due to the insistence of Daha. That technique did not help to deliver the placenta. While Zahara was complaining about pains in her legs and back, Tatta was performing different techniques to deliver the placenta. She asked Zahara to put a thread in her nose to make her sneeze and afterwards her finger in her throat, to make her vomit. The different techniques Tatta was performing to deliver the placenta were the knowledge that counted. Zahara’s knowledge over her body pain had no value. In the process, the knowledge of Tatta was the authoritative one. Even if some techniques had been initiated by other persons, Tatta was the right person to legitimize the knowledge. She allowed Zahara to rest when she thought it was necessary to do so before delivering the placenta.

Zahara did not have any experience about placenta. She asked her mother after delivering the baby why her abdomen was still swollen. Everybody laughed. They joked with her

saying that there was a second baby afterwards, describing the placenta like a goat's placenta that Zahara was supposed to know. And her mother assured her that delivering the placenta did not cause much pain compared to the baby. Throughout the process of delivering the placenta, they referred to different things or names to talk about it. This play with words (see Bernus 1989) was regular in their talk. They talked about *'baby's friends'* and *'Fourie's luggage'* when referring to the placenta.

Tatta helped Zahara in labour in a *'very'* successful way and received blessings in return from Zahara's family *"may God bless you Tatta"*, *"may God give you long life and good health"* to show their appreciation of Tatta's performance. Tatta answered saying that *"I thank God for giving me skills to help Zahara in labour"*. After having succeeded in doing her work, Tatta said that it was God's power that made her succeed. This acknowledgement of God's power over her skills is important since it shows her Muslim identity and also her attachment to her religion. Zahara gave birth on a Monday. This day was also believed that that it would bring luck to the baby and the family. Referring to the date, Tatta said *"this is good luck; today is Monday and the labour has not been long"*. The fact that the birth was in the morning was also believed to make the baby healthier. In Rasmussen's work in a Tuareg community of Niger, she said that the morning is a time of relative lack of danger; hence babies born in the morning are believed to be healthier (Rasmussen 1989: 134).

In Trevathan's work, he reported some birth experiences from women like *"well, my birth experience terrible, but at least I have a healthy child"* and *"I had a wonderful birth experience, but the baby is not healthy"* (Trevathan 1997: 84). These *'general'* statements about giving birth seem to not fit with the cultural values of this Tuareg community, which explain that what the labouring woman experiences giving birth is God's will. The delivered mother must say that she has survived along with her baby because God allowed them to survive. That was also Tatta's attitude towards God's power over her skills. She knows she has some skills to perform delivery, but said she succeeded doing it because of God's will.



I wrote above that Tatta and others receive modern equipment from DDRK and use them in their work. But in the film (*Tatta a Traditional Tuareg Midwife*), we only see Tatta using the latex gloves. The reason for that is because she performed that delivery before receiving her new delivery kit. She had some gloves from her previous supply.

## 5.2 - Training session

The training I attended was the first one organized by DDRK, but the third training session that traditional midwives attended. The previous two were organized by Médecin du Monde. At the training, there were the six traditional midwives from the village (Adjelhoc), three traditional midwives from Tessalit (a town in Kidal region about 90 kms from Adjelhoc), and two modern midwives (one from Adjelhoc's health centre and the other from Tessalit's health centre). Among the trainer staff, only some were medical doctors but all of them worked at DDRK except Mohamadine, the main trainer (see the film *Tatta a Traditional Tuareg Midwife*; he is the one showing the poster to attendants of the training) who worked at Médecin du Monde. Mohamadine is not a medical doctor but underwent a particular training for doing this work. He was also the one running these three different training sessions for the traditional midwives. He was quite acquainted with these women. The training was a review session of the two previous ones. So, the traditional midwives were already familiar with the topics<sup>21</sup> discussed.

At the training, traditional midwives were quite knowledgeable when it came to how to perform a delivery. But explaining their empirical knowledge to prove that they possessed such knowledge was a challenging exercise. When Mohamadine asked them to explain what they did with a labouring woman, their responses were expressed through gestures. It was difficult to rationalize their knowledge. Assimakate (traditional midwife) tried to explain what she does. She argues that *“you lay down the mother like that”*, *“you*

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<sup>21</sup> The training was on different types of women at risk in labour like a young girl, a short woman, an aged woman, a woman who experiences repeated stillborns, a woman who does abortion, a woman who has jaundice, a woman who undergoes sterility treatment, a multipara, a woman who underwent a caesarean section, and a disabled woman (inferior limbs). It was also on the different symptoms and illnesses that represent a danger for a pregnant woman like the bleeding, the anaemia, the severe headaches, the persisting underbelly pain, when the foetus does not move anymore in the abdomen, the jaundice, the bad smell of vaginal discharge, the convulsion attack, the vomiting, and the swelling of hands and legs. Mohamadine had different posters to illustrate some illnesses and types of women at risk in birthing process.

*touch her abdomen like that...*”, “*you check the dilation with towels like that*”, and so on. The hand gestures were performed on the floor and on her body, commented with few words to explain her knowledge. Though known as skilful in the community, Assimakate had difficulty explaining what she did. Zeneba, a modern midwife, knows her very well; she commented on Assimakate’s knowledge saying that “*she is very skilful performing delivery but she cannot explain how she does*”. This was what Jordan (1993, 11) tried to argue in her work that “*...birth is an event of great interactional complexity, where people know how to do without necessarily being able to talk about the detail of what they do*”.

**Figures 2 and 3:** Assimakate on the left side and Ichainase on the right one performing delivery techniques with gesture to explain their knowledge



Source: B.A. Diallo, fieldwork in Adjelhoc, 2010



Source: B.A. Diallo, fieldwork in Adjelhoc, 2010

All of these women attending the training knew how to deal with childbirth before they met the NGOs. Mohamadine confirmed that, but he had never seen any of them perform a delivery. He added that what was missing in their work were aspects like hygiene and how to protect the mother and newborns from infections. There were also different types of women at risk that traditional midwives needed to know more about. These were different aspects that DDRK was putting an emphasis on at the training.

As I mentioned above, traditional midwives were supposed to know much about the symptom of illnesses or type of women at risk in labour since it was their third time seeing the same topics. But they had difficulty answering many of the questions posed by Mohamadine at the training. When I discussed with Mohamadine, later referring to the performance of traditional midwives at the training, he told me that these women are

illiterate and also aged. Because of that, he found it was difficult for traditional midwives to remember what had been said during previous session. But what drew more my attention was actually a clash between the two knowledge systems. It was difficult sometimes for traditional midwives to admit that what they knew about certain symptoms of illnesses was not right. I talked about *'inezad'* above here I refer to the discussion between Mohamadine and traditional midwives when he asked them about the symptoms of jaundice.

TM: *"in our opinion, it [jaundice] is the deficit of blood in the body which is provoked by 'tahafinit' and the lack of vitamin. Some pregnant women refuse to eat; they drink only milk and water which cannot provide sufficient energy for them during pregnancy."*

Trainer: *"deficit of blood... So, do you all agree about that?"*

TM: *"This is what we know about it"*

Trainer: *"...from now, remember that what you referred to, has nothing to do with jaundice. It is only caused by liver diseases. We notice sometimes that you keep the ill person and treat the case with traditional laxative remedies and others until she dies whereas she had liver illness. You have to refer such cases to health centre".*

TM: *"There is also what I have said"*

Trainer: *"This point of view, forget it from now."*

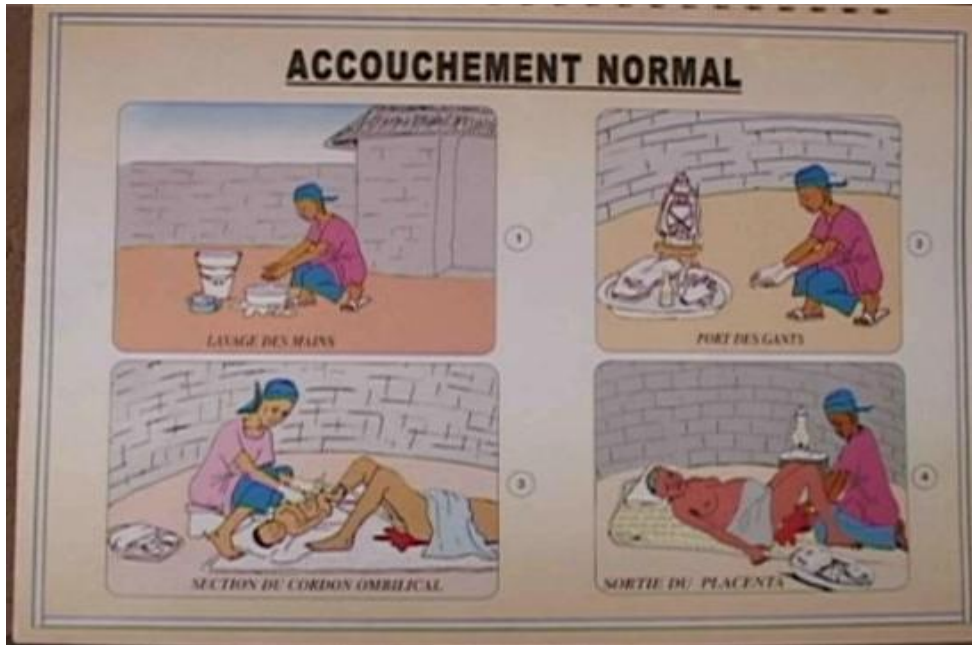
TM: *"Why am I saying this? I treated a case where the woman had this jaundice illness. She was weak and had anaemia exactly like you described it, do you follow me? She didn't have any liver illness. In the morning when she woke up, she vomited the yellow; everything was yellow even her skin colour. After some series of treatment with our traditional remedies she recovered. She didn't have any liver illness, it was a jaundice provoked by the deficit of blood."*

Improving traditional midwives' awareness when it comes to different risks to pregnant woman aimed also to strengthen their relationship with health centre where they have to

refer the cases they detect of pregnant women. For doing this, DDRK initiated and provided them with the referral tickets they have to give them to pregnant women; they were looking for both antenatal visits and for deliveries. Each traditional midwife has her name written on her ticket. When a pregnant woman comes to the health centre with the ticket, health workers will know the traditional midwife who sent that woman. This referral system enables health workers to record the performance of traditional midwives sending women to the health centre. And the bonus, as aforementioned, these women will get is paid based on their performance of collaborating with the health centre to improve the use of services.

At the training, Mohamadine used different posters to teach traditional midwives about different topics. There was a poster on delivery where we could see an almost naked woman giving birth. Mohamadine presented that poster to illustrate a normal delivery. This was perceived as a cultural shock according to the attitude of Assimake, a traditional midwife. When Mohamadine was showing the poster (see poster below), Assimakate left the training room to avoid seeing the image. Mohamadine even said “*don't you want to see that image?*” This was not her first time seeing that image. We can argue that from the reaction of Mohamadine asking her, that it was not the first time that Assimakate had avoided the image. Assimake has been working with NGOs since 2005, so her reaction can better illustrate that the cultural values concerning privacy remain a strong issue to be considered. The poster that illustrates the delivery in a normal way does not respect such cultural values the Tuareg women have about giving birth.

**Figure 4:** Poster illustrating a normal delivery Mohamadine showed at the training session.



**Source:** B.A. Diallo, fieldwork in Adjelhoc, 2010

### 5.3 - Picking up the delivery kit

Traditional midwives had regularly received a delivery kit since 2005, first from Médecin du Monde and now from DDRK. In the film (*'Tatta A Tuareg Traditional Midwife'*), we see three traditional midwives (Tatta, Wissa, and Ichainasse) out of six of Adjelhoc present at the meeting in the health centre where they receive their delivery kit. The initial kit is composed of latex gloves, thread, lamps, bleach, soaps, puromycin, plastics, new blades, a mat, fabric, a bucket and a bag for carrying the equipment. But at that moment, some items in the kit were missing, such as the latex gloves, bleach, puromycin, and the threads. These missing items were added some weeks later.

Receiving the equipment, some of the reactions from the traditional midwives were interesting for me. They could tell some other details on the collaboration of traditional midwives with DDRK. With Médecin du Monde, they used to get the equipment every six months. Once Médecin du Monde withdrew to the benefit of DDRK, traditional midwives spent more time, one year, waiting for the equipment that should be provided

by DDRK. Traditional midwives were upset about that situation. Before that day, Tatta told me that *“I don’t know what they are waiting for when providing us with our materials. I don’t have any more left to do my work”*. Tatta attended some deliveries before getting the equipment. Before picking up their incomplete kit, El Moctar (my contact person; he represented DDRK at the health centre) discussed with them whether they should wait some more weeks until the kit was completed. While the discussion was going on, Ichainasse picked up her share. She was upset by the delay because they spent more time than before getting the new supply of equipment and said that *“it’s disgusting when it takes time”*.

This meeting was also an opportunity for health workers to interact with traditional midwives. Ichainasse and Wissa got their referral tickets (Tatta already got hers some days before) from health workers and traditional midwives also informed health workers about the delivery they attended and the pregnant women they had sent to health centre. Health workers recorded these statistics from traditional midwives as their performance of improving the outcomes on the health centre.

#### **5.4 - Community health centre of Adjelhoc**

As mentioned above, the tasks of a community health centre are more preventive rather than curative. In the health policy system of Mali which is built up like a pyramid, the community health centre represents the first level of that pyramid that provides health services in the country. The main target of a community health centre is pregnant women and children with different immunization campaigns (vaccines, tablets) for preventing illnesses.

At Adjelhoc’s health centre, there is a medical doctor hired by DDRK. There is also a male Technician Nurse paid by the State and representing the medical staff chief, two Nurses (male and female) paid locally by the region of Kidal through the Heavily Indebted Poor Countries (HIPC) Fund<sup>22</sup>, and the Manager (female) of the pharmacy, paid

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<sup>22</sup> The HIPC program is an initiative of the International Monetary Fund and the World Bank. It provides debt relief and low-interest loans to cancel or reduce external debt repayments to sustainable levels in some countries in the world ([http://en.wikipedia.org/wiki/Heavily\\_Indebted\\_Poor\\_Countries](http://en.wikipedia.org/wiki/Heavily_Indebted_Poor_Countries)). In Mali, the State

by the community (Adjelhoc). The medical staff chief is a Bamanan, an ethnic group of Mali, coming from Koulikoro, a region in the west-southern part of the country. The medical doctor, hired by DDRK, is a Tuareg coming from Tombouctou, a neighbouring region of Kidal, and the three others are native of Kidal region but among them the manager of the pharmacy and the male nurse are native of Adjelhoc. Apart from the Technician Nurse, all of them understand Tamasheq, the local language.

The Centre is composed of four different wards: consultation, maternity, treatment, and observation, and two other rooms are made up of the cold storage (storage of vaccines) and the pharmacy. The health area of the community health centre is for about 6069 inhabitants and also contains three “*Postes de Santé Avancés (PSA)*”<sup>23</sup>. The main financial partner of the community health centre of Adjelhoc is DDRK. In addition to the medical doctor, DDRK provides it with various equipment (see above). The Technician Nurse has his accommodation in the courtyard of the health centre.

At the health centre, they offer different services such as immunization, counselling for pregnant women, family planning, ultrasonography, different tests, etc. Among these services, some are free in charge, such as immunization, counselling for pregnant women and tuberculosis test, but all the other services are charged.

The medical doctor was responsible for the consultations. If he was absent, the technician nurse replaced him. I noticed a huge communication problem between him and the clients in terms of understanding their illness. He used to refer to the male nurse who played the role of interpreter between him and the patients. In terms of antenatal visits for pregnant women, the female nurse was in charge of that. She was a young nurse, approximately 23 years old. In this community, in addition to the relationship, the age aspect is identified as important criterion towards the traditional midwife. An aged traditional midwife is also perceived as skilful because of a long period of practice and a trustworthy person with

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allocated this fund to the different regions in the country. Based on that fund, the regions recruit some manpower and pay them with that support.

<sup>23</sup> “*Poste de Santé Avancé*” (Advanced Health Post) is an initiative of Médecin du Monde in the commune. These health posts played the role of nursery in different localities in the commune far from the main health centre. The personnel of these Posts are recruited by Médecin du Monde with the partnership of the local community. The NGO has built the health posts and provided with the initial stock of medicine. The community, through running the post with the initial stock, should be able to renew the stock of medicine.

wisdom due to age. So, her young age could contribute to the disapproval for obstetric services by women, especially aged ones. She started working there in the beginning of 2010 as a newly trained nurse. Because of her young age and physical appearance of being short and thin, she was underestimated by many local women. She told me since she was there, many Tuareg women refused that she gets access to their intimate parts either doing breast and abdomen checks or vaginal examinations . In her ward, there were also two tables (see photos below), one for consultation and the other for delivery. In this community, the technique of health workers of putting woman on the table either for consultation or delivery is strongly rejected by women. Seeing these tables in her ward might also create a feeling of women against further consultations. She told me that since she had been there, she never managed to use these tables with Tuareg women. The deliveries that occurred there happened on a mattress put on the floor. She received help from Wada<sup>24</sup>, the pharmacy manager, for attending delivery in the health centre.

**Figures 5 and 6:** Different tables in the nurse's ward



Table for performing delivery

Source: B.A. Diallo, field work in Adjelhoc



Table for examination

At the health centres in Mali, the client normally pays the consultation ticket (or medical card) in order to be admitted to the consultation. At Adjelhoc's health centre, this medical card costs 200FCFA<sup>25</sup> but health workers struggled to receive this money due to the community's reluctance of paying it. In the view of many Tuareg people, the treatment

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<sup>24</sup> In addition to her task of pharmacy manager, she is also known as skillful in birth attendance in the village. She underwent nursery training. In comparison to the traditional midwives' work, the community pays for her services since she belongs to the health centre.

<sup>25</sup> 0.30 Euro



should be free. In addition to that, paying money in order to be consulted is a new way for them seeking treatment. In a traditional way of seeking remedies from traditional healers, the payment is made upon satisfaction of the client about the treatment (see Diakité 1993). Due to the community reluctance about the ticket payment, health workers initiated a strategy which constituted to add the ticket money to the cost of the prescription the patient will pay for getting medicines from the pharmacy. Patients paid systematically the 200FCA without knowing when they purchased medicines at the pharmacy. Since people only got medicines from that pharmacy, this strategy enabled health workers to receive their money.

Sometimes, even when buying medicine, the pharmacy manager struggled with certain people who believed that she charged them for her own benefit. In their view, even the medicines are free.

I also noticed at the health centre the practice of indirect consultation. In general, it was a man who came to explain the illness of his children or wife or another kin to the medical doctor. The prescription was delivered based on the explanation of that person. Sometimes health workers refused and required that he should bring the ill person but for some other reasons like the distance from the health centre and the lack of means transportation constrained them.

## **5.5 – Traditional midwives collaborating with health centre**

One of the problems local professional health workers face in rural areas in Mali is the distance between the community and the health centre. To lessen this gap by spreading health services information in the community, traditional midwives represent an asset that health workers can rely on (see Jessen 1992; Sanogo and Giani 2009; Phiri 2006). In Adjelhoc, the contribution of traditional midwives to the health system has been very beneficial for health centre. It helped the health centre to improve the statistics on the utilization of services especially referring to antenatal visits and delivery. This amelioration was clearly expressed by the health workers.

Because of spreading health information that traditional midwives do in the community with expectant women, some started to frequent the health centre. But in most of the cases, pregnant women decided to use the health centre as a last resort; they start to come only when their illness becomes complicated. One day, Wissa, a traditional midwife, brought a pregnant woman to the health centre. She was pregnant in her seventh month. Wissa told that she encouraged her several times to come at the health centre but the woman was reluctant. She had refused because she said that she was ashamed in front of health workers. When she started to notice some complications about her health state, she finally decided to come accompanied by Wissa. According to Wissa, the two previous pregnancies of the woman were miscarriage cases. She adds that the woman had a congenital illness that provoked the two miscarriages. This preliminary information may have helped the medical doctor to know more about the past of that woman. In addition to sending women, traditional midwives can also provide information to the health workers of the past of women. Their position in the community enables them to get such information since they live in the same community with women and even sometimes provide with some traditional remedies.

Tatta and the five others know how to detect a danger to a pregnant woman and when to refer her to the health centre. But other traditional midwives in the community who do not possess this new knowledge delay referral to the health centre. According to local health workers most of the women in labour sent by these untrained traditional midwives had severe obstetrical complications. One day, a woman brought a young labouring woman at the health centre. She was 16 years old and a first-time-mother as well. The parents of the young woman decided to resort to the health centre when they found themselves incapable to deal with the case. They lived in a camp about 10kms from the health centre. Due to the length of the labour, the young woman got an eclampsia attack. She gave birth at the health centre but it was a stillborn case. After the delivery, she stayed two days unconscious in the health centre. From the onset of her pregnancy till her referral, her parents said she had not had any contact with a health worker. During my fieldwork, health workers attended another case similar to the above example where the parents of the labouring woman hesitated to refer her to the health centre. She also gave

birth at the health centre but, her baby born with respiratory problem and died some hours following the delivery. That was also due to the long term of labour according to health workers. In general, the cases sent by untrained traditional midwives are as the technician nurse called it, a '*catastrophic delivery*'. He refers to this term to qualify the deliveries occurred at the health centre where the lives of mothers and the newborns are at risk.

The work of traditional midwives also helped the health centre to improve their statistics on delivery. In Adjehoc, the deliveries performed by Tatta and the five others are systematically recorded in the health workers' report as '*assisted delivery*'. They used this term to qualify the delivery performed in health centre or at home by specialized or professional personnel. For instance, in their semester's report from January to June, they recorded 15<sup>26</sup> '*assisted deliveries*'. Among them, nine were performed by traditional midwives. According to Modibo (Technician Nurse), before the collaboration with traditional midwives, their statistics on delivery were seriously weak; except for some complicated referred cases they did not record many deliveries in the locality.

## **5.6 - Traditional midwives collaborating with DDRK**

DDRK works with traditional midwives in Adjehoc and replaces Médecin du Monde. Between the withdrawal of Médecin du Monde (2009) and the starting up of DDRK's activities (2010), traditional midwives had a time of a lack of support. And during this in-between period, they stayed uninformed about their situation. The moment DDRK was supposed to start, 2009 right after the withdrawal of Médecin du Monde, its activities were delayed. The meeting of DDRK with traditional midwives, as I referred to in methodological chapter which guided me about the choice of Tatta, was their first contact with traditional midwives. During that meeting, they discussed the new approach of DDRK, explaining that traditional midwives should try to get more pregnant women to come to the health centre both for antenatal visits and for childbirth itself. The training session I refer to in this thesis as well was the first activity of DDRK with them in

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<sup>26</sup> This statistic on delivery did not reflect at all the number of deliveries occurred in the health area. Many deliveries occurred in the locality are not recorded. I even noticed that when I accompanied health workers during some of their ambulatory healthcare (advanced strategy) in different localities of the commune, we noticed many newborns. In Ag Erless's (2010) work he argues that the births' rate is highest in Kidal Region compared to what has been said in official reports in Mali.

Adjelhoc. As a motivation to encourage them doing the work of middleman DDRK initiated the aforementioned bonus.

During my research period, one of the first six traditional midwives working with DDRK, an Arab woman, dropped out. She was the only Arab woman within the group. Wada told me her husband stopped her from doing such work. This woman had been replaced by a well-known traditional midwife from community. Ethnographically, this situation is interesting. It enables us to know more about the work of these traditional midwives and shows that the renewed traditional midwife's position challenges the established gender role in the community. It tells us that the work is discussed (and approved) within a couple. It also stresses that the work of DDRK with traditional midwives challenges the established relationship in traditional midwifery field by maintaining this new category of traditional midwives in the community. We can argue that other untrained traditional midwives might be looking forward to getting such an opportunity (money and equipment) that DDRK provide in the community.

In the field, traditional midwives interacted many times with health workers rather than DDRK's personnel. They reported their activities to the health centre with the medical doctor who represented DDRK in Adjelhoc. He was the person in charge of collecting information on the work of traditional midwives. In case of a shortage of equipment or any other practical information about traditional midwives' quotidian activities, El Moctar dealt with it.

Traditional midwives accepted to play this new role of middleman between the community and the health centre, but they were disappointed not only by the attitude of some women but also because the money proposed by DDRK was judged insufficient for them. Tatta said that *"the problem is not with women because they will come to the health centre when their illness will oblige them, but the money is not enough for what DDRK asks us to do"*. This dissatisfaction about the payment was an important issue for them. The argument from DDRK's workers was that the money should be enough since they had taken care of women in the community for free before any NGO came. In

addition to that, DDRK's workers talked about their concern over the budget they had for supporting health centre and traditional midwives.

The equipment and money provided by DDRK alters the role of traditional midwives in this community which constituted of offering help to a friend and relative receiving blessings for the service. Working with DDRK changed their status but also increased their expectation of improving their condition in the community. They have been receiving equipment and money for a year. This situation has made them people doing formal work in the community. So, how would they become after the withdrawal of DDRK? Traditional midwives are also concerned about that situation. Tatta feels uncertain about the future of her work and told me that her expectation is to have her own centre where she can practice her work. Since she has a good reputation, she believes that the new centre she expects, would improve her condition and her work.

### **5.7 - Tatta's attitude towards the community**

Should we talk about a bad attitude towards the community or a transformation taking place in traditional midwifery's field in Adjelhoc? Tatta had a good reputation as a traditional midwife in her community. And during my fieldwork, she was still the most requested for birth attendance in Adjelhoc. She attended four deliveries from April to June. From Médecin du Monde to DDRK, something changed in Tatta's role as traditional midwife in her community. Working with Médecin du Monde, Tatta was not asked to go to women to campaign about going to the health centre. But collaborating with DDRK, she and the five others have been assigned this new role. DDRK wanted them to make more women interested in using obstetric services available at the health centre. Performing that new role, Tatta encountered women's reluctance, an attitude that it is not necessary to resort to the health centre when there are no complications. Tatta complained about women's attitudes saying that "*some people in this village are primitive*". She uses '*primitive*' to say that some women are not capable of understanding anything. She showed that attitude to me, at first being reluctant with me because she did not want me to follow her around in the village. Then, when I asked her about going to visit some pregnant women she was looking after, she was also hesitant. I experienced

with Tatta in her community what Goffman (1967: 15) calls “*the avoidance process*” when he argues that “*the surest way for a person to prevent threats to his face is to avoid contacts in which these threats are likely occur.*” Tatta’s respectability became under threat. She didn’t want to lose her ‘*face*’ (Goffman 1967) in any social situation.

Tatta may see things differently than some people in her community. But the fact that that she qualified some people as ‘*primitive*’ supposes an interaction between her and these people. And this ‘*primitive*’ attitude should occur in several social interactions so she could identify it as regularities to these people. My analysis about that is she might not have to endure some attitude from some people if she avoided the work that DDRK assigned her. In order to receive the bonus, the traditional midwife should succeed doing her work. When referring to this new role of traditional midwives, Wada argues (during a discussion with some traditional midwives) that “*campaign to them [women]... you have a lot to do because it’s not as easy as people say. They simplify things when really it’s very difficult to deal with*”.

One day I went with my video camera with Tatta to visit a family where there were two pregnant women. Tatta was looking after these two young expectant mothers. Being in the house, an old woman forbade me from filming. She did not allow the presence of camera because she said they were not wearing their nice clothes. That situation disappointed Tatta and said afterwards that “*the people we have just visited are primitive, they don’t know anything. That is why there are some people I don’t want to come to. I cannot bear their attitude.*” Some weeks later, one of the two pregnant women gave birth with Tatta in attendance. The day after she reported me what happened and added that “*I am doing my work for God’s blessing if not so, these people don’t know anything*”. That situation could be also be understood as the influence of the presence of the video camera on the ongoing situation, but Tatta did not feel respected because she offers help to women without asking to be paid. Since she does not ask for payment, she expects to receive respect from the community when it comes to her work. Tatta’s claim of respectability is also that the people should listen to her when she talks about going to health centre for preventive health services. She tried several times convincing pregnant women but they did not feel it necessary to go without being forced by illness. In Tatta’s

opinion, even men did not do anything to help her convince their spouse to go to health centre. Due to the (neglecting) attitude of some people towards her attempt of bringing women closer to the health centre she said *“they don’t realize they are hurting themselves.”*

During a discussion between some traditional midwives, Wissa, Tatta, and Ichainasse, and Wada at the health centre when they went to pick their delivery kit, they exchanged their experience of convincing pregnant women to go to the health centre.

Wada: *“If I understood right, the woman you accompanied at the health centre she didn’t want to come by herself...”*

Wissa: *“Yes. I met her some days ago and she explained to me her pain but she didn’t want to come to the health centre.”*

Ichainasse: *“They don’t know that they are hurting themselves rather than health workers, or anybody else either ... There is one of our daughters who is due soon; I have said everything to her about the health centre but she still refuses.”*

Wissa: *“Me either, I am not able to convince them.”*

Ichainasse: *“The one I told, even yesterday, I told her to not delay coming to the health centre. She said to Inagfa that she was ashamed to come to health workers.”*

Tatta: *“I swear..., you should follow my example. I gave a ticket [referral ticket] to a woman, and then said to her, let’s go now straight to the health centre. If not, nobody will come.”*

Wada: *“let them, one day, they will come...”*

Ichainasse: *“this is my idea, too. The one I am talking about, she is a first-time-mother. She said that her back hurt. I told her that is the illness they treat at the health centre. She refuses to listen to me. What can I do then about her? In her opinion, this is a way to be brave.”*

## 5.8 Findings on different social fields

In Adjelhoc, there was a distance between actors. They could meet sometimes but everybody was in his 'world'. They scarcely interacted together within a specific domain. To me, where more interaction should be seen should be between health workers and traditional midwives, but this distance was evident. Neither health workers nor DDRK's personnel had seen traditional midwives doing their work in Adjelhoc. But they knew that traditional midwives were skilful persons to offer help to women, or living in the same community with women but in a practical way they do not know how traditional midwives helped at delivery; how traditional midwives interacted with pregnant women in the community; or what kind of relationship existed between traditional midwives and the persons receiving their help. For instance, my footage on the delivery with Tatta was the first time for health and DDRK workers seeing one of these women helping at birth.

Collaborating with traditional midwives we notice that DDRK values their position but not their knowledge. DDRK told traditional midwives that they can attend birth themselves but their main task should be now to send more pregnant women to the health centre. That means that their knowledge in birth attendance should be replaced by the knowledge of professional health workers attending to pregnancy and delivery.

In the field, I noticed a kind of mistrust between traditional midwives and health workers when it came to reporting the information of their activities. At a meeting, Tatta reported that she attended four deliveries; some people from health centre were sceptical about that number. Tatta insisted on her information while providing details on the people who received help from her in labour, their names, and which families they were from. That same attitude occurred again when Tatta talked about some pregnant women she sent to the health centre for follow-up. A health worker said "*we have not seen here at the health centre any women you have sent*". Tatta replied saying that "*of course they came here I even accompanied some of them here.*" At that moment they had not started using the referral ticket with traditional midwives. Sometimes, health workers said that traditional midwives reported false information on their work in order to get more money like the bonus.



In addition to the skills and the reputation, the age criterion was also important choosing traditional midwives in Adjelhoc. The advanced age that was seen as an asset became a problem training traditional midwives. Mohamadine, the trainer, confirmed that because of their age, they forgot what they had learned previously. The performance of these traditional midwives at the training shows that it is challenging DDRK to succeed in their training activity. It takes time for an old person to learn new things.

## CHAPTER VI: CONCLUSION

The main concern of this work has been the practice of traditional midwifery in Adjelhoc. Through it, I explored a practice in transition. This work did not have the ambition of showing the concrete knowledge level of these traditional midwives. However, it intended to show some of the transformation taking place in different social fields dealing with pregnancy and delivery in this Tuareg community in the east-northern Mali. Adjelhoc like many other localities in Kidal region is in transition between tradition and modernity, that is, nomadism and sedentary life. This transitional aspect is described in this thesis in relation to the health centre which is seen as new way attending to pregnancy and birth giving. This example also shows something in general about the relation between the *'outside world'* and the rural communities.

In the field, Tatta was my main informant. I was observing her in her daily life with a video camera as main tool to record social realities where she and other persons in Adjelhoc were involved. As a man working with Tatta I was limited to doing field research with her due to her concern of the social rules in this Tuareg community concerning the relation between a foreign man and a married woman.

In Adjelhoc, pregnancy and delivery is family's affair or *'women's world'*. Expectant mothers throughout their pregnancy and labour prefer to get help from the traditional midwives they knew. These traditional midwives have a reputation based on their skills, their relation to the expectant mother or her family, and the cultural values of the intimacy of women's body. This stands in contrast to the professional health workers. At the health centre, they might use some techniques that the pregnant women dislike such as undressing, or lying down on a table, etc. and they might also be asked to pay. In addition, in the health centre all the relevant needed relatives (see in the film "*Tatta, a Tuareg Traditional Midwife*") are not welcome to provide social security, that is, comfort, to the labouring woman she might need.

In order to bridge the gap between the community and the health centre, some traditional midwives have been chosen by DDRK along with the community. This knowledge of

helping women in labour was shared knowledge among Tuareg women (of a certain age and with a certain experience) has become altered; a new category of traditional midwives has been created. They have gone through different training sessions and are getting support such as monetary payment and modern equipment from DDRK. In their collaboration with DDRK, they have been assigned to play the role of middleman between the community and health workers by encouraging pregnant women to resort to health centre both for antenatal visits and deliveries.

The equipment traditional midwives got from DDRK enabled them to improve their work attending births and giving better care to mothers and newborn. People, especially pregnant women are getting improved services in their home with their help. In the film we see Tatta in the delivery tent saying that “*we don't bathe the newborn anymore straight after the delivery*” or “*you should fasten the umbilical cord with a thread before cutting it*”; Tatta's knowledge astonished some women sitting around her since they had not seen these techniques before. This new knowledge of practicing midwifery has a transformation taking place in Tata's work in the community. That can be understood as a transformation pattern in the community because women are receiving new techniques that belong to hospital settings from the traditional midwives in the house. Other example of transformation taking place in the community is the fact a man was accepted to attend the delivery with a video camera. Some days following the delivery, Daha told me that “*if she was a lady who had not travelled, she will not allow you to film her giving birth*”. The fact of being in touch with outside ‘*world*’ like Zahara, the woman who gave birth, who has lived in Bamako, the capital of Mali with her husband contributes to this transformation. Ethnographically this example can also show the importance of trust relationship in a transformation pattern. They accepted me because Zahara has been exposed to outside *world* but also they trusted in me.

The collaboration with these traditional midwives is beneficial for the health centre. Before their integration into the local health system, the statistics on antenatal visits and deliveries were extremely low, according to the chief of medical staff. Through the work of traditional midwives in spreading health service information in the community, the awareness of local women has increased when it comes to the services that are available

at the health centre. However, Tatta, like the other traditional midwives was a respectable woman providing services in her community in birth attendance and traditional remedies and saw her status under threat when trying to succeed bringing expectant mothers closer to the health centre. Traditional midwives find themselves in an in-between position and uncertain with their future in the community. Pregnant women, in most of cases, do not feel the necessity to come to the health centre unless being forced to by illness. Due to the refusal of local women of Tatta's encouragement of going to health centre, especially at an earlier stage, she qualified them as being '*difficult*' or '*primitive*'.

Traditional midwives' work, though, beneficial for different fields, is in an in-between situation. They now find themselves in a position where they need to be trusted by DDRK and women in the local community. What will happen to Tatta's relation in the community if she forces pregnant women to go to the health centre? And what will happen when DDRK withdraws in the community? The future of Tatta and the five other traditional midwives is uncertain.

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