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Social Determinants of Mixed Relations between Midwives and Pregnant Women in the Health District of Abobo-East Abidjan, Côte d'Ivoire

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Abstract: ***Pregnancy in our society is an important event that deserves special attention in each country. However, it seems that in the practical realization of pregnancy monitoring there are great differences. The health situation in Côte d'Ivoire specifically that of pregnant women, remains critical despite the efforts made by the government. Health programmes have long focused on epidemiological and demographic factors rather than on the social and institutional dimension, which may better make explicit some of the beliefs and value judgements made about pregnancy and midwifery. Such a situation may negatively influence the achievement of the third point of the Sustainable Development Goal, which envisages "to reduce the global maternal mortality ratio to below 70 per 100,000 live births by 2030". Since the medical causes of maternal fetal deaths are preventable, it is important to understand the social determinants related to the mixed relationship between midwives and gestational carriers. This work focuses on the interactions between two categories of actors, namely midwives and pregnant women. A mixed type study (quantitative, qualitative) was conducted from June 2015 to February 2016 in the Abobo-East Health District. A total of 318 pregnant women were surveyed and 22 midwives were interviewed. The findings showed that the relationship between midwives and gestants is the result of insufficient mutual communication between both actors in the fight against maternal and infant mortality, insufficient availability of health facilities and the strengthening of human resources, as well as the quality of maternal and neonatal health services and cultural constraints. All these factors constitute an obstacle to the proper functioning of the health-care system and contribute to the low utilization of maternal health services and the persistence of maternal mortality. This study is intended to be an important lever for the sustainability of an action and Behaviour Change Communication (BCC) strategy in health establishments, targeting midwives and pregnant women, in order to contribute to the fight against maternal and neonatal deaths in maternity services in Côte d'Ivoire.***

Keywords: Determinants, mixed relationships, midwives, gestants, Côte d'Ivoire

1. Introduction

"No woman should die giving life" is the slogan launched during the 4th Session of the Conference of African Ministers of Health held in May 2009 in Addis Ababa, Ethiopia on the theme: "Africa cares" to prevent or safeguard all the factors that may cause a woman to die while giving birth. Indeed, maternal mortality is a growing concern worldwide. About 830 women die every day from complications related to pregnancy or childbirth (WHO, 2019). It is therefore important to double efforts to improve maternal health in the countries of the South, particularly in sub-Saharan Africa. Achieving a progressive reduction of maternal mortality is one of the Sustainable Development Goals which envisages "by 2030 to reduce the global maternal mortality rate to below 70 per 100,000 live births" (WHO, 2019).

The 2011-2012 Multiple Indicator Demographic and Health Survey (EDS-MICS) in Côte d'Ivoire puts the mortality rate at 614 maternal deaths per 100,000 live births. According to the latest information, this rate has increased by 617 per 100,000 live births according to the latest WHO report published in 2019. As a palliative measure, against this "tragedy" since 2016, a national policy document on improving the quality of health care and health services had been developed by the Ministry of Health and Public Hygiene to set new directions to improve the health system in Côte d'Ivoire. In 2017, the National Strategic Plan for the Improvement of Quality, Hygiene and Safety was adopted. It highlighted the general framework for quality development in the health sector. In 2019, the government reopened certain general hospitals, namely the Abobo Nord's, which was closed in 2017 for rehabilitation. All these government actions aim to improve the quality of care in the health services, particularly mother and child health.

In the face of all these actions, the contribution of certain disciplines, particularly socio-anthropology, is necessary to understand the social determinants of the mixed relationship between midwives and pregnant women. Thus, within the framework of this research we aim to answer this question: "what are the social determinants that favour or deteriorate the midwife-pregnant relationship in the Abobo-Est Health District in Côte d'Ivoire? In other words, this concern is related to the following three questions: what are the institutional factors that influence the quality of care in maternal health services? What are the behaviours of the actors, particularly midwives and gestants, who are at the origin of critical relationships? What are the socio-cultural practices of pregnant women that call into question the medical knowledge of midwives in maternal health services? The understanding of these various questions made it possible to describe the institutional determinants in terms of quality of care in the various establishments, then to define the behaviours that explain the inadequacies resulting from midwifery and pregnancy relationships, and finally to identify the socio-cultural practices that lead to complex relationships between midwives and gestants in the Abobo-East Health District.

2. Method

Study site

This study was conducted in three health facilities in the municipality of Abobo (Figure 1): the General Hospital of

Abobo north, the only reference centre of the said District; of the Community-Based Urban Health facility of Avocatier (FSU COM of Avocatier), called Henriette Konan Bédié health facility, and the education training health facility of Aboboté (CES of Aboboté), a private health facility. The municipality of Abobo has two large Districts named Sanitary District of Abobo-West and that of Abobo-East. The health district of Abobo-East remains the largest with nine health areas and a significant number of maternal deaths reported over three consecutive years during our visit.

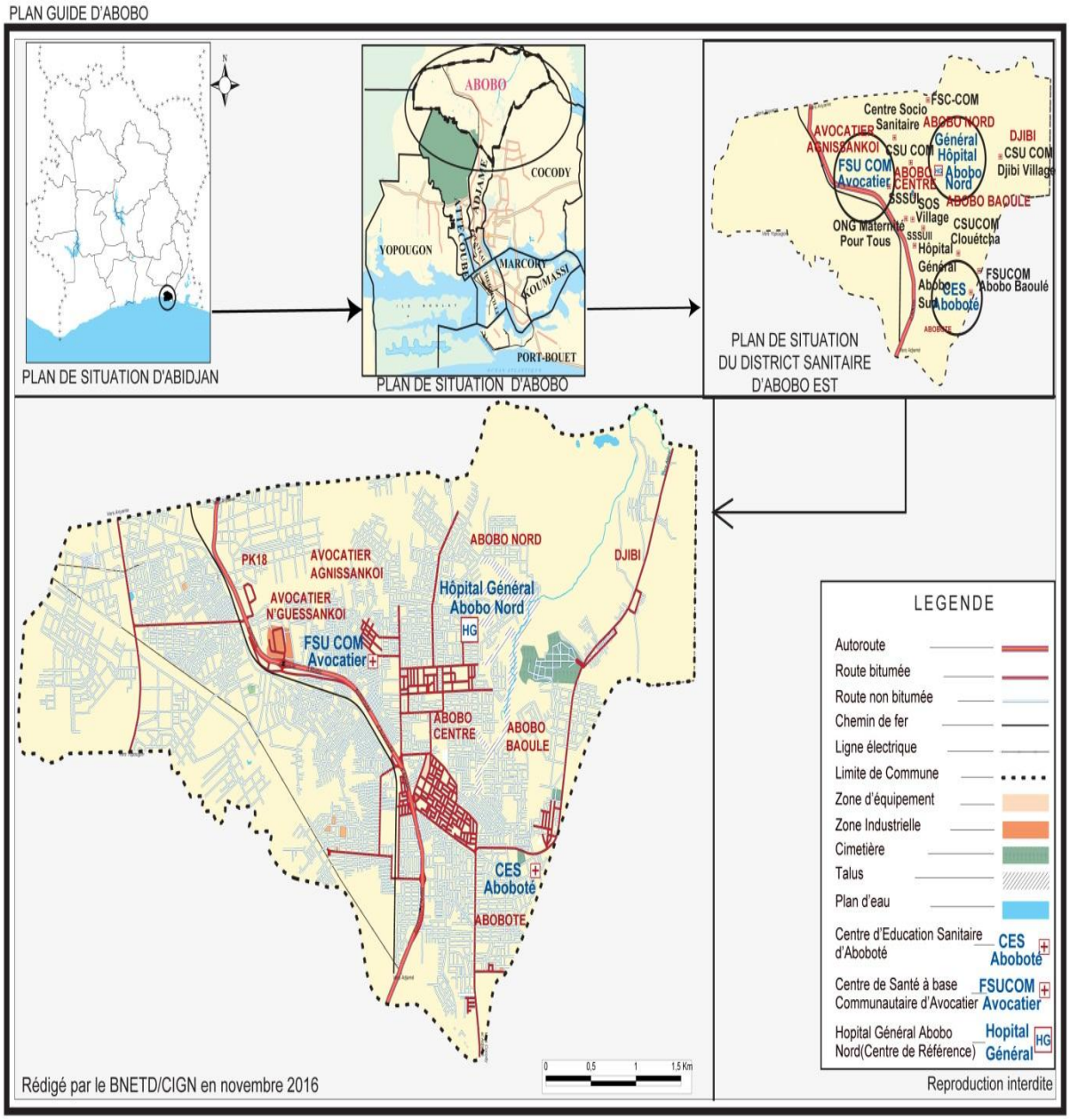

Figure 1: Health District of the municipality of Abobo with the study area, Abidjan, Côte d'Ivoire

Study procedures and sampling

This study is based on a qualitative and quantitative approach. Pregnant and midwives are the main categories of actors in our surveys. The secondary targets are: pregnant patients, referrals, hospital directors, etc. The investigation techniques are: semi-structured interview (an interview guide submitted to midwives, pregnant and sick pregnant women, Hospital directors etc.), a questionnaire administered to pregnant women and direct observation.

The construction of the sample was carried out according to the following criteria: any woman who came for prenatal consultation and who had one or more deliveries. The criteria were limited to this category of women because they had already experienced the delivery room and the aftermath. This individual survey was constructed from quota sampling and accidentally sampled using a questionnaire with 318 pregnant women (Table I). It is a reduced model of the mother population (Loubet Del Bayle 1991) that Irigo 2012 cites. It was also constructed from the characteristics of the basic population which includes all social categories (age, level of education, etc.). In addition, the reasoned choice method was used for the categories of actors such as directors of structures, Supervisors of care units, referred women, etc (Table III).

Table I: Quantitative sample of target primary

Sanitary facilities	Number pregnant investigated
General Hospital of Abobo North	155
FSU COM of Avocatier	88
Health Education Center of Aboboté	75
Total	318

Source : Field data 2015

Table II: Qualitative sample of primary targets (Midwife)

Sanitary facilities	Number of interviews with midwives
General Hospital of Abobo North	12
FSU COM of Avocatier	06
Health Education Center of Aboboté	04
Total	22

Source : Field data 2015

Table III: Distribution of secondary targets interviewed

Intermediate targets interviewed	General Hospital of Abobo North	FSU COM of Avocatier	Health Education Center of Aboboté	Total by category
Structure Director	01	00	01	02
Care Unit Supervisor	01	00	00	01
Chairman of the Board of Directors	00	01	00	01
Gynecologists	01	01	01	03
Accompanying	10	05	00	15
Women giving birth	10	10	00	20
Women referred	10	00	00	10
Total	33	17	02	52

Source: Field data 2015

Data processing and analysis

Processing and analysis of qualitative data was done by the combination of structural descriptive approaches and the analysis of the content of the speeches of the different actors in order to have more recent and in-depth information. The data were coded and transferred to the MAXQDA software, version 12. Analysis of quantitative data is based on the questionnaire. The database was entered and built up using the Epi info software. This database was subjected to further analysis to compare the demographic variables of pregnant women with other variables of interest in order to identify mixed relationships between midwives and pregnant women.

3. Results

"Mixed relationships" are unfavourable relationships that are observed between actors including midwives and pregnant women in health care services. More importantly, they highlight the difficulties that these actors face in health services. For this study, mixed relationships can be observed around three main approaches. The first approach relates to the institutional determinants that reduce or make attractive the attendance of health structures. The second approach highlights the behaviours that explain the disputes between midwives and pregnant women in maternal health services. Finally, the third approach reports on the socio-cultural determinants that influence the midwife and pregnant relationship.

Institutional determinants of mixed relationships

- **Perceptions of midwifery as perceived by pregnant women**

The majority (80%) of pregnant women surveyed in the three health facilities gave credibility to the training received by the midwives. According to the respondents from the three health facilities, midwives are competent in the sense that 70% of pregnant women say they are satisfied with the medical follow-up offered during their stay in the prenatal consultation and maternity services. Moreover, the majority (83.3%) chose the midwife and then (55.6%) expressed their confidence in her. It emerges from this section that the quality of care appreciated by pregnant women depends on the cognitive training received by the midwife. However, this training appreciated by pregnant women does not seem to be enough to meet the quality of care according to some respondents.

- **The contrast between the human and professional quality of midwives**

The modalities relating to human quality through the item "nice" were listed at length by all categories of respondents. According to them, the reception is acceptable when the midwife is more emotional or even if she is "kind" regardless of her shortcomings in professional practice. The human quality of the midwife is more appreciated than the professional quality.

- **Constraints on waiting time**

According to the comments collected from referred and sick pregnant women, the delay in care is one of the reasons for the dissatisfaction of pregnant women in the different health structures. Waiting for prenatal consultations is considered too long. A respondent from the reference centre told us the following: "*Here, you come at 5 o'clock in morning, you go back at 2 o'clock in the afternoon*". However, at the Health Education Centre of Abobo-Est the duration of prenatal consultations is explained by the insufficient number of midwives. Indeed, this centre had only one midwife assigned by the State and two other temporary workers who came to give private prenatal care during our investigations.

- **Perception of work demands**

The midwives surveyed emphasised that in order to provide quality and adequate care to their clients, they adopt professional behaviour, i.e. give medical instructions for good prenatal care. However, these professional behaviours are not all accepted by pregnant women. Indeed, 15% of the pregnant women questioned the professional practice of midwives. The words of a major midwife are an illustration of this: "*You know, madam, I asked my client for an ultrasound scan because I suspected a malformation. The lady answered me in these terms" "Humm midwife now*"" " (Interview midwife major 15 09 2015). In addition, during the study period, about ten respondents reported giving birth at home. For good reason, they mentioned fear of certain practices such as episiotomies (sectioning of the perineum) and other efforts such as the walks that midwives recommend to pregnant women. All these professional requirements would constitute a real obstacle in the medical care of pregnant women.

- **Perception of free care for pregnant women and the cost of services**

Inadequate full recovery of care is not excluded in the mixed relationships. Ninety per cent of all respondents raised the question of the cost of services in public institutions. The justification for complaints related to the cost of services lies in the inadequacy of total recovery according to the interviews conducted. By way of illustration, according to the interviews conducted with sick pregnant women, apart from malaria and HIV-AIDS, other pathologies related to pregnancy are not targeted by free health care. Moreover, it appears that biological examinations and ultrasounds were expensive for them. According to these respondents, the cost of initial blood tests varies between 25,000 and 30,000 CFA francs. The cost of ultrasounds amounts to 6,000 CFA francs in public institutions and 10,000 CFA francs in private institutions. In addition, the cost of prenatal consultations varies from 200 CFA (Albumin test at Abobo Nord General Hospital) to 500F CFA (Avocatier Community-based Health Training). In private establishments, according to the interviews carried out, the cost of consultations varies from 1000 CFA (consultation with midwives) to 3000F CFA (consultation with a gynaecologist).

Mixed relationship behaviours

Defection of the reception in relation to the level of education

Non-educated population at the North Abobo General Hospital has the highest rate (48.8%) of drop-outs from reception. However, in Avocatier, pregnant women with primary level were the most numerous to denounce the quality of reception, with rates of (57.1% and 47.4) respectively (Table IV).

Table IV: Hospitality attrition rates by education level

Level of education	General Hospital of Abobo North n =23		FSU COM of Avocatier n= 19		Health Education Center of Aboboté n= 07	
Non-educated	11	48,8	06	31,6	01	14,3
Primary	04	17,4	09	47,4	04	57,1
Secondary	02	8,7	04	21	02	28,6
Superior	06	26,1	00	00	00	00
Total	23	100	19	100	07	100

Source: Field data 2015

The defection of the reception in connection with parity

Pauci pares and multipares have similar proportions and the highest (34.8%) in terms of attrition at the North Abobo General Hospital. At the Avocatier Community-Based Urban Health Training Center, primiparous women had the highest rate (47.4%) of dissatisfaction with the reception. The same applies to the primiparas at the Aboboté Health Education Centre (57.1%). (See table below). This defection from reception by category of actor reflects the experience that pregnant women have already had in maternity wards.

Table V: Hospitality attrition rate by parity rank

Parity rank / Names of structures	Primiparae		Pauci pares		Multiparous		Large multiparous		Total	
	n	%	n	%	n	%	n	%	n	%
General Hospital of Abobo North	03	13	08	34,8	08	34,8	04	17,4	23	100
FSU COM of Avocatier	09	47,4	05	26,3	05	26,3	00	00	19	100
Health Education Center of Aboboté	04	57,1	03	42,9	00	00	00	00	07	100

Source : Field data 2015

Perception of pregnant women related to the mode of communication

According to the questionnaire survey, 90% of the reasons for leaving the reception area result in a communication deficit. In this regard, we note that 34.8% of multiparous women at the North Abobo General Hospital mentioned verbal violence through shouting and insults proliferated by the midwives. In response to this statement, the midwives questioned at the reference centre indicated that *"midwives raise their voices to get the parturient to expel the foetus without wasting enough time"*. However, this attitude is interpreted differently by the parturient because of the pain she feels, according to one of the midwives. According to the testimony of a Malinké respondent *"the tanties there often when you are in pain like this, you can't even walk they ask you to walk"* Another adds: *"Often you don't even have the strength to push; they shout at you: "You have to push! You have to push!" While you don't have strength anymore*" Interview Malinke woman 12 /09/ 2015. "Violence" in midwife-parturient communication is frequent in all public health establishments in the Abobo-Est Health District according to the information gathered.

Socio-cultural determinants related to the mixed relationship

This approach depends on the social trajectory of the gestates. It reflects the socio-cultural discourse of pregnant women vis-à-vis maternity services. These discourses, at times, influence the attendance of health facilities. The results below allow a better appreciation of this reality.

The traditional therapeutic course for pregnant women

Most pregnant women surveyed (85%) said they used both modern and traditional medicine. According to some of them, traditional medicines are very effective. These include leaves, bark or roots of plants, kaolinite, among others. These medicines are said to have two functions, one preventive and the other curative. As a preventive measure, according to the words of a pregnant Malinke woman from Abobo Avocatier, *"In our house, a pregnant woman should not stay out late at night if she stays, she can take out a ghost child. For this she can go to a traditional practitioner to give her a medicine to prevent this if she practices*

activities that lead her to stay out late" (Interview Malinke woman 08 /10/ 2015).

The words of this Akan woman from the reference centre on the curative functions of traditional medicines in these terms: *"When I am pregnant, it is malaria that tires me a lot. Twice it kills my children in childbirth when I asked why my children die, the midwife told me that malaria is too much in my body, so now it's an old Abbey who follows me. Since she has been following me since my fifth pregnancy, I have two children at home*" justifies this reality. (Interview Malinke woman 30/ 10/ 2015).

Food bans in relation to reproductive health

All the pregnant women surveyed claimed to have food bans during pregnancy. However, these bans vary from one community to another. For the Malinke, most of their bans are of animal origin. In the sense that it was repeatedly pointed out by our interlocutors that the consumption of red meat, especially beef, monkeys and the like, leads to poor health of the child and violates certain pre-established rules in the community. On the other hand, in the Akan community, especially among the Baoule, the most evoked prohibitions are related to species of fish origin. Excessive consumption of catfish fish during pregnancy causes respiratory difficulties in the child. Compliance with all these food bans during pregnancy plays a protective role for the pregnant woman and her foetus. The variation from one food ban to another by analysis depends on the cultural habits of the community in which the pregnant woman is living.

4. Discussion

The main points that were discussed are addressed through three approaches: the institutional approach, the socio-demographic approach and the socio-cultural approach. The empirical and critical justification that we are addressing for the concept of "mixed relationship" can be explained in summary through the points discussed below. The terms relating to the institutional approach are availability, accessibility and quality of services. At the level of this study, the results are discussed around the quality of services and financial accessibility.

The unfavourable relations between midwives and pregnant women were observed around the quality of services. They are subject to representations of reception in these health facilities. The study carried out by Kouadio and al (2014) echoes ours. The results of their study on the problem of abandonment of antenatal consultations highlighted the long waiting times during antenatal consultations in public health facilities. The length of consultations leads pregnant women not to use health facilities on a regular basis. Also, Amadou (2013), shares the same opinion as previous authors. He mentionned in his study that some pregnant women felt that the reception is good, however, others thought that it should be improved. The poor reception is linked to shortcomings in communication (physical and verbal violence) and delays in care (length of prenatal consultations). According to this author, poor reception was therefore a factor in the low use of health facilities.

Financial accessibility, which is reflected in the cost of examinations and ultrasounds, sometimes makes the relationship between midwives and gestational carriers complex. In this sense, some pregnant women did not pay attention to the examinations recommended by midwives. A conflict arose between midwives and pregnant women when these examinations and ultrasounds were not honoured by the first. The work of M'bea, (2004), at the Abobo General Hospital in 2002 that Kouadio(2013) quotes, on the profile of the pregnant women at the first prenatal consultation corroborated the previous results. For M'bea, the main obstacle to carrying out medical activities was the lack of financial means. This result was in line with that of Kouadio and al (2014), which emphasized that pregnant women effectively linked the late prenatal consultation to the spouse's travel and lack of financial means. Financial accessibility had a close impact on health facility attendance. Consultations that were previously scheduled from the first trimester onwards are delayed due to lack of financial means. Mafuta, (2011) in a study also testified to the fact that the late antenatal consultation is justified for most respondents by financial difficulties in that the activities of pregnant women did not allow them to take charge of their antenatal care. This situation then reflects the difficult relationship between midwives and pregnant women because, by referring to the standards of modern obstetrics to which midwives belong, it is difficult to accept these late prenatal consultations in view of the risks associated with pregnancy.

A clear cleavage between midwives and gestational carriers is presented. The exemption policy that could improve the system of care makes any application confusing. Indeed, blood tests and ultrasounds were half covered by the recovery of care. Given the vital interest of these examinations in the prenatal follow-up of pregnancy, there were conflicting relationships between midwives and pregnant women in that midwives demand the results for better care of the pregnancy. Free care seemed here to weaken the health care system rather than improve it. This result was like that of Magali and bouchon (2012) in a study conducted in San Pedro, Côte d'Ivoire. In their study, they pointed out that any conflict or dysfunction in the health establishments was due to poor communication about free care. Other authors such as Olivier De Sardan and Ridde, V (2012) add that direct payment for antenatal care was largely due to a lack of efficiency in the implementation of this policy.

The inadequacy of the institutional approach is one of the social determinants that make midwifery and pregnancy relations difficult. This is why Atchouta and al (2016), link these difficult relations to the inadequacies of health facilities which are noted at the level of inputs in the fight against maternal and neonatal mortality (availability of human resources, skills of human resources, low availability of materials and medicines, absence of memory aids in maternity hospitals).

The socio-demographic aspect is crucial in the search for the determinants of mixed relations between midwives and gestating women. Indeed, the relatively low schooling rate of these women reflects their lack of knowledge of the

norms governing the profession of midwifery and a difficulty of communication between midwives and gestates. The parity rank was dependent on misunderstandings between midwives and pregnant women due to the inexperience of some pregnant women. Women with more experience of motherhood, i.e. multiparous women, deplored the quality of care in public establishments. This situation was explained by the regular attendance of maternity services. Nkurunziza's study (2008) was different from ours. For him, the use of prenatal care decreased with parity. Aboussad and al (2010) concluded that a woman's delivery experience, especially if the first experience was without serious complications, encouraged her to give birth at home. Parity rank remains a determining factor in the use of health care services. In the long term, low education levels and parity of gestational age closely influenced the midwife/pregnant relationship.

The frequent use of traditional medicine was justified by the attachment to the customs and habits of our respondents. To this end, Diop A is better understood. (1988), when he states in his study that there are certain tribal customs such as women drinking an herbal decoction that is believed to help them give birth quickly. Olivier de Sardan (1993) also reported on this situation in a study in Niger. Women used practices that were not accepted in the delivery room by modern medicine. This was the drinking of decoctions used by pregnant women to accelerate labour. In fact, the therapeutic paths of pregnant women cast doubt on some of the professional practices of midwives because many women use therapeutic paths other than modern ones. From this point of view, Akoto and al (2002) have shown that the cultural models conveyed within a group influence considerably. According to these authors, these traditional values still carry considerable weight and women therefore tend to make more marginal use of modern care, even in cases of serious illness. As a result, modern medicine is relegated to the background by the followers of the culture. There is little agreement among health care providers, especially midwives who refer to modern medicine, on the various practices adopted by pregnant women during pregnancy.

Food bans were observed by different ethnic groups. And each ethnic group attaches particular importance to its eating behaviour. Kouadio (2013), in his study showed that Akans were the most likely to attach importance to these bans in that they gave a good result to traditional obstetrics. Koné and al (2018), for their part, point out that the food ban, particularly among the Agnis Akan, contributes to the conservation of biodiversity with repercussions for the cultural well-being of the communities. On the other hand, traditional food bans are established for more spiritual than natural monitoring. Kouadio (op cit), in her study, pointed out that according to the "counsellors", pregnant women who do not observe these food bans could be exposed to complications during childbirth.

In the light of all the above, the mixed relations between the two categories of actors, particularly midwives and pregnant women, are justified by the functioning of the health care system. The intersection of our health care system between modernity and tradition also justifies the hybridism of the different actors in the health care system. In order to make this system as efficient and attractive to pregnant women, it is necessary for the actors to look at the socio-cultural logics on which our health care system depends.

5. Conclusion

The aim of this study was to understand the social determinants related to the mixed relationships between midwives and gestates. The analyses showed that mixed relationships were subjected to complaints about reception, insufficient full recovery, and the hold of cultural values through food bans observed by pregnant women. The conclusion of this study shed light on midwifery and pregnancy relations, which pose a real problem of interpersonal communication in health facilities. To overcome this, an integrated approach to communication strategies in the hospital environment between the two categories of actors, i.e. between midwives and pregnant women, is needed to make these services more attractive. This will thus contribute to the reduction of maternal and neonatal mortality and morbidity.

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