

A maternity clinic in Mali

Bioethics and moral experiences in a zone of awkward engagement

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The article explores how claims about the universal applicability of biomedicine work out in the particular context of a private health care project in a non-western setting. The empirical data are derived from an ethnographic study in and around a maternity clinic that was set up on request of a village population in southwest Mali. From a Dutch midwifery perspective this clinic can be perceived as a zone of awkward engagement for the imagined universality of biomedicine within the local health and gender arena. Biomedically trained midwives working in the clinic perceived the dissemination of information on pregnancy and birth as potentially dangerous and equated 'modern' healthcare with dispensing drugs. The midwives were not autonomous and experienced logistic and existential challenges when referring patients with obstetric complications to a higher echelon of care. Gender relations and a moral discourse of shame inhibited pregnant women's access to healthcare facilities; local perceptions of the power of words impacted the quality of care. Biomedicine was made to fit the local context with its specific moralities. However, the new practice raises the question whether it is ethically justified. Small-scale private healthcare initiatives may do more harm than good in circumstances of extreme poverty, gender inequality and poor infrastructure, and should therefore be implemented with caution.

[maternal and child health, midwifery, globalisation, medical anthropology, ethics, morality, Mali]

Introduction

It was a coincidence that the first author, in the role of midwife and anthropology student, ended up in a maternity clinic in the small village of Faradala¹ in south-western Mali. Her anthropology professor, Jan Jansen, had been doing research on oral tradition and divination in the area for more than ten years (see Jansen 2004, 2007), when the wife of his key informant lost yet another baby during a difficult delivery. The men of the village asked for help to find funding for a maternity clinic. Jansen agreed and secured financial support from two Dutch charitable organizations.² Two women

were chosen by the villagers to go to the capital, Bamako, for a six-month course in midwifery, and the men of the village built the three-room clinic. Jansen asked Holten, an anthropology student at the time and practicing midwife interested in studying pregnancy strategies in a non-western country, to do her anthropological fieldwork in Faradala and start the clinic. Holten agreed, and in January 2007 arrived in Faradala, to equip the clinic, help the midwives and simultaneously start her ethnographic research. In this article Holten's experiences as a midwife and her anthropological field data are used to describe and analyze the process of awkward engagement between standards of western biomedical midwifery and local health and gender discourses and practices.

Biomedicine moves across the globe as "an inextricable mix of things (e.g., medicines, medical devices, machines), techniques (e.g., medical procedures), and bundles of shared understandings and epistemological practices" (Janes & Corbett 2009: 168). It is often portrayed as universally applicable and superior to 'traditional' medicine. Through development projects, such as the setting up of a maternity clinic, biomedicine is able to travel. However, the flow of biomedicine is not without restraint. The people of Faradala were not simply a blank slate waiting to receive the 'truth' of an imagined universally applicable biomedicine. As in many countries in the South, biomedicine has not been successful in setting all the terms in Mali; it is not the only form of healthcare and it does not work smoothly. 'Global' biomedicine interacts with local communities, "where it is transformed and transforms, through being adopted, used and resisted" (Janes & Corbett 2009: 177).

Tsing's concept of 'friction' is useful for understanding how the so-called 'global' is humanly mediated through the translation and negotiation of differences between biomedical and local health and gender discourses and practices (Tsing 2005: xi). Friction is creative, it is a moment of 'productive confusion' when the universal of biomedicine and the particular of Faradala come together and a new medical culture is co-produced. Friction takes place in 'zones of awkward engagement' (Tsing 2005: 4) between 'global health' aspirations and the realization of medical practice in a local context. The clinic in Faradala proved to be such a zone. We first present the setting of the maternity clinic in 2007, the methodology of the anthropological fieldwork in 2007 and 2009, and, finally our findings on the friction in and around the clinic in terms of bioethics and locally grounded moralities.

Setting

Faradala is a small village with less than 400 inhabitants, all of Malinke ethnicity. The village is located in the Mandé Mountains, 120 kilometres from the capital, Bamako. It is geographically isolated since portions of the dirt track leading to the village are washed away in each rainy season. Until ten years ago, there was no doctor within a radius of 50 kilometres.

In the village there were herbalists and experts in sand divination (*somaw*) whom people consulted when ill. Each extended family in Faradala had a *musokòròba*, a post-menopausal woman, specialised in assisting during births and treating sick infants and

children. There were also travelling salesmen who visited the village and sold Western drugs. Two state health clinics were built in 2000, one 20 kilometres from Faradala, in Sandama, where the *piste* (dirt road) to the capital Bamako begins, and the other, 20 kilometres in another direction, in Nioumamakana. Both clinics were staffed by a doctor, a midwife and a pharmacist. But even in the dry season, transportation to both clinics and the nearest hospital in Bamako (120 kilometres away) was a problem, as no inhabitant of Faradala owned a car. Six men did own a small motorcycle, but gasoline was often prohibitively expensive and it takes one hour to drive 20 kilometres because the terrain is so rough. So even though state health facilities were only 20 kilometres away, they were not easily accessible. Another factor that discouraged the use of these health clinics was the cost of a consultation and medicine. The people of Faradala are extremely poor and live on less than a dollar a day. In cases where villagers were financially and physically able to reach a health clinic, they did not always receive adequate care from the ill-equipped and poorly staffed clinics. For example, the staff doctor in each state-supported clinic was not always present, and neither blood transfusions nor caesarean sections were possible in the clinics; the patient had to be transported to Bamako for that.

The people of Faradala felt that the state was unable to reach them in their isolated area and that the state health facilities were inadequate; therefore they wanted an easily accessible small private biomedical health facility in their village.

Method

A participatory action research design with a concurrent triangulation strategy was used in this research study (Creswell 2003). During three months of fieldwork in 2007 and another three months in 2009, Holten obtained reproductive life histories³ of 56 of the 65 women living in the village. Qualitative data from these reproductive life histories, in addition to semi-structured and open interviews and focus group discussions, were collected from ten older women specialised in attending births (*musokòròbaw*), five traditional healers, five midwives and two doctors in the region. This was necessary to understand the complex factors that influenced decision-making in the village. In 2009, 49 respondents (mothers, fathers and mothers-in-law) were interviewed, many for the second time.

Participant observation was an important research tool as only a few villagers spoke the official national language (French) and Holten did not always have a translator for the local language (Bambara). Luckily one of the midwives spoke a little French and Holten managed to learn enough Bambara to be able to do a prenatal examination and take a simple history. If she ran into language problems while working in the clinic, she called a research assistant, who lived in the village, to translate for her. Although the translator was a man, the women spoke freely in front of him (often even more freely than in front of other women) as long as he left while they were being examined. For the interviews and focus group discussions, Holten also had an anthropology student from Bamako translating for her.

During both fieldwork periods Holten lived in the village compound of the large, polygamous, family of a renowned sand divination expert (*soma*). In the maternity clinic, she worked with the midwives performing approximately 100 consultations with sick children, 80 prenatal check-ups and 12 deliveries.⁴

Quantitative and qualitative data derived from the reproductive life histories were coded and analysed with a Categorical Principal Components Analysis in SPSS. A grounded theory approach (Charmaz 1990) was used to identify categories and concepts in the interview data and fieldwork notes. Important themes that emerged were the power of words in Faradala and the importance of *màlòya*: the discourse of shame. The data was approached a second time, in consideration of the Dutch midwifery categories of prevention, risk, monitoring, diagnosis, complications and referral.

Findings

Until 2007, it was rare for a woman in Faradala to seek prenatal care (7%) and even more unusual for babies to be born in a clinic or hospital (3%). Most of the women delivered their babies at home with the help of the *musokòròbaw* and the deliveries went well for the mothers. The respondents could name only one woman who had died during labour. The real problem was child mortality; 40% of all of the respondents' children had died.⁵ By 2009 the majority of pregnant women in Faradala came to the new maternity clinic for at least one prenatal check-up and most women delivered their baby there. This does not imply that the implementation of biomedicine in Faradala went smoothly, as we will demonstrate in our presentation below of the various elements of friction that made the clinic into a zone of awkward engagement.

Perceptions of prenatal care

Healthcare is structured and experienced through medical discourse. Medical discourse gives meaning to illness, determines the role of healers and patients, produces concepts of the normal and abnormal, and generates strategies for prevention, treatment and care. The newly trained midwives and the Dutch midwife introduced a biomedical discourse, endorsing a model of pregnancy as a biological event needing medical attention with an emphasis on prevention. This biomedical discourse differed substantially from the indigenous medical discourse on prenatal care, with which Holten and the midwives had to negotiate, each in their own way. In this section we focus on the differences in perceptions of the scope of prenatal care and the resulting strategies for its use.

Perceptions of reproductive risk and prevention

Most women in Faradala had not been exposed to education or media coverage of biomedical views on pregnancy, and thus were unable to recognize what biomedicine

considers to be an obstetrical complication or to assess its severity. For example, malaria, which is endemic in the region, was perceived as a normal part of life and not as a serious condition causing obstetrical complications such as premature delivery and stillbirth. Villagers were not familiar with the biomedical causal link between prevention and risk reduction.

Risk assessment and prevention, pillars of Dutch midwifery, were not a standard of care in Faradala. A resigning attitude towards pregnancy hampered agency; the pregnant women in Faradala were not always convinced that they could (or should) do anything to improve their pregnancy outcome. If life and death are determined by God, spirits, or sorcery, medical interference in fertility is not always justified or desirable. Brand (2001) calls this attitude the 'default option'. Pregnancy was perceived to be a special time in a woman's life, but not necessarily a time that needed special care. During a reproductive life history interview in 2007, a mother who had delivered eight babies at home with the assistance of the *musokòròbaw* responded "Nothing" when asked what she had done during her pregnancies to have healthy babies. She persisted when Holten probed further.

Holten: "Isn't it necessary to do something different when you are pregnant?"

Mother: "No, nothing."

Holten: "Would you have wanted to have prenatal check-ups?"

Mother: "The idea did not occur to me. That is not the custom here."

Interviews with other women confirmed that before 2007 most women did nothing special when they were pregnant. They had not followed a special diet and in most pregnancies they had not used traditional or modern medicine. The women had not worked less hard or rested more. They had no system of saving money for medicine or for transport to a clinic in times of emergency. In 274 of their 293 pregnancies the women had not sought prenatal healthcare in a 'modern' health facility. Only when they were very ill with malaria, did the women seek (biomedical) help. If they had had an extremely difficult previous birth they sometimes moved to Bamako to deliver in the hospital. The *musokòròbaw* did not perform routine prenatal examinations of the pregnant women. A few women did ask a *musokòròba* to make them a *tafu* – a string over which incantations have been said and then tied around a pregnant woman's hips to protect her from pain and premature labour. Prevention consisted mainly of *not* speaking about pregnancy and birth and not witnessing a birth while pregnant. We will explain the reasons for this behaviour below.

Drug use

The villagers often equated biomedicine with strong effective drugs so the main reason to visit the maternity clinic was not prevention but drugs. If the midwife did not dispense drugs during a prenatal check-up, the care was perceived as ineffective. If drugs were not an option, then visiting a traditional healer in the village could be a more logical choice. If, during a delivery, the midwife did not give an injection, she

was potentially perceived as 'not having done anything'.⁶ This was illustrated by one case when a husband refused to pay the bill for his wife's delivery since no injection had been given. The pregnant or labouring women's demand for drugs made it difficult for the midwives to let nature take its course and not interfere when it was not necessary to interfere.

Biomedical discourse considers drugs as potentially dangerous (especially for pregnant women) and only to be used if necessary (and by prescription). In Faradala it is possible to buy modern drugs without a prescription at a pharmacy or in the market; they are usually not perceived as dangerous and are often not used properly. Most women in Faradala did not realise that modern medicine was potentially dangerous for their unborn children. One exception was chloroquine, an anti-malarial; the women thought that an overdose of chloroquine induced an abortion. The drug was in fact used by them for this purpose.

Monitoring the foetus

One important aspect of biomedical prenatal care is to monitor the growth of the foetus. In the Netherlands midwives do this by comparing the growth of the uterus (in centimetres) to the number of weeks that the woman is pregnant. In Faradala, the women did not use a calendar in their daily life; they did not know the precise date of their last menstruation, and thus could not say with any accuracy how many weeks they had been pregnant. While the midwives used calendar months to follow a pregnancy, in Faradala pregnant women thought a normal gestation was between 9 and 11 lunar months.

Because it was impossible to calculate the gestation by date, Holten taught the midwives to estimate the duration of pregnancy by measuring the uterus using a measuring tape. The midwives found this difficult as they had never used a measuring tape before. Holten tried to make it easier for them by using a visual aid: She drew a pregnant abdomen in each month of pregnancy including the corresponding amount of centimetres on the wall of the clinic. However, this only confused the midwives as the link between the drawing on the wall and the pregnant belly they were examining was not obvious to them. Finally she was successful by repeating, over and over, the number of centimetres that corresponded to the number of (lunar) months of a pregnancy.

In this way a biomedical prenatal care technique was re-interpreted to fit the situation in Faradala. The midwives were socialized in an oral culture, barely literate and unaccustomed to visual aids. Instead of comparing centimetres of growth to a date on a calendar, the midwives used centimetres of growth to estimate the date of the pregnancy. In this way they could estimate when a woman should be referred to a hospital in the capital for cases of a breech presentation, twins or previously difficult birth. The result of this friction between biomedicine and traditional care was not the standard biomedical procedure, but a new biomedical practice born out of negotiation.

Managing obstetric complications

For the Faradala biomedical project to work as it had been intended, midwives should be able to refer pregnant women with (anticipated) complications to the government healthcare system. In the indigenous medical discourse of Faradala, however, severe illnesses were often regarded as disturbances of the social order; they concerned relations with spirits or relations with other people within the community (see also Imperato 1977; Slobin 1991). For example, if the illness was thought to be caused by a *jinn* (an invisible being that can possess people) or betrayal by an enemy, the preferred cure could be a sacrifice, not drugs. If obstructed labour was thought to be caused by a woman's infidelity, then confession rather than transport to a health clinic could be seen as the proper treatment.

In Faradala referral to a clinic during the second or third stage of labour was nearly impossible because of the transport problems mentioned earlier. The only option was for the midwife to ask a man from the village to go by motorcycle to fetch a doctor or midwife from the neighbouring town. To do this the midwives needed to take action. However, action can be problematic. In the Mandé region, change is seen as 'hot and dangerous', delay in taking action and waiting for someone else to take the initiative are deliberate strategies for 'cooling down' society (Jansen 2004: 146). Deliberately postponing or delaying action slows down the process of change (in this case the change from normal to problematical delivery); in this way, waiting and doing nothing can be understood as a healthcare strategy for the midwives and villagers of Faradala.

Although the midwives in Faradala were 'skilled personnel' as a result of their biomedical training, their ability to handle obstetric complications was limited. This is illustrated by a story one of the two midwives told in 2009 about a delivery she had assisted the year before.

Howa Keita⁷ had come to the maternity clinic to deliver her first baby. After an uncomplicated first stage of labour, the second stage stagnated due to the fact that Howa had been circumcised. The midwife did not dare to perform an episiotomy because she had never done this before. After Howa had been pushing for one hour, the midwife sent a family member to fetch another midwife who worked in the health centre in Nioumamakana, which took two hours. By the time this midwife arrived and delivered the baby (after performing an episiotomy), the baby had died.

When the maternity clinic was set up, the stakeholders agreed that the *musokòròbaw*, with all their experience, should also be present at deliveries in order to assist the newly trained (and relatively inexperienced) midwives. But as it turned out, young women coming to the clinic often did not want the *musokòròbaw* to be present during their delivery. They were afraid that the *musokòròbaw* would gossip about their comportment during birth. The young women perceived the maternity clinic as a modern space where women could avoid a *musokòròbaw*'s involvement (their family's involvement) in their delivery.

The use of healthcare in a landscape of shame

Healthcare is also experienced and structured through gender discourse. The concept of gender discourse, as used here, refers to the way people talk about men and women, the meaning given to the categories of 'man' and 'woman', and a set of conditions that regulate proper behaviour for both. Gender power relationships within the household often inhibit the women's abilities to seek care or to have access to information and resources (Mezey 2000; Okojie 1994).

Respondents (male and female) often emphasized that for them 'women do not have as much knowledge as men', and therefore it is not 'the work of women' to plan a course of action in cases of illness; this is a man's job. Women usually wait for others around them (e.g., husbands, in-laws, neighbours) to make healthcare decisions. Particularly young women do not always perceive themselves as able or entitled to make such decisions.

In the village women often spoke of 'having shame' (*màlòya*). They explained that 'having shame' is a good thing; it means that one is not shameless. The term *màlòya* incorporates several concepts such as respect for one's elders, female chastity, hospitality, trustworthiness, being careful not to upset people, and not speaking without thinking. It is honourable for a woman to have shame, because then she demonstrates 'correct' behaviour (see Iliffe 2005; Jamieson 2000). In Faradala the discourse of shame inhibited women's ability to take action, voice an opinion, or ask for help, for if they did so they might be seen as shameless and this could damage the patriliney (Bourdieu 1966). Generally, in Faradala, shamelessness could be avoided by not showing too much initiative (Jansen 2004: 158). However, from a biomedical perspective, this avoidance jeopardized the quality of care for women.

Shame in disclosing pregnancy

Women 'had' shame and therefore did not speak about their pregnancy, because to do so was considered boasting and therefore shameless behaviour. Holten asked a young woman, who was heavily pregnant, if she wanted to go to the clinic for a prenatal check-up, and to her surprise the response was: "I am not pregnant". Women were afraid of gossip, as a young mother explained during a focus group discussion:

Women only tell their best friends when they are pregnant, not everyone. They are afraid others will gossip 'look, she is pregnant' which is the same as saying 'look she has sex with her husband'. When a doctor says 'you are pregnant' the woman also has shame (Kinjaba Kante, December 2009).

Kinjaba explained further that she waited until others saw that she was pregnant before talking about it. She was afraid that if someone knew she was pregnant they would 'do *gris-gris*'⁸ because of jealousy (*keleja*) and egoism (*njagoja*) and doing evil (*juguja*). For example, a woman who had fewer children than she had might be motivated to perform *gris-gris* on her.

Pregnant women often came for their first prenatal check when they were six months along and could no longer hide their pregnancy. Or pregnant women waited for local midwives to notice their swollen belly before going to the maternity clinic. Once inside the clinic, women 'had shame' when uncovering their abdomen during an examination, which made them uncomfortable. In public (and sometimes even in private) a woman's thighs and belly should be covered at all times. One of Holten's male informants told her that in 17 years of marriage he had never seen his wife's belly because '*elle a honte*' (she has shame). In Faradala it is shameless for a woman to be seen naked by a woman who is younger than she is. Sometimes this was problematic in the maternity clinic since one of the midwives was only thirty years old; if an older woman was in labour, the other midwife, who was approximately fifty years old, had to be called in.

Speaking about pregnancy-related problems was also perceived as shameless for some women, as the case of 37-year-old Nakani Bagajogo illustrates:

Nakani came to the clinic after her husband had explained to Holten's translator that she had not become pregnant since she was given to him in levirate⁹ four years ago. The husband wanted to know if she was ill. After talking for a while, Nakani asked Holten if they could talk without the midwives and only the translator present.¹⁰ She subsequently said that she had shame in telling Holten in front of the others that her menstruations were different than before; they were shorter. According to her, women do not usually talk about menstruation. Nakani had asked advice from a *musokòròba*, once. The *musokòròba* had said that she was not ill. Out of shame, Nakani did not dare talk about her problem again, even though she was worried. She was afraid that if she spoke about wanting to become pregnant with her new husband, people would say: "She does not think about Moussa anymore." [Moussa was her first husband who died.] It would not be respectful.

Shame in asking for help to access health care

For women it was especially difficult to reach state healthcare facilities, as a woman needed her husband's permission for prenatal care and his money for transport. Furthermore, in Faradala it was unseemly for a woman to sit behind her husband on a motorcycle as people might think that the man and woman 'love each other' and this made the women feel shameless. Unfortunately, a motorcycle was the only means of transportation for a woman to reach healthcare facilities that were 20 kilometres away.

Women also 'had shame' when they had to ask for the necessary money to pay for transportation to a clinic or for treatment. The women often told Holten that they preferred not asking someone other than their husband for money. They did not want to 'disturb' anyone by making them feel uncomfortable if they had to refuse the request due to lack of funds. The next case study presents an example of how shame made it difficult for the parents of a sick infant to access adequate health care.

One day, Holten saw that Kadjatou Culibali's baby had laborious and fast breathing. She suspected the child was in an early stage of pneumonia and gave Kadjatou antibiotics

and medicine for malaria on credit. The next day the baby was having more difficulty breathing and had fever, so Holten told the mother that now she must take the baby to the doctor in Sandama. The next day, Holten asked around to verify if Kadjatou had gone to the doctor; she had not. By then it was late in the evening and the baby was not doing well, but it was too late to arrange for transportation. When asked why she had not gone to the doctor, Kadjatou said that there was no money. She said that her husband had asked people (she did not know who) for money without success. She said she herself had “no one she could ask.” In response to further probing, Kadjatou said that she had shame in asking Holten for money because she could not even pay for the medicine Holten had given her two days earlier.

Asking someone other than one’s husband for money to go to a clinic was perceived as shameless; as it implied that a husband was not a good provider. The women were dependent on their husband’s family and had limited access to resources of their own. Protecting their husband’s family’s reputation was of utmost importance to the women in Faradala.

Difficulties in talking about health (other than shame)

While the previous section pointed out that not taking the initiative, not asking for help, not voicing an opinion and delaying action when a pregnant woman or her child is ill, can be seen as strategies women use to avoid shame, there were also other reasons that made talking about pregnancy problematic in Faradala, and thus influenced the quality of care provided in the local clinic.

The secrecy and danger of knowledge

Indigenous medical knowledge is not standardized or accessible to everyone in Faradala. Postmenopausal women had knowledge of matters pertaining to pregnancy and birth, young women and men did not (see also Castle 1993; Slobin 1991). Each traditional healer or birth attendant had his or her own personal secret knowledge (*dalilu*) of the required incantations (*kirisi*) for preparing specific traditional medicines. *Musokòròbaws*’ secret knowledge was acquired from their mothers or old women ‘teachers’ who gave knowledge in exchange for payment. Knowledge was only shared in private; it was a one-to-one activity. The *musokòròbaw* each had their own distinct sets of incantations they used to prevent premature labour, speed up a delivery and protect a baby against illness. Holten never heard two incantations that were the same from various *musokòròbaw* during her fieldwork. *Musokòròbaw* did not talk with each other about their knowledge and did not know exactly what the others know. Their personal knowledge was not shared with their patients. This is in contrast to the Netherlands, where midwives share standardised knowledge about pregnancy and childbirth and it is generally clear to their patients what that knowledge is.

In Faradala, knowledge of pregnancy and childbirth is thought to be dangerous; it can cause a miscarriage or premature labour, and therefore young (potentially pregnant) women were not given this knowledge. Although Holten, as an outsider, was allowed to provide information on pregnancy and birth to the pregnant women of Faradala, the newly trained midwives were reticent to share anything more than the most basic information.

A good healer asks little

Biomedical healthcare for pregnant women is based on providing patients with (standardised) information on recognition and prevention of complications and asking women a fairly standardised set of questions. Biomedical encounters feature an 'incitement to speak', constructing the patient as a communicating subject and language as a tool for 'truthful reference to inner states' (Wilce 2009: 206). While in biomedical care the patient does a great deal of talking in response to a doctor's questions, in indigenous healing practices in Faradala, the situation is often reversed. The patient offers the healer only a limited amount of information and the healer does most of the talking. A sign of a good healer is one who quickly knows the diagnosis, sometimes with the aid of divination (see Jansen 2007). A healer's diagnosis is made without having to ask numerous questions. To the people of Faradala, therefore, the sign of a good doctor is someone who asks very few questions, since a doctor should sense or know the diagnosis by other means. Therefore, it cannot be taken for granted that the midwives at the clinic can ask the questions they, from a biomedical viewpoint, need to ask in order to give good prenatal advice and still acquire the status of a 'good healer'. In 2009, the midwives in the clinic asked pregnant women a minimal number of questions and provided little information. The pregnant women, who were not used to being asked questions, were shy and reticent when answering them.

Not speaking as a sanction

Women were sometimes reluctant to speak to their husbands about their health or the health of their children. When Holten asked women why, they told her that there was a '*sentiment de conflit*' (a feeling of disagreement); they were unhappy that their husbands did not honour their duty as providers. And because their husbands showed no interest in them, the women retreated into themselves and did not talk to their husbands. This behaviour was a women's sanction for men not living up to their role as 'good husband'. This sanction, however, contributed to a delay in seeking healthcare, as women in Faradala were dependent on their husbands for access to that care.

Social and economic conditions under which midwives work

The social conditions under which the midwives in Faradala had to work were not always conducive to continuity of care. They had to wait for the male village elders to

‘ask them to work’, before they could do their job in the clinic. One of the midwives was unable to work in the maternity clinic for a year because of tensions between specific men in the village; her husband’s brother had been convicted of stealing money destined for a village development project and therefore she had not been asked to work in the clinic. Also the *musokòròbaw* proved to have some authority over the midwives. When one of the midwives became pregnant, the *musokòròbaw* forbade her to work in the clinic because seeing women in labour would be dangerous for her and her unborn baby.

Another reason that midwives were absent from the clinic was their economic situation. The midwives’ salary was so meagre that they were obliged to cultivate millet and peanuts in their fields in order to feed their families. During a village meeting, the men had agreed to help the midwives by working in their fields, but despite these good intentions, this help had not materialized. This meant that the midwives were often not in attendance at the clinic. In December 2009, the doors of the clinic were often closed: one midwife was away working in her fields, 10 kilometres from Faradala, and the second midwife went to the goldmines most days to ‘look for money’.

An extra burden for the local midwives was that they lodged and fed women from other villages, who had come to Faradala to deliver at the clinic, just as many women in the village did. The Faradala women seemed to see this as hospitality that was taken for granted and for which they were not paid.

Discussion

The findings of this research demonstrate how, through friction, a new ‘form’ of biomedicine emerged in Faradala. Holten’s role as midwife enabled her to identify areas of friction and her anthropological research helped to provide an understanding of how that friction operated. We will now reflect on the outcome of the health care project, the Faradala maternity clinic, as it developed during the first two years using a primarily Dutch midwifery perspective. More ethnographic research would be needed to evaluate the project from the perspective of the Faradala community.¹¹ We suggest that such research should be done by an anthropologist who has no medical role in the clinic, since such a role significantly influences what people say and do not say in response to questions. On the other hand, the advantage of Holten’s double role was the opportunity for direct observation of the friction through which biomedicine operates.

Holten was not a passive facilitator of the change process; she had the power to direct and shape the management of the clinic. She chose the interview topics and recorded information she found relevant (cf. Mosse 2005: 91). She ‘collaborated’ with the midwives of Faradala, but was aware that it was collaboration between unequal partners; as the coordinator of the project she held a dominant position. She attempted to validate her findings during discussion groups, ‘maximising the capacity of actors to object to what is said about them’ (Mosse 2005: x). However, it remains uncertain if the respondents had the capacity to object at all. It was almost impossible for the midwives to voice their opinions to Holten, as she was older and an outsider, two

characteristics that demand respect; it would have been shameless and disrespectful to disagree with her. The midwives and *musokòròbaw* deflected all Holten's questions about their opinions and agreed with all her suggestions. Only by participant observation, working alongside them, could Holten see what 'worked' (from a midwifery perspective) and what did not.

From a biomedical midwifery perspective, biomedicine's awkward engagement in Faradala did lead to the improvement of the quality of care for pregnant women in certain areas. The pregnant women had access to malaria prophylaxis, iron tablets to treat their (often severe) anaemia, and medication to prevent postpartum haemorrhage. Antibiotics and oral rehydration salts were available for the children. However, perhaps the most important outcome of the health care project for the pregnant women was the realization that prenatal care was now available and this had the potential to empower them. On the other hand, the implementation of the local maternity clinic led to a new medical practice that raises some ethical dilemmas.

There is a risk that the expertise of the *musokòròbaw* will be lost. Before the clinic was established, the maternal mortality rate in Faradala was relatively low. One reason may have been that these older women did not interfere in the natural process of childbirth. Their assistance consisted of saying incantations and giving moral support. The newly trained midwives can perform pelvic examinations, artificially break membranes and give injections. Their relative inexperience and the pressure to give drugs will make it difficult to take no action when appropriate and to let nature take its course. Thus, in all likelihood, this clinic (like so many biomedical prenatal care facilities) will increase the medicalization of pregnancy and birth. Medicalization can be seen as an agent of social control (especially over women) as it makes people unnecessarily dependent on medical experts and pharmaceuticals. The biomedical discourse of reproductive risk targets certain populations for intervention. In this way globalization, in the form of biomedicine, could even be seen as the re-colonization of a woman's body (Mohanty 2002).

Civil society projects, such as the Faradala maternity clinic, can have the undesired effect of masking the state's institutional shortcomings and this can lead to the demobilization of villagers working to improve their healthcare situation (Brown et al. 2008: 26). The maternity clinic has not solved the healthcare problems in Faradala. Thinking that the clinic will suffice, while it is ill-equipped and poorly staffed to handle obstetric emergencies, could be dangerous; it could lead to a delay in getting to a facility that can perform the necessary intervention. Pregnant women who are at risk for obstetrical complications must still be referred to the capital in order to have access to adequate treatment.

The implementation of the project has unintentionally led to an increase in the burden for the women of the village, who housed and fed pregnant women coming to deliver in the clinic. In a context of extreme poverty and lack of autonomy for women, the midwives were not always able to work in the clinic, which jeopardized the continuity of care. From a Western feminist perspective the ideal would be a clinic that works as a space of empowerment, where knowledge about pregnancy is shared (even if only to a limited degree) and a context is created wherein pregnant women would

perceive themselves as able and entitled to make health care decisions (Parpart 2002: 240). In this sense, empowerment is about individual 'conscientization' but a focus on the individual may be problematic in Faradala.

Autonomy, one of the principles of (Western) bioethics, asserts that the individual patient must have a freedom of choice in treatment, thereby inferring individual responsibility. In order to make a choice, the patient must have adequate disclosure of pertinent information from their physician (Finkler 2008). Patient autonomy depends on the information an individual patient possesses and this information can vary according to social status and gender. In Faradala 'informed consent' is problematic. Firstly, the individual and the family are one in Faradala; for pregnant women choices are seldom made autonomously. Secondly, the *musokòròbaw*, who initially had a monopoly on the knowledge of pregnancy and birth, may fear loss of status/power if this kind of knowledge becomes 'common' knowledge. Thirdly, midwives may be reticent to provide information on pregnancy and birth because this information is thought to be dangerous for pregnant women. It is difficult to determine what adequate disclosure means in Faradala; too much information could cause harm (see Cox Macpherson & Connolly 2002: 7).

Small-scale private health initiatives can do more harm than good in circumstances of extreme poverty, gender inequality and poor infrastructure, and should therefore be implemented with caution. The project in Faradala has shown that before implementing a biomedical health care project, ethnographic investigation of reproductive health as it is locally understood is needed. It is crucial to pay special attention to a gender-sensitive appraisal of the social relations of health care delivery. Furthermore, there should be accountability for what transpires when health messages are introduced into a community. Patient-provider interactions should be approached as having dynamic ongoing effects; this means that community responses must be monitored over time (see also Boonmongkon et al. 2002). The health care initiative in Faradala attempted to address one Millennium Development Goal (i.e., maternal and child mortality reduction) but will have little chance of success if other goals (such as reducing poverty and increasing education) are not addressed simultaneously.

Conclusion

This article has argued that the maternity clinic in Faradala was a zone of awkward engagement where the so-called universal of biomedicine and the particular of a small Malian village came together. In areas of friction, negotiation of competing discourses and practices take place which over time result in a new bio-medical practice. An appraisal of the two-year process of engagement raises the question whether this practice will be effective and ethically justifiable. We found that moral issues, such as what it means to be a 'good healer' and a 'good woman', to be at the core of the friction out of which this new biomedical practice was born. Moral processes differ in a fundamental way from ethical discourse. Where (bio)ethical discourse is principle based and intellectualist, emphasizing rational choice and coherence, moral experience is

about practical engagements in particular local worlds (Kleinman 1999: 364-65). As Kleinman states: “[T]he moral may be unethical, just as the ethical may be irrelevant to moral experience” (ibid: 366). With this descriptive ethnography, we have attempted to contribute to a more inclusive engagement between bioethical discourse and moral experience by looking at how social agents – including the researcher in her double role of anthropologist and midwife, form, justify and apply judgements on good medical practice (cf. Fassin & Stoczkowski 2008: 332).

Notes

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- 1 The name Faradala is a pseudonym, chosen to protect the privacy of the villagers.
- 2 The construction of the maternity clinic in Faradala was financed by a 3 million FCFA (approximately 6400 Euro) gift from Mies Louwman, an elderly Dutch lady who had approached Jan Jansen for a meaningful small project in Mali she could support. The choice to build a maternity clinic was made by the people of Faradala, who were of the opinion that the presence of the building would decrease the high child mortality rate in the village. The equipment for the clinic was financed by a donation from a Dutch civil initiative (‘the Third World Group Soest). Previously, an even smaller Dutch group (Foundation Wereldwijd [Worldwise] from Tilburg) had financed, at Jansen’s request, a six month apprenticeship for two Faradala women at one of Bamako’s bigger maternity clinics (in the Jikoroni-Para neighbourhood). In hindsight it would have been preferable to have done medical anthropological research before setting up the maternity clinic, but Holten was faced with a *fait accompli* and was asked to ‘bring biomedicine to Faradala’.
- 3 In reproductive life-history interviews the female respondents were asked to describe all their pregnancies (including possible miscarriages and/or abortions), deliveries and postpartum periods in detail. Special attention was paid to therapy decision-making and the health of their babies.
- 4 If research had been done before the clinic was set up, it would have been clear that there were too few deliveries in Faradala itself and too few women coming from neighbouring villages, for a maternity clinic to be sustainable.

- 5 Of their 293 pregnancies, 30 had ended in a miscarriage. Of the 263 babies born, 18 were stillborn and 81 children died before they reached the age of five. Seven children died between the age of 5 and 10.
- 6 This strong preference for 'Western' medicines is widespread in the region (cf. Van der Geest & Whyte 2003).
- 7 All names of respondents in this article are pseudonyms.
- 8 *Gris-gris* is a magical substance, which can be used, in amulets, for example, to protect the wearer. *Gris-gris* can also be used to bring bad luck.
- 9 Levirate is the practice by which a man may be required to marry his brother's widow.
- 10 This illustrates that the respondents had less shame in speaking in front of Holten's male translator who was also an inhabitant of Faradala.
- 11 In an evaluation of this healthcare project we need to take into account what the villagers themselves consider to be ethically justified healthcare. The research so far has not addressed this issue as yet.

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