Sudan: Situational analysis of maternal health in Bara District, North Kordofan

Martha Campbell & Zeinab Abu Sham

Introduction

Women in Sudan face a high risk of death in pregnancy and childbirth. Hospital statistics indicate a range of maternal mortality ratios from 541 to 2,770 deaths per 100,000 live births. Maternal mortality rates differ significantly by region with the eastern and western regions having higher rates than the central regions and Khartoum. According to a study conducted in 1989, the maternal mortality ratio is 407 deaths per 100,000 live births in Bara District of North Kordofan.

In partnership with the Ministry of Health, CARE International in Sudan implemented the Bara Maternal Health Project (BMHP) to reduce maternal mortality in selected Rural Councils of Bara District over the period 1990-92.

As the first stage of the BMHP, CARE and the Ministry of Health (MOH) conducted a qualitative study on maternal health services and maternal health-seeking behaviour in Bara District. The BMHP Study on maternal health in Bara District explored the factors contributing to the high maternal mortality ratio measured in the region. The study provides in-depth information on maternal health from the perspective of the rural communities and front line health workers. Based on the results of the Study, CARE and the MOH, with assistance from a technical consultant of WHO, identified appropriate interventions to be supported by the BMHP which address the factors directly involved with maternal mortality.

Materials and methods

The study was based on a simple multi-stage stratified format to obtain information from the target groups at four levels:

(i) Village (mothers of children under 5 years; community leaders or village health committee; and trained and untrained traditional birth attendants (TBAs));

(ii) PHC unit, Village Midwife Post (village midwives (VMWs) and community health workers (CHWs));

(iii) Rural dispensary (Medical assistants, village midwives and nurses); and

(iv) District health centre, rural hospital (Medical officers, nurse-midwives and health visitor).

The study was implemented in the rural councils of Bara, Gerejikh and Taiyba. These rural councils were selected because they represent the western and eastern Bara Health Areas and the location of the first referral level in Bara Rural Council. The Study relied on qualitative information collection techniques to reveal beliefs, attitudes and practices of the study groups. The methods applied were focus group discussions, semi-structured individual interviews and direct observations.

The study was designed and implemented over the period March to July 1990. In consultation with the Regional and District MOH, the project developed question guidelines. The guidelines consisted of open-ended questions for each target group. The BMHP relied on 3 facilitators from the Ministry of Education and 3 project staff members. The team received 5 days of training. Following each interview or discussion, the interviewer and recorder or supervisor reviewed and expanded their notes in the afternoon or evening. They recorded the information on prepared forms for filing and later reference.

The team met periodically throughout the study to review the guidelines and conduct a preliminary analysis of the data.

Following the data collection phase, the data were analyzed by reviewing each topic area by strata and identifying the types of responses emerging from the data. This document summarizes the findings of the study.

Results

Causes of maternal mortality

The community groups and health cadres identified several causes of maternal mortality. The direct causes of maternal deaths, caused by complications of pregnancy or delivery, are hemorrhage (during the first and last trimesters and postpartum), puerperal infection, obstructed labour and toxemia. Other existing conditions, such as viral hepatitis, anemia and urinary tract infections, can be aggravated or prove fatal during pregnancy or delivery.

The target groups emphasized other contributing factors to maternal mortality or morbidity such
as pharaonic circumcision, a woman's reproductive history, the inaccessibility of health facilities, women not seeking care unless they are seriously ill, and other socioeconomic factors. Pharaonic circumcision, estimated at 97% in Bara District, causes many complications in pregnancy and childbirth for women, including a higher risk of urinary tract, reproductive tract and puerperal infections, the need to be deinfibulated during delivery, tearing of scarred vulva tissue that does not dilate properly to allow the safe passage of the baby through the vagina, and urinary or rectal fistula.

Within the MOH system, health workers at all levels are limited in their abilities to prevent, diagnose, treat and manage complications of pregnancy and labour due to the chronic inadequate supply of drugs, their lack of training, the lack of supervision within the MOH infrastructure, and the poor status of the health facilities.

Prenatal care
Factors which influence whether a pregnant woman would seek prenatal care are the location of the facility or post of the village midwife, the travel distance that results from this distribution, the available transportation means necessary to cover the distances, previous experience with the health care system, and perceived quality of care.

In areas within access to the District Health Centre, a rural dispensary or a village where a village midwife (VMW) is posted, an overwhelming majority of pregnant women (90-100%) seek prenatal services from the Health Visitor, VMW or Medical Assistant. If mothers are not within 30 minutes by local transport (camel or donkey), they generally do not seek prenatal care unless they are very sick. The mothers explain that the financial and opportunity costs are high. In addition, the facilities or the VMW often do not have the supplies to treat their problems or are simply not adequately staffed. The women may travel the long distance only to discover that the health worker is absent. The role that quality of care played in the women's decision to seek care is directly a product of their own assessment of service delivery made through their and other women's experience with the health system.

The mothers involved in the study equated prenatal care to treatment of any illnesses or disorder present during their pregnancy and referral, if required. The mothers identified several conditions which they recognize as serious enough to justify seeking medical treatment during pregnancy such as bleeding, swelling, dizziness and malaria. An individual's assessment of a health condition is of course influenced by the prevalence of the condition. Anemia is endemic in Sudan, yet women with anemia often do not recognize that their condition warrants medical care.

The effect of distance on service-utilization varies with the quality of care provided. Where the village mothers have access to more than one health post, their responses to questions about service-utilization reflect that their judgment about the quality of care often takes precedence over concerns about the relative distances involved. For example, mothers in one village in Gerejikh Rural Council prefer to access services from the Health Centre in Bara Town, which is 4 hours by donkey, despite the presence of a VMW and a trained TBA near them, because they desire the higher quality and broader range of services offered at the Bara Health Centre.

At the Health Centre and Rural Dispensaries, the health workers offer comprehensive services, including a physical check of the fetal position, urine and blood analysis, and blood pressure monitoring, if the equipment is available and functioning. The health workers at this level are hampered in their delivery of services by the lack or poor state of the equipment and their limited training. The VMWs posted in villages generally provide only physical exams of the fetal position and nutritional advice to pregnant women on a balanced diet. The VMWs generally refer complicated cases to the rural dispensary and, in some cases, the community health workers (CHW) for treatment (e.g. malaria). The VMWs are limited in their service provision to mothers by their inadequate equipment (thermometer, weighing scale, blood pressure cuff, or strips or test tubes to test urine for albumin or sugar), supplies (anesthesia, drugs and vitamins), and knowledge to assess risks or diagnose pelvic disproportion and fetal positions. Trained TBAs provide nutritional counseling and physical exams to pregnant women. They know the major signs for referral. The untrained TBAs basically only assist pregnant women at the stage of labour. All through the health system, the health workers focus on screening patients for high risks. Pregnancy monitoring through repeated contact is practiced infrequently. In sum, the health workers can only offer limited prenatal care for screening or monitoring of any value.

Delivery
The mothers prefer to give birth at home where they receive good support and services from their relatives and neighbors. Delivery at home also eliminates high costs of the mother's transport to the referral centre and for her relatives to visit her.

The mothers prefer delivery services from trained workers: the trained TBA or the VMW. The mothers interviewed prefer the trained workers because they use hygienic practices, proper "sterilized" instruments, local anesthesia and cat gut for stitching the wounds and reinfibulating the women, and assist the women to deliver on local beds.
not in a squatting-position, pulling on a suspended rope, which is deemed humiliating.

The “wounds” referred to by the mothers and health cadres are incisions to widen the opening for the safe passage of the newborn which involve a decircumcision process and often a lateral incision or anterior lateral episiotomy. After delivery, the VMWs and TBAs reinfibulate women under local anesthesia by sewing together the edges of the scar tissue.

Despite the preference of mothers to receive trained assistance, 61% of mothers in areas with no trained health worker in Bara Rural Council were attended by untrained TBAs, according to a study conducted by UNICEF in January 1990. The individual caseload of the TBAs, however, is very low relative to the trained health cadres. The untrained and trained TBAs deliver on average one baby per month. The VMWs posted in villages deliver two babies per month. The Rural Dispensary has an average caseload of twelve deliveries per month.

Referral for emergencies
The health cadres make the recommendation to refer a woman, although the husband usually makes the final decision whether a patient will be referred. The village health committee assists when necessary in arranging transport to the referral facility. Generally, a woman will deliver in a referral centre. Generally, a woman will deliver in a referral facility, if the referral recommendation is made by a health cadre.

The community groups identified several delays in providing prompt, effective treatment to women at risk of death:

(i) Delayed recognition by the health worker or TBA of the complication and need for referral. The untrained TBAs are not aware of simple danger signs of the most common complications and how to stabilize a patient with complications for referral. The untrained TBAs did not report any referrals over the last quarter and appear to have little contact with the MOH infrastructure. The health cadres recognized certain conditions which require management, such as hemorrhage, prolonged labour, and high blood pressure, but they cannot always stabilize a patient before referral due to lack of supplies or knowledge in proper referral procedures.

(ii) Delay in decision-making by the husband or community leaders if the patient should be referred. When a woman is identified at high risk or experiences complications in delivery, her husband must make the decision whether she can travel to a referral facility. The husband may not be present or may not have the knowledge to make a timely decision.

(iii) Delays in obtaining transport to the referral facility. There are no permanent roads throughout Bara District and most travel is on sand tracks. Emergency patients are often transported by camel, donkey or on a stretcher, carried on the shoulders of men-volunteers from the village. If lorries or other transport means are available, the patient’s family may not have the funds to cover the costs of the transport.

(iv) Delays in receiving proper care once the patient arrives at a referral facility. An obstetric patient with complications often does not receive prompt and effective care due to the prevailing lack of supplies, equipment, trained manpower, and evidence of poor management, staff errors and misdiagnosis. The status of the Bara Hospital, the first referral level, with its chronic shortages of paper, electricity, essential drugs, supplies, blood and blood substitutes, makes the referral less effective. At the Bara Hospital, the obstetric patients are put in the same ward as the surgical and medical patients which increase their risk of infection. The hospital health information system is inadequate. The records do not provide complete information on maternal deaths, time between admittance and treatment, and outcomes of each patient with obstetric complications.

Postnatal care
Mothers who have delivered at home receive care from their relatives for a period of 40 days after the delivery. The relatives assist with food preparation, child care, water transport, and cleaning.

The Medical Assistants, VMWs and trained TBAs provide follow-up visits up to one week after delivery. The untrained TBAs generally make one visit the day after delivery and again 7 days after delivery on the occasion of the traditional ceremonies to name the child and celebrate the birth. During their visits, the TBAs will wash the mother’s wound and check the child’s cord. The VMWs and trained TBAs provide the following services during postnatal visits: detection and referral for hemorrhage; referral of infants with low birth weight; washing the mother’s wound with disinfectant; and counseling on breast feeding, hygiene, birth spacing and nutrition. The health workers generally seem unaware of the need to detect and refer mothers for postpartum infection, despite the fact that infections of the uterus, breasts or urinary tract are common after delivery, especially in circumcised women. There was virtually no care offered after 4 weeks at any level to examine the woman’s uterus and vagina to detect any signs of infection, to make sure the uterus has returned to normal, and for other problems.

Birth spacing
The mothers state that an ideal birth interval is 2-4 years to allow proper rest for the mother and
feeding for the child. If a woman becomes pregnant while she is still breast feeding, the mother abruptly and completely weans the child, whether the infant is 1 month or older. The mothers recognize the importance to space children for the health of the child and mother. In Bara, however, women have on average a birth interval of 18-24 months, according to a UNICEF study conducted in January 1990. The Sudan Demographic and Health Survey, conducted in 1989, measured the total fertility rate for women at 5.0; and reported that 58.4% of currently married women would like to limit or space births of their children.

The mothers manage birth intervals of 18 months or more by the methods of postpartum separation for 40 days after delivery and sexual abstinence for a period of 14 days after menstruation. With a high proportion of men who seek wage income outside of Bara District on a seasonal basis, it is not clear how this migration of husbands affects reproductive patterns.

The mothers expressed a high interest in gaining knowledge in modern contraceptive techniques, although some mothers cautioned that their husbands would strongly object. The mothers prefer to receive birth spacing services from the Medical Assistant or the VMW. The mothers clearly specified their interest in birth spacing and not in limiting their family size.

Most of the health cadres support the concept of birth spacing. The Medical Assistants, VMWs, trained TBAs and some CHWs and nurses already promote birth spacing. Two Medical Assistants even purchase contraceptives from private sources to give to patients. The Medical Assistants and VMWs expressed their interest in learning more about modern birth spacing methods and counseling.

**TBA training**

The study involved an assessment of the impact of the TBA training conducted in Bara District by the MOH in 1989 with assistance from the Rural Health Support Project. The study analyzed the communities' accounts of TBA performance and TBAs personal observations. In general, the health cadres were supportive of training TBAs. Since the TBAs will continue to offer delivery assistance whether or not they are trained, the health cadres feel that it is better to improve TBAs' practices so they are able to offer safer delivery services. The health cadres emphasized, however, that TBAs selected for training should be relatively younger than those TBAs trained recently, whose ages ranged from 40 to 65 years, with the majority in the higher end of the age scale.

In general, the community leaders and mothers positively reflected on the training. They particularly supported sessions on prenatal check-ups, use of local anesthesia, suturing the wound, and delivering on a bed. The TBAs, however, are weak in applying the majority of these new skills, according to the different groups interviewed. The health cadres and mothers all commented that the TBAs did not receive enough practical training. They indicated that the TBAs did not get the opportunity to develop fully their skills to inject, sterilize, administer drugs, and deliver on a bed.

Some TBAs simply reverted to their old practices. Since their training ended in November 1989, the TBAs have not been supervised or followed up by MOH officials. With no follow-up, the TBAs could not develop confidence in their new skills. The training proved to be extremely expensive and inefficient at US$1,000 per TBA when their caseload remains low and when many TBAs were in the age bracket of 50 to 65 years of age.

The community leaders and women expressed their willingness to contribute financially or in-kind to the costs of future training courses for TBAs, if they are involved in the selection process and planning for the training. In some areas, however, the community leaders recommended that it would be a more effective use of the resources to allocate the funding toward training of young girls as village midwives, who remain the preferred health cadre for trained assistance at birth.

Based on interviews with trained and untrained TBAs, the trained TBAs are more likely to refer women who have signs of being at risk of complications. They are also more likely to observe hygienic procedures of washing their hands before delivery and using a clean, if not sterile, instrument to decircumcise the woman and cut the umbilical cord.

The TBAs were also trained in infant and child care: nutrition, ORT and EPI promotion, and birth and death registration. It is clear, however, that the TBAs did not take on this expanded role in their communities as expected by the MOH. Several possible reasons why the TBAs have not provided all of the services for which they received training are outlined below:

The TBAs may not identify with these additional roles given to them. The TBAs perceive themselves as first and foremost as birth attendants. Their interest in the training stems from their central role as birth attendants in the community. The fact that the TBAs do not receive any remuneration in their roles as child health promoters from mothers or the community may also negatively affect their motivation in carrying out these tasks.

The training was also deficient in addressing child care topics. The focus was clearly on developing the TBAs' delivery skills. The only practical component of the training was in deliveries.

Some TBAs complained about the length of the course. They find it difficult to stay three months in training without being able to go back home to see their children and families. The last sessions were
The course packed too much information in one course for TBAs who are not used to classroom settings. The TBAs may have left the training saturated with information and not able to apply the knowledge they had gained in child care and some aspects of maternal health care.

Upon their graduation, the TBAs were given kits with 26 items that help make deliveries cleaner and safer. The TBAs do not use all of the items either for fear of running out of supplies or for being ignorant about their function. Although the kits do represent a symbol of their new status as trained TBAs, the issue of replenishing supplies and even the appropriateness of the kit itself was not given careful consideration.

The necessity of constant supervision and follow-up is acknowledged. This will be facilitated by decentralizing the supervision to the Dispensary staff or the VMW in the neighboring village. The supervisory system should be established and referral facilities and means to replenish the TBA kit supplies identified before the training activities are initiated. The TBAs should not be over 51 years of age, because the ability of old TBAs to adapt new knowledge and skills is very poor. The training course should not attempt to create a new health cadre, but focus strictly on the enhancement of the TBAs' skills through adopting more hygienic methods of midwifery and to link the TBAs to the referral system. For the training conducted in 1989 in Bara District, these recommendations were not adequately addressed. As a result, the TBAs and the mothers have lost some confidence in the training programme.

**Supervision**

The supervision of midwifery services in Bara District has also been deficient. It is not uncommon for a VMW not to have received any supervisory visits since her posting. The VMWs feel abandoned in the field. The MOH has no plan for refresher courses, despite that fact many VMWs have been working in the field for over 10 years and evidently forget the proper use of the MOH issued equipment or drugs. The Medical Assistants could act as the direct supervisor of the VMWs, but they are not as skilled or trained as the VMWs in the maternal health field.

**Discussion**

Maternal mortality is high in Bara District and calls for programmatic action. The direct obstetric causes of maternal deaths in Sudan, similar to the causes reported throughout the developing world, are hemorrhage, obstructed labour, toxemia and infection. Other contributing factors are institutional, socioeconomic and cultural. The requirements for reducing maternal mortality must involve several fields such as obstetrics, control of infectious diseases, birth spacing, health communications and community development.

Low socioeconomic status of the population in the region contributes to the high maternal mortality rate through the low awareness of complications in pregnancy or delivery which require medical care, lack of access to health care, malnutrition, poor transportation systems and low social status of women.

Within the MOH system, health workers at all levels are limited in their abilities to prevent, diagnose, treat and manage complications of pregnancy and labour due to the chronic inadequate supply of drugs and supplies, their lack of training, the lack of supervision within the MOH infrastructure and the poor status of the health facilities.

The TBA training programme and emphasis on prenatal care is predicated on the assumption that the referral system functions. Each higher level of the referral system, however, must provide a wider range of services than the ones available at the sending end. Necessary accompanying components to risk assessment and referral are transport and a referral site where a woman can receive obstetric emergency care. Presently, the referral system in Bara District is inadequate and unreliable.

The risk approach or prenatal screening would not have a large impact on maternal mortality in Bara District because most maternal deaths occur among low risk women who would not be identified for referral and the health cadres and trained TBAs have not received the training to enable them to provide emergency care or stabilize patients for referral.

A real problem exists in determining which criteria to use to identify women at high risk of obstetric complications. If the basic criteria of age, parity, past history, pelvic disproportion and anemia are used in Bara District for prenatal screening, a large majority of women would be labelled "high risk" and selected for referral to the Bara Hospital. Clearly, the criterion would overwhelm the system.

Any training programme must assess the efficiency of the costs involved. For example, TBAs have a low caseload of an average of one delivery per month. Training TBAs has cost implications not only for the actual training, but also supervision and replenishing supplies. The TBA training conducted in Bara District was not cost efficient in relation to its benefits, nor did it address the primary factors directly involved with maternal mortality.

Programme interventions to prevent maternal mortality should address the above findings and those factors directly related to maternal mortality. In conclusion, the most effective and appropriate programme options would include family planning, improved access to medical treatment for
complications of pregnancy and treatment, and community education.

Summary

A high maternal mortality ratio was estimated in Bara District in Sudan during the late 1980’s with approximately 407 women dying per 100,000 live births. In order to design effective intervention strategies, Care International and the Ministry of Health in Sudan conducted a study to identify the attitudes of women, staff, and TBAs towards motherhood, prenatal care, and practices affecting the health of women in the district. The previously conducted training programme for TBAs was also assessed in its impact.

The study yielded the following results. In addition to the commonly known risk factors for maternal health e.g. haemorrhage, puerperal infection, obstructed labour, and anemia, the women in the villages and health staff identified female genital mutilation (pharaonic circumcision) as a major threat to safe motherhood.

Health seeking behaviour was linked to problems of access and perceived quality of care: women did generally not wish to spend more than 30 minutes for reaching a facility. But if the quality of a particular institution was considered good, and supplies and equipment were available, women would cover great distances to reach such a facility. Participation in prenatal care suffered from the equation of preventive with curative care. Women would therefore tend to turn to a clinic or service provider, if symptoms of illness occurred during a pregnancy. The village-based services suffered from the lack of equipment and poor staff training, which further undermined the motivation to seek prenatal care.

When health staff recommended referral of a pregnant woman for delivery, the advice was usually followed. But the decision to refer had to be agreed upon by the husband which caused delays when a husband was absent and could not be reached quickly. Lack of transport posed a problem for timely referral. Delayed recognition of risk conditions by some health staff and untrained TBAs was also identified. Further delays upon arrival at a facility were considered problematic.

Postnatal care was seen as insufficient and in particular with a view to controlling infections which are common amongst circumcised women after delivery. The ideal birth interval was considered to be 2 to 4 years, but it effectively was 18 to 24 months. For reasons of birth spacing women were interested in learning more about modern contraceptives.

The completed TBA training programme was generally regarded as satisfactory by the women and health staff in the communities particularly in view of the improved skills of TBAs to provide for timely referral. But there was need to establish supervisory mechanisms and support to the TBAs after conclusion of the training programme. This would enhance the TBAs newly acquired knowledge and re-inforce use of the materials in their TBA kit. The TBAs regarded the course programme as having been too lengthy and having surpassed their capacity to absorb all the information offered. The child care component of the course did not seem to have met its target as it did not correspond to the traditional role perception of TBAs as providers of delivery care only.

Résumé

Soudan : La santé maternelle dans le district de Bara, province du Northern Kordofan – analyse de situation

D’après les estimations, le taux de mortalité maternelle était élevé à la fin des années 1980 dans le district de Bara, avec environ 407 décès pour 100 000 naissances vivantes. Afin de mettre au point des interventions efficaces, l’organisation Care International et le Ministère de la Santé du Soudan ont conduit une enquête sur les attitudes des femmes, des personnels et des accoucheuses traditionnelles à l’égard de la maternité, des soins prénatals et des pratiques qui influent sur la santé des femmes au niveau du district. On a également évalué l’impact du programme de formation d’accoucheuses traditionnelles exécuté auparavant.

L’enquête a donné les résultats suivants : outre les facteurs de risque bien connus pour la santé maternelle que sont l’hémorragie, l’infection puerpérale, la dystocie et l’anémie, les femmes des villages et les agents de santé ont indiqué les mutilations sexuelles féminines (circumcision pharaonique) comme une grave menace pour la santé maternelle.

L’attitude des femmes à l’égard des prestations de santé est fonction des possibilités d’accès, et de la façon dont est perçue la qualité des soins : en général, les femmes ne sont pas disposées à perdre plus d’une demi-heure pour aller jusqu’à un centre de santé. En revanche, lorsqu’un établissement a la réputation de dispenser des soins de qualité et de posséder des fournitures et du matériel, les femmes peuvent couvrir de grandes distances pour y aller. Il semble que le recours aux soins prénatals pâtit de l’assimilation des soins préventifs aux soins curatifs. Ainsi, les femmes tendent à ne s’adresser à un dispensaire ou autre que lorsque qu’elles présentent des symptômes de maladie au cours de la grossesse. Les postes de santé de village souffrent du manque de matériel et de la formation insuffisante du personnel, ce qui décourage encore plus les femmes de solliciter des soins prénatals.

Quand les agents de santé recommandent à une femme enceinte d’accoucher dans un service compétent, leur avis est généralement suivi. Cette décision doit cepen­dant être approuvée par le mari, ce qui entraîne des retards lorsque celui-ci est absent et difficile à joindre. Le manque de moyens de transport est également un obstacle à une prise en charge en temps opportun. On a également constaté que certains agents de santé et accoucheuses non qualifiées identifiaient parfois trop tard certains facteurs de risque. Enfin, des retards ont également été observés après l’arrivée au service de recours.
Les soins postnataux ont été jugés insuffisants compte tenu en particulier de la nécessité de combattre les infections qui sont fréquentes après l’accouchement chez les femmes circoncises. L’intervalle idéal entre deux naissances est considéré comme de 2 à 4 ans, mais en réalité, il est de 18 à 24 mois. Les femmes se sont montrées intéressées par les méthodes modernes de contraception afin d’avoir des grossesses plus espacées.

Le programme de formation des accoucheuses traditionnelles a dans l’ensemble été jugé satisfaisant par les femmes et les agents de santé, en particulier dans la mesure où, grâce à leurs compétences accrues, les accoucheuses orientent à temps les cas difficiles. Il faudrait cependant mettre en place des mécanismes de contrôle et d’appui des accoucheuses traditionnelles à l’issue de leur formation. Ce serait un moyen de renforcer leurs connaissances nouvellement acquises et de les encourager à se servir davantage des instruments et fournitures mis à leur disposition. Les accoucheuses ont considéré pour leur part que le programme était trop long et trop ambitieux et elles ont eu le sentiment de ne pouvoir absorber toutes les informations données. Enfin, la partie du programme consacrée aux soins aux enfants ne semble pas avoir atteint son but car elle ne correspondait pas à la perception traditionnelle qu’ont les accoucheuses de leur rôle comme consistant à intervenir uniquement au moment de l’accouchement.