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Yemeni women's perceptions of own authority during childbirth: What does it have to do with achieving the Millennium Development Goals?

Annica Kempe, BA, MPH (Postgraduate research student)[a,*], Töres Theorell, MD, PhD (Professor)[a,b], Fatoom Noor-Aldin Alwazer, RNM, MN (Secretary-General)[c], Kyllike Christensson, RN, RM, PhD (Professor)[d], Annika Johansson, BSc, PhD (Associate Professor)[a]

[a] Department of Public Health Sciences, Karolinska Institutet, SE–17177 Stockholm, Sweden
[b] Stress Research Institute, Stockholm University, Stockholm, Sweden
[c] National Yemeni Midwives Association, Sana'a Capital, Republic of Yemen
[d] Department of Women's and Children's Health, Karolinska Institutet, Stockholm, Sweden

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ABSTRACT

Background: women's underutilisation of professional care during childbirth in many low-income countries is a serious concern in terms of achievement of maternal Millennium Development Goal 5.
Objective: to explore women's perceived own authority within the modern and traditional spheres of childbirth in a high maternal mortality setting on the Arab peninsula. Yemen is a signatory to the Millennium Development Goals and one of 10 countries chosen for the United Nations Millennium Project. In Yemen, home birth has remained the norm for several decades in spite of high maternal mortality and morbidity rates.
Design: a multistage (stratified-purposive-random) sampling process was used. Two hundred and twenty women with childbirth experience in urban/rural Yemen were selected at random for interview. Answers to the question 'Did you feel that you were the authority during childbirth?' were analysed using qualitative content analysis.
Setting: the governorates of Aden, Lahej, Hadramout, Taiz and Hodeidah.
Findings: three main themes emerged from the analysis: (i) 'Being at the centre', including two categories 'being able to follow through on own wants' and its opposite 'to be under the authority of others'; (ii) 'A sense of belonging' with the categories 'belonging and support among women in the community' and 'the denial of support, the experience of separation' and (iii) 'Husband's role in childbirth' including one category 'opportunity to show authority over the husband'. Authority was experienced primarily among women within the traditional childbirth sector although a general complaint among women delivered by trained medical staff was the loss of own authority.
Key conclusions and implications for practice: these findings show that women's authority during childbirth is decreasing in the context of Safe Motherhood and the expansion of modern delivery care. This is likely to be an important reason why women underutilise professional care. Acquisition of knowledge from the traditional childbirth sector regarding how women exercise authority to facilitate childbirth would constitute an asset to skilled delivery and Safe Motherhood. The findings from Yemen are likely to be relevant for other low-income countries with similar persistent high home delivery rates, low status of women, and high maternal mortality and morbidity rates.

Introduction

More than 343,000 women die during pregnancy and childbirth every year (Hogan et al., 2010). The attendance of skilled health workers at delivery is vital to improve delivery outcomes, yet women in many low-income countries underutilise professional care during childbirth. Research from different parts of the world has examined women's low utilisation of professional care in terms of cost, demographics, sociocultural issues and obstetric need (Gabrysch and Campbell, 2009). Across geographical settings, it has been found that perceptions of the quality of care by women and their families are among the strongest predictors of utilisation of services and of delay in

* Corresponding author.
E-mail addresses: annica.kempe@ki.se, annica.kempe@yahoo.se (A. Kempe).

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seeking care (Barnes-Josiah et al., 1998; Abrahams et al., 2001; Griffiths and Stephenson, 2001; AbouZahr, 2003; Glei et al., 2003; Gill and Ahmed, 2004; Stekelenburg et al., 2004; Berry, 2008; Basaleem, 2012).

The importance of local understanding has been emphasised in attempting to motivate women to seek biomedical care during childbirth (Asowa-Omorodion, 1997; Obermeyer, 2000; Liamputtong et al., 2005; Kempe et al., 2011). Anthropological research has found imbalances in power and knowledge central to women's reluctance to seek biomedical obstetric care, especially when local non-biomedical resources are viewed negatively (Asowa-Omorodion, 1997; Davis-Floyd, 2003; Berry, 2006; Izugbara et al., 2009). Women's perceptions of safety and risk within a certain cultural context are of crucial importance (Kruske et al., 2006; Capelli, 2011). A recent review by Evans (2013), which investigated the influence of cultural factors on the maternal mortality rate, concluded that careful consideration and examination of the ways in which culture dictates maternal health-seeking behaviour and affects the maternal mortality rate is needed.

In many low-income countries, different approaches to care during childbirth exist side by side and are used simultaneously by women. A need for the integration of local perspectives into the systems of care advocated by the internationally defined Safe Motherhood Initiative has been recognised (Kwast, 1998; Pittrof et al., 2002), and the importance of learning from local communities and traditional care has been highlighted (Van Roosmalen et al., 2005; Gabrysch et al., 2009; Dietsch and Mulimbalimba-Masururu, 2011). In some settings, successful attempts have been made to integrate local concepts and practises into the modern system of care (Fujita et al., 2012), and indigenous women with little formal education have been shown to use delivery services with high levels of satisfaction when their needs are met (Gabrysch et al., 2009).

The concept of authoritative knowledge

Jordan (1993, 1997) stated that authoritative knowledge results when one type of knowledge gains ascendance and legitimacy at the expense of other types of knowledge, which are devalued or dismissed. The concept was originally elaborated as knowledge, which remains vested in biomedicine and, depending on local conditions in high- and low-technology settings, may need adaptation. Davis-Floyd (2001) distinguished between three different paradigms of childbirth: the technocratic, the humanistic and the holistic paradigms. Although in line with its hierarchical structure, the technocratic model invests authority in clinicians and in institutions and their personnel (Jordan, 1997; Cahill, 2000; Davis-Floyd, 2001), whereas authority is shared between childbirth participants within the humanistic model (Kempe et al., 2010). Some aspects inherent in the humanistic model of childbirth are the patient as a relational subject to the practitioner, and the sharing of information, decision-making and responsibility between patient and practitioner (Davis-Floyd, 2001). The holistic paradigm insists on the oneness of body, mind and spirit, and defines the body as an energy field in constant interaction with other energy fields (Davis-Floyd, 2001).

Yemen, a country chosen for the Millennium Development Project

Yemen is ranked low in the United Nations Development Indexes (United Nations Development Programme, 2013).[1] Over the last 40 years, Arab countries have made striking progress in increasing life expectancy and decreasing infant mortality rates (Arab Human Development Report, 2009). However, health is by no means assured for all citizens, with women suffering the most from neglect and gender-biased traditions (Arab Human Development Report, 2009). In 2005, secondary school enrolment among Yemeni girls was still 50% of that of Yemeni boys. The literacy rate among females was 43% whereas that among males was 79% (United Nations Development Programme, 2007/8).

Women in Yemen give birth to an average of five children (International Confederation of Midwives, United Nations Family Planning Agency, 2012). Yemen has a long tradition of home birth in both rural and urban areas. The proportion of home births has only decreased minimally over the last few decades, and is estimated to account for 76% of all deliveries (United Nations Development Programme, 2007/8). According to the International Confederation of Midwives and the United Nations Family Planning Association (2012), the maternal mortality rate in Yemen is estimated to be 210 maternal deaths per 100,000 live births, and the lifetime risk of maternal death is one in 91. Antenatal coverage is estimated to be approximately 47% for one visit; only 11% of women attend for four visits, as recommended by the World Health Organization. Midwives attend five of every 1000 live births. Midwives practice at all levels of the health system: in hospitals, health clinics, health units and in the community. A study from North Yemen (Abdulghani, 1993) found that the strongest risk factor for maternal death was delayed seeking of medical care after complications arose at home. In 2010, a cross-sectional study (Basaleem, 2012) in four districts of Yemen's capital Sana'a showed that 47% of births occurred at home and only 36% of these births were attended by a skilled birth attendant.

Yemen is one of the 10 countries chosen for the United Nations Millennium Project; as such, the Government of Yemen has made dedicated efforts to address Safe Motherhood in order to achieve the maternal and infant health Millennium Development Goals (MDGs) by 2015 (Al Serouri et al., 2012). However, recent reviews suggest that it is unlikely that the maternal health MDG will be reached (Economic and Social Commission for Western Asia, 2007; Yemen Ministry of Planning and International Cooperation and United Nations Development Programme, 2010). The maternal mortality rate has been reduced by 61% since 1990, partly due to expansion of emergency obstetric care services. However, skilled attendance at birth remains low at 12% in rural areas and 34% in urban areas (Al Serouri et al., 2012).

This qualitative study from Yemen aimed to explore women's preferences with regard to location and attendance at birth from a cultural and gender perspective, with a focus on women's perceptions of their own authority at birth.

Methods

Study setting, participants and data collection

This study on women's authority is part of a larger research project, aiming to gain insight into the experience of Yemeni women of modern and traditional care during childbirth and their health-care-seeking patterns. The main study (Kempe et al., 1994) was conducted in the five governorates of Aden, Lahej, Hadramout, Taiz and Hodeidah. A multistage (stratified-purposive-random) sampling process was used to select a total of 220 women (44 from each governorate). Half of the women lived in urban areas and half of the women lived in rural areas. The study group was defined as the female head of each identified household with experience of childbirth. A detailed account of the study design has been published elsewhere (Kempe et al., 2010).

[1] Human Development Index: Yemen rank: 160/186.
Gender Inequality Index: a composite measure reflecting inequality in achievements between women and men in three dimensions: reproductive health, empowerment and the labour market. Yemen measure: 0.747. At the country level, losses due to gender inequality range from 4.5% in the Netherlands to 74.7% in Yemen. The Arab States, together with Sub-Saharan Africa and South Asia, suffer the largest losses due to gender inequality.