Midwifery Care for the Amazigh of Morocco: A Scoping Review of Barriers to Care

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ABSTRACT

Despite improvements in health care services, Morocco continues to experience poor perinatal outcomes in rural and remote regions. In response, a series of initiatives were proposed including strategies to strengthen the profession of midwifery which was identified as a key component. In 2008 a Moroccan framework for midwifery education, regulation, and funding was established. Midwifery care, while highly utilized in urban hospitals, is not accessed as frequently in rural regions. A scoping review examined the social barriers to midwifery uptake using the Arksey and O'Malley's 2005 framework. The socio-cultural context was found to significantly impede the uptake of midwifery care and thus impact maternal and neonatal outcomes. Language barriers, cultural differences, gender inequality and socioeconomic factors were found to be key barriers impacting the acceptability of midwifery care in rural Morocco.

RÉSUMÉ

Malgré l'amélioration des services de soins de santé, le Maroc continue de connaître de mauvaises issues périnatales dans les régions rurales et éloignées. En réaction à ce problème, des initiatives ont été proposées, y compris des stratégies de renforcement de la profession de sage-femme, qui a été déterminée comme étant un volet essentiel. En 2008, un cadre marocain a été établi pour l'enseignement, la réglementation et le financement de la pratique sage-femme. L'accès aux soins des sages-femmes n'est pas aussi fréquent dans les régions rurales que dans les hôpitaux urbains, où les services des membres de la profession sont très utilisés. Un examen de la portée a été réalisé à l'aide du cadre de 2005 d'Arksey et O'Malley afin d'étudier les obstacles sociaux à l'utilisation des services des sages-femmes. On a constaté que le contexte socioculturel nuisait de façon significative à l'adoption des soins des sages-femmes et qu'il avait ainsi une incidence sur les issues maternelles et néonatales. Les barrières linguistiques, les différences culturelles, l'inégalité entre les sexes et des facteurs socioéconomiques se sont révélés les principaux obstacles à l'acceptabilité des soins des sages-femmes dans les régions rurales du Maroc.

KEYWORDS

midwives, midwife, Morocco

BACKGROUND

Morocco is a low-middle-income country in Northwest Africa whose native inhabitants are the Amazigh people (also known as Berber).[1,2] Colonization by Arab, French, and Spanish have had lasting and significant impacts politically, economically, linguistically, and culturally.[2,3] The background of colonialism has contributed to large disparities in health equity despite political efforts to improve access to sexual, reproductive, maternal, and newborn health (SRMNH) care. Political, administrative, judicial, economic, and social systems based on colonial European and Arab influences continue to disadvantage the Amazigh people, who make up the majority of the rural population.[2–4]

National statistics addressing poverty, education, the maternal mortality ratio (MMR), the infant mortality rate (IMR) and child mortality rates show rural and remote communities to be the most disadvantaged with very poor outcomes in these areas. In 2010, the MMR in Morocco was reported as 112–240/100,000 live births, the highest MMR among North African nations.[5,6] The neonatal mortality rate (NMR), IMR and under 5 mortality rates (U5MR) are 21.7, 28.8 and 30.5 per 1000 live births, respectively.[7–9] Rural Moroccan women are attended at birth by midwives or other trained health care personnel at only 55% of births, versus 92.1% in urban areas.[10] Only 60% have at least one prenatal visit vs 91.6% in urban areas, and only 13.3 % have any postnatal visits compared to 30.5% for their urban counterparts.[8,10] The lower rate of care and poorer perinatal outcomes for rural communities is alarming, especially since these data show that this is the case even when midwives are available and accessible in the community.

National strategies to improve outcomes have focused on improving the accessibility and quality of midwifery care in Morocco. This is due to overwhelming evidence that maternal newborn health outcomes are substantially improved by providing a complete package of SRMNH services when provided by midwives.[11–13] Despite governmental support and funding for midwifery care, women in rural settings continue to give birth without a trained midwife. A socio-cultural exploration was needed to address the barriers to midwifery care uptake to improve perinatal outcomes.

METHODOLOGY

A scoping review methodology, as described by Arksey and O'Malley (2005), was used to examine the available evidence.[14] This methodology was utilized because of its ability to examine "key concepts underpinning a research area and the main sources and types of evidence available."[14] The research question identified was: "What social and cultural barriers may impede the uptake of maternity care from trained and publicly funded midwives in rural Morocco?" Articles were gathered by searching electronic databases, including CINAHL and OVID, as well as the World Health Organization (WHO), United Nations Population Fund (UNFPA), International Confederation of Midwives (ICM), and the Moroccan Government websites for grey literature resources. Networks and organizations were contacted, including L'Association Marocaine de Sages Femmes and Association Nationale des Sages Femmes au Maroc.

The initial search produced 1268 results for the broad keywords "Moroc*", "wom*" and "health". A subsequent search, using keywords "Maroc*" and "midw*" generated another 85 sources. Thus, inclusion and exclusion criteria were used to focus the search to relevant studies to address the central research question, these were devised *post hoc*, as familiarity with the topic evolved. Relevant studies were included in English, an exception was made for government literature and personal correspondence, which were translated from French. The evolved themes included a historical examination of midwifery in Morocco, cultural ideology on childbirth, language, and gender biases.

MATERNITY CARE IN MOROCCO

Midwifery care has been integrated into the health care system for over 70 years, and significant efforts have been made to strengthen and expand the profession. A large, organized midwifery workforce is legislated and funded within the Moroccan health care system. Midwifery education is standardized, and a professional association is well established.

The government has funded and supported the expansion of midwifery. Midwives largely provide maternity care in Morocco.

However, before 1950, maternity care in rural and semi-urban areas was provided almost exclusively by traditional birth attendants (TBAs), called *kabla*, the Arabic word for midwife.[15] In 1950, training was instituted for women interested in attending births, who were to be called *moualidates,* an Arabic word with a similar meaning to the French noun *accoucheuer*. This two-year program was the earliest formalized Moroccan midwifery training.[15] TBAs continue to provide maternity care in rural areas. However, due to the increased medicalization of birth at the time, a law was instituted in 1960 that required the *kabla* to report to a medical officer who directed the care of the *kabla.*[15] Between 1963 and 2003, several health care cadres were trained in maternity care, resulting in the *infirmière accoucheuse*, a nurse with one year of training, *CAP en obstétrique*, certificate in obstetrics, *spécialiste en obstétrique*, a nurse-midwife with graduate-level training, and the *sage-femme 'nouveau regime'*, a nurse-midwife with three years of undergraduate level training.[15] Throughout this history, midwives worked as an extension of the medical profession, with medical officers and physicians having the final authority, regardless of whether they were trained in gynecology and obstetrics.[15]

In 1990, the first midwifery association was established, the *Association des Sages-Femmes Marocaines* (AMSF) and became an ICM member at its inception (Harrizi T. Personal correspondance. 2019). AMSF has been active in midwives' recruitment, training, curriculum planning, and career development.[15] The AMSF has also further developed partnerships with non-governmental agencies, international professional associations, and other national associations to strengthen the profession and promote midwifery. Another professional association, l'Association Nationale de Sage Femmes au Maroc, was established in 2011, and is also an ICM member association. The Ministry of Health regulates the profession, and legislation from 1960 was updated in 2016. It details the scope of practice, educational requirements, responsibilities, places of practice, and potential consequences of non-adherence to the legislation.[16] The AMSF advocates for developing an Order of Midwives to establish an autonomous regulatory body (Zalim FO. Personal Correspondance. 2019).

Today, Moroccan midwives have a wide scope of practice and work in multiple settings. The scope of practice for midwives in Morocco includes a full spectrum of SRMNH care from adolescence, preconception, and prenatal care through birth, postpartum to menopause, and for the newborn to the age of 5 years.[17] Midwives have greater autonomy in their practice than previously and are no longer subject to the final authority of the medical officer when conducting routine care.[15,16] Care is provided in various institutional settings, from large university hospitals to small community health centres and birthing houses.[18–24] Most recently, legislation allows for midwives to work in private hospitals and clinics.[17] Most midwives in Morocco are assigned to labour wards or postpartum services rather than continuity of care models of practice.[17] Limitations of midwifery scope is more likely when working in interdisciplinary perinatal care teams in larger centres.[17] In this context, the midwife is often considered a "technician of birth" and an auxiliary to the physician, but the midwives conduct the deliveries.[17] In rural settings, the Moroccan midwife will provide continuity of care in addition to deliveries.[17] However, rural midwives lack support and access to health care resources such as transportation, ambulance, and physician assistance.[17]

UPTAKE OF MIDWIFERY CARE: THE IMPACT OF LANGUAGE AND CULTURAL DIFFERENCES

Global research shows that even when SRMNH care is available from trained midwives, utilization can be impacted by cultural factors.[25] Coast et al., note that culture should not be positioned as a barrier to utilization of maternal health services, but rather, as an attribute of the community that care providers seek to serve.[1] This framing recognizes and respects a community's culture, values, beliefs and traditions and provides space to celebrate differences.[25] In the Moroccan context, language and cultural differences between healthcare providers (HCPs), including midwives, negatively impact maternity service uptake.

Language

Morocco is a multilinguistic country and is ethnically diverse. The main languages are French, Spanish, Modern Standard Arabic (MSA), Moroccan Arabic (*Darija*), and Amazigh languages (often referred to as "Berber" which is considered derogatory).[2,4,21] French, MSA and Spanish, due to the legacy of colonialism, are the languages of government, education and public administration.[2,4,21] The Amazigh languages are a group of ancient languages used by the Indigenous Amazigh tribes of North Africa.[4] the main Amazigh languages in Morocco include Tachelhit in the South, Tamazight in Central Morocco, Tarifit in the Rif region, and at least a dozen others.[21,22] Most women in rural locations speak only Amazigh languages while most midwives speak MSA and/or *Darija*. The variety of languages and dialects impact access and acceptance of midwifery care due to language barriers and the history and values ascribed to the language.

Language barriers in the Moroccan health care system impede access to high-quality care, particularly for Amazigh women. Physicians are often trained abroad, in France and Belgium, and come from the dominant Arabic-speaking population.[2,21] Similarly, pharmacists, nurses and midwives are predominantly Arabic-speaking, urban, and educated in French and MSA.[2,15,19,21,23] A study by Guerch found only 10 of the 70 healthcare workers interviewed spoke an Amazigh language.[2] Most speak Darija, French, and MSA, with some Spanish or English, while working in rural areas where the population is 100% Imazighen speakers or in urban and semi-urban regions with a majority of Imazighen-speaking populations.[2] Only four nurses of the 70 health care professionals interviewed reported receiving training in cultural and linguistic specificities for the communities in which they worked.[2]

Language barriers contribute to low uptake of trained midwifery care. In rural areas, the husband is usually needed to translate the HCP and the parturient.[2,21] In urban and semi-urban regions, a nurse, child, mother, mother-in-law or husband may translate.[2,21] Due to the presence of a third person, many Amazigh women do not disclose aspects of their health due to embarrassment, modesty, illiteracy and lack of knowledge about their bodies.[2,21] Domestic violence, gynecologic concerns and mental health concerns are largely undisclosed.[2,21] Language barriers limit the ability for midwives to build trusting relationships and provide quality maternity care.

Language barriers reduced the ability of rural Amazigh women to disclose personal health concerns, understand health information and make informed decisions.[2] International evidence has documented poor health outcomes are more likely when there are language barriers between HCPs and patients.[32] Language barriers also contribute to negative experiences and perceptions of quality of care.[2,21,25,32]

Culture

The language and cultural barriers in rural settings are exacerbated by a 'forced appointment' policy where Arabic-speaking physicians and midwives are stationed in Amazigh rural and semi-rural region health centres.[2,15,21] Contract appointments are short term with few resources or supports, and have very high turnover rates, leading to a lack of continuity and failure to integrate into the community. The HCP arrives with language barriers and little or no understanding of cultural aspects of the community. Due to their short employment duration, a "revolving door" of HCPs who fail to develop cultural awareness or connection to the community is established. This leads to a lack of trust in trained HCPs, including midwives, and negatively impacts the acceptability and uptake of maternity services.[1–3]

New midwifery graduates lack experience and are routinely posted into rural settings due to the extreme shortages of trained midwives and other HCP.[15,19,24] These new midwives tend to be Arabic, young, with no social connections to the Amazigh community.[15,19,24] As with other HCP, the posts are short-term with a high turnover rate, preventing the development of trust, continuity of care and development of culturally relevant knowledge.[15,19,24] The *kabla*, or local traditional birth attendants (TBAs), are part of the community and tend to be older, have more experience with birth, have intimate knowledge of the cultural and traditional norms, and have the trust and respect of the community.[15,19,24] Thus, rural women choose care

from the untrained TBAs, rather than the trained midwife.[15,19,24,25,28]

Many young Arab Moroccan midwives stationed in rural communities feel lonely away from their families. Additionally, there are few marriage prospects (which is culturally significant) for the young midwives and they desire to leave as soon as possible. Their lack of commitment to the rural community combined with their lack of understanding of Amazigh culture leads to fractured and often hostile relations. Many midwives stationed in rural communities are judgemental and critical of the nomadic Amazigh women who live traditionally. The Amazigh women will avoid the trained midwives and turn to their trusted well-established community TBA midwives for care.[15,19,21,24]

Capelli found that midwives were also not trusted because of perceived alignment to state policies to promote institutional birth and disregard the cultural norms and values of women.[24] Women are required to walk to the health centres for care, sometimes many miles, while the TBA will attend them in their homes. Temmar's analysis of midwifery in Morocco noted the patriarchal and biomedical beliefs about maternity and health "underlie the reasons why home delivery often represents a form of reassuring refuge, especially for the most vulnerable women."[15]

Pregnancy and childbirth represent a significant social and cultural event in people's lives and are strongly influenced by social norms. Dominant cultural norms are embedded in social institutions, such as laws, education and health care and may be beneficial, neutral or detrimental. Cultural factors that impact maternity care include differences in biomedical and traditional childbirth approaches. Cultural differences between HCP and pregnant persons can negatively impact care and lead to avoidance of maternity care.[11,25] HCPs who lack cultural awareness are perceived as culturally insensitive and professionally incompetent and provide low-quality care.[25]

In Morocco, the dominant biomedical culture has strongly influenced midwifery, moving away from traditional practices, knowledge and woman-centred care and toward a medicalized model.[3–5] The health care system is rooted in Arab and biomedical culture and regulated by legal and institutional policies that reduce the ability of midwives to attend to the social, cultural and emotional aspects of maternity care.[15,26] In contrast, many Moroccan women have a health culture that embodies a plurality of Islamic and Amazigh cultural and traditional health.[15,19,24] Several authors have noted influences of the Galenic and Prophetic beliefs on the traditional practices related to pregnancy and childbirth.[19,24,27]

The Galenic approach is based on philosophical notions of balance and natural remedies, emphasising the use of hot and cold and medicinal plants used by traditional herbalists and healers.[24] The Prophetic medicinal approach is based on the ideology that illness is caused by an invasion of the spirit, potentially *jinn*, an Arabian mythical being similar to a spirit, which can be managed through *fiqh*, Islamic jurisprudence, religious ceremonies, religious healers and *fuqaha*, those trained in *figh*.[24,27] In Morocco these concepts are intertwined with biomedical concepts. Women and families rely on heterogenous sources of knowledge to inform their choices, values and interpretations of maternity care.[15,19,24] While the traditional and cultural beliefs and practices may differ, they are not entirely incompatible with evidence-based quality care.[15,19,24] Most Moroccan midwives reject traditional knowledge and cultural practices in favour of a medicalized approach to pregnancy and birth, even if the traditional practices are compatible with 'safe' birthing processes.[24]

The impact of the differences in healthcare views between HCP and the childbearing woman can be mitigated. Temmar notes the challenge for midwives in Morocco is 'creative reconciliation, where the best elements of the medical model are integrated into local knowledge and practices'.[15] In Morocco, some midwives work informally with TBAs.[19,24] This is attributed, in part, to the trust and influence TBAs have with women and their families.[15,19,24] In addition, some midwives will attend women at home if they refuse to attend a facility for birth. In this way, they can mitigate the risks related to unskilled birth attendants.[19,24] However, midwives do so at their own risk, as the current legislation and infrastructure does not support home birth or working with TBAs. And unfortunately, midwives are subject to prosecution under the criminal code.[17]

Thus, the barriers to midwifery uptake are rooted in language and cultural differences from bringing an Arab urban-born and trained midwife into a traditional Amazigh community.

Gender Inequalities

Another factor that needs to be considered on the impact of perinatal outcomes is gender discrimination. Morocco is a patriarchal society and gender inequality is deeply rooted in social and cultural norms. This negatively impacts the agency and choices of Moroccan pregnant people and works against midwives as a female profession.[8,10,15,19,26,31,39,43] Gender discrimination has contributed to the lack of recognition of midwives as trained, autonomous healthcare professionals and undervalued the services they provide, reinforcing a gendered hierarchy in the healthcare system.[15,19,26,31,39] In addition, gender discrimination disadvantages the relationship between women and midwives by eroding the trust needed to contribute to the uptake of SRMNH services provided by midwives.[39] This is through complex mechanisms that involve gender discriminatory laws, policies, institutional practices and social values that limit open communication, uptake of care and often place decision-making in the hands of male family members or physicians.[39] These factors contribute to poorer outcomes for birthing people and their newborns.

Future Directions to Improve Midwifery Care Uptake

To increase the uptake of midwifery, collaborative strategies need to be developed that include community members, parturients, midwives and other HCPs.[29,30] In particular, working with the local TBAs instead of forbidding her to practice would dramatically improve the uptake of trained midwifery care. Strategies to train midwives from Amazigh communities such as scholarships, local placements and other supports should be implemented. In addition, context-specific participatory action plans can improve implementation, adherence and success of strategies to improve SRMNH.[15,25,26,31]

A review of the literature and exploration of international evidence has identified the key factors to improve the uptake of midwifery care. A Cochrane review on the provision and uptake of routine antenatal services concluded that initial and continued use of antenatal care depends on the perception that doing so will be a positive experience.[29] Important aspects of improving the experience for women included continuity of care, and personalized care that is kind, caring, supportive, culturally sensitive, and respectful of the need for privacy.[29] Similarly, in a systematic review evaluating what matters to women during childbirth, a positive experience in a clinically and psychologically safe environment with practical and emotional support, competent, reassuring, kind clinical staff, and desire for physiological labour and birth were found to be most important.[30] "Basing maternity service design and care provision on what women want and need is essential to the uptake of, and continuing access to, service provision."[30]

Language has been identified as an important determinant of uptake of health care services.[25,32] Strategies to bridge language barriers and improve communication are needed to promote the acceptability and uptake of healthcare services in rural Morocco. Strategies may include using professional translators to assist HCPs and women in communication. A preference was noted for professional interpreters over family members, to assist with translation in research conducted by Guerch.[2]

Strategic recruitment and training of community members should be considered to address the cultural acceptability of midwifery care and reduce high turnover rates of staff in rural regions. Potential strategies include prioritizing the recruitment and training of midwives from wider cultural and ethnic backgrounds, including those with knowledge of Imazighen culture and traditions. Recruitment and training of local community members to become HCP may be a sustainable and effective strategy. Ideally, targeted recruitment and training of midwives proficient in Imazighen languages should be promoted. Training community members to become HCPs has the dual benefit of improving communication and cultural acceptability of maternity care services. Training midwives from rural communities who wish to work within their home communities could improve continuity of care and relationship building within rural communities. Training midwives in their own communities may

allow for increased representation of Imazighen, rural and remote midwives, and increased retention in their respective communities.

This strategy has been successful in other regions. For example, a training model has been developed in the Canadian arctic regions of Nunavik and Nunavut to support local Indigenous midwifery education and birth in small remote communities.[34,35] Training needs to be accessible in smaller communities and not just in the capital and other large urban centres. Further exploration is required to identify specific requirements and the effectiveness of such an approach in Morocco.

The development of a model of maternity care in which trained midwives work together with local TBAs may be an effective strategy to increase midwifery care uptake and improve perinatal outcomes. Several studies in Morocco identified midwives working with TBAs although this work was informal and not recognized.[15,19,24] There is evidence that TBAs influence sexual and reproductive health choices and the practices.[15,19,25,26] The WHO emphasises the importance of building links with TBAs and finding new roles so that they can continue to support women during pregnancy, birth and in the postpartum and provide a culturally appropriate link to formal health care services.[25] TBAs can be a resource to midwives in the community and provide perinatal education, act as health care advocates, assist in health promotion, provide linguistic and cultural interpretation, and assist in aspects of health care and birth.[25,36]

Where programs have been implemented to promote the collaboration of midwives and TBAs, women and their families preferred them, and antenatal care was perceived to be better than when such collaboration was lacking.[25,29,36] This is especially the case where the local community leaders initiated the use of TBAs in partnership with midwives and endorsed by local healthcare systems.[36] In remote areas, TBAs outnumber midwives, are closer geographically, socially, culturally and linguistically and can bridge gaps in care and cultural competence.[36] The strategy of TBAs and midwives cooperating in Morocco has been implemented informally in rural regions in various ways, and evidence from these areas could guide future initiatives. Institutional barriers to collaboration and support from TBAs should also be removed to facilitate cooperation. The critical factor that will determine the success of any strategy, is the involvement of the childbearing people within the various communities to identify barriers, strategies, facilitate research and project planning for increased uptake of the midwifery care.[26,31]

A final strategy to increase the acceptability of midwives is to address the curriculum in Midwifery Education Programs (MEPs). Midwifery education needs to include cultural competency and traditional practices to reduce discrimination and enhance care for rural Amazigh communities. In addition, MEPs should address formal training for midwives to work with TBAs.

LIMITATIONS OF THE SCOPING REVIEW

Limitations include a lack of research on Moroccan midwifery, poor data on perinatal outcomes and a lack of information on rural women's experiences of maternity care. In addition, professional translation services were not possible, limiting the reviewed literature to English, except for the 2016 legislation regulating midwifery and some correspondence which was translated using Google Translate.

CONCLUSION

Midwifery care should be available, accessible, and acceptable and provide quality services to meet women and newborns' and their home communities' healthcare needs.[18] In Morocco, government strategies have focused on improving the availability and quality of services through funding, healthcare infrastructure, and professional midwifery education.[6,8,15] While these strategies must be applauded, further measures are needed to improve the uptake of midwifery care and, thus, perinatal outcomes. Acceptable midwifery care needs to be sensitive and responsive to the social, cultural, and linguistic needs of individuals, families, and their communities.[18–30]

This information should inform and guide the planning and implementation of culturally appropriate strategies with input from a range of stakeholders, including parturients, their families, midwives, other HCPs, and healthcare administrators.[31–42] Research has shown that parturients and newborns benefit from midwifery

care. However, to improve midwifery care uptake, parturient preferences must also be considered in health care service planning. Developments and improvements to increase the uptake of midwifery services must incorporate the social and cultural factors that influence the acceptability and uptake of midwifery care.

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