

RÉPUBLIQUE OF NIGER
MINISTRY OF RURAL DEVELOPMENT

ANNUAL 430
1AN 14352
USAID
NIGER

Contract No AID-683-o2o2-S-oo-2o23-oo
Niger Range and Livestock Project
No 683-o2o2
Consulting Services Report

MOTHER AND CHILD CARE
IN THE PASTORAL ZONE :
PROPOSALS

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Rapport préliminaire - Discussion paper

October 1982

Projet Gestion des Pâturages
et Elevage

Niger Range and
Livestock Project

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PROGRAMME

Introduction

The lack of traditional birth attendants ("matrones") among pastoral populations in Niger raises the problem of how to address mother and child care needs. The National Primary Health Care Programme (Auto-encadrement sanitaire) as implemented in the villages, cannot be extended to cover the pastoral zone unless it is modified. It is inadvisable to graft birth attendant training programmes onto societies where there is no tradition of them and this approach is very likely to result in failure.

After a brief analysis of the current situation, the general guidelines for an MCC programme are set out, adapted to the specific features of this region of Niger. It is hoped that they may provide food for thought and that, taken together with experiments in the field, they may lead to the development of a national programme adapted to the pastoral zone.

1. Maternal and child care (MCC)

At present the health services aim to cater for the needs of women and small children chiefly through the activities of maternal and child care (MCC) and the traditional birth attendants.

1.1 Maternal and child care units (MCC)

Most dispensaries usually set aside two half-days per week for MCC curative and preventive activities. These consist of pre-natal consultations with a view to detecting complications of pregnancy, and consultations for infants, at which the children are weighed and advice is given to the mothers. Some nurses organise health and nutrition consultations with demonstrations on how to prepare baby food and a properly balanced diet. Home visits are also made, usually by an "aide assistante" or the social worker in large population centres.

Since 1982 the dispensaries at Tchik Tabaraden and Abalak have carried out a certain number of vaccinations in their respective localities within the context of MCC. A limited number of vaccinations (measles and DPT) have been given to children aged 6 months to 3 years at clinics held on Saturdays. The medical post is equipped with a refrigerator. Unfortunately this programme was very quickly abandoned owing to the lack of available vaccine.

The regular implementation and success of these activities naturally depends on the competence and dynamism of the nurse in charge. Some MCC units function well while others are seldom visited by the women at all.

In the area covered by the project, there are two maternal units, one at Agadez and the other at Tchik Tabaraden. Each unit has a midwife ("sage-femme") or midwives (Agadez).

In the pastoral zone, language is a serious problem. Of the 18 male and female nurses and 3 health auxiliaries in service within the area covered by the project, only 3 speak Tamasheq. However, in the MCC context, the ability to speak Tamasheq

and Fulfulde, which are the languages used by the herders, is an essential requirement. There is also the fact that the number of nurses is small and in many dispensaries the nurse is forced to provide maternal and child care himself or herself.

Women are infinitely preferable for this type of work. The fact of being a man is only an additional obstacle which has to be overcome.

1.2 Birth attendants ("matrones")

In Niger, the National Primary Health Care Programme is based on the concept of the village health team (VHT). "A village health team is a health unit in the village consisting of at least two health auxiliaries ("secouristes") and two birth attendants" ("matrones").*

The birth attendant is "a traditional midwife ("accoucheuse") of mature years, born in the village, working on a voluntary basis, chosen and accepted by the people. She is trained to:

- detect pregnancy
- monitor pregnancy
- provide care to the mother and new-born infant
- refer pregnancies at risk
- provide advice about hygiene
- promote health education
- provide nutritional guidance
- provide information on family planning
- provide information on problems related to infertility."*

The training and subsequent supervision of the birth attendants is usually carried out by the nurse at the dispensary to which he or she is attached or by the trained midwife ("sage-femme"), if there is one.

In the pastoral zone, and especially in the area covered by the project, a number of birth attendants have been trained, but most of them live in the villages.

* Auto-Encadrement Sanitaire, "Méthodes de formation des agents de santé de village", (National Primary Health Care Programme, "Methods of Training Village Health Workers"), Republic of Niger, 1980.

Of the 25 birth attendants trained in the area covered by the project, only 2 live in the bush (in a camp of Twareg agro-pastoralists north of Kao).

Traditional habits still largely prevail and most women give birth at home. In 1981 for instance, the 3 birth attendants ("matrones") in the In Gall area helped with 240 deliveries, while 32 deliveries took place at the dispensary. Whereas the birth attendants play a far from negligible role in the larger population centres as regards the supervision of deliveries, their influence is only felt in the area where they are resident and does not reach as far as the surrounding pastoral population.

MCC activities and the activities of the birth attendants are concentrated in those places covered by the project which have a dispensary and do not therefore cover the herders. There are serious limitations as regards the expansion of this kind of activity with respect to the pastoral population, stemming from the lack of female staff, linguistic differences and the rare occasions when women coming from the bush meet nursing staff. Indeed, the women journey to market less than the men. A clear distinction should, furthermore, be drawn in this respect between the Wodaabe and the Twareg. The Wodaabe occasionally go to market accompanied only by their new-born infant. It is rare for a child of 3-4 years old to go to market. In traditional Twareg society, and especially among the imageren (nobles), ineslemen (marabout) and imrad (vassals) tribes, women very seldom, if ever, go to market. This activity is limited almost exclusively to the wives of blacksmiths (inaden) and former servants (eklan). Contacts with the health services are therefore rare and if a Twareg woman comes for a consultation, she comes accompanied by her husband.

If the pastoral population are to benefit from health care, and women are to have access to it, the services must be taken out of the population centres and a programme will have to be designed which takes account of the prevailing customs and practices in this society.

* Source : Quarterly reports from the medical station at In Gall, 1981.

2. The activities of women in pastoral areas

In the Fulani and Twareg pastoral societies, the woman plays an essential role in the life of the settlement. In addition to her tasks as wife and mother, the woman provides manpower essential for the functioning of the family unit. It is she who is responsible for the home, for preparing meals and looking after the children. She supplies the camp with water and sees to it that young animals unable to make the journey to a distant well have enough to drink. She is also responsible for grazing and watering the herd when her husband is away or ill.

When she marries, it is she who provides the bed, the tent and the utensils which remain her property and which she takes with her if she is repudiated or decides to leave her husband. She also owns animals, which are looked after by her husband with the rest of the herd.

Naturally, there are considerable differences between the boDaaDo (singular of Wodaabe) woman and the Twareg woman. In Twareg society too, the woman engages in different activities and has different responsibilities if she is of imajeren or eklan stock. Among the Wodaabe the woman herself milks the cows which belong to her or which her husband gives her to look after. It is she who decides the portions of food due to the men, herself and the children. This also applies to the milk, a portion of which is hers for preparing the butter or exchanging it for cereals or selling it at market. The barter engaged in by the women when there is sufficient milk enables some families to achieve self-sufficiency without having to buy cereals in the markets, from the rainy season to the cold season (December - January). Her role in the family economy is thus extremely important.

The housekeeping responsibilities and the availability of the woman for work vary in accordance with many factors : the size of the family, the age of the children, the distance of the settlement from a water source, the frequency of moves, the quantity of milk available, etc.

The dry season is the hardest time for most herders. The women's tasks increase in number, considerable time being spent pounding millet and on long trips to the well.

The boDaaDo woman enjoys a certain amount of freedom. She is neither in purdah nor veiled. She greets visitors herself and brings them food; she goes to the market or sometimes leaves her husband for several days to visit her family. Although she does not take part in the men's discussions and decisions, she is nevertheless informed of them and has a definite influence on the running of the camp.

It is more difficult to sum up the activities of the Twareg woman. The life she leads differs greatly according to whether she belongs to a wealthy branch of Twareg society with servants, whether she is the wife of a blacksmith or whether she is of iklan stock.

Traditionally, imajeren women especially but also ineslemen and imrad owned slaves or servants who performed the heavy tasks such as pounding millet, fetching water or striking camp. After the abolition of slavery, some servants left their masters to become herders in their own right. Others stayed on and carry out the same tasks as they always have done, in return for food, accommodation and a small wage.

The woman who has servants leads an active social life, meeting the women from neighbouring camps, engaging in handicrafts (making utility objects from leather) and musical activities. Incidentally, in many Twareg tribes music not only provides entertainment but is also used for medical purposes. Amzad (a single-stringed violin) or tende (drum) performances are organised to bring relief and heal certain types of illnesses.

In the evening, when lively discussions develop between the men, women take an active part and are not excluded.

The housewife supervises all the household activities. It is she who places the spoons on the dish and pours the milk into the vessels before taking the food to her husband who serves it. The children eat after the adults, taking what is left on the plates.

However, most Tamasheq women have no servants and are forced to do the domestic chores themselves. Their life is thus harder. However, the men do some of the household tasks. They milk the animals and it is not a rare sight to see a man pounding millet. The women play an important economic role by virtue of the animals they own, by bartering or the profit they make from selling cheese, milk or handicraft goods on the market.

In the inislemen (marabou) tribes, the women are more confined to their tents and when they go out, wrap themselves in a mat to hide from the eyes of strangers. As a rule Tamasheq women do not wear the veil.

Unlike the Wodaabe, the Twareg woman does not appear when a stranger calls. She remains at a distance and it is the men who receive the visitor.

It is therefore clearly dangerous to over-generalise and lose sight of the importance of individuals.

Government services and development projects frequently concentrate on men and the proposed actions do not take women into consideration. There is therefore the danger that their economic role may be reduced, which may have repercussions when one considers the size of the contribution made by barter or the sale of dairy products. The impoverishment of the special resources of women could have repercussions on the nutritional status of the children, since part of the profit women make often goes towards the purchase of additional food for the children.

The ILP project must ensure that this aspect of development is not neglected. It could be made to include women via the women's action programme, proposed in the sphere of public health.

3. Towards an MCC programme adapted to the pastoral zone

3.1 Traditional practices

Among the Twareg and Wodaabe there are no traditional birth attendants ("matrones"). On the occasion of her first pregnancy, the woman leaves her husband's camp and returns to her family, where she gives birth, assisted by her mother or sisters. Subsequent pregnancies generally take place in the husband's camp, although in many cases the woman returns to her mother. In some large Twareg camps, certain experienced women help with most deliveries, but as a general rule there are no birth attendants. After one or two deliveries, in which they are assisted by their mothers, women in the pastoral zone quite often give birth with no assistance from anyone. They continue their daily activities until pregnancy reaches its term, so that it is not unusual for a woman to give birth when the group is on the move or while on the way to market. This independence seems particularly appropriate in societies where the members of one clan may be scattered over wide areas. It would be ill-advised to be dependent on the help and know-how of a handful of women experts in view of the small likelihood of their being present at the moment of birth. It is essential that this situation is kept in mind and that the national birth attendant training programme is tailored accordingly.

3.2 Objectives

In view of the absence of traditional birth attendants in the pastoral zone, the national primary health care programme approach adopted in the villages must be modified. Moreover, the efforts undertaken along traditional lines at Tchín Tabaraden for example, proved ineffective. The candidates did not register for training.

The general aim of the programme will not be to train a handful of qualified birth attendants who will then be under-employed, owing to the dispersal of the population. On the contrary, every possible effort will be made to ensure that the know-how and skills taught are passed on, so that a large number of women

can benefit. It is more important that activities such as the MCC should be adapted to the realities of the pastoral zone, rather than the training of birth attendants.

Naturally, the objectives laid down by the National Primary Health Care Programme still remain valid (Auto-encadrement sanitaire, 1980). However, although the latter represent the long-term aims, the area for action should be limited at the outset. It seems too much to attempt to cover pregnancy, delivery, care for the new-born, nutrition and hygiene all at once.

The women's education programme in question should concentrate on one single topic which coincides with the wishes and needs of the women concerned, for example, acceptable standards of hygiene for childbirth. The various aspects of childbirth would be discussed, including personal hygiene, the importance of breathing, synchronisation of bearing down with contractions, ligation and disinfecting of the umbilical cord, the cleanliness of the place where the mother gives birth, the use of a clean mat, observation of the placenta after delivery of the child, cleansing of mother and infant and toilet thereafter.

The approach should always be based on traditional practices, reinforcing the positive aspects and suggesting alternatives to those practices which are unsuitable. The basis for the success of a programme of this kind is winning the confidence of the women, and this is achieved by recognising the validity of most of the current practices and attitudes.

The National Primary Health Care Programme is based on the participation of the rural population, which means that those concerned assume responsibility for their own health care.

The traditional practices and concepts of the population concerned are used and applied daily. They are this society's way of assuming responsibility for the health care it developed long before the advent of the health services. The National Primary Health Care Programme, supported by the health services, therefore has no chance of succeeding unless the traditional practices and concepts are respected and integrated. It is only in the second stage that those practices and concepts which prove unsuitable can be adapted.

For example, the diet of the pregnant woman in Tamasheq society is of great importance. The greater part of what is traditionally recommended has some justification and can serve as the basis for discussions aimed at reaching a better understanding of the nutritive value of the various foods and for promoting alternative balanced foods, when the supply of milk runs out, for instance.

3.3 Which women should be contacted and how is this to be achieved?

The potential obstacles to a programme of this kind are far from negligible. A start should therefore be made in those areas where the chances of success are greatest. The pastoral associations provide an ideal setting, because the community in question is clearly defined and contacts with the government services (including the health service via the health auxiliaries ("secouristes")) are more developed. The camps of the important tribal chiefs will also be contacted in order to secure their participation and cooperation. Subsequently it will be possible to include other tribes and lineages within this programme, according to the amount of interest shown in it by the herders.

In our view, the interest and the need already exist. They have not been expressed because no solution suited to the herders' way of life has yet been proposed. It is out of the question for the herders to attend the dispensary for a delivery or for a prenatal consultation.

Initially, meetings will be held in camps in the bush, in order to reach as many of the women as possible and to show the men the usefulness of this training. Subsequently, it is quite possible that some women, who are more competent and more interested than others, may be designated to undergo more intensive training. The training will, furthermore, be designed to train group leaders ("animatrices"), or relay-women ("femmes-relais"), able to pass on the teaching and the new techniques they have learned.

3.4 Training

The topics proposed by the National Primary Health Care Programme constitute the basis of the teaching. They should be adapted and above all should be few in number. Days of instruction in

the bush will not make it possible to cover all the topics. It would be preferable to reduce the scope of the programme and concentrate training on the areas the women are interested in. In this connection, infertility is a serious problem in some pastoral societies. The fertility rate in these societies is lower than that observed in sedentary populations. The cause or causes are not fully understood. It may be that social factors play an important role (prolonged post-natal abstinence), although certain diseases causing secondary sterility or miscarriages may also be the cause (gonorrhoea, syphilis, tuberculosis, rickettsiosis, toxoplasmosis, etc.) (M.A. Belsey, 1976). The fact remains that childlessness is seen as a great misfortune, and is often a cause of divorce. The women are therefore very alive to this problem, whose consequences affect themselves first and foremost. Useful work could be undertaken, in conjunction with epidemiological surveys, for example, to encourage women whose husbands are suffering from urethritis to undergo treatment.

The "Guide de formation des Matrones" (Birth Attendant Training Guide), published by the Ministry of Health in 1982, should include a supplement to adapt it for use in the pastoral zone.

Instruction should take place during a season when the women are available, for instance in the period between the rainy and the cold seasons. Furthermore, it is not advisable to teach Wodaabe and Tamasheq together at the outset.

It is important for the women to have access to certain medicines, such as chloroquine for new-born infants and pregnant women during the rainy season, mercurochrome to disinfect the umbilical cord, ferrous sulphate if anaemia is common in women with a lot of children. These can be distributed by the health auxiliary, although it would be preferable if all the women were supplied with small bottles of mercurochrome and cotton wool when receiving instruction or if some women who had assumed responsibility themselves distributed the drugs suggested later.

3.5 Supervision

Supervision is based on the same principles as for the health auxiliaries, that is to say using the markets to cover the women who go there and visits in the bush every three months by the nurse responsible for the primary health care programme within each dispensary.

3.6 Support for the programme

Ideally, the basis for a female education programme of this kind should be female nurses with a knowledge of the local languages. The reality is far from this. The nurse in charge of the health auxiliaries at each dispensary will therefore be made responsible for it. The nurse will be assisted by a male interpreter (no female interpreters being available), and if possible, by a female instructor ("animatrice") from the health education service. The lack of female staff able to speak the local languages clearly creates a serious obstacle. It is therefore essential that the few nurses who speak Fulfulde or Tamasheq are assigned to the pastoral zone and that relay-women able to speak both a local language and Hawsa are identified without delay and trained to provide an acceptable channel of communication between the herders and the nurses. The nurses in charge of this programme will receive additional training in instruction techniques and matters related to the herders, which will be reorganised by the ILP project each year. The person in charge of the primary health care programme part of the project will be responsible for coordinating these activities with those undertaken in the context of the pastoral associations and also for training the existing nurses in close cooperation with the "DDS" (Departmental Health Office).

Financing should be the responsibility of the Rural Health Improvement Project, which provides all training for health auxiliaries and birth attendants within the area covered by the ILP project. The ILP project will provide training support and vehicles.

4. Conclusion

In Niger, the National Primary Health Care Programme is based on the concept of village health teams (VHT). A VHT consists of health auxiliaries and birth attendants ("matrones"). In the pastoral societies of Niger there are no traditional birth attendants. Therefore, if the National Primary Health Care Programme is to provide a certain amount of maternal and child health cover, a different approach will have to be used from that which has been adopted in the villages, where traditionally it is the birth attendants who carry it out.

In this region of Niger, where the pastoral populations are dispersed and mobile, the aim of an adapted maternal and child care programme should be to disseminate the proposed new knowledge and practices as widely as possible, so that the women can obtain the benefit of them while retaining their independence and self-sufficiency. In view of the conditions of isolation which often prevail it is essential that every woman should be able to apply what she has learned herself without being obliged to turn to a third person, a midwife, who is very likely not to be there when needed.

The proposed programme is chiefly based on the pastoral associations concentrating in the initial phase on "séances d'animation" organised in the bush and bringing together the women from the surrounding camps. The training programme will be organised on the basis of the interests of the women concerned. Starting with traditional practices still in use, it will concentrate on a precise and limited field with practical implications (delivery in hygienic conditions, care of the newborn infants, breast feeding, etc.).

Subsequently, women who show the most interest and competence will be able to undergo more complete training at the dispensary, organised in such a way that these "relay women" can teach the others who have remained behind in the bush.

This type of programme is hampered by lack of nursing staff able to speak the local languages and lack of knowledge of the practices in use in pastoral societies. Additional training

courses for nurses in the field should therefore be organised by the project, to familiarise them with teaching techniques and give them a better knowledge of the herders. The linguistic barrier should be overcome by means of the teaching programme ("animation") and above all by training women able to speak Hausa and a local language to act as intermediaries with the wives of the herders.

The proposed programme should remain flexible and seek the solutions best suited to the situations encountered.

Traditional practices among a Twareg group

The practices and attitudes reported here stem from repeated conversations with Twareg women who have had several pregnancies. A questionnaire covering all the topics dealt with was drawn up and commented on in detail with the discussion leader, himself a Twareg, before the start of the investigation.

The information collected at meetings in the camps was reported in writing by the discussion leader. Traditional practices vary from group to group and from region to region. It is therefore dangerous to use the attitudes reported from one particular group as a basis for generalisations about all of them. In this case the group in question are the 'Twareg Ayt Awari, who belong to a marabout tribe, inislimen, living mainly in the area of Tchén Tabaraden, north of Tahoua.

Fertility

It is in the few days following her monthly periods that the woman is fertile. At that time her "intestines" are red and ready to receive the child.

The child, which comes from the father's sperm, develops in the part of the mother's stomach called igila. The child, is pictured as being seated, its arms and legs tucked under it and covered in the issilisa, the foetal membrane. The placenta, shimeden, serves to protect it. It is "the child's clothing". Some time before the birth the child turns around and positions itself with its head pointing downwards.

The child is fed by what its mother eats. The first spoonful is reserved for the child. Other people believe that the child feeds on the foetal liquids, imadadan, or on some special food.

Pregnancy

2.1 The periods

Pregnancy lasts from 9 to 10 lunar months. It is recognised by the absence of periods and by the following changes in the pregnant woman : her look becomes more intense, her breasts swell

and grow darker, her personality changes; the woman becomes childlike, delicate, timid, tired, and unable to bear thirst and hunger. She tends to lose interest in her husband. She also develops a taste for red ochre, and the earth from termite nests or wasp nests, which are fertility symbols.

For the Twareg, a pregnant woman has one foot in this world and one in the next, in so far as she is exposed to death.

First trimester :

The first months are characterised by the appearance of the shiniten. These are the fits of nausea, vomiting and headaches associated with the start of pregnancy.

Second trimester :

This is when the imitikwien, the first movements of the child, commence.

Third trimester :

Towards the seventh month the imitikwien cease and become real movements. A girl moves more than a boy; the stomach expands sideward and the baby is situated on the right. A boy pushes the belly forwards and is positioned on the left. The longer the period of pregnancy, the greater is the woman's feeling of hunger in the upper stomach. She also experiences palpitations and frequently needs to urinate even though sometimes producing only a few drops. This stage is also characterised by the onset of abdominal cramps, talawet, and by the first contractions.

If the birth occurs between the 7th and 9th months of pregnancy, the risk that the new-born infant may die is high.

Ninth and tenth months :

This is when the delivery, issihi, takes place.

Rules of conduct

In the sixth month of pregnancy the woman returns to the home of her parents. If possible, she will return to her family each time she is pregnant; but very often she only leaves her husband's camp on the occasion of her first pregnancy and sometimes for the second and third deliveries.

During pregnancy the woman is helped and advised by her mother, her grandmother, her sister or a close relative - her mother-in-law, perhaps, or her sisters-in-law.

Whereas meat, milk and millet are recommended foods, salty or fatty dishes, tea and very sour milk are considered inadvisable, not to say forbidden. A proper diet has to be followed to avoid catching anagho.

The expectant mother should avoid walking on hot sand, going out in the midday heat and doing very heavy jobs. However, she should maintain a certain amount of activity, taking walks morning and evening. Very often women are forced to continue their daily household activities until shortly before the delivery. A pregnant woman should not be frightened or violently treated, tikma, as this could induce a miscarriage.

Complications of pregnancy

- shiniten : fits of nausea, vomiting, loss of appetite, headaches, dizzy spells at the onset or sometimes in the final stages of pregnancy. A woman who has a lot of shiniten has fewer colics, talawet, in the final stages of pregnancy.
- tagnot : digestive disorders, gastritis.
treatment : washing, application of herbal p^otions, drinking animal urine.
- ezzaz : osteo-articular pains induced by the warm sand.
treatment : eating onions, ground millet with onions and teyst leaves (Cadaba glandulosa), water containing black soap or sugar.
- tikma : ill-treatment of a pregnant woman, such as beating her, making her run, etc.
treatment : eating pounded millet to which has been added red ochre (temezget), alol (grain of Andropogon gayanus) and tazaqk (Salvadora persica) Slitting open an animal's stomach and showing the entrails to the pregnant woman.
- tirimeqk : fear caused by the anticipation or the announcement of bad news.
treatment : identical to that for tikma.
- ashushif : miscarriage - a miscarriage is regarded as being when the foetus or the child is born before the seventh month

of pregnancy. It can be caused by extreme fright, the announcement of bad news, severe illness, eating salt, tea or hot* food, seeing food one has longer for, turmak.

3. Delivery, issihi

3.1 Assistance

When she has returned to her family, the woman who is to give birth is most often assisted by her mother or sister or, failing that, by a close relative. As the results of a survey conducted in 6 Twareg families show : out of a total of 20 births, it is the mother of the woman in childbirth who helps her in 6 cases and her sister in 13 cases. When she remains in her husband's camp she can be helped by her female in-laws.

3.2 Location

The delivery takes place in a tent. Children are kept at a distance in order not to disturb the woman giving birth.

3.3 Delivery

After the onset of contractions, a marabout is summoned to recite some verses from the Koran to facilitate and speed up the birth. A normal birth lasts less than 24 hours from the onset of labour pains, talawet. The actual birth itself takes no more than a few moments and the delivery takes place less than an hour later. The woman is laid out on the sand, surrounded and hidden from the eyes of curious onlookers by a mat, shitik. She is laid on her side, changing from one side to the other alternately, her lower limbs held tight together and stretched out straight. When the contractions grow stronger and the birth draws near, she bends her knees. The new-born child is received by one of the assistants and then placed on a cloth laid on the ground. A few moments after birth, the umbilical cord, abutu or azar is severed with a razorblade or knife, usually by an old woman as the younger women are afraid of this job. Severing of the umbilical

* For the Twareg, food is either "hot" or "cold". There are also hot and cold illnesses, events, etc. To conserve good health a balance must be maintained between these two poles. In general, a cold ailment is treated with a hot medicine and vice-versa. Pregnancy is a hot phenomenon so that hot foods are forbidden.

cord takes place before delivery of the placenta, shimeden. No ligature is made. The umbilical cord bleeds a little and then dries up. In most cases no plaster is applied but sometimes a little sand is strewn on it. Normally the mother bleeds for less than half an hour. If a woman bleeds heavily, some people think that the following delivery will be less painful.

After delivery, the placenta is carefully buried in the tent where the birth took place or else in the bush, far from the camp.

3.4 Complications in childbirth

- aghashed n'barar : literally "damaging the child".
What is meant by this is dystocia or prolonged delivery. When this occurs in certain tribes in the west, two women hold the mother-to-be by the shoulders and make her run. Another method consists of making her drink water containing ink from verses of the Koran. Sometimes experienced women endeavour to position the child's head in such a way that the birth will be easier, by introducing a hand into the mother's uterus.
- shighalen : (haemorrhage of the post-partum). When the haemorrhage goes on too long (more than half an hour), the treatment provided is to wash the woman in cold water.
- abus : (infection of the post-partum). This is an internal injury sometimes with suppuration and loss of blood in the area of the genital organs, accompanied by a pain in the lower stomach, fever, headaches and loss of weight.
treatment : heat and drink urine from a castrated camel.
- miknud : anatomical deformities of the child.
treatment : recital of verses from the Koran.
- tamatant n'barar dagh tadist : "death of the child in the stomach".
treatment : recital of verses from the Koran.
- akiriki : fainting of the woman during labour.
treatment : her helpers sprinkle her with cold water.

If a woman dies in labour she goes to paradise, aljanet. At present few women are evacuated to the dispensary when serious complications arise (dystocia, haemorrhage). When this does occur, the decision is taken by the women helping and by the husband.

3.5 The post-partum

In the week following the delivery, the mother remains in the tent. On the seventh day, when the child's naming ceremony takes place, she once again starts to leave the tent. She is then free to return to her husband. However, as a rule and especially as regards the first delivery, the new mother stays with her family for 40 days or even longer. This period spent away from her husband is called the amzur. The amzur is characterised by the persistence of serosanguinous discharge and the absence of periods. Throughout this time, the woman ceases to pray and has to follow certain rules of conduct.

She eats a rich diet consisting of fresh milk, meat, millet balls and sour milk. She is spared heavy tasks such as pounding millet. During this period, the woman can neither touch nor drink water. She cannot wash until the end of the amzur. She should not expose herself to the sun nor walk on hot sand. When the discharge ceases, the amzur is approaching its end and the woman can return home. It is the husband who decides which day she will return to his camp. He then undertakes the izizlay, the preparations announcing the return of his wife. He buys her fine clothes, perfume, henna and tobacco. His wife washes, beautifies herself with makeup and puts on the new clothes before returning to her husband.

From then on she is permitted to receive her husband in her bed, for the first time since the birth.

Now that the amzur is over, she can once more pray.

If the birth occurs at the time of the transhumance, it does not interrupt the herders' moves.

4. The new-born infant

4.1 Care of the new-born infant

When it is born, the infant is congested, ihididiy. After a short time, the infant is therefore washed in cold water to reduce this congestion, wipe away the vernix and make it clean. Its nose is held to clear the nostrils and shape it so that it

will be long and straight. Its body and head are massaged to get rid of any deformities. The new-born infant must sneeze, otherwise it runs the risk of being deaf, amzag.

When all of this has been done, the infant is put beside its mother. A knife is placed on its northern side to keep away the aljenen, the "devils" and their evil works.

The child stays with the mother night and day. She carries it on her back while going about her household chores. During the midday heat, the child is placed in a little cradle/hammock, eghawa or esakensak, hung from the tent posts, where it is gently rocked by means of a string.

If the mother dies, the new-born child is taken care of by her maternal grandmother. An aunt or close relative on the mother's or the father's side may also take charge of the child.

4.2 Feeding the new-born infant

During its first 12 hours, the infant drinks nothing. However, some women follow the practice of ewet nangha : when the child is only a few hours old they give it a little milk to drink.

12 hours after the birth, the child is put onto its mother's breast. Any earlier than this and he might become greedy, which is bad manners. When the mother does not have enough milk the first few days, the new-born child is given the milk of another woman who is nursing.

Other foodstuffs are introduced at five months. It is not considered a good idea to start earlier. It can give rise to various ailments. Although the child is still being breast-fed at this age, it starts to receive "heavy" food such as millet paste and meat. Millet is considered preferable to sorghum. Cow's milk and then goat's milk are introduced at a later stage.

If, on the other hand, the child can no longer be breast-fed, owing to the death of its mother or because she has not enough milk, the child is given "light" foods; in particular goat milk, as goats can be milked at any time of day. At one year old, the child eats with the rest of the family.

4.3 Breast-feeding

The nursing mother is encouraged to observe a rich diet consisting of fresh milk, meat and tida, balls of millet with sour milk. The water is drunk from a different receptacle, since eating millet paste with water causes tinismut, a cold sickness. Lactation can be stimulated by eating "niebe" (a leguminous plant) in the form of a paste. When the mother falls ill, she continues to breast-feed her child if the ailment does not affect her breasts. If the woman has a breast ailment, another woman nurses the child. The woman chosen as her substitute must have a legitimate father and have no illegitimate children. Her milk must not exhibit any simiya, a blackish, fatty secretion which is fatal to the child.

Furthermore, two children of different mothers who have suckled at the same breast and drunk the same milk can never marry, as it is said that "they have tasted one another", iniramen or that "they have suckled one another", niminkassan.

The complications of breast-feeding are:

- tissisfirt : when excess milk is produced, not all of it can pass through the nipple, becoming blocked by small clots.
The breast swells and sometimes exhibits a purulent discharge.
treatment : remove the clots by manually milking the breast or by getting an older child to suckle.
- attagka : a painful skin rash and then a sore around the nipple, occurring in women with little milk.
treatment : cease breast-feeding.
- azaba : a red patch, gradually spreading, sometimes to the point where it destroys the breast. This ailment is caused by lack of personal hygiene.
treatment : cover the breast with red ochre, tamazget, mixed with water and milk.

4.4 Weaning

Breast-feeding can continue for as long as three years, unless the mother becomes pregnant again. In that case, weaning occurs when she is in her fifth month or thereabouts. The milk of an expectant mother is called lehu. It causes diarrhoea, sickness

and retards the growth of the child who drinks it. Furthermore, if the child continues to suckle, the future baby is in danger of not having enough milk from its mother.

The decision to wean the child is taken by the woman herself or on the advice of her mother or husband. Weaning, ikus daa fifan, generally takes place gradually by preventing the child suckling one of the breasts. For rapid weaning, the woman covers the nipple in red pepper, tobacco, henna or cow dung to discourage the child. Sometimes she entrusts the child to her mother until it has forgotten about breast-feeding.

I should like to express my gratitude to Mr. Mohamedoun Abdourabahi, who patiently gathered this information and kindly passed it on to me.

Traditional practices among the Wodaabe

This material was collected during conversations with Wodaabe women from the Tchín Tabaraden and Filingué districts ("arrondissements"). The author has done his best to transcribe the practices as they were related to him in order to provide a better understanding of the customs and concepts of the Wodaabe.

Pregnancy

For the Wodaabe, pregnancy lasts 10 lunar months. The child is sometimes born earlier. If it is born at seven months, which is extremely rare, it is so small that it cannot be carried on its mother's back. It is placed in a calabash. There is no subdivision of pregnancy into distinct periods. The Wodaabe recognise certain peculiarities in the pregnant woman, such as vomiting at the onset of pregnancy (pepere), moodiness, the desire to eat certain plants or earth from termite nests, which are a fertility symbol. The skin of the pregnant woman is redder and a slight swelling can be observed at the root of the nose. Her urine is less plentiful. According to some women, she should not eat meat or sweet things, nor should she drink tea, as this would be harmful to the child. Other women believe that the pregnant woman can eat anything she chooses, including salt.

Without being aware of the exact position of the child in its mother's belly, they believe that it turns until its head is pointing downwards at birth.

Some women do not recognise complications of pregnancy at all; others point out that, if the ankles swell, it is the fault of the woman for not doing what she should have during previous pregnancies. There is no known treatment for this. In cases of haemorrhage, the old women recite verses (ayaare); they do not know the cause of this ailment.

In the fifth month of her first pregnancy, the boDaaDo woman returns to her mother's. She remains there for a year or more, sometimes even until the child is weaned. During this period

she is referred to as boffiDo. Her mother gives her a long necklace containing many talismans. It is during this long period away from her husband that the mother learns to care for her child.

During subsequent pregnancies, the woman remains with her husband, although some women return to their mothers, taking with them their small children, for the confinement and delivery.

Confinement and delivery

Whereas the woman is assisted the first time by her mother, she subsequently gives birth alone or with the assistance of a woman in the camp. There are no traditional birth attendants, such as are found in villages in the south. A woman with fourteen children, for example, was assisted by her mother on the occasion of her first delivery and by her sister at her second, but for the twelve subsequent births she delivered the baby alone.

When the woman suffers the first birth pangs, she leaves the camp and hides from view behind a thorn bush with one or two women helpers. If the birth pangs occur while the group is on the move, the mother goes to one side and gives birth very often without any assistance at all.

During the birth pangs the woman eats nothing and drinks very little. If another woman is present, the latter spits into her hands and rubs them on the body of the woman in labour while reciting verses (ayaare). Sometimes she is given potions to drink made from the bark of the noomayel gorel (Indigofera), kahi (Kaavia senegalnesis) trees and yaaDya roots (Leptadenia hastata), an iron needle being placed in the receptacle to lessen the pain. A potion made from goat droppings and ground cotton seeds soaked in water is given to hasten the birth, as sometimes the delivery takes considerable time, occasionally as much as two days.

The woman gives birth in a kneeling position on the ground and the child is received by the woman helper. No mat is used.

The umbilical cord (sibiiru) is severed at finger length with a razor blade or knife. The child is stretched out face down to prevent the blood from being reabsorbed into its belly, which would be fatal. The umbilical cord bleeds very little. No ligature is made. A plaster made from doum leaves boiled in water is then applied and is kept in place for two days. Subsequently, pottery dust is sprinkled on it. Some women simply wash the umbilical cord in water and others sprinkle it with sand from beneath the ashes to make it dry more quickly. The new-born infant is washed in cold water - three times for a boy and four times for a girl, cold water being used the first day and hot water the following days. The women do not blow into the child's nostrils to clear them.

It is normal for the woman to bleed copiously during childbirth. If this does not occur, it indicates that the blood has been reabsorbed into her body and will make her ill.

The placenta, which is commonly called minyiraawo ("brother"), is buried, covered with a stone, near the rope to which the calves are attached in front of the suudu. If the placenta is not delivered, this signifies that the woman will die. If such is the case, ayaare (incantations and spitting) are made over her belly and into the water she drinks. Sometimes attempts are made to induce delivery of the placenta by causing the woman to vomit, which is achieved by introducing a spoon into her throat.

On the days following the birth, the woman is relieved of her domestic duties by her co-wives, her sisters-in-law and her parents or relatives. She is visited by her neighbours and her parents, although men are not normally admitted. Special food (kunu) is prepared for her, based on millet, to which generous quantities of milk, Bilma salt, natron and red pepper have been added.

A week after the birth, the infant's head is shaved and this is repeated two and three weeks later.

The child's naming ceremony takes place a week after birth or during the worso, when the whole group is assembled. For the first-born child, regardless of whether it is a boy or a girl,

the father slaughters a bull or a cow. For the other children, he may simply slaughter a ram or a sheep. "Without this spilling of blood, the child will be nameless and fatherless; he will be nothing."

After the child's birth, a period of sexual abstinence lasting nine months is usually observed. However, very often the reality is quite different. Some women believe that it is a good idea to have children every year, but there are many others who prefer to spread out their children at intervals of two or three years.
