Birth at the Checkpoint, the Home or the Hospital? Adapting to the Changing Reality in Palestine

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Women have the right to feel safe during childbirth and to choose the place where they want to give birth. This certainly has not been the case for Palestinian women living under occupation in the past two years. The emergency situation has changed the parameters of maternity care. In the previous decade, the trend had been toward a decrease in home births, with ninety per cent of pregnant women in the West Bank giving birth in maternity facilities in 1999. Recently, however, the frequent and severe closures, the extended curfews, and the unpredictable emergency situation has led to a considerable increase in childbirth at home or in doctors' clinics. During these periods of siege, midwives (both formally trained ones and the *dayas* or traditional birth attendants), physicians, and even family members were called upon to be birth attendants. Birthing women have shown strength and courage despite the atmosphere of fear linked to the siege and the periodic inability to reach the hospital in case of emergency. Midwives have calmed many anxious pregnant women, reassuring them that they will accompany them throughout the birth and give them the necessary encouragement and support that they need to give birth successfully, in spite of the obstacles. Some health professionals, unaccustomed to birth outside of the hospital, had to overcome their own anxieties in order to assist pregnant women and deal with the complications in the community. Many of the births resulted in healthy babies. However, some of the cases ended in tragedy with the death of the infant and in rare cases with maternal death, when the laboring woman was delayed at the checkpoint. In one incident, the husband was shot by the Israeli army when attempting to bring his wife in labor to the hospital.

Planned home birth with a skilled birth attendant, available transport and a back-up hospital in the vicinity has been shown in many countries to be equally safe for healthy low-risk pregnant women as birth in the hospital (Olsen 1997; Wiegers 1996; Ackermann-Liebrich et al 1996). However, the fact that these women chose to give birth at home, because they felt it was the safest place for them most likely contributed to the usually positive outcomes. In the current situation in Palestine, pregnant women live in constant fear of not being able to reach the hospital or a birth attendant before giving birth. Both healthy pregnant women and those with complications have no choice but to live with this uncertainty. Unplanned birth outside of the hospital in an atmosphere of fear and without access to higher-level care for the mother and newborn in case of emergency tends to result in poor outcomes in maternal and neonatal mortality and morbidity (Rodie 2002). Thus, any action for safe motherhood in Palestine requires both *political strategies* to ensure the basic human right of all women and children to safe childbirth (access to skilled birth attendants and emergency care, including free passage of ambulances, access to hospitals, and safe conditions for medical personnel), and *decentralized health care* which provides alternative options for safe childbirth, given the unpredictable reality of the Palestinian context.

This paper will give a brief background of the characteristics and practices of the licensed community midwives in the West Bank, who had assisted birthing women at home for decades and who have once again during the past few months fulfilled this vital function. It will then describe how the place of birth has been gradually changing in the past years. Some of the challenges that need to be met for safe and satisfying childbirth for Palestinian women and newborns will be described, including the importance of creating and supporting policies and structures which reinforce different options for place of birth and type of birth attendant. Specific examples of emergency childbirth will be raised, illustrating the broader issue of the need to obtain the basic human right of safe childbirth for all Palestinian women and children. Even within the context of conflict, childbirth in the twenty-first century should be protected as a life-affirming event.

Background:

Fifty years ago, most births in Palestine took place at home as they had for centuries and were assisted by respected and experienced women in the community called *dayas* in Arabic, or in today's development rhetoric, 'traditional birth attendants' (TBAs: Pigg 2000). In the 1950s, the Jordanian government, which ruled the West Bank, began licensing the *dayas* in order to train and supervise them and to report the births. This same system exists to the present day. However, the licensing and supervision of midwives needs urgently to be systematized and adapted to the changing reality in Palestine. While the *dayas* can legally assist home births, only a small number of midwives who have graduated from a midwifery school have been licensed, even though many have requested this license in order to be able to practice home births in their community. The implicit policy of the Palestinian Ministry of Health since it was established in 1994 was to encourage hospital births. Trained midwives were not permitted to do home births, and *dayas* continued to be licensed only as a stopgap measure until they became too old to practice.

The information about the community midwives is based on a study which was carried out by the Institute of Community and Public Health at Birzeit University at the request of the Ministry of Health in 1999 in order to assess training needs and to determine how to incorporate the community midwives into the health system. The design of the study included interviews with all the licensed midwives (both the traditional *dayas* and the trained nurses and midwives) in the nine districts of the West Bank using a structured questionnaire, interviews with policy-makers and district supervisors, a general audit of the midwives' records of home births, and focus group discussions with mothers in the north, south and center of the West Bank.

Social and demographic characteristics of the licensed community midwives:

The characteristics and roles of the *dayas* have been gradually changing over the years. The one hundred and sixty-nine midwives licensed by the Palestinian Ministry of Health to practice home births in the West Bank are composed of a heterogeneous group whose common attribute is that they provide home-based midwifery care. In the three health districts, which have by far the highest number of home births, there are approximately seven *dayas* per 10,000 women of reproductive age. Seventy-seven per cent of them are traditional birth attendants who have learned their profession

empirically by apprenticing with a family member or friend but who have not had a formal degree course in midwifery. Twenty-three per cent have a midwifery or nursing degree, which classifies them according to the WHO definition as trained birth attendants. Although these two types of community midwives are issued the identical license for practice by the Ministry of Health and are carrying out the same functions in the community, they have learned their skills in very different ways and environments, which is reflected in their differing attitudes and practices as well as the varying ways in which they are accepted by other health professionals. The midwives and nurses (mean age of 42 years) working in the community tend to be about ten years younger than the traditional *dayas* (mean age of 53 years). The large majority of both groups are married, with a mean number of live children of five. However, only fifty per cent of the entire group are living with their spouses, the others having been widowed, divorced or separated, a situation, which according to many of the *dayas* initially motivated them to seek a profession. Although the majority of the licensed community midwives work in villages and refugee camps, one fourth of them continue to practice in cities, which demonstrates the continued demand for such services in spite of the easy access to maternity facilities in these areas. Most of them are situated in the north (Jenin district) and south (Hebron district) of the country where home birth is more frequent than in the central region, due to a variety of reasons including the isolation of many of the villages and the greater poverty of these areas, the fact that fewer physicians are competing for clients, some women's preference for female birth attendants, and perhaps the lack of high quality care in existing maternity facilities. The level of education of these midwives covers a broad spectrum with about one third of them being illiterate and about one fifth having continued their studies beyond the high school degree with some having completed the university. Those who had never attended school were in the older age group, reflecting the general progression in the overall population toward high literacy levels and toward higher degrees that lead to professions with more social status. Concerning work experience, the majority of the midwives (77%) have been working for over ten years in their profession and 40% have been practicing for over twenty years, indicating a considerable degree of experience in home birth and community care under difficult conditions. Their caseload ranges from one to 263 births per year, some of them assisting only family members and close friends, and others serving a large catchment area (in refugee camps, for example).

Profile of the Palestinian *dayas:*

Most of the *dayas* are middle-aged women and have experienced childbirth themselves. With the experience of age and childbearing, they tend to have more authority in the community. By virtue of their seniority, procreation and experience, the *dayas* are conferred power, status and respect within their particular domain. Many of them are divorced or widowed and needed to become economically independent to support their children. As women coming from modest backgrounds, this profession was one opportunity that was open to them where they could learn experientially by working alongside a skilled *daya* without leaving their village. For some, it was a way of life they had been familiar with from a young age, benefiting from experiences and traditional customs that women had handed down for generations. When the *dayas* were asked about their decision to choose this vocation, many said that they responded to a need or a 'calling', where often the 'gift of God' was handed down within families from one generation to the next, and where the *daya*

believed that her services on earth would earn her a good life after death (Giacaman 1988). They were motivated by a humanitarian or religious desire to serve their people. In the words of one, "I like the work; I like women, and I wanted to lessen their pain." Women emphasized how much they trust the *daya* and how she talks 'sweet words' and comforts them in a nice way. The *daya* sees herself as an independent-minded woman. Several of them stated that they consider themselves to have a "brave heart", that they are in other words both compassionate and courageous. At times the profession requires taking a great deal of responsibility such as providing emergency care, being authoritative, going out alone at night or during a curfew, all of which are roles that women in this society are not necessarily accustomed to assuming and which do indeed require a brave heart.

The fact that the *daya* is of the same gender and social class as the birthing women she attends, and lives in the same locality, facilitates the process of support during childbirth. The home birth takes place in the context of daily family life. Women in focus groups who had chosen to give birth at home reported how much they appreciated the fact that they knew the midwife well, that she respected their privacy and intimacy, that the surroundings for birth were familiar, and that they didn't have to leave their other children when they were in labor or worry about getting to the hospital on time. The *daya* also helps them with their housework and childcare after the birth. It would seem apparent that the continuity of care, the *daya's* deep understanding of the structural constraints of women's lives in this society, and the responsibility that the woman herself must assume for her birthing in this context are aspects which contribute to the positive experience which these women recounted.

Traditional practices of the *dayas:*

The *daya* has a holistic concept of health and disease, which she expresses in her attitudes, practices, and way of life. She believes that stress and emotions have an effect on the physical state of the mother. Thus, during childbirth she puts a great emphasis on psychological support and traditional methods of pain relief such as massage with olive oil and drinking herbal teas. She calms women in labor with readings from the Qur'an or distracts them from the pain by telling stories. Although the *daya* is familiar with and utilizes modern medicine, she is also part of the indigenous health system. The *daya*, like the women she works with who tend to use both traditional medicine and Western biomedicine, navigates between the two worlds. As described by a researcher ten years ago, the *daya* combines old methods and new, "suggesting synthesis rather than competition, and adaptation of beliefs and practices to new realities" (Giacaman 1988, p.145). Massage (*tamlis),* herbal treatments (*a'shaab),* spiritual healing with the Qur'an ('*ilaaj bil-Qur'an*), and cupping (*kassat hawa)* are some of the indigenous practices still used by a large number of the Palestinian *dayas.* The herbs that are used during childbirth to strengthen the contractions are sage (*mayramieh)* and cumin *(kamoun)*, prepared in an infusion with sugar. The birthing mother is often given dates (*tamr)* to eat, as the example in the Qur'an with Maryam (Surat XIX; Verse 25-26). The traditional foods that the mother is given after the birth are chicken soup and rice pudding with raisins, nuts, and cinnamon. Fenugreek (*hilbeh)* and anis (*yansoun)* are used to increase the mother's milk supply. The practice of rubbing salt on the baby's skin dates back to Biblical times and is still a custom today in some areas in spite of efforts of modern medicine to change the habit. The old d*ayas* continue to use salt water to disinfect the

cord of the newborn. One of the midwives claims that she has rarely seen an infection with this method, "The cord withers like a flower without water". The *daya* regularly massages the baby's body with olive oil when she visits the mother in the post-partum, and the majority continues to swaddle the newborn.

Home birth practices:

Just as quality of care is difficult to assess in hospital births in this country, the outcome of home births has also never been appropriately assessed. Inaccuracy or lack of reporting in both home and hospital births, particularly still births and neonatal and maternal complications, is an obstacle to such an evaluation. However, the midwives through their district supervisory system, have been trained to refer high-risk cases for hospital delivery and to transport the woman to the hospital in case of prolonged labor or other birth-related complications. Although one third of the licensed midwives reported having delivered some cases considered high-risk at home (in particular women younger than eighteen years and older than forty years), it seems that they do refer pregnant women with complications to the hospitals. In a country where accessibility to hospitals is relatively good when roads are open and where transportation exists in all villages, it would appear that there were few serious problems of emergency care linked to the midwife's failure to refer. The study indicated that community midwives provide continuity of care during pregnancy, childbirth and the postpartum period and tend to have a physiological approach to childbirth, intervening only when necessary. They are not apt to practice frequent vaginal examinations, early rupture of the membranes, augmentation of labor, and episiotomies. They remain constantly with the laboring woman, supporting her and monitoring changes in her appearance, reactions, and psychological state. They use all of their senses to be in touch with the progress of labor and the state of the mother and the fetus. The few reported cases of complications with planned home births prior to the period of severe closures were linked to newly graduated hospital-trained midwives who were not experienced with home births and who utilized oxytocin to augment labor.

Transition to hospital births:

There was a rapid decline in home births in Palestine during the last decade of the twentieth century. It was estimated in 1993 that one third of all deliveries occurred without supervision by a trained birth attendant (World Bank 1998). In 1996, the Ministry of Health reported that 18% of all births in the West Bank took place at home (Palestinian Ministry of Health 1997). By 1999 the home birth rate had declined to 8% in the West Bank, with a national figure of 96% of births assisted by trained birth attendants (PCBS, Health Survey 2000).

Thus, childbirth before the Second Intifada had changed radically for many women over a short period of time from traditional childbirth in the home with female birth attendants to a hospital delivery with primarily male doctors and in some places highly medicalized management. Factors accounting for the transition to hospital deliveries included modernization, proximity to Israel where the per capita health expenditure was estimated at around nine times that of the West Bank and Gaza (World Bank 1998), the influx of Palestinian doctors after the Gulf War seeking employment, the policy of the Ministry of Health which lowered the cost of deliveries

in government hospitals in order to increase the utilization of these services, and women's reported preferences. One survey reported only three per cent of women citing the home as the best place for delivery (Lennock and Shubita 1998). Although it is important not to idealize the traditional *dayas* and their indigenous practices (Jeffery et al 1988), the difficulties which occur with a rapid transition to hospital birth need to be faced, because as long as the question of the quality of care is not dealt with, in addition to the place of delivery, childbirth will be neither safe nor satisfying for women. Women complained in the focus groups about the health providers in some hospitals not being empathetic and respectful of them, screaming at them, leaving them alone for long periods of time, and not giving them any psychological support. Family members were often not allowed to stay in the labor room with them to fulfill these neglected functions. Women objected to lack of privacy and being exposed to male health providers, and to the lack of cleanliness and the overcrowding of the hospitals.

When responsibility for the health sector was turned over from the Israeli Civil Administration to the Palestinians in 1994, the neglected and fragmented health services had innumerable needs. Transforming disparate services into a system is a daunting task. Some maternity facilities provide quality care, but others are lacking regulation, accountability, systematic reporting, and an on-going system of monitoring and evaluation. While women prefer female health providers for such an intimate process as childbirth, qualified midwives are scarce. Out of eighty-three obstetricians in the West Bank, only six are female (verbal communication with the Medical Association 1999) and in the government health sector only eight per cent of physicians are female (Women's Health and Development Department 1999). The government hospitals, where delivery is affordable, are over-crowded and under-staffed. Although health providers do their best under very difficult conditions and limited resources, midwives and nurses work under constant stress, sometimes delivering fifteen women in a single shift (communication with hospital-based midwives). Birthing women find themselves without support in an unfamiliar environment. Due to lack of space and insufficient staff to support the birthing woman, oxytocin is sometimes used to speed up normal labor, even when it is not indicated, with the idea that the woman will deliver quickly and free a bed for the next one in line (communication with hospital-based midwives). It has been shown in other developing countries that inappropriate use of oxytocics is associated with an increased stillbirth rate and an increased need for infant resuscitation (Dujardin et al 1995). With the current conditions of limited resources and restriction of movement, the safest care for birthing women is not to intervene in the physiological process of childbirth unless absolutely necessary (WHO 1996).

The lack of postpartum care also creates a gap in quality maternal health services. Women tend to leave the hospital a few hours after delivery due to their anxiety to get home to the rest of their family in an unstable political situation; however, only twenty-six percent of women receive any postnatal care (PCBS 2000) provided primarily by physicians, and the timing of these visits is usually six weeks after delivery. With little follow-up in the immediate post-partum, a valuable opportunity for health promotion and prevention for the mother and the newborn is missed. While the extended family may provide assistance and guidance to the mother after childbirth, many women currently find themselves living in a nuclear family without

the traditional support network, particularly when movement is severely restricted as it has been for the past year.

The current context:

Circumstances since the beginning of the second Palestinian Uprising or Intifada in September 2000 have had an effect on the health and economic status of the population, on the capacity of health service provision, and on the daily lives of the Palestinians. In addition to the closure of East Jerusalem and Israel to Palestinians from the West Bank and Gaza Strip, the internal closure imposed by some one hundred and twenty military checkpoints (Palestine Monitor 6/17/2002) and closure of roads to Palestinian vehicles has severely restricted movement in the Occupied Territories. Physical access to medical services including maternity facilities has been greatly impeded, as has been the affordability of services due to the drastic rise in unemployment. Health providers working under stressful conditions have organized and cooperated admirably to meet the emergency needs of the injured as well as routine health care needs, but hospital services are constantly disrupted by difficult access of both health personnel and clients. This also has affected maternity care. Midwives (both graduates of midwifery schools and *dayas*) and physicians are fulfilling an essential role in the communities, assisting women during home births and in the postpartum and providing first aid and home-based nursing care.

There have been at least thirty-nine *documented* cases of women giving birth while blocked at military checkpoints (Palestine Monitor 17/6/2002) - a humiliating and dangerous experience for the mother and a rude passage into this world for the newborn. Such was for example the case for Amina, who lives in a village that is normally about forty minutes away from the nearest city. After being delayed several times on her way to the hospital, she finally gave birth at the third roadblock. At the fourth, even though her husband had implored the soldiers to let them through, she was forced out of the car with her newborn infant whose umbilical cord was not yet cut. Amina and her baby finally reached Ramallah Hospital three and a half hours after their departure. The baby girl was named Sabreen, patience (Amira Hass, *Ha'aretz*, Jan.29, 2001). Rihab Nufal, a thirty-year-old pregnant woman from Husan village not far from Bethlehem, had been trying to travel to a hospital in Bethlehem to give birth to her child. She and her unborn child died on October 19, 2001 while waiting at the checkpoint (New Profile-Movement for the Civilization of Israeli Society). Heira Abu Hassan from the Jenin area spent twelve hours in labor trying desperately to get to the Jenin hospital. She had visited the village midwife who advised her to try to get to the hospital, as the labor was premature and the newborn would require an incubator for survival. They tried in vain to get an ambulance from Jenin, but there was no way it could get out of the city under siege, even for a woman in labor who was only a few kilometers by the main road from the maternity hospital. In the middle of the night when Heira could no longer remain at home, her husband attempted to take her by car through the fields to the nearest doctors' house, in spite of the danger of being shot. The car got stuck in the mud and could only be moved when a tractor came to assist them. When they finally reached the doctors' house, the doctor realized that he had no choice but to deliver the baby, as the mothers' life was in danger. The baby, although he cried immediately at birth, died one hour later. As the grieving mother said, "The army killed him. If we could have reached Jenin, I would have a living boy. It is a crime. If I were Jewish, what would have happened?"

In the words of the Israeli journalist who reported this event, "These are not exceptional cases. This is policy" (Gideon Levy, "The War against the Unborn", *Ha'aretz Magazine,* January 18th, 2002).

Under such circumstances, home births have increased drastically. During the month of April 2002 when there was a tight curfew in Ramallah, there were 226 home births in the Ramallah district and 374 hospital deliveries. In Jenin during the same period, there were almost twice as many births at home as in the hospital with 450 births at home and 250 in the hospital (Dr. Asad Ramlawi, Ministry of Health). These home births have been assisted by *dayas,* trained midwives, physicians, and family members. Two midwives who normally work at the Red Crescent Hospital in Ramallah carried out twelve home births in their villages (Shukbe and Der Qadiis) during the one month siege, while obstetricians in the hospital received some of the emergency cases (communication with Dr. Odeh Abu Nakleh). In several areas that have been isolated by the closures, doctors' clinics have been turned into birthing centers. The Al-Karmel center in Biddo village, with a catchment area of 40,000 people, provided assistance to forty-three birthing women during this one-month period (communication with Dr. Khalid and Salaam Ayash). Although this area when the roads are open is close to both Ramallah and Jerusalem hospitals, the people of these villages are under siege daily from 4 PM to 9AM when the access road, which passes near the neighboring settlement, is closed. About five kilometers north of Ramallah in the village of Birzeit, forty women gave birth in the clinic of the Birzeit Women's Society (communication with Dr. May Keileh). Back-up for complicated cases was provided by an obstetrician in Ramallah who followed the cases by telephone. The Juzoor Foundation set up a network of volunteer health professionals in response to the need for emergency obstetric care. Through this network, women's health providers guided home births by telephone when family members were alone under curfew to assist in labor and birth. They provided technical assistance, reassurance and support to anxious pregnant women and their families and to other health professionals who were attending home births for the first time in the north, south and center of the West Bank (communication with Dr. Selwa Najjab and Dina Nasser). Obstetricians in hospitals were able to prevent some maternal deaths, as with the case of ectopic pregnancy which arrived at Mustaqbal Hospital in Ramallah, where the woman in a critical state had finally been able to walk across the checkpoint into Ramallah from a surrounding village, after having tried with severe pain for two days to reach the hospital (communication with Dr. Walid Barghouthi). During this same period, Makassed Hospital, the main referral hospital in East Jerusalem, reported a significant increase in caesarian sections and complicated deliveries (communication with Dr. Nihad Abu Asab). While these are only a few examples of how one district in the West Bank faced emergency care, other areas responded in similar ways. All of these responses to the crisis situation in the community illustrated once again the capacity and courage of health providers at all levels to organize to meet the needs of the community under extreme duress and in many cases dangerous conditions.

Conclusion:

As a woman and a midwife, it is horrific for me to think of the conditions in which so many Palestinian women were forced to give birth and in which newborn babies came in to this world. Where is the right to safe childbirth? Why the silence to the cries of

the laboring woman and the newborn baby? Health providers the world over and international aid should insist on a safe haven for all birthing women and newborn babies no matter what the context.

Although it is difficult to build a health system in a state of on-going emergency crises, lessons should be drawn from the reality on the ground. The Palestinian health system needs to provide alternatives for safe childbirth. Supporting different options for birthing is not a luxury but a necessity. The environment, including access to medical facilities, changes so rapidly that options need to be built in to the system to ensure as much as possible that women can give birth with protection, safety, and satisfaction. In this context it is important to link and support the entire team of maternal and neonatal health providers, including *dayas*, midwives, nurses, physicians, obstetricians and pediatricians. Their skills are complementary. The traditional *dayas* embody a deep cultural understanding of how to support women to give birth normally and have years of experience in hands-on care and tricks of the trade. Trained midwives, for their part, possess updated knowledge and skills in midwifery care. Doctors have the most expertise in emergency obstetric care and saving lives. To ensure access, maternal and newborn health care needs to be decentralized, with community and home-based care made available by health providers who live in the community and are linked to a system of supervision, transport and referral. Competent and experienced personnel are doing their utmost, but the prerequisite to building an effective system lies in a commitment to coordinating resources and skills to meet the challenges of safe and satisfying childbirth in spite of the difficult conditions.

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