

No safe place for childbirth: women and midwives bearing witness, Gaza 2008–09

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Abstract: Women seek to give birth in a place where they feel safe, protected and secure. However, in conflict settings, many are forced to give birth in dangerous and frightening situations, where even the most rudimentary help and protection is unavailable. This study, based on interviews with women who gave birth and midwives during the 22-day Israeli attack on Gaza in December 2008 – January 2009, illustrates the vulnerability and trauma women experience when there is no safe place for childbirth. They recounted their overwhelming fear of not knowing when they would go into labour, not reaching a hospital or skilled attendant during the bombing, complications in labour without emergency care, and fear for the safety of their families and being separated from them. Most of the midwives were unprepared both materially and psychologically to attend births outside a hospital setting, while physicians were overwhelmed with severely injured patients. The capacity of midwifery care to keep birth normal whenever possible is particularly crucial in situations of political instability, conflict, poverty and disaster. Planning for emergency care by mapping the location of midwives, supplying them with basic equipment and medications, and legitimizing their profession with an appropriate scope of practice, licensing, back-up, and incentives would facilitate their ability to respond to birthing women's needs.
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"When we were in the middle of the sea, halfway to Beirut, we had a pregnant woman on board, she was in labour. Who was going to help her? 'Oh people! Wake up! We need help in God's name!' So my aunt, God have mercy on her soul, told her, 'Come over here' and made her squat. And a baby was born and it was a boy. They had nothing to wrap him in. I had a bundle of things for my son, so I undid it and gave her some. There wasn't anything to cut the umbilical cord. My younger brother Isma'il had a piece of iron in his pocket. They took it from him and cut the cord." (Imam Mahmoud, Jaffa)¹

2009

"The husband called me at 4am and told me that his wife had labour pains and the ambulance was unable to come as it was too busy transporting the injured from the shelling. I told him, 'Try to bring

her to my house and I will try to help. We were with no electricity and little gas. The woman arrived at my home after 20 minutes of walking accompanied by two of her female relatives. I tried to get prepared. In the dark I searched for a pair of scissors and boiled them. I moved inside my dark home with confusion as I had nothing prepared for such a case. I examined her upon her arrival and realized that she would deliver soon. I searched again in the dark and found an old cord clamp that was kept by chance since the previous siege in one of the drawers. Then I kept reading the Koran and asking God to help me. I was so scared of complications and then what would I do? I delivered her on the floor by candle light at 5:30am. This was my first home birth. It was cold and dark, but we managed to keep the mother and the newborn warm." (Imam Ahmed, Gaza midwife)

This study explores some experiences of birthing women and midwives in Gaza during the 22-day

Israeli military attack between 27 December 2008 – 19 January 2009, during which: *“The almost total closure of the borders, coupled with a lack of early warning systems or bomb shelters, denied the civilian population any refuge during three weeks of almost uninterrupted aerial and sea bombardments, artillery shelling, and ground operations.”*²

This attack resulted in 1,417 dead, of whom 116 were women and 313 children; 5,380 were physically injured including 800 women and 1,872 children.³ Thus, 30% of the deaths and 50% of the injured were women and children. As the primary caregivers of large families, women are particularly vulnerable in the aftermath of trauma, when they must rebuild the lives of their families amidst loss and destruction.⁴ Even during times of relative stability, the work of caring for the needs of the extended family falls on the shoulders of women,⁵ particularly where few social services exist. The myriad consequences of war leave women without shelter and as widows unprotected, or as the only caretakers for injured family members. Thus, Gazan women, following the attack, reported a lower quality of life than men.⁶

Thoraya Obaid, then Executive Director of UNFPA, remarked that the fact-finding reports did not mention the deaths and delivery-related injuries of pregnant women who could not access care, because they were invisible.⁷ In fact, some 3,700 women went into labour during those 22 days. Hospital records show a 31% increase in the number of miscarriages, a 50% increase in neonatal deaths, and an increase in the number of premature births, obstetric complications, and caesarean sections in that period.²

Women seek to give birth in a place where they feel safe, protected and secure. However, in conflict settings, many women are forced to give birth in dangerous and frightening situations, where even the most rudimentary help and protection is unavailable. The Palestinian situation exemplifies the importance of context and the highly political nature of achieving safe motherhood, and shows that maternity care is more than a psychosocial and bio-medical event. Unfortunately, humanitarian aid practitioners tend to focus mostly on technical solutions.^{8,9} This paper shows how the political situation may result in egregious outcomes for women and their babies.

The attack on Gaza

Gaza is a small strip of densely populated land, 360 km², with 1,600,000 inhabitants, and is com-

pletely enclosed by borders with Israel, Egypt, and the Mediterranean Sea.¹⁰ Israel remains in control of its airspace, coastal waters and borders, creating a “hermetic ghetto”.¹¹ Following the election of Hamas in 2006, Israel imposed a blockade which severely restricted the movement of people and goods, stifling the economy and access to basic necessities.² Contact between Gaza, the West Bank and Jerusalem was virtually suspended, with severe consequences for governance, the economy and health care. Internal conflict since 2007 has compounded this situation of deprivation.

The presence of routine health care services, a relatively high number of physicians, and short distances have not compensated for the harmful effects on many social determinants of health. Seventy-five percent of Gazans have suffered from food insecurity with 40% of the workforce unemployed.¹² Thirteen per cent of children under five are stunted, indicating chronic malnutrition and risk of poor cognitive development.¹³ Reconstruction has been impeded by the siege; electricity continues to be cut much of the day. The closure has had devastating effects on the health care services, with shortages of facilities, essential drugs (40% out of stock in Gaza in early 2011), equipment and training, and difficulties in referrals for specialized treatments.¹⁴ Under such conditions, different forms of violence and isolation affect the entire population, touching all aspects of life.^{15,16}

In spite of this, there has been very high coverage of maternity services: 99% of women receive skilled attendance at birth, with reliance on large hospitals and doctors’ clinics, with few home births (1%). Almost all pregnant women receive antenatal care, primarily from physicians, except in the refugee camps, where midwives are the key providers. Only about one-third receive post-partum care, however, and even fewer during the first few days after early discharge from hospital, as home visits are not routine and women tend not to leave their homes soon after childbirth. While the quality of care needs improvement, this high utilization of maternity services is important in a population where the total fertility rate is 5.3.¹³ The maternal mortality ratio for Palestine has been estimated at 46 per 100,000 live births.¹⁷ Little information is available on maternal morbidity. Accompanied by a discourse of modernization, the Palestinian health authority and the previous Israeli administration had persuaded all pregnant women to give birth in maternity facilities;¹⁸ however, no system of emergency care in case of conflict was planned for;

thus, pregnant women and midwives were caught totally unprepared during this attack.

Before the attack, the medical infrastructure in Gaza consisted of 27 hospitals, 129 primary health care facilities, and 3,711 physicians,¹² with around 102 midwives working in the government sector and 53,450 births annually.¹⁹ During the military operation, 15 of these hospitals were damaged, 43 primary health clinics and 29 out of 148 ambulances were damaged or destroyed.³ The relatively high proportion and greater influence of physicians in relation to midwives has led to their domination of antenatal and intra-partum care and the marginalization of midwives, with both psychosocial and gender implications, given that most physicians are male and women prefer female birth attendants. Midwives before the first Gulf War in 1991 attended most normal hospital births; however, the influx into Gaza of Palestinian physicians expelled from the Gulf States resulted in pressure for employment, relegating midwives to assisting physicians. Health authorities during this period no longer permitted midwives to deliver in public hospitals, clinics or homes.²⁰ In 2006 the UN Relief and Works Agency (UNRWA), responsible for health services for Palestinian refugees (two-thirds of Gaza's population), closed the six midwifery-led maternity units in refugee camps in Gaza, where delivery was provided free of charge and close to home for normal births.²¹ The network of *dayat* (traditional midwives) and community midwives providing perinatal care in the past was disrupted, leaving a gap if access to hospitals was limited. Midwifery schools and training were also neglected during this period.

As two midwives working in the West Bank, we wanted to make the diverse childbirth experiences of Gazan women in a war-like situation visible. By connecting these stories to the political, developmental, and health system context, we aim to contribute to the development of strategies to improve childbirth care in all conditions. Women's narratives of everyday experiences in crisis and the role of the family and community provide insights into their ways of coping and portray the lack of protection during childbirth. They depict the ongoing, insidious nature of the occupation, where pregnant women for three to four generations now have been dealing with the anxiety and reality of "no safe place". While the Israeli occupation, with its (usually) low-intensity warfare may at times produce few casualties,¹¹ these birth histories depict not just the experience of several weeks of bombing

and destruction, but the repetition for generations of Palestinian women of birth in flight, whether blocked at a checkpoint¹⁸ or under the bombs. The way we are born does not always get the same attention in public health as the way we die, despite the impact of maternal stress on pregnancy and birth outcomes,²² but it should.

Political and economic crises frequently determine where and how women give birth; the stories here address the "collateral damage" of world politics for having children. Birth stories live on in time and in memory, and not only in the hearts and minds of the mothers. In a study of Palestinian adolescents, one 16-year-old boy from Bethlehem began his life story with his mother's difficulty in getting to the hospital for his birth, her delay at the checkpoint by the Israeli soldiers, his father not being allowed to enter Jerusalem with her, and his frightened mother having to continue alone.²³ Over the generations, such stories, and the maternal and neonatal morbidity explicit in them, have become an integral part of Palestinian identity and way of perceiving the world.

Methods

This qualitative study provides the testimony of 16 women who gave or assisted birth during the 22-day assault. As we live in the West Bank and interviews in person were not possible due to the ongoing closure of Gaza, we conducted telephone interviews with the women. We utilized the snowball method to identify participants by asking some midwives if they knew of women who had given birth or other midwives who had attended births during that period and contacted these women directly, also asking them if they knew of other cases. The 16 interviews, 11 with women who had given birth and five with midwives who attended other births, took place between 17 February and 22 March 2009. They were conducted by one of us in Arabic, and lasted about 45 minutes each.

It was explained to the women that the purpose of the study was to give voice to their experience, that participation was optional, with the right to decline at anytime, and that confidentiality would be respected. Only one woman declined; the others expressed trust and enthusiasm at the opportunity to tell their stories. Women were asked to recount their experiences and probing questions were asked to prompt further explanation. The woman's dignity, privacy and sensitivities were

fully considered, respecting silences and listening attentively to what was communicated.²⁴

When no new themes appeared in the narratives, we stopped data collection. Interviews were transcribed through written notes and translated into English by the interviewer. The content was coded, producing a thematic code scheme and categories by the two researchers separately, and then discussed, compared and revised to identify emerging themes in the transcripts. These included lack of protection, fear, imprisonment, isolation, and family support. Our findings represent women's perceptions of their birth experience at only one point in time, whereas the experience of trauma may change over the course of time and with the duration of suffering and disruption.²⁵ But so far, it has been impossible to do further follow-up.

Findings

Reaching the place of birth

"I tried to locate any physician, midwife or nurse in my neighbourhood but I couldn't find any! My husband was also very stressed and kept asking his sisters what to do if I began labour and could not get to the hospital. We prepared all our important papers in one small bag to take if we were shelled. We kept the bag next to us when we slept." (Salam)*

"I was labouring while walking. When I had a contraction, I stopped walking and squatted on the side of the path or leaned on a wall until the contraction wore off. Then I continued to walk. I walked for about 30 minutes while military airplanes were overhead. I was so scared and I wanted to stay home and give birth, but my family discouraged me because I have always needed assistance."(Nadia)

Seven of the 11 women interviewed gave birth in a hospital, three in someone's home and one in a private clinic. Six women walked to their place of birth, three were transported by ambulance and two in private cars.

Due to the absence of protection for civilians and the impossibility of knowing when and where bombing would take place, women in labour were at a loss for what to do. When women called for an ambulance to take them to hospital, the drivers frequently refused, either because they were not allowed to enter residential areas where shelling

was heavy, or they were giving priority to the injured. Some women were turned back from the hospital, as they were too early in labour, there were not sufficient staff, or the maternity ward was being used for the injured. Hospital staff were exhausted, though did their best to be kind. The women feared not finding a birth attendant; at the same time they feared leaving their families and not being able to make it back to them again. Husbands for the most part were extremely nervous and didn't know how to cope. They usually remained with the children, and the woman went alone or with female relatives.

"I felt labour pains one day and went to the doctor and he told me it was just fear and sent me back home. The second time, labour began at 4am; we were at my brother in-law's home. We called an ambulance, which took me to hospital. At the hospital, the doctor shouted at me and said: 'Weren't you afraid for your life? If not for your own safety, you should have been afraid for the ambulance driver! Can't you hear the shelling and bombing? How come you came to the hospital?' He made me feel guilty and I started to think, 'What if the ambulance driver had been killed?'" (Dalal)

In spite of the extremely vulnerable situation they were in, however, the women also showed resilience and determination.

"Thank God I am alive and safe after all this! Sometimes I say to myself... how did I go from home at night? Maybe God gave me the strength to do all this. I believe that my strength came from my contractions. The stronger the contraction, the more strength I had! I walked, not feeling anything but the wind, the cold, the darkness, the shelling." (Nadia)

Labour and giving birth

"Fear, horror, whatever I try to describe, I cannot use the right words to express the real feelings at that time! Nothing can describe what I went through or how I felt being worried about my pregnancy and birth. Where to go?" (Salam)

Fear was the overriding emotion that women expressed: fear of not knowing when they would go into labour, of not reaching the hospital under the bombing, of complications without recourse to emergency care, fear for the safety of their families and being separated from them. The waiting felt interminable, and there was "no safe place" at home, in the hospital, or in the street.

*All names are pseudonyms.

“The days after my due date were very hard. The nights were like nightmares. What would happen if I had labour pains at night? What should I do? How would I manage? Who would accompany me? They were shelling even the ambulances! Each morning, I breathed a sigh of relief that daylight had appeared.” (Rana)

“I ran to the hospital while I was having labour pains!... Does anyone understand what that felt like to me? Now, I try not to think of that time, as thinking about it brings back painful and bitter feelings again. I suffered alone!” (Reem)

“I walked alone for an hour and a quarter in pain. When I arrived at the hospital, the doctor turned me away as there were not enough staff and the hospital was full of injured people.” (Rula)

Midwife Maysoon told the following story of a Bedouin woman who came to her clinic to have her newborn vaccinated:

“Her labour pains had started while Israeli tanks were in their village. It was impossible for her to leave the house to seek help. She held her six children and sat in a corner of the house waiting, afraid, and trying to keep silent so that her children and husband would not be frightened. She tolerated her labour pains for hours while her children were sitting around her for protection, until she gave birth surrounded by them. She started bleeding and bled a lot until she remembered the midwife’s advice at a previous birth in the clinic to keep massaging her uterus to stop the bleeding. She did that until it stopped. When the tanks got far enough from the house, the husband opened the door and shouted to women in the surrounding houses to come and assist his wife, who he feared was dying. Thirty minutes later a woman was able to come with a pair of scissors and cut the umbilical cord. Her children are still shocked from the event, watching their mother soaked in blood with a little baby hanging out of her body! The woman told me that she felt like a cow or a goat giving birth. She felt ashamed and guilty!”

Birth outcomes

“I saw one woman who was 41 weeks and had had 7 previous caesarean sections. She was scheduled for a caesarean two weeks previously and did not go because of the war. She had no idea this could threaten her life if labour began... I transferred her immediately to the hospital.” (Intisar, midwife)

“There were many women with miscarriages and pre-term labour. This was because of fear and phosphorous bombing.” (Samar, midwife)

Seven of the 11 women had vaginal deliveries, three had caesareans and one a miscarriage. The complications they reported included puerperal sepsis, back and neck pain from anaesthesia, eclamptic fits, and hypothermia of the newborn. Midwives and women described overcrowding in the hospital, with women sharing beds and lying on the floor, and frequent use of oxytocin to speed up labour. Women were shocked at seeing the wounded in the hospital, who sometimes spilled over into the maternity ward for lack of space elsewhere. Women and newborns were discharged soon after birth. Several of the 11 mothers reported that their babies suffered from respiratory problems, due to the cold weather, lack of heat and drafts in their houses as windows were broken.

Voices of midwives

“When they called me, without thinking, I left my house, my husband and my kids, and walked down narrow small streets. My house was at risk of being shelled as our neighbours were targeted. I found the woman in labour 8 cm dilated... I assisted her to deliver normally, on the floor, by candlelight, in a full house where there were more than 40 people! Everything around us was shaking from the heavy shelling!” (Maysoon, midwife)

“When she arrived at the hospital, she was examined and told that she was still in early labour and should walk to strengthen her contractions. So she went to walk around in the hospital backyard. She was hit by a missile and lost both her legs, which had to be amputated. She was delivered by caesarean, but died soon after the operation. The baby is alive and well.” (Samar, midwife)

“I was teaching old women in the community what to do if labour pain started and how they could help women give birth. I received many calls from people asking what to do.” (Intisar, midwife)

“I heard about lots of cases delivered at home with the assistance of family members. How stupid a policy it is to abandon homebirth and encourage women to go to hospitals! Especially in our unstable situation!” (Hanan, midwife)

The five midwives, for the most part, said they were ill-prepared when women in labour sought their assistance. At home, they reported boiling scissors,

using kitchen gloves for vaginal exams and using old disposable cord clamps from other babies or tying the umbilical cord with a thread. At the hospital, they reported working double shifts, as some of the staff couldn't reach the hospital. There were more admissions than usual, given the increased number of miscarriages and premature labours. Supplies and medications were insufficient in the hospital, but no one dared go out to resupply. Pain medication (pethidine) was reserved to facilitate labour for women who had experienced the death of a family member or who were otherwise particularly traumatized. One midwife had to attend three patients with severe eclamptic fits in the intensive care unit. In spite of the extremely difficult conditions they were working in, they tried to be responsive to women's needs.

"We were all nervous and feeling angry and tense. Sometimes we were not sensitive to women during their deliveries. Then I would approach the women before they went home and ask them to forgive me for any roughness or insensitivity that I might have shown while working with them." (Samar)

Midwives, physicians and other hospital workers showed solidarity with each other, the midwives said. When at home, they would call up those living in dangerous areas, if cell phones were working, to reassure themselves regarding their safety. They felt that all health care providers working during that period were courageous, given that their lives were in danger. Samar's family asked her not to risk her life by going out. She replied: *"I will do what I can to help people, and God will take care of me."*

Family solidarity and rebuilding lives

Within all of the narratives, the extended family played a key role, and the social network of the family was also crucial in reconstructing fragmented lives. Women turned to family members for shelter when displaced, for support during labour, for food to feed their families, for help with child care and for emotional strength. Family support helped them to survive. This expression of solidarity was weaved into all the narratives, but it was considered to be normal, not exceptional.

The women felt rooted in their communities through family support. They gave the impression that they were undergoing a process of healing after the attack ended, and that in this space of

destruction, with nowhere else to go, they had begun to remake their lives.

"I cannot believe that I did not die. Actually I feel I was born again. Now I try not to think of that time." (Reem)

"Now I feel good, relaxed and safe. I am happy because we were not killed, and we're back in our home and we still have a house that was not destroyed. My kids are safe. My husband is not working, but we are managing. We got assistance from my parents and his parents." (Dalal)

Discussion

The birth stories reported here were intrinsically linked with the women's memory of war, the bodily pain of labour and the fear of death and danger to their families. They linked their fear and stress to the complications they experienced, including haemorrhage, premature labour and eclamptic fits. They had no safe place to give birth, and no emergency plans to guide them, and they feared the onset of labour. Many searched for providers near their homes to avoid the dangers of the journey to the hospital, but frequently to no avail. They were trapped between their conditioning to go to the hospital to give birth and the danger of being bombed during the journey.

Even so, women were active agents in their experiences of labour and birth. Their desire to survive and the compulsion to bring a new life into existence seemed to push them almost irrationally to transcend their fears and the imminent danger of death. They were driven to find a solution. Some expressed severe trauma, but also resilience.

During the attack, one experienced Gazan midwife, Fiza Shraim, due to individual initiative and courage, assisted 52 births at home and in the village clinic.²⁶ Most midwives, however, felt ill-equipped as they did not have the basic skills, materials and confidence to provide care in the community. They had no birthing kits or emergency supplies, and did not feel protected by the system in case of complications. Physicians, on the other hand, were not available in the communities, and those in the hospital were overwhelmed with severely injured patients. A system of skilled midwives, trained and equipped to work under difficult conditions within a supportive structure would have increased the accessibility of maternity care in a crisis such as this.

Policy implications

The lessons from this history are not only relevant for Palestine but also for many countries experiencing political turmoil, military intervention and disasters.²⁷ Political realities at the root of human insecurity must be recognised as precluding the necessary conditions for safe motherhood and as a contributory cause of maternal and neonatal mortality and morbidity. While communities might recover from violent events, continued exposure to the daily stressors of conflict may erode coping mechanisms and resilience.²⁵ A human rights framework to promote health, as envisaged by Yamin,²⁸ allows us to move from theory to practice, but only if the political issues infringing people's rights and well-being are addressed.

Midwives provide women with the needed conditions for giving birth normally, care and support during critical points in pregnancy, childbirth, post-partum and motherhood, and referral for complications. The capacity of midwifery care to keep birth normal whenever possible is particularly crucial in situations of political instability, conflict, poverty and disaster. Midwives tend to be closer to the community, both geographically and socially, and thus more readily available and responsive, increasing access for marginal groups and in times of crisis; they are trained to attend births with minimal equipment, and to provide caring, counselling and support. However, as long as their particular skills are not recognized by decision-makers as key to maternal and neonatal health provision, it is difficult to improve their performance, education or motivation. They need to be key players in a functioning maternity care team and health system, not just called upon in times of crisis. They need to be supported, supervised and equipped to assist pregnant and birthing women and newborns at any time and in any circumstances. Planning for emergency care by mapping the location of midwives, supplying them with basic equipment and medications at home and in clinics, and legitimizing their pro-

fession with an appropriate scope of practice, licensing, back-up, and incentives would facilitate their ability to respond to birthing women's needs.

In spite of the evidence for the benefits of midwife-led care,²⁹ women and newborns in Gaza were left without access to services in an unstable political context, while physicians were overburdened. Improving maternal and newborn care is urgent, not only in countries with the highest mortality, but also where improved perinatal health care would contribute to people's awareness of human solidarity aimed at decreasing inequity and injustice.²⁸

The collective right to development has been suggested as an alternative to the narrow concept of the individual's right to health as a framework for international development policy, and includes the need for a functioning public health system that can address synergistically the underlying determinants of women's health.³⁰ This study of childbirth in Palestine illustrates the importance of an environment conducive to respect for the promotion of maternal and neonatal health and well-being, and the responsibility these entail. Political and social commitments and interventions, both local and global, lie at the heart of initiatives intended to create an environment for safe motherhood and social justice to thrive.

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Résumé

Les femmes souhaitent accoucher là où elles se sentent protégées et en sécurité. Néanmoins, en cas de conflit, beaucoup sont obligées d'enfanter dans des situations dangereuses et angoissantes, sans protection et privées de l'aide la plus rudimentaire. Cette étude, fondée sur des entretiens avec des accouchées et des sages-femmes pendant l'attaque israélienne de 22 jours sur Gaza en décembre 2008-janvier 2009, illustre la vulnérabilité des

Resumen

Las mujeres buscan dar a luz en un lugar donde se sientan seguras y protegidas. Sin embargo, en ámbitos de conflicto, muchas se ven forzadas a dar a luz en situaciones peligrosas y espantosas, donde no hay disponible ni siquiera la ayuda y protección más rudimentarias. Este estudio, basado en entrevistas con mujeres que dieron a luz y con parteras durante el ataque israelí sobre Gaza, que duró 22 días, desde diciembre de 2008

femmes et le traumatisme qui leur est infligé quand elles ne peuvent accoucher dans un endroit sûr. Elles ont raconté leur peur extrême de ne pas savoir quand elles commenceraient le travail, ni si elles arriveraient à l'hôpital ou pourraient joindre une aide qualifiée pendant les bombardements, leur crainte des complications obstétricales sans soins d'urgence et d'être séparées de leur famille, et leur inquiétude pour la sécurité de leurs proches. La plupart des sages-femmes n'étaient préparées ni matériellement ni psychologiquement à s'occuper de naissances hors du milieu hospitalier, alors que les médecins étaient surchargés avec des patients gravement blessés. La capacité des sages-femmes à conserver une naissance normale chaque fois que possible est particulièrement cruciale dans les situations d'instabilité politique, de conflit, de pauvreté et de catastrophe. La planification des soins d'urgence, en localisant les sages-femmes, en les dotant d'un équipement et de médicaments essentiels, et en légitimant leur profession avec un champ d'activité approprié, une certification, un soutien d'urgence et des avantages, faciliterait leur aptitude à répondre aux besoins des parturientes.

hasta enero de 2009, ilustra la vulnerabilidad y el trauma que sufren las mujeres cuando no hay un lugar seguro para dar a luz. Relataron su temor incontenible de no saber cuándo iban a entrar en trabajo de parto, no llegar a un hospital o a una asistente calificada durante el bombardeo, tener complicaciones durante el parto sin cuidados de emergencia, y su temor por la seguridad de su familia y estar separadas de ésta. La mayoría de las parteras no estaban preparadas, ni material ni psicológicamente, para atender partos fuera del ámbito hospitalario, mientras que los médicos estaban abrumados con pacientes con graves lesiones. La capacidad de las parteras para mantener el nacimiento normal siempre que sea posible es de fundamental importancia en situaciones de inestabilidad política, conflicto, pobreza y desastre. Al planificar para cuidados de emergencia mapeando la ubicación de las parteras, suministrándoles equipo y medicamentos básicos y legitimando su profesión con responsabilidades adecuadas, autorización, respaldo e incentivos, se facilitaría su capacidad para responder a las necesidades de parto de las mujeres.



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Women await treatment provided by Médecins sans Frontières in a mosque basement, Khan Younis, Gaza, 2002