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'Shedding light' on the challenges faced by Palestinian maternal health-care providers

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ABSTRACT

Objective: to explore the challenges and barriers faced by Palestinian maternal health-care providers (HCPs) to the provision of quality maternal health-care services through a case study of a Palestinian public referral hospital in the Occupied Palestinian Territory.
Design and method: descriptive qualitative study. The data are from a broader study, conducted in 2005 at the same hospital as part of a baseline assessment of maternal health services.
Participants: 31 maternal HCPs; nine midwives and 14 nurses and eight doctors.
Findings: the quality of care provided for women and infants at this Palestinian public hospital is substandard. The maternal HCPs work within a difficult and resource-constrained environment.
Issues include: high workload, poor compensation, humiliation in the workplace, suboptimal supervision and the absence of professional support and guidance. Midwives are perceived to be at the bottom of the health professional hierarchy.
Conclusions: there is a need for managers and policy makers to enable maternal HCPs to provide better quality care for women and infants during childbirth, through facilitating the roles of midwives and nurses and creating a more positive and resourceful environment.
Implications for practice: Palestinian midwives need to increase their knowledge and use evidence-based practices during childbirth. They need to unite and create their own circle of professional support in the form of a Palestinian midwifery professional body.

Introduction

> Unfavorable working conditions, widespread shortages……there is an ever-growing demand for health workers worldwide. How can we give people the care they need if we don't have enough health workers? (F. Omaswa, 2008)

In the quote above, Dr. Omaswa, Executive Director of the Global Health Workforce Alliance, accurately frames one of the key factors in the dysfunction and, in some areas, the near collapse of the health system; the desperate need for health-care workers. There are currently 57 countries with critical shortages, amounting to a global deficit of more than 4 million health-care workers (World Health Organization, 2006).

Current scientific literature (Diallo et al., 2003; Narasimhan et al., 2004; Fritzen, 2007; McCourt and Awases, 2007) continues to address the crisis in health human resources. Kurowski et al. (2007) analysed the challenges facing human resources in Tanzania, and presented a model for strategic human resource for health planning, while Dussault and Dubois (2003) argued that policies and other multifaceted factors are responsible for chronic imbalances in human resources for health. Furthermore, an analysis of human resources management and functioning in the health systems of various countries concluded that proper management of human resources is crucial for the provision of high-quality care (Kabene et al., 2006).

Recently, the World Health Organization (International Council of Nurses et al., 2008) described various approaches for developing and implementing incentive schemes for health workers. Countries have also considered other techniques to improve the situation, such as expanding the responsibilities of various categories of providers in Mozambique, Tanzania and Malawi (Rosenfield and Min, 2007). In addition, a study conducted on the performance of maternal health-care providers (HCPs) in Armenia (Fort and Voltero, 2004) found that non-monetary incentives in the form of recognition, in-kind contributions, community respect and assistance with services can be powerful motivators to enhance performance, subsequently affecting quality of care. In a recent analysis of human resources for maternal health, seven key areas were proposed that must be improved to scale up midwifery for the community: policies and regulations, equity,

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recruitment and education, supervision and support, enabling environment, monitoring and evaluation and resource mobilisation (Fauveau et al., 2008). This is particularly important for women in economically and politically unstable countries, such as the Occupied Palestinian Territory, where women have less access to maternal health care, particularly in the case of an emergency.

The Israel–Palestine conflict has been on-going for over 50 years, resulting in a never-ending state of conflict and instability. There is clear evidence regarding the impact of protracted conflict (Abdul Rahim et al., 2009) and war on women, infants (Al Gasseer et al., 2004), health systems and the health workforce (Dyer, 2003; Mataria et al., 2009). Studies have shown that various health sector assessments placed human resource problems among the major deficiencies of the current Palestinian health-care system (Ministry of Health, 1996; Barghouthi and Lennock, 1997). However, the national health plans have had limited achievements in addressing this issue (Abu Mourad et al., 2008), and have kept the 'so-called' Palestinian health system plans functioning mostly under emergencies plans. The Palestinian human resource problems have not been addressed properly in terms of performance, regulations, geographical distribution or the 'brain drain' of health personnel. This is challenging the country's specific needs, considering its particular economic and political context (Hamdan and Defever, 2003).

In 2006, approximately 24% of the HCPs in the public sector were nurses, 17% were doctors and only 1.8% were midwives (Ministry of Health, 2006). More than half of Palestinian births (55%) occur in public hospitals free of charge, midwives attend almost all vaginal births, except for instrumental deliveries and nurses are the main staff in the postpartum wards.

The purpose of this study was to explore the challenges and barriers faced by Palestinian maternal HCPs to the provision of quality maternal health-care services through a case study of a Palestinian public referral hospital in the Occupied Palestinian Territory. To the authors' knowledge, this is the first study to illustrate the working environment of Palestinian midwives and nurses.

Methods

Study setting

This study was conducted in the labour ward and the postpartum/gynaecology wards in a public referral hospital with 143 beds, located in the West Bank.

Study participants and data collection

Quantitative and qualitative research methods were utilised, with in-depth interviews and field observation notes. Participants included all but one of the maternal HCPs (nine midwives, 14 nurses and eight doctors), including their ward managers, who care for women and infants during childbirth. The content of the questions focused on the HCPs' main responsibilities, actual practices, working environment, obstacles to better care, training needs and their recommendations.

Before beginning the study, written and oral permission were obtained from the General Director of Hospitals at the Ministry of Health, the hospital director and the head obstetrician and midwife. Field observations were recorded by the principal investigator (PI) for 14 days (120 h) at different intervals in the week during the three shifts in the labour and delivery ward and the postpartum/gynaecology wards. Oral consent was always obtained from the different HCPs on duty, and participants were assured of confidentiality and anonymity.

The interviews were conducted over a period of four months to minimise the impact on the HCPs' heavy workloads and demanding schedules. Clarifications and elaborations on answers were requested to ensure correct interpretation. Each interview lasted for 45–70 min.

All midwives and nurses interviewed were females and had been employed for less than five years. Although most of the midwives held university degrees, most of the nurses only had a diploma. All of the doctors were males; four specialists held a Palestinian Board and four were general residents. Only one of the specialists had international credentials (from the UK). Unlike midwives and nurses, almost all of the doctors had been working for more than five years.

Data analysis

Qualitative data from the interviews, including field notes, were transcribed, coded and tabulated by the PI. The information was then extracted from the content line-by-line using key words or phrases, analysed and categorised under the main themes. Themes, categories and content were discussed thoroughly, with frequent reference to and review of the original transcripts, until consensus was reached between investigators.

Triangulation was utilised to validate qualitative data from various resources. For example, issues could be observed and discussed informally with the team.

Findings

The following sections emphasise two major themes that were drawn from the findings, focusing on the working conditions of HCPs and suboptimal management. These are amplified by resource constraints, and subsequently affect the quality of care.

Poor working conditions and suboptimal management

Workload and responsibilities

The HCPs reported that their heavy workload was a major constraint to the provision of high-quality care. They reported that it was 'usual' to have one midwife on duty, especially in cases of sickness, urgent leave, feasts, annual holiday, travel restrictions due to the unstable political situation and unplanned transfer/deployment. Moreover, during the field work, it was witnessed that the number of midwives decreased from nine to five. Nurses also considered their workload to be a cause of stress, and some described themselves as 'machines' and described their workload as 'insane':

> …They give us loads that are extremely exceeding our abilities as individuals and humans. It's insane! (Nurse 26)

Table 1 shows the responsibilities for midwives, nurses and doctors. It shows the quantity and quality of duties and responsibilities, as observed during the study and reported by the HCPs themselves. Midwives have an overwhelming number of duties, followed by the nurses and then the doctors. Despite their high level of education and various responsibilities, midwives reported earning the lowest salaries.

The doctors acknowledged that there is a shortage of staff in relation to workload. However, they are usually able to rest when they are not busy with cases that require their attendance and they earn almost twice as much as midwives and nurses.

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Table 1
Observed and reported responsibilities of maternal health-care providers.

Midwives' responsibilities	Nurses' responsibilities	Doctors' responsibilities
• Assist doctors in admitting obstetric and gynaecology cases. • Care for women during labour including activities to follow up progress of labour and conducting all necessary nursing procedures such as withdrawing blood, inserting cannulas, regulating intravenous fluids, administering medications,…etc. • Conduct all normal vaginal deliveries. • Suture episiotomies and perineal tears if doctors are delayed or busy. • Provide immediate postpartum care for both mother and infant. • Care for all infants after caesarean delivery. • Care for high-risk cases during labour. • Assist doctors in receiving and triaging all emergency outpatient cases for obstetrics and gynaecology. • Assist doctors while conducting their deliveries, i.e. instrumental deliveries or high-risk vaginal deliveries such as twins. • Administration tasks, including follow-up on supplies, equipments and maintenance. • Clean and sterilise all utilised surgical/delivery equipment and supplies, and perform janitorial duties. • Clean and dust all surfaces in the labour and delivery ward. • Guide/train midwifery, nursing and medical students and new resident doctors. • Keep all records in the labour ward.	• Assist in admitting patients to the ward and receive women after childbirth. • Provide nursing care for women after surgery and childbirth; daily nursing and midwifery care, pre- and post-operative care. • Observe regular vital signs for all women. • Withdraw blood tests. • Insert cannulas and observe intravenous fluids. • Check and execute new medical orders. • Assist doctors in ward rounds and wound dressings. • Check ward supplies and disposals and dust patients' rooms.	• Admit and discharge patients. • Conduct some vaginal deliveries, i.e. twins, instrumental, breech and whenever a complication arises during the second stage. • Suture episiotomies and tears. • Responsible for managing cases of induction of labour. • Conduct ward rounds and follow up on the progress of cases. • Receive emergency and outpatient cases. • Conduct surgery. • Provide antenatal care. • Back up midwives, if there are any deviations from normal during labour or delivery. • Prescribe all required medication.

Teamwork, supervision and management styles

> …sometimes we feel humiliated a lot by our managers especially when they shout at us in front of physicians and women. (Midwife 2)

A striking finding was that midwives and nurses reported feelings of humiliation in the workplace due to the public, managers and doctors. During the interviews, midwives and nurses reported that 'shouting' was a daily communication style between managers and HCPs. Midwives reported that they were shouted at whenever they failed to follow the ward policy, such as not starting an intravenous line for labouring women or allowing women to be mobile. The PI witnessed shouting by the doctors; first at a woman in labour, because she was walking, and second at a midwife because he found a woman's bed empty during the ward round as the midwife allowed her to go to the toilet. The midwives' communication skills were not much better, but no instances of a midwife shouting at a woman were observed.

In addition, midwives and nurses face harsh treatment from the public as they are in direct daily contact with the women and their families. They have to face the families' frustration when they cannot rationalise certain material deficiencies, including the inadequate number of beds or explaining why the doctor might be busy or delayed. Midwives and nurses reflected on the creation of an enabling work environment through continuous availability of resources, recognition of their vital role in maternal health care, and their need to be respected. Furthermore, the scarce number of midwives limited any opportunities to experience a sense of team work while at the hospital. Few midwives reported any form of social networking that could help to provide an informal mechanism of support. The HCPs reported rare brief meetings, and only to discuss an incident or diffuse a new policy. No formal meetings are held to guide, audit or provide feedback on work practices.

The senior midwife has no time for supervision, as she divides all work duties with another midwife. Nurses reported that the focus of supervision is on mistakes and gaps in work, rather than a real evaluation of the quality of work. Both midwives and nurses reported that 'punishment' is the most common way of dealing with their errors. This varied from reducing their off-duty hours to depriving them of a whole day off, depending on the gravity of the error. Failure to document aspects of care, follow-up on patients' laboratory tests, a midwife conducting a delivery for a first-time mother, and suturing an episiotomy were seen as common types of 'errors'.

A few of the doctors reported that supervision is inadequate because they are viewed as trusted health professionals, while the rest reported that there is adequate supervision by the head of the department:

> No I don't have any supervision because they trust my work. I usually consult with the specialist. They dump the work on my shoulder. I would like this to change, but with this system, nothing will change! (Resident Physician 1)

The evaluation process follows a routine traditional style that is confidential, non-participatory and is not based on merit. Although the evaluator is known to the HCPs, the HCPs were not able to tell the basis of their evaluation and most of them consider their evaluation to be 'unfair', 'inadequate' and 'inefficient', because they have never been informed about their weaknesses or strengths, or given the chance to improve:

> …We tried to discuss problems several times, but we have been always told: you have no right to discuss anything. Do not discuss. Your duty is only to receive and admit patients and work with them. If you don't like it here, just leave work and go home. Or we got no response. (Nurse 26)

The doctors elaborated that there is no written report and no motivation, and two doctors were not even aware of the evaluation criteria. Doctors are also feeling the strain of the system, displayed by their feelings of despair and frustration. This was illustrated by the only doctor who refused to participate in this study:

> Things will never get better through participation in a study.

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Conformation to substandard care

The absence of a 'culture of quality' in maternity services in Palestinian public hospitals is a result of functioning within a poor infrastructure during decades of military occupation, and political and socio-economic instability. During field observations, many aspects of care were observed that are contrary to scientific evidence or even unsafe for the mother or the infant (Hassan-Bitar and Wick, 2007), such as commencing oxytocin during labour without dropper machines, not cleaning the newborn area after each usage, and caring for infants without changing gloves or washing hands. Women were seen giving birth on plastic bags when few sheets were available in the delivery rooms. Midwives and nurses acknowledged that they omit certain aspects of care for women due to their workload, and some indicated that they never meet women's health-care needs:

> I do not give time to teach women or I omit certain aspects of needed care for some women, i.e. not to check their uterus or not measuring their BP. (Nurse 3)

Similarly, doctors reported conducting incomplete medical examinations and histories due to workload and lack of time.

Midwives and nurses also reported difficulties with communicating and interacting with women and families due to their workload and low educational levels, while doctors reported that communicating with families is a waste of time. Midwives also reported feelings of nervousness, physical exhaustion and displaying harshness while providing care. They also spent time in search of supplies and assisting doctors, instead of caring for women. The uncooperative attitudes of some doctors force the midwives into difficult situations with families, or oblige midwives to conduct duties on their own responsibility. The midwives gave examples where the doctors failed to attend cases during the night shifts, and delayed the suturing of episiotomies, leaving women waiting in the lithotomy position for a long time. Some midwives take the initiative and suture episiotomies themselves instead of keeping the woman waiting. It should be noted that the Ministry of Health has decreed that midwives are not allowed to suture episiotomies or perineal tears, despite the fact that they are trained in this procedure.

Discussion

A limitation of this study is that only a small number of HCPs were interviewed, and they all worked at one public hospital. The aim of this research was not to generalise the results, but to explore the conditions under which most Palestinian women give birth, with the aim of implementing improvements. As all public hospitals operate under the same health system, this 'case study' highlights the main systemic problems that can be found in other local public hospitals.

Two major themes emerged from the study findings and will guide the course of this discussion. The first theme, 'Caring while being trapped', refers to HCPs being trapped in a health system that is dominated by the country's political and socio-economic instability. The second theme, 'A system set up to fail', targets midwives in conflict and discusses the challenges specific to Palestinian midwives while attending to women during childbirth.

Caring while being 'trapped'

As a result of many years of occupation, the Palestinian Ministry of Health has weak and fragile health services. The combination of continued political complexities, internal conflicts, funding problems, an absence of a regulatory professional body, lack of supportive policies and no appropriate infrastructure (Maclean, 2003) has further twisted the health system. This has had a major effect on HCPs, particularly midwives and nurses in maternal health, as they have to deal with many difficulties such as access, mal-distribution, staff shortages, poor working conditions, interrupted low wages and little or no social/professional support and guidance. Over the years, this has led them to provide substandard health care.

Midwives and nurses have no access or means to advocate their status in the health system. They do not have the luxury of leaving their job if they are dissatisfied. Instead, they are 'trapped' and obliged to practice in a non-enabling work environment. This on-going situation has led some midwives and nurses to feel desperate, isolated and burnt out (Kirkham and Stapleton, 2000), particularly when they are forced to work additional hours.

Caring is the essence of nursing and midwifery. Many nurses face feelings of disappointment and confusion regarding their own abilities to care for women while no one cares for them. 'No one listens!', 'nobody cares' and 'poor management' were frequent responses given by the HCPs when asked how they had tried to improve the situation. Lynch (2002) discussed how exhaustion, the work environment and its hierarchical organisational structure hinder support and caring for each other, but others have argued that nursing and midwifery managers can improve the working environment for their team (Demerouti et al., 2000; Raikkonen et al., 2007). In this study, HCPs felt hopeless about their managers, the system and any future improvements. The ward managers acknowledged that they are also experiencing pressure from their superiors, and they do not consider that maternal health is a priority for the hospital or the Ministry of Health as all hospitals are suffering the same barriers.

Previous studies have reported that a heavy workload and nurses' dissatisfaction may affect the quality of care provided to their patients (Aiken et al., 2002; Mrayyan, 2006). This study found three levels of dissatisfaction among the Palestinian midwives and nurses. First, there is an absence of professional supervision that could provide support, improve performance and have a positive effect on the quality of midwifery care (Lyth, 2000). Second, there is an absence of implementation of job descriptions for midwives and nurses. Thus, employee evaluations are not based on their performance, leading to a failure to guide or improve their work performance. Third, there is an absence of an active and strong, regulatory professional midwifery/nursing body that can plan, advocate and improve the standards of midwifery and nursing care within the existing male-dominated environment, and within the overall political situation.

Like other nurses from other parts of the world (Gray-Toft and Anderson, 1981; Mackin and Sinclair, 1998; Farrell, 1999), Palestinian midwives and nurses are experiencing horizontal violence and humiliation. The feelings of humiliation arise when Palestinian midwives and nurses are confronted by the public, particularly regarding inadequate resources. Few midwives talked about their future aspirations; this may reflect their lack of hope, confusion regarding their professional identity or lack of career satisfaction.

As in many other countries (Hijazi and Al-Ma'aitah, 1999; Kabene et al., 2006), doctors in the Occupied Palestinian Territory enjoy a high status, because of their strong lobby in the current health system. They control national health policies and health planning and occupy all decision-making posts at central and peripheral levels in the public health services. Moreover, Palestinian doctors enjoy better professional support from their union, and have many active specialised professional associations, along

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with enjoying a prestigious image and high social status in the Palestinian community.

In parallel with this, doctors have limited the growth and involvement of other health professional roles, allowing a fragmented model of midwifery practice (Carlisle et al., 1994) and a limited role for nurses in maternal health. For example, the Ministry of Health policy does not allow midwives to provide certain elements of midwifery care such as antenatal care, postpartum care, family planning or even to practice midwifery in their own communities. Instead, they are limited to being doctors' 'assistants'. Moreover, there is no career pathway (i.e. grading) that would allow midwives and nurses to progress in their career. Management and leadership nursing and midwifery positions are generally allotted to nurses based on political affiliation and years of experience, rather than on their level of competency.

Palestinian midwifery: 'a system set up for failure'

Palestinian midwives are the preferred type of HCPs to staff the labour and delivery ward in governmental and non-governmental hospitals, due to their unique competencies in caring for women during the process of childbirth.

Empowerment constitutes a core of professional midwifery and the essence of midwifery care. During childbirth, midwives generally work with women to empower, assist and increase their confidence, which in turn can improve the quality of care (Hayas et al., 2006). However, in the Palestinian case, how will the midwives be able to empower childbearing women if they never experience empowerment and power in their own professional career or sometimes in their lives as women (Kirkham, 1999)? Mathews et al. (2006) identified four factors for midwives' empowerment; control, support, recognition and skills. However, field observations noted the limited role capability, lack of interest and opportunity for midwives to support labouring women. Palestinian midwives are in a weak subordinate position to assume control over their profession.

Moreover, during field observations, midwives expressed feelings of disappointment, a sense of helplessness and feelings of failure while interacting with women. There is evidence that the burn out of midwives has a negative effect on their relationships with women in their care, and can lead to loss of their sense of personal accomplishment (Bakker et al., 1996). Also, this study showed that there is a mismatch between the number of midwives available in the labour and delivery ward and their responsibilities, although the evidence for an association between appropriate staffing and quality of care is strong (Ellis et al., 2006). Adding to their frustration, many HCPs have more than one job (Jan et al., 2005) in order to meet their families' financial needs, given the country's unstable condition. The PI witnessed that many of these HCPs suffer from exhaustion, lack of sleep, lack of interest in communicating with women and have a general attitude of the subordination of the public services.

For a culture that holds the childbearing role of women in high regard, and prefers and demands female HCPs during childbirth, Palestinian midwives are somehow invisible on the health agenda.

Conclusion

Ensuring that women receive safe care during childbirth is a basic human right. This study will hopefully assist policy makers to enable maternal HCPs to provide better quality care for women and infants during childbirth through strengthening midwifery services, and expanding the scope of midwifery practice in the clinics, hospitals and their communities, as reported from other countries (Currie et al., 2007).

Implications for future practice

On the basis of the study findings, several key points were raised to help strengthen midwifery services in the Occupied Palestinian Territory.

1. While living in a zone of conflict adds an extra layer of burden and complexity for women, midwives should be the strategic cost-effective choice for investment by the main donors and policy makers to ensure holistic, safe, sustainable high-quality care during childbirth for Palestinian women and their infants. This lays a huge responsibility on the Ministry of Health to hire more midwives, and retain and utilise them efficiently by creating a supportive enabling working environment, and initiating the midwife-led care model (Hatem et al., 2008).
2. In the era of evidence-based care, Palestinian midwives need to increase their knowledge and adopt evidence-based practices to promote normal childbirth. Moreover, midwives need to adapt a different approach to childbirth from 'being in control' of the childbirth process to assuming a more 'assisting' role for women. This would be possible by better communication with women, families and their own communities. Palestinian midwives need to strive to humanise childbirth experiences for Palestinian women, and to increase their commitment towards the rights of poor women giving birth in public hospitals to high-quality care.
3. Amidst the mixed uncertain political and contextual difficulties, Palestinian midwives need to unite and formulate their own circle of support by creating their own professional networks and platforms based on mutual respect, and sharing knowledge and experiences. If Palestinian midwives succeed in initiating their professional networks away from political conflicts, this will gear their efforts towards improving the standards of midwifery care and increasing their commitment towards women. These initial steps will eventually empower midwives to act to establish the basis of their professional association that will enable them to advocate their significant role in maternal health in order to affect national health strategies in the Occupied Palestinian Territory.

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