Giving birth in Gaza

Dr. Silvia Pivetta, WHO Gaza

Dr. Waleed Abu Hatab, Nasr Complex, Khan Younis, Gaza

Oona Campbell, Wendy Graham. Lancet 2006
On behalf of The Lancet Maternal Survival Series steering group.

Maternal mortality: What works.

"The implementation of an effective intra-partum care strategy is the overwhelming priority for addressing the fifth MDG, according to the best available evidence"

“Intrapartum care involves:

- preventive best practices
- avoidance of iatrogenic procedures
- management of complications.

This shall be targeted at all women who are giving birth”

Oona Campbell, Wendy Graham. Lancet 2006

Some facts on childbirth in Gaza

- 60,000 babies were born in 2011
  (3.3% pop annual increase, TFR 5.4)
- Most women deliver in health facilities
  (virtually no home deliveries)
- 80% of deliveries happen in 5 hospitals
  (4 MoH + 1 NGO)
- The demand for health services related to pregnancy and childbirth is almost one half of total demand for health care

Deaths and complications related to childbirth/intrapartum care in Gaza

- Among 30 maternal deaths (2008-9) at least 14 were avoidable with good intrapartum care
- Post partum hemorrhage, sepsis and eclampsia caused half of deaths.
- Uterine rupture is up to 20 times higher than expected (in Shifa H, WHO 2009)
- Almost half of disabilities in the adult population are determined by birth complications and cong. anomalies
- About half of deaths of children under 5 and 68% of deaths in infants happen in the first week or days of life

Quality of childbirth care in Gaza

Summary findings, WHO assessment, 2009 and 2010

Strenghts

1. Good knowledge and skills in management of complications (e.g. CS techniques)
2. Good availability of drugs and supplies
3. Good Laboratory support
4. Fair availability of basic equipments and tools
5. Good number of doctors

Weaknesses

1. Over-medicalized and unsafe management of uncomplicated labour
2. Lack of support, privacy and caring attitude to women
3. Delayed detection and management of complications
4. Premature discharge after childbirth (e.g. 2 hours)
5. Limited number and disempowered role of midwives

In 2011: Shift to a new model of care for safe childbirth in Gaza

Key elements:

1. Midwives in charge of low risk labours
2. Standard criteria and procedures for detection of risk and complications
3. Team work: Obstetrician, Midwife, Neonatologist

Step one: Risk assessment at admission

risk assessment

Low risk

High risk

delivery by midwife:

Natural childbirth

delivery by doctor:

Medicalized childbirth

Step two: Midwifery-led care
(low risk)

- *Continuous support during labour*
- *Encourage drinks and light food, frequent voiding*
- *Changing position, walking, breathing, physio*
- *Labour surveillance (Partogram)*
- *Mother-baby contact after birth, BF, warm chain*

- AVOID harmful or non-evidence based procedures
- *Call the doctor when risk or complications (standard)*

Step three: post partum care and safe discharge.

- *Remain for at least 6 hours after birth*
- *Mother post partum examinations (standard)*
- *BF counseling*
- *Health education on danger signs*
- *Newborn complete examination by a pediatrician before discharge*

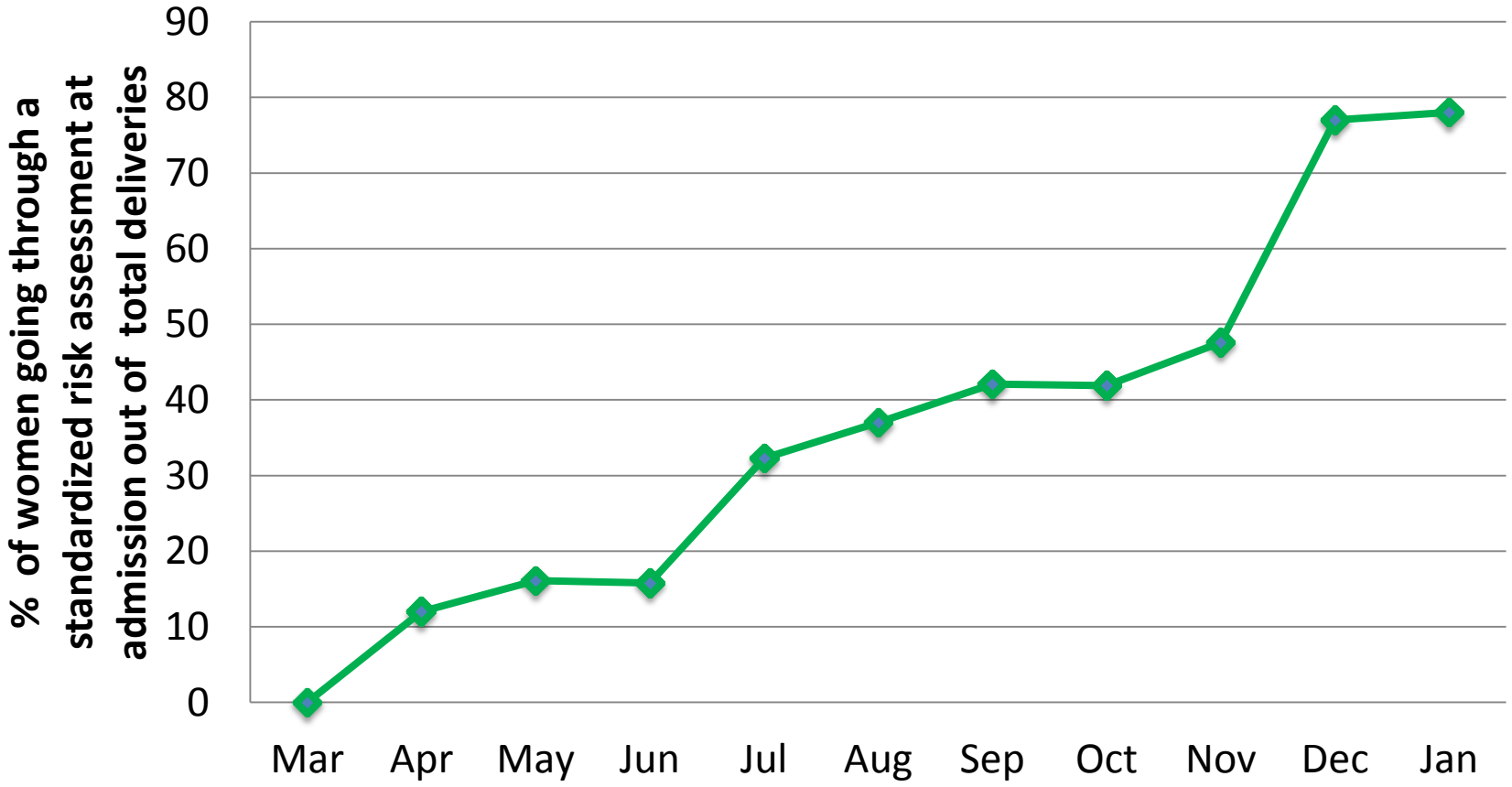
Potential of the new model

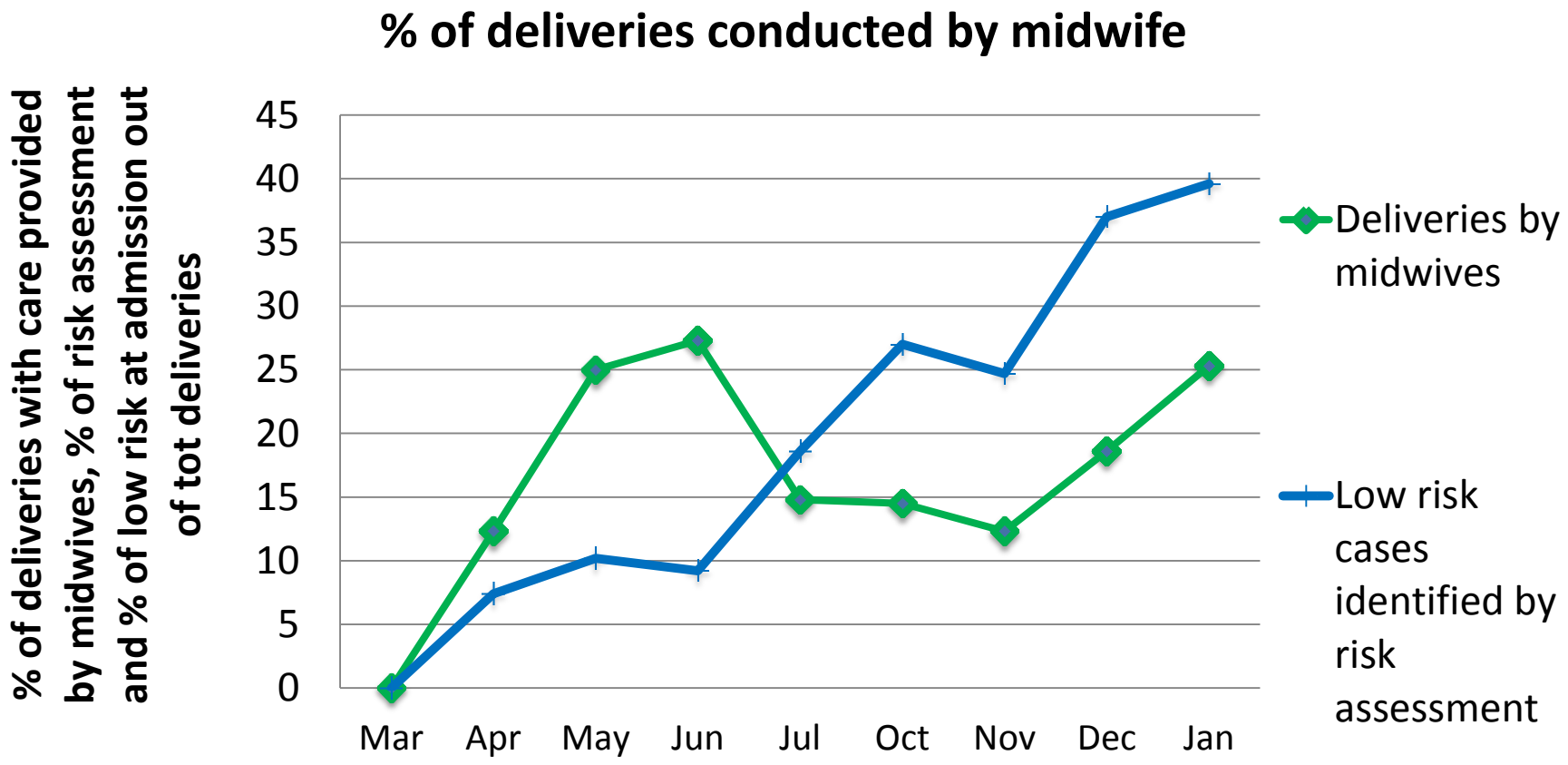
1. To avoid iatrogenic complications from unsafe procedures
2. To enhance early detection and timely management of complications
3. To improve women support, privacy and respect

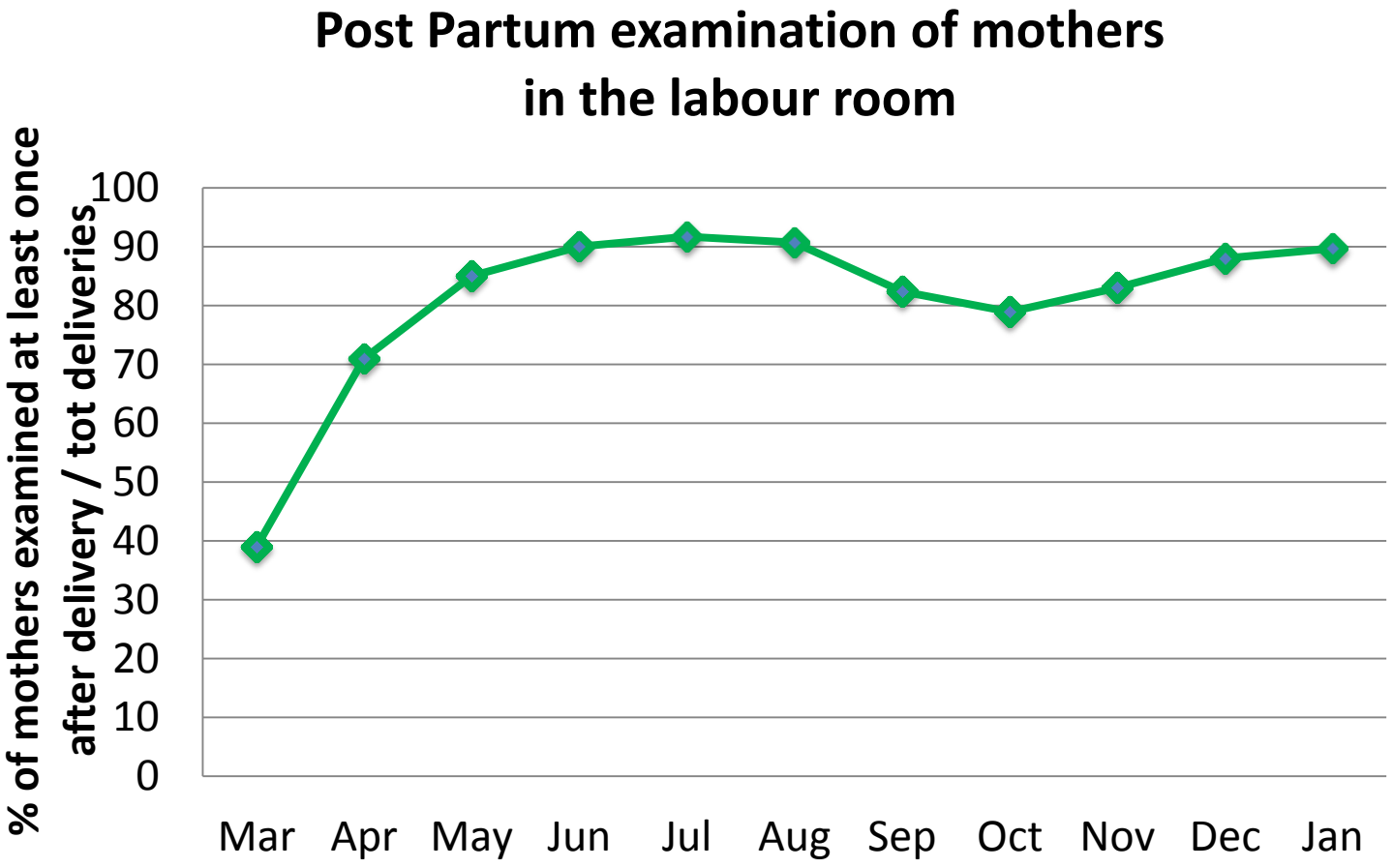
Timetable for the implementation of the new approach

- Apr 2011: Nasr Tahrir (Khan Younis) - 900 d/m
- Jan 2012: Tal Al Sultan (Rafah) – 600 d/m
- Jul 2012: Shifa (Gaza) – 1300 d/m
- Jan 2013: Al Aqsa (Mid Zone) – 500 d/m

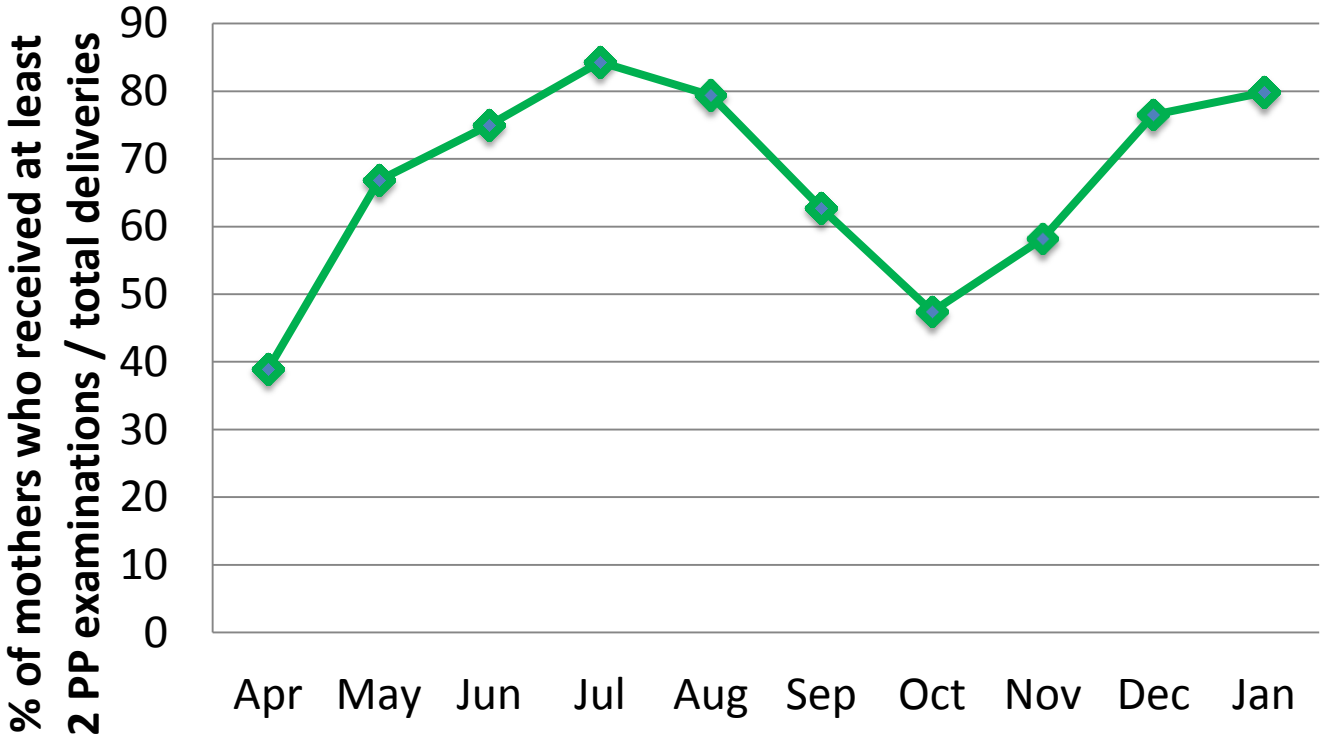
% Risk assessment at admission

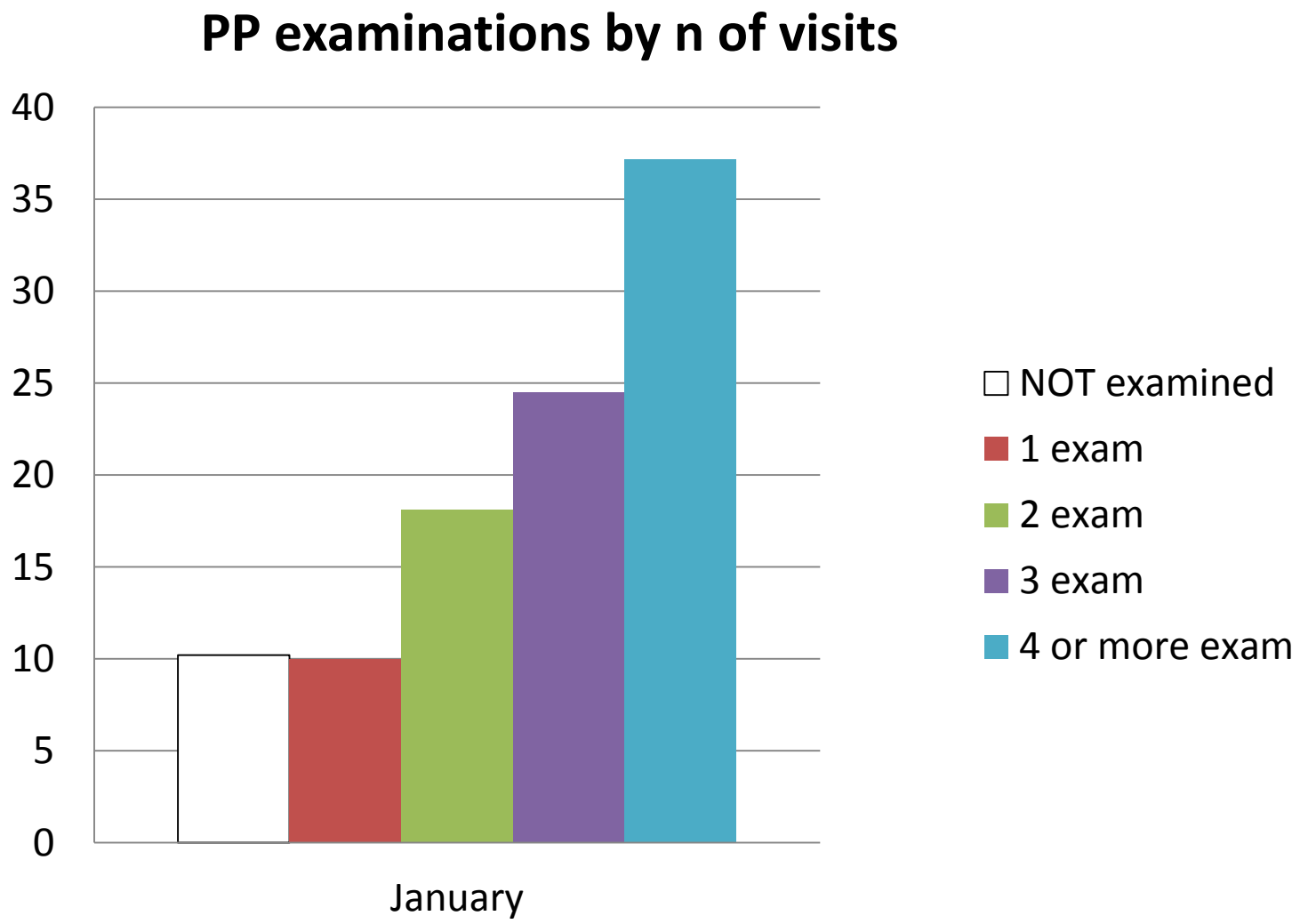


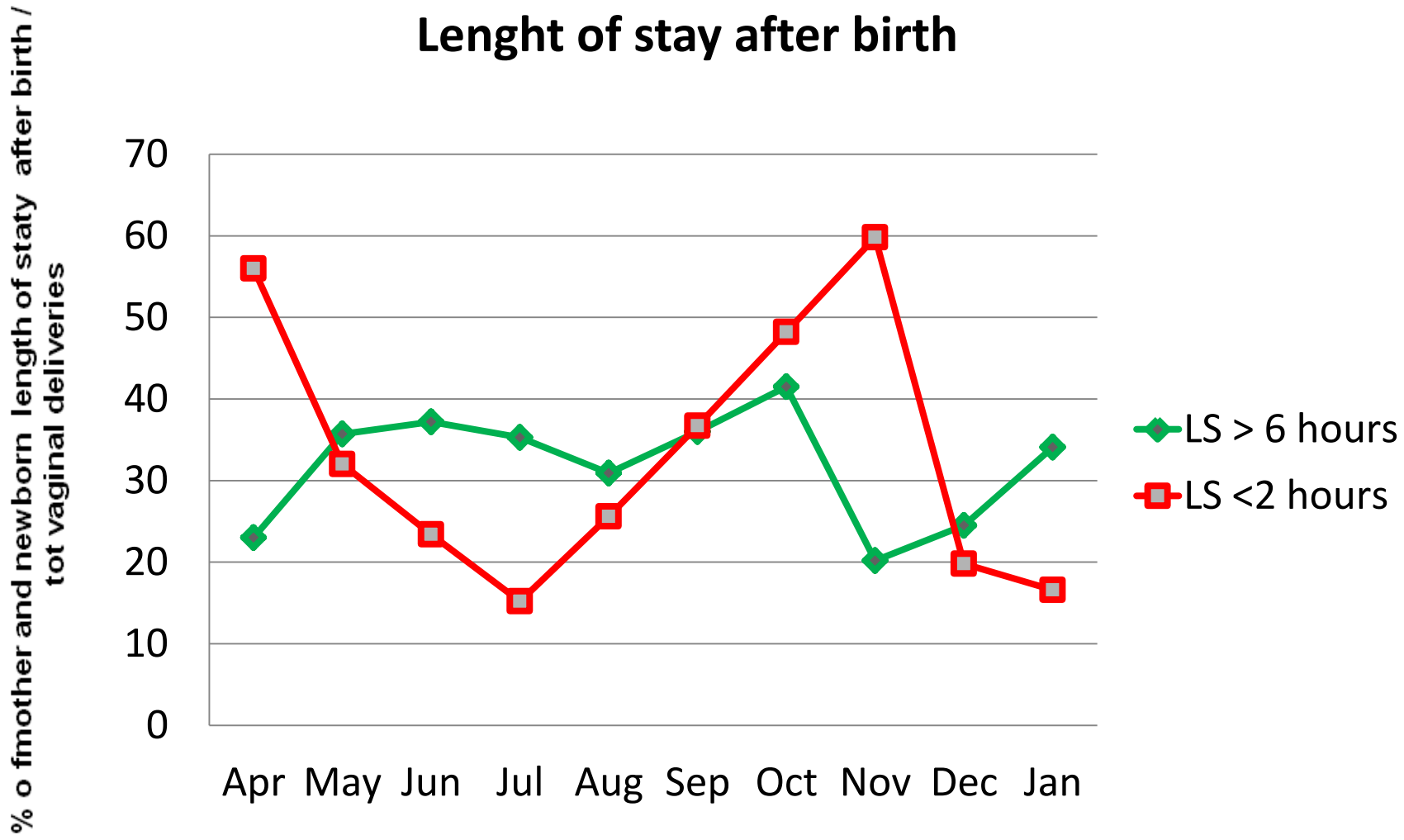

% of deliveries conducted by midwife
% of deliveries with care provided by midwives, % of risk assessment and % of low risk at admission out of tot deliveries
45
40
35
30
25
20
15
10
5
0
Mar
Apr
May
Jun
Jul
Oct
Nov
Dec
Jan
Deliveries by midwives
Low risk cases identified by risk assessment

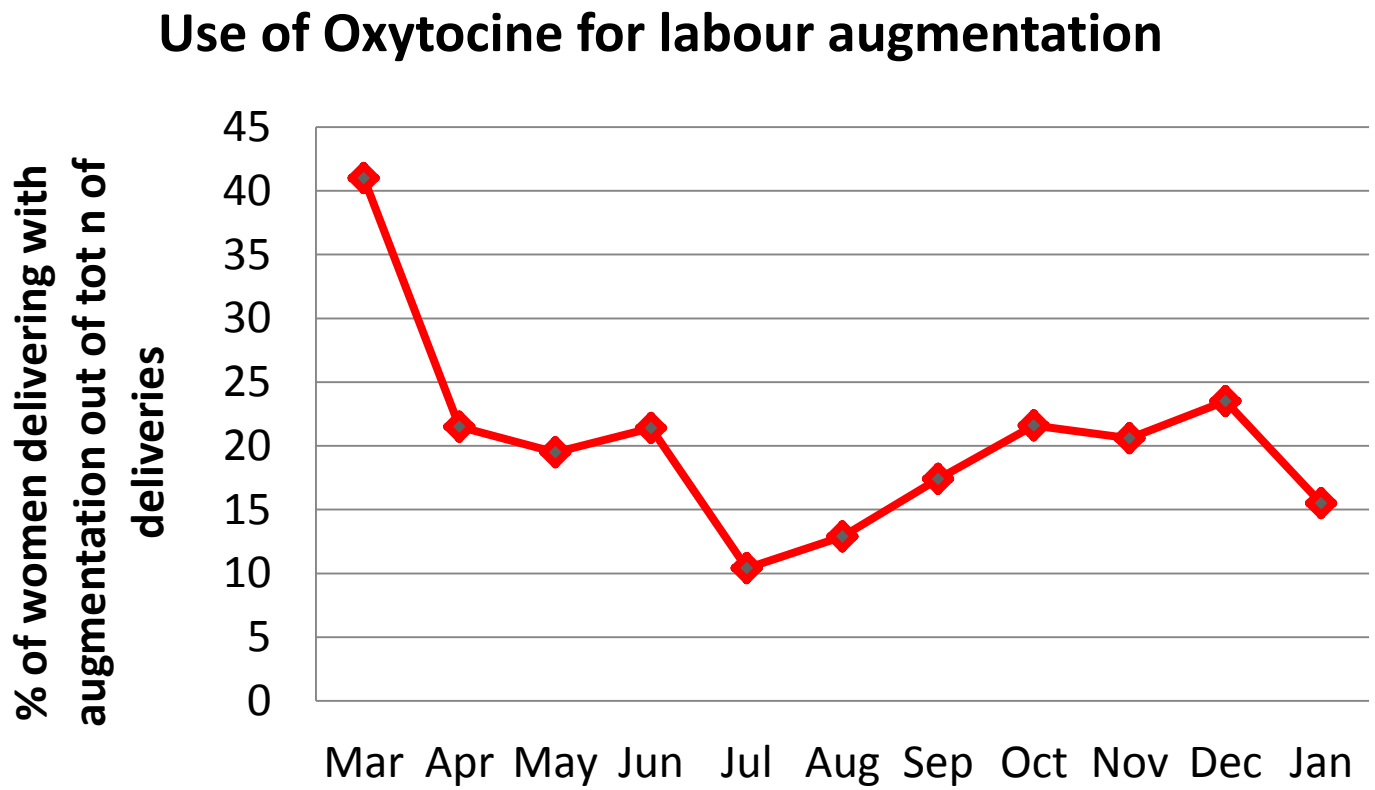

Post Partum examination of mothers in the labour room
% of mothers examined at least once after delivery / tot deliveries
100
90
80
70
60
50
40
30
20
10
0
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan

Post Partum Examination in the PN ward




PP examinations by n of visits
40
35
30
25
20
15
10
5
0
January
NOT examined
1 exam
2 exam
3 exam
4 or more exam


Lenght of stay after birth
% o fmother and newborn length of staty after birth / tot vaginal deliveries
70
60
50
40
30
20
10
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan
LS > 6 hours
LS <2 hours



The risk of **stillbirths** or **neonatal distress** has proved to increase between 2 to 5 times as a result of inappropriate use of oxytocine.

Up to 44 % of cases of **ruptured uterus**, a disastrously poor outcome of labour, has been associated with inappropriate use of oxytocine for induction and augmentation.

What made change happening?

- Assessment/agreement on standards of care
- Establishment of information system
- Training but only practical
- Visiting other reality: Makassed
- Involvement of H managers and policy makers
- Top down directions/Recognition to the staff

How change will be sustained?

1. Audit and feedback to the staff
   - Routine statistics (measuring what is being done)
   - Quality of some procedures
   - Perinatal death audit
2. Information to the women
   - PHC AN visit (MoH and UNRWA)
   - Community “conferences” (Women NGOs)

What takes to success?
Some considerations in progress

- The innovation must be visible
- De-medicalize medics is too difficult
- Midwives must raise their own pride
- Bottom up and top down must go together
- Training is not the way
- The amazing power of information