"Obstetricians Are Always Taking a Position against Us": The Politics of Contemporary Midwifery and Childbirth in Palestine

Frances S. Hasso and Aisha Barghouti Saifi

Abstract

Although until the late 1960s women's reproductive health care had been largely the domain of Palestinian women healers, midwives, and nurse-midwives, the contemporary reproductive healthcare system in Palestine is medicalized, masculinized, and commodified in an indigenous society already suffering from the brutality of Israeli occupation. Based on interviews with eight experienced Palestinian midwives, scholarly and field research, and field knowledge, this article examines ideological and practice differences among midwives, and between some nurse-midwives and traditional midwives (*dayat*), largely in contemporary Jerusalem and the West Bank. It highlights sharp gendered class contradictions in midwives' relations to obstetrician-gynecologists and the Palestinian Authority Ministry of Health; points to the rise and impact of a biomedical interventionist risk sensibility on the physician-led hospital shop floor; and considers the psychic and sexual dimensions of working with women seeking reproductive healthcare, including the impact of trauma and limited reproductive agency.

Keywords:

Obstetrics-gynecology; biomedicalized reproduction; childbirth risk; Palestinian midwifery; Palestine Ministry of Health; sexual and reproductive agency.

The professionalization of reproductive, childbirth, and maternal care since the nineteenth century has aligned with its masculinization and medicalization

the world over, and its commodification in capitalist societies. Two dimensions of medicalization are the "modern" rationalization of treatment and care (breaking the whole into discrete specialized parts) and substantial state legal interventions that have served the economic interests of the field of obstetrics-gynecology. Palestine today offers less a counterpoint to this trajectory than an important case study shaped in specific ways by Zionist settler-colonial rule in Palestine since 1948. The presence of the Palestinian Authority (PA), established by the Oslo accords in 1993 as an "interim" self-governing body for Palestinians in parts of Palestine occupied by Israel in 1967, has also been an influencing factor. Physicians have played a significant political role historically and in the present in Palestine, actively supporting and frequently leading Palestinian resistance movements, institutions, and political parties – nationalist, Marxist, and Islamist.[1] Reproductive healthcare, which had largely been the domain of women in Palestine as late as the 1960s, has since become dominated by male Palestinian obstetrician-gynecologists (ob-gyns) and highly medicalized.[2] As one Palestinian nurse-midwife explained, in Palestine today, "Most women do not feel safe delivering without the hospital complex behind them."[3]

This article is based on informant interviews conducted in June 2017 with a purposive sample of eight experienced midwives in Palestine, as well as scholarly and field research, and field knowledge. The research found ideological and practice differences among contemporary Palestinian nurse-midwives and between some nurse-midwives and traditional midwives, and clear gendered class contradictions in their relations to ob-gyns and the Palestine Ministry of Health, established in the mid-1990s.

The Palestinian nurse-midwives were divided as to whether they should have more independence in delivering reproductive healthcare. While most advocated and struggled for increased autonomy as holistic practitioners, including the ability to provide care such as suturing perineal or vaginal tears after birth, many have internalized a biomedical interventionist risk logic, common in physician-led reproductive care and a litigious environment. Holistically inclined midwives are challenged by the dominant realities in Israeli-occupied Palestine, which include medicalization and a male-dominated society, healthcare system, and political system. These problems are exacerbated by overwork, low pay, and understaffing. Some midwives discussed the psychic and sexual dimensions of working with women seeking reproductive healthcare, including the impact of trauma and limited reproductive agency. These concerns are not included in biomedical training and institutional practices focused on profit, technological interventions, the ideologically normative family, and international metrics of "development."

Most Palestinian families in Palestine have a limited income and live in segmented areas under layered regimes of racialized rule. Patchy healthcare is delivered in private and government hospitals and in outpatient clinics sponsored by individual physicians and physician groups, religious institutions, UNRWA, Israel, and the PA in a health system whose every dimension – funding, movement, accessibility, imports and access to materials and equipment – is ultimately controlled by Israel. This situation

has "direct implications for [Palestinian] quality of life and mortality" and powerfully shapes how reproductive healthcare is delivered to and experienced by Palestinian women and the work conditions of nurse-midwives.[4] Interviewed midwives and the authors took as axiomatic the violence and extreme mobility and health difficulties Israeli settler-colonial rule imposes on Palestinian medical staff and women seeking reproductive care. Walls and checkpoints, for example, produce travel delays and extra expenses, circuitous and exhausting routes, and closures.[5]

After methodological remarks, the article discusses conflicts between Palestinian nurse-midwives and physicians as gendered social classes, with the autonomy of ob-gyn and subordination of nurse-midwives reinforced by the PA Ministry of Health in public and private healthcare settings. This section also shows how the profit motive produces specific gendered class contradictions and consciousness on the hospital shop floor. The subsequent section discusses a divide among the midwives interviewed about their degree of treatment autonomy, with some accepting medical limits to the scope of their treatment practices and/or worried about increased litigious sensibilities among patients and their families. The final section considers sexual agency, knowledge, and trauma among patients as dimensions of reproductive care and overall wellbeing.

Methodological Remarks

This article is based on interdisciplinary qualitative research and takes seriously the analysis, experiences, and insights of midwives. Rather than a representative sample of all contemporary Palestinian midwives, it uses a purposive sample of informants – midwives who are also mentors, teachers, professors, institution builders and leaders in the field – in order to understand observed and experienced structural and institutional power differentials and tensions. Frances Hasso chose the midwives interviewed in 2017 guided by how other midwives reported their significance in maternal healthcare knowledge and practice networks in Palestine. The interview protocol was shaped by her interest in the transformation of midwifery and reproductive healthcare in modern Palestine. Some attention was paid to generational and regional diversity among midwives, although the latter was limited due to the apartheid grid of movement restrictions imposed by Israel. The interviewees, all women, included six nurse-midwives and two traditionally trained midwives, most of whom worked in the Jerusalem, Ramallah, and Bethlehem areas, but had trained and worked in multiple areas in Palestine and abroad. A strong tradition of Palestinian midwifery continues in Hebron, but no midwives were interviewed from that district because of travel difficulties. Gaza, too, was inaccessible because of the Israeli siege.[6] Hasso recorded all interviews and conducted Arabic-to-English translations.

In early 2023 on a visit to Palestine, Hasso invited Aisha Barghouti Saifi, one of the nurse-midwives originally interviewed in 2017, to co-author the paper given her analytical contributions and professional experiences and knowledge in the

field. Saifi's contributions to the empirical and analytical dimensions of the article are substantial and not placed between quotation marks unless they originate from the interview conducted by Hasso in 2017. Inviting her as a coauthor corrected and deepened the empirical and analytical dimensions of the article and provided a concrete way to name the degree to which the midwives interviewed are professional practitioners, historical and ethnographic observers and analysts, and theorists.

In the spirit of renegotiating consent, maintaining good relations with and in a small community of high-level professionals, and assuring accuracy, we shared a pre-submitted draft with the interviewed midwives and invited and incorporated their comments, including about their anonymity and association with direct quotes.[7] While one double-blind reviewer asked for all names to be anonymized, we did not follow this recommendation because this is an interdisciplinary ethnographic endeavor informed by feminist sensibilities that consider how gender and class determine which "experts" and "leaders" are named as analysts and informants in scholarship.

Given the forced segmentation of Palestinians, the fragmented and layered political regimes governing healthcare and healthcare workers, the plural healthcare systems, limited available archival documentation, and the importance of different periods and locations in colonized Palestine, we include information on the professional trajectories of identified nurse-midwives in endnotes at first mention. This information may be useful as a line of inquiry for other researchers. Rather than considering this article an exhaustive treatment, we hope it is taken as an invitation for especially Palestinian researchers and health practitioners to do further research and analysis.

Gendered Class Antagonisms in the "Ministry of Physicians"

The autonomy and preponderance of Palestinian midwives in treating women's sexual and reproductive needs and assisting with childbirth in Palestine has largely disappeared because of medico-legal and policy changes led by male ob-gyns in alliance with governments.[8] Rita Giacaman shows the increased biomedicalization of childbirth by the early 1980s in the Israeli-occupied West Bank.[9] She and her colleagues found medicalized pregnancy and hospital birth to be the most significant trend between 1967 and 1993 in the West Bank and Gaza, largely motivated by Israeli concern to improve the tracking of Palestinian birth rates. The trend intensified under the PA Ministry of Health established after the Oslo accords.[10]

The Palestinian Union of Nursing and Midwifery (*naqabat al-tamrith wa-l-qibala al-filastiniyya*) split from the Jordanian organization in 1988 to create an independent Palestinian body. In 1994, the Palestinian union created two branches, in the West Bank and in Gaza. After 2007, the Gaza branch became completely independent of the West Bank branch. The ruling Fatah faction in the West Bank does not allow the union to operate independently or hold elections and bans substantive representation for other political factions or non-affiliated midwives. In comparison, the Gaza organization, led by Hamas since 2007, represents all Palestinian political factions by

organizational quotas and includes a representative for midwives.

One nurse-midwife called the PA Ministry of Health a "Ministry of Physicians" that sets the rules in their favor, removes power from midwives and nurses, and pretends that "physicians know everything." The PA has "given all the authority to physicians," she added, a situation that only worsened over time. Palestinian men physicians are policymakers at all levels of the Ministry of Health and lead general directorates, hospitals, hospital wards, clinics, and primary healthcare centers. Physicians use these positions to influence ministers and other high-level stakeholders and to open doors to other opportunities, promotions, and career development.

A mid-1990s decree from the first PA Minister of Health, Riyadh Za'nun (1994–2002), banned traditional midwives and nurse-midwives from assisting in homebirths. The ministry partially reversed this position after the outbreak of the second intifada in 2000, allowing traditional birth attendants (*dayat*) to assist with homebirths because of heightened Israeli violence, closures, and invasions.[11] It remains difficult, however, for the ministry to exert control over all Palestinian women in need of pregnancy and childbirth assistance in a highly fragmented country with no meaningful Palestinian sovereignty, especially in villages and towns distant from the urban centers where medical support is concentrated.

The formal subordination of Palestinian nurse-midwives to physicians in the West Bank exists despite Sahar Hassan's establishment in 1997 of a training and licensing system for Palestinian midwives based on international criteria.[12] The Ibn Sina Nursing and Midwifery College she revitalized as dean used International Confederation of Midwives' "documents, recommendation, and criteria" to design its licensing requirements "because we didn't have anything else here to reference."[13] Nevertheless, using the Ministry of Health, Palestinian physicians weakened the authority of nurses, midwives, and medical lab technicians, groups that have recently begun to call for their rights. Rules established by Palestinian ob-gyns under the ministry decree that only physicians, no matter the experience and training of a midwife, can decide "who can and cannot suture," without "any criteria or system."[14] Nurse-midwives in Gaza are more likely to operate as nurses rather than caring for pregnant women from initial evaluation to childbirth–although the protocols for their scope of practice apparently would allow them to do so–because they are less likely "to want these responsibilities," according to a senior nurse-midwife and researcher in Gaza.[15]

Each Palestinian hospital in the West Bank and Jerusalem creates bespoke job descriptions for midwives designed by the leading ob-gyn, and some have no such scope of practice descriptions. Some hospitals require a physician to conduct the first pregnancy exam and take charge of a woman's first pregnancy. Some hospitals allow midwives to deliver preterm babies. Whereas there is some variety among Palestinian government hospitals, private hospitals give no authority to nurse-midwives, who must always follow the decisions of the physician in charge. In all cases, only physicians are authorized to suture vaginal tears. Ultimately, the scope of practice of a midwife is entirely dependent on what an individual physician cedes to her in a particular medical institution. The busier he is with other locations, the more he may

give the midwife a margin of freedom in her work. However, the same physician will immediately withdraw this scope of responsibility when he is experiencing a slowdown in business.

Vartouhi Koukeyan explained that having autonomy from physicians in treatment protocols and a holistic approach to the woman patient distinguishes midwives from nurses.[16] For holistically oriented midwives and nurse-midwives, the birthing woman should decide how she wants to give birth. Traditional midwives, she explained, knew "how to work with women in labor," 96 percent of whom do not fall into high-risk categories that require biomedical allopathic interventions in Palestine or elsewhere. Like Hassan, Koukeyan drew on international midwifery standards to make her forceful points: "If we speak of the International Confederation of Midwives directives, internationally midwives are women – I hope this job will stay as a women's job – who are autonomous in their ways of thinking and practice and very different from nurses, who are usually guided to do things…. Nurses may not take decisions and manage the case…. That's the difference between nurses and midwives."[17] She glossed further on the social power that accrues to successful midwives:

> Midwifery is known to have had strong women or else you cannot do it physically, mentally, or socially. You must have leadership character so that you lead the whole community you work within. Women in Eastern societies do take decisions, even when it may appear as a male decision. They often do it covertly [*taht batin*] and put the man in front; they have no problem with this system if they get what they want. Usually this was the role of midwives in local communities. That was their power, these women, whether they were dayat [traditional] or *qabilat* [institutionally trained and licensed]. This is why they were powerful and respected in their communities beyond childbirth and were involved in marriages, engagements, and so on. People kissed their hands when they saw them on the street. I remember daya Malakeh Wahbeh in Jerusalem, she probably birthed the entire Nasara area of the Old City. When she walked with shopping bags, she could demand of any man to carry her load home for her. He would say, "Thank you, Khalti," instead of her thanking him.[18]

Palestinian nurse-midwives regularly explained that pregnancy and childbirth healthcare is a substantial market and source of wealth for physicians, surgeons, and other medical "experts" (commenting, for example, "obstetrics makes you a rich man" or "obstetrics brings you money"), leading to competition with midwives. Obstetrician-gynecologists "do not want a midwife or daya around them who would be paid something quite symbolic anyway. So, it's good business to be an obstetrician even though most pregnant women require midwifery, not obstetrics."[19] Midwives allowed to practice within their full scope of training and experience would pose real competition to obstetricians not only as alternative sources of care, but by reducing the frequency of lucrative visits as women patients become more informed about their bodies and non-medical options. Miriam Shibli, a Palestinian nurse-midwife at the

EMMS (Edinburgh Medical Missionary Society) Nazareth Hospital, discussed similar power conflicts between midwives and physicians, and midwives and hospitals: "Israel rewards women for giving birth in hospitals and gives them money for doing so. They didn't want to give insurance to home birth midwives so there was a struggle because of economic self-interest, all on the backs of women."[20]

Huda Abu El Halaweh, a midwifery supervisor and professor at al-Quds University, also linked the subordination of midwives to the economic interests of ob-gyns, backed by the Palestinian Authority:

> Today in Palestine, midwives have not reached the independence we want for a variety of reasons. We are trying to develop curricular programs but need assistance from Palestinian health policies and institutions. The obstetricians want to keep the work. [They think,] This is a small country and if you get stronger as midwives you would take the work from us. Obstetricians and physicians are always taking a position against us. We had a proposal to allow nurse-midwives to make the cut to the perineum if needed, an episiotomy; we held workshops and trainings, but the doctors resisted. They said, we know what things midwives worldwide are capable of, but we don't want you to do them. There are medications we are allowed to prescribe but we can do more. We should be able to do internal physical assessments, but they don't allow us to do it. Pushing further requires fighting with the doctors and Ministry of Health about the limited job description for us. We are fighting for scope of practice – a more open approach related to our training. Do not delimit us this way.[21]

In her research with midwives and birth attendants working in al-Makassed Islamic Charitable Society Hospital in Jerusalem and with the Union of Palestinian Medical Relief Committees in the 2000s, Livia Wick found high class consciousness and resentment among midwives and birth attendants about their long work hours, low pay, and limited ability to be with their families or have leisure in comparison to the physicians who supervised them.[22] A male obstetrician complained to Wick that Palestinian midwives are "mutinous! It is not like Europe and America," where he presumed midwives are more agreeable.[23]

Palestinian nurse-midwives suffer the heaviest workloads and least respite and earn "the lowest salaries" among healthcare workers, according to a 2005 study at a large West Bank hospital.[24] Nurse-midwives and nurses reported they are frequently humiliated at work by patients and their families, managers, and physicians, often bearing the brunt of abuse for lack of staff, material support, and time for patient care in the hospital system.[25] Nurse-midwives in the European Hospital in Gaza similarly reported overwork, "low professional status," poverty, minimal support, and limited training as they provided maternal care during the Covid-19 pandemic.[26]

Gendered labor relations, the content of labor, capitalist commodification and profit logic, and medicalization divide nurse-midwives from ob-gyns and even from different-minded midwives in how they relate to the pregnant, birthing, and

postpartum woman. Ob-gyns' approach to profit and time are key. Midwifery requires giving patients the time necessary to allow them to understand the things that happen to their bodies and feelings during pregnancy and labor.

Most ob-gyn physicians in the West Bank and Jerusalem, however, are balancing work in multiple hospitals and their own private clinics, so when on shift, they want to finish quickly. When women are in labor, nurse-midwives recognize there is an unspoken race for physicians to deliver them as soon as possible. This dynamic is intensified because Ministry of Health policies in hospitals give physicians the first and last responsibility for the pregnant, laboring, and postpartum woman and fetus or newborn. A nurse-midwife explained the labor relationships to Wick, deliberately within the hearing of a physician, "Even with complicated births, we stay with the woman until she is fully dilated. Then, at the very end, the doctor comes in." To which the obstetrician defensively responded, "Doctors have other responsibilities such as operative deliveries, outpatient cases and gynecology cases."[27]

Overmedicalization in hospitals increases exposure to infections and unnecessary surgeries in comparison to home births, which also allow women to move around during labor to expand the space for a baby's head to emerge. Hospital methods anchor women patients to beds and are tied to the time and schedule concerns of physicians, management, and other hospital staff, greatly increasing the rate of surgical or Cesarean section births – around 32 percent overall and 37 percent in private hospitals in the occupied West Bank excluding Jerusalem in 2018.[28] Time pressures also impact the work of nurse-midwives in hospitals, irrespective of their sensibility and orientation. Overworked nurse-midwives in understaffed institutions cannot afford to spend individualized time with patients in labor because they "can barely keep up with the work."[29]

Biomedicalization and hospital conditions have other consequences. Traditional midwives immediately cleaned the mother after birthing and "put her baby on her chest" rather than taking it away to conduct examinations. They fed the postpartum mother, "sometimes with a nine- to ten-egg omelet," whereas in hospital settings they express "nurse-midwives fear feeding her because of the epidural." Saifi explained the differences to Hasso when interviewed in 2017:

> In the old houses, the room in which she gave birth was next to the kitchen, allowing her to eat and nurse at the same time. The daya would check the afterbirth and blood while the woman used the bathroom. She bathed the baby. It was continuous follow-up by one person. In the hospital, I will have finished my eight-hour shift and someone after me will take over. Each midwife has her own way. Some people now say that it's important not to immediately cut the cord, to wait five minutes, because there are many, many, many benefits. In hospitals today they are violently efficient to placentas. On the other hand, in the old days, they did not stitch a tear to the perineum, which is necessary, whereas today we help it tear and stitch it. People who say midwives were not hygienic

are wrong. They always had hot water, everyone had clean hands and there weren't many hands involved.[30]

Gendered class-based antagonisms between midwives on the one hand and ob-gyns, hospitals, and the Ministry of Health on the other align with the values of a capitalist, patriarchal, undemocratic society under Israeli occupation, and articulate in most homes and workplaces as well. Nurse-midwives' ability to improve their work conditions is limited by an ever-deteriorating economic situation and unstable job opportunities. The unpredictable day and night nature of the work combined with ubiquitous Israeli-imposed closures, crises, and delays also create drains on time, money, and emotions, especially for married midwives and midwives with young children. As a result, many midwives switch in and out of the field or a particular hospital to recover from unsustainable work conditions, or leave midwifery to work in medical administration or the beauty industry.

"Stopping at Our Limits:" Risk, Litigation, Documentation

By the late 1960s and increasingly since, the male physician-led biomedical childbirth experience in a hospital came to exemplify modernity and safety for Palestinians. Pregnancy and childbirth are now thoroughly medicalized processes that require pregnant Palestinian women in areas under PA administration to go to a hospital to establish a formal file for prenatal care and delivery.[31] A visit to an ob-gyn typically begins with an ultrasound to determine the gender of the fetus, "which plays a big role in our Eastern society," and take a woman's blood pressure.[32] Jerusalem is a different political field with overlapping jurisdictions where one nevertheless finds similar Palestinian pregnancy and childbirth dynamics. In this context, some Palestinian nurse-midwives expressed anxiety about the legal and professional consequences of decision-making autonomy in reproductive care. Some even argued that the ob-gyn on call should ultimately be in charge, even if midwives delivered most babies.

These anxieties were rooted in a number of factors: low healthcare information-seeking by most Palestinian patients, an increased litigious sensibility, the organization of the male-dominated physician and hospital legal-medical complex itself, and perennial understaffing/overwork.

A Palestinian obstetrician in Jerusalem alluded to the legal risk attached to being in charge when he explained to Wick, "The biggest problem for us is that in the end, we are responsible for everything that goes on in the labor room. If there is a problem or a mistake, the obstetricians are held accountable for it."[33] From a different angle, Abu El Halaweh connected the high rate of C-sections in Palestine to fear among nurse-midwives that something might go wrong with the patient under their care: "When nurse-midwives lack information on the problem with the woman in labor, we quickly send everything to Cesarean, Cesarean, Cesarean. As soon as we're a little afraid, we go for a Cesarean."[34]

Hasso came to realize the impact of fear of litigation in Palestine during repeated attempts to find archives of missionary hospitals serving Palestinians, most of which

continue to operate under their foreign sponsors based in the United States, Germany, Italy, France, and the United Kingdom. She was dissuaded, redirected, and blocked with every visit, phone call, and email, as were local Palestinian health professionals who tried on her behalf. When she asked a southern West Bank nurse-midwife about hospital medical archives in her area, the latter explained that the law does not require hospitals to keep medical records beyond twelve or at most fourteen years and thought that institutions actively got rid of them in case they might be recalled for lawsuits. Abu El Halaweh, who works in Jerusalem, also noted fear of litigation as a possible motive when asked why Palestinian-serving hospitals seemed to destroy historical archives and added that no Palestinian sovereignty exists in any case to establish archival protection and standards.[35]

Unwarranted perceptions of risk among midwives and obstetricians have increasingly led to "unnecessary intervention and surveillance" over low-risk women in labor in other parts of the world.[36] A valuable meta-analysis of fourteen articles published between 2009 and 2014 for six countries (UK, United States, Australia, New Zealand, Belgium, and Canada) found midwives increasingly likely to absorb a technocratic model of pregnancy and labor that "extols technology and anticipation of pathology" in obstetrician-led medical settings.[37] While practice guidelines encourage midwives and obstetricians to understand pregnancy and birth as normal events for low-risk women and babies, "women's confidence in their ability to have a normal birth is increasingly diminished," often because of "an increased focus on risk assessment and risk management with high-tech maternity units often viewed as the safest place to birth."[38]

The analysis found that neither obstetricians nor midwives working in such settings understood risk and "intra-partum uncertainty" as a part of life for low-risk pregnancies and labor or saw "technology as a servant and not a master."[39] Midwives have also absorbed "time restriction" logic and learned to fear litigation in hospital settings, leading to higher perceptions of risk despite similar perinatal outcomes for limited and high-tech intervention pregnancies among low-risk women.[40] Midwives in one study explained that given the nature of hospital settings, "where control is often taken from the woman," it can be very difficult to approach pregnancy and labor as a shared responsibility between midwife and patient where they both resist "the dominant obstetric discourse of risk."[41]

In June 2017, Hasso conducted an interview with a traditionally trained and experienced Palestinian midwife in her sixties while accompanied by an experienced Palestinian nurse-midwife in her thirties. Given the sensitive content of the conversation and the apparent disagreement that developed, each is given a first-name pseudonym (Amal and Zaynab).

As Amal discussed touch remedies she used to help women become pregnant, including massage and internal examination of the uterus, Zaynab explained, "It might be flipped a bit." Amal responded, "No, not turned, sometimes it has slipped." The younger midwife glossed, "Sometimes it is pushed to one side, we find in internal examinations," while Amal said, "Sometimes most of it is wrapped to the right side." When the younger midwife asked, "Have you ever done a *surra* [herbal remedy]

to help women get pregnant?", Amal said she had, but, "Today I suggest fertility products [*tahamil*] they can buy from the pharmacy. I used to make such mixtures of garlic or onion peel [wrapped into tightly wound cheesecloth]. A woman boiled it in a large pot of water and then stood over the steam for ten or fifteen minutes while she had her period, so if anything is closed, it will open." Zaynab seemed torn, declaring that some traditional infertility treatments are myths but that others work.

To Zaynab, what Amal knows "is not knowledge based on theory." Amal agreed, "Exactly. It's based on skills." Hasso added, "It's also based on experience, on whether or not something works." Zaynab explained, "The educated midwife knows the rationale of why to do, for example, a delayed cord clamp. There are people who use the same method but don't know the rationale – nevertheless, they are correct." Amal switched the framing, however, from abstract "knowing" to individualized and grounded "learning with" a particular woman's body:

> My goal is to learn with a given woman, does her uterus work or not? I examine it with my hands and listen for the beats, the pulse [in English], whether it is working or not. Sometimes it is not beating. I do a massage that lasts five or ten minutes with light oil, which activates the uterus [*bi shaghil al-rahm, ba'ti nashat*].

Zaynab agreed, using biomedical terminology instead, "Correct, it redistributes the blood [circulation]."

While they agreed that traditional and medically trained midwives provide great psychological and physical comfort to women in labor, the conversation became tense when Amal told us the story of delivering a breech birth at her home maternity:

> Amal: When I saw her, I realized she was breech. I said to myself that I can't scare her and I didn't tell her husband for the same reason. I ordered him to stay outside. Where are her clothes, I asked? He said, I can bring them. The woman was full, ripe [*mistawiyya*]. When I came out of the examination room, he asked, what do you see? He was suspicious because my face had changed.
>
> Zaynab: Breech births are scary.
>
> Amal: I told him everything is fine. He asked, are you sure? I said, yes. I wore gloves and delivered her.
>
> Zaynab: That means the breech was out [meaning, resolved].
>
> Amal: No, no, it was not out.
>
> Zaynab: Today, all breeches are Cesarean.
>
> Amal: Haram, haram [what a shame, shame].

> Zaynab (disapproving): I'm with us stopping at our limits. After fifteen years as a midwife and ten years of reading, I say we must know where to stop [*baqulik lazim inna ni'rif wayn inwaqif*]. Because a small accident, God forbid, burns all the good things you have done.
>
> Amal: That's true.
>
> Zaynab: This is *imkhatareh* [risky], two souls, the woman and the baby.
>
> Amal: I know where to stop.

Amal responded in the affirmative when Hasso asked, "If there is a rip, do you suture?" When asked if she had ever faced problems while assisting a childbirth:

> Sometimes, sometimes there is a bit of bleeding. But I know how to deal with it. I give her Methergine [*methylergonovine maleate*] or a shot of Syntocinon and I massage her. I wear sanitized gloves and I clean her entire uterus and with the other hand I massage her like this [on her thigh]. When I do this massage, everything ends, the uterus contracts. Before she even begins nursing, before everything, she must go to the bathroom to have a bowel movement after she gives birth. If she does this, she has no problems afterward. Nothing. I order her to go to the bathroom right away. Thank God. This is a rare event.

The conversation illustrates epistemological, knowledge, and sensibility differences based on generation and praxis, but Amal (like "traditional" midwives generally) integrated pharmaceutical interventions and scientific knowledge as she deemed necessary. In comparison, Zaynab, a nurse-midwife with university and hospital training and certifications, was much more constrained by a biomedical epistemology and legal and social fears that encourage risk-adverse methods (that are not necessarily less risky in Palestine, empirically) under the leadership of obstetricians. Amal worked mostly outside hospital settings and brought longer experience as a practitioner and a range of knowledge sets to the work, including in collaboration with Palestinian physicians in private practice.

Litigation is necessary for incompetent physicians. Many medical errors should be examined carefully and in some cases, autopsies conducted. Such errors are coded in ways that avoid investigation in hospitals run by the Palestinian Authority. In Jerusalem, this is less likely to occur because the Palestinian-serving hospitals are regulated by an intimidating Israeli colonial system. Palestinians have brought many valid malpractice lawsuits against Palestinian and Israeli hospitals. Physicians often do not take careful medical and surgical histories, which would improve patient care and protect them from liability if something they could not control goes wrong.

Hospitals and clinics are understaffed, health staff work under extreme time pressure, and pregnant women and their families can be deliberately non-transparent

when communicating medical histories. When a pregnant woman comes in for an appointment in a Palestinian setting in Jerusalem, there are typically thirty women waiting outside the exam room over the entire shift, making it impossible to conduct thorough histories. In the limited time afforded each patient, an ob-gyn must conduct an ultrasound, measure many other vital and health indicators, and speak with the patient about other problems. The situation is the same in PA-run health institutions: medical staff and time are limited. In addition, while parents usually know of a longstanding medical problem with a pregnant daughter, they do not always share the information with medical staff because they consider it taboo or the girl is afraid of her husband knowing and divorcing her. In such cases, complications during pregnancy and labor are more likely, but the family may still blame the hospital.

Jamilah al-Kawasmi, an experienced Jerusalem nurse-midwife, is among the few Palestinian nurse-midwives licensed by Israel to assist women in homebirths, although she does not do this. She linked litigation fears among nurse-midwives with biomedicalization and lack of knowledge-seeking and agency (for lack of better terms) among the typical young Palestinian women she treats. She believed that "for Palestinians today, childbirth is almost worse than it was in the past because it is both biomedicalized and women patients have given up all authority to the hospital." She explained:

> Midwives worry they will be blamed if anything goes wrong in a homebirth because now parents want to go to court to benefit materially or to blame someone else, even if they lose. Whereas if the same incident occurs in a hospital, people are more likely to accept it.[42] Even so, today's midwives know a lot more than traditional midwives and consider and prepare for many possibilities during childbirth. They know who to contact if there is any problem during a homebirth. Nevertheless, I do not have the courage to do homebirths here.
>
> The mentality differs between Arab and Israeli maternity patients. The latter read, know and ask more about pregnancy and childbirth based on my experiences of birthing both in hospitals. By the time she is twenty-two, the Palestinian *sitt* I see typically has two children and is usually not independently prepared for pregnancy and childbirth when she comes into the hospital. She depends for information on her mother and mother-in-law, who ultimately make the decisions even as she is sitting on the hospital bed. When I worked in the village of al-'Isawiyya, I would tell her, "This is your body, decide what you want for yourself. Do you want assistance with the labor or not? Take a course on pregnancy and childbirth." In comparison, Israelis take a complete course on pregnancy and childbirth and visit the maternity department and compare it with others.[43]

Al-Kawasmi explained, in addition, the implications of computer-based documentation within the dominant medico-legal system for pregnancy and childbirth care in Jerusalem:

> Now, every single thing must be entered into the computer. Before, you used to write *and* explain to patients. No, it is not like that today. If something a patient said or you said is not written into the computer, it is not considered to have occurred. In turn, whatever is written is what you are held accountable for. Nurse-midwives are very scared now. They say we must protect ourselves before the courts. I must think about how I would be held to account if I make a mistake. They may force me to leave my work or punish me, and I would lose my profession and livelihood. If I do not work, I cannot educate my children, eat or live. Our life here is very difficult economically.[44]

Class- and education-based differences surely divide most Israeli settlers from most colonized Palestinians seeking reproductive healthcare in Jerusalem, but so do comparatively more conservative attitudes and restrictions regarding marital relations, sexuality, and reproduction among Palestinians. The latter holds true even when comparing occupied Palestine to most other Arab countries, which indicates that Zionist settler colonialism exacts particular gendered and sexual cultural costs from Palestinians. The following section considers these and other dimensions as they shape the pregnancy, delivery and postpartum sensibilities and experiences of Palestinian women.

Hang-ups, Secrets, and Traumas

Hasso had not considered patient sexual agency, awareness, or trauma in relation to reproduction, reproductive care, and reproductive experiences until she interviewed Saifi. Sexual trauma, secrets, and social hang-ups came up in more than one of the interviews with midwives. This section considers these matters non-systematically. It further illustrates the health and social costs especially for women of a medicalized and fragmented capitalist healthcare system in a male-dominated society that is ultimately governed by a Zionist settler-colonial entity and a comprador Palestinian economic and political class. Moreover, external political forces, funders and institutions (including missionary and Western "gender-sensitive") are invested in maintaining and being involved in the existing system to sustain their material and ideological interests. In this sense, Palestinian healthcare differs little from other Palestinian social sectors suffering under the extraordinary weight of Western and especially U.S. imperialism and Zionist settler-colonialism.

Like pregnancy and labor, postpartum healthcare is medicalized, whereas most postpartum Palestinian women report they need emotional support. Postpartum quality of life is especially low for poor Palestinian women and those "who had an unwanted pregnancy."[45]

Abu El Halaweh shared her frustration that postpartum Palestinian women are less concerned with their own health than the health of the baby: "A very small percentage of women who deliver regularly return for examination for themselves even if it is important for their health, but 100 percent return five to ten times for examinations of

their baby. We really need to know about mothers' well-being in that period."[46]

Saifi in the 2017 interview explained the consequences of lack of postnatal checkups:

> We still do not have real statistics on morbidity and mortality rates during pregnancy, labor, and after childbirth in Palestine. Women can experience complications and die related to childbirth up until a year after giving birth. In this country's hospitals, such deaths are not recorded as related to childbirth but to other medical matters. They code them differently even if they are mostly related to pregnancy and childbirth.[47]

In a 2006 cross-sectional survey of 264 women who had delivered a baby within the previous fifteen months and were visiting one of three PA Ministry of Health clinics in Jenin, Ramallah, and Hebron for any reason, only 36.6 percent had obtained postpartum care.[48] The reasons they provided for not doing so were that they "did not feel sick and therefore did not need postnatal care (85 percent), followed by not having been told by their doctor to come back for postnatal care (15.5 percent)." The rates of obtaining postpartum care were higher among women who had had a difficult delivery, a C-section, or an "instrumental vaginal delivery," as well as those who had given birth in a private hospital or lived in Jenin.

Saifi argues that Palestinian nurse-midwives are too often part of the problem in hospital labor and delivery rooms, allowing the biomedical priorities of the hospital setting, as well as gossip, "religion, and personal hang-ups" to shape their responses to laboring women:

> If she wants to cry, let her cry. Sometimes she wants to put her head on my chest or for me to hold her hand. Too often our midwives are standing between her legs and forget the upper, most important part. They separate the baby from the mother when they should be taking care of the whole person, the physical, spiritual, environmental. The fact is that sometimes a baby is unwanted…. Some *sittat* are afraid of the baby that comes out, thinking it is an alien. That's one reason traditional dayat quickly dried an infant and gave them to the mother. Today, there is another woman waiting outside ready to give birth so there is no time as the baby is quickly taken away for exams.[49]

Koukeyan noted how autonomous midwives were more likely "to talk to the woman, teach her important things about pregnancy and her rights."[50] This requires "privacy," which is impossible for most Palestinian women seeking reproductive healthcare in Palestine:

> How much privacy is there in a doctor's office or a hospital? The local daya would first and foremost protect women's secrets. That's why they used to call her the keeper of the secrets of wombs and paternity [*katimat asrar al-arham wal-ansab*]. She really was a unique individual. By the way, in Islam it was required to have oaths from two women relative to

> one from a man. But the daya's oath was equal to a man's oath. Did you know that? Because she always knew whose baby it was and was the only one who knew and kept that knowledge.[51]

Abu El Halaweh similarly linked the intimate knowledge and skills of traditional midwives and their ability to protect women's secrets with their social power.

> The daya's skills in touching, feelings, and psychology made her like the mukhtar of the neighborhood. She owned all the family secrets. She could deal with all social matters, resolve problems, connect couples together and marry them, examine, confirm and successfully deliver pregnancies…. She probably also confirmed virginity. She used all her intelligence to understand the psyche of the people and impact the community. She was probably the highest status person in many communities.[52]

Palestinian nurse-midwives working in the capitalist and under-resourced hospital model under Israeli occupation cannot maintain a holistic treatment approach, although some try. Al-Kawasmi explained: "This is our problem right now as midwives. I help a *sitt* give birth and two hours after birth I transfer her to another unit and after that, I might see her and I might not. The point here is that if I had time, I would go up to visit her. Sometimes I contact her by phone. But I do not keep in touch with her much after that."[53]

When interviewed, al-Kawasmi was "studying alternative medicine, *al-tibb al-badil*," including reflexology, reiki, "Chinese medicine," and Korean Su Jok therapy, which is "based on working on the hands and feet to release healing energy. It's wonderful. I apply the skills in my midwifery and at home." She explained that "illness is not only bodily. Sometimes psychological or spiritual ailments can produce bodily illness."[54] Shibli had completed courses in psychodrama and psychoanalysis at Haifa University and was similarly alert to trauma for some pregnant women, "especially sexual abuse. Such women want a midwife to take care of them in pregnancy."[55]

Some of the psychological and spiritual ailments are produced as a result of Palestinian women's limited reproductive agency. In the 2017 interview, Saifi found in her practice that:

> Most Palestinian women do not take decisions in relation to their health or childbirth. If she wants tubal ligation, she cannot get it. If she has had girls and knows that her husband determines the sex of a child, she does not defend her rights if he chooses another wife. It is not right that we are always focused on women's health, women's health, women's health but do not acknowledge she's not the decision maker in most cases. The situation is much better in terms of health and sex education in other Arab countries.[56]

She called attention to psychic suffering during labor for women who marry young and have no sexual experience or knowledge, including about their own bodies and

sources of pleasure: "You must cover your head and body but suddenly you marry a guy you barely know and must undress and act like a whore [in English]. It's a shock." While most Palestinian women

> eventually learn they have a right to sexual satisfaction, they often do not know their bodies because they assume it is shameful to touch your breasts. But if they do not, they don't feel masses or understand that discharge from nipples indicates that cancer has reached third or fourth stage. They do not necessarily know how hymens work…, or why menstruation may be delayed in some girls or that a woman may not bleed at first intercourse…. Women's traumas during labor are often tied to these social hangups.[57]

Women patients are also affected by young men's lack of sexual experience or care. Saifi recounts:

> We've had many women come to the hospital to be sewn up because of the difficulty of first sexual intercourse. He did not prepare her, engage in foreplay…. She is afraid, doesn't know, or her body is not working or prepared. Her fear of pain controls everything. No one discusses it because it is considered shameful to discuss the bedroom. You should take it. You might be depressed, angry, lose weight, be broken, but the most important thing is to protect the secrets of marital relations.[58]

Reproduction, the quality of reproductive healthcare, and the well-being of healthcare providers and patients cannot be extracted from larger systems and communities or their priorities. Palestinians are situated in multiple violent carceral systems that ensnare them differently depending on class and gender positionalities, family, and hegemonic power relations. A radically reconstituted and liberated Palestine alert to the dignity and wholeness of each person would integrate every sector of society in its authorship. Its institutional design, including healthcare, would prioritize the wellbeing of the most disfranchised and address class, gendered, and sexual contradictions together.

* * *

This article examines tensions raised by leading contemporary Palestinian midwives, who were informants and analysts as much as subjects of analysis, and the conditions of reproductive healthcare for Palestinian women especially since the establishment of the Palestinian Authority. It is not guided by public health, demographic, or nationalist frames of analysis, which are more legible and apparent in scholarship on Palestine. It names the male-dominance that structures Palestinian political and health systems, considers the violence of the medicalization and commodification of reproductive healthcare, and challenges by its focus the sexual respectability politics that exact additional substantial costs on all Palestinians in a brutally colonized

society. At times intense gendered class tensions emerge between midwives and Palestinian obstetrician-gynecologists and the Ministry of Health. Ideological and practice differences also produce tensions among contemporary Palestinian midwives as workers shaped by their training, the risk logic and priorities of the health systems in which they practice, and the ever-present violence of Israeli settler-colonial rule. Palestinian midwifery is a community-based praxis and form of labor that indisputably interpellated tens of thousands of Palestinian women over generations, probably only superseded by women in the teaching profession. But this form of midwifery is now replaced by biomedicalized reproductive healthcare in the underresourced and understaffed male physician-led hospitals and clinics where most nurse-midwives work.

Frances S. Hasso is a professor of gender, sexuality, and feminist studies, history, and sociology at Duke University in Durham, North Carolina. Her publications may be found at franceshasso.net.

Aisha Barghouti Saifi is a nurse-midwife, social worker, health educator, and clinical instructor of third-year nursing students at Bethlehem University in Israeli-occupied Palestine.

Endnotes

1 Livia Wick, "Building the Infrastructure, Modeling the Nation: The Case of Birth in Palestine," *Culture, Medicine, and Psychiatry* 32 (2008): 328–57, especially 350.

2 Wick, "Building the Infrastructure," 342, n. 17; Yousef Mohammad Mustafa Jaradat, "Workplace Stress among Nurses: Stressful Working Conditions, Shift Work, and Workplace Aggression among Nurses in Hebron District, West Bank, Palestine" (PhD diss., University of Oslo and National Institute of Occupational Health, Oslo, Norway, 2017), appendix A.3, 92; and Saifi personal communication with Dr. Suha Ba'loushah, August 2023. In 2021, there were 11,494 registered nurses in the West Bank and 10,984 nurses in Gaza, according to the Palestinian Union of Nursing and Midwifery. About 1,500 of the West Bank nurses were nurse-midwives and 668 of Gaza nurses were nurse-midwives with four-year degrees (an additional 570 midwives in Gaza held two-year diplomas). More than 90 percent of Palestinian obstetrician-gynecologists working in the Palestinian territories are men and about 48 percent of registered Palestinian nurses are men (56 percent in Gaza and 38 percent in the West Bank), based on 2012 data.

3 Hasso interview with Miriam Shibli in 'Arab al-Shibli village on 14 June 2017. At the time of the interview, Shibli was a nurse-midwife and maternity ward supervisor in the Nazareth Hospital. She began her career as a nurse's aide and then a practical nurse at Nazareth Hospital between 1982 and 1986. When Israel passed a regulation requiring all such workers to be registered nurses to be promoted, Shibli studied intensively for two years and passed the Israeli equivalent of A-levels and then completed a "bridge course" to move from practical nursing to midwifery. In the mid-1990s, she completed in one year a three-year BSc program in maternity and midwifery at the University of Surrey and was appointed "in charge" of the midwifery ward when she returned in 1997. In 2007 she earned an MSc in midwifery at the University of Surrey and has been a supervisor of the labor and maternity wards at different times in the hospital since 2000.

4 Yara Asi, "The Conditional Right to Health in Palestine," *al-Shabaka: The Palestinian Policy Network*, 30 June 2019, online at al-shabaka.org/briefs/the-conditional-right-to-health-in-palestine/ (accessed 3 July 2024).

5 For more on this context, see Nadera

Shalhoub-Kevorkian, "The Politics of Birth and the Intimacies of Violence against Palestinian Women in Occupied East Jerusalem," *British Journal of Criminology*, 55 (2015): 1187–206.

6 In addition to Miriam Shibli, a prominent Palestinian nurse-midwife in the Nazareth region whose analysis is used in this article, Hasso interviewed Palestinian nurses, obstetricians, and traditional healers from other parts of Palestine for a separate research project.

7 Some direct quotes were already anonymized based on Hasso's judgment.

8 Frances S. Hasso, *Buried in the Red Dirt: Race, Reproduction, and Death in Modern Palestine* (Cambridge: Cambridge University Press, 2022).

9 Rita Giacaman, *Life and Health in Three Palestinian Villages* (Atlantic Highlands, NJ: Ithaca Press, 1988), 12–13, 74–77.

10 Rita Giacaman, Laura Wick, Hanan Abdul-Rahim, and Livia Wick, "The Politics of Childbirth in the Context of Conflict: Policies or De Facto Practices?" *Health Policy* 72 (2005): 129–139, especially 133–35. A study on Egypt, Jordan, Lebanon, Palestine, and Syria from the early 1990s found over-medicalization of childbirth generally and especially in Palestine and Jordan. Oona M.R. Campbell and Gillian Lewando-Hundt, "Profiling Maternal Health in Egypt, Jordan, Lebanon, Palestine, and Syria," in *Reproductive Health and Infectious Disease in the Middle East*, ed. Robin Barlow and Joseph W. Brown (Brookfield, VT: Ashgate, 1998), 22–44.

11 Wick, "Building the Infrastructure," 353.

12 Hasso interview with Sahar Hassan in al-Bireh, 13 June 2017. Hassan had worked at Birzeit University since 2005, initially as a researcher in the Institute of Community and Public Health. She graduated with a nursing degree from al-Quds University in 1989 and MSc in nursing from the University of Pennsylvania in 1992. She worked as a midwifery and continuing education supervisor at Jerusalem's Makassed Hospital between 1994 and 1997. In 1997, Hassan left Makassed at the behest of the PA Ministry of Health to restructure the dated and neglected Ibn Sina College for midwifery and nursing that had previously been run by the Israeli "civil administration" on two campuses, Ramallah and Nablus. As dean of Ibn Sina, Hassan established the first four-year midwifery training program in the Arab world as well as a national Palestinian accreditation system. She earned a PhD in women's health from the University of Oslo School of Medicine in 2014.

13 Hasso interview with Sahar Hassan.

14 Hasso interview with Sahar Hassan.

15 Saifi personal communication with Dr. Suha Ba'loushah in late July 2023. It was difficult for us to study the reasons for this difference. We could not find *documented* language on scope of practice for nurse-midwives in the West Bank or Gaza despite significant effort.

16 Interview with Vartouhi Koukeyan in Jerusalem on 12 June 2017. When interviewed, Koukeyan was a professor of midwifery at al-Quds University for bachelor students. She studied at the Augusta Victoria (United World Lutheran) Hospital Nursing School in the 1970s (Mount of Olives) and completed a midwifery course in Jordan because the Occupied Palestinian Territories did not have a professional midwifery school. She graduated through the Ministry of Health in Jordan. She completed an additional bachelor's degree at al-Quds University, then a master's degree in mother and child health at Case Western University in Cleveland, Ohio.

17 Hasso interview with Vartouhi Koukeyan.

18 Hasso interview with Vartouhi Koukeyan.

19 Hasso interview with Vartouhi Koukeyan.

20 Hasso interview with Miriam Shibli.

21 Hasso interview with Huda Abu El Halaweh in Ramallah on 21 June 2017. Abu El Halaweh earned a BA in nursing and MA in maternal and child healthcare and has worked in a number of hospitals and primary healthcare centers, including Makassed Hospital in the 1990s. When interviewed, she had since 1998 been teaching nursing and midwifery at al-Quds University, where she directs the Midwifery Unit.

22 Wick, "Building the Infrastructure," 341.

23 Wick, "Building the Infrastructure," 343.

24 Sahar Hassan-Bitar and Sheila Narrainen, "'Shedding Light' on the Challenges Faced by Palestinian Maternal Health-care Providers." *Midwifery* (May 2009): 154–59, quote at 155.

25 Hassan-Bitar and Narrainen, "Shedding Light," 156.

26 Suha R. Baloushah, Nidal Abu-Hamad, Nooredine Mohammadi, Areefa S. M. Alkasseh, and Motasem S. Salah, "Gaza

Midwives' Experiences in Providing Maternity Care during COVID-19," *European Journal of Midwifery* 6 (August 2022): 1–7.

27 Wick, "Building the Infrastructure," 343.

28 Bara'a Samara and Anton R. Sabella, "The Knowledge and Attitudes of Palestinian Women towards Different Childbirth Delivery Options," *Clinical and Experimental Obstetrics and Gynecology* 48, no. 1 (2021): 138–43. Complications occur more frequently with C-sections than with vaginal deliveries. In a large study of Palestinian women during pregnancy, labor, delivery and up to seven days postpartum in Ramallah's public hospital over a three-month period in 2011–12, almost 27 percent had one or more maternal morbidities, with hemorrhage, preeclampsia or eclampsia, and infection being the most common. Of 1,209 women who gave birth, nearly 25 percent had a C-section and were almost three times more likely to experience morbidities. Sahar J. Hassan, Laura Wick, and Jocelyn DeJong, "A Glance into the Hidden Burden of Maternal Morbidity and Patterns of Management in a Palestinian Governmental Referral Hospital," *Women and Birth* 28 (2015): e148–e156.

29 Hasso interview with Huda Abu El Halaweh.

30 Hasso interview with Aisha Barghouti Saifi in Ramallah on 28 June 2017. Saifi completed a BSc in nursing and a high diploma in midwifery at Bethlehem University, an MA in social work, a diploma in training of trainers, and courses and workshops on pregnancy health, women's health, and breastfeeding. She worked as a nurse in Augusta Victoria Hospital (1986–89) and the Union of Palestinian Medical Relief Committees (1990–92) and as a nurse-midwife in the Dajani Hospital in Jerusalem (2002–6), the Red Crescent Hospital in Jerusalem (2007–8), Medicins du Monde France (2008–9), Dajani Hospital (2013–15), and St. Joseph Hospital (2015–16). Since then, she has been the clinical instructor of third-year nursing students at Bethlehem University who intern at the Red Crescent Hospital in al-Bireh.

31 According to Palestinian statistics from the areas governed by the Palestine Ministry of Health, 96.7 percent of women delivered in a hospital in 2004, and 99.99 percent of women delivered in a hospital in 2016. See: Rita Giacaman, Niveen M. E. Abu-Rmeileh, and Laura Wick. 2006. "The Limitations on Choice: Palestinian Women's Childbirth Location, Dissatisfaction with the Place of Birth, and Determinants," *European Journal of Public Health* 17, no. 1 (2006): 86–91; and Berit Mortensen, Marit Lieng, Lien My Diep, Mirjam Lukasse, Kefaya Atieh, and Erik Fosse, "Improving Maternal and Neonatal Health by a Midwife-led Continuity Model of Care – An Observational Study in One Governmental Hospital in Palestine." *EClinicalMedicine* 10 (2019): 84–91. For comparison, in Nablus in the 1970s, 70 percent of births occurred in women's homes attended by traditional or nurse-midwives, "and earlier it was a much higher rate." Hasso interview with Dr. Abdulraham Qasem Suleiman Shunnar in Nablus, 27 June 2017.

32 Hasso interview with Vartouhi Koukeyan.

33 Wick, "Building the Infrastructure," 343.

34 Hasso interview with Huda Abu El Halaweh.

35 Hasso interview with Huda Abu El Halaweh.

36 Sandra Healy, Eileen Humphreys, and Catriona Kennedy, "Midwives' and Obstetricians' Perceptions of Risk and Its Impact on Clinical Practice and Decision-Making in Labour: An Integrative Review," *Women and Birth* 29 (2016): 107–16.

37 Healy, Humphreys, and Kennedy, "Midwives' and Obstetricians' Perceptions," 107.

38 Healy, Humphreys, and Kennedy, "Midwives' and Obstetricians' Perceptions," 107.

39 Healy, Humphreys, and Kennedy, "Midwives' and Obstetricians' Perceptions," 107–8, 112–13.

40 Healy, Humphreys, and Kennedy, "Midwives' and Obstetricians' Perceptions," 108, 112.

41 Healy, Humphreys, and Kennedy, "Midwives' and Obstetricians' Perceptions," 113–14.

42 Obstetrician-gynecologists are legally liable in hospital births whereas midwives are liable in homebirths.

43 Hasso interview with Jamilah al-Kawasmi in Tur, Jerusalem on 26 June 2017. When interviewed, al-Kawasmi was a nurse-midwife working in the labor room and natural childbirth department at Hadassah Ein Kerem hospital in West Jerusalem. She has worked there or at Hadassah's hospital in Jabal al-Masharif, East Jerusalem since 2002. She graduated from the Augusta Victoria Hospital nursing school in 1975, which included three months of training in Nazareth Hospital. In 1980, she joined the first cohort of students in a one-year training course on midwifery at Makassed Hospital and between

then and 2002, she worked in Makassed's labor room as a midwife, Bekor Holim Hospital in West Jerusalem as a nurse (since Palestinian licensing is recognized only in Palestinian institutions), Israeli Kopat Holim outpatient clinics, and as an assistant director of the nursing department in Augusta Victoria Hospital. She studied Hebrew and completed a new certification in midwifery through the Israeli Ministry of Health in a hospital in Tel Aviv to acquire the Israeli midwifery license that allowed her to work in Hadassah.

44 Hasso interview with Jamilah al-Kawasmi.

45 Weeam Hammoudeh, Awad Mataria, Laura Wick, and Rita Giacaman, "In Search of Health: Quality of Life among Postpartum Palestinian Women," *Expert Review of Pharmacoeconomics and Outcomes Research* 9, no. 2 (April 2009): 123–32, especially 125, 127.

46 Hasso interview with Huda Abu El Halaweh.

47 Hasso interview with Aisha Barghouti Saifi. According to the World Health Organization, "maternal death" statistics include "female deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy"; "pregnancy-related death" and "late pregnancy-related death" are the deaths of women while pregnant or within forty-two days or twelve months of termination of pregnancy, respectively, irrespective of cause. World Health Organization, "WHO Guidance for Measuring Maternal Mortality from a Census" (Geneva: World Health Organization, 2013), online at apps.who.int/iris/bitstream/handle/10665/87982/9789241506113_eng.pdf (accessed 12 July 2024).

48 Enas Dhaher, Rafael T. Mikolajczyk, Annette E. Maxwell, and Alexander Krämer, "Factors Associated with Lack of Postnatal Care among Palestinian Women: A Cross-sectional Study of Three Clinics in the West Bank," *BMC Pregnancy and Childbirth* 8, no. 26 (2008): 1–9.

49 Hasso interview with Aisha Barghouti Saifi.

50 Hasso interview with Vartouhi Koukeyan.

51 Hasso interview with Vartouhi Koukeyan.

52 Hasso interview with Huda Abu El Halaweh.

53 Hasso interview with Jamilah al-Kawasmi.

54 Hasso interview with Jamilah al-Kawasmi.

55 Hasso interview with Miriam Shibli.

56 Hasso interview with Aisha Barghouti Saifi.

57 Hasso interview with Aisha Barghouti Saifi.

58 Hasso interview with Aisha Barghouti Saifi.