It was my first night in a rural mansion where I was spending a couple of weeks on holiday with my family. But all thoughts of holiday disappeared shortly after I went to bed. From the street came cries of “Doctor! Someone fetch the doctor!” I hurriedly put on my clothes and went outside.

When I mentioned that I was a doctor, I was quickly taken to a house nearby and ushered into a dark, poorly ventilated room full of women. Amid the chaos, voices gave unrelated suggestions such as “Bring some hot water,” “You must help yourself,” “Why do you not pull it?” “And push hard.” One of the guests told me that a young woman was in labour with her first baby. At that moment a blanket was spread on the floor and the pregnant woman was helped to lie on it. Then the women got ready to lift her up, explaining that the position of the baby was still high and they wanted to shake the woman as they lifted her in the blanket to help the baby to drop.

I spoke to the village birth attendant, who took a defiant attitude. She had been attending births in the village for over 35 years, and the mothers did not want the services of a doctor. The young woman herself was very pale and in great pain. She was screaming: “Help me! Get me a doctor!”

At my insistence, they allowed me to examine the young girl. It was impossible for her to give birth in her condition. The cervix had not dilated enough for the baby to pass through. She needed some medication as well as a doctor’s help.

I tried to persuade the birth attendant that I wanted only to give whatever help I could. The birth attendant – let us call her Umm Ahmad – looked to the lady of the house, the young woman’s mother-in-law, for support. This lady said: “This is the method we have been following for ages and with every child born in this family. We are going to stick to it and we require no service from anyone else, doctor or otherwise!” But the young woman at the centre of this ordeal appealed to me for help, saying: “Please doctor, save me. They have been trying everything for six hours and they do not realise that I am dying.”

Dr Ghada Hafez, Regional Adviser on Mother and Child Health at EMRO, was formerly Head of the MCH Department in Hama, Syrian Arab Republic (1961-1980), and Chief, MCH and Family Planning, in Dubai, United Arab Emirates (1980-1984).

Mothers and children wait patiently for a consultation at a village health centre.

Impossible to give birth

It was a typical case of pregnancy at a very early age. The girl had not yet reached her fifteenth birthday but had been married for ten months. She had not been examined by a doctor at any time during her pregnancy. At the same time, she was required to help with household duties, including preparing lunch for the men working in the field and taking it to them, and she was clearly undernourished.

The girl was not aware that a health
centre was available in the village where she could have had some tests and have her blood pressure measured. She said she was too poor to pay for such services. Yet these services were available free of charge. The health centre would have advised her about proper diet and about whether her pregnancy was normal or not. She might have been given some tablets to strengthen her body.

When I explained that it was vital that the young woman be moved to the nearest clinic, the opposition was very stiff. They wanted to wait until her husband arrived from somewhere. I explained that by the time he arrived, it might be too late to save his wife and their baby. I tried to get Umm Ahmad, the birth attendant, on my side, but she protested that she had always used the same method in attending childbirth. She accused doctors of being too quick to make an incision in order to dilate the cervix, and said that it was not unknown for doctors to give young women medicines which stopped them from getting pregnant again.

Unsterilised tools
To my horror I saw a knife near where Umm Ahmad sat. I asked her what she wanted to do with that knife, and she said that it was for cutting the umbilical cord. I explained the danger of using unsterilised tools, which meant that either the baby or the mother or both could contract tetanus. Support came finally from an unexpected quarter. The young woman's father-in-law arrived and he allowed me to take her to the clinic.

This case had a happy ending. I was able to give the young mother the help she badly needed and to deliver her safely. The girl's mother and the other ladies surrounded her in a joyous mood after the distress of the night. As they talked, I took Umm Ahmad aside to assure her it was never my intention to take her job away from her. In fact, I wanted her to come along to see how delivery could be conducted in a health centre in clean and sterilised conditions. Her long experience would not be wasted, but she would be able to get clean cotton wool and proper medicine to use in cases when the dilatation of the cervix is too slow.

Umm Ahmad listened attentively. I told her that she could be of immense help; when she saw a young girl who was pregnant, she should insist that her family give her the proper nourishment and allow her enough rest. She could be of even greater help if she herself brought the young woman to the centre for an early examination. I tried hard to make her understand that she could be a link between the village population and the health centre, and that this link could be beneficial all round.

It was well into the morning before I got back to the village to which I had come for rest and relaxation. My first night was sleepless. Nevertheless, I felt happy because I was able to save a young life and prevent an unnecessary tragedy.

An added bonus for me was the fact that I managed to establish a long relationship with Umm Ahmad and with her family. Working with birth attendants like her and training them is absolutely necessary, because through them we are able to reach every pregnant woman in every village. Getting the Umm Ahmads of this world on our side is of vital importance in saving the lives of newborn babies and young mothers. With suitable training, birth attendants can recognise their limits so that, when there is a difficult case, they are
Women's lot is often hard in the Eastern Mediterranean region; bringing water for the family takes time and effort.

Facing page: "A happy ending." A Palestine refugee beams with satisfaction as her baby is weighed at a child health clinic in Syria.

Photos WHO/P. Almasy

the ones who persuade the family that the pregnant woman must have proper medical care.

In my present job as Regional Adviser for Mother and Child Health in EMRO, I have a chance to expand this early experiment into a regional policy with the overall objective of having a well-trained birth attendant for every village. Voices were raised in opposition to this policy. Within the medical profession, there were those who objected to training illiterate women in the art of child delivery. But although medical services have certainly expanded in most countries of the Region, at best they cover only 50 per cent of the population. People in mountainous and remote areas do not have access to even the basic minimum in medical care. They are bound to continue with traditional birth attendants, if only because they have no alternative.

We have had an extremely encouraging experiment in Pakistan where birth attendants were trained in an area of several thousand villages. The rate of maternal mortality in that area dropped to less than half its previous level over a relatively very short period. The training course lasts only two to three weeks and stresses the importance of maintaining cleanliness at the time of delivery. Furthermore, we teach the birth attendant to look for symptoms which help identify cases which need medical care at the health centre.

We have had a very positive response on the part of governments as well as birth attendants themselves. We have already expanded the Pakistani experiment to include Egypt and the Syrian Arab Republic, where more than 4,000 birth attendants have been trained, and last April we convened a meeting of an Advisory Expert Panel at the Regional Office to expand the training programme to other countries.

Training birth attendants is only the cornerstone of a full programme which has several components. If the birth attendant identifies a serious case during labour, will she have access to transport to rush the woman to the health centre? When she arrives there, will she find a doctor or a qualified midwife? Will the necessary medication, blood for transfusion, and experienced staff be available? The programme must be a complete and well-integrated one; but the trained birth attendant serves as the early warning system to prevent unnecessary tragedies.