

Checkpoints on the Long Road to Palestinian Women's Health

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I. Introduction and background:

The long road to maternal death has been well delineated (Fathalla 1987); however, the diverse pathways down the road to women's health have yet to be traced. The health of Palestinian women is shaped by the context in which they are living, their experience of the past, and their hope for the future. Based on the assumption that all women have the right to adequate and safe health care, this overview of women's health will explore some of the social, political and biomedical factors which affect women's health and the provision of health services in the occupied Palestinian territory (oPt).

Presenting a portrait of Palestinian women's health, the provision of care, and the external and internal challenges faced in the provision of effective and equitable health care, this review aims to promote local and international dialogue to improve the well-being of Palestinian women and their families, in line with the goals of the International Conference on Population and Development. While the Millennium Development Goals in low income countries show trends in key universal indicators of women's health, they do not depict the quality or experience of care, or how the conditions in which women live affect their physical and psychological health. Rather, over-reliance on quantifying women's health care through coverage indicators can deflect attention away from what has been called the 'structural violence' (Farmer 2003) of poor women's everyday life, that goes unnoticed or ignored. A broader approach to women's health is needed for a better understanding of how to improve the lives of Palestinian women and how to go beyond emergency aid to develop a vision and plan for sustainable development based on and emanating from the local context.

Palestinian women's health and well-being has been shaped by the interplay of different factors over the years of Israeli military occupation. Over one-half (57%) of households were living under the poverty line in 2007,¹ with increasing socio-economic and regional inequalities (Mataria et al 2009). Most critically in the past year, women in Gaza are suffering from the casualties and the destruction of the Israeli attacks in December 2008- January 2009, and the continuing siege of the Gaza Strip, prohibiting reconstruction and daily subsistence. Within the context of deteriorating living conditions, this review will present the research data available on women's health status throughout the life cycle and how women's health care has evolved over the recent decades. Finally, it will investigate the quality, safety and gaps in the provision of health care. Understanding the process of care and its systemic deficiencies may contribute to improving the quality, safety and efficiency of care and its responsiveness to women's needs both locally and regionally, where similar challenges to quality care have been identified (UNDP 2009).

¹ The national poverty line is \$3.18 per person daily (PCBS 2007).

II. Palestinian women's health in context- from childhood to old age

Life span approach

Women's health is determined by multiple factors, including social, psychological, behavioral, environmental, and biological forces across the life span. The health of one generation of women may have a crucial impact on the next. For childbearing women, what happens long before pregnancy begins may have a critical influence on pregnancy outcome, and what happens to children may affect their health as an adult (Misra et al 2003). Focusing on risk factors during prenatal care has not resulted in improved infant outcomes in various countries, raising the question of whether interventions during pregnancy come too late to reduce disparities in birth outcomes (Lu and Halfon 2003). The accumulation of factors early in life and throughout the life course may influence perinatal outcomes and women's health later in life (Misra et al 2003). In addition to experiences during sensitive developmental periods of pregnancy and childhood which have been associated with the onset of chronic diseases later in life, there is evidence that the life course also affects reproductive health. "Chronic accommodation to stress results in wear and tear, what Bruce McEwen refers to as 'allostatic load', on the body's adaptive systems, and that the cumulative impact of the allostatic load on their reproductive health is manifested in the increasing rates of low birth weight" (Lu and Halfon 2003, p.17).

This life course perspective of women's reproductive health is particularly pertinent to the oPt, where a prolonged occupation and resistance has resulted in a context fraught with daily stress over generations. In addition, this approach signals the importance in a resource-poor environment of targeting appropriate interventions during the sensitive periods of development early in life, in order to promote protective factors which may offset the risk factors over the life course (Lu and Halfon 2003). Thus this overview will review information about women's health throughout the life cycle, taking into consideration social as well as medical conditions to inform the development of public health policy.

Data collection

The Palestinian Central Bureau of Statistics (PCBS) has provided considerable population-based data with three Demographic and Health Surveys (1996, 2000, 2004), the Palestinian Family Health Survey 2006 (PFHS), and most recently the Palestinian Census 2007. This review will utilize these surveys as well as other literature, studies and reports related to this topic. Facility-based data including hospital records are frequently incomplete, and data is sometimes improperly analyzed (Mataria et al 2009). Morbidity data and information on women's perceptions are scarce, making it difficult to plan health care based on disease prevalence and outcomes, service delivery mechanisms, and health expectations and behaviors (Abdel-Rahim et al 2009). PCBS has broken down many population health statistics by region, age and sex, so that some gender comparisons and identification of vulnerable groups has been made possible.

Population and living conditions:

Out of 3.76 million Palestinians living in the oPt (comprised of the West Bank including Palestinian Arab East Jerusalem and the Gaza Strip) (PCBS 2009) 49% are women, of which 30% are under 15 years of age, 46.4% are of reproductive age (15-49 years), and only 23.4% of the female population are over 50 years of age (PCBS Census 2009).² A woman's average life expectancy at birth is 73.2 years of age (compared to 71.7 for men). Slightly less than half of the population are registered refugees (1.8 million), whose families lived before 1948 in the territory that is now Israel. Other Palestinian refugees have been dispersed since that time in the region and worldwide, but are not the subject of this overview, even though their importance in any political settlement is paramount.

The large majority of the population reside in urban areas, 96% in the Gaza Strip and 61% in the West Bank (Khawaja 2003). The population density in the Gaza Strip is one of the highest in the world; the average number of individuals in a household in the oPt is 6.3 (7.0 in the Gaza Strip and 5.9 in the West Bank) (PCBS 2007) Thus overcrowding, poor infrastructure and environmental hazards, in the refugee camps and other areas of the oPt, affect women's and children's lives and health. This is exacerbated by the tightening of the closure system with over 600 checkpoints in 2008 and the Separation Wall restricting the movements of Palestinians and goods in the oPt (Jubran 2005).³ Collective exposure to violence has become an integral part of women's lives at all ages. The violence of a long-term Israeli military occupation and the associated deterioration of living conditions have led to a rise in gender-based violence within Palestinian society (PCBS 2006, Giacaman et al 2007, Shalhoub-Kevorkian 2009). The example of Iraq has shown that domestic violence increased with economic and social insecurities (UNDP 2004), and a study of refugee camps in Jordan has also identified this risk to women's health (Khawaja 2003). Without minimizing the danger of gender-based violence, one author has noted that "seldom does the literature on the Middle East address the issue of affection among husbands and wives and how bonds of mutual support and caring are constructed within households" (Ali 2002, p. 328).

Education, work, marriage and childbearing patterns:

Adult literacy rates (93.9%) are among the highest in the region (PCBS 2007) and 88.9% of women over 15 years in 2005 were literate (PCBS 2005). The United Nations Relief and Works Agency (UNRWA) played a key role in universalizing education for the refugees, and in the 1970s and 1980s the level of education of refugee men and women surpassed that of other Arab countries. Family cohesiveness played a role in this process, where older siblings supported the schooling of brothers and sisters (Rosenfeld 2002). In spite of their education, women's participation in the labor force has remained quite low, at 13%,⁴ compared to 67% of men (PCBS 2007)), and is concentrated primarily in the services (teaching and health workers). It is possible that the current levels of education and employment patterns may transform

² These statistics were calculated from the PCBS Census 2009 data by Weeam Hammoudeh, Institute of Community and Public Health, Birzeit University, 2009.

³ For a description of the hierarchy of classifications of Palestinians according to their identity cards and system of permits and the tribulations of married couples who do not receive family reunion rights to live together in the same enclave of territory, see Edouard Conte, 2005.

⁴ Women's labor force has, nevertheless, increased from 5.8% in 1995 to 10.7% in 2004 (Assaf and Khawaja 2008).

the patriarchal gender and age relations within the family (Rosenfeld 2002, Fargues 2003). In 36% of recent marriages, there is an educational gap in favor of women (Rashad et al 2005). There is also a trend in the region for girls to surpass the educational level of both their mother and their father, thus bringing into question the authoritative base of the patriarchal system (Fargues 2003).

However, women are frequently active in the informal sector and responsible for extensive tasks within the family. Insufficient social benefits and gendered family roles mean that women are the primary care-takers of all family members throughout childhood, old age, distress, illness, rehabilitation⁵ or imprisonment. Women carry out these roles within the constraints of the stress and trauma of daily life. In 2006, 8.5% of households were headed by women (PCBS 2007), and these households tended to be the poorest. The “erosion of human security” leads to losses of welfare that are long-term and cumulative (UNDP 2006). However, close family ties cannot be reduced to a heavy burden on women’s workload. They would also seem to provide support and cohesiveness (Courbage and Todd 2007) and contribute to the resilience of Palestinian communities to a long-term occupation (Nguyen-Gilham et al 2008). Kinship ties with solidarity across borders and remittances of family members in the diaspora who send money back to the oPt to sustain the extended family have played an important role in the survival of Palestinians despite the economic deterioration (Hordenak et al 1997). The dislocation of this family structure when members are separated by the wall or checkpoints or borders for reasons of work, education or marriage causes suffering and affects women’s ability to cope, as there is no alternative network for protection and support. Thousands of Palestinians have had to flee conflict areas and move to other parts of the territories in search of work, once again experiencing internal displacement (UNFPA 2009).

In spite of the educational level of Palestinian women in the oPt, fertility, although declining, has remained one of the highest in the world (Giacaman et al 2009), with a total fertility rate of 4.5 births per woman in the oPt (4.1 in the West Bank and 5.3 in the Gaza Strip) (PCBS 2007). What has been referred to as the ‘demographic puzzle’ indicates that factors such as higher education or employment usually associated with fertility decline, may not be universal, and that political and cultural circumstances in the Palestinian setting might influence family size (Khawaja 2003). Early marriage contributes to the high fertility rate (14% of 15-19 year olds were already married in 2004), and twenty-eight percent of women in the oPt had short birth intervals of less than 18 months. On the other hand, a growing number of women remain single. Twelve per cent of Palestinian women aged 35-39 years had never been married, which may be partially attributed to movement restrictions within the oPt and the fact that women cannot marry Palestinians from Jordan and bring them to live in their country (Rashad et al 2003). Consanguineous marriages (between close relatives) is a frequent practice, reaching 45% of all marriages in 2004, with 28% to first cousins. These were associated with early marriage and were higher in the Gaza Strip and in rural areas, but the education level of women was not found to be a significant predictor (Assaf and Khawaja 2008).

⁵ The number of Palestinians injured by Israeli forces between January 2000 and March 2008 was 32,569 (PCBS in The Arab Human Development Report 2009, p. 171).

Infant and child health:

The infant mortality rate (IMR) in the oPt is 27.6 deaths per 1,000 live births, and higher in Gaza (30.7) than the West Bank (25.5), but with no gender disparity. Unlike some other countries in the region, infant mortality in the oPt has not fallen since 1990 (Abdul-Rahim et al 2009). The major causes of death are prematurity and low birth weight, respiratory diseases and congenital malformations (UNFPA 2009). The low birth rate (less than 2,5 kgs) was 7% of all newborns. Almost all babies are breastfed (98%); however, the exclusive breastfeeding rate is only 27%, which indicates the need for better breastfeeding advice and support in the early months when mothers tend to supplement with other liquids, decreasing the protective factors of breastfeeding. In a context of poverty, inadequate clean water supply and sanitation, exclusive breastfeeding is a critical factor in infant health, which could reduce the child mortality rate by 13% (UNICEF 2004). A study in Lebanon has shown that cultural beliefs and family attitudes influenced women's practices of exclusive breastfeeding. The mothers of lactating women, convinced that the capacity to breastfeed was inherited, in some cases discouraged their daughters from exclusive breastfeeding, as they had not practiced it themselves (Osman et al 2009). The mean duration of breastfeeding in the oPt was 13 months and the continued breastfeeding rate from 9-12 months was 58% (PCBS 2006).

While the high prevalence of breastfeeding has contributed to infant health, increasing chronic malnutrition in children under five years raises concern, particularly given the long-term effects on cognitive development. Stunting, low height for age, was present in one out of ten children. The prevalence of stunting has risen between 1996 and 2006 from 6.7% to 7.9% in the West Bank and from 8.2% to 13.2% in the Gaza Strip (Abdul-Rahim et al 2009). Food insecurity is of particular concern in Gaza, where 56% of the population is classified as food insecure compared with 25% in the West Bank (WFP 2008). The anemia rates of infants 9-12 months has increased from 70% to 77.5% (WFP 2008). The mortality rate for children under five is 31.6 deaths per 1000 live births. Child immunization has high coverage (99%).

Adolescent health:

Addressing adolescent health and access to services is critical to improving maternal health. Thirty per cent of Palestinian women in the oPt are under age fifteen (PCBS 2009), and it is estimated that between 2002-2015 the number of women of reproductive age in the oPt will increase by 64%, the highest rate of increase in the region with the exception of Yemen (Roudi-Fahimi and Abdul Monem 2003). Teenage marriage has declined slightly in the oPt, but continues to be a frequent practice in some locations. In 1996, 17% of women were married at 15-19 years, which decreased to 14% in 2004 and 9% in 2006 (PCBS 1997, 2005, 2007). Early marriage is associated with early childbearing and high fertility (Rashad et al 2005) and pregnant adolescent women are twice as likely to die during childbirth and have higher infant and child mortality. Social, cultural and economic factors contribute to early childbearing (Mahaini 2008); but, in addition, in the oPt the unstable and turbulent political context and restriction on mobility may also play a role in marriage patterns, including age and preference for cousin marriages (Assaf and Khawaja 2009). During the first Intifada the age of marriage decreased (Khawaja 2003).

Childbearing outside of marriage is extremely rare, as society still remains quite traditional. Few health services are available to unmarried adolescents (boys or girls),

given the cultural biases, and sex education, as in other countries in the region, is not provided in schools (De Jong and El-Khoury 2006). Single young women, who are increasing in number, seem to be particularly vulnerable and at risk in Palestinian society. One study reported that violent deaths and suicides among the single women was almost twice as high as among the married women, mainly in those below age twenty-five, and that single women faced barriers to accessing health care. (Al-Adili et al 2008). The dearth of services adapted to the needs of single women is all the more important given that this group is growing in numbers.

The rate of smoking in Palestinian adolescents is high. Adolescents in the West Bank and Gaza Strip are also slightly overweight or obese, and girls more than boys, which might be expected given that they get less exercise (Husseini et al 2009). In one study, 13% of boys in the Hebron area were overweight or obese and 21% of girls in the Ramallah area (Mikki in Husseini 2009). Two out of three adolescents do not have safe spaces for recreation and interaction with friends (UNICEF).

Palestinian young people perceive their quality of life to be low (Giacaman et al 2007). However, commitment to education and the routine of going to school structure their lives in an otherwise unpredictable environment with few opportunities for distraction or hope for change in the future. Particularly for many young girls, going to school may be their only activity outside of the home, due to family restrictions and duties. School also provides them with a social network and a sense of political identity and resilience, in that they see continuing their education as a defiance of the will of the occupier to disrupt their lives and force them to flee (Nguyen-Gilham et al 2008). As stated by a Palestinian girl “Education means everything. It is our only weapon. They can kill everybody including our families but not our education because it is in our heads” (Nguyen-Gilham et al 2008, p. 295). There is little gender disparity between boys and girls in basic and secondary education (UNFPA 2009), but over the years access to education has been disrupted by the occupation. UNRWA has reported “the collapse of education standards due to the cumulative effects of the occupation, closures, poverty and violence” (Ging, UNRWA 2007), where drop-outs and failure rates may have lifelong implications. Due to the Separation Wall, almost one-third of teachers in East Jerusalem and 6,000 students face routine difficulties reaching their schools. Among the youth (aged 15-29 years) 70% were employed (UNFPA 2009).

Violence permeates the lives of these young people. Between 2000 and 2008, 952 Palestinian minors were killed by Israeli security forces (Save the Children 2008).⁶ In Israel’s attack on Gaza in December 2008-January 2009, 252 children younger than 16 were killed (B’Tselem 2009). In January 2008, over 300 children were being held in Israeli jails (The Guardian 2010).

Reproductive age women’s health:

Maternal mortality

While the fifth millennium development goal is to reduce the maternal mortality ratio by three-fourths between 1990-2015 and provide universal access to reproductive health services, the Eastern Mediterranean region has had a decrease in maternal

⁶ For a detailed analysis of the different types of injuries, see R Batniji et al, 2009.

deaths of only 19% between 1990-2005. In the oPt the maternal mortality was first estimated to be 74 per 100,000 births (PCBS 1996) and in 2000 the WHO estimate was 100 per 100,000 births. As indicated by Palestinian Ministry of Health officials, maternal deaths are underreported (Abdul-Rahim et al 2009). One facility-based study identified the main causes of death to be postpartum hemorrhage, pre-eclampsia or eclampsia, post-operative hemorrhagic complication, and sepsis; but misclassification in reporting was frequent (Al Adili et al 2006). Worldwide, more than half of all maternal deaths take place within 24 hours of delivery (Roudi-Fahimi and Abdul-Monem 2003). While most births in the oPt take place in a hospital, timely access cannot be ensured due to the checkpoints, and delay has sometimes been the cause of maternal or neonatal deaths. Between 2000 and 2006, 69 cases were reported of Palestinian women giving birth at checkpoints, with 4 maternal deaths and 34 neonatal deaths (Human Rights Council 2007). Between 1995-2000, 141 maternal deaths from unsafe abortions were reported (Hessini 2007), although information is not available on these cases.

Maternal morbidity

Very little information is available on morbidity in women's health. A UN agency reported that during the twenty-two day Israeli attack on Gaza the number of miscarriages reported in the hospital had doubled and premature deliveries had increased (UNFPA 2009). Between October 2007 and March 2008, 32 patients (including 19 women) died after lack of timely access to referral health services outside of Gaza (WHO 2009). In 2008, 73 women were security prisoners and suffered from multiple illnesses.⁷ Self-reported reproductive tract infections and urinary tract infections were common complaints of women during pregnancy (PCBS 2006) and were a major complication associated with perinatal mortality (Bargouthi et al 2006). The reporting of sexually transmitted infections is inadequate (PMOH 2006). The most common infections reported among women were pelvic inflammatory disease and candidiasis, but more thorough reporting (including the private sector) and greater accuracy is needed for a true picture of such infections. Few cases of HIV/AIDS (44 cases since 1988) have been reported (PMOH 2007); but precautions should be taken given the dearth of information, increasing drug abuse in some locales, and the frequent movement and displacement of the population.

Breast cancer is the leading cause of death in women, followed by cerebro-vascular disease. The incidence of breast cancer is 15.1 per 100,000, which is high for the region (Aoyama 2001), and it is often diagnosed only at an advanced stage (Tarabeia et al 2007). On the other hand, cervical cancer is infrequent; while the Pap smear has been a component of some reproductive services, a cervical screening program has not been adopted.⁸

Nutrition, obesity, chronic diseases, smoking

Women's nutrition in the oPt is a concern, given the rising poverty and the increasing food insecurity. As in other low income countries, undernutrition and overnutrition seem to coexist, along with a nutritional transition away from the traditional Palestinian Mediterranean diet to a Western style one (Husseini et al 2009). High rates of obesity in adults was identified in a study in two Palestinian communities in the West Bank, particularly among urban women (Husseini et al 2009). The militarization of space and lack of urban planning prohibit a healthy life style with exercise. About

⁷ For the story of a Palestinian woman's birth experience in an Israeli prison, see Emma Gilmore.

⁸ In 1997 a survey in the West Bank showed that 2,444 Pap smears were analyzed and reported by seven laboratories with very few pathological results (Wick 1998).

one-third of pregnant women were anemic (PCBS 2002), and health services had poor nutrition counseling (ICPH 2006). The prevalence of diabetes among urban and rural women is 15% and 10%, respectively (Abdul-Rahim et al 2001). The rate of smoking among women is low (2%), but women are exposed to passive smoking given the high prevalence among men, the overcrowded living spaces, and the widespread smoking in public places.

Family Planning

Fifty-three percent of women use contraception, with three-fourths of them using modern methods and one-quarter traditional methods. The most common reason for not using contraceptives was the desire to have a child (46%) followed by fear of side effects and discomfort with the method (16%) [Hammoudeh 2009]. In spite of widespread knowledge about family planning and availability of services, about 30% of women who reported not wanting another child were not using any form of contraception, indicating a need for further understanding of women's decision-making and the acceptability of health services (Hammoudeh 2009).⁹ The IUD was the most frequently used method, followed by oral contraceptives, but women rarely received adequate counseling on a variety of methods (ICPH 2006). Monitoring of complications with these methods is needed to address women's fears of side effects. The unmet need for contraception was 28%, but the desire for large families persisted with 4.6 children considered the ideal number (PCBS 2007).

Elderly women's health:

Women 60 years and above constitute 4.4% of the Palestinian population (PCBS 2007), and their numbers are increasing. Only about 3% are supported by the government, and the rest by their families (Abu Khader and Zeidani 2009). However, little is known about how elderly women in different areas cope with aging and the associated health problems. Traditionally, older women have had a respected role within the family, and maintained a useful function as provider of child care. However, as the nuclear family in the oPt is becoming the norm and emigration is increasing, many older people are left isolated without family caretakers or social services. Homes for the elderly are scarce and the services are very limited (Abu Khader and Zeidani 2009). Care and activities for the elderly is a public health question which needs to be addressed.

III. The evolution of women's health care under occupation

Palestinian women's health care: 1967-1994

The organization, content and quality of health services in the oPt has been shaped by the political processes of the past forty-two years of Israeli occupation. This brief recent historical background of the development of women's health services within the broader context of general health care in the West Bank and Gaza since 1967 will delineate how the political context has altered access as well as the administration and focus of these services over the years. These developments contribute to understanding women's health outcomes, as well as the current barriers to providing

⁹ One author has illustrated in Egypt how the ideology behind the promotion of family planning services is implicitly embedded in notions of women's empowerment through informed choice, individual decision-making and the small nuclear family (Ali Kamran Asdar 2002), which does not necessarily correspond to the social and familial context of many Palestinian women.

good quality of care in an equitable manner. How the society acted and reacted to political events in the past and the profound changes which have occurred give indications of how the future might evolve, and thus assists in planning health care with different scenarios in view.

When Israel occupied the West Bank and Gaza Strip in 1967, it took over the administration of the existing health services, which had been previously under the authority of the Hashemite Kingdom of Jordan for the West Bank and Egyptian military administration for the Gaza Strip. Thus the public health services for the Palestinians, which consisted of clinics and hospitals primarily in the cities, were subsequently controlled by the Israeli Ministry of Defense under the auspices of what was called the Israeli Civil Administration. Israel, according to international conventions, is legally responsible for maintaining the overall health of the occupied population. The refugee population continued to be served by UNRWA, which had provided schools, social services and health care to the refugees in the aftermath of the 1948 expulsion.

Israeli-administered government health services:

The Israeli-administered government health services consisted of clinics where limited components of primary health care were provided as well as emergency, obstetric and other hospital services in the large urban hospitals. The health providers in these institutions were Palestinians, but the planning and decision-making including the hiring and firing of staff and the allocation of budgets was entirely in the hands of the Israeli Civil Administration. Israeli priorities for Palestinian health care focused primarily on disease control in the form of a child immunization program and an intervention program to promote hospital deliveries (Acker 2003), limiting maternal and child health in the government clinics to antenatal consultations and vaccinations. Both government clinics and hospitals were severely under-funded and neglected and had little interaction with the experienced Palestinian health providers in the non-governmental and private sectors. Six public hospitals were closed down by the Israelis between 1968 and 1992 and three of these were converted into a police station, a military base, and a prison (Challand 2008). Although some training for health providers was offered by the Israelis, the lack of investment in material and human resources to build a functioning Palestinian health system¹⁰ led to a situation of reliance on the Israeli medical system for referral for specialized care (Bargouthi and Giacaman 1990). In addition, being subjected to Israeli control compounded by low salaries, understaffing, and lack of investment in basic repairs or in upgrading equipment (Giacaman et al 2003) engendered low staff morale and lack of leadership, the remnants of which can be seen today, even though the administration since 1994 has been transferred to the Palestinian Ministry of Health.

Women were encouraged to give birth in hospitals, both for normal and high-risk cases, with the dual motives of lowering infant mortality¹¹ and controlling the number and registration of Palestinian births. As part of their widespread surveillance practices, the Israeli authorities issued at birth, and continue to do so, Palestinian identity cards according to the parents' status and the area of the oPt where the baby was born, thus making the place of birth crucial to the identity card that one's child

¹⁰ In 1991 Israel was spending \$20 per person on health services in the oPt compared to \$306 per capita in Israel (Challand 2008).

¹¹ One justification for this policy was to reduce infant mortality, even though no evidence was available of outcomes of either home or hospital births.

will be issued (Zureik 2001), and the rights and conditions which that signifies. While promoting the institutionalization of birth, little attention was given to the conditions of hospital maternity facilities or the quality of care provided. Women's health services during this period were limited to pregnancy and childbirth with little preventive or high-risk care for the mother or newborn and a total lack of services not linked to reproduction. Childbirth at home (about one-third of births¹² in 1993 according to the World Bank) was attended by *dayas* (the Arabic term for what has come to be known as 'traditional birth attendants') and community midwives and nurses who had received formal training.¹³ A system of licensing and supervising these *dayas* and midwives had been established first by the Jordanian administration in 1966 and was continued by the Israelis. *Dayas* learned their skills by apprenticeship and six month's training in government hospitals (Wick 1999).

Home birth with the *daya* was a family and community event. In most communities the *daya* was highly respected, of the same gender and social class as the birthing woman, and lived in the same locality, which facilitated the process of support during childbirth. Women in focus groups reported how much they appreciated being well acquainted with the midwife, that she respected their privacy and intimacy, that the surroundings for birth were familiar, and that they didn't have to leave their children when they were in labor or worry about getting to the hospital on time. The *daya* also helped them with their housework and child care after the birth (Wick 1999). The *daya* in her practices tended to navigate between the two worlds of Western biomedicine and traditional medicine, as did the women she attended. She emphasized psychological support and traditional methods of pain relief, such as massage with olive oil and drinking herbal teas. She calmed women in labor with readings from the Qur'an, or distracted them from pain by telling stories. The *daya* combined old methods and new "suggesting synthesis rather than competition, and adaptation of beliefs and practices to new realities" (Giacaman 1988, p. 145). Massage (*tamlis*), herbal treatments (*a'shaab*), spiritual healing with the Qur'an (*'illaj bil-Qur'an*), and cupping (*kassat hawa*) were some of the indigenous practices still used by *dayas* and midwives. The herbs used during childbirth to strengthen the contractions were sage (*mayramieh*) and cumin (*kamoun*), prepared in an infusion with sugar. The birthing mother was often given dates (*tamr*) to eat, as the example in the Qur'an with Maryam.¹⁴ The traditional foods given after childbirth were chicken soup or rice pudding with raisins, nuts and cinnamon (*irfeh*). Fenugreek (*hilbeh*) and anis (*yansoun*) were used to increase the mother's milk supply. The *daya* regularly massaged the baby's body with olive oil when she visited the mother in the post-partum and swaddled the newborn. She was trained to refer any abnormal cases or complications. In addition, the *daya* practiced a physiological approach to the management of birth (avoiding frequent vaginal examinations, early rupture of membranes, augmentation of labor, and episotomies). She was sensitive to the woman's individual needs, giving continual labor support and monitoring changes in

¹² In 1996 the MOH reported that 18% of all births took place at home, and by 1999 it had declined to 10% with one-half attended by *dayas* and the rest by midwives and doctors.

¹³ For a detailed description of the characteristics, role and work of the Palestinian *dayas*, see the survey report *Traditional Birth Attendants in the West Bank: an Assessment of System Building and Training Needs* (Wick 1999).

¹⁴ "And shake towards thyself the trunk of the palm tree: It will let fall fresh ripe dates upon thee. So eat and drink and cool (thine) eye." Surat XIX (Maryam) verse 25-26. (Hashim, p. 42).

appearance, reactions and psychological state to assess the progress of labor (Wick 1999).

However, the Israeli childbirth policy aimed to phase out gradually the home birth attendants by not registering younger ones to replace the old. All women were encouraged to give birth in the urban public hospitals, and hospital fees were reduced to a minimal sum as an incentive (Acker 2003).¹⁵ However, the role of the *daya* was not replaced when birth was institutionalized. Women came to the hospital and gave birth in crowded conditions with midwives and physicians whom they didn't know, and returned home a few hours later without any immediate postpartum care in the hospital or in the community. When the first *intifada* (uprising) broke out, access to these urban hospitals was frequently compromised by checkpoints and curfews, and many women once again reverted back to the care of community midwives and *dayas*.

The sumud and popular health movements:

It was within this context, that Palestinian health providers mobilized to fill the gaps left by the insufficient government services, both at the hospital level and amongst the rural population who had little access to health services. Two strategies emerged between 1967 and 1987 to develop the Palestinian medical infrastructure: first, the *sumud* (steadfastness) policy, whereby the PLO and Arab governments provided Palestinians with funds to build up and maintain services; for the local population *sumud* referred to the everyday way of life, involving non-violent resistance to stay on the land in spite of the difficult conditions (Wick Livia 2007). Secondly, the popular health movement emerged, mobilizing committed health providers to extend services to the rural areas (Barghouti 2005). Health care during this period was both shaped by the political events of its surroundings and, at the same time, became an integral part of the process of the struggle for liberation—it was an entry point to mobilize the young and the old, health professionals and lay people, to meet the health needs of the population under occupation.

As part of the *sumud* movement, the nationalist Palestinian medical elite, who had obtained their degrees and specializations outside the country, worked to build up the non-governmental (NGO) health sector (both non-profit and for profit) as an alternative to the deteriorating government sector. They concentrated primarily on modernizing hospital care and acquiring modern technology and equipment. These institutions, established and managed by Palestinian physicians, were faced with constant reprisals from the military occupation, including the refusal of building permits, withholding of equipment, and the imposition of economic sanctions. The founding story of Makassed Hospital, the main Palestinian referral and teaching hospital in Jerusalem, as recounted by one of the specialists, shows how the health care was closely linked to political events:

“In 1964, the Al-Makassed Foundation started building a hospital on the Mount of Olives in Jerusalem. In 1967, when Israel occupied the West Bank and Gaza, the hospital was being built on land owned by the Islamic Awqaf. Right after the occupation of Jerusalem, the Israeli army decided to expropriate the still empty hospital building and transform it into a police station. Hundreds of doctors and nurses mobilized. They moved beds, equipment and even patients from private clinics and homes into Makassed

¹⁵ This description of Israeli birthing policy for Palestinian women in the oPt (Acker 2003) by a supervisor of the Israeli Civil Administration gives no account of the government hospital conditions for childbirth or the budget allotted to the maternity services.

premises and stayed in the hospital. The Israeli authorities gave up control of the building.” (Wick Livia 2007, p. 12)

This hospital, with the most expert specialists in the country, assumed the role of training Palestinian physicians, midwives and nurses, and under very difficult conditions treated the most serious referral cases from the West Bank and Gaza, until 2002, when the Israeli closure policy strictly limited access to Jerusalem.

While the *sumud* movement attempted to develop health services and resist occupation within its legal confines, the popular health movement, which emerged in 1978 and was very active throughout the pre-Oslo period (including the first *intifada*), adopted different strategies and focused primarily on providing services to the poor in the rural areas rather than building medical infrastructure (Barghouti and Giacaman 1990). It was initially created by a group of physicians, both women and men, mostly returning from the ex-Soviet Union, where they had received a free medical education and were exposed to the concept of the right to ‘health for all’ of the Alma Ata Declaration of 1978. These health providers based their actions on a different approach to health care than that which was expressed by the specialists engaged in upgrading the hospitals and technology; in their discourse they expressed a holistic approach to health and health care, socio-economic and environmental explanations for poor health status, the notion of equity, and the right to health care as an entry point for mobilizing the population. Grassroots women’s committees active in many areas had already paved the way for the health organizations and provided local contacts and cooperation in political and community-based activities (Wick Livia 2006). Concretely, the popular health committees organized mobile clinics to provide free services to the underserved areas, campaigns to raise awareness about health promotion and neighborhood committees to develop community health (Giacaman 1988). The Union of Palestinian Medical Relief Committees (UPMRC) was the first to be established in 1979 and later followed by other organizations, such as the Union of Health Work Committees in 1985. Like the women’s committees, each health committee had affiliations with one of the political factions. The users of the services, on the other hand, came from all walks of life and all ideological tendencies. These committees had similar activities, establishing networks of primary health care clinics in underserved areas of the West Bank and Gaza, where physicians would come on a regular basis to provide services. To increase access and community-based care, community health workers were trained to run the clinics and make home visits. The UPMRC established a school for community health workers which continues to function to this day, where young women from villages and camps are trained in primary health care and then return to work in their community. From the end of the 1980s onward, Islamic non-governmental organizations followed a similar model of health service provision through voluntary participation. In addition, *zakat*, the Islamic institution of social welfare, also has committees active at the grassroots level to provide health care and relieve poverty (Challand 2008).

It was within the grassroots health committees that the concept of women’s health first came to light in Palestine. A sensitivity to gender questions within the popular movement as well as the influence of the international women’s movement calling for consciousness-raising, self-reliance and health awareness as a means of empowerment introduced a new concept of women’s health services in Palestine, going beyond the boundaries of the usual antenatal and childbirth care. In addition to pregnancy and postpartum care, female physicians integrated the provision of family planning services, breast examination and Pap smears for the early detection of breast and

cervical cancers, and treatment for reproductive tract infections. While these clinics served only a small portion of the female population, they nevertheless created a model for integrated and woman-centered reproductive health services and raised awareness of the limitations of other services. While the patient-provider contact time in some other clinics was limited to approximately four minutes (Barghouti and Daibes 1993), these clinics aimed to provide time, space and a gender-sensitive environment for listening and counseling. Physicians were confronted not only with women's physical problems, but also the psycho-social distress emanating from the on-going stress and violence of every day life, which was frequently manifested through physical illness. In a country with few mental health specialists, the physician was also faced with playing the role of the therapist.

The health committees had years of experience in decentralized primary health care, emergency aid, and mobilization when the first *intifada* broke out in December 1987, much to the surprise of all observers, including the leadership of the Palestine Liberation Organization. The popular committees all over the West Bank and Gaza organized communities for self-reliance in health, education, and food provision in face of the repressive measures taken by the Israeli military to quell the massive uprising. Women as well as men took part in providing first aid training, organizing blood donations for the wounded, animating home schooling sessions when the schools were closed down by the Israeli army (including kindergartens), or carrying food at night into refugee camps under curfew. Although the popular committees were declared illegal in 1988 and many active members were arrested, women from all backgrounds and political views were occupying public spaces and were playing a major role in civic involvement.

This grassroots period in the development of Palestinian primary health care increased access to health services by reaching out to the rural and underserved areas; it expanded the range of services for women's health care and promoted community participation in health planning and promotion; it mobilized the population for self-reliance to meet their basic needs in times of curfew, siege and conflict. It was also innovative in soliciting international solidarity¹⁶, a crucial lifeline for the recognition of the right to self-determination and for putting the Palestinian struggle for health on the international agenda. It established a de-centralized mode of functioning, which enabled it to provide services even when mobility and communication were constrained by the political situation on the ground, unlike the hierarchical government sector which became dysfunctional when the chains of command were disturbed.

However, in spite of its dynamism and innovation, the grassroots committees could not be a substitute for the building of a health system. Services remained fragmented, and meeting basic needs and emergencies under conditions of total disruption of normal life was a formidable challenge. Health providers and citizens risked their lives to provide care. International and humanitarian organizations were not visible, as they were frequently not permitted to enter conflict areas, and it was the local population that organized to provide relief. Health providers treated injuries in their homes, as wounded patients were frequently afraid to go to the emergency rooms of

¹⁶ One example was a conference organized by the UPMRC, 'The Concept of Health under National Democratic Struggle'. It promoted south-south exchange and cooperation by inviting Dona Maria, the Sandinista Minister of Health, and others who shared experiences from South Africa and Mexico.

the government hospitals for fear of being arrested by Israeli soldiers, who freely entered these hospitals looking for political activists. All types of health providers played their part in the resistance to occupation and community solidarity—from the doctors, nurses and ambulance drivers who broke the curfews to treat emergency cases, to the specialists who daily stood at checkpoints to reach the hospital to provide care, to the *dayas* and midwives who assisted home births, to the traditional bone-setters who repaired broken bones of youth who had been beaten. Even older women, who were less likely to be arrested than men or young people, had their role to play—they were frequently in the streets during demonstrations arguing with the soldiers and trying to prevent the arrest of the young demonstrators or going to the prisons in hopes of visiting their loved ones. This situation of daily resistance and unpredictable conflict lasted until the Oslo Accords of 1994.

Palestinian women's health care: 1994 to the present

When the Oslo Accords were signed in 1994, the large majority of the population supported what was then called 'the peace process' and hoped for a normal life. However, the limitations of the accords and the continuation of the repressive measures of the occupation impinged on any efforts of state building or economic growth. Health services, suffering from years of neglect, were turned over to the newly established Palestinian Ministry of Health (MOH), but it had no authority over other essential aspects of public health, such as control over the borders, basic resources such as water and electricity, freedom of movement, and free passage of goods (Sayigh 2007). Attempts to create an effective and equitable health system have failed, due to the legacy of poor quality health services passed on from the Israeli military government, the inherent characteristics of the Palestinian Authority which has been plagued by inefficiency, cronyism and excessive centralization (Mataria et al 2009), and the continuation of Israeli oppressive measures destroying lives, grabbing land, restricting access to services and damaging the infrastructure financed by international donors. Severe restrictions on mobility accentuated the problems of an inflexible and hierarchical system of health provision, which unlike the grassroots organizations, were not able to function in a decentralized manner (ICPH 2006).

International donor assistance was directed largely to the newly established Authority. Between 1994 and 2000, donors committed \$353 million to the health sector and disbursed about half of that in actual assistance (Mataria et al 2009). Since its establishment the MOH has opened about 170 new primary health care facilities, while those of non-governmental organizations have decreased considerably due to lack of donor funding which was directed toward the government sector; however, the non-governmental sector continues to play an active role in primary health care, including community-based rehabilitation, mental health, health education, and care for chronic diseases, and it remains an important platform for debate and discussions of health policy and planning.

In 2000, following the outbreak of the second *intifada*, health care in the government sector became free of charge for victims of Israeli violence as well as for pregnancy and delivery services and care of infants and children. With the deterioration of economic conditions, utilization of government services increased considerably, particularly for childbirth care, and many of the non-governmental and private hospitals which had expanded during the immediate post-Oslo period were under-

utilized, due to both financial inaccessibility and checkpoints limiting internal movement within the oPt. However, the greater burden of service delivery in the government sector was not accompanied by an increase in staffing or infrastructure, thus accentuating the existing problem of poor quality of care and patient safety (Abdul-Rahim et al 2009).

Within this general structure of fragmented and inefficient health services under the Palestinian National Authority (Mataria et al 2009), an attempt was made to expand women's health services. Women's health was formally institutionalized when it was allotted its own directorate within the Ministry, the Women's Health and Development Directorate (WHDD) funded primarily by the United Nations Population Fund (UNFPA) and reporting directly to the Minister. However, rather than becoming a genuine priority of the policy-makers, its importance was largely defined by donors. It was responsible for drawing the strategy for women's health in the National Health Plan. It coordinated the development of national protocols for women's health with the participation of the three health sectors (government, non-governmental and UNRWA) and gradually expanded the range of reproductive health services offered at government primary health clinics to include family planning services and counseling, and in some clinics the management of sexually transmitted infections and preventive screening services for breast and cervical cancers. However, with weak infrastructure, substandard quality and unpredictable access, effectiveness was compromised.

In spite of the considerable investment in the health sector ¹⁷, the women's health services remain sub-standard, both at the primary health care level (ICPH 2006) and at the hospital level (Hassan-Bitar and Wick 2007), and the population is dissatisfied with the services (World Bank and Bisan 2006). At the political level, the insidious nature of the occupation hinders the building of a functioning health system, which is a pre-requisite for certain essential services requiring a complex service delivery, such as emergency obstetric care, clinical care of sick children and postnatal care (Countdown Coverage Writing Group 2008). The restrictions on mobility, the obstacles to supervision and monitoring in the field, the eruption of violence which destroyed infrastructure and focused providers and donors on emergency care all contributed to perpetuating an already weak organization of services and lack of accountability.

In general, commitment to women's health has lagged behind commitment to other components of health care for a variety of reasons, both at the global level, where poor women's lack of voice in the political process has been identified as one contributing element (Shiffman and Smith 2007) and at the local level, where government maternity facilities, for example, are much less developed (Hassan-Bitar and Wick 2007) than other departments like cardiac care in the same hospital. The organizational culture of the Ministry is unable to decentralize services. Health planners and decision-makers in the MOH are almost exclusively men and primarily physicians, with little representation of allied health professionals or of women's

¹⁷ In 2002, total health expenditure was 8.6% of gross domestic product (GDP) and in 2005 per person expenditure was \$135 (Mataria et al 2009). The Ministry of Health budget accounts for about 10% of the overall budget of the Palestinian National Authority (Hamdan et al 2003), while 34% of the Palestinian budget is spent on security (while remaining under occupation), 0.7% on agriculture, and 0.1% on culture (Presentation by Dr. Mustafa Barghouti 2009).

groups. Donor funding for health care training or conferences is usually shared among the same small group of decision-makers, with few opportunities to build the capacity of providers working in the field.

Donors, as in other countries, have played a major role in Palestinian politics, making and breaking institutions, defining issues, creating identities (Ali 2005), and filling the vacuum of a weak Ministry, which has lacked clear vision for developing health care, for stewardship capacity to guide and regulate services, and for a participatory approach involving stakeholders in planning and decision-making (Mataria et al 2009).¹⁸ Financial aid per capita in the oPt is the highest in the world (Barghouti 2009) with ever-increasing dependency on assistance and subsequent reduction of productivity in the oPt, highlighting the crucial issue of self-sustainability for any just solution to ending the occupation and state-building. To give an idea of the extent of donor dependence in the oPt, by 2005, \$10 billion had been contributed by over forty donors to the Palestinian Authority (Mataria et al 2009). Although different types of donors had diverse agendas and ways of functioning, many wanted to convey political priorities of promoting Western democracy and civil society (Challand 2008) rather than self-sufficiency and basic health care of the population. Some of the large NGOs became professionalized and dependent on extensive donor funding, while other small charitable organizations and *zakat* committees were locally funded and maintained close ties to the community, promoting community self-help through educational activities, health services, and distribution of assistance to the needy (Challand 2008). Donors' preference for funding infrastructure and equipment rather than human resources, their concern for immediate visibility and their inflexible timeframes has impeded the implementation of projects. Short-term vertical donor projects lured qualified health professionals away from their clinical practice in the government services to administering projects with endless bureaucratic paperwork and poor coordination. These disruptions weakened the long-term and complex process of improving the quality of care in the government sector. Many donors have utilized a carrot and stick policy to impose political pressure¹⁹, leading, for example, to the Israeli and international boycott of the Hamas government since its election in Gaza in 2006, with severe health implications for the population and growing inequalities.²⁰

IV. Women's health services: distribution, access, and quality

Achievements in maternal and infant health services over the years, among other factors, have contributed to a relatively low infant mortality rate (27.6 deaths per 1,000 live births) [PCBS 2006], which is lower than some more stable countries in the region like Morocco and Egypt. This decline was undoubtedly due partially to the network of health services, which were relatively cheap and accessible. UNRWA has continually provided readily available services in the refugee camps, anticipating both

¹⁸ Mataria et al explains that since the establishment of the Ministry, non-Ministry stakeholders have not been involved in the planning process, thus precluding any overall development policy which would engage different types of providers, sectors and groups (Mataria et al 2009, p.6).

¹⁹ For example, USAID required non-governmental organizations to sign a paper disclaiming any involvement with 'terrorist organizations' before agreeing to fund any project.

²⁰ The growing disparities between the West Bank and Gaza Strip are evident in the rate of unemployment, the poverty rate (PCBS 2007), infant survival, the percentage of food insecurity and the rate of stunting in children (Abdul-Rahim et al 2009). The enormous disparity between Israel and the oPt is illustrated by the GDP per capita which is 26 times higher in Israel (Bargouthi presentation, 2009).

emergency services to treat injured in case of conflict, as well as routine maternal child health services. The non-governmental and public services have also ensured care throughout the years and since 2000 the free government services have perhaps prevented serious deterioration of health indicators such as infant mortality,²¹ which, however, has stalled, indicating the worsening of conditions (Giacaman et al 2009).

While the coverage indicators for maternal and infant health care are relatively high compared to other countries in the region, they do not begin to tell the story of women's access to quality health services or their experience of care. Ninety percent of women have four or more antenatal visits, 99% of live births are attended by skilled personnel, and only 3% of births take place at home or on the way to the hospital (PCBS 2007). Nine-nine percent of infants receive immunizations. Yet postnatal coverage is only 30%, in spite of the evidence that most neonatal deaths take place in the first few days following delivery, which is a critical time for prevention and care. High coverage without good quality of care does not necessarily improve outcomes (Countdown on Health Policies and Health Systems 2008), as has been shown in other countries (Miller et al 2003). It would appear from experience in the field, that those interventions that are relatively simple to administer and can be planned in advance, for example, to vaccinate an infant or to have a woman visit an antenatal clinic sometime during her pregnancy, are possible to realize in most situations no matter what the context. However, other interventions which are unpredictable, like childbirth care, require timely and skilled treatment to save lives (Lawn et al 2005). Based on the maternal and child health framework of 'continuum of care', care needs to be provided to all women and children throughout the life cycle from pregnancy to childhood in an integrated manner and with good quality services (Kerber et al 2007). The weak and fragmented Palestinian health system is filled with gaps, both in the continuity across the different perinatal time periods and across the linkages of the different levels of health care from the family, community, outpatient clinics and hospital.

Effective provision of services has been hindered by both external factors related to the occupation and internal factors related to the performance of the Palestinian health care system. Limited and unpredictable access to health services due to checkpoints effecting both users and providers is compounded by poor organization, understaffing, outdated practices, and lack of commitment to women's health at the policy level. Health planning post-Oslo neglected to take into consideration the possibility of lack of access to maternity hospitals for childbirth. The gaps in adequate maternal or neonatal morbidity data make it difficult to measure the extent of the consequences of these conditions. But sporadic reports give us the picture of what is most likely only the tip of the iceberg.

A network of primary health care (PHC) clinics is where most women first seek care. The oPt has 659 primary health care clinics, 529 in the West Bank and 130 in the Gaza Strip (PMOH 2009), with about two-thirds belonging to the government sector and one-third to the non-governmental sector and UNRWA (whose 53 PHC facilities are primarily in the refugee camps, serving the 1.8 million Palestinian refugees living in the oPt). Some of these clinics have offered a comprehensive package of reproductive health services, while others have limited provision to antenatal care and

²¹ In this respect the PNA reference in their recent plan to 'the abuse of free health insurance' is questionable, given that 57% of Palestinian households live under the poverty line (PCBS 2007).

family planning. While these clinics are widely distributed geographically, they do not provide 24 hour access to services, as physicians, the key providers, do not live in the community but come from the city, and are available only during certain hours or days. Nurses, midwives or community health workers staffing the clinics usually live in the community, but their roles in providing services have been limited by the MOH to assisting the physician (ICPH 2006). UNRWA PHC clinics have been providing family planning services since 1993, in addition to antenatal and postpartum care. Approximately 56 hospitals provide maternity services in the West Bank and Gaza, with the private sector having the most hospital beds, even though over half of the annual number of births take place in the government hospitals. Many private maternity facilities opened after the Oslo Accords, anticipating a growth in private health services, but remained underutilized and had to lower their fees as people's capacity for out-of-pocket payments decreased. Government maternity facilities are located in urban areas and tend to have high caseloads (for example, Shifa Hospital in Gaza with 14,000 births per year) and to be overcrowded.

Antenatal care:

Most pregnant women (99%) (PCBS 2007) receive some antenatal care. While 14% of women received less than the WHO-recommended number of four visits, about one-fifth reported 10 or more visits during the last pregnancy (PCBS 2005). Evaluations of quality of antenatal care have indicated deficiencies in its effectiveness. While targeted consultations providing counseling and detection and treatment of complications is recommended, assessments showed gaps in evidence-based practices, over-use of some unnecessary practices, insufficient provider-patient contact time (6-9 minutes) for adequate diagnosis and counseling, and gaps in effective and timely referral (ICPH 2006). Most women receive no preconception care; thus the prevention of neural tube defects with preconception supplements of folic acid is not utilized, in spite of the high rate of congenital abnormalities and the evidence of its effectiveness and low cost. The incidence of smoking among pregnant women is low, 1.8% (PCBS 2006), but passive smoking may be high given the crowded conditions of many households. Environmental factors have certainly had a deleterious effect on perinatal health, although it is difficult to quantify. UNFPA, after the Israeli bombardment of the Gaza Strip in December 2008-January 2009, reported a high number of miscarriages and premature deliveries during that period.

Ninety percent of women had a least one ultrasound during pregnancy for medical indications and sex determination, and physicians tend to do an ultrasound exam at every consultation (PCBS 2006). This overuse of technology is wasteful, and a burden on families' out-of-pocket expenditures.²² Given the preference for having sons, prenatal knowledge of the sex of the fetus might have a negative effect on fetal development (Al-Qutob 2004).²³ In a country where ultrasound technology is wide

²² In a recent survey households reported spending an average of 40% of their own out-of-pocket resources on health , which has been shown to be the most inequitable way of financing health care (Matariaet al 2009).

²³ In the DHS 2000 and 2004, the birth weights of boys is higher than that of girls, and low birth weight is more prevalent in girls than in boys (PCBS 2001, 2006), raising the question of whether knowledge of the sex of the fetus from ultrasound examinations early in pregnancy influences women's diet and well-being during pregnancy, and indirectly the birth weight of the baby (Hleileh et al 2008).

spread and poorly regulated,²⁴ incorrect information on sex determination from ultrasound scans might lead to psychological stress and marital conflicts (Dobson 2007). Furthermore, frequent inaccurate ultrasound examinations have been associated in other contexts with an increase in the rate of low birth weight babies, apparently from elective cesarean operations conducted before the full term of the pregnancy (Villar et al 2006).

Childbirth care:

The place of birth shifted rapidly to the hospitals, and in the 1990s male physicians replaced midwives in the largest hospital in Gaza to do deliveries, despite women's preference for female birth attendants. Women had reported preferring the hospital for giving birth (Giacaman et al 2008), and they perceived private hospitals as providing better services (World Bank and Bisan 2007). However, since 2000 most women use the free government services. Emergency cases have also increased in this sector due to the closure of Jerusalem with its referral and tertiary hospital, Makassed Hospital.

All pregnant women have experienced intense anxiety about reaching a place of birth and getting safely back home to their family, the effects of which cannot be quantified. Those women who gave birth under the bombing and shelling of Gaza in December 2008-January 2009 had even more acute traumatic experiences, risking their lives getting to the hospital. Midwives attending home births recounted that they were totally unprepared both materially (without minimal supplies) and psychologically for the emergencies. (Hassan-Bitar and Wick 2009).

The insufficient number of health providers also contributed to the suboptimal quality of maternity care in the public sector, raising the issue of the safety of childbirth. Midwives in the West Bank attend all normal births and assist high-risk cases, while physicians assume this role in Gaza hospitals. However, the staffing and infrastructural capacity of the government hospitals has not been increased or upgraded to meet the needs of the heavy caseloads and more severe referral cases. Midwives reported lack of time for even the most basic childbirth care.²⁵ Obstetricians reported being ill-equipped and trained for the emergency cases they encountered. Women felt inhibited with male doctors (Hassan-Bitar and Wick 2007).²⁶ Furthermore, poor working conditions, low salaries and lack of incentives in the public sector lead most physicians to engage simultaneously in a private practice (Hamdan et al 2003), hindering any impetus for improvement in the government facilities. With such resource-poor conditions for childbirth, utilizing evidence-based practices and avoiding unnecessary routine interventions, which may cause iatrogenic complications, is all the more important than in richer countries where well-

²⁴ There is no regulation throughout the government and NGO sector of the acquisition and distribution of equipment based on need, the training and credentials for those who use the technology, or the indications and frequency of its use.

²⁵ For sustainability of maternal and infant health services, the shortage and poor utilization of midwives needs to be addressed. The MOH reports a total of 679 midwives in the oPt and a ratio of .12 per 1000 persons (compared to .63 in the UK) [MOH National Strategic Health Plan 2008]. While graduating midwives from the MOH college had an obligation to work in the public sector after their free education, they were not employed by the government hospital, in spite of the need.

²⁶ Only 16% of obstetricians registered in the West Bank Medical Association are females, very few of whom actually practice in maternity hospitals (Wick and Mikki 2004). Information from Gaza was not available.

functioning emergency obstetric care facilities can rapidly treat maternal and neonatal complications effectively. Assessments of services have identified the frequent use of practices that are inconsistent with the latest scientific evidence (Kalter et al 2008, Wick et al 2005, ICPH 2006). The routine delivery practices adopted by obstetricians who have acquired their specialization in the West are frequently not adapted to the understaffed and inefficient context in which they are applied. Inappropriate intrapartum care included denying a companion during labor with insufficient support and monitoring from the caregiver, frequent use of oxytocin to augment labor without adequate monitoring and regulation of the dose, inaccurate record-keeping and absence of a partogram, insufficient monitoring of the mother and newborn in the immediate post-partum, and little counseling or advice to the new mother before early discharge. An example of gaps in evidence-based high risk care was the infrequent use of magnesium sulfate as the treatment of choice for pre-eclampsia, in spite of its availability and low cost (Hassan-Bitar and Wick 2007).

While the national cesarean delivery rate of 15% does not appear to be high compared to some other developing countries, the fact that the prevalence has doubled in the past decade (PCBS 1996, 2006) in this context of high fertility, poor access, and substandard operative conditions raises concern for the long-term outcomes for women's health. Three large government hospitals had cesarean delivery rates over 25% for 2008 (PMOH 2009), while staffing rates have not increased to assume adequate operative and post-operative delivery care. Recently the MOH started paying obstetricians in the government hospitals a supplement for each cesarean they performed, a financial incentive which does not appear to promote clinical decision-making based on evidence. While national data on indications for cesarean deliveries and outcomes is not available,²⁷ anecdotal evidence from physicians showed that cesarean operations were frequently performed due to mobility restrictions, when it appeared unsafe to send the woman home if she was not in active labor. The timing of deliveries, when the obstetrician works also in the private sector, has been shown elsewhere to be a reason for unnecessary interventions (Murray 2000). Cesarean deliveries in the oPt were associated with lower breastfeeding rates, which is not surprising given that most cesarean operations are performed with general anesthesia, which hinders early initiation of breastfeeding (Abdul-Rahim et al 2009). Given women's preference for large families and the increased risk with cesarean section of post-operative complications and maternal death (Deneux-Tharoux et al 2006), of higher neonatal morbidity (Villar et al 2006), and of complications in subsequent pregnancies and in repeated cesarean deliveries, clinical decision-making on conducting cesarean operations needs to take into consideration Palestinian women's long-term reproductive health and not just the immediate delivery.

Post-partum care: Post-partum care in the oPt has wide gaps in its utilization, acceptability, timeliness, content, and integration of maternal-infant services (PCBS 2007, Dhaher et al 2008, Hammoudeh et al 2009). In spite of early discharge from the hospitals due to overcrowding and women's anxiety about being able to reach home safely, post-partum care has continued to have low coverage (currently at 30%) and usually takes place after the most critical period for the health of the mother and newborn in the first few days after birth. Furthermore it focuses primarily on the infant. In one assessment, only about one-half of women received a physical

²⁷ For the analysis of the rates and indications of cesarean section in Makassed Hospital, the major Palestinian referral hospital in Jerusalem, see Mikki et al 2009.

examination or any family planning services (Sarriot et al 2004), inspite of the relatively high unmet need for contraception (28%) and short birth intervals (27%). A recent quality of life study of Palestinian postpartum women showed that the unwantedness of pregnancy was linked to the perception of a lower quality-of-life score in the postpartum (Hammoudeh et al 2009). It also raised questions about the cultural context of postpartum care. Where female relatives have always passed on the knowledge and support to new mothers, currently couples having moved away from their families to find employment, experience isolation during this period when they are cut off by roadblocks from the traditional family support network. More than half the women reported that emotional support rather than medical care was what they needed most and they desired more involvement of their husbands (Hammoudeh et al 2009).

V. Conclusion

Any hope of improving the safety and quality of women's health care in the oPt is contingent upon transformations in the field of policy and the process of policy-making. This overview has highlighted the neglected areas of women's health provision, identified underserved groups and emphasized the need for equity. It has shown the importance of promoting normal pregnancy and birth in a poorly resourced environment and utilizing evidence-based practices with appropriate distribution of tasks for different types of providers to ensure access and sustainability of care. Finally, it has illustrated the need to view and plan women's health care through the lens of the lifespan, as the health of the next generation depends on that of today's children.

Palestinian women's health and health care has been shaped over the years by the interaction of multiple factors. Women's daily lives and their health service provision have faced numerous challenges in a context of protracted warlike conditions. This investigation of the evolution of health care, under the dual external constraints of occupation and donor dependency and the internal dynamics of Palestinian society, has helped to unravel the requirements of improved women's health in this complex labyrinth. Meanwhile, women continue to find ways of surviving and of nurturing their families. While international public opinion may be touched by the casualties and destruction caused by occupation, the response takes the form of humanitarian aid rather than political action, creating further dependency of the population rather than promoting sustainable development. The social and political determinants of health are well demarcated in global scientific research, but logical conclusions and resultant imperatives for taking on the root causes of women's ill health are not being faced head on. The precondition for improvement is the breaking down of the checkpoints on the long road to women's health; this presupposes a different perspective on women's health based on the lifespan, and the adoption of effective interventions at critical periods during the life cycle where they can have the most impact. Likewise, the reinforcement of women's social support networks and the framing of community strategies from within would assist women in building on the existing resources of their daily lives. This approach may under current conditions appear utopian, but it is in fact the only one that holds the promise of putting women at the center of their own care.

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