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## 2. HEALTH AND POPULATION

### 1. Introduction and context

#### AN ALTERNATIVE DISCOURSE

The first issue to address in order to understand health and disease in appropriate ways is what the World Health Organization emphasized in 2008, namely, that the 'the conditions in which people are born, grow, live, work and age, including the health system' are the social determinants of health (Commission on Social Determinants of Health, 2008). Interestingly, Palestinian health professionals had already understood the impact of the broader social, economic and political contexts on health in the 1980's and appreciated the notion that health is a social construction even then, perhaps because the conditions of Israeli military occupation were so glaring, and clearly affected the health status of the population, especially during the first Palestinian Uprising with thousands injured and disabled (Giacaman, R, 1989). This alternative notion of how health and disease come about is the cornerstone of any attempt to address women's and population health. This is **because to improve health conditions, there is a need to work beyond the clinic and the hospital, indeed, beyond services and sectors, and integrate health interventions with community involvement, participation, and inter-sectoral collaboration while focusing on equity, that is, based on primary health care principles.**

The second issue to address is that much of the focus of writings on Palestinian health has been on disease, not health. In fact, the largely biomedical indicators and measures used to assess health are relevant to disease only. Consider for example indicators such as the maternal and infant mortality rates, anemia levels among pregnant women and chronic diseases. All pertain to the last stages in the continuum of Ease  $\longleftrightarrow$  Disease, where people oscillate on this continuum daily, and, depending on insult or injury (whether physical, emotional or social, or, in the case of Palestinians, political), including cumulative insult over the life course, could end up in the disease spectrum of the continuum, which is what is normally measured, and not the states preceding this disease state which accumulate and lead to disease over the life course (Giacaman R, et al, 2010).

Third, if health is not disease, and it is not, then it is imperative that we begin to use indicators of health for health and indicators of disease for disease. This necessarily leads to the need include subjective measures (that is, measures based on people assessing their own health status, such as the World Health Organization's WHO Well-being Index (Psychiatric Research Unit, World Health Organization, 1998), in addition to biomedical (objective) measures which are necessary, but not sufficient, to assess health.

Fourth, simple percentages, that is, numbers, do not speak for themselves. Numbers need to be analyzed and interpreted to form the knowledge base needed for use as a tool for policy. It does not do us much good to continue stating that postnatal care services are not well sought after by women and citing the small proportion attending such services. What is crucial is to try to understand why women do not seek post-natal care services, without blaming the victim, that is, without automatically assuming that the reason for their lack of attendance is 'ignorance' requiring health education, which is often ineffective. Indeed, a study in the final stages of completing at the Institute of Community and Public Health, Birzeit University, raises questions about the type and quality of services provided to these women and their relevance to women's needs in post-natal care clinics, and points to the necessity of

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conducting evaluation of these services with women's needs in mind before moving forward.

Finally, and in line with many of the international conventions as well as the Palestinian Ministry of Women's Affairs view, and to make this view clearer, what needs to be assessed is why some groups within the population (women, those living under the poverty line etc) have worse health than others, and what are the structures and processes within society which create this disparity in health between one group and another. A biomedical examination of issues usually leads to the assessment of individual health, not group health, omitting the important factors contributing to ill health among specific groups within the population who are most affected by the social determinants of health. **This is precisely why the biomedical indicators, as necessary as they may be, are insufficient, and why there is a need to go beyond the microscopic view into a broader macroscopic contextual view to locate the root causes of ill health in Palestinian society, especially among women.**

#### A FRAMEWORK FOR ANALYSIS

Palestinians living in the occupied Palestinian territory (oPt) have lived in a state of ongoing protracted warlike conditions for decades. These extra-ordinary circumstances have affected the population's health status in various ways not usually taken into account when counting dead bodies, injuries and disability as a result of political violence. Paradoxically, during the 1980's for example, Palestinian biomedical health indicators in fact improved. However, these indicators deteriorated during the post Oslo period largely because of Israeli measures of imposed closures, siege, and the lack of sovereignty over borders, movement of people and goods and control over land and water which made a public health approach to health system building impossible (Giacaman, R, et al, 2009). In addition, the lives of Palestinians under Israeli military occupation have been significantly affected by chronic human insecurity, distress, and social suffering related to war (Batniji, R, et al, 2009) (Ziadni, M, et al, 2011). Research on Palestinians demonstrates that, other than the negative effects on health of direct exposure to and witnessing political violence, human insecurity and distress also have negative health outcomes as measured, for example, by health related quality of life (Abu-Rmeileh, N, et al, 2011). In addition, it is now widely recognized that stress, through distress, can lead to disease (Stewart-Brown, 1998) thus such subjective measure where people assess their own health should also be taken into consideration when developing health related policies. **Understanding the wider context of people's lives is essential for an understanding of health, especially women's health.**

## 2. Key findings – trends and challenges

### DEMOGRAPHIC AND EPIDEMIOLOGICAL TRANSITIONS

During the past 20-30 years, Palestinians have been undergoing a demographic transition, characterized by declines in infant mortality, the development of what is called a 'youth bulge', that is, with young people 15-29 years old forming a high 29% of the population, and with 72% of the population under the age of 30 years. (Palestinian Central Bureau of Statistics, 2010). At the same time, the population is aging with 4.4% of the population 60 years and over. Fertility is declining, down to 4.1 in 2008-2009, with a low of 3.8 for the West Bank and 4.9 for the Gaza Strip (Palestinian Central Bureau of Statistics, 2008). This demographic transition has been followed by an epidemiological transition characterized by a reduction in communicable diseases, especially those of childhood, leading to a reduction in infant and childhood mortality and increase in average life expectancy; and the rise of what seems to be an epidemic of non-communicable diseases such as hypertension, diabetes mellitus, cardiovascular disease and cancer.

Studies of mortality data confirm the view that the oPt is undergoing a rapid demographic and epidemiological transition, where 30 years ago communicable diseases accounted for the major causes of death, while today chronic diseases account for an important proportion of deaths (Abu-Rmeileh, N,

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et al, 2008). The emergence of chronic diseases is of particular relevance to women's health. **Recent studies indicate that women report higher rates of diabetes mellitus at 25% of women 51-60 years old compared to 16% among men. Likewise with hypertension where 32% of women reported having hypertension compared to 16% among men, and for cancer among those 41-50 years old with 0.7% of women reporting having this disease compared to 0.2% among men** (Palestinian Central Bureau of Statistics, 2010). Studies also demonstrate (Husseini, A, et al, 2009) that urbanization, nutritional change from a healthy Mediterranean diet to a western-style diet are compounded by a rise in obesity (especially among women), all leading to the rise in the rates of these diseases. **Such changes are not easy to tackle by health services used to providing maternal and child care, and now faced with a double burden, that of dealing with maternal and child health care and at the same time dealing with diseases afflicting older populations. In the meanwhile, the population itself has to also deal with these demographic and epidemiological changes by changing lifestyles, that is, increasing physical activity, reducing weight, and changing diet.** However, such changes are difficult to achieve given movement restrictions by the Israeli military, social restrictions on the movement of women, and insufficient physical exercise because of a move of the population away from activities related to income generation from the land, to activities of a sedentary nature (such as in civil service). Likewise changing dietary patterns to reduce the risk factors associated with these diseases, by reducing fat and carbohydrates intake, is also a problem facing women because dietetic and healthy foods are generally expensive, and often, poverty (not only what is called ignorance among some health care providers) comes in the way of achieving dietary control. **This raises important questions as to the benefit of health education when the context women live in do not allow for behavioral changes, and points to the need to change at least some elements of the context in which women live in so that they are able to utilize the health education they receive.**

#### DISEASES OF UNDERDEVELOPMENT

Despite the current epidemiological transition and the rise of chronic diseases, some diseases related to underdevelopment and poverty continues to afflict Palestinian women. For example, a **PCBS study found that anemia levels among non-pregnant women were slightly higher than among pregnant women** at 35% of married women of child bearing age and 31% respectively (Palestinian Central Bureau of statistics. Birzeit University, 2003). **These results are unusual in view of the fact that globally, anemia levels among pregnant women are higher those who are not pregnant.** If we combine this information with our knowledge that Palestinian health care services and health research tends to be fixated on prenatal services and maternal and child health, ignoring the other aspects of women's health needs; and with the continued local emphasis on chronic diseases as a major concern among men only, we can only conclude **that an urgent priority for policy and intervention change is addressing women's health status and morbidity within a broad public health framework not restricted to maternal and child health, which can deal with needs of all Palestinian women, regardless of marital and pregnancy status.**

#### EARLY MARRIAGE AND INCREASING SINGLEHOOD

PCBS projections data indicates that the Median Age at First Marriage for women has risen to 20 years in 2011, 20.2 years for the West Bank and 19.8 years for the Gaza Strip (Palestinian Central Bureau of Statistics, 2011). However, initial analysis of PCBS data sets 1997 -2007 seems to indicate that we may have a rise in the proportion of marriages under 18 simultaneously with a rise in singlehood, affecting different regions of the oPt differently, with the highest levels of early marriage found in the Hebron District, and the highest levels of singlehood in the Ramallah/al-Bireh District (Abu Rmeileh N, Hammoudeh W, 2008). **PCBS reports increasing singlehood among women in 2010**, with 9% of women 30 years or over reported being single compared to only 3% among men (Palestinian Central Bureau of Statistics, 2010). These changes are bound to influence women's health status. **On the one hand, early**

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**marriage and early pregnancy are risk factor for health and other complications, and therefore need a special focus on the Hebron district in particular.** On the other hand, other than social and family life potential problems, **increasing singlehood carries with it the risk of the lack of access to health care services, since most, if not all, current health services cater mostly to maternal and child health needs.**

The underlying logic here is that women's health needs pertain to reproduction only, suggesting that women's sole role which can affect health is biological reproduction and not other aspects of living such as wage work, domestic work or even particular health needs related to stages in a woman's lifecycle. Such a view of women's role in society inevitably leads to omitting the health needs of single and married, non-pregnant women. **This is yet another area requiring policy and operational attention, since 9% of Palestinian women living in the oPt 30 years old and above are single, or about 190,000 women, and are generally excluded from access to health services because of the lack of health services programs specifically geared to the needs of single women.** Moreover, single women, especially if they are to be 30 years old or more and unmarried, are **also subjected to a social stigma associated with singlehood, expressed in an un-scientific and derogatory term in Arabic (اعنس) instead of simply single (عزباء) which is the term used for single men.** This also raises the need to **ensure to include objective/biomedical and subjective/related to quality of life and well-being indicators for single women's health in future endeavors related to monitoring women's health.**

#### PREGNANCY, CHILDBIRTH, AND POST NATAL CARE

Research indicates that prenatal care coverage and childbirth under the supervision of skilled attendants (that is, in hospitals or clinics as opposed to at home) have been consistently high since 2000, and almost universal (Abdul Rahim, H, et al, 2009). However, the quality of this care remains a question. For example, there has been an important rise in cesarean section deliveries in the oPt, from 6% of all births in 1996, to 15% in 2006 (Abul-Rahim, H, et al, 2009) and to a high of 19% for the West Bank in 2010, (oPt Health and Nutrition Cluster, 2012) surpassing the accepted rates recommended by the World Health Organization. These results are thought to be possibly a reflection of unnecessary interventions, which may be harmful to the health of women and newborns where high fertility and inadequate health care can increase the risks of cesarean deliveries. These results also indicate a potential problem with emergency obstetric services requiring further investigation. **There is a need to look further into this problem by investigating the indications used and outcomes of cesarean delivery. That is, practices need to be audited, and new indicators set in place, so that gaps in appropriate obstetric care are identified. The identification and reduction in cesarean sections, especially for non-medical reasons which can overburden the already burdened health system financially and in terms of human resource constraints, should be a priority for policy making.**

Post natal care services continue to be seriously underused by women (and this is not about ignorance), with PCBS data indicating that only 38% of women reporting on their last two births had received postnatal care by a skilled attendant (Palestinian Central Bureau of statistics, 2010). According to PCBS, postnatal care comprises of one visit to a health specialist during the first six weeks after birth (Palestinian Central Bureau of Statistics, 2007). This is also the strict definition of the World Health Organization which may be relevant to a minimum of care required. In truth, this post-partum period is a critical period for the health and well-being of mother and newborn, and research has generally focused on the biomedical aspects, such as the visit to a health specialist, which Palestinian women do not seem to value greatly. **A study focusing on the quality of life of women in the postpartum period revealed a variety of health needs going beyond the doctor's visit. It called into question the services offered to postpartum women, with 44% of women reporting that emotional support is the most important support they needed during this period, in contrast to 21% who reported that medical support was the most important support needed. This necessarily means that indicators of childbirth and postnatal care need to go beyond the strictly biomedical aspect of postnatal care. It also indicates**

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**that health services must go beyond standard health care (inside the clinic) to fulfill women's needs as women express them. That it, home visiting programs within existing maternal and child health services are essential to provide women with the support they need.**

#### FERTILITY AND INFERTILITY

Palestinian fertility has been the subject of much debate because of its integral link to the Palestinian people's struggle for survival, justice and a viable and sustainable state of their own. The issue is about a population balance between Palestinians and Israelis, where Israelis visualize fertility as a threat, while Palestinians perceive it as a weapon of resistance (Courbage, Y, 1999). And although Palestinian fertility has been declining from a Total Fertility Rate of 6.1 in 1991 (Palestinian Central Bureau of Statistics, 2006) to 4.1 in 2008-2009 (Palestinian Central Bureau of statistics, 2010) the continued relative high demand for children and high fertility is seen from a particular viewpoint as enigmatic in that it does not correspond to the educational level of women, where college educated women in the Gaza Strip have higher fertility levels than other college educated women in other parts of the world.<sup>1</sup>

However, it is believed that the under-utilization of the adult female population in the labor force can explain this persistent, although declining, high fertility. In addition, the demand for children among Palestinians does not seem to have seriously negatively affected investments in children's health, given low infant mortality rates as stated above, or investments in children's education, as Palestinians are known to be one of the most educated people in the Arab World. Indeed, the needs of ordinary Palestinians, and the context within which population and fertility are situated are not taken into consideration in these debates. For example, **individual and family survival strategies continue to create the demand for children and thus high fertility levels are maintained.** Indeed, **as long as there is no social protection system in place which can guarantee the survival of older people in dignity, and covering different aspects, including health care, income, nutritious food, especially those related to reducing the risks of chronic diseases, good housing, disability care, etc., Palestinians are likely to continue to rely on their children in lieu of social security in old age, explaining to some extent the continued higher fertility rates we observe compared to what is expected given a particular developmental stage** (Giacaman, R, 1997).

**Such a reality requires broader level policies going beyond access to family planning as an indicator of change,** which is emphasized by MOWA and some UN documents (MOWA indicators 2011-2013) (Division for the Advancement of Women. Department of Economic and Social Affairs, undated ) ; or population control; **or a focus on access to health care where unmet need is mechanically interpreted as the need for family planning, instead of broader level needs related to the survival and well-being of women, especially in old age.** In other words **such a complex reality requires broader level policies going beyond family planning and into the formulation of socially and gender sensitive policies across all sectors that can address the intricacies of population issues in the oPt. It is only through an integrated and balanced policy approach which takes into consideration people's survival needs that we can effectively address this seeming split between immediate family survival and planning for sustainable development in the future.**

If we were to take women and men's needs in the area of fertility reduction seriously, we would need to also take the problem of infertility seriously as well. **For years, we have known that the rate of infertility among Palestinian couples is in the range of 7-10% of all couples, and at 8.4% in 2010**

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<sup>1</sup> Personal communication with Professor Marwan Khawaja, a leading Palestinian demographer and social statistician, Center for Research on Population and Health, ESCWA, Beirut.

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(Palestinian Central Bureau of Statistics, 2011). Yet, we find that indicators related to women's health fail to take note of this important point related to the needs of women and men to have access to fertility care and treatment. Given the above discussion of how children are important for social protection in old age, and the absence of effective social security for Palestinian citizens, it should not be surprising to know that infertile couples endure much suffering as a result of their infertility. In Palestinian society, procreation is understood as among the main purposes of marriage. In addition, **by having children, especially male children, Palestinian women acquire more status and power and are able to access some social domains with more freedom.** Adding insult to injury, **infertile women are often blamed, sometimes scorned and sometimes rejected or even divorced. They also live under a very strong social pressure, not only from husband and family, but also from community and society at large. Thus infertility poses a major threat to women's status and power in society, in addition to the prospects of lacking financial and health protection and other forms of sustenance in old age** (Giacaman, R, 2012). Paradoxically, there has been little investment in dealing with infertility, including by international aid and humanitarian agencies working to increase the status of Palestinian women. Instead, what seems to count is birth control, in the form of a focus on family planning services which is emphasized by development aid. Emphasis on access to family planning services is indeed important, but not sufficient, as it does not take into consideration the basic human right of people, especially women, to have children. **This is precisely why a priority for policy formulation and program implementation is ensuring the provision of quality and low cost infertility care by governmental health services.**

#### MENOPAUSE AND ELDERLY WOMEN'S HEALTH

To date, little information is available on the type and quality of women's health services offered by service providers in the oPt. While there is a good amount of reporting related to the number of cases (not persons) visiting clinics, we still need more research to uncover the gaps in service provision, **especially that women's health care is not merely about providing pre and post natal services, but should cover the health needs of all women, whether single, married but not pregnant, menopausal and older women.** However, initial research conducted in the Ramallah district reveals some of these gaps in services (Khatib, R, et al, 2011). This research indicates that these clinics offer antenatal and post natal care, family planning and gynecological care in the main. Gynecological care includes medical care for infections, breast problems, screening tests and ovarian or uterine problems. Results also reveal that almost all women attending clinics during the period of study (4 months) were married and about half were attending clinics in order to receive antenatal care. The second reason for seeking care was for the purpose of obtaining family planning services. **Postnatal care provision was minimal. In general, available services marginalize and excluded the needs of some women, especially unmarried women, those in the menopausal period and the elderly.** The study concluded that for an expanded view of what women's health care should be, **there is a need for the training of staff, following up and supervising them so that they implement women's health protocols.** Even diagnosis and prescribing patterns were found problematic to some extent with recommendations that those too should be observed, with proper monitoring and follow up.

**However, the needs of menopausal and elderly women go beyond what can be provided by health services and, once again, require a concerted effort at integrating the different policies developed by the various ministries and groups to effectively address need.** For example, some menopausal women suffer from stigma related to the biological fact: cessation of menstruation and ability to bear children. Even medical professionals use the term سن اليأس ( in English meaning the age of despair) to refer to menopause, highlighting the degree to which even medical care providers have absorbed and accepted this stigmatizing view of a natural stage in a woman's life cycle. Once again, as if the sole role of women

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in society is to bear children, and once she is no longer able to do so, then she must despair, since she loses her main role in life. In the meanwhile, **symptoms and consequences of menopause, which can create a substantial amount of suffering are still neglected in the main, and require effective action inside and outside the clinic, through home visits and community education and involvement.**

A few statistics on the Palestinian elderly are sobering. In 2010, only 12% of families in the oPt were of the extended variety, meaning that **increasingly, older people are living alone.** About 91% of elderly men were married, in contrast to 43% among women, **with a high of 50% of elderly females were widowed, compared to 8% among the men** (clearly an indication that when wives die, men remarry, but women do not). 25% of elderly persons were poor, that is, 5% of the total number of poor people in the oPt even though they amount to 4.4% of the population. **That is, elderly people are poorer than the rest of the population.**

Thus with the clearly aging trend in the oPt, where the average life expectancy has risen to 71 years for men and 73.9 years for women in 2011 (Palestinian Central Bureau of Statistics, 2011), combined with the increasing nuclearization of families raises the question of **who is will be taking care of the elderly and how, given the almost complete absence of institutional, as opposed to family, elderly care. The fate of the elderly, and the way they are being cared for in nuclear households, which lack the physical, emotional and social support needed by the elderly, and which is usually provided by younger adults in the family, is a question that cannot be under-estimated. Given age-gaps in marriage, and the higher life expectancy of women compared to men, women are disproportionately widowed and thus particularly vulnerable in old age.** That is, aging is gendered, with significantly more females living longer than men are being affected by disabilities of different sorts.

**Thus as more and more people reach old age, they are bound to require the presence of a variety of services, not only health, but also aspects such as home care, social services care, even 'meals on wheels'. This is not only a matter of human rights, equity, and justice; it is also a matter related to decreasing the burden of elderly care imposed on young people, especially women, so that they can more effectively participate in the labor force, if institutional support for the elderly and children as well, are institutionalized.** This can rejuvenate the economy, and improve women's and elderly people's autonomy, quality of life, dignity and self-confidence as well. **Overall, the demographic trend observed during the past decade presses the issue of elderly care as a priority for future investigation, policy formulation, and intervention.**

#### PERSONS WITH DISABILITY

Disability rates in the oPt have been more or less constant over the years, with 2.7% of the population reported as disabled in 2011, 2.9% in the West Bank and 2.4% in the Gaza Strip. Disability affects all ages, beginning at childbirth. However Palestinians must also face the consequences of an aging population, which also adds to the burden of disability and inability to function among the elderly.

PCBS's Disability Survey 2011 is informative. As one would expect, disability rates increase with increasing age, with 32% of those 75 years or more reported as disabled, and with 34.1% for women compared to 28.9% for men. Among children younger than 18 years old, 1.8% of boys and 1.3% of girls were reported as disabled. About a third of disabled people have never been married, 87% were not working, and another third had not attended school at all. **The study found a high level of unmet need among these disabled, including simple devices support, such as glasses to help them see, hearing aids, wheelchairs and other equipment to help them function, as well as physical, occupational and speech and other forms of therapy which could alleviate some of their suffering. The disabled suffer**

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**from the lack of social integration as well.** A high of 76.4% of the disabled do not use public transport because of the lack of infrastructure to allow them to do so; about a fifth left school because of financial and environmental impediments, and most suffer from the stigma associated with disability (Statistics, Palestinian Central Bureau of, 2011). **These results clearly indicate a need to integrate the needs of the disabled and the elderly in all sectoral policies.**

#### Exposure to Israeli political violence and health

It is well acknowledged that war and conflict have negative effects on health. As well as death, injury, disability, displacement, and lack of access to health services, conflict entails a constant exposure to life-threatening situations, and can lead from stress, through distress to disease (WHO, 2008). However, Palestinians have largely been described in terms of counting dead bodies, injuries and the disabled, without due regards to how war affect people's health, and 'the wounds inside.'

The human security framework therefore opens up the space for using subjective measures - reports by people themselves assessing their insecurities, the threats they face, and their own health status, such as self-rated health, quality of life, and well-being - to complement objective measures and to assess health outcomes (Schalock, RL, 2004). In the case of the oPt, these measures provide us with the means for evaluating the impact of warlike conditions on population health status in ways that cannot be captured by classical biomedical measures alone.

To assess the quality of life of Palestinians living in the oPt, the World Health Organization's quality of life index was used in a 2005 survey containing a representative sample of adults from the general population. Life quality in the oPt proved to be lower than that in almost all other countries included in the WHO study (Mataria, A, et al, 2009). The study also showed that respondents had high levels of fear: threats to personal safety, safety of their families; loss of incomes, homes and land, as well as fear about their future and the future of their families; and feelings of *Hamm* – which in Arabic refers to feelings of the heaviness of worry, grief, sorrow and distress - and anxiety, incapacitation, and deprivation. Most people reported being negatively affected by the constant violations of Israeli military occupation, closures and siege, and inter-Palestinian violence.

It is interesting to note that overall, women had higher quality of life scores compared to men (Mataria, A, et al, 2009). These results are surprising given that Palestinian women are generally disadvantaged compared to men in view of the patriarchal social order which discriminates against them and restricts their freedoms. These results raise the question of a possible paradoxical protective effect of patriarchy which restricts women's movement outside the home, and pushes men to move beyond the domestic sphere in search of family livelihoods. The public sphere, or the men's world, is fraught with daily threats of violation and distress when crossing checkpoints, being held, stripped, detained, not allowed to cross and enduring humiliation, and may explain these results. **However, these results point to the need to pay attention to men's health as well, and to the problem of how often gender is misconstrued to mean aspects of life related to women only, when gender is in fact about both men and women.**

Studies on the West Bank revealed high levels of psychological distress at home especially during Israeli army invasions, including severe distress, sleeplessness, uncontrollable fear, fatigue, depression and hopelessness (Giacaman, R, et al, 2004). Other studies also found that collective exposure to violence, and humiliation were also significantly associated with negative health outcomes. A study of adolescents in the Ramallah District revealed that exposure to humiliation was significantly associated with subjective health complaints (Giacaman, R, et al, 2007) while collective exposure to violence was

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significantly associated with negative mental health outcomes, even after adjusting for sex, residence and other associated factors.

These studies are also significant in that they demonstrate variation between boys and girls in their exposure to violence and the development of symptoms. While the level of exposure to violence was extremely high for both sexes, **boys reported significantly more exposure to violence** such as having been beaten by the Israeli army, humiliated, used as a human shield, exposed to tear gas, body searched, and detained or arrested, among other violations. **In contrast, girls reported significantly higher levels of symptoms, including depressive like symptoms.** These results are consistent with other studies of both the oPt and elsewhere, and can be partially explained as gender differences stemming from the way in which boys and girls are socialized, with societal norms allowing greater freedoms for boys, especially outside the domestic sphere or the school, and consequently leading to higher exposure to political violence among boys, compared to girls (perhaps once again the paradoxical protection against violation effects of patriarchy on girls).

Studies completed in the Gaza Strip in 2008 revealed similar results to those of the West Bank, with high levels of distress and fears, especially among children. Children were reported as being highly exposed to traumatic events, such as witnessing a relative being killed, seeing mutilated bodies, and having homes damage. These studies reported several psychosocial problems, including behavioral problems, fears, speech difficulties, anxiety, anger, lack of concentration at school and difficulty in completing homework (United Nations, 2008).

While perhaps not much can be done immediately in relation to the daily and chronic Israeli military violations that the population is exposed to, **it is absolutely vital to 'do no harm'. Palestinian people's violations have their roots in socio-political causes, and consequently, these require socio-political resolution, not the prescription of tranquilizing medications, psychological therapies, or the labeling of trauma and distress as sicknesses, which risks pathologizing the social suffering of war, adding more burdens on the victims.** Indeed, our study of psycho-social mental health institutions in the oPt during the height of the second uprising was indicative of a fixation on therapies, to the exclusion of advocacy for the removal of the root cause of people's distress and suffering (Giacaman, R, et al, 2004). While it is certainly true that some in the population require medications and therapies, their proportions are very small. **The large majority of Palestinians lives between the ease-dis-ease continuum, affected daily by exposure to violence, trauma and distress. And although they exhibit symptoms which are a natural consequence of this exposure, they are not sick. They are violated and call for the end of violation and for justice to be attained.**

#### **WOMEN WITH HUSBANDS IN ISRAELI JAILS**

Reports indicate that there has been over 800,000 cases of arrests and detention of Palestinians by the Israeli military on political grounds since 1967 (Palestinian Central Bureau of Statistics and Ministry of Detainee and Ex-detainee Affairs, 2012), and with an estimated 4000 persons imprisoned in November 2012 (B'tselem, 2012). While the issue of political detention is often the subject of media and other types of reports, little is known of the consequences of the imprisonment of men on their wives and children. Termed the 'invisible victims' of political violence, a recent study (Rabaia, Y; Balsam, C; Giacaman, R, 2013) indicates that women whose husbands are detained or sentenced in Israeli jails suffer from a range of daily life problems. On top of the list of negative consequences of men's imprisonment for families is financial crisis, especially if the prisoner was a main breadwinner. While the Palestinian Ministry of Detainee and Ex-detainee Affairs provides a 'salary' and lawyers to political detainees, this assistance was often described as "nothing" by women. A good proportion of this salary

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is spent on over-priced items for detainees in the Israeli prison canteen, including clothes, foods and cigarettes. The sense of the Ministry's assistance as 'nothing' also revealed a strong sense of isolation that is not alleviated by governmental financial support. It furthermore demonstrated that the value of political incarceration in communities and society has also diminished after the Oslo Accords of 1993 compared to the First *Intifada*, leading to the isolation of women even within their own communities (Rabaia, Y; Balsam, C; Giacaman, R, 2013).

The results from this research also shed light on the suffering and humiliation endured when visiting husbands in Israeli prisons. Women moreover reported that the absence of the husband can further curtail women's autonomy, with wives often placed under the authority of her in-laws, with increasing restrictions on their movement, dress, and freedoms by family and community. Psycho-social problems were also evident. Women reported on the psychological problems of their children such as increased distress, behavioural problems, and missing their father, especially during holidays and feasts. Finally, elements of apprehension regarding the future were clearly evident. Some wives were worried about changed family dynamics once the husband released from prison. On one hand, they were always waiting and praying for his release; on the other hand, some were worried about how he would treat the children, who have grown since he entered prison, and themselves, as wives who have likewise aged, perhaps inducing the husbands to re-marry (Johnson, P; Giacaman, R, 2013). **While there seems to be a range of institutions catering to the needs of prisoners, very few are paying attention to the needs of wives, especially in relation to the needed social support, assistance with children, and also in dealing with pressures imposed by community when husband is in prison. These findings alert to the need to pay special attention to the wives of Palestinian political prisoners, and to ensure that their needs are included in integrated policies all working towards the alleviation of their suffering.**

### 3. Strategic opportunities and policy priorities

#### Global level recommendations:

- ✓ Health is made, and broken, largely in the broader context in which people live. This means that we need to gain an understanding of the wider context of people's lives if we are to understand, and address the health status of Palestinian women and men.
- ✓ It is absolutely vital to 'do no harm'. Palestinian people's violations have their roots in socio-political causes, and consequently, these require socio-political resolution, not the prescription of tranquilizing medications, psychological therapies, or the labeling of trauma and distress as sicknesses, which risks pathologizing the social suffering of war, and adding more burdens on the victims. Palestinian women and men are violated and call for the end of violation and for justice to be attained.
- ✓ That is, to improve health, we need policy and operational measures within and outside the health sector. We need to work beyond the clinic and the hospital, beyond the various sectors, indeed, beyond services, and integrate actions with community involvement, participation, inter-sectoral collaboration while focusing on equity, that is, based on the primary health care principles.
- ✓ This is precisely why biomedical indicators (such as blood pressure and anemia testing), as necessary as they may be, are insufficient, and that there is a need to go beyond the microscopic view into a broader macroscopic contextual view to locate the root causes of ill health in society. Future monitoring of health status needs to take into consideration new indicators, and not only those of the disease variety. These indicators include measures of life quality, self-rated health, distress, human and food insecurity and other measures relying on self-reports, which can inform us of the

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social, political, psychological and economic factors which precipitate disease. Such measures have been repeatedly shown to predict death.

- ✓ An urgent priority for policy and intervention change is addressing women's health status and morbidity within a broad public health framework not restricted to maternal and child health, which can deal with the needs of all Palestinian women, regardless of marital and pregnancy status. Women's health care is not merely about providing pre and post natal services, but should cover the health needs of all women, whether single, married but not pregnant, menopausal and older women. For this to be achieved, there is a need for the training of staff, following up and supervising them so that they implement women's health protocols, which are not being implemented properly, perhaps with the exception of prenatal care.
- ✓ This requires broader levels policies going beyond access to family planning as an indicator of change, which is emphasized by MOWA and some UN documents (MOWA indicators 2011-2013) (Division for the Advancement of Women. Department of Economic and Social Affairs, undated ) ; or population control; or a focus on access to health care where unmet need is mechanically interpreted as the need for family planning, instead of broader level needs related to the survival and well-being of women, especially in old age. Broader level policies must go beyond family planning and into the formulation of socially and gender sensitive policies across all sectors that can address the intricacies of population issues in the oPt. It is only through an integrated and balanced policy approach which takes into consideration people's survival needs that we can effectively address this seeming split between immediate family survival and planning for sustainable development in the future.
- ✓ Gender is a social construction, affecting the roles and responsibilities of men and women. Palestinian men suffer from a high level of exposure to violence which needs to be addressed. Thus there is a need to pay attention to men's health as well, and to the problem of how often gender is misconstrued to mean aspects of life related to women only, when gender is in fact about both men and women.
- ✓ The current health and demographic information systems are in need of quality improvement. The problems of under-reporting, inaccurate recording and suboptimal presentation of report data need to be addressed. Such reports should be used for policy and planning, and the information contained in them must be an accurate reflection of population demographic and health features. We will not be able to ascertain average life expectancy, for example, without accurate age specific death rates. We will not be able to make the needed projections on how many chronic diseases clinics we will need without knowing the prevalence rates not only overall, but also by age, sex, region and locale. Relying on periodic surveys is an expensive endeavor. Quality improvement of the existing information systems, which may take some time and effort, is ultimately cheaper, and more effective.
- ✓ Overall, the demographic trend observed during the past decade presses the issue of elderly care as a priority for future investigation, policy formulation, and intervention.

#### **Specific recommendations**

1. Given the rapidly rising levels of chronic diseases among women,, policy and operational measures within and outside the health sector should be used to help women reduce their weights, exercise and return to the healthier old Palestinian diet. This traditional diet is mainly based on vegetables, olive oil and what is produced on the land, instead of foods with high fat levels, and the processed variety that people have been gradually getting accustomed to.

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2. Another priority is addressing early marriage, in particular in the Hebron district, while at the same time expanding health services to include services needed by single women throughout the oPt. This also raises the need to include indicators for monitoring single women's health.
3. Given the unacceptably rising levels of caesarean sections, there is a need to look further into this problem by investigating the indications used and outcomes of cesarean delivery. That is, practices need to be audited, and new indicators set in place, so that gaps in appropriate obstetric care are identified. The identification and reduction in caesarean sections, especially for non-medical reasons which can overburden the already burdened health system financially and in terms of human resource constraints, should be a priority for policy making. This necessarily means that indicators of childbirth and postnatal care need to go beyond the strictly biomedical aspect of postnatal care. It also indicates that health services must go beyond standard health care (inside the clinic) to fulfill women's needs as women express them. That is, home visiting programs within existing maternal and child health services are essential to provide women with the support they need.
4. Attention should be paid to infertility care. A priority for policy formulation and program implementation is ensuring the provision of quality and low cost infertility care by governmental health services.
5. There must be more attention paid to menopausal care, focusing on the symptoms and consequences of menopause, which can create a substantial amount of suffering are still neglected in the main, and require effective action inside and outside the clinic, through home visits and community education and involvement.
6. Findings from various studies alert to the need to pay special attention to the wives of Palestinian political prisoners, and to ensure that their needs are included in integrated policies all working towards the alleviation of their suffering.

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