NO PALESTINIAN IS SAFE: POPULATION DYNAMICS AND THE WELL-BEING OF MEN, WOMEN AND CHILDREN THROUGH OBJECTIVE MEASURES AND SUBJECTIVE INDICATORS

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I. INTRODUCTION AND CONTEXT

A decade of crisis, violence, and various forms of human rights violations and human insecurity has made life for Palestinians harder, more dangerous and less secure. While such a comprehensive crisis has spared no one, it has affected the health and well-being of population groups differentially, whether by gender, social class or location. Have these political transformations been accompanied and complicated further by demographic, family life and health changes? How have violence and violation affected population health, and not only disease states?

This essay with provide an overview of available statistical and other data to answer some of these questions to delineate time trends, and to point to future challenges and directions needing attention by researchers and policymakers alike. These challenges cannot be understood, however, let alone met, unless objective measures of health are combined with subjective indicators in a wider human security framework that addresses the social suffering triggered by sustained war-like conditions and rights violations.

In conditions of chronic conflict, high levels of exposure to violence, and pervasive insecurities, the human security framework complements the biomedical framework, and offers us the opportunity to make the link between health and wellbeing, and the sociopolitical conditions that Palestinians are enduring. For Palestinians are people who were never safe (Das 2006)and to this day continue to experience violation daily, enduring the social suffering associated with war that cannot be explained solely by objective measurements The human security framework focuses on people and their protection from social, psychological, political and economic threats that undermine their well being (King et al, 2001).It emphasizes the capability of people to manage daily life, and the importance of social functioning and health. (Caballero-Anthony, 2004).

Thus the importance of this causal framework (from human insecurities and violations, to social suffering, to negative health outcomes) is that it allows us to reveal the Palestinian reality, and the broader determinants of the health of women, men and children. It prompts us to analyze health more comprehensively beyond body counts and morbidity patterns. It leads us to the use of indicators essential for the study of the consequences for health and well being of war

and conflict, and for the exposition of the humanitarian crisis Palestinian are enduring, where the 'home front is the battlefront', especially in the Gaza Strip.

II. TRENDS AND INDICATORS: CONSEQUENCES OF CRISIS

Fertility unusually high but declining

Table I indicates that the population of the occupied Palestinian territory (oPt) has increased from 2.9 million to 3.8 million in a decade, a reflection of high fertility and a pre 1997 sharp decline in infant mortality. While the fertility rate declined, from 6.1 Total Fertility Rate (TFR) in 1997 to 4.6 in 2007, it remains higher than expected, given the relatively high educational levels of Palestinian women, and in comparison with fertility rates in other neighboring Arab countries – with a TFR of 3.7 for Jordan, 1.9 for Lebanon, 3.8 for Syria and 3.1 for Egypt (Abdul-Rahim et al, 2009). This decline may be an indicator of improving women's health over time, because of the association between high fertility levels and maternal mortality, and the added burdens on women which usually accompany large family sizes, with possible negative effects on her health. This question is important to research in the future.

As a partial consequence of this decline in TFR, the average family size declined as well, from 6.4 persons per family in 1997 to 5.8 in 2007. Family size is also influenced by the proportion of nuclear and extended families among the population. The table indicates that the percentage of nuclear families rose slightly during the past ten years, from 73% in 1009 to 78% in 2007. While nuclearization may increase women's status and autonomy within the family, in the context of the oPt, one is also compelled to raise the question of possible negative ramifications of nuclearization on family life. As observed locally, extended family support, mostly by women, during childbirth, in child care and meal preparation is a primary form of support allowing women to work outside the home, given the almost absent public or institutional support for working women. Increasing restrictions to mobility due to geopolitical and financial reasons, and increasing movement of young couples from their homes of origin to seek employment in cities, especially the center of the West Bank (Taraki, L ed, 2006) may have partially induced this nuclearization, and diminished this support system so crucial for women, especially working women with young children.

Infant mortality: the significance of stalling

The table also indicates that Infant Mortality Rate (IMR) has not changed much during the past decade. IMR declined during the 1980's and early 1990's, but 'stalled' , or slowed down, since then , and remained at a relatively stable level of 25 deaths/1000 live births. Stalling is an unusual demographic phenomenon suggesting a slowdown of health improvements, a possible

increase in health disparities, or an indication of deteriorating conditions (Giacaman et al, 2009) relevant to all of the population, not only children. Analysis of the 2006 PAPFAM data however indicates that IMR is increasing in the Gaza Strip, reaching 29 deaths/1000 live births on that year, and quite likely to have increased even more since that time, especially since the Israeli attack on the Gaza Strip of December 08 January 09, and the continued blockade, and strict closures and siege endured by the population there.

Youth Bulge

The age distribution of the population has also changed. There is a decline in the percentage of children< 15 years old from 47% in 1997 to 45% in 2006, and a corresponding increase in the percentage of people 15-64 years, that is, a decline in dependency and a rise in the number of people who are eligible to participate in the labor force. What this implies given the Israeli policy of separation and economic strangulation, and high current rates of unemployment and poverty levels, especially the high unemployment levels of young people, remains speculative.

As the proportion of children < 5 years old is declining, the proportion of Palestinian young men and women 15-29 years old is rising, and forms 27% of the population, bringing the proportion of those under the age of 30 years to over 70% of the total population. In demographic terms, these figured seem to signal the beginning of a new trend, called the 'youth bulge', the result of declining IMR and high fertility levels. It is maintained that large youth cohorts in a population increases the susceptibility of countries to political violence (Urdal 2006). One would argue with this approach in that it situates violence 'within' young people, especially boys who usually manifest distress through increased aggression and behavioral modification, compared to girls who report higher levels of somatic complaints (Giacaman et al, 2007). In contrast, it can be argued that increased violence may be the result of their violation, the lack of personal freedoms, and the lack of space for economic, social and political participation that brings about this violence to begin with. That is, their lack of integration into society and alienation.

The advent of TV, the Internet, and cell phones may also have intensified intergenerational conflict, as modern technologies have allowed Middle Eastern (including Palestinian) youth to witness what is happening elsewhere in the world, and to connect to a world unknown to their parents. This is believed to intensify young people's desire for change, rather than the reproduction of the old way of life, and for seeking the personal freedoms which other youth enjoy. We must also reflect on the probable additive effects of Israeli military violations, experienced daily by the majority of the population, including young people.

Challenge of Aging

The proportion of people 65 years or more has also changed slightly during the past decade, down from 3.8% in 1997 to around 3% in 2007. This decline may be a distortion, a reflection of the increased in the proportion of young people, given that the absolute number of the elderly increased during the past decade. The average life expectancy also seems to be rising from 72.2 years for women in 1997 to 73.2 in 2007 and from 70.7 for men in 1997 to 71.7 in 2007. However, caution should be taken when interpreting the data on average life expectancy. This is because it remains incompatible with global trends where the difference in life expectancy between men and women is usually at least 4 years. This discrepancy is probably at least partially due to the fact that, to date, average life expectancy is calculated by projecting from infant mortality rates, which have declined over time, and therefore produce a parallel increase in life expectancy. The more accurate method for life expectancy calculations is based on age specific mortality rates, which are still unavailable to date for the oPt.

Combining the gradual ageing trend in the oPt, with the increasing nuclearization of families begs the question of who is and 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. 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.

Early Marriage and Increasing Singlehood

Data related to 1996-2004 may have indicated a slight rise in women's age at first marriage (PCBS DHS 2000, 2004) for a certain period, if judged by the proportions married under the age of 18 years over time. In fact, the more appropriate method of delineating time trends is by comparing the Median Age at First Marriage over time, and this remained constant at age 18 as was the case in 1995. Further data analysis is warranted to assess this issue more comprehensively. However, initial analysis of PCBS data 1997 -2007 seems to indicate that we may have a rise in the proportion of marriages < 18 simultaneously with a simultaneous 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 and Hammoudeh, unpublished data). These changes are bound to

influence women's health status. On the one hand, early marriage and early pregnancy are risk factor for health and other complications. On the other hand, other than social and family life potential problems, increasing singlehood carries with is 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, as if women's health needs only pertain to reproduction, and omitting in this way the health needs of single and married, non-pregnant women. This is yet another area requiring further investigation, and dis-aggregation of data in analysis.

First cousin marriage also remained remarkably constant during the past decade, with 28% of marriages noted as first cousin marriages in 1997 and in 2006 each. This phenomenon remains largely unexplained, although the socio-economic conditions that Palestinians have endured, especially with increased closures and siege, and the negative ramifications of these conditions on economic and social life may offer us a partial explanation (see Johnson in Taraki 2006). Clearly, more research needs to be done in order to understand why this phenomenon is unyielding, and its consequences on family life and health, including fertility patterns.

Death, injury, disability and imprisonment

Since the beginning of the Second Uprising (*Intifada*) in 2000, bombing of civilian areas and use of gunfire by the Israeli army has increased civilian deaths to proportions substantially higher than deaths during the First Uprising. From September 28 2000 till December 26 2008, almost 5000 Palestinians, including about 1000 children were killed by Israeli military action, the majority civilians (B'tselem, 2009). The 22 day attack on the Gaza Strip of December 27-08 till January 18th 09 alone, led to the death of about 1400 people and the injury of about 5000 (Amnesty International, 2009). As of September 2009, there were more than 7,000 Palestinians held in Israeli jails, mostly men, but including women and minors (B'tselem, 2009). These high levels of death, injury and disability due to injury (estimated by the author from PCBS figures at 6% of the total disabilities of about 3% prevalence rate, or around 7000 persons) and imprisonment, place a high burden on individuals, health services and society, especially the families who have lost their livelihood with the death, disability or imprisonment of breadwinners; and women since they are the primary caretakers of the family, including the disabled. Because very little is known of the fate of such families, every effort must be made to investigate the consequences of the violence of death on the lives and well being of the living, the remaining family members.

Diseases: objective indicators: stunting of children, maternal mortality

With the stall in IMR indicating deteriorating conditions in general, malnutrition among children < 5 years old is also on the rise. Table 1 indicates that the percentage of stunted children < 5

(low height for age) has risen from 7.2% in 1996 to 10.2% in 2006, and that stunting levels are higher among the children of the Gaza Strip, and probably rising since 2006. Stunting levels are another indication of overall deteriorating population health conditions. Stunting is also associated with increased disease burden and death, including compromised cognitive development and educational performance (Walker et al 2005), and obesity and chronic diseases in adulthood (Sawaya et al, 2003).

The Maternal Mortality Rate (MMR, the annual number of deaths of women from pregnancy-related causes per 100,000 live births) was estimated at around 100 in 1997(Abdul-Rahim et al, 2009). Unfortunately, this important indicator continues to be either unavailable through surveys or flawed and impossibly low when based on calculations from the Palestinian Ministry of Health's records. In 2005, the MMR was estimated at 15.4 in Ministry reports, although the Ministry acknowledged the improbability of such estimates, pointing to the probable under-reporting of deaths as part of the problem (Ministry of Health, 2006).

Epidemiological Transition: Women and Chronic Disease

The population of the oPt is undergoing an epidemiological transition, with non-communicable diseases such as cardiovascular diseases, hypertension, diabetes and cancer having overtaken communicable diseases as the main causes of morbidity and mortality. Thus, chronic diseases are fast becoming a major public health problem. Chronic diseases today account for over half of the total death in the oPt, while communicable diseases account for less that 10% of total mortality rates (Husseini et al, 2009). In contrast to the international literature, where men are generally found to be at higher risk of developing chronic diseases and dying compared to women, various studies conducted in the oPt indicate that Palestinian women have similar or higher rates of chronic disease morbidity compared to men, similar risk of mortality from chronic diseases; and higher levels of obesity and anemia (Abu-Rmeileh et al, 2008; Husseini et al, 2003; Abdul-Rahim et al, 2001).

Despite changes that appear to be similar to changes taking place in more developed countries, anemia levels among women continue to be high, with anemia levels among non-pregnant women found to be slightly higher than among pregnant, at 35% of married women of child bearing age and 31% respectively (PCBS, 2002), and presenting another contrast to the global literature, where pregnant women have higher prevalence rates of anemia compared to non-pregnants. 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 needs of non-pregnant, single, menopausal and elderly women; 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 research and intervention is addressing women's health status and morbidity within a broad public health framework not restricted to maternal and child health, which can address the needs of all Palestinian women, regardless of marital and pregnancy status.

Health: subjective indicators reveal low quality of life, distress, fear

It is increasingly being acknowledged today that low income, inadequate housing, unsafe workplaces and lack of access to facilities, in addition to conflict, have negative effects on health. Other than 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 (Watts et al, 2007).

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, 2004). In the case of the oPt, these measures provide us with the means through which we can evaluate the impact of warlike conditions on population health status in ways that cannot be captured by objective 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 et al, 2009). The study also showed that respondents had high levels of fears; threats to personal safety, safety of their families; loss of incomes, homes and land; 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 (Table 2). 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 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 humiliation, and may explain these results.

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, 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, 2007), while collective exposure to violence was 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 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 among boys, compared to girls (perhaps the paradoxical protective 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 completely homework (United Nations, 2008).

III. ISSUES, ACTORS AND OPPORTUNITIES: THE CHALLENGES AHEAD

This brief review raises key challenges and offers directions for future research and action. A most important overall finding is related to the weakness of local scientific research and analytical capacity. While PCBS is 'way ahead' of local analytical capacity in producing quality

data sets covering a range of issues, these data sets remain largely un-analyzed. Most grey literature reports utilizing PCBS data are restricted to the presentation of simple percentages without further analyses, as if the data explains itself. Furthermore, in the process of searching for indicators of time trend changes, inconsistencies in reporting of even simple percentages are observed, necessitating that researchers analyze the data themselves sometimes, using the PCBS data sets in order to arrive at reasonable estimates reflecting realities.

A probable cause of this problem is the lack of attention of universities and government alike to the significance of building up the research base in the country, and the importance of the production of evidence for policy, planning and interventions. Another probable cause is the lack of peer review of produced grey materials, where reports are published without having been submitted for review by individuals who know the subject, and who can assist and mentor writers in improving their capacity and producing quality reports. Lastly, quality statistical data analysis requires a good amount of training combined with practice over extended periods of time. One off training schemes without close follow up and mentorship is not sufficient, especially when the research base locally is so weak, and the opportunity to complete analyses is not usually part of formal work, even at universities.

Quality records are essential for policy and planning not only for addressing maternal mortality, as noted above, but all other disease conditions as well. Furthermore, drawing on health records for quality information gathering and health system building is a much cheaper method of gathering data than by periodically conducting surveys. This is precisely why vigorous capacity and record keeping system building at the Ministry of Health and other ministries continues to be an urgent priority for action. Relying on periodic surveys is an expensive endeavour. Quality improvement of the existing information systems, which may take some time and effort, is ultimately cheaper, and more effective.

A main finding of this report relates to what already has been observed by various groups locally: a shift in demographic trends towards a substantial increase in the proportion of young people in the population, and a generally aging population. Both these groups will urgently need the attention of policy and interventions in the near future, if not already. Unless we cater to the needs and aspiration of young people, we are likely to have violated them, and consequently produced the context in which they can become violent. Clearly, and as the most recent Arab Human Development Report recommends, taking the issue of youth, and addressing their unmet needs, seriously, and investing in them is necessary in order to promote human security. Youth can be seen as agents of change and progress if invested in through quality education entailing skills and 'knowledge-based capabilities' corresponding to the needs of the local, and global economy; and if investments in health, housing, and labor markets are

made in order to meet the needs of youth as a workforce, and provide them with what is required to increase productivity (Arab Human Development Report 2009). This contrasts with investments focusing on providing activities and entertainment for young people to keep them ' off the street', as we sometimes observe in the oPt. Thus policy and operational investments in youth are not only a question of human rights and social justice; this investment can also have potential economic benefits and can increase societal security as well.

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 central and 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.

Otherwise, while perhaps not much can be done 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 indicate of a fixation on therapies, to the exclusion of advocacy for the removal of the root cause of people's distress and suffering(Giacaman, 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.

Finally, this essay demonstrates the usefulness of combining objective – medical and demographic – and subjective - people's reports - measures to assess demographic trends and health status, and to frame health in a broad public health perspective, encompassing the social determinants of health. There is every reason to believe that the human security, social suffering and symptoms causal framework is a more appropriate framework to use not only to expose and understand Palestinian people's predicament and health, but for the exposition and understanding of the health and well being of other population, especially in conflict settings.

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Table 1: Demographic and health indicators

Indicator	1995-2000 West Bank	2005-2007– West Bank	1995-2000 Gaza Strip	2005- 2007– Gaza Strip	1995-2000 Total West Bank and Gaza Strip	2005-2007 Total West Bank and Gaza Strip
Total Population	1,873,476	2,350,583	1,022,207	1,416,543	2,895,683	3,767,126
Total Fertility Rate	5.6	4.2	6.9	5.4	6.1	4.6
Average family size	6.1	5.5	6.9	6.5	6.4	5.8
Nuclear families	74%	80.7%	71.8%	73%	73%	78%
Population growth rate –Yearly				++	3.8%	2.8%
Infant Mortality Rate	25	23	27	29	25.5	25
Boys						27
Girls						23
Age						
Persons <15 years old	45.1%	41.3%	50.2%	48.3%	47%	45%
Persons 15-29 years old						27%
Persons < 30 years old						72%
Persons 15- 64 years	51.1%	55.3%	46.9%	49%		
Persons 65 years or more	3.8%	3.4%	2.9%	2.7%	3.5%	3%
Men > 60	3.1%		2.4%		2.9%	
Women> 60	4.1%		3.2%		3.7%	
Male/Female Ratio	103.2	103.1	103.1	103		103
Average life expectancy						
Women					72.2	73.2
Men					70.7	71.7
Median age at first marriage – women					18	18

First cousin marriage	26.8	26	31.5	32	28.1	28.1
Malnutrition: moderate or severe stunting (low height for age) among children<5	6.7%	7.9%	8.2%	13.2%	7.2%	10.2%
Maternal Mortality Rate					100	
Disability					1.9%	2.7%

Table collated from:

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Table 2: Reported feelings, fears, worries, and threats in a random representative adult population sample of the occupied Palestinian territory (Derived from the Palestinian Quality of Life data set –Institute of Community and Public Health, Birzeit University 2005).

1 in 2 Palestinians fear for themselves in their daily life
Almost all Palestinians fear for their family's safety in their daily life
Almost 2 in 3 Palestinians feel threatened by losing their home, their land or being forcibly uprooted and dispossessed
Almost all Palestinians worry over their future and the future of their families
Almost 1 in 2 Palestinians live with distress, anxiety, worry and grief
Almost 1 in 3 Palestinians feel incapacitated
More than 1 in 3 Palestinians feel deprived
More than 1 in 3 Palestinians feel that suffering is part of their life
More than 1 in 3 Palestinians are fed up with life