



The politics of childbirth in the context of conflict: policies or de facto practices?[☆]

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Abstract

The impact of warlike conditions on the lives of Palestinian women and children is far reaching. Beginning in September 2000, curfews, closures, siege and the parceling up of the country into small isolated entities have all led to a lack of access to basic maternity services, rendering pregnant women and their newborns a highly vulnerable group. Because any discussion of childbirth in the Occupied Palestinian Territories (OPT) cannot be separated from the larger historical context of international health politics, we begin with a brief review of international historical trends in childbirth policies, focusing on the relationship between discourse in the developed and developing world contexts to show how these models have intersected and diverged. We point to the similarities between the OPT and other developing countries, but also highlight the specificities that characterize the Palestinian experience today that include local political systems, medical dominance, professional group interests and the politics of gender, as well as the legacy of colonialism intertwined with an ongoing national conflict. We then provide a review of the history of childbirth in the OPT and analyze the various forces that led to the emergence of today's chaotic and contradictory de facto policies and practices. By assessing the health policy environment, we demonstrate the seeming impossibility of developing national level childbirth policies, given the current political conditions and a mix of other determinants that are not all within Palestinian control. Finally, we emphasize the importance of establishing a process as opposed to a blueprint of health policy-making based on people's immediate and long-term needs in all areas of the country. We also propose interim measures that rest on the notion of developing decentralized sub-strategies relevant to different zones of political reality and stages of system and human resource development, aiming at combining survival imperatives with those of improving women's birth experiences and women's health.

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Keywords: Childbirth policies; Developed/developing countries; Ongoing conflict; Decentralization; Women's health

[☆] This paper is part of a larger regional research project on Changing Childbirth in the Arab Region, sponsored by the Center for Research on Population and Health at the American University of Beirut, Lebanon, with generous support from the Wellcome Trust.

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1. Introduction

The impact of childbirth on the lives of Palestinian women and children is far-reaching. Perinatal health care (i.e. care before, during, and after childbirth) is one of the major reasons women seek health services. In the Palestinian context of high fertility (total fertility rate of 5.93 [1]), perinatal care services take on an added

significance, and it is essential that they be accessible, effective, efficient, equitable, and gender-sensitive. The emergency situation, beginning in September 2000 and continuing with no end in sight, led to very difficult living conditions characterized by frequent curfews, closures, states of siege, and more recently, the erection of the Separation Wall between Israel and the West Bank, separating families from each other, and from access to land, resources and services [2]. Access to maternity facilities has thus been greatly impeded, and pregnant women and their newborns, regardless of socio-economic status, have become a highly vulnerable group within the population. These political contextual reasons have brought the Palestinian childbirth experience in war-like conditions to the forefront of the national consciousness [3] as well as the attention of the international humanitarian community [4,5].

Innovative and systematic approaches are needed to manage childbirth effectively in this complex setting of ongoing conflict, so as to meet emergency humanitarian needs in addition to building an equitable and sustainable childbirth/health care system. Such objectives, however must take into account the various and possibly contradictory forces at work. Understanding the specificities of the local Palestinian context as well as the process of policy-making over time assists in identifying the changes necessary to meet the needs of the population in a manner that is both evidence-based and mindful of strategic priorities [6]. The lessons potentially learned through this exercise can assist in building a sustainable childbirth policy for the future as well.

No discussion of childbirth in the Occupied Palestinian Territories (OPT) can be separated from the larger historical context of international health politics. We will begin therefore by reviewing some international historical trends in childbirth policies. Specifically, we will focus on the discourse of childbirth in the developed and developing world to show where these models have intersected and diverged. While the OPT share with other developing regions some of the influences that helped shape and determine birthing practices of the 21 century, there are also specificities that characterize the Palestinian experience today that go beyond local political systems [7], medical dominance [8], professional group interests [9], and the politics of gender [10], and delve into a legacy of colonialism intertwined with an ongoing national conflict.

2. Putting childbirth in an international context: the development discourse

Worldwide, public health policies regarding childbirth emerged from the development discourse reflecting basic ideas formulated in the 1940s and 1950s, which saw modernization as an important force capable of progress. Governmental agencies and international organizations drove the development process forward. According to this ideology, the world was divided into developed and developing regions. Arturo Escobar has shown how development professionals attempted to fit societies into a pre-existing model that embodies the structures of modernity in the developed world, instead of seeing change as a process rooted in each country's history and culture. He concludes his work on the discourse of development by saying that it constantly wavers between the sameness or difference of the developed and developing world [11]. In the end, whether or not a given policy calls for the developing world to adopt models from the developed world, the discourse of development relies on the separation between the Third World and the First World and the implicit exemplarity of the latter. In our study of childbirth policies, we will see this tension between sameness and difference of Third World and First World, in particular with regard to the disparate factors that brought about changes in childbirth practices over time. We will also see the problematic consequences of trying to impose vertical solutions, that is to say, those deemed effective in the developed world, to complicated developing country problems, using the safe motherhood initiative (SMI) as the relevant example in this case.

2.1. *The childbirth debate in developed countries: forces of change*

Midwifery is an age-old tradition that has progressively adapted to social transformations over time and continues to play a major role in the world today. Indeed, traditional birth attendants are believed to assist two thirds of the world's births [12]. Historically, laws governing midwifery appear to have been first established in Europe in the 16th century followed much later by the United States at the end of the 19th century. It also appears that regulations aimed at controlling midwifery reflected concerns for public health and a reformulation of the birthing experience in 'scientific'

as opposed to natural terms, ending with the ‘abnormalization’ of midwifery [13]. Nineteenth century Canada witnessed similar changes with midwives displaced by nurses and physicians, reflecting the move towards the medicalization of childbirth [14]. Trends toward the hospitalization of birth followed suit in different parts of the world, reaching the extreme of illegalizing key midwifery practices and home birth itself in countries such as Costa Rica [15]. These developments likewise appear to have signaled the masculinization of control over child birth care, where, until recently, men have taken the larger share of medical education and physician positions [16], perhaps especially in the developing world.

Dramatic changes took place in the birthing scene of industrial countries during the 20th century. In the United States, midwife attended births declined over time. This decline was influenced by campaigns by physicians and public health reformers aimed at reducing maternal and infant mortality, competition between obstetricians and midwives, the introduction of health insurance and the proliferation of hospitals, all attracting patients to hospitals despite the continuing availability of home birth services. However, by the late 1940’s, middle class women began to call for the re-organization of birthing services and demanded greater involvement in their childbearing experience, based on their desire to ‘control their own destiny’. A movement was thus launched setting the stage for major changes in perceptions and practices, including the introduction of the natural childbirth concept. In the process, nurse-midwifery became recognized as a specialty that encouraged women’s greater participation in birthing, leading to the development of the homelike free-standing birthing center. But with midwifery winning professional recognition in the hospitals of the US in the 1960’s, the demise of most home birth and birthing center services was signaled, with the re-creation of institutions specifically designed for the practice of midwifery from the 1970’s onwards. By that time, the practice had also developed from an early focus on reproductive health care, including the maternity cycle and gynecological care, to the primary care of women of all ages [17]. The picture appears to be similar elsewhere in the industrialized countries, leading to the development of midwifery-led antenatal clinics and/or birthing centers. Yet the main issue seems to have gradually turned into who provides care

and the legitimization of midwives as professionals, with home births being replaced for the most part by either the hospital setting, or, for a small number of women, by birthing centers [18–23].

Thus the impetus behind industrial country calls for re-organizing their own childbirth systems seems mainly to have stemmed from discourses exemplifying a mix of feminist concerns related to control over the birthing process and the need for “women-centered” care, worries about spiraling costs, and power struggles of professional groups over who should provide care. This contrasts with calls for improving childbirth conditions and outcomes in the developing world, the need to take into account continuing high maternal mortality and morbidity levels and women’s lack of access to basic services, and contrasts in turn with the Palestinian perspective of focusing on the birth itself in relation to process, quality and outcome within the context of ongoing conflict and war-like conditions, combined with the requirements of system and nation building.

2.2. *The safe motherhood initiative: a problem of verticalization?*

Other than the demise and later re-emergence of the trained midwife, with exceptions noted in a few industrialized countries [24], and the obstinate presence of the informal traditional birth attendants in the developing world, primarily assisting home births, one finds a dearth of information regarding how child birth policies were formulated and how they changed over time. In the first decades after independence from colonial powers, most developing countries tried to adopt a system where hospital births would become the norm. In the early 1980s, partly due to the lobbying of developing world professionals and activists who highlighted the issue of high maternal mortality levels, WHO, UNFPA, and other organizations collaborated to institute the safe motherhood initiative [25]. The Initiative formulated strategies based on the multiplicity of causes bringing about such high levels of morbidity and mortality among women of the developing world and focusing on the improvement in women’s status as well as the strengthening of health services. The SMI recommended action at three levels: the reinforcement of community health services, the strengthening of referral services, and the implementation of an alarm and transport system for emergencies and for pregnant

women at high risk. Those translated into strategic objectives: the provision of universal primary health care from infancy to adolescence, the provision of good prenatal care, ensuring the presence of trained birth attendants at the hospital and also at home, and the strengthening of emergency obstetric care services [26].

Years later, the world is still struggling with the problem of safe motherhood, as evidence is emerging that the health of women in the developing world continues to be precarious, and that serious structural constraints impede the success of the SMI. The constraints cited in the literature are wide ranging, not the least of which are the lack of national maternal survival strategies and programs and insufficient government and social commitment to improve services, ignoring the needs of women with low status; and differing priorities of donor countries [27–30]. And although some parts of the world registered reductions in maternal mortality, those were not seen as sufficient, and the relative success achieved was attributed to those causes (hemorrhage, obstructed labor, and abortion) for which specific interventions could be effective [31]. There are those that assert, however, that governmental policies focusing on human development, and activities for health and social development encompassing a host of inter-related improvements, ranging from improvements in women's education, strengthening of health care services, expansion of MCH services and other public health related measures, and expansion of family planning services seem to together have succeeded in reducing maternal mortality rates and marching on the road to safe motherhood [32].

It appears then that the requirements for safe motherhood, in a developing world context where home birth is an integral part of the system entail inter-sectoral orchestrated actions at different levels that go beyond vertical solutions deemed effective in the developed world.

That is, it is not sufficient to adopt successful developed world strategies for the developing world (prenatal care, family planning and improvement in women's status) without sufficiently investing in the quality of care in basic and emergency obstetric facilities [33], as by focusing on those strategies alone, maternal mortality rates have not improved over the past decades [34]. At the same time, we cannot conclude that just because quality obstetric services were instrumental in alleviat-

ing this problem in the developed world, they would necessarily have the same results in the developing world. It is questionable in particular whether developing countries can afford to build up the high quality obstetric care services [35] achieved in industrialized countries in the face of serious poverty, educational shortcomings, shortages of well-trained staff, and minimal investments in the health care infrastructure and operating budgets, to name a few major constraints. Even on the assumption that basic obstetric care is the answer, it is not clear that this is a realizable goal in the developing world context, which is being complicated further by the imperatives of globalization as well as wars. The question remains as to the means for providing such care in specific political, social, cultural and medical systems.

3. Childbirth in the Palestinian context

During the late 20th century, the OPT, like other regions of the world, witnessed a dramatic shift away from home births towards hospital-based and physician-oriented maternity care. Prior to this shift, indigenous birth attendants, *dayat*, were the principal providers of perinatal care for women, as a tradition of female birth assistants had always existed in Palestine [36]. During the British Mandate period, licensed midwives were trained, which led to an increase in access to midwifery care in the late 1940's, with about 315 midwives becoming operational in 1946 [36]. A professional midwives association also existed during this period [37]. However, most births continued to be assisted by *dayat*, with 1200 operating with permits in 1938. During the 1960s, the Jordanians continued the licensing of midwives and *dayat* to practice in the community according to the Jordanian Public Health Law of 1966 (which is still effective to this date, until the Palestinian Legislative Council ratifies the new public health law).

In this section we will analyze the influences that have shaped the process of childbirth in the OPT in its emergence from colonial rule to military occupation; the various forces at work during the past decades of resistance and struggle for nationhood and during the late 1990's following the Oslo Accords; and the period of the second Uprising since September of 2000.

3.1. Birthing policy under the Israeli Civil Administration: 1967–1993

Prior to the signing of the Oslo Accords of 1993, the Israeli Civil Administration under the Ministry of Defense was responsible for operating the Palestinian governmental health sector—taken over from the Jordanian government—and the delivery of health services to the Palestinian population living in the OPT (the West Bank and Gaza Strip). While the actual health providers were all Palestinians, Israelis primarily handled budgeting, decision-making, and management. There were only 13 Israeli health officers responsible for administering health services in all of the OPT [38]. The government health services in the West Bank were financed entirely through taxation levied from Palestinians [39] and were starved for funds. The scarcity of resources allocated to the Palestinian health services led to the deterioration and marginalization of much of the governmental health infrastructure over the years of occupation, and its dependence on the Israeli medical system [40].

The childbirth policy of the Israeli occupation authorities appears to have had at least two main motives. The first was the conviction that hospital births would lower infant mortality. Based on the assumption that the high rate of infant mortality in the 1970s was due in part to the large number of home births in the West Bank, the Israeli authorities undertook an intervention program to promote hospital births. Their strategy entailed reducing the fees for delivery in government hospitals while continuing the supervision of the *dayat* and community midwives who had been originally licensed during the Jordanian rule of the West Bank [41]. The plan was to gradually phase out the *dayat* by not licensing new ones. The cost of giving birth in the governmental hospitals was lowered first in 1984 and again in 1991, when it was reduced to the equivalent of US\$ 43.00 [42]. Follow-up and supervision of the *dayat* was delegated to Palestinian district nursing supervisors, most of whom were untrained in assisting childbirth, but were experienced instead in the care of the newborn and in the implementation of the vaccination program. Supervision consisted primarily of periodic checking of the birth kits and reporting on the home births [43]. However, the belief that shifting from home to hospital birth would improve neonatal and maternal outcomes was not based on research

evidence, as little was done to evaluate the outcome of home births by the midwives and *dayat* compared to those taking place within the government maternity facilities. Furthermore, studies from other developing countries [44,45] have shown that institutionalization of childbirth alone without attention being paid to the quality of care does not necessarily result in better outcomes.

At the same time, this policy of shifting childbirth to government hospitals was also motivated by political concerns related to population enumeration, an issue that cannot be underestimated in the context of the Palestinian–Israeli conflict where demography plays a significant role [46]. Promoting hospital births meant that the Palestinian population could be more easily counted, registered, identified and thus controlled. Knowledge and control are potential tools in demographic strategy formulation, which are an integral part of the Palestine–Israeli conflict. It would appear that the promotion of hospital births was not merely a strategy derived from biomedicine, but also a political strategy related to the imperatives of military occupation. It was therefore not necessarily based on the health needs of the population and the state of existing services. Whereas improvements in the infrastructure and the quality of care would have helped to stimulate the demand for births in the hospital, little was done to improve the conditions of the maternity units [47] confirming the supposition that politics, control, and finances—rather than health needs and conditions—play an important role in public health decision-making, particularly in an occupied country.

3.2. The 1994–2000 period of the Oslo Accords: building a Palestinian health system

The efforts to pull together the fragmented Palestinian health services into a health system during the post Oslo period can generally be described as insufficient and unsystematic. This was due to a host of externally generated impediments (ongoing conflict as well as the influence of international aid policies that were not necessarily compatible with and sometimes contradictory to local needs) as well as internally structured ones (the particular development of the Palestinian political system). Although time and energy went into negotiations and coordination among the different health sub-sectors (governmental,

non-governmental, the United Nations Relief and Works Agency which caters to the needs of refugees, and private) as well as providers and international aid agencies, the driving forces were often conditioned by the availability of funds by international donors as well as issues of power and control as opposed to the promotion of a process of national health planning based on an assessment of the health status, on needs and on evidence-based interventions [48].

Essentially, the post-Oslo period was focused on the “peace process” and driven by the illusion of progress, development and the end of conflict. The period was characterized by a lack of clear national health planning or policy directives, perhaps understandable in the context of a situation of conflict that continued despite peace agreements. In the health sector, efforts were placed on building capacity within the Ministry of Health (MOH) and, with a strong biomedical flavor, on building or upgrading hospitals and equipment. Basic issues relevant to health care, such as accessibility in terms of distance, cost and cultural access, among other factors, were considered only in light of ‘normal’ conditions, with access considered merely as a function of distance to health services, and based on the assumption that people would continue to have free access with no travel restrictions. Thus there was a failure to envisage these issues in relation to the local realities, where cultural factors prevent some women from seeking assistance by male doctors, and where a rapidly changing and unstable political situation can at any time severely limit access to health facilities, as has happened since the beginning of the current Uprising.¹

3.3. Birthing policy under the Palestinian Ministry of Health since 1994: a case of contradictory *de facto* policies

The approach to childbirth of the nascent Palestinian Ministry of Health coincided to some extent with that of the Israeli Civil Administration in that both viewed childbirth in Western biomedical terms. Most of the Palestinian physicians who were placed

in policy-making positions in the post-Oslo period had been trained in medical schools outside of the country and had lived in the diaspora for some years. They were primarily males and had adopted the dominant medical ideology where hospital birth, no matter what the conditions, is considered safe, and home birth, no matter what the conditions, is considered a risk to the life of the mother and the newborn. Our field experience has shown that homebirth was associated with the image of the illiterate, barefoot *dayat*, and hospital birth, on the other hand, was associated with modernization, medicalization, and progress. In the case of childbirth, all women were encouraged both by policy-makers and by medical providers to give birth in hospitals, and to eliminate home birth gradually, continuing the same policy that had been initiated by the Israeli Civil Administration since the 1980s. Indeed, by the late 1990s, 96% of births in the OPT were assisted by qualified birth attendants [49], and 92% of births in the West Bank took place in health facilities, and only 8% at home [50]. However, the continuation of the policy of shifting the place of birth to the hospital was not accompanied by any assessment of the quality of care, the monitoring of outcomes, or the establishment of systems of accountability that can ensure quality care.

While most Palestinian physicians in the health sector and the policy-makers in the Ministry of Health promoted hospital deliveries, the Women’s Health and Development Directorate (WHDD) within the Ministry of Health did consider the role of the licensed midwives and *dayat* in the development of community perinatal care in the West Bank. The sustainability of the primary health care system had become a major concern of policy-makers as they assumed responsibility for the health services of a rapidly growing population, which drew attention to the role of women’s health care providers, other than physicians. The WHDD thus undertook an assessment of the current practices, training needs, and potential role of these birth attendants to see if and how they could be integrated into the emerging community health system. This assessment revealed that in 1999, there were 157 home birth attendants working in the West Bank and licensed and supervised by the MOH. About one-third of these attendants were midwives or nurses with formal training and two thirds were *dayat* [51].

The WHDD also promoted the development of midwifery education in the OPT and invested in

¹ For a more comprehensive analysis of the workings and the context of the present Palestinian health care system see Giacaman R, Abdul-Rahim H, Wick L. Health sector reform in the Palestinian occupied territories (OPT): targeting the forest or the tree? Health Policy and Planning 2003;18(1):59–67.

capacity building in the area of midwifery. However, an ambiguous attitude toward home-based midwifery care on the part of health administrators created serious problems. Trained midwives with diplomas from midwifery schools were no longer issued licenses to assist births in the community. This suggests an implicit policy aimed at phasing out community midwives, and contradicting the WHDD outlook and orientation, an orientation that is less likely to prevail, as WHDD is staffed by women and primarily non-medical personnel, and consequently, is of weaker influence on system development. Thus this contradiction, exemplifying the lack of clear policy directives and periodic un-orchestrated de-facto shifts permitted traditional *dayat* to assist home births, but not trained midwives. Old *dayat* who no longer practiced were not replaced, except for rare cases in isolated areas.

In practice, each health directorate in the then nine West Bank districts proceeded to develop its childbirth system as it saw fit, depending on the director's point of view and the specific needs of the region, an understandable practice to some extent. This practice of decentralization and self-regulation has been a survival mechanism in times of crisis management, which has permitted the continuation of essential services even when isolated from the central structure or authority. Especially in remote regions, it was essential to support the health activities of licensed community midwives, as access to maternity hospitals could always be impeded. The possibility of humiliation of birthing women by Israeli soldiers as they tried to reach maternity facilities remained present in the mind of some regional health administrators and de facto policy makers, a premonition which became all too real and frequent in the following years [52].

3.4. Childbirth policies since September 2000: an infrastructure under siege

Since the outbreak of the second uprising in September 2000, the Israeli army imposed unprecedented and stringent restrictions on the movement of Palestinians in the OPT. Closures, checkpoints, curfews, sieges and a number of other restrictive policies have been preventing Palestinians from leaving their immediate area of residence and sometimes their homes. Palestinians have thus encountered difficulties even in carrying out ordinary, daily life activities, such

as reaching work, school, university, and accessing basic services in towns, including the largely urban based hospitals, where most of the childbirth infrastructure is located. For most Palestinians therefore, transport to the hospital has become an integral and critical part of the birthing process, which constantly preoccupies women, the families, and their birth attendants.

Severe restrictions on movement resulted in a drastic change in birth location patterns. When in 1999, only 8% of births took place at home, by the summer of 2002, births attended at home had increased to 33% [53], many of which were unplanned home births. Women giving birth at checkpoints increasingly became a news item, where by early 2004, the Palestine Ministry of Health had documented at least 55 cases of women giving birth at checkpoints, and 33 cases of babies who have died after delivery because of delays at checkpoints [54]. The closures and curfews thus created different conditions in each locality, eliciting differing local responses to this state of affairs. The efforts of the Palestinian MOH to centralize and systematize birthing in Palestine, by encouraging urban hospital births, by licensing *dayat* for home births but reducing their work, and by not authorizing any other type of birth attendant to assist home births, have all come to a halt since the uprising started. Each locality and sector within a particular area has had to come up with its own system of assisting births. As hospitals are located in urban centers, which were placed under repeated lengthy periods of curfews and closures (except for East Jerusalem), they reported quasi-empty maternity wards, with some serving temporarily as emergency rooms caring for the injured. Even when curfews were lifted, hospitals reported a clear decrease in deliveries [55]. Many private hospitals running on expensive hospital fees had to shut down temporarily because of the lack of demand. East Jerusalem hospitals on the other hand, reported a significant increase in the number of births attributed to the difficulty for villagers to get to hospitals in Ramallah and Bethlehem. The higher caseloads in some maternity hospitals due to the change in utilization patterns was generally not accompanied by an increase in the number of health providers, thus resulting in overwork and understaffing affecting both midwives and physicians.

One of the remarkable popular responses to restrictions on mobility was the creation of networks of health

professionals organized to provide assistance to women giving birth in their villages or neighborhoods. Some doctors, for example, transformed the village immunization clinic into a maternity clinic and recruited local people to help assist births. While these were outstanding efforts, many of those attending births did not have sufficient training or experience in this area. Before the uprising, only licensed *dayat* were permitted to assist home births, and it was illegal for the trained midwives to attend to births at home. With the increasing restrictions on movement however, these laws were annulled *de facto* and midwives, obstetricians, physicians, health workers, nurses and even lay people assisted births. In these crisis conditions, there is no possibility to regulate the practices of all these birth attendants. In addition, and this is a problem that predates the uprising, a functional legal system to hold birth attendants including obstetricians in hospitals, responsible for malpractice is still absent. The only responsibility obstetricians, midwives and *dayat* have is towards the community.

Thus, boundaries and curfews caused the place of birth to be remapped and reconsidered in the minds of health providers and women, with new childbirth networks, birth assistants and birthing centers arising by virtue of crisis. Donor organizations became interested as well in funding ad hoc solutions to the birthing dilemma, with initiatives including training of medical personnel in emergency life support, short training courses for community health workers in assisting births, distribution of birthing kits to community midwives, mobile birthing clinics and the transformation of some of the local clinics into pilot maternity homes [56]. While the upgrading of skills of village health workers and the distribution of homebirth materials may well be short-term emergency care projects, the establishment of pilot maternity homes in different areas of the West Bank, by the scale of its resources and its intended purpose, appears to address both the immediate emergency need for access to health facilities and the long-term development of a different type of birthing facility. Although any initiative in the current situation that provides women with access to maternity care is likely to be beneficial, the concern is that pilot maternity homes would be yet another example of the way in which childbirth policies get instituted *de facto*, become a reality on the ground, and then remain fixed, without thorough planning, organization, and integration into the larger health system.

The initiative of maternity homes in the OPT is an attempt to deal with the reality of an unjustifiable political situation, impeding women's right to health and access to maternity care. Experts have identified the lack of political will and commitment as one reason that global initiatives such as safe motherhood have not resulted in the reduction of maternal mortality rates [57]. Perhaps the need for physical access to maternity care in the OPT is one example where high-level commitment from donors, governments, the United Nations and professional medical associations is necessary to ensure the right to safe childbirth. Addressing the problem of the Israeli restrictions on the movement of Palestinians could be more effective than coping strategies at the local level.

4. An inevitable vacuum of national level policy

Childbirth policy, in the sense of a national policy formulated by the government in order to guide or regulate childbirth practices [58] has yet to be formulated in the OPT. Firstly, a Palestinian national state with fixed boundaries, sovereignty, and formal constitution does not exist to date. As health is a function not only of service delivery, but also of the political, social and economic environment, it is difficult to imagine how health policy under occupation can be elaborated without some degree of control over the facets of the health of the population. Secondly, although the Palestinian Ministry of Health took over the health services in the OPT from the Israeli Civil Administration in 1994, it was primarily concerned with establishing itself as an institution and maintaining the existing health services by virtue of its nascent and unstable state. Developing a vision of the kind of health system that is most appropriate for an occupied country undergoing transition was not on the agenda, and perhaps could not have been. While much effort went into elaborating the Palestinian National Health Plan as well as other national level plans, most of these were severely curtailed by political instability and the absence of a vision for sustainable development that was largely dictated by ongoing conflict. In the end, such plans were never put into action as they could not have been realized, given that their underpinnings rested on the pre-condition of peace. Formulation of health policy, and the necessary networks of inter-related decisions at least at the sys-

temic level, appeared to be at the bottom of the list of priorities. On the other hand, a public health approach to health care policy formulation, planning and service provision, originating in the 1980's in the OPT [59], continues in limited spheres within parts of the health sector belonging to civil society institutions and within society at large. Here the social space for an open debate of politics and priorities has always existed among people of all classes and ideologies, even though in the post-Oslo period, this space was increasingly diminishing, and by some accounts, being gradually obliterated [60]. For the most part, the Palestinian National Authority has not yet codified this public health approach into health policy.

In the meanwhile, existing policies are also being transformed by de facto un-integrated practices. Numerous actors have played a key role in shaping and reshaping policy at different times. Israel has continued to have its influence, both in its legacy of the past and its on-going control over many aspects of the development process and of the health and well being of the Palestinian population. Major donors have a considerable influence in determining the type of health system that is emerging and its management, in ensuring that certain issues they consider a health priority—such as family planning programmes, for instance—are placed on the health agenda, and in determining which institutions are likely to survive in the scramble for resources. The number, training tradition and power base of health professionals are also important. The key policy-makers are male physicians, sensitive to the political pressure of other physicians, while the paramedical professions are poorly represented in the decision-making structures. Thus male physician policy-makers are likely to be influenced by the increasing number of unemployed physicians [61], which in turn is likely to have an influence on the type of health professionals providing perinatal health services.

Palestine is in a unique position in the international arena. While some countries in the region are in the process of centralizing their health care system, the situation in Palestine has required decentralization, self-regulation and flexibility of services for decades in order to function at all. Policy on the ground is being determined de facto, which makes it imperative to render transparent what is being done and to raise questions, before the sporadic changes become institutionalized and fixed. The direction that this policy takes

is important, as it is difficult to change institutions or patterns of behavior once they have become the norm, as is exemplified by the over-medicalization of childbirth [62] in developed as well as some developing countries. Adopting models that worked elsewhere is not necessarily the most appropriate solution here. Sustainable improvement of the health system is a long-term endeavor and requires comprehensive analysis and grass-roots participation, building from the bottom up in addition to the top-down approach of reinforcing the capacity of the Ministries.

5. Where to go from here

This account of the state of perinatal health care delivery in Palestine highlights some of the challenges confronting policy-makers and health providers in a period of prolonged conflict and political transition. It raises questions concerning what kind of maternity care is needed, what can be provided realistically, and the manner in which perinatal health care delivery interfaces with the larger health care system, which is itself in need of rehabilitation and reform.

There are no clear answers, particularly when the system needs to be built in the face of the many internal and external obstacles outlined here. The situation on the ground is one in which the country is physically divided into numerous zones with differing political realities and a diverse range of capabilities and resources (human, infrastructural, and technical). Such a situation points to the necessity of district level decentralization of service delivery, as the facts on the ground and existing practices dictate, in order to respond to the crisis in ways that are specific and appropriate for the contexts, needs and resources of the particular location, and as district health system building is increasingly being seen as key to the delivery of basic health services in developing countries [63]. In terms of childbirth policy, this calls for different types of childbirth settings, patterns of care and providers to meet the needs and preferences of diverse regions and groups of women in a safe and sustainable fashion.

Decentralization should not, however, result in chaos or compromise the quality and standards of care, nor should it be implemented in such a way as to make the eventual reintegration into an overall health system unworkable. Despite the importance of decentralized

area-specific responses to the crisis, such responses are bound to be stop gap measures that cannot substitute for a high-level political and moral commitment from all concerned parties to ensure Palestinian women's basic right of attaining a safe birthing experience by lifting curfews, removing the siege, and improving their health and living conditions.

Finally, with a view to the future, it is imperative to establish a *process as opposed to a blueprint* of health policy-making based on people's immediate and long-term needs in all areas of the country. It is essential to include the different voices of women, the main recipients of perinatal health care, as well as midwives, nurses and physicians, the key providers of this care, in the decision-making process. Creating a platform, where the issues of childbirth are debated among an inclusive group of interested participants would help to shape a perinatal policy that is meaningful and sustainable in the Palestinian context.

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