Taylor & Francis
Taylor & Francis Group

Reproductive Health Matters

An international journal on sexual and reproductive health and rights

ISSN: 0968-8080 (Print) 1460-9576 (Online) Journal homepage: https://www.tandfonline.com/loi/zrhm20

Palestinian Women's Sexual and Reproductive Health Rights in a Longstanding Humanitarian Crisis

Marleen Bosmans, Dina Nasser, Umaiyeh Khammash, Patricia Claeys & Marleen Temmerman

To cite this article: Marleen Bosmans, Dina Nasser, Umaiyeh Khammash, Patricia Claeys & Marleen Temmerman (2008) Palestinian Women's Sexual and Reproductive Health Rights in a Longstanding Humanitarian Crisis, Reproductive Health Matters, 16:31, 103-111, DOI: 10.1016/S0968-8080(08)31343-3

To link to this article: https://doi.org/10.1016/S0968-8080(08)31343-3

ELSEVIER
www.rhm-elsevier.com

Reproductive Health Matters 2008;16(31):103–111
0968-8080/08 $ – see front matter
PII: S0968-8080(08)31343-3

REPRODUCTIVE HEALTH matters
www.rhmjournal.org.uk

Palestinian Women's Sexual and Reproductive Health Rights in a Longstanding Humanitarian Crisis

Marleen Bosmans,[a] Dina Nasser,[b] Umaiyeh Khammash,[c] Patricia Claeys,[d] Marleen Temmerman[e]

a Political Scientist, International Centre for Reproductive Health, Ghent University, Gent, Belgium. E-mail: marleen.bosmans@ugent.be

b Health Advisor, Juzoor Foundation for Health & Social Development, Jerusalem

c Director, UNRWA (UN Relief and Works Agency) Health Services in the West Bank, and Chairperson, Juzoor Foundation for Health & Social Development, Jerusalem

d Scientific Coordinator, International Centre for Reproductive Health, Ghent University, Gent, Belgium

e Director, International Centre for Reproductive Health, Ghent University, Gent, Belgium

Abstract: *This paper results from a study conducted in the Occupied Palestinian Territory in September 2002 to test the usefulness of a guide for a comprehensive approach to sexual and reproductive health rights and needs of refugee women. In-depth interviews with key informants from 19 organisations and two focus group discussions were carried out in the West Bank and Gaza. Three refugee camps were visited as well as five health facilities. The findings revealed that severe restrictions on mobility had reduced access to health facilities for both staff and patients in a significant way. For pregnant women, this had resulted in decreased access to antenatal and post-natal care and an increasing number of home deliveries, induced deliveries and deliveries at military checkpoints. Lack of donor interest and withdrawal of donor support were mentioned as hampering the implementation of the National Reproductive Health Guidelines, and the sustainability and quality of existing sexual and reproductive health services. Family planning had become a politically sensitive issue, and there were indications of increased gender-based violence. Lack of access to reproductive health services was the most visible aspect of the impact of the conflict on women's sexual and reproductive health. Little attention is paid to the less visible evidence that women's reproductive rights have been subordinated to the political situation.*

Keywords: sexual and reproductive rights, humanitarian crisis, access to health, donors, Occupied Palestinian Territory

THIS paper results from a policy support research project on sexual and reproductive health and the rights of refugee women, commissioned by the Belgian Development Cooperation. The basic assumption of the study was that sexual and reproductive rights should be promoted and protected at all times and in all circumstances, as defined in the ICPD Programme of Action.[1] One of the objectives of the study was the preparation of a guide for the development of sexual and reproductive health programmes for refugee women using a rights-based approach. The guide was first tested in the Occupied Palestinian Territory. The aim of this paper is to highlight that the complexity of the Israeli–Palestinian conflict is seriously affecting the sexual and reproductive rights of both refugee and non-refugee women in the West Bank and Gaza.

The Palestinian health system

Complex emergencies are always associated with crisis in governments, which is often translated into ever more deficient health systems and crumbling health services.[2] The decades-long history of fragmentation of the Palestinian Territory, combined with military occupation, has been a constant factor hampering the development of sound and coherent health policies and programmes. Insight into the history of the Israeli–Palestinian conflict is important for a better understanding of the status of sexual and reproductive rights of Palestinian women.

The roots of the conflict go back to 1947, when the United Nations agreed upon the division of the Palestinian Territory to the West of Jordan into a Jewish state and an Arab state. In 1948 Israel established itself as a state in Palestine, and the first Arab–Israeli war broke out. Long years of conflict were to follow. From 1948 until 1967 the West Bank was under the direct rule of Jordan, while the Gaza Strip fell under the jurisdiction of the Egyptian administration, with both administrations also taking control over the health systems in the respective areas. In 1950 a third health system was introduced, with the creation of the United Nations Relief and Work Agency for Palestine Refugees in the Near East (UNRWA). UNRWA holds a specific mandate to provide relief services, including for health, to Palestinian refugees. In June 1967, Israeli forces occupied the West Bank and Gaza and annexed East Jerusalem. Health in the Occupied Palestinian Territory became a responsibility of the Israeli Civil Administration, and more specifically of the Israeli Ministry of Defence. Israel did not invest in the development of a health system that could deal with the needs of a growing Palestinian population, nor in the promotion of Palestinian ownership in this respect.[3]

In December 1987, the first *intifada*, the Palestinian uprising against the Israeli occupation, started. It lasted for five years, until the signing of the so-called Oslo Peace Accords on 13 September 1993. The accords were conceived as a provisional measure and meant to be the first in a series of negotiations in a process leading towards a sustainable and lasting solution. As a result of the peace accords, an interim self-ruling body, the Palestinian Authority, was established in 1994. The Palestinian Authority was expected to act like a state but is far less than a state.[4] It was invested with only a limited range of responsibilities, including for health, without being granted full civil control over the territory, 59% of which remained solely under Israeli rule. From the moment of its establishment, the Palestinian Ministry of Health was faced with an ailing health system, which relied on an inexperienced and politicised administration and had to deal with three different categories of health care providers: 1) services run by the Ministry of Health for people with health insurance (60%); 2) services run by non-governmental organisations (31%); and 3) UNRWA services for registered Palestinian refugees (9%). Most public health doctors also had private practices, and for specialised and tertiary sector care the private sector is crucial.[5]

Since its establishment, the Ministry of Health has remained highly dependent on substantial support from a large number of external donors, who are driven by their own mandates and agendas rather than by a concern for establishing a sustained health system and policy dialogue. Their support is characterised by the strategies used in humanitarian interventions, i.e. short-term commitments and the pursuit of short-term outcomes, instead of a concern to develop a health-sustaining environment. Such an approach has also affected the development and implementation of reproductive health policy. The emphasis here is also on "quick fixes" (e.g. through a narrow focus on family planning services) rather than addressing the underlying determinants of high fertility, such as improving the quality of family planning services in weak and overburdened health care facilities.[3]

As key issues in the Israeli–Palestinian peace process remained unresolved, a second *intifada* broke out in September 2000. This second *intifada* is ongoing and is characterised by an increasingly harsh regime of severe mobility restrictions imposed by the Israeli occupying forces. Catherine Bertini, the Personal Humanitarian Envoy of the UN Secretary-General, has asserted that the situation in Palestine cannot be described as a traditional humanitarian crisis, "such as those caused by famines or droughts, but as a crisis of access and mobility", which has also generated a steep decline in overall access to health services. In this respect, she referred to a 52% decrease in refugee women attending post-natal care services provided by UNRWA and reports that ambulances of the Palestinian Red Crescent Society and the

Union of Palestinian Medical Relief Committees have been denied passage at military checkpoints or obliged to wait for several hours. Patients, including women in labour, have often been forced to leave the ambulance and walk to the other side.[6]

Palestinian refugees in the Occupied Palestinian Territory

The situation of the Palestinian refugees in the West Bank and Gaza is very peculiar as they are refugees from what is now Israel living within the boundaries of the Palestinian Territory. The Palestinian Central Bureau for Statistics differentiates between registered refugees, non-registered refugees and non-refugees. Registered refugees are those holding a refugee registration card, issued by UNRWA. Non-registered refugees do not hold such a card. Non-refugee status applies to any Palestinian not falling into either of these categories.[7] 39.8% of the Palestinians living in the Occupied Palestinian Territory are registered as refugees and 1.4% are non-registered refugees. In the West Bank, refugees are a minority (24.6% of the population registered and 1.9% non-registered). In Gaza, the majority of the population are refugees (64% of the population registered and 1.1% non-registered).[8]

Most refugees are dispersed throughout the towns and villages of the West Bank and Gaza together with non-refugees, often in the environment of official refugee camps.[9] Only 42.3% of refugees live in the camps. In the West Bank, 26.9% of the refugee population live in 19 official camps; in Gaza, 53.3% of refugees are living in eight official camps.[10] The average size of households in refugee camps is 7.73 persons.[11] The refugees are protected by international humanitarian conventions, not by Palestinian law, though in some cases and according to their areas of residence and the specific services they need, they can appeal to the Israeli and/or Palestinian authorities. Non-refugees should also be protected by international humanitarian law, as they are living under military occupation. Occupying forces have an international duty to ensure and maintain health services for the civilian population.[12] The traditional distinction between refugees and non-refugees is becoming increasingly blurred, however, as the socio-economic consequences of the conflict and the regime of closures and curfews are affecting more and more of the Palestinian population.[5]

Study methodology

The field study was conducted in the West Bank and Gaza in September 2002, two years after the start of the second *intifada*. It was part of a broader research project aimed at the development of a guide for programme officers that contained a comprehensive and rights-based approach to the sexual and reproductive health of women displaced by war and armed conflict. Researchers for the field study used the guide as a basic framework for interviews and focus group discussions and analysis of the findings. Organisation of the field study and identification of the key informants were supported by the UNFPA country office and Juznoor, a Palestinian NGO.

The researchers did in-depth interviews with key informants from 19 organisations and two focus group discussions in the West Bank and Gaza. They also visited three refugee camps and six health facilities. The key informants were selected from three international humanitarian agencies, two international agencies involved in the development of sexual and reproductive health policies and their implementation, one international child protection agency, two Palestinian NGOs for sexual and reproductive health, five health centres (two UNRWA health centres, two NGOs and one public health centre), one Palestinian NGO providing mental health services, one referral hospital for maternal health, three Palestinian human rights organisations, one Palestinian women's rights organisation and the Palestinian health authorities. All key informants held high positions as director, acting director, programme coordinator or head of unit. In one health centre the interview was organised with the nurse and the midwife, who were the only people remaining from the former staff, which had been forcibly reduced as a result of the conflict. Because of security reasons and curfews, another four interviews had to be cancelled.

The researchers visited five health facilities as well as three refugee camps, two in the West Bank and one in Gaza. Because of the security situation, planned visits to another refugee camp in the West Bank and a health centre in Gaza had to be cancelled. For the same reason, only two focus group discussions could be carried out, one with a women's committee and one with staff at a local health centre in one of the refugee camps in the West Bank.

The interviews and focus group discussions were conducted in English. Overall, the use of the English language constituted no problem as the overall majority of respondents were highly educated. Only twice translation into Arabic was necessary, and more particularly for the focus group discussion in the refugee camp. The translation was facilitated by a Palestinian nurse with expertise in reproductive health and rights.

No ethical approval was required as we did not interview patients and did not ask any personal questions. All respondents participated on a voluntary basis and were fully informed of the objectives of the study.

Preliminary results of the study were discussed at a debriefing meeting organised at the end of the visit and further supplemented by academic literature and UN documents on health policies in the Occupied Palestinian Territory and the rights-based approach to sexual and reproductive health. Although the focus of the study was on the sexual and reproductive health needs and rights of Palestinian refugee women, the situation of non-refugee women was also taken into account, as they too were affected.

Results

Mobility restrictions affecting access to services

Respondents from 13 of the 19 interviews and in one of the two focus group discussions specifically highlighted that since the start of the second *intifada* access to sexual and reproductive health services had become a huge problem for patients, health staff and humanitarian agencies, regardless of whether they were attending refugees, non-refugees or both. Since March 2002, UN and humanitarian organisations were no longer granted privileged status for obtaining permits to enter the areas under closure or curfew. Maintaining the supply of drugs, contraceptives and medical equipment had become time-consuming and complicated. One public health centre, where antenatal and postnatal services, as well as family planning and counselling services, were provided was no longer attended by a physician, as the repeated curfews and checkpoints had made it impossible for her to reach the centre. Services were provided by the local midwife and an assisting nurse who could only do some general follow-up of the mothers and their babies (measuring and weighing).

Respondents at a referral hospital in the West Bank reported that during periods of curfew the number of deliveries in the maternity unit decreased from an average of five to three per day. This decrease was considered to indicate an increase in the number of home deliveries. There had also been an increase in the number of caesarean sections due to pregnancy complications resulting from the reduced access of pregnant women to antenatal care. The hospital had observed a rising number of pre-term births as women more frequently asked for induction of labour for fear of being trapped by a curfew and unable to reach the hospital in time. For the same reason, women asked to be discharged immediately after delivery. Because of security problems, women failed to make use of postnatal care. Respondents from two Palestinian and two international organisations also mentioned that they were keeping records of deliveries, stillbirths and cases of women dying during delivery at the military checkpoints because they were denied passage to reach the hospital. One international organisation had reports of 33 deliveries and 19 stillbirths at military checkpoints in the two years since the start of the second *intifada*.[13] Another had documented 36 cases of women who had given birth at checkpoints, including three that resulted in maternal deaths and four stillbirths.[5] The other two organisations were preparing a publication on deliveries at checkpoints, but their figures were not yet available.

In order to respond to the worsening situation, a variety of emergency measures had been developed. The health staff at the maternity unit in the referral hospital used to stay at the hospital throughout the periods of curfew in order to secure attendance for the women who were already there. One NGO had set up a hotline and a network of volunteers to assist home deliveries by phone or to identify a doctor or midwife quickly who could be called upon to attend women in labour at home. One humanitarian agency was forced to employ extra health staff, who were requested to change their residences to live near the health centres. In very remote areas where no qualified health staff were available, midwives and doctors were exceptionally providing home health services. Another international agency had started organising training sessions for midwives on home deliveries and providing them with clean delivery kits.

Female employees of a Palestinian NGO pointed to the particularly stressful situation generated by the mobility restrictions on pregnant women who are entitled to access health services in Jerusalem but live and/or work in the West Bank outside Jerusalem. They and their families ran the constant risk of losing their Jerusalemite citizenship, particularly if a child was born outside of East Jerusalem. The child would also face serious obstacles to being registered as a Jerusalemite. Jerusalemites enjoy many more privileges than other West Bankers, and many have an Israeli health insurance that entitles them to access the better equipped Israeli hospitals and maternity units.

Impact on sexual and reproductive health policies and programmes

Since the establishment of the Palestinian Ministry of Health, women's health has been a priority in Palestinian health policy. In 1995 the Women's Health and Development Directorate was created, which at the time mainly focused on family planning. The Ministry of Health developed the "National Unified Reproductive Health Guidelines & Protocol" with UNFPA support. The basic idea was to integrate comprehensive reproductive health services into all primary health care services. The implementation of the guidelines was seriously hampered by the geographical separation of the West Bank and Gaza, a situation which has been aggravated by the severe mobility restrictions. The Ministry of Health officials in Gaza and Ramallah and the Deputy Minister of Health in Nablus were often not even granted permission by the Israeli Defence Forces to travel and meet physically.

Respondents from two international agencies, a Palestinian NGO and the Palestinian health authorities highlighted that the provision of sexual and reproductive health services was highly dependent on external funding, but that reproductive health was no longer a donor priority within the context of the escalating political violence. Donor fatigue, lack of donor interest in sexual and reproductive health programmes and poor donor coordination were mentioned as main reasons for the lack of sustainability of family planning and other reproductive health programmes, such as the prevention and treatment of sexually transmitted infections.

Before the start of the second *intifada*, Palestinian refugee women had access to a broad array of sexual and reproductive health services, including information, education and sensitisation about family planning, sexually transmitted infections and HIV/AIDS. Respondents from international humanitarian agencies informed us that they had noticed "a certain weariness" among international donors since September 2000 and that many programmes had to be cut back. Sexual and reproductive health services for refugees were reduced to the strict minimum of mother and child health and family planning services. Policies on attendance at delivery that had aimed to replace the *dayats* (traditional birth attendants) by trained midwives had had to be reconsidered. There was no other option than to reintegrate the *dayats* for home deliveries and post-natal visits, even though some of them had not received any midwifery training. They said that the cuts in external funding had affected the quality of services, as health staff training sessions could no longer be organised or regular supervision and monitoring guaranteed.

Three Palestinian respondents, one from the Palestinian Authority, one from a referral hospital and one from an NGO providing sexual and reproductive health services, highlighted the need for more female staff qualified in reproductive health. They felt that the prevailing cultural norms, both among the Muslim and Christian population, whereby motherhood and fertility were highly valued, were reinforced by the harsh political situation and were a serious barrier for women to take up a professional career.

Five Palestinian respondents explicitly expressed their concern that the strong cultural taboos on sexuality, the many deaths caused by the political situation and the Palestinian Authority calling upon women to bear more children as their contribution to the *intifada*, had resulted in an increasing sensitivity surrounding sexual and reproductive health issues which also hampered the implementation of the Palestinian reproductive health policy. They explained the need for caution regarding the promotion of family planning programmes, which were easily perceived as population control programmes. "It is a woman's duty to have children," the respondents at a women's health centre in one of the refugee camps said. The *dayat* working in the camp explained how difficult it was to promote family

planning during home visits, as the reactions of the family could at times be very aggressive. Because of the widespread resistance to family planning, modern contraceptives were promoted as a means for birth spacing, meant to protect a woman's health, and not as a means to reduce the number of children in a society where the total fertility rate is among the highest in the Arab region.

Seven respondents – including those from most of the international organisations and the Palestinian authorities – pointed to the urgent need for reliable, up-to-date data on health in general, and on sexual and reproductive health in particular, especially where sensitive issues such as sexually transmitted infections were concerned. They had observed a problem not only of lack of data collection but also of data analysis. The available data did not allow for analysis of whether the impact of the political situation on the sexual and reproductive health status of women was different for refugees and non-refugees.

Gender-based violence thought to be increasing

Nine respondents - international as well as Palestinian – pointed out that violence against women was a very sensitive but neglected issue. They explained that there were serious indications, though not backed up by verifiable data, that violence against women was becoming an ever more serious problem. In some areas, violence against women was said to be reaching alarming proportions as more and more cases of women being killed by their husbands were reported. These murders used to be considered – or presented – as "crimes of honour" and were dealt with by tribal law courts. The maximum sentence was said to be no more than six months of imprisonment.

Violence against women was said to be widely accepted socially and culturally. The Palestinian legislative system dealt with it in an indirect way as "harm against a person" and "rape and abuse" but did not recognise marital rape. The National Reproductive Health Guidelines did not include a protocol for comprehensive aid to the victims, as the issue was considered to be too sensitive. Aid to victims was provided as part of medical treatment of any physical injuries. For legal and psychosocial support victims could be referred to the Ministry of Welfare or to one of the few NGOs specialising in this field. Referral, however, was a personal decision of the health care provider and not a generalised policy.

Several respondents also warned that gender-based violence should be addressed with great caution. Those from Palestinian human rights organisations explained that there was a tendency to overemphasise political and civil rights in the fight against the Israeli occupation and to disregard social, economic and cultural rights. Gender-based violence was looked upon as a consequence of the political situation and not as a violation of women's social, cultural and civil rights. Women's reproductive rights were certainly not considered a priority. One respondent from a human rights organisation even insisted that denouncing violations of sexual and reproductive health needs and rights, such as women having to deliver their babies at military checkpoints, was not a priority at all. Another human rights organisation had abandoned its programmes on women's rights and violence against women because, they said, the political situation had become "too complicated". A third human rights organisation, as well as a women's rights organisation, had even had to suspend their programmes for police training on this subject.

Discussion

Although the study was intended to focus on the sexual and reproductive health rights of refugee women, the respondents did not really distinguish between refugees and non-refugees. All were affected by the severely worsening humanitarian crisis since the start of the second *intifada*, particularly since the Israeli military occupation does not operate by the rules of international humanitarian law and refuses to accept responsibility for meeting Palestinian health and human rights needs.[14]

From September 2000 through April 2005, there was a ten-fold increase in the number of home deliveries and a five-fold decrease in the number of mothers receiving antenatal care.[15] When Israel decided to build the Separation Fence (the Wall) in and around the West Bank, over 100,000 Palestinians in the West Bank who depended on health facilities in East Jerusalem were prohibited from entering East Jerusalem.[16,17] Reports and articles about the impact of the crisis

on the Palestinian health system have tended to focus on the impact of restrictions on mobility on access to health facilities.[18] The impact of the Israeli–Palestinian conflict on the promotion and protection of women's sexual and reproductive health needs and rights, however, is hardly mentioned. Reduced accessibility of childbirth services as a result of ongoing closures and curfews and cases of women having to deliver at checkpoints are dealt with as a violation of the right to movement rather than a violation of women's right to a protected place of birth.[19] Forcing pregnant women to deliver at checkpoints constitutes a threat not only to their health and rights but also that of their babies, as well as a form of gender-based violence.

However, these are only the most visible aspects of the impact of the conflict on women. Less visible is the impact in provoking a worsening in social, cultural, legal and political obstacles to the recognition of women's rights more broadly. Decades of military occupation have resulted in increased violence and discrimination against Palestinian women.[20] Issues such as family planning and gender-based violence have been subordinated to challenging the ongoing political violence in the area rather than understood as part and parcel of that violence. A woman's contribution to national development and survival is mainly understood in terms of her reproductive role, and persistent gender inequalities prevent her from using contraception.[21]

Whereas the total fertility rate of 4.6 in Palestine is among the highest in the Arab region (5.8 in Gaza and 4.1 in the West Bank), and the use of modern contraceptives is still low (37.3% in 2004), addressing basic sexual and reproductive health issues such as family planning has unavoidable political implications.[22,23] One of the characteristics of the Israeli occupation of the West Bank, East Jerusalem and, until recently, Gaza is the containment of the Palestinian population within restricted areas and the systematic movement of Jewish settlers onto Palestinian land. As a result, population and population growth have become crucial instruments for both the occupying and the occupied parties, each of whom attempts to outnumber the other to gain control over the land.[24] In such a context, promotion of reproductive rights becomes a highly political issue, as it constitutes a potential influence on demographic growth.

Our findings also raise questions about the failure of the international donor community to respond adequately to the sexual and reproductive health needs and rights of women in Palestine. Lack of donor interest and withdrawal of donor support were mentioned as main factors hampering the implementation of the National Reproductive Health Guidelines, as well as undermining the sustainability and quality of existing programmes. When the international community decided to withdraw its support to the Palestinian Authority after the electoral victory of Hamas in 2006, observers began to fear a complete collapse of the health system.[25] The international financial boycott has resulted in a further exacerbation of the quality of basic care services, staff shortages, lack of supplies and adequate supervision at maternity hospitals.[26] The World Health Organization warned of a further paralysis of the Palestinian Ministry of Health, a growing "lack of homogeneity of standards and protocols" and "inequities in access to health services", including the likelihood of a drastic reduction in antenatal, postnatal and delivery services provided by the public health facilities.[27] This is particularly problematic in Gaza, where Hamas has taken full control over 1.4 million inhabitants, who are being forced to live without free access to the outside world. The population of Gaza is expected to double in the next 22 years. The area is characterised by extreme aid dependency, and the failure of the peace process and withdrawal of the donor community are posing major threats to health and human security.[28]

Donors and international organisations must go beyond the traditional humanitarian relief approaches that are intended as short-term, technical interventions. They need to fulfil their international commitments to protect and fulfil the rights of women in the Occupied Palestinian Territory to life and health. Sexual and reproductive health programmes should not only be developed from a medical and public health perspective, but also address the underlying social and cultural determinants, including gender-based violence. A failure of the international community to explicitly address the violations of women's sexual and reproductive health needs and rights, caused by the military occupation and a regime of severe restrictions on mobility, may contribute to the false perception that such violations are inevitable, and thus politically, socially and culturally acceptable.

Acknowledgements

Special thanks to Jihan Anastas, who inspired and invited us to go to Palestine to do the field study. We also want to acknowledge the UNFPA Humanitarian Response Unit and the UNFPA Country Office in Jerusalem for their indispensable and enthusiastic support for this study, as well as the members of Juzoor for their warm-hearted commitment. We also thank all the respondents for their openness, hospitality and willingness to grant us some of their precious time.

References

1. United Nations Population Fund. Programme of Action adopted at the International Conference on Population and Development, Article 7.2–7.3. Cairo, 5–13 September 1994.
2. Lautze S, Leaning J, Raven-Roberts A, et al. Assistance, protection and governance networks in complex emergencies. Lancet 2004;364:2134–41.
3. Giacaman R, Abdul-Rahim HF, Wick L. Health sector reform in the Occupied Palestinian Territory (OPT): targeting the forest or the trees? Health Policy and Planning 2003;18(1):59–67.
4. Sayigh Y. Inducing a failed state in Palestine. Survival 2007;49(3): 7–40.
5. Office for the Coordination of Humanitarian Affairs. Occupied Palestinian Territory. Preliminary Humanitarian Damage Assessment and Humanitarian Action Plan (May–December 2002). Jerusalem, June 2002.
6. United Nations Security Council. Personal Humanitarian Envoy of the Secretary-General – Mission Report 11–19 August 2002. At: <www.reliefweb.int/rw/rwb.nsf/db900SID/OCHA-64BLGF?OpenDocument>. Accessed 9 June 2006.
7. Palestinian Central Bureau of Statistics. Statistical Atlas of Palestine, 2004. Ramalla, 2004. p.25–26.
8. Palestinian Central Bureau of Statistics. Population and Housing Census. Palestinian Population by Refugee Status, Region and Sex. At: <www.pcbs.org/english/phc_t7.htm>. Accessed 25 September 2002.
9. Birzeit University. The Occupied Palestinian Territory. Country Population Assessment. Prepared for UNFPA/Programme of Assistance to Palestinian People. Birzeit, 2000. (draft)
10. UNRWA. Refugee Camp Profiles. At: <www.un.org/unrwa/refugees/me.html>. Accessed 23 October 2002.
11. Palestinian National Authority. Palestinian Central Bureau of Statistics. Household size and average household size by region and residence – 1995. At: <www.pcbs.ps/Portals/_pcbs/populati/table2.aspx>. Accessed 15 February 2008.
12. Geneva Convention (IV) Relative to the protection of Civilian Persons in Time of War of August 12, 1949. Article 55–56.
13. UNFPA. Improving Availability and Access to Reproductive Health Services, Information and Counseling with Emphasis on Emergency Obstetric Care. Project Proposal, 2002.
14. Stefanini A, Ziv H. Occupied Palestinian Territory: linking health to human rights. Health and Human Rights 2004;85(1): 161–76.
15. United Nations Economic and Social Council. Commission on Human Rights: Integration of the human righs of women and the gender perspective. Written statement submitted by the Palestinian Centre for Human Rights, a non-governmental organization in special consultative status. E/CB.4/2006/NGO/128, 62nd Session. 2 March 2006.
16. United Nations Economic and Social Council. Report of the Special Rapporteur of the Commission on Human Rights on the situation of human rights in the Palestinian Territory occupied by Israel since 1967. A/59/256, 59th Session, 2004.
17. United Nations Economic and Social Council. Commission on Human Rights: Question of the Violation of Human Rights in the Occupied Arab Territory, Including Palestine. Report of the Special Rapporteur of the Commission on Human Rights, John Dugard, on the situation of human rights in the Palestinian Territory occupied by Israel since 1997. E/CN.4/2005/29, 61st Session. 7 December 2005.
18. Summerfield D. Palestine: the assault on health and other war crimes. BMJ 2004;329:924.
19. Giacaman R, Abu-Rmeileh NVE, Wick L. The limitations on choice: Palestinian women's childbirth's location, dissatisfaction with the place of birth determinants. European Journal of Public Health 2007;17(1):86–91.
20. Amnesty International. Israel and the Occupied Territories. Conflict, occupation and patriarchy. Women carry the burden. At: <www.amnesty.org/en/library/info/MDE15/016/2005>. Accessed 6 April 2005.
21. Donati S, Hamam R, Medda E. Family planning KAP survey in Gaza. Social Science and Medicine 2000;50:842–49.
22. Palestinian National Authority. Palestinian Central Bureau of Statistics. Age-Specific Fertility Rates and Total Fertility Rates During Year Preceding Survey, by Region, 2004 (Direct Method). At: <www.pcbs.gov.ps/Portals/_pcbs/health/

dhs04Table4.aspx>. Accessed 23 December 2007.
23. Palestinian National Authority. Palestinian Central Bureau of Statistics. Percentage of currently married women aged 15–49 years who are using (or whose partner is using) a contraceptive method, by selected background characteristics, 2004. At: <www.pcbs.gov.ps/Portals/_pcbs/health/dhs04Table5.aspx>. Accessed 23 December 2007.
24. Abu-Lughod J. The Demographic War for Palestine. The Link 1986;19(5): At: <www.ameu.org/printer.asp?iid=163&taid=207>. Accessed 11 January 2007.
25. Devi S. Rising tensions boost humanitarian concern for Palestinians. Lancet 2006;327: 973–74.
26. Hassan-Bitar S, Wick L. Evoking the guardian angel: childbirth care in a Palestinian hospital. Reproductive Health Matters 2007;15(30):103–13.
27. World Health Organization. Possible consequences on the health sector due to the reduction of support to the public services. 7 April 2006. At: <http://domino.un.org/UNISPAL.NSF/361eea1cc08301c485256cf600606959/318ce7bfbee88d5785257148006e5ebc!OpenDocument>. Accessed 30 December 2007.
28. Hill AG, Clark CJ, Lubbad I, et al. Hope and despair over health in Gaza. BMJ 2006;333: 845–46.

Résumé

Cet article résulte d'une étude réalisée dans le Territoire palestinien occupé en septembre 2002 pour tester l'utilité d'un guide pour une approche intégrée des droits et des besoins des femmes réfugiées en matière de la santé génésique. Des entretiens approfondis avec des informateurs clés de 19 organisations et deux discussions de groupes d'intérêt ont été menés dans la Rive occidentale et Gaza. Trois camps de réfugiés ainsi que cinq établissements de santé ont été visités. L'étude a révélé que les graves restrictions à la mobilité avaient sensiblement réduit l'accès aux centres de santé du personnel et des patientes. Pour les femmes enceintes, cela avait abouti à moins d'examens prénatals et postnatals, et à un nombre accru d'accouchements à domicile, d'accouchements provoqués et d'accouchements aux points de contrôle militaire. Le manque d'intérêt des bailleurs de fonds et le retrait de leur appui ont été cités comme des entraves à l'application des "Directives nationales de santé génésique" et à la viabilité et la qualité des services existants. La planification familiale était devenue une question politiquement sensible et la violence sexiste semblait en augmentation. Le manque d'accès aux services de santé génésique était l'aspect le plus visible des conséquences du conflit sur la santé génésique des femmes. Peu d'attention est accordée aux données moins apparentes montrant que les droits des femmes en matière de la santé génésique. ont été subordonnés à la situation politique.

Resumen

Este artículo es el resultado de un estudio realizado en el Territorio Palestino Ocupado, en septiembre de 2002, para probar la utilidad de una guía para una enfoque integrado de los derechos y las necesidades de salud sexual y reproductiva de las mujeres refugiadas. Se realizaron entrevistas a profundidad con informantes clave de 19 organizaciones y dos discusiones en grupos focales, en Cisjordania y Gaza. Se visitaron tres campos de refugiados, así como cinco establecimientos de salud. Los resultados revelaron que severas restricciones en movilidad habían reducido de manera considerable el acceso del personal y los pacientes a los establecimientos de salud. Las mujeres embarazadas tenían menos acceso a la atención antenatal y posnatal, y aumentó el número de partos en el hogar, partos inducidos y partos en los retenes militares. La falta de interés de los donantes y el retiro de su apoyo se mencionaron como obstáculos a la aplicación de las Directrices Nacionales de Salud Reproductiva, así como a la sostenibilidad y calidad de los servicios de salud sexual y reproductiva. La planificación familiar pasó a ser un tema políticamente delicado, y hubo indicios de aumento en la violencia basada en género. La falta de acceso a los servicios de salud reproductiva fue el aspecto más visible del impacto del conflicto en la salud sexual y reproductiva de las mujeres. Se presta poca atención a la evidencia menos visible de que los derechos reproductivos de las mujeres han sido subordinados a la situación política.