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# Maternal and Neonatal Care in Conflict Zones: A Case Study on Care in Occupied Palestinian Territories

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## Abstract

This research paper explores the relationship between maternal health and conflict, specifically looking at the situation in occupied Palestinian territories. The framework used, situates health outcomes within broader structures of settler colonialism and political violence. The biopolitical control Israel exerts over Palestinians has shaped their health since 1948 and has worsen after the blockade placed in Gaza from 2007. Issues such as requiring permits to access hospital care to restrictions at checkpoints leading to avoidable deaths all of which exacerbates health disparities for Palestinians and reinforces colonial dynamics. Using a structural violence framework, the research evaluates how Israeli-imposed mobility restrictions and geographical fragmentation contributes to systemic barriers in accessing maternal care.

Contrary to assumptions that conflict settings led to underutilisation of services, findings reveal higher institutional birth rates and rising caesarean sections with stagnant infant mortality rates in Palestine, driven by international aid and policy pressures. However, these trends obscure deeper issues of autonomy and the Westernisation of policies in the Global South without addressing population needs. This research paper argues that dominant, top-down interventions often replicate Western biomedical models without addressing the unique political and cultural context of Palestine.

It calls for a shift towards community-led maternal health policies that centre Palestinian women's voices, restoring birth agency and recognising health as a site of resistance. With reclaiming health sovereignty and decentralising health systems, Palestinians can challenge dependency frameworks to assert resilience within the settler colonial context. This work contributes to the growing discourse on decolonising global health and reimaging care in conflict settings

## Introduction

Maternal and neonatal health (MNH) refers to care provided to women during pregnancy, childbirth and postpartum as well as to newborns in the first weeks of life (3)- which is a long-standing public health priority.Maternal mortality (death within 42 days of pregnancy) rises during conflict due to a multitude of factors which include restricted access to maternal services, safety concerns, financial constraints and

geographical barriers (4). Neonatal mortality (death within the first 28 days of life) remains higher than universal standards, particularly in conflict settings where there are significant gaps in healthcare and lack of specialised services (5). While much of the literature includes logistical and health system challenges, there is limited understanding of the geo-political barriers that shape access to care. This makes outcomes more complex and context-specific which is essential for developing targeted interventions in conflict zones.

When examining the case of Palestine, ongoing occupation and repeated escalations of violence has created a multitude of complex barriers. MNH is an important element regarding health in the oPt as women of reproductive age and children under five make up approximately 39% of the population according to the 2010 Family Survey (6). Settler colonialism is fundamental in preceding all economic, social, and political determinants of health in Palestine (7). Addressing barriers to accessing MNH services in Palestine requires more than just health system strengthening, it demands political solutions to achieve quality care (8). This research paper will discuss and connect these components of health to address a wider reality to Palestine, reorienting the focus to root causes.

## How does political instability in oPt affect health infrastructure and the availability of services?

### 3.1 Epidemiology of maternal care in the oPt

Within the occupied territories of Gaza and the West Bank, women of reproductive age make up approximately 22% of the population with a high fertility rate of 3.3. By 2002, the maternal mortality rate (MMR) in Palestine was estimated to be 24 (9, 10). While maternal and newborn mortality rates in the oPt have decreased since the 1960s, across all maternal child health(MCH) indicators, the oPt preforms worse than Israel and surpasses Jordan in only MMR value (11). There is considerable under-reporting by the Palestinian MOH with regular audits and near-miss investigations not being done- the death registration system is often unreliable with data for maternal complications often missing (10).

A study on coverage of antenatal care(ANC) in Palestine discovered that 72% of women met the WHO recommended visits but with variations across the region- 33% in the Southwest Bank did not meet this standard (12). Another study on the association of ANC quality and the MCH handbook states that 60% of women utilised services and were more likely to receive a higher quality of care among handbook users (13). One possible explanation is the prioritisation of maternal health by the Palestinian MOH with the provision of around 475 ANC clinics in 2020 (12). Furthermore, the integration of ANC into the primary care system may have contributed to the higher figures. Despite this, it is important to note that context of socioeconomic and geographical disparities continue to affect timely and adequate care- whilst coverage may be high, quality and consistency of that care can still reflect the structural inequalities.

In relation to maternal care, poor communication and inadequate supervision were identified as major factors affecting the delivery of care (14)- this contributes to the willingness of mothers accessing care, which is consistent with data from other LMICs in the literature review. Another study looking at maternal mortality in the West Bank found that 25 of 36 maternal deaths can be classified as avoidable due to either complications or unjustifiable delays in life-saving interventions (10).

PNC is typically a service utilised the least by women globally, where 55% of maternal deaths in Palestine occur within this period. Despite large antenatal coverage in Palestine, PNC utilisation only reached 30% in 2006, with roughly two-thirds of women not receiving any postpartum care(15). Figures doubled in the Gaza Strip within the year, however the West Bank saw a regression after 2004 potentially due to the tightening of Israeli mobility restrictions (16). Looking at the quality of PNC, it is difficult to quantify the level as perceptions of care are deeply affected by education and birthing situation which can be masked in the context of occupation (17).

Infant mortality dropped sharply in the 1980s but declined much more slowly over the following decades, with only a 1% annual decrease from 1990 to the early 2000s reported by Giacaman, Khatib (18). Another study found that in the Gaza strip, the infant mortality ratebegan to decline slowly due largely to a rise in neonatal mortality. In 2009, the Palestinian MOH reported infant mortality rates to be 21.5 per 1,000 live births (19). Rates have remained stagnant at 16 since 2006 with further insight needed into quality of care during birth(20). This isn't a simple matter of medical capability which is the case in other countries in the Global South but deeply tied to mobility restrictions and systemic neglect. It is important to consider how additional intervention from specialist care and restricted mobility may have reduced the infant mortality further.

Prevention from timely specialist services exacerbates preventable deaths and impedes progress.

Differences in ANC/PNC and perceived quality suggests a reality shaped by prolonged occupation and overreliance on external aid. Under these conditions, perception of care is survival-based rather than measurable, comprehensive health data.

### 3.2 The politics of childbirth in Palestine

Many childbirth-related health policies, are heavily influenced by Western ideas of modernisation and development, ignoring a country's own specific history and culture (21). After independencewas gained from colonial powers, many countries tried to establish a system where hospital births were the norm, influenced by international organisations that focussed on high maternal mortality. Despite vertical solutions in addressing safe motherhood in the Global North, these strategies have not significantly reduced maternal mortality in poorer contexts that are affected by war and globalisation (22).

From the mid-1990s, childbirth policy under the Palestinian Ministry of Health (MOH) was driven to reduce infant mortality rates which they believed was due to high levels of home births, and so they encouraged hospital births; by the end of 1999, almost 99% of births occurred in medical facilities in Palestine(23). Both the MOH and Israeli Civil administration adopted this notion that home births, no matter the conditions, was a risk to both mother and newborn(21). This idea was not established in research as outcomes were not assessed and studies from other developing countries highlight the misleading institutionalisation of childbirth without a focus on quality (24). This practice also allowed a greater oversight to document, register and monitor Palestinians as part of a bigger plan tied to the political dynamics of the conflict. The proportion of caesarean sections in Palestine also increased from 6.0% in 1996 to 14.8% in 2006 with this procedure being more common in governmental sectors (25). This shift reflected a broader global trend of westernisation of childbirth that did not align with local realities and imposed models of colonial control.

With the implementation of the separation wall and Gaza blockade in the early 2000s as seen in figure 1, access to maternity facilities had been severely disrupted, changing birth location patterns- births at home had increased by roughly 20% in the span of 3 years (21). The isolation of regions created conditions that required local responses, as the efforts of the Palestine MOH to centralise birth was proven redundant. Many hospitals were placed under long periods of curfew and closures with private hospitals having to shut down with the decline in deliveries. However, through this we have witnessed the creation of a new network of childbirth with the focus on birthing centres, dayats (TBAs) and birthing homes to accommodate the new reality (21, 26). This comes at a risk as policies that are implemented without planning or integration into the wider system, reinforces existing power imbalances that have historically shaped maternal care in conflict. Although decentralisation of health systems is useful in emergency settings, it lacks the foresight and sustainability to form stronger health systems in the future.

### 3.5Undermining health systems under settler colonialism: Beyond fragmentation

To critically examine the health of Palestinians, we must understand that settler colonialism is a fundamental determinant of health, where the health system does not only need strengthening but an anti-colonial approach is essential to deconstruct structural discrimination. Farmer expands on the concept of structural violence by applying it through a global heath lens, stating how structural factors such as colonial histories, economic exploitation and political marginalization often determines health outcomes far more than biology alone (27). This is foundational in the State of Israel as defining a state around a single religious identity coupled with settler colonial practises creates unequal health outcomes (28). A wider understanding of health is needed in the humanitarian field for medics as it exposes how marginalisation becomes a form of long-term harm towards an individual's health which cannot be solved with the practise of medicine alone.

As part of the International Covenant on Civil and Political Rights, it states that "Everyone lawfully within the territory of a State shall, within that territory have the right to liberty of movement and freedom to choose his residence" (29).This right has systematically been denied within the context of settler colonialism in Palestine. The Israeli state imposes restrictions that will be discussed further to fragment and control indigenous populations.

Access to health in the oPt is shaped by two major structural barriers- the division of the West Bank into areas and the development of the Israeli permit system. Both impose strict movement restrictions on those seeking medical care. The attempt at developing a health system in Palestine can be dated back to the Oslo

Accords where the West Bank was divided into Areas A, B, and C; only areas A was administered full control to the Palestinian Authority, while area C, which covered 60% of the land, remains under full Israeli control(30). Figure 2illustrates the fragmentation caused by the permit system and restricted zones (1).

Even without active conflict, movement within the West Bank remains severely limited. This form of governance that restricts movement and creates classes of citizens is a key example of structural violence.Healthcare and movement are allocated based on citizenship rather than need causing long-term harm that is largely invisible and institutionalised.

Since the early 2000s, there have been extreme restrictions on movement with closures, sieges and curfews that extend beyond reasons for security. With the erection of the separation wall in 2002 along the entire West Bank, this was followed by a new permit system that restricted access to tertiary care facilities (31). To this day, Palestinians living in the West Bank cannot access Jerusalem or Israel without obtaining a permit, which contains roughly six Palestinian hospitals for the entire West Bank population- this creates a hierarchy of mobility and entitlement in accessing care. In order to access the hospital, you must have a referral from a Palestinian hospital and coordination documents- a process that can take several weeks (32). A study quantitively looking at health barriers in the occupied territories found that in 2011, nearly 35,000 patients were referred by the MOH requiring Israeli permits for access to hospitals. 19% has their application denied with the death of 6 patients whilst waiting for permits(33). These systematic delays illustrate how a permit regime functions not only as a bureaucratic hurdle but as a structural determinant of health outcomes.

The Palestinian health system remains heavily focused on responding to ongoing emergencies due to recurrent attacks and prolonged blockades. This state of constant crisis disrupts daily operations and long-term development initiatives. While some level of coordination exists along international organisations, efforts are limited as the root causes of the crisis are political in nature and cannot be resolved through humanitarian support alone (34). Settler colonialism functions not only through territorial control but through the gradual erosion of institutional capacity and sovereignty. The intentional design of bureaucratic barriers continues to disrupt efforts to build a cohesive, resilient health system. Understanding health access in this context demands a lens that centres it within the broader settler colonial framework that perpetuates dependency and de-development.

### 3.6 Mobile restrictions on maternal and neonatal access to care

Another unique issue affecting delay in accessing care is the implementation of checkpoints. Scholars have understood checkpoints as spaces marked by systematic monitoring which is characterised by fear and humiliation, specifically in the oPt (35). During labour, a process that is considered a medical emergency, some women are forced to wait for lengthy periods at the checkpoints, whilst others are told to leave the ambulance and walk to the opposite side. This points towards the broader purpose of the checkpoints, to institutionalise the occupation under the guise of order or legality in line with the biopolitical objectives of Israel (36). A news article by the UN found that 69 babies were born at checkpoints, leading 35 neonatal deaths and 5 maternal deaths from 2000 to 2007 (37). These avoidable deaths reflect more than just delays but is the product of a wider system that normalises the denial of healthcare through bureaucratic barriers.

One study researched the rise in women crossing military checkpoints to give birth in Jerusalem hospitals so their children will be eligible for ‘permanent residency’ allowing them to live and work in East Jerusalem(38). Despite this, some women restrict their movement to avoid checkpoints and other forms of political violence. This exposure to risky conditions coupled with a lack of social support during birth was perceived as affirming the Palestinian presence in the City and a show of resistance. Palestinian residents of Jerusalem must constantly prove they live within the city’s boarders to prevent their residency from being revoked. However, these restrictions do not apply to Jewish residents who retain their right to live regardless of their place of birth(38). This form of resistance works to reverse power dynamics within a larger system of control, maintaining space and identity through personal sacrifice. While this paper primarily focuses on how policy shapes maternal care, this serves as a powerful reminder that individuals can challenge the system of oppression through choice and childbirth.

The research highlights how MNH outcomes are not merely the result of poor health behaviours but the consequences of entrenched political structures and past policies, further emphasising Farmer’s ideas. As such, this framing is crucial to any analysis of health under occupation and sets the stage for exploring how settler

colonial practices continue to undermine the right to health in the oPt.

## Conclusion- The path to resilience and resistance

This research paper emphasises how generic maternal health interventions often fail to address the specific socio-political dynamics of conflict zones like the oPt. Research moving forward, needs to prioritise frameworks grounded in local political and cultural realities. Viewing maternal care through a solely biomedical lens is harmful and exacerbates disparities, failing to address the intersectionality of politics, human rights and public health.

To address the political and structural constraints shaping childbirth in the oPt, policies must support the re-establishment of midwife-led birthing centres as alternatives to hospital births. The imposed shift towards hospital births may not align with the socio-political realities. This restores autonomy within a context of disempowerment where research has consistently proven that care which is informed and by choice leads to better outcomes(39). The Westernisation of childbirth reinforces the idea that their bodies are governed by systems outside of their control, where re-establishing decision-making is a form of both health interventions and socio-political justice.

The heavy reliance on international aid interventions hinders the development of a self-sustaining and resilient health infrastructure by reinforcing dependency and colonial structures. Rather than positioning Palestine solely as a recipient of external aid, the experience of systemic violence has created a unique form of resilience and adaptability. Thus, there is a need to switch the traditional humanitarian learning hierarchies to position Palestine and other conflict affected countries as a site of knowledge production from which others can learn where maternal care can advance despite conflict. Moving forward, international actors must rethink the role of aid in fragile health systems. Despite the well intentions of assistance, it reinforces dependency and undermines local capacity by flooding the Palestinian system with short-term emergency solutions. True solidarity lies in supporting Palestinian-led health initiatives and financing community-based infrastructure to disrupt power dynamics.

Settler colonialism isn't just a historic event but a reshaping of land and services to serve the settler population. This manifests through the criminalisation of motherhood where women are subjected to violence and neglect during pregnancy resulting in preventable and unjust health outcomes. These are not health system failures but direct outcomes of settler colonialism which cannot be improved without sovereignty and liberation. Policies dictating this medical apartheid do not simply create gaps in care but decides the value of lives. Until Palestinians can determine the conditions of their own care, free from occupation and control, health outcomes will always remain a reflection of broader systems of domination.

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