Despite security problems, population growth, increase in the price of goods and the Agency's financial limitations, the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) provides quality health care to 4 million Palestine refugees.

Facing socio-economic decline: Delivering health to Palestine refugees

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THIS ARTICLE OUTLINES the difficulties faced by Palestine refugees and the challenges of UNRWA in ensuring the highest attainable level of health for all of them.

On one side, the growing number of registered refugees and the great diversity of socio-economic conditions in which they live in the five Fields of operation constitute a challenge for UNRWA, as management of programmes requires coordination of customized decentralized activities for each Field. However, it is also a great strength of the Agency, as the long term commitment to one group of refugees in such a wide area has enabled UNRWA to understand the health needs of its served population and to make a difference in health delivery through an extensive network of primary health care facilities.

Today more than four million Palestine

refugees are assisted by UNRWA. The Agency was established in 1949 to carry out direct relief and work programmes for Palestine refugees: individuals and descendants of individuals whose residence was Palestine between June 1946 and May 1948, and who lost both homes and means of livelihood as a result of the 1948 Arab-Israeli conflict.¹ However, primary health care in camps is also provided to Palestinians displaced in Jordan after the 1967 war.

UNRWA operates in five Fields: Lebanon, Syria, Jordan and the occupied Palestinian territory (oPt), consisting of Gaza and the West Bank, in a context characterized by episodes of violence and a worsening socio-economic situation. During the Agency's early years, the aid delivery focus evolved into a human development approach, with UNRWA serving the Palestine refugees in the areas of education, health, vocational training, relief and social services.² In recent years a self-supported programme of microcredit and microfinance has been operational to assist the most needy refugees.

UNRWA's health programme aims to protect, preserve and promote the health of Palestine refugees and to meet their basic health needs. It is organized in four sub-programmes: health protection and promotion, curative medical care services, disease prevention and control and environmental health, which over the years have adjusted to meet the changing epidemiological profile of the Palestine refugee population.

Living conditions of Palestine refugees

The living conditions of Palestine refugees in the host countries vary according to the local political and economic situation, the recognition of refugee status and access to

government services, as determined by national laws.

LEBANON, JORDAN AND SYRIA

Lebanon hosts 413,962 refugees registered with UNRWA, of whom about 50 percent live in 12 refugee camps and the rest in 27 “gatherings”.³ Palestine refugees in Lebanon constitute 10 percent of the Lebanese population. They do not, however, benefit from the State’s social services: they are denied access to the national taxation system, to health and social benefits, to water and sanitation systems and to free exchange of goods and services.⁴ Therefore they rely heavily on UNRWA for the provision of health care.

Only those who arrived in Lebanon shortly after 1948 are legal residents, the rest are considered, at various levels, illegal immigrants.⁵ They are not allowed to work in 70 professions including medical ones and their diplomas are not recognized. The high cost of work permits combined with a general reluctance of employers to pay social and pension benefits to this traditionally underpaid group, account for their protracted financial dependence⁶ and acceptance of undeclared jobs.

As inhabitants of Lebanon, Palestine refugees also suffer the consequences of political unsettlement. In 2006, almost the entire Lebanese territory was targeted as a result of the war between Israel and Lebanon. A total of 1,184 people were killed and more than 4,000 wounded while 900,000 people were displaced from southern Lebanon. The direct impact on Palestine refugees was due to sporadic targeting of three Palestine camps. For the Palestine refugees living in gatherings the effects of the war were comparable to those

suffered by the Lebanese population.⁷ Syria and Jordan host 451,467 and 1.9 million refugees respectively.⁸ Palestine refugees in these countries enjoy full social rights. In Syria they are given the rights of citizens. In Jordan, Palestine refugees are granted citizenship based on criteria such as place of origin (i.e. the West Bank) and year of arrival. The Gazans living in Jordan face restrictions on access to higher education and jobs⁹ and are therefore the most vulnerable group.¹⁰ The Palestine refugees, whilst remaining a potentially fragile population overall, have in these countries been allowed to enter the labour market and do have social mobility.

THE OCCUPIED PALESTINIAN TERRITORY

The occupied Palestinian territory is suffering the long-term effects of socio-economic hardship and the observed trend is towards a tightening of restrictions with increased isolation of Gaza and a growing lack of geographic contiguity in the West Bank. Israeli restrictions on the movement of Palestinian people and goods in and out of Gaza and within the West Bank are affecting not only access to basic services such as health, and limiting commercial activities,¹¹ but are also hindering UNRWA operations. Following the Palestinian Legislative Council elections in 2006, the impounding of Palestinian tax and VAT revenues by the Government of Israel and the donor boycott of the Palestinian Authority (PA)¹² led to a fiscal crisis. The consequential non-payment of public sector wages generated severe strikes. Salary payments were resumed after the lifting of the international embargo in June 2007; however, contextually the Israeli imposed closure policy on Gaza was intensified. Even consignments of essential medicines and

consumables have recently been delayed at Gaza's borders.

According to the November 2007 UNRWA socio-economic report there has been a sharp economic regression in the oPt with a per capita GDP drop of 30 percent in the past seven years. In the private sector, which constitutes 54 percent of work in Gaza, movement restrictions contributed to the detectable reductions in construction (12.9 percent) and manufacturing businesses (6.8 percent).¹³ This is partly explained in Gaza by the fact that the majority of commercial activities are export driven and are dependent on Israel for raw materials.

By mid-2006, there had been a 30 percent increase in poverty levels overall, and in Gaza nearly 80 percent of the population was living in conditions of extreme poverty, a 54 percent increase as compared with 2005.¹⁴ Conditions in the oPt since 2000 have been summarized by the UNRWA Health Department as follows: there has been a "near collapse of the Palestinian economy, rising unemployment, increased poverty, reduced commercial activities [...] and rising dependency on humanitarian assistance."¹⁵

Delivering health to Palestine refugees

UNRWA is mandated by the UN General Assembly to provide comprehensive health care and environmental health services to Palestine Refugees in the Near East. In 2007, more than three million refugees accessed UNRWA's preventive and curative services that include immunization, expanded maternal health and family planning and communicable and non-communicable diseases prevention and control programmes. Primary health care (PHC) is delivered by a network of 128 clinics serv-

iced by 443 doctors and 3,000 health care workers. Hospital care both in district (secondary level care) and referral hospitals (tertiary level care) is provided by contracted hospitals with a 75 percent fee reimbursement scheme throughout UNRWA's Fields of operation except in situations of extreme poverty where higher fee coverage is provided.

The demographic profile of the registered Palestine refugees depicts a young population where 38.8 percent are children below 18 years of age with a high fertility rate. This profile is comparable to that of

Access restrictions in the West Bank involve patients and UNRWA staff alike.

other countries in the Near East (table 1). Post-delivery and neonatal assistance is mainly provided by public health care services in the host countries and, as would be expected, infant mortality rates in 2003 were similar to those of the host countries. The first three observed causes of infant mortality are low birth weight, malformations and respiratory tract infections. This confirms a generalized trend in the region where a decline in infectious disease incidence is observed and consequently non-communicable diseases are increasingly frequent causes of mortality and morbidity.

Compared with the 1997 survey conducted in Jordan, Gaza, Lebanon and Syria, infant mortality has decreased in all fields by 2003 (Table 1).

As the leading causes of infant death were prematurity, low birth weight and mal-

Country/served population	Year	Percent of the population aged 0–14 years	Fertility rate	Infant mortality rate per 1000 live births
Syria (MoH)	2000–2005	39,5	3,47	16
Syria (UNRWA)	2003–2006	30,2	2,4	28,1
Jordan (MoH)	2000–2005	37,1	3,53	19
Jordan (UNRWA)	2003–2006	30,3	3,3	22,5
Lebanon (MoH)	2000–2005	27,3	2,32	22
Lebanon (UNRWA)	2003–2006	23,7	2,3	19,2
Palestinian Authority (MoH)	2000–2005	46,3	5,57	18
West Bank (UNRWA)	2003–2006	33,8	3,1	15,3
Gaza (UNRWA)	2003–2006	40,1	4,6	25,2
Israel (MoH)	2000–2005	28,35	2,85	5
Denmark (MoH)	2000–2005	18,66	1,75	4
Sweden (MoH)	2000–2005	18,11	1,64	3

Table 1: Social and Health indicators for the UNRWA-served population¹⁶ and Ministry of Health (MoH) data for countries in the Eastern Mediterranean and Scandinavia.^{17,18}

formations, the Agency focused its attention on: carefully monitoring pregnancies and referring high risk cases to hospital delivery; encouraging early registration of newborn children and carrying out a close clinical follow-up, especially in the neonatal period, and implementing community awareness on the risk of pregnancies at extreme ages (very young or old), of high parity, and of interfamily marriage. Nevertheless, harder living conditions experienced by refugees, and especially in Gaza, might change the positive trend. Preliminary surveillance data indicates that infant and maternal deaths have increased in 2007. A survey to assess the current situation started in January and will be concluded by July 2008.

The relevance of communicable diseases as causes of morbidity and mortality among refugees is decreasing. Vaccine-preventable diseases are well under control and communicable diseases such as tuberculosis and HIV/AIDS have low endemicity. However, communicable diseases associated with poor environmental health, such as viral hepatitis and enteric fevers, are still a public health threat. This reflects endemicity patterns observed in the region. The reduction of communicable disease incidence combined with a longer life expectancy and modifications in life style have led to a change in the refugees' morbidity profile with the emergence of non-communicable diseases such as cardiovascular diseases, diabetes mellitus and cancer.

Micronutrient deficiencies, especially iron deficiency anaemia and vitamin-A deficiency, remain severe public health problems and are most probably due to the combined effect of several con-causes. Nutritional deficiencies related to a combination

of poor consumption, poverty or poor availability of specific foods, and/or to an increased biological need for example during pregnancy, have been identified as causes of micronutrient deficiency in all Fields. However, also high met-haemoglobin (Met-Hb) levels, due to toxic environmental pollutants such as nitrates and medical conditions such as thalassemia,²⁰ have been referred to as causes for the observed high prevalence of anaemia, especially in closed and hardship stricken communities such as Gaza.

Prevention and treatment of post-traumatic stress and other psychological and behavioural disorders, that are documented consequences of exposure to traumatic events,²¹ are emerging health priorities for Palestine refugees. The chronically harsh living conditions coupled with long-term political instability, violence and uncertainty are starting to take their toll, in particular on children and adolescents in the oPt and Lebanon. In Lebanon both the severe internal political tensions throughout the country and the aftermath of the 2006 conflict are keeping the population in a state of chronic distress. In the oPt the escalation of violence since September 2000 has led to destruction and demolition of homes, sieges, closures, curfews and spiralling poverty among the civilian population. The erection of the "separation wall" has divided families, limited access to school, work and basic services. This contributes to the decline of mental health, in particular among Palestinian youth.²²

Challenges for UNRWA

The growing vulnerability of the population it serves, access restrictions and logistical problems, as well as the financial burden of

the increased cost of medicines, supplies and staff salaries are the main challenges facing UNRWA's health programmes today.

First, the deteriorating socio-economic conditions among Palestine refugees, in particular in the oPt, have caused an increase in people living under the poverty line of 2.8 USD per capita daily expenditure. In UNRWA's view, "poverty and ill health form a vicious cycle. Poverty leads to ill health through increased personal and environmental risk, increased malnutrition and food insecurity, less access to knowledge and information, and a reduced ability to access health care. At the same time, ill health leads to poverty by reducing a household's income and lowering people's ability, productivity and quality of life."²³ The increased need for health care among the refugee population is not only the result of a demographic increase, but also a consequence of the swelling numbers of a highly vulnerable group of newly poor with no alternative healthcare providers.

Second, restrictions on movement in the oPt remain a complex problem for the resident population and a severe drawback for UNRWA. Problems differ according to the types of limitations imposed on the movement of people and goods in Gaza as opposed to the West Bank.

GAZA

Both UNRWA and the World Health Organization (WHO) have repeatedly expressed concern about the consequences of the strict closure policy imposed on Gaza on the health of the population residing there, and on their right to enjoy the highest attainable standard of health. The conditions are extremely volatile and impositions of complete closure, as happened in January

2008, resulted in severe consequences for the resident population. On that occasion the power plant, the pumps at water wells and the wastewater management plants stopped functioning due to fuel shortage. Many houses in Gaza remained without water and there was an increased risk of wastewater floods. The interruption of energy provision jeopardized primary health care services, medical supply delivery and, at secondary health care level, had a particularly severe impact on intensive care units, operation theatres and emergency rooms.²⁴

Tertiary health care services are available only outside Gaza. The frequent closure of borders has made it increasingly difficult for Gazan patients to seek high-level specialized health care. De facto, the referral system can no longer be ensured for Palestine refugees. In short, "Palestine patients with urgent life threatening conditions or in urgent need of care are particularly vulnerable and there are reports of patients dying at the Erez check point, in Gaza hospitals or in their homes."²⁵

THE WEST BANK

Access restrictions in the West Bank involve patients and UNRWA staff members alike. In 2006, a total of 385 UNRWA health staff members were denied or delayed access to their work place. The total person-days lost were 372, corresponding to a loss of 91,000 USD to the Agency.²⁶

Restrictions on health care for Palestinians, including primary health care services, are well known and have, since 2003, led to the activation of UNRWA Mobile Health Teams. These are composed of medical, nursing, and laboratory staff as well as a pharmacist and a professional driver, offering a full range of essential medical services

including immunisation, control of communicable and non-communicable diseases and first-aid treatment for conflict-related injuries. The objective of these teams is essentially to facilitate access to health services in locations affected by closures. The Mobile Health Teams were restricted at 36 road access points in 2006 with an estimated work loss of a week and a half. The Nablus team was particularly

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affected by access restrictions. On six occasions it was denied access altogether; on other occasions it was delayed for up to six hours.

Also, in 2006 a new UNRWA clinic was established in Beit Surik (the North West of Jerusalem) to serve the 30,000 inhabitants of the area that, due to Israel's restrictive permit procedures, no longer had access to the health care clinic in Jerusalem's Old City, to which they were referred in the past.

A combination of rapid population growth, increased demand for services and integration of new activities within primary health care is overstressing UNRWA's Health Programme. Despite the increasingly unstable operational environment, UNRWA continues to provide one of the most cost-effective and efficient health delivery systems in the region. However, developments such as access restrictions have compelled the Agency to increase its healthcare offer in order to maintain standards of care. This has involved recruitment

of more personnel, establishment of the mobile clinics described above and an increase in the number of health centres in the West Bank.

UNRWA's work is funded almost entirely by voluntary contributions from donor countries, and "while donations to UNRWA have risen steadily over the years, they have failed to keep pace with the rate of natural growth of the refugee population"²⁷ and of their needs. Although fundraising activities are essential in order to fill the gaps and deliver much needed health care services to the Palestine refugees, the Health Programme today is tackling financial restrictions and increased demand of health care also through an internal reorganization. Prioritization of services delivered and increased efficiency through the establishment of health information systems at Health Centre level are coupled with the updating of management guidelines and revision of available drug lists to better respond to the needs of the refugees.

Looking ahead

UNRWA has been contributing to the welfare and human development of four generations of Palestine refugees and is now facing challenges related to the changing needs of the population it serves and to the deteriorating socio-economic conditions in which the refugees live.

The increased awareness of non-communicable diseases and morbidity has sustainability implications for the Agency due to the higher cost and duration of treatments. On the one hand, early detection and case management of hypertension and diabetes have become one of the cornerstones of the Disease Prevention and Control Programme in response to the generalized epi-

demiological shift in the region. On the other hand, old enemies such as communicable diseases and micronutrient deficiencies are still severe public health concerns. The double burden of communicable and non-communicable diseases remains one

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of the major challenges UNRWA faces.²⁸

Moreover, the nutritional status, particularly for vulnerable groups among the refugees such as the extremely poor, pregnant women and children, has to be monitored. Specific supplementary feeding programmes including distribution of food baskets, iron fortification of products such as flour, and vitamin A campaigns are implemented in response to this need.²⁹

UNRWA is struggling to maintain a good quality of care. Utilization of outpatient services in 2007 had increased to approximately nine million medical consultations per year with an average of 95 visits a day per doctor.³⁰ Significant changes in the host nations' attitudes to refugees within the context of their national health service are not foreseeable in the near future and UNRWA is facing a long-term commitment to Palestine refugees. Specific studies address patient flow analysis in order to optimize doctor-patient contact time and avoid overcrowding. Quality evaluation of care in health centres and contracted hospitals as well as a thorough analysis of the outcome of visits and the nature of repeat visits (whether due to patient follow up, to new

conditions or to lack of improvement after treatment) are providing the keys to reorganization of services and increased internal efficiency.

Notwithstanding the difficulties it faces, the Agency cannot stand away from addressing priority unmet health needs such as mental health, cancer screening and treatment and physical rehabilitation services. Mental health and psychological well-being are expected to become major issues in the next years in view of the growing poverty and social segregation of the Palestine refugees. Moreover, early detection and management of cancer will become a future challenge. The major share of the effort will fall on the health care system,³¹ as will the expected increase in demand for physical rehabilitation services.

The effort to address the needs of Palestine refugees will require the mobilization of additional human and financial resources and the support of individuals, countries and institutions from all over the world.

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ACKNOWLEDGEMENTS

The authors acknowledge the contributions of Dr. Yousef Shahin, Ms. Rawan Saadeh, Mr. Ahmad Al-Naotur, and Ms. Mariem Omari.

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