

## **Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan**

At the request of the Director of Health, UNRWA, the Director-General has the honour to transmit the attached report to the Sixty-second World Health Assembly.



## ANNEX

**REPORT OF THE DIRECTOR OF HEALTH, UNRWA, FOR 2008****THE PALESTINE REFUGEES IN THE OCCUPIED PALESTINIAN TERRITORY**

1. Of the 4.7 million Palestinians who are refugees registered by the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), 1 836 123 live in the occupied Palestinian territory, constituting about half the population. A total of 1 073 303 refugees (71.6%) live in the Gaza Strip and 762 820 (31.7%) in the West Bank.<sup>1</sup>
2. There are 27 refugee camps in the occupied Palestinian territory (19 in the West Bank and eight in the Gaza Strip). About one third of Palestine refugees still live in refugee camps (46.9% in the Gaza Strip and 25.4% in the West Bank), and the rest live in towns and villages with the host population.
3. Population density is high throughout the occupied Palestinian territory, but overcrowding is particularly severe in the Gaza Strip, one of the most densely populated places in the world. Population density (inhabitants/km<sup>2</sup>) increased from 481 in 1997 to 626 in 2007 (416 in the West Bank and 3881 in the Gaza Strip where 1.4 million people live on an area of 365 km<sup>2</sup>).<sup>2</sup>
4. Demographically, the occupied Palestinian territory has a young population. The proportion of individuals below 15 years of age is slightly higher among refugees (45.8%) than non-refugees (45.3%). High fertility rates (3.1 among refugees in the West Bank and 4.6 in the Gaza Strip) explain this difference. Similarly, the proportion of elderly refugees is 2.8% compared with 3.1% among non-refugees.<sup>3</sup> In 2008, the refugee age dependency ratio (refugees under 15 and over 65 years) was 87% in the Gaza Strip and 73% in the West Bank.<sup>4</sup> Consequently, the economic burden on family units is particularly high.
5. Palestine refugees are a particularly vulnerable population. As in previous years, in 2008 they experienced higher levels of unemployment than non-refugees. Unemployment during the first six months of 2008 was about 5.5% higher among refugees than non-refugees. According to a labour force survey conducted by the Palestinian Central Bureau of Statistics, in the first quarter of 2008, the percentage of employed refugees aged 15 years or above in the occupied Palestinian territory was 38.5% compared with 42.2% among the same population of non-refugees. Similarly, female refugees' participation in the labour force was 14.2% compared with 15.1% among female non-refugees. The data also point to higher rates of unemployment among refugee camp dwellers than among urban or rural residents.<sup>5</sup>

---

<sup>1</sup> UNRWA Annual Report of the Department of Health 2008, in press.

<sup>2</sup> Palestinian Family Health Survey of 2006.

<sup>3</sup> Palestinian Central Bureau of Statistics. Press Release: The Demographic Characteristics of the Palestinian Refugees, June 2008.

<sup>4</sup> UNRWA Annual Report of the Department of Health 2008, op.cit.

<sup>5</sup> PCBS Labour Force Survey of the first quarter of 2008.

## OVERVIEW OF THE SOCIOECONOMIC DETERMINANTS OF HEALTH IN THE OCCUPIED PALESTINIAN TERRITORY

6. Despite large-scale, well-targeted programmes of social security over the past eight years, poverty continues to affect large numbers in the occupied Palestinian territory. As at the third quarter of 2008, 51% of Palestinians were living below the poverty line (48% in the West Bank and 56% in the Gaza Strip) and about 19% lived in conditions of extreme poverty and therefore were unable to meet their basic needs in terms of food, clothing and housing. As in 2007, in 2008 more than half of all Gaza households were living in poverty (56%). In the West Bank household poverty rates were 48%. Those residing in the middle areas of the West Bank were found to be the least likely to be poor and household poverty rates in east Jerusalem were estimated at 19%. Conversely, poverty rates were highest in the northern and southern areas in the West Bank (Hebron, Bethlehem, Tubas and Jenin).<sup>1</sup> Deep household poverty determined by reference to income was estimated at 46.3% of occupied Palestinian territory households in 2007 (34.1% in the West Bank and 69% in the Gaza Strip).<sup>2</sup>

7. The protracted crisis in the occupied Palestinian territory is exacting a devastating human and economic cost on an increasingly vulnerable population, with further deterioration in 2008. The continuation of the blockade on the Gaza Strip, the entrenchment of the closure system in the West Bank and a continuing political divide between Palestinian political parties are leading to increasing socioeconomic hardship and growing dependency on humanitarian assistance.

8. The construction of the West Bank barrier continued, physically separating Palestinian communities from kin and essential services including schools and health-care facilities. The process of fragmentation of Palestinian land and communities continued throughout 2008. This, when combined with house demolitions, eviction orders and permit restrictions, not only undermined economic productivity and opportunities for recovery and growth but also increased displacement. A joint UNRWA/United Nations Office for the Coordination of Humanitarian Affairs (OCHA) survey published in November 2007 estimated that around 1200 families in the northern West Bank had to leave their communities as a result of the construction of the barrier. The year 2008 also saw an increase in the rate of house demolitions. Israeli authorities demolished 124 Palestinian structures in Area C in the West Bank during the first quarter of 2008, leaving 435 Palestinians homeless. These buildings were destroyed because they were constructed without permits, which are frequently denied to Palestinians living in Area C (more than 60% of the West Bank territory). After a temporary halt between April and August, demolitions resumed in Area C with a further 108 structures destroyed between August and October 2008.<sup>3</sup> Demolitions in east Jerusalem continued throughout the year. According to OCHA there are pending demolition orders for more than 3000 Palestinian structures in the West Bank, with at least 10 communities at risk of complete displacement.<sup>4</sup> In the Gaza Strip the blockade adversely affects essential services such as health care, running water, electricity, and education.

9. The level of violence is high. Between January and October 2008 a total of 433 Palestinians, including 80 children, were killed in conflict-related violence in the occupied Palestinian territory

---

<sup>1</sup> UNDP Fast Facts Poverty in focus ([www.papp.undp.org](http://www.papp.undp.org)).

<sup>2</sup> PCBS poverty report 2006.

<sup>3</sup> OCHA Humanitarian Monitor, September 2008 and occupied Palestinian territory CAP 2009.

<sup>4</sup> OCHA Special Focus; "Lack of Permit" Demolitions and Resultant Displacement in Area C.

compared to 304 during the same period in 2007.<sup>1</sup> A further 2009 people were injured, including 478 children – a 27% increase over the same period in 2007. Child casualties were higher in both absolute and proportional terms, with almost a doubling of the number of child injuries and deaths in 2008 compared to 2007. Settler violence against Palestinian civilians in the West Bank also escalated during 2008, with the monthly average of settler-related incidents increasing from 20 in 2006 and 24 in 2007 to 38 in 2008.<sup>2</sup> By the end of October 2008, OCHA had recorded more incidents of settler violence and harassment than in any year since 2001, with around half all incidents occurring in Hebron.<sup>3</sup>

10. In 2008, Israel did not relax the closure regime and the first half of the year saw an intensification of Israeli military operations, including air strikes and incursions. Renewed hostilities in November and December culminated in a major Israeli offensive on 27 December. Israeli aircraft bombed more than 300 targets in the first three days of the operation. By 31 December, about 350 Gazans, including at least 38 children, were killed.

11. During the military operation named Operation Cast Lead, launched by the Israel Defence Forces between 27 December 2008 and 18 January 2009 in response to the launch of rockets from the Gaza Strip, almost 1400 people were killed. Among those were 431 children and 112 women. At least 5380 people were injured, including 1872 children and 800 women. Injuries were often multiple traumas with head injuries, thorax and abdominal wounds. Critical health services had never stopped functioning and by 20 January all UNRWA's health centres in the Gaza Strip had resumed operations. The reactivation of treatment of chronic diseases, also through active case-finding and catch-up immunization campaigns, was organized in the immediate aftermath of hostilities. The mitigation of the effects of the conflict is estimated to require years of physical and psychological rehabilitation. Cases of post-traumatic stress disorder and other psychological and behavioural disorders triggered by exposure to traumatic events are expected to rise, as are the refugees requiring physical rehabilitation. Following Israel's unilateral ceasefire declaration on 18 January 2009, UNRWA expanded emergency operations to meet additional humanitarian needs arising from the crisis and to support the longer-term recovery.

12. During 2008, the Palestinian economy was stagnant, its productive capacity waning, unable to generate sufficient employment to absorb a young and growing population or replace job losses. Unemployment rates both in the Gaza Strip and the West Bank were higher than in the same period in 2007.<sup>4</sup> A total of 32.7% of the labour force in the occupied Palestinian territory was out of work during the third quarter of 2008 compared to 10% in year 2000. In the Gaza Strip, the situation was more severe (46.1% compared to 15.5% in 2000) than in the West Bank (24.6% compared to 7.5% in 2000). By 2007, real Palestinian gross domestic product (GDP) was more than 8% below its 1999 level, despite population growth of around 25%. On a per capita basis, GDP was around one third lower than in

---

<sup>1</sup> OCHA Protection of Civilians Database, see [www.ochaopt.org](http://www.ochaopt.org).

<sup>2</sup> OCHA Humanitarian Monitor reporting.

<sup>3</sup> OCHA Protection of Civilians database.

<sup>4</sup> PBCS labour force surveys and data sets provided to UNRWA by special request.

1999,<sup>1</sup> and preliminary data point to further economic contraction during the first half of 2008 compounded with increasing inflation rates.<sup>2</sup>

13. Across the occupied Palestinian territory, food insecurity rose. A joint FAO/UNRWA/WFP survey estimated that in 2008, 1.4 million Palestinians were food insecure (38% compared to 34% in 2006) and a further 500 000 were at risk of becoming food insecure. Food insecurity in the Gaza Strip is more widespread (56%) compared with the West Bank (25%). Palestinians were eating less, many parents reducing their intake for the sake of their children. Half the surveyed population had decreased their spending on food, 89% had reduced the quality of food they buy, while 75% had reduced the quantity of food since January 2008. Almost all Palestinians have reduced their consumption of fresh fruit, vegetables and animal protein to save money. These behaviours may have serious health consequences considering the already high prevalence of anaemia and other micronutrient deficiencies in the occupied Palestinian territory.<sup>3</sup>

14. Palestine refugees remain more vulnerable to poverty than non-refugees.<sup>4</sup> Conditions in refugee camps in the occupied Palestinian territory continued to deteriorate faster than in non-refugee urban and rural settings. A total of 38.6% of refugee camp households suffered from poverty compared to 29.5% and 29.3% non-refugee rural and urban households respectively; moreover, sharp rises in poverty levels were recorded among refugees during 2007.<sup>5</sup>

15. In contrast to the trends in poverty and unemployment, illiteracy rates among Palestine refugees in the occupied Palestinian territory were lower than for non-refugees. The illiteracy rate in 2007 among Palestine refugees aged 15 years and above was 5.7% compared to 6.5% among non-refugees. Moreover, the proportion of Palestine refugees aged 15 and above holding at least a first university degree was 9.2% compared with 8.4% among the same population of non-refugees.<sup>6</sup>

## **THE HEALTH STATUS OF PALESTINE REFUGEES IN THE OCCUPIED PALESTINIAN TERRITORY: A WIDENING EPIDEMIOLOGICAL GAP**

16. There is a remarkable difference in the Millennium Development Goal indicators and other health indicators between the West Bank and the Gaza Strip. Overall, the Gaza Strip compares unfavourably with the West Bank despite the fact that both share the same health-care providers and have comparable populations. This finding applies equally to refugees and non-refugees (the Palestine Authority and WHO monitor the entire population; UNRWA specifically monitors the refugee population).<sup>7</sup> The Gaza Strip has consistently higher infant mortality rates (UNRWA data: West Bank 15.3/1000, the Gaza Strip 25.2/1000; WHO data: West Bank 23.2/1000, the Gaza Strip 29/1000) and

---

<sup>1</sup> 2007 Economic Developments and Prospects, World Bank, Middle East and North Africa region.

<sup>2</sup> PCBS Preliminary Estimates of Quarterly National Accounts, 1st and 2nd quarters 2008.

<sup>3</sup> WFP, Food Security and Market Monitoring Report Number 19, July 2008.

<sup>4</sup> UNDP Fast Facts Poverty in focus, op.cit.

<sup>5</sup> Palestinian Family Health Survey of 2007.

<sup>6</sup> Palestinian Family Health Survey of 2006.

<sup>7</sup> Unless otherwise stated, in this section the UNRWA data refers to 2007, WHO data to 2005–2006.

maternal mortality ratios (UNRWA data:<sup>1</sup> West Bank 8.2/1000, the Gaza Strip 37.5/1000; WHO data: West Bank 6.7/1000 against Gaza Strip 21.3/1000), a lower life expectancy<sup>2</sup> (West Bank 74.3 years, the Gaza Strip 73.2 years), and reports higher levels of undernutrition and micronutrient deficiency.

17. The factors contributing to the observed differences between Palestine refugees in the Gaza Strip and the West Bank are diverse. West Bank residents have some level of access to Israeli health services of higher quality, to which access for Gazans is more difficult. Moreover shortages of medical supplies and other essential supplies such as fuel and electricity are much more frequent in the Gaza Strip and have led to dysfunctions in the provision of health care.<sup>3</sup>

18. Despite widespread availability of health services and high immunization coverage rates, health indicators did not improve substantially. No noticeable progress was made in reducing infant mortality during the period 2000–2006. This was, however, to be expected as post-delivery and neonatal assistance is primarily provided by public health-care services. Infant mortality rates, therefore, cannot decrease significantly below national levels until secondary and tertiary services are developed to reduce the leading causes of infant mortality – namely premature births, low birth weight and congenital malformations.

### **Communicable diseases**

19. Vaccine-preventable diseases are well under control in both the Gaza Strip and the West Bank and measles immunization coverage is consistently above 95% and in line with nationally reported rates.

20. Communicable diseases, such as tuberculosis and HIV/AIDS, have a low incidence (only five cases of tuberculosis were reported from the Gaza Strip and one case from the West Bank in 2008), and endemic zoonoses, such as brucellosis, continued to have a low incidence, with only three cases reported in the West Bank and two in the Gaza Strip.

21. Diseases associated with poor environmental health are still a public health threat reflecting local endemicity patterns. Prevalence data for the Gaza Strip and the West Bank in 2008 revealed a striking difference in the rates of water- and food-borne infections such as acute hepatitis (81.0 per 100 000 in the Gaza Strip and 23.7 per 100 000 in the West Bank) and typhoid fever (10.6 per 100 000 and zero, respectively). The incidence of both conditions increased from 2003 to 2007 by more than 1.5 cases per 100 000 in the Gaza Strip. In the West Bank viral hepatitis prevalence decreased by more than 1.5 cases per 100 000 and cases of typhoid fever remained at zero reporting levels throughout the period.

### **Noncommunicable diseases**

22. There has been a growing awareness of noncommunicable diseases in the refugee population and current epidemiological trends project an increasing disease burden as the socioeconomic conditions are expected to worsen. UNRWA will have to face the socioeconomic consequences of the growing prevalence of invalidity related to noncommunicable diseases and the economic burden of the growing number of chronically ill patients requiring medical care. The detection rate of diabetes

---

<sup>1</sup> UNRWA data on maternal mortality reflects only beneficiaries attending UNRWA antenatal care services.

<sup>2</sup> CIA Fact Book 2008.

<sup>3</sup> UNRWA Health Director's report to the World Health Assembly in May 2008.

mellitus among Palestine refugees older than 40 years of age in 2008 was 11% in the West Bank and 13% in the Gaza Strip. The detected rate of hypertension in the same population was 15% and 19% respectively.

23. Although the severe undernutrition reported in the 1950s and 1960s is no longer highly prevalent in the Gaza Strip, stunting is still a problem among children under five years of age. According to a review conducted by the Palestinian Central Bureau of Statistics in 2008, prevalence of stunting among children under five years of age in the Gaza Strip is 12.4 %, against 7.9% in the West Bank.<sup>1</sup>

24. Micronutrient deficiencies, especially iron deficiency anaemia and vitamin A deficiency, remain severe public health problems. The latest UNRWA survey on anaemia prevalence was conducted in 2006. Prevalence of anaemia among children aged 6–36 months was found to be significantly higher in the Gaza Strip (57.5%) compared with the West Bank (37.1%), again highlighting an epidemiological difference within the occupied Palestinian territory. The same pattern was observed among pregnant women as prevalence was higher in the Gaza Strip (44.9% compared with 31.1% in the West Bank). In the countries of the WHO Eastern Mediterranean Region, nutritional anaemia is a moderate public health problem (with prevalence between 20.0% and 39.9%).<sup>2</sup> Among Palestine refugees in the Gaza Strip, anaemia is a severe public health problem and prevalence is consistently higher than 40% among the vulnerable groups examined. A combination of poor consumption, linked to poverty or poor availability of specific foods, and/or an increased biological need, has been identified as the cause of micronutrient deficiency in the Gaza Strip. However, high methaemoglobin concentrations due to toxic environmental pollutants such as nitrates<sup>3</sup> and medical conditions such as thalassemia<sup>4</sup> have also been claimed as causes of the persistently high anaemia prevalence observed, despite the long-term iron supplementation programme implemented by UNRWA.

25. Post-traumatic stress and other psychological and behavioural disorders, a documented consequence of exposure to traumatic events, are an emerging health priority. The chronically harsh living conditions of Palestine refugees coupled with long-term political instability, violence and uncertainty are taking their toll, in particular on children and adolescents.<sup>5</sup> As noted above, since September 2000, the Palestinian population has been affected by demolition of homes, siege, closures and curfews that caused spiralling poverty among the population. The barrier has divided families and limited access to schools, work and basic services, contributing to increasing the relevance of mental health issues notably among Palestinian youth.<sup>6</sup> Successive studies have highlighted the short- and long-term negative effects of the ongoing conflict on Palestinian children and youth, including fear, bedwetting, difficulty in concentrating, eating and sleeping disorders, irritability, and increased anti-

---

<sup>1</sup> PBCS Health situation in the Palestinian Territory 2008 ([www.pcbs.gov.ps](http://www.pcbs.gov.ps)).

<sup>2</sup> McLean E, Egli I, Cogswell M, de Benoist B, Wojdula D. Worldwide prevalence of anemia in pre-school aged children, pregnant women and non-pregnant women of reproductive age, in: *Nutritional Anemia*. Basel, Switzerland, Sight and Life Press, 2007.

<sup>3</sup> Abu Naser AA, Ghbn N, Khoudary R. Relation of nitrate contamination of groundwater with methaemoglobin level among infants in Gaza. *La Revue de Santé de la Méditerranée Orientale*. 13(5): 994–1004, 2007.

<sup>4</sup> Sirdah M, Bilto YY, el Jabour S, Najjar K. Screening secondary school students in the Gaza Strip for beta-thalassemia trait, *Clin Lab Haematol*. 20(5): 279–283, 1998.

<sup>5</sup> Qouta S, El Sarraj E. Prevalence of PTSD among Palestinian children in Gaza Strip, *Arabsynet Journal* 2004.

<sup>6</sup> Giacaman R, Saab H, Nguyen-Gillman V, Naser G. *Palestinian adolescents coping with trauma*. Birzeit University, 2004, pp. 1–89.



social behaviour during adolescence and neurotic problems during adulthood. Palestinian students experience the lowest levels of self-satisfaction compared with 35 other countries according to a study conducted on almost 3500 students in Ramallah<sup>1</sup> and according to screening activities conducted by UNRWA in schools in the Gaza Strip, a quarter of Palestinian students are estimated to be affected by symptoms of psychological disorders related to stress and trauma.<sup>2</sup> During 2008, the most common disorders treated by the UNRWA mental health programme in the Gaza Strip were aggressive behaviour (17%), family problems (11%) and lack of motivation (8%).

26. Among Palestine refugee children in the Gaza Strip the prevalence of post-traumatic stress disorder after major traumatic experiences is high. After a bombing in El-Bureij refugee camp (central Gaza Strip) in February 2008, 68% of UNRWA students in the camp had symptoms consistent with the disorder. After the Israeli invasion of northern Gaza in March 2008, 39 000 Palestine refugee students were screened for psychosocial disorders. A total of 94% showed significant post-traumatic reactions and the potential for developing post-traumatic stress disorder.<sup>3</sup>

27. Disabilities affect 2.5% of the population with comparable prevalence between refugees (2.6%) and non-refugees (2.4%). A total of 14.8% of the elderly suffer from at least one disability. About half of the disabled population suffers from some kind of physical disability (50.1% among refugees and 45.6% among non-refugees). The second cause of disability is visual and/or hearing impairment (27.4% and 27.2% respectively).<sup>4</sup>

## UNRWA'S HEALTH SERVICES

28. UNRWA has been the main comprehensive primary health-care provider of Palestine refugees for the past 60 years and is the largest humanitarian operation in the occupied Palestinian territory, providing assistance to about half the population. The Agency operates through two Field Offices in the West Bank and the Gaza Strip and a network of 61 primary health-care facilities. Access to secondary and tertiary care is ensured by one hospital in the West Bank (Qalqilya) and by contracted hospitals in both locations.

29. In the West Bank there are currently 41 primary health-care facilities comprising 26 health centres and 15 health points. In the Gaza Strip services are provided in 20 primary health-care facilities (17 health centres and three health points). To respond to the increasing demand for health services from the growing refugee population in the Gaza Strip, given the inability of UNRWA to establish additional health facilities, five health centres, in the largest camps, have been operating on double shifts for 16 years.

30. In 2008, about one and half million refugees residing in the occupied Palestinian territory (70% of all registered refugees in the West Bank and 80% in the Gaza Strip) accessed UNRWA's preventive and curative services. These include postnatal follow-up of infants (growth curve monitoring, medical check-ups and vaccinations), outpatient consultations, family planning, antenatal

---

<sup>1</sup> Giacaman R, Khatib R, Shabaneh L, Ramlawi A, Sabri B, Sabatinelli G, Khawaja M, Laurance T. Health status and health services in the occupied Palestinian territory, *The Lancet*, March 2009 doi:10. 10.1016/S0140-6736(08)61345-8.

<sup>2</sup> Zaqout I. Community Mental Health Programme 2008 Annual Report.

<sup>3</sup> Zaqout I. Community Mental Health Programme March 2008 Monthly Report.

<sup>4</sup> Palestinian Family Health Survey of 2006.

care of pregnant women, oral health, and secondary prevention and management of diabetes and hypertension in refugees over 40 years of age.

### **Curative services**

31. The number of medical consultations conducted in 2008 compared with 2007 showed a slight increase in the Gaza Strip (from 3.6 to 3.8 million) whilst remaining stable in the West Bank (from 1.7 to 1.72 million). UNRWA's health system is overstretched with each doctor seeing on average 103 patients a day in the Gaza Strip and 89 in the West Bank.

32. Oral health services are provided through 14 clinics and three mobile dental units in the Gaza Strip and 22 clinics and one mobile dental unit in the West Bank. By the end of 2008, trends in service use showed an increase of 8% in dental consultations and dental screening in the Gaza Strip. This entailed an increase in the daily dental surgeon's workload from 52 to 62.4 dental consultations per day in the Gaza Strip. There was no significant change in the West Bank.

33. In order to meet the increased demand for physical rehabilitation in the occupied Palestinian territory as a result of violence and accidents, UNRWA operates nine physiotherapy units in the Gaza Strip and six units in the West Bank, providing a wide range of physiotherapy and rehabilitation services, including therapeutic physical exercise, manipulation, massage, occupational therapy, hydrotherapy, electrotherapy, heat therapy and postural gymnastics, also through an outreach programme. In 2008, 13 903 patients were treated. Patients suffering from sequelae of physical trauma and injuries sustained during military incursions accounted for 25% of patients.

34. To assist refugees' household coping mechanisms, UNRWA is placing special emphasis on developing Agency-wide strategies for psychosocial well-being, especially among children and youth. Structured mental health programmes are being implemented in the Gaza Strip and West Bank. These started in 2002 as psychosocial support projects with the recruitment of counsellors. The programmes then expanded with the recruitment of an international expert in 2005 to become the present-day Community Mental Health Programme. The Agency assigned 246 counsellors to schools, 34 to health centres and 28 to the community centres throughout the occupied Palestinian territory and provided a range of services aimed at promoting the development of constructive coping mechanisms for refugees in crisis situations and preventing long-term psychological consequences.

35. In 2008 the Community Mental Health Programme in the occupied Palestinian territory conducted 35 278 individual counselling sessions, 12 193 group counselling sessions, 21 753 group guidance awareness sessions, 4802 public awareness meetings and 4863 home visits, reaching almost 700 000 beneficiaries. The aim is to raise awareness and build resilience to the psychosocial consequences of chronic emergency and traumatic experiences.

36. Forty laboratories in the West Bank and 17 in the Gaza Strip provide comprehensive laboratory services that include chemistry, haematology, serology, and urine and stool direct microscopy. Automated cell counters have been introduced in all laboratories and chemistry analysers have been made available at area level. During 2008, the number of tests performed was 2 570 017 (1 779 474 in the Gaza Strip and 790 543 in the West Bank).

37. UNRWA operates 14 radiology units in the occupied Palestinian territory (nine in the West Bank and five in the Gaza Strip). During 2008, a total of 56 218 plain X-rays were performed, 32 001 in the Gaza Strip and 24 217 in the West Bank.

38. Five mobile health teams, composed of a medical officer, a practical nurse, a laboratory technician, an assistant pharmacist, and a driver have operated in the West Bank since February 2003. Their objective is to deal with the additional burden on the health system and mostly to facilitate access to health services in locations affected by closures, checkpoints and the barrier. They offer a full range of essential curative and preventive medical services to around 13 000 patients per month – refugees and non-refugees – living in over 150 isolated locations. Since becoming operational, the mobile clinics have played a crucial medical role and they have treated an increasing number of Palestinian refugees, from 69 500 in 2003 to 139 992 in 2008.

39. The number of refugee patients from the West Bank and the Gaza Strip who were admitted to contracted hospitals increased by 1.9% from 23 045 in 2007 to 23 488 patients in 2008. In addition to outsourced hospital services, UNRWA operates a 63-bed hospital in Qalqilya. Founded in 1950, the hospital offers medical care, surgery, gynaecology and obstetric services to refugees and needy non-refugees in the northern West Bank. It accommodates 14 surgical, 12 medical, 20 paediatric, 15 obstetric/gynaecological and two intensive care beds in addition to a five-bed emergency ward. In 2008 the average daily bed occupancy rate was 55.3% with a total of 6026 people admitted.

### **Preventive services**

40. Control of communicable diseases is achieved in part by high vaccination coverage and in part by the early detection and management of outbreaks through a health centre-based epidemiological surveillance system. In 2008, the vaccination coverage rate for infants 12 months of age was 100% in the Gaza Strip and 99.7% in the West Bank, and the coverage rate for children aged 18 months receiving booster doses was 100% in both locations. No case of poliomyelitis, acute flaccid paralysis, cholera, tetanus, diphtheria, or pertussis was reported among the refugee population, and no outbreak occurred.

41. Maternal and child health is one of the cornerstones of UNRWA's primary health care. During 2008, UNRWA provided antenatal care to 39 565 pregnant women in the Gaza Strip and to 13 354 in the West Bank, postnatal care to some 47 240 women, and family planning to more than 66 000 clients. A total of 136 000 children younger than three years of age were assisted by the programme in 2008.

42. School health services, including medical examinations, immunization, screening for vision and hearing impairment, oral health consultations, vitamin A supplementation and a deworming programme in addition to health education and promotion activities, were conducted for more than 250 000 children enrolled in UNRWA schools.

43. Secondary prevention of the late complications of diabetes and hypertension is one of the main functions of UNRWA's noncommunicable diseases clinics. By the end of 2008, a total of 78 437 patients with diabetes and/or hypertension were under care in UNRWA health centres in the occupied Palestinian territory (49 528 in the Gaza Strip and 28 909 in the West Bank).

### **Environmental health**

44. UNRWA's environmental health services continued to focus on maintaining acceptable standards of solid-waste management, provision of safe water and sanitation in refugee camps, employing 20 engineers and 340 sanitary workers. In 2008, all camp shelters had access to safe water while a connection to sewerage systems was present in 95% of camps in the West Bank and 85% in the Gaza Strip.

45. UNRWA has intervened to support municipalities and providers of utility services on several occasions during 2008 to ensure continued service provision. UNRWA provided fuel and spare parts to municipalities, solid-waste management councils and utility companies for the operation of water and wastewater treatment plants and solid-waste equipment. In addition, UNRWA hired contractors to remove waste from unofficial dumping grounds to authorized landfill sites.

46. Among vector control activities, in 2008, chemicals, oil and tools were provided to municipalities for mosquito-eradication campaigns, particularly for the stagnant water pools in the Wadi Gaza.

### **Food supplementation programme**

47. UNRWA's food aid programme benefits pregnant women and nursing mothers attending prenatal/postnatal clinics at UNRWA's primary health-care facilities. Entirely supported through in-kind contributions, the programme aims to meet their additional physiological nutritional needs and prevent nutritional deficiencies. In 2008, UNRWA provided food aid to about 45 000 beneficiaries in the occupied Palestinian territory (30 000 in the Gaza Strip and 15 000 in the West Bank).

## **CHALLENGES AND CONSTRAINTS IN HEALTH SERVICE DELIVERY**

48. Access restrictions for Palestinians and the 2008 strike of health-sector workers in the Gaza Strip put a strain on an already stressed national public health system. This caused the cut-back of services provided by the public sector and consequently led to an increase in the demand for UNRWA services.

49. Difficulties in the movement of UNRWA staff and goods and increases in prices of goods including medicines and food commodities are two of the main issues that affected UNRWA's health programme in 2008, alongside the complication of logistics and consequent increases in operational costs stemming from the closure policy imposed on the occupied Palestinian territory.

50. In the West Bank, despite a strengthening of UNRWA's coordination mechanisms with the Israeli military liaison officers, staff movement became more restricted and unpredictable at several Israeli checkpoints, notably those controlling access to east Jerusalem. These restrictions limit the Agency's ability to meet the needs of increasingly vulnerable communities.

51. In 2008, the ability of UNRWA staff to enter operational areas remained contingent on requests for vehicle searches that do not respect the privileges and immunities of the United Nations. As a consequence, timely access of personnel and goods to places of work and to the vulnerable communities isolated by the barrier was seriously affected. A total of 275 members of the UNRWA health staff faced 65 incidents (delay, denied access or detour) because of checkpoints or closures, with 167 hours lost (26 lost days). In 2008, the reimbursement cost alternative transport (taxi) for UNRWA staff due to detours was US\$ 11 773 compared to US\$ 5500 in 2007, a 113% increase. This resulted in increased waiting time for patients and disturbance of routine and regular activities at health centres due to the delay or absence of staff. Many pregnant women who had appointments for follow-up in UNRWA health centres were unable to reach them in due time because of closures and restriction on movements. The lack of access to UNRWA health services has also undermined the control status of diabetic and hypertensive patients who were prevented from being regularly monitored and treated.

52. The UNRWA mobile medical team was unable to access Bart'a village in the year 2008. The village is located in the area between the West Bank barrier and the 1949 armistice line, and entrance is controlled by Israeli military forces which demand search of UNRWA vehicles and UNRWA personnel (an action that is contrary to the 1946 Convention on United Nations Privileges and Immunities).

53. The access of patients to contracted Jerusalem hospitals was increasingly difficult. UNRWA documented a 62% decrease in the number of admitted Palestine refugees to Jerusalem hospitals in 2008 compared with 2007.

54. A combination of rapid population growth, increased demand for services, integration of new activities within primary health care and growing financial constraints, is overstressing UNRWA's Health Programme and undermining its capacity to buffer the negative effects of poverty, food insecurity, unemployment, violence and social and institutional isolation on the health of its beneficiaries.

55. Financial constraints remain a serious concern for the Agency. In 2008, the Health Programme was not able to reimburse costs for all deliveries taking place in hospitals opting to select cases at high and moderate risk. For the same reason, life-saving tertiary care treatments such as dialysis, are still not reimbursed by the Agency.

56. The doubling of the cost of food commodities puts the Agency in the position of having to decide whether to discontinue food provision to all beneficiaries in order to guarantee assistance to the most vulnerable groups. In this context the supplementary feeding programme for pregnant women and nursing mothers was forcibly reoriented to target only those below the poverty line.

## **LOOKING AHEAD**

57. Palestine refugees are victims of health inequalities, for all the reasons mentioned above. UNRWA aims to iron out these socioeconomic disparities and mitigate their effects on health through the provision of the best possible comprehensive primary health-care services. UNRWA's aim is ultimately to enable them to live healthy, full and productive lives.

58. With its cross-cutting approach to comprehensive primary health care, UNRWA is in a unique position to implement targeted preventive and curative services and to access vulnerable communities. The Health Programme covers refugees' health from birth to old age, implementing health prevention and promotion activities at various levels. This is done in coordination among the Health, Education and Relief departments of UNRWA. Health education from exclusively medical environments reaches schools and other community aggregation centres allowing the development of community-based initiatives. The impact of infrastructure on health is directly supervised, essential medicines are made freely available and their management is constantly monitored to comply with WHO standards.

59. Supported by the international community, UNRWA has developed over the years a refined, tailored and effective package of measures to mitigate the effects of the conflict on occupied Palestinian territory refugee communities. These measures comprise employment programmes, cash and in-kind assistance, food aid, reconstruction and repair of conflict-damaged infrastructure, emergency medical care and psychological counselling and support and monitoring and reporting of humanitarian law violations.

60. The Health Programme has been contributing to the welfare and human development of four generations of Palestine refugees and is now facing the challenges related to the changing needs of the population it serves and to the deteriorating socioeconomic conditions in which the refugees live.

61. The increased awareness of noncommunicable disease morbidity has sustainability implications for the Agency due to the higher cost and duration of treatments. The need to resolve the double burden of communicable and noncommunicable diseases remains one of the major challenges UNRWA faces.

62. The nutritional status, particularly of vulnerable groups among the refugees such as the extreme poor, pregnant women, children and isolated rural communities has to be monitored and effective interventions implemented. Specific supplementary feeding programmes including distribution of food baskets, iron fortification of products such as flour, and vitamin A campaigns need to be implemented in response to need.

63. The chronic imbalance between the needs and demands of the refugee population on the one hand and the human and financial resources available to the Programme on the other has led to a constant renegotiation and prioritization of activities to cope with budget constraints. The effort to meet the needs of Palestine refugees will require the mobilization of additional human and financial resources and the support of individuals, governments and institutions from all over the world.

64. Quality assurance is a leading concern for the Health Programme. Specific studies need to be conducted to optimize doctor-patient contact time through avoidance of long waiting times and to evaluate the quality of care in health centres and contracted hospitals. A thorough analysis of the outcome of visits and the nature of repeat visits will provide the keys to reorganization of services and increased internal efficiency.

65. Compensation mechanisms need to be in place to limit the consequences of movement restrictions in the occupied Palestinian territory on patients' and staff members' access to UNRWA duty stations and on medical supply provision. The Agency will continue to meet the increased demand on the medical care services.

66. Notwithstanding the difficulties it faces, the Agency cannot distance itself from priority health needs such as mental health, cancer screening and treatment and physical rehabilitation services. The attainment of the highest possible levels of psychological well-being is expected to become one of the major targets in the coming years in view of the growing poverty and social segregation of the refugees in the occupied Palestinian territory. Moreover, early detection and management of cancers will become a challenge as the major share of the effort will fall on the health-care system as will the expected increase in demand for physical rehabilitation services.

## CONCLUSIONS

67. Given the utmost importance of health as a fundamental human right, indivisible from other human rights, it is critically important for all stakeholders to exert every effort to ensure sustainable access to health care for Palestine refugees in the occupied Palestinian territory.

68. It is necessary for all parties to ensure that in keeping with UNRWA's status as a neutral and impartial United Nations agency, the privileges and immunities of its staff are respected and that the security of UNRWA personnel is guaranteed at all times. The access of UNRWA health staff to their

duty stations as well as to isolated communities should be ensured, in respect of international laws and conventions.

69. It is vital for the international community to renew its financial support to enable UNRWA sustain the planned activities of its Health Programme, overcome the current logistic difficulties, face the rising cost of supplies and adjust services to meet the growing needs of the refugees and to continue addressing the seemingly unending humanitarian emergency in the occupied Palestinian territory.

= = =