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

The Director-General has the honour to bring to the attention of the Health Assembly the attached report of the Director of Health, UNRWA, for the year 2006.

ANNEX

REPORT OF THE DIRECTOR OF HEALTH, UNRWA, FOR 2006**GENERAL SITUATION**

1. The year 2006 has seen a continuation of violence, loss of life and by far the worst levels of suffering since the occupied Palestinian territory was plunged into a severe humanitarian crisis in September 2000. The implementation of the disengagement plan was accompanied by unprecedented limitations of movement between the Gaza Strip and the outside world, and more complicated restrictions were imposed on civilians in the West Bank through hundreds of checkpoints. In March 2006, after the election of the Hamas-led Government, a further blow to the Palestinian economy resulted from the Israeli Government's decision to stop transferring to the Palestinian Authority the tax monies owed to them. Lacking access to this major source of revenue, the Palestinian Authority fell into a severe fiscal crisis leading to the current difficulty in paying the salaries of its 150 000 employees, upon which about one quarter of the population in the West Bank and the Gaza Strip is dependent. The economy suffocated and humanitarian conditions were further deteriorated.

2. Figures from the Palestinian Central Bureau of Statistics show that in the latter half of 2006, subsistence poverty (affecting those who cannot afford or can hardly afford the basics of survival) was 23% and that 56% of all households in the occupied Palestinian territory are living below the poverty line (80% in 2006 – versus 63% in 2005 – in the Gaza Strip, and 43% in the West Bank). In real terms, this means that over two million people are attempting to subsist on less than US\$ 2 per person per day. Refugees are affected particularly hard as they have been traditionally more dependent on wage labour in Israel and have fewer assets that they can sell.

3. Food is generally available in the Gaza Strip and the West Bank, but access to food is limited due to physical restrictions (curfews and closures) and economic reasons (high unemployment, depletion of resources, exhaustion of coping strategies and strained social support networks). Food security in all areas of the West Bank and the Gaza Strip has declined since 2000 and most recently, new population groups have become food insecure due to the loss of Palestinian Authority income. Dietary diversity seems to be negatively affected by the rising poverty; in particular, lack of micronutrients could have long-term consequences on the nutritional well-being of the population. The 2006 Comprehensive Food Security and Vulnerability Analysis concluded that 34% (1 322 019) of the population in the occupied Palestinian territory is food insecure, 20% (777 658) is marginally secure, and 12% (466 595) is vulnerable to becoming food insecure. Deeper analysis of the food insecurity shows that the refugee population is more severely affected.

4. Poverty is one of the most important determinants of health and invariably leads to general malnourishment, micronutrient deficiencies, stunting in children, increased mortality and morbidity of high-risk groups, and weakened population immunity. In addition, increased poverty prevents those who suffer from noncommunicable diseases, such as diabetes and hypertension, from purchasing medications and continuing their treatment, with consequent negative outcomes. Mental disorders continue to be of major concern in the occupied Palestinian territory.

5. The fiscal consequences of political developments in the occupied Palestinian territory in 2006 have had an impact on the Ministry of Health's budget, and consequently on the delivery of health services and programmes. For instance, they affected its capacity to maintain a stock of

pharmaceuticals and consumables and pay salaries to its staff, which has resulted in a prolonged health workers' strike across the West Bank.

6. In the areas of the West Bank most affected by closures and movement restrictions, immunization coverage with full primary and booster doses of programmed vaccines is below the target of above 95% achieved in other localities. Notwithstanding the sustained high immunization coverage field-wide, some localities are showing declining coverage indicators as a direct result of access problems. Similarly, non-attendance or default rates of noncommunicable disease patients under treatment at UNRWA clinics were higher in localities affected by closures and restricted movement, such as Jerusalem and Hebron.

7. A study conducted by UNRWA's Department of Health in 2006 revealed that the prevalence of anaemia among pregnant women was 44.9% in the Gaza Strip and 31.1% in the West Bank, while prevalence of anaemia among children 6 to 36 months of age was 57.5% in the Gaza Strip and 37.1% in the West Bank, a sharp increase from 54.7% and 34.2% respectively, as observed in the 2004 survey.

UNRWA'S RESPONSE

8. UNRWA cares for almost half of the population of the occupied Palestinian territory and is the largest humanitarian operation in the region. UNRWA has developed a refined package of measures to mitigate the worst effects of the conflict on refugee communities within available means. 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.

9. In the West Bank, there are currently 37 primary health facilities, 23 health centres and 14 health points, serving approximately 720 000 registered refugees, 26% of whom reside in camps. Seventeen of the 23 health centres are situated inside the camps, while six are in villages or towns with a large population of refugees. All of the 14 health points are located outside the camps. The ratio of primary health care facilities per 100 000 registered refugees is 5.3 and the number of doctors per 100 000 individuals is 9.8 – an improvement from 2005, but still far below international standards.

10. Since October 2000, UNRWA has launched eight appeals to support its programme of emergency humanitarian assistance in the occupied Palestinian territory, on top of its regular programme activities. In the West Bank, the emergency appeal launched in 2006 resulted in a total of US\$ 1 370 000 for the health programme, which was allocated as follows: mobile clinics, US\$ 755 000; major health centres, US\$ 273 194; emergency employment, US\$ 31 508; health teams for Beit Surik, Ein Arik/Beit Our and Fara, US\$ 91 536; Qalqilya specialists, US\$ 12 800 and hospitalization, US\$ 150 000. In the Gaza Strip, the appeal resulted in US\$1 319 000, which was entirely allocated to medical supplies and equipment.

11. Patients, staff members, and medical supplies have been severely affected by access restrictions. However, despite the situation, UNRWA has managed to operate according to its standards by recruiting more personnel, establishing mobile clinics or by opening new clinics. For instance, a new UNRWA clinic was established in the village of Beit Surik, north-west of Jerusalem, in 2006. Prior to the construction of the separation wall, the 30 000 inhabitants of this area reported to the health centre in Jerusalem Old City, which is no longer accessible.

12. Additional staff were recruited under a job creation programme in order to meet the increased demand on UNRWA's medical care services, and replace staff who were unable to reach their duty stations due to restrictions imposed on movement of vehicles and personnel. Recruitment under the job creation and training programme are of short duration, lasting three and six months respectively.

13. Mobile health teams – composed of a medical officer, a practical nurse, a laboratory technician, an assistant pharmacist and a driver – have been operating in the West Bank since February 2003. The objective of these teams is to meet the additional burden on the health system, mostly to facilitate access to health services in locations affected by closures, checkpoints, and the separation wall. The teams offer a full range of essential medical services, including immunization, control of communicable and noncommunicable diseases, and first-aid treatment for conflict-related injuries, all of which are provided in places made available by communities or even in the street if nothing else is found. During 2006 five mobile teams operated in the West Bank, attending to patients in 135 localities in the areas of Bethlehem (19 localities), Hebron (25), Jenin (29), Nablus (25), and Jerusalem (37). Most of the locations were visited once a month, while others followed a rotation schedule, with certain villages visited more frequently because they were more affected and deprived of health services than others.

14. During 2006 the mobile health teams encountered a total of 36 different constraints on the road, with an average of 1 hour and 35 minutes' wait per incident. Considering all mobile health teams together, the total waiting time at checkpoints was 48 hours and 31 minutes, representing an estimated work loss of a week and a half. The Nablus team was particularly affected by access restrictions imposed by the Israel Defense Forces. This team usually visits numerous remote villages in the Nablus area and often needs to pass through the exceptionally severe checkpoints of Hamra, Huwwarah, and Beit Iba. On six occasions, the team was denied access altogether. During a number of the delays the team had to wait up to six hours before being allowed to pass. In the majority of cases, "no reason" was quoted as the cause for the delay or denial of access, while on 14 occasions incidents were due to closure. Nablus and Jenin mobile teams were subjected to search in five instances.

15. Among UNRWA employees, 385 health staff were either denied access or delayed in about 100 incidents during 2006. The total man-days lost were 374, causing a loss of US\$ 91 000 to the Agency. Compared to the early years of the intifada, these figures represent a significant improvement. By contrast, during 2004 and 2005 the days lost were 369 and 349, respectively.

16. The only hospital run by UNRWA in the five fields is in Qalqilya. Secondary and tertiary care is otherwise provided through contracted hospitals. Currently there are four hospitals in Jerusalem, one in Ramallah, two in the Nablus area and three in the Hebron area, which are under contract with UNRWA. Access is not completely free of charge, as in the case of primary health care. UNRWA reimburses the hospital for 75% of the cost of secondary care and for 70% of the cost of tertiary care. Only in the 5% of the refugee population, deemed "special hardship cases" because of their socioeconomic status, is the reimbursement 95% of the hospital fee. Patients must be referred from UNRWA clinics to be admitted to contracted hospitals, except in emergencies, when patients are allowed to be self-referred. In 2006 a total of 17 572 people were referred for secondary and tertiary care, a marked increase from 14 559 in 2005 and 12 856 in 2004. Reimbursement to contracted hospitals amounted to a total cost of US\$ 300 000.

17. Qalqilya hospital has been severely affected by the recent emergency situation. Recognized as a high-quality and efficiently run hospital, it provides 63 beds, houses a blood bank, and offers medical care in four specialist areas: paediatrics, internal medicine, general surgery, and gynaecology and obstetrics. Qalqilya village is practically under siege, being completely surrounded by the separation wall, with only one checkpoint connecting it to the rest of the West Bank. The 40 000 people living in

Qalqilya, refugees and non-refugees, are unable to access medical facilities on the other side of the wall. The hospital has seen a surge in demand for its services from both non-refugees and refugees who previously attended private hospitals or Nablus Hospital. The reasons for this range from restriction of access, to increased poverty and the strike of health personnel. In fact, the number of non-refugees, including municipality-referred poor patients and non-refugee emergency cases, was twice as high in 2006 as in 2005.

18. In both the Gaza Strip and the West Bank, additional medical supplies were made available to meet the increased demand on UNRWA treatment services and a two-month stock reserve was maintained in each health centre to meet urgent needs in case of disruption of the supply chain. In addition, three hospitals were contracted in the West Bank to overcome access problems to Agency-contracted hospitals, including hospitals in East Jerusalem.

19. Under its emergency psychological counselling and support programme, UNRWA assigned counsellors to schools and health centres throughout the occupied Palestinian territory. Armed conflict, the tight regime of closure and prolonged curfews are sources of acute psychological stress for Palestinians, both adults and children. The signs of stress, particularly among children, are readily apparent. UNRWA 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. Programmes targeting schools, health centres, social services and community-based centres were under way throughout the reporting period. Health personnel, social workers and teaching staff received training on early detection and referral of persons who need psychosocial support, and partnerships were maintained with community mental health institutions in the Gaza Strip and the West Bank. The Agency is also seeking to enhance cooperation with other partners within the framework of the national mental health plan developed by the Ministry of Health in collaboration with WHO, which assisted in establishing community mental health centres in Ramallah, Hebron and Gaza.

ADDRESSING THE ONGOING CHALLENGES

20. UNRWA is confronting the enormous difficulties brought on by economic suffocation and relentless violence, to the best of its ability. Despite an overwhelming desire to be economically productive and self-sufficient, the refugee population cannot, under the current conditions, support itself or rebuild its communities. The main challenge to UNRWA during the crisis has been to prevent the breakdown of essential services while addressing development needs with an emergency budget that has been seriously underfunded for more than four years. One of the major consequences of the current crisis in the occupied Palestinian territory, is that it has gradually diverted international support to the Palestinian people away from development assistance towards emergency response. This change was inevitable under conditions of a near-collapse of the economy, exhaustion of coping mechanisms, destruction of infrastructure, stunting of civil society institutions, damage to public-sector functions and services and implementation of strict separation and closure policies.

21. UNRWA's strategic approach is to ensure that developmental and socioeconomic opportunities arising from any positive developments on the ground are effectively utilized to better the living conditions of the Palestine refugees in the occupied Palestinian territory, through a mix of developmental, rehabilitative and crisis-related interventions.

22. UNRWA has maintained close collaboration with the Palestinian Authority and other United Nations organizations in preparing the Consolidated Appeals Process, as well as the medium-term

development plan, and the Agency is intensifying its links with WHO in its work on health action in crises, as well as with other local partners for strengthening technical cooperation in priority and commonly defined areas including nutrition, mental health, the Expanded Programme on Immunization, food safety and advocacy. Supported by the international community, the Agency will be prepared to act quickly in response to developments on the ground.

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