

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 2007.

ANNEX

REPORT OF THE DIRECTOR OF HEALTH, UNRWA, FOR 2007**GENERAL SITUATION**

1. Three quarters of the Palestinian population was forcibly dispossessed and expelled between 1947 and 1949 from Palestine as a consequence of the first Arab-Israeli war. Following this event the United Nations General Assembly established the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) with the mandate of assisting registered Palestinian refugees in the fields of health, education and social relief in the occupied Palestinian territory and in countries hosting refugees (Jordan, Lebanon and Syrian Arab Republic).

2. Today the occupied Palestinian territory is suffering the long-term effects of socioeconomic hardship and the observed trend is towards a tightening of restrictions with increased isolation of the Gaza Strip and a growing lack of geographical continuity in the West Bank. Restrictions on the movement of Palestinian people and goods in and out of the Gaza Strip and within the West Bank are affecting access to basic services such as health, limiting commercial activities, and 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 led to a fiscal crisis.¹ The non-payment of public-sector wages caused serious strikes. Salary payments were resumed after the lifting of the international embargo in June 2007, but the closure of the Gaza Strip was tightened; even consignments of essential medicines and consumables have been recently delayed at its borders.

3. By the end of 2007, 1.8 million Palestinian refugees registered with UNRWA were living in the Gaza Strip (about one million) and the West Bank (just under 750 000), constituting around 46% of the 3.9 million Palestinians residing in the occupied territory, with 47% of the refugees in the Gaza Strip and 25% in the West Bank living in 8 and 19 refugee camps, respectively (the rest live in towns and villages with the host population). Although population density is high throughout the occupied territory, overcrowding is particularly severe in the Gaza Strip, one of the most densely populated places in the world. Population density in the West Bank is 439 persons/km² (versus 411 in 2006), while it has reached 4033 persons/km² (versus 3780 in 2006) in the Gaza Strip where 1.4 million people live on an area of 365 km².

4. Registered Palestinian refugees living in the occupied territory are a young population with a male to female ratio of one; 44% are children younger than 18 years of age (39% in West Bank and 47% in the Gaza Strip) and 68% are either children younger than 18 or women of reproductive age. Fertility rates, although declining, are still high (4.6 in the Gaza Strip and 3.1 in West Bank) with an average family size of almost six (5.77 in the West Bank and 5.74 in the Gaza Strip) (see Table 1).

5. Post-delivery and neonatal assistance are mainly provided by public health-care services in the host countries and, as would be expected, infant mortality estimates in the last UNRWA survey (in 2003) were similar to those of the host countries. The leading observed causes of infant mortality are

¹ UNRWA. Emergency Appeal 2008, available on web <http://www.un.org/unrwa/publications/pubs07.html>.

low birth weight, malformations and respiratory tract infections, confirming a generalized trend in the region where a decline in infectious disease incidence is observed and consequently noncommunicable diseases are increasingly frequent causes of mortality and morbidity (Table 1).

6. The combined reduction of fertility and infant and child mortality rates over the years and increased screening and treatment of diseases such as diabetes and hypertension that typically affect the older population is likely to result in increased life expectancy among the refugees. However, because of the rising poverty and high unemployment rates, especially in the occupied Palestinian territory, this will probably add to the economic burden on families and consequently raise the dependency ratio (measured as the proportion of children younger than 15 years and elderly over 60 years of age in the population). The data for 2007 indicate that the dependency ratio has reached 89.6% in the Gaza Strip and 75.4% in the West Bank.

7. The deteriorating socioeconomic conditions among Palestinian refugees living in the occupied territory have caused a rise in the number of people living below the poverty line (US\$ 2.8 per capita daily expenditure). The higher demand for health care among the refugee population is the result of both demographic factors and swelling numbers of a highly vulnerable group of newly poor with no alternative health care provider.

UNRWA'S HEALTH SERVICES

8. UNRWA is the largest humanitarian operation in the region, providing assistance to almost half the population of the occupied Palestinian territory. Despite the increasingly unstable operational environment, it continues to provide one of the most cost-effective and efficient health systems in the region. The Agency operates through two field offices in the West Bank and the Gaza Strip. UNRWA provides comprehensive primary health services to the registered Palestinian refugees in the occupied territory through a network of 57 primary health care facilities. Access to secondary and tertiary care is ensured by one hospital in the West Bank and through contracted hospitals. Environmental health services are also provided in the camps.

9. Access restrictions have compelled the Agency to increase its health care coverage to maintain standards of care. The result has been recruitment of more personnel, establishment of mobile clinics in the West Bank and an increase in the number of health centres in the Gaza Strip.

10. In the West Bank there are currently 38 primary health facilities, 23 health centres and 15 health points; of the 23 health centres, 17 are situated inside the camps and six in villages or towns where many refugee families live. In the Gaza Strip services are provided in 19 primary health care facilities, five in the largest camps and which have been operating with double shifts for 15 years. In 2007 a new health centre was established in Shouka (in the south of the Gaza Strip).

11. In 2007, more than one million refugees residing in the occupied Palestinian territory accessed UNRWA's preventive and curative services that include immunization, expanded maternal health and family planning, and programmes for the prevention and control of communicable and noncommunicable diseases. This figure amounts to 67% of all registered refugees in West Bank and 80% in the Gaza Strip, where refugees have the least access to alternative health service providers and rely most heavily on UNRWA for medical assistance.

Outpatient services

12. Compared with 2006, medical consultations in 2007 increased from 3.1 to 3.6 million in the Gaza Strip and from 1.6 to 1.7 million in West Bank. The health system is overstretched with each doctor visiting on average 116 people a day in the Gaza Strip and 88 in the West Bank. During 2007, UNRWA provided antenatal care to 37 403 pregnant women in the Gaza Strip and to 13 956 in the West Bank, postnatal care to some 46 000 women, family planning to more than 50 000 clients, child care to 131 610 children younger than 3 years of age and school health services to more than 250 000 children enrolled in UNRWA schools. More than 70 000 patients suffering from diabetes and/or hypertension received regular monitoring and care.

Mobile health teams

13. 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 separation wall. They offer a full range of essential medical services. Since becoming operational, the mobile clinics have played a crucial medical role. They have treated an increasing number of Palestinian refugees, from 69 500 in 2003 to 133 122 in 2007.

Hospital care

14. The number of refugee patients from West Bank and the Gaza Strip who were admitted to contracted hospitals increased by 7% from 17 572 in 2006 to 18 980 patients.

15. In addition to outsourced hospital services, UNRWA operates a 63-bed hospital in Qalqilya, West Bank. 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 2 intensive care beds in addition to a five-bed emergency department. In 2007 the average daily bed occupancy rate reached 55.6% with a total of 6545 people admitted.

Laboratory services

16. Some 37 laboratories in the West Bank and 16 in the Gaza Strip provide comprehensive laboratory services. Automated haematology analysers have been introduced in all laboratories and clinical chemistry analysers have been made available at area level. During 2007 the number of tests performed increased by 12.8% in the Gaza Strip and 11.3% in the West Bank.

Oral health

17. Oral health services are provided through 13 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 2007, trends in service use showed a 7% increase in dental consultations and an 8% increase in screening activities compared with 2006, with the daily dental workload increasing in the Gaza Strip from 43 to 57 dental consultations per day.

Physiotherapy services

18. Since 2000, UNRWA has operated six physiotherapy units throughout the occupied Palestinian territory, providing a wide range of physiotherapy and rehabilitation services including manual treatment, heat therapy, electrotherapy, and gymnastic therapy with an outreach programme. In 2007, 10 945 patients were treated, 12.3% more than in 2006. Patients suffering from sequelae of physical trauma and injuries sustained during military incursions accounted for 25.3% of the total patients.

Radiology services

19. Fourteen radiology units operate in the occupied Palestinian territory (nine in the West Bank and five in the Gaza Strip) for patients referred from UNRWA health centres. This service is complemented by contractual agreements with hospitals and private radiology clinics. During 2007, a total of 60 510 plain X-radiographs were performed, 31 369 in the Gaza Strip and 29 141 in the West Bank.

Environmental health

20. UNRWA's environmental health services, employing 20 engineers and 340 sanitary workers, continued to be focused on maintaining acceptable standards of solid-waste management, provision of safe water and sanitation in refugee camps. In 2007, 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. The Environmental Health Division maintained all camps' sewerage systems in operational condition through regular sanitary inspections and clearing of sewer manholes.

Community mental health programme

21. Post-traumatic stress and other psychological and behavioural disorders, a documented consequence of exposure to traumatic events,¹ are an emerging health priority for Palestinian refugees. The chronically harsh living conditions coupled with long-term political instability, violence and uncertainty are taking their toll, in particular on children and adolescents in the occupied Palestinian territory. The increase in violence since September 2000 has brought destruction and demolition of homes, siege, closures, curfews and spiralling poverty among the civilian population. The separation barrier has divided families and limited access to schools, work and basic services, contributing to the decline of mental health notably among Palestinian youth.²

22. 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 territory and provided a range of services aimed at promoting the

¹ Qouta S, El Sarraj E. 'Prevalence of PTSD among Palestinian children in Gaza Strip'. *Arabpsynet Journal* 2004.

² Giacaman R, Saab H, Nguyen-Gillman V, Naser G. *Palestinian adolescents coping with trauma*. Birzeit University, 2004, pp 1-89.

development of constructive coping mechanisms for refugees in crisis situations and preventing long-term psychological consequences.

Food supplementation programme

23. UNRWA's food aid programme benefits pregnant women and nursing mothers attending pre-natal preventive health care and supervision at UNRWA's primary health care facilities. Entirely supported through in-kind contributions, the programme aims to meet the additional physiological nutritional needs of women of reproductive age and prevent nutritional deficiencies associated with high fertility and short birth intervals. In 2007, UNRWA provided food aid to more than 50 000 beneficiaries (36 000 in the Gaza Strip and 15 000 in West Bank).

EPIDEMIOLOGICAL SITUATION

24. When UNRWA began operations in 1950, the health status of the refugee population was extremely poor. The refugees suffered high infant mortality, high prevalence of malnutrition, and high morbidity and mortality from communicable diseases such as malaria, gastroenteritis, tuberculosis, trachoma and venereal diseases with severe levels of illness and mortality. Environmental health conditions were appalling with most refugees living in tents or communal barracks. Water was collected from public distribution points, and communal toilets and bath houses were the only sanitation facilities. The Figure shows the subsequent evolution of the UNRWA's health programme.

Communicable diseases

25. An expanded programme of immunization was introduced in mother-and-child health clinics in 1954 to provide refugees with protection against diphtheria, tetanus and pertussis, smallpox, tuberculosis and enteric fevers, and mass immunization campaigns began for school-age and pre-school-age children. Over the years, UNRWA has introduced other vaccines, namely those against poliomyelitis, hepatitis B and the combined vaccine against measles, mumps and rubella. As a result of the improved hygiene in the occupied Palestinian territory since the 1960s and the Agency's pioneering work in introducing childhood vaccinations, morbidity and mortality related to communicable diseases have decreased. High vaccination coverage has been achieved among the Palestinian refugee population in the occupied territory and today vaccine-preventable diseases are well under control.

26. In 2007 vaccination coverage rates for infants 12 months of age was 100% in the Gaza Strip and 99.6% in the West Bank, and the respective coverage rates for children aged 18 months receiving booster doses were 98.4% and 99.3%. No case of poliomyelitis, acute flaccid paralysis, cholera, tetanus, diphtheria, or pertussis was reported among the refugee population, and no outbreaks occurred.

27. Communicable diseases, such as tuberculosis and HIV/AIDS, have a low incidence (only 10 cases of tuberculosis from the Gaza Strip and three from the West Bank were detected in 2007), but infections associated with poor environmental health, such as viral hepatitis and enteric fevers, are still a public health threat, reflecting endemicity patterns observed in the region.

28. The incidence of typhoid fever and bloody diarrhoea increased in the Gaza Strip compared to 2005, but such an increase was not observed in the West Bank. This finding could be an early indicator of deteriorating hygienic conditions in spite of UNRWA interventions.

29. Brucellosis is an endemic zoonosis in Mediterranean countries, especially in rural communities. The incidence of brucellosis among UNRWA refugees continued to be low in 2007 with 1.8 cases/100 000 in the West Bank and 0.4 in the Gaza Strip.

Noncommunicable diseases

Diabetes and hypertension

30. There has been a growing awareness of noncommunicable diseases in the refugee population and current epidemiological trends project an increasing disease burden in future years. UNRWA will have to face the socioeconomic consequences of the growing prevalence of invalidity related to noncommunicable diseases and of the economic burden posed by the growing number of chronic patients requiring medical care.

31. By the end of 2007, a total of 70 786 patients with diabetes and/or hypertension were under care in the UNRWA health centres in the occupied Palestinian territory (44 675 in the Gaza Strip and 26 111 in the West Bank).

Micronutrient deficiencies

32. Micronutrient deficiencies, especially iron deficiency anaemia and vitamin A deficiency, remain severe public health problems and are most probably due to several causes combined. Nutritional deficiencies related to a combination of poor intake, linked to 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 throughout the occupied territory. However, high concentrations of methaemoglobin, due to toxic environmental pollutants such as nitrates,¹ and conditions such as thalassaemia² have been invoked as causes of the observed high prevalence of anaemia, especially in closed and hardship-stricken communities such as in the Gaza Strip.

33. The latest UNRWA survey (in 2006) on the prevalence of anaemia among Palestinian refugees in the occupied Palestinian territory revealed that prevalence of anaemia among children aged 6–36 months was 57.5% in the Gaza Strip and 37.1% in the West Bank, and among pregnant women 44.9% and 31.1%, respectively. In the WHO Region of the Eastern Mediterranean, nutritional anaemia is a moderate public health problem (with a prevalence of 20.0% to 39.9%);³ however, the situation is particularly worrisome in the Gaza Strip where, in both studied population groups, anaemia is a severe public health problem. Observed prevalence rates in the Gaza Strip and West Bank are extremely different, as would be expected from the different socioeconomic conditions in the two territories.

¹ Abu Naser AA, Ghbn N, Khoudary R. Relation of nitrate contamination of groundwater with methaemoglobin level among infants in Gaza. *Revue de Santé de la Méditerranée Orientale*. 2007, 13(5):994–1004.

² Sirdah M, Bilto YY, el Jabour S, Najjar K. Screening secondary school students in the Gaza Strip for beta-thalassaemia trait. *Clin. Lab. Haematol*. 1998, 20(5):279–283.

³ McLean E, Egli I, Cogswell M, de Benoist B, Wojdyla 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.

Mental health

34. During 2007 counsellors conducted a total of 21 205 mental health education sessions reaching almost 300 000 beneficiaries. They held parental meetings and undertook other activities for more than 400 000 beneficiaries. The aim is to raise awareness and build resilience to the psychosocial consequences of chronic emergency and traumatic experiences.

35. Over the past year the counsellors conducted 24 160 individual counselling sessions and 10 159 group sessions (for a total of 32 105 beneficiaries) in the occupied Palestinian territory. Through 3780 home visits they reached 8953 beneficiaries. The most common disorders observed in 2007 were aggressive behaviour and lack of motivation. The programme has also developed community interventions covering both the clients' regular needs and emergency interventions.

36. The situation is particularly severe in the Gaza Strip where a quarter of the population is estimated to be affected by symptoms of psychological disorders requiring intervention as a consequence of trauma.¹ Among children the prevalence of symptoms qualifying post-traumatic stress disorder after major traumatic experiences is high (68% of exposed students after the El-Bureij explosion in February 2008) and resistance to treatment is emerging. The mean number of sessions required before improvement or recovery increased from 3.17 at the beginning of the programme to 6.7 in July 2007. Subjects need prolonged follow-up and families are manifesting greater difficulties in restraining their children.

POLITICAL AND SOCIOECONOMIC SITUATION IN THE OCCUPIED PALESTINIAN TERRITORY

Impact on the health of refugees

37. Since 2000 there has been a near collapse of the Palestinian economy, rising unemployment, increased poverty and reduced commercial activities² especially among refugees. Residents have been experiencing a phase of extensive, prolonged and continuing humanitarian crisis, with widespread poverty and a high prevalence of extreme poverty.³

38. UNRWA's report in November 2007 on socioeconomic developments⁴ records the sharp economic regression in the occupied Palestinian territory, with a drop in per capita gross domestic product of 30% in the past seven years. In the private sector, which accounts for 54% of employment in the Gaza Strip, movement restrictions contributed to the detectable reductions in construction (12.9%) and manufacturing businesses (6.8%).⁵ The decline in the Gaza Strip is partly explained by

¹ Zaqout I. Enhancing resilience in Refugee Population in the Gaza Strip, chronically stressed population. A report of the UNRWA Mental Health programme in the Gaza Strip. Amman, UNRWA, 2008.

² UNRWA Health Department. Impact of the humanitarian crisis in the occupied Palestinian territory on people and services, Amman 2003.

³ UNDP. Poverty in the occupied Palestinian territory 2007. Development Times, Issue No. 1, July 2007.

⁴ UNRWA, 2007. *Prolonged crisis in the occupied Palestinian territory: recent socio-economic developments* (Report No. 2). Gaza, Palestine: United Nations Relief and Works Agency, November 2007.

⁵ UNRWA. Prolonged crisis in the occupied Palestinian territory: recent socio-economic developments, 2007. Resource available on web <http://www.un.org/unrwa/publications/pubs07.html>.

the fact that most commercial activities are export driven and depend on Israel for raw materials. At present, unemployment in the Gaza Strip is close to 40% and expected to rise.¹

39. By mid-2006 poverty levels had increased by 30% overall, and in the Gaza Strip nearly 80% of the refugee population was living in conditions of extreme poverty, a 54 % increase compared with 2005.² In 2007, on average, households were spending some 62% of their total income on food compared with 37% in 2004. In response to this situation, UNRWA increased its food aid to meet the needs of this increasingly impoverished population. The number of families depending on UNRWA food aid has increased 10-fold in the last 10 years; today more than one million people – some three-quarters of Gaza's population – depend on food aid.

40. The humanitarian assistance provided so far has fallen short of what is needed to relieve poverty. In 2006, the value of assistance provided by UNRWA to poor refugees in the occupied Palestinian territory was around US\$ 100 million. Data indicate that an additional US\$ 484 million in humanitarian assistance would have been required to eliminate poverty in refugee households.³

41. 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 household income and lowering people's ability, productivity and quality of life.⁴ The increased need for health care observed today, in particular among residents of the Gaza Strip, is the consequence of a decreasing social and economic resilience that has led a growing, vulnerable refugee population to an almost complete dependency on humanitarian assistance.

42. Conflict presents additional hazards to health, not just through injury, death and disability, but also by increasing physical displacement, existing inequalities, discrimination and marginalization, and by preventing access to health services. Constant exposure to life-threatening situations in a setting of conflict is an additional, specific social determinant of health, promoting the progression from stress, through distress, to disease.⁵

43. Restrictions on movement in the occupied Palestinian territory remain a complex problem for the resident population. Difficult access to health care contributes to the continuing deterioration of the health status of Palestinian people. The United Nations Office for the Coordination of Humanitarian Affairs and WFP maintain that the closure system is the main cause of the humanitarian crisis in the occupied territory; it restricts Palestinian access to basic services, such as health and education, and separates communities from their land and places of work.

¹ The Gaza Strip: a humanitarian implosion - a report issued by Catholic Agency for Overseas Development, Amnesty International, CARE International UK, Christian Aid, Médecins du Monde UK, Oxfam, Save the Children UK and Trocaire, March 2008. Available at <http://i.l.cnn.net/cnn/2008/images/03/06/gaza.implosion.pdf>, accessed on the 25 March 2008.

² UNRWA. UNRWA in 2006, in *Official Report of United Nations Relief and Work Agency for Palestine Refugees in the Near East*, 2006. Resource available on web <http://www.un.org/unrwa/publications/pubs07.html>.

³ UNRWA: 'Emergency Appeal 2008' resource available on web <http://www.un.org/unrwa/publications/pubs07.html>.

⁴ UNRWA Health Programme Five Year Strategy 2008–2012. Amman, UNRWA Health Department, 2008.

⁵ Watts S, Siddiqi S, Shukrallah A, Karim K, Serag H. Social determinants of health in countries in conflict: the Eastern Mediterranean perspective, Draft Version 2. Health Policy and Planning Unit, Division of Health Systems, Cairo, WHO Regional Office for the Eastern Mediterranean, June 2007.

44. Problems faced by the refugees differ according to the different types of limitations imposed on the movement of people and goods in the Gaza Strip and the West Bank. Both UNRWA and WHO have repeatedly expressed concern about the consequences that the strict closure policy imposed on the Gaza Strip will have on the health of the population living there and on their right to enjoy the highest attainable standard of health. The conditions are extremely volatile and imposition of complete closure result in severe consequences for the resident population, as happened in January 2008. On that occasion the power plant, the pumps at water wells and the wastewater-management plants stopped functioning owing to fuel shortage, many houses remained without water and there was an increased risk of wastewater floods. UNRWA's environmental health routine activities were hindered, representing yet another threat to the health of the Palestinian refugees.

45. Service provision in UNRWA's primary health care centres has not been affected by fuel shortage; however, conservative measures have been implemented to minimize consumption during the crisis. On the other hand, UNRWA is ensuring hospital care by referring refugee patients to hospitals run by the ministry of health and private or charitable organizations. Any relevant obstruction to secondary service delivery will inevitably affect the refugees who cannot access alternative health-care providers.

46. The failing health system in the Gaza Strip is cause of concern also because of its indirect implications for the Agency. The reported discontinuation of diagnostic and curative services in almost half the health ministry's centres for primary health care and the difficulties in maintaining stocks of viable medicines, vaccines and other medical supplies due to discontinuity in refrigeration and the uncertainty of transportation of goods are limiting access to health care for Gaza residents, 70% of whom are refugees. The implication is an increased burden on UNRWA, as it is the main international organization delivering health services in the Gaza Strip.

47. Tertiary health care services are available only outside the Gaza Strip. The frequent closure of borders has made seeking high-level specialized health care increasingly difficult for Gaza patients. According to WHO, the proportion of patients given permits to exit the Gaza Strip for medical care decreased from 89.3% in January 2007 to 64.3% in December 2007, an unprecedented low figure. It is important to note that even those patients who are granted permits are often denied access at the crossing itself; 27 such cases were reported in the month of October alone. *De facto* a referral system can no longer be ensured for Palestinian refugees. Palestinian patients with urgent life-threatening conditions or in urgent need of care are particularly vulnerable¹ and WHO's system for monitoring access of patients to specialized health services not available within the Gaza Strip confirmed 20 deaths (including five in children) due to lack of access to referral services between October and December 2007.

48. In the West Bank, the closure regime continues to impede access to workplaces, markets and health and education services. The number of physical obstacles, including checkpoints, increased from 528 to 563 between January and September 2007.² At least half a million people live within one kilometre of either side of the barrier and passage into East Jerusalem is especially problematic with one quarter of its 230 000 inhabitants living east of the separation barrier. Only four entry points into the city are currently available for West Bank Palestinians carrying appropriate permits. The

¹ UNRWA. Health situation in Gaza. United Nations Relief and Work Agency for Palestine Refugees in the Near East Report, 21 January 2008.

² Office for the Coordination of Humanitarian Affairs. West Bank closure count and analysis occupied Palestinian Territory, September 2006.

movement restrictions caused by the closure system in general and the separation barrier in particular have significantly limited UNRWA's ability to provide humanitarian and health assistance to the refugee community in the West Bank.

Impact on UNRWA's operations

49. Difficulties in the movement of staff and goods and increases in procurement prices of goods including medicines and food commodities are two of the main issues challenging UNRWA's health programme today, alongside the complication of logistics and consequent increases in operational costs stemming from the closure policy in the occupied Palestinian territory. In 2007, UNRWA incurred estimated additional costs of US\$ 2.04 million due to access restrictions, transit fees, storage, demurrage and palletization costs.

50. UNRWA's health budget for 2007 was just over US\$ 113 million (with US\$ 73 425 885 for the Gaza Strip and US\$ 39 713 102 for the West Bank). Because of financial constraints, the Agency was not able to reimburse costs for all deliveries, including low-risk ones, taking place in hospitals or to pay for life-saving treatments, such as dialysis. The cost of medicines has increased by 20% in the past year, also thereby limiting the Programme's purchasing power.

51. 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.

52. Consignments of essential medicines and consumables have been delayed at the borders of the Gaza Strip. Alternative solutions through Kerem Shalom (UNRWA and WHO) have been sought but long-term guarantees on the continuity of access to medical supplies need to be found. Although completed in 2007, the health centres in Tal Sultan-Rafah and Khan Younis cannot function because of the lack of authorizations to import equipment and furniture and reconstruction of the health centre at Jabalia was frozen owing to lack of building materials.

53. Increased demands for searches of United Nations vehicles and requirements that United Nations staff go through heavy security checks in order to enter areas in the area between the separation wall and the Green Line (the "seam zone") are creating major operational difficulties, leading to delays, higher costs and reduced outreach, ultimately limiting agencies' ability to meet the needs of increasingly vulnerable communities. Since September 2007, new search regulations were established at Reikhan terminal to access the Barta'a community, which is isolated by the West Bank barrier (Jenin Governorate). As a result, UNRWA mobile health teams have been unable, since early September 2007, to conduct twice-weekly visits to patients. Before then, difficulties accessing this community had already increased with UNRWA health teams often prevented from passing through checkpoints to reach communities in need. Difficulties in accessing Jerusalem increased three-fold at the beginning of 2008, with requests for vehicle searches and demands to inspect national passports of UNRWA international employees a constant feature.

54. Access restrictions in the West Bank involve patients and UNRWA staff members alike. In 2007, a total of 348 UNRWA health staff members were denied or delayed access to their work place, mostly owing to closures. The total amount of time lost reached 272 hours, corresponding to 42 person-days (one person-day amounts to 6.5 hours for medical personnel), and 13% of the employees in the West Bank were affected. On 11 August 2007, three UNRWA staff members were roughed up, kicked and beaten by Israeli Defence Force soldiers for no apparent reason while trying to pass through a checkpoint at Nablus.

55. Many of the aforementioned restrictions on access, particularly in relation to demands to search United Nations vehicles, are inconsistent with the 1946 Convention on the Privileges and Immunities of the United Nations and the 1967 Comay-Micheltmore Agreement between Israel and UNRWA, by which the Government of Israel is obliged to “facilitate the task of UNRWA to the best of its ability, subject only to regulations or arrangements which may be necessitated by considerations of military security”.

56. Movement of UNRWA staff across the West Bank and transport of UNRWA goods into occupied West Bank from Israel are likely to become even more problematic. Since July 2007, the statements of Israeli Authorities indicated that “full security checks” similar to those in place in Erez would be required for all UNRWA staff travelling to the seam zone, and that these checks could be extended to the crossing points into Jerusalem (including East Jerusalem). There were also suggestions from the authorities that the number of crossing points for goods into the West Bank would be reduced, and that a “back-to-back” system for goods transfer would be imposed. If these new restrictions had been implemented, UNRWA and other humanitarian organizations would have suffered unprecedented logistical and financial consequences and a loss of control over the logistic supply chain. By the end of 2007, however, the tightened regime had not been put into place.

57. The ability of UNRWA staff to enter operational areas remained contingent on an unpredictable “security clearance” system that disregards the privileges and immunities of United Nations staff. 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. “Total closures” were imposed by the Israeli Authorities for 91 days in 2006 and 45 days in 2007.

LOOKING AHEAD

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

59. The health programme has been contributing to the welfare and human development of four generations of Palestinian 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.

60. The increased awareness of morbidity due to noncommunicable diseases has implications for the sustainability of the Agency because of the higher cost and duration of treatments. Moreover, the need to face up to the double burden of communicable and noncommunicable diseases remains one of the major challenges to UNRWA.¹

61. The nutritional status, particularly of vulnerable groups among the refugees such as people living in extreme poverty, pregnant women, children and isolated rural communities, has to be

¹ UNRWA. Annual Report of the Department of Health. Amman, UNRWA Health Department, 2006.

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 need.¹

62. Significant changes in the access of Palestinian refugees to high-quality care both inside and outside the occupied Palestinian territory are not foreseeable in the near future. The increasing use of UNRWA's medical services coupled with the prospect of a long-term commitment to the refugees has led the Agency to prioritize interventions, reorganize services and increase internal efficiency in order to maintain a good quality of care.

63. Compensation mechanisms were put in place to limit the consequences of movement restrictions in the occupied Palestinian territory on patients, access of staff members to UNRWA duty stations, and provision of medical supplies. During 2007, emergency programme support staff was employed to meet the increased demand on the medical care services or to replace members of staff who were unable to reach duty stations, in both the Gaza Strip and the West Bank. Furthermore, additional medical supplies were made available to meet patients' needs and maintain a reserve sufficient for two months in each health centre in order to avoid immediate disruption of stocks following closures. Three hospitals were contracted in the West Bank to overcome problems of access to Agency-contracted hospitals, including hospitals in East Jerusalem.

64. UNRWA maintained close collaboration with the Palestinian Authority and other organizations in the United Nations system for preparation of the Consolidated Appeal Process and the medium-term development plan, and is intensifying its links with WHO (through the programme for Health action in crises) and other local partners for strengthening technical cooperation in priority and commonly defined areas including nutrition, mental health, expanded programme of immunization, food safety and advocacy.

65. Notwithstanding the difficulties it faces, the Agency cannot step away from unmet high-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 next years in view of the growing poverty and social segregation of the Palestinian refugees in the occupied territory. Moreover, early detection and management of cancers will become a future challenge as the major share of the effort will fall on the health care system² as will the expected increase in demand for physical rehabilitation services.

66. A major consequence of the current crisis in the occupied Palestinian territory is the gradual diversion of international support to the Palestinian people from development assistance to emergency response. This change was inevitable in conditions of an economy in near collapse, 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.

67. The nature of the health programme, however, is to guarantee continuity of assistance to beneficiaries. There is a 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 that has led to a constant renegotiation and prioritization of activities to cope with budget constraints.

¹ UNRWA. Prevalence of anaemia among Palestine refugee pregnant women and children 6–36 months of age in the Gaza Strip and West Bank. Amman, UNRWA Health Department, 2006.

² UNRWA. Annual Report of the Department of Health. Amman, UNRWA Health Department, 2006.

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

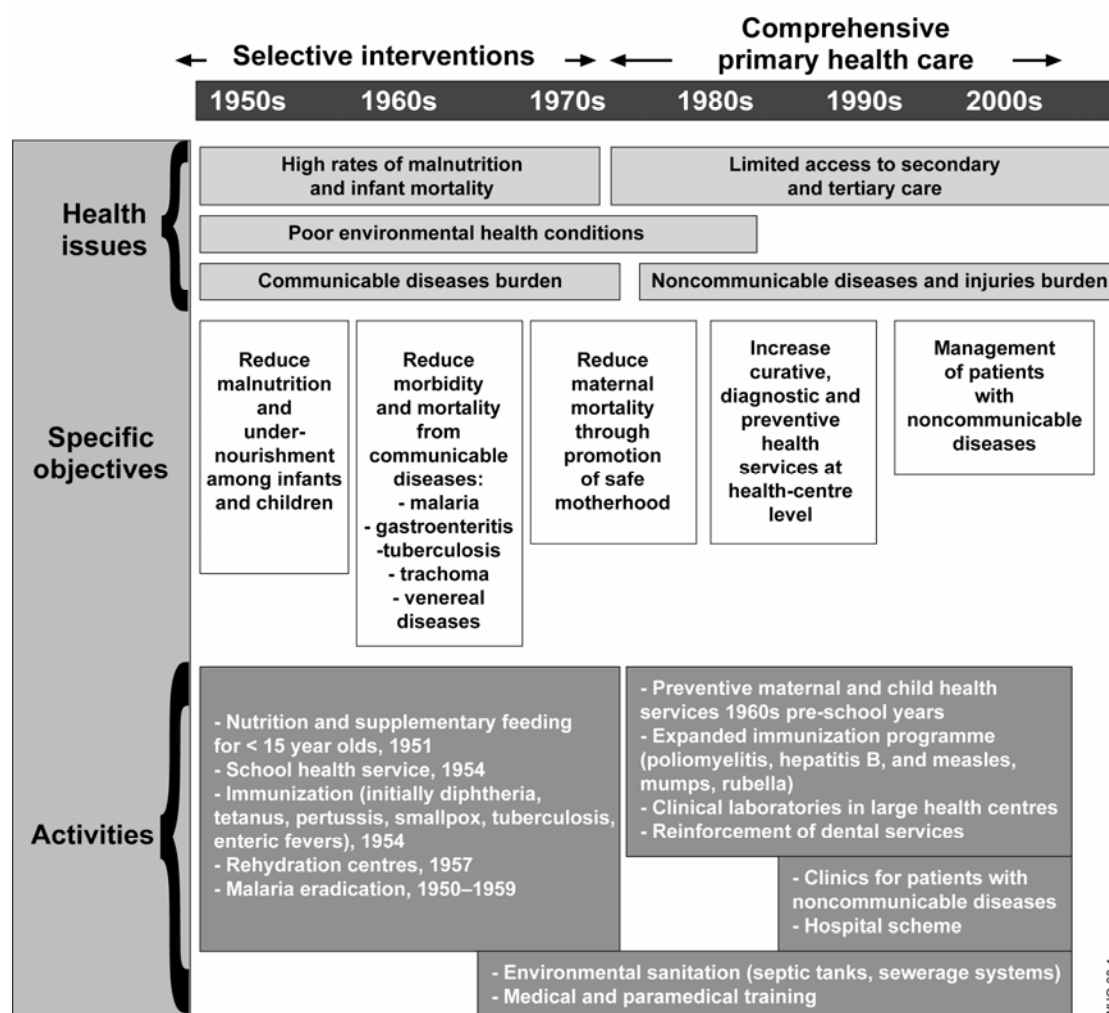
CONCLUSIONS

69. Given the utmost importance of health as a fundamental human right indispensable for the exercise of other human rights, it is crucially important for all stakeholders to exert every effort to ensure access to health care for Palestinian refugees in the occupied territory. To achieve this, access to duty stations as well as to isolated communities must be guaranteed to all UNRWA staff and goods.

70. It is necessary to stress the need for all parties to recognize UNRWA as an impartial aid agency and to respect the privileges and immunities of United Nations staff. The security of all UNRWA's personnel must be unconditionally guaranteed at all times. UNRWA's humanitarian action must be acknowledged as independent, with full and secure access of diplomatic and humanitarian personnel allowed, as required under international humanitarian law.

71. For UNRWA to continue to respond to the seemingly unending humanitarian emergency in the occupied Palestinian territory, it is vital for the international community to renew its support to the Agency. A 20% increase in funding is necessary to sustain the existing activities of UNRWA's health programme, overcome the current logistic difficulties, face the rising cost of supplies, and adjust services to meet the growing needs of the refugees.

Figure. Evolution of the UNRWA health programme from the 1950s to the present day



WHO 08.4

Table 1. Social and health indicators for the population served by UNRWA in the occupied Palestinian territory¹ and ministry of health data for Israel as well as selected countries of the WHO Eastern Mediterranean Region

Country/territory/served population	Year	Percentage of the population aged 0–14 years	Fertility rate	Infant mortality rate/1000 live births
Palestinian Authority*	2000–2005	46.3	5.57	18
West Bank (UNRWA)	2003–2006	33.8	3.1	15.3
Gaza Strip (UNRWA)	2003–2006	40.1	4.6	25.2
Israel	2000–2005	28.35	2.85	5
Syrian Arab Republic	2000–2005	39.5	3.47	16
Jordan	2000–2005	37.1	3.53	19
Lebanon	2000–2005	27.3	2.32	22

* Ministry of Health

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¹ UNRWA. Annual Report of the Department of Health. Amman, UNRWA Health Department, 2006.