# Long and Healthy Lives

## The Life Cycle Approach to Health

UNRWA commemorates **60** years

# protecting & preserving the health of Palestine refugees

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# Foreword

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As UNRWA approaches its 60th year, we have an opportunity to look back at what has been accomplished by our efforts in the arena of health.

Today, most Palestine refugees continue to live under harsh socio-economic conditions, where exposure to a violent environment and unequal access to health care are a common feature. In this context, the long standing commitment of UNRWA to protect, preserve and promote the health of Palestine refugees has made a difference. UNRWA’s health programme has delivered comprehensive primary care, while the Agency’s education and relief programmes have mitigated the impact on the refugee population of a decline in the social determinants of health.

We commemorate the 60 years of UNRWA with a mixture of sadness and pride. Sadness, that the human tragedy that has afflicted generations of Palestine refugees sees no signs of ending; yet, also pride in our enduring efforts to buffer the effect of that tragedy on their health. The year 2009 started with an Israeli military operation in the Gaza Strip. Although affected by the conflict, UNRWA demonstrated its commitment to providing much-needed health services, even in the darkest hours.

The strong commitment of UNRWA's staff and the vision of its leaders have shaped what the Agency is today. In health, this has meant a move from a pure emergency and relief orientation to a comprehensive primary health care approach that embraces the "life cycle" of refugees. The new approach is the inheritance of the health directors that preceded me: Dr J.S. McKenzie Pollock until 1961, Dr S. Flache until 1963, Dr M. Sharif until 1974, Dr J.H. Puyet until 1979, Dr G. Meilland until 1981, Dr M.K. Muzayyin in 1992, Dr H.J. Hiddlestone until 1988, Dr R. Cook until 1992, Dr M. Abdelmoumene until 1996 and Dr F. Mousa until 2006. It is a privilege for me to acknowledge the work of these individuals.

In this document, we track the journey of UNRWA's health programme from its earliest form to the comprehensive set of services that currently exists. We will not only show how our beneficiaries' health status has improved, but also highlight the old and new threats still faced by Palestine refugees.

I am confident this document will be a testimony of the strength of this UN Agency, its endurance in time and its capacity to meet the changing needs of Palestine refugees.

”

**Dr Guido Sabatinelli**
*Director of the UNRWA Health Programme*

# Refugee Health

"Health is a right, not a privilege"

## THEN....

When on the 1st of May 1950, the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) began its operations, the health status of the 750,000 Palestinians under its care was extremely poor. Conditions of overcrowding and low hygiene in camps favoured the transmission of air and water-borne infections. Reducing the malnutrition and under-nourishment affecting infants and children was a major priority. With the launch of its supplementary feeding programme, UNRWA began to provide fresh midday meals to children, as well as monthly dry rations, milk and cod liver oil. One of UNRWA's key innovations in the field was the introduction in 1957 of Najjar salts, a special oral rehydration formula for the treatment of dehydrated diarrheic infants. In later years, this treatment was adopted and used extensively by UNICEF.

One particularly difficult challenge faced by UNRWA was the fight against communicable diseases. In the 1950s, UNRWA introduced immunization both routinely and in its promotion of mass immunization campaigns. The presence of malaria in the Jordan Valley was also eradicated. Combined with a dramatic improvement in living conditions, these interventions have precipitated a steady decline in mortality rates in the camps.

## .... AND NOW

Today, a rapidly growing population of 4.7 million Palestine refugees is assisted by UNRWA in Jordan, Lebanon, Syria, the West Bank and the Gaza Strip. As the life expectancy of this population increases, its demography has changed. Almost 40 per cent of the refugees are under 18 years of age, and there is a growing elderly population. These developments place an economic burden on families that is aggravated by the problems of generalized poverty and unemployment. This is particularly acute in the Gaza Strip, where almost 90 per cent of refugees are either younger than 15, or older than 65 years.

The indicators of achievement for refugees in relation to the Millenium Development Goals for health closely resemble those of their host countries. However, in the Gaza Strip, infant and maternal mortality is comparatively higher, and general life expectancy lower than in the West Bank. While communicable diseases, so prevalent in the early years of UNRWA's activities, are now under control, new diseases such as diabetes, hypertension and obesity are emerging as a significant threat to the ability of refugees to live long and healthy lives.

# Goals and Policies

"Health is the key to human development and human security"

There can be no human development without good health. Health affects an individual's productivity, their income and their standard of living. It also influences the socio-economic state of households, having an effect on levels of education and, ultimately, on social mobility.

Palestine refugees are a socially disadvantaged group whose lives have been conditioned for generations by social, political and economic forces well beyond their control. These refugees are currently the victims of health inequality simply because they are Palestine refugees. UNRWA's effort to provide the best possible health care to Palestine refugees is part of the greater joint mission of the UN and national governments to address the social determinants of health and to achieve health equity. UNRWA's network of primary health care facilities and mobile clinics provides the foundation of its health assistance to refugees, offering preventive, general medicine and specialist care services tailored for each stage of life.

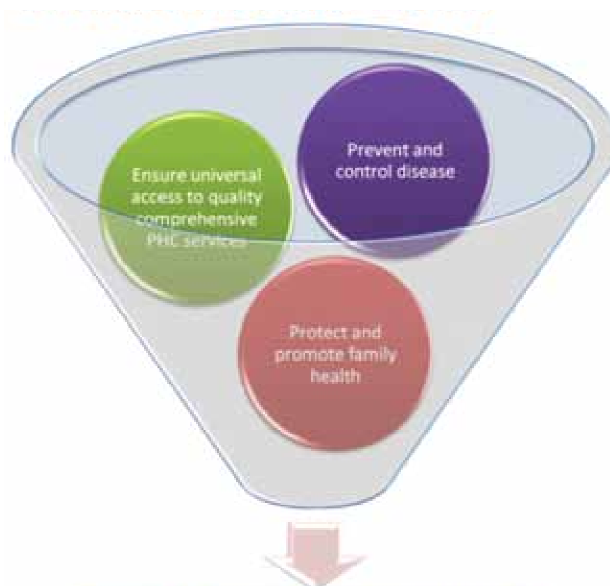
Health, however, is not only health care provision. This is why the scope of UNRWA's work reaches beyond the immediate treatment of disease to the provision of a 'social safety net', encompassing education, food assistance, job creation programmes and micro credit schemes.

Guided by the Millennium Development Goals on health and by the standards of the World Health Organisation (WHO), UNRWA delivers basic health services and is responsible for contributing to a healthy living environment for Palestine refugees. One of UNRWA's four overarching human development goals is to enable refugees to live long and healthy lives. Under this goal UNRWA has three strategic objectives for the medium term:

- To ensure universal access to quality comprehensive services;
- To prevent and control disease;
- To protect and promote family health;

While its long-term commitment to its beneficiaries is as strong as ever, today the Agency faces serious challenges.

The combination of rapid population growth, increased demand for services, the changing nature of primary health care and growing financial constraints has served to overstretch UNRWA's health programme. The result is the undermining of the Agency's capacity to buffer the effects of a harsh socio-economic environment on the health of its beneficiaries.




**Enable Palestine refugees to live a long and healthy life**

# From Emergency to Development

"UNRWA has delivered health care to Palestine refugees in an environment of conflict and socio-economic hardship for 60 years"

UNRWA began its operations in 1950, in a post-conflict situation. Since then, a chronically volatile security context in many of its areas of activity has obliged the Agency to balance emergency relief with human development. UNRWA's aim is to guarantee the continuity of its services through situations of occupation and closure, as well as during full blown conflicts.

Over the years, the living conditions of Palestine refugees have evolved according to their socio-economic and legal status in each host country and their level of access to governmental health care services. In each field of operation, refugees have diverse health needs that UNRWA strives to meet.

**Lebanon** currently hosts over 400,000 Palestine refugees, of whom over 50 per cent live in refugee camps. Refugees in Lebanon are ineligible for the state's social services, including health care, and are exposed to recurrent episodes of violence. The employment restrictions faced by refugees, combined with the high cost of obtaining work permits, account for their protracted financial dependence. Access to health care for these individuals is restricted to UNRWA, international organizations and the private sector, with the latter demanding high fees for its services. Uniquely in this field, UNRWA has made agreements with Palestinian Red Crescent Society hospitals in order to guarantee equity for Palestine refugees in access to secondary health care. In all other fields, a reimbursement scheme is in place for secondary and tertiary care.

**Jordan** hosts nearly 2 million Palestine refugees, most of whom have been granted citizenship based on criteria such as their place of origin and year of arrival in the country. Whilst they remain a potentially fragile sector of the population, Palestine refugees have been allowed to enter the labour market, can access the country's health services, and enjoy considerable social mobility. Those who emigrated from the Gaza Strip during or after the 1967 conflict, however, face restrictions on their access to higher education and jobs. They are therefore the most vulnerable group. In **Syria**, almost 500,000 Palestine refugees have full access to government services, including health care, to the labour market and have almost the same legal protection as Syrian citizens although they are not granted citizenship.

Almost 2 million Palestine refugees reside in the **West Bank** and the **Gaza Strip**. This population in particular suffers from the long-term effects of socio-economic hardship. This is due in large part to the current closure regime which effectively restricts the movement of people and goods in and around the areas. The fragmentation of the West Bank through settlements and military installations is generating disparity in public access to healthcare, making access to these services in East Jerusalem from other parts of the West Bank increasingly difficult for Palestine refugees. In the Gaza Strip, a blockade continues to impair critically the supply of essential medical goods, delaying reconstruction and hindering patient referral. Conflict and severe poverty are further undermining the determinants of health, and a growing epidemiological divide is emerging among Palestine refugees in the occupied Palestinian territory (oPt). Those living in the Gaza Strip are experiencing worsening health conditions, despite the fact that they have access to the health services of both the local authorities and UNRWA.

# The Life Cycle Approach

> UNRWA addresses the health needs of refugees from preconception to active ageing

A healthy life is a continuum of phases from infancy to old age. Each one of these phases has specific needs for the maintenance of good health. Health care should, therefore, be designed to provide packages of prevention and clinical assistance that are best suited to each phase of an individual's life. It is for this reason that the life cycle approach to health was developed.

Refugees are assisted from preconception to active ageing through curative and preventive health services. These include post-natal follow-up and infant care (growth curve monitoring, medical check-ups and vaccinations), outpatient

Enabling Palestine refugees to live long and healthy lives, from **preconception** to **active ageing**

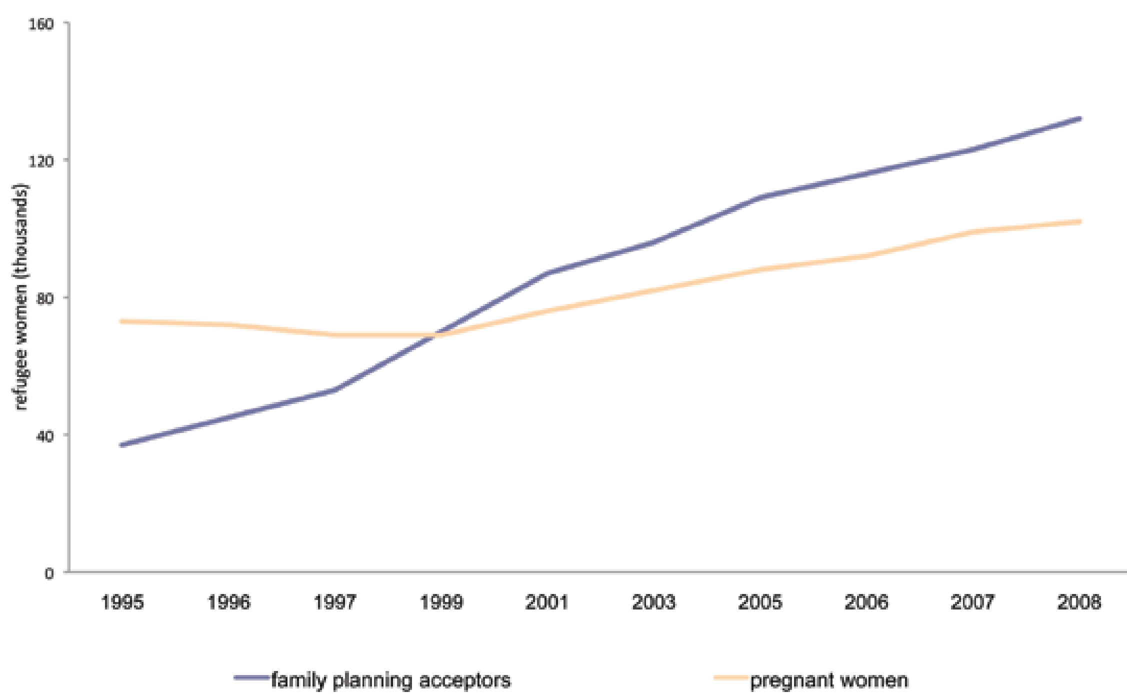
consultations, family planning, antenatal care of pregnant women, oral health. Secondary prevention and management of diabetes and hypertension are provided for refugees over 40 years of age. Control of communicable diseases is achieved in part through high vaccination coverage and in part by the early detection and control of outbreaks through a health centre-based epidemiological surveillance system. The environmental health programme controls the quality of drinking water, provides sanitation and carries out vector and rodent control in refugee camps, thus reducing the risk of epidemics.

# Preconception Care

“UNRWA works to encourage healthy family planning”

Preconception care is widely recognized as a critical component of maternal and child health. It can be broadly defined as the provision of biomedical and behavioural interventions prior to conception, in order to optimize womens' health and the outcomes of pregnancy. Couples receive counseling within UNRWA when planning a pregnancy and are advised to avoid pregnancies that are too frequent, too early or too late through modern family planning methods. In 2008, more than 23,000 new couples were enrolled in the programme, and the total number of continuing users of modern contraceptive methods increased by seven per cent compared with the previous year. With the increased role of family planning, fertility rates among Palestine refugees have steadily decreased (from 4.7 to 3.2) over the past ten years.

**Total number of UNRWA assisted family planning acceptors and pregnant women, 1995-2008**



# Perinatal Care

"In 2008, 96 per cent of all pregnant women assisted by UNRWA delivered in hospital"

Some 4 million neonatal deaths occur throughout the world each year, the majority within the first few days of birth. Research by the WHO suggests that a small number of effectively delivered interventions from before conception to immediately after birth can substantially reduce newborn deaths, particularly in low income communities. Their increasing economic vulnerability and/or limitation to health access are making Palestine refugees more and more dependent on UNRWA as their sole health care provider. This is particularly evident for maternal and child health, and has led to a dramatic increase in the coverage of UNRWA's mother and child health services since the 1990s.

On average, each pregnant woman assisted by UNRWA receives 7.4 antenatal visits. During these check-ups, the risk status of the pregnancy is assessed in order to provide a personalized and appropriate follow-up. Tetanus immunization is carried out, as is screening for gestational diabetes and hypertension. In addition to check-ups, UNRWA meets the increased nutritional needs of pregnant women and nursing mothers, providing dry rations of vegetable oil, rice, sugar and pulses, from the third month of pregnancy until six months after delivery. Pregnant women are also protected against micronutrient deficiencies and are provided with iron supplementation throughout their pregnancy.

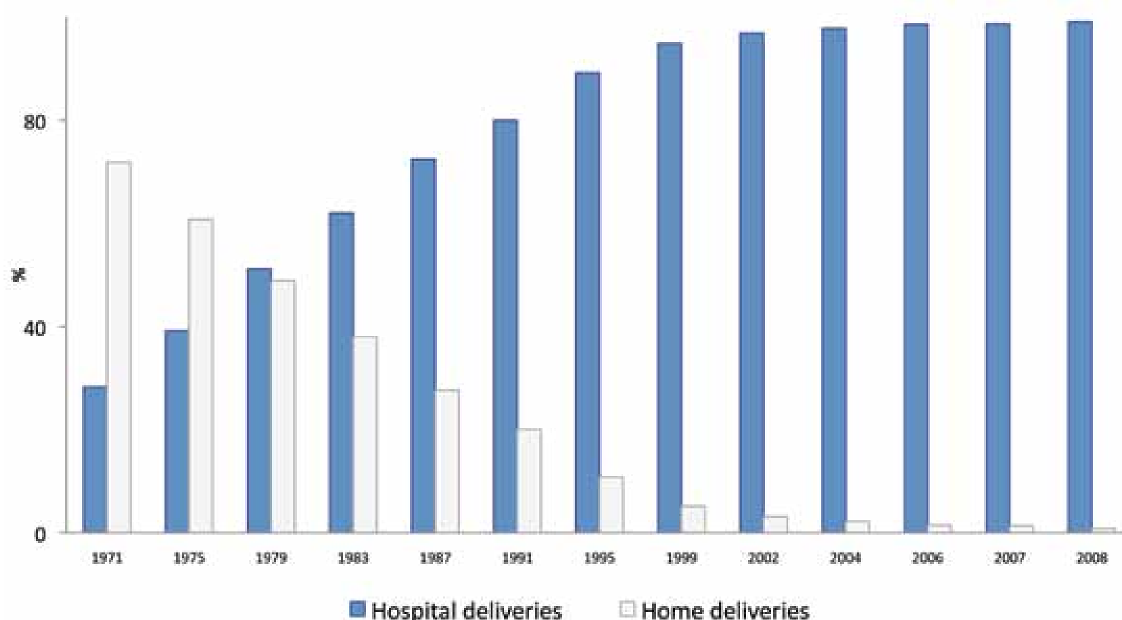
# Safe Motherhood

UNRWA promotes safe motherhood and the prevention of perinatal deaths by subsidizing delivery in hospital for high-risk pregnancies. Mothers and newborns are then followed up after childbirth, either in the UNRWA health facilities or through visits at home. In 2008, almost 90,000 women benefited from UNRWA post-natal care services.

WHO reports that each day worldwide, 1,500 women die due to complications in pregnancy or childbirth, 10,000 babies die who are less than a month old, and an equal number of babies are born dead. Skilled care around the time of birth would greatly reduce the number of these needless deaths.

UNRWA's antenatal care services follow over 80 per cent of the expected pregnancies among the refugee population. Most of these women start their check-ups in the first trimester, enabling doctors to recognize at an early stage complications and risk factors. Of the pregnant women under UNRWA's care, 99 per cent are protected against tetanus and rubella. No cases of tetanus *neo-natorum* and congenital rubella have been reported in the last decade.

**Proportion of hospital deliveries vs home deliveries among refugee women assisted by UNRWA perinatal care services, 1971-2008**



# Infant and Child Health

> "In 2007-2008, UNRWA assisted nearly 2,500 school children with special health needs"

Children represent the future. Ensuring their healthy growth and development ought to be a prime concern of all societies. The particularly fragile health status of a child in the first months of its life, as well as the greater vulnerability of children to malnutrition and infectious diseases compared with other age groups, demands an efficient and competent network of preventive and curative paediatric services. Prevention starts in UNRWA with health education and counseling for mothers on appropriate feeding practices and baby care. Infants and children below 36 months of age receive preventive care at UNRWA health centres, including a thorough medical examination, growth monitoring, immunization* and screening for disabilities. Micronutrient deficiencies are prevented through supplementation of iron, vitamin A and vitamin D.

In 2008, almost 300,000 infants and children benefited from UNRWA's paediatric preventive services. In the same clinics, sick children receive health care from general practitioners, paediatricians and cardiologists. When a child is enrolled in an UNRWA school, a thorough medical examination including immunization and disability screening is carried out. Particular attention is given to diseases and disabilities that can negatively impact the child's learning capacity such as hearing or vision impairment. Oral health, vitamin supplementation and health education are also a priority. Once identified, children with disabilities are assisted towards provision of eyeglasses, hearing aids and other prosthetic devices. During the school year 2007-2008, nearly 2,500 school children with special health needs were identified and assisted medically or provided with prosthetic devices according to their needs.

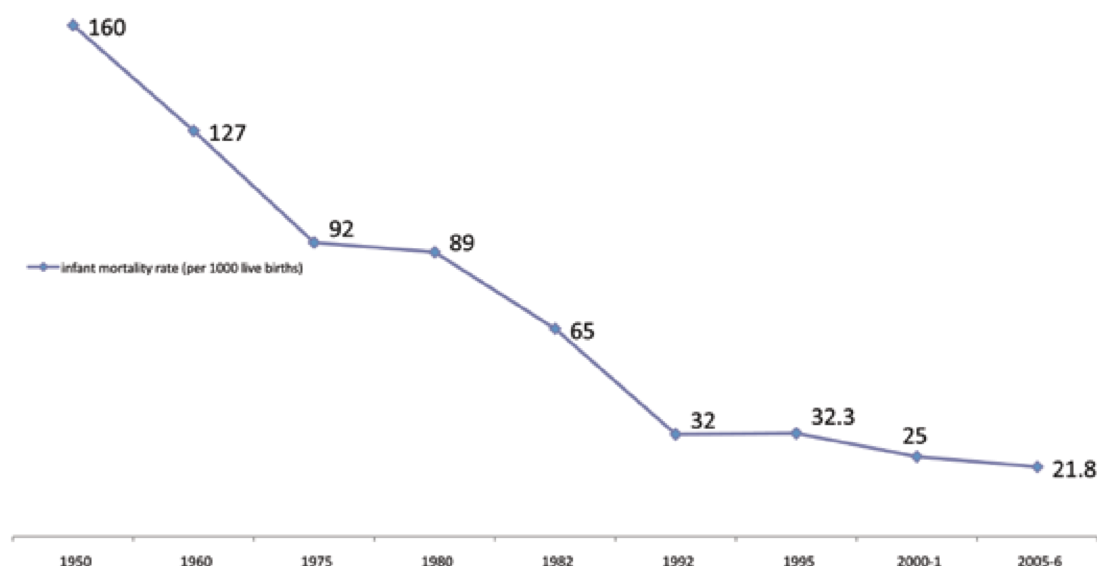
* the full immunization schedule for a refugee includes tetanus, diphtheria, pertussis, TB, measles, rubella, mumps, polio, hepatitis, Hib

# Reducing Infant Mortality: The Millenium Development Goals

In September 2000, the leaders of 189 countries met at the United Nations in New York and endorsed the Millennium Declaration, a formal commitment to build a safer, more prosperous and equitable world. The Declaration was translated into a road map with eight time-bound, measurable goals to be reached by 2015. These are known as the Millennium Development Goals (MDGs), three of which relate to health. The fourth goal aims at reducing child and infant mortality in each country by two-thirds of its 1990 rate.

Today, more than halfway towards the 2015 deadline, infant and child mortality among Palestine refugees is declining steadily. This is a result of an overall improvement in water and sanitation, vaccination coverage of between 98 and 100 per cent, a tight network of surveillance and control of communicable diseases, and the availability of adequate food.

All of the above are conducive to improving the immune status and general health of Palestinian children. Innovative interventions like the introduction of hydrating solutions for treating dehydrated diarrheic infants and the constant provision of high quality services have led to a decrease in the mortality of all age groups. In Lebanon and the oPt, the goal of eradicating infant mortality among Palestine refugees has been met ahead of time, while in Jordan the objective is well within reach. More efforts will be required in Syria.



# Adolescent and Adult Health

> "Adolescence is both a challenge and an opportunity for a long and healthy life"

Adolescence and young adulthood are unique periods in the lifespan of an individual, representing a challenge but also an opportunity to pave the way towards a healthy and productive adult life. Adolescent and adult refugees benefit considerably from the preventive and curative services available in UNRWA clinics. On average, an adolescent or young adult will attend a clinic six times during the year, normally to treat mild upper respiratory tract infections and arthrosis. In 2008, UNRWA staff performed 9.6 million medical consultations. Each of the Agency's health centres provides free diagnostic services, and uses radiology units and laboratories. Moreover, UNRWA has the capacity to provide microbiology services covering the needs of every health centre, either directly or through hospital referral agreements with the host countries. In 2008, over 80,000 X-rays and 4.7 million laboratory tests were performed in UNRWA clinics. Each health centre provides prescribed medication free of charge.

UNRWA does not only provide general medical care, however; the Agency also offers specialist preventive and curative services. These include screening for cervical and breast cancer among post-puberal women, mental health programmes in the Gaza Strip and West Bank, oral health curative and preventive services and physical rehabilitation in the oPt to treat disabilities, some of which are conflict-related.

## In 2008:

- Over 760,000 oral health consultations and almost 250,000 oral health screening sessions took place;
- Some 3,000 women were screened for breast cancer by mammography and/or breast ultrasound;
- Almost 2,000 women were screened for cervical cancer with Pap smear tests in Lebanon and Syria;
- Over 14,000 refugees benefited from individual mental health counseling sessions, over 40,000 attended group counseling sessions and over 11,000 benefited from home visits by mental health staff;
- In the oPt, over 11,000 patients were treated in the UNRWA physiotherapy units.

# Active Ageing

> Emerging diseases such as obesity pose a particular challenge to older people

Ageing is a privilege and a societal achievement. It is also a challenge that will impact all aspects of 21st-century society. In developing countries in particular, measures to help older people remain healthy and active are a necessity, not a luxury.

The reduction of the incidence of communicable disease, combined with modifications in lifestyle and longevity, have led to a change in Palestine refugees' morbidity profile, with a rise in cases of cardiovascular diseases, diabetes and cancer. Moreover, global changes in eating habits and lifestyles are leading to higher caloric intakes and a lack of physical activity. Obesity is highly prevalent, mostly affecting older refugees. The highest rates of obesity have been reported among Palestine refugee women in Jordan (53.7 per cent), while the lowest prevalence was found in Lebanon (23.6 per cent for men, 40.6 per cent for women).

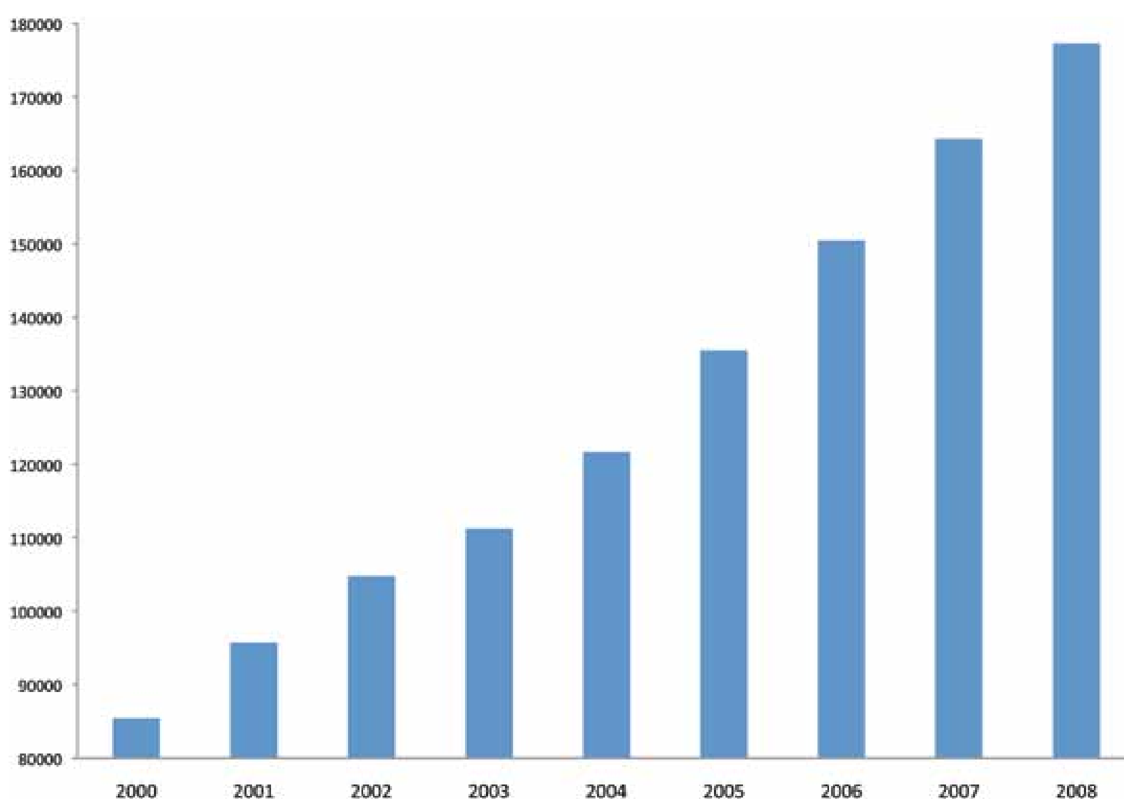
Older refugees are assisted in UNRWA toward active and healthy ageing though a set of preventive and curative services especially targeted for them such as screening, treatment and follow up for diabetes, hypertension and associated complications.

# The Burden of Chronic Diseases:

Today, a wide range of non-communicable diseases, including bronchial asthma, hereditary anaemia, and cancer is prevalent among the refugee population. However, it is not yet possible to allocate part of the limited resources of the health programme to ascertain the burden of these diseases in terms of morbidity, disability, and mortality, or to introduce interventions to address them adequately. As patients come to UNRWA's clinics, they are provided with appropriate assistance including medical treatment and hospitalization.

Conversely, specific activities are in place to prevent and treat diabetes and hypertension. Both conditions are common among the refugee population, respectively affecting 16.4 per cent and 10.7 per cent of patients older than 40. In 2008, almost 180,000 refugees received care for diabetes and hypertension. As older people require constant monitoring and can be more exposed to disease, this specific subgroup of patients attends clinics more frequently than the general population: on average eight times during the year.

**Patients with diabetes and/or hypertension under UNRWA care, 2000-2008**



# Addressing the Determinants of Health

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A safe and healthy environment can be a major determinant of health

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Health is of central importance to human development. However, many major determinants of health lie outside the health sector. In order to improve the health status of Palestine refugees, UNRWA aims to provide them with a healthy and safe living environment, and the highest possible level of social security. To this end, the Agency's health programme has worked in collaboration with its education and relief and social services programmes to set in place a number of activities to reduce poverty, increase health awareness and fight environmental conditions that favour the spread of disease. Among these activities is the community-based initiative, a self-sustaining, locally-orientated strategy which aims to address people's basic development needs.

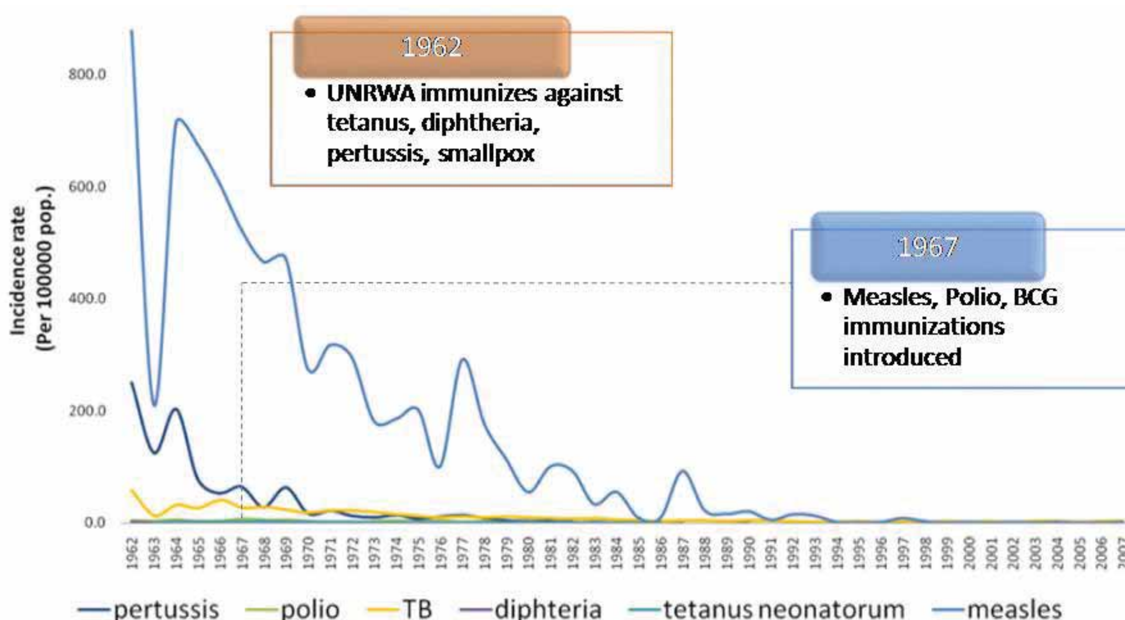
Poverty is a major issue faced by camp dwellers. It is a multi-dimensional problem that delays economic and social development in refugee communities. The use of a bottom-up approach, which envisions the full involvement and participation of local populations, has shown that it is possible to mobilize, encourage and empower communities to identify and advocate for their basic needs. The community-based initiative specifically targets the mitigation of poverty through the design and implementation of revenue generating activities. The scheme is currently being piloted in two refugee camps in Jordan and Syria.

# Fighting Communicable Diseases:

UNRWA's fight to decrease the incidence of communicable diseases among Palestine refugees has been successful, thanks to the improvement of environmental conditions in camps and to high immunization coverage. The Agency's environmental programme monitors the quality of water and sanitation and controls rodents and vectors in refugee camps. These services are provided to approximately 1.4 million Palestine refugees residing in 58 official camps. As of 2008, nearly 100 per cent of refugee camp shelters had access to safe water, and 83 per cent to sewage facilities.

UNRWA's vaccination programme provides immunization for ten diseases: tetanus, diphtheria, pertussis, TB, measles, rubella, mumps, polio, Hib and hepatitis. Today, the programme's coverage is close to 100 per cent. This extraordinary achievement has led to a substantial decrease in the incidence, morbidity and mortality of communicable diseases.

**Introduction of the basic immunization package and incidence of targeted diseases**



# Access to Health Services

"Palestine refugees face physical and economic barriers to accessing health care"

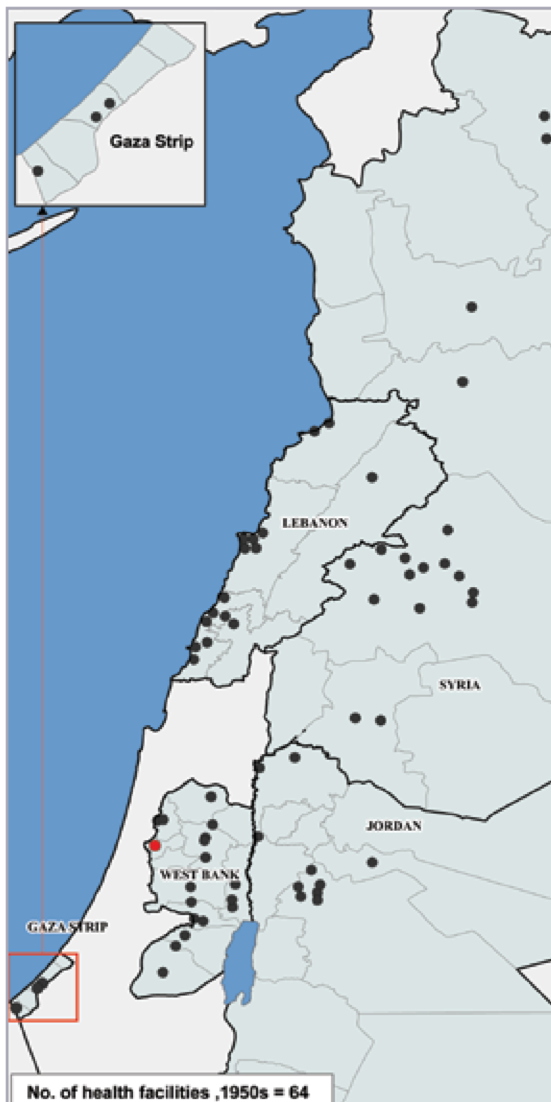
Ensuring equity in access to health care can be particularly difficult in UNRWA's areas of operation. This is because of the level of violent conflict, restrictions on movement and the entitlements of refugees under the host government.

In the 1950s, the Agency counted 91 health centres run by 75 doctors in its area of operations. Today, medical care services are provided through a network of 137 primary health care facilities, in which 480 physicians work. This significant presence on the ground has notably decreased the physical and economic barriers that preclude access to health care for Palestine refugees.

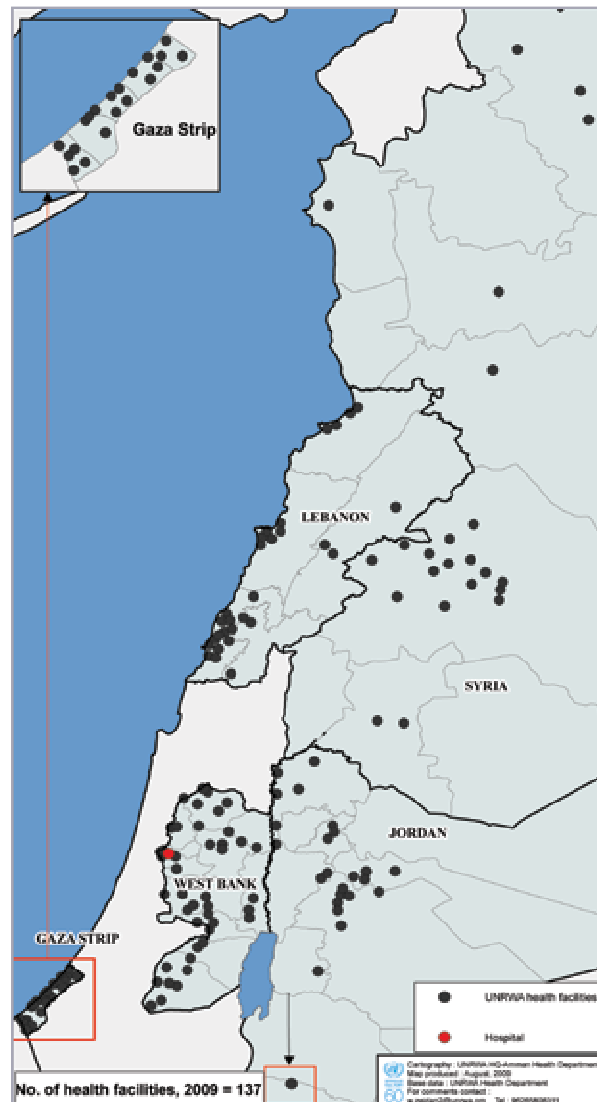
Since February 2003, five mobile health teams have operated in the West Bank in order to facilitate access to health services in those areas affected by closures, checkpoints and the Barrier. Each team is composed of a medical officer, a nurse, a laboratory technician, an assistant pharmacist, and a driver. They offer a full range of essential curative and preventive medical services to around 13,000 patients per month, in over 150 isolated locations. Since becoming operational, the mobile clinics have treated an increasing number of Palestine refugees, from nearly 70,000 in 2003 to 140,000 in 2008.

Although UNRWA mostly focuses on primary health care, the Agency also assists its beneficiaries in accessing secondary and tertiary care services. In 2008, about 85,000 refugees were assisted in covering hospital costs, either in contracted secondary care facilities or in UNRWA's 63-bed hospital in Qalqilia, West Bank. Qalqilia Hospital is the only hospital operated by the Agency and accommodates 14 surgical, 12 medical, 20 paediatric, 15 obstetric/gynaecologic and two intensive care beds, in addition to a five-bed emergency ward. In 2008, over 6,000 people were admitted.

## Expansion of UNRWA's health care facilities from 1950




Year 1955: 64 health centres




Year 2009: 134 health centres

# Protecting the Victims of Violence

“UNRWA ensures continuity in Palestine refugee health, and responds to the needs of victims of conflict”

As an organization working in a chronically unstable environment, UNRWA is continuously challenged by upsurges of violence. Conflicts in Lebanon and more recently in the Gaza Strip have forced the Agency's health programme to react rapidly in order to ensure continuity of services. New services such as mental health care, physiotherapy and rehabilitation were established. These deal specifically with the consequences of protracted violence and insecurity.

UNRWA's health programme is strongly decentralized and is able to adapt rapidly to different security concerns and logistical impediments. This has limited the disruption of those activities that are typically most challenging to perform in times of conflict, such as epidemiological surveillance and treatment of chronic diseases.

## ...IN THE GAZA STRIP

Between 1,380 and 1,480 people were killed during the Israeli military operation known as Operation Cast Lead, launched in the Gaza Strip between 27 December 2008 and 18 January 2009. Among the dead were over 310 children and over 100 women. At least 5,380 people were injured, including 1,872 children and 800 women. [1]

Fifty-one UNRWA installations were damaged in the fighting, including seven health centres and the Agency's Gaza field office. As a result of severe shelling, UNRWA's main warehouses and their contents were destroyed. The estimated cost of repairs to damaged Agency installations exceeds USD 3.5 million. The estimated cost of supply replacement is USD 5.8 million, including USD 3.3 million for medicine and medical supplies.

During the conflict, UNRWA provided temporary shelter to over 50,000 Palestinians who sought refuge in the Agency's schools. Although security constraints severely limited the movement of staff, UNRWA continued delivery of its health services, adjusting to the needs of displaced people and to a deterioration in local environmental health standards. The Agency also continued its implementation of higher levels of surveillance of communicable diseases throughout the post-conflict period. No outbreaks took place among the refugees resident in the Gaza Strip, who constitute 70 per cent of the population.

Photo courtesy of AFP

1 Estimates of the number of Palestinians killed during the period vary. Frequently cited examples include 1,166 (Israeli military), 1387 (B'Tselem), and 1471 (Palestinian Centre for Human Rights).

# UNRWA Health Landmarks

### 1950s

- 1950: UNRWA commences operations
- 1951: Supplementary feeding programme begins
- 1953: Maternal and child health services launched
- 1954: An expanded programme of immunization is introduced; the school health programme is established and the health education programme set up.
- 1957: Special rehydration formula known as Najjar salt introduced for the treatment of diarrhea

### 1960s

- 1962: Eight rehydration centres for the maintenance and restoration of electrolyte balance and body fluids begin operations in Jordan, Syria and the Gaza Strip
- 1964: Trivalent poliomyelitis vaccine introduced
- 1967: UNRWA undertakes major emergency relief operation to assist 150,000 refugees displaced by the 1967 war

### 1970s

- 1970: Live attenuated measles vaccine introduced as part of the immunization programme

### 1980s

- 1982: UNRWA undertakes major emergency relief operation following the Israeli invasion of Lebanon in June 1982. In the same year, UNRWA begins integrating laboratory services within the Agency's primary health care facilities
- 1985: The risk approach in maternal health care is introduced in the West Bank
- 1988: Following *intifada* in the West Bank and Gaza Strip, UNRWA embarks on an extended programme of assistance to improve living conditions in refugee camps
- 1989: In cooperation with UNICEF, UNRWA establishes a physiotherapy programme in the oPt for those with conflict-related injuries

### 1990s

- 1990: UNRWA introduces programme of "extraordinary measures" in Lebanon and in the oPt to meet emergency needs
- 1991: Gulf War leads to influx of about 400,000 Palestinians into Jordan and other fields. Many are eligible for UNRWA services. In the same year, a standardized gender-specific WHO growth chart replaces the previous chart for children; the supplementary feeding programme is reoriented to focus on providing milk and dry rations to vulnerable refugees; UNRWA implements new plan for the management of anaemia among preschool children and women in reproductive age; a new strategy for prevention and control of diabetes is integrated into UNRWA's primary health care activities

- 1992: UN Fund for Population Activities funds a three-year project to upgrade UNRWA's maternal health programme, introducing post-natal care and family planning services
- 1993: Expansion of mother and child health package, based on the integration and continuity of perinatal, post-natal and family planning services; Peace Implementation Programme (PIP) established to upgrade infrastructure and improve the living conditions of refugees; special environmental health programme set up to address critical needs in the Gaza Strip
- 1994: UNRWA starts coordination with newly-established Palestinian Authority
- 1995: Hepatitis B vaccine and combined measles, mumps and rubella vaccines introduced
- 1996: UNRWA completes construction of the 232-bed European Gaza Hospital and the affiliated Gaza College of Nursing
- 1999: PIP replaces/rehabilitates 11 primary health care facilities and constructs 21 additional centres

### 2000s

- 2000: UNRWA launches programme of emergency humanitarian assistance to address hardship in the oPt resulting from second *intifada*
- 2001: UNRWA establishes programme of psychological counseling and support in the oPt; *haemophilus influenza* vaccine introduced
- 2002: Expansion and upgrading of the UNRWA hospital in Qalqilia completed. In the same year, a diabetes and hypertension screening programme is established, targeting refugees over 40 years of age
- 2003: Maternal health and family planning system introduced along with de-worming programme for school children
- 2005: New health information system introduced; physiotherapy programme introduces postural screening in UNRWA schools, provides rehabilitation aids for disabled people, and establishes screening programme for diabetic foot complications. Introduction of automated laboratory equipment increases productivity and efficiency of UNRWA laboratories
- 2006: Breast and cervical cancer screening programmes introduced. In the same year, vitamin A supplementation targets nursing mothers, infants and school children
- 2007: Geographic information system introduced, for mapping of epidemiological data
- 2008: Maternal and child handbook introduced in the West Bank and expanded to other fields in subsequent years. In the same year, oral health services are re-oriented with stronger focus on prevention
- 2009: A newly developed WHO growth monitoring system changes the span of monitoring from 0-3 to 0-5 years; preconception care is introduced in maternal health services in all fields; community-based initiative launched with the support of WHO; Drug Therapeutic Committee established to monitor cost-effectiveness and quality of care

# Looking Ahead

In the past 60 years, UNRWA's health programme has achieved extraordinary results. However, given the traditional public health care model on which it was originally structured, which relied mostly on fixed assets, a permanent workforce and direct provision, the performance of the current programme is close to its limit. Today, the environment in which UNRWA operates has changed dramatically.

The Agency faces enormous challenges: maintaining comprehensive care delivery against a rising number of beneficiaries and increasing costs, expanding its services, particularly those pertaining to the screening and treatment of chronic, non-communicable diseases, and increasing the accessibility of quality hospital care. In order to maintain the programme's extensive infrastructure and invest in an increasing need for staff, an annual constant, reliable increase in funds is necessary. UNRWA's impressive growth cannot be sustained forever.

Unfortunately, the capacity of the international community to guarantee sustained investment in humanitarian agencies is waning. Funds are scarcer than ever and more sporadic. This is incompatible with a service provision model with high recurrent costs, such as the one currently in place. A combination of raised expectations, resource constraints, rigid management habits, and widespread inefficiency has meant that the massive investments made by the Agency in the past are now under significant strain.

A key question facing the programme today is how it can move to adopt a more dynamic and sustainable model of health care delivery. It is clear that hard choices must be made. Already, the type of assistance provided by UNRWA is shifting from a mainly curative service to preventive care, enabling the Agency to serve more refugees, and preventing disease rather than treating it at a much higher cost. Where possible, greater integration into the health care systems of host countries could enable the Agency to deliver better quality services, use available resources better and avoid duplication.

Finally, a move away from a universalist approach, which fails to distinguish between destitute refugees and the rest, should be envisaged. By adopting a vertical equity approach, according to which unequal resources are allocated to address unequal health needs, the health programme could provide a stronger service to those who need it the most. Formulating a new policy that takes equity considerations into account will require a better understanding of the socioeconomic stratification of refugees and of the host population, but once achieved, such an approach will allow UNRWA to do more with less.

Notwithstanding the numerous challenges facing UNRWA today, the Agency will not neglect its duty to protect the health of Palestine refugees. For this reason, UNRWA will continue to adapt in order to balance properly its resources with the pressing needs of its beneficiaries. Until a political solution is found, UNRWA will be there for Palestine refugees, protecting their right to health, education and social security, and enabling them to live long and healthy lives.