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Availability of public health data about Palestinian refugees

Fafo

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Introduction

Within the Refugee Working Group (RWG) in the Multilateral Peace Process for the Middle East, Norway has responsibility for shepherding the database theme and shall coordinate database activities for the other shepherds. The Fafo Institute for Applied Social Science has been appointed by Norway to be the implementing agency for these activities. In the following paper, we will give an overview of available data on public health for Palestinian refugees living in the West Bank, Gaza, Lebanon, Jordan, and Syria.

The paper is organized into two parts. Firstly, we will give an overview of available databases and existing research publications covering issues of interest for the planning and development of health services for Palestinian refugees. Secondly, we will briefly outline some of the results that can shed light on the status of the health situation and the health services for refugees, both in the areas under the control of the Palestinian Authority and in the neighboring host countries. The paper builds on a bibliography of recent studies and on ongoing research into public health for Palestinian refugees[1]. The titles in the Fafo bibliography of relevance for the public health theme are appended (appendix 1).

Research into public health addresses both the health conditions of the population and the organization of health services into a public health system. Public health research is usually of an applied nature, carried out with the aim of monitoring developments and of assisting in the planning of health services. The wide field of research may be divided into three main sub-sections, namely (1) studies of health conditions, (2) studies of health services, and (3) studies of the health behavior of the population.

Even if a lot of data is available on public health in the areas where the Palestinian refugees are located, we are faced with a general problem of breaking the available data down according to refugee status. Studies addressing the health situation for refugees are becoming more and more numerous, but they are geographically concentrated on the West Bank and Gaza, and many of the studies are rather limited in coverage even within this area. For Lebanon and Syria there is little information available that specifically addresses the situation for refugees, except for administrative data gathered by the UNRWA. In Jordan, the recent Jordan Living Conditions Survey[2] yields information that

[1] The bibliography has been collected by the researcher Lena C. Endresen (Fafo) and Professor Elia Zureik (Queen's University, Kingston, Ontario), with funding from the Royal Norwegian Ministry of Foreign Affairs. The bibliography was presented to the Refugee Working Group's plenary meeting in December 1995. Fafo will publish a full project report later this year.

[2] On the recommendation of the Multilateral Refugee Working Group, Norway and Jordan agreed to implement this survey. It was funded by Unicef, with a Norwegian grant, and by Canada through the International Development Research Center and the Canadian International Development Agency. In the project, living conditions for the entire Jordanian population, including Palestinian refugees, were surveyed with particular focus on the situation of women and children.

permits an analysis of the situation of refugees as well as a comparison with non-refugees in the country.
The picture emerging from recent studies of the health status of Palestinian refugees is one indicating that the general health status is in a transitional state. The characteristics and indicators available fall mostly between those for developing and those for developed societies. With the possible exception of Lebanon, the available sources do not in general lend support to an hypothesis that the health status is substantially different between refugees and other inhabitants in the host countries. This general picture indicates that UNRWA, together with the host governments, has been successful in ensuring basic health services for the refugee population.

Since we can well suspect that the general picture includes substantial local differentiation, it is regrettable that the available data is in general insufficient for the assessment of such a differentiation or for targeting local level development assistance for the refugees. These shortcomings have lead the Norwegian shepherd to suggest that a survey instrument be developed for appraising the situation within the various areas of interest for the other RWG shepherds. This tool – called the Rapid Living Conditions Appraisal – is presented further in Appendix 2, with the aim of soliciting feedback and ideas from the Italian Shepherd for the Public Health Theme.

Availability of data

Health is determined by biological, demographic, economic and social factors. Thus, public health may be conceived of as an integral aspect of living conditions, affected by other aspects such as housing, working conditions, education, civil rights, water, food and nutrition. Accordingly, the potential need for data for use in improving the public health system is relatively broad.

The available studies of public health have mainly been written in English, and the most popular geographical areas covered are the West Bank and Gaza. The material reviewed consists of a large number of studies that have been carried out mainly for planning purposes, and there is also a substantial amount of service statistics. As is commonly the case, break-downs on refugees are scarce. Because there are a large number of service providers, it is difficult to construct an overall picture from data available from these providers. This research has evidently been stimulated by a variety of forces, local as well as international, and the changing political environment and the ensuing institutional development in the West Bank and Gaza have also been crucial.

Reviewing the research material, the overall impression is one of considerable activity from well-established associations and institutions engaged in research, planning and professional development within the field of public health. As an example, in the West Bank and Gaza, the Health Development Information Project (HDIP) has published, among other things, a third edition of *Health in the West Bank and Gaza Strip: an Annotated Bibliography* (HDIP 1995a). This bibliography contains summaries of 290 research papers and policy reviews, most of which have been published during the past few years[3].

[3] The HDIP bibliography includes the following categories: Demographic Research, Community Health, Family Planning, Health Services Research, Health Planning and Policy Reviews, Infectious Diseases Research,

UNRWA is a major contributor of data on public health, both in the form of its service statistics and its applied research. There are, in addition, contributions submitted to the RWG and a few larger surveys, which have a wide regional or thematic scope. Several of these contributions also deal with local health issues in places where Palestinian refugees live.

Health status data may be considered at three different levels. On the one level there are data that may be used to evaluate the overall status of health in the refugee population. On the second there are data that may be used for differentiating within the population, and on the third level data so detailed that they may be used for targeting and monitoring. If we consider the available data for the various geographical areas under consideration, the simplified picture given in Table 1 emerges.

One should note that, peculiarly enough, the general picture of refugee health is covered more elusively than the localized. Due principally to the work of UNRWA, local level service data are generally available, although access is sometimes difficult. Those data, however, mainly cover the part of the refugee population that actually uses UNRWA services. Their relation to the total refugee population is somewhat uncertain. The fact that there are other service providers with other – often much more unsystematic – ways of collecting and of presenting data, also make the generalization to the total refugee population difficult.

At the general level, most national statistical series are not broken down by refugee status. The data base activities that have been conducted within the framework of the Refugee Working Group have improved the availability. Both the Fafo living conditions study (Heiberg and Øvensen 1993) and the Demographic Survey conducted by the Palestinian Central Bureau of Statistics (PCBS) and Fafo[4] have improved the general picture for the West Bank and Gaza. These two surveys contain data on refugees that can be compared with statistical series conducted by the Israeli Central Bureau of Statistics. In Jordan, the Jordanian Department of Statistics and Fafo have implemented a living conditions survey that contains information about the health situation and about health services. The results from this survey – that are expected within the first half of 1997 – can be broken down by refugee status. We have no similar survey data available for Lebanon and Syria.

Nutrition Research, Physical Therapy and Rehabilitation, Health and the Uprising, Psycho-social Health Research, Women and Health, Water and Sanitation, Mother and Child Health, Miscellaneous Research. HDIP is currently involved with other organizations in developing an information sharing network which involves making research articles, abstracts and data bases on Palestinian health available for on-line searching and retrieval.

[4] The Demographic Survey was funded by the European Commission, and reports are available at the PCBS.

Table 1 Availability of health data for Palestinian refugees

Area	Overall status	Differentiation	Targeting
West Bank & Gaza	Fairly good	Some data (often difficult to separate refugees from others)	In general available, but not integrated due to large number of providers of health care
Jordan	Fairly good	Little data	Data available on UNRWA registered refugees (that use services)
Lebanon	Little data	Little data	Data available on UNRWA registered refugees, but lack of integration due to multiple service providers
Syria	Little data	Little data	Data available on UNRWA registered refugees (that use services)

The future amalgamation of the numerous health providers in the West Bank and Gaza into one integrated health system has not been extensively dealt with in health services research yet, and definite knowledge about the functions of the health care system as organizations is insufficient. There is a lack of overarching health research and of quality monitoring on the ground. Health data based on the routine reporting of medical diagnosis are highly relevant for studies of public health. Such reporting, however, depends on adequate institutional and professional structures. Not only must there be a system for routine reporting, with appropriate issues being reported and monitored, but the health personnel at each level must also be able and motivated to carry out thorough and adequate reporting[5]. A large amount of data and statistics on the Palestinian population is produced, but there seems to be a lack of procedures that can ensure the quality of the level of data collection, and, subsequently, of the level of statistics production.

For the Palestinian refugee population long-term routine reporting on health can only be found in the UNRWA system. A uniform reporting system across the five UNRWA Fields of operations, Syria, Lebanon, Jordan, the West Bank and Gaza, provides unique opportunities for comparisons. The UNRWA health system provides a substantial proportion of the health services to Palestinians. UNRWA health data, however, suffer from certain limitations. The main shortcoming stems from the lack of integration with registration records and other data produced by UNRWA. Further, the administrative data cover only refugees who choose to use UNRWA's services, and not the whole group of UNRWA refugees as such (Endresen and Øvensen 1994). As we lack adequate data for services supplied by others, as well as information about the sizes of the various target populations, it is impossible to calculate what percentage of the total health services UNRWA covers in each of the Fields.

While there are studies on children's nutrition and nutritional status, with a few exceptions, the adult population has not yet been studied, (Yip et. al 1990, Cook 1992, UNCTAD 1994b). Various surveys (Cook 1992, Heiberg and Øvensen 1993, UNRWA 1992b, 1994a, UNCTAD 1994b) indicate that conditions such as diabetes mellitus and cardiovascular diseases are on the increase, a fact that adds to our interest in more

[5] As an example, reports on birth weight must be precise, and the practical nurses or other personnel who carry out the weighing must see the importance and purpose of filling in and delivering correct information. A common weakness in systems of reporting «upwards» to central bodies is that those who carry out the reporting seldom receive any feedback on their reporting work. Motivation may then be weakened, and the quality of the information may suffer.

research on nutrition[6]. Furthermore, research into the elderly and their care has not been addressed. Mental health seems to be a field calling for further research. To our knowledge, no reliable survey has been published on the prevalence of mental disorders among Palestinian refugees. Research into health behavior is essential for the construction of an efficient health system, but so far, existing research has not outlined health behavior sufficiently.

As a response to the observed absence of adequate data concerning the living conditions of the Palestinian refugees for targeting development assistance projects that can improve the conditions within confined areas, Norway has suggested designing an instrument to gather high priority data required by the Shepherds. The instrument is called the Rapid Living Conditions Appraisal (RCLA) Survey. The idea was well received at the Oslo Inter-sessional Expert Meeting in June 1996, and since then Fafo has been preparing a more detailed design for discussion among the RWG shepherds[7]. A complete list of the indicators that Fafo suggests be included in the survey instrument is appended (Appendix 2).

The main idea of the RCLA is to standardize the need for data from all the RWG shepherds with a view to coordinating the production of data needed for assistance projects and monitoring the development of living conditions. It is important to construct standard indicators that allow for a comparison with both internationally used ones (UN system and World Bank) and with national statistical series. The main source of models for the design is the recent Jordan Living Conditions Survey. The Norwegian Shepherd is planning to invite the other Shepherds to provide their input and comments as soon as feasible in order to conclude the design of the instruments during the first half of 1997.

Status of public health: some findings from current research

General

Studies of the general health status of Palestinian refugees (Heiberg and Øvensen 1993, State of Israel 1991, 1992, 1993a, UNRWA 1992b, 1994a) indicate that the health condition of the refugees is in a transitional state, with characteristics and indicators falling in between those of developing and those characterizing developed societies. With the possible exception of Lebanon, the available sources do not in general lend support to a hypothesis that the health status of refugees is substantially different from the other inhabitants of the host countries.

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[6] There is, however, an ongoing research project on these issues initiated by the University of Oslo on cooperation with Palestinian researchers.

[7] The RCLA instrument is being designed by a Fafo team consisting of researchers Ole Fredrik Ugland (lead), David Drury, Åge A. Tiltnes, Marie W. Arneberg and research directors Jon Hanssen-Bauer and Jon Pedersen.

Morbidity and mortality from communicable diseases that can be prevented by immunization and improved living conditions have dropped significantly. Although research and service statistics (e.g. Ministry of Health, Israel, 1990, 1994) covering total populations find that communicable diseases are, in general, things of the past, several local or specific studies indicate that such diseases still affect the lives of some refugees (Barghouthi 1993, Rizkallah 1991, Smith 1993, Yusef 1992). At present, it is difficult to assess whether this is caused by inaccuracy or lack of precision in measurements in the general studies, or whether the local studies have been concentrated in remaining pockets of disease.

In a general assessment of the conditions of Palestinian refugees UNICEF (1989a) gives a rate for maternal mortality of 40 per 100,000 live births. The PCBS/Fafo demographic survey of 1995 produced a slightly higher figure of around 70-80 maternal deaths per 100,000 live births for the West Bank and Gaza (PCBS 1996a). With this comparatively low[8] level of maternal mortality the survey based data cannot easily be broken down by refugee status. Service based data appear not to be available in a systematic fashion[9].

The most important providers of health services to the Palestinian refugees are UNRWA (with WHO), PRCS (Palestine Red Cross Society), PCH (Palestine Council of Health), International- and National NGOs, and the health systems of the host countries. In the West Bank and Gaza, the Israeli Ministry of Health provided a substantial part of the health services to the population until the Palestinian Authority assumed control over the health services in December 1994. All these bodies commission and carry out research into the needs and priorities of the refugee communities. UN organizations, such as UNCTAD and UNICEF, have also provided research into public health, mainly health services, with focusing mainly on the West Bank and Gaza (UNICEF 1992a, 1993c, UNCTAD 1993d, 1994b). The research has often been carried out by Palestinians, or the organizations have used Palestinian researchers as consultants.

UNRWA provides primary and secondary health services, including mother and child care. The agency operates 119[10] primary health care and specialist clinics across their five Fields of Operations, and serves refugees both inside and outside the camps. The agency offers extensive maternal and child care services, and its health program

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[8] To give some sense of proportion to the numbers, the rates from the following countries may be considered: Norway 3; Israel 3; USA 8; Saudia Arabia 41; Malaysia 59; Syria 140; Egypt 270; Uganda 300; Niger 900; Mali 2000 (source: UNICEF 1994, *The State of the World's Children* 1994, Oxford: Oxford University Press.

[9] The improved monitoring of maternal health is part of the development of maternal and child health care services, and may consequently improve the service based data on maternal health. Expanded Maternal Health Projects, which include a monitoring and evaluation framework funded by UNFPA (United Nations Fund for Population Activities), have been implemented in the West Bank and Gaza. The forthcoming PCBS *Health Survey* will provide data on maternal and child health in the West Bank and Gaza. In Jordan, the *Jordan Living Conditions Survey* will update the existing DHS data. In Syria, the 1989 PAPchild survey (a survey focusing on demographic factors and maternal and child health) data provide information on maternal health.

[10] As of 1993.

includes laboratory analysis, treatment for hypertension, diabetes, dental care, and physiotherapy. In 1992 UNRWA's clinics handled over 6.1 million patient visits (UNRWA Update, April 1993, 3). UNRWA also subsidizes hospitalization in some cases and spent $ 50.9 million on health services, about 17 percent of its total expenditure in 1991 (UNRWA 1992f).

Curative medicine is thus given lower priority than preventive medicine by UNRWA whose policy is to develop maternal and reproductive health issues as a major effort, also in the years to come (UNRWA 1994a). Refugees who need hospitalization are referred to area hospitals through a variety of local arrangements. Thus, the level of hospital care offered to refugees varies more than primary health services.

The study of health behavior focuses on how the population relates to issues of importance for their health: life-style as well as local knowledge of health and disease and responses to disease and treatment. There are few studies available that inform us about the health behavior of refugees, and most of them refer to the West Bank and Gaza. The Fafo survey of the West Bank and Gaza (Heiberg and Øvensen 1993) studied utilization of maternity and child health care services. The utilization increased along with the educational level of the mother, but was not dependent on the wealth of the household. Geographical accessibility seemed to be the most important factor determining the use of these services. The Jordan Living Conditions Survey will also provide similar information for refugees living in Jordan.

A significant part of studies pertaining to health behavior in the West Bank and Gaza have been carried out by the Birzeit University Community Health Department (e.g. Giacaman 1994). Abu Hiljeh (1993) which interviewed mothers in the West Bank to map out their knowledge, attitudes and practices regarding children with diarrhea. The study concludes by recommending the launching of a health program for mothers about the management of diarrhea at home.

Cigarette smoking has not been much studied. In the West Bank and Gaza, according to the Fafo study (Heiberg and Øvensen 1993), very few women (2 percent) and nearly half (47 percent) of the men reported that they smoke. The level of smoking is similar in Jordan, according to the Jordan Living Conditions Survey. Drug abuse is a topic which has not been studied systematically. UNRWA notes that in their women seminars, the prevention and detection of substance abuse is discussed, indicating that drug abuse takes place in Palestinian society (UNRWA 1992e). Abdallah and Fasheh (1993) claim that drug addiction has become a serious problem in Palestinian society. According to the Israeli Anti Drug Authority and the Israeli Ministry of Health, over 30,000 people use drugs in the West Bank and Gaza (Al-Quds 3 July 1992).

West Bank and Gaza

There are two main studies that provide a general picture of the health conditions of refugees in the West Bank and Gaza, namely the Fafo Living Conditions survey from 1992[11] (Heiberg and Øvensen 1993) and the Demographic Survey conducted in 1995 (PCBS 1996a). PCBS has also completed a survey of children's health with a sub set of the sample of the demographic survey, but results are yet to be published. In addition to these sources, the Israeli Ministry of Health has published a number of reports that describe the health situation in the West Bank and Gaza (e.g. Ministry of Health, Israel,

[11] N=2.500 households.

1990, 1994). These reports do not describe refugees separately, but as pointed out here, there is little evidence that refugees are very much different from the rest of the Palestinian population in the West Bank and Gaza.

The Fafo report presents data on patterns, prevalence and consequences of self-reported acute and chronic health problems, psychological and psychosomatic distress, as well as on the utilization of health services and health insurance coverage[12]. Twenty-five percent of the survey's respondents reported that they had had an illness or an injury during the months immediately before the interview took place. Thirty percent reported that they had had an illnesses of a prolonged nature or afflictions due to an injury or handicap. Pain in the musculo-skeletal system was the most frequent reason for prolonged illness[13]. Not surprisingly, increase in age was the strongest determinant of the prevalence of illness. Women and men had similar overall rates of both acute and chronic illness, but differences between specific groups of prolonged illnesses were found. The frequency of acute and prolonged illness was inversely related to household wealth and the level of education of the individual. Refugee status did not seem to influence the rate of reported illness and injury.

Reported rates for symptoms of psychological distress were high. Only twenty percent of the population reported no such symptoms, fifty percent reported 1–3 symptoms, and thirty percent reported a high degree of distress (4–7 symptoms). Somatic illness was a strong determinant of psychological distress. When corrected for illness, the degree of distress increased slightly with age.

The demographic survey data of most relevance for health conditions are mainly related to fertility and mortality. In general, refugees and non-refugees are fairly similar. Thus adult, infant and child mortality are similar for the two groups. The same is true of fertility. The data show a picture of comparatively low mortality (infant mortality around 25 per 1000 in the West Bank and 32 in Gaza, under-5 child mortality at 32 in the West Bank and 41 in Gaza, life expectancy at birth at around 70 years).

The data also show extremely high fertility with Total Fertility Rates of 5.6 for the West Bank and 7.4 in Gaza. In The West Bank there is some evidence of a fertility decline, while in Gaza fertility appears quite stable. Interestingly marital fertility is high and quite stable in both areas (at around 10), suggesting that the main influences on fertility are currently the age at marriage and also the proportion married. An important corollary of high fertility is very short birth intervals. The median birth interval in the West Bank is 21.9 months while in the Gaza strip it is 21.6. Again there is little difference between refugees and non-refugees, or between camp-dwellers and residents elsewhere. These short intervals are similar to those found in Jordan, but are otherwise quite unique, even when compared to those observed in other high fertility populations.

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[12] Patterns and prevalence of self-reported health problems reflect both underlying disease and cultural concepts of illness. This calls for caution when analyzing self-reported health-problems. Utilization of health care services is measured more easily through interviews.

[13] More than half (55 percent) of the women, and more than one third (39 percent) of the men reported to have suffered chronic illnesses due to pain in the musculo-skeletal system. This corresponds to a prevalence in the population of 12 percent for men and 16 percent for women. In a Norwegian health survey (Norway, Central Bureau of Statistics. *Health Survey 1985* Oslo 1987) such pain was an even more dominating cause of illness with a prevalence of 21 percent.

The PCBS/Fafo demographic survey data are remarkably consistent with the data recently published by the Israeli Central Bureau of Statistics (1996) on the demography of the West Bank and Gaza.

As with health conditions, the health care systems for refugees can be said to be in a transitional state. While the health sector, at least in the West Bank and Gaza, has highly advanced medical equipment and expertise, support functions, such as hospital administration and maintenance of equipment, are claimed to be insufficient. There seems to be no systematic overview of the situation available. The World Bank, however, recommends de-emphasizing spending on tertiary care[14] and giving priority to a consolidation of the existing health services in the West Bank and Gaza (World Bank 1993f).

The Fafo survey (Heiberg and Øvensen 1993) showed a frequent use of health care services in the West Bank and Gaza. More than 96 percent of those who had been ill had consulted a physician or other from health service. In other words, once people define themselves as ill, they consult health personnel. As there were no differences across subgroups and refugee status, the result indicates a very good availability of health services and no economic threshold for seeking medical assistance. This is unique in the context of a developing country. Apparently UNRWA, the Israeli Ministry of Health, NGOs and other actors, have been successful in counteracting social inequality in health care. Low health insurance coverage did not prevent people from using health care services. There is little documentation available about the appropriateness and quality of the health care, so those factors probably vary across social strata.

Research into public health services in the Palestinian areas has found that the health care system in those areas is fragmented and that the services suffer from lack of an overall health care strategy. These services have been formed partly under the Israeli administration and partly by a number of actors like UNRWA, local and foreign NGOs, as well as foreign donors, who have all worked according to their own priorities. Recent research laments the lack of coordination among the major health providers. Numerous national and international NGOs have favored small and decentralized health projects. Consequently there has been larger investment in short-term, fact-finding studies than in the running of long-term health services and studies into long-term, coordinated policy.

As the political picture changes, and the Palestinian Authority has now taken over responsibility for the health care sector in the West Bank and Gaza, other priorities emerge for public health research. An impressive amount of up-to-date studies is already available of the West Bank and Gaza and of the development of the Palestinian health care system[15]. These reports emphasize the disjointed nature of the current health care systems and call for better planning and coordination between the various administrative

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[14] Tertiary health care is health services from highly specialized providers, such as intensive care units or specialized physicians. Such services frequently require highly sophisticated technological and support facilities.

[15] Important studies are Lindahl 1993, Barghouti 1993, Barghouti and Daibes 1993, World Bank 1993e and 1993f, UNCTAD 1994b, Planning and Research Centre (PRC) 1993, 1994a, 1994b, 1994c, 1994d, 1994e and 1994f, Giacaman, Salem and Filfil 1995 (circa), Multilateral Working Group for Refugees 1993, 1994d and 1995, The March of Palestinian Nurses Conference 1994, Barnea and Asfour (eds.) 1995 and Health Development Information Project (HDIP) 1996.

units. Further, they address the need for improved training at all levels of the health care system, from nurses and doctors to hospital administrators. The Planning and Research Centre (1994a) has formulated a set of detailed goals for a complete health sector and debates whether health care should be financed through individual responsibility for health expenses or be based on collective solidarity. The general model of provision of health services in the West Bank and Gaza will determine the division of roles and responsibility between the public and the private sectors. It seems that it will be costly to build up alternatives to UNRWA health services. The overall design of a taxation system and a health insurance system – together with a range of policies at a macro level concerning areas such as water resources, land, taxation, education of health personnel, and so forth – will provide the core determinants of the future policies on public health for all inhabitants in the West Bank and Gaza, including the refugees (Barghouti 1993).

Syria

In Syria, UNRWA provides health services to the refugees, and has data on health conditions and services delivered. Government hospitals are available to Palestinian refugees, free of charge. Except for the UNRWA data, Syrian health data is, to our knowledge, not provided for refugees. A PAPchild survey (a survey focusing on demographic factors and maternal and child health) was conducted in Syria in 1989, but the data have not been reported separately for refugees.

Lebanon

In Lebanon, UNRWA provides the major part of the health services to the refugees. PRCS used to be another major provider, but its services have declined during the last decade or so. UNRWA provides emergency assistance to registered and non-registered Palestinian refugees alike. For example, UNRWA subsidizes hospital expenses for refugees and non-registered refugees (UNRWA 1992c; 19). Several reports express a concern about the decline in UNRWA's budget and the potential effects on the health conditions and the services delivered to refugees in Lebanon.

An Italian report to the Multilateral Working Group for Refugees points to a number of health care challenges in Lebanon. Environmental health is poor in the camps where appropriate sewage systems and water supplies are the norm. The report further addresses the poor coverage of secondary health care, and suggests several projects to improve the health services for the Palestinian refugees in Lebanon (Multilateral Working Group for Refugees; 1994d).

A conference report from an on-going project titled *Palestinians in Lebanon* is concerned with health conditions. It states that «a whole category of refugees does not even have access to UNRWA's services. For those who do, the services which UNRWA can provide are partial and insufficient.» The report advocates integrating health considerations into the general development efforts towards the rehabilitation of the environment, improvement of housing conditions, building of adequate sanitation, and establishment of acceptable standards of hygiene – rather than providing high-tech, curative medicine as the best answer to health problems. To sum up, the conference report recommends investment in sanitation, clean water and primary health care to improve the health conditions of the refugees in Lebanon (Refugee Studies Programme and Centre for Lebanese Studies 1995). The overall picture that emerges from a reading

of the few studies available on public health in Lebanon is the scarcity and poor reliability of quantitative data.

Jordan

According to UNICEF (1989a; 14), UNRWA provides the main health services to the refugees in Jordan. Survey data indicates that 68% of Palestinians go first to an UNRWA health center for medical advice or care. Another 25% consult a private doctor first, and 7% go to a Jordanian government hospital or clinic.

The *Jordan Living Conditions Survey,* carried out by the Jordanian Department of Statistics and Fafo in 1996, provides data on health and the use of health institutions both by the Palestinian refugees and other groups in Jordan[16]. Only preliminary results from the survey are available at the moment, and the figures presented below must be interpreted with caution.

On all self-reported indicators on health status, the refugee population scores lower than the non-refugees. sixty-nine per cent of the camp refugees claim to be in good health, while 18% state that their health is fair, and 13% that their health is bad. seventy-six per cent of the refugees residing outside camps say that they are in good health, 19% in fair health, and 5% in bad health. In contrast, 81% of the non-refugees claim to be in good health, while 15% report that their health is fair, and 4% are in bad health. These results are supported by the replies given to questions about ability to go for a brisk walk, carry a load, or go up and down stairs. The pattern is similar also when we asked about sight and hearing. Before we have analyzed the possible effects of demographic differences among the groups, they should be taken as indications of a trend only.

The survey also contains information about psychological symptoms, such as nervousness, anxiety, feeling depressed, feeling worthless and feeling hopeless about the future. On these indicators refugees are worse off than non-refugees, with about 5% more reporting suffering from a given distress. Camp refugees are even worse off than the average for the refugee group.

In the total population, 7% suffer from prolonged illness or injury. A bigger proportion, 10%, have been hit by chronic disease or injury among the refugees living in camps, while 8% of refugees living outside camps and 6% of non-refugees fall into the same category. The incidence of acute illness during the two weeks prior to interview, however, is similar across the groups, varying from 10% among refugees in camps and non-refugees, to 13% among refugees living outside the camps. The same picture applies to children under 5 years of age. Smoking is widespread among males in Jordan; 43% smoke daily, while only 5% of the women smoke.

The three groups have similar patterns of use of health services. sixty-seven per cent of both the refugees in camps and non-refugees who had suffered from an acute illness during the last two weeks, had approached a general practitioner, a specialist or a pharmacist for help. sixty per cent of the refugees living outside the camps sought medical assistance during their illness. None of those who did not seek help claimed that

[16] The fieldwork was carried out in January-April 1996. Preliminary results were presented at a public seminar in Amman in November 1996. The tabulation report is expected to be published by the Jordanian Department of Statistics during the first quarter of 1997. Data on women and children will be published in UNICEF's land report. The tabulations for this report were made by researchers Åge A. Tiltnes and Marie W. Arneberg at Fafo.

there was no appropriate medical facilities nearby, while 5% of the refugees and 2% of the non-refugees claimed they did not seek help because they could not afford to pay for treatment. The rest gave various reasons for not seeking help, like treating themselves or not being sufficiently ill to need help.

Asked about the place they sought a consultation, only 27% of the refugees living in camps and 3% of refugees living outside the camps went to an UNRWA clinic for medical assistance. Twenty-nine per cent of camp dwellers and 42% of refugees living outside the camps consulted a government hospital or clinic. Forty per cent of camp refugees and 30% of refugees outside camps obtained help from private clinics or hospitals. Non-refugees mostly go to government clinics or hospitals for medical assistance (65%), while 30% use private medical services. A very high percentage in all groups claims that they are satisfied with the services obtained (80% and above).

Women were asked about the use of antenatal care. About 15% of the ever pregnant and ever married women (15-54 years old) had not consulted any health service providers during their most recent pregnancy. Fifty-four per cent of the camp refugees and 11% of the refugees living outside camps, consulted an UNRWA clinic. The rest consulted other services very much in the same way as non-refugees. A third of the women had 1 to 5 visits, 23% had 6-8 visits and 30% had 9 visits or more. There were no significant differences between refugees and non-refugees. Six per cent of all women were not assisted by trained personnel during their most recent birth. The figure is higher (13%) for refugees living in camps.

Conclusions

In this paper we claim that the data available on public health in general suffers from an insufficient possibility of breaking the information down according to refugee status. This fact severely limits our ability to obtain a good and reliable overall picture of the health situation for refugees. Recent large-scale surveys in the West Bank and Gaza, and in Jordan, cover this lacuna to some extent, while we have close to no overall information available about refugees living in Syria and Lebanon. At the local level, the situation is somewhat better, but the data available contain other methodological challenges that make generalization difficult. For the Refugee Working Group to improve our general picture of Syria and in Lebanon should take high priority. We have also indicated the need for a standardized survey tool that can be used for local area assessments, the so-called Rapid Living Conditions Appraisal. Core health indicators should be integrated into this tool.

The data available for mental health in the area show high levels of symptoms when compared to European surveys. The situation seems to be worse for refugees than for non-refugees. On the other hand, the overall high levels and the scarcity of studies available, indicate that more research is warranted to evaluate the reliability of the methodology when transferred from a European to a Middle Eastern contextThe available data indicate that health problems may exist in local areas. The general studies, however, reveal that the refugees in the West Bank and Gaza have a similar health status as their non-refugee neighbors. All in all the indicators available show that health conditions for refugees in this area are in a transitional state. In several reports, the

fragmented nature of the health service system in the West Bank and Gaza has been underlined. There is a need for integrating the system better within the framework of an overall strategy.

The preliminary data from the Jordan Living Conditions Survey depict refugees enjoying poorer health than the non-refugee population. The data also tell that the refugees make broader use of the national health services than reported earlier, and that UNRWA is a less dominant provider of health services to the refugee population in the country than reported by others.

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Appendix 2
Suggested Indicators to be included in the Rapid Living Conditions Appraisal

The Rapid Living Conditions Appraisal (RCLA) is a survey instrument being designed by Fafo. The purpose is to design a survey instrument that can produce quickly and at low cost a wide range of indicators of living conditions for a community or a confined area. It will be particularly useful for assessing needs and access to services, for identifying vulnerable groups in the community, and for comparing the situation in different communities in order to target development assistance at a local level.

The RCLA will consist of eight modules, each covering an important dimension of living conditions at the individual, household or community level. Each module can be expanded in a flexible way to cover areas of particular interest. The indicators will be designed in accordance with international standards, so that the RCLA will produce indicators that are compatible with core UN and World Bank data as well as with national statistical series. Trained local interviewers will administer the questionnaire to a limited sample of households in the target area, and the survey results will be supplemented by administrative data from local governments or NGOs.

The modules and the planned indicators are presented in the table below. The eight modules cover population, health, human resources, employment, household economy, housing conditions, infrastructure and social networks, and child welfare. The 64 indicators defined so far, can be summed up in two aggregate indicators of living conditions, one at a household level and the other at a individual level.

In order for Fafo and the Norwegian Shepherd for Databases to proceed with the design of this instrument, we will solicit comments on general aspects and on particular data needs from each of the RWG Shepherds.

The following table summarizes the indicators that are planned to be included in the RCLA. A draft model questionnaire is available from Fafo on request.

The Rapid Living Conditions Appraisal Indicators

Item no	Measure	Indicator
1. POPULATION		
1	Population density	Population size/area
2	Fertility	Child/woman ratio
3	Fertility	General fertility rate
4	Household size	Average household size
5	Household with children	Proportion of households with <5 children (and <15 children)
6	Female headed households	Proportion female headed households
7	Sex distribution	Ratio of males to females
8	Age distribution	Ratio of population <15-65> years
9	*Refugee incidence	Refugee status
10	*Citizenship	Proportion of citizens
B. Migration		
11	In-migration	**In**migrants last year/1000 inhabitants
12	Temporary absences	Total household members temporarily abroad/away
13	Absent money earners	Proportion absentee money earners
14	Absent students	Proportion absentee students
2. HEALTH		
A. The health situation		
15	Physical health	Proportion with prolonged disease/disability
16	Self-assessment of health	Proportion with bad health
17	*Disease pattern	Proportion with selected diseases last year
18	Health insurance	Proportion covered by insurance
B. Therapeutic component		
19	Availability of health services in the community	Average health services index score
20	*Availability of doctors	Number of doctors/1000 population
21	*Availability of nurses	Number of nurses/1000 population
3. HUMAN RESOURCES		
A. Enrolment		
22	Gross primary enrolment rate	Proportion enrolled/total age group
23	Gross secondary enrolment rate	Proportion enrolled/total age group
24	Gross higher enrolment rate	Proportion enrolled/total age group
B. Literacy		
25	Literacy rate	Proportion able to read & write
26	Female literacy	Proportion of females able to read & write
C. Dropouts		
27	Primary level dropouts	Proportion of previously enrolled who have quit/age group

Item no	Measure	Indicator
D. Educational attainment		
28	Highest educational level	Proportion with secondary or higher education
29	Vocational skills	Proportion with vocational skills other than formal education
4. EMPLOYMENT		
A. Employment		
30	Labor utilization	Crude labor force participation rate
31	Female labor utilization	Proportion of females in the labor force
32	Division of labor	Proportion unpaid family workers
33	Employment structure	Proportion in primary/secondary/ tertiary industry
34	Occupational structure	Proportion in selected occupation
35	Number of hours worked	Proportion working less than normal hours
B. Labor under-utilization		
36	Unemployment	Unemployment rate
37	Underemployment	Proportion of underemployed in labor force
5. HOUSEHOLD ECONOMY		
A. Income and expenses		
38	Household total income by income source	Average income
39	Household expenses by expenditure category	Food proportion to total expenses
B. Income distribution		
40	Poverty	Proportion below median income
41	Extreme poverty	Proportion of population below national poverty line
C. Vulnerability		
42	Ability to raise money	Proportion who cannot raise (sum of money) in a week
43	Alternative incomes	Proportion with access to arable land
6. HOUSING CONDITIONS		
A. House type		
44	Type of dwelling	Proportion residing in substandard dwellings
45	Dwelling ownership	Proportion not owning their own dwelling
B. Dwelling size		
46	Crowding	Average persons per room
C. Housing characteristics		
47	Household amenities	Average amenity index score
48	Household consumer durables	Average durables index score
D. Household indoor climate		
49	Indoor damp, temperature, air quality	Proportion living in substandard dwellings

Item no	Measure	Indicator
7. INFRASTRUCTURE AND SOCIAL NETWORKS		
A. Infrastructure		
49	Availability of public social services in community	Average social infrastructure index score
50	Safe water	Proportion without pipe connection (%)
51	Safe water stability	Proportion without stable pipe connection
52	Pollution	Proportion without systematic garbage collection (%)
53	Sewage	Proportion without sewage connection
54	Electricity	Proportion without grid connections
55	Availability of economic infrastructure in community	Average economic infrastructure index score
B. Social network		
56	Availability of social networks in the community	Proportion with weak social networks
8. CHILD (<5) WELFARE		
A. Child presence		
57	Proportion of children to adults	Child dependency ratio
B. Child deprivation		
58	Children and household economy	Proportion of children living in poverty
C. Child health		
59	*Child mortality	Under 1 and under 5 mortality rate
60	Child vaccination	Proportion of children vaccinated against one or more basic diseases
61	Child nutrition	Proportion of children with <12,5 and with 12,5-13,5 middle upper arm circumference (MUAC)
62	Respiratory infection	Proportion of children with respiratory infections (last 14 days)
63	Diarrhea	Proportion of children with diarrhea (last 14 days, currently)
D. Environmental safety		
64	Household with children and exposure to environmental pollution	Proportion of children with low outdoor or indoor environmental quality (incl exposure to smoking)
9. AGGREGATE LEVEL OF LIVING		
65	Household level of living	Proportion of households below average RLCA score
66	Individual level of living	Proportion of individuals below average RLCA score

Availability of public health data about Palestinian refugees

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