Birzeit University
Community Health Unit

Planning for Health in Occupied Palestine

Occasional Papers

Table of Contents

1. Introduction

Until very recently, the Palestinian question has been largely viewed as essentially a national problem. The absence of a national government interested in the welfare of people, and the continuous presence of the Israeli military occupiers in the West Bank and Gaza Strip have been almost invariably provided as explanations for a generally dismal living situation. The same argument has also been put forward to explain the unacceptable level of health of the population living in the area.

Undoubtedly, Israeli military occupation is playing a primary role in perpetuating this situation, not only by exercising complete control over people's lives, but also by providing a complex and sometimes subtle framework through which political, economic and social manipulations can occur. Military occupation represents a crucial mechanism through which underdevelopment in the health sector is perpetuated.

This presentation attempts to show the impact of the occupation on the health sector. It also attempts to show why any hopes for change are linked to a precondition: the end of military occupation.

Erratic and at times inappropriate developments in the health infrastructure are major features characterising the situation today. And though to a large extent determined by the presence of the military occupier, these problems are also due to a lack of understanding of the reality of health conditions, and to our failure in planning corrective programmes that are compatible with people's needs. This point has to be stressed, not only because it has been successively and sometimes systematically neglected, but especially because initiatives in health development at the present stage must be prevented from reproducing and compounding current problems in the future.

2. The Health Picture

In spite of the relative scarcity of reliable information, data is available which indicates that the health conditions of the Palestinian population living under occupation have to be termed at least inadequate. We may draw such a conclusion from the examination of the infant mortality rates of the area (infant mortality rates are generally considered indices of the health of a population). The infant mortality rate figures provided by the military government for the period between 1975 and 1980, for instance, fall within a range of 26-36 deaths/1,000 live births for the West Bank (1), and 43-69.3 for the Gaza Strip (2). Health professionals, however, including those working within the military government's health apparatus, are well aware that these figures represent a substantial underestimation of the problem. This is due to a variety of reasons, most important the fact that only a portion of births occur in hospitals, specifically 44.4% for the West Bank and 33.1% for the Gaza Strip during 1979 (3). As a consequence, birth and death registration is generally inaccurate. This problem is further compounded by a lack of interest on the part of the military government's health apparatus in developing and maintaining an accurate record-keeping system, and the lack of incentive on the part of the population to register the death of their infants.

Several infant mortality rate studies have been attempted by non-governmental agencies and health personnel. One such study provides us with an estimate of 71 deaths per 1,000 live births for the West Bank in 1973, 74 in 1974 and 84 in 1975 (4). Others are estimates for specific groups within the population. The infant mortality rate for a village population in the Jordan Valley area was found to be 100 deaths/1,000 live births in 1980 (5), while that of the refugee population was 58 deaths/1,000 live births for those living in the West Bank, and 79 for those living in the Gaza Strip (6). In all, one may safely conclude that the infant mortality rate in the Occupied Territories is likely to be in the range of 50-100 deaths per 1,000 live births, a range that places the area in the category of underdeveloped countries as far as the health status of the population is concerned.

It is becoming increasingly clear that morbidity, and not only mortality, constitutes a major health problem in the Occupied Territories. Studies have also been conducted in this field. Children are emphasised because they are a priority in health, and because it is generally accepted that children function as a barometer reflecting the overall health of a population. Information on child morbidity is particularly useful in the case of the Occupied Territories where data on birth and death

registration as well as disease incidence and distribution is unreliable, and where political, financial, and infrastructural factors block the way of an overall health status assessment. Thus, by way of various physical measurements, we are able to accurately assess the health status of children, and thereby also gain an understanding of the health conditions of adults. By conducting studies on target (children and mothers) and prototype populations (representative villages or groups, for instance), we are in a position to arrive at the understanding necessary for planning health services that are compatible with people's needs.

Such studies demonstrate that major causes of death as well as morbidity are malnutrition and infection (primarily respiratory and gastrointestinal), two disease categories that are known to be preventable. It was found, for instance, that over half of the infant deaths among refugee populations in both the West Bank and the Gaza Strip were due to respiratory and gastrointestinal diseases during the 1975 to 1977 period (7). In another study conducted in three villages in the Ramallah district, an area which is known to enjoy better living conditions than most other districts, it was found that 30% of the children under the age of three years were infected with one or more parasites, 18% were anaemic, and 44% were malnourished. The rate of anaemia among their mothers was 15% (8). In the case of the Jordan Valley rural community mentioned above, 50% of all the children under five years of age were found to be malnourished (9).

Another contributing, if not major factor determining the health status of the population in question is their living conditions, particularly in rural areas where approximately 70% of the population live. In 1981, for instance, only 26.9% of all households in West Bank villages were provided with electricity around the clock, 29.3% had running water, 21.5% had no toilet facilities at all, and none of the villages had a sewage system (10). Crowding in the homes is another characteristic of households in the Occupied Territories. In 1980, 53% of all dwellings in the West Bank and Gaza Strip consisted of 2 rooms or less, while the average number of persons per household was 6.7 for the Gaza Strip and 6.9 for the West Bank.

A health picture such as the one described above may be corrected relatively easily by simple preventive measures that do not necessarily require large expenditures nor sophisticated curative centres of the type found in industrialised countries. Such a health picture indicates that disease in the Occupied Territories is due not only to the lack of health services, but, more importantly, to an unhealthy environment that is conducive to the spread of disease. The obvious appropriate approach to the solution of such health problems is one that is geared towards the removal of the cause of sickness rather than the institution

of curative services and the treatment of symptoms. Specifically, the solution to health problems in the Occupied Territories is linked with the provision of a clean water supply designed to reduce the incidence of gastrointestinal diseases and the ensuing mortality, and to control and lower the incidence of skin and eye diseases. It is also linked with the provision of adequate living space, proper garbage and sewage disposal so as to reduce the spread of disease. It is ultimately linked to the improvement of people's incomes, and of health and nutrition education as means of eradicating malnutrition and disease in general.

3. The Interaction Between Underdevelopment in the Health Sector and Military Occupation

Following the 1967 Arab-Israeli war, the Israeli military government took over control of existing government health facilities previously administered by the Jordanian and Egyptian governments, and at which the majority of the population received health care. Since 1967, the military government has at best neglected even the maintainance of the existing health infrastructure, and, at worst, systematically suppressed the growth and development of both the public and private health sectors. Today, health services are provided to the population by three types of institutions: governmental institutions that are controlled by the military government; UNRWA, delivering services to refugees; and the private sector, a rather homogeneous group of institutions including foreign and local voluntary agencies, charitable societies, individual private practitioners and profit-making health establishments.

One of the most outstanding features of the health sector in the Occupied Territories is the absence of a comprehensive development plan, and the lack of coordination and cooperation among the various groups and institutions that deliver health services to the population. This seems to lead to erratic and inappropriate development initiatives. To begin with, any attempts at coordination and cooperation among the various private groups are usually met with retaliation on the part of the military government, taking various forms, from harassment of individuals to denial of permits to initiate and operate needed health projects. This kind of suppression usually accounts for arbitrary intervention programmes that come into being largely for political reasons. The example of the newly licensed project of a 300-bed hospital in the Ramallah district is a case in point. The plans for erecting the hospital (when there are already 17 in the West Bank) were approved during the same month when another health group was told, after eighteen months of waiting, that approval for a running water supply project in one of their villages would not be granted unless they requested help from the Village League.

Thus health sector developments and the direction they take are not determined on the grounds of a health development plan or people's actual needs, but rather because of political considerations. This is also an example of how health care is being used as an instrument of political control.

Another important feature of the health sector under occcupation is the maldistribution of health resources that is being perpetuated and compounded by both the control of the occupying

authorities and Palestinian political and economic considerations. Today, for instance, the West Bank boasts 17 hospitals: nine governmental and eight private hospitals. Of these, six are located in the Bethlehem district alone, where 11% of the population live, and all are located in urban centres. In 1979, of the total manpower employed in the governmental health service, 60% of all physicians and 58% of all nurses were employed in hospitals, leaving the rest scattered in health departments, rural and urban health centres, school health services, and laboratories and training units (12). The same type of urban bias is reflected in budget allocations: in 1977, over half of the grossly inadequate governmental health services budget was allocated to hospitals alone (13).

The situation in the private sector does not appear to be different. According to the records of the Public Health Department, for instance, of a total of 53 registered physicians in the Bethlehem district, 31 were employed in private hospitals; all except for one operated private clinics in urban centres. Yet 70% of the population of the West Bank live in rural areas.

Various influences contribute to this inappropriate distribution of health resources. Again, the single most important factor that allows the perpetuation of such a situation is the absence of a national governmental authority that is interested in the welfare of people, conscious of the impeding problem, and able to control and direct development in such a way as to coordinate the activities of both the public and private sectors according to a plan that is deemed compatible with people's needs. But other factors are important here as well. Lack of a transportation system linking rural areas to urban centres, the difficulty of attracting qualified medical personnel to the type of work involved, and the usual problems of instituting services in rural areas are all part of the general picture.

Education of the medical personnel is another important factor. The majority of health professionals in the Occupied Territories were trained in establishments abroad that emphasise curative rather than preventive medicine; they thus tend to replicate work situations which they are acquainted with, and which allow them a greater profit margin as well. Additionally, since under military occupation no plan exists for manpower development, choices of specialisations are largely left to individuals who are likely to follow their personal tastes rather than base their choice on the appropriateness or collective need for a given speciality. The result is an inappropriate and arbitrary distribution of specialisations and absurd situations of extremes. Examples include the presence of 60 unemployed physicians in the Ramallah district alone in 1981 (14), while at

the same time, nurses were very difficult to find. Also, of the 53 physicians registered in the Bethlehem district, 26 were registered as specialised, 11 were surgeons, and there was not a single public health specialist (15). Such a situation further reinforces the bias towards urban-based curative services, i.e. a health care delivery system that may not necessarily be appropriate nor a priority at the moment.

The situation is further compounded by the inability of Palestinians under occupation to participate in public debates and discussions over what their health priorities are and, therefore, where the financial aid which they receive from outside sources should be channelled. What is more, it has been observed that individuals and institutions who are financially supported from abroad tend to be urban-based and politically powerful; they sometimes receive funds in exchange for political support, rather than because of established need and in accordance with a national plan of priorities. The rural majority and those very few whose concern with health development is geared towards removing the cause of the pathology rather than providing the temporary cure, have not proven to be politically powerful. Thus it is only to a very limited degree that they can exert pressure or offer incentives to the funding agencies provided, of course, they are able to reach them in the first place.

A third feature characterising the health infrastructure under occupation is the increasing and systematic weakening of Palestinian health institutions and, as a consequence, a growing dependence of Palestinians on Israeli health establishments. In addition to the ineffective and inefficient administration of governmental health services, budget allocations are known to be insufficient in so far as they do not even cover the maintenance of health facilities that existed before 1967 and, in general, fail to fulfil people's basic health needs. The 1975 budget for West Bank medical services, both hospital and public health, for instance, has been shown to be equivalent to about 60% of the budget of one Israeli hospital alone for the same year (16). Adding insult to injury, this already insufficient budget is being reduced from year to year. The health budget for 1978 was 12% less than that of 1977, the 1979 one 8% less than that of 1978, and that of 1980 6% less than the 1979 budget. What is more, it is known that about 30% of the Occupied Territories' health budget is paid to Israeli hospitals for referral services (17), which would not be necessary were it not for the lack of interest on the part of the military government in maintaining adequate health services.

The weakening of Palestinian health institutions, their inability to support the health needs of the Palestinian

population, and the push towards dependence on Israeli health institutions can only be seen in their most dangerous form, namely as an attempt to paralyse Palestinian efforts at maintaining the infrastructure that is needed for reconstructing their society independently. It is precisely this dependence that Palestinians reject, and not the services that the Israeli health establishment can offer them. From the Palestinian point of view what is needed is a serious attempt at developing existing health institutions in such a way as to allow and enable them to care adequately for the health of Palestinians in a self-reliant and non-dominated manner. This, however, seems impossible to achieve without the removal of the occupation.

Of importance also are the economic consequences of the occupation on health. Under Jordanian rule, the economy of the West Bank was largely based on agriculture, with a diversified output. Among the most important crops were wheat, barley, lentils, olives and citrus fruits. Agriculture in general provided work for almost half of the labour force. But at the same time, the agricultural work force was underemployed, and a high rate of open unemployment prevailed (18).

The major economic effects of the occupation have been the incorporation of the Palestinian labour force into the Israeli economy and the opening-up of the West Bank and the Gaza Strip markets to Israeli products. More than one third of the labour force became employed in Israel, approximately 73% of whom came from rural areas. Wage labour opportunities in Israel led to the increasing neglect of the land (19), a shift in food consumption patterns, and an ever increasing dependence on Israel for the provision of food. Today processed foods are replacing locally produced items as part of the everyday diet. In the case of a village in the Ramallah district, for example, only 29% of all married women under 50 breast-fed their infants, and over half introduced "Cerelac" (a Nestle weaning food that must be reconstituted, like powdered milk, with water, when a clear water supply is unavailable in this village) as an early weaning food into their children's diet. The village stores were almost exclusively stocked with processed food items including, of course, carbonated and sweet drinks that are replacing water in the villagers' diet. The link between this kind of food consumption pattern and the fact that in 1982 40% of all the children under three in this village were found to be malnourished, and 30% were infected with one or more parasites, cannot be overestimated. Similar results were obtained in two other villages in the Ramallah district (20).

At present, the few health programmes that are geared towards fulfilling people's basic needs remain the burden and the responsibility of voluntary agencies (both local and foreign) as

well as charitable societies. The efforts of some such agencies have at times proven to be remarkable. These efforts however, remain limited. They are bound to be sporadic in view of licensing procedures, fund-raising activities and acquisition of grants, the absence of a plan for health development, and the inability of these agencies and societies to coordinate their activities. Duplication of services is also evident: one finds a relative abundance of health services in some easily accessible areas such as the Ramallah and Bethlehem districts, but a shortage in others that are more difficult to reach, and yet most in need, such as the Jericho/Jordan Valley area (21).

Of crucial importance is the approach that most of these agencies and societies take in the delivery of health care. Their perspective remains essentially charitable, does not include community mobilisation and participation as an integral aspect of intervention programmes, and, in the final analysis, fosters, perpetuates, and reinforces the very dependence that is the crux of our problem. And certain intervention programmes even seem to be creating new health problems. An American agency operating in the Occupied Territories, for instance, is known to link its mother and child health programmes with the distribution of food, including powdered milk, to mothers and their children. Despite several attempts to reason with this agency, powdered milk distribution continues until today. It may be revealing to add that, according to reliable sources, the financial viability of this agency rests, at least in part, on the continuation of the food aid programme since the agency receives a substantial portion of its operating budget in return for food distribution efforts. Here then is a classic example of intervention programmes launched in the name of Palestinian people, but in fact serving the interest of other groups.

4. Planning For Better Health

It is obvious that the prevailing Palestinian approach to the solution of health problems requires re-evaluation, particularly so since the actions of today may well determine the direction of development in the future. The first point to stress is that our approach so far has largely been the bio-medical or engineering approach of working on the symptoms, rather than dealing with the causes, which are largely determined by political, economic, social, and ecological realities. And, as has been stated and shown so many times before, this approach stops short of what would be necessary to change the conditions that produce and perpetuate disease. The institution of health services alone has not solved our problems of health, and will not do so in the future. Planning for health improvement, and the eradication or control of disease can ultimately only be successful if they are linked with an overall national development plan. And our success or failure in reaching our objectives is determined by the nature of the development strategy that we formulate.

The second point to make is that we must, as we plan for health care, keep a clear focus as to where our priorities lie. Available information regarding both the nature and cause of disease in the Occupied Territories shows that the focus of our attention must be directed towards the improvement of people's living conditions, towards better accessibility to health services, particularly preventive ones for the rural population, and towards health and nutrition education of the public at large. Special attention should be paid to women of child-bearing age and children under 15 years, not only because they constitute an important high risk group due to biological reasons, but because these groups comprise about 70% of the total population living in the Occupied Territories.

The third point relates to the financial feasibility of plans and the justification for establishing further curative-oriented medical centres especially in the towns. It has repeatedly been stated that there does not seem to be any choice in the matter, since our ability to achieve a real improvement in the health status of people is extremely limited due to the constraints imposed by the political reality, since funds are available at least for the erection of centralised curative services, and since approval of such services by the military government is possible. Perhaps there really is no choice, but the lack of choice is not solely due to the presence of the military occupier. It is also due to Palestinian political and financial considerations that are not necessarily geared towards what should be our main objective, namely, the improvement in the health status of people. Otherwise, why were there no apparent

efforts made to pool existing financial and manpower resources in such a way as to improve existing medical centres or hospitals? Clearly, such a step would have been less costly and more rational than the construction of new, large-scale medical centres. Support should have been given to Maqassed Hospital in Jerusalem, for instance, which has recently been taking expansion steps directed towards high-technology, specialised medicine and thereby, at least partially, towards reducing our dependence on Israeli establishments for specialised care.

At present, a potential for unnecessary and possibly detrimental competition exists. More importantly, the stage is set for the development of a vicious circle where an increasing portion of the total expenditure on health must go towards covering the expensive operating budgets of high-technology medical centres. The experience of other Arab and Third World countries makes us suspect that the increased costs would probably be incurred at the expense of the public and rural health portions of the budget. Even the World Health Organisation is finally responding to the evidence that hospital medicine, while being too expensive to be replicated in rural areas, does not and cannot eliminate the cause of disease (23). This kind of inappropriate development is costly, incompatible with people's needs, yet probably compatible with the needs of health care providers and therefore difficult to reverse.

Finally, it is even more obvious that most of the health intervention programmes in the Occupied Territories today remain in the form of arbitrary activities largely determined by the political reality. Any prospects for change are therefore linked with the end of military occupation. Only then would the possibility for a self-directed development exist, and, with it, the hope for change. In the meantime, very little can be done; most of our efforts are thus doomed to remaining no more than a palliative treatment to a recurring disease.

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