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Finding Means

UNRWA's Financial Crisis and Refugee Living Conditions

Volume III: Social Service Delivery to Palestinian Refugees:
UNRWA and other providers, UNRWA financial and
donor environment

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Volume III: Social Service Delivery to Palestinian Refugees: UNRWA and other providers, UNRWA financial and donor environment.

Contents

Preface	6
Chapter 1 Health Services,	
<i>Laurie Blome Jacobsen, Lena Endresen, Gro Hasselknippe</i>	9
Summary of Main Findings	9
Introduction	11
Overview of UNRWA and National Health Services	12
UNRWA Programme of Emergency Assistance in the West Bank and Gaza	15
A Measure of Health System Responsiveness: Satisfaction with health services	23
Specific Health Programmes	26
References	46
Annex 1.1 Examples of UNRWA Austerity Measures and their Effects on Health Services 1990-2000.....	48
Annex 1.2 UNRWA Health Expenditures 1999-2000.....	49
Chapter 2 Education Services,	
<i>Laurie Blome Jacobsen, Lena Endresen, Gro Hasselknippe</i>	51
Summary of Main Findings	51
Introduction	53
Overview of UNRWA Education Services	54
Coordination with Host Country Ministries, Access Issues and Other Providers	57
Education Services and Trends in Provision	60
References	85
Chapter 3 Mental Health in the West Bank and Gaza: A summary of the mental health status, policy and service delivery during the Palestinian transition,	
<i>Marzio Babilie, MD, MPH, DTM&H</i>	87
Introduction: Less Exclusion More Care.....	87
The Scope of the Chapter	88
The Current Political Framework of Health	88

The Problem Dimension	91
Mental Health Services and Stakeholders' Analysis	95
West Bank	98
Gaza	103
Children's Mental Health and Cognitive Development	108
The Current Work of the UNRWA and UNICEF in Mental Health.....	110
Problems to be Addressed	114
Remainder of Key Priorities	117
References	119
Annex 3.1 Mental Health and the 199-2003 national Health Plan	123
Annex 3.2 Putting Policy into Action	125
Annex 3.3 List of Palestinian NGO's Active in Mental Health	127

**Chapter 4 UNRWA Health Care in the West Bank and Gaza:
A descriptive overview of stakeholders perceptions on policy
process and quality of services,**

<i>Marzio Babilie, MD, MPH, DTM&H</i>	129
Summary of Main Findings	129
Introduction: The Health System Building Context.....	131
Scope	133
Design	134
Methods.....	134
Limitations	134
Availability of Health Services	135
The Role of the UN in the Transition in the WBGS	136
The Nature and Supply of UNRWA Health Services	137
The Role of UNRWA in the Health System Development Tasks	142
Complementation and Quality of Services.....	144
Developing Service Evaluation	146
Human Resources Development	148
Progress and Shortcomings	148
References	151
Annex 4.1 Quality of Health Care	152
Annex 4.2 List of Interviewed Officers	154

Chapter 5 Donor Contributions to UNRWA,

<i>Rex Brynen, McGill University</i>	157
Methodological Issues	159
Trends in Donor Support	164
Burden-Sharing	167
Donor Policy-making	172
Conclusion: Looking Ahead	175
References	178

Chapter 6 UNRWA's Budgetary Process: Budgets and Expenditure 1990 to 1998,

<i>Ian Barney, Centre for Development Studies, University of Wales, Swansea, UK</i>	179
Summary of Main Findings	179
UNRWA Budgetary Processes 1990 to 2001	181
Strategic Priorities	183
Analysis of the UNRWA Budgeting Process	196
Conclusion	204
References	208
Annex 6.1 Schedule of Meetings	210
Annex 6.2 Overview of Major Differences between Previous and Current Budget Preparation Exercises.	212
Annex 6.3 Example of Budget Technical Instructions	213
Annex 6.4 Example of Standard Norms	214
Annex 6.5 Analysis of Actual and Budgeted Expenditure by Sub Programme	215
Annex 6.6 Analysis of Change in Significance of Expenditure by Sub Programme	217
Annex 6.7 Actual Management Costs as a Percentage of Actual Total Costs	219

Preface

Since the early 1990s, the budget of the United Nations Relief and Works Agency for the Near East (UNRWA) has faced a significant shortage of resources relative to the level of funding identified by the Agency as necessary to maintain a constant level and quality of basic services to the growing population of Palestinian refugees. Refugees themselves, the Agency and donors alike have voiced a concern about the effect on the living conditions of the refugee population due to this shortage of funds.

As Norway has financed a series of studies of living conditions and surveys among the Palestinian refugees, Norway commissioned the Fafo Institute for Applied International Studies to produce accurate and objective data and analysis relevant for the policy debate on the impact of UNRWA's present financial situation on refugees, and the future financing of services to refugees. Switzerland joined the project with an aim to help create debate among professionals within the Palestinian community on the pertinence and meaning of the findings. Both countries have done so out of commitment to the Agency and in solidarity with the refugees. On this basis, Fafo embarked on a collaborative effort with a network of professionals in the region.

Fafo is proud to present the result of this work in the form of a three-volume report in addition to a summary report. Limitations in the available data has, of course, restricted both coverage and analysis, but this report nevertheless provides the most comprehensive and updated compilation of data and analysis of the living conditions for Palestinian refugees living in the host countries in the Middle East that has ever been made.

We are grateful to all our colleagues outside of and within Fafo for their excellent work in authoring the report. All authors are identified on their contributions. Laurie Blome Jacobsen from Fafo has directed the project and edited the volumes, and I thank her for persistent and well-managed coordination.

We are also in debt to UNRWA for their interest in the project and for forthcoming cooperation throughout the project. We have discussed our findings and we have shared

views, but it should be needless to say that all results and views presented in the report are the sole responsibility of the authors and do not reflect any position taken by the Agency nor by the institutions financing the study.

This study has received the generous contribution of many individuals. We thank all of the individuals who offered their insights to us during fieldwork interviews and workshops, including UNRWA staff at Gaza Headquarters and UNRWA Headquarters in Amman, and UNRWA Programme and Field Directors. Our gratitude also goes to the members of our Editorial Advisory Group (Randa Fatah, Rema Hammami, Ahmad Hammouda, Muhammad Ali Khalidi, Youssef Al Madi, Adnan Abdel Rahim, Rosemary Sayigh, Abdel Fattah Abu Shokor, Salim Tamari, Ali Zaghal) who have been closely involved throughout the project. We thank them for their time and their excellent counsel.

Acknowledgement is due to the Norwegian Ministry of Foreign Affairs for their funding of both this particular project and for the living conditions surveys from which we have taken most of the statistical data. We are grateful for their incessant interest and support. Acknowledgment is also due to the Swiss Agency for Development and Cooperation (SDC) for their funding of the workshop series and the Editorial Advisory Group, and for providing feedback and participation in the final workshop at Montreux, Switzerland. We also thank Max Fahrni for his help in arranging the Montreux workshop.

We also thank the Fafu staff in Jerusalem (Akram Attalah and Hani El Dada) and in Amman (Gro Hasselknippe) who provided valuable assistance in fieldwork and arranging workshops.

Oslo, March 2003

Jon Hanssen-Bauer
Managing Director
Fafu Institute for Applied International Studies

Chapter 1

Health Services

Laurie Blome Jacobsen, Lena Endresen, Gro Hasselknippe

Summary of Main Findings

UNRWA provides an important safety net in the area of health for the refugee population and for this reason any reduction or limitation on services will impact the most vulnerable group of refugees most. Others commonly use alternative providers.

There are many signs that UNRWA is functioning quite well to reach the most needy and vulnerable part of the refugee population in health care provision. As options for high-quality, subsidised government health care increase, more refugees use the public system (Jordan). Those that can afford to use private and specialist health services often do so. This is the case despite being eligible for free services by UNRWA. Women and individuals in low income groups are the typical users of UNRWA as a main or sole health care provider. For women, UNRWA is heavily used for prenatal care either alone or together with care by another provider. For primary care, women and low-income individuals are common users.

Needs in the refugee community have changed over time. UNRWA has not been able to extend services to meet health transitions.

Many of the results of the study pointing to gaps in coverage exemplify the fact that UNRWA was created to meet an acute health crisis. Now, refugee health indicators more closely resemble middle-income countries (except Lebanon). Refugees have passed through health and demographic transitions changing the nature of health needs. The question is whether or not retargeting and expanding resources to meet that need is in line with the original mandate of the Agency.

Health outcomes are poorer among refugees in Lebanon (and to some extent Syria) than elsewhere, and in Jordan, poorer in camps than outside.

In Lebanon and Syria, child malnutrition is more serious and gaps exist in vaccination coverage. In Lebanon, childhood chronic illness and disability is double that found among camp refugees in Jordan, and four times that found among non-camp refugees in Jordan. Adult

health is also poorer. Within Jordan, camp refugees have higher rates of chronic illness and psychological distress than those outside camps.

More resources needed in Lebanon to bring refugee health outcomes up to the same level as other refugees, and to that of the national population on core health outcome measures.

Here we witness the implications of an Agency being the primary provider for refugees versus a supplementary provider (as in Jordan). Access to public and private providers is limited and costly. This is primarily due to domination of the private sector health providers and lack of capacity in the public sector. Refugees in Lebanon must bear considerable costs when needing private or governmental provider services, such as for hospitalisation, specialist and emergency care.

Gaps in health care for refugees in the current network of UNRWA, government, private and NGO providers are evident beyond primary care, such as specialty, disability and mental health.

While UNRWA primary care has improved basic health, there are gaps in coverage for other types of care evident. This appears to be due both to UNRWA's inability to expend more resources on current programs or expand its scope of services, and an apparent lack of other providers to fill the gap satisfactorily --

either due to refugee's lacking access to services or due to the national health system lacking capacity.

UNRWA mostly has met expectations of its patients and, therefore, can be considered to be a responsive health system. But compared to other providers, UNRWA less often meets expectations.

Refugees are generally pleased with individual health visits at UNRWA clinics, but less so than with other providers. This may, however, have less to do with actual performance of UNRWA than quite high expectations on the part of refugees. The decline in per capita expenditure, in some cases, in real terms, freeze on staffing and other signs of lowering the level of services may result in lower satisfaction, simply because it appears to be "less" regardless of the relative service level compared to other providers. We cannot know from the data available the reason for slightly less satisfaction, but regardless, the fact that most are satisfied with services, and given the scarce resources available to UNRWA, this should be considered a good result.

UNRWA provision of primary health care results in less health disparities across the refugee population and represents a health system prioritising equality of access.

UNRWA's provision of free primary health care means it is equally accessible

to all registered refugees regardless of income level. However, difficulties in covering hospitalisation and special care costs may erode the good results of such a system. This is especially the case as refugees go further through a health transformation in which certain chronic illness associated with more developed countries begin to predominate over communicable diseases as contributing most to mortality and morbidity.

Introduction

The aim of this chapter is to give a broad introduction to the types of providers and health systems in each of the fields of UNRWA operation, describe trends in UNRWA provision of health services during the 1990s, and to point out specific areas in which it appears that lack of UNRWA resources to expand the level of scope of services has implications for health outcomes among Palestinian refugees.

As described in Volume 1, Chapter 7, “Health and Nutrition”, in most fields (except Lebanon) many basic health outcomes favour refugees and are better than in developing countries as a whole. This is despite higher poverty levels in camps. Favourable health outcomes among refugees are the result of UNRWA’s health services caring for those lacking access to national and/or private health care. The importance,

therefore, of UNRWA’s contribution is largest in Lebanon, where access to other providers is poor for refugees, and less so, but still lacking for all Lebanese due to the high cost of the private-dominated system. But, at least in the other fields, good health outcomes are also the result of other providers, (which refugees also commonly use for some types of services) and national investments in health programs. These national health systems differ, each with various combinations of advantages and disadvantages in terms of equality of access, affordability and quality.

This chapter starts with a descriptive overview of UNRWA and national health care systems, including various indicators of capacity, access and quality: Such as (1) facilities and human resources capacity; (2) insurance coverage and cost-sharing arrangements, and (3) satisfaction with services reported by individuals.

Next, the chapter will look in more detail at the different kind of services (primary, secondary and tertiary) as well as those aimed at specific population groups (women and children, disabled and so on). The aim of this section is to not only describe capacity and access to different providers of this care, but also identify user profiles and gaps in health care provision existing in the network of private, national and UNRWA service delivery.

Overview of UNRWA and National Health Services

UNRWA Health Services

UNRWA's health care mandate is to meet basic health needs in a manner consistent with the basic principles of the World Health Organisation (WHO), and to provide a similar level of services as the host government. UNRWA provides primary health care according to WHO strategies in infant and child health, maternal health, control of communicable diseases, diagnosis and treatment of common diseases, and dental care. In a number of its health centres the Agency also offers limited specialist services.

UNRWA operates no secondary facilities with the exception of a maternity hospital in Gaza and a hospital in the West Bank, but instead assists patients in receiving "essential hospital services". This assistance ranges from patient reimbursement to contracting of hospital beds, and to a mix of the two strategies. The reimbursement rate ranges from 75 to 90 percent of hospitalisation costs.

During the 1990s little growth in actual UNRWA health facilities, but increase in scope of services.

The number of UNRWA primary care centres has remained stable throughout

the 1990s. The main element of growth in UNRWA health services is the expansion in the scope of services. Types of services for which the Agency has expanded capacity during the 1990s include special care for hypertension and diabetes, dental care and family planning.

Each facility serving more refugees, but ratio of professional health personnel to registered refugees overall has generally kept pace with population growth.

While the number of facilities has remained essentially constant, the population size UNRWA's mandate calls for the Agency to serve has grown. The effect of this in quantitative terms is difficult to estimate due to lack of a reliable denominator, or actual population regularly served. UNRWA reports costs and personnel on a per capita basis, but not all refugees use UNRWA health services.

Thus, although clinics are being charged with serving a larger and larger population, there has not been a substantial decline in health staff relative to population during the 1990s. Overall, there has been a slight decline in the proportion of nurses to population, but the proportion of physicians and dentists has remained essentially the same (Table 1.1).

Capacity, in these terms, varies quite a bit by the field of operation. One trend during the 1990s, however, has

been to reduce large differences in nurse staffing that existed in 1990. This has meant substantial reductions in some fields, notably the West Bank; slight increases in Gaza and fairly even nurse staffing in Lebanon and Syria. In Jordan, there continues to be lower UNRWA nurse staffing than elsewhere relative to the refugee population in that field.

Differences in physician staffing levels across the fields present in the early 1990s continue to exist. In 1990, the proportion of physicians to population was lowest in Jordan with 5.5 per 100,000 and highest in Lebanon and Syria (11.9 per 100,000). The most growth in physicians has been in the Gaza Strip and Lebanon, with 8 percent annual increase in physicians. The least growth in physician staffing has occurred in Syria (6.2 percent annual increase). As of 1999, there were slightly higher proportions of physicians to population in Lebanon and Syria at about 12 physicians per 100,000 population than in Gaza and the West Bank at roughly 9

physicians per 100,000 population. There is a large gap between these fields and Jordan field, similar to the case of nursing staffing, which has only 5 physicians per 100,000 population.

The most striking aspect of UNRWA health personnel relative to the population size is the low numbers compared to what one is accustomed to as indicators of investment in health care. This is due to the overlap in UNRWA and national and/or private systems, and difference in measurement. In the case of UNRWA, this measure is misleading as an indicator because it is not possible to directly compare to national measures. Typically this proportion is the number of physicians divided by the total population, regardless of actual utilisation.

However, we can come up with a rough estimate of the proportion of UNRWA physicians per user -population in order to better reflect the numbers regularly served. This also helps to adjust for the fact that UNRWA physicians do not provide secondary care. Table 1.2 includes a number of adjustments of the total population using population estimates from 1999 and the proportion utilising UNRWA services from the Living Conditions Survey data for Jordan, Lebanon and the West Bank and Gaza (WBGS). The resulting physician to population ratio is more on target with what we would expect for a developing

Table 1.1: UNRWA physicians per 100,000 refugee population (UNRWA registered population).

	Jordan	West Bank	Gaza	Lebanon	Syria
1990	5.5	9.2	7.5	11.9	11.9
1991	5.7	10.1	7.6	12.3	12.7
1992	5.4	9.4	7.9	11.0	11.7
1993	4.8	8.7	7.5	10.4	10.0
1994	5.0	9.8	7.4	12.9	11.4
1995	4.8	9.9	8.1	13.1	11.4
1996	5.0	10.8	7.5	13.5	11.6
1997	5.1	10.2	9.2	13.0	11.9
1998	5.0	9.9	9.3	12.5	11.9
1999	5.0	9.7	9.2	13.1	12.2

country. While the estimated ratios are imprecise in the sense that we do not take into account, for example, the difference in user population by type of care (only including a recent acute illness or injury) which would raise the proportion for some types of care (prenatal) but lower it for other types of care (hospital care), the point is to demonstrate that we come to very different conclusions regarding the sufficiency of staffing. If we take Table 1.1 as a rough estimate of actual staffing per population, we see considerable under-staffing in Gaza.

UNRWA's actual health expenditure by programme during the period 1990 through 2000 are listed in Appendix 1.1. According to this data, UNRWA's expenditure on health services per capita has

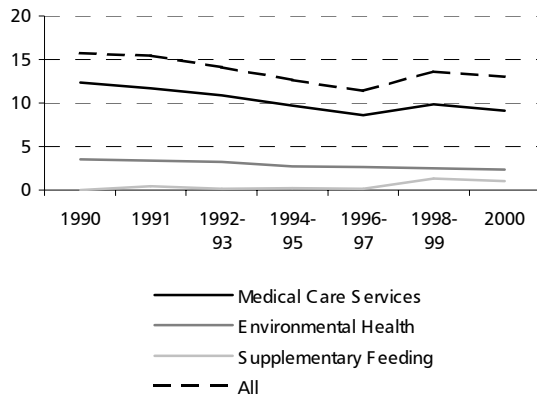
declined during the 1990s. The largest declines in expenditure ratios occurred during 1994 and 1995, and in recent years have increased slightly again (Figure 1.1). Overall there has been a 17 percent decline in health expenditure per capita (from 15.7 USD in 1990 to 13.0 USD in 2000), some 1.9 percent decline per year. Expenditure per capita on supplemental feeding is quite small, but has increased slightly. Declines in per capita expenditure are largest for environmental health, 4 percent annually compared to 3 percent annual declines in medical care services per capita expenditure. Despite these reductions relative to the registered refugee population, expenditure per medical consultation has increased during the 1990s, although not evenly so in every year (Figure 1.2). Per

Table 1.2: Ratio of physicians to population; UNRWA registered, Fafo population estimated, and Fafo user population estimated.

	Total UNRWA physicians 1999	UNRWA registered population 1999	Physicians per 100,000 registered population	Fafo refugee population estimate, 2002 ⁽¹⁾	Revised UNRWA physicians per 100,000	% utilising UNRWA hith services (recent illness)	2002 Population of UNRWA users	Physicians per 100,000 user population
Jordan								
camp				171,012		25	42,753	
non-camp				1,050,308		2	21,006	
total	77	1,541,000	5.0	1,221,320	6.3		63,759	120.8
Lebanon								
camp				106,000		35	37,100	
non-camp				92,000		28	25,760	
total	49	373,000	6.5	198,000	24.7		62,860	78.0
WBGS								
camp								
non-camp								
total	130	1,384,000	9.4	1,357,000	9.6	40	542,800	23.9
Syria								
camp				159,000		18	28,620	
non-camp				137,000		23	31,510	
total	46	378,000	12.2	296,000	15.5		60,130	76.5

⁽¹⁾ For Jordan, 1999 population estimates are used instead of 2002.

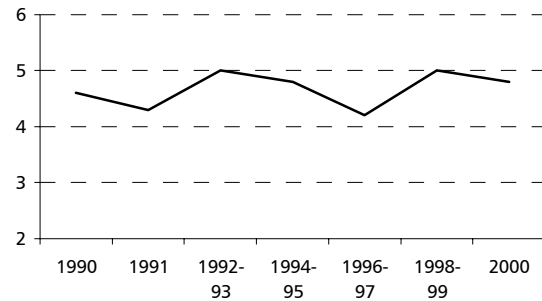
Figure 1.1: UNRWA annual expenditure on health per registered refugee by programme and budget year(s) (USD).



consultation expenditure has increased a total of 4.3 percent from 1990 to 2000, or .4 percent increase per year.

Similar to the Table 1.2, we can get a rough estimate of UNRWA's health budget per refugee actually using UNRWA services for all fields except Syria with living conditions survey data and Fafo population estimates (Table 1.3). Here we see that the apparently lower expenditure in Jordan per capita (estimated by UNRWA as 7.35 USD) increases considerably per user due to both somewhat lower population size estimated by Fafo, and quite low utilisation rates for Agency services among Jordan's non-camp population.

Figure 1.2: UNRWA annual expenditure on health per consultation (medical, nursing and dental) by budget year(s) (USD).



UNRWA Programme of Emergency Assistance in the West Bank and Gaza

A special note in addition to the information presented above, is warranted to describe the special emergency programme implemented by UNRWA in the West Bank and Gaza in 2000. Given the severe disruptions to UNRWA's provision of services due to the recent and continuing conflict, as well as the large increase in persons needing assistance, UNRWA launched an emergency appeal for an expanded programme of assistance for refugees in the West Bank and Gaza. UNRWA's emergency strategies under the program are to provide emergency humanitarian assistance including emergency medical care, food assistance, post-injury physical rehabilitation, psychological support and counselling,

cash assistance and emergency employment creation (UNRWA, 2000).

National Health Systems and Coordination with UNRWA

Investment in, and development of, host country health systems matter for refugee health due to UNRWA's limited involvement in secondary and tertiary care, and refugee use of other providers. Secondary and tertiary care require coordination among service providers at different levels and perhaps different segments of the health system. Patient information must be properly channelled and referrals made for treatment. Finally, health care financing and insurance schemes impact

refugees' ability to purchase care not covered wholly through UNRWA referrals and reimbursement programmes.

Figure 1.3 includes panel figures on national health account indicators for certain countries in the Middle East region, as well as Europe for comparison purposes. These indicators help to describe the structure of health finance and overall investment in health. The Figures highlight differences across the fields of Jordan, Lebanon and Syria and those between more and less developed countries. There is relatively higher out-of-pocket and private expenditure in Lebanon, Syria and Morocco, and lower public sector proportion. In the cases of

Table 1.3: UNRWA regular health budget per UNRWA registered refugee, Fafo refugee population estimates and Fafo user population estimates. (USD).

	2000-2001 biennium health budget	UNRWA registered population 1999	Annual per capita health budget	Fafo UNRWA registered pop 2002 est. ⁽¹⁾	Revised annual per capita health budget	% utilising UNRWA health services (recent illness)	2002 Population of UNRWA users	Annual health budget per user
<i>Jordan</i>								
camp				171,012		25	42,753	
non-camp				1,050,308		2	21,006	
total	21,872,000	1,541,000	7.1	1,221,320	9.0		63,759	171.5
<i>Lebanon</i>								
camp				106,000		35	37,100	
non-camp				92,000		28	25,760	
total	18,394,000	373,000	24.7	198,000	46.4		62,860	146.3
<i>WBGS</i>								
camp								
noncamp								
total	33,620,000	1,384,000	12.1	1,357,000	24.8	40	542,800	31.0
<i>Syria</i>								
camp				159,000		18	28,620	
non-camp				137,000		23	31,510	
total	9,265,000	378,000	12.3	296,000	15.7		60,130	77.0

⁽¹⁾ For Jordan, 1999 population estimates are used instead of 2002.

Syria and Morocco this corresponds to a lower overall investment in health as a percent of GDP found in the developed countries. However, while Lebanon spends a similar proportion on health as a percent of GDP as the developed countries shown here, a large share of this expenditure is private and out-of-pocket - reflecting the private sector domination of health care provision. Considering the three fields of Jordan, Syria and Lebanon, only in Jordan do we see a similar structure of health expenditure to the developed countries, with a large public investment and relatively smaller private and out-of-pocket expenditure share. Syria has the lowest health expenditure as a percent of GDP and per capita expenditure among the three countries.

Lebanon not only has higher health expenditures, but also the most health capacity (Table 1.4). Gaza and West Bank have very few physicians per population size; the situation is especially acute in Gaza.

The National Health System in Jordan

Jordan's health sector includes a private sector; a public system including the Ministry of Health (MOH), the Royal Medical Services (RMS), the Jordan University and Jordan University of Science; and UNRWA and other NGO providers (Brosk 2000). UNRWA is the main primary care provider for registered refugees in camps.

Jordan's health sector has been characterised as performing "well in terms of access and health outcomes, which are among the best in the region and among other middle income countries" (The World Bank 1997). The capacity of hospital facilities and physicians is high (The World Bank 1997). Jordan is a major provider, in fact, of tertiary care for the region as a whole, with a number of Middle Eastern countries sending patients to Jordan for specialty health care. In addition, the health system includes policies and programmes aimed at providing a health safety net for the poor and disabled: The Ministry of Health provides insurance coverage to these vulnerable groups through the Civil Insurance Program and provides services at Ministry of health clinics and hospitals at highly subsidised prices, including health care for individuals without insurance coverage.

The Health System in the West Bank and Gaza Strip

The new Palestinian Authority health-related administration and activities have struggled under the continuing conflict with Israel. In addition, rapidly growing costs will not be sustainable in the longer term. In particular, establishing a coherent health sector is hampered by a deteriorating economic situation, border closures disrupting the movement of pharmaceuticals and supplies, patients and staff. The result is an imbalance and lack of coherence of delivery of service

Figures 1.3a to 1.3d: Selected national health accounts indicators, estimates for 1997. The World Health Report, 2000, WHO.

Figure 1.3a

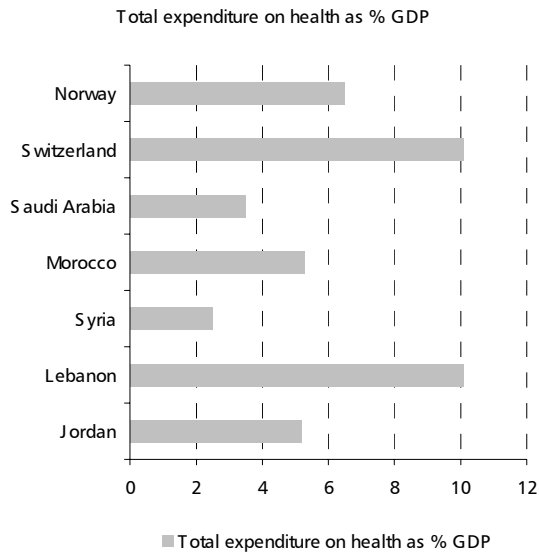


Figure 1.3b

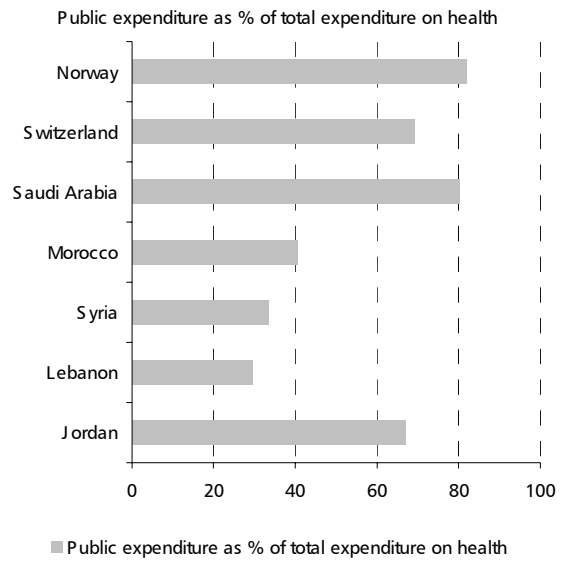


Figure 1.3c

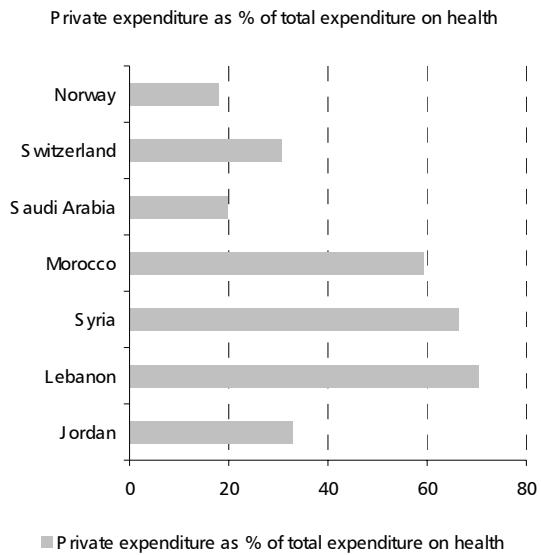


Figure 1.3d

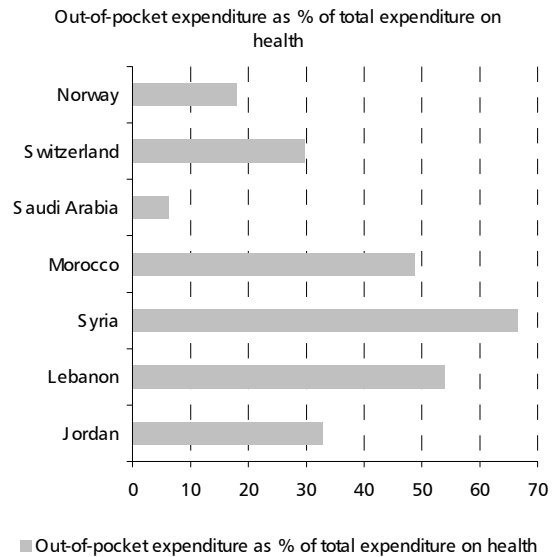
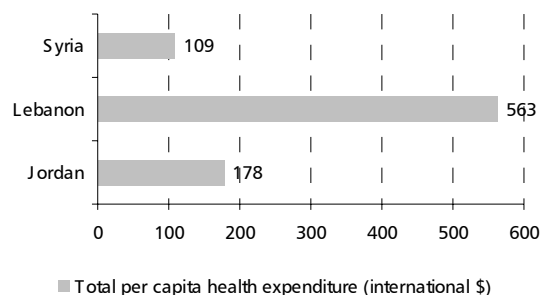


Figure 1.4: Per capita expenditure. World Health Report, 2000.



between the West Bank and the Gaza Strip. (The World Bank 1998)

Health provision in the West Bank and Gaza Strip has, historically, included a large NGO sector. Since the establishment of the Palestinian Authority, Ministry of Health coordination with NGOs has been institutionalised in national committees. In some areas of health care, particularly in disability care, the two types of providers directly coordinate delivery.

Structural problems in the national health system result from the above mentioned conflict situation as well as a high level of centralisation, lack of health policy development and poor financial administration (Zaucher, Griffel and Gubser 1995). Information links and referral systems between the various types of providers and types of care (primary, secondary and tertiary) are weak. Supply is reported to be poor in rural areas, and the quality of secondary care and personnel training is less than adequate. (Zaucher 1995) .

Table 1.4: Physicians per 100,000 population and hospital beds per 1,000 population at a national level.

	Doctors per 100,000 population ⁽¹⁾	Hospital beds per 1,000 population ⁽²⁾
Lebanon	210	2.7
Jordan	166	1.7
Syria	144	1.4
West Bank	33	1.1
Gaza	68	1.1
Middle East	104	2.9
Latin America	125	2.7
W. Europe, N. America	309	9.3

⁽¹⁾ Source: Lebanon, Jordan, Syria: UNDP Human Development Report 2001.

West Bank and Gaza: Sector Working Group on Health, Health Sector Profile, 1996.

Regions: World Bank, 1993 World Development Report.

⁽²⁾ Source: Lebanon, Council for Development and Reconstruction, Sector Overview Report: Health Sector, 1998.

WBGs: MOH Annual Report, 1998. Data is for West Bank and Gaza combined. Jordan: Statistical Yearbook, MOH, 1999

Regions: World Bank, 1993 World Development Report.

The National Health System in Lebanon

In Lebanon, the Palestinian Red Crescent (PRCS), a PLO-affiliated body, provided health care to Palestinian refugees in Lebanon until 1982. With the removal of the PLO from Lebanon at that time, PRCS health services were suspended until recently. The PRCS has restored a measure of services to Palestinian refugees in Lebanon in the past few years. In the years 1982 to 1990, UNRWA provided services to all Palestinians in Lebanon, also those who were not registered refugees, under a special emergency programme. As this programme was stopped, the Agency provides in principle only to registered refugees. The exceptions are needy people who may get UNRWA special hardship case relief and education

services after a bureaucratic procedure and the approval of the Field Director. The Lebanese social services ministries have no formalised cooperation with UNRWA.

The NGO sector providing health-related services is quite large. The NGO sector has about 1,500 employees working in health according to an estimate by Norwegian People's Aid and Welfare Association, out of whom 900 are full time employees and 633 are employed on a part-time basis, and 420 are volunteers (Norwegian People's Aid and Welfare Association 2000).

In addition to NGO providers, refugees also utilise private and public sector health institutions, but in the case of the latter, without government reimbursement for costs. Lebanon's private sector share of health care delivery is quite large and expensive - reflecting the longer term development of the national health system. Structural problems in the Lebanese health care system largely stem from long-term conflict, during which the role of the private sector grew rapidly as governmental services collapsed (UNDP 1998). Despite an effort to respond to these problems with an adoption of a health sector strategy in 1993, health expenditures in Lebanon have continued to grow substantially without corresponding improvement in health status indicators as expected (The World Bank 2000).

The National Health System in Syria

The relationship between UNRWA and the Ministry of Health in Syria is reported to be close and positive. The Agency and the Ministry cooperate and share resources across a wide range of health activities including disease control, vaccination, and health statistics generation. The Ministry of Health in Syria follows the WHO recommendations very closely, and provides special vaccines outside of UNRWA's regular programme free of charge to UNRWA. Joint training and workshops with UNRWA and the Ministry are common.

Syria's health system is a state-managed national health service with universal coverage. The advantage of this type of system is it facilitates high accessibility (including for refugees), but the disadvantage is that extreme centralisation can lower quality and efficiency. The government does not operate an insurance program, but provides all care (both primary and hospital care) free of charge at government clinics and hospitals. This includes Palestinians.

The main problem of the health system at present is the inability to meet demand, primary arising from rapid population growth - especially in urban areas (Galley 2001). In addition, recent economic problems have led to a limited health budget and the necessity for focus on primary care at the expense of better developing hospital care. Primary care is

delivered at the village, district and provincial level. Rural health centres serve villages. At the district level, public health services are provided through district health centres and a district hospital (WHO 2001). At the province level more services are offered at health centres including immunisation, maternal and child health, family planning, care for chronic diseases and health education. Some of these services are available at the district centres, but not universally. Each province also has a public general hospital and availability of specialized care.

High levels of centralisation have led to bureaucratic inefficiency, and, similar to most state-run health systems, there are plans to restructure the health system, allowing more autonomy at the province and local levels (Galley 2001).

Most physicians, including government clinic and hospital physicians also operate their own private clinics in the evening after government facilities close (Galley 2001). Overall, a large proportion of physicians and dentists are reported to be employed in the private sector (77 and 94 percent respectively) (WHO 2001).

Insurance Programs, Benefits and Patient Cost-Sharing

Jordan

Jordan's various public programs (RMS, Civil Insurance, University) provide benefits for most health services and pharmaceuticals with very low patient cost-sharing (The World Bank 1997). As noted above, uninsured individuals pay highly subsidized prices at Ministry of Health facilities, however, they usually must pay the full price for pharmaceuticals. Royal Medical Services (RMS) covers active and retired members of the military, police, intelligence and civil defence and their dependents. The Civil Insurance Program issues insurance cards to active or retired civil servants and their dependents, the poor and their dependents and the disabled. Jordan University covers employees and their dependents (Tiltne 1997). Palestinian refugees registered with UNRWA are reimbursed for a portion of secondary care received at government hospitals. Costs in government hospitals are reimbursed by UNRWA provided that the treatment is of an emergency nature and that patients are referred to the hospital by an UNRWA medical officer. The rates of reimbursement are 90 percent for refugees registered in the special hardship category and 75 percent for other registered refugees.

A World Bank Health Sector Study conducted in 1996 estimated that 80 percent of the population is covered by

some health insurance (Tiltne 1997). The study, relying on data from the health programs, estimates much higher insurance coverage than was found by the Fafo, DOS Living Conditions survey (JLCS), which found from individuals reporting their own insurance coverage only 53 percent were covered by at least one insurance program, and 5 percent covered by multiple programs (Tiltne 1997). The JLCS also found much fewer reporting coverage by private insurers (5 percent) than the World Bank study. According to the JLCS, military insurance is the most commonly held (25 percent). Ministry of Health and University insurance was reported to cover 23 percent. Variations in insurance coverage were found to be marked regionally, urban versus rural and between Palestinian refugees and others. The main explanatory factor in this case is the possession of military insurance: Individuals in certain regions, in rural areas and who are Jordanian non-refugee nationals have higher insurance coverage overall than others due to heavier reliance on military insurance coverage (Tiltne 1997).

Lebanon

Very few of the surveyed camp and gathering refugee population in Lebanon are covered by health insurance (less than 10 percent). However, there are many insurance schemes operating in the country. In the public sector, the Civil Service Cooperative (CSC), the army and internal security cover most public sector

employees with health insurance. The National Social Security Fund covers employees in the formal sector, contracted staff in the public sector and other groups of employees with health care coverage (The World Bank 2000). In addition, some 80 private entities provide health insurance. A large proportion of Lebanese citizens are not insured, about 50 percent of the population (UNDP 1998). Those who are Lebanese citizens and are uninsured qualify to receive reimbursement for high cost services from the MOH. Under the public health insurance programs, upwards of 80 percent of the consultation, medicines and hospitalisation costs are covered. Among private insurers, the percent of expenses covered varies by provider. NGO and public health centres subsidise outpatient consultations and medicines cost with low user fees and low fees for basic drugs.

Syria

As noted above, Syria does not operate a national insurance program, but provides free, universal coverage health care in government owned and operated clinics and hospitals. Private insurance is available, however. According to the LIPRIS survey, some 7 percent of camp and gathering refugees report they have purchased private insurance. Few refugees are not registered with UNRWA and do not have private insurance (2 percent). Regardless, all have access to

health care without charge at government facilities.

The West Bank and Gaza

Government health insurance is the primary type of health insurance available and affordable for refugees living in the West Bank and the Gaza Strip. Government insurance is provided on a mandatory basis to Palestinian Authority employees, police and security officers and those who receive health insurance as part of their acceptance into the social welfare program. For Authority employees and security personnel, insurance premiums are deducted from salaries. Palestinian workers in Israel are also covered by government health insurance, with premiums deducted by their Israeli employer from salaries and transferred to the Palestinian Authority. The Ministry of Social Welfare provides temporary health insurance (for 6 month period) to ex-prisoners and their families, and other vulnerable, low-income households who apply to the Ministry. The average cost of government health insurance premiums for a family of 4 children and 2 parents is about 22 USD (Lennock 1998). Benefits include free services and subsidised medicines at government hospitals and clinics. In addition, in the event that services are not available at government institutions they are purchased by the government at NGO or private facilities, Israeli facilities or facilities abroad, with a ceiling amount paid for the cost of treatment.

There are 3 firms offering private health insurance in the WBGS, and their premiums are relatively quite high compared to government insurance (estimated as 61 USD per year for family of 6 persons) (Lennock 1998). In addition to the high premiums, there are many conditions for exclusion including pre-existing conditions, maternal services and others (Lennock 1998).

A Measure of Health System Responsiveness: Satisfaction with health services

A series of questions regarding satisfaction with health services is included in the Living Conditions Surveys in Jordan, Lebanon and Syria. The Health, Development, Information and Policy Institute (HDIP) has also conducted a number of household surveys collecting data on individual perceptions of health services in the WBGS.

In the WBGS about 50 percent rate health services as good, and over 60 percent rate hospital care as good. In Jordan, Lebanon and Syria, the majority (60-70 percent) report being 'satisfied' with health services. How does this compare with developed countries? In a recent study of European countries, the proportion reporting they were very or partly satisfied with health services reached 80 percent for the Netherlands, Sweden, Germany and France, and 60

percent for Great Britain (Massialos 1997).

WBGS

The West Bank and Gaza Service Health Delivery Survey from 1998, provides household data on satisfaction with health services. The survey, finds that there are no differences in satisfaction with health services between refugees and non-refugees, but West Bank residents are less satisfied than those in Gaza (Figures 1.5 and 1.6). (Cockcroft 1998).

Most people judge health services to be good or very good (about 50 percent), with another 25 percent stating a neutral view of health services. That is, less than 20 percent view the overall health system as being poor or unsatisfactory. There is marked differences between satisfaction with health services among individuals in the West Bank compared to the Gaza Strip: About 20 percent fewer are satisfied with both general available health services and hospital care in the West Bank.

Jordan, Lebanon and Syria

Respondents in the JLCS, Jordan Camp Survey, LIPRIL and LIPRIS surveys were also asked about their level of satisfaction with a medical consultation they had during the last two weeks. Among camp refugees, satisfaction ranges from 60 to 80 percent. In Jordan, satisfaction with the medical consultation among non-

Figure 1.5: WBGS. Household opinion of available health services, percent of households (1998, HDIP).

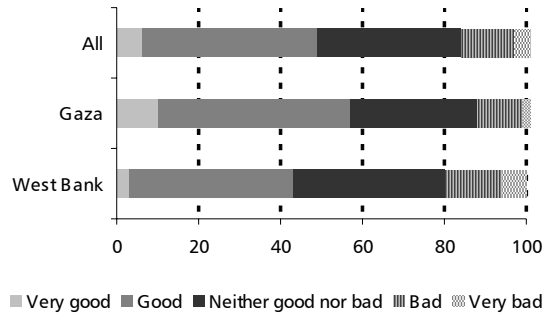
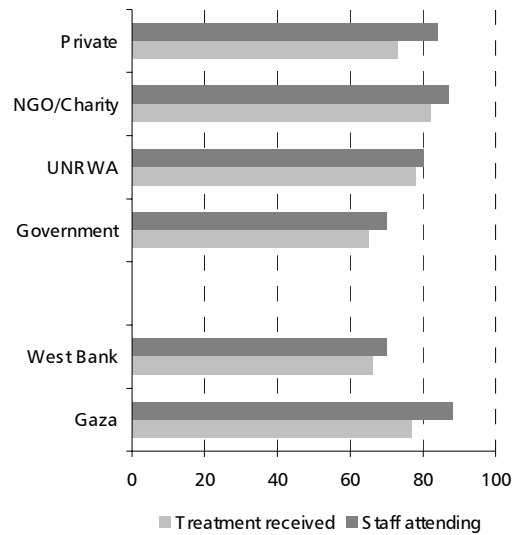


Figure 1.6: WBGS Opinion of hospital care. Percent of users satisfied or very satisfied. (1998, HDIP).



refugees and non-camp refugees is quite high regardless of the type of provider. Over 80 percent of both groups are satisfied with the consultation for all of the types of providers. Slightly more are satisfied with private clinics, and slightly less with government hospitals, but the differences are very small. Too few non-

camp refugees in Jordan use UNRWA health clinics to draw any conclusions about the satisfaction with services. However, camp refugees in Jordan are somewhat less satisfied with the health services they received. About 5 to 10 percent fewer are satisfied across all providers compared to others in Jordan. Nonetheless, over 60 percent are pleased with the health services they chose. Camp refugees were also most satisfied with private clinics (80 percent satisfied), but report distinctly less satisfaction with UNRWA clinics (70 percent satisfied).

Figures 1.7a through 1.7c show camp refugees' contentment with a number of different health providers in Jordan, Lebanon and Syria. Similar to the situation among Jordan camp refugees, UNRWA is the least favoured provider among camp refugees in Lebanon, and those who used private facilities are the most satisfied. Among camp and gathering refugees in Syria, satisfaction is higher overall, and especially among those using private clinics (86 percent are satisfied) and hospitals. Private clinics are the most common provider for camp and gathering refugees in Syria as well, as 47 percent used a private clinic for care during a medical consultation in the 2 weeks prior to the survey. UNRWA is much less often used as a provider and gets lower levels of satisfaction than all other main providers.

Figures 1.7a - 1.7c: Percent individuals satisfied or very satisfied with medical consultation. Those seeking any care during recent acute illness or injury (last 2 weeks).

Figure 1.7a: Jordan camp refugees (JCS, 1999)

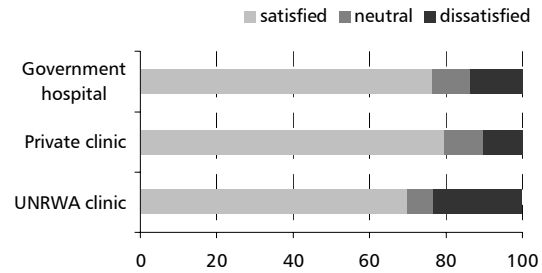


Figure 1.7b: Lebanon camp and gathering refugees (LIPRIL, 1999)

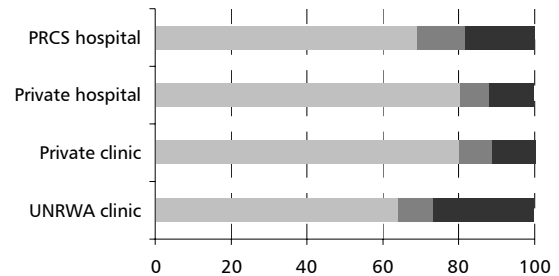
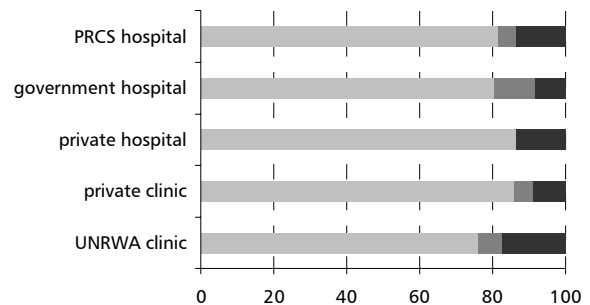


Figure 1.7c: Syria camp and gathering refugees (LIPRIS, 2001)



Specific Health Programmes

The capacity of a health care delivery system - the level of inputs and their distribution geographically (rural versus urban areas and regional) — can be described in several ways. On the one hand, the overall level of investment into health care is demonstrated in, for example, the number of hospitals and health clinics proportional to the population served as described earlier in this chapter. On the other hand, key to a satisfactory health delivery system is that this level and distribution of institutions, personnel and medical goods is appropriate to meeting the health needs of distinct populations. For this first assessment we compared the level of inputs across the fields in per capita or patient terms. For the second assessment we must draw on some of the conclusions found in the health conditions chapter describing the state of health of the population. Description of inputs will be organised according to types of care, starting with basic primary care provided in clinics, including women and child care and disability care. Second, specialty care for chronic illnesses such as diabetes and heart disease will be discussed. The second will conclude with an overview of hospital care.

Women and Child Health Care

Good health outcomes for children, especially small children are dependent

on many factors, such as breast-feeding and proper birth spacing, access to safe drinking water and good sanitation, and immunisation. Some of these factors involve the health system's educating women and influencing the mother's behaviour and some factors are directly related to access to adequate health care. Given the importance of women and child health programmes within and outside of UNRWA, we will go into some detail regarding services, and levels of satisfaction among users of different types of providers. Due to UNRWA and other providers' focus on mother and child care, infant mortality rates have decreased dramatically among refugees (and others) in each of the fields of operations. Prenatal health coverage is quite good, but there could be access problems among non-camp refugee women in Jordan receiving prenatal care and UNRWA has noted concerns about meeting the needs of women outside of camps, where they have relatively few health clinics:

“Coupled with the availability of the services of other health care providers...the limitations on the Agency's ability to expand its network of primary health care facilities outside the camps had affected access of refugees to UNRWA's maternal and child health services.” (UNRWA 2000).

One of the main problems UNRWA identifies among its patient population receiving prenatal care is the tendency

for late registration, often after the first trimester of pregnancy (UNRWA 2000). According to a study conducted of the maternal patients by the Agency in 1999, only some 13 percent of women had registered for prenatal care during the first trimester, and there were large field-level differences, with the proportion in the Gaza Strip quite low and the proportion in Lebanon larger (9 and 34 percent respectively).

Utilisation patterns can shed light on whether access of non-camp refugees to UNRWA maternal services appears to be related to lack of prenatal or delivery care.

Prenatal and Delivery care

UNRWA provides prenatal and postnatal health monitoring free of charge, with high risk pregnancies also specially monitored by specialists. UNRWA has one maternity hospital in the Gaza Strip. Otherwise, women deliver in other secondary facilities. UNRWA subsidises the hospital costs in arrangements similar to other secondary health care with one exception: Women with high risk pregnancies are reimbursed fully for the hospital delivery costs.

In Jordan, the WBGS and Syria, government primary health clinics also provide prenatal care and primary care for children under three years of age. Vaccination programs are offered to all individuals free of charge. Women with

government health insurance can use maternity services at government hospitals free of charge in the WBGS. Fees, however, are charged at WBGS government facilities for postnatal health care checkups. In Jordan and Syria, prenatal monitoring and young child monitoring is provided free of charge.

The utilisation of UNRWA health clinics for prenatal care varies considerably by field, with different patterns in each.

Use of UNRWA prenatal care by most women, but often supplemented with other providers.

In the WBGS, most refugees in the Gaza Strip use UNRWA clinics (86 percent) but a much smaller proportion do so in the West Bank (43 percent). While the data source presented here has a fairly small sample size (n=51 in West Bank, n=85 in Gaza), it nonetheless corresponds to less UNRWA facilities' use in the West Bank for health services in general. It is also similar to UNRWA's estimates of prenatal care coverage for the 2 regions (90 and 54 percent respectively) based on the number of women registered and crude birth rates. The private sector makes up most of the difference in the West Bank with 39 percent of women (Table 1.5).

According to the HDIP study, in the West Bank most users went to clinics

requiring a fee, in contrast to Gaza, where most paid no fee (HDIP 1998). The study also found those utilising government and UNRWA clinics chose this provider mostly on a basis on cost of services (37 to 40 percent). In addition, they also chose UNRWA because they are registered or went there before (20 percent each). Private providers were chosen mostly on the basis of quality of services (54 percent) and familiarity with 20 percent (HDIP 1998).

In Jordan, Lebanon and Syria, the client profile of UNRWA prenatal care users is clearly one of women in relatively lower socio-economic groups (Blome Jacobsen 2002). Typical private and special pregnancy clinic clients, therefore, are highly educated and well-off women, in addition to those with high-risk pregnancies (Blome Jacobsen 2002).

Considering all pregnancies during the five years preceding the survey, UNRWA is the provider most often consulted among those seeking any prenatal care: Seven in 10 in Syria and Jordan, and 8 in 10 in Lebanon (Table 1.6). Refugee women do, however, often

use other providers either in combination with UNRWA or otherwise. The use of multiple providers is more common among refugee women in Syria than elsewhere (30 percent) compared to some 20 percent in other fields (Table 1.7).

Heavy use of specialist pregnancy clinics and private physicians in Syria. In Lebanon, pregnancies nearly exclusively overseen by UNRWA.

How common it is to use a non-UNRWA provider varies by field. More women use special clinics and private doctors in Syria than elsewhere. This is paralleled to a degree in Jordan camps, where about one-quarter of the pregnancies were overseen by private physicians. Unique in the case of Jordan is relatively high government facility use, at 15 percent. This reflects the good access and high quality of government facilities in Jordan compared to elsewhere. It is most common to use UNRWA among refugees in Lebanon. In addition, it is here that we find the largest proportion of pregnancies overseen at home or by another unidentified provider.

Users of UNRWA clinics least often begin prenatal care early on in pregnancy

Beginning prenatal care during the first month of pregnancy, or at least during the first trimester is important to the health of both mother and child. Those

Table 1.5: WBGS. Percent of women using various prenatal care providers. (1998, HDIP).

	Government	UNRWA	NGO	Private
West Bank	10	43	8	39
Gaza Strip	7	86	2	5

Source: HDIP, 1998. *Health Insurance and Health Service Utilisation in the West Bank and Gaza Strip.*

Table 1.6: Percent of pregnancies overseen by various prenatal care providers. Pregnancies last 5 years.

	No Care	Of those receiving care, care at						
		UNRWA	PRCS	Special Pregnancy Clinic	Private Physician	Private Hospital	Government Clinic, Hospital	Home, Other
Syria	4	66	2	24	28	2	2	0
Lebanon	5	83	7	8	4	1	7	8
Jordan	5	67	n.a.	9	23	2	15	1

Table 1.7: UNRWA prenatal care users. Percent using UNRWA alone or with other providers. Pregnancies last 5 years.

	and special					
	UNRWA only	and private MD	pregnancy clinic	and PRCS	and govt clinic	and home, other
Syria	60	21	17	1	0	0
Lebanon	80	3	4	3	4	5
Jordan	77	12	6	n.a.	5	0

using UNRWA prenatal care have a worse record in this regard than others. In Jordan, non-camp refugees utilise prenatal care less than camp refugees, but start prenatal care early. This difference is related to the provider of prenatal care: Those in both camps and outside camps using UNRWA started care much later than others. Among them, only 7 percent of camp and 12 percent of non-camp refugees sought care during the first month, and 23 and 37 percent during the first trimester. In contrast, the best results are among those using private physicians and specialty pregnancy clinics. For example, most of those using private physicians sought care at least during the first trimester (64 percent) and 41 percent during the first month. The likelihood to commence care within the first trimester is considerably higher for nearly all other providers than UNRWA.

Relatively fewer refugee women in Lebanon start receiving prenatal care during the first month of pregnancy. Only 10 percent of camp refugees and 15 percent of gathering refugees start care in the first month. However, many catch up during the first trimester, with altogether 65 percent of camp and 73 percent of gathering women having their first visit by the 3rd month of pregnancy. Similar to the case in Jordan, those attending UNRWA clinics for prenatal care less often get it during the first month - only 8 percent compared to 33 percent of those attending PRCS hospitals and 31 percent of those attending special pregnancy clinics. This pattern is the same for both camp and gathering refugees. Of those attending UNRWA clinics, 65 percent had started care at least during the first trimester, while this is true for 73 percent of those attending PRCS hospitals.

“Pregnant women usually go to the Mother and Child clinic for regular check ups, but in this camp they generally start late in the pregnancy - about in week 16. The doctor has asked the women why they come so late, but she does not get good answers. She thinks the reason is that many of the women work, and they cannot afford to take time off to see the doctor. Many work in the fields or in factories. She has asked if they are dissatisfied with the clinic, but they say they are not.”

UNRWA Health Clinic, Khan Esheib camp, Syria

As noted earlier in this section, UNRWA provides delivery services only in the Gaza Strip. Elsewhere, refugee women utilise public and private providers of delivery services. (Tables 1.8 and 1.9).

For the WBGs we do not have a breakdown by refugee status, but do have by camp, urban and rural location provided by the PCBS, 2000 Health Survey. Considering the last two births during the most recent three years, some 40 percent of camp residents’ births were in government hospitals, 20 percent in UNRWA maternity centre and about 15 percent each in private physician clinics and private hospitals. According to the HDIP report, 27 percent of refugees consider government and 25 percent consider private hospitals as being the ‘best place for delivery’. Another 22

percent consider UNRWA clinics as the best place. Data is not available on the satisfaction with delivery services, but data from the PCBS on the main reason for choosing the place of delivery gives some indication of perceptions of quality. Those choosing UNRWA clinics mostly cite being satisfied with services as the main reason, and another 30 percent cite less cost or insurance as the main reason. In contrast, less cost or insurance and pregnancy complication are more of an issue for those attending government hospitals (39 and 21 percent), while satisfaction with services was the main reason for only 25 percent. Satisfaction with services and preferring a private physician are the main reasons for choosing a private hospital or private physician clinic.

In Jordan, Lebanon and Syria about 20 percent of camp refugee women reported giving birth at home (compared to some 10 percent of non-camp refugee women in Jordan). In Jordan and Syria, about half of camp refugee women gave birth in government hospitals, and most of the remainder in private hospitals (Table 1.9). There is relatively heavy use of PRCS (30 percent) and private hospitals (40 percent) for delivery among camp and gathering refugee women in Lebanon.

Refugees in Jordan were more often pleased with care received at private hospitals (85 percent) for delivery than at

Table 1.8: WBGs. Place of delivery, last 2 births in last 3 years. (PCBS, 2000).

	Government hosp, clinic	Private hosp, clinic	UNRWA hosp, clinic	NGO hosp, clinic	Physician clinic
Camp	42	14	20	6	15
Urban	39	31	7	7	14
Rural	52	29	2	4	4

Source: PCBS, 2000. Health Survey, Main Findings

Table 1.9: Jordan, Syria and Lebanon. Place of delivery.

	home	PRCS/NGO hospital	government hospital	private hospital	other
Syria ⁽¹⁾					
Camp	22	12	31	30	5
Gathering	23	7	33	32	5
Lebanon ⁽¹⁾					
Camp	22	27	8	41	2
Gathering	19	28	5	45	4
Jordan ⁽²⁾					
Camp	28	n.a.	53	19	0
Non-camp	11	n.a.	50	38	1

⁽¹⁾ Births in last 5 years.

⁽²⁾ Most recent birth.

government hospitals (68 percent). The main complaints among those delivering in government hospitals were the need for better hygiene (22 percent) and more skilled or attentive health workers (16 percent). In Lebanon, overall, camp and gathering refugees reported to be quite pleased with the delivery care they received at all three types of facilities as roughly 75 percent reported satisfaction and no changes with care at private, PRCS and government hospitals. Better hygiene and more skilled or attentive health workers were suggested by about 10 percent of patients in each of the types of facilities.

Family Planning

Family planning, as noted earlier in the chapter, is a relatively new programme

for UNRWA, being first implemented in 1993 in Lebanon and gradually expanded to all UNRWA clinics. Here, women are given education, counselling on family planning and distribute contraceptives. The majority of refugee women, especially those in camps, who have ever used contraceptives, obtained them first from UNRWA clinics. The general knowledge about contraceptives, among all refugee women, is also higher than among the non-refugee population - regardless of actual contraceptive use. UNRWA has documented the Agency's success in decreasing fertility and increasing birth spacing in a recent follow-up study in 2000 to a base-line study conducted among contraceptive users in 1995 (UNRWA 2000). The proportion of birth intervals among UNRWA registered

births occurring at less than 12 months has been halved, and all birth intervals less than 24 months have decreased considerably. Very close birth spacing is particularly common among camp refugees in Jordan and the WBGS, and UNRWA family planning services play a key role in addressing this issue. The ability of UNRWA to continue expanding its efforts in this regard is important not only for the obvious health implication for both mother and child, but particularly important given the absence of other providers — no government sponsored family planning services exist in Jordan and the WBGS.

Young Child Health Care

In UNRWA facilities, infants and children under 3 years of age are monitored regularly to check growth and development. It is through this monitoring process that malnourished children are identified and provided with supplementary feeding. In addition, infants and children are given primary health care and immunisations for no charge. Booster immunisations are provided through UNRWA's school health services. Child health outcomes were found to be overall good among refugees, but some negative points include relatively higher incidence of young child malnutrition among camp and gathering refugees in Lebanon and Syria according to the MUAC measure and moderate stunting among refugees in Jordan. In addition, although vaccination coverage was found

to be quite good among especially camp refugees in the WBGS (better than other groups in the WBGS), there is a lag in measles and polio vaccination among camp refugees in Jordan and Syria, and very poor measles coverage among camp refugees in Lebanon. This is in contrast to the nearly 100 percent coverage reported by UNRWA. Our concern on both counts is that it appears these children affected are not gaining access to UNRWA services or their parents are not educated about the importance of vaccination.

Young child acute malnutrition (as measured by the MUAC) among camp and gathering refugees in Syria and Lebanon associated with lack of UNRWA transfers.

The incidence of young child malnutrition as measured by the MUAC is much higher in Lebanon and Syria than in Jordan camps. For example, in Lebanon, this represents an estimated population size of 300 and 440 children under five years respectively at risk or seriously malnourished. As noted in volume 1, Chapter 7, "Health and Nutrition", there is a strong correlation by regional location in Lebanon. Most of the malnourished children are residing in camps in the south, in particular, in Zaida. Those at risk for malnourishment reside in camps in Tyr. Both the regional location and residence specifically in camps versus outskirts of camps or gatherings are significantly related to higher mal-

nourishment or at risk. A second factor that is significantly correlated with young child malnutrition in both Lebanon and Syria is the lack of UNRWA support. In nearly all cases the households fall into the middle income groups, are not Special Hardship Cases and do not receive UNRWA in-kind transfers of foodstuffs.

The incidence of stunting among refugees in Jordan, in contrast, is associated with household income levels and not related to UNRWA registration or assistance. At some 8 percent for refugees, the prevalence of stunting is considered “low” by WHO publications comparing across developing countries (less than 20 percent). In addition, stunting is more prevalent in rural areas and Balqa.

Lack of full vaccination coverage among children 12-23 months of age in Syria and Lebanon associated with lack of UNRWA registration.

Vaccination coverage is somewhat poor among refugees in Syria and Lebanon, primarily measles coverage. This is associated with lack of UNRWA registration - which leads to 1.5 times or higher likelihood of lack of full vaccination coverage compared to registered children in this age group.

Secondary Care

UNRWA has various reimbursement schemes and contracted bed programmes in each of the fields of operation. UNRWA refers patients to these contracted hospitals. Austerity measures are reported to have led to fewer hospital referrals. A lack of funds for hospital procedures has also led to long waiting lists for surgeries.

UNRWA allocates the most hospital services resources to the West Bank, including the nearly half of the total hospital services budget, largest annual per capita amount at 50 USD, and hospital services makes up the largest proportion of the medical services budget for this field.

UNRWA’s expenditure on secondary care currently constitutes some one-quarter of total expenditure in the Medical care Programme. The cost of providing hospital services per capita varies by field, but reported to be largest in Lebanon and lowest in Jordan. In 2000, the Agency reports that per capita costs on hospital services were some 9 USD in Lebanon, 6 USD in the West Bank, 1.7 USD in Syria, 1.4 USD in Gaza and .3 USD in Jordan. The per capita amounts budgeted for the 2000-2001 biennial budget for hospital services is shown in Figure 1.8, together with the distribution of hospital care budget across the fields (percent allocated in each field of the total for hospital care), and the percent hospital care represents of the total

medical services budget within each field.

We are unable to examine trends in hospital care expenditure over time for each field as UNRWA has been unable to provide this information. However, we can see from the Figure that the majority of hospital services budget, some 50 percent of the total budget line, is allocated to the West Bank. It is also in the West Bank where we find the highest budgeted per capita at 6.5 USD, compared to 3.9 in Lebanon. In the case of Lebanon, however, this is only including amounts allocated in the regular health budget for medical services and not funds from special programmes, which are reported to provide the bulk of hospital cost funding for the Lebanon field.

Estimated costs for hospital services per patient and per bed day is shown in Figure 1.9. Here, costs represent the annual cost per patient and per day based on the proposed budgeted amounts for annual hospital services in the 2000-2001 UNRWA budget in each field and the actual number of patients admitted and bed days in 2000.

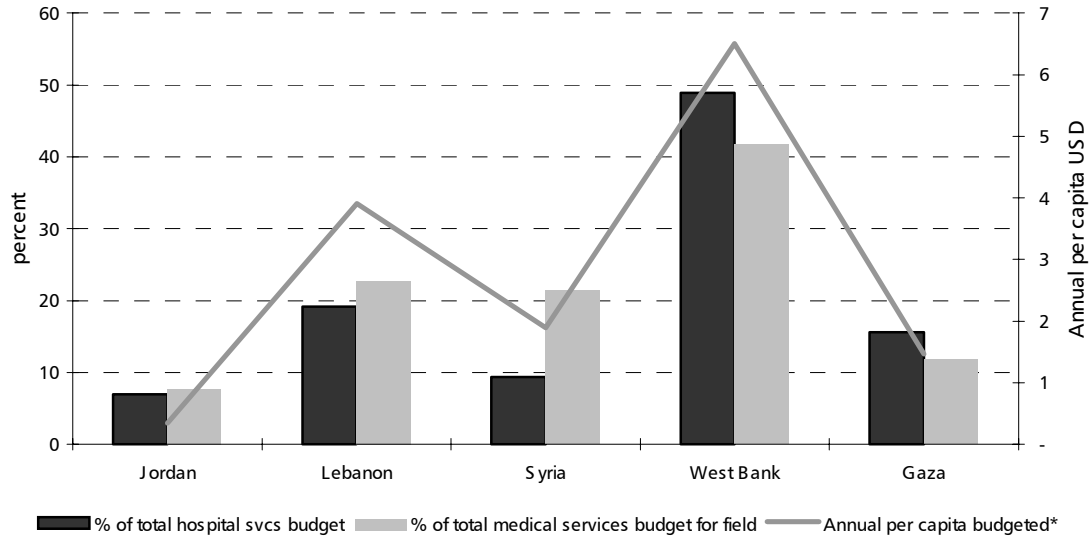
In the Jordan field, UNRWA operates only a reimbursement scheme for hospital services. Until 1993, UNRWA also contracted for subsidised beds in private and government hospitals, but ceased this practice in order to cut costs.

There is a ceiling on reimbursement rates in that charges at private facilities will only be reimbursed at government hospital rates. Jordan has a very advanced secondary and tertiary care system which is utilised by the region as a whole.

In Lebanon, as noted earlier, nearly all secondary and tertiary care is provided by private institutions in Lebanon (90-95 percent) (World Bank 2000). UNRWA contracts beds in private and PRCS hospitals for secondary health care of registered refugees. The five private hospitals (Sahael, De la Paix, Dalla'a, Hammoud and Hiram hospitals) account for 1110 bed days per month, and the five PRCS hospitals (Haifa, Nasira, Safad, Hamshari, and Balsam hospitals) account for 2310 bed days per month. Out of this number 300 beds per months are in tertiary/specialized hospitals (Sahel and Hammoud hospitals). In addition, UNRWA contracts 1350 bed days per month in psychiatric hospitals in two private hospitals (De la Croix and Dar Al-Ajzeh). UNRWA does not cover the cost of emergencies if the patient is taken to hospitals other than those it has contracts with. In addition, as of January, 2000, UNRWA ended a reimbursement program to cover costs of treatment in non-contracted hospitals due to lack of financial resources. This has caused problems for a number of refugee families. For planned operations, there are waiting lists.¹

¹ The waiting list for hospital treatment is often three months

Figure 1.8: UNRWA proposed budget for hospital services 2000-2001. Per capita and distributional measures by field.



* Based on UNRWA registered refugees reported by UNRWA for 1999.

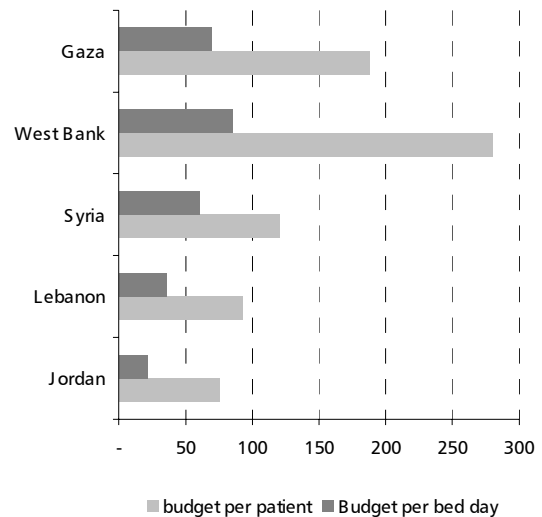
For most basic hospital services, UNRWA does not require refugee co-payments. For a number of more expensive treatments, UNRWA only pays a small portion of the cost (up to USD 1,500) (USCR 1999). This is the case for implants, CT scanning and major surgical procedures such as open-heart surgery (this and other operation costs between USD 7,000 and 12,000 per operation, and for stay in specialized hospitals exceeding 10 days (USCR 1999).

Hospitalisation is free of charge for the patients in the PRCS hospitals.² The

or longer in the North (USCR 1999; 18)

² The UNRWA cost involved for the beds they contract with PRCS is substantially lower than for the beds in private hospitals because PRCS has foreign funding that covers parts of their costs. Certain legal problems pertain to PRCS however, as the PRCS hospitals are not registered as hospitals by the Lebanese authorities. PRCS is not allowed to register as an

Figure 1.9: Estimated per patient and per hospital bed day costs for 2000 (USD). UNRWA proposed 2000-2001 budget amounts and actual patient and bed day amounts for 2000.



Lebanese branch of PRCS operates four district hospitals and one general hospital. PRCS hospitals serve both registered and unregistered Palestinian refugees, as well as poor Lebanese citizens and many foreign nationals.

The non-governmental Health Care Society, established in 1997, provides financial assistance to disadvantaged people in need of major surgery, (as well as monthly assistance to 110 patients with chronic illness). According to information from the organization, it has been able to provide surgery assistance for 490 patients per year, out of whom 10 percent are children.³

In Syria, UNRWA has contracted beds at eight public hospitals and two PRCS hospitals. PRCS operates four hospitals in total. Cases referred by UNRWA to the hospitals are basically surgery and high-risk pregnancies (including caesarean sections). Registered refugees pay 12 percent of hospitalisation costs, and Special Hardship Cases, 5 percent. In very critical cases and lifesaving surgery, registered refugee patients are referred to public hospitals and UNRWA covers one-third of the cost. Previously, UNRWA has covered two-thirds of the cost for emergency

surgeries, but this portion has declined due to austerity measures. Theoretically, public hospitals are free of charge, but patients often must pay some portion of the costs.

Specialty and Chronic Illness Care

UNRWA's health services for treatment of chronic illness fall primarily within the Disease Prevention and Control Activities Programme, and activities include surveillance and control of noncommunicable and communicable diseases. UNRWA's strategy regarding noncommunicable diseases is limited due to lack of resources to implement a population-based prevention program (UNRWA 2000). However, the agency focuses on the identification and treatment of diabetes mellitus and hypertension (UNRWA 2000). This program is integrated into UNRWA's primary care services.

In addition, UNRWA operates a programme, introduced in 2000, to prevent and treat pregnant women and children with iron deficiency anaemia. UNRWA studies have revealed that some 60 percent of women of childbearing age and young children are affected by iron deficiency anaemia (UNRWA 2000).

Specialty treatment of other diseases is limited, with UNRWA primarily referring patients to public or private facilities. UNRWA lacks the financial

organisation as it is politically affiliated with the PLO. According to Yassir (2000) UNRWA objects to sign any cooperation agreement with PRCS under the pretext that PRCS physicians are not licensed to work in Lebanon.

³ According to Yassir (2000), Health Care Society provided assistance to 1, 780 cases (all from the refugee camps) in 1998.

resources to provide monitoring or treatment of therapies necessary for long term illness such as cancer and haemoglobinopathy (UNRWA 2000). This includes, for example, medicines involved in treatment of cancer. These medicines do not appear on UNRWA's list of free pharmaceuticals, but some medicines are partially reimbursed. In the case of cancer drugs, the reimbursement rate is 25 percent of cost and 50 percent of the cost for Special Hardship Cases. This reimbursement rate is a sharp decline from previously, when registered refugees were reimbursed 50 percent for these drugs and Special Hardship Cases 90 percent of the cost. Reductions in reimbursement rate are the result of austerity measures.

In the WBGS, special care for the monitoring and treatment of chronic diseases is not offered uniformly through government primary health clinics. In addition, there is some chronic disease care offered through NGO clinics, but their coverage is uneven, both in terms of priorities and geographic location (HDIP 1998). Specialist care in private facilities is reported to be readily available (HDIP 1998). The uneven coverage by government and NGO providers is reported to have several negative repercussions for individuals suffering from chronic diseases: First, given the especially important need for regular access to monitoring and treatment, individuals with chronic illnesses may experience

higher health care costs (due to the need to pay for specialist care in private clinics) and higher transportation costs (for travel to specialist clinics frequently) (HDIP 2000).

Disability Health Care and Rehabilitation

Closely related to chronic illness is the level of disability. That is, the largest portion of years of life lived with a disability is caused by a chronic illness of some sort. Moreover, certain chronic illnesses have multiple disabling effects (such as diabetes). Thus, treatment of the disease itself must also include treatment and assistance in coping with the disability caused by the illness. The level of disability in a population can be measured as the burden of disease in terms of years lived with a given disability, and causes in terms of their contribution to this proportion. A recent WHO study has found that worldwide, in fact, congenital anomalies account for only 2.9 percent of the total prevalence of disability (WHO 2000). Iron-deficiency anaemia was found to be the second most important cause of disability, meaning UNRWA's focus on the treatment of this chronic illness is well placed. Psychiatric conditions were found to be previously considerably underestimated as causes of disability, as out of the 10 leading causes of disability, five of these were psychiatric conditions. World wide the leading illness contribut-

ing to years lived with a disability is unipolar depression.

There are many kinds of disability and many different definitions of what constitutes a disability are used in surveys and censuses. The United Nations Statistics Divisions is developing a set of indicators on disability as well as the situation of persons with disabilities, the Disability Statistics Database (DISTAT). The WHO has developed a family of classifications of disability, the International Classification of Functioning and Disability (ICIDH). Nonetheless, comparable data on disabilities is lacking and aside from lack of comparability, there are measurement difficulties due to the tendency for disability to be 'hidden' due to cultural prejudices against persons with disabilities.

In this section we will discuss the incidence of disability found in the Living Conditions Survey Data as well as available programs for the rehabilitation offered through UNRWA and other providers. In Volume I, Chapter 7, "Health and Nutrition", we looked only at those persons who were reported to have a long term chronic illness or injury. Here we will expand this examination to include different types of functional impairment for individuals 15 years of age and above. Overall, according to 1999 population estimates from the Living Conditions Surveys in Jordan, Lebanon and Syria, there are some

53,000 Palestinian camp and gathering refugees with severe chronic illness or functional impairment, representing between 12 and 20 percent of the camp and gathering refugees in each field.

It is unclear the level of services being provided to disabled Palestinians in camps in addition to UNRWA's very limited provision of physiotherapy in rehabilitation centres. UNRWA operates six such rehabilitation centres in each of the West Bank and Gaza (with some 2550 and 3700 patients respectively), and one center in Jordan (with 420 patients). UNRWA operates no rehabilitation facilities in Lebanon. UNRWA provides financial assistance for prosthetic devices necessary on medical grounds. In addition to UNRWA operated facilities, there are some 32 community-based rehabilitation centres which are mostly operated by the camp residents themselves. The centres engage in activities such as providing home-based activities, mainstreaming into education and vocational training programmes, job placement, self-support projects and cash assistance.

Little UNRWA resources target physical rehabilitation activities for the chronically ill and/or functionally disabled despite upwards of about 15 percent of the refugee population suffering from such health problems - and most of what is allocated goes to the West Bank and Gaza. In contrast, chronic illness and func-

tional disability is most prevalent among refugees in Syria and Lebanon.

Using UNRWA registration numbers as a denominator, there is about 1.0 USD to 2.7 USD allocated in each field per capita for physical rehabilitation (Figure 1.10). Across fields, most of UNRWA's physical rehabilitation budget is allocated for the West Bank and Gaza, where we also find the higher per capita expenditure for these services. Physical rehabilitation has a low priority in the budgets across all fields, ranging from less than .1 percent in Lebanon to about 1 percent in Syria and 2.7 percent in the West Bank.

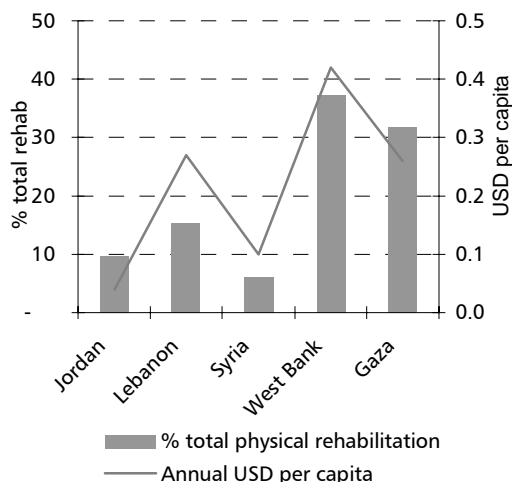
There are many international and local NGOs in Lebanon providing various services to the disabled including a wide range of medical and educational services, but the number of patients served is unknown. In Jordan, a clear lack of facilities for the disabled in general has been reported. In Jordan, activities for and support of persons with disabilities is coordinated by the Ministry of Social Development, and include limited governmental, NGO and private care providers. At present, most activities are provided by international and local NGOs. King Hussein, in 1993, signed a Law for the Care of the Handicapped, as a first step in outlining a legal framework for integrating the disabled into the labour force; provision of special support to the disabled and their families, and finally to increase the accessibility of

public buildings and transportation for the disabled. Little, however, has been actually implemented in terms of policy or practice.

In the West Bank and Gaza Strip services for the disabled, including physical rehabilitation and other services, have been largely led by the local NGO sector in cooperation with international NGOs. Co-operation between the local NGO sector and the PA is reported to be close, with the PA Ministry of Health having established contractual agreements with NGOs for the provision of services in addition to NGO input into the adoption of sector plans for service delivery to the disabled by the MOH and other relevant ministries (Brunborg 2001). A referral system for the disabled has been introduced and is reported to be functioning at the community level, and links and referrals between the community level and the national level are also in place. The Rehabilitation Program (RP) is estimated to cover close to 50 percent of the disabled population.

While we lack precise data on service delivery for the disabled outside of UNRWA, we do have data available through the Living Conditions Surveys that is useful in pointing to the needs and vulnerabilities of disabled camp refugees in Jordan, Lebanon and Syria. In this section, we will profile the disabled in terms of age groups and participation in 'normal' everyday activities such as

Figure 1.10: UNRWA regular health programme budget allocated to physical rehabilitation. (2000-2001)



school and work, and in terms of apparent level of socioeconomic need and vulnerability.

Data indicating disability from the Living Conditions Surveys are of two types: For all individuals, information was collected on whether or not they had a chronic illness or injury and whether that illness or injury was severe enough that the person had difficulties with, or could not, go out alone due to the condition. Second, among individuals 15 years and older selected randomly (one from each household), data was collected on types of functional impairment. These types include movement, sight and hearing. Thus, for children under 15 years we do not have information on functional impairment, but only chronic illness or injury (Table 1.10).

Over all chronic illness was reported in a higher proportion of the refugees in camps and gatherings in Syria than among refugees in the other two countries for both children and adults. Functional impairment was more commonly reported in the adult camp and gathering population than in the other fields as well. The lowest proportion with chronic illness and/or functional impairment was that reported by camp refugees in Jordan (Table 1.10).

Childhood chronic illness and disability a major factor in discouraging education achievement - leading to a high risk for never enrolled or drop out, indicating a failure to integrate these children into the regular school programme.

Starting with chronic illness or injury in children under 15 years of age, resulting in severe disability, enrolment of these children in preschool or elementary school varies by field. Among camp and gathering refugees in Lebanon, overall enrolment of disabled children is the same as that for non-disabled, but there appears to be a tendency for disabled children to stay in preschool longer. In contrast, among camp refugees in Jordan, 14 percent of those five to 14 years of age and disabled are not enrolled in school compared to 3 percent of non-disabled children. Among camp and gathering refugees in Syria there is also less enrolment among the disabled children, but better than in Jordan camps:

Table 1.10: Estimated number of camp and gathering refugees with disabilities and/or chronic illness (Fafo, 1999).

	Jordan camps		Lebanon camps, gatherings		Syria camps, gatherings	
	est. population	%	est. population	%	est. population	%
(a) 0-14 years: Severe chronic illness, injury*	871	1.1	1,332	2.7	2,163	3.4
(b) 15+ years: Severe chronic illness, injury	8,951	8.4	9,946	12.4	18,114	17
(c) 15+ years: Functional Impairment**	8,104	7.6	7,653	9.6	7,397	6.7
(d) 15+ years: Severe chronic illness or functional impairment	13,120	12.3	13,988	17.5	21,602	19.6
Total all ages (a+d)	13,991		15,320		23,765	

*Cannot, or only with difficulty go out alone due to chronic illness, injury.

**Functionally impaired movement, sight or hearing.

9 percent of disabled are not enrolled compared to 5 percent of non-disabled. For refugees in Syria and Lebanon, it was also asked if the cause of the disability was war-related. The results are similar for each location but slightly higher in Lebanon. In Syria, 3 percent of children less than five years of age are disabled due to war events, and 6 percent of children five to 14 years. In Lebanon, 4 percent of those less than five years are disabled due to war events and 7.6 percent of children five to 14 years. Across all fields except the WBGs, disability is the single most important factor leading to school drop out aside from age.

Among disabled and chronically ill adults we also find strong evidence for systematic exclusion from education in the past, and therefore, limited labour market participation. This is most marked in Lebanon.

For persons 15 years and older, in addition to the obvious health implications, there are quite large implications of functional impairment and chronic illness on individuals educational achievements and participation in the labour force. Of course, these effects vary by age group. There are very few cases of individuals 15 to 24 years with functional impairments - too few to assess differences according to other variables, so here we will focus on individuals 25 to 55 years of age. Taking educational achievement first, it is perhaps in Lebanon where the impact of functional impairment is most marked. Over 90 percent of those 25 through 54 years with a functional impairment have not completed basic school (compared to 46 percent of the non-disabled). Among camp and gathering refugees in the same age group who are functionally impaired 33 percent have not completed basic school compared to 13 percent of the non-disabled.

Participation in the labour force is hugely affected by functional impairment, with about double the proportion not in the labour force among those with a functional impairment and in their prime earning years (25 to 55 years of age) in both Lebanon and Syria. For example, among camp and gathering refugees in Lebanon, 81 percent those with a functional impairment are not in the labour force compared to 45 percent of those without impairments in the 25-54 year age group. In addition, half the proportion 55 years and older are employed among those with functional impairment (10 percent compared to 21 percent without).

Given this information on the apparent lack of ability of persons with functional impairment and chronic illness to participate in education and have work opportunities, there is a clear lack of programs to foster disabled participation in everyday life functions.

Mental Health Care

As was demonstrated in Volume 1, Chapter 7, “Health and Nutrition”, the psychological state of camp refugees in Jordan and Lebanon is stressed: some 50-60 percent of adults over 15 years are regularly bothered by at least 3 psychological distress symptoms. Among those with chronic illness or functional impairment, the proportion with additional psychological distress increases to over

70 percent. Given the prolonged nature of a ‘crisis’ situation for many camp refugees and uncertainty about their future, it is not surprising that stress is a burden. In addition to life as a refugee, economic stress was also found to lead to higher rates of psychological stress, with those with the most economic hardship being over represented.

The World Health Organisation (WHO) has recently increased focus on the need to better address mental health issues, including increasing access to and scope of services to those suffering from mental health problems, as well as to implement information campaigns to reduce the prejudices and stigmatisation often surrounding the issue of mental illness. Inclusion of information on mental health service to refugees is relevant not only as a general health topic, but also because Palestinian refugees have been found to be more vulnerable to psychological distress due to their refugee status and accompanying involvement in some cases in armed conflict. Chapter 3 in this volume dedicates an entire chapter to the issue as it is experienced in the WBGS. Here, we will first discuss the availability of mental health services provided to refugees in all fields through UNRWA and the Palestinian Red Crescent Society, and then present an overview of other providers’ services within each field.

PRCS and UNRWA Mental Health Services to Refugees

The PRCS, serving refugees both within and outside of the Palestinian Authority, has a mental health programme as part of its overall health plan for the Palestinian population. However, the extent of PRCS treatment of mental health patients is not known. Since a meeting between UNRWA and a WHO consultant on the topic of drafting a mental health programme for UNRWA occurred in 1989, UNRWA has arranged for four medical officers to receive special training in mental health. Despite a number of studies being carried out by UNRWA and international organisations finding a high prevalence of psychological disturbance among camp refugee children, UNRWA services in this regard is limited to referrals and assistance through the Relief Services Division for mentally handicapped persons. Under its emergency programme in the West Bank and Gaza Strip, however, UNRWA has expanded its efforts in these fields. At present, UNRWA has begun negotiations in the West Bank to form partnership agreements with special NGOs and in-camp organisations that will provide counselling and psychological support for refugees (UNRWA 2000). Similar plans are underway in Gaza Strip.

Given the limited availability of mental health services for refugees through UNRWA, most rely on government or privately provided assistance.

The availability of such services is described for each field in turn below. This information has mostly come from data sheets produced by the WHO in conjunction with World Health Day 2001 highlighting mental health.

West Bank and Gaza Strip

Mental health services in the West Bank and Gaza Strip have been severely limited during the period of occupation, and continue to be lacking in the territories under the jurisdiction of the Palestinian Authority. However, there has been notable improvement in developing more capacity. In 1990, the Gaza Community Mental Health Programme was established providing psychosocial therapy, training for mental health specialists and community workers and to conduct research. The Gaza Community Mental Health Programme has trained a number of physicians and allied health workers and developed a manual for health care and education professionals.

At present there is one public mental hospital in the Gaza Strip (34 beds) and one in the West Bank (320 beds). In addition, 2 public general hospitals in the West Bank allocate 4 beds each for psychiatric patients (WHO 2001). There are no private mental hospitals. There is also no mental health specialist training facility available for postgraduate specialisation - psychiatry is included as an examination topic as part of general medicine (WHO 2001).

Jordan

In 1987 a National Centre for Mental Health was set up in Jordan to provide services to the mentally ill in addition to the already existing mental hospital in Fahis. In addition, the same year a national committee was set up to develop and implement a national mental health program.

According to a profile of mental health services in Jordan from the WHO (2001), the lack of mental health human resources is a major impediment to increasing services in this area in Jordan. Those who have received training often work in neighbouring countries (with higher salaries) or the private sector. There are few psychiatrists (50 total), and most are employed in the private sector. Psychologists are also lacking. Effort has been made, however, to increase trained mental health professionals including additional training for general physicians and nurses. The goal of the Ministry of health, in addition to this increase in human resources, is to provide diagnostic assistance to public health centres, mental health sections to public hospitals and school mental health programs.

Lebanon

The Ministry of Health in Lebanon has focused its efforts in providing a national mental health programme on two main areas: (1) Ambulatory mental health services in primary health centres, and

(2) a psycho-geriatric care systems for the elderly (WHO 2001). At present, neither of these programmes is implemented, although a survey is being conducted to identify the scope of psychiatric problems and reorganisation of human resources and training of existing staff in health centres has begun.

Two mental health facilities in Lebanon provide inpatient care to the mentally ill. Graduate, specialised training in psychiatry has only recently been available to university medical graduates and is arranged through the Psychiatric Hospital of the Cross. Previously, the only option for medical graduates wanting specialisation in psychiatry, was to complete their training abroad - most often in France or the United States. There are an estimated 45 psychiatrists employed in Lebanon. A limited number work for the Psychiatric Hospital of the Cross alongside private practice and the remaining work in private clinics (WHO 2001).

Syria

A national committee to develop a national mental health plan was formed in Syria in the last 1980s. The WHO assisted the committee in outlining a series of national mental health programme objectives to be implemented during the 1990-95 health plan. The objectives include the provision of specialised administrative and professional staff to carry out mental health

service delivery in the context of primary health care, organising specialized post-graduate education, establishing a mental health research centre, and establishing two centres for drug addiction treatment (WHO 2001).

At present, a number of general and university hospitals have beds allotted for psychiatric patients and provide therapeutic outpatient services, although no specialised facilities are in operation.

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Annex 1.1 Examples of UNRWA Austerity Measures and their Effects on Health Services 1990-2000

- (1) Implementation of double shifts in health clinics in some fields.
- (2) In Jordan, contractual services with hospitals at subsidized costs terminated (1991) and practice of reimbursement of some portion of costs implemented.
- (3) In Lebanon, decrease in the number of contracted hospital beds by 36 per cent to meet increasing cost of hospital services (1991).
- (4) In Jordan, restriction on reimbursement of hospital costs in private hospitals such that reimbursement authorised provided costs do not exceed rates in government hospitals (1993).
- (5) Hospital costs maintained at 1987 levels only by diverting funds from sources outside the regular budget.
- (6) Waiting list for surgeries implemented (1993).
- (7) Levels of reimbursement reduced for hospital services (1993).
- (8) Total reimbursement for hospital services capped and restrictions on reimbursement of some types of secondary care (1993).
- (9) Inability to establish a planned and WHO-recommended mental health programme.
- (10) Inability to assist in costs of some treatments for long term diseases (cancer).
- (11) Inability to keep pace with recent medical advances and medical technologies such as new vaccines and screening for cancers.
- (12) Freeze on recruitment and establishment of new posts (throughout the 1990s).
- (13) Gap in disease burden and capacity to detect and maintain patients with non-communicative diseases growing (2000).

Annex 1.2 UNRWA Health Expenditures 1999-2000

	Year end 1990				Year end 1991			
	USD	% of total health expenditure	annual per capita (1)	per consultation (2)	USD	% of total health expenditure	annual per capita (1)	per consultation (2)
Programme Management	0	0,0	0,0	0,0	0	0,0	0,0	0,0
Medical Care Services	26 502 000	78,0	12,3	4,6	26 515 000	75,7	11,7	4,3
Environmental Health	7 489 000	22,0	3,5	---	7 654 000	21,9	3,4	---
Supplementary Feeding	0	0,0	0,0	---	851 000	2,4	0,4	---
Total	33 991 000		15,7		35 020 000		15,4	
	Biennium end 1993				Biennium end 1995			
	USD	% of total health expenditure	annual per capita (3)	per consultation (4)	USD	% of total health expenditure	annual per capita (3)	per consultation (4)
Programme Management	0	0,00	0,0	0	0	0,00	0,0	0
Medical Care Services	60 576 000	76,9	10,9	7,2	61 669 000	77,2	9,7	6,6
Environmental Health	17 630 000	22,4	3,2	---	17 119 000	21,4	2,7	---
Supplementary Feeding	585 000	0,7	0,1	---	1 053 000	1,3	0,2	---
Total	78 791 000		14,1		79 841 000		12,6	
	Biennium end 1997				Biennium end 1999			
	USD	% of total health expenditure	annual per capita (3)	per consultation (4)	USD	% of total health expenditure	annual per capita (3)	per consultation (4)
Programme Management	0	0,00	0,0	0	0	0,00	0,0	0
Medical Care Services	58 987 000	75,9	8,6	5,6	71 107 000	72,1	9,8	6,5
Environmental Health	17 848 000	23,0	2,6	---	18 058 000	18,3	2,5	---
Supplementary Feeding	909 000	1,2	0,1	---	9 450 000	9,6	1,3	---
Total	77 744 000		11,4		98 615 000		13,6	
	Year end 2000							
	USD	% of total health expenditure	annual per capita (3)	per consultation (4)				
Programme Management	2 601 000	5,2	0,7	0,5				
Medical Care Services	34 499 000	69,5	9,1	6,1				
Environmental Health	8 697 000	17,5	2,3	---				
Supplementary Feeding	3 824 000	7,7	1,0	---				
Total	49 621 000		13,0					

(1) per UNRWA registered refugees

(2) All medical, nursing, dental consultations

(3) Annual ratio computed by summing number of registered refugees for both years as the denominator

(4) Annual ratio computed by summing number of consultations for both years as the denominator.

Chapter 2

Education Services

Laurie Blome Jacobsen, Lena Endresen, Gro Hasselknippe

Summary of Main Findings

More rapid improvement in educational outcomes among refugees than non-refugees in Jordan and the WBGs.

Refugees commonly achieve better or similar results than non-refugees or the national host country population in all fields but in Lebanon. Gender disparities in education among the younger cohorts have been eliminated in Jordan but persist in Gaza.

UNRWA has contributed greatly to achieve often superior education outcomes of refugees compared to non-refugees in all fields except Lebanon. This is despite often having a poorer level of inputs in terms of facilities and quantity of teaching staff than national systems. However, variations in educational achievement and level of investment by UNRWA do exist between fields, and only recently does UNRWA report improved outcomes in some fields.

There is a declining level of UNRWA service provision at the elementary level in Jordan coupled with an outflow of refugee students to government schools .

In Jordan, we see fewer resources invested per pupil than average and declining investment at the elementary level, coupled with stable education outcomes as reported by UNRWA (drop out, repetition and pass scores on exams). However, living conditions survey data show a deteriorating situation for young camp males. One explanation for this discrepancy could be that the superior performance of the non-camp population and female refugee population in Jordan masks the negative trends in UNRWA's aggregated data. UNRWA has reduced the number of elementary schools from 82 to 64 schools. The decrease has outstripped the decline in enrolment also witnessed at this level. Among those who have left the UNRWA schools to attend other institutions, it appears the government schools provide a better alternative, with lower pupil to teacher

ratios and a developing educational program able to offer an expanded curriculum. UNRWA has not had the resources to comply with these new curriculum standards. However, among those remaining in UNRWA schools, and despite pupil to teacher ratios being in the lower range across fields, nearly all are still enrolled in double shift facilities. In contrast to the elementary level, UNRWA has invested more at the preparatory level over the 1990s, with some 12 new schools and an increase in teaching staff (30 percent) equal to that of the increase in enrolment (mostly occurring in 1992-93).

In the West Bank and Gaza Strip, better West Bank education outcomes reported by UNRWA are apparent and coupled with varying levels of UNRWA investment between the two regions.

In the West Bank, UNRWA invests more USD per pupil than in any other field except for Lebanon, and more than in Gaza. In addition, the West Bank has considerably lower student to teacher ratios than in UNRWA schools in Gaza (and other fields) and lower than in West Bank government schools. In the West Bank we also see higher pass rates on exams than among refugees in the other fields and lower repetition rates than average across the fields. In Gaza, repetition rates have been higher than average throughout the period, but are reported to have improved to average recently.

During the 1990s, refugees in Gaza have had the lowest pass rates on end of the year exams of all fields except Lebanon, the highest student to teacher ratios and highest classroom occupancy rates.

In Syria, generally poorer UNRWA input levels than most fields, but relatively stable and average education outcomes with the exception of high drop out at the preparatory level, recently reported by UNRWA to have been decreased.

In Syria, UNRWA schools are viewed positively in comparison to public sector schools and performance has been quite stable among refugees through the 1990s. The one exception to this is a positive one: drastic reduction in preparatory drop out reported by UNRWA (as seen in Lebanon) in the 1998/99 scholastic year. Otherwise, there has been little change in the repetition rate, which is somewhat higher than average. This is coupled with the low investment in education by UNRWA in terms of USD per pupil and per capita expenditure, with all schools with double shifts and quite high student-teacher ratios.

In Lebanon, UNRWA expends the most resources per capita and per pupil with very poor education outcomes during the 1990s, although drastic improvement reported by the Agency in 1998/99.

Relatively high levels of resources per pupil and positive level of inputs in the Lebanon field have been coupled with poor education outcomes. UNRWA expenditure in Lebanon per pupil is far higher than in any other field. There are relatively fewer schools on double shift compared to in the other fields and the lowest student to teacher ratios. In contrast, we see quite high repetition and drop out rates throughout the 1990s with a drastic reduction reported by the Agency in the 1998/99 school year. Similar to the case with health services, this is related to higher cost levels in Lebanon. This result may also be related to a lack of alternative suppliers of services to refugees in Lebanon after the primary level, and poor access to the labour market.

Introduction

That delivering basic education is one of the major goals of UNRWA is clear from Agency policy, resource use and its education outcomes over the last 40 years. Some one-half of UNRWA annual expenditure and some three-quarters of all UNRWA staff are dedicated to this goal. Large outlays of financial and human resources for education are in following UNRWA's focus on development of the refugee community. This effort by UNRWA has had large implications for the refugee community in terms of literacy and gender equality in educa-

tion. The result is refugees as a group showing equal or better levels of education than host country populations everywhere but in Lebanon. Overall achievement trends, however, are countered by some negative trends among camp refugee youth in Jordan and worse performance among refugee youth in Lebanon compared to other fields (Volume I, Chapter 4, "Education and Human Capital"). Here it appears that worsening socioeconomic conditions paired with deteriorating levels of UNRWA education resources may be contributing to higher youth illiteracy, drop out and inadequate performance among the youngest generation of Palestinian refugees.

This chapter describes the general characteristics, level and scope of UNRWA education provision. The first two sections give an overview of service provision across fields, and how UNRWA's education resources are divided across different educational "products". In the third part of the chapter, we look at trends in UNRWA expenditure for each type of education service, covering the period from 1990 through 1999. The final part of the chapter sums up the major problem areas, discussing parents' satisfaction with education services, and bringing together conclusions from the education outcomes described in Volume I, Chapter 4, "Education and Human Capital" and problems in provision identified here.

Overview of UNRWA Education Services

UNRWA provides primary education, limited secondary education in Lebanon, vocational training, teacher training and some university scholarships awarded on a merit basis to Palestinian refugees registered with the Agency. UNRWA runs 316 elementary and 331 preparatory schools. As of 1999, UNRWA also had established three secondary schools in Lebanon. The Agency operates eight vocational training institutes open to those who have a certificate of completion of preparatory school. UNRWA's teacher training program prepares new UNRWA teaching staff with both academic and practical training. This includes pre-service teacher training for basic professional qualification and in-service teacher training for updating skills in program planning and curriculum development. UNRWA has contributed financially together with program donors to a university scholarship program annually awarded some 200 to 300 students scholarships to study at an Arab university, but this program is being phased out.

During the 1990s, the number of UNRWA schools have not kept pace with increases in the student populations – resulting in very high occupancy rates. Looking at the number of schools (elementary, preparatory and secondary) and teacher and vocational training

Table 2.1: UNRWA elementary, preparatory and secondary schools per 100,000 registered refugees.

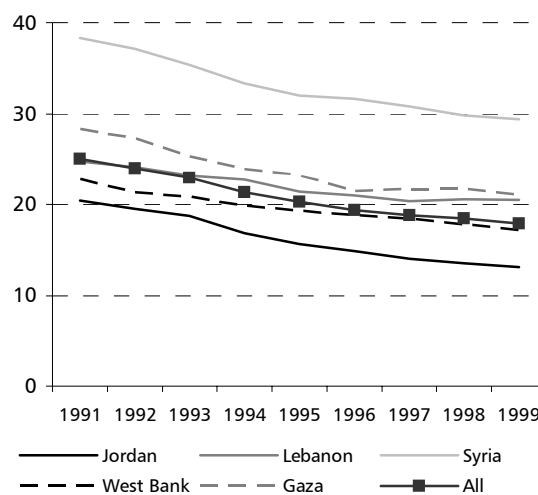
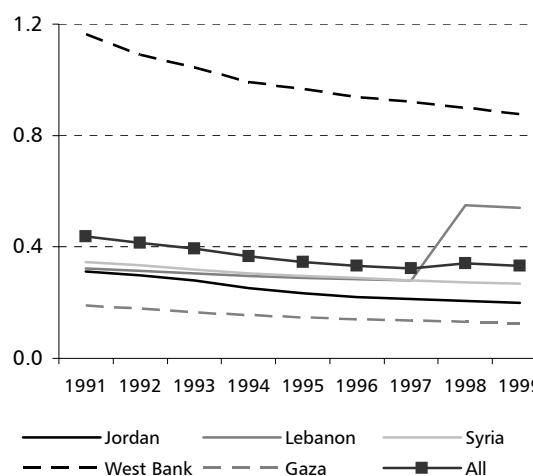


Table 2.2: UNRWA vocational training and pre-service teacher training facilities per 100,000 registered refugees.



facilities per 100,000 registered refugees allows us to compare changes in the level of educational facilities across the different fields taking into account the size of the target population in each field and changes over time (Tables 2.1 and 2.2).

Facilities relative to the population size have declined. The sharp rise in vocational/teacher training facilities per population in Lebanon in the most recent year is due to an additional two-year pre-service teacher training program opening up in that field. Syria has the most schools per 100,000 refugees and Jordan the least, but schools in both fields are quite crowded relative to other fields.

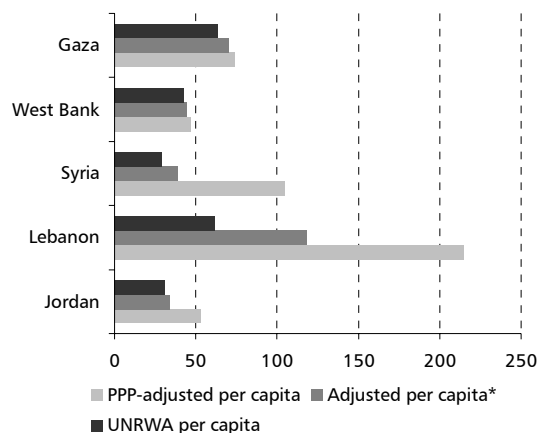
UNRWA budget formats and reporting have changed from year to year, making comparisons over the entire period difficult, but it is nonetheless possible to get an indication of the priorities of the Agency by looking at the biennial expenditure across programs (Annex 2.1). The Agency allocates some 50 percent of its education resources to elementary and 35 percent to preparatory education. This forms the bulk of UNRWA expenditure on education. Vocational education makes up another 7 to 9 percent. Financial reporting on expenditure for the pre-service teaching program is not clear since changes in UNRWA expenditure reporting format were implemented in 1993-94. There-

fore, costs per pupil for the program are not available.¹

According to UNRWA education department, actual expenditures by field sometimes vary from budgeted figures in order to adapt to situations as they develop on the ground. However, UNRWA was not able to provide actual expenditure amounts by field and educational program for the entire period. Nonetheless, budgeted expenditure for 2001 is available by field (Figure 2.3).

UNRWA reported per capita amounts rely upon the Agency's registration data. These registration data are not population estimates, and therefore, subject to some error as deaths may go unreported, and changes of residence

Figure 2.3: Per capita UNRWA reported, and adjusted budget estimates for the general education program, 2001.



*Based on Fafo population estimates for 2002.

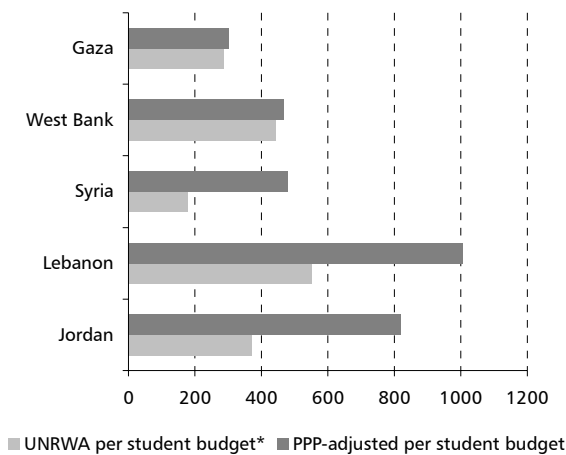
¹ Some other non-direct program costs are also not included as reporting on these items varied too greatly from year to year to make a coherent category of expenditure.

outside of the Agency's fields of operations may similarly not be reflected in the Agency's registration data. In some fields, particularly Lebanon, estimates of the refugee population are considerably different than UNRWA registration data. Taking such population estimates into consideration changes the per capita resource use by UNRWA. We can further adjust the amounts by taking into consideration cost differences across the fields (adjusting UNRWA reported amounts to international dollars using purchasing power parities (PPP). It should be noted that PPP-adjusted amounts should be interpreted with caution. Purchasing power parity estimates based directly on price survey data are lacking for about half of the countries (United Nations Economic and Social Council Statistical Commission 2002). Purchasing power parities for the remaining are estimated

with assumptions about economic patterns that may not be equally applicable across different kinds of economies (UN 2002). Moreover, even with high quality price survey data, purchasing power estimates have large margins of error (UN 2002). Nonetheless, we use the PPP-adjust amounts here as we have good reason to believe that, at least for the case of Lebanon, that higher costs in that field lead to an even larger difference between Lebanon and the rest than is the case prior to adjustments.

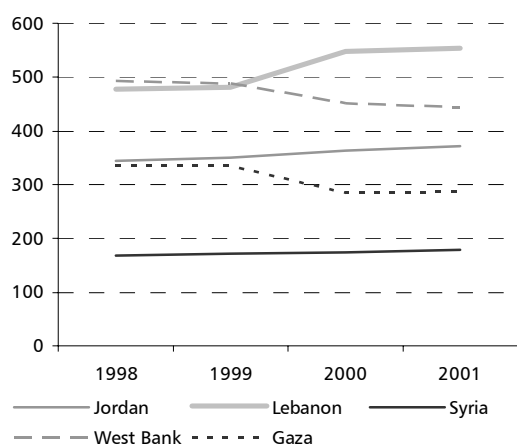
Per pupil budget amounts are based on actual reported enrolment in UNRWA schools. Here we see that again, per pupil budget is highest in Lebanon both before and after cost adjustments. Gaza and Syria have the lowest per pupil budget, with the West Bank also falling in the ranking from second most to fourth highest after cost adjustments. Considerable changes have occurred in budget allocation by field in the late 1990s and early 2000s. Figure 2.5 shows the budget amount per pupil for recent years. Considering only the unadjusted budget amounts per pupil, we see that historically this amount has been highest in both the West Bank and Lebanon. However, whereas investment per pupil in Lebanon has increased in every year since 1997, the reverse is the case in the West Bank (and Gaza). Decreasing investment is coupled with increasing enrolment in both the West bank and Gaza Strip. The figure shows the differ-

Figure 2.4: Per student UNRWA reported and adjusted budget estimates for the general education program, 2001.



*Based on UNRWA reported enrolment for 2001/2002 academic year and 2001 general education budget (UNRWA in figures 30 December 2001).

Figure 2.5: Per student UNRWA budget amounts (1997 to 2001).



Based on UNRWA reported enrolment for beginning academic year and general education budget for year (UNRWA in figures for 1997 through 2001).

ence in investment between the two areas, with the West Bank receiving higher budget amounts per pupil than the Gaza Strip both in the present and historically. The figure also shows a gradual increase in budget per pupil in Jordan recently. However, this is due more to falling enrolment (the only field in which there has been a decrease in enrolment in UNRWA schools every year since 1997), than increase in allocation for education over all.

In addition to expenditure from the general fund, some 50 percent of all project funding is budgeted for education in 2001-2002. This amounts to an additional 62,351,000 USD or 16 percent of the total regular and project budget for this biennium. Most of the project resources are targeted for general educa-

tion activities (84 percent) and the main activity is for upgrading and expanding primary education infrastructure (72 percent of general education project funding). This funding is primarily generated through the Peace Implementation Program. Although there is no information reported by UNRWA on project budget by field and programme, a large portion of project funding is directed to the West Bank and Gaza Strip (52 percent for all programs).

Coordination with Host Country Ministries, Access Issues and Other Providers

The proportion of government expenditure on education is highest in Jordan and the West Bank and Gaza Strip, and relatively low in Lebanon. These relative differences reflect different priorities and educational systems in each of the fields. The lower level of public spending on education in Lebanon has had an impact on refugees from the standpoint that it reflects a system with little public investment at the lower levels of education

Table 2.1: Public expenditure on education as percent of total expenditure.

Lebanon (1)	8.2
Jordan (2)	17.7
Syria (1)	13.6
WBGS (3)	17

(1) 1996
(2) 1997
(3) 1998

Source: UNESCO, 1999.

and a dominance of private institutions not found in other fields at this level, which have further limited access to primary and secondary education (as discussed below). We now turn to national systems and UNRWA's position within each field.

Jordan

In Jordan, UNRWA has institutionalised cooperation only with governmental bodies. Senior UNRWA staff regularly participate in educational development activities hosted by the national authorities. UNRWA's Chief of Education is also a member of the Board of Education at the Ministry of Education. Recent changes in the national education program will have large implications for UNRWA, which is expected to also introduce some measures in UNRWA schools. For example, the Ministry of Education has added computer science as part of the national curriculum for the preparatory cycle for the 1999 – 2000 academic year. UNRWA has only been able to integrate this subject in the 10th grade due to financial constraints. Moreover, among them, some 10 percent of pupils had access only to under-equipped computer rooms (UNRWA 2000).

Registered refugees have free access to public educational institutions, and the government of Jordan has stepped in to fill the gap in education provision where UNRWA services stop. For example, in the case of secondary educa-

tion, the Jordanian government provides 11 public secondary schools in refugee camps to serve refugee youth.

Unlike registered refugees, Palestinian refugees from Gaza face differential treatment. Those who have a “pink card”, or two-year Jordanian passport, can attend Jordanian government schools, but those without a Jordanian passport cannot. Those with the two-year passport cannot attend any public Jordanian higher education institution directly, but must approach the Palestinian embassy for approval. Here, even those with the pink card may be denied access to higher education in public facilities due to quota restrictions. Gaza refugees with a two-year passport have the right to attend all UNRWA education institutions and benefit from UNRWA scholarships.

In addition to UNRWA and government schools, the private sector provides some 1,500 preschools, and 380 basic and secondary schools. About 8 percent of students in the basic and secondary cycles attend private institutions at the national level.

The West Bank and Gaza Strip

In the West Bank and Gaza Strip, UNRWA cooperates very closely with the Palestinian Authority Ministry of Education and other relevant agencies. The Ministry of Education, as part of its restructuring program, has implemented

a number of reform measures in the mid to late 1990s. The Ministry has extended compulsory education from six to 10 years, established a staff development program and has drafted a 2000 – 2004 reform plan (PCBS 1999a). A joint UNRWA – Authority technical coordination committee has been established that meets several times each year in order to discuss issues such as textbooks, school buildings, teacher training and developments in the new Palestinian curriculum. UNRWA has provided the Palestinian Authority with in-service teacher-training courses and other instructional materials for the Authority's in-service teacher training program. A new technical cooperation committee between UNRWA and the Ministry of Higher Education was established in 1998. Thus, UNRWA staff has participated in the development of the new Palestinian curriculum including the development of the Authority vocational training system. As elsewhere, UNRWA schools follow the curriculum used in public schools. However, recent changes increasing basic education from nine to 10 grades have not yet been implemented by UNRWA due to resource constraints. Thus, UNRWA students attend government schools for the 10th grade.

Lebanon

There is no formal coordination between UNRWA and the Lebanese Ministry of Education in service provision, with the exception that UNRWA students sit for

the national exams given at the end of preparatory school.

Refugees' access to public and private education in Lebanon is limited. Another issue is that most UNRWA elementary schools are situated inside camps, making access difficult for those living some distance from the camps (IPS 1994). Armed conflict in the country throughout the 1980s and early 1990s has likewise posed obstacles to education for refugees – after 17 years of civil war (1975-1992), most of the educational infrastructure was destroyed or badly damaged. In the post war period, UNRWA has been forced to use much of its budget to repair and rebuild school buildings (IPS 1994).

A result of this special situation is that in Lebanon we find solutions arranged by UNRWA and other providers that are unique compared to the other fields. Government schools may admit non-Lebanese students, but no more than three per class. In practice, the pressure on the Lebanese education system from its own citizens makes admission of Palestinians to government schools very difficult and very rarely achieved.² This leaves private education as the only real alternative to UNRWA – a very expensive option and not affordable for most refugee families. UNRWA offers basic education to Palestinians irrespective of lack of formal UNRWA refugee registra-

² Interview with Rosemary Sayigh, 2000.

tion, providing secondary education and some preschool education. UNRWA opened its first secondary school in Beirut (Burj-al-Baranjeh camp) in 1993, followed by one in Saida in 1997 and one in Tyr. Secondary schools have now also been established in 2000 in the North and Beqaa.³

Syria

Palestinian refugees in Syria can attend UNRWA or Syrian government schools. The Syrian national education system includes six years of compulsory elementary education and three years of preparatory education. Beginning with the school year 2002/2003, the preparatory cycle will also become compulsory. After the preparatory stage, there are a number of options for continuing education. For the academic route, students can go on to attend the secondary cycle for three years, and then be able to go on to University education. Technical secondary, also three years provides technical training and also the option for university education. There are two vocational tracks, one is vocational secondary education (three years) and the other is vocational education (two years).

In order to be accepted into the free university education individuals must pass an entrance exam. However, those who do not pass the exam can utilise a so-called “Free University” where they

pay a certain fee per subject (about 3,000 SYP). This system is also available for Syrians residing abroad who have not passed or received a high enough score on the national exam.

In the past, foreign schools were not allowed in Syria, but the ban on foreign-owned schools was recently lifted by the Minister of Education. The opening of an international primary school in Syria is part of the government’s efforts to improve and modernise the educational system in the country.

Education Services and Trends in Provision

Preschool/Kindergarten Education

UNICEF’s recent study on the situation of Palestinian children in the region outline a number of problems that have been found by researchers in the provision of kindergarten education, and include: a limited number of facilities, substandard physical environment, lack of unified policies, lack of appropriate learning resources and developmental programmes, and lack of properly trained staff (UNICEF 2000).

UNRWA does not provide kindergarten education, but kindergartens are sometimes operated from UNRWA-sponsored facilities and programs (such

³ Enrolment in UNRWA secondary schools is only offered to registered refugees.

Table 2.2: Gross enrolment ratio in preschool.

Field	Gross Enrolment	Age Group	Year	Population	Source
West Bank	37.1	4-5	1998-99	National	PCBS, 1999
Gaza	28.7	4-5	1998-99	National	PCBS, 1999
Jordan	26.0	3-5	1998-99	National	MOE, 1999
Jordan	13.8	4-5	1999	Palestinians in camps, gatherings	Fafo, Jordan Camp, 1999.
Lebanon	74.0	3-5	1998-99	National	UNESCO, 1998.
Lebanon	50.2	3-5	1997-98	Palestinians in camps, gatherings	Fafo, Lipril, 1999.
Syria	7.0	3-5	1995	National	UNESCO, 1998.

as the women's program centres) in some camps. NGOs, charity organisations and private institutions provide kindergarten facilities for refugees in all fields. Table 2.2 summarises various estimates of enrolment ratios in preschool facilities at the national level and among refugees in some fields.

Preschool enrolment is much higher in Lebanon than elsewhere, both at the national level and among camp and gathering refugees. In Lebanon, however, camp and gathering enrolment in preschool is lower than the national level. About one-half of camp and gathering refugees are enrolled compared to three-quarters at the national level. More emphasis on preschool education in Lebanon in general is due to the high competition for places in government and NGO schools in a national education system heavily reliant on private institutions with high tuition fees. Due to the high demand, many of these schools require that students entering the first

grade already have some basic reading and writing skills. As the only option is high priced private education for the remainder of the child's education years, at a national level, parents tend to invest much in their children's preschool education in order to earn a place in the public schools. Therefore, there are more kindergarten facilities in Lebanon than are found elsewhere. The Community Survey conducted by Fafo and PCBS found that there are more kindergartens in camps than in gatherings. Most camp households have access to at least one kindergarten (96 percent live in communities with a kindergarten while this is the case for 69 percent of gathering households). UNRWA recently has set up four French language preschools with the assistance of the French embassy in Beirut. The preschools are attached to UNRWA schools in Lebanon, two in camps and two outside camps. Otherwise, Palestinian NGOs have taken on responsibility for most preschool education in the camps. For example, in the

1998-99 school year, 28 different NGOs operated altogether 85 preschools for Palestinian refugee children throughout Lebanon (National Institution of Social Care and Vocational Training 2000).⁴ Unlike the situation in Jordan where there is some central organisation in kindergarten provision, a large problem with this manner of education service provision in Lebanon (and the other fields aside from Jordan) is that there is little coordination and large variations among preschools regarding curriculum, qualification of teachers and tuition.

Kindergarten education appears to be on its way to being a developed part of the educational services in Jordan. Preschool is provided by private and NGO institutions, although the Ministry of Education supervises all preschools which must design school plans in accordance with Ministry curriculum regulations and follow Ministry regulations regarding staff qualification. As with teachers at all levels in Jordan, kindergarten teachers are required to have a university degree. Preschool is not compulsory in Jordan, but available to children at least three years and eight months at the start of the school year. The Ministry of Education aims at providing a curriculum that provides an educational environment, helps develop sound health habits and social relation-

ships, and encourages a positive attitude towards school. A national team of various providers and public sector representatives has developed a kindergarten teacher manual offering ideas for the implementation of these basic topic units. Procedures for the follow-up with children including preparation of reports on the children's progress are included as tools for continuous feedback to both staff and parents.

Preschool education facilities and enrolment has grown considerably in Jordan during the 1990s. The number of facilities and teaching staff has grown by over 70 percent (from 546 kindergartens in 1990/91 to 932 in 1997/98) and enrolment has increased by 55 percent (Jordanian Ministry of Education 1999). Although the faster growth of teachers than enrolment has meant lower student to teacher ratios (from 23:1 in 1990/91 to 21:1 in 1997/98) this is still quite high (Jordanian Ministry of Education 1999). On average there were 24 children per class in 1997/98, which is more than the 15 children UNICEF reports as being generally recognised as appropriate for this age (UNICEF 2000). Preschools operating in refugee camps are also included in the national figures and must comply with the same regulations. The Department of Palestinian Affairs (DPA) reports that there were a total of 17 kindergartens operating in refugee camps in Jordan (DPA 1997). Camp refugees have only one-half the proportion en-

⁴ An unambiguous number of children enrolled is not available. Another source (Yassir 2000) claims the number of 68 kindergartens with a total number children of approximately 6800 per year.

rolled in kindergartens than at the national level (14 percent compared to 26).

Private and NGO institutions are also the exclusive providers of kindergartens in the WBGS. Kindergartens must be licensed and are regulated by the Ministry of Education. However, aside from this, there is little central organisation of preschool education provision, resulting in a situation similar to that in Lebanon with many different providers, curriculum and standards. Nonetheless, similar to Jordan, we see an increased accessibility and participation in preschools in both areas. The number of facilities and enrolment has increased considerably since the establishment of the Palestinian Authority. Since 1995, the number of kindergartens in the WBGS has increased by 88 percent (from 436 in 1995-96 to 823 in 1998-99) and the number of young children enrolled has more than doubled (PCBS 1999c). The rate of increasing facilities has not kept up with demand, and there are quite high pupil to teacher ratios for the kindergarten level, reported as 28.6 children per teacher in 1998-99 (PCBS 1999c). Overall, less than 10 percent of kindergarten teachers have university degrees, although the qualification of kindergarten teachers in Gaza is higher than in the West Bank, with 18 percent of teachers having at least a first university degree compared to nine percent.

In Syria, there are some 1200 kindergartens in operation. Kindergarten education includes children three to six years of age. All kindergartens are supervised by the Ministry of Education, under the Division of Early Childhood Education. The Division has renovated the educational syllabi for kindergartens in 1998-99 to accommodate wider education renovations in the country (Syrian Ministry of Education 2000). The child to teacher ratio is also high in Syria, as found in the other countries, with 24 students per teacher reported by the Ministry of Education.

Basic Education

Most refugee youth, particularly those in camps, attend UNRWA elementary and preparatory schools (elementary plus preparatory comprise the basic cycle). About 90 percent or more camp refugees attend UNRWA basic schools, and 60 to 70 percent of those residing outside camps in Jordan and the WBGS also attend UNRWA basic level schools. In Lebanon, most of the refugees living in gathering areas attend UNRWA basic school (98 percent).

Pupils attending UNRWA schools are provided with textbooks free of charge, and special hardship family members are also provided with school supplies such as notebooks and pencils. UNRWA's Department of Education provides basic education with technical

Table 2.3: UNRWA budget per pupil per year in 2000 (all figures in USD).

	Gaza	West Bank	Jordan	Lebanon	SAR	Average
Elementary school	243.3	356.6	335.5	485.7	133.6	285.8
Preparatory school	436.4	517.6	400.3	547.9	198	405.2
Total	679.7	874.2	435.8	1,033.60	331.6	691

Source: UNRWA HQ Amman (Education Planning Officer Dr. Mohammad Abbas)

support from UNESCO in accordance with an agreement signed between the two agencies in 1951.⁵ UNRWA's basic education is divided into a six-year elementary cycle, and a three-year (in West Bank, Gaza, Syria and Lebanon) or four years (in Jordan) preparatory cycle. Children must be at least five years and eight months of age in September of the school year to register at UNRWA schools.

Expenditure

Basic school provision is the main component of UNRWA education services, and has comprised over 50 percent of the total annual education expenditure consistently throughout the last 10 years. Per pupil budgeted amounts for each field in 2000 are listed in Table 2.3. Across fields, resource allocation is highest for Lebanon at both the elementary and preparatory levels, with a total about 50 percent higher than the average for all fields. Allocations are lowest for

Syria, at 134 USD per pupil at the elementary level and 198 USD at the preparatory level this is some 50 percent lower than the average across fields for both levels.

Facilities

The physical condition of UNRWA education facilities has been a major concern to the Agency. School construction has primarily been funded by external donors, and since 1993, through the Peace Implementation Program (PIP). Over the period of 1993 through 1999, USD 235,800,000 has been pledged and contributed to UNRWA through the PIP I and PIP II programs (UNRWA 2000). Out of this amount, 42 percent has been used for the education program. Thus, a large school building/refurbishing programme has been undertaken through PIP funding during the 1990s that is reported to have "improved the educational atmosphere significantly" (UNRWA 2000). Figure 2.6 shows this development. Although the total number of facilities has not increased much (6.5 new schools in total), nearly all of the prefabricated facilities (15 out of 16

⁵ UNESCO has technical responsibility of the Education Programme with some technical and managerial staff on a non-reimbursable loan to UNRWA. Since 1995, UNESCO has sponsored some senior level local area staff. UNESCO staff members advise the Agency's Commissioner-General on policy aspects of Education Programme activities.

were in Jordan in 1990) have been replaced with Agency built schools and the proportion of rented facilities has decreased by 25 percent. Despite this effort, lack of space and suitable facilities is still a problem.

Two issues have led to an inadequate state of UNRWA education facilities: (1) A substantial number of rented and some prefabricated facilities (from the 1950s), and (2) an inadequate number of facilities. Both prefabricated and rented facilities are not very suitable for holding schools due to their structures being too small, inadequately arranged, lack of specialized rooms and outdoor recreation areas, and they have fallen into a state of disrepair. The prefabricated facilities in Jordan simply were not meant to last. As these have largely been replaced, the main problem at present is the sometimes large proportion of rented facilities. This varies largely by field, from none in Gaza to some 50 percent in Lebanon. UNRWA has placed priority on reducing the number of rented facilities, for both cost and space reasons. Figure 2.7 shows this development over the last 10 years. UNRWA-constructed schools are generally physically adequate in terms of space and arrangement, although among the older buildings, most lack heating and many have deteriorated.

The second issue relating to facilities is simply the lack of them – UN-

Figure 2.6: Distribution of UNRWA school buildings by type. All fields.

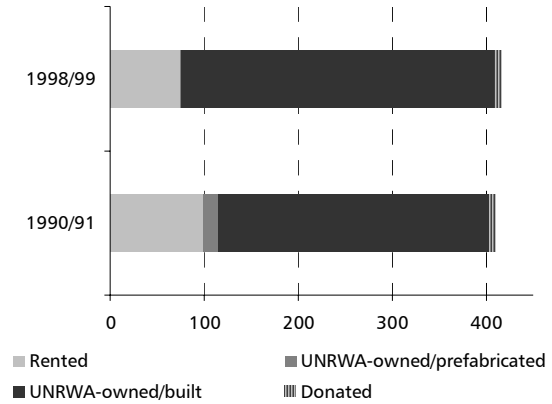
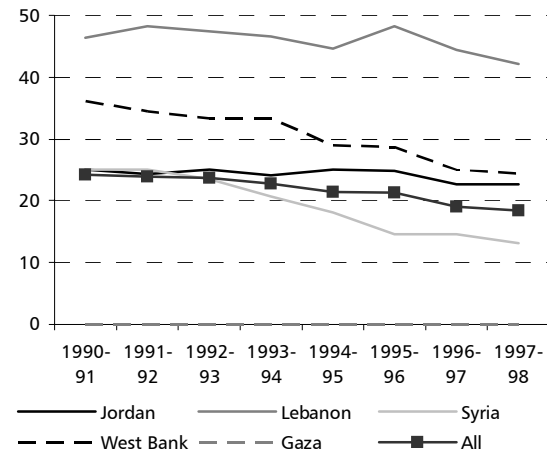


Figure 2.7: Percent of UNRWA school buildings rented.



RWA has not had the resources to build enough education facilities to keep up with the natural population growth. This has led to the necessity of “double shifting” in schools. A double shift facility operates one shift in the morning and one shift in the afternoon. For example, in Jordan, double shift schools

have the first shift beginning at 7:00 a.m. and the second at 12:00 p.m.

Double shifting is reported to have serious implications for the quality of education. First, double shift schools have shorter hours, meaning less learning time. Touq (1998) estimates that in Jordan and Lebanon UNRWA schools, students on double shift lose more than one entire school year (980 hours) due to shorter school hours cumulative over the 10-year basic cycle. Other issues include the limitation put on usage of specialised rooms (libraries, laboratories, etc.) and outdoor recreation areas – both spaces that are often used outside of classroom hours. Beyond the issue of the space being available, extracurricular activities in these spaces must be limited. For the morning shift students, activities cannot interfere with the afternoon shift, for which the lateness of the schedule limits activities taking place during after-school hours. Finally, double shifting must pose some burden on families who do sometimes have children attending different shift schedules.

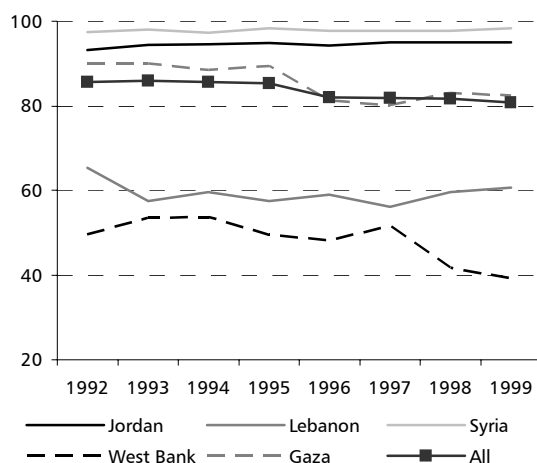
Elementary schools are most prone to double shifting, and Agency-wide four out of five elementary pupils are on a double shift schedule. Figure 2.8 shows the percent of elementary pupils attending double shift schools. There has been an overall decline from 86 to 81 percent, but it is only in the West Bank and Gaza Strip that a smaller proportion of stu-

dents are on double shift now than 10 years ago. In other fields, the proportion has remained the same or increased.

Other indications of over-crowdedness in schools are the classroom occupancy rates and area per student, both measures that show space to be inadequate in UNRWA schools. According to Touq (1998), UNRWA classroom occupancy rates (at 43.6 persons per class section) are considerably higher than the average for the host country schools – ranging from four to 10 students more (Touq 1998). The average square meters per student, at 1.02 in Agency built schools and .84 in rented schools, is low, falling below the minimum standard set by UNESCO of 1.4 square meters for elementary and 1.5 square meters for preparatory (Touq 1998).

The difference between UNRWA basic school facilities and those of other providers is, however, in some cases not that different. For example, in the WBGS there is also crowded classroom space in government schools. In the West Bank, UNRWA schools actually have more space per pupil than government schools at 1.12 square meters (the same as private schools) compared to 1.04 for government schools (PCBS 1999b). However, in Gaza, UNRWA schools are much more crowded than either government or private schools. In addition, private schools are housed in rented buildings more often than either UN-

Figure 2.8: Percent of UNRWA elementary school students in double-shift schools.



RWA or government schools. In the West Bank, 39 percent of private schools are in rented buildings compared to 25 percent of UNRWA and 12 percent of government schools (PCBS 1999b).

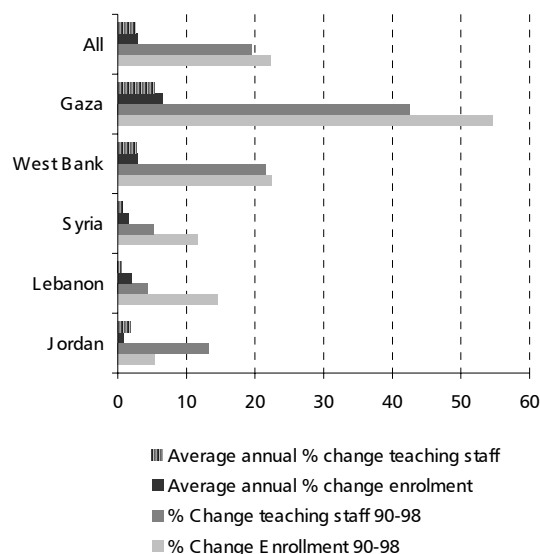
Teaching Faculty

As Touq explains in his report on the UNRWA education program (1998), one way UNRWA has coped with high occupancy rates at Agency schools was to hire more teachers — a tool less available since the introduction of austerity measures limiting and/or freezing new teacher and supervisory personnel. The disparity between the growth in enrolment and growth in teaching staff during the 1990s is apparent with higher enrolment increases than teaching staff increases. This disparity has had differing repercussions in stu-

dent/teacher ratios. Although having increased only slightly overall during the 1990s for Agency schools as a whole, ratios were considerably higher at the end of the 1990s than the beginning in Gaza, Syria and Lebanon. In Gaza and Syria, the effect is large at the elementary level, and these are fields already having quite high student/teacher ratios in 1990-91. In Gaza, elementary school ratios increased from 40 to 44 students per teacher between 1990 and 1998. In Syria, student/teacher ratios increased from 39 to 42 during the same period.

We also see an increase in student/teacher ratios in Lebanon, overall from 28 to 31, but this has mostly been due to increases at the preparatory level. In Jordan, the growth in teaching staff over the period is mostly due to large increases in teacher hiring in 1992-93 when

Figure 2.9: Percent change in enrolment and teaching staff (1990-91 to 1997-98).



UNRWA introduced the 10th grade level. Although adding a grade level also resulted in a sharp jump in enrolment for that year, enrolment in UNRWA schools has actually been declining in Jordan.

The student/teacher ratios at UNRWA schools are higher than among government schools in Syria and Lebanon, but not much different than public schools in the West Bank and Gaza Strip. Estimates were unavailable for comparisons to government schools in Lebanon. In Jordan, the average student/teacher ratio at the basic level for government schools during the 1997-98 academic year was 24:1 compared to 36:1 in UNRWA elementary and 31:1 in UNRWA preparatory schools (Figure 2.10). In the West Bank, government schools are more crowded than UNRWA basic schools with 34 students compared to

UNRWA's 31 students – the reverse is the case in the Gaza Strip, but the difference is not large (37 for government and 39 for UNRWA schools).

Not only is it important that there are enough teachers to provide a positive, interactive learning environment, but also that these teachers are adequately trained. UNRWA operates two types of facilities to provide this training: The Educational Sciences Facilities (ESFs) located in the West Bank, Jordan and recently, one in Lebanon, and the Institute of Education which is located in each field. The ESFs currently offer a pre-service teacher training program leading to a first university degree (four years) and an in-service training program leading to a first university degree (three years) for those who only have a 2-year diploma (community college level). The

Figure 2.10: Number of students per teacher, UNRWA schools. All education levels by field and academic year.

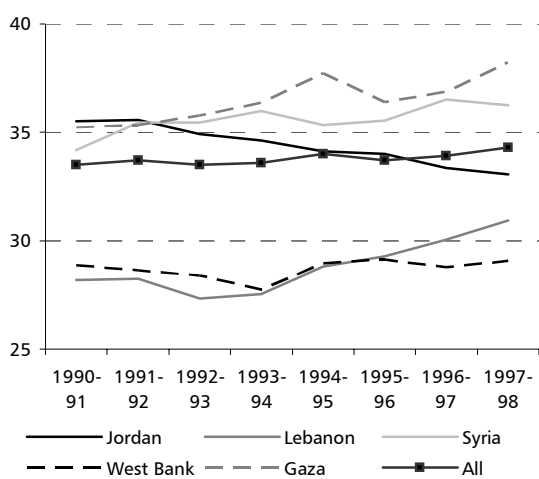
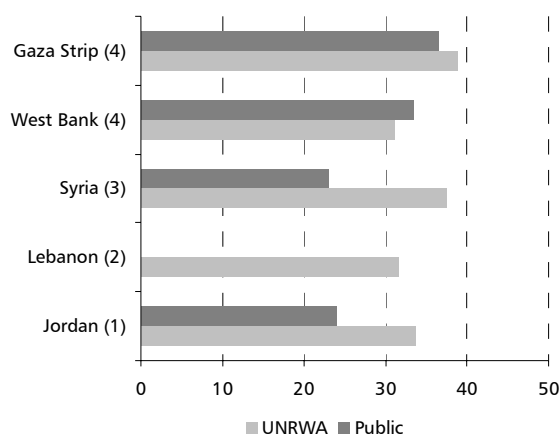


Figure 2.9: Pupils per teacher in government and UNRWA basic cycle schools.



(1) 1998-99. Source: Jordan Ministry of Education.
 (2) National figures unavailable.
 (3) 1996. Source: UNESCO Statistics.
 (4) 1998-99. Source: PCBS.

latter program began in 1992 as a response to Jordan (and later the PA) requiring that elementary teachers have first university degrees. The Institute of Education provides an in-service teacher training program offering some 20 courses focusing on building upon skills and upgrading the competence of already qualified teachers.

As we have seen in some fields that austerity measures have impacted student/teacher ratios, it is also reported by Touq (1998) that the ESF training facilities' ability to provide teacher education has been undermined by the inability of the Agency to retain qualified professors (Touq 1998). Salaries and hourly lecture fees for internal and external lecturers being lower than at local government and private universities, and teaching loads being higher are reported to have made it difficult to attract instructors (Touq 1998). According to UNRWA's Jordan Field office, the reduced job security and pay that the austerity measures have led to, has reduced the ability to attract the most competent teachers. Motivation among the teachers is, likewise, reduced.⁶

In assessing the professional qualifications of teaching staff at the elementary and preparatory levels we look at both the academic qualifications and UNRWA qualification criteria of teaching staff. UNRWA's internal system of

qualification is as follows: Teachers are considered qualified for the elementary school teaching if they have a secondary certificate (Tawjih) plus completion of a two-year post secondary teacher training course. Teachers are considered qualified for secondary school teaching if they have one of the following:

(1) Completion of at least two years of an approved study course plus at least one year professional teacher training, or

(2) Completion of a special advance academic course of two years at the UNRWA/UNESCO Institute of Education following completion of the two-year post-secondary basic teacher training course, or

(3) Completion of a three-year post-secondary combined teacher training/academic training course at one of the Agency's teacher training centres.

Compared to the host country regulation of a first university degree for all teachers in most of the fields, the largest discrepancy in UNRWA-qualified teachers and this requirement is at the elementary level. Here, teachers are UNRWA-qualified with a full two years less education than is normally required in the host country. At the preparatory level, UNRWA teachers falling into the first and last categories end up with three years training compared to the usual four-year university program.

⁶ Interview with unidentified staff, November 2000.

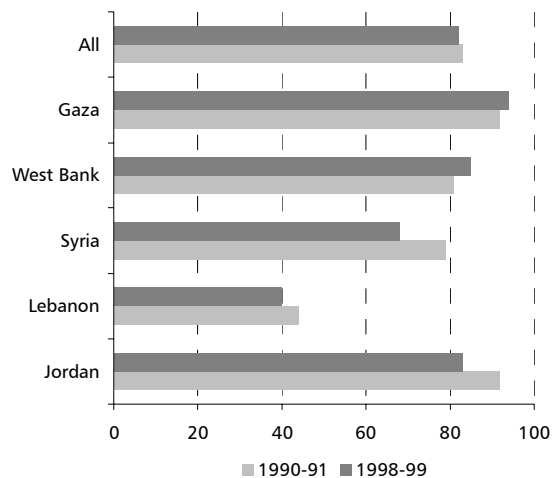
At the elementary level, nearly all teaching staff meets the UNRWA-qualification requirements and has done so since 1990 (between 95 and 99 percent). However, very few have university degrees (less than 5 percent in 1998/99) and the proportion has not increased much during the 1990s. Jordan is one exception, where UNRWA elementary teachers with university degrees increased from 2 percent in 1990/91 to 44 percent in 1998/99. At the preparatory level, there is a problem with many teachers' not meeting UNRWA-qualification requirements (20 percent do not), although quite a large proportion has university degrees (about 75 percent over all).⁷ Thus, in a number of fields more teachers have university degrees than have UNRWA-qualified status. This may be due to degrees in a non-education subject. However, the relationship between UNRWA qualification and other higher academic qualifications are unclear in UNRWA reporting.

There are large differences in teachers' qualifications across fields at the preparatory level. Figures 2.10 and 2.11 show preparatory teacher qualification according to UNRWA's internal criteria and according to academic qualification. Less than one-half of

teachers in Lebanon are UNRWA-qualified (40 percent) compared to the average for all fields of 82 percent. In Syria, only 68 percent are UNRWA qualified. This is a decline from 1990 in both fields. However, many teachers in both fields have university degrees. This is in contrast to the other fields in 1990 and still higher than other fields in 1998/99.

In the West Bank and Gaza Strip, fewer UNRWA teachers have at least a first university degree compared with either government or private schools teachers (Figure 2.12). Only some 30 percent of UNRWA teachers in Gaza have university degrees compared to 55 percent of government teachers and 70 percent of private school teachers. The difference is not as large, but similar in the West Bank.

Figure 2.10: Proportion of teachers at UNRWA preparatory schools UNRWA-qualified for the preparatory level.



⁷ UNRWA report figures on the proportion qualified classify teachers as "professionally qualified" at the preparatory level even though they are only professionally qualified for the elementary level and teaching at the preparatory level. A Department of Education official agreed that this proportion could be considered as unqualified, and would take note of the reporting.

Use of temporary and contract teachers has increased, especially the latter, during the 1990s as a way of coping with the financial crisis. Touq reports they are paid about 50 percent less than regular Agency teachers. UNRWA figures on teacher qualifications include contract but not temporary teachers. Over the whole period the number of temporary teachers has generally been quite small, however, varying from .2 to 1 percent of the total teaching staff. The largest temporary staff has been employed in Lebanon, where roughly 2 percent of the teaching staff is temporary. The use of contract teachers is more common, and has increased in the latter 1990s, such that in the 1998-99 academic year 8.5 percent of teaching staff was hired on a contract basis (Figure 2.13). Contract teachers are used heavily in Gaza and the West Bank (and less frequently in Jordan).

Curricula

The national curricula which UNRWA uses as a basis for education provision has been found to be outdated, relying heavily on rote learning, inflexible and include “widespread gender stereotyping” (UNICEF 2000). Both UNRWA and host governments in each field have begun implementing new updated curricula incorporating more up-to-date educational theories and tools during the latter 1990s. In fact, over 50 percent of UNRWA’s Biennial Work Plan (BWP)

Figure 2.11: Percent of teachers at UNRWA preparatory schools with a first university degree.

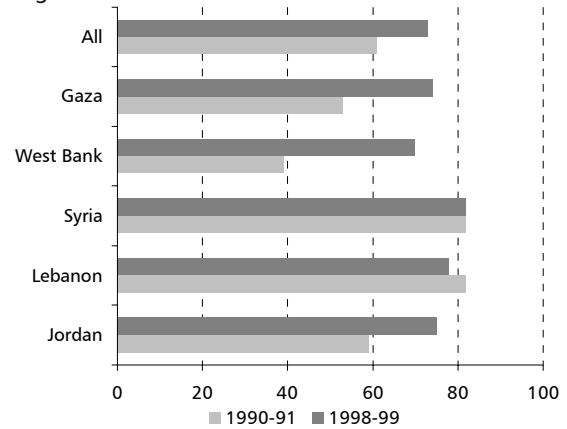
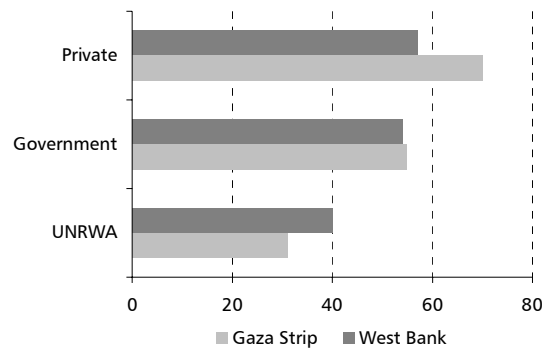
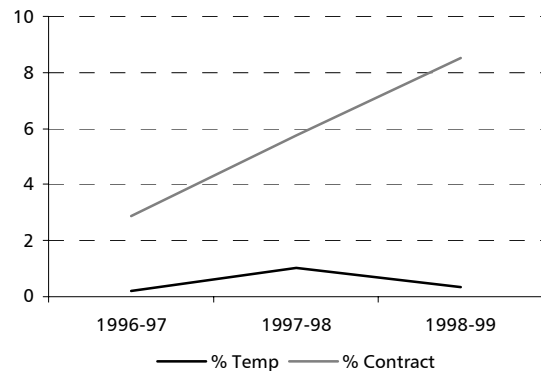


Figure 2.12: West Bank and Gaza Strip: Percent of teachers (all levels) with at least a first university degree, 1998-99.



Source: PCBS and MOE, 1999. *Education Statistical Yearbook*

Figure 2.13: Percent of total elementary and preparatory teaching staff on contract and temporary.



activities during 1998-99 were centered on curricula enhancement activities in order to remedy this problem. New curricula have been introduced for many grades in UNRWA schools over the past several years.

In the West Bank, government and UNRWA schools have followed the Jordanian curriculum and in Gaza, both UNRWA and government schools followed the Egyptian curriculum – although in both cases, the curricula had been heavily censored by Israeli occupation authorities. The Palestinian Authority Ministry of Education approved a new curriculum in 1998 that is to be phased in by grade level over the next five years. In Jordan, the second phase of the Educational Development Plan (1996-2000) concentrates on preparing new curricula and textbooks for all basic and secondary grades and subjects. With assistance from international organizations the Ministry of Education has shifted focus to problem-solving and critical thinking. Language skills such as French and English, and a much expanded computer skills program form part of the new curricula (Drury 1998). Similar developments have taken place in Syria, including comprehensive curricula revisions and implementation during the latter 1990s.

Enrolment

Enrolment in UNRWA basic schools has increased on average about 3 percent per year overall. As we have seen in examining pupil/teacher ratios, across fields the trends vary considerably –enrolment has increased much more than this in Gaza and it has actually declined overall in Jordan during the 1990s. Figure 2.14 and 2.15 shows the enrolment for elementary and preparatory during the 1990s.

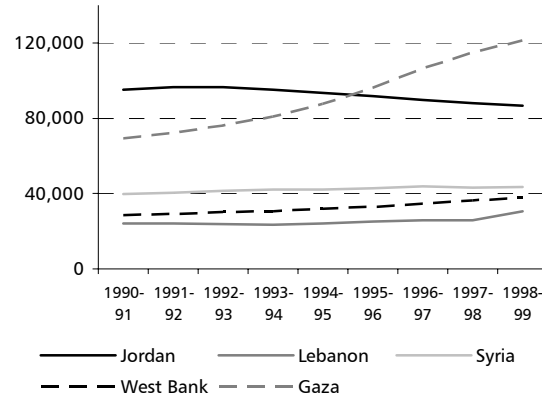
Part of the change in enrolment is generated by changes in the size of the population of school age, part by changes in the proportion of children actually attending any school, and part by changes generated by preferences, such as more or fewer refugee students attending UNRWA versus other institutions. We see the relative importance of such factors on enrolment levels is different across fields.

At the elementary level, there have been large changes in enrolment levels in both Jordan and Gaza – but generated by two different factors. In Gaza, growth in elementary-aged registered refugees coupled with a steady proportion of registered refugees attending UNRWA versus other schools (89 percent reported by UNRWA) has led to large increases in enrolment. In Jordan, however, a similar increase in elementary aged youth coupled with a much larger proportion reported by UNRWA to be attending government schools (from 14 percent in

1990-91 to 30 percent in 1998-99) has led to decline in UNRWA enrolment in that field. Moreover, as UNRWA mentions in its reports, there is little incentive for reporting enrolment at non-UNRWA institutions, and UNRWA reported enrolment ratios have actually decreased considerably among Jordan registered refugees, to levels much lower than other sources report. Thus, we can assume that a large share of this is due to non-reported attendance at a non-UNRWA school. Interviews with UNRWA field staff support this conclusion, revealing that UNRWA schools were traditionally associated with high quality in Jordan. During the last decade, however, the quality of UNRWA schools is reported to lag behind public schools.

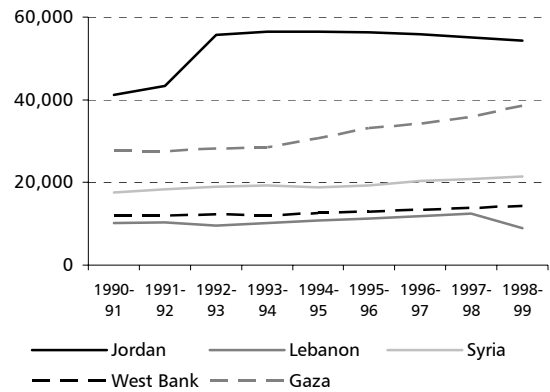
The pattern in each field is similar at the preparatory level. However, UNRWA enrolment data reveals a decline in preparatory enrolment in Lebanon after 1997. This is due to the cycle changing from four to three years duration for the 1998-99 school year, and the inclusion of this year into the secondary cycle. The sharp jump in enrolment numbers for Jordan in 1992-93 is the result of the introduction of the fourth year of preparatory into the curriculum that year and the influx of Palestinians to Jordan following the Gulf crisis. This rapid increase in students, however, was met with a large increase in teaching staff. Pupil to teacher ratios remained stable in the Jordan field

Figure 2.14: Enrolment in UNRWA elementary schools.



Source: UNRWA

Figure 2.15: Enrolment in UNRWA preparatory schools.



Source: UNRWA

between 1990 and 1993 for both the elementary and preparatory levels.

Performance

The performance of UNRWA education services and pupils can be measured in a number of ways as reported by UNRWA: (1) repeat rates, (2) drop out rates, and (3) percent of pupils passing national/

UNRWA examinations. UNRWA also calculates the coverage rate, or percent of school-age children they estimate are enrolled in school. UNRWA results on enrolment ratios, show good coverage rates for elementary and preparatory education for registered refugees with 96 percent enrolled overall in 1998.

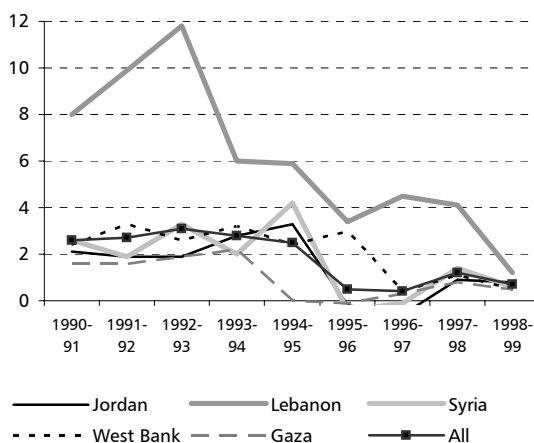
Two trends are apparent in UNRWA-reported data on drop out and repetition rates. First, both are high in Lebanon for both elementary and preparatory levels during the 1990s except the most recent reported year (1998-99), and also high in Syria. Second, drop out has declined gradually over the whole period for all fields, but a large fall in drop out is reported in all fields except Gaza in the most recent 1998-99 academic year. It is reported by the Agency that during this academic year, in all fields but Gaza, drop out rates have halved in just one academic year. The reason for this sudden decline according to UNRWA is that different methods of measurement were used prior to 1998 for drop out, which relied on estimates, while the 1998-99 figures are derived from actual records obtained from government and private institutions on enrolment.

Figures 2.16 and 2.17 show the drop rates at the elementary and preparatory level. At the elementary level over 1.2 percent are reported as having dropped out in 1998-99. Falling drop out rates are particularly evident in Lebanon,

although it is also here that we see much higher drop out at the elementary level than in any other field. Drop out reached a high of 12 percent in 1992-93, gradually falling to about 4 percent in 1997-98, and in the most recent academic year falling to much the same level as elsewhere.

At the preparatory level, we again see higher drop out in Lebanon, at least double of that found in all fields except Syria, and the difference only narrowing in the most recent reported period (1998-99). Similarly, in Syria drop out at the preparatory level is quite high, especially jumping in the 1994-95 academic year. UNRWA reports a sharp decline in enrolment this year and mentions this is possibly due to movement of Palestinian refugees to the Gaza Strip with the establishment of the Palestinian Authority (UNRWA 1995b).

Figure 2.16: Drop out rate from UNRWA elementary schools.

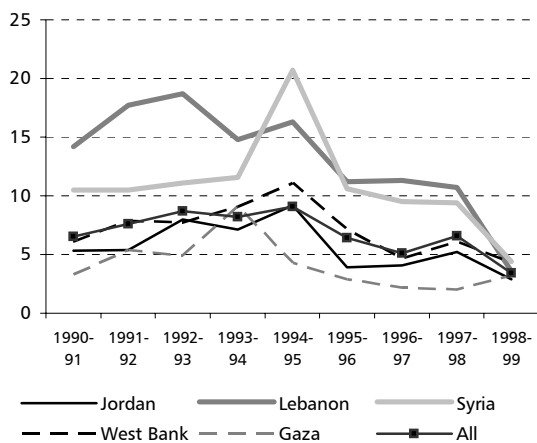


Repetition rates in UNRWA schools vary distinctly across the fields, more so than drop out rates. This is to be expected as many factors impact the student's decision to leave school than performance or quality – factors which often pose similar circumstances to groups of youth in all the fields: family poverty, the need to work, marriage patterns. Repetition, however, is often followed by drop out, as students who repeatedly fail to perform up to standard are much more likely to leave school entirely. With repetition rates we see a clear divide between those fields in which students are performing better than the rest.

Overall there is a 3.6 percent and 5.4 percent repetition rate at the elementary and preparatory levels respectively as reported by UNRWA (Figures 2.18 and 2.19). Repetition rates have been modestly declining in all fields, although

declines mostly occur in 1993-94 and 1998-99. Students in Jordan and the West Bank are doing better than average. Youth in Syria are not performing too badly at the elementary level (slightly above average repetition) but poorer at the preparatory level with repetition rates about double the average at 10 percent in 1998-99. Gaza youth also have shown high repetition rates compared to the average during most of the period, but large improvements in recent years as reported by the Agency have brought these down to average. Similar to the picture depicted with drop out rates, youth in Lebanon also appear to be performing quite poorly, worse than in any other field when considering repetition rates. While repetition rates are reported by UNRWA to have fallen in Lebanon considerably in 1998-99 at the preparatory level, they have actually increased at the elementary level.

Figure 2.17: Drop out rate from UNRWA preparatory schools.



We cannot compare the UNRWA data with the Living Conditions Survey data due to the latter being an estimate of the total proportion behind in school rather than the rate (we do not know in what year the student became delayed). However, the UNRWA data supports the general trends found in the survey data with much higher repetition in Lebanon than the other fields, and better performance of Jordan refugees than elsewhere. While we cannot compare UNRWA and Fafo results directly, the rapid decrease in repetition and drop out rates

Figure 2.18: Repetition rate in UNRWA elementary schools.

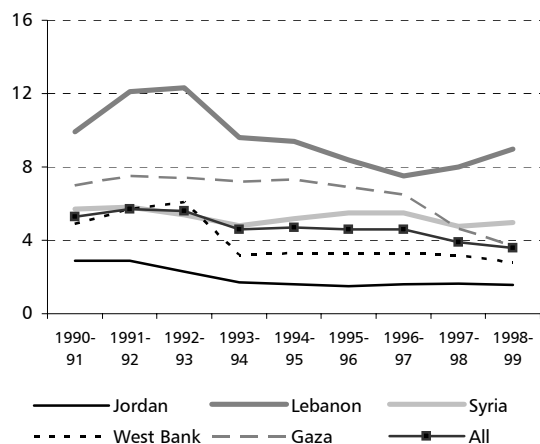
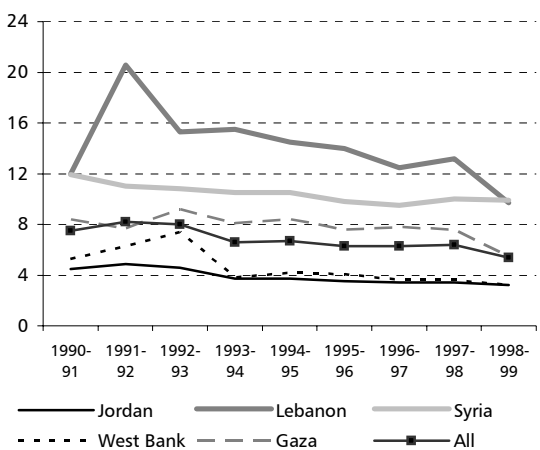


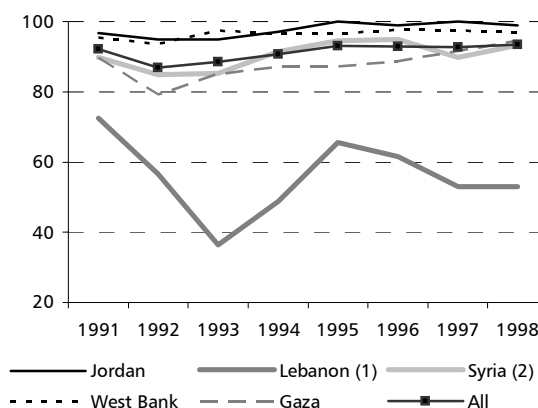
Figure 2.19: Repetition rate in UNRWA preparatory schools.



in some fields reported by the Agency in the 1998-99 academic year is not found evident in recent survey data.

Students' academic performance in UNRWA schools is monitored through examinations (Figure 2.20). In Lebanon and Syria, students take national exams

Figure 2.20: Results from end of the preparatory cycle examination: UNRWA exam in Jordan, WBGs and National exam in Syria and Lebanon.



⁽¹⁾ 1991 results are from an UNRWA exam, as the government exam was not administered this year.

⁽²⁾ Results from the government exam all years.

administered by the Ministry of Education at the conclusion of preparatory. In the other fields, national exams are not conducted, but UNRWA administers its own at the end of each year to determine advancement to the next grade. Finally, UNRWA, since 1998, has begun administering standardised achievement tests to students in the fourth and eighth grades.

Although the pass rates are quite low in Lebanon for the national examination, UNRWA pupil pass rates are comparable to those among students in government schools with 53 percent compared to 52 percent in government schools (UNRWA 1999b). In Syria, UNRWA students perform considerably better than pupils in government schools with 93 percent passing the national

exam compared to 58 percent of government school pupils in 1997-98 (UNRWA 1999b).

In keeping with the pattern of comparatively good performance of refugee students in Jordan, more pass the UNRWA exam at the end of the preparatory cycle than elsewhere, although the difference across fields has narrowed quite a bit over time. Students in Gaza, who previously have had lower levels of pass rates are now catching up to pupils in other fields.

Secondary Education

UNRWA only provides secondary education in Lebanon. As of 2001, UNRWA operates three facilities in Lebanon, opened in 1993, 1997 and 1998, and accommodating a total of 1,367 secondary students in 1998-99. While at the other levels of education there is rather equal enrolment of males and females in UNRWA schools, there are more females in UNRWA secondary schools in Lebanon at 57 percent of enrolment. Students in the new secondary schools in Lebanon are performing well, as about 30 percent more passed the official government examinations on math, science and philosophy in Lebanon than those in government secondary schools on during the 1998/99 school year. UNRWA secondary students had a pass rate of 100 percent in math, 89 percent in science and 90 percent in philosophy.

In the other fields, refugee students attend government schools, which are free of charge or private schools that normally require a tuition fee. In Jordan, secondary education is divided into three streams: Secondary Comprehensive education includes both an academic track and a vocational track. Applied Secondary consists of vocational training and traineeship programs. As we have seen in the previous section, of those enrolled in secondary, academic is the most common, especially among women.

Vocational Education

Since the 1950's UNRWA has offered vocational training under one centralised curriculum. Training is offered through eight vocational training centres, one in Gaza, two in Jordan, one in Lebanon, three in the West Bank and one in Syria. Four of these are purely vocational and technical institutions, while the other four provide teacher training in addition to vocational training programmes. The workshops at the vocational training facilities have been modernised during the 1980's with assistance from donors.

UNRWA's vocational and technical training services include three tracks: (1) Vocational course programs require completion of at least the third year of preparatory school, (2) Semiprofessional technical and commercial course programs require the completion of secondary education, and (3) Short vocational

courses of 20 to 40 weeks' duration are open for those who need updating of skills to meet the immediate needs of the labour market.

UNRWA vocational training courses have been less affected by growth in terms of large class sections and pupil/teacher ratios than other educational levels (although somewhat) and there are generally uniform conditions across the fields, with 17 to 18 students per section and nine to 10 pupils per teacher. UNRWA has spent between USD 2,000 to USD 3,000 per pupil on vocational training. According to estimates for the 1998-99 academic year, expenditure per pupil has increased recently after three consecutive biennial periods of falling per pupil expenditure (Figure 2.21) (UNRWA 2000).

Some 4,500 students are enrolled in UNRWA vocational training facilities and 2,000 graduate each year. There has been roughly a 2 percent average annual increase in both enrolment and graduation during the 1990s (Figure 2.22).

More men than women are enrolled, and they enrol in different types of courses (Figure 2.23). Less female enrolment in vocational courses in general discussed in the Volume I, Chapter 3, "Education and Human Capital" holds true here in the case of UNRWA-provided courses. However, more women are taking vocational

courses now than 10 years ago. In 1998-99, 30 percent of vocational training participants were women, which is quite a large increase in female participation since 1990-91, when only 21 percent of enrolment was female.

The choice of courses also vary considerably by gender, with men most often taking electronics (24 percent), automotive (18 percent) and machine/metal fabrication (14 percent); and no women in any of these fields. Among women, commercial and computer was most popular (34 percent), followed by paramedical training (25 percent). In the "courses for girls" most were enrolled in hairdressing courses.

UNRWA does not report enrolment by the level of course (vocational, semiprofessional training, or short course) but includes all in enrolment statistics. We do, however, have data regarding enrolment in vocational short courses from living conditions surveys in Jordan refugee camps and Lebanon refugee camps and gatherings. In Jordan refugee camps, enrolment in short vocational courses (any provider) defined as lasting less than 12 months was actually higher overall among women than men (21 percent versus 15 percent) among those over 15 years of age and completed formal education (Tiltnes 2002). But, gender discrepancies in the likelihood to enrol in UNRWA short vocational courses exist only among those

with secondary or less education. Among those with higher levels of education, participation in vocational short courses is not only more common (25 percent) but also equally pursued by men and women. (Tiltnes 2002).

Making vocational training coursework relevant to the needs of businesses is key, and the most difficult aspect of vocational training. It requires constant updating of curriculum and course offerings in addition to close ties to the business community. UNRWA's vocational program for women could be improved upon in this respect. Fitting vocational programs to local needs requires flexibility rather than unified vocational programs operating in perhaps very different contexts. It is common, however, that many businesses are small, family-owned enterprises. It is difficult to encourage such businesses to participate in vocational training programs (VTC 1998). Jordan's Vocational Training Corporation (noted later) has attempted to overcome this by offering special services to the companies like start-up and small company management courses. UNRWA's unified vocational program across all fields, while efficient from an administrative standpoint, may not be the best solution to achieving the best possible "local fit".

In Jordan, public vocational programs are integrated with secondary education in general. Nonetheless,

Figure 2.21: UNRWA per pupil biennial expenditure from the general fund on vocational training. USD.

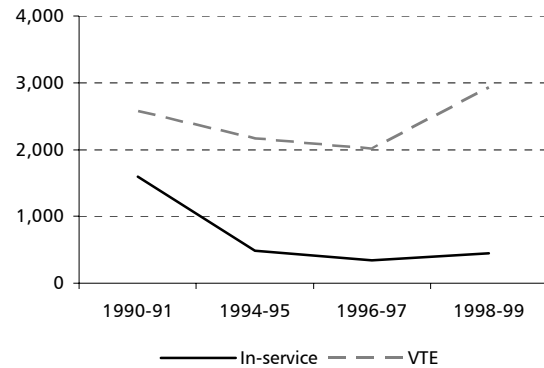
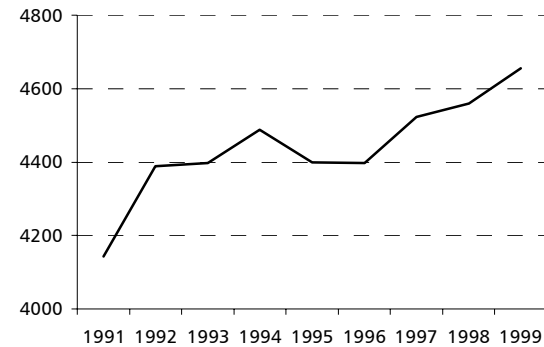
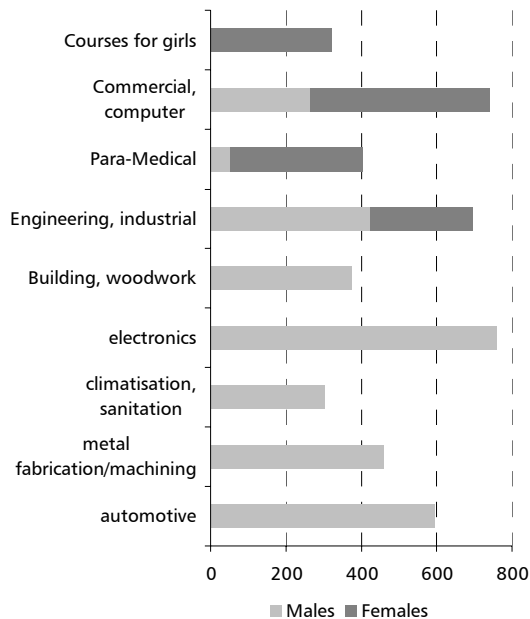


Figure 2.22: Enrolment and graduation rate in UNRWA vocational training facilities.



vocational studies are viewed as inferior and attract fewer students. This is despite the fact that the Ministry of Education has done much to upgrade and make vocational programs more relevant to labour market needs in the mid-1990s. Jordan has also set up a single, semi-autonomous body charged with revamping the country's vocational training sector, the Vocational Training Corporation. The Corporation has been successful in getting local business involved in

Figure 2.23: Enrolment in UNRWA vocational training courses by type of course, 1998-99.



vocational programs, both by taking on vocational trainees and by providing feedback on local needs.

A stigma against vocational education also is reported to exist in the West Bank and Gaza Strip, where those who pursue this track are assumed to have Tawjihi (secondary completion exam) scores too low to be accepted at an academic institution. At present, the public sector mainly provides formal technical training at the post-secondary community college level. As part of a national plan to address the lack of participation and attitudes towards vocational training, a Bachelor of Technology degree (B-Tech) was scheduled to

begin to be offered at select technical schools in 1999. A draft strategy for developing a unified technical education program describes the present system as being highly fragmented with many providers leading to duplication and reducing efficiency. Even within the public sector, vocational training is provided through a number of ministries including Labour, Education and Higher Education. In addition, NGOs (aside from UNRWA including the YMCA, charities and women’s organisations) and private institutions have increasingly offered vocational training and many different levels since the early 1990s.

In Lebanon, vocational and technical training is an area of considerable NGO provision of services to refugees. Four NGOs provide vocational training to refugees, often in direct cooperation with UNRWA. These include: (1) Norwegian People’s Aid, (2) National Association for Vocational Training and Social Services, (3) National Association for Social Medical Care and Vocational Training, and (4) Association Najdeh.

University Education

UNRWA provides a limited amount of university scholarships for excellent pupils. This programme started in 1955, and is financed jointly with donors using extra budgetary resources. In 1998/1999 UNRWA awarded 866 scholarships, 398 (46 percent) were for women.

Higher education in Jordan, similar to elsewhere, has two levels including a system of two-year community colleges and four-year university degree programs. There are seven public universities, nine private universities and 45 community colleges. Students are required to pay tuition fees in the public universities of some 340 JD per semester. However, the private universities are much more expensive, with tuition fees three to four times higher than the public institutions. There have been a number of important changes in the system of higher education in Jordan recently. The Ministry of Education has set up a higher education accreditation board to review private community colleges and universities, and the public universities have been granted a great deal more independence as individual institutions. Each public university now has a board of trustees that review and supervise the universities at a local level, including program, management and funding activities.

Higher education in Syria is offered at two-year intermediate institutes, one higher institute and four universities. Acceptance into university is based on passing the secondary school leaving certificate (*Al Shahada Al Thanawiya*). The first degree offered by universities is a bachelor's degree. Most bachelor degree programs are four years (with the exception of medicine, engineering, and architecture each five to six years in duration). Like all public education,

universities and institutes are free of charge for both Syrian and Palestinian students.

Adult Continuing Education

Educational courses for adults, such as literacy programs, are often offered through UNRWA-supported, but community-led women's and community centres. These centres are increasingly becoming financially self-sufficient and are managed and staffed by local volunteers. Aside from this, UNRWA does not provide adult continuing education as part of its regular education program. NGOs also provide adult refugee literacy programs, especially for women. In both Jordan and the West Bank and Gaza, the public sector operates literacy and education programs for adults that are open for refugees.

In Jordan, the Ministry of Education provides adult education through a wide range of programmes – an effort to reduce illiteracy that is part of the Ministry's Educational Development Plan began in 1997/98. The adult literacy programs include evening classes, summer courses and home studies that allow adults to sit for school and general examinations. Non-formal, vocational training courses are also provided as a part of a continuing education program. Over 600 literacy program centres have been established which included some 11,200 participants during 1997-98.

Such non-formal vocational and academic short courses offer a certificate certified by the Ministry at the conclusion of the course.

Special Education

Aside from its support of community-led rehabilitation centres, UNRWA relies entirely on project funding to provide special education for a limited number of students with special needs. These include pupils with learning problems who do not pass the end of the year examinations in the first three grades, and those who are identified by teachers as having learning problems. Such students are offered special classes for a two-year period to catch up. Disabled students, those deaf, blind or mute, are offered class sections taught by specialist instructors.

The lack of a comprehensive program targeting refugees with special needs (due to learning disabilities, physical disabilities or long-term illness) remaining in education may be a problem, and indications of un-met need in this area can be found among a number of studies. Tiltnes found that among Palestinian refugees in refugee camps in Jordan, chronic illness was a major factor in determining the odds of quitting school (Tiltnes 2002). An UNRWA study on leavers from UNRWA schools in the Lebanon field found that the main reason

for leaving school after the first grade among males was mental retardation.

In Jordan, the Ministry of Education's Division of Special Education provides specialised educational programs to those with learning difficulties, the handicapped and "talented" students with special abilities. Services are provided in special facilities and resource rooms, and in addition, the Division is working on integrating those with mild to medium handicaps into public schools. A number of programs are in place to train teachers in special education. Also, the Ministry of Social Development runs special education programs for the deaf, blind and handicapped for grades one through 10, in addition to vocation education for the handicapped. The Queen Alia Fund for Voluntary Social Work provides workshops, training and development of diagnostic tools, resource rooms and supervisors. The University of Jordan trains teachers in special education as part of its teacher training programs and provides resource rooms for special students. Finally, Princess Sarvat College training programs include those for educational directors and supervisors for special student facilities through the Learning Difficulties Centre. NGO and private institutions provide special centres and schools.

Refugee Parents' Satisfaction with Educational Services

Similar to data gathered in the JLCS and Jordan Camp Survey at the household level, in Lebanon, the Community Survey conducted by Fafo and the PCBS, gathered information at the community level about general satisfaction with educational services. Out of a total of some 55 communities in camps and gatherings, slightly over one-half of households were in communities which reported they were "satisfied" with the quality of education services. Thirty-five percent of households were in communities reporting that they were unsatisfied or very unsatisfied. Large differences appear to exist between communities in camps and those in gatherings, with the former being much happier with the quality of services, which reflects positively on the provision of UNRWA camp schools. Twice as many camp households are in communities that report being satisfied (65 percent versus 33 percent in gatherings). Urban areas get better quality ratings than rural areas, although this is much more of an issue for those living in gatherings where a very high percentage of rural households are in communities unsatisfied with services (86 percent compared to 37 percent of camp rural households).

The JLCS reported that parents with children in UNRWA basic schools more often reported the quality of education in their child's school being less than

adequate than those with children in government schools (about 10 percent). Private schools were rated better than both government and UNRWA schools with 95 percent of parents judging them as at least adequate. Those with a child in UNRWA basic most often report no opinion compared to parents with children enrolled in government or private schools (about 5 percent compared to 1 percent in government and none for those with a child in basic private), which may indicate less active interest in the child's schooling. The parents of children in UNRWA basic schools also had somewhat different suggestions for improvements than others, and complained most often of there being too many pupils in class (roughly 15 percent) compared to 11 percent for those with a child in a government school and 5 percent for those with children in private schools (Drury 1997). However, there are more similarities than differences among the parents with children in UNRWA and government schools: Teachers' lack of qualifications was the most common (18 percent) followed by crowding and a lack of teachers' commitment to teaching (10 percent) (Drury 1997). Parents of children in private schools were primarily concerned with such issues as curriculum, teaching methods and educational equipment.

Among camp and gathering refugees in Syria there is little difference in the satisfaction of parents with government

compared to UNRWA schools. Parents were asked to evaluate the performance of the school that their oldest enrolled child in basic attended. Here we see that government schools are slightly more often rates as good or excellent, but also more often rated as poor. The important point, here, however, is that most (over 60 percent) evaluate UNRWA schools as good or excellent and nearly all rate UNRWA schools as adequate or better.

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Chapter 3

Mental Health in the West Bank and Gaza: A summary of the mental health status, policy and services delivery during the Palestinian transition

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Introduction: Less Exclusion and More Care

Mental health is one of the least developed areas in the Palestinian health system that only recently has regained attention at the planning level in the West Bank and Gaza Strip (WBGS). Previously, psychiatric ailments were ignored and patients were neglected and/or held responsible for their illnesses. Health professionals considered mental ill health simply as madness. Its care had no prestige, nor adequate level of profit. Priority was given to organic and infectious diseases, which caused substantial mortality and morbidity. When the *Intifadah* erupted in 1987, the mounting psychological problems passed undetected by primary health care professionals. Consequently, the question of mental health was brought up and received increasing attention after the *Intifadah*, when the consequences of military occupation, violence and stress became

prominent in the behavioural picture of children, youth and adults alike.

The concept of mental health is still not well understood in the Palestinian community setting. In fact, mental disorders are perceived as extremely negative forms of illness. As in most Middle Eastern countries, Palestinian culture retains a traditional explanation of mentally disturbed people. The common belief is the mental disorders are mainly attributed to one or two explanatory models. The first is based on the work of supernatural forces known as “evil spirits” or “the evil eye” and in Arabic as *djinn* or *a-fa-reet*. The traditional healer is seen as the only person able to extract the *a-fa-reet* from the human body. The second explanatory model is that mental disorders are neurobiological disturbances that need chemical treatment. Because mental ill health is highly stigmatized, sufferers usually seek help of traditional healers or present their

psychological complaints in the form of physical symptoms. These attitudes may not be expressed freely, but they constitute a major obstacle to the development of rational and modern mental health services.

For decades the relative roles of primary care and secondary care in mental illness have been debated, as the capacity of general practitioners to detect and effectively treat mental illness. In the WBGS (Abu Hein 1993, Garbarino 1996, GCMHP 1999), it has clearly been shown that psychiatric hospitals are regressive, rarely efficient and not cost-effective institutions. The integration of mental health into primary health care services has only recently started in the public sector and they are often overwhelmed by patients whose physical complaints disguise anxiety and depression. Furthermore, patients' attributions influence the detection of mental health problems in primary care. Doctors are twice as likely to detect a psychiatric problem if the patient attributes his or her reason for consultation to psychological rather than physical causes, although doctors still miss around one-third of true cases (GCMHP 1999).

The Scope of the Chapter

The scope of this chapter is attempting at a global review of the mental health strategy and care available in the WBGS.

The focus of the report will be advocacy, presentation of the evidence base for mental health initiatives, and technical information to contribute guiding decisions in mental health reform and services provision. The working questions that inspired the work were aimed at (1) depicting the mental health problem dimension in the WBGS, (2) assessing the main determinants of mental health problems, (3) assessing entitlement and access to the services rendered, and (4) analyzing whether, and to what extent, coordination in the provision of services exists. The chapter ends with a remainder of the key-priorities to date.

The Current Political Framework of Health

Since the Oslo Declaration of Principles, the Palestinian Authority embarked in a difficult transformation of its political and socioeconomic system and the health system and services inherited after the Israeli occupation. The epidemiological transition highlighting the reduction of mortality and morbidity from infectious or preventable diseases and the consequent increase in the prevalence/incidence of chronic diseases such as diabetes, cardiovascular diseases, cancer and mental/physical disability has shaped the new vision of the Palestinian Ministry of Health that was established in 1995.

The social consequences of the transition, however, have been negative and dramatic. Setting aside the political unrest and uncertainty of the future relationship with the Israelis, they include a reduction of the country's resources for education and health services that started in 1997, a wide gap between the richest and the poorest irrespective of the status of refugees or residents, the spread of poverty and growth of corruption and, in some areas, of organized crime. Palestinians are disappointed with the transition and 40 percent of them regard themselves as having better off under the Israeli occupation (PCBS 1998, 1999).

The Burden of Second Intifadah on Mental Health of Palestinian Children

According to various reports, as a result of the continued clashes between the Israeli and the Palestinians (erupting on 28 September 2000, termed the *Al Aqsa Intifadah*), more than 318 Palestinians were killed and more than 10,500 were injured, maimed or disabled. Children under the age of 18 years constituted more than one-third of the casualties. Three deaths and 111 injuries in the age range 9 through 15 years were recorded in UNRWA schools in the West Bank only (UNRWA 2000). The huge dramatic effects caused by such situation on the sub-sector of Palestinian children for the second time in a decade went mainly

unreported. Aside from the interruption in the school education process and the severe limitation exerted on their activities, these children hear and see first hand bloodshed and watch the horrific pictures of other children being injured or killed broadcast by the TV.

The violence permeates all parts of the WBGS, and affects virtually all Palestinian communities, schools, families and children. Wounds are physical and psychological. Fear and panic for the younger children, frustration, hatred and loss of trust for the older ones are the most commonly expressed signs of current psychological distress of Palestinian children. In some pockets of the country, accessing schools is either impossible (due to the tight closures imposed) or very risky. Emergency health services are often prevented from accessing the wounded. Mobility restrictions of health personnel increase the burden on health services delivery.

As a recent UNICEF documents points out:

“during the current crisis, children – and especially adolescents – are too often portrayed and perceived as contributing to the escalation of violence. Yet, adolescent stone throwers – one more group of victims thrown into the conflict – represent a small proportion of an estimated adolescent population of 600,000. Entangled in personal conflicts between the values of tolerance

and peace they were brought in and their will to defend the Palestinian land, the vast majority of the Palestinian adolescents - children of the peace process – need to seek their “way out” to peacefully contribute to the preparation of a better future.” (UNICEF 2000).

The Palestinian National Authority Action and the Supply Side

While establishing the 1999-2003 National Strategic Health Plan in the WBGS (see Annex 3.A), the rationale was introduced by all the government, stakeholders and donors that there was a need to act in an holistic approach to reduce the social exclusion assuring both the rehabilitation and integration of people who suffer from mental or family disorders. The main aims for launching a comprehensive new vision were: (1) To contribute supporting an integrated community-based system of mental health in WBGS by networking the available resources of the government and NGO sectors, and (2) To contain specific morbidity, mental handicap, learning disabilities, and the social exclusion and alienation as consequences of the traumatic syndrome that both adults and youths had undergone in the Territories.

According to the type of care available, sound legislation protecting the right of citizens suffering from mental problems is highly needed as well as clearly estab-

lished mechanisms for entitlement. Other priorities have emerged that are functional to the need of securing (1) special training and continuing education for medical doctors and nonmedical personnel, (2) appropriate drugs (into services), and (3) operational research into trauma therapy.

Community-Based Mental Health and the Demand Side

A community mental health model to delineate the strategy for mental health advocacy in a transitional WBGS recognises the primacy of primary prevention:

“..to forestall dysfunction by reducing rates of occurrences of disorder in the population at large over long time periods and to promote psychological health and well-being.”
(Cowen 1973)

Primary prevention is contrasted with secondary prevention (early detection of, and intervention upon, psychological dysfunction) and tertiary prevention (prevention of side effects of full-blown mental illness). The community-based mental health approach was substantiated by a structured approach in the WBGS context described in *A Proposal for the Implementation of a Government Community Mental Health Service in Gaza* (Afana, 1992), and further documents (Al-Ashhab 1995). The psychiatric hospital was perceived not to be a

natural social environment and, therefore, hospital-based treatment could not provide the full range of experiences that enable patients to gain confidence and self-esteem through success in their social roles and in their extended families. The hospital in Bethlehem was described as a place “where there is an excessive emphasis on physical treatment”.

In the Gaza Strip, the proposal offered scope and planning for the decentralisation of care and the establishment of a community-based setup in Khan Younis, Rafah and Jabaliya that could integrate the efforts and activities of all the stakeholders (government, NGOs, PVOs and UNRWA). Such an approach was repeatedly refined over the time even though the key factor of the community-based mental health movement remained to protect the interests of the most severely distressed and/or chronically disabled psychiatric service users, who are the least socially equipped to exercise self-advocacy.

Unlike other worldwide community-based mental health movement that adopted almost all the local community problems, the movement stated well-defined and limited aims for the community-based approach and activities since it was thought that “it is not possible to solve all problems of an area by micro-methods, since many of them are macro-problems that require macro-solutions

(bad housing, inequalities, lack of entitlements simply cannot be solved from a local base)”. On these grounds, the national health plan, still regarded as the blueprint for health system development and social re-organisation in the WBGS, gives special attention to the promotion of well-being, to programs for the population at large, social planning and lobbying for a just and health Palestinian society at the macro-system level, including use of the political arena. Efforts to avoid stigmatization and exclusion of such people went on requiring a clear allocation or reallocation of resources, staffing and human resources development activities that sometimes never materialized.

The Problem Dimension

Data of case load at psychiatric hospitals' level is described later in the report. However, no structured, updated information exists that assesses performance and/or quality of service provision at the hospital level in the WBGS. The available information mainly regards post-traumatic distress syndrome (PTDS) studied in children and adolescents.

In the WBGS, the prevalence of mental health problems is accounted for 73 percent of the total outpatient consultations at the level of primary health care services with users complaining of anxiety and/or depression (The Status of

Health in Palestine 1997-98, Thabet 1998, GCMHP 1999). At the general practitioner's level, however, the detection rate of such symptoms is only of 11 percent, that is not different from other health system contexts. There are also reasonable questions on whether, when detected, such conditions are treated. Reports have recently raised some important issues in the debate about common mental disorder (Goldberg 1992, Kessler 1999, Araya 2000). They indicate that this is a common condition that requires greater recognition and effective treatment. Reported prevalence figures in the WBGS are high, and most of this is undifferentiated anxiety and depression. What other medical condition or group of conditions occurs with this frequency? If this is taken at face value as representing a condition requiring medical or at least clinical intervention, this is bound to overwhelm the current Palestinian primary health care network and leave general practitioners dispirited, exhausted, and even depressed. In general, general practitioners are much better at recognizing the absence of common mental disorders than its presence, but are repeatedly criticized for their failure at recognition (Kirmayer 1993, Ustun 1995, Dorwick 2000).

Nashef (1992) and Baker (1990) both found during the *Intifadah* that children displayed conduct and psychological disturbances, fears and depres-

sion. This is supported by Garbarino's (1996) findings in his study with Gaza and the West Bank children after the *Intifadah*. Traumatized children in Northern Ireland (Fraser 1974), Uganda (Dodge 1987), Southeast Asia (Eisembruch 1991), Lebanon (Fahood 1993), Kuwait (Nader 1993) and former Yugoslavia (Zivic 1993, Tolfree 1997), or the inner cities of the U.S. (Garbarino 1992) exhibit similar behaviours. Whereas these are normal reactions to abnormal circumstances, studies are showing that a single instance of overwhelming terror can actually alter the balance of a child for long time. The child can show signs of psychological disorders, grief and loss reactions, impaired intellectual development, school problems, truncated moral development, pathological adaptation to violence, and identification with the aggressor. These signs are usually described as the impact of violence as PTSD (Yule 1999). Children who experience additional life stressors are even more likely to be negatively affected. Refugee children with the many stressors with which they live, can be placed in a very high-risk status.

Exposure to a variety of stressful situations, including imprisonment, beating, house demolition, killings resulted in a variety of mental health diseases and problems such as anxiety, PTSD, and depression among Palestinians. According to Abu Hein et al.(BMJ

1993) study of a sample of 1500 Palestinian children in the Gaza Strip (age of 11 years), 92.5 percent of them had been teargassed, 42 percent had been beaten, 19 percent had been detained and 85 percent had had their house raided.

Thabet et al (1998, 1999, 2000), found that 21.5 percent of the nine through 13 year old children in the Gaza strip showed anxiety disorders. Parents of a sample of six through 13 year old children reported that 48 percent of them scoring above cutoff score and 40 percent showed moderate to severe PTSD reactions. In a longitudinal study of children aged seven through 13 years, results indicate that 11 percent reported moderate to severe post-traumatic reactions, teachers rated 36 percent of being deviant, and parents rated 21 percent of children with mental health problems.

In 1998, the relations between traumatic events, perceived parenting styles, children's resources, political activity and psychological adjustment were examined among Palestinian boys and girls of 11 and 12 years of age (Qouta 1998). Results showed that the more traumatic events children had experienced, the more negatively they perceived their parenting. And the poorer they perceived their parenting, the more they suffered from high neuroticism and low self-esteem. Furthermore, the more traumatic events children had experi-

enced, the more political activity they showed, the more active they were, and the more they suffered from psychological adjustment problems. In general, therefore, in the WBGS the perception of good parenting protects children's psychological adjustment by making them less vulnerable in two ways. First, traumatic events decrease their intellectual, creative and cognitive resources, while in a model excluding perceived parenting a lack of resources caused many psychological adjustment problems. Second, political activity increased psychological adjustment problems in the same model, but not in the model including perceived parenting.

More recent evidence has accumulated on stress and trauma, particularly among the Palestinian youth. In a recent epidemiological study on the prevalence of stress-related disorders, an overall profile of mental health in the Gaza Strip was provided (Qouta 1999) after assessing the extent and nature of exposure to trauma among Gazans, and identifying the psychological consequences of trauma and risk factors associated with psychiatric disorders. Thirty-four percent of the sample were found to suffer from stress-related psychiatric disorders. PTSD was the commonest diagnosis, occurring in 14.7 percent of the refugee and 11.7 percent of resident citizens. Some 37 percent reported at least one episode of maltreatment during their childhood, most commonly repeated verbal abuse by

parents or relatives, 42 percent had witnessed the death of a family member, while 35 percent had witnessed violent clashes with the Israeli Defence Forces.

The effects of cognitive capacity, perceived parenting, traumatic events, and activity which were first mentioned in the midst of political violence of the *Intifadah* in 1993, were examined on PTSD, emotional disorders, school performance, and neuroticism three years later in more stable conditions in children 14 years old. Results showed first, that PTSD was high among children who had been exposed to a high level of traumatic events and had responded passively (not actively) to the *Intifadah* violence. Discrepant perceived parenting was also decisive for adjustment: children who perceived their mothers as highly loving and caring but their fathers as not so showed a high level of PTSD. High intellectual but low creative performance was also characteristic of the Palestinian children suffering from emotional disorders. Second, the hypothesis that cognitive capacity and activity serve a resilience function if children feel loved and non-rejected at home was confirmed. Third, neuroticism decreased significantly over the three years, especially among the children who had been exposed to a high number of traumatic events.

Consequently, what has been labelled the psychosocial dimension of

the impact of war and organized violence has been of increasing interest in the development field and in international agencies. This offers some positive possibilities but the danger is that a narrowly medicalized and psychologized view of trauma will be imposed in the Palestinian setting (a typically North-South transfer of concepts and practices). The Palestinian conflict has been, and still is, chronic and fluctuating, with hostilities varying in intensity and location. People feel besieged and threatened even when their particular site is quiet. Social tension and clashes is not extraordinary or abnormal in the WBGS context and have come to be incorporated into economic and social life, eliciting diverse and shifting adaptation from variably affected groups.

The threat posed by drug addiction to the WBGS should also not be underestimated, although scientific terminology (occasional users versus addicted people) and legal and judicial definitions used by different Palestinian institutions and stakeholders differ.

In Jordan, where addicts are seen as sick citizens and not criminals by the Law No.11 issued in 1980, 50,000 addicts are reported by the Jordanian Anti Drug Administration (Palestinian Council of Health-ECF 1999). In the West Bank, Horani estimates that 20,000 to 25,000 individuals suffer from drug addiction, out of which 7,000 to 10,000

qualify for daily use, excluding East Jerusalem, in 1999. In Gaza, the Anti-Drug Council estimates the number of drug abusers to be higher than 5,000, 300 of which are under treatment. An unpublished account by Hanon from the Al-Najah University in Nablus indicates the total estimate of drug addicts in the WBGS to be 36,000. Finally, the PCBS reports a total of 340 drug-related crimes in the WBGS in 1997 related to cultivation, distribution, possession and use and a yearly trend of increase.

Statistics regarding drug addiction are not available at the Palestinian Ministry of Health (PMOH). The PMOH's conviction is that drug addiction is a chronic disease that needs two to five years of treatment. Since its establishment in 1960, the Bethlehem psychiatric hospital receives drug abusers seeking help to overcome their addiction, and who are referred by primary services and general practitioners. At the primary health care level, public mental health services offer a four-weeks withdrawal programme that is centered on psychotherapy and tranquilizers. Financial support for those in need is provided by the Ministry of Social Affairs and health insurance. Statistics on successful rate of treatment are unavailable.

The National High Commission for Drug Prevention and the Palestinian Anti Drug Authority are about to draw up a comprehensive national plan to combat

drug abuse in the WBGS. In 1998, the problem magnitude was conducive to repeated events of knowledge and experience-sharing activities between Palestinian and Israeli institutions and stakeholders. GCMHP and Ben Gurion University cooperated in several occasions and training workshops and sensitization seminars were organized by the UN Drug Control Program Regional Office for the Middle East and North Africa. Local police officers, professional and teachers from governmental and NGO sectors underwent training to play a more effective and coordinated role in preventive activities. A prospective substantial increase in drug abusers was detected both in the West Bank and Gaza Strip who resorted to mental health services seeking treatment and advice.

Mental Health Services and Stakeholders' Analysis

The Central Issue

Evidence indicates that mental health policy and promotion must rank high in the agenda for health development in the WBGS, given the priority attached to it in the Five-year National Strategic Health Plan (1999). Beyond the philosophy, approach and conceptual model, the development of a fully comprehensive system of care for those suffering from mental health problems and human rights violations in the WBGS poses a funda-

mental challenge for service organisation and delivery in a setting where the government health expenditure per capita is USD 34.4 (against a total expenditure per capita of USD 121.6) (PCBS 1998).

As the site of care has shifted from mental health institutions to community-based services almost everywhere in the world, a key issue is how to ensure the range of functions which are met on one site, namely the psychiatric hospitals of Bethlehem and Gaza (asylum, treatment, accommodation, social support, rehabilitation), could be transposed across multiple settings and integrated within the current available primary health care system (Al-Ashhab 1995).

The Mental Health Services Delivery

The mental health services in the WBGS are currently characterized by fragmentation and duplication, even though inter-ministerial collaboration has been started by October 2000 among the Ministries of Health, Education, Social Affairs, Planning, of ex-Detainees, the Palestinian Red Crescent Society and other prominent sectoral NGOs. To date, the Ministry of Health does not have established a specific Directorate General for Mental Health, which is able to encompass services management, decentralization and integration with other primary health care services; reform and management of the secondary services; and,

finally, coordination of funding and implementation with NGOs, PVOs, and the private sector.

Accessibility of mental health services was never a main concern in the West Bank and Gaza. When examining the demand and supply equation, while the public system delegated almost always the service provision to NGOs and PVOs at the primary care level, the seniority and insufficient availability of specialists in the country have always fostered a strong private market for mental health.

The community-based approach that emerged over the last five years in its general conceptualisation and initial setup fostered by NGOs and enlightened professionals found effective roots in the well-established primary health care network and the use made of it by general practitioners. Consultation fees vary. While the public and NGO system offer services for free or at a nominal fee (clinical consultation of NIS 50 in the West Bank; 15 to 25 NIS in Gaza Strip), private consultations flare up to NIS 150 to 200.

Finally, when examining the adequacy and limitations of the sub-sector economic context, discrepancies in salary scales of human resources must be considered. Qualified health workers are inclined to work for NGOs and private groups where salaries are higher, holding

a disruptive power of the market flows. While a certified psychologist earns NIS 1,800 per month in the public sector, the same may currently make USD 1,500 per month if enrolled by an NGO or PVO. Such attitudes pose a major threat to the future of clinical psychiatry in public settings. High costs and an aversion to the business aspects of service delivery have left the public sector at a disadvantage in the marketplace.

There are two psychiatric hospitals in Palestine: one in the Gaza Strip and the other in the West Bank. Both have limited staff and together have a capacity of 372 beds. The two hospitals offer bedside care without community mental health services and attempts to introduce a decentralized service on a community-based mental health approach have had limited results. The majority of the working staff has gained knowledge of mental health through work experience and routine practice. The severe restrictions posed repeatedly by the political situation, the Ministry of Health cash flow crisis of 1998-99 and the fact that mental health has become a recent structured development have had a considerable impact on the declining quality of services provided up to the last five years. However, over the last two years, one of the most relevant efforts of the Ministry of Health's Health Management Information System Department was that of rationalizing the whole data collection, analysis and

interpretation process by using the WHO International Classification of Diseases ICD 10 form and tabular list.

The Pharmaceutical Sector

The annual cost of drugs to the individual and the society is high and increasing. The per capita consumption is USD 21 to 29, and in total USD 47 to 67 million. The 1998 budget for drugs and consumables is 26 percent of the total Ministry of Health expenditure -- down from 30 percent in 1997 and 28 percent in 1996. The drug costs are high when compared to countries at the same level of socioeconomic development. About 10 drugs, often very sophisticated ones, consume about 25 percent of the annual drug budget.

The national drug policy has just started by publishing the Essential Drug List, but a very antiquated legislation and complex, too quick or too slow procedures for licensing are major impediments to the rational and cost-effective development of the sector. Psychiatric drugs are available, although their quality, efficacy and cost differ in the public-private mix.

There are maybe as many as 4,000 different drugs on the market in the WBGS. This is very high compared to countries with a rational drug policy. There is a trend towards limited drug lists and many NGOs and UNRWA use

such essential drug lists while the Ministry of Health tenders for only 600 different drugs under generic names.

There is a good availability of drugs. However, drug consumption is very much demand and consumption driven, rather than based on medical needs and morbidity statistics. Drug prices are very high in the private sector. The Ministry of Health is reasonably successful in securing prices for most drugs that are not much higher than average international prices. However, UNRWA's prices are consistently lower. The Israeli requirement that drugs must be registered in Israel hinders the import of low-cost generics into WBGS. Households spend about USD 168 per year on drugs and vitamins, which is equivalent to their total health budget. Both the NIS 3 paid per drug item by patients in Ministry of Health facilities and the 17 percent VAT in private pharmacies revert to the Ministry of Finance.

There is a widespread overprescription and polypharmacy, particularly antibiotics, antidepressants, injections and combination products. The absence of, or disrespect to, the standard treatment protocols makes it difficult to monitor and control prescription policies. While psychiatric-specific drug availability increased in the WBGS, the quality assurance mechanisms are still insufficient to ensure efficacy of treatments. There are currently nine pharmaceutical

companies in the WBGS that produce about 50 percent of total consumption. Although none of the factories are producing according to good manufacturing standards, they are quite successful in winning Ministry of Health tenders. Existing drug formulations are copied locally and marketed as branded generics.

In the Palestinian specialists' assessment, efficacy of specific drugs is part of the case management problem when, for example, they are decisive for the management of epilepsy. While Tegretol produced in Israel (@ Teryl) is judged reliable and effective, the Palestinian brand (@ Tegrebyl) is highly questioned. Efloxotine has been shown to counter depressive disorders. While the U.S. brand Prozac shows good results, the Israeli brands (@Flotine, @Affectine) show less reliability and therapeutic effects and the efficacy of Palestinian products (@Floxocare) comparatively is very low.

West Bank

Government Health Services

Bethlehem Psychiatric Hospital

The yearly publication *Status of Health in Palestine Report* (1996, 1997, 1998) gives the reader a detailed account of population, health services, vital statistics and morbidity and mortality information (Tables 3.1 and 3.2).

Table 3.1: Mental Hospitals' Staffing patterns, 1997

	No. Beds	Physicians	Nurses	Technicians	Admin.	Other	Total
Bethlehem	320	7	77	3	45	11	143
Gaza Nasr	52	8	23	3	9	29	72
Total	372	15	100	6	54	40	215

Source: *The Status of Health in Palestine, PMOH 1998*

Table 3.2: Mental Hospital General Statistics, 1996 and 1997

	No.	Discharge		Deaths		Days of care		BOR		ALS		OPD	
		1996	1997	1996	1997	1996	1997	1996	1997	1996	1997	1996	1997
Bethlehem	320	571	525	4	3	127823	131464	109.1	112.6	223.9	250.4	3336	2526
Gaza	34	602	605	0	0	10140	11423	81.7	92.05	16.8	18.8	24922	26255

BOR = Bed Occupancy Rate; ALS = Average Length of Stay; OPD = Outpatients Department visits
 Source: *The Status of Health in Palestine, PMOH 1996, 1997*

Since 1967, only one Jordanian physician worked at Bethlehem psychiatric hospital *mustashfa el mazanyin* with Dr. Mohammad Said Khamal, the leading personality in the Palestinian psychiatric movement. Historically, Dr. Anton Dabdouf and Dr. Ahmed Khalaf are also among the founders of mental health and psychiatry in Palestine. The Bethlehem psychiatric hospital hosts 320 residential patients, 30 percent of those suffer from chronic epilepsy. In WBGs, in 1997 the hospital average length of stay was 260 days for a total number of 525 patients. Total outpatient department consultations performed in the mental health hospitals were 2,526. Currently, hospital staff include two senior psychiatrists and four medical doctors undergoing specialist training, all of them working part-time; four psychologists; and nine social workers. The hospital's recurrent costs in 1998 were 3.5 millions NIS per year (equivalent to USD 885,000 approxi-

mately), showing an annual increase of 7 percent.

In 1984-85, the first reconsideration of infrastructure rehabilitation and change in approach was made for the mental hospital because of a progressive decreasing quality of services reported over the previous 10 years. Problems of career development and upgrading, seniority and a conflicting vision of the future of mental health have deeply marked further intra-sectoral fragmentation among specialists, mental health and social workers that continue today.

Community Mental Health Services

In the West Bank, the peripheral mental health facilities include one governmental clinic for each of the nine districts and four small residential facilities in Tulkarem and Betlehem (three to four beds). Specialists are available at Nablus and Tulkarem public hospitals where eight specialist beds are available for

inpatient care and management of crisis. The northern West Bank area is certainly under-served (two psychiatrists and four social workers).

The mental health work in the West Bank public sector revolves around nine Community Health Centers totally integrated with the primary health care network. In total, four teams of eight professionals offer service and care that are made of a physician, a psychologist, a nurse and a social worker.

In 1999, 44,000 visits took place at government clinics for around 8,000 registered patients (5.5 visits per person per year). Acceptable quality of care is offered and a one in eight users is a refugee entitled to free care. It should be noticed that 30 patients per day are examined at each Community Health Center, at a 5 to 6 percent increase yearly. Referral is internal and/or spontaneous. At the government services' level,

outreach activities are not implemented yet.

In Tables 3.4 and 3.5 prevalence and incidence of mental disorders and their classification breakdown are depicted, excluding the PTSD cases which are overwhelming services and activities since October 2000.

Epilepsy ranks first in the West Bank problems, as relevant as it was in its forms of chronic, long-term patients of the Bethlehem psychiatric hospital, thus indicating the need of a clear distinction and eventual technical complementation between neurological disorders and pure psychological-psychiatric conditions. Schizophrenia and affective disorders represent conditions that require also most of the attention.

Table 3.3: Prevalence and incidence of mental disorders by West Bank Provinces, 1999.

Provinces	Total Population	Cases up to 31/12/98	New cases 1999	Total cases up to 31/12/99	Prevalence /1000 pop.
Jenin	243,278	2,839	85	2,924	12.02
Tulkarem	137,381	1,758	76	1,834	13.05
Qalqilya	74,605	765	49	814	10.91
Salfit	49,993	350	36	386	7.72
Nablus	267,650	3,768	85	3,853	14.4
Ramallah	221,436	2,356	97	2,453	11.08
Bethlehem	141,187	369		369	2.61
Jericho	36,058	76	27	103	2.86
Hebron	418,293	2,789	74	2,863	6.84
Total	1,589,881	15,070	529	15,599	9.81

Source: HMIS/PMOH, Nablus 1999

Table 3.4: Prevalence of mental disorders by clinical diagnostic category, West Bank Provinces, 1999.

Provinces	Cases up to 31/12/98	New cases 1999	Total cases up to 31/12/99	Total Population	Prevalence /1,000 pop.
Organic	168	37	205		0.219
Addiction	66	3	69		0.043
Schizophrenia	3,347	104	3451		2.171
Affective	1,976	68	2044		1.286
Neurosis	1,476	78	1554		0.977
Personality	12	9	21		0.013
Mental Retard.	831	74	905		0.569
Epilepsy	5,104	136	5240		3.296
Other	2,090	20	2110		1.327
Total	15,070	529	15,599	1,589,881	9.81

Source: HMIS/PMOH, Nablus 1999

Table 3.5: Prevalence distribution of mental disorders cases by West Bank Provinces, 1999.

Provinces	Total pop.	Organic	Addict	Schiz	Affective	Neurosis	Personal	M.R.	Epilepsy	Other	Total cases	Prevalence /1000 pop.
Jenin	243,278	75	5	605	427	79	6	59	985	683	2,924	12.02
Nablus	267,650	36	16	948	434	549	0	130	1274	466	3,853	14.4
Tulkarem	137,381	8	12	430	342	31	0	180	552	279	1,834	13.05
Qalqilya	74,605	6	5	153	177	19	2	82	263	107	814	10.91
Ramallah	221,436	8	27	528	272	295	8	71	880	364	2,453	11.08
Bethlehem	141,187	n.a.	2	71	64	15	2	51	123	41	369	2.61
Salfit	49,993	48	0	98	36	3	0	50	139	12	386	7.72
Jericho	36,058	2	0	21	22	12	0	13	24	9	103	2.86
Hebron	418,293	22	2	597	270	551	3	269	1000	149	2,863	6.84
Total	1,589,881	205	69	3,451	2,044	1,554	21	905	5,240	2,110	15,599	9.81

Source: HMIS/PMOH, Nablus 1999

The Non-Governmental Sector and Community Mental Health Services

A number of NGOs have pioneered in introducing the concept of mental health, and in providing nonmedical preventive and interventive mental health services in the West Bank and East Jerusalem: (1) The Union of Medical Relief Committees, (2) the Palestinian Counseling Center (which introduced two models that are now duplicated by the Ministry of Education and the

Palestinian Red Crescent Societies: School Counseling and Integrating Mental Health in Primary Health Services), (3) the Palestinian Happy Child Center, and (4) the Guidance and Training Center for the Child and the Family in Bethlehem. Other NGOs provide primary care services, namely a Center run by *Medicines Sans Frontieres* in Hebron; a Center run by *Terre des Hommes* in cooperation with the Ministry of Social Affairs, and a programme to rehabilitate the Al Esham Center for mental disables in Hebron.

Their contribution to the Palestinian national health plan, both in terms of ideas and also work on the ground has been remarkable. Even though problems of coordination occur, their cooperation with the Ministries of Education, Health, Youth and Sport, and Social Welfare, are good examples of how NGOs and government can complement each other in servicing wider geographical areas more efficiently.

The main components of their projects/programmes can be summarized as follows:

(1) *Therapeutic support* to all age groups, with particular attention to children and adolescents. Some NGOs teams are clinically-oriented and available to treat patients for individual, family and group therapy. Referrals are made from various institutions such as schools and universities and through a network of contacts with the WBGH hospitals, refugee camps, local households and some community organizations;

(2) *Psychosocial Counseling* to children and adolescents;

(3) *Training* is being provided by staff and supplemented on occasions by lectures from selected local and foreign professionals. It includes team taught courses in counseling and psychotherapeutic skills, as well as the monitoring of actual counseling sessions. Special short-term

training or onetime lectures are being given in the community to promote learning about mental health issues and to respond to specific continuing education needs;

(4) *Special education*. Children seen at the centres who present special education needs such as learning disabilities are provided with the services of the mental health team and a special education therapist.

A long-term plan of action for the latest political developments was also drawn. Requests for crisis intervention at school level - including the East Jerusalem area - led the Palestinian Counseling Center, in coordination with the Secretariat of the National Plan of Action for Palestinian Children to produce information literature for teachers and households. An easy-to-read manual was produced by the Palestinian Counseling Center in 1989 during the first *Intifadah* in coordination with the Early Childhood Resource Center (*The Simple Guide*). It offers easy communication messages and illustrations targeting parent that explain how relatives can, and when they should resort to professional help when working with children to overcome their fears. Both organizations are now working together on an updated version.

Finally, measures to ensure government-NGO, and inter-NGO coordination were recently taken in order to

delegate responsibility and maximise the use of emergency funding. A network of Jerusalem NGO and other institutions (“The PNGO”) is currently chaired by the Palestinian Counseling Center and includes as members: Spafford Children’s Center; Nidol Community Center; UPMRC; Al-Saraya Community Center; Women’s Center for Legal Aid and Counseling; Palestinian Agricultural Relief Committees; Old City Youth Organization; Jerusalem Youth Union; Old City Counseling Center-Caritas Jerusalem; and AlQuds University-Jerusalem Branch.

Gaza

Government Mental Health Services

El Naser Psychiatric Hospital

In Gaza, the Palestinian Health Authority runs a psychiatric hospital in Gaza City that was rehabilitated in 1994. It has a capacity of 52 inpatient beds and its main function is the treatment and admission of acute/emergency psychiatric cases. However, part of these beds are not used since El Naser hospital underwent an infrastructure and managerial transformation towards a more open model of assistance and care. This hospital had a staff of five trained physicians, four psychologists, three social workers, 17 nurses, pharmacist, and other administrative staff. In 1997,

the average bed occupancy was 92 percent and the average length of stay in the hospital was of four to five weeks. The current occupancy rate of the psychiatric hospital is 60 to 70 percent. The majority of patients suffer from psychotic disorders and the majority of the discharged mental health patients faces a sense of stigmatization with no integration into their community.

Admissions for mental disorders in Gaza Strip general hospitals broken down by the ICD-10 WHO classification are depicted later.

Community Mental Health Services

Deep poverty and lack of social networks characterize the setup in the Gaza Strip as in the 1980s. The influence of oppression, violence and poverty on people’s mental health has been taken high in the priorities of both the government and the NGOs active in community health and social sectors in the Gaza Strip.

The Ministry of Health runs three community mental health centers in the Gaza strip that have been established in recent years with no availability of psychologists; one rehabilitation center is run by the Ministry of Social Affairs.

(1) Sabba Community Mental Health Centre: This center has been established in May 1995 in Gaza City. This center is staffed with a psychiatrist, two trained physi-

cians, a psychologist, two social workers, three nurses, two rehabilitation specialists, a secretary, and an administrative officer. Up to date, this center treated 600 cases (Annual Report of Mental Health Department 1996).

(2) *Khan Younis Community Mental Health Centre:* This center was opened in Khan Younis in January 1996. The center covers the mental health services in South of the Gaza Strip. It is staffed by a trained psychiatrist, one psychologist, two social workers, two nurses, a pharmacist, a clerk, and other administrative staff. The total number of visits in the last five months ranges from 1600 to 2000 cases.

(3) *El Remal Child Psychiatry Clinic:* This clinic opened in December 1994 on two hours per week basis. This clinic receives cases from schools, general practitioners and other organizations for initial assessment and then cases are followed up at one of the community-based mental health centers.

The Non-Governmental Sector and Community Mental Health Services

In the Gaza Strip, there are no community mental health services offered by the nongovernmental sector but from Gaza Community Mental Health Programme (GCMHP), which was provided legitimacy of service provision by the Minis-

try of Health upon its creation. The Gaza Community Programme was established in 1990 to address the mental health needs of a devastated community in the midst of massive social upheaval. The Mentally Retarded Society, Shamas Center, and the Union of International Churches offer a variety of minor services. Clinical work remains the core of the Gaza Community Programme sustained efforts to meet the continued and changed needs of the Palestinian community in Gaza.

In the last six years, the clinical staff has become increasingly specialized through advanced training and experience. Its staff consists of 4 psychiatrists, 6 trained physicians, 6 psychologists, 5 social workers, 3 nurses, 3 EEG technicians, one assistant pharmacist, 2 psychotherapists, 1 occupational therapist and other helping administration staff. The program runs 4 outpatients clinics in the GS and is served by multi-disciplinary teams (one psychiatrist, psychologist, nurse, social worker and physio-psychotherapist – for torture survivors and trauma patients).

The GCMHP has adopted a specialized case management process that allows for differential handling of cases for women, children and victims of human rights violations. The clinics are located in Gaza City, Khan Younis, Jabalia refugee camp and in 1999. A new clinic in Deir El Balah was established in 1999. The clinic

serves the middle area of the Strip, which previously lacked a specialized mental health facility. In the last three months of 1999, it treated 104 new cases and conducted 300 home visits in conjunction with 514 follow-up sessions. The benefits of this process are clear from the tremendous increase in the success of the community-based work over the last two years. While the number of new cases remains constant at nearly 1,200 per year under ordinary circumstances, the number of follow-up visits has doubled to over 10,000 per year.

The GCMHP adopts a community-based approach in its work with a combination of psychological, family, and community interventions to meet the mental health needs of the society. Families are involved in the treatment/rehabilitation plan and patients are often visited in their homes, to ensure a supportive environment and to emphasize the communal aspect of mental health treatment. In addition, the clinics provide different forms of psychotherapy, occupational therapy, family therapy and physiotherapy. Auxiliary services include a pharmacy and an electroencephalography (EEG) unit.

The total cases enrolled in 1998 was 2,337, while in 1999 was 2,386, consolidating a previous trend. Up to the end of 1999, GCMHP clinics have treated 11,742 patients from all parts of the Gaza Strip. Seventy-five percent of the total are refugees who have come from camps that are poorer and pose

more social and economic hardships than towns and villages. Of this total, 40 percent were youngsters under 18 years of age. The male/female ratio of new cases (1.8:1 in 1988 and 1.4:1 in 1999) is very close to the gender ratio of the Palestinian society.

When taking an accurate account of the female exposure to mental health services it is possible to see a steadily increasing number of contacts: Thirty-three percent of total adult contacts in 1991, 45 percent of the total adult contacts in 1994, up to the 48 percent of 1999. This directly implies an increased access, a lowered gender-based stigmatization even though many women suffering from acute or chronic mental health problems still do not reach the clinics and are not detected as case-persons. This basically applies for schizophrenic women who still remain secluded at home without treatment and are discovered by chance during community rallies and home visits. More than 60 percent of cases over the last two years were treated free of charge.

The vast majority of cases are self and family referrals, which comprise 82 percent of the user's intake over the past two years. This proportion is slightly higher than the 1996/97 figure, which stood at 80 percent. Furthermore, the increased referral from general practitioners and community health workers shows an encouraging trend in identifica-

tion and effective decision-making on mental-health problems. Finally, it is a strong indication of the increasing awareness of the importance of therapy as a result of the extensive public awareness and community outreach activities conducted by Gaza Community Mental Health Programme, the Ministry of Health and other professionals.

In the Gaza Strip, the field uptake of cases shows an increase in mood disorder cases over the past two years (from 17 to 20 percent of the total) stemming from a rising depression associated with the deteriorating social and economic situation. Meanwhile, as depicted in Table 3.6, there is a decrease in the presentation of organic disorders (from 20 to 14 percent of the total) given their referral to other specialized service providers.

Multi-disciplinary teams use numerous forms of therapy. Counseling remains the most common form. Supportive therapy comes second and is provided mainly for cases with chronic

disorders. Cognitive therapy is also used for individuals with depressive conditions and cognitive-behavioural therapy for those suffering from PTSD.

Behavioural therapy is used mainly for patients with obsessive-compulsive disorders and phobic problems. Children receive different forms of therapy, mainly behavioural, drawing and play therapy, a strategy that also UNRWA adopts in the WBGs. Occupational therapy is also provided to patients with chronic conditions in order to enable them to function as independently as possible in their daily activities and work environment. During therapy sessions, patients develop their skills in recreational and vocational activities. Over the last two years, 1162 sessions were undertaken. In a self-assessment exercise, Gaza Community Mental Health Programme states that the drop out rate improves but remains high (18 percent) and 25 percent of patients show no significant change in their complaints.

Table 3.6: Percent of mental disorders by clinical diagnostic category, Gaza Provinces, 1996-99.

Diagnosis	1996	1997	1998	1999
Organic	22	18	15	13
Somatoform dis.	7	4	n.a.	n.a.
Anxiety disorders	19	16	14	14
Mood disorders	13	17	17	20
Psychosis	5	4	6	6
Drug dependence	1	1	2	2
PTSD	n.a.	n.a.	5	4
Childhood	18	19	20	18
Other	4	4	12	11

Source: GCMHP Reports

Table 3.7: Proportion (%) of treatment methods applied to mental patients in Gaza, 1996-99.

Treatment	1996	1997	1998	1999
Counseling	47	44	37	35
Supportive	26	29	25	25
Cognitive	10	11	10	13
Behavioural	5	5	5	5
Play	4	6	6	6
Other	8	5	17	16

Source: GCMHP Reports

The Academic Involvement in Mental Health at Bir Zeit and Al-Quds University

A strong academic involvement on mental health policy analysis, formulation and services delivery has always characterized the Palestinian setting.

At Bir Zeit University, the Community and Public Health Institute offers mental health modules at postgraduate level within the framework of the Master in Public Health and the Primary Health Care Diploma. Such courses enroll professionals from UNRWA, government, NGO and private sector and aim at standardizing knowledge and practices.

A cross-sectional study on the “Impact on mental health status undergraduate student during the *Al Aqsa Intifadab*” was recently finalized at the Community and Public health Institute, and a preliminary report handed in to the University Board (Community and Public Health Institute 2000). Out of a sample of 1,566 undergraduate students, 49 percent complained of not being helped psychologically by anyone during the current events; 11 percent referred that their families had severe economic

hardship and, finally, 8 percent were physically injured in the clashes. Out of the total injured, 57 percent were exposed to gas and 26 percent to rubber bullets.

Fifty-seven percent of the interviewed reported one or more injured people in their living environment. Inability to concentrate on anything (73 percent), inability to perform usual daily tasks – incapacitation (73 percent), sleep disturbances (67 percent), feeling unusually tired and drained of energy (52 percent) were the most common symptoms referred thus depicting the somatization of stress. Behavioural problems such as beating and screaming were reported and increased cursing and use of bad language (58 percent).

As far as training and research are concerned, the Al Quds University framed a Master Course in community-based mental health care at the School of Public Health in Gaza. Training is focused on PTDS, child abuse and coping strategies, and learning disability. Analytical tools are standardized for health professional and social workers that

participate. Recent research focuses on “normalization” concepts for children, which is considered extremely relevant given the socioeconomic context of Gaza. Parenting is also studied through a cross-sectional survey of 220 households in which parental attitudes towards children’s mental health are studied.

The effects of the *Al Aqsa Intifadah* (PTDS reactions, phobias, anxiety level) are studied by random-sampling four refugee camps in Gaza Middle Area and addressing questionnaires to nine through 18 year old youngsters and their mothers. The Gaza Trauma Scale is used (an adapted and revised trauma scale measurement tool developed in Gaza), as well as the ICTD 10 Classification and, finally, the GHEQ is applied to mothers for better consistency. A recent, unpublished study conducted in Al Magazy and Nuseyrat refugee camps assessed 109 children for PTDS signs and symptoms. The prevalence of moderate to severe PTDS exhibiting depression and fear was 49 percent. Fifty percent reported that life is “worthless”, while 60 percent of the total did not lose trust. A high proportion of respondents reported that negative feelings were elicited by watching the TV coverage of the ongoing conflict. Finally, a case-control study is underway that explores the effects of house demolition on child mental health in Rafah in the southern part of Gaza Strip and the relation with the internal

closures enforced by Israeli for the first time within the Strip.

The School of Public Health faculty is also assisting the Near East Churches newly established Trauma Center located in Sajayeh, near Sabha quarter in Gaza City that aims at providing assessment, parental counseling and play therapy for acute stress reactions in children.

Children’s Mental Health and Cognitive Development

The mental health and well being of refugee and resident Palestinian children requires, therefore, attention. Today, it is possible to help young people live more productive and fulfilling lives through programmes that include life skills education, mental health education, school-based health intervention, and when indicated, professional treatment.

Nearly one in five children and adolescents will have an emotional or behavioural disorder at some time during their youth, regardless of where they live and how well to do they are. Children with emotional disturbances exhibit their impairments in a variety of ways. They may fail academically, be socially rejected and have a poor self-image. They may also have difficulties in relating to peers or adults, and may have little respect for the laws or rules of their society. In

addition, they may live within financially and emotionally impoverished environments. Academic failure and social rejection often have lasting consequences, because failure to learn in school limits a person's chances to succeed in the future -- and the WBGS is no exception to such a rule. As a consequence, such children are more likely to drift from main stream society and become targets for unemployment, homelessness or other symptoms of social dysfunction.

Therefore, consistent with the mental health objectives outlined in the National Health Plan, it is relevant to relate socialization values and practices, such as the parental informal pedagogical theory, and ways of transmitting culture to mothers' education and the formal education system in a setting which seems to be in a cultural transition from a traditional to a modern society influenced by conflict.

Observations from the school health program run by the Ministry of Health and UNICEF, and data from the PCBS, indicate that Palestinian mothers emphasize compliance, passivity, morality and respectful manners in their child-rearing practices, even toward boys in whom they usually prefer some authority and daring. Cognitive stimulation is important, even though it seems considered rather theoretic. This teaching pattern makes for considerate and pleas-

ant children, but it does not prepare them for a complex verbal world: It rather prepares them for a passive, dependent role in school. At the same time, the mothers put an unrealistic demand on their children's academic achievements, with endless time and effort expanding toward this often disappointing end. The burden on the children is extraordinary and can easily drain them of self-assurance and vitality. Such patterns do not differ from other works in the Middle East context (Dawoud 1998, Kodaih 1995, Dawoud-Nursi 1995)

During the recent *Al Aqsa Intifadah* events, public mental health services organized workshops for social workers working with children at risk. In collaboration with the Union of Psychologists and Social Workers, they focused on (1) awareness of trauma and conflict resolution, (2) minimum support to cases, (3) process of case identification and referral, (4) shielding hospital emergency rooms from inappropriate case load, and (5) use of 24-hour, open phone lines.

All psychiatrists have repeatedly tried to influence the media conduct with respect to the conflict and its psychological consequence on the public. They were repeatedly interviewed about trauma and coping strategies. Scientific knowledge, facilitation and problem solving skills, and affirmation strategies were addressed by expert communication. A special target was the population

segment of 20 to 30 years of age that is the most mentally affected because of anger and hatred.

The Current Work of the UNRWA and UNICEF in Mental Health

UNRWA

Under the current crisis, donors' attention was put on psychosocial initiatives of two to three years' duration targeting the refugee population by good funding. UNRWA leads the national programme with a Multi-disciplinary approach substantiated by networking broad participation of local civil society organizations. Consequently, "emergency" activities directly interact and influence the "ordinary" mental health service provision and counseling.

Under the banner "Healing the Wounds: UNRWA Responding to the Crisis" initiative (UNRWA 2000), the Agency received USD 5 million to be used in addition to the USD 7.5 million allotted earlier to implement humanitarian assistance to the Palestinian refugees burdened by the conflict started on October 2000. UNRWA had all its Divisions mobilised by the following components: (1) Emergency relief operations, (2) emergency medical supply first aid material, supply and drugs distribute to 100 localities, and (3)

emergency educational requirements (protecting human rights of refugee children, psychological counseling for pupils, out-of-class peace initiatives). The latter initiative deserves attention, since UNRWA became the coordinating body streamlining the aid influx earmarked for conflict resolution and psychosocial support. Out of the 19 refugee camps in the West Bank, eight referral centres for mental health problems referrals have been activated by UNRWA in coordination with other stakeholders. A mechanism of subcontracting NGOs-managed health centers was chosen by the Agency starting from October 2000 in order to maximize the field response to trauma. Unfortunately, overlap in damage assessment and case finding in refugee camps between UNRWA and NGO teams must be reported that hampers high quality of response.

Focus groups were conducted with UNRWA medical staff teams of the 34 centers and health posts of the West Bank including Qalqilya hospital during the first two weeks of December 2000. Beyond the unprecedented traumatizing situation of patients, (having a "martyr" in the family, being injured and disabled, having the properties hit and damaged), results indicated that staff were overwhelmed by strains they confronted. One of the first needs to meet was, therefore, organizing psychological training and counselling to UNRWA staff.

A Network for Mental Health and Psychosocial Support was established, and UNRWA was able to combine training of trainers, needs assessment, support, assistance, counseling and monitoring of activities by building a network of allied NGOs through a partnership approach. A well-structured framework encompasses the whole WBGS and allows for a coordinated response conducted by 100 UNRWA health staff, 50 counsellors, and 50 community activists. Since October 2000, 22,000 person-contacts took place at UNRWA health clinics, including a high proportion of mental health problems that forced the Agency to activate three mobile clinics together with the UPMRC and UHWC human resources.

UNRWA provides basic education at the primary and preparatory levels to 55,700 refugee schoolchildren in the West Bank, their ages being six through 15 years, in 95 schools. It also provides vocational and teacher training in its three colleges and two Education Science Faculties respectively. At the moment, however, UNRWA has only four counsellors who can only partially meet the needs of the schools. In 1998, therefore, the Agency started training one teacher per school as “teacher/counselor” and the current training programme for guidance and counselling (GCT) is built on the basis of 30 contact hours. The multiplicity of tasks and teaching gave little time left for the teacher/

counsellor to develop his second responsibility. Insufficient follow-up and the fact that the training was designed to meet the needs of children in the routine school life and not in a war and emergency context hampered the process. New skills, plans and structure were required.

Currently, therefore, UNRWA Education Department would hire 50 counselors from other NGOs in order to conduct education and social services project planning in 32 centres. In each camp, one local NGO would implement health promotion and psychosocial activities. All social counselors would undergo results-oriented training and the Foundation for Health and Social Development (a newly established Palestinian NGO) would offer monitoring and supervision on local NGOs fieldwork.

The school psychological counseling training of teachers (190), and the training of counselors (20) would be implemented by: (1) PCC for the long-standing expertise in training and referral of children with emotional/behavioural problem, (2) YMCA, (3) Women Center for Legal and Psychological Counselling, (4) Happy Child, (5) Early Childhood Resource Center, and (6) the Guidance and Training Center for the Child and the Family. Furthermore, UNRWA will (1) participate in compiling an inventory of resources available at community level, (2) design a more structured training

programme to strengthen the skills of doctors and nurses towards mental health and primary health care in collaboration with Palestinian Universities, (3) conduct health promotion activities in refugee camps (lectures, health fairs and festivals, TV spots and ICE material), and (4) implement a mental health surveillance system.

UNRWA provides social and relief services that function as a corollary to specific psychosocial counseling provision for refugees. Forty-two social workers are involved in the activities of UNRWA Relief Services Department in its two branches. The division focuses on helping families confronted by special hardship and provides assistance in kinds and counselling. The Social Services' Division is in charge of specific programmes addressing the needs of women, disabled and youth, mainly through acting as facilitators in a network of community centers established in the WBGs camps (including 15 Women's Programme Centers, 13 Community rehabilitation Centers for the Disabled and 19 Youth Activity Centers assisting young males of 12 to 40 years of age). The Social Services are also in charge of a programme of poverty alleviation. However, the community centers experience difficulties in maintaining a continuous and coherent level of functioning because of restriction in human resources allocation and funding.

UNICEF

The UNICEF response to the needs of Palestinian children builds upon its core corporate commitment as well as the 1998-2000 programme of cooperation. UNICEF relies on strategic partnerships with Palestinian Authority ministries and NGOs it has forged over the recent years in areas such as information and communication, health, education, psychosocial, and youth participation (UNICEF 1998). One of the most successful projects is the work developed jointly with both the Ministries of Education and Health in the health promoting schools initiative.

In general, in order to protect the rights of Palestinian children under difficult circumstances and provide them with psychosocial support and learning opportunities, some areas have been developed that encompass the development of psychosocial programmes through the health and educational systems, as well as community services and the media. The advocacy for the rights of Palestinian children is implemented by assessing flagrant violations of children's rights and promoting the right of protection from exposure to violence and promotion of rights to access education and psychological support. Partnership with local media, global press statements and messages to communities, families, children and youth.

Under the current contingency, and beyond the emergency health support mainly borne by bilateral donors, UNICEF provided (1) 1,900 schools with first aid kits and training in their utilization, (2) basic health supplies to the Palestinian red Crescent Society running seven mobile clinics close to the site of clashes, and (3) equipment (bulletproof jackets) for emergency health workers. This support complements the UNICEF support to the blood banking system in the West Bank and Gaza, as per its 2000 *Plan of Action*.

New initiatives for the psychosocial support during the current crisis (USD 350,000) foresee the following: (1) Development, printing and distribution of brochures for 25,000 parents, 6,000 teachers and 1,000 social workers on first aid psychological support for children, (2) training of 500 school counselors of the Palestinian Ministry of Education and follow up supervision, (3) training of 35 social workers of the Palestinian Ministry of Social Affairs, (4) training of 175 volunteers affiliated to Defence of Children International/Palestinian section, (5) set up of psychosocial support services for the wounded, in cooperation with the Ministry of Health and the Palestinian Authority Secretariat, as well as other key mental health institutions, (6) set up of hot lines with psychological assistance by, and for young people, in cooperation with NGOs, (7) production of 12 TV spots for parents

and children on psychological support, and (8) provision of playing, learning, reading and self-expression material for children.

In partnership with local NGOs, UNICEF provides peaceful opportunities for the participation of young people in solving the crisis. These include publishing stories by young people about the crisis as it is lived and seen by themselves, peers and communities under the leadership of a group of 14 young people trained by UNICEF in 2000 on leadership, journalism and the Convention of the Rights of the Child. Other activities include supporting the organization of youth-led press conferences and small-scale youth-led community initiatives aiming at alleviating the suffering of communities.

In the light of the growing burden of mental and brain disorders, the World Health Organisation has made mental health one of the priorities for its work aiming at dismantling common myths about mental/brain disorders and addressing the problem of stigma and discrimination. A number of high-profile advocacy and awareness-raising activities are being planned for 2001 that focus on mental health problems and related disorders.

Problems to be Addressed

Policy Fora and Policy Content

The mental health services have suffered from low priority, low advocacy from top policy makers and insufficient allocation of resources to the public sector. The integration and harmonization between government and other ongoing NGOs-led projects should be pursued by a mental health redefinition and the agreed adoption of the “open door” policy. Finally, there is no doubt that the public sector needs more services infrastructure upgrading, increased sub-sector resources, and evaluation and research.

Another issue regards the policy content with respect to chronic problems, stigma, elderly and youth. Combined together, epilepsy and mental retardation represent 40 percent of conditions followed up by community mental health services in the WBGS in 1999. Modern approaches and field evidence indicate that epilepsy emerges as a childhood priority and a factor of exclusion/seclusion in the elderly affected. Citizens suffering from epilepsy alone are 36 percent of the total case load at the primary level. Causal investigation, diagnosis, case management at both primary and secondary level is still insufficient.

Mental retardation is shown as one of the main congenital anomalies in the

WBGS, amounting to 25 percent of infant morbidity and more than 36 percent of mortality when prematurity is added. It represents more than 6 percent of primary service users. Neurology and Psychiatry are still incorporated in the same service package, thus affecting both the quality of service delivery and continuing education needs inappropriately.

The exclusion of older people from the mental health service framework and the delays in publication of the National Health Plan have caused many managers to be concerned that, as in many other areas of health service planning and provision, the needs of older people are not being adequately addressed by government and health service planners. Encouragement that the needs of older adults have not been forgotten should provide an authoritative focus, which will help general practitioners and psychiatrists, their multi-disciplinary and management colleagues and commissioners of services to push forward improvements in services for older people with mental illnesses. As far as youth is concerned, considering the socio-demographic factors and specific indicators outlined, adolescent counseling and/or genetic counseling and activities aiming at decreasing the intra-family marriage rate should be pursued when feasible. The classroom must be a major target in creating a backup of the “open door policy” in mental health in the WBGS

(Olweus 1992, WHO 1993, Dawoud 1998). The almost complete governmental control of school policy and the primacy it holds in the Palestinian Authority development agenda makes the school the most potent instrument in existence for creating primary and secondary preventive activities and mental health promotion (Ziara 1998).

A Training Plan and a Drug Policy

Since the Palestinian Authority is fundamentally constrained by lack of resources, constructive ways of harnessing existing local resources must be given consideration, not only in terms of integrating mental health care into the primary care system but also in terms of engaging other professionals and leaders in a continuing education process.

Planning a training plan for mental health in collaboration with the academic institutions and active NGOs is felt mandatory to offset the current fragmentation. Training of trainers aimed at specialists (psychiatrists) and primary health care doctors in order to involve and engage family doctors in the prevention and treatment of mental health and promotion of mental health needs urgent attention. Postgraduate specialization in neurology and psychiatry abroad could also be effectively offered through bilateral and multilateral funding and partnership.

Of the psychological problems present in patients who attend primary health care doctors, diagnosable mental illness is only an important subset. Local general practitioners do not use conceptual models other than classification system such as (at best) the International Classification of Diseases. Palestinian general practitioners may recognise and respond to psychological distress in ways other than “standard” psychiatric treatment, but in ways that are therapeutic nonetheless. A need emerges in the Palestinian context that it revolves around how the general practitioners detection of psychiatric illness can improve, but also what organising principles they use to classify possible psychological problems, and how these influence their clinical practice.

In many cases, in fact, the first “port of call” for an individual with mental disorder or distress (or a member of their household) is the traditional of general practitioner. Mental health training for these local public and private providers might represent an effective means of improving the detection, referral and management of common mental health problems. Of particular relevance in this respect is the currently widespread prescription by local private practitioners of medications for these disorders, the cost of which is invariably met by the patient or family. Training in the detection and treatability of common mental disorders needs to be accompanied by

the availability of suitable drugs if not subsidized, at reasonable cost, and simple psychosocial interventions. Although the high acquisition cost of the newer antidepressants is an obvious constraint, conventional tricyclics are very cheap and equally effective (if not quite as well tolerated). And yet many of the pharmacies visited in the present study do not stock or cannot get such medication in a highly deregulated environment. The establishment, implementation and enforcement of a revision of the essential drug list for mental disorders is likely to represent a further policy consideration in the WBGS.

Finally, cross-sectional training and continuing education of specialists could as well be supported for non-medical and social workers on the community-based mental health model, thus multiplying positive effects of assertive outreach and case-holding.

Trauma Work or Community Development?

Violence, and the fear of violence is the most debilitating, corrosive force in the lives of Palestinian children. Kids who are scared cannot learn or develop properly. Such concepts are at the base of the main public health concerns related to the recurrent waves of violence and conflict that sweep the WBGS and constitute a relevant proportion of mental health activities.

For most children, healing psychological trauma depends on the strength of adult-child relationships. The adult's strength develops through knowledge of how to help children cope with the stress of traumatic events and from learning personal coping skills. The literature on resiliency and coping confirms that children are more able to deal with trauma when adults are not pushed beyond their capacity to cope with a stressful situation. When the latter occurs, buffering children's stress becomes difficult and the risk of harm to children increases. Therefore, providing support to parents, educators, relief workers, and other adults working in situations of conflict must be an integral part of mental health capacity building and services support.

Many years of subjugation and conflict have left the Palestinians deeply traumatized; thus, the process of transcending the ashes must be accomplished under a burdensome handicap. It is no surprise, then, that the mental health professionals in the WBGS have utilized most of their resources for rehabilitation of traumatized populations. However, for a closer assessment of evidence, if supreme consideration is given to rehabilitation, there is the risk of neglecting to allot resources to primary prevention, to full integration with the primary health care service network, to building a society that will minimize future trauma and exclusion and maximise health and

rights of citizenship. In addition to the de-traumatization of its youth, community health professionals have the obligation to address the primary and secondary prevention aspects of traumatisation – the traumatic experience must be given a new meaning and incorporated into a narrative of freedom.

Households and Services' Costs

There remains a chronic shortage of economic data to support discussions on mental health policy or resource allocation at a national or regional level. There is, consequently, a need to undertake studies that address the relative cost-effectiveness of alternative intervention strategies (using not only a prospective, experimental study design but also qualitative techniques where possible). Other issues must be addressed such as broadening the understanding of the interrelationship between psychiatric morbidity and disability on one hand, and access to, and uptake of, services on the other. Indeed, interventions for common mental disorders need to be carefully planned in accordance with the prevailing types of health-seeking behaviour of the local population, as well as other socioeconomic, cultural and demographic factors. These factors are likely to contribute significantly to their overall cost-effectiveness and the extent of inclusion sought.

Remainder of Key Priorities

The pace at which health planning takes place is crucial to appropriate health policy development. Now that the need to rapidly strengthen political legitimacy has been fulfilled by the Ministry of Health, the choice of focus, capacity and motivation of Palestinian decision-makers remains the core of action. Since it is no longer credible to discuss health care only in terms of inputs, the strategic issues and implications from the demand and supply cycle need to be addressed where the formulation of policies of balance, regulation and accreditation of different types of health care providers are at stake. The sub-sector of mental health is not exempt from this rule:

(1) Mental Health System Development:

Concerns the institutional setup of the mental health policy analysis and formulation in the WBGs and the way in which the functions of the system (steering role of the health authority, financing, insuring, and provision of services) are organized and are being performed;

(2) Provision of Mental Health Services:

The design and implementation of mental health care delivery models and specific ways in which community-based and personal care services are organized and managed in order to provide the community and clinical interventions. While the latter includes the organisation of emergency services for acute cases to provide

intensive short focused intervention for a limited time during crisis, the former relates to the establishment of the cycle of rehabilitative-therapeutic work in mental health care.

(3) Development of a legislative, awareness and capacity building process: The establishment of a multi-disciplinary working group on legislation for mental health rights aimed at developing the Palestinian Mental Health Act is of primary importance given that the Mental Health Act is effective in Israel since 1994.

(4) Expansion of advocacy, information and communication: Outreach and care management for the client and the family and attending public meetings to raise public awareness about mental health as primary prevention and educational programmes should be standardized and generously funded.

Among the better-known paths tread by community mental health professionals in the WBGS are the following: (1) creating and strengthening counselling advocacy groups, (2) establishing, training and advising self-help and mutual aid groups, (3) spearheading reform in the criminal justice system, (4) encouraging volunteer organizations and setting an example for other professionals by doing some (but not all) work in a voluntary capacity, (5) working with religious officials and activists to emphasize the mental health aspects in religion

and undermine religious basis for extremism, (6) use of the media to pass messages for democratic conduct of life to citizens and community leaders, and (7) creation of a “mental health lobby” which will expose elected bodies to issues that influence the mental health of the whole community.

Notwithstanding the current crisis, a results-oriented, equitable and community-based mental health care approach can bring about measurable gains to the Palestinian population. Furthermore, nothing could be more tangible than the health gains from an improved medical care for the Palestinian family (mothers, children and relatives of the extended family) which represents the core of the civil society. Advocacy for and action towards healthier Palestinian families in the broadest and holistic fashion would directly contribute to their healthier lifestyles, the fulfillment of their economic aspirations and role as active members of the Palestinian society.

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Annex 3.1

Mental Health and the 1999-2003 National Health Plan

The 1999-2003 National Strategic Health Plan for Palestine focuses on mental health as follows: (p. 146).

Vision Statement: The Palestinian society accepts and integrates mentally ill patients into productive Palestinian life by removing stigma and fears towards persons with mental disorders and/or any kind of disability.

Mission Statement: To provide community based and caring therapy (psychological and psychiatric) to restore, improve, enhance develop and maintain the abilities of children, adults, the elderly population and their family members who are or who may become developmentally disabled, emotionally disturbed, or mentally ill. Ensure that they have the opportunity for maximum participation in the life and resources of the community with a full range of responsive and accessible mental health services.

National Objectives:

(1) Raise awareness among workers and other professionals, as well as communities, in accepting and treating people

with mental or psychological disorders with respect and dignity.

(2) Establish a National Crisis Intervention Center with 24-hour hot line assistance.

(3) Develop and appropriate Palestinian model for mental health services and therapy.

(4) Use integrated and comprehensive approaches to community mental health, including both psychiatric and psychological care.

(5) Upgrade community mental health centers to become comprehensive providers.

(6) Promote mental health quality care by using explicit guidelines and performance indicators.

(7) Provide adequate training of trainers to mental health personnel, including community mental health workers, and increase sub-specialized mental health practice.

(8) Improve accessibility to an integrated and comprehensive mental health service tailored to individual needs.

(9) Develop an ongoing system for continuity of care.

(10) Maximize the use of the PHC facilities for mental health services, especially levels III and IV.

(11) Develop a national system for cooperation and coordination for mental health services between the public sector, NGOs, UNRWA and private sector.

(12) Develop community support systems for mentally ill patients.

(13) Develop specific legislation and legal framework concerning the rights of mentally ill people, with a certified national code of ethics.

(14) Promote mental health in schools, mental health education and networking.

National Strategies:

(1) Develop a special law under which the PMOH will serve as a supervisory national gate keeper in terms of regulating and enforcing predetermined standards for professional licensure and a code of ethics for mental health.

(2) Ensure an active participation of primary health care providers in early

detection and care for mentally ill persons.

(3) Link persons in need with appropriate services by enabling networking to produce an integrated service, including coordination and referral of patients to PHC or psychiatric facilities, or to social and health services.

(4) Make specialized psychotherapy widely available and accessible.

(5) Improve follow-up and continuity of care in clinics or outreach community-based programs before and after, or as an alternative, to institutional care.

(6) Raise knowledge and interest in mental health among general professionals.

(7) Establish partnership projects between governmental agencies and NGOs who are working in the field of mental health”.

Annex 3.2

Putting Policy into Action

(1) Strategising a rational and sensitive approach to mental health; an increased number of specialised personnel for mental health activities; information, communication and education activities for behaviour change of the concerned Palestinian health medical and nonmedical personnel (nurses, social workers, students, volunteers, specialists and nonspecialist medical doctors) in hospital and PHC settings. General practitioners and primary care teams are seen as crucially important, but often in need of more support and advice from specialist mental health professionals. Low-referring general practitioners should be contacted and offered support and training. General practitioners' views should be sought. Referral protocols should be developed to help them identify memory problems, depression or other signs of mental illness in early, as well as late life.

(2) Strengthening of the Ministry of Health's Department of Mental Health, its integration with other services and institutions (NGOs, Ministry of Youth, PMOE, UNRWA, and UNICEF

programmes), and its operational efficacy through the multilateral collaboration with the Mental Health Division of WHO and Nations for Mental Health;

(3) Decentralization of curative, preventive and promotive mental health activities and establishment of local committees in order to strengthen community participation. Effective communication, shared expertise and the need to exchange information are stressed. This might include joint assessments/reviews, use of a Care Programme Approach, shared management plans and specialist home-care workers. A local comprehensive strategy for these services is needed in both West Bank and Gaza Strip. This should be developed with users, carers, professionals and independent providers, and it should examine process and outcome indicators. Services should be well coordinated and jointly managed services should be considered.

(4) Strengthening of qualified mental health services serving resident and refugee population alike, and further improving services accessibility by

reducing geographical disparities in services location;

(5) Integrating governmental and NGOs mental health services on specific subjects and in specific areas. Research shows that in the armed conflicts children simultaneously exhibit both psychologically health and creative responses and serious disturbances. To be able to help children to recover from their traumatic experiences, one has to be familiar with their resources and salutogenic processes. Furthermore, it is important to understand how exposure to experiences of political violence affects these protective processes. Research on “children at war” should therefore concentrate less on the post-traumatic symptoms and learn more about the psychological processes restoring mental health.

(6) Establishing a synergetic action with screening activities of the national school health promotion programme regarding learning disability and psycho-social counselling, as strongly recommended by WHO.

(7) A sound documentation on mental health for creating and backing up public awareness.

Annex 3.3

List of Palestinian NGOs Active in Mental Health

UHCW: Union of Health Workers' Committees

UPMRC: Union of Palestinian Medical Relief Committees

PCC: Palestinian Counseling Center (East Jerusalem and West Bank)

GCMHP: Gaza Community Mental Health Programme (Gaza)

WCLAC: Women's Center for Legal Aid and Counseling

PRCS: Palestinian Red Crescent Society

PHCC: Palestinian Happy Child Center (East Jerusalem and West Bank)

GTC: Guidance and Training Center for the Child and the Family (West Bank)

ECRC: Early Childhood Resource Center (East Jerusalem and West Bank)

YMCA: Young Men's Christian Association (East Jerusalem and West Bank)

MRS: Mentally Retarded Society-Shamas Center (Gaza)

UIC: The Union of International Churches (Gaza)

Foundation of Health and Social Development (newly established - East Jerusalem and West Bank)

Chapter 4

UNRWA Health Care in the West Bank and Gaza: A descriptive overview of stakeholders perceptions on policy process and quality of services

Marzio Babilie, MD, MPH, DTM&H

Summary of Main Findings

The critical lesson from the past seven years' experience in the WBGS is that health sector reform requires a policy package rather than a series of independent reforms.

Flexibility and Partnership

According to the majority of those interviewed, providing an organizational structure with the flexibility needed in Palestine is the task for the future: An amalgam of private market, government bureaucracy and medical hierarchy in a specific form to suit local needs. As the UNRWA and Palestinian Ministry of Health seem to have recently started within, the crucial step here, as elsewhere, is likely to be the emergence and the cohesion of a group within the professions concerned which is committed to a more advanced and sophisticated management system than either the

medical-technical or the obsolete bureaucratic. Senior management training ought to be pursued further.

Depending on UNRWA

The debate regarding the future of UNRWA and its service provision in the WBGS has progressively become less consensual and more conflictual. Seen in perspective, innovative ways of collaboration between and among local and regional partners have not taken off from logical frameworks because of lack of readiness and political pressure. So far, they have remained technical abstractions. However,

“UNRWA has a political mission and it will exist until the refugee problems are resolved. Once the mandate of UNRWA finishes the same organization that accumulated experience can become a new agency for rehabilitation”.

Some interviewed feared that UNRWA might be dissolved and people supported by it should be taken care by the Ministry of Health. However, “for the time being, the Ministry of Health is not prepared to replace UNRWA in providing health services.”

Lessons from the recent Palestinian health sector experience lead the majority of stakeholders to consider that both the UNRWA-led system and the government system are dependent upon one another. The process that followed the issuing of the National Health Plan required dedication, understanding of the process of policy development under an unstable situation, and assessment of the relative strength of alternative strategies. Sometimes these years greater sensitivity and flexibility from the international community has failed to comply with the imperative of conceptualising that one of the primary limitations of UNRWA is its financial insecurity. Dependence on donors and other financial stakeholders affects the internal decision-making processes. Financial insecurity perpetuates also centralisation.

Less Projectisation

The fragmentation of aid and the multiplicity of service providers are too frequently mentioned to have been major obstacles to aid effectiveness and health system development, while underlying reasons have been rarely addressed in

depth. The insufficient coordination has been imputed being a concurrent cause of process dysfunction. In fact, “little attention has been paid to the perceptions of recipients on the desirability, need, impact and preferred methods of coordination”. It emerges that the perseverance of donors in “*projectising*” their support “has undermined the capacity of the recipient institutions not only to set priorities for the health system development process but also to manage their own, coherent development programs”. Sustainability has too often become a protective shield used for conditional use of aid. Yet, there are new trends that make better aid coordination possible in the WBGs, desirable and necessary.

Unified Vision

Common to all the stakeholders, a two-pronged approach strategy seems essential in the Palestinian context -- to tackle the needs of the transitional period including the emergency needs, and to develop the capacity to finance and manage a sustainable quality health care system in the end. Striving for a strengthened unified vision and consistent planning should lead the Ministry of Health progressively away from trends that predominantly indicate that supply drives the health system. The lack of regulatory norms and procedures and the inadequate licensing and accreditation process must be tackled. Effective

technical dialogue among health care institutions in policy and planning ought to be enhanced. With this respect, a UNRWA and NGOs representation should be part of a Planning Unit at the Ministry of Health. This consultative role ought to be key in unifying and streamlining policy formulation, monitoring, and performance appraisal of services.

Improving Culture of Quality of Services

A quality improvement strategy with a user focus, initiatives for developing service evaluation and expanding human resources development, and approaches to action-research in public health are relevant. Now, with the development of practical strategies for enhancing QI as part of the National Health Plan, both the government and UNRWA have put greater effort into implementing its policies. Even so, stronger leadership is needed from the national and regional offices to turn rhetoric into institutionalised activities attending systematically to quality of care and leading to quality improvements.

Introduction: The Health System Building Context

In the 1980s, UNRWA and western NGOs became an important vehicle for the delivery of aid in the Occupied

Territories. The negotiated peace proposals were accompanied by the genesis of an aid framework for the rehabilitation and reconstruction of the country and its health services. Such a vehicle would not have been effective without the political and strategic leadership of both the United Nations Relief and Work Agency for Palestine Refugees (UNRWA) and historical Palestinian NGOs sustaining health services delivery in the West Bank and Gaza Strip (WBGS).

From 1989 to 1993, on the verge of *Intifadah*, UNRWA efforts to sustain refugee health focused on specific at-risk population segments of women and children building on Expanded Programme of Immunizations (EPI), Maternal and Child Health (MCH) and environmental health. The Palestinian NGOs operated on relatively small budgets and working predominantly in health, water, and agriculture to keep survival and hopes high. Responsibility for health was transferred from the Israeli Civil Administration to Palestinian Authorities in Gaza and Jericho following the May 1994 Agreement on the Gaza Strip and Jericho and then in the entire West Bank following the August 1994 Agreement on the Preparatory Transfer of Powers and Responsibilities. At that time, support to the health system building was based purely on voluntary financial contributions from individual countries and organizations, while substantial funding was absorbed for coordinating functions

of the UN family through the establishment and maintenance of the United Nations Special Coordination Office (UNSCO).

The Palestinian Ministry of Health was established in 1995 in the WBS. During the period of transition 1998-99, it was forced to scale down its operations due to a sharp loss of revenue, a lack of external funding and an unprecedented conditionality of aid. Public services and public sector investments, despite being needed were criticized and put off. Meanwhile, also, UNRWA underwent a serious financial and managerial crisis.

Health programmes currently being conducted by the Ministry of Health alone or in collaboration with UN agencies or NGOs include: (1) prevention and control of locally endemic diseases, (2) health education and health promotion, (3) immunization, (4) health of mothers and infants, (5) reproductive health and family planning, (6) school health (medical, dental, psychological and health promotion), (7) environmental care, (8) laboratories and blood banks, (9) physical medicine and rehabilitation,

(10) mental health, and (11) oral health. However, quality improvement projects, although benefiting from substantial funding in 1997-98, failed to fulfil their objectives and were abandoned.

According to economic and health indicators, the WBS has made a significant progress in the development process as a whole (Table 4.1). Central to the understanding of the entitlement and provision of care equation, when analysing the process of matching investment needs against donors' actual disbursement of funds, the Ministry of Planning (MOPIC) offered the picture shown in Table 4.1.

It was surprising that an essentially economic model was embraced to rehabilitate and build the national health system, taking it through what has been labeled 'the relief-rehabilitation continuum' (Abbasi 1999). In the recent World Bank document on strategic directions for the Palestinian health system (World Bank 1998), the focus was on monetary and foreign exchange objectives, and the means already established in economic policy. To a large

Table 4.1. Palestinian development needs as reflected in different investment programmes by sectors, 1996-2000.

Sector	(%)		PDP*, 1998-2000			Average 1996-2000
	Core 1996	PIIP 1997	1998	1999	2000	
Infrastructure	56	42	51	47	46.3	48.5
Social	27.3	34	24.2	23.4	25.7	26.9
Productive	6.8	16	16.6	19.6	15.4	14.9
Institution Building	7.2	8	6.7	8.6	11.8	8.5

Source: MOPIC, 1998
* Palestinian Development Plan

extent, the economic agencies intensified the need for planning for contraction in the government's health and social services, but have rarely provided the appropriate planning procedures.

However, the 1998 Poverty Report showed the need of channeling essential health care to people living in remote provinces and districts of the WBGS; providing maximum support to the health of mothers and children; starting caring for chronic conditions; paying particular attention to the special needs of those who suffered the consequence of *Intifadah* and prolonged closures and retaliations induced in 1997-98; involving communities in decisions about their health services; and coordinating more the planning and fieldwork with UNRWA and the Palestinian NGOs active in the health sector. Unfortunately, consistent activities started only being discussed in late 1999 and implemented after the Spring 2000 when an impending political crisis was about to bring new problems to the Peace Process negotiations.

Gaza Strip was the area where a majority of donor inflows of assistance started to come and was comparatively affected by population pressure and heavy closures over the last five years. In the West Bank, on the other hand, Hebron and Jenin were identified as the worst areas in terms of relative poverty, access, quality of services, and attracted

relatively little international aid for the health system building tasks over time.

Scope

Since the inception of the Oslo Declaration of Principles, NGOs, UNRWA, the Ministry of Health and private providers have progressively shaped the Palestinian health system. First, a focus on health services transition in the WBGS is provided hereby from an historical and UNRWA's policy perspective. Mechanisms of cooperation and coordination in the health sector and the role of the United Nations and the World Bank in development cooperation for health in WBGS are outlined elsewhere. Discussions and in-depth interviews with all the stakeholders allow outlining findings of the health policy process and quality of services with respect to the ongoing efforts of the Palestinian health sector reform. The political constraints and effects of the violence on the health system development and the way they affected health security and social welfare are not described here.

Second, there are new issues in health services delivery in the WBGS after changes that took place over the last five years. Comparative access, appropriate use, duplication, multiple providers and competition, integration versus separation of service delivery all need to be assessed, including possible

disparity in service access between resident and refugee citizens. This summary report is meant to contribute to such task.

Design

The rapid assessment design was based on qualitative techniques to quickly outline strengths and weaknesses, adequacy and limitations of process and major outcomes in UNRWA quality of service performances. The research report builds upon the latest UNRWA experience such as quality of action-oriented activities; ability to establish the rules with vigor and continuity; reorient services and providers according to needs and institutions building in the midst of a complex start-up of health system reform.

Methods

During summer and winter 2000, careful review of published and unpublished documentation on the process of health system building and transition in the WBGS, group discussions and interviews with key-informants (government officials, academic forces, NGO field workers, private practitioners and UNRWA appointees) were undertaken. The working questions were (1) what kind of quality improvement policy is needed to ensure good quality of care? and (2) how

can a quality improvement policy be put into practice in the current Palestinian context?

Freelisting was used whereby respondents are asked to develop lists of problems, health care resources, or community priorities. Quantification and ranking were also applied, whereby problems or illnesses are ranked according to several different criteria. In-depth interviews completed and enriched the information gained by desk review and in the field. Open questions provided a wealth of information, including the wider context in which health activities and tasks take place; insight into the players; unexpected information; unique phrasing of concepts; and personal stories. A list of Palestinian officers participating in the joint interviewing of individual in-depth assessment is outlined in Annex 4.2. Quotations identify individual perceptions in the text.

Limitations

Given the Terms of Reference, the research is necessarily circumscribed, and its strength is the focusing that occurs as a consequence of this. However, lack of comprehensiveness and insufficient detail and quantitative information must necessarily be mentioned as primary limitations. Furthermore, focus groups with the refugee community were not possible because access was restricted by

the ongoing conflict (October-November 2000).

Availability of Health Services

The difficulty of establishing policy institutions in earlier years meant that the organization of the health sector was not undertaken in a strategic manner. Now that the need to rapidly strengthen political legitimacy has been fulfilled by the Ministry of Health, the choice of focus, capacity and motivation of Palestinian decision-makers remains the core of action.

As it is worth recollecting, free services provided by the Ministry of Health to all Palestinians include: (1) immunisations, (2) antenatal and postnatal care with the exception of institutional delivery, (3) child health care, preventive and curative, until the age of three years, (4) school health services for the whole student population, (5) ambulatory and hospital psychiatric services, and (6) corollary environmental health services. Services provided by the Ministry of Health to the insured population include: (1) primary care services (basic curative services), (2) secondary care services, (3) tertiary care services (mainly referrals or treatment abroad).

Tertiary care services are bought by the Ministry of Health from the available

market from Palestinian institutions, private for-profit or benevolent in the WBS and East Jerusalem, as well as Israel, Jordan and Egypt. The partition into these two groups is essential since it sets the basis for the Ministry of Health distribution of the available resources. In fact, while in theory government hospitals sell services to the government sick fund and NGOs, in practice hospitalisation is provided by the government at subsidised rates. Along with direct government transfers, these subsidies constitute only part of the government allocation to the sick fund and other nonprofit organisations. The true extent of government subsidies has never been clearly defined. Sick funds and NGOs have consistently maintained that the government does not reimburse them for the real cost of treating users. Although its establishment has been negotiated with some donors since 1997, the lack of adequate financial information system for monitoring activities and for financial accounting still contributes to the inability to settle any of these issues in a rational fashion.

In the last few years, the curative side has been emphasised. All the stakeholders agree that more input on the primary health care side is envisaged. Some believe that strengthening of secondary services was essential because the Palestinian Authority inherited weak hospital services. Hospitals are essential and support primary health care services.

The reasons for supporting hospital services were threefold: First, frequent closures of the Territories inhibited referrals. Second, economic issues played a role as 25 percent of the health budget was for referral to neighbouring countries. Third, psychological reasons included that people wanted to catch up with neighbouring countries. Therefore, there was pressure from the public opinion to improve the hospital services.

Users are more satisfied in the last few years. A recent study shows that more than 70 percent of the population - residents and refugees alike - expresses their satisfaction about health services (Barghouti 1999). The health insurance coverage increased from 17 to 45 percent. However, this is not due to voluntary insurance but the mandatory insurance of Palestinian Authority employees (14,000 and about 33,000 social welfare). The existing insurance is inherited from the Israeli system and is said not to reflect to the current Palestinian reality.

The Role of the UN in the Transition in the WBGS

The United Nations have played a significant role in development in the West Bank and Gaza Strip, beginning with UNRWA in 1950. UNRWA has provided health, education and social welfare services to Palestinian refugees for almost 50 years. The United Nations

Development Programme (UNDP) opened its office in 1980 and has since become an influential factor in the establishment and improvement of infrastructure and the provision of technical assistance.

The UN cooperation is part of the expanded development effort initiated after the September 1993 signing of the Israel-PLO Declaration of Principles on Interim Self-Government Arrangements, the 'Oslo accord'. A high-level task force subsequently appointed by the Secretary-General to assess needs in the WBGS highlighted the need to implement projects which would produce rapid and visible benefits in the daily lives of Palestinians, and stressed the importance of continuing support to ongoing programmes which contribute to Palestinian socioeconomic well-being. At the time, UN activities, particularly through UNRWA, accounted for approximately one-half of public sector spending in the Gaza Strip and one-third in the West Bank.

After the signing of the DOP and the accords, the UN adapted their roles to the new fast changing situation by meeting the health sector needs in order to sustain it in the transitional phase and planning for long-term sector development. While the primary attention of the Palestinian Authority during the interim period was to sustain the inherited health system, the focus was mostly applied on

physical development of health infrastructure (primary health care centers and hospitals) in the WBGS. During the next phase, the development of Palestinian human resources and the provision of technical assistance to the Palestinian Authority and later the Ministry of Health have figured prominently in the attempt to ensure that infrastructure investments would achieve the expected results. However, the process was not exempt from major limitations.

The UN agencies in collaboration with the Palestinian Authority and the donor community identified and planned key-priority intervention for rehabilitation of the health infrastructure, an engagement where UNRWA, UNDP, and WHO played a major role that lasted for five years (1995-2000). The prerequisites of the UN approach were that:

“such interventions would as a by-product, benefit the local economy, and mainly aim at building, renovating and expanding a number of health facilities. Moreover, the UN play a primary role in the implementation of such projects: the logistics, the technical expertise and the experience on the ground of the UN agencies allow them to start projects in a relatively short time.” (United Nations Strategy Paper of Health 1997).

The Nature and Supply of UNRWA Health Services

When addressing the nature and supply of UNRWA services in the area of health and how this supply and characteristics have changed over time since 1992, it should be stated that UNRWA has been, and still is the major pillar of support for the health of Palestinian but the Ministry of Health.

UNRWA provides services to 520,000 in the West Bank and more than 60 percent of the population in Gaza Strip, mainly primary health care clinics. Before the establishment of the Authority, UNRWA was the caretaker in the areas of health and education. Along the Peace Process, donors decreased about 50 percent its budget (amounting now to approximately USD 45 million deficit per year) while on the other hand refugees are increasing due to high fertility rate, low mortality and a certain degree of returnees. The number of beds run by UNRWA decreased dramatically and referral system almost collapsed. Since 1977, national staff is taking over to run health services. In the last three years, no recruitment of new health staff took place:

“After the Oslo DOP, reduction in funding to UNRWA and Palestinian NGOs even providing specialized services occurred and a progressive increase of private sector services

(pharmacies - diagnostic services - hospitals) took place, detrimental to equitable distribution of services.”

All these factors had contributed to the increased work load and, sometimes, questionable quality of service provision.

Earlier, UNRWA's strategic approach in the health sector was focused on maintaining and upgrading its medical infrastructure at the primary health care level under a “Western Approach”. Under the Agency's Peace Implementation Programme Phase I and II, UNRWA launched a large number of health and health-related projects which included: maintenance and/or construction of UNRWA and PA clinics, procurement and supply of medical equipment as well as a number of interventions in the field of environmental health (ranging from the procurement of garbage trucks to feasibility studies).

In September 1994, UNRWA launched the phase II building on the preceding success. In the health sector, the agency heightened focus on environmental needs of both the West Bank and GS. Funding was received for a number of sewerage and drainage projects in Deir El Balah and Beach Camp in Gaza. Out of other undertakings, in the West Bank funds were allocated towards the construction of the Palestinian Public Health Laboratory and the completion of the sewerage system in Tulkarem.

In 1999, the Department of Health employed 3,400 health personnel (mainly locally recruited Palestinian refugees) in all the concerned areas of operation. The total annual per capita cost of delivering primary health care, environmental and nutritional support services throughout was reported by the agency USD 13.5 million. The same year, approximately 5.5 million patient-visits were paid by UNRWA clinics for medical consultations and more that 508,000 dental consultations were reported in the whole region. The average daily consultation rate per doctor remained high as of 105 in Gaza and Jordan (UNRWA 1999).

During the same year, the Agency continued its efforts to introduce major management and budgetary reforms in order to both maintain humanitarian assistance and reducing administrative costs. A major effort was put on revising technical guidelines, operating manuals and the existing standard management protocols in collaboration with UN sister agencies with the view of redefining the strategic approaches of the various programme components. Specific emphasis was placed on enhancing the process of capacity building and development of human resources for health, in collaboration with the Palestinian academic institutions - in particular Bir Zeit University, and foreign partners.

Additional funding was received for the completion of the European Gaza

hospital. Following a tripartite evaluation by UNFPA, UNRWA and the Ministry of Health on UNRWA's expanded maternal health project in the Gaza Strip, a strategic plan and operational framework for sustainable women health programme was developed late in 1995. UNRWA efforts went to the improvement of maternal health services with particular emphasis on staff training including the Palestinian Health Authority (the Ministry of Health was not formalised yet), NGOs and UNRWA. The first turnover of UNRWA health facilities to the Ministry of Health took place in spring 1996.

UNRWA's strategy is also aimed at maintaining the highest level of coordination and harmonisation of health policies and services with those of the Ministry of Health ultimately leading to a smooth hand over of the Agency's health care system when the decision for such a transfer of authority and responsibility would be taken. The agency holds close consultations with the Ministry of Health on all related matters in order to facilitate the process of progressive complementation and harmonization. In 1999, the zero incidence of poliomyelitis and neonatal tetanus in the WBGS was maintained and this shows a good outcome of networking efforts. Over time, the expansion of Qalqilya hospital and the construction of few MCH Centers, such as that in Askar Camp and a wide range of environmental health activities

characterized the agency's progress. Good collaboration with the Palestinian Authority took also place in both occasions of the Gaza European hospital construction and in the establishment of the Central Public Health Laboratory.

Notwithstanding the 1998 financial stringency, the Agency carried through the extraordinary support to refugee health needs providing primary care, dental care, family health and a range of specialist services in refugee camps and both in the Palestinian territories. In Gaza, progress was attained under the Special Environmental Health Programme that implemented improvements in cost-efficiency gains by mechanization of refuse collection and disposal equipment to offset the high recurrent cost of the current labour intensive system. The Agency played a relevant role in subsidising 80 percent of beds at Ahli Arab hospital in Gaza and upgrading health system infrastructure building the Gaza European hospital in Khan Younis area (232 beds) and the Central Public Health Laboratory in Ramallah and its satellite site in Gaza. Finally, during 1999 the agency reported medical care for 214,000 children under 3 years of age and 68,843 pregnant women and preventive care for 468,000 school children.

In the West Bank, UNRWA currently runs 34 health centers that serve a population of around 600,000 Palestinian refugees. New components of the

project nationwide are rehabilitation works at the government clinic level, supply of equipment and commodities. Progressive standardization with the Ministry of Health services is actively sought. As for women's health, here is a demand to moving from community awareness of reproductive and family planning to school awareness and information, communication and education activities. However, sustainability goes with the respect of the peace agreements. From qualitative evidence, sustainability is not a debatable issue for the agency since it is and will not be possible to approach from UNRWA revenues alone.

The reliability of the Management Information System (MIS) setup represents a remarkable success. The system underwent review and upgrading through a process of collaboration established by UNRWA with the Center for Diseases Control (CDC) in Atlanta. Such a relationship entails CDC apply MIS management training, capacity building of UNRWA Department, Total Quality Management activities, reproductive health training courses in Amman. A comparative analysis of laboratory work load and cost-benefit of services was carried out on the basis of the 1999 statistical data using WHO/EMRO recommended measurement techniques. The analysis revealed that the productivity target of 50 units/hour was achieved, with the highest rates in Gaza with 82/hour. In its latest 1999 Annual Report of

the Department of Health, UNRWA states that improving MIS is a matter of national interest, a strategic objective on which the Italian Shepherd for Health advocated throughout the whole transitional period.

In the Gaza Strip, beyond the major undertaking of school health and a strong and effective environmental action, UNRWA undertakes many women's and family health activities in collaboration with two NGOs: the Research and Social Development Institute on issues such as reproductive health education emphasizing social and cultural issues; and The Human Research and Social Development that is part of Al-Azhar University. The Agency focuses on the human dimension of reproductive health, which is ordinarily left aside together the psychosocial dimension. In Gaza, reproductive health is still seen as a threat because of the politicisation of the issue. Field problems include the fact that opening shops or pharmacies for contraceptive purchase is seen as a provocation to the religiosity of households and could become counterproductive. Reproductive health remains very attractive to many NGOs because of the issue of recurrent cost. UNRWA provides reasonable family planning services on demand, including counseling. However, the Agency under-funding and the zero growth budget have jeopardised selection and recruitment of staff and poses a major problem in mobilizing

reproductive health and family planning nurses on counseling.

UNRWA is going to prepare collaborative initiatives in information, communication and education for the upcoming projects, many of them in partnership with UNICEF. It is going to offer the upcoming USD 36 million USAID-funded Expanded Health initiatives as follows: (1) Packages of health education for girls prep schools (menstruation, pregnancy, breast feeding, contraceptives, family health), (2) introduction to support packages for boys on family health education in schools (books, stationary, 10-20 teachers allowances. It is mentioned the experiment of involving community and religious leaders and professionals in order to draw sex organs on health education books. Such practices are discouraged and many teachers resent because they are not prepared to teach sensitive issues), (3) women's empowerment sessions through talking about their reproductive experience at the presence of medical specialists, (4) use of UNRWA facilities for information, communication, education and training, (5) increase of updated nurses on reproductive health and family planning, (6) support of essential drugs policy and procurement of essential drugs that are frequently unavailable (i.e. hypertension), and (7) contracting out the Agency for production of educational posters, leaflets.

Responding to the conflict that broke in October 2000, ("the second *Intifadab*") UNRWA required the mobilisation of all the professionals working in health, social services and education. The general objective was to counter the devastating direct effects and the hidden consequences of violence on Palestinian refugees and residents and promote the development of constructive coping mechanisms.

The "Healing the Wounds: UNRWA Responding to the Crisis" project envisaged: (1) A systematic training programme for UNRWA medical staff on trauma and counseling in the primary care framework, (2) compiling a directory of all the available resources in the community in different regions, (3) implementing a broad array of health promotion activities, (4) initiating a surveillance system on mental health and psychological conditions, (5) training and appointment of an additional group of 20 school counselors to offer the necessary support to teachers, refugee school children and their families, (6) implementing a skill-building initiative for the staff of the Relief and Social Services branch, and (7) increase assistance and support to marginalised groups of children, women and the elderly.

The Role of UNRWA in the Health System Development Tasks

First and foremost, UNRWA health services continue to represent the backbone of health service delivery for the Palestinian refugees across the region. Not surprisingly, the international figures available depict that the health profile of resident and refugees in the WBGs settings is homogeneous. Perceptions, entitlement, access, service use, ability to pay are determinants that let the Agency to encourage and assist appropriate modes of health service organization and delivery and to monitor progress in quality.

UNRWA today is even more important than in the past. The policy of the agency shifted and modified according to the political events in the area from a vision merely biomedical mutated by the WHO to a role of UNRWA as policy-maker, guidelines-maker and native executed. Now the Agency's approach is qualified by the interviewed as "effective, efficient, managerial, organized".

However, evidence shows that in early years:

"...(1) UNRWA was perceived mainly as a curative system; (2) inability of health workers to understand why diagnostic-therapeutic guidelines should be devel-

oped and why it was necessary to abide by them often hampered the process; (3) no community participation was contemplated or emphasized; (4) no inter-sectoral collaboration took place."

The example goes to the spill-over of the sewage system in Jalazone refugee camp in the West Bank that caused a serious epidemic outbreak of diarrhoea. UNRWA centralised and bureaucratic management failed to empower local people to participate in the environmental protection activities and assessment of damage. Finally, key-informants indicate that a highly vertical and separate system was implemented that collapsed in its sub-sector parts when the financial crisis hit. The superb, medical setup of maternal and child health services (MCH) was mainly curative and its quality progressively declined under financial stringency (1996-99). "UNRWA was unable to meet the needs of the people at that time".

By 1993 and the Oslo DOP, UNRWA moved towards hand over. Local policy making became essential. The Agency decided for the first time to appoint a Palestinian Director of Health offering long-term vision of needs and solutions built on national consultation: (1) Professionals who understand the concept and strategy of PHC were appointed. (2) The process began of appropriate guidelines development. (3) More openness towards the community

was implemented. Bir Zeit University became involved in evaluation exercises and sent its researchers to study and participate in committees in camps and quarters. (4) Less financial resources were devoted to drug supply and a rationalization of the sector leads, for example, to fewer hospitalizations at Augusta Victoria hospital. (5) UNRWA became progressively leader in good managerial structure pioneering ideas on community participation in primary care, during medical emergencies. When donors and other UN started emphasizing reproductive health projects and sub-sectoral funding mounted (a total of USD 10.3 million was mobilized in 1998-2000 on reproductive health and family planning only), UNRWA took a balanced stance. "Quality of services increased because of the inclusion of different Palestinian cadres in decision-making".

Consultative mechanisms with technical committees prove to work, as univocally government and NGOs admit. There is now a serious attempt to shift from bureaucracy to real participatory planning. The Agency moves "from meetings to in-service training and improved human resources development". However, there are several compelling reasons why highly participatory, local level policy-making was also important, and should, therefore, receive greater emphasis that it does today.

Policy-making at macro levels has not been sensitive to the diversity of local conditions, to refugees and resident assets and limitations that directly affect the health and well-being of Palestinian citizens of different communities. Important health-related planning, policy-making and action originate at the local level. Also, "the motivation of local leaders to practice health policy-making must be high, since they are affected by their own decisions". In the present assessment the participatory community health development process activated by UNRWA is seen as it can:

"...shift people's thinking beyond the illness problems of individuals, to consideration of how programmes and policies could support or weaken community health. They may well illuminate community's capacity and control to improve local conditions for a healthier Palestinian society."

UNRWA is now "liberated by the western colonization and is given the chance to maneuver". Measures of quality, however, are not always quantifiable. It is of course important to acknowledge the obvious barriers that must be overcome. As usual, there are pathfinders to show the way. Palestinian workers identified the weaknesses of the referral system and inappropriate referral issues of primary concern. Second, issues to be separated in the current assessment are viability of bureaucracy and quality of care provided and, in particular, the

relationship between top management and financial viability. UNRWA over-bureaucracy still plagues efficiency “because western forces want to maintain control”. Furthermore, there are limitations inherent in, and attributable to the “(1) slowdown of process because building democracy takes time, (2) colonial mentality, and (3) internal power struggle”. Finally, what is needed for the future is also “a shared framework of information” that can provide a basis to coordinate efforts examining roles and stakeholders, identifying inter-sectoral linkages and information gaps.

Factors that are thought to be key in building healthy and sustainable refugee communities are:

“..good communication; community involvement; local control; opportunities for leadership development; confidence in one’s community; coordination and cooperation in service delivery; ethics, values and spirituality; and respect for one’s culture and history.”

Some refugee communities in the WBGS still need processes to evaluate specific proposals, for example road-building or water supply projects, public safety issues or educational policies. “Schools and work places need to be focused in order to gain more participatory insight”.

Among many blueprints, it is likely that gradually and systematically the main principle of “planning from health needs” might be conducive to effective results in quality-based service delivery in the WBGS by all government agencies, UNRWA, NGOs and private, thus avoiding that “UNRWA and NGOs are merely replacing the public sector providing services for the poor”. In particular, UNRWA shows to have embraced modern concepts of health planning and management that drive new potential for change within the Palestinian community of professionals and decision-makers. The development of criteria, standards and norms regulating the services that prevent disease and maintain health have been started and should be viewed as a priority for attention.

Complementation and Quality of Services

When available findings from the global burden of disease in the WBGS are looked at, response is needed to the emergence of new health problems in the WBGS: nutritional related diseases; tobacco-related deaths (cancer and cardiovascular diseases); urbanization in absence of a normative environment.

In the WBGS, the new agenda embedded in the Five-year National Health Plan commits all government agencies, UNRWA, NGOs and private

providers to delivering the highest quality health care; therefore a process for quality assurance and a framework for monitoring and regulation of services (see also Annex 4.1). This will come about through the establishment of standards of practice, intensive training and supervision, the use of sanctions and rewards and the strengthening of supervisory and regulatory mechanisms. “Improving quality of health services in the search for efficiency and equity constitutes a fundamental health policy for the next four years”.

In the past, the quality improvement (QI) process began with an initial focus on patients’ perceptions of outpatient department services. The main tool used for monitoring quality was a locally developed exit interview. Quality improvement teams used the information from these patient perceptions to develop low-cost activities for improving service quality. The next step was to extend this monitoring and improvement of quality to primary health care facilities. There is a high expectation of this process to advance steadily. Now that quality improvement has become more institutionalized in the WBGS, the emphasis should move towards clinical and management quality issues. However, if there is no genuine commitment from the top, quality improvement initiatives can develop in a piecemeal way. Different geographical areas may develop at a different rate, and they may

use different approaches. This can fragment the drive for quality and increase geographical disparities between and within the West Bank and Gaza Strip.

Quality improvement has been re-proposed as an approach that Palestinian health managers should consider in their attempts to systematically monitor and improve service delivery. On this subject a large financial injection is also upcoming through the Expanded Health Project funded by USAID. If quality improvement is a planned and “systematic approach to monitoring, assessing and improving the quality of health services on a continuous basis within the existing resources”, it emerged that quality of care has different meanings to different stakeholders. The same applied for the three perspectives on quality that are Clinical Standards; Performance Management; and Client Satisfaction.

Several elements within the quality improvement system, such as clinical audit, standards setting, client satisfaction surveys, and quality control of laboratory services would probably need to be proposed by both UNRWA and Ministry of Health to donors for further implementation in the Palestinian health system. These components do not have to be introduced simultaneously, but can be introduced as distinct packages. Palestinians participating in this assessment exercise guarded providers imple-

menting quality improvement initiatives against over-ambition. Finally, implementing “quality is as much a ‘people’ issue as a ‘technical’ one” and ownership by local service providers remains the secret to success in turning policy on quality of care into practice.

Developing Service Evaluation

In a recent undertaking aimed at developing service evaluation, a systematic audit of UNRWA services for diabetic patients was conducted at Bir Zeit University (Nasser 1998). The study attempted to highlight problems pertaining to services offered for patients with Type 2 diabetes (NIDDM), with a focus on the gap between policy and practice. UNRWA services were chosen, as the Agency offers sound policies that are within WHO recommendations. A close observation of the use of records reflected first a problem in the completeness of the records. The lack of completeness was due to many factors, including the layout that did not allow for a sequential recording of the development of complications or referral for screening practices. Second, the organization of the primary services within each center surveyed showed a weakness in teamwork. A clear gap in responsibilities, in terms of screening and testing practices was reported. As a result, a low rate of blood tests that should be per-

formed on a regular basis was discovered.

The relevance of this study on practices gaps for diabetes patients clearly depicts that morbidity can be substantially reduced by paying attention to preventive measures at primary level of care (optimization of blood glucose and blood lipid control, reduction of smoking, BP control, simple foot care measures, sight surveillance). By the WHO standards, the UNRWA policy for diabetes health care is judged “adequate and the best available in the WBSG”. However, as the study contends, even with a structured system guided by standardised protocols, good staffing and fair record keeping, there are gaps in implementation, quality and, of utmost importance, lack of data use for better social responsibility. These gaps led researchers to realize that it is unrealistic for a non-NGO Agency such as UNRWA to adopt a population strategy. The latter is “a responsibility of government and needs collaboration of the Ministry of Health with other sectors within the system”. Furthermore, “the answers are not found in the medical records, but in the interaction between patients and health staff” (Nasser 1998).

Most of the participants in the assessment agree that capacity building within the health sector should be supported further to improve the quality of record keeping and to establish an

effective referral system as a general primary care system matter in the WBS, irrespective of the provider. Greater donors support to 'software' projects is needed to make qualitative changes in the health system including capacity building and human resource development through training and continuing education. The best prospect for improved management systems lies with a national merging of critical professional subgroups - health administrators at the local institutional level, and broadly qualified health managers, epidemiologists and public health staff at the national level.

Expanding service evaluation and developing service evaluation on new sub-sector priorities may be one of the approaches that both donor agencies and UNRWA might activate together with the Ministry of Health and NGO community "on a series of value-laden, common and costly conditions". Starting from those that are already targeted by UNRWA and NGO projects and programmes they may be summarised as follows: monitoring of diabetic patients (diabetic retinopathy and open-angle glaucoma); prevention of dental caries and periodontal diseases; health counselling for adolescents; mapping of social exclusion (learning disability and mental disorders); low birth weight; staging of breast cancer detection; chronic renal failure and transplant; treatment of otitis media; follow-up of abnormal Pap-

smears; quality of care and appropriate medication for respiratory conditions.

Capitalising on the report's results, there is one approach to research that could be proposed for further reflections in the WBS context. This is the whole notion of comparative data sets. National health accounts can be taken as an example of comparative data sets, which involve not just a collection of comparable data, but in fact the development of methods and instruments for collecting such information.

The basic statistics and epidemiological data might have been more and more used to determine priorities for cross-treatment of conditions according to their weight and influence on the health status, as well as the use of epidemiological quantitative data to evaluate the health services. "The increased prevalence and incidence of chronic diseases and their relation to nutrition" have been repeatedly underlined in UNRWA documents as "a major concern for the immediate future. Refugee camps should be better targeted by health and community development programmes to include poor areas outside camps". There is an urgent need to establish methods of evaluation that are explicit, transparent, and scientific and conducted in a form that encourages efficient communication between the stakeholders. This will help refine the approach, to the benefit of both the

recipients, in ensuring effective health care provision, and the donor, in improving value for money.

Human Resources Development

The process of health sector reforms adds a new perspective to the analysis of human resources for health in the WBGs. Many reform programmes aim at increasing efficiency and reducing waste in the use of health resources, particularly in the public sector, thus focusing the attention of policy-makers on the area of human resources where potential for savings would appear to be greater:

“Management techniques for prioritisation and resource allocation are insufficient at the Ministry of Health level, while UNRWA improved”; “UNRWA since one year started performance appraisal and cost-containment”.

Second, UNRWA seems to have realized that support from health personnel (or at least no opposition) for health reform policies is essential for their successful implementation. This requires that management is able to look at options for improving efficiency and effectiveness whilst simultaneously responding to the demands and aspirations of health personnel (“Management training should lead to improving conditions, scales, benefits and salaries” of

those who attend it). In this case, further analyses need to accommodate a number of complex areas - employment rights, career ladders, salary structures and so on, many of which may fall outside the responsibility of the UNRWA and Ministry of Health management.

Furthermore, when reconciling the issue of standardization of public health training and continuing education, it becomes central the issue of the intricate set of concepts and solutions for Palestinian “middle health managers requiring the inputs of various disciplines: epidemiology and statistics, social and preventive medicine, health management adapted to the understanding of the local health systems and cultures”.

Progress and Shortcomings

As acknowledged by the majority of interviewed, the main successful effort undertaken by UNRWA in these years was contributing in the rehabilitation of primary health care and secondary infrastructure network and the reorganization of environmental health; community health; school health; and nutrition branches. The concept behind such progress encompassed the objectives of serving remote areas and villages; increase the geographical distribution according to funding; offer combined UNRWA-NGO provision of services; and institutionalise new coordination

mechanisms with government and NGOs via technical committees.

UNRWA also advocated technical training in order to upgrade doctors and increase the managerial skills and technical competence of human resources at different levels. A thorough collaboration with the Palestinian institutions (Bir Zeit and Al Quds University) offering public health postgraduate training and continuing education was also sought, that started harmonising knowledge and attitudes in service delivery in the WBGS. Finally, UNRWA progressively attempted to unify strategy with the Ministry of Health and apply, since 1999, performance appraisal of its services. On these grounds, therefore, the assessment considers that UNRWA developed a sustained process of policy, institutional systems development and implemented extended and flexible forms of partnership successfully.

The improvement in the health information system led to progress in the EPI schedules throughout the country, and improved surveillance system and better prevention, detection and control of infectious diseases. However, there are no efforts to produce unified face-to-face forms providing government against UNRWA primary care information.

Unfortunately, the majority of stakeholders agree that despite the enunciation of the primary care orienta-

tion of health services as a major goal, an explicit framework which pulls together the many different kind of objectives and strategies that could potentially serve to guide such a process has been lacking for most of the last seven years. However, the availability of the Five-year National Health Plan could counter such a drawback if used appropriately. While many countries have had partial successes in this arena, in the WBGS, this issue has not been framed for long time in such a way that those experiences may be shared and built upon.

Many countries have made considerable efforts to improve access to health services and the efforts that started in that direction in 1996 in the WBGS are visible. However, “public health resources have been so stretched that the quality of services has declined markedly over the last five years”. Palestinian policy makers have realised that health services of inferior quality do not promote equity or maximise health gain and that this represents the most urgent step of the whole health sector reform (“We are weak in monitoring and quality control. Wide expertise is needed” - the government says). As a result of this, the public is becoming attracted more to private providers than to public and UNRWA health clinics and hospitals. Since 1997, refugees are requested to pay for services (30 percent of hospital stay and surgical operations). Therefore, both refugees and residents resort to repeated

consultation for “second opinions” that often leads to additional treatment. Finally, it is also increasingly reported referral from UNRWA primary care services (70 percent of which paid by UNRWA) to private hospitals.

It remains a challenge to find innovative approaches that improve the quality of health service delivery in the WBGs. National quality improvement programmes are one way to improve standards, but in the recent past strategies to implement quality improvement at district and subdistrict level have been only partially implemented because of insufficient funding and some managerial misconceptions. A variety of blueprints exists, which governments of recipient countries might find attractive in providing a ‘quick fix’ solution to improve health service quality. This is exactly what happened in the period 1996-98 in the WBGs. However, experience shows that “changes in health service culture are a prerequisite for achieving quality improvements”. Evidence suggests quality improvement action developed by UNRWA facility-based staff are more likely to respond to local priorities and are far more likely to bring about the kind of quality improvements that service users themselves will appreciate.

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Annex 4.1

Quality of Health Care

Government health policies usually include statements on the quality of their health services. Such quality improvement statements usually reflect a concern for ensuring that health services are both cost-effective and responsive to public needs. The 1999-2003 Palestinian National Strategic Health Plan, for instance, states at page 69 - as an example of national policy statements:

Vision Statement: The Palestinian health establishment is adopting and implementing well-defined and valid methods to continuously measure, monitor and improve quality and efficiency of health care services in Palestine.

Mission Statement: Each Palestinian citizen has the right to receive the highest possible level of health care quality at affordable cost. Health personnel have also the right to work in the best possible environment within the available resources. The MOH-Quality Improvement Project, and its team is in a position to lead, enhance and activate the improvement efforts for the benefit of the Palestinian People.

National Objectives:

- Create sustainable capacity in quality improvement at the national, regional and local levels by linking processes of quality improvement programme to national strategic objectives.
- Demonstrate best practice as a result of quality improvement interventions.
- Create a national culture for quality improvement, its acceptance and application.
- Develop institutional ownership of quality improvement as an integral part of existing resources and integrate existing QIP into national institutions.
- Revise the quality improvement training programme to meet forthcoming needs.
- Develop management information system for quality improvement activities and disseminate results of quality improvement programmes.
- Rely on Palestinian resources for institutionalization of quality improvement programmes.

National Strategies:

- Implementing infection control policies at the level of primary and secondary care.
- Implementing the food service system at the level of secondary care.
- Implementing the WHO guidelines on the management of upper respiratory tract infections.
- Implementing the Diabetes Management System.
- Implementing the guidelines aimed at rationalising ordered laboratory tests.
- Computerizing the system of medical supply disbursement from the medical stores to the village clinics.
- Implementing the guidelines aiming at rationalize ordered X-Ray examinations.
- Computerizing the blood bank system.
- Computerizing the referral system for the secondary care sector to primary health care village clinics.

Annex 4.2

List of Interviewed Officers

- H.E. Dr. Riyad Al-Zanoun, Minister of Health, Palestinian Authority
- H.E. Dr. Munzer Sharif, Deputy Minister of Health, Palestinian Authority
- Mr. Emad Sh'aat, Director General, International Cooperation, Ministry of Planning and International Cooperation, Gaza
- Dr. Yousef Al-Hindi, Director General, External Relations & International Cooperation, Ministry of Health
- Dr. Nadim Toubasi, Director General, Primary Health Care, Ministry of Health, West Bank
- Dr. Dina Abu Shahban, DG, Women Health & Development Department, Ministry of Health
- Mr. Dieb F. Ahmad, Director General, Health Insurance, Ministry of Health
- Dr. UMMAYA KHAMASH, Director, UNRWA West Bank Operations - Health
- Ms. Dina Yousef Antone Nasser, UNRWA Operations Officer - Health, West Bank
- Dr. Ayoub El Alem, Director, UNRWA Gaza Operations - Health
- Dr. Mustafa Barghouti, Director, HDIP - UPMRC
- Dr. Ejad El Sarraj, Director, Gaza Community Mental Health Program
- Dr. Ahmed Maslamani, Director, Union of Health Workers Committees
- Dr. Hidmi Arafat, Medical Director, Al Makassed Holy Charity Hospital
- Dr. Yehia Abed, Dean, School of Public Health, Gaza
- Dr. Abdel Aziz Thabet, General Coordinator of Programs, SPH, Gaza
- Ms. Rita Giacaman, Head, Community & Public Health Institute, Birzeit University
- Ms. Rana Al-Khatib, Deputy Head, Community & Public Health Institute, Birzeit University
- Dr. Ahmed Abu Nasser, Director, Public Health Laboratory, Gaza
- Dr. Asad Ramlawe, Deputy Director, Primary Health Care, Ministry of Health, West Bank
- Dr. Kasem Maani, Deputy Director, Human Resources Development, Ministry of Health
- Dr. Samir Ziara, Director, School Health Department, Ministry of Health, Gaza
- Dr. Ayesha Sammour, Director, Community Mental Health, Ministry of Health, Gaza

Dr. Bassam Al-Ashhab Director, Community
Mental Health, Ministry of Health, West Bank

Ms. Sanaa' Kanaan Shadid, Reproductive Health
Project Coordinator - WHHD

Dr. Jihad Mashal, Director, Union of Palestine
Medical Relief Committees

Dr. Belal Al-Taher, Health Coordinator, Patients
Friends Society, Jenin

Dr. Salwa Najjab, Director, Women's Center for
Legal Aid and Counseling

Dr. Jumana Odeh, Director, Palestinian Happy
Child Center

Ms. Rana Nashashibi, Director, Palestinian Coun-
seling Center

Ms. Siham Rashid, Deputy Director, Palestinian
Counseling Center

Chapter 5

Donor Contributions to UNRWA

Rex Brynen, McGill University

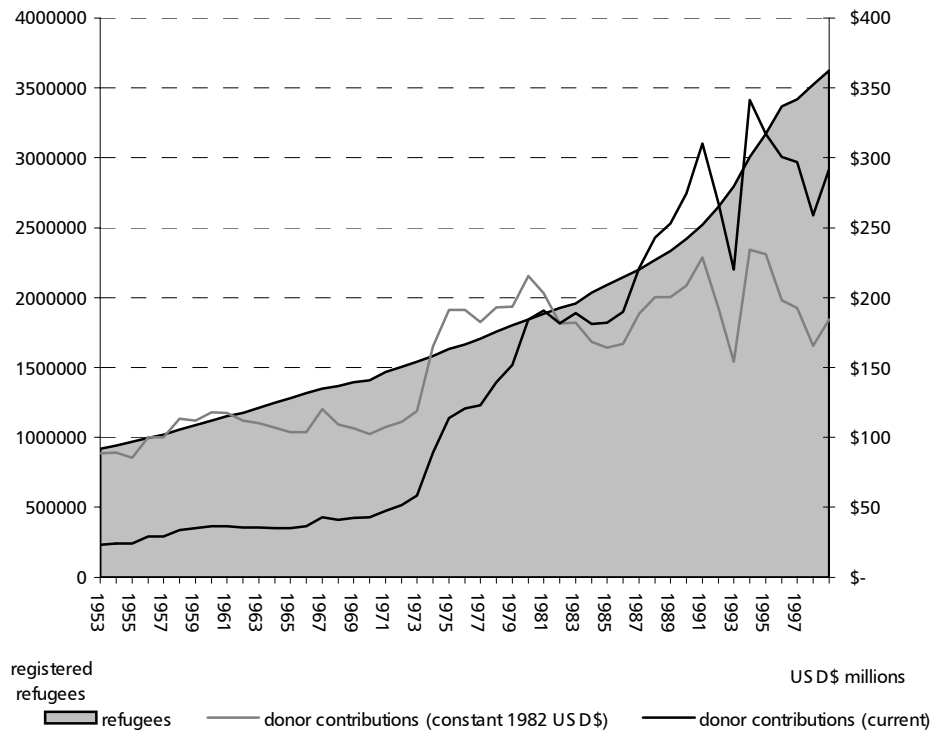
Since its first establishment in 1949, the United Nations Relief and Works Agency (UNRWA) has provided essential health, educational, and other social services for an ever-expanding population of Palestinian refugees. Financial support for UNRWA's activities has been largely dependent on direct bilateral commitments by donor states rather than resources from the general UN dues levy and budget. Indeed, in the 2000-2001 biannual budget, donor cash and in-kind contributions were projected to comprise 95 percent of UNRWA income. Of the remainder, 3.2 percent of UNRWA income was to come from the United Nations through UN funding of all international staff positions; 0.9 percent from overhead costs levied on project financing; 0.5 percent from income generated by UNRWA's micro-credit program; and 0.4 percent from interest on deposits (UNRWA 1999). In this respect, UNRWA's situation parallels that of the United Nations High Commission for Refugees (UNHCR), which receives only 2 percent of its budget from general UN funds (UNHCR 2001).

This reliance on voluntary contributions from the international community has meant that UNRWA activities are fundamentally dependent on the willingness of donors to provide adequate support. Over the years, the Palestinian refugee population has grown exponentially, increasing from 912,425 in 1955 to some 3,737,494 by 2000 (year-end)—an average increase of over 3 percent per year. While donor support has also increased substantially, both absolutely and in real terms, it has generally failed to keep pace with the rapid growth of UNRWA's clientele (Figure 5.1).¹ This has meant that the level of resources available per registered refugee has generally shrunk through the 1980s and 1990s (Figure 5.2).² Consequently, the Agency has faced a worsening financial crisis. Most recently, this crisis has been

¹ Source for Figure 5.1: Benjamin Schiff, *Refugees unto the Third Generation: UN Aid to the Palestinians* (Syracuse, NY: Syracuse University Press, 1995), pp. 23, 113; various annual *Report[s] of the Commissioner-General of the United Nations Relief and Works Agency for Palestine Refugees in the Near East*. Data on changes in US Consumer Price Index drawn from <http://www.unm.edu/~bber/econ/us-cpi.htm> for purchasing power conversions.

²Data derived from Figure 5.1.

Figure 5.1: Trends in Refugee Population and Donor Assistance to UNRWA, 1953-99.



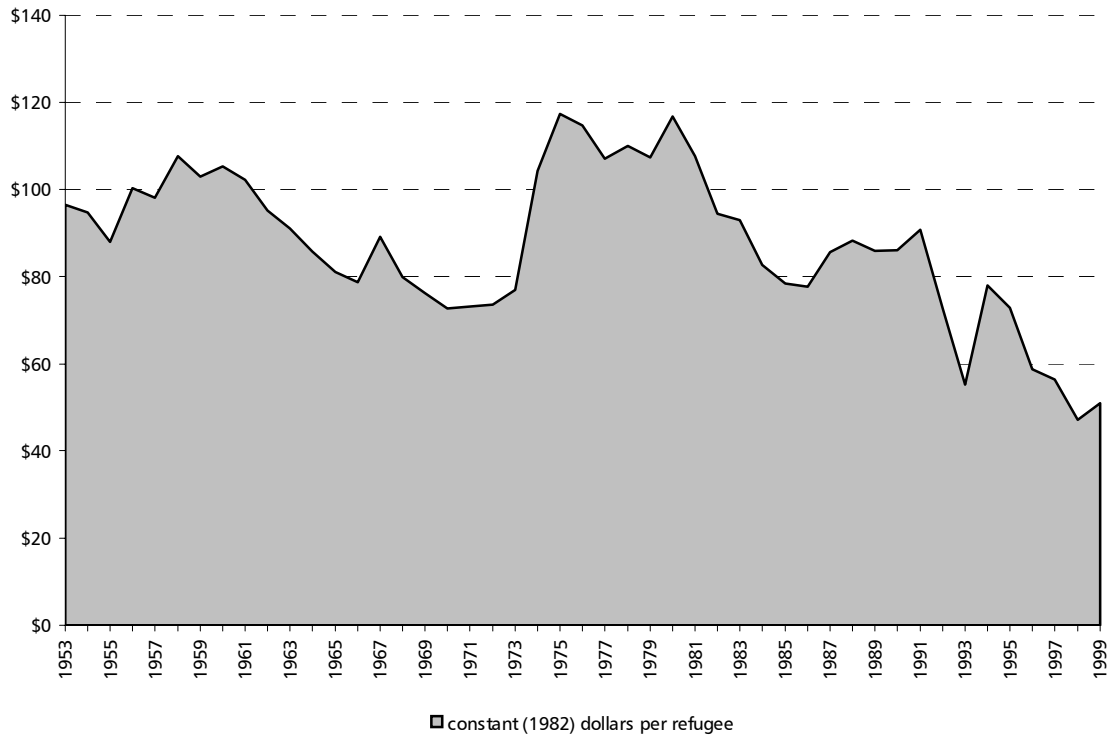
further aggravated by violence, closure, and the collapse of the local economy in the West Bank and Gaza since the eruption of the second *Intifadah* in September 2000—all of which has increased the need for UNRWA services even as it has complicated the challenges of delivering them.

This chapter will explore patterns and trends in donor assistance to the Agency, and especially since the signing of the Palestinian-Israeli Declaration of

Principles in 1993. In doing so, it will examine four key issues.

First, it will explore apparent changes in levels of donor commitment, measured both in absolute terms and relative to overall trends in international development assistance. It will also examine charges, often made in the highly-politicized context of the refugee issue, that donors have shifted support from the diaspora to the West Bank and Gaza, from refugees to other recipients, or that they are attempting to “liquidate”

Figure 5.2: Real per capita assistance to UNRWA Refugees, 1953-99.



the refugee issue by deliberately starving the agency of necessary resources.

Second, this chapter will examine variations in levels of support across donors. In so doing, it will offer several possible indicators of “generosity” or burden-sharing.

Third, the chapter will briefly examine the specific dynamics of donor policy-making, in an attempt to identify the sorts of political, institutional, and other factors that shape decisions on UNRWA support. In doing so, the cases of four bilateral donors will be briefly

highlighted: Canada, the United States, the United Kingdom, and Norway.

Finally, the chapter will offer an assessment of UNRWA’s long-term funding prospects, and the implications of this for the Agency’s programs.

Methodological Issues

Before undertaking any of this, however, it is first necessary to address a number of methodological issues. Assessing the magnitude of, and trends in, donors support for UNRWA poses a number of challenges.

Exchange Rates and Prices

One of the most serious methodological challenges is presented by changes in exchange rates and prices. With regard to the former, donors typically pledge funds in national currencies, which are then converted to US dollars for UNRWA accounting and reporting purposes. As a consequence, steady or even increasing donor contributions can appear as a reduction in support (or vice-versa) due to a changing US exchange rate. In September 2000, for example, UNRWA reported that while the pledges it had so far collected that year had been valued at USD 213.3 million when first made, their actual value had dropped to USD 206.2 million by the time the funds had actually been received—resulting in a shortfall of USD 7.1 million.³ A further loss of USD 3.3 million was anticipated on 2000 pledges that had yet to be collected. Depreciation of donor currencies accounted for this shortfall, with the two important donor currencies—the Euro and the Japanese yen—having lost over 13 percent and 10 percent respectively in value against the US dollar during the year.⁴

In turn, the bulk of UNRWA expenditures are, in practice, neither in donor currencies nor US dollars, but rather in Jordanian dinars, Syrian or

Lebanese pounds, or Israeli shekels. This, coupled with poor information on the impact of local price changes on UNRWA costs, makes it difficult to assess short-term trends in the real value of donor assistance. Most existing analyses—including the data presented in Figures 5.1 and 5.2—utilise a price deflator for US dollars (typically, the US Consumer Price Index), based on US prices. While this may present a rough approximation of the effects of inflation over the years, it is a highly imperfect measure. UNRWA has recently initiated a biannual program to assess the cost of living in each of its areas of operations, but with the intention of better assessing employee pay levels rather than determining the longer-term effects of local price fluctuations.⁵

In the meantime, however, it is possible to track the rough effects of price and exchange rates changes in each of UNRWA's area of operations, using data on local exchange rates (against the US dollar) and the local consumer price index for each area of operations. This has been done in Figure 5.3, which shows how local inflation and currency fluctuations have shaped the purchasing power of UNRWA dollars.⁶ In addition, a general “UNRWA price index” has been suggested, comprised of a weighted

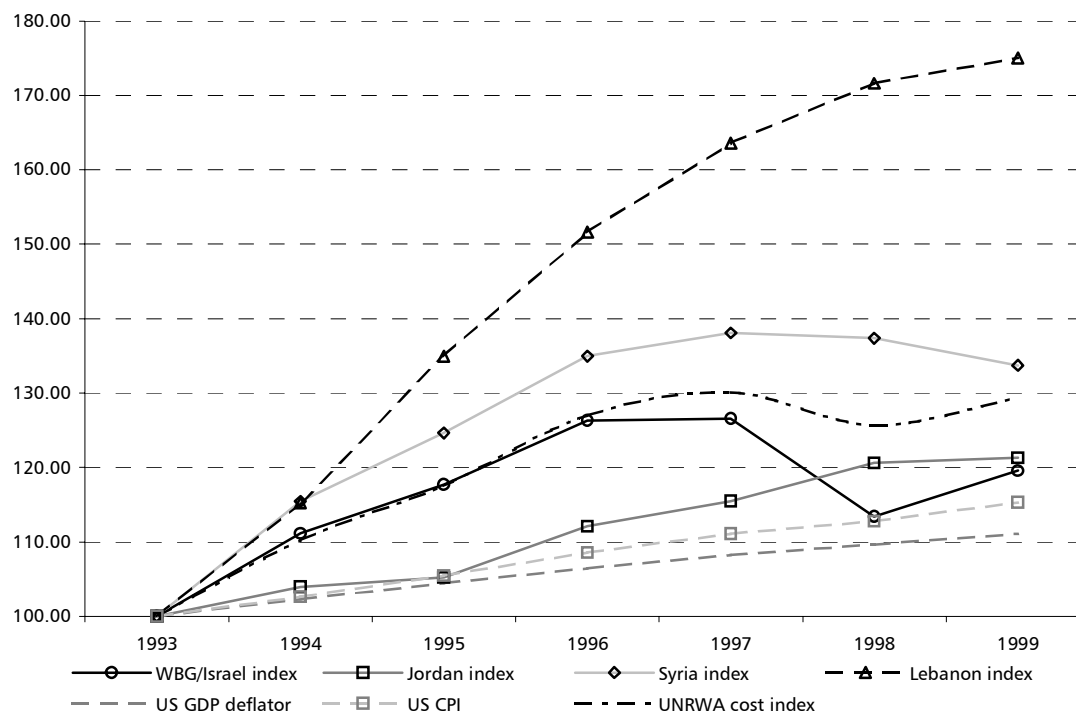
³ “Impact of Exchange Rates,” UNRWA, *Informal Briefing on UNRWA's Financial Situation* (overhead slides), 26 September 2000.

⁴ Historical exchange rate data from 2000 drawn from <http://www.exchangerate.com>.

⁵ *Jordan Times*, 10 June 2001, reproduced in *FOFONET Digest* listserv, 8 Jun 2001 to 10 Jun 2001 (#2001-146).

⁶ World Bank and IMF data. In the case of the West Bank and Gaza, Israeli currency and prices have been used, reflecting

Figure 5.3: Cost and Exchange Rate Indices for UNRWA Areas of Operation.



* 1993 prices and exchange rates = 100

average of price changes in each field of operations.⁷ Compared to the US CPI, this data generally suggests an even sharper increase in local cost levels in the 1990s, and hence a greater erosion in the value of donor contributions.

Other developments can also affect UNRWA costs. In the West Bank and Gaza, for example, the Palestinian

widespread use of the shekel (NIS) in the territories, and the close relationship between Israeli and Palestinian price levels. While CPI data is available for the WBGs, it is not wholly comparable throughout the period under examination.

⁷ This index is weighted by a ratio of 26% Jordan, 7% Syria, 15% Lebanon, and 52% West Bank and Gaza prices/exchange rates, based on the distribution of actual UNRWA expenditures in each of its fields of operations. As noted earlier, NIS rates have been used for the WBGs.

Authority has not exempted UNRWA from VAT charges (as it should), nor has it repaid those taxes already paid. At the May 2001 biannual donor meeting, UNRWA reported that this had cost the Agency some USD 19 million.

Budgets, Pledges and Disbursements

A second set of complications is created by the gap between donor pledges and disbursements, the sometimes irregular timing of the latter, and the differences between the calendar year used by UNRWA for accounting purposes and

the different financial years used by different UNRWA donors. From a donor's perspective, a disbursement in March 2002 rather than November 2001 may both fall within the same financial year, and hence be financially indistinguishable. From UNRWA's perspective, however, these contributions would fall within different years, thus creating appearances of a shortfall in one year and an upswing the next. Such unpredictability in the size and magnitude of donor disbursements can also create both shortfalls in its budget and temporary cash-flow shortages within the agency.

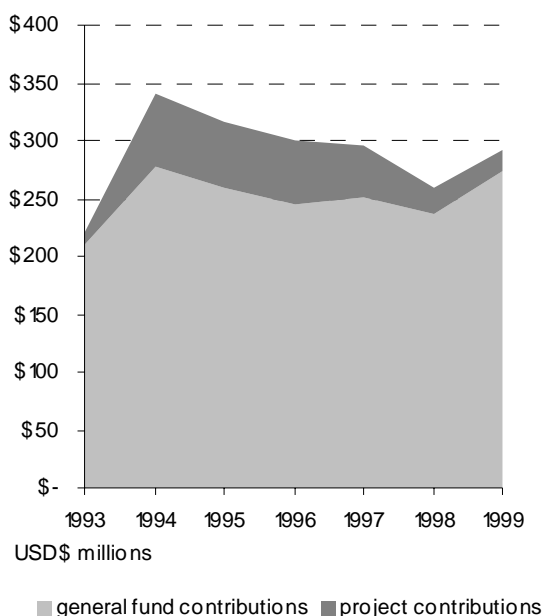
In turn, neither pledges nor disbursements are strictly related to UNRWA's budget, which is approved by the UN General Assembly. The budget represents, in theory, the Agency's estimate of what is required to do its job—and not an actual forecast of estimated receipts and expenditures. In practice, however, it is likely that UNRWA sets its budget somewhere between needs (which are, in reality, greater than the approved budget suggests) and probable receipts (which are always lower than desired) in a way of enhancing its ability to raise funds. The budget "gap" or "shortfall" spoken of by UNRWA officials is thus the gap between what it would like to have and what it has. What the Agency "needs" is a rather more ambiguous concept, and sometimes disputed between the refugees, UNRWA, and the donors. This, in

turn, has generated a certain amount of cynicism at times among donors, who have been unconvinced that UNRWA budgeting is a wholly legitimate process. Reforms in UNRWA accounting and management procedures have helped address this, as did the decision of the Agency to move to a two-biennial budget structure.

Programs and Projects

Finally, in evaluating changes in donor support for UNRWA the effects of different types of contribution must be taken into effect. Most contributions to UNRWA's General Fund are not earmarked, and hence can be used by the agency to support its regular service

Figure 5.4: Project and General Fund Contributions, 1993-99.



activities. Other funds, however, may be allocated for specific activities. Two types of these are particularly important:

Project funds support particular capital investments, such as shelter upgrading, or the improvement or expansion of educational, medical, and social facilities. Since the 1990s, the most important of these have been Peace Implementation Projects (PIP), launched by UNRWA after the signing of the Israeli-Palestinian Declaration of Principles (Oslo Agreement) in 1993. While contributions to PIP-type projects improve UNRWA's infrastructure, they generally do not finance service delivery costs. Indeed, given the staff and maintenance costs associated with many capital projects, the end result may be a *heavier* burden on the regular budget. At times, budget and cash flow shortages have forced the Agency to "borrow" operating resources from its project financing. Donors have protested at this "highly questionable financial practice," which has threatened to curtail project implementation because of the redirection of project funds to other purposes.⁸

Emergency funds support emergency activities and additional UNRWA service delivery costs associated with particular events. The EMLOT (Extraordinary Measures for Lebanon and the Occupied

Territories) program, for example, supported emergency-type expenditures in Lebanon (arising from the dire conditions of refugees there) and the West Bank and Gaza (associated with the first *Intifadah* and the Gulf War). Later, with the eruption of the second *Intifadah* in late September 2000, UNRWA launched a "flash" appeal for additional funds in October 2000 (USD 1.7 million pledged). This was later followed by "emergency appeals" in November 2000 (USD 44.5 million pledged) and February 2001 (USD 23.1 million pledged) (UNRWA 2001). A third emergency appeal was issued in June 2001. While donor support for emergency appeals increases UNRWA's ability to deliver critical services, the very launching of such appeals also reflects new and acute demands being placed on the Agency by the eruption of violence or other circumstances. In such cases, increases in donor support may indicate a *decline*—rather than an improvement—in UNRWA's ability to perform its primary functions.

UNRWA also carries some recurrent debt items, arising from its ability to meet earlier obligations. The most important of these are unfinanced costs associated with the transfer of UNRWA headquarters from Vienna to Gaza; cost overruns arising from the construction of Gaza European hospital; and the development of a reserve fund to cover staff indemnifications in the event of the termination of UN employees.

⁸ Comments by western aid official, May 2001. The same official also decried UNRWA's "creative accounting" in the way it reported its budgetary shortfalls.

From the perspective of refugee services, it is donor contributions to the general fund that most directly impact on the long-term ability of UNRWA to fulfil its mandate. However, not surprisingly, many donors may tend to see their aggregate contributions to UNRWA (that is, *including* support for emergency funds and special projects) as the best indicator of their general support for Palestinian refugees.

The effects of this were particularly great after the signing of the Oslo Agreement 1993. With donors anxious to support Palestinians in the West Bank and Gaza, substantial amounts of new and increased special project funding flowed through UNRWA (Figure 5.5). Contributions to UNRWA's general program did not substantially increase, however. Thus, despite an apparent (short-term) increase in international funding for the Agency, its ability to deliver core programs was not enhanced. Rather, in a context of a growing refugee population, its ability to support recurrent services actually continued to contract.

Trends in Donor Support

As discussed above, UNRWA has, in the face of price inflation and a rapidly expanding refugee population, received increasingly inadequate support. As can be seen in Figure 5.1, donor support

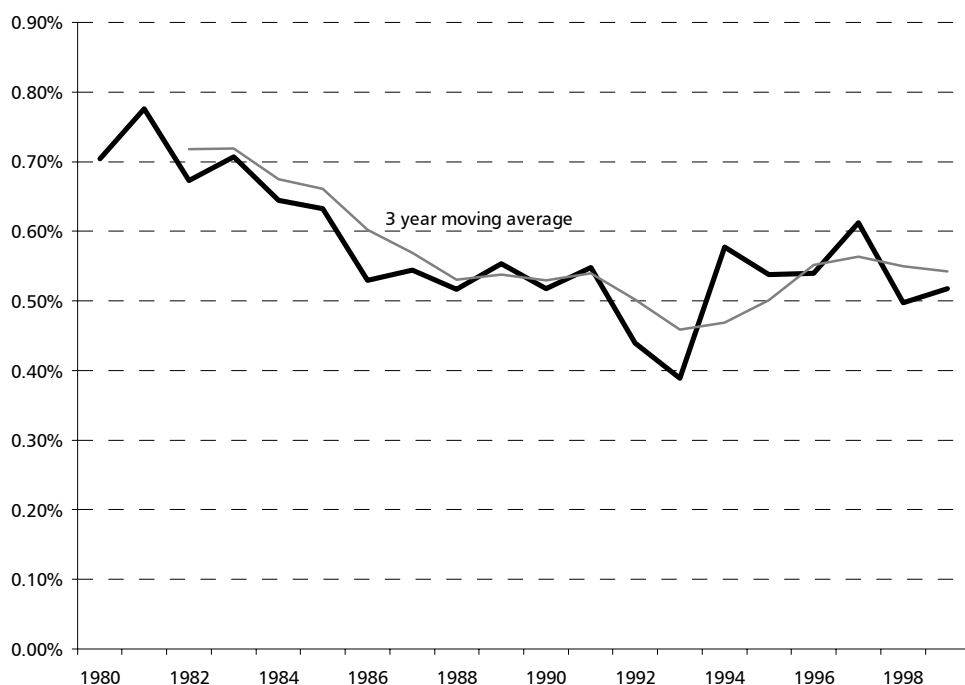
declined in real terms by over 12 percent (using US prices) between 1988-89 and 1998-99, and even more in local prices. As evident in Figure 5.2, real per capita assistance declined by a substantial 46 percent during this same period. Clearly, from the perspective of both the Agency and the refugees, the mobilization of real donor resources waned through the 1990s.

Many donor officials, however, would likely paint a different picture. In nominal terms, donor support for UNRWA increased by around 11 percent through the 1990s. More significantly, this increase took place at a time when Western aid budgets were generally stagnant. By this measure, donor support for UNRWA—measured relative to Western official development assistance (ODA)—may have declined in the 1980s, but has stabilized (and even recovered a little) in the 1990s (Figure 5.5).⁹

To this, many donors would suggest, should be added the dramatic increase in bilateral donor assistance to the West Bank and Gaza Strip that followed the Oslo Agreement and the establishment of the Palestinian Authority. Between 1994 and 2000, some USD 3.3 billion in ODA was disbursed in the territories, making Palestine one of the

⁹ Data from the Development Assistance Committee (DAC) of the Organization for Economic Cooperation and Development (OECD), *2000 Development Co-operation Report*, at <http://www.oecd.org/dac/htm/dacstats.htm>.

Figure 5.5: UNRWA Funding as a Percentage of Western Official Development Assistance (ODA).



largest per capita recipients of foreign aid in the developing world (Palestinian Ministry of Planning and International Cooperation 2000). Based on their share of the general WBGS population, refugees could be said to have benefited from around 47 percent of this, or approximately USD 250 million per year—an amount far exceeding the level of support channeled through UNRWA.¹⁰

¹⁰ Of course, there is no easy way of knowing whether the benefits accruing to refugees from general aid programs were proportionate to their share of the population. However, given the disproportionate concentration of ODA funds on Gaza, and the very high proportion of refugees there, it is possible that the benefits accruing to refugees *exceeded* this proportion. According to opinion survey data presented in *Aid Effectiveness in the West Bank and Gaza* (World Bank, June 2000), “those living in refugee camps generally have the most positive assessment of changes in local conditions since 1994” (p. 74).

This has occurred, moreover, despite a substantial increase in humanitarian needs around the world in the 1990s. According to UNHCR, the total number refugees worldwide increased from 14.9 million in 1990 to 27.4 million in 1995, before declining to 21.5 million by 1999 (UNHCR 200, Table 1). During the 1990s, the international community faced major reconstruction needs in Mozambique, Cambodia, Haiti, the Balkans, East Timor, and elsewhere. Continued support for UNRWA amid all of these competing claims suggests that Palestinian refugees have remained a high priority. Despite a decline over the years, Palestinian refugees still received USD 80 per capita in UNRWA assistance

in 1999—substantially more than the USD 55 per capita received by the (generally very much needier) refugees dealt with by UNHCR. Moreover, unlike the UNHCR budget, most UNRWA funds go to provide routine health and education services to a client population whose mean standard of living is well above the (non-refugee) average for the developing world, and indeed for the Middle East and North Africa as a whole. Indeed, while refugees in Lebanon do suffer from serious disadvantages, there is little or no significant difference between the standard of living of refugees and non-refugees in the WBGs, Jordan, or Syria. In providing regular, recurrent, long-term services to a relatively well-off population, UNRWA is thus unique among international relief agencies.

What then of the claim, frequently made by many refugee activists, that donors have been deliberating starving UNRWA, so as to “liquidate” the agency and thus the refugee issue? Is it fair to assert (as one UNRWA official did privately) that the agency’s budgetary problems reflect “political agendas aimed at closing the page on the refugee problem by writing off the agency?” (quoted in Brynen 2000). As the leading Palestinian refugee advocacy NGO, Badil, noted in a report on the Agency:

“Despite the growing consensus in regards to the unlikelihood of a rapid

Table 5.1: Comparative indicators of infant mortality.

Population	Infant mortality
Palestinian refugees (2000)	29 (Syria)
	35 (Lebanon)
	31.2 (Agency-wide)
All developing countries	61
Africa (1997)	107
Arab States (1997)	44
Lebanon (1999)	28
Jordan (1999)	29
Syria (1999)	30
Egypt (1997)	41

Source: UNRWA data and UNDP Human Development Report 2001.

formal dissolution, the debate about the termination of UNRWA services continues. Fears of a formal dissolution have been replaced by fears of a de-facto dismantling by the ongoing cuts of the Agency’s regular programs. If the donor policy of responding generously to special UNRWA projects... while neglecting the financial requirements of the Agency’s regular programs continues, UNRWA will not be able to provide adequate services to the refugee population in the future. It will then be forced to relinquish the responsibility for vital services, which then may - or may not - be provided by the various state authorities....

Refugee and UNRWA sources frequently express their concern about what they believe is the current US-approach: “Of course the US and Israel would like to see UNRWA disappear.” They describe the strategy as consisting of reducing US contributions to UNRWA’s regular budget, thus working for the forcible transfer of Agency tasks

to the PA and the Arab host governments. Any such transfer will then diminish the scope of Israeli and international responsibility for the Palestinian refugee question. What remains will then be dealt with as national problems of the Arab countries (Pulfer and Gassner 1997).

The answer is both yes and no. Certainly it is true that, in the long term, donors look forward to the termination of the Agency. As one participant noted in a workshop on the future of UNRWA, it is unreasonable to expect donors to support a “permanent internationally-sustained welfare system”—especially in the aftermath of a political settlement (PRRN 2000). A senior donor official in one donor country, commenting on the much greater need of other refugees in other parts of the world, noted that the cost of maintaining UNRWA was more dead children in the Congo (quoted in Brynen 2000). Immediately following the Oslo agreement, there was hope that the peace process would see the eventual resolution of the refugee issue—and with it, the end of a need for the Agency. UNRWA itself foresaw a possible five-year transitional period. Also with Oslo, many donors shifted support into projects rather than programs, whether executed in conjunction with UNRWA or otherwise. Resources also flowed disproportionately to the West Bank and Gaza, compared to other UNRWA areas of operation.

It would be misleading, however, to see this as an effort to starve the Agency of resources. Instead, donors were attempting to buttress the peace process and help build the nascent institutions of the Palestinian proto-state.

Judged from the perspective of limited ODA budgets, UNRWA has done relatively well. This observation, however, is scant consolation to the Agency. Simply put, UNRWA's real resources have been shrinking in the face of a growing client population. The longer-term implications of this will be dealt with below. First, however, two other issues need be addressed: the question of burden-sharing among donors, and the donor policy-making processes that shape contribution levels.

Burden-Sharing

The question of shifts in donor support for UNRWA is closely bound up with issues of burden-sharing. From the point of view of the Agency, those countries that are providing relatively low levels of support represent a potentially important sector from which increased contributions might be garnered in future. From the perspective of donors, perceptions of unequal burden-sharing can affect both the dynamics between donors and the willingness of donors to increase their contributions.

The recent (1999) distribution of donor financing for UNRWA is shown in Figure 5.6. As can be readily seen, two donors—the United States, and the European Union—together account for around half of all donor assistance to the Agency.¹¹ The ten largest donors together comprise around 88 percent of all UNRWA contributions.

Substantial variations are also evident in the extent to which donor pledges have or have not grown over time. According to UNRWA data, four donors (Luxembourg, France, Ireland, Switzerland) increased their general fund contributions by more than 100 percent between 1995 and 2000, while a further three donors (Netherlands, Denmark, UK, Saudi Arabia) increased general fund contributions by 50 percent or more. Of the remainder, most (Norway, Kuwait, Australia, EU, Spain, Canada, Belgium, US, Sweden, Finland) increased core funding by less than 50 percent, while four others either failed to increase funding (Austria) or actually reduced it (Japan, Germany, Italy) (UNRWA 2000).¹²

Leaving aside political and historical considerations for a moment, it is reasonable to assume that richer countries ought to assume a larger share of support

for the Agency. Figure 5.7 attempts to gauge the relative “generosity” of donors by using two measures: UNRWA contributions as a percentage of donor Gross National Product, and donor contributions relative to the 2000 United Nations scale of assessment (utilised for general dues owed by member states to the UN, and based on economic measures) (U.S. Mission to the UN 2001).¹³ In the latter case, any number greater than 100 percent indicates contributions greater than the share that the UN scale of assessments would indicate, were it applied to UNRWA funding. In the case of members of the European Union, adjustment should also be made for collective EU contributions to UNRWA. In Figure 5.7 (and 5.8), this has been done by assigning each EU member a share of EU funding proportionate to its share of the total population of the European Union.

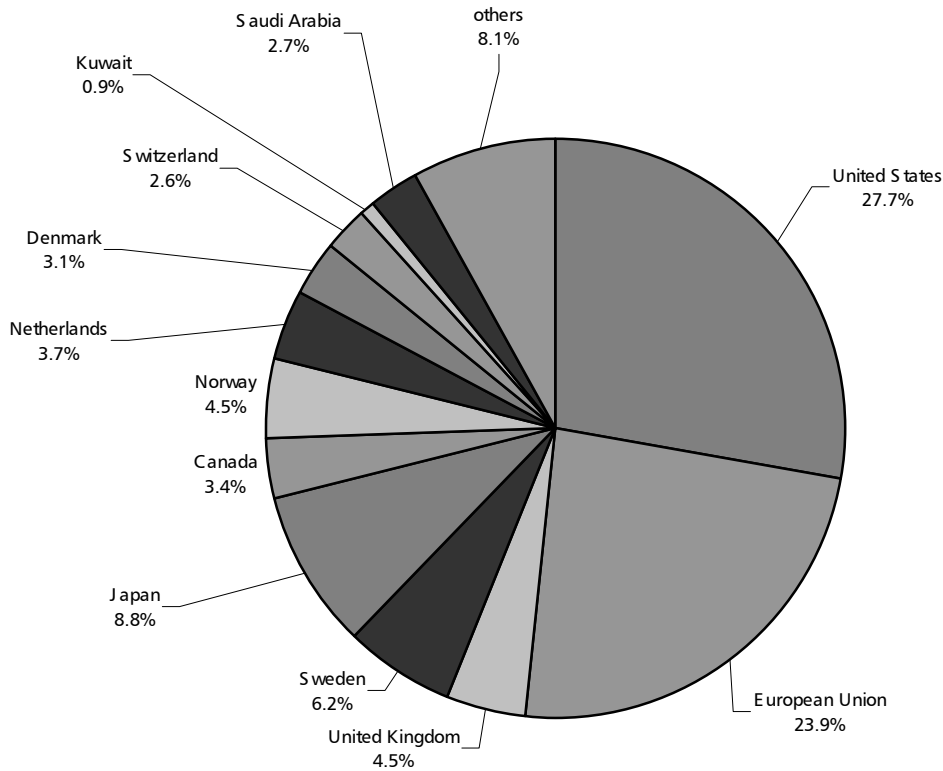
By this measure, most major donors are already contributing more than a proportionate share. A notable exception is Japan. Were Japan to have contributed proportionate to its UN assessed rate, its contribution would have increased by roughly USD 34 million in 1999, essen-

¹¹ Figure includes donor support for projects, emergencies, and the general fund.

¹² Figures are calculated in donor currencies, and do not reflect new pledges made late in 2000 (including an additional USD 6.6 million from the US).

¹³ “The UN Regular Scale of Assessment was created in 1946 based broadly on “capacity to pay” as measured by Member States’ shares of the world Gross National Product. The scale includes discounts for countries based on low per capita income and external debt.” See also United Nations Association of the USA, *The New UN Assessment Scale: An Analysis of the Rate Revisions Adopted by the 52nd United Nations General Assembly*, at <http://www.unausa.org/Programs/scale.htm>. The UN scale of assessment caps US contributions, which would otherwise be larger given the size and wealth of its economy.

Figure 5.6: Distribution of Total Donor Funding for UNRWA (1999).



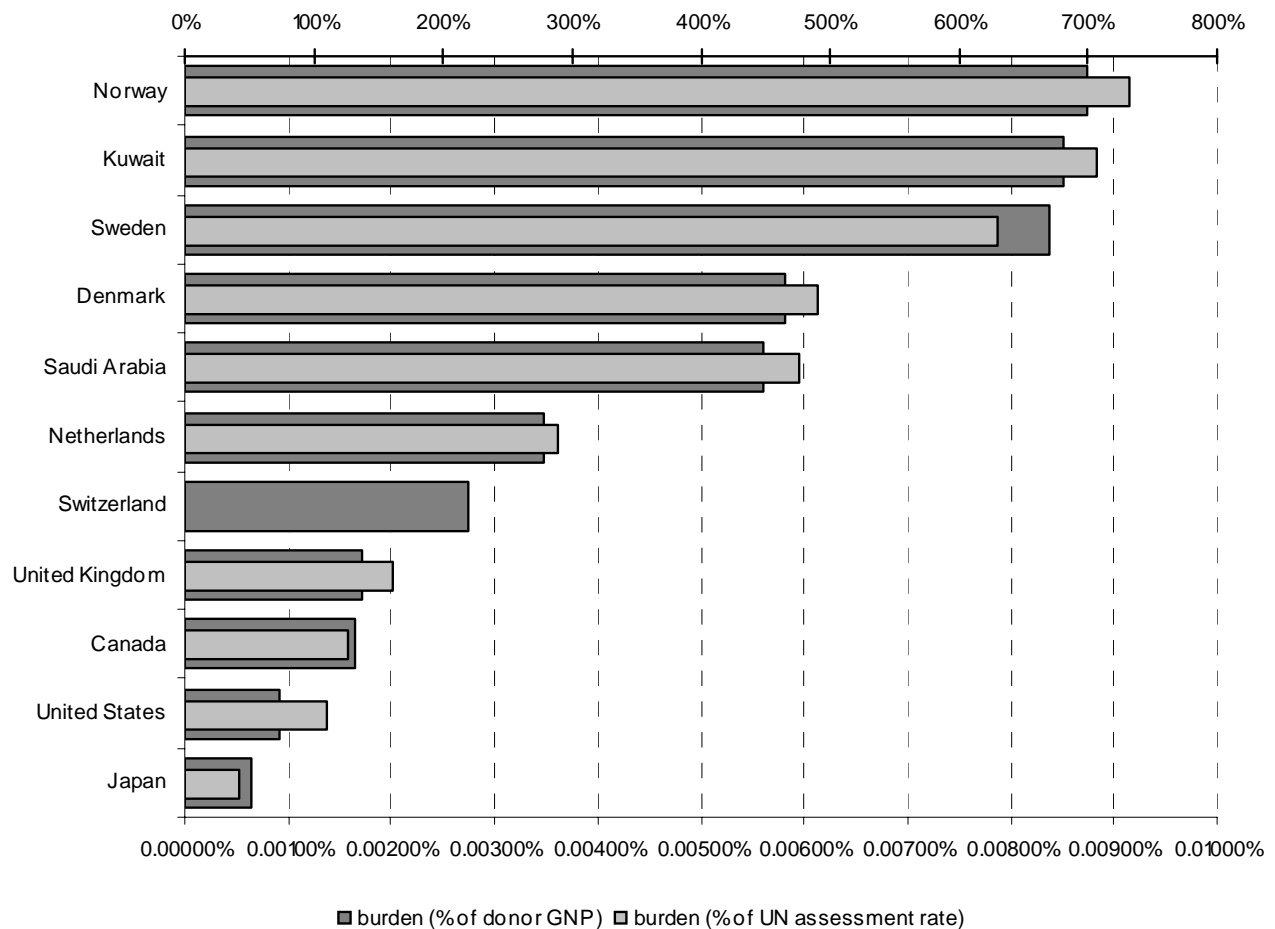
tially offsetting most of the agency's shortfall that year.

Burden-sharing can also be examined from the perspective of overall donor ODA budgets, rather than the underlying size of the economy. This perspective says less about the “fairness” of relative donor contributions, but does speak to the degree of humanitarian, developmental, and political emphasis placed on the Agency by donor agencies and foreign ministries. In other words, the greater the share of ODA budgets

that UNRWA consumes, the greater importance it reflects in donor priorities.

As Figure 5.8 shows, this sort of assessment places US contributions in a far more favorable light—reflecting the fact that while the US aid budget is proportionately smaller than any other Western country (0.11 percent of GNP in 1998-99, compared to an average of 0.25 percent for Western countries as a whole) (OECD 2000, Table 7), UNRWA represents a relatively high priority within that budget. Conversely, by this indicator

Figure 5.7: Indicators of UNRWA Donor Burden (1999).

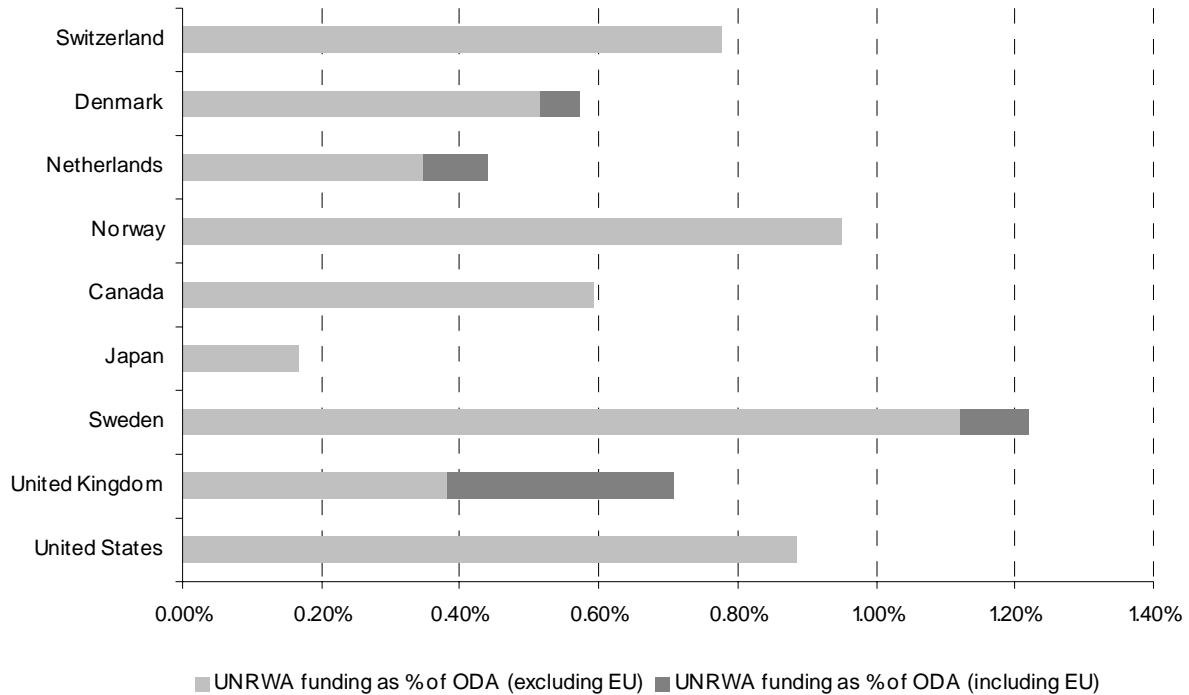


too, Japan shows a relatively low level of priority assigned to UNRWA funding.

In discussions of UNRWA’s long term financing problems, it is common to hear both Agency and donor officials speak of the need to “broaden” UNRWA’s donor base beyond its current key donors. While this would be useful, it is far from a panacea.

Among European contributors, Germany is an “undercontributor” to the tune of approximately USD 25 million per year (compared to the UN scale of assessments), while France (USD 14 million), and Italy (USD 10 million) also fall short by level that might be predicted by this measure. Among other European countries, Spain falls short by approximately USD 5 million per year, and

Figure 5.8: Indicators of UNRWA as a Donor Priority (1999).



Austria and Belgium by around USD 2 million per year.

Both within and outside the Agency, Arab countries are frequently identified as a pool of heretofore untapped resources. On the Arab side, however, there have been a number of reservations about supporting the Agency. Traditionally, the political argument has been advanced that the broader international community bears responsibility for the establishment of the state of Israel and hence the creation of the Palestinian refugee problem. In this view, it is unreasonable to expect Arabs to pay for an Arab refugee problem caused by other parties. Moreover, the Arab host coun-

tries (especially Jordan and Syria, which extend a broad range of public services to the refugees) can be said to have already borne a disproportionate price for the refugee issue. Israel's unwillingness to offer more than a minuscule contribution to the UNRWA budget (typically, a few tens of thousands of dollars per year), despite its role in the displacement of the Palestinians, has heightened Arab unwillingness to contribute.

On top of this, most Arab economies are relatively small compared to those of Western countries. Nevertheless, Saudi Arabia and Kuwait, and to a lesser extent the UAE, have emerged as significant donors to the Agency (espe-

cially for project funding). In 1999, these Gulf states accounted for 2.2 percent of UNRWA regular budget financing, and 25.5 percent of project funding—proportions well in excess of their share of the global economy. Measured by the indicators used in Figure 5.7, both Saudi Arabia and Kuwait are among the most generous donors to the Agency. UNRWA has asked Arab foreign ministers to increase their contribution 7.8 percent of the agency's annual core (general fund) budget (*Jordan Times* 2001, *United Nations Daily Highlights* 2001), but it remains to be seen whether this target can be achieved. UNRWA Commissioner-General Peter Hansen, while attempting to encourage greater Arab contributions, has frankly acknowledged that there is a limit: "As an internationalist, it is very good to see the Arabs come round, and many are now contributing" (Williams 2000). However, "Arab countries are not doing so badly. All the Gulf countries together do not have the income levels they had in 1973. In fact, their combined GNP is much less than that of Italy, and they are paying more. Half of them are meeting the UN capacity-to-pay rules. Fewer than half of Western countries are." (Williams 2000).

Other donors—such as the wealthier developing countries in Asia and Latin America, or transitional ex-communist countries in Europe—might also be tapped. By the UN scale of assessment, China, Brazil, and Mexico alone might

together be expected to contribute USD 10 million per year to the Agency. It is unlikely, however, that these donors could have a major long-term impact on the health of UNRWA's finances. Lower-middle income countries of this sort only represent around 9 percent of the global economy. Most still have pressing developmental needs, many have and few have relatively high foreign policy priorities in the Middle East. As a result, UNRWA's traditional major donors will likely continue to provide the lion's share of financial resources for the foreseeable future.

Donor Policy-making

In understanding the patterns, trends, and variations in donor support for UNRWA, it is important to go beyond simple aggregate data on donation levels and examine the processes whereby donors make decisions on allocating scarce ODA resources. In this process, political considerations obviously loom large—after all, the Middle East is a highly strategic area, and it is hardly surprising that patterns of development assistance reflect this underlying geopolitical reality.

In the case of UNRWA, the Agency is seen as providing essential services to a politically sensitive refugee population. Failure to provide such services could result in growing discontent, with ad-

verse implications for both host countries (notably the Palestinian Authority and Jordan), as well as for the broader search for Middle East peace. Moreover, after 1993, project support for UNRWA was seen as a way of providing tangible benefits from the peace process, and visibly indicating donor support for that process.

It is for this reason that UNRWA receives larger amounts per refugee than does UNHCR (and especially UNHCR programs in sub-Saharan Africa), and why the West Bank and Gaza Strip generally receive such high (per capita) amounts of international assistance. Not surprisingly, many countries close to the region are large contributors, and many more distant ones are comparatively less generous. Geopolitics may thus play a role in shaping Japan's (relatively weaker) level of support for the Agency—whose clients are rather distant from Japan, and who have only indirect impact on Japanese interests—and the relatively high priority assigned to the Agency in the American ODA budget.

It would be a mistake, however, to try to understand donor policies solely through the lens of geopolitical interest. The Nordics are far from the Middle East and have few overwhelming foreign policy interests there, but are highly generous donors. Domestic sympathy for the Palestinians may play a role. So too does the general public orientation

towards development assistance. In some countries (notably the U.S.), tight linkages exist between the determination of aid priorities and foreign policy interests. In other countries, however, the independent, developmental and humanitarian mandate of aid agencies may assume considerable independent importance.

Related to this may be the bureaucratic architecture of aid agencies. In some countries, aid agencies may be subordinate to foreign ministries, or UNRWA financed from foreign ministry budgets. In other cases, foreign ministries and foreign ministers may have no authority over aid decisions, which are the purview of another minister and ministry/agency altogether. The internal architecture of aid agencies may also affect the way in which funding decisions being made. UNRWA might be funded from a refugee budget envelope, a humanitarian affairs envelope, an UN/multilateral envelope, or a Middle East envelope.

In Canada, for example, most regular budget funding for UNRWA is provided not out of a Middle East envelope or by CIDA's bilateral Africa and Middle East Branch, but rather by the International Humanitarian Assistance (IHA) division located within the Multilateral Programmes Branch. As a consequence, funding for UNRWA has had to compete, in effect, with funding for UNHCR, the International Commit-

tee of the Red Cross, and other similar humanitarian agencies. It also means that UNRWA funding is seen in the first instance from the perspective of humanitarian need and the concerns with the cost-effectiveness of multilateral agencies, rather than with emphasis on broader, longer-term development programs in the region (the emphasis of the bilateral branch).

This affects both the dynamics of funding and the sort of perspective that relevant CIDA personnel bring to bear on the topic. Indeed, at one point in 1998-99, officials in the International Humanitarian Affairs branch recommended a cut to UNRWA funding, citing among other issues more important humanitarian concerns elsewhere. Officials in the Department of Foreign Affairs and International Trade lobbied hard against this, citing Canada's role as gavel-holder of the Refugee Working Group of the multilateral track of the peace process. In the end, only effective lobbying by Canadian representatives in the field—and a fortuitous visit to the region by the CIDA minister—transformed the proposed cut into an increase for the Agency.

In the U.S., UNRWA is financed not by USAID but from the Population, Refugees, and Migration (PRM) Bureau of the State Department. This probably heightens the impact of political considerations, and especially the review that

the delivery of UNRWA services plays an important role in regional stabilisation. PRM also tends to press UNRWA less forcefully on issues of administrative reform than do donor officials coming from within aid agencies: in the words of one State Department official, “[the Agency] does a pretty good job, an impossible job, in a [highly] politicised environment.”¹⁴ PRM has special expertise in and concern with, refugee issues. It also receives specific congressional appropriations for its activities, and does not fund other humanitarian emergencies out of the same resources. UNRWA's budget is thus quite secure within the Middle East sub-envelope.

In the UK, yet another model exists. There, UNRWA is financed by the Department for International Development (DFID), and specifically through its Western Asia Department. Unusually among donor agencies, DFID both produced and published a strategy paper on UK funding for UNRWA, entitled *Working in Partnership with UNRWA* (DFID 1999). This reflected a broader DFID policy of producing “institutional strategy papers” every three years for each major multilateral agency with which DFID works—and highlights the way in which broader donor operating procedures, unrelated to either UNRWA, Palestinian refugees, or the Middle East—may shape donor responses. In the

¹⁴ Interview with State Department official, December 2000.

paper, DFID identified three priorities for UK influence: helping to improve UNRWA effectiveness; helping to develop a productive relationship between UNRWA and donors; and helping to maintain quality services to refugees. It also identified three primary means to achieve these: providing timely and appropriate technical assistance; maintaining regular contact and other donors at a senior level; and increasing contributions to UNRWA's regular budget in tandem with "progress and confidence in its improved effectiveness." (DFID 1999). While not the only donor to imply a degree of connection between the pace of UNRWA administrative reform and increases in regular budget contributions, the UK statement is perhaps the most explicit form of such conditionality.

In the case of Norway, UNRWA funding flows from the "Support for Human Rights, Humanitarian and Refugee Assistance" budget envelope of the Ministry of Foreign Affairs. Norwegian policy stresses the provision of regular budget support for the Agency, rather than project funding.¹⁵ As with other donors whose contributions flow through MFA channels, Norway is sensitive to the political challenges facing the agency, is generally not perceived as one of those donors pressing hard for UNRWA administrative reform amidst difficult circumstances.

¹⁵ Interview with Norwegian Ministry of Foreign Affairs official, December 2000.

In recent years, UNRWA has become increasingly aware of the extent to which donors differ, and the role that personalities, budgetary and administrative architecture, and other idiosyncratic factors can play in shaping donors' willingness to contribute to the Agency. While the Agency has made progress in preparing donor profiles and similar reference materials to support their engagement with contributors, there remains more that it wishes to do in this area.

Conclusion: Looking Ahead

As final status negotiations approached and began in 2000, all parties began to think seriously about the future of UNRWA. Analysts discussed how the agency might be transformed or wound-down in the aftermath of a comprehensive peace agreement and resolution of the refugee issue. In the various talks that stretched from the Camp David summit in July 2000 to the Taba summit of January 2001, Palestinian and Israeli negotiators specifically addressed what was to become of the Agency. Donors too reflected on the needs of a potential transition.¹⁶

¹⁶ See, for example, the Palestinian Refugee ResearchNet Workshop on "The Future of UNRWA," Minister Lovell, UK, 19-20 February 2000, at <http://www.arts.mcgill.ca/MEPP/PRRN/prunrwa.html>. On the Taba negotiations and the refugee issue, see Akiva Eldar, "How to Solve the Palestinian Refugee Problem." *Ha'aretz* 29 May 2001; and *Ha'aretz*, 31 May 2001, both archived at <http://www.arts.mcgill.ca/MEPP/PRRN/papers/eldar.html>.

Today, the situation has become—tragically—very different indeed. With the collapse of the peace-process and the eruption of widespread Israel-Palestinian violence, no one serious expects a quick return to meaningful negotiations, foresees a political resolution of the refugee issue in the near future, or therefore contemplates the mutually-agreed wind-down of UNRWA. The Agency will continue, likely for years to come. However, while its existence is assured, its budgetary future is unclear.

The emergency in Palestine has created major new demands on the Agency. Closure and confrontation have complicated its efforts at service delivery in the West Bank and Gaza, home to over one-third of all UNRWA-registered refugees. Some projects have slowed or stopped altogether.

In the short term, donors have responded promptly and quite generously to UNRWA's emergency appeals. This reflects an awareness of the mounting challenges and needs in the Palestinian territories, and a fundamental confidence in the effectiveness and dedication of the Agency and its personnel. As many regular aid projects in the territories grind to a halt because of impossible local conditions, donors might well redirect otherwise stalled funds into UNRWA, seeing in it one of the few practical channels for the delivery of much needed development aid, social services, and

humanitarian assistance. This will be particular the case if the Palestinian Authority collapses, whether from fiscal insolvency, local chaos, or Israeli military activity.

In the medium term, however, donor fatigue may set in. With the current level of funding for the Palestinians linked to the peace process, donors may begin to slowly reprogram scarce ODA funds away from the Middle East and towards regions where developmental prospects are brighter, or where the path from war to peace seems more promising.

All of this is highly speculative, against a backdrop of great political uncertainty. Even leaving this aside, the long-term budgetary prospects for UNRWA do not seem bright for the reasons outlined at the outset of this chapter: the Palestinian refugee population is growing, and will continue to grow, while ODA funds will remain scarce and subject to multiple, competing claims. Local cost inflation will further compound this erosion of Agency resources. Efforts to broaden UNRWA's donor base might postpone the financial crunch, but they are unlikely to resolve this fundamental dilemma.

There are only so many ways of dealing with declining *per capita* funding for Palestinian refugees. There may be some gains in cost-effectiveness that

might be made, but these are limited. In general, it is not possible for the Agency to “do more with less”—rather, it can only do “less with less.” It can continue to trim away at all services, reduce their quality or availability, forcing refugees to either do without or make use of other (more expensive) service providers. It can make deep cuts in some areas, in the hopes of preserving others. It can narrow service availability by some mechanism (such as fees, means testing, or reducing the number of geographic locations offering key services). Or it can change its overall approach to key areas, whether by revising the nature of its partnerships with host governments, or changing its role in some more fundamental way.

What UNRWA’s response will be remains to be seen, for it is unclear that the Agency has developed a strategic vision of the necessary adaptations it may have to undergo in the future. Indeed, it is not clear that it *can* develop such an alternative vision (given the political constraints, and likely refugee or host country responses) or *wants to* (seeing it, appropriately enough, as the donors’ responsibility to offer such leadership—and bear the resulting political costs). But in the absence of such foresight, the likely result will be an acceleration of what refugees have already begun to sense—a gradual, almost inexorable, erosion of key social services due to a shortage of the resources needed to provide them.

It is unfitting future for an Agency that has worked so hard to meet the needs of its refugee clients. But at present, it is the future that seems to lie ahead.

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Chapter 6

UNRWA's Budgetary Process: Budgets and Expenditure 1990 to 1998

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Summary of Main Findings

In a complicated political environment, UNRWA continues to play a vital role in support of Palestinian refugees and ensuring the stability of the region. During the 1990s donor expectations of UNRWA (and other multilateral agencies) changed in light of the changing global political situation, the changing role of overseas development assistance and regional political developments (for example, the establishment of the Palestinian Authority in 1993).

The Agency's donor relationships in the first half of the decade were symbolised by "mutual suspicion". A lack of trust was both a symptom and cause of under-funding and the resulting financial crisis. Under-funding resulted in the need for austerity. Austerity measures involve stretching existing resources (for example implementing double shifts in schools) and cutting non-immediately essential

expenditure (such as building, maintenance, and training). Cutting programmes is generally not an option given the political and security implications of such a move. Certain sub programmes are more resistant to austerity measures than others; with education followed by health the most resistant, and common services the most likely to suffer as a result of deficit funding.

Five key factors have affected and continue to affect the level of trust between UNRWA and donors:

- The role of UNWRA in the changing political situation,
- stakeholder Participation in the UNRWA planning processes,
- transparency of Financial Management Systems

- accurate and timely data to inform UNRWA donor decisions, and
- donor funding commitment.

Despite the fact that UNRWA's role was defined by UN Mandate in 1948/49, a lack of clear consensus of the role of UNRWA today has undermined the planning processes of UNRWA. Agreement on the quantity and quality of services to be delivered would provide clear benchmarks from which to assess performance and support funding requests.

Uncertainty about UNRWA's role (relief agency, development organisation or proxy government) creates a lack of clarity in objectives, funding criteria, accountability and modus operandi. Moreover, the historic UNRWA mandate and huge symbolism that the Agency continues to have to refugees limits the willingness of stakeholders to engage in discussions about resource allocation.

There is a widespread feeling that neither donors, civil society organisations nor refugees have had the opportunity to participate in UNRWA decision-making and resource allocation processes. Thus, further steps are required to increase and broaden stakeholder participation in UNRWA strategic and financial decision making processes. This type of participation has the potential to become a tool of refugee empowerment and address

donor calls for greater accountability. Greater involvement of citizens requires building their capacity to participate and knowledge of budget issues.

Programme-based budgeting and financial management system reform is widely perceived to have resulted in the better presentation of financial data and more thoughtful preparation of budgets. However, it has had little real impact on the ground.

In addition, establishing trust between donors and UNRWA is dependent upon building confidence that the Agency's strategic priorities are informed by accurate and timely data, collected in an inclusive process of stakeholder engagement. UNRWA has recognised this weakness, and positive steps have been taken to strengthen the capacity of the PMU. Further steps are required particularly in making UNRWA more inclusive to other agencies.

The uncertainty surrounding funding has undermined reform processes. A multi-donor commitment to support UNRWA on successful completion of certain clear and verifiable performance targets is a necessary step.

It is widely accepted that UNRWA has, over the course of the last decade, made positive advances in the presentation and transparency of financial issues. Additionally, UNRWA has shown an

increasing willingness to improve the efficiency of technical service provision programmes, control costs and enter into dialogue with donors. However, reforms, whilst well received, are viewed by many as donor driven and superficial. Further progress will depend upon (1) a greater degree of clarity and consensus of stakeholder expectations, (2) increased stakeholder participation, (3) increased internal ownership of the reform process, (4) further investment in developing an inclusive research capacity, and finally, (5) a clear multi-donor commitment to UNRWA.

UNRWA Budgetary Processes 1990 to 2001

Introduction

The aim of this chapter is to capture relationships between the internal financial management systems (including the budget mechanism), the external funding environment, and the impact that this has on the UNRWA programme.

The research principally involved interviews with key stakeholders within UNRWA, in the donor community, in civil society organisations and representatives of the Palestinian Authority. Sources of data for this analysis include data provided by UNRWA and donors for secondary data analysis.¹ The extent

of primary data collection, particularly of a qualitative nature among refugee groups, has been limited. It is recognised that, in linking the budget process to impact, this is a weakness.

UNRWA Financial Reform

After 1989, and the collapse of communism, the whole rationale for overseas development aid budgets changed dramatically. As the role of aid in the new world order evolved, so donors became increasingly interested in the efficiency and effectiveness of aid flows. By the mid-1990s, once bilateral programmes had been reviewed, huge international attention focused on multilateral agencies. The wider UN family responded to these pressures by encouraging change in the financial management of agencies. Among these changes was the shift to the use of programme-based budgets (PBB) among its organisations. This, it was hoped, would present greater transparency to donors, aid internal management and make explicit linkages between expenditure and outcomes (rather than focusing on line items of expenditure).

UNRWA, like other UN agencies, increasingly came under pressure to display value for money. Following the 1993 Oslo peace accord, UNRWA also had to compete for donor contributions with other regional demands (the Palestinian Authority). Subsequent donor attention and under funding led to

¹ I would like to acknowledge the complete co-operation of UNRWA staff throughout the study period, 2-13 July 2001.

Box 6.1: The Budgetary Process

A budget is merely an allotment of monetary values to a plan of action. Budgets can be prepared at a variety of different levels, and form cascading interlocking mechanisms. Like any tool if used effectively it can be helpful and if used poorly it can be counter productive. The budgeting process, or the way in which the tool is used, is therefore of greater significance than the tool itself.

The budgeting process involves both planning and control dimensions. The starting point of an effective budgeting process is usually a strategic goal or objective.

To decide how best to achieve the desired outcome, alternative courses of action are identified, and data and information gathered to permit an informed decision of the most appropriate course of action. At this stage, resource constraints, strengths and weakness vis-à-vis challenges and opportunities presented by the external environment become key factors. Risk factors further affect decisions.

In order to manage the implementation of the chosen option, costing of planned activities is a useful tool. Its value relies heavily on the quality of information available and its value upon the way in which it is compiled, presented and disseminated.

Key to this is the need to ensure that a budgetary process is dynamic, inclusive and comprehensive. This involves constant monitoring of budgets and analysis of variances from expected amounts. This control function minimises risks of actual expenditure being very different to budgeted expenditure. At the most basic level it can provide a stimulus for management to ask why variances have occurred and what can be learned. An active response to the changing external environment and responses to the analysis of financial data provides the basis for sound financial management.

Budgeting in a nonprofit environment carries additional challenges over commercial organisations in that outputs are not measured in monetary terms. As a result the tendency is to focus on inputs (expenditure). Programme Based Budgeting (PBB) attempts to reconcile this link between expenditure and accomplishments. PBB fits more purposefully into the long-term planning process of an organisation. Once objectives and choice of alternatives have been agreed it is possible, but extremely difficult, to rank the options on a cost/benefit basis. The number of options undertaken is determined by income.

deterioration (“mutual frustration” and “hostility”²) in the relationship between UNRWA and donors.

In December 1998, a meeting was held in Montreux, Switzerland, in an attempt to identify and address the key concerns of donors and UNRWA. This meeting coincided with an internal process of financial systems’ reform instigated by UN-wide change and institutionalised by UNRWA’s Management Committee in September 1998. This was operationalised by the *budget task force* in November of the same year. At the centre of this reform process was a shift to programme-based budgeting and a major overhaul of the financial management system.

The shift, culminating in UNRWA’s first programme based budget in the biennium 2000/2001, was driven by the need to:

- Enhance the usefulness of the budget as a management and fund-raising tool, and “a means to allocate scarce resources to best meet the needs of Palestinian refugees”,
- enable managers to know full costs of activities,
- involve senior managers more fully in budget preparation and link budget allocations to goals,

² Internal donor communication

- facilitate fund-raising by making stronger arguments to donors, and
- enhance transparency by directly linking requirements to programme activities, and clearly showing what those programmes actually cost (UNRWA 1998a).

While the underlying principles of the budgeting process have changed significantly (Annex 6.3) the timing of the process remains fairly consistent. A recent study by Deloitte and Touché outlines this framework in Box 6.2. The following section describes the budget cycle from the establishment of organisational priorities, the identification

and costing of activities, to the passing of the budget at the United Nations' General Assembly. It will also pursue the process into the implementation phase as the funding situation evolves and austerity measures are implemented.

Strategic Priorities

In December and January of the year preceding the start of the budget period, UNRWA's management committee established a series of planning assumptions and key strategic priorities.³

The *budget coordination committee* is entrusted by the management committee to take the budget process forward. This entails reviewing programmes of work, planning assumptions and key performance indicators to ensure they are in line with the overall objectives, and overseeing the budget preparation process. This committee replaced the budget task force that helped steer the budget process during the first programme-based budget cycle.

Strategic priorities and assumptions are presented in the *budget preparation instructions* and circulated to the five fields in the early part of the year. Additionally, the instructions provide clarification of the budget process and the information

Box 6.2: Summary of Budget Procedures, 2001

Phase 1: Planning

- Setting Goals and Objectives
- Preparing Budget Instructions and Assumptions
- Preparing Programme of Work and Priority List

Phase 2: Preparation Stage

- Preparing Project Budget at the Field Level
- Preparing Budget Estimate Sheets for Regular Budget at Field Level
- Preparing Manning Table Agency Wide
- Adjusting Estimates and finalising Budget

Phase 3: Implementation Stage

- Certification of Funds and creation of Obligation
- Creating Budgets for Funded Projects
- Releasing Funds for Justification reserves
- Translating Funds among Object Codes and Programs
- Usage and procurement Budget
- Monitoring Expending on Budgets and Generating Periodic Reports

Source: Deloitte and Touché 2001

³ The UNRWA budgeting processes fell in line with other UN agencies and became biennial in 1992, prior to 1992 budgets were conducted annually

requirements of the budget division (Box 6.3).

Over time, these priorities and assumptions have reflected the reality of uncertain income streams and changing refugee needs. (Box 6.4 shows examples of these strategic decisions over time.) The claim that budgets have been need driven is hard to substantiate due to little historic emphasis on outcomes in the budgeting process. A lack of clear expectations concerning standards and scope of service delivery on the part of UNRWA is evident. It follows that such assessments are at best difficult.

As funding has tightened and greater emphasis has been placed on the value for money, it is widely perceived that UNRWA's programmes have become increasingly lean. The common perception is that waste and excess within UNRWA has been reduced, and at the same time, that there has been deterioration in the quality of UNRWA services. UNRWA's current budget could be described, therefore, as a pragmatic assessment of likely need and income.

Like many organisations, particularly public sector service providers, UNRWA fights a constant battle to satisfy growing needs with limited resources. In addition to the prioritisation, pressure to utilise existing resources more effectively clearly exists.

UNRWA decisions reflect cost/benefit analysis of activities, sub-programmes or programme's vis-à-vis other competing demands. Such assessments appear to be made principally by the three Programme Directorates. Whilst the shape and detail of the programme has clearly evolved over time (often in collaboration with UN agencies such as UNESCO and WHO), reflecting changing assessments of priorities, staff refer to certain areas of activity as "untouchable". Security and stability concerns mean that any substantial change in UNRWA policy, particularly a cut in services, needs to be taken at the

Box 6.3: Extracts from Major Planning and Budgeting Assumptions 2002/2003

General:

- Non-staff costs based on current programme level
- Expansion of or additions to regular programme through project funding only
- No increase in admin cost, travel budget
- All capital expenditure items budgeted in projects budget.

Programme Specific:

- Triple shifting in schools to be avoided.
- Construction and equipping of schools only through project funds.
- Health Additional staff posts to respond to increased demand, change in morbidity and counter historic zero growth of staff. Current staff levels maintained in Environmental Health
- Social worker training to increase by 10 percent
- Number of social workers to increase by 8 in 2002 and 9 in 2003
- No increase in fleet size.
- Increase in maintenance budget to "reverse deterioration of built stock".
- No increase in admin costs over previous biennium.

very highest level of the organisation, normally in dialogue with donors and local host countries.

Prior to the first programme-based budget process in 1999, relating to the Biennium 2000/2001, budget-ceilings were in place. These ceilings were based on the previous year's ceiling adjusted by a growth factor based on inflation, population growth, and the changing needs of the refugee population. UNRWA Headquarters established this ceiling centrally with resources allocated at the field level within these established parameters. At this time field management had considerable latitude to manage funds as it saw fit. Prioritisation was very much a local management decision made in the light of personal judgement. As the funding crisis worsened and the political situation became ever more volatile, so was the scope for local decision-making reduced. More and more decisions had to be referred to central officers.

Operational Priorities

At the field level, the budget preparation instructions are passed to the Field Directors. The Field Directors coordinate the field contributions to the UNRWA budget during a six-week period (March to April). However, in practice, it is the Field Finance Officer who coordinates the process and establishes a local timetable for the process at this level.

This normally occurs in collaboration with the Field Programme Chiefs. The Chiefs, in turn, consult with Programme Directors in the Agency's Amman Headquarters to ensure that the activities and programmes outlined are consistent with the overall programme aims of UNRWA (and to share information).

Each year a meeting of the five Field Programme Chiefs (West Bank, Gaza, Lebanon, Jordan and Syria) is held during which changing circumstances and challenges facing the different fields are the main topic. Within this context, the

Box 6.4: Examples of Key Strategic and Operations Priorities made by UNRWA

1982: UNRWA stopped issuing food and relief to all refugees, now targeted to only special hardship cases identified by social workers. (Criteria no male 19-60, female headed household, over 60, in prison, etc.

1994: Mental health programme stopped. "management decisions to drop it" given focus of programme (clinical rather than community based), cost benefit analysis said better off linking with host government programmes.

1995: Supplementary feeding dropped in consultation with external agencies to ensure that the action would not cause great hardship and could be picked up by other agencies.

1999: In response to the need to align UNRWA salaries with host government terms and conditions and to reduce costs, UNRWA salaries and terms and conditions were reduced. This has led to difficulty in recruiting and keeping hold of quality staff.

1998. Free distribution of prosthetic devices restricted to children and those who need the aids to work (this means no hearing aids/ glasses for OAPs).

priorities for the three main programmes (health, education and social services) are agreed upon. UNRWA staff participation in host country bodies helps to inform internal debate on macro policy issues at the field level. Information from lower down in the organisational hierarchy feeds into the budget/needs prioritisation process on an informal basis. One Field Education Chief, for example, described how regular meetings and seminars with teachers; area education officers, school head-teachers, throughout the year, provided him with a good perception of the challenges and needs of the programme on the ground. In general, however, staff on the ground appear to have little control over resources, “we don’t manage budgets, we get staff, we get medicines. *Khalas (That is it)*”.

Similarly, civil society organisation and refugee representatives’ involvement appears to be on a very informal basis — with much depending on personal relationships with UNRWA staff. While civil society involvement is considered to be small, one NGO active in the region felt that UNRWA’s willingness to involve such organisations in planning had dramatically changed for the better since the start of the present *Intifadah* (September 2000).

Prior to 1999, budget ceilings were strictly imposed by the central finance department, but fields were allowed more

freedom in the way in which those allocations were then spent. Since the start of programme-based budgeting, the view is widely held that there is much more involvement of technical field staff in budget preparation, but less scope once allocations have been made. The more proactive and supportive role of finance personnel during the budget preparation stage is viewed as constructive and helpful (with finance staff visits to the field particularly well received). Nonetheless, some staff question the process’s value. Given the high proportion of costs being salaries and the “relative continuity in programme activities over time” (UNRWA 1998a), there appears to be little to decide. In the 1998/1999 biennium salaries accounted for 77.6 percent of total expenditure and are predicted to account for over 70 percent in the 2002/2003 biennium.

For some, increased participation in planning has meant more ownership. The process itself has also encouraged staff to think through and question their programme “now we use minds to think through the process”. However, the move to programme-based budgeting has come with special challenges. The change was described by one staff member as “difficult” for both budget and technical staff. In order to smooth this transition, a series of in-house training programmes and seminars were designed to help educate staff. Nonetheless, frustration with tighter central control of costs and

the apparent hopelessness of the funding situation has eroded the positive impact of this staff education effort.

Table 6.1 displays budgeted expenditure by sub programmes in the 1990 and 2000 financial years. A comparison suggests that the shape of the UNRWA programme has remained fairly consistent over the decade with very little difference in the prioritisation of resources by sub programme.

Costing

Costing programmes in each of the five fields occurs once priorities are set and programmes outlined. This process consists of a detailed assessment of standard costs or norms. Each activity is broken down into basic inputs, and to each input is attached a norm. These norms are reviewed each biennium to ensure that they are realistic. The review involves both field staff and headquarters' budget staff, with some consultation with schools, clinics, and so on. Proposed norms are agreed upon with Programme Directors and issued in the form of a series of *budget technical instructions*. The instructions are produced for each of UNRWA's sub-programmes. Many of the agreed norms can be benchmarked against established international norms (for example, UNESCO educational standards). Appendix 6.3 provides an example of norms used by UNRWA in the course of costing activities. A

Table 6.1: Comparison of Sub-programme Significance. 1990 and 2000.

	Budget YE 31/12/90	Budget YE 31/12/00
Education		
Programme Management	0%	2%
Elementary	29%	28%
Preparatory	17%	18%
Secondary	0%	0%
Vocational Professional Training	4%	4%
Other	2%	0%
subtotal	52%	54%
Health		
Programme Management	0%	1%
Medical	12%	12%
Environ. Sanitation	3%	3%
Other (Nutrition/Supp. Feeding)	0%	2%
subtotal	15%	18%
Relief and Social Services		
Programme Management		0%
Relief Serv.		9%
Social Services Other		1%
Sub Total	12%	10%
Protection and Emergency Services		
	0%	0%
Income Generation		
	0%	0%
Operational Services		
Supply and Transport	5%	4%
Architect and Engineering Serv.	2%	1%
Self Support Units	0%	0%
Sub Total	7%	5%
Common Services		
General Management	5%	5%
Administration	8%	8%
Sub Total	13%	13%
Total General Fund	100%	100%

better indication of the detail contained within these estimates is given in Appendix 6.4, where each of these figures is broken down into an extraordinarily detailed assessment of standard usage and unit cost.

A *budget estimate sheet*, compiled by programme administration staff, is produced for every activity centre (Appendix 6.5). After review by Field Directors, completed budget estimate sheets are sent to Agency Headquarters' budget division for approval. Discrepancy, both above and below established norms, has to be explained. Any suggested amendments are communicated by the issue of a *budget review note*. This is communicated to the Field Director and to Programme Directors, and is the start of a process of dialogue and negotiation between the field and headquarters. Agreement will be made in consultation with field staff within context of last year's norms. While it is stated that there is no ceiling to the budgets, historic data is used as a base-line to assess the appropriateness of budgets, with staff referring to the implicit existence of no growth policies.

A *budget hearing* takes place at the field level to finalise field-wide budget submissions. Inevitably, programme "requirements" exceed notional budget limits. When this occurs "budget hearings" are held with Programme Chiefs. At the hearings, Programme Chiefs are encouraged to reduce requirements to a

"minimum". Appendix 6.5 shows an adjustment made as a result of a budget hearing with reduced cost estimates.

At present, while budgets are produced at the activity-centre level, it is unlikely the new financial management system will record expenditure in this detail. The new system has the capacity to do this, but the cost effectiveness of doing so is questioned. One of the key questions is the extent to which costs are apportioned to specific activities. While the allocation of costs is recognised to be of value, there is concern that apportionment will be costly, arbitrary and with little practical advantage. It is likely that reports will be produced at the area level.

Presentation

The way in which the budget is presented is crucial to its success. Within the UNRWA context, two key factors have affected the presentation of the budget. These include (1) the shift to a programme-based approach and, therefore, the emphasis on programmes and sub programmes rather than expenditure items and, (2) the differentiation between general fund and project activities, and the subsequent presentation of a unified budget.

Whilst the shift to a programme-based budgeting system suggests a major change in approach, there are some

within the organisation who see the reform process as superficial:

“In a certain way it doesn’t make a difference — the new budget is merely a different presentation of the old budget.”

From this view, the old budget presented as expenditure lines has merely been apportioned or repackaged to programmes. In a similar vein, there are those who see the significance of salaries as being a major factor limiting the extent to which programme-based budgeting can bring about meaningful change in the budget process.

Despite costs being calculated at the delivery-unit level (schools, hospitals), budgets are presented only at the programme and sub-programme levels. For example, budgets are formulated for elementary, preparatory and secondary education. Although the new financial management system has the capacity to record and analyse data down to the smallest cost centre, the decision to do so will be based on an assessment of costs and benefits.

Increasing donor demands for greater accountability and transparency, and the internal shift to a programme-based budgeting system have increased the focus on “projectised” activities within UNRWA’s portfolio. In the latest budget, all construction over USD

50,000 is projectised and excluded from General Fund estimates. Effective as of the biennium 1998/1999, income generation activities were also removed from the General Fund and treated as a self-financing entity. Indeed, taken to its logical conclusion, programme-based budgeting is effectively the separation and parcelling of individual activities or programmes of activities. This allows greater scrutiny of costs and benefits. It also, theoretically, results in a better assessment for priorities. During the 1990s, however, projects peaked at 27 percent of total UNRWA expenditure, but stood at only 7 percent at the year end of 2000.

Proposals for project funding are raised at the field level in collaboration with programme chiefs.

“Currently, projectising is not made to the core general fund activities. It is mainly used to fund nonrecurrent type of items such as constructions, comprehensive maintenance etc. Very little of projects deal with recurrent items unless there is a long term commitment by the donor.” *Interview*

Field Directors prepare a prioritised list of projects and present them to the *project review board*. Prioritising projects is an “excruciating task” with the review board having to “choose between diverse but equally worthwhile causes”. External Relations take a more pragmatic approach, and classify the various projects

according to field and technical area to appeal to donor's priorities and funding preferences. While projects are more attractive to donors because they are finite, allow external auditors to scrutinise expenditure, and can be clearly identified with a particular donor, they are resource intensive exercises for UNRWA.⁴ The identification, development and presentation of project proposals are widely recognised by UNRWA staff as an unnecessary burden. Equally significant is the fact that projects, even when funded, can be delayed. This affects the delivery of the wider UNRWA mandate. Unless donors share a long-term commitment to supporting projects, there are likely to be serious implications for the Agency's ability to fulfil its mandate in the future. There is risk that projectisation of activities is perceived as denoting secondary nature to the core General Fund activities.

UNRWA is increasingly keen to stress linkages between projects and General Fund activities - a move culminating in the presentation of a unified budget for the next biennium. Some senior UNRWA managers are unconvinced that this will result in a positive donor response. Concerns have been raised among donors regarding the sovereignty of project activities as a result of questions raised about whether or not projectised or earmarked funding had been used to underwrite general fund activities.

Donor Consultation and Pledging

Although informal liaison with donors is ongoing, formal meetings only became a reality in 1998. In recent years, regular meetings held in the region (in May and September each year) have addressed key issues of the day. In the course of recent meetings, proceedings have been dominated by discussions of the reform process and updates on UNRWA's financial position. The September meeting preceding a new budget period will be presented with the completed budget to be submitted to the UN General Assembly the following month. In recent years, this meeting has also been the setting for donor analysis of UNRWA figures and an evaluation of urgent funding needs.

This year for the first time a donor meeting was convened in July. It was organised in direct response to donors' desire for greater involvement, earlier in the budget process. This meeting presented details of the Biennium 2002/2003 budget to donor partners.

In December prior to the budgeting period, a pledging conference is held in New York. At the conference, donors pledge funds to UNRWA to meet the needs of the approved budget. Over recent years, funds amounting to only 25 percent of the budget total are pledged at this time. Whilst this is an important event in the calendar, the informal dialogue that occurs with key donors is considered to be of greater significance.

Informal consultation with the USA and conventions with the EU provide greater assurances of funding than the “staged” New York session. Additionally, many donors give informal assurances that future payments will not be lower than last year.

Allocation

After the approval of the budget at the UN and funding implications from the pledging meeting, budget allocations are made to the five fields. Allocations are likely to be less than the approved budget. This provides a further check and control mechanism on expenditure with authorisation required from UNRWA Headquarters for the purchase of certain items. Headquarters makes sure that money goes to planned purchase and not to any other. The creation of a *Justification Reserve*, of approximately 10 percent of the total budget, is one mechanism by which this process is managed. Drawing from this reserve requires permission of Headquarters’ finance staff. Finance staff view this as a means to “ensure budgetary discipline” and efficiency, but others perceive it differently, “HQ tries to cut, not to help”. Allotments to fields and programmes are made with the strict understanding that all expenditure should be justified and subject to scrutiny - whether approved or not. This represents a major cultural change from the days

when “fields could do anything as long as they keep within ceiling”.

The increasingly active role of Headquarters’ finance staff (in technical issues) is noted widely. This role includes both constructive engagement in issues of allocation and control functions. Indeed, the firm control that Headquarters’ finance is perceived to hold over expenditure is perceived both as “restrictive” and in the same breath “pragmatic and realistic” given the funding situation.

Allocation decisions are further complicated by changing external factors. Two of the most serious are the rapidly evolving political situation (particularly since the start of the current *Intifadah*), and changes in host country policies. UNRWA is committed to ensure consistency in education and health provision with host countries. Recent curriculum changes in both Jordanian and Palestinian Authority schools have resulted in considerable demands on the UNRWA programme. For example, last year Jordan extended the compulsory teaching of computers and English to first grade students. For those actually delivering services the reality is often even more stark. The much centralised UNRWA supply system and lack of financial control at the activity centre level means that, for example, schools and health centres are entirely dependent upon UNRWA for continuity of supply. This can clearly disrupt service provision.

Income

UNRWA can predict likely income levels with some degree of accuracy based on honoured pledges and informal dialogue. While certainty of income is unlikely until the end of the third quarter, a relatively accurate prediction of funding can be made much earlier, perhaps even prior to the financial year.

As UNRWA is not in a position to borrow or raise money, expenditure cannot exceed income raised. Expenditure is, therefore, bound by the level of donor contributions. It is not just the actual amount of money raised that creates challenges for UNRWA management, however, but also the timing of donations. The most acute impact on Agency operations is caused by the uncertainty of cash flow. This uncertainty is a result of both timing and exchange rate fluctuations. For example, the response to the recent *Intifadah* was slower than hoped due to the lack of working capital to bridge the time necessary to receive donor funds.

Interest in alternative funding sources has increased as a result of constraints on activities from donor income. Increasingly, for example, funding constraints have encouraged UNRWA to seek contributions from refugees: In 1997, refugees were asked to contribute to the education programme by paying school fees. The plans were made with little consultation and were

met with strong resistance. Great sensitivity to such proposals exists, with some seeing the provision of services as a right. Any attempt to diminish that right is viewed as an attempt to compromise the status of refugees.

Despite this sensitivity, steps have been successfully taken to increase refugee contributions to UNRWA services. Most basic health care is offered free of charge (primary health care, family planning, antenatal care), but some other health services are not. For example, individuals pay 40 percent of hospitalisation costs, 70 percent of costs for community-based rehabilitation programmes for disabled come from the community, and pupils are no longer provided with school meals, books or clothing.

Monitoring and Financial Information

The current financial management system at UNRWA focuses on recording cash expenditure. As a result, relevant data on outputs and outcomes are lacking. Even expenditure data is unlikely to offer accurate and timely insights (Box 6.5). Growing mistrust between donors and UNRWA during the 1990s was flamed by this weakness. Internally also, management has not been given the information they need.

“Under the Biennium Budget 2002-3, and as part of productivity improvement and efficiency enhancing mechanisms, a computer-based Budget Preparation System is being tested by users for redeployment in May 2001. It will accelerate the shift from “object expenditure” to budgeting to “programme budgeting” and enable tracking through the Budget Monitoring System. Periodic performance will be assessed against the key performance indicators.” *UNRWA 2001a*

The design and implementation of key performance indicators will make a major contribution to establishing the link between input and outcome. The implementation of the new financial management system, while delayed, will, it is hoped, make the ongoing analysis of expenditure and output data a reality.

Some within the organisation raise the issue of capacity to manage this information. They warn that “we (UNRWA) should not be slavish and produce information for its own sake”. The ability of UNRWA to use and analyse information positively needs to be enhanced to avoid information overload. In the existing system, expenditure is reviewed against agreed upon budget estimate sheets. This occurs on an ongoing basis while budgets are reviewed and modified in the light of income on a quarterly basis (KPMG 1999). This assessment of expenditure against

income determines the need for austerity measures.

Box 6.5: Financial Systems Reform

Since 1998 UNRWA has embarked on a process of financial management system reform. Partly funded by DFID this reform process aims to upgrade the existing system to “prepare more transparent reports for donors and management” (KPMG 1999). The existing IFIS system is basically a cash accounting system that “cannot easily be interrogated”. It is also increasingly difficult to support. The large number of databases operated within this system creates “lags and scope for errors”.

Reform aims to “shift its (UNRWA) management and accounting focus from controlling expenditure at levels defined by historical precedent to measuring consumption and the quality of expenditure on outputs in terms of meeting refugee needs” (KPMG 1999). This involves switching from a modified accrual basis (income being recorded on a cash basis and expenditure on an accrual basis) to an accruals system of accounting. Accounts receivable and payable and fixed asset ledgers will be added to the general ledger capacity. “The most important changes that are required to the existing system are the upgrading of the FMS so that it provides complete, accurate, reliable and timely data on budgeted and actual income, expenditure, assets and liabilities... and an overarching management information system.” (KPMG 1999).

While the process of introducing the new management information system is well underway the transformation is behind schedule e.g. it was hoped that the new budget module, would be used in this biennium’s budget process. It however went online on 1/7/01 in the hope that it would be fully operational by the start of 2002.

Further work is being funded by DFID to establish Key Performance indicators to allow meaningful interpretation and monitoring of UNRWA’s performance. Additional support has also even provided in recent years to tighten procurement

At the field level data is collected on daily feedback forms (for example recording the number and type of patient seen at health centres). However, UNRWA staff have seen little evidence that this information is being used for planning. It is hoped that programme-based budgeting will make use of this information in the future.

Austerity

Since 1991, the Agency's income has failed to match budgeted expenditure and UNRWA has been forced to restrict planned expenditure levels and activities. This has become a regular event, and managers appear to have accepted the necessity of implementing austerity measures as part and parcel of the job. In addition, cash flows and host country policies also present management challenges within an uncertain funding environment. Decisions about what to cut and what not to cut are clearly taken based on professional judgement and managerial skill:

“We (UNRWA Managers) are clever enough to save here and there. We can manage but with difficulty.”

An informal assessment of “soft” areas identifies typical items that are earmarked for cost saving (training, maintenance, the purchase of new equipment). For other “harder” areas, UNRWA will attempt to stretch existing

resources but cutting services does not appear to be an option.

Community participation in such decisions does not appear to be widespread. Although, there is some evidence that communities have an informal role in resource allocation decisions. In one case, a community had been active in support for a new maternity unit. Local UNRWA staff felt that a dental unit would have greater value and talked through the implications with local people. On a more immediate level some medical staff felt very little control over prioritisation processes reflecting the stark operational reality of deficit and poor cash flow “if stocks don't come we don't distribute and take criticism”. One doctor commented that “doctors are able to diagnose, but not treat.”

Among staff, there is an increasing level of frustration in the fact that cost cutting measures are slowly undermining the longer-term ability of UNRWA to meet the needs of refugees and diminishing service quality.

“So far, there are no other cuts in services than the erosion of the quality that is caused by having more and more children in each classroom, more and more patients for each doctor every day, and generally having fewer social workers per number of families. These kinds of “reductions” are erosion of quality rather than it is a reduction in the quantity of services.” *UNRWA 2001f*

While the rationale for cost cutting and stretching resources is recognised among staff, frustration with the “capacity but not the financial wherewithal” to fulfil their mandate exists. Tensions between central finance staff (who insist on cost cutting) and programme staff (who must explain falling standards to refugees) are evident. There is also a clear frustration with the fact that austerity measures have become an annual event — regardless of the impact on service quality and progress in financial reform and efficiency.

An assessment of the impact of under funding on the shape of the UNRWA programme can be drawn from Annexes 6.6, 6.7, and 6.8. Annex 6.6 shows budgets and actual figures by sub programme since 1990. Note that some columns are displayed in calendar years while others are shown as biennium. In 1990, the actual expenditure exceeded the budget by 1 percent. From 1991, however, actual expenditure fell below budgeted expenditure as a result of under funding and austerity measures. The difference between actual and budget peaked in Biennium 1996/1997 and 1998/1999 where actual expenditure fell to 78 percent of the approved budget. Within this context, certain sub programmes appear to have been better able to resist austerity measures. Elementary education, for example, remains strong in the face of under funding. For this subprogram expenditure never falls

below 95 percent of the budget level. Medical service provision, the biggest of Health’s sub programme is similarly resistant to change with actual expenditure dropping only once below 90 percent of the budget figure. This simple analysis does not reflect sub programmes expenditure relative to total expenditure.

Annex 6.7 shows expenditure by sub-programme as a percentage of the total UNRWA programme. The *difference* column displays the change in significance of sub programmes to the programme as a whole. Those with a positive difference are clearly those most resistant to falling income and austerity measures while those with a negative change are clearly those earmarked to take relatively more of the funding cut. While education in particular shows positive differences and health maintains its significance, common services and to a lesser degree Operational Services reduced in significance to the programme as a whole. In biennium 1996/1997, actual expenditure on common costs was only 10 percent of the total General Fund expenditure. This represented a dramatic decline in its significance to the programme as a whole. Annex 6.8 assesses management costs as a percentage of General Fund expenditure and total expenditure (General Fund and Projects) and confirms the reduction in management costs from 22 percent of General Fund expenditure at year end

1991 to only 13 percent of General Fund expenditure in biennium 1998/1999.

Analysis of the UNRWA Budgeting Process

Impact of Reform Process

This section of the report aims to put the changes in budgetary approach and financial systems within the context of the wider planning process. It draws on stakeholder perceptions of the process that has been undertaken in the last five years, in particular, to provide a deeper understanding of the planning process within UNRWA.

This study has not included substantial consultation with refugees. This fact, plus the complexity of the environment make the establishment of causal relationships between financial reforms and impact on programmes and ultimately on refugees very difficult.

It is clear from the research that there is a general recognition of the hugely valuable role that UNRWA plays in what are extraordinarily challenging conditions. Donors expressed their “highest respect” for UNRWA’s work recognising that “UNRWA offers incredible value for money”. There is little question that UNRWA has “cut much of the wastage that was so obvious 10 years ago”. There is almost universal evidence

to support UNRWA’s proposition that austerity measures over a number of years have resulted in them being “beyond the bone” with morale internally suffering. One representative of a local civil society organisation observed UNRWA’s “now impoverished facilities, doctors fatigued, nurses cynical”.

Views on the financial reform process vary enormously both inside the organisation and externally. While many see UNRWA as becoming more transparent over the last 10 years, and particularly the last five, with a better-presented and researched budget and tighter cost control, there is a significant perception that it is too early to judge the impact of the reform process. The response from within the UN family, however, appears unequivocal

“The Committee welcomes the changes made to further improve the format of the budget, better integrating the programmatic aspect with the narrative supporting the presentation of the financial requirements of the Agency. The Committee believes that the changes effected have considerably improved the quality of the document, presenting in a more transparent manner the resources required, the programmes involved, and the results to be achieved with those resources.” *UNRWA 1999*

The significance of the additional narrative component to budgets is viewed as a positive move, as is the

establishment of a clearer link between resources programmes and objectives. Donors feel more confident of what they are being asked to fund. On the control side, the improved management information at the sub-programme level and prospect of information at activity centre level is clearly welcomed. Additionally, managers appear more confident that information provided is accurate: “We know better what is coming in and going out”.

One staff member noted that the reform process had given him “increased confidence that as managers we are only asking for what we need”. The move to programme-based budgeting had also “forced the Agency to crystallise its thinking ... (it was a) really useful process”. There is evidence that the second programme-based budgeting process for the biennium 2002/2003 is more thorough than the first. While support of the reform process, in theory, was complete, there are those who in practice feel its impact is limited. “Although in theory we have programme-based budgeting, in reality we still operate quotas.”

Constraints imposed by the way in which the reform was instigated, the already lean nature of UNRWA, the perpetual funding deficit were felt to have undermined its potential value. Indeed many saw the changes as “cosmetic” or “window dressing” with key

reforms addressing symptoms rather than causes.

Additionally, a feeling exists amongst staff that the reform process has been forced on UNRWA (few donors would disagree with this). A consequence of this is that the reform lacks ownership internally. Clearly this has implications for the sustainability of the reform process. For some, the impact of austerity measures over the years has restricted the ability of UNRWA to participate and benefit from reform.

Four dimensions are identified as crucial to an effective UNRWA budgeting process: (1) UNRWA’s mandate and the political situation, (2) participation and ownership, (3) transparency and accountability, and (4) openness or inclusively.

The Political Environment and Mandate

Central to all discussions about the allocation of UNRWA resources, programme priorities and future direction is the organisation’s mandate and the complexity of the political situation in the region. The sensitivity of UNRWA’s role undermines the willingness or ability of stakeholders to openly debate these issues. A lack of clear vision of how the organisation’s mandate might evolve in the future also clearly affects the ability

of stakeholders to engage in present policy discussion (Schiff 2000).

UNRWA has huge symbolism to Palestinians as a statement of their right to return home (Bowker 2000). This symbolism limits the willingness of refugees to engage in resource allocation issues (BADIL 2000). The potential impact on regional stability of cutting programmes is widely recognised. Thus, debates crucial to the budget process are difficult to instigate. Indeed, there is a tendency to view discussion of resource prioritisation issues as a sign of weakening support for refugees' rights.

While donors share common understanding of UNRWA's role on some levels, their views also reflect specific interests and knowledge of the Agency. The lack of clarity and consensus (even amongst donors) about UNRWA's role today, as opposed to the Agency's role in 1948, is central. The extent to which UNRWA is viewed as a relief or development organisation varies greatly, with some seeing it as fulfilling the role of a quasi government or public sector provider.

As a "relief" activity, UNRWA finds itself competing for scarce donor resources with earthquakes, floods and famines. The label of "development" agency carries a completely different set of expectations. In this respect, UNRWA competes with a host of less developed

countries. In a similar vein, the term "quasi public or government sector" suggests democratic accountability. UNRWA is all, and yet none, of these. This lack of clarity influences expectations of the Agency. Further, tensions resulting from unclear expectations are liable to become more acute in the future (Brynen 2000).

The political importance of UNRWA in ensuring regional stability is clear. Donor interests are inevitably linked to this fact. This has the potential to discourage reform processes where "donor contributions are related to interest not effectiveness". Since 1993 and the Oslo Peace Accord, donor interest and priorities in the region have changed considerably. The introduction of the Palestinian Authority, development of a flourishing civil society sector, and more active international agencies have all impacted the operation of UNRWA. Some donors felt that these events warranted a more proactive UNRWA and the definition and shaping of a new and evolving mandate.

Clarifying perceptions of UNRWA's role vis-à-vis host governments, donors, civil society organisations and other multilateral agencies is central to agreeing upon the Agency's core funding needs (Bowker 2000). This, in turn, is a prerequisite for establishing a link between reform and funding.

At the centre of this reluctance to drive agendas forward is the extremely volatile and complex political environment. An additional factor, however, is the organisational culture of UNRWA. One senior Agency staff member noted, “Even within the UN system UNRWA is particularly conservative- they are frightened by change.”

Conservatism is not a unique characteristic of UNRWA, but has reinforced perceptions of bureaucracy and inflexibility within the Agency. Central among these perceptions is the “Centralisation of power, very limited delegation of authority”. Again, however, the link with funding questions can be established. Unless funds are available, new and innovative programmes and initiatives cannot be supported in a climate of continual austerity. “People have tried, staff have entered enthusiastically, tried to change things, but then there is no money for it.” In essence, the budget deficit situation is seen as reducing the ability of the Agency to be innovative.

There is little doubt that while donors would like a more confident, proactive and open UNRWA, this would require a major change in culture; of UNRWA staff, UNRWA as an institution, and on the donor side. At a time when donors are coming under greater scrutiny to justify overseas development assistance, “arrogant” attitudes are not

well received. Although there is evidence of improvement in the Agency’s responsiveness to donor needs, and acknowledgement of the enormous value of its work, the perception of arrogance remains. One donor recalled a senior UNRWA official stating it was the role of donors to “write cheques”. The donor continued, “It does not work like that anymore!” The relationship between donors and multilateral agencies has changed irreversibly. UNRWA must respond to the need of donors and take greater ownership in its decision-making processes.

Participation and Ownership

It is generally accepted that the degree to which stakeholders participate in and feel ownership of a planning and implementation process, the more likely they are to be committed to its success. Historically, donors generally have felt little involved in these processes, but now appear to recognise a change within UNRWA. “You used to listen to UNRWA, now they are much more open”.

Indeed UNRWA staff, although concerned about the desire of donors to micro manage, appear to have begun to recognise the value in this process, and “...would rather have proactive donors than disinterested ones”. “UNRWA needs a healthy exchange of views”. However, this is clearly not the case for all staff. The informal donor meeting

**Box 6.6: The Evolving Nature of the Donor/
UNRWA Relationship**

Lack of Information
Imperfect Information
Education
Consultation
Participation
Ownership

held in Amman in July 2001 was described by a senior finance officer, as an opportunity to “present” the budget document rather than “discuss” it. In the same vein, staff referred to the need to “educate donors”. An invitation to enter a process of dialogue might have been closer to the aspirations of donors. Nonetheless, it is important to recognise differences in the desire and ability of donors to participate in these processes. Different donor attitudes, and the nature of their representation, make responding to donors’ needs and expectations extremely challenging.

While senior UNRWA management, obviously have a substantial role to play in prioritisation and budget reform, it is clear that others appear less involved. “UNRWA staff doesn’t feel ownership ...stuck in a bureaucracy”. The reform process needs to recognise the importance of getting buy-in from staff throughout the Agency. An ongoing change management support programme, aligned to the process of establishing key performance indicators for the Agency, appears to be helping to address this issue.

The extent to which refugee beneficiaries are involved in UNRWA allocation decisions is not clear. Greater involvement of refugees appears to occur informally, but there are challenges to further dialogue. Rhetoric tends to dominate, with many representative organisations unwilling to discuss the need to prioritise service provision. Alternative research methods have been discussed, including the greater willingness of women to provide meaningful insights into refugee’s needs and priorities. Further developing relationships with civil service organisations could provide an additional entry point for UNRWA into refugee communities.

However, the complexity of the political environment clearly presents considerable challenges to wider refugee involvement. Moreover, it has been suggested that the original humanitarian /relief mandate of the Agency has resulted in an organisational structure that is not sympathetic to this aim: “UNRWA is very bureaucratic, as a result community participation is missing.” While some local refugee representatives and local UNRWA staff have noted the willingness of UNRWA management to listen to their views, they identified little evidence of their input being acted upon. Civil society organisations equally felt that their informal contacts with UNRWA were not significant enough. Although a positive change in the way in which UNRWA relates to civil society

organisations has been detected since the start of the October 2000 *Intifadah*.

Greater civil society involvement in planning and budgeting processes is becoming a new and key area of macro development policy. This provides an important link in building good governance, improves accountability and contributes to citizen empowerment. “The act of participation is itself an aspect of empowerment, which is a key element of effective strategies against poverty and social inequalities.” (Catatay 2000).

Perhaps, a growing recognition exists in UNRWA that interested and proactive donors tend to have a greater understanding of the UNRWA mandate and are likely to be more supportive. Greater involvement and ownership by a wider stakeholder constituency (not just donors) is crucial to establish trust. While considerable progress has been made in relationships with donors, there is still a way to go in establishing real participation and ownership.

Transparency and Accountability

Trust between stakeholders and transparency of operations are central to the reform issue. A lack of trust between stakeholders has been a recurrent theme throughout the last decade. “Up to three or four years ago, UNRWA was anything but transparent.” Establishing meaning-

ful trust between stakeholders is crucial to move forward on reform:

“One of the barriers to resolving the current financial crisis is the lack of transparency and communication which has developed between UNRWA and its donors.” *Oxfam 1999*.

This Oxfam report continues to emphasise the two-way nature of trust — trust that UNRWA is delivering agreed upon services, and doing so cost effectively on the one hand, and trust that donors will respond by funding UNRWA adequately on the other:

“Increased stakeholder involvement; this includes improved communications and transparency between UNRWA and its donors, more effective financial systems and cost-effectiveness measures. What is therefore needed is a change in approach and attitude among the stakeholders, so that fundamental issues of refugee entitlements are not challenged and that options for change are openly debated.” *Oxfam 1999*.

Establishing trust is not a simple exercise. It requires both sides to accept the scope and limits of responsibilities. Trust in the strategic direction of UNRWA; trust in the operational and technical quality of UNRWA’s programme; and accountability and transparency in financial procedures are all crucial elements.

Recent technical assistance projects have specifically addressed technical and financial aspects with some success. It is recognised that UNRWA has made considerable strides in this direction. The better presentation of the budget, ongoing reform of the financial management system, technical support to programmes, and changes in the nature of the donor dialogue have all contributed to this perception. In an internal memo one donor made the following observations: “The donors meeting in Amman in September demonstrated further the developing rapport and transparency between UNRWA, donors, and host countries.” Others confirmed this positive shift describing UNRWA as “very open...good access to projects and clear information on a monthly basis”.

Donors’ wish for greater involvement early in the planning cycle has, in part, been answered by the organisation of meetings in July 2001 in which initial drafts of the budget were presented to the donor community. Donors described it as a “step in the right direction” and “if nothing else this gives us 3 months to digest the budget proposal before September meeting”. While some UNRWA staff acknowledge the value of encouraging constructive stakeholder engagement, others seem less willing to accept this.

The provision of timely and accurate socioeconomic data is needed to

building on the considerable advances that have already been made. Socioeconomic conditions’ monitoring will give the Agency and stakeholders the ability to establish a link between monetary input and outputs/outcomes. This link is necessary to move debates about UNRWA planning processes from superficial and entrenched positions towards more meaningful dialogue. The current development of key performance indicators has an important role to play in this regard, but justifying funding requests is likely to entail more.

Communication, Information Collection and Dissemination

Establishing trust between donors and UNRWA is dependent upon building confidence that UNRWA’s strategic priorities are informed by accurate and timely data collected in an inclusive process of stakeholder engagement. Building trust in the reform process and resource allocation decisions is crucial to success. The extent to which an organisation is successful in engendering support amongst a wide constituency of stakeholders can have a significant bearing on this. The technical knowledge of donors, civil society organisations and refugees is an important, but at present under-used, resource.

Effective decisions require good information. This has consistently been identified as a weakness with respect to

UNRWA. A lack of information on key socioeconomic factors has hindered meaningful and informed debate on the context and impact of UNRWA activities.

Donor expectations and demands for clear analytical information to support funding requests have certainly risen. The Agency is still perceived by some not to have the capacity to provide this quality of data. UNRWA has responded to this by establishing an internal department, the Policy Analysis Unit. The Unit, which aims to disseminate timely and accurate information, has recently been strengthened and now consists of three international and six local staff.

“Since late 2000, the Policy Analysis Unit has shifted its strategy and objectives towards producing responsive analysis of the dynamic political situation faced by the refugees and the agency...data/collection/generation, long-term strategic planning, analytical reporting, and daily briefs.” *UNRWA 2001a*

Enhancing the Policy Analysis Unit’s capacity and building a reputation for this unit will be a major step in building trust in UNRWA’s ability to identify need and prioritise activities and programmes. As a recent KPMG report highlighted, this would address a major donor concern:

“...by clearly defining the needs of the refugees and demonstrating how UNRWA is meeting those needs, thereby providing a more powerful case for presenting to Donors and attracting funds” *KPMG 1999*.

A further positive move would be for the agency to encourage the Unit to widen its scope and pull together research from other agencies in the region. An increasingly strong community of civil society organisations has, over the last 10 years, produced information and research that could add to UNRWA’s knowledge base. UNRWA potentially has much to learn from others while others would certainly welcome access to increasingly strong UNRWA research. There was a common perception, however, amongst these organisations that, “not only UNRWA but donors generally are not willing to incorporate the views of Palestinian organisations”.

Effective communication strategies are crucial to developing a more inclusive planning process. The way in which stakeholders are approached or encouraged to participate in planning and budgetary processes is fundamental. The establishment of the External Affairs department appears to have helped keep donors informed. The challenge for UNRWA is to take this further and encourage channels of two-way dialogue for all stakeholders.

Conclusion

During the 1990s considerable advances have been made in the transparency and presentation of UNRWA financial information. Donor pressure in conjunction with UN-wide reform has encouraged the introduction of programme-based budgeting and a new accounting system. Coupled with these advances has been UNRWA's increased willingness to enter into dialogue with donors. Within the wider budgetary process (of needs identification, prioritisation, funding and monitoring and evaluation) there remains significant challenges for UNRWA to meet.

At the centre of UNRWA's financial crisis is a lack of trust in the credibility of the planning process. Mutual suspicion has led donors to doubt the efficiency and effectiveness of UNRWA and UNRWA to question the commitment of donors to the internationally defined UNRWA mandate. Donor expectations of a well-run Agency include sound financial management but go well beyond it. Establishing trust in UNRWA's budgetary process requires (1) evidence that UNRWA is well informed, (2) that the Agency is willing to be inclusive and open, and (3) that UNRWA is accountable to donors and to other stakeholders.

The budgeting process, itself, is affected by wider institutional and political factors. The planning process

has been undermined by persistent underfunding since 1991 and a lack of clear agreement on UNRWA's mandate (quantity and quality of services) in the changing Middle East scenario. It is widely regarded that at existing funding levels the quality of services are declining and UNRWA's longer-term ability to deliver services is weakened. Inadequate socio-economic data collection and analysis on the part of the Agency, plus a lack of willingness to address evolving stakeholder expectations, have compounded suspicions and allowed this spiral of mistrust and underfunding to develop.

UNRWA's strategic priorities are determined by the Management Committee within the context of likely funding scenarios. The impact of successive deficit years has become operationally more significant. At the same time and related, need and expected funding levels have played an increasingly important part in determining budgets. The impression that neither donors, civil service organisations nor refugees have had the opportunity to influence these priorities is widespread. Programme-based budgeting (introduced 1999) has resulted in better presentation of financial data and more thoughtful preparation of budgets. It has not, however, had considerable, real impact on the ground. Prior to programme-based budgeting, field staff were given relative freedom in spending resources as long as expenditure was below a ceiling amount. This level of

autonomy at the field level has been considerably reduced in recent years as a result of more active participation by finance staff during the budget preparation phase and associated rigorously-monitored budget proposals and expenditure.

Allocations are made on a pragmatic basis of budget and expected income. Income is estimated following pledges at a UN Conference in the December prior to the budgeting period. However, ongoing informal contact with donors provides a better indication of ultimate funding levels. The inevitable austerity measures necessary during the year will result in programme management at the field level stretching existing resources (such as double shifts in schools) while cutting nonessential expenditure (such as building, maintenance, and training). Cutting programmes is generally not an option given the political and security implications of such a move. Such decisions can only be taken at the Management Committee level and in consultation with donors and host countries.

Reforms, while welcomed, are perceived by many as donor driven and superficial. There is a clear need to develop local staff ownership of the process. Recent strengthening of formal meetings for donor dialogue is viewed as a positive step. Nonetheless, lack of participation by civil society organisations, donors and beneficiaries earlier

in the planning process is widely perceived as a weakness. Some consider the meetings as “set piece” and “superficial”. One donor referred to them as “presentation not participation” suggesting that further steps are necessary to make dialogue meaningful. UNRWA attitudes need to move further. A more open meeting held annually in December or January, inviting stakeholders to participate in frank discussion about key socioeconomic and political issues affecting Palestinian refugees, would give stakeholders early input into UNRWA priority setting and planning. Moreover, this would inhibit micro management among donors later on in the process, and could also help raise awareness among stakeholders about the complexity of delivering UNRWA’s mandate.

Additionally, the lack of available, timely and accurate socioeconomic data to support UNRWA policy decisions further undermines trust and confidence, as well as claims on scarce donor resources. Many donors feel that UNRWA demands for funds are unsubstantiated and not supported by verifiable and trustworthy data. “UNRWA cut to the bone? How do we know that”? UNRWA has recognised this weakness and positive steps have been taken to strengthen the capacity of the Policy Analysis Unit. The Policy Analysis Unit needs to further improve its competence to produce relevant and accurate data and analysis. As an alternative, or in addition to this,

utilising outside capacity from research institutes, donor agencies and civil service organisations should be considered. A more inclusive approach to data collection would also contribute to this aim.

UNRWA's ability to enhance communication processes with and among stakeholders is key. More effective strategies are necessary to raise awareness and encourage participation of stakeholders in UNRWA decision-making processes.

The distribution of actual Agency expenditure by sub-programme correlates closely with budgeted amounts. Austerity measures resulting from under funding are generally spread throughout the programme. However, certain sub-programmes are more resistant to austerity measures than others. Education and Health are the most resistant. Common Services is the most likely to suffer as a result of deficit funding. Given the existing financial management system, analysis by field and sub-programmes is not possible. Within sub-programmes, certain groups of expenditure items (maintenance, equipment purchase and travel) are considered "soft" and liable to bear the brunt of cost savings.

Enhancing accountability requires clarification of who is accountable to whom and for what. This clarification will undoubtedly require a revisiting of

the UNRWA mandate and, in so doing, reaching a consensus on the quality and quantity of service provision. UNRWA's acceptance of accountability to a wider range of stakeholders is crucial to establishing trust and ownership and allowing for progressive relationships, particularly with donors.

There is a significant international trend to encourage citizen awareness and participation in macro level budgeting processes. Greater participation in the identification and prioritisation of need is seen as an empowering tool and increasingly seen as good governance:

"Budget-making processes often involve not only the citizens of a country, whether placed inside or outside the government, but also international actors. This is because both the revenues and the expenditures of governments are affected by linkages of their economies to other economies through capital and trade flow, debt and overseas development assistance." *Catatay et. al. 2000*

The political sensitivity of UNRWA's mandate and role, while presenting clear challenges, should not be allowed to deter such potentially beneficial initiatives.

"We must understand the power relations at play at all levels. The global context limits our governments' capacity to respond to issues at national and sub-

national levels, and, while it must not be allowed to paralyse internal debate and activity, it must be acknowledged and understood.” *IBP 2000*

Participation can become a tool of empowerment for the refugees and address donor calls for greater accountability in the creation and monitoring of budgets within UNRWA. UNRWA’s greater accountability to refugees as citizens (not directly to donors) could help to create an environment where issues of accountability are less controversial. In turn, greater involvement of citizens requires building their capacity to participate and knowledge of budget issues. Initial steps could include the production of a “Refugees’ Guide to the UNRWA Budget”, regular information for refugees on income, expenditure, and planning processes (highlight mechanisms of ‘voice’), and finally, UNRWA achievement on key performance indicators.

Considerable strides made by the Agency in the reform of the budget and financial management system need to be built upon. Willingness to review efficiency and effectiveness of current service delivery (for example, DFID-funded education reform programme) is also a positive sign of forward thinking and progressive management. Staff members need to be helped to see change as a positive step. This, in part, demands the clear establishment of a link between

performance (based on key performance indicators and agreed upon mandate) and funding. A multi-donor commitment to support UNRWA on successful completion of certain clear and verifiable performance targets would be a positive step.

UNRWA has made very positive advances in presentation and transparency of financial issues, and continues to play a vital role in support of Palestinian refugees and in the stability of the region. Further progress will depend upon a greater degree of clarity and consensus of stakeholder expectations of UNRWA. Building trust is central to progress. The establishment of clear performance targets, mechanisms for wider stakeholder participation in UNRWA’s planning processes, further progress in ensuring transparency of UNRWA financial management and clear donor commitments will all help build this trust.

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Annex 6.1

Schedule of Meetings

- 27 June 2001, Martin Rapley, West Asia Desk Officer, DFID
- 2 July 2001, Peter Hansen, Commissioner General, UNWRA HQ Gaza.
- 2 July 2001, Fritz Froehlich, Deputy Head of Liaison Office, Swiss Agency for Development and Co-operation, Jerusalem
- 3 July 2001, UNRWA HQ, Gaza: Subash Gupta, Comptroller; Ramadan Omari, Chief Budget Division; Safiye Cagar, Director, External Relations Office.
- 4 July 2001, UNRWA HQ, Gaza: Lionel Brisson, Director of Operations, Dr. Ayyoub El-Alem, Chief Field Health programme, Gaza Field; Dr. Ahmad Y. Mousa, Chief Field Education Programme, Gaza Field; Karen Koning AbuZayd, Deputy Commissioner General; Mian Qadrud-Din, Chef de Cabinet; Ramadan Omari, Chief Budget Division.
- 4 July 2001, Hassan Jebrel, Chief of Camp Committee, Palestine Liberation Organisation, Burg Camp, Gaza
- 5 July 2001, Jouda Juda, Department of Refugee Affairs, Palestinian National Authority, Gaza.
- 5 July 2001, Ata El Omari, Field Budget Officer, UNRWA, Gaza Field.
- 5 July 2001, Abdel Hamid Afana, Director of Training Education, Gaza Community Mental Health Programme, Gaza
- 5 July 2001, Nancy Missak, Operations Manager for Women's Credit Programme, ASALA, Gaza.
- 6 July 2001, Richard Cook, Director of UNRWA Operations, West Bank Field, Jerusalem.
- 6 July 2001, Chris Metcalf, Consul (Development), DFID, Jerusalem.
- 6 July 2001, Sally Goggin, Deputy Director, British Council, Jerusalem
- 6 July 2001, Maha Abu-Dayyeh, Director, Women's Centre for Legal Aid and Counselling, Jerusalem.
- 7 July 2001, Thomas Staal, Office Director, General Development Office, US Agency for International Development, West Bank and Gaza Mission, Jerusalem.
- 8 July 2001, Rania Malhis, MASS, Ramallah (Telephone Conversation)
- 9 July 2001, Chris White, Budget Officer, UNRWA West Bank Field, Jerusalem.
- 9 July 2001, Tom Neu, American Near East Refugee Aid, Jerusalem (Telephone Conversation)

- 9 July 2001, Rana Bishari, Palestinian NGO Network, Ramallah (Telephone Conversation)
- 9 July 2001, Dr. Jihad Mashal, Vice President, Union of Palestinian Medical Relief Committees, Jerusalem
- 10 July 2001, UNRWA Operations, Jordan Field, Amman: William Lee, Director of UNRWA Operations; Charles Kapes, Deputy Director of UNRWA Operations; Dr Mousa A. Bashir, Deputy Chief Field Health Programme; Dr Omar Mahmoud Ghabayen, Chief Field Education Programme; Fouad Shawa, Chief Field Relief and Social Services Programme.
- 11 July 2001, Jebel Al Hossain, Refugee Camp, Health Centre, Amman
- 11 July 2001, Jebel Al Hossain, Refugee Camp, Women's Centre, Amman
- 11 July 2001, UNRWA Donors Meeting, Amman
- 11 July 2001, UNRWA HQ, Amman: Beth Kuttab, Director of Relief and Social Services; Dr Shahin, Chief Education Planning and Management Division, UNRWA/UNESCO Department of Education; Reem Barghouti Damen, Chief, Institute of Education; Dr F.S. Mousa, Director of Health

Annex 6.2

Overview of Major Differences between Previous and Current Budget Preparation Exercises.

Previous Budget Format/Process	New Budget Format/Process
Budget was derived mainly from predetermined ceilings and expenditures incurred in previous years.	Budget will be derived mainly from a specified programme of work for the years ahead.
Programme goals/objectives were general and provided at the programme level only.	Programme goals/Objectives will be specific and provided at the programme and sub-programme level, based on attainable targets and measurable outcomes.
Budget was organized around object of expenditure items and the Agency's Organisational structure.	Budget will be organised around programme and sub-programme activities.
Budget covered only the regular budget excluding items funded by project contributions, etc.	Budget will cover all financial requirements for programme activities, regardless of source of funding.
Financial requirements for programme activities were in practice defined as regular budget allocations.	Final requirements will be defined as all costs incurred for activities, regardless of source of funding.
Budget preparation was viewed as primarily a financial technical exercise.	Budget preparation will be viewed as primarily a programme planning exercise.
Oversight of the budget preparation process was provided by Budget Division	Oversight of the budget preparation process will be provided by senior management (COMGEN/DCG, MC, TFBPP)

Annex 6.3

Example of Budget Technical Instructions

105 4105 Office, Stationery and Scholastic Supplies (Continued)

BTI No. 9 Part II
Page 6 of 22

- (D) Per School
The standard annual budget allowances for stationary & scholastic supplies are as follows:

Field	Standard Annual Budget Allowances Per	
	Preparatory School	
	2002	2003
	US\$	US\$
Gaza	27.28	27.83
Lebanon	31.87	32.51
Syria	41.02	41.84
Jordan	31.97	32.61
West Bank	30.37	30.98

For details please refer to Attachment E6' to this B TI.

- (E) For School Libraries
(Applicable to all Fields)
The standard annual budget allowance for book cards, glue, pens, pencils, etc. used in school libraries is US\$ 0.030 per pupil for the year 2002 and US\$0.031 for the year 2003.
- (F) For Arts and Craft Classes
(Applicable to all Fields)
The standard annual budget allowance for office and stationery supplies used in Arts and Craft classes is \$0.20 per pupil for the year 2002 and 2003.
- (G) For Home Economics Classes
(Applicable only to Gaza and Syria, girls in prep. classes 1-3)
- (i) Per Pupil
The standard annual budget allowances are as follows:

Annex 6.4

Example of Standard Norms

Applicable To 11 Fields
 Activity **XX-427-03 (Preparatory Education)** New L-EG06
 Object Code 105 Office Stationery Supplies IGroun O51 New L-4105
 Norm Per School

Catalogue No.	Description	Unit of Issue	Standard Number Of Issues Per School					Budget Standard Price Per Unit	Budget Standard Allowance Per School				
			Gaza	Lebanon	Syria	Jordan	West Bank		Gaza	Lebanon	Syria	Jordan	West Bank
									US \$	US \$	US \$	US \$	US \$
05.4.332.1	Carbon blue	BX	1.0	1.0	1.0	1.0	1.0	2.806	2.81	2.81	2.81	2.81	2.81
05.4.571.1	Paper offset-white mimeograph	RE	2.0	2.0	2.0	2.0	3.0	3.086	6.17	6.17	6.17	6.17	9.26
05.4.679.1	Paper stencil gestetner	BX			1.0			6.118	0	0	6.12	0	0
05.4.681.1	Paper stencil rex rot	BX		1.0	1.0	1.0		6.118	0	6.12	6.12	6.12	0
05.4.904.1	Paper writing ruled	RE	2.0	2.0	2.0	2.0	2.0	3.304	6.61	6.61	0.292	6.61	6.61
05.5.422.1	File shanon blue	PC	20.0	20.0	20.0	20.0	20.0	0.123	2.46	2.46	2.46	2.46	2.46
05.5.622.1	Ledger without index	PC	2.0	2.0	2.0	2.0	2.0	1.457	2.91	2.91	2.91	2.91	2.91
05.6.017.1	Gum mucilage	BT	10.0	10.0	10.0	10.0	10.0	0.164	1.64	1.64	1.64	1.64	1.64
05.6.066.1	Stamp pad, Violet	PC	0.5	0.5	0.5	0.5	0.5	0.747	0.37	0.37	0.37	0.37	0.37
05.6.080.1	Ball point pen blue	PC	2.0	1.0	2.0	2.0	2.0	0.067	0.13	0.07	0.13	0.13	0.13
05.6.080.1	Ball point pen red	PC	1.0	1.0	1.0	1.0	1.0	0.067	0.07	0.07	0.07	0.07	0.07
05.6.220.1	Perforator desk type	PC	0.3	0.3	0.3	0.3	0.3	1.163	0.29	0.29	0.29	0.29	0.29
05.6.245.1	Pin - ordinary (2.5 cm)	PK	2.0	2.0	2.0	2.0	2.0	0.277	0.55	0.55	0.55	0.55	0.55
05.6.247.1	Pin - Drawing	BX	3.0	3.0	3.0	3.0	3.0	0.229	0.69	0.69	0.69	0.69	0.69
05.6.399.1	Paper Clips small	BX	2.0	2.0	2.0	2.0	2.0	0.087	0.17	0.17	0.17	0.17	0.17
05.6.747.1	Stapler small ACE	PC	0.3	0.3	0.3	0.3	0.3	1.321	0.44	0.44	0.44	0.44	0.44
05.6.753.1	Staples 24/6	BX	3.0	3.0	3.0	3.0	3.0	0.092	0.28	0.28	0.28	0.28	0.28
05.6.780.1	Adhesive tape, 15mm	RO	0.5	0.5	1.0	1.0	0.5	0.077	0.04	0.04	0.08	0.08	0.04
05.6.804.1	Ink mimeograph	CN	0.5		1.0		0.5	2.924	1.46	0	2.92	0	1.46
05.6.813.1	Ink stamp pad violet	BT	0.5	0.5	0.5	0.5	0.5	0.375	0.19	0.19	0.19	0.19	0.19
2002 Budget	Standard Allowances								~27:28	31.87	41.02	31.97	30.37

Annex 6.5

Analysis of Actual and Budgeted Expenditure by Sub Programme

	Year End 31/12/90			Year End 31/12/91			Biennium End 31/12/93			Biennium End 31/12/95		
	Budget	Actual	Act/Bud %	Budget	Actual	Act/Bud %	Budget	Actual	Act/Bud %	Budget	Actual	Act/Bud %
<u>Education</u>	US\$'000	US\$'000		US\$'000	US\$'000		US\$'000	US\$'000		US\$'000	US\$'000	
Programme Mgt.												
Elementary	66278	66524	100%	64606	64757	100%	139592	137992	99%	142782	140217	98%
Preparatory	37460	37615	100%	39867	39579	99%	87931	86542	98%	94699	91870	97%
Secondary												
Vocational	9376	9491	101%	9250	8464	92%	19639	17958	91%	23886	19812	83%
Other	5464	5364	98%	5652	5898	104%	11823	11244	95%	17626	10216	58%
subtotal	118578	118994	100%	119375	118698	99%	258985	253736	98%	278993	262115	94%
<u>Health</u>												
Programme Mgt.												
Medical	26502	27779	105%	26224	26515	101%	61363	60576	99%	68297	61669	90%
Environ. Sanit.	7489	7552	101%	7958	7654	96%	17931	17630	98%	19731	17119	87%
Other (Nutrition/Supp.)	0	0	100%	1233	851	69%	909	585	64%	1064	1053	99%
subtotal	33991	35331	104%	35415	35020	99%	80203	78791	98%	89092	79841	90%
<u>Serv.</u>												
Programme Mgt.												
Relief Serv.				24830	23427	94%	58529	53503	91%	44447	42564	96%
Other				2381	2229	94%	3724	3534	95%	3364	2766	82%
Sub Total	28029	26609	95%	27211	25656	94%	62253	57037	92%	47811	45330	95%
<u>Protection and Emergency Services</u>												
							764	630	82%	1107	1104	100%
<u>Income Generation</u>												
							1109	766	69%	435	365	84%
<u>Operational Services</u>												
Supply and Transport	11374	11523	101%	17680	13363	76%	30426	8846	29%	42107	30248	72%
Architect and Engineering Serv.	5330	5420	102%	6355	6329	100%	11242	11179	99%	11864	10069	85%
Self Support Units	133	26	20%									
Sub Total	16837	16969	101%	24035	19692	82%	41668	20025	48%	53971	40317	75%
<u>Common Services</u>												
Management	12311	12644	103%	14339	13441	94%	29872	28390	95%	32443	30065	93%
Administration	17089	16236	95%	20535	17775	87%	50846	35980	71%	58223	35127	60%
Sub Total	29400	28880	98%	34874	31216	90%	80718	64370	80%	90666	65192	72%
<u>Excess Valuation</u>												
		3077			1418			1115			753	
Total General Fund	226835	229860	101%	240910	231700	96%	525700	476470	91%	562075	495017	88%

	Biennium End 31/12/97			Biennium End 31/12/99			Year End 31/12/2000		
	Budget	Actual	Act/Bud %	Budget	Actual	Act/Bud %	Budget	Actual	Act/Bud %
Education	US\$'000	US\$'000		US\$'000	US\$'000		US\$'000	US\$'000	
Programme Mgt.							6899	5466	79%
Elementary	160642	155777	97%	168862	160814	95%	84954	88356	104%
Preparatory	109687	100015	91%	118515	103603	87%	54778	55009	100%
Secondary				435	84	19%	905	811	90%
Vocational	21878	19001	87%	27313	28229	103%	13056	13793	106%
Other	10397	10217	98%	10163	9665	95%	1129		
<i>subtotal</i>	<i>302604</i>	<i>285010</i>	<i>94%</i>	<i>325288</i>	<i>302395</i>	<i>93%</i>	<i>161721</i>	<i>163435</i>	<i>101%</i>
Health									
Programme Mgt.							3197	2601	81%
Medical	64802	58987	91%	80915	71107	88%	35220	34499	98%
Environ. Sanit.	18775	17848	95%	23217	18058	78%	9832	8697	88%
Other (Nutrition/Supp. Feeding)	15681	909	6%	22791	9450	41%	5098	3824	75%
<i>subtotal</i>	<i>99258</i>	<i>77744</i>	<i>78%</i>	<i>126923</i>	<i>98615</i>	<i>78%</i>	<i>53347</i>	<i>49621</i>	<i>93%</i>
Relief and Social Serv.									
Programme Mgt.							1470	1305	89%
Relief Serv.	48827	44238	91%	80216	52531	65%	26805	24012	90%
Social Services Other	3374	2893	86%	5990	5124	86%	2802	2698	96%
<i>Sub Total</i>	<i>52201</i>	<i>47131</i>	<i>90%</i>	<i>86206</i>	<i>57655</i>	<i>67%</i>	<i>31077</i>	<i>28015</i>	<i>90%</i>
Protection and Emergency Services	1074	1017	95%						
Income Generation	2248	1310	58%						
Operational Services									
Supply and Transport	31501	16991	54%	28594	18430	64%	12263	14769	120%
Architect and Engineering Serv.	13235	10221	77%	16907	9810	58%	2992	2920	98%
Self Support Units				0	-257			334	
<i>Sub Total</i>	<i>44736</i>	<i>27212</i>	<i>61%</i>	<i>45501</i>	<i>27983</i>	<i>61%</i>	<i>15255</i>	<i>18023</i>	<i>118%</i>
Common Services									
General Management	31595	27078	86%	33426	23635	71%	13994	11632	83%
Administration	90858	22265	25%	54728	16928	31%	25497	9946	39%
<i>Sub Total</i>	<i>122453</i>	<i>49343</i>	<i>40%</i>	<i>88154</i>	<i>40563</i>	<i>46%</i>	<i>39491</i>	<i>21578</i>	<i>55%</i>
Excess Valuation									
Total General Fund	624574	488767	78%	672072	527211	78%	300891	280672	93%

Annex 6.6

Analysis of Change in Significance of Expenditure by Sub Programme

	Year End 31/12/90			Year End 31/12/91			Biennium End 31/12/93			Biennium End 31/12/95		
	Budget %	Actual %	Diff	Budget %	Actual %	Diff	Budget %	Actual %	Diff	Budget %	Actual %	Diff
Education												
Programme Mgt.	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Elementary	29%	29%	0%	27%	28%	1%	27%	29%	2%	25%	28%	3%
Preparatory	17%	16%	0%	17%	17%	1%	17%	18%	1%	17%	19%	2%
Secondary	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Vocational	4%	4%	0%	4%	4%	0%	4%	4%	0%	4%	4%	0%
Other	2%	2%	0%	2%	3%	0%	2%	2%	0%	3%	2%	-1%
subtotal	52%	52%	-1%	50%	51%	2%	49%	53%	4%	50%	53%	3%
Health												
Programme Mgt.	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Medical	12%	12%	0%	11%	11%	1%	12%	13%	1%	12%	12%	0%
Environ. Sanit.	3%	3%	0%	3%	3%	0%	3%	4%	0%	4%	3%	0%
Other (Nutrition/Supp. Feeding)	0%	0%	0%	1%	0%	0%	0%	0%	0%	0%	0%	0%
subtotal	15%	15%	0%	15%	15%	0%	15%	17%	1%	16%	16%	0%
Relief and Social Serv.												
Programme Mgt.	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Relief Serv. Social Services	0%	0%	0%	10%	10%	0%	11%	11%	0%	8%	9%	1%
Other	0%	0%	0%	1%	1%	0%	1%	1%	0%	1%	1%	0%
Sub Total	12%	12%	-1%	11%	11%	0%	12%	12%	0%	9%	9%	1%
Protection and Emergency Services												
	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Income Generation												
	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Operational Services												
Supply and Transport	5%	5%	0%	7%	6%	-2%	6%	2%	-4%	7%	6%	-1%
Architect and Engineering Serv.	2%	2%	0%	3%	3%	0%	2%	2%	0%	2%	2%	0%
Self Support Units	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Sub Total	7%	7%	0%	10%	8%	-1%	8%	4%	-4%	10%	8%	-1%
Common Services												
General												
Management	5%	6%	0%	6%	6%	0%	6%	6%	0%	6%	6%	0%
Administration	8%	7%	0%	9%	8%	-1%	10%	8%	-2%	10%	7%	-3%
Sub Total	13%	13%	0%	14%	13%	-1%	15%	14%	-2%	16%	13%	-3%
Total General Fund	100%	100%	0%	100%	100%	0%	100%	100%	0%	100%	100%	0%

	Biennium End 31/12/97			Biennium End 31/12/99			Year End 31/12/2000		
	Budget %	Actual %	Diff	Budget %	Actual %	Diff	Budget %	Actual %	Diff
<u>Education</u>									
Programme Mgt.	0%	0%	0%	0%	0%	0%	2%	2%	0%
Elementary	26%	32%	6%	25%	31%	5%	28%	31%	3%
Preparatory	18%	20%	3%	18%	20%	2%	18%	20%	1%
Secondary	0%	0%	0%	0%	0%	0%	0%	0%	0%
Vocational	4%	4%	0%	4%	5%	1%	4%	5%	1%
Other	2%	2%	0%	2%	2%	0%	0%	0%	0%
<i>subtotal</i>	48%	58%	10%	48%	57%	9%	54%	58%	4%
<u>Health</u>									
Programme Mgt.	0%	0%	0%	0%	0%	0%	1%	1%	0%
Medical	10%	12%	2%	12%	13%	1%	12%	12%	1%
Environ. Sanit.	3%	4%	1%	3%	3%	0%	3%	3%	0%
Other (Nutrition/Supp. Feeding)	3%	0%	-2%	3%	2%	-2%	2%	1%	0%
<i>subtotal</i>	16%	16%	0%	19%	19%	0%	18%	18%	0%
<u>Relief and Social Serv.</u>									
Programme Mgt.	0%	0%	0%	0%	0%	0%	0%	0%	0%
Relief Serv.	8%	9%	1%	12%	10%	-2%	9%	9%	0%
Social Services									
Other	1%	1%	0%	1%	1%	0%	1%	1%	0%
<i>Sub Total</i>	8%	10%	1%	13%	11%	-2%	10%	10%	0%
<u>Protection and Emergency Services</u>									
	0%	0%	0%	0%	0%	0%	0%	0%	0%
	0%	0%	0%	0%	0%	0%	0%	0%	0%
<u>Income Generation</u>									
	0%	0%	0%	0%	0%	0%	0%	0%	0%
<u>Operational Services</u>									
Supply and Transport	5%	3%	-2%	4%	3%	-1%	4%	5%	1%
Architect and Engineering Serv.	2%	2%	0%	3%	2%	-1%	1%	1%	0%
Self Support Units	0%	0%	0%	0%	0%	0%	0%	0%	0%
<i>Sub Total</i>	7%	6%	-2%	7%	5%	-1%	5%	6%	1%
<u>Common Services</u>									
General									
Management	5%	6%	0%	5%	4%	0%	5%	4%	-1%
Administration	15%	5%	-10%	8%	3%	-5%	8%	4%	-5%
<i>Sub Total</i>	20%	10%	-10%	13%	8%	-5%	13%	8%	-5%
<i>Total General Fund</i>	100%	100%	0%	100%	100%	0%	100%	100%	0%

Annex 6.7

Actual Management Costs as a Percentage of Actual Total Costs

	Year end 31-12-90	Year end 31-12-91	Year end 31-12-93	Biennium end 31/12/95	Biennium end 31/12/97	Biennium end 31/12/99	Year end 31-12-00
Programme Management Costs Identified at Field Level							9372
Operational Services	16969	19692	20025	40317	27212	27983	18023
Common Services	28880	31216	64370	65192	49343	40563	21578
Total Management Costs	45849	50908	84395	105509	76555	68546	48973
Total General Fund Costs	229860	231700	476470	495017	488767	527211	280672
Management as a % Total General Fund Expenditure	20%	22%	18%	21%	16%	13%	17%
Total Expenditure (incl. Project Activities)	292545	308118	605319	678811	651533	583974	300328
Management as a % of Total Expenditure	16%	17%	14%	16%	12%	12%	16%