SITUATIONAL BRIEF: PALESTINIAN REFUGEES IN THE OCCUPIED PALESTINE TERRITORIES DURING COVID-19

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1. REFUGEE CONTEXT IN PALESTINE

1.1 Today, there are over 5 million Palestine refugees registered with UNRWA[2]. About one third of these refugees live in the Occupied Palestinian Territory (OPT), while the majority of refugees are in Jordan, Lebanon and Syria[2] (Figures 1 & 2). This is a result of over 700,000 Palestinians being forcibly displaced from Palestine for the establishment of Israel during what Palestinians refer to as the **Nakba "catastrophe"** in 1948[1], becoming refugees. The United Nations Relief and Work Agency for Palestine Refugees in the Near East (**UNRWA**) was established in 1949 to support these refugees[2].

1.2 There are currently 2 million refugees who are **internally displaced** within the OPT[3,4]. They comprise 44% of the total OPT population (over 5 million)[5]. About 63% of these refugees live in the Gaza Strip[3] and 37% live in the West Bank and East Jerusalem[4]. **The Israeli occupation** continues to target Palestinians' livelihoods through continuous: blockade and attacks on the Gaza Strip, demolition of homes, and attacks on infrastructure including healthcare facilities in the OPT[6], and to annex land in the OPT[7]. This has led to further substantial morbidity, mortality and internal displacement of Palestinians[6].

1.3 **Living conditions** among refugees in OPT are characterized by extreme poverty (about 39% as of 2017)[8], and high levels of food insecurity (14.1% in the West Bank and 67.3% in the Gaza Strip)[9]. About 30% of the total refugees in the OPT live in 27 overcrowded refugee camps[3,4]. These camps suffer from poor housing conditions, and lack adequate infrastructure such as roads, sewage and electricity[2,10].

1.4 The Palestinian Ministry of Health (MOH) is the main provider of healthcare services in Palestine[11], followed by UNRWA, the leading provider of primary health care services for Palestinian refugees[3,4]. The fragmented **health system** is one particular challenge that raises concerns for public health in the OPT[11], specifically in the Gaza Strip where 73% of its population are refugees[3], and where a series of wars and continuous sieges have further crippled its health system[6].

1.5 As of 12 June 2020, there are 667 confirmed **COVID-19 cases** in the OPT (565 of which are recovered cases), and 48% of which (320 cases) are in East Jerusalem and its suburbs. Additionally, there have been 5 reported COVID-19 deaths (1 in the West Bank, 1 in Gaza and 3 in East Jerusalem)[12]. There is no aggregated data available yet to indicate the number of cases among refugees in the OPT. However, the two most affected areas in the suburb of Jerusalem are Biddu and Qattana, with 85 confirmed cases[13]. Approximately 92% of Biddu and Qatanna population are registered refugees, showing that certain refugee-populated areas are largely affected[14]. The first cases of COVID-19 infection in the OPT were due to direct contact with infected tourists in Bethlehem. The first 37 cases were a result of both direct and indirect contact with these tourists, the following wave was largely imported (Palestinians returning from abroad), followed by community transmission[11]. The majority of the cases (about 69%) in the OPT (excluding East Jerusalem) are among Palestinian workers who are employed in Israel and those in direct contact with those workers who have COVID-19[12].

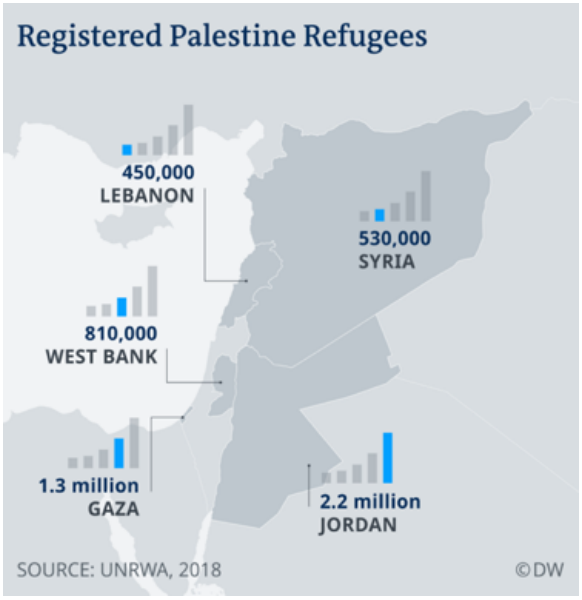

Figure 1: Palestinian refugee population in neighbouring countries[15]

Figure 2: OPT- West Bank, East Jerusalem and Gaza Strip[6]

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2. RISKS FOR REFUGEES IN PALESTINE DURING COVID-19

2.1 Living Conditions

a. Approximately 38.5% of refugees in Palestine are **unemployed**[16]. The **poverty** rate among refugee households is 38.7%, in comparison to 22.3% among non-refugee households in Palestine[8]. This will impact refugees' ability to take preventative measures including buying masks and disinfectants. Unemployment and poverty are expected to increase in the OPT, and globally, due to the pandemic[17]. During a press conference in Ramallah on 15 April, the Palestinian Minister of Social Affairs Mr Ahmad Majdalani stated that some 53,000 Palestinian families have fallen below the poverty line since the start of COVID-19 spread in the OPT, and this number is expected to rise[18]. Subsequently, this may aggravate refugees' food insecurity[19] and limit their access to healthcare services, thereby threatening their physical and mental health. In the OPT, out-of-pocket payments represent the largest source of health financing, contributing to 39% of the current health expenditure[20]. UNRWA provides primary healthcare for refugees but only partial reimbursement costs for inpatient care at public, non-governmental and private healthcare facilities[21].

b. Physical distancing, often referred to as 'social distancing', is an essential preventative measure against COVID-19 spread[22,23]. **Overcrowding** in refugee camps means that 'physical distancing' is technically impossible. Figures from 2009 show that 46% and 49% of spaces in refugee camps in the Gaza Strip and the West Bank respectively are overcrowded in terms of area per person and number of persons per room[24]. It is likely that these figures are higher now.

c. Good hygiene practices including regular hand washing are some of the most important preventative measures against COVID-19 infection[25]. **WASH** systems are poor in Palestine, especially in refugee camps[10]. Water is scarce in Palestine due to complete Israeli control of water resources[26]. In the Gaza Strip, 96% of water is unfit for human consumption[27].

2.2 Health Vulnerabilities

a. The risk of infection or severe illness from COVID-19 is high among the elderly population and those with **non-communicable disease (NCDs)**[28]. The elderly population in Palestine is relatively small; about 5% of refugees are 60 years of age or above[29]. However, 24.8% and 17.6% of registered refugees who are 40 years of age or above in the Gaza Strip and the West Bank, respectively, suffer from at least one NCD[30]. NCDs are expected to increase among refugees during and after this outbreak in low and middle-income countries as a result of aggravated poverty, which has been linked to increased NCD risk[31]. Those with existing chronic conditions related to NCDs will find it difficult to access adequate healthcare services, also due to increased poverty.

b. **Gender-Based Violence (GBV)** is another risk among refugee populations in Palestine. Almost one in three women reported violence by their husbands in 2018-2019 in the OPT[32]. There is no aggregated data available regarding GBV levels among refugees in Palestine, however, research shows that people facing hardships including displacement, unemployment and poverty are at a higher risk of GBV[33]. According to a study by the United Nations Population Fund (UNFPA) and Juzoor for Health and Social Development in the West Bank and East Jerusalem, fears about the infection, the poor economic situation and lockdown measures have resulted in increased domestic violence in the OPT[34], consequently threatening their physical and mental health. Local NGOs in the West Bank have reported an increase in GBV consultations (which are being done remotely) during the outbreak period[34].

c. Refugees in Palestine suffer from **mental health issues** that may affect their ability to cope with this pandemic. Approximately 50% and 35% of Palestinian youth in the Gaza Strip and the West Bank suffer from depression and anxiety respectively[35]. It is predicted that the spread of COVID-19 will increase these mental health issues due to: fear of infection, restrictions on movement and social interaction, increased poverty and unemployment[36]. The study by UNFPA and Juzoor shows that the main fears during the COVID-19 outbreak include: contracting COVID-19, inability to secure food for the family, lack of access to medicines, lack of access to healthcare facilities, interruption of children's education, and loss of income[34]. Furthermore, 85% of study participants reported poor wellbeing (quality of life) based on the World Health Organisation (WHO) 5-Wellbeing Index[34].

2.3 Health System Fragility in Palestine

a. The health system is **over-stretched** in the OPT. There are daily electricity cuts in Gaza[37], and Israeli attacks have caused 48,175 injuries in the OPT since 2018[38], including attacks on health centres and personnel[39]. These factors have further strained an already struggling system. The health system in Palestine suffers from acute shortages of medications, medical equipment, testing kits, Personal Protective Equipment (PPE), hygiene kits, and trained health staff[11]. UNRWA healthcare facilities are also suffering from these shortages[19,40]. There are only 375 ICU beds and 295 ventilators in Palestine[11]. Furthermore, Israel's full control of borders and restrictions on the movement of people and goods has resulted in longstanding shortages of health workers, supplies and essential drugs, particularly in the Gaza Strip[39]. This pandemic is expected to increase the fragility and shortages suffered by the Palestinian health system.

b. The **fragmented health system** in Palestine affects refugees' access to health services. Refugees are entitled to UNRWA's primary health care services, and hospital services provided by one UNRWA hospital, MoH services, NGOs and private hospitals[3,4,21]. UNRWA has been a key provider of health services for Palestine refugees, and its fiscal cuts have led to shortages in healthcare services for refugees in Palestine[41]. These cuts may be further constrained by the pandemic and its fallout.

3. PALESTINIAN HEALTH SYSTEM RESPONSE FOR REFUGEES DURING COVID-19

a. UNRWA is following WHO guidelines and the OPT Interagency Response Plan (prepared by the Humanitarian Country Team)[19] in its **COVID-19 Preparedness and Response** Plan, which includes priority areas and recommended actions that are necessary to reduce the risks of COVID-19 transmissions among Palestine refugee communities in Jordan, Lebanon, Syria, and the OPT[40]. The MoH is leading the COVID-19 response in Palestine including for refugees: those who show COVID-19 symptoms are being tested by the MoH, and all confirmed patients are treated at MoH hospitals[11,19,40]. There are 19 quarantine centres for COVID-19 patients in the OPT, in addition to community-based centres in refugee camps that are being established by UNRWA[19]. However, the plans do not indicate clear coordination measures between the MoH and UNRWA in their COVID-19 response. Therefore, any current **coordination** mechanisms may be unclear for refugees.

b. **Palestinian workers** (including refugees) employed in Israel and returning to the OPT every day were advised to home quarantine or to stay in Israel[19]. However, it was difficult for these workers to stay in their homes due to the risk of losing their jobs. Now these workers are restricted from entering Israel, and those who were staying in Israel are returning to their homes and required to self-quarantine[42]. It would be difficult for these refugees to self-quarantine in overcrowded living conditions. Furthermore, this demonstrates poor coordination of decision-making between the Palestinian government and Israeli authorities regarding the Palestinian workers in Israel.

c. All UNRWA **primary health care** centres (43 in the West Bank and 22 in the Gaza Strip[3,4]) are still operating[40]. UNRWA is providing **psychosocial support** services remotely through dedicated phone lines[19]. **Sexual and Reproductive Health (SRH**) services have been reduced by UNRWA and local non-governmental organisations, which increases the risk of morbidity and mortality amongst girls, pregnant women and new-borns[43].

d. UNRWA has increased cleaning and hygiene measures in its facilities[44]. It is unclear whether any additional **WASH services** are being provided to refugees in the OPT. However, UNRWA aims to increase WASH services and is appealing for $1.5 million to meet this goal[44]. Moreover, the WASH Cluster in Palestine has put together a budget and plan for WASH activities by cluster partners including UNRWA as part of its COVID-19 response[17].

e. Various UN agencies and NGOs (health cluster partners) have been coordinating their efforts in **responding to the COVID-19 outbreak** in the OPT. A Risk Communication and Community Engagement (RCCE) campaign was led by WHO and UNICEF, and supported by other NGOs including the Palestine Red Crescent Society (PRCE) and the Palestinian Medical Relief Society (PMRS), Medical Aid for Palestinians (MAP), and world vision, reaching over 300 000 people in April alone with awareness-raising messages on the radio, social media, mobile networks and through brochure distribution. Organisations are also supporting the outbreak response by providing Mental Health and Psychological Support Services (MPSS), trauma care, and Infection Prevention and Control (IPC), and Sexual and Reproductive Health (SRH) services, and supporting quarantine centres and hospitals[45]. However, more data is required on which of these services are also serving refugee communities (specifically those residing in camp settings).

4. URGENT NEEDS AND RECOMMENDATIONS IN RESPONSE TO COVID-19

4.1 Adequate access to healthcare for Palestine refugees

a. **Maintain and protect essential health care services** including regular health visits and access to essential medications for patients with NCDs, sexual and reproductive health services including family planning and GBV services, and scaling up of mental health and psycho-social consultations. New and innovative modalities of health care delivery such as the use of the internet and digital health outreach could facilitate remote access to health care services and information. About 96% of Palestinian households have access to mobile phones and 65% have access to the internet[5]. In-person services should consider maintaining physical distancing where possible and good hygiene practices.

b. **Strengthen Health System Capacity** by mobilizing resources to secure adequate medications, consumables, PPE, ventilation, ICUs and bed capacities, particularly in the Gaza Strip where the health system is especially overstretched. It is essential to increase training in infection prevention and control for healthcare workers at MoH and UNRWA facilities. Longer term plans need to be put in place for securing hospital resources and increasing specialization and outbreak response trainings for healthcare workers.

c. **Improve coordination between different healthcare actors** by scaling up inter-sectoral work and collaboration between the MoH administrations in both Gaza and the West Bank, UNRWA, WHO and other local and international non-governmental organizations in their preparedness and response to COVID-19. This includes continuous monitoring and evaluation of resources including funds, facilities and services, in order to prevent misallocation of funds and resources, and any duplication of public health measures. Additionally, it is important for all actors to collaborate in planning and implementing a concise and harmonised exit strategy and developing long-term plans for a more effective and resilient health system.

d. **Increase advocacy efforts** by local and international human rights organizations to address the situation of refugees in the OPT and their basic right to health. This should include calls for the immediate lifting of all restrictions on freedom of movement imposed by the Israeli occupation on Palestinians by removing all checkpoints and lifting the blockade on the Gaza-Strip. These measures would ensure the right of refugees to access adequate medical care without any restriction on their movement or the transportation of medications and equipment in the OPT. In addition, the Israeli authorities must

remove their restrictions on access to water and electricity for Palestinians, and halt all demolitions and arrests in the OPT. Finally, to increase the international community's financial support for UNRWA, including resumption of US funding, to ensure the continuation of services prioritising the dignity and health of Palestinian refugees.

4.2 Inclusion of Palestine refugees in COVID-19 prevention and response

e. **Water, Hygiene and Sanitation (WASH)** (i) Prioritise healthcare facilities and quarantine centres, and provide them with regular and effective WASH supplies and infrastructure to mitigate the risk of COVID-19 spread; (ii) support the local WASH cluster with implementing its urgent priorities as per the OPT humanitarian country team's Response Plan[16] with increased efforts on refugee camps; and (iii) support wastewater treatment with sustainable power sources in the Gaza Strip.

f. **Protect refugees' livelihoods** by (i) ensuring the distribution of food assistance, electronic food vouchers or in-kind food baskets, and non-food items for all vulnerable refugee households;, (ii) formulating and implementing financial and economic plans that will reduce the levels of unemployment and poverty among refugees who suffer from poverty and food insecurity (this includes increased fundraising efforts for the Palestinian government and UNRWA); and (iii) planning for more sustainable alternatives that will protect refugee livelihoods in the short and long terms.

4.3 Responsible and context-specific information strategy

g. **Conduct urgent research studies** that (i) enable better understanding of COVID-19 among the general public and healthcare providers; (ii) promote evidence-based policy recommendations; and (iii) advise on effective COVID-19 management that is specific to the different areas and contexts in the OPT. This will support local efforts in containing and suppressing COVID-19 spread, especially among the refugee population in the OPT.

h. **Strengthen refugee specific Risk Communication and Community Engagement (RCCE)** that is already being planned by UNRWA in its' COVID-19 strategic objectives[44] by (i) financially supporting UNRWA with its needs to implement this strategy as wide as possible; (ii) collaborating with ongoing RCCE activities that are being implemented by the government, MoH, WHO and local organisations in the OPT to improve the implementation and monitoring of RCCE activities among refugee populations; (iii) including refugees in the planning for and implementing these activities; and (iv) considering RCCE activities that would target non-camp refugees in the OPT (where already planned camp activities would not be possible).

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