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Survey of Health in the Occupied Palestinian Territory

April 2007
by Near East Consulting

In collaboration with the Swiss Development Cooperation in Jerusalem

Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
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TABLE OF CONTENTS

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Introduction

During the period 4-8 February, Near East Consulting (NEC) conducted a health survey of over 1,100 randomly selected Palestinians in the West Bank, the Gaza Strip, and East Jerusalem; 781 of the interviews were successfully completed. The survey covered a number of issues relating to family health and well, including mental health, the prevalence of different diseases, health insurance and medical coverage, obstacles to health care service delivery, quality of health services and evaluations of healthcare professionals. Interviews were conducted by telephone. The margin of error for the survey is +/- 3.5%, with a 95% confidence level.

I. Summary of findings

1. Prevalence of depression; and 2. chronic illness and disability

31% of respondents, and slightly more men than women, characterized themselves as 'very depressed.' This figure is nearly one-third lower than that recoded during the worst month of 2006. Extreme depression was more prevalent among refugees then the remainder of the population.

47% of all Palestinian households include at least one person suffering from some type of chronic illness or disability. 'Diabetes' and 'Heart Related Problems' were cited as the most common ailments by slightly more than one quarter of all respondents, respectively.

Both the incidence of depression and illness were strongly related to poverty. One third more hardship cases than non-poor households suffered some kind of depression. Families falling within the hardship category were more than 2.5 times as likely to suffer disability than non-poor families, and more than 1.5 times as likely to suffer chronic illness.

3. Insurance coverage and main care providers

64% of households said all their members enjoy some type of health insurance coverage. Coverage tended to be family-wide: if one member was insured, the remainder were also likely to be so; only 17% of families indicated that they had partial coverage. 20% had no coverage at all.

Though villagers were somewhat less likely than city dwellers to be insured, there were no significant differences across income groups; indeed, hardship families were least likely to be without any coverage. In addition, refugees were at least 1.3 times more likely to enjoy full coverage than the rest of the population.

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The Palestinian Authority is by far the largest health insurance provider in the Occupied Territories, covering 69% of households. Between them, UNRWA[1] and private insurance companies account for an additional 14%.

In the main however, the PA covers medical expenses for only 30% of families; 33% covered their own expenses. Poor households were nearly 1.5 times more likely to rely primarily on the PA than were families above the poverty line. Hardship cases relied comparatively less on the PA (24%) and more on UNRWA (16%).

The PA Ministry of Health was the main care provider for nearly half of all families; private institutions accounted for 28%, and UNRWA for 21%. Households above the poverty line were nearly twice as reliant on private care (40%) as were poor households (24%).

4. Use of health care services

Household use of different types of health services generally ranged in incidence from 40% in the case of specialized care for non-acute problems, to 13% in the case of general urgent health care service s. However, only 4% of families had received mental health care in the past year, notwithstanding high levels of depression.

Variance across sub-groups was primarily determined by poverty level. Hardship cases were up to 2 times more likely than non-poor households to have used most types of services. Both refugee camp residents and hardship cases were twice as likely to have benefited from mental health services.

Only 35% of Gaza households had received specialized cared, compared to 43% of West Bankers. One reason may be that the only Palestinian center for tertiary care– the Muqassed Hospital in East Jerusalem, is located in the West Bank.

More than half of all households indicated that care was received within two hours; 11% had sought some type of care but not received any. In addition, 15% had needed care but deferred seeking it. This figure included 19% of West Bank respondents but only 9% of Gazans, a difference is possibly attributable to internal movement restrictions prevailing in the West Bank.

Rural households and poor families - particularly hardship cases - were about 1.5 times more likely than comparable sub groups to have been denied care, or to have waited longer hours. The greater difficulties encountered by such families were also notable because they were less likely than better-off respondents to have deferred treatment.

5. Obstacles to health care delivery

The most prevalent obstacles to care delivery were financial and capacity constraints; 25% of respondents said they could not afford care, 23% that there were too many other people waiting, and 17% that there was not enough staff attending to them.

[1] It is worth noting that UNRWA does not offer its own health insurance scheme, although the Agency (partially) covers hospitalization costs and also some medication charges.

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As expected, financial constraints impacted households below the poverty line much more than other categories of respondents. However, for refugees and refugee camp residents in particular, capacity constraints were a relatively bigger obstacle than cost.

Rural households were over two times more likely than urban families to cite either distance or lack of transportation as a significant obstacle, and were also much more likely to be affected by checkpoints and other Israeli movement restrictions

6. Evaluation of service quality

Capacity constraints were generally felt more in terms of the time afforded patients, rather than the time spent waiting; nearly one third of families suggested that they would have liked more time with their health care professional; whereas less than one fifth were outright dissatisfied with waiting time.

Refugee camp families expressed the highest incidence of dissatisfaction with the duration of their consultation (49%), along with hardship families (42%), who were nearly twice as likely to have wanted more time as were non-poor households.

Though 90% of respondents were to some degree satisfied with the availability of drugs, poor households were at least twice as likely find drugs hard to come by than were non-poor households. Gazans were also having more difficulty (14%) than West Bankers (8%), possibly owing to their greater poverty or tighter external closures.

Overall, a vast 96 % of respondents expressed some degree of satisfaction with the working hours or their PHC and its distance from their homes. Hospitals were deemed somewhat more difficult to reach, but in general, distance seems to be a problem primarily when compounded by lack of affordable transportation, and the existence of checkpoints.

92% majority households were satisfied to some degree with the attitude of the health staff who attended them, with 57% finding it friendly and supportive, and 35% cold but respectful. Responses did not vary significantly among different categories of respondents.

7. Evaluation of health professionals

For no category of health professionals evaluated for their qualifications and professionalism did more than 10% of respondents give a rating of ‘very bad’ or ‘bad.’ This, the lowest rating was given to general practitioners, who fared poorly compared to specialist doctors. In general, other health professional with which families have frequent contact, including pharmacists, nurses and para-professionals, were given high ratings.

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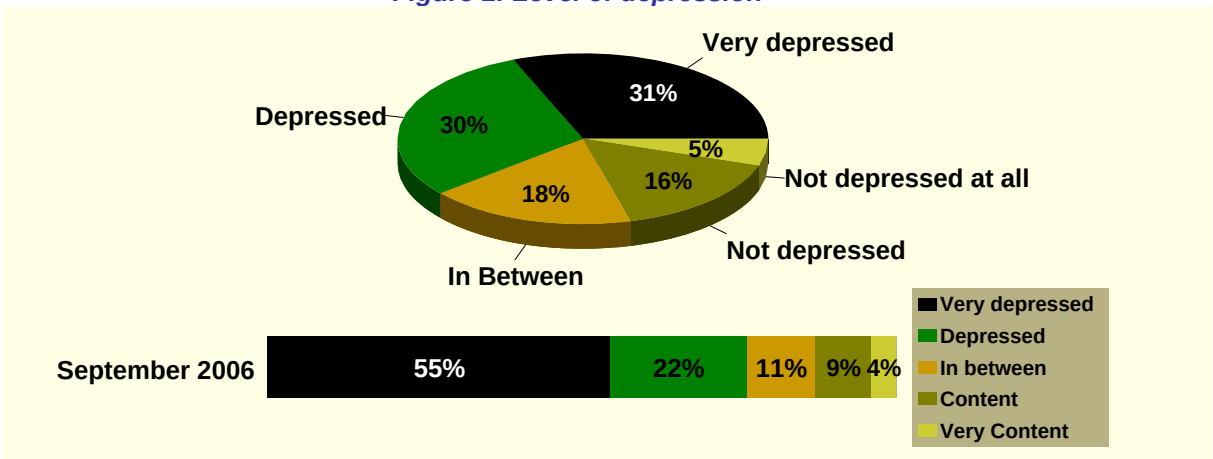
II. Discussion of Findings

1. Prevalence of depression

Questions about the health status of sampled households were prefaced by brief queries into their mental health. It should be emphasized that the results, pictured below in Figure 1, do not reflect strict diagnoses of clinical depression, post-traumatic stress disorder, or their likes, but are to be understood merely as a general indication of how respondents assessed their own frame of mind. As the NEC has regularly posed this question in the context of previous polls, there was added interest in comparing results over time.

Figure 1: Level of depression



As shown, depression levels surveyed in February 2007 were lower than those polled in September 2006. Whereas in September 2006, 77% of respondents were either depressed (22%) or very depressed (55%), that figure had sunk to 61% by February, (31% and 30% respectively). Over the same period the percentage of respondents who were contented or not depressed, rose by a total of 15 %, to 39%.

Not surprisingly, depression levels were deeper and more widespread among the poorest respondents, classified as hardship cases by the Palestinian Ministry of Social Affairs. As detailed in Table 1 below, a full 40% of such respondents said they feel 'very depressed,' compared to 25% and 27% of those living below and above the poverty line, respectively. In total, 69% of the hardship cases are depressed to one extent or another.

It was also not surprising that extreme depression was considerably more pronounced among refugees than non-refugees, with 37% of former category saying they felt 'very depressed,' compared to 27% of the latter. The results can be attributed to a likely correlation between low income and refugee status, and the oftentimes more trying living conditions that obtain in refugee camps, though it should be noted that only approximately 30% of UNRWA-registered West Bank refugees live in camps. Generally, it was also noted that men were slight more likely to feel depressed than were women.

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Table 1: Level of depression, by gender, refugee status and poverty level

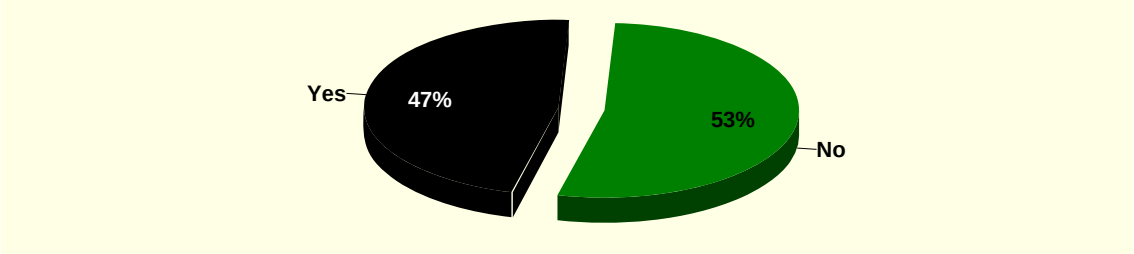
		Very depressed	Depressed	Depression In between	Not depressed	Not depressed at all
Gender	Male	33%	31.1%	16.7%	15.5%	3.4%
	Female	30%	28.2%	19.0%	16.7%	6.6%
Refugee Status	Refugee	37%	29.9%	17.0%	12.5%	3.9%
	Non-Refugee	27%	29.4%	18.8%	18.6%	6.1%
	Hardship cases	40 %	29.0%	15.9%	11.5%	3.6%
Poverty level	Below the poverty line	25%	33.3%	19.0%	16.2%	6.0%
	Above the poverty line	27%	27.2%	20.3%	20.0%	5.9%

2. Prevalence of chronic illness and disability

In order to begin mapping the physical health status of the sampled population, interviewers asked respondents to indicate the prevalence of chronic illnesses or psychological disabilities within their household, and to enumerate the three most prevalent ailments in that household.

2.1 Overall incidence of chronic illness and disability

Figure 2: Chronic illness or psychological disability in HH?



As shown, 47% of all Palestinian households include at least one person suffering from some type of chronic illness or disability. 39% indicated that one or more person in the household is suffering from a chronic illness, and 14% of indicated that at one or more household members were disabled, as shown in Figures 3, and 4, below.

Figure 3: Number of HH members that are disabled

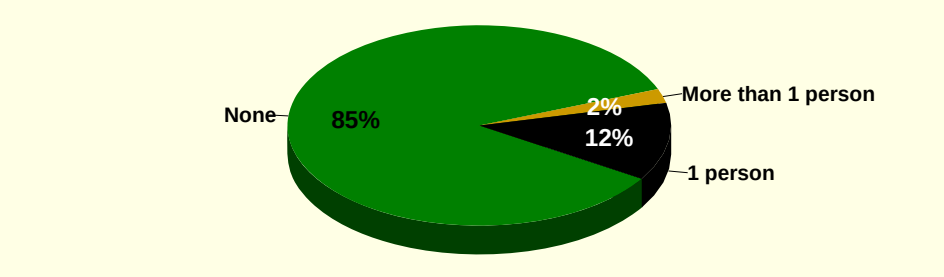


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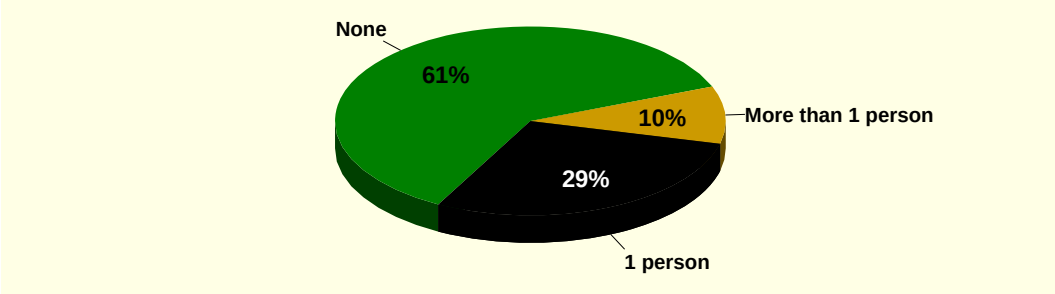
Figure 4: Number of HH members that are chronically ill



As with the incidence of depression, the prevalence of disability varied most dramatically across income groups. Hardship-classified households were more than 2.5 times as likely (22%) to suffer from disability than non-poor households (8%), with poor households occupying an intermediate position. Though it was slightly more likely to find at least one disabled resident among refugee camps household, and to a lesser extent villages, no major differences were observed between households in the West Bank and Gaza Strip.

Table 2: Number of HH members that are disabled, by area of residence and poverty level

		Number of HH members that are disabled		
		None	1 Person	More than 1 person
Area of residence	City	87%	11%	2%
	Village	84%	13%	3%
	Refugee Camp	82%	17%	1%
Region	West Bank	86%	11%	3%
	Gaza Strip	84%	15%	1%
Poverty level	Hardship cases	78%	19%	3%
	Below the poverty line	87%	11%	2%
	Above the poverty line	92%	6%	2%

In the case of chronic illnesses, responses followed a similar pattern. Respondents enduring hardship were more than 1.5 times as likely (49%) to have at least one chronically ill household relative than were those living above the poverty line (27%). Significantly, they were nearly twice as likely (11%) as the latter (6%) to live with more than one ill or disabled person, with poor respondents occupying an intermediate position. Generally, urban households were slightly less likely to have at least one sick member (36%) than those in villages (41%) or refugee camps (42%).

Table 3: Number of HH members that are chronically ill, by refugee status, area of residence and poverty level

		Number of HH members that are chronically ill		
		None	1 Person	More than 1 person
Refugee Status	Refugee	60%	31%	9%
	Non-Refugee	63%	27%	10%
Area of residence	City	64%	26%	10%
	Village	59%	30%	11%
	Refugee Camp	58%	39%	3%
Poverty level	Hardship cases	51%	38%	11%
	Below the poverty line	60%	28%	11%
	Above the poverty line	73%	21%	6%

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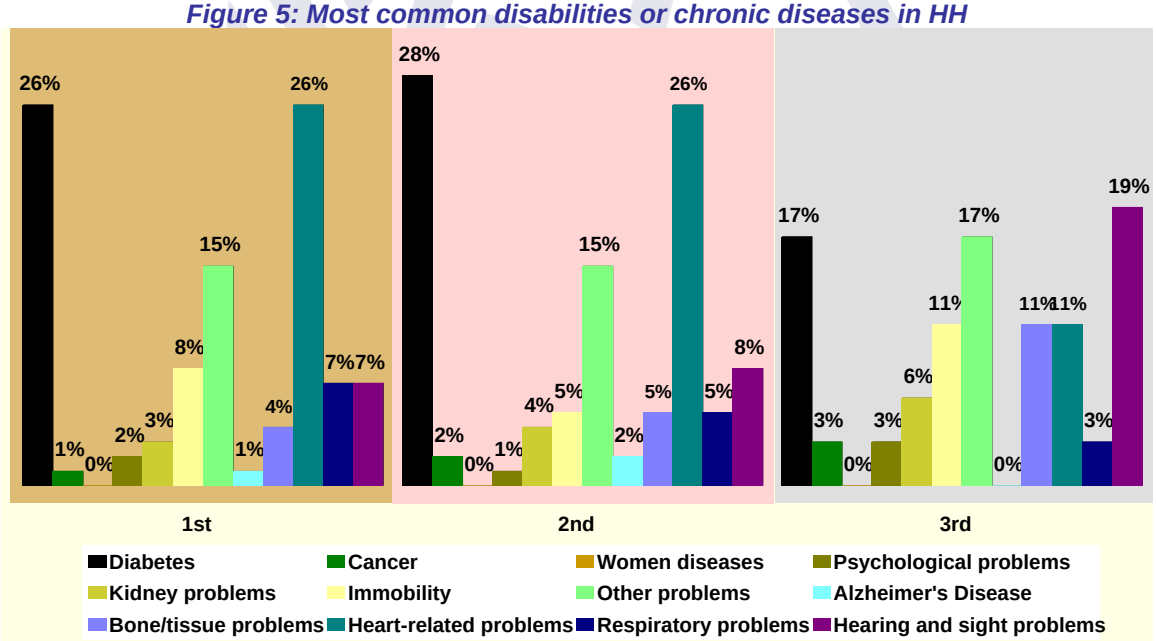
The relationship between poor health and poverty – particularly extreme poverty - evinced by these responses is not surprising. Likely, the explanation is both symptomatic and causal. Households in which at least one family member suffers from a serious ailment are more likely endure financial stress because of costs associated with medication and treatment. They are also more likely to suffer a loss of income if the person in question is a breadwinner. Just how vulnerable the poor are to deteriorations in health is underscored by the fact that households who have fallen into the hardship category report a significantly higher prevalence of illness or disability than those who are 'merely' below the poverty line. Approximately 60% of the population of the West Bank and Gaza currently lives below the poverty line.

2.2 Most prevalent chronic illnesses or disabilities

In identifying most common chronic or physiological ailments suffered by their household, respondents were asked to choose from a menu of possible descriptors, including an 'Other' category. In interpreting these results, it should be noted that many of the options provided were not necessarily unrelated; e.g. 'Immobility,' 'Sight problems," and 'Bone/Tissue' problems are all possible outcomes of advanced diabetes.

As shown below, in Figure 5, respondents listed diabetes and heart related problems first, at 26% each, followed by 'other problems,' 'hearing and sight problems,' and 'immobility.' In so far as these results provide some indication of the overall prevalence of illness in the population, the responses are not surprising. Inter alia, the incidence of diabetes in Palestine is known to be relatively high, though not more so than in surrounding countries such as Jordan and Egypt, and lower than in Saudi Arabia.

Figure 5: Most common disabilities or chronic diseases in HH



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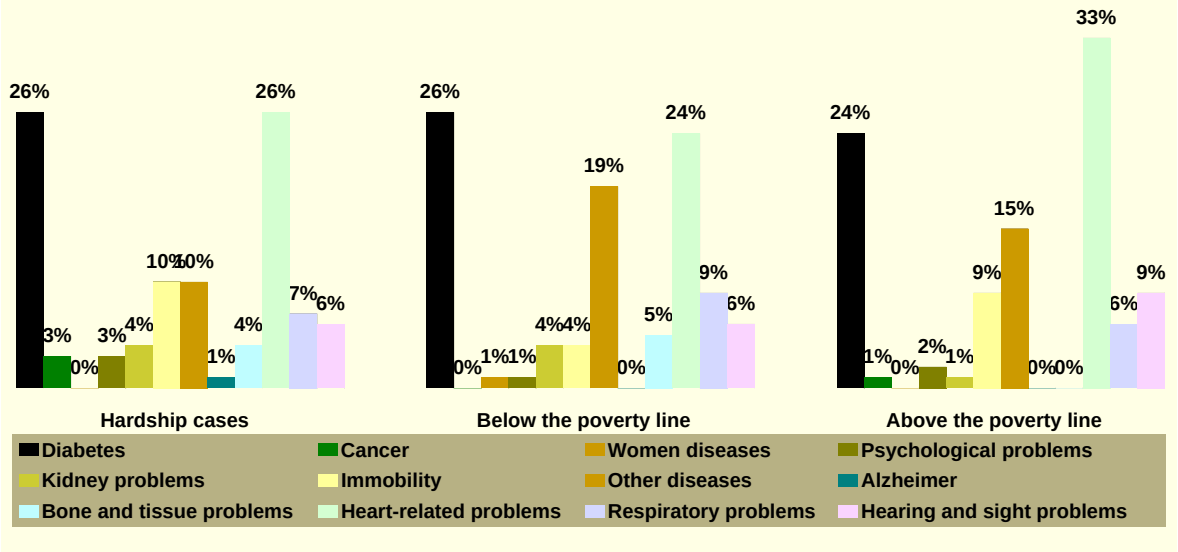
In light of the fact that living conditions, environmental factors, diet, age, and poor access to preventative health care are often precipitating factors in the onset of many illnesses, one might also expect variations across categories of respondents. However, it can be seen in Figure 13 that among the most common illnesses cited by respondents, only heart related problems - which may be linked to overly rich and otherwise unhealthy diets - evinced a notable relationship to income. 33% of families living above the poverty level with at least one ill member, cited such problems, compared to 26% and 24% of hardship cases, and poor households, respectively. Diabetes, which is often linked to obesity - if also to numerous other factors - was actually slightly less widely cited as the most common illness among non-poor households.

Figure 6: Most common illness in HH, by poverty level



Relatively greater variation is evinced when parsing responses by place of residence, as detailed in Table 4, below. Predictably, among households with at least one ill resident, respiratory problems were more often cited as the most prevalent illness in cities (9%) than in villages (6%). Cancer was as such twice as prevalent in refugee camps (2%) than in cities or villages (1%), though very rare overall; similarly for hearing and sight problems, which were twice as likely to be cited by camp residents (10%) than urban households (5%) as the most common household health problem.

Table 4: Most common illness in HH, by place of residence

		Most prevalent illness											
		Diabetes	Cancer	Women diseases	Psychological problems	Kidney problems	Immobility	Other diseases	Alzheimer	Bone and tissue problems	Heart-related problems	Respiratory problems	Hearing and sight problems
Area of residence	**City**	26%	1%	0%	3%	4%	9%	14%	1%	2%	27%	9%	5%
	Village	25%	1%	1%	1%	4%	7%	16%	1%	6%	25%	6%	8%
	Refugee Camp	24%	2%	0%	4%	0%	10%	12%	0%	4%	27%	6%	10%

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Overall, responses differed very little depending on whether the respondents were living in the West Bank or the Gaza Strip, though Gaza households were significantly more likely to be most afflicted with 'immobility.' In so far as this finding approximates the true prevalence of such health problems in the overall population, physical disability, possibly owing to injuries from shelling or bombing, may provide some part of the explanation. Over the course of the Intifada, the Gaza Strip has suffered more intense and sustained fighting and bombardment than the West Bank. It should be underscored however, that this explanation is only conjecture.

Figure 7: Most prevalent illness in HH, by region

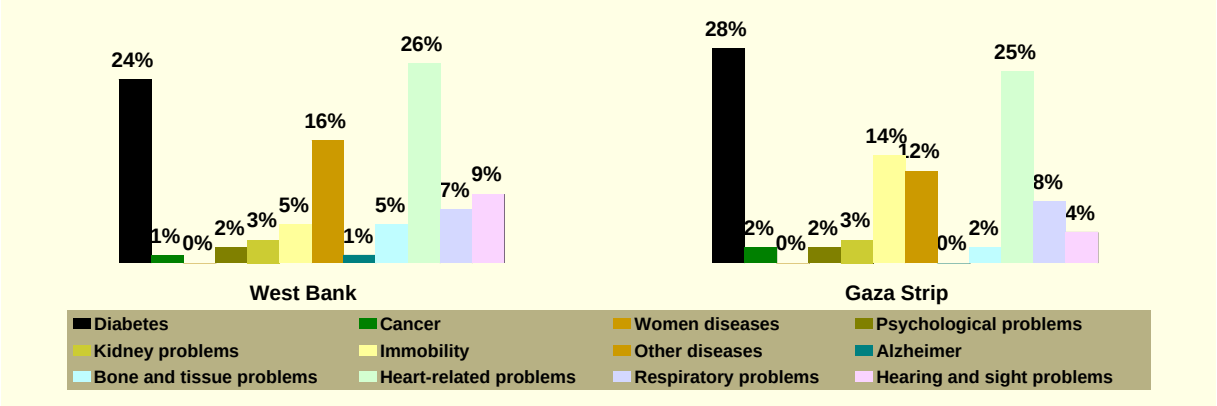

Table 5 below suggests finally what household members are likely to suffer the most common illness. As expected, poor respondents with at least one ill family relative cited the father (36%) - the most common breadwinner –more frequently than the mother (24%), though the response was slightly more likely to be mothers than fathers in the case of extreme hardship cases. It is difficult to speculate on the reasons for these findings.

Otherwise, the most notable result is that in refugee camps, children were more likely (32%) than their parents to suffer the most common illness (20% for fathers and 28% for mothers), whereas the trend for the rest of the population was the reverse. In refugee camps, the father was also slightly less likely than the mother to suffer the most common illness (20%). Qualified health policies experts who wish to interpret this data may wish to bear in mind the environmental factors, poor infrastructure, and cramped space that obtain in refugee camps. They may also consider the possibility that for lack of space or money to build new housing, refugee households may be home to a disproportionate number of adult children.

Table 5: Household member with the most common illness, by place of residence

		Most common illness - Household member					
		Father	Mother	Brother Sister	Son/ daughter	Uncle Aunt	Grandparent
Area of residence	**City**	37%	31%	14%	12%	2%	4%
	Village	31%	27%	13%	16%	7%	6%
	Refugee Camp	20%	28%	8%	32%	2%	10%
Poverty level	**Hardship cases**	29%	32%	14%	14%	5%	5%
	Below poverty	36%	24%	11%	19%	2%	8%

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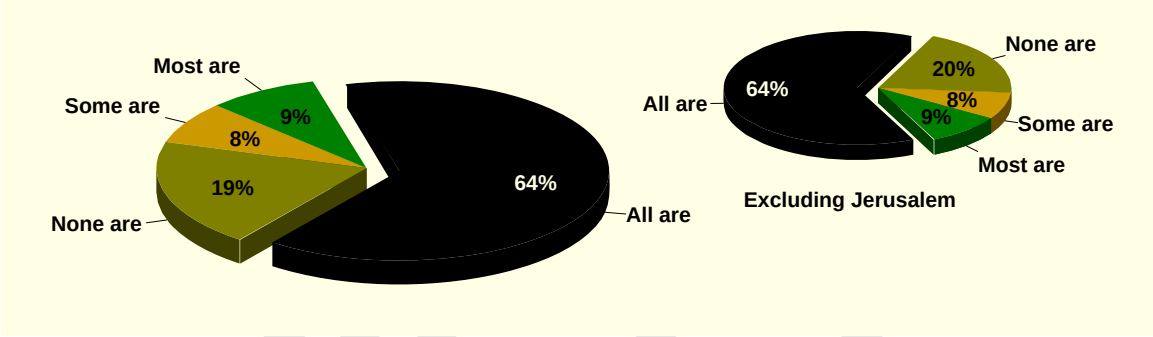
3. Insurance coverage and main care providers

As part of the survey, respondents were asked about their access to health insurance and to identify the main providers of health care for them and their families. Answers by respondents residing in Jerusalem were excluded from the final statistics, since Jerusalemites largely rely on Israeli government health coverage. Because a relatively small number of Palestinians are registered with the Israeli authorities in Jerusalem - about 200,000-300,000 in a total population of 3.5 million - this omission is not likely to have more than a 1-2% impact on the overall results for this part of the survey. The following section synthesizes these results.

3.1 Health insurance coverage by household

Figure 8: Are HH members covered by a health insurance scheme?



As illustrated above, 64% of respondents said that all of their family members enjoy some type of health insurance coverage; 20% enjoyed no coverage at all. In general, coverage was family-wide: if one member of the family were covered, the remainder were also likely to be covered; only 17% of respondents indicated that they had partial coverage.

When parsing these results by sub-groups, as detailed in Table 6, below, two major variances were noted. Firstly, refugees (76%) are at least one third more likely to enjoy full health insurance coverage than are non-refugees (58%). Since over 80% of the population of the Gaza Strip is composed of refugees, it is consequently not surprising that a similar gap exists between Gaza respondents, and those from the West Bank; as well as between refugee camp residents and residents of other areas. Second, it was noted that village households (58%), who compose the majority of the population in the West Bank, were somewhat less likely to enjoy full coverage than their urban counterparts (66%).

Conspicuously, there were no significant differences in coverage across income groups; indeed, hardship cases were least likely (14%) to enjoy no coverage for any household member, compared to 23% of poor respondents, and 21% of those living above the poverty line.

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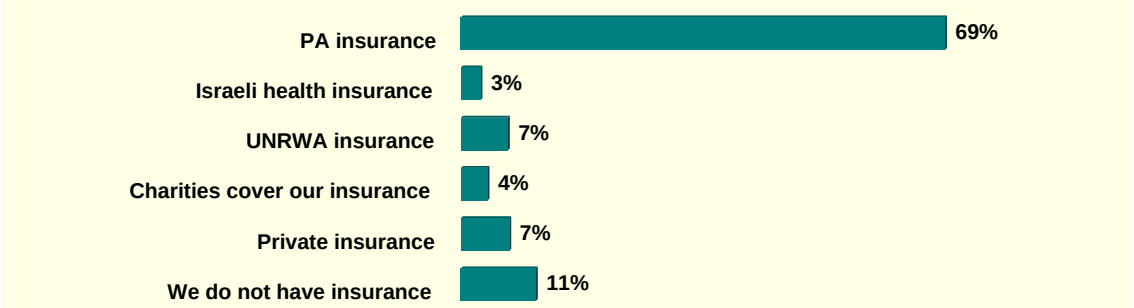
Table 6: Are HH members covered by a health insurance scheme?, by refugee status, area of residence, region and poverty

		Are the HH members covered by a health insurance scheme?			
		All are	Most are	Some are	None are
Refugee Status	**Refugee**	73%	6%	9%	12%
	Non-Refugee	58%	11%	7%	25%
Area of residence	**City**	66%	9%	6%	19%
	Village	58%	10%	8%	24%
	Refugee Camp	73%	3%	13%	11%
Region	**West Bank**	56%	11%	6%	26%
	Gaza Strip	76%	6%	9%	9%
Poverty level	**Hardship cases**	63%	11%	12%	14%
	Below poverty line	62%	9%	6%	23%
	Above poverty line	65%	7%	6%	21%

3.2 Sources of health insurance coverage

As shown in the figure below, the Palestinian Authority is by far the largest provider of health insurance in the Occupied Territories, covering 69% of respondent households. Between them, UNRWA[2] and private insurance companies cover an additional 14%, and charities 4%.

Figure 9: Source of health insurance



The PA insurance scheme generally sustained its coverage across all sub-groups when the above results were broken down further, as detailed in Table 7 below. The exception was when households from the Gaza Strip (79%) were compared to West Bank households (68%).

Two additional variances were noted. First, refugees (12%) were predictably much more likely to draw on UNRWA health insurance than non-refugees (2%), as were refugee camp residents (16%), compared to village (2%) residents and urban households (7%). Second, and also as expected, households above the poverty line were somewhat more likely to rely on private insurance rather than PA insurance (65%), compared to poor households (77%), or those classified as hardship cases (75%). One

[2] It is worth noting that UNRWA does not offer its own health insurance scheme, although the Agency (partially) covers hospitalization costs and also some medication charges.

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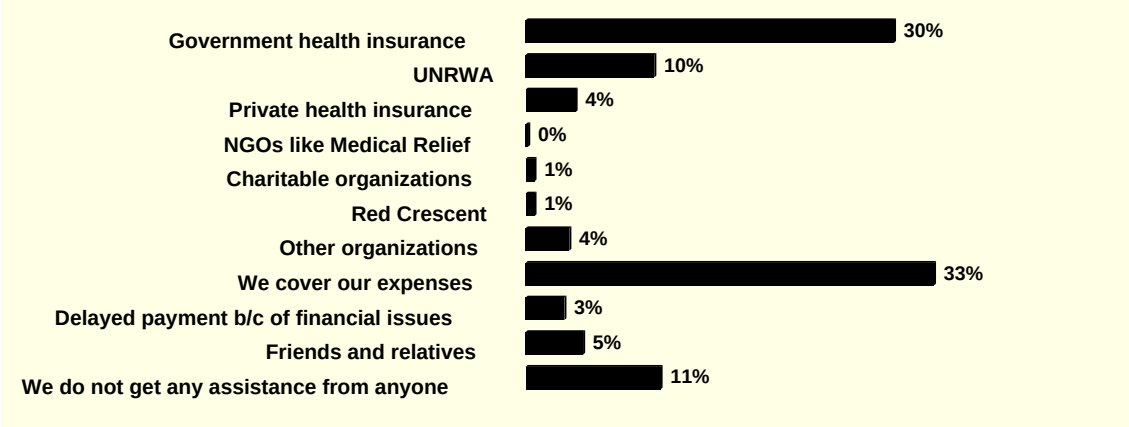
apparent reason may be that private insurance offers wider or better coverage than the PA alternative.

Table 7: Source of health insurance, by refugee status, area of residence, region and poverty level

		Where is your health insurance from?				
		PA	UNRWA	Charities	Private	None
Refugee Status	Refugee	73%	12%	3%	7%	5%
	Non-Refugee	72%	2%	5%	7%	14%
Area of residence	City	73%	7%	4%	8%	7%
	Village	72%	2%	4%	6%	16%
	Refugee Camp	70%	16%	5%	3%	6%
Region	West Bank	68%	3%	5%	8%	16%
	Gaza Strip	79%	11%	4%	5%	2%
Poverty level	Hardship cases	75%	9%	7%	3%	7%
	Below the poverty line	77%	6%	4%	2%	11%
	Above the poverty line	65%	5%	3%	15%	12%

3.3 Source of assistance for covering medical expenses

Figure 10: Source of assistance for covering medical expenses



The aforementioned explanation is given further credence by the manner in which sampled households answered the question of how they cover their medical expenses. Though the government provides insurance to 69% of all households, only 30% indicated that this was their main means of covering medical expenses. A higher number, 33%, said that they covered their own expenses. This may be explained by deductible clauses in the PA insurance scheme, or other limitations or inadequacies. By comparison more households rely on UNRWA for assistance (10%) than are actually covered by UNRWA insurance (7%).

Notably, a very small number of households (6%) said that they rely most on assistance from friends and relatives, notwithstanding the strength and prevalence of extended family networks in the West Bank and Gaza. Nevertheless, after the PA and

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UNRWA, this was the largest source of external assistance. In this respect, charities, the Red Crescent, and NGOs were nearly negligible.

These contrasts are further accentuated when the responses are broken down by sub-group, as detailed in Table 8 below. Though refugees (30%) and non-refugees (27%) receive comparable levels of assistance from the government, UNRWA assists with medical expenses among 20% of such households, though only 12% indicate that UNRWA is their main insurance provider. The difference is even starker in the case of refugee camp residents, with a full 32% relying on UNRWA for their expenses, compared to 8% and 4% of city and village households, respectively. Generally, only slightly more than 20% of refugees, refugee camp residents, and households in the Gaza Strip are forced to cover their own expenses, compared to 36%-42% of their counterparts.

Otherwise it was also noted that poor households were the most reliant on government insurance to cover their expenses (35%), compared to families above the poverty line (26%). The fact that hardship cases also relied less on the PA (24%) was compensated for by the fact that UNRWA provided assistance to a greater number of such families (16%) than to their poor (9%) and non-poor counterparts (6%). The most likely reason is that there a larger number of refugees among such families than in the general population.

Table 8: Source of assistance for covering medical expenses, by refugee status, area of residence, region and poverty

		Source of assistance for covering medical expenses										
		Government health	UNRWA	Private health	NGOs like Medical	Charitable organizatin	Red crescent	Other organizatin	We cover our	Delayed payment	Friends and relatives	We do not get any
Refugee Status	Refugee	30%	20%	3%	1%	1%	1%	3%	25%	1%	6%	10%
	Non-Refugee	27%	3%	5%	0%	0%	1%	2%	41%	5%	4%	11%
Area of residence	City	31%	8%	2%	0%	1%	1%	4%	36%	5%	4%	9%
	Village	30%	4%	7%	0%	1%	1%	1%	37%	3%	5%	11%
	Refugee Camp	18%	32%	5%	2%	2%	2%	2%	21%	0%	8%	11%
Region	West Bank	27%	4%	5%	0%	0%	0%	2%	42%	4%	5%	10%
	Gaza Strip	32%	22%	3%	1%	1%	1%	3%	21%	2%	4%	10%
Poverty level	Hardship cases	24%	16%	2%	0%	2%	1%	5%	23%	5%	6%	16%
	Below poverty line	35%	9%	3%	1%	0%	0%	2%	38%	3%	4%	5%
	Above poverty line	26%	6%	6%	0%	0%	1%	1%	45%	3%	5%	6%

3.4 Main health care providers

Since over two thirds of Palestinians are covered by the PA health insurance scheme, it is not surprising that the PA Ministry of Health (MoH) was the main care provider for the largest number of families (48%), as shown below. Private institutions accounted for

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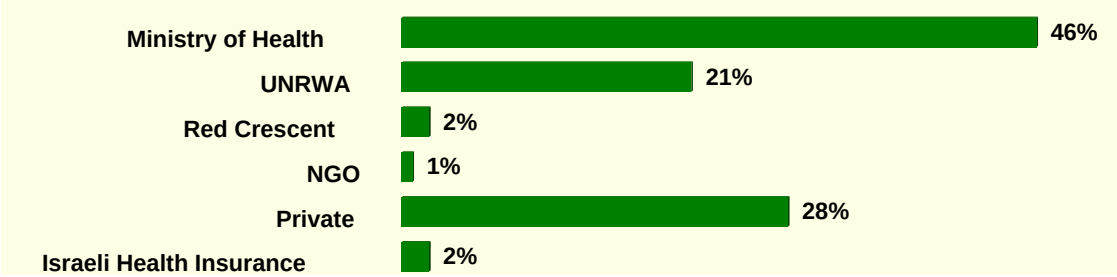
28% of respondents, and UNRWA an additional 21%. The Red Crescent and Israeli Health Insurance were main providers for only 4% of sampled households.

Figure 11: The main provider of the health service for you and your family



When parsing responses by categories of households (and excluding Jerusalem resident covered by Israeli health insurance) a number of variances became evident. As enumerated in Table 9 below, many of these reflect underlying patterns identified by responses to preceding questions.

Though the MoH is the main provider for about half of most sub-groups, with only slight difference for instance between villagers (48%) and city residents (54%), refugee camp residents are comparatively much more reliant on UNRWA (63%), even more so than refugees in general (42%). One explanation may be that proximity to a suitable care center - not to mention the very existence of one - is a determinant factor in decisions about where to seek care. As noted earlier, a majority of registered refugees in the West Bank do not live in camps.

As may be expected, households above the poverty line relied slightly less on the MoH (42%) than poor households (51%), and were overwhelmingly more reliant on private care (40%) than were the latter category (24%). Inter-alia, this suggests a significant quality gap between private and public health care providers. In this context it was also notable that West Bank households relied much more on private care providers (39%) than those in the Gaza Strip (12%). This discrepancy is somewhat disproportionate to the actual income gap between these two regions, or the distribution of refugees/camp residents between them.

Table 9: Main provider of health service for you and family, by refugee status, area of residence, region and poverty level (excepting Jerusalem)

		Main provider of health care for you/family				
		Ministry of Health	UNRWA	Red Crescent	NGOs	Private
Refugee Status	Refugee	36%	42%	1%	1%	19%
	Non-Refugee	55%	7%	2%	1%	34%
Area of residence	City	48%	20%	1%	1%	30%
	Village	54%	11%	3%	1%	31%
	Refugee Camp	23%	63%	2%	0%	12%
Region	West Bank	45%	12%	2%	1%	39%
	Gaza Strip	49%	37%	1%	1%	12%
Poverty level	Hardship cases	48%	31%	1%	1%	18%
	Below poverty line	51%	24%	2%	0%	24%
	Above poverty line	42%	15%	2%	1%	40%

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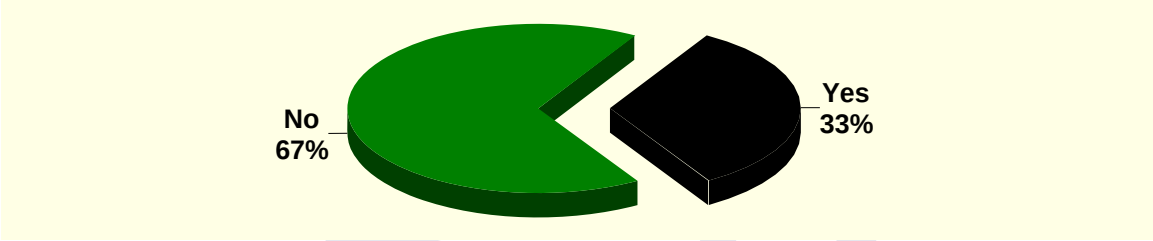
4. Use of health care services

As part of the survey, sampled households were asked about the health services they have received in the past year, including emergency hospital care, ambulance services, maternity services, specialized care for non-acute problems, mental health care, vaccinations, etc. The following section reviews and analyzes the resulting response patterns.

4.1 Emergency hospital care

Figure 12: In general, did you receive emergency hospital care in the past year?



As noted above, one third of respondent households said they had received some form of emergency hospital care for injury of severe acute illness over the past year.

As detailed in Table 10 below, variance across sub-groups was noted primarily on the basis of income, and region of residence. Poorer households (33%) were somewhat more likely than non-poor ones (29%) to have relied on emergency hospital care; hardship cases (37%) even more significantly so. This result is not surprising, in so far as families falling within the hardship category were earlier found to suffer a considerably higher incidence of illness.

Poverty related explanations, however, do not explain why households in Gaza Strip relied considerably less on emergency care (28%) than did those in the West Bank (36%).

Table 10: Received emergency hospital care in past year, by place of residence

		Emergency hospital care in past year?	
		Yes	**No**
Refugee Status	**Refugee**	35%	65%
	Non-Refugee	32%	68%
Area of residence	**City**	33%	67%
	Village	32%	68%
	Refugee Camp	37%	63%
Region	**West Bank**	36%	64%
	Gaza Strip	28%	72%
Poverty level	**Hardship cases**	37%	63%
	Below the poverty line	33%	67%
	Above the poverty line	29%	71%

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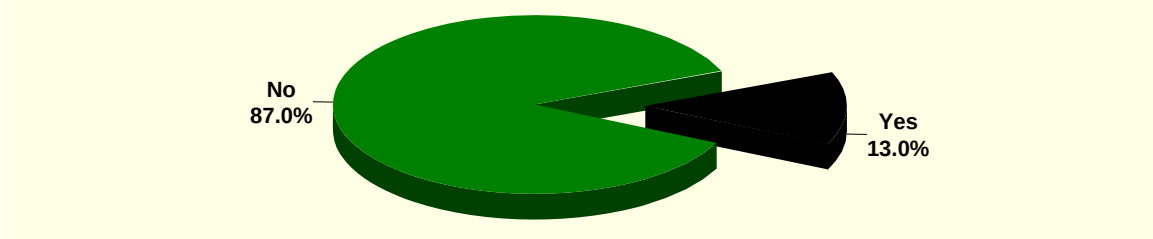
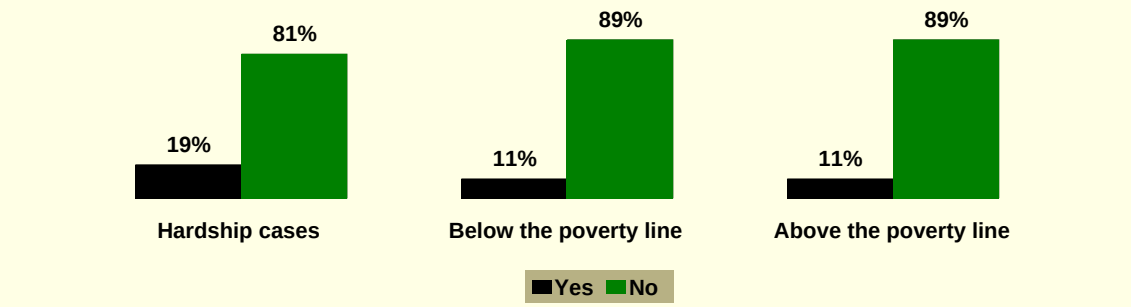
4.2 Urgent health care service for children

Figure 13: In general, did you receive urgent health care service for children in the past year?



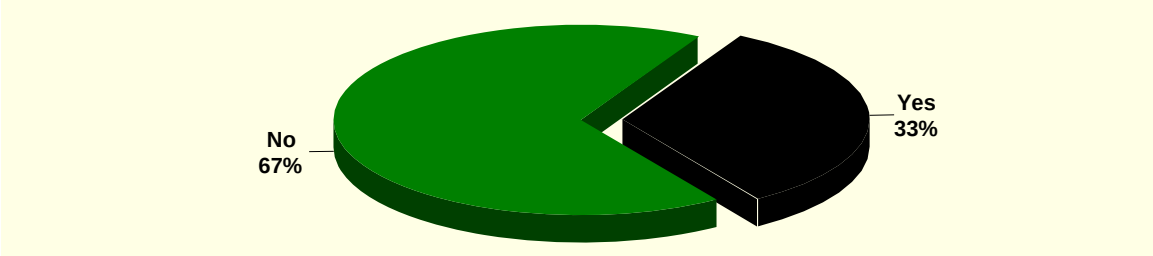
In general, 13% of respondents had received some form of urgent health care service s in the past year. That figure was significantly higher for hardship cases (19%), but there were otherwise no difference between poor and non-poor households, as further illustrated below.

Figure 14: Received urgent health care service in the past year, by poverty level



4.3 Ambulatory care for children

Figure 15: Received urgent health care service for a sick child in the past year



A higher number of respondents, 33% said that they had received ambulatory care for a sick child in the past year. Parsing results by sub-groups, it was again noted that poorer households (35%) and hardship cases (39%) had had to make more use of this service than non-poor families (28%).

It was also notable that village households had relied somewhat less on ambulatory care for children (30%) than families residing in cities (35%) and refugee

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camps (38%), potentially signifying difficulties providing such services in remoter locations.

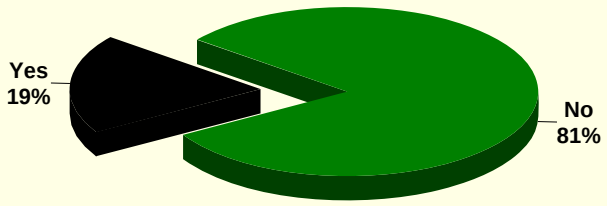
Aggregate discrepancies between villages and refugee camps may partly explain why Gaza households were much more likely to have had use for such services (40%) than those in the West Bank (29%), where a greater share of the population is rural.

Table 11: Received urgent health care service for a sick child in past year, by place of residence, region and poverty level.

		Received urgent health care service for a sick child (cough, diarrhea, etc.) in past year	
		Yes	No
Area of residence	**City**	35%	65%
	Village	30%	70%
	Refugee Camp	38%	62%
Region	**West Bank**	29%	71%
	Gaza Strip	40%	60%
Poverty level	**Hardship cases**	39%	61%
	Below the poverty line	35%	65%
	Above the poverty line	28%	72%

4.4 Hospital and maternity services

Figure 16: Received hospital/maternity service for delivery



19% of respondents, meanwhile, said they had received hospital or maternity services to assist in delivery over the past year. At 23%, hardship cases were again more likely to have used such services than non-poor households (14%), with poor families occupying an intermediate position (18%) Reflecting previously cited usage patterns, more Gazans (23%) have received hospital maternity service for delivery care in the past year than have West Bankers (17%). It may be speculated that the difference owes at least in part to Israeli-imposed internal movement restrictions prevailing in the West Bank.

Table 12: Received hospital/maternity service for delivery in the past year, by region and poverty

		Received hospital/maternity service for delivery care in the past year	
		Yes	No
Region	**West Bank**	17%	83%
	Gaza Strip	23%	77%
Poverty level	**Hardship cases**	23%	77%
	Below the poverty line	18%	82%
	Above the poverty line	14%	86%

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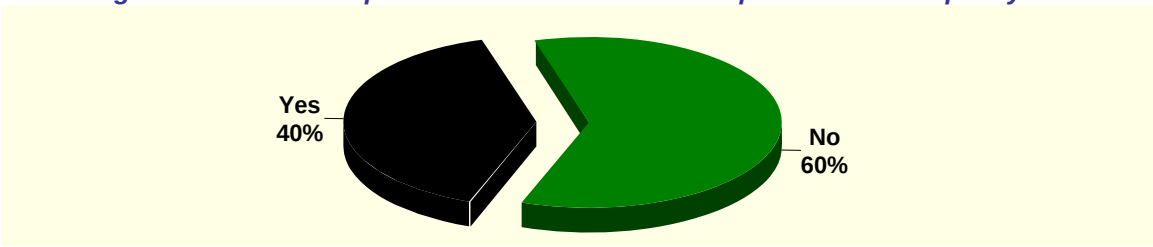
4.5 Specialized care for non-acute problems

Figure 17: Received specialized care for non-acute problems in the past year



40% of respondent households had received specialized care for non-acute problems in the past year. However, this was somewhat less the case for city residents (35%), particularly compared to village (45%) and refugee camp households (46%).

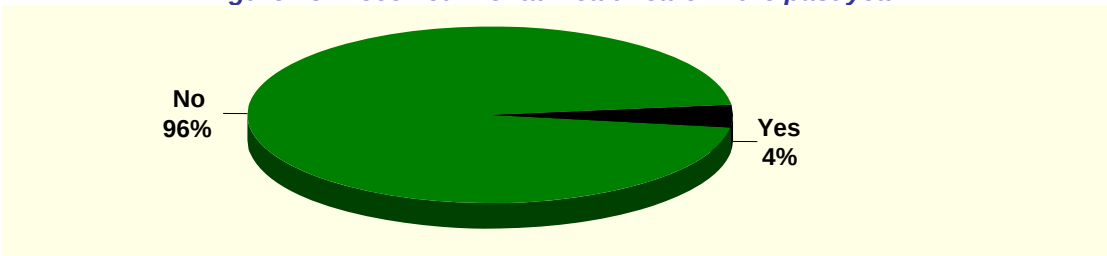
Also of note, only 35% of Gaza households had received specialized cared, compared to 43% in the West Bank. One explanation may be that the only Palestinian center for tertiary care in the Occupied Territories – the Muqassed Hospital in East Jerusalem - is relatively more difficult to reach from the isolated Gaza Strip, requiring the applicant to go through an arduous Israeli clearance process. It can be speculated that individuals with non-acute problems are less likely to seek and obtain such clearance. In this context it should be noted that access to Muqassed is also to a lesser, effective extent restricted for West Bank residents without Israeli-issued Jerusalem ID's.

Table 13: Received specialized care for non-acute problems in past year, by place of residence and poverty

		Received specialized care for non acute problems in past year	
		Yes	No
Area of residence	**City**	35%	65%
	Village	45%	55%
	Refugee Camp	46%	54%
Region	**West Bank**	43%	57%
	Gaza Strip	35%	65%

4.6 Mental health care

Figure 18: Received mental health care in the past year



In general, only a very small, 4% fraction of respondents had received mental health care in the past year. This is a sobering finding, given earlier survey results showing a high incidence of self-diagnosed depression, and the fact that Palestinians in the

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Occupied Territories are generally cited as suffering a very high rate of post traumatic stress disorder and other conflict- related psychosocial problems.

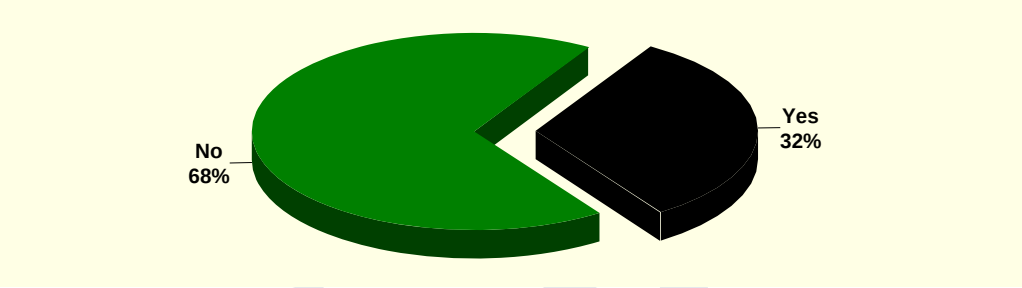
Encouragingly, however, the poorer the household, the more likely were they to have benefited from some kind of mental health care, with hardship cases (7%) followed by those living below the poverty line (4%) and finally by non-poor households, at 2%. Generally speaking, among respondents that indicated that they received mental health care in the past year, 9% resided in refugee camps, 5% in cities and only 2% in villages. Overall, Gazans (8%) received mental health care more than West Bankers (2%).

Table 14: Received mental health care in the past year, by place of residence

		Received mental health care in the past year	
		Yes	No
Area of residence	**City**	5%	95%
	Village	2%	98%
	Refugee Camp	9%	91%
Region	**West Bank**	2%	98%
	Gaza Strip	8%	92%
Poverty level	**Hardship cases**	7%	93%
	Below the poverty line	4%	96%
	Above the poverty line	2%	98%

4.7 Follow-up for chronic diseases

Figure 19: Received follow-up for chronic disease in the past year



When respondents were asked whether they received follow-up care for a chronic disease, nearly one third indicated that they had. Though the incidence of follow-up care did not vary greatly across areas of residence, there was again a significant correlation with levels of poverty, as detailed in Table 19 below. 40% of households living at the hardship level had benefited from follow-up, compared to 35% of poor families, and 21% of non-poor families.

Table 15: Received follow-up for chronic disease in the past year, by place of residence

		Received follow-up for chronic disease (diabetes, hypertension, etc) in the past year	
		Yes	No
Area of residence	**City**	30%	70%
	Village	35%	65%
	Refugee Camp	30%	70%
Poverty level	**Hardship cases**	40%	60%
	Below the poverty line	35%	65%
	Above the poverty line	21%	79%

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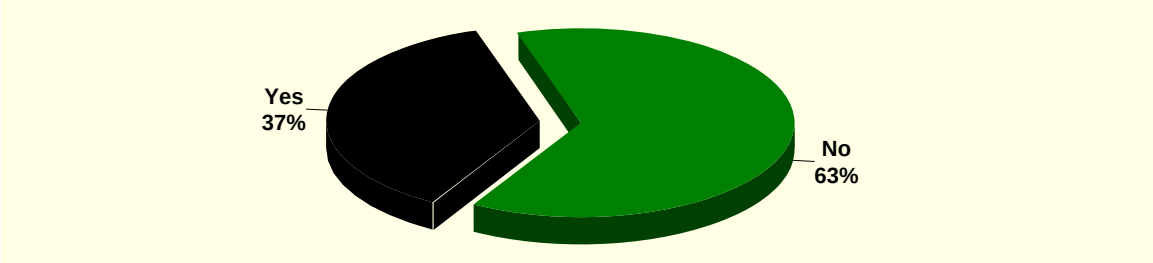
4.8 Vaccinations

Figure 20: Has HH received vaccination in the past year?



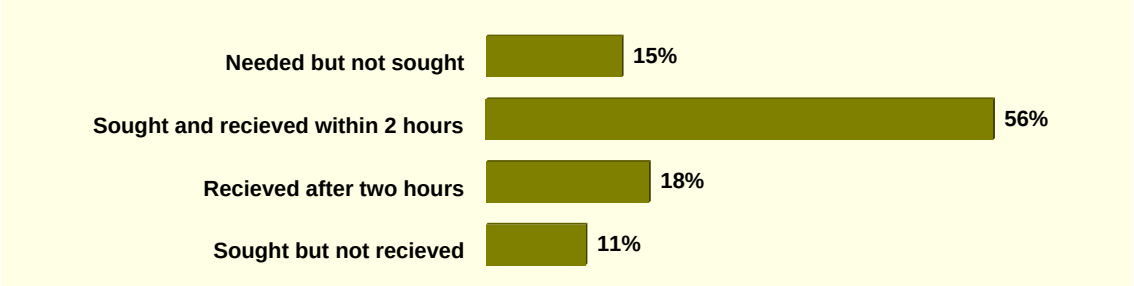
As illustrated, over one third of households had received vaccinations over the past year. Within this sample, it was noted that refugee camp residents were more likely to have received vaccinations (43%) than village residents (39%) and city residents (35%).

Table 16: Received vaccination in the past year, by place of residence

Received vaccination in the past year	Area of residence		
	City	Village	Refugee Camp
Yes	35%	39%	43%
No	65%	61%	57%

4.9 Responsiveness of care provider

Figure 21: Was care received for health problems in the HH?.



In order to help gauge efficiency of care provision, the survey asked respondent households whether they had sought and managed to obtain care, and if so within what amount of time? In response, 11% indicated that they had sought some type of health care had not received any; 15% said they needed care but had never sought it. More than half indicated that assistance was received within two hours, and 18% were required to wait for more than two hours

When parsing these responses, as detailed in Table 17 below, a number of additional variances were observed. Not surprisingly, health care provision seems to have been least timely in rural areas, with only 47% of village households having waited less than 2 hours, compared to 61% of urban households and 59% of refugee camp

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residents. A considerably higher share of rural respondents (15%) also indicated that they had been denied care, compared to 9% of urban residents and 8% of refugee camp families.

Though hardship cases were less likely than better-off respondents to have deferred treatment despite needing it, they were more likely (22%) to have waited more than two hours, compared to 16% among the former category. Both hardship cases (14%) and poor households (13%) were also more likely than non-poor households to have been denied care (8%). This finding is notable inter alia because earlier responses indicate that hardships cases are as likely as other income groups to enjoy health insurance coverage – or even slightly more so. Since inability to pay is the most likely explanation for being denied care, one possible explanation may be that they were unable to afford even small co-payments, or to cover other costs – e.g. medication – associated with treatment.

Overall, West Bank households (19%) were considerably more likely than Gaza families (9%) to have needed care but not sought it out. The reasons for this discrepancy are unclear; one likely explanation may be that disincentives to accessing care, such as movement restrictions, are relatively more prevalent in the West Bank.

Table 17: How was care received for health problems in the HH?, by area of residence, region and poverty

		Efficiency of care provision			
		Needed but never sought	Sought and received within 2 hours	Received after two hours	Sought but not received
Area of residence	**City**	16%	61%	14%	9%
	Village	15%	47%	22%	15%
	Refugee Camp	13%	59%	21%	8%
Region	**West Bank**	19%	50%	17%	13%
	Gaza Strip	9%	64%	19%	8%
Poverty level	**Hardship cases**	12%	53%	22%	14%
	Below the poverty line	18%	53%	16%	13%
	Above the poverty line	17%	59%	16%	8%

5. Obstacles to health care delivery

As noted in the previous section, nearly one quarter of Palestinian households are either deterred from seeking health care, or have been denied care altogether. Nearly one fifth of respondents experienced waiting times longer than two hours. In this context, the following section seeks to identify the main obstacles to timely health care provision in the Occupied Territories.

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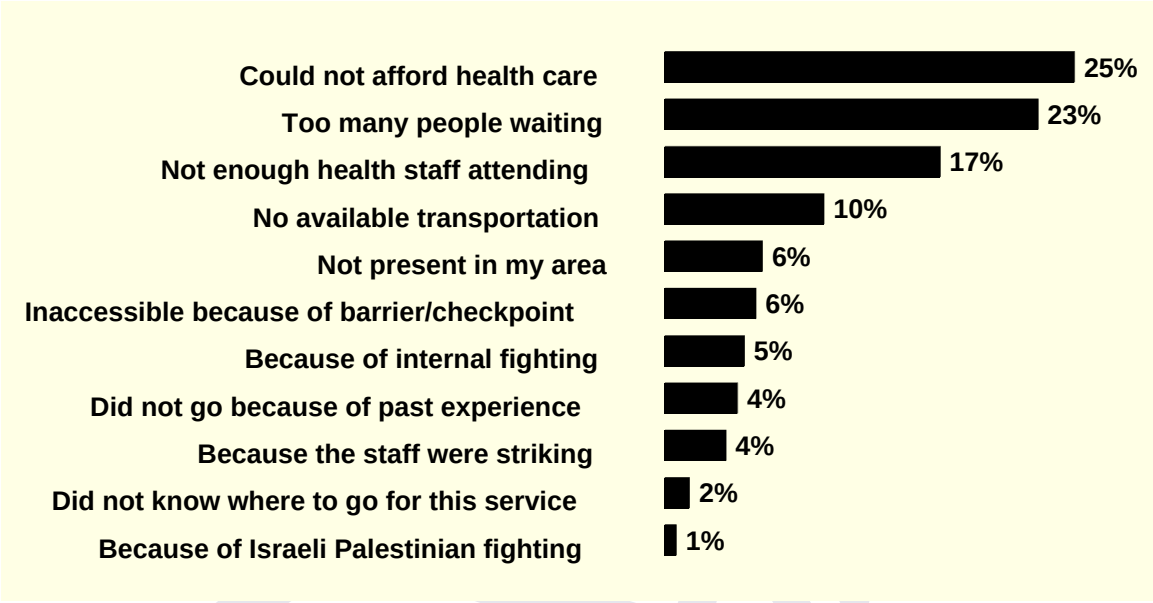
5.1 Main obstacles for the general population

Figure 22: Reasons for denied or delayed provision of health care



As illustrated above, the single greatest obstacle was financial; 25% of respondents said that they were denied care because they could not afford it. Capacity constraints were cited as a comparably significant problem; 23% of households said that there were too many other people waiting when they went to seek care, and 17% said that there was not enough staff in attendance. However, a very small number, 6%, said that there was no health care available in their area. Of note, a relatively small number of households cited movement restrictions or constraints associated with the Israeli occupation (6%).

5.2 Main obstacles for poorer households

As noted in the preceding section, poorer household - and particularly those classified as falling within the hardship category - often made more frequent use of a variety of different health services, and were also more likely to suffer longer delays, or of being denied care. When asked why they encountered such problems, the most common answer was that could not afford care; this was the case both for hardship cases (28%) and households falling poverty line (27%) a figure that is slightly higher than the national average, and much higher than the 17% cited by non-poor households. Such households by comparison cited crowding (29%) as their greatest obstacle. Nevertheless, households below the poverty were slightly more likely than non-poor families to report that no health professional were attending to them.

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Table 18: Main reason for denied or delayed provision of health care, by poverty level

Main reason for the denied or delayed provision of health care	Poverty level		
	Hardship cases	Below the poverty line	Above the poverty line
I did not know where to go for this health service	3%	0%	1%
Did not want to go because of past unsatisfactory service	2%	3%	11%
The service was too far from my residence, no transportation	10%	10%	9%
Service was present but inaccessible b/c of checkpoint, etc.	7%	3%	5%
It was too dangerous b/c of conflicts in my area	0%	1%	1%
Because of internal fighting	4%	5%	5%
Because it is not available in my area	6%	8%	4%
Because there were too many people waiting	21%	18%	29%
Because of the strike	3%	5%	3%
There were no health professionals to attend to us	16%	19%	13%
I could not afford it financially	28%	27%	17%

5.3 Main obstacles by place of residency

Though a fairly consistent, mid-20% share of respondents from urban, rural and refugee camp settings cited financial constraints as the main obstacle to care delivery, the other major reasons given by respondents from the three groups varied considerably.

Not surprisingly, village households were much more likely to cite either distance or lack of transportation as a significant obstacle (16%), compared to 6% of urban families; virtually no refugee camp respondents cited this as a main obstacle. In addition, rural households were much more likely to be affected by checkpoints and other Israeli movement restrictions (11%), than were urban families (1%), or refugee camp respondents (3%); and were most likely to cite unavailability of any health care provider as a main obstacle (8%), compared to 5% of urban respondents, and 3% of those from refugee camps.

Conversely, rural respondents were least likely to cite capacity constraints at their care providing center as a chief obstacle; only 13% said that there were no health professional attending them; or that too many people were waiting with them (15%). These were however the main reasons cited by that refugee camp residents; 38% of whom cited the former obstacle, and 21% the latter, compared to 25% and 19% of urban respondents, respectively. For refugee camp residents, indeed, overcrowding was a bigger problem – if likely also a less severe one - than inability to pay for care.

Overall, these responses indicate that whereas refugee camp residents enjoy comparatively good access to health care, their main providers may be suffering capacity constraints disproportionate to those encountered by providers primarily serving other sub-groups.

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Table 19: Main reason for the denied or delayed provision of care, by place of residence

Main reason for denied or delayed provision of care	Area of residence		
	City	Village	Refugee Camp
I did not know where to go for this health service	3%	1%	0%
Did not want to go because of past unsatisfactory service	6%	3%	3%
The service was too far from my residence, no transportation	6%	16%	0%
Service was present but inaccessible b/c of checkpoint, etc.	1%	11%	3%
It was too dangerous b/c of conflicts in my area/health center	0%	1%	3%
Because of internal fighting	4%	6%	5%
Because it is not available in my area	5%	8%	3%
Because there were too many people waiting	25%	15%	38%
Because of the strike	4%	5%	0%
There were no health professionals to attend to us	19%	13%	21%
I could not afford it financially	27%	22%	26%

5.4 Main obstacles for refugees

When the responses of refugees as a group were analyzed, it became apparent that the capacity problems adumbrated in the previous discussion are more likely to be determined by residence of a refugee camp, rather than refugee status per se. Specifically, it suggests that such constrains are most likely associated with UNRWA health care providers, which, as noted earlier in the survey report, serve 63% of refugee camp residents, but only 42% of refugees per se. The reason for this discrepancy, as also noted earlier, is that in the West Bank a majority of refugees do not live in camps.

Accordingly, whereas refugees were more likely than the rest of the population to be unattended by health professionals (21% compared to 13% for non-refugees) and to be troubled by overcrowding (26% compared to 20%) these differences are less pronounced than those observed in the case of camp dwellers. Otherwise, it can again be noted that refugees were not more likely to cite financial constraints than were the general population, and that a lower number of them (4% compared to 7% of non-refugees) said that there were no care provider in their area, or that it's facilities were too far away (6% compared to 13% of non-refugees.)

Table 20: Main reason for the denied or delayed provision of care, by refugee status

Main reason for the denied or delayed provision of health care	Refugee Status	
	Refugee	Non-Refugee
I did not know where to go for this health service	1%	2%
Did not want to go because of past unsatisfactory service	3%	5%
The service was too far from my residence, no transportation	6%	13%
Service was present but inaccessible b/c of checkpoint, etc.	7%	4%
It was too dangerous b/c of conflicts in my area/health center	1%	1%
Because of internal fighting	5%	5%
Because it is not available in my area	4%	7%
Because there were too many people waiting	26%	20%
Because of the strike	2%	5%
There were no health professionals to attend to us	21%	13%
I could not afford it financially	24%	25%

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5.5 Overall differences between the West Bank and Gaza Strip

In general, differences between responses from the West Bank and those from the Gaza Strip were largely in line with patterns identified earlier in the section. In so far as poverty and extreme poverty is more prevalent in the Gaza Strip than in the West Bank, it was not surprising that 34% of families from this region said that there were unable to afford care, compared to 18% of West Bank respondents.

Since a higher proportion of Gaza residents are registered as refugees and live in camps, it was also to be expected to a greater number of them would cite capacity constraints as a main obstacle to care delivery: 23% of Gaza households said that they had been unattended by health staff when seeking care, compared to only 12% of West Bank respondents, and 25% cited overcrowding as a main problem, compared to 21% of West Bankers.

With the population of the West Bank being more dispersed and rural in character, it was equally unsurprising that 15% of respondents from this region said that their care provider was too far away or that they could find no transportation (15%); or that care was inaccessible due to checkpoints and other movement restrictions (9%). The corresponding incidence of such problems among Gaza respondents were 2% and 0%, respectively.

In addition, it could be noted that though the percentage of respondents who were deterred by past unsatisfactory experiences was generally small, it was twice as high in the West Bank (6%) than in the Gaza Strip (3%).

Table 21: Main reason for denied or delayed provision of health care, by region

Main reason for the denied or delayed provision of health care	Region	
	West Bank	Gaza Strip
I did not know where to go for this health service	2%	1%
Did not want to go because of past unsatisfactory service	6%	3%
The service was too far from my residence, no transportation	15%	2%
Service was present but inaccessible b/c of checkpoint, etc.	9%	0%'
It was too dangerous b/c of conflicts in my area/health center	1%	1%
Because of internal fighting	5%	5%
Because it is not available in my area	6%	5%
Because there were too many people waiting	21%	25%
Because of the strike	6%	1%
There were no health professionals to attend to us	12%	23%
I could not afford it financially	18%	34%

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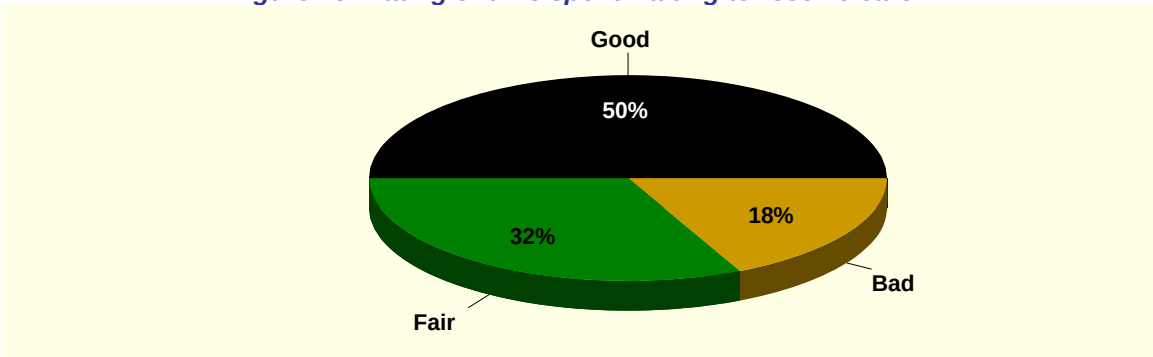
6. Evaluation of service quality

As part of the survey, respondents were asked to evaluate the quality of health care in terms of waiting time, consultancy duration, availability of drugs, working hours of PHC center, distance of PHC center from the home, distance of hospital from the home and health staff attitude. The responses are reviewed in the following section.

6.1 Time spent waiting to receive care

Figure 23: Rating of time spent waiting to receive care:



As shown, 82% of respondents felt that the time they spent waiting for care was very satisfactory, or fair. In so far as respondents above the poverty line tend to rely disproportionately on private care providers, it was not surprising that they expressed the highest degree of approval, with 59% citing waiting time as 'good.' Conversely, hardship cases were most likely to be dissatisfied, with 24% saying that waiting time was 'bad,' compared to 18% of poor respondents, and 13% of non-poor households. In no other sub group categories did more than 19% of respondent express strong dissatisfaction with waiting time. In light of the findings review in Section 5, which showed that overcrowding and long waiting hours were a disproportionately greater obstacle to health care delivery for refugee camp residents, it is indeed interesting to note that this category of respondents were most satisfied overall; only 14% said that waiting time was 'bad.'

Table 22: Rating of time spent waiting for care, by refugee status, area of residence, region and poverty level

		Rating of waiting time when receiving health care		
		Good	Fair	Bad
Refugee Status	**Refugee**	48%	35%	17%
	Non-Refugee	52%	29%	19%
Area of residence	**City**	55%	26%	18%
	Village	44%	38%	18%
	Refugee Camp	48%	38%	14%
Region	**West Bank**	53%	30%	17%
	Gaza Strip	47%	34%	19%
Poverty level	**Hardship cases**	39%	37%	23%
	Below the poverty line	51%	31%	18%
	Above the poverty line	59%	27%	13%

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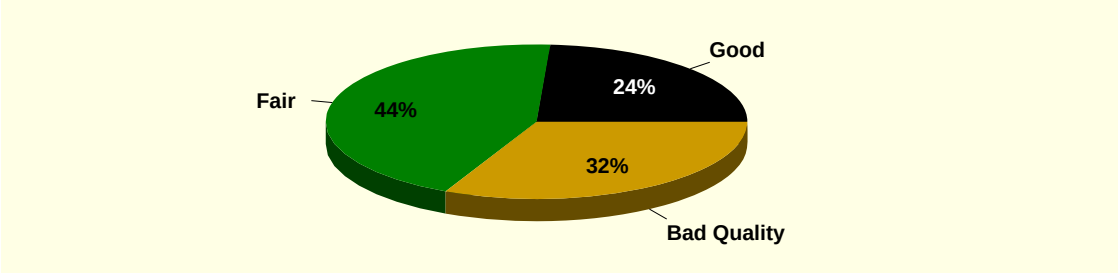
6.2 Duration of consultation

Figure 24: Rating the duration of consultation



Overall, respondents tended be less satisfied with the length of the consultation afforded them than they were with their waiting time; nearly one third suggested that they would have liked more time with their health care professional(s).

Refugee camp families expressed the highest incidence of dissatisfaction (49%); far above the general average, and considerably higher than villagers (33%) or urban families (27%). Accordingly it is not surprising that refugees in general were more like to be unhappy (37%) than non-refugees (28%), as were Gazans (41%), compared to West Bankers (26%).

In the above context, it may also be noted that hardship cases, which are more prevalent in the Gaza Strip, were more likely to be dissatisfied with the duration of their consultation (42%) than were poor families in general (34%) and non-poor families, who expressed the lowest overall rate of dissatisfaction, at 22%. Rural respondents were also slightly more likely to be unhappy (33%) than their urban counterparts (27%).

In so far as local capacity constraints most impinge on the care delivered to refugee camp residents and refugees, it may accordingly be speculated that these constraints are felt more in terms of the time afforded patients and then their families, rather than the time spent waiting.

Table 23: Evaluation of consultancy duration, by refugee status, place of residence, region and poverty

		Rating of consultancy duration		
		Good	**Fair**	**Bad**
Refugee Status	**Refugee**	23%	40%	37%
	Non-Refugee	25%	47%	28%
Area of residence	**City**	27%	46%	27%
	Village	22%	46%	33%
	Refugee Camp	18%	33%	49%
Region	**West Bank**	26%	47%	26%
	Gaza Strip	21%	38%	41%
Poverty level	**Hardship cases**	20%	38%	42%
	Below the poverty line	20%	46%	34%
	Above the poverty line	31%	47%	22%

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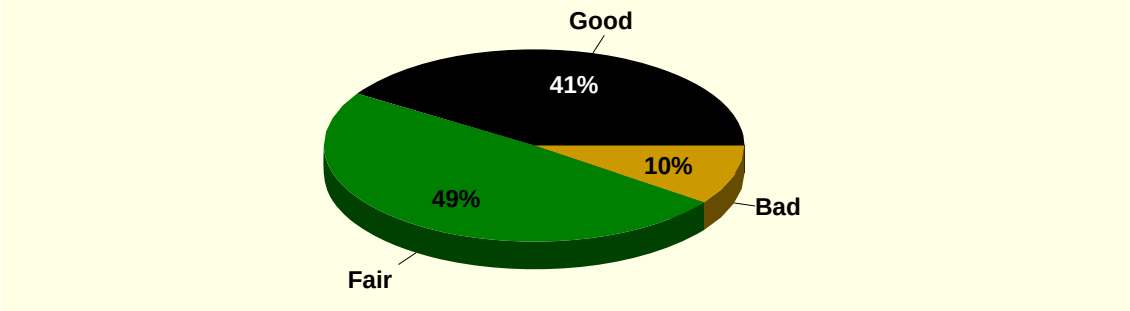
6.3 Availability of prescribed drugs

Figure 25: Rating the availability of prescribed drugs



External Israeli closures, particularly affecting the Gaza Strip, and internal movement restrictions which are felt especially among rural communities of the West Bank, has made the availability of certain prescription drugs an enduring concern among public health officials in the West Bank and Gaza. In this context it is noteworthy that a full 90% of respondents were to some degree satisfied with the availability of such drugs.

The aforementioned problems may however explain why respondents from the Gaza Strip evinced a higher degree of dissatisfaction (14%) than did West Bankers (8%), and a much lower incidence of strong satisfaction (25%) compared to the latter (51%). Notably however, rural and urban respondents expressed identical levels of satisfaction across all rating categories.

It can also be noted that hardship cases (15%) and poor-households (12%) were much more likely to find drugs hard to come by than were non-poor households (6%). This is to be expected, in so far as better off patients and their families are willing to pay more for medications, or travel a greater distance to find it. This 'income effect' may also partly explain the discrepancy between responses from the Gaza Strip and the West Bank.

Table 24: Rating the availability of prescribed drugs, by refugee status, area of residence, region and poverty level.

		Rating of the availability of prescribed drugs when receiving health care		
		Good	**Fair**	**Bad**
Refugee Status	**Refugee**	33%	55%	11%
	Non-Refugee	46%	44%	10%
Area of residence	**City**	44%	46%	10%
	Village	44%	46%	10%
	Refugee Camp	21%	67%	12%
Region	**West Bank**	51%	41%	8%
	Gaza Strip	25%	61%	14%
Poverty level	**Hardship cases**	29%	56%	15%
	Below the poverty line	40%	48%	12%
	Above the poverty line	52%	42%	6%

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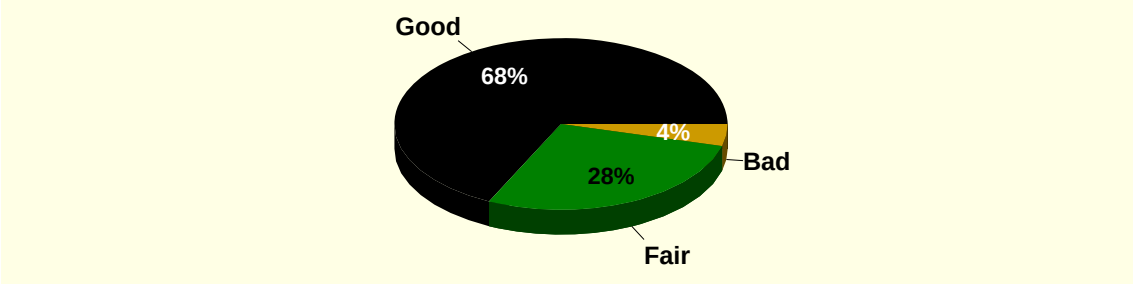
6.4 PHC working hours

Figure 26: Evaluation of health service in terms of PHC working hours



Overall, a vast 96 % majority of respondents expressed some degree of satisfaction with the working hours or their local PHC. However, refugee camp respondents (60%) and villagers (65%) were somewhat less likely than urban households to feel that these hours were very satisfactory (71%); 6% of rural respondents were also outright unhappy with these hours, compared to 3% of urban households, and 2% of refugee camp residents; a not entirely surprising discrepancy, given that rural respondents generally need to travel longer distances to reach their PHC. (See section 6.5 below.)

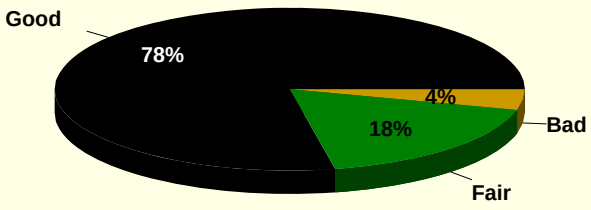
Similarly, hardship cases were more likely (6%) to be unhappy than were poor households (3%) and other poor households (4%). It is difficult to speculate on the reasons for this discrepancy without further contextual information. One possible explanation may be that hardship cases seeking are more financially constrained in their ability to travel, or take time of. In general however, opening hours seem to be a relatively small problem as far as patients and their families are concerned.

Table 25: Evaluation of working hours of PHC center, by place of residence and poverty level

		Rating of working hours of the PHC center		
		Good	Fair	Bad
Area of residence	**City**	71%	26%	3%
	Village	65%	29%	6%
	Refugee Camp	60%	38%	2%
Poverty level	**Hardship cases**	64%	30%	6%
	Below the poverty line	65%	32%	4%
	Above the poverty line	74%	23%	3%

6.5 Distance of PHC from home

Figure 27: Rating distance of PHC from home



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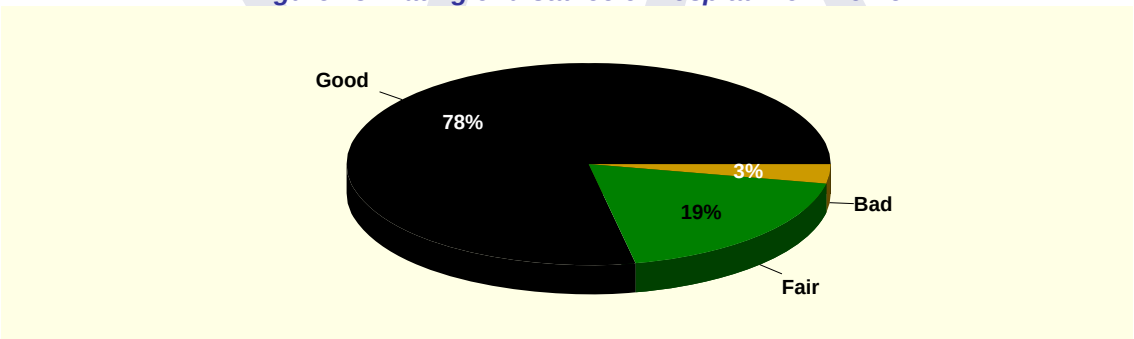
As shown above, an overwhelmingly 96% of respondents were to some degree satisfied with the distance required to travel between their home and their nearest PHC. As expected, however, rural respondents evinced the highest degree of outright dissatisfaction (7%), compared to 3% of urban families, and 0% of refugee camp residents. It can also be noted that families above the poverty line were somewhat more likely to feel inconvenienced by this distance (6%) than were poorer households (4%) and hardship cases (2%). One possibility may be that better-off residential districts enjoy a lower concentration of PHCs, or that such respondents value their time differently than do poorer families.

Table 26: Rating of distance of PHC from home, by place of residence and poverty level

		Rating of distance of PHC center from home		
		Good	Fair	Bad
Area of residence	**City**	80%	16%	3%
	Village	70%	23%	7%
	Refugee Camp	87%	13%	0%
Poverty level	**Hardship cases**	75%	23%	2%
	Below the poverty line	79%	17%	4%
	Above the poverty line	80%	14%	6%

6.6 Distance of hospital from home

Figure 28: Rating of distance of hospital from home



As is to be expected, respondents were generally more concerned about the distance required to travel to hospitals than to their nearest PHC. Villagers were most likely to feel inconvenienced, with only 64% of them rating this distance as 'good' compared to 86% of urban respondents, and 88% of refugee camp households. However, a relatively small number of respondents from any of these categories put down 'bad' as an answer (5% of villagers, 2% of urban households, and 1% of refugee camp households). Though a very slight variance was noted among respondents of different income levels, the same held true for these sub-groups. Referencing the obstacles to health care delivery identified by respondents in section 5, it would seem distance only become a more significant problem when compounded by a lack of transportation and the existence of checkpoints and other movement restrictions.

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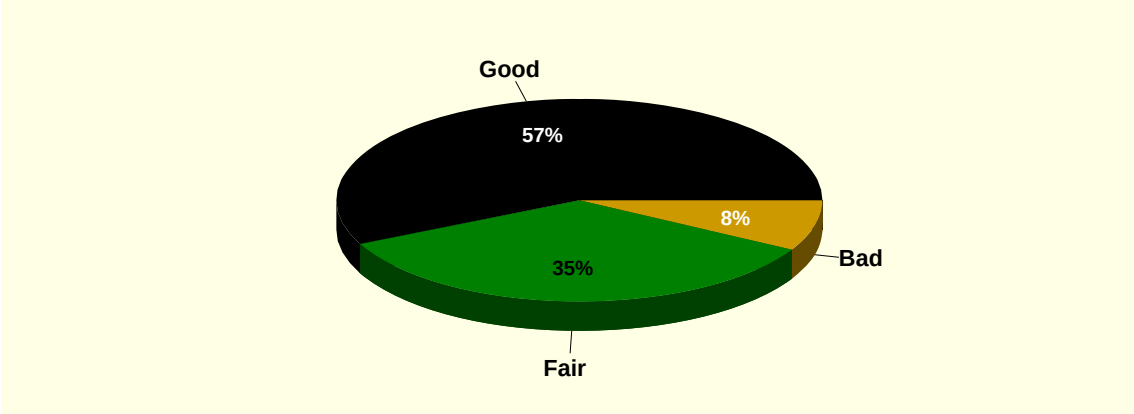
Table 27: Rating of distance of hospital from home, by place of residence, region and poverty level

		Rating of distance of hospital from home		
		Good	Fair	Bad
Area of residence	City	86%	11%	2%
	Village	63%	32%	5%
	Refugee Camp	88%	11%	1%
Region	West Bank	75%	21%	4%
	Gaza Strip	83%	15%	2%
Poverty level	Hardship cases	76%	20%	4%
	Below the poverty line	74%	23%	3%
	Above the poverty line	82%	15%	3%

6.7 Attitude of attending health staff

Figure 29: Rating of health staff attitude



As shown above, an overwhelming 92% majority households were satisfied to some degree with the attitude of the health staff who attended them, with 57% finding it friendly and supportive, and 35% cold but respectful. These responses did not seem to vary significantly among different categories of respondents. It might however be worth noting that a relatively high share of refugee camp respondents (42%), and Gazans (39%) felt that this attitude was cold but respectful.

Table 28: Rating of health staff attitude, by refugee status, area of residence and region

		Rating of health staff attitude		
		Friendly and supportive	Cold but respectful	Cold and offensive
Refugee Status	Refugee	59%	35%	6%
	Non-Refugee	55%	35%	10%
Area of residence	City	57%	35%	8%
	Village	59%	31%	10%
	Refugee Camp	52%	42%	7%
Region	West Bank	58%	32%	9%
	Gaza Strip	55%	39%	6%

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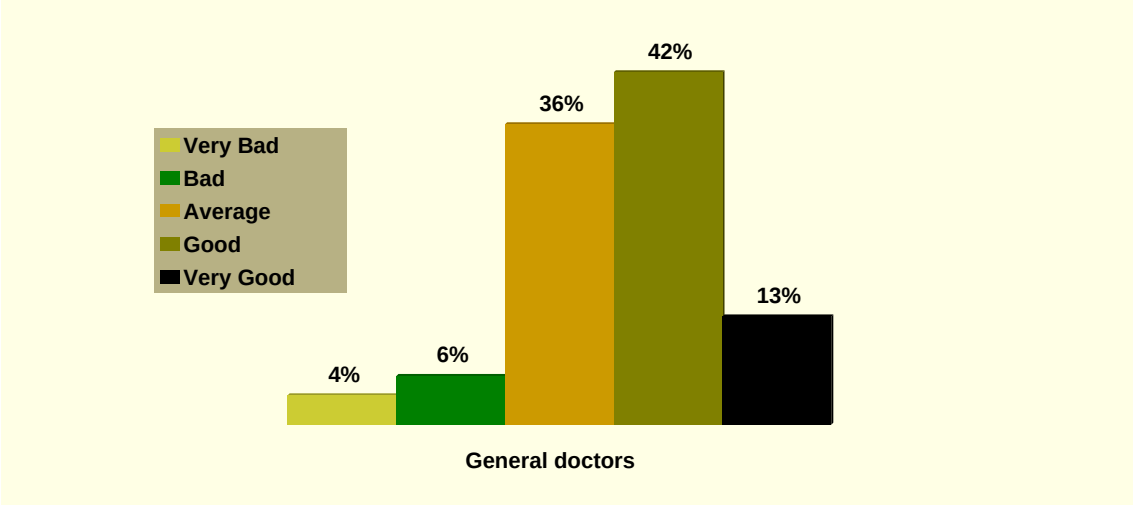
7. Evaluation of health professionals

The final section of the report reviews household perceptions of different categories of health professionals in the Occupied Territories. Respondent were asked to rate these professional on the basis of their professionalism and qualifications, along a sliding, five-tiered scale. It should be emphasized that these are subjective assessments based on criteria that are naturally likely to diverge in some respects from those employed by public health professionals.

7.1 Rating of general practitioners

Figure 30: Rating of general practitioners



55% of respondents rated their GP as being very good or good, whereas only 10% felt that they were bad or very bad. Overall, there was very little variance across sub-groups, though hardship cases were marginally less satisfied than better-off respondents. In hazarding the reasons for this, it may be noted, as per earlier sections, that poorer households were, less likely to rely on private health care providers, more inclined to be dissatisfied with the duration of their consultation, and more likely than higher income groups to suffer chronic disability or illness. As such, their experience with doctors, upon whom they foremost rely on for relief, may have been more negative.

Table 29: Rating of general practitioners, by region and poverty level

		Evaluation of General doctors				
		Very Bad	Bad	Average	Good	Very Good
Region	**West Bank**	3%	7%	34%	43%	13%
	Gaza Strip	4%	4%	39%	40%	12%
Poverty level	**Hardship cases**	5%	7%	37%	42%	10%
	Below the poverty line	4%	3%	39%	39%	15%
	Above the poverty line	2%	6%	33%	45%	14%

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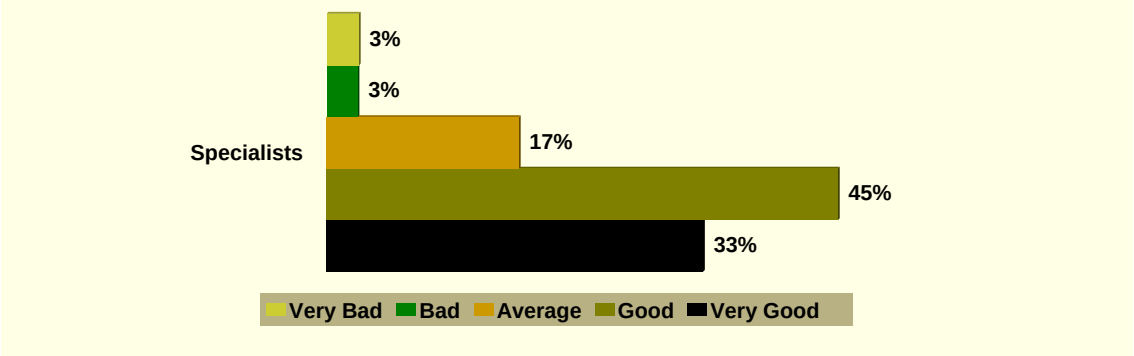
7.2 Rating of specialist doctors

Figure 31: Rating of specialist doctors



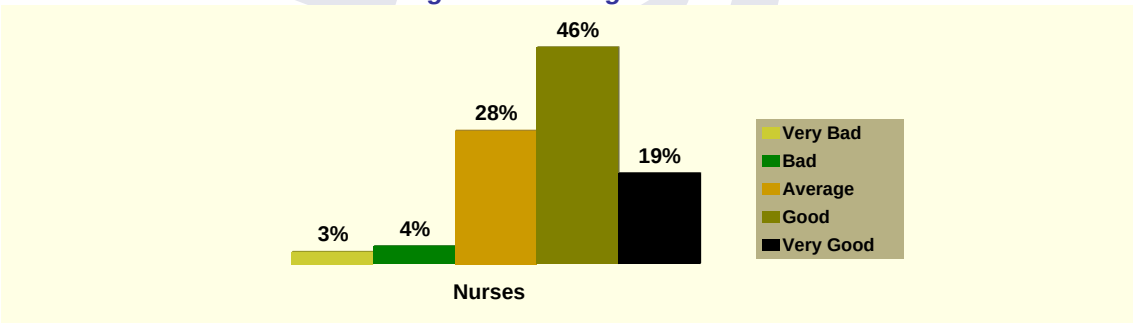
It is notable, if not perhaps surprising, that specialist were generally much more highly evaluated than GP's; 33% of respondents rated their specialist as very good, and 45% said good. Again, responses did not vary significantly across sub-groups, excepting the tendency of hardship cases to give slightly less favorable assessments across the scale of options provided.

Table 30: Rating of specialists, by place of residence and poverty level

		Evaluation of Specialists				
		Very Bad	Bad	Average	Good	Very Good
Area of residence	City	2%	2%	17%	47%	31%
	Village	4%	3%	14%	45%	35%
	Refugee Camp	3%	4%	24%	34%	34%
Poverty level	Hardship cases	4%	5%	21%	41%	30%
	Below the poverty line	3%	1%	15%	48%	34%
	Above the poverty line	2%	2%	15%	46%	35%

7.3 Rating of nurses

Figure 32: Rating of nurses



It's interesting to note that although nurses have lower qualifications than GP's, they were generally more highly evaluated than the latter: 19% of respondents rated them as very good, and 46% as good. Again, responses did not vary significantly across sub-groups, including the hardship category. It may be noted that the embryonic national health system in the Occupied Territories is generally seen as suffering a deficit of highly trained GP's and specialists, whose ability to serve patients is further limited by Israeli

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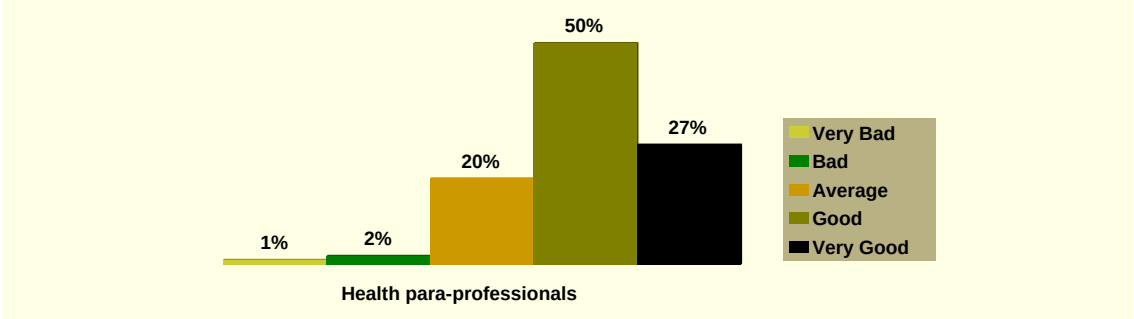
movement restrictions, particularly in rural areas. As a result, nurses have become disproportionately important links in the health care delivery process; in many rural locations they are often called upon to dispense duties that would otherwise be handled by GPs.

Table 31: Rating of nurses, by place of residence, region and poverty level

		Evaluation of Nurses				
		Very Bad	Bad	Average	Good	Very Good
Area of residence	City	3%	3%	27%	49%	19%
	Village	3%	5%	30%	42%	20%
	Refugee Camp	2%	3%	28%	46%	21%
Region	West Bank	4%	5%	29%	43%	19%
	Gaza Strip	1%	2%	27%	50%	20%
Poverty level	Hardship cases	2%	5%	32%	43%	19%
	Below the poverty line	2%	2%	30%	43%	22%
	Above the poverty line	3%	4%	25%	49%	18%

7.4 Rating of health para-professionals

Figure 33: Rating of health para-professionals



Health para-professionals, such as midwives, are another category of health worker whose relative importance has grown in the context of national human resources constraints and Israeli movement restrictions. Again, is therefore interesting to note that they are rated even more highly than nurses: 27% of respondents evaluate para-professionals as very good, and 60% as good.

Table 32: Rating of health para-professionals, by poverty level

Evaluation of para-professionals	Poverty level		
	Hardship cases	Below the poverty line	Above the poverty line
Very Bad	1%	1%	2%
Bad	4%	2%	1%
Average	24%	13%	20%
Good	46%	57%	49%
Very Good	25%	27%	29%

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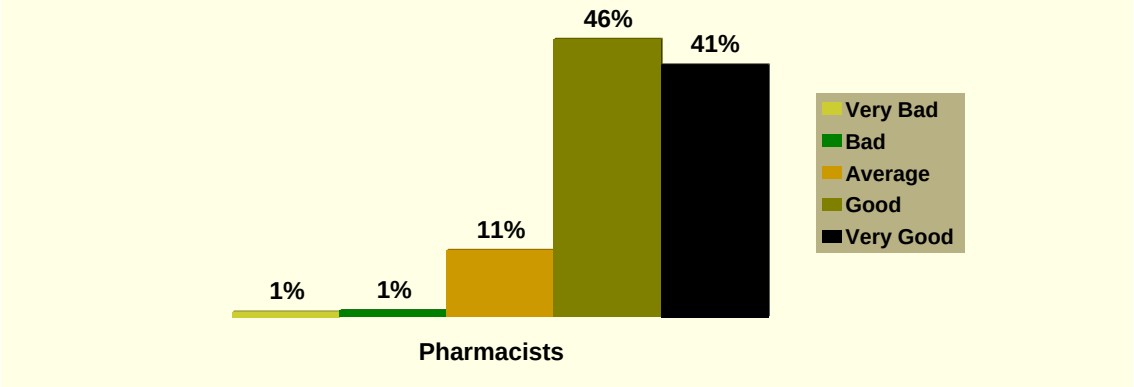
7.5 Rating of pharmacists

Figure 34: Rating of pharmacists



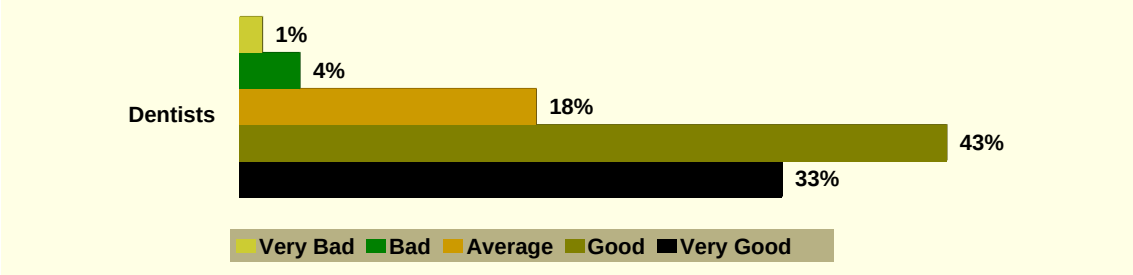
Pharmacists, meanwhile, are clearly the favorite category of health professional in the Occupied Territories; a full 41% of respondents rate them as very good, and 46% as good. Since households are likely to have the most frequent and familiar contact with this category of health professional, this finding is to some extent unsurprising. It should also be noted that pharmacists in the Occupied Territories generally fill a larger advisory role than would otherwise be the case in many countries with more heavily regulated and better-administered health systems. Many categories of drugs are often dispensed without prescription, including antibiotics. Because GP's also tend to over-prescribe antibiotics, researchers have noted a rising prevalence of antibiotic-resistant infections. Ironically then, the very helpfulness that is likely endear many respondents to pharmacists may not necessarily testify to the latter's professionalism, but rather the opposite.

Table 33: Evaluation of pharmacists, by place of residence

Evaluation of Pharmacists	Area of residence		
	City	Village	Refugee Camp
Very Bad	1%	1%	1%
Bad	1%	0%	2%
Average	10%	11%	14%
Good	46%	45%	46%
Very Good	42%	42%	36%

7.6 Rating of dentists

Figure 35: Rating of dentists



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Dentists were last category of health professional evaluated by respondents, and as shown above, they enjoy relatively high ratings, comparable to that of specialist doctors. 33% of respondents assessed their dentist as being very good, and 43% said that they were good. Again, responses varied very little across different categories of respondents.

Table 34: Rating of dentists, by area of residence and poverty level

		Evaluation of Dentists				
		Very Bad	**Bad**	**Average**	**Good**	**Very Good**
Area of residence	**City**	1%	2%	18%	45%	34%
	Village	2%	4%	17%	44%	33%
	Refugee Camp	0%	10%	24%	35%	31%
Poverty level	**Hardship cases**	2%	7%	20%	42%	29%
	Below the poverty line	1%	2%	21%	43%	33%
	Above the poverty line	1%	3%	15%	45%	37%

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III. Index

Figures

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