



bridges

ISRAELI-PALESTINIAN PUBLIC HEALTH MAGAZINE

DECEMBER 2004 - JANUARY 2005

Palestinian Perspective

Poverty and
Social Services

Israeli Perspective

Health Inequity:
A Challenge to
Every Society

Special Interview

Dr. Richard
Horton, Editor,
The Lancet



Poverty and Health Inequity: A Daily Battle

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Mission Statement

bridges, the Israeli-Palestinian Public Health Magazine, is a unique publication conceived of, written, edited, produced and managed jointly by Palestinian and Israeli academics and health professionals under the sponsorship of the World Health Organization (WHO). The magazine embodies the WHO paradigm of "Health as a Bridge for Peace": the integration of peace-building concerns, strategies and practices with health care.

Developed with health care professionals, decision makers and academics in mind, the magazine will cover public health topics relevant to both populations and will seek to analyze the impact of the conflict on the health and well-being of both societies. In both structure and content **bridges** is a cooperative endeavor between Israeli and Palestinian health care professionals seeking to build relationships, links and common understanding.

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Why bridges?

by **Ambrogio Manenti**

“There are two ways to survive the hell of living. The first is easier for many people: to accept the hell and become a part of it until they no longer see it anymore. The second one is risky and requires continuous attention and study: to seek and to be able to recognize who and what, in the middle of hell, is not hell and make it last and give it space to grow.” This is what the Italian writer Italo Calvino wrote in his novel *The Invisible Cities*, in 1972.

Here in the Middle East there has been no tangible progress towards resuming the peace process with severe consequences on the health and well-being of both Palestinians and Israelis. Violence continues to claim innocent lives and military occupation continues to have severe negative effects on the daily lives of the people.

In recent years war has been framed as a public health problem. Indeed, war (including long-term “low-grade” conflict) affects human health both directly through the violence of bombs and bullets, and indirectly, by disrupting economic and social systems that address health needs. This highlights the role of health workers in preventing conflict and limiting its destructiveness, and raises questions surrounding the challenges they face.¹

One series of responses by the World Health Organization to these challenges has been through the Health as a Bridge for Peace² (HBP) approach purported to promote both health and peace.

“Joint action in a technical space” is an expression referring to HBP initiatives in which health personnel coming from different parties in conflict work jointly in the areas of health policy, training, service delivery and health information. Field experience shows that health-related goals may be shared among conflicting parties, providing them the necessary basis for cooperation. This may create an opportunity to build a framework for negotiation, to counteract the stereotypic dehumanization of the other, and even to demonstrate the possibility of ending violence and oppression.

Advocating for health and peace-related values is another HBP strategy. Armed conflicts (including the Israeli-Palestinian) show common features such as increasing isolation, polarization, stereotyping, lack of empathy, use of selective communication, discrimination, racism and violence. In such a context, promoting health means also promoting principles, values, and attitudes that promote peace and are against war, such as: dialogue, inclusion, tolerance, multiculturalism, humanization of the enemy, peaceful coexistence.

Could the HBP approach also be considered relevant to the Israeli-Palestinian context? WHO strongly believes that there is a real need for greater understanding between the Palestinian and Israeli public health communities, and that this could be enhanced through the initiation of a health magazine, among other strategies.

bridges, the Israeli-Palestinian Public Health Magazine, is a new

initiative, written, produced and managed by Palestinian and Israeli health professionals and academics under the sponsorship of the WHO. It will cover public health topics of importance to both populations; will seek to analyze the impact of the conflict on the health and well being of both societies; and will bring readers information in different health and social fields.

For the first issue of **bridges** we selected “Poverty and Health Inequity” since increased poverty and rising health inequities are, in different ways, burning issues for both Palestinian and Israeli societies. Importantly, socio-economic factors are recognized worldwide as powerful health determinants that could be modified. In addition to the two leading articles, one on poverty among Palestinians and the other one on inequity among Israelis health, this issue includes five other articles that will constitute regular features: an interview with a leading personality - this time the Editor in Chief of *The Lancet* - Dr. Richard Horton, news on health projects, a students’ page, a “how to...” section and a “a day in the life...” section.

bridges will “seek and... recognize who and what, in the middle of hell, is not hell and make it last and give it space.”

The war that will come/is not the first. Before/there were other wars./At the end of the last/There were winners and losers./Among the losers the poor people/were starving. Among the winners/the poor people were starving. Equally.
Bertold Brecht
(pre WW II German playwright)

1. Graeme MacQueen and Joanna Santa Barbara, Peace Building Through Health Initiatives, McMaster University. Briefing Paper <http://www.pgs.ca/pgs.php/health/18/>, 2001
2. Health as a Bridge for Peace was a program of the Pan American Health Organization / World Health Organization that was launched in 1984 in order to implement the Expanded Program on Immunization (EPI) for Polio in conflict areas of Central America. The program called for Days of Tranquility in the framework of which the armies and rebel groups were asked to lay down their arms and collaborate with health workers in the immunization of children country-wide (site: www.who.int/disasters/bridge.cfm)

Poverty and Social Services in the Palestinian Society

by **Amin Haj Yahya**

האינתיפאדה ותוצאותיה משקפות מציאות חמורה שבה התערער המאזן הפנימי של הפרט, המשפחה והחברה. לפי דו"ח של הבנק העולמי, יותר מ-60 אחוז מן הפלשתינים נתונים כעת מתחת לקו העוני (ברצועת עזה - כ-80 אחוז), וכשני מליון מתוך שלושה מליון נזקקים לסיוע חוץ. הקושי שבו נתקלים האזרחים בקבלת תשלומי ההעברה ממשרדי הממשלה ומלשכותיה מהווה את אחת הבעיות הקשות ביותר והיא אחת הסוגיות הרלבנטיות ביותר. בשל העימות החמירו תופעות שלילות כגון אלימות בתוך המשפחה, אונס וסוגים אחרים של תקיפה מינית, וכן רצח נשים. המשבר הכלכלי המעמיק והולך מחליש את מעמדו של האב כמפרנס, הן בעיניו הן בעיני משפחתו. הדבר מוליך במרוצת הזמן לירידה ביכולת ההורים לשלוט בילדיהם, ולהתרחקותם של צעירים וצעירות מן הבית. פעולתם של עובדים סוציאליים ומומחים אחרים מתמקדת ב"כיבוי שרפות", כאשר דגש חזק מושם על סידורים מינהליים. לכן כל הסיוע המוגש כעת הוא ראשוני בלבד, ואינו מסוגל לדרת לרשטי המשבר.

לقد أدت الانتفاضة الحالية، وما ترتب عنها من آثار، إلى خلق واقع مؤلم؛ حيث تم إضعاف التوازن الداخلي بين الأفراد والأسرة والمجتمع لدرجة كبيرة. ويشير تقرير البنك الدولي إلى أن أكثر من ٦٠٪ من أبناء الشعب الفلسطيني تحت خط الفقر، ٨٠٪ منهم في قطاع غزة. ويعتمد مليونان من أصل ثلاثة ملايين فلسطيني على المعونات الأجنبية.

كما يعتبر حصول المواطنين على مستحقاتهم من المكاتب الحكومية والوزارات من أكثر المشاكل صعوبة. وقد نجم عن هذا الواقع ظواهر سلبية؛ منها العنف الأسري، والاغتصاب وغيرها من الاعتداءات الجنسية وقتل النساء. كما أدت المشكلة الاقتصادية المتفاقمة إلى إضعاف مكانة رب الأسرة، بصفته معيلاً الوحيد، سواء من وجهة نظره، أو من وجهة نظر الأسرة. وأدى ذلك إلى إضعاف قدرة الوالدين على السيطرة على أبنائهم؛ مما جعل الأبناء ذكورا وإناثا يفضلون قضاء معظم وقتهم خارج المنزل. ويتركز دور الأخصائيين والخبراء على إطفاء النار، مع التركيز على الترتيبات البيروقراطية. وبالتالي فإن كل الخدمات المقدمة هي خدمات أولية ولا تلامس لب وجوهر المشكلة.

The Intifada, now in its fifth year, touches many sectors and domains of Palestinian society. It has created a new reality that requires us to deal with it in a spirit of activism and maturity. The Intifada and its consequences, as we see them today, impact on the internal balance of the individual, the family, and the society – all of which have been undermined.

Recent statistical indicators on the socio-economic conditions in Palestinian society indicate a sharp increase in social problems and in the number of individuals and families entering the cycle of need and poverty. Children and the elderly, who are the most vulnerable groups in society, are the primary victims.

Indicators of social distress, such as individual and family income, population density, educational and health conditions, and unemployment all show a decline in the standard of living and in the quality of life. The data show a deepening of deprivation.

This new reality challenges institutions, their employees and sectors served. In addition to all the tasks they encounter on a daily basis, they face increased responsibility in solving problems and overcoming obsta-

cles. And this occurs while essential services and resources have decreased.

Indicators of Poverty

The Intifada has directly impacted the Palestinian economy and social life: personal income has decreased by more than half. Over 120,000 Palestinian workers have lost their jobs while the unemployment rate is about 35% of the work force. Around 60% of the population of the West Bank and 75% of the population of Gaza lives on less than \$2 per day, or about NIS 300 monthly, a figure that is defined by the World Bank as the poverty line. (1)

The number of Palestinians under the poverty line tripled from 640,000 in the year 2000 to two million at the beginning of 2003. Food consumption has decreased by 30%. Since the



outbreak of the Intifada, the situation has deteriorated quickly with the loss of job markets. (1)

[In comparison to the period before the Intifada, and if we establish \$2.10-per-day (\$750 per year) as the poverty line for the individual, then not less than one-fifth (21%) of the West Bank and Gaza population have been poor since the end of 1995. Poverty in Gaza is more widely spread than it is in the West Bank]. (1)

The severity of the poverty lies in the growing unemployment and continuous shocks resulting from closures imposed on the West Bank and Gaza, which hinder the workers from getting to their places of work and hold back the expansion of the private sector and the creation of new job opportunities.

Surveys by the Palestinian Central Bureau of Statistics show that unem-

ployment regularly hovers around 20% of the labor force but goes up to 30% on average during closures, when Palestinian workers are prevented from reaching their places of work in Israel. Unemployment averages rise even higher in the Gaza Strip. (2)

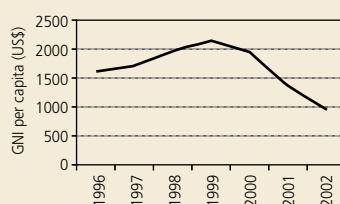
In Jerusalem and its suburbs,

reports from the Israeli Central Bureau of Statistics (3) and the annual report of Israel's National Council for the Child (4) indicate that poverty is reaching previously unheard of levels. The Israel National Insurance Institute (5) figures show the percentage of poor in East Jerusalem to be more than 50% of the popula-

Box 1: Poverty trends during the intifada

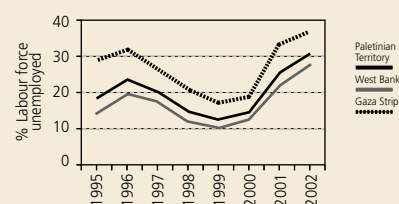
The *intifada* and Israeli military action have had a devastating impact on poverty in the Palestinian Territory, particularly in Gaza. Income per capita (figure 1) has dropped by over half since 1999, and the proportion of the population living below the Palestinian poverty line (US\$2.10 a day) has risen from 21% to 60% (75% in Gaza). Unemployment (figure 2) has more than doubled from pre-*intifada* levels.

Figure 1. GNI per capita: 1996-2002



Source: World Development Indicators (2003)

Figure 2. Proportion of the Palestinian labour force that is unemployed: 1995-2002



Source: Palestinian Central Bureau of Statistics (2003)

tion – or around 110,000 individuals. Approximately 30,000 of them are clients of the social welfare offices in East Jerusalem.

The percentage of children living under the poverty line in East Jerusalem reaches 68%, compared to 28.9% in West Jerusalem. Severe and widespread unemployment is one of the factors in this economic situation. According to the Palestinian Annual Book of Statistics, 43.5% of Jerusalem's Arab residents earn less than the minimum wage, in contrast with 10% of Jerusalem's Jewish citizens. Additionally, indicators on education show the situation to be critical for Palestinian residents. Over 60% of the population in East Jerusalem has elementary school education or less. (3)

A report prepared by the Jerusalem Institute (6) draws a picture of severe poverty, crime and drugs. Within one

square kilometer, the report shows, inside the walls of the Old City live more than 32,000 people, making the area one of the most densely populated in the world. Indicators show that the percentage of poverty in the Old City of Jerusalem reaches 57.7% compared to 21.7% in West Jerusalem. The adverse conditions within the Old City of Jerusalem have led many families to leave. The Israeli government has taken away the Jerusalem ID from those families who moved away from their Old City homes, depriving them of their rights and of social services.

One of the hardest problems and most relevant issues here is the difficulty citizens face in getting their entitlements from government offices and ministries. Most families seen by the welfare services have a multiplicity of problems, not all stemming from social conditions. This sort of suffering is what is unique about the needy in East Jerusalem. Most families have several children, suffer from unemployment, have only one source of family support, suffer from domestic violence, have children with disabilities, and live in extremely harsh conditions. In addition, many children run away from school to look for work and other opportunities.

This situation is playing itself out throughout Palestinian society in the West Bank and Gaza, where families faced with deepening poverty and brutal conditions are developing multiple problems threatening individual, family and societal well-being. A study done for the Israeli security forces (7) confirms that the Israeli-Palestinian conflict has worsened negative phenomena – domestic violence, rape, other sexual assaults and the murder of women (on the background of “family honor”). The deepening financial crisis weakens the status of the father as the breadwinner, in his own eyes and in the eyes of his family. Eventually, this leads to a decline in parents' ability to control their children, and young men and women tend to stay away from home. The report also shows that in the year 2002, 31 women were mur-

dered against a background of “family honor,” while the comparable figure for 2001 was eight. In 2002 more than 50 babies were left in boarding institutions by single mothers, and there was an increase in the number of girls turning to prostitution. Divorce increased by 4% in 2002 over the year before. The report also mentions a rise in drug use and smoking.

Role of Social Services and Welfare Organizations

Social service and welfare organizations play a primary role in overcoming individual, social, and

On Tuesday, 23 November the World Bank and the Palestinian Central Bureau of Statistics (PCBS) published a report on poverty in the West Bank and Gaza Strip. The main findings include:

- 16% of the Palestinian population is affected by subsistence poverty: their monthly consumption is NIS 205 or less and they cannot afford to consume the minimum caloric intake as established by the UN Food and Agriculture Organization and the World Health Organization.
- Nearly 50% of the Palestinian population lives below the poverty level (a monthly household income of less than NIS 1,800).
- Refugees and those in female-headed households are not significantly more likely to be poor than are others.
- Emergency assistance has reduced the number of individuals affected by subsistence poverty by one third. However, 32% of the needy do not receive emergency assistance at all.
- A resolution of the current crisis, including the lifting of closures and a return to pre-Intifada levels of unemployment would help to reduce poverty in general, but would do little to reduce subsistence poverty. By contrast, development and implementation of structural policies aimed at lowering dependency ratios and improving labor productivity could have much larger impacts on poverty rates.



communal problems – whether by lessening stressful situations; helping to raise the standard of living and improve the quality of life for the individual; or bettering social welfare. As the numbers of the needy and those turning to welfare organizations grow, so grow the importance of these organizations and their role.

On the whole, there is ambiguity and uncertainty around the ability and effectiveness of those organizations over the last three years. Few studies have been done on the momentum created by current conditions and their effects.

The social welfare organizations

active in Palestinian society fall into several categories: international volunteer agencies; local charitable organizations; organizations of the Palestinian National Authority (inherited from the Israeli military rule); United Nations organizations (such as UNRWA, which works with the refugee population); and Israeli bodies (specifically in Jerusalem) such as the National Insurance Institute and the Welfare Ministry.

There is no need to go into the details of these organizations (their structure, management and formation, funding and scale of services)



but one of the most important elements to be noted is the absence of a directing body that centralizes and guides. The absence of a clear social hierarchy and organizing principle results in lack of coordination and cooperation between these organizations and institutions; a duplication in the provision of services; a lack of supervision of their performance and use of resources; and ineffective management. Thus:

- There are communities and social groups in need that have not been reached and are not helped by these institutions.
- There is a concentration of such organizations in urban areas and a

lack of them in rural areas.

- Families obtain aid from several organizations due to the lack of coordination and sharing of information.

- It is difficult in these circumstances to plan ahead and develop programs to overcome current conditions.

These organizations provide minimal services and demonstrate little efficiency. Their resources are limited, and there is a marked deficiency in certain areas (psychological services and rehabilitation). Aid is still considered in its financial aid meaning – to insure minimum income or



to guarantee food and shelter for those in need.

The work of social workers and specialists and their professional performance focuses on what is called “putting out fires” with much emphasis given to bureaucratic arrangements. Thus all aid that is being given is preliminary and does not touch upon the underpinnings of the crisis.

Without doubt, the Intifada shapes society. The previous Intifada saw changes in the number of those going into social work and also in the number of case files; there were changes in the characteristics of aid beneficiaries and their problems;

changes in the relationship of the aid beneficiary and the social worker; changes in the social specialist role and mind-set; and changes in social work priorities.

There has also been an increase in volunteer work, the establishment of national and local committees and attempts to reach out to those in need instead of waiting for them to seek help. The Palestinians have seen a strengthening in family ties and mutual bonding and also expressions of solidarity.

Conclusion

Palestinian society lives with great uncertainty due to the uncertainty in the political situation. People are living under occupation, a bloody Intifada, conflict and crisis. This is reflected in the social and economic situation – a lowered standard of living and greater poverty – and individual, domestic and social problems. Palestinian society has suffered over many years from brutal socio-economic circumstances and has been in need of external aid. The situation has deteriorated, and a social Intifada is needed to face it.

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Health inequity:

A challenge to every society whether rich or poor

by **Leon Epstein**

כלל הנראה לא קיימות חברות בהן מצבה הבריאותי של האוכלוסייה מנותק ממאפייניה החברתיים, התרבותיים והאחרים. הצהרת אלמה-אטא קבעה כי "חוסר השוויון החריף במצבם הבריאותי של בני האדם, בעיקר בהשוואה בין מדינות מתפתחות ומפותחות אך גם בקרב תושבי מדינות, הוא בלתי מקובל - פוליטית, חברתית וכלכלית". ישראל אינה נטולת פערים חברתיים בתחום הבריאות, כפי שמתבטא בין היתר בשיעורי עישון, סכרת ומשקל יתר בקבוצות אוכלוסייה שונות. פערים אלה דורשים הכרה בחשיבותה של הבעיה, קבלת החלטות מרחיקות לכת בדרגים הפוליטיים והמקצועיים הגבוהים ביותר, ורצון להתמודד עם בעיות שפתרון דורש שיתוף פעולה בין-מגזרי.

من الصعب أن نجد مجتمعا من المجتمعات لا يرتبط فيه الوضع الصحي بواقع السكان الاجتماعي والثقافي، وغيرها من الجوانب. فقد جاء في إعلان «Alma Ata» بأن «الواقع الصحي العام للسكان وخصوصا في الفجوة الحاصلة بين الدول المتطورة والدول النامية، وحتى داخل الدول ذاتها، هناك تفاوت كبير. وهذا أمر غير مقبول سياسيا أو اجتماعيا أو اقتصاديا». وإسرائيل ليست بمعزل عن الظلم في الخدمات الصحية، كما عكسته التوزيعات التفاضلية، وخاصة التدخين، والسكري، والسمنة، وغيرها. ولتحقيق المساواة علينا الاعتراف بإلحاح المشكلة، وأهمية اتخاذ قرارات بعيدة المدى، وعلى أعلى المستويات وأكثرها مهنية، والإرادة لمعالجة القضايا التي تتطلب تعاونًا ما بين القطاعات المختلفة.

What is Inequity?

Differences in health status between population groups on the basis of socio-economic status have been reported in the scientific literature for a long time. (1) There are probably no societies in which health is not related to the social, cultural, and other characteristics of the population. While there may well be complacency about this finding in many countries, recent decades have witnessed a growing appreciation of the negative impact of these differences on the individual, the family, and society as a whole. While poor health is obviously deleterious to the individual, it is the loss of functional potential and thereby the economic implications for the country that led international organizations such as the World Health Organization (WHO) (2,3) and the World Bank (4) to initiate endeavors to reduce differences in health.

The groundbreaking Declaration of Alma Ata (5) stated that "the existing gross inequality in health status of the people particularly between developed and developing countries as well as within countries

is politically, socially, and economically unacceptable and is, therefore, of common interest to all countries". Obviously, not all health differentials can be closed. Whitehead (2) has stressed the important conceptual difference between inequality and inequity. While the first refers to any difference in health status that cannot be changed, inequity "has a moral and ethical dimension. It refers to the differences that are unnecessary and avoidable but, in addition, are also considered unfair and unjust."

WHO has published guidelines with regard to differences in health that can be defined as unjust. Health inequalities which are due to "natural or biological variation, freely chosen health damaging behavior, or the transient health advantage of one group over another" are not delineated as health inequities. (2) On the other hand, those which are determined by "health damaging behavior due to limited lifestyle choices, exposure to unhealthy, stressful living and working conditions, and inadequate access to basic health services" are regarded as inequities. For exam-

ple, natural, genetic variations are at present not considered to be potentially avoidable and are not usually seen as unacceptable. However, with the mapping of the human genome, availability of genetic screening, and the advent of genetic engineering, even genetic characteristics will potentially provide the basis for inequity if they are associated with a differential availability to groups within the population. (6) Restricted access to health care and exposure to excessive health risks in the physical and social environment are potentially avoidable and therefore constitute the basis for inequity.

The Role of Policy in Correcting Inequity

Equity does not mean that everyone in the population should have the same level of health as differences in health status will always be found. "The aim of policy for Equity and Health is not to eliminate all

sible to initiate. A policy reflects the values that a society has and the manner in which the values relate to an issue, in this instance that of health inequity. Policies that are developed will perforce be in conflict with injustices that are at the base of health inequities manifest in a country. If such health equity policies are defined, their aims will reflect the degree to which a country is committed to this issue, and does not accept that the underprivileged will always be at a health disadvantage. The international community has over the years made commitments to the reduction of health inequity. These have included, among others, the United Nations Declaration of Human Rights in 1948 and WHO Health for All Policy in 1977 and reaffirmed in the Alma Ata Declaration in 1978. In more recent years this has been restated at the International Conference on Population and Development in Cairo in 1994



health differences so that everyone has the same level and quality of health, but rather to reduce or eliminate those which result from factors which are considered to be both avoidable and unfair". (2)

The role of policy is to provide a systematic, powerful, and sustainable effort to challenge inequities (7) and to clearly identify the actions that are available, desirable and pos-

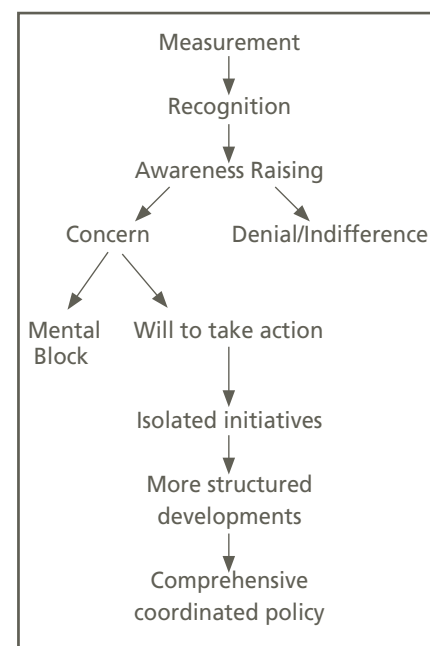
sible to initiate. A policy reflects the values that a society has and the manner in which the values relate to an issue, in this instance that of health inequity. Policies that are developed will perforce be in conflict with injustices that are at the base of health inequities manifest in a country. If such health equity policies are defined, their aims will reflect the degree to which a country is committed to this issue, and does not accept that the underprivileged will always be at a health disadvantage. The international community has over the years made commitments to the reduction of health inequity. These have included, among others, the United Nations Declaration of Human Rights in 1948 and WHO Health for All Policy in 1977 and reaffirmed in the Alma Ata Declaration in 1978. In more recent years this has been restated at the International Conference on Population and Development in Cairo in 1994

2000 and 2010" in the United States. (10) However, the process of equity policy development is not a one-time or one-step process and as such it is incorrect to assume that it either exists or does not. The commitment to health equity is long-term and requires planning, resources and evaluation.

A Tool to Rank a Country

Whitehead constructed an action spectrum (Figure 1) on the basis of which many countries in Europe have been assessed. (2,11) It is a tool that defines the place of a country in relation to inequity policy development, and as such the degree to which it has recognized the existence of inequity, a readiness for change and a decision to act, and finally the achievement of a comprehensive coordinated policy.

Figure 1: Action Spectrum on Inequalities in Health



Source: Whitehead M. 1990. The concepts and principles of equity and health. Copenhagen: World Health Organization

While there are many countries that lie outside the spectrum and have not yet acknowledged the presence or importance of inequalities in health in their populations, there are nations that are developing national strategies toward comprehensive, coordinated policies. The



on the possible processes leading to these findings, it is in the area of intervention to reduce the differences that there is a relative dearth of information. Any intervention will be directed at the hypothesized causes of the inequality. These may be related to underlying socio-cultural factors (education, income, employment) that determine the health of a population; to specific risks to which individuals are exposed (environmental, behavioral, biological); and, finally, to specific health problems or outcomes differentially distributed in sections of the population and related specifically to the functioning of the health care system.

Tackling Determinants

This strategy aims at reducing inequalities at the societal level that are related to the basic determinants of health while addressing differences in many health outcomes simultaneously. They address the fundamental root



causes of inequalities in health and tend to be comprehensive in nature. An example would be to implement strategies that redistribute income, reducing inequalities in the education system, especially the education of women, or focus on unemployment. All of these societal inequalities have been shown repeatedly and in many countries to be related to health inequality and inequity. While it is clear

importance of the action spectrum model is in the basis that it provides for seeing health equity policy as a process and a country's position in relation to others.

It should be clear that the development of policy in this regard is not only dependent on a country's health but is also related to the existence of political will to contend both at the policy level nationally and regionally, as well as in relation to any action that will require the allocation of probably scarce resources. While there are obvious health benefits to a country and its population in the activation of policies related to health

inequity, there are highly significant economic implications. All countries face a potentially sizeable loss in production when groups of people, due to ill-health, are not at their fullest capacity to contribute to the country's economy and development. This is reflected in the World Bank including health inequalities as a central issue in the preparation of the 2006 World Development Report. (12)

Are there Interventions to Undo Inequities?

While the literature abounds with data on the existence of health inequality and inequity and indeed

that reducing inequality in these factors would impact considerably on health, this requires far-reaching decisions at the highest political levels, substantial resources, and the will to handle problems that require intersectoral collaboration and the combined will to accept the priority of the

is not only the role of the health care system. It requires the collaboration of, among others, the media, industry (especially food, tobacco), and urban planning to facilitate suitable areas for physical activity. Health education within the overall framework of health promotion policies is

However, it is well-known that mortality, life expectancy, and especially infant mortality have a clear socio-economic gradient. In many of the chronic diseases, e.g. diabetes, the situation is similar. However, it is in relation to health outcomes that the health care system has a major re-

“Inequity refers to differences in health status that are unnecessary, avoidable, unfair and unjust.”

problem. This is especially problematic where the funding of ministries is vertical with little link between them, and when funding is planned on an annual basis since tackling inequality is a long-term endeavor.

Not Everybody is at Equal Risk

The differential class distribution of the risk associated with personal behavior and healthy or unhealthy lifestyles is well-documented. This includes smoking, poor diet, sedentary lifestyle, and alcohol consumption that tend to be more common among those with little education and low income. and the unemployed. In developed countries, smoking is more prevalent among the disadvantaged. However, in developing countries, smoking is more common among the better off, as was the situation previously in the industrialized world. The developed countries are at a more advanced stage of the smoking epidemic than the developing countries and thus present a strong relationship between lower socioeconomic status and smoking. The association of nutrition and health inequities is such that disadvantaged groups generally consume less of protein-rich foods, fruits and vegetables and far more carbohydrate rich foods. This linked to differential involvement in leisure time physical activity and is associated with higher prevalence of obesity and being overweight among disadvantaged population groups. This association between food consumption, being overweight and a sedentary lifestyle has as an important outcome in the rising incidence of diabetes worldwide.

It should be recognized that any targeted “attack” on differential risk

an important element in the attempt to reduce risk overall in the population and especially among those in the lower socio-economic strata.

Health Problems Differentially Distributed

Tudor-Hart’s Inverse Care Law states that health care provision is usually inversely associated with the need for health care. (13) This manifests both in availability and access to care, as well as in the quality of care provided. The identification of this situation and its rectification is a major responsibility for those involved in health care at all levels.

On Tuesday, 23 November the National Insurance Institute of Israel released its annual report on poverty. The main findings include:

- There were 1,427,000 people living below the poverty line in Israel in 2003 - some 22.4 percent of the population. The report also estimated that in 2004 a further deterioration in poverty numbers would take place. People below the poverty line in Israel are defined as having an income of less than 1,763 NIS (approximately 410 dollars) for a single person and 2,777 NIS (650 dollars) for a couple.
- 139,000 families in which the head of the household is employed live in poverty. In some 17,000 of these families, there are two incomes.
- The number of employed people defined as poor has increased by 12,500, a rise of about 10 percent. This is a sharper rise compared to other groups of individuals classed as poor.
- Approximately 652,000 children in Israel can be defined as poor, a total of 30.8 percent of the children in the country. Almost 83,000 of the poor are elderly.
- Among Arab households the poverty rate reached in 2003 48.4 percent. 27.6 percent of single parent families are below

sponsibility. In the recent publication of the Institute of Medicine in Washington, D.C., entitled “Unequal Treatment”, there is clear documentation of differential outcomes of disease management, in many conditions, related to socio-cultural disparities. (14) This has been documented in other countries as well.

Inequity in Israel

It is possible to illustrate this discussion with data related to the existence of health inequality/inequity in Israel. When considering the extent of these differentials in health status within the Israel population, it is clear that they exist even though there has been a National Health Insurance Law in operation since 1995. These inequalities manifest, among others, in relation to overall mortality. The Central Bureau of Statistics (CBS) has constructed a composite measure of the socio-economic status (SES) of the towns in Israel. Data have shown that there is a relationship between age, standardized mortality and the CBS measure of SES. (15). This relationship can be seen in the individual characteristics that make up the composite measure, e.g. education, income, unemployment. In a series of studies Manor and colleagues confirmed the relationship in both men and women. (16,17).

Over the past decades infant mortality has dropped in both the major population groups in the country. However, there are still substantial differences between the districts of the country, as well as towns in both the Arab and Jewish sectors. (18)

It is, however, not only in relation to mortality that there are inequalities. A recent study has shown significant differences in the reported



al will that will facilitate action to reduce health inequities that are not acceptable in modern society.

About Prof. Epstein:

Leon Epstein is on the staff of the Smokler Center for Health Policy Research, Myers –JDC – Brookdale Institute and Hebrew University-Hadassah School of Public Health & Community Medicine, Jerusalem, Israel.

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prevalence of diabetes between Arabs and Jews as well as in relation to measures of obesity. (19) Diabetes, hypertension and obesity can be considered to be major public health problems, especially in the lower socio-economic groups in the population. (20). Of late, the Ministry of Health reported a significant relationship between educational level and the prevalence of smoking. (21)

The above is just a small portion of the reported data that indicates differences in mortality, morbidity, health-related behavior and outcome of treatment in Israel. In addition, there

is evidence that access to certain aspects of health care, e.g. related to the existence of co-payments, will differentially impact on people at different SES levels in the population.

What can We Conclude?

Clearly, health inequity has a multifactorial etiology in society. This calls for a multifaceted policy for intervention in order to make a change. The overriding questions relate to the identification and assessment of the problem, the recognition of its importance to society, and the need for the political and profession-

'Tell success stories and give voice to the voiceless,' says Dr. Richard Horton, Editor of The Lancet, in an interview that considers how a journal can be a bridge to peace

by **Oriella Ben-Zvi**

What role can medical journals play in promoting health as a bridge to peace, either on the international level, through prestigious journals such as *The Lancet*, or locally, through efforts such as *Bridges*?

Medical journals can provide several different contributions to promoting peace. First, we can provide a space where detailed research findings about health problems in con-

empirical findings and debate them. And it forces accountability for what can be politically difficult issues, which sometimes doesn't happen when the arguments are only political or ideological.

For example, there can be various views of the number of casualties in war or conflict areas. The answer to this, rather than who is right or wrong, becomes how can we get better information and data about casualty numbers - and this involves science. This means we need to search for better evidence. And that is tremendously powerful.

Secondly, such journals provide a neutral forum for discussion and debate. Civilized differences can be played out and individuals can be held accountable for their point of view.

Can you give an example?

The *Lancet* published an article about the health burden facing Pal-

Violence as a health

flict areas can be published. This is a very important area of research that is too often neglected.

If one takes the Iraq war, the entire debate around the justification of a preemptive strike was held around different political and ideological opinions. While that's the traditional, even natural, way to debate these issues, it makes it hard to pin down the details of the various arguments. The strength of using research as a means and way to process and understand foreign policy is that it forces people to come to grips with numbers, details and empirical evidence from which one can't escape. It forces people to confront these

estinians, which looked at aspects of human rights abuses. In the article, strong comments were made about delays faced by the injured and sick and issues of access to health services. These comments were quite blunt and there followed a storm of response saying we, at *The Lancet* were naïve at best, or one-sided at worst. Various people said we didn't understand that Red Crescent ambulances had been in the past commandeered by terrorists as a means to cover their activities.

Because of this debate, I commissioned an Israeli writer who served in the IDF (Israel Defense Forces) and understood the issues faced by



issue

Palestinians related to health care, to provide a counterview, which set out the Israeli side. We were able to lay out different points of view, letting each side understand the point of view of the other.

Are there “danger zones” for a magazine dealing with health issues in conflict areas?

I'd say there is one dangerous area, which is advocacy - trying to advocate for a particular point of view that might side with one faction.

For example, I tried to write about the death of an Israeli physician's daughter in a suicide bombing, and I drew a parallel with the death of a son of a Hamas leader, who was

also a physician, to show how lives of physicians are intertwined. I received some really angry letters suggesting that there was no moral equivalent between an Israeli physician and a Hamas physician. You see, I was trying to be well-meaning, but I may have done more harm than good. I tried to step into the middle of a situation that I haven't experienced, not as an Israeli or a Palestinian; not having experienced terror, not having experienced fear - I stepped into the debate from a point of comfort or even ignorance. So while it's important to advocate, it needs to be handled carefully. The challenge is how to better report the voices of those in conflict to a wider international readership in a way that is right.

What are your thoughts on the challenge of finding a balance between the presentation of the

negative impact of the occupation and the conflict on both sides and the positive cooperative efforts that are taking place?

I would say the main thing is that it is important to tell success stories and give voice to the voiceless in this conflict.

At first the latter can seem negative, but one needs to have a balance between the two. I think such magazines need to try to present a range of opinions in as even-handed a way as possible.

I certainly don't want to criticize any specific journal, but some have very open discussion forums on the internet and while I would be the first to promote open discussion and debate - with passion and commitment, in fact - sometimes having these forums with such negative comments about others, labeling others as racist, anti-Semitic or anti-

Arab is very unhelpful. So the role of publications should be to moderate discussions, to ensure they are even-tempered but passionate.

Sometimes debates can do more harm than good because they focus on insults which hurt bridge building. The job of an editor is to strive for balance and get all shades of opinion. And to give voice to the voiceless, particularly children.

At the same time, you have to try to make sure that old labels and boundaries that tend to separate are blurred or erased. You need to look at difference in a new way and in human terms rather than in pre-existing cultural, social, or purely religious terms.

What health and medical journals specifically can bring to this debate is a fresh perspective. When all is said and done, when you strip away his-

tions. What types of innovations have there been in the work or study of health in conflict areas?

I would say that looking at violence as a cause of death and disability has brought a new and unique concentration of attention on violence as a health issue that wasn't there before. We have to pay tribute to the work of the WHO, which led to the World Report on Violence and Health. It was a landmark study. The difficulty was that the report shied away from political violence. For any agency or scientist, it is hard to interpose oneself in areas of political violence. Criticism can be paralyzing on the work of an organization. At the same time, this focus on violence has forced study of the epidemiology of violence.

Look at Kosovo. Look at the consequences of violence in Darfur;

researchers in the Middle East in thinking about their role in establishing health as a bridge to peace?

Too often I receive comments and contributions from people about the region who don't even live there. I would love to receive more contributions from local Israelis and Palestinians. I'd love to get more descriptive work from people there about all the challenges they face in the public health sphere.

Perhaps it's the last thing on researchers' minds, but we need descriptive work to be written and shared. The voices of Israelis and Palestinians are silenced outside of the area. You don't hear from individuals. You only hear when they write or comment on others' work, and this is very reactive. I would very much welcome contributions from people involved in bridges, individuals or groups, not as formal research, but as pieces of descriptive prose of what it is like to work day-to-day in the region, just telling their story, describing it in simple and straightforward terms. This does an enormous amount to open eyes, to mobilize interest and support. I would issue a call to individuals to write and tell their stories and challenge medical journals to give space to these descriptive works, which we often don't give space to.

We make mistakes all the time in the way we try to report on profound public health issues in conflict areas, and we need help from the people living in these situations to make the outside world understand what it is like to exist in those conditions. It allows others to do their job better, but we need magazines like yours to speak out on behalf of the people in the area. I encourage you to think about that.

Dr. Richard Horton joined *The Lancet* as an assistant editor and moved to New York as North American editor in 1993. Two years later he became Editor-in-Chief in London. He encourages all interested parties to submit their comments or work to him: richard.horton@lancet.com



tory, culture, religion and upbringing, we are simply naked, vulnerable human beings, and we need to ask what we can do to throw a protective veil over individuals to help protect them from harm and violence, irrespective of background.

Health, in the most basic way, strips away those barriers that prevent us from looking afresh at conditions. Health is an incredible leveler. It is unique among disciplines in terms of what it can do to strip away barriers.

You report on medical innova-

Iraq – there is a real reorientation of the health community to study these issues. There has also been an astonishing collaboration between the Western world and local health workers to bring about really brave research and data collection in areas of danger and constant threat. These partnerships are new and must be praised and supported. Medical journals can offer support by publishing such research even if it is difficult and controversial.

What words of advice would you give to health professionals and



photo Ilya Melnikov

A student's reflections on water

A call for the adoption of the Water Poverty Index

by **Mai Abu Moghli**

“When the drums of war are beating, why grant a great deal of attention to an apparently fruitless effort?”

When I read this sentence I started wondering, and had one question in my mind: Why?

Why do we care about the environment, sustainable development and many other words and terms while we cannot even satisfy our basic needs during the dark days of war, violent confrontations and severe poverty? Why do we care about hygiene and malnutrition while we don't know if we will be alive in the coming seconds? I guess the most important question is: Why not? Why not think of a better future and standard of living for the coming generations, of the basic needs and how to preserve the basic elements of life—water!

Water is the ultimate element of the environment, with unique physi-

cal properties, complex economic characteristics, important cultural features and an essential role in supporting all life on earth – to distinguish it from every other natural resource.

Fulfilling the water-related needs of the poor is fundamental to the elimination of poverty, since water is vital for human development. The issue of water in our region is quite complicated and needs a lot of attention and serious effort. Lack of resources, armed dispute, separation between the areas, and the hard social, political and economic situations create severe water problems - scarcity, poor quality and limited access.

The long-term costs of these problems are not taken into consideration when governments plan and legislate; they ignore the firm link between water and development. Better management and monitoring of natural resources, especially

water, should be adopted by using new tools such as the Water Poverty Index. The Water Poverty Index is a powerful tool to determine priorities and empower local communities by allowing them to participate in the process of their development.

The concept of the Water Poverty Index is simple. It's an interdisciplinary tool, linking indicators of water and human welfare, to stress the impact of water scarcity. The main focus of this index is the poor and their limited access to water, in addition to the five indicators that the index measures: resources, access, capacity, use and environment. The Water Poverty Index is directed toward poor societies but it does not overlook the issues of environmental integrity and ecosystem water needs, or the balancing needs for different uses. It would be a great step forward to use such an index or any other, insuring human development and social and economic well-being even in the dark present.

Mai Abu Moghli is an MSc Student (Environmental Economics)



Highlights of the report by the Director-General of WHO

Poverty and A global view

More than one thousand million of the world's people have been excluded from the benefits of economic development and the advances in human health that have taken place during the twentieth century. At the start of a new century, WHO is committed to playing its role, within the United Nations Development Group and in partnership with other members of the international community, in mounting a global response to the challenge of reducing poverty.

What are the Challenges?

The basic facts are increasingly well known. About 20% of the world's population, or 1300 million people, live in absolute poverty with an income of less than 1US\$ per day. Surviving on less than 2US\$ per day is a reality for almost half the people on the planet. Aggregate figures for economic growth disguise the fact that the number of people in absolute poverty is still rising. Although poverty cannot be defined by income alone, the resulting inequalities in health outcomes are stark. To take some examples: those living in

absolute poverty are five times more likely to die before reaching the age of five, and two-and-half times more likely to die between the ages of 15 and 59, than those in higher-income groups.

Why is Better Health an Important Component of Poverty Reduction?

Evidence now shows that better health translates into greater, and more equitably distributed, wealth by building human and social capital and increasing productivity. Healthy children are better able to learn,

Health

while healthy adult breadwinners are more able to work and provide for their families. The significance of these findings is clear: to move from a vicious to a virtuous cycle, means focusing resources on improving and protecting the health of the poor.

Which Health Strategies are Effective in Reducing Poverty?

Interventions which rely on the health system for their delivery will be inadequate if the poor do not have access to organized services. Moreover, even if universal access

to health services were possible, it is unlikely that this in itself would be sufficient. The reason is that many of the determinants of ill-health, and thus the means for bringing about significant improvements in the health of the poor, will depend on developments beyond the health sector. An approach is needed which combines investment in health more broadly with better focused investment in health systems.

A health strategy to reduce poverty should include the components described below.

Acting on the determinants of health by influencing development policy. Equitable distribution of the benefits of economic growth is central to reducing poverty. Success will depend on strengthening the capacities of ministries of health to take the lead in cross-sectoral initiatives, and continuing to build on WHO's widening network of relationships, at all levels of the Organization, beyond the traditional range of health sector partners.

Reducing risks through a broad approach to public health. The challenge facing governments is to improve the access of the poor to basic public health services, including safe and adequate food, clean water, and sanitation.

Focusing on the health problems of the poor. A small number of conditions affect the health of the poor disproportionately. WHO can support governments by providing the tools and guidelines needed for implementing an optimal set of cost-effective health service interventions to tackle these specific problems.

Ensuring that health systems serve the poor more effectively. Beyond assuring the capacity to deliver essential services, there are several other characteristics of a pro-poor health system. At a minimum, it is one which ensures access irrespective of income, and treats clients with dignity and respect. It protects poor people from unsafe practices and financial exploitation in both public and private facilities. WHO has a role in advising governments

on the reforms needed to achieve these objectives.

What Principles will Guide WHO's Country Support?

To implement the strategy described above, the support WHO provides to countries will be guided by certain principles.

- Ensuring nationally led and owned policies, adapted to the local context.
 - Working in partnership with different parts of government, with development partners, nongovernmental organizations and civil society.
 - Drawing on the resources of "one" WHO.
 - Integrating gender and human rights perspectives in strategies.
 - Listening to the voice of the poor.
- The poor have assets and capabilities that can be built upon to sustain their livelihoods, and opinions on the most effective approaches to development. WHO will encourage governments to use approaches which foster greater participation of the poor, or their representatives, in the design of policies and programmes.



How to... Gauging Poverty

A review of how social scientists define who is poor

by **Joseph Katan**

Most developed countries measure in a systematic way the rate of poverty in their population and publish an annual report that presents data about the rate of poverty and the number of poor people in different regions and sectors.

The publication of this information contributes to the achievement of two main purposes: first, raising the public awareness about the existence of poverty and increasing the pressures on the government to act in order to minimize the number of poor people and, second, getting feedback about the success or failure of policies and programs designed to cope with the problem of poverty.

The methods used in different countries to measure poverty are not identical; the most popular method, used in Israel and in most European countries, is the relative measure, which measures the distance between the income of poor people and the income of the general population. A family (or an individual) is considered poor if its income is much lower than the income of most of the people in the country. In Israel, where this method has been used since 1970, a family is considered poor if its income is less than half of the median income of the total population.

The basic assumption underlying the measure is that an individual or a family having such a low income is placed at the margins of society and

cannot maintain a proper standard of living.

The family's income is adjusted to its size. This measure is called relative, because the poverty line changes according to the changes in the income level of the general population.

Other countries, such as the United States, use a different method, called an absolute measure. The basic assumption underlying this measure is that a family (or an individual) is poor if it cannot afford to acquire basic items such as food, clothes, proper housing and medical equipment. The absolute measure used in the U.S. is based on the cost of a basket of vital food items recommended by experts. The cost of this basket is multiplied by three since a consumption survey conducted in the U.S. in 1955 indicated that an average American family spends on food one-third of its total expenditure. Thus a family is considered poor if its income (adjusted to its size) falls below this figure (three times the cost of the basket).

These two methods offer different approaches to the measurement of poverty, but both view the individual or family income as the item that should be taken into account. In recent years several experts have raised doubts about the logic of viewing income as the basis for measuring poverty and suggested to replace it with the measurement of expenditure. This approach is based on the assumption that the level of expendi-

photo Ilya Melnikov

ture of individuals and families better reflects their real standard of living because it indicates the extent to which they acquire vital items such as food, clothing and housing. According to this measure, a family is poor if its expenditure is below a certain level; as in the case of the two income measures, this measure is also adjusted to the size of the family.

A totally different approach to the measurement of poverty is suggest-





shortage of basic life conditions.

The measure of life conditions and the combined measures have been used in studies on poverty, but have not been used by formal bodies such as the National Insurance Institute in Israel, which publishes the government's annual poverty report.

Two other measures used by researchers are the consensual income measure and the Sen measure developed by Nobel Laureate Amaryta K. Sen.

The consensual income measure is based on the definition of the people themselves rather than on a poverty line determined by experts who say that people with income below it are poor.

The Sen measure combines three items: the rate of poverty in the population, the gap between the incomes of various populations and the inequality within the poor population.

The measurements of poverty described above are relevant to developed countries. In developing countries the income level that differentiates between poor and non poor people is income of \$1 per day (in some countries) and \$2 elsewhere. The living conditions used as indicators of poverty include a severe shortage of vital items such as food and clean water and housing.

This review of the various measures shows that the task of measuring poverty is complex, each measure having its advantages and disadvantages. The search continues for an optimal measure that will provide a real picture on the rate of poverty and its persistence.

About Prof. Katan:

Professor Yoseph Katan is an associate professor at the Bob Shapell School of Social Work at Tel Aviv University, and a coordinator of the welfare team at the Taub Center for Social Policy Studies in Israel. His main areas of specialization are: poverty, social policy, and human service organizations. His most recent publications include: "The welfare state on the eve of a new century" (Jerusalem, The Szold Institute 2000). And "The problem of poverty: causes, components and coping strategies" (Jerusalem, The Szold Institute 2002).

ed by those who view the concrete conditions of peoples' lives as the real indicators of poverty. According to this approach, individuals or families are poor if they are deprived of basic social conditions and material items such as food, clothing, shoes, heating, vital medical equipment and proper housing. This method thus measures concrete indicators of social exclusion and material deprivation rather than the income or

expenditure level.

The conviction that both the financial situation of people and their real life conditions are necessary for the measurement of poverty has led to the development of several combined measures that include both income or expenditure and various indicators reflecting real life conditions. According to these measures poor people are those who suffer from both: financial hardships and a



How to... Gauging Poverty

כיצד קובעים במדעי החברה מי באמת עני

מאת יוסף קטן

לאומי, המפרסם את דו"ח העוני השנתי של ממשלת ישראל.

עוד שתי שיטות מדידה המשמשות למחקר הן מדד ההכנסה המוסכמת ומדד סן (Sen), שפיתח חתן פרס נובל, אמריטה ק' סן.

מדד ההכנסה המוסכמת מבוסס על ההגדרה שמספקים הנמדדים עצמם, ולא על קו-עוני שקובעים מומחים באומרים כי מי שהכנסתו פחותה מקו זה הוא עני.

מדד סן משלב שלושה גורמים: שיעור העוני באוכלוסייה, הפער בין ההכנסות של אוכלוסיות שונות, והאי-שוויון בקרב האוכלוסייה הענייה.

מדדי העוני שתוארו עד כאן הם רלבנטיים למדינות מפותחות. במדינות מתפתחות, רמת ההכנסה המבדילה בין עניים לבין מי שאינם עניים היא הכנסה של דולר אחד ליום במדינות מסוימות, ושני דולר ליום בשאר המקומות. תנאי המחיה המשמשים כמדדים לעוני כוללים מחסור חמור בפריטים חיוניים כגון מזון, מים נקיים ודיור.

סקירה זו על המדדים השונים מלמדת כי משימת מדידתו של העוני היא מורכבת, ולכל מדד יש יתרונות ומגרעות. נמשך החיפוש אחרי מדד אופטימאלי, שיספק תמונה אמיתית של שיעור העוני והתמדתו.

פרופ' יוסף קטן הוא פרופסור-חבר בבית הספר לעבודה סוציאלית ע"ש בוב שאפל של אוניברסיטת תל אביב, וכן מתאם צוות הרווחה במרכז ע"ש טאוב למחקרי מדיניות חברתית. תחומי התמחותו העיקריים הם העוני, המדיניות החברתית, וארגונים למתן שירותי אנוש. בין פרסומיו האחרונים: "מדינת-הרווחה לפתחה של מאה חדשה" (ירושלים: מכון סאלד, 2000) ו"תופעת העוני: גורמים, מרכיבים ודרכי התמודדות" (ירושלים: מכון סאלד, 2002).

ב-1955 הראה כי משפחה אמריקנית ממוצעת מוציאה על קניית מזון כשליש מכלל הוצאותיה. כך נחשבת משפחה לענייה אם הכנסתה (המד תואמת לפי גדלה) פחותה מן הנתון הזה (פי שלושה מעלות סל המזון).

שתי השיטות הללו מציגות גישות שונות למדידת העוני, אבל שתיהן רואות בהכנסה של המשפחה או הפרט את הנתון שיש להביאו בחשבון. בשנים האחרונות הטילו כמה מומחים ספק אם יש הגיון בראייה זו של ההכנסה כבסיס למדידת העוני, והציעו להחליף מדידה זו במדידת ההוצאה. גישה זו מבוססת על ההנחה כי רמת ההוצאה של פרטים או משפחות מיטיבה יותר לשקף את רמת-חייהם האמיתית, מפני שהיא מראה באיזה היקף הם רוכשים צרכים חיוניים כגון מזון, בגדים ודיור. לפי מדידה זו, משפחה היא עניה אם הוצאותיה פחותות מרמה מסוימת; גם מדידה זו, כמו שתי השיטות המודות דות את ההכנסה, מתואמת לגודל המשפחה.

גישה שונה לחלוטין למדידת העוני מציעים אלה הרואים בתנאי-המחיה המוחשיים של האדם את המדד האמיתי של העוני. לפי גישה זו, פרטים או משפחות נחשבים לעניים אם

רבות המדינות המפותחות נוהגות למדוד בדרך שיטתית את שיעור העוני בקרב תושביהן, ולפרסם דו"ח שנתי המציג את הנתונים אשר לשיעור העוני ולמספר העניים באיזורים ובמדינות שונים.

פרסום המידע הזה תורם להשגתן של שתי מטרות חשובות: ראשית, העלאת המודעות הציבורית לקיומו של העוני והגברת הלחצים על הממשלה שתפעל כדי למזער את מספר העניים; ושנית, השגת היזון חוזר אשר להצלחה או לכשלון של המדיניות והתכניות שנועדו להתמודד עם תופעת העוני.

מדדי העוני הנהוגים במדינות שונות אינם זהים. המדד המקובל ביותר, הנהוג בישראל ובמרבית מדינות אירופה, הוא המדד היחסי, המודד את הפער שבין הכנסתם של העניים לבין הכנסת כלל האוכלוסייה. משפחה (או פרט) נחשבת לענייה אם הכנסתה נמוכה בהרבה מהכנסתם של רוב תושבי המדינה. בישראל, שבה נהוג מדד זה מאז 1970, משפחה נחשבת לענייה אם הכנסתה פחותה ממחצית ההכנסה החציונית של כלל האוכלוסייה.

למצוקה

נשללים מהם תנאי-יסוד חברתיים ופריטים חומריים כגון מזון, בגדים, נעליים, הסקה, ציוד רפואי חיוני ודיור נאות. לכן שיטה זו מסתמכת על מדדים מוחשיים של הדרה חברתית וחוסר חומרי, במקום רמות ההכנסה או ההוצאה.

ההבנה כי גם המצב הכספי וגם תנאי-החיים הממשיים נחוצים למדידת העוני הביאה לפיתוח חן של כמה שיטות למדידה משולבת, הכוללות הן את ההכנסה או ההוצאה, הן מדדים שונים המשקפים את תנאי-המחיה הממשיים. על פי שיטות המדידה האלה, עני הוא מי שסובל גם ממצוקה כספית וגם ממחסור בתנאי-מחיה בסיסיים.

מדידת תנאי המחיה והמדידות המשולבות כבר שימשו למחקרים על העוני, אבל טרם הונהגו אצל גופים רשמיים כגון המוסד לביטוח

הנחת היסוד שעליה מושתת מדד כזה היא שפרט או משפחה בעלי הכנסה כה נמוכה נדחקים לשולי החברה ואינם מסוגלים לקיים רמת חיים נאותה. הכנסת המשפחה מחושבת על-פי גודלה. מדד זה נקרא יחסי מפני שקו העוני משתנה לפי השינויים ברמת ההכנסה של כלל האוכלוסייה.

במדינות אחרות, כגון ארצות הברית, נהוג מדד אחר, הנקראת מדד מוחלט. הנחת היסוד שעליה מושתת מדד זה גורסת שמשפחה (או פרט) היא ענייה אם אין לאל ידה לרכוש צרכי יסוד כגון מזון, בגדים, דיור נאות וציוד רפואי. המדד המוחלט הנהוג בארצות הברית מבוסס על העלות של סל-מזון חיוני, הנקבע על פי המלצת מומחים. עלות הסל הזה מוכפלת פי שלושה, מאחר שסקר צריכה שנעשה בארה"ב



מדד

الملائم أو على المعدات الطبية. ويعتمد المقياس المطلق الذي يستخدم في الولايات المتحدة الأمريكية على ثمن سلة الطعام الأساسية كما يوصي بها الخبراء. وتبلغ تكلفة هذه السلة مضمرة في ثلاث تبعا لمسح الاستهلاك التي قامت به الولايات المتحدة الأمريكية عام ١٩٥٥ والذي أظهر أن متوسط إنفاق الأسرة الأمريكية على الطعام يشكل ثلث مصروفها الكلي. وبالتالي فإن الأسرة تعتبر فقيرة إن كان دخلها (وفقا لحجمها) أدنى من هذا الرقم (ثلاثة أضعاف تكلفة السلة).

رغم أن هذين الأسلوبين يقدمان طرقا مختلفة لقياس الفقر، إلا أنهما يعتبران دخل الفرد أو الأسرة أداة يجب أخذها بعين الاعتبار. وقد شكك عدد من الخبراء خلال السنوات الماضية بالمنطق الذي يدعو إلى استخدام الدخل كأساس لقياس الفقر، اقترحوا ضرورة استبدال هذا الأسلوب بمقياس المصروفات. الذي يقوم على افتراض أن مستوى مصروفات الأفراد والأسر يعكس بصورة حقيقية مستوى المعيشة وذلك لأنه يشير إلى الحد الذي يحصلون من خلاله على المواد الأساسية؛ كالطعام والملابس والسكن. وتبعا لهذا المقياس فإن الأسرة تعتبر فقيرة عندما يكون مصروفها دون مستوى معين كما هي الحال في المقياسين الآخرين وهو معدل ليلائم حجم الأسرة.

وهناك مقياس مختلف تماما لقياس الفقر اقترحه أولئك الذين يأخذون بعين الاعتبار الظروف الملموسة التي تؤثر في حياة الناس والتي تعتبر مؤشرا حقيقيا للفقر. وتبعا لهذا المقياس فإن الأفراد أو الأسر تعتبر فقيرة عندما تحرم من الظروف الاجتماعية الأساسية والعناصر المادية كالطعام والملبس والتدفئة والأدوات الطبية الضرورية والسكن الملائم. يركز

هذا الأسلوب على أساس قياس المؤشرات الملموسة للصد الاجتماعي والحرمان المادي أكثر من التركيز على الدخل أو مستوى الصرف.

إن الاقتناع بدور كل من الوضع المالي للناس وظروف الحياة الحقيقية الضرورية في قياس الفقر قد أدت إلى تطوير عدد من المقاييس الموحدة التي تركز على كل من الدخل أو المصروف من ناحية والمؤشرات المختلفة التي تعكس ظروف الحياة الحقيقية من ناحية أخرى. وتبعا لهذه المقاييس فإن الفقراء هم أولئك الذين يعانون من صعوبات مالية ونقص في متطلبات الحياة الأساسية.

لقد استخدم مقياس ظروف الحياة والمقاييس الموحدة في الدراسات المتعلقة بالفقر ولكن لم تستخدمها الجهات الرسمية كمؤسسة التأمين الوطني في إسرائيل التي تقوم بنشر التقرير الحكومي السنوي عن الفقر.

وهناك مقياسان آخران يستخدمهما الباحثون وهما مقياس الدخل الرضائي



Photos UNVP/Steve Sabella

ومقياس (سين) الذي طوره نوبل لوريان أمارياتا سين.

يرتكز مقياس الدخل الرضائي على المعلومات التي يقدمها الناس أنفسهم أكثر من ارتكازه على خط الفقر الذي يحدده الخبراء والذين يرون بأن الناس يعتبرون فقراء حين يكون دخلهم أقل منه.

أما مقياس (سين) فهو يضم ثلاثة عناصر وهي: مستوى الفقر عند السكان، والفجوة بين المدخولات لمختلف السكان وعدم المساواة عند الفقراء.

مقاييس الفقر التي وصفت سابقا تلائم المجتمعات المتطورة. أما في المجتمعات النامية فالذي يميز بين الفقراء وغير الفقراء هو الدخل بمعدل دولار واحد لليوم (في بعض الدول) ودولارين في الدول الأخرى. أما ظروف الحياة التي تستخدم كمؤشر للفقر فتشمل النقص الحاد في المواد الضرورية مثل الطعام والماء النقي والسكن.

تظهر هذه المراجعة للمقاييس المختلفة أن عملية قياس الفقر هي عملية معقدة؛ فكل مقياس حسناته وسيئاته. ولا يزال البحث جاريا عن المقياس الأمثل الذي يمكن أن يعطي صورة حقيقية عن مستوى الفقر واستمراريته.

نبذة عن البروفسور يوسف قطان:

بروفسور يوسف قطان هو محاضر في كلية بوب شابل للخدمة الاجتماعية في جامعة تل أبيب وهو منسق لفريق الرفاه في مركز (تاوب) لدراسة السياسة الاجتماعية في إسرائيل. وأهم مجالات تخصصه هي: الفقر، والسياسة الاجتماعية ومؤسسات الخدمة الإنسانية. ومن منشوراته الأخيرة «دولة الرفاه عشية القرن الجديد» (القدس، مؤسسة سزلاد ٢٠٠٠) و«مشكلة الفقر: أسبابها، عناصرها واستراتيجية الاضطلاع» (القدس، مؤسسة سزلاد ٢٠٠٢)



How to... Gauging Poverty

مقياس البؤس

مراجعة الكيفية التي يقرر بموجبها علماء الاجتماع من هو الفقير الحقيقي
يوسف كتان

مثل هذا الدخل المتدني يضعها على هامش المجتمع وبالتالي لا تستطيع توفير مستوى حياة ملائم.

يعدل دخل الأسرة وفقاً لحجمها. ويطلق على هذا الأسلوب بالنسبي نظراً لتغير خط الفقر تبعاً للتغيرات في مستوى دخل عموم الناس.

وتلجأ دول أخرى كالولايات المتحدة الأمريكية مثلاً إلى استخدام أساليب مختلفة مثل المقياس المطلق. ويرتكز الافتراض الأساسي لهذا المقياس على أن الأسرة (أو الفرد) يكون فقيراً عندما لا يتمكن من الحصول على الحاجيات الأساسية كالطعام أو اللباس أو السكن

قياس درجة الفقر؛ ويعتبر المقياس النسبي من أكثر الأساليب شيوعاً وهو المستخدم في إسرائيل وغالبية الدول الأوروبية. ويعتمد هذا الأسلوب على قياس الفارق بين دخل الإنسان الفقير ودخل عموم الناس. وتعتبر الأسرة أو الفرد في حالة فقر إن كان الدخل أقل من دخل معظم السكان في الدولة. بالنسبة لإسرائيل التي تم تطبيق هذا الأسلوب فيها منذ عام ١٩٧٠ فتعتبر الأسرة فقيرة عندما يكون دخلها أقل من نصف متوسط دخل السكان.

الافتراض الأساسي الذي يقوم عليه هذا المقياس هو أن حصول الفرد أو الأسرة على

تلجأ معظم الدول المتطورة إلى قياس مستوى الفقر لديها بصورة منتظمة وتقوم بنشر تقرير سنوي تعرض بموجبه المعطيات المتعلقة بمستوى الفقر وعدد الفقراء في مختلف المناطق والقطاعات. يهدف نشر هذه المعلومات إلى تحقيق هدفين رئيسيين: الأول زيادة الوعي العام حول وجود الفقر وبالتالي زيادة الضغط على الحكومة من أجل اتخاذ الإجراءات الملائمة للحد من عدد الفقراء وثانياً الحصول على تغذية راجعة حول نجاح أو فشل السياسات والبرامج المصممة للتعامل مع مشكلة الفقر. تختلف الأساليب التي تتبعها الدول في

Detecting Breast Cancer is Good Business

As part of international Breast Cancer Awareness Month, the fashion house chain Comme il Faut and the One in Nine organization conducted a breast cancer self-examination workshop in October for well-known media figures and politicians. Comme il Faut also announced it would donate NIS 300 for every ninth customer during the month to the One in Nine Organization.

"Studies prove that early detection of the disease increases the chance of recovery to 90%," says Nurit Tulani, the CEO of One in Nine. "Self-examination is one of the central ways to detect breast cancer early and in time."

The organization's breast self-examination project has been running dozens of workshops for a year and reaches the disadvantaged (former drug addicts and abused women) and targets certain communities (Bedouin women, immigrants from the Commonwealth of Independent States) to provide knowledge about how to stay healthy. CEO Tulani says, "We advise women to get familiar



with their breasts and to take responsibility over their bodies and health, in order to be better protected."

The Comme il Faut - sponsored workshop drew Yuli Tamir, Yael Dayan, Einat Erlich, Meirav Michaeli, Lihi Lapid, Bili Moskuna-Lerman, Smadar Hirsh, Anat Mordechai, Shachar Segal, Roni Halpern, Tali Rozin, Menuela Dviri, Tamara Yuvel Jones, Ila Bar, and Yahaloma Levi.

According to Sibil Goldfinger, Comme il Faut's CEO, "We decided to help raise awareness about the importance of early detection of breast cancer, targeting especially disadvantaged women, as we believe every woman has the right to know how to take a breast cancer self-examination. Comme il Faut supports women as part of its business strategy."

Conference in Rome on Palestinian Health Care

The Palestinian health care system needs to address both old and new challenges in a highly volatile situation with constant difficulties in communication, coordination, and, above all, with poor financing of health care. There is particular concern for the vulnerable—children, the elderly, women and the unemployed and others who are low income.

The Health Sector Review (HSR) is contributing to the understanding of these issues from different angles. As

part of this process, the conference Health Care in the Palestinian Territories: A Chart for the Future will be held in Rome from December 14-16, 2004. The main objective of the conference is to provide a forum for further dialogue and consensus among stakeholders on what has been achieved through the efforts of the HSR.

The conference will offer an opportunity to assess the challenges facing the health care system in Pal-

estine, its institutional environments and donors' contributions. It is being organized by the Italian Cooperation of Italy's Foreign Ministry, with the support of the Palestinian Ministry of Health and other Palestinian ministries, the World Health Organization, the World Bank, the European Commission and the Department for International Development (DFID) of the United Kingdom and the main stakeholders in the Health Sector Review.

Creating Dialogue: Physicians for Human Rights – Israel

What should medical workers do about the crisis in the occupied territories? Can they contribute to the Israeli discourse? Physicians for Human Rights-Israel, together with the Gaza Community Mental Health Program, invited the public to a debate on the issue on October 13, 2004 in the conference hall of the Ambassador Hotel in Jerusalem. There were presentations on the situation by Dr. Ambrogio Manenti, head of the office of the WHO in the West Bank and Gaza, and by Dr. Mohammed Skafi from the Union of Palestinian Medical Relief Committees. A statement from GCMHP was read, as Dr. Iyyad al-Sarraj was not granted a permit to exit Gaza. All presentations emphasized the devastating effects of Israel's closure policy on the lives of Palestinians in the occupied territories and their right to health.



Following the screening of *Detail*, a documentary short by Avi Mograbi that depicts one incident at a temporary checkpoint, Mograbi described his bitter experience when filming in the West Bank. The arbitrariness of it all – with no connection to security – was what struck him most, he said.

A discussion followed in which Dr. Dani Filc of Physicians for Human Rights-Israel represented the organization's views. Those of the Israel

Defense Forces were represented by Lt. Col. Mey-Tal from the Civil Administration. He emphasized Israel's security concerns and highlighted the efforts made to balance these with the humanitarian needs of the Palestinians. It was a rare opportunity to hear them both.

Israeli health professionals in the audience spoke of their dissatisfaction with the role of the Israel Medical Association, saying it should take a more explicit stand in the name of medical ethics and the right to health. Dr. Filc expressed the concern of PHR-Israel that its criticism is not taken into consideration, and that the claim of security is used to explain any action being made by the IDF. PHR-Israel believes it must work with Palestinian colleagues for freedom of movement for medical workers and patients alike.

A WHO Initiative on Eliminating Health Inequities

Take any of a series of social determinants such as wealth, education, ethnicity, gender, upbringing or employment, and the story is the same. People's health prospects worsen as they descend the social ladder. Edwin Chadwick's 1842 report on the sanitary conditions of working people in London showed the disparity in life spans between laborers and gentry, and the United Kingdom's 1980 Black Report noted that while the first 35 years of the National Health Service had improved health across all classes, social status was still strongly correlated with infant mortality, life expectancy and use of medical services. To quote the report: "The three main social determinants of health are income, social



Photo WHO

class and education."

The World Health Organization (WHO) hopes to engender change by setting up a new body called the Commission on Social Determinants of Health. The Commission is planned to run for three to five years, starting early in 2005, and will look at the inequities within societies that

create inequalities in health. It also hopes to draw attention to examples of global, national and local policies that have strengthened health equity between and within countries.

From Bulletin of the World Health Organization. The International Journal of Public Health (Vol. 82, N10, October 2004)

As many as two billion people face threats to health because they are at risk of, or exposed to, crisis conditions. These are due to sudden natural disasters, complex and continuing emergencies, and slow-onset processes – the increasing prevalence of fatal HIV infection or others. Continuing emergencies are due to more than 100 violent conflicts, and their associated displacement. The WHO Health Action in Crisis department aims to improve the management of public health issues in crisis-affected communities.

WHO seeks to work with other health stakeholders to support communities affected by crisis – to strengthen the national authorities so that suffering and death are mini-

of the response include ensuring equitable access to safe water and sanitation; to food and to shelter. They also include the protection of affected populations from ill-health and violations. Responses should concentrate as a priority on the most vulnerable people: women, especially when pregnant, young children, the elderly and persons who are disabled or chronically ill.

3. recovery and rehabilitation – ensuring that the local health system is functioning with integrated risk-reduction measures. From a health perspective, crises can be considered resolved when essential health systems have been repaired and rebuilt; when the major health needs of the most vulnerable populations receive attention; and when health care environments are safe for both patients

capacity to implement best practices with regards to the health aspects of crises. It supports the assessment of situations prior to or during crises, with an emphasis on trends, vulnerabilities and inequities. WHO supports the analysis of information and anticipation of future events, the development of strategies, implementation and the revision of crises in relation to the health aspects. WHO also supports the assessment of critical areas of the health system and the identification of weaknesses affecting the capacity to address crisis-specific health needs that therefore require immediate remedial action. WHO supports the monitoring of progress in responding to the crisis together with other sectors.

2. WHO ensures technical back-up and coordination for effective prepa-

WHO's Health Action in

The UN agency plays a multi-dimensional role

by **David Nabarro**

mized and systems are protected and repaired. The focus of attention on health aspects of crises will open the way to better survival rates and improved well-being in crisis-affected communities. WHO support focuses on three main aspects:

1. preparedness – strengthening the overall capacity of countries to manage all types of crises. For the health sector, preparedness typically entails making health facilities resilient when faced with extreme conditions and ensuring availability of priority hospital services (with a focus on trauma, women's health, child care and chronic conditions); the management and triage of mass casualties; evacuation of the injured and quarantine procedures; capacity for search and rescue operations; and the ability to establish disease surveillance and control measures rapidly.

2. response – essential elements

and health personnel. To achieve this, WHO joins with national authorities and international agencies in developing and agreeing to a sector recovery plan, which frequently forms the health element of the Consolidated Appeal (CAP) and Transition Planning processes.

WHO has developed an organization-wide strategy for health action in crises, through which WHO's country teams provide services in ways that support national institutions, within the overall response by the international community.

Critical Elements

The three critical elements to WHO's contribution are:

1. WHO has an operational role, prior to, during and after crises to ensure adequate local-level capacity for specific functions. WHO ensures that, within a crisis-prone and/or crisis-affected location, there is the

ration, mitigation, response and recovery. It engages partners, accesses necessary inputs, helps guarantee that gaps are filled, anticipates the possible health consequences of a crisis, helps enable the resilience of health infrastructures and systems; optimizes and enhances local and national response to crises, so there is readiness to call for and absorb external assistance when needed; and enables policy people and implementers to access technical advice, systems and wide support as needed.

3. WHO works effectively with, and strengthens, the systems that influence health and are implemented via local or national institutions. WHO convenes different stakeholders, encouraging consensus on priorities and best practices, sets standards for health action, implements life-saving interventions, and contributes to system repair and recovery within central and local government



Crises

as well as civil society; draws on lessons from the past, and using this expertise, prepares for, mitigates and improves responses to future crises; contributes to the combined effort of the international humanitarian community by implementing the above measures, thus earning the right to lead on health sector issues.

The value of preparedness, the positive influence on health of prompt and focused response and the merit of coordinated recovery efforts was shown in the Islamic Republic of Iran immediately following the Bam earthquake in December 2003; in the Democratic People's Republic of Korea following the train accident in Ryongchon in April 2004, and in Djibouti following severe floods in April 2004.

The need to ensure that the most vulnerable population groups gain access to functioning health services without threats to their security has

been once more highlighted in 2004 during conflicts in Haiti, the Darfur region of Sudan, refugee camps in Chad and in parts of Iraq.

WHO West Bank and Gaza

In the West Bank and the Gaza Strip, the continuation of the Israeli-Palestinian conflict, coupled with an increased depression of the socioeconomic environment resulting from closures and curfews, has had a complex impact on the functioning of the health system and health outcomes for the Palestinian population. Detailed analysis shows that the complex situation lasting now for more than four years has impacted the health of the Palestinian population.

To address the challenges faced by the Palestinian people and the Palestinian health care system, the WHO has developed a five-pronged strategy for its ongoing work. The strategy considers improving impact of health interventions through efficient and effective coordination; obtaining, collecting and interpreting health information; maximizing

health through up-to-date technical assistance; promoting and protecting the right to health through an advocacy/ rights-oriented approach; and, promoting dialogue and collaboration between Palestinian and Israeli health professionals, NGOs and health institutions.

The promotion of dialogue is a specific interest of WHO, following the World Health Assembly Resolution of 1981 which highlighted "the role of physicians and other health workers in the preservation and promotion of peace as the most significant factor for the attainment of health for all"¹. Field experience shows that health-related goals may be shared among conflicting parties, giving them the needed basis for co-operation. This may create an opportunity to build a negotiating framework, and even to demonstrate the possibility of ending the violence.

David Nabarro is the representative of the WHO Director-General for Health Action in Crises

1. WHA Resolution 34/38, 1981

Bearing witness to the human cost of conflict

by **Daniel Ben Simon**

He had this dream since he was a young boy playing in the streets of Jerusalem. Whenever Issa Dawiyat saw an ambulance or heard the sirens, he felt an instinctive urge to help. The sight of the ambulance or the sound of the sirens signaled that somebody was in trouble. More than once he witnessed doctors and paramedics rushing out of the ambulance to save the lives of people in need - the victims of car accidents, people with health problems and those hurt in terrorist attacks. Living in Jerusalem, Issa learned from an early age, meant that terrorist attacks were a part of life's daily routine.

"I remember the ambulances of Magen David Adom in action," he says of Israel's ambulance service. "I was just a kid but I remember the

paramedic. "I must tell you that in some cases being a paramedic is like being a doctor," Issa asserts, "I have all the means to treat people in case of an emergency. I am equipped like a doctor and in most cases, I arrive before the doctors."

For the last 20 years he has seen and experienced almost everything. But the last four years were an experience in itself. Shortly after the Intifada erupted, Issa found himself in personal turmoil. Jerusalem was transformed into a battlefield. Not a week passed without a suicide bombing that rocked the city. The sights were horrifying. Women and children and elderly lying in agony. Dead or injured.

"I think that I saw more than 20 suicide attacks in the last four years," he says. "I saw everything you can imagine. Usually we treat

A Day in the Life Angels in white

people dressed in white leaning on the floor to treat the wounded from a car accident. I was filled with awe. I said to myself that one day, with God's help, I will also be part of these angels in white."

When he applied to be recruited into the Israeli army, he was told that as an Israeli Arab, he could only volunteer to do national service - military service without an army uniform. Issa asked if he could serve as a paramedic. The army said why not start as an ambulance driver. Issa agreed wholeheartedly.

After a year of doing national service, he began to study to become a

people who are in danger of dying. It takes a few seconds to know. Very quickly you know who is dead and who is still alive. When you see a body without a head, you know that it's over for him or for her.

"My job is to treat the worst cases. I must tell you that with time you develop indifference but it's only on the outside. I come home and sometimes my wife and my kids don't understand why I am so depressed. Go and tell them that you saw kids totally burned. With their morning sandwich on the floor. Once I saw a woman sitting on the bus after a suicide attack. I felt happy that she was



alive. I saw her from behind and she looked OK. When I tried to talk to her, I saw that her face was missing and her brain was open. Of course she was dead. From what was left of her, she must have been a very beautiful woman. It shocked me for days."

Issa, born in Beit Safafa, an Arab village on the southern edge of Jerusalem, knew in his heart that in these abnormal times, being an Israeli Arab, his Israeliness would be tested. Conflicts tend to sharpen split identities, and this new bloodshed between Israelis and Palestinians was no exception to the rule.

"You don't see yourself as an Arab or Jew when tragedies occur," he explains. "The first thing you are trying to do is to keep your sanity. Because in these moments, when you see kids bleeding to death, you are crying. Your heart is crying. Kids leave you with a different feeling. Because

they are so helpless and they don't deserve to die. Also you know that innocent people should be spared in wars but, unfortunately, it didn't work this time."

He treats Jews and Arabs as if they were part of his own family. He remembers that a few years ago, when he rushed to the scene of a burning bus, he saw a female soldier on fire inside the bus. He went in and took her out. Had he not done so, she would have died. The day after, he went to hospital to visit the wounded from bus 18, which blew up on Jaffa Road in the beginning of 1996. Sixteen people died in that suicide attack. "I saw the female soldier surrounded by family members," recalls Issa, "I came close to her and said 'hi' and wished her a speedy recovery. She said 'thank you'. I didn't tell her that I was the one who took her out of the burning bus and saved

her life. I thought that it was my duty."

Since he became a paramedic, no one has ever raised doubts about his readiness to treat Jews. His friends at work never asked him about his political views, and he never asked them about their political views. "I must say that we work together in such harmony that we don't need politics to spoil our friendship," he says.

Issa, 51, the father of three, wishes that the conflict would subside. He wouldn't mind it, he says, if his beeper stays quiet for a long, long time.

About Daniel Ben Simon:

Daniel Ben Simon writes for the Israeli newspaper "Haaretz". His focus is Israeli society. He has written three books about the linkage between society and politics. In 2004 he received the Sokolov Prize for Journalism.

An ambulance driver in the Gaza Strip talks about his work

by **Taghreed El Khodary**

Moeen Abu Al Eish, 39, is an ambulance driver in Jabalya, a Palestinian refugee camp in the northern Gaza Strip. He and his wife have seven children, aged 4 to 15 years old. Last September Moeen worked day and night during Israel's intensive military operation in the northern part of the Gaza Strip, which lasted 17 days and led to 442 Palestinians being injured (among them 177 children) and 103 killed, including 28 children and 41 Palestinian fighters. After four days of the operation Moeen moved his family out of Jabalya, hoping to focus his energies on saving lives, and to avoid the haunting fear of having to save his own family. In an interview conducted at Al Awda Hospital in the Jabalya camp, Moeen answers

him in the thigh while he was trying to save someone's life at the Erez checkpoint. He came back to work after two years and now we work together.

What is your job?

To offer service to every person who is injured or sick or in need. I don't ask names or if they are from the resistance. All I care about is saving someone's life. I once tried to save the life of an Israeli businessman who was shot in the head in Beit Lahiya during the first intifada.

How was it to work in Jabalya for 17 days straight?

It was difficult. For the first time Israel used drones to strike civilians. Many children and women were killed or injured. The first bomb was fired toward a large number of children. Around 21 were injured in one spot.

What were the most difficult moments?

I was shocked after an attack on three fighters. I started by collecting the body parts. I held a body that had lost its right leg, and placed the body part next to the torso. When I reached the hospital, the body that I had thought was dead straightened up. I started screaming 'God is great'

rifice their lives in front of drones and tanks. It is the will of resistance that enables them to forget about the most powerful weapons. I see them as heroes. They are planting these primitive bombs under the most advanced tanks.

Is your job difficult? Have Israeli soldiers fired at you?

It is humiliating. My colleagues went to collect a body, and they were asked to hold up their hands. They are a medical team with a clear medical symbol.

A year ago, a tank shell hit a house in Beit Lahiya. We headed toward the house. Many Israeli soldiers were shooting. We were very surprised when they started shooting toward our vehicle. Two bullets were aimed my chest. I was lucky that I was driving and lying low to avoid the bullets, but I still have shrapnel in my head.

How do you feel? Do you feel satisfied with the work you've done?

I did a lot. Thank God, we were saved! We don't think of the money. Once we hear an explosion, we run toward it. We have saved many lives. We did all we could. I moved my family out so nothing personal would keep me away from work,

A Day in the Life Under the

questions about his life as an ambulance driver in a Palestinian refugee camp.

Where were you trained?

I was trained in Israel by the Magen David Adom ambulance service during the first intifada. When the Palestinian Authority was set up, I worked with the Palestinian Ministry of Health and the Palestinian Red Crescent Society. I also started working as a volunteer at Al Awda Hospital when my friend was injured in December 2000. Israeli soldiers shot

he turned out to be alive! I often ask about him. He is still alive.

Another difficult moment was when I saw a group of fighters, still alive, but I also saw Israeli tanks and drones, and I said to myself, I'm going to collect their body parts. And I did. That affected me deeply, and made me sad. One of them was lying on the ground and his brain was spilled out. He died about an hour and half later. Another man's body was on fire, and I had to put it out. I wonder why these young men sac-

and I go to my family all the time to make sure they are fine.

Were any of your relatives injured?

Four of my relatives were killed, and two were injured. Also during the first intifada, my sister was hit by six Israeli rubber bullets while buying potatoes in the souk. Those were the days when the Israelis used to impose a curfew, then lift it for two hours, so my sister went to the market during these two hours. It was my shift so the ambulance driv-



fire of guns

er had to pass by so I could replace him. When I was about to drive off, I heard my sister's voice asking me to take care of her nine kids. I was so shaken when I realized who was speaking, I couldn't move, so my colleague took over.

May I ask how much are you paid?

I get NIS 1,800 [around \$400] a month for my work at the Red Crescent society through the Ministry of Health, and I also get NIS 1,000 [about \$220] as an honorarium from

Al Awda Hospital for my work there. From time to time there was also a \$150 bonus from our late President Arafat. We were promised one before the incursion but we haven't received it yet.

Have you thought about changing jobs?

No, and I won't. People need me. I feel as though I'm fighting through this work. I consider myself more than a fighter who is holding a weapon. I'm used to it.

How many hours did you sleep

daily during the intense 17-day military operation in the Gaza Strip?

For three days I slept five hours a day but the rest of the days, I was sleeping one to two hours just enough to be able to keep working.

What is needed to make your job better?

An Intensive Care Unit vehicle. There is not a single one in Northern Gaza. Also we need new vehicles. Those we are using are old. And, then, I'm dreaming about 10 days off in a safe and secure place every six months.

Taghreed El Khodary is an Al Hayat - LBC correspondent and also works as a stringer for The New York Times in the Gaza Strip.



Nurse in Training

'I'm the youngest Palestinian nurse'

by **Abdel Baset Khalaf**

Eleven year old Fairuz Mansour is not embarrassed to sing her own praises as the youngest Palestinian nurse. Of course, she does not have nursing school credentials. But she has been working in a clinic for some time now, helping her father, Dr. Mansour Yaqeen, a general practitioner who did his practical training in surgery. His clinic is in Biddu, a village northwest of Jerusalem known for its grapes.

From behind a desk in the humble clinic, Fairuz gets up to wear what she calls her "beautiful white nurse's gown". She hurries around the clinic fixing appointments, cleaning medical instruments, offering water to thirsty patients and calming them with soothing words.

What started as a love of the clinic

many years ago, recently turned into a practical necessity after her father was hurt in a protest against Israeli bulldozers near the Wall. Since then, he has had two pins in his left leg and has had to use crutches. His daughter helps at whatever she can. She learned how to use a thermometer to take a patient's temperature and record it. She learned to hand her father needed implements, and he taught her the differences between various bandages and the components in anesthetics. She has learned to spot the symptoms of chicken pox and anemia and of many other conditions.

She explains: "I no longer fear blood, wounds and the implements my father uses. And most of all, I no longer feel disgusted with patients throwing up or screaming from pain. It all has become very normal to me.

I do not fear anything anymore and it is not hard to watch my father in surgery." She says that the hardest situation she faced was assisting her father with a patient in critical condition.

Fairuz, who was born on February 14, 1993, began going to elementary school a year before the customary age, and by the time she was five, she was carrying her bag of school books on her own to the school in a village next to hers. She has written for her school's radio station about health issues and has even watched filmed surgery -- the sort of thing that might evoke a cry of disgust from someone else in her age group. About school and about her dreams for the future she says: "I love the Arabic language, the English language, science and national education. I dream of being a pediatrician one day when I grow up. To look after the wounded -- it's the most human profession I know of."

Dr. Yaqeen, her father, is the son of a farmer who worked his beloved land until the day he died. Till this day, Dr. Yaqeen ends every day tending his family's vineyards -- no matter how hard he has worked in the clinic. With the same precision he brings to suturing wounds of patients, he trims the stems and removes the leaves, straightens the stone trimming that protects the soil from drifting. And he has passed this on to his daughter as well, explaining that working the land is very important for those practicing medicine. It offers a release from the stress of handling patients all day. It connects one to something larger than the daily toils at the clinic. Fairuz takes this lesson seriously. She participates in each harvest and prays for the health of the land as she does for the health of patients. But the ever encroaching Wall is one disease she does not know how to treat.

Fairuz is the sixth child in the family of Doctor Mansour Yaqeen. Her brother Yaqeen studies dentistry in Al Qahira University, the same one in which their father studied.



All Sides Focus on Disease Outbreaks

A field epidemiology course builds ties and knowledge

by **Gayle Meyers**

W I think we as professionals can do more than politicians can. I hope the politicians can learn from us," said an official from the Jordanian Ministry of Health. The comment came after 35 Palestinian, Jordanian and Israeli health professionals spent five days together, from September 5-10, 2004, learning how to monitor and respond to disease outbreaks.

"I don't think anyone in our country believed it could happen," said an Israeli. And a Palestinian lab director from Gaza said, "We didn't just listen, but we also were heard."

For many this course provided the first opportunity to work with their counterparts from other countries, says the sponsoring organization, Search for Common Ground. It formed the Middle East Consortium for Infectious Disease Surveillance (MECIDS) to improve the ability of nations in the Middle East to respond to disease outbreaks – whether naturally or deliberately caused – and to build trust.

Since its formation two years ago,

MECIDS has had the backing of the Israeli, Palestinian and Jordanian health ministries. It has advisers from the World Health Organization and European and American organizations. But there are significant obstacles to a coordinated response to a health threat. The WHO places Israel in a separate administrative region from its neighbors, and the past four years of Israeli-Palestinian violence have stifled cooperation.

The September course in Istanbul was MECIDS' first project and focused on establishing a surveillance system for foodborne disease outbreaks. All the participants will play a role in maintaining this system. The course's objectives were to provide each participant with the following:

- An understanding of how to plan, implement and evaluate a disease surveillance system.
- Knowledge of how to perform outbreak investigations.
- An understanding of the use of the principles of epidemiology and studies in outbreak investigations, case control, and cohort studies.
- A clear understanding of his or her

current role in the larger framework of the MECIDS foodborne disease surveillance program.

Each ministry of health sent six participants and two or three facilitators to the course. Ministry officials joined in at the end. Participants included doctors, nurses, laboratory technicians and administrators. The curriculum was supervised by a volunteer from the European Program for Intervention Epidemiology Training (EPIET). Search for Common Ground provided training in interpersonal communication and cooperative problem solving, with an emphasis on workplace skills and meeting people from opposing factions in the Middle East conflict.

"I could learn epidemiology from reading a book," commented an Israeli. "To meet this group is amazing." Another Israeli from the Ministry of Health said, "Personally I knew professionals were the same everywhere, but it was important for



me to see it with my own eyes."

A Palestinian Ministry of Health officer from Gaza said, "There was wonderful unexpected interaction between the three peoples. We wish that peace were coming. We wish for more collaboration to make life easier for all people."

A Jordanian Ministry of Health official summed up the experience: "Epidemiology is the core of public health. The objective of training is to minimize bias, to speak the same language."

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