Between Personal Experience and Communal History: Health Perceptions and Attitudes toward Health Services in Two Palestinian Refugee Camps in Lebanon

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2005

Of all the forms of inequality, injustice in health is the most shocking and the most inhumane.

MARTIN LUTHER KING, JR.

Disease occurs, of course, not in the body, but in life. Localization of a disorder, at very best, tells little about why it occurs when or how it does. Disease occurs not only in the body – in the sense of an ontological order in the great chain of being – but in time, in place, in history, and in the context of lived experience and the social world. Its effect is on the body in the world!

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ACKNOWLEDGEMENTS

This project was generously funded by the Institute for Community and Public Health of Birzeit University.

This research would not have been possible without the help of Kholoud Hussein, my interpreter, and without the cooperation of UNRWA, PRCS and the NGOs in the camps. Special thanks go to Dr. Jamil I. Yousef and Hala Daifallah, UNRWA Field Office Lebanon; Dr. Mohammad Othman, PRCS Lebanon Field; Olfat Mahmoud and Suha Hussein, Women's Humanitarian Organisation; Samira, Association Najdeh Wavel; and to Rita Giacaman and Penny Johnson, Birzeit University and Rosemary Sayigh for their invaluable insights during the editing phase.

None of the research would have been possible without the cooperation and kindness of the people in the camps who willingly participated and welcomed me during the length of this research project.

GLOSSARY

Argileh	Arabic water pipe
Fatah	Main Palestinian faction formerly headed by Yassir Arafat; acronym for *Harakat al-Tahreer al-Wataniah al-Falasteeniah* (Palestinian National Liberation Movement) spelt backward
Hamdullilah	Thank G-d
Haram	Word meaning 'shame' or used to indicate something that is prohibited
ICPH	Institute for Community and Public Health
ICRC	International Committee of the Red Cross
Intifada	Word meaning literally 'to shake off' and used to denote the popular uprisings in the Palestinian Occupied Territory of the West Bank and Gaza Strip
LRCS	League of Red Cross Societies
NGO	Non-governmental organisation
PA	Palestinian Authority
PLO	Palestine Liberation Organisation
PRCS	Palestinian Red Crescent Society
Saratan	Cancer
Shabab	Young unmarried men
Suq	Open-air market place
Tawtin	Word used to refer to the permanent settlement of Palestinian refugees in Lebanon
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East

ABSTRACT

This study is qualitative in nature and aims to assess health status through perceptions of health and health services in two Palestinian refugee camps in Lebanon: Bourj el-Barajneh and Wavel. It builds upon past health research by focusing exclusively on the point of view of camp residents and the medical personnel servicing these camps, while highlighting differences in perceptions across gender, age and camps.

INTRODUCTION

The Palestinian refugees in Lebanon are generally seen as comprising the most vulnerable, deprived and marginalised of all of the Palestinian refugee populations in the Middle East (FAFO 2003: 15; Soweid and Al-Khalidi 2004: 4; Roberts 2001: 15). Fifty-six years of exile, years of intermittent warfare and conflict, restrictions on civil rights and movement, as well as recent decreases in service provision have all combined to create a worsening health situation for Palestinians in Lebanon.

The most recent health and living conditions studies[1] outline an alarming situation. According to UNRWA's Annual Health Report (2003), hospitalisation for diseases of the respiratory system was highest by a significant margin in the Lebanon field: 17.4 % as compared with 6.1 % in Jordan and the West Bank (36). Palestinian refugees in Lebanon also had the highest rate of hospitalisation for disease of the blood and blood-forming organs (3.7 % as compared to 1.6 % in the West Bank), and the second highest rates for neoplasms (2.8 % as compared to 4.2 % in Syria), diseases of the circulatory system (10.8 % as compared to 12.0 % in the West Bank) and diseases of the digestive system (16.7 % as compared to 26.1 % in Syria) (36). In addition, the highest rate of hypertension (55.0 % as compared with 50.2 % in Syria and 43.5 % in the West Bank) is also found among the refugees in Lebanon (UNRWA 2003: 79).

UNRWA's statistics are complemented and corroborated by a number of other studies, the most authoritative of which is that of FAFO (2003). FAFO's findings are based in large part on self-reporting, and some of the most important of these indicate that 15 % of adults perceive their health status to be bad or very bad (63), as compared with only 5 % in Jordan. Nineteen percent also stated having a lasting physical or psychological problem/injury (67). Of great significance, is also the fact that 17% - 61 % of people reported various symptoms of psychological distress, while fully 84 % reported at least one symptom (74). This markedly differs from self-reporting in Jordan, where 59 % stated to suffer from one symptom of psychological distress (Soweid and Al-Khalidi 2004: 12).

Other recent and more general health studies highlight the ever-growing problems of high costs of treatments such as kidney dialysis, as well as the rise in respiratory problems and chronic diseases, again confirming UNRWA findings (Geha 2000; Zabaneh 2004; PARD 2002 and 2004; ECHO/MAP-UK 2003; AUB 2004; UNRWA/ECHO 2004; Soweid and al-Khalidi 2004; FAFO 2003; El-Madi 2001).

While these health studies are useful, they still remain relatively few, and it seems that the camps elicit the particular interest of social scientists – from historians to anthropologists – perhaps because of their status as liminal places, as places outside of and yet affecting regional history, as places marked out for and by violence. While this interest is encouraging, most observers would be struck by the extraordinary *lack* of interest that the camps seem to hold for most other researchers – from public health professionals to educators and human rights advocates. The dearth of information on such a critical issue as health is striking, all the more so since it is continuously identified as an acute problem and source of grievances by both camp residents and outside observers.

ICPH interest in the camps in Lebanon came about as a consequence of its interest in focusing on refugee health in its Masters of Public Health Programme. The Palestinian refugee experience was to be of central importance and it seemed important to integrate refugee communities outside of the West Bank and Gaza into the course curriculum. Interest in working in the camps in Lebanon, however, was further motivated by the realisation of the immense gap in current literature that leaves much to be desired where health is concerned. The few studies that have been conducted are in most cases extremely general, offering little beyond what can be gleaned from UNRWA statistics and annual reports. Most are close to a decade old and even the more recent studies are limited in either their statistical information or narrative content.

In light of all of this, ICPH aimed to carry out a small study that could serve a number of purposes and that could be used by various actors. A qualitative approach was chosen because this type of inquiry is usually the first step in entering and trying to understand a community, but also because of limited human and financial resources, that precluded the possibility of completing a useful and accurate statistical study of health in the camps.

The results of this study can be seen as overall *indicators* of what the refugees themselves perceive to be important broad health problems. In addition, the qualitative and ethnographic nature of the study adds special depth to the findings – as this is one of the few studies that attempts to systematically and principally document what refugees themselves say, think and feel about their personal health *and* the health situation of the camps they

[1] While health and health-related studies focusing on Palestinian refugees in Lebanon have been identified as far back as the 1970s, 16 were identified from 2000 onwards – four focus exclusively on unofficial gatherings and displacement centres.

live in, and includes the views of the medical personnel who work in these camps. In addition, this study takes a comparative approach to understanding health and disease in camps and in their contexts, pointing to the importance of disaggregating data according to camp as a necessary step in understanding and responding to specific camp health needs and problems.

Finally, while this study is exploratory nature, it may well serve to orient future interventions, as well as assist in highlighting future research needs.

GENERAL BACKGROUND

A reminder of the historical context

The creation of the State of Israel in 1948 and the subsequent Arab-Israeli war saw the massive exodus of thousands of Palestinians who were either forcibly evicted or fled in fear of violence and war. These refugees fled toward neighbouring countries, with approximately 100, 000 finding their way into Lebanon (Parsons 1997: 248). Initially the LRCS and other charitable organisations intervened to help these refugees (Weighill 1997: 295). Then, on December 8, 1949 UNRWA was established by the UN, to be able to deal with the humanitarian problems of the new refugee population in a more consistent manner (Weighell 1997: 297; Roberts 1997: 7). In Lebanon, 16 official refugee camps were established, mainly on the peripheries of major cities like Beirut, Tyre and Tripoli, as well as in more remote rural areas such as in the Beqa'a (UNRWA 2004). UNRWA is mandated to *only* deal with social services, health and educational aspects of the refugees' predicament; its mandate specifically precludes any political representation or protection of the Palestinian refugee population. Palestinian refugees are furthermore denied political protection based on the *1951 Convention relating to the Status of Refugees* – something that all other recognised refugee populations enjoy.[2]

The attitude of both the Lebanese government and people towards the refugee population at this time was generally welcoming or at worst, indifferent. (Weighill 1997: 296).

The Lebanese state, although accepting of a refugee population on its soil, always maintained a policy of extremely tight security control on all the camps – a policy that become even more severe when General Chehab came to power in 1961 and when the Palestinian resistance first started establishing bases in southern Lebanon from which to launch guerrilla raids into Israel (Suleiman 1999: 67). The camps were subjected to harsh regulations, intermittent curfews and restrictions on movement.

This situation changed dramatically with the arrival and stay of the PLO in the early 1970s. The PLO was to act as a de facto state for the Palestinians in Lebanon, providing them with additional education and health services, setting up cultural centres, improving the camps' infrastructure, offering physical protection, as well as acting as an important employer.

Although the arrival of the PLO alleviated the suffering caused by the Lebanese governments' former restrictions, providing healthcare and other services, including employment, its presence in Lebanon was marred by problems. Only five years after the PLO's arrival, the first phase of the Lebanese civil war broke out (1975-76). That the PLO's presence at least contributed to the outbreak of the war is undisputed, and this involvement inevitably dragged the Palestinian civilian population into the war (Brynen 1990: 77; Tar Kovacs 1998: 38).

While fighting continued intermittently, an important watershed in the civil war was undoubtedly the 1982 Israeli invasion of Lebanon. This invasion saw the massive and indiscriminate shelling of major Lebanese cities and

[2] The reason for this was the incorporation of exclusion clauses at the time of the drafting stating all refugees receiving services from another UN agency would no be covered by the convention. Palestinians, being serviced by UNRWA, were thus excluded. This stipulation was included at the behest of various member states, many of them Arab, who at the time felt that including the Palestinian refugees under the convention would dilute their particular political problem, already being addressed through Resolution 181 of November 1947 (Tahri and de Donato 2000: 12).

Palestinian refugee camps, as well as the three-month siege of the capital, Beirut. In addition to massive infrastructural damage and thousands of civilian casualties, the major consequence of the invasion was the departure of the PLO from Lebanon, effectively ending the privileges it had formerly provided for the Palestinian refugees, and leaving the camps largely unprotected. It was following the departure of the PLO and the total Israeli capture of Beirut that the Sabra-Shatila massacres occurred, leading to high civilian casualties.

Following the Sabra-Shatila massacre, Israeli troops redeployed to Saida and south Lebanon, leaving the Palestinian camps in Southern Lebanon under Israeli control and those in Beirut[3] under that of the Lebanese army. After early 1985, the Beirut camps came under the control of various Lebanese militias – each of which dealt with the Palestinian population in different ways depending on previous history, alliances and grievances.

Palestinian forces, however, continued to be present in the North and Beqa'a valley for a little while longer. In 1983, during this time of erratic fighting with both Israel and Lebanese groups, Fatah split – something that was to have profound effects on political alignments in the camps. This split led to a confrontation between the breakaway faction, known as *Fatah-intifada*, and the Arafat loyalists in the northern and Beqa'a camps, and later also in Beirut (especially Shatila camp). This confrontation ended with the defeat of the loyalists and their evacuation from the northern camps (Suleiman 1999: 67-68).

Beginning in 1985 and over a period of three years, the Lebanese Shi'a Amal militia besieged some Beirut and southern camps four times, with the longest of these sieges lasting six months. The reasons for the sieges are contentious, but three main issues are generally highlighted: 1) the long-standing grievances felt by many Shi'a with regards to the suffering caused them by the ongoing battle between the PLO and Israel in south Lebanon; 2) the newly gained strength and position of Amal, a Shi'ite militia in a sectarian country, vis-à-vis the Christians and the Sunni Muslims; and 3) a momentary convergence of interests between Amal, Syria and Israel – all of whom stood to gain from the camps' capitulation (Suleiman 1999: 68; Abu Khalil *in* Hagopian 1985: 9). However, despite suffering extensive damage and heavy casualties, not one of the camps surrendered or fell[4]. On April 6, 1987, under Syrian pressure, the final siege was lifted (Sayigh 1994: 321).

The sieges gave way to intra-Palestinian conflict between Arafat loyalists and opposition forces, mainly in the Beirut camps. This ended with the capitulation of loyalist forces and their redeployment to the southern camps.

The Ta'if Agreement that ended the Lebanese civil war in 1990 left the Palestinian refugees in an unclear position in the new Lebanon. With reference to the Palestinian refugees, the Agreement only clearly states that *tawtin* – permanent resettlement – is prohibited.[5] As for civil rights, the Agreement neither prohibits nor protects these in the case of Palestinian refugees. However, given the Lebanese government's unilateral termination in 1987 of the Cairo Accords[6] – which had bestowed limited civil rights for Palestinian refugees – there is currently no official document that clearly delineates Palestinian refugee rights and responsibilities in Lebanon.

A series of discussions were held between the Lebanese government and the PLO following Ta'if, in an attempt to formalise the status of Palestinian refugees in Lebanon. According to Palestinian sources, an unpublished agreement was reached whereby Palestinians would 'hand over heavy and medium weaponry and redeploy Palestinian military personnel inside the refugee camps, in exchange for the Lebanese government's agreement to give Palestinians civil and social rights (short of citizenship and eligibility for government positions) (Suleiman 1999: 69).'[7]

[3] The camps in the North and in the Beqa'a Valley were always largely under Syrian control.
[4] The small gathering of Sabra, on the outskirts of Shatila was, however, overrun.
[5] Introduced by the Constitutional Law of September 21, 1990, *point I of the Preamble to the Ta'if Agreement* states: '[…] There shall be no […] settlement of non-Lebanese in Lebanon. (Report on Fact-finding Mission to Lebanon, Danish Immigration Services 1998).
[6] Accords signed between the PLO and Lebanese state in 1969, delineating Palestinian military and civil rights in the country.
[7] The details of the discussions are summarised in a memorandum entitled 'Memorandum Concerning a New Palestinian-Lebanese Relationship,' which was submitted to the Lebanese government in April 1999.

Palestinian weaponry was handed over and military personnel redeployed to the camps by June 1991 (Suleiman 1999: 69). Following this, the Palestinians formed a unified delegation that submitted a memorandum entitled 'The Civil and Social Rights of the Palestinian People,' to the Lebanese government. The Lebanese committee requested a delay in order to study the proposal, but discussions never resumed (Suleiman 1999: 69).

While Palestinian refugees in Lebanon have to deal with local difficulties and conflicts, they are also affected by wider regional decisions made by the PLO. The most important of these were the Oslo Accords of 1993, which determined that the refugees were a 'final-status' question to be discussed in 1996, thus sidelining the refugee issue altogether. The international community's gaze and aid were re-directed to the new 'autonomous' areas of the West Bank and Gaza Strip in the hopes of creating a viable Palestinian state there. The refugees in Lebanon waited with greatly reduced – if any – support, 1996 coming and going with no resolution to their situation.

The continued political instability that has visited the region since fall of 2000 has further complicated the situation of Palestinian refugees in Lebanon.

This long history of repeated displacements, conflict and political exclusion has almost certainly had a lasting impact on the health of the Palestinian refugee population. For instance, FAFO reports (2003) that approximately three-quarters of medical facilities, as well as water and sewerage systems were damaged during the war (185). In addition, almost half the schools and residences in the camps were damaged (185). Compounding this destruction of infrastructure and deterioration of the environmental and hygienic conditions of the camps are the conflict's effects on mental health, as well as poor nutrition during long sieges and disabilities resulting from war wounds. All of these and other consequences, while challenging to quantify, have undisputedly had a negative effect on health.

A reminder of the legal context

The presence of Palestinian refugees in Lebanon is a contentious issue for a variety of reasons, with two standing out in importance: their perceived role in and responsibility for the civil war and their status as primarily Sunni Muslims in a country of precariously delicate sectarian balance. Lebanon is a deeply divided country and Palestinian responsibility for the civil war is perhaps one of the few issues of general agreement in Lebanese society. Consequently, it is the general consensus that they should never be settled (thus the constitutional prohibition against *tawtin*). Adding weight to this position is the fact that most Palestinians are Sunni Muslims and their naturalisation would further tip the sectarian balance in favour of the Muslims (Haddad 2000: 3; El-Khazen 1997: 281).

Limitation of civil rights stems more from an absence of special legislation for Palestinian refugees in Lebanon, rather than actual prohibitions. Palestinians who are registered with UNRWA and/or the Lebanese authorities are granted residency papers that allow them to stay in Lebanon indefinitely (i.e. until a final solution to the Palestinian refugee issue emerges) – something that other foreigners and refugees in the country do not enjoy. In addition, where acquiring citizenship is concerned, Palestinians' have a separate status from other foreigners, because of recommendations of the Arab League, which suggested that it was necessary for Palestinians in Arab host states to retain their own (Palestinian) nationality[8] (Al-Natour 1997: 375).

Where all other civil rights are concerned, however, Palestinians fall under the same laws as any other foreigner; no exception is made in recognition of their particular situation and inability to either return to their country of origin (Palestine) or be resettled in another country (as other refugees may do through resettlement schemes with UNHCR) (Al-Natour 1997: 374).

Rights of foreigners (and thus of Palestinians) are limited in Lebanon, as in most other countries. The particular problem for Palestinian refugees is the fact that they many of their rights are derived from laws envisioned for

[8] The Arab League recommendations do, however, state that Arab host countries should provide job opportunities for Palestinians.

temporary residents. Therefore Palestinians find themselves constrained by laws that in essence *should* not apply to them in terms of their civil rights in Lebanon. Nonetheless, no alternate set of laws has been drafted to address the particular situation of the Palestinian refugees, where constraints on rights include:

Work. Palestinians are barred from all liberal professions such as medicine and engineering that are syndicated and function according to reciprocity principles[9]. Palestinians also do not have the right to work in most occupations without the issuance of a work permit (Al-Natour 1997: 368; Aasheim 2000: 50). Although theoretically Palestinians can apply for these permits, it seems that in practice few actually obtain them (Al-Natour 1997: 368; Roberts 2001: 12).[10] When these various restrictions are taken together, Palestinians are effectively barred from working in over 70 occupations.

Healthcare. Palestinians are barred from accessing all public healthcare services (Zakharia and Tabari 2001: 11).

Education. Palestinians are also restricted in their access to secondary public education, as only a limited number of places in public schools are available to foreigners, including Palestinians (with priority given to Lebanese applicants at all times) (Al-Natour 1993).

Palestinians can, however, access any private sector health and educational services if they can afford those.

Property Ownership and Inheritance. Since 2001, Palestinians are further legally prohibited from owning or inheriting property in Lebanon. The property ownership law was amended in March 2001 to allow foreigners to own property; however the law excludes Palestinians from this amendment through an exclusionary clause which prohibits ownership of property by anyone who is not a citizen of a recognised state, or whose ownership of property would run counter to the constitutional prohibition against *tawtin* (Amnesty International 2003: 7). Furthermore, the amendment prohibits those Palestinians who already own property from passing this on to their next of kin when they pass away (Fisk 2001).

A reminder of the living conditions

Of the original 16 official camps established after the 1948 exodus[11], three – Nabatiyeh, Dikwaneh and Jisr al-Basha – were destroyed and abandoned during the war and never rebuilt or replaced due to Lebanese prohibitions against the rebuilding of destroyed camps and the construction of new camps; one, Gouraud, was evacuated in the late 1950s and its inhabitants transferred to Rashidiyeh camp near Tyre (UNRWA 2004).[12]

Today most refugees live in the 12 remaining official camps, in addition to approximately 20 gatherings scattered throughout the country. Official camps are those that are built on land formally made available to UNRWA by the Lebanese authorities and that are thus provided with UNRWA services and with basic amenities, such as electricity and sewerage. While Palestinians have the right to residence on this land, they do not own it. These official camps are distinct from 'gatherings' – those camps that, for various reasons, are built on land that was not formally made available to UNRWA; UNRWA does provide some of these gatherings with limited services, but not to the same extent as the official camps (UNRWA 2004).[13]

[9] Principles which state that a foreigner may practice in Lebanon so long as Lebanese can practice in the foreigner's country of origin.

[10] On 28 June 2005, the outgoing Lebanese Labour Minister Tarrad Hamadeh stated that Palestinians born on Lebanese land and registered officially with the Lebanese Ministry of Interior will be allowed to work in manual and clerical private-sector jobs and will be allowed to obtain work permits. While this change is welcome, it is not yet clear if it will be implemented or not. In addition, the ban on all professional employment is still in place (http://www.dailystar.com.lb/article.asp?edition_id=1&categ_id=2&article_id=16304).

[11] Please refer to tables in Annex I at the end of this paper.

[12] http://www.un.org/unrwa/refugees/lebanon.html. Please note that while Tal al-Za'atar was also destroyed during the war, it was never an official camp under UNRWA mandate; it was however the largest Palestinian gathering.

[13] http://www.un.org/unrwa/refugees/wheredo.html.

UNRWA statistics place the number of registered[14] refugees for its Lebanon field of operation at 399, 152 (UNRWA 2004). This is the total registered population for the field (in camps, gatherings and other places in Lebanon), but does not mean that this is the number of refugees currently *residing* in Lebanon (as some emigrate and fail to inform UNRWA of this change of status). UNRWA statistics indicate that the number of refugees living in camps in Lebanon is 210, 155 (UNRWA 2004).

Despite these being the only statistics available, UNRWA itself acknowledges that the number of registered refugees in Lebanon is most probably *lower* than the population recorded (Report of the UNRWA Commissioner-General 2004). Most observers place the *total* Palestinian refugee population in Lebanon at between 190, 000 – 300, 000 (Al-Natour 1993: 15; Roberts 2001: 14; Tiltnes 2005: 11).

As a result of the various restrictions imposed upon Palestinians, the consequences of the war and the current economic woes that Lebanon as a whole is experiencing, all of the camps suffer from serious problems: poor infrastructure, limited access to electricity and water, overcrowding and high unemployment.

Infrastructure and housing conditions. The camps have neither been allowed to formally expand outside their original limits nor to become permanent structures. Larger populations have inevitably had to make do with the available space, something that has led to overcrowding and deteriorating housing conditions. The most important indoor environmental problems are such things as dust, humidity, lack of light and ventilation (FAFO 2003: 202; personal observations). Noise levels are also a severe problem, which is often a result of overcrowding both within homes, as well as generally in the camps (FAFO 2003: 203; personal observations). In terms of general camp environmental problems, air pollution, sewer smells, the presence of rats and cockroaches are often cited (FAFO 2003: 203; personal observations). Despite all these problems, camp residents are often very meticulous about their dwellings, and expend large amounts of time keeping them clean and tidy (personal observations). This may account for the FAFO (2003) study result that shows that the level of household dissatisfaction was higher for outdoor pollution than for indoor environmental problems (37 % and 23 % respectively) (204).

Electricity. All of the camps and gatherings seem to have access to electricity – 98 % according to the FAFO (2003) study, but the supply is often intermittent and in the hot summer months is often strictly rationed[15] (FAFO 2003; personal observations). In addition, the wiring in many camps is dangerous, with wires hanging through the camps and cases of electrocution in the winter months when the camps are often extremely wet (Personal communication, Olfat Mahmoud and Ruth Campbell 2005, personal observations).

Sewerage. Sewerage networks are most often provided by UNRWA and sometimes by local municipalities (FAFO 2003). UNRWA states that nine of the 12 official camps in Lebanon are linked to sewerage networks, of which five have had their water, sewerage and drainage systems rehabilitated between 2004-2005 – something which will certainly help to improve sanitation, as UNRWA data show that only 63 % of camp shelters in Lebanon have access to sewerage systems – the lowest proportion of any of its areas of operation (UNRWA 2003: 88).

Water. While FAFO data indicate that only 64 % of camp and gathering households have water piped into their residence (195), UNRWA states that fully 97 % of camp households have indoor connections to water systems (UNRWA 2003: 88). In addition, all camps have access to drinking water sources, of which piped potable water and water provided by tanker trucks can be considered to be relatively safe (FAFO 2003: 195).

[14] Registered refugees are those that are recognised and registered by UNRWA (and the Lebanese authorities) and thus can access UNRWA services and have residency rights in Lebanon. In addition to these, there are refugees that are only registered with the Lebanese authorities, and thus have the right to residence but not to access UNRWA services, although some exceptions are made (Report of the Commissioner-General of UNRWA 2004). Lastly, there are some refugees that are neither registered with UNRWA nor with the Lebanese authorities; these refugees are considered to be residing illegally in Lebanon.

[15] Electricity is rationed throughout Lebanon during the summer and is a problem that not only affects the camps, although seems to affect them with greater severity compare to others (personal observations).

Refuse collection. UNRWA is clearly the main collector of refuse in the camps (FAFO 2003: 199; UNRWA 2003: 90; personal observations), as it services all 12 official camps.

Unemployment. While it is difficult to accurately assess the level of unemployment, most estimates place it at *least* 40 % (El-Madi 2003: 3; Shaaban 1997: 385; Tiltnes 2005: 24). In a country where unemployment is generally high, and where there are legal barriers to working, this estimate is not unrealistic. However, if by work one means guaranteed employment with benefits, then the unemployment would be much higher than the 40 % estimate, as few other than UNRWA employees can actually claim to be employed in such a way (Sayigh 1995: 49-50; Shaaban 1997: 386). Those who work often do so with no work permit, often resulting in lower wages and no benefits (Sayigh 1995: 50).

High unemployment, compounded by the myriad restrictions outlined above, inevitably impact on health status and on people's ability to access health care services for illnesses they may suffer. Most studies indicate that the cost of operations in Lebanon can range from 1, 000 – 12, 000 $ US (Sayigh 1995: 48; Edminster 1999: 18) – clearly, and even with the help of UNRWA subsidies for hospital treatment (Sayigh 1995: 48), most Palestinian refugees would be unable to pay for even part of such treatments.

Poor housing and environmental conditions, then, are made worse by the inability to access proper care for the health consequences that inevitably arise from living in such conditions.

UNRWA

UNRWA provides all the camps with basic health, educational and social services. Contrary to common understanding, UNRWA is not responsible for administering the camps – its responsibility is limited to basic service provision and the maintenance of its own installations (UNRWA 2004). UNRWA services in the camps include:

Healthcare. UNRWA runs 25 primary healthcare clinics in Lebanon: each is run by at least one doctor, one dentist, a number of nursing staff and other paramedical and support staff. (UNRWA 2004). The services offered by these clinics are oriented toward preventive medical and primary care services, and focus heavily on women and child health, as well as disease prevention and control. These clinics also run outpatient services comprising medical consultations, oral health services, radiological and laboratory investigations, as well as the dispensing of medication. Lastly, UNRWA also has contracts with PRCS and private Lebanese hospitals for secondary and tertiary health care, as well as for psychiatric treatment (Personal communication, Dr. Jamil I. Yusef 2005).

Social Services. UNRWA is also responsible for garbage disposal and sewerage in the camps, while 45, 460 refugees benefit from UNRWA's special hardship programme (UNRWA 2004)[16].

Education. UNRWA runs 81 elementary (grades 1-5) and preparatory (grades 6-9) schools, and has recently established 5 secondary (grades 10-12) schools because of the difficulties Palestinian students encounter in accessing Lebanese secondary public institutions (not deemed a difficulty in other UNRWA fields of operation, such as Syria and Jordan). Nevertheless, most of these schools are overcrowded and work on a double-shift system, whereby one group of students attends school in the morning and the other in the afternoon.

Other Service Providers

PRCS and a variety of NGOs supplement UNRWA services in the camps. PRCS offers additional health services – simple surgeries (such as appendectomies), castings, x-rays, etc. (Personal communication, Dr. Mohammad Othman 2003). PRCS services have been drastically cut since August 17, 1993, when the PLO announced that it was freezing its financial support for PRCS in Lebanon (Hassan 1996: 13). The institution then almost faced collapse, and has had to reduce the number of hospitals and clinics it originally operated (Personal communication,

[16] A programme that provides direct material and financial assistance to the most vulnerable groups in Palestinian refugee communities, such as widowed women, the elderly and the disabled.

Dr. Mohammad Othman 2004). Most NGOs in the camps were formed during the civil war and have since its end shifted to more 'development' oriented objectives. The dire living conditions in the camps, however, often force these institutions to offer 'emergency' assistance to camp residents, whether in helping individuals pay for hospitalisation fees or supplementing children's meagre class time with additional lessons. Most NGOs tend to work within the same fields, focusing heavily on children, pre-school education, cultural activities and vocational training (Suleiman 1997: 402-403; personal observations). There are also (in some camps more than others) charitable organisations, often Islamic in orientation, that provides basic assistance – often in the form of clothing, food or money (Roberts 2001: 18 & 35) – but do not actually engage in development work as such.

Despite the limited assistance provided to camp residents by these institutions, even when taken as a whole, most refugees recognise that without this 'security network' many would not survive the living conditions and economic difficulties of the present (Sayigh 1995: 47).

CASE STUDY: BOURJ EL-BARAJNEH

History and Description

Bourj el-Barajneh camp is located in the southern suburbs of Beirut, close to the international airport. According to UNWRA, it is 104, 200 m^2 in size (Roberts 2001: 32), although there are buildings now considered to be part of the camp that may not fall within these official limits. Official records show that Bourj el-Barajneh was first established in 1948 by the League of Red Cross Societies (UNRWA 2004)[17], although many people in the camp claim that refugees had already congregated in the area (Jalloul 2004; Roberts 2001: 32). This claim is often made and is quite plausible as people tried to group themselves along family and village lines in an attempt to stay close, in such an uncertain environment, to the people that they knew. Regardless, it is accepted by everyone that Bourj el-Barajneh was one of the first camps established in Lebanon. Although the camp was initially established on barren sandy land some distance from the heart of Beirut, it has since then been incorporated into the city suburbs.

Given its proximity to Beirut, Bourj el-Barajneh was one of the camps that suffered most during the civil war. Being central, all Palestinian political parties were present in it and it was a highly politicised camp. It suffered extensive damage throughout the PLO's stay in Lebanon from Israeli air raids, and was partially destroyed during the Israeli invasion in 1982, with most of its inhabitants fleeing their homes for the relative safety of abandoned apartment buildings in other parts of Beirut. The camp was also besieged various times between 1985 and 1987 – although the camp never fell, it nonetheless suffered a heavy toll in terms of both infrastructure and human lives. In general, this history has limited its residents' contact with the Lebanese areas adjoining the camp, although there is no open hostility and entry and exit from the camp is not hindered (personal observation and informal discussions with camp residents).

UNRWA maintains that there are 15, 433 registered refugees living in the camp. Most camp residents tend to agree with this figure, placing the camp population at between 13 and 17, 000. Of these, not all are registered Palestinians (although the vast majority are); some are non-registered Palestinians, while others are foreigners (i.e. non Palestinians) (Roberts 2001: 33).[18]

Bourj el-Barajneh can best be described as a series of elaborate mazes. It has never been allowed to incorporate sizeable portions of new land into its limits, and so the residents have been forced to build upward – some homes with weak foundations rise as high as four stories, blocking out most sunlight. Additional houses are built wherever there is any available space, making the camp a chaotic mess of precariously balanced edifices. The cramped conditions result in their being only alleyways between the homes, some not wide enough to allow two people to walk side by side. There is but one road that allows motor traffic, which goes around the outer edge of the camp,

[17] http://www.un.org/unrwa/refugees/lebanon/barajneh.html.

[18] There are some Syrians, Lebanese, Iraqis, Sudanese and Sri Lankis – among others – who live in the camp due to its cheaper rent. Roberts (2001) reported that her data suggests there are 2, 300 unregistered Palestinians and some 200 foreigners residing in Bourj el-Barajneh.

not through it. Although there is a main entrance into the camp, its myriad alleyways allow for multiple entrances, all of which can be used.

There are few open spaces in the camp and children have to make do with the cramped quarters of alleys in order to play. Homes are overcrowded and noisy, with people coming and going continuously, and thus afford very little by way of privacy or calm. Perhaps the only space in the camp that allows for any respite is the roof. All homes are built with flat roofs that provide cool breezes and a place to sleep in the hot summer months, a place to pot a few plants and to sit with large groups of people sharing tea or coffee.

While people's homes are very clean, it is common to find garbage and dirty water in the alleys, as well as rats and cockroaches, particularly in the hot summer months. This is inevitable given the size of the camp versus the number of people living in it – a population density of approximately 0.2 persons/m^2 – as well as the absence of adequate sanitary services.

Perhaps due to its proximity to Beirut, Bourj el-Barajneh residents tend to be more open and flexible than other Palestinian refugees in Lebanon. They are necessarily exposed to the changing fashions and opinions of urbane Beirut society and have been influenced by these styles and ideas. The atmosphere is relaxed and easygoing and people are highly hospitable and friendly to strangers.

Services

Bourj el-Barajneh is by all accounts one of the better-serviced camps in Lebanon. This is most likely because it is adjacent to the capital – it has the advantage of proximity to UNRWA headquarters, as well as being of easy access for international donors and NGOs.

UNRWA provides it with a clinic and seven elementary and preparatory schools; students who are eligible have access to the UNRWA secondary schools for the Beirut area (UNRWA 2004).[19] In addition, UNRWA also employs sanitation staff whose responsibilities include rodent and insect control, collection of solid waste and maintenance of water and sewerage systems. While these services are provided regularly, it seems that the water and sewerage systems in Bourj el-Barajneh need comprehensive rehabilitation – something which is currently under study (Personal communication, Dr. Jamil I. Yusef 2005).

Not enough to fulfil the needs in the camp on their own, UNRWA services are complemented by those of PRCS – which operates a hospital (Haifa Hospital) in the camp and another nearby in Beirut.[20] There are also the services of various NGOs that support the work of both UNRWA and PRCS. There are an estimated 18 NGOs working in Bourj el-Barajneh (personal observations) – offering pre-school education, after-school tutoring, dentistry, physiotherapy, vocational training, language courses and many other services. The camp's closeness to Beirut also allows its residents to access alternative health and educational services easily, without incurring exorbitant transport costs, and provides more opportunities for employment than in other areas in Lebanon.

CASE STUDY: WAVEL

History and Description

Wavel camp is located on the outskirts of Ba'albek, a large town located in the eastern part of the Beq'a valley not far from the Syrian border. It was originally an old French army barracks, but in 1948 it was used as a camp for Palestinian refugees by the League of Red Cross Societies. In 1952 UNRWA formally assumed responsibility for

[19] http://www.un.org/unrwa/refugees/lebanon/barajneh.html.
[20] There is a partnership agreement between UNRWA and PRCS whereby UNRWA subsidizes hospital beds from PRCS' Haifa Hospital in Bourj el-Barajneh.

services in the camp (UNRWA 2004).[21] It is 42,300 m^2 in size according to UNRWA, making it the second smallest camp in Lebanon (UNRWA 2004), with a population density of approximately 0.18 persons/m^2.

Wavel is located in a remote region of the country that has traditionally been under the tight control of Syria. These two factors have ensured that the camp endured little hardship during the civil war. There was hardly any fighting in this part of Lebanon, with the notable exception of the 1982 Israeli invasion, and even then it was short lived. Traditionally Wavel was never of great military or political import for the PLO, boasting at best some political offices at the height of PLO supremacy in Lebanon (Personal communication, Najdeh Wavel Director 2004). There are no longer any political parties officially present in the camp, although people do have political allegiances. Unlike many other camps, the residents of Wavel themselves attest to the friendly and open relations with the neighbouring Lebanese; this is a relationship which was neither altered by the war nor by what was happening to other camps. In general, Wavel is – along with Dbayeh, the only remaining camp in East Beirut[22] – a forgotten camp, with many other Palestinians in the country unaware of its existence (personal observations).

UNRWA maintains that there are 7,553 registered refugees in the camp, although most camp residents place it at no more than 2 – 3, 000. Wavel residents say that a very high rate of emigration, mainly caused by high unemployment rates (Roberts 2001: 26) has caused a steady decline in the population – leaving behind many elderly and young children, and a noticeably smaller number of youth.

Wavel at first glance seems to boast more open space than Bourj el-Barajneh. It has a number of wide streets running through the camp that can all accommodate motor traffic. The alleys are neither as small nor as numerous as those in Bourj el-Barajneh, and the houses are not higher than two stories. The noticeable exception are the old French army barracks themselves, which rise about four stories high and are in dilapidated shape, and precariously close to collapse according to many camp sources. The camp is cleaner than Bourj el-Barajneh, with fewer rodents and cockroaches.

Despite these benefits, the camp suffers from other problems that are not as serious in Bourj el-Barajneh. Overcrowding within homes – despite the much smaller overall population – is far more acute, with most families forced to divide a room into two floors (i.e. to place a fake ceiling in a room so as to create two small floors) in order to have a living room and a bedroom. Where houses are larger, they often have the kitchen, bathroom and rooms built around a central courtyard[23], thus making access more difficult. Compounding all of these difficulties are the harsh winters that visit the Beq'a valley. It snows in this area and most families can only afford one diesel fuel heater that serves to warm a single room; few can afford to keep this running constantly.

Wavel residents are more conservative than their Bourj el-Barajneh counterparts[24] – a fact most easily attributed to the general conservativism of the Beqa'a valley, particularly as compared to Beirut (personal observations). They are, however, just as friendly and welcoming of strangers.

The camp is in an isolated region of Lebanon – an agricultural hinterland – which generally receives scant attention. Work here is mainly seasonal for everyone (including the Lebanese); work in the winter seems to be reserved to employees only.

Services

[21] http://www.un.org/unrwa/refugees/lebanon/wavel.html.

[22] While Mar Elias camp originally housed mainly Christian Palestinians, given population displacements during the war, it currently houses mainly Muslim families.

[23] A tradition imported from Palestine, but common throughout the Levant.

[24] Women in Wavel dress more conservatively than their Bourj el-Barajneh counterparts, and in my two years of overseeing volunteers in Wavel, it was clear that using music in classes, or having mixed girl-boy activities with youth, etc., was not as feasible as it was in Bourj el-Barajneh – an indication of higher conservatism in Wavel compared to Bourj el-Barajneh.

Unlike Bourj el-Barajneh, Wavel can be said to be one of the least serviced camps in Lebanon. UNRWA provides it with a clinic and two elementary and preparatory schools; students who are eligible have access to the UNRWA secondary school for the Beq'a area (UNRWA 2004).[25] UNRWA also has a contract with a private Lebanese hospital in the nearby town of Ba'albek for in-patient services for Wavel residents. In addition, the camp water and sewerage, as well as storm water drainage systems have been recently rehabilitated (Personal communication, Dr. Jamil I. Yusef 2005, UNRWA 2003: 87; personal observations).[26] UNRWA also ensures that solid waste is collected daily.

While UNRWA services are proportionate to the camp's small population (Personal communication, Dr. Jamil I. Yusef 2005), other service provides can hardly be said to be present. PRCS has since 1993 only maintained a clinic in the camp, with its principal regional hospital in Bar Elias, some 40 km away and of difficult access. NGOs are few, with only a handful providing some children's activities. There are very few vocational training courses offered in the camp, and no summer activities the likes of which are common in Bourj el-Barajneh.

Post-secondary education is difficult to access given that all universities are located outside of Ba'albek, the closest and most convenient town. Therefore young people would most probably have to move to Beirut or to the Beq'a town of Zahle, and either pay rent or daily transportation fees respectively. Either way, costs are often too exorbitant and people are reluctant to let their children live alone; most move to Beirut to study only if they have extended family living in the city or in one of its camps.

ANALYTICAL FRAMEWORK

How does one begin to define health? What does it mean and is its meaning constant over time, through space and across cultures? Is it an individual condition, a socio-cultural fact, a political reality? Health is, in fact, all of these things. It is a biological condition affected by individual predispositions and environmental surroundings; it is a socio-cultural construct that provides a framework for the explanation of pain and suffering, well-being and resilience, which changes with time; it is a politico-economic reality in that access to those services, medications and treatments that ensure health are mediated by power, both local and international (Goodman and Leatherman 1998; Farmer 2003).

Because of its multifaceted meanings, health (and illness) will be defined within the general framework of biocultural synthesis (Goodman and Leatherman 1998). This approach focuses on how culture and political economy[27] both affect human biology – e.g. spread of disease, exposure to violence, nutritional status – and how the biological consequences of these problems can then further affect cultural, social, economic and political systems. It is an approach which, emphasising as it does cultural variations, gender differentials and larger power structures, seeks to bridge the abyss between local experiences of disease and illness and large-scale historical, political and economic forces that inevitable impinge upon human biology.

Within such a framework social and politico-economic structures determine the power differentials between members of a society (men-women, youth-elderly) and thus the roles that it specifies for each one (with its concomitant attitudes). These attitudes and roles, in turn, affect health related behaviour; this behaviour then determines people's experiences and perceptions of health and illness – experiences and perceptions which then shape how people interact with the larger social world. That is roles, attitudes and behaviour act as mediators between health and larger power structures (Giacaman and Odeh 2002).

Perceptions of health, however, are not only determined by larger power structures. Culture is another powerful force affecting them – and it makes up the second half of the biocultural synthesis approach. Experiences of

[25] http://www.un.org/unrwa/refugees/lebanon/wavel.html.

[26] Please note that at the time of interviewing, this rehabilitation of the water/sewage/drainage systems was still underway and therefore people's opinions of water/sewage quality have to be considered in light of them not yet benefiting from these improvements.

[27] Approach which looks at how resources are allocated in society (and how biological variation affects this allocation), and how this allocation then affects behaviour, which in turn can affect power structures (political, economic, social) in the society.

illness, disease, suffering and health are all, to a certain extent, culturally constructed and specific, and they are being constantly negotiated and redefined in response to past experiences and present needs. Power in this context, is seen as more diffuse than what is allowed for in political economy. Foucault's (1978) insight that power manifests itself primarily in its ability to define what is normal, acceptable and moral is useful here, for culture constrains people in unconscious ways, without the obvious oppression that obtains within political economy. In this sense, people's perceptions of health can be seen as reflecting what is socially expected of them, what is considered acceptable and normal within that context. Culture, however, is not only a constraining element or one of pervasive power; it also makes available myriad mechanisms by which people can express their distress and give meaning to their suffering. These local meanings to *suffering* are generally termed idioms of distress, and they constitute the culturally constructed and accepted ways for people to manifest health, illness and suffering (Kleinman, Das and Lock 1997). People's perceptions of health are also mediated by these cultural factors that affect the experience and expression of health and illness, as well as of perceptions.

Biocultural synthesis is fundamental in that it allows one to link local idiosyncrasies with supra-structural forces – the analysis of a person's suffering and of practical reasons for disease causation (Goodman and Leatherman, 1998). However, it fails to adequately address the question of how access to and deployment of power can vary throughout an individual's life, and how this variation is linked to changes in perceived and experienced health. In order to account for this nuance, the biocultural synthesis approach will be supplemented by what is termed the life cycles approach (Lane, 1991). This framework looks at health and perceptions of health as a function of life cycles and stages, each of these stages being marked by specific roles and responsibilities (which are also split along gender lines). While age is a biological category, it is also a socially constructed one. The particular roles and responsibilities associated with each stage will in turn affect how health is perceived, how illness is manifested and with what ease health resources can be accessed. This approach integrates the notion of change into any analysis, providing an explanatory model for redefinitions of health and illness as well as variations in access to resources as people age.

Individual psychology completes the picture, adding to biocultural synthesis and life cycles the idiosyncratic internal strengths, coping mechanisms and attitudes of the individual person. This individual psychology can be either strengthened or weakened by the environment with which it comes into contact, while at the same time provide the person with tools with which to face difficult circumstances and overcome them (Giacaman and Odeh 2002).

The approach adopted here is a combination of all of these theories, acknowledging the importance of power structures, age, culture and individual predispositions and how these change over time, as well as how all of these elements can, at one time or another, both empower and constrain individuals, thus affecting their perceptions of health and illness.

Health, then, is an interplay between an individual's biological predispositions and psychology, and social, economic, political and cultural factors which together affect the expression and success of these particular predispositions. It is an interaction which changes with age, in response to both the biological changes suffered by the body and mind, and the differing cultural meanings and possibilities that are associated with the changed life cycles – cultural meanings that demarcate the boundaries between health and illness, well-being and suffering and the moment when a person can legitimately access health resources. Health is also in the mind – literally – a state of being in the world, a psychological attitude: it encompasses people's ability to cope, to resist, to reformulate and renegotiate what is harmful in a bid to contain and limit illness. This individual component is not to be disregarded, for in contexts of generalised poverty, hopelessness and ill-health, it can be a useful explanatory tool for why some people are healthy while others are ill.

Health is thus an indicator of an individual's biology and the socio-political and cultural context in which this individual is located, as well as a personal experience, a personal narrative of life and suffering.

RESEARCH QUESTION

What do Palestinian refugees and medical personnel in the refugee camps of Bourj el-Barajneh and Wavel (Lebanon) think of the general health situation in the camps, their own health and the health services provided? What are the main differences, if any, across gender, age and camp lines? Are these differences important in terms of health needs and service provision?

METHODOLOGY

CAMP SELECTION AND TIMEFRAME

Two official camps were chosen as study sites – Bourj el-Barajneh in the southern suburbs of Beirut and Wavel on the outskirts of Ba'albek, in the Beq'a valley. My previous experience in the Palestinian camps in Lebanon was predominantly in Bourj el-Barajneh, where I spent three consecutive summers working and living as a volunteer and coordinator for a small Canadian NGO.[28] In addition, I coordinated the CEPAL volunteer programme in Wavel for two summers. Having lived and worked in these two camps for a total of 12 months (though not consecutively), I knew the camps very well and had a solid and extensive network of friends and NGO contacts to facilitate the completion of this study. Entry into the camps was therefore easy and my previous stays in the camps provided a means of identifying possible interviewees without wasting much time.

In addition to practical considerations in camp selection, there was also the desire to look at regional differences between the camps, and so a 'city' camp (Bourj el-Barajneh) and a 'rural' camp (Wavel) were selected. Although this is to a certain extent an artificial divide, it is nonetheless one which coincides with some important life differences between camps, and which was elicited in my previous camp experience as a particularly important factor in shaping people's perceptions of their lives. In addition, few previous studies have taken a comparative approach: rather most assume that there are few differences across camps to warrant separate analysis. Finally, it was also an attempt to integrate Wavel into current research on the Palestinian camps. Bourj el-Barajneh, being close to Beirut and of easy access, has been disproportionately studied, while Wavel, one of the most isolated of the official camps, has been consistently sidelined. We wanted to benefit from the previous studies on Bourj el-Barajneh and take a step in a new direction with the inclusion of Wavel. The fieldwork began in fall of 2003 and continued through to the summer of 2004, for a total of 8 months.

METHODS

This is a qualitative study focusing on camp residents' perceptions and opinions about health and illness, and as such employed two main data collection methods: individual semi-structured interviews followed by focus group discussions. In as much as possible, the interviewees and focus group participants represented different generational and gender categories, in an attempt to identify differences among various groups within the camp communities. In addition to camp residents, medical personnel were also interviewed, in order to compare their perceptions (from a service provision perspective) to those of the people who benefit from their services. These interviews and focus group discussions were supplemented both by meetings with various researchers and NGO workers knowledgeable with the camps, as well as by my own personal observations and informal discussions with camp residents.

1. Semi-Structured Individual Interviews[29]

The interviewees were selected through local NGOs and personal contacts, although I expressly chose not to interview anyone that I had previously known. The samples in both camps are therefore neither random nor representative (although representing various age and sex groups), but their views nevertheless offer insights into these groups' perceptions of health and illness.

[28] CEPAL (Canadian-Palestinian Educational Exchange) offers educational classes to Palestinian refugee children and youth in cooperation with local NGO partners.
[29] See table in Annex II.

Different semi-structured questionnaires were drafted for the five samples - women, men, youth[30], elderly[31] and medical personnel – based on previous ICPH experience in the West Bank, as well as previous research in Lebanon (FAFO 2003; Geha 2000). While the bulk of questions were similar across all the samples – so as to allow for comparisons – there were enough questions of particular concern to each sample so as to justify the formulation of separate questionnaires for use by each of the specific groups.

The questionnaires were pilot tested with a small number of camp residents that were previously known to me, in an attempt to ensure that questions were properly understood and to ascertain whether it would be appropriate to ask them in the context of the camps or not.

These interviews lasted between 40 minutes and 1 hour. As I did not speak enough colloquial Arabic, it was necessary to use an interpreter, and given the isolation of the camps from the surrounding Lebanese society, someone from the camps had to be chosen as an interpreter. An interpreter from Bourj el-Barajneh was used for all interviews conducted in Arabic[32], although this was not without its problems. Necessarily, interpreting breaks the natural flow of conversation, the natural rhythms of questions, answers and interjections – and inevitably the interpreter could not translate every single little detail of the longer narratives that some questions produced.

The presence of an interpreter from the camps, furthermore, was bound to shape people's answers, how much they thought they could complain about things, or even – to the extent that there are no secrets in such small and overcrowded spaces – may have caused people to partially self-censor some of their answers. Not only did the interpreter's presence shape discourse, but the presence of a foreign researcher also probably did. The extent to which people thought I could offer help (although the purposes of the study were explained to all interviewees), or to which they saw me as an outsider to whom things might be over-exaggerated or hidden can never be fully ascertained. However, I do believe that the presence of an outsider and a camp resident probably provided some balance to people's answers, moderating the extent they felt they could alter their stories without appearing illegitimate to both parties. In analysing the data, however, the possible impact of the interpreter was kept in mind, particularly with reference to women's interviews. Nonetheless, it is impossible to gauge the actual impact that the interpreter had on answers provided.

Homes in both camps are small and overcrowded and it was difficult in most cases – if not nearly impossible – to ensure that the interviews were one-on-one engagements. There was usually at least one family member or friend of the family present, if not more. These were not just passive listeners but active participants – confirming, contradicting and adding to the interviewee's answers; even children as young as six felt that they had a contribution to make to the interviews, and forcefully interjected their opinions when not actively listened to.

2. Initial Semi-Structured Interviews Data Analysis

The initial findings from the interviews were analysed with the aim of identifying main and sub-themes contained in the narratives. The data were arranged in general thematic categories, within which specific responses to questions were coded and analysed. The coded data was also used to identify possible topics of interest for the focus group discussions.

3. Focus Group Discussions

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[30] The UN definition of youth as being between the ages of 15 and 24 was adopted here, excluding those falling into this range that were married (http://www.un.org/esa/socdev/unyin/ganda.htm). As marriage is a definite rite of passage in the Arab world – particularly for women – youth shift to a new phase in their life cycle and are not considered or recognised as youth any longer (ESCWA 2001).

[31] For the purposes of this study, the elderly were considered to be those persons 55 years of age or more. This is perhaps the biggest shift from the international standard of 65 years. However, what justifies this cut off point for old age is the fact that life in the camps is extremely harsh and difficult, in many ways aging their bodies unnaturally, and causing gerontological problems to manifest themselves earlier than in developed countries (Ruth Campbell & Olfat Mahmoud, personal communication 2003; personal observations).

[32] In cases where interviewees spoke good English, interviews were conducted in English.

The original intention was to complete focus group discussion in both camps and across all groups. However, for practical purposes and due to time constraints, it was only possible to conduct two focus group discussions – with youth and women – in Bourj el-Barajneh camp. These two focus group discussions looked at themes derived from the semi-structured interviews, focusing on issues of concern that had been elicited by youth and women.

4. Meetings

The information gathered in the interviews and the focus group discussions was further supplemented, checked and discussed in meetings with UNRWA and PRCS Lebanon Field staff, local NGO directors, and independent researchers knowledgeable about the Palestinian refugee situation in Lebanon. (See Annex V for list of meetings).

5. Personal Observations and Informal Discussions

Knowing people in the camps well gave me ample time to discuss my research with them, debate and discuss possible explanations for some of the answers given, while also permitting me to observe their own behaviours related to health – this, although not formal, did provide a broader picture of people's behaviours, attitudes and opinions that supplemented that provided by the interviewees.

6. Study Limitations

One of the study's main and most important limitations is that it was conducted with the help of an interpreter and therefore some information was necessarily lost, and some questions could not be discussed with as much detail as might have been possible in Arabic.

FIELD STUDY RESULTS

CAMP RESIDENTS SEMI-STRUCTURED INTERVIEW AND FOCUS GROUP FINDINGS[33]

Baseline Information on Consultations, Medical Problems and Service Providers Accessed

I. NUMBER OF CONSULTATIONS OVER THE PAST YEAR 2003-2004 (TABLE 1)

1) Just over half the respondents stated having consulted a medical care provider at least once or a few times over the past year for their personal needs, mainly in the peak winter and summer seasons.

2) The elderly were the main group where multiple consultations were reported, most probably due to the chronicity and severity of the ailments they suffer.

3) Only eight respondents claimed to have never consulted any medical care provider over the past year. Nevertheless, the question referred to consultations with medical professionals in institutions, and therefore does not mean that people did not access family or friends who were doctors, pharmacists, etc.

II. REASONS FOR PERSONAL CONSULTATIONS OVER THE PAST YEAR 2003-2004 (TABLE 2)

1) Respiratory and ENT[34] ailments emerged as the *single* most important problem, particularly because they cut across all gender and age groups. Given the cramped and damp conditions of many homes, the high population densities in both camps, and the lack of adequate heating (more severe in Wavel where the winters are

[33]All interview questions were open-ended and did not offer options; all options in the tables are taken from the answers of interviewees themselves and were coded in this way for analytical convenience. All quotations from camp residents are taken from interviews and focus groups conducted. See Annex III for tables.

[34] Acronym for ear-nose-throat ailments.

bitterly cold) and ventilation, it is not surprising that people suffer from a variety of respiratory and ENT ailments *throughout* the year. The common cold[35], for instance, while increasing sharply in winter, was still identified by camp residents as a problem that afflicted them throughout the year.

2) All but two consultations for chronic diseases were among the elderly. While it may be a good sign that chronic diseases seem to emerge mainly in old age – thus replicating a pattern more akin to developed countries – it is still worrisome that *most* of the elderly claim to be affected by a chronic disease, given that the chosen cut off age was 55 rather than 65 years, raising questions as to the prevalence and onset of these chronic diseases compared to other populations. While the younger generations may seem to be relatively healthy, the elderly seem to be affected by a wide range of mild and severe, chronic and acute, problems.

3) Of the chronic diseases mentioned, hypertension and heart problems (often linked) were the main reasons for consulting.

4) Men reported a higher number of bone and muscle problems than women, which may be linked to men's physical work (with many repairing homes and working as day construction labourers), which exposes them to greater physical stress and harm. Nonetheless, musculoskeletal problems are generally more often reported among women than men. Perhaps this higher rate among men may be the result of the small sample sizes chosen.

IV. CHOICE OF SERVICE PROVIDER FOR PERSONAL CONSULTATIONS (TABLE 3)

1) UNRWA was clearly the main service provider camp residents accessed. This may be because UNRWA is the only *totally free* service provider available to Palestinian refugees in Lebanon. However, this may also be due to UNRWA structures having been set up earlier, with the specific mandate of catering to refugee needs. Unlike all other service providers in the camps, UNRWA is the only one who has been providing continuous services since the beginning of the refugee problem.

2) In general, access to other providers was mediated mainly by the gravity of the problem and the person's financial situation. UNRWA, for instance, does offer consultations to cancer patients, indicating that perhaps financial considerations also affect access to service providers, and not only the seriousness of the condition.

3) The majority of respondents reported tending to go seek private clinics *outside* the camp, when seeking care in institutions other than those of UNRWA. According to some interviewees, this is because all healthcare providers other than UNRWA in the camps charge fees and provide significantly poorer services than can be obtained from private clinics outside the camp.

4) Far fewer Wavel residents seemed to access PRCS services. This may be because PRCS operates one clinic in Wavel, while it operates a hospital in Bourj el-Barajneh camp offering a greater range of services. The PRCS clinic in Wavel offers only extremely basic services (bone casting, general check-ups, sutures, etc.) and cannot handle any surgery that requires general anaesthesia. In addition, most of the Wavel interviewees mentioned the fact that PRCS charges fees for its services, a problem that seems more acute in Wavel compared to Bourj el-Barajneh[36].

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[35] Influenza is a colloquial term used to refer to the common cold. It was not possible to distinguish between those who suffered from common colds and those suffered from real influenza, and therefore the term 'common cold' will be kept to encompass both problems.

[36] This was also corroborated by a Wavel PRCS doctor who stated: *''Before we used to see many more cases. Now very few people come [to PRCS]. It's probably because people have no money. Everything used to be free at PRCS, but not anymore. So many people go to UNRWA only because they can't afford even the minimal payment here. And you can't really blame them given all their difficulties.'*

5) Men had a greater tendency than women or the elderly to access services other than those of UNRWA or PRCS. UNRWA services in large part seem to cater principally to women and children (operating a maternal and child health programme, as well as a birth control programme) (UNRWA 2003). This may create a greater incentive for women to visit UNRWA clinics than for men. In addition, men suffering from chronic diseases such as heart disease may not always find the appropriate treatment (particularly open-heart surgery) at UNRWA, and would have to go elsewhere, although it is to be noted that with respect to open-heart surgeries, UNRWA has an agreement with a private Lebanese hospital (Personal communication, Dr. Jamil I. Yusef 2005).[37]

6) Youth were the group that most accessed PRCS services, particularly in Bourj el-Barajneh. Of those going to PRCS, seven out of eight were young men. It was suggested by some camp residents that young men generally do not like consulting, and if they do, they prefer going to PRCS, where they often know one of the doctors or nurses. They can thus disguise what is in effect a consultation behind the façade of paying a long overdue visit to a friend, who then simply 'counsels' them as to what they should do for their particular problem.

7) Three people in Wavel also mentioned going to Syria for medical treatment, highlighting an option not as readily available to Bourj el-Barajneh residents. Wavel camp is about 30 km from the Syrian border, and as such it is actually cheaper for Wavel residents to go to Damascus than it is to go to Beirut[38] – not to mention that medical services are cheaper in Syria than in Lebanon.

V. REASONS FOR CHILDREN'S CONSULTATIONS OVER THE PAST YEAR 2003-2004(TABLE 4)

Children were brought to a physician mainly for respiratory and seasonal problems that, again, can be well accounted for in Bourj el-Barajneh by the dampness and overcrowding of the homes and the lack of proper heating and ventilation. While Wavel is less damp and humid than Bourj el-Barajneh (due to its location in the mountains rather than near the sea), it suffers from extremely harsh winters, and more cramped homes.

VI. CHOICE OF SERVICE PROVIDER FOR CHILDREN'S CONSULTATION(S) (TALBE 5)

1) As with adult consultations, UNRWA was the main service provider accessed for children's consultations. This may be both because it is the only free clinic, but also because most children suffering from mild respiratory and seasonal ailments can find appropriate and effective treatment at UNRWA.[39]

2) A 'service provider' accessed for children and not previously mentioned was the pharmacy. Although the pharmacy is clearly not a formal place of consultation, many camp residents attest to going there for mild problems such as the common cold, stating that usually the pharmacist prescribes the same medication and course of treatment as consulted doctors. Especially where people want to simply purchase previously effective medication (rather than consulting a physician), the pharmacy is both a cheap and effective option for camp residents.

Perceptions of Main Service Providers and Medical Personnel

[37] Riyak Hospital, located midway between Chtaura and Ba'albek.

[38] All Palestinians who carry a *Lebanese Travel Document for Palestinian Refugees* can cross into Syrian easily and at no charge. It is for this reason that Palestinians in Wavel may opt to go to Syrian rather than Beirut.

[39] UNRWA implements the 'Integrated Management of Childhood Illness' (IMCI) programme for management of sick children, which is approved by WHO and UNICER. This programme has been evaluated in many countries and its efficiency has been confirmed. In the camps, sick children are assessed according to this programme and it has proven its value in management of childhood illness within the refugee community through the elimination of deaths from diarrhoeal diseases, and the reduction of deaths from acute respiratory infections among children below the age of five (Personal communication, Dr. Jamil I. Yusef 2005).

VII. PERCEPTIONS OF MAIN SERVICE PROVIDERS (TABLE 6)

1) Generally, there seemed to be dissatisfaction with UNRWA services, with most people feeling that the services offered there are unsatisfactory – paucity of equipment and medication, absence or insufficiency of specialists. Men seemed to have a more negative view of UNRWA services than other groups, and this may be because some UNRWA services cater primarily to women's health needs – increasing women's satisfaction of UNRWA compared to men.

It is crucial when speaking of satisfaction with UNRWA's services then, to see *who* is speaking and *what* services are available for them at UNRWA clinics. In addition, there is a deep misunderstanding of UNRWA in the camps (Roberts 1997: 44), whereby many people assume that it is an organisation that should provide them with everything – anything falling short of this is often interpreted as a plot to further marginalize the refugees. In reality, UNRWA services – while certainly decreased due to austerity measures – continue to address the same basic problems that they initially tackled at their inception and fall within their defined mandate: primary education, primary health care, basic social services.

2) Wavel residents tended to have a more critical view of UNRWA. This may be the result of more limited healthcare services in the camp, causing people to be more dependent – and thus more demanding – of UNRWA. In addition, these reports are likely linked to the high turnover rate of UNRWA doctors at the Wavel clinic (one doctor every three-four months). UNRWA explained this continued change in attending doctors as resulting from the fact that no doctor from the Beqa'a has been found to work in the Wavel clinic. As a consequence doctors are hired from other regions of the country, and none usually wishes to remain in the area and provide the service for longer than half a year (Personal communication, Dr. Jamil I. Yusef 2004).

3) Perceptions of PRCS tended to be more positive than those of UNRWA, although most people described the institution only as acceptable and not as actually satisfactory.

The difference in perception between PRCS and UNRWA may be the result of a variety of factors. It is impossible to ignore the effect of the quality and breadth of PRCS services prior to 1982 (noted as a watershed after which services consistently deteriorated) on people's current perceptions of the organisation. In addition, some camp residents suggest that PRCS may be better perceived because it is regarded by many as an indigenous *Palestinian* organisation. UNRWA, on the other hand, is seen as an *outside* organisation, despite its undeniable role in helping the refugees survive. PRCS was described to me by some interviewees with the Arabic expression '*minnah wa finah*' meaning roughly 'it is one of us'. People may thus perceive PRCS as an integral part of their community and also as a 'gift' bestowed upon it. UNRWA, on the other hand, has been described as an obligation of the international community (Roberts 1997: 40), and therefore is rarely seen as something to be grateful for.

4) A particular complaint mentioned in relation to PRCS was the charging of fees – a problem most highlighted by Wavel residents. This may be because of harsher economic conditions in Wavel (Roberts 2001 and personal observations), as well as because of the limited services offered by the PRCS clinic in the camp in return for the fees paid.

5) Some people explained that PRCS and UNRWA services are only satisfactory for simple conditions – the common cold, appendectomies, etc. This perception of both PRCS and UNRWA is not altogether wrong. Both have had to implement austerity measures and are open about the problems and limitations caused by their increasing starvation for funds. In the case of UNRWA, this has lead to an inability to move into new areas of need, while in the case of PRCS in a reduction in services.

VIII. PERCEPTIONS OF MEDICAL PERSONNEL (TABLE 7)

In the cases of both UNRWA and PRCS, perceptions of the respondents towards medical personnel were more positive and forgiving than those related to the institution where they worked. Many people explained this difference by speaking of the doctors' heavy workload, limited resources and lack of continuing education. This displacing of responsibility from the *individual* to the *institution* may be a compromise allowing people to vent their frustrations, while avoiding a confrontation with the doctors who themselves often live in the camp. However, many interviewees did have a good understanding of the limitations placed upon the doctors and did not expect them to be able to function properly in such a constraining environment. This understanding stems in part from the fact that many doctors and nurses working at PRCS and UNRWA are Palestinians themselves, often living in or near to the camps. However, similar understanding was expressed even in reference to Lebanese doctors and nurses working at PRCS.

Perceptions of Health and Illness in the Camps

XIII. CHANGES IN THE LEVEL OF HEALTH (TABLE 8)

1) All but *two* of the 80 interviewees felt that the health status of the camp population had deteriorated over the past ten years, indicating that despite approximately 13 years of peace, people perceived their health as worse now than it was just after the war had ended – when the situation in terms of housing, environment, food, etc., is generally acknowledged as having been more critical than at present by most outside observers (personal observations). Nonetheless, most interviewees felt that the deterioration in health was *recent* rather than *gradual* – focusing on the past four to five years as critical in the assessment of health in the camps. It must be noted that this perception is linked to certain important changes in medical and health provision to the camp – namely, the overwhelming reduction in PRCS services in 1993 – services that prior to and even during the war were greatly admired and extremely effective.

2) Environmental conditions[40] generally were seen as the most important factor in the decrease in health over the past ten years.

3) Almost all the interviewees who mentioned food as a cause of the deterioration in health were speaking of the *inherent* quality of the foodstuffs themselves – not of what people ate. In other words, they spoke of chemical pesticides and fertilizers, not of whether people at too many carbohydrates or too few vegetables.

'Everything in the past was natural, now nothing is natural and everyone complains of pain in their bodies' – Bourj el-Barajneh woman (36 years old, 6th grade education, married, mother, housewife)

'Before it was better – now you eat, and are scared of all the diseases you could get from the food, but before you with your eyes closed' – Bourj el-Barajneh woman (36 years old, 6th grade education, married, mother, housewife)

4) As a singular factor, the economic situation was cited as the second most important negative influence on health over the past ten years. In general, interviewees spoke of the heavy burden placed on families – financially and emotionally – particularly if persons suffer from chronic illnesses.

Considerable effort seems to be expended by camp residents trying to alleviate people's suffering and to heal them. NGOs working in and knowledgeable of the camps suggest that this is a reaction that has deep cultural roots. They explained that very few camp residents accept the idea of resigning oneself to a family member's death before this has occurred, so that most people die in hospitals rather than at home – even when doctors have diagnosed a terminal illness for which no therapies can be effective.

[40] Environmental conditions subsume a wide range of problems from poor housing to water quality, rodents, garbage, sewerage, etc.

'The most important worry for people isn't dying, it's not being able to do everything possible to alleviate the suffering of their loved ones' – Bourj el-Barajneh elderly woman (82 years old, married, mother)

5) While people could not explain the causal mechanism between depression and decreased health, depression was nonetheless mentioned various times as a cause of ill health. Camp residents suggested that most people make this link because of the belief that *sudden* onsets of disease (such as diabetes or heart disease, that although are progressive, seem to emerge suddenly), can be caused by 'shocks' – such as the loss of money, death of a loved one, etc. They therefore explained that the belief that depression can cause a widespread decrease in health might be an extension of this commonly held understanding of illness.

For instance, one woman explained how her mother became diabetic upon hearing of her son's death. Here, diabetes is not an illness of the body or a consequence of a sedentary life style and bad eating habits. Here, diabetes is an explanatory story, an idiom of distress, for a deeper sadness. It *physically* links a mother to the death of her son by actualising the sadness as a disease. It is a way both of explaining a bodily ailment that seems to emerge suddenly and a way of perhaps dealing with the loss of a son. Sadness and disease seem to be locally connected in a wider explanatory framework of suffering. In a way this rationalises disease for people, it gives disease a legitimacy that it might not otherwise possess, it integrates disease into the normal life history of a person – not just biologically – but historically and personally.

'My brother's wife – they are in Denmark – called us to tell us that my brother had died, from a heart problem. When my mother found out she immediately collapsed. She was so sad! She was so sad that he had died far away from her and that she did not have the chance to see him before he died. A few days after we received the news, she became very ill. We took her to the doctor and they did some tests. They told her that she had diabetes. The sadness made her ill. It weakened her and her body and it is easy in such a situation for a disease to make a person ill.' – Bourj el-Barajneh elderly woman (70 years old, widowed, mother)

6) Improvement in health

a. Two respondents, both Wavel women, said that health had improved. Mainly, they tended to focus on greater sources of information (i.e. the media), and an increased variety of service providers.

'Health is much better now. People are more educated than they used to be. They can learn from television and there are lectures. So they learned things they should and should not do. There are also many more services. There are the PRCS and UNRWA clinics, but now people can also choose from among the few small clinics in the camp and they can go to Ba'albek, and even to Syrian where things are very cheap. So we have more choices than people used to have' – Wavel woman (35 years old, 8th grade education, married, mother, housewife)

XV. PERSONAL HEALTH (TABLE 9)

1) Women tended to express feelings of gratitude at being as healthy as they were – and particularly, at still being able to carry out their daily tasks. Perceptions of personal health, then, seemed to be affected by more than just actual presence or absence of medical conditions. Women felt that if they were capable of fulfilling their responsibilities or if they were better off than others they knew, than this warranted saying that their health was good.

'Sometimes I don't feel too well, but al-hamdullilah, I am well. I cannot complain. I can still get up in the morning and take care of my house and kids, so it's ok' – Wavel woman (38 years old, 9th grade education, married, mother, housewife)

2) Personal health and its importance were also weighed against other life priorities. One example is sufficient to illustrate this. A woman mentioned that she suffered from chest pains and that these were caused by a

piece of shrapnel still lodged in her chest. When asked why it had never been removed she explained that at the time of the injury she had recently been engaged and the doctor encouraged her *not* to have the shrapnel removed, as this would leave visible scarring on her breasts – the knowledge of which supposedly might dissuade the suitor to marry her. She was swayed by this and decided not to have the operation, instead enduring years of chronic sporadic pain. It may seem that the doctor ought to be accused of malpractice, while the woman deemed foolish. However, if one sees health more broadly the decision was probably both rational and in the woman's best interest. It is incumbent upon a doctor not to cause harm, but a doctor is also aware of and acting within a local context. In this case, he believed that the young girl's life would be worse off if the wider society deemed her as 'damaged'. And he was most probably correct; the young woman followed his advice because she too probably understood the impact that such an operation might have on her *life chances*.

A health decision, then, was made according to its social rather than health consequences. It is important to note this because often health programmes aim at changing behaviour so that it conforms to a 'logical' pattern, the assumption being that people make bad decisions because they are ignorant. It is thus supposed that once armed with proper knowledge, they will automatically make correct ones. This case shows that even when one is aware of what is *medically* better, one may still choose another option. People make medical decisions *in their lives*, not in a vacuum, and like all decisions, medical ones will be judged on a scale of general priorities. In trying to change behaviours then, it is important to remember that people will apply knowledge selectively, so long as change does not create imbalances in their larger context.

3) Men, as the women, tended to view their health in terms of their ability to work and still be able to do what they usually do. The men who were unemployed at the time of the interviews and therefore unable to fulfil their social responsibilities tended to define their health in more negative terms. A corollary of this is that those men who were ill but working tended to emphasise that their health was good, even if obviously not so.

'So long as I am able to work, I consider myself to be healthy' – Bourj el-Barajneh man (32 years old, 12th grade education, married, father, construction painter, casual labourer[41])

4) While elderly, who often suffering from various ailments, also tended to view their own health in positive terms, they made up the majority of people who described their health as bad.

'Life has been long for us [elderly] and hard in the camp. There were many difficult times, and the elderly had to raise their kids and take care of things throughout everything – the wars, the economic difficulties. We are tired from being refugees. We have been refugees for fifty-six years. And we site here now are tired from everything' – Wavel elderly man (66 years old, married, father)

IX. MAIN CAUSES OF DEATH (TABLE 10)

1) Chronic diseases were seen, on the whole, as the leading cause of death.

2) Of the chronic diseases mentioned, cancer was particularly feared by women, and it was generally seen as *the* leading chronic cause of death. The women interviewed rarely used the Arabic work for cancer '*saratan*' preferring to call it 'that disease'. My interpreter as well as some NGO workers in the camp suggested that there is a greatly exaggerated fear of cancer in the camps, possibly stemming from the fact that most camp cancers become terminal (due to limited financial resources and the nature of the disease itself).[42] In addition, some

[41] Casual labourers usually work on a daily basis, and therefore are not permanently employed. They cannot really be considered as employed, as many work one or two days a month only.

[42] UNRWA confirms that the Agency is able to contribute more toward the management of diabetes and cardio-vascular diseases than of cancer – something that may also be affecting perceptions of cancer. However, UNRWA has a health education programme on self-breast examinations (SBE) for the detection of breast masses, as breast cancer is the most common form of cancer among women. This programme has been effective at detecting breast cancer in the early stages (Personal communication, Dr. Jamil I. Yusef 2005).

people also mentioned that cancer frightens people because it is seen as a disease that strikes the young as well as the old, and thus transgresses the proscribed time in the life cycle when it is considered 'normal' to fall ill.

'Unless you have a family member abroad, you are dead for sure from cancer' – Bourj el-Barajneh woman (31 years old, 6th grade education, married, mother, shopkeeper in camp)

'It is terrible to see people coming to ask for money. Especially those who come for cancer. You know that they have gone everywhere and that they are begging you. And it's terrible to see people like that. To see people pleading for the life of someone that they love. It makes me so sad. – Bourj el-Barajneh woman (45 years old, university education, married, mother, volunteer with a camp NGO)

3) Age is interesting because old age is an obvious cause of death, and in its obviousness its *absence* from most people's answers stands out all the more starkly. That natural death was not perceived as common even among the elderly may be an indication of the extent to which death in the camp is perceived to be – if not inherently unnatural – then caused by unnatural events. Even diseases may be seen as deriving from the social world and history of the camps, thus the references to the political situation as a cause of death.

Interviewees' comments regarding death carry tremendous insight in terms of how the social world is seen to actually impinge on the life chances of the body itself. The Palestinian refugee camps are not the first place where the idea of how hopelessness or a fractured social world can shorten life. While the direct causal mechanism is unknown, in the camp the idea that death derives from the lived experience of the society and its history seems common, and as such death is often seen as unnatural or untimely; rarely is death seen as the consequence of *individual* habits or actions (e.g. food habits, lack of exercise, smoking, etc.), as these narratives demonstrate:

'The political situation is killing us, everyone is against us. There is no hope. Life is shorter because there is no reason to live' – Bourj el-Barajneh elderly woman (57 years old, 5th grade education, widowed, mother, social worker with local NGO)

'You have to see all these deaths as side effects of history' – Bourj el-Barajneh man (44 years old, 12th grade education, married, father, political cadre)

'No disease comes suddenly, it is a product of time' – Wavel man (50 years old, university education, married, father, teacher, unemployed)

4) That depression was mentioned 12 times as a cause of death – even though not by a majority of people – was still surprising, especially as depression is not often discussed openly and with the full measure of complexity that it deserves. However, depression here may not necessarily be understood in the Western sense; it may not be depression over a *personal* issue – bad work, personal problems, etc. While these problems certainly do exist in the camps, when people speak of depression as a general cause of death, it may be that they are referring to a 'social' depression. A depression caused by a general condition of political exclusion, economic marginalisation and social scorn. It is in this communal sense that depression might be seen as a widespread problem. In other words, personal circumstances may either ease or worsen this general sense of depression that affects everyone, but they are not its primary cause.

The overall misery of life in camp residents' minds then could lead to death (with or without a personal reason for depression) either because of too many imbalances between the communal context and the individual body, or because the heavy burden of misery reduces the individual willingness/desire to continue surviving.

The references to land introduces are some of the direct references to the homeland, Palestine. History here may be seen as linked to the body – a demonstration of how people try to legitimise in one stroke both their personal illnesses and their communal history. In linking death and illness (and therefore health) to Palestine, it becomes impossible to erase or rewrite the camp residents' version of history – it is a way of embodying Palestine to such

an extent that healing is seen as residing *only* or at least *primarily* in Palestine, and as such, in the realisation of the return.

'Depression [kills people] – people think that they have no home, because this land is not theirs, and the elderly have their memories of Palestine' – Bourj el-Barajneh elderly woman (68 years old, married, mother)

'We are broken down, we have our dreams of returning to Palestine' – Bourj el-Barajneh elderly man (70 years old, married, father)

'Mental health is what makes health better – here no one has good mental health. This is not our country and we don't feel at home here. If our mental health were better, we wouldn't have as many health problems' – Wavel woman (37 years old, 4th grade education, married, mother, shopkeeper in camp)

'Death is a rest for us here, if there is a rest in the end' – Wavel woman (37 years old, 6th grade education, married, mother, housewife)

X. MOST PRESSING HEALTH PROBLEM (TABLE 11)

1) Seasonal and environmental problems were seen as the most pressing health problem in the camp. Of these, poor water quality, unhealthy homes and environmental conditions were the most important.

2) Poor water quality was a problem that was *exclusively* mentioned by Wavel residents[43] and seems to be related to the water distribution system in the camp. In Bourj el-Barajneh camp, each home generally has its own water tank on the roof which is refilled daily – this water is used for washing and cooking. Drinking water is purchased at various places in the camp at a low fee, and is brought in from outside the camp. This is spring and river water from the mountains, and is said to be filtered. In Wavel, on the other hand, drinking and washing water come from the same source – a large water reservoir built to provision the entire camp. There have been serious problems with this reservoir, either at the source or because water pipes throughout the camp are old and may be mixed up with sewage pipes.[44] Regardless, the interviewees and other camp residents told me that the mosque often announces that the water is not to be drunk and that people should go out of the camp to get water. Most camp residents explained that this filtered spring water is either very cheap (about 15 cents / 10 litres) or free, depending on the provider.

3) Unhealthy homes were seen as a problem *predominantly* in Wavel. This may be attributed to the fact that homes in Wavel are smaller and more cramped than most of those in Bourj el-Barajneh. While Bourj el-Barajneh is also undoubtedly crowded, there is generally more room than in Wavel. Also, the very cold winter conditions in Wavel may make people feel that their homes are more inadequate at shielding them from the elements – and therefore are unhealthier. In addition, Wavel has the particular problem of the old French army barracks that stand at the centre of the camp. These barracks date back to around the 1930s and seem to be extremely dilapidated. The rooms are extremely small and narrow (as originally envisioned as soldiers' barracks) and often up to four people may be living in only one of these small rooms.

'This old building [part of Wavel camp] was built by the French and it's going to fall down on our heads one day. The stairs are so high and I live on the second floor so I would have to go up four flights of stairs. My legs are too

[43] Only two medical personnel (and no camp residents) mentioned this problem in relation to Bourj el-Barajneh camp.

[44] UNRWA installed a new sewage system in Wavel in early 2004, which seems to have improved the water situation in the camp, as revealed by the water analyses done regularly (Personal communication, Dr. Jamil I. Yusef 2005). In relation to this, it is important to note that very few interviewees made the link between poor water quality and possible sewage contamination, and therefore how the UNRWA project was benefiting them. Most interviewees, on the contrary, felt that the sewage project was unnecessary. This is most probably a communication problem between UNRWA and camp residents. However, it highlights the importance of, if not involving people in decisions that affect their camp, at least informing them as to the *rationale* behind a project.

weak, so now I just stay here in my home. Sometimes I go visit some neighbours on this floor, but that's it. I can't go down and see other people in the camp, or even go to the doctor' – Wavel elderly woman (80 years old, widowed, mother)

4) Chronic diseases as a whole were seen as the second most important health issue in the camps.

5) Of the chronic diseases, diabetes was mentioned most frequently, probably because it affects a large segment of the population – and not only the elderly. Its chronicity also ensures that it can be a problem over a long period of time, and thus makes it a visible problem that people speak about and deal with daily. Generally, most persons suffering from diabetes in the camp seem to prefer medicines to lifestyle changes. This is supported by a UNRWA Lebanon field study that indicates the difficulty UNRWA faces in convincing people to opt for a lifestyle change treatment (Yusef 2000: 7). However, it must be kept in mind that lifestyle changes are hindered by the context and poverty of the camps. Lifestyle changes require money, social support and willingness. It does little good – and is certainly not effective – to tell a person what to eat or not eat when poverty, overcrowding and other daily problems come in the way.

XI. SUGGESTIONS TO IMPROVE HEALTH IN THE CAMP (TABLE 12)

1) Most interviewees felt that the most important way of improving health was to help people financially and to increase funding for UNRWA and PRCS services. It is interesting and important to note that most people suggested improving and financing already *existing* medical services – and not the creation of new or alternative ones.

2) The absence of sufficient free or low-cost medication is a serious problem in the camps that has been noted in other health studies (Soweid and Al-Khalidi 2004; Geha 2000). UNRWA has a free pharmacy, whose medicines are in line with the WHO Essential Drug List and the UNRWA Medical Supplies Catalogue is updated regularly. Despite this, it seems that most interviewees felt that these pharmacies often lacks many basic medicines. Therefore, most interviewees explained that prescribed medication from UNRWA doctors often have to be purchased at other pharmacies.[45]

3) Access to medication was perceived as a critically important problem in relation to chronic diseases, such as diabetes, heart problems, kidney failure, etc., where such medications have to be purchase regularly. In a situation of financial duress, having a continuous medical expense is often a great burden.

4) Some interviewees from both camps mentioned having gone to Syria to purchase medication for chronic diseases, claiming that it is cheaper as the medicines are local versions of European and American pharmaceutical drugs. It is impossible to gauge the efficacy of these drugs based on our interviews alone, but their low price makes them a very convenient option for camp residents.

5) Improving infrastructure and dealing with environmental issues were reported as the second most important way – after funding – of improving health in the camps.

6) Suggestions to actually create new health services or to create new medical infrastructure (such as a hospital) were mainly discussed by Wavel residents. This may be linked to the fewer health services in Wavel as compared to Bourj el-Barajneh, but also – importantly – to the absence of an actual PRCS hospital *in* or even near the camp (there is only a small clinic).[46]

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[45] UNRWA suggests that this dissatisfaction may stem from the fact that there are many medicines used by the private sector that are not available at UNRWA clinics, although the Agency states that alternatives are available (Personal communication, Dr. Jamil I. Yusef).

[46] While UNRWA does have a contract with the Tartari Hospital in nearby Ba'albek for Wavel residents, this may not provide the same service and access as a PRCS hospital might be able to provide.

7) Related to the fewer medical services available in Wavel, one particularly interesting problem was mentioned: the absence of night or 24 hr medical services. In general, only hospitals maintain 24 hour shifts, and the absence of a hospital in Wavel leaves people with two options: going to a private Lebanese hospital and paying high fees[47], or finding a way to get to the PRCS Bar Elias hospital about 40 km away. Both options are hindered by the financial difficulties of camp residents, as well as generally inaccessible transport, and result in most people waiting it out until the morning.

'There is nowhere to go [inside the camp] if you have a serious problem at night. You have to go to Ba'albek and pay or find a way to get to the PRCS hospital in Bar Elias. It is very difficult for people because there is no money. So most people just stay in the camp and wait until the morning, but in some cases it is very bad. Like if you have a heart problem or it a small infant has a very high fever. There are many problems that become worse because people do not go to a doctor when they should. If we had a small clinic open 24 hours it would at least give people the chance to see someone who could tell them what to do until the morning when they PRCS and UNRWA clinics open' – Wavel woman (35 years old, 8th grade education, married, mother, housewife)

8) The importance of improving and supporting UNRWA was discussed *separately* from other service providers by a number of interviewees. This may be because UNRWA is often perceived to be the only *permanent* (until the end of the refugee problem theoretically) and *free* health service provider for Palestinian refugees. As such, it makes sense to suggest strengthening its services, as these are the backbone around which all other health service providers constellate.

9) There was a general dissatisfaction with doctors' examinations, although not directly mentioned by all interviewees. In the case of UNRWA in particular, with a patient load of more than 60 per day, it may be difficult to ask for even 5-minute examinations. However, the view remains that doctors sometimes do not do their best within the limits imposed on them, and instead content themselves with simply prescribing medication based on a patient's self-diagnosis. Because of this, people do not often return to consult for the same problem – they simply go to the pharmacy and purchase the medication that was initially prescribed to them.

'For me, if I had to say what could improve health in the camp, I would say that the relations between the doctors and the patients need to be chanced. Now when we go to the doctor, he or she just asks you what you have and then gives you a list of medication. They don't consult or examine you at all. Maybe it's because they have too many patients. But also, I think, now they are used to working like this. And I think that doctors need to take care and spend more time with patients. So that when you go to the doctor it's not just a bad experience. That's why people here only go to the doctor if they are sick, no one will go just to have a check up when they are well' – Bourj el-Barajneh female youth (24 years old, university student, single, nursery school teacher)

'You go in and the whole process is like 30 seconds. The doctor asks you what you have and then gives you the medication according to your own diagnosis, not his. It is just like going to the pharmacist – so instead of wasting my time at UNRWA now I just go to the pharmacy because it's the same thing. The doctor doesn't even take ten seconds to feel your stomach or look down your throat – you can't tell me that there aren't even 10 seconds to spare' – Wavel female youth (25 years old, 5th grade education, single, hairdresser, unemployed)

XIV. MENTAL HEALTH (TABLES 13 & 14)

1) Most camp residents felt that mental health was bad, using the following terms to describe it.

'The mental health is terrible – zift [nothing]' – Wavel female youth (18 years old, 9th grade education, engaged, studying hairdressing)

[47] Camp residents explained that they have to pay a deposit upfront at the hospital, which is returned to them once they provide the hospital with a certificate/receipt from UNRWA that indicates that the treatment will be covered by the Agency. This, however, does not solve the problem for most people, as many do not have the money to pay in the first place.

'Col al-nas ta'aban [all the people are tired]' – Bourj el-Barajneh woman (30 years old, 7th grade education, married, mother, housewife)

'We run and run, but we stay in the same place' – Bourj el-Barajneh woman (29 years old, 9th grade education, married, mother, housewife)

It's [mental health] getting worse, especially for the youth. There is no future for us in this country' – Wavel man (46 years old, 11th grade education, married, father, journalist, unemployed)

2) It is to be noted that while all interviewees generally felt that the community's mental health was in a bad state, Wavel residents seemed to compare their particular situation to that of other Palestinians in Lebanon, and marked it out as especially dire.

'It's [mental health] very bad. It's only because sons are abroad that people survive. The youth accept to marry the daughter or son of anyone who is abroad. And it's worse here than in Bourj [el-Barajneh] – there, there are [more] NGOs, more opportunities even if these are limited. Even in terms of schools, it's better. Here, youth have to leave to go to university, and often parents don't have the money to send them, or if they are girls, the parents won't send them to Beirut unless they have a family member living there. We are unluckier here, because we are Palestinians, but also because we are isolated. So we suffer twice' – Wavel woman (42 years old, 11th grade education and 2 years pharmaceutical training, married, mother, housewife)

3) The economic situation stood out in importance when people discussed mental health – both in terms of financial problems, meeting family responsibilities and unemployment, but also in terms of the repercussions that lack of money has on the ability to leave Lebanon – something particularly relevant to male youth. While economic hardship is seen as a push factor for migration in the camp, not everyone can migrate, even illegally. Most youth in the camp are in the position to *want* to leave, but very few have the *capacity to actually* leave the camp. There is a political economy of illegal/legal migration that becomes evident, for while the harsh conditions illegal immigrants face in host countries are often commented upon, little thought is given to the fact that their very ability to travel represents a capacity that most others in their communities lack. Among male youth, in particular, *illegal* migration is seen as a *privilege* and an *opportunity*.

'Last summer a whole group of guys left illegally through Russia and the Ukraine into Western Europe. Most got sent back, but some got through and now they are in Germany or Denmark. I didn't go because I didn't have the money. Even knowing what happened to them, and how badly they were treated in jail and how much money their families had to borrow, I would still go if I had the chance. There is no point in staying here, all we do here is to be bored. I wake up and watch television all day, smoke all day. There is no hope here. If I had the money, I would go immediately' – Bourj el-Barajneh male youth (27 years old, 7th grade education, single, construction painter, casual labourer)

4) Financial difficulties were also cited as a major mental health problem for *women*.

'*That is what all the women talk about, that they don't have money' – Bourj el-Barajneh woman* (36 years old, 6th grade education, married, mother, housewife)

'The economic situation is what most affects women, because women have to carry the consequences of this. They have to see their kids deprived of things they need, and have to try and keep the house going on very little' – Bourj el-Barajneh woman (32 years old, 5th grade education, married, mother, housewife)

'*The economic difficulties are women's biggest problem. They always have to worry about this and think about it. The woman has to find a way to buy her kids' schoolbooks, or how to buy a new bag for the beginning of the*

school year. She is constantly trying to find solutions, and this puts a lot of pressure on her' – Wavel woman (38 years old, 9th grade education, single, local NGO director)

'All of these financial difficulties are hard for everyone to deal with and affect everyone. And it causes problems between a husband and wife, because there is no money. And so someone has to stay silent in order to avoid fighting all the time. And most often, it is the woman who does this, she puts aside her problems and keeps them inside to not make the situation worse' – Wavel woman (26 years old, 4th grade education, married, mother, housewife)

5) The economic situation was also discussed in the framework of women working at jobs that, while very exploitative, nonetheless bring in needed money and allow them to be out of their homes for some time. However, the feeling transmitted was one of marked dissatisfaction with the work itself.

'I know I am being exploited and that I should work a lot less for this money. And even sometimes we don't always get paid. But at least I am doing something, I am out of my house, I have my friends and my life that is away from my family. I have something that is mine, and only mine – something that no one else can comment on or knows about really. And that is important to me. I make a little money, I can help my family a little and get myself a few things. That is enough. If I had the choice, I would do something else, rather than work in this factory, but there is nothing else right now. So I would rather stay here and be tired and work hard and not be paid much, rather than stay at home all day in front of the television in my pyjamas' – Bourj el-Barajneh woman (37 years old, 6th grade education, single, factory worker)

6) The economic situation was also held responsible for youth's inability, or difficulties, in marrying – something which elicited great frustration on the part of youth, and added to their mental health burden.

'You know, we can't even get married now because of the economic situation. We can't stay here and build a life for ourselves, even a limited one. And we can't leave and try to make things better, so what are people expecting from us exactly, a miracle? Of course, we will just sit around' – Bourj el-Barajneh male youth (25 years old, 8th grade education and 2 years vocational training, single, delivery man)

'Get married? No one my age can even think of getting married. Now it has become something that you can do, maybe, once you're over like thirty-five or something. And even then, often guys borrow money from the elderly to get married. But for us, we don't even think about it. It's useless. Besides, even if you want to marry a girl now, someone else will probably come from abroad with lots of money and a passport, and she will marry him. It's normal, what else are they going to do? Wait for us to make enough money to marry them? Of course, they are right to leave. But it means that there is no point in thinking about marriage for us now' – Wavel male youth (22 years old, 6th grade education, single, plumber, casual labourer)

'We used to wait for the guys to come, especially from abroad, because here the guys cannot marry very early. But now, the guys from abroad choose very young brides – like 15 years old. So someone like me, at 18, is considered old to them and so I find myself not being looked at by some of those guys. They think maybe that we are too independent or educated and that if they take us abroad we will not listen to them all the time. That is what I think it is – they are looking for someone that they can dominate and control completely, someone who won't know what to do or won't know that a husband is permitted to do to his wife. So now my friends and I, we find that fewer men are looking at us with intentions to marry' – Wavel female youth (19 years old, 9th grade education and 1 year management training, single, studying hairdressing)

7) Unemployment was seen as mainly a male issue, but one that indirectly affects everyone in the camp. Women particularly tended to worry not only about financial difficulties brought on by unemployment, but about the very fact that their male sons were spending their days idly.

'I wish I had work. Of course I need the money, my family needs the money. But more than anything I think my mother would like me out of the house, doing something, anything. Even me, I am so depressed from being at home all day, waking up at eleven and watching television, drinking coffee and smoking. At least if I worked, I would have a reason to change out of my pyjama instead of wearing it all day' – Wavel male youth (26 years old, 8th grade education, single, construction painter, casual labourer, unemployed)

'Mental health is so bad for everyone. I am old and tired. But my son is young and he is also tired. There is no work, no hope' – Wavel elderly man (69 years old, married, father)

'If there were work, the mental health situation would be better, especially for the men' – Bourj el-Barajneh woman (31 years old, 6th grade education, shopkeeper in the camp)

8) The context of life in the camps itself was seen as greatly impinging on mental health. A primary contextual issue, particularly relevant to youth, was boredom.

'All the youth are so bored here – what can we do? We can't work, we can't go to school, and we can't leave. So we just sit here' – Bourj el-Barajneh male youth (24 years old, 7th grade education, single, construction worker, casual labourer, unemployed)

'The youth sitting around in the alleys and smoking argileh, that's a problem. If there were work, no one would just sit around like that' – Bourj el-Barajneh woman (43 years old, university education, married, mother, housewife)

'The youth do nothing. They are so bored here and so many of them start hanging out, smoking argileh, smoking hashish. This is the real problem – drugs. Not everyone, of course, but it seems that it's increasing. And women have to deal with this. First, because they are mothers, and of course, they worry – that is natural – about their sons' futures and their health. But also because our society thinks that the behaviours of children reflect upon the mother and are an indication of how good a job she did as a mother. So if your son is doing drugs, then it indirectly means you failed to do something right as a mother. So women have to carry both their own worries and the burden of what people will say about them' – Wavel man (33 years old, 12th grade education and 2 years of university, currently studying nursing, married, father, teacher in Lebanese private school)

'If you're going to talk about free time, it assumes that with the rest of your time you are doing something. But we are doing nothing, and there is no logic in saying that your entire day is just 'free' time. Maybe you can say that we are oppressed by time here, by all this 'free' time, as you call it' – Bourj el-Barajneh male youth (19 years old, 8th grade education, single, construction worker, casual labourer)

'There is really nothing that I do during my 'free' time, because what I mentioned to you is what I do most of the time. Working for me is the exception. So playing cards or watching endless television, that's what I do with my time, not my 'free' time. It's what I do with my life' – Bourj el-Barajneh male youth (23 years old, 9th grade education, single, carpenter, casual labourer)

9) Geographic isolation was mentioned *exclusively* by Wavel interviewees and seemed to be constructed in reference to Beirut – not to the closest city centre (in this case, Ba'albek or Zahle, both of which are closer than Beirut). Nonetheless, most people commented on the distance to Beirut and to the *sea*, when describing the issues associated with geography. The problems associated with geographical isolation are closely linked to lack of educational opportunities in the Beqa'a valley and the social barriers to young women leaving home before marriage to go study in a different city.

'We can't get anything we need here. For everything we want or need, we have to go down to Beirut. Even if we want to have fun. In Beirut, at least, they have the sea in the summer, but here we don't even have the sea. We can go to the rivers sometimes, but you always have to pay money. At the sea, some spots are still free, but it is

too far for us to go from here' – Wavel male youth (23 years old, 12th grade education and vocational training in graphic design, single, freelancer graphic designer, unemployed)

'If we want to continue our education we have to go to Beirut. Here, there are no universities or even such things as technical schools. We are far away from everything' – Wavel male youth (22 years old, 12th grade education, single, student)

'We need to be more educated, even after university. But there are no universities here, we would have to go to Beirut or Damascus and rent a home. And that is not easy, especially for the girls, because even if you have the money most parents won't let their daughters leave to live alone or with friends' – Wavel female youth (16 years old, 7th grade education, single, unemployed)

'There are more problems for the guys, because they want their own lives. They feel trapped here and see Beirut as better. They become so excited when foreigners come because they just want to leave. They would be happy just to leave to Beirut' – Wavel female youth (15 years old, 4th grade education, single, unemployed)

10) Emotional issues, such as loneliness among the elderly and hopelessness for the future were also perceived as important factors affecting mental health.

'Even though my eyes are very bad now, I will keep on crying until I go blind because I can't accept what is happening in Palestine' – Bourj el-Barajneh elderly woman (68 years old, married, mother)

'The elderly are often alone and are left to just think of all the people who have died' – Bourj el-Barajneh elderly woman (70 years old, married, mother)

'There is little hope – what should we hope for? If I think about it, I feel that we must hope for everything – for our homeland, for our rights, for a better future – and what is the meaning of having to hope for everything? It is better to forget about it and just think about today. About working a little bit, buying some food, going over my children's homework.' – Wavel women (31 years old, 10th grade education, married, mother, housewife)

'Sometimes I try to make myself think of the future – but it's hard because we don't even have the certainty of where we are going to be. A poor person somewhere else, a Lebanese poor person for instance – at least he knows he's going to be in Lebanon, in his village. That is certain, and so it's a place to start. But how can I think of what I want to do or what I would like to achieve, when I don't know if I'm going to be in this camp in a week's time?' – Bourj el-Barajneh male youth (20 years old, 7th grade education and vocational training in computer maintenance, single, unemployed)

11) Closely linked to hopelessness is the absence of educational opportunities for youth. In understanding how much of an effect the absence of educational opportunities or the inability to take advantage of them can have on youth's mental health, it is interesting to introduce the concept of *social hope* (Hage lecture 2003). Social hope is partly defined as those social opportunities or routes that provide the possibility of 'going somewhere', whether or not actual physical mobility occurs. This symbolic mobility is everything from actual migration to simply getting educated or finding employment. Hage argues that when symbolic mobility is blocked it can have the equivalent effects as when physical mobility is actually hindered. In the case of these youth, for instance, their physical mobility is theoretically open; but their 'symbolic' mobility is almost completely blocked – and nowhere more poignantly than in terms of education and its supposed benefits.

'What can we do? I am studying but I know that it won't help me. I want to get married, but I see the young men leaving. They leave and we [the girls] stay here. But we have our needs too, we also need to leave this place and find a better life' – Bourj el-Barajneh female youth

'I left school early because I saw my brothers who were educated and were sitting at home watching television all day. And I thought that if that's what education brings you, then why make all the effort? Why face those stupid teachers and put up with their harsh words? It's just better to try and find odd jobs and that's it. Either way, we guys all end up painting and building houses, from the engineer to the guy who only finished second grade' – Bourj el-Barajneh male youth (21 years old, 6th grade education, single, construction worker, casual labourer)

12) The political situation of Palestinian refugees was mentioned as important mainly in terms of creating a permanent sense of instability and uncertainty in people's lives – something that makes planning and future-oriented thinking difficult, while plaguing the present with worries.

'We have no good leaders. Everyone now who claims to be our leaders, they do not care about us. We need someone to give us direction. But there is no one to do this. So we just sit here' – Wavel elderly man (70 years old, married, father)

13) Problems of infrastructure and the environment again emerged as important – generally cited as issues that make life more difficult or less pleasant on a day-to-day basis, and therefore have a wearying effect on people.

14) While many respondents stated that everyone was equally affected in terms of mental health, the one group whose mental health was seen as most vulnerable were youth.

15) Financial solutions to mental health problems were the most common responses – primary among these was the creation of job opportunities. The importance in terms of mental health of giving people, and youth in particular, some sort of job opportunity or some sense of accomplishment cannot be overstated. Youth feel particularly depressed because they are so often *bored* (as was detailed above). Even the desire to emigrate is often framed by the belief that in other countries youth will be able to 'do things', whether this is working, studying, travelling, etc.

16) Supporting people, and especially youth, in achieving what were termed 'small goals' – such as helping someone finish school or helping someone start a small shop – were seen as ways to simultaneously ease mental health problems and provide people with ways of alleviating their economic problems.

'For us here, it would be so useful if we could continue our education. But it's hard, because unless you have some family in Beirut or other places were there are schools, then most families don't have the money to let you rent a house, even a room. So if there could be help, like scholarships, for kids to go then it would let them finish their school' – Wavel female youth (16 years old, 9th grade education, single, student, hairdresser)

'There is such a feeling of insecurity in the camps. If this feeling could just be lessened it would be a very good thing. Just to have a bit of work, or some money, or to finish school. Small differences like this would make a big difference on people's morale' – Bourj el-Barajneh woman (36 years old, 8th grade education, married, mother, housewife)

17) Improving the context of life in the camps was also seen as important for mental health status, especially in terms of social life – something true both for youth and the elderly.

18) It is important to note that there is a marked difference between the two camps in terms of access to the Internet and other forms of clubs and social activities. Bourj el-Barajneh enjoys the presence of more Internet cafes, more NGOs with activities for youth and more sports clubs for young men. In addition, being close to Beirut, access to phone lines and computer equipment stores is easier in Bourj el-Barajneh, and certainly makes setting up Internet cafes simpler. Unlike Wavel, where the few Internet cafes in the camp seem to be male dominated, in Bourj el-Barajneh cafes are divided into those for men exclusively and those where everyone can go

(although this is not official, it seems to be an accepted rule). The ones open to all are crowded with girls chatting and emailing. Camp residents noted that the second *intifada* acted as an important catalyst for general Internet use, while it also help rapidly legitimise female use of the Internet, as many young women were going to get news about Palestine and to chat with people in the Occupied Territory.

'There is this one centre for the guys, but there is nowhere for us [the girls] to go. We don't usually go to the Internet cafes because they are filled with boys, and I feel so shy, but also sometimes the other girls feel that it would be 'haram' for them to go there and that people will start talking about them' – Wavel female youth (19 years old, 9th grade education, single, currently studying hairdressing)

19) An important component of elderly mental health in both camps pertained to the absence of a place for the elderly to congregate, to share their past experiences and spend time together on new activities. While it is true that traditionally in Palestinian society the elderly are held in high regard and taken care of by their sons (usually the oldest), many local NGOs have been noticing a weakening of this traditional network of support. Some suggest that it may be due to: 1) the immigration of large number of males who are then not present to support their ageing parents, often resulting in daughters taking on this responsibilities, which they cannot always meet due to the fact that the may be taking care of their husband's parents, or may no longer be living in the same area; and 2) the financial difficulties many families face, making it difficult – both financially and emotionally – to deal with ageing and often ill parents (Personal communication, Olfat Mahmoud 2004).

'The elderly are always alone. Especially if they can't move well, then they are usually just let to sit at home alone. No one really has time for them anymore. If there were a centre for them, at least they could sit together and talk a bout their own problems, the past. If would be good for them' – Wavel elderly man (73 years old, married, father)

'There are no elderly centres. The elderly have to wait until someone comes to help them in the home, but they are often alone' – Bourj el-Barajneh elderly man (70 years old, married, father)

17) Some camp residents said that nothing could be done to improve mental health. Generally, people had difficulty thinking of practical ways to improve mental health. Over the past five years, there has been a growing feeling of desperation and hopelessness in the camps, with more and more people seeing emigration as the *only* permanent solution to their predicament (Sorvig 2001: 102-104; personal observations). Therefore, the fact that some people were unable to clearly articulate a possible solution or improvement is not surprising. It may simply be a reaction to their current context – for what is the point of trying to change things when everything else is making the situation worse?

XII. HEALTH KNOWLEDGE (TABLE 15)

1) The overwhelming majority of camp residents interviewed felt that health knowledge had improved over the past ten years.

Improved health knowledge

2) While NGO lectures[48] are cited by interviewees as of significant importance in improving health knowledge, what stands out starkly is the fact that most people believe the improvement in health knowledge to be a simple by-product of a more educated community – and not the result of actual efforts to improve it by health care professionals and NGOs.

[48] It should be noted that in addition to NGO lectures, UNRWA celebrates all the international health events in all camps in Lebanon. In each locality there is a 'Camp Health Committee' that meets regularly, and the health education programme at UNRWA clinics is active mainly on issues related to mother and child health and disease prevention and control (Personal Communication, Dr. Jamil I. Yusef 2005).

'The old women used to put ground coffee all over an open wound, thinking that this would help stop the bleeding. Of course it may have reduced bleeding, but it only made the wound worse. Now, no one believes in this anymore and women know how to deal with these things properly' – Bourj el-Barajneh woman (33 years old, 6th grade education, married, mother, housewife)

'The NGOs and PRCS especially really try hard to do good work for this [health knowledge]. But it's still difficult, it's still a big challenge. But they work very hard to get people to come and in the end people do go. They are the main reason why people know more about health' – Wavel woman (38 years old, 9th grade education, single, local NGO director)

3) Despite feeling that health knowledge had improved, the majority of interviewed men felt that it was of little practical consequence given that people's financial situation prevented knowledge from being put into action. Men, therefore, tended to view the improvement in health knowledge in relation to how effectively this knowledge could actually be used, something not mentioned by other groups.

While it is true that for many health issues it would be difficult to actually improve health through knowledge, one of the reasons why camp residents may not integrate health knowledge into their lives is because few professional health educators have worked in the camps consistently – and also because there has been little effort to try and devise solutions that would be effective in the camp context.

'Knowledge has improved but people don't have the tools to improve their actual health. People know that they should eat good foods, but they don't have the money to do this' – Bourj el-Barajneh man (43 years old, 12th grade education and vocational training in finances/accounting, married, father, financial supervisor for local NGOs)

4) Men also felt that lectures – one of the main vehicles of health education – were neither structured to integrate men nor addressed health issues of concern to men. Indeed, very little has been done by NGOs and others to include men as an integral part of health education programmes in the camps. Perhaps this is because few people see men and young males particularly as a vulnerable group – something most often reserved for women and children. In the specific context of the camps, however, serious consideration needs to be given to this issue, as men may be *equally or more* vulnerable than women. There are large social networks that women have access to – networks of support, whether from family, friends or other women in their neighbourhoods. These networks give them financial, emotional and social support when they need it, and women draw upon these various networks continuously both for themselves and for their families. The investment in these relationships gives women both an actual sense of security, but also a sense of belonging and of active engagement with others that can be an immense protective factor for health and mental well being. Men, on the other hand, have none of these networks among themselves. Certainly, their family and friends will help them financially or with any problems they may have, but it would be hard to argue that men have any networks paralleling those of women. Because of the social role ascribed to men that defines them as strong, independent and responsible for their families, they are often isolated and left alone to deal with their problems. They have almost no idioms of distress available to them, which would allow for the legitimate cultural expression of depression, sadness or illness. Most times, men tend to withdraw into themselves and away from their families as a coping mechanism. However, this tends to add to their stress rather than help them in the long term.

'None of the men go to the lectures, even though the NGOs sometimes try to get us to come. But there is no man who will go with the women especially. It's difficult because often also most of the lectures are about children or about women's problems, so it's not really relevant to men. Or at least, the men don't see it as important for them. And also, I think that for most men, to go to a health lecture can come off as being too interested in your health. You know men here have to act careless about themselves, that is how we should be. Socially we are supposed to be strong and uncomplaining'' – Wavel man (29 years old, 8th grade education, married, father, internet shop owner in camp)

5) In general, the elderly felt that improved health knowledge was something that did not relate to their needs, explaining that health knoweldge had improved only for the younger generations. In addition, the elderly also noted that they were not being targeted by health education programmes.

'Health knowledge has improved fore the young. But the people who organise lectures don't really invite the elderly. I personally don't go' – Wavel elderly woman (77 years old, married, mother)

The elderly also expressed the feeling that although knowledge had improved, life itself – and health – had not necessarily followed suit.

For the elderly, improved health knowledge was also linked to larger changes in camp life and increased diversity of opinions, which were seen as possibly fracturing the community. As such, increased health knowledge was not necessarily seen as a *wholly* positive development. The elderly tended to emphasise *quality of life* rather than increased health knowledge or access to health services.

'There is more knowledge now, but in the past there were none of these diseases. We depended on G-d only, people loved each other. Neighbours used to help one another. Children ate healthy foods, none of these sandwiches. Even in religion, things were simpler. We just prayed and were not troubled by all of these different opinions from sheikhs' – Bourj el-Barajneh elderly woman (70 years old, married, mother)

In addition, most elderly did not see the benefit of their going to a health lecture. They tended to see themselves in a stage of the life cycle where illness was the norm and health a privilege. Thus preventive health options such as health education seemed superfluous and in many ways as inevitably doomed to failure.

'Most elderly just refuse to go to lectures, they just think – ok I have a disease, now I won't be well again' – Bourj el-Barajneh elderly woman (57 years old, 5th grade education, widowed, mother)

'People just go to the doctor. They don't care to do things themselves. It's easier to just get some medication and let that work rather than changing things or going to lectures. It's easier. And because it works most of the time, it's difficult to make people believe that they should go to a lecture or do something about their health' – Wavel elderly woman (84 years old, widowed, mother)

Lack of improvement in health knowledge

6) Youth reports contrast to all other groups in maintaining that health knowledge has remained essentially the same over the past 10 years. Perhaps this is because of youth's future oriented, rather than past oriented perspective. Unlike the elderly and the middle aged, who might compare current health knowledge to the little understanding people used to have, youth may tend to compare things to an idealised image of what the present ought to be. In addition, perhaps because they are young, their stage in the life cycle may preclude youth having a perspective over time.

In addition, youth tended to report more traditional causal explanations about death and suffering, such as the evil eye, as evidence for the lack of improvement in health knowledge. Health education seemed to be understood more as a *disproval* of faulty medical ideas, rather than a refinement of previously held understandings about health.

'Health knowledge hasn't changed. People didn't improve. They don't care about improving it. If they had improved their knowledge, then there wouldn't be as many problems. But people just prefer to go to the doctor when the are ill' – Bourj el-Barajneh male youth (24 years old, 8th grade education, single, construction worker, casual labourer)

'Even if I say that people's health knowledge has improved, this doesn't mean that it's good. People still don't know very much. They still believe in old ideas or that people get sick or die from the evil eye' – Bourj el-Barajneh female youth (22 years old, 9th grade education, single, secretary for local NGO)

Health knowledge also does not seem to be a major concern for young people, as it seems that finding work is of primary importance.

'I know about the lectures, all the guys do, but we don't go. We are not interested. We all smoke a lot even when we know it's not healthy. I say this honestly, even now that we are talking about it, I am not going to leave and go to some lecture. It's just not a problem for me right now. I want to work' – Wavel male youth (22 years old, 9th grade education, single, furniture painter, casual labourer)

7) Young women expressed the feeling that, in their particular case, health knowledge was often *withheld* on the grounds of social mores. Unlike young men, who may have more friends knowledgeable about sexuality and who do have more access to media, Beirut city life, etc., the young women expressed feelings of isolation and imposed ignorance. Their frustration at not being able to learn basic information from either their parents or their school was evident.

'Even if people want to learn, there are very few opportunities. There are some lectures, but really not many. And even at school, they limit what we can learn. They removed the part in biology on sexual reproduction – even in animals- because they feel that it is inappropriate. So even if we have simple questions, we can't ask them at school. Especially about our bodies as girls. And even with our mothers it's difficult. It's not just about this subject, but in general it's hard to get good information about health' – Wavel female youth (16 years old, 7th grade education, single, unemployed)

Perceptions of Birth Rates[49] and Birthing Locations

XVI. CHANGES IN BIRTH RATE OVER THE PAST 10 YEARS (TABLE 16)

1) Opinions about an increase or decrease in birth rate over the past ten years were almost evenly split. Some camp residents suggested that this may be because the more dramatic changes in birth rate in the camps occurred over a longer period of time: for instance, if the question had been phrased 'over the past 20 or 30 years', more people may have said that the birth rate had decreased. A number of NGO workers also agreed with this, saying that an important decrease in birth rate in most (but not all) camps can be noticed when comparing to the 1960s and 1970s.

UNRWA date suggests that the fertility rate[50] for Palestinian refugees in general has declined (following the trend in the host countries), with the rate in the Lebanon field falling from 3.8 in 1995 to 2.5 in 2000/2003 (UNRWA 2003). In addition, UNRWA records show that the mean birth interval (in months) among the camps in Lebanon is 43 months – the longest birth interval of all UNRWA fields of operation (UNRWA 2003), something that also contributes to the increased survival of infants, which dropped to a figure significantly below that of Lebanon: 19.2 and 26 per 1000 live births, respectively (Personal communication, Dr. Jamil I. Yusef 2005). All this certainly seems to support the perception that birth rates have dropped.

2) Mentioned mainly by women, the reference to Palestine was more precisely a reference to the then ongoing second *intifada*. This may suggest that the perceived rise in birth rate may be a recent rather than gradual occurrence. It is difficult to gauge the veracity of this causal link, but it cannot be discounted as an

[49] Birth rate as used in the interviews was understood to be just the total number of children born and whether this had increased or decreased. Technically, birth rate is defined as the number of live births yearly per 1, 000 population.
[50] Number of live births yearly per 1, 000 women aged between 15 – 44 years.

incentive or *motivating factor* to have another child. In addition, the general stance of Palestinian society has been a pro-natalist one (Giacaman, personal communication 2004), linking reproduction to the survival of the Palestinian people, although this stance in and of itself is not the only factor influencing fertility decisions.

'We have the right as Palestinians to have more kids' – Wavel woman (38 years old, 8th grade education, married, mother, housewife)

3) Lack of knowledge was also perceived as an equally important factor in the increase in birth rate, and interestingly, one only mentioned by women. A number of the younger married women interviewed felt that increased birth rate was a negative thing, not because having many children was generally thought to be bad, but because given the current economic situation in the camps, they felt that it was irresponsible to have many children when affordable and safe methods of birth control were available.

'Some of the women here feel that just because we are Palestinian and there is a war with Israel, then we should have many children, regardless of what their future will be like or even if we have the means to support them. Most of them have husbands who aren't working and who have to borrow money to feed their families – and they want more children? It is so ignorant to act this way.' – Bourj el-Barajneh women (37 years old, 6th grade education, married, mother, housewife)

'Many people feel that having boys is still the most important thing – even though nowadays having boys doesn't really help you more than having girls. In the end, the elderly are often taken care of by their daughters, since their sons leave for abroad and never come back. But people still have this old idea and they are willing to have six girls only to get one boy if necessary – and in the end they don't even know how they will take care of everyone.' – Wavel woman (35 years old, 8th grade, married, mother, housewife)

4) Economic situation

While it seems logical that financial difficulties might lead to a decrease in birth rate, in many other contexts poverty and high birth rate often seem to go hand in hand. However, in the camps there is one factor that seems to play a major role in facilitating a decrease in birth rate (whatever the initial push factor): easy and free access to a variety of birth control methods – from the pill to IUDs and condoms. Family planning was introduced by UNRWA in 1993 (Personal communication Dr. Yusef, UNRWA 2004), and is widely used in the camps, with 776 women in Bourj el-Barajneh and 172 women in Wavel using some method of contraception (UNRWA 2003). UNRWA records show that among the women who use the UNRWA Mother and Cihldcare Programme in Lebanon, 64.7 % are using some contraceptive method – the second highest use of contraceptives in UNRWA's fields of operation (UNRWA 2003) among this female population.

Despite the obvious success of UNRWA's family planning progrogramme, the fact that the majority of people who felt the birth rate had decreased attributed this to the economic situation exclusively is indicative of the little impact that family planning is perceived to have *independently* from the economic factor.

'If my economic situation were better, I would have ten kids!' – Wavel man (37 years old, 10th grade education, married, father, construction worker, casual labourer)

5) Emigration

Although not mentioned by many interviewees, emigration as a reason for decreased population is often mentioned in relation to Wavel camp – both by camp residents themselves, as well as outside observers. It is difficult to say if emigration from this camp is acutally higher than that from other camps; perhaps because it is such a small camp, emigration has a more visible impact than in larger camps.

'There are so many people from this camp [Wavel] outside – more than from any other camp. It is like a tradition here, and every summer the boys and girls outside come back to find someone to marry here. Each summer so many people leave this way. If people meet a foreigner, for sure they will think that this person is here to marry' – Wavel man (29 years old, 8th grade education, married, father, internet shop owner in camp)

XVII. MAIN PERCEIVED BIRTHING LOCATIONS (TABLE 17)

1) A majority of interviewees said that most births took place at midwife clinics – a third of the interviewees who felt this way were from Wavel camp. This may reflect the absence of easily accessible hospital services in Wavel as opposed to Bourj el-Barajneh. Nonetheless, in both camps these perceptions indicate that a significant number of women still give birth with midwives attending.

2) Hospital births were overwhelmingly mentioned by Bourj el-Barajneh residents. This is most easily explained by the presence of the PRCS hospital in the camp that has a very good maternity ward which is of easy access and generally affordable. As there is no hospital in Wavel camp and as UNRWA only covers hospital fees for births classified as 'at risk'[51], all other hospital births would have to take place in Lebanese hospitals in nearby Ba'albek (and at camp residents' personal costs), and this may account for the perception in Wavel that hospital births are not the norm.

2) Home births with a midwife in attendance were *exclusively* mentioned in Wavel. Again, this is most probably due to the fewer services available in Wavel, and the absence of a PRCS hospital. Nonetheless, what is important to notice is that even in Wavel, home births are seen as taking place with the presence of a trained midwife.

3) Perceptions about main birthing locations were mediated by opinions on conservativism and morality and the belief in the 'superiority' of hospital birthing.

'Some husbands prefer to send their wives to the hospital and even to male doctors believing that they are more qualified and more professional than even the trained midwives. While this isn't necessarily the case, a lot of men think this way' – Bourj el-Barajneh man (38 years old, 10th grade education, married, father, driver)

'Some women don't like going to the hospital very much because there are so many people there, and a lot of men. They feel more comfortable going to the midwife clinic. It is more private and more relaxing' – Bourj el-Barajneh woman (25 years old, 7th grade education, married, mother, housewife)

'I am scared of the midwife clinic, it doesn't have all the necessary equipment and I feel safer in the hospital. Many women prefer the hospital because they feel it's safer, but some also ask the midwife to be in attendance at the hospital birth' – Bourj el-Barajneh woman (37 years old, 6th grade education, married, mother, housewife)

MEDICAL PERSONNEL SEMI-STRUCTURED INTERVIEW FINDINGS[52]

Baseline Information on Consultations and Medical Problems

I. NUMBER OF *DAILY* CONSULTATIONS DONE BY MEDICAL PERSONNEL (TABLE 18)

1) The majority of medical personnel said that they conducted between 10 – 20 *daily* consultations.

[51] This classification is made in accordance with well-established criteria (Personal communication, Dr. Jamil I. Yusef 2005).
[52] All questions were open-ended and did not offer options; all options in the tables are taken from the answers of interviewees themselves and were coded in this way for analytical convenience. See Annex IV for tables.

2) The two UNRWA doctors by far had the highest number of consultations, both stating that they conducted between 50 – 100 *daily* consultations. This confirms UNRWA records, which indicate that the average daily number of consultations for UNRWA doctors in Lebanon is 89 patients (UNRWA 2003).

II. REASONS FOR PEOPLE CONSULTING MEDICAL PERSONNEL OVER THE PAST YEAR 2003-2004 (TABLE 19)

As with the camp residents, medical personnel stated that chronic diseases and respiratory ailments were the main reasons for patient consultations.

III. AVERAGE LIFE EXPECTANCY (IN YEARS) ACCORDING TO MEDICAL PERSONNEL (TABLE 20)

1) Most medical personnel placed the average life expectancy at birth at between 55 – 65 years of age, with 65 years being the most likely average.

2) The highest life expectancy suggested was 85 years. The lowest life expectancy suggested was 55 years.

Perceptions of Health and Illness in the Camps

IV. CHANGES IN THE LEVEL OF HEALTH (TABLE 21)

In stark contrast to camp residents, most medical personnel felt that health had improved over the past ten years.

Improvement in health

1) The medical personnel who felt that health had improved focused on increased service provision and on the fact that camp residents tended to be more educated generally, thus influencing health status positively.

'It [health] is better now. There are two ultrasounds in the camp, and there are a few specialised doctors who weren't here before. Also, there are some medical lectures, and also there are computers and satellite television, so people can watch health shows or just be more aware of things that can affect their health' – Wavel private doctor (gynaecologist, trained in Moscow, runs her own private clinic in the camp)

'Health is much better now. People forget the number of diseases there used to be that are no longer a real issue. They used to have to worry about so many different problems – TB, measles, etc. Now these are very rare, and even though there are cancers and diabetes and such, still health has generally improved in the camps. But given the current pressures on people and the reduced funding, it may start to deteriorate again' – Bourj el-Barajneh PRCS nurse (trained at PRCS in Lebanon)

'Health is better – there are more services and many new medicines that didn't exist before. Generally medicine has improved and even if we are limited, this still has an impact here in the camps' – Wavel PRCS doctor (orthopaedic surgeon, trained in Syria and Germany)

Deterioration in health

3) Psychological distress was mentioned by some medical personnel, who felt that psychosomatic disorders had increased in the past ten years, causing a deterioration in health.

'The same number of people comes as did ten years ago, but now there are fewer infectious diseases. But maybe people think that there are more diseases and that their health is worse because there are many more psychosomatic manifestations and problems now than there were ten years ago. So maybe people feel that they need to consult more often, or just generally feel sicker now. There are many people who come to see me complaining of pain all over but they have no physical problem' – Bourj el-Barajneh UNRWA doctor (general practitioner, trained in Spain)

4) The economic situation was seen as having caused a deterioration in health quite *recently*, rather than gradually over ten years.

'If you're only going to compare this precise moment to ten years ago, then maybe you are justified in thinking that the level of health has improved. It was after the war then, and there were so many health problems that are just not present right now. Even though the camp is crowded and has many problems, it is much better than it was at the end of the war. So in that sense maybe it's better. But for me, I also look at what is happening now – health is deteriorating now, even if it's better than it was ten years ago. And maybe in a few years it will be worse than it was even during the war. There is so little funding, the economic situation is getting worse so people can't even go to other service providers' – Bourj el-Barajneh PRCS doctor (surgeon, trained in Romania)

V. MAIN CAUSES OF DEATH (TABLE 22)

1) As with camp residents, doctors stated that chronic diseases were the main causes of death.

2) However, most medical personnel noted that the perceived increase in cancer and heart disease may be linked to the dramatic decline of infectious diseases.

'Now most of the deaths are from cancer and cardiac problems, but there were cancer and heart problems before as well. The only difference is that before people used to die from everything – from typhus and measles, and the war of course. People did not always have the chance to reach the stage in their life where cardiac complications might be a problem. Now, medicine has provided the means of dealing with most of these 'smaller' problems – contagious diseases – that used to be quite deadly, especially in the context of the camps and their living conditions. Now people only die from more serious illnesses. Perhaps that's why they think that there has been an increase in cancer and heart disease – because now they see mainly these diseases and they have forgotten that in the past children used to die from influenza and measles' – Wavel PRCS doctor (orthopaedic surgeon, trained in Syria and Germany)

While it seems to be true that infectious diseases have declined dramatically and are well under control (UNRWA 2003), UNRWA also suggests that, based on the number of cancer patients who attend UNRWA clinics, there is sufficient evidence to support the hypothesis that there is an increased incidence of cancer, particularly 'malignant neoplasms especially leukemia, cancers of the lung, breast and cervix' (UNRWA 2003).

IV. MOST PRESSING HEALTH PROBLEM (TABLE 23)

As with camp residents, medical personnel stated that seasonal and environmental ailments, chronic disease and respiratory problems were the most pressing health problems in the camps.

V. SUGGESTIONS TO IMPROVE HEALTH IN THE CAMP (TABLE 24)

1) Financial solutions to the problem of health were singled out by medical personnel, as they were with camp residents.

2) However, just as many medical personnel spoke of another way of improving health that was *not* broached by camp residents – health education.

a. The importance of health education was brought up generally. [53]

'Health education is the most important problem and solution. I'll tell you that health education is more important even than medication. Let me explain. Take this case here that the nurse just came in to discuss with me. The patient is a diabetic and he has a foot ulcer. He must take insulin and he is refusing because he thinks that it will kill him. Now what are we supposed to do? We don't even have enough staff here, so if someone leaves it means that those who stay have even more work. But because it's an emergency I will send a nurse to his house now to try and talk to him and convince him' – Bourj el-Barajneh UNRWA doctor (general practitioner, trained in Spain)

b. Health education was also cited as important in relation to women's health, early pregnancy and family planning.

'Younger marriages are increasing, and in general the marriage age is around 18 or 19. Most girls, even though their mothers do help, still don't know how to properly take care of a child, and sometimes a lot of problems come from this lack of knowledge. And not only when the child is very young, it's also about the mother's impact on a child's nutrition and general health as he is growing up' – Bourj el-Barajneh PRCS doctor (general practitioner, trained in Bulgaria)

'People like to have big families still, they think of the past war and the current [al-Aqsa] intifada, and of who will take care of them when they are old. A lot of women use pills or condoms now, but mainly because the economic conditions are so hard for them that they simply can't have kids. But if they didn't have this problem, the UNRWA [family planning] programme wouldn't be as successful as it is now. People use the pill, from the women I see and talk to, generally for birth spacing, and not to actually reduce the sizes of their families. Of course, if there is greater time between each birth, a woman will naturally and automatically reduce the number of children she will probably have – but this is not her intention' – Bourj el-Barajneh midwife (professional midwife, trained at Lebanese institute in Sour)

VI. MENTAL HEALTH (TABLES 25 & 26)

1) As with camp residents, the majority of medical personnel felt that mental health was in a bad state among camp residents.

2) Economic factors were cited as the primary determinant of mental health problems, again confirming the views of camp residents.

3) Similarly to camp residents, medical personnel generally felt that everyone was equally affected by mental health problems, with equal numbers citing women, men and youth.

4) Unlike camp residents, however, there was no particular importance attributed by medical personnel to youth in terms of vulnerability to mental health problems. UNRWA suggests that this may be related to the

[53] UNRWA states that, while health education is an important factor in promoting healthy life style practices, yet admits that population-based interventions that focus on reduction of the main risk factors are beyond its capabilities, and would be better achieved through either enrichment of the school curricula or promotion of primary intervention through Lebanese mass media (Personal communication, Dr. Jamil I. Yusef 2005).

fact that some mental health problems among youth may be detected in schools, and also that when youth consult they often do so with psychosomatic problems rather than pure mental or psychiatric complaints – this may cause some mental health problems to remain undetected (Personal communication, Dr. Jamil I. Yusef 2005).

5) Again unlike camp residents, political solutions were seen as particularly important in resolving problems of mental health. In fact, many medical personnel felt that nothing could really be done to improve mental health significantly in the current political context and that therefore suggestions such as activities for youth were only temporary band-aids and not long term solutions.

6) Medical personnel suggested that health education be provided to both camp residents – in terms of coping strategies for psychological distress – and to medical personnel – in terms of workshops on how to handle patients with mental health problems.

VII. HEALTH KNOWLEDGE (TABLE 27)

1) The majority of medical personnel felt that health knowledge among camp residents had improved over the past ten years.

2) Medical personnel held opinions similar to those of camp residents, stating that NGO lecture and a generally higher level of education were largely responsible for the improvement in health knowledge.

Perceptions of Birth Rates and Birthing Locations

VIII. BIRTH RATE (TABLE 28)

1) Again replicating the pattern among camp residents, medical personnel were almost evenly split in terms of whether the birth rate had increased or decreased.

2) Economic constraints again emerged as an extremely important limiting factor on the birth rate in the camps.

3) Nonetheless, a few medical personnel also highlighted the importance of family planning (independently of the economic situation) in the decline in the birth rate.

IX. MAIN PERCEIVED BIRTHING LOCATIONS (TABLE 29)

1) Unlike camp residents, *all* medical personnel stated that births generally take place in hospitals. This lends support to UNRWA data that indicates that of the women who visit UNRWA clinics, 96.1 % delivery in hospitals (Personal communication, Dr. Jamil I. Yusef 2005).

2) Just over half the medical personnel stated that as a *second choice*, some women sought childbirth care at the midwife clinic.

3) No medical personnel other than the midwife in Bourj el-Barajneh alluded to hospital births with a midwife in attendance or to the issue of high rates of caesarean sections in hospitals.

'The veiled women often prefer to come to me because there are so many people in the obstetrics department at the hospital – men and women. So they feel more comfortable there. Others are scared and prefer to go to the hospital, but many times women ask me to be present during the birth even if it's at the hospital. Other women

prefer to come to my clinic because they feel that in the hospital the doctors aren't patient and resort to caesarean sections too quickly. For the first child, they usually allow a maximum wait of 24 hours, while for each subsequent child they only allow for 8 hours. So some women prefer to come here and wait until they deliver naturally. Of course, if a caesarean section is needed, I send them to the hospital right away' – Bourj el-Barajneh midwife (professional midwife, trained at Lebanese institute in Sour)

SUMMARY, DISCUSSION AND CONCLUDING REMARKS

Trying to assess health through perceptions of health and health services in the camps is a challenge. Many past studies have taken broader approaches to some of the questions discussed in this paper, but almost never from the exclusive point of view of camp residents and the medical personnel servicing them.

In trying to determine the main health issues in Bourj el-Barajneh and Wavel, we opted to seek clarity on a variety of health issues by asking residents and medical personnel their views. In addition, this study sought to highlight possible differences in perceptions across gender, age and camps. The cross-camp difference was of particular concern, as it has been elicited by camp NGOs as important, but has been consistently sidelined in previous health studies.

Important similarities in the findings

The most important reason for seeking medical consultations in the camps was respiratory ailments and ENT problems – particularly because these cut across gender and age lines. The continued presence of certain communicable diseases is corroborated by UNRWA records, which indicate that many problems associated with the environmental conditions in the camps, such as typhoid fevers, intestinal and respiratory problems are still largely present (UNRWA 2004).

The main chronic diseases for which people consulted were hypertension and heart problems, something corroborated by UNRWA records that indicate that there is a high incidence of hypertension and chronic diseases in the Palestinian refugee population generally (not only in the Lebanon field) – patients suffering from hypertension and who are being treated at UNRWA clinics make up 7.9 % of the refugee population 40 years and above (UNRWA 2003).

All but two of the 80 camp residents interviewed felt that health had deteriorated over the past ten years, with environmental conditions and the economic situation cited as the most important factors in this deterioration. Many camp residents and medical personnel stated that the deterioration in health was a *recent* rather than *gradual* occurrence, indicating that the factors adversely affecting health may be due to developments in the last few years rather than over a longer period of time. Certainly, economic conditions in the camps and in Lebanon have been rapidly declining in the past five years (personal observations), and this most probably has had an impact on people's ability to pay for needed treatments and medications – something which may have caused health to deteriorate rapidly.

Chronic diseases were seen as the leading cause of death, with cancer being singled out as most deadly. Some medical personnel suggested that this perceived increase in cancer may not be real, but simply the reflection of an extraordinary decline in infectious diseases. Nonetheless, UNRWA records suggest that there has been an actual increase in the incidence of certain types of cancers (UNRWA 2003).

While the most pressing *group* of health problems were seasonal and environmental ones such as poor water quality, unhealthy homes and general environmental conditions, the *single* most urgent problem identified by the interviewees was diabetes. Diabetes may be seen as particularly problematic because it affects a large segment of the population and because of its chronicity. UNRWA records support the impression

that diabetes is an issue of critical concern – the diabetic patients under UNRWA supervision represent 5.2 % of the Palestinian refugee population generally (not only in the Lebanon field) (UNRWA 2003).

The main suggestions to improve health in the camps were financial, with the funding of *existing* healthcare providers (UNRWA and PRCS) being highlighted as crucial.

Most interviewees also felt that the mental health of the camp population was in a bad state and that the factor most adversely affecting mental health status was the economic situation. Camp residents felt that youth were the most vulnerable group in terms of mental health because they are affected by current problems and stresses associated with the economic situation, while they also have little hope for the future in terms of either education or work. While a variety of suggestions were put forth to improve mental health, the ones that stood out were creating employment opportunities and helping people achieve small goals (such as finishing school).

Overall, perceptions of whether the birth rate had increased or decreased over the past ten years were evenly split. This similarity in opinion may in part be due to the explanation offered by some camp residents (in both camps) that the second *intifada* encouraged what may be a *temporary* increase in births. For those who felt the birth rate had decreased the single most important factor was the economic situation, not the availability of contraceptive methods, although it was acknowledged that contraceptive availability made birth spacing feasible and effective.

Most camp residents felt that births usually take place at a midwife's clinic – a third of these respondents live in Wavel.

The average life expectancy at birth was placed by a majority of medical personnel at between 55 – 65 years. The average life expectancy at birth for Lebanon for the years 2000-2005 was estimated at 73.5 years[54], making the perceived range in the camps slightly below that of the general population (ESCWA 2004 source DESA 2002). Nonetheless, the particularly harsh living conditions in the camps, coupled with the extensive wartime attacks directed with particular ferocity at the camps, can partially explain the shorter life expectancy perceived by medical personnel.

The problem of maternal and infant mortality was never mentioned as problematic by any of the camp residents. Most camp residents felt that the health service providers (particularly UNRWA and PRCS) were particularly adept and capable of dealing with maternal health and birthing. Not one camp resident perceived the issue to be problematic or pressing. This may in large part be due to the fact that the rate of maternal mortality in the camps in Lebanon seems low, with UNRWA stating that of the total 16 maternal deaths reported from its fields of operation in 2003, *none* were from Lebanon (UNRWA 2003: 56). In addition, hospitalisations for problems related to pregnancy, childbirth and puerperium[55] were the lowest of any UNRWA field (14.6 % as compared to 27.2 % in Syria) (UNRWA 2003: 36).

The question of infant mortality was also not perceived as important. This may be due to the fact that infant, early child (under 3 years of age) and neonatal mortality rates have *all* dropped significantly in Lebanon between 1997 and 2003: infant (37 to 20.2 per 1,000 live births), early child (35 to 19.2 per 1,000 live births) and neonatal (26 to 15 per 1,000 live births) (UNRWA 2003: 61). In fact, UNRWA statistics show that the neonatal mortality rate in Lebanon experienced the greatest decline of any field between 1997 and 2003 (UNRWA 2003: 61) – a development which has most probably influenced camp residents' perceptions of the problem. Given this low rate of incidence, it may be that camp residents do not perceive these to be generalised problems of pressing concern,

[54] The WHO estimates for the average life expectancy of the Lebanese population at birth are 67.6 years for males and 72.0 years for females – also higher than the estimates provided by medical personnel on life expectancy among the Palestinian refugee population in Lebanon (Personal communication, Dr. Jamil I. Yusef 2005).
The average life expectancy at birth for Palestine (West Bank and Gaza Strip) for the years 2000-2005 is estimated at 72.4 years (ESCWA 2004 source DESA 2002).

[55] Puerperium is the time immediately after the birth of a baby.

as compared with other causes of death (Personal communication, Dr. Jamil I. Yusef 2005). Nonetheless, UNRWA statistics do indicate that the main causes of infant mortality have shifted from infectious diseases, to low birth weight/prematurity and congenital malformations (UNRWA 2003: 59).

The question of disabilities was also not highlighted as particularly important or urgent by any of the camp residents or medical personnel. In terms of this issue, it is to be noted that none of the camp residents or medical personnel interviewed had a direct family member who was disabled, and this may in part account for why this issue was not highlighted. In addition, disability may not be perceived as a *widespread* and *common* problem; the rate of disability over all the Palestinian camps and gatherings in Lebanon is estimated at 2.3 %[56] of the total population (El-Madi 2003: 1) – and while this may not be low as even in Palestine the rate is between 1.8 – 2 % (Personal communication, Rita Giacaman 2005), it may be that there is a low level of awareness in the camps on the importance of including the disabled. In addition, the fact that disability is not *contracted* in the way that influenza or stomach problems might are, may also affect the extent to which it is perceived to be an urgent health issue.

Important differences in the findings

Men had a greater tendency than either women or elderly to access healthcare services other than UNRWA or PRCS. In the case of UNRWA, this is explained by the fact that more women seem to access its services (perhaps due to specialised programmes for women and children such as the Mother and Childcare and Family Planning Programmes), an observation supported by UNRWA (UNRWA 2003).

Far fewer Wavel residents seemed to access PRCS services and many highlighted the problem of PRCS fees with greater vigour than residents in Bourj el-Barajneh, indicating a possibly harsher economic context in the Beqa'a region than in Beirut. In addition, PRCS fees and the limited services the clinic offers in Wavel seem to greatly reduce the number of people who feel that PRCS services are worth accessing.

Generally, Bourj el-Barajneh residents felt that despite evident gaps in health service provision, the basic infrastructure of hospital, clinics and medical personnel is solid – the main need is to improve and build upon the skeleton structure that is already in place. On the other hand, Wavel residents felt that there was a dearth in health service provision and that new infrastructure was needed as a prerequisite to improving the health situation – enlarging the PRCS clinic, opening a night clinic in the camp, building a hospital, etc. Therefore, there is a perceived need for health infrastructure development in Wavel that is not evident in Bourj el-Barajneh.

In stark contrast to camp residents, most medical personnel stated that health had improved over the past ten years, mainly due to increased service provision and a better general education among the refugee population.

The problem of poor water quality was repeatedly and *exclusively* mentioned in the case of Wavel, indicating that this is the most serious environmental health issue in the camp – a problem that did not emerge with any sense of urgency in Bourj el-Barajneh. Indeed, camp residents and local NGOs attest to the fact that there are regular calls from the local mosque *not* to drink the water because it is contaminated. And UNRWA's sewerage renewal project in the camp in 2004 (personal observations) certainly indicates that water cleanliness and quality most probably was a problem in the camp that needed to be addressed.

Unhealthy homes were also a problem *predominantly* in Wavel. This is most likely linked to the smaller houses in the camp, the colder winters in the Beqa'a valley and the presence of the old French army barracks that according to many camp residents are near to collapse.

[56] This rate, while high, corresponds well with the overall rate of disability in Lebanon, which stands at between 1.5 % UNDP 2002 in Thomas and Lakkis 2003: 12) and 4.0 % (Thomas and Lakkis 2003: 2).

The importance of health education in improving health was identified exclusively by medical personnel, perhaps indicating that many people are frustrated by their actual *inability* to improve health, despite their acknowledgement that health knowledge has improved in part due to NGO work in health education. This should raise the question to service providers of the utility of health education measures that people cannot implement because of contextual reasons, and indicates that more effort needs to be put into working towards identifying realisable options for people who continue to live under very difficult living conditions.

The effect of geographic isolation on mental health was mentioned *exclusively* by Wavel residents, and was constructed in reference to Beirut. While other city centres are *nearer* – such as Ba'albek and Zahle – this tendency to measure isolation with reference to Beirut is common in Lebanon (personal observations), and as Ba'albek and Zahle are much smaller than Beirut, it is not strange that Wavel residents look to Beirut in their sense of geographic isolation. In addition, the presence in Beirut of more work opportunities, schools, universities, etc. is also an important factor that may contribute to the interviewees' perception of Beirut as the reference point in relation to which isolation is determined.

Hospital births were overwhelmingly mentioned in Bourj el-Barajneh, most probably a result of the presence of a PRCS hospital in the camp.

All medical personnel felt that births generally take place in hospitals, in great contrast to camp residents, who felt that a large number of births still take place outside of the hospital structure. This may indicate that medical personnel at UNRWA and PRCS do not have easy communication with midwife clinics in or near the camps, and therefore are not aware of how many births take place there. Nonetheless, it is to be noted that all camp residents who spoke of births at midwife clinics stated that these were *trained* midwives – not traditional birthing assistants that were formerly responsible for most births in the camps (Personal communication, Bourj el-Barajneh camp residents 2003).

Overall, the findings of this initial study indicate that there are both differences and similarities in perceptions of health and access to medical and health care across gender, generation and camp lines. Most people identified similar problems, indicating that there may be general agreement on issues such as main health problems, mental health, service providers, etc. However, there are important nuances in the data that suggest that for interventions and research to be accurate, differences in age, gender and camp locations do have to be borne in mind. It is not so much that people disagree with one another, but rather that certain *specificities* pertaining to one particular population group or camp may have important consequences if overlooked.

The extent to which one would have to bear these particulars in mind would depend on the nature of the study or intervention being undertaken. However this study indicates that general health studies would not be able to identify the extent and urgency of particular problems in specific camps, and that assessing needs, community by community, may well be what is required in order to address the specific health problems and needs of camps with different contexts.

DISCUSSION AND CONCLUDING RECOMMENDATIONS

Health among camp residents

Camp residents' perceptions of heath seem to be a combination of the biomedical disease framework – with references to cancer, diabetes, etc. – combined with a broader definition of health and disease that incorporates ailments related to their social suffering, especially in the areas of mental health. Health is intimately linked to the social domain, and often, narratives gathered in this study, combined disease experiences with the social and political domains of Palestinian refugee life. Discourse around health, then, should be seen as a gauge not only for actual and diagnosed disease, but also for broader societal concerns and needs that determine health and disease

status. A corollary to this is that health interventions can often be interpreted through the prism of the social and the political, thereby giving a health intervention of seemingly little social meaning to an outsider, a great deal of importance to those affected.

Not only discourse, but also action, is a measure of broader concerns. As was previously mentioned, the extent to which people acted on knowledge of ill health was measured on a scale of *life* and not *health* priorities. People do not disassociate health from life, and therefore actions that affect health are not undertaken in a vacuum – the woman who did not remove shrapnel lodged in her chest for fear of scarring and how this might affect her chances for marriage is but one example of a wider pattern. Health issues such as smoking, birth control, early marriage and nutrition, then, are all intertwined with and affected by other life concerns. In addition, what constitutes health and illness in the local context will also affect what *actions* people do or do not take in order to ensure health. In the camps, it often seems that to if one is well enough to work and to fulfil basic *social* obligations then one is *healthy*. Being ill is therefore not necessarily defined as being actually *physically ill*, as one may be sick (suffering from chronic back pain or from diabetes, for instance) and still be able to do what is expected of them socially. In such a context, then, where health is defined in *social* terms, thoughts about *improving* only and exclusively biological health are not often entertained. Rather, people link their individual well-being to that of their community and social world. Being a successful *social* individual is the prime definition of health, not actual physically fitness or presence/absence of illness.

Research priorities

While UNRWA provides basic and important statistics on incidence of diabetes and hypertension, as well as many other communicable diseases (such as tuberculosis, typhoid fever, meningitis, etc.) (UNRWA 2003), it also maintains that there are currently no data on the incidence of cancer. However, its clinics' records attest to an increased incidence of cancer in the general Palestinian refugee population (UNRWA 2003). The absence of proper statistics stems from the fact that most cases of cancer are treated mainly in private hospitals/clinics, and therefore are not recorded by UNRWA (UNRWA 2003).

UNRWA's suggestions that cancer cases have increased, coupled with this study's data that shows a high level of concern with cancer and a belief that it is the most important cause of death, make it imperative for studies to be conducted to ascertain the prevalence of this particular disease and delineate time trends. Incidence, causation, types of cancers, prevalence in different camps and different population groups are all questions that need to be answered – in addition to the formulation of possible preventive and curative strategies, whether medical, environmental or otherwise.

Based on this study's findings, mental health research clearly emerges from this study as an urgent need, both because all interviewees reported bad mental health states among camp residents, but also because there is little information on the state of mental health in the camps to corroborate such views, although quite plausible. While NGOs note an increase in depression, in abuse and child behavioural problems (Personal communication, Olfat Mahmoud 2004; Nouhad Hamad 2004), they find it difficult to intervene due to lack of information on the extent and type of problems present – making a future research focus on psyco-social and mental health, particularly among youth, a priority.

This study has highlighted the importance of comparative research across camps in terms of determining the urgency of various problems in each community, and differing community needs. While this study demonstrates many similarities in perceptions, these are mainly in terms of *actual* incidence and types of diseases, but not necessarily in terms of specific areas of concern, such as environmental health needs, community priorities or infrastructure needs. Further comparative research is needed, then, to complement the larger body of general health studies on the Palestinian refugees in Lebanon, and in order to respond effectively to the particular needs of specific refugee communities.

Intervention priorities

Given that most interviewees mention UNRWA as a primary healthcare provider (findings that confirms Soweid and al-Khalidi 2004, UNRWA 2003, as well as a number of other studies), it would be of crucial importance to invest, improve and upgrade UNRWA services before creating alternate ones. Certainly in the case of camps such as Wavel, where PRCS services are limited, improvement of and support for UNRWA is all the more important. Specifically, it would be important to increase the number of staff, particularly specialists, as well as ensure the UNRWA pharmacies' supplies of basic medication.

The environmental conditions in the camps – sewerage, water, homes, insects, rodents, etc. – were singled out repeatedly as important to health and as essential components of good health, both by camp residents and medical personnel. This perception is further supported by UNRWA, which maintains that improving environmental conditions is an important and needed health intervention (UNRWA 2003). In addition, improving environmental conditions is a broad approach that affects all camp residents and improves health while limiting the prevalence of communicable diseases.

Health education as one of the means to improve health was mentioned by all medical personnel as being extremely important. Even camp residents acknowledged its importance in improving health knowledge, while also noting that *lack of knowledge* is one of the reasons for increasing birth rates, for instance. The importance of health education as a preventive approach to improve health is also noted by UNRWA (2003). Most people, however, felt disillusioned with health education because they could not envisage how it might have practical consequences on their lives. Certainly, there is a great need for health education, and prevention programmes can certainly decrease the incidence of many problems in the camps such as diabetes and hypertension. However, efforts should be made to focus on approaches that would allow for the transfer of knowledge into behaviours and practices that are relevant and realisable in the context of the camps.

What are needed are programmes that can link the acquisition of health knowledge to the day-to-day needs and life styles of the camps, and that focus on what is realistic for the population. For instance, health education would have to target issues and behaviours that people can actually change in each camp, whether eating habits, environmental conditions, etc. In addition, most health education programmes lack crucial follow-up components. Caritas Lebanon (2004) has recently completed health education schemes with groups of women in some camps, and conducted need and outcome assessments both before and a few months after the training to see what initial problems were and if the women were actually applying the learning they had received in their actual lives (Personal communication, Jim Kelly 2004). This follow-up of participants to see if and how they are using their new knowledge is crucial in any health education programme, as it allows both to see what is successful and what is not – and more importantly, why certain elements are not integrated into daily life – are they too difficult, misunderstood, economic unfeasible, etc.

UNRWA states that the prevalence of HIV/AIDS is still low and is not currently a health threat to the general Palestinian refugee population. In fact, not a single interviewee (including medical personnel) mentioned HIV/AIDS as a current or possible future problem, indicating that the disease has not yet visibly affected enough people for the population to take notice of it. Nonetheless, the incidence of HIV/AIDS is increasing in the Arab world, and there are reported cases of HIV/AIDS among the Palestinian refugee population in Lebanon (UNRWA 2003). In addition, it seems that the incidence of HIV/AIDS among the Palestinian population may be higher than that of any of the host countries[57] (Personal communication, Dr. Yusef UNRWA 2004). For the time being, UNRWA has an agreement with the Lebanese government whereby retroviral drugs needed to treat HIV/AIDS are provided to the agency (UNRWA Commissioner-General Report 2004).

While researching HIV/AIDS in the camps would most probably be extremely difficult given the taboo around this disease and the entire subject of sexuality, it might be possible to begin a preventive health education programme on the subject. It is to be noted that UNRWA records indicate that of the women accessing UNRWA's family

[57] Countries that host official Palestinian refugee camps are Palestine itself, Jordan, Syria and Lebanon.

planning services in Lebanon, 34.4 % of these opt for condoms.[58] This significant prevalence of condom use as a method of contraception in the camps would make a preventive health education programme on HIV/AIDS feasible, as the community is already using and is used to this prime method of prevention.

Diabetes is the main health problem interviewees identified, and all studies cited in this paper, as well as UNRWA (2003), highlight this problem. UNRWA does have a special diabetes (and hypertension) programme, but given the extent and the seemingly rapid spread of this disease, as well as the fact that the average age of those diagnosed seems to be declining into the 40s (Personal communication, Ruth Campbell 2004), it would be important to develop more comprehensive health plans and programmes to address this problem from a community based prevention perspective, and not only from the perspective of providing services for those who have already been afflicted by this disease.

The relatively high prevalence of disability, combined with evidence from this study of a low level of appreciation for the special needs of the disabled, suggests that perhaps in the case of Palestinian refugees in Lebanon, where everyone has only minimal rights, the disabled are relegated to an unimportant position in the eyes of camp residents. Awareness-raising on the issue of disability, as well as the conditions, rights and abilities of the disabled, may then contribute to a better understanding of their needs and life conditions.

Interventions priorities specific to Bourj el-Barajneh and Wavel refugee camps

Interviewees in Bourj el-Barajneh acknowledged the presence of a reasonable health infrastructure. Nevertheless, there is a felt need to improve and upgrade what is already present, particularly the PRCS Haifa Hospital in the camp. On the other hand, people in Wavel expressed the need to actually build new infrastructure – such as a hospital or more clinics – in order to really improve health services.

Follow-up is needed in Wavel on the issue of water quality following the UNRWA sewage renovation in the camp. Not only was poor water quality a serious concern in Wavel, but it is an important determinant of many preventable health problems (diarrhoea, parasitic disease, kidney stones, etc.), and a short study of the situation in Wavel would indicate if further infrastructural works are needed to improve the situation, or if the problem lies elsewhere than with water quality.

Finally, this study demonstrates the dire need of health and medical assistance in the Palestinian refugee camps studied, and the need to support UNRWA and PRCS in the provision of basic services to these populations. It points to the importance of addressing health and not only disease, and to work towards alleviating problems that emanate out of the context within which camp residents live. The study offers interesting insights into people's perceptions of health and disease that, on the whole, seem to be compatible with perceptions and views of the medical professionals who provide services to this population, as well as with UNRWA data.

This study also highlights the importance and limitation of context, especially in the area of mental health and youth education and unemployment. There are certain problems where interventions are likely to have limited success because of the overwhelming importance of context both in creating and sustaining the problem, as well as in limiting the possible responses to it – including behavioural changes among the camp population. Nevertheless the question of mental health remains crucial and while the possibility for effective interventions seems uncertain, it is imperative and urgent that research on the range and variety of mental health problems be conducted as a first step toward improving mental health.

Lastly, it is hoped that this research will allow for the production of future research and intervention schemes aimed at understanding the context of health and disease in the camps and at alleviating the suffering of the longest displaced and disenfranchised people in the world today.

[58] 32 % of women accessing UNRWA's family planning services use pills and 30.7 % use IUDs.

ANNEX I: TYPOLOGY OF PALESTINIAN CAMPS AND GATHERINGS IN LEBANON

Typology of Palestinian Camps in Lebanon

Camp	Population[59]		Additional Information
North (close to Tripoli)	UNRWA	ROBERTS[60]	
Nahr el-Bared	30, 208	35, 000	With the exception of Ain el-Hilwe, Nahr el-Bared is the most highly populated camp in Lebanon. Differentiated from the other camps by the presence of a large *suq* inside the camp.
Baddawi	15, 584	18, 470	The camp appears to be the most spacious of the camps in Lebanon (Roberts 2001).
Beqa'a Valley			
Wavel	7, 537	3, 073	Also known as al-Jalil camp. Only official camp in the Beqa'a Valley region. Seems to be the only camp where residents regularly visit Syria (Roberts 2001 and personal observations).
Beirut			
Bourj al-Barajneh	15, 433	13, 000 – 17, 000 10, 700 – 14, 700 OR 2, 300 NR[61] 200 NP[62]	Largest camp in Beirut.
Shatila	8, 184	12, 000	Characterised by presence of large numbers of Lebanese and Syrians in the camp. Some observers state that only half the camp's population is Palestinian, although this has been contested by various local NGOs.
Mar Elias	613		Smallest camp in Lebanon.
Dbayeh	3, 991	2, 500	Only camp remaining in East Beirut – partially overrun during the war. Camp residents are Christian. Some observers state that the residents have Lebanese nationality, although this has been contested by various local NGOs.

[59] UNRWA figures as of 31 December 2004. Figures include only registered refugees – no unregistered Palestinians or other camp residents are included in these figures.

[60] Roberts' studies (2000 and 2001) include demographic information as perceived by camp residents and Camp Services Offices (UNRWA).

[61] Non-registered Palestinian refugees.

[62] Non-Palestinians.

South (Saida)			
Ein el-Hilwe	44, 820	50, 000 – 85, 000	Largest camp in Lebanon.
Mieh Mieh	4, 464	5, 000	
South (Sour)			
Bourj al-Shemali	18, 557	17, 000	A third of residents are said to have gained Lebanese citizenship in the late 1990s, although this is not confirmed (Roberts 2001).
El-Buss	8, 990	5, 000	
Rashidiyeh	25, 623	23, 000	
UNRWA Employees and Refugee Women Married to Non-Registered Husbands[63]			
Within all official camps	9, 654		Palestinian women married to non-registered husbands remain registered with UNRWA. However, they cannot currently benefit from UNRWA services while married to non-registered men; if they become divorced or widowed, they may then once again access UNRWA services (Personal communication, Dr. Jamil I. Yusef 2005).
Destroyed Official Camps			
Dikwaneh	9, 151		Camp in East Beirut destroyed during the war (1970s). Not clear where the residents of this camp currently reside. Regardless of residence, however, they remain registered with UNRWA and can benefit from its services.
Nabatiyeh	7, 080		Camp in South Lebanon largely abandoned after 1977 due to repeated Israeli attacks. Not clear where the residents of this camp currently reside. Regardless of residence, however, they remain registered with UNRWA and can benefit from its services.
UNRWA total registered camp population as of 31 December 2004	210, 155		
UNRWA Lebanon Field total registered refugees as of 31 December 2004	399, 152		

[63] Distributed within official camps.

Typology of Palestinian Gatherings in Lebanon

Gathering	Population[64]	Additional Information
Beqa'a Valley		
Bar Elias	5, 000	Location of main PRCS hospital for the Beqa'a Valley region. While not a gathering, this area has a large Palestinian community.
Tha'alabaya		While not a gathering, this area has a large Palestinian community.
Sa'ad Nayl		While not a gathering, this area has a large Palestinian community.
Beirut[65]		
Sabra (Gaza buildings 1-4)	1, 572	The Gaza buildings were formerly the main PRCS hospital in Lebanon, which was destroyed during the war. These are displacement centres for people displaced by the war – not actual gatherings.
Daouq	360	
Said Ghawash	2, 586	
Salwa al-Hout	186	
South		
Ma'ashouq	2, 400	Gatherings located in the coastal area 5 – 20 km from Buss camp – the closest official camp (PARD 2004).
Al-Qasmiyeh	2, 400	
Shabreheh	1, 890	
Jal al-Bahr	1, 200	
Kafr Badda	660	
Al-Aytaniyeh	270	
Al-Wasta	486	
Al-Burghaliyeh	1, 278	
Jim Jeem	210	

[64] Figures taken from PARD Information Sheet 2004 and Soweid and Khalidi 2004.
[65] Some observers consider that there is also a Palestinian gathering in the Beirut district of Bourj Hammoud, although statistics on the population are not available.

Sharnay	150	
Shaheem	15, 000	Communities formed by displaced Palestinian refugees, who evacuated Beirut during the war (Soweid and Khalidi 2004).
Al-Jaya		
Wadi al-Zeina		
Al-Naimah		
Damour		
Zaroot		
Destroyed Gatherings[66]		
Tal al-Za'atar	7, 403	Large Palestinian gathering in East Beirut destroyed during the war. Not clear where the residents currently reside and if they are registered with UNRWA.
Jisr al-Basha	1, 236	Small Palestinian gathering in East Beirut destroyed during the war. Not clear where the residents currently reside and if they are registered with UNRWA.
Total Palestinian refugee population in gatherings and displacement areas as of 2004[67]	44, 287	

[66] Population figures for 1968 – no more recent figures identified for these two gatherings (Brynen 1990).

[67] While many refugees in gatherings are registered refugees, some are not. These figures are totals for each gathering, not only the registered refugee population.

ANNEX II: DESCRIPTION OF INTERVIEWEES AND FOCUS GROUPS

Group Code	Camp	Number of Interviewees / Participants	No. of Males	No. of Females	Description	Age (Years)
SEMI-STRUCTURED INTERVIEWS: CAMP RESIDENTS						
G1	Bourj el-Barajneh	10	10	-	Men, mainly lower middle class and poor. Mainly intermediate education, some secondary education. Eight engaged in temporary labour at time of interview; none had permanent work. All married with children.	25 – 45
G2	Bourj el-Barajneh	10	-	10	Women, mostly lower middle class and poor. Mainly elementary education, some intermediate. Only one working, all others housewives. All mothers and married.	25 – 45
G3	Bourj el-Barajneh	10	5	5	Elderly, generally poor, most living with or near family members. None working, although all women involved in housework.	55 – 90
G4	Bourj el-Barajneh	10	5	5	Youth, generally lower middle class and poor. Six in school, four drop-outs. All drop-outs in intermediate cycle or lower. All unmarried, none engaged. Two working – one permanently the other as a day labourer.	15 – 24
G5	Wavel	10	10	-	Men, mainly lower middle class and poor. Mainly intermediate education, some secondary and university education. Two engaged in permanent work, four in temporary labour. All married with children.	
G6	Wavel	10	-	10	Women, mostly poor. Mainly intermediate education, some elementary. Only two working. All but one mothers and married.	25 – 45
G7	Wavel	10	5	5	Elderly, generally poor, most living with or near family members. None working, although all women involved in housework.	55 – 90
G8	Wavel	10	5	5	Youth, generally poor. Only one still in school, all drop-outs but one before the end of the intermediate cycle. All worked on an ad-hoc basis and as day labourers. All unmarried, none engaged.	15 – 24
SEMI-STRUCTURED INTERVIEWS: MEDICAL PERSONNEL						
G5	Bourj el-Barajneh	4	3	1	PRCS doctors all working at Haifa Hospital in the camp, all trained in Eastern Europe and Russia.	
G6	Bourj el-Barajneh	4	-	4	PRCS nurses all working at Haifa Hospital in the camp, all trained by PRCS in Lebanon.	
G7	Bourj el-Barajneh	1	1	-	UNRWA doctor working at the UNRWA clinic in the camp, trained in Spain.	
G8	Bourj el-	1	1	-	Traditional practitioner working in the camp,	

	Barajneh				trained in the Gulf.	
G9	Bourj el-Barajneh	1	-	1	Traditional bone caster working in the camp, trained by her uncle.	
G10	Bourj el-Barajneh	1	-	1	Midwife working in the camp in her own clinic, trained in Lebanon.	
G11	Wavel	3	2	1	PRCS doctors all working at PRCS clinic in the camp, trained in Russia, Western Europe and Syria.	
G12	Wavel	1	-	1	PRCS nurse working at PRCS clinic in the camp, trained by PRCS in Lebanon.	
G13	Wavel	1	1	-	UNRWA doctor working at the UNRWA clinic in the camp, trained in Russia.	
G14	Wavel	1	-	1	Private doctor (gynaecologist) working in the camp in her own clinic, trained in Russia.	
TOTAL	TOTAL	TOTAL	TOTAL	TOTAL		
	18	98	45	49		
BB	10	52	22	26		
W	8	46	23	23		
FOCUS GROUPS: CAMP RESIDENTS						
G16	Bourj el-Barajneh	15	6	10	Youth, mainly lower middle class and poor. Most still in school.	15 – 18
G17	Bourj el-Barajneh	10	-	10	Women, mainly lower middle class and poor. All working with NGOs in the camp.	25 – 45
TOTAL	TOTAL	TOTAL	TOTAL	TOTAL		
BB	2	25	6	20		

ANNEX III: CAMP RESIDENTS SEMI-STRUCTURED INTERVIEW FINDINGS TABLES

Table 1: # of consultation(s) over past year (2003-2004)

	Interview Groups								
	Men		Women		Elderly		Youth		TOTAL
	BB[68]	W	BB	W	BB	W	BB	W	
# of Consultations									
Once	6	2	4	3	0	0	5	8	28
A few times	1	4	2	4	4	6	3	2	26
Many times	3	2	2	1	6	4	0	0	18
Never consulted	0	2	2	2	0	0	2	0	8

Table 2: Reasons for personal consultation(s) over the past year (2003-2004)

	Interview Groups								
	Men		Women		Elderly		Youth		TOTAL
	BB	W	BB	W	BB	W	BB	W	
Reasons for consulting									
Chronic Diseases									
Hypertension		1			4	3			8
Heart disease		1			4	2			7
Diabetes					4	1			5
Prostate problems					1	2			3
Poor blood circulation						1			1
									24
Respiratory / ENT[69]									
Respiratory problems		1	1		3	1	1		7
The common cold				2			1	3	6
Ear infection		1		1		2			4
Tonsillitis		1		1					2
Sinus problems			1						1
									20
Stomach / Digestive / Urinary Tract									
Stomach problems	2		1		1		2	1	7
Urinary tract infection	2							2	4
Kidney stone				1		1	1		3
									14
Bone / Muscle									
Back problems	2				1	1	1		5
Accident	1							1	2
Rheumatism				1		1			2
Neck pains		1	1						2
Osteoporosis					1				1
Joint problems	1								1

[68] **BB** will be used to indicate Bourj el-Barajneh camp; **W** will be used to indicate Wavel camp.
[69] Ear-nose-mouth ailments.

									13
Seasonal / Environmental									
Typhoid					1			1	2
Allergies	1					1			2
Skin rash							1		1
Fever		1							1
									6
Women									
Cysts				2					2
Vaginal infection				1					1
Birth control			1						1
									4
Mental Health									
Depression	1		1						2
Migraines		1						1	2
									4
Nutritional									
Nutritional anaemia							1		1
Dizzy spells			1						1
									2
Other									
Toothaches			1					2	3
Eye problems			1			2			3
Hernia	1		1						2
Haemorrhoids		1				1			2
Gall bladder			1						1
									11
No complaint		1	1	2			2		6

Table 3: Choice of service provider for personal consultation(s)

	Interview Groups								
	Men		Women		Elderly		Youth		
	BB	W	BB	W	BB	W	BB	W	TOTAL
Service Provider									
In the camp									
UNRWA	4	6	6	8	7	5	4	6	46
PRCS	2		1	1	2		6	2	14
Private clinic	1				1		1		3
NGO clinic			1		1				2
Mosque clinic		1							1
									66
Out of the camp									
Private clinic	4	6			2	5		2	19
Hospital	2		2		1	3	1		9
Hospital in Syria		1		1		1			3
									31

Table 4: Reasons for children's consultation(s) over the past year (2003-2004)

	Camp		
	Bourj el-Barajneh	Wavel	TOTAL
Reasons for consulting			
Respiratory / ENT			
The common cold	6	9	15
Respiratory problems	6	2	8
Tonsillitis	3		3
Ear infection	2		2
			28
Seasonal / Environmental			
Fever	2	2	4
Allergies	2	1	3
			7
Stomach / Digestive / Urinary Tract			
Stomach problems		3	3
			3
Other			
Toothache		1	1
			1
No complaint		1	1

Table 5: Choice of service provider for children's consultation(s)

	Camp		
	Bourj el-Barajneh	Wavel	TOTAL
Service provider			
In the camp			
UNRWA	12	10	22
PRCS	3	3	6
Private clinic out of camp	5	1	6
Pharmacy		3	3
Mosque clinic in camp		1	1
			38
Out of the camp			
Hospital	3		3
Hospital in Syria		2	2
			5

Table 6: Perceptions of main service providers

	Interview Groups								
	Men		Women		Elderly		Youth		TOTAL
	BB	W	BB	W	BB	W	BB	W	
Service provider									
UNRWA									
Unsatisfactory	3	8	2	4	1	5	4	4	31
Insufficient	4	2	3	6		2	3	2	22

Acceptable	3				7	3	2	1	16
Highly satisfactory			4		2				6
Only satisfactory for simple problems			1				1	3	5
PRCS									
Acceptable	3	3			7	1	4	4	22
Acceptable but charges fees	2	3	2	6		5	1	2	21
Only satisfactory for simple problems	3	1	2	3	1	1	2	1	14
Unsatisfactory	2	3	2			3		2	12
Highly satisfactory			4	1	2		3	1	11

Table7: Perceptions of medical personnel

	Interview Groups								
	Men		Women		Elderly		Youth		TOTAL
	BB	W	BB	W	BB	W	BB	W	
Medical Personnel									
UNRWA									
Qualified	2	2	5	4	5	4	3		25
Not qualified	2	5	3	1	1	1	3	5	21
Not all qualified	2	2		4	1	3		5	17
Not qualified for everything	4	1	2	1	3	2	4		17
PRCS									
Qualified	2	6	6	9	5	8	4	5	45
Not qualified for everything	4	3	2	1	2	2	2	2	18
Not all qualified	2				2		4	1	9
Not qualified	2	1	2		1			2	8

Table 8: Changes in and explanations for the level of health (over past 10 years)

	Interview Groups								
	Men		Women		Elderly		Youth		TOTAL
	BB	W	BB	W	BB	W	BB	W	
Changes									
Deteriorated	10	10	10	8	10	10	10	10	78
Improved				2					2
Explanations for deterioration									
Environmental									
Decreased quality of foods	2	3	4	4	2	4	1	2	22
Environmental conditions	3	2	2	2		3	2	2	16
Overcrowding	1	1		1		1			4

Weather						2		2	4
War-related pollution			2	1					3
Poor water quality		1				1			2
Unhealthy homes						1		1	2
									53
Economic / Financial									
Economic situation	4	4	4	1	4	4	5		26
									26
Mental health									
Depression	2	3	3	1		2	1	2	14
Stress	1	1					1		3
Boredom				2		1			3
									20
Political / Context									
War	1		3						4
Political situation	1	1							2
Drugs	1								1
Social problems		1							1
Lack of exercise					1				1
									9
Diseases / Medical Services									
Increase in incidence of diseases					2				2
Poor doctors' examination and prescriptions					1				1
Cancer					1				1
Decreased medical services	1								1
									5

Table 9: View of personal health

	Interview Groups								
	Men		Women		Elderly		Youth		
	BB	W	BB	W	BB	W	BB	W	
View									TOTAL
Good	6	4	6	4	3	3	5	3	34
Acceptable	4	3	3	4	5	4	3	4	30
Bad		1			1	2	1	3	8
Very bad		2			1	1			4
Depends			1	2			1		4

Table 10: Main causes of death

	Interview Groups								
	Men		Women		Elderly		Youth		TOTAL
	BB	W	BB	W	BB	W	BB	W	
Main causes of death									

Chronic									
Cancer	5	7	6	3	4	3	3	2	33
Heart disease	4	5	5	2	4	7	2	2	31
Diabetes	4	5	2	3	5	1	1	2	23
Hypertension	2	2	1	3	4		1	1	14
Strokes					1			2	3
									104
Context / Life Cycle									
Poverty	3		2	3		3	1		12
Age		1			3				4
Fate			1		2				3
									19
Mental Health									
Depression	4	2			3	2		1	12
Stress		3							3
Suicide								1	1
									16
Respiratory / Environmental									
Unhealthy foods	2	1				2			5
Respiratory problems			1	1			1		3
Environmental conditions[70]	1		1	1					3
Unhealthy homes		1		1					2
The common cold			1						1
									14
Conflicts / War									
Camp conflicts			1						1
War	2		2		3				7
									8
Behavioural									
Smoking						1		1	2
									2
Other									
Accidents	1				1		1	1	4
Unsatisfactory medical services				2					2
Kidney stones		1							1
									7

Table 11: Most pressing health problem

	Interview Groups								
	Men		Women		Elderly		Youth		TOTAL
	BB	W	BB	W	BB	W	BB	W	
Health problem									
Seasonal / Environmental									
Poor water quality		3		4		2		4	13
Unhealthy homes	2	1	2			7			12

[70] This label subsumes problems such as lack of proper heating and ventilation, dampness and humidity, air pollution, lack of light, etc.

Environmental conditions	3	2		1	1		3	2	12
Overcrowding in homes	1		2	1		1	2		7
Weather (winter)		1				3			4
Unhealthy foods								2	2
Typhoid				1					1
Closeness of houses			1						1
									52
Chronic									
Diabetes	5	2	3	1	7		1		18
Cancer	3	1		2	1	1	2		10
Heart disease	2	1	2	2		1	1		9
Hypertension		1	2		2				5
Strokes					1				1
									43
Respiratory / ENT									
Respiratory problems	2		3	2	1	1			9
The common cold			1	2	1	1			5
Rheumatism			1						1
									15
Bone / Muscle									
Back problems			1						1
Joint problems			1						1
Reduced mobility					1				1
Osteoporosis					1				1
									4
Mental Health									
Stress	2								2
Depression		1			1				2
									4
Stomach / Digestive / Urinary Tract									
Diarrhoea				1					1
Kidney stones		1							1
									2
Context / Life Cycle									
Poverty				1		1			2
									2
Other									
Unsatisfactory medical services			1	1			1		3
Thalassemia[71]		1		1				1	3
									6

[71] Genetic disorder commonly found in the Mediterranean basin and seemingly more dominant in camps whose populations were originally from coastal areas in pre-1948 Palestine (Personal communication Dr. Yusef, UNRWA 2004).

Table 12: Suggestions to improve health in the camp

	Interview Groups								
	Men		Women		Elderly		Youth		TOTAL
	BB	W	BB	W	BB	W	BB	W	
Suggestions									
Financial / Economic									
Funding for health services (already in place)	3		4	2	4	1	3		17
Free or low-cost medication	1	3		3	1		2		10
Improve UNRWA		2		2			1		5
Funding to cover costly treatments such as open-heart surgeries	1				1		1	3	5
Create work for people						3	2		5
PLO funding for PRCS and the camps					1				1
Funding for NGOs		1							1
									44
Infrastructure / Environmental									
Rebuild the camp	1					5			6
Move out of the camp			2						2
Improve the environmental conditions in the camp	2								2
Fix homes			1						1
Water quality control				1					1
									12
Medical / Service Provision									
Better doctors' examinations at UNRWA and PRCS							1	2	3
Set up specialised clinics in the camp		1			1				2
Night clinic / 24 hr medical services				1		1			2
Closer cooperation between UNRWA and PRCS	1								1
Increase dentists		1							1
Hospital		1							1
									10
UNRWA									
Increase number of		1	1						2

specialised doctors at UNRWA									
Demonstrations at UNRWA			2						2
UNRWA contracts with good hospitals								2	2
Evaluation and supervision of UNRWA services to improve them				1					1
									7
Political									
Improve political situation	1								1
									1

Table 13: Level of and factors affecting mental health

	Interview Groups								
	Men		Women		Elderly		Youth		TOTAL
	BB	W	BB	W	BB	W	BB	W	
Level									
Bad	9	10	10	9	9	8	10	10	75
Depends on the economic situation of the family	1			1	1	1			4
Acceptable						1			1
Factors									
Financial / Economic									
Economic situation	4	4	5	4	2	6	2		27
Family responsibilities	6		4	8	7		1		26
Unemployment	3	4	5	3	1	3	1	2	22
Inability to leave Lebanon					1		2	1	4
Inability to marry								1	1
									82
Context / Life Experience									
Boredom					2		3	2	7
Growing up with problems	3	2		1	1				7
General living conditions				1	2		1		4
Geographic isolation		1		1				2	4
Plagued by memories (elderly)			1		2				3
Tired of life (elderly)					1	1			2
Lack of social activities		1							1
									28

Emotional / Hope									
Hopelessness for future	2	5	1	1	2		3	1	15
Loneliness (elderly)					3				3
									18
Education									
Lack of educational opportunities / Inability to finish education		1					3	3	7
Low level of education			1						1
									8
Political									
Political situation	1	1			1			1	4
Not being able to return to Palestine					2				2
Lack of good leadership						1			1
									7
Infrastructure / Environmental									
No place to play (children)	1				1				2
Overcrowding					1				1
Unhealthy homes	1								1
Weather (winter)				1					1
									5
Health									
Stress	2								2
Reduced mobility (elderly)					1				1
									3

Table 14: Population group most adversely affected in terms of mental health and suggestions to improve the mental health situation

	Interview Groups								
	Men		Women		Elderly		Youth		TOTAL
	BB	W	BB	W	BB	W	BB	W	
Group									
Everyone	4	3	4	3	4	7	5	5	35
Youth	2	5	2	1	1	2	5	5	23
Women	2	1	2	5	1				11
Men	1	1	2	4	1				9
Elderly	1		1		4	1			7
Children	2	1		1					4
Suggestions									
Financial / Economic									
Create work opportunities	2	4	6	3	3	4	5	5	32

Help people achieve small goals (i.e. finishing high school, opening small shop, etc.)	2			2			2	3	9
									41
Context / Life Experience									
Improve living conditions generally		1	2	1	1		1		6
Activities and clubs for youth		2			1				3
General activities – sports, clubs, etc.	1			1					2
Elderly centre					1				1
									12
Political									
Change political situation		1		1					2
Return to Palestine		1							1
Need more responsible leaders						1			1
									4
Nothing can be done	3		2		4	1	1		11

Table 15: Perceptions of and explanations for changes in health knowledge (over past 10 years)

	Interview Groups								
	Men		Women		Elderly		Youth		TOTAL
	BB	W	BB	W	BB	W	BB	W	
Perceptions of changes									
Better now	8	4	7	4	7	8	4		54
Same		3		3		1	6	9	26
Much better now	2	3	2	3	1	1			13
Worse now			1					1	3
Explanations for improvement									
Generally higher level of education	2	1	3	2	5	3	2		18
NGO lectures	5	2		2		1	2		12
Access to new forms of media	2	2		1	1	1			7
Experience of illness and diseases	1	2	2	1	1				7
Greater desire to learn, people are more proactive			2		2	1			5
Increased contact with healthcare professionals			1		1	2			4
Development			2						2

UNRWA lectures				1					1
Mothers are more educated and teach children						1			1
PRCS lectures				1					1
Explanations for lack of improvement									
People do not care unless ill	2			1			3		6
People prefer to go to the physician						1	3	1	5
Few opportunities to learn about health, so most people learn from parents				1				3	4
Youth are not interested in health								3	3
People feel that health knowledge is not a priority	1							1	2
People do not follow medical advice properly								2	2

Table 16: Changes in birth rate (over the past 10 years)

	Interview Groups				
	Men		Women		TOTAL
	BB	W	BB	W	
Change					
Decreased	7	5	3	4	30
Increased	3	3	7	5	25
Same		2		1	3
Explanations for increase					
Palestine		1	2	2	5
Lack of knowledge			3	2	5
Unemployment / men at home	1	1	1		3
Recent marriages / social expectations	2		1		3
Tradition		1		1	2
Explanations for decrease					
Economic situation	5	4	3	3	15
Emigration		2			2
Increased knowledge	2				2
Women are more educated				1	1

Table 17: Main perceived birthing locations

	Interview Groups				
	Men		Women		TOTAL
	BB	W	BB	W	
Location					
Midwife[72] clinic	2		9	20	31
Hospital	7		8	2	17
Home with midwife present				15	15
Hospital with midwife present	1				1

[72] All camp residents spoke of trained midwives and not of traditional birth assistants or elderly women, as were present in the past.

ANNEX IV: MEDICAL PERSONNEL SEMI-STRUCTURED INTERVIEW FINDINGS TABLES

Table 18: # of *daily* consultations done by medical personnel[73]

	Interview Groups			
	PRCS	UNRWA	Other	
# of daily consultations				TOTAL
< 10	5		3	8
10 – 20	7			7
50 – 100		2		2
20 – 50			1	1

Table 19: Reasons for people consulting medical personnel over the past year (2003-2004)

Reasons for consultations	TOTAL
Chronic	
Heart disease	7
Diabetes	5
Hypertension	5
Cancer	3
	20
Respiratory / ENT	
Respiratory problems	10
The common cold	7
	17
Bone / Muscle	
Accident	7
Osteoporosis	2
Joint problems	1
Back problems	1
	11
Stomach / Digestive / Urinary Tract	
Stomach problems	5
Diarrhoea	5
	10
Women	
Vaginal infection	3
Miscarriage	2
Birth control	1
	6
Seasonal / Environmental	
Fever	1
Typhoid	2
	3
Other	

[73] All information on medical personnel is not disaggregated according to camp for two reasons: 1) there are no significant differences between medical personnel in the two camps; 2) the samples are not equal in number.

Gall bladder	2
Nutritional anaemia	1
Appendicitis	1
Varicose veins	1
	5

Table 20: Average life expectancy (in years) at birth according to medical personnel

Ave. life expectancy	TOTAL
55 – 65	8
65 – 75	3
75 – 85	2

Table 21: Changes in and explanations for the level of health (over past 10 years)

Changes	TOTAL
Improved	12
Deteriorated	4
Same	2
Explanations for improvement	
More services available	4
Camp residents are more educated	4
New medication	2
Little increase in incidence of chronic diseases and dramatic decline in incidence of infectious diseases	2
Doctors are more knowledgeable and experienced	1
Explanations for deterioration	
Economic situation	2
Increase in incidence of diseases	2
Depression	1
Overcrowding	1

Table 22: Main causes of death

Main causes of death	TOTAL
Chronic	
Cancer	10
Heart disease	9
Diabetes	5
Hypertension	1
	25
Context / Life Cycle	
Poverty	3
Age	1
	4
Respiratory / Environmental	
Respiratory problems	2
Unhealthy foods	1

Fever	1
	4
Mental Health	
Depression	3
Stress	1
	4
Behavioural	
Lack of knowledge	4
	4
Other	
Accidents	4
Bad medical services	1
	5

Table 23: Most pressing health problem

Health problem	TOTAL
Seasonal / Environmental	
Poor water quality	4
Unhealthy homes	4
Environmental conditions	2
Diesel heaters[74]	2
Overcrowding in homes	1
Weather (winter)	1
Typhoid	1
Fever	1
Unhealthy foods	1
	17
Chronic	
Diabetes	4
Cancer	3
Heart disease	1
Hypertension	1
	9
Respiratory / ERM	
Respiratory problems	6
The common cold	1
	7
Context / Life Cycle	
Poverty	6
	6
Mental health	
Stress	1
Depression	1
	2
Other	
Lack of knowledge	4

[74] Similar to coal heaters, but function with diesel fuel – extremely polluting. Used only in Wavel, not in Bourj el-Barajneh – due to lower temperatures in winter.

Bad medical services	2
Primary care	1
Smoking	1
	8

Table 24: Suggestions to improve health in the camp

Suggestions	TOTAL
Financial / Economic	
Create work for people	3
Funding for health services	3
Free or low-cost medication	2
	8
Health Education	
Health education	8
	8
Medical / Service Provision	
Set up specialised clinics in the camp	1
	1
Infrastructure / Environmental	
Improve the environmental conditions in the camp	1
	1

Table 25: Level of and factors affecting mental health

Level	TOTAL
Bad	16
Acceptable	1
Satisfactory	1
Factors	
Financial / Economic	
Economic situation	11
Family responsibilities	6
Unemployment	2
Inability to marry	1
	20
Context / Life Experience	
Hopelessness for future	3
Conflicts within the camps	1
Few opportunities to go out of the camp	1
	5
Political	
Political situation	3
Not being able to return to Palestine	1
	4
Health	
Stress	2
	2

Education	
Lack of educational opportunities / Inability to finish education	1
	1

Table 26: Population group most adversely affected in terms of mental health

Group	TOTAL
Women	5
Men	5
Youth	5
Children	4
Elderly	1
Suggestions	
Political	
Change political situation	5
Need more responsible leaders	1
	6
Financial / Economic	
Create work opportunities	4
Make needed medication available at low-cost or for free	1
	5
Medical Services / Health Education	
Lectures for camp residents on how best to cope with the current situation	3
Mental health workshops for medical personnel	1
	4
Context / Life Experience	
Activities and clubs for youth	2
Improve living conditions generally	1
	3
Nothing can be done	1

Table 27: Perceptions of and explanations for changes in health knowledge (over past 10 years)

Perceptions of changes	TOTAL
Better now	12
Same	4
Much better now	1
Worse now	1
Explanations for improvement	TOTAL
NGO lectures	4
Generally higher level of education	3
UNRWA lectures	2
Increased contact with healthcare professionals	2
Greater desire to learn, people are more proactive	1
Access to new forms of media	1
Mothers are more educated and teach children	1

Table 28: Changes in birth rate (over past 10 years)

Change	TOTAL
Decreased	11
Increased	7
Explanations for increase	
Unemployment / men at home	3
Lack of knowledge	2
Recent marriages / social expectations	1
Tradition	1
Explanations for decrease	
Economic situation	10
Family planning	2
Increased knowledge	1

Table 29: Main perceived birthing locations

Location	TOTAL
Hospital	18
Midwife[75] clinic	10

[75] All camp residents spoke of trained midwives and not of traditional birth assistants or elderly women, as were present in the past.

ANNEX V: LIST OF MEETINGS/DISCUSSIONS

Dr. Mohammad Othman	PRCS Lebanon Headquarters (October 2003)
Dr. Jamal Yusef	UNRWA Field Office Lebanon Field (June 2004)
Jim Kelly	CARITAS – Lebanon (October 2003)
Manal Rabbani	Women's Centre Wavel camp (September 2003)
Olfat Mahmoud	Women's Humanitarian Organisation (WHO) (October 2003)
Rosemary Sayigh	Independent Researcher (October 2003)
Ruth Campbell	CARITAS – Lebanon (January 2004 and January 2005)
Sukeina Salameh	National Associational for Vocational Training and Social Services (NAVTSS) (January 2004)
Zeinab Madhoum	Women's Centre Bourj el-Barajneh camp / Sabra gathering (September 2003)
2 Male refugees[76]	Bourj el-Barajneh camp (October 2003)
2 Female refugees[77]	Bourj el-Barajneh camp (October 2003)

[76] Names excluded at persons' request.
[77] Ibid.

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