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CHILDREN SITUATION IN PALESTINE

By
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I. CURRENT SOCIOECONOMIC SITUATION

The devastation of the Palestinian economy, through measures carried out in contravention of Israel's binding obligations under international humanitarian and human rights law, and the resulting loss in livelihood, is the primary cause of a deepening humanitarian crisis in the West Bank and Gaza Strip. Sixty per cent of the Palestinian population are now living under the US$ 2 per day poverty line, as compared with 21 per cent in 2000—indicating that the number of poor has tripled to just under 2 million from a pre-*intifada* level of 637,000.[1] Female-headed households, representing 9 per cent of Palestinian households, constitute more than half of the poorest Palestinian households with 30 per cent falling below the poverty line.[2] Moreover, average daily consumption of a poor person in both the West Bank and Gaza is well below the US$ 2 mark and has dropped from a pre-*intifada* level of US$ 1.47 per day to US$ 1.32.[3]

The deterioration of Palestinian health and nutritional status has been steadily monitored since September 2000. While the Palestinian Authority (PA) continues to provide for the healthcare needs of the Palestinian people, in light of the competing burdens the PA must negotiate, there are far fewer funds available for healthcare, education, and development initiatives. Thus, as indicators of the prevailing socioeconomic conditions, it is to be expected in a society where by late 2002 the median monthly income had dropped by 52 per cent, where people are no longer able to afford the same basket of food items, where over half a million people are now fully dependent on food aid, and where per capita food consumption is down by 30 per cent in three years, that malnutrition and micronutrient deficiencies such as chronic malnutrition and anemia, are increasing in prevalence.[4]

Data analysis from a 2002 nutritional assessment conducted by Johns Hopkins University and Al-Quds University concluded that the household income level in Palestine was strongly associated with the presence of acute and chronic malnutrition as well as anemia. Findings of the study predictably showed that a significant proportion of children in the West Bank and Gaza are chronically malnourished, with acute malnutrition in Gaza reaching 13.3 per cent of the population—a level comparable to that of Zimbabwe (13 per cent) and Congo (13.9 per cent).[5] Moreover, the study found that anemia among children and women of reproductive age was a

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[1] World Bank. "Two Years of *Intifada*, Closures and Economic Crisis", p. 3.

[2] Christian Aid. "Losing Ground: Israel, Poverty and the Palestinians", January 2003, p. 37.

[3] World Bank, op. cit., p. 3.

[4] Christian Aid, op. cit., p. 3.

[5] CARE. "Nutritional Assessment of the West Bank and Gaza Strip", conducted by Johns Hopkins University/Al-Quds University and financed by USAID through CARE International, September 2002.

severe endemic problem.[6] Survey results of health care clinics from the Johns Hopkins and Al-Quds University study also indicated that healthcare providers cite 'family economic problems' as the primary cause of malnutrition. Consistent with the findings of the clinic survey, a market survey from the same report concluded that the same factors that were depressing the economy—curfews, closures, military incursions, border closures and checkpoints—affected the availability of key high protein foods which are necessary to prevent anemia, and protein-energy malnutrition in infants, young adults, and women of reproductive age.[7] Finally, the overall conclusion of the study clearly indicated that the conflict and its economic consequences have created a state of food insecurity that is worsening chronic malnutrition in children, decreasing macronutrient consumption in women, and rendering acute malnutrition intractable despite interventions.[8]

Mobility restrictions have also made it difficult and often impossible for health care professionals to report to work on a regular basis, thus leading to an overall decrease in immunization levels, dangerous limits on care for patients suffering from chronic disease, and mothers seeking pre and post-natal care. Women and children are particularly vulnerable to restrictions affecting their ability to seek healthcare given the fact that 46.1 per cent of the population is under the age of 15, and Palestinian women have an average of five children during their lifetime.[9]

The provision of emergency healthcare has been hampered by acts of non-compliance by the Israel Defense Forces (IDF) with its legal obligations under the Fourth Geneva Convention, and with commitments made by the Government of Israel to the United Nations Secretary General's Humanitarian Envoy Catherine Bertini in August 2002 pertaining to the free passage of humanitarian goods and emergency healthcare vehicles. On average, 60 ambulances faced delays at checkpoints each month from January to May 2003, one quarter of these were denied access through checkpoints all together, and 15 ambulances were fired upon during the month of March 2003 alone.[10]

The increased incidence of water-born illnesses in communities and the inability of those suffering from them to seek and receive care for these highly treatable conditions are also a result of mobility restrictions. A study conducted in March 2003 by the Palestinian Hydrology Group (PHG) and funded by the European Commission

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[6] Ibid., p. 34.

[7] CARE. "Humanitarian Update on West Bank and Gaza", April 2003. Available at: www.careinternational.org.

[8] CARE. "Nutritional Assessment of the West Bank and Gaza Strip", op. cit., p. 34.

[9] Palestinian Central Bureau of Statistics, 2003. Available at: http://www.pcb.org.

[10] United Nations Office for the Coordination of Humanitarian Affairs (OCHA). "Humanitarian Action Plan for the Occupied Palestinian Territory 2003: Mid-Year Review", p. 3.

Humanitarian Office (ECHO) and Oxfam-GB on the water, sanitation, and hygiene situation in the West Bank and Gaza supports this assertion. The study, based on research conducted in 615 communities in the West Bank and Gaza, observed the following water, sanitation and hygiene related problems: strong evidence of water related disease, inaccessibility to nearest public health centre, lack of funds to pay for wastewater evacuation, a high percentage of families unable to afford to pay water bills, destruction of water and sanitation infrastructure, dependence on water tankers for fresh water, limited supply of water, no access to water networks, and curtailed or completely cut off water supply from Mekorot—Israel's national water company which is the main water source for between 201 and 213 communities in the West Bank and Gaza Strip.[11] Thus, due to the insidious effect of the regime of closures and curfews, the provision of water and sanitation services has become expensive, dangerous, and often impossible. For example, there are over 200,000 Palestinians living in rural communities relying on water brought in by tanks.[12] However, those transporting water in tankers have reported enduring difficulty accessing water sources, forcing them to risk their lives in order to gain access to alternate sources. This and other factors lead to increased costs of up to NIS 40 (US$ 8-10) per cubic meter—costs that are passed on to the consumers of water.[13] Thus, consumers who are either unable to pay for their water, or who have given up on a water tanker that never arrives, are forced to make use of contaminated water sources from which they are exposed to illnesses, for which they may subsequently be unable to attain treatment.

It is also significant to note that the construction and completion of Israel's 'Separation Wall', in addition to further damaging the livelihood of an estimated 95,000 Palestinians residing in 27 towns and villages who will be caught between the 1967 Green Line and the Wall, will also have real water and sanitation repercussions.[14] The first segment of this Wall, already well underway, will be composed of 145 kilometers of electric and barbed-wire fences, trenches and walled structures. The PHG reported that during the construction of this first phase, 30 groundwater wells would likely be affected, while at least 15 villages will be separated from their land by the wall.[15]

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[11] Palestinian Hydrology Group. "Water and Sanitation, Hygiene (WaSH) Monitory Project: Impact of the Current Crisis, Technical Report No. 7", March 2003, p. 10.

[12] OCHA, op. cit., p. 37.

[13] Palestinian Hydrology Group, op. cit., p. 11.

[14] OCHA, op. cit., p. 2.

[15] Palestinian Hydrology Group, op. cit., p.12.

II. CHILDREN AND THE INTIFADA

Under *jus in bello*[16] children are afforded both the general protection of all civilians *hors de combat*,[17] as well as special protections. Children are also protected by the binding obligations of various international human rights treaty regimes including the United Nations Charter, the International Covenant on Civil and Political Rights (ICCPR), and the International Covenant on Economic, Social and Cultural Rights (ICESCR). In addition, the Convention on the Rights of the Child (CRC), one of the most universally accepted human rights instruments, complements and more precisely defines provisions in both international humanitarian law and general human rights law related to children. The protections in the CRC include, among other rights, the right to survival, protection, health, development, and education. Despite this formidable body of codified international law, children are paying a disproportionately high price in the current conflict.

Final comments addressed to Israel

The United Nations Committee on the Rights of the Child has addressed final comments to the Israeli government in regard to the implementation of the Convention on the Rights of Children (CRC) and the Israeli violations of the CRC in the Occupied Palestinian Territory (OPT). These comments were developed upon the presentation of the alternative report by a delegation from the Palestinian Child Coalition to the Committee in Geneva in June 2002. The report addressed all Israeli violations to the rights of Palestinian children, as stipulated in the United Nations CRC, during the period from the start of the enforcement of CRC in 1991 and up to the date when Israel submitted its preliminary report to the Child Rights Committee in 2000. The Palestinian delegation has organized a number of activities to accompany the presentation of the report. These included seminars, lectures, and meetings with various institutions. These activities have been successful in raising the level of international awareness of the Israeli violations to the rights of the Palestinian children, particularly through the Swedish press.

The Coalition's decision to submit an alternative report was not made discretely, but was rather based on the article 45 of the CRC that ensures non-governmental organizations (NGOs) the right to submit alternative reports to the periodic reports submitted by states.

Of the 1.5 million Palestinian children (53 per cent of the population), 405 Palestinian children have been killed in the current conflict, 7,000 have been injured, and about 500 of those injured are likely to experience permanent disabilities as a

[16] *Jus in bello* refers to the laws governing the conduct of warfare which are part of codified international humanitarian law.

[17] *Hors de combat* refers to those persons not taking direct part in hostilities.

result.[18] Between 170 and 375 Palestinian children are now being held in Israeli military or civil detention, with some under the age of 18 being held in detention among the detained adult population. Many children are held without charge, access to legal representation, parental visits or notification of the child's whereabouts, without adequate food or access to bathroom and shower facilities, and are subject to both physical and psychological torment and abuse.[19] These are clear violations of the rights of the child under numerous international law regimes to which Israel is bound.

The Palestinian educational system, despite a decade of exertions to improve it, is now seriously compromised. In aggregate, closures, curfews, and the daily threat of injury to innocent civilians from military forces are leaving a deleterious effect on the quality and quantity of education for an entire generation. Some 226,000 children and 9,300 teachers have been unable to reach their regular schools, and 580 schools have been closed due to curfews, closures, or Israeli military order, thereby severely disrupting the curriculum.[20] Furthermore, despite the best efforts of flexible and creative teachers and school administrators, the school environment is hardly conducive to learning. Teachers report that students are distracted, classrooms are overcrowded, and the level of student violence has increased.

The psychosocial health of Palestinian children has been the subject of several recent studies that report a disturbing percentage of children with noticeably altered behavior patterns. The Palestinian Ministry of Health reported that there has been a 105 per cent increase in new cases at mental health clinics since October 2000, and that children under 18 constitute a majority of these.[21] Further, in 2003 UNICEF reported that 75 per cent of parents have noticed behavioral changes and greater emotional problems in their children compared with one year ago, including problems sleeping, being afraid, and finding it hard to concentrate.[22] These findings are hardly surprising given the severe disruptions of normal childhood activity that characterize the daily lives of Palestinian children. For example, children have limited opportunities for hobbies, sports, and other leisure activities, and are often confined to their homes where parents report that children are spending an increasing amount of time watching television. Additionally, children along with their parents are isolated from the support systems and joy of spending time with grandparents, uncles, aunts,

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[18] UNCHR. "Question of the violation of human rights in the occupied Arab Territories including Palestine". Report of the Special Rapporteur of the CHR, Mr. John Dugard, March 2002.

[19] Defence for Children International (DCI). "Palestinian Children in the Judicial System", June 2003. Available at: www.dci-pal.org.

[20] OCHA, op. cit., p. 41.

[21] Quoted in Save the Children Sweden and Save the Children UK "Growing up under Curfew: Safeguarding the Basic Rights of Palestinian Children", March 2003, p. 20.

[22] UNICEF. "Mid-Year Update of the Humanitarian Appeal-Occupied Palestinian Territory", 2003, p. 2.

cousins, and friends whom they can no longer physically reach. One of the most telling studies recently conducted by Save the Children UK and Save the Children Sweden revealed from interviews with Palestinian children, that because of the uncertainty, fear, and violence that dominate their lives, many could not envision a future.[23]

III. CHILD HEALTH

A child's health encompasses his or her complete physical, mental, and social well-being, and it is also a right under international law. Provision of the necessary health services to fully encompass that right has regrettably not been a consistent feature in the lives of Palestinian children. Generations throughout the last 84 years have weathered a United Nations administrator, displacement and refugee status through forced migration, Jordanian and Egyptian administrators in the West Bank and Gaza respectively, another forced migration, and what is now a decades' long occupation characterized by jurisdictional shifts in healthcare provision between Israel, Palestinian civil society, and the Palestinian Authority. In fact, one might say that the only constant has been the omnipresence of change. Thus, the development and sustainability of health services for Palestinian children has been, and remains severely handicapped despite the noteworthy efforts of resourceful and dedicated international and local healthcare agents and tremendous donor support.

A. CHILD HEALTH INDICATORS

1. *Infant mortality rate*

The infant mortality rate is low in the Palestinian territories in comparison with other developing countries. In 2002, the rate was 20.5 per cent per 1000 infants compared with 22.9 in 2001 and 22.7 in 2000. The main causes of infant mortality were reported to be premature births, followed by respiratory infections, congenital malformations, sudden clinical death, and infectious diseases.[24]

2. *Child mortality rate (children under age five)*

There has been a recent drop in the mortality rate of children under five in the Palestinian territories. In 2000 the child mortality rate was 290.5 per 100 thousand children and in 2002 it stood at 223.3 per 100 thousand children. The main causes of child mortality are congenital malformations, pneumonia, respiratory infections, and infectious diseases.[25]

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[23] Save the Children-UK, and Save the Children-Sweden, "Education Under Occupation: Palestinian Children Talk About Life and School", March 2002, p. 37.

[24] Department of Information Systems. "Ministry of Health Draft Report", 2002.

[25] Ibid.

3. *Child mortality rate (children aged 5-19)*

The mortality rate in this age group of children has increased since 2000. Particularly as a result of *intifada*-related violence. The 2002 rate was 66.6 children per 100 thousand children (48.5 males and 18.1 females), up from the 2000 rate of 36.4 per 100 thousand children. The primary causes of death were reported to be Israeli violence, followed by traffic or other accidents, tumors, cerebral palsy, congenital deformations, and finally, pneumonia.[26]

4. *Malnutrition*

Conclusions from a 2002 nutritional assessment requested by the Minister of Health and conducted by a team from Johns Hopkins University and Al-Quds University under the auspices of CARE International declared that there is a "concerning prevalence" of acute malnutrition in the West Bank and that the Gaza Strip faces a "distinct humanitarian emergency" due to the prevalence of Global Acute Malnutrition.[27] The table below lists select indicators related to malnutrition from this nutritional assessment.[28]

Nutritional Parameters	Location	Prevalence (Percentage)	Location	Prevalence (Percentage)
Global Acute Malnutrition[a/] (6-59 month olds)	West Bank	4.3	Gaza Strip	13.3
Chronic Malnutrition[b/] (6-59 month olds)	West Bank	7.9	Gaza Strip	17.5
Global Anemia[c/] (6-59 month olds)	West Bank	20.9	Gaza Strip	18.8

a/ Acute malnutrition, or wasting, reflects inadequate nutrition in the short-term period immediately preceding the survey.

b/ Chronic malnutrition, or stunting, is an indicator of past growth failure, thus implying a state of longer term undernutrition. Chronic malnutrition may lead to serious irreversible growth and development delays.

c/ Anemia refers to the reduced oxygen carrying capacity of the blood due to a decrease in the mass of red blood cells. Iron, folic acid and dietary protein are necessary for hemoglobin and red blood cell production. Anemia can lead to impaired learning and growth development in children as well as decreased immunity from infectious diseases.

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[26] Ibid.

[27] Johns Hopkins University and Al-Quds University. "Rapid Nutritional Assessment for the West Bank and Gaza Strip", 2002, p. 11.

[28] The Johns Hopkins University/Al-Quds University nutritional assessment included a survey of 1,004 randomly selected households in the Palestinian territories.

Other results from the assessment indicated that four out of five children (in the West Bank and in the Gaza Strip) had iron and zinc deficiencies that cause anemia and immune deficiency respectively, and over half of the children in the Palestinian territories have inadequate caloric and vitamin A intake.[29]

The Johns Hopkins University and Al-Quds University team formed several conclusions related to the efficiency and effectiveness of the healthcare provision related to the prevalence of malnutrition based on the information gathered through surveys with 1,104 Palestinians randomly selected in addition to a survey of 68 clinics geographically linked to the former. Important among the conclusions from this clinic survey was the assertion that healthcare providers may not be adequately identifying and diagnosing malnutrition in the community for the following four reasons:

(a) Children in the age group 2-3 years are not monitored sufficiently to make the diagnosis of malnutrition or anemia;

(b) Only 60 per cent of pre-school children have anthropometric measurements taken and if they do, only 60 per cent of malnourished cases are recognized;

(c) Clinic managers underestimate the magnitude of the malnutrition problem in their community, further limiting their ability to detect and mange the problem;

(d) Most clinics lack protocols or guidelines for assessing and diagnosing malnutrition cases.[30]

B. INFECTIOUS DISEASE

The weakened state of a child's immune system, particularly when influenced by factors such as the lack of clean water, overcrowded living conditions, poverty, lack of sewage disposal and incomplete immunization can lead to a whole host of other diseases.[31] While the Ministry of Health has engaged in an aggressive immunization programme and other preventive measures to combat infectious diseases in the Palestinian territories, coverage levels are not 100 per cent. Infectious diseases remain one of the most important causes of child mortality. In 2002, death due to infectious diseases accounted for 42.4 per cent of mortalities in children less than five years of age, 35.5 per cent among infants, and 5.1 per cent among children from five to nineteen years of age. The following is a select list of infectious disease indicators for the Palestinian child population.[32]

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[29] Ibid., p. 7.

[30] Ibid., p. 11.

[31] Defence for Children International - Palestine Section, op. cit., p. 95.

[32] The source of all infectious disease data is the Department of Information Systems, Ministry of Health Draft Report, 2002.

1. Since 1982, there have been no reported cases of diphtheria or leprosy and there has been no trace of plague or malaria for a considerable length of time.

2. There have been very few cases of measles and tetanus.

3. Due in part to effective vaccination campaigns since 1992, cases of tuberculosis and hepatitis B continue to decline.

4. Mumps and rubella cases are registered predominantly in the child population above ten years of age due to the face that vaccinations in this area only started in 1987.

5. Hepatitis A is endemic in Palestine, as in all other areas of the Middle East.

6. Chickenpox and parasitosis are endemic in Palestine.

7. Prevalence of bacterial and viral meningitis are improving

(a) Meningoccus Meningitis:

(i) 2000, 3.6 per 100 thousand children;
(ii) 2002, 3.9 per 100 thousand children.

(b) Bacterial Meningitis:

(i) 2000, 11.8 per 100 thousand children;
(ii) 2002, 7.9 per 100 thousand children;

(c) Viral Meningitis:

(i) 2000, 59.9 per 100 thousand children;
(ii) 2002, 13.2 per 100 thousand children.

8. Brucellosis remains endemic in Palestine, but indicators are improving thanks to the efficiency of the national programmes to combat the disease.

9. No cases of polio have been registered since 1984.

10. Increased incidence of water-borne diseases such as scabies, skin infections, shigellosis, and diarrhea.

As previously mentioned, an enormous amount of effort and money has been spent on improving these indicators, yet many of them, particularly in the area of malnutrition remain sedentary. Prominent among the reasons for this is that the Palestinian healthcare industry seems destined for 'quick fix' solutions mandated by

both by international donors and international and local policy makers who take biological and medical indicators such as those listed above and divorce them from their social and environmental determinants in favor of investing in narrowly focused technical and administrative solutions.[33] This often ends in shortsighted solutions that are not grounded in a rights-based approach to healthcare development.

IV. IMPACT OF THE INTIFADA ON HEALTH

While the Palestinian territories are characterized by many of the typical health problems related to its status as a developing nation, there are specific negative outcomes in child health that are directly attributable to the Israeli occupation and the escalation in violence of the last three years. Israeli collective punishment has prevented those seeking health services to be able to reach these services and those in the medical profession looking to provide treatment from reaching those in need. Mobility restrictions, in addition to the destruction of health facilities, power lines and water filtration facilities, continue to impede needed improvements in the national health infrastructure. For example the smooth coordination and distribution of medical supplies and equipment such as vaccines among hospitals and clinics is a process that cannot be guaranteed through no fault of the hospital or clinic staff. In addition to the checkpoints, closures, curfews, and other delays that are likely to hold up this process, a February 2003 United Nations World Health Organization report provided the example of nine facilities that were forced to suspended immunization clinics for two or more days in the prior two weeks—a quarter of them sighting power outages. Similarly, another component of the health infrastructure that has been identified as a problem area is follow-up. The diagnosis and follow-up process for possible cases of infectious disease, for example, can also be occluded when a regional health clinic cannot physically transport a sample to a laboratory for diagnosis. These are just a few examples, but for the same reasons, there are numerous other direct healthcare consequences that have been widely reported, including but not limited to the following: the disruption of prenatal, postnatal, and medical screening; an increase in the number of still births when expectant mothers are not able to reach hospitals; disruptions in the referral system that most severely affect patents with cancer, renal failure, and other chronic conditions that require maintenance therapy; and reduced ability for those requiring surgery to reach hospitals.[34]

That said, it is important to reiterate that Israel, as an occupying power, is responsible under international humanitarian law to ensure that the healthcare needs of the Palestinian.

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[33] Giacaman, Rita, Abdul-Rahim, Hanan, and Wick, Laura, p. 3.

[34] Defence for Children International - Palestine Section, op. cit., p. 37.

People are met according to the terms of the Fourth Geneva Convention. For example, under articles 20 and 56, Israel is obliged to secure the access of medicine, medical services and medical personnel, yet 75 per cent of healthcare professionals are unable to report to work regularly.[35] Moreover, although Israel has not included the status of Palestinian children in any areas covered by the CRC in its periodic report to the CRC treaty monitoring body, the Committee on the Rights of the Child, Israeli is specifically violating article 24 which proclaims the right of every child "to the enjoyment of the highest standard of health and facilities for the treatment of illness and rehabilitation". Finally, while Israel continues to deny that it has any responsibility vis-à-vis its actions in the occupied Palestinian territories under the Fourth Geneva Convention and the CRC, nowhere do the feats of intellectual gymnastics by which Israel devises support for its lack of culpability under these regimes—often citing this technicality and that technicality of the wording of these treaties—seem more like.

A. CHILD DEATH AND INJURIES

Defense for Children International (DCI) - Palestine documented the death of 192 children below the age of 18 in 2002. These children were killed as a direct result of the Israeli presence in the Palestinian territories. The tables below illustrate the most common injury locations, type of weapon causing the injury (and subsequent death), and the circumstances surrounding those injuries.

Analysing the data collected DCI observed the following trends in Israeli violence toward Palestinian children:

1. The number of child deaths as a direct result of the Israeli army and settler presence in the Palestinian territories doubled in 2002.

2. The number of child deaths in 2002 exceeded all records of Palestinian child deaths documented by DCI since 1996 (when they began operating).

3. A higher percentage of the children killed are young children, with 43.2 per cent of all children killed in 2002 under the age of 12.

4. In 2002, the absolute number of child deaths under the age of eight quadrupled from the previous year.

5. The use of 'deadly force' against children increased dramatically, as indicated by the 45 per cent of children who were killed through air and ground attacks by IDF 15.

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[35] Refugees International. "Human costs of non-compliance with the fourth Geneva Convention", March 2003. Available at: www.reliefweb.org.

6. Soldiers attempting to assassinate adults.

7. 84.4 per cent of children were killed in situations where there was no confrontation occurring at the time of death.

Although no aggregate data for 2003 was available, DCI statistics from the first quarter of 2003 show the trends observed above are largely unabated.[36] The total number of child deaths (September 2000 to mid-June 2003) now stands at 459.[37]

Causes of death	2000-2003
Live bullets	262
Exploding bullets	38
Rubber-coated steel bullets	5
Heavy artillery	47
Tank shells	16
Tank shell shrapnel	12
Vehicular manslaughter	6
Other	6
Closure	16
More than one type	20
Unexploded Ordinance (UXO)	21
Missile	19
Bomb	5
Tear gas	6
Energia grenade	1
House demolition	5
Live ammunition shrapnel	5
Bomb sharpnel	1
Surface to surface missile	2
Beating	1
Total	514

Source: Defence for Children International - Palestine Section documentation.

* 28 September 2000 until December 2003.

[36] Defence for Children International - Palestine Section. "Breakdown of Palestinian Child Deaths, end-September 2000 to mid-June 2003". Available at: www.dci-pal.org/statistics.

[37] Ibid.

DISTRIBUTION OF CHILD DEATHS ACCORDING TO AGE GROUP

Age	Total
0-8	83
9-12	85
13-15	174
16-17	172
Total	514

Source: Defence for Children International - Palestine Section documentation.

* 28 September 2000 until 31 December 2003.

In addition to the 192 documented child deaths from 2002, DCI recorded the injury of 2,524 Palestinian children as a direct result of the Israeli presence in the Palestinian territories. The tables below illustrate the most common injury locations and the type of weapon causing the injury.

By the first quarter of 2003, DCI documented the injury of 679 children.[38] Although no comprehensive data was available, if the number of injuries continued at this rate throughout 2003, the number of child injuries would exceed that of 2002. In addition to the trauma associated with sustaining such injuries, there has also been a tremendous increase in the number of disabled children in Palestine. The United Nations Special Reporter of the Commission on Human Rights noted in his March 2002 report that approximately 700[39] of the children injured since the start of the *intifada* were likely to experience permanent disabilities as a result.[40] These children will join other children in being amongst the most vulnerable members of Palestinian society irrespective of provisions in both international human rights law under article 2 of the CRC and Palestinian Basic Law 4 specifying the rights of disabled persons. Even though disabled Palestinians had acquired heightened recognition, during the first *intifada* and under Palestinian domestic legislation in the 1990s, rights and service provision to disabled children have suffered serious setbacks.[41]

Treaty technicalities or not, the principles of distinction, proportionality and choice of means and methods of warfare (enshrined in the Fourth Geneva Convention)

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[38] Defense for Children International - Palestine Section. "Breakdown of Palestinian Child Injuries, 2002". Available at: www.dci-pal.org/statistics.

[39] The United Nations Special Rapporteur made this estimate on the basis of data indicating that approximately 7,000 children had been injured between September 2000 and the issue of his report.

[40] Quoted in Save the Children Sweden and Save the Children UK. "Growing Up Under Curfew: Safeguarding the basic rights of Palestinian Children", March 2003, p. 28.

[41] Save the Children Sweden and Save the Children UK, op. cit., p. 28.

are widely accepted as part of international customary law. The number of child deaths and injuries, the weapons causing death and injury, and the circumstances surrounding the majority of the injuries as described above, clearly indicate that Israel does not consider itself to be bound by these fundamental principles.

B. SUMMARY OF PROBLEM AREAS IN CHILD HEALTH

The list below summarizes some of the problem areas that decision-makers should consider in future policy making. In general, future policy directives should emphasize an approach to healthcare that is part of a single cohesive strategy, that targets the health needs of the population in consultation with that population, sets up a resource base through which implementation can be monitored and evaluated, and which gives due consideration to the environmental and social factors that shape healthcare delivery on the ground.

1. Coordination among healthcare providers has not reached adequate levels.

2. There is a lack of clear national policy mandates that place individual health interventions as part of an overall strategic framework to strengthen the public health infrastructure.

3. National insurance schemes do not cover all children in the three to six age group and they do not cover all procedures for school-aged children.

4. Children with special needs and disabled children are particularly left out of national insurance schemes.

5. There is a paucity of qualified personnel working in healthcare and a lack of child specialists.

6. There is a lack in the diversity of treatment that is available in the Palestinian territories as a whole.

7. 'Quick-fix' solutions are often implemented that do not give due consideration to the relevant social and environmental context or a rights-based approach to healthcare development.

8. Child health information systems are inadequate and require redesigning and updating.

9. There are disparities in the number of healthcare facilities among geographic regions.

10. The sector suffers from weak follow-up and referral systems among all healthcare agents; nutritional surveillance systems following trends in malnutrition and food security are weak.

11. Efforts at caregiver education to combat chronic malnutrition are insufficient.

12. There is a lack of food fortification strategies to combat anemia and macronutrient deficiencies.

V. PSYCHOSOCIAL HEALTH

Until recently, the subject of psychosocial health of war-effected populations has been a low priority among the matrix of competing needs that governments as well as international aid organizations negotiate when developing their strategic response to a complex humanitarian emergency. One now finds increasing budget allocations for psychosocial programming and subsequent implementation of programmes on the ground. As a logical accompaniment to this phenomenon, there has been a heightened interest in academic research in this area specifically analysing the impact of living in a war zone as a function of other risk factors in a child's social environment.[42] The psychosocial health of Palestinian children is a subject that has been the focus of a good deal of research, particularly following the first *intifada* in 1987.

Among the notable research initiatives focusing on the Palestinian territories was a study initiated in 1989 to examine the behavioral consequences of the experience of political violence on Palestinian children in the context of the functionality of their families and a series of specific vulnerability factors (gender, age, and community context).[43] Using a 'risk accumulation' model as the backbone of their study, the authors, Garbarino and Kostelny, found that:

> "As the number of risks related to political violence and family negativity increased, the level of child symptomatology also increased significantly. Political violence exerts a significant effect, but family negativity exerts a greater influence, and when coupled with political violence reveals a very serious 'clinical' impact."[44]

Their results showed that most children who had repeated exposure to *intifada*-related violence (up to three exposures) were not in need of clinical interventions if they were found to be part of a functional family. These findings support the widely

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[42] Garbarino, James and Kostelny, K., "The Effect of Political Violence on Palestinian Children's Behavior Problems: A Risk Accumulation Model". *Child Development*, vol. 67, No. 1, January/February 1994, p. 33.

[43] Ibid., p. 41.

[44] Ibid., p. 41.

acknowledged premise that several factors, including the type, degree and duration of stressful events, in addition to a child's subjective understanding of the events and the child's developmental stage all contribute to determining the severity of the child's reaction to events—not necessarily the simple occurrence of a traumatic event or even a series of traumatic events in isolation. However, Garbarino and Kostelny found that exposure to *intifada*-related violence, when compounded with exposure to 'family related risk',[45] was generally enough to put the child over the threshold indicating a need for clinical intervention.

While we cannot assume that present circumstances are a perfect reflection of the circumstances of the first *intifada*, of particular importance to decision makers within the context of the current *intifada* are the study findings related to the 'community context'—one of the three vulnerability factors measured by the study. The 'community context' measured the relationship between five indicators of socioeconomic status (living conditions, father's educational level, father's employment status, mother's educational level, and mother's employment status) against communities with low and high levels of violence respectively, and with the behavior problems displayed by children in those communities. While no correlation between low socioeconomic status and the amount of behavioral problems a child manifested was found, the study did indicate that children whose families were of a low socioeconomic status were more exposed to violence and thus more exposed to '*intifada-related*' risk. The authors additionally noted "given the overall correlation between family dysfunction and lower socioeconomic status observed in most societies, we can predict that the most vulnerable children...are most likely to be found among low-income populations".[46] In summary, among other findings from this study, the authors concluded that prevalence of exposure to *intifada*-related violence, coupled with negativity in the family and family dysfunction—the latter which is strongly correlated with socioeconomic status in all societies—accumulated enough risk in Palestinian children to push many of them into the range for clinical intervention.

It is well document that Israel's stepped-up regime of collective punishment since the outbreak of the *Al-Aqsa intifada* has brought with it unprecedented violence directed at the Palestinian civilian population—including the child population—and unprecedented levels of poverty. These circumstances have at best made it difficult to be a carefree child, and at worst have lead to a striking increase in the number of children requiring psychosocial interventions. This is evidenced by Ministry of Health data reporting that there has been a 105 per cent increase in new cases at mental health

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[45] Family related risk was defined in the study as one of the following: physical violence directed at the child by the mother, physical violence in the family directed at the mother, verbal aggression in the family directed at the mother by the father, maternal depression, and physical violence directed at the child by someone other than the mother.

[46] Garbarino, James and Kostelny, K., op. cit., p. 43.

clinics since October 2000, and that children under 18 constitute the majority of the new cases.[47] A 2003 Secretariat study by Palestinian National Plan of Action (NPA) conducted to gain insight into how Palestinian children themselves see their situation reported that almost half of the children taking part in the survey (1,266 children in the West Bank and the Gaza Strip were surveyed) had experienced directly *intifada*-related violence, or witnessed and accident befalling an immediate family member.[48] Other select findings from this study are indicated in the following box.

Children on their situation

- 93 per cent reported not feeling safe and exposed to attack—fearing not only for themselves but also for their family and friends;
- Almost 50 per cent felt that their parents could no longer meet their care and protection needs;
- 32 per cent reported that their father was unemployed;
- 11 per cent reported that their fathers worked only part-time;
- 16 per cent reported that they are living in homes with 11 or more people, 51 per cent living with 7-10 people, and the remaining 33 per cent reported living in households with six or less people;
- 84 per cent reported the need to move out of their homes either temporarily or permanently since the start of the *intifada*;
- 84 per cent felt that their homes were no longer a safe place.

The NPA Secretariat study also surveyed 449 parents from 270 households. Discussions with parents revealed that the violence and unpredictable external events are wearing them down and severely undermining parental confidence in being parents, and their control inside the home. Select indications from parents can be found in the box below.

[47] Quoted in Save the Children Sweden and Save the Children UK, "Growing up under Curfew: Safeguarding the Basic Rights of Palestinian Children", March 2003, p. 20.

[48] Arafat., Dr. Cairo. "A Psychosocial Assessment of Palestinian Children". Secretariat for the National Plan of Action for Palestinian Children, July 2003, p. 5.

Parents on their situation vis-à-vis their children

- 89 per cent of parents reported symptomatic traumatic behaviour amongst their children, including, nightmares and bedwetting, increased aggressiveness and hyperactivity, as well as a decrease in attention span and concentration;
- 50 per cent felt unable to meet their children's needs under present circumstances—even though they felt it was their responsibility to care for the children;
- 25 per cent admitted not spending time with their children because they were stressed or burdened by other concerns;
- 100 per cent felt that their ability and capacity to protect their children decreased since the start of the *intifada*;
- 12 per cent considered their homes to be safe from danger.

Therefore comments from children and their parents cannot be used as constitutive evidence of the scope of psychological damage to Palestinian children in lieu of more quantitative studies on the second *intifada* and children's psychosocial well-being.

VI. EDUCATION SITUATION

Perceptions of children and their parents, when taken in aggregate seem to again fit Garbarino and Kostelny's 'risk accumulation' paradigm from the first *intifada.*

The Israeli occupation had hurt the infrastructure of the educational process in various ways and means, and the following are facts about what is happening:

1. As result of rockets and tanks shelling, 282 school buildings were damaged since the breakout of the Intifada.

2. Nine schools are still closed, of which three serve as military bases, similar to what is still taking place in Usama Ibn-Al-Munqith, Banat Joher and Al-Ma'aref schools in Hebron.

3. The estimated value of the Israeli damage in Palestinian schools is US$ 5.2 million.

4. The estimated value of the Israeli damage in Palestinian Universities is US$ 4.85 million.

5. 600 Palestinian children were killed from the beginning of Al Aqsa Intifada until 10 May 2004, 465 of whom were enrolled in the school system.

6. 4,600 students were injured from the beginning of Al Aqsa Intifada until 10 May 2004.

7. 27 school teachers were killed from the beginning of Al Aqsa Intifada until 10 May 2004.

8. 295 schools were shelled, 9 of which were totally destroyed from the beginning of Al Aqsa Intifada until 10 May 2004.

9. 15 schools were ordered closed from the beginning of Al Aqsa Intifada until 10 May 2004.

10. Three schools in Hebron were occupied by the military.

11. The total cost of school and university damage caused by the Israeli army during the Intifada is estimated at US$ 15 million.

From the beginning of Al Aqsa Intifada until 12 February 2004		
	Students	Teachers
Killed	429	26
Arrested	543	167
Injured	3 354	51

Source: Ministry of Education Report, 12 February 2004.

The educational infrastructure was no less harmed, as shown in the table below:

From the beginning of Al Aqsa Intifada until 12 February 2004				
	Schools closed due to curfews and closures	Schools demolished due to bombing	Schools closed completely	Schools transformed into military places
Schools	498	282	9	3

Source: Ministry of Education Report, 12 February 2004.

Case	Description	From 28 September 2000 to 6 April 2004
Martyrs	Teachers	27
	School students	450
	University students	195
	Employees	7
Detainees	Teachers	167
	School students	542
	University students	710
	Employees	29
Injured	Teachers	53
	School students	3 354
	University students	1 245
	Employees	12

Source: Palestinian Centre for Human Rights, May 2004.

The worst scenario is Nablus district, since it is suffering from tight and strict curfews and closures, where an approximate number of 500 teachers could not reach their schools. Despite all these difficulties, 9 schools challenged the hard sieges and closures, and thus, education was not completely disrupted in these schools. Also in Kufor Ain's schools (girls and boys) in Ramallah, studying was disrupted as a result of the tight curfew.

With all the obstacles and restrictions mentioned above, there still are 1.1 million students in the Palestinian basic education schools in the West Bank and Gaza, in addition to 110,000 university and collage students. Also, the 2003-2004 surveys show that 97.5 per cent of children 6-15 years of age enroll in basic education schools; females account for 49 per cent of school students, and 57 per cent of university and college students.[49]

[49] Ministry of Education Report, 2004.

HOMES DEMOLISHED IN 2003

Location of demolition	Number of homes demolished
Hebron	67
Bethlehem	6
Jerusalem	65
Jericho	2
Ramallah	9
Nablus	27
Tulkarem	5
Jenin	2
Gaza	854
Total	1 037

Source: Defense for Children International - Palestine section documentation, 2004.

CHILDREN AFFECTED BY HOME DEMOLITIONS IN 2003

Children's ages	Number of homeless children
0-2	637
3-5	759
6-8	749
9-11	765
12-14	696
15-17	460
Total	4 066

Source: Defense for Children International - Palestine section documentation, 2004.