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OPERATIONAL ACTIVITIES FOR DEVELOPMENT

Health needs of Palestinian refugee children

Report of the Secretary-General

1. The present report is submitted to the General Assembly in pursuance of General Assembly resolution 33/81 of 15 December 1978, concerning the health needs of Palestinian refugee children, in which the Assembly requested Member States and the agencies concerned, in particular the Food and Agriculture Organization of the United Nations (FAO), the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), to co-operate with the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) in taking effective action to remedy the basic deficiencies identified in the annex to the report of the Secretary-General (A/33/181) which had been presented to the Assembly at its thirty-third session. The Assembly also requested the Secretary-General to keep the situation under constant review and report his findings to the Assembly at its thirty-fourth session.
2. In communications dated 12 April 1979 addressed to Member States and agencies concerned, the Secretary-General drew attention to his reporting responsibility under the resolution and requested that he be furnished with relevant information in response to the General Assembly's request.
3. The information set out below has been supplied by the Commissioner-General of UNRWA who, in connexion with the implementation of the General Assembly resolution, has been in contact with the Member States and agencies concerned. It should also be noted that UNRWA's Director of Health, like four other senior members of the Agency's Department of Health, is on loan from WHO and directs the Agency's health programme in accordance with WHO's technical expertise.

* A/34/150.

4. The 1978 nutrition survey was only one of many similar surveys previously carried out by UNRWA with WHO technical support for the purpose of appraising the general nutritional state of the Palestine refugees registered with the Agency.

5. The 1978 survey showed a very low prevalence of acute malnutrition as expressed in low weight for height of children. In fact, the distribution of weights for heights corresponded closely to that of a national sample of the United States of America which was chosen as the reference population (figure 1). Outside the limit of two standard deviations below the median of the reference population, there are 3.1 per cent of the refugee children as against 2.3 per cent of the reference population. The percentage of very thin children is thus only marginally higher than in the reference population. A comparison with the results of the previous surveys, in 1974 and 1975, shows that a definite improvement has occurred since 1974 (figure 2).

6. While the prevalence of acute malnutrition is not significantly greater than in the United States of America, the refugee child population has a greater proportion of very short children: 17.4 per cent are below the limit of two standard deviations as against 2.3 per cent of the reference population (figure 3). Not only are there more short children, the child population as a whole is shorter than the reference. In contrast to the weight curves, the curves of the height distributions of the surveys in 1974, 1975 and 1978 are identical and super-imposed (figure 4). Thus, the situation has not changed. A breakdown of the heights by age groups reveals a normal height development up to 9 months of age. Thereafter, heights increasingly lag behind those of the reference (figure 5).

7. In a population, growth retardation in early childhood is usually interpreted as indicative of early or chronic malnutrition. But, as stated above, in the refugee children, no significant acute malnutrition was observed at any age. Furthermore, in no age group was thinness associated with shortness. In view of the general paucity of signs of acute malnutrition in the population, unavailability of food would seem unlikely to be responsible. Rather, one may have to look for causative factors in the environment. Two obvious possibilities are infections and weaning. The incidence of diarrhoeal disease in the population is high and seems not to have changed much over recent years (figure 6). The field trial on the impact of oral rehydration in the management of infantile summer diarrhoeas which is being carried out in the Gaza and West Bank offers an opportunity to study also the effect on growth. Information on breast feeding and growth is available on a subsample of about 900 children in the 1978 survey. A first analysis has shown a distinct difference between weaned children and those still receiving breast milk, the latter being, on average, taller for their age than the former. The mean weight for age of the weaned children corresponds to the peak of the curve for refugee children in figure 3 while the mean of the children still receiving human milk is near the peak of the reference children. However, this point needs verification by further analysis.

8. As has been previously reported, a considerable proportion of children show low haemoglobin levels and a certain degree of anaemia. The observed large differences between operational fields have cast some doubt on the reliability of current haemoglobinometric methods.

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9. In response to the survey results and in order generally to improve the health of the refugee children, UNRWA has, during the last year, introduced a series of modifications of its services. The national and local health authorities concerned have been duly informed of these improvements and have generally concurred in the action taken by the Agency. These modifications are as follows:

(a) Milk programme: dry milk distribution (whole and skim) was generalized up to age 3 years effective 1 January 1979. The new scheme has increased the regularity of attendance at the child health clinics (from 54 per cent to 77 per cent) and the utilization of milk (from 18 per cent for liquid milk to 60 per cent for dry milk).

(b) Hot meals programme: hot meals were made available to all-comers up to the age of 8 years (instead of 6) starting April 1979. It is still early to evaluate the impact of utilization, but an increase of at least 20 per cent in the number of beneficiaries is expected.

(c) Protein supplement: the issue of 2 meat tins (12-ounce each) per month to every eligible pregnant or nursing mother was implemented in July 1978. About 25,000 women are benefiting.

(d) Malnutrition clinics: the number of such clinics increased from 10 in 1977 to 20 in 1978 and 26 in 1979.

(e) Surveillance of child growth: a new chart based on weight for height (instead of weight for age) was produced by WHO headquarters, Geneva. It is in use in one or more child health clinics in every field on a trial basis for 6 months, after which an evaluation will be made for possible extension to other clinics.

(f) Anaemia: a new haemoglobinometer has been introduced in the fields aiming at more accurate determination of Hb levels. More emphasis is paid by the fields on the consumption of iron folate tablets at home by pregnant and lactating women.

(g) Health education: is now concentrated more on the prevention of diarrhoea and on the promotion of breast feeding.

(h) Diarrhoea: in the Gaza and West Bank a field trial has been started on the impact of oral rehydration in the management of infantile summer diarrhoeas. The trial is conducted by the local health authorities in collaboration with UNRWA and with the Division of Communicable Diseases of WHO.

10. The Agency expects that the adopted modifications of its supplementary feeding services for the benefit of the most vulnerable groups of the refugee population registered with UNRWA will have a further beneficial impact on their nutritional state. However, it is too soon for a statistical analysis of the situation to demonstrate with reasonable accuracy any definite developments.

Key to figures 1, 2, 3, 4, 5 and 6

Figure 1

UNRWA survey 1978, all Fields combined, children 0-35 months old.
Distribution of weight for height (solid line) plotted over the distribution of the reference population (interrupted line).

Abscissa: standard deviations from the mean of the reference population
Ordinate: frequency in percent. by 0.5 SD classes. Reference population; NCHS, USA.

Figure 2

UNRWA surveys 1974, 1975 and 1978, GAZA and JORDAN Fields combined, children 0-35 months old.
Distributions of weight for height in 1974, 1975 and 1978.

Abscissa: standard deviations from the mean of the reference population
Ordinate: frequencies in percent. by 0.5 SD classes.

Figure 3

UNRWA survey 1978, all Fields combined, children 0-35 months old.
Distribution of height for age (solid line) plotted over the distribution of the reference population (interrupted line).

Abscissa: standard deviations from the mean of the reference population
Ordinate: frequency in percent. by 0.5 SD classes.

Figure 4

UNRWA surveys 1974, 1975 and 1978, GAZA and JORDAN Fields combined, children 0-35 months old.
Distributions of height for age in 1974, 1975 and 1978.

Abscissa: standard deviation from the mean of the reference population
Ordinate: frequencies in percent by 0.5 SD classes.

Figure 5

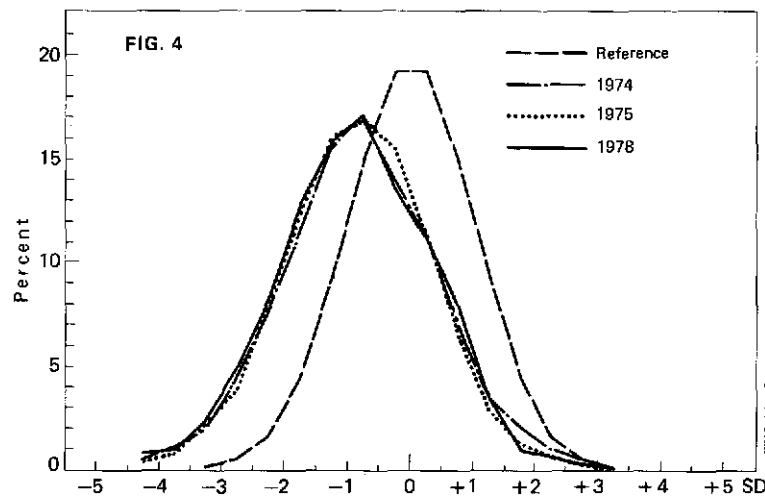
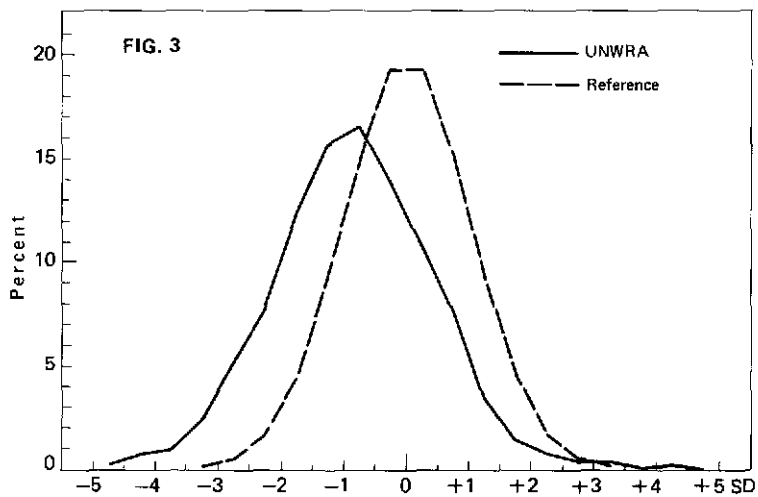
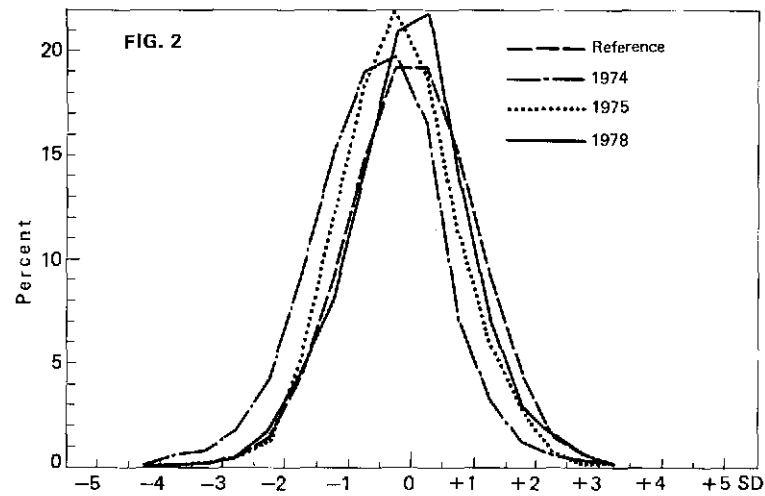
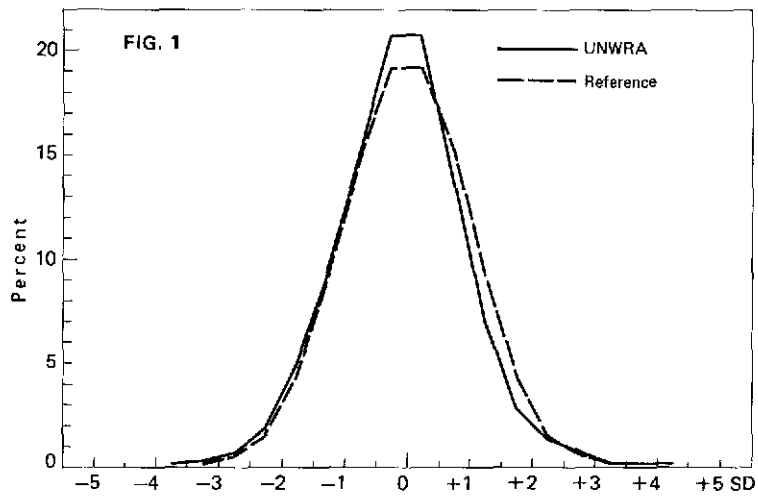
UNRWA survey 1978, all Fields combined.
Distributions of height for age by age groups of 3 months, 0-23 months.

Abscissa: standard deviations from the mean of the reference population
Ordinate: frequencies by 0.5 groups.

Figure 6

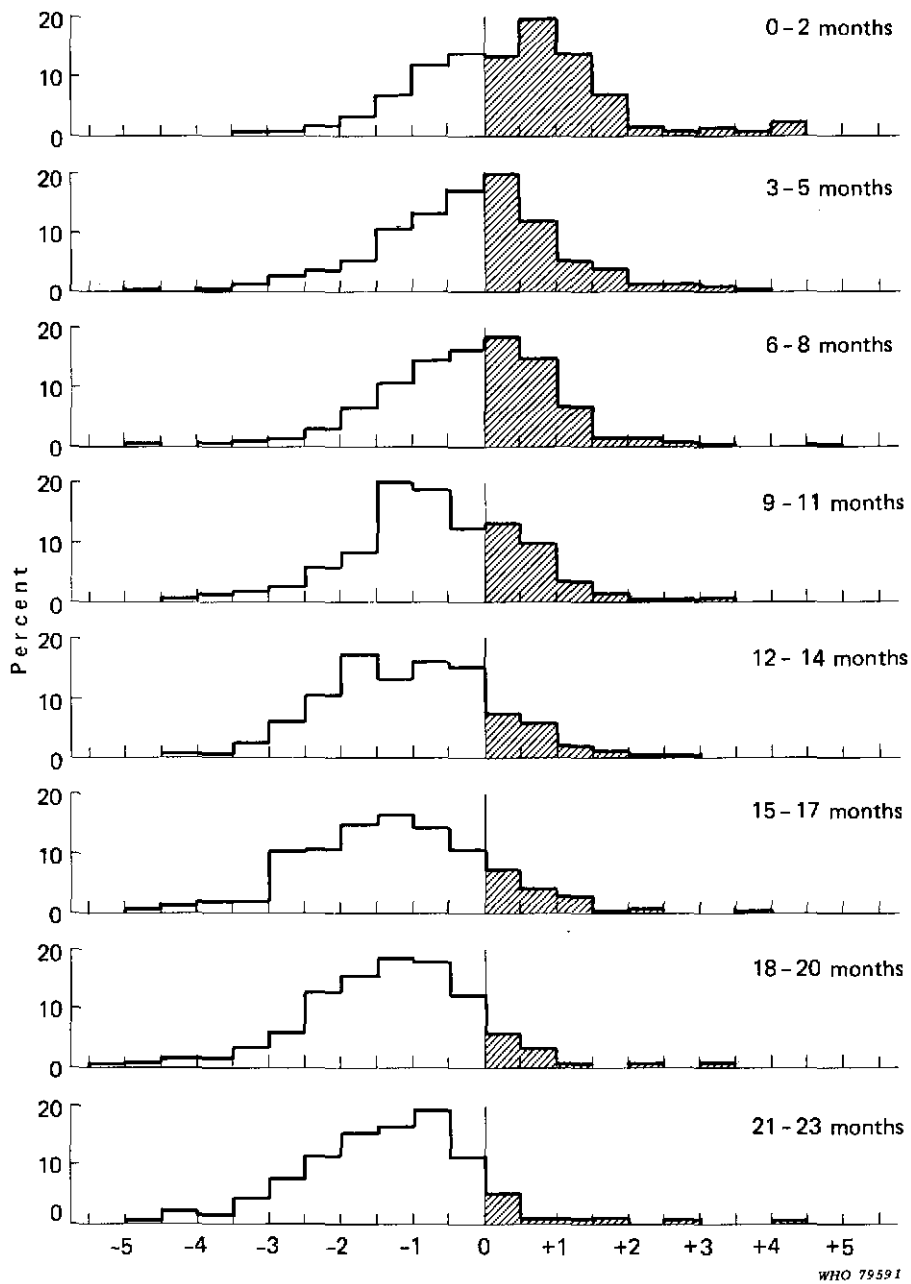
Recorded cases of children with diarrhoea and with underweight in UNRWA clinics, all Fields (quarterly, in thousands).

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FIG. 5



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