REFUGEES & ASYLUM

What are the maternal, infant and child mortality rates amongst Palestinian refugees and what are their causes?

“War does not determine who is right - only who is left.”
~Bertrand Russell

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Abstract:

Background: Refugee and Asylum seekers come from all around the world and seek sanctuary, in an attempt to escape the traumatic experiences they faced back home. Instead, they are welcomed in the most inhumane, distressing and humiliating manner. The focus group for this report is the Palestinian population of refugees. The 1948 war between Israel and Palestine generated the largest and most vulnerable refugee population of the world (currently 7.1 million). Within this population of refugees, women and children are the most likely to be susceptible to the harsh living conditions. The mortality rates amongst this population of refugees are indicative of the overall health and living conditions.

Aims: To identify the changes in maternal, infant and child mortality rates over the years in the different refugee settlements and to account for the causes of the rates and their effect.

Methods: In a systematic process articles, journals and statistical data are gathered, critically appraised and analysed in a comparative way. The data is used to draw conclusions as to whether there are essential differences. The databases used for the research of articles are Medline and Google Search. The Critically Appraisal Skills Programme is used in order to class the articles as reliable and relevant for usage. Also, to facilitate the study, personal contact with refugees is encountered.

Results: The study showed that there has been a general decrease in infant and child mortality rates over the years. On the other hand the maternal mortality rates seem to not have clearly defined results, as there seem to be many factors affecting the rates.

Conclusions: On consideration of the results and the fact that there is an inconsistency of data collection for some areas as the conflict in the Middle-East is ongoing, it can be concluded that the mortality rates depend on a vast amount of causes which often combine. Also the scarce amount of data does not allow for major comparisons to be made. On the whole infant and child mortality rates have decreased as a result of mothers being able to give birth in local hospitals (hence the data is more comparable to the local population and not a result of solely the refugee community). On the other hand maternal rates seem to be inconsistent with time changes as many other factors and causes come into the equation.
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# Learning Objectives:

1) To understand the system of refugees and asylum seekers
2) To identify the key issues with Palestinian refugees in neighbouring countries
3) To explore the changes in maternal, infant and child mortality rates over the past years, amongst the Palestinian refugee population.
4) To detect the underlying causes of the mortality rates in the above population
Definitions:

- **Refugee**: “... a person who ‘owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country...’ (Definition quoted from the 1951 Refugee Convention)”

- **Asylum Seeker**: “... someone who has lodged an application for protection on the basis of the Refugee Convention or Article 3 of the ECHR.”

- **European Convention on Human Rights (ECHR)**: “…an international legal instrument adopted under the auspices of the Council of Europe. Its provisions are enforceable in UK law courts.”

- **United Nations High Commissioner for Refugees (UNHCR)**: “... the UN agency with a mandate to protect refugees worldwide.”

- **UNRWA**: United Nations Relief and Works Agency for Palestine Refugees in the Near East

- **Maternal Mortality Rate**: calculated per 100,000 live births. ("Maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.")-WHO definition

- **Infant Mortality Rate**: “Probability of dying between birth and exactly one year of age expressed per 1,000 live births.”- UNICEF definition

- **Child Mortality Rate**: for the purpose of this report it is the number of children under the age of 5, dying per 1,000 live births.

- **BADIL**: Resource Center for Palestinian Residency and Refugee Rights

- **Displaced Person**: A person living in a foreign country who has been driven from his or her homeland by war.

- **Internally Displaced Person**: "persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalised violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognised State border." (Guiding Principles on Internal Displacement, Introduction, para. 2)

- **NGOs**: Non Governmental Organisations

- **WHO**: World Health Organisation

- **Blockade**: to prevent entry or exist in a specific area.
Introduction:

Wherever there is war and conflict, there are casualties, injuries and an increase in the incidence of diseases. War however, also creates a huge number of refugees and asylum seekers. The social disintegration, the unsafe environment, the elements of pain, fear, torture and sexual violence, force people to migrate beyond the borders of their country or region, and to seek a safer environment.

The ongoing conflict between Palestine and Israel since 1948 has not only scarred the history of the Middle East, but has also been a major determinant in the history of refugees and asylum seekers. The Palestinian refugees generated, make up the largest single group within the world refugee population, most of who flee to neighbouring countries. Each of these countries behave differently towards the refugees and although there are refugee camps to provide some basic support, Palestinian refugees are often found in situations which restrict them financially and socially, hence making them the most vulnerable and financially dependent community of refugees under UNRWA, outside the occupied Palestinian territories.

Like most refugees and asylum seekers, the Palestinians are forced to move out of their land due to mitigating circumstances and are usually heavily impacted by the traumatic experiences of war. These people are stripped from their homes, their land, their families and friends and often their dignity and liberty. They are continuously subject to humiliation and as a consequence of all the aforementioned they are found to suffer from mental distress and mental disorders. As a result of this physical and psychological suffering, most of the refugees and asylum seekers end up travelling for miles under horrific circumstances in search of a better and safer place. At the same time they may be faced with further public humiliation, inhumane living conditions, distress, a degrading lifestyle in camps and once again they find themselves in situations where most of their human rights are being breached. (See Appendix 1 for Human Rights Act)

It is clear that even amongst an extremely vulnerable refugee population there are certain individuals who are more exposed to risk and are more prone to being affected by diseases and difficult circumstances. Usually this group of individuals consist of women and children. Pregnant women and young children are even more susceptible to the effects of malnutrition, hard living conditions, changes to their environment and instability (both on a social and on a personal level).

Looking at maternal and child mortality rates allows for the formation of an indication of socioeconomic conditions, the state of primary health care, perinatal care and the environmental factors affecting health, such as nutrition, communicable diseases as well as hygiene and sanitation provided in an area.
Key Statistics of Palestinian Refugees:

Number of displaced Palestinians worldwide is 7.1 million

Of which: 6.6 million are refugees and 427,000 are internally displaced persons (IDPs)

67% of all Palestinians worldwide are refugees or IDPs, and 4,766,670 refugees registered with the UNRWA. The table shows a quick comparison of where most Palestinian refugees are found and the rights that they are entitled to within those countries.  

<table>
<thead>
<tr>
<th>Country</th>
<th>Number Registered with UNRWA</th>
<th>Rights</th>
<th>Number of Official Camps</th>
<th>Number of Unofficial Camps</th>
<th>Extra</th>
</tr>
</thead>
<tbody>
<tr>
<td>JORDAN</td>
<td>~1.9 million</td>
<td>Full citizenship rights (except 120,000 people who originally came from Gaza strip)</td>
<td>10</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>LEBANON</td>
<td>~ 425,000</td>
<td>Stateless, denied basic rights (i.e barred from 20 professions, no access to social service) Health and education services-limited</td>
<td>12</td>
<td>-</td>
<td>3,000 Palestinians not registered with UNRWA-have no form of identification documents- Have no form of assistance expect NGOs</td>
</tr>
<tr>
<td>SYRIA</td>
<td>~ 427,000</td>
<td>Citizenship rights</td>
<td>9</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>GAZA</td>
<td>~ 1.1 million out of a total population of 1.5 million</td>
<td>8 UNRWA Camps</td>
<td>19- overcrowded and poorly serviced</td>
<td>19- overcrowded and poorly serviced</td>
<td>1967 blockade from the Israeli government created huge economical suffering. This blockade has restricted the work of UNRWA, and has also not allowed the rebuilding of destroyed homes and infrastructure in the area of Gaza since the conflict in 27 December 2008</td>
</tr>
<tr>
<td>WEST BANK</td>
<td>~ 779,000</td>
<td></td>
<td>19- overcrowded and poorly serviced</td>
<td>The closure by military forces and the constant checkpoints has put a huge economic strain of the West Bank.</td>
<td></td>
</tr>
<tr>
<td>ISRAEL</td>
<td>~ 335,204</td>
<td>Right to Israeli citizenship, but denied the right to return to home villages/towns</td>
<td>335,204 Palestinians displaced in 1948 and remain within the know known Israeli borders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EGYPT</td>
<td>~ 11,544</td>
<td>No permanent residency rights. They cannot register as refugees</td>
<td>~ 50,000 people, who fled to Egypt in the 3 major wars of 1948, 1956, 1967</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IRAQ</td>
<td>~ 11,544</td>
<td>Population in 2006- ~ 34,000. The Palestinians where a targeted group in 2003 Iraqi war, and where forced to become displaced for a second time, seeking refuge usually in the neighbouring Syria or Jordan</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
It is important to note that Palestinians of the West Bank are labelled as refugees, since they are living in camps and are under the support of the NGOs. They are subjected to the army blockade and have minimal access to basic medication, food and building supplies. They are refugees within their own land.

Another important issue to be noticed is the fact that from the above list of countries most have been subjected to war and conflict themselves. This tragic irony finds the Palestinian refugees who flee for a safer environment in the middle of other crises. Therefore, this in itself affects the Palestinian population in terms of number of deaths, incidence of diseases and health rates without being directly related to the conflict between Palestine and Israel.

Furthermore, on a more humanitarian level, the Palestinian refugees are being subjected to further suppression of their rights and addition trauma and distress.

It is essential to understand that due to the various conflicts at different times in history, there are major gaps in the collection of data within the 63 years on conflict. This inconsistency of information can be a barrier in a clear follow up of health rates, and may cause a disruption when trying to form an overall conclusion on the specific population of refugees.

**Media Portrayal:**

Refugees and asylum seekers generate a good deal of media coverage. However, they are often described with a negative attitude and in general the cruel story and the facts behind them are avoided. The media tend to use language that depersonalise refugees, i.e. “floods” and “masses” and have a tendency to portray them as people who have a negative affect on the socio-economic aspects of a country. Most of the refugee stories that hit western headlines are those related to criminal acts and those that portray a negative impact on the local society. This can create a negative unilateral opinion on refugees, amongst a community, which may be a result of underlying political aims.\(^5\)
The conflict between Palestine and Israel has been going on for almost 63 years. This in itself has attracted media coverage from all over the world. However, where conflicts exist, media representation may very likely be subjective or even deliberately biased in order to influence public opinion. This does not mean that data is fictional, however the way it is interpreted and represented to the public may create an intended false-fact general opinion. This in itself can cause problems, as the public debate can create a false idea or false picture of the issues.  

It is also common for the media to present the actual war scenes and talk about the current war zones, and tends to put aside the millions of refugees and asylum seekers who face severe problems too.

The general public is often accused of ‘refugee fatigue’, which does not detract from the reality of lives of the refugees.
**Case Study 1:** personal interview with refugee.

The interviewee is a female refugee, born in Jerusalem, who considers herself a “Palestinian in exile”.

She was forced to leave her home, which was in a small village just outside Jerusalem, at the age of seven and has been in exile for about 44 years. Her family fled during the six-day war (1967-which produced a large number of refugees).

Her memories are scarred within her. She remembers her grandfather asking her to sit against a wall in her garden with other children, when he found out that the army would invade the village. They feared reliving another “Deir Yaseen” (she explains that this was a massacre of a village which left no one alive, as an example to the rest of the country). Her next thoughts are not well defined. She recalls loud noises and the command to run up in the mountains. Her grandfather had a small van and managed to catch up with the villagers who were running, and he took as many children as possible. Her next images are those of a dark underground room, which they were hidden in, in a nearby village. She said, “Us, Palestinians, we never talk about what happened then, especially in our family. We feel ashamed about it, it hurts us…” This was followed by “Only, a while back did I find out from my aunty that, that room was a grave yard, I don’t remember how we lived or what we ate, only the dark…”

(She confessed that 43 years later her fears remain with her; she can still not stay in a dark room alone, and fears the absence of light.)

Her father was studying in Jordan at the time and eventually her mother and siblings managed to meet him, when the borders opened, and flee as refugees. She grew up and studied mathematics, got married and found herself living in the UK.

She recalls being treated as a refugee for most of her life, where her only proof of identity was her refugee card, given to her in order to get some free food, and a free pass in certain countries.

She admits to having had psychological problem, and states her fears, weaknesses and nightmares.

Only recently on an outing with her friends did she realise her extreme hidden fear for army planes. She was found in a hysterical condition “crying like a baby-people around me thought I was mad”, when a training army plane in the UK flew very low, next to the boat she was in, reminding her of the sounds and images of the war.

Her beliefs are strong, her faith is endless, her heart is huge and her dream is only one…”to return home”. Today she fights for the rights of the Palestinians, and tries to support the asylum seekers and the refugees in Liverpool.

As a child she survived, and managed to flee, but her trauma remains within her.
Case Study 2:
A fourteen-year old girl describes her life in the Shatila refugee camp in Lebanon. She explains that she was not born when the massacre occurred (September 1982) and she has only heard stories about the events from her parents.

She explains that she lives in an insecure environment, and that those who survived the massacre live in the shadows of those three days, where thousands of refugees were killed. She claims that it was the dream and determination of the Palestinians to return home one day, that made the conflict chase them even in the refugee camps, and kill them in masses.

She states that she is living a daily massacre, as she is a refugee with no homeland. She is suffering over her fading dreams, and identifies the fact of children dropping out of school, the removal of human rights from the refugees, the horrific conditions in the camps as a daily massacre she has to live.

She lives by one dream, to return home.

These two case studies are given as an indication of the suffering that the refugees have to go through and can help in the understanding of their psychological context.

The first case study deals with a young child fleeing from the war zone and being a refugee in the western culture where she is stigmatised as a refugee and still has major post-traumatic stress syndromes. Whilst the second is a young girl in a refugee camp in Lebanon, who describes the inhumane conditions they live in and how she is deprived from her rights to live as a normal child.

These studies will help understand the background of the report and identify key areas of analysis.

Methodology:

In order to obtain the required information for the report various databases and research engines were used.

Firstly, a research was conducted using Medline. Key words were entered followed by limitation criteria. In this case the search was focused on “maternal mortality”, “child mortality” within the limits of birth-five years of age, and on Palestinian origin refugees. The search results were combined or eliminated according to relevance. The “OR” was used initially to identify as many articles of similar context as possible, and in the combined search the “AND” was used to eliminate as many irrelevant articles as possible. The following table is a sample of how the search was conducted:
From the above searches only the highlighted articles where revised in order to identify which ones were relevant for the study.

Due to the fact that the report is based on current data, which require various sources of information from various organisations, in addition to the above search Google was used as another database to facilitate the relevance of articles found. The key words in Google Search were: “Palestinian Refugees”, “Maternal mortality rates amongst Palestinian refugees” and “Child mortality rates amongst Palestinian refugees”.

The Critical Appraisal Skills Programme (CASP) was used in order to differentiate between relevant and irrelevant articles. According to the CASP criteria the article had to be relevant to the above limitations, had to be of minimal bias, had to have evident and clear explanations of how the data was retrieved and had to be based on clear facts.

Another aspect of the search was fieldwork, where refugees were met and their situations were discussed in order to understand, identify, and establish the situations these people face and acknowledge the difficulties they must overcome.

On finding the articles, and critically appraising them, the data was compared and analysed.
Results:

In order to reach the results the following steps were followed in eliminating and keeping articles.

In addition to the above search, a parallel search was conducted in Google Search in order to enable the identification of key definitions, complimentary data and to help deduce the background of the current situation in the Palestinian refugee community. There were multiple sources most of which were eliminated due to bias. The results of the search show key features of the current state of the Palestinian refugees.
Infant and child mortality rates:

The table above shows that the areas which contain the most Palestinian refugees have shown a decline in the number of deaths as far as neonatal, post-natal and after 1 year of age, are concerned.

The reason the West Bank does not have any data from 1997 is due to the conflict that existed at the time, which made data collection impossible.

The same study showed that there are various factors that can affect the mortality rates, which are not directly linked to a disease. Some of these factors are listed below:

1) Time of registration of the baby: when the child is registered, it is weighed, examined and vaccinated for BCG and OPV. In different areas the baby is registered at different times, and this delay may cause a child’s life if it has a major illness.

2) The age of the mother.

3) Gender of preceding child

4) Mean parity according to mother’s age

5) Mother’s education

The above study compared the data it found to already published data. The results showed that:

There is a general decline in child mortality rates in the Arab world, and the Palestinians demonstrate the lowest rates of all. However, it is believed that this is due to the local action of UNRWA. It is interesting to note that a comparison between the studies conducted by UNRWA is very similar to other organisation’s studies:
The table shows the comparison of different studies conducted for infant mortality rate. In general it can be seen that the UNRWA studies are comparable to the other studies conducted by the host countries and this allows for the data to be more reliable.

It is important to realise that all the studies that show the greatest similarity are those conducted by major organisations such as WHO and EMRO, which are considered reliable and tend to be less biased than a national survey that may aim to portraying particular results for personal benefit.
The main causes of infant and child mortality rates in accordance with the same study again, are as follows: 3

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>Infant Jordan</th>
<th>Child Jordan</th>
<th>All Jordan</th>
<th>Infant Gaza</th>
<th>Child Gaza</th>
<th>All Gaza</th>
<th>Infant West Bank</th>
<th>Child West Bank</th>
<th>All West Bank</th>
<th>Infant Lebanon</th>
<th>Child Lebanon</th>
<th>All Lebanon</th>
<th>Infant Syria</th>
<th>Child Syria</th>
<th>All Syria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low birth weight</td>
<td>25</td>
<td>0</td>
<td>25.8%</td>
<td>29</td>
<td>0</td>
<td>29.6%</td>
<td>14</td>
<td>2</td>
<td>16</td>
<td>28.1%</td>
<td>10</td>
<td>0</td>
<td>25.0%</td>
<td>27</td>
<td>0</td>
</tr>
<tr>
<td>Respiratory diseases</td>
<td>20</td>
<td>2</td>
<td>22.7%</td>
<td>22</td>
<td>1</td>
<td>22.1%</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1.8%</td>
<td>8</td>
<td>0</td>
<td>20.0%</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Cong. Malformations</td>
<td>27</td>
<td>2</td>
<td>29.9%</td>
<td>29</td>
<td>1</td>
<td>20.0%</td>
<td>8</td>
<td>1</td>
<td>9</td>
<td>15.8%</td>
<td>8</td>
<td>1</td>
<td>9.2%</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>Gastroenteritis</td>
<td>3</td>
<td>0</td>
<td>3.1%</td>
<td>3</td>
<td>0</td>
<td>1.0%</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1.8%</td>
<td>1</td>
<td>0</td>
<td>2.5%</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Heart diseases</td>
<td>3</td>
<td>2</td>
<td>5.2%</td>
<td>5</td>
<td>2</td>
<td>8.8%</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>8.8%</td>
<td>7</td>
<td>0</td>
<td>7.1%</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Birth trauma</td>
<td>2</td>
<td>0</td>
<td>2.1%</td>
<td>2</td>
<td>0</td>
<td>2.5%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Accidents</td>
<td>1</td>
<td>3</td>
<td>4.1%</td>
<td>4</td>
<td>1</td>
<td>2.5%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Septicaemia</td>
<td>1</td>
<td>0</td>
<td>1.0%</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>5.3%</td>
<td>2</td>
<td>0</td>
<td>5.0%</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Aspiration pneumonia</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>6</td>
<td>0</td>
<td>6</td>
<td>5.7%</td>
<td>2</td>
<td>0</td>
<td>2.5%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Jaundice</td>
<td>2</td>
<td>0</td>
<td>2.1%</td>
<td>2</td>
<td>0</td>
<td>2.5%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>1</td>
<td>0</td>
<td>1.3%</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Cot death</td>
<td>2</td>
<td>1</td>
<td>3.1%</td>
<td>3</td>
<td>1</td>
<td>2.5%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>1</td>
<td>0</td>
<td>1.3%</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Meningitis</td>
<td>1</td>
<td>0</td>
<td>1.0%</td>
<td>1</td>
<td>0</td>
<td>1.0%</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1.9%</td>
<td>1</td>
<td>0</td>
<td>1.8%</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Renal diseases</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1.8%</td>
<td>1</td>
<td>0</td>
<td>2.5%</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hepatic disease</td>
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<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<td>0</td>
<td>0</td>
</tr>
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<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hypoglycemia</td>
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<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cancer</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Intussusception</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>1</td>
<td>1.3%</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Others</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>87</td>
<td>10</td>
<td>100.0%</td>
<td>95</td>
<td>10</td>
<td>105.0%</td>
<td>90</td>
<td>7</td>
<td>57</td>
<td>100.0%</td>
<td>38</td>
<td>2</td>
<td>40.0%</td>
<td>70</td>
<td>6</td>
</tr>
</tbody>
</table>

It is also important to notice that prematurity, malformations and low-weight babies have replaced the communicable diseases. Also, the idea behind the decrease in infant death rates may underlie the concept that refugees can now give birth in public hospitals. Hence, the death rates become similar to those of the local population. 2

A brief comparison of all the Arabic countries Infant mortality rates is as follows:

The table shows the reduction in mortality rates in children younger than 5 in the Arab countries between 1990 and 2005. 9
Maternal Mortality Rates:

This study was conducted with 137 women and published by the UNRWA.\textsuperscript{10}

The data presented here is not as clearly defined as the above. There seems to be a more complex outcome when it comes to Maternal Mortality Rates.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Jordan</td>
<td>7.2</td>
<td>17.7</td>
<td>3.8</td>
<td>19.2</td>
<td>23.3</td>
<td>19.3</td>
<td>29.3</td>
<td>17.7</td>
<td>17.2</td>
</tr>
<tr>
<td>West Bank</td>
<td>16.5</td>
<td>16.1</td>
<td>36.1</td>
<td>17.9</td>
<td>0</td>
<td>9.2</td>
<td>17.2</td>
<td>26.9</td>
<td>17.5</td>
</tr>
<tr>
<td>Gaza</td>
<td>14.9</td>
<td>34.5</td>
<td>33.0</td>
<td>8.1</td>
<td>41.7</td>
<td>16.1</td>
<td>23.7</td>
<td>18.6</td>
<td>23.7</td>
</tr>
<tr>
<td>Lebanon</td>
<td>0</td>
<td>21.4</td>
<td>0</td>
<td>43.1</td>
<td>22.5</td>
<td>44.9</td>
<td>44.6</td>
<td>45.2</td>
<td>27.1</td>
</tr>
<tr>
<td>Syria</td>
<td>73.1</td>
<td>48.1</td>
<td>12.4</td>
<td>25.3</td>
<td>37.6</td>
<td>77.5</td>
<td>25.4</td>
<td>25.0</td>
<td>40.6</td>
</tr>
<tr>
<td>All Fields</td>
<td>17.6</td>
<td>26.3</td>
<td>18.8</td>
<td>17.4</td>
<td>27.4</td>
<td>24.4</td>
<td>26.1</td>
<td>21.6</td>
<td>22.4</td>
</tr>
</tbody>
</table>

The table shows the maternal mortality rate by field and year.\textsuperscript{10}

Again it must be noted that the results are from women who were taken care of by UNRWA; hence it is not representative of the entire population, which may have completely different outcomes.

The important aspect of this study is that the factors and causes affecting maternal mortality rates can be identified.

Some of the major factors are as follow: \textsuperscript{10}

1) Age of death-the study showed a positive correlation between age and death. i.e. the older the mother the higher the risks for hr dying prior, in the process or post giving birth.
2) Parity- women with fewer children seemed to hold a lower portion in maternal deaths
3) Place of death- 74.4\% of deaths were in a hospital as opposed to home or private clinics.
4) Time of death- 63.5\% post-partum, 19.7\% ante-partum, 176.8\% intra-partum.
5) Birth attendant at time- surprisingly most deaths occur in the presence of a qualified doctor
6) Type of delivery- (in total vaginal delivery (including abortions) was responsible for 58.2\% of maternal deaths, Caesarean Section included 26.1\% and deaths before delivery made up 15.7\% of the total).
The causes of maternal deaths can be summarised in the following table:\textsuperscript{10}

<table>
<thead>
<tr>
<th>Field</th>
<th>Embolism</th>
<th>Heart disease</th>
<th>Haemorrhage</th>
<th>Pre-eclampsia</th>
<th>Other causes</th>
<th>All causes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>No.</td>
<td>No.</td>
<td>No.</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Jordan</td>
<td>9</td>
<td>5</td>
<td>9</td>
<td>9</td>
<td>5</td>
<td>37</td>
</tr>
<tr>
<td>West Bank</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>Gaza</td>
<td>8</td>
<td>3</td>
<td>7</td>
<td>14</td>
<td>16</td>
<td>48</td>
</tr>
<tr>
<td>Lebanon</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Syria</td>
<td>2</td>
<td>1</td>
<td>11</td>
<td>7</td>
<td>5</td>
<td>26</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>11</td>
<td>34</td>
<td>35</td>
<td>33</td>
<td>137</td>
</tr>
</tbody>
</table>

The causes of maternal mortality rates can again be linked to some of the factors listed above.

There are plenty of factors affecting mode of delivery and diseases. For example this study showed that haemorrhaging deaths were more common in vaginal deliveries, whilst pre-eclampsia (hypertension with proteinuria or oedema, or both; it usually occurs in very young or very old women), was a leading cause of maternal mortality where Caesarean section was used.

A comparison table for the time of deaths and the various diseases can be seen below:\textsuperscript{10}

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>Ante-partum</th>
<th>Intra-partum</th>
<th>Post-partum</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Embolism</td>
<td>6</td>
<td>8</td>
<td>10</td>
<td>24</td>
</tr>
<tr>
<td>Heart disease</td>
<td>3</td>
<td>1</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Haemorrhage</td>
<td>1</td>
<td>6</td>
<td>27</td>
<td>34</td>
</tr>
<tr>
<td>Hypertension/Toxaemia</td>
<td>9</td>
<td>3</td>
<td>23</td>
<td>35</td>
</tr>
<tr>
<td>Infection</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Malignancy</td>
<td>0</td>
<td>1</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Sickle cell disease</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Other causes</td>
<td>7</td>
<td>4</td>
<td>9</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>27</td>
<td>23</td>
<td>87</td>
<td>137</td>
</tr>
</tbody>
</table>

The highlight areas stress the highest percentage of the disease in combination to the time of death. It is evident that most deaths occur during or after birth (intra or post partum respectively). This shows that perhaps the health care provision is not adequate and substantial to support the needs of these women.
One of the major factors linking both maternal mortality and child mortality was the level of education and the amount of information provided in order to explain and clarify the consequences and preventions of key events.

The more educated the mother, the more she understood the importance of going for regular check-ups and the more likely she would be to adhere to the doctor’s advice.

**Limitations:**

Due to the fact that the data was being collected over a period of constant conflict, it was hard to get information on all the sites of interest and there are clear gaps in the research. Also the data is not as up to date and although it is debatable as to how much the specific type of data may change within a few years, it is essential to have the latest data in order to have the means to make a more complete comparison.

As the rights of refugees change over the years, i.e. allowed to work, access to healthcare, so does their level of health. In addition when looking at improvements of health it is important to take into account the advances of technology, the local change in epidemiology and the political stability of the host country. Most of this data may not be available in times of conflict, especially when dealing with developing countries.

The data used for this report was mostly from UNRWA and there was not enough literature to make essential comparisons. Hence, there was a clear limitation as to where the information came from and the inability to compare and contrast it with other reports.

Finally, due to the conflict of different parties, a lot of the articles found were prone to bias and could not be used to establish clear medical knowledge without becoming politically engaged.

**Conclusion/Discussion:**

From combining the various studies it is clear that infant and child mortality rates have decreased to a certain extent over the years in the Palestinian refugee population in the Arab countries. On the other hand the data show that the maternal mortality rates do not seem to have made a major difference.
It is clear that a multiple number of factors and causes affect both the aforementioned mortality rates. Also, it is obvious that the health of the mother will affect that of the baby and vice versa during the periods of pregnancy.

On the whole, it must be noted that even though there seems to be a decrease in the infant/child mortality rates, it is only due to the excess help of the UNRWA and the fact that refugees are now more capable of seeing a medical professional. In addition the improvement in child mortality is mainly due to the fact that women can now give birth in hospitals and so the mortality rate is compared to that of the local rates rather than in effect of the refugee status.

This however, does not mean that the refugees are living in adequate and humane living conditions, which can support them as people without humiliating their lives.

**Recommendations:**

When dealing with any healthcare system there is always room for improvement. Refugees need to be treated with the respect that any human deserves. This means that not only must there be no breaching of their rights, but they must be supported socially and psychologically to minimise their trauma.

When dealing with the specific healthcare issue of mortality rates it is important to try and improve the understanding and education of females. This will allow them to understand the risks of very early or very late pregnancies, interfamily marriages, not following check ups and not adhering to professional advice. In addition it is important to strengthen the surveillance of pregnant women, by having a larger number of professionals working towards the pre-natal and antenatal care.\textsuperscript{10}

It is also important to conduct the correct autopsies in dead infants and children in order to obtain correct information.\textsuperscript{3}

By improving simple aspects of the system, like the first line of contact, and prioritising emergency deliveries, (things taken for granted in the western culture), there may be quite a difference made in mortality rates.
Reflection:

This Special Study Module (SSM) has been the ideal vehicle to widen our horizons and to understand what goes on outside our safe environment.

Searching and writing up this report has allowed me to appreciate the distress that refugees and asylum seekers are facing and how inhumanely they are treated. The reading of articles and the gathering of information as to how these people spend an entire lifetime battling either in an attempt to escape from their countries problem or in the urge to prove to the world that they are not criminals but individuals who need help and support, could only open my eyes to the real situation.

The past three weeks have made me a lot more sensitive to refugees and asylum seekers, and have urged me to try and volunteer in helping and supporting them. The only certain thing is that it really is up to us to help those people, and there is no doubt that every small act will make them feel better.
References:


7. UNHCR complains of “refugee fatigue” -DAWN - International; December 21, 2001 [Internet]. 2001 ;Available from: http://archives.dawn.com/2001/12/21/int17.htm


Appendices:

Appendix 1: Human Rights Act

The Human Rights Act was established in 1998 and was enforced in the UK Government in 2000.

Following are the main titles of the articles of the Human Rights to which the UK has signed:

- Right to life
- Freedom from torture and inhumane or degrading treatment
- Right to liberty and security
- Freedom from slavery and forced labour
- Right to a fair trial
- No punishment without law
- Respect for your private and family life, home and correspondence
- Freedom of thought, belief and religion
- Freedom of expression
- Freedom of assembly and association
- Right to marry and start a family
- Protection from discrimination in respect of these rights and freedoms
- Right to peaceful enjoyment of your property
- Right to education
- Right to participate in free elections

During war and conflict just about all the above rights are breached.

According to the refugee and asylum seekers who were interviewed, they fled from their countries in search of a place of justice, where they can lead a peaceful life. Instead they claim to be faced once again with the breaching of their human rights, as they are not allowed to work, get married or have a home until they have been given asylum. If they are not granted asylum they may be placed in detention centres where conditions are inhumane and resemble prisons without the locked rooms. There have also been numerous accounts of refugees or asylum seekers being beaten and tortured whilst they are in a western country seeking protection.
Appendix 2:

Following is a testimony from a male Pakistani refugee in his mid-fifty’s in Asylum Link. He was extremely distressed and asked for his words to be written as regards to his rights as a human. The only thing he asked for was for people to hear his story and understand the cruelty he is facing.

“We are disbelieved and criminalised. We are treated badly and with no respect. Sometimes I think that I left the torture at home to find myself tortured in a different way in a different country. Why do they not want to help us? We are humans too! We did not want to leave our country; we were forced. We don’t get good medical care; we don’t get enough money to live. 35 pounds a week is very little. So why don’t they let us work? We fight other’s wars and no one helps us. We have no human rights! They treat their animals better than us. My son came here too and he is now taking pills-medicine, he suffers from stress problems, he was fine before we came here. What can we do so they can listen?”

Beyond this point he started to crack and could not hold his tears.

Appendix 3: 19

As potential medical professionals it is important to understand and keep in mind that it is our duty to follow specific rules, in order to help as many people as possible without discriminating.

Following is the summary of the GMC guidelines of a good professional doctor:

- The patient care must be prioritised.
- There must be a promotion and protection of good health.
- The standard of practising medicine and the care of the patient must be of a good level
- Respect the dignity of patients, and always treat them as individual people and not as part of a group
- Be honest with patient, and work with truthfulness.

These criteria must be kept when dealing with people from all over the word, regardless of their background or state in society.
Appendix 5: A presentation of six slides was given on the topic of Palestinian refugees. The presentation is as follows:

**Palestinian refugees outside the occupied Palestinian territory**

doi:10.1016/S0140-6736(09)61015-1,
3/2/2011,

AGNI-LEILA SALEM

YEAR 1

TOPIC: Palestinian Maternal and Child Health in Asylum

This includes:
- Maternal and child health in refugee camps within occupied Palestinian territories
- Maternal and child health in refugee camps outside occupied Palestinian territories (focusing on their neighbouring countries)
- A comparison of health issues of Palestinian mothers and children refugees with those the equivalent Israeli and UK population

Key Points of Article

- 1948- the Israeli-Palestinian War generated the largest refugee population of the world.

- “Of 4·6 million Palestinians with refugee status, 2·8 million reside outside the occupied Palestinian territory, in Syria, Lebanon, and Jordan.”

- This refugee community is the most vulnerable and financially dependent of those served by UNRWA (*United Nations Relief and Works Agency*) outside the occupied Palestinian territory
RESULTS AND DISCUSSION

- Main issues: mental disorders, distress and trauma. Sided by all the physical illnesses, which are a result of poor sanitation, nutrition and health provision.
- There has been a clear improvement in the number of infant mortality due to communicable disease; however, they seemed to be replaced by prematurity, malfunction and under-weight cases.
- “The data depict a complex situation, with emerging diseases and chronic and endemic unsolved health problems.”

It’s Never Simple …

- Studies show that refugees suffer severely from mental and physical illnesses.
- They do not only depend on a safe journey from the war zone to a refugee camp, but their life is affected majorly by the politico-economic stability of their host country.
- Palestinian refugees seem to be suffering mostly from the feel of public humiliation and the sense of not being safe anywhere. (i.e. September 1982 Sabra and Shatila massacre in Lebanese refugee camps)
- On the contrary war always effects everyone… although it has produced millions of refugees it has caused severe damage to the mental health of the Israeli people (TSD, acute stress, trauma) http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1472271/

Conclusion

- War leaves a mark on everyone.
- It is a HUMAN RIGHT to get medical help, shelter and feel secure.
- Palestinian Refugees suffer enough, they do not need to feel excluded, humiliated and tormented on top of their existing pain
- Young children and mothers refugees are the most vulnerable populations and must be taken particularly care of.

“The Palestinian Refugee Child in Israel. With parents nowhere to be seen, and debris all around, this Palestinian child has become a refugee in his home land.”

A lucky survivor – now a homeless orphan!!

http://www.corbisimages.com/Enlargement/HU050406.html

THE END
Thank you
Appendix 6: Timetable of the 3 weeks

**WEEK 1:**

<table>
<thead>
<tr>
<th>MONDAY 24/1</th>
<th>TUESDAY 25/1</th>
<th>WEDNESDAY 26/1</th>
<th>THURSDAY 27/1</th>
<th>FRIDAY 28/1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chester- Meeting with convener to revise SSM topic and introductory lectures</td>
<td>LASAR and LCIP visit - Talk to refugees</td>
<td>Asylum Link Meet staff, understand how organisation works, talk to refugees</td>
<td>Wrexham Refugee council.</td>
<td>Fade Library</td>
</tr>
</tbody>
</table>

**WEEK 2:**

<table>
<thead>
<tr>
<th>MONDAY 31/1</th>
<th>TUESDAY 1/2</th>
<th>WEDNESDAY 2/2</th>
<th>THURSDAY 3/2</th>
<th>FRIDAY 4/2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research Articles</td>
<td>Research Articles</td>
<td>Meeting with Palestinian Refugee-Case study 1</td>
<td>Preparation of Presentation on Palestinian Refugees</td>
<td>Chester Presentation on Palestinian Refugees and lectures on SSM write up</td>
</tr>
</tbody>
</table>

**WEEK 3:**

<table>
<thead>
<tr>
<th>MONDAY 7/2</th>
<th>TUESDAY 8/2</th>
<th>WEDNESDAY 9/2</th>
<th>THURSDAY 10/2</th>
<th>FRIDAY 11/2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lectures on SSM topics Critical Appraisal and write-up of SSM</td>
<td>Fade Library Write up of SSM</td>
<td>Finish SSM write-up</td>
<td>Re-visit SSM and make corrections</td>
<td>SSM to be handed in</td>
</tr>
</tbody>
</table>

Appendix 7: Acknowledgment and Thanks.

In order to write up this report a lot of people gave up their time to help analyse ideas, explain processes and identify key features to be presented.

I would like to therefore thank the following people and organisations;

Dr. O’Neil, Siobhan Harkin, the Fade Library staff (special thanks to Kieran Lamb), Asylum Link, Wrexham Refugee Council, LASAR and LCIP, Ms. Gwen Backwell, Ms Dickson, Ms Vicky Canning, STAR, Ms. Jacqueline Morris.