Summary points

- The scale and effect of conflict and other disasters in the Eastern Mediterranean region are likely to increase
- Humanitarian agencies need to learn from their experience
- The response to disaster needs to be informed by good evidence
- More investment is needed to make communities better prepared for disaster and less vulnerable

strategies would save not only billions of dollars but thousands of lives, and funds currently spent on intervention and relief could be devoted to enhancing equitable and sustainable development, which would further reduce the risk of war and disaster.[17] Recent resolutions endorsed by the World Health Assembly of WHO and the Regional Committee of the Eastern Mediterranean region also emphasise preparedness along with response and are the guiding force behind a number of new initiatives (see bmj.com).

Contributors and sources: AM and IS have been extensively involved in emergency preparedness and response related health policy and planning, operations, and research and as first responders in the humanitarian/complex emergencies in the Eastern Mediterranean region. This article is the product of their observations from the field, discussions with peers, review of relevant documents, and on-going capacity building initiatives at the Regional Office for the Eastern Mediterranean. Both authors gathered data for the article. AM wrote the first draft and IS made revisions for important intellectual content. AM is the guarantor.

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Hope and despair over health in Gaza

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The Israeli re-invasion of Gaza this July has redrawn the world's attention to the dire straits of the population living in the Gaza Strip. There, within an area the size of the Isle of Wight, 1.4 million people live without free access to the outside world. Contrary to international hopes, the Israeli decision to withdraw from Gaza in September 2005 has led to increasingly tight control over the movement of goods and people. The destruction of the Gaza power station in addition to the damage to bridges, roads, and other infrastructure can only worsen the plight of Gazans in the coming months.

Untenable dependence on aid

But the current crisis has been looming since well before the renewed hostilities this July. Despite the massive investment by Western donors in public infrastructure over the past decade, the Gaza Strip was never designed to sustain a viable and developed society. For the past 50 years it has hosted the largest concentration of refugees in the world, maintained in a state of dependency on international assistance at the highest levels per head since the second world war. The Oslo peace process was launched to tackle this structural dependency, hoping to transform Gaza into a self sustaining and open economy based on links to the West Bank and beyond.

Gaza is the first region in the Occupied Palestinian Territory to experience the effect of Oslo's demise in the form of major threats to health and human security. Its population will double in the next 22 years.[1] Water resources are on the verge of exhaustion; residential overcrowding is severe, with several generations living in the same house; schools are running on two to three shifts; and unemployment and poverty have both doubled in the past five years. In 2004, 36% of men and 33% of women were unemployed or underemployed in Gaza; daily wage rates were less than half those in Israel and the settlements; and 27% of school aged children were at work rather than attending school. For the last quarter of 2005, the monthly income of 63% of households fell below the poverty line and 43% were living in deep poverty.[2]

Aid dependency is extreme.[3] Before the recent cuts, the value of government assistance per household had risen to $188 (£100; €148), with an additional $42 provided by the United Nations Relief and Works Agency

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and $125 by political parties. The boycott of the Hamas government has led to most of this aid being blocked.

Surprisingly, some key health indicators are good. Infant mortality is close to 30/1000, almost all children are fully vaccinated, and the proportion of professionally assisted deliveries is high. But the limits of these technology based interventions in isolation are becoming clear. We see a disturbing pattern of excess death rates, especially for young men. Non-communicable diseases and cancer are growing in importance.[1] Prevention requires interventions to change behaviour (such as diet and smoking control). Such change is not readily accomplished without strong government control, which seems increasingly remote.

Where next?

One reason for the current situation is the international community's focus on the palliative effect of aid rather than promotion of human security and human development concerns. It is time to move beyond the narrow technical and medical approaches to health and for the region to exert independent control over its health issues. One way ahead is to adopt a population based approach that concentrates on equity and the social, political, and economic determinants of health. For years, the world has been impressed by the remarkable outcomes of public health and education programmes in the Palestinian refugee community. Yet, these outcomes are not sustainable and cannot subvert the requirements for a stable and open society, such as equity of access to quality services, planning for development, productive employment, free movement of people and goods, and democratic governance.

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Darfur—dependent population at risk of another catastrophe

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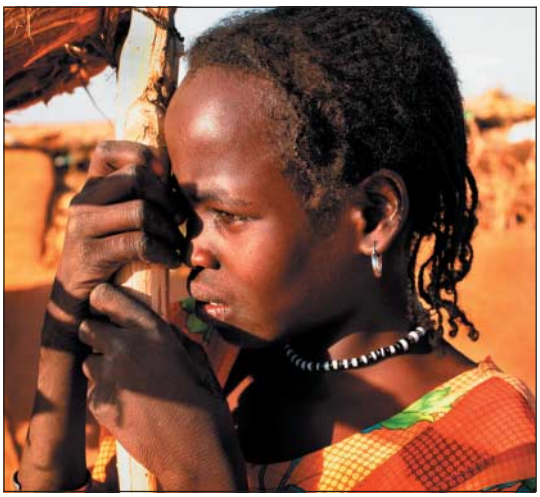
When I arrived in south Darfur in late 2005, the humanitarian situation, although fragile, seemed under control. The estimated 100 000 internally displaced people at Kalma camp, where I worked in a primary health clinic, had stable health indicators. My colleagues and I worked hard on training local health workers and building infrastructure within the community. The first months of 2006 were hopeful, but six months later the situation has changed dramatically.

Since February 2006, displacement has increased in all states of Darfur. New internal refugees arrive daily in the camps on the edge of Nyala. These camps have few facilities available, and violence and sexual abuse are rampant.

The World Health Organization and United Nations agencies have medical professionals trained in managing outbreaks of disease and coordinated approaches to complex emergencies. Unfortunately, many of these trained professionals have already left Darfur as a result of the insecurity and reduced funds available for non-governmental organisations in the region. WHO has introduced incentives to hospital staff and compensates hospitals for operating expenses by providing essential medicines. Although this strategy is a valid response to the initial crisis, it becomes counterproductive in the long term. Health workers and the local community become dependent on this aid without creating a viable health system.

Humanitarian aid

International non-governmental organisations share responsibility with WHO for this flawed situation. In 2004, they flocked to confront an emergency situation,



People in Darfur lack food and medicines

as this was the place where substantial funds could be obtained. In the health sector, ambitious programmes were set up hastily and focused on accessible camps for displaced people rather than on isolated or insecure areas that were difficult to reach.[1] This led to an imbalance in available services. In some places two organisations provided the same essential non-food items, such as blankets and bed nets, and some camps had three health clinics whereas others had none. Kalma camp has become politicised and violent partly as a result of this dynamic.

Humanitarian access is currently hampered by an escalation of violence. Twelve humanitarian workers were killed in July and August 2006. Access is at its lowest since the beginning of the conflict in 2003.