National Strategy for Suicide Prevention

2021-2026

State of Palestine

I. Situation Analysis

Suicide has a devastating impact on individuals, their families, and wider communities. Silence and stigma prevent those in need from seeking help; and families, friends, and communities affected or bereaved by suicide or suicide attempts are often left without adequate professional support.

Close to 700,000 people lose their life to suicide every year; this corresponds roughly to one death every 40 seconds; and suicide is one of the leading causes of death among 15–29-year-olds globally.[1] Recently with risk factors which can be exacerbated In public health emergencies such as the COVID-19 pandemic may increase risk for suicide- however tends In suicide mortality In 21 countries (high Income and upper middle Income) showed no evidence of a significant increase in risk of suicide since the pandemic began in any country or area (Pirkis et al; 2021). Nevertheless, this might not apply to lower-income countries, with "concerning signs that the pandemic might be adversely affecting suicide rates "; In addition these countries lack systemic studies and data on suicide rates.

Other risk factors include prolonged quarantine (Brooks et al; 2020), widespread societal fear (Gunnell et al; 2020), severe economic stress, medical equipment shortages (Reger et al;2020), decreased access to mental healthcare, and the neuropsychiatric effect (Rogers et al., 2020) that have impacted the mental health of the people and increased the need for mental health care. Specific populations such as young people, older adults, (Kisely et al ; 2020) and frontline healthcare workers may be particularly vulnerable to the psychological impact of infectious outbreaks such as the COVID-19 pandemic(Reger et al., 2020); However, the risk for worsening psychosocial health does not yet confer to risk for suicide.

Suicide prevention is a crucial public health priority (World Health Organization, 2018); Key risk factors for suicide include psychological and social stressors, adverse life events, feeling trapped, life transitions and losses, physical illness, and mental disorders (Fazel & Runeson, 2020), previous suicide attempts, mental health problems, harmful use of alcohol, drug use, job or financial loss, relationship breakdown, trauma or abuse, violence, conflict or disaster, and chronic pain or illness (WHO, 2014). It is one of the priority conditions identified as part of the World Health Organization (WHO) mental health Gap Action Programme (mhGAP), launched in 2008 to provide evidence-based technical guidance to scale up service provision and care in countries for mental, neurological and substance use disorders. In the WHO-Mental Health Action Plan 2013–2023, WHO Member States committed themselves to working towards the global target of reducing the suicide rate in countries by 10% by 2020.[2] Suicide mortality rate is also one of the indicators of Target 3.4 of the Sustainable Development Goals (SDG): '*By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being*'.[3]

Suicide is a growing public health issue in Palestine, where traditionally suicide has been rare. While further studies on suicide prevalence, suicidal attempts, ideation, and behavior in Palestine are scarce are needed, available data indicates that suicide is on the rise. (Box 1).[4]

Suicides: In 2018/ 2019, the Palestinian Police and prosecution Office reported that 19 persons died (15 males, 4 females) by suicide in the West Bank. in Gaza 20 persons died by suicide in 2018 and 16 in 2019.
Suicide Attempts: In 2018/2019, 224 cases of attempted suicides (113 females and 111 males) and 19 have committed suicide(4 Females, 15 males)were recorded by district public prosecution offices in the West Bank. In Gaza 504 attempted suicide in 2018 and 352 attempted suicide in 2019. UNRWA Gaza has reported 103 cases attempted suicide and 150 cases suicidal thoughts in 2019.
Suicide methods: The Palestinian Police and Prosecution Office report that using medication, ingestion of poison, using sharp instruments and falling from a high altitude, are the most common means of suicide.
Suicide Ideation: A study, published in 2017, explored suicidal ideation among students in grades 7, 8, and 9 in Palestine and refugee camps and analyzed data from Global School-based Student Health Survey. The study found that the overall prevalence of suicidal ideation and/or planning was 25.6%. Males were more likely than females to report suicidal thinking.

Due to social stigma, religious concepts of 'shame' and 'sinfulness' associated with suicide, or concerns about potential legal complications, attempted and actual cases of completed suicides in Palestine are likely to be under-reported, in addition, suicides are commonly found misclassified, especially as 'accidents'. Suicide statistics are thus difficult to collate, highlighting the need for reliable documentation of cases of attempted suicides and quality vital registration data.

Law and Suicide In Palestine: to set punishment on individual attempting suicide, or help or motivate other individual to commit suicide, In Gaza law n 74 for 1936(material 225) who ever attempt suicide is considered an offense. In the WB law; number 16 In 1960(material 339); who motivated or helped another Individual to commit suicide will be punished and put in prison for a period of time, and If suicide Is Initiated , the Individual will be punished form 3 months to two years or to three years If the Individual Is being harmed or physically disabled.

Risk Factors

Understanding risk factors is very significant towards the development of effective suicide prevention interventions. Global evidence indicates that no single cause or stressor alone can explain a suicidal act. [5] A seminal study on risk factors of attempted suicide patients in the West Bank, conducted by Médecins du Monde (MdM) Switzerland in 2019, found that suicide attempts are multifactorial and multi-causal, indicating that several risk factors can act cumulatively to increase a person's vulnerability to suicidal behavior.[6]

According to this study, risk factors can be categorized as:

- individual level: including mental disorders, substance abuse, job loss, financial hardships, academic failure, feeling out of control…,
- familial level: marital, family, conflict, discord or loss, breakdown of relationships...
- societal level: discrimination, gender-based violence, abuse, and lack of social support.

The MdM study confirms that health system level risks include lack of expertise and skills of health care providers at the emergency department, regarding assessment, treatment, and referral of people who have attempted suicide. By far, the strongest risk factor for suicide

may be a previous suicide attempt, in line with global evidence. Deep-rooted stigma associated with seeking help for mental disorders, distress and suicide attempts compounds the situation, and ultimately to higher suicide risk. Accessing the care needed – including improved treatment, referral, and active follow-up – of suicidal patients who present to hospital – thus remains a crucial need, as does reducing social stigma and promoting help-seeking behavior.

Suicide Prevention Activities that have been implemented

To lead and coordinate efforts on suicide prevention, the National technical Committee of Suicide Prevention led by Ministry of Health was established in 2017. It is composed of representatives from the Ministry of Health (MoH), the Ministry of Education and Higher Education (MoEHE), the Ministry of *Awqaf*, the Public Prosecution Office, the Family Protection Unit of the Police, United Nations Relief and Works Agency (UNRWA), the WHO, and international and national NGOs, including MdM, and Palestinian Counselling Center (PCC), and were meeting periodically till end of 2019 to finalize the Suicide Prevention Strategy 2020- 2025. In January 2021 the Palestinian Prime Minister Office has decided to Establish a national Committee for Suicide prevention, this committee Is responsible to set an action plan for suicide prevention; to scale up mental health and psychosocial services and to develop Mental Health Act In Palestine.

Spearheaded by the Mental Health Unit of the MoH, a number of suicide prevention efforts actions have taken place in the past few years by different ministries and local NGOs In both Gaza and WB, including to upgrade the quality of care, referral, and active follow up. Most notably, a directive has been issued by the Minister of Health to facilitate the referrals of cases of attempted suicides from general hospitals to community mental health centers (CMHC) for follow up and treatment, exempt of fees. Initiatives included training to build the capacity of health care professionals for almost 30 mental health professionals in 2020 on suicide intervention. In total, 220 nurses and doctors in general hospitals across the West Bank have been trained. Furthermore, health staff working in governmental Primary Health Center (PHC) have received training on mhGAP by WHO and other local and international NGOs to improve build their capacity to detect, treat, and refer persons with common mental health problems, including self-harm/suicide. Preliminary efforts have been made to work with media on responsible reporting, so that media outlets refrain from presenting suicide a solution or problem, respecting the privacy of family, and raising awareness on where to seek help, when reporting on completed or attempted suicide.

While these interventions are starting to yield results, a comprehensive multisectoral suicide prevention strategy, for the population, and vulnerable persons in particular, is critically needed.

II. Strategic Goals

The proposed **National Suicide Prevention Strategy for 2020-2025** signals the commitment of key stakeholders not only from the mental health and health sectors, including from PHC centers and general hospitals, but also education, social development, justice, law, religious affairs, and the media sectors, to address the issue of suicide in Palestine. The Strategy, proposed by the National Committee of Suicide Prevention, represents a collective collaborative effort to ensure that suicide prevention receives the resources and attention

that it requires from the State of Palestine and its development partners. Its **overall goal** is to prevent premature deaths from suicide or disability from attempted suicide.

It will **focus on five interconnected strategic objectives:**

Strategic Objective 1: Improve surveillance, monitoring and reporting of suicide and self-harm.

Suicide often remains misclassified, un-, or under-reported. The availability, quality, and timeliness of data on suicide and self-harm will be improved, to allow national and international partners to better monitor rates, identify trends with regards to suicidal behavior, and better identify individuals-at-risk, especially those that have engaged in one or more acts of attempted suicide or self-harm. Case registration and surveillance systems of suicide attempts and non-fatal self-harm, presenting at hospitals, will be improved as will the accuracy of death registrations at hospitals. Improved quality and timeliness of suicide and self-harm data will allow stakeholders to continue to monitor rates, identify trends and develop effective prevention measures.

Strategic Objective 2: Reduce stigma/taboo related to suicidal behavior and increase public awareness of suicide, attempted suicide, and self-harm

Suicide remains a taboo in Palestine and stigma remains a major obstacle to seeking help and treatment. Breaking down the barrier of stigma is vital to conversation and understanding and so that individuals concerned become aware of where to seek help or recognize signs in family or community members. Working with families (parents, spouses, siblings of suicidal individuals), wider communities, including schools, the police (Family Protection Unit), health service providers, religious leaders, university students, and community-based organizations (CBOs), and media is needed to promote broad public awareness raising of suicide, attempted suicide, and self-harm.

Strategic Objective 3: Enhance the capacity of health services and gatekeepers to provide suicide prevention services.
A key element of suicide prevention is ensuring early detection. Healthcare professionals may frequently encounter patients with suicidal risks and are in a unique position to Identify suicide-warning signs in their patients and to intervene early. Training for doctors, nurses, other health service providers, and gatekeepers (those in a position to identify whether someone may be contemplating suicide) including at the level of schools is needed to equip them to work with at-risk individuals as part of their professional and/or therapeutic role. in addition; increase responsible reporting by the media and build their capacity on less stigmatizing reporting .

Stigma in health care and education settings may affect the quality of care and services provided and needs to be also addressed.

Strategic Objective 4: Improve accessibility, consistency, and care pathways of services for people vulnerable to suicidal behavior.

Individuals with suicide risk need to have timely access to evidence-based treatments and continuity of care from detection to response and follow-up. An important component of suicide prevention is thus improving consistency in care pathways for the assessment and management of people vulnerable to suicidal behavior through strengthening of referral mechanisms and protocols, outlining roles and responsibilities. Current gaps in referrals (between schools, child protection networks, Ministry of Social Development, Ministry of

Health, Family Protection Unit of the Police) need to be better assessed and addressed in order to ensure effective services are provided to individuals-at risk and their families specifically building socio-emotional skills in children attending school. The result is for persons at risk to have access to comprehensive Mental Health and Psychosocial Support (MHPSS), including Steady Case Management; Certified Psychiatrist; Psychotherapy; Social reintegration; and Outreach services.

Strategic Objective 5: Restrict access to highly lethal methods of suicide and attempted suicide, including pesticides, poison, and frequently used drugs.

Restricting access to means (is the key universal intervention for suicide prevention.
One of the key methods of suicide that may be under-investigated and under-reported involves self-ingestion of pesticides, poison, and frequently used drugs. Monitoring the use of such means in suicide or attempted suicide facilitates an understanding of the problem; and engaging regulatory bodies and relevant government sectors (e.g. Ministry of Agriculture) in the national regulation of access to such means is necessary.

III. Targeted Populations

Universal interventions that target the general population will be implemented through activities that improve population-wide understanding of suicidal and self-harm behavior, or which benefit the whole population such as restricting access to means, responsible media reporting; as well as **indicated interventions** aimed at persons who are already known to be vulnerable to suicide or who have attempted suicide, and **selective interventions** that target groups that demonstrate elevated risk. Although more research is needed to identify risk and protective factors for suicide, at-risk populations are likely to include:

- Persons with mental health disorders.
- Prisoners and ex-detainees/prisoners.
- Persons with substance abuse.
- Survivors of gender-based violence (GBV).
- Adolescents.
- Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) persons.
- people with chronic physical health conditions, Including chronic pain

In addition to the population of persons at potential elevated risk of suicide, this strategy will target health service providers, caregivers, gatekeepers, and influencers:

- Health workers in PHC facilities.
- Health workers in general hospitals, especially emergency care staff.
- Mental health service providers, including in community mental health centers (CMHC); psychosocial centers.
- Imams and Sheikhs In mosques.
- School Counselors and teachers.
- GBV focal points in general hospitals.
- Police, especially the Family Protection Department.
- Local media reporters.
- Parents and wider communities.

IV. Actors that have a crucial role to play in suicide prevention

The government, with the support of its development partners, need to take a lead in suicide prevention. Prevention of suicide however cannot be accomplished by the government alone; it requires support from a wide range of actors in different settings.

- **In health settings (PHC, secondary care health facilities, CMHC)**

A key element of suicide prevention is improving the quality of identification and subsequent care (or community follow up) for suicide risk in health care setting and systems. Especially because not everyone who attempts suicide seeks mental health treatment or support for high distress, but most people seek health care, it is crucial that health providers at PHC are trained on detection and how to support suicide prevention when working with patients. It is equally important that emergency room (ER) staff are trained on detection of Suicide Attempt, grave self-harm action and risky behaviors that lead a person to reach the ER for urgent medical treatment. A key element of this strategy is to ensure a competent healthcare workforce trained and prepared for suicide risk assessment, intervention, monitoring, and follow-up and that referral pathways (to other health or community settings) are clear to ensure effective and timely continuum of care.

- **At the police level:**

Police officers can be a first line resource for people who may be suicidal and may potentially play a critical role in removing access to lethal means from people at high risk of suicide. Police are also informed by hospitals when suicidal patients are admitted to ER. The Family Protection Unit has an important role to play in recognizing the suicide potential in situations involving domestic disputes or violent deaths.

- **At homes:**

Families – **parents, spouses, siblings of suicidal individuals** – need to be supported to engage in suicide prevention and recovery efforts. Given how sensitive the topic of suicide is, it would be more effective to undertake awareness-raising within the broader issue of mental health and well-being and general parenting/family programs rather than organize specific sessions on suicide prevention. Home visits may also be useful tool to support families in providing follow-up care for people who attempted suicide.

- **At schools:**

School counsellors can be considered as 'gate keepers' at schools are they are the main persons that deal with at-risk students. There are an estimated 1,100 counsellors in government schools. UNRWA also has school counsellors to provide psychosocial support to refugee students. Educational counselors generally serve several schools at once, and some have been trained in psychosocial support but would need further trainings.

Teachers are also important 'gate keepers' and can play a key role in identifying students with suicidal thoughts and behavior and in referring them to school counsellors for example.

The participation of **school administrators** in prevention efforts is also key as the administrators are generally those that are responsible for referring at-risk students to intervention services, mainly through the **Child Protection Networks** under the **Ministry of Social Development Department (MoSD)**. The Child Protection Networks need to also receive training in suicide prevention and response and strengthen referral with Ministry of Health to deal with cases.

Parents of students also have a key role to play in suicide prevention efforts, through providing them with awareness-raising and/or training. Global experience also highlights that it is important to include young people in prevention efforts. Peer-to-peer training is an important intervention to strengthen help-seeking norms, to recognize warning signs in depressed or suicidal peers, and to empower them to report those signs to an adult. **School Parliaments** have an essential role to play in conducting student-led activities, including awareness raising, information dissemination, and campaign activities.

- **In wider communities:**

Religious leaders can play a crucial role in educating society about the role of faith in reducing depression and anxiety and facilitate healing, in reducing the silence and isolation around suicide, and in changing the conversation about suicide to one that will facilitate healing. There are over 1,000 imams, and training of trainers (ToT) would be an effective outreach strategy to enable religious leaders to contribute to suicide prevention.

Engaging and working collaboratively with the **media** in relation to media guidelines, tools and training programs to improve the reporting of suicidal behavior within broadcast, print and online media (exercise care in the use of languages and details ; respecting the private hurt of the bereaved family and minimizing the possible effect on other vulnerable people) will also be an important strategy.

CBOs may be well-positioned to support individuals-at-risk and their families. **Community outreach campaigns** run by CBOs are examples of ways to lower an individual's barriers to obtaining help, such as not knowing what services exist or believing that help would not be effective. **University students** may also be engaged in community prevention efforts especially given that the main age group at risk tend to be youth. In refugee camps, **popular committees** are key players and may play a positive role for disseminating information and ensuring referral to service providers. **UNRWA** has a role to play in ensuring coordination with popular committees in refugee camps especially in cases where police are unable to enter the camps.

Women's protection agencies, including shelters run by civil society organizations, are also important to include in suicide prevention efforts as domestic violence survivors tend to have higher suicide risks. Integrated protection and MHPSS services need to be made available through GBV prevention and response programs and the to do so, the capacity of protection agencies in mental health and suicide prevention needs to be upgraded. **Helplines are one of the best practices in suicide prevention, for persons** who are suicidal but are reluctant to seek help from face-to-face health services or support from friends or family members. The confidential services offered by crisis lines may help overcome the barrier of stigma surrounding suicide and mental health problems that could prevent a person from seeking help in other ways.[7] In Palestine, helplines supporting victims of violence are available, and with appropriate technical assistance, can potentially serve as a hotline for suicide prevention intervention by responding to needs of suicidal persons.

Prisoner rehabilitation centers need to be targeted to reduce levels of suicide and self-harm amongst prisoners. **Drug rehabilitation centers** are also key settings for the detection and referral of at-risk persons.

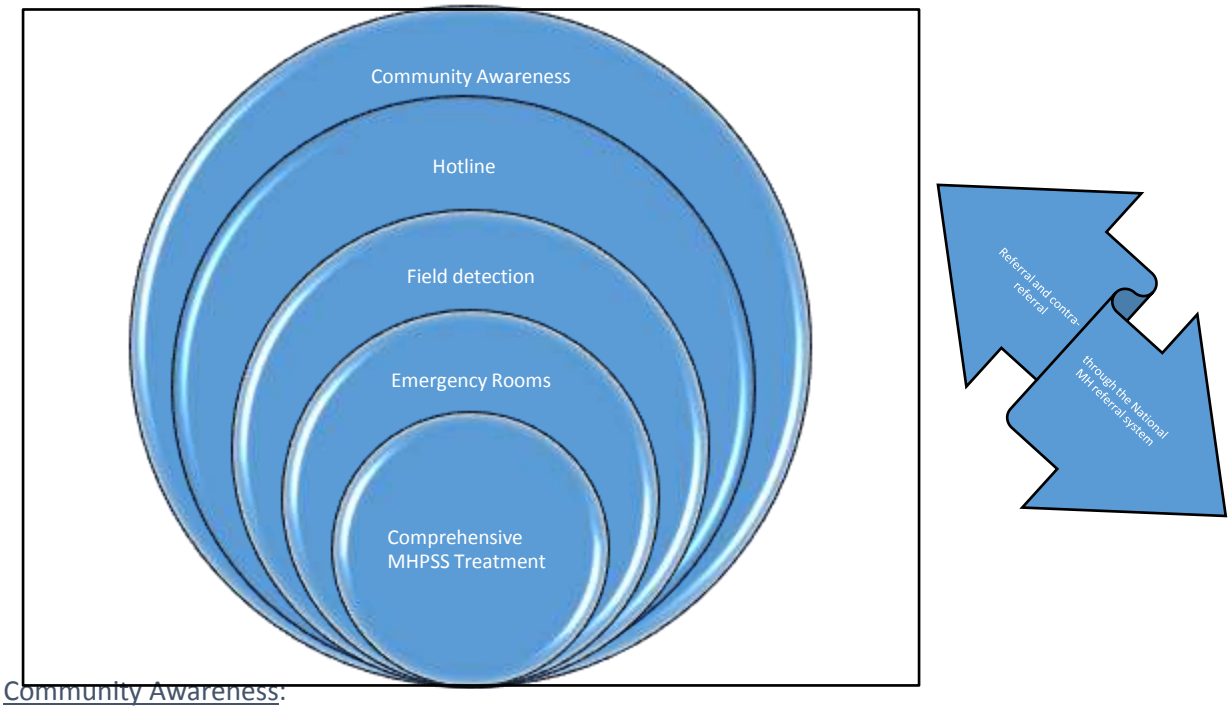
- **Ministry of Agriculture:**

The Ministry of Agriculture has a role to play in pesticide regulation for suicide prevention. While pesticides are not the primary means of suicide, it is important to restrict access to this highly lethal method of self-harm.

V. Implementation of Effective and Timely Interventions

The **Suicide Prevention National Committee** has been assigned to articulate and advise on the strategy. A **technical committee** (with a **clear focal point person**) will be established for the monitoring and implementation of **Intervention Matrix** described below, which will be based on the proposed **identification and referral pathways** (Diagram 1).

Identification and Referral Pathways



Community Awareness:

□ Media & social media campaign
□ School & University information
□ Religious leaders
□ Information leaflets at health centers

Hotline:

□ Person with suicide ideation and/or plans
□ Anyone concerned by a person presenting suicide ideation and/or plans

Field detection:

□ Schools and Universities
□ Youths association
□ GBV association and shelters
□ Police station and Family Protection Unit
□ Prisoner Rehabilitation Center
□ Families of Patients with MHD association
□ Child Protection Network
□ PHCs
□ LGBT association
□ CMHC
□ Prison
□ Drugs users associations and Rehabilitation centers
□ Ministry of Social Development Units
□ Ex-detainees

Emergency Rooms:

□ Public and Private hospitals
□ PHCs emergency stations

Comprehensive MHPSS treatment:

□ Steady Case Management
□ Certified Psychiatrist implication
□ Psychotherapy
□ Social reintegration
□ Outreach services

Intervention Matrix/Action Areas

The table below details action areas per key actors (described in section IV) that have a crucial role to play in progressing towards all five strategic objectives of this plan.

STAKEHOLDERS	ACTION AREAS
Strategic Objective 1: Improve surveillance and monitoring of suicide and self-harm	
Led by MoH	Assessment of registry, data collection, set a standardized form: A- At the general hospitals B- At the PHC facilities C- Schools D- Police (Family Protection Unit) E- Protection networks
Emergency Departments of Hospitals and CMHC	Improve the quality and timeliness of case registration of suicide attempts and self-harm collected at Emergency Departments and at CMHC. Provide MHPSS support for patients. Improve accuracy of death registrations at hospitals
Police & Prosecutor's Office	Improve suicide investigation. Provide PSS support for the individual with suicidal attempts (rather than stigmatizing and criminalizing them) Collate data from police, public prosecutor's office, and health facilities on completed and attempted suicides
Strategic Objective 2: Reduce stigma/taboo related to suicidal behavior and increase public awareness of suicide, attempted suicide, and self-harm	
Media	Provide ongoing training and awareness sessions for media professionals on responsible reporting (including not sensationalizing; respecting privacy of family) and positive reporting (e.g. success or resilience stories and anti-stigma and awareness campaigns).
Religious Leaders	Design and deliver training of trainers (ToT) of imams to enable religious leaders to contribute to suicide prevention efforts; and decrease stigma.
Parents of students	Support schools to provide awareness-raising and/or training for parent/caregiver representatives in the community;
Student Parliaments	Provide peer-to-peer training, support Student Parliaments to design and implement student-led awareness raising and campaigning activities.
CBOs/ youth groups/ MoSD/MoEHE/MoH	Conduct awareness campaigns to fight stigma. Include online and social media-based awareness interventions. Carefully assess the potential of involvement of survivors / parents whose children have committed suicide to do awareness work
Strategic Objective 3: Enhance the capacity of health services and gatekeepers to provide suicide prevention services	
Health Service Providers	Provide training to specialized and non-specialized health service providers, in the assessment and management of suicidal behaviors and ensure service providers meet competency requirements.

School counsellors, teachers, and administrators	Equip schools (Ministry of Education and UNRWA) with skills and tools to build mental health literacy and respond effectively to at-risk students. Provide gatekeeper training. Work closely with schools to deliver emotional and life-skills training for children.
Child Protection Networks	Deliver child-centered training in suicide prevention and response and strengthen referral with MOH
Women's protection agencies	Integrate mental health and suicide prevention in GBV prevention and response.
Strategic Objective 4: Improve accessibility, consistency, and care pathways of services for people vulnerable to suicidal behavior	
MoH	Build the capacity of the health workers at the general hospitals health especially the ER teams on MHPSS (how to communicate, build trust , provide support ,Identify cases and provide MHPSS support or referral) Assign a focal point/liaison person (mental health specialist or an ER staff to be trained on MHPSS to be linked with a MH specialist form CMHCs in MoH) in each hospital to assess attempted suicide patients' risk.
MoH, in consultation with multiple stakeholders	**Set a referral Pathway** A - Step care model set Intervention protocols for Hospitals, PHC, schools, GBV department or shelters. B -Screening tool - mhGAP, GHQ 12, suicidal risk assessment. C - Guidelines to be developed and distributed on ER in Hospitals. D- Identify MHPSS specialists services from MOH in each district.
Civil Society Organization/MoH	Establish one operational national crisis helpline for suicide prevention
Strategic Objective 5: Restrict access to highly lethal methods of suicide and attempted suicide, including pesticides, poison, and frequently used drugs.	
Ministry of Agriculture, MoH, Prosecutor's Office, Police	Put in place systems to monitor completed and attempted suicides by pesticide ingestions and by frequently used drugs
Ministry of Agriculture,	Put in place/enforce regulations on the sale of pesticides.
MoH	Put in place/enforce regulations for pharmacies for drugs used intentionally for overdose

VI. M&E

The technical committee will be responsible for identifying clear measurable outcomes, targets, indicators, timelines, milestones, designated responsibilities, including Monitoring and Evaluation (M&E) responsibilities, and budget allocations.

Potential **indicators** include:

- Referral protocols in place.
- Better data collection systems in place.
- Percent of doctors, nurses, health workers trained in management of suicidal behavior.
- Number of police offers trained in the risk, consequences, and management of suicidal behavior
- Number of media professionals trained in responsible media reporting of suicidal behavior.
- Number of religious leaders trained on mental health and suicide risks.
- Number of gatekeepers trained, including school counsellors, teachers, administrators.
- Number of students reached through parent and student-led awareness raising and campaigns.
- Helpline for suicide prevention in place.
- Number of crisis callers counselled through the helpline.
- Number of patients with suicidal thoughts, ideation and severe self-harm referred to services from gatekeepers including school, Child Protection Networks, rehabilitation centers, after establishing referral pathways and protocols.
- Providing continued care and active follow-up for % of cases that are referred to emergency departments due to suicide attempt.
- Regulations put in place to reduce access to highly lethal methods.

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[4] Sources for Box 1; Statistics on completed suicide cases: Police Research and Planning Department, as quoted in Wafa, published, 2019/09/09 http://english.wafa.ps/page.aspx?id=68bUL1a111490249926a68bUL1; statistics on suicide attempts: Palestinian Public Prosecution Office, 2017 Annual Report; Suicide ideation: Source: Itani, T, Jacobsen, KH and Kraemer A, 2017, Suicidal ideation and planning among Palestinian middle school students living in Gaza Strip, West Bank, and United Nations Relief and Works Agency (UNRWA) camps. Int J Pediatr Adolesc Med. 2017 Jun; 4(2):54-60. doi: 10.1016/j.ijpam.2017.03.003. Epub 2017 Jun 20

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