DEALING WITH DEATH AND DISTRESS:

THE IMPACT OF COVID-19 ON THE MENTAL HEALTH OF PALESTINIAN HEALTHCARE WORKERS

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MAP

MEDICAL AID FOR PALESTINIANS

INTRODUCTION

A health worker collects a nasal swab sample for a COVID-19 test in Gaza City. Credit: Habboub/ABACAPRESS.COM.

The global coronavirus (COVID-19) pandemic has placed unprecedented strain on healthcare systems all over the world, at times exceeding the capacity of even the most well-resourced national health systems. Healthcare personnel – those directly involved in the diagnosis and treatment of COVID-19 patients and those in other fields that have seen resources diverted and experienced new challenges to their services – have endured significant additional pressures and stresses in their work.

Healthcare workers are known to suffer high rates of poor mental health outcomes, including burnout, anxiety, depression, moral distress, and post-traumatic stress. This has been compounded during the pandemic. As documented in a recent article in the Lancet:

> *"Extrinsic organizational risk factors – including increased work demands and little control over the work environment – and the trauma of caring for patients who are critically ill have been heightened by the COVID-19 pandemic and represent important exacerbating factors for poor mental health among health-care workers."*[1]

In the occupied Palestinian territory (oPt), half a century of military occupation and 14 years of illegal closure and blockade of Gaza have resulted in a Palestinian healthcare system that was fragile and fragmented before the arrival of COVID-19. The chronic financial crisis and resource and infrastructure limitations affecting the Palestinian Ministry of Health and hospitals in East Jerusalem have severely hampered pandemic response.[2]

Medical teams from across the health sector – including pharmacists, nurses, doctors, social workers, paramedics, and ambulance drivers – have been on the frontline against COVID-19, while also working to maintain other essential (non-COVID) health services. This workforce has faced severe challenges in diagnosing, treating, and caring for their patients, including shortages of essential healthcare resources, specialist staff and essential medicines and equipment; restrictions placed on their freedom of movement and that of their patients; and a continuing pattern of attacks on Palestinian health facilities by Israeli authorities during the pandemic.[3]

Inequitable access to COVID-19 vaccines and other essential medical items such as personal protective equipment (PPE) has exacerbated these challenges in the oPt. Whereas Israel had vaccinated more than 60% of its citizens by June 2021, only 9% of Palestinians in the West Bank and Gaza had been vaccinated during the same period.[4] This is despite Israel's legal duty as an occupying power to ensure rapid, comprehensive, and equitable access to vaccines for all people under its effective control, including in the territory it occupies.[5]

ASSESSING PALESTINIAN HEALTHCARE WORKERS' EXPERIENCES DURING COVID-19

This briefing draws on interviews with healthcare workers in the oPt to examine how the COVID-19 pandemic has impacted their wellbeing and mental health. MAP conducted semi-structured interviews with 17 health workers in the oPt: seven in the West Bank, six in Gaza, and four in East Jerusalem. This cohort included doctors, nurses, lab technicians, and paramedics who were identified for interview through the Palestinian Ministry of Health and through MAP's local partner organisations. They were asked about sources of stress during the pandemic, their workload, particular moments of hardship, what support was available to them, and their coping mechanisms. Their responses were transcribed, and recurring themes and issues identified.

Our research illustrates the way in which psychological distress experienced by Palestinian health workers is deeply intertwined with social, economic and political factors. Interviewees reported that they felt uncertain and unprepared throughout the pandemic, experiencing fear, anxiety, and concerns regarding their own safety and that of their families. These experiences were common across the oPt, though disparate working conditions in varied roles and locations also gave rise to specific issues and stressors. The hardships faced when responding to the global pandemic were particularly compounded by the indignities and abuses of living and working under military occupation.

These interviews were conducted prior to Israel's large-scale military assault on Gaza in May 2021 and the protests in the West Bank, including East Jerusalem, which have been met by the widespread and systematic use of excessive force. This has only further degraded the capacity of hospitals and clinics, and exacerbated the pressures and strains identified by the interviewees.[6]

Palestinian healthcare workers walk as they arrive to collect swab samples from people to be tested for COVID-19 in southern Gaza, 14 January 2021.
Credit: REUTERS/Ibraheem Abu Mustafa.

KEY THEMES: A DIVERSITY OF ADVERSITY

UNPREPAREDNESS, RESOURCE-SHORTAGES, AND WITNESSING THE SUFFERING OF PATIENTS

The rapid spread of COVID-19 and high number of deaths in even well-resourced health systems illustrates that many countries struggled with a lack of preparedness for a global health emergency on the scale of the current pandemic. In the oPt, however, the pandemic arrived in a healthcare system undergoing de-development and lacking human, financial and material resources as a result of occupation, fragmentation, and blockade. This resource-constrained environment created inevitable challenges for the Palestinian healthcare workforce, which in turn impacted their mental health and job performance.

Shortages of personal protective equipment (PPE) and a lack of professional skills to deal with COVID-19 patients were identified as persistent problems by our respondents. One doctor from the West Bank reported that she was asked to conduct a home visit for one of the first COVID-19 patients in Nablus district without receiving specialised training or adequate PPE to protect her from infection. She told MAP it was *"one of the most stressful moments in my career"*, adding:

> *"I was scared as I did not have enough information regarding the virus nor regarding treating or examining COVID-19 patients. I begged my supervisor not to send me, but these were the instructions. If I wouldn't go, I would receive a formal warning. When I arrived at the home of my first COVID-19 patient, I cried. I remembered my daughters. I was very scared of getting infected and infecting them."*

Several healthcare workers reported buying PPE at their own expense. A paramedic from Gaza told MAP:

> *"I am on the front line. My work requires coming into contact with COVID-19 patients and transferring them to quarantine centers or hospitals. I had to buy my masks and gloves. I was very stressed about getting infected and infecting my family. My wife and I live with my parents, I was stressed about infecting my pregnant wife and my father, he has a respiratory disease."*

The lack of essential resources was identified as a source of stress and anxiety by the majority of interviewees (12 out of 17). With the inevitable increased caseload during the pandemic, it became harder for medics to provide the care their patients needed. An Intensive Care Unit (ICU) nurse working in East Jerusalem described the distress this situation caused:

> *"It was a very difficult scene to see the suffering of the patients, most of them were cancer patients or patients with kidney diseases who needed dialysis. COVID-19 had worsened their medical situation. We witnessed the death of some of the patients as well."*

Another interviewee, a senior ICU and emergency doctor in East Jerusalem said:

> *"We witnessed the suffering and sometimes the death of our patients which had a painful impact on us as medical teams; we felt sometimes helpless despite our tremendous efforts to help them. More importantly, most of our patients were from Gaza or the West Bank, and some did not have their companions, so we felt bad that they were isolated from their families."*

An anaesthesia technician at a hospital in Hebron, described the impact this situation had on her as a recent graduate:

> *"The main challenge was dealing with death. Most patients who received mechanical ventilation died. This breaks our hearts. We have done our best to save their lives, but they did not make it … I have encountered so many deaths in my first year of work. Nobody trains you or prepares you for this, you just need to experience it by yourself and deal with it."*

She further reported feeling "mentally exhausted":

> *"In my night shifts, I couldn't even rest my eyes, I was scared that any of my patients would die during my shift. In general, I had sleep distress especially from September to December 2020."*

The impact was not only felt by those treating COVID-19 patients, but also within other services which lacked adequate resources. One senior nurse working in Gaza said:

> *"[T]here were feelings of helplessness. Some of the treatments for cancer patients are unavailable in Gaza, there were shortages in oncological drugs, and the number of patients increased due to the fear of traveling outside of Gaza and the reduced referrals. During the pandemic, with the limited resources we had, we became a psychologist to our patients. We were only able to encourage them, comfort them and provide them with painkillers."*

The nurse said this situation made him feel "overwhelmed", and that *"conditions were similar to the times we experienced war on Gaza"*.

FEAR OF BECOMING A SOURCE OF INFECTION

As healthcare workers coming in regular contact with patients are at high-risk of infection and becoming a source of transmission of COVID-19, three quarters of interviewees (13 out of 17) expressed a fear of making other people ill, particularly family members, coworkers and vulnerable patients. One oncologist in Gaza stated:

> "I was very worried of transmitting the virus to my family, especially to my six-year-old autistic daughter. I taught my five children how to take all preventable measures, but I knew that the chances of me bringing the virus into my home and infecting my kids were higher. What an intolerable guilt."

This feeling was intensified when the number of infections and deaths increased, when there was a scarcity of adequate PPE, and when operating in locations where implementing social distancing measures was difficult. For example, a doctor working with communities south of Hebron in the West Bank shared her worries and concerns of being a source of infection to her family:

> "As a doctor at the mobile clinic, I am aware of the high probability and risk of getting infected; we are constantly exposed to different patients and children in different bases of the mobile clinic and could not always implement social distancing or sanitize surfaces. Knowing this, I was worried about infecting my family, especially my father who has high blood pressure and cardiovascular disease. Therefore, I refrained from physically contacting him for three months."

Fear of becoming infected was particularly salient when respondents had a family member suffering from other diseases. A family doctor in Nablus reported:

> "Although I was very cautious, I was very worried of transmitting the coronavirus to family, especially to my eldest daughter who has asthma and my father who suffers from respiratory disease. I am still worried about being the source of infection to my beloved family."

Guilt and worry of becoming the source of infection among respondents stemmed from a sense of responsibility towards families, community, coworkers and patients.

An estimated 5,000 Palestinian health workers have themselves been infected with COVID-19.[7] A nurse in Hebron who contracted coronavirus in September 2020 described how she continues to be affected by her illness:

> "When I tested COVID-19 positive, I was hospitalised and attached to a respirator … I have never been through something like this. I was mentally and

A Palestinian healthcare worker sanitises the hands of a woman at a mobile clinic in Gaza, 23 September 2020. Credit: REUTERS/Suhaib Salem.

> physically ill. Until this day, I am trying to overcome the aftermath of my illness. Physically, I still have complications and, mentally, I fear going through such an experience one more time."

Imposing social distancing measures is difficult in some hospitals and clinics, particularly in Gaza where workspaces reflect the high population density of the area. A senior oncology nurse working in Gaza emphasised that restrictions imposed on patients' ability to exit Gaza for treatment during the pandemic meant that his department was forced to treat a higher than usual caseload. As a result, they could not impose effective restrictions, beyond requiring the wearing of face masks and limiting the number of visitors:

> "The structure of the oncology department did not allow imposing social distancing measures, and we were overwhelmed with the increased number of patients who we did not have capacity or the necessary medication for."

Some respondents were also unable to socially distance while at home with their families. One paramedic in Gaza, for example, described how he lives in a house along with his wife, daughter, and extended family (parents and siblings), with no space for separation or isolation. This reflects a broader problem caused by high population density in Gaza: UN OCHA has reported that among families forced to undergo home isolation due to coronavirus infections, 50% lack a separate bedroom or bathroom for members who test positive, and 60% report at least one family member in these situations showing some sign of psychological distress.[8]

Palestinian health workers wave to a recovered patient outside a makeshift hospital for serious cases of COVID-19, in the West Bank city of Bethlehem. Credit: Luay Sababa/Xinhua/Alamy Live News.

Several healthcare workers reported having been separated from their families during the pandemic, leading to feelings of isolation and loneliness. Some, fearing they might be a source of infection, had made an active decision not to come into direct contact with family members who would otherwise be a source of support. A family medicine doctor said she had refrained from seeing her parents or sending her daughters to visit them for months:

> *"I felt isolated and lonely, I couldn't visit my family or send my daughters to visit their grandparents. Our daily routine changed, we used to have lunch at my parents' house. My daughters used to constantly ask me 'when are we going to see our grandparents?'"*

Others were separated from their families not through choice, but due to imposed lockdowns within and between cities. These restrictions exacerbated existing barriers to movement between areas and geographical fragmentation imposed by the policies of Israel's occupation.

Healthcare professionals working in East Jerusalem whose families live in the West Bank experienced additional challenges. During the early period of the pandemic, when Israel had a high rate of infections, managers of Palestinian hospitals in occupied East Jerusalem noticed that staff from the West Bank were facing restricted movement to work because the Palestinian Authority implemented checkpoints to limit movement in and out of the city to control the outbreak of the virus. This compounded existing physical and bureaucratic movement restrictions into the city imposed by Israel.[9] As a result, hospital administrators provided accommodation for these staff members inside Jerusalem.

Doctors, such as a senior ICU and emergency specialist that we interviewed who works at a hospital in East Jerusalem, lived in hospital-provided accommodation for several months, separated from family. The doctor we spoke to reported feeling isolated and helpless:

> *"Heading to work was an impossible mission back then. The hospital provided an alternative solution, renting hotels for us. … I felt isolated and separated from my family. It was a relief to know that I wouldn't infect my family or have to go through several checkpoints on my way to work, but I felt isolated and lonely. I stayed in Jerusalem for three months without visiting my family."*

In Gaza, the issue of isolation had been salient long before the arrival of COVID-19, as a result of Israel's 14-year-long illegal closure and blockade and associated restrictions on exit to the rest of the oPt or abroad. Permits to exit Gaza for patients requiring treatment elsewhere, or for health workers seeking to access training or professional development, are frequently denied or delayed by the Israeli authorities.[10] Healthcare workers in Gaza told MAP that the pandemic had further entrenched the isolation they felt, making them more separated than ever from fellow health practitioners in Palestine and beyond.

A senior nurse at a Gaza hospital described having had all permit requests to the Israeli authorities rejected, preventing him from enrolling in medical trainings to develop his knowledge and skills before the outbreak of COVID-19. He said they were anticipating a *"catastrophe"* as the health system in Gaza was already on the brink of collapse:

> *"The 14 years of isolation from medical development was reflected during the pandemic. We had to learn how to contain an infectious disease in a besieged city with our limited resources."*

Separation from colleagues and family members during the pandemic has led to health workers feeling isolated, distressed, and cut off from necessary support at a time of crisis.

SOCIAL STIGMA AND LACK OF RECOGNITION

Healthcare workers reported experiencing social stigma during the pandemic as a result of communities' perceptions that, being regularly exposed to COVID-19, health workers are a vector of the virus. This perception applied to healthcare workers whether they worked directly with COVID-19 patients or indirectly. One doctor in Gaza, said:

> "Another source of stress and frustration is the social stigma towards me and the medical teams associated with COVID-19 patients. They used to call us 'corona'; people used to get away from me, while others used to look at me differently. It is frustrating to be stigmatized after risking your life and working in the frontline to save others' lives."

Interviewees reported stigmatisation as being a source of stress, impacting both themselves and their families. A laboratory technician in Hebron, told us:

> "My son told me that one student refused to sit next to him in the classroom claiming that he was infectious due to his father's work in the laboratories."

In the early stages of the pandemic, two health workers reported being subjected to pressure from their families to quit their jobs due to fear of infection and concern about threats to their reputation. This pressure stemmed from the reactions of community members, including their extended families and neighbours who disengaged socially and avoided contact with health workers and their families. This led to anxiety and feelings of discomfort when encountering neighbours in closed places such as elevators or stairways. In turn, health workers reported changing their own routines and practices when in public to avoid harassment and stigma.

A paramedic and ambulance driver MAP spoke to in Gaza said:

> "I used to avoid wearing my uniform in public. Some people used to stare at me and call me 'corona' while others used to speed up to run away from me. I could feel how stressful my presence was."

Another healthcare worker indicated that they refrained from doing their grocery shopping at their usual shopping centres so as not to encounter fearful stares or people avoiding contact. One nurse from the West Bank told us:

> "Nobody told me that I am not welcome here, but their behaviours were not welcoming and discouraged me from returning to the store. During the first wave of COVID-19, the owner of the minimarket in our neighborhood sanitized the money and every corner of the store upon my entrance."

A healthcare worker prepares to collect swab samples to be tested for COVID-19, 28 March 2021. Credit: SOPA Images Limited/Alamy Live News.

Exposure to social stigma had a negative impact on the wellbeing of respondents, who reported feeling isolated and socially ostracised, and interpreted the reactions and behaviours of community members as a lack of recognition and respect for their efforts and sacrifices throughout the pandemic. The paramedic in Gaza said:

> "We expected from our community members acknowledgment for the great risk and the pressure we underwent, taking into consideration the conditions we functioned under. People treated us as if we were the ones responsible for infecting society, we were the guilty ones instead of being viewed as heroes."

Incidents of stigmatisation were most prevalent during the early stage of the pandemic, decreasing by the second wave as public understanding of COVID-19 increased.

Many health workers also reported feeling under-appreciated, and that their efforts and sacrifices were not recognised by their employers, communities, and families. Even at times between peaks in caseload, some healthcare workers reported not being given any respite in appreciation of their additional efforts at busier times. A doctor in Nablus said:

"Throughout these difficult times we did not receive any reward or consideration for us as working parents. Daily, we used to check more than 100 patients, with limited access to sterilisation materials and PPE. I felt we were risking our lives."

Another doctor in Gaza said:

"The Gaza war (2008-2009) lasted 25 days, the war in 2014 lasted 51 days. Today, we are not certain when all of this will be over; we cannot see any rays of hope. When will this war end? … the medical teams are constantly working, adjusting themselves to any plans, and until this day, no one received a day off, bonus, or recognition. We are mentally and physically drained."

Three working mothers stressed the need for childcare services to be provided. A family medicine doctor from Tulkarem told MAP:

"After they announced a state of emergency, we were not allowed to use our leave days. I wish they were considerate of our circumstances and what working moms are going through. They could have kept schools or nurseries open for the kids of medical teams."

One lab technician in the West Bank said:

"Our lives are filled with psychological stresses, I remember we spent our time either at work or on the roads, crossing checkpoints just to bring or send our kids to their grandparents' houses. I will not allow my kids to be in the medical field, it is the field that works the most with the least appreciation. … Most working mothers received a 30% reduction in their working hours except those in the medical field. We did not have any kind of motivation to work after they increased our working hours."

Other examples given by interviewees on how they would have hoped to be recognised for their work included salary bonuses, improved working conditions such as providing adequate PPE, and not preventing workers from taking leave days.

A Palestinian healthcare worker takes swab samples for COVID-19 testing from family members who had contact with people infected, in the city of Beit Hanun, Gaza, 23 September 2020. Credit: ZUMA Press, Inc. / Alamy Stock Photo.

CONCLUSION

Healthcare workers around the world have endured significant hardships during the COVID-19 pandemic, which have undermined their mental health and wellbeing. [11] Similarly, in the occupied Palestinian territory, high workloads, separation from loved ones, the frequent loss of patients, and lack of essential resources such as PPE have caused widespread stress, loneliness, and anxiety. Those we spoke to frequently said that the pandemic had left them mentally and physically exhausted. Our interviews also illustrated that these universal challenges have been compounded by the specific pre-existing social, economic and political context of occupation and blockade.

The Palestinian healthcare workers we spoke to have not only been separated from their families, friends and support networks by their work, but also by the fragmentation of Palestinian territory and the physical and bureaucratic barriers to movement imposed by Israel. Their ability to save lives has not only been challenged by the rapid influx of COVID-19 patients, but also by pre-existing fragility and chronic shortages of essential financial and medical resources in the Palestinian healthcare system. In densely populated Gaza, the fear of infecting others has been exacerbated by the impossibility of maintaining effective social distancing. Additionally, social stigma from communities and a perceived lack of recognition, support, and consultation in key decision-making by employers has made many feel ostracised and under-appreciated.

At the time of preparing this report, with just 9% of the Palestinian population vaccinated, the pandemic is far from over in the oPt. Health workers in Palestine are in urgent need of support. Some action can be taken by local duty bearers and civil society, notwithstanding the constraints of the occupation, to ensure better recognition, practical assistance and an end to stigma. The health workers we spoke to highlighted a number of ways that their mental health and wellbeing could be better supported, including:

- **Training on how to deal with anxiety, stress and loneliness**

- **Small gestures to acknowledge and reward their efforts**

- **More time to spend with their families and children, and better child support**

- **Greater investment in human resources and essential supplies such as PPE**

Ultimately, concerted international action is needed to ensure rapid recovery from COVID-19 and a release from the immediate, acute pressures on Palestinian healthcare workers. At the same time, the international community must work to address the compounding factors that are the root causes of fragility, fragmentation and de-development of healthcare in the oPt. Specifically, third states should:

1. Urgently take all necessary measures to guarantee that Israel respects its duties as an occupying power toward the health and wellbeing of the Palestinian population, including:

   a. ensuring rapid, comprehensive and equitable access to essential COVID-19 healthcare goods, including vaccines and PPE, offering financial or other resources as required by the Palestinian Authority to ensure stocks of sufficient quantity and quality;

   b. Immediately ending violations of international law that undermine the capacity of the Palestinian healthcare system to respond to the COVID-19 pandemic, including the illegal closure of Gaza and blanket restrictions on the free movement of patients and health workers.

2. Publicly monitor Israel's compliance with its obligations under international humanitarian and human rights law in this regard and support international initiatives to promote accountability where these are not met.

3. Provide technical, economic and humanitarian assistance to the Palestinian Ministry of Health and the broader Palestinian health system to address the challenges to the mental health and wellbeing of healthcare workers by:

   a. ensuring access to financial and material resources needed to address healthcare needs arising from the COVID-19 pandemic and to enable the long-term sustainable development of Palestinian healthcare;

   b. assisting the implementation of a comprehensive programme of support for the mental health and wellbeing of Palestinian health workers, including psychological support services and childcare; and

   c. implement public information campaigns to tackle stigma against healthcare workers involved in COVID-19 response, and to recognise their tireless work during the pandemic.

ENDNOTES

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