



Quality of Life of Palestine Children Exposed to Wars in Gaza

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Authors' contributions

This work was carried out in collaboration between both authors. Author AMT designed the study and wrote the protocol. Author SST performed the data collection and statistical analysis, managed the literature search. Author AMT wrote the first draft of the manuscript with assistance from author SST. Both authors read and approved the final manuscript.

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ABSTRACT

Aim: This study aimed to investigate the impact of trauma due to wars on quality of life of Palestine children living in Gaza with special reference to 2009 war.

It is analytic study; the study sample consisted of 195 children and adolescents who were selected purposely from three areas in the Gaza Strip. Those children exposed to variety of traumatic events besides losing their homes during ground incursion of the border and shelling and bombardment of the area. They were 101 boys (51.8%) and 94 girls (48.2%). The age ranged from 7 to 18 years with mean age of 12.84 (SD = 2.9). Children were assessed by socio-demographic questionnaire, Gaza Traumatic Events Checklist, and Health Related Quality of Life.

Results: the highest frequencies of reported traumatic events by Palestinians children were 97.9% hear shelling of the area by artillery, 93.3% hear the sonic sounds of the jetfighters, 90.8% watched mutilated bodies in TV, and 85.6% were forced to move from home to a safer place during the war. The study showed that mean total quality of life was 62.80, physical functioning was 69.87, emotional functioning was 51.96, mean of social functioning was 77.62, and school functioning

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mean was 47.53. Total traumatic events reported by children were negatively strongly correlated with total Health Related Quality of Life (HRQoL), physical, emotional, and social functioning. However, traumatic experiences by children were not correlated with school function.

Conclusion: In summary, this study not only supports the findings of the body of research as it relates to traumatic experiences in children and adolescents and impact of their health quality of life, but also has important implications for establishing and implementation of different psychosocial intervention programs for the school-aged population in Gaza Strip. There are need to be considered in the planning of educational and mental health support services by different governmental United Nations organizations, and non-governmental organization in Gaza. Also, successful treatment of the mental health symptoms associated with traumatic events first requires an acknowledgment of the trauma and then a process which allows for comprehensive assessment and accurate diagnosis.

Keywords: Children; Gaza; quality of life; trauma; war.

1. INTRODUCTION

The Gaza Strip is a narrow elongated piece of land, bordering the Mediterranean Sea between Israel and Egypt, and covers 360 km². It has high population density. About 17% of the population lives in the north of the Gaza Strip, 51% in the middle, and 32% in the south area. There is high unemployment, socioeconomic deprivation, family overcrowding, and short life expectancy. Nearly two-thirds of the populations are refugees, with approximately 55% living in eight crowded refugee camps. The remainder lives in villages and towns [1].

On 27 December, Israeli forces launched a massive military operation in the Gaza Strip codenamed "Cast Lead". In the first three days of the operation, hundreds of air strikes took place against a range of targets, resulting in the death of well over 300 Palestinians, including 9 UNRWA students and 2 UNRWA staff, and the injuring of more than 800, among them a large number of civilians, women and children [2].

This military operation continued for 23 days. As a result, 1420 Palestinians, including 446 children and 110 women and 108 elderly, were killed and 5320 others, including 1855 children and 795 women, were injured. This doesn't mean that the rest of the fatalities and injuries were engaged in hostilities, or that they are not innocent civilians. A large number of men and male youth were killed in their homes, in the presence of their families. Its phases resulted in a mass destruction of private properties. At least 4000 houses were totally destroyed and other 16, 000 houses were partially damaged [3].

There is probably no greater traumatic experience for children and adolescents than

exposure to the consequences of war and associated violent acts. They often are the innocent victims of such events. Some of the earliest research on humans' response to extreme trauma has occurred in this area. Others, distinguishes between two types of childhood trauma: Single episode events versus longstanding or repeated trauma. She describes trauma in children as "the mental result of one sudden, external blow or a series of blows, rendering the young person temporarily helpless and breaking past ordinary coping and defensive operations" (p. 11). However, a single event that takes a parent's life or leaves a child handicapped or leaves him or her in prolonged pain may exhibit personality changes and numbing, more typically seen in repeated trauma. Still, these children may remember events clearly, while those subjected to years of abuse or trauma may become amnesiacs, sometimes blanking out several years of their lives [4].

Most current attempts to define quality of life (QoL) have been guided by the definition of health by the World Health Organization [5] that described health as "a state of complete physical, mental and social well-being". Despite this definition, in today's literature QoL is not yet defined in a uniform way and lacks clarity, and large discrepancies exist between operational definitions of QoL and in the identification of different areas of QoL [6,7].

All current definitions have in common that QoL is described as a multidimensional construct that primarily concerns the patient's personal evaluation of his/her life with regard to functional impairment, handicaps, and living conditions. An important distinction can be made between health-related QoL and overall QoL. Health-

related QoL comprises disease and treatment related aspects of functioning of the individual, such as pain, limitations in motor ability, or nausea, whereas overall QoL encompasses also non-medical aspects of a person's life, like social, educational, and occupational functioning [8].

Quality of Life (QoL) and links to health have been examined in many scenarios and for survivors of conditions like cancer, the assessment of survivors—individuals and societies—of chronic exposure to violence is lacking. Quality of Life (QoL) is a complex, abstract, and multidimensional concept which is difficult to define and has relevance to virtually all areas of human function [9]. HRQoL is a main part of QoL and is considered to be an important construct in describing one's overall condition within the health context [10,11]. Generally, it is conceptualized as a multidimensional construct built up by several domains [12,13]. There is some consensus considering physical, emotional and social aspects of health to be core domains of Health Related Quality of Life (HRQoL) [14,15]. Others follow the WHO definition of health as a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity [16].

Nevertheless, the overall quantity of domains differs in the literature. For example, "behavioural, cultural, and psychological dimensions" as well as "a global perception of health and well-being" are regarded as important domains of HRQoL [17].

Based on a commonly accepted definition by the WHO Quality of Life group [18], the following operational definition as stated by von Rűden defined HRQoL is a multidimensional construct covering physical, emotional, mental, social, and behavioural components of well-being and functioning as subjective perceived by a person depending on the cultural context and value system one is living in [10]. Others Mendlowicz and Stein (2000) have noted, "functioning" is a rather broad construct that is labeled in many different ways (e.g., functioning, disability, illness intrusiveness, well-being, interference, activities of daily living, QoL). Although distinctions do exist, these terms are often used interchangeably to describe the ability to complete tasks or fulfill roles successfully (e.g., work functioning), health status, or levels of satisfaction with particular aspects of one's life (e.g., social relationships and home life). Functioning measures range from crude, face-valid single items to more

comprehensive, psychometrically supported instruments [19].

In recent years there has been growing interest in how post traumatic stress disorder (PTSD) affects functioning and quality of life (QoL), fueled in part by concerns about the consequences for survivors of current wars and recent human-caused and natural disasters. Today, information about the well-being of persons living in this conflict zone is largely restricted to mortality and morbidity rates and access to health care services [20].

This study aimed to investigate the impact of trauma due to wars on quality of life of Palestine children living in Gaza with special reference to 2009 war.

2. METHODS

2.1 Participants

The study sample consisted of 195 children who were selected from three areas in the Gaza Strip which had more exposure to war included home demolition. Those children exposed to variety of traumatic events beside losing their homes during ground incursion of the border and shelling and bombardment of the area. They were 101 boys (51.8%) and 94 girls (48.2%). The age ranged from 7 to 18 years with mean age of 12.84 (SD = 2.9).

2.2 Study Procedure

The data was collected on August 2009 after nine months of end of war on Gaza, by 4 trained psychologists worked with children' mother before. They approached mothers in the 3 areas of the Gaza Strip and asked them to choose one child from each family for the study and they were informed about the purpose of the study and procedure. Children were interviewed in their homes after getting written consent from parents to participate in the study. Socio-demographic information was collected from parents and information about traumatic events, health quality of life from children themselves.

2.3 Measures

2.3.1 Socio-demographic questionnaire

The researcher prepared a questionnaire which included; name, gender, date of birth, place of residence, number of siblings, and other demographic information.

2.3.2 Gaza traumatic events checklist

The checklist was developed to reflect the particular circumstances of the regional conflict which could not be captured by other war trauma measures and had been reported previously [21,22,23]. This checklist consisted of 23 items covering three domains of events typical of the war on Gaza: (1) hearing traumatic events (items number 1-4 include hearing about killing of relatives or friends) (2) witnessing trauma (items number 5-13, experiencing witnessing of home demolition, killing of others); and (3) personal experiences (items number 14-23, being personally the target of violence, being shot, injured, or beaten up by soldiers). The respondents rated their answer whether they had been exposed to each of these events as (0) 'no' or (1) 'yes'. A total score was estimated. In this study the reliability of the scale using Cronbach's alpha was 0.92 and split half was 0.86.

2.3.3 Pediatrics quality of life scale (PedsQL 4.0)

Children related quality of life was measured using PedsQL 4.0 which is a self-administered paper-and-pencil questionnaire that includes parallel child self-reports (age range 5–18 years) and parent/carer proxy reports (age range 2–18 years) [24]. It includes 23 items and four subscales: Physical functioning (PF, 8 items), emotional functioning (EF, 5 items), social functioning (SCF, 5 items) and school performance (SHF, 5 items), from which total, physical, and psychosocial summary scores are derived. A 5-point response scale is utilized as follows: 0 = never a problem; 1 = almost never a problem; 2 = sometimes a problem; 3 = often a problem; 4 = almost always a problem. Items are reverse scored and linearly transformed to a 0–100 scale (0 = 100, 1 = 75, 2 = 50, 4 = 0), so that higher scores indicated better HRQoL. Scale scores are computed as the sum of the items divided by the number of items answered. In a previous study, Cronbach's alpha was 0.90 [24]. This scale was validated in our culture and showed high reliability [25]. The scale had acceptable reliability, with Cronbach's alpha coefficient of 0.86 (95% Confidence Intervals 0.83-0.88). The split half was 0.70.

2.4 Statistical Analysis

All the statistical analyses were performed using the SPSS software version 20. Frequency distribution was used in statistical analysis.

Means and standard deviations of QOL and subscales, and traumatic events scores were recorded.

T- Independent tests were applied to analyse gender differences in trauma and quality of life. Linear regression investigated the association between independent (traumatic events) and dependent variables (QOL subscales).

3. RESULTS

3.1 Demographic Characteristics of the Study Sample

The demographic results of the study described the study sample according to sex, place of residence, type of residence, number of sibling, mother & father educational level, mother & father job, and monthly income. The sample consisted of 195 children, 101 were males (51.8%) and 94 were females 48.2%. The age ranged from 7 to 18 years with mean age 12.84 (SD = 2.9). According to place of residence, 37.5% were from Gaza city, 35.9% were from north Gaza, and 26.7% were from Middle area. According to family monthly income, 90.3% had less than \$300 monthly, 6.2% had \$301-650 monthly, and 3.6% had \$651 and above.

3.2 Exposure to Traumatic Events

As shown in Table two, the highest frequencies of reported traumatic events by Palestinians children were 97.9% hear shelling of the area by artillery, 93.3% hear the sonic sounds of the jettfighters, 90.8% watched mutilated bodies in TV, and 85.6% were forced to move from home to a safer place during the war. While the least common traumatic events were: physical injury due to bombardment of your home (11.8%) and exposure to burn by bombs and phosphorous bomb (7.7%).

3.2.1 Differences in mean of traumatic events

Children reported from no events to 23 traumatic events, mean traumatic events was 10.6 (SD = 4.1). The results showed that mean traumatic events reported by males was 10.90 (SD = 4.37) compared to mean in female =10.43 (SD = 3.94). No significant differences were found between males and females in reporting total traumatic events ($t=0.80$, $p = 0.24$).

In order to find differences in age group of children, the age was recorded in to (7-11 y),

(12-15y), and (16-18 years). One Way ANOVA test was performed in which total traumatic events was the dependent variable and age of children as independent variable. Post hoc test showed that adolescents (16-18 years) reported more traumatic events than the other two groups ($F = 5.16, p = 0.006$). Also, no differences in traumatic events according to family monthly income ($F = 0.98, p = 0.41$).

Table 1. Sociodemographic characteristics of study population (N = 195)

	N	%
1. Sex		
Male	101	51.8
Female	94	48.2
2. Age: Mean = 12.84 (SD = 2.91)		
3. Place of residence		
Gaza	37	37.4
North Gaza	70	35.9
Middle area	52	26.7
4. No of siblings		
Less than 4	49	25.1
5-7 siblings	73	37.4
8 and more	73	37.4
5. Family monthly income		
Less than\$ 300	176	90.3
\$301-650	12	6.2
\$651 and more	7	3.6

3.3 Quality of Life in Children

As shown in Table 3, 39% of children said they had difficulty running, 50% of children said the feel sad or blue, 22.3% of children said they had difficulty keeping up with other, and 44% said they were paying attention in class.

3.3.1 Means and SD of children health quality of life scale

As shown in Table 4, mean total quality of life was 62.80 (SD =15), mean of physical functioning was 69.87 (SD= 21.54), mean of emotional functioning was 51.96 (SD= 24.62), mean of social functioning was 77.62 (SD= 19.53), and school functioning mean was 47.53 (SD =18.14).

3.3.2 Differences in children health quality of life

T independent test was conducted, showed that there no statistically significant differences between boys and girls in total of quality of life and physical, emotional, social, and school functioning subscales.

One Way ANOVA test was performed in which each quality of life subscales was entered as the dependent variable and age of children as independent variable. Post hoc test showed that adolescents (16-18 years) reported more physical dysfunctioning than the children at age of (7-11 y) ($F = 4.90, p = 0.008$), school dysfunctioning was also more in adolescent age (16-18 years) than the younger age children (7-11y) ($F = 5.97, p = 0.003$). However, no difference in emotional, and social functioning according to age of children and no significant differences in any of the quality of life subscales and family monthly income.

3.3.3 Relationships between traumatic events, total HQoL, and subscales

As shown in Table 5, Pearson correlation test was done to find the relationship between. Correlations are reported with the degrees of freedom (which is N-2), total traumatic events reported by children were negatively strongly correlated with total HRQOL ($r (195) = - 0.32, p=0.001$), physical functioning ($r (195) = - 0.21, p=0.001$), emotional functioning ($r (195) = - 0.41, p=0.001$), and social functioning. However, traumatic experiences by children were not correlated with school function ($r (195) = 0.001, p=ns$).

3.3.4 Prediction of quality of life by traumatic events exposure

As shown in Table 6, a multiple univariate linear regression analysis, each of the HQoL subscales was entered as dependent variable and each traumatic event as independent variable.

Physical functioning was predicted by destruction of personal belongings during the war($\beta=0.20, p=0.01$), and forced to move from home to a safer place during the war ($\beta=0.17, p=0.01$), emotional functioning was predicted by witnessed the shelling and destruction of neighbour home ($\beta=0.24, p=0.001$) and deprivation from water, food, or electricity during the war ($\beta=0.18, p=0.01$), social functioning was predicted by witnessed firing by tanks and heavy artillery at owns home ($B=0.19, p=0.001$) and forced to move from home to a safer place during the war($\beta=0.16, p=0.01$), school functioning was predicted by witnessed killing of a relative ($\beta=0.16, p=0.02$), cognitive functioning was predicted by deprivation from water, food, or electricity during the war ($B=0.20, p=0.007$) and threatened by shooting ($\beta=0.18, p=0.01$).

Table 2. Percentage of traumatic events

Traumatic events	Yes	No
1. Heard shelling of the area by heavy artillery	97.9	2.1
2. Heard the sonic sounds of the jetfighters	93.3	6.2
3. Watching pictures of mutilated bodies in TV	90.8	9.7
4. Forced to move from home to a safer place during the war	85.6	14.4
5. Deprivation from water, food, or electricity during the war	79	21
6. Were detained at home during incursion	68.7	31.3
7. Destruction of personal belongings during the war	60.5	39.5
8. Witnessed firing by tanks and heavy artillery at owns home	53.8	46.2
9. Threatened by shooting	52.3	47.7
10. Witnessed the shelling and destruction of neighbor home	51.3	48.7
11. Heard killing of non relative	39.5	60.5
12. Witnessed the shelling and destruction of owns home	36.9	63.1
13. Witnessed firing by tanks and heavy artillery at neighbor home	34.9	65.1
14. Threaten of being killed	27.7	72.3
15. Heard killing of a relative	24.1	75.9
16. Witnessed killing non relative	22.6	77.4
17. Witnessed shooting of a friend	22.1	77.9
18. Witnessed shooting of a relative	19	81
19. Witnessed killing of a relative	17.9	82.1
20. Beaten and humiliated by the army during the war	16.4	83.6
21. Threatened to death by being used as human shield to arrest your neighbors by the army	14.4	85.6
22. Physical injury due to bombardment of your home	11.8	88.7
23. Exposure to burn by bombs and phosphorous bomb	7.7	92.3

4. DISCUSSION

This study aimed to investigate the impact of trauma due to wars on quality of life of Palestine children living in Gaza with special reference to 2009 war. Palestinian children had reported variety of traumatic events due to war. Children reported from no events to 23 traumatic events, mean traumatic events was 10.6. Children commonly exposed to hearing shelling of the area by heavy artillery, hearing the sonic sounds of the jetfighters watching pictures of mutilated bodies in TV, and forced to leave their homes to more safe area due to land incursion. Children forced internal displacement is one of the most traumatic experiences because those children had previous experiences of other types of traumatic experiences, but at last war one Gaza, they were forced to move from their homes under bombardment and uncertainty where to go and how long they will stay away from home. Such traumatic experiences increase children' disruption daily life activities including going to school and helping their families in home. Our results showed that there were no significant differences were between males and females in reporting total traumatic events. Adolescents (16-

18 years) reported more traumatic events than youner age children (less than 15 years). Such findings were consistent with previous studies in Gaza Strip which due to setting of the area and collective exposure to the same types of traumatic events [23,26,27,28]. Others found that males are more likely to be victimized by or to witness community violence than are females, regardless of their developmental ages and ethnicity while females are significantly more likely to have a higher level of distress symptoms than their male counterparts [29].

The study showed that mean total quality of life was 62.80, physical functioning was 69.87, emotional functioning was 51.96, social functioning was 77.62, and school functioning mean was 47.53. Boys and girls quality of life and physical, emotional, social, and school functioning were not different. Similarly in study of Health Related Quality of Life (HRQoL) in Swedish children and adolescents with various disabilities in Vasterbotten County, Sweden showed no significant sex differences in HRQoL, but girls with intellectual disabilities reported increased pain/discomfort compared with boys [29].

Table 3. Descriptive distribution of overall and domain of quality of life in children

	No/ rarely	Sometime	Most of the time/ always	
Physical functioning				
1	Difficulty walking more than one block	48.71	22.56	29
2	Difficulty running	50.77	21.54	39
3	Difficulty participating in sports/exercises	57.95	25.13	23
4	Difficulty lifting something heavy	37.43	17.44	38
5	Difficulty taking shower/bath by self	83.08	8.21	8.2
6	Difficulty doing chores around house	75.9	13.33	10
7	Having hurts or aches	71.14	15.46	15
8	Low energy level	62.9	22.7	18
Emotional functioning				
9	Feeling afraid or scared	30.73	26.67	48
10	Feeling sad or blue	35.37	25.64	50
11	Feeling angry	37.48	29.74	45
12	Trouble sleeping	39.52	31.28	37
13	Worrying about what will happen	35.06	27.32	40
Social functioning				
14	Trouble getting along with peers	77.9	14.87	12
15	Other kids not wanting to be friends	77.4	14.87	5.1
16	Getting teased	75.9	13.85	11
17	Difficulty doing things peers do	71.32	19.49	12
18	Difficulty keeping up with others	66.46	18.56	22
School functioning				
19	Paying attention in class	14.59	23.44	44
20	Forgetting things.	36.94	34.87	30
21	Keeping up with schoolwork	19.53	16.41	36
22	Missing school, not feeling well	49.69	29.74	22
23	Missing school, going to doctor/hospital	57.47	26.67	16

Table 4. Means and SD of quality of life scale

Quality of life and subscales	Mean	SD
Total HRQOL	62.80	15.00
Physical functioning	69.87	21.54
Emotional functioning	51.96	24.62
Social functioning	77.62	19.53
School functioning	47.53	18.14

Table 5. Pearson rank correlation coefficient: traumatic events, total HQoL, and subscales of children

	Traumatic events
Physical functioning	-.21**
Emotional functioning	-.41**
Social functioning	-.39**
School functioning	.001
Total HRQOL	-.34**

This study showed that exposure to traumatic events by children had strong negative impact on

children HRQoL, physical, emotional, and social functioning and not with school function. Such findings were consistent with other studies which showed that frequent exposure to trauma in older childhood and adolescence has been shown to be associated with worse HRQoL [30,31,32,33, 34], psychosomatic complaints [35,36,37], poor physical functioning [38,39]. Similarly Coker and colleagues found that children with more trauma exposure had greater odds of impaired HRQOL compared with children without any trauma exposure [24]. Further, increased HRQOL has been linked to mental health stressors including depression, lowered self-esteem, post-traumatic stress, and perceived stress in children after road traffic accidents [40]. Similarly, in community-based, cross-sectional survey of 170 children and their parents in an urban city in the Northeastern United States, found a significant negative association between experiencing different types of traumatic events and impaired HRQoL and psychosocial health in young children [41].

Table 6. Regression results from selected determinants of QoL domain scores and traumatic events

QoL	Traumatic events	Unstandardized coefficients		Standardized coefficients	t	p	95.0% confidence interval for B	
		B	Std. error	Beta			Lower bound	Upper bound
Physical functioning	Destruction of personal belongings during the war	2.78	0.98	0.20	2.84	0.01	0.85	4.70
	Forced to move from home to a safer place during the war	3.31	1.34	0.17	2.47	0.01	0.67	5.96
Emotional functioning	Witnessed the shelling and destruction of neighbor home	2.38	0.64	0.24	3.74	0.00	1.13	3.64
	Deprivation from water, food, or electricity during the war	2.17	0.79	0.18	2.75	0.01	0.62	3.72
Social functioning	Witnessed firing by tanks and heavy artillery at owns home	1.51	0.58	0.19	2.60	0.01	0.37	2.65
	Forced to move from home to a safer place during the war	1.81	0.72	0.16	2.51	0.01	0.39	3.24
School functioning	Witnessed killing of a relative	-1.543	.671	.16	-2.29	.023	-2.867	-.219

5. CONCLUSION AND RECOMMENDATIONS

This study showed that Palestinian children exposed to variety of traumatic events during the last war on Gaza. Such traumatic event had negative impact of children quality of life in all fields including physical, psychological, social and school functioning. Such findings highlight for need of improving the existence psychosocial services in schools and community mental health center to target children with high exposure to traumatic experiences. Also, programs targeting caregivers such as parents, teachers, and counselors should include training courses in impact of trauma on children health quality of life. Furthermore, more research in the field of trauma, quality of life, social support, and family support as protective factors for improving children quality of life in time of war and conflict should be conducted. Also, research in parental quality of life and effect on their children health and mental health are needed. There are need to be considered in the planning of educational and mental health support services by different governmental United Nations organizations, and non-governmental organization in Gaza to include non curriculum activities to improve children quality of life.

6. STUDY LIMITATIONS

There are several limitations to the present study that needs to be addressed. The study was done in area of high exposure to traumatic events and presence of control group from other areas in the Gaza Strip or West Bank would me more informative about the differences in types of traumatic events and impact in quality of life in different settings.

ETHICAL APPROVAL

It is not applicable.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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