

Report of a field assessment of health conditions in the occupied Palestinian territory

February 2016

Ambrogio Manenti
Claude de Ville de Goyet
Corinna Reinicke
John Macdonald
Julian Donald

DISCLAIMER: The views expressed in this report are those of the authors solely and do not necessarily represent the views, policies, or decisions of WHO.



© World Health Organization 2016
All rights reserved.

Contents

1. Summary findings.....	5
2. Introduction	7
3. Context.....	8
3.1 Demography	9
3.2 Health profile.....	9
3.3 Health system	10
4. Methodology	12
5. Findings	13
5.1 Health care access	13
5.2 Physical injuries, damage to health infrastructure and impediments to safety of health staff.....	18
5.3 Effect on mental and physical health, including in prisons.....	18
5.4 Effect on health of impeded access to water, food and livelihood.....	21
5.5 Contribution of the humanitarian and development community	24
6. Conclusion and recommendations	25
7. Annexes.....	27
7.1 Maps of West Bank and Gaza	27
7.2 Assessment team	27
7.3 List of persons interviewed	27

List of acronyms

B'Tselem	The Israeli Information Centre for Human Rights in the Occupied Territory
COGAT	Coordination of Government Activities in the Territory (Israel)
DNA	Detailed Needs Assessment and Recovery Framework for Gaza Reconstruction
EWASH	Emergency Water Sanitation and Hygiene group in the Occupied Palestinian Territory
GA	General Assembly
GoI	Government of Israel
ICRC	International Committee of the Red Cross
JWC	Joint Water Committee (Israel-Palestine)
LACS	Local Aid Coordination Secretariat
MDA	Magen David Adom (Israel Red Cross Society)
MoH	Ministry of Health (Palestinian)
MRD	Medical Referral Directorate (Ministry of Health)
NIPH	Norwegian Institute of Public Health
OCHA	UN Office for the Coordination of Humanitarian Affairs
PA	Palestinian Authority
PCHR	Palestinian Centre for Human Rights
PHR-Israel	Physicians for Human Rights Israel
PMRS	Palestinian Medical Relief Society
PNIPH	Palestinian National Institute of Public Health
PRCS	Palestine Red Crescent Society
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief and Works Agency for Palestine Refugees
WHA	World Health Assembly
WHO	World Health Organization

1. Summary findings

1. In 2015, the Sixty-eighth World Health Assembly adopted decision WHA68(8), in which it requested the Director-General, inter alia, “to report on the health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan, to the Sixty-ninth World Health Assembly, through a field assessment conducted by the World Health Organization, with special focus on: (a) barriers to health access in the occupied Palestinian territory, including as a result of movement restrictions and territorial fragmentation, as well as progress made in the implementation of the recommendations contained in WHO’s 2014 report, *Right to health: crossing barriers to access health in the occupied Palestinian territory, 2013*; (b) physical injuries and disabilities, and damage to and destruction of medical infrastructure and facilities as well as impediments to the safety of health care workers; (c) access to adequate health services on the part of Palestinian prisoners; (d) the effect of prolonged occupation and human rights violations on mental and physical health, particularly the health consequences of the Israeli military detention system on Palestinian prisoners and detainees, especially child detainees, and of insecure living conditions in the occupied Palestinian territory, including east Jerusalem; (e) the effect of impeded access to water and sanitation, as well as food insecurity, on health conditions in the occupied Palestinian territory, particularly in the Gaza Strip; (f) the provision of financial and technical assistance and support by the international donor community, and its contribution to improving health conditions in the occupied Palestinian territory.”
2. This report is a summary of the assessments carried out in the West Bank and Gaza Strip between December 2015 and February 2016 by five independent experts, recruited by the WHO Office for West Bank and Gaza Strip in cooperation with counterparts from the Ministry of Health, with the overarching aim of reporting on the health conditions of the Palestinian population through a field assessment in line with decision WHA68(8). The assessment report complements the Secretariat’s report.¹ WHO through its Regional Director for the Eastern Mediterranean, sent a letter, dated 20 December 2015, to the Permanent Representative of Israel to the United Nations Office and other international organizations in Geneva to provide information on the planned field assessment and to seek support from and collaboration with the Israeli authorities; mission members had a consultative meeting with representatives of the Israeli Ministry of Health on 14 December 2015. Over a period of 44 days in December 2015 and in early 2016, the experts interviewed 114 key informants at locations in the West Bank and Jerusalem (61), Gaza Strip (46), Tel Aviv/West Jerusalem (5) and Amman (1) including health facilities, ministries, field sites and offices of governments and international and national nongovernmental organizations.
3. The health system in the occupied Palestinian territory is operating under severe pressure due to rapid population growth, lack of economic opportunities and adequate financial resources, shortages in basic supplies and the inherent limitations of occupation or blockade. The coordination and collaboration challenges between the West Bank and Gaza Strip are further impediments for efficient health sector planning and management.
4. **Health access.** Access to health services is restricted through the separation wall and checkpoints, which prevent patients, health personnel and ambulances from directly accessing the main Palestinian referral hospitals located in east Jerusalem. The over-60 years age group represented 23.3% of referrals in 2015, although constituting only 4.5% of the population, reflecting the burden of noncommunicable diseases. For Palestinians from the West Bank – excluding east Jerusalem – and the Gaza Strip, access to east Jerusalem referral medical centres is only possible after obtaining a permit issued by the Israeli authorities, a complex process that can result in delays in and denial of care. In 2015, more than half of Ministry of Health referrals were to destinations requiring permits for access.

¹ Document A69/44.

5. Of the 168 278 applications for health access permits submitted to Israeli authorities, 16.4% (12.8% for patients and 19.5% for companions) were denied or received no answer. For patients in the Gaza Strip, permit applications to exit through Erez checkpoint for referral medical care increased by 17% over one year to more than 22 000, while the percentage of requests denied almost doubled (from 2.89% to 5.72%). Orthopaedic, neurosurgery, general surgery and psychiatry are more likely to be denied. The number of referrals from the Gaza Strip to Egypt continued to decline in 2015 owing to the closure of the Rafah border. Reconstruction of health facilities, especially in the Gaza Strip, is hampered by the lack of funds in addition to the restrictions to import construction material and medical equipment. Since October 2015 an escalation of violence in the occupied Palestinian territory has triggered new road blocks and checkpoints, restricting ambulance movements with consequent delays in access to health care.
6. **Attacks against health and physical injuries and disabilities.** Violence against health services and patients is a new development in the West Bank and east Jerusalem. In October and November 2015, several health facilities, including the largest Palestinian hospital in east Jerusalem, were forcefully entered by security forces in search of individual patients and their respective documentation. In one incident, this resulted in the death of a visitor in a Hebron hospital. Other acts of violence against ambulances, personnel or patients were also reported.
7. **Mental and physical health, including in the prison population.** The population of the occupied Palestinian territory is experiencing threats to their mental well-being. According to reports² and interviews, the situation deteriorated further in late 2015 as a result of increasing violence starting in September 2015. The United Nations Office for the Coordination of Humanitarian Affairs recorded 15 377 Palestinians and 350 Israelis injured during 2015, with more than 80% of casualties recorded in the last quarter of the year.³
8. Regarding mental health, the occupation itself was noted as a major cause of problems. Depression, anxiety disorder and psychological distress are the most common mental disorders. Research in east Jerusalem has shown that the psychological toll of demolitions and forced evictions hits women harder.⁴ Also, the imprisonment of Palestinians in Israeli jails affects not only the prisoners (mainly men) but also their families. A high percentage of the male population has spent time in some form of confinement with long-term effects on their mental well-being. There are severe mental health consequences for children and their families. The time spent in detention for these children represents a period of chronic stress, traumatic experiences (threats to physical integrity which are experienced as overwhelming and are accompanied by intense fear and helplessness), loneliness and loss of faith in adults, possibly even their own parents. The actual mental health damage inflicted on the detainees themselves as well as their families is likely to have a long-term health impact.
9. The main reported issues of concern related to the physical well-being of the 6066 Palestinian security detainees and prisoners held in Israeli prisons are: lack of access to timely and adequate medical care, both diagnosis and treatment; inadequate nutrition and housing conditions; and denial of family visits and communications. Physical and psychological abuse especially in interrogation, the use of arbitrary punishments and administrative detention without trial are seen as important problems for many prisoners. The assessment team did not have access to Israeli prisons and Palestinian prisoners therein, and was not able to validate independently the reported conditions.

² See WHO situation reports October and December 2015 (<http://www.emro.who.int/pse/palestine-infocus/situation-reports.html>, accessed 25 April 2016).

³ United Nations Office for the Coordination of Humanitarian Affairs press release, 30 December 2015 (https://www.ochaopt.org/documents/press_release_170_palestinians_and_26_israelis_killed_in_2015_english.pdf, accessed 25 April 2016).

⁴ Women's Centre for Legal Aid and Counselling, 2010: Forced evictions. Assessing the impact on Palestinian women in east Jerusalem, <http://www.wclac.org/english/etemplate.php?id=29>, accessed 25 April 2016.

10. **Food/water.** Water consumption in the West Bank and Gaza Strip is well below the WHO-suggested service delivery level of 100 L per capita per day. The Palestinian water network in the West Bank only connects 81% of localities owing to separation walls and roads in Area C, which is under Israeli civil and security authority, according to the Oslo peace accords. In the Gaza Strip, although almost all households (more than 98%) are connected to the water supply network, 90–95% of that water is not potable due to wastewater leakage, seawater intrusion or other contamination. The water quality varies widely in the West Bank and is at crisis levels in the Gaza Strip. Of particular concern are the rising bacteriological and pesticide concentrations in the water supply and the lack of resources for chemical analyses and water treatment. Wastewater treatment infrastructure is also largely inadequate, creating environmental hazards. Administrative delays in the Joint Water Committee and its associated bodies are another factor impacting water quantity, water quality, and wastewater management in the West Bank.
11. **Financial and technical assistance.** International assistance is closely tied to the peace process and is provided despite critical unresolved political, economic and security issues. Donor support has significantly declined in recent years, mainly due to other competing crises in the region.
12. Palestinians continue to be negatively affected by occupation-related policies and practices; they are at risk of conflict and violence, house demolitions and displacement, denial of access to livelihoods, administrative detention, psychosocial distress or exposure to explosive remnants of war. The root causes of the conflict remain unaddressed. Social resilience, seen as a positive adaptation in the face of adversity, is still holding Palestinian society and its economy together, including the health system.
13. Recommendations formulated in previous reports to the Health Assembly remain valid; and some immediate concrete steps are proposed in addition. These include the upholding of the right to health, the strengthening of coordination of national and international partners, advocacy to support inter-Palestinian reconciliation and the strengthening of the Israeli Ministry of Health's Health Coordination Unit. Health-specific recommendations focus on improvement of health data collection and analyses, and strengthened integration of mental health into primary health care services.

2. Introduction

Several long-standing health issues in the occupied Palestinian territory were reported to the Sixty-seventh⁵ and Sixty-eighth World Health Assembly (WHA),⁶ such as:

- barriers to physical access to local primary/secondary health care (for patients and/or staff particularly in the West Bank);
- impact on the development of quality health services;
- reduced affordability of services for patients; and
- health coordination challenges.

In order to further assess the health impact of the ongoing conflict, the Sixty-eighth World Health Assembly adopted decision WHA68(8), in which it requested the Director-General, *inter alia*:

- (1) to report on the health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan, to the Sixty-ninth World Health

⁵ Document A68/37. Report by the Secretariat. Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan. In: Sixty-eighth World Health Assembly, Geneva, 15 May 2015.

⁶ Document WHO-EM/OPT/006/E. De Ville de Goyet, C., Manenti, A., Carswell, K. and van Ommeren, M. Report of a field assessment of health conditions in the occupied Palestinian territory (oPt), 22 March to 1 April 2015.

http://www.who.int/hac/crises/international/wbgs/opt_field_assessment_health_conditions_1april2015.pdf?ua=1

Assembly, through a field assessment conducted by the World Health Organization, with special focus on:

- (a) barriers to health access in the occupied Palestinian territory, including as a result of movement restrictions and territorial fragmentation, as well as progress made in the implementation of the recommendations contained in WHO's 2014 report, *Right to health: crossing barriers to access health in the occupied Palestinian territory, 2013*;⁷
- (b) physical injuries and disabilities, and damage to and destruction of medical infrastructure and facilities as well as impediments to the safety of health care workers;
- (c) access to adequate health services on the part of Palestinian prisoners;
- (d) the effect of prolonged occupation and human rights violations on mental and physical health, particularly the health consequences of the Israeli military detention system on Palestinian prisoners and detainees, especially child detainees, and of insecure living conditions in the occupied Palestinian territory, including east Jerusalem;
- (e) the effect of impeded access to water and sanitation, as well as food insecurity, on health conditions in the occupied Palestinian territory, particularly in the Gaza Strip;
- (f) the provision of financial and technical assistance and support by the international donor community, and its contribution to improving health conditions in the occupied Palestinian territory;⁸

In late 2015 and early 2016 a team of five international experts conducted a series of on-site missions to collect information through field assessments. Findings and recommendations are summarized and presented in this report. WHO has no access to the occupied Syrian Golan and thus cannot provide a report on the prevailing health conditions there. The initial draft developed by the consultants was subsequently revised substantially by the local office, based on inputs and comments received from local stakeholders and partners.

3. Context

The health situation in the occupied Palestinian territory remains affected by the occupation – now approaching its 50th year – and by the absence of a fully unified Palestinian central administrative control over the West Bank and the Gaza Strip. The long-lasting siege and the serious constraints imposed by the occupation also impact the physical and mental health of the population as well as the further development of quality health services, especially in Gaza Strip. This has been aggravated by the internal Palestinian political divide and the financial crisis of the Palestinian Authority.

For the past nine years, since mid-2007, the Gaza Strip has been subject to strict closure and blockade by land, sea and air. While needs surged in the Gaza Strip from mid-2014, following a 51-day escalation of hostilities, the underlying challenges remain unchanged across the occupied Palestinian territory. This recent military conflict caused major human and infrastructure losses. In the Gaza Strip, in particular, the scale of the devastation was unprecedented. 2251 people were killed and 11 231⁹ were injured of whom 10% suffered permanent disability as a result. Furthermore, “the hostilities left 23 health care workers dead, 16 of whom died while on duty. 83 health care workers were injured. Ambulance drivers were disproportionately affected.”¹⁰ The economic losses for the health sector were

⁷ [In original]: *Right to health: crossing barriers to access health in the occupied Palestinian territory, 2013*. Jerusalem: World Health Organization; 2014
(http://www.emro.who.int/images/stories/palestine/documents/WHO_RTH_crossing_barriers_to_access_health.pdf?ua=1, accessed 20 May 2015).

⁸ World Health Assembly Decision WHA68(8). Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan. http://apps.who.int/gb/ebwha/pdf_files/WHA68-REC1/A68_R1_REC1-en.pdf

⁹ United Nations Office for the Coordination of Humanitarian Affairs, <http://gaza.ochaopt.org/2015/06/key-figures-on-the-2014-hostilities/>

¹⁰ Annual report of the United Nations High Commissioner for Human Rights and reports of the Office of the

estimated at over 380 million US dollars.¹¹ The indirect impact on health went beyond damage to medical care infrastructure to encompass water and sewage facilities, electricity, food supply and houses destructions and damages, compounded by a loss of household income.

During the 2014 war in the Gaza Strip, one rehabilitation hospital (Al-Wafa) and the primary health care centres (PHCC) of Atta Habib, Juhr Al Deek and Khoza'a, were completely destroyed while another 19 hospitals and 57 PHCCs were damaged.¹² To date, nearly all partially damaged facilities have been repaired, while reconstruction of the totally destroyed Al-Wafa hospital is still in need of donor funding.

Barriers to access health care facilities are a serious enduring and well-documented problem. According to reports¹³ and interviews, the situation deteriorated further in late 2015 as a result of increasing violence starting in September 2015. OCHA recorded 15 377 Palestinian and 350 Israeli injuries during 2015, with more than 80% of casualties recorded in the last quarter of the year.¹⁴

Under the measures adopted by the Security Cabinet of the Government of Israel (GoI), closure of roads, checkpoints and barriers grew in numbers, while scrutiny and delays increased at pre-existing barriers. Military checkpoints were erected next to Augusta Victoria, Makassed and St Joseph's hospitals in east Jerusalem with negative impact on their functioning, such as delaying access for staff and patients. The Augusta Victoria hospital, which provides services unavailable at other hospitals such as radiation and chemotherapy, recorded a 30–40% reduction in outpatient visits between 9 October and 1 November 2015.

Overall, close to 100 newly established fixed and temporary barriers (checkpoints, roadblocks, earth mounds, etc.) were erected mainly in east Jerusalem and around Hebron in late 2015, restricting vehicular movement and affecting regular medical services at hospitals and clinics such as the Ministry of Health clinics in Ad Dahiriya, Samua, Jericho, Beit 'Awwa, and Deir Samit.¹⁵

3.1 Demography

By mid-2015, the total population of the occupied Palestinian territory was 4 682 467, with 61.1% living in the West Bank, including east Jerusalem, and 38.9% in the Gaza Strip. Two million are registered refugees, of whom 800 000 live in 27 refugee camps, 19 in the West Bank and 8 in the Gaza Strip. The population is young with 39.4% of Palestinians aged 0–14 years, 30.0% aged 15–29 years, and 4.5% above 60 years.¹⁶

3.2 Health profile

The population in the occupied Palestinian territory is in epidemiological transition, with the burden of noncommunicable diseases rising. In 2014, heart disease was the leading cause of death in the West Bank, causing 31.2% of all reported deaths.¹⁷ Cancers, when combined together, were the second

High Commissioner and the Secretary-General Human rights situation in Palestine and other occupied Arab territories, A/HRC/28/80/Add.1, paragraph 24.

<http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session28/Pages/ListReports.aspx>

¹¹ Detailed needs assessment (DNA) & recovery framework for Gaza reconstruction, Ministerial Committee for the Reconstruction of Gaza, August 2015.. http://www.lacs.ps/documentsShow.aspx?ATT_ID=21974

¹² UNDP/Government of Palestine. Detailed infrastructure damage assessment – Gaza, (December 2014). Cited in Detailed Needs Assessment (DNA) & Recovery Framework for Gaza Reconstruction, Ministerial Committee for the Reconstruction of Gaza, August 2015.Strategy, 2014 Gaza Strip Escalation, Health Sub-Sector, April 2015. http://www.lacs.ps/documentsShow.aspx?ATT_ID=21974

¹³ WHO situation reports (2015), <http://www.emro.who.int/pse/palestine-infocus/situation-reports.html>

¹⁴ United Nations Office for the Coordination of Humanitarian Affairs. Press release,

https://www.ochaopt.org/documents/press_release_170_palestinians_and_26_israelis_killed_in_2015_english.pdf

¹⁵ United Nations Office for the Coordination of Humanitarian Affairs. Movement restrictions on West Bank roads tightened. Humanitarian Bulletin (January 2016).

https://www.ochaopt.org/documents/ocha_opt_the_humanitarian_monitor_2016_01_05_english.pdf

¹⁶ http://www.pcbs.gov.ps/portals/pcbs/PressRelease/Press_En_WelderlyD2015E.pdf and

http://www.pcbs.gov.ps/portals/pcbs/PressRelease/Press_En_Youth-Day-2015-e.pdf

¹⁷ Palestinian Health Information Centre, Health annual report, Palestine 2014 (August 2015).

leading cause of death, accounting for 14.2% of reported deaths, followed by cerebrovascular diseases (11.3%), diabetes mellitus (8.9%) and infant diseases and prenatal conditions (5.2%). This disease burden has contributed to the increase in costs in the health sector and necessitates a greater focus on health prevention and integrated disease management including mental health.

In spite of the protracted crisis and – as noted by the Palestinian Ministry of Health – with the support of the international community, achievements have been made in relation to some health indicators in recent years– although they compare negatively to health indicators in Israel. In 2014¹⁸, life expectancy was 71.3 years for men and 74.1 years for women, under-5 mortality rate dropped to 14.9 and infant mortality rate decreased to 12.6 per 1000 live births. Vaccination coverage is close to 100%. Most women receive antenatal care and 99.7% of registered newborns are delivered in hospitals.

Nevertheless, the decline in under-5 mortality did not achieve Millennium Development Goal 4, which aimed to reach below 14 child deaths per 1000 live births. The occupied Palestinian territory had the smallest reduction in this rate compared to all Arab countries.¹⁹ Similarly, although the maternal mortality rate is better than the regional average, it remains higher than the target rate.

According to the 2009 and 2014 nutrition surveys, declines in the prevalence among children under 5 of wasting, stunting and underweight, were observed. However, overweight increased from 5% to 8%. Various micronutrient deficiencies of grave concern were reported. Although no severe anaemia was reported, mild and moderate anaemia were 17-33% among children and 35% among pregnant women. The increasing burden of malnutrition is leading to a rise in the incidence of noncommunicable diseases.²⁰

Communicable diseases are by and large under control. The Gaza Strip has experienced an outbreak of mumps since April 2013, which has continued to spread at an increasing rate, and a viral meningitis outbreak, which started in March 2014 and has continued to spread but at a decreasing rate. The incidence of tuberculosis is lower than in the surrounding countries and the occupied Palestinian territory is declared poliomyelitis free.²¹

In the Gaza Strip, the more than 6000 people with disabilities and/or injuries that require rehabilitation are particularly vulnerable.²² According to one assessment, using WHO estimates of up to 20% as the prevalence rate for mental disorders among emergency-affected populations, up to 360 000 people could be suffering psychological trauma and would be in need of interventions.²³ These numbers may underestimate the real burden of disease in Gaza Strip.

3.3 Health system

The health system in the Palestinian territory has three distinct political, financial and coordination features.

- It operates in a context of political instability and conflict, which undermines effective system governance.
- Its financial viability is severely constrained by its dependence on donor funding, which is subject to fluctuations depending on political considerations.

¹⁸ Palestinian Health Information Centre, Health annual report, Palestine 2014 (August 2015).

¹⁹ Abdul Rahim, H., Wick, L., Halileh, S., Hassan-Bitar, S., Chekir, H., Watt, G., and Khawaja, M. (2009), Maternal and child health in the occupied Palestinian territory, *The Lancet*, Vol. 373 March 14, DOI:10.1016/S0140-6736(09)60108-2.

²⁰ World Food Programme, Summary evaluation report – State of Palestine Country portfolio (2011–mid-2015) <http://documents.wfp.org/stellent/groups/public/documents/eb/wfp280904.pdf> accessed 19 01 2016.

²¹ Palestinian National Institute of Public Health. Vaccine preventable diseases in Palestine, Ramallah, Palestinian National Institute of Public Health, 2014.

²² Healing the wounds, Handicap International Gaza Emergency Response Action Report March 2015.

²³ Health Cluster in the oPt. Gaza Strip, Joint health sector assessment report. (September 2014), http://www.emro.who.int/images/stories/palestine/documents/Joint_Health_Sector_Assessment_Report_Gaza_Sept_2014-final.pdf

- The coordination and collaboration challenges of implementing Ministry of Health programmes in the West Bank and Gaza Strip are further impediments for planning and management of health services under occupation.

These are further compounded by each region's geopolitical challenges: while the Gaza Strip is a contiguous territory but closed, the West Bank is fragmented into dozens of isolated 'islands' by the presence of settlements, military zone, controlled roads and barriers, requiring health services coverage for small and access-restricted Palestinian communities. Furthermore, the Palestinian health system includes the six specialized nongovernmental hospitals that developed historically in east Jerusalem but which are today separated from their catchment areas in the rest of the West Bank and Gaza Strip by administrative and physical barriers.

The Ministry of Health is responsible for all of the functions of the health system, including coordination, financing, service provision, licensing and regulation. The emphasis to provide a wide range of services and to address the health needs of the population in a chronic crisis context with acute emergencies has to some extent hindered its full exercise of the stewardship role and its ability to steer longer term planning.

The majority of funding for Ministry of Health services emanates from foreign assistance and taxes. The Palestinian Authority government insurance plan is the principal health insurance provider, while 37.7% of all spending on health care in Gaza Strip and the West Bank is paid out of pocket.²⁴

3.3.1 Health services provision

The Ministry of Health provides health services to Palestinians under its jurisdiction in accordance with the Palestinian Basic Law, which serves as the interim constitution, and the Public Health Law.

- The Ministry of Health has a network of 472 primary health care centres (PHCCs, 418 in the West Bank and 54 in Gaza Strip), and 26 hospitals (13 in the West Bank and 13 in Gaza Strip).²⁵
- Nongovernmental organizations play an important role in service delivery, especially in providing tertiary, ambulatory and rehabilitative care services. In 2014, nongovernmental organizations operated 137 PHCCs (129 in the West Bank and 8 in Gaza Strip) and 34 hospitals (20 in the West Bank and 14 in Gaza Strip), supplying about one-third of bed availability in the occupied Palestinian territory. They are important providers especially for mental health counselling, physical therapy and rehabilitation.
- UNRWA provides services – mainly through fixed and mobile primary health care clinics as well as contracted hospitals – to registered refugees: to 727 471 people in the West Bank through 42 primary health centres and one hospital, and to 1 167 572 people in Gaza Strip through 22 primary health centres.²⁶ About 74% of eligible refugees utilized UNRWA's health services in 2014.
- The private health sector is growing; in 2014 there were 16 private hospitals, supplying 8.6% of bed capacity, as well as pharmacies, laboratories and rehabilitation centres.²⁷ A pharmaceutical industry has also developed, which is able to supply about one half of total Palestinian demand for prescription medicine.
- The Ministry of Interior runs 23 primary health care clinics and three hospitals for military employees, but not their families.

²⁴ Palestinian Central Bureau of Statistics and Ministry of Health, Palestinian Health Accounts 2013, <http://www.pcbs.gov.ps/Downloads/book2105.pdf>

²⁵ Palestinian Health Information Centre, Health Annual Report, Palestine 2014 (August 2015).

²⁶ Document A68/INF.4. UNRWA. Health conditions in the occupied Palestinian territory, including east Jerusalem. http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_INF4-en.pdf

²⁷ Palestinian Health Information Centre, Health Annual Report, Palestine 2014, (August 2015).

The surveillance system for communicable diseases in the occupied Palestinian territory is robust and well established. The Central Public Health Laboratory in Ramallah and its affiliate in Gaza Strip conduct public health related investigations with regards to water and food safety, vector and waste control. In spite of the diverse access barriers within the occupied Palestinian territory, delays of transporting samples were reported as rare occurrences. A lack of reagents, some laboratory capacity and training opportunities was noted, however.

Emergency medical services are transitioning gradually to a system whereby all ambulances (including from private providers) will be registered with the Ministry of Health and coordinated by the Palestinian Red Crescent Society (PRCS), which is the main ambulance provider with 144 ambulances, 27 centres and sub-centres, two training institutes and about 350 employees. One ambulance centre with three types of ambulances (for emergency transport, patient transportation and for dead bodies) per 30 000 inhabitants is planned. A fixed fee per kilometre will be charged to the patients.

3.3.2 Human resources

In 2014, the number of physicians per 10 000 people was 21.5 across the territory (compared to 29.4 in Jordan and 30.6 in Lebanon). The number of nurses per 10 000 people was also low at 25.3, compared to the neighbouring countries (31.7 in Jordan and 33.0 in Lebanon).²⁸ Furthermore, the Palestinian territory suffers from acute shortages in certain sub-specialties (e.g., oncology).

Due to persisting disagreements between authorities in the Gaza Strip and the West Bank little progress has been made to reintegrate health professionals in the Gaza Strip, with regular payment of staff salaries for a substantial number of health workers in Gaza Strip unresolved.²⁹ About 2163 health workers who stood down from their jobs in 2007 at the request of the Palestinian Authority and who are not presently working in the health services continue to receive their full pay. About 4508 workers hired by the then de facto authority from 2007 to 2013, and 530 workers employed by the Palestinian Authority who remained working after 2007 have received irregular and partial payments since mid-2014.³⁰

Israel represents an important employer with significant work opportunities, higher salaries and attractive working conditions, especially for young doctors who can also train on-the-job. Palestinian health workers are in high demand in Israel, specifically for clinics serving Arab communities. Palestinians from medical schools in the West Bank are eligible to sit for the Israeli licence exam to practice in the Israeli health system. Palestinians who graduated from al Quds University medical school in Abu Dis were not eligible to sit for the Israeli licence exam until very recently.³¹

4. Methodology

Between December 2015 and February 2016 a multidisciplinary team of independent experts carried out the assessment in the West Bank and Gaza Strip, recruited by the WHO Office for West Bank and Gaza Strip in cooperation with counterparts from the Ministry of Health and facilitated by the WHO Office under the overarching aim of reporting on the health conditions of the Palestinian population through a field assessment as requested in WHA68(8) (see Annex 2 and 3 for list of team members and persons interviewed). The areas of expertise of the team members included public health, communicable disease surveillance, mental health, prison health, water and sanitation, and emergency preparedness and response.

²⁸ World Health Organization Regional Office for the Eastern Mediterranean, Regional Health Observatory Data Repository, Health workforce: physicians by country, <https://rho.emro.who.int/rhodata/node.main.A31>

²⁹ Salaries represented 52% of the budget of the Palestinian Ministry of Health in 2014.

³⁰ The World Bank and donors made a one-time contribution.

³¹ "Court tells state to recognize Al-Quds University medical graduates", (07 April 2014), <http://www.haaretz.com/israel-news/premium-1.584183>; also Physicians for Human Rights – Israel, Divide & conquer: Inequality in health. January 2015. <http://reliefweb.int/sites/reliefweb.int/files/resources/256771352-Divide-Conquer-Inequality-in-Health-PHR-Israel.pdf>

WHO through its Regional Director for the Eastern Mediterranean had sent a letter, dated 20 December 2015, to the Permanent Representative of Israel to the United Nations Office and other international organizations in Geneva to inform of the planned field assessment and to seek the support from and collaboration with Israeli authorities; mission members had a consultative meeting with representatives of the Israeli Ministry of Health on 14 December 2015.

Following an extensive literature review, 114 semi-structured and informal interviews were carried out over a period of 44 days in December 2015 and in early 2016 at locations in the West Bank and Jerusalem (61), Gaza Strip (46), Tel Aviv/West Jerusalem (5) and Amman (1) with representatives of key stakeholder institutions, including:

- the Ministry of Health and related departments
- health facilities and institutions
- national and international (including Israeli) nongovernmental organizations
- UN and donor organizations
- Field visits.

Transcripts were prepared after the interviews and on-site assessments, and shared among the independent experts to allow for additions and corrections and ensure a common understanding. The WHO Office for West Bank and Gaza Strip was consulted to clarify, where possible, any contradictory information and to provide additional information where necessary. The initial draft developed by the independent experts was subsequently revised substantially by the local office, based on inputs and comments received from local stakeholders and partners.

5. Findings

5.1 Health care access

The challenges in access to quality health care are distinct in east Jerusalem, the West Bank and Gaza Strip. While Gaza Strip is a geographically contiguous territory under blockade, the West Bank is divided into three areas (A, B and C). Area C in particular is fragmented in dozens of ‘Palestinian islands’ between Israeli settlements, military zones and controlled roads. Part of the population is separated from local health services by checkpoints and/or walls. In east Jerusalem, the Israel National Health Insurance Act applies to Palestinian residents. However, the level of health services available for Israelis and resident Palestinians can differ in practice.³² Within Jerusalem, Jerusalem residents of the UNRWA-administered refugee camp of Shufat are separated from access by walls and checkpoint. Health services in prisons have been reported to be of concern due to delays in treatment, long wait time for specialist care and conditions of transport to clinics.³³

Health and Nutrition Cluster partners have identified the following vulnerable population groups – in addition to prisoners – who are particularly suffering from the lack of access to primary health care, emergency services and mental health services:³⁴

- 80 000 people in the Gaza Strip with limited access to health services as a result of the destruction of health facilities serving their immediate communities (Shajayia, Juhr Al Deek, Khuza’a);
- 250 000 people in communities in access restricted areas within 2 kilometres of the Gaza Strip border; over 1 million people in vulnerable groups across the Gaza Strip, including 287 000

³² For example, regarding mother-and-baby health centres and mental health services, <https://www.acri.org.il/en/2014/05/24/ej-numbers-14/>

³³ Inhumane transport conditions for Palestinian prisoners for medical treatment and court hearings constitute ill-treatment, (14 April 2015), <http://www.adalah.org/en/content/view/8523>

³⁴ Health and Nutrition Cluster Humanitarian needs overview 2015 (unpublished).

neonates and children, 60 000 pregnant women, 700 000 chronic disease patients, 41 000 elderly people³⁵ and 6475 of the most vulnerable people with disability due to conflict.³⁶

- 253 625 people in communities in Area C with restricted access to health services where there is no fully functional primary health care centre at level 2 and above, including 132 communities in South Hebron, the Jordan Valley and the north of the West Bank, as well as east Jerusalem communities behind the barrier, which have limited access to mental health and emergency services (80 589 people).

The quality of the health care received by the patient once s/he has overcome the many access barriers is stagnating according to the views of many of the interlocutors. The Palestinian Ministry of Health has had to operate in an emergency mode for several years. New investments in the health sector by various donors are often vertical projects which pose sustainability challenges to the Ministry of Health. The access restrictions in particular for health professionals from Gaza Strip, and the limited opportunity for health professionals to attend trainings outside and to get familiar with new medical techniques is also negatively affecting health care services development in Gaza Strip.

5.1.1 Access to local primary and secondary health care

In the West Bank, the population that had learned to cope somewhat with lengthy delays for access to routine or emergency health services was faced with an acute aggravation of obstacles as a result of recently introduced stricter security measures.

In late 2015, Palestinian residents of east Jerusalem, who normally access health facilities without security control, were severely delayed by dozens of roadblocks and checkpoints on many of the main streets leading to and from Palestinian neighbourhoods in east Jerusalem. Search and checking procedures at checkpoints disrupted access for some 140 000 people to health services and raised concern from the UN.³⁷ As reported by OCHA, “in Al Issawiya, home to approximately 15 000 people, all seven routes connecting this neighbourhood with the rest of the city and to adjacent agricultural land were blocked, and all traffic to and from this area directed to a single road controlled by a checkpoint”. These additional obstacles had been removed by December 2015.³⁸ The interviews pointed to newly evolving concerns in addition to the time lost, namely the unpredictability of routine security checks and reported concerns over the perceived increased risk of personnel attacks from settlers or security forces. Travel to and from Hebron was also reportedly particularly difficult during this period.

5.1.2 Access to emergency medical services

While patients did experience considerable obstacles to reach health facilities, emergency medical services were also prevented or delayed from reaching the wounded. The PRCS spokesperson reported on October 19 that of the 136 incidents of damage and injury or delayed or denied access involving their ambulances, one-third occurred in occupied east Jerusalem,³⁹ while the Ministry of Health reported 116 emergency cases for which on-site care was reportedly delayed. Similar complaints were reported in Gaza Strip regarding denial or delay of access to wounded people within the buffer zone close to the wall separating Israel from the Gaza Strip.

³⁵ Palestinian Health Information Centre, Health annual report, Palestine 2013 (August 2014).

³⁶ Healing the wounds, Handicap International, March 2015.

<http://reliefweb.int/sites/reliefweb.int/files/resources/Healing%20the%20Wounds%20-%20Handicap%20International%20-%20Gaza%20-%20March%202015.pdf>

³⁷ <http://www.emro.who.int/palestine-press-releases/2015/un-agencies-call-for-respect-of-health-premises-and-the-right-to-health-care-november-2015.html> and

http://www.emro.who.int/images/stories/palestine/documents/HC_Statement_East_Jerusalem_health_careFinalVersion.pdf?ua=1

³⁸ http://www.emro.who.int/images/stories/Palestine/documents/WHO_Sitrep_on_oPt_health_attacks_12.2015_-_final.pdf?ua=1

³⁹ http://www.emro.who.int/images/stories/Palestine/documents/WHO_Sitrep_on_oPt_20_10_15_FINAL.pdf?ua=1

5.1.3 Access to medical supplies

A chronic shortage of pharmaceuticals, supplies, spare parts and gaps in general maintenance led to further challenges for sustaining the quality of services in Gaza Strip and to a lesser extent in the West Bank. The observation in the Detailed Needs Assessment following the 2014 conflict that “nearly 50 per cent of Gaza Strip’s medical equipment is outdated and the average wait for spare parts is approximately six months”⁴⁰ remains largely relevant. However, during the assessment mission, the local health authority in the Gaza Strip reported that their infrastructure has recently improved in some hospitals. Rehabilitation of hospitals was carried out mostly by the ICRC. Improvements in the capacity of new generators though presented a new challenge to donors as the request for fuel increased from 220 000 litres to 340 000 per month due to increased fuel consumption of more powerful generators and prolonged hours of electricity cuts to 12 hours per day.

According to the Ministry of Health,⁴¹ the average rate of drug shortages in both the West Bank and Gaza Strip ranged between 20% and 30% in 2015, and drugs and vaccines were distributed both to the West Bank and the Gaza Strip, with an average of 40%-45% sent to the Gaza Strip, according to its population size.

Frequently mentioned is the lack of essential spare parts for sophisticated equipment leading to a greater need for referral of patients outside the Gaza Strip. According to the maintenance department of the health authority in Gaza Strip, about 5% of the over 6000 items of medical equipment require spare parts with an estimated cost of US\$ 1 million. The main reason cited for the shortage was the insufficient budget rather than security restrictions imposed by Israel.

The list of ‘dual use’ items which are restricted for Gaza Strip by the Government of Israel is changing frequently and remains subject to very broad interpretation and ad-hoc changes according to the security and political context.

5.1.4 Access to tertiary care and referrals

Referrals and access to tertiary care have a human rights dimension. In most countries, referral to tertiary care is a simple internal procedure influenced mainly by availability of service capacities and insurance considerations. In the occupied Palestinian territory it has become a complex process due to the need to cross checkpoints or border crossings and the restrictions on movement of Palestinian patients and ambulances enforced by the Israeli Government.

Access to tertiary health care is limited by many barriers, many but not all resulting from the occupation. Data related to the referral and permit process are available from various sources: the Ministry of Health Medical Referral Directorate, UNRWA, the Palestinian General Authority for Civilian Affairs, and the Government of Israel – Coordination of Government Activities in the Territory (COGAT). Each source is recording different indicators (the Ministry of Health is recording financial decisions to approve the referral, and Civilian Affairs and Coordination offices are recording security permits to exit the West Bank or Gaza Strip) making comparison of data gathered by stakeholders difficult. Access to tertiary health care is subject to availability of funding provided by the Palestinian Authority in Ramallah, by a nongovernmental organization or – in 3.7% (Gaza Strip) – by the patient.⁴² In September 2015, the accumulated debts to the east Jerusalem hospitals for referral services had amounted to NIS 158 million and jeopardized their ability to pay salaries.⁴³ Ministry of Health hospitals and clinics face chronic drug and disposable shortages, as well as shortages of laboratory reagents, and certain drug shortages trigger the need for referral services. The cost of referrals represents a significant part of the Palestinian Authority health budget (27% in 2013 and 23% in 2014). As a part of government health expenditures, referral costs were 25% in 2014, and, when including the NIS 300 million spent for referral services in Israeli hospitals,

⁴⁰ Ministerial Committee for the Reconstruction of Gaza, Detailed needs assessment (DNA) and recovery framework for Gaza reconstruction (August, 2015), http://www.lacs.ps/documentsShow.aspx?ATT_ID=21974

⁴¹ Communication to WHO, March 2016.

⁴² Referrals cost is the second most important item (after salaries) in the budget of the Ministry of Health

⁴³ The debts are due to payment delays for referral services by the Palestinian Authority.

the percentage almost doubles to 47%).⁴⁴ The Palestinian Authority with support from the World Bank and from several donors has recently streamlined the referral process, with tangible achievements:

- a reduction in costs of health referrals from a peak of NIS 189 million for the period January to June 2014 to NIS 132 million during the same period in 2015;
- strengthened capacity of the Ministry of Health team in verifying and checking invoices; and
- significant improvement in the Ministry of Health's efficiency and control systems.⁴⁵

The Palestinian Authority is striving to centralize, further consolidate and streamline the referral process in the West Bank and the Gaza Strip. Proposed referrals are reviewed by Palestinian Authority medical committees.⁴⁶ According to the Ministry of Health, the main criteria for financial approval are the unavailability of services on site and the eligibility for health insurance coverage. The lack of service availability locally may often result from a temporary shortage of essential medicines, reagents or spare parts for medical equipment, or the unavailability of a respective specialist. Detailed breakdowns of the number of applications received and approved/rejected by the Palestinian Authority medical committees could enhance transparency as would disaggregated data by location of approval/denial by the Ministry of Health medical committees.

In 2015, more than half of Ministry of Health referrals were to destinations requiring permits for access. The permits security clearance process by Israel remains challenging. Companions' permit applications are submitted together with the patients' applications and both require security clearance by security services. Companions should also be a first degree relative. This has become more difficult and time-consuming recently due to Israel requiring all companions below 55 years to undergo additional security scrutiny.

The over-60 years age group represented 23.3% of referrals in 2015, although comprising only 4.5% of the population, reflecting the burden of noncommunicable diseases which require regular and predictable follow up to be properly managed.

In the Gaza Strip, there has been a significant increase in the reported number of Ministry of Health referrals in 2015. Requests for referrals from January to December were 18% above the equivalent figure for 2014.⁴⁷ Oncology remains the main indication (approximately 25% in November 2015). The number of referrals from the Gaza Strip to Egypt continued to decline in 2015 due to the closure of the Rafah border.

Referrals and access data

Ministry of Health referral data are based on the financial decisions taken rather than on numbers of patients referred. The same patient may require several financial decisions (for diagnostic procedures, for treatment and possibly for additional or extended hospitalizations beyond the initially approved one-month period). UNRWA data include the number of patients approved for referral treatment, while the Palestinian General Authority for Civilian Affairs, which coordinates permit applications and COGAT data include the number of personal applications for individual travel permits received and approved, including patients and accompanying family members. A patient may submit a new request after a denial or for a continuation of treatment.

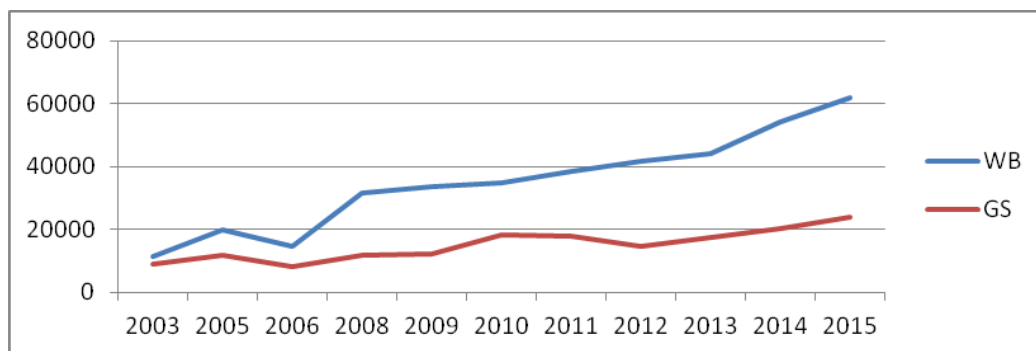
Graph 01 2003 to 2015 referrals West Bank and Gaza Strip⁴⁸

⁴⁴ Palestinian Authority, Ministry of Health Annual Report 2014, pp. 211 and 217.

⁴⁵ The Government of Palestine's Report to the Ad Hoc Liaison Committee, Deepening reforms, strengthening institutions, 30 September, 2015 New York, USA.

⁴⁶ Members of the medical committees, one for oncology and one for other disciplines, are selected by the Ministry of Health.

⁴⁷ It is unclear to what extent this increase may reflect partly a change in data definition or collection.



While the number of applications for referral permits increased, the percentage of Gaza Strip requests denied almost doubled over one year (from 2.89% to 5.72%). Little change was noted in the rate of delayed approvals during the first 11 months of the year, but in December 2015 the rate of delayed approvals was double the rate in December 2014.⁴⁹ A review of aggregated data for November 2015 indicates that some specialties are between two and four times more likely to be denied than others: orthopaedic, neurosurgery, general surgery and psychiatry among others.

In the West Bank, patients in need of referral services outside are facing somewhat similar constraints. All West Bank ID holders are prevented from directly accessing the main Palestinian referral hospitals located in east Jerusalem⁵⁰ without first obtaining an Israeli-issued permit, a complex process which can result in delayed or denied access to health care.

In 2015, 168 278 Palestinians (50.2% were patients and 49.8% were companions) applied for permits to access Jerusalem from the West Bank for health-related reasons, according to the Palestinian General Authority for Civilian Affairs. 16.4% (12.8% for patients and 19.5% for companions) were denied or received no answer to their permit request.⁵¹ In 2014, a WHO analysis of permit applications submitted in Q4 of 2014 at district level showed that the most frequent reason given for denying a permit was “security” (24% of patients’ denials and 26% for companions).

The constructive role played by the Government of Israel Ministry of Health (Coordination Unit) which is reviewing the medical applications from a right to health point of view, monitoring and facilitating with security authorities the approval for critical cases, is a positive development for the West Bank. The senior staff of this small unit is available on call on a 24/7 basis and keeps daily liaison with the receiving hospitals. The unit has no jurisdiction or role in the referrals from Gaza Strip, though. Nevertheless, it facilitated the travel, logistics and permit clearance of 10 specialist physicians from the Gaza Strip to assist the Ministry of Health staff in Ramallah and Nablus in providing services to the more than 1500 injured Palestinians caused by the recent violent escalation.⁵² This contribution of the Israeli Health Coordination Unit, in spite of its modest resources, is recognized and appreciated by Palestinian counterparts for its humanitarian approach.

East Jerusalem hospitals remain the main referral hospitals for Palestinians. The permit regime, checkpoints and the barrier negatively impact those patients who require care at the six east Jerusalem hospitals or at Israeli hospitals which provide specialized health services unavailable elsewhere in the occupied Palestinian territory.

Decreased access to and availability of reproductive health care and family planning services also leads to higher prevalence of low birth weight and significantly higher fertility, putting both mothers and

⁴⁸ WHO from Ministry of Health data.

⁴⁹ Patients are typically informed of the permit decision the day before their scheduled appointment or travel, http://www.emro.who.int/images/stories/palestine/documents/WHO_monthly_Gaza_access_report-December_2015-final.pdf?ua=1

⁵⁰ The six hospitals were established before 1967.

⁵¹ Palestinian General Authority for Civilian Affairs office, communication, 3 February 2016.

⁵² WHO Situation Report #1. 15 October 2015.

http://www.emro.who.int/images/stories/palestine/documents/WHO_Sitrep_on_oPt_20_10_15_FINAL.pdf?ua=1

infants at increased risk of morbidity and mortality. 11% of women in the West Bank have unmet needs for family planning.⁵³

Restrictions to ambulance transport of patients from the West Bank or Gaza Strip remain a human rights concern. As noted in earlier reports to the World Health Assembly, the so-called “back to back” procedure requires the ambulance from the Palestinian side to stop at the crossing point, unload the patient, submit to security check and “walk” or be transported on a gurney (more than one hundred metres at the Gaza Strip crossing) to the other side where an Israel-registered ambulance is waiting.⁵⁴ “Back to back” transfer of emergency cases at Erez crossing takes an average 55 minutes on-site, excluding the time required for logistic and administrative arrangements (permit checks, etc.).^{55 56}

Health authorities report that Palestinian ambulances often have lower priority in waiting lines for clearance at the checkpoints within the West Bank. Even for emergency cases in the West Bank, this procedure is doubling the average time spent at the checkpoint (from 6 to 12 minutes). Such delays can have serious health consequences for severe cases.

In March 2015 some travel restrictions for Palestinian health staff working in the Palestinian hospitals in east Jerusalem were eased, supported through an initiative by the Israeli Ministry of Health. Employees of the east Jerusalem hospitals can since travel directly from the West Bank to their place of work. In spite of the emergency security measures, this initiative was not rescinded. Subject to a review by the Government of Israel, it may be extended to 150 health workers. Also, the Government of Israel/Ministry of Health facilitated the part-time services of a specialized oncologist from an Israeli hospital to assist colleagues in east Jerusalem.

5.2 Physical injuries, damage to health infrastructure and impediments to safety of health staff

Violence against health services and patients is a new development in the West Bank and east Jerusalem. In one month alone, October 2015, hospitals in east Jerusalem received more than 370 injured persons⁵⁷. In October and November 2015, several health facilities including the largest Palestinian hospital in east Jerusalem were forcefully entered by security forces in search of a patient and respective documentation. In one incident a stand-off between the hospital staff and security forces seeking to re-enter the hospital culminated with use of teargas and rubber bullets, with a patient and staff member injured⁵⁸. Another incident resulted in the death of a visitor in a Hebron hospital. Other acts of violence against ambulances, personnel or patients were reported.

5.3 Effect on mental and physical health, including in prisons

Some of the major factors rendering the entire occupied Palestinian territory population more vulnerable to higher incidence of symptoms of mental health and psychological distress are exposure to displacement, arrests and detention, home raids and periodic outbursts of shelling, rocket attack and bombardment. The National Mental Health Strategy 2015 notes: ‘In Palestine, the high levels of acute and chronic stress due to the protracted occupation and related political violence are taking a heavy toll on mental health.’⁵⁹ One third of people attending Palestinian Ministry of Health (MoH) Primary Health Care (PHC) centres in the Gaza Strip and the West Bank have suffered from mental health problems; a prevalence that is higher than in more stable countries.⁶⁰ The World Health Organization (WHO) estimates based on global figures that following the violence in 2014 20% of the population of Gaza Strip suffered from mental health problems and would need short- to long-term support to recover. The

⁵³ PCBS, UNICEF, UNFPA, Multiple Indicator Cluster Survey (MICS), February 2015.

⁵⁴ Emergency Services, Red Crescent, Jerusalem – October 2015 data analysis.

⁵⁵ Emergency Services, Red Crescent, Jerusalem – October 2015 data analysis.

⁵⁶ As reported by the Red Crescent, Erez back to back transfer on average was only slightly better for emergency cases (55m) versus non-emergency cases (1h8m).

⁵⁷ <https://www.icrc.org/en/document/access-healthcare-non-negotiable>

⁵⁸ *Idem*

⁵⁹ National mental health strategy Palestine, 2015-2019 (State of Palestine, Ministry of Health 2015).

⁶⁰ World Health Organization (WHO). (2009). Prevalence of common mental disorders in the PHC. Unpublished report, Gaza.

prevalence of post-traumatic stress disorder (PTSD) among children in Palestine is particularly high, ranging from 23% to 70%,⁶¹ compared to the general population in a stable country such as the United States, which is 7.8%.⁶² 30% of Palestinian children who experienced traumatic events during the 2012 Israeli aggression on Gaza Strip have developed PTSD, in addition to having an increased risk of co-morbidity with other disorders such as emotional symptoms and neuroticism.⁶³ Several particular determinants of mental illness may be specifically relevant for the Palestinian population, including those below.

5.3.1 The “siege situation”

The devastating impact of the bombardments in the war of 2014 and the siege, as well as the ongoing experience of the stress of being confined in Gaza Strip, may best be described as a “siege situation”. Some evidence suggests that one-third to one-half of people exposed to political violence may endure some type of mental distress.⁶⁴

Mental health workers interviewed listed the most common mental health issues as: affective disorders, anxiety, depression, epilepsy, aggression, insomnia, neurosis, schizophrenia, total exhaustion, drug-induced conditions and post-traumatic stress disorder. Depression is reported to be one of the top five causes of disability in the occupied Palestinian territory.⁶⁵ Many of those interviewed also spoke of a sense of hopelessness and a sense of insecurity.

5.3.2 Discrimination

Simply by being born in the Gaza Strip, the West Bank or east Jerusalem, a person experiences discrimination, confronted with a reality of being quasi-stateless. The complicated identity arrangements and concomitant ID demands imposed on people are a potential source of continuous stress.

5.3.3 Adverse early life experiences

Parents and health workers reported children having nightmares, bedwetting, and disrupted education, which has been a consistent feature of the occupation. The detention of children by the occupying forces is of particular concern.⁶⁶

5.3.4 Unemployment

Unemployment is a major issue with well-documented negative consequences for the financial well-being of families, but also for the mental health of men who often feel they are not fulfilling their social and family role as providers. In the case of ex-prisoners, it was reported that even with “office” jobs being provided for them, many felt the unsuitability of such positions and a consequent feeling of lack of meaningful contribution.

5.3.5 Adverse features of the built environment

Destruction and obstacles are a characteristic of the environment with potential mental health implications for the Palestinian population. In the Gaza Strip the destruction of houses is obvious. Evictions are a common experience for the Palestinian population in east Jerusalem, for example, in Silwan, just below the Old City Walls. Excavations and tunnelling under the houses of the inhabitants

⁶¹ Thabet, A.A. et al. (2008). Exposure to war trauma and PTSD among parents and children in the Gaza strip. *European Child & Adolescent Psychiatry*. 17, pp. 191-199.

⁶² Molicca, R.F. et al. (2004). Mental health in complex emergencies. *Lancet*. 364, pp. 2058-67.

⁶³ Gaza Community Mental Health Program (GCMHP). (2013). Long-Term Psychological Effects of the 2012 Israeli Offensive on Gaza on Palestinian Children and Parents. GCMHP, Gaza, pp. 2-3.

⁶⁴ Sousa C.A., Kemp S. and El-Zuhairi M., Dwelling within political violence: Palestinian women’s narratives of home, mental health, and resilience, *Health & Place* 30 (2014) 205–214.

⁶⁵ Canetti D., Hall B.J., Greene T., Kane J.C. and Hobfall S.E. (2014), Improving mental health is key to reduce violence in Israel and Gaza, *The Lancet*, Vol 1384 pp 493-494.

⁶⁶ Concern over conditions and violence against Palestinian children in detention, in https://www.ochaopt.org/documents/ocha_opt_the_humanitarian_monitor_2016_01_05_english.pdf

has caused walls to crack and houses to become insecure. The mental insecurity resulting from the threat of expulsion is difficult to gauge. Yet again, the communal resilience factor of the Palestinian people has been protective. There are many reports of rapid community response and offers of support to those evicted. The effects of urban fragmentation – being divided by settlements, which is strikingly obvious in the case of Hebron, cause daily frustrations and a sense of embattlement, as well as physical and psychological fragmentation.

The chronic trauma and continuous psychological distress for the Palestinian population places more demand on the already overstretched health staff. There will always be a need for comprehensive community mental health services, but given the external and internal barriers, the integration of primary health care facilities and mental health services which is being promoted in the occupied Palestine territory is clearly a strategy to be further supported. Palestinian academics have documented the importance of this approach⁶⁷ and make the case for greater coordination of psychosocial services. The National Mental Health Strategy recognizes that improving mental health and mental health facilities will depend on “strengthening partnerships between the Ministry of Health, UNRWA, Nongovernmental organizations and the universities in order to develop efficient and comprehensive mental health services.”⁶⁸

The imposed occupation and the sum of its consequences for daily life generally and health systems development specifically and the stigmatization of mental illness which is prevalent in the Palestinian community are two barriers for delivering high quality mental health services. The interaction of these two factors—one imposed from without and one inherent in its traditional culture—presents unique challenges to clinicians and policy planners.⁶⁹

The Israel Prison Service reports 568 Palestinians in administrative detention at the end of January 2016⁷⁰ and 6072 in prison, including 406 children, 25% of whom were aged below 16 years.⁷¹ Children reported that they were often in overcrowded cells with gaps of adequate food, blankets, heating and hygiene and restricted access to legal counsel and to adequate health care.⁷² After the July 2015 passing of an Israeli law legalizing force-feeding of hunger-striking prisoners, and a high-profile case of a hunger-striking Palestinian administrative detainee, a number of human rights, medical and UN bodies expressed concern that right to health would be compromised if the law was put into effect.⁷³

⁶⁷ Giacaman R (2004), Psycho-social/mental health care in the occupied Palestinian territory: the embryonic system, Institute of Community and Public Health in cooperation with the Centre for Continuing Education / Birzeit University (ICPH website); Bassam AH., Jones N., Al Boyoumi N. & Samuels F 2015, Mental health and psychosocial service provision for adolescent girls in post-conflict settings. The case of the Gaza Strip, *ReBuild*, ODI, London.

⁶⁸ Palestinian Ministry of Health, National mental health strategy Palestine 2015-2019; see also <http://www.emro.who.int/palestine-press-releases/2015/moh-with-eu-and-who-launch-5-year-mental-health-strategy-june-2015.html>

⁶⁹ Jabr S, Morse M and Berger E, Mental health care in Palestine, Barriers to excellence, Academia, https://www.academia.edu/9558178/Mental_Health_Care_in_Palestine_Barriers_to_Excellence

⁷⁰ http://www.btselem.org/administrative_detention/statistics, accessed April 4, 2016.

⁷¹ http://www.btselem.org/statistics/detainees_and_prisoners, accessed April 4, 2016.

⁷² Defence for Children International – Palestine, Concern over conditions and violence against Palestinian children in detention, in

https://www.ochaopt.org/documents/ocha_opt_the_humanitarian_monitor_2016_01_05_english.pdf; in 2011, of detained children from Silwan in Jerusalem, 90% had experienced anxiety, 80% had suffered from insomnia, 47% had suffered from withdrawal, and 40% had experienced a drop in their school performance. Madaa Creative Center. (2012). The impact of child arrest and detention. Madaa Creative Center, east Jerusalem, p. 11.

⁷³ UN Office of the High Commissioner for Human Rights statement against legalizing force-feeding, <http://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=16269&LangID=E>; UN joint statement on new Israeli law on force-feeding,

https://www.ochaopt.org/documents/ocha_opy_press_release_english_8_august_2015_english.pdf;

United Nations Coordinator for Humanitarian Assistance and Development Aid, Robert Piper, statement on Israel’s continued practice of administrative detention,

<http://www.unsco.org/Documents/Statements/SC/2016/Statement%20by%20UN%20Coordinator%20for%20Humanitarian%20Assistance%20and%20Development%20Aid%20Robert%20Piper%20->

Reported effects of the arrests, detention, sexual abuse⁷⁴ and solitary confinement⁷⁵ and the reported incidents of physical violence on the prisoners' health include acute and post-traumatic stress disorder (PTSD), depression and emotional disturbances.⁷⁶ As outlined in one report⁷⁷ mental illness is one of the most severe disorders suffered by Palestinian prisoners. The most significant of these are:

- a) acute hysterical reaction, reported related to interrogation methods employed by Israeli interrogators;
- b) acute depression and severe introversion, which is related to prisoners being disconnected from their families and friends;
- c) suicide, as a potential reaction to severe psychological stress; and
- d) anxiety and insomnia.

Released prisoners report a number of different mental health related problems upon release from prison. These include specific and unspecific anxiety, avoidance of reminders, hyper-vigilance and re-experiencing of the traumatic arrest, detention and confinement. Other reported effects of prior detention/imprisonment include fear of re-arrest, problems finding work, and the fact that children tend to easily disengage from schooling. Some of the main concerns articulated by Palestinian prisoners are: access to timely and adequate medical care and medications; adequate nutrition and housing conditions; and family visits and communications.

Health services in prisons are reported to be understaffed and the available care facilities are reported as often inadequate. Medical treatment within the prison and referral to specialist diagnostics and treatment are frequently delayed, the latter at times up to several months. Important health services such as rehabilitation services and mental health assistance are reported to be insufficient within the prisons. The assessment team did not have access to Israeli prisons and Palestinian prisoners therein, and was not able to independently validate the reported conditions therein.

5.4 Effect on health of impeded access to water, food and livelihood

Water-related diseases are estimated to account for over one fourth of illnesses and are the primary cause of child morbidity in the Gaza Strip. In spite of these reports, further analysis of the health impact of the impeded access to water is seriously restricted due to the overall gaps in morbidity data (which is not available disaggregated to local community level, may be underreported, and is often not laboratory

[%202%20February%202016.pdf](#); Israel Medical Association on ethics of force-feeding hunger-strikers, <http://www.ima.org.il/ENG/ViewCategory.aspx?CategoryId=4497>; Physicians for Human Rights statement on possible force-feeding, <http://physiciansforhumanrights.org/press/press-releases/israels-plan-to-force-feed-hunger-striking-journalist-violates-medical-ethics-and-international-law.html?referrer=https://www.google.co.il/>; WHO statement of concern over Palestinian hunger strikers, <http://www.emro.who.int/palestine-press-releases/2016/who-statement-of-concern-over-palestinian-hunger-striker-february-2016.html>;

⁷⁴ Weishut, D. (2015), Sexual torture of Palestinian men by Israeli authorities, *Reproductive Health Matters*, 2015 Nov; 23(46):71-84, Doi: 10.1016/j.rhm.2015.11.019

⁷⁵ Between 2012 and 2015, Defence for Children International - Palestine documented 66 cases involving the solitary confinement of Palestinian children.

http://www.dci-palestine.org/haris_boys_sentenced_to_15_years_despite_fair_trial_violations; see also, http://www.dci-palestine.org/youth_conviction_palestinian_children_describe_solitary_confinement_in_israeli_military_prisons

⁷⁶ UNICEF, *Children in Israeli military detention* (February 2013), http://www.unicef.org/oPt/UNICEF_oPt_Children_in_Israeli_Military_Detention_Observations_and_Recommendations_-_6_March_2013.pdf; Communication of Physicians for Human Rights – Israel to World Health Organization (WHO) on health in prisons (December 2014); B'tselem and HaMoked, *Backed by the system: Abuse and Torture at the Shikma Interrogation Facility*, (December 2015),

http://www.btselem.org/sites/default/files/201512_backed_by_the_system_eng.pdf; Public Committee Against Torture in Israel and the Treatment and Rehabilitation Center for Victims of Torture (TRC), *Country Factsheet, June 2015: Torture in Israel*, http://stoptorture.org.il/wp-content/uploads/2015/11/CF_Israel_Final-2.pdf

⁷⁷ Sawsan Ramahi, *Increasing psychological and neurological illness among Palestinian prisoners*, *Middle east Monitor*, 12 February 2013.

confirmed) and the shortage in testing capacities and materials, particularly for virology and chemical contaminants including pesticides.

5.4.1 Drinking water coverage

Largely, the water offered to the Palestinian population can be classified as insufficient and unsuitable for human consumption. The WHO/UNICEF Joint Monitoring Programme estimates that drinking water coverage in urban areas in the occupied Palestinian territory overall fell from 100% in 1995 to 50% in 2015.⁷⁸ Additionally, and as a proxy indicator of the poor condition of the water network, losses in the system amount to approximately 40% overall.⁷⁹ As a consequence, per capita water consumption in the West Bank continues to fall. Some estimates are around 79 litres per capita per day; others estimate an aggregate of only 40 L per capita per day after losses, well below the WHO suggested service delivery level of 100 L per capita per day.⁸⁰ In the Gaza Strip, 96% of the domestic water supply is produced from 247 water wells drilled into the coastal aquifer. The remaining 4% is purchased from Mekorot, the Israeli national water company. Taking into account losses, the average daily per capita water use in the Gaza Strip in 2014 was 79.8 L per capita per day.⁸¹

5.4.2 Water network

The Palestinian water network is not well interconnected, only 81% of localities in the West Bank are connected due to separation walls and roads that are classified as Area C.⁸² Due to water shortages, 24.3% of all households depend on water trucking.⁸³ In the Gaza Strip, although almost all households (>98%) are connected to the water supply network, 90-95% of that water is not potable due to wastewater leakage, seawater intrusion, or other contamination.⁸⁴

5.4.3 Water quality

The water quality varies widely in the West Bank and is at crisis levels in the Gaza Strip. The Environmental Health Department of the Ministry of Health reports 15.75% of all water network samples failing bacteriological testing of any kind in 2015.⁸⁵ Approximately 20% of hospital reservoirs and 20% of locally produced bottled water failed faecal coliform tests in the last year.⁸⁶ Water quality testing in Gaza Strip found coliform bacteria in 84% of the total drinking water supply: 47% of contamination occurred at source from the producer, 17% in supply lines or delivery methods, and 20% at the household level.⁸⁷ In addition, 48% of seawater samples taken from the Gaza Strip shoreline were contaminated with parasites, including *Ascaris lumbricoides*, *Giardia lamblia*, *Strongyloides stercoralis*, *Hymenolepis nana*, *Entamoeba histolytica/dispar*, and *Cryptosporidium parvum*.⁸⁸

Chemical analyses are lacking due to resource constraints; only about a third of required tests under the jurisdiction of the Ministry of Health can be performed with any regularity. Previous studies have raised

⁷⁸ WHO/UNICEF, 2015. Joint Monitoring Programme for Water Supply and Sanitation. Palestine Country file. Palestine: estimates on the use of water sources and sanitation facilities (1980-2015). http://www.wssinfo.org/documents/?tx_displaycontroller%5Btype%5D=country_files&tx_displaycontroller%5Bsearch_word%5D=Palestine

⁷⁹ Ministry of Health, State of Palestine (2015), internal reports.

⁸⁰ EWASH (2015), Year in Review.

⁸¹ Palestinian Water Authority (2015), internal reports.

⁸² Applied Research Institute, Jerusalem. (2015), Water Resources Management.

⁸³ Applied Research Institute, Jerusalem. (2015). Water Resources Management.

⁸⁴ Department of Environmental Health, Palestinian Authority Ministry of Health, internal reports.

⁸⁵ Ministry of Health, State of Palestine (2015), internal reports; Palestinian Water Authority (2015), internal reports.

⁸⁶ Ministry of Health, State of Palestine (2015), internal reports.

⁸⁷ Coastal Municipality Water Utility (2015), internal reports; Palestinian Water Authority (2015), internal reports.

⁸⁸ Hilles, A.H., Al Hindi, A.I., & Abu Safieh, Y.A.. (2014). Assessment of parasitic pollution in the coastal seawater of Gaza city, Journal of Environmental Health Science and Engineering, 12(1): 1. <http://doi.org/10.1186/2052-336X-12-26>

an alarm over rising pesticide concentrations in the water supply.⁸⁹ Nitrate levels more than 5 times the WHO standard of 50 mL for drinking-water have been reported from some areas.⁹⁰

5.4.4 Wastewater treatment

Wastewater treatment infrastructure is also largely inadequate, creating environmental hazards for the entire West Bank. According to WHO/UNICEF, while access to improved sanitation facilities rose from 87% in 1995 to 92% in 2015,⁹¹ local data suggests that many of these facilities do not adequately treat or protect the environment from faecal contamination. Only 40.6% of households are connected to a sewage network in the West Bank, with the rest largely relying on septic tanks or open cesspits.⁹² The sewage network itself is very under-resourced; only a fraction of wastewater is collected and even less is treated.⁹³

In the Gaza Strip, 83.5% of households are connected to the sewage network which collects 41.27 MCM of wastewater per year. Wastewater treatment theoretical maximum capacity is approximately 37.6 MCM/year; in practice, electricity shortages, supply shortages, and maintenance problems often result in the majority of the wastewater being dumped directly into the sea, either before or after treatment. Untreated sewage outflow contributes to the contamination of the groundwater.⁹⁴

Lack of resources and poor infrastructure stemming from deteriorating equipment, difficulties with maintenance, and cooperation challenges between the Joint Water Committee (JWC) and the Israeli Civil Administration (ICA) make mitigation and improvement measures lengthy or impossible.⁹⁵ EWASH reports that in 2011–2013, up to 97% of all permit applications, including water infrastructure applications, for Area C were rejected by the JWC. Administrative delays in the Joint Water Committee and its associated bodies are another factor impacting water quantity, water quality, and wastewater management in the West Bank.⁹⁶

Gaza Strip restrictions through the Government of Israel's 'dual-use' list on the importation of drilling equipment, construction materials, and water pumping supplies, make maintenance and improvements to the water network lengthy, costly, and often require the intervention of international agencies, donors, and monitoring bodies. Treating the water is also an issue, as high-concentration chlorine compounds (>11%) are also banned from import and there are few operational reservoirs.

⁸⁹ Shomar, B., et al. (2006). Occurrence of pesticides in groundwater and topsoil of the Gaza Strip, *Water, Air, & Soil Pollution*, 171(1-4): 237-251.

⁹⁰ Coastal Municipality Water Utility (2015). Internal Reports; PWA (2015). internal reports, Palestinian Water Authority.

⁹¹ WHO/UNICEF, 2015. Joint Monitoring Programme for Water Supply and Sanitation. Palestine Country file. http://www.wssinfo.org/documents/?tx_displaycontroller%5Btype%5D=country_files&tx_displaycontroller%5Bsearch_word%5D=Palestine

⁹² http://pcbs.gov.ps/portals/pcbs/PressRelease/Press_En_IntPopDy2015E.pdf

⁹³ Hilles, A.H., Al Hindi, A.I., & Abu Safieh, Y.A.. (2014). Assessment of parasitic pollution in the coastal seawater of Gaza city, *Journal of Environmental Health Science and Engineering*, 12, 26. <http://doi.org/10.1186/2052-336X-12-26>; Palestinian Water Authority, Palestinian Water Sector: Status summary report, September 2012; <http://reliefweb.int/report/occupied-palestinian-territory/palestinian-water-sector-status-summary-report-september-2012>

⁹⁴ Coastal Municipality Water Utility (2015). Internal reports; Palestinian Water Authority (2015), Internal reports; Interviews with Gaza Municipality, February 2016.

⁹⁵ Selby, J. (2013). Cooperation, domination and colonisation: The Israeli-Palestinian Joint Water Committee. *Water alternatives*, 6(1), 1.

⁹⁶ EWASH (2015). 2015 Year in review.

Hizma village

An illustrative example of the problems around the water supply is the case of a proposal for two wells in Hizma to improve and increase the water supply. The original application was submitted to the Joint Water Committee in 2000. One well was approved in 2002 and sent to the ICA for final approval – as the proposed site was in Area C – a process involving 13 departments. At least 4 proposed sites for the well were rejected by the ICA over the next 5 years until final approval was received to drill the well in an active quarry with poor hydro-geological conditions. Consequently, the well was never built. As of 2011, water pumping in Hizma was approximately 71 L per capita per day, with system losses of 26.5%, resulting in water availability in the village of only 52 L per capita day. (Applied Research Institute-Jerusalem (2015), Water Resources Management; EWASH (2015). Year in Review; Palestinian Water Authority (2015), internal reports).

5.5 Contribution of the humanitarian and development community

5.5.1 Funding

Funding is increasingly linked to effective reconciliation and policy dialogue, whilst at the same time the global economic recession and other competing crises in the region have reduced the level of funding. According to UNDP (2015), the overall external budget support to the Palestinian Authority fell significantly between 2009 and 2014. The policy dialogue of the international community focuses on strengthening the role and capacities of the Palestinian Authority in managing, coordinating and integrating international aid investments and increasing governance efforts. Overall commitments (not only health sector related) of non-Arab countries have decreased from US\$ 1.74 billion in 2014 to 1.1 billion in 2015; the budget support has declined by about 50% since 2008.⁹⁷

Direct financial assistance to the Palestinian Authority from the EU, selected EU member states, World Bank, Saudi Arabia, Iraq, Algeria and others continues to contribute substantially to the payment of pensions, salaries, social allowances, and to cover debt payments to east Jerusalem Hospitals for referral patients.

5.5.2 Capacity development

In addition to the direct financial assistance various donors support institutional capacity development of the health system, such as the:

- health information systems (USAID);
- Palestinian National Institute of Public Health PNIPH (Norway);
- integration of mental health services (EU);
- support for east Jerusalem hospitals and the network (EU, and several EU and Arab donor countries);
- health insurance and referral master plan (World Bank).

Some targeted health initiatives focus on:

- efforts to facilitate health worker re-integration in the Gaza Strip including a solution to ensure sustainable salary payments by the Swiss Government, EU and others;
- a World Bank grant to sustain catering and cleaning services in Gaza Strip hospitals (ended in 2015);
- negotiations with Israel to strengthen transparency to enable the Palestinian health authorities to rationalize the payment regime for referral health services in Israeli hospitals;

⁹⁷ The Government of Palestine's Report to the Ad Hoc Liaison Committee, Deepening reforms, strengthening institutions, 30 September, 2015 New York, USA.

- World Bank plans for continued support to the Palestinian Authority till 2019 to secure continuity in service delivery and to build health system resilience.

5.5.3 Aid coordination

Humanitarian and development aid is delivered through UN agencies, international and national Nongovernmental organizations, ICRC, IFRC and various donor countries. While the UN's annual appeal (Humanitarian Programme Cycle and the Humanitarian Response Plan) has remained a mechanism for responding to immediate humanitarian needs, and the UNDAF has been implemented since 2012 to coordinate development priorities, an integrated sector-wide planning for development and humanitarian aid is yet to be further developed.

In 2015, overall, funding for humanitarian assistance has been good, with a more even distribution of funding across clusters than in recent years⁹⁸. Despite funding gaps, humanitarian assistance clusters were able to reach many of those targeted however, in most cases this has been with fewer types of interventions than planned. A total of US\$416 million (covering 59% of total needs) was contributed in 2015 by the international donor community for the Humanitarian Response Plan⁹⁹. In the health and nutrition sector, it should be underlined that the funding situation was more challenging, with international donor contributions of \$10.3 million covering only 49% of assessed needs. This funding gap reduced the numbers of people in need reached by the health and nutrition cluster from a target of 1.6 million to 0.89 million¹⁰⁰.

The main coordination mechanisms in health are the Health Sector Working Group, the core group and the thematic sub-groups, and the Health and Nutrition Cluster (HNC).

The Health Sector Working Group is the strategic health coordination mechanism. It is chaired by the Minister of Health and co-chaired by USAID, with WHO as the technical adviser. The Health Sector Working Group convenes the main health development partners usually twice a year in Ramallah as a forum for information exchange and stakeholder coordination.

The core group provides the secretariat function for the health sector working group, such as setting the agenda and organizing the meetings. Most of the eight thematic groups (pharmaceutical, referral, noncommunicable diseases, mental health, reproductive health, etc.) are led by the Ministry of Health and co-chaired by health partners engaged in the subject matter and meet regularly to coordinate the respective technical activities. The HNC meets monthly and ad hoc if required in Ramallah, with the Gaza Strip group connected through video-conference. It is chaired by WHO and co-chaired by the Ministry of Health and coordinates humanitarian health interventions.

6. Conclusion and recommendations

The health of Palestinians continues to be negatively affected by the occupation and related policies and practices; Palestinians in the occupied territory continue to experience or remain at risk of conflict, violence, displacement, denial of access to livelihoods, administrative detention, psycho-social distress or exposure to explosive remnants of war.

The period between the two field assessments mandated by the Sixty-seventh and Sixty-eighth World Health Assembly has seen a further aggravation of distrust. The recent tightening of security measures and in particular the forceful incursions by security forces into hospitals represent a new setback in respecting the right to health. While there is some progress, the access restrictions to health care services and the quality of services remain of continued concern.

⁹⁸

https://www.humanitarianresponse.info/en/system/files/documents/files/monitoring_dashboard_march_2016.pdf

⁹⁹ *idem*

¹⁰⁰ *idem*

The recommendations in the WHO report *Right to health: crossing barriers to access health in the occupied Palestinian territory* remain valid.¹⁰¹ In addition, the following concrete steps towards compliance with the recommendations from the WHO 2013 *Special report on right to health* are recommended:

To the Ministry of Health of Israel:

- To strengthen and increase the resources of its Health Coordination Unit:
 - to continue its current humanitarian health support in the West Bank;
 - to establish a health-liaison with the security authorities at Erez crossing to facilitate timely approval and transit of patients, medicines and health supplies based on humanitarian principles.
- To support the right to health by requesting Israel security authorities to:
 - revisit the “back to back” procedure for the ambulance transfer of patients across checkpoints into Israel;
 - ease the system of health referral permits, including the new age-restriction placed on relatives accompanying patients referred from the Gaza Strip;
 - strengthen prison health care provision and address gaps.

To the Palestinian Authority:

- To pursue efforts to secure external funding for the modernization and improvement of health services;
- To further improve the coordination between the Ministry of Health in Ramallah and authorities in Gaza Strip in facilitating sustainable solutions on regular payment of health workers and timely release of disaggregated data on the approval of referrals by the Ministry of Health and the flow and stocks of supplies;
- To strengthen the health coordination mechanisms at all levels with national and international partners.

To the WHO Office for the West Bank and Gaza Strip:

- To continue supporting the Palestinian Authority and the Palestinian Ministry of Health to build and consolidate health system capacities and to enhance advocacy for health system recovery in Gaza Strip;
- To coordinate on a regular basis with the Health Coordination Unit of the Israeli Ministry of Health;
- To support strengthening of health coordination;
- To further support the integration mental health into primary health care;
- To strengthen the psychosocial approach being developed in health facilities.

To the international community:

- To continue supporting the Palestinian Authority and the Palestinian Ministry of Health in strengthening health system development and reform;
- To continue supporting the efforts of WHO and other actors in advocating the right of Palestinians to quality health care;

¹⁰¹ WHO (2013), Special report on right to health: barriers to health access in the occupied Palestinian territory, 2011 and 2012.

[http://www.emro.who.int/images/stories/palestine/documents/WHO - RTH crossing barriers to access health.pdf?ua=1&ua=1](http://www.emro.who.int/images/stories/palestine/documents/WHO_-_RTH_crossing_barriers_to_access_health.pdf?ua=1&ua=1)

- To place priority on the funding of the long term improvement of health services;
- To support the independent monitoring of prison health care services.

7. Annexes

7.1 Maps of West Bank and Gaza

New Movement Restrictions in east Jerusalem, OCHA, 5 November 2016.

http://www.ochaopt.org/documents/ej_2015oct21.pdf

Occupied Palestinian territory, the West Bank including east Jerusalem, and the Gaza Strip, OCHA, December 2014, p. 2.

http://www.ochaopt.org/documents/atlas_2015_web.pdf

7.2 Assessment team

Ambrogio Manenti
 Claude de Ville de Goyet
 Corinna Reinicke
 John Macdonald
 Julian Donald

7.3 List of persons interviewed

Name	Title, institution and place
Abdelatif Al-Haj	Directorate General of Hospitals' Administration, Ministry of Health, Gaza
Abdelnasser Soboh	Health Coordination and Information, WHO, Gaza
Abdelnaser Farwana	Commission of Detainees and ex-Detainees Affairs, Gaza
Abdelrahman Murad	Bio-medical Eng. - Maintenance Department, Ministry of Health, Gaza
Abdurrahman Abu-Alqumbuz	Health Officer, Gaza Municipality
Adnan Aesh	Al-Azhar University
Aed Yaghi	Palestine Medical Relief Society, Gaza
Ahmad Bitawi	Palestine Medical Complex, MoH, Ramallah
Ahmed Al-Yaqubi	Palestinian Water Authority, Gaza
Akram Al Kahlout	Bio-medical Eng. - Field Officer, ICRC
Akram Atallah Alayasa	International Relations Coordinator, Commission of Detainees and ex-Detainees Affairs, Ramallah
Amany Dayif	Prisoners and Detainees Department, Physicians for Human Rights Israel, Tel Aviv
Amjad Al Shawa	Director, Palestinian NGOs Network (PNGO), Gaza
Ammar Dweik	General Director, The Independent Commission for Human Rights, Ramallah
Andrea Barsony	International Advocacy Coordinator, Physician for Human Rights - Israel, Tel Aviv
Amira al-Hindi	Director, Medical Referral Directorate, Ministry of Health, Ramallah
Anita Vitullo	Project Manager, Right to Health, WHO occupied Palestinian territory, Jerusalem
Asad Ramlawi	Deputy Minister of Health, Ministry of Health, Ramallah
Ayman Qandel	Deputy Minister, Palestinian General Authority for Civilian Affairs, Ramallah
Azzam Ali Nimer	Emergency Service Department, Palestinian Red Crescent Society, Jerusalem
Bashar Jamal	Advocacy Officer, Defence for Children International - Palestine, Ramallah
Bashar Murad	Head of emergency and disaster management unit, PRCS, Gaza
Bassam Al-Badri	Referral Abroad Department, Ministry of Health, Gaza
Basem Al Rimawi	Director General, Emergency and Disaster Unit, MoH, Ramallah
Carol Awad	WASH Coordinator, UNICEF
Dalia Basa	Health Coordinator, Coordination and Liaison Office, State of Israel
David Hutton	Head of Community Mental Health Program UNRWA, Gaza
Enrico Materia	Health Coordinator, Italian Cooperation
Einav Shimron Grinboim	Deputy Director General, Information and International Relations, Ministry of

	Health, State of Israel
Erab Fuqaha	Director of Media and Dissemination, PRCS, Ramallah
Efrat Shir	International Advocacy and Resource Development Officer, Public Committee Against Torture in Israel, Jerusalem
Ehteram Ghazawneh	Documentation and Research Unit Coordinator, Addameer Prisoner Support and Human Rights Association, Ramallah
Fadel Al Mzainy	Researcher, PCHR, Gaza
Fouad Al Assawi	Directorate General, Primary Health Care, Ministry of Health, Gaza
Gerald Rockenschaub	Head of Office, WHO occupied Palestinian territory, Jerusalem
Ghada Al Jadba	Chief, health programme, UNRWA, Gaza
Hazem Ashour	Chairman, Mental Health Unit Ministry of Health, Ramallah
Hadil Dalloul	Research Officer, PNIPH, Ramallah
Hani Abdeen	Dean, Al Quds University Medical School, Jerusalem
Hassan Zeyada	Psychologist, GCMHP Gaza Community Mental Health Programme, Gaza
Helmi Al Araj	Executive Director, Centre for Defence of Liberties and Civil Rights (al-Hurryyat), Ramallah
Ibrahim Atieh	Engineer, Environmental Unit, Ministry of Health, Bethlehem
Issa Qaraqe	Head of Commission, Palestinian Commission of Detainees and ex-Detainees Affairs, Ramallah
Jaber Wishah	Deputy Director, Palestinian Centre for Human Rights, Gaza
Jad Ishaq	General Director, Applied Research Institute, Jerusalem
Javier Tena Rubio	Detention Doctor, International Committee of the Red Cross, Tel Aviv
Jane Sami Hilal	Head of Water & Environment Research, Applied Research Institute Jerusalem
Khader Rasras	Executive Director/ Senior Clinical Psychologist. Torture Rehabilitation Centre, Ramallah
Khaled Joudeh	Director General, Palestine Red Crescent Society, Ramallah
Khalid Tibi	Food and Water Safety Unit, Ministry of Health, Gaza
Khaldoun Ewees	UNODC, Jerusalem
Khadra Amassi	Psychiatric Hospital, Ministry of Health, Gaza
Khalil Abu Foul	Director, Palestine Red Crescent Society, Gaza
Khalil Shaheen	Director, Economic & Social Rights Unit, PCHR, Gaza
Khawla Abu-Diab	UNRWA Field Nursing Officer Jerusalem
Kirrily Clarke	Health Coordinator, International Committee of the Red Cross, Jerusalem
Luma Tarazi	Palestinian Counselling Centre, Ramallah
Majdi Dhair	Department of Epidemiology, Ministry of Health, Gaza
Majida Alawneh	Central Coordination, Palestinian Water Authority, Ramallah
Maria Alaqra	Director of International Cooperation Department, Ministry of Health, Ramallah
Michael Voegele	Head of Operations Section, Office of the European Union Representative
Mahmoud Deeb Daher	Head of Sub-office, WHO, Gaza
Mahmoud Shatat	Water Engineer, Oxfam GB, Gaza
Mark Choonoo	UNICEF, CFO, Gaza
Meriem el Harouchi	Project Manager, Office of the European Union Representative, Jerusalem
Mithkal Hassouna	Newborn Health project, WHO, Gaza
Mohamed Lafi	Advocacy/Right to Health officer, WHO, Gaza
Mohammed Beseiso	Advocate, Palestinian Centre for Human Rights, Gaza
Mohammed Yaghi	National officer - NCDs, WHO, Gaza
Mona Zagroul	YMCA, Beit Sahour, West Bank
Monther Shoblaq	General Director, Coastal Municipal Water Utility, Gaza
Mousa Abed	Sabha PHC Centre, Ministry of Health, Gaza
Motasem Hamdan	Dean of Public Health School, Al Quds University, Jerusalem
Mazen Hamada	Al-Azhar University, Gaza
Nader Amsheh	YMCA, Beit Sahour, West Bank
Nasser Damaj	Director, Mandela Institute, Ramallah
Nemeh Hamad	Staff nurse, UNRWA, Shufat camp, Jerusalem
Niveen AbuRmeileh	Director, Institute of Community and Public Health, Birzeit University
Noor Khan	First Secretary, Representative Office of Norway to the Palestinian Authority
Omran Hussain	Director of West Bank Districts Coordination offices, General Authority for Civilian Affairs
Osama Abueita	National Programme Officer, UNFPA, Gaza

Rafiq Husseini	Director, Makassed Hospital, Jerusalem
Rand Salman	Project Manager, Palestine National Institute of Public Health (WHO), Ramallah
Rima Abu Muddein	Team Leader, Environmental Programme, UNDP, Jerusalem
Rita Giacaman	Head of Research, Institute of Community and Public Health, Birzeit University, West Bank
Raji Sourani	Advocate, Director, Palestinian Centre for Human Rights
Rami Saleh	Advocate, Director, Legal Aid and Human Rights Centre, Jerusalem
Ray Dolphin	Barrier Specialist, OCHA, Jerusalem
Rebecca Barrell	Health Program Manager, International Committee of the Red Cross, Gaza
Reem Abu Shomar	Palestinian Water Authority, Gaza
Shaha Odeh	General Director, Health Work Committees, Ramallah
Safaa Nasser	Gaza Community Health Centre, Gaza
Sahar Abassi	Madaa Creative Center, Silwan, Jerusalem
Salwa Massad	Research Manager, Palestine National Institute of Public Health (WHO), Ramallah
Sami Owaida	National Officer -Mental Health, WHO, Gaza
Samir Hassaniya	Palestinian Centre for Human Rights, Gaza
Samir Saliba	Department Director, Palestine Medical Complex
Segolene Adam	Deputy Director of Cooperation, Swiss Cooperation Office, Jerusalem
Seita Akihiro	Health Director, UNRWA (WHO), Amman
Suha Shehade	Psychiatrist, Bethlehem Arab Society for Rehabilitation, Beit Jala, West Bank
Tanya Abu Ghoush	Director of International Cooperation, Palestine Red Crescent Society, Ramallah
Tareq Mkhaimer	Human Rights Officer. Officer for the High Commissioner for Human Rights, Gaza
Wael Qadan	Director of Health Services, Palestine Red Crescent Society, West Bank
Waleed Khatib	Deputy Director, Nursing, St. John's Hospital, Jerusalem
Umaiye Khammash	Chief Field Health Programme, UNRWA, West Bank
Virginie Mathieu-Tahboub	Medecins du Monde Suisse, Jerusalem
Walid Nammour	Chief Executive Officer, Augusta Victoria Hospital, Jerusalem
Yahea Khader	Psychiatric Hospital, Gaza
Yaser Bouzieh	Acting Director of Public Health, Ministry of Health
Yousef Abu Alrresh	Senior health official, Ministry of Health, Gaza
Yasser Abu Jamee	Director, General Gaza Community Health Centre, Gaza
Yasser Nassar	WASH Coordinator, UNICEF, Gaza
Yousef Awadallah	Union of Health Work Committees, Gaza
Yousef Muhaisen	Health Cluster, WHO, occupied Palestinian territory, Jerusalem