

Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan

Report by the Director-General

1. In 2019, the Seventy-second World Health Assembly adopted decision WHA72(8), which requested the Director-General *inter alia* to report on progress in the implementation of the recommendations contained in the report by the Director-General,¹ based on field monitoring, to the Seventy-third World Health Assembly. This report responds to that request.

SUPPORT AND TECHNICAL ASSISTANCE TO THE POPULATION IN THE OCCUPIED PALESTINIAN TERRITORY, INCLUDING EAST JERUSALEM, AND TO THE OCCUPIED SYRIAN GOLAN

2. In 2019, WHO continued work to provide support and technical assistance to the Palestinian people in the occupied Palestinian territory, including east Jerusalem, in line with the four strategic priorities identified jointly with the Palestinian Ministry of Health and partners in the Country Cooperation Strategy for WHO and the occupied Palestinian territory 2017–2020. These priorities align with WHO's Thirteenth General Programme of Work, 2019–2023.

3. The first priority under the cooperation strategy is to contribute to strengthening and building resilience of the Palestinian health system and enhancing Ministry of Health leadership to progress towards universal health coverage. The Secretariat mobilized experts from WHO to support review of existing policies for progressing towards universal health coverage, including health financing, service delivery planning, primary health care, health-care quality and patient safety. Recommendations of these reviews will constitute the basis for developing a universal health coverage implementation road map, which will integrate work towards primary health-care reform, financing and governance. With funding from the Government of Italy, WHO continued to promote the strengthening, use and management of hospital-based health information for decision-making. WHO experts supported the validation and analysis of local health accounts, measurement of financial risk protection and projections of health expenditures, as well as the implementation of an e-Health strategy and support to the east Jerusalem hospitals network through the hiring of a coordinator to follow up on technical priorities of the network. With funds from the Government of Japan, WHO worked on the implementation of a system-strengthening approach to reduce neonatal mortality and improve quality of care, called the Early Essential Newborn Care package. Ten maternity hospitals in the Gaza Strip received support for capacity-building and periodic quality improvement. Ongoing efforts to strengthen primary health care

¹ Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan, document A72/33.

services have focused on the family practice approach and aligning all relevant stakeholders, including donors, in common initiatives to facilitate greater impact.

4. Within the cooperation strategy's first priority, the Palestinian National Institute of Public Health, a WHO-led project funded by the Government of Norway, is progressing on its transition to become an independent governmental institution in line with its legal framework, endorsed by the Palestinian President in 2016. The Institute works *inter alia* to develop evidence through public health research, to strengthen surveillance systems, and provide capacity-building and advocacy to promote improved health outcomes. The Institute has established and strengthened registries for maternal and child health, mammography, gender-based violence, cancer, noncommunicable diseases, primary health care statistical reports, cause of death, and road traffic accidents and injuries. It has also put in place an observatory for human resources for health, as well as health information systems in primary care through the roll-out of the District Health Information System 2 software. With support from the Government of Norway and the World Bank, the Institute is working to advance universal health coverage through supporting the family practice approach, monitoring and strategic planning of human resources for health. In July 2019, the Institute officially launched the Human Resources for Health Observatory and produced a report to map the Palestinian health workforce.

5. The second priority under the cooperation strategy is to strengthen core capacities for the International Health Regulations (2005) (IHR) in the occupied Palestinian territory, including east Jerusalem, and the capacities of the Ministry of Health, its partners and communities in health emergency and disaster risk management, and to support humanitarian health response capacities. With funds from the Government of Norway, WHO continued work to strengthen core capacities for the IHR, to enhance detection, assessment and response to public health events. In 2019, within the framework of the Palestinian three-year IHR plan for 2017–2019, the Secretariat supported implementation of local guidelines on communicable disease outbreaks; operationalizing of an event-based surveillance system; training for staff in infection prevention and control, laboratory capacities, epidemic management and emergency response; development of a draft risk communication strategy; and revision of emergency preparedness plans. WHO also delivered essential supplies to the Ministry of Health to prevent, detect and manage outbreaks of communicable diseases, including providing support to the public health response to a measles outbreak, and to support preparedness efforts for coronavirus disease (COVID-19).

6. WHO's Health Emergencies Programme received contributions from the Governments of Austria, Japan, Spain, Switzerland, Turkey and the United Kingdom of Great Britain and Northern Ireland, and from the European Union, the United Nations Central Emergency Response Fund and the country-based Humanitarian Pooled Fund. The programme supported the Ministry of Health through procurement and delivery of essential medical supplies and drugs to address critical shortages in the health sector in the occupied Palestinian territory. In the West Bank, WHO and its partners worked closely with the Ministry of Health to ensure the delivery of life-saving primary health care interventions to around 100 000 Palestinians in the most vulnerable communities. In the Gaza Strip, WHO supported the Ministry of Health and partners in provision of life-saving medical supplies for patients with noncommunicable diseases, enhancing supply chain management and strengthening the care of trauma patients from pre-hospital to hospital to post-operative care and rehabilitation. The latter work included support to enhance Ministry of Health trauma stabilization points, surge support to first response by the Palestine Red Crescent Society and establishment of a limb reconstruction unit in the Gaza Strip.

7. As the United Nations Cluster Lead Agency for Health, WHO co-chairs humanitarian coordination meetings with the Ministry of Health, and coordinates humanitarian health interventions with partners in the occupied Palestinian territory, including east Jerusalem. In 2019, the Health Cluster coordinated the development of the Humanitarian Needs Overview and the Humanitarian Response Plan

for health and provided support to resource mobilization efforts of partners. On a monthly basis, the Health Cluster and WHO issued situation reports outlining priority humanitarian needs, cluster capacity, gaps and challenges, including a funding update. In 2019, the Health Cluster reviewed the Gaza Strip preparedness and contingency plan, with the participation of over 40 operational partners, and coordinated the collective partner response in specific areas through the establishment and strengthening of working groups for trauma, nutrition, mobile clinics and emergency preparedness.

8. The third priority under the cooperation strategy is to strengthen capacity to prevent, manage and control noncommunicable diseases, including mental health disorders, and to reduce risk factors for violence and injuries. Throughout 2019, WHO continued to implement evidence-based interventions for the effective prevention, detection and management of noncommunicable diseases. Technical support was provided to improve early detection of noncommunicable diseases by strengthening the registration of patients, including establishing electronic noncommunicable disease patient files in five primary health care clinics in the Gaza Strip, and introduction of a screening programme, implemented in all districts of the West Bank and two in the Gaza Strip. The Secretariat assisted in the development of a local noncommunicable disease registry and further implementation of the Package of Essential Noncommunicable Disease Interventions (PEN approach). WHO additionally supported the Ministry of Health in prevention and awareness campaigns for major risk factors for noncommunicable diseases, including tobacco control, healthy diet, salt reduction and physical exercise, and provided support to the public health laboratory to detect and regulate trans-fats in processed foods. WHO's Mental Health Gap Action Programme, with funds from the European Union, supported the Ministry of Health and United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) primary health care facilities to further implement the Programme. Almost 2000 staff were trained from across the full range of mental health and psychosocial support services, from school mental health counselling to primary care detection of common mental health problems and rehabilitation skills for mental health staff. The Programme has supported development of mental health emergency response plans, training of mental health emergency teams, procurement of essential psychotropic drugs and emergency drugs, infrastructure renovation for mental health institutions and establishment of mental health liaison units in general hospitals. WHO is supporting the Ministry of Health to define mental health priorities and gaps for the Mental Health Strategy 2020–2024, and the revision of mental health guidelines and development of a local suicide prevention strategy.

9. The fourth strategic priority is to strengthen the capacity of the Ministry of Health and health partners to advocate with all legal duty-bearers to protect the right to health, to reduce access barriers to health services, and to improve the social determinants of health. In 2019, the Government of Switzerland and the European Union supported WHO's Right to Health Advocacy programme. WHO worked to build evidence and understanding of major obstacles to the right to health for Palestinians living under Israeli occupation in the occupied Palestinian territory, including east Jerusalem, including through strengthening regular reporting on barriers to health access and attacks on health care personnel and facilities. WHO finalized a study into the impact of Gaza Strip patient permit denial and delay on cancer mortality and completed an initial review of the extent and nature of health attacks and protection gaps during the "Great March of Return" to inform collective efforts to strengthen the protection of health care and the right to health. The Secretariat worked to build the capacity of the Ministry of Health and partners for the right to health and human rights-based approaches to health; strengthening monitoring of attacks on health care and protection; and identification of indicators to enhance monitoring of barriers to the right to health for treaties reporting and advocacy. WHO continued to advocate with all duty-bearers to strengthen respect for, and protection and fulfilment of, the right to the highest attainable standard of physical and mental health for all Palestinians in the occupied Palestinian territory, including east Jerusalem.

10. As part of the global COVID-19 response operations, WHO offered health-related technical support for strengthening the COVID-19 response capacity in the occupied Syrian Golan. As at early May 2020, WHO was informed that there were no active COVID-19 cases and three recovered COVID-19 cases (one in the village of Majdal Shams and two in the village of Bugata); information regarding COVID-19 was accessible to all residents of the occupied Syrian Golan in Arabic; and all residents had access to health care under the Israeli health maintenance organization scheme.

REPORT ON THE HEALTH CONDITIONS IN THE OCCUPIED PALESTINIAN TERRITORY, INCLUDING EAST JERUSALEM, AND IN THE OCCUPIED SYRIAN GOLAN

Demographics, health outcomes and health inequities

11. The estimated Palestinian population living in the occupied Palestinian territory by mid-2020 is 5.1 million, with 3.05 million in the West Bank, including east Jerusalem, and 2.05 million in the Gaza Strip.¹ Over 335 000 Palestinian residents live in east Jerusalem.^{2,3} More than 2.2 million registered refugees reside in the occupied Palestinian territory, and more than 3.2 million reside outside.⁴ There are 1.4 million refugees living in the Gaza Strip, comprising almost 70% of Gaza Strip's population. One quarter of the refugees in the West Bank live in the 19 camps located there and over half a million refugees live in the eight camps in the Gaza Strip.⁴ The overall Palestinian population is predominantly young: nearly 40% of Palestinians are aged 0–14 years, while 5% are aged 65 years or older.⁵

12. Life expectancy at birth for Palestinians in the occupied Palestinian territory was 73.9 years in 2018.⁶ In the same year, infant mortality for Palestinians in the occupied Palestinian territory was reported to be 17.3 per 1000 live births and under-5 mortality was 20.3 per 1000.⁷ Health inequities, representing systematic differences resulting from the political, economic and social conditions in which people are born, grow, live, work and age, exist for Palestinians in the occupied Palestinian territory.⁸ There are differences in health outcomes between Palestinian populations, including between the West

¹ Estimated Population in Palestine Mid-Year by Governorate, 1997–2021. Palestinian Central Bureau of Statistics (PCBS); 2017 (http://www.pcbs.gov.ps/Portals/_Rainbow/Documents/2017-2097%20%20المحافظات%20انجليزي.html, accessed 27 April 2020).

² Korach, M. & Choshen, M., 2019. Jerusalem: Facts and Trends 2019. Jerusalem Institute for Policy Research: (https://jerusalemintstitute.org.il/wp-content/uploads/2019/05/PUB_505_facts-and-trends_eng_2019_web.pdf, accessed 27 April 2020).

³ “References to Gaza Strip, West Bank and West Bank, including east Jerusalem are used in this report where technical accuracy so requires, it being understood that the terminology of “occupied Palestinian territory, including east Jerusalem”, which is the standard formulation for WHA documentation, remains as such”.

⁴ Where we work. United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNRWA) (<https://www.unrwa.org/where-we-work>, accessed 27 April 2020).

⁵ Indicators. PCBS; 2020 (http://www.pcbs.gov.ps/site/lang__en/881/default.aspx#, accessed 27 April 2020).

⁶ Health Annual Report: Palestine 2018. Palestinian Health Information Centre (PHIC); 2019. Life expectancy statistics for the occupied Palestinian territory exclude the majority of Palestinians resident in east Jerusalem, due to lack of access to vital statistics collected by Israeli authorities for the annexed territory.

⁷ United Nations Inter-agency Group for Child Mortality Estimation, 2019 (<https://childmortality.org/data/State%20of%20Palestine>, accessed 27 April 2020).

⁸ 10 facts on health inequities and their causes. Geneva: World Health Organization; 2020 (https://www.who.int/features/factfiles/health_inequities/en/, accessed 27 April 2020).

Bank and Gaza Strip, as well as between those living in towns, villages, refugee camps or Bedouin camps, as well as between populations in differently categorized areas, such as Area C, east Jerusalem and the access restricted area in the Gaza Strip. There are different patterns of ill-health or disease according to age and gender. However, gaps in the disaggregation of data for different Palestinian populations, particularly by geographical location, limit analysis of health inequities. Israeli settler population in the West Bank, estimated to comprise more than 600 000 persons, compared to Palestinians living in the same territory, have a life expectancy almost nine years higher, infant mortality more than six times lower and maternal mortality nine times lower.^{1,2,3,4}

13. Noncommunicable diseases remain the leading cause of mortality in the occupied Palestinian territory, accounting for more than two thirds of all Palestinian deaths in 2018.⁵ According to statistics from the Palestinian Ministry of Health, perinatal deaths and congenital malformations accounted for more than 10% of deaths; infectious diseases for 8.1%; and transport accidents, assault and falls together accounted for 2.8%.⁵

14. Palestinians living under chronic occupation are exposed to high levels of violence. In 2019, 134 Palestinians were killed and 15 492 injured in the context of occupation and conflict,⁶ 80% of those killed and 76% of those injured were in the Gaza Strip, as violence towards demonstrators continued in the context of Gaza Strip's "Great March of Return", with a number of escalations in the Gaza Strip over the course of 2019. A fifth (20%) of Palestinians killed in the occupied Palestinian territory in 2019, and almost two fifths (39%) of those injured, were children under the age of 18 years, while 7% of those killed and 7% of those injured were women or girls. Ten Israelis were killed and 121 injured in the same year.⁶ Men and boys accounted for 93% of occupation-related injuries and deaths in 2019.⁶ Meanwhile, 29% of women surveyed by the Palestinian Central Bureau of Statistics had experienced some form of intimate partner violence in 2019.⁷

15. Mental health and psychosocial problems represent one of the most significant public health challenges. A study published in 2017 indicates that the occupied Palestinian territory has the largest burden of mental disorders in the Eastern Mediterranean Region.⁸ In 2019, WHO estimated that one in five people (22.1%) in conflict and post-conflict settings has depression, anxiety disorder, post-traumatic

¹ United Nations Inter-agency Group for Child Mortality Estimation, 2019 (<https://childmortality.org/data/State%20of%20Palestine>, accessed 27 April 2020).

² Humanitarian Facts and Figures. Occupied Palestinian Territory. Jerusalem: United Nations Office for the Coordination of Humanitarian Affairs (OCHA); 2018.

³ Comparison for 2016, the latest year for which comparable data was available. Israeli Central Bureau of Statistics; 2019 (http://www.cbs.gov.il/reader/cw_usr_view_SHTML?ID=591, accessed 27 April 2020).

⁴ Trends in maternal mortality 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: World Health Organization; 2019.

⁵ Health Annual Report: Palestine 2018. Palestinian Health Information Centre (PHIC); 2019. Life expectancy statistics for the occupied Palestinian territory exclude the majority of Palestinians resident in east Jerusalem, due to lack of access to vital statistics collected by Israeli authorities for the annexed territory.

⁶ Occupied Palestinian Territory: Data on casualties. Jerusalem: OCHA; 2019 (<https://www.ochaopt.org/data/casualties>, accessed 27 April 2020).

⁷ Preliminary Results of the Violence Survey in the Palestinian Society 2019. PBCS; 2019 (<http://www.pcbs.gov.ps/Downloads/book2480.pdf>, accessed 27 April 2020).

⁸ Charara R, Forouzanfar M, Naghavi M, Moradi-Lakeh M, Afshin A, et al. The burden of mental disorders in the Eastern Mediterranean Region, 1990–2013. PLOS One, 2017 (<http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0169575>, accessed 27 April 2020).

stress disorder, bipolar disorder, or schizophrenia.¹ In the occupied Palestinian territory, this means that more than 250 000 individuals require essential mental health and psychosocial interventions.² A study by Médecins du Monde Switzerland in 2019 found that young Palestinians aged 16 to 25 years were at highest risk of self-harm, accounting for 52% of all cases of attempted suicide.³

Fragmentation and fragile health-care provision

16. Palestinians in the occupied Palestinian territory, including east Jerusalem have been under chronic occupation for more than 52 years. Policies of legal and administrative fragmentation and division of the Palestinian territory and population compound the physical separation of the West Bank and Gaza Strip, with further subdivision of the West Bank into east Jerusalem, Areas A, B, C, H1 and H2. In the wake of over 12 years of blockade, since 2007, severe restrictions on the movement of people and goods in and out of the Gaza Strip have additionally isolated it from the rest of the territory. Palestinians carry different types of Israeli-issued identity cards, according to their place of residence and status, that mean they are governed by separate legal systems, permitted different levels of free movement, and granted differential access to health services. Palestinian residents of east Jerusalem, separated from the rest of the occupied Palestinian territory by the separation barrier and restrictions on family unification, are subject to the Israeli civil court system and able to move into and throughout Israel without requiring permits or needing to cross checkpoints. Palestinians from the rest of the Palestinian territory occupied since 1967 are subject to the Israeli military court system, while their access, including to east Jerusalem and Israeli settlements in the West Bank, is governed by the Israeli permit regime. Physical barriers, including the separation wall, the extensive network of checkpoints and the expanding settlement infrastructure, additionally hamper the free movement of Palestinians within the West Bank, including into east Jerusalem.

17. With regards to health coverage, Palestinians with residency status in east Jerusalem have access to Israeli health insurance. However, the residency status of Palestinians in east Jerusalem is dependent on them repeatedly demonstrating their continued “centre of life” (place of residence or work) in the city. From 1967 to May 2017, Israel revoked the residency status of 14 595 Palestinians – a number that increases to approximately 86 000 when including dependent children who have also lost their residency rights.^{4,5} In the remainder of the occupied Palestinian territory, the Palestinian Authority and the de facto authority in the Gaza Strip assume responsibilities for administration of public health-care provision to the Palestinian population.

¹ Charlson F, Ommeren M, Flazman A, Cornett J, Witford H, Saxena S, et al. New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. *Lancet*, 2019; 394: 240–48. (<https://www.thelancet.com/action/showPdf?pii=S0140-6736%2819%2930934-1>, accessed 27 April 2020).

² Humanitarian Response Plan OPT 2020. Jerusalem: OCHA; 2020, p41 (https://www.ochaopt.org/sites/default/files/hrp_2020.pdf, accessed 27 April 2020)

³ Khatib S, for Médecins du Monde Switzerland. Mixed study on attempted suicide patients risk factors and suicide prevention strategies in Palestine, 2019. (https://medecinsdumonde.ch/wp-content/uploads/2020/03/2019_MdM-Suisse_Attempted-Suicide-Patients-Risk-Factors-Suicide-Prevention-Strategies-in-Palestine_Study_EN-002.pdf, accessed 27 April 2020).

⁴ East Jerusalem Facts and Figures 2017. Tel Aviv: The Association for Civil Rights in Israel; 2017. (<https://law.acri.org.il/en/2017/05/24/east-jerusalem-facts-and-figures-2017/>, accessed 27 April 2020).

⁵ Residency revocation: Israel’s forcible transfer of Palestinians from Jerusalem. Ramallah: Al Haq; 2017 (<http://www.alhaq.org/advocacy/6331.html>, accessed 27 April 2020).

18. Chronic occupation has profound implications for the sustainability of health-care provision by public authorities, in terms of both revenue raising and affordability. Responsibilities for the right to the highest attainable standard of health for Palestinians are divided between Israel as occupying power, the Palestinian Authority, the de facto authority in the Gaza Strip and third States.¹ The Palestinian Authority holds responsibilities for the provision of health care to the Palestinian population in the West Bank and Gaza Strip upon its establishment under the Oslo Accords. However, lack of control over natural resources (including water), points of entry and other potential sources of revenue, have created a situation of aid dependency that constrains the capacity of the Palestinian Authority to fulfil such responsibilities. Evisceration of the economy and productive base have further deepened this profound dependency, which has particularly affected the Gaza Strip.² In 2012, the United Nations estimated that the Gaza Strip would be unliveable by the year 2020.³ Since the start of the Gaza Strip blockade, there have been worrying trends in indicators for health sector capacity, as well as health outcomes, that would be expected to reflect progressive realization of the right to the highest attainable standard of health over time. For example, the Ministry of Health reported an increase in infant mortality and child mortality between 2009 and 2011, as well as from 2016/17 to 2018.⁴

19. Only 10–12% of the Palestinian Ministry of Health's revenue for the provision of public-health-care services derives from insurance contributions.⁵ The majority of revenue for Palestinian public health care comes from the Palestinian Ministry of Finance, underlining the importance of public revenue for sustainable health-care provision. Without full control over points of entry or defined borders, the Palestinian Authority receives reimbursement of customs revenues and insurance contributions for Palestinian employees working in Israel from Israeli authorities.⁶ In 2019, Israeli authorities withheld revenues as they did previously on a number of occasions.⁷ The economic regulations implemented under the Paris Protocol on Economic Relations created an effective customs union between the occupied Palestinian territory and Israel. Continuation of the provisions of this Protocol, combined with the effects of restrictions on the free movement of people and goods, has an impact on the affordability of health care through price inflation, including for medicines and medical supplies. The Palestinian Ministry of Health pays higher prices for medicines compared to international

¹ Report of the Special Rapporteur on the situation of human rights in the Palestinian territories occupied since 1967. United Nations Human Rights Council; 2018 (<https://undocs.org/A/HRC/37/75>, accessed 28 April 2020).

² Report on UNCTAD assistance to the Palestinian people: Developments in the economy of the Occupied Palestinian Territory. United Nations Conference on Trade and Development (UNCTAD); 2018 ([https://undocs.org/TD/B/65\(2\)/3](https://undocs.org/TD/B/65(2)/3), accessed 28 April 2020).

³ Gaza in 2020: A liveable place? UNRWA; 2012 (<https://www.unrwa.org/userfiles/file/publications/gaza/Gaza%20in%20in%202020.pdf>, accessed 27 April 2020).

⁴ Health Annual Report: Palestine 2018. PHIC, 2019.

⁵ Data provided by the Palestinian Ministry of Health, 2019.

⁶ Palestinian fiscal revenue leakage to Israel under the Paris Protocol on Economic Relations. United Nations Conference on Trade and Development; 2013 (https://unispal.un.org/pdfs/UNCTAD_RevLkStdy.pdf, accessed 26 August 2020).

⁷ Economic costs of the Israeli occupation for the Palestinian people: fiscal aspects. Report prepared by the secretariat of the United Nations Conference on Trade and Development, 2019 (https://unctad.org/meetings/en/SessionalDocuments/a74d272_en.pdf, accessed 26 August 2020).

benchmark prices, linked to import restrictions and large arrears that limit its ability to negotiate lower prices.¹

20. The Palestinian Ministry of Health is the main provider of primary health care in the West Bank, accounting for over 71% of the 585 clinics.¹ In the Gaza Strip, the Ministry of Health accounts for approximately a third (34%) of the 147 primary care clinics, with a larger role played by UNRWA and nongovernmental organizations.¹ Additionally, there were 11 mobile clinics operating in Area C of the West Bank by the end of 2019, the majority provided by nongovernmental organizations.² There are 82 hospitals in total, with 52 in the West Bank and 30 in the Gaza Strip.¹ Bed capacity is 1.3 beds per 1000 of the population, which is approximately the same for the West Bank and Gaza Strip.¹ The Ministry of Health accounts for 43% of bed capacity in the West Bank and 71% of bed capacity in the Gaza Strip.¹ Nongovernmental organizations account for 39% of bed capacity in the West Bank and 24% in the Gaza Strip, while private institutions provide 16% of hospital beds in the West Bank and no hospital beds in the Gaza Strip.¹ UNRWA delivers primary health care in the occupied Palestinian territory through a network of 65 primary health care centres: 22 in the Gaza Strip and 43 in the West Bank, including east Jerusalem. UNRWA also provides secondary and tertiary care through a network of contracted hospitals and direct care through Qalqilya, the agency run hospital in the West Bank. In 2019, 51% of Palestine refugees in the West Bank and 88% of those in the Gaza Strip accessed UNRWA preventive and curative services.³

21. Due to gaps in the availability of services in the public health-care sector in the occupied Palestinian territory, the Palestinian Ministry of Health makes referrals to non-Ministry of Health providers. In 2018, over a third (34%) of Ministry of Health expenditure was for the purchasing of non-Ministry of Health services. Salary payments comprised half (49%) of Ministry of Health expenditure, while spending on medicines and medical consumables comprised 13% of the total and capital and other running costs comprised 4%.¹ In 2019, hospitals in east Jerusalem accounted for the single largest destination for referrals from the Ministry of Health (45%), followed by West Bank hospitals (39%), Gaza Strip hospitals (6%), Egyptian and Israeli hospitals (each 5%) and Jordanian hospitals (1%).¹ There was a substantial reduction in the proportion of referrals to Israeli hospitals, declining from 17% of the total in 2018 to 5% in 2019, reflecting a policy announced by the Palestinian Authority in May 2019 towards ending referrals to Israeli hospitals in the context of Palestinian revenues withheld by Israel.⁴ There are inequities in shortages of essential medicines and medical disposables in public health-care facilities between the West Bank and Gaza Strip, according to data reported by the Ministry of Health. In 2019, an average of 42% of categories of essential medicines in the Gaza Strip were completely depleted, with 26% of essential medical disposables at less than a month's supply at the time of monthly stock takes.⁵ Data are outstanding for 2019, but in 2018 there was an average 95% availability of essential medicines in the Central Drugs Store in the West Bank.⁶

¹ Public Expenditure Review of the Palestinian Authority: Towards Enhanced Public Finance Management and Improved Fiscal Sustainability. Washington: World Bank; 2016 (<http://documents.worldbank.org/curated/en/320891473688227759/pdf/ACS18454-REVISED-FINAL-PER-SEPTEMBER-2016-FOR-PUBLIC-DISCLOSURE-PDF.pdf>, accessed 27 April 2020).

² Data provided by Health Cluster oPt, 2020.

³ Information provided by UNRWA, 2020.

⁴ Data provided by the Palestinian Services Purchasing Unit of the Ministry of Health, 2019–2020.

⁵ Data provided by the Central Drugs Store in the Gaza Strip, 2020.

⁶ Health Annual Report: Palestine 2018. PHIC, 2019.

Israel's permit regime and impacts on health access

22. Israel's permit regime limits the movement of Palestinians between different parts of the occupied Palestinian territory. This includes travel between the West Bank (including east Jerusalem) and the Gaza Strip; movement into east Jerusalem from the rest of the West Bank; and all movement of Palestinians from the occupied Palestinian territory into Israel (including all exits from the Gaza Strip via Erez crossing, irrespective of final destination). By 2014, there were more than 100 categories of Israeli-issued permits for Palestinians in circulation.¹ Patients, companions and health workers are among the groups exempted from the general ban on Palestinian free movement between these different parts of the occupied Palestinian territory and to Israel.

23. Patients from the Gaza Strip needing access to hospitals in the West Bank, including east Jerusalem, and Israel require Israeli-issued permits to travel. In 2019, the approval rate for patient applications to exit the Gaza Strip was 65%. There has been a decline over time in the approval of patient permits, which peaked at over 90% in 2012 and reached a low of 54% in 2017.² The vast majority of unsuccessful patient permit applications do not receive an explanation of the reason for denial or delay. The proportion of patient applications denied was 9%, while the percentage delayed was 26%, with these patients receiving no definitive response to their applications by the date of their hospital appointments.³ Patient permit applications to access cancer care account for 31% of the total and constitute the single largest reason for referral of patients from the Gaza Strip.⁴ A WHO study of cancer patient applications for chemotherapy and/or radiotherapy from 2008 to 2017 demonstrated that patients whose applications were initially delayed or denied between 2015 and 2017 were 1.45 times less likely to survive than those initially approved permits to exit.⁴

24. The approval of permit applications for patient companions from the Gaza Strip was lower than for patient applications, with just half (50%) of companion applications approved in 2019.³ Patients can apply for one companion to accompany them for health care. Children, elderly and severely unwell patients particularly need the accompaniment of relatives. In 2019, just under two fifths (38%) of permit applications approved for children did not have a parent permit approved to accompany the child, a reduction from the more than three fifths (62%) of children who had permits approved to travel without parents in 2018.⁴ Over the course of 2019, 70 patients and 76 companions were called for security interrogation as a prerequisite to Israeli processing of their permit applications. After attending for interview, two patient companions were arrested and detained by Israel.

25. The majority of patients from the West Bank needing access to hospitals in east Jerusalem and Israel similarly require Israeli-issued permits, however there are a number of exemptions. The majority of women over 50 years, men over 55 and children under the age of 14 years travelling with a permitted adult companion are exempted from needing to apply for a permit, provided they travel at certain times of the day. In 2019, 81% of patient and companion permit applications from the West Bank were approved for travel to hospitals in east Jerusalem and Israel.³ Disaggregation was available for 11 of

¹ Levinson, C., 2014. Israel has 101 different types of permits governing Palestinian movement, Haaretz.

² Data provided by the Palestinian Coordination and Liaison Office, 2020.

³ Data provided by East Jerusalem Hospitals, 2020.

⁴ WHO, 2019. Right to Health in the occupied Palestinian territory: 2018. Available at: http://www.emro.who.int/images/stories/palestine/documents/who_right_to_health_2018_web-final.pdf?ua=1 (accessed 20 February 2020).

12 months, with an approval rate of 84% for patient permit applications from the West Bank and 78% for companion permit applications.¹

26. For health staff applying for permits to exit the Gaza Strip through WHO, 71% of permit applications were approved. Meanwhile, 89% of permit applications made by WHO on behalf of health staff to enter the Gaza Strip were approved. There were over 22 000 crossings by staff working with humanitarian organizations to exit the Gaza Strip via Erez. Palestinian staff working in hospitals in east Jerusalem and Israel coming from the West Bank outside east Jerusalem and from the Gaza Strip require Israeli-issued permits to access their places of work. Of 1518 permit applications by east Jerusalem hospitals for their staff to access workplaces in 2019, 97% were approved for 6-month permits, 2% for 3-month permits, and 1% were denied.¹

The Gaza Strip blockade, the Great March of Return, escalations of violence and insecurity and attacks on health-care personnel and facilities

27. More than 12 years of blockade have had a profound effect on the health sector, as well as on underlying determinants of health, in the Gaza Strip. Restrictions on the movement of people, including access of workers to the Israeli labour market, and goods into and out of the Gaza Strip has eviscerated Gaza's economy, exacerbating the situation of aid dependency. Prior to the blockade, many Palestinians from the Gaza Strip relied on access to work in Israel and the West Bank, including east Jerusalem. At the peak of this reliance, between 1980 and 1987, 45% of the Gaza Strip's employed population worked in Israel.¹ In 2019, 46% of people in the Gaza Strip lived below the poverty line of US\$ 5.5 purchasing power parity, with 62% of people experiencing severe or moderate food insecurity and an unemployment rate of 47% in the second quarter of the year – higher at 64% for youth unemployment.^{2,3} The Gaza Strip's infrastructure has fared badly, affecting access to water and sanitation, as well as electricity. 96% of the Gaza Strip's aquifer remains unfit for human consumption, while untreated sewage is pumped into the sea off the Gaza Strip coast, worsening during times of electricity shortage. Over the⁴ course of 2019, there was an average 12 hours of electricity per day available to the Gaza Strip households.⁵

28. Palestinians living in the Gaza Strip can exit via two crossings: through Erez to Israel in the north and Rafah to Egypt in the south. In 2019, Erez crossing was open for those with Israeli permits to cross on 299 (82%) of 365 days, with 19 281 crossings by patients and 16 242 crossings by patient companions from the Palestinian Authority controlled 5/5 checkpoint towards Erez. Of the days on record (data is missing from the first quarter), Rafah terminal was open for 152 (52%) out of 290 days and closed on 106 days. The terminal was open for return only on 5 days, exit of pilgrims only on

¹ Arnon, A. Middle East Journal, Vol. 61, No. 4 (Autumn, 2007). Israeli Policy towards the Occupied Palestinian Territories: The Economic Dimension, 1967–2007.

² Economic Monitoring Report to the Ad Hoc Liaison Committee – September 2019. The World Bank; 2019 (<https://www.worldbank.org/en/country/westbankandgaza/publication/economic-monitoring-report-to-the-ad-hoc-liaison-committee-september-2019>, accessed 27 April 2020).

³ Humanitarian Needs Overview, December 2020. Jerusalem: OCHA; 2019 (https://www.ochaopt.org/sites/default/files/hno_2020-final.pdf, accessed 27 April 2020).

⁴ Data provided by East Jerusalem Hospitals, 2020.

⁵ Gaza Strip electricity supply. Jerusalem: OCHA; 2020 (<https://www.ochaopt.org/page/gaza-strip-electricity-supply>, accessed 27 April 2020).

14 days and return of pilgrims only on 13 days.^{1,2} From April to December 2019, 8904 patients and 4306 companions crossed Rafah terminal to Egypt. Prior to its closure in mid-2013, more than 4000 Palestinians from the Gaza Strip crossed Rafah each month for health-related reasons.

29. Humanitarian supplies enter the Gaza Strip from Israel via Kerem Shalom crossing in the south of the Gaza Strip. In 2019, 103 161 truckloads of goods entered the Gaza Strip, including 909 truckloads of medical supplies. Only 705 truckloads were permitted to cross with exports from the Gaza Strip, while 2441 truckloads were permitted to transport goods from the Gaza Strip to the West Bank.³ Israel restricts the entry of items to the Gaza Strip that it considers “dual use” for potential military utilization. In the health sector, this has affected the supply of electricity generators for hospitals; communications equipment for coordinating ambulances and emergency response; and materials used in treatments or prostheses, such as certain materials used in prosthetic limbs. Israel indicated a potential easing of restrictions on personal protective equipment for health staff in 2019. Prolonged waiting times to obtain approvals for the delivery of complex medical equipment and spare parts pose a barrier to the updating and maintenance of medical devices.

30. The Gaza Strip’s “Great March of Return” continued in 2019. The report of the United Nations Independent Commission of Inquiry on the protests made recommendations to promote the protection of civilians, including children, journalists, health workers and persons with disabilities, who pose no imminent threat to life.³ Additionally, there were two major escalations in the Gaza Strip in 2019, in May and November. From the start of the “Great March of Return” to the end of 2019, 322 Palestinians had been killed in occupation-related violence in the Gaza Strip, with 33 141 injuries verified by WHO, in the context of demonstrations. Of those injured, 7951 persons had suffered gunshot wounds, of whom 88% experienced wounds to the limbs. The high incidence of severe injuries during demonstrations continues to place strain on an already overburdened health sector. Between 25% and 40% of limb gunshot wounds are at high risk to develop bone infection over the 12 months following injury, while 20 to 25% of those who experienced open fractures are likely to require specialized orthoplastic reconstructive surgery.⁴ There have been 156 amputations, including 30 in children, while 24 persons have been paralysed as the result of brain and spinal cord injuries and 21 are recorded to have suffered permanent loss of vision.⁵

31. Since the start of the Gaza Strip’s “Great March of Return”, on 30 March 2018, WHO has recorded 565 attacks on health care, with 3 health workers killed and 844 injured in the context of demonstrations and escalations. During this period, 118 ambulances, ten other forms of transport, one hospital and six other types of health facility have been damaged. Of those injured, 5% were wounded by live ammunition, 5% by shrapnel, 8% with rubber bullets, combined or other injuries, 17% with gas canisters, and 64% with gas inhalation. Qualitative research conducted by WHO in late 2018 and early

¹ Gaza crossings: movement of people and goods. Jerusalem: OCHA; 2019 (<https://www.ochaopt.org/data/crossings>, accessed 27 April 2020).

² Data provided by Rafah terminal authorities.

³ Report of the independent international commission of inquiry on the protests in the Occupied Palestinian Territory. United Nations Human Rights Council; 2019 (<https://undocs.org/A/HRC/40/74>, accessed 28 April 2020).

⁴ Emergency trauma response to the Gaza mass demonstrations 2018–2019. Geneva: World Health Organization and Health Cluster; 2019 (http://www.emro.who.int/images/stories/palestine/documents/who_emergency_trauma_response_to_gaza_demonstrations_2018_2019.pdf?ua=1&ua=1&ua=1&ua=1, accessed 27 April 2020).

⁵ Health Cluster Bulletin November–December 2019. Health Cluster OPT; 2020 (http://www.emro.who.int/images/stories/palestine/documents/HC-Bulletin-OPT-NOV-DEC-2019_FINAL.pdf?ua=1, accessed 27 April 2020).

2019 found underreporting of attacks that did not lead to injuries or damage. The United Nations Independent Commission of Inquiry found that all three paramedics killed were clearly marked as health workers and did not pose an imminent threat of death or serious injury.¹

Vulnerable populations, restrictions and health attacks in the West Bank, including east Jerusalem

32. Administrative division of the West Bank, in addition to its physical division through Israel's separation barrier, expanding settlement infrastructure with limited Palestinian access and extensive and shifting network of checkpoints (1893 flying checkpoints recorded in 2019) has produced geographic vulnerabilities for populations that create additional obstacles to accessing health services, as well as challenges to underlying determinants of health.² These vulnerabilities particularly affect Palestinian communities in Area C, east Jerusalem, the H2 area of Hebron and the Seam Zone between the 1949 Armistice Line and Israel's separation barrier.

33. Area C is under direct Israeli civil and military control and comprises more than 60% of the West Bank. Zoning of Area C and discriminatory planning policies and practices towards Palestinians severely constrain the development of permanent health facilities, as well as essential infrastructure needed for livelihoods, water and sanitation, education and shelter that are necessary for the protection and promotion of good health and well-being.³ Over 160 000 people in Area C, Hebron H2 and the Seam Zone are dependent on provision of primary health-care services by mobile clinics. By the end of 2019, there were 11 mobile clinics providing primary health care to approximately 96 000 people in 116 communities. Communities living in Area C are particularly exposed to demolishing Palestinian homes and other structures. In 2019, Area C accounted for 63% of the 623 structures demolished and 55% of the 914 persons displaced.⁴ Access for mobile clinics is additionally limited by road closures and adverse weather events. In 2019, three mobile clinics were prevented by Israeli forces from reaching communities in Area C.

34. Israel's occupation of east Jerusalem and access restrictions for Palestinians in the remainder of the West Bank through the separation barrier have isolated the city and its approximately 335 000 Palestinian residents.⁵ Access restrictions affect patients, companions, health staff and ambulances, with east Jerusalem hospitals a cornerstone of the Palestinian health system. For east Jerusalem residents, approximately 140 000 live within the Jerusalem municipality on the West Bank side of the separation wall, with entry to the city only possible through a handful of often crowded checkpoints.⁶ These areas,

¹ Health Cluster Bulletin November-December 2019. Health Cluster OPT; 2020 (http://www.emro.who.int/images/stories/palestine/documents/HC-Bulletin-OPT-NOV-DEC-2019_FINAL.pdf?ua=1, accessed 27 April 2020).

² Data provided by OCHA, 2020.

³ Planning Policy in the West Bank. Jerusalem: B'tselem; 2017 (https://www.btselem.org/planning_and_building, accessed 27 April 2020).

⁴ Data on demolition and displacement in the West Bank. Jerusalem: OCHA; 2020 (<https://www.ochaopt.org/data/demolition>, accessed 27 April 2020).

⁵ Korach, M. & Choshen, M., 2019. Jerusalem: Facts and Trends 2019. Jerusalem Institute for Policy Research (https://jerusalemstitute.org.il/wp-content/uploads/2019/05/PUB_505_facts-and-trends_eng_2019_web.pdf, accessed 27 April 2020).

⁶ OCHA oPt, 2019. Data on casualties. Available at: <https://www.ochaopt.org/data/casualties> (accessed 27 April 2020).

which include Kufr Aqab, Shuafat refugee camp and Anata, are overcrowded and underserved by Israeli municipal services, such as refuse disposal, but they represent more affordable neighbourhoods with a high cost of living in Jerusalem compared to average Palestinian household incomes. Rates of poverty are high for Palestinian communities in Jerusalem, with 76% of residents and 83% of children living below the poverty line.¹ East Jerusalem residents also experience high rates of demolitions of homes and other structures, accounting for 33% of demolished structures and 40% of persons displaced in 2019.¹

35. The H2 area of Hebron comprises 20% of the city, including Hebron's historic old city, and is under direct Israeli civil and military control.² Access restrictions and settler acquisition of homes by different means in the area has reduced the Palestinian population, which now stands at approximately 33 000.³ According to the Hebron municipality, by 2018, 518 Palestinian businesses in H2 had been closed by military order, while more than a 1000 others had closed due to restricted access for customers and suppliers.³ A study in 2019 revealed that more than four fifths (81%) of residents of H2 need to pass a checkpoint by foot to reach their homes. Rates of settler violence are high, with a half (48%) of residents experiencing physical assault and a third (33%) experiencing stoning.³ In January 2019, Israel ended the mandate of the Temporary International Presence in Hebron. The city experienced high levels of violence over the year, accounting for almost two fifths (38%) of all Palestinian injuries in the West Bank.³

36. Movement restrictions in the West Bank affect access to health services, including access for ambulances. In 2019, there were 36 incidents recorded in WHO's Surveillance System for Attacks on Healthcare related to obstruction to access for medical teams, with 31 of these incidents involving ambulance access. Meanwhile 90% of 1161 ambulance journeys requiring access into east Jerusalem had to undergo the back-to-back procedure at checkpoints into the city, with transfer of patients from Palestinian-registered ambulances to Israeli-registered ambulances delaying transit. In 2019, the Palestine Red Crescent Society additionally faced obstacles in obtaining licenses for ambulances to operate in east Jerusalem, in spite of a respective memorandum of understanding. Palestinian Red Crescent Society emergency medical services serve approximately 400 000 Palestinians living in Jerusalem and the surrounding areas.³

37. WHO recorded 68 attacks on health care in the West Bank in 2019, with 33 of these involving physical attacks against health staff or facilities, 36 involving obstructions to access and two incidents of incursion into Palestinian hospitals. There were nine incidents recorded of obstruction of medical teams to accessing to provide medical assistance to 11 Palestinians who had been fatally wounded. A first responder working with the Palestinian Medical Relief Society was shot and killed while providing medical assistance during a raid on the Dheisheh refugee camp. He wore a vest that clearly distinguished him as health worker.

Health of the prison population

38. Palestinian prisoners in Israeli detention continued to face barriers to accessing independent health care. The Israeli Prison Service is the provider of primary care services, rather than the Ministry

¹ East Jerusalem Facts and Figures 2017. Tel Aviv: The Association for Civil Rights in Israel; 2017. (<https://law.acri.org.il/en/2017/05/24/east-jerusalem-facts-and-figures-2017/>, accessed 27 April 2020).

² Data provided by the Palestine Red Crescent Society, 2020.

³ OCHA, 2019. The Humanitarian Situation in the H2 Area of Hebron City: Findings of Needs Assessment.

of Health. Civil society human rights organizations report problems with oversight, being unable to access prisons for monitoring purposes, as well as problems with the provision of timely and appropriate treatments and with review or implementation to ensure effective care pathways. In 2019, three Palestinian detainees died as the result of alleged medical negligence, making the total number 222 since the beginning of the occupation in 1967.¹ Human rights organizations, on the basis of affidavits, report the systematic use of alleged torture and ill-treatment at Israeli interrogation centres, with a lack of intervention, medical care or reporting by Israeli Prison Service doctors. In the last quarter of 2019, these organizations monitored around 50 cases of alleged torture and/or other ill-treatment. The International Committee of the Red Cross accesses the Israeli Prison Service, but does not report publicly on conditions for the estimated 5000 Palestinian prisoners, of whom 308 were from the Gaza Strip and 185 were minors as at December 2019.² There are reports of inadequate nutrition for prisoners, including for patients with cancer or other severe conditions, and of inadequate access to psychosocial support, with denial of family visits and communications.²

SUMMARY UPDATE ON THE IMPLEMENTATION OF THE RECOMMENDATIONS OF THE DIRECTOR-GENERAL FOR IMPROVING THE HEALTH CONDITIONS IN THE OCCUPIED PALESTINIAN TERRITORY, INCLUDING EAST JERUSALEM, AND IN THE OCCUPIED SYRIAN GOLAN

39. In 2017, the Seventieth World Health Assembly made recommendations to Israel and to the Palestinian Authority to improve health conditions in the occupied Palestinian territory, including east Jerusalem. Progress on the implementation of these recommendations was reported in last year's WHO report.³ This section provides a brief summary report on the further progress made towards implementing those recommendations.

Regarding the recommendations to Israeli authorities to ensure access for all Palestinian patients requiring specialized health care outside the occupied Palestinian territory and to ensure that health workers have unhindered access to their workplace and possibilities for professional development and specialization:

40. Access for patients, patient companions and health staff remains a challenge in the occupied Palestinian territory, especially for Palestinians in the Gaza Strip. The approval rate of patient applications for Israeli permits to exit the Gaza Strip in 2019 was 65%, 50% for patient companion applications, and 71% for health staff applications through WHO. Of ambulances needing entry to east Jerusalem from the rest of the West Bank in 2019, 90% were required to undergo back-to-back procedures, while 1% of health staff applications for Israeli permits to access east Jerusalem for work were denied.

Regarding the recommendations to the Palestinian Authority to improve the referral system and to consolidate efforts to progress towards universal health coverage:

41. The Palestinian Ministry of Health committed to produce a road map for universal health coverage starting with strengthening primary health care through the family practice approach, including establishing provider networks. The road map will also encompass health financing reform,

¹ Information provided by Ad-Dameer, 2020.

² Information provided by civil society organizations, 2020.

³ Document A72/33.

incorporating strengthening of costing and strategic purchasing, and enhancing service delivery and planning, including through defining a universal health coverage-benefit package.

Regarding the recommendation that options for medical goods to be exempt from the Paris Protocol trade restrictions should be explored:

42. Temporary import restrictions for vaccines to the occupied Palestinian territory have been fully resolved. Israel also indicated that it would ease restrictions on the entry of protective equipment.

Regarding the recommendations that a comprehensive health workforce strategy should be developed:

43. WHO's Palestinian National Institute of Public Health project launched the Human Resources for Health Observatory and issued a comprehensive report, with a view to develop and implement a health workforce strategy.

Regarding the recommendation to consolidate efforts to overcome the political divide between the West Bank and the Gaza Strip:

44. The Health Cluster, co-chaired by the Ministry of Health and WHO, conducted joint coordination meetings between the West Bank and Gaza Strip. However, there has been limited progress to overcome the political divide between the West Bank and Gaza Strip.

Regarding the recommendation that all parties should adhere to the United Nations Security Council resolution 2286 (2016) stating relevant customary international law concerned with the protection of the wounded and sick, medical personnel engaged in medical duties, their means of transport and medical facilities:

45. Attacks on health care continued, with a higher incidence of attacks in the Gaza Strip in the context of the "Great March of Return".

RECOMMENDATIONS BY THE DIRECTOR-GENERAL FOR IMPROVING HEALTH CONDITIONS IN THE OCCUPIED PALESTINIAN TERRITORY, INCLUDING EAST JERUSALEM

46. To the Government of Israel:

- (a) Review the permit system to ensure unhindered access for patients requiring health services as recommended by medical practitioners, and for companions to accompany patients, in particular, access for parents accompanying children.
- (b) Ensure access for Palestinian health staff to places of work and for the purposes of continuous professional development, and facilitate the timely entry of medical equipment and supplies.
- (c) Facilitate the free passage of Palestinian ambulance services, including through licensing of Palestinian ambulances in east Jerusalem.
- (d) Ensure respect for, and protection of, medical personnel and medical facilities as required by international humanitarian law.

(e) Ensure the independent and timely provision of health services to Palestinian prisoners, improve prison conditions, including through adequate nutrition and care of patients in prison, and ensure no one is subjected to torture or other cruel, inhuman or degrading treatment or punishment.

(f) Respect, protect and fulfil underlying determinants of health for Palestinians in the West Bank, including east Jerusalem, and the Gaza Strip, including ending movement restrictions, closures and practices of demolitions and displacement and enable the expansion of essential services and infrastructure.

47. To the Palestinian Authority

(a) Ensure equity of health-care provision to the Palestinian population in the West Bank, including east Jerusalem, and the Gaza Strip, with equitable provision of essential medicines, supplies, referrals and services, including through strengthened monitoring and reporting of health inequities and the disaggregation of health data by demographic markers, including gender, and geographical location.

(b) Strengthen collaboration and coordination at the technical level between health authorities in the West Bank, including east Jerusalem, and the Gaza Strip, and ensure that provision of health care to the Palestinian population is not politicized in the context of political divide.

(c) Work to end stigma, including for persons with disabilities, mental ill-health and cancer, and to ensure access to health services for all Palestinians, including for comprehensive sexual and reproductive health care.

(d) Improve prison conditions and ensure no one is subjected to torture or other cruel, inhuman or degrading treatment or punishment.

48. To third States:

(a) Promote development of the Palestinian health sector and work to protect underlying determinants of health through continued support for essential services and the Palestinian economy.

(b) Support efforts to strengthen the protection of Palestinians, including Palestinian health staff and services, from violations.

(c) Promote coordination at the technical level between health authorities to ensure the protection of health for all by all and ensure that health services are ring fenced and de-politicized.

ACTION BY THE HEALTH ASSEMBLY

49. The Health Assembly is invited to note the report.

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