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FIFTY-NINTH WORLD HEALTH ASSEMBLY
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Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan: progress report

1. The Arab population in the occupied Palestinian territory continues to be subject to high levels of poverty and unemployment (43% and 22.5%, respectively, in 2005). Structural constraints such as the permit and closure system regulating the movement of people and goods, continuing construction of settlements and bypasses, and the lack of control over water and water resources are affecting the daily lives of the population.
2. Effective health services have prevented any major outbreak of disease or significant deterioration in terms of health indicators. Life expectancy in 2004 was 72.6 years. Maternal and infant mortality rates were 10.6 per 100 000 and 24.2 per 1000 live births, respectively. These indicators are lower than in several countries of the region.
3. Noncommunicable diseases, in particular cardiovascular diseases, and perinatal conditions together constitute the main causes of death. The number of deaths due to accidents increased from 9 per 100 000 in 1995 to 32.2 per 100 000 in 2004. The number of accidental injuries, mainly road traffic injuries continued to rise. Iron-deficiency anaemia represents the major nutritional problem in the occupied territory; other micronutrient deficiencies of concern are subclinical vitamin A deficiency, rickets and iodine deficiency. Chronic malnutrition levels among children under the age of five appear to be slowly increasing. Mental disorders continue to be of concern in the occupied Palestinian territory.
4. Recent political developments in the occupied Palestinian territory are having an impact on health-sector performance. As a large share of the health ministry's budget has been provided by international aid in previous years, a change in donors' funding policies is expected to have repercussions for delivery of and access to public health services, and may lead to a weakening of essential primary health-care programmes such as immunization and maternal and child care.
5. The Secretariat has strengthened its efforts to improve the physical, mental and social well-being of the Palestinian people. The Organization has been supporting UNRWA's health programmes for assistance to the refugee population for more than 50 years.
6. More details about the socioeconomic situation, health status and the health system are given in the fact-finding report (see annex), produced in response to the request in resolution WHA58.6.
7. During 2005, the Palestinian authorities, WHO, UNRWA, other United Nations agencies, nongovernmental organizations and other stakeholders in the health sector collaborated closely on a medium-term strategy for the health sector, defining the main areas of intervention as well as the strategic focus.

8. The cooperation strategy for the occupied Palestinian territory (2006-2008) was launched in November 2005. It reflects the medium-term analysis and consensus for cooperation, focusing on long-term capacity building in the Palestinian Ministry of Health, in order to enhance sustainability in the health sector, and addressing the continued need for humanitarian operations in case of crises. The success of the strategy will depend largely on comprehensive planning of the process that synergizes the regular budget and extrabudgetary contributions from the international donor community.

9. In 2005, WHO continued to support the Ministry of Health in its strategic response to the health needs of Palestinians through: improvement of the results of health interventions through efficient and effective **coordination**; collection and interpretation of health **information**; enhancement of health through advanced **technical assistance**; promotion and protection of the “right to health” through advocacy; and promotion of **dialogue and cooperation** between Palestinian and Israeli health professionals, nongovernmental organizations and health institutions.

10. In **coordination** activities WHO has been involved in both strengthening the capacity of the Ministry of Health and directly promoting a shared vision and approach among United Nations and other international agencies within the health sector. Monthly meetings to coordinate emergency support are co-chaired by WHO and the Ministry of Health in the West Bank and Gaza Strip. Similar meetings have also been held at the district level. WHO maintains its technical advisory role in the Health Sector Working Group and within that framework, acts as the technical agency in the thematic groups on nutrition and mental health and the secretariat for the women and child health group.

11. The Secretariat supports the Ministry of Health in formulating and implementing **health policy**. For the occupied Palestinian territory. Specific technical support has been provided in key areas such as mental health, nutrition, essential medicines, control of communicable diseases and food safety in order to strengthen policies, strategies and local capacities.

12. Provision of **technical assistance** responded to programme-specific needs. In the field of mental health it has focused on policy, service delivery and training. In the area of nutrition, technical assistance was provided to enable the Ministry of Health to elaborate a state-of-nutrition document, nutrition policy and strategy; furthermore, a nutrition surveillance system is being set up and ad hoc research on nutrition is underway. Input is also being provided to the current review of the health sector, in partnership with the European Commission, World Bank, Department for International Development of the United Kingdom of Great Britain and Northern Ireland and Italian Cooperation.

13. Health Inforum (led by WHO) continues to focus on consolidating **information** about health and health-sector activities, the status of health facilities, and the availability of medical supplies. It has gathered and disseminated information concerning the humanitarian health situation and response, and reports on these matters through its web-site¹ and monthly newsletters. A process of integration with Ministry of Health information centres has been initiated.

14. The Secretariat has facilitated and supported effective communication between Israeli and Palestinian health professionals and institutions, by promoting platforms for **dialogue**. Examples include continuation of the Palestinian-Israeli professional dialogue through a network of European, Israeli and Palestinian cities for health and social partnership, as well as *Bridges*², the Israeli-

¹ www.healthinforum.org.

² www.bridgesmagazine.org.

Palestinian public health magazine, conceived, edited and produced jointly by Israeli and Palestinian professionals every two months.

15. As requested by the Health Assembly in resolution WHA58.6, the Director-General supported the Palestinian Ministry of Health in its efforts to overcome the current difficulties and helped it during and after the Israeli withdrawal from the Gaza Strip and parts of the West Bank. The health situation in the Gaza Strip during the withdrawal phase was monitored in close collaboration with the Ministry of Health and nongovernmental organizations. An initial assessment of the health status and the state of preparedness measures before the withdrawal was completed, focusing on a basic set of health indicators on mortality, morbidity and service provision by district and areas at risk. The health status, as measured by the indicators, did not change during the withdrawal.

16. In response to paragraph 5(2) of resolution WHA58.6, the Director-General completed an assessment of the enhanced screening machine used by Israel at Palestinian border-crossings, whose use has raised concerns about health and safety. The device, although referred to in that resolution as an "X-ray machine", does not emit X-rays, but rather transmits and receives waves at radio-frequencies up to 30 GHz. A transceiver (antenna) transmits and receives microwave signals reflected off the body and any objects carried on it. Unlike metal detectors, the system is designed to detect plastic or ceramic weapons, plastic explosives and other non-metallic objects under clothing. A sensor array captures the reflected waves and sends the information to a high-speed image-processing computer, which analyses the information and produces a high-resolution, three-dimensional image from the signals. To form an image over the surface of the skin the device emits microwaves at a frequency between 24 and 30 GHz. At such frequencies almost all the energy is absorbed by the skin. None of the microwave energy penetrates deeper than about 1 mm into the tissue. Tissues and organs beneath the skin surface do not receive significant microwave exposure and so cannot be damaged. From a health and safety viewpoint, the assessment concludes that based on information currently available, there is no evidence that the device constitutes any hazard to health.

17. In the current conditions – with the possibility of donors adopting new policies and the funding reductions – scenarios need to be envisaged for emergency humanitarian actions in response to possible crises. The Consolidated Appeals Process assessment seems to offer an appropriate framework for developing a consensus on these scenarios and preparing coordinated humanitarian interventions. The Palestinian Ministry of Health has already issued a public appeal for assistance in meeting emerging shortages. There is a shortfall in the budget for purchasing medicines, supplies and disposables, and laboratory, X-ray and diagnostic material amounting to about US\$ 4.5 million per month. The Secretariat is conducting an objective assessment and monitoring of the current health situation and is drawing up, with other health partners, a three-month contingency plan.

18. WHO will continue to work with United Nations agencies, particularly UNRWA, and the Palestinian Authority to monitor the health situation in the occupied Palestinian territory and keep members states informed.

ACTION BY THE HEALTH ASSEMBLY

19. The Health Assembly is invited to note this report.

ANNEX

Health and economic situation in the occupied Palestinian territory: fact-finding report

1. The Health Assembly resolution WHA58.6 requested the Director-General to submit a fact-finding report on the health and economic situation in the occupied Palestinian territory. Several in-depth situation analyses were made during the second half of 2005. The findings and main conclusions of the following missions and documents are summarized below: cooperation strategy for WHO and the Occupied Palestinian Territory, 2006-2008; Needs Analysis Framework, Inter-Agency Standing Committee, 2005; Common Assessment for the occupied Palestinian territory; The State of Nutrition: West Bank and Gaza Strip. A comprehensive review of the nutrition situation of West Bank and Gaza Strip. Palestinian Ministry of Health, WHO, UNICEF, 2005; Ministry of Health. Health Status in Palestine: Annual Report 2004, Ministry of Health, 2005.

SOCIOECONOMIC SITUATION

2. Most surveys point out that the adaptation of the Palestinian economy to closures and restrictions was insufficient to counteract the adverse combination of multiple stresses on it.

3. The World Bank estimates that real growth of gross domestic product in the West Bank and Gaza Strip may have reached 8% to 9% in 2005, continuing the recovery that began two years ago (following the period of severe crisis between 2000-2002, in which period the per capita figure declined by about 36%, and 2003-2005, a period of stabilization and gradual recovery, in which growth has averaged about 7% per annum). Data for 2005 show unemployment at 22.5% compared to 27% in 2004, more than double pre-intifada levels. Some 43% of the Palestinian population still lives below the poverty line¹ compared with 47% in 2004, with perhaps 15% classified as living in deep poverty compared with 16% in 2004. Estimates consistently showed that the number of poor Palestinians doubled between 1999 and 2005 from 788 400 to 1 565 000. Poverty levels are higher in the Gaza Strip than in the West Bank and East Jerusalem, and groups affected include new poor, chronic poor, children, women of reproductive age and young people.

4. The imbalance between population growth and economic growth, as reflected in the gap between the rate of 3.4% for the former and an oscillating gross domestic product, is a challenge for the Palestinian economy and an obstacle to development in the occupied Palestinian territory.

5. By 2005, the number of dependents per worker had risen to 5.6. In the Gaza Strip, the increase in the dependency ratio was even more pronounced: from 5.9 in 2000 to 8.2 in 2005.

6. In the aftermath of disengagement in late 2005 and early 2006, the international community, with support from the United Nations, accelerated measures to stimulate employment in the occupied Palestinian territory, as part of a broader economic recovery programme. Questions remain, however:

¹ Defined as per capita consumption of US\$ 2.3 per day for a benchmark household of two adults and four children.

can new jobs be sustained over time, and can their number match the number of new entrants into the labour force?

7. The social and psychological effects of more than four years of conflict on the whole population are considerable, but young Palestinians are especially vulnerable.

HEALTH FINDINGS

8. The Palestinian population in the occupied Palestinian territory is undergoing a demographic transition as the result of relatively low infant mortality and under 5-year-old-mortality rates (28.3/1000 live births), a high fertility rate and an increase in life expectancy (see paragraph 2 in main document).

9. Although according to the indicators, the overall health status of Palestinians in the occupied Palestinian territory has not changed significantly, the current situation gives reason to predict a deterioration in health standards of the Palestinians. Poverty and food insecurity in particular have increased among vulnerable groups, including communities living near the separation barrier where residents are prevented from reaching jobs and markets. Among those affected by the wall, 50.3% were reported to have reduced food supplies, 51.5% were living below the poverty line and 47.7% were reported not to be connected to a sewage disposal system, compared to 40.1%, 40.9% and 37.8%, respectively, of those not affected by the wall.

10. The coverage of prenatal services remains at a high level (96.5% in 2004). Postpartum care coverage, however, is still low but appears to have increased over time in the occupied Palestinian territory from 19.7% in 1996 to 26.3% in 2000 and 33.3% in 2004; still about two-thirds of women in the occupied Palestinian territory are not receiving any postpartum care. The fertility rate has declined from around 6 in 2000 to an estimated 4.5 in 2005. The use of family planning methods increased from 45.2% in 1996 to 51.4% in 2000 but dropped to 49% in 2004.

11. The infant and under-5 mortality rates are lower than the average values in countries in the Middle-East and North Africa (infant mortality rate 53/1000 live births) and comparable with those in neighbouring Arab countries, but considerably higher than in Israel (infant mortality rate 5/1000; under-5 mortality rate 6/1000).

12. Acute malnutrition affected 2.8%, 1.4% and 1.9% of young children in the occupied Palestinian territory in 1996, 2000 and 2004, respectively. Stunting, on the other hand, continuously increased from 7.2% of children under five in 1996 to 9.4% in 2004, thus representing a mild public health problem. However, in the event of a further deterioration in the economic situation, stunting levels are likely to increase.

13. Over one quarter of children under the age of five and 31.1% of women of child-bearing age have Iron-deficiency anaemia. Other micronutrient deficiencies concern vitamin A, vitamin D and iodine. Some 22% of children under five are vitamin A deficient and 53.9% are at the threshold of deficiency. The figures for vitamin A deficiency are significantly higher in the Gaza Strip (26.5%) than in the West Bank (18.9%). Rickets is widely reported throughout the Gaza Strip but rarely occurs in the West Bank; in 2003 and 2004, respectively 444 and 325 cases were reported in the occupied territories. Studies conducted in 2004 indicated a prevalence of iodine deficiency of 15%. However, more than two thirds of households report the consumption of iodized salt, the figures being significantly higher in the Gaza Strip (82.7%) than in the West Bank (56.5%).

14. The prevalence of common mental disorders (post-traumatic stress, anxiety, mood and somatoform disorders in 2003 was reported to be 40.3% among the 59% of the population that had been directly exposed to violence, compared to 12.6% among the 31% of the population that had not had such exposure. Research carried out by the Palestinian Counseling Center in the Qalqiliya area showed that a substantial proportion of those surveyed had thoughts of ending their life; the majority felt no hope for the future and expressed feelings of constant anger because of circumstances beyond their control; all reported feeling stressed. Feelings of insecurity also increased in areas directly affected by the separation wall (90% compared to 75% in other areas of the West Bank).

15. Over the past few years, the Palestinian Authority has succeeded in preventing and controlling most infectious diseases through public health programmes of immunization, health education and strengthened epidemiological surveillances. In 2004, communicable diseases accounted for only 10.1% of the total mortality. Hepatitis A, B and C are endemic in the occupied Palestinian territory and the surrounding region generally. The immunization schedule for children includes hepatitis B vaccine with a coverage rate of more than 95%. The rate of tuberculosis in the occupied Palestinian territory has dropped to 0.85 per 100 000 in 2004. The incidence rates for both AIDS and HIV infection are reported as 0.03 per 100 000.

16. Cardiovascular diseases (39.6%), cancer (9.9%), diabetes mellitus (3.6%) and renal failure (3.4%) and perinatal conditions (9.7%) are currently the main causes of death among the general population.

17. There has been a sharp increase in the number of fatal accidents, with a specific death rate of 9.1/100 000 in 1995 and 36.0/100 000 in 2002. In 2003, this rate decreased to 24/100 000 but increased further in 2004 to reach 32.4/100 000. The main cause of accidental injuries remains road-traffic crashes.

HEALTH SYSTEM

18. The Ministry of Health and UNRWA are the main providers of health services in the occupied Palestinian territory. UNRWA covers the 1 635 000 refugees and the Ministry has regulatory responsibility for the health system. Local nongovernmental organizations and private professionals also provide some health services. The multiplicity of health providers operating without a unified policy causes some fragmentation of health service delivery.

19. The health facility network in the occupied Palestinian territory is well developed, in quantitative terms. At the end of 2004, the number of comprehensive primary health-care clinics totalled 731 (606 in the West Bank and 125 in the Gaza Strip); of these, 413 (56.5%) are run by the Ministry of Health, 53 (7.3%) by UNRWA and 265 (36.3%) by nongovernmental organizations. In addition, there are 230 maternal and child health clinics (202 in the West Bank and 28 in the Gaza Strip), 153 specialized clinics (64 in the West Bank; 89 in the Gaza Strip), 197 clinics for family planning (153 in the West Bank; 44 in the Gaza Strip) and 58 dental clinics (27 in the West Bank; 31 in the Gaza Strip).

20. Of the 19 544 employees in the Palestinian health system in 2004, more than half (56.9%) worked in the public sector (Ministry of Health). Human resources in the health sector of the occupied Palestinian territory are unevenly distributed between regions and types of professionals. The ratio of nurses to doctors is low (1.5 nurse per doctor), compared to recommended standards.

21. It has been estimated that, until 2002, Palestinian doctors graduated from 450 different universities in 120 countries. There is no recognized medical specialist training in the occupied Palestinian territory, although in some hospitals it is possible to undertake internships and residencies in some specializations recognized by Jordanian and Palestinian boards.

22. The per capita health expenditure in the occupied Palestinian territory is higher than the regional average. According to the latest estimation from an ad hoc survey, per capita total health expenditure was US\$ 138.4 in 2003. The public health system relies heavily on international assistance and its sustainability is a matter of great concern. A breakdown of total health expenditure in 2002 by source of funding showed that the Ministry of Finance accounted for 15%, the general population for 38% (including health insurance premiums, co-payments and fees in public and private facilities) and donors for 48%. Salaries represent nearly half health Ministry's budget, and referral abroad is the third highest expense item. Every year thousands of patients seek care abroad, mainly in Egypt, Israel and Jordan. In 2004 the total number of patients referred for admission to hospital and consultation abroad was 31 744, an increase of 57.9% compared with 2003.

23. About one quarter of the population is not covered by health insurance. In 2004, 76.1% of households in the occupied Palestinian territory were reported to be covered by health insurance. Of these, more than half had government coverage, and about one third were covered by UNRWA. The remaining population was covered by social security, military health-insurance schemes, or Israeli insurances.

24. Access to health care is generally fair. However, there are strong grounds for assuming that Palestians' access to services has been adversely affected by the restrictions of movement, the separation barrier and the deterioration in the economic situation. Furthermore, the recent political developments and the reduction of funding to the Ministry of Health are likely to have a negative impact on the health sector. A decline in public health programmes and possible disruption of health services are expected if this funding crisis continues.

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