Addressing the health situation in the occupied Palestinian territory

June 2006

World Health Organization

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I. Introduction

The funding crisis which the Palestinian Authority is facing since February 2006 is affecting the funding of the Ministry of Health. The lack of adequate funding threatens to negatively affect the health care delivery and public health programmes. The health situation in the occupied Palestinian territory (oPt) was discussed during the 59th World Health Assembly in May 2006 and Resolution WHA59/3 was passed, requesting the WHO Director General to convene an emergency meeting to discuss the health crisis.

Within this framework, WHO and partners aim at reviewing the current health situation and identifying courses of action for averting a humanitarian health crisis and ensuring the provision of health services in the occupied Palestinian territory. This document provides an update on the status of the Palestinian health system and public health programmes; it explores the potential impacts of inadequate funding on the public health system and attempts to review mechanisms to fill gaps and address humanitarian needs.

II. The health situation

1.2 General living conditions

Since September 2000, the conflict in the occupied Palestinian territory has precipitated the deterioration of the Palestinian economy into a deep unemployment-led recession, causing increased vulnerability among the population. In 2005, the World Bank had estimated that some 43% of Palestinians lived in poverty, with an income of US$ 2.3 per day per capita. According to the latest figures available from the World Bank, this percentage may increase to 67% in 2006 should the current funding crisis prevail (World Bank, West Bank and Gaza update, April 2006).

Unemployment in Gaza rose from 15.5% in the third quarter of 2000 to 34.6% in 2005. In the West Bank, unemployment rose from 7.5% to 25.5% during the same period. Under current conditions, the World Bank expects the unemployment rate to increase to up to 40% in 2006.

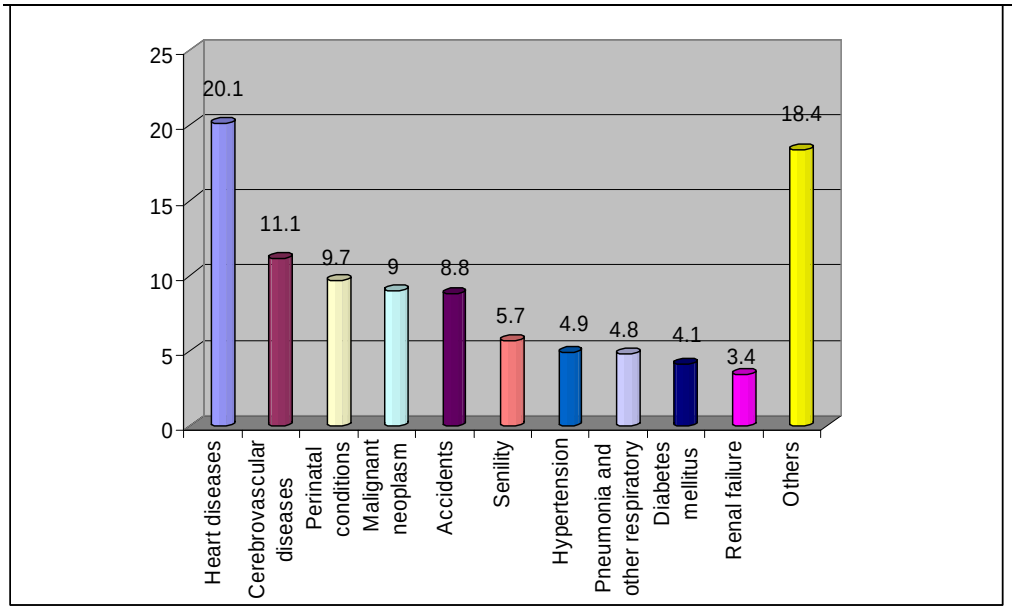
The proportion of people living below the poverty threshold will increase substantially if the recent funding crisis preventing the provision of salaries to the 152 000 employees of the Palestinian Authority (PA) continues.

2.2 Health trends

Life expectancy in 2004 was 72.6 years. Maternal (MMR) and infant mortality rates (IMR) were 10.6 per 100 000 and 24.2 per 1000 live births, respectively.

Noncommunicable diseases, in particular cardiovascular diseases, and perinatal conditions together constitute the main causes of death (Fig. 1). The number of accidental injuries, mainly road traffic injuries continued to rise. Iron-deficiency anaemia represents the major nutritional problem in the oPt; other micronutrient deficiencies of concern are subclinical vitamin A deficiency, rickets and iodine deficiency. Chronic malnutrition levels among children under five appear to be slowly increasing.

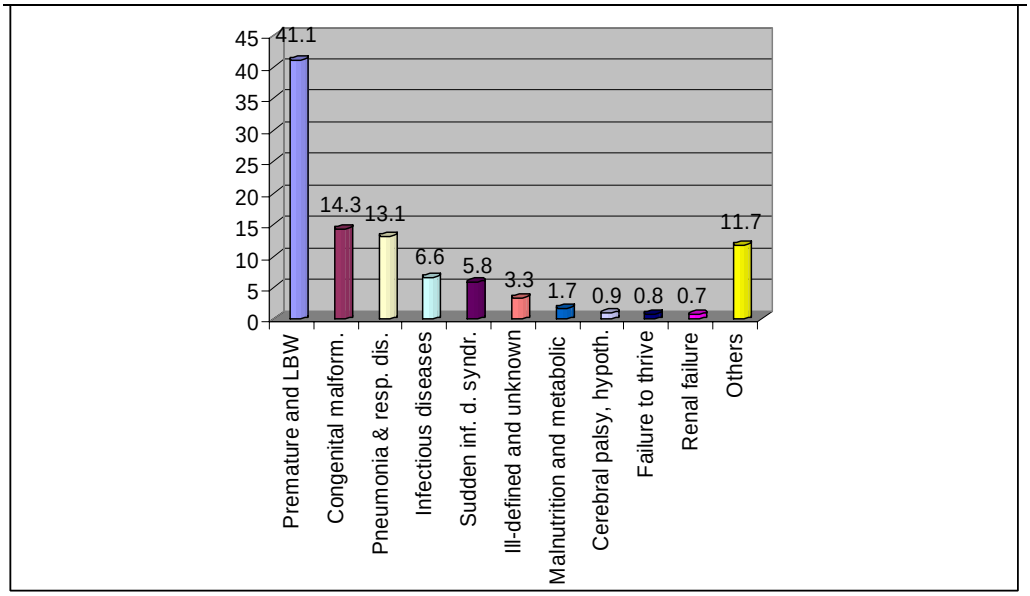
Fig. 1: 10 leading causes of death



In the oPt, the IMR has declined over the past two decades from an estimated 150 per 1000 prior to 1967 to about 24.2 per 1000 live births in 2004.

Reduction in IMR is a result of the cumulative effects such as control of the major childhood infectious diseases, successful immunization and oral rehydration solution (ORS) programmes, reduced morbidity from diarrhoeal conditions, increased number of deliveries taking place in hospitals and medical centres and rising educational levels as well as socioeconomic and nutritional standards. As shown in Figure 2 four out of ten infant deaths can be attributed to low birth weight/premature birth. Infectious diseases account for only 6.6% of infant mortality.

Fig. 2: 10 leading causes of infant death



The health outlook in the oPt, before the current crisis, was characterized by a lack of sufficient resources, both human and material, to adequately address the increasing demands of the population.

Mental health continues to be an increasing concern in the oPt. Anecdotal evidence and recent localized studies have shown that the stressors present in every-day Palestinian life due to the occupation seriously impact personal, familial and community functioning. A survey conducted by WHO/Birzeit University in 2005 using the adapted WHO Quality of Life questionnaire concluded that the living conditions in the oPt are difficult, even in comparison to countries with lower income or worse health indicators. The survey found that 25.6% feel that life quality is poor or very poor, 22% suffer from physical health problems, 33.3% feel anxious, 38.3% feel frustrated and 37.9% are fed up with life. Furthermore, one in two Palestinians reported dissatisfaction with their overall living conditions, one in four has psychological stress, and almost half have insufficient money to meet the needs of their families.

Furthermore, the recent outbreak of avian influenza in the Gaza Strip is worrisome, and if human cases are detected, the health system may experience an additional burden.

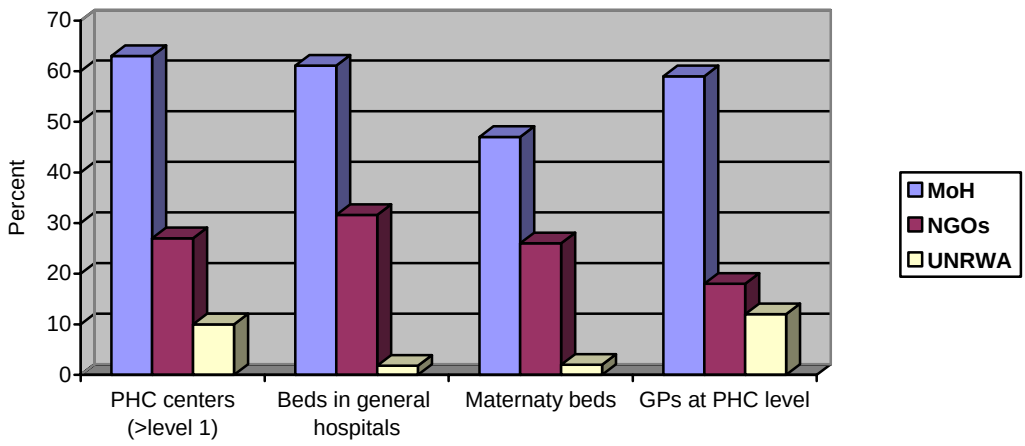
2.3. Health service delivery

The Ministry of Health (MOH) is the largest provider of health services at all levels of care (Fig. 3). A substantial share of tertiary care is provided by neighbouring countries, mostly Egypt, Jordan, and Israel.

The MOH operates over 60% of the primary health care (PHC) facilities (above level 1), over 60% of all beds in general hospitals and 47% of all maternity beds.

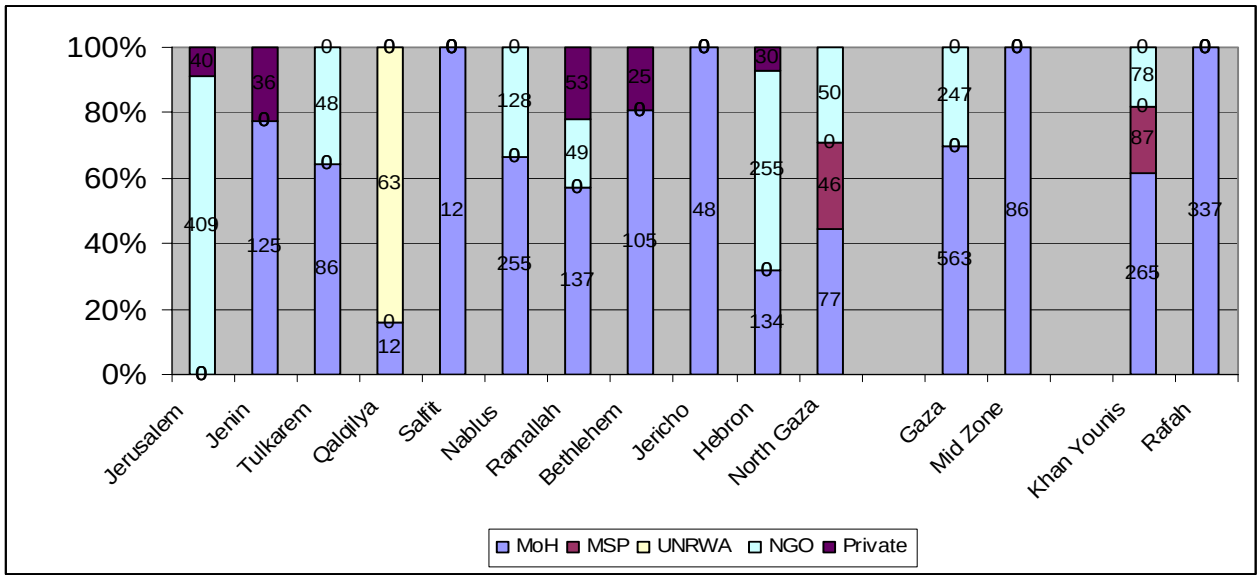
General and maternity hospitals run by non-governmental organizations (NGOs) are concentrated in few governorates, e.g. four governorates out of ten governorates in West Bank. In four governorates (Jericho, Nablus, Gaza Mid Zone, and Rafah) the MOH is the only service provider of health care.

Fig. 3: Health care services by provider



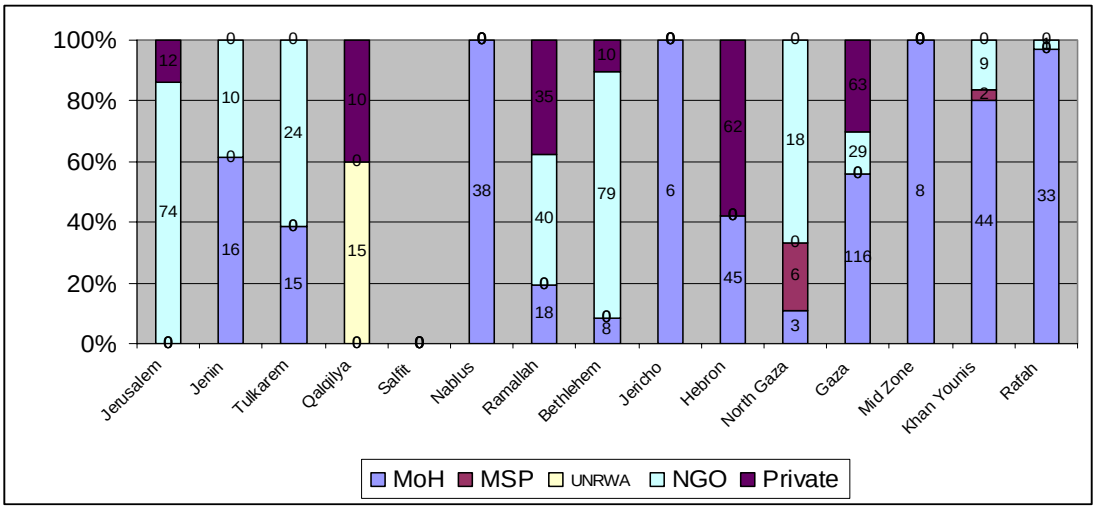
The MOH is the sole service provider of secondary health care in Salfit, Jericho, Mid-Zone and Rafah governorates (Fig. 4).

Fig. 4: Distribution of general hospital beds by governorate and provider



NGOs account for 31% and 26% of beds in general hospitals and of maternity beds, whilst UNRWA manages respectively 1.8 and 2% of them. An extra 25% of maternity beds are in private hospitals (Fig.5).

Fig. 5: Distribution of maternity beds by governorate and provider



Sixty-four percent of all General Practitioners (GPs) and 73% of all nurses in the oPt are working in primary health care (PHC) centres and hospitals run by the MOH. Among the GPs working in PHC facilities, 70% work in PA facilities (59% with the MOH and 11% with the Police Medical Services - MSP), 18% in NGOs and 12% in UNRWA.

Figure 6 presents the distribution of PHC facilities disaggregated by governorate and provider.

Fig 6: Distribution of primary health care facilities by governorate and provider

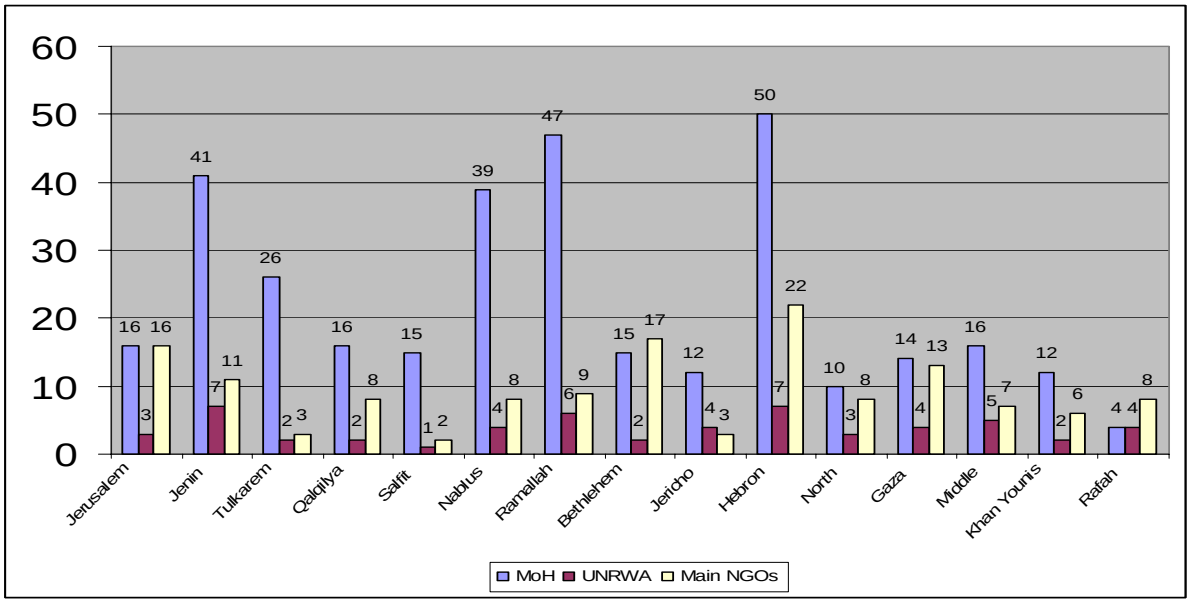


Figure 7 illustrates some of the health needs of the Palestinian population at the different levels of care.

Fig. 7: People seeking health services every month in the oPt

- 35 000 people are admitted to hospital, of which, 23 000 (64.5%) to the MOH hospitals.
- 85 000 people receive specialized out- patient care in hospital, out of them 62 000 (73.5%) in the MOH hospitals.
- 11 000 people undergo surgical operations, of which 8000 (72.5%) in the MOH hospitals.
- 9000 women deliver babies, of which 5000 (55%) in MOH hospitals and PHC facilities.
- 8600 children are immunized, of which 5500 (63.5%) receive their vaccination in MOH facilities.
- 5300 children receive Vitamin A and D supplementations, all in the MOH facilities.
- 8400 and 2900 women receive antenatal and postnatal care, of which 7500 and 2600 (90%) in MOH facilities.
- 73 000 people are affected by diabetes, and 110 000 with hypertension, that go for a monthly medical follow-up and receive drugs at the PHC centres. Three quarters of them rely on MOH centres.
- 500 patients are in need of haemodialysis twice a week who receive this life saving health care at MOH health centres.

2.4. Public Health issues

Immunization

The immunization programme in oPt is functioning well and guarantees universal access and very high coverage.

The vaccination schedule in the oPt is shared with UNRWA, which vaccinates refugee children, and the MOH, which vaccinates non-refugees children. Reports of vaccinations done by UNRWA are sent regularly to the MOH Epidemiology Unit, the Manager of the oPt National Expanded Programme of Immunization (EPI).

NGOs and private physicians do not regularly offer routine immunizations to children. A few NGO-run clinics jointly operated with the MOH offer vaccination for children, but these are provided only by a staff nurse from the MOH. On the other hand, a small number of private Paediatricians in Ramallah and Bethlehem offer such services through private care.

Reproductive Health

Estimated at 3.89 (4.7 in the Gaza Strip and 3.4 in the West Bank), the total fertility rate (TFR) in the oPt is high compared with countries of similar economic development.

The total number of clinics has increased from 102 family planning (FP) clinics in 1997 to 197 in 2003 (44 in the Gaza Strip and 153 in the West Bank). The MOH is responsible for about 49.7% of all FP clinics.

The current use rate of contraceptive methods is 51.4% among married women. It is higher in the West Bank (54.3%) than in the Gaza Strip (46.1%).

Immunization coverage for tetanus among newly pregnant women was 50.4% (61.4% in the West Bank and 42.3% in the Gaza Strip).

More than 95% of births are taking place in health institutions. About 55% of deliveries take place in MOH facilities. Part of the rest is divided between NGO-run hospitals with 30% (11.8% in the Gaza Strip and 42.9% in the West Bank) of deliveries and UNRWA with 3.3%.

Noncommunicable Diseases

Non-communicable diseases present major public health problems and are the leading causes of death. Accidents have sharply increased as a cause of death: from 9 per 100,000 in 1995 to 32.2 per 100,000 in 2004. Accident injuries are mainly caused by road incidents.

Communicable diseases

Communicable diseases account for 10.1% of all deaths. Among them, pneumonia and other respiratory infections, particularly among children, have the highest specific death rate. The immunization coverage is very high: more than 95% for DPT, HepB and MMR.[1]
Viral hepatitis A, B, C are endemic in oPt. Brucellosis, which was a serious problem a few years ago, is under control. The incidence of Brucellosis fell from 32.4 per 100,000 in 1998 to 4.4 per 100,000 in 2004. HIV/AIDS is not yet a significant problem. The reported incidence of

[1] Ibid

tuberculosis is low (0.85 per 100,000 in 2004)[2]. However, data on communicable diseases remain inaccurate as the surveillance system is still insufficient.

2.5 Financial requirements of the Ministry of Health

The funding crisis of the PA has been reported to result from four main factors: (a) an accumulated deficit of about US$ 39 million during 2005, due mainly to the cessation of support by donors; (b) the recent interruption or reduction in international support from the major donors; (c) the delay of transfer of tax revenues; (d) constraints of the banking system.

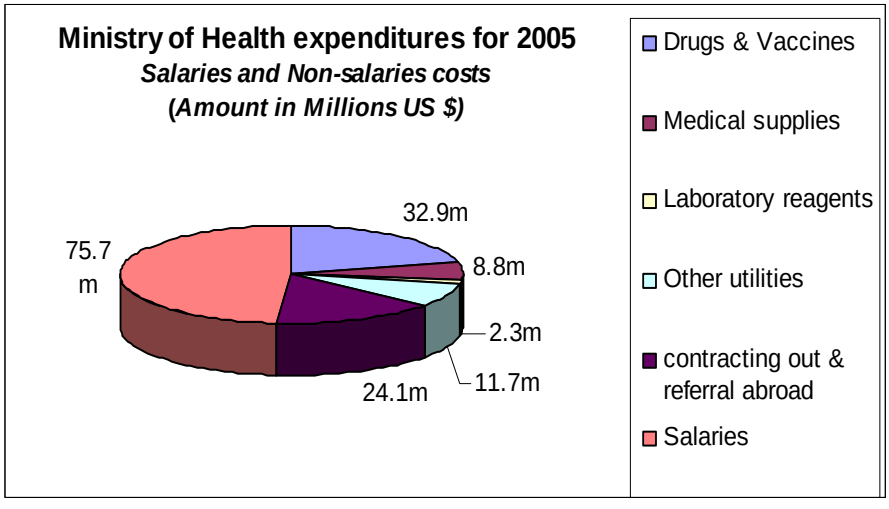
In 2005, according to the Ministry of Finance, the MOH expenditure amounted to US$ 155.6 million, representing 8.75% of the PA total budget. The expenses of the MOH are divided between salaries and non-salary items.

In 2005, salaries accounted for US$ 75.7 million (12 200 technical and administrative staff) and non salary items for US$ 79.8 million, including out-sourced services (Fig. 11). The budget for salaries is covered by the Ministry of Finance, and the funding sources are: 25-33% international aid, 25-29% directly collected taxation, 42-46% taxation collected by Israel.

The non salary items expenses covered the following (see Figure 8 below):

- Drugs and vaccines for primary and secondary health care (US$ 32.9 million)
- Medical supplies and consumables (US$ 8.8 million)
- Laboratory reagents (US$ 2.3 million)
- Other utilities such as medical gauzes, office running costs, office supplies, fuel, maintenance and cleaning services (US$ 11.7 million)
- Contracting out of health services, including referral abroad (US$ 24.1 million).

Fig. 8: MOH expenditures for 2005



[2] Ibid

III. Health consequences of the current situation

3.1 Possible consequences on the health sector with estimated impact on health status

Lack of sustainable funding may result in disruption of essential public health functions and of substantial part of the delivery of basic health services. If the current financial crisis is not addressed, the negative impact will include higher malnutrition rates, increase in mental health disorders, reduced coverage of immunization programmes, inadequate early detection and rapid response for communicable diseases and increased risk of disease outbreaks, and disruption of reproductive health services including antenatal, natal, postnatal and family planning services with potential rise in mother and child morbidity and mortality, and an increased risk of unwanted pregnancies.

The collapse of MOH-provided health services will particularly affect four governorates: Jericho, Salfit, Gaza Mid Zone, and Rafah. Here, the MOH is the only service provider for the delivery of care. The majority of all deliveries are conducted in MOH facilities, and over 73% of all surgical operations are performed in MOH hospitals.

Furthermore, the capacity of the MOH to provide critical regulatory functions such as stewardship and oversight in the health sector would be undermined, resulting in increased fragmentation of the health system from lack of homogeneity of standards and protocols.

Inadequate funding would generally lead to reduced capacity in public health financing, and specifically to failure to pay salaries of the civil servants (57% of all health workers).

Maintenance, rehabilitation and development of health facility network equipment and infrastructure would also be negatively affected.

Impaired functioning of PHC would provoke a significant reduction of service availability and accessibility. Figures 9-11 illustrate the impact of the possible collapse of MOH health facilities with regards to the availability of general hospital beds and the increased burden of hypertension as well as diabetes patients on the PHC centres.

A decline in implementation of school health programmes because of similar difficulties in the education sector may have additional negative implications on immunization with mid-term and long-term health implications;

Frequent – and sometimes lengthy – cuts in electrical supplies in MOH institutions (potentially resulting from the inability of the MOH to pay the electricity bill) will affect the vaccine stocks at central and peripheral level.

Inadequate functioning of municipal services will have a negative impact on disposal of solid waste and on access to safe drinking water in the Gaza Strip and West Bank.

Fig. 9: Availability of general hospital beds by governorate with and without MOH

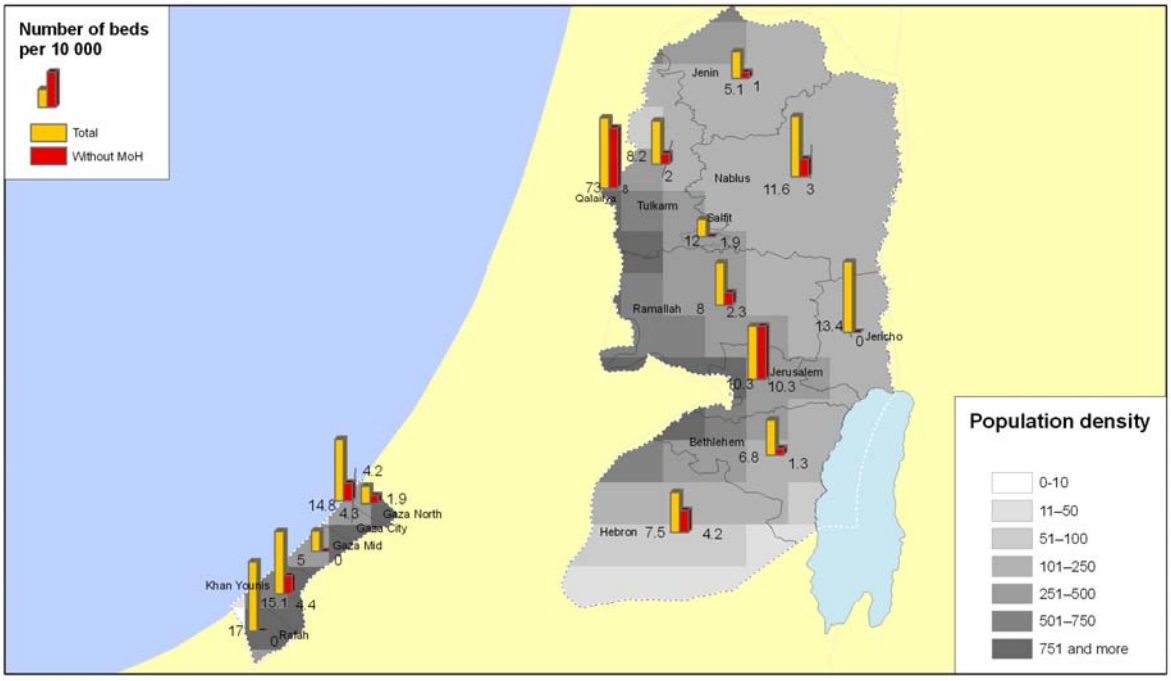
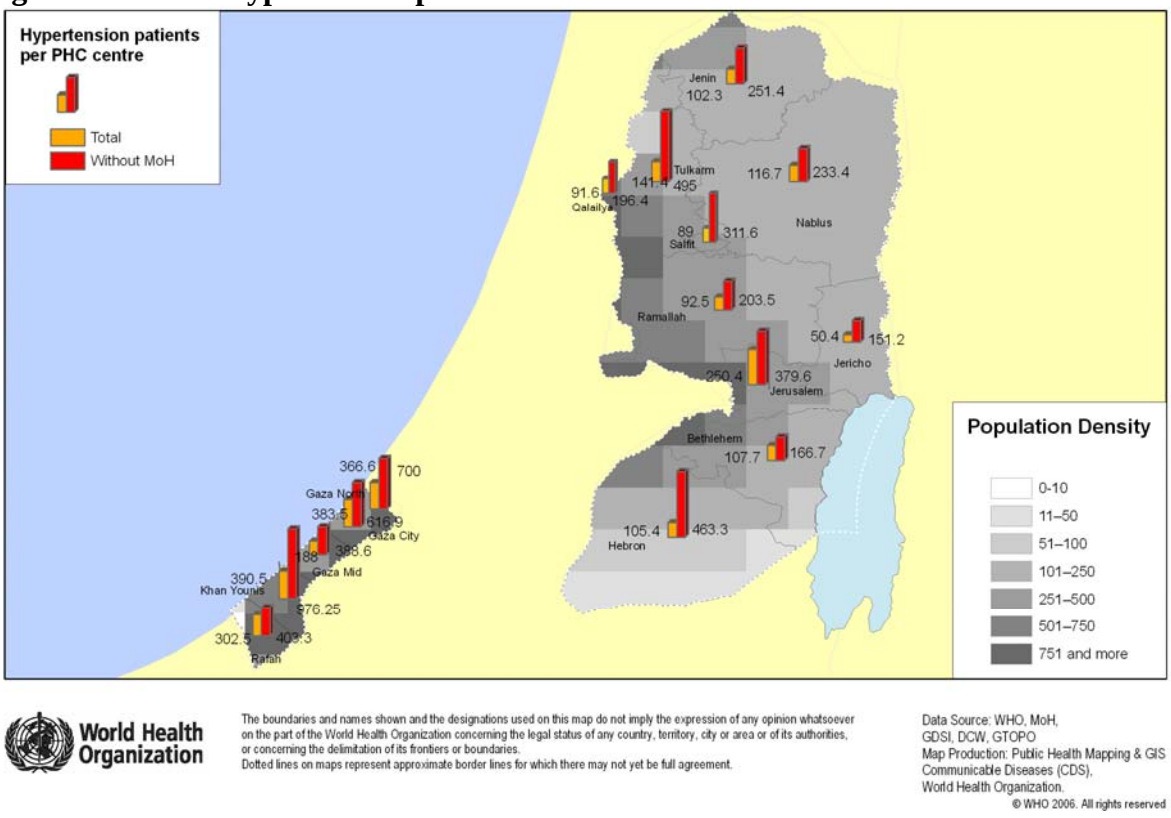
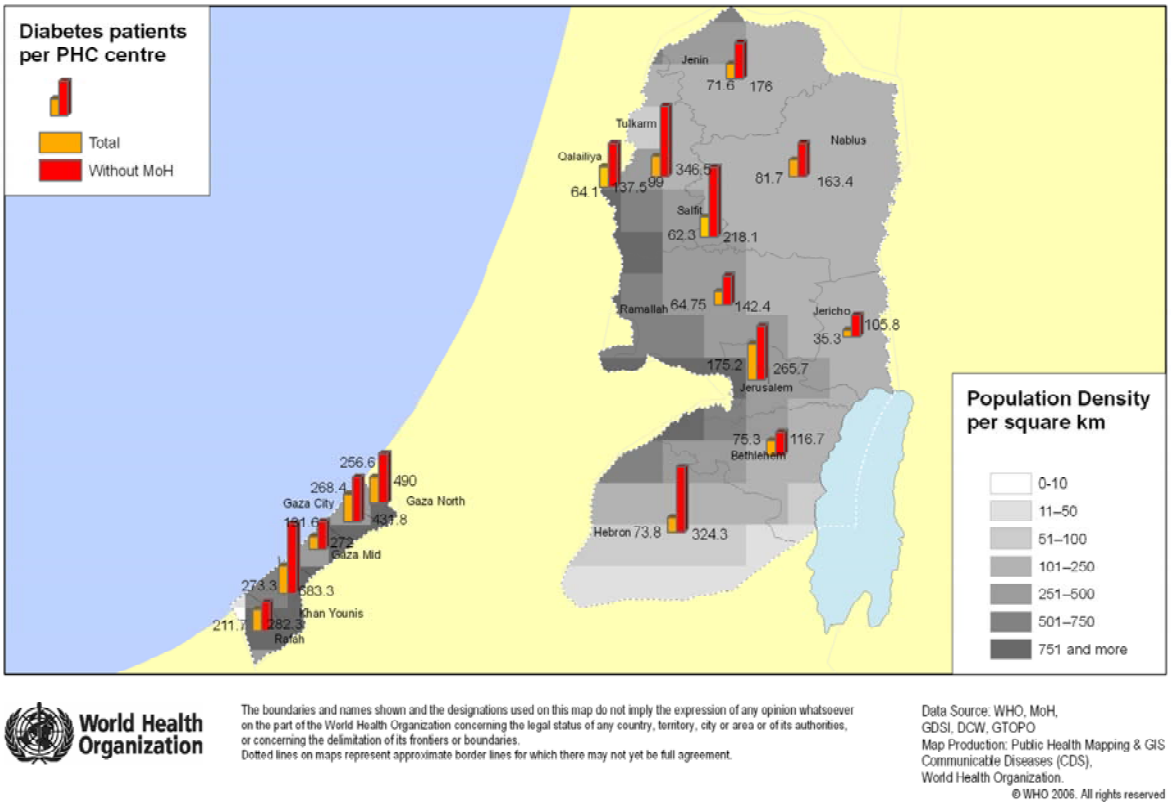


Fig. 10 Burden of hypertension patients on PHC centres with and without MOH[3]



[3] Estimated number of patients from the total population by governorate.

Fig. 11: Burden of diabetes patients on PHC centres with and without MOH[4]



3.2 Early indication of negative impacts[5]

Health staff attendance**:** In some health facilities (Gaza European Hospital and PHC centres in the West Bank), increased absenteeism has been reported for staff who pay transportation costs. In Shifa hospital, Gaza European Hospital and in the West Bank PHC centres staff members are using alternative strategies to cope with the lack of salaries, such as taking annual leave, doing extra time some days and attending alternate days to save transport expenses and others.

Drug availability: PHC centres and community mental health centres in the West Bank, as well as Shifa hospital and the Gaza European hospital in Gaza lack their usual minimum stock of essential drugs (e.g. 22 items are reported to be out of stock in Shifa hospital and several anaesthetics and oncology drugs are also reported to be out of stock at the Gaza European hospital).

Hospital services: In Shifa hospital, specialized services like surgical operations are limited to only urgent and semi-urgent operations; the oncology department in the Gaza European hospital reduced its service delivery due to the lack of necessary drugs. Also, Hebron and Nablus hospitals reported difficulties to continue the payment of patients' food supply and hospital cleaning services. Contractors are not willing to continue unless they are paid for past expenses.

Fuel shortage and health services**:** Hebron district health directorate reported difficulties to continue MCH services including vaccination at village health rooms (VHR) – e.g. 74 VHR in Hebron – home visits and health inspectors' field visits due to lack of funds to cover fuel

[4] Estimated number of patients from the total population by governorate

[5] Information collected by WHO staff through field visits (April-May 2006)

expenses. Few governorates (e.g. Jenin, Salfit) indicated the need to restrict their MCH outreach services if the fuel situation does not increase.

An ad hoc monitoring tool with a set of indicators relevant to the current situation has been developed by WHO/Healthinforum in cooperation with the MOH, Birzeit university and other UN agencies. This monitoring tool is made of two different sets of indicators. The first set, *health system surveillance indicators,* is meant to monitor the midterm trends (monthly and quarterly) of selected health status/health services/health system performance; the second set, *sentinel indicators,* is intended to detect (biweekly) early signals of an impending collapse of health service delivery, both at hospital and district PHC level. This overall tool is being used to monitor the possible crisis of the health system and its consequences on the health of the population (see Annex 1).

IV. Ensuring the delivery of health services in the occupied Palestinian territory

4.1 Urgent needs

The estimated monthly financial needs to cover costs for both salaries and non salary items, according to 2005 expenditure, correspond to US$ 6.3 and 4.6 million per month respectively (excluding out-sourcing).[6]

Many essential drugs, vaccines and consumables are reported to be already out of stock.[7] A comprehensive list of drugs and a partial list of medical supplies, consumables, laboratory materials and other utilities needed have been provided by the MOH.

Since March 2006, the general emergency situation has been complicated by the outbreak of avian influenza in domestic poultry in the Gaza Strip.[8]

[6] Minister of Health sources

[7] The reported out of stock items include: Drugs, mainly concerning secondary and tertiary care with few items covering maternal and child health conditions and emergencies and non EPI vaccines (US$ 684 000 for three months). Lab reagents and disposables (US$ 569 466 for 3 months). The lab reagents are mainly for specialized laboratories although some items are also for primary and secondary care.

[8] Avian Influenza. Since 22 March 2006, H5N1 virus infection was confirmed in domestic poultry, on several farms in the Gaza Strip. The culling process has started and almost 400 000 birds have been culled in 45 farms, representing approximately 20% of Gaza poultry. Although there are no human cases reported so far in the West Bank and Gaza Strip, some specific groups are currently at high risk of exposure. The outbreaks in Gaza, as well as the proximity of other infected locations in Israel and Egypt puts the whole region at risk if future outbreaks are not handled quickly and effectively.
The consequences of a possible spread of the outbreak would have an impact on several dimensions of Palestinian wellbeing such as public health, veterinary and agriculture, nutrition and socio-economic conditions. Particularly worrisome is the socio-economic impact, including loss of livelihoods of the most vulnerable people and structural decline in the rural economy. This risk is particularly acute in Gaza, which is a confined and overcrowded area affected by frequent closures resulting in a shortage of basic food supplies. Chickens and eggs are the main source of proteins for poor families.

MOH Needs of Drugs and Supplies

Item	Monthly needs for the non salary budget of the MOH in US$	Annual needs for the non salary items in US$	Three months urgent needs in US$
Drugs and non EPI vaccines	2 744 998	32 939 976	684 000
Laboratory supplies	189 822	2 277 864	569 466
Disposables	736 206	8 834 472	984 565
Other items (including fuel, food and stationary)	974 762	11 679 148	NA
Total	**4 645 780**	**55 731 460**	**2 238 031**

Source: MOH, 1st June 2006

4.2 Possible mechanism for bridging the gaps

The decision of the Quartet meeting on 9 May 2006 to create a mechanism for the international aid to facilitate donors' support aims to provide the needed assistance to the Palestinian population. However, the timing of the implementation of this initiative is crucial to ensure its efficacy. Until the mechanism is ready and operational, alternative and interim ways and procedures may be put in place to cover the gaps and to avoid an imminent crisis of the health sector.

Addressing the pressing health needs of the majority of the population in the oPt, in light of the current financial crisis requires a series of immediate measures constituting an agile **interim mechanism** that could be put in operation in the short run, while the definite solution of the multisectoral mechanism being discussed by the Quartet is attained.

This interim mechanism has to be agreeable to all stakeholders and should be implemented rapidly and effectively, avoiding duplications and ensuring transparency and reliability and without undermining existing institutional capacities.

The following have been suggested as possible immediate measures and interim mechanisms for bridging the existing gaps:

1) A detailed mapping of the financial needs for the delivery of health services, disaggregated by governorate and by health provider, and of the financial requirements of the execution of public health programs by the national and sub national public health authorities, for the period June to December 2006. This may be rapidly completed by joint teams of technical officers of the Palestinian health governorates, national public health programs, major NGOs and international organizations.

This mapping would constitute the baseline for the allocation of those resources made available by the international community for addressing the health needs of the Palestinian population.

This exercise would have to identify with precision the salary and non salary requirements broken down by object of expenditure. It would be a sort of "projectization" of the current and capital expenditure that will help to define in a programme-budget the terminal application of the resources that can be channelled through the interim mechanism.

2) A fast track Multidonor Trust Fund or Pooled Fund, administered by an international agency, with an inclusive and transparent MOH-multiagency governance mechanism. This can

be established immediately for receiving contributions from donors and immediately applying them to the priorities identified in the "program budget" described in section 1.

This Fund has to have the ability of rapidly capturing resources, preferably un-earmarked, that will be channelled immediately to the priority programs and services identified in the mapping exercise so the regular provision of services and public health functions can be guaranteed. The governance mechanism can include major donors, the World Bank, UN agencies, health officials of the MOH both from governorate and national level, and NGO representatives.

The operating procedures for the execution of the fund should not be a new creation with high transaction costs, but rather capitalize on the existing operating procedures for implementation of programs available in pertinent agencies, once the decisions for allocating the available resources are made by the governance structure.

There will be a need for establishing a fully decentralized operation with the ability to function at a fast speed and with ample powers of delegation of authority and strong mechanisms of accountability and transparency.

3) The channelling of the funds made available to cover the needs of the program budget for services delivery and implementation of public health programs will have to address two major types of expenditures: salaries and non-salary items.

For the salaries three options can be entertained:

1. The Multidonor Trust Fund could transfer salaries or incentives directly to the bank accounts of the health workers of MOH services and major NGO providers, based in rosters produced in the mapping exercise described in item 1. The monthly allocation could be reviewed by the governing body of the Fund and audited periodically.
2. The Multidonor Trust Fund could transfer resources to bank accounts of the MOH at district level and for National Public Health Programs and then have those administrative levels fulfil the payroll function .
3. Donors could make direct deposits into escrow accounts in pertinent banks with the provision that they will be used for directly paying salaries to the roster of personnel identified in the mapping exercise.

For the non-salaries the options are as follows:

1. Direct local and international procurement by the implementer of the Multidonor Trust Fund of medicines, vaccines supplies and equipment, based on the requirements generated by the mapping exercise, and delivering it to the health governorates, national public health programs and major NGO providers.
2. Procurement by the regular mechanisms that governorates, national programs and NGOs utilize, based on the mapping exercise, and having the Multi Donor Trust Fund paying directly to the providers ensuring appropriate transparency and accountability of the process.
3. Direct procurement of services corresponding to the non-salary, non-supply expenditures by the implementer of the Multidonor Trust Fund.
4. Direct payment by the Multidonor Trust Fund of the expenditures corresponding to the non-salary, non-supply expenditures.

It is clear that the two dimensions of salaries and non salaries expenditures need to be addressed simultaneously. Activating one in the absence of the other will not accomplish the objective of bridging the existing gaps in the delivery of health services and the execution of public health programs in the oPt.

MAP DISCLAIMER: *The presentation of material on the maps contained herein does not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or areas or of its authorities, or concerning the delineation of its frontiers or boundaries.*

ANNEX 1:
1) HEALTH SECTOR SURVEILLANCE INDICATORS

Indicators	Sources of data	Frequency of collection
Health status		
1. Neonatal mortality rate: Number of deaths under 28 days of age per 1000 live births	PHC directorate, West Bank and Gaza	**Quarterly**
2. Infant mortality rate: Number of deaths under 1 yr of age per 1000 live births.	PHC directorate, West Bank and Gaza	**Quarterly**
3. Low Birth Weight: Live births with BW less then 2500 gr per 100 live births.	PHC Directorate, West Bank and Gaza MCH Department	**Quarterly**
4. Underweight and wasting: a. N of children aged < 2 years whose weight for age is less 5th percentile per n of children measured. b. N of children aged 9 months weight-for-height is less than -2 standard deviations per n of children measured.	PHC Directorate, West Bank and Gaza, Nutrition Department	**Monthly** **Monthly**
5. Anaemia a. N of children measured at 9 months with HB <11 g/l per total n of children measured b. N of children measured at 6-12 months with HB < 11 g/l per total n of children measured c. N of pregnant women (at first prenatal visit) measured with HB <11 g/l per total n of women measured	PHC Directorate, West Bank and Gaza MCH Department UNRWA, field office	**Monthly** **Monthly** **Monthly**
6. Infectious diseases in refugees a. N. of consultations for diarrhoea per total n of consultation	UNRWA Epidemiology Dept West Bank and Gaza Field offices	**Monthly**
Health Services		
7. Non institutional delivery (deliveries occurring outside appropriate health facility): Absolute number of NI deliveries.	PHC Directorate, Hospital Directorate West Bank and Gaza MCH Department	**Monthly**
8. Caesarean births: Number of caesarean births per 100 live births.	Hospital Directorate, West Bank and Gaza	**Monthly**
9. Place of delivery by service providers: (MOH, NGOs, Private hospitals/clinics)	Birth certificate showed at PHC during BCG immunization	**Monthly**
10. Hospital services: In-patient admissions in hospitals by providers (MOH, NGOs, Private hospitals)	Hospital Directorate West Bank and Gaza	**Monthly**
10. PHC outputs a. N of PHC facility consultations by governorate (MOH clinics) b. N of PHC facility consultations by governorate (UNRWA clinics) c. N of monthly performed haemoglobin tests (MOH clinics) d. Immunization coverage of measles	PHC Directorate, West Bank and Gaza, MCH Dept UNRWA Epidemiology Dept West Bank and Gaza Field offices	**Monthly** **Monthly** **Monthly** **Monthly**
Health System		
11. Salary MOH staff received the last month salary	Financial Department	**Monthly**
12. Contracting out	Referral Abroad	

N. of requests issued by MOH for referral abroad	Department	**Monthly**
13. Emergency Transportation N. of MOH working ambulances per total MOH ambulances	Emergency Department	**Monthly**
14. Transportation Fuel consumption MOH	Financial Department	**Monthly**

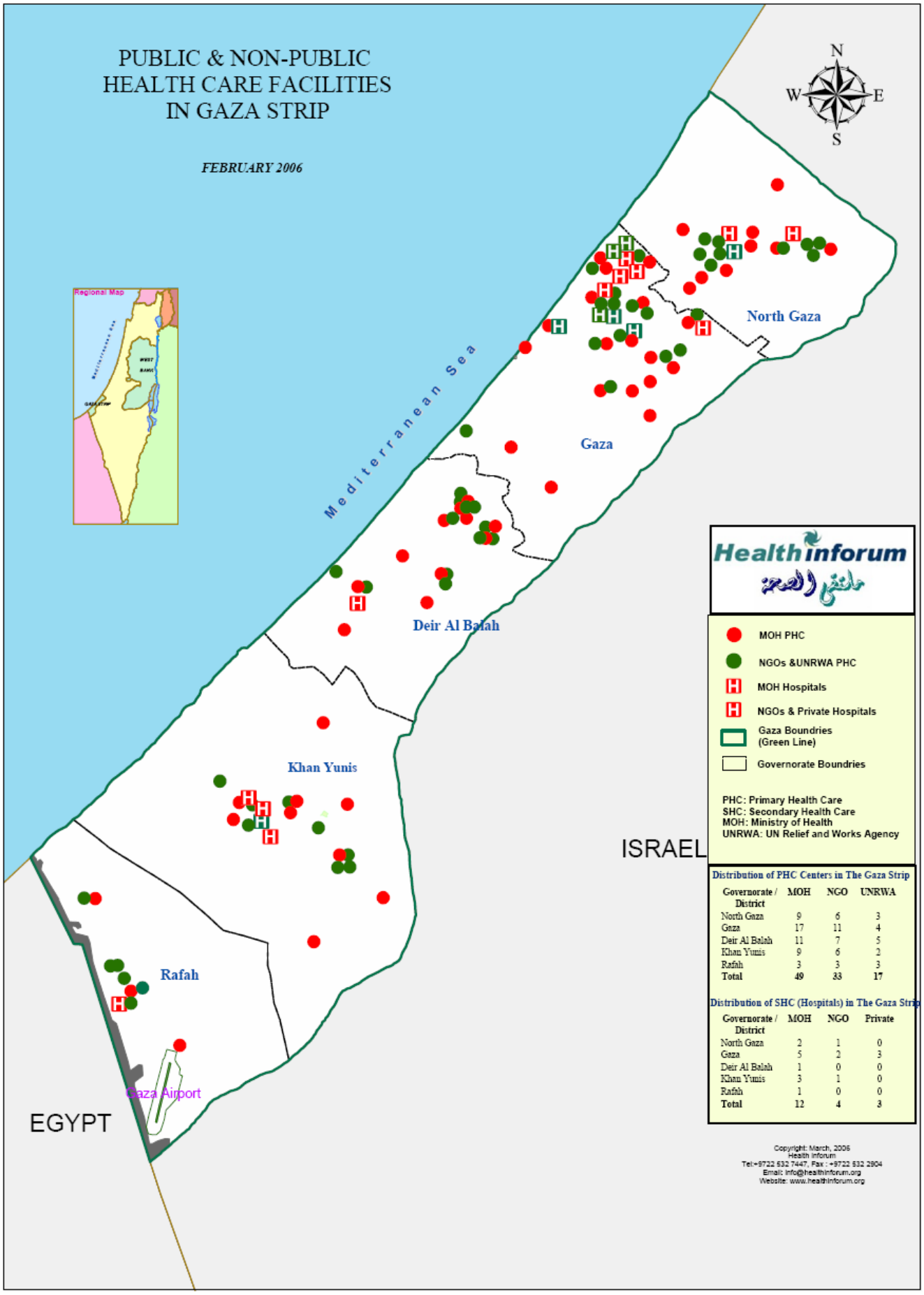
2) SENTINEL INDICATORS

HOSPITAL LEVEL	
Respondent: Contact person at Hospital level **Collection: Every two weeks by phone interview**	
Question/Item	**Answer Modalities**
Hospital open and serving	Yes/No
Number and type of suspended services	Quantitative: Number
Number and type of services of reduced functioning	Quantitative: Number
Cumulative number of person-days of personnel who failed to appear to work	Doctors: Nurses: Technicians: Administrators:
Is there a two-month's stock of drugs/supplies at the facility?	1. Yes, all drugs available 2. Some not available 3 Most not available
Number of out-of-stock items (specify)	Quantitative: Number
Number of cases of pregnancy complications	Quantitative: Number
General Waste disposal	Fully Functional/Sometimes not Functional/Not Functional most of the Time
Medical Waste disposal	Fully Functional/Sometimes not Functional/Not Functional most of the Time
Electricity	Fully Functional/Sometimes not Functional/Not Functional most of the Time
Water supply	Fully Functional/Sometimes not Functional/Not Functional most of the Time
Refrigeration system	Fully Functional/Sometimes not Functional/Not Functional most of the Time
Number of day care patients (chemotherapy)	Quantitative: Number
Number of day care patients (dialysis)	Quantitative: Number
Number of emergency visits	Quantitative: Number
Number of admissions from emergency room	Quantitative: Number
Number of elective surgical operations performed	Quantitative: Number

Number of patients who could not get treatment because of lack of capacity (drugs/equipment/ staff…)	Quantitative: Number Specify

DISTRICT PHC LEVEL	
Respondent: Directors of Primary Health Care Directorates **Collection: Every Two Weeks by phone interview**	
Question/Item	**Answer Modalities**
Number of times the cold-chain was interrupted and has been out-of-service in the governorate	Quantitative: Number
Intra-governorate communications	Functional/Interrupted Partially/Interrupted almost completely
Cumulative number of hours the work at the PHC centres was interrupted during the last month	Quantitative: Number of hours
Cumulative number of person-days of personnel who failed to appear to work	Doctors: Nurses: Technicians: Administrators:
Number of suspended operational programs (specify)	Quantitative: Number
Number of facilities with less than a two-month's stock items	Quantitative: Number Specify item
Number of facilities with one or more out-of-stock items	Quantitative: Number Specify item
Is the governorate vehicle functioning?	Yes/No. If no, specify
Number of facilities with non-functioning water supply for one or more days	Quantitative: Number
Number of facilities with non functioning electrical supply for one or more days	Quantitative: Number
Number of facilities with non functioning refrigeration system for one or more days	Quantitative: Number
Number of patients referred to different facility because of lack of capacity (drugs/equipment/ staff…)	Quantitative: Number Specify reason

ANNEX 2: MAPS OF THE PUBLICH AND NON PUBLIC HEALTH FACILITIES IN OPT



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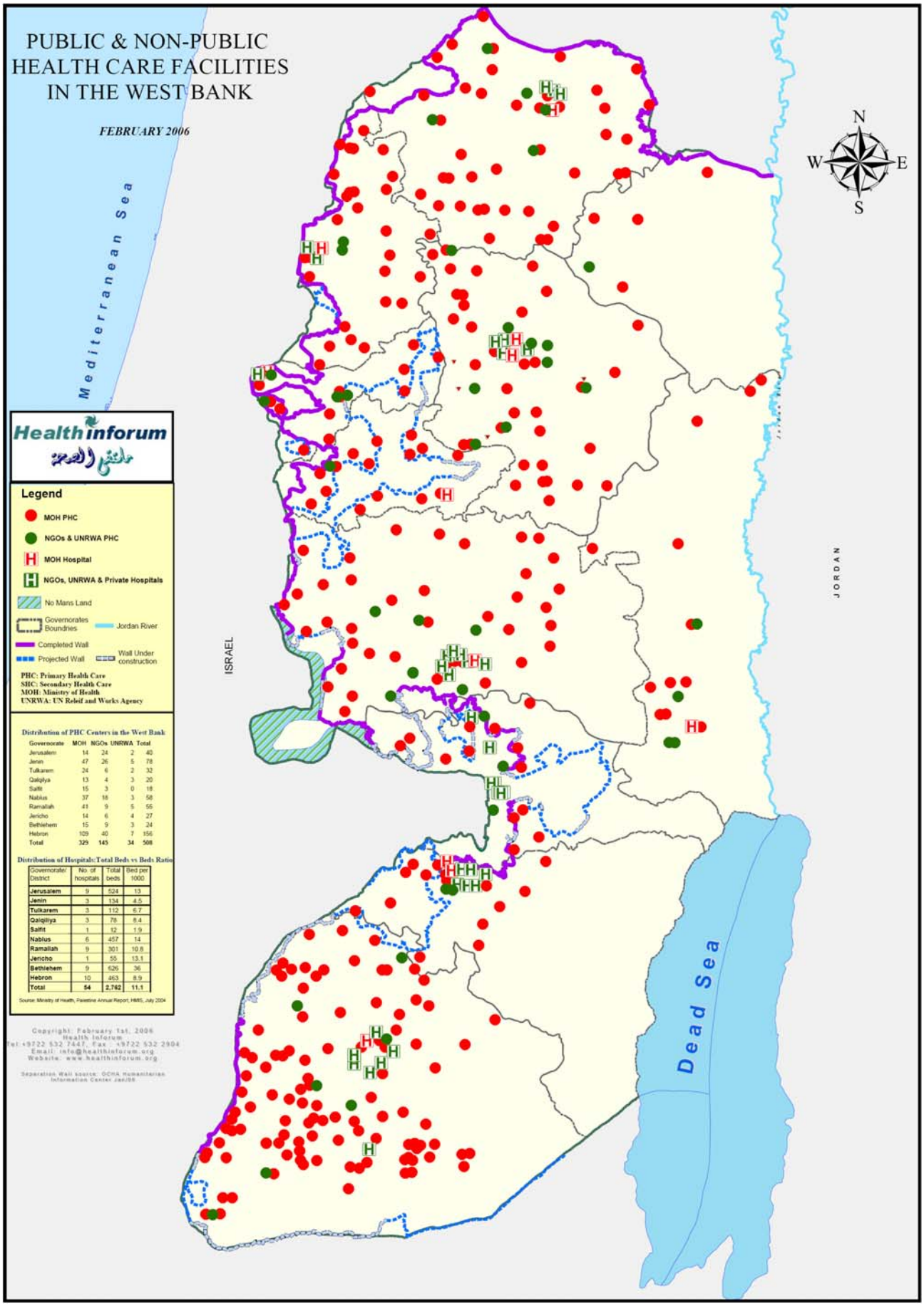

Distribution of PHC Centers in the West Bank

Governorate	MOH	NGOs	UNRWA	Total
Jerusalem	14	24	2	40
Jenin	47	26	5	78
Tulkarem	24	6	2	32
Qalqilya	13	4	3	20
Salfit	15	3	0	18
Nablus	37	18	3	58
Ramallah	41	9	5	55
Jericho	14	6	4	27
Bethlehem	15	9	3	24
Hebron	109	40	7	156
Total	329	145	34	508

Distribution of Hospitals: Total Beds vs Beds Ratio

Governorate/ District	No. of hospitals	Total beds	Bed per 1000
Jerusalem	9	524	13
Jenin	3	134	4.5
Tulkarem	3	112	6.7
Qalqiliya	3	78	8.4
Salfit	1	12	1.9
Nablus	6	457	14
Ramallah	9	301	10.8
Jericho	1	55	13.1
Bethlehem	9	626	36
Hebron	10	463	8.9
Total	54	2,762	11.1

Source: Ministry of Health, Palestine Annual Report, HMIS, July 2004

Separation Wall source: OCHA Humanitarian Information Center Jan/06