



World Health
Organization

occupied Palestinian territory

Right to Health 2018



Right to Health 2018

WHO Library Cataloguing in Publication Data

World Health Organization. Regional Office for the Eastern Mediterranean

Right to health 2018 / World Health Organization. Regional Office for the Eastern Mediterranean

p.

ISBN: 978-92-9022-287-3

ISBN: 978-92-9022-288-0 (online)

1. Health Services Accessibility - Palestine 2. Patient Rights 3. Delivery of Health Care

4. Health Care Costs 5. Human Rights I. Title II. Regional Office for the Eastern Mediterranean

(NLM Classification: WA 300)

© World Health Organization 2019

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: "This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition".

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization.

Suggested citation. Right to Health in the occupied Palestinian territory: 2018.

Cairo: WHO Regional Office for the Eastern Mediterranean; 2018. Licence: CC BY-NC-SA 3.0 IGO.

Sales, rights and licensing. To purchase WHO publications, see <http://apps.who.int/bookorders>. To submit requests for commercial use and queries on rights and licensing, see <http://www.who.int/about/licensing>.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimer. The designations employed and the presentation of the material in this publication do 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 area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

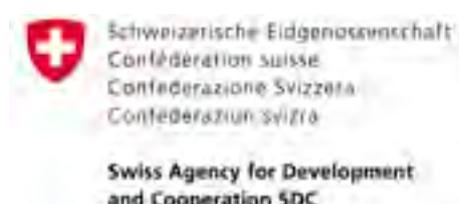
The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Acknowledgements

WHO in the occupied Palestinian territory would like to express sincere gratitude to all who contributed and made this report possible. WHO would like to thank the Palestinian Ministry of Health, Palestinian General Authority for Civil Affairs, Palestinian Red Crescent Society, Palestinian Medical Relief Society, Union of Health Work Committees, East Jerusalem hospitals and human rights organizations in the Gaza Strip and West Bank for their continuing and invaluable inputs and support. The right to the highest attainable standard of health is only achievable through the dedicated work of frontline health workers, who put their lives at risk in the service of patients. A section of this report examines attacks against health workers in the West Bank and Gaza Strip, and we take this opportunity to express our heartfelt thanks and full admiration for their work. Finally, Palestinian patients, their companions and all those affected by broader barriers to the right to health in the West Bank and Gaza Strip are the cornerstone of WHO's work in the occupied Palestinian territory. We are deeply grateful to all those who have shared their stories and personal experiences.

This report is produced by WHO oPt's Right to Health Advocacy programme, which in 2018-19 was supported by funds from the Swiss Agency for Development and Cooperation (SDC) and EU Humanitarian Aid. WHO oPt's Health Systems programme and colleagues at the Palestinian National Institute of Public Health kindly provided inputs to sections on financing and expenditure; health coverage and provision; and human resources for health.



Disclaimer: This document covers humanitarian aid activities implemented with the financial assistance of the European Union. The views expressed herein should not be taken, in any way, to reflect the official opinion of the European Union, and the European Commission is not responsible for any use that may be made of the information it contains.

Contents

Acknowledgements



Executive summary

7



Background: the right to health in occupied Palestinian territory

11

- The right to health: conceptual framework
- Occupation and duty bearers for the right to health in the West Bank and Gaza Strip
- Demographics and health inequities
- Fragmentation and fragility: a health system under occupation
- Barriers to access: the Israeli permit system



Availability: Financing and provision of healthcare

21

- Public healthcare financing and expenditure
- Health coverage and provision
- Human resources for health
- Essential medicines and medical supplies
- Ministry of Health referrals



Access: Barriers to health access in Gaza

35

- Patient permits
 - Impact of access barriers on survival of cancer patients
 - Patient companion permits
 - Health staff permits
 - Access through Rafah
 - Access of medicines and medical supplies
-



Access: Barriers to health access in the West Bank

49

- Patient and companion permits
- Health staff permits
- Ambulance access
- Mobile health clinic access



Underlying determinants of health

55

- Exposure to violence under occupation
- Impacts of blockade and conflicts on health determinants in the Gaza Strip
- Fragmentation and vulnerable populations in the West Bank



Health attacks

63

- System for monitoring
- Gaza health attacks
- West Bank health attacks
- Security interrogation and arrest of patients and companions
- Protection needs and coordination



Conclusions and recommendations

59

- Conclusions
 - Recommendations
-





Executive summary

“Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity.”¹

The right to the highest attainable standard of physical and mental health is protected under international human rights law and international humanitarian law. It is a right that incorporates State obligations for the provision of accessible, acceptable and quality health services, as well as duties to safeguard the conditions of life needed to protect and promote health and wellbeing for all.

This report analyses some of the major barriers to realization of the right to health for Palestinians in the occupied Palestinian territory. It focuses on four main topics: provision and availability of healthcare; access to healthcare; underlying determinants of health; and health attacks.

The West Bank and Gaza Strip have been under Israeli **military occupation for over 50 years**. In the Gaza Strip, blockade since 2007 has resulted in severe limitations on movement in and out for 2 million Palestinians, while restriction on the entry and exit of goods and services has had a devastating effect on Gaza’s economy. In the West Bank, 3 million Palestinians navigate a territory that is divided administratively into Areas A, B, C, H1, H2 and East Jerusalem, with more than 60% of land under direct Israeli civil and military control. Checkpoints, the tortuous route of the separation wall, and an expanding Israeli settlement infrastructure hamper the free movement of people, goods and services – with social and economic consequences for Palestinians. The effective customs union with Israel results further in unfavourable conditions

1. CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)

for the Palestinian economy, with cost inflation and “an import-dependent, captive market” that affects both State revenue and the sustainability of public healthcare provision. A huge resource gap persists due to an ongoing trade deficit, savings deficit and budget deficit.²

The Palestinian Authority was transferred responsibility for **provision of healthcare** to 5 million Palestinians in the West Bank and Gaza Strip under the Oslo Accords. Of this population, some 323,700 Palestinians with East Jerusalem ‘residency’ have access to Israeli health insurance – though the right of Palestinian ‘residents’ to remain in Jerusalem depends on them continuously demonstrating their ‘centre of life’ in the city, through place of work, study or residence. From 1967 to May 2017, Israel had revoked the Jerusalem residency status of 14,595 Palestinians.³ When including dependent children, the number of Palestinians who have lost residency rights increases to approximately 86,000.⁴ The health sector overall is largely donor dependent, with fragmentation of provision between public providers, UNRWA delivery of primary care to refugees, non-governmental organizations and private companies. The Palestinian Ministry of Health spends more than a third (34%) of its expenditure on purchasing services from non-State providers of healthcare. The broader Palestinian health sector faces a shortage of nurses and midwives compared to WHO recommended staffing levels, as well as a scarcity of doctors for a number of medical specialties. In 2019, reports of specialist doctors leaving Gaza points to a worsening of the situation in the Strip. Obstacles to adequate provision of essential medicines also confront the health sector, with higher prices compared to international benchmark prices and long-term depletion of essential medicines and medical disposables exacerbated in the Gaza Strip in past years.

Division of the Palestinian territory and population creates specific barriers to **health access**. Twelve years of blockade of the **Gaza Strip** by land, sea and air has drastically limited the movement of Palestinians in and out. Patients, patient companions and health workers are three groups eligible to apply for Israeli permits to exit Gaza. In 2018, almost two-fifths (39%) of patient permit applications were unsuccessful, either denied outright or delayed, with patients receiving no definitive response to their applications by the time of their hospital appointment. Over a quarter (28%) of patient applications were for cancer care, and almost a third (32%) of patients applying were children under the age of 18. Research by WHO, completed in 2019, has demonstrated that cancer patients requiring chemotherapy and/or radiotherapy who were initially denied or delayed permits between 2015 and 2017 were 1.5 times less likely to survive in the years after application compared to patients who were initially approved permits. Companions aged 18 to 40 and male patient companions aged 41 to 60 have significantly lower approval rates than others, which has meant a shift towards older, female companions in recent years. In 2018, 5,256 applications for 1,821 children were approved patient permits without the approval of either parent to accompany them for healthcare outside the Gaza Strip. Health staff from Gaza applying to exit to travel for continuous professional development or international conferences faced substantial barriers to exiting, with only 15% of those applying through WHO approved over the year. Israel’s dual use list has a significant impact

2. UNCTAD, Report on UNCTAD assistance to the Palestinian people: Developments in the economy of the Occupied Palestinian Territory, 23 July 2018, UN Doc TD/B/65(2)/3, para. 12, 13, 39

3. The Association for Civil Rights in Israel, 2017. East Jerusalem Facts and Figures 2017. Available at: <https://law.acri.org.il/en/2017/05/24/east-jerusalem-facts-and-figures-2017/> (Accessed 26 July 2019)

4. Al Haq, 2017. Residency revocation: Israel’s forcible transfer of Palestinians from Jerusalem. Available at: <http://www.alhaq.org/publications/papers/VP-ResidencyRevocation-FINAL-20170612.pdf> (Accessed 26 July 2018)

on access of medical supplies, including the provision and maintenance of medical equipment in the Gaza Strip. Restrictions on import reported by partners include for communications equipment; medical equipment with components on the dual use list, such as nuclear scanning technology; and materials used in treatments or prostheses, such as certain materials used in types of prosthetic limbs. There have been some indications of easing of restrictions for specific supplies, such as personal protective equipment and radiotherapy, but in general access for supplies and equipment remains a major challenge. These restrictions are compounded by customs limitations, with delays in delivery, incomplete deliveries, under-developed systems to rationalise allocation and maintenance, and overall inadequate equipment.

Palestinian communities in the **West Bank** are separated from one another, and often isolated, creating specific barriers to health access. More than 60% of the territory comprises Area C under direct Israeli civil and military control, while Israel's separation wall leaves 9.4% of the West Bank on the Israeli side and limits access to land and nearby towns and villages, while it contributes to isolating East Jerusalem from the rest of the West Bank. The expanding settlement infrastructure includes 40km of road inaccessible to Palestinians, and the extensive system of fixed and 'flying' military checkpoints hampers free movement and creates unpredictable delays, including for ambulances. Approval rates of permits for patients and companions who require these are higher compared to the Gaza Strip, though almost one in five (18% of) permit applications were still unsuccessful in 2018. For health staff needing permits to reach their places of work in East Jerusalem hospitals, 1.5% were denied permits, while 1.6% were granted work permits for three months only. More than four in five (84%) of the 1,462 recorded journeys by ambulances requiring entry to Jerusalem from other parts of the West Bank in 2018 had to transfer patients to another ambulance at checkpoints, diverting health resources and delaying transit. Of approximately 300,000 Palestinians living in Area C, 114,000 (35%) depend on mobile clinics for access to essential primary health services. In 2018, six of these clinics were denied access to communities for a period of at least two weeks and Israeli authorities confiscated one mobile clinic vehicle.

The **underlying conditions of life** needed for enjoyment of good health and wellbeing by Palestinians are also detrimentally affected by the situation of ongoing military occupation of the West Bank and Gaza Strip. In 2018, 299 Palestinians were killed and 31,723 injured in the context of occupation and conflict. 87% of those killed and 81% of those injured were in the Gaza Strip, with a substantial increase in exposure to violence since the beginning of the Great March of Return on 30 March 2018. A fifth (19%) of those killed and a quarter (24%) of those injured in the Gaza Strip in 2018 were children under the age of 18 years, while 2% of those killed and 8% of those injured were women or girls. Thirteen Israelis were killed and 142 injured in 2018. In addition to death and injury, exposure to violence has longer-term implications for physical and mental health, with Palestinian adolescents having one of the highest burdens of mental disorders in the Eastern Mediterranean Region. In the Gaza Strip, blockade by land, sea and air has limited development opportunities and separated Palestinians from access to the Israeli labour market, on which there was a large degree of dependence since Israel's occupation of the territory in 1967. In the second quarter of 2018, the unemployment rate in Gaza reached 54%, higher for young people (70%) and women (78%). Poverty reached 53%, while 68% of the population suffered moderate or severe food insecurity. The West Bank is also affected by ongoing occupation practices, where overall unemployment is 16%. Territorial

division has created particularly vulnerable populations in Area C, H2 area of Hebron and East Jerusalem. Policies to create a coercive environment in these areas include the promotion of plans to relocate communities to urban townships; restrictions on access to natural resources; the denial of basic service infrastructure; and the lack of secure residency.⁵ These policies impact on access to basic amenities necessary for good health, such as water and sanitation, nutritious food, livelihoods and housing. Area C and East Jerusalem have been particularly targeted by Israel's practice of home demolitions. Together they accounted for 97% (448) of the 460 structures demolished and 84% (396) of the 472 persons displaced as the result of demolitions in the occupied Palestinian territory in 2018.

Patients, health staff and facilities in the occupied Palestinian territory are vulnerable to **attacks on healthcare**. In 2018, there was an unprecedented number of attacks on healthcare in the Gaza Strip in the context of the Great March of Return. Over the course of the year, WHO recorded 432 attacks against healthcare (369 in Gaza and 63 in the West Bank). In the Gaza Strip, these attacks resulted in the killing of three health workers and 570 injuries among health staff, 41 of which were injuries with live ammunition. In the West Bank, a larger proportion of health attacks recorded involved obstruction to delivery of services, particularly affecting ambulances delayed at checkpoints. Of the 63 recorded attacks, 37 incidents involved delay or prevention of ambulance access, including three incidents where access was prevented to injured Palestinians who were fatally wounded and subsequently died of their injuries. Of the West Bank total, 18 incidents involved physical attack or damage to ambulance vehicles and 18 included physical attacks against staff.

Israel, as occupying power, retains the primary responsibility to respect, protect and fulfil the right to the highest attainable standard of physical and mental health in the occupied Palestinian territory, comprising the West Bank, including East Jerusalem, and the Gaza Strip, in line with its obligations towards the protected Palestinian population under international human rights law and international humanitarian law. The Palestinian Authority and de facto authority in Gaza also have obligations to fulfil the right to health to the extent of their jurisdiction, including ensuring the equitable provision of healthcare. Finally, third States have obligations to uphold the right to health and to ensure respect for international law. The full **recommendations** of this report are outlined in the final chapter. The findings of WHO's research on the impact of denial or delay of permit applications on the survival of cancer patients underline the urgent need to reform Israel's permit system as it is applied to vulnerable patients, to remove barriers and to depoliticize humanitarian health access. The increasing number of attacks on healthcare in 2018, continuing in 2019, also points to the immediate need for strengthening the protection of healthcare, in the context of broader efforts to ensure protection of all Palestinians from excessive use of force and other forms of conflict-related violence.

5. OCHA oPt, 2018. 2019 Humanitarian Needs Overview. Available at: https://www.ochaopt.org/sites/default/files/humanitarian_needs_overview_2019.pdf (Accessed 26 July 2019)



Background: right to health in the occupied Palestinian territory

The right to health: conceptual framework

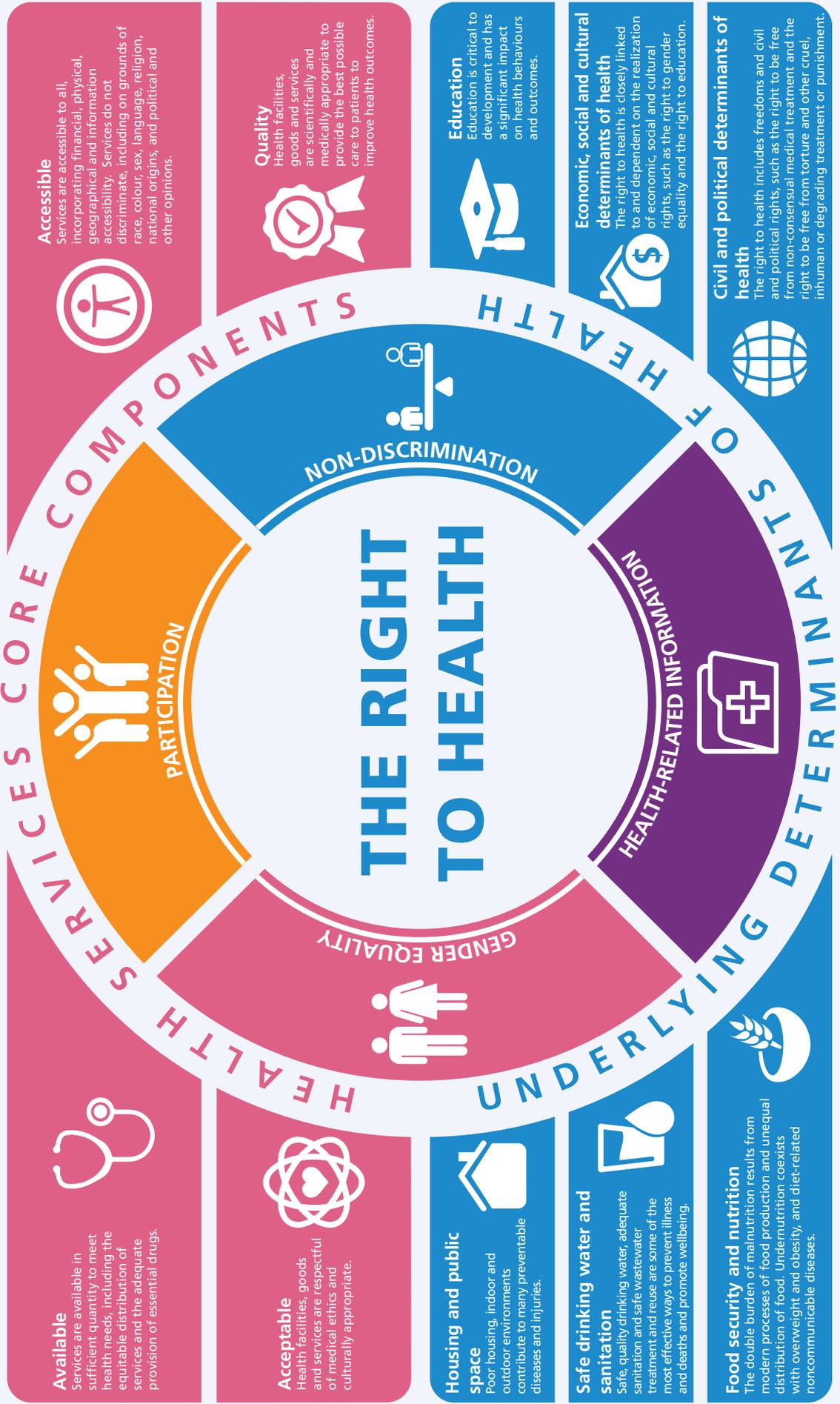
The right to the highest attainable standard of health means that every person should have access to health services that are available, of high quality and acceptable to the population. It also means that every person should enjoy living conditions that enable her or him to realize optimal health through fulfilment of essential needs such as access to nutritional food, clean water and sanitation, and housing, as well as protection from risks to health.⁶ Fulfilment of the right to health is closely dependent on the realization other human rights, as integral components of the right to health. These include the right to food, adequate housing, work, education, human dignity, life, non-discrimination, equality, privacy, and access to information, as well as prohibition against torture and freedoms of association, assembly and movement.⁷

Figure 1 provides an outline of core components of the right to health. This report focuses on core components of **availability** and provision of healthcare in the occupied Palestinian territory; barriers for **access** to essential healthcare; **underlying determinants of health** in the West Bank and Gaza Strip, including exposure to violence; and **attacks on healthcare**. Healthcare quality and acceptability, as well as human rights principles such as participation, non-discrimination, gender equality and access to health-related information, are core components of the right to health. Aspects of these components are addressed within the main chapters of this report.

6. OHCHR & WHO, 2008. Fact Sheet Number 31: The Right to Health. Available at: <https://www.ohchr.org/Documents/Publications/Factsheet31.pdf> (Accessed 26 July 2019)

7. CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), para. 3.

Figure 1: THE RIGHT TO HEALTH



Occupation and duty bearers for the right to health in the West Bank and Gaza Strip

The West Bank and Gaza Strip have been under Israeli military occupation for over 50 years. Israel unilaterally withdrew ground forces from the Gaza Strip in 2005, with commencement of the Gaza blockade in 2007.⁸ The consequences of Israel's 12-year blockade of the Gaza Strip mean that the nature of barriers to the right to the highest attainable standard of physical and mental health differ between the West Bank and Gaza. In the Gaza Strip, a population of 2 million Palestinians faces severe restrictions on movement in and out of the 365 km² coastal area, with one of the highest population densities in the world.^{9,10} The limited number of persons able to obtain permission to exit the Gaza Strip do so through only two entry/exit points, while entry and exit by air or sea is completely prohibited. Meanwhile, 3 million Palestinians in the West Bank continue to navigate a territory that is divided administratively into Areas A, B, C, H1, H2 and East Jerusalem, with more than 60% of the 5,640 km² land mass that comprises Area C under direct Israeli civil and military control.¹¹ Physically, they confront an extensive system of checkpoints with restrictions on movement between different parts of Areas A and B under Palestinian civil control; the tortuous route of the separation wall that limits access to land and nearby towns and villages; and an expanding Israeli settlement infrastructure.

The primary responsibility for the right to health of Palestinians in the West Bank and Gaza Strip lies with Israel as occupying power. The Palestinian Authority and de facto authority in Gaza have responsibilities for the right to health, to the extent of their jurisdiction.¹²

Box 1: Principal duty bearers for the right to health in the occupied Palestinian territory

1. **Israel as occupying power** has overall responsibility for the protection of Palestinian civilians in the occupied Palestinian territory, including for the provision of and access to healthcare, in accordance with its obligations under international humanitarian law and international human rights law.
2. **The Palestinian Authority** has responsibilities to the extent of the jurisdiction emanating from the 1995 Interim Agreement, including for the equitable provision of healthcare to the Palestinian population in the West Bank and Gaza Strip. Hamas, serving as **de facto governing authority** in the Gaza Strip, has the responsibility to fulfil administrative governmental functions, including the administration of health services.
3. **Third States of the international community** have a responsibility to promote human rights, to ensure the respect for international law by Israel, the occupying power, and other parties to the conflict, and to protect the population when a State fails in this regard.

8. OCHA oPt, 2019. Gaza Blockade. Available at: <https://www.ochaopt.org/theme/gaza-blockade> (Accessed 26 July 2019)

9. OCHA oPt, 2018. 2019 Humanitarian Needs Overview. Available at:

https://www.ochaopt.org/sites/default/files/humanitarian_needs_overview_2019.pdf (Accessed 26 July 2019)

10. UNCTAD, Report on UNCTAD assistance to the Palestinian people: Developments in the economy of the Occupied Palestinian Territory, 23 July 2018, UN Doc TD/B/65(2)/3, para. 26

11. Central Intelligence Agency [US], 2019. The World Factbook. Middle East: West Bank. Available at: <https://www.cia.gov/library/publications/the-world-factbook/geos/we.html> (Accessed 26 July 2019)

12. Human Rights Council, 37th Sess, Agenda item 7, UN Doc A/HRC/37/75 (15 March 2018)

The international community, providing a large proportion of funds to the Palestinian health sector as well as broader humanitarian assistance, have the responsibility to uphold international human rights treaties while operating outside their territories. Third States also have a duty to respect and to ensure respect for international humanitarian law by all parties under Common Article 1 to the Geneva Conventions of 1949, and to protect any population from serious breaches of international humanitarian law.¹³

Demographics, health outcomes and health inequities

By mid-2019, the estimated population of the occupied Palestinian territory was approximately 5 million, with 3 million in the West Bank and 2 million in the Gaza Strip.¹⁸ Over 300,000 Palestinians live in East Jerusalem and are given 'resident' status by Israel.¹⁹ More than 2.2 million of the population in the occupied Palestinian territory are registered refugees, with 1.4 million refugees in the Gaza Strip (70% of the population) and 800,000 in the West Bank (more than a quarter of the population). Additionally, more than 3.2 million Palestine refugees reside outside of the occupied Palestinian territory.²⁰ The Palestinian population is predominantly young: nearly 40% of Palestinians are aged 0–14 years, while 5% are aged 65 years or older.²¹

Health inequities are systematic differences in health outcomes among different populations that result from the political, economic and social conditions in which people are born, grow, live, work and age.²² Health inequities are unjust and indicative of barriers to the right to health for affected populations. Life expectancy for Palestinians in the West Bank and Gaza Strip was more than 8.5 years less than life expectancy in Israel in 2018. Palestinian infants were over six times more likely to die in their first year of life compared to Israeli infants, with a similar difference for

13. Geneva Conventions, Common Article 1. Available at:

<https://ihl-databases.icrc.org/ihl/WebART/365-570004> (Accessed 26 July 2019)

14. Palestinian Health Information Center of the Ministry of Health, 2019. Health Annual Report: Palestine 2018

15. OECD, 2018. Life expectancy at birth. Available at:

<https://data.oecd.org/healthstat/life-expectancy-at-birth.htm> (Accessed 26 July 2019)

16. World Bank, 2019. Life expectancy at birth

17. UN Inter-agency Group for Child Mortality Estimation, 2018. Available at:

<https://childmortality.org/> (Accessed 26 July 2019)

18. Palestine Central Bureau of Statistics. Estimated population in Palestine mid-year by governorate, 1997–2021. Available at: http://www.pcbs.gov.ps/Portals/_Rainbow/Documents/%20المحافظات%20انجليزي2017-2097.html (Accessed 26 July 2019)

19. East Jerusalem facts and figures 2017. Tel Aviv: The Association for Civil Rights in Israel; 2017.

Available at: <https://law.acri.org.il/en/2017/05/24/east-jerusalem-facts-and-figures-2017/>

(Accessed 26 July 2019)

20. UNRWA, 2018. Where we work. Available at:

<https://www.unrwa.org/where-we-work> (Accessed 26 July 2019)

21. Palestine Central Bureau of Statistics, . (<http://pcbs.gov.ps>, accessed 23 January 2019).

22. WHO, 2017. 10 facts on health inequalities and their causes. Available at:

https://www.who.int/features/factfiles/health_inequities/en/ (Accessed 26 July 2019)



73.9 years¹⁴

Life expectancy in occupied Palestinian territory, 2018



82.5 years¹⁵

Life expectancy in Israel, 2016



74.3 years¹⁶

Life expectancy in Jordan, 2017



17.9 per 1,000 live births¹⁷

Infant mortality rate in occupied Palestinian territory, 2017



2.9 per 1,000 live births¹⁷

Infant mortality rate in Israel, 2017



14.6 per 1,000 live births¹⁷

Infant mortality rate in Jordan, 2017

under-5 mortality.¹⁷ As outlined within the right to health framework, differences in health outcomes arise from differential access to, availability, acceptability and quality of health services, as well as from determinants of health beyond the health system. The right to health framework also recognizes that countries and territories start from different baselines with regards health outcomes. For this reason, States have the obligation for progressive realization of the right the highest attainable standard of health, meaning that there should be measurable improvements in health outcomes over time.

The duty to progressive realization for improvements in health links closely to Palestine’s commitment to achieving the Sustainable Development Goals – and particularly Goal 3, to “ensure healthy lives and promote well-being for all at all ages.”²⁴ This framework sets specific targets for improvements in health indicators by 2030. SDG priorities include exposure to violence and injury, as well as mental ill health, which are addressed in Chapter 6 in discussion of underlying determinants of health.

The leading cause of mortality for Palestinians in the occupied Palestinian territory in 2018 was noncommunicable diseases such as heart disease, stroke, lung disease, diabetes and cancer, which accounted for more than two-thirds of deaths.²⁵ These deaths are largely preventable through effective interventions to tackle tobacco use, unhealthy diet and physical inactivity associated with urbanization and changing societies.²⁶ Noncommunicable diseases are a challenge to health, as well as to development – including achievement of Sustainable Development Goals. Noncommunicable diseases contribute to catastrophic expenditures on health and further entrench poverty.²⁶



20.9 per 1,000 live births¹⁷

Child mortality rate in occupied Palestinian territory, 2017



3.6 per 1,000 live births¹⁷

Child mortality rate in Israel, 2017



17.0 per 1,000 live births¹⁷

Child mortality rate in Jordan, 2017



27 per 100,000 live births²³

Maternal mortality rate in occupied Palestinian territory, 2017



3 per 100,000 live births²³

Maternal mortality rate in Israeli, 2017



46 per 100,000 live births²³

Maternal mortality rate in Jordan, 2017

23. WHO, 2019. Trends in maternal mortality 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Available at:

<https://www.who.int/reproductivehealth/publications/maternal-mortality-2000-2017/en/>

(Accessed 30 September 2019)

24. UN, 2109. Sustainable Development Goals. Goal 3: Good Health and Wellbeing. Available at:

<https://www.un.org/sustainabledevelopment/health/> (Accessed 16 September 2019)

25. Palestinian Health Information Center of the Ministry of Health, 2019. Health Annual Report: Palestine 2018

26. WHO, 2013. 10 facts on noncommunicable diseases. Available at:

https://www.who.int/features/factfiles/noncommunicable_diseases/en/#/ (Accessed 26 July 2019)

Fragmentation and fragility: a health system under occupation

The health system in the Palestinian territory occupied by Israel since 1967 is fragmented and fragile. In the Gaza Strip, blockade since 2007 has led to de-development of the health sector, with prioritization of emergency humanitarian interventions over much-needed development efforts in the context of successive escalations.²⁷ In 2012, the United Nations warned that Gaza would be unfit for human inhabitation unless socioeconomic trends were reversed. In fact, since that time socioeconomic indicators, including indicators for healthcare, have worsened. Against this background, the volume of mass casualties from the Great March of Return demonstrations in 2018 pushed the health system to brink of collapse.

The physical and administrative division of the West Bank further compounds its geographical separation from the Gaza Strip. Israel effectively annexed and incorporated East Jerusalem into the municipality of Jerusalem after 1967. Today, it is physically divided from the rest of the West Bank by Israel's separation wall, which cuts into the occupied Palestinian territory, including in and around East Jerusalem. When completed, 9.4% of the West Bank will be located on the Israeli side of the wall, creating significant obstacles to health access for Palestinian communities located in this area – known as the 'Seam Zone'.²⁸

The West Bank was administratively split into Areas A, B and C under the Oslo Accords in the early-mid 1990s, while areas H1 and H2 in Hebron were created as a result of the Protocol Concerning the Redeployment in Hebron in 1997 (see Map 1). Area C and H2 are under direct Israeli civil and military control, with Area A and H1 under Palestinian civil and security control and Area B under Palestinian civil and Israeli military control. Area C makes up more than 60% of the West Bank, breaking the contiguity of the Palestinian territory. The territorial division and physical separation of Palestinian communities poses a major barrier to free movement in the West Bank, together with the separation wall, expanding settlement infrastructure (with Palestinian access prevented to 40 km of road),²⁹ and the extensive network of checkpoints (140 fixed checkpoints and 2254 "flying" checkpoints were recorded in the West Bank in 2018).³⁰

Lack of sovereignty and the division of Palestinian territory in this way not only prevents free movement and access but has significant implications for the Palestinian economy, including public revenue and expenditure, and hence the sustainability of public healthcare provision, with high rates of public debt and donor dependency.³¹ The financial implications for the health sector are further explored in Chapter 3.

Responsibilities for the provision of healthcare to Palestinians are divided, both in terms of public provision of healthcare and in terms of provision by non-State actors. The Palestinian Authority (PA), established under the Oslo Accords, was transferred responsibility for administration

27. OCHA oPt, 2019. Gaza Blockade. Available at: <https://www.ochaopt.org/theme/gaza-blockade> (Accessed 26 July 2019)

28. B'tselem, 2017. The Separation Barrier. Available at: https://www.btselem.org/separation_barrier (Accessed 26 July 2019)

29. B'tselem, 2017. West Bank roads on which Israel forbids Palestinian vehicles. Available at: https://www.btselem.org/freedom_of_movement/forbidden_roads (Accessed 26 July 2019)

30. Over 700 road obstacles control Palestinian movement within the West Bank. East Jerusalem: United Nations Office for the Coordination of Humanitarian Affairs; October 2018. Available at: <https://www.ochaopt.org/content/over-700-roadobstacles-control-palestinian-movement-within-west-bank> (Accessed 26 July 2019)

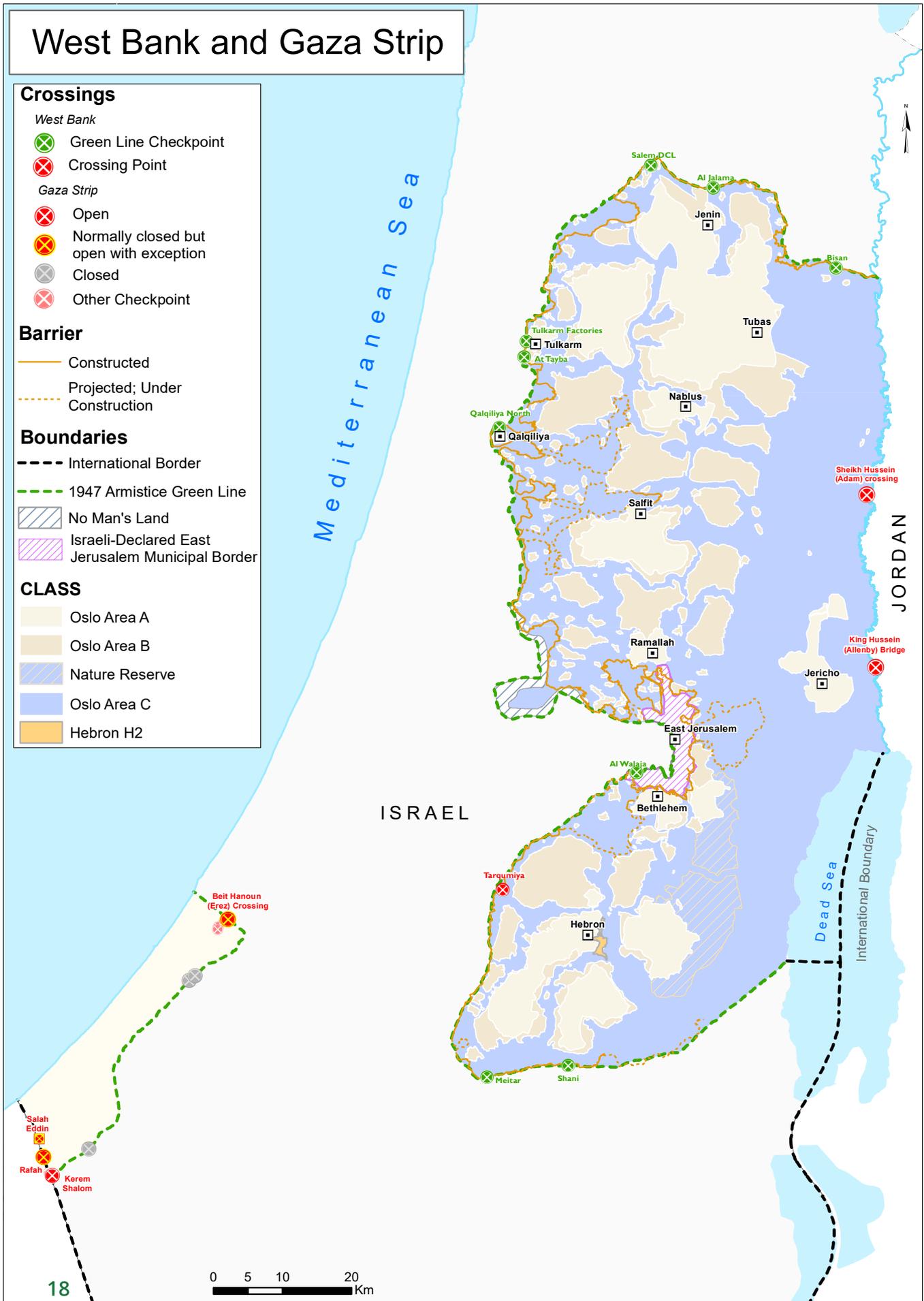
31. Palestinian Health Information Center of the Ministry of Health, 2019. Health Annual Report: Palestine 2018

of the Palestinian health system in 1994 under the Agreement on Preparatory Transfer of Powers and Responsibilities. However, more than 300,000 Palestinians in East Jerusalem³² have a 'permanent residency' status that allows them to access Israeli health insurance, which is not accessible to Palestinians in the rest of the occupied Palestinian territory. In Gaza, the de facto governing authority has assumed the responsibility to fulfil administrative governmental functions, including the administration of health services. Responsibilities for public healthcare provision in Gaza are shared, with the Palestinian Authority continuing to fund a significant proportion of public healthcare. With regards healthcare provision by non-State actors, the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) provides a large proportion of primary healthcare (as well as one hospital in the West Bank), while non-governmental organizations and private institutions account for a significant proportion of secondary and tertiary healthcare provision. Chapter 3 further explores the availability and provision of healthcare in the occupied Palestinian territory.

32. The Association for Civil Rights in Israel, 2017. East Jerusalem Facts and Figures 2017. Available at: <https://law.acri.org.il/en/2017/05/24/east-jerusalem-facts-and-figures-2017/> (Accessed 26 July 2019)



Map 1: West Bank and Gaza Strip



Barriers to access: the Israeli permit system

Israel's permit regime for Palestinians arose with its increasing restrictions on Palestinian free movement from the early-1990s.³³ By 2014, there existed over 100 types of Israeli-issued permits for Palestinians.³⁴ These movement restrictions extend to patients, patient companions and health staff, for whom specific types of Israeli-issued permits exist. There has been historic dependence on tertiary referral facilities in East Jerusalem and Israel, with lack of specialized health services and long-term shortages of essential medicines in the Palestinian health sector. Trends in health access are examined in more detail in Chapters 4 and 5.

In the Gaza Strip, all Palestinians require Israeli-issued permits to exit via Erez crossing, while in the West Bank certain groups may be exempted from permit applications. This includes women over 50 years of age, men over 55 years and children under 14 traveling with a permitted adult companion. The permit application process is lengthy and non-transparent, creating uncertainty and anxiety. Overall restrictions on movement have had a devastating impact on Palestinian living conditions, particularly in the Gaza Strip. Moshe Dayan's 'Open Borders' policy in 1972 granted Palestinians a general exit permission that allowed them relative free movement past the 1949 Armistice Agreement Line to travel, study and work.³⁵ At the peak of this policy, between 1980 and 1987, 45% of Gaza's employed population worked in Israel.³⁶ Blockade, with the strict application of Israel's permit system, has "eviscerated Gaza's economy and productive base and reduced the Strip to a humanitarian case of profound aid-dependency."³⁷



33. Abu Zahra, N. & Kay, A. *Unfree in Palestine: Registration, Documentation and Movement Restriction*. Pluto Press: UK, 2013.

34. Levinson, C., 2014. "Israel has 101 different types of permits governing Palestinian movement", Haaretz, 26 June 2014. Available at: www.haaretz.com/print-edition/news/israel-has-101-differenttypes-of-permits-governing-palestinian-movement-1.403039 (Accessed 26 July 2019).

35. Gazit, Shlomo. *Trapped Fools: Thirty years of Israeli policy in the Territories (Israel history, politics and society)*. Routledge: UK, 2003.

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

37. UNCTAD, Report on UNCTAD assistance to the Palestinian people: Developments in the economy of the Occupied Palestinian Territory, 23 July 2018, UN Doc TD/B/65(2)/3, para. 26.





Availability: Financing and provision of healthcare

Public healthcare financing and expenditure

Responsibilities for provision of healthcare to the Palestinian population in the West Bank and Gaza Strip were transferred to the Palestinian Authority upon its establishment following the Oslo Accords. From 2014 to May 2019, Palestine had acceded to 97 international conventions, agreements and optional protocols, including those containing commitments relevant to the right to the highest attainable standard of physical and mental health - such as the International Covenant on Economic, Social and Cultural Rights, to which the State of Palestine acceded without reservations on 2 April 2014.³⁸ Only 10-12% of Palestinian public healthcare financing comes from insurance contributions.³⁹ The Palestinian Ministry of Finance provides the remainder, meaning that tax revenues and centralized financing of the Palestinian Authority are significant to ensure the sufficient availability, quality and sustainability of healthcare. However, lack of sovereignty and effective control over natural resources or other potential sources of State revenue hamper the ability of the Palestinian Authority to adequately finance public healthcare and fulfil these duties towards the Palestinian population in the West Bank and Gaza. The Palestinian economy under occupation suffers overall de-development, with lack of control over its natural resources, reliance on humanitarian assistance and external donors, and extreme

38. Information provided by the Palestinian Ministry of Foreign Affairs, 2019

39. Information provided by the Palestinian Ministry of Health, 2019

dependency on access to the Israeli labour market.⁴⁰ In 2014, as a conservative estimate, the World Bank calculated a loss of USD 3.4 billion each year to the Palestinian economy due to lack of access to resources in Area C alone.⁴¹ Unemployment in the Gaza Strip was 54% in the second quarter of 2018, higher for young people (70%) and women (78%), and one of the highest rates in the world.⁴² In the West Bank in the final quarter of 2018, unemployment was 16%.⁴³ Prior to the beginning of the Gaza blockade in 2007, with negligible access for Palestinians in Gaza to the Israeli labour market since, the overall Palestinian economy – and particularly the Gazan economy – was extremely dependent on access to Israel’s labour market. This peaked from 1980 to 1987, when 45% of Gaza’s employed population and 32% of the West Bank employed population worked in Israel.⁴⁴

The customs union of the occupied Palestinian territory with Israel, established in 1967 and formalized by the Paris Protocol on Economic Relations in 1994, results in unfavourable conditions for the Palestinian economy. The customs union is unequal and selectively applied by Israel. Restrictions on the movement of people and goods further contribute to cost inflation and “an import-dependent, captive market” that has consequences for both State revenue and the sustainability of public healthcare provision, with a huge resource gap resulting from a persistent trade deficit, saving deficit and budget deficit.⁴⁵ Import restrictions from the customs union also have implications for healthcare affordability and hence healthcare expenditure, with the Palestinian Ministry of Health overpaying substantially for medicines, compared to international benchmark prices.⁴⁶

In 2018, salary payments to staff comprised the single largest proportion of Palestinian Ministry of Health expenditure at 49% of the 1,743,439,622 NIS total expenditure. This was followed by expenditure on referrals outside the Ministry of Health (34% of the total), medicines and medical consumables (13%) and capital expenditures and other operating costs (4%).⁴⁷ Total accumulated debts reached 839,538,906 NIS in the same year.⁴⁷ This chapter looks in further detail at each of these major expenditures (human resources, medicines and disposables, and referrals outside the Ministry of Health) to examine the barriers to availability and hence to the right to the highest attainable standard of physical and mental health for Palestinians in the West Bank and Gaza Strip.

40. UNCTAD, 2017. UNCTAD Assistance to the Palestinian People: Developments in the Economy of the Occupied Palestinian Territory. Available at: https://unctad.org/en/PublicationsLibrary/tdb64d4_embargoed_en.pdf (Accessed 26 July 2019)

41. Niksic, O., Nasser Eddin, N. & Cali, M., 2014. Area C and the Future of the Palestinian Economy. International Bank for Reconstruction and Development / The World Bank, Washington DC. Available at: <http://documents.worldbank.org/curated/en/257131468140639464/pdf/Area-C-and-the-future-of-the-Palestinian-economy.pdf> (Accessed 26 July 2019)

42. OCHA, 2018. 2019 Humanitarian Needs Overview, p7. Available at: https://www.ochaopt.org/sites/default/files/humanitarian_needs_overview_2019.pdf (Accessed 26 July 2019)

43. PCBS, 2018. The Labour Force Survey Results Fourth Quarter (October– December, 2018). Available at: <http://www.pcbs.gov.ps/post.aspx?lang=en&ItemID=3381> (Accessed 26 July 2019)

44. Arnon, A., 2007. Israeli Policy Towards the Occupied Palestinian Territories: The Economic Dimension, 1967-2007. Middle East Journal, Vol. 61, No. 4 (Autumn, 2007), pp. 573-595.

45. UNCTAD, Report on UNCTAD assistance to the Palestinian people: Developments in the economy of the Occupied Palestinian Territory, 23 July 2018, UN Doc TD/B/65(2)/3, para. 12, 13, 39.

46. World Bank, 2016. Public expenditure review of the Palestinian Authority: towards enhanced public finance management and improved fiscal sustainability. Report no. ACS18454. Available at: <http://documents.worldbank.org/curated/en/320891473688227759/pdf/ACS18454-REVISED-FINAL-PER-SEPTEMBER2016-FOR-PUBLIC-DISCLOSURE-PDF.pdf> (Accessed 26 July 2019)

47. Palestinian Health Information Center of the Ministry of Health, 2019. Health Annual Report: Palestine 2018

Chart 1: Ministry of Health expenditure, 2018



Health coverage and provision

Almost four-fifths (78%) of Palestinians in the West Bank and Gaza Strip are covered by some form of prepayment for healthcare.⁴⁸ The major providers of health coverage, the Government Health Insurance and UNRWA, account for over 90% of the coverage provided and overlap significantly. Approximately 41.8% of health financing comes from out-of-pocket payments, the majority of which is the result of expenditure on pharmaceuticals.⁴⁹ Around 1% of the population has encountered catastrophic financial payments, while a further 0.8% has been made impoverished due to out-of-pocket payments for healthcare.⁵⁰

Government Health Insurance covers access to publicly provided primary services including maternal and child health services, secondary care, prescription medicines on the essential medicines list, and tertiary care services needed but not available in Ministry of Health facilities, purchased from non-Ministry of Health facilities within and outside the occupied Palestinian territory. The Palestinian Ministry of Health provides 71% of the 583 primary health clinics in the West Bank and 33% of the 160 primary health clinics in the Gaza Strip. In Gaza, UNRWA and non-State actors play a larger role. Conversely, the Ministry of Health accounts for 73% of hospital bed capacity in the Gaza Strip and 43% of bed capacity in the West Bank. Private and non-governmental organizations play a larger role in the West Bank, including East Jerusalem. In Area C of the West Bank, the Ministry of Health faces substantial barriers to healthcare provision to the approximately 300,000 Palestinians living there. Approximately 114,000 (35% of the Area C population) are dependent on mobile health clinics for access to essential primary care services. By the end of 2018, there were 15 mobile health clinics operating in Area C, the majority of which were provided by non-governmental organizations.⁵¹

48. Palestine Central Bureau of Statistics/Ministry of Health national health accounts report, February 2016.

49. Palestine Central Bureau of Statistics, 2019. 2017 الحسابات الصحية الفلسطينية.

50. Improving health system financing and service provision for universal health coverage in Palestine: addressing the challenges for a sustainable and equitable health system development. WHO – World Bank Mission Report, 2016.

51. Data provided by the health cluster, occupied Palestinian territory.

Human resources for health

The total cost of human resources for health for the Palestinian Ministry of Health in 2018 was 856,189,016 NIS, comprising 49% of total Ministry of Health expenditures (excluding debt repayments).⁴⁷ Of 14,224 health workers registered in the West Bank, the Ministry of Health employs almost two-fifths (37%), while in the Gaza Strip the Ministry of Health employs nearly three-fifths (58%) of the 10,413 registered health workers. Other major employers are private providers (34% WB; 17% GS), NGOs (23% WB; 15% GS), and UNRWA (4% WB; 8% GS).⁵²



49%

of total Ministry of Health expenditure was for human resources

In 2019, the Palestinian National Institute of Public Health, a WHO-led project funded by the Government of Norway that is transitioning to become an independent governmental institution, worked with the Ministry of Health and WHO to complete mapping of the Palestinian health workforce. A density of 3.0 doctors, nurses and midwives per 1,000 population is above the WHO's international benchmark of 2.3 per 1,000 population established as necessary to deliver essential maternal and child health services. However, the composite figure of 3.9 doctors, nurses, midwives, pharmacists and dentists falls below the WHO international benchmark of 4.45 per 1,000 population. The number of 2.0 nurses and midwives per 1,000 falls below the WHO suggested threshold of 3 per 1,000, while the figure of 1.1 employed doctors per 1,000 persons in the West Bank and Gaza Strip is above WHO's suggested threshold of 1 per 1,000. There exist potential shortages for specific specialties, including family medicine, neonatology, oncology, psychiatry, haematology, emergency and ICU medicine, neurology, pathology, paediatric surgery and vascular surgery.⁵²

Table 1: Number of health professionals per 1,000 compared to international benchmarks and WHO suggested thresholds

Health profession	Number per 1,000	International benchmark (IB) or suggested threshold (ST)
Doctors	1.1	1 (ST)
Nurses and midwives	2.0	3 (ST)
Dentists	0.3	-
Pharmacists	0.5	-
Doctors, nurses and midwives	3.0	2.3 (IB)
Doctors, nurses, midwives, dentists and pharmacists	3.9	4.45 (IB)

52. PNIPH, Palestinian Ministry of Health & WHO 2019. National Human Resources for Health Observatory: Mapping the Palestinian Health Workforce July 2019.

Essential medicines and medical supplies

The provision of essential medicines is one of the core minimum obligations for States that have acceded to the International Covenant on Economic, Social and Cultural Rights.⁵³ Palestine has had in place an Essential Medicines List (EML) since 2000. Today there are 526 drug items on the EML in the West Bank, while the list comprises 516 separate drug items for nine drug categories in the Gaza Strip. In the Gaza Strip, the categories of the EML are divided into: emergency, surgery and intensive care (148 items); primary care (143); chemotherapy and blood disorders (65); mental health (41); immune and genetic disorders (41); maternity and paediatric (29); kidney transplant and haemodialysis (22); ophthalmic (18); and radiology and diagnostics (9). In 2018, the Palestinian Ministry of Health spent 218,933,543 NIS, or 13% of overall expenditure (excluding debt), on medicines and medical consumables.⁵⁴

According to the Ministry of Health Central Drugs Store in the Gaza Strip, almost half (46%) of the EML had less than a month's stock remaining at the time of monthly stock takes over the course of 2018. This represents an increase of 15% compared to 2017, when the figure was 31%. There have been longstanding shortages and depletion of essential medicines and medical disposables in the Gaza Strip, see Chart 2. Depletion of essential medicines and medical disposables has significant implications for the capacity of the public healthcare system to provide adequate services to the population. In Gaza, the long-term depletion of essential medicines and medical disposables has also been a major factor contributing to reliance on referrals outside the Ministry of Health.



46%

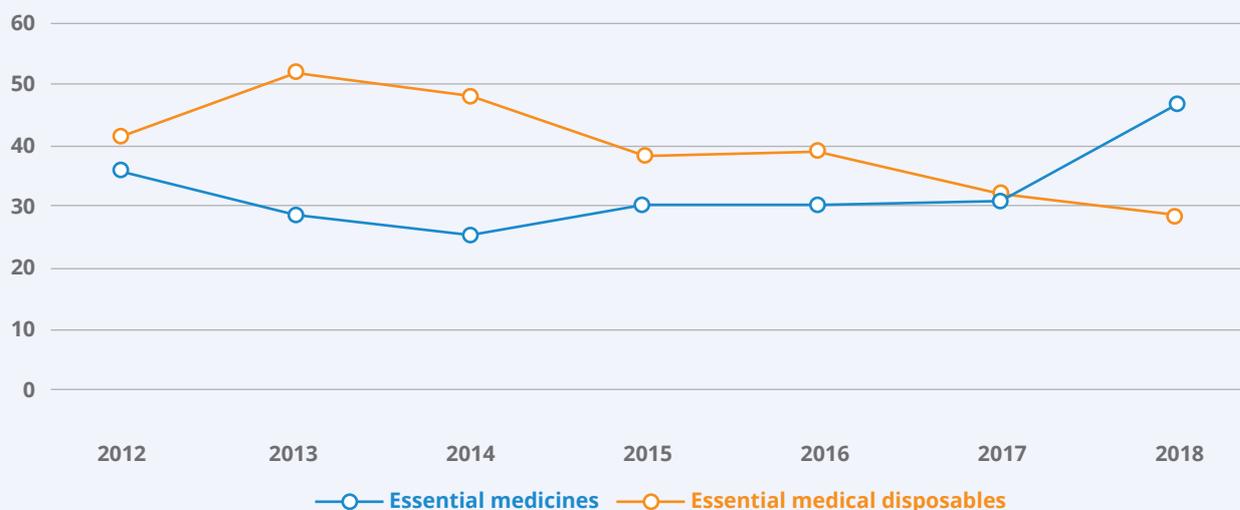
of essential medicines at less than a month's supply over 2018 in the Gaza Strip



53. OHCHR & WHO, 2008. The Right to Health: Fact Sheet No. 31, p25.

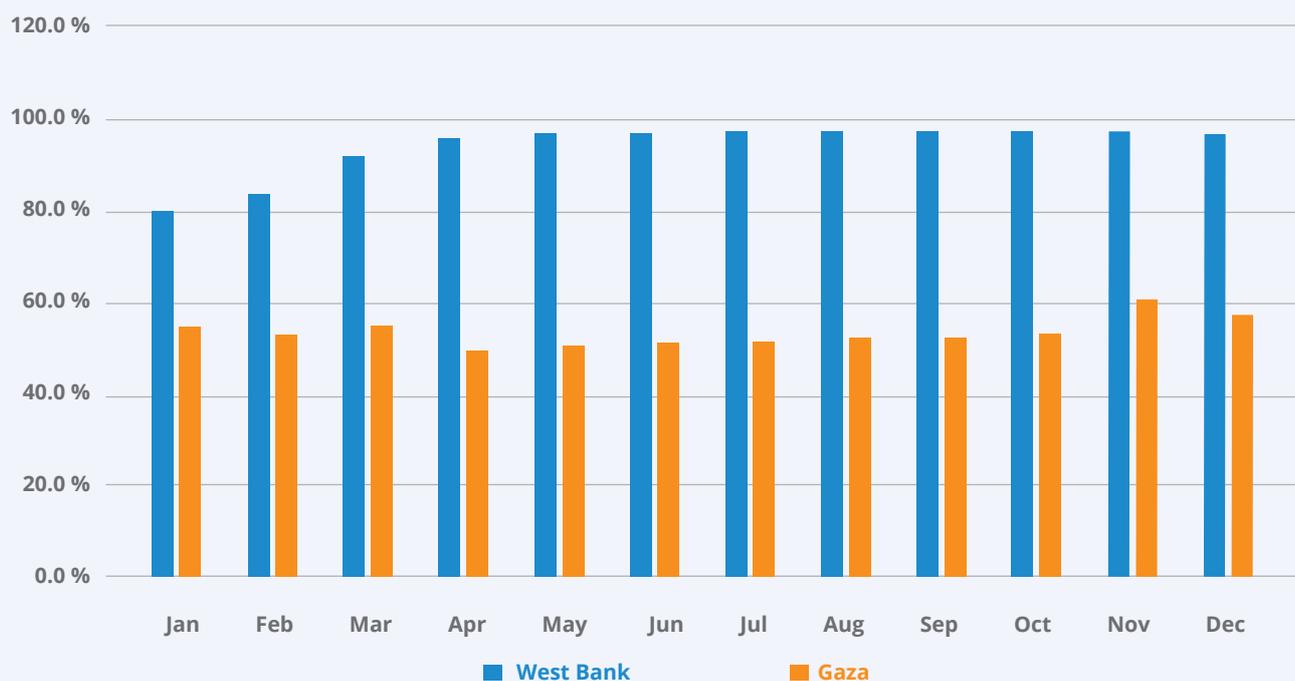
54. Palestinian Health Information Center of the Ministry of Health, 2019. Health Annual Report: Palestine 2018

Chart 2: Average percentage of essential drugs and medical disposables with less than a month's supply remaining at the time of monthly stock takes in Gaza, 2012 to 2018



Data on availability of essential medicines in the West Bank is published less frequently. According to annual data from the Palestinian Health Information Center, there was an average 95% availability of essential medicines at the Central Drugs Store of the Ministry of Health in the West Bank at the time of monthly stock takes.⁵⁵ The Central Drugs Store in the West Bank records absolute depletion of stocks at the time of monthly stock takes, as opposed to less than a month's supply remaining. Chart 3 shows the percentage of medicines depleted in the West Bank compared to the percentage with less than a month's supply in the Gaza Strip over the course of 2018.

Chart 3: Percentage of drug items available in the MoH central drug store, 2018



55. Palestinian Health Information Center of the Ministry of Health, 2019. Health Annual Report: Palestine 2018

Higher costs compared to international benchmark prices

A major barrier to the provision of essential medicines by the Palestinian Authority is the high cost of medicines relative to international benchmark prices, as a result of the effective customs union with Israel. In 2008, the World Bank reported that the cost of generic medicines procured in the occupied Palestinian territory was on average 6.9 times higher compared to international median price ratios (MPRs).⁵⁶ Similarly, in 2016, the World Bank found the Palestinian Ministry of Health was paying relatively higher prices for pharmaceuticals, where “import restrictions and large arrears owed to suppliers hamper its ability to negotiate better prices.” The report found that the unit price for rituximab for the Ministry of Health in 2014 was 3.4 times higher than international benchmark prices based on the WHO’s International Drug Price Indicator Guide.⁵⁷

In 2018, Israel took steps to apply restrictions to the country of origin of vaccinations imported by the Palestinian Authority, in accordance with the effective customs union. The financial consequences of this enforcement were potentially severe for the Palestinian Ministry of Health, jeopardizing the highly successful vaccination programme in the West Bank and Gaza Strip. A temporary solution was found in early 2019. Following further negotiations in 2019, a permanent solution was found and the issue has been resolved.

Ministry of Health referrals

The Palestinian Ministry of Health refers Palestinian patients to non-Ministry of Health facilities for specialist healthcare not available in the public system. The main destinations for these referrals overall are East Jerusalem (39%), the West Bank outside East Jerusalem (34%), Israel (17%) and the Gaza Strip (11%), see Table 2. Referrals to facilities outside the Ministry of Health are driven by lack of specific services and equipment within Ministry of Health facilities, such as radiotherapy or nuclear medicine scanning, as well as by the longstanding depletion of essential medicines in the Gaza Strip.⁵⁸ In 2018, the Palestinian Ministry of Health spent 592,005,962 NIS, 34% of its total expenditure excluding debt repayments, on purchasing health services from non-Ministry of Health facilities. There is an aim to transition to strategic purchasing of services to reduce inefficiencies in health financing.

56. The World Bank, 2008. Reforming Prudently Under Pressure: Health Financing Reform and the Rationalization of Public Sector Health Expenditures, p74. Available at:

<http://siteresources.worldbank.org/INTWESTBANKGAZA/Resources/WBGHealthPolicyReport.pdf>
(Accessed 26 July 2019)

57. The World Bank, 2016. West Bank and Gaza: Public Expenditure Review of the Palestinian Authority. Available at: <http://documents.worldbank.org/curated/en/320891473688227759/pdf/ACS18454-REVISED-FINAL-PER-SEPTEMBER-2016-FOR-PUBLIC-DISCLOSURE-PDF.pdf>

(Accessed 26 July 2019)

58. Lafi, M., Ammar, W., Vitullo, A., Al-Farah, N. & Daher, M., 2016. Reasons for medical referrals of Gaza patients, 2015. Unpublished (poster at the Lancet Palestine Health Alliance conference 2016)



109,816

referrals to non-Ministry
of Health facilities



30,546

Gaza



79,270

West Bank



54,671

patients referred to non-
Ministry of Health facilities



16,280

Gaza



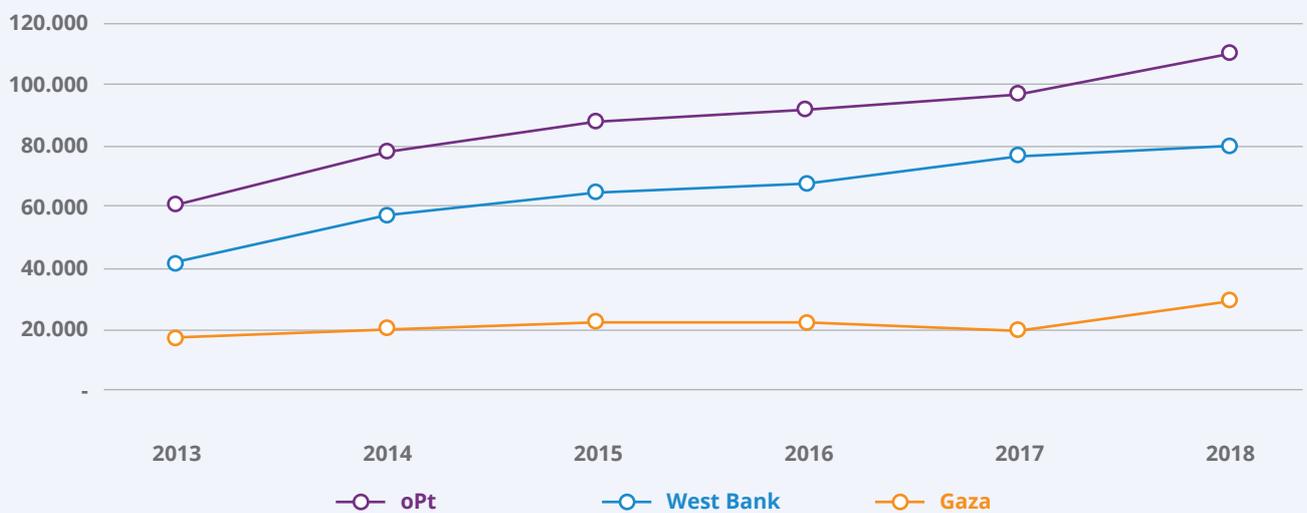
38,379

West Bank

Time trend analysis

The Services Purchasing Unit of the Ministry of Health issued 109,816 referrals to non-Ministry of Health facilities for 54,671 unique patients in 2018. The number of referrals issued increased by almost 15,000 referrals from 94,939 referrals in 2017 (see Chart 4), while the number of patients funded by the Ministry of Health to access non-Ministry of Health facilities increased by 2,684 from 51,987 in 2017. 30,546 referrals were issued for 16,280 patients from the Gaza Strip, while 79,270 referrals were issued for 38,379 patients from the West Bank, including East Jerusalem. Within the West Bank, 12,674 referrals were issued specifically for 6,125 patients from East Jerusalem.

Chart 4: Palestinian MoH referrals for the Gaza Strip, West Bank and overall, 2013 to 2018



The increase in referrals since 2017 was proportionately greater for the Gaza Strip compared to the West Bank (a 49% versus 6% increase respectively). However, the percentage increase in referrals for the Gaza Strip and West Bank was more similar using 2016 or earlier as the baseline. From 2016, there was a 24% increase in referrals from the Gaza Strip and an 18% increase from the West Bank, while from 2013 the percentage increases were 76% and 79% respectively.



Table 2: Ministry of Health referrals by region of origin, destination and permit requirement, 2014 to 2018

Destination	2014						2015						2016						2017						2018					
	West Bank		Gaza		All		West Bank		Gaza		All		West Bank		Gaza		All		West Bank		Gaza		All		West Bank		Gaza		All	
	No.	% of total	No.	% of total	No.	% of total	No.	% of total	No.	% of total	No.	% of total	No.	% of total	No.	% of total	No.	% of total	No.	% of total	No.	% of total	No.	% of total	No.	% of total	No.	% of total	No.	% of total
West Bank	23,703	44%	3,481	17%	27,184	36%	29,986	47%	5,753	24%	35,739	41%	28,944	43%	4,803	20%	33,747	37%	34,530	46%	3,013	15%	37,543	40%	34,669	44%	2,854	9%	37,523	34%
East Jerusalem	26,463	49%	7,410	36%	33,873	45%	27,149	43%	9,583	40%	36,732	42%	29,636	44%	10,584	43%	40,220	44%	27,772	37%	8,642	42%	36,414	38%	30,228	38%	12,148	40%	42,376	39%
Gaza	-	0%	3,288	16%	3,288	4%	-	0%	3,016	13%	3,016	3%	-	0%	2,993	12%	2,993	5%	-	0%	3,380	16%	3,380	6%	84	0%	6,841	22%	6,925	11%
oP total	50,166	92%	14,179	70%	64,345	86%	57,135	90%	18,352	77%	75,487	86%	58,580	87%	18,380	75%	76,960	84%	62,502	84%	15,035	73%	77,337	81%	64,981	82%	21,843	72%	86,824	79%
Egypt	21	0%	2,454	12%	2,475	3%	14	0%	1,744	7%	1,758	2%	9	0%	1,746	7%	1,755	2%	3	0%	1,313	6%	1,316	1%	45	0%	2,487	8%	2,532	2%
Jordan	72	0%	31	0%	103	0%	34	0%	38	0%	72	0%	24	0%	26	0%	50	0%	4	0%	8	0%	12	0%	11	0%	19	0%	30	0%
Israel	4,086	8%	3,674	18%	7,760	10%	6,462	10%	3,838	16%	10,300	12%	8,698	13%	4,464	18%	13,162	14%	12,121	16%	4,148	20%	16,269	17%	14,219	18%	4,663	15%	18,882	17%
Turkey	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	4	-	1	-	-	-	2	-	-	-	-	-
Elsewhere total	4,179	8%	6,159	30%	10,338	14%	6,510	10%	5,620	23%	12,130	14%	8,731	13%	6,236	25%	14,967	16%	12,132	16%	5,470	27%	17,602	19%	14,277	18%	7,169	23%	21,446	20%
Not reported	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Grand Total	54,345	73%	20,338	27%	74,683		63,645	73%	23,972	27%	87,617		67,311	73%	24,616	27%	91,927		74,434	78%	20,505	22%	94,939		79,270	72%	30,546	28%	109,816	100%
Israeli permit required to access health care	30,642		14,596		45,238		33,659		19,212		52,871		38,367		19,877		58,244		39,900		15,811		55,711		44,503		19,684		64,187	
Egyptian approval required to exit Gaza via Rafah border	-		2,454		2,454		-		1,744		1,744		1,746		1,746		1,746		-		1,313		1,313		-		2,487		2,487	
Total permits	-		47,692		47,692		54,615		54,615		54,615		59,990		59,990		59,990		57,024		57,024		57,024		57,024		66,674		66,674	

Distribution of referrals by geographical area

Approximately 60% of the population in the occupied Palestinian territory resides in the West Bank, including East Jerusalem. Referrals from the West Bank, including East Jerusalem, accounted for 72% of total referrals. Meanwhile, patients referred from the West Bank accounted for 70% of all Palestinian patients referred to non-Ministry of Health facilities for healthcare. Severe restrictions on access out of Gaza, with a substantially lower approval rate for patient permit applications (61% approval rate for patient permit applications in Gaza compared to 82% approval rate for patient and companion applications in the West Bank, see Chapters 4 and 5) are likely a significant factor contributing to this discrepancy.



Gender distribution of referrals

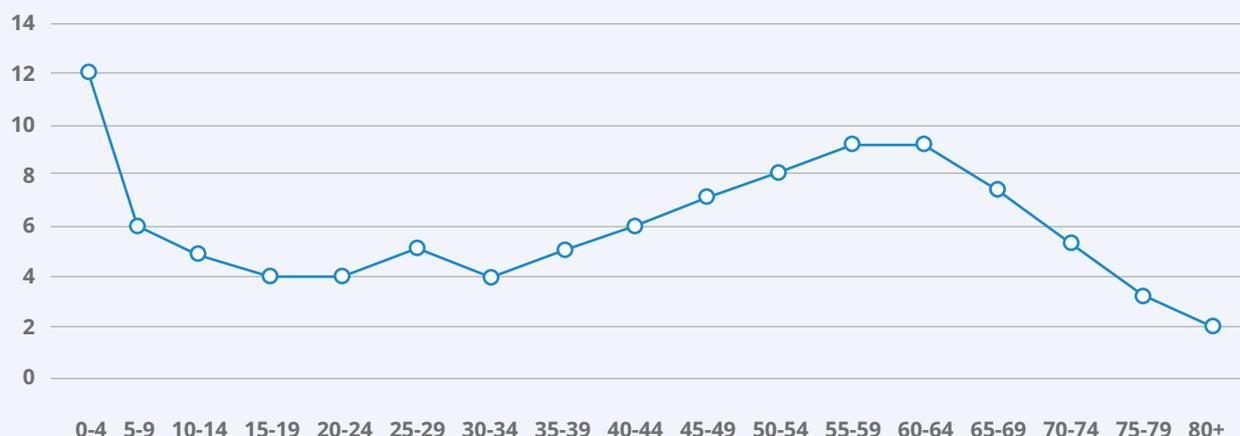
In 2018, 53% of West Bank referrals and 57% of Gaza referrals were for male patients. This does not represent a significant change in gender distribution from 2017, when 52% of referrals from the West Bank and 56% from the Gaza Strip were for male patients. Female and male patients have overlapping but distinct healthcare needs, and discrepancies in availability of specific services within the public healthcare system affects the overall gender distribution of referrals outside it. The gender distribution of referrals differs for different specialties. For instance, the proportion of permit applications for male patients was 76% for vascular surgery, 75% for paediatric surgery and 74% for urology. On the other hand, a higher proportion of permit applications were for female patients for plastic surgery (66%), oncology (58%) and nuclear medicine (55%).

Age distribution of referrals

Chart 5 shows the age distribution of referrals from the Palestinian Ministry of Health to non-Ministry of Health facilities in 2018. There continue to be two peaks in the age groups most frequently referred. Children under 5 years represent 12% of referrals, with 27% of referrals for persons under 20 years. Adults from 55 to 64 years form the second peak, together comprising approximately 18% of referrals.



Chart 5: Age distribution of referrals to non-MoH facilities, 2018



Destination of referrals

A fifth (20%) of referrals in 2018 were to facilities outside the occupied Palestinian territory, principally to Israeli (17%) and Egyptian (3%) hospitals, with a small number of referrals to Jordan (30) and Turkey (2). Israeli referrals alone accounted for 30% of total costs spent on purchasing services from non-Ministry of Health providers.

Hospitals in the West Bank, including East Jerusalem, accounted for almost three-quarters (73%) of referrals and 65% of costs. 11% of referrals were to non-Ministry of Health facilities inside Gaza (all referrals from within Gaza) and 2% of referrals were to hospitals in Egypt (98% of these referrals from Gaza).

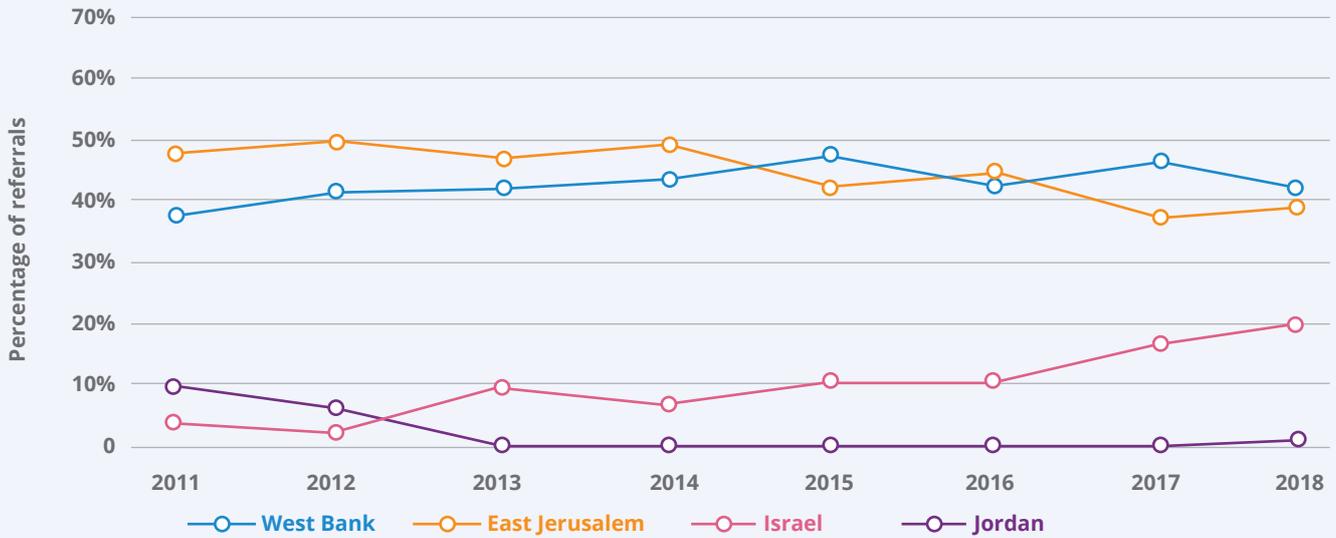
In the West Bank, referrals to West Bank hospitals outside East Jerusalem accounted for the single largest proportion of referral destinations in 2018 (44%), followed by referrals to Palestinian hospitals in East Jerusalem (38%), Israeli hospitals (18%) and hospitals in Jordan (1%). A growing proportion of West Bank referrals have been to Israeli hospitals, increasing from 4% of all referrals in 2011. Referrals within the West Bank also increased slightly during this period, from 38% in 2011, while referrals to East Jerusalem hospitals declined slightly from 48% of West Bank referrals in 2011 and 50% in 2012. From 2011 to 2013 there was a substantial decline in referrals to Jordan, from 10% to less than 0.5%. This low proportion referred to Jordan has persisted since 2013, see Chart 6.



73%

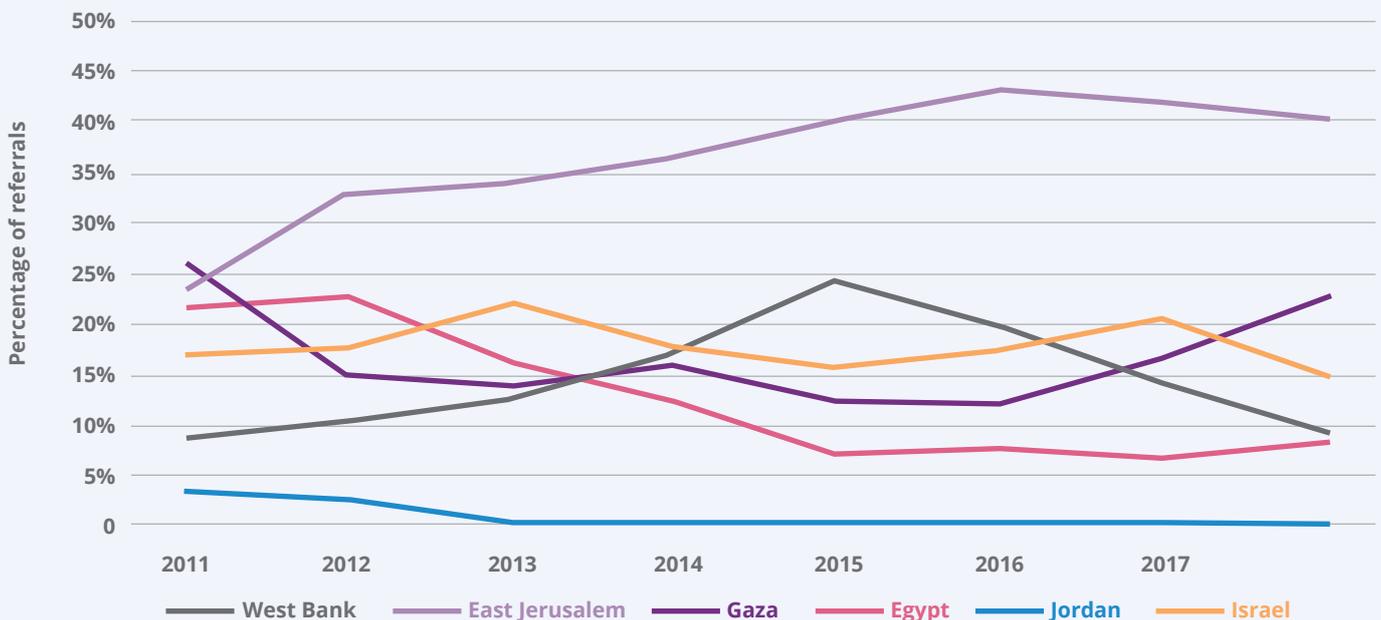
of referrals were to hospitals in the West Bank including East Jerusalem

Chart 6: Destination of MoH referrals for West Bank patients, 2011 to 2018



In the Gaza Strip, referrals to East Jerusalem hospitals accounted for the single largest proportion of referral destinations in 2018 (40%). This was followed by referrals within Gaza (22%), referrals to Israeli hospitals (15%), referrals to the West Bank (9%) and referrals to Egypt (8%). Overall, the proportion of referrals to East Jerusalem hospitals increased from 23% of Gaza referrals in 2011. The proportion of referrals within Gaza declined from 26% in 2011 to a low of 12% in 2016, before increasing again to 22% in 2018. The proportion of referrals to Israeli hospitals has been relatively stable, between 15% in 2018 and 22% in 2013. Gaza referrals to West Bank hospitals increased between 2011 and 2015, from 9% to 24%, before declining again to 9% in 2018. Referrals to Egypt declined during this period, from 22% in 2011, while referrals to Jordan dropped from 2011 (3%) to 2011 (0%) and have remained at 0% since – see Chart 7.

Chart 7: Destination of MoH referrals for Gaza patients, 2011 to 2018



In-patient versus out-patient referrals

Overall, 74,608 referrals (68% of the total) were for in-patients, while 32,621 (30% of the total) were for out-patient clinic visits. The remainder of referrals were for day care, laboratory tests or radiology, or were unclassified. In the Gaza Strip, there was a higher proportion of in-patient referrals compared to the West Bank: 86% of Gaza referrals were for in-patients compared to 61% of West Bank referrals. Conversely, 36% of West Bank referrals were for out-patient clinic visits (with 2% day care cases), while only 13% of Gaza referrals were for out-patient clinic visits.

Medical reasons for referral

Cancer care continues to be the single largest reason for purchasing of services by the Palestinian Ministry of Health in 2018, comprising 23% of all referrals (24% of West Bank referrals; 22% of Gaza referrals). Other major specialties include: urology and nephrology (8% oPt, 10% WB, 5% GS), cardiology (8% oPt, 10% WB, 5% GS), haematology (8% oPt, 6% WB, 10% GS), gastroenterology and general surgery (7% oPt, 6% WB, 7% GS), paediatrics (6% oPt, 6% WB, 7% GS) and ophthalmology (6% oPt, 6% WB, 5% GS). Cardiac catheterization (8% GS) and orthopaedics (8% GS) accounted for a significantly larger proportion of referrals in the Gaza Strip compared to West Bank referrals (3% and 2% of West Bank referrals, respectively). See Chart 8 for further details.

The top three medical reasons for referral



24%

oncology



9%

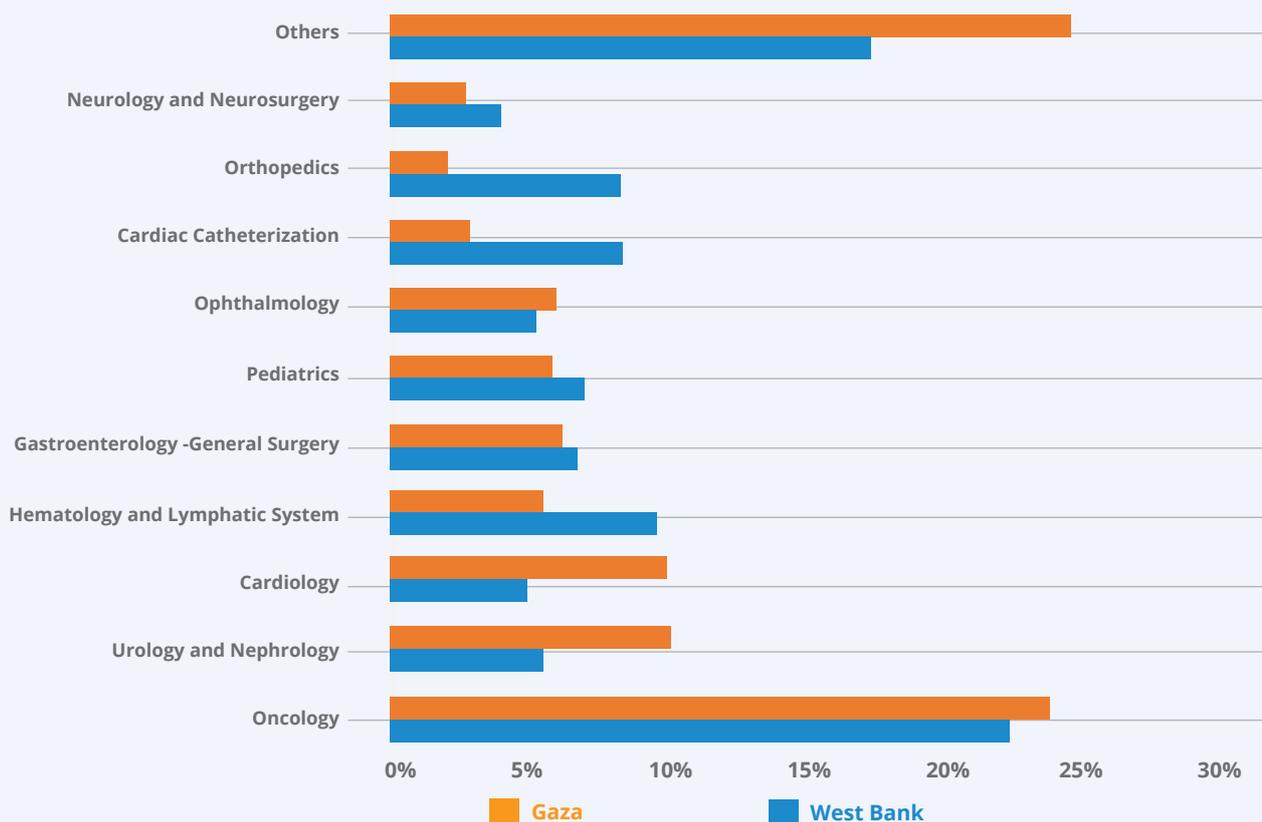
cardiology



9%

urology and nephrology

Chart 8: Distribution of referrals to non-Ministry of Health facilities for the oPt in 2018, by specialty







Access: Barriers to health access in Gaza

Palestinians living in the Gaza Strip have faced severe restrictions in movement in and out since the start of blockade by land, sea and air in 2007. Exit from Gaza is possible only via two crossings: through Beit Hanoun/Erez checkpoint to the north and Rafah border crossing to Egypt in the south. In 2018, 70% of Gaza referrals needed access via Beit Hanoun/Erez – to Palestinian hospitals in the West Bank, including East Jerusalem, and Israeli hospitals. All these patients required Israeli-issued permits to cross in order to access healthcare. The approval rate of 61% for patient applications in 2018 represents the second lowest recorded by WHO.

In 2018, Israel continued its requirement for the submission of non-urgent patient permit applications 23 working days in advance of any hospital appointment, increased from 10 working days in 2017. Given that ‘non-urgent’ applications include time-dependent referrals, including for cancer investigation and treatment, enforcement of this policy has significant implications for quality of care and patient outcomes. WHO carried out survival analysis for cancer patients referred for chemotherapy and/or radiotherapy from 2008 to 2017, following patients up for a minimum of six months. The study found that patients initially delayed or denied permits from 2015 to 2017 were nearly 1.5 (1.45) times less likely to survive. The findings demonstrate the critical importance of timely access to treatment for cancer patients.



70%

of Gaza referrals require Israeli-issued permits to access care



61%

of patient permit applications to exit Gaza approved



48%

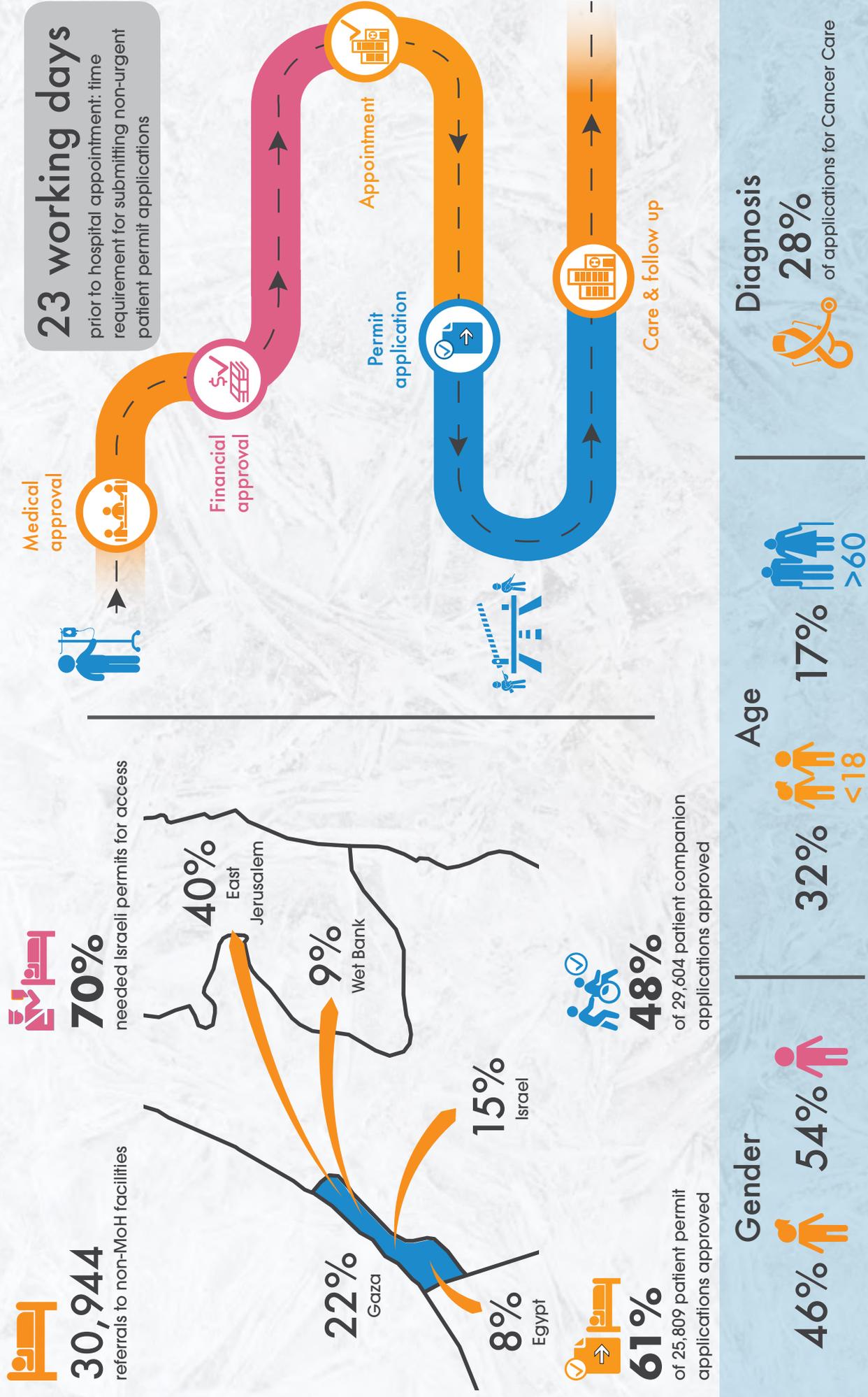
of patient companion permit applications to exit Gaza approved



8%

of Gaza referrals to Egypt requiring access through Rafah crossing

Figure 2: Gaza health access, 2018



Patients applying for permits to exit Gaza for healthcare face a complex bureaucratic process with lengthy and non-transparent procedures, creating uncertainty and anxiety. If granted permits, patients and their families must manage financial burdens such as costs of travel and costs of accommodation for companions. There is no true limit on the processing time by authorities, with patients waiting or engaged in the process for months. In November 2015, Israel put new directives in place for Gaza requiring male patient companions aged 16 to 55 years and female patient companions aged 16 to 45 years to undergo more intensive security investigation to be eligible to receive permits. Previously this requirement had only been applied to those under the age of 35 years. All patients may be called for security interrogation as a prerequisite to permit processing.

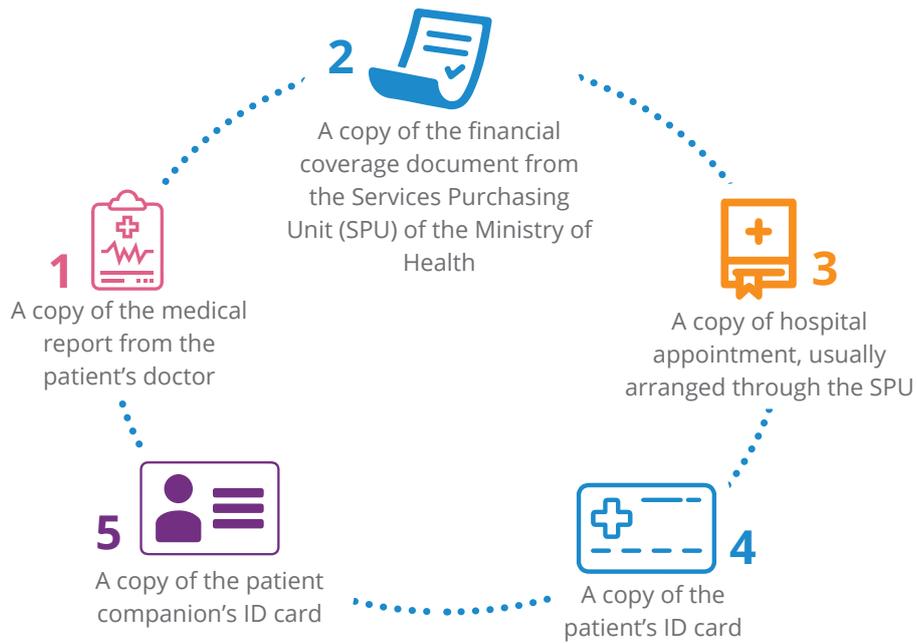
This chapter also examines barriers to access for patients through Rafah crossing to Egypt. During 2018, 8% of referrals from the Gaza Strip were to Egypt. The process for exit through Rafah is confusing and obscure, while the journey across the Sinai is long, arduous with many checkpoints, and complicated by a night curfew imposed by Egyptian authorities.

Entry of humanitarian supplies is restricted by Israel's dual use list. Permitted supplies enter the Gaza Strip via Karam Abu Salem/Kerem Shalom crossing to Israel in the south and Salah ad-Din crossing to Egypt. In 2018, Karam Abu Salem/Kerem Shalom crossing was open for the entry of humanitarian supplies, including medical supplies, on 238 days and there were seven truckloads of medicines allowed to enter Gaza through Salah ad-Din gate for the private sector from July to December 2018. Salah ad Din gate was not open for the entry of supplies in the first half of 2018. There are also prolonged waiting times to obtain approvals for the delivery of complex medical equipment and spare parts, and of devices needed for treatment and rehabilitation, including prosthetic limbs.

Patient permits

The permit application process and opening of Beit Hanoun/Erez crossing

Patients requiring Israeli-issued permits to reach health facilities outside the Gaza Strip must navigate a complex and lengthy bureaucratic process, outlined in Figure 2 on page 36. Once the patient's doctor identifies the need for referral, the patient must seek medical and financial approval for the referral from the Services Purchasing Unit (SPU) of the Ministry of Health. The SPU requests an appointment date from health facilities offering the required medical intervention. Following this, the patient must apply to Israeli authorities through the Palestinian Coordination and Liaison Office in the Gaza Strip. Israeli authorities require permit applications to be submitted a minimum of 23 working days prior to the patient's hospital appointment. The patient's application is then approved, denied or delayed; the latter meaning that patients receive no definitive response to their application by the date of their hospital appointment. Patients can remain engaged in this process for months on end without any definitive response to their applications. To apply for a permit, patients must provide:



Over the course of 2018, Beit Hanoun/Erez crossing was open for those with Israeli permits to cross on 306 of 365 days. The crossing was closed on 59 days (52 Saturdays, five Jewish holidays and two days of closure after a military escalation on 17 and 18 October).

Total number of patients and patient applications

In 2018, there were 25,811 permit applications to Israeli authorities through the Palestinian Health Liaison Office for 9,644 patients. Over the last 11 years, there has been an increase in number of patients applying for permit to exit, and proportionally greater increase in the number of applications, see Chart 9.



25,811

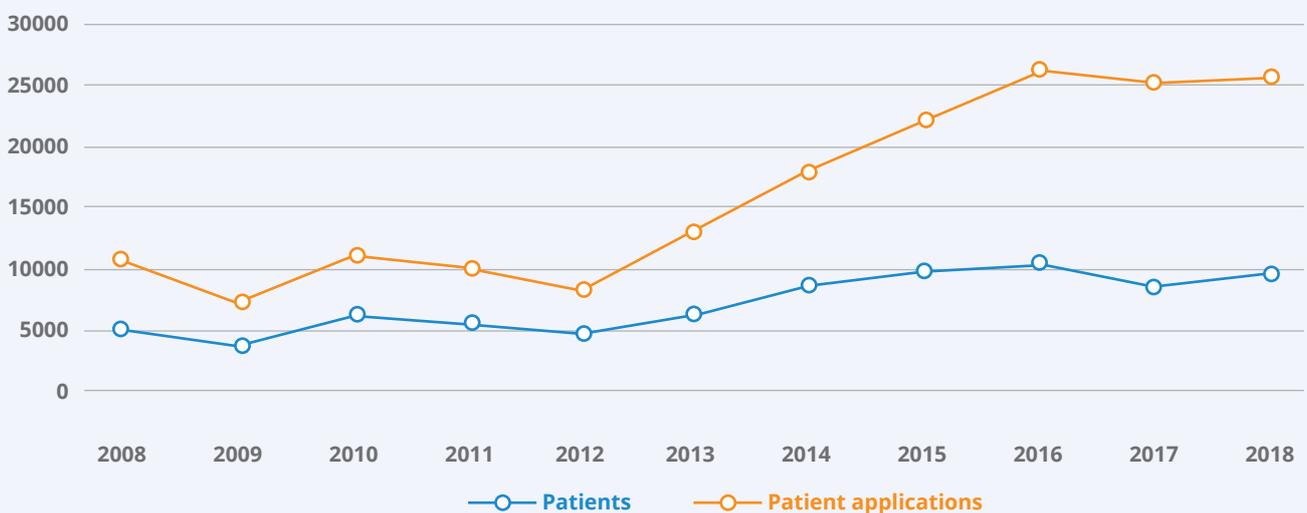
patient permit applications to exit Gaza via Beit Hanoun/Erez



9,644

patients applied for permits

Chart 9: Patients applying for Israeli permits to exit Gaza and number of patients applications, 2008 to 2018

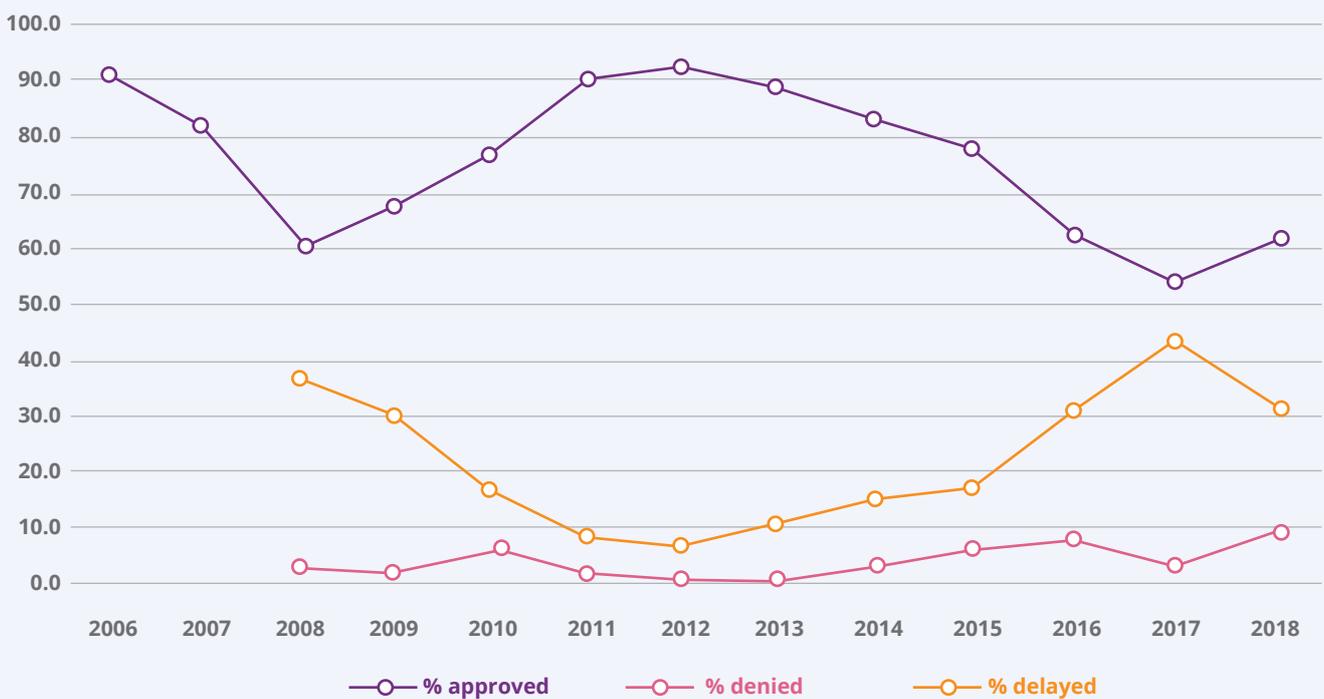


From 2008 to 2018, there was an 86% increase in number of patients making applications, from 5,183 to 9,644 patients. In the same period, there was a 151% increase in patient applications, from 10,299 to 25,811. From 2008 to 2012, the number of patients and applications remained relatively constant, except for a marked reduction in 2009. 2012 to 2016 was the longest sustained increase in patients and applications: the former almost doubled from 5,232 to 10,229, while the latter saw an almost threefold increase from 9,191 to 26,269. From 2016 to 2018, there was a decline in patients applying and number of applications made, with a 6% reduction in patients applying (from 10,229 in 2016 to 9,644 in 2018) and a 2% reduction in number of applications made (reducing from 26,269 in 2016 to 25,811 in 2018).

Rates of approval, delay or denial of permit applications

In 2018, patients applying to exit Gaza for healthcare had the second lowest approval rate recorded by WHO since 2006, with 15,834 (61.4%) of 25,811 patient permit applications approved. This approval rate represents an increase from 54.2% approved in 2017, but a decline from 92.5% in 2012, see Chart 10. 2018 represents the highest denial rate recorded since WHO records began disaggregation in 2008, with 1,962 patient applications, or 7.6% of the total, denied. The reason for unsuccessful application is not stated in 70% of denials. The lowest denial rate recorded was 0% in 2013. Delays of patient permit applications continue to represent the largest reason for non-approval, with 8,017 or 31.0% of patients receiving no definitive response to their permit applications before the time of their hospital appointment. The proportion of patient applications delayed reached a low of 7% in 2012 and peaked in 2017, when 43% of patient applications were delayed.

Chart 10: Israeli responses to Gaza patient permit applications, 2006 to 2018



Number of applications per patient

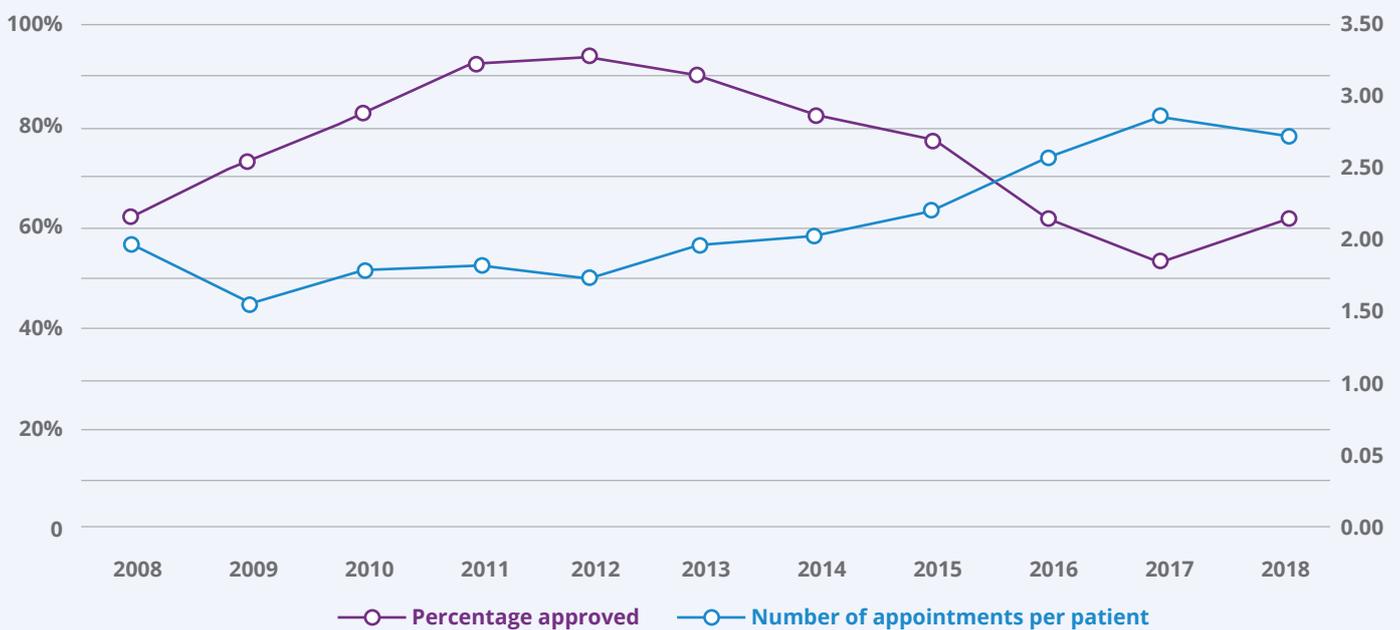
After a reduction of almost a fifth (19%) from 2.0 applications per patient in 2008 to 1.6 applications per patient in 2009, the number of applications per patient increased every year from 2012 to a peak of 2.87 applications per patient in 2017 (an increase of 45% from the 2008 baseline). In 2018, the proportion declined slightly to 2.67. Chart 11 shows the relationship between number of applications per patient and the approval rate for patient permit applications, from 2008 to 2018.



2.67

permit applications per patient

Chart 11: Applications per patient compared to trend in acceptance rate, 2008 to 2018



Destination of permit applications

More than three-quarters (78%) of patient applications to exit Gaza through Beit Hanoun/Erez crossing were for appointments at Palestinian hospitals in East Jerusalem (59%) or the remainder of the West Bank (18%). Just under a quarter of applications (22%) were for appointments at Israeli hospitals.

The top six hospital destinations accounted for three-quarters (75%) of patient permit applications. The top two destinations were Makassed Hospital (28%) and Augusta Victoria Hospital (24%) in East Jerusalem. Augusta Victoria Hospital is the main referral centre for cancer patients in the occupied Palestinian territory. The other top hospital destinations were: Hadassah Ein Kerem (Ain Karem) Hospital in Israel (7%); An-Najah University Hospital in the West Bank (6%); Tel Hashomer Hospital in Israel (6%); and St. John’s Eye Hospital in East Jerusalem (4%).



The top two referral destinations for Gaza patients



28%

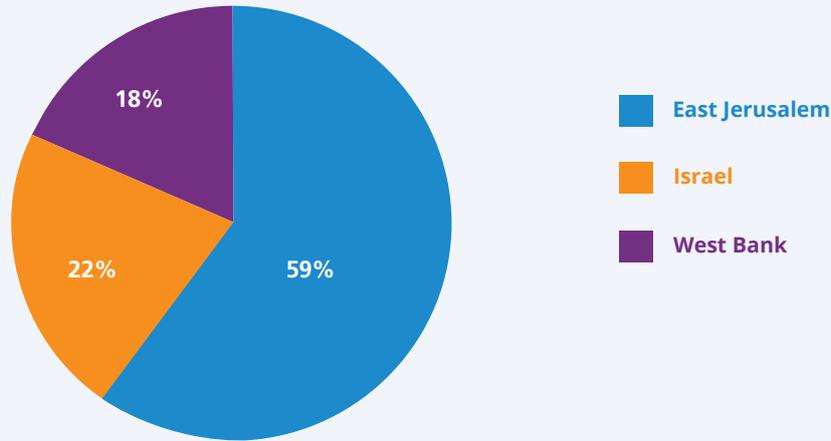
Makassed Hospital



24%

Augusta Victoria Hospital

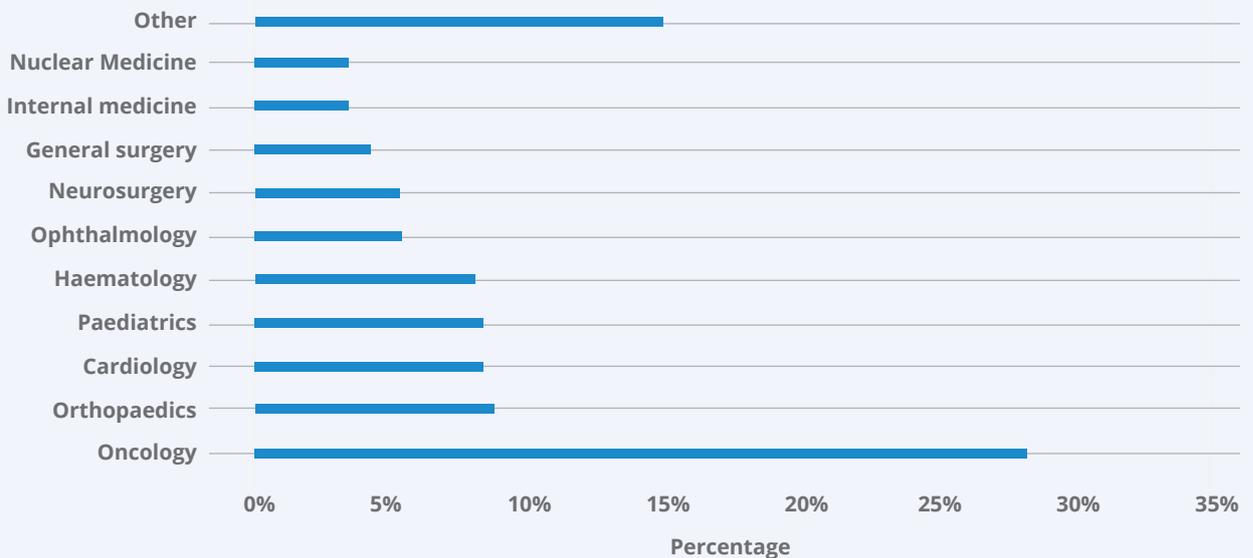
Chart 12: Destination by geographical area, 2018



Permit applications by medical specialty

Oncology – i.e. cancer treatment and diagnosis – was the single largest medical specialty for patients requiring permits to exit Gaza in 2018, accounting for more than a quarter (28%) of Gaza patient applications. Other major specialties included orthopaedics (9%), cardiology (8%), paediatrics (8%), haematology (8%), ophthalmology (5%), neurosurgery (5%), general surgery (4%), internal medicine (4%), nuclear medicine (4%) and 15% for 25 other specialities.

Chart 13: Distribution of permit applications by medical specialty, 2018



The highest approval rates by specialty were for thoracic surgery (93%), intensive care (91%), paediatric surgery (78%), paediatrics (77%), oncology (76%), and haematology (72%).

The lowest approval rates, for specialties with more than 50 applications, were for orthopaedics (35%), urology (42%), general surgery (44%), neurosurgery (44%), ENT (46%), ophthalmology (47%), internal medicine (48%), dermatology (48%), and maxillofacial surgery (49%). Age and gender differences between specialties are likely to be significant factors influencing the different rates of approval by specialty, with higher rates in women, as well as children and the elderly.

Age and gender

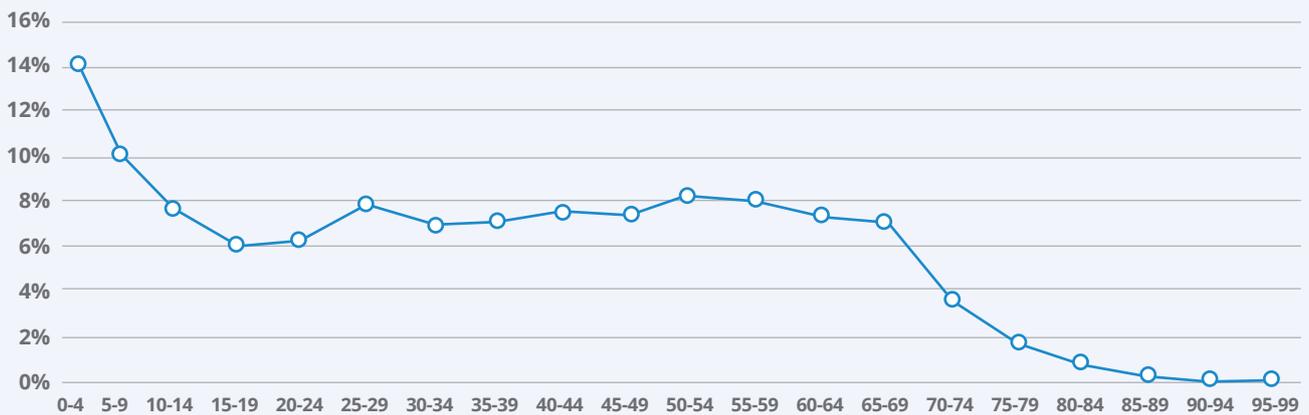
Chart 14 shows the age distribution for patients applying for permits to exit Gaza for healthcare in 2018. 3,046 or a third (32%) of patients applying were under the age of 18 years. Children under 5 years accounted for 12% of patients applying, children under 10 years accounted for more than a fifth (21%) of patients. Over half (57%) of patients applying were aged 20 to 64 years, with just over one in ten (11%) aged 65 years or older.



12%

of applicants aged under 5 years

Chart 14: Age distribution of patient permit applicants, 2018



46% of patient permit applications from Gaza were for female patients in 2018. All Gaza male patients aged 16 to 55 years and female patients aged 16 to 45 years must undergo additional security clearance procedures when applying for permits to exit through Beit Hanoun/Erez for healthcare. This can mean additional delays for these groups of patients. In addition, younger adult patients and men have overall lower approval rates for permits, see Chart 15.

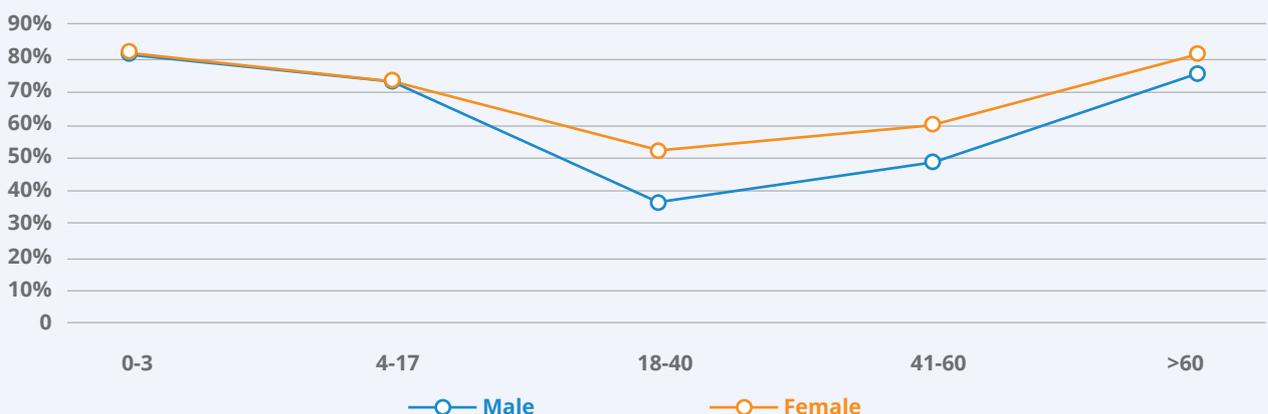


46%

of applications to exit Gaza via Erez crossing were for female patients

In 2018, men aged 18 to 40 years had the lowest approval rate of any demographic, with just over a third (35%) of applications approved for this group. Men aged 41 to 60 years (approval rate 48%), women aged 18 to 40 years (52%) and women aged 41 to 60 years (60%) were the groups with rates of approval below the overall approval rate. Children aged 0 to 3 years (M 81%; F 82%) and women over 60 years (81%) had the highest approval rates. Children aged 4 to 17 (M 73%; F 73%) and men over 60 years (75%) also had approval rates that were above the overall approval rate.

Chart 15: Approval rate for Gaza patient permit applications by age and gender, 2018



Access for those injured during demonstrations of the Great March of Return

In 2018, there were 435 applications to Israeli authorities to exit Gaza via Erez/Beit Hanoun crossing by those injured during the Great March of Return demonstrations since 30 March. The approval rate for these patients was much lower than the overall approval rate. Of the 435 applications, 82 (19%) were approved, 130 (30%) were denied and 223 (51%) were delayed.



435

applications to exit Gaza via Erez crossing by those injured during the GMR



19%

of GMR patient permit applications to exit Gaza approved

Impact of delay and denial of permits on survival of cancer patients

In 2018-19, WHO carried out research on the impact of denial and delay of permit applications on patient survival, in collaboration with a researcher from the University of Eastern Piedmont and two independent researchers. The team matched ten years of data on patient permit applications, comprising 153,037 applications for 44,812 patients from 2008 to 2017, with data on mortality from Gaza's death registry. To examine the impact of delay or denial on patient survival, the team looked specifically at cancer patients referred for chemotherapy and/or radiotherapy – where barriers to access would be expected to have an impact on survival. During the period, there were 3,816 cancer patients referred for chemotherapy and/or radiotherapy, who made 17,072 permit applications to exit the Gaza Strip. The study split these patients into two groups: those approved Israeli permits following their first application to exit Gaza to access chemotherapy and/or radiotherapy and those initially delayed or denied Israeli permits to access healthcare. The study period was split to examine the impact of denial or delay of permits from 2008 to 2014, when alternative access to healthcare (including to Egypt through Rafah) was relatively easier, and from 2015 to 2017, when alternative access to healthcare was more restricted. **The study found that cancer patients applying for chemotherapy and/or radiotherapy who were initially delayed or denied permits to exit Gaza from 2015 to 2017 were almost 1.5 times (1.45 times) less likely to survive in subsequent years.** There was no significant difference in survival between the two groups from 2008 to 2014, when alternative access to care may have been relatively greater. The findings of the study underline the critical importance of timely access for cancer patients to lifesaving chemotherapy and radiotherapy treatments.

Patient companion permits

Israeli authorities permit one patient relative to accompany Gaza patients to health facilities outside the Gaza Strip. The application is made along with the patient application, as detailed on page 38.

Total number of applications

In 2019, there were 29,605 companion applications, compared to 25,811 patient permit applications. Gaza patients are only permitted one companion to accompany them out of Gaza, but patients may be asked to reapply for a different companion if the first is not successful. The ratio of companion to patient permit applications has increased over the last three years, rising from between 1.02 and 1.06 during the period 2012-2015 to 1.15 in 2018. Increased processing time for applications and a proportionately greater reduction in approval rates are likely to have contributed to larger increase in companion applications compared to those for patients, see Chart 16.

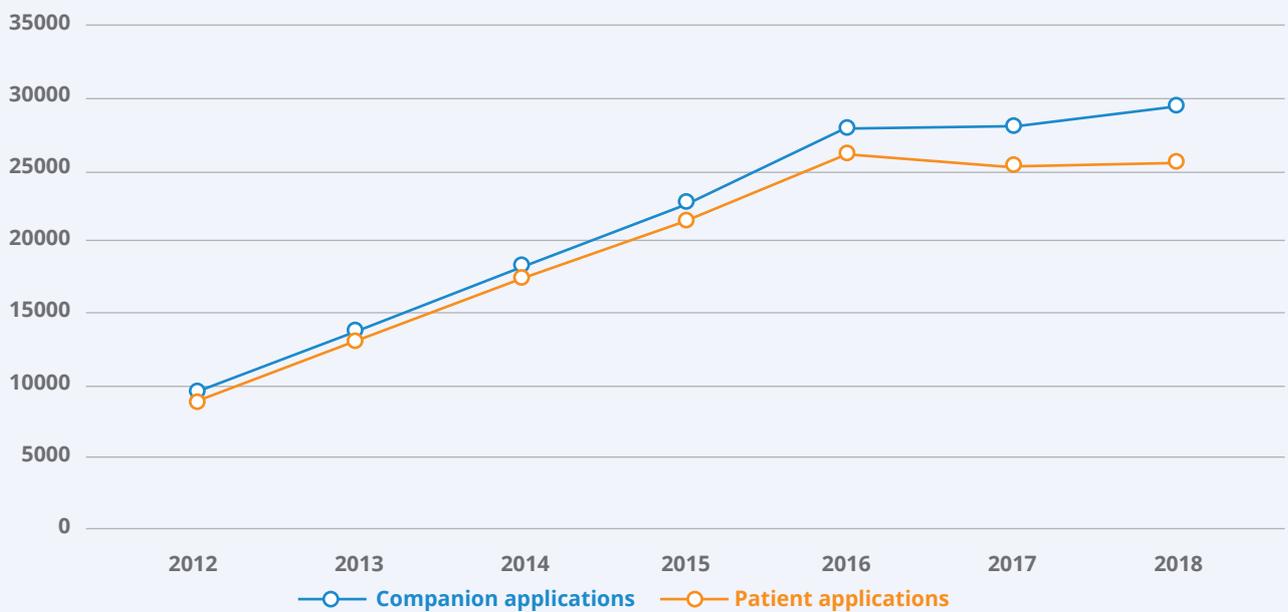


29,605
patient companion applications to exit Gaza



47.5%
of patient companion permit applications approved to exit Gaza via Erez Crossing

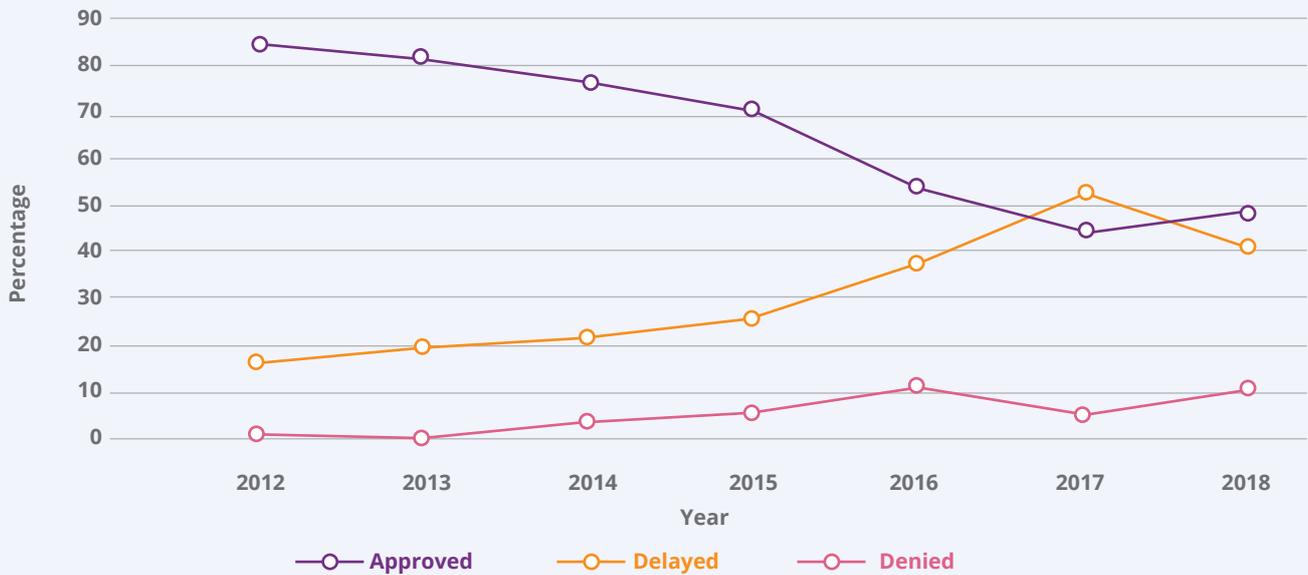
Chart 16: Number of Gaza companion permit applications compared to patient applications, 2012 to 2018



Rates of approval, delay or denial of companion applications

Patient companions have an overall lower approval rate than patients, and there has also been a proportionately greater decline in the approval rate for companions compared to patients, from 2012 to 2018. In 2018, 14,067 out of 29,605 companion permit applications, or less than half (47.5%), were approved. This approval rate represents 57% of the approval rate of 83% in 2012. By comparison, the patient approval rate of 61% in 2018 is 66% of the 2012 patient approval rate of 92.5%, taking this as a baseline. In 2018, 12,445, or 42%, of companion permit applications were delayed, while 3,093 or 10% were denied. The companion permit approval rate declined successively year on year from 83% in 2012 to 44% in 2017. The 2018 approval rate is the second lowest on record and the second year that less than half of applications to exit have been successful.

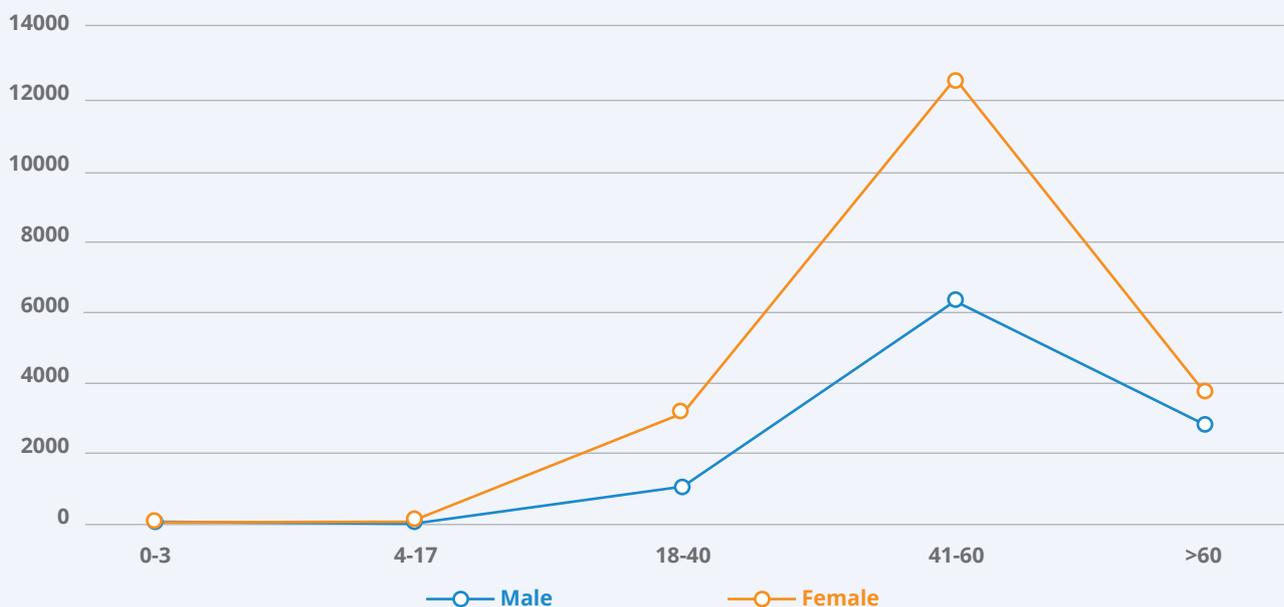
Chart 17: Israeli responses to Gaza patient companion permit applications, 2012 to 2018



Age and gender of patient companions

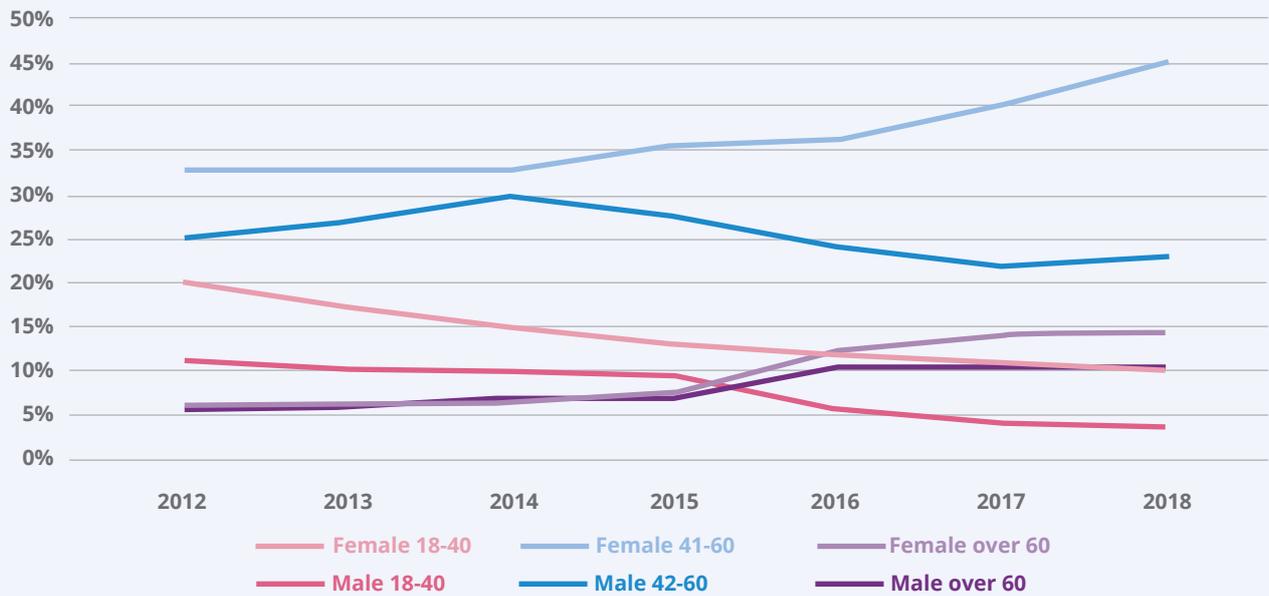
Women accounted for nearly two-thirds (65%) of patient companion applications in 2018. The gender distribution of companion applications varied significantly across different age groups. Female applications comprised 73% of applications for companions aged 18 to 40 years; 66% for those aged 41 to 60 years; and 58% for those aged over 60. More than three-fifths (63%) of patient companion applications were for companions aged 41 to 60 years old. Almost a quarter (23%) of applications were for companions aged over 60 years, while 14% were for companions aged 18 to 40 years.

Chart 18: Age and gender distribution of Gaza patient companion applications, 2018



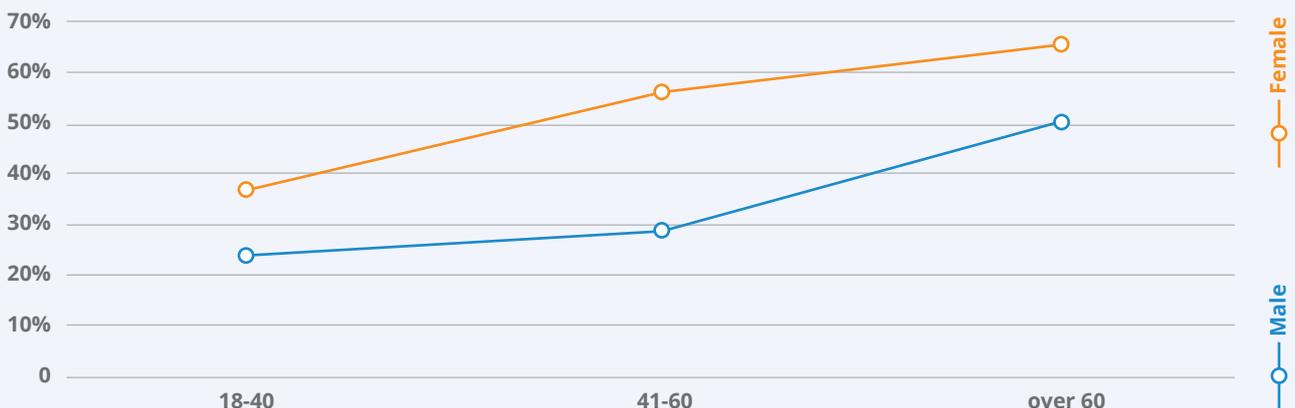
2018 continued the shift towards older, female companions. This reflects the greater barriers to access for younger patient companions and male patient companions. Chart 19 shows that in 2018, the proportion of older, female companions continued to increase, with over a half (57%) of patient companion applications for women over 40 years of age. 14% of applications were for women over 60 years. Since 2012, there has been an increase in the proportion of applications for women over 40 (39% of applications in 2012) and men over 60 (from 6% in 2012 to 10% in 2018). Meanwhile, the proportion of applications for women aged 18 to 40 years, men aged 18 to 40 years and men aged 41 to 60 years has declined (from 2012 to 2017 from 19% to 11%; 11% to 4%; and 25% to 22% respectively).

Chart 19: Change in the age and gender distribution of Gaza patient companions permits, 2012 to 2018



Men applying to accompany patients had a substantially lower approval rate compared to women: 35% compared to 54% respectively. Men aged 18 to 40 years of age had the lowest approval rate, with just under a quarter (24%) of applications approved. Men aged 41 to 60 also had a substantially lower approval rate than those aged over 60 years: 29% versus 51% respectively. Women aged 18 to 40 years had a significantly lower approval rate compared to older women, with 36% in this group approved compared to 56% in women aged 41 to 60 and 65% in women over 60.

Chart 20: Approval rates for Gaza patient companion permit applications over by age and gender, 2018

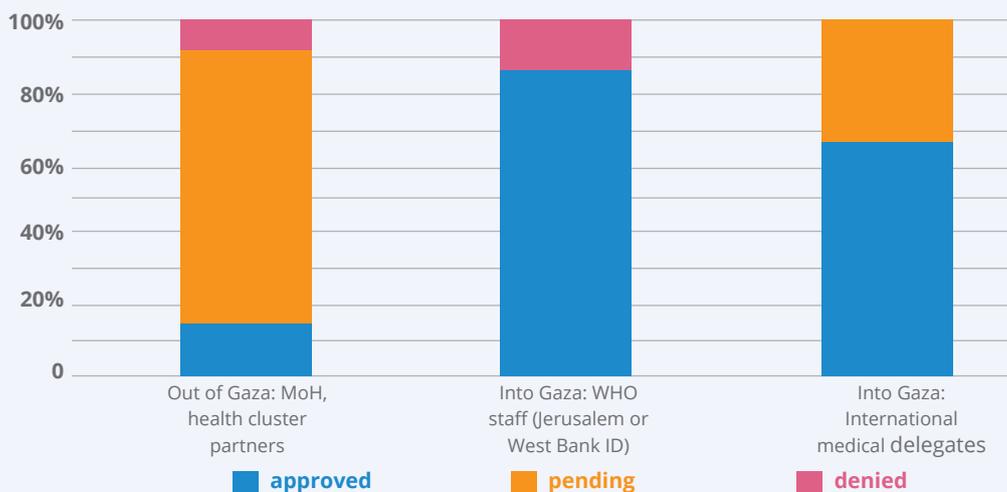


Health staff permits

Humanitarian workers are exempted from the general travel ban on Palestinians to exit the Gaza Strip through Beit Hanoun/Erez crossing, which allows them to apply for permits to exit for professional reasons. According to data from the Palestinian Ministry of Civil Affairs, there were 2,776 permit applications for health and non-health staff to attend conferences, training courses and workshops. Of these applications, only 63 (2%) were approved, while 836 (30%) were denied and 1,877 (68%) remained pending.

Data collected on humanitarian health staff applications by WHO also demonstrates that the majority of permit applications to exit for humanitarian health staff are unsuccessful, with 11 out of 74 applications (15% of the total) made through WHO for Gaza health partners approved in 2018 – see Chart 21. The approval rate for permit applications for entry of humanitarian health staff was higher in comparison, with 21 out of 27 (78%) applications approved. The approval rate was greater for WHO staff holding East Jerusalem or West Bank identity cards (87%) compared to international medical delegates (67%).

Chart 21: Outcomes of permit applications for humanitarian health staff applying through WHO, 2018



Access through Rafah

Patients are one category of persons in the Gaza Strip permitted to apply to cross Rafah into Egypt. In 2018, Rafah terminal to Egypt was open for 188 days in both directions. During this time, there were 59,849 crossings by Palestinians exiting the Gaza Strip, of which 1,510 crossings were for patients and 1,464 were for patient companions. According to data from Rafah terminal authorities, 7,070 attempted crossings to Egypt were unsuccessful (11% of all attempted crossings), with those Palestinians affected returned to the Gaza Strip by Egyptian authorities. The number of patients among these was not recorded. Prior to the closure of the Rafah border crossing by the Government of Egypt in mid-2013, more than 4,000 Palestinians from the Gaza Strip crossed Rafah each month for health-related reasons.

*Journey out of Rafah*⁵⁹

Procedures regulating exit of Palestinians through Rafah are obscure, with allegations of the payment of bribes to expedite access. After reaching the Egyptian side of Rafah terminal, Egyptian authorities can take one to eight hours to approve the passenger list shared by the de facto authority Ministry of Interior. Some passengers never receive a response from Egyptian authorities and must continue waiting or return to Gaza. There is no separate system for patient access. The 450km journey should take five to seven hours, but currently takes over 12 hours due to the many checkpoints en route to Qantara. Additionally, night curfews by Egyptian authorities mean patients may have to spend the night at Rafah terminal before onward travel to Cairo.

Access of medicines and medical supplies

The entry of medical supplies occurs through Karam Abu Salem/Kerem Shalom crossing from Israel and Salah ad-Din crossing from Egypt. According to OCHA, Karam Abu Salem/Kerem Shalom opened on 238 days in 2018 to allow goods to enter into the Gaza Strip and there were seven truckloads of medicines allowed to enter Gaza through Salah ad-Din gate for the private sector from July to December 2018. Salah ad Din gate was not open for the entry of supplies in the first half of 2018.

Israel's dual use list has an impact on the provision and maintenance of medical equipment in the Gaza Strip. Health partners have reported restrictions on the import of communications equipment; medical equipment with components on the dual use list, such as nuclear scanning technology; and materials used in treatments or prostheses, such as certain materials used in types of prosthetic limbs. There have been some recent indications of easing of restrictions for specific supplies, such as personal protective equipment and radiotherapy, but in general access for supplies remains a major challenge.

Problems with provision of medical equipment supplies in Gaza are compounded by customs limitations, with delays in delivery, incomplete deliveries, under-developed systems to rationalise allocation; and overall inadequate equipment. There are problems with the upkeep of equipment related to the inability of staff to access adequate training, the unpredictable electricity supply that adversely affects highly sensitive electronic circuits and structures contained in many types of medical equipment, and the limitations on delivery and return of equipment or spare parts when complex machinery is not operating properly. For example, when Shifa Hospital's MRI machine was not working the hospital had to request three electronic boards because of uncertainty in what was causing the fault. Similarly, the difficulty of returning equipment such as defective control boards, exhausted x-ray tubes, and other parts means additional costs footed by the Ministry of Health and donors. Highly complex diagnostic equipment like CT scanners, MRI scanners, cardiac catheterisation equipment and diagnostic laboratory analysers are the most affected by this situation.

59. OCHA, 2018. Recent trends in Palestinian access from Gaza: Erez and Rafah crossings. Available at: <https://www.ochaopt.org/content/recent-trends-palestinian-access-gaza-erez-and-rafah-crossings> (Accessed 26 July 2019)

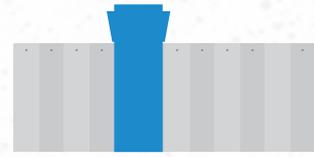
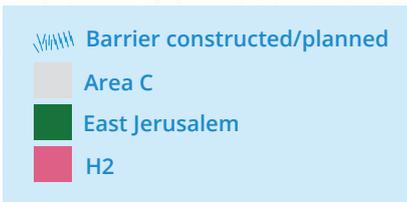
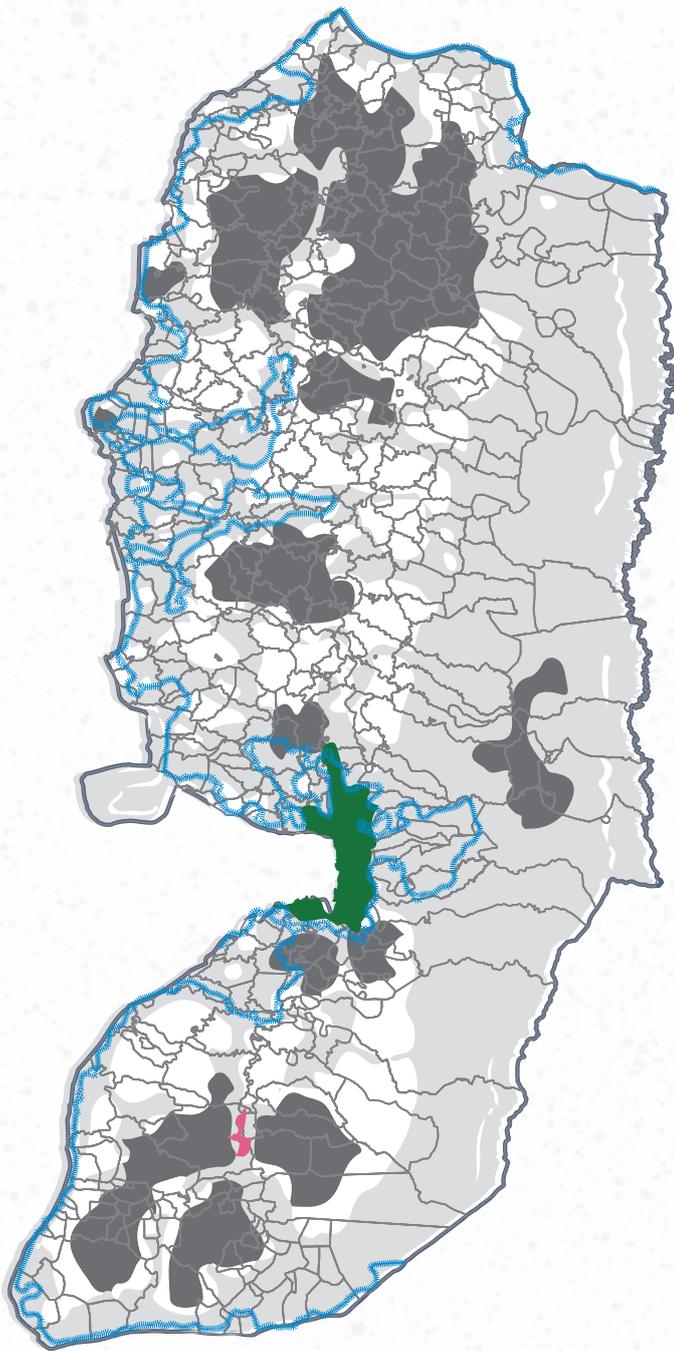


Barriers to health access in the West Bank

The nature of barriers to health access in the West Bank differs from those in the Gaza Strip. Here, the administrative and physical subdivision of the territory separates, and often isolates, Palestinian communities from one another. More than 60% of the West Bank comprises Area C under direct Israeli civil and military control. Once completed, 9.4% of the West Bank will fall on the Israeli side of the separation wall, creating additional challenges to access for the communities living in these areas. The separation wall also isolates East Jerusalem from the rest of the West Bank. Meanwhile, an expanding settlement infrastructure and the extensive system of fixed and 'flying' military checkpoints hampers free movement and creates unpredictable delays, including for ambulances.

Of the 3 million Palestinians living in the West Bank, Israel's permit system applies to those living outside of East Jerusalem who are not exempted according to age restrictions. The majority of

Figure 3: Barriers to health care access in the West Bank



Separation barrier¹

712km planned route



Checkpoints²

140 fixed checkpoints

2254 "flying" checkpoints were recorded in the West Bank in 2018



Permit system

To access health care in East Jerusalem and Israel

Restricted areas

Area C

Seam Zone**

East Jerusalem

H2



Settlement infrastructure³

- No Palestinian access to 40km of roads
- Fragmentation of Palestinian communities



Financial barriers to access

78% health insurance coverage⁴

42% out-of-pocket payments⁵

1. B'Tselem, 2017. 'The Separation Barrier.' Available at: https://www.btselem.org/separation_barrier

2. Data provided by OCHA in 2019

3. B'Tselem, 2017. 'Statistics on Settlements and Settler Population.' Available at: <https://www.btselem.org/settlements/statistics>

4. Palestinian Central Bureau of Statistics/ Ministry of Health national health accounts report, February 2016

5. Palestinian Central Bureau of Statistics, 2019. 2017 الحسابات الصحية الفلسطينية

** Area between the barrier and 1949 armistice line.

women over 50 years, men over 55 years and children under 14 years of age traveling with a permitted adult companion are exempted from needing to apply for permits. The approval rate of permits for patients and companions is higher in the West Bank compared to the Gaza Strip, though almost one in five (18% of) permit applications were still unsuccessful in 2018. This chapter also examines access for health staff, ambulances and mobile clinics in the West Bank.

Patient permit applications

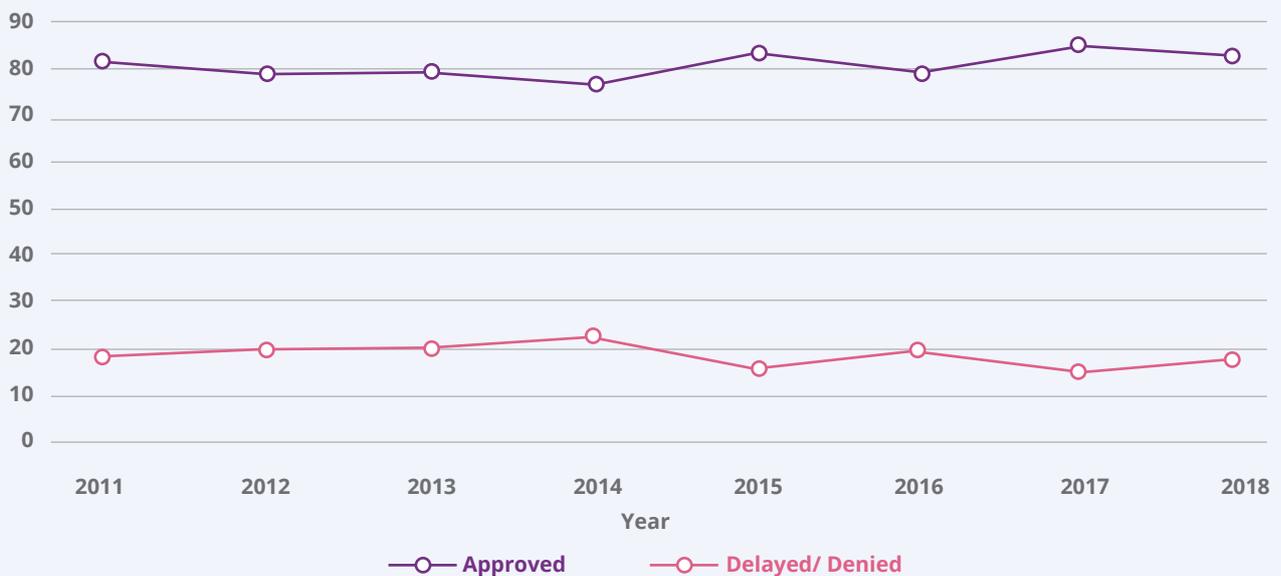
In 2018, there were 191,309 permit applications on behalf of patients and patient companions. It was not possible to get data disaggregated separately for patients and companions, but on the basis of 2017 data approximately 48% are patient applications, and 52% patient companion applications. 156,903 patient and companion applications were approved during the year, or 82% of the total. Meanwhile, 28,713 (15%) applications were denied and 5,693 (3%) were pending at the time of monthly reporting. Chart 22 shows the trend in approval rate for West Bank patients and companions from 2011 to 2018.*



82%

of West Bank patient and patient companion permit applications approved

Chart 22: Israeli responses to West Bank patient and companion permit applications to access health, 2011 to 2018



Health staff permits

The majority of Palestinian staff working in hospitals in East Jerusalem carry West Bank identity cards, meaning that they require permits from the Israeli authorities to enter Jerusalem. There are also a small number of health staff from Gaza still able to obtain permits to reach their place of work in Jerusalem, though they are only issued three-month permits to travel. Of 1,768 permit applications by East Jerusalem hospitals for their staff to access work places in 2018, 96.8% were approved for six-month permits, 1.6% for three-month permits, and 1.5% were denied.

* According to additional data provided by the Israeli Coordination of Government Activities in the Territories, 12% of patient permit applications from the West Bank were not approved in 2018, indicating an 88% approval rate for patient permits.

Table 3: Access for Palestinian health staff requiring permits to reach hospitals in East Jerusalem, 2018

Hospital	Total applied	Approved (6m)	Approved (3m)	Denied
St. Joseph Hospital	271	266	3	2
Augusta Victoria Hospital	448	440	0	8
St John's Ophthalmic Hospital	122	120	0	2
Makassed Hospital	740	702	26	12
Princess Basma	57	57	0	0
Palestinian Red Crescent Society	130	127	0	3
Total	1768	1712	29	27
Percentage		96.8%	1.6%	1.5%

Ambulance access

In 2018, according to data collected by the Palestine Red Crescent Society (PRCS), 84% of the 1,462 recorded journeys by ambulances requiring entry to Jerusalem from other parts of the West Bank each year had to transfer patients to another ambulance at checkpoints, diverting health resources and delaying transit. Similarly, access for mobile health clinics is hampered in certain instances by checkpoints, the separation wall and settlement infrastructure, as well as natural barriers and the remoteness of some communities. Ambulances from Qalqilya, Tulkarem, Jenin and Tubas had the highest rates of ambulances required to undergo the back-to-back procedure (100%), while ambulances from Jericho and Al Bireh had the highest rates of direct access (22%) – see Table 4.



84%

84% of ambulances entering Jerusalem required to carry out back to back procedures

Table 4: Ambulance access from West Bank to East Jerusalem, 2018

District	Back to back - private ambulance	Back to back - PRCS ambulance	Direct access	Total	Percentage back-to-back
Hebron	15	242	6	263	92%
Bethlehem	0	146	4	150	97%
Jericho	0	50	14	64	78%
Qalqilia	0	16	0	16	100%
Tulkarem	0	19	0	19	100%
Jenin	0	29	0	29	100%
Nablus	0	50	2	52	96%
Al Bireh	17	663	169	849	78%
Tubas	0	20	0	20	100%
Total	32	1235	195	1462	84%

Mobile health clinic access

Discriminatory planning and zoning policies and practices in Area C of the West Bank prevent the development of permanent or semi-permanent health facilities for remote communities, meaning that 114,000 (35%) of the 300,000 Palestinians living in Area C have limited access to primary healthcare and are reliant on mobile health clinic provision for access to essential primary care services. In 2018, there were six reported incidents where mobile clinic teams were prevented access to communities in Area C. Four incidents were for the area of Khan Al-Ahmar. Three incidents occurred in July where clinics delivered by the Palestinian Ministry of Health, Medical Aid for Palestinians (MAP-UK) and the Palestinian Medical Relief Society were prevented access for up to 11 days. A further incident happened from 26 August to 22 September, when MAP-UK's clinic was prevented access to provide primary care services. Khan Al-Ahmar is an area encompassing 12 Palestinian communities of approximately 1,400 residents.⁶⁰ Like many communities in Area C, the residents have had properties demolished due to lack of permits to build, though permits for Palestinians are virtually impossible to obtain.⁶¹ The entire community has continued to face the threat of demolitions and forced displacement for over ten years, creating a coercive environment. This includes the promotion of plans to relocate Palestinian Bedouin communities to designated urban townships, not suitable for maintaining their livelihoods and way of life; restrictions on access to land and natural resources for livestock grazing; the denial of basic service infrastructure; and the lack of secure residency.⁶²

60. B'tselem, 2018. Communities facing expulsion: The Khan al-Ahmar area. Available at: https://www.btselem.org/communities_facing_expulsion/khan_al_ahmar (Accessed 26 July 2019)

61. B'tselem, 2017. Planning Policy in the West Bank. Available at: https://www.btselem.org/planning_and_building (Accessed 26 July 2019)

62. OCHA, 2018. 2019 Humanitarian Needs Overview, p7. Available at: https://www.ochaopt.org/sites/default/files/humanitarian_needs_overview_2019.pdf (Accessed 26 July 2019)

Two further incidents of preventing mobile health clinic access occurred in Hebron in May 2018, for clinics delivered by the Health Work Committees. One incident affected the community of Tal Al-Rumeideh, while the second affected the community of Haret Al-Jabari. In addition to prevention of access, Israeli forces confiscated a Palestinian Ministry of Health mobile clinic vehicle on 13 August, on its way to deliver care to four communities in the Masafer Yatta district, in the South Hebron Hills. The clinic vehicle has still not been returned. The Ministry of Health has had to reduce the frequency of its clinic visits since the incident.





Underlying determinants of health

The underlying determinants of health are those conditions of life that promote or hinder health and wellbeing. They include, but are not restricted to, the fulfilment of essential needs such as access to nutritional food, clean water and sanitation, and housing, as well as protection from hazards in the environment that are harmful to health.⁶³ Assessment of underlying determinants of health is closely linked to assessment of what determines inequalities in health outcomes. Indeed, health inequities are the unjust systematic differences in health outcomes among different populations that result from the political, economic and social conditions in which people are born, grow, live, work and age.⁶⁴ Fulfilment of the right to health is closely dependent on the realization of other human rights, as integral components of the right to health. These include the right to food, adequate housing, work, education, human dignity, life, non-discrimination, equality, privacy, and access to information, as well as prohibition against torture and freedoms of association, assembly and movement.⁶⁵

In this chapter, we examine the underlying determinants of health in the occupied Palestinian territory, including exposure to violence, the impact of blockade and conflicts in Gaza, and the fragmentation and creation of vulnerable populations in the West Bank.

63. OHCHR & WHO, 2008. Fact Sheet Number 31: The Right to Health.

Available at: <https://www.ohchr.org/Documents/Publications/Factsheet31.pdf> (Accessed 26 July 2019)

64. WHO, 2017. 10 facts on health inequalities and their causes.

Available at: https://www.who.int/features/factfiles/health_inequities/en/ (Accessed 26 July 2019)

65. CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), para. 3.

Exposure to violence under occupation

One significant characteristic of Israel's on-going occupation of the West Bank and Gaza Strip is the high level of exposure to violence for the occupied population. In 2018, 299 Palestinians were killed and 31,723 injured in the context of occupation and conflict.⁶⁶ 87% of those killed and 81% of those injured were in the Gaza Strip, with a substantial increase in exposure to violence, including excessive use of force, since the beginning of the "Great March of Return" on 30 March 2018. A fifth (19%) of those killed and a quarter (24%) of those injured in the Gaza Strip in 2018 were children under the age of 18 years, while 2% of those killed and 8% of those injured were women or girls. Thirteen Israelis were killed and 142 injured in the same year.

For Palestinians injured during demonstrations in the Gaza Strip, over half (53%) were transferred to hospitals, and 6,239 people were injured by live ammunition. The majority (87%) of live ammunition injuries were to the limbs.⁶⁷ 113 amputations took place in 2018 in the Gaza Strip as the result of injuries sustained during demonstrations, with 21 people paralysed due to spinal cord injuries and nine people suffering permanent sight loss.⁶⁸ In the West Bank, over half (58%) of injuries also occurred in the context of demonstrations, with 16% of injuries occurring during search and arrest operations and 10% the result of settler-related violence.⁶⁶

Exposure to violence has an impact on mental as well as physical health. A WHO study in 2019 estimates that more than a fifth (22.1%) of the population is affected by mental disorders (depression, anxiety, post-traumatic stress disorder, and schizophrenia) at any point in time in conflict-affected populations.⁶⁹ Mental health represents one of the most significant public health challenges in the occupied Palestinian territory. Over half of conflict-affected children in Gaza may be affected by post-traumatic stress disorder.⁷⁰ A further estimated 210,000 people in the Gaza Strip, or over 10% of the population, suffer from severe or moderate mental health disorders.⁷¹ Overall, the occupied Palestinian territory has one of the highest burdens of adolescent mental disorders in the Eastern Mediterranean Region. About 54% of Palestinian boys and 47% of Palestinian girls aged six to 12 years reportedly have emotional and/or behavioural disorders. The overall disease burden for mental illness accounts for an estimated 3% of disability-adjusted life years.⁷²

66. OCHA, 2019. Data on casualties. Available at: <https://www.ochaopt.org/data/casualties> (Accessed 26 July 2019)

67. Data provided by the Palestinian Ministry of Health

68. Data provided by As-Salama Society and the Palestinian Ministry of Health

69. Charlson, F., et al., 2019. New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. *The Lancet*. [http://dx.doi.org/10.1016/S0140-6736\(19\)30934-1](http://dx.doi.org/10.1016/S0140-6736(19)30934-1)

70. Thabet A, Thabet S, Vostanis P. The relationship between war trauma, PTSD, depression, and anxiety among Palestinian children in the Gaza Strip. *Health Science Journal*. 2016;13:621. doi: 10.21767/1791-809X.1000621.

Available at: <http://www.hsj.gr/medicine/the-relationship-between-war-trauma-ptsd-depression-and-anxiety-among-palestinian-children-in-the-gaza-strip.php?aid=11302> (Accessed 26 July 2019)

71. OCHA, 2018. 2019 Humanitarian Needs Overview, p7.

Available at: https://www.ochaopt.org/sites/default/files/humanitarian_needs_overview_2019.pdf (Accessed 26 July 2019)

72. Charara R, Forouzanfar M, Naghavi M, Moradi-Lakeh M, Afshin A, Vos T et al. The burden of mental disorders in the Eastern Mediterranean Region, 1990–2013. *PLOS One*. 2017. Available at: <http://doi.org/10.1371/journal.pone.0169575> (Accessed 26 July 2019)

Impacts of blockade and conflicts on health determinants in the Gaza Strip

Ongoing blockade and successive conflicts have had a devastating impact on underlying factors that contribute to health and wellbeing, known as underlying determinants of health, in the Gaza Strip.

Economic conditions have profound implications for health.⁷³ Restrictions on the movement of people and goods, including denial of access to the Israeli labour market (prior to the blockade, the Gaza population was largely dependent on access to the Israeli labour market), has led to de-development in Gaza since the start of the blockade in 2007. Unemployment in 2018 was 54% in the second quarter, higher for young people (70%) and women (78%). The poverty rate increased from 39% in 2011 to 53% in 2018, according to the last Household Expenditure and Consumption Survey. Severe and moderate food insecurity reached 68%.⁷⁴ The latest estimates indicate that 11% of children under 5 years are stunted.⁷⁵

In 2018, Gaza continued to suffer a “dual water crisis,” characterized by a lack or shortage of potable drinking water and unsatisfactory wastewater treatment.⁷⁶ 96% of water from Gaza’s aquifer continues to be unfit for human consumption, while 108,000 cubic metres of untreated wastewater flowed into the Mediterranean Sea each day in September 2018.⁷⁴ The risk to public health in Gaza is considerable, both in terms of poor hygiene and in terms of potential biological and chemical contamination of water for consumption or food preparation.

Good housing conditions and housing security can save lives, prevent disease and increase quality of life.⁷⁷ In Gaza, in November 2018, 14,000 people remained internally displaced. The ongoing electricity crisis, with four to six hours of electricity per day from January to October 2018, impacts on the ability of families to adequately heat their homes and hence winter resilience. In 2018, 434,000 people were vulnerable and unprotected from harsh winter weather.⁷⁴



73. WHO, 2019. Health impact assessment: the determinants of health.

Available at: <https://www.who.int/hia/evidence/doh/en/> (Accessed 26 July 2019)

74. OCHA, 2018. 2019 Humanitarian Needs Overview, p7. Available at:

https://www.ochaopt.org/sites/default/files/humanitarian_needs_overview_2019.pdf (Accessed 26 July 2019)

75. Palestinian Ministry of Health and UNICEF, 2014. Palestinian Micronutrient Survey 2013

76. RAND corporation, 2018. The Public Health Impact of Gaza’s Water Crisis: Analysis and Policy Options.

Available at: https://www.rand.org/pubs/research_reports/RR2515.html (Accessed 26 July 2019)

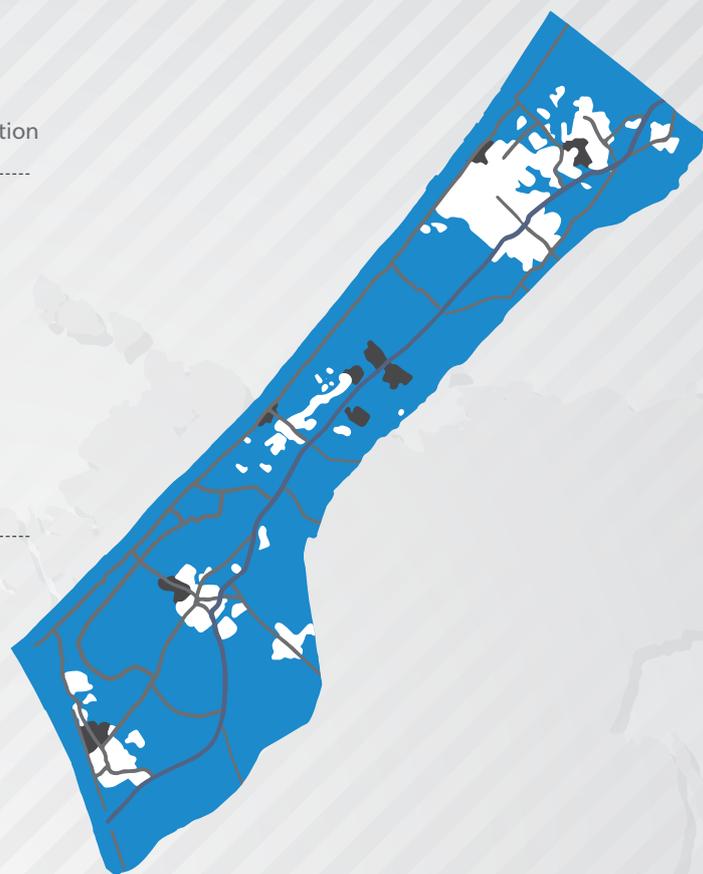
77. WHO, 2018. WHO Housing and health guidelines. Available at:

<https://www.who.int/sustainable-development/publications/housing-health-guidelines/en/> (Accessed 26 July 2019)

Figure 4: Gaza Underlying determinants of health



12 years of blockade on Gaza and more than **50 years** of occupation



FOOD SECURITY AND NUTRITION



68%

moderate and severe food insecurity¹



10.8%

stunting in children under 5 years²

WATER AND SANITATION



Over 96%

of water from Gaza aquifers is unfit for human consumption¹



108,000

cubic metres of untreated wastewater flowed into the Mediterranean Sea each day¹

HOUSING



53%

in need of temporary shelter cash assistance¹



14,000

internally displaced persons¹

EXPOSURE TO VIOLENCE



299

killed in the context of the occupation and conflict³



31,723

injured in the context of occupation and conflict³

POVERTY AND EMPLOYMENT



54%

unemployment rate¹



70%

youth unemployment rate¹



53%

poverty¹

ENERGY



4-6

hours of electricity per day¹

1. OCHA, 2018. 2019 Humanitarian Needs Overview. Available at: https://www.ochaopt.org/sites/default/files/humanitarian_needs_overview_2019.pdf (Accessed 26 July 2019).
 2. Palestinian micronutrient survey 2013.
 3. OCHA, 2019. Data on casualties. Available at: <https://www.ochaopt.org/data/casualties> (Accessed 26 July 2019).



Impacts of fragmentation and occupation on health determinants in the West Bank

In the West Bank, administrative and physical division of the territory has created harsh conditions of life and particularly vulnerable and marginalised communities, with consequences for health and wellbeing.

Area C

In Area C, under direct Israeli administrative and military control and encompassing over 60% of the West Bank, discriminatory planning and zoning policies and practices towards Palestinians not only limit the development of and access to health services, but impact deeply on underlying determinants of health for Palestinians living there. Access to water and sanitation, nutritious

food, livelihoods and adequate and secure shelter are all detrimentally affected by coercive environment measures.⁷⁴ In all of the West Bank, 22% or 649,000 are affected by lack of access to water and poor water quality. This includes 270,000 Palestinians in Area C, with water and sanitation infrastructure vulnerable to demolition and stop work orders. By the end of October 2018, Israeli authorities had demolished or seized 16 related structures, including cisterns, water pipes and mobile latrines.⁷⁸ There is a need for improved data on health inequalities in the occupied Palestinian territory. A study by the Palestinian National Institute of Public Health in 2016 demonstrated higher rates of stunting and malnutrition in the Jordan Valley area – much of which is designated Area C – compared to the general population. Stunting in under-5s was 16% compared to the West Bank overall prevalence of 9.5%, while half (49%) of children were anaemic and over a quarter (27%) moderately or severely anaemic.^{79,80} There is a double burden of malnutrition, with 8% of children overweight or obese and 4% of children under-10 underweight.⁷⁹ Lack of ability to develop infrastructure or facilities in these often-remote communities limits access to livelihoods and adequate income. High rates of demolition of buildings causes displacement and disruption for families, while demolition orders and the continuing threat of demolitions creates considerable psychological stress. In 2018, 271 structures were demolished leading to displacement of 220 people in Area C alone.⁸¹

Hebron H2

The H2 area of Hebron is another area where the physical and administrative division of territory has created particular health vulnerabilities. H2 comprises 20% of Hebron city in the West Bank. It is under direct Israeli civil and military control, and has been the target of intense settlement activity in the heart of the city. The 33,000 Palestinians living there are exposed to a coercive environment that creates impediments to realization of conditions of life needed for fulfilment of the highest attainable standard of physical and mental health and wellbeing. There are severe access restrictions, with more than four-fifths (81%) of residents needing to pass a checkpoint by foot to reach their homes. According to a study conducted by OCHA in the summer of 2018, from October 2015 to the time of the survey, more than two-fifths (44%) of Palestinian households living in H2 had their houses temporarily occupied, while one in five (21%) had a child arrested at least once.⁸² Rates of settler violence are high, with a half (48%) of respondents experiencing physical assault and a third (33%) experiencing stoning.⁸² More than four-fifths (81%) reported psychological distress as a result of settler attacks, while almost a fifth (18%) had a resulting physical injury. Access restrictions and closures have devastated commercial life in H2, once the vibrant heart and Old City of the town. According to the Hebron municipality, 512 Palestinian businesses in the affected areas of H2 have been closed by military order, and more than 1,000 others have shut down due to restricted access for customers and suppliers.⁸² Almost two-fifths (39%) of residents require food assistance in kind or through coupons.⁸²

78. OCHA, 2018. 2019 Humanitarian Needs Overview, p7. Available at:

https://www.ochaopt.org/sites/default/files/humanitarian_needs_overview_2019.pdf (Accessed 26 July 2019)

79. PNIPH, 2016. Prevalence and Determinants of Malnutrition and Intestinal Infections among Children and their Mothers in the Jordan Valley. Available at: <https://www.pniph.org/public/uploads/A4%20Report.pdf> (Accessed 26 July 2019)

80. Palestinian Ministry of Health and UNICEF, 2014. Palestinian Micronutrient Survey 2013

81. OCHA, 2019. Data on demolitions and displacement in the West Bank. Available at:

<https://www.ochaopt.org/data/demolition> (Accessed 26 July 2019)

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

East Jerusalem

Since its unilateral annexation of occupied East Jerusalem in 1967, Israel has implemented policies that separate the city from the rest of the West Bank and Gaza Strip and isolate its Palestinian residents. According to the Association for Civil Rights in Israel (ACRI), in 2017 there were 323,700 Palestinian ‘permanent residents’ of Jerusalem that comprised almost two-fifths (37%) of the city’s population.⁸³ The residency status of Palestinians in East Jerusalem is precarious and depends on residents continuously demonstrating that the city remains their ‘centre of life’, which means that Palestinians who move away to work or study for lengthy periods may have their right to reside in their city of birth revoked. From 1967 to May 2017, Israel had revoked the residency status of 14,595 Palestinians.⁸³ Israel’s construction of the separation wall in the West Bank from the early 2000s has cut off some 140,000 Palestinian residents who reside within the Jerusalem municipality, but on the West Bank side of the wall, making up over a third of Jerusalem’s Palestinian population. This includes approximately 80,000 Palestinians living in Shufat refugee camp and around 60,000 Palestinians in the area of Kufr Aqab.⁸³ These areas are overcrowded and underserved by Israeli municipal services, including refuse disposal, but are relatively more affordable compared to other neighbourhoods of Jerusalem. Residence in Shufat refugee camp, Anata or Kufr Aqab enables Palestinians to retain their East Jerusalem residency status, allowing them free movement into Israel and continued access to Israeli health insurance – which are both denied to Palestinians in the rest of the West Bank. As with Area C, Palestinians in East Jerusalem are exposed to high rates of home demolitions by Israeli authorities. For the ten-year period from 2009 to the end of 2018, 1,053 structures were demolished in East Jerusalem resulting in the displacement of 1,899 Palestinians.⁸⁴ Jabal al Mukabbir (135 structures) and Beit Hanina (133) were the two areas most affected by demolitions. Areas that have seen the concentration of Palestinian East Jerusalem residents, such as Shufat refugee camp (23 structures) and Kufr Aqab (3 structures), were relatively spared in comparison.⁸⁴ Rates of poverty for Palestinians in East Jerusalem are high, with 76% of residents and 83% of children living below the poverty line.⁸³



83. The Association for Civil Rights in Israel, 2017. East Jerusalem Facts and Figures 2017.

Available at: <https://law.acri.org.il/en/2017/05/24/east-jerusalem-facts-and-figures-2017/> (Accessed 26 July 2019)

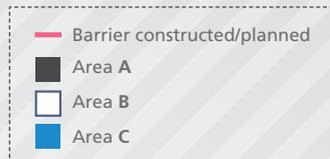
84. OCHA, 2019. Data on demolitions and displacement in the West Bank.

Available at: <https://www.ochaopt.org/data/demolition> (Accessed 26 July 2019)

Figure 5: West Bank Underlying determinants of health



more than **50 years** of occupation



FOOD SECURITY AND NUTRITION



12%

moderate and severe food insecurity¹



9.5%

stunting in children under 5 years²

WATER AND SANITATION



22%

affected by lack of access to water and poor water quality¹



83,000

people in Area C receive bad quality drinking water¹

HOUSING



Over 13,000

demolition orders in Area C of the West Bank¹



Over 10,000

people live in 63 communities in Area C of the West Bank at heightened risk of forcible transfer¹

EXPOSURE TO VIOLENCE



39

killed in the context of the occupation and conflict³



6,082

injured in the context of the occupation and³

POVERTY AND EMPLOYMENT



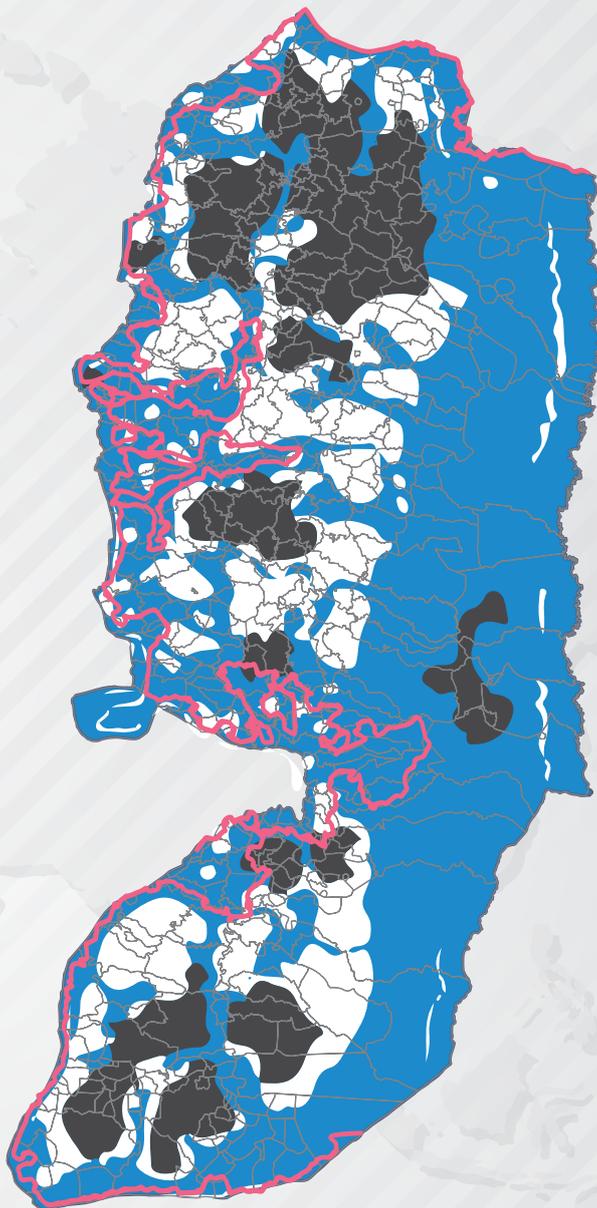
19%

unemployment rate¹



13%

poverty¹



1. OCHA, 2018. 2019 Humanitarian Needs Overview. Available at: https://www.ochaopt.org/sites/default/files/humanitarian_needs_overview_2019.pdf (Accessed 26 July 2019).
 2. Palestinian micronutrient survey 2013.
 3. OCHA, 2019. Data on casualties. Available at: <https://www.ochaopt.org/data/casualties> (Accessed 26 July 2019).



Health attacks

World Health Assembly Resolution 65.20 called on WHO's Director General to "...provide leadership at the global level in developing methods for systematic collection and dissemination of data on attacks on health facilities, health workers, health transports, and patients in complex humanitarian emergencies..." WHO launched its Surveillance System for Attacks on Healthcare (SSA) in January 2018, which is a global standardized tool for recording incidents of attacks on healthcare. As of mid-2019, the system has been implemented in 10 countries and territories, including the occupied Palestinian territory.⁸⁵

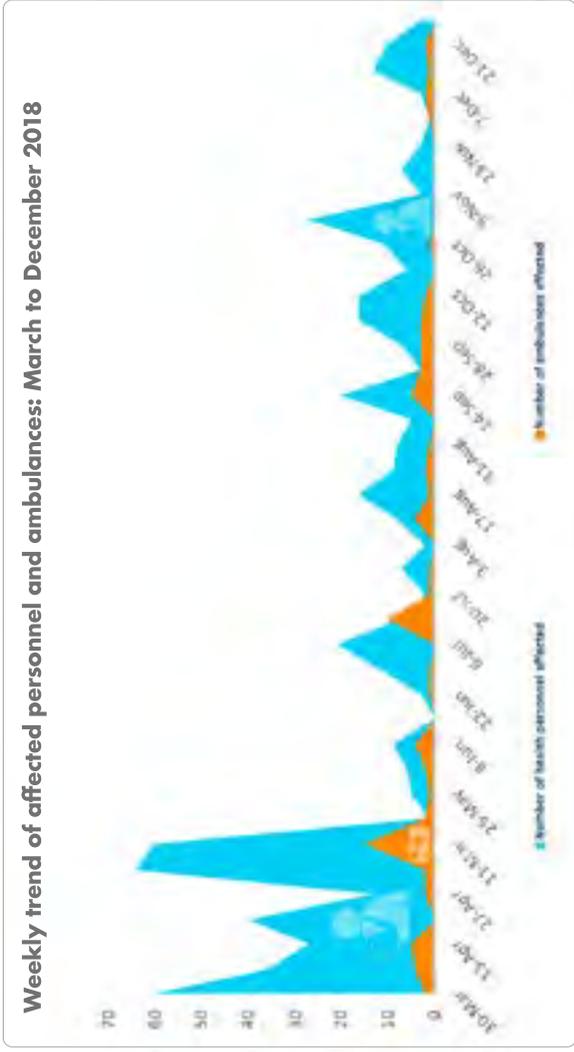
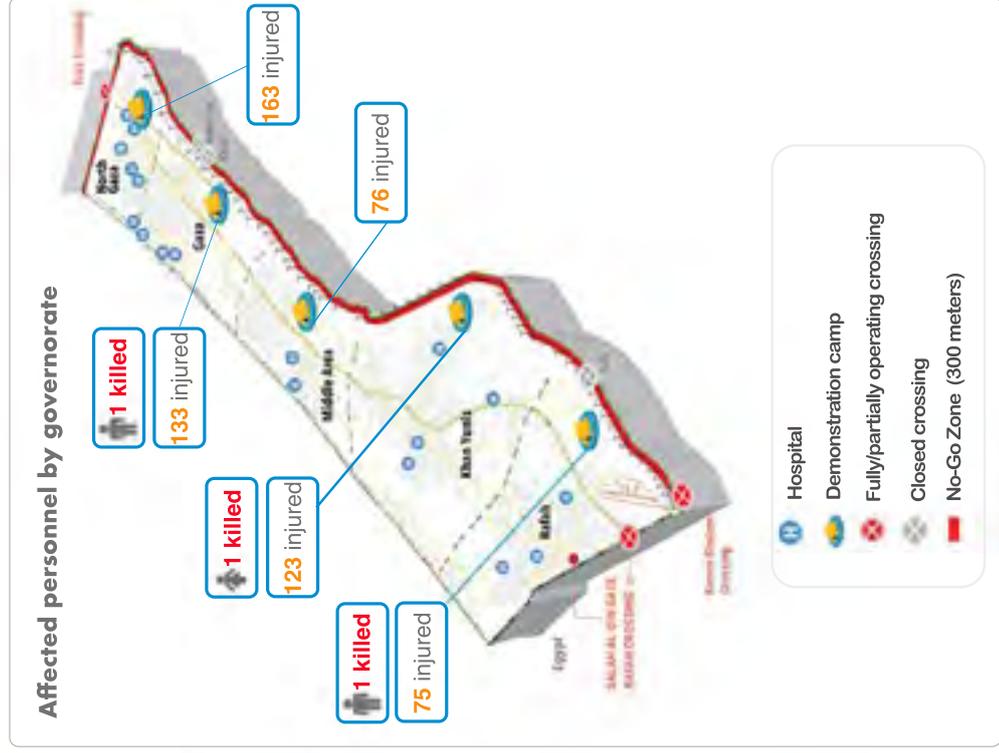
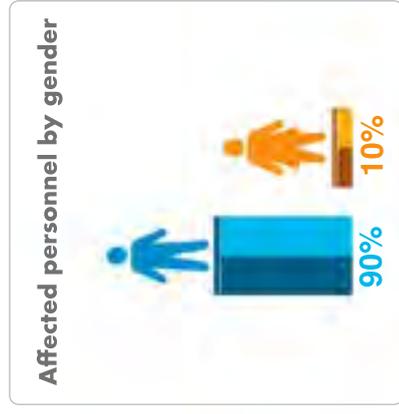
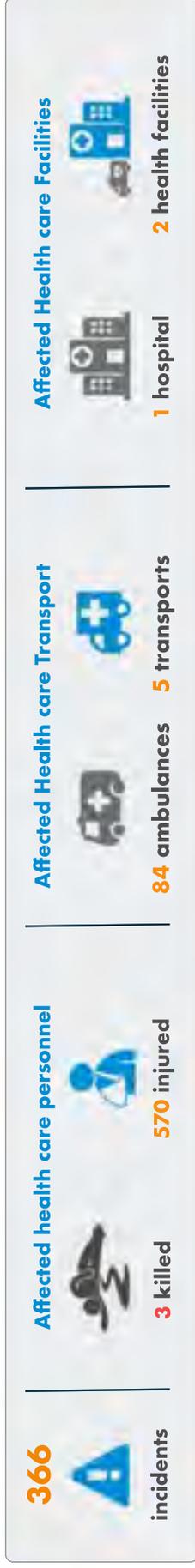
WHO's definition of a health attack is **"any act of verbal or physical violence, threat of violence or other psychological violence, or obstruction that interferes with the availability, access and delivery of curative and/or preventive health services."**

Systematic barriers to "availability, access and delivery" of health services are addressed in other chapters of this publication, while the SSA data presented in this chapter outlines data on incidents of attacks on healthcare.

WHO in the occupied Palestinian territory has worked to strengthen incidents reporting, building on existing monitoring of attacks on healthcare and setting up monitoring systems with partners not previously actively reporting. There are challenges with under-reporting for

85. WHO, 2019. Surveillance System for Attacks on Healthcare (SSA): Public Dashboard. Available at: <https://publicspace.who.int/sites/ssa/SitePages/PublicDashboard.aspx> (Accessed 26 July 2019)

Figure 6: Attacks on healthcare during the Gaza Great March of Return, March to December 2018



specific types of attacks, and some types of attack – such as “psychological violence” – are not easily captured in an incidents-based monitoring system, for example, compared to attacks involving physical injury.

Gaza health attacks

In 2018, the vast majority of attacks on healthcare in the Gaza Strip occurred in the context of Gaza’s Great March of Return. During the year, WHO recorded 369 attacks against healthcare in the Gaza Strip, of which 366 occurred since the start of Great March of Return demonstrations. As a result of these attacks, three health workers were killed with live ammunition while 570 were injured. Injuries were the result of live ammunition (41), shrapnel (34), wounds and burns from gas canisters (90), rubber bullets (18), gas inhalation (376) and other physical injury (11). Of the health workers killed or injured during attacks, 514 (90%) were male and 59 (10%) female. 85 ambulances, five other forms of health transport, and three permanent health facilities were damaged in attacks. The United Nations Commission of Inquiry on the 2018 protests in the occupied Palestinian territory “found reasonable grounds to believe that Israeli snipers intentionally shot health workers, despite seeing that they were clearly marked as such.”⁸⁶ In particular, the Commission found that all three health workers killed in the context of the Great March of Return in the Gaza Strip in 2018 were clearly marked as health workers and did not pose an imminent threat of death or serious injury to Israeli soldiers at the time they were shot and killed.⁸⁷

In late 2018, WHO carried out qualitative research to review the effectiveness of implementation of the SSA in the occupied Palestinian territory, and to understand the extent, nature and impact of attacks on healthcare in the Gaza Strip. The findings of the research indicate overall under-reporting of the extent of attacks, with study participants describing attacks and injuries that were not reported to the SSA. There was also a focus of reporting on physical attacks resulting in injury or damage to facilities. Participants described incidents that included verbal violence, threat of violence, psychological violence, and obstruction to delivery of services that were not reported to the SSA.

Case study: Zeiad, a first responder with the Palestinian Red Crescent Society

Zeiad is 50 years old. He began volunteering as a first responder with the Palestinian Red Crescent Society (PRCS) in 2015. He decided to join PRCS because he believes in humanitarian health work as a way to help others and to impact on the deteriorating situation in the Gaza Strip. While providing first aid to persons injured during demonstrations of the Great March of Return on 15 April, Zeiad was injured.



86. Report of the independent international commission of inquiry on the protests in the Occupied Palestinian Territory, 25 February 2019, UN Doc A/HRC/40/74, para. 71.

87. Report of the detailed findings of the independent international Commission of inquiry on the protests in the Occupied Palestinian Territory, 18 March 2019, UN Doc A/HRC/40/CRP.2, para. 524.

“My colleague and I went to the ambulance to refill the first aid kit. While refilling the kit, I was shot with live ammunition, which went through my abdomen into my back and then went through another person’s elbow (who was standing behind me). After that, it hit a car which was in the way. I lost consciousness and was transferred to the Al-Aqsa Hospital [government hospital], before PRCS decided to refer me to Al-Quds hospital [the PRCS hospital in the Gaza Strip]. That day the situation was completely overwhelming in the governmental hospitals. The doctors said I’d sustained internal bleeding and I was in a very critical state. Without an operation, I would have survived 20 minutes. I was admitted immediately for an operation. They managed my case by resecting a part of liver, a part of the large intestine and some of my ribs. After the operation, I stayed at the hospital for 10 days.”

From 13 to 15 May 2018 alone, there were 2,221 injuries during the Great March of Return demonstrations treated at Ministry of Health hospitals, with 1,104 (50%) of those injuries from live ammunition. On 14 May, 1,193 injuries from the demonstrations were treated at NGO field medical points and hospitals in Gaza, of which 262 (22%) were live ammunition injuries. 61 people died as the result of their injuries from 13 to 15 May.

Zeiad stated: “When I remember the events of that day, it makes me very sad. Even us health workers – carrying out our humanitarian work and clearly marked with our PRCS vests – were targeted with live ammunition.”

Zeiad is married and has six children. The oldest is 25 year old and the youngest 5 years old. The family live in the east of Al Bureij refugee camp, close to the Return Camp of the Middle Area of the Gaza Strip. Although Zeiad’s health has improved since his injury, he still suffers:

“The injury has changed my life for the worse. I still have breathing difficulties and feel tired after making even a small effort. I had to stop working in the Return Camp and changed my role to one needing less physical exertion... I can’t work in carpentry as before, which affects us badly financially. My daughter was studying at university, but I can’t afford her fees any more. Her sister has finished high school and also wants to study at university, but I’ve told her we will have to wait.”

West Bank health attacks

The nature of health attacks in the West Bank differs from those in Gaza, relating closely to ongoing Israeli ground occupation in the West Bank, the extensive system of military checkpoints, and the vulnerability of ambulances and staff to delays and detention. Here, a much greater proportion of attacks on healthcare related to obstruction to access and delivery of services. In 2018, WHO recorded 63 incidents of attacks on healthcare in the West Bank. Of these, 37 incidents included delay or prevention of ambulance access; 18 included physical attack or damage to ambulance vehicles; and 18 included physical attacks against staff. One incident can incorporate one or more aspect of the definition of an attack on healthcare. Twelve clinics were affected by attacks on healthcare, including six mobile clinics that were prevented access to communities in Area C for durations of up to two weeks and one mobile health clinic vehicle from the Ministry of Health that was confiscated by Israeli forces. Four incidents affected primary health clinics and a hospital was also affected by militarization of health facilities and violence. Seven recorded attacks were carried out by Israeli settlers. Prevention of access to injured patients included three incidents where patients were fatally wounded.

Case study: Khalid, a paramedic with Palestinian Red Crescent Society in the West Bank

Khalid (pseudonym) joined the Palestinian Red Crescent Society (PRCS) in 2000, during the Second Intifada. He has been working as a paramedic ever since, in 4 different district offices across the West Bank. Like many ambulance and emergency health workers in the West Bank, Khalid faces substantial risks and frustrations in his daily work as the result of the ongoing military presence and occupation.

On 13 April 2018, Khalid was on the receiving end of a health attack when he attended student demonstrations at Birzeit University. During the protests, Israeli forces had cornered one of the students demonstrating with a military jeep. The jeep hit the student's leg as he tried to escape. Khalid describes the incident:

"It was clear that the student had fractured his femur, and we tried to go forward to reach him and treat him. There were 3 ambulances trying to get to where the student was, but the soldiers wouldn't let us pass. We tried to explain the seriousness of the injury and that we were there to provide medical support, but still they refused and tried to push us back. They fired pepper spray towards us, and after that I just remember seeing yellow gas and feeling a burning pain in my eyes. Other paramedics later told me that I sat on the ground with my eyes closed with clashes going on around me. Because I was in the middle, no one could reach me. In the end, someone pulled me aside until other paramedics were able to reach me and provide support. I was treated in the field and then taken to Ramallah Hospital. Later, I went to Musallam Ophthalmology Hospital for treatment. After receiving treatment, I continued my shift that day at work."

Six other health workers were injured in the same incident.

Interrogation, arrest and detention of patients and companions

During 2018, 133 patients (90 male; 43 female) and 52 patient companions (41 male; 11 female) were called for security interrogation as a prerequisite to traveling out of Gaza for healthcare.

One patient and 4 patient companions were arrested by Israeli forces at Beit Hanoun/Erez terminal in 2018. The patient was a 28-year-old man arrested en route to receive specialist surgery in Jordan. He was later sentenced to 20 months in prison. Of the four patient companions arrested, two were men aged 42 and 44 years, who were later released (after 19 days and 24 days). One companion, a 33-year-old man, was sentenced to 24 months imprisonment. The final companion, a 35-year-old woman, has been detained since 6 December 2018 and is awaiting trial, scheduled for 23 September 2019.

In the West Bank, a 13-year-old boy was detained from Makassed Hospital after admission for burns. He was taken away by Israeli forces in a military ambulance. No further information was available on the outcome of the patient's detention.

Protection needs and coordination

In late 2018 and 2019, WHO undertook assessment of protection needs for healthcare in the Gaza Strip through focus groups with 44 field health workers and key informant interviews with 5 field medical point coordinators and a senior health. The research flagged need for

strengthened protection in the field, including through measures such as making available personal protective equipment like bulletproof vests, helmets and gas masks; training and standard operating procedures for certain partners; improved communications equipment; and enhanced coordination of field protection, as well as clarification of roles and responsibilities of different actors. The Israeli COGAT have indicated a willingness to consider facilitating the entry of personal protective equipment for health staff in 2019. While many health workers saw value in monitoring of attacks on healthcare, the majority called for stronger advocacy – particularly by international organizations and third States – and the need for legal accountability and consequences for perpetrators to prevent future attacks. In 2019, WHO is working with partners, including the Ministry of Health, the Office of the High Commissioner of Human Rights and the Protection Cluster, to bring together a cross-sectoral strategy focused on strengthening protection for healthcare, including through preventing future attacks.





Conclusions and recommendations

Conclusions

In 2018, there continue to be major barriers to realization of the right to the highest attainable standard of physical and mental health for Palestinians in the West Bank and Gaza Strip. The situation of continued and prolonged military occupation has entrenched the physical and administrative division of the Palestinian territory and population. Sustainability of quality healthcare provision is hampered by lack of territorial sovereignty, affecting public revenue and creating a situation of donor and aid-dependency.

Israel's permit system creates bureaucratic barriers to timely access for patients, their companions, health staff, and medical supplies. Patients in Gaza face profound restrictions on free movement as the result of the ongoing blockade of the Gaza Strip. Despite an increase in approval of Gaza patients to exit for healthcare, 2018 was still the second lowest approval rate (61% approved) on record, since 2006. Cancer patients initially unsuccessful in their applications to exit for chemotherapy and/or radiotherapy from 2015 to 2017 were 1.5 (1.45) times less likely to survive than patients who were initially granted permits to exit.

In the West Bank, too, almost a fifth (18%) of patient and companion applications for Israeli-issued permits to access healthcare in East Jerusalem and Israel were unsuccessful. Patients face additional barriers to access resulting from the extensive network of checkpoints, tortuous route of the separation wall and expanding settlement infrastructure. Checkpoint delays can affect ambulances, while 1.5% of health staff in East Jerusalem hospitals were denied permits to access their place of work in 2018.

Dire economic conditions, particularly in the Gaza Strip in the wake of 12 years of blockade and among fragmented and vulnerable populations in the West Bank, affect the conditions of life necessary for good health, wellbeing and human dignity. Palestinians are exposed to high rates of violence, with 299 Palestinians killed and 31,723 injured in the context of occupation and conflict in 2018. Exposure to violence affects longer-term mental and physical health, with a high burden of mental health in the occupied Palestinian territory. Access to adequate water and sanitation, food, shelter, education and a healthy environment are all detrimentally affected.

In 2018, WHO recorded an unprecedented number of attacks on healthcare, including three deaths. The vast majority of these attacks occurred in the context of Gaza's Great March of Return, where the high number of injuries overwhelmed an already debilitated health sector. In 2019, the health sector is still struggling to cope with the longer-term consequences of more than 6,200 live ammunition injuries in 2018 alone, including complex injuries requiring multiple surgeries and injuries complicated by infection.

Recommendations

Recommendations for strengthening respect, protection and fulfilment of the right to the highest attainable standard of physical and mental health for Palestinians in the occupied Palestinian territory have been put forward by the special rapporteur on the situation of human rights in the Palestinian territories occupied since 1967, as well as the United Nations Commission of Inquiry on the 2018 protests in the occupied Palestinian territory. The findings of this report underscore the need to reiterate these recommendations and for all duty bearers to take steps to ensure their realization.

Recommendations of the special rapporteur on the situation of human rights in the Palestinian territories occupied since 1967

1. To ensure **regular and reliable access**, at all times, for all Palestinian patients who require specialized health care outside of their jurisdictions, consistent with genuine Israeli security concerns;
2. To **end the conditions which obstruct the free passage of Palestinian ambulances** to access and transport patients to health care facilities in an expeditious fashion;
3. To ensure the **respect and protection of medical personnel and medical facilities** as required by international humanitarian law;
4. To substantially **improve prison conditions** and the provision of adequate health care for Palestinian prisoners and detainees;
5. To remove the unnecessary barriers that prevent Palestinian health care staff from acquiring **professional training and specialization** elsewhere in the occupied Palestinian territory and abroad, and to receive training at their home institutions from international health professionals;
6. To ensure that no one is subjected to **torture or degrading treatment**;
7. To take meaningful steps to improve the many **social determinants that influence health**

outcomes in the occupied Palestinian territory;

8. To comply fully with its **obligations under international human rights and humanitarian law** with respect to fulfilling the health needs of the protected population.⁸⁸

Recommendations of the UN Commission of Inquiry on the 2018 protests in the occupied Palestinian territory

The report of the UN Commission of Inquiry on the 2018 protests in the occupied Palestinian territory made a number of recommendations with regards respect for human rights obligations and the right to health specifically.

1. With regards **realization of human rights**: “The commission calls upon all duty bearers to implement fully previous recommendations made by United Nations human rights and fact-finding bodies. It also calls upon States Members of the United Nations to promote compliance with human rights obligations and to ensure respect for international humanitarian law in the Occupied Palestinian Territory and Israel, in accordance with article 1 common to the Geneva Conventions.”
2. Regarding **attacks on healthcare**, the Commission of Inquiry recommended Israel to: “Refrain from using lethal force against civilians, including children, journalists, health workers and persons with disabilities, who pose no imminent threat to life.” The commission also made recommendations to States Members of the United Nations to “employ every means to prevent further use of lethal force against civilians at demonstrations, including by demarches and by ensuring protective monitoring of the demonstrations by independent entities (United Nations entities or non-United Nations).”
3. Regarding **ensuring access to medical services and fulfilment of the right to health** of injured persons, the commission recommended “that the Government of Israel:
 - (a) Lift the blockade on Gaza with immediate effect;
 - (b) Ensure that all those injured at demonstrations are permitted prompt access to hospitals elsewhere in the Occupied Palestinian Territory, in Israel or abroad;
 - (c) Ensure timely access of medical and all other humanitarian workers to Gaza, including to provide treatment to those injured in the context of demonstrations;
 - (d) Ensure efficient coordination for entry of medical items and equipment into Gaza, and remove the prohibition of entry applied to items with legitimate protective and medical uses, including carbon fibre components for the treatment of limb injuries.”

The commission also recommended “that the de facto authorities in Gaza and the Palestinian Authority ensure timely and efficient coordination for the entry of medical supplies and equipment into Gaza,” and “that States Members of the United Nations and civil society support the health-care system in Gaza, particularly with the resources necessary to treat injuries incurred at the protests.”⁸⁹

88. Human Rights Council, 37th Sess, Agenda item 7, UN Doc A/HRC/37/75 (15 March 2018).

89. Human Rights Council, 40th Sess, Agenda item 7, UN Doc A/HRC/40/CRP.2 (18 March 2019)





بالدقائق ما تفكر
ادكي وكتر

الجمعية الوطنية لحقوق الإنسان
National Society for Human Rights



**World Health
Organization**

occupied Palestinian territory

For further information please contact:

Advocacy

WHO West Bank and Gaza

POB 54812

Jerusalem 91547

emacopseadv@who.int

www.emro.who.int/palestine