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

Report by the Director-General

1. In 2020, the Seventy-third World Health Assembly adopted decision WHA73(32), which requested the Director-General, inter alia, to report on progress made in the implementation of the recommendations contained in his report,[1] based on field monitoring, to the Seventy-fourth World Health Assembly. This report responds to that request.

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

2. In 2020, WHO provided support and health-related technical assistance to the Palestinian people in the occupied Palestinian territory, including east Jerusalem, in line with the strategic priorities identified jointly with the Palestinian Ministry of Health and partners in the Country Cooperation Strategy for WHO and the occupied Palestinian territory 2017–2020. These priorities align with WHO's Thirteenth General Programme of Work, 2019–2023. Following the declaration of COVID-19 as a public health emergency of international concern in January 2020, WHO scaled up its critical functions for emergency response, in line with the International Health Regulations (2005) and as the lead agency of the Inter-Agency Standing Committee's Global Health Cluster.

3. The WHO Health Emergencies Programme, in line with the second strategic priority of the Country Cooperation Strategy, was instrumental in preparedness and response to the COVID-19 pandemic in the occupied Palestinian territory in 2020. With contributions received from the Governments of Austria, Canada, Croatia, the European Union, France, Germany, Italy, Kuwait, Spain, Switzerland, the United Kingdom of Great Britain and Northern Ireland, as well as the country-based Humanitarian Pooled Fund, the programme supported the Palestinian Ministry of Health across all core pillars for the effective country readiness and response operations outlined in WHO's Strategic Preparedness and Response Plan for the 2019 Novel Coronavirus.[2] For emergency coordination and planning, WHO worked closely with the office of the United Nations Resident and Humanitarian

[1] Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan; document A73/15.

[2] WHO, 2019 Novel Coronavirus (2019-nCoV): Strategic preparedness and response plan; 2020. (https://www.who.int/publications/i/item/strategic-preparedness-and-response-plan-for-the-new-coronavirus, accessed 11 March 2021).

Coordinator for the occupied Palestinian territory to lead the efforts of the United Nations Humanitarian Country Team, including by organizing the production and updating of the Inter-Agency COVID-19 Response Plan.[1] The plan outlined a joint strategy for the humanitarian community to respond to the public health needs and immediate humanitarian consequences of the COVID-19 pandemic. This included the humanitarian health response coordinated by the Health Cluster, co-chaired by WHO as the United Nations Cluster Lead Agency for Health with the Palestinian Ministry of Health and involving 100 partner organizations operating in the occupied Palestinian territory, including east Jerusalem. The health response priorities included stopping the further spread of COVID-19 across the occupied Palestinian territory and reducing demand for hospital critical care services; providing adequate care for patients affected by COVID-19 and support to their families and close contacts; and minimizing the impact of the epidemic on the functional capability of the health system. The plan complemented Palestine's Emergency COVID-19 Response Plan, for which WHO further provided technical assistance.[2] Throughout 2020, WHO issued frequent COVID-19 situation reports on public health emergency needs and WHO assistance, while as the Cluster Lead Agency for Health the Secretariat supported the production of Health Cluster bulletins on broader humanitarian health needs and cluster partners' capacities, gaps and challenges.

4. For the core pillars of surveillance/rapid response, control at points of entry, national laboratories, infection prevention and control and case management, the WHO Health Emergencies Programme worked with the Ministry of Health and partners to assess and build the capacities of the health system by providing technical assistance and work support for the procurement and entry of essential supplies. Activities included the establishment of respiratory triage centres and quarantine, isolation and treatment facilities. They also covered providing technical support for the implementation of good practices for disease surveillance; contact tracing; laboratory diagnosis of 2019-nCoV; infection prevention and control; clinical management of critical cases; and respiratory triage through the training of front-line workers and provision of the latest evidence-based guidance as knowledge and understanding of effective interventions to prevent, treat and control COVID-19 developed. For essential supplies, WHO worked to mobilize resources, while providing operational and logistical assistance for procurement and entry, essential equipment, disposable materials and medicines, as identified in the Inter-Agency COVID-19 Response Plan. For risk communication and community engagement, WHO assisted in the formation of a task force comprising the Palestinian Ministry of Health, the United Nations Children's Fund (UNICEF), the Bank of Palestine and the Palestinian International Cooperation Agency, with representation and inputs from other UN agencies and nongovernmental organizations, to produce a national health awareness campaign. The Secretariat contributed to fortnightly social media assets, videos and brochures; the dissemination of risk communications messages through billboards, text messages, radio, media interviews and social media; and the establishment and maintenance of a COVID-19 dashboard and website.

5. The final core pillar for preparedness and response to COVID-19 is to ensure the continuity of access to essential services during the pandemic in order to prevent or mitigate secondary impacts on morbidity and mortality. The WHO Health Emergencies Programme continued to provide support to pre-hospital first response services, emergency departments, acute surgical capacities and the provision of limb-saving and limb-reconstruction surgery and treatment, responding to substantial and persistent long-term needs from injuries sustained during demonstrations of the "Great March of Return", which

[1] United Nations Humanitarian Country Team in the occupied Palestinian territory, COVID-19 Response Plan; 2020. (https://www.ochaopt.org/sites/default/files/covid-19-response-plan-inter-agency-opt.pdf, accessed 11 March 2021).

[2] State of Palestine, State of Emergency: Palestine's COVID-19 Response Plan, 2020. (http://www.emro.who.int/images/stories/palestine/documents/Palestine_Authority_COVID-19_Response_Plan_Final_26_3_2020.pdf?ua=1, accessed 11 March 2021).

was held in the Gaza Strip from March 2018 to December 2019. Assistance was provided in the form of training; the development of technical guidelines and standard operating procedures; and the funding of human resources and materials to maintain the limb reconstruction centre at Nasser Medical Complex in Khan Younis, Gaza Strip. Surgery for patients in need was adversely affected in the early stages of the pandemic, with a 50% decline in April 2020 compared with the monthly average for the first quarter of the year. By the third quarter of the year, the level of monthly surgery had returned to pre-COVID-19 levels, although by the end of 2020 an estimated 500 persons injured during the "Great March of Return" were still awaiting specialist interventions, with patients requiring up to 1.5 years of treatment.

6. The first strategic priority of the Country Cooperation Strategy is to contribute to strengthening and building resilience of the Palestinian health system and enhancing the Ministry of Health's leadership to progress towards universal health coverage. In 2020, work towards this strategic priority was supported by funds provided by the Governments of Belgium, Italy, Japan and Norway and by core WHO funding. The Secretariat supported East Jerusalem Hospitals, a cornerstone of the Palestinian health care system, by financing a coordinator to assist data collection, analysis and reporting for the effective monitoring of hospital needs and challenges; donor mobilization efforts to address funding gaps; and liaison with partner organizations. The hospitals faced a financial emergency during the year, due to reduced utilization and outstanding arrears as a result of the fiscal crisis facing the Palestinian Ministry of Health, with WHO working to support donor mobilization. With the protracted nature of the situation in the occupied Palestinian territory, the Humanitarian Development Peace Nexus aims to transform United Nations strategic planning processes. WHO is supporting a joint humanitarian-development-peace analysis in the West Bank, including east Jerusalem, and the Gaza Strip, which will form the basis of collectively agreed outcomes across different sectors. The Secretariat continued its longer-term health system strengthening activities, including by enhancing hospital-based information systems, building hospital capacities through implementation of a regional framework for action and undertaking an initiative assessing current strengths and weaknesses in primary health care management and performance. Early essential newborn care, a cost-effective package of evidence-based interventions, has been put in place in five government hospitals and six nongovernmental hospital maternity units in the Gaza Strip. By the end of 2020, coaching in early essential newborn care had been conducted for 294/416 (60%) of midwives and nurses and 169/198 (85%) of doctors, with dedicated hospital teams formed in all 11 hospitals. Work has been initiated to institute a quality assessment team within the Ministry of Health. In 2020, the team conducted a further review to address vulnerabilities in the context of COVID-19, which led to the implementation of standard operating procedures for infection prevention and control for pregnant women and newborns with the Ministry of Health.

7. Within the first strategic priority, the Palestinian National Institute of Public Health, a WHO-led project funded by the Government of Norway, continued progress in its transition to an independent governmental institution in line with its legal framework, which was endorsed by the Palestinian President in 2016. The Institute works, inter alia, to develop evidence through public health research, strengthen surveillance systems and provide capacity-building and advocacy to promote improved health outcomes. It has established and strengthened registries for maternal and child health, mammography, gender-based violence, cancer, noncommunicable diseases, primary health care statistical reports, causes of death and road traffic accidents and injuries. The Palestinian National Institute of Public Health has also implemented an observatory for human resources for health, as well as health information systems in primary care through the roll-out of District Health Information System 2 (DHIS2) software. With support from the Government of Norway and the World Bank, the Institute is working to advance universal health coverage through supporting the family practice approach and the monitoring and strategic planning of human resources for health. In 2020, the Institute focused on the COVID-19 response by developing the national COVID-19 Surveillance System, in collaboration with the Ministry of Health and the DHIS2 Country Team; developing a public-facing website with the Ministry of Health to provide information and indicators on COVID-19; undertaking a

survey on the experiences of stigma; assessing access to antenatal and postnatal care, immunization and medicines during the pandemic; providing support for the implementation of the WHO Toolkit of Public Health and Social Measures in the context of the COVID-19 pandemic; providing training for front-line health care workers, in partnership with the Ministry of Health, Juzoor for Health and Social Development and Augusta Victoria Hospital, in basic assessment and support in intensive care and basic life support, as well as infection, prevention and control; and completion of a COVID-19 sero-survey for the occupied Palestinian territory, as part of global efforts to understand the extent of exposure to the virus versus confirmed cases.

8. The third strategic priority under the Country Cooperation Strategy is to strengthen capacity to prevent, manage and control noncommunicable diseases, including mental health disorders, and to reduce risk factors for violence and injuries. In 2020, work under this strategic priority was supported by funds from the Governments of Canada, Italy and Kuwait, as well as the European Union. WHO continued to provide technical and logistical support to the Ministry of Health to sustain implementation of the WHO Package of Essential Noncommunicable Disease Interventions programme across all primary health care centres in the West Bank and the Gaza Strip, while working to provide guidance to policies for the maintenance of essential primary care services during the COVID-19 pandemic. The Secretariat contributed to improving the quality of surveillance and reporting in respect of noncommunicable diseases by providing technical support and delivering essential IT equipment for primary care centres; assisted in evaluating the effectiveness of programmes on noncommunicable diseases; and supported campaigns to promote the prevention of noncommunicable diseases during the COVID-19 pandemic, addressing risk factors, including tobacco control, diet and physical exercise. Meanwhile, WHO's Mental Health Programme supported the Ministry of Health in developing the national emergency action plan to respond to mental health needs during the COVID-19 pandemic and assisted the finalization of the national suicide prevention strategy. In the Gaza Strip, the Secretariat supported an awareness-raising campaign on substance abuse and purchased essential psychotropic medicines to address critical shortages, while in east Jerusalem aiding a local nongovernmental organization to provide mental health and psychosocial capacity-building during COVID-19 for two Palestinian hospitals in the city. WHO conducted a study with another local nongovernmental organization on the impact of the COVID-19 pandemic on Palestinian adolescent mental health; it also adapted efforts to build capacities for health professionals to provide mental health and psychosocial support remotely in the West Bank and the Gaza Strip. WHO continued to provide support to the Ministry of Health to define mental health priorities and gaps for the Mental Health Strategy 2021–2026, which had been postponed due to the COVID-19 pandemic, and to the Bethlehem Psychiatric Hospital.

9. The fourth strategic priority is to strengthen the capacity of the Ministry of Health and health partners to advocate with all legal duty bearers to protect the right to health, reduce access barriers to health services and improve the social determinants of health. In 2020, the Government of Switzerland and the European Union supported WHO's Right to Health Advocacy programme. WHO continued its monitoring, documentation and regular reporting on barriers to health access and attacks against health care. The end to coordination between the Palestinian Authority and Israel in May 2020 left many patients in the Gaza Strip without the means to submit permit applications to reach health care in other parts of the occupied Palestinian territory, with the capacity of nongovernmental organizations unable to meet the demand of the large numbers of people in need. The Secretariat worked to establish a temporary coordination mechanism for patient and companion permit applications and, in cooperation with the Ministry of Health referrals system, submitted more than 1400 patient applications and more than 1600 companion applications for permits during its three months of functioning. The programme adapted capacity-building workshops to online platforms, including training workshops and a short course on the right to health with United Nations and academic partners, while work to finalize an indicator set for the enhanced monitoring of barriers to the right to health for treaties reporting was

postponed after the outbreak of COVID-19. The Secretariat collected and synthesized evidence to inform advocacy products and briefing materials, which constituted the basis of public campaigning, United Nations reporting, and bilateral and multilateral engagement with duty bearers to promote respect for, and protection and fulfilment of, the right to the highest attainable standard of physical and mental health for Palestinians in the occupied Palestinian territory.

10. Regarding the public health situation in the occupied Syrian Golan, the following information was provided by the Israeli Ministry of Health. All residents of the Golan Heights (Arab, Druze, Jewish or otherwise) have full access to universal health care under the Israeli health care scheme of health maintenance organizations, including testing, medical care, contact tracing and vaccination. There are four health maintenance organizations in Israel – in Clalit, Maccabi, Meuchedet and Leumit – while most residents of the occupied Syrian Golan receive their medical care through the health maintenance organization in Clalit. All are covered by the National Public Health Services through its northern district's health authority. There is an emergency medical centre in the Druze village of Ein Qiniyye and the nearest full-scale hospital – the Rebecca Ziv Medical Center in Safed – is within an hour from the northern city of Majdal Shams. In response to COVID-19, the Israeli Ministry of Health intensified its testing efforts in the occupied Syrian Golan and conducted about 15 000 tests in November 2020, covering almost all residents. From the start of the pandemic to end of January 2021 in the Druze towns of Magd and Shams, there were 1602 COVID-19 cases registered and 83 patients hospitalized; and in Bukata, there were 895 COVID-19 cases and 27 patients hospitalized; 15 COVID-19 fatalities were reported in each town. A vaccination campaign was launched in early 2021 and as of 25 January 2021, 16.5% of the Druze residents in Majdal Shams have received a first dose of COVID-19 vaccine and 6.1% have received the second dose. In Bukata, 16.8% of residents have received a first dose of COVID-19 vaccine and 3.95% a second dose. As of 8 April 2021, the vaccination coverage for the general population in Israel was 57% for the first dose and 53% for the second dose, while in Majdal Shams, Bukata, Masade Ein Kenia it was 55–64% for the first dose and 50–57% for the second dose.[1]

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

Demographics, health outcomes and health inequities

11. The estimated Palestinian population living in the occupied Palestinian territory by mid–2021 is 5.2 million, with 3.12 million in the West Bank, including east Jerusalem, and 2.11 million in the Gaza Strip.[2] Approximately 350 000 Palestinian residents live within the Israeli-defined municipality[3] of Jerusalem, an area annexed by Israel after 1967 that comprises the pre-1967 municipality of east Jerusalem (6km^2) and 64km^2 of surrounding land in the West Bank.[4] More than 2.3 million United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA)-registered

[1] The Israeli Ministry of Health Corona Dashboard. (https://datadashboard.health.gov.il/COVID-19/general).

[2] Palestinian Central Bureau of Statistics (PCBS), Estimated Population in Palestine Mid-Year by Governorate,1997–2021; 2017. (http://www.pcbs.gov.ps/Portals/_Rainbow/Documents/2017-2097%انجليزي20%المحافظات.html, accessed 11 March 2021).

[3] Korach, M. & Choshen, M., Jerusalem: Facts and Trends 2019; Jerusalem Institute for Policy Research, 2019. (https://jerusaleminstitute.org.il/wp-content/uploads/2019/05/PUB_505_facts-and-trends_eng_2019_web.pdf, accessed 11 March 2021).

[4] Salem, W, "The East Jerusalem Municipality: Palestinian Policy Options and Proposed Alternatives", Jerusalem Quarterly 74 (2017). pp.120–136.

Palestine refugees reside in the occupied Palestinian territory and more than 3.4 million reside outside it.[1] In the Gaza Strip, the 1.48 million Palestine refugees constitute about 70% of its population. One quarter of the refugees in the West Bank live in the 19 camps located there and more than half a million refugees live in the eight camps in the Gaza Strip.[2] The overall Palestinian population is predominantly young: nearly 40% of Palestinians are aged 0–14 years, while 5% are aged 65 years or older.[3]

12. Life expectancy at birth for Palestinians in the occupied Palestinian territory was 74.0 years in 2019 (73.6 for the Gaza Strip; 74.3 for the West Bank).[4] In the same year, infant mortality for Palestinians in the West Bank and the Gaza Strip was reported to be 16.6 per 1000 live births and the under-5 mortality was 19.4 per 1000.[5] Health inequities represent systematic differences resulting from the political, economic and social conditions in which people are born, grow, live, work and age.[6] There are differences in health outcomes among Palestinian populations, including among those living in the West Bank and those living in the Gaza Strip; among those living in towns, villages, refugee camps or Bedouin camps; and among populations in differently categorized areas, such as Area C, east Jerusalem and the access restricted area in the Gaza Strip. There are different patterns of ill health or disease according to age and gender. Gaps in the disaggregation of data for different Palestinian populations, particularly by geographical location, limit the analysis of health inequities. The Jewish Israeli settler population in the West Bank, estimated to comprise more than 600 000 persons,[7] compared to Palestinians living in the same territory, have a life expectancy more than nine years higher,[12,8] an infant mortality more than five times lower and a maternal mortality rate nine times lower in 2019.[5,9] For the same year, Israel reports that non-Jewish groups who self-define as Palestinian or Arab with Israeli residency or citizenship, including Palestinians in the Israeli-defined municipality of Jerusalem, have a life expectancy 3.2 years lower for women (81.9 versus 85.1) and 3.7 years lower for men (78.1 versus 81.8).[8]

13. Noncommunicable diseases remain the leading cause of mortality in the occupied Palestinian territory, accounting for more than two thirds of all Palestinian deaths in 2019.[4] According to statistics provided by the Palestinian Ministry of Health, perinatal deaths and congenital malformations accounted for more than 10% of deaths; while transport accidents, falls, drowning and assault together accounted

[1] Data provided by the United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNRWA, 2021).

[2] UNRWA, Where we work. (https://www.unrwa.org/where-we-work, accessed 7 March 2021).

[3] PCBS, Indicators; 2020 (http://www.pcbs.gov.ps/site/lang__en/881/default.aspx#, accessed 7 March 2021).

[4] Palestinian Health Information Centre (PHIC), Health Annual Report: Palestine 2019; 2020. Life expectancy statistics for the occupied Palestinian territory exclude the majority of Palestinians resident in east Jerusalem, due to lack of access to vital statistics collected by Israeli authorities for the annexed territory.

[5] United Nations Inter-Agency Group for Child Mortality Estimation, 2020. (https://childmortality.org/data/State%20of%20Palestine, accessed 7 March 2021).

[6] WHO, "10 facts on health inequities and their causes"; 2020 (https://www.who.int/features/factfiles/health_inequities/en/, accessed 11 March 2020).

[7] United Nations Office for the Coordination of Humanitarian Affairs (OCHA), Humanitarian Facts and Figures. Occupied Palestinian Territory; 2018.

[8] Israeli Central Bureau of Statistics; 2020 (https://www.cbs.gov.il/he/publications/doclib/2020/3.shnatonhealth/st03_05.pdf, accessed 7 March 2021).

[9] United Nations Inter-Agency Group for Child Mortality Estimation, 2020. (https://childmortality.org/data/Israel, accessed 11 March 2021).

for 2.9%. Suicide as a recorded cause of death accounted for 0.3% of overall mortality and was more than eight times higher among males than females.[4]

Structural vulnerabilities of the Palestinian health system before COVID-19

14. Prior to the outbreak of COVID-19 in the occupied Palestinian territory on 5 March 2020, the Palestinian health care system was already fragmented and fragile. Responsibilities for the right to the highest attainable standard of health for Palestinians in the occupied Palestinian territory apply to all duty bearers: Israel as occupying power, the Palestinian Authority, the de facto authority in the Gaza Strip and third States. The Palestinian Authority was endowed with "powers and responsibilities in the sphere of Health in the West Bank and the Gaza Strip" under the Oslo Accords. However, in practice, health system governance and the ability of the Palestinian Ministry of Health to reach communities in all parts of the West Bank and the Gaza Strip is hampered by the administrative and physical fracturing of the occupied Palestinian territory, accompanied by heavy controls and limitations on the movement of people within and between, as well as into and out of, areas under Palestinian control. Meanwhile, adequate and sustainable financing of public health care is impeded by the economic conditions of occupation. Revenue-raising for public health care provision has been detrimentally affected by the cumulative loss of billions of dollars to the Palestinian economy through lack of control over natural resources,[1] fiscal leakage of trade tax revenues, reduced income tax revenues due to high levels of unemployment and the economic impacts of restrictions on the movement of people, goods and services.[2]

15. In the Gaza Strip, the closure and blockade that have lasted more than 13 years, since 2007, have contributed to its isolation from the West Bank, including east Jerusalem, and affected all aspects of life from the underlying determinants of health to the availability and quality of, as well as access to, health care. Successive major escalations of violence in 2008–2009, 2012, 2014 and, most recently, during the "Great March of Return" in 2018–2019, have had a detrimental effect on the development of the health system, diverting funds to emergency humanitarian response and needs, while political division has further contributed to persistent and growing inequities between the Gaza Strip and the West Bank. In the public health care system, the longstanding lack and shortage of essential medicines and medical disposables adversely impacts the effective coverage and quality of health services, while increasing out-of-pocket payments for patients and their families when drugs and supplies are available in the private sector. In February 2020, before the outbreak of COVID-19 in the occupied Palestinian territory, already 39% of essential medicines and 31% of essential medical disposables had less than one month's stock remaining in Gaza's Central Drugs Store.[3] Over the duration of 2020, an average of 44% of essential medicines and 31% of essential disposables were at "zero stock" (less than one month's supply) at the time of monthly stocktakes.[3] In the whole of the occupied Palestinian territory, there are critical shortages of human resources affecting certain medical and surgical specialties, including family medicine, nephrology, ophthalmology, cardiac surgery, psychiatry, emergency medicine, radiology,

[1] World Bank, Area C and the Future of the Palestinian Economy; 2013. (documents1.worldbank.org/curated/en/137111468329419171/pdf/AUS29220REPLAC0EVISION0January02014.pdf, accessed 11 March 2021).

[2] United Nations Conference on Trade and Development (2020). Report on UNCTAD assistance to the Palestinian people: Developments in the economy of the Occupied Palestinian Territory report. TD/B/67/5.

[3] Data provided by the Central Drugs Store, Gaza Strip, 2021.

rheumatology, pathology, neurology and neurosurgery.[1] These shortages and lack of medicines, supplies and expertise compound gaps in the availability of certain medical equipment, such as for radiotherapy and nuclear medicine scanning, and drive dependence on referrals to health care providers outside the Ministry of Health, most of which are within the occupied Palestinian territory yet require Israeli-issued permits to pass the Israeli checkpoint at Beit Hanoun (Erez).[2]

16. The annexed area of east Jerusalem, more than 90% of which comprises the land of Palestinian villages and municipalities in the West Bank that surrounded the pre-1967 municipality of east Jerusalem,[3] has been physically disconnected from the rest of the occupied Palestinian territory by the route of the separation barrier to the east, with Palestinians from the West Bank and the Gaza Strip outside east Jerusalem required to obtain Israeli-issued permits to reach the city.[4] Palestinians in the city may apply for a residency status that is dependent on repeatedly demonstrating a continued "centre of life" (place of residence or work) in the city. From 1967 to May 2019, Israel revoked the residency status of 14 643 Palestinians – a number that increases to approximately 86 000 when including dependent children who have also lost their residency rights.[5,6] East Jerusalem residency entitles Palestinians to access Israeli health insurance, to which Palestinians in the rest of the West Bank and the Gaza Strip are not entitled. The six major Palestinian hospitals of the East Jerusalem Hospital Network are subject to the clinical and safety regulations set by the Israeli Ministry of Health and are remunerated under the Israeli health insurance system for eligible patients. However, the hospitals form a cornerstone of the Palestinian health care system, with a substantial proportion of their income dependent on reimbursement for services to Palestinian patients funded by the Palestinian Ministry of Health. Barriers to revenue-raising for the Palestinian Ministry of Health and successive fiscal crises have therefore had a knock-on effect on arrears with non-Ministry of Health providers, including the East Jerusalem Hospital Network, which accounted for 38% of all referrals by the Palestinian Ministry of Health in 2020.[7]

17. In the West Bank outside east Jerusalem, administrative subdivisions have created areas nominally under Palestinian civil and security control (A, H1), Palestinian civil and Israeli military control (B) and Israeli civil and military control (C, H2). In practice, the Israeli military operates in all areas of the West Bank. Growing physical division due to the separation barrier, expanding settlement infrastructure and extensive road obstacles – including fixed and "flying" checkpoints – has contributed to the atomization of areas under Palestinian civil control, accompanied by severe constraints on development and access for Palestinian communities in other areas, including Area C, which comprises more than 60% of the surface area in the West Bank, where even the establishment of permanent or semi-permanent facilities for the provision of health care is constrained by planning policies that are

[1] WHO, Palestinian Ministry of Health and PNIPH, National Human Resources for Health Observatory: Health Workforce Dynamics in Palestine; 2020.

[2] For more detail on data on access barriers, see para. 29 and ff.

[3] Salem, W, "The East Jerusalem Municipality: Palestinian Policy Options and Proposed Alternatives", Jerusalem Quarterly 74 (2017), pp.120–136.

[4] In the West Bank, most women over 50 years, men over 55 years and children under 14 years are exempted from this requirement, provided they are not traveling on a Saturday, before 8 a.m. or after 7 p.m.

[5] The Association for Civil Rights in Israel, East Jerusalem Facts and Figures 2019:; 2019. (https://fef8066e-8343-457a-8902-ae89f366476d.filesusr.com/ugd/01368b_20dc66c3a088465286ce4c6d5a87c56c.pdf, accessed 7 March 2021).

[6] Al Haq, Residency revocation: Israel's forcible transfer of Palestinians from Jerusalem; 2017 (http://www.alhaq.org/advocacy/6331.html, accessed 11 March 2021).

[7] Data provided by the Services Purchasing Unit of the Palestinian Ministry of Health, 2021.

discriminatory against Palestinians.[1] An area known as the "Seam Zone" lies between the 1949 Armistice Line, which demarcates the West Bank, and the separation barrier. This Zone is within the 9% of land in the West Bank that falls on the Israeli side of the barrier. Palestinians who live here require Israeli approval to enter or exit their communities, with Palestinians from outside those communities required to obtain Israeli permits to enter. Access is constrained and frequently controlled via a single gate along the barrier, such as for the communities in Beit Iksa near Jerusalem and Arab ar-Ramadin ash-Shamali near Qalqilya. Constraints on development and access contribute to humanitarian health needs, particularly in Area C, H2 of Hebron and the Seam Zone. Over 170 000 people in 180 communities in Area C, H2 of Hebron and the Seam Zone depend on the provision of primary health care services by mobile clinics; by the end of December 2020, mobile clinic partners reached 146 925 people.[2]

18. In addition to these geographical and economic vulnerabilities, long-term displacement and refugeehood since 1948 has created enduring and large-scale humanitarian needs for the Palestinian people, including for the provision of essential basic health care. UNRWA is mandated to provide humanitarian assistance for health care to Palestine refugees, with more than two fifths (44%) of the Palestinian population in the West Bank, including east Jerusalem, and the Gaza Strip holding registered refugee status. UNRWA delivers primary health care in the occupied Palestinian territory through 65 primary health care centres, with 22 in the Gaza Strip and 43 in the West Bank, including east Jerusalem, while providing secondary and tertiary care through its network of contracted hospitals, as well as through the direct provision of services at Qalqilya Hospital in the West Bank. In 2020, 45% of Palestine refugees in the West Bank and 81% of those in the Gaza Strip accessed UNRWA preventive and curative services. Meanwhile, 36 991 Palestine refugees were provided secondary or tertiary care funded by UNRWA. In 2020, UNRWA's financial situation remained critical. The Agency's shortfall for its programme budget was US$ 75 million, with an additional sum of US$ 152 million needed for its COVID-19 response. As of December 2020, the Gaza Strip had received 55% of total requirements, while 86% was received for interventions specific for COVID-19 response in the West Bank.[3]

COVID-19 preparedness and response in 2020

19. The Palestinian Authority announced a state of emergency after the first cases of COVID-19 were confirmed in the occupied Palestinian territory on 5 March 2020, in the Bethlehem area. The entry of foreign tourists was prohibited, while schools, universities, mosques and churches were closed for the initial duration of one month.[4] Palestine's COVID-19 Response Plan was released on 26 March 2020, outlining the Government's overall strategic response to the pandemic, an aid coordination approach and its financial needs to undertake effective public health measures while sustaining existing functions. The Palestinian Ministry of Health established the National COVID-19 Health Committee and the National Epidemiological Committee, with technical support and representation from WHO, to strengthen the effective monitoring of the public health and epidemiological situation and provide recommendations to the Palestinian National Emergency Committee. The United Nations Country Team

[1] United Nations Human Rights Council , Israeli settlements in the Occupied Palestinian Territory, including East Jerusalem, and in the occupied Syrian Golan: Report of the United Nations High Commissioner for Human Rights, document A/HRC/46/65; 2021.

[2] Data provided by the Health Cluster in the occupied Palestinian territory, 2021.

[3] Information provided by UNRWA, 2021.

[4] WAFA News Agency, "Palestinian premier, with emergency powers, shuts down country for one month over corona"; 2020. (https://english.wafa.ps/Pages/Details/101601, accessed 11 March 2021).

established an Inter-Agency COVID-19 Task Force, which published a response plan on 14 March 2020 that was updated on 27 March and 23 April.[1] As of 28 January 2021, for the health response, the numbers of items delivered or procured for identified case management needs covered: 92% of ventilators, 119% of patient monitors, 88% of oxygen concentrators, 66% of additional beds in intensive care units and 88% of additional patient beds. For infection prevention and control, by the same date, deliveries and procurements of items had covered: 68% of needed surgical masks, 130% of N-95 respirators and 117% of surgical gloves. Meanwhile, for laboratory equipment, deliveries and procurements by 28 January 2021 had met 51% of needs for polymerase chain reaction (PCR) tests for COVID-19 and 53% of needs for swabs/medium for sample collection.[2]

20. For risk communication and community engagement, the Palestinian Ministry of Health set up a task force comprising WHO, UNICEF, the Bank of Palestine and the Palestinian International Cooperation Agency, with representation from other United Nations agencies and nongovernmental organizations, which implemented a national health awareness campaign. An evaluation of health promotional activities and community awareness, published in September 2020, found that half of the respondents had high levels of knowledge about COVID-19, while a further two fifths of respondents had mid-high levels of knowledge – correlating with highly positive (45%) and moderately positive (52%) levels of self-reported adherence to preventive practices.[3] However, barriers to adherence of public health measures in practice included the economic impact of restrictions, combined with a lack of adequate social security, with 90% of respondents reporting worry about the impact of the pandemic on household income. Furthermore, the survey found an overall high impact on self-reported mental well-being. Over the course of the pandemic, public adherence to guidance and regulations for preventing the spread of COVID-19 declined substantially.[4]

21. The public health surveillance system in the occupied Palestinian territory is well established and was able to effectively respond to the COVID-19 outbreak by collecting, analysing and reporting data on total confirmed cases, active cases, recovered cases, deaths from COVID-19, trends in time and place, and with disaggregation by age, gender and specific groups, such as health workers, travellers and workers in Israel and its settlements in the West Bank.[5] The Palestinian Authority's lack of effective control in east Jerusalem, combined with the end to coordination with Israeli authorities between May and November 2020, created barriers to its reliable and comprehensive detection of Palestinian COVID-19 cases in the city. Data reported by the Palestinian Ministry of Health on positive cases of Palestinians in east Jerusalem was derived from public and unofficial sources. Effective surveillance has depended on comprehensive detection of COVID-19 cases in the population through the availability of testing and laboratory equipment. In the West Bank, the positivity rate of COVID-19 tests carried out exceeded 30% in early April 2020, indicating that more than three in every 10 tests carried out were

[1] United Nations Humanitarian Country Team in the occupied Palestinian territory. COVID-19 Response Plan; 2020. (https://www.ochaopt.org/sites/default/files/covid-19-response-plan-inter-agency-opt.pdf, accessed 11 March 2021).

[2] United Nations Office for the Coordination of Humanitarian Affairs in the occupied Palestinian territory, COVID-19 Emergency Situation Report 27 (14–28 January 2021); 2021. (https://www.ochaopt.org/content/covid-19-emergency-situation-report-27, accessed 11 March 2021).

[3] ABC Consulting, KAP Study for the "Risk Communication and Community Engagement Plan (RCCE)" for the State of Palestine; 2020.

[4] United Nations Office for the Coordination of Humanitarian Affairs in the occupied Palestinian territory, COVID-19 Emergency Situation Report 25 (17–30 December 2020); 2020. (https://www.ochaopt.org/content/covid-19-emergency-situation-report-25, accessed 11 March 2021).

[5] Palestinian Ministry of Health, "CORONAVIRUS – COVID19 Surveillance System"; 2021. (المرصد الالكتروني لفايروس كورونا المستجد - كوفيد 19 (moh.ps), accessed 11 March 2021).

positive and that the level of testing may not have been sufficient for the number of COVID-19 cases in the population. The positivity rate rose again to greater than 20% on average from late November to late December 2020, during a major peak in incident cases. The figure had been consistently below 5% from late April to mid-June 2020.[1] In the Gaza Strip, there was also a substantial increase in the positivity rate, from a low of less than 4% in mid-September to reach a high of more than 37% in mid-December 2020.[2] This increase in the positivity rate occurred in the context of a major peak in COVID-19 cases and in the wake of a period of severe shortages of laboratory testing kits in the Gaza Strip.

22. Control of population movements and implementation of quarantine measures at points of entry has been essential for an effective public health response to COVID-19. In the occupied Palestinian territory, all points of entry except for the Rafah border crossing to Egypt, are controlled by, and have required coordination with, Israel. On 18 March 2020, the Palestinian Authority reported a high level of coordination with Israeli authorities in measures taken to contain the virus in and around Bethlehem, recognizing the need for this in the context of "shared borders and relations".[3] However, on 19 May 2020, after Israeli announcements of the further annexation of large parts of the West Bank, the Palestinian Authority announced that it considered itself to be absolved of its agreements with Israel and that it would cease coordination activities with Israeli authorities. This had profound implications for the coordination of the public health response to the pandemic, particularly at points of entry, and affected the movement of health workers, ambulances, patients and their companions, as well as import approvals for essential medical supplies. Meanwhile, Israel continued to impose bureaucratic and physical restrictions on Palestinian movement through its permits regime for Palestinians in the occupied Palestinian territory outside east Jerusalem and its infrastructure of settlements, roads, checkpoints, road barriers and the separation wall in the West Bank.

23. Efforts to ensure effective infection prevention and control in health care facilities incorporate administrative and environmental measures, in addition to the supply of personal protective equipment, including masks and gloves. With regard to administrative measures, humanitarian health partners worked to provide training to front-line health care workers for effective protection from respiratory viruses. From the start of the COVID-19 outbreak in the occupied Palestinian territory to the end of January 2021, health partner organizations had provided 75 training events that benefited 4182 health care workers. By 2 February 2021, at least 4356 health care workers had tested positive for COVID-19 (2314 in the West Bank, as of 26 January 2021; 2042 in the Gaza Strip).[37] Health facilities also adopted new protocols to minimize COVID-19 risks for patients and staff, including limiting face-to-face consultations and expanding telemedicine services.

24. Early during the COVID-19 outbreak in the occupied Palestinian territory, the Palestinian Authority and de facto authorities in the Gaza Strip implemented strict quarantine procedures, including mandatory quarantine in designated facilities. In the West Bank, this policy was phased out as the number of cases increased, with a shift towards home quarantine and isolation. In the Gaza Strip, however, the policy of mandatory quarantine in designated facilities remained in place from 15 March until 14 November 2020, continuing after the first occurrence of community spread of the virus there

[1] Data provided by the Palestinian National Institute of Public Health, 2021.

[2] Palestinian Ministry of Health, Palestinian National Institute of Public Health and WHO, "COVID-19 Cases in the Gaza Strip: Weekly epidemiological bulletin from (10/01 TO 16/01 2021) and (17/01 TO 23/01 2021)"; 2021. (http://www.emro.who.int/images/stories/palestine/documents/COVID-19_Gaza_epidemiological_bulletin_24Jan2021.pdf?ua=1, accessed 11 March 2021).

[3] Abu Toameh, K., " Israel, Palestinians set up joint operations room to combat coronavirus", Jerusalem Post. (www.jpost.com/israel-news/israel-palestinians-set-up-joint-operations-room-to-combat-coronavirus-621431, accessed 11 March 2021).

on 24 August 2020. The policy was applied to all persons entering the Gaza Strip, except for some humanitarian workers. This included patients and their companions returning from receiving health care outside the Gaza Strip; by 24 August, the required length of quarantine was 21 days. Similarly, beginning at an early stage, the Palestinian Authority and de facto authorities established isolation centres to accommodate persons with confirmed COVID-19 cases, irrespective of their symptom severity. Following the community spread of the infection, there was a shift towards home isolation, with hospital admissions limited according to symptom severity.

25. For case management, health services had to be upscaled and adapted to improve the effective detection and treatment of persons with COVID-19 infection. In east Jerusalem, St Joseph Hospital and Makassed Hospital were designated as treatment centres for COVID-19 patients, with an additional ward established at St Joseph Hospital to increase bed capacity for COVID-19 treatment from 50 to 72 hospital beds in east Jerusalem.[1] In the West Bank outside Jerusalem, the Bethlehem drug rehabilitation centre was repurposed to treat COVID-19 patients, while every Ministry of Health governorate hospital designated a ward for the treatment of COVID-19 patients. Services from health care providers outside the Ministry of Health also had to be negotiated wherever the capacity of designated wards was exceeded in the West Bank. In the Gaza Strip, the European Gaza Hospital in Khan Younis was repurposed to receive moderate, severe and critical cases of COVID-19, while the Turkish Hospital in the Gaza Strip received patients with moderate severity COVID-19. In November 2020, bed capacity in the Gaza Strip for COVID-19 patients was: 70 intensive care unit beds (for critical severity, all at the European Gaza Hospital); 80 high-dependency beds (for patients with severe COVID-19, all at the European Gaza Hospital); 350 hospital beds for moderate cases (180 at the European Gaza Hospital; 170 at the Turkish Hospital).[2] Humanitarian health partners also supported the strengthening of case management protocols. For example, WHO supported the capacity-building of 637 health workers, including doctors and nurses who provide respiratory triage and the case management of severe and critical care in intensive care units. The case fatality rate in the occupied Palestinian territory was 1.1% as of 28 January 2021.[3] This compares unfavourably to Israel (0.75%) but is lower than neighbouring Jordan (1.3%) and Egypt (5.5%).[4] A higher positivity rate for COVID-19 testing indicates a lack of available testing supplies and a greater number of undetected mild/moderate cases of COVID-19, however, which affects the denominator for calculating the case fatality rate and inflates it.

26. Vaccines save millions of lives each year and have become a critical tool in efforts to end the COVID-19 pandemic. In December 2020, the Palestinian Authority submitted a request for COVID-19 vaccines for Palestinians in the West Bank and the Gaza Strip through the COVID-19 Vaccine Global Access (COVAX)/Advance Market Commitment (AMC) facility. On 30 January 2021, the COVAX/AMC facility confirmed approval for the occupied Palestinian territory to receive an initial 37 440 doses of Pfizer/BioNTech vaccine, intended for front-line health care workers and subject to approvals of supply agreements with manufacturers, with a further 240 000 doses of the AstraZeneca

[1] Data provided by East Jerusalem Hospital Network, 2021.

[2] Data provided by health authorities in the Gaza Strip, 2021.

[3] WHO, "Coronavirus disease (COVID-19) in the occupied Palestinian territory"; 10 March 2021. (https://app.powerbi.com/view?r=eyJrIjoiODJlYWM1YTEtNDAxZS00OTFlLThkZjktNDA1ODY2OGQ3NGJkIiwidCI6ImY2MTBjMGI3LWJkMjQtNGIzOS04MTBiLTNkYzI4MGFmYjU5MCIsImMiOjh9, accessed 11 March 2021).

[4] United Nations Office for the Coordination of Humanitarian Affairs in the occupied Palestinian territory, COVID-19 Emergency Situation Report 28 | February 2021; 2021. (https://www.ochaopt.org/content/covid-19-emergency-situation-report-28, accessed 11 March 2021).

vaccine expected subsequently, with delivery planned from March to June 2021. Civil society organizations raised concerns regarding Israel's fulfilment of its obligations under the Geneva Conventions in connection with vaccinating Palestinians in the occupied Palestinian territory. In particular, concerns focused on Article 55(1) of the Fourth Geneva Convention as establishing Israel's duty as occupying power to ensure the provision of medical supplies to the civilian occupied population, to the fullest extent of the means available to it.[1] Initially, after Israel began the administration of COVID-19 vaccines in December 2020, only Palestinians with residency in east Jerusalem, Palestinian prisoners in Israeli gaols and Palestinian health care workers in Israeli hospitals or Palestinian hospitals in east Jerusalem were eligible to receive vaccines. Subsequently, from the beginning of March 2021, Israel began vaccinating Palestinians with permits to work in Israel and its settlements in the West Bank. By the end of January 2021, Israel had transferred 2000 doses of vaccines to the Palestinian Authority. The Palestinian Ministry of Health completed its National Deployment and Vaccination Plan for the equitable distribution of vaccines received through the COVAX/AMC facility to the Palestinian population in the West Bank and the Gaza Strip, which aims to prioritize the protection of front-line health care workers and those with an underlying predisposition to more severe health consequences from contracting the virus, in line with WHO recommendations. Findings of a qualitative study undertaken in early March suggest significant scepticism towards the COVID-19 vaccine in the occupied Palestinian territory, despite historically high rates of uptake for other vaccines.[2]

27. The maintenance of provision of essential health services for the population has been detrimentally affected by the need to reallocate limited resources, including human resources, to COVID-19 preparedness and response. In the Gaza Strip, for example, only 12 of the 54 primary care facilities (22%) remained open throughout the outbreak of COVID-19 in the occupied Palestinian territory, while 12 facilities (22%) remained closed by the end of October 2020.[3] There were efforts made to ensure sustained provision of essential services, such as immunization, prenatal and postnatal care and the management of chronic conditions, as well as to adapt services for remote consultations or telemedicine, where possible; however, the quality and coverage of services was challenged by reduced capacity and overstretching. Similarly, in the West Bank, East Jerusalem Hospitals observed a 40% decline in hospital admissions in March 2020 and 54% decline in April, compared with corresponding months in 2019.[4] With severe access restrictions affecting the Gaza Strip, the proportion of referrals to East Jerusalem Hospitals declined from 50% in the latter half of 2019 to 36% in 2020.[5] Outpatient appointment consultations had declined by 57% in March 2020 and 72% in April 2020, compared to the corresponding months in 2019, while the rate of elective surgery declined by 43% and 66% and that of essential non-elective surgery by 68% and 74% for the same months compared to the corresponding months for 2019.[6] For Palestinian Ministry of Health hospitals in the West Bank outside east Jerusalem, there was a similar dramatic reduction across different measures of hospital utilization. From March to May 2020, the largest observed reductions were in April for hospital outpatient appointments (81% reduction), surgical operations (51% reduction), hospital emergency admissions

[1] "Racism and Institutionalised Discrimination in the Roll-Out of the COVID-19 Vaccine", PNGO, PNIN & PHROC Joint Statement; 2021 (https://www.alhaq.org/advocacy/17767.html, accessed 11 March 2021).

[2] Information provided by the Protection Cluster in the occupied Palestinian territory, 2021.

[3] Data provided by the Palestinian Ministry of Health, 2021.

[4] WHO, "Coronavirus disease (COVID-19) in the occupied Palestinian territory"; 10 March 2021. (https://app.powerbi.com/view?r=eyJrIjoiODJlYWM1YTEtNDAxZS00OTFlLThkZjktNDA1ODY2OGQ3NGJkIiwidCI6ImY2MTBjMGI3LWJkMjQtNGIzOS04MTBiLTNkYzI4MGFmYjU5MCIsImMiOjh9, accessed 11 March 2021).

[5] Data provided by the Services Purchasing Unit of the Palestinian Ministry of Health, 2021.

[6] Data provided by the East Jerusalem Hospital Network, 2021.

(49% reduction), hospital general admissions (30% reduction) and hospital bed occupancy (23% reduction).[3]

28. For the provision of essential humanitarian health care, the huge demands and redirection of efforts due to COVID-19 hindered the ability of Health Cluster partners to meet the targets set at the beginning of 2020. Consequently, partners were only able to reach 58% of the population targeted by the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP). Specific Special Programme-related activities were more severely impacted by underfunding, such as mobile clinic service delivery, for which only 36% of activities were funded. Public health measures introduced to combat COVID-19, such as movement restrictions, also meant that many partners had to postpone or adapt Special Programme activities for most of 2020.

Exacerbated barriers to accessing essential health services and cessation of coordination between the Palestinian Authority and Israel

29. Israel continued the implementation of its permits regime for Palestinians in 2020, with longer-term access barriers for Palestinian patients, companions, health care workers and ambulances exacerbated in the context of the COVID-19 pandemic and the end to coordination between the Palestinian Authority and Israel. By the end of February, before the outbreak of COVID-19 in the occupied Palestinian territory, more than 1000 patient permit applications from the Gaza Strip[1] and more than 1500 patient permit applications from the West Bank had been unsuccessful, either denied by Israel or without any definitive response by the time of the patient's hospital appointment.[2] For the Gaza Strip, 69% of the 3554 patient permit applications submitted in January and February were approved, while 81% of the 16 574 submitted in the West Bank were approved for travel to reach health care. By April 2020, there had been a more than 90% decline in permit applications for patients and companions from the Gaza Strip and the West Bank, outside east Jerusalem, compared to monthly applications for January and February.[1,2] A similar decline was recorded in the number of patient and companion exits through the checkpoint at Beit Hanoun (Erez) to reach the rest of occupied Palestinian territory, Israel and Jordan from the Gaza Strip. The reduction in patient and companion permit applications was proportionately larger than the decline in referrals issued by the Palestinian Ministry of Health, which in April 2020 had reduced by 41% for the West Bank and by 60% for the Gaza Strip, compared to the monthly referrals for the first two months of the year. In the West Bank, the monthly number of referrals issued recovered to pre-COVID-19 levels by June 2020,[4] with a decline in patient permits applications by 31% for the whole of 2020 compared to 2019 (from 112 881 to 78 385 applications over the year).[3] In the Gaza Strip, however, low numbers of referrals persisted for the rest of the year, with an average of 1122 referrals per month for Gaza patients from April to December 2020 (a 56% reduction).[48] There was a proportionately greater impact on referrals outside of the Gaza Strip, which declined from 82% in 2019 to 65% in 2020, with a similar decline in the proportion of referrals requiring permits, from 70% in 2019 to 52% in 2020.[4] Recorded patient permit applications for the Gaza Strip declined by 65%, from 26 279 in 2019 to 9085 in 2020.[3]

[1] Data provided by the Health Liaison Office in the Gaza Strip, 2021.

[2] Data provided by the Palestinian Civil Affairs Office, 2021.

[3] Permits data provided by Israeli COGAT, 2021.

[4] Data provided by the Services Purchasing Unit of the Palestinian Ministry of Health, 2021; for 2019, data for the destination of referrals is reported for April to December due to problems with data disaggregation from January to March.

30. The Palestinian Authority ceased coordination with Israeli authorities on 19 May 2020, in the context of the further annexation of large parts of the West Bank announced by Israel. This end to coordination affected permit applications, including for patients and their companions. In the West Bank, patients continued to apply for permits directly to Israeli authorities through the Israeli District Coordination Office located inside the West Bank. In the Gaza Strip, however, patients and companions were dependent on the coordination of permit applications by a third party. Several organizations assisted patients and their companions with permit applications from 19 May, including the Palestinian Centre for Human Rights, Physicians for Human Rights Israel, Augusta Victoria Hospital, Makassed Hospital, St John Hospital and the International Committee of the Red Cross. From 6 September, WHO established a temporary coordination mechanism in a system for permit applications that was integrated with the Palestinian Ministry of Health referrals system. This integration enabled a greater capacity to manage the high demand for patient and companion permits that had overwhelmed the capacities of other organizations. From June to September 2020, the number of referrals issued by the Palestinian Ministry of Health declined each month, in line with limited capacities to obtain permits, from 1288 in June to 783 in September. Referrals increased moderately after the introduction of WHO's temporary coordination mechanism in September 2020, with the Palestinian Authority re-establishing coordination with Israeli authorities from 24 November 2020.

31. With outbreaks of COVID-19 in neighbouring Egypt and Jordan, passage to and from these countries was affected considerably for much of 2020. From April to July 2020, there were no recorded exits from the Gaza Strip to Egypt. Despite this, referrals to Egypt continued to be issued, with more than 1100 issued from April to June 2020. Passage for Palestinians to Jordan from the West Bank was similarly not possible for much of the year. While there were no referrals to Jordan in March and April 2020 and two referrals each in May and June, more than 100 referrals to Jordan were issued by the Ministry of Health from August to December. WHO documented the case of Manal, a 6-year-old girl from Jabalia refugee camp in the Gaza Strip, who was unable to travel to Jordan for an appointment for an allogeneic bone marrow transplant on 9 March. After more than three months waiting in accommodation provided by An-Najah Hospital in Nablus, she returned to the Gaza Strip without receiving treatment. After spending 21 days in quarantine, Manal died on 7 August in the Gaza Strip.[1]

32. Limitations on movement also affected access for health care workers, medical teams and ambulances in 2020. For ambulances requiring passage to east Jerusalem from the rest of the West Bank, 97% were made to undergo the back-to-back procedure, with transfer of patients from Palestinian-registered ambulances to Israeli-registered ambulances delaying transit.[2] Palestinian ambulances require Israeli licenses for their operations in east Jerusalem. In 2019 and 2020, the Palestine Red Crescent Society faced difficulties renewing licenses for its ambulances, reportedly being asked to remove the word "Palestine" from emblems. New ambulance licenses were being renewed on a three-month basis rather than the previous biannual (every two years) basis, creating additional administrative and bureaucratic demands on the organization's administration.[2] This issue was resolved in early 2021. For health staff requiring permits to reach places of work in east Jerusalem, for four of the six hospitals reporting data in 2020, 98% of applications for staff permits were approved for six months, while just over 1% were approved for three months and nine applications were denied.[3] In the Gaza Strip, permit

[1] WHO, "6-year-old Manal returns to the Gaza Strip after being unable to cross to Jordan for treatment"; 2020. (http://www.emro.who.int/pse/palestine-infocus/6-year-old-manal-returns-to-the-gaza-strip-after-being-unable-to-cross-to-jordan-for-treatment.html, accessed 11 March 2021).

[2] Data provided by the Palestine Red Crescent Society, 2021.

[3] Data provided by East Jerusalem Hospitals, 2021.

applications for training, conferences and workshops – including for health care workers – declined by 64% from 2019 to 2020.[1] Similarly, recorded exits across the checkpoint at Beit Hanoun (Erez) for Palestinian employees of international organizations declined by 72%.[2]

33. The end to coordination with Israel in May 2020 exacerbated the fiscal crisis facing the Palestinian Authority, which did not accept tax revenues collected by Israel. The situation impacted all major expenditures for the Palestinian Ministry of Health, namely staff salary payments, payments to nongovernmental, private and other health care providers of referral services, the provision of essential medicines and supplies and debt payments.[3] Escalating arrears with Palestinian health care providers, such as East Jerusalem Hospitals, Al Ahli Hospital in the West Bank and Al Hayat Specialized Hospital in the Gaza Strip, had a knock-on impact on payments for hospital staff and the ability of these institutions to sustain services. For East Jerusalem Hospitals, this came in the context of significantly reduced services utilization and bed occupancy, affecting hospitals' income, due to reductions in referrals and restrictions of movement that particularly affected the Gaza Strip. By the end of September 2020, the Palestinian Ministry of Health had accumulated debts of US$ 68 million with East Jerusalem Hospitals, the majority (78%) owed to Augusta Victoria Hospital.[2] Similarly, Makassed Hospital faced near-closure in July 2020 due to outstanding debts and reduced revenues, which forced the hospital to lay off 108 staff and withhold or severely reduce salary payments to others – who received from 0 to 30% of their salaries during critical periods.[4] For Al Hayat Specialized Hospital in the Gaza Strip, cumulative debt for services provided to patients referred by the Palestinian Ministry of Health had reached 50 million new shekels by the end of October 2020. The hospital introduced a policy to restrict services provision only to cancer patients who experienced delays or denials in permit applications. In December 2020, Al Ahli Hospital in the West Bank stopped receiving thyroid cancer patients referred for radioiodine ablation therapy due to outstanding debts from the Ministry of Health, though the situation was resolved in that same month.

Underlying determinants of health, exposure to violence and attacks against health care

34. All aspects of life, encompassing underlying determinants of health, have been profoundly affected by the chronic occupation and situations of long-term displacement and blockade for Palestinians in the West Bank, including east Jerusalem, and the Gaza Strip. Israel's demolitions policy creates a precarity of housing, particularly for Palestinians in east Jerusalem and Area C, which collectively accounted for 98% of structure demolitions (79% of the total were in Area C) and 96% of persons displaced (72% of the total were in Area C) from 2009 to March 2021.[5] In addition to home demolitions, nearly one in 10 (9%) structures demolished were constructed for the purposes of water, sanitation and hygiene, while 13% were related to livelihoods and 29% to agriculture.[3] More than one third (34%) of households in the West Bank have limited access to safely managed water sources.[6] This includes over 170 000 persons in more than 100 communities in Area C who depend on rainwater

[1] Data provided by the Palestinian Civil Affairs Office, 2021.

[2] Data provided by 5/5 terminal authorities in the Gaza Strip, 2021.

[3] PHIC, Health Annual Report: Palestine 2019; 2020.

[4] Data provided by East Jerusalem hospitals, 2021.

[5] Data on demolition and displacement in the West Bank. OCHA; 2021. (https://www.ochaopt.org/data/demolition, accessed 11 March 2021).

[6] WASH Cluster State of Palestine, "Critical access to water during COVID-19 endangered by a rise in demolitions in the West Bank: The case of Masafer Yatta", 2021.

harvesting and water trucking, with tanked water supplies costing about six times more than piped water,[4] as well over 350 000 Palestinians with access to piped water receiving less than 50 litres per person per day, well below the WHO recommended daily amount of 100 litres.[1] At least 50 settlements are estimated to be discharging about 35 million cubic metres of wastewater onto Palestinian land each year, leading to the contamination of natural springs and crops and with implications for livestock and general population health.[2,3] In the Gaza Strip, 96% of households have limited access to safely managed water sources,[4] while only 4% of the 180 m^3 of groundwater abstracted each year from the Gaza aquifer meets drinking-water quality standards, owing to seawater intrusion and sewage pollution.[5] Meanwhile, the Gaza Strip discharges about 100 000 cubic metres of sewage into the Mediterranean daily,[4] the treatment of which falls below international standards due to power shortages and poor infrastructure.[6] Efforts to strengthen, build or rehabilitate infrastructure for the water, sanitation and hygiene services in health care facilities (WASH), health and other sectors are hindered by restrictions on the entry of materials and Israel's application of a dual use list applied to the whole of the occupied Palestinian territory, with an extended list applied to the Gaza Strip. Impacts on the health sector include the application of regulations for broad categories such as communications equipment, as well as limitations on the entry of specific supplies (such as for nuclear medicine scanning or certain materials used in limb prostheses) and delays associated with bureaucratic approval processes for the provision of spare parts for complex medical equipment.

35. The ongoing occupation, with the associated fragmentation of territory, limited access to natural resources, movement restrictions, import limitations and lack of control over customs revenues, has negatively affected the Palestinian economy and contributed to rising levels of poverty, food insecurity and unemployment.[7] In the Gaza Strip, closure and blockade has eviscerated the economy and contributed to some of the highest rates of unemployment in the world.[8] The COVID-19 pandemic has only exacerbated the situation. In the second quarter of 2020, unemployment in the Gaza Strip was 49.1%, an increase from 45.5% in the first quarter prior to the COVID-19 outbreak in the occupied Palestinian territory.[6] Unemployment is persistently higher among young people and women[6] and compares unfavourably in the Gaza Strip to an already high rate of just under 15% in the West Bank.[6] Meanwhile, the World Bank forecast that the poverty rate would increase from 53% to 64% in the Gaza Strip and more than double from 14% to 30% in the West Bank by the end of 2020. Food

[1] Palestinian Water Sector Regulatory Council , Water Service Providers Performance Report; January 2020.

[2] Premiere Urgence International, Environmental Impunity: The impact of Settlements Waste Water Discharge in the West Bank; 2021.(https://www.premiere-urgence.org/en/environmental-impunity-the-impact-of-settlements-waste-water-discharge-in-the-west-bank-2/, accessed 11 March 2021).

[3] Action Against Hunger, Settlements' wastewater dumping contaminating lands and springs. Case study: Nahhalin, Bethlehem Governorate; 2018.

[4] PCBS, Palestinian Multiple Indicators Cluster Survey (PMICS) 2019–2020; 2020. (http://www.pcbs.gov.ps/site/512/default.aspx?lang=en&ItemID=3871, accessed 11 March 2021).

[5] World Bank, Securing Water for Development in West Bank and Gaza 2018; 2018. (http://documents1.worldbank.org/curated/en/736571530044615402/Securing-water-for-development-in-West-Bank-and-Gaza-sector-note.pdf, accessed 11 March 2021).

[6] OCHA , Humanitarian Needs Overview OPT: Humanitarian Programme Cycle 2021; 2020.(https://www.ochaopt.org/sites/default/files/hno_2021.pdf, accessed 11 March 2021).

[7] UNCTAD, Report on UNCTAD assistance to the Palestinian people: Developments in the economy of the Occupied Palestinian Territory, document TD/B/67/5.

[8] UNCTAD, Occupied Palestinian Territory Has World's Highest Unemployment Rate; 2018 (https://www.ochaopt.org/sites/default/files/hno-hrp_dashboard_-_english.pdf, accessed 11 March 2021).

insecurity, which affected 68% of households in the Gaza Strip in 2018, affected 72% – over 1.4 million people – at the start of 2021.[5] In the West Bank, the rate of food insecurity again more than doubled from 12% of the population in 2019[1] to 28% by the beginning of 2021.[5]

36. The situation in the occupied Palestinian territory is a protracted protection crisis, with Palestinians exposed to high levels of violence. In 2020, 30 Palestinians were killed and 2751 injured in the context of occupation and conflict.[2] For 2020, 88% of recorded Palestinian fatalities related to occupation and conflict and 98% of recorded injuries were in the West Bank, in contrast to 2018 and 2019, when 84% of the 436 recorded Palestinian fatalities and 79% of the 46 750 recorded injuries were in the Gaza Strip; the vast majority of these occurring in the context of Gaza's "Great March of Return".[72] In 2020, nine of the 30 fatalities (30%) and 19% of recorded injuries where disaggregated data was available were among children under 18 years, while none of the fatalities and 1.4% of injuries were among women or girls.[72] There were three Israeli fatalities and 58 injuries in the same year.[72] In 2019, 29% of women surveyed by the Palestinian Central Bureau of Statistics reported experiencing some form of intimate partner violence in 2019.[3] In 2020, in the context of increased financial pressures, unpaid household work and restricted movements outside of households during COVID-19, providers of helplines for survivors of gender-based violence reported a 70% increase in calls.[4] Insecurity related to employment, housing and income, as well as experiences of violence, adversely affect mental health and well-being for Palestinians in the West Bank, including east Jerusalem, and the Gaza Strip. COVID-19 has exacerbated many of the drivers for poorer mental health and well-being, with nearly 550 000 persons estimated to be in need of mental health and psychosocial support services due to experience of distress and mental ill health at the start of 2021.[5]

37. High levels of exposure to violence have direct implications for schools and health care. In 2020, the United Nations verified 11 attacks against schools,[6] while WHO recorded 59 health attacks in the occupied Palestinian territory in its Surveillance System for Attacks on Health Care. Of these, 50 (85%) occurred in the West Bank compared to 9 (15%) in the Gaza Strip, while 49 (83%) occurred after the outbreak of COVID-19 in the occupied Palestinian territory. There were 25 (42%) health attacks that involved obstruction to the delivery of health care services, including 12 incidents of obstructing access for ambulance crews to reach persons who had been fatally wounded. Three fifths (61%; 36 attacks) involved physical violence against health workers, ambulances and health facilities, while six incidents (10%) involved the detention and/or arrest of health care workers, ambulance crews, patients, and patient companions. One incident may include more than one type of attack. Humanitarian space for health care provision, including for COVID-19 services, continued to be restricted, particularly in east Jerusalem and Area C of the West Bank. For example, on 15 March 2020, four paramedics of the Palestinian Medical Relief Society were arrested in east Jerusalem for distributing COVID-19 awareness materials.

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[1] OCHA, Humanitarian Needs Overview: Dashboard; 2019. (https://www.ochaopt.org/sites/default/files/hno-hrp_dashboard_-_english.pdf, accessed 11 March 2021).

[2] OCHA, Occupied Palestinian Territory: Data on casualties. (https://www.ochaopt.org/data/casualties, accessed 11 March 2021).

[3] PBCS, Preliminary Results of the Violence Survey in the Palestinian Society 2019; (http://www.pcbs.gov.ps/Downloads/book2480.pdf, accessed 11 March 2021).

[4] Data provided by the Gender-Based Violence Subcluster in the occupied Palestinian territory, 2021.

[5] OCHA, Humanitarian Needs Overview OPT: Humanitarian Programme Cycle 2021; 2020. (https://www.ochaopt.org/sites/default/files/hno_2021.pdf, accessed 11 March 2021).

[6] Education Cluster, Education Under Attack in 2020; 2021. (https://reliefweb.int/report/occupied-palestinian-territory/education-under-attack-2020-year-ongoing-violations-against, accessed 11 March 2021).

Similarly, a Relief Society mobile clinic providing essential primary health care to three communities in Area C close to Qalqilya was prevented access for four weeks, from 9 April to 7 May 2020, when they were not issued a permit to access the communities. Denial of access to ambulance crews to persons fatally wounded by Israeli forces included the incident of the shooting Iyad Al Hallaq, a 32-year-old Palestinian man with a learning disability who was shot in east Jerusalem on 30 May 2020.

Health of the prison population

38. In 2020, people deprived of liberty in institutionalized settings were at high risk of exposure to COVID-19.[1] WHO issued guidance on preparedness, prevention and control of COVID-19 in prisons and other places of detention, which was shared with the State of Israel and the Palestinian Authority.[2] The guidance provided recommendations on upholding human rights principles, risk assessment and risk management, referrals and clinical protocols, contingency planning, training, risk communication, prevention measures and case management. Palestinian prisoners in Israeli detention continued to receive health care services from the Israeli Prison Service, rather than the Israeli Ministry of Health or another independent provider. The International Committee of the Red Cross was able to access Israeli prisons to monitor implementation of guidance on preparedness, prevention and control of COVID-19, but is not able to report publicly on conditions for the estimated 4400 Palestinian prisoners, of whom 440 were under administrative detention without trial, 140 were child prisoners and 36 were women as of March 2021.[3] Civil society human rights organizations report problems with oversight, being unable to access prisons for monitoring purposes, as well as problems with the provision of timely and appropriate treatments and with review or implementation to ensure effective care pathways. In 2020, four Palestinian detainees died while incarcerated in Israeli prisons.[4] There are seven bodies of Palestinian prisoners who died in Israeli prisons currently withheld by Israel (two bodies from 2020; four bodies from 2016–2019; and one body from 1980).[4] As of January 2021, the number of COVID-19 cases recorded among Palestinian prisoners had reached 366, of which about 100 cases were documented in Gilboa Prison near to Beisan/Beit She'an.[5] Approximately 700 Palestinians were reported to be in need of medical assistance in Israeli prisons in January 2021, of whom 300 had chronic illnesses and at least 11 had a diagnosis of cancer.[5] Human rights organizations, on the basis of affidavits, report the systematic use of alleged torture and ill-treatment at Israeli interrogation centres, with a lack of intervention, medical care or reporting by Israeli Prison Service doctors. In 2020, of 118 visits to 154 Palestinian prisoners in Israeli jails, Addameer documented 48 cases of reported torture and 43 cases of reported ill and degrading treatment, with a further 12 prisoners documented to have been placed in harsh conditions of solitary confinement.[4] There are reports of inadequate nutrition for prisoners, including for patients with cancer or other severe conditions, and of inadequate access to psychosocial support, with denial of family visits and communications.[5]

[1] WHO, Prevention and control of COVID-19 in prisons and other places of detention; 2021. (https://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/focus-areas/prevention-and-control-of-covid-19-in-prisons-and-other-places-of-detention, accessed 11 March 2021).

[2] WHO, Preparedness, prevention and control of COVID-19 in prisons and other places of detention: Interim guidance; 2020. (https://apps.who.int/iris/bitstream/handle/10665/336525/WHO-EURO-2020-1405-41155-55954-eng.pdf?sequence=1&isAllowed=y, accessed 11 March 2021).

[3] Addameer, Prisoner Support and Human Rights Association; 2021. (https://www.addameer.org/, accessed 11 March 2021).

[4] Information provided by Addameer, 2021.

[5] Information provided by civil society organizations, 2020.

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

39. Progress regarding previous recommendations made to Israel, the Palestinian Authority and third States to improve health conditions in the occupied Palestinian territory, including east Jerusalem, is outlined in the content of this report. Many of these recommendations remain relevant for 2021.

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

40. To the Government of Israel:

(a) Re-examine the permits system to ensure unhindered access for patients requiring health services as recommended by medical practitioners, and for companions to accompany patients, and to end the arbitrary denial or delay of permit applications.

(b) Coordinate with the Palestinian Authority to ensure provision for the equitable and universal health coverage of the entire Palestinian population in the West Bank, including east Jerusalem, and the Gaza Strip and that no community is left behind or made vulnerable by occupation policies.

(c) Ensure access for Palestinian health care staff to places of work and for the purposes of continuous professional development, and facilitate the timely entry of medical equipment and supplies.

(d) Facilitate the free passage of Palestinian ambulance services, including through extending the licensing period of Palestinian ambulances in east Jerusalem to reduce bureaucratic hurdles.

(e) Ensure respect for, and protection of, medical personnel and medical facilities as required by international humanitarian law.

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

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

41. To the Palestinian Authority:

(a) Strengthen monitoring and reporting on inequities to uphold transparency, equity and accountability in health care provision to the Palestinian population in the occupied Palestinian territory, including for the provision of essential medicines and supplies, services provision,

referrals and health outcomes, with disaggregation by demographic markers, including gender, and geographical location.

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

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

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

42. To third States:

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

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

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

ACTION BY THE HEALTH ASSEMBLY

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

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