

**Report of a field assessment of health  
conditions  
in the occupied Palestinian territory (oPt)**

**22 March to 1 April 2015**

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Document WHO-EM/OPT/006/E/05.15

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## List of Acronyms

B'Tselem	The Israeli Information Center for Human Rights in the Occupied Territories
COGAT	Coordination of Government Activities in the Territories (Israel)
DNA	Damage Needs Assessment
EWASH	Emergency Water Sanitation and Hygiene group in the occupied Palestinian territory
GA	General Assembly
Gol	Government of Israel
JWC	Joint Water Committee (Israel-Palestine)
LACS	Local Aid Coordination Secretariat
MoH	Ministry of Health (Palestinian)
NIPH	Norwegian Institute of Public Health
OCHA	UN Office for the Coordination of Humanitarian Affairs
PHIC	Palestinian Health Information Center
PHR	Physicians for Human Rights (Israel)
PNA	Palestinian National Authority
PNIPH	Palestinian National Institute of Public Health
SPD	Service Purchasing Department (MoH)
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief and Works Agency for Palestine Refugees
WHA	World Health Assembly
WHO	World Health Organization

## 1. Introduction

The Sixty-seventh World Health Assembly requested WHO to report on the health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan, to the Sixty-eighth World Health Assembly, based on a field assessment.

Areas to be covered by this assessment included: barriers to access to health care (general population and in particular the Palestinian prisoners); the impact of the (situation/occupation) on mental health, particularly on child detainees; the health impact of impeded access to water and sanitation, as well as food insecurity, and the provision of financial and technical assistance and support by the international donor community.

The Terms of Reference are listed in Annex 1,

Methodology and Limitations in Annex 2.

## 2. Background

### 2.1. The occupation

The Israeli occupation of Palestinian territory (the West Bank including East Jerusalem and the Gaza Strip) is now in its fifth decade. The Occupying Power, Israel, is legally bound to ensure sufficient hygiene and public health standards, as well as the provision of food and medical care to the population under occupation.<sup>1</sup>

The security modalities of this occupation are complex.

In the West Bank: "Over 60% of the West Bank -with an estimated 300,000 inhabitants- is considered Area C where Israel retains near exclusive control including over law enforcement, planning and construction" (OCHA, 2014 (A) – update Aug 2014). Approximately 18% of the West Bank has been designated as a closed military zone. This fragmentation and the construction of the "Barrier" have divided communities and separated them from their health centers and land. Only 1% of Area C has been planned for Palestinian development. Small residential communities with West Bank ID holders have been trapped on the 'Israeli' side of the barrier built mostly inside the West Bank and East Jerusalem.<sup>2</sup> In addition, movement of Palestinians in the West Bank is further impeded by up to 500 fixed or mobile check points and roadblocks.

For the past seven years, Gaza has been subject to strict closure and blockade by land, sea and air. Since the 67<sup>th</sup> World Health Assembly (WHA) in May 2014, a third military conflict caused major human and infrastructure losses (See sections 2.2 and 2.3). From July 2013, the access to health

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<sup>1</sup>The duties of the occupying power are spelled out primarily in the 1907 Hague Regulations (arts 42-56) and the Fourth Geneva Convention (GC IV, art. 27-34 and 47-78), as well as in certain provisions of Additional Protocol I and customary international humanitarian law.

<sup>2</sup> Upon completion, 33000 Palestinians holding West Bank ID cards will be located between the Barrier and the "Green Line". (OCHA/WHO 2010).

services through Rafah border, which had been the easiest exit route for travelers, including for health care in Egypt and beyond, was very limited.

## 2.2. The 2014 conflict

The third conflict in six years lasted from 7 July to 26 August. According to the joint UN Damage and Needs Assessment (DNA) and Recovery Strategy for the Health sub-sector (draft, March 2015): “During the 51 day escalation, bombardments, air strikes, and ground incursions resulted in an estimated 2,260 direct casualties, including 612 children (27.1 per cent) and 230 women (10.2 per cent). 10,625 people were injured, among them 3,827 children (36 per cent) and 1,773 women (16.7 per cent). 899 people were left permanently disabled”.

According to the DNA, “the hostilities left 23 health care workers dead, 16 of whom died while on duty. 83 health care workers were injured. Ambulance drivers were disproportionately affected”.<sup>3</sup>

A close collaboration between the Ministry of Health, UNDP, and WHO produced a detailed field damage assessment of 87 health facilities of which 25 have been severely damaged or destroyed and 52 with minor damage.<sup>4</sup> El-Wafa Rehabilitation Hospital in Gaza, which is the only facility treating long-term injuries and physical disabilities, was specifically targeted and totally destroyed following warnings from the GoI to evacuate its patients and staff. The DNA estimated the economic losses to the Health Sector at over 380 million US Dollars. The impact was not limited to medical care infrastructure: water and sewage facilities, electricity, food supply and houses damage were compounded by a loss of household income. The conflict and its damage on personal properties increased the poverty resulting from the blockade.

Reconstruction is hampered by the blockade targeting more specifically construction material, and also by the challenges in coordination and dialogue within the MoH and donors’ failure to release promptly the funds pledged for the reconstruction.

## 3. Health care access

### 3.1. The health system

First, the geographical challenge to primary health care is distinct in the West Bank and Gaza: Gaza is a geographically contiguous territory under siege while the occupation fragmented the West Bank in dozens of ‘islands’ separated by settlements, military zones and controlled roads, reducing or complicating access to health care. The approach to the management of the health system has also evolved differently over the last decade. For instance, in Gaza, there is no co-payment for local health care (except medicines). The type and number of facilities in the West Bank and Gaza shows also differences.<sup>5</sup>

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<sup>3</sup> It is a common situation in recent conflicts, leading the Red Cross Red Crescent Movement to launch the initiative “Health Care in Danger” <https://www.icrc.org/eng/what-we-do/safeguarding-health-care/>

<sup>4</sup> UNDP/Government of Palestine. (December 2014). Detailed Infrastructure Damage Assessment - Gaza.

<sup>5</sup> According to the Health Annual Report Palestine 2013 (MoH 2013), there are respectively in the West Bank and the Gaza Strip, 622 and 147 Primary Health care centers run by four main providers: government, NGOs, UNRWA and the Palestinian Medical Military Services. A center is covering 4,340 persons in West Bank and

Beside the challenges that the occupation poses for realizing the full potential of Palestinian economic development, which also affects the health sector development, there are critical and specific issues that limit access to health care:

- A chronic shortage of pharmaceuticals, supplies, spare parts and poor general maintenance led to a deterioration of quality of services in Gaza and to a lesser extent in the West Bank. The Health Cluster Damage and Needs Assessment following the 2014 conflict observed that “nearly 50 per cent of Gaza’s medical equipment is outdated and the average wait for spare parts is approximately 6 months”. In 2014, the MoH Central Drug Store in Gaza reported that an average of 25.7% of medicines on the essential drug list (124 of 481 items) and 47% (424 of 902 items) of medical disposables were at or near zero stock for MoH facilities.<sup>6</sup> The main reason is an insufficient budget rather than security restrictions imposed by Israel.
- Limited opportunity for health professionals in Gaza to attend trainings outside and access restrictions to get familiar with new medical techniques is also slowing down improvements in developing health care services in Gaza. Political disagreements between the political parties remain a challenge in spite of the May 2014 reconciliation. In interviews, there were clear signs of continuing disagreements between health officials on both sides (and the respective political parties). The pending progress in consensus building and participative decision making is hindering collaboration and an integrated approach. Undoubtedly, a unified and fully integrated management system is in the best interest of the health sector.
- Salaries represent 44% of the budget of the MoH. For the 4,508 workers recruited by the Ministry of Health of the Gaza de facto authorities since 2007 and the 530 workers employed by the PA who remained working after 2007 a solution for re-integration and regular salary payment is still pending. As a result, several strikes are carried out or planned by health workers and maintenance staff. At the same time, 2,163 health workers who stood down from their jobs in 2007 at the request of the Palestinian Authority and who are not presently working in the health services have continued to receive their pay. The situation is further aggravated by fiscal difficulties, and lately compounded by the delay in Israel forwarding the tax revenues collected on behalf of the PNA.<sup>7</sup> The Swiss Government is jointly with partners working on a compromise for health workers re-integration and remuneration -in the context of re-integration for all public sectors - while the World Bank is planning to cover the salary gaps of the cleaning/maintenance workers.
- In the West Bank, travel restrictions for health staff (especially to East Jerusalem) are affecting the health service delivery: Permits are granted on a short but variable term and renewal is occasionally and temporarily denied without apparent reason. Unpredictability is prevalent. Interdiction, so far, to use a West Bank-plated vehicle in East Jerusalem is further complicating the commute of many health workers.

### 3.2. Access to tertiary care: referrals

Referrals and access to tertiary care have a human rights dimension. A matter determined in most countries by availability of service capacity, treatment urgency and economic considerations is

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11,565 in the Gaza Strip. Hospital beds are more evenly distributed between West Bank (including East Jerusalem) and Gaza (respectively 1.2 and 1.3 bed / 1000 inhabitants). The largest hospital is located in Gaza while the most advanced specialized care is concentrated in the 6 non-profit hospitals of the East Jerusalem Network. The only rehabilitation hospital in Gaza was totally destroyed during the conflict.

<sup>6</sup>Zero stock = the number of items at or within 1 month of exhaustion.

<sup>7</sup> The tax revenues represent 40 to 60% of PA budget according to conflicting estimates.

complicated by security concerns and consecutive limitations of movement of patients and ambulances enforced by the Israeli Government.<sup>8</sup>

The increasing poverty is the most pervasive barrier to access to specialized health services. Access to tertiary health care, as in many countries, is subject to availability of funding. Social security insurance coverage (Government, UNRWA or private) normally cover only part of the costs (70% or up in West Bank and 100% in Gaza). Co-payment by the patient for their care and accommodation of accompanying relative and full payment for transportation and incidental medical costs can represent a serious burden.

Access to tertiary health care is limited by many barriers, some but not all related to the occupation. Data on the referral and permit process are available from various sources: MoH Service Purchasing Department (SPD), UNRWA, and the Government of Israel –Coordination of Government Activities in the Territories (COGAT). Each source is collecting information on different steps and indicators (decision to refer, approval of financing, security travel clearance...), making data cross referencing and comparison difficult.<sup>9</sup>

### The referral process

Requests for medical referrals are made either by the specialist doctor (West Bank) or the director of the hospital (Gaza). Proportionally, the number of referrals from the West Bank (16.3/1000 inhabitants) is higher than from Gaza (10.2/1000) (MoH/PNIPH 2014).<sup>10</sup> The assessment has not been able to determine the relative role of factors such as security concerns, financial burden of co-payment for travel and accommodation, possible bias in the approval of financing or other factors. Oncological diseases are the main medical conditions for referrals (15%). Referral patients are slightly more male, especially in Gaza (in 2014: West Bank: 52.3% male and 47.6% female; Gaza: 56.7% male and 43.2% female).

Proposed referrals are reviewed by a medical committee of the MoH Service Purchasing Department (SPD) both in Gaza and Ramallah. The main criteria for approval are the unavailability of services on site and the coverage by health insurance. This lack of service locally may often result from a temporary shortage of essential medicines, reagent or spare part or unavailability of the specialist. Detailed statistics of number of applications received and approved or rejected by the medical committee (SPD) is not routinely released. A rate of 6% of denial of financing in the last month was mentioned as indicative by the MoH in the interview. Disaggregation of approval/denial data (by place of origin among others) would be useful for further analysis.

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<sup>8</sup>Referrals cost is the second most important item (after salaries) in the budget of the MoH

<sup>9</sup>MoH data are not patients referred but financial decisions made. The same patient may have several financial decisions (for diagnostic procedure, for treatment and possibly for additional hospitalization exceeding the amount initially approved). UNRWA data are including the number of patients approved for referral while COGAT data are including the number of personal applications for travel permit received and approved (including patients and accompanying family members).

<sup>10</sup> The rates are calculated for the total population. The discrepancy is likely to be much higher if the rate is calculated for the population insured by the MoH.

There are several referral destinations: Within the Northern Governorates (West Bank) or Southern Governorates (Gaza) (to a private facility for instance), to East Jerusalem, to Israel or Egypt.<sup>11</sup> The volume of referrals from Gaza to Egypt has declined by 93% after the July 2013 closure of the Rafah border. This reduction affected particularly self-funded private patients. MoH funded referrals to Egypt declined 37% from 2011 levels, reducing sharply the access to health care for patients or companions who may have potential concern with Israeli security procedures.

Patients approved financially by MoH should secure an appointment with the hospital before applying for an Israel permit for themselves and one for an accompanying relative. The choice of the “companion” is particularly critical for young children.<sup>12</sup> Data on responses to permit applications are regularly monitored by WHO and cases of denials leading to further suffering and medical consequences are documented. Challenges in the permit process by the Israel authorities are reported and regularly published by WHO (monthly for Gaza and annually for both Gaza and West Bank). Problems have been confirmed in extensive interviews during this survey:

- Increasing rate of denials or delayed processing of permits for either the patient or the selected companion (mother, husband, etc.): According to a WHO review for Gaza patients, the percentage of permit applications by patients denied or delayed has increased from 10.2% in 2011 to 17.4% in 2014 (and 19.5% for the first 2 months in 2015). The rate of denial is significantly higher in the West Bank while in Gaza delays or lack of reply (“pending”) are more common. Reasons given for denial, if any, are varied and seen as unpredictable by interviewees. Perceived unpredictability of the process outcome and the contact with Israeli authorities are complaints most consistently mentioned in interviews.
- In Gaza, security interviews before permit issuance or during the actual crossing are increasing in frequency.
- Companions, especially younger adults, are frequently denied permits, forcing senior relatives to accompany the patient, often separating children from parents.
- Finally, holding a permit is no guarantee for being allowed to cross the border. Border guards or military have and unpredictably can use their authority to deny access to patients.

Health coordinators from GoI (COGAT) posted in the West Bank and at the Erez crossing point in Gaza have played a positive role to follow up on individual requests for medical transfers. Their 24 hour availability and willingness to assist on a humanitarian basis has been praised by most Palestinian interlocutors.

Restrictions to ambulance transport of patients are perceived by interviewees as unnecessarily affecting the welfare and dignity of the patients. The “back to back” procedure as it is known requires the ambulance from the Palestinian side to stop at the crossing point, to unload the patient even if under oxygen or perfusion treatment, submit to security check and “walk” to the other side where an Israeli ambulance is waiting. On the West Bank side, ambulances are reportedly often required to take their turn in the queue of Israeli plated vehicles. Coordination of the arrival of the two ambulances is causing additional delays. According to reports from the Emergency Services, security processing of patient transfers is often not adequately accelerated for patients with severe

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<sup>11</sup> Referral of patients by the MoH to Jordan has basically stopped. Destinations of private patients seeking care abroad at their own cost are not covered in this study.

<sup>12</sup> The companion should be a first degree relative who might not be available.

or urgent medical conditions. Such delays to rapid access to emergency referral care are generating considerable resentment without perceivable security benefits for Israel.

Once approved and cleared, long term referrals (for instance for sessions of cancer treatment) present a financial burden for out patients and companions unable to support the cost of accommodation.

The cost of referrals is representing a significant part of the health budget (26.8% in 2013), second only to the expenditures to cover salaries. It is a significant source of income (60-70%) for the six non-profit Palestinian hospitals in East Jerusalem. It is also a non-negligible source of income for selected Israeli hospitals. Bills were until recently not detailed or respecting the ceiling (days of admission or amount) defined and approved by the MoH and were paid directly by the Gol from the taxes collected by Israel on behalf of the PA. Recently, progress has been made to allow the MoH to review the charges and negotiate pre-agreed reimbursement rates for procedures and diagnoses.

### **3.3.Implementation of recommendations WHA**

The WHA requested a report on “progress made in the implementation of the recommendations contained” in the special report (WHO 2012). Those recommendations are listed in Annex 6. Selected interviewees were invited to share their opinion regarding whether or not progress was made on some or all of the recommendations. The results are representative of the Palestinian and international community views only, given the lack of interlocutors from Gol.

The majority of interviewees expressed the opinion that little progress has been made in regard to the implementation of the recommendations to facilitate patient access to health care or travel for health workers. As noted earlier, the support from the Israeli Health Coordinating officer (MoH) was usually praised. Regarding the recommendations to the PA, some progress was seen by a few interlocutors in the assistance to patients encountering difficulties in the referral process. Encouraging are the efforts of the new leadership in MoH/SPD to improve management and accountability in the referral process.

Regarding the recommendations on the Rafah Border the closure has substantially reduced the number of referrals to Egypt as well as incoming health or humanitarian supplies.

Although health interlocutors felt that little overall progress was made, independent observers point to very modest but encouraging recent openings: greater flexibility allowing Palestinian doctors and possibly later other health workers to use their own car in East Jerusalem, decrease in the age threshold for travel of West Bank residents and therefore patients and companions (males 55 years and above; females 50 years and above no longer need a special permit), and efforts to build the capacity of referring doctors and stimulate dialogue through workshops sponsored by the MoH of Israel.

### **3.4.Conclusions**

The occupation and restrictions to movements of persons and goods is continuing to restrict the access to health care. Sustained additional advocacy is needed at international level to ensure that the consequences be minimized.

Of particular concern is the unpredictability of the process at all levels including at the check point. Legitimate security considerations of the occupying power do not justify delays in processing genuine emergencies.

The closure of the Rafah access to Egypt has affected the transit of humanitarian goods and personnel and reduced the possibilities of life saving evacuations from Gaza to Egypt.

#### **4. Access to adequate health services on the part of Palestinian prisoners**

The health of Palestinian prisoners is a serious public health issue affecting over the years several hundred thousand boys and men, and hundreds of women held in Israeli prisons<sup>13</sup>. The general situation of Palestinian prisoners is described in the report by the Secretariat. In addition, WHO is currently conducting a study on ex-prisoners.<sup>14</sup> Preliminary results of the ongoing study documenting experiences of ex-prisoners indicate multiple barriers to health.

NGOs report that prisoners with severe mental health problems often do not receive treatment for their condition and some are held in solitary confinement as a way of managing agitated behavior, which may exacerbate any mental health problems. Concerning the mental health of prisoners, an important factor is the infrequent, or lack of, contact with parents, relatives and friends for long periods during their stay in prison.

#### **5. Mental health consequences**

##### **5.1. The current situation in the oPt concerning mental health**

Epidemiological studies in the occupied Palestinian territory (oPt) have shown high prevalence rates of common mental disorders (de Jong et al. 2003), (Ibedour et al. 2007). While the observed rates vary by sample and study methodology, rates are consistently higher than those found in Israel (Levinson et al. 2008) or in neighboring Lebanon (Karam et al. 2008). Further studies have reported reduced quality of life among Palestinians (Mataria et al. 2009). This is relevant as the concept of mental health is broader than that of mental disorder and includes well-being.<sup>15</sup>

An infrastructure of community mental health centers exists in most places across the West Bank and Gaza provided by the Ministry of Health and NGOs. There is good infrastructure of primary health care (PHC) services in every town and village and important steps have been taken to integrate mental health into PHC, especially in Gaza. There is also a range of psychosocial care providers outside the health sector, including within schools. These existing services provide a good

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<sup>13</sup> The Israeli Information Center for Human Rights in the Occupied Territories Statistics on Palestinians in the custody of Israeli security forces ([http://www.btselem.org/statistics/detainees\\_and\\_prisoners](http://www.btselem.org/statistics/detainees_and_prisoners), accessed 1 April 2015).

<sup>14</sup> A literature review was conducted on health access in various prison contexts. A research project is ongoing aimed at qualitative in-depth interviews with selected ex-prisoners in the West Bank, including Jerusalem, reflecting different ages and periods of confinement of both women and men, including minors.

<sup>15</sup> The WHO defines health as: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

foundation for the further development of effective and comprehensive community mental health care. Whilst in terms of the overall care system the basic structure of a community based mental health system has been established, the quality and quantity of care requires further improvement. WHO is working closely with the relevant governmental departments and coordinating with NGOs to further strengthen the existing system.

## **5.2. Findings from the literature**

Different facets of the occupation, including reported human rights violations, affect the lives of Palestinians (Batniji et al. 2009). The following facets of occupation are relevant to mental health: military conflict, reduced freedom of movement (blockade of Gaza; roadblocks in West Bank), lack of economic and social development opportunities with high rate of unemployment and difficult management of education and health systems, arrests of children and adults, treatment of child and adult prisoners in the military detention system, the barrier and its impact on access to land and access to economic opportunities, building of settlements and associated military presence in the West Bank, lack of approval of building permits and demolition of housing.

With regards to the relationship between these facets of occupation and mental health, the scientific literature is unequivocal on the negative effects of adversity (e.g. trauma, loss, severe life stressors) on mental health and mental disorder (Dohrenwend, B.P. 1998; Kessler et al. 2010). The facets of the occupation listed above involve a sense of unpredictability and uncontrollability in daily life that have been shown to have a detrimental impact on mental health (Gallagher et al. 2014). Palestinians report experience of chronic humiliation during the occupation (Giacaman et al. 2007), with humiliation being shown to be associated with health (Giacaman et al. 2007) and mental health complaints (Kendler et al. 2003).

## **5.3. Findings from the field visit**

The findings from the empirical literature were confirmed by interviews conducted during a field visit. Interviewees reported that a substantially negative aspect of the occupation of the West Bank is the sense of insecurity and unpredictability created by aspects such as people having to regularly re-apply for permits, uncertainty about being detained at checkpoints and insecure living conditions due to threat of house demolition, whilst at the same time, few building permits are reportedly provided. People reported that such events left individuals and families with a sense of entrapment and disempowerment. In turn this was reported as leading to hopelessness and anxiety and other mental health and behavioral problems. In particular, interviewees expressed that experiences of humiliation could be a driver of violence. The effect of detention on child detainees was highlighted, with a number of interviewees expressing the need for initiatives to help detainees with the psychological (e.g. mental health difficulties) and social (e.g. loss of schooling) effects of detention.

Interviewees highlighted the important differences between the situation in Gaza and in the West Bank, in particular the substantially higher exposure to trauma for adults and children in Gaza from the experience of recent episodes of conflict. These experiences create additional risk for mental health, through exposure to loss, trauma and the destruction of infrastructure caused by these events. In the West Bank, very vulnerable groups such as the Bedouin and rural communities bounded by settlements also face disproportionate risks of displacement and insecurity.

## 6. Water, food and livelihood

### 6.1. Access to water

Access to water is an issue pre-dating the occupation. The demographic growth, the conflict between Israel and Palestine, the establishment of settlements in the West Bank and the blockade of Gaza have only made the problem more urgent and difficult to address in a negotiated and fair manner. Access to scarce water is critical for the economic development of each side leading to an unequal war of conflicting statistics on water rights and use.

In Gaza<sup>16</sup>: Water resources are essentially restricted to the coastal aquifer shared with Israel. Already before the occupation, extraction from deep wells was exceeding the recharge capacity of the aquifer. With demographic growth, the rate of extraction exceeds over three times the regeneration capacity. The result is a rapidly increasing salinization of the water. In addition, the unregulated use of fertilizers led to a continuous increase of nitrates. Both chloride and nitrates are reaching levels exceeding 5-10 times the recommended acceptable level. The problem is compounded by the destruction of wells and water infrastructure during the conflicts and incursions. It is estimated that between 95 to 97% of the water is now unfit for human use.

Salted water is unpalatable leading to 95% of the population relying on desalinated water from commercial sources. It is an additional expense difficult to absorb by the poorest sectors. The bacteriological quality of the commercial desalinated water and its storage at home are of concern.

The deterioration or destruction of the sewage system constitutes a high risk for contamination and water borne diseases. Up to date, there is however no clear epidemiological data confirming a massive impact on health at short term (outbreaks) or long term (chemicals) attributable to the water problem. The absence of data does not preclude the urgency of retuning the quality of water to internationally acceptable levels.

Large sea water desalination plants are seen as the solution. That will require massive improvements of power, sewage and water infrastructure as well as adequate availability of fuel and investments. The blockade especially on construction material and the resulting economic stagnation needs to be addressed. Meanwhile damages caused by periodic escalations of the conflict with bombardments and related damages of water supply have to be repaired.

In the West Bank, the water issue is mostly one of quantity (OCHA 2014 (B)). The estimated average daily consumption of water (all use) is 71 liters/person, below the recommended level of 100L. According to UNICEF, 55,000 Palestinians consume less than 30 liters. Under the joint agreement on water resources signed in the context of the Oslo accords, an Israeli-Palestinian Joint Water Committee (JWC) was established. In practice, it gives Israel veto power on the construction or even renovation of wells or water systems throughout the West Bank. The Palestinian Authority is not able to extract the full amount allotted<sup>17</sup>, nevertheless old or new water facilities (wells, water tanks, latrines, cisterns, etc.) are destroyed by the Israeli authorities on the grounds that they lacked the

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<sup>16</sup> This section is based on the comprehensive "systematic literature review and recommendations on water usage in the Gaza strip" NIPH/PNIPH 2014

<sup>17</sup> The PA extract less than half its promised quota and buys part of the balance from Israel Water Utilities. Losses for unaccounted-for-water are estimated at 33%.

adequate permit from the JWC. The result is an enormous discrepancy between Palestinian and Israeli actual water use.<sup>18</sup>

Waste water treatment facilities are subject to the same approval by JWC, out of 30 Palestinian proposals since 1995, four have been approved (OCHA 2014 (B)) and one project treating 5% of the total waste water has been completed.<sup>19</sup>

That water supply situation represents a clear risk for the public health.

## 6.2. Food security in the Gaza Strip

Food insecurity is primarily a political and economic issue. According to WFP, 95% of vegetables and 100% of white meat and eggs needed are produced in Gaza. The blockade and the recent conflict pushed an increasing number of people into poverty making them dependent on in kind distribution of food by WFP and UNRWA. The rapid assessment following the conflict found 57% of the population exposed to food insecurity. If there were no notable restrictions imposed on food import to Gaza, severe limits are still in place for exports.

WFP and UNRWA have launched a special food distribution program aiming to reach 730,000 conflict-affected people in Gaza. In summer 2014, WFP has reached up to 330,000 people with emergency food assistance including people taking refuge at UNRWA shelters and public shelters as well as people in hospitals, while people staying with host families receive emergency food vouchers. Prior to the Gaza crisis WFP and UNRWA were already reaching 1.1 million people. This effort has maintained the levels of malnutrition within acceptable limits.

## 6.3. Livelihood and poverty

In oPt, one of the most important social determinants for health (in its broad Alma Ata definition) is economic development. Unhindered access to health care, water, sanitation and food is restricted by the blockade in Gaza and the fragmentation and Israeli settlements in the West Bank.

As noted by the World Bank, GDP growth (in the West Bank) has fallen from 9 percent in 2008-11 to 5.9 percent by 2012 and to 1.9 percent in the first half of 2013. *“This slowdown has exposed the distorted nature of the economy and its artificial reliance on donor-financed consumption”*. As a result, real percapita income in the occupied Palestinian territory declined, and unemployment, poverty and food insecurity worsened.

The delays in releasing the tax revenues collected by Israel on behalf of the PA are challenging stable budget allocations by the MoH, causing shortages of supplies, delays in salary payments and postponements of necessary maintenance and infrastructure investments.

This fiscal situation reflects at the household level. High unemployment reduces livelihood, preventing access to health care (referrals require out of pocket contributions), food and clean water.

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<sup>18</sup> A “Fact Sheet” issued by the Israel Civil Administration of Judea and Samaria stressed that West Bank Palestinian “have access” to 124 m<sup>3</sup>/capita/year (340 Liters/day) including the 21 million cubic meters Israel “supplies beyond its obligation”. In practice access is prevented by denial of permits or economic restrictions.

<sup>19</sup> Treatment for 20% of the total waste water is purchased from Israel.

Some concessions considered by Israel at the time of this survey such as easing the permit process to allow travel for some or possibly authorizing Gaza workers to work in Israel are encouraging but will need to be expanded to enhance development.<sup>20</sup>

## **7. The role and contribution of the international community**

The traditionally high support by the international community for the Palestinian population, both in providing development support and humanitarian aid, has been showing a decrease in the funding commitment over the recent years. According to UNDP (2015), the overall external budget support to the PA fell significantly between 2009 and 2014. This decline is affecting the health sector although no disaggregated data by sector were available during the assessment.

The phenomenon is evident in the international support to Gaza reconstruction after the recent conflict during July and August 2014. As highlighted in a recent statement by the Palestinian Minister of Health (Gaza speech March 2015), only a small fraction of the donor pledges and commitments confirmed in the September 2014 Cairo conference have been actually disbursed. The substantial gap between pledges and disbursements is perceived as an additional sign of a partial disengagement of the international community from the oPt.<sup>21</sup>

The main donors for the health sector are Brazil, the European Union, Italy, Korea, Kuwait, Norway, Qatar, Saudi Arabia, Switzerland, Turkey, United Arab Emirates, United States of America and World Bank.<sup>22</sup> Some well targeted health initiatives are particularly valuable in addition to those implemented by WHO and mentioned in the report to the 68<sup>th</sup> WHA (2015):

- Negotiations to facilitate health worker re-integration in Gaza including a solution to ensure sustainable salary payments (in progress) by the Swiss Government;
- The World Bank grant for remuneration of maintenance and cleaning staff in Gaza hospitals.
- The negotiations with Israel to strengthen transparency and control of Palestinian health authorities to rationalize payments for referral health services charged by Israeli hospitals.<sup>23</sup>

International aid coordination addresses both development and emergency needs. While the UN's annual appeal (Humanitarian Programme Cycle) has remained a mechanism for responding to immediate humanitarian needs in the oPt, a range of bilateral donors and EC have been focusing also on longer-term investment.

Policy dialogue is continuing within the international community focused on the need to strengthen the role and capacities of the Palestinian Authority in managing and coordinating international aid investments, and to better integrate the Palestinian Authority's aid management and governance efforts.

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<sup>20</sup>“Under the impact of yet another year of prolonged occupation, 2013 proved to be one more year of lost Palestinian development” (UNCTAD 2014). So did 2014.

<sup>21</sup>This could be related to different factors such as competing priorities in the region (Syria, Iraq, Libya and Yemen crisis) and elsewhere for donors, fatigue after three wars in Gaza during the last 6 years and the lack of a political horizon that makes donors unsure whether any investments will be sustained in a few years.

<sup>22</sup>By alphabetical order.

<sup>23</sup> Previously, the amount charged for referrals to Israel hospitals could not be inquired or challenged by the PA before its payment by Gol from the tax revenues fund.

The technical assistance needs to further integrate humanitarian and emergency aid into sound and constructive sector-wide planning. There are established complex coordination mechanisms to facilitate further integration<sup>24</sup>:

The Health Sector Working Group is the main health coordination mechanism; it is chaired by the Ministry of Health and co-chaired by USAID, with WHO as the technical adviser. The Ministry of Planning and Administrative Development, Austria, Belgium, Italy, the delegation of the European Union, France, Japan, United Kingdom, UNFPA, UNICEF, UNRWA, United States, World Bank are members together with NGOs (Health Work Committee, Palestinian Medical Relief Society).

In summary, the continuous flow of foreign aid is supporting the health sector to minimize the health impact of the occupation, a responsibility normally borne by the occupying power. The more gap filling nature of foreign aid is however no alternative to a full and unrestricted realization of the development potential of the oPt and the long term need to further develop and strengthen the health system.

## 8. Conclusions and recommendations

### 8.1. Conclusions

“Key determinants of health in Gaza are socio-economic and political in nature, as the lack of a functioning economy has impacted the ability of patients to purchase health care services and medications out of pocket, and seek referrals abroad as transportation to treatment destinations must be paid by the patient, as well as to meet food and nutrition needs” (Health Cluster 2015). However not all health problems can be attributed to the occupation. Internal Palestinian political disagreements remain to be resolved through high level dialogue and consultation between Ramallah and Gaza.

Individual permits to allow access to health care in 2013 and 2014 continued to be denied based on sometimes unclear and unpredictable reasons; rising poverty, increasing frustration and lost hopes have had serious mental health implications.

However, some signs of Israeli flexibility are visible. The support provided by the Coordinator of Health and Welfare for the Israeli Civil Administration (operated by COGAT, a unit of the Israeli Ministry of Defence), and praised by most interlocutors, suggests that there are opportunities for more constructive dialogue and cooperation between the Palestinian and the Israeli health sectors.<sup>25</sup>

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<sup>24</sup> Aid coordination in oPt represents a challenging task. International assistance is closely tied to the peace process and is delivered while critical political, economic and security issues have remained unresolved. The Palestinian Authority is highly dependent on foreign aid. Donors have traditionally strong (and often competing) strategic and/or economic interests and bilateralism is pervasive.

33 donor countries, 12 International agencies including WHO, 8 PA institutions and one representative of NGOs are members of the Local Development Forum served by Local Aid Coordination Secretariat (LACS). The ad-hoc Liaison Committee deals with high level political and economic matters, provides regular coordination at the operational level to direct donor assistance towards Palestinian Authority priorities.

<sup>25</sup> <http://www.ncbi.nlm.nih.gov/pubmed/12504491>  
[http://www.who.int/hac/techguidance/hbp/cease\\_fires/en/](http://www.who.int/hac/techguidance/hbp/cease_fires/en/)

The World Health Assembly, Resolution 34.38, 1981 stated that *“the role of physicians and other health workers in the preservation and promotion of peace is the most significant factor for the attainment of health for all”*. It remains true and applicable to oPt and Israel. More efforts to place health considerations above political issues are required. Cooperation and dialogue between the two ministries of health should be further strengthened and promoted by WHO in the interest of public health and as a modest contribution to the peace process. There are precedents to support this approach.<sup>26</sup> The WHO “Health as a Bridge for Peace” initiatives maintained the dialogue and cooperation between Ministries of Health during the Central American conflicts (1984) and had a positive impact during the Yugoslavia conflict in the 90s. They could serve as model to WHO in the Palestinian Israeli context. An initial step was taken between 2005 and 2008 through the publication of the *Bridges* magazine featuring news and articles from both oPt and Israel.

## 8.2. General recommendations

The assessment findings translate into the below general and specific recommendations.

- Donors should sustain and consider increasing their longer term funding commitments for sustainable health system and infrastructure development. The amounts pledged should materialize into actual disbursements.
- The Israeli Health Coordination office should strengthen and expand the support provided in facilitating permits for referrals and developing the capacity of their Palestinian counterparts. Budget and staff should be assigned for this purpose.
- Further consensus and trust building is needed between Gaza and West Bank Palestinian institutions to further strengthen the government of consensus and to overcome political disagreements.
- WHO should consider launching a comprehensive Health as Bridge for Peace initiative to strengthen and promote technical dialogue and operational collaboration between the Palestinian and Israeli health authorities on humanitarian and development health issues.
- WHO/oPt should strengthen its engagement and liaison with the Israeli MoH to enhance advocacy for public health and health priorities in oPt.

## 8.3. Recommendations for access to health care

These short term recommendations do not address the underlying causes but may greatly contribute to improve access and reduce tensions:

- The Government of Israel should facilitate the rapid and priority transfer of patients from the West Bank to East Jerusalem by allowing passage and security check of Palestinian ambulances on a priority basis. The “back to back” procedure should be formally abandoned.
- The Government of Egypt should consider developing a special mechanism to allow a re-opening of the Rafah Border crossing for medical referral of patients from Gaza and for the entry of humanitarian foreign personnel and supplies into Gaza, while respecting Egypt’s legitimate security concerns.
- Donors and the PA should increase their funding allocations for procurement of essential health supplies to avoid unnecessary referrals caused by temporary shortages of medicines.

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<sup>26</sup>[http://www.who.int/hac/techguidance/hbp/HBP\\_WHO\\_learned\\_1990s.pdf?ua=1](http://www.who.int/hac/techguidance/hbp/HBP_WHO_learned_1990s.pdf?ua=1)  
<http://www.who.int/hac/techguidance/hbp/en/>

- Health stakeholders should support analysis and development of strategic plans for investments in specific treatment and diagnostic capacities locally, i.e. radiotherapy or MRI capacity, to reduce the number and cost of referrals.
- Capacity building opportunities for health professionals should be further expanded supported by resources from donors and facilitated by Israel authorities through easing travel permit procedures for health professionals.

#### **8.4.Recommendations for access to health care of prisoners**

Based on the principle that adequate medical care should be accessible to all Palestinian prisoners:

- The basic determinants of health - such as appropriate living space and conditions, access to adequate food, visits of parents and relatives - should be guaranteed.
- Diagnostic and treatment services for prisoners including for severe mental health issues should be accessible. Special attention should be given to the needs of detainees with mental health problems, including avoiding the use of solitary confinement.
- Health monitoring should be considered.

#### **8.5.Recommendations on mental health**

Improving mental health will require improving of living conditions and service integration and respectful attitude by the occupying power's security forces:

- Donors and WHO need to continue to support the MoH in sustainable development of mental health services to improve both the quantity and quality of mental health care in oPt.
- Specific investments are needed to reintegrate detainees into society (particularly child detainees) with due focus on both psychological and social aspects.

## **ANNEX 1: Terms of reference**

### **West Bank/Gaza/Jerusalem Consultant**

The WHO West Bank and Gaza office requires an expert consultancy to conduct a short-term field assessment which contributes toward fulfilling the request made by the 67<sup>th</sup> World Health Assembly for the following:

**Task:** To report on the health conditions in the occupied Palestinian territory... to the Sixty-eighth World Health Assembly, particularly on access and with special focus on:

- (a) barriers to health access in the occupied Palestinian territory, as well as progress made in the implementation of the recommendations contained in the World Health Organization 2013 report on “Right to health: barriers to health access in the occupied Palestinian territory”;
- (b) Access to adequate health services on the part of Palestinian prisoners;
- (c) The effect of prolonged occupation and human rights violations on mental health, particularly the mental consequences of the Israeli military detention system on child detainees;
- (d) The effect of impeded access to water and sanitation, as well as food insecurity, on health conditions in the occupied Palestinian territory, particularly in the Gaza Strip;
- (e) The provision of financial and technical assistance and support by the international donor community, and its contribution to improving health conditions in the occupied Palestinian territory.

## ANNEX 2:Methodology

The external consultant, Dr. Claude de Ville de Goyet, was assisted by three WHO experts: Dr. Ambrogio Manenti, Dr. Kenneth Carswell and Dr. Mark van Ommeren.

This survey was conducted through:

- A review of the extensive documents available in paper format or online. (See Annex 2). A total of 75 reports, newsletters, articles, fact sheets and other documents in English were consulted. Of the total, 38 were published by UN or international organizations and 8 by the Palestinian National Authority (PNA). 16 were peer reviewed publications in scientific journals.
- The analysis of statistics and data collected by UN agencies and in particular the World Health Organization (WHO office for West Bank and Gaza Strip (WHO oPt) or the Ministry of Health (MoH) of the PNA.
- Interviews with 54 WHO staff and key stakeholders (See Annex 3). These semi-structured interviews were conducted face to face without the presence of staff from the WHO/oPt office. 19 contacts were from NGOs or Red Cross / Red Crescent movement, 13 from UN or international agencies, 11 from PNA and six from donor countries.
- The organization of two focus groups with former prisoners.
- Interviews with two former child detainees, one child awaiting a court hearing and one child previously arrested but not prosecuted.

An advanced version of the draft was sent to all interviewees for comments. Suggestions were valuable to correct factual and interpretative errors.

### Limitations

A field assessment in such a complex conflict situation has some limitations:

- The situation in the occupied Syrian Golan was not reviewed due to lack of access.
- Time and human resources prevented in depth review of the broad range of topics to be covered.
- Repeated interviews were not always possible, however, information reported here received some form of triangulation.
- Except in one case, the interviews requested from Gol authorities, admittedly at rather short notice, could not be arranged.
- At the time of the assessment, consolidated official statistics for 2014 were only partly available.

### ANNEX 3: List of persons interviewed

First and Last name	Title, institution and place	Email
Aed Yaghi	Palestine Medical Relief Society, Gaza	<a href="mailto:Pmrs.gaza@gmail.com">Pmrs.gaza@gmail.com</a>
Amella Marzal	Federation Representative, IFRC Ramallah	<a href="mailto:Amella.marzal@ifrc.org">Amella.marzal@ifrc.org</a>
Amin Abu Ghazaleh	Emergency Service department, Red Crescent Society, Jerusalem	<a href="mailto:ems@rcsh-jerusalem.org">ems@rcsh-jerusalem.org</a>
Anas Musallam	Operation Coordinator, Food Security Sector WFP Gaza	<a href="mailto:Anas.musallam@foodsecuritycluster.net">Anas.musallam@foodsecuritycluster.net</a>
Anees Mahareeq	Care	<a href="mailto:mahareeq@carewb.org">mahareeq@carewb.org</a>
Anita Vitullo	Project Manager–Advocacy/Right to Health, WHO, Jerusalem	<a href="mailto:vituloo@who.int">vituloo@who.int</a>
Amira al-Hindi	Director, Service Purchasing Department, Ministry of Health, Ramallah	
Asaad Ramlawi	General Director of PHC & Public Health, Ministry of Health, Ramallah	<a href="mailto:Ramlawi_asad@hotmail.com">Ramlawi_asad@hotmail.com</a>
Ashraf Abu Mhadi	Director General, Pharmaceuticals (Gaza), Ministry of Health	
Ayed Yaghi	Palestine Medical Relief Society, Gaza	
Ayman Shuaibi	Area Manager West Bank, CARE in Ramallah	<a href="mailto:shuaibi@carewb.org">shuaibi@carewb.org</a>
Bassam Abu-Libdeh	Medical Director, Makassed Hospital Jerusalem	<a href="mailto:drbassam@hotmail.com">drbassam@hotmail.com</a>
Bassem Naim	Former Minister of Health, Gaza	
Cheryl Kamin	Health and Humanitarian Office -USAID, West Bank	<a href="mailto:ckamin@usaid.gov">ckamin@usaid.gov</a>
Dalia Bassa	MoH Israel, Office of Liaison and Health Coordination, Beit El	<a href="mailto:daliabas@gmail.com">daliabas@gmail.com</a>
Dyaa Saymeh	National Programme Officer- Mental Health, WHO, Gaza	
Enrico Matera,	Head of Health Sector, Italian Cooperation	
Feletcia Adeeb/Saleh	Aid Project Management Specialist USAID, West Bank	<a href="mailto:fsaleh@usaid.gov">fsaleh@usaid.gov</a>
Gerald Rockenschaub	Head of Office, WHO oPt, Jerusalem	<a href="mailto:rockenschaubg@who.int">rockenschaubg@who.int</a>
Hadas Ziv	Physicians for Human Rights-Israel	<a href="mailto:hadas@phr.org.il">hadas@phr.org.il</a>
Hadeel Al Qassis	Health Information System Officer, WHO, Jerusalem	<a href="mailto:hadeel@who-health.org">hadeel@who-health.org</a>
Hashimeh Ammar	WHO field researcher on ex detainees health access	
Hazem Ashour	Chairman of Mental Health Unit Palestinian Ministry of Health, PNA	<a href="mailto:hnashour@hotmail.com">hnashour@hotmail.com</a>
Hussam Liftawi	Physicians for Human Rights-Israel	<a href="mailto:hussam@phr.org.il">hussam@phr.org.il</a>
Issa Elayan	Human resource Director, Makassed Hospital, Jerusalem	<a href="mailto:lssamie@yahoo.com">lssamie@yahoo.com</a>
Jochen Peters	Aid Coordination (Economic Sector), Local Aid Coordination Secretariat	<a href="mailto:jpeters@lacs.ps">jpeters@lacs.ps</a>
Khalil Abu Foul	Director of Palestine Red Crescent Society in Gaza	
Kirriy Clarke	Health Coordinator, International Committee of the Red Cross, Jerusalem	<a href="mailto:kclarke@icrc.org">kclarke@icrc.org</a>
Maher Daoudi	Swedish Consulate, Jerusalem	
Maria Yousef Al Aqra'	Director of International Cooperation, Ministry of Health, Ramallah	<a href="mailto:alagraqa@yahoo.com">alagraqa@yahoo.com</a>
Medhat Abas	Director General International Cooperation (Gaza), Ministry of Health	<a href="mailto:Raynode20000@gmail.com">Raynode20000@gmail.com</a>
Monther I. Shoblak	Director General, Coastal Municipalities Water Utility, Gaza	<a href="mailto:monthersh@cmwu.ps">monthersh@cmwu.ps</a>
Amany Dayif	Physicians for Human Rights-Israel	<a href="mailto:amany@phr.org.il">amany@phr.org.il</a>

Morag MacDonald	Social and Research and Evaluation Unit, UK	<a href="mailto:Morag.macdonald@bcu.ac.uk">Morag.macdonald@bcu.ac.uk</a>
Mustafa Barghouthi	Secretary General Palestine National initiative, West Bank	<a href="mailto:Mmustafa953@gmail.com">Mmustafa953@gmail.com</a>
Ramesh Rajasingham	Head of OCHA, Jerusalem	<a href="mailto:rajasingham@un.org">rajasingham@un.org</a>
Rana Nashashibi	Director, Palestinian Counseling Center, Jerusalem	<a href="mailto:pcc@palnet.com">pcc@palnet.com</a>
Rand Salman	Director, Palestine Institute of Public Health, Ramallah	<a href="mailto:salmanr@who.int">salmanr@who.int</a>
Randa Aburabie/ Nabulsi	National prof Officer Communicable Diseases, WHO Jerusalem	<a href="mailto:aburaber@who.int">aburaber@who.int</a>
Sami Lubbad	Director of Public Health Laboratory, Ministry of Health, Gaza	
Segolene Adam	Deputy Director of Cooperation, Swiss Agency for Development and Cooperation	<a href="mailto:segolene.adam@eda.admin.ch">segolene.adam@eda.admin.ch</a>
Taiser Alsultan	UHWC, Gaza	
Tasneem Atatrah	Advocacy and Health Promotion Off. WHO, Jerusalem	<a href="mailto:tat@who-health.org">tat@who-health.org</a>
Umaiye Khammash	Chief Field Health Programme, UNRWA West Bank	<a href="mailto:u.khammash@unrwa.org">u.khammash@unrwa.org</a>
Ureid Amad	Aid coordination Officer –Local Aid Coordination Secretariat, Social Development Sector, Ramallah	<a href="mailto:uamad@lacs.ps">uamad@lacs.ps</a>
Wael Qadam	Director of health Services, Palestine Red Crescent Society	<a href="mailto:wael@PalestineRCS.org">wael@PalestineRCS.org</a>
William Hadweh	Director of Nursing, Augusta Victoria Hospital, Jerusalem	<a href="mailto:whadweh@avh.org">whadweh@avh.org</a>
Yased Abu Jamei	Director of Gaza Community Mental Health Programme, Gaza	
Yehezkel Lein	Head of research and Analysis Unit, OCHA, Jerusalem	<a href="mailto:lein@un.org">lein@un.org</a>
Yousef Awadallah	Union of Health Working Committee (UHWC), Gaza	
Youssef Abu Elreesh	Deputy Minister of Health, Gaza	
Carol Zoughbi	YMCA – Rehabilitation Program, Ex-Detainee Children (West Bank Program)	

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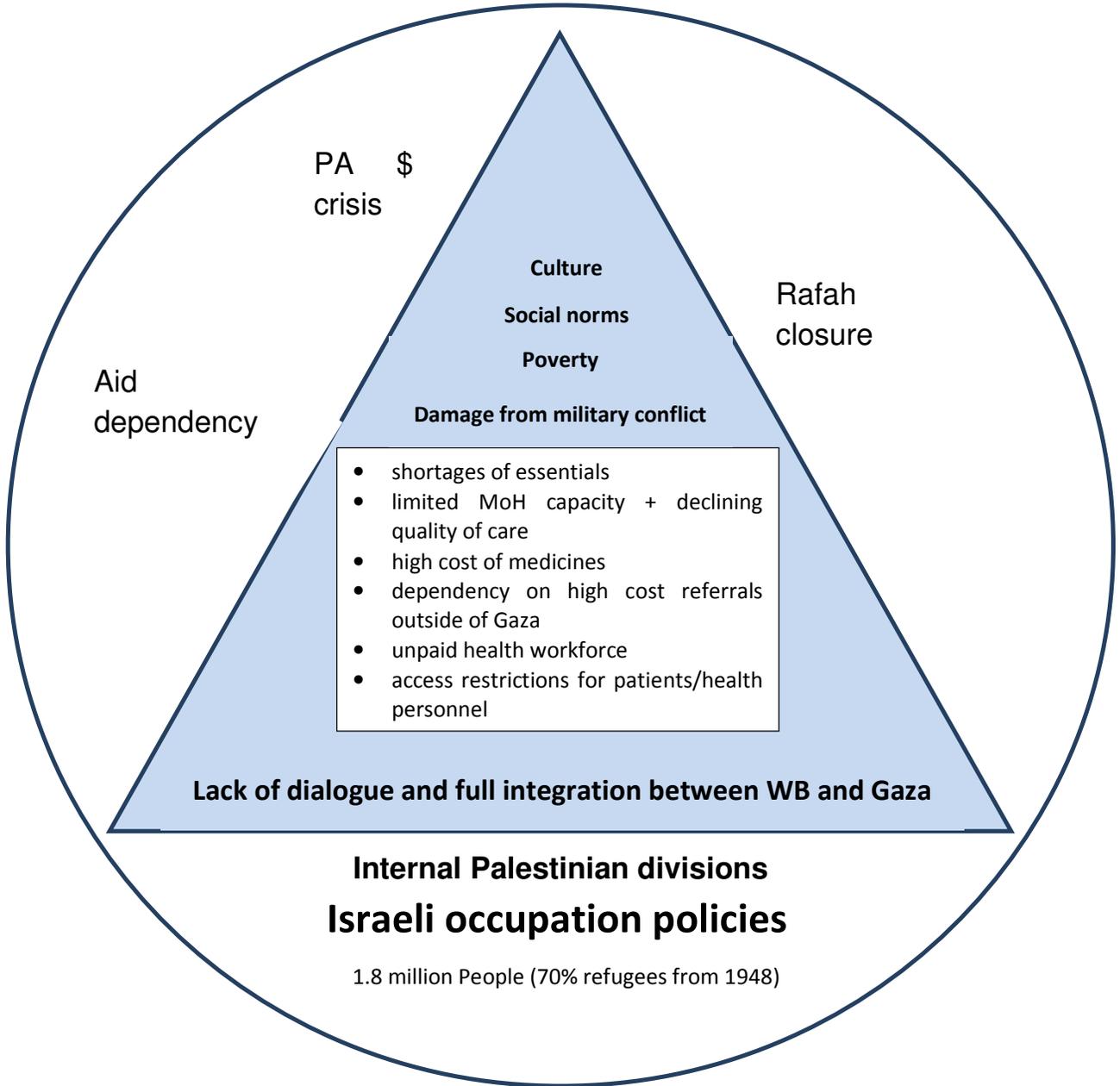
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**ANNEX 5: Restricted Access to Health -adapted from WHO 2015(B)**

**Restricted access to health in Gaza**



## **ANNEX 6: Recommendations from the WHO 2013 Special report on Right to health: Barriers to health access in the occupied Palestinian territory, 2011 and 2012**

### **Government of Israel**

1. Humanitarian access should be available 24/7 and without delay for all Palestinian patients requiring specialized health care, including exit out of Gaza and access into Jerusalem.
2. Registered ambulances should have direct access through Jerusalem checkpoints to East Jerusalem hospitals.
3. Permit application procedures should be clear, consistent and predictable to all parties and criteria for permit approvals must be written and publicly accessible.
4. Israeli permit personnel should not interfere in health care decisions, including the Ministry of Health's choice of destination hospitals for patient referrals.
5. Reasons for denial of a health permit should be made in writing and delivered to the patient. There must be a clear and speedy mechanism for appeal of a denied permit.
6. East Jerusalem hospital personnel should be issued long-term permits to access their workplace.
7. Patients needing frequent treatment sessions, such as cancer patients, should be facilitated with timely access.
8. Health professionals in Gaza and the West Bank require access to continuous medical education and opportunities for upgrading skills

### **Palestinian Authority**

1. The provision of adequate and equitable supply of all essential drugs and medical disposables should be ensured to all MoH hospitals and primary health care centers in the West Bank and Gaza.
2. A mechanism should be established for financial support to poor patients who cannot afford the out-of-pocket costs of the referral process (transportation and daily living costs in hospital; tests and medicines).
3. A help line should be created to support patients who encounter difficulties in the referral process and an effective system should be established to receive and address patient's complaints.
4. A monitoring system should be established to ensure smooth functioning of the referral process for patients and to detect any problems or rights violations.

### **Government of Egypt**

1. Humanitarian access should be available 24/7 and without delay for all Palestinian patients requiring exit out of Gaza through the Rafah border.
  2. Palestinian referral patients from Gaza should have prearranged appointment dates for hospital admission, or immediate hospital review of documents and placement in Egyptian health facilities on the same day, rather than be forced to wait for up to one month for treatment.
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