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Country cooperation strategy for WHO and the Occupied Palestinian Territory 2017–2020

Occupied Palestinian Territory

World Health Organization
Regional Office for the Eastern Mediterranean

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1. Introduction

The Country Cooperation Strategy (CCS) is WHO's medium-term strategic vision to guide its work in support of a country's national health policies, strategies and plans and to support a country's development efforts within the Sustainable Development Agenda.[1] The CCS forms the basis for the formulation of WHO's biennial country work plans with the Ministry of Health, and functions as a tool for harmonizing cooperation with partner United Nations (UN) organizations.

The health of Palestinians in the occupied Palestinian territory has been uniquely affected by occupation by Israel, which has been ongoing since 1967. Health concerns relate not only to the direct effects of conflict and military action but also to the impact of the occupation on human security, well-being and the wider determinants of health. Periodic escalations of violence especially affect the Gaza Strip, and geographical fragmentation and restrictive policies further compound public health risks and constrain opportunities for development. In addition to the health consequences of the occupation and frequent bouts of violence, the Palestinian people face the challenge of a rising burden of noncommunicable diseases, similar to neighbouring countries.

This current CCS, covering 2017–2020, shares similarities and maintains continuity with the previous strategic agenda developed for 2009–2013. The gap between the two strategic cycles results from the urgent response to the severe humanitarian needs caused by the Gaza conflict in 2014 and the decision to harmonize the new strategy and planning cycle with those of the government and the UN.

The latest WHO guidance for developing the CCS, issued in 2014, emphasizes the need for a more inclusive process at country level to ensure co-ownership by the government and the WHO Secretariat. This document focuses on strategic priorities that link to related WHO and UN strategies and planning processes (WHO biennial plans, Common Country Assessment, UN Development Assistance Framework) and align with the WHO Twelfth General Programme of Work and the regional strategic plans. The CCS also aligns with national planning strategies for Palestine, including the National Policy Agenda and the National Health Sector Strategy for 2017–2022.

Since the previous CCS in 2009, the global policy debate on development and humanitarian aid has evolved from the recognition that the Millennium Development Goals did not sufficiently target the poorest and those living in fragile, conflict-torn states. Key global initiatives and events have marked progress in building on the experience of the Millennium Development Goals, such as the High Level Forum on Aid Effectiveness in Busan in 2011, the agreement on Sustainable Development Goals in New York in 2015 and the first World Humanitarian Summit

[1] Guide for the formulation of the WHO Country Cooperation Strategy. Geneva: World Health Organization; 2014 (http://www.who.int/country-cooperation/publications/ccs-formulation-guide-2014/en/, accessed 4 September 2017).

in Istanbul in 2016. One common denominator of these initiatives has been consensus on the need for equity and for focusing aid on vulnerable, fragile countries that present a higher risk of instability and insecurity at national, regional and global levels. Within countries, there is equally a need to focus on the most disadvantaged groups, as underlined by the UN Secretary-General's call to "leave no one behind".[2]

Since 2010, most development agencies, including WHO, have been negatively affected by the global financial crisis. With fewer financial resources available, WHO's leadership and its Member States agreed that the agency must improve its performance and efficiency in order to be responsive to challenges of the changing environment. Hence, WHO embarked on reforms at the programmatic, governance and managerial levels, with the overall aims of improving people's health; increased coherence in global health; and organizational excellence, including a stronger human rights approach to health.[3] The Ebola crisis of 2014–2015 in Western Africa highlighted gaps and challenges for WHO, and a further aim of the reforms is to enhance WHO's capacity to prepare for and respond to public health emergencies.

Universal health coverage is a global priority target for health. It is specifically promoted through Sustainable Development Goal 3: "Countries are urged to achieve financial risk protection, access to quality essential health care services, and access to safe, effective, quality and affordable essential medicines and vaccines for all", with particular attention to ensuring financial protection for all disadvantaged and excluded groups.[4] Removing financial barriers, increasing the proportion of the population covered and the quality and extent of health services included are all necessary dimensions to attaining universal health coverage and ensuring a health system that is equipped to respond to crises and emerging health needs. The World Bank and WHO completed a mission in 2016 to evaluate the existing situation for universal health coverage in Palestine, including a situational analysis and appraisal of some of the key challenges facing the health system. Based on this evaluation, the mission proposed strategic directions and actions to improve health financing and health service delivery for universal health coverage in the West Bank and Gaza.

At country level, the Palestine National Development Plan 2014–2016 has identified health system strengthening and equity among its social protection and development strategic objectives: "A more integrated health care system, providing high-quality and equitable public health care services for all".[5] Health system strengthening is also a cornerstone of the National Policy Agenda 2017–2022, reflected in national policy priority 9: "Quality health care for all".

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[2] Ban calls strongly on governments to 'leave no one behind'. New York: United Nations Organization; 2016 (http://www.un.org/sustainabledevelopment/blog/2016/01/ban-calls-strongly-on-governments-to-leave-no-one-behind/, accessed 5 September 2017).

[3] WHO reform. Geneva: World Health Organization; 2015 (http://www.who.int/about/who_reform/en/, accessed 5 September 2017).

[4] SDG 3: Ensure healthy lives and promote wellbeing for all at all ages. Geneva: World Health Organization; 2015 (http://www.who.int/sdg/targets/en/, accessed 5 September 2017).

[5] National Development Plan 2014–16. Ramallah: State of Palestine; 2014 (http://www.rightsecretariat.ps/portal/uploads/Palestine_State_final.pdf, accessed 8 September 2017).

This CCS aims to incorporate these major developments in global and national priorities and forge a way forward to improve the health of Palestinians. Section 2 describes the achievements and challenges in the current health context, looking specifically at the development framework, health status and system, and the contributions of major stakeholders. Section 3 focuses on the review carried out by the WHO Office in the occupied Palestinian territory in late 2015 through participatory consultations with key partners (foremost with the Ministry of Health) on the technical achievements and challenges of the previous CCS and recommendations for future work. Section 4 lays out the four strategic priorities and the focus areas within each priority that define the Strategic Agenda for WHO's cooperation in the West Bank and Gaza Strip for 2017–2020. Section 5 outlines the human and financial resources required for WHO's implementation of the CCS. Finally, Section 6 details WHO's plans for stakeholder engagement to implement an effective and relevant framework for monitoring and evaluating the CCS in preparation for mid-term and final reviews.

2. Main health achievements and challenges

2.1 Context

The CCS acknowledges the fragility of the overall development and humanitarian situation and the challenges confronting Palestine. These include worsening violence and an inability to safeguard the security and human rights of the population; deep-rooted political uncertainty; economic contraction; a dire humanitarian situation; and signs of aid decline. International efforts to restart negotiations toward a political resolution, which have faltered over the past 20 years, broke down more than two years ago.

Chronic effects of the occupation and prolonged conflict have been exacerbated by continuous settlement expansion, the acute humanitarian crisis that followed the July–August 2014 war in Gaza and the violence that erupted in late 2015 in the West Bank and continued into 2016.[6] The Gaza conflict in 2014 resulted in more than 2100 Palestinians killed and more than 10 000 wounded, a huge burden on the psychosocial well-being of the population, and a third of the population forcibly displaced from their homes. A substantial number of hospitals and health centres and approximately 11 000 homes were destroyed with 6800 severely damaged or uninhabitable, leading to the highest rate of internal displacement since 1967. Power and water supplies were also seriously disrupted along with other essential services, including health services.[7] Economic losses were estimated to exceed US$ 1 billion,[8] which further aggravated the ongoing contraction of the economy, widespread poverty[9] and an already high unemployment rate in Gaza. One quarter of the Palestinian labour force is unemployed, and the rate in Gaza is double that in the West Bank. The most recent household survey in 2011 estimated that over a quarter (26%) of Palestinians live in poverty, while the situation is worse in Gaza, with over a third (39%) of the almost 2 million Palestinians living there in poverty, based on household income and expected consumption.[10,11] In addition to the direct effects of the war, the closure of tunnels with Egypt led to price inflation and reduced consumption, with continued movement restrictions. In 2014, there was a 15% contraction of real gross domestic

[6] Protection of civilians weekly report 23 August–5 September 2016. East Jerusalem: United Nations Office for the Coordination of Humanitarian Affairs; 2016 http://www.ochaopt.org/content/protection-civilians-weekly-report-23-august-5-september-2016, accessed 8 September 2017).

[7] Fragmented lives: humanitarian overview 2015. East Jerusalem: United Nations Office for the Coordination of Humanitarian Affairs; 2015 (http://www.ochaopt.org/humanitarian-overview-2015, accessed 8 September 2017).

[8] Detailed needs assessment and recovery framework for Gaza reconstruction. Ramallah: State of Palestine; 2015 (http://www.lacs.ps/documentsShow.aspx?ATT_ID=21974, accessed 8 September 2017).

[9] According to the World Bank, almost 80% of the population of Gaza is currently aid-dependent. The World Bank in West Bank and Gaza. Washington DC: World Bank; 2017 (http://www.worldbank.org/en/country/westbankandgaza/overview, accessed 21 September 2017).

[10] Palestine in figures 2015. Ramallah: Palestinian Central Bureau of Statistics; 2015 (http://www.pcbs.gov.ps/Downloads/book2188.pdf, accessed 26 April 2017).

[11] Palestine human development report. Poverty. New York: United Nations Development Programme; 2015 (http://www.ps.undp.org/content/dam/papp/docs/Publications/UNDP-papp-research-PHDR2015Poverty.pdf, accessed 10 September 2017).

product (GDP) in Gaza, and a 3% reduction in real GDP for the Palestinian economy as a whole.[12]

The 2014 war in Gaza also accentuated chronic problems in the health sector caused by the long-standing Israeli blockade, movement restrictions and tightly constrained development opportunities. Health facilities had to operate with an unreliable power supply, depending on fuel to run emergency generators. They battled with chronic shortages of drugs and medical supplies, and had difficulty procuring and importing spare parts for medical equipment and maintenance services. This led to deterioration in the quality of services with avoidable health consequences. A WHO needs assessment in 2014 noted that almost half of Gaza's medical equipment was outdated, estimating that the average wait for spare parts was 6 months.[13] Post-war reconstruction is progressing very slowly,[14] with only 35% of the US$ 3.5 billion aid pledged for reconstruction disbursed as of late 2015.[15]

In the West Bank and East Jerusalem, illegal settlement construction has expanded through confiscation of land, demolition of Palestinian houses, settler violence, forced displacement and depopulation of rural areas. The security wall separates East Jerusalem from the rest of the West Bank, restricting movement, trade and access to referral health facilities and emergency health care.

According to the Ministry of Health, Israeli security forces in the West Bank and Gaza killed 129 Palestinians in the last three months of 2015 and intensified access restrictions across the West Bank, erecting additional checkpoints, roadblocks and security controls that resulted in long delays for patients referred to health care facilities.

Access to Gaza remains very limited and much of Area C, which represents approximately 60% of the West Bank, is inaccessible to Palestinians. The physical separation between the West Bank and Gaza, together with the continued political impasse between Hamas and Fatah, have had severe consequences in terms of a fiscal imbalance between the two areas and also in terms of policy and planning, including for the health sector. Socioeconomic inequality between the two areas persists and has widened following the 2014 war in Gaza.

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[12] Economic monitoring report to the ad hoc liaison committee. Washington DC: World Bank; 2015 (http://documents.worldbank.org/curated/en/118611468189870664/main-report, accessed 21 September 2017).
[13] de Ville de Goyet C, Manenti A, Carswell K, van Ommeren M. Report of a field assessment of health conditions in the occupied Palestinian territory (oPt), 22 March to 1 April 2015. Geneva: World Health Organization; 2015 (http://apps.who.int/gb/Statements/Report_Palestinian_territory/Report_Palestinian_territory-en.pdf, accessed 20 September 2016).
[14] Gaza: two years on. East Jerusalem: United Nations Office for the Coordination of Humanitarian Affairs; 2016 (http://www.ochaopt.org/pages/gaza-two-years-on, accessed 8 September 2017).
[15] West Bank and Gaza: report to the Ad Hoc Liaison Committee. Washington DC: International Monetary Fund; 2015 (https://www.imf.org/external/country/WBG/RR/2015/092115.pdf, accessed 8 September 2017).

The Health and Nutrition Cluster humanitarian programme for 2017 estimated that 1.0 million people are in need of emergency health and nutrition interventions: 830 000 people in the Gaza Strip and over 205 000 in the West Bank.[16]

Palestinian public finances have depended on foreign aid to a significant extent over the past decade, albeit marked by large fluctuations and unpredictability. Despite increasing needs, aid for Palestine has declined, dropping 30% in 2015 from the previous year, resulting in a US$ 650 million budget gap reported in early 2016.[17] Factors contributing to this gap include the global economic recession, an increase in humanitarian needs in other countries and regions, and donor "fatigue" or "occupation fatigue", due in part to the lack of any progress towards any political resolution of the conflict. Volatility and withdrawal of aid severely hinder the government's capacity to allocate resources according to its plans and constrain its potential to embark on long-term, ambitious reforms.

2.2 Development framework

The national strategy framework for health in Palestine consists of two key documents: The National Development Plan 2014–2016 and the Palestinian National Health Strategy 2014–2016.[18] These are complemented by subsector and programme strategies and policies, for example for health information systems, nutrition, cancer prevention and mental health.

The National Development Plan provides the overall strategic framework for government priority actions and development spending, and is composed of four key sectors. The Social Protection and Development sector integrates the main health priority: "A more integrated health care system, providing high quality, National Health Strategy" and identifies three main programmes:

- sustainable high quality primary health care services,
- promoting healthy lifestyles and secondary and tertiary health care services,
- administration and governance.

[16] Humanitarian needs overview, 2017. East Jerusalem: United Nations Office for the Coordination of Humanitarian Affairs; 2016 (https://www.ochaopt.org/content/2017-humanitarian-response-plan-occupied-palestinian-territory , accessed 26 April 2017).

[17] Palestine's economic outlook – Spring 2016. New York: World Bank; 2015 (http://www.worldbank.org/en/country/westbankandgaza/publication/economic-outlook-spring-2016, accessed 21 September 2017).

[18] National health strategy, 2014–16. Ramallah: Ministry of Health; 2013 (http://www.moh.ps/Content/Books/qnUY18Rl5ytCU8paOCdKtuJduEK3isyvayYFMJHoOPS1A32h2ttv1Y_DOHrIaecDFUGDcRA4784Q4cmum3zeBPhP6pplSENYMOmYQ8L5OcWb2.pdf, accessed 20 September 2016).

Box 1. Strategic objectives of the National Health Strategy

1. Ensure rights-based, comprehensive and integrated health care services for all citizens (taking into consideration gender, age, geographic distribution and political and socioeconomic equity).
2. Promote preventative health care and management of noncommunicable diseases.
3. Establish an effective, comprehensive and sustainable quality system for all health services.
4. Ensure the availability of a qualified health workforce capable of delivering high quality health services.
5. Enhance institutional development and governance of the health sector.

The strategic objectives of the Palestinian National Health Strategy are outlined in Box 1.

The government has embarked on the formulation of a new National Policy Agenda 2017–2022, which defines "quality health care for all" as National Priority 9. Within this, the government has outlined "better health care services" and "improving citizens' health and well-being" as national policies, and under each of these it lists the policy interventions for the 6-year period. The National Policy Agenda constitutes the basis for the next National Health Sector Strategy 2017–2022, which includes more detail with regard to strategies and programmes for progressing towards universal health coverage and the introduction of the family practice approach. The strategy aligns with several of the UN Sustainable Development Goals and directly with Sustainable Development Goal 3, to "ensure healthy lives and promote well-being for all at all times".[19] It addresses specific aspects of Sustainable Development Goal 3 in promoting maternal and child care (3.1 and 3.2), the prevention of noncommunicable diseases (3.4 and 3a), universal access to health care (3.7 and 3.8), strengthening of the health workforce (3c) and coordination for health (3d). The objectives of the National Health Sector Strategy are outlined in Box 2.

Box 2. National health sector strategic objectives for 2017–2022

1. Ensure the provision of comprehensive health services to all Palestinians, heading towards localization of health services in Palestine.
2. Promote the management of noncommunicable diseases, preventive health care, community health awareness and gender related programmes.
3. Institutionalize quality systems in all aspects of health services.
4. Promote and develop health workforce management systems.
5. Strengthen health governance, including effective health sector management, laws and legislation development and enforcement, cross-sectoral coordination, intra-sectoral coordination and integration towards achieving the localization of services and universal health coverage. Enhance the health financing system and protection of citizens against financial hardship of paying health care costs.

[19] Sustainable Development Knowledge Platform., Sustainable Development Goal 3. New York: United Nations: 2017 (https://sustainabledevelopment.un.org/sdg3, accessed 8 September 2017).

In parallel, the United Nations Country Team is developing the strategic directions and the programmatic priorities for the UN system in Palestine for the next UN Development Assistance Framework for 2018–2021. The common country analysis initiated the process by identifying the key issues through an analysis of structural disadvantages, chronic vulnerability and most vulnerable groups that will aid the formulation of the UN framework. Thus the concurrent planning processes in 2016 and 2017 present unique opportunities for harmonizing strategy and planning cycles and aligning strategic objectives between the government and its partners.

2.3 Health status

The occupied Palestinian territory has been faced with the challenges of prolonged conflict and adverse social determinants: widespread poverty, a high prevalence of lifestyle risk factors, vulnerability to man-made and natural hazards, health system weaknesses and difficult access to health care. These all have a negative impact on health. Despite this, key health outcomes in Palestine show improving trends, are better than the average in the Eastern Mediterranean Region and are similar to those of neighbouring countries, though they lag far behind Israeli indicators (Table 1). National figures, however, mask the substantial differences between the West Bank and Gaza, which reflect historical, regional, security and socioeconomic disparities. It is likely that the disparities between Gaza and the West Bank have increased since the data in Table 1 were collected in 2013 following the Gaza 2014 war and its aftermath.

The World Bank estimates that life expectancy at birth in the West Bank and Gaza increased from 68 years to 73 years between 1990 and 2013 (Table 1).[20] Since only partial and modest improvements in health outcomes have been achieved, the country was not able to meet the targets of Millennium Development Goal 4 (Reduce child mortality by 2/3) and Millennium Development Goal 5 (Reduce maternal mortality by 3/4) by 2015.

Table 1. Key health outcome indicators in Palestine, Israel and selected countries of the Region, 2013

Country	Life expectancy at birth (years)	Infant mortality rate (per 1 000 live births)	Under 5 mortality rate (per 1 000 live births)	Maternal mortality ratio (per 100 000 live births)
Palestine	73	18	22	25
West Bank	–	17	20	20
Gaza	–	20	24	31
Lebanon	80	8	9	16
Iraq	74	14	17	23
Jordan	74	16	19	50
Israel	82	3	4	2
Regional average	68	43	55	170

Sources: World health statistics 2015; multiple indicator cluster survey 2014; Palestine Health Information Centre 2015.

[20] Life expectancy at birth, total. Washington DC: World Bank; 2015 (http://data.worldbank.org/indicator/SP.DYN.LE00.IN?end=2014&start=1990m, accessed 8 September 2017).

Mortality rates in children have improved, with steadily declining trends in the last decades. In 2015, the infant mortality rate was 10.9 deaths per 1000 live births and the under-5 mortality rate was 13.9 deaths per 1000 live births, as recorded by the Ministry of Health.[21] The multiple indicator cluster survey of 2014 showed infant and under 5 mortality rates of 18.2 and 21.7 deaths per 1000 live births, pointing to declining trends and modest improvements in these health outcomes (Table 2).[22] However, the same source also indicates a stagnating trend of neonatal mortality in recent years.

The findings of a study on infant mortality among refugees in Gaza, published by the UN Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) in 2013, raised concerns that mortality rates had increased among infants and neonates.[23] A repeat survey by UNRWA in 2015 estimated that this upward trend had continued. In 2016, in response to these concerns and in close cooperation with the Ministry of Health and UNRWA, WHO conducted a validation study of the UNRWA survey findings from 2015 to further verify and analyse infant and neonatal mortality levels in Gaza and to clarify the main causes of death. The revised and validated data indicate an infant mortality rate of 21.3 per 1000 live births in Gaza, suggesting a slow but steady downward trend, in line with the findings of the multiple indicator cluster survey 2014. However, the same data also showed no decline in neonatal mortality. The WHO validation study identified infections, congenital anomalies and birth asphyxia as the main causes of infant and neonatal deaths, and prematurity and low birth weight as main contributory factors. The study makes recommendations on how to improve death registration and notification.

Table 2. Neonatal (NMR), infant (IMR) and under-five (U5MR) mortality rates in Palestine, 2005–2014

Year	NMR (per 1 000 live births)	IMR (per 1 000 live births)	U5MR (per 1 000 live births)
2010–2014	11.2	18.2	21.7
2005–2009	11.8	20.3	24.1
2000–2004	12.9	21.3	23.4
1995–1999	13.2	22.8	28.6
1990–1994	20.3	31.9	41.5

Source: Multiple indicator cluster survey 2014.

[21] Health annual report 2015. Ramallah: Ministry of Health; 2016:90.

[22] Palestinian multiple indicator cluster survey 2014, final report. Ramallah: Palestinian Central Bureau of Statistics; 2015 (http://www.pcbs.gov.ps/Downloads/book2175.pdf, accessed 5 September 2017).

[23] van den Berg MM, Madi HH, Khader A, Hababeh M, Zeidan W, Wesley H, et al. Increasing neonatal mortality among Palestine refugees in the Gaza Strip. Plos One. 2015 (http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0135092, accessed 5 September 2017).

Table 3. Top ten causes of reported death, 2015

Rank	Cause of reported deaths	% of all reported deaths
1	Cardiovascular disease	27.5
2	Cancer	13.8
3	Cerebrovascular disease	9.9
4	Perinatal conditions	6.9
5	Diabetes mellitus	6.8
6	Respiratory disease	6.6
7	Accident	5.1
8	Congenital malformation	3.9
9	Infectious disease	2.4
10	Senility	2.3

Source: Health annual report, 2015. Ramallah: Ministry of Health; 2016.

Palestine, with one of the youngest populations in the Region, is experiencing a demographic and epidemiological transition. Total fertility is high but declining, slowing population growth. Noncommunicable diseases account for four of the five leading causes and over half of reported deaths, according to Ministry of Health data (Table 3).

Palestine has a successful immunization programme and a well functioning surveillance system for the control of communicable diseases. Some diseases, such as schistosomiasis, leprosy, rabies and wild poliovirus, were historically eradicated and continued efforts for polio eradication in the territory include surveillance for acute flaccid paralysis (AFP), for which there were 38 cases in Palestine in 2015 (2.1 cases per 100 000).[21] A seroprevalence study for hepatitis B carrier status indicates an estimated prevalence of 1.80% for Palestine, which is lower than the estimated prevalence of 3.01% for the WHO Eastern Mediterranean Region and a global estimated prevalence of 3.61% for the same period.[24] The incidence of tuberculosis is similarly low, with 29 cases reported in 2015, or 0.61 per 100 000.[21] The national immunization schedule covers tuberculosis, hepatitis B, poliomyelitis, diphtheria, pertussis, tetanus, Haemophilus influenzae type B, rotavirus, pneumococcus, measles, mumps and rubella. Immunization coverage is consistently high, ranging from 96% to 99% in 2013.[25]

Noncommunicable diseases are the major causes of mortality and morbidity for Palestinians, with cardiovascular disease, cancer and cerebrovascular disease constituting the three leading causes of death.[21] Noncommunicable diseases are on the rise and contribute significantly to premature death and reduced healthy life expectancy.[26] They account for a significant proportion of referrals and have substantial financial implications for patients and the health sector. Their prevention and management requires a focus on reducing lifestyle risk factors

[24] Schweitzer A, Horn JS, Mikolajczyk RT, Krause G, Ott JJ. Estimations of worldwide prevalence of chronic hepatitis B virus infection: a systematic review of data published between 1965 and 2013. Lancet. [online] 2015 (http://www.thelancet.com/pb/assets/raw/Lancet/pdfs/S014067361561412X.pdf, accessed 8 September 2017).
[25] Immunization summary. A statistical reference containing data through 2013. Geneva: World Health Organization; 2014 (http://www.who.int/immunization/monitoring_surveillance/Immunization_Summary_2013.pdf, accessed 8 September 2017).
[26] Health profile, Palestine. Geneva: World Health Organization; 2015.

(tobacco use,[27] unhealthy diets, and physical inactivity) and an integrated case management approach.

Robust data are not available on the prevalence of mental disorders, which are both under-recognized and stigmatized and therefore under-reported and under-treated. In light of high levels of exposure to chronic political violence, poverty and unemployment – all known risk factors for mental health conditions – there is likely to be a large burden of mental ill health in the occupied Palestinian territory. According to data from the *Global burden of diseases*,[28] depression ranks among the top five causes of disability in the country. One third of people attending Ministry of Health primary health care centres in Gaza and the West Bank report suffering symptoms of mental ill health.[29] Based on WHO estimates that mental disorders double in populations after emergencies,[30] and in light of the violence in Gaza,[31] it is likely that the scope and duration of psychological trauma experienced in the 2014 war affected several hundred thousand Palestinians in Gaza, particularly children, who require short- to long-term mental health and psychosocial support for recovery.

Other important health concerns include an increase in road traffic accidents and injuries;[32] a high burden of disease from perinatal conditions; the double burden of malnutrition with overweight and obesity in adults and chronic undernutrition among children; and poor promotion, support and practice of breastfeeding, which protects against both neonatal mortality and nutritional disorders in children and adults.

2.4 The health system

A defining feature of the health system in Palestine is its fragmentation[33] at the historical, geographic, institutional and organizational levels.[34] This fragmentation is difficult to examine

[27] An estimated 39% of the adult male population smokes, according to the WHO health profile 2015. Survey estimates from 2010 of the adult male population indicate 37.6% smoke. (http://www.pcbs.gov.ps/Portals/_pcbs/PressRelease/MoH&PCBSSmoke2012E.pdf, accessed 8 September 2017).

[28] Mokdad A, Jaber S, Aziz M, AlBuhairan F, AlGhaithi A, AlHamad NM, et al. The state of health in the Arab world, 1990–2010: an analysis of the burden of diseases, injuries, and risk factors. Lancet. 2014;383:309–20.

[29] Prevalence of common mental disorders in PHC, unpublished report. Gaza: World Health Organization; 2009.

[30] 10 facts on mental health; fact 4. Geneva: World Health Organization; 2014 (http://www.who.int/features/factfiles/mental_health/mental_health_facts/en/index3.html, accessed 5 September 2017).

[31] Llosa A, Casas G, Thoman H, Mairal A, Grais R, Moro M. Short and longer-term psychological consequences of Operation Cast Lead: documentation from a mental health programme in the Gaza Strip. Conflict and Health. 2012;6:8. also, Long-term psychological effects of the 2012 Israeli offensive on Gaza on Palestinian children and parents. Gaza: Gaza Community Mental Health Programme; 2013.

[32] According to the annual reports by the Palestinian Central Bureau of Statistics, the number of road accidents recorded in the West Bank increased by 51.2% between 2010 and 2014, and injuries increased by 4.3%. Ramallah: Palestinian Central Bureau of Statistics, 2014 (http://www.pcbs.gov.ps/Portals/_Rainbow/Documents/main%20ind_e.htm, accessed 20 September 2016).

[33] Pavignani E, Riccardo F. Mirror and mirages. Interpretations of the multiform, trans-border Palestinian healthcare arena (draft). Copenhagen: University of Copenhagen and DANIDA; 2011 (http://globalhealth.ku.dk/events/2013/health-as-a-human-right/programme/PalestineFinal2011-1.pdf, accessed 5 September 2017).

[34] Giacaman R, Khatib R, Shabaneh L, Ramlawi A, Sabri B, Sabatinelli G, et al. Health status and health services in the occupied Palestinian territory. Lancet. 2009;373:837–49 (http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(09)60107-0.pdf, accessed 5 September 2017).

adequately both at a structural and functional level, and poses enormous challenges to the Ministry of Health in formulating robust strategies and coordinating stakeholders.

There are four main providers of health care services in the West Bank and the Gaza Strip: the Ministry of Health, UNRWA, nongovernmental organizations and the Palestinian Military Medical Services, each with its own respective network of primary health care centres and hospitals. For example, UNWRA operates an extended network of clinics providing free services to registered refugees and the nongovernmental organizations are a mixture of traditional charities, Islamic charitable committees, Christian charities and non-profit organizations, often supported by the Palestinian diaspora and mainly offering primary care, maternal health care, rehabilitation and specialized care in referral hospitals, complementing the public sector services. In 2009, there were 129 Palestinian nongovernmental organizations involved in health.[35] The Palestine Red Crescent Society, with its extended network of volunteers, has gradually shifted the focus of its programmes to emergency services. The private for-profit sector increasingly occupies a major role in service provision[36] although dual practice is prevalent, a common finding in many countries, which blurs the line between the public and private sectors.[37] Traditional alternative medicine continues to play an important role in health care.[38] Additionally, Israeli hospitals admit patients referred from both the Gaza Strip and the West Bank at a very high cost, further exacerbating financial problems.

Barriers to accessing health services represent a serious challenge to ensuring adequate provision for Palestinians. Permits must be obtained for each health consultation requiring travel to Jerusalem or to neighbouring countries, including Israel, as well as for Gaza patients to travel to the West Bank, and applications for permits are often delayed or denied without apparent reason.

In the West Bank in 2016, 22.6% of travel permit applications by patients and their companions were denied or delayed. This is an increase from 2015, when the rate was 16.8%. Ambulance transportation for patients from the West Bank to Jerusalem hospitals requires a

[35] Challand B. Palestinian civil society: Foreign donors and the power to promote and exclude. Routledge studies on the Arab–Israeli conflict. London: Routledge; 2009.

[36] A 2005 Palestinian Central Bureau of Statistic survey reported more than 3200 private health service delivery points, mostly medical and dental clinics, accounting for 21% of health care contacts and employing 27% of health sector personnel; inpatient care was provided in 23 private hospitals, with 8.6% of total hospital beds. Health care providers and beneficiaries survey 2005. Main findings. Ramallah: Palestinian Central Bureau of Statistics; 2006 (http://www.pcbs.gov.ps/PCBS-Metadata-en-v4.3/index.php/catalog/115, accessed 5 September 2017).

[37] Dual practice was recently banned by the Ministry of Health, prompting large-scale strikes in the public sector. As of 2014 it was still a common phenomenon. Ozaltin E, Alaref J. Managing health sector dual practice in the Palestinian territories: a policy note. Washington DC: World Bank; 2014. Cited in: West Bank and Gaza. Public expenditure review of the Palestinian Authority. Towards enhanced public finance management and improved fiscal sustainability. Washington DC: World Bank; 2016 (Report No: ACS18454) (http://documents.worldbank.org/curated/en/320891473688227759/pdf/ACS18454-REVISED-FINAL-PER-SEPTEMBER-2016-FOR-PUBLIC-DISCLOSURE-PDF.pdf, accessed 8 September 2017).

[38] "Herbal medicine is considered an integral part of the Palestinian culture and plays a pivotal and indispensable role in the current public healthcare." In: Jaradat NA. Medical plants utilized in Palestinian folk medicine for treatment of diabetes mellitus and cardiac diseases. J Al-Aqsa Unv. 2005;9 (https://www.alaqsa.edu.ps/site_resources/aqsa_magazine/files/90.pdf, accessed 21 September 2016).

"back-to-back procedure," with transfer of patients from a West Bank to a Jerusalem ambulance at checkpoints, prolonging transit times. Health personnel of the six Palestinian specialized hospitals in Jerusalem, who do not have Jerusalem residency, must obtain permits to travel to work, and these require re-approval every 6 months. In the West Bank, 117 communities, primarily in Area C, have no primary or secondary health care services.[39] Jerusalem hospitals, among the best in the Palestinian health care system, are in dire financial straits. Ministry of Health referrals, as well as private patients, seek specialized care in East Jerusalem hospitals, which have historically been a pivotal part of the Palestinian health care system. Some Ministry of Health and private referrals are for specialized services in Israeli hospitals, although at high cost. With the financial sustainability of the health sector an increasing concern, the Ministry has attempted to reduce costs by strengthening its oversight of these referrals.

The stratification of the health sector creates some redundancy among service providers and contributes to overall inefficiency, although arguably it offers choice and access to users and enhances system resilience to shocks.[40] In the West Bank, there is one Ministry of Health clinic for every 6000 inhabitants, with a wide variation among its governorates,[41] while in Gaza the ratio is more than double at around one clinic for every 12 000 population.[42] According to the Ministry of Health, there were 12.6 hospital beds per 10 000 population in 2012 (13.9 in Gaza and 11.8 in the West Bank). The distribution is uneven across governorates, from 27.5 beds per 10 000 population in Bethlehem to 5.4 in Deir Al Balah in Gaza.[43] Health resources and access are also problematic in Area C of the West Bank, which is not under the civilian control of the Palestinian Authority.

In 2014, human resources for health remained at the same gross levels as they were in 2010, with about 14 000 employees for Palestine. However, this overall figure obscures the fact that human resources for health increased in the West Bank and decreased in Gaza, in the wake of the political divide between Fatah and Hamas.[44] Low remuneration and delays in salary payment have resulted in low morale and large-scale strikes, with implications on service delivery. Yet, according to the World Bank,[45] public spending on health is close to 5% of GDP, exceeding the regional average of 2.6% and the low- and middle-income country average of

[39] Vulnerability profile+ 2015; survey based on interviews with heads of village councils or community representatives. Ramallah: OCHA–Palestinian Central Bureau of Statistics.
[40] Pavignani E, Riccardo F. Mirror and mirages. Interpretations of the multiform, trans-border Palestinian healthcare arena. Brisbane: University of Brisbane and DANIDA; 2012 (draft) (http://globalhealth.ku.dk/events/2013/health-as-a-human-right/programme/PalestineFinal2011-1.pdf, accessed 20 September 2016).
[41] Modol X. Assessment of PHC in the West Bank. Geneva: World Health Organization; 2013.
[42] Public expenditure review: Palestinian territories. Washington DC: World Bank; 2014.
[43] Health care providers and beneficiaries survey 2005. Main findings. Ramallah: Palestinian National Authority, Palestinian Central Bureau of Statistics; 2006 (http://www.pcbs.gov.ps/Portals/_PCBS/Downloads/Healthcare05_e.pdf, accessed 8 September 2017).
[44] The Palestinian Authority President called on public sector workers in 2007 to stop reporting to duty in Gaza, but continued paying salaries and did not recognize newly hired employees.
[45] Public expenditure review of the Palestinian Authority. Washington DC: World Bank; 2016 (http://documents.worldbank.org/curated/en/320891473688227759/pdf/ACS18454-REVISED-FINAL-PER-SEPTEMBER-2016-FOR-PUBLIC-DISCLOSURE-PDF.pdf, accessed 8 September 2017).

1.7% of GDP, and fuelled by relatively high spending on salaries, medical referrals for tertiary care[46] and pharmaceuticals. Public and private spending for health more than tripled from 2000 to 2012, to US$ 1.3 billion, more than 12% of GDP. Per capita total health expenditure more than doubled between 2000 and 2012, from US$ 126 to US$ 294,[47] reflecting high out-of-pocket spending, especially for pharmaceuticals.

Pharmaceutical expenditure is affected by import restrictions set by the Paris Protocols,[48] which have resulted in an average cost of publicly procured medicines almost 7 times above global market costs,[49] debt arrears, delays in payments and limited Ministry of Health capacity to negotiate better prices. The Ministry frequently seeks donations for urgent needs and purchases medicines on an emergency basis from Israeli companies at a high cost. The strict border control and restrictions and the inability of the Ministry of Health in the West Bank to fully resupply Gaza health facilities has resulted in considerable chronic shortages of drugs and medical disposables. In 2016, health facilities in Gaza reported that on average 30% of essential drugs and 40% of required medical disposables were at zero stock.

Health service coverage and utilization are high, with full coverage of DPT3 and measles immunization for 1-year old children in 2015, universal antenatal care and skilled health workers at almost all deliveries. Outpatient consultations constitute 88% of all services provided by public hospitals. Overall, health outcomes are reasonably good, showing the resilience of the Palestinians and their health system, as well as the capacity of various actors, public and private, national and international, to provide health services. However, reform and rationalization of the health sector, as well as sustained financial support and political commitment, are necessary to ensure durable and sustainable health system development. The role of WHO is to provide technical assistance to the Ministry and its partners and to document and advocate in the international arena for the removal of political barriers. In the humanitarian field, WHO coordinates assistance with international and local partners and is the provider of last resort for critical gaps in emergencies. The Country Cooperation Strategy guides these efforts.

[46] Ministry of Health expenditures do not include the sizable direct reimbursements to Israeli hospitals for referral services, which Israel deducts from tax reimbursements before transfer to the Palestinian Authority.
[47] West Bank and Gaza Public Expenditure Review of the Palestinian Authority. Washington DC: World Bank; 2016 (http://documents.worldbank.org/curated/en/320891473688227759/pdf/ACS18454-REVISED-FINAL-PER-SEPTEMBER-2016-FOR-PUBLIC-DISCLOSURE-PDF.pdf, accessed 21 September 2016).
[48] The Paris Protocol was intended as a 5-year interim economic agreement signed in 1994 after Oslo, which created a single customs union for the Palestinian Authority and Israel. The impact on health care was the application of the Israeli regulatory framework for Palestinian procurement of medical goods, which has restricted markets, raised transaction costs and imposes Israel's cost structure onto the much less developed Palestinian economy. Palestinian–Israeli economic relations: trade and economic regime. Stockholm: Palestine International Business Forum; 2015 (http://www.quartetoffice.org/files/image/report.pdf, accessed 8 September 2017).
[49] West Bank and Gaza. Reforming prudently under pressure: health financing reform and the rationalization of public sector health expenditures. Washington DC: World Bank; 2009, (http://siteresources.worldbank.org/INTWESTBANKGAZA/Resources/Summary.pdf, accessed 8 September 2017).

2.5 Development cooperation

2.5.1 Global and national agenda

At a global level, the aid effectiveness agenda has expanded through an ambitious number of commitments, targets and frameworks. In health, the International Health Partnership (IHP+), established in 2007, joins more than 60 national governments, development agencies, and civil society organizations with the aim of promoting more-effective development cooperation for health. In 2016, the International Health Partnership signatories agreed to expand their development agenda to include coordination and advocacy for health system strengthening and universal health coverage[50] in the transition to the Sustainable Development Goals, and to enable greater alignment and coordination on common health systems approaches. At the country level, the National Development Plan 2014–16 was the framework for providing external assistance to the Palestinian Authority until the end of 2016. The National Policy Agenda 2017–2022, organized under a hierarchy that includes the national vision, the three pillars of the National Policy Agenda, 10 national priorities and 29 national policies, with elaborated policy interventions, provides the planning framework for the next six years, allowing for available financial resources. Under the pillar of "sustainable development", "quality health care for all" is a national priority to be implemented through national policies for "better health care services" and for "improving citizens' health and well-being," under which are included a number of policy interventions.[51] The national sector strategies, including those for health, have been developed based on the National Policy Agenda, and integrate the Sustainable Development Goals.

2.5.2 Aid coordination mechanisms

The Local Aid Coordination Secretariat supports local aid coordination structures in providing coherent technical assistance and financial support to the Palestinian people based on national priorities and in line with the Paris Declaration on Aid Effectiveness. The Ad Hoc Liaison Committee, chaired by Norway and co-sponsored by the European Union (EU) and the United States of America, serves as the principal policy-level coordination mechanism for development assistance. In addition, the United Nations participates together with the World Bank (Secretariat), the International Monetary Fund and the Office of the Quartet in reviews of and discussions about political and economic progress and assessments of the priorities for donor support. Sector working groups operate to ensure coordination of donor support in key sectors, underpinned by thematic working groups. The main coordination mechanism for health development support is the Health Sector Working Group with a core group and several technical thematic subgroups for referrals, pharmaceuticals, etc. The Health and Nutrition Cluster coordinates the humanitarian health response. The Health Sector Working Group is

[50] Transforming IHP+. Geneva: World Health Organization; 2016 (http://www.internationalhealthpartnership.net/en/about-ihp/transforming-ihp/, accessed 8 September 2017).
[51] National policy agenda: priorities, policies and policy interventions, submitted to the Ad Hoc Liaison Committee. Ramallah: State of Palestine; 2016.

chaired by the Ministry of Health and co-chaired by USAID, with WHO as the technical adviser; it convenes the main health development partners biannually for information exchange and stakeholder coordination. Part of the UN Office for the Coordination of Humanitarian Affairs-managed cluster system, the health and nutrition cluster meets monthly, with the Gaza Strip cluster representatives connected through video conference. It is co-chaired by WHO and the Ministry of Health and coordinates humanitarian health interventions, including emergency programmes, needs assessments, response plans, advocacy and resource mobilization.The policy dialogue of the international community focuses on strengthening the role and capacities of the Palestinian Authority in managing, coordinating and integrating international aid investments and increasing governance efforts. Direct financial assistance to the Palestinian Authority from the EU, selected EU member states, World Bank, Saudi Arabia, Iraq, Algeria and others continues to contribute substantially to the payment of pensions, salaries and social allowances, and to cover debt payments to East Jerusalem Hospitals for referral patients.

2.5.3 Aid to the health sector

In addition to leading the Health and Nutrition Cluster along with the Ministry of Health, WHO provides technical assistance to the Ministry and partners for developing preparedness plans and strengthening capacities for implementing the International Health Regulations.

Various donors support the health sector through institutional capacity development of the health system as well as through financial assistance for specific projects, for example:

- the Palestinian National Institute of Public Health (Norway);
- health information systems (USAID);
- reform of mental health services (EU);
- support for East Jerusalem hospitals and the network (EU, and several EU and Arab donor countries);
- health insurance and referral master plan (World Bank).
- Some targeted health initiatives focus on:
- efforts to facilitate health worker re-integration in Gaza, including a solution to ensure sustainable salary payments (supported by the Swiss Government, EU and others);
- a World Bank grant to sustain catering and cleaning services in Gaza Strip hospitals (ended in 2015);
- negotiations with Israel to strengthen transparency to enable the Palestinian health authorities to rationalize the payment regime for referral health services in Israeli hospitals;

World Bank plans for continued support to the Palestinian Authority until 2019 to secure continuity in service delivery and to build health system resilience. Contribution of the country to the global health agendaDespite the challenges of occupation and closure, there is strong political commitment from the government to advance global health security in the context of the International Health Regulations. The Norwegian Institute of Public Health, the Palestinian

Ministry of Health and WHO jointly conducted an assessment of the status of core capacity development for the International Health Regulations in the West Bank and Gaza in 2015. The findings have been translated into an action plan to strengthen the International Health Regulations core capacities, currently being implemented, geared to advancing regional and global health security.Stakeholder mapping

The UN Development Assistance Framework identifies priorities for joint UN programming for the medium term, and aligns with the National Policy Agenda to support national development efforts. The aim of the common country analysis and the UN Development Assistance Framework is to identify those areas where the UN Development Group can make a difference and to ensure that various interventions will address the structural drivers of vulnerabilities. Many of the emerging government policy priorities require close interagency collaboration and strengthening of joint programming. Along with UN agencies and partners, WHO leads health coordination to meet the national health strategy needs and heads humanitarian health coordination efforts through the Health and Nutrition Cluster together with the Ministry of Health.

UNRWA delivers basic health services and is responsible for providing a healthy living environment for Palestinian refugees. Their health programme has been delivering comprehensive primary health care services, both preventive and curative, to refugees, and WHO supports refugees' access to health care services through coordination with the health cluster and advocacy efforts for health access for referral patients, especially patients in Gaza and Area C.

UNICEF works with the Palestinian Authority and a broad range of partners to protect children and women from the impact of violence, and to prevent further deterioration in their conditions and well-being. Their programmes target the most vulnerable children and women, focusing on health and nutrition and water, sanitation and health (WASH) in addition to the procurement and distribution of medical supplies in crises.

UNFPA focuses on advocacy, policy dialogue and knowledge management to promote reproductive health and reproductive rights to avert maternal deaths, increase postnatal care coverage, reduce the unmet need for family planning, empower young people and respond effectively to gender-based violence.

The World Bank aims to strengthen the capacity of the Ministry of Health to manage health expenditures, as outlined in its Assistance Strategy of 2015–2016 for the West Bank and Gaza. It is focusing efforts to reduce expenditures for referral patients in facilities outside the Palestinian health system, and aims to help the Ministry of Health implement the policy recommendations from a recent World Bank-supported referral analysis. This includes an assessment of the cost–effectiveness of developing priority tertiary care services within Palestine, technical assistance for rationalizing and organizing referrals and the development of

a referral manual.[52] In 2015, the World Bank launched a project to strengthen Palestinian health system resilience and to cover service sector debts for hospitals in Gaza in addition to constructing and equipping six operating rooms in the Hebron governmental hospital in the West Bank.

International development support for the health sector is coordinated through the International Cooperation Directorate in the Ministry of Health. The Ministry has developed bilateral cooperation agreements with various donors and governments, both for developing the health system and for building the capacity of Ministry of Health staff.

The EU supports the Ministry of Health through the PEGASE Direct Financial Support Mechanism for institution building for the Palestinian Authority. It aids the health sector by providing budget support to pay the Palestinian Authority referral service debts to the East Jerusalem hospitals and promotes reform of the health referral system. The EU has been supporting the reform of the mental health services in Palestine and intends to support a new WHO mental health project to enhance Palestinian well-being and build resilience through improving mental health and psychosocial response in emergencies.

The Ministry of Health also has a bilateral agreement with the Italian Agency for Development Cooperation to develop the health services in Hebron governorate, including the construction of two hospitals in Halhoul and Dura, and a health centre in the area.

USAID acts as "shepherd" of the health sector-working group and is an active supporter of various health projects, including a substantial initiative in Gaza (Envision Gaza 2020), which promotes recovery, reconstruction, and redevelopment in Gaza through four major activities: water and sanitation, private sector development, health and humanitarian assistance.

The Ministry of Health also has ongoing cooperation with Arab States and funding institutions, such as the Qatari Red Crescent Society, the Red Crescent of the United Arab Emirates and the Islamic Development Bank.

[52] Assistance strategy 2015–2016 for the West Bank and Gaza. Washington DC: World Bank; 2014 (Report No. 89503 GZ; http://documents.worldbank.org/curated/en/817581468321831929/text/895030CAS0CORR010Box385333B00OUO090.txt, accessed 9 September 2017).

3. Review of WHO's previous Country Cooperation Strategy cycle, 2009–2013

3.1 Evaluation and assessment

An evaluation process for the previous Country Cooperation Strategy was initiated by WHO in late 2013 with an internal workshop that assessed programme achievements and challenges. However, a formal final evaluation of the CCS 2009–2013 did not take place at the end of the cooperation cycle due to WHO's prioritization of the crisis response to the 51-day emergency during the Gaza war in mid-2014 and its aftermath. In 2015, in order to launch the process for developing a new CCS, WHO opted for a review of the achievements of the previous cooperation strategy to inform the new Strategic Agenda.

The assessment consisted of a desk review of key documents and a broad consultation with 27 key partners and 14 WHO staff in Jerusalem, Ramallah, Nablus and Gaza, and was completed in early 2016. The CCS strategic priorities were compared for consistency and alignment with national and global strategies and plans: the Palestine National Development Plan, the National Health Strategy, the WHO Twelfth General Programme of Work and the UN Sustainable Development Goals and targets (Table 4). The interviews and group discussions also assessed the technical and financial capacity of WHO to pursue the recommended priorities for the next CCS cycle, taking into consideration the changing national and global contexts. The findings were discussed in two internal WHO workshops in Jerusalem, with participation of staff from the Gaza Office.

Table 4. Country and global strategic framework: comparison of health strategic documents

National Development Plan 2014–2016	National Health Strategy 2014–2016	WHO Country Cooperation Strategy 2009–2013	WHO Twelfth General Programme of Work 2014–2019
Strategic objectives		**Leadership priorities**	
Continue to provide better access for all social groups to high-quality health care as a human right, especially for poor and vulnerable persons throughout the Palestinian territory, particularly in remote areas, communities adjacent to the Wall, Area C, East Jerusalem and Gaza. Additionally, the Health for All principle will be adhered to.	• Ensure rights-based comprehensive and integrated health care services for all citizens (taking into consideration sex, age, geographical distribution, political and socioeconomic equity); • Promote preventative health care and management of noncommunicable diseases • Establish an effective, comprehensive and sustainable quality system for all health services • Ensure the availability of a qualified health workforce capable of delivering high quality health services	• Building institutional capacity of the Ministry of Health to strengthen health systems • Addressing the unfinished agenda for communicable diseases • Addressing noncommunicable diseases • Strengthening health sector cooperation and partnership • Addressing humanitarian and emergency needs • Advocacy for health as a human right	• Advancing universal health coverage: enabling countries to sustain or expand access to all needed health services and financial protection • Health-related Millennium Development Goals – addressing unfinished and future challenges: this includes completing the eradication of poliomyelitis and selected neglected tropical diseases
Develop and upgrade the infrastructure of hospitals, clinics and health care centres, particularly in East Jerusalem, provide necessary support to protect them against dysfunction, and keep up effective and efficient operation. Also, provide qualified staff and cover necessary expenses	• Enhance institutional development and governance of the health sector		• Addressing the challenge of noncommunicable diseases and mental health, violence and injuries and disabilities; • Implementing the provisions of the International Health Regulations; • Increasing access to quality, safe, efficacious and affordable medical products
Improve management of chronic diseases, promoting early detection and preventive health care. Campaigns will be designed to raise public and individual awareness about healthy lifestyle and behaviour.	Programmes: • high quality primary health care services and promotion of healthy lifestyles • high quality secondary and tertiary health care services • health governance and administration		• Addressing the social, economic and environmental determinants of health as a means to promote health outcomes and reduce health inequities within and between countries

National Development Plan 2014–2016	National Health Strategy 2014–2016	WHO Country Cooperation Strategy 2009–2013	WHO Twelfth General Programme of Work 2014–2019
Strategic objectives		**Leadership priorities**	
Conduct a comprehensive review of the patient transfer system, with a view to contracting the best health care services in terms of quality and cost. Conduct a comprehensive review of Israeli deductions from clearance revenues. Invest in human capital and infrastructure, to reduce referrals.			Categories of work: • Reducing the burden of communicable diseases • Reducing the burden of noncommunicable diseases • Promoting health throughout the life-course
Enhance health sector development and governance through effective and efficient institutional development/management of the health care system. We will work with medical schools and nursing institutes to supply qualified human resources, capable of delivering high-quality, gender-responsive services.			• Supporting the strengthening of the health system • Preparedness, surveillance and response to disease outbreaks, acute public health emergencies and disasters • Ensure corporate services/enabling functions for an efficient functioning of WHO
Extend the computerised health care system to all government hospitals, Ministry of Health directorate district offices, and Ministry of Health clinics, which will be integrated with the health insurance system and central warehouse systems to ensure a comprehensive, computerised government health care system.			
Continue to develop primary health care service delivery, particularly maternal and child care, and reproductive health, with a particular emphasis on postnatal health care. Develop and integrate psychological and community health within primary health care service delivery. The family health approach will also be in place.			
Develop partnership, cooperation, coordination and integration between the Ministry of Health, UNRWA and other health service providers, including private operators and nongovernmental organizations.			

3.2 Main findings from the consultation

3.2.1 Relevance

There was overall agreement among both managers and technical staff that the CCS priorities were aligned with those of the national strategies and plans, except for emergency preparedness and response, which was not specifically reflected in the National Health Strategy. The analysis of alignment of the CCS with the WHO Twelfth General Programme of Work and with the UN Sustainable Development Goals was complicated by the fact that the documents cover different, nonoverlapping, periods. The current global health agenda focus is toward social protection and removing access barriers for universal health coverage, reducing maternal and neonatal mortality and strengthening country capacities for implementing the International Health Regulations. Informants also agreed that the past CCS priorities are still relevant today, with the possible exception of communicable diseases, an area where the national capacity was considered adequate.

3.2.2 Effectiveness

Most informants stated that WHO was successful in implementing programmes based on the CCS strategy, but with variable performance in different areas. More progress has been reportedly achieved in noncommunicable diseases, emergency response and advocacy, and health system development, and less progress in the effective roll-out of the family practice model and mental health, which require sustained efforts over a longer period. Several informants agreed that in addition to technical priorities, WHO has a key role in improving the dialogue and coordination between the Ministry of Health and other health actors, and that this role requires dedicated resources at senior level for a sustained period. There was no duplication seen between WHO's strategic agenda and that of other agencies.

Despite the reported success, most informants agreed that WHO had inadequate technical and financial capacity to pursue its strategic agenda effectively and highlighted the need for strengthening WHO with additional senior staff in key areas, especially in health systems, and for increased and more-predictable funding. Informants stated the need for stronger and timelier support from the Regional Office and headquarters and better use of local consultants for improving collaboration with partner agencies.

With the exception of new staff, WHO managers were familiar with the CCS and used it for a variety of purposes: defining priorities for action plans and biennium budgets, agreements with partners and developing the health chapter of the UN Development Assistance Framework. Technical informants highlighted the importance of ensuring regular monitoring and review of the next CCS to track its progress and make necessary adjustments.

3.2.3 Context changes relevant to the Country Cooperation Strategy

Informants pinpointed the main contextual changes that impact on WHO's strategic agenda as:

- donor fatigue due to global economic recession, regional conflicts and the refugee crisis in Europe, leading to declining and unpredictable aid for Palestine;
- geopolitical separation of the West Bank and Gaza;
- a deteriorating political, security and economic situation, which negatively impacts on the capacity of poorer households to access health services;
- an increasingly fragmented health sector, presenting a difficult operating environment for WHO and other health agencies.

These changes underline how important it is for WHO to focus in the next CCS cycle on human rights protection and advocacy for access to health care for vulnerable and marginalized communities and households. Support to national emergency preparedness and response plans also becomes even more critical in this fragile situation.

3.3 Review conclusions and recommendations

WHO plays a crucial role in the complex and dynamic Palestinian context by providing technical support to the Ministry of Health in strategic areas and facilitating dialogue among partners around priorities that are reflected in the National Health Strategy. The CCS review showed there was a strong convergence of opinion among informants on a few interlinked priorities for WHO. These included: supporting the Ministry of Health and partners in the delivery of essential quality health services; giving priority to noncommunicable diseases, mental health and maternal and child health; ensuring that all Palestinians, especially in Gaza, can access those health services without suffering financial hardship; strengthening emergency preparedness and response; and ensuring that core capacities for the implementation of the International Health Regulations are strengthened. These recommendations were based on assessment of WHO country level resources and the need to remain responsive to contextual changes and emerging needs.

3.4 WHO programmatic achievements and challenges, 2009–2013 and beyond

3.4.1 Overview

Currently, WHO supports the Ministry of Health in formulating and implementing the National Health Policy according to the principles of equity and sustainability, and advocates for the right to health as a national priority. The Ministry of Health endorsed the Joint Collaboration Programme for 2014–2015 and 2016–2017 with WHO.[53] This identifies health priorities and technical support for communicable diseases, noncommunicable diseases, promoting health

[53] WHO Secretariat reports: Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan. Geneva: World Health Organization; 2015 and 2016 (A68/37 and A69/44; http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_37-en.pdf, and http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_44-en.pdf, accessed 8 September 2017).

across the life course, health systems and preparedness, surveillance and response. Notably, gender, equity and human rights are essential WHO cross-cutting themes.

Category 1. Communicable diseases

For communicable diseases, WHO supports the Ministry of Health to sustain high vaccination coverage and effective monitoring of surveillance indicators. In support of activities against HIV/AIDS, and with funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria, WHO acted as technical adviser to the UN Thematic Group for Tuberculosis and HIV/AIDS in the West Bank and Gaza Strip. Activities supported by the Global Fund ended in November 2015. The Organization supports a programme for the deworming of children attending UNRWA-assisted schools, and has explored the possibility of a similar collaboration with the Ministry of Health. Additionally, WHO continues to support the Ministry of Health with technical advice and assistance, including through its efforts to strengthen surveillance, laboratory and health system capacities to manage communicable disease outbreaks.

Category 2. Noncommunicable diseases

For noncommunicable diseases, WHO has provided technical support to the Ministry of Health to develop a national policy and strategy for prevention and management, with a focus on primary health care. Together, WHO and the National Noncommunicable Diseases Committee, a multisectoral national committee with members from different governmental and nongovernmental bodies, worked to develop and agree a noncommunicable diseases strategy. Technical support was provided to the Ministry of Health to conduct the first national STEP survey on noncommunicable disease risk factors, the first national Global Student Health Survey and the Global Youth Tobacco Survey. Following this collection of data, WHO supported efforts and campaigns to raise awareness, targeting noncommunicable disease risk factors, and with a particular focus on tobacco use. The Organization has further promoted capacity-building within the Ministry of Health through facilitating the participation of Ministry experts in international meetings and workshops and by organising on-the-job training.

The WHO package of essential noncommunicable disease interventions (WHO PEN) for primary care, an innovative and action-oriented response to noncommunicable diseases, has been rolled out in all West Bank districts and in two districts in Gaza. It prioritises a set of cost–effective and evidence-based noncommunicable diseases interventions. The trainings conducted by WHO aimed to reinforce health system strengthening and to empower primary care physicians and health workers to deliver quality services for noncommunicable diseases. The WHO package of essential noncommunicable disease interventions approach supports progress towards universal health coverage, ensuring equitable access to quality services.

The Ministry of Health has adopted the family practice approach to provide primary care services in a team-based, continuous and comprehensive manner. This integrates preventive and curative interventions, and has proven to be both effective and efficient as a primary care service delivery model. Health system strengthening through capacity-building at primary care level supports progress towards universal health coverage and is consistent with WHO's human

resources for health policy. This provides an evidence base for specific training of primary care professionals to move away from vertical programmes and to integrate treatment and prevention of physical and mental ill health at the individual, family and community level. Two studies have been conducted by WHO to assess current gaps in the primary care system and to propose models for change, moving towards a family practice approach so that appropriately trained family practitioners and family medicine specialists will be able to provide high-quality primary care services.

A programme for postgraduate training and continuous professional development for family medicine residents and graduates was initiated at An-Najah National University, in consultation with other partners.

From 2009–2013 the mental health programme supported the establishment and consolidation of mental health units in the West Bank and Gaza, to provide leadership for mental health services within the Ministry of Health. These now play a key role in the development of mental health services, and represent the main mechanism through which WHO and other agencies implement their projects.

The WHO mental health project has focused on reshaping mental health services from a traditional institution-based approach towards community-based care. During the previous CCS period, WHO conducted extensive training of mental health professionals, and currently continues to work with the staff to improve mental health services at the community mental health centre and primary health care level. The programme of integrating mental health services into primary care was initiated during the same period and continues to be implemented in the current project. The activities related to the rehabilitation programme are ongoing (horticulture and handicrafts) at Bethlehem Psychiatric Hospital and the Psychiatric Hospital in Gaza. Two family nongovernmental organizations were also established in the West Bank and Gaza respectively, focusing particularly on advocating for the rights of mental health service users and raising community awareness about mental health issues. The National Mental Health Strategy 2015–2019 was launched in June 2015 and emphasizes the importance of continuing the integration of mental health into primary health care, promoting community mental health services and strengthening the mental health emergency response.

Category 3. Life course

Women, children and neonates are among the most vulnerable groups, in particular within the already vulnerable overall population in Gaza. During 2009–2013, WHO intervened to improve the quality of maternal and neonatal health care in all public maternity units in Gaza by shifting from a highly medicalized approach to childbirth to midwifery-led care for low risk pregnancies and normal deliveries, enabling greater medical attention for high-risk deliveries.

However, recent findings show a lack of substantial improvement in neonatal mortality and the under-5 mortality national target for 2016 was not met. Neonatal deaths represent 50% of all deaths in children under 5 years of age, and access to and quality of care at birth is an important determinant of neonatal mortality and morbidity. The majority of these deaths occur

during the first days of life and are preventable, by improving care for sick neonates and those born prematurely or with low birth weight. Following up its previous programme, WHO addressed these issues in 2016 with an intervention aimed at all neonates born in public hospitals in Gaza, with a particular focus on those who are sick and those born prematurely or with low birth weight.

The project uses an essential package of care based on global guidelines, delivered during labour, delivery and early postpartum, and in the postnatal period. The objectives are: to ensure consistent adoption of Early Essential Newborn Care; to improve the availability and quality of perinatal information through strengthening the capacity of routine information systems to collect accurate data on perinatal health; and to ensure availability of equipment, supplies, essential medicines and infrastructure for Early Essential Newborn Care in routine and emergency situations. These efforts focus on the maternity and neonatal units in all public hospitals in Gaza, with complementary and coordinated activities at Ministry and UNRWA primary health clinics and in the community, especially for postnatal care.

The project also supported a study on infant mortality in Gaza through a validation exercise for recently published UNRWA data (see also Section 2.3 above).

Following ad hoc initiatives, WHO began formal engagement in advocacy to promote the right to health in 2009, with a 9-month project focused on health access in the wake of the 2008–2009 violence in Gaza. This led to WHO developing two successive 3-year comprehensive programmes for 2010–2016 in the West Bank and Gaza Strip, supported by the government of Switzerland. The key objectives of the project were: to build the capacity of the Ministry of Health and other key health partners and academia in international humanitarian and human rights law; to improve data quality, collection and reporting of health and human rights issues; and to carry out direct and indirect advocacy activities at the WHO, UN, international, donor and local levels to help address right to health challenges. Emerging public health issues such as attacks on hospitals, clinics and ambulances and injury to health personnel were also identified and monitored, especially during and following the 2012 and 2014 conflicts in Gaza, and during the 2015 escalations and clashes in the West Bank.[54]

The project succeeded in raising the profile of WHO as an active health rights advocate in the occupied Palestinian territory, and in putting the right to health for Palestinians on the agenda of the international community. The advocacy programme provided technical assistance to offices in the Ministry of Health and in the Civilian Affairs Authority. This improved data quality for monitoring the right to health and carried out the original research necessary to examine how patients experience health access barriers; WHO collected and analysed access data from a wide range of health providers and from patients for evidence-based monthly and annual

[54] WHO situation reports, http://www.emro.who.int/pse/palestine-infocus/situation-reports.html (accessed 09 February 2017).

publications on access barriers.[55] There was a particular focus on Gaza patients and vulnerable West Bank communities in Area C. Indirect advocacy was conducted through reports within WHO, including facilitating two missions of experts for field assessments to inform World Health Assembly reports,[56] and also UN human rights bodies, international and academic organizations,[57] the Palestinian Authority, individuals and the media.[58] Direct advocacy included maintaining dialogue with legal duty-bearers, principally Israeli authorities and the Palestinian Ministry of Health, on access and equity issues, which has resulted in some mitigation of difficulties for patients in accessing referral hospitals in the West Bank, although access for Gaza patients became more difficult in 2016 with longer security procedures and increased rates for denied permits.

Advocacy for the right to health, particularly for ensuring the functioning of the public health system in Gaza to meet the needs of the population, is an important component of WHO's role in Palestine. Challenges have been the declining humanitarian space and an increase in access restrictions in Gaza, in addition to the continuing blockade and siege, the political divide between the West Bank and Gaza, and maintaining ongoing support, including in the meetings of regional and global governing bodies and related events.

Category 4. Health systems

The WHO Regional Office has been engaged in health systems strengthening in the occupied Palestinian territory. It is supporting the Palestinian Ministry of Health using the WHO health systems framework, comprising the six building blocks of leadership and governance: health care financing, health workforce, medical products and technologies, information and research and service delivery. The work aims to enhance access and coverage to high quality, safe and people-centred (family practice) health care. Based on joint efforts with the World Bank, and following a joint support mission, a policy dialogue for improved health financing and health care coverage is planned to further develop strategic options to promote health system reform for the pursuit of universal health coverage.

In terms of quality improvement, WHO supported the Ministry of Health's implementation of the Patient Safety Friendly Hospital Initiative. This important WHO tool addresses key hospital measures of leadership and management; patient and public involvement; safe, evidence-based clinical practice; a safe environment; and lifelong learning. In fact, WHO participated in the baseline and follow-up assessments of 20 critical standards in 13 hospitals across the West

[55] WHO, Right to health: crossing barriers to access health, annual reports http://www.emro.who.int/pse/publications-who/annual-opt-access-reports.html (accessed 09 February 2017); WHO monthly monitoring reports, Health access for referral patients from the Gaza Strip, http://www.emro.who.int/pse/publications-who/monthly-referral-reports.html (accessed 09 February 2017).
[56] Report of a field assessment on health conditions in the occupied Palestinian territory. Geneva: World Health Organization; 2015 and 2016 (WHO-EM/OPT/006/E; https://unispal.un.org/pdfs/WHOEMOPT006E.pdf and http://apps.who.int/gb/Statements/Report_Palestinian_territory/Report_Palestinian_territory-en.pdf?ua=1, accessed 8 September 2017).
[57] http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60200-7/abstract.
[58] See WHO reports, http://www.emro.who.int/pse/publications-who/who-information-in-other-publications.html.

Bank, and is committed to supporting the Ministry of Health in the ongoing assessments and quality improvement efforts.

The Palestinian Authority decided to establish the Palestinian National Institute of Public Health in 2011, and the initial 2-year project to establish the Institute commenced in 2012. This was implemented by WHO with the support of the Norwegian Institute of Public Health and the Norwegian Ministry of Foreign Affairs in close collaboration with the Palestinian Ministry of Health. The Palestinian National Institute of Public Health was formally established in 2016, when its legal framework was approved by the cabinet and signed by the President's Office. The law ensures Palestinian National Institute of Public Health independence under the umbrella of the Prime Minister's Office, which chairs the board of trustees. A further 3-year transition period commenced in September 2016 during which the Institute will gradually progress from a WHO project to a sustainable and independent Palestinian institution.

The Palestinian National Institute of Public Health undertakes health surveillance, data analysis and research in order to provide evidence-based information and advice on health issues to the Palestinian Authority and Palestinian civil society.[59] It also plays a role in training and capacity-building for the health sector and acts as a bridge between health researchers in the academic community and decision-makers in the Palestinian Authority. Activities during the WHO project stage and the consecutive transition period include:

- development of a harmonized reproductive health registry, a computerized reproductive health registry that covers all stages of pregnancy and neonatal care;
- quantitative and qualitative assessment of the cause of death registry[60] and an action plan to improve the registry;
- assessment of civil registration and vital statistics, and the development of an action plan to improve data collection and communication;
- development of road traffic accident and injury surveillance, with a centralized information system for the West Bank and with national indicators agreed by relevant stakeholders;
- assessment of the cancer registry, including the current situation and data quality;
- completion of a mammography screening study, a retrospective examination of the performance of mammography screening in the national breast cancer screening programme;
- assessment of malnutrition and intestinal infections among children of the Jordan Valley area and their caregivers, a prevalence study conducted at the request of the Ministry of Health;

[59] See http://pniph.org/site/.

[60] Iversen BG, Abul Hawa M, Pedersen AG, Gåsemyr S, Soboh A. Assessment of the cause of death registry in the occupied Palestinian territory: a qualitative study. Lancet. 2013;382(Suppl. 4):S21 (http://www.sciencedirect.com/science/article/pii/S0140673613625933, accessed 8 September 2017).

- assessment of neonatal health services in private and public hospitals in Palestine;
- implementation of a human resources for health observatory to inform health workforce policies in the West Bank and Gaza, with an electronic system;
- completion of a prevalence study of high-risk drug use, including both illicit and non-medical use of prescription drugs and needs and resources with regard to drug dependence treatment and care services for a continuum of care approach;
- utilization of a geographic information system (GIS) to map health care facilities.

Since 2003, WHO has been supporting the East Jerusalem Hospitals through EU-supported projects.[61] These hospitals are the main referral centres for the Palestinian Ministry of Health and include six non-profit facilities: Makassed Hospital, St. Joseph Hospital, St. John Eye Hospital, Palestinian Red Crescent Society Hospital, Augusta Victoria Hospital, and Princess Basma Rehabilitation Centre for Palestinians. The interventions have focused on strengthening the East Jerusalem Hospitals, specifically to improve the quality of services and patient safety, and to strengthen the hospital network to serve as a viable coordination and advocacy entity. A later phase of the project gave support to the hospitals to work toward accreditation by the Joint Commission International, a rigorous global hospital standard, which all six of the hospitals have now successfully achieved. In line with the Palestinian Ministry of Health's vision to ensure access to quality services within the East Jerusalem hospitals and with EU funding, WHO continued to support improvement in quality of services and strengthening of institutional capacity until 2016.

Category 5. Emergency health cluster

To develop the capacity for emergency preparedness and response, WHO has provided technical support to the Ministry of Health and its partners. This involved providing training and workshops to develop the expertise of the Emergency and Ambulance Directorate in the Ministry of Health and the Ministry has adopted an all-hazards emergency risk management approach, engaging all relevant sectors. Hospitals have developed their own contingency plans. In addition, the Ministry of Health is in the process of developing contingency plans for primary health care facilities and directorates and a national health emergency and preparedness plan.

The Organization has continued to lead the Health and Nutrition Cluster, which it co-chairs with the Ministry of Health. The Cluster includes 40 humanitarian health organizations, including UN agencies and nongovernmental and private sector organizations, providing essential services to vulnerable communities. Together with the Ministry of Health and partners, WHO coordinates the development of the health component of the humanitarian needs overview on a yearly basis; this includes an analysis of the humanitarian health situation and identification of priority needs.

[61] Supporting patient safety and quality care. Cairo: World Health Organization; 2011 (http://www.emro.who.int/pse/programmes/east-jerusalem-hospital-network-project.html, accessed 8 September 2017).

The Cluster provided a vital forum for coordination, donor mobilization efforts and information on how the violence in Gaza in 2014[62] and in the West Bank in 2015 affected the health sector, health personnel and patients. The cluster coordinated a 2014 post-war detailed needs assessment of the health sector in Gaza, which was instrumental in defining health needs and gaps for the recovery and reconstruction process.[63]

A representative panel on the Health Cluster selects projects for potential funding from donors as part of the overall humanitarian response plan administered by the UN Office for the Coordination of Humanitarian Affairs; WHO has ensured that gender, equity and human rights remain key selection criteria when deciding which projects to prioritize for donor funding.

The aim of the International Health Regulations 2005 is "to prevent, protect against, control and provide a public health response to the international spread of disease".[64] They represent a shift from the previous regulations, with a focus on control of diseases at source rather than control at borders. This is a concern for all significant public health risks, including chemical, radiological and environmental hazards, as opposed to solely infectious diseases, and from preset health measures to adapted responses. In this respect, they are designed to respond to new challenges and emerging diseases for an increasingly urbanized and highly mobile global population. In the West Bank and Gaza, health authorities face the specific challenges of movement restrictions of patients, health care personnel and medical supplies and equipment under occupation, further compounded by the fact that points of entry are under the control of the occupying power.

The Palestinian Ministry of Health, WHO and the Norwegian Institute of Public Health conducted a joint assessment of the International Health Regulations core capacities that are necessary to effectively prevent, detect, assess, notify and respond to diseases and hazards, with implications for global health security. The core capacities assessed include: national legislation, policy and financing for effective systems to prevent and control diseases; coordination and communication arrangements; surveillance structures; response mechanisms; emergency preparedness; risk communication strategies; human resource capacities; laboratory facilities; monitoring at points of entry; procedures for response to zoonotic events; and the coordination of food safety requirements.

The Ministry of Health, WHO and the Norwegian Institute of Public Health have also collaborated to finalize a 3-year action plan to implement the recommendations of the joint assessment and to address priority gaps and challenges highlighted. Key recommendations from the assessment include further work to develop existing surveillance and laboratory

[62] Gaza Strip: Joint health sector assessment report. Ramallah: Health Cluster in the occupied Palestinian territory; 2014 (http://www.emro.who.int/images/stories/palestine/documents/Joint_Health_Sector_Assessment_Report_Gaza_Sept_2014-final.pdf?ua=1, accessed 10 September 2017).
[63] Detailed needs assessment and recovery framework for Gaza reconstruction. Ramallah: Ministerial Committee for the Reconstruction of Gaza; 2015 (http://www.lacs.ps/documentsShow.aspx?ATT_ID=21974, accessed 8 September 2017).
[64] International Health Regulations (2005), 2nd ed. Geneva: World Health Organization;2008.

systems; the strengthening of health care infection, prevention and control through staff training, facilities and the provision of adequate equipment; and the implementation of communication protocols and institutional structures to ensure the effective assessment of public health hazards and adequate mechanisms for coordination and control.

4. The strategic agenda for WHO country cooperation

4.1 Strategic priorities and focus areas

The development of the strategic agenda for 2017–2020 is based on consultations within WHO and with key partners and aims to align WHO priorities with those of UN and country partners. The strategic agenda has been developed to incorporate:

- the common country analysis;
- consultations with WHO staff and key stakeholders on the outcomes of the previous CCS[65] and a thorough review of WHO's role;
- continuity of ongoing priority programmes;
- a consensus to improve the coherence of WHO country strategic priorities in relation to global, national and WHO health development agendas (Table 4).

It is also a timely opportunity to align priorities with the next UN Development Assistance Framework, the Palestinian National Policy Agenda and the new Health Sector Strategy.

The strategic agenda for WHO cooperation in Palestine for 2017–2020 includes four medium-term priorities, for which WHO intends to focus its resources and technical assistance in support of the Palestinian National Policy Agenda and the Health Sector Strategy. In coordination with health development partners, it aims to:

- contribute to strengthening and building the resilience of the Palestinian national health system and enhance Ministry of Health leadership to progress towards universal health coverage;
- strengthen the country's core capacities for the International Health Regulations and the capacities of the Ministry of Health, its partners and the communities in health emergency and disaster risk management to carry out effective humanitarian health response;
- strengthen the capacity of the Ministry of Health and partners to prevent, manage and control noncommunicable diseases, including mental health disorders, and risk factors for violence and injuries, with a particular focus on road safety;
- strengthen the capacity of the Ministry of Health and health partners to advocate with all legal duty-bearers to protect the right to health of the population under occupation, reduce access barriers to health services, and improve the social determinants of health.

The focus areas and the planned activities within each focus area are outlined under each strategic priority.

[65] Country cooperation strategy for WHO and the occupied Palestinian territory, 2009–2013. Cairo: World Health Organization, Regional Office for the Eastern Mediterranean; 2010 (WHO-EM/ARD/040/E; http://applications.emro.who.int/docs/CCS_Occupied_Palestinian_Territory_2010_EN_14486.pdf?ua=1, accessed 8 September 2017).

4.2 Strategic priority 1: Contribute to strengthening and building resilience of the Palestinian national health system and enhance Ministry of Health leadership to progress towards universal health coverage

In Palestine, WHO has consistently supported health system strengthening through: enhancing health service delivery capacity of the East Jerusalem Hospitals network; providing technical and financial assistance to the Patient Safety Friendly Hospital Initiative;[66] strengthening the national health information system; and providing technical assistance for the formulation of national health strategies and plans.

Women's health, particularly reducing maternal, neonatal and child mortality, features prominently in the Sustainable Development Goals; WHO has developed a global initiative, the harmonized Reproductive Health Registry, to improve data quality and data collection techniques for maternal, neonatal and child health. Through the Palestinian National Institute of Public Health project, the Ministry of Health has offered to become a pilot for implementing the harmonized Reproductive Health Registry in all 390 maternal and child health clinics in the West Bank and in 24 clinics in Gaza.

For the next CCS cycle, the strategic emphasis of health system strengthening and resilience building will focus on:

- promoting universal health coverage and strengthening the Ministry of Health leadership, with the overall goal of improving the effectiveness and quality of health services delivery and ensuring financial risk protection;
- providing technical support to prepare a strategic plan for the implementation and roll out of the family practice approach in Palestine; WHO will assist the Ministry of Health in planning, piloting and evaluating the implementation of family practice, which will include the adoption of a continuous education programme developed by WHO Regional Office for the Eastern Mediterranean in close collaboration with the American University of Beirut;
- strengthening the national civil registration and vital statistics system to improve coverage, quality and utilization as part of broader efforts to enhance the national health information system, to support the development of evidence-based policies and strategies and the strengthening of hospital information systems;
- providing technical assistance to the Ministry of Health and its partners for the development, implementation and monitoring of the National Health Sector Strategy and Plan.

[66] WHO interregional technical consultation on Safe Childbirth Checklist. Geneva: World Health Organization; 2017 (http://www.who.int/patientsafety/en/, accessed 10 September 2017).

Focus areas:

- Policies, financing and human resources are in place to increase access to people-centred, integrated health services. Activities include:
  - providing technical support for reviewing and upgrading norms, standards and protocols for health care quality assurance at hospitals and primary health care centres, and promoting the establishment of a hospital accreditation system to enhance patient safety and satisfaction and health care quality;
  - assisting in building health workforce capacity, both technical and managerial, in health financing and service delivery, following relevant WHO models and guidelines for health workforce development and retention;
  - providing technical and logistic support to roll out the family practice approach while ensuring integration and feedback with referral services;
  - continuing to provide technical assistance to the Ministry of Health to adopt evidence-based practices for neonatal care, focusing on the most important causes of death.
- Country has a properly functioning civil registration and vital statistics systems, with an effective health information system for policy guidance. Activities include:
  - developing a computerized web-based database for enhanced registration and reporting of births and deaths and improved monitoring of the quality of registered data;
  - implementing the harmonized Reproductive Health Registry using District Health Information Software 2;
  - supporting the Ministry of Health, through the Palestinian National Public Health Institute project, to design an integrated national health information system to report on the regional core health indicators and health-related Sustainable Development Goals;
  - promoting evidence-based decision-making in the management of hospital care through regular comparative analysis of hospital performance in service quality and efficiency;
  - providing technical assistance to the Ministry of Health to design and implement active infant mortality surveillance and to strengthen routine death registration.
- National health sector and subsector policies, strategies and plans are assessed and upgraded. Activities include:
  - providing technical support for the development and implementation of a national health strategy and plan that pursues universal health coverage;
  - promoting policy dialogue for exploring health financing reforms and provide technical support for the development of a health financing strategy that enhances performance of the health financing system and ensures financial risk protection;

  - assisting the Ministry of Health and stakeholders in assessing and defining their roles in relation to the essential public health functions, and developing strategies and policies to enhance the leadership of the Ministry of Health in relation to essential public health functions.
  - supporting the development of an evidence-based 5-year national reproductive and child health strategy, with engagement of stakeholders in the West Bank and Gaza;
- Support the implementation of the National Newborn Action Plan consistent with the global and regional Every Newborn Action Plan initiative

4.3 Strategic priority 2: Strengthen the country's core capacities for International Health Regulations and the capacities of the Ministry of Health, its partners and the communities in health emergency and disaster risk management, and to support humanitarian health response capacities

Palestine is highly vulnerable to a large variety of natural and human-made hazards: war- and conflict-related violence, earthquakes, floods, landslides, droughts and desertification. Disaster risk reduction, emergency preparedness and response are therefore of high priority for the Ministry of Health and its partners. WHO as the Health and Nutrition Cluster lead agency, together with the Ministry of Health, has traditionally played a key technical, advocacy and coordination role in this area. The main activities include: joint needs assessments and monitoring of the humanitarian situation, support for the formulation of preparedness plans and response strategies, training of Ministry of Health officials, awareness-raising and advocacy in documenting the most critical humanitarian needs and for mobilising resources and filling key gaps in a coordinated manner. In addition, WHO has been increasingly involved in efforts to strengthen national capacities for the implementation of the International Health Regulations and for enhanced public health surveillance. A recent joint assessment by WHO and the Norwegian Public Health Institute of the existing capacity for implementing the International Health Regulations has highlighted priority gaps that need to be addressed.

In Gaza, WHO has supported emergency health programmes, especially in responding to humanitarian health needs during and in the aftermath of armed conflicts; a further focus of technical support has been on promoting evidence-based interventions to improve women's health and obstetric care in Gaza, including programmes to improve the health of neonates.

For the next CCS cycle, the strategic emphasis for health emergency risk management will focus on building International Health Regulations core capacities in key areas, such as legislation, policy, surveillance, risk communication, laboratory, food safety, antimicrobial resistance, etc., continuing the strengthening of national capacity in emergency preparedness and response, and coordinating and implementing the response to humanitarian emergency needs.

Focus areas:

- Country has the minimum core capacities required by the International Health Regulations for all-hazard alerts and responses. Activities include:
  - supporting the Ministry of Health in the implementation of the 2016–2019 International Health Regulations action plan;
  - providing technical assistance, guidance and training in priority areas identified by the International Health Regulations capacity assessment.
  - supporting the Ministry of Health and partners to develop a system to monitor antimicrobial resistance and to develop an action plan to address antimicrobial resistance.
  - providing technical and financial assistance to the Ministry of Health to improve surveillance and response capacities to detect, notify, assess and respond to outbreaks of communicable diseases and other public health events.
  - providing direct technical support to Ministry of Health in the event of an outbreak of communicable diseases.
- Country has the capacity to respond adequately to threats and emergencies with public health consequences. Activities include:
  - supporting the capacity of the Ministry of Health Directorate of Emergency and Ambulance with technical and financial assistance;
  - assisting the development of the National Health Emergency Plan;
  - contributing to the capacity-building of health professionals in emergency medicine;
  - organizing training for Ministry of Health officials and partners in public health emergencies;
  - continuing to provide technical assistance for the coordination of humanitarian interventions through the Health and Nutrition Cluster.

4.4 Strategic priority 3: Strengthen the capacity of the Ministry of Health and its partners to prevent, manage and control noncommunicable diseases, including mental health disorders, and to reduce risk factors for violence and injuries

Noncommunicable diseases are the leading cause of death and a major economic and social burden to Palestinians. They remain high on the Ministry of Health Strategic Agenda since the establishment of a noncommunicable diseases department in 2008; WHO has provided technical and logistic assistance to the Ministry for the implementation of the package of essential noncommunicable diseases interventions. Mental health disorders also contribute significantly to the burden of disease in Palestine and have been addressed by WHO's continuous work to integrate mental health support into primary care and community settings. For the growing problem of injuries due to road traffic accidents, WHO, through the Palestinian

National Institute for Public Health, has begun to work on establishing links between several stand-alone road traffic surveillance systems administered by different stakeholders, through collaboration with various Ministry of Health departments and the police. In addition, WHO has worked to improve national data on death and injuries due to violence through coordination efforts with health providers in the West Bank and Gaza.

For the next CCS cycle, the strategic emphasis for noncommunicable disease management will focus on:

- continuing to strengthen access to and quality of a variety of evidence-based interventions for the prevention and management of noncommunicable diseases;
- improving access to and the quality of mental health services;
- supporting the development of initiatives to prevent injuries from road accidents.

Focus areas:

- Palestinians have increased access to interventions for the prevention and management of noncommunicable diseases and their risk factors. Activities include:
  - strengthening the Ministry of Health national noncommunicable diseases committee, by supporting the review and update of the national noncommunicable diseases strategy, the preparation of terms of reference, the development of action plans and the definition of national noncommunicable diseases targets;
  - strengthening the surveillance system of the country through the STEPS survey, which will assist the monitoring of risk factors and the evaluation of progress toward noncommunicable diseases targets and assist in the conduct of the Global Youth Tobacco Survey;
  - providing technical assistance for the development of a national noncommunicable diseases patient registry that will cover all heath care providers and will enhance knowledge of the coverage of noncommunicable disease interventions;
  - supporting the Ministry of Health for the continued roll-out and implementation of the WHO package of essential noncommunicable disease interventions and for the extension of the screening programme piloted in Salfit to all districts;
  - assisting the Ministry of Health in targeting preventive interventions and awareness campaigns for key risk factors for noncommunicable diseases: tobacco control, healthy diet, salt reduction, physical exercise, etc.
- Palestinians have increased access to mental health services. Activities include:
  - assisting the Ministry of Health in further strengthening the integration of evidence-based interventions to address priority mental health problems in primary health care, with the support of an adequate referral system;
  - assisting the Ministry of Health in scaling-up community mental health care and ensuring a specific focus on trauma and crisis intervention;

  - providing technical assistance to the Ministry of Health for the development of a national emergency mental health plan and intervention guidelines;
  - contributing to the establishment of competent mental health emergency teams and the availability of psychotropic drugs and support the integration of emergency mental health care into long-term rehabilitation programmes;
  - contributing to the strengthening of community-based mental health services by improving the quality of service provision, developing a wide range of community rehabilitation programmes and improving accessibility to mental health services in general hospitals in Gaza, the West Bank and East Jerusalem.
- Country uses evidence-based strategies and interventions to reduce risk factors for violence and injuries. Activities include:
  - continuing efforts to improve national data on death and injuries due to violence, including attacks on health, through coordination efforts with health providers;
  - providing technical and financial support for developing a national injury surveillance system linked to the registry of road traffic accidents, in close collaboration with the Ministry of Health;
  - developing a national web-based database for the formulation of an evidence-based national road traffic accident and injury strategy, programmes and action plans.

4.5 Strategic priority 4: Strengthen the capacity of the Ministry of Health and health partners to advocate with all legal duty-bearers to protect the right to health of the population under occupation, reduce access barriers to health services, and improve the social determinants of health

Since 2009, WHO West Bank and Gaza has promoted the right to health for Palestinians through its advocacy programme. This programme focuses on health access barriers in the West Bank and Gaza and supports capacity-building of health partners in legal obligations and concepts, such as gender mainstreaming and social determinants; improved data quality and reporting; and evidence-based advocacy with duty-bearers and stakeholders.

Palestine has demonstrated its commitment to gender, equity and human rights in health through the previous and current National Health Sector Strategy. Gender, equity and human rights, along with consideration for the social determinants of health, are important cross-cutting themes of the Sustainable Development Goals; WHO guidelines call for the full integration of gender, equity and human rights in all technical programme areas, and also, through close collaboration with the Ministry of Health, for the identification of the root causes of ill-health and vulnerable groups and for the development of appropriate interventions. The Organization promotes a Health-in-All policies approach that builds the capacity of the Ministry

of Health to guide the government towards ensuring that the health impacts of policies are recognized and considered, especially for vulnerable population groups.

For the next CCS cycle, the strategic emphasis for the right to health approach will focus on:

- ensuring the integration and implementation of human rights, gender, equity and social determinants into all WHO–Ministry of Health programmes;
- supporting a Health-in-All-policies approach and the implementation of mechanisms to measure and address the social determinants of health, reduce health inequalities and enable equitable access to quality services.

Focus area:

- Support for the broadening of gender, equity and human rights integration is provided, and these will become core principles for the work of WHO and its national partners in all health areas. Activities will include:
  - working to improve the disaggregation of health data by sex and at least two other variables (age, education, rural/urban, socioeconomic status) to enable the identification of vulnerable and disadvantaged groups;
  - working to improve WHO programme development to ensure it is evidence-based, rights-based and has mechanisms to enable participation and nondiscrimination, and links with gender, equity and human rights, social determinants of health and the Sustainable Development Goals;
  - carrying out evaluations to ensure that gender, equity and human rights are measured in health programmes and addressed explicitly in reports;
  - promoting empowerment through support and capacity-building for organizations representing health vulnerable populations;
  - strengthening national capacity-building and increasing the use of tools for mainstreaming social determinants of health in health policies and programmes and for monitoring progress;
  - supporting national engagement with international health and human rights mechanisms.
- Intersectoral policy coordination to address social determinants of health and Health-in-All policies is increased. Activities include:
  - promoting policy dialogue on social determinants of health and provide support for a Health-in-All policies approach through utilization of global tools to integrate social determinants of health in different programmes and to build capacities through the national committee on social determinants of health;
  - providing support for monitoring access and risks for vulnerable populations to health services and mitigate risks through advocacy with duty-bearers;
  - ensuring the use of data for addressing discrimination in law, policy or practice and for promoting services respectful of human rights principles.

5. Implementing the strategic agenda: implications for the Secretariat

The strategic agenda for the next CCS cycle has important implications for the WHO office in Palestine. In order to pursue the priority objectives effectively, the necessary technical, managerial and financial resources must be available, as well as the required support from the WHO Regional Office and headquarters.

In alignment with the national strategies and the WHO Twelfth General Programme of Work, the next CCS aims to ensure continuity with the priorities of the previous cycle while refocusing WHO's role of support to the Ministry of Health and partners on critical areas of health system strengthening and key health programmes. In a fragile situation and chronic crisis context, with occupation and closure likely to continue, WHO seeks to strike the right balance between preparedness to respond to acute and chronic humanitarian health needs and a focus on development support, including efforts to build institutional capacities. By facilitating policy dialogue for robust, realistic and balanced national policies, strategies and plans and by providing focused technical support to the Ministry, WHO aims to contribute to better health outcomes, reducing financial barriers and improving protection from the financial consequences of ill health.

The WHO office aims to contribute to these objectives by supporting the Ministry of Health and its partners in making health systems in Palestine more effective and resilient in the delivery of responsive and integrated health services. This will involve ensuring financing mechanisms and institutions are oriented towards universal health coverage, addressing the main causes of morbidity and mortality and strengthening national health emergency and disaster risk management capacities, including through the strengthening of core capacities for the International Health Regulations. The WHO office will advocate for the application of gender, equity and human rights principles in all policies and programmes to ensure equitable access to health care for all Palestinians.

The review of the previous CCS highlighted the partners' appreciation of the expertise and commitment of WHO staff. However, it also highlighted the need for further development and expansion of the local capacity of WHO to address new challenges, particularly those reflected in the new strategic agenda. These include a stronger technical capacity, complemented by predictable funding and more timely and sustained support from within the organization. This will be crucial to sustain and enhance WHO's leadership role in health and its technical credibility.

Given the envisaged limitations in expanding the number of staff in the WHO office, efforts will focus primarily on retaining current national staff and on ensuring their continuous professional development. Alongside this there will be a focus on complementing local capacity with the recruitment of one or two senior international public health experts with specific expertise in strategic aspects of health systems strengthening and public health. In this way

WHO aims to continue to provide quality and sustained technical support to the Ministry and its partners in the priority areas identified. This will take place alongside efforts to attract young and talented experts through the UN Volunteers and Junior Professional Officers recruitment systems. As recommended in the review, the Head of Office will strive to make best use of short-term national and international consultants for providing specific technical inputs and filling competence gaps in critical areas.

With regard to the support of WHO headquarters and the Regional Office, visa restrictions for entry to Israel are an impediment to regional advisers and directors of programmes of certain nationalities. These constraints can be mitigated by identifying in advance those advisers who can travel and provide on-site support. Distance support through videoconference, exchange of documents and telephone calls are an option for those advisers denied an entry visa. Additional support is required from headquarters and the Regional Office for coordinated advocacy and mobilization of resources through contacts with multilateral and bilateral donors at their level.

The clearance process entailed the strategic agenda being shared with the Ministry of Health and key partners in consultations, and the final draft being presented in a stakeholder meeting. There was a broad consensus on the strategic priorities and minor additional inputs were incorporated into the final draft. This draft was then shared with relevant technical advisers at the Regional Office for comments and finalization. The final document was jointly signed by the Minister of Health and the WHO Regional Director, published and disseminated and will constitute the basis for the biennial plans during the period covered by the CCS.

6. Evaluation of the Country Cooperation Strategy

The CCS strategic agenda calls for the establishment of a monitoring and evaluation system, with the aim of gauging progress towards the specified objectives and flagging any necessary adjustments. Hence, WHO aims to engage relevant stakeholders, including the Ministry of Health, to develop a monitoring and evaluation framework for the CCS, based on its biennial work plans. The framework will include input, process and output indicators, the data sources for indicators, the intended frequency of data collection, and baselines, targets and reporting formats.

The CCS will be implemented by WHO through its biennial work-plans and biennial work-plan monitoring and evaluation mechanisms; WHO intends to carry out 6-monthly work-plan monitoring meetings to determine the status of implementation of planned activities and to make necessary adjustments. The Organization will hold a mid-term review of the strategy at the end of the second year (end 2018), to determine the implementation status of planned activities and to potentially reprogramme actions and redefine cooperation strategies for the remaining two years.

At the end of the cooperation cycle, WHO will commission an independent final evaluation to determine progress made, analyse lessons learnt and define priorities and mechanisms for the next cooperation cycle. The results of the final evaluation will be presented to the Ministry of Health and other interested parties, including technical and financial partners.