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Palestine



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Foreword

The Government of Palestine and WHO are working together to effectively improve the public health situation in the country with special emphasis on the five key regional priorities:

- health security and prevention and control of communicable diseases;
- noncommunicable diseases, mental health, violence and injuries, and nutrition;
- promoting health through the life-course;
- health systems strengthening; and
- preparedness, surveillance and response.

The strategic directions to address these priorities are broadly in line with WHO's 12th General Programme of Work, the Programme Budget 2016–2017 endorsed in May 2015 by the 68th World Health Assembly and the five strategic areas of work endorsed by the WHO Regional Committee for the Eastern Mediterranean in 2012.

Reliable and timely health information is essential for policy development, proper health management, evidence-based decision-making, rational resource allocation and monitoring and evaluation of the public health situation. While the demand for health information is increasing in terms of quantity, quality and levels of disaggregation, the response to these needs has been hampered because of fragmentation and major gaps and weaknesses in national health information systems.

The strengthening of health information systems is a priority for WHO in the Region. Intensive work with Member States since 2012 has resulted in a clear framework for health information systems and 68 core indicators that focus on three main components: 1) monitoring health determinants and risks; 2) assessing health status, including morbidity and cause-specific mortality; and 3) assessing health system response. In order to successfully achieve this important goal, concerted and aligned action at national and international level are required to address the gaps and challenges in the health information systems of all countries. This will ensure the generation of more effective evidence to monitor improvement in the health situation, nationally, regionally and globally.

This comprehensive health profile is intended to serve as a tool to monitor progress in the health of the population. WHO's collaboration with its Member States will strengthen the national health information systems, and enable the generation of timely and reliable evidence to assess the health situation and trends, and the health system response. Most important, it will provide the information needed by health policy and decision-makers.

Palestine faces many challenges related to the occupation and its consequences which negatively affect access to health care, monitoring and supervision, and have increased the health burden. The conflicts in the Gaza Strip in recent years have resulted in large numbers of permanently disabled people, many of whom are children, loss and injury of medical personnel and damage to the health system infrastructure. The Ministry of Health, nevertheless, strives to provide the best possible health services at all levels of health care and has achieved great progress in health.

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Introduction

The population of the country has increased by 54.2% in the past 25 years, reaching 4.5 million in 2015. It is estimated that 25.4% of the population live in rural settings (2012), 36.1% of the population is between the ages of 15 and 24 years (2015), and life expectancy at birth is 74.4 years (2012). The literacy rate for adolescents (15 to 24 years) is 99.3%, for total adults 95.9% and for adult females 93.6% (2012).

The burden of disease (2012) in the West Bank attributable to communicable diseases is 15.1%, noncommunicable diseases 74.9% and injuries 5.5%.

The public health issues facing the country are presented in the following sections: communicable diseases, noncommunicable diseases, promoting health across the life course, health systems strengthening, and preparedness, surveillance and response. Each section focuses on the current situation, opportunities and challenges faced, and the way forward. In addition, trends in population dynamics and in selected health indicators are analysed to provide policy-makers with evidence and forecasts for planning.

Communicable diseases

HIV

Tuberculosis

Malaria

Neglected tropical
diseases

Vaccine-preventable
diseases

Communicable diseases

- There is a low prevalence of HIV infection among the general population. Voluntary HIV counselling and testing is available free of charge, integrated with other health services in all districts and through the outreach programmes of nongovernmental organizations targeting people who inject drugs.
- Strong political commitment and a public health law make diagnosis and treatment free of charge for the whole population.
- The country has a well-established vaccination programme, with no known pockets of unvaccinated children and very high coverage of measles and DPT3 vaccines.

HIV

There is a low prevalence of HIV infection among the general population. Routine testing is administered on 89.0% of blood collected (1). However, information concerning sex workers and men having sex with men is not available, and a 2013 study in three districts revealed that almost half of all people who inject drugs are positive for hepatitis C. HIV testing in antenatal care is not routinely done.

A national strategic plan for HIV/AIDS for 2014–2018 has been produced. The Global Fund to Fight AIDS, Tuberculosis and Malaria supports the national AIDS response; the country is in the transitional funding mechanism phase. Current interventions include opioid substitution therapy and needle exchange. Voluntary HIV counselling and testing is available free of charge, integrated with other health services in all districts and through the outreach programmes of nongovernmental organizations targeting people who inject drugs. The Ministry of Health surveillance system requires immediate reporting of an HIV-positive diagnosis. Antiretroviral therapy is provided through two central specialized clinics (one in Gaza and one in Ramallah). Services are provided by trained staff (physicians, nurses, laboratory technicians, a psychologist and a psychiatrist).

Population size estimates for the most-at-risk populations have not yet been done, national antiretroviral therapy guidelines require updating, additional work is needed in preventive interventions for hepatitis C, and more involvement is needed in regional discussions.

Tuberculosis

The tuberculosis-related mortality rate is estimated at 0.2 per 100 000 population (2013) (2). Drug-resistant tuberculosis is estimated at 3.7% among new cases and 20.0% among previously treated cases (2). The reported incidence of active tuberculosis is under 1 per 100 000 population, much lower than in neighbouring countries.

There are concerns about possible underreporting and low case detection among national tuberculosis programme and other providers, as well as under-detection in Bedouin populations. An inventory study addressing these issues was conducted during 2013.

Malaria

Palestine is considered a low burden and low risk country. Total confirmed malaria cases decreased from 1 in 2003 to 0 in 2012 (3). The country is free from local malaria transmission. Most primary health care clinical laboratories are able to run some microbiology tests, and at least one per district can carry out cultures.

The main priorities for the country are strong vigilance and disease surveillance, and the availability of quality malaria diagnosis and effective treatment in health facilities.

Neglected tropical diseases

The Ministry of Health faces several challenges in fighting leishmaniasis. One challenge is the political division of the West Bank into three areas (A, B and C) that delays access, hindering the Ministry's ability to deal with the disease, with most cases occurring in the Jordan valley (area C). Another challenge is coordination with neighbouring countries (Israel and Jordan) in preventing the disease through spraying. As only a few kilometres separates the countries, any action taken that does not involve all three countries will be limited in its effectiveness. In addition, there are funding issues, complicated by the donor-driven nature of funding, and climate change is facilitating the spread of leishmaniasis in the West Bank in the Jericho and Jordan valley areas.

Opportunities include strong political commitment and a public health law that makes diagnosis and treatment free of charge for the whole population, a good surveillance system for communicable diseases, and the involvement of academia in research on genotyping and drug resistance.

Vaccine-preventable diseases

Immunization coverage among 1-year-olds improved between 1990 and 2013 for BCG from 89.0% to 100.0%, DTP3 from 96.4% to 100.0%, measles from 96.0% to 98.9%, and poliomyelitis from 95.9% to 100.0%.¹

The country has a well-established vaccination programme, with no known pockets of unvaccinated children and very high coverage of measles and DTP3 vaccines in 2013.

¹ Ministry of Health, unpublished data, 2014.

Hepatitis B vaccine was introduced in 1992, *Haemophilus influenzae* type B vaccine in 2007 and pneumococcal conjugate vaccine in 2011. Interruption of poliomyelitis and elimination of neonatal tetanus have been maintained for many years and there have been no reported endemic cases of measles for >3 years. No case of diphtheria has been reported for decades. Cases of *Haemophilus influenzae* type B meningitis and hepatitis B were reported in 2013, but no cases were detected in 2014.

Noncommunicable diseases

Noncommunicable diseases

Mental health and substance abuse

Violence and injury

Disabilities and rehabilitation

Nutrition

Noncommunicable diseases

- A dedicated noncommunicable diseases unit exists within the Ministry of Health.
- The mental health strategy involves devolving care to the community level, giving additional responsibilities to primary health care teams who manage common mental disorders, while specialists based in community mental health centres and hospitals provide referral care for severe mental illness.

Noncommunicable diseases

The burden of noncommunicable diseases in the West Bank causes 74.9% of all deaths: cardiovascular diseases account for 44.2%, cancer 18.3% and diabetes mellitus 1.2% (4). As a result, 21% of adults aged 30 to 70 have a probability of dying from the four main noncommunicable diseases.² In Gaza, 21.4% of young people aged 13–15 years of age (30.2% boys, 11.6% girls) have ever smoked cigarettes, while 47.4% have been affected by passive smoking (5). The prevalence of age-standardized insufficient physical activity is 75.3% (63.9% males, 86.7% females) (6). Raised blood pressure, in adults above 18 years of age, affects 35.8% of the population (36.0% males, 35.6% females), while obesity affects 26.8% of the population (23.3% males, 30.8% females) (6). All eleven essential medicines required for treatment of noncommunicable diseases are available in the public health sector.²

A dedicated noncommunicable diseases unit exists within the Ministry of Health and the National Centre for Noncommunicable Diseases was established in 2011. A national multistakeholder committee for noncommunicable diseases has also been established, as well as national committees for tobacco control and for cancer prevention and control. In 2013, the Ministry of Health introduced the WHO package of essential noncommunicable diseases interventions for primary health care (PEN), which will be rolled out to all districts. The first STEPwise approach to noncommunicable disease risk factor surveillance survey was conducted in 2011. A law banning smoking in public places has been passed, but bylaws have yet to be adopted. Tobacco taxation is at the highest level, but unregulated sale of informally produced cigarettes remains a challenge. Although 80% of the population is covered by public insurance, registered noncommunicable diseases patients at public primary health care clinics are far fewer than expected. The introduction of the PEN approach, including the training of staff, adapting record-keeping and the health information system, and strengthening supervision, has devolved most noncommunicable diseases management responsibilities to general practitioners and nurses working in primary health care clinics.

² WHO Regional Office for the Eastern Mediterranean, unpublished data, 2013.

Public policies concerning diet and physical exercise need to be developed, and cancer registries and screening programmes, particularly for breast cancer, require strengthening.

Mental health and substance abuse

A new national mental health strategy, endorsed by mental health stakeholders, was launched by the Ministry of Health on June 16 2015. The human rights-based strategy emphasizes three priorities: trauma and crisis intervention, integration of mental health services into general health facilities and community-based mental health services. The strategy involves devolving care to the community level, giving additional responsibilities to primary health care teams, who will be managing common mental disorders, while specialists based in community mental health centres and hospitals will provide referral care for severe mental illness.

Over the past decade, mental health care has moved from a traditional biomedical model, based mainly on two psychiatric hospitals, towards a community-based system. Community mental health centres are now functioning in all districts. Mental health workers continue to undergo capacity strengthening in a range of evidence-based approaches including cognitive behavioural therapy, recovery in practice, family therapy, and child and adolescent psychiatry. Care of common mental disorders is in the process of being integrated into primary care. Friends and family associations have been established to support service users and their families and to advocate for their rights. Mental health units have been established in the Ministry of Health in the West Bank and Gaza. These units are developing mental health human resources strategic plans and an operational policy for community mental health centres. A database for compiling and analysing routine data from community mental health centres was established in 2014.

The mental health units need ongoing support to maintain technical momentum and to advocate for mental health care among the medical community. Capacity-building is needed in interpretation and use of mental health service data. The mental health treatment gap remains large and ongoing advocacy is needed to combat misconceptions and stigma.

Violence and injury

The percentage of deaths caused by injuries in 2012 in the West Bank was 5.5%. Of this, unintentional injuries accounted for 84.0% (35.2% due to road traffic injuries and 5.0% as a result of drowning), while intentional injuries accounted for 16.0% (9.8% as a result of self-harm and 90.2% as a result of interpersonal violence) (4). In 2010, the estimated road traffic fatality rate was 3.2 per 100 000 population (7). For post-injury trauma care, there is a universal emergency access telephone number; however, less than 10.0% of the seriously injured are transferred by ambulance (7).

A violence, injuries and disability programme has commenced with the establishment of a road traffic casualties information system and a national injury information system, supported by the Palestinian National Institute of Public Health. A challenge is the multisectoral nature of the information required. However, the road traffic injury information system is improving. Laws exist covering all key road safety risk factors, but some need to be made more comprehensive. Medical care for injured persons is provided by nongovernmental organization-managed emergency medical services and by Ministry of Health hospitals, in addition to private-sector providers. Specialized national emergency care training is available for both doctors and nurses.

There is a need to have an in-depth trauma care system assessment to identify and address existing gaps to improve different aspects of services. Approaches to data collection and analysis must be harmonized among stakeholders.

Disabilities and rehabilitation

Disability prevalence is 6.9% according to the wide definition (faces some form of difficulty in functioning), but 2.7% using the narrow definition (faces very significant difficulties), with 2.9% in the West Bank and 2.4% in Gaza, and 2.9% for males and 2.5% for females (8). The prevalence of disability in those aged 0–17 years is 1.5% (1.6% West Bank, 1.4% Gaza; 1.8% males, 1.3% for females) (8). Mobility-related disabilities have the highest prevalence at 49.0% (49.5% West Bank, 47.2% Gaza), with learning disabilities second at 24.7% (23.6% West Bank, 26.7% Gaza), noting that a person may have more than one disability (8).

The UN Convention on the Rights of Persons with Disabilities was ratified in 2014 and the Constitution includes articles on disability. The overarching disability legislation is Law No. 4 on the Rights of the Disabled (1999). The Supreme Council for the Affairs of Persons with Disabilities has been the national coordination mechanism since 2004, and is chaired by the Minister of Social Affairs, with representation of persons with disabilities. A national strategic plan for the disability sector has existed since 2012, and some ministries have developed their own strategic frameworks on disability based on it. Challenges include inadequate resources and funds, the chronic crisis situation, challenging administrative structures and inadequate data systems. However, efforts to address different disability issues are being pursued. Legislation, policies and programmes are being reviewed against the Convention on the Rights of Persons with Disabilities and human rights principles, and a multisectoral disability strategy is being developed. Screening programmes for the early detection and prevention of disability, including vision and hearing screening, are run through the school health programme.

The International Classification of Functioning, Disability and Health has been introduced to Ministry of Health primary health care managers and technical representatives from the ministries of Social Affairs, Education and Labour, and the Ministry of Health is considering

its application, but a major challenge is the lack of funding. The updating and upgrading of the existing screening programme, and including learning disabilities and genetics in it, has been included in the Ministry of Health's strategic plan.

Nutrition

The prevalence of various conditions due to malnutrition in children under 5 years of age is 4.4% wasting, 10.3% stunting and 20.0% overweight (9). The prevalence of anaemia in women of reproductive age (15–49 years) is 27.0% and iodine deficiency affects 26.8% of the population (10). Initiation of breastfeeding within one hour after birth is 40.8%, while 38.6% of children under 6 months of age are exclusively breastfed (10). Low birth weight is 8.3% (10).

A national nutrition policy, strategies and an action plan are available for the period 2011–2013. Anaemia among under-fives and pregnant women is an issue of ongoing concern; however, the majority of cases are either mild or moderate. Overweight and obesity are of significant concern among all age groups, with associated low levels of physical activity. Nutritional surveillance systems are in place through routine growth monitoring of under-fives and periodic screening of school children. The International Code of Marketing of Breast-milk Substitutes has been adopted and applied through national regulation, accompanied by regulation of infant formula and follow-on formula, infant and young child foods, and medical foods.

National policies and interventions targeting unhealthy nutrition practices and physical inactivity are yet to be developed.

Promoting health across the life course

Reproductive,
maternal, newborn,
child and adolescent
health

Ageing and health

Gender, equity
and human rights
mainstreaming

Social determinants
of health

Health and the
environment

Promoting health across the life course

- The primary care package of reproductive health services is comprehensive, covering the entire reproductive life period and beyond, including: youth and adolescent care; premarital care; care during menopause; and screening for breast and cervical cancers.
- The Ministry of Health provides primary health care and hospital services to all insured citizens irrespective of age; however, the specific needs of the ageing population have not been integrated into the health service delivery system.
- In 2013, a national multisectoral social determinants of health committee was established to identify and act on key social determinants of health, to draft a plan to address priority issues, and to integrate social determinants of health into all relevant policies and programmes.
- The government has endorsed the WHO regional environmental health strategy and framework for action 2014–2019, and will initiate a national multistakeholder process to develop a strategic environmental health framework for action in 2015–2016. This will focus on several environmental health priorities, including environmental health preparedness and response to emergencies.

Reproductive, maternal, newborn, child and adolescent health

The maternal mortality ratio declined by 61.9% between 1990 and 2015 from 118 to 45 per 100 000 live births (11) and the under-5 mortality ratio decreased from 43 to 21 deaths per 1000 live births (12). The proportion of women receiving antenatal care coverage is (at least one visit) 99.4% and (at least four visits) 95.5% (10). The unmet need for family planning is 10.9% and the contraceptive prevalence ratio is 57.2% (10).

Reproductive, maternal, newborn and child health services are available free of charge at Ministry of Health primary care facilities. The primary care package of services for reproductive health is comprehensive, comprising services covering the entire reproductive life period and beyond, including: youth and adolescent care; premarital care; care during menopause; and screening for breast and cervical cancers. Health care facilities administer all deliveries, mainly in hospitals and a few stand-alone maternity units. Postpartum coverage remains low. Newborn and child health services include growth monitoring, breast feeding support and micronutrient supplementation, testing for enzyme and hormone deficiencies,

and the Integrated Management of Childhood Illnesses, a strategy implemented in all Ministry of Health facilities and for which most health providers have received training. However, maternal and under-5 mortality indicators are far from achieving Millennium Development Goal targets.

There remains a need to update and standardize the guidelines for antenatal, postnatal and neonatal care, and to implement a harmonized reproductive health registry in the Ministry of Health and a computerized health information system to ensure continuum of care.

Ageing and health

Life expectancy for males is 71.5 and females is 74.4 (4). In 2010, the ageing population, above 60 years, represented 4.4% of the total population (13).

While there are national interventions aimed at supporting the growing elderly population, there is no national multisectoral and interdisciplinary programme on ageing. The Ministry of Social Affairs includes a department on ageing and provides a small monetary stipend to the elderly living in poverty. The Ministry of Health provides primary health care and hospital services to all insured citizens irrespective of age; however, the specific needs of the ageing population have not been integrated into the health service delivery system. The National Higher Council on Ageing, which includes the major stakeholders, has developed a law for the elderly. However, due to the political situation, it has yet to be ratified. With the lack of public elderly services, nongovernmental organizations have programmes providing day care, nursing home care and home care to the elderly, but these are fragmented and unregulated.

The Ministry of Health has initiated an initial assessment of the health situation of the elderly population in the country. Based on the resultant findings and recommendations, an interdisciplinary and multisectoral national committee will be established to develop a strategy with appropriate interventions to ensure that the elderly receive the necessary support.

Gender, equity and human rights mainstreaming

Female adult (above 15 years of age) literacy is relatively high at 93.6% (15) and participation in the labour force is relatively low at 15.2% (14).

The national health strategy aims to ensure rights-based comprehensive and integrated health services to all citizens (regardless of gender, age, disability, geographical distribution, and the political and socioeconomic situation). The Ministry of Health promotes gender considerations in policies and multisectoral efforts against social violence. However, there is a need to improve monitoring and evaluation to ensure gender equity and human rights

principles are well applied. Equitable access to services, including referral care, remains difficult to monitor without improved data quality and analysis.

Challenges include the chronic crisis and unstable political situation, and inadequate human and financial resources, with intermittent international funding. This is further complicated by the ongoing occupation, frequent military escalations and the deteriorating economic situation. The public health system lacks needed specialists, diagnostic equipment and medical capacity to provide comprehensive services, and depends heavily on referring patients to nongovernmental facilities for specialized diagnoses and treatments. This translates into unmet medical needs, particularly for complex medical cases. Patients often need to travel to neighbouring countries for treatment and diagnosis, and rely mostly on governmental financial support. The financial crisis of the government has resulted in shortages of essentials such as medicines and medical disposables in the Ministry of Health, particularly acute in Gaza, and large debts to suppliers. The increasingly unpredictable nature of international funding has at times paralyzed the health system, placing several hospitals at the edge of closure in 2013.

Social determinants of health

The *Human development report 2014* ranked the country at 107 out of 187 countries across the world on the human development index (14). The population at poverty level was 25.8% in 2011 (16). The urban population increased between 1990 and 2012 from 67.7% to 74.6%, while the access of rural population to improved water sources has remained constant at 100.0% (18). In 2010, those aged 0–24 years accounted for 63.5% of the total population (13). The adult literacy rate is 95.3% (17), while unemployment is 23.0% and for youth (15–24 years) 34.6% (16).

In 2013, the government established a national multisectoral social determinants of health committee. The committee has been commissioned to identify and act on key social determinants of health, to draft a plan to address priority issues, and to integrate social determinants of health into all relevant policies and programmes. Among the major challenges are the occupation, the political situation and scarce financial resources.

A major opportunity is the explicit commitment of the Ministry of Health to mainstreaming social determinants of health and to reducing health inequities. This commitment needs to be escalated and translated into practical action, in the form of further allocation of human and financial resources to support the work of the national committee.

Health and the environment

There are no estimates for the burden of environmental factors on health, although access to improved sanitation facilities is 99.0%, while access to improved drinking-water is 92.0% (4). However, there is reason to believe that the burden of disease is magnified as a result of the different environmental health emergencies in the country. Although ambient air pollution is not properly monitored, the evidence indicates high levels of particulate matter in the air of the West Bank and Gaza.

Environmental risk factors contribute heavily to both communicable and noncommunicable diseases. Poor water quality and sanitation services remain major environmental hazards contributing to the burden of communicable diseases in some parts of the country. There is an increasing trend of air pollution and other (modern) risk factors responsible for the rising burden of noncommunicable diseases. Unfortunately, owing to the ongoing emergency situation, the level of environmental health services is deteriorating.

The government has been working on strengthening national capacity for environmental health preparedness and response to emergencies related to waste management and water and sanitation. The government endorsed the WHO regional environmental health strategy and framework for action 2014–2019, and initiated a national multistakeholder process to develop a national strategic environmental health framework for action in 2015–2016. In order to cover the whole Palestinian population, there is a need to strengthen cooperation between the health and environment sectors in the West Bank and Gaza.

Health systems

National health
policies, strategies
and plans

Integrated people-
centred health
services

Access to medicines
and health
technologies

Health systems,
information and
evidence

Health systems

- The Ministry of Health has adopted a three-year national health strategy as the main planning process for the public sector.
- Over 80% of the population is covered by at least one type of health insurance scheme.
- The Ministry of Health is now moving towards a people-centred approach with the adoption of a family practice model.
- The first national pharmaceutical policy has been produced.
- A comprehensive national health information system assessment has been conducted.

National health policies, strategies and plans

The Ministry of Health has adopted a three-year national health strategy. The national health strategy focuses on five areas: 1) universal access to a comprehensive health care service; 2) priority preventive care and management of noncommunicable diseases; 3) quality; 4) availability of a qualified workforce; and 5) institutional development and governance. The Ministry develops an annual operational plan linked to the national health strategy and its objectives. The country's national health planning cycle is addressed in the national health strategy for 2014–2016. Total expenditure on health per capita increased between 2005 and 2013 from US\$ 169.0 to US\$ 304.0, of which general government expenditure on health increased from US\$ 214.0 million to US\$ 583.0 million (18). General government expenditure on health as a percentage of total expenditure on health also increased during the same period from 38.4% to 43.3% (18). However, total expenditure on health as a percentage of the gross domestic product has decreased from 12.5% in 2005 to 10.9% in 2013 (18). In addition, the share of out-of-pocket spending has increased from 34.1% in 2005 to 37.7% in 2013 (18). There are no documented external sources for expenditure on health.

Just over 80% of the population is covered by at least one type of health insurance scheme. Officially, the main health financing mechanism for the public health sector is the government health insurance scheme, which is compulsory for public sector workers and voluntary for the remaining population. Other health insurance schemes are private, except for one for security personnel. Around 3000 people are entitled to United Nations Relief and Works Agency for Palestine Refugees in the Near East support, mostly for primary health care. There is also coverage for those enduring hardship. The unemployed are covered through the Ministry of Labour, the poor through the Ministry of Social Affairs, and detainees and their families through the Commission of Detainees and Ex-Detainee's Affairs. Through a presidential decree, the Gaza population is covered free of charge. People can also enrol

in the government health insurance if hospitalized, becoming immediately entitled to normal coverage. Governmental health insurance premiums represent less than 10% of the Ministry of Health budget. Therefore, most public health expenditure is funded by general taxes and revenues, which are heavily dependent on the prevailing political climate. This has forced the Ministry of Health to incur large debts, which substantially impacts on annual operational expenditure.

Recently, the Ministry of Health, with the support of WHO, completed the WHO Organizational Assessment for Improving and Strengthening Health Financing (OASIS) template. A draft report has been developed that describes the current health financing mechanism in the country. Discussion and plans are underway to organize a policy dialogue in 2015 in order to discuss the options for a sustainable health financing system while ensuring universal health coverage for the population.

Integrated people-centred health services

According to health service delivery data, the total number of primary health care centres increased between 2010 and 2014 from 706 to 767 (4). Hospital beds per 10 000 population increased during the same period from 12.6 to 13.5 (4). Human resources for health per 10 000 population have also increased: for physicians from 20.0 to 21.5, nurses from 17.3 to 23.0, midwives from 1.4 to 2.1, and dentists from 5.2 to 6.3 (4).

The country has an adequate geographical coverage of primary and hospital level services. Service delivery in the public sector currently adopts a selective, service-centred approach, whereby specific conditions are managed by specific staff. The Ministry of Health is now moving towards a people-centred approach with the adoption of a family practice model. Management of communicable diseases is integrated within the routine activities of the network of primary health care facilities managed by the Ministry of Health, as well as its hospitals. The package of essential noncommunicable diseases interventions for primary health care, which is already being implemented, takes a people-centred approach and forms a natural component of the family practice model. Eventually, the targeted needs of the ageing population will be integrated. Further, efforts are underway to integrate mental health into the family practice model.

A people-centred strategy is being developed around quality improvement initiatives. The Ministry of Health, supported by WHO, is working to develop and institutionalize a quality programme. In primary health care, national standards have been developed, quality coordinators have been appointed and training is underway. In the coming period, an initial assessment and implementation of primary health care standards will be carried out in selected districts. In the hospital sector, the Ministry of Health has adopted WHO's Patient Safety Friendly Hospital Initiative. Hospital leadership and quality coordinators are undergoing training and mentoring in order to implement the critical standards. Two

nongovernmental organization hospitals have joined the initiative and two East Jerusalem hospitals became the first to achieve accreditation from Joint Commission International in 2013. All hospitals have an infection control committee, as well as a morbidity and mortality committee. In accordance with the Ministry of Health's strategic objective to ensure universal health coverage, efforts are underway to develop a national health coverage plan that will guide health leaders on the health service needs of the population. As a first step, a national hospital planning task force has been developed to facilitate the development of a national hospital master plan.

Access to medicines and health technologies

The Ministry of Health produced the first national pharmaceutical policy in 2013 and the national essential drugs list was updated in 2014. Most medicines are registered in the territories. Procurement is done through an annual tender by the Ministry of Health procurement unit, involving local manufacturers and importers. Nationals cannot use international tenders because the country is signatory to the Paris Protocol, which establishes that imported drugs must be previously registered with the Israel Drug Authority. This in practice prevents the government purchasing medicines from cheaper international manufacturers. Quantification is based mainly on consumption. Items are stored in central and district warehouses and distributed every two months. Various standard treatment guidelines have been developed for selected conditions, but are not consistently available in facilities. Limited information is available on the rational use of medicines.

Provision of essential medicines is challenged both by the dire financial situation of the government and the limitations resulting from the Paris Protocol. Debts to local suppliers reached US\$ 200 million in 2013. Stock-outs are a chronic problem, impacting both quality of care and effective stock management. Furthermore, when lifesaving medications are unavailable in the public system, patients are referred to the private sector or to neighbouring countries, placing additional strain on the already heavily indebted Ministry of Health.

In order to promote effective regulation and control of medical products in the country, the Ministry of Health has reviewed progress made, identified challenges in the regulation of medical products and proposed solutions to address them. The country has achieved phase 1 of the Good Governance for Medicines approach and has started the implementation of phase 2. The translation into practice of policy-level initiatives that promote rational use of medicines is needed, along with quality standards in health care and family practice, and a high level of commitment by development partners to align external assistance to the national health plan.

Health systems, information and evidence

The establishment of a comprehensive national health information system is a priority for health systems strengthening in the national health strategy. The Ministry of Health, with the support of WHO, conducted a comprehensive national health information system assessment with the participation of the main stakeholders, and a strategy has subsequently been developed. An electronic patient record system has been introduced in several hospitals and some primary health care facilities. Most primary health care facilities still use paper-based patient records and registers. Monthly activity reports are submitted to district health offices and from there to a health information centre. Compiled national data are available quarterly. Information on the prevalence and outcome of communicable diseases reaches the relevant Ministry of Health departments through a weekly epidemiological report and a monthly activity report, where diagnoses of attended cases are included. While much of the required data is generated, analysis and use of data require strengthening.

The government has established the Palestinian National Institute of Public Health to provide evidence-based information for action. Health information system strengthening is a core function of the Institute, with continued assessment of the ability of current systems to generate evidence-based data for decision-making. The Institute, with the support of WHO, is establishing a human resources for health observatory by completing a national census of the health workforce and developing a national web-based database on the health workforce to enhance information flow for better monitoring, planning and strategizing. A profile for human resources for health in the West Bank has been completed. A national health facility assessment has also been conducted, geographic information system coordinates of health facilities collected and the Ministry of Health, with the support of WHO, is establishing a dynamic web-based mapping of services and health facilities. In addition, a comprehensive assessment of the civil registry and vital statistics has been conducted, and recommendations are being implemented by the various stakeholders, including the introduction of a computerized system to link hospitals with the Palestinian Health Information Centre at the Ministry of Health and with the Ministry of Interior. Furthermore, an assessment for a cause of death registry has been conducted and recommendations implemented. Activities are also underway to establish a national road traffic accidents registry and a harmonized reproductive health registry. A virtual health sciences library, which will organize and collect all public health research and reports, is also under development and various research studies are being conducted.

The Palestinian National Institute of Public Health, with the support of WHO, will continue with the establishment of both a road traffic accidents registry and injury surveillance to enhance evidence-based decision-making, as well as with a national assessment of neonatal health services, in order to enhance the quality of services and improve the current referral system.

Preparedness, surveillance and response

Alert and response
capacities

Epidemic and
pandemic-prone
diseases

Emergency risk and
crisis management

Food safety

Poliomyelitis
eradication

Outbreak and crisis
response

Preparedness, surveillance and response

- An inter-ministerial committee on International Health Regulations (IHR) 2005 with clear terms of reference has been established.
- The country's public health surveillance system has proved to be effective and responsive in the timely detection of epidemic influenza in one of its recent episodes.
- Disaster preparedness within the health system is generally weak, except for mass casualty management within hospitals.

Alert and response capacities

The government has requested a second extension in order to meet its obligations for implementation of the International Health Regulations (IHR) 2005 by June 2016. The government is committed to complying with the requirements. The country has the following components in place: a national IHR focal point, a strong surveillance system, a detailed emergency preparedness and response plan, a risk communication plan, a strong laboratory capacity, and a strong capacity for responding to zoonotic events. However, chemical, radiological and nuclear capacities are weak. Furthermore, owing to the occupation, the government does not have any control over the designated points of entry.

An inter-ministerial committee on IHR has been established with clear terms of reference, including assessing the existing capacity of the public health system for detecting, reporting and responding to public health risks and public health emergencies of international concern to meet the minimum core capacity requirements under IHR.

There is a need to strengthen the capacity of the national IHR focal point. More work needs to be done to include IHR requirements within national legislation, and the IHR national committee needs to be strengthened and encouraged to meet regularly. There is also a need for advocacy in different sectors for IHR and to conduct an awareness campaign on their importance and objectives.

Epidemic and pandemic-prone diseases

The country's public health surveillance system has proven to be effective and responsive in the timely detection of epidemic influenza in one of its recent episodes. However, given the complexity of the bifurcated health system in the two administrated control areas, and owing to the complex geo-political and humanitarian situation in the country, efforts need

to be directed to making the public health system resilient and able to detect and respond to any health threats in a timely and adequate manner.

Emergency risk and crisis management

Disaster preparedness within the health system is generally weak, except for mass casualty management resulting from the ongoing occupation. The planning process for mass casualties is strong within each hospital. The experience gained in past incidents is maintained thanks to the stability of medical staff and their acute awareness of the risk of further incidents.

A multi-hazard preparedness effort is a priority, expanding its vision beyond the response to political violence. The territories are located within a geographical zone prone to earthquakes, and are vulnerable to flooding and drought. As part of strengthening emergency preparedness, the Ministry of Health should ensure adequate resources and capacity, including buffer stocks and an early warning system. A mechanism for national coordination of the mass casualty plans of individual hospitals should be established. Such coordination will be required for natural disasters as well as widespread conflict. This should include an information system to monitor the flow of casualties, rate of bed occupancy, availability of key staff and the inventory of key supplies. This will facilitate the redistribution of existing resources if conditions permit, and where they do not, it will allow better documentation of the obstacles faced in the delivery of basic emergency services.

Food safety

Several ministries are concerned with food safety. The country has food safety legislation, standards and guidelines, but there is a need for their updating and refinement as the current legislation is short of detailed bylaws. An overall review of food safety activities and the development of a strategic plan are needed to address structural issues.

Poliomyelitis eradication

The last case of indigenous poliomyelitis was detected in 1988. The wild poliovirus detected in sewage samples in 2013 was genetically similar to the wild poliovirus type 1 that has been isolated in more than 100 sites in Israel. According to the Ministry of Health, the virus came originally from Israeli settlement sewage in the West Bank due to the lack of separate infrastructure. Two rounds of oral polio vaccine immunization were conducted for all children under-five years of age: the first in December 2013 and the second in January 2014, with coverage of 99.0% for both rounds. The polio importation preparedness and response plan needs to be updated.

Outbreak and crisis response

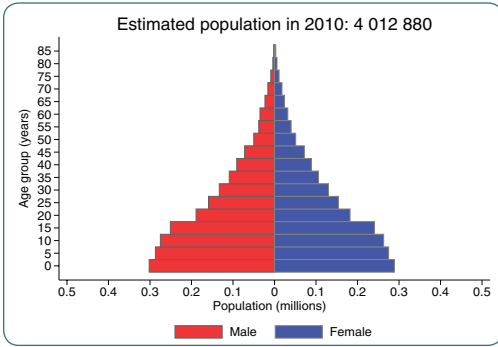
An estimated 1.9 million people out of a population of 4.5 million in the territories are deemed to be in need of humanitarian assistance, comprising 42.0% of the population. Access to basic health care, education, and water and sanitation services remains severely restricted for many Palestinians in the West Bank and Gaza (19).

Regular coordination is maintained between the Ministry of Health, local and international nongovernmental organizations, and United Nations agencies particularly the United Nations Relief and Works Agency for Palestine Refugees. During emergencies, the Ministry of Health, with strong support from WHO, implements the following humanitarian interventions closely with other health stakeholders: 1) assessment of the impact of the crisis on the health system and health status of the population, including damage to health infrastructure, the degree of functionality of health facilities and the availability of human resources at health facilities; 2) ensuring effective coordination of the immediate health response and the early recovery of the health sector, including the flexibility to respond rapidly to new needs; 3) supporting other health stakeholders in coordinating and responding to the health needs of the Palestinian population; and 4) ensuring a seamless transition from relief to recovery, so that local health systems and the capacity of national and local health authorities are restored and strengthened. In late 2014, the government began scaling-up its preparedness for Ebola virus disease by assessing and measuring its level of preparedness using the WHO assessment checklist and accordingly identifying critical gaps for improvement.

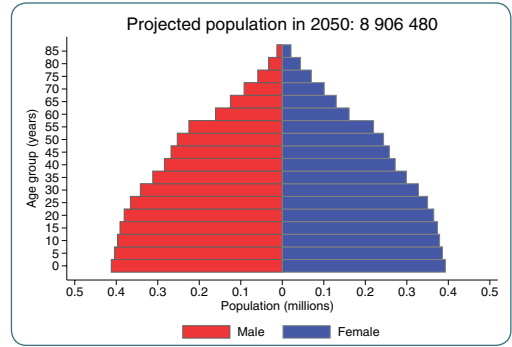
The Health and Nutrition Cluster mechanism is well-established, health humanitarian interventions are smoothly and efficiently coordinated, and a health cluster contingency plan is in place. With a view to improved emergency preparedness planning, a review of the health sector response and a review of existing emergency preparedness and response plans are needed.

Demographic profile

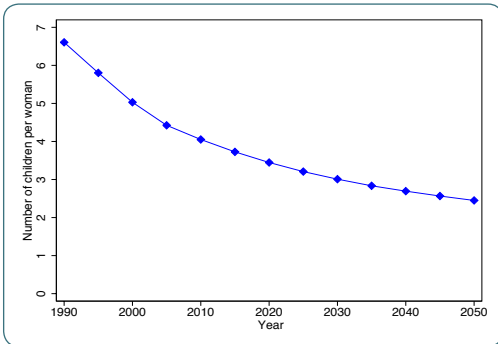
Population pyramid 2010



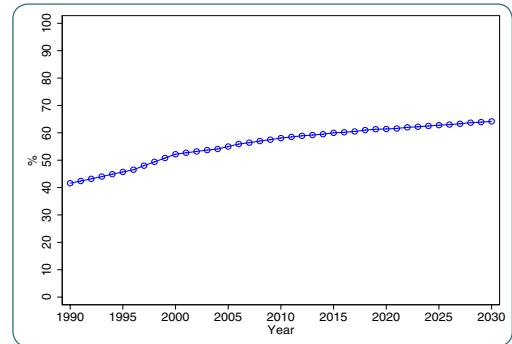
Population pyramid 2050



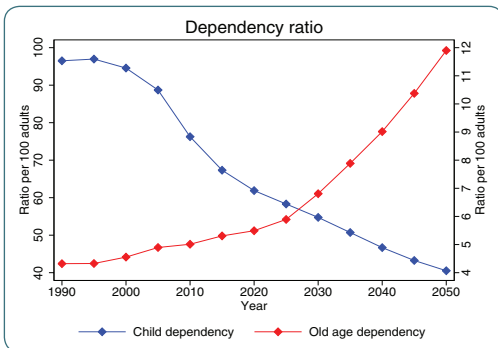
Total fertility rate



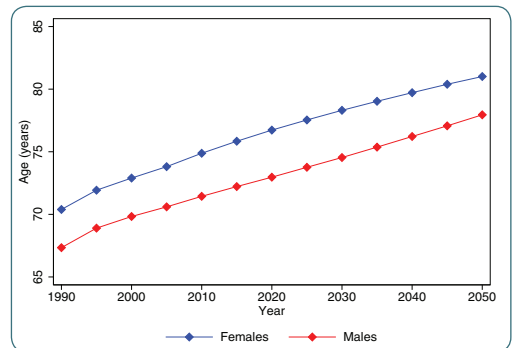
Need for family planning satisfied



Dependency ratio



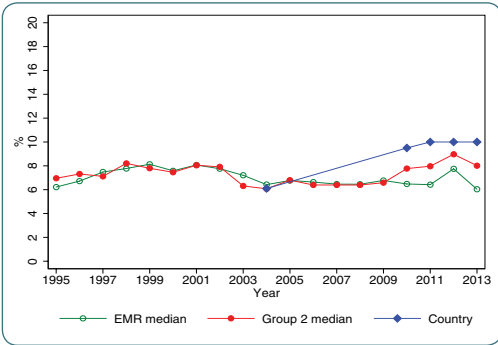
Life expectancy at birth



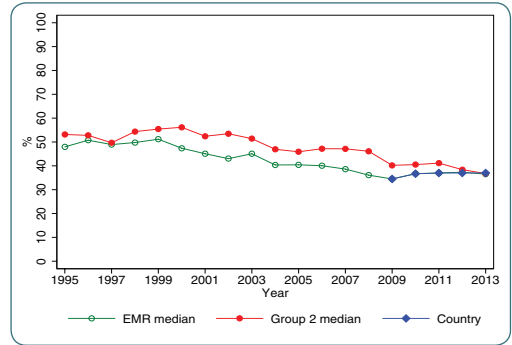
Source for all graphs: (13)

Analysis of selected indicators

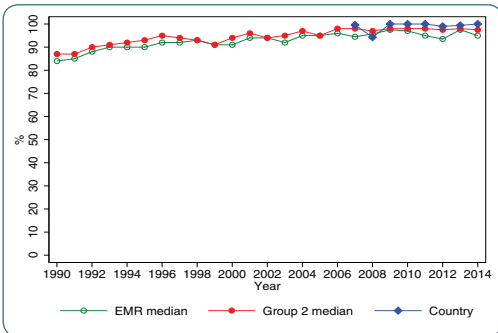
General government expenditure on health as % of general government expenditure (18)



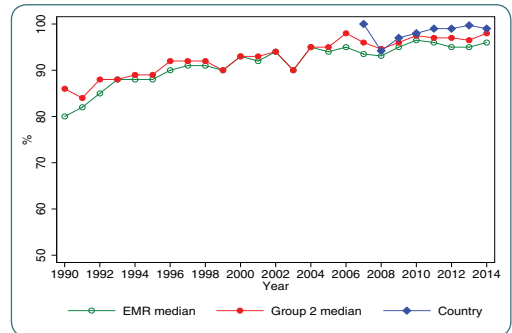
Out-of-pocket expenditure as % of total health expenditure (18)



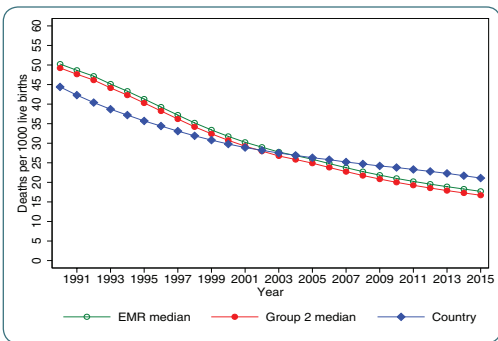
DPT3/pentavalent coverage among children under 1 year of age (%)¹



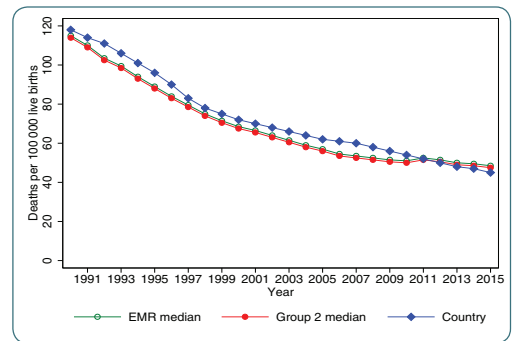
Measles immunization coverage (%)¹



Under-5 mortality (per 1000 live births) (12)



Maternal mortality ratio (per 100 000 live births) (11)



¹ Ministry of Health, unpublished data, 2014.

References

1. UNAIDS Middle East and North Africa regional report on AIDS 2011. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2011 (http://www.unaids.org/sites/default/files/media_asset/JC2257_UNAIDS-MENA-report-2011_en_1.pdf, accessed 3 February 2015).
2. WHO Global tuberculosis database 2014. Geneva: World Health Organization; 2014 (<http://www.who.int/tb/country/data/profiles/en/>, accessed 25 March 2015).
3. Malaria in the Eastern Mediterranean Region 2013. Cairo: World Health Organization Regional Office for the Eastern Mediterranean; 2014 (http://applications.emro.who.int/dsaf/emropub_2014_EN_1778.pdf?ua=1, accessed 2 April 2015).
4. Health Annual Report Palestine 2013. Nablus: Ministry of Health; 2014.
5. Global youth tobacco survey 2005. Cairo: World Health Organization; 2010 (http://www.emro.who.int/images/stories/tfi/documents/GYTS_FS_GAZA_STRIP_R2.pdf?ua=1, accessed 12 October 2014).
6. Palestine STEPS Survey 2010–2011. Geneva: World Health Organization (http://www.who.int/chp/steps/Palestine_FactSheet_2010-11.pdf, accessed 12 October 2014).
7. Global status report on road safety 2013: supporting a decade of action. Geneva: World Health Organization; 2013 (http://www.who.int/violence_injury_prevention/road_safety_status/2013/en/, accessed 12 October 2014).
8. Disability Survey, 2011: Press conference report. Ramallah: Palestinian Central Bureau of Statistics and Ministry of Social Affairs, 2011 (http://www.pcbs.gov.ps/Portals/_pcbs/PressRelease/disability_e2011.pdf, accessed 3 July 2015).
9. UNICEF-WHO-The World Bank. 2013 Joint child malnutrition estimates: Levels and trends, 2014 revision. Geneva: World Health Organization; 2014 (<http://www.who.int/nutgrowthdb/estimates2013/en/>, accessed 31 March 2014).
10. Multiple Indicator Cluster Survey 2014. Ramallah: Palestinian Central Bureau of Statistics, United Nations Children's Fund and United Nations Population Fund; 2014 (<http://mics.unicef.org/surveys>, accessed 31 March 2014).
11. Trends in maternal mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, the World Bank and the United Nations Population Division. Geneva: World Health Organization; 2015 (<http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/>, accessed 11 January 2016).
12. Levels and trends in child mortality. Report 2015. Estimates developed by the UN Inter-agency Group for Child Mortality Estimation. New York: United Nations Children's Fund; 2015 (http://www.who.int/maternal_child_adolescent/documents/levels_trends_child_mortality_2015/en/, accessed 11 January 2016).

13. World population prospects: The 2012 revision, DVD edition. New York: United Nations, Department of Economic and Social Affairs, Population Division; 2013.
14. Human development report 2014. New York: United Nations Development Programme; 2014 (<http://hdr.undp.org/sites/default/files/hdr14-report-en-1.pdf>, accessed September 2014).
15. UIS Stat [online database]. Montreal: UNESCO Institute for Statistics; 2012 (<http://data.uis.unesco.org/>, accessed 30 April 2015).
16. World development indicators [online database]. Washington DC: World Bank Group; 2014. (<http://databank.worldbank.org/data/views/variableSelection/selectvariables.aspx?source=world-development-indicators> , accessed 12 October 2014).
17. Global health observatory data repository: Indicator and measurement registry: Literacy rate among adults aged ≥ 15 years (%). Geneva: World Health Organization; 2014 (http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=77, accessed 7 April 2015).
18. Palestinian Health Accounts 2013. Ramallah: Palestinian Central Bureau of Statistics; 2015 (<http://www.pcbs.gov.ps/Downloads/book2105.pdf>, accessed 8 August 2015).
19. Office for the Coordination of Humanitarian Affairs (OCHA). 2014 Strategic response plan, occupied Palestinian territory. Jerusalem: Prepared by OCHA on behalf of the Humanitarian Country Team; 2014 (https://docs.unocha.org/sites/dms/CAP/SRP_2014_oPt.pdf, accessed 30 April 2015).

