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Report

Right to Health

Barriers to health and attacks on health care in the occupied Palestinian territory, 2019 to 2021



World Health
Organization

occupied Palestinian
territory

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CONTENTS

	ACKNOWLEDGEMENTS	4
	PREFACE	6
	EXECUTIVE SUMMARY	7
	RECOMMENDATIONS	12
	BACKGROUND	15
	Methodology.....	18
	Responsibilities and a human rights-based approach to health	18
	Social determinants of health and health inequities in the oPt	20
	COVID-19 and the right to health in the oPt.....	21
	HEALTH SERVICES AVAILABILITY: Challenges to sustainable provision and equity	22
	Gaps in the public health care provision	24
	Referral system of the Palestinian Ministry of Health	25
	Destination, type, and cost of referrals.....	27
	Referral pathways for cancer care.....	31
	HEALTH ACCESS: Barriers affecting the Gaza Strip	33
	Patient permits	35
	Companion permits	41
	Opening of Erez (Beit Hanoun) checkpoint and Rafah border crossing	43
	Access for health care workers, ambulances, and medical supplies	44
	HEALTH ACCESS: Barriers affecting the West Bank	47
	Patient and companion permits.....	49
	Access for health staff and ambulances to east Jerusalem	53
	Health access in Area C, H2 and the Seam Zone.....	55
	HEALTH ATTACKS: Protection vulnerabilities for health care	57
	Impact of health attacks.....	60
	Criminalization of health care and security interrogations	61
	CONCLUSION	63

PREFACE

This report is produced as part of WHO's Right to Health programme in the occupied Palestinian territory, which focuses on monitoring and documentation of barriers to the right to health for Palestinians; capacity-building for strengthening the right to health and a human rights-based approach to health; as well as advocacy towards ending barriers and violations of the right to health.

The purpose of the report is to provide analysis of data collected through monitoring, to support evidence-based advocacy to strengthen respect, protection, and fulfilment of the right to health in the occupied Palestinian territory. The data and analysis included in the report builds on previous annual reporting (see more recent years: 2018, 2017, 2016, 2014–2015); WHO monthly access reporting; and WHO health attacks monitoring. Further information resources for the right to health produced by WHO in the occupied Palestinian territory can be found online.

This report specifically analyses data on barriers to the right to health for Palestinians in the West Bank, including east Jerusalem, and the Gaza Strip for 2019 to 2021, with additional retrospective analyses to demonstrate longer-term trends and structural limitations. It focuses on:



Health services availability: Challenges to sustainable provision



Health access: Barriers affecting the Gaza Strip



Health access: Barriers affecting the West Bank



Health attacks: Protection vulnerabilities for health care

A final draft of this report was shared with counterparts at the Palestinian Ministry of Health, the Israeli Coordinator of Government Activities in the Territories (COGAT), and partner UN organizations.



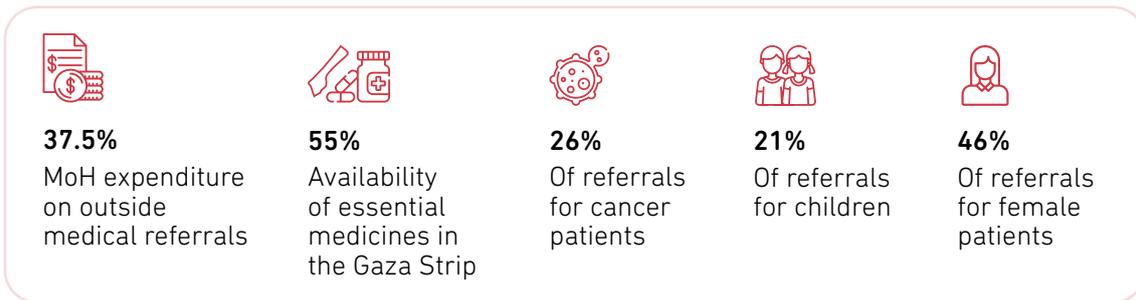
Realization of the right to the highest attainable standard of health and wellbeing (right to health) means safeguarding social conditions of life that determine health, including politically, economically and through legal protections, **as well as ensuring the availability, accessibility, acceptability, and quality of health care**. It equally means upholding core human rights principles of participation, equity, non-discrimination, and accountability in the delivery of health care.

The central aim of a human rights-based approach to health is to develop the capacities of duty bearers to fulfil their obligations – specifically the state obligations outlined in relevant international treaties – and to empower rights holders to effectively claim their health rights.¹ In the occupied Palestinian territory (oPt), duty bearers for the right to health comprise Israel as occupying power; the Palestinian Authority; the de facto authority in the Gaza Strip; and third states of the international community.

From 2019 to 2021, considerable barriers to the right to health for Palestinians continued in the West Bank, including east Jerusalem, and the Gaza Strip. Palestinians' health is impacted by structural determinants of health inequities that include ongoing occupation, political divisions, fragmentation of territory, blockade of the Gaza Strip, physical obstacles to movement, and implementation of a permit regime. These factors influence health service availability including through financing limitations; health access including to outside medical referrals; and health attacks.

1. WHO, 2008. A Human Rights-Based Approach to Health. Available at: https://www.ohchr.org/sites/default/files/Documents/Issues/ESCR/Health/HRBA_HealthInformationSheet.pdf.

Health services availability: Challenges to sustainable provision



Fragmentation of territory and health service provision presents major challenges to governance of the Palestinian health sector, which faces barriers to sustainable provision, inefficiencies, and the need for stronger transparency, including communication of entitlements, and accountability. The Palestinian health sector consists of four main health service providers: the Ministry of Health (MoH), the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), NGOs and for-profit providers. The MoH provides most health services, especially primary and secondary care, through a network of governmental primary health care centres and hospitals. The MoH also offers tertiary health services and purchases services from other hospitals and medical centres, including non-profit Palestinian hospitals in east Jerusalem.

Public provision of health services in the oPt is challenged by limited government expenditure on health (domestic general government health expenditure per capita 158 US\$, 2021). This is attributable to limited overall economic growth in the oPt (GDP per capita 3,664 US\$, 2021)² related to lack of control over natural resources, high unemployment, as well as other challenges to revenue raising such as fiscal leakages due to withholding of customs revenue by Israel.³ Over a third of MoH spending (37.5% in 2021) is on outside medical referrals (i.e. referrals to non-MoH providers, including within and outside the oPt), which represent a significant source of budget inefficiencies.⁴ The Palestinian Authority faced a severe fiscal crisis throughout the reporting period, with implications for MoH expenditure.⁵

Gaps in health care availability are additionally due to lack of human resources, essential medicines, supplies and technology, and inability to develop infrastructure – including severe planning restrictions in Area C⁶ of the West Bank preventing the establishment of permanent or semi-permanent health facilities. Longstanding gaps and inequities in the availability of essential medicines persisted in 2019-2021. In the Gaza Strip, the Central Drugs Store consistently reported lower availability of essential stocks compared to the West Bank, with an average 55% availability (more than one month's supply remaining) over the three years. The lowest annual availability was in 2019, when 52% of essential medicines had more than a month's supply remaining at the time of monthly stock takes.

Lack of sub-specialty services within MoH facilities drives outside medical referral.⁷ From 2019 to 2021, cancer care continued to be the most common reason for referral (26% of the total). Twenty one percent of referrals were for children and 46% for female patients. A larger proportion of outside medical referrals from the Gaza Strip (97%) were for inpatient services compared to the

2. World Bank national accounts data, and OECD National Accounts data files. Available at: <https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=PS>.

3. UNCTAD, 2022. Report on UNCTAD Assistance to the Palestinian People: Developments in the Economy of the Occupied Palestinian Territory, UN Doc. TD/B/EX(72)/2.

4. Palestinian Health Information Center of the Ministry of Health, 2022. Health Annual Report: Palestine 2021

5. World Bank, 2022.

Economic Monitoring Report to the Ad Hoc Liaison Committee (English). Available at: <http://documents.worldbank.org/curated/en/099407305062233565/IDU091fed1da019eb042d6090100a9320aa572de>.

6. Area C (60 percent of the territory in the West Bank, containing all the Israeli settlements) is under full Israeli jurisdiction for civil and security matters apart from issues for which powers and responsibility have been transferred to the PA by agreement, for example, in education and health services.

7. Outside medical referral is defined as the referral of Palestinian patients from governmental (public) hospitals to NGO-, private-, east Jerusalem-, Israeli- or out of country hospitals.

West Bank (35%), likely linked to reduced accessibility for Gaza patients to referral destinations. Most Gaza patients who were referred outside MoH facilities required permits to reach health facilities (40% to east Jerusalem, 17% to rest of West Bank, 3% to Israeli hospitals, and 1% to Jordan required permits; 24% to Gaza and 15% to Egypt did not), while most outside medical referrals from the West Bank did not require permits (55% within the West Bank, outside east Jerusalem; with most referrals to east Jerusalem (40%) and Israeli hospitals (5%) requiring permits). Further, 69% of requests by private companies through the Presidential Committee for Commodities Coordination of the Palestinian Authority for entry of machines or spare parts to Gaza for x-ray, CT, or oxygen delivery were denied by Israeli authorities in 2021.

The impact of COVID-19 on health service utilization was exacerbated by access restrictions and the end to coordination between the Palestinian Authority and Israel in 2020, when the issuance of outside referrals by the MoH dropped 24%, disproportionately affecting the Gaza Strip (51% decline) compared to the West Bank (8% decline).

Health access: Barriers affecting the Gaza Strip



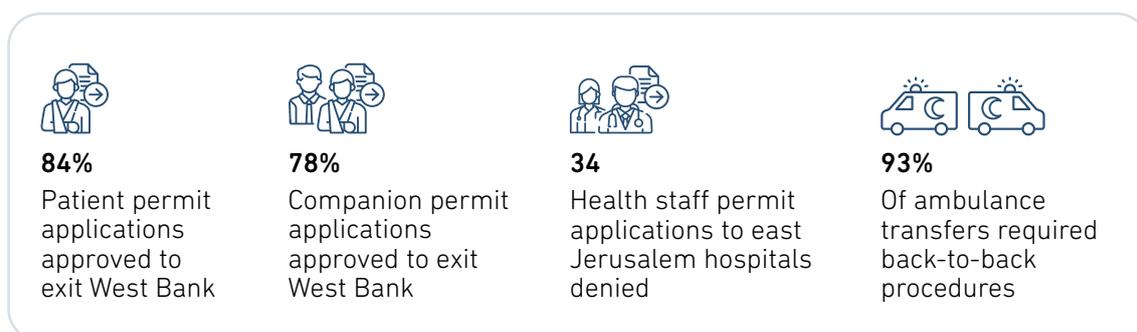
The blockade of the Gaza Strip since 2007 has severely affected movement of people, as well as goods and services. To reach the rest of the oPt (West Bank, including east Jerusalem), Israel, or Jordan, Palestinians in the Gaza Strip must apply for Israeli permits to cross the checkpoint at Beit Hanoun (Erez). Since 2017, Israel more than doubled the required time for submission of non-urgent patient applications from 10 to 23 working days prior to the hospital appointment.

Patients applying for permits to exit Gaza are vulnerable, with a mortality rate at six months from first permit application approaching one in 10 (8.8%). Despite the severity of their conditions, from 2019 to 2021 only 65% of patient permits were approved in time to reach the patient's hospital appointment. Over the past 15 years, there has been considerable variation in rates of approval (ranging from a high of 94% approved in 2012 to a low of 54% approved in 2017). Additionally, individual patients can be consecutively delayed or denied permits and then approved, or vice versa, pointing to the arbitrariness of the permit regime and the impact on subsequent access to needed health services. In most instances, there is no explanation for delay or denial of permits, indicating lack of due process and transparency. Different population groups are approved at different rates, with men aged 18 to 40 years experiencing the lowest approval rate (47%). By medical specialty, the lowest approval rates were for urology (44%), orthopaedics (45%) and ophthalmology (48%). Long periods of closure of the Rafah crossing to Egypt further exacerbated restrictions on access to health care during this period, particularly during the COVID-19 pandemic, with a 31% reduction in referrals to Egypt in 2020 compared to 2019.

Companion accompaniment of patients is particularly critical for children, incapacitated patients, and those with disabilities that may affect medical consent, emotional support needs, and capacities for self-care. Yet, from 2019 to 2021, only 46% of companion permits were approved in time for the patient's hospital appointment. Of child medical permits approved for travel, nearly a third (32%) of did not have the child's mother or father listed as companion. This is due to non-approval of parent applications, as well as non-application for parent permits (25% of child applications listed a parent as companion in the same period).

Ambulances transporting patients across Erez (Beit Hanoun) checkpoint frequently faced long delays, with ambulances transferring patients out of Gaza having to wait 68 minutes on average during 2019 to 2021, with the highest wait time in 2020 (80 minutes). Of 1493 permit applications via the Palestinian General Authority of Civil Affairs for health and non-health staff to exit the Gaza Strip for conferences from 2019 to 2021, just 10% were approved, with 51% denied and 39% remaining pending.

Health access: Barriers affecting the West Bank



In the West Bank, access between Palestinian urban centres is restricted by Israeli checkpoints, the separation barrier, and an expanding settlement infrastructure, while movement of Palestinians into east Jerusalem and Israel is controlled by the Israeli permit regime. The age distribution for patient and companion permit applications differs from the Gaza Strip, with 19% of patient applications for children (vs. 29% in Gaza) and 7% of applications for patients 65 years and over (vs. 14% in Gaza). Permit exemptions in the West Bank apply to women over 50 years and men over 55 years old, while children on occasion can pass through checkpoints with approved adults. A higher proportion of the West Bank population have permits to enter east Jerusalem and Israel for reasons not related to health, such as work.

The approval rate for patient and companion permits has been consistently higher for the West Bank than for the Gaza Strip, with 84% of patient applications and 78% of companion applications approved between 2019 and 2021, according to the Palestinian General Authority of Civil Affairs. With a higher number of applicants from the West Bank, however, this resulted in nearly 24 000 patient applications and nearly 37 000 companion applications not being approved during the period. As with the Gaza Strip, approval rates vary by age and gender with men aged 18 to 40 years facing the lowest approval (79% vs. 87-88% for all other age/sex categories). Differences were also observable by district and sub-district origin of referrals, with Jenin having the highest rate of denial (19%), compared to Jericho with the lowest (10%).

Most Palestinian health care workers in the West Bank outside east Jerusalem continued to require permits to access their places of work in east Jerusalem and Israel. From 2019 to 2021, 34 staff permit applications to reach east Jerusalem hospitals were denied. Almost all (93%) recorded ambulance transfers to Jerusalem from the rest of the West Bank were required to undergo the back-to-back procedure where the patient is transferred between two ambulances at a checkpoint, demanding use of additional resources and delaying patient transit. Palestinian ambulances entering Israeli hospitals in Jerusalem faced additional hospital security checks, which were reported to be carried out regardless of medical urgency.

Communities in Area C, the Seam Zone⁸ and H2 of Hebron⁹ face substantial barriers to accessing primary care services, with dependence on expensive mobile clinics that are difficult to maintain

8. Areas in the West Bank situated between the West Bank Barrier and the Green Line (1949 Armistice Line).

9. An area of Hebron in the West Bank, under Israeli military control and Palestinian civil control. Approximately 33,000 Palestinians live in H2, alongside several hundred settlers.

and overall under-provision due to funding gaps. For mobile clinics operating in these areas, communities in the Seam Zone may only be accessible through a single point of entry/exit, such as for Arab ar-Ramadin ash-Shamali, where entry is dependent on prior permission and coordination with Israeli authorities. In more remote parts of Area C, poor infrastructure can limit access – particularly in winter – while high costs of private transport to reach health care disproportionately affect women and children, such as in Jubbet adh-Dheib in Bethlehem district.

Health attacks: Protection vulnerabilities for health care



WHO defines an attack on health care as any act of verbal or physical violence or obstruction or threat of violence that interferes with the availability, access, and delivery of curative and/or preventive health services during emergencies.¹⁰

The protracted protection crisis in the oPt contributes to vulnerability of health care to attacks, where the incidence of health attacks has correlated with peaks in occupation-related Palestinian casualties and fatalities. Between 2019 and 2021, there were 563 attacks on health care in the oPt. Two fifths (N=235; 42%) occurred in 2021, with 169 of these in the West Bank mostly associated with use of force during demonstrations and 66 in the Gaza Strip, mostly during the May 2021 escalation associated with damage to health facilities from heavy aerial and artillery bombardment. Over a third (N=200; 36%) of health attacks were in 2019, the last year of demonstrations at the Gaza fence for the Great March of Return.¹¹ Overall, four fifths (78%) of health attacks involved acts of physical violence (higher in the Gaza Strip, at 96%), while one fifth (21%) involved obstruction to delivery of health care (higher in the West Bank, at 39%). During 2019 to 2021, one health care worker was killed while providing first aid assistance in Dheisheh refugee camp in Bethlehem and there were 463 health care worker injuries recorded. In the same period, 207 ambulances were affected, including 114 damaged as the result of attacks, while 151 health facilities were affected, including 148 exposed to physical attack and damage.

There has been growing concern over the criminalization and securitization of health care, with 385 interrogations of patients and companions needing access out of the Gaza Strip and the arrest and detention by Israel at Erez (Beit Hanoun) checkpoint of 35 patients, companions, or health care workers. In 2021, a health care organization was proscribed¹² by Israel and charges of supporting terrorism brought against staff working for the organization. The proscription was issued in the context of Israel's designation of six other NGOs as 'terrorist organizations'. According to a public statement by nine EU member states who had reviewed dossiers given to them by the Government of Israel in support of the designations, they had not received "substantial information" from Israel that would justify reviewing their policy [of funding the six NGOs].

10. WHO (2022). Stopping attacks on health care. Available at: <https://www.who.int/activities/stopping-attacks-on-health-care>

11. The Great March of Return entailed frequent (approximately weekly) demonstrations by Palestinians near the fence that since 1996 has enclosed the Gaza Strip along the Green Line, or armistice line, demanding that the blockade imposed on Gaza be lifted and demanding the return of Palestinian refugees.

12. Deemed illegal.



RECOMMENDATIONS

The report by the WHO Director-General to the Seventy-fifth World Health Assembly on Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan (document A75/26) concluded with a series of recommendations to Israel, the Palestinian Authority, and the international community. The recommendations relevant to this report are reiterated in the numbered lists below (1, 2, etc.). For effective implementation, expanded technical-level recommendations are listed below some of the WHO Director-General's recommendations (under letters a, b, etc.).

To the Government of Israel:

1. **End the arbitrary delay and denial of permits for Palestinian patients** in need of essential care and ensure unhindered access for patients and their companions throughout the occupied Palestinian territory, including between the West Bank and Gaza Strip and including to all administratively divided areas of the West Bank.
 - a. Dedicate resources to ensure that no patient misses their hospital appointment due to delays in permit processing.
 - b. Patients with chronic conditions should be issued longer permits (of 6 to 12 months; currently two thirds are issued permits for a day) which cover the duration of the treatment.
 - c. The time requirement for submission of permit applications in advance of hospital appointments (currently 23 working days for non-urgent appointments) should be removed, to ensure alignment with the time according to medical need.
 - d. No child applying for a patient permit with the accompaniment of a parent should be denied that accompaniment.

- e. No patient permits should be denied on medical grounds, including grounds of urgency; the Palestinian Ministry of Health and the patient's physician should decide the appropriateness of referral according to medical need.
 - f. Patients and companions have the right to information on why they are being denied access to medical care and there should be greater accountability for instances of arbitrary delay and denial of access that have grave implications for patient health.
2. **End the arbitrary delay and denial of ambulances and health care staff** at checkpoints and the arbitrary arrest of health care workers and ensure that Palestinian health care providers can work unobstructed throughout the occupied Palestinian territory, including in east Jerusalem and including in providing immediate first aid to all persons seriously or fatally injured.
 - a. Dedicate resources to ensure that no health care staff requiring permits to access continuous professional development and training are prevented from doing so.
 - b. Ensure that no ambulances or health care staff encounter arbitrary delay by military personnel at checkpoints or by security staff on entry to Israeli hospitals.
 - c. End the interrogation of patients and companions as a prerequisite to processing permit requests.
 - d. End the arbitrary detention and arrest of health care staff.
 3. **Facilitate entry of all essential medicines and medical supplies**, including through simplification of administrative requirements and processes; ensure transparency and timely responses to requests for entry of medicines, medical supplies and equipment, particularly to the Gaza Strip; and safeguard health care providers and organizations, as well as international donors, from incurring additional costs due to administrative delays.
 4. **End discriminatory planning policies** in Area C that prevent the development of permanent and semi-permanent health care facilities and ensure access for mobile clinics.
 5. **Ensure respect for, and protection of, medical personnel and medical facilities**, as required by international humanitarian law, and refrain from acts of intimidation and the arbitrary arrest and detention of health care workers.
 6. **Ensure the independent and timely provision of health services to Palestinian prisoners**, improve prison conditions, including through adequate nutrition and care of patients in prison, and ensure that no one is subjected to torture or other cruel, inhuman, or degrading treatment or punishment.
 7. **Respect, protect and fulfil underlying social determinants of health** for Palestinians in the West Bank, including east Jerusalem, and Gaza Strip, including through ending movement restrictions, closures, and practices of demolitions and/or displacement, and refraining from the use of excessive force.

To the Palestinian Authority:

- 1. Prioritize health care expenditure** to ensure the continuity of essential health care services across the occupied Palestinian territory and urgently address indebtedness to Palestinian health care providers.
 - a. Review current systems for financing to promote sustainability and ensure the availability of essential supplies.
- 2. Implement policies and procedures to strengthen the protection** of Palestinian households against catastrophic health expenditure and impoverishment.
- 3. Simplify and streamline the referrals system** to promote accessibility and transparency for patients, including through identifying and promoting understanding and awareness of patient entitlements to essential health care services.
 - a. Integrate referral and permit application processes for patients and companions, to reduce administrative barriers to health access.
 - b. Develop public policies, strategies, and regulations for the referral system in compliance with relevant laws and regulations.
 - c. Train and build capacity of MoH staff working at different levels of the referral process.
 - d. Ensure infrastructure, equipment, resources, and technology to ensure efficient operations, and delivery of services and referrals based on established protocols.
 - e. Strengthen monitoring and evaluation of referral procedures and referral service provision, including through regular audit, and strengthen transparency and engagement of civil society to promote equity and accountability.
- 4. Promote monitoring and reporting to strengthen transparency, equity, and accountability** in health care provision to the Palestinian population in the occupied Palestinian territory, including for essential medicines and supplies, services provision, and health outcomes.
- 5. Strengthen mechanisms for identifying priorities in health sector and build multi-sectoral engagement** to address determinants of health for Palestinians and promote access and acceptability of health services.
- 6. Improve the prison conditions of all prison services** and ensure no one is subject to torture or other cruel, inhuman, or degrading treatment or punishment.

To the international community:

- 1. Promote development of the Palestinian health sector** through expanding investment in essential health services in line with strategic priorities of the Palestinian Ministry of Health and by technical support through the WHO Secretariat and its representation in the occupied Palestinian territory.
- 2. Work to protect underlying determinants of health** for Palestinians, including through investment in related sectors and the Palestinian economy.
- 3. Support efforts to strengthen the protection of Palestinians** from violations, including for Palestinian health care staff, patients, and services, and work to uphold accountability under international law.
- 4. Promote coordination at the technical level between health authorities**, and support the coordination of humanitarian interventions, to ensure the protection of health for all by all and that health services are ring fenced and de-politicized.



The occupied Palestinian territory (oPt) comprises the West Bank, including east Jerusalem, and the Gaza Strip. These areas are physically separated from one another (see Map 1). In the Gaza Strip, a barrier erected along the Green Line enclosing the Strip in the 1990s and the blockade imposed by the Government of Israel since 2007 have resulted in severe limitations on movement of people, as well as goods and services.¹³ Israel's permit regime fundamentally affects health access, controlling the passage of Palestinians from the Gaza Strip across Erez (Beit Hanoun) checkpoint and the passage of most Palestinians with West Bank identity cards¹⁴ at checkpoints to pass the separation barrier, principally to reach east Jerusalem or Israel. Administrative subdivisions in the West Bank complicate health governance and comprise Areas A and H1, Area B, Areas C and H2, and east Jerusalem.¹⁵ Israel's separation barrier in the West Bank further disconnects 9% of its land, comprising East Jerusalem and the Seam Zone, while checkpoints and an expanding settlement infrastructure limit movement between Palestinian controlled areas.¹⁶

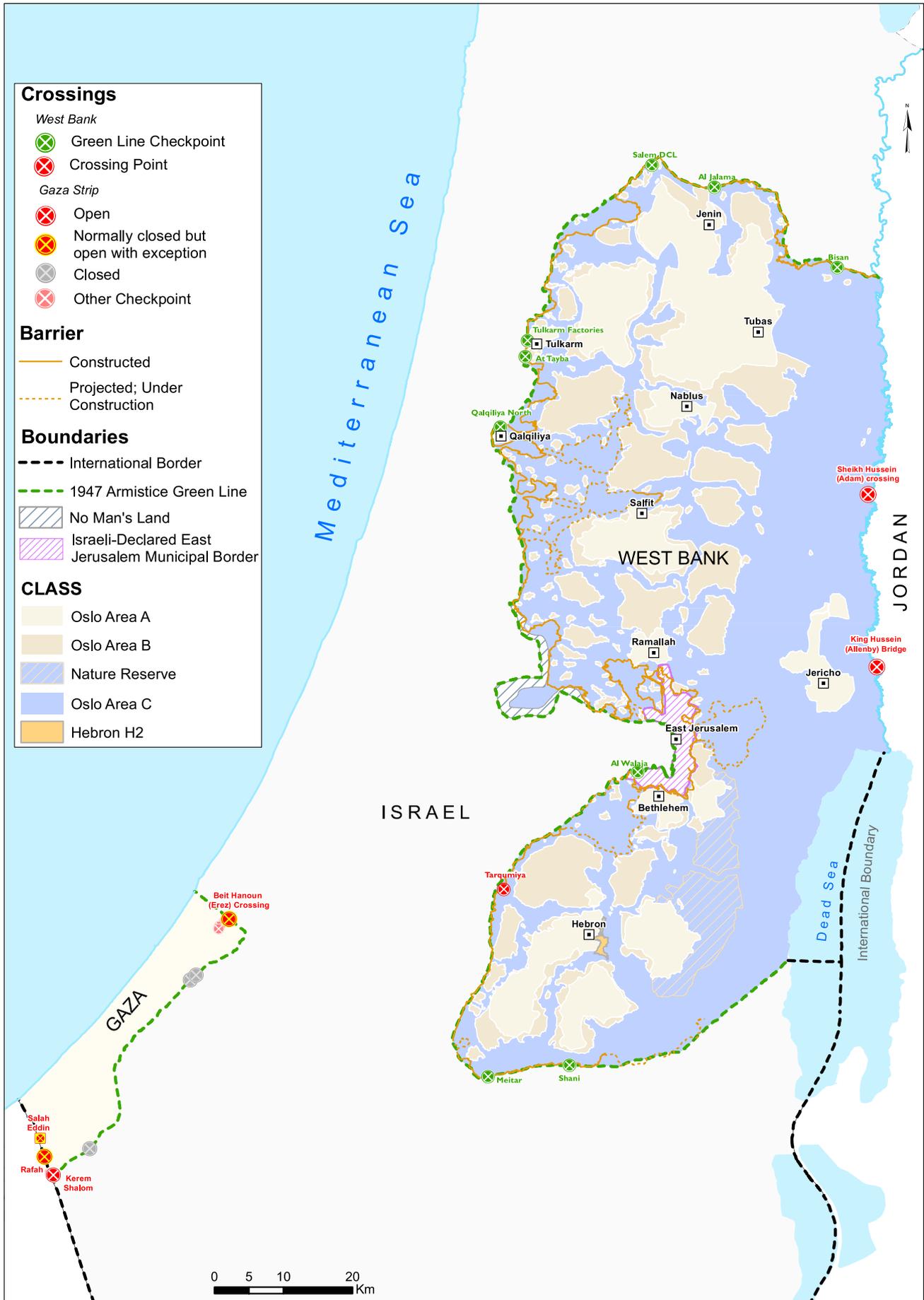
13. OCHA (2022). Gaza Strip: The humanitarian impact of 15 years of the blockade. Available at: ochaopt.org/content/gaza-strip-humanitarian-impact-15-years-blockade-june-2022.

14. Most Palestinian women with West Bank identity cards over 50 years of age and more Palestinian men over 55 years are exempted from permit requirements to pass checkpoints into east Jerusalem and Israel.

15. The 1995 Interim Agreement ("Oslo II") granted the Palestinian Authority (PA) full jurisdiction over civil affairs in Areas A and B (comprising about 40 percent of the territory and 90 percent of the Palestinian population in the West Bank). The PA also assumed full responsibility for "internal security and public order" in Area A, while in Area B it is responsible only for public order, with Israel maintaining the "overriding responsibility for security for the purpose of protecting Israelis and confronting the threat of terrorism." According to the Agreement, Area C (60 percent of the territory in the West Bank, containing all the Israeli settlements) is under full Israeli jurisdiction for civil and security matters apart from issues for which powers and responsibility have been transferred to the PA by agreement, for example, in education and health services. The city of Hebron is divided into H1 and H2 under the 1997 Hebron Protocol. H1 covers approximately 80 percent of the city and is under Palestinian civil and security control. East Jerusalem was unilaterally annexed by Israel in 1980, east Jerusalem has a population of more than 350000 Palestinians and more than 200000 Israeli settlers. For the United Nations, east Jerusalem remains occupied territory in which international humanitarian law applies.

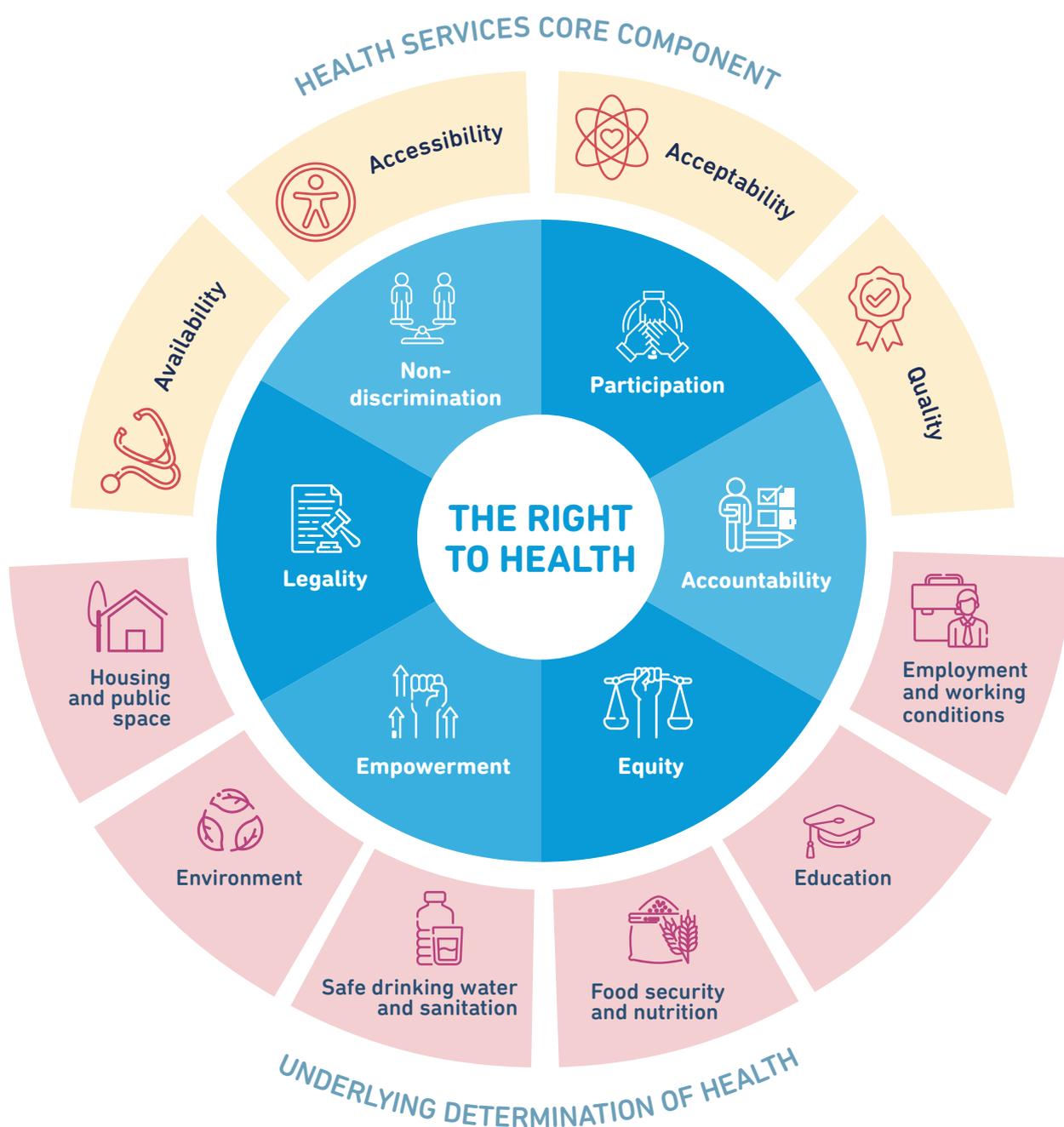
16. B'tselem (2017). The Separation Barrier. Available at: https://www.btselem.org/separation_barrier

Map 1: The occupied Palestinian territory



Realization of the right to the highest attainable standard of health and wellbeing (right to health) means ensuring the availability, accessibility, acceptability, and quality of health care, as well as safeguarding social conditions of life that determine health, including politically, economically and through legal protections. It equally means upholding core human rights principles of participation, equity, non-discrimination, and accountability in the delivery of health care, see Figure 1.¹⁷

Figure 1: The right to health



17. WHO (2022). Human Rights. Available at: <https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health>.

Methodology

This report synthesizes data regularly collected and reported by WHO, including in monthly health access reporting¹⁸ and the Surveillance System for Attacks on Health Care (SSA).¹⁹ Additional annual data were collected and analysed from key health and human rights partners, principally the Palestinian Ministry of Health, in line with key indicators relevant to availability and accessibility of health care, as health services core components of the right to health. The report focuses on the period from 2019 to 2021, building on previous annual reporting (see more recent years: 2018, 2017, 2016, 2014–2015) to examine longer-term trends, as well as disaggregation by place, age, and gender, where available, to analyse potential inequities and the differential impact of barriers to the right to health for different subsections of the Palestinian people. Data on health attacks are collected and reported according to the global SSA methodology and definitions, with systematic reporting of attacks from local partners, principally health care providers, and follow up and verification by WHO.

Responsibilities and a human rights-based approach to health

The central aim of a human rights-based approach to health is to develop the capacities of duty bearers to fulfil their obligations – specifically the obligations outlined for states in relevant international treaties – and to empower rights holders to effectively claim their health rights.²⁰

In the oPt, duty bearers for the right to health comprise Israel as occupying power; the Palestinian Authority and the de facto authority in the Gaza Strip; and third states of the international community (Box 1).^{21,22}

Box 1: Duty bearers for the right to health in the oPt

1. **Israel as occupying power** has overall responsibility for the protection of Palestinian civilians in the oPt, including ensuring respect, protection, and fulfilment of their right to health in accordance with its obligations under international law. This includes not raising any obstacles to the exercise of economic, social and cultural rights in those fields where competence has been transferred to Palestinian authorities.
2. The **Palestinian Authority** has responsibilities to the extent of its jurisdiction, including ensuring equitable provision of health care in the West Bank and Gaza Strip.
3. Hamas, as **de facto governing authority** in the Gaza Strip, has the responsibility to fulfil administrative governmental functions, including those applicable to health care.
4. **Third states of the international community** have a responsibility to promote human rights and High Contracting Parties to the Geneva Convention relative to the Protection of Civilian Persons in Time of War have duties to ensure the respect for its provisions by Israel, the occupying power, and other parties.

18. WHO (2022). Monthly report on health access:

<https://www.emro.who.int/opt/information-resources/monthly-report-on-health-access.html>.

19. WHO (2022). Surveillance System for Attacks on Health Care: <https://extranet.who.int/ssa/Index.aspx>.

20. OHCHR & WHO (2009). A Human Rights-Based Approach to Health. Available at:

https://www.ohchr.org/sites/default/files/HRBA_HealthInformationSheet.pdf.

21. Human Rights Council, 37th Sess, Report of the Special Rapporteur on the situation of human rights in the Palestinian territories occupied since 1967, Agenda item 7, UN Doc A/HRC/37/75 (15 March 2018)

22. United Nations General Assembly, 72nd Sess, Resolution 72/85, UN Doc A/Res/72/85 (7 December 2017)

General obligations for the right to health include demonstrating steps taken towards the progressive realization of improved population health through use of maximum available resources, while ensuring non-retrogression (no worsening of health indicators) and non-discrimination.²² Overall, obligations of duty bearers for the right to health fall into categories of:



Respect, i.e. refraining from actions that would be harmful to health rights



Protect, i.e. take steps to actively prevent harm from third parties



Fulfil, i.e. take steps to actively promote the health of populations under their effective control

Under the International Covenant on Economic, Social and Cultural Rights, core minimum obligations on duty bearers for the right to health include ensuring non-discriminatory access to and equitable distribution of health facilities, goods, and services; provision of essential medicines; adoption and implementation of a national public health strategy; and access to minimum essential food, safe and potable water, basic shelter, housing, and sanitation.²³ For third states of the international community, specific obligations include “to take steps, individually and through international assistance and cooperation, especially economic and technical, towards the full realization of ... the right to health.” In that regard, States parties “have to respect the enjoyment of the right to health in other countries, and to prevent third parties from violating that right in other countries, if they are able to influence these third parties by way of legal or political means, in accordance with the Charter of the United Nations and applicable international law.”²⁴



23. Core minimum obligations as outlined in General Comment 14 by the Committee on Economic, Social and Cultural Rights: <https://digitallibrary.un.org/record/425041?ln=en>.

24. General Comment 14, CESCR

Social determinants of health and health inequities in the oPt

Health inequities are systematic and unjust differences in health outcomes between different populations, resulting from the political, economic, and social conditions in which people are born, grow, live, work and age.²⁵ Structural determinants of health inequities relate to systems of governance and policies that produce social stratification according to classifications such as race, nationality, class, gender, and disability. These structures determine differential exposure to intermediary ('down-stream') determinants of health that include material living conditions, including food, nutrition, water and sanitation, housing, environmental conditions, and exposure to violence. Such structurally produced differences have a cumulative impact on health throughout the course of a person's life.²⁶

Life expectancy for Palestinians in the oPt in 2021 was 74.2, higher for girls and women than boys and men and higher in the West Bank than Gaza Strip.²⁷ In the West Bank in 2020, life expectancy of Palestinians was lower than that of Israeli settlers (75.6 years vs. 85.2 years for women; 73.3 years vs. 81.6 years for men).²⁸

The infant mortality rate across the oPt in 2020 was 12 deaths per 1000 live births, although the rate for infants born in Palestinian refugee camps was significantly higher (17 per 1000). Gender differences are also evident: the under-five mortality for Palestinians in 2020 was 16 per 1000 live births for boys and 12 per 1000 for girls.²⁹ In the same year in Israel, infant mortality and under-five mortality rates were significantly lower overall, at 3 per 1000 and 4 per 1000, respectively.³⁰

In the oPt, the application of a dual legal and political system governing the rights and lives of Israeli settlers and Palestinians inhabiting the same territory represents a fundamental structural determinant contributing to observed health inequities.³¹ Within this context, determinants of health inequities and humanitarian health needs are driven by policies of territorial fragmentation; political division; implementation of a permit regime; blockade of the Gaza Strip; physical obstacles to movement, restrictive planning policies, and home demolition in the West Bank; and protection gaps affecting Palestinian communities and health care.³² This report acknowledges the important impact of structural determinants while focusing on intermediate determinants of health inequities that constitute measurable differences in living conditions, including those affecting access to and protection of health care.

Life expectancy in years

	oPt	73.3
	Israel	81.6
	oPt	75.6
	Israel	85.2

Infant and Child Mortality (per 1000 live births)

	oPt	12
	Israel	3
	oPt	15
	Israel	4

25. WHO, 2017. 10 facts on health inequities and their causes. Available at:

<https://www.who.int/news-room/facts-in-pictures/detail/health-inequities-and-their-causes>

26. WHO, 2010. A Conceptual Framework for Action on the Social Determinants of Health

27. Palestinian Health Information Center of the Ministry of Health, 2022. Health Annual Report:

Palestine 2021; Female life expectancy 75.4 years (75.7 in West Bank; 75.0 in Gaza Strip); male life expectancy 73.2 years (73.5 years in West Bank; 72.5 years in Gaza Strip); Palestinian Central Bureau of Statistics (2022), Summary of Demographic Indicators in the Palestine by Region. Available at: https://www.pcbs.gov.ps/statisticsIndicatorsTables.aspx?lang=en&table_id=1228

28. Central Bureau of Statistics (Israel). Life expectancy, by sex, religion and population group. Available at: https://www.cbs.gov.il/he/publications/doclib/2021/3.shnatonhealth/st03_05.pdf

29. UNICEF, 2021. Children in the State of Palestine: Child development data from the 2019/2020 multiple indicator cluster survey. Available at: www.unicef.org/sop/media/1681/file/Children%20in%20the%20State%20of%20Palestine.pdf

30. World Bank (2022). Mortality rate, infant (per 1,000 live births). Available at: <https://data.worldbank.org/indicator/SP.DYN.IMR.IN>; World Bank (2022). Mortality rate, under-5 (per 1,000 live births). Available at: <https://data.worldbank.org/indicator/SH.DYN.MORT>.

31. Human Rights Council, 49th Sess, Report of the Special Rapporteur on the situation of human rights in the Palestinian territories occupied since 1967, Agenda item 7, UN Doc A/HRC/49/87 (21 March 2022)

32. OCHA (2022). Humanitarian Needs Overview: oPt. Available at: <https://www.ochaopt.org/content/humanitarian-needs-overview-2022>

COVID-19 and the right to health in the oPt

The COVID-19 pandemic profoundly affected the right to health of populations across the world, laying bare global health inequities through the disproportionate impacts on poorer communities, persons more vulnerable due to existing illness or age, and essential workers, including frontline health staff, experiencing greater risk of exposure and contracting more severe strains of the virus. Immediate concerns for the fragility and limited capacity of the Palestinian health system to cope with surges in critical cases contributed to strict and early limitations on movement by the Palestinian Authority and de facto authority in Gaza, to reduce potential spread and the burden on health facilities during successive peaks in COVID-19 incidence. Health inequities were starkly apparent in the differential access for Palestinians to COVID-19 vaccines, following rollout, prompting reiteration of international legal obligations on Israel regarding provision of essential health services and protection of public health in the oPt.^{33,34} Additional limitations on movement exacerbated many of the barriers to health care access outlined in this report. Meanwhile, balancing individual and collective rights – including upholding the Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights³⁵ – was constrained by structural limitations of occupation, fragmentation of responsibilities, lack of democratic accountability, and pre-existing arbitrary restrictions on movement.



33. OHCHR (2021). Israel/OPT: UN experts call on Israel to ensure equal access to COVID-19 vaccines for Palestinians. Available at: <https://www.ohchr.org/en/press-releases/2021/01/israelopt-un-experts-call-israel-ensure-equal-access-covid-19-vaccines>

34. Diakonia, 2021. COVID-19 and IHL. Available at : <https://www.diakonia.se/ihl/thematic-focus/ihl-covid19/>

35. American Association for the International Commission of Jurists. Siracusa Principles on the Limitations and Derogation Provisions in the International Covenant on Civil and Political Rights. Available at: <https://www.icj.org/wp-content/uploads/1984/07/Siracusa-principles-ICCPR-legal-submission-1985-eng.pdf>



HEALTH SERVICES AVAILABILITY: Challenges to sustainable provision and equity

In the occupied Palestinian territory, structural barriers to sustainable provision of health care arise from limitations on economic development; high levels of unemployment; lack of control over customs revenues and the movement of population and goods; and fragmentation of territory and responsibilities for health services provision, see Figure 2.³⁶ During 2019 to 2021, services provision was severely affected by successive fiscal crises, which affected all main health expenditures of the MoH: referrals to non-public providers (37.5% of expenditure in 2021); salaries (37.2%); and provision of medicines and supplies (19.4%).³⁷ Inefficiencies affecting public sector expenditure, particularly with regards procurement of outside medical referrals (including higher costs of services compared with the public sector and inconsistencies in pricing and contracting) also pose a challenge to sustainable provision. There are limited mechanisms for promoting participation, empowerment, and accountability in the health sector.

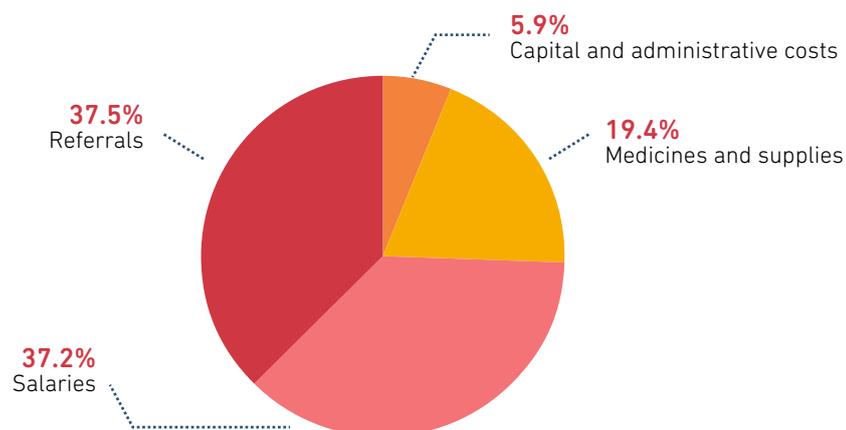
Despite substantial obstacles, indicators of health care availability for the oPt are similar – and some instances favourable – compared to neighbouring Jordan and Egypt, see Figure 2. For instance, the oPt has a higher density of primary care clinics than Egypt (1.6 vs. 0.6), though a considerably lower density compared to Jordan (7.0). On all example indicators except for the density of pharmacists and mammography services, however, the oPt has lower capacity compared to the occupying power, Israel. Meanwhile, there are significant differences in availability indicators between the West Bank and Gaza Strip.

36. 75th World Health Assembly (2022). Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan. A75/26. Available at: https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_26-en.pdf

37. Palestinian Ministry of Health, 2022. Health Annual Report for Palestine 2021, p188.

Figure 2: Public expenditure and indicators of health care availability

Main expenditures of MoH



West Bank	Gaza	Egypt	Jordan	Israel
2021	2021	2019	2019	2020

Facility density

(per 10000 population)



	West Bank	Gaza	Egypt	Jordan	Israel
Primary care facility	2.2	0.8	0.6	7	-
Hospital bed density	14.6	12.4	14.3	14	29.8 (2018)

Health workforce density

(per 10000 population)



	West Bank	Gaza	Egypt	Jordan	Israel
Physician	25.7	15	8.2	27	36.26
Nurse and midwife	36.4	21.7	15.5	32.8	119.9
Dentists	13.1	1.1	2.1	6.7	11.7
Pharmacists	17.5	16.3	4.9	11.3	9.89

Medical devices density

(per million population)



	West Bank	Gaza	Egypt	Jordan	Israel
Computed tomography	-	-	-	5.5	9.88
Radiotherapy	-	-	0.8 (2017)	0.8	4.12
Magnetic resonance imaging	-	-	-	2.1	5.53
Mammography	-	-	-	129.1	10.9

Gaps in the public health care provision

The Palestinian health sector consists of four main health service providers: the Ministry of Health (MoH), the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), NGOs and for-profit providers. The MoH provides most health services, especially primary and secondary care, through a network of governmental primary health care centres and hospitals. The MoH also offers tertiary health services and purchases services from other hospitals and medical centres, including non-profit Palestinian hospitals in east Jerusalem.

Gaps in public health care drive dependence on referral to non-public (outside) providers primarily located in both the oPt, as well as in Israel, Egypt and Jordan. These gaps include lack of available and trained staff – particularly for certain specialties or sub-specialties – and shortages in essential medicines, supplies, and medical equipment. Functional needs to strengthen public health care provision and reduce dependence on outside referrals include building MoH capacities and resources for supply chain management for medicines and equipment – specifically for medical imaging and diagnostics;³⁸ defining the package of essential services provided by the Palestinian MoH for improved patient understanding of entitlements; and enhancing systems for upholding transparency and equitability in provision, particularly for referrals.

Shortages of essential medicines persisted in 2019 to 2021, disproportionately affecting the Gaza Strip. During the three years, there was an average monthly availability of 90% for essential medicines in the Central Drugs Store (CDS) of the MoH in the West Bank. There was, however, a significant drop in availability in the West Bank during the period, declining from 97.0% average availability for 2019 to 85.7% in 2020 and 87.1% in 2021 (see Chart 1). Meanwhile, the CDS of the MoH in the Gaza Strip consistently reported lower monthly availability of essential medicines (defined as more than a month's supply of stock remaining),³⁹ which averaged 55% over the three years. The lowest annual availability was in 2019, when the monthly average was 52%. The discrepancies in availability of essential medicines between the West Bank and Gaza Strip point to the need for strengthening supply chains and systems for upholding equity among the affected Palestinian populations.

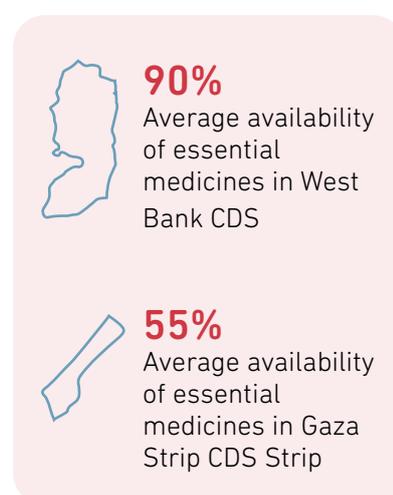
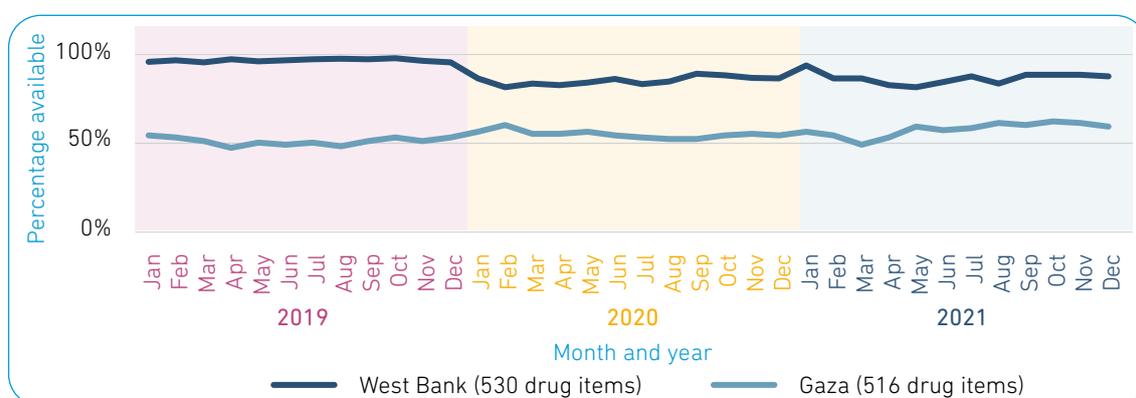


Chart 1: Availability of essential medicines at the Central Drugs Stores in the West Bank and Gaza Strip, 2019 to 2021



38. World Bank (2021). Towards Effective Chronic Case Management: Improving the Efficiency of Outside Medical Referrals in West Bank and Gaza. Available at: <https://openknowledge.worldbank.org/bitstream/handle/10986/37264/P17354106933170e08f75037bb896706d0.pdf?sequence=1&isAllowed=y>

39. The inverse of 'zero stock' (less than a month's stock remaining at monthly stock takes). This approximates complete depletion: in 2019, 42% of essential medicines were completely depleted at the time of monthly stock takes, compared to 48% with less than a month's supply remaining.

Referral system of the Palestinian Ministry of Health

The Palestinian MoH has created a system of medical referrals to compensate for shortages in governmental health institutions, whether shortage of specialties, medical expertise, equipment, supplies, or medical facilities. Any patient requiring referral services must first be seen by a medical professional working within a Palestinian MoH facility. The patient can then be referred to the medical and financial committees of the Services Purchasing Unit (SPU) if the service they require is not available in Palestinian MoH hospitals due to lack of qualified personnel, drugs, equipment, or medical devices and they meet requirements according to the legal framework for health insurance and outside medical referral stipulated in Cabinet Decision 11 of 2006. This Decision constitutes the basic regulatory reference for financial coverage of referral procedures related to public health insurance. The following criteria are used to determine whether a patient is entitled to referral:

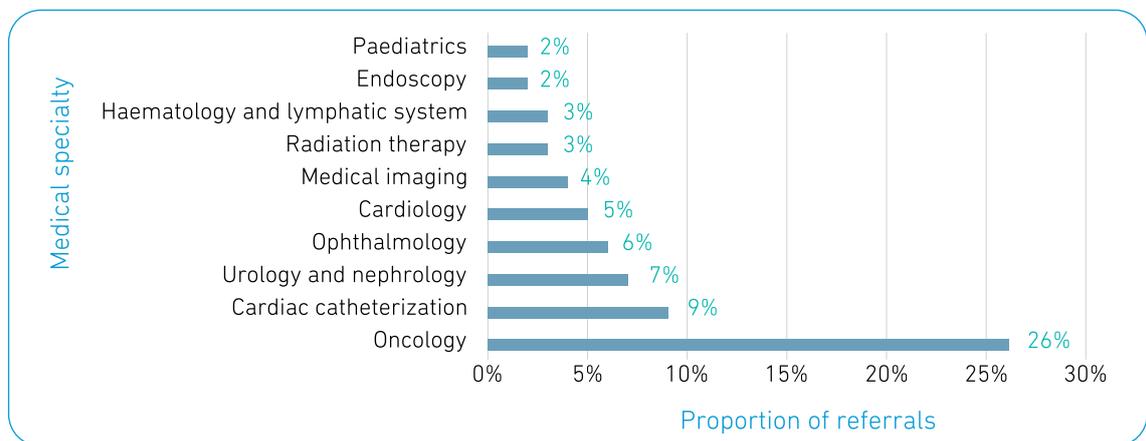
-  The required service is unavailable in Palestinian MoH facilities.
-  There is lack of resources and equipment needed to provide care.
-  There is lack of beds due to high occupancy rates.
-  Waiting lists for a procedure exceed six months, for non-emergency cases.
-  There is approval by the referral committee of recommendations proposed by public providers, outlined in standardized referral forms.
-  There is a situation where emergency treatment is required, where medical care is essential and provided through established and appropriate referral pathways.

Top three medical reasons for referral

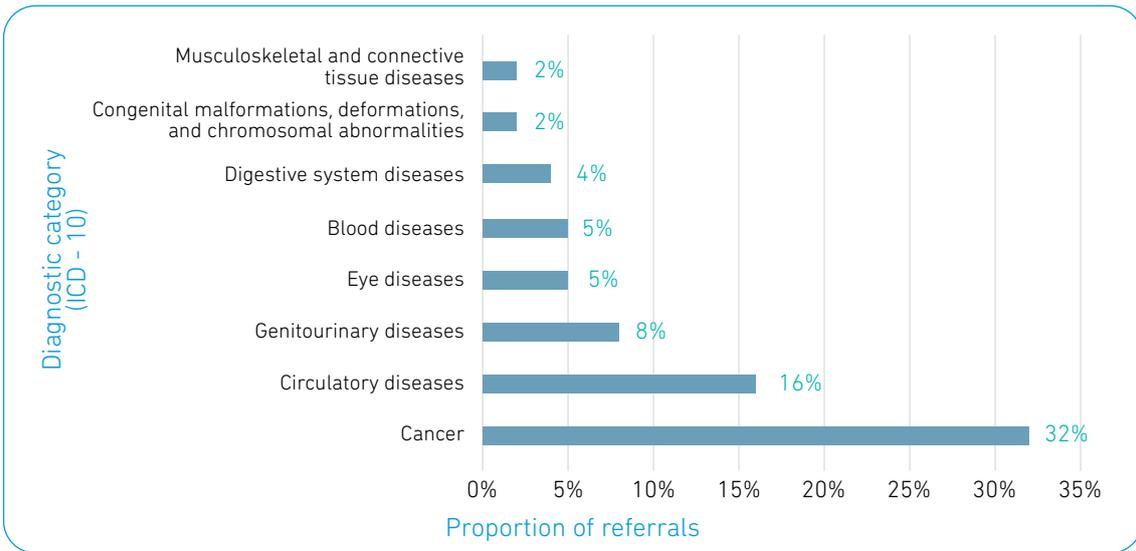
-  **26%**
Oncology
-  **9%**
Cardiac catheterization
-  **7%**
Urology and nephrology

Once the patient is approved referral, there is commitment to pay an established percentage of the total treatment cost, as stipulated under the health insurance law and other cabinet decisions. The MoH arranges the referral appointment with nongovernmental and private providers in the oPt, or providers outside the oPt, according to the health care entitlements guaranteed to the Palestinian population in the West Bank and Gaza Strip. Some of the medical and diagnostic needs for referrals from 2019 to 2021 are outlined in Chart 2. Oncology remained the single largest reason for referral, while leading primary diagnoses referred (by major International Classification of Disease-10 categories) included cancer, circulatory diseases, and genitourinary diseases.

Chart 2: Top reasons for referral by medical specialty and diagnostic category, 2019 to 2021⁴⁰



40. Data for diagnostic categories was only available for June 2019 to December 2021

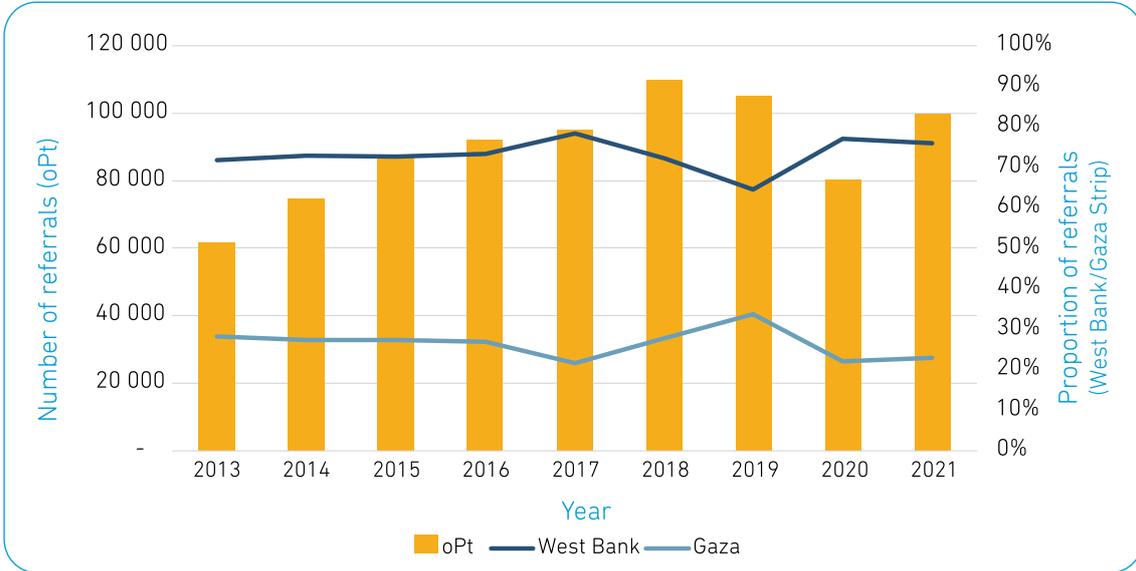


 **284 601**
Referrals to outside providers of health care over three years

 Percentage reduction in referrals from 2019 to 2020
51% ↓
Gaza Strip
8% ↓
West Bank

From 2019 to 2021, there were 284 601 referrals issued by the Palestinian MoH to outside providers of health care. In 2020, there was a substantial (24%) reduction in referrals issued compared to the previous year, in the context of increased restrictions on movement during the COVID-19 pandemic and the cessation of coordination between the Palestinian Authority and Israel from May to November. By 2021, the number of referrals had significantly recovered. The reduction in referrals in 2020 disproportionately affected the Gaza Strip, where referrals declined by 51% compared to an 8% decline in the West Bank. The proportion of referrals issued for patients from the Gaza Strip decreased from 34% of total referrals for the oPt in 2019 to 22% in 2020, a trend that continued in 2021 (23% of oPt referrals were from the Gaza Strip). Overall, during the three years, just over a quarter (27%) of referrals were issued for patients from the Gaza Strip, where Gaza’s population represents approximately 40% of the total, see Chart 3.

Chart 3: Total number of annual referrals and proportion of referrals for patients from the Gaza Strip compared to the West Bank, 2013 to 2021



Age and gender disaggregation for referrals

From available disaggregated data from June 2019 to December 2021, 46% of referrals were for female patients. The proportion of female referrals was higher for East Jerusalem (57%) and lower for the rest of the West Bank (44%), while it was the same for the West Bank overall and the Gaza Strip (46%). For the same period, the age distribution of referrals was bimodal: there is a peak at 10% for the under-five age group and again at 10% in the 55 to 59-year-old age group, see Chart 4. Overall, 21% of referrals were for children under 18 years and 19% were for persons aged 65 and over.



46%

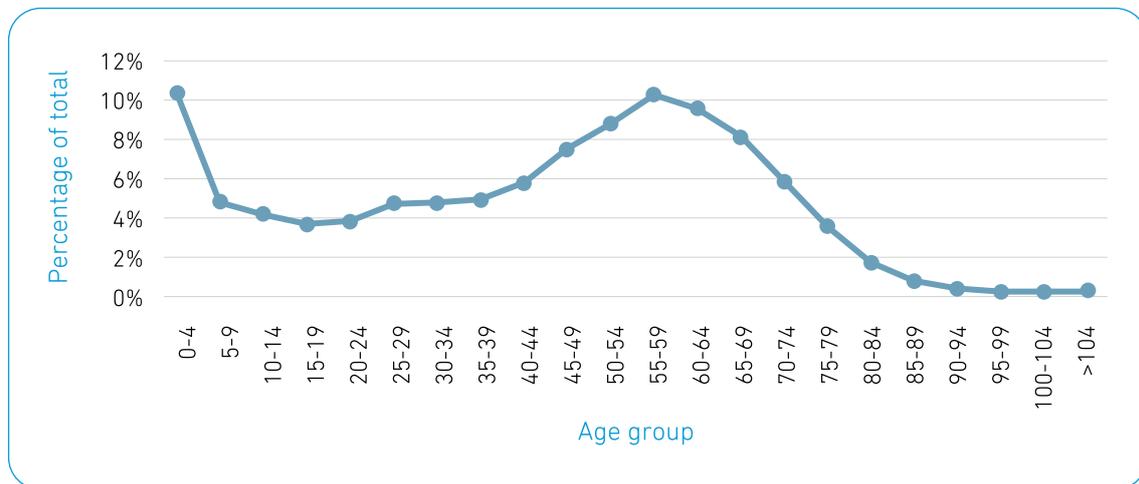
Of referrals were for female patients



21%

Of referrals were for children

Chart 4: MoH referrals by age group from June 2019 to December 2021

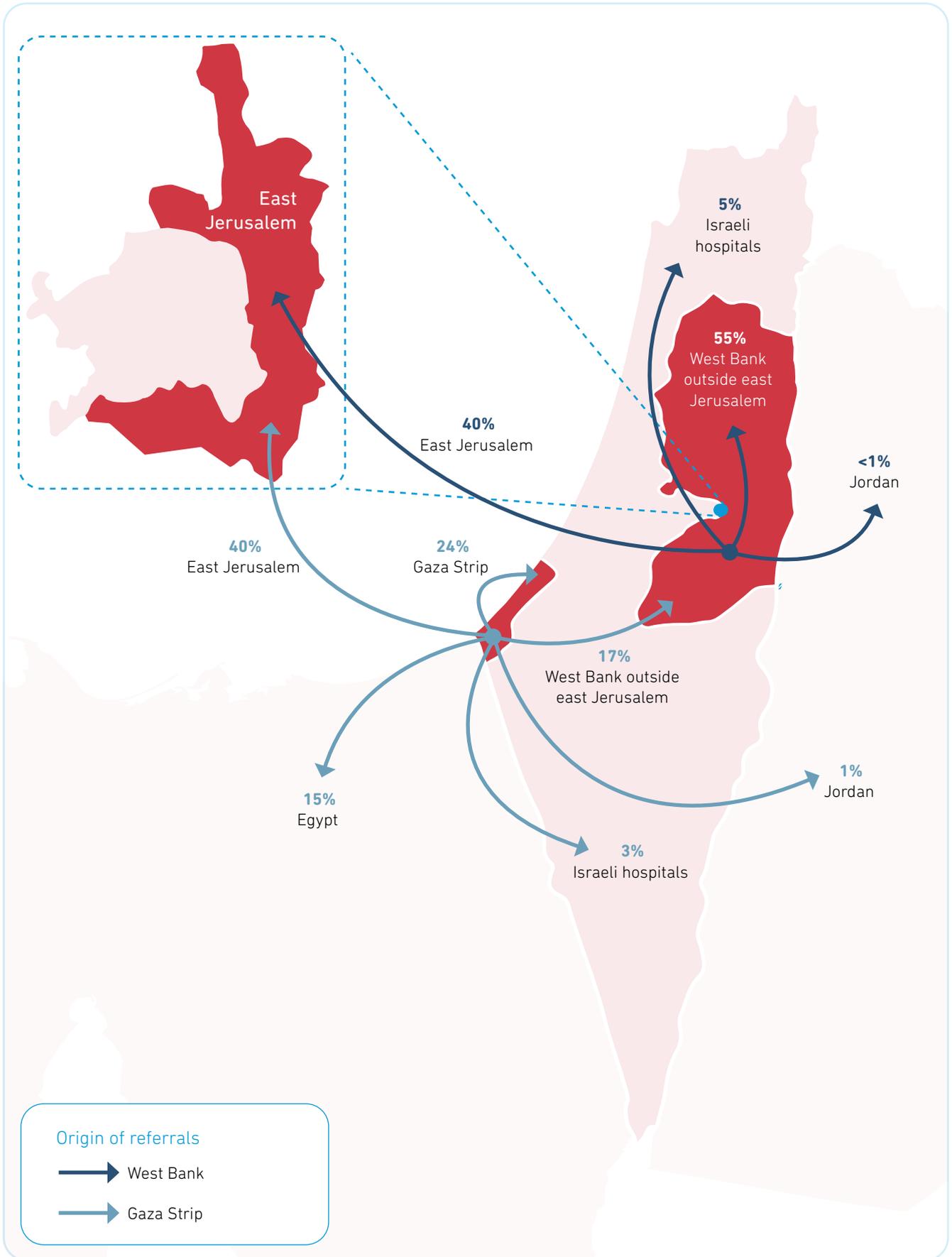


Destination, type, and cost of referrals

Referral destinations

The destination of referrals differs according to their origin in the West Bank or Gaza Strip and varies according to referral need, see Figure 3. A larger proportion of referrals from the West Bank were to facilities within the West Bank, including east Jerusalem (95%; 40% specifically to east Jerusalem) compared to referrals from the Gaza Strip (57% of referrals to the West Bank including east Jerusalem; 40% specifically to east Jerusalem).

Figure 3: Origin and destination of outside medical referrals by the Palestinian MoH, 2019 to 2021



In 2020, with exacerbated restrictions on movement, there was an increase in the proportion of referrals from the West Bank to non-MoH hospitals within the West Bank outside east Jerusalem, which continued in 2021. Similarly, a larger proportion of referrals from the Gaza Strip were within the Gaza Strip in 2020, to non-governmental and private referral facilities, though this trend reversed in 2021. There was also a decline in the proportion of referrals issued for east Jerusalem from the Gaza Strip, from 50% in 2019 to 36% and 35% in 2020 and 2021, respectively.

Reduced referrals to east Jerusalem and increased referrals to the rest of the oPt since 2019

The top destination for referrals from the West Bank were An-Najah University Hospital in Nablus (19%), Augusta Victoria Hospital (AVH) in east Jerusalem (17%), Al Ahli Hospital in Hebron (9%), Al Makassed Hospital in east Jerusalem (8%), and Istishari Hospital in Ramallah (7%). For referrals from the Gaza Strip, the top destination institutions were AVH (27%), Amana Specialized Medical Centres in Egypt (12%), Al Makassed (11%), Al Hayat Specialized Hospital in Gaza (11%), and An-Najah University Hospital (8%).

Referral costs and types

Average annual expenditure on referrals from 2019 to 2021 was 922.7 million NIS (around US\$ 280 million),⁴¹ highest for 2021 and lowest for 2020. Expenditure per referral, meanwhile, was 9774 NIS (around US\$ 3000) for the three years. The highest expenditure per referrals was in 2020, when there was a reduction in total referrals and overall higher severity of cases, while 2019 had the lowest expenditure per referral, see Table 1.

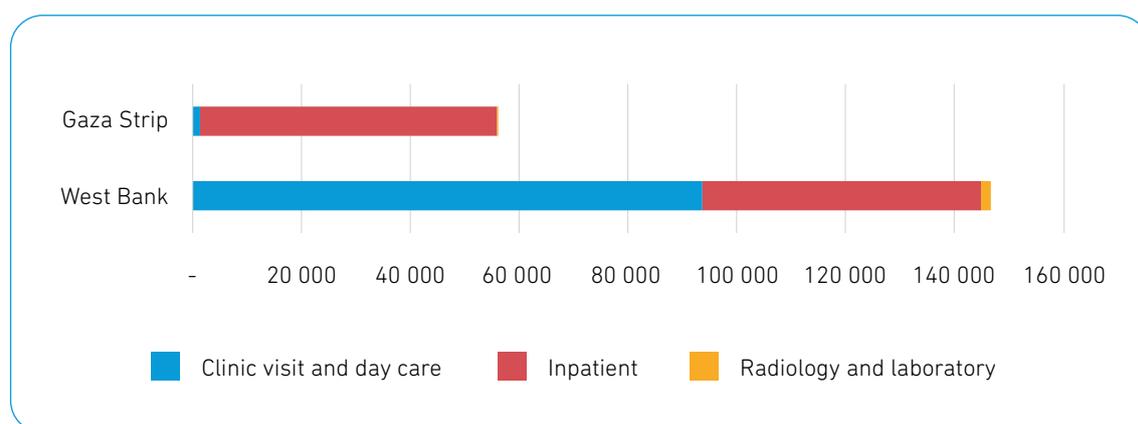
Table 1: Expenditure on referrals, 2019 to 2021

Year	Number of referrals	Expenditure on referrals (million NIS)	Expenditure on referrals (approx. million US\$)	Expenditure per referral (NIS)	Expenditure per referral (approx. US\$)
2019	104 881	967.6	297	9225	2840
2020	80 020	825.7	254	10 319	3170
2021	99 700	974.8	300	9777	3000
Annual average (mean)	94 867	922.7	284	9774	3000

41. Palestinian Health Information Center of the Ministry of Health, 2022. Health Annual Report: Palestine 2021. Using exchange rate on 26 August 2022

The type of referral issued for patients from the Gaza Strip significantly differs to those issued for patients from the West Bank, see Chart 5. Between June 2019 and December 2021, 97% of referrals from the Gaza Strip were for inpatient services, while in the West Bank inpatient referrals comprised 35% and clinic visits and day care comprised 64% of the total. Greater restrictions on access for patients from the Gaza Strip may be a factor in the increased reliance on inpatient referrals.

Chart 5: Type of referral from the West Bank and Gaza Strip, Jun 2019 to Dec 2021



A significant factor in understanding expenditure differences is the average cost by referral destination and the expenditure per type of referral – with inpatient referrals costing more on average than clinic visits, day visits, or attendance for radiology or laboratory investigation. Investigation by the World Bank of data from 2013 to 2019 found that inpatient referrals accounted for 66% of referrals and 70% of referral expenditure.⁴² Table 2 shows the average cost per referral by destination, according to the same report, with expenditure on referrals to Israeli institutions nearly 5 (4.9) times higher than expenditure for referrals within the Gaza Strip.⁴²

Table 2: Average expenditure per referral by destination⁴²

Destination of referral	Average cost (approx., NIS)	Average cost (approx., US\$)
Israel	38 000	11 700
Egypt	21 000	6 460
West Bank outside east Jerusalem	9 500	2 920
East Jerusalem	8 400	2 580
Gaza Strip	7 700	2 370

42. World Bank (2021). Towards Effective Chronic Case Management: Improving the Efficiency of Outside Medical Referrals in West Bank and Gaza. <https://openknowledge.worldbank.org/handle/10986/37264>

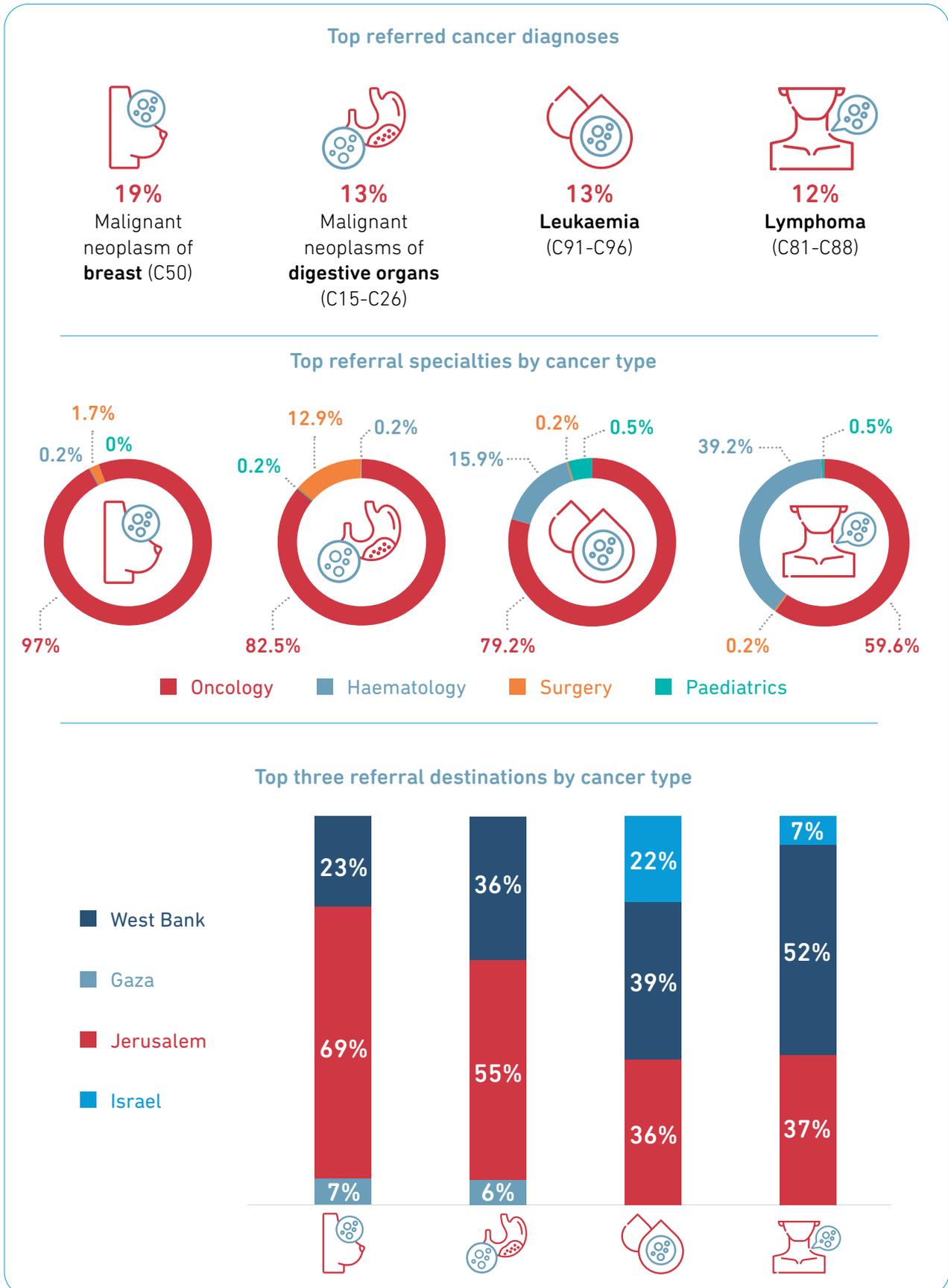
Referral pathways for cancer care

Cancer comprises the single largest reason for the referral of patients to outside health care providers by the MoH, with oncology services accounting for 26% of all referrals for the oPt from 2019 to 2021 and 31.5% of referrals for patients with a primary diagnosis of cancer⁴³. Figure 4 provides further details of referral pathways for cancer care in the oPt, from 2019 to 2021.



43. Available data for ICD-10 diagnostic categories was from June 2019 to December 2021.

Figure 4: Referral pathways for cancer patients from the Gaza Strip requiring Israeli-issued permits to reach health care





HEALTH ACCESS: Barriers affecting the Gaza Strip

In the Gaza Strip, the blockade since 2007 has left two points of land entry/exit for people, through Beit Hanoun (Erez) checkpoint in the north to reach the West Bank, as well as Israel and Jordan, and via Rafah border terminal to Egypt in the south of the Gaza Strip. Closures were made possible by Israel's completion of a fence in the 1990s along the Armistice Line, with restrictions on access 500m from the fence into Gaza and a 'high risk' zone extending a further 1500m into Gaza. To reach the rest of the occupied Palestinian territory (West Bank, including east Jerusalem), Israel, or Jordan, Palestinians from the Gaza Strip must apply for an Israeli permit to cross the checkpoint at Beit Hanoun (Erez). Groups eligible in 2020 to apply for permits to exit the Gaza Strip via Erez/Beit Hanoun included patients, their companions, and health care workers.

The outcome of applications for patient and companion permits is decided by Israeli authorities, while the Health Liaison Office (HLO) of the Palestinian Authority in the Gaza Strip coordinates to submit applications to Israel on behalf of patients and companions. To obtain a health-related permit, patients and their companions in the Gaza Strip must attend the office of the HLO, where they are required to submit: a copy of the patient's medical report; a copy of their hospital appointment; a pledge of financial coverage for their appointment; the patient's ID details and functioning telephone number; and the companion's ID details and functioning telephone number. During 2020 and 2021, patients and companions were also required to submit documentation of their COVID-19 status. Permits are classified as lifesaving, urgent and non-urgent. Since 2017, Israel more than doubled the required time for submission of non-urgent applications from 10 to 23 working days prior to the patient's hospital appointment. Meanwhile, Israel should process urgent applications within 48 hours, while lifesaving applications can be dealt with in a matter

of hours. The large discrepancy in processing times for urgent/non-urgent requests exacerbates bureaucratic obstacles, where medical need may frequently require an appointment date between 48 hours and 23 working days. In practice, there is no maximum period for processing a permit application, and patients and companions can be engaged in the application process for months without receiving any definitive response.

Permit requirements



A copy of the patient's medical report



A copy of their hospital appointment



A pledge of financial coverage for their appointment

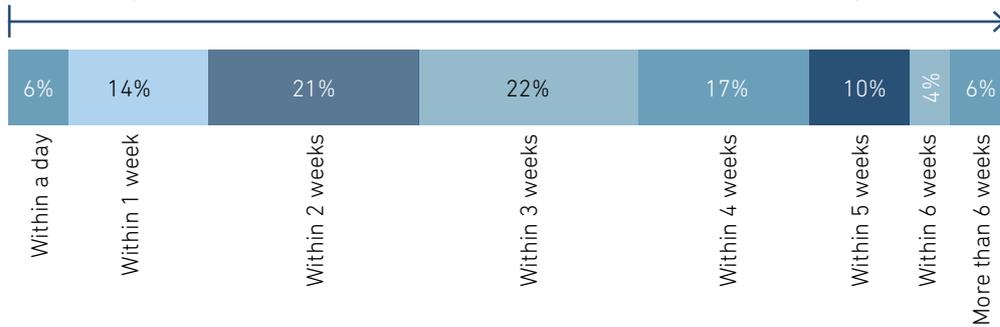


The patient's ID details and functioning telephone number

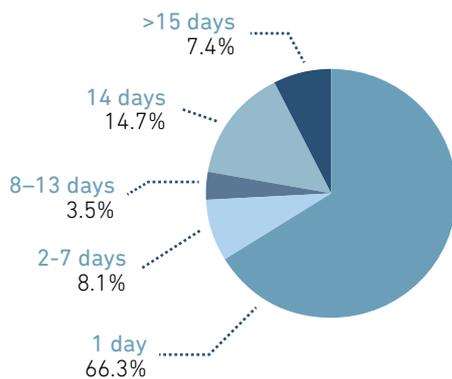


The companion's ID details and functioning telephone number

Processing time by Israeli authorities (from application date to receiving a response)



Duration of permits (2019–2021)

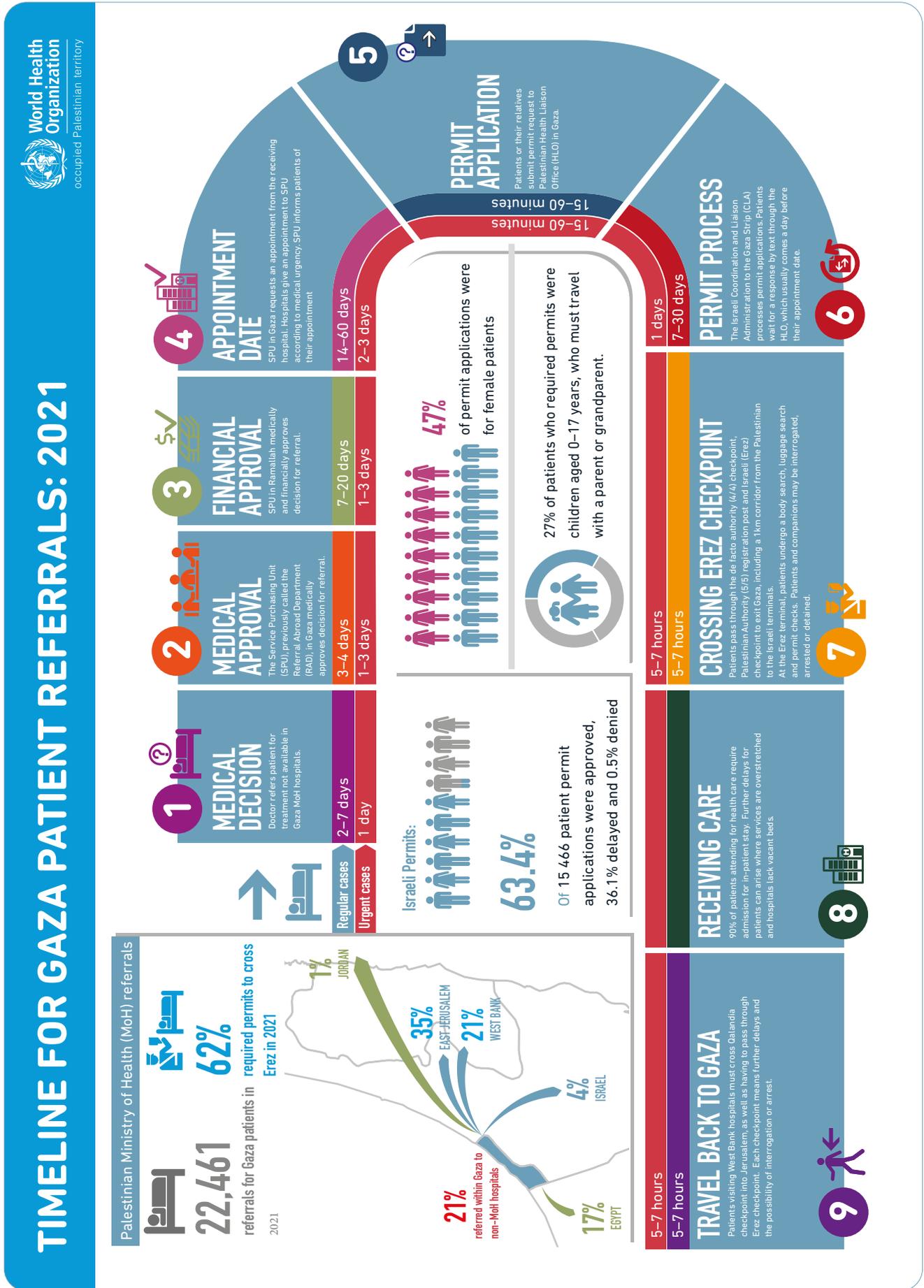


Patient permits

Ninety per cent of permit applications from the Gaza Strip between 2019 and 2021 were for services funded by the Palestinian Ministry of Health. Figure 5 outlines the stages needed for patients to be referred to services outside the Gaza Strip. From 19 May to 23 November 2020, the Palestinian Authority stopped coordination with the Government of Israel due to its threatened annexation of Area C, along with the submission and coordination of permit applications through the Health Liaison Office and the General Authority of Civil Affairs. During this period, a combination of NGOs, hospitals, ICRC and WHO submitted permit applications on behalf of Palestinian patients from the Gaza Strip. No data on permit applications and outcomes were provided by the HLO during this period, with WHO collecting data instead from different nongovernmental and international organizations who stepped in to coordinate permits. From 6 September to 23 November, WHO administered a temporary coordination mechanism directly and recorded outcomes of permits submitted through this mechanism, which was integrated with referral applications to the Services Purchasing Unit (SPU).



Figure 5: Timeline and access for Gaza patients to cross Erez checkpoint 2021



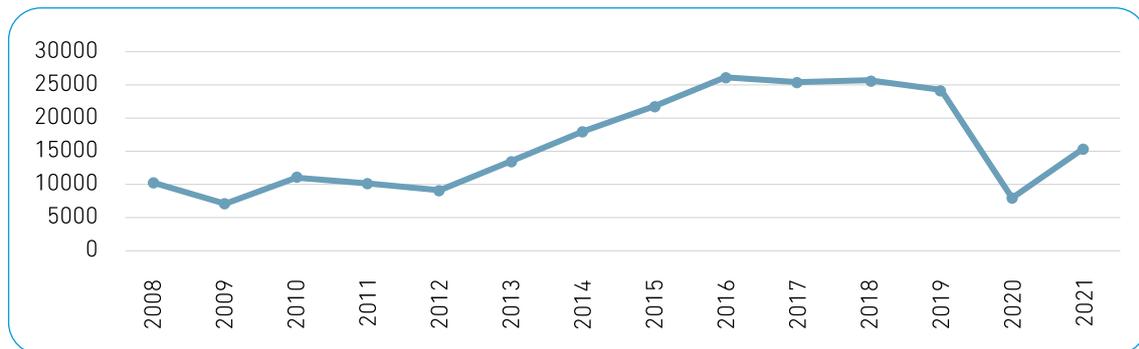
Total number of patient applications



67%
Decline in patient permit applications in Gaza from 2019 to 2020

From 2019 to 2021, there were 47 887 patient permit applications from the Gaza Strip. In 2020, there was a substantial (67%) decline in patient permit applications (see Chart 6) in the context of increased movement restrictions during COVID-19 and the end to permit applications by the Palestinian Authority to Israel between May and November. In 2021, the number of patient permit applications increased to 15 466, still 36% below the number submitted for 2019.

Chart 6: Annual patient permit applications to Israeli authorities from the Gaza Strip, 2008 to 2021



65%
Of patient permit applications to exit Gaza approved

Approval, delay, and denial of patient permits

From 2019 to 2021, the average approval rate by Israeli authorities for patient permit applications was 65%, according to data collected by the Palestinian HLO, WHO, and other civil society organizations. The approval rate was higher in 2020 (68%) in the context of considerably reduced applications and a higher proportion of urgent applications, and lower in 2021 (63%). The largest

sustained decline in approval of patient permit applications occurred between 2012 (94%) and 2017 (54%), see Chart 7. The highest proportion of patient permit applications denied before their hospital appointments was in 2019 (9%), subsequently reducing to a low of 0.5% in 2021. In all years, most non-approved patient permit applications have been due to delays, where patients receive no definitive response to their application by the date of their hospital appointment. In 2020, delays comprised 99.5% of non-approved applications, while in 2010 they comprised 68% (with denied applications accounting for 32% in the same year).

Chart 7: Israeli responses to Gaza patient permit applications, 2006 to 2021



Most applications recorded as delayed are eventually denied, according to data provided by the Israeli Coordination of Government Activities in the Territories (COGAT). COGAT does not account for delays in categorizing outcomes of permit applications, with data for 2019 to 2021 showing higher rates of denial of medical referral permits (denial rate of 33% for COGAT vs. 6% for HLO; delay rate 29% for HLO) and overall slightly higher rates of eventual approval of permits, not accounting for missed hospital appointments (67% for COGAT vs. 65% for HLO). Hospital appointments for patients are decided according to medical need, hence missed appointments due to delays are significant as a clinical outcome. Research by WHO demonstrated that cancer patients referred for chemotherapy and/or radiotherapy from 2015 to 2017 were 1.45 times less likely to survive if initially delayed or denied permits compared to patients initially approved, and accounting for baseline differences in diagnosis, age, sex, and reason for referral.⁴⁴

Age and gender



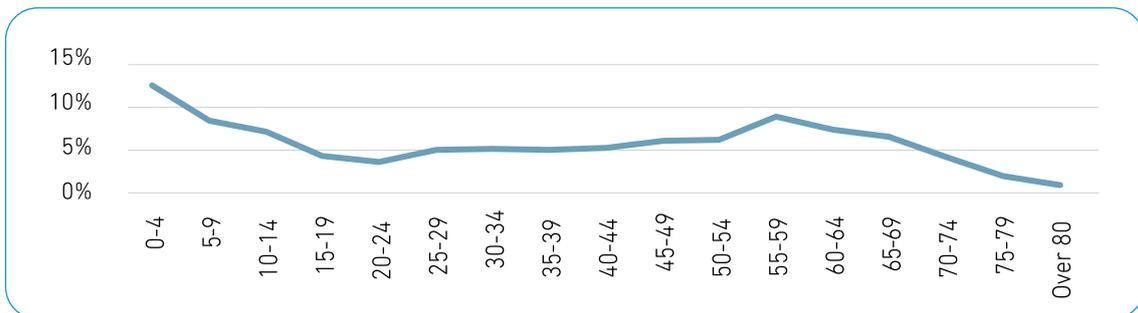
46%
Of patient permit applications were for female patients



21%
Of patient permit applications were for children under the age of 18 years

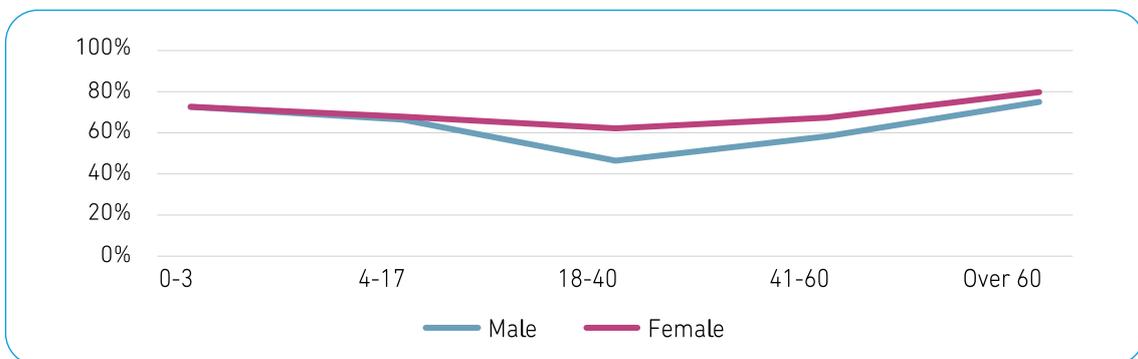
Just under half (46%) of permit applications were for female patients from 2019 to 2021. Meanwhile, over a quarter (29%) of applications were for children under the age of 18 years. There was a bimodal distribution similar to that of referral patients overall, with 13% of applications for children under 5 years and 9% for those 55-59 years. Over one in ten (14%) applications were for adults aged 65 years and over, see Chart 8.

Chart 8: Age distribution of patient permit applications, 2019 to 2021



Rates of approval, denial and delay differ significantly according to age and gender, see Chart 9. From 2019 to 2021, men aged 18 to 45 years had the lowest approval rate (47%), while the highest approval rate was for women over 60 years (80%).

Chart 9: Approval rate for patient permit applications by age and sex, 2019 to 2021

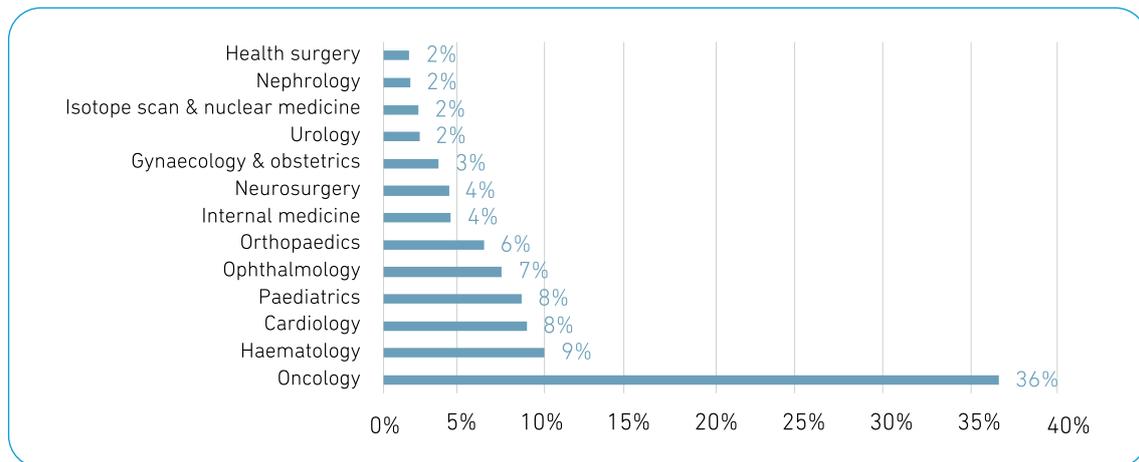


44. Bouquet, B., Barone-Adesi F., Lafi M., Quanstrom K. et al. (2021). Comparative survival of cancer patients requiring Israeli permits to exit the Gaza Strip for health care: A retrospective cohort study from 2008 to 2017, PLOS One. Available at: <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0251058>

Referral needs for patients requiring permits

Treatment and diagnostic services for cancer (oncology) comprised the single largest reason for patient permit requests to exit the Gaza Strip for 2019 to 2021, see Chart 10. In the context of a substantial decrease in overall referrals, the proportion of permit applications to reach oncology services increased from 31% in 2019 to 40% in 2020 and 41% in 2021.

Chart 10: Reasons for patient permit applications by medical specialty, 2019 and 2021

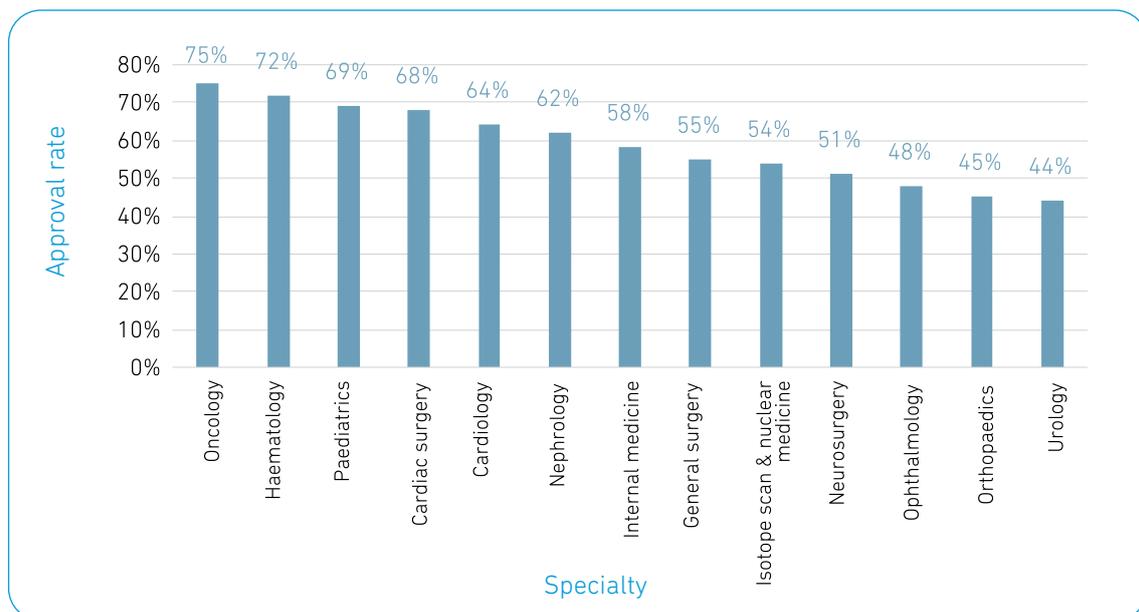


Rates of approval, delay and denial vary according to the reason for patient referral. Of major reasons for referral from 2019 to 2021, oncology had the highest approval rate by specialty (75%), while urology had the lowest (44%), see Chart 11.

Specialties with lowest approval rates

		
44%	45%	48%
Urology	Orthopaedics	Ophthalmology

Chart 11: Approval rates by specialty for patient permit applications, 2019 to 2021



Appeals for patients and companions facing delay or denial

The arbitrariness⁴⁵ of non-approval of patient permits is demonstrated by the variation in aggregate approval rates by month and year, as well as the inconsistency of responses to consecutive requests by the same individual. Appeals against the denial of patient or companion permits are frequently upheld by complaints procedures and the Israeli court system. From 2019 to 2021, according to data provided by Al Mezan Center for Human Rights (Al Mezan), the Palestinian Center for Human Rights (PCHR), and Physicians for Human Rights Israel (PHRI), 54% of appeals were successful for patients initially delayed or denied permit applications from the Gaza Strip. PHRI had the highest success rate of appeals during this period (66%), while 2020 was the year with the highest success rate overall (67% for the three organizations). Meanwhile, Al Mezan had the lowest success rate for appeals (42%), with the lowest success rate by year for 2021 (44%), see Table 3.

Table 3: Success rates of patient permit appeals in 2019 to 2021

		Total applications					
Year	Overall approval rate	Al Mezan Center for Human Rights		Palestinian Center for Human Rights		Physicians for Human Rights Israel	
		Number	% approved	Number	% approved	Number	% approved
2019	48%	535	35%	1170	52%	161	57%
2020	67%	364	56%	357	73%	259	74%
2021	44%	636	39%	572	47%	110	62%
Total	51%	1535	42% N=641	2099	54% N=1136	530	66% N=351

Mortality of patients requiring permits to access health care from the Gaza Strip

WHO matched data for referrals and permit applications from the Gaza Strip with mortality data from 2008 to 2021. During the period there were 234 142 applications for 58 203 patients. The mortality of patients at six months (180 days) from first permit application was 8.8% overall – i.e. 91.2% of patients lived beyond six months of applying for their first permit. These data indicate the significant vulnerability of patients needing permits from Gaza. Mortality six months from first permit application varied significantly according to whether patients were referred on a non-urgent, urgent and lifesaving basis, see Table 4. Data for 2021 excludes the last six months of the year, to allow six months follow up of mortality.

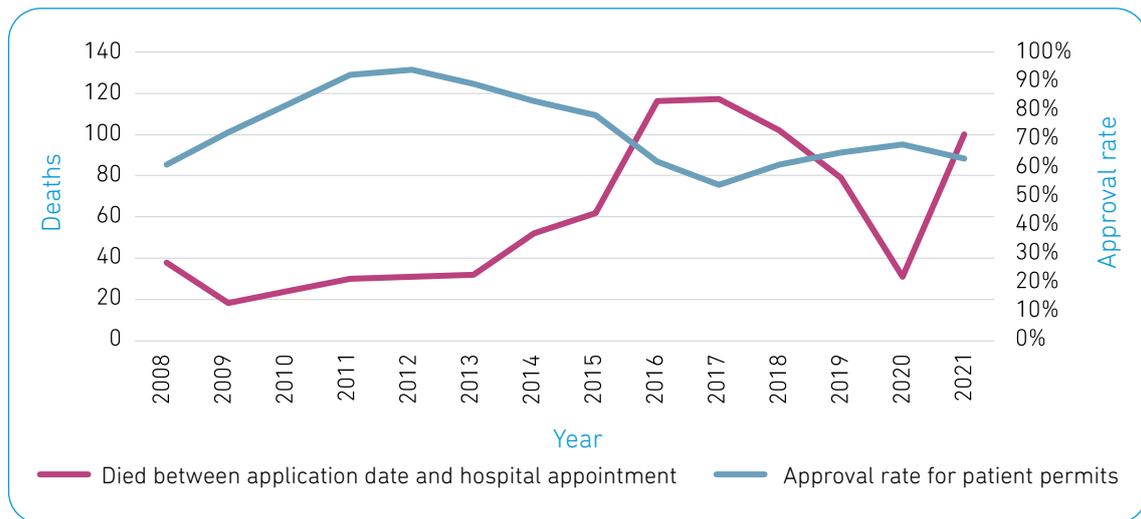
Table 4: Mortality outcomes among patients requiring permits to access essential health care outside the Gaza Strip, 2008 to 2021

Total number of first appointments for individual patients per year	Mortality at 180 days from first appointment			
	Non-urgent	Urgent	Lifesaving	Total
58 203	5.7%	17.3%	32.6%	8.8%

45. UN Human Right Council 31st session (2016). Human rights situation in the Occupied Palestinian Territory, including east Jerusalem: Report of the Secretary General. A/HRC/31/44.

Chart 12 shows an inverse correlation between patient deaths before hospital appointments each year and the approval rate for patient permits – i.e. lower approval rates were associated with a higher number of deaths of patients waiting for the response of their permit applications. Notably, in 2017 the requested time for processing of non-urgent patient permits by Israeli authorities more than doubled from 10 working days to 23 working days. From 2008 to 2021, 839 patients died while waiting for permit responses.

Chart 12: Deaths while waiting (between application date and hospital appointment date) compared to approval rate for patient permits, 2008–2021



Companion permits

Patients are permitted one companion to accompany them for travel out of the Gaza Strip through the Israeli checkpoint at Beit Hanoun (Erez) checkpoint. Children, patients who are severely incapacitated, and patients with severe disabilities require companions for adequate care, protection, and in instances for consent for medical interventions. Parental accompaniment of children has additionally been shown to improve care outcomes and as central to the best interests of the child.

Children, persons with disabilities, and incapacitated patients have increased need for accompaniment when accessing health care

From 2019 to 2021, there were 53 928 permit applications for companions. There was a 68% decline in applications reported by the Palestinian HLO, nongovernmental and international organizations in 2020 (8520) compared to 2019 (26 696), with an increase again to 18 632 in 2021. This substantial drop in 2020 was linked to the COVID-19 outbreak and to the end to coordination between the Palestinian Authority and Israel

between May and November. The total number of permit applications for companions has broadly followed a similar trend to that seen for patient permit applications. Due to requests to change companion, the number of companion applications each year is consistently higher than patient applications.



46%
Of patient companion permit applications to exit Gaza approved

Approval, delay, and denial of companion applications

Between 2019 and 2021, 46% of companion permit requests were approved – lowest in 2021 (40%) and highest in 2019 (50%). Companion permit outcomes similarly follow broadly similar trends by year to patient permits, though approval rates for companions are consistently


 Denial rate: **8%**
 Approval rate: **47%**
 Delay rate: **46%**


 Approval rate: **56%**
 Denial rate: **44%**

lower, while rates of delay and denial are higher. The largest sustained decline in approval rates for companion permit applications occurred between 2012 (83%) and 2017 (44%).

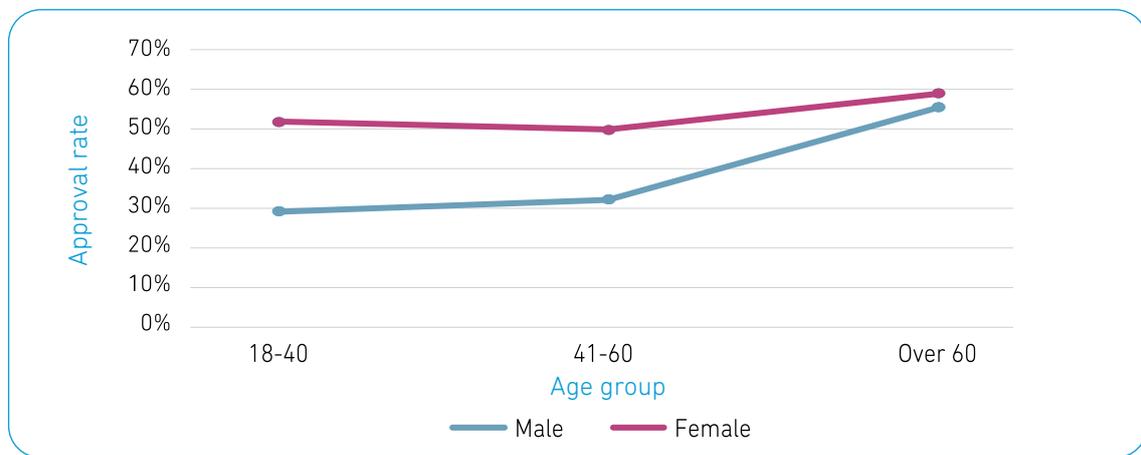
As with patient permit applications, data provided by Israeli COGAT do not include information on non-approval by the time of the patient’s appointment (delay). From 2019 to 2021, the average (mean) annual rates of denial and approval were higher for data reported by Israeli COGAT (44% and 56%, respectively) than the rates reported by the

Palestinian HLO (8% and 47%, respectively). The Palestinian HLO reported an average annual rate of delay of 46%, meaning no definitive response to companion permit applications was issued by the date of the patient’s hospital appointment for these applications.

The age and sex distribution of companion permit applications has changed since 2012, with a shift upwards in 2018 towards a higher proportion of older, female applications. From 2019 to 2021, 65% of applications were for female companions. Women aged 41 to 60 accounted for the single largest demographic of companions (36% in 2021), though the proportion has declined in the last four years, from 42% in 2018.

There is variation in rates of approval, delay and denial by age and sex, which is a factor in the changing demographic of companions. From 2019 to 2021, female applications had a higher approval rate (52%) than male applications (38%). Women over 60 years had the highest approval rate (59%) by age and sex, while men aged 18 to 40 years had the lowest approval rate (29%), see Chart 13.

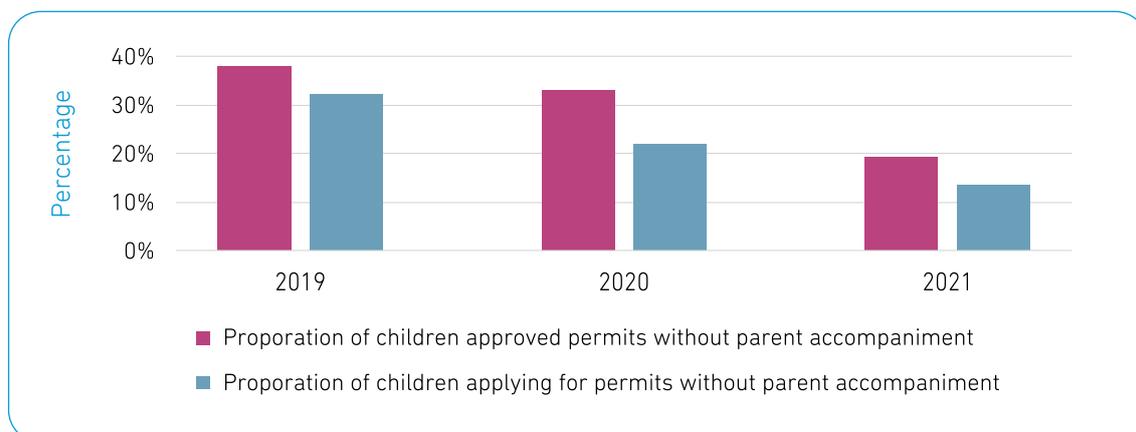
Chart 13: Approval of companion permit applications by age and sex, 2019 and 2021



Parental accompaniment of child patients

The parental accompaniment of children requiring health care is recognized as particularly important for promoting effectiveness of treatment, including for issues of consent, for enhancing understanding and adherence to follow up, and for supporting children through difficult experiences. From 2019 to 2021, 32% of children approved permits to travel for health care from the Gaza Strip did not have a parent approved a permit to accompany them. This is only partly attributable to non-application for permits by parents, with 25% of patient permit applications for children listing a person other than one of the child’s parents as companion. Since 2019, the proportion of children approved permits for travel without a parent has declined, see Chart 14.

Chart 14: Percentage of children approved and applying for permits without parental accompaniment, 2019 to 2021



Opening of Erez (Beit Hanoun) checkpoint and Rafah border crossing

Erez (Beit Hanoun) checkpoint

Erez checkpoint was open on average for 301 days per year from 2019 to 2021, with closure for Saturdays, holidays, and during military escalations, see Table 5. During the period, there were 36 093 patient-exits for health care, with a 67% reduction in 2020 compared to 2019. Companion-exits were consistently lower than patient-exits, comprising 84% of patient-exits in 2019, 80% in 2020 and 78% in 2021.

Table 5: Crossings at Erez (Beit Hanoun) for health care

Year	Days open	Person-exits for health care	Person-transfers by ambulance
2019	299	19 281 patients 16 242 companions	860 patients 821 companions
2020	310	6386 patients 5138 companions	439 patients 408 companions
2021	294	10 426 patients 8135 companions	861 patients 853 companions

Rafah and referrals to Egypt

Patients and their companions face considerable administrative, financial, and geographical or infrastructural barriers to accessing health care in Egypt. Patients and their companions make payments to secure and expedite exit. The price of expedited exit has ranged between approximately US\$ 5000 in 2017 and US\$ 1200 more recently in 2019, with a reduction in cost since an easing of access around mid-2018, in the context of the Great March of Return.⁴⁶ These costs remain substantial, with more than half of Gaza's population living below the poverty line of US\$ 4.6 per day.

46. Data provided by Dr Caitlin Proctor (2020), study pending publication

Long processing times on the Egyptian side of Rafah mean people attempting to cross can wait between one and eight hours for approval of the passenger list compiled by the authorities in Gaza. Some applicants never receive a response. There is no separate system for patient access, though a proportion of patients are transferred by ambulance. On the Egyptian side of Rafah, the lengthy journey of 450km to Qantara, with multiple checkpoints, means an arduous journey that usually takes more than 12 hours.⁴⁷

Access to health care in Egypt is dependent on the opening of Rafah border terminal, with close correlation between overall person-exits and referrals to Egypt by the Palestinian Ministry of Health (virtually all from the Gaza Strip). The lowest person-exits and referrals were recorded in 2008 and 2015–17, see Chart 15. In 2021, access improved, with 100 246 person-exits compared to 65 949 in 2020 and referrals to Egypt increasing from 2297 to 3914.

Chart 15: Person-exits across Rafah border terminal and referrals to Egypt, 2006–2020



Access for health care workers, ambulances, and medical supplies

Health care workers

Data provided by the Palestinian General Authority of Civil Affairs (GACA) indicates that from 2019 to 2021 there were 1493 permit applications for health and non-health staff to exit the Gaza Strip for conferences, training courses, and workshops. Of these applications, 10% (149) were approved, 51% (764) denied and 39% (580) remained pending. In 2020, there was a 64% reduction in applications in the context of increased movement restrictions, from 793 to 283, which was a further decrease from the 71% reduction from 2018 (2776 applications) to 2019. In 2021, there was an increase in applications to 417.

For permit applications for health staff submitted through WHO, between 2019 and 2021, overall 78% (64/82) were approved for travel, with a higher rate for international medical delegates for entry to Gaza (85%) and a lower rate for applications for non-WHO partner staff to exit Gaza (72%), see Table 6.

47. OCHA (2018). Recent trends in Palestinian access from Gaza: Erez and Rafah crossings. Monthly Humanitarian Bulletin: September 2018. Available at: <https://www.ochaopt.org/content/recent-trends-palestinian-access-gaza-erez-and-rafah-crossings> (accessed 15 October 2020)..

Table 6: Outcomes of permit applications for humanitarian health staff via WHO, 2019 to 2021

2019 to 2021	Approved	%
Out of Gaza: MoH, health cluster partners	21	72%
Into Gaza: WHO staff (Jerusalem ID-Holder)	26	79%
Into Gaza: International medical delegates	17	85%
Total	64	78%

Ambulance access

Ambulances from the Gaza Strip transferring patients to hospitals in the rest of the occupied Palestinian territory, or to Israel or Jordan, are not permitted passage across Erez/Beit Hanoun checkpoint.



68 minutes
average ambulance waiting time to exit at Erez

Instead, these ambulances face long delays waiting to coordinate the “back-to-back” procedure with Israeli-registered ambulances from destination hospitals. From 2019 to 2021, ambulances of the Palestine Red Crescent Society (PRCS) from east Jerusalem were made to wait 49 minutes on average at the checkpoint, with a longer waiting time for patients exiting the Gaza

Strip (68 minutes) than entering (25 minutes). In 2020, there was a 48% reduction in the number of patients transferred by PRCS ambulance, from 1512 in 2019 to 788, with an increase again to 1377 in 2021. Ambulances faced the longest wait times to exit in 2020 (80 minutes).

Access for medical supplies

Most medical supplies, including essential medicines, disposables and medical equipment and spare parts, enter the Gaza Strip via Karam Abu Salem/Kerem Shalom Israeli checkpoint in the south of the Gaza Strip. From 2019 to 2021, there were 2433 truckloads of medical supplies imported to Gaza through Karam Abu Salem/Kerem Shalom crossing (887 in 2019; 881 in 2020; 665 in 2021), of which four-fifths (77%) were commercial and one-fifth (23%) were humanitarian.⁴⁸ The other entry/exit point for supplies is Salah ad-Din Gate to Egypt in Rafah, also in the south of the Gaza Strip. From 2019 to 2021, 115 truckloads of medical supplies (medicines, disposables including for infection prevention and control, and solutions for intravenous infusion) entered through Salah ad-Din Gate from Egypt (22 in 2019; 41 in 2020; 52 in 2021). Between 95% (2020) and 100% (2019; 2021) were imported by the private sector.⁴⁹

Israel’s dual-use list applies to the entry of medical supplies, with restrictions having affected communications equipment, spare parts, nuclear medicine technology, and materials used in limb prostheses. Customs limitations lead to delays and incomplete deliveries, with shortages of equipment and spare parts, inadequate technical capacity for the maintenance of some specialized equipment, and underdeveloped systems to ensure appropriate monitoring, replacement, and allocation.

48. OCHA oPt (2020). Gaza crossings: movement of people and goods. Available at: <https://www.ochaopt.org/data/crossings> (Accessed 15 October 2020).

49. Data provided by the office of the United Nations Special Coordinator for the Middle East Peace Process (UNSCO).



69%

Of requests by private Palestinian companies for entry of equipment denied

Uncertainty about which specific parts might be faulty and difficulties of returning defective equipment or parts add to costs borne by the Ministry of Health and donors.⁵⁰ Unpredictable electricity supplies additionally cut short the lifespan of machinery with highly sensitive electronic circuits.

Data provided by the Presidential Committee for Commodities Coordination of the Palestinian Authority showed: 83 out of 120 requests (69%) by private

Palestinian companies for entry to the Gaza Strip of machines or spare parts for x-ray or CT were denied by the Israeli authorities.⁵¹ Meanwhile, 9 of 13 requests (69%) for entry of oxygen generators or associated spare parts were denied and two requests for entry of an MRI machine and associated spare parts were both approved.



50. Summary of key findings from an assessment conducted by WHO in 2018.

51. In response to request for comments, the Government of Israel indicated that a proportion of applications for entry of medical equipment are denied due to missing information on applications. The extent of this issue has not been quantified.



HEALTH ACCESS: Barriers affecting the West Bank

In the West Bank, physical and administrative division of areas creates barriers to health access. Movement is hindered by disconnection of territory by the separation barrier, restricted-access infrastructure, road obstacles, and the large number of fixed and ‘flying’ checkpoints. Administratively, the West Bank is divided into Areas A and H1 of Hebron, Area B, Areas C and H2, and east Jerusalem.⁵² East Jerusalem and the Seam Zone are physically disconnected from the rest of the West Bank by Israel’s separation barrier, with the land on the Israeli side of the barrier comprising 9% of territory in the West Bank. Added to this physical disconnection, Palestinians from the West Bank without residency for east Jerusalem or the Seam Zone are required to obtain Israeli-issued permits to access these areas or Israel. Patients, companions, and health care workers all require permits to reach major health facilities in east Jerusalem, as well as to access referral care in Israeli hospitals. Palestinian ambulances require Israeli licensing and specific permissions to operate in, or to enter, east Jerusalem. Meanwhile, mobile clinics providing essential primary care services to communities in the Seam Zone similarly require special permits to access.

Permit requirements



A copy of the patient’s medical report



A copy of their hospital appointment



The patient’s ID details and functioning telephone number

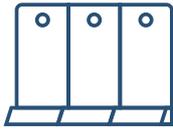


The companion’s ID details and functioning telephone number

52. See page 54 for map of administrative divisions.

Figure 6: Health access restrictions in the West Bank

Physical obstacles obstructing access



712km
Separation barrier



140 Fixed checkpoints
2254 Flying checkpoints

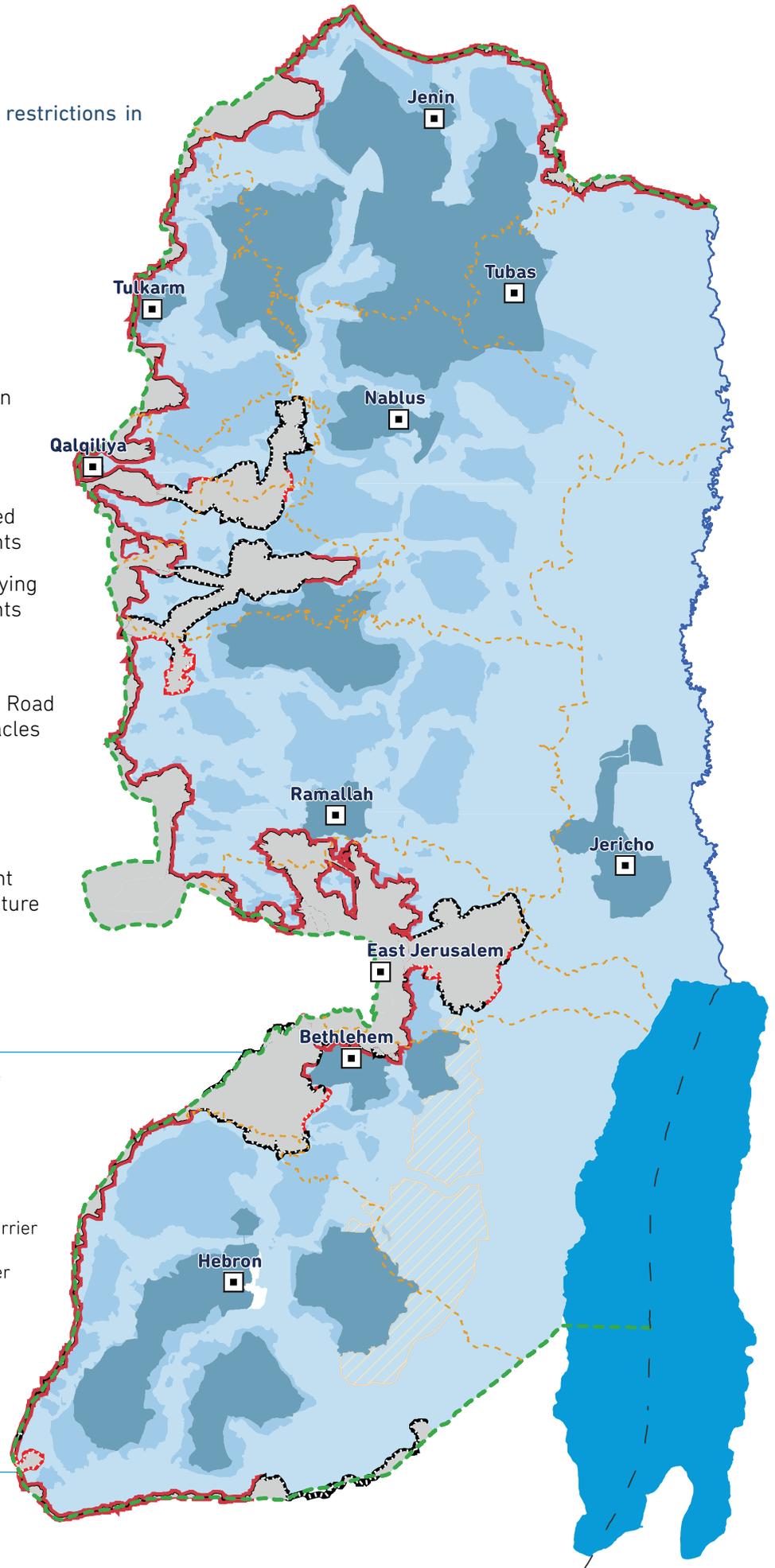


500 Road obstacles



50km²
Settlement infrastructure

- Governorate Boundary
- Armistice Green Line
- Constructed Barrier
- Projected Barrier
- Under Construction Barrier
- Area Behind the Barrier
- Area A
- Area B
- Nature Reserve
- Area C



Patient and companion permits

Total applications and rates of approval and non-approval



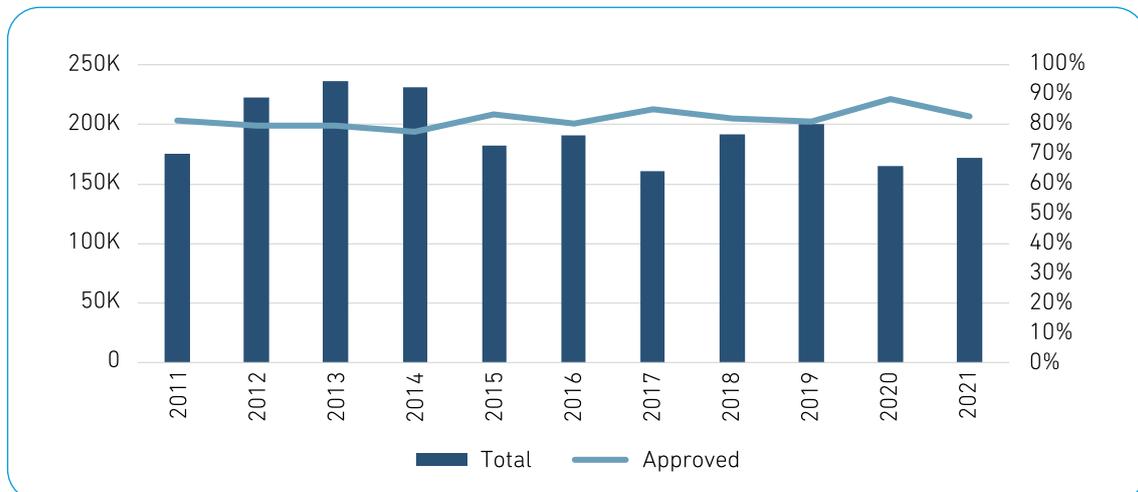
84%
Patient permit applications to exit the West Bank approved



78%
Of patient companion permit applications to exit the West Bank approved

From 2019 to 2021, according to data reported by the Palestinian General Authority of Civil Affairs (GACA), approval rates of permits for patients (84%) and companions (78%) from the West Bank were higher than for the Gaza Strip. Since 2011, the approval rate for health-related permits has remained relatively constant, ranging between a low of 77% in 2014 and a high of 85% in 2020 - see Chart 16. Disaggregation of rates of approval and denial/delay was available for 2019 to 2021, as well as for 2017, with approval rates consistently higher for patients than companions (85% versus 79%, respectively, for those years with available data). Although rates of approval are consistently higher for the West Bank, between 2011 and 2021 there were 331 678 patient or companion permit applications denied, equivalent to 30 153 each year.

Chart 16: Number of West Bank patient and companion applications approved and total each year, 2011 to 2021⁵³



In the West Bank, patients and companions can apply directly to Israeli authorities (District Coordination Office, with data reported by COGAT) for permits to travel, without applying through GACA. In 2019, the total number of patient permit applications reported by GACA represented 92% of total permit applications for patients reported by COGAT. This was similar to the proportion of applications through the HLO in the Gaza Strip for the same year (93%). In 2020, with suspension of coordination between the Palestinian Authority and Israel from May to November 2020, this proportion dropped substantially to 36% in the West Bank, increasing to 55% in 2021. The trend was similar for companion applications. COGAT was the only provider of comprehensive data on patient and companion permits for 2020, during suspension of coordination between the PA and Israel, reporting a 31% decrease in patient permit applications and 37% decrease in companion applications compared to 2019. The number of applications submitted through COGAT in 2021 (152 040), meanwhile, surpassed those in 2019 (112 881).

53. Data for 2020 is from Israeli COGAT due to the suspension of coordination of permit applications through GACA during that year.

GACA in the West Bank reported an overall lower approval rate than COGAT for patient (84% versus 89%) and companion (78% versus 88%) permit applications from 2019 to 2021. GACA also reported higher rates of denial, at 12% compared to 11% for patients and 17% compared to 12% for companions. 4% of patient applications and 5% of companion applications were delayed or pending when reported by GACA.

Rates for patient permits



Origin and destination of referrals

From 2019 to 2021, GACA reported submitting a total of 401 206 permit applications for patients and companions. Hebron (22%), Bethlehem (15%), Abu Dis (14%) and Ramallah (10%), Nablus (9%) and Ar-Ram (9%) together accounted for nearly 4 in 5 (79%) permit applications from the West Bank – approximately corresponding to the distribution of population in these districts.

The highest approval rate was recorded for Jericho (87%) and the lowest for Ramallah (77%), with the latter having the highest rate of pending applications (7%). The highest reported rate of denial was for patients from Jenin (19%), with the lowest for Jericho (10%), see Chart 17.

Top three districts submitting permit applications on behalf of patients and companions

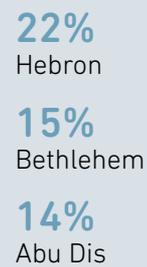
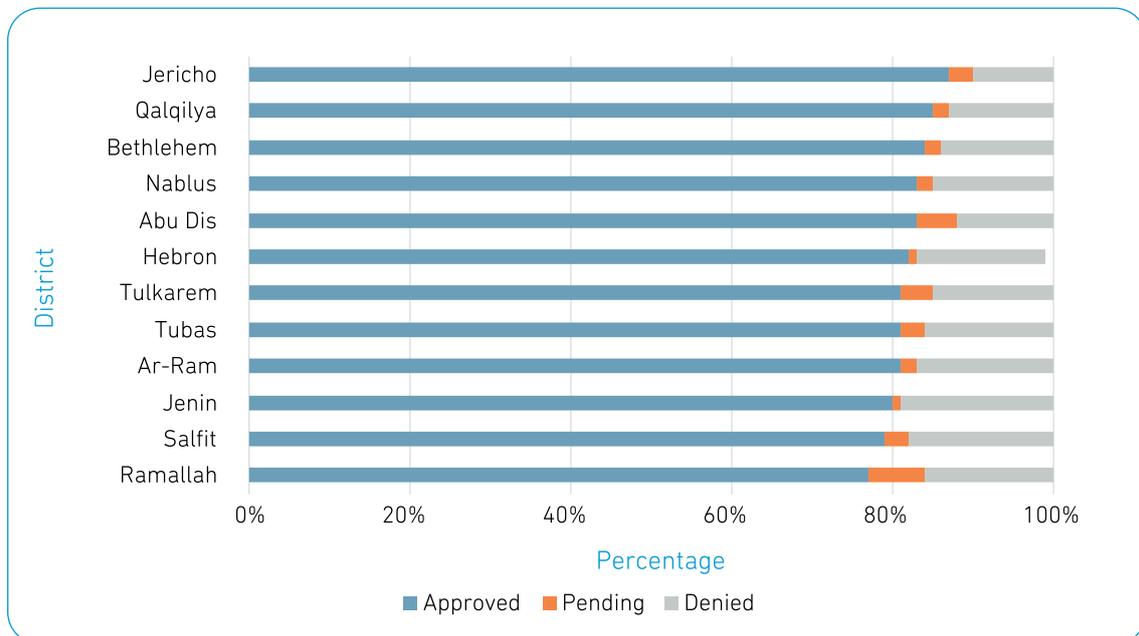


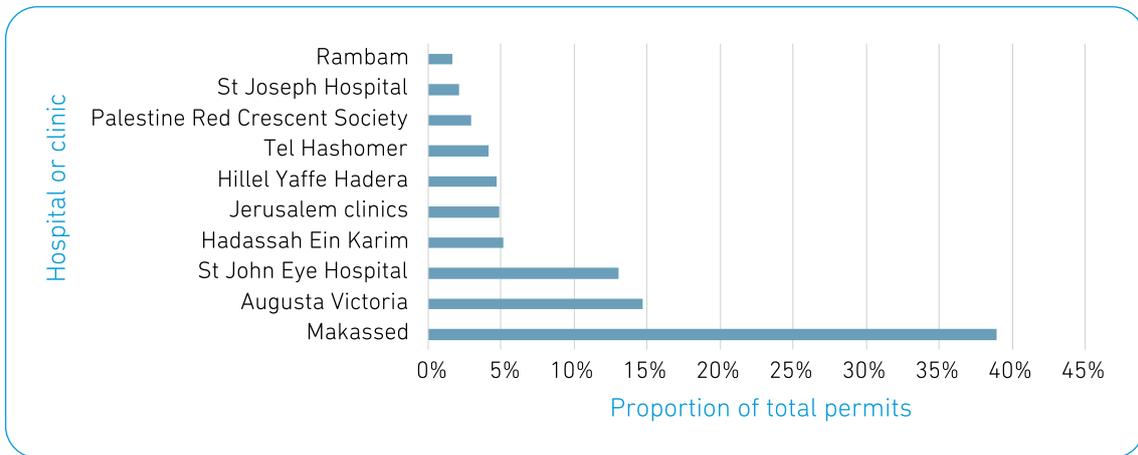
Chart 17: Approval rate for West Bank patient and companion permits by district and sub-district, 2019 to 2021



For available data from 2019 to 2021, 72% of applications were for appointments at hospitals in east Jerusalem; 23% for Israeli hospitals; and 5% were to Jerusalem clinics (unspecified whether east or west). The top five hospital or clinic destinations accounted for over three-quarters (77%) of the total.

These were Makassed, Augusta Victoria, and St John Eye Hospital in east Jerusalem; Hadassah Ein Karim, an Israeli hospital; and Jerusalem clinics – see Chart 18.

Chart 18: Destination of permit applications by hospital or clinic, 2019 to 2021



Age and gender

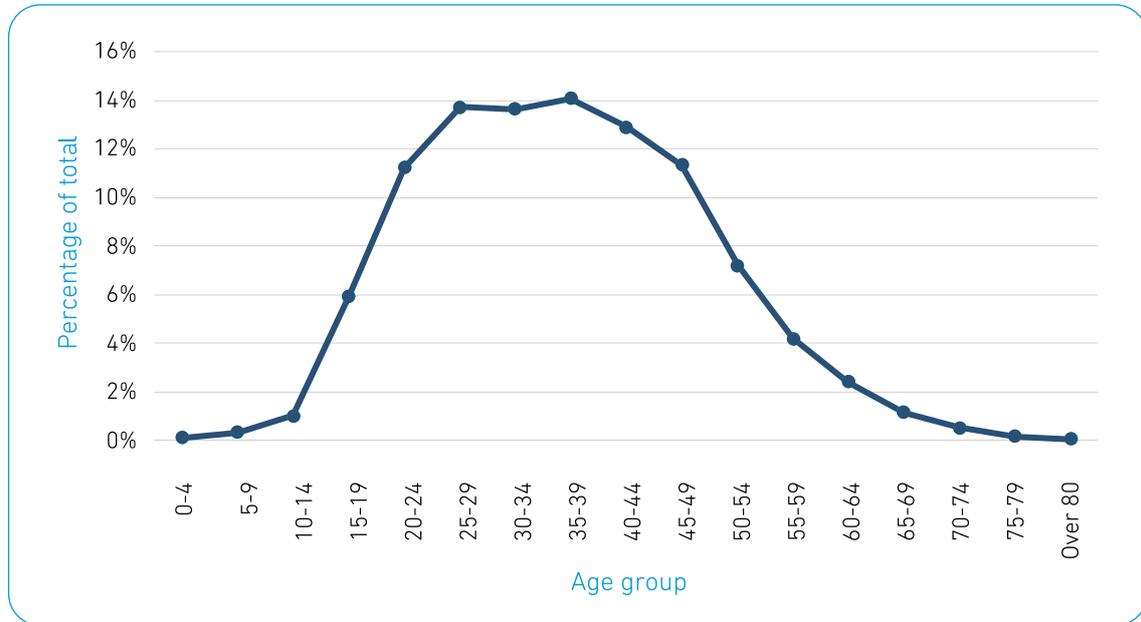
The distribution of patient permit applications by age is significantly different in the West Bank compared to the Gaza Strip and compared to the age distribution for referrals. From 2019 to 2021, the peak age for applications was young adults, with a third (32%) of applications for patients aged 20 to 34 and three-fifths (62%) for those between 15 and 49 years, while 19% were for children – see Chart 19. The difference in the age distribution is linked to exemptions from permits for Palestinians in the West Bank, for whom most women over 50 years and men over 55 years are exempted from being required to obtain a permit to enter east Jerusalem or Israel. Younger children similarly can often pass through checkpoints without permits, if accompanied by an approved adult. Families continue to submit permit applications from the West Bank for these age groups, to be more certain of passage at checkpoints and for individuals facing greater restrictions on movement. For distribution by sex, 52% of permit applications were for female patients, which may be affected by men of working age being more likely to have work permits that allow them to reach hospitals in east Jerusalem and Israel.

Chart 19: Age distribution for patient permits from the West Bank, 2019 to 2021



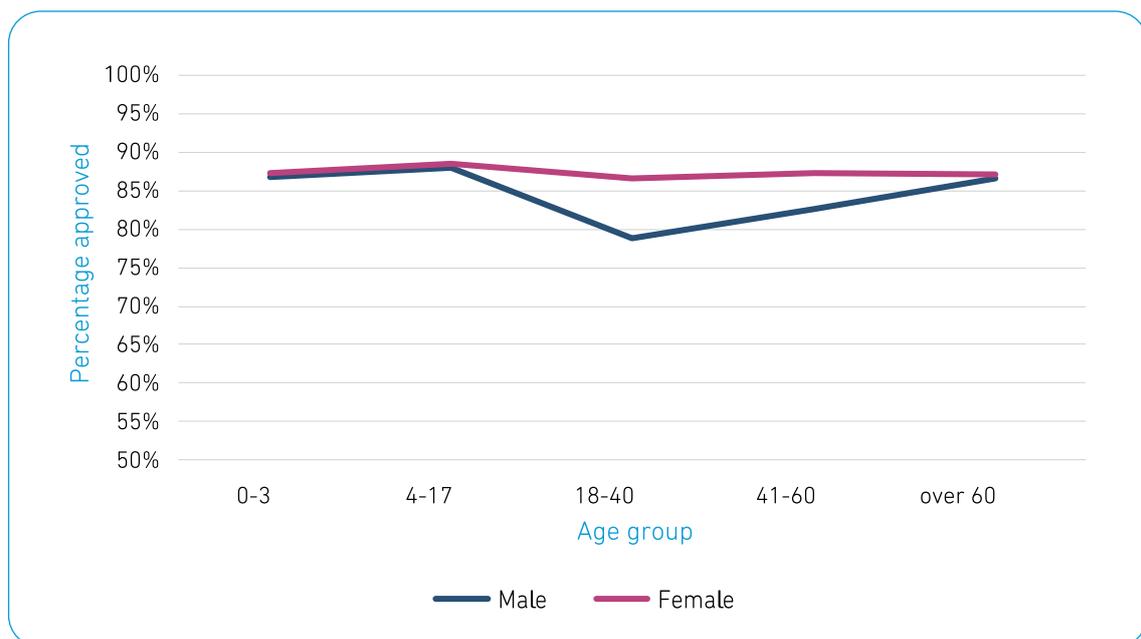
More than four fifths (83%) of companion permit applications were for persons between the ages of 15 and 49 in the same period, see Chart 20. It is rare for children to be listed as a companion (just 1% of applications), while most companions in older age groups are again exempted from permit requirements.

Chart 20: Age distribution for companion permits from the West Bank, 2019 to 2021



As with the Gaza Strip, approval of patient permits differs significantly by age and sex. Between 2019 and 2021, women had a higher approval rate (87%) than men (83%). There was no significant difference in approval rate for females of different age groups (range of 87% to 88%), but men aged 18 to 40 year (79%) and 41 to 60 years (83%) had a lower approval rate than other age/sex groups (87%-88%), see Chart 21.

Chart 21: Approval rate of patient permit applications from the West Bank by age and sex, 2019 to 2021



Access for health staff and ambulances to east Jerusalem

Health care worker access

Most Palestinian health care workers in east Jerusalem hospitals coming from the rest of the West Bank require permits to reach their places of work. Since the beginning of the blockade of the Gaza Strip in 2007, Palestinian health care workers from the Gaza Strip who worked at hospitals in east Jerusalem or Israel have been unable to reach their places of work. From 2019 to 2021, for five east Jerusalem hospitals (Augusta Victoria, Makassed, St John Eye Hospital, the Palestine Red Crescent Society, and Princess Basma), 34 permit applications for health care workers (1% of the total) were denied. A further 39 health care worker permits (also 1% of the total) were approved for 3 months, while most (98%) were approved for 6 months.

Health care personnel have two types of permits: "medical doctor on duty" and "hospital health staff." The former group is permitted to cross checkpoints by car, while the latter category must cross checkpoints by foot and face greater risk of arbitrary delays when travelling from the rest of the West Bank. The hospitals have lobbied to end the discrimination between doctors and other health care staff, including nurses, but these procedures at checkpoints persist. While there is no explicit permit quota for the number of West Bank ID-holding staff that can be employed by east Jerusalem hospitals, hospitals report being told when they are close to reaching a quota.

Permit applications for health care workers



1%
Of the total applications were denied (34 applications)



1%
Of the total were approved for 3 months (39 applications)

98%
Of the total were approved for 6 months

Ambulance access and licensing for Palestinian organizations in east Jerusalem

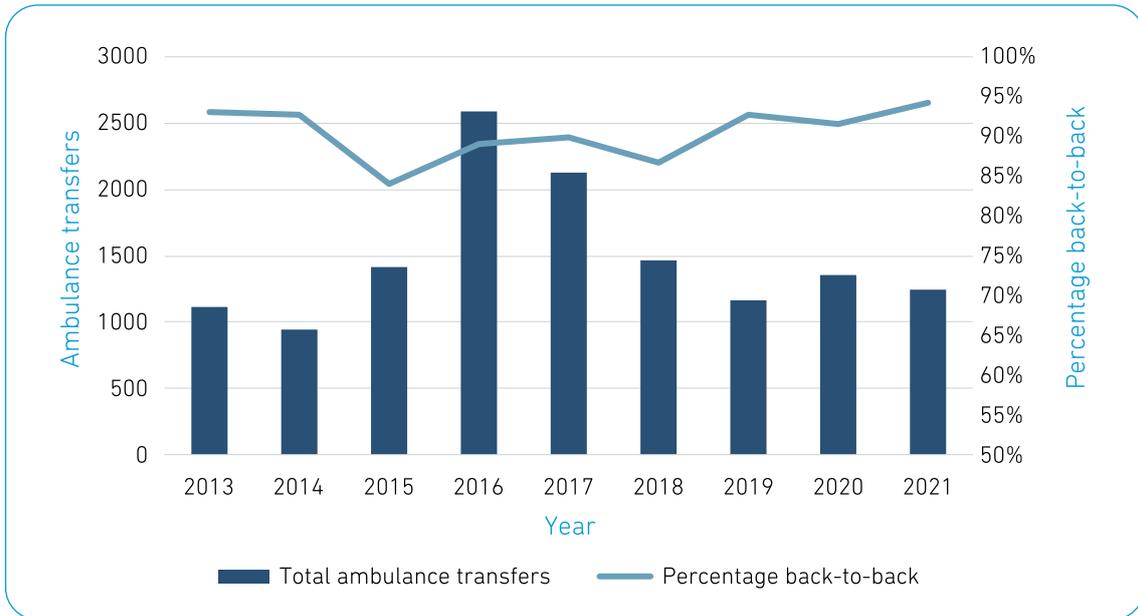
In 2019 and 2020, PRCS faced obstacles to obtaining licenses for its ambulances in east Jerusalem, citing issues of Israeli authorities requesting removal of the term 'Palestine' in their emblem. By 2021, the barriers encountered by PRCS had been resolved without change to their logo; other organizations who face similar barriers have removed the word 'Palestinian' to maintain access and operations in east Jerusalem.



93%
Of ambulances entering Jerusalem required to carry out back-to-back procedures

Most ambulances entering east Jerusalem from the rest of the West Bank are required to undertake the back-to-back procedure with Israeli-licensed ambulances at checkpoints into the city, delaying patient transit. Data provided by the Palestine Red Crescent Society indicates that from 2019 to 2021, there were 3488 back-to-back transfers from a total of 3758 ambulance journeys to east Jerusalem from the rest of the West Bank. These journeys comprised 93% of the total, with 7% of patient transfers to Jerusalem recorded by PRCS as having direct access. Between 2013 and 2021, the proportion of back-to-back transfers of total ambulance journeys has ranged between 84% in 2015 and 94% in 2021. The number of ambulance journeys to east Jerusalem from the rest of the West Bank recorded by PRCS ranged between 946 in 2014 and 2586 in 2016, see Chart 22.

Chart 22: Ambulance transfers to east Jerusalem recorded by PRCS and the proportion required to undergo the back-to-back procedure at checkpoints, 2013 to 2021



When PRCS ambulance crews transfer a patient to an Israeli hospital, they are required to call ahead to notify the hospital security, providing the ambulance vehicle licence and details of the staff and patient. The dispatcher needs also to provide information on whether those in the vehicle hold a Jerusalem or West Bank ID. PRCS reports consistent ambulance delays at the entrance to Israeli hospitals, including searches of vehicles and ID checks of staff and patients, regardless of medical urgency, placing patients at risk. When more severe these delays may be reported as attacks on health care.



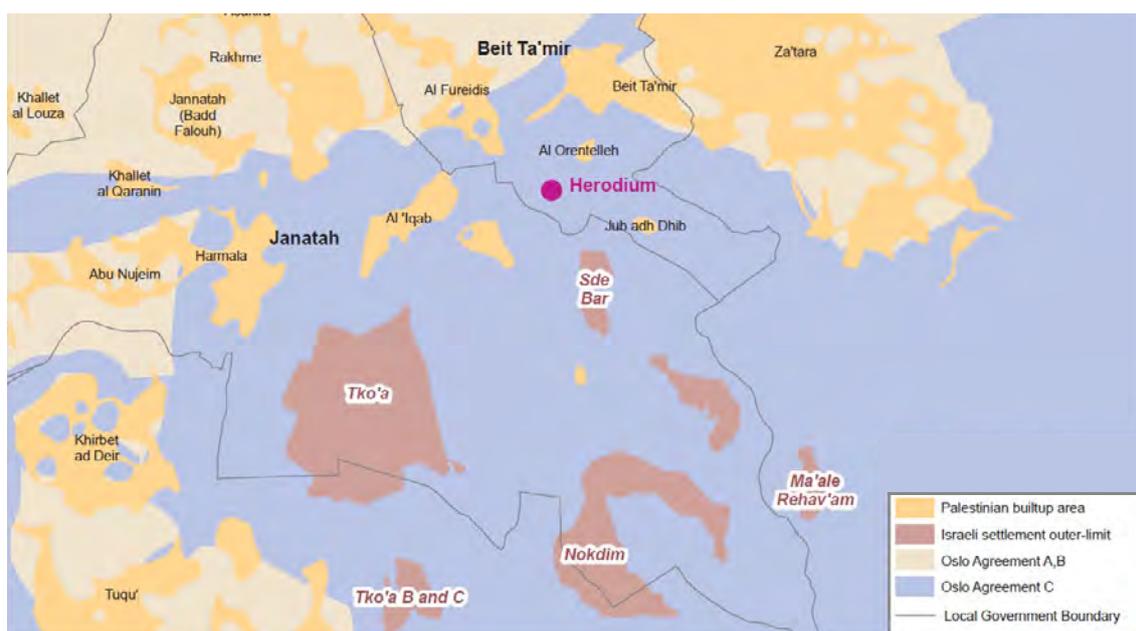
Health access in Area C, H2 and the Seam Zone

Palestinian communities in Area C, H2 of Hebron, and the Seam Zone face additional barriers to health access due to under-provision of services; restrictive planning policies that limit the development of permanent or semi-permanent health facilities; and physical obstructions to access that include the separation barrier, checkpoints, road obstacles, checkpoints, and restricted-access infrastructure associated with settlements. Around 150 000 Palestinians in these areas depend on the provision of mobile clinic services, which face challenges to sustainable financing as well as precarious access. At the beginning of 2022, 112 000 people faced severe under-provision of primary care services. Determinants of health for Palestinians in these areas are also affected by housing precariousness due to high risk of demolition and displacement; policies affecting livelihoods and food security; access to adequate water and sanitation; and increased exposure to occupation- and settler-related violence.

In focus: Health access for Jubbet adh-Dheib in Area C

The community of Jubbet adh-Dheib is situated in the Bethlehem governorate and comprises approximately 185 people living in 27 households. The village is bordered by four Israeli settlements, which include Sde Bar, Kfar Eldad (El David), Ma'ale Rehav'am, and Nokdim. The land of the village, which previously comprised more than 400 dunams,⁵⁴ is today limited to around 8 to 9 dunams, with most of the village land controlled by the surrounding Israeli settlements and the archaeological site of Herodium, administered by the Israeli Civil Administration and the Israel Nature and Parks Authority. The community has no permanent health care facilities, there is no public transport to the village, and most families do not own a vehicle. Taxi services are unaffordable. The village used to receive services from a mobile clinic run by the Palestinian Medical Relief Society, which visited the community once a week to provide primary health care, including specific services for gynaecology and diabetes. The clinic stopped functioning in September 2021 due to lack of funds. The closest primary health care centre is in neighbouring Za'tara village, an approximate 30-minute walk. Fadya, a member of the community, discussed the barriers: "My son has asthma and faced complications that required frequent visits to the doctor. For each visit, we have had to pay around 100 NIS (around US\$ 25 to US\$ 30) for a private taxi to and from the clinic. I had to sell my wedding band to cover the costs. Women suffer the most from the lack of health services in our village. When it's about our children we do everything that we can, but when it's for our own health we often wait."

Map 2: Jubbet adh-Dheib and surrounds in the West Bank⁵⁵



54. ARIJ (2010). Jubbet adh Dhib Village Profile. Available at: http://vprofile.arij.org/bethlehem/pdfs/VP/Jubbet_Adh_Dhib_vp_en.pdf

55. Maps provided by OCHA oPt, 2021

In focus: Health access for Arab ar-Ramadin ash-Shamali in the Seam Zone

Israel requires that persons and vehicles obtain special permission to enter Palestinian communities in the Seam Zone (between the 1949 Armistice Line and separation barrier). Palestinians who are resident in these areas carry specific identity cards so that they can pass checkpoints that control points of entry and exit. Such restrictions can hamper access to health care, particularly in urgent situations. Arab ar-Ramadin ash-Shamali is a Palestinian village in the Qalqiliya governorate comprising 36 families with a population of 200 to 220 people. The separation wall around Arab ar-Ramadin ash-Shamali is made of concrete and a fence-like construction. There is one point of entry/exit for the village, via a permanent checkpoint (Zufin/Tzofim) to the south. Passing the checkpoint is only possible for registered residents and those carrying valid permits, including for mobile clinics and ambulances.

In the Seam Zone, communities may have just single gates of entry and exit, with medical teams and ambulances requiring permits to reach them

with eight cars in the community that are registered to cross the gate. A mobile clinic run by the Palestinian Medical Relief Society visits the community once a week, though staff were unable to reach the community for five weeks in 2020 when the organization did not receive an Israeli permit. In emergencies, the village relies on health services in Qalqiliya, which is close geographically (around 3 km directly), but with access hindered by the need for coordination of entry at the checkpoint and poor road infrastructure. A member of the village council commented, "In emergencies it's easier for us to transport people ourselves in private cars, rather than wait for an ambulance to get coordination to enter the village. The delay at the checkpoint can take anywhere between 10 minutes to an hour, depending on the search."

Map 3: Arab ar-Ramadin ash-Shamali and surrounds in the West Bank





HEALTH ATTACKS: Protection vulnerabilities for health care

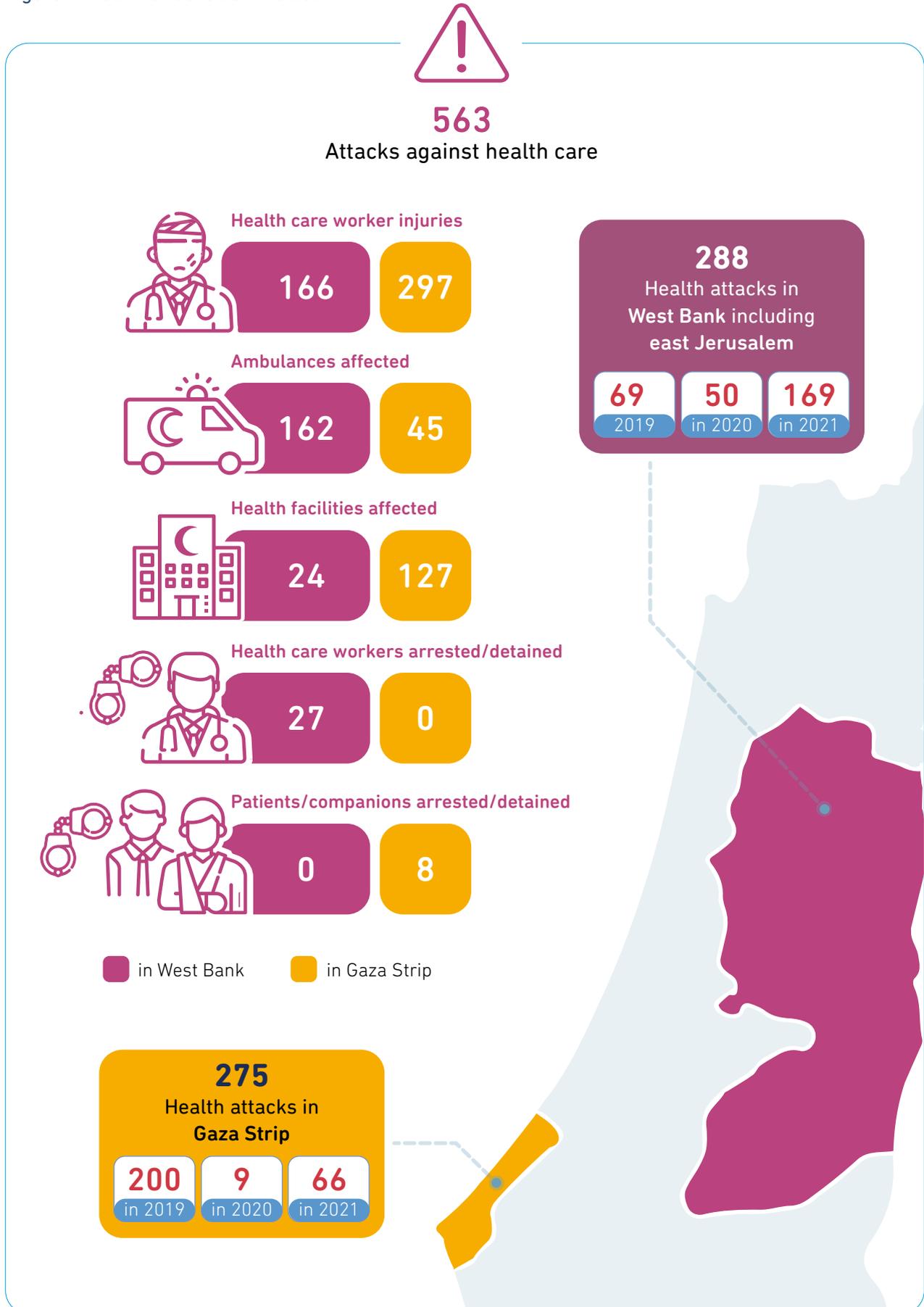
WHO defines an attack on health care as “any act of verbal or physical violence or obstruction or threat of violence that interferes with the availability, access and delivery of curative and/or preventive health services during emergencies.”⁵⁶ The protracted protection crisis in the occupied Palestinian territory creates specific vulnerability to health attacks, related to both the exposure of health care to acts of violence; incidents of obstructing the delivery of health care; the militarization of health facilities; and criminalization of health workers and health care organizations. Implementation of the WHO Surveillance System for Attacks on Health Care (SSA) began in January 2018 in the occupied Palestinian territory, though available data collected before this on violence against health care and obstruction of health care delivery have been included in this chapter.

Incidence and nature of health attacks

From 2019 to 2021, there were 563 attacks against health care, with 288 in the West Bank (of which 93 were in east Jerusalem) and 275 in the Gaza Strip.

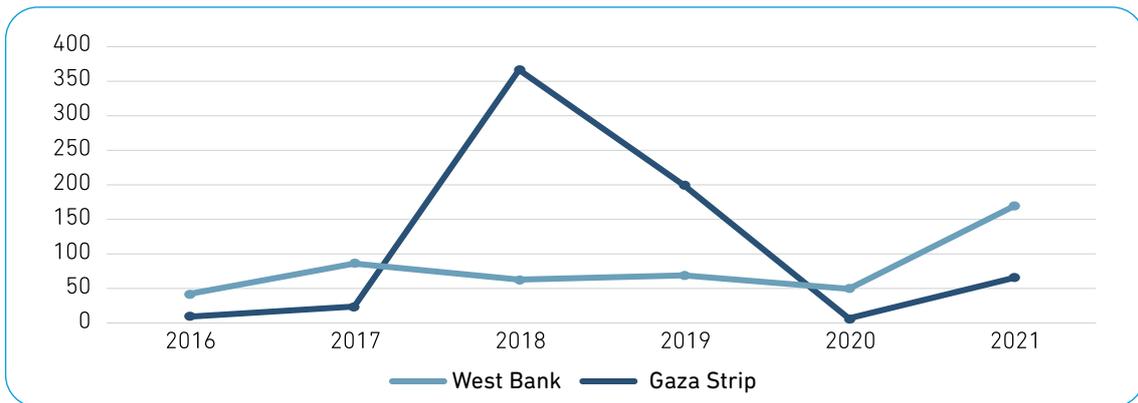
56. WHO (2022). Stopping attacks on health care. Available at: <https://www.who.int/activities/stopping-attacks-on-health-care#:~:text=WHO%20defines%20an%20attack%20on,preventive%20health%20services%20during%20emergencies>

Figure 7: Health attacks 2019 to 2021



In 2019, most attacks (200/269) occurred in the Gaza Strip with the continuation of the Great March of Return (GMR). In 2020, during the COVID-19 pandemic and associated limitations on movement in that year, there were 59 health attacks, the lowest annual incidence since implementation of the SSA, with most (50/59) occurring in the West Bank. The year 2021 witnessed an increase in health attacks with the use of force in demonstrations across the West Bank, including east Jerusalem (169/235 attacks in the West Bank), and the May escalation involving aerial and artillery bombardment of the Gaza Strip. Longer-term trends, shown in Chart 23, show the highest recorded attacks against health care occurring in 2018 marking the peak of the GMR, with 367 health attacks in the Gaza Strip that year out of a total of 430 across the oPt.

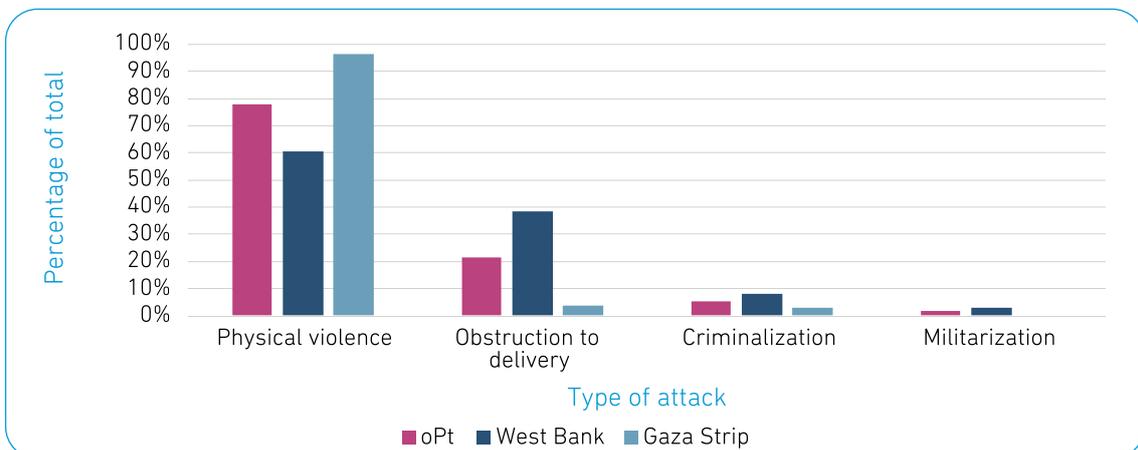
Chart 23: Trend in annual incidence of attacks against health care in the West Bank and Gaza Strip, 2015 to 2021



Type of attacks: Physical violence, obstruction to delivery, militarization, and criminalization

From 2019 to 2021, 78% of health attacks involved acts of physical violence; 22% involved the obstruction to delivery of health care; 6% involved the criminalization of health care, including arrest and detention of patients, their companions, and health care workers; and 2% involved militarization of health care facilities. Notably, one incident can involve more than one type of attack. There was a significant difference in the type of health attacks between the West Bank and Gaza Strip. In the Gaza Strip, the overwhelming proportion of health attacks involved acts of violence (97% vs. 60% in the West Bank). This is partly related to the separate monitoring of structural barriers to access affecting the Gaza Strip, outlined in the chapter, Health access: Barriers affecting the Gaza Strip. In the West Bank, on the other hand, a higher proportion of attacks involved obstruction to delivery of health care (39% vs. 3% in the Gaza Strip), where the physical presence of Israeli forces and large number of checkpoints contributed to a higher number of incidental obstructions to health care delivery, see Chart 24.

Chart 24: Distribution of health attacks by type for oPt, West Bank and Gaza Strip, 2019 to 2021



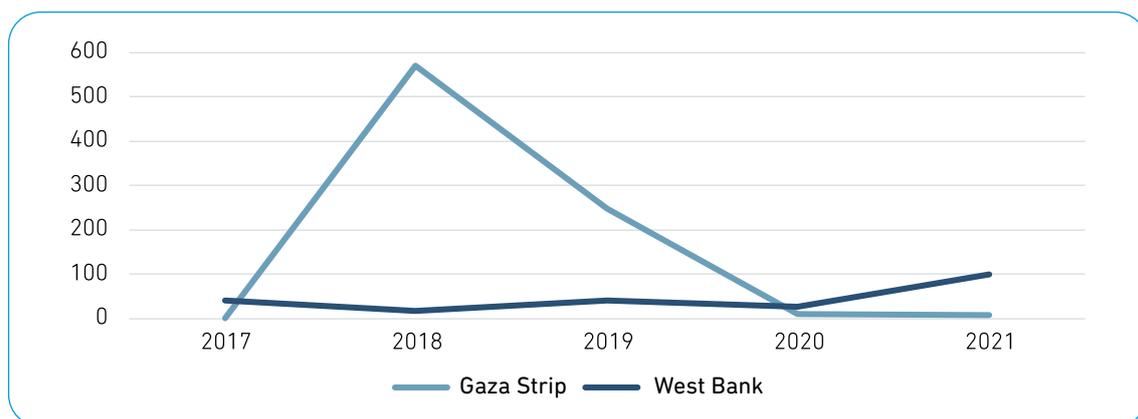
Impact of health attacks

Casualties and fatalities of health care workers

From 2019 to 2021, WHO documented one fatality of a health care worker killed while on duty, Sajed Mizher, in March 2019 in Dheisheh refugee camp in Bethlehem in the West Bank. In the same period, WHO documented 463 health care worker casualties in the oPt, with 166 in the West Bank and 297 in the Gaza Strip. The highest number of casualties from 2019 to 2021 occurred in the Gaza Strip in 2019, when there were 248 (54% of the total) injuries related to the GMR. The second highest peak was in the West Bank in 2021, with 100 (22% of the total) injuries. Chart 25 shows longer-term trends, with a large peak in health care worker casualties in 2018, when 570 injuries were recorded in the context of the GMR.



Chart 25: Health care worker casualties in the West Bank and Gaza Strip, 2017 to 2021



Affected resources: health care transport and facilities

From 2019 to 2021, 207 ambulances and 151 health care facilities were affected in attacks against health care in the occupied Palestinian territory. Most ambulances affected (162/207, or 78%) were in the West Bank, while most health facilities affected (127/151, or 84%) were in the Gaza Strip. As with disaggregation by type of attack, an ambulance or health facility may be affected in multiple ways, see Chart 26. Physical violence or damage affected most health facilities (148/151, or 98%), while 9 were affected by incidents (6% of the total) involving military incursion. Ambulances affected in the Gaza Strip were exposed to physical violence and damage and were not affected by incidents of obstruction or detention. Meanwhile for ambulances affected in the West Bank, 43% (69) were damaged, 68% (110) were exposed to obstruction, and 7% (12) were detained.

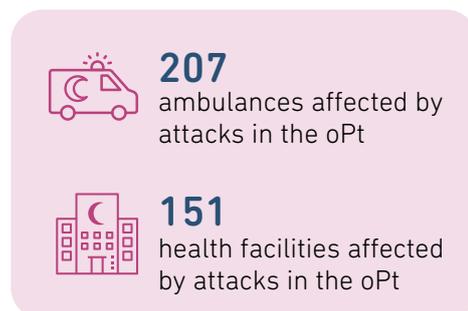
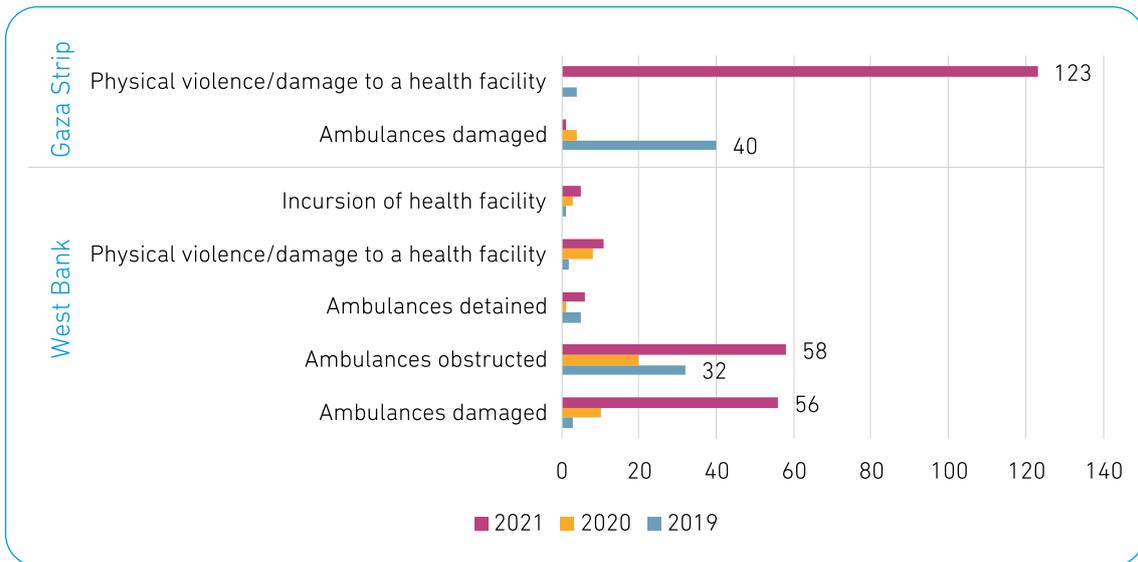


Chart 26: Types of impact of health attacks on facilities and ambulances in the West Bank and Gaza Strip, 2019 to 2021

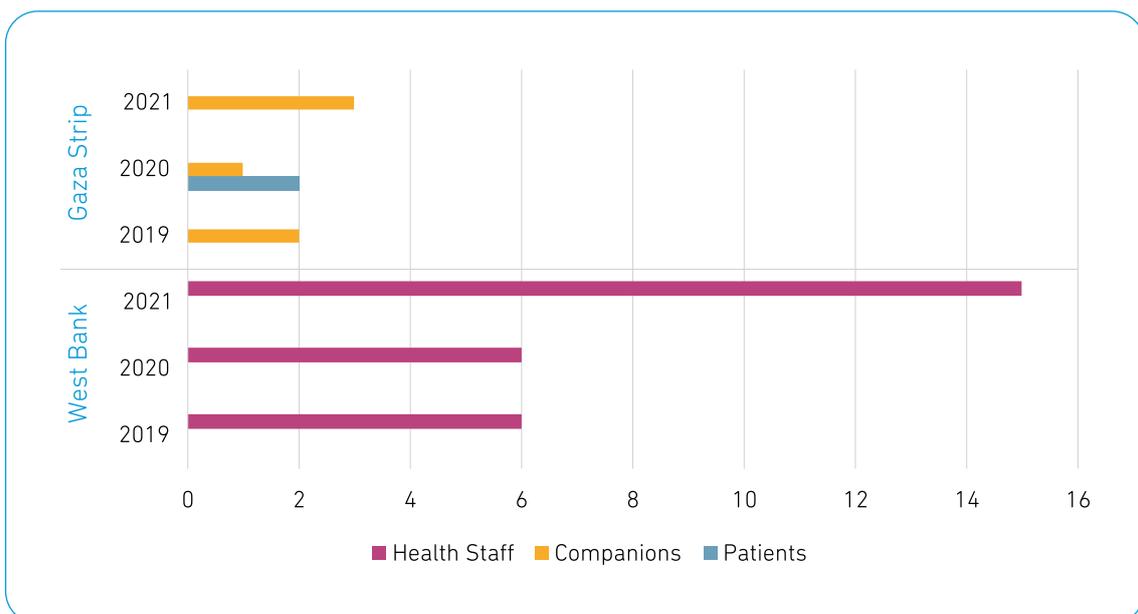


Criminalization of health care and security interrogations

Arrest and detention of patients, companions, and health care workers

From 2019 to 2021, there were 35 patients, companions and health care workers arrested or detained. In the Gaza Strip, all recorded incidents were arrests by Israel of patients (2) and companions (6) travelling across Erez (Beit Hanoun) checkpoint to reach health care in the West Bank, including east Jerusalem, Israel, and Jordan. In the West Bank, meanwhile, all incidents of arrest and detention (27) were of health staff, with most (15/27, or 56%) occurring in 2021 – see Chart 27.

Chart 27: Arrests and detention of health staff, patients and companions, 2019 to 2021

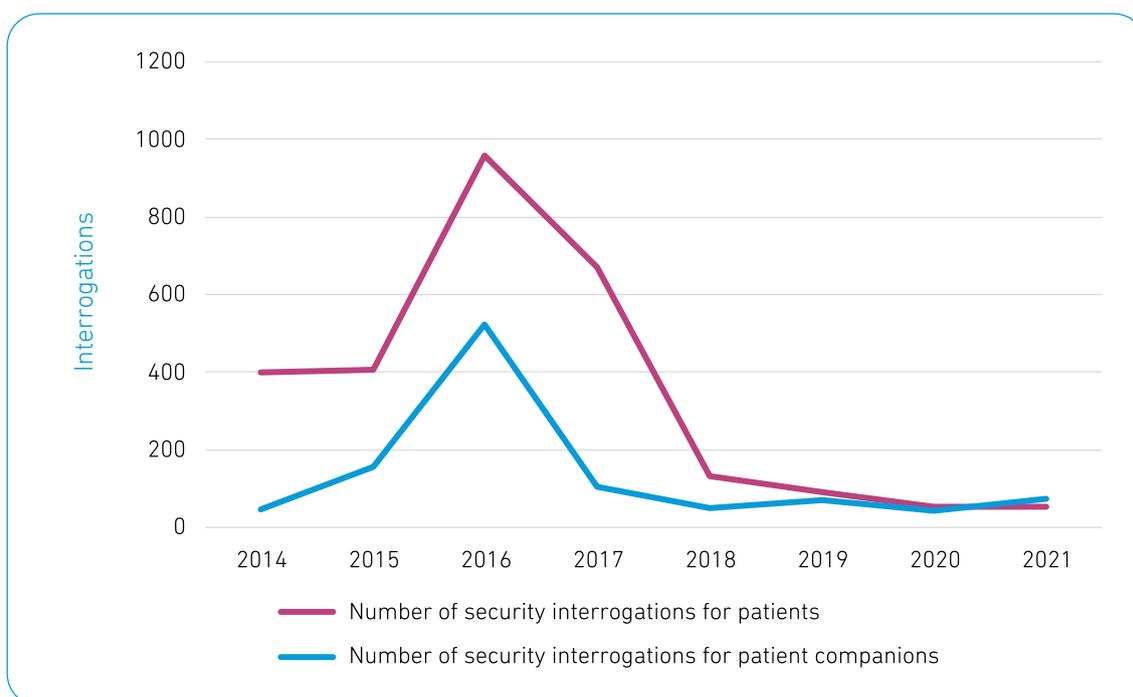


Three employees arrested in 2021 belonged to the Health Works Committees (HWC). In addition to their individual arrest, HWC itself was proscribed by Israel in charges that were brought against the health workers. This occurred in the context of proscribing another six Palestinian civil society organizations, which Israel labelled as ‘terrorist’. As of 2022, no substantive evidence has been brought forward to support this designation, which has been condemned and challenged by the international community.

Security interrogation of patients and companions

From 2019 to 2021, Israeli COGAT called 200 patients and 185 companions from the Gaza Strip for security interrogation as a prerequisite to their permit applications for access to health care. For data available since 2014, the highest annual incidence of interrogations occurred in 2016, when 959 patient applications for permits and 522 companion applications were made conditional on attendance for security interrogation by Israeli intelligence services, see Chart 28. Of patients required to undergo interrogation from 2019 to 2021, 10% were over 60 years of age and close to a third (31%) were of female patients. Most patients (91%) were destined for hospitals in the West Bank, including east Jerusalem. Following interrogation, just 12/200 (6%) permit applications were subsequently approved, while 35 (18%) were denied and over three quarters (77%) delayed, receiving no definitive response by the date of their hospital appointments. Of companions interrogated, 18% were over 60 years and 37% were female companions. As with patients, just one in twenty (5%) permit applications were subsequently approved after interrogation.

Chart 28: Number of security interrogations for patients and companions needing exit from Gaza each year, 2014 to 2021





CONCLUSION

The findings in this report outline the considerable barriers to the right to health affecting the sustainable provision of health care, health access, and protection of health care in the occupied Palestinian territory from 2019 to 2021. The durability and persistence of these barriers indicate the potential need for stronger mechanisms of accountability for implementation of UN resolutions and related actions, including recommendations made to international decision-making bodies.

This report reiterates the recommendations from the report by the WHO Director-General to the Seventy-fifth World Health Assembly on Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan (document A75/26). These recommendations, directed to Israel, the Palestinian Authority, and the international community, are outlined in the numbered lists from p12 (1, 2, etc.). For effective implementation, expanded technical-level recommendations are listed below certain of the recommendations (under letters a, b, etc.).





**World Health
Organization**

occupied Palestinian
territory

HOUSE DEMOLITION



From 2001, the occupied Palestinian territories have been subject to a policy of house demolition. In 2002, the Israeli government announced that it would demolish 1,000 houses in the occupied territories. This policy has been widely condemned by the international community as a violation of international law. The World Health Organization has expressed concern over the impact of house demolition on the health and well-being of the Palestinian people. The destruction of homes and infrastructure has led to the displacement of thousands of people and has severely damaged the social and economic fabric of the occupied territories. The WHO calls for an immediate end to house demolition and for the implementation of measures to protect the health and well-being of the Palestinian people.