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1 Executive summary

The *right to the highest attainable standard of health* is a fundamental human right encompassing all elements of life necessary to enjoy good health. It incorporates accessible, available, acceptable and high quality **health services** as well as meeting needs such as access to adequate food, clean water and housing that are considered **underlying determinants of health**.

This report provides an overview and analysis of the right to health in the occupied Palestinian territory (oPt), and focuses on two major issues: access restrictions for patients, companions and health staff – specifically due to Israel’s permit regime – and health attacks affecting patients, companions, health workers and health facilities.

In 2017, patients from Gaza faced increased restrictions on movement and additional bureaucratic barriers to accessing care outside the Gaza Strip, with a mere 54% of patient permit applications approved in time to attend hospital appointments. This 2017 approval rate is the lowest annual rate recorded by WHO for patients seeking health care outside Gaza, following a successive decline each year since 2012, when 93% of patient permit applications were approved.¹ These figures are distinct from those for people in the West Bank, where patient applications for access to hospitals in Israel and East Jerusalem were approved 88% of the time. Additionally, under current regulations, Palestinian women over 50 years of age and men over 55 residing in the West Bank are exempt from having to apply for security permits to travel to East Jerusalem or Israel, provided that they travel from 8am to 7pm, not on Saturday, and that they have no existing restrictions placed on their movement.

During the year, Israeli authorities more than doubled the time allowed to them for processing ‘non-urgent’ permit requests from Gaza, requiring patients to submit applications 23 working days prior to their hospital appointment, up from 10 working days at the start of 2017. This additional time requirement complicates an already unpredictable application process that can lead to long delays in receiving care. With no true limit on the processing time by authorities, some applicants wait or engage in the process for months. Male patients aged 16 to 55 years and female patients aged 16 to 45 years face additional, lengthy security clearance processes, while

1. WHO, 2017. *Right to health: Crossing barriers to access health in the occupied Palestinian territory 2016*. Available at: http://www.emro.who.int/images/stories/palestine/documents/WHO_-_Access_Report_2016_Book_Final-small.pdf?ua=1&ua=1

all patients and patient companions can be called for security interrogation as a prerequisite to permit processing. Once and if approved, the need for treatment outside the patient's district of residence can mean high costs of transport and accommodation, which is a particularly heavy burden for patients and their companions from Gaza, who can be separated from family and friend support networks for weeks or even months on end.

In spite of the higher permit approval rate for patients, there are particularly vulnerable groups in the West Bank who face substantial physical and financial barriers to accessing adequate care, such as communities in Area C and the Seam Zone. These communities live in conditions made precarious by the legislative and administrative division of the West Bank and severe restrictions placed on development and access in these areas by Israeli authorities. For remote communities in Area C, planning restrictions prevent the development of permanent or semi-permanent structures, including health facilities. Subsequently many communities reliant on mobile health clinics, though coverage of these clinics is incomplete. Similarly, communities in the Seam Zone between the 1949 Armistice Agreement Line and Israel's separation wall that cuts into the occupied West Bank are isolated from access to health services in nearby towns. Both of these areas remain difficult to serve due to health attacks levied through restrictions on movement. In 2017, seven mobile clinics providing primary care to these communities were denied access for two to more than nine months.

WHO defines a health attack as "any act of verbal or physical violence, threat of violence or other psychological violence, or obstruction that interferes with the availability, access and delivery of curative and/or preventive health services." In 2017, WHO documented 111 incidents of attacks on health care, but it is very likely that this number represents an under-estimation of the situation in reality, with a significant number of health providers not actively reporting data. As of 2018, WHO is implementing the global Surveillance System of Attacks on Healthcare (SSA) to improve data collection and reporting, in order to strengthen advocacy efforts to prevent future attacks and protect health workers.

The right to the highest attainable standard of health is recognized in International Human Rights Law and International Humanitarian Law and places a number of obligations on States that include ensuring access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; the provision of essential drugs; and the equitable distribution of health services. The obligations on States also pertain to the underlying determinants of health, such as ensuring access to minimal essential food that is nutritionally adequate and safe, as well as access to shelter, housing and sanitation and an adequate supply of safe drinking water.² As occupying power, Israel has a number of obligations under international law to respect, protect and fulfil the right of Palestinians to the highest attainable standard of health and wellbeing. The Palestinian Authority and de facto authority in Gaza also bear responsibilities for ensuring the right to health for Palestinians, to the extent of their jurisdiction. Finally, the international community has a duty to monitor and promote fulfilment of the responsibilities of the occupying power, including its responsibility for the health and welfare of the Palestinian population.³

2. OHCHR & WHO, 2008. *Factsheet Number 31: The Right to Health*. Available at: <https://www.ohchr.org/Documents/Publications/Factsheet31.pdf>

3. Human Rights Council, 37th Sess, Agenda item 7. UN Doc A/HRC/37/75 (15 March 2018)

2 Background

Palestinians in the West Bank and Gaza Strip have been under Israeli military occupation for more than half a century. After 1967, Israel constructed a separate legal and administrative system for Palestinians living in the West Bank and Gaza Strip that has entrenched the legislative and physical division of the occupied Palestinian territory. The West Bank remains separated from the Gaza Strip, with movement for Palestinians severely restricted between the two areas. The West Bank itself is divided into Areas A, B and C, in addition to the Israeli-controlled areas of H2 in Hebron and East Jerusalem, presenting further difficulties for the cohesiveness of the health system and for access for staff, ambulances, patients and relatives.

Israel accords Palestinians living in different areas of the occupied Palestinian territory different statuses that permit them differential access to health services and different levels of free movement. Palestinians in East Jerusalem are given a residency status different to Palestinians living in the rest of the West Bank. This status grants them access to Israeli health insurance and health services, but is insecure and dependent on them continuing to live or work in Jerusalem. East Jerusalem 'residents' are able to move freely within Israel, while the majority of Palestinians in the remainder of the Palestinian territory occupied since 1967 are not. Similarly, Palestinians living in the occupied Palestinian territory outside of East Jerusalem are not entitled to Israeli health insurance or health services. Here, the Palestinian Authority assumes responsibility for the administration of the public health system, though it is not financially independent from Israel: the occupying power controls Palestinian customs revenue, which it has in the past withheld. Additionally, the World Bank estimates that at least \$3.4 billion is lost each year to the Palestinian economy due to lack of control of its territory and resources in Area C alone.⁴

Under the Israeli-Palestinian Interim Agreement on the West Bank and the Gaza Strip (the Oslo II accord), the West Bank was divided into Areas A, B and C. Area A is under Palestinian civil and security control; Area B under Palestinian civil control and Israeli military control; and Area C under Israeli civil and military control. In Area C, which comprises more than 60% of the West Bank, Israel has significantly expanded its settlement infrastructure since the accord, while development efforts for the some 300,000 Palestinians who live in this Area, including efforts to develop health services, are severely restricted. Since 2002, Israel's construction of a separation wall has further complicated access to health services for Palestinians residing in the "Seam Zone" – the area between the 1949 Armistice Agreement Line and the separation wall. These Palestinians must now navigate additional checkpoints and take convoluted routes to nearby towns and health facilities. All Palestinians in the West Bank must also navigate the extensive and shifting system of Israeli military checkpoints that restrict access within Area C and between major Palestinian urban centres, which can lead to unpredictable delays, including for ambulances.

The Gaza Strip has been under land, sea and air blockade for more than ten years, compounding barriers to access for patients, patient companions and staff and detrimentally affecting the

4. World Bank, 2013. *West Bank and Gaza - Area C and the future of the Palestinian economy* (English). Washington DC ; World Bank Group. Available at: <http://documents.worldbank.org/curated/en/137111468329419171/West-Bank-and-Gaza-Area-C-and-the-future-of-the-Palestinian-economy>

availability of health services for the population. Palestinians living in Gaza are only able to leave the Gaza Strip via Erez crossing to Israel in the north and via Rafah crossing to Egypt in the south. Access through Erez is critical for patients needing to reach major Palestinian referral hospitals in East Jerusalem and the West Bank, as well as for those patients from Gaza referred to Israel for health care not available in Gaza or elsewhere in the occupied Palestinian territory. The health sector in Gaza has witnessed de-development since the start of the blockade, with a reduction in the number of hospital beds, nurses and doctors per head of the population since 2010 and long-term shortages of medicines and medical supplies.

Israel's permit system presents a major barrier for the access of Palestinian patients from Gaza and the West Bank to health facilities within and outside the occupied Palestinian territory. Access to health care remains a fundamental element of the right to health, which must be respected, protected and fulfilled by duty bearers. Israel as occupying power has a primary responsibility to ensure the health and wellbeing of Palestinians according to International Human Rights Law and International Humanitarian Law. The Palestinian Authority and de facto authority in Gaza have a duty to respect, protect and fulfil the right to health of Palestinians, to the extent of their jurisdiction. The international community has obligations under International Humanitarian Law to monitor and promote fulfilment by the occupying power of its responsibilities to the occupied population, see Box 1.⁵

Box 1: Principal duty bearers for the right to health in the occupied Palestinian territory

1. **Israel as occupying power** has the primary responsibility for ensuring the right to the highest attainable standard of health for the Palestinian population in the West Bank, including East Jerusalem, and the Gaza Strip. As State Party to the International Covenant on Economic, Social and Cultural Rights, Israel must observe International Human Rights Law throughout the area of its effective jurisdiction, including the occupied Palestinian territory. As State Party to the Fourth Geneva Convention, Israel as occupying power has overall responsibility for access to health care for the occupied Palestinian population.
2. **The Palestinian Authority** and the **de facto authority** in Gaza have responsibilities for the provision of health care to the occupied Palestinian population, and the Palestinian Authority has acceded to 20 international Covenants and Conventions, including 8 human rights treaties. These authorities are duty bearers to the extent of their jurisdiction, but Israel as occupying power bears ultimate responsibility.
3. **The international community** has obligations for the right to the highest attainable standard of health for the occupied Palestinian population. Under International Humanitarian Law, the international community has a responsibility to help States to fulfil their responsibility to protect populations under their jurisdiction and the international community takes responsibility to protect the population when a state fails in this regard. Under accepted application of International Human Rights Laws, states are bound by international human rights standards when acting outside their boundaries.

5. Human Rights Council, 37th Sess, Agenda item 7. UN Doc A/HRC/37/75 (15 March 2018)



3 Right to health in the occupied Palestinian territory

Conceptual framework of the right to health

The right to health, or the *right to the enjoyment of the highest attainable standard of physical and mental health*, is a fundamental human right linked closely to other human rights, such as the right to life, the right to water, the right to food and nutrition, the right to freedom from discrimination and the right to information and education. The right to health is recognized in International Humanitarian Law and International Human Rights Law, including the International Covenant on Economic, Social and Cultural Rights, which is “widely considered as the central instrument of protection for the right to health.”⁶

As outlined in the diagram on page 8, the right to health encompasses the availability, accessibility, acceptability and quality of health services, as well as the underlying determinants of health such as access to safe drinking water, food security, shelter and education. Crosscutting components of the right to health include participation in public life, the right to health-related information, as well as the principles of non-discrimination and gender equality.

States have the obligation to respect, protect and fulfil the right to health under International Human Rights Law. The principle of *progressive realization* of the right to health recognizes that different States have different means available to meet their obligations to the right to health of their population. However, the existence of health inequalities anywhere points to barriers to realizing the right to health for those populations with worse health outcomes.

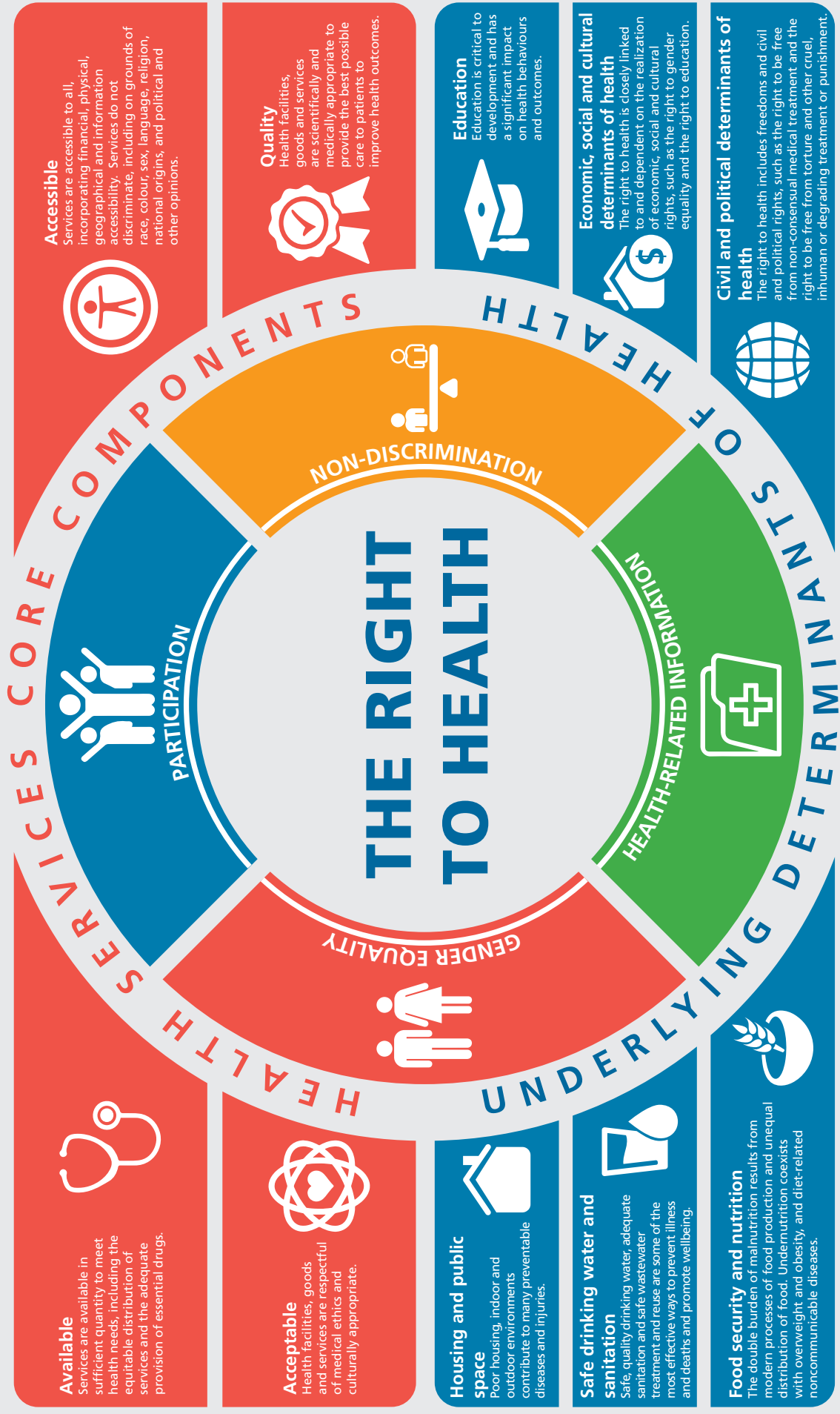
Box 2 details the core minimum obligation for States, as outlined by the Committee on Economic, Social and Cultural Rights.⁶

Box 2: Core minimum obligations for the right to health

- The right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
- Access to the minimum essential food which is nutritionally adequate and safe;
- Access to shelter, housing and sanitation and an adequate supply of safe drinking water;
- The provision of essential drugs;
- Equitable distribution of all health facilities, goods and services

6. OHCHR & WHO, 2008. *Factsheet Number 31: The Right to Health*. Available at: <https://www.ohchr.org/Documents/Publications/Factsheet31.pdf>

Figure 1: THE RIGHT TO HEALTH



Key indicators for the right to health in the occupied Palestinian territory

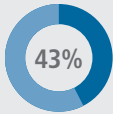
Identified indicators for the right to health enable States to assess the existing situation and to identify steps needed to strengthen the right to health for the population. In 2017, WHO began efforts to identify an indicator set for the right to health relevant to the situation in the occupied Palestinian territory with key partners. Several of these indicators are outlined in Figures 2 and 3 on pages 10 and 11, for the Gaza Strip and West Bank respectively. The indicators are shown separately for the Gaza Strip and West Bank because of the unique barriers to the right to health that apply to each situation. Similarly, this report examines barriers to health access separately in Sections 5 and 6 for the Gaza Strip and West Bank respectively, to enable a more detailed analysis of the contingent barriers that Palestinians face in these two parts of the occupied Palestinian territory. Section 7 outlines in more detail the situation of health attacks.

Figure 2: Right to health indicators for the West Bank





DEMOGRAPHIC STATISTICS





 Population **3.01 million** ¹

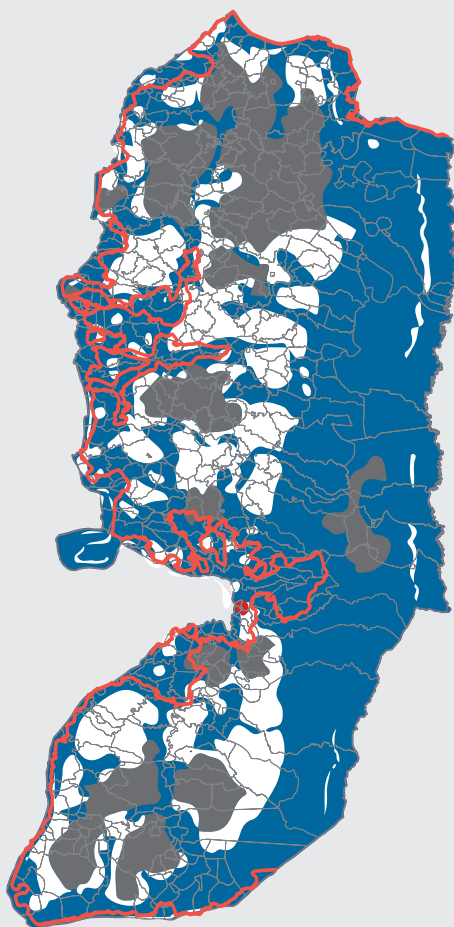
 **0.8 million** registered refugees ²

 **43%** under the age of **18** ¹

HEALTH SERVICES

-  **587** primary health clinics ³
-  **51** hospitals ³
-  **3,747** hospital beds ³
-  **23%** of essential medicines completely depleted during 2017 ⁷
-  **19%** of essential medical disposables completely depleted during 2017 ⁷
-  **78%** of people covered by health insurance ¹⁴
-  **45.5%** out of pocket payments for the population for the year 2016 ¹⁵

 Barrier constructed/planned
 Area A
 Area B
 Area C



UNDERLYING DETERMINANTS OF HEALTH

-  **22%** affected by lack of access to water and poor water quality ⁶
-  **140,301** people in Area C with no connection to water network or irregular water supply ¹¹
-  **61** checkpoints obstructing access to schools ⁶
-  **13%** severe or moderate food insecurity ⁶
-  **20%** unemployment rate ⁶
-  **9.5%** stunting in children under 5 years ¹²


HEALTH ACCESS IN 2017


-  **12%** patients denied health access to East Jerusalem and Israeli hospitals ⁹
-  **74,400** West Bank referrals to East Jerusalem and Israel ⁷
-  **18%** of patient companion applications denied access ⁸
-  **90%** of the 2,125 ambulances trips requiring entry to Jerusalem denied direct access ⁹
-  **40,220** referrals to East Jerusalem hospitals from the West Bank and Gaza ⁷
-  **174,444** people in Area C served by mobile health clinics ¹⁰


HEALTH ATTACKS IN 2017 ¹³

-  **70** incidents against ambulances, ambulance staff, patients and companions
-  **10** incidents against hospitals and health centres
-  **7** mobile clinics unable to access communities in Area C

HEALTH STATISTICS

 Life expectancy at birth **74** years ³

 Infant mortality **18** deaths per **1,000** live births ⁴

 Maternal mortality **45** deaths per **100,000** live births ¹⁶

 **7%** people with disabilities ⁵

 **157,612** people in need of psycho-social support ⁶

1. PCBS, 2017. Palestinian Central Bureau of Statistics (PCBS) and National Population Committee: The International Population Day 11/07/2017. Available at: <http://www.pcbs.gov.ps/post.aspx?lang=en&ItemID=1975>

2. UNRWA, 2017. Where we work: West Bank. Available at: <https://www.unrwa.org/where-we-work/west-bank>

3. PHIC, 2017. Health Annual Report, Palestine 2016

4. UN-IGME, 2015. Levels and Trends in Child Mortality.

5. PCBS, Disability Survey, 2011

6. OCHA, 2017. Humanitarian Needs Overview, 2018

7. Palestinian Ministry of Health, 2018 - preliminary annual figure based on data for Jan-Oct and Dec 2017

8. Palestinian Coordination and Liaison Administration, 2018

9. Palestinian Red Crescent, 2018

10. Health cluster data, 2018

11. OCHA, Vulnerability Profile of Palestinian Communities in Area C, updated 2017. Available at: <http://data.ochaopt.org/vpp.aspx>

12. Palestinian Ministry of Health, 2014. Palestinian Micronutrient Survey (PMS) 2013. Available at: [file:///C:/Users/Ben/AppData/Local/Microsoft/Windows/NetCache/Content.Outlook/PKZ6T80F/Micronutrient%20survey%20\(2\).pdf](file:///C:/Users/Ben/AppData/Local/Microsoft/Windows/NetCache/Content.Outlook/PKZ6T80F/Micronutrient%20survey%20(2).pdf)

13. WHO, 2018. Monitoring database

14. PCBS, Preliminary Results of the Population Housing and Establishments Census, 2017

15. PCBS, National Health Accounts. Available at: http://www.pcbs.gov.ps/site/lang_en/797/default.aspx


16. UN-MMEIG, 2015. Trends in Maternal Mortality.

Figure 3: Right to health indicators for Gaza

DEMOGRAPHIC STATISTICS


Population **1.94 million**¹


1.3 million registered refugees²



50% under the age of **18**¹


HEALTH SERVICES



152 primary health clinics³



30 hospitals³


2,399 hospital beds³



32% of essential medicines completely depleted in the last four months of 2017⁷


24% of essential medical disposables completely depleted in the last four months of 2017⁷



95% of people covered by health insurance¹⁰


45.5% out of pocket payments for the population for the year 2016¹¹


HEALTH ACCESS IN 2017⁸


46% of patient applications denied or delayed health access out of Gaza via Erez



12,075 patients exited via Erez


56% of patient companion applications denied or delayed access through Erez


1,405 exited Rafah terminal for health reasons

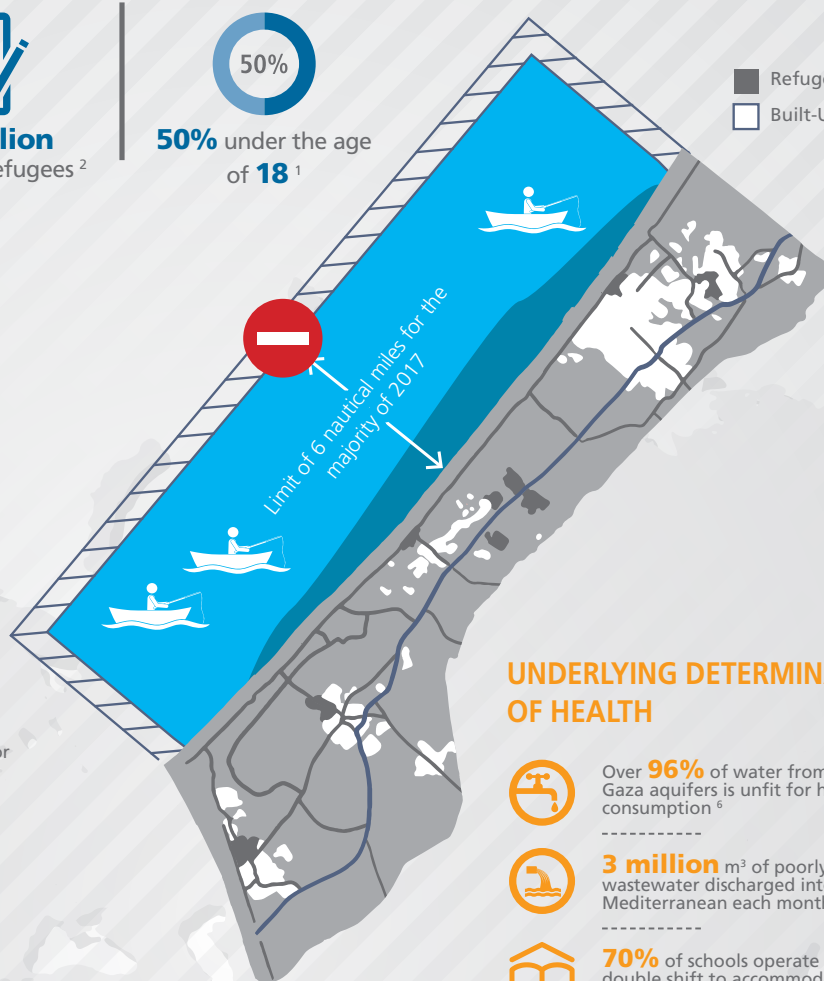

Rafah terminal open for exit for **21** days over the course of the year

HEALTH ATTACKS IN 2017⁸


24 incidents against ambulances, health facilities, patients and companions


60% of humanitarian health staff applying through WHO for exit from Gaza unsuccessful



596 patients called for security interrogation as a prerequisite to travel for health care




UNDERLYING DETERMINANTS OF HEALTH


Over **96%** of water from Gaza aquifers is unfit for human consumption⁶


3 million m³ of poorly treated wastewater discharged into the Mediterranean each month⁶


70% of schools operate a double shift to accommodate limited teaching capacity⁶



40% severe or moderate food insecurity⁶


44% unemployment rate⁶



10.8% stunting in children under 5 years⁹


20,300 people remain internally displaced following the 2014 conflict⁶

HEALTH STATISTICS


Life expectancy at birth **73** years³


Infant mortality **18** deaths per **1,000** live births⁴


Maternal mortality **45** deaths per **100,000** live births¹²


7% people with disabilities⁵


210,000 people in need of psycho-social support⁶

1. PCBS, 2017. Palestinian Central Bureau of Statistics (PCBS) and National Population Committee: The International Population Day 11/07/2017. Available at: <http://www.pcbs.gov.ps/post.aspx?lang=en&itemID=1975>

2. UNRWA, 2017. Where we work: Gaza. Available at: <https://www.unrwa.org/where-we-work/gaza-strip>

3. PHIC, 2017. Health Annual Report, Palestine 2016

4. UN-IGME, 2015. Levels and Trends in Child Mortality.

5. PCBS, Disability Survey, 2011

6. OCHA, 2017. Humanitarian Needs Overview, 2018

7. Palestinian Ministry of Health, 2018

8. WHO, 2018. Monitoring database

9. Palestinian Micronutrient Survey 2013

10. PCBS, Preliminary Results of the Population Housing and Establishments Census, 2017

11. PCBS, National Health Accounts. Available at: http://www.pcbs.gov.ps/site/lang__en/797/default.aspx

12. UN-MMEIG, 2015. Trends in Maternal Mortality.



4 Palestinian referrals outside Ministry of Health facilities in 2017

The Palestinian Authority refers patients for specialized health care to non-Ministry of Health facilities, principally Palestinian hospitals in East Jerusalem and the West Bank, as well as to hospitals in Israel. The continued need for such referrals relates to the historic dependence on existing specialist referral centres in Jerusalem and Israel, with the development of alternative specialized care facilities in fragmented parts of the occupied Palestinian territory constrained by financial and legislative barriers. The initial estimated cost of medical referrals for Palestinian patients in 2017 is NIS 431,074,775, or approximately \$USD 120 million. Palestinian cancer patients account for 22% of all referrals. These patients depend on referral to East Jerusalem and Israel for access to full investigation and treatment services, with essential technologies for treatment and investigation of cancer, including facilities for radiotherapy and nuclear medicine scanning as well as some chemotherapy drugs, completely lacking in the rest of the West Bank and Gaza.

This section examines Palestinian referrals to non-Ministry of Health facilities, including trends in time; distribution between the West Bank and Gaza, and in terms of gender and age; referral destinations and reasons for referral.



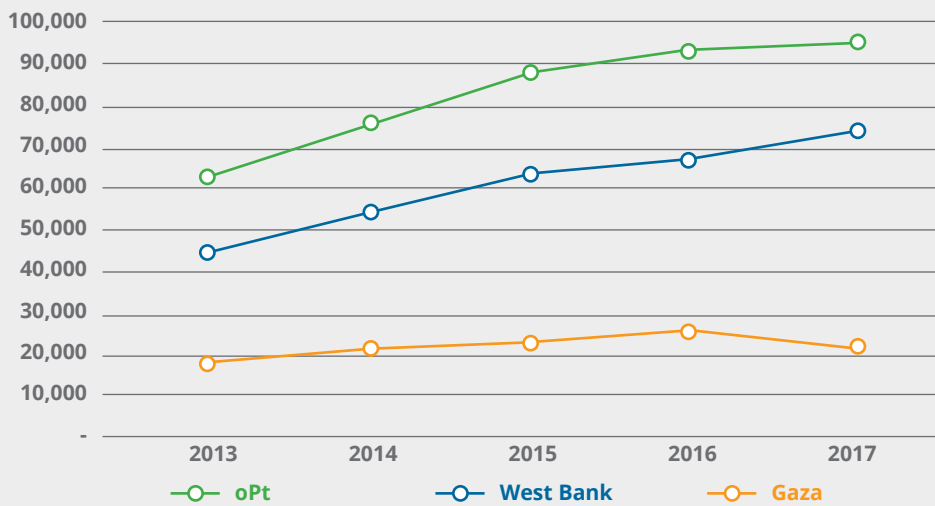
NIS 431,074,775

paid for referrals to non-MoH facilities

Time trend analysis

In 2017, the Services Purchasing Unit of the Palestinian Ministry of Health approved 94,939 referrals for 51,987 patients to non-Ministry of Health facilities, which include non-governmental hospitals and private hospitals within the occupied Palestinian territory, as well as public and private hospitals outside the occupied Palestinian territory. Of the total number, 20,505 referrals were for 12,153 patients from the Gaza Strip and 74,434 referrals were for 39,834 patients from the West Bank. Since 2013, there has been a marked increase in the overall number of referrals by the Palestinian Ministry of Health, increasing by more 54% from 61,635 in 2013 – and increasing more than 15-fold from 6,176 in 1996 – see Chart 1.

Chart1: Palestinian MoH referrals, total, West Bank, Gaza, 2013-2017



From 2016 to 2017, there was an increase in the overall number of referrals by 3,012: from 91,927 to 94,939. In the West Bank, the number of referrals increased by 7,123 from 67,311 in 2016 to 74,434 referrals in 2017, representing an 11% increase. In Gaza however, the total number of referrals dropped by 4,111 from 24,616 in 2016 to 20,505 in 2017, representing a 20% decrease.

The increase in the number of annual referrals since 1996 has been proportionately greater for the West Bank compared to the Gaza Strip. In the West Bank, there was a more than 18-fold (1716%) increase in the total number of referrals over this period, from 4,098 referrals for patients in 1996 to 74,434 referrals in 2017. In Gaza, meanwhile, the total number of referrals increased almost 10-fold (by 887%) from 2,078 referrals in 1996 to 20,505 in 2017. The West Bank and Gaza saw estimated population increases of approximately 61% and 91%, respectively, during the same period^{7,8}

7. Palestinian Central Bureau of Statistics. *Estimated Population in the Palestinian Territory Mid-Year by Governorate, 1997-2016*. Available at: http://www.pcbs.gov.ps/Portals/_Rainbow/Documents/gover_e.htm

8. Palestinian Central Bureau of Statistics. *Palestine in Figures: 2017*. Available at: <http://www.pcbs.gov.ps/Downloads/book2362.pdf>



94,939

referrals to non-Ministry of Health facilities



20,505

Gaza



74,434

West Bank



51,987

patients referred to non-Ministry of Health facilities



12,153

Gaza



39,834

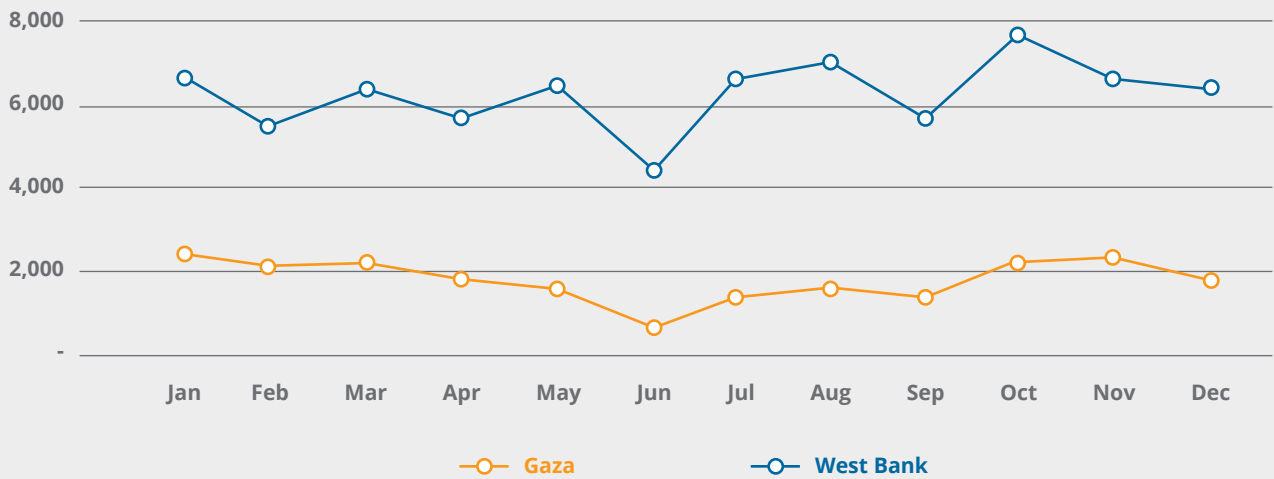
West Bank

Table 1: Ministry of Health referrals by region of origin, destination and permit requirement, 2014-2017

Destination	2014						2015						2016						2017					
	West Bank		Gaza		All		West Bank		Gaza		All		West Bank		Gaza		All		West Bank		Gaza		All	
	No.	% of total	No.	% of total	No.	% of total	No.	% of total	No.	% of total	No.	% of total	No.	% of total	No.	% of total	No.	% of total	No.	% of total	No.	% of total	No.	% of total
West Bank	23,703	44%	3,481	17%	27,184	36%	29,986	47%	5,753	24%	35,739	41%	28,944	43%	4,803	20%	33,747	37%	34,550	46%	3,013	15%	37,543	40%
East Jerusalem	26,463	49%	7,410	36%	33,873	45%	27,149	43%	9,583	40%	36,732	42%	29,636	44%	10,584	43%	40,220	44%	27,772	37%	8,642	42%	36,414	38%
Gaza	-	0%	3,288	16%	3,288	4%	-	0%	3,016	13%	3,016	3%	-	0%	2,993	12%	2,993	5%	-	0%	3,380	16%	3,380	6%
oPt total	50,166	92%	14,179	70%	64,345	86%	57,135	90%	18,352	77%	75,487	86%	58,580	87%	18,380	75%	76,960	84%	62,302	84%	15,035	73%	77,337	81%
Egypt	21	0%	2,454	12%	2,475	3%	14	0%	1,744	7%	1,758	2%	9	0%	1,746	7%	1,755	2%	3	0%	1,313	6%	1,316	1%
Jordan	72	0%	31	0%	103	0%	34	0%	38	0%	72	0%	24	0%	26	0%	50	0%	4	0%	8	0%	12	0%
Israel	4,086	8%	3,674	18%	7,760	10%	6,462	10%	3,838	16%	10,300	12%	8,698	13%	4,464	18%	13,162	14%	12,121	16%	4,148	20%	16,269	17%
Turkey																			4		1			
Elsewhere total	4,179	8%	6,159	30%	10,338	14%	6,510	10%	5,620	23%	12,130	14%	8,731	13%	6,236	25%	14,967	16%	12,132	16%	5,470	27%	17,602	19%
Grand Total	54,345	73%	20,338	27%	74,683		63,645	73%	23,972	27%	87,617		67,311	73%	24,616	27%	91,927		74,434	78%	20,505	22%	94,939	
Israeli permit required to access health care	30,642		14,596		45,238		33,659		19,212		52,871		38,367		19,877		58,244		39,900		15,811		55,711	
Egyptian approval required to exit Gaza via Rafah border			2,454		2,454				1,744		1,744				1,746		1,746				1,313		1,313	
Total permits					47,692						54,615						59,990						57,024	

The monthly trend for referrals in 2017 demonstrates a dramatic decline in the number of referrals in June, as shown in Chart 2. In Gaza, the number of referrals dropped from an average of 2,149 referrals per month for the first quarter to 613 referrals in June, or less than a third (29%) of the previous monthly average. There was slight improvement in the third quarter from July to September, where the average number of monthly referrals was 1,299 (60% of the average number for the first quarter). By the final quarter of the year, the monthly number of referrals had almost reached previous levels, with an average of 2,051. In the West Bank, a less dramatic decline was also observed for June, with the number of referrals declining from an average of 6,088 during the first quarter to 4,345 in June (71% of the previous average). The monthly number of referrals returned to previous levels in subsequent months, with an average number of 6,691 referrals per month for July to December.

Chart 2: Palestinian MoH referrals for the West Bank and Gaza Jan to Dec 2017



Spend on referrals

The overall spend by the Palestinian Ministry of Health on referrals to health facilities outside of the public system was fairly constant from 2013 to 2016 with an average spend of NIS 555,315,612, see Chart 3. In 2017, the annual spend of the Ministry of Health on referrals dropped by 24% to NIS 431,074,775. In Gaza, the decline in spend on referrals was relatively greater than for the West Bank: for Gaza, spend on referrals dropped by 46% from NIS 164,948,307 in 2016 to NIS 89,860,641 in 2017; in the West Bank, spend on referrals dropped by 15% from NIS 401,772,673 in 2016 to NIS 341,214,134 in 2017. From 2016 to 2017, the percentage spend on Gaza referrals also dropped from 29% of all Palestinian referrals in 2016 (an average of 28% from 2013 to 2016) to 21% in 2017.

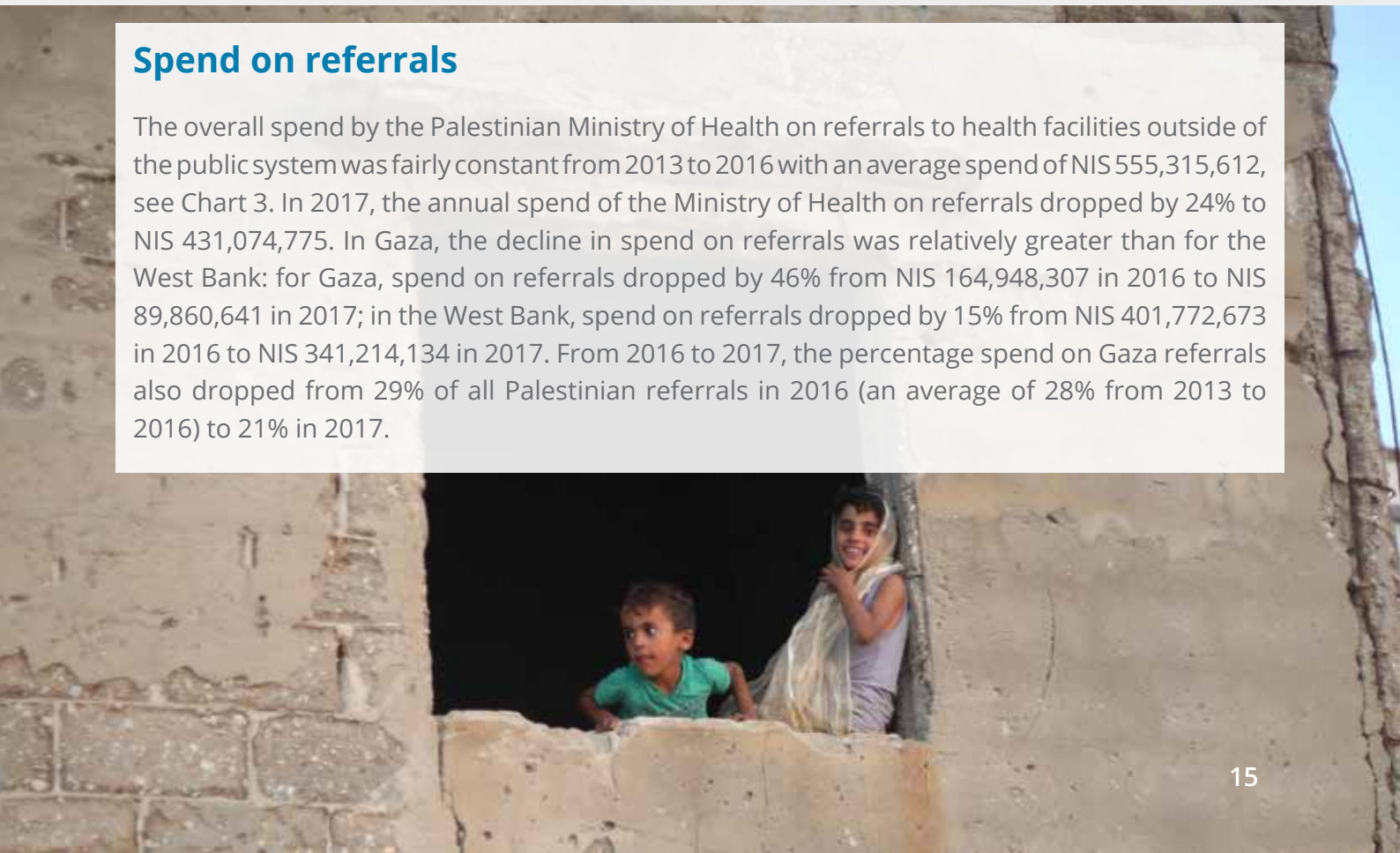
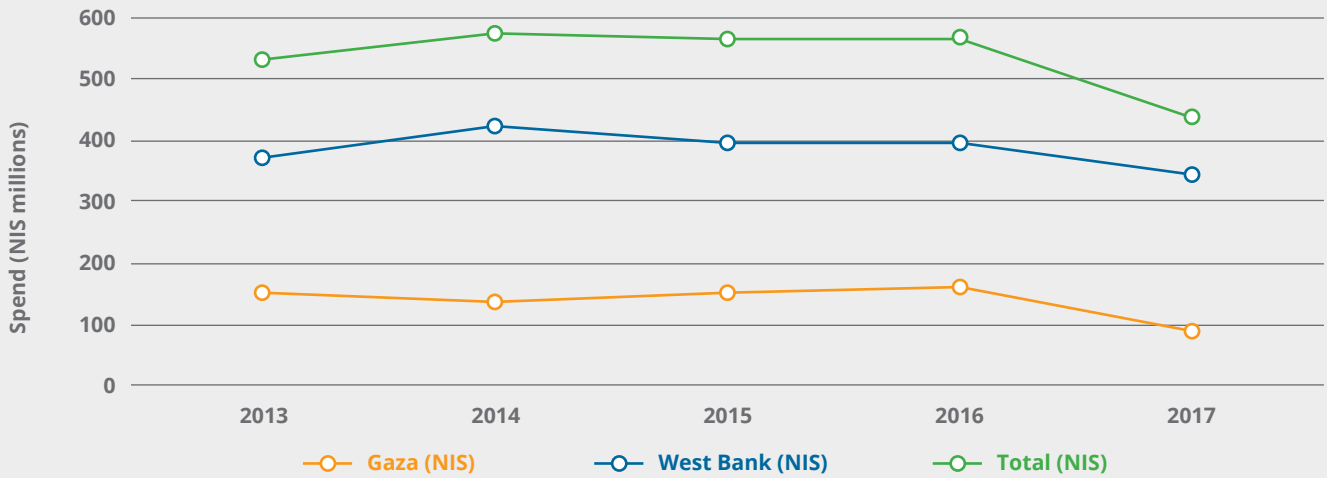
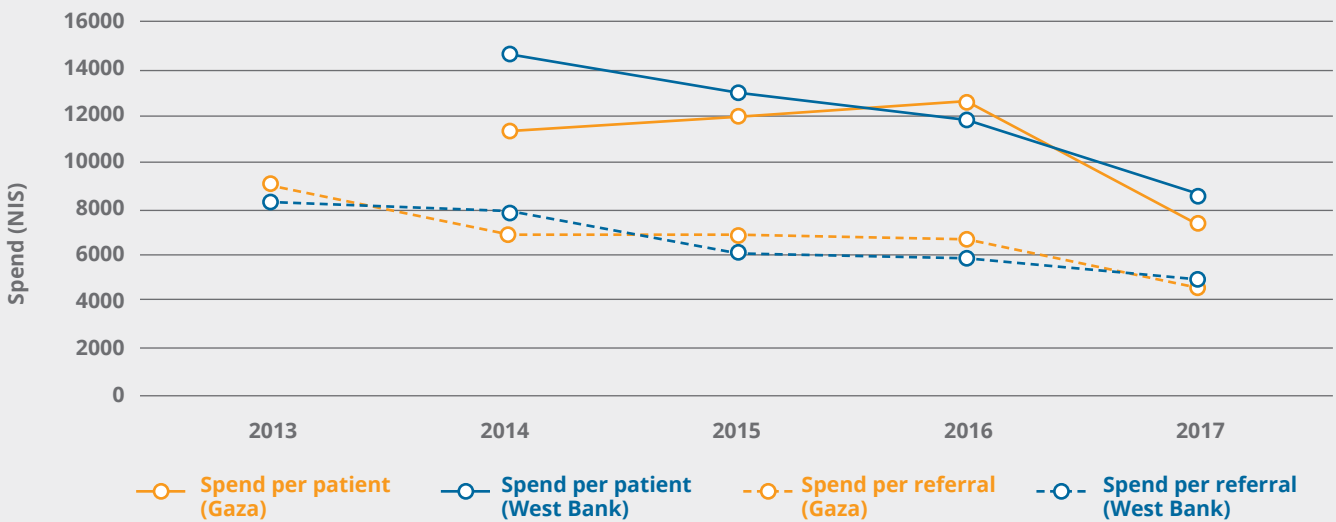


Chart 3: Spend by the Palestinian Ministry of Health on referrals, 2013 to 2017 (NIS millions)



From 2013 to 2017, spend per referral was similar for the West Bank and Gaza for each year, but reduced by 47% from NIS 8,503 in 2013 to NIS 4,584 in 2017 – see Chart 4. Data for spend per patient was available from 2014 and shows convergence between the West Bank and Gaza from 2014 to 2015, with the spend per patient higher for the West Bank in 2014 (NIS 14,611 compared to NIS 11,346). As with spend per referral, there was an overall decline in spend per patient, by 39%, from NIS 13,627 in 2014 to NIS 8,292 in 2017.

Chart 4: Chart 4: Spend per patient and spend per referral for the West Bank and Gaza, 2013 to 2017



Distribution analysis

Distribution of referrals

Gaza referrals accounted for 22% of the total number of Ministry of Health referrals to non-Ministry of Health facilities in 2017. Gaza referral patients accounted for 23% of the total and 21% of all costs of referrals for the Palestinian Ministry of Health. This means a significant change in the distribution of referrals for patients between the West Bank and Gaza: from 2013 to 2016, referrals for patients from Gaza constituted approximately 27-28% of referrals and 28% of referral costs, with the Gaza population representing approximately 40% of the Palestinian

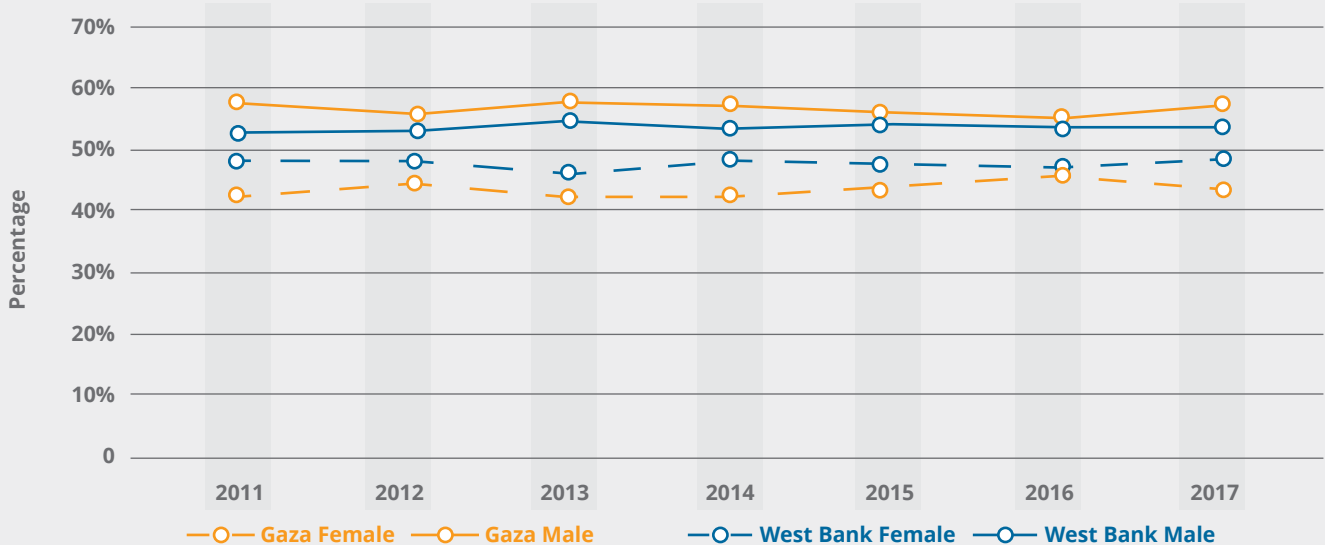
population living in the Palestinian territory occupied since 1967. The severe restrictions on access for Gaza patients, outlined in Section 5, are likely to have a significant impact on referral spend for Gaza patients: in 2017, 54% of patient permit applications from Gaza were approved by Israeli authorities compared to 88% of permit applications to Israeli authorities for patients from the West Bank.

Gender distribution of referrals

In 2017, 52% of referrals from the West Bank and 56% of referrals from Gaza were for male patients. There has been little variation in the gender distribution of referrals over the seven years from 2011 to 2017, though consistently a greater proportion of Gaza referrals are for male patients, see Chart 5. The particularity of health care needs and the different lack of availability of services in the West Bank and Gaza will affect the gender distribution of referrals. For instance, in Gaza during 2017 a higher proportion of referrals were for male patients in paediatrics (61%) and ENT (64%), while a greater proportion of referrals were for female patients in oncology (60%), nuclear medicine (58%) and plastic surgery (61%).



Chart 5: Gender distribution of referrals to non-MoH facilities, 2011 to 2017

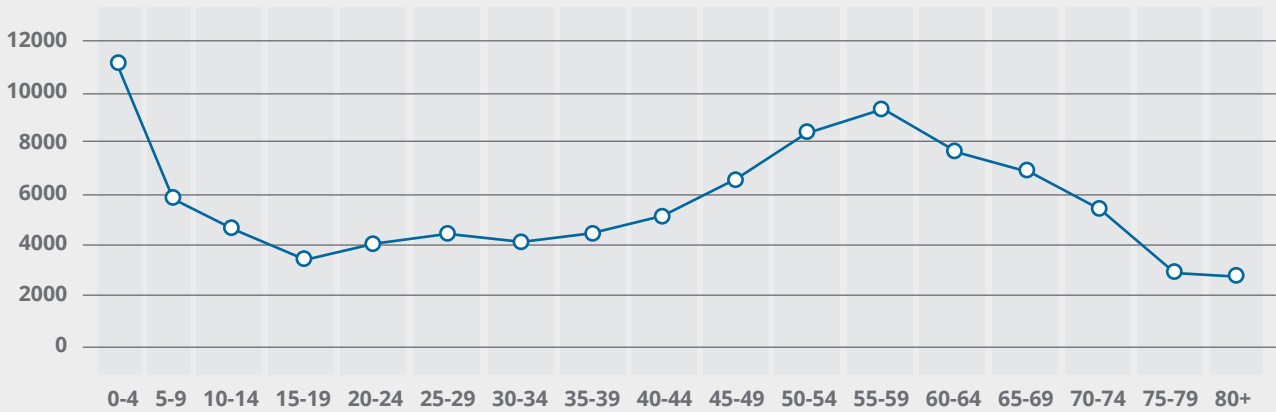


Age distribution of referrals

Chart 6 demonstrates the age distribution of Ministry of Health referrals to non-Ministry of Health facilities, with two peaks: the first in children under 5 years of age, representing 12% of all referrals, and the second in patients aged 55-59, representing 10% of all referrals. The distribution reflects both population healthcare needs and the gaps in specific services within Ministry of Health facilities to meet specific health needs in these age groups. Referrals for children under 18 years of age constituted approximately a quarter (24%) of all referrals.



Chart 6: Age distribution of referrals to non-MoH facilities, 2017



Destination of referrals

Hospitals in the West Bank, including East Jerusalem, accounted for more than three-quarters (78%) of referrals by the Palestinian Ministry of Health to non-Ministry of Health facilities. 17% of referrals were to hospitals in Israel, 4% to hospitals in Gaza (all referrals from the Ministry of Health in Gaza) and 1% were to hospitals in Egypt. A small number of referrals were also made to Jordan (12) and Turkey (5).

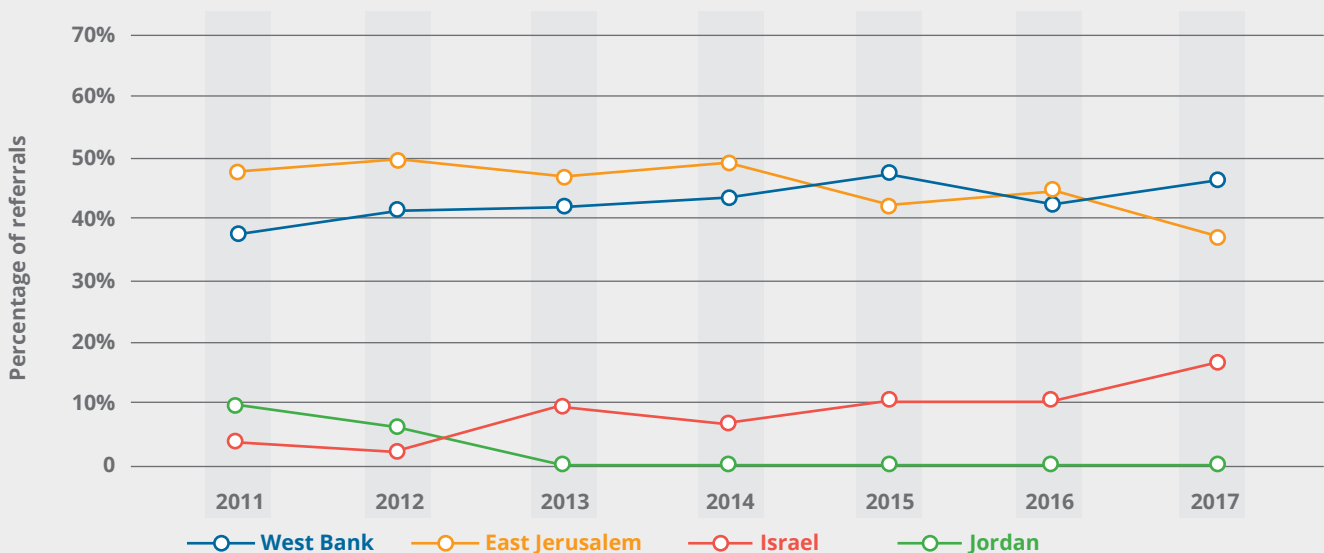
In 2017, just under half (46%) of West Bank referrals were to hospitals in the West Bank outside East Jerusalem, while almost two in five (37%) were to East Jerusalem hospitals and 16% were to hospitals in Israel. For West Bank referrals from 2011 to 2017: there was a fourfold increase in the proportion of referrals to hospitals in Israel (from 4% to 16%); an 8% increase in the proportion of referrals to the West Bank (from 38% to 46%); an 11% decline in the proportion of referrals to East Jerusalem hospitals (from 48% to 37%); and an approximate 1000-fold decrease in referrals to Jordan (from 10% to 0.01%).



78%

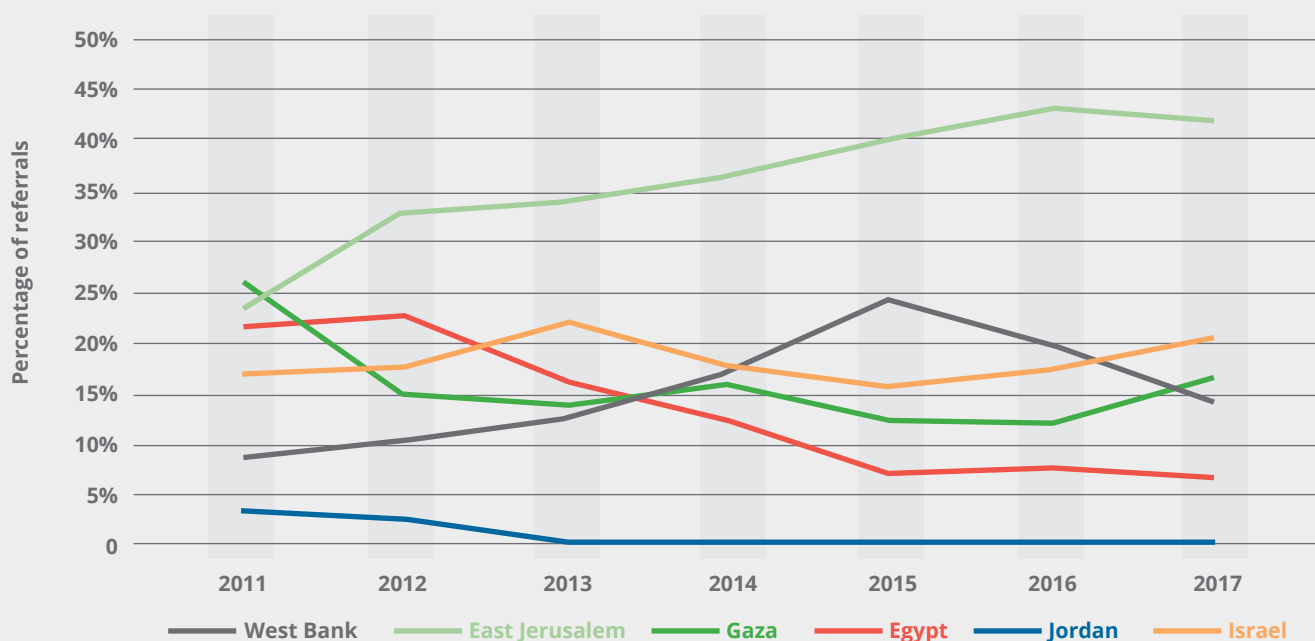
of referrals to hospitals in the West Bank, including East Jerusalem

Chart 7: Destination of MoH referrals for West Bank patients, 2011 to 2017



In Gaza in 2017, the single most frequent referral destination was to hospitals in East Jerusalem, which accounted for more than two-fifths of all referrals. Israel, Gaza and the West Bank were the next most frequent destinations for Gaza referral patients, accounting for 20%, 16% and 15% of referrals respectively. Egypt accounted for the remaining 6%. Since 2011, the proportion of Gaza referrals to East Jerusalem almost doubled, from 23% in 2011 to 42% in 2017. The proportion of Gaza referrals within Gaza declined from more than a quarter (26%) of referrals in 2011 (when Gaza was the single most frequent referral destination) to an average of 14% of referrals from 2012 to 2017. Egypt similarly declined, from more than a fifth (22%) of referrals in 2011 to just over 1 in 20 (6%) in 2017, with successive declines year-on-year from 2012 to 2015. The proportion of referrals to the West Bank increased from 9% in 2011 to almost a quarter (24%) of referrals in 2015, before declining again to 15% in 2017. The proportion of referrals to Israel remained relatively constant during this period, averaging 19% from 2011 to 2017.

Chart 8: Destination of MoH referrals for Gaza patients, 2011 to 2017



Reasons for referral

In-patient versus out-patient referrals

Three-quarters (76%) of Palestinian referrals to non-Ministry of Health facilities were for in-patients, accounting for 83% of referral costs. In Gaza, the proportion of in-patient referrals was larger compared to the West Bank: 83% of Gaza referrals were for in-patients, accounting for 85% of referral costs, compared to 74% of West Bank referrals, accounting for 83% of West Bank referral costs.

Referrals inside and outside the occupied Palestinian territory

Over a quarter of Gaza referrals (27%) were to hospitals outside the occupied Palestinian territory, mainly in Israel and Egypt, accounting for two-fifths (41%) of Gaza referral costs. In the West Bank, one in six referrals (16%) were to hospitals outside the occupied Palestinian territory, mainly to Israel, accounting for just under a third (31%) of West Bank referral costs. In

the occupied Palestinian territory as a whole, referrals to hospitals outside the West Bank and Gaza accounted for a third (33%) of costs.

Medical reasons for referral

In 2017, the single largest referral specialty for patients from the West Bank and Gaza was oncology, for treatment and investigation of cancer. In Gaza, this specialty accounted for almost a quarter (25%) of referrals, while in the West Bank oncology accounted for just over a fifth (21%) of referrals – see Chart 9. Cardiac catheterization was also a significant reason for referral in both areas, accounting for 8% of Gaza referrals and 11% of West Bank referrals. Ophthalmology, referrals for the treatment of eye disorders, and gastroenterology/general surgery accounted for a similar proportion of both Gaza and West Bank referrals. Ophthalmology accounted for 5% of Gaza referrals and 8% of West Bank referrals, while gastroenterology/general surgery accounted for 6% of Gaza referrals and 5% of West Bank referrals. In Gaza, a larger proportion of referrals were for haematology (8% compared to 4% in the West Bank) and paediatrics (7% compared to 3%). In the West Bank, a larger proportion of referrals were for urology and nephrology (10% compared to 3% in Gaza) and for medical imaging (6% compared to 3%). The differences in the distribution of referrals by specialty reflects the different needs and availability of services within the Ministry of Health between the West Bank and Gaza.

The top three medical reasons for referral



22%

oncology



10%

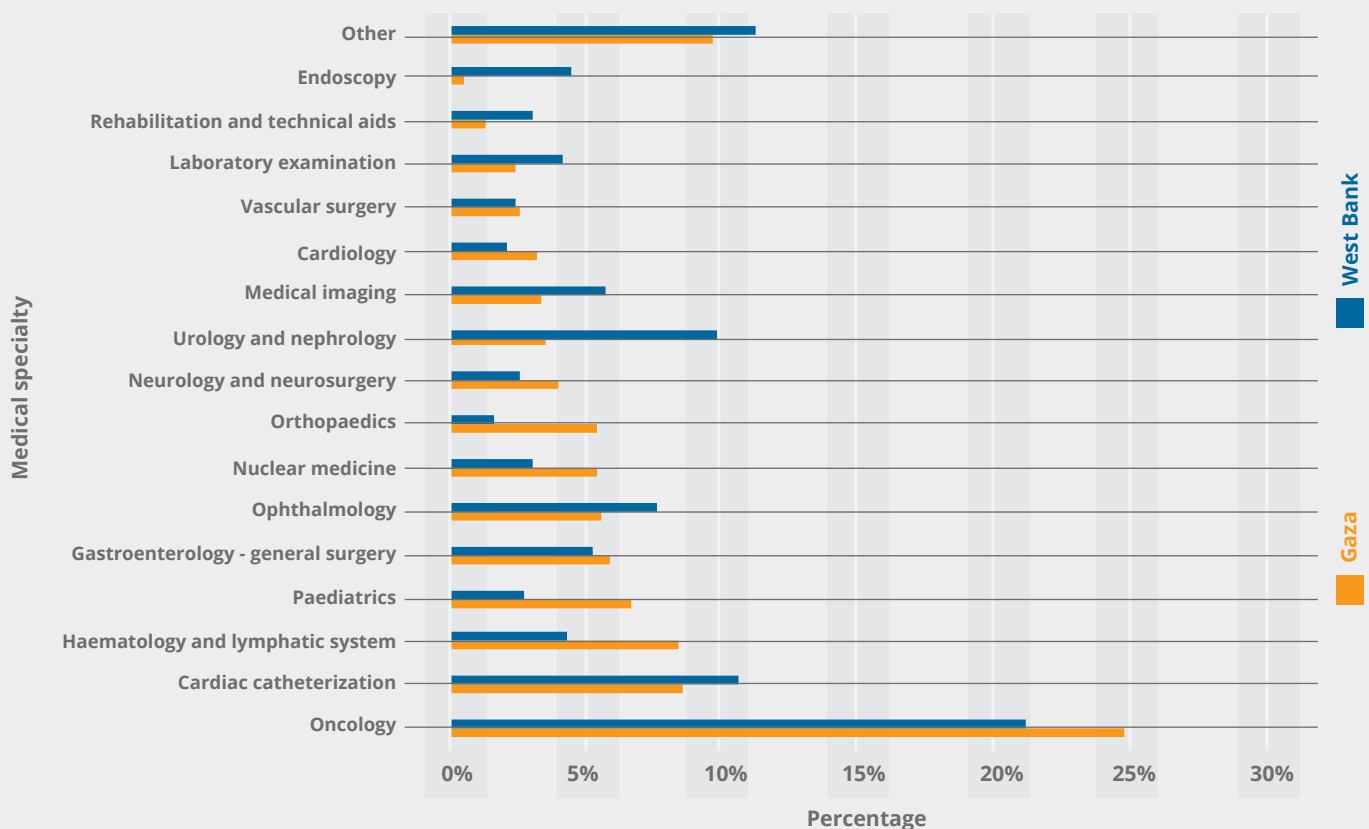
cardiac catheterization



8%

haematology and lymphatic system

Chart 9: Distribution of referrals to non-Ministry of Health facilities for the West Bank and Gaza, by specialty





5 Barriers to health access in Gaza

The Gaza Strip has been under land, sea and aerial blockade for more than ten years, with significant ramifications for the health sector and health access. The majority of Gaza patient referrals (77%) require access through the Israeli-controlled Erez crossing to reach hospitals in East Jerusalem, other areas of the West Bank and Israel. All these patients must apply to Israeli security services for permits to exit Gaza in order to access health care. In 2017, the approval rate for patient permits reached the lowest level recorded by WHO since 2006, with 54% of patient applications accepted – i.e. almost half of patient applications were either denied or did not receive any definitive response by the time of the hospital appointment.

Patients are referred as emergency, urgent or non-urgent cases. In theory, access for urgent and emergency cases can be processed on the same day, though in reality the processing time of these applications can take longer. For patient applications labelled as ‘non-urgent’, the processing time is considerably longer. Israeli authorities previously required that Palestinian patients submit permit applications at least ten working days in advance of their appointments. In 2017, Israeli authorities initially doubled this time requirement to 20 working days in May, and later increased it further to 23 working days in November. ‘Non-urgent’ patients include those referred for cancer treatment and investigation, as well as others referred for time-dependent – though not necessarily immediately life-saving – treatment, such as heart surgery or other surgeries.

Patients applying for permits from Israel authorities face additional financial burdens including costs of travel and costs of accommodation for their companions, as well as the emotional stress of a process that lacks transparency, is unpredictable and often lengthy. There is no true limit on the processing time by authorities, and some applicants wait or engage in the process for months. Male patients aged 16 to 55 years and female patients aged 16 to 45 years face additional, lengthy security clearance processes, while all patients and patient companions can be called for security interrogation as a prerequisite to permit processing.

This section also examines the barriers that patients face to accessing care through Rafah border terminal, with 6% of Ministry of Health referrals to Egypt in 2017. While access through Rafah can be an important option for some patients, the primary duty for respecting, protecting and fulfilling the right to health of Palestinians lies with Israel as the occupying power.



77%

of Gaza referrals require to access through the Israeli-controlled Erez crossing



54%

of patient permit applications to exit Gaza approved



44%

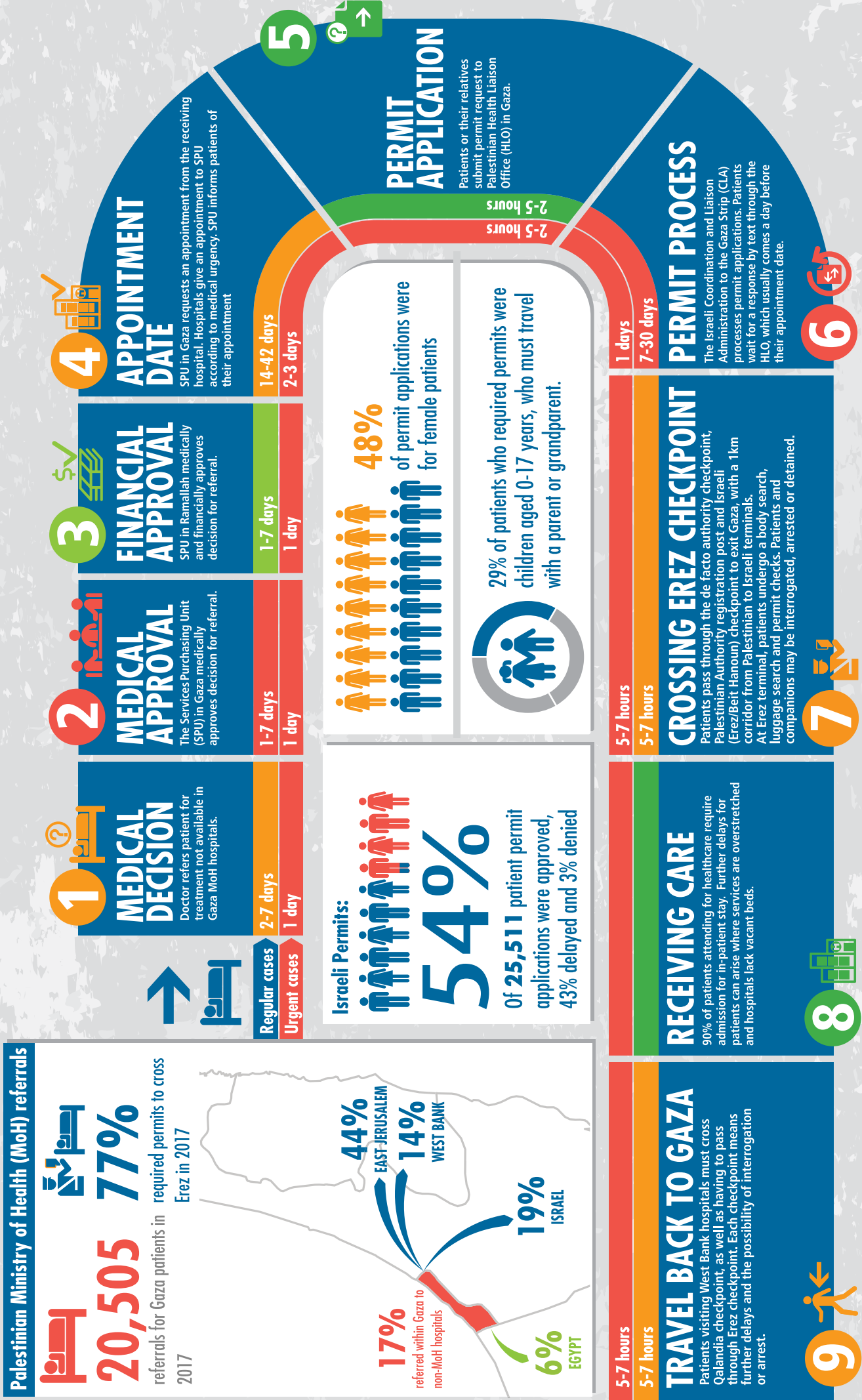
of patient companion permit applications to exit Gaza approved



6%

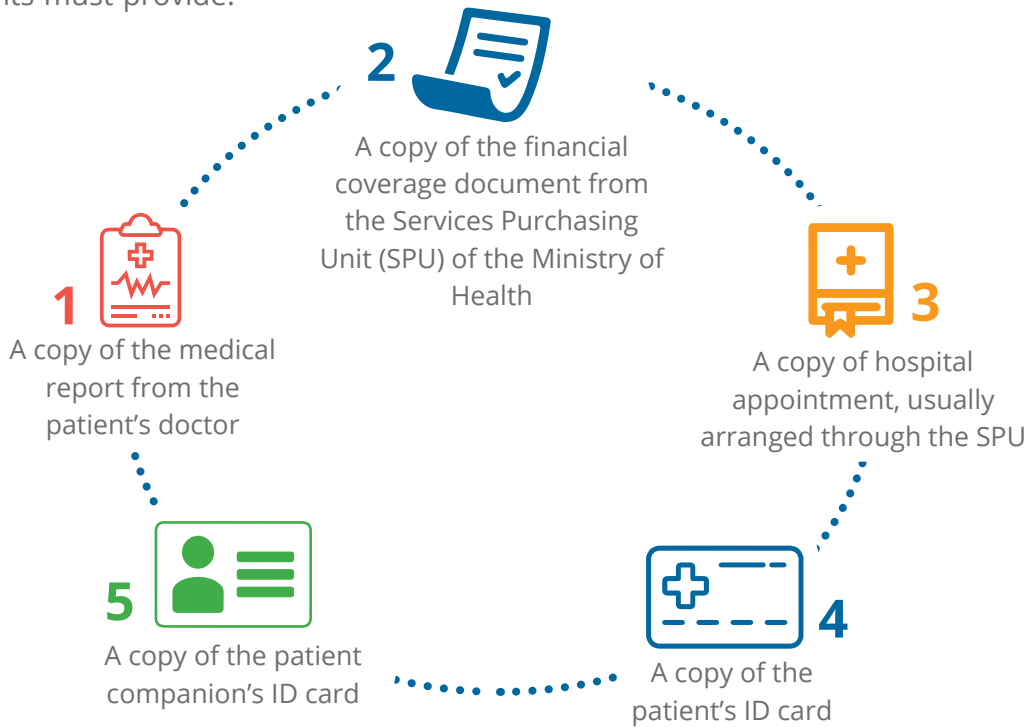
of Gaza referrals to Egypt, requiring access through Rafah crossing

Figure 4: Timeline for Gaza patient referrals



Patient permit applications

Patients requiring a permit to reach medical services not available in the Gaza Strip must go through a lengthy bureaucratic process in order even to be able to apply for such a permit. As outlined in Figure 4 on page 22, once a patient’s doctor has recognized the patient’s need for referral, they must first make an application through the Services Purchasing Unit of the Palestinian Ministry of Health, who will review the patient’s application and, if approved, make a hospital appointment and issue financial coverage for referral. After this, the patient can make an application to Israeli authorities through the Palestinian Health Liaison Office in Gaza. To do this, patients must provide:



Total number of patients and patient applications

In 2017, there were 25,511 permit applications to Israeli authorities through the Palestinian Health Liaison Office for 8,828 patients. Over the past ten years, there has been an increase in the number of patients applying for permits to exit, and a proportionately greater increase in the number of applications, see Chart 10. There was a 70% increase in the number of patients making applications, from 5,183 patients in 2008 to 8,828 patients in 2017, while there was a 146% increase in patient applications. From 2008 to 2012, the number of patients and applications fluctuated but remained relatively constant. 2012 to 2016 was the longest sustained increase in patients and applications: the former almost doubled from 5,232 to 10,229, while the latter saw an almost threefold increase from 9,191 to 26,282. From 2016 to 2017, there was a decline in patients applying and number of applications made, with a 14% reduction in patients applying (from 10,229 in 2016 to 8,828 in 2017) and a 3% reduction in number of applications made (reducing from 26,282 in 2016 to 25,511 in 2017).



25,511

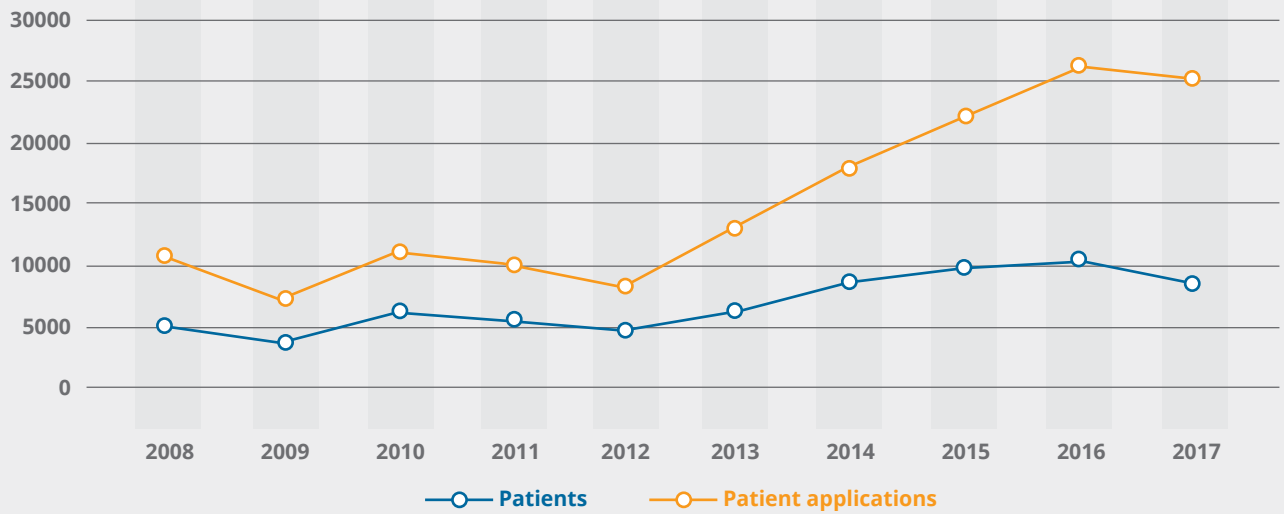
permit applications to exit
Gaza via Erez crossing



8,828

patients applied for permits

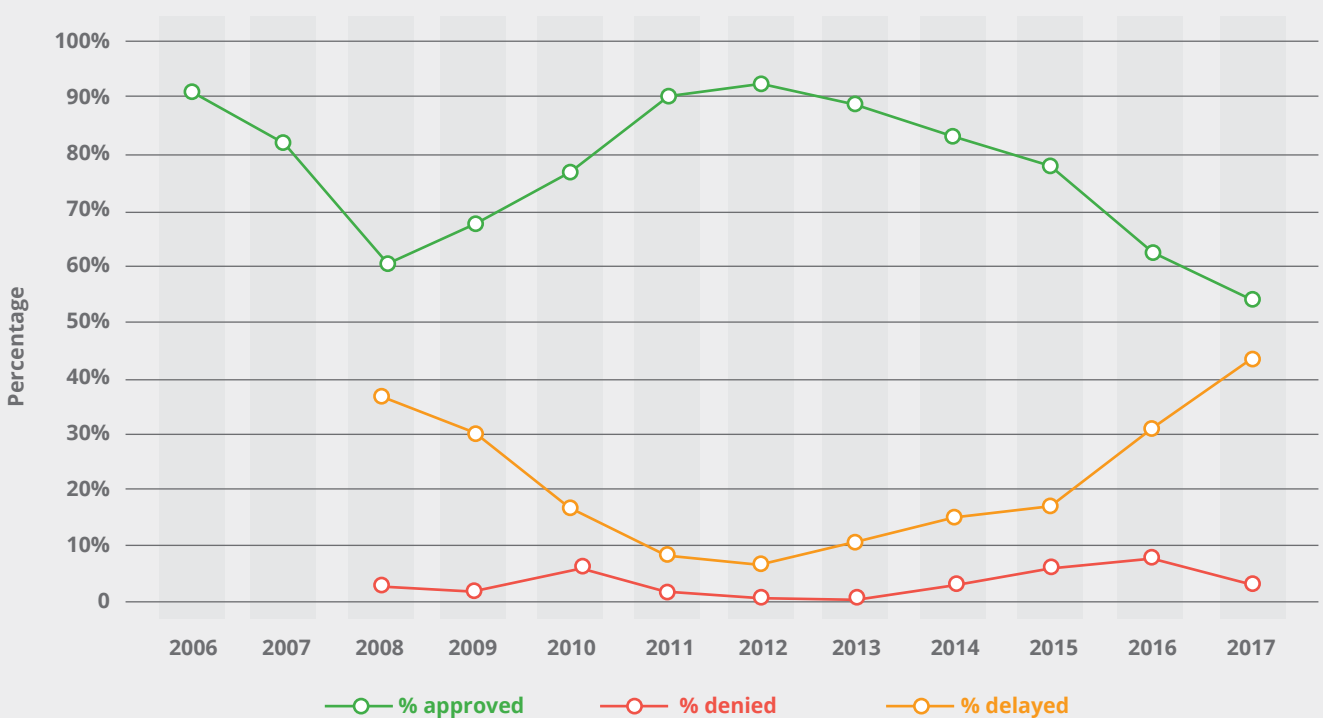
Chart 10: Patients applying for Israeli permits to exit Gaza and number of patient applications, by year



Rates of approval, delay and denial of permit applications

In 2017, patients applying to exit Gaza for health care had the lowest approval rate recorded by WHO since 2006, with 54% of patient applications approved, declining from 93% in 2012 – see Chart 11. The rate of denial has fluctuated between 0% of applications in 2013 to 7% in 2016; from 2016 to 2017 the proportion denied more than halved to 3%. The proportion of patient applications delayed has been approximately the inverse of the approval rate, with a low of 7% in 2012 and reaching its highest level yet in 2017, when 43% of patient applications were delayed.

Chart 11: Israeli responses to Gaza patient permit applications, 2006 to 2017



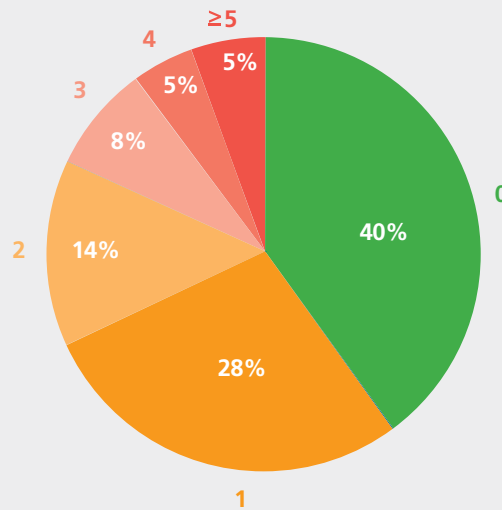
Of unique patients in 2017, 60% faced at least one or more denial or delay to their application. This figure is higher than the denial/delay rate for applications of 46%, signifying that a larger proportion of patients face some form of barrier to accessing health care outside Gaza than the proportion of applications that is unsuccessful – see Chart 12.



60%

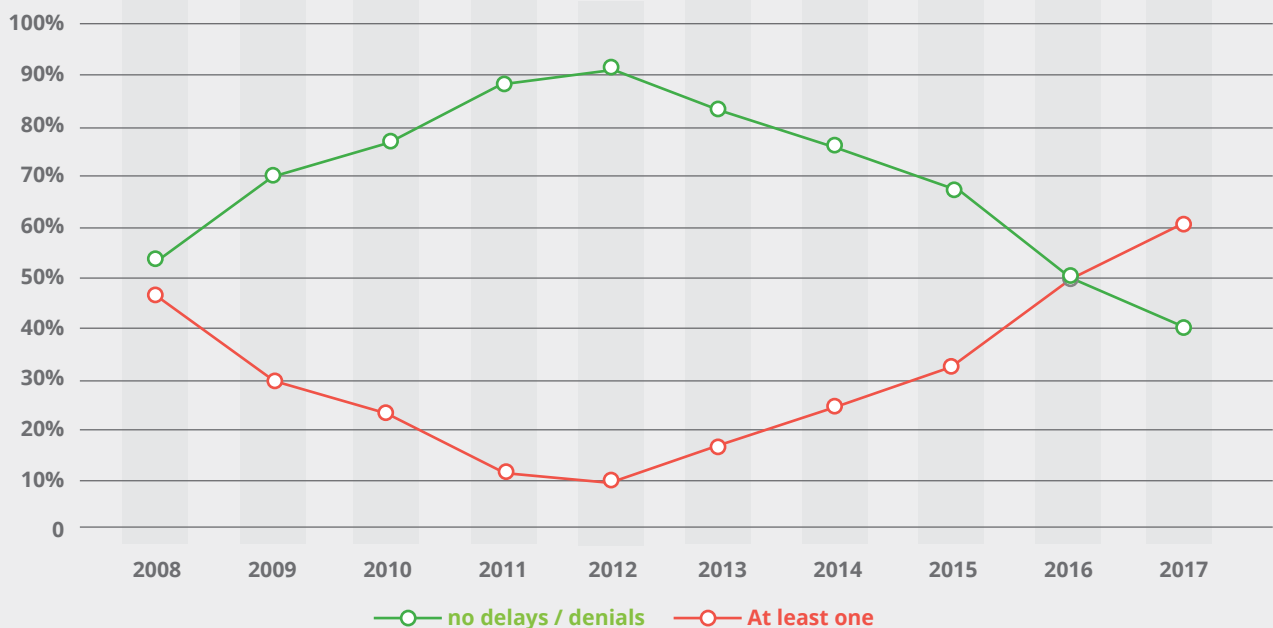
of patients face one or more denial or delay to their application

Chart 12: Patients facing one or more delay or denial to their application to exit Gaza



The proportion of patients facing one or more application denial or delay shows a similar pattern of variation over the past ten years since 2008, but with a higher range of variation. The proportion facing at least one application denial or delay reduced from almost a half (48%) in 2008 to less than one in ten (9%) in 2012. Since 2012, the proportion has been increasing year-on-year reaching a high of 60% in 2017. The proportion of patients each year who face no denial or delays to applications represents the inverse, as shown in Chart 13.

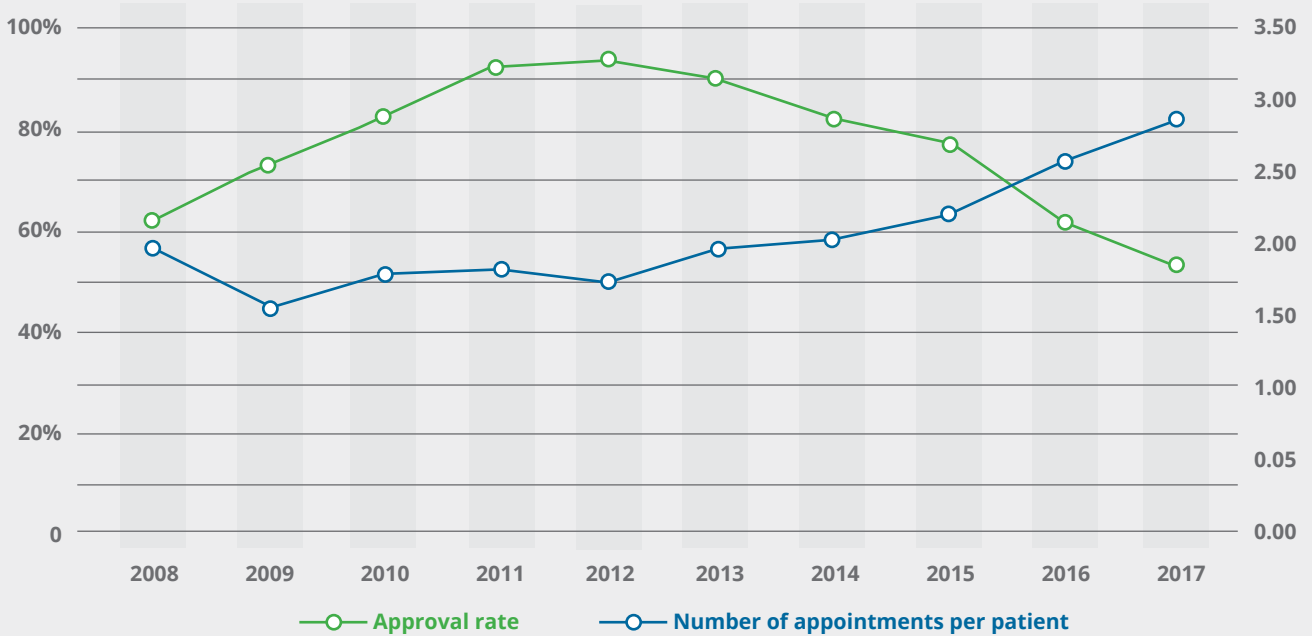
Chart 13: Proportion of patients facing one or more application denial or delay compared to those facing no denial or delay, 2008 to 2017



Number of applications per patient

The number of applications per patient has changed with time, with a relatively larger increase in permit applications compared to the number of unique patients applying since 2012. Chart 14 shows how the number of applications per patient has changed over time from 2008 to 2017, compared to the approval rate for patient permit applications.

Chart 14: Applications per patient compared to trend in acceptance rate, 2008 to 2017



Destination of permit applications

More than three-quarters (77%) of patient applications to exit Gaza through Erez were for appointments at Palestinian hospitals in East Jerusalem (58%) or the remainder of the West Bank (19%). Just under a quarter of applications (23%) were for appointments at hospitals in Israel.

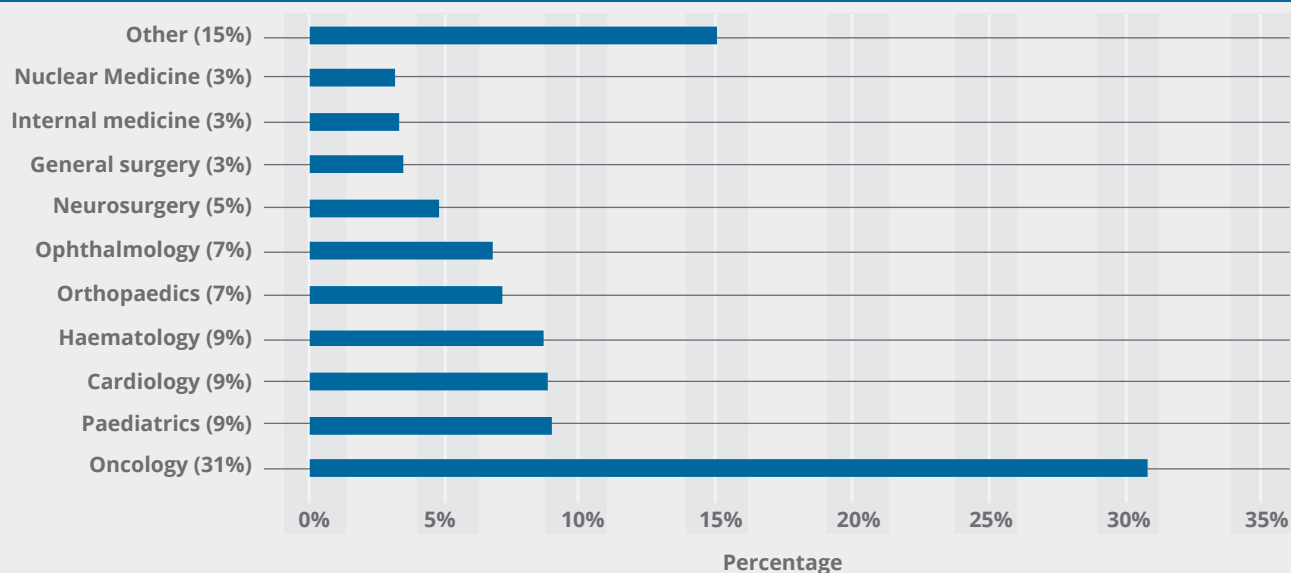


The top six hospital destinations accounted for more than three-quarters (76%) of patient permit applications. The top two destinations were Augusta Victoria Hospital (27%) and Makassed Hospital (25%) in East Jerusalem. Augusta Victoria is the main referral centre for cancer patients in the occupied Palestinian territory. The most frequent hospital destinations after Makassed Hospital were Hadassah Ein Kerem in Israel (7% of permit applications); Najah University Hospital in the West Bank (7%); Tel Hashomer in Israel (6%); and St. John's Hospital in East Jerusalem (4%).

Patient permit applications by medical specialty

Oncology, or cancer treatment and diagnosis was the single largest medical specialty for patients requiring permits to exit Gaza in 2017, accounting for almost a third (31%) of Gaza patient applications. Other major specialties included paediatrics (9%), cardiology (9%) haematology (9%), orthopaedics (7%) and ophthalmology (7%).

Chart 15: Distribution of referrals by specialty



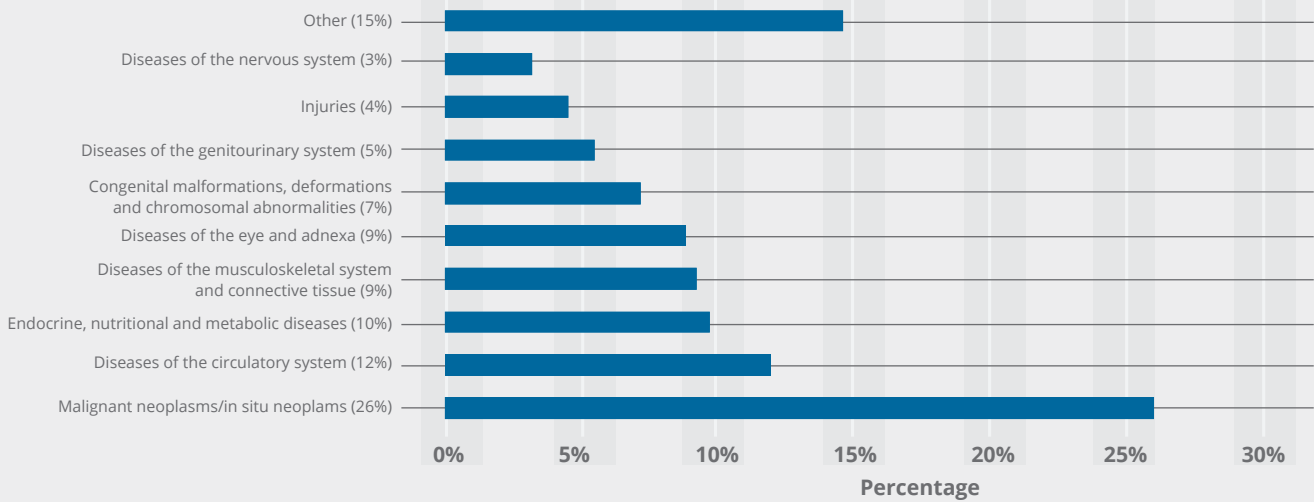
The highest approval rates by specialty were for intensive care (92%), paediatric surgery (82%), paediatrics (66%) and oncology (64%). The lowest approval rates, for specialties with more than 50 applications, were for maxillofacial surgery (34%), plastic surgery (37%), orthopaedics (39%), nuclear medicine (40%), urology (40%) and neurosurgery (40%). Age and gender differences between specialties are likely to be significant factors influencing the different rates of approval by specialty, with higher approved rates for women, as well as children and the elderly.

Diagnostic categories for patients applying to exit Gaza

Cancer represented the single largest broad category of patients applying for permits to exit Gaza, accounting for more than a quarter of patients (26%) and almost two-fifths of permit applications (39%). The second single largest category by number of patients was diseases of the circulatory system, accounting for 12% of patients and 9% of applications. More than half of patients in this group (528 out of 1,027) had been referred for chronic ischaemic heart disease, which represented the single largest narrow diagnostic category by number of patients.

Other major disease categories included endocrine, nutritional and metabolic diseases (10% of patients; 8% of applications); diseases of the musculoskeletal system (9% of patients; 7% of applications); diseases of the eye and adnexa (9% of patients; 6% of applications); and congenital malformations, deformations and chromosomal abnormalities (7% of patients; 5% of applications).

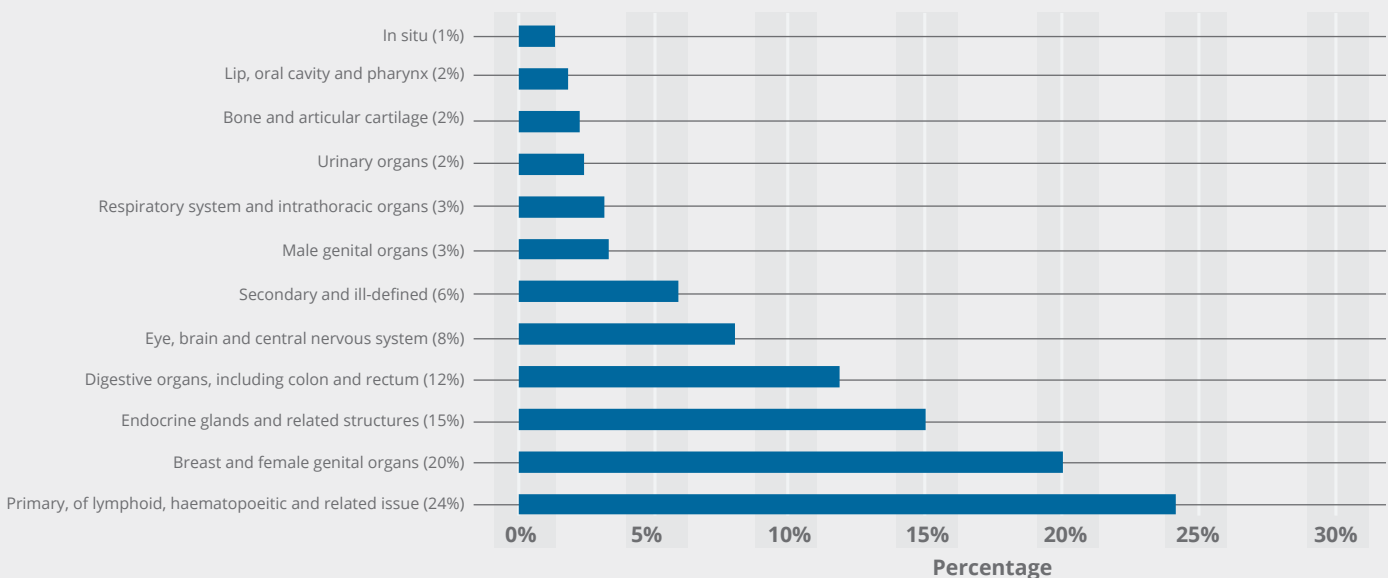
Chart 16: Broad disease categories of patients applying for permits to exit Gaza



Types of cancer for oncology patients applying to exit Gaza

In 2017, 2,286 cancer patients made 9,831 applications to exit the Gaza Strip for cancer treatment and investigation at hospitals in the West Bank, including East Jerusalem, and Israel. The rate of approval for cancer patient applications was 61%, slightly higher than the overall approval rate of 54%. For cancer diagnoses with more than 50 patients applying, those with cancer of the colon, prostate and breast had the highest rates of approval (70%, 66% and 65% respectively); while those with Hodgkin’s lymphoma and thyroid cancer had the lowest approval rates (48% and 50% respectively).

Chart 17: Types of cancer in patients applying for Israeli permits to exit Gaza, as a percentage of all cancer patients applying



Age and gender

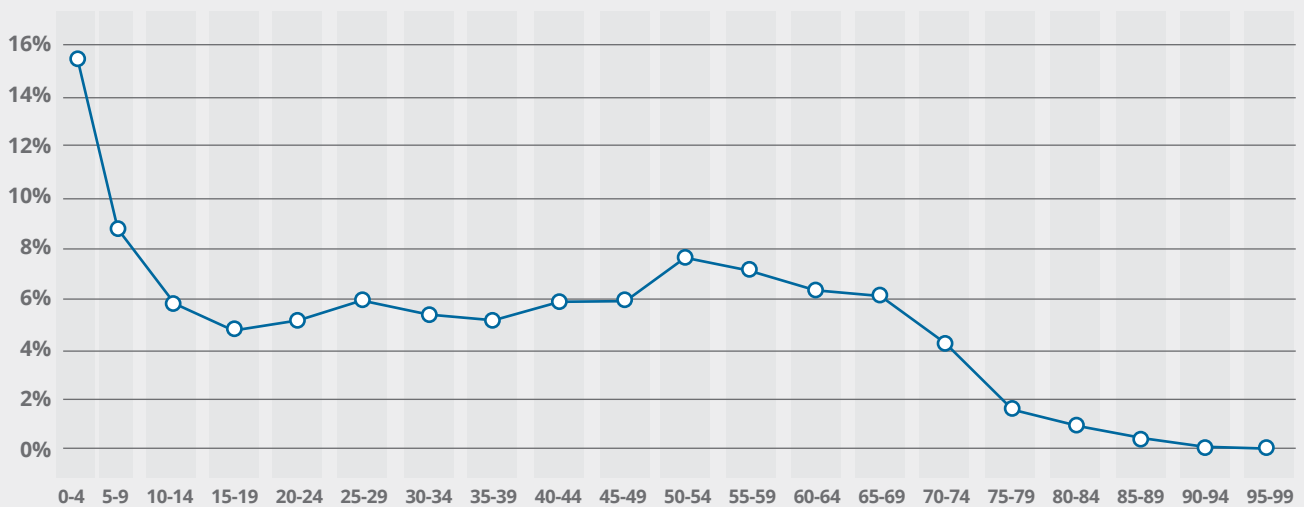
As shown in Chart 18, children under 5 years of age represented the largest single age group, comprising 16% of all applicants. Children under 10 years of age accounted for a quarter (25%) of applications and children and young people under 20 years represented over a third (34%) of all Gaza applicants. There is a smaller second age peak for patients in their 50s, with applicants aged 40 to 69 accounting for almost two-fifths (38%) of applicants. Only 4% of applicants were aged 70 years or older.



16%

of applicants aged under 5 years

Chart 18: Age distribution of patient permit applicants, 2017



48% of applications to exit Gaza via Erez were for female patients. All Gaza male patients and patient companions aged 16 to 55 years old and female patients and patient companions aged 16 to 45 years old must undergo supplementary security clearance process when applying for security permits from Israeli security services to exit via Erez. This can mean additional delays in processing applications. Male patients aged 18 to 40 years had the lowest approval rates to exit for health care via Erez in 2017, with less than a third (29%) approved. Male patients aged 41 to 60 years also had a lower than average approval rate (37%), as did female patients aged 18 to 40 (43%). Women over 60 had the highest rates of approval, with approximately four-fifths (79%) of applications approved. Children aged 0 to 3 years similarly had a higher than average approval rate (75%), as did children aged 0 to 17 years overall (67%). Men aged over 60 also had a higher than average approval rate (66%), see Chart 19.

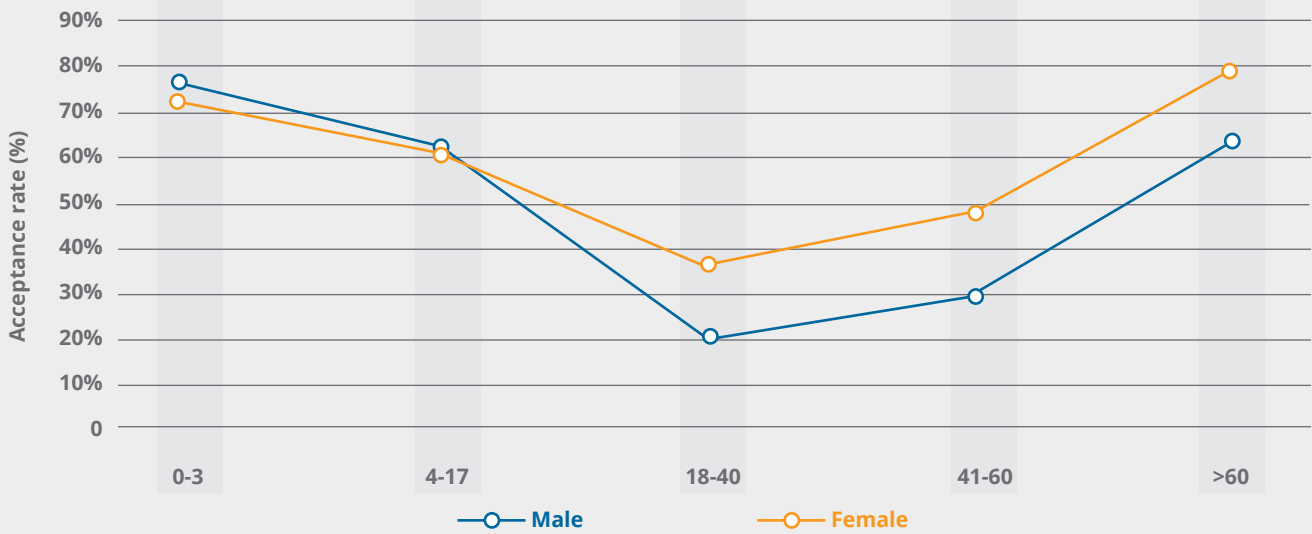


48%

of applications to exit Gaza via Erez for female patients



Chart 19: Approval rate for Gaza patient permit applications by age and gender, 2017



Patient companion applications

Israeli authorities permit one patient relative to accompany Gaza patients to health facilities outside the Gaza Strip. The application is made along with the patient application, as detailed on p23.

Total number of applications

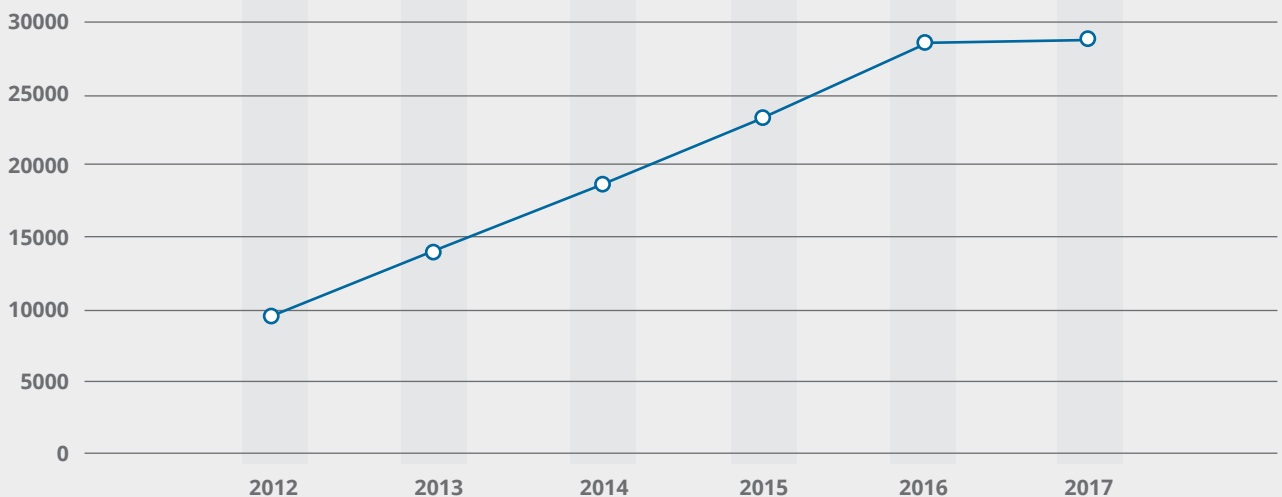
The total number of patient companion applications parallels the total number of patient applications to exit Erez. From 2012 to 2016, the total number of patient companion applications nearly tripled (increasing by 190%) – see Chart 20. There was a minimal increase from 2016 to 2017, however, when the number of patient companion applications for permits to exit via Erez rose from 28,204 to 28,654.



28,654

applications for permits for patient companions

Chart 20: Total number of Gaza patient companion applications, 2012-2017



Rates of approval, delay and denial of permit applications

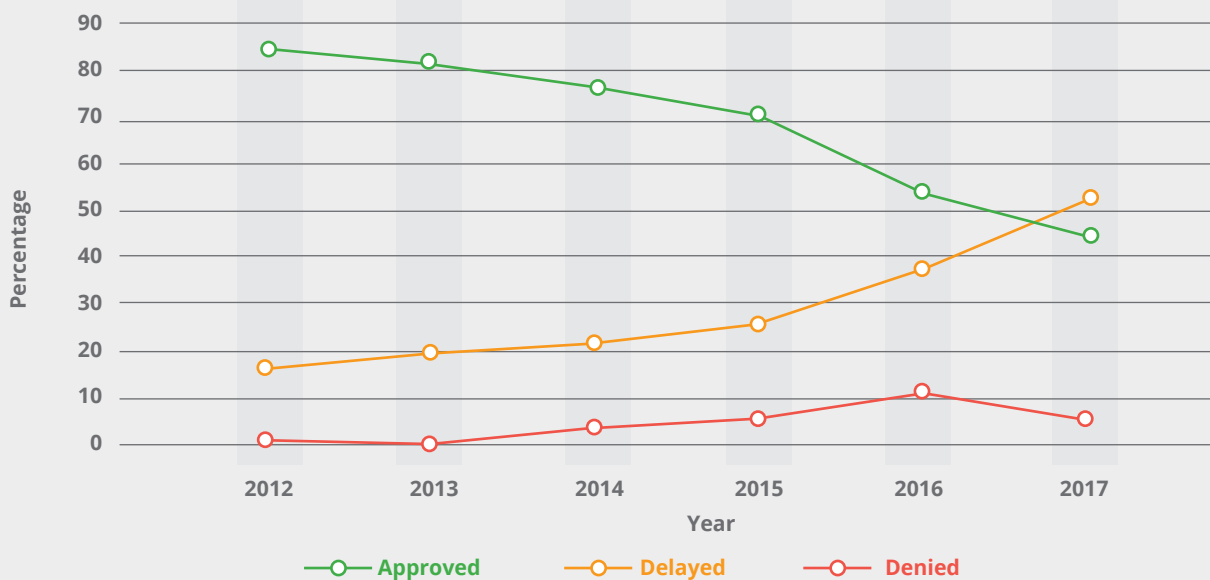
Patient companions have a lower approval rate than patients, with less than half of applications (44%) approved in 2017. Just over half of applications (52%) were delayed and 4% were denied. Just as with patient applications, since 2012 the approval rate for patient companion applications has declined successively year on year, from 83% in 2012 to 44% in 2017, the first year on record that less than half of applications to exit have been unsuccessful. From 2016 to 2017 there was a decline in the proportion of patient companion applications that were denied, from 10% to 4%. However, there was a greater increase in proportion of those delayed, from 37% to 52% - see Chart 21.



44%

of patient companion permits approved

Chart 21: Israeli responses to Gaza patient companion permit applications, 2012 to 2017



Age and gender of patient companions

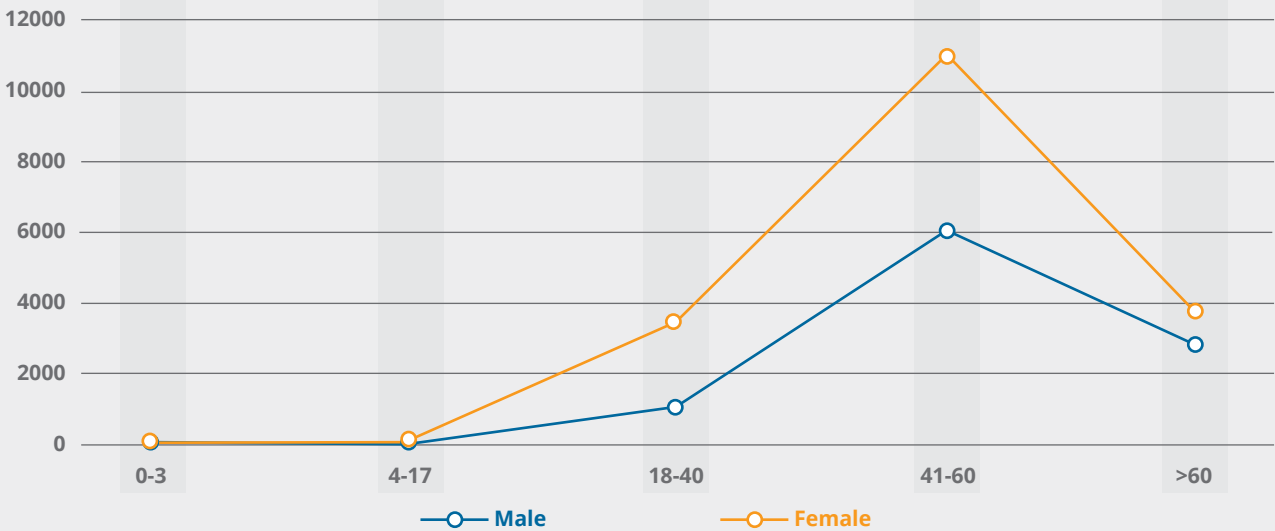
Women accounted for almost two-thirds (64%) of patient companion applications in 2017. The majority of women companions were aged 41-60 years, accounting for two-fifths (39%) of all applications in 2017. 13% of patient companion applications were for women over 60 years of age, and 12% were for women aged 18 to 40. Men aged 41 to 60 accounted for a fifth (21%) of all applications, and the majority of male applications. 10% of patient companion applications were for men over 60 years and 4% were for men aged 18 to 40 years, who also have the lowest approval rates. Overall, patient companions over 60 comprised approximately a quarter (24%) of all applications.



64%

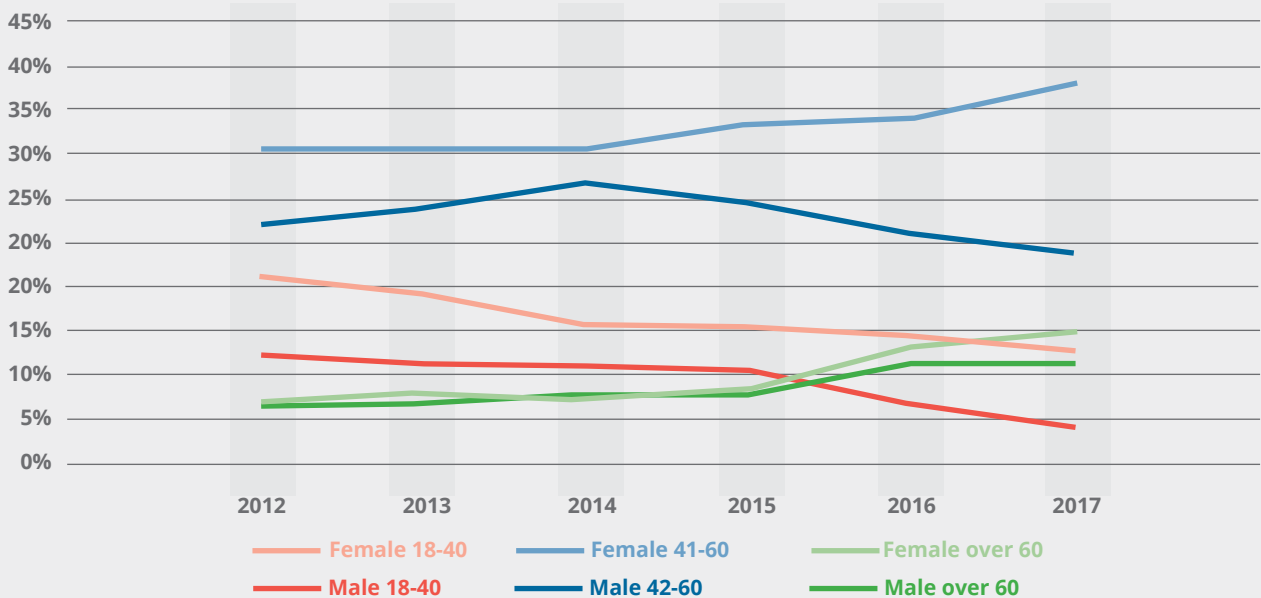
of patient companion applications were for females

Chart 22: Age and gender distribution of Gaza patient companion applications, 2017



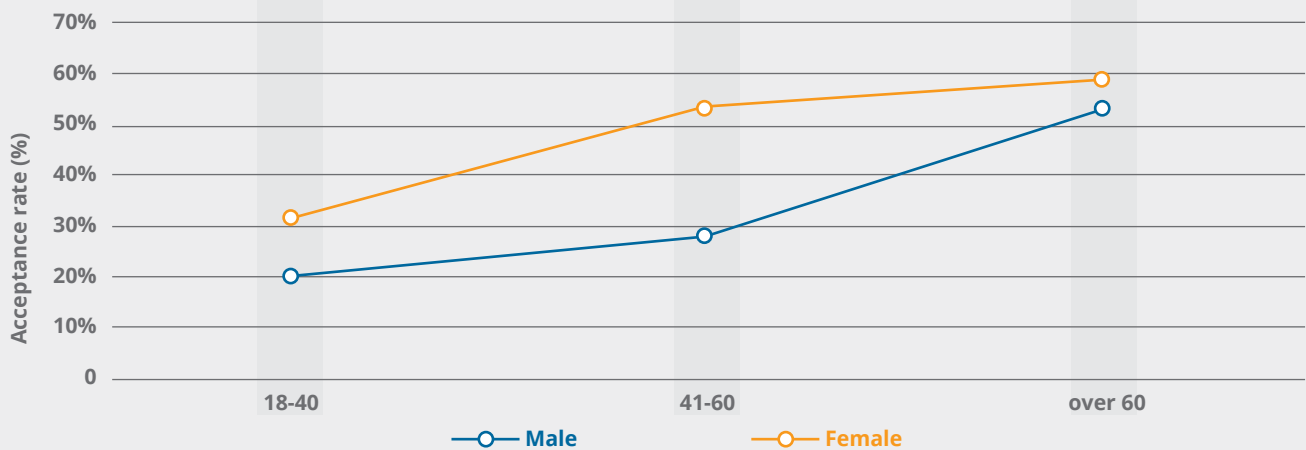
Since 2012, there has been a shift in the demographic of patient companion applications towards a greater proportion of older, female companions – reflecting the increased barriers to access for younger, male companions. Chart 23 shows that a rise in the proportion of patient companion applications for women aged 41 to 60 and over 60, and men aged over 60. Meanwhile, the proportion of patient companion applications for men aged 18 to 40 and 41 to 60, as well as women aged 18 to 40, has declined.

Chart 23: Change in the age and gender distribution of Gaza patient companions, 2012 to 2017



In terms of approval rates, men applying to accompany patients had a substantially lower approval rate compared to women in 2017: 33% compared to 47% respectively. Men aged 18 to 40 years of age had the lowest approval rate, with only a fifth (20%) of applications approved. Men aged 41 to 60 also had a substantially lower approval rate than those aged over 60 years: 28% versus 52% respectively. Women aged 18 to 40 years had a significantly lower approval rate compared to older women, with around a third of applications in this group approved (31%).

Chart 24: Approval rates for Gaza patient companion permit applications by age and gender, 2017

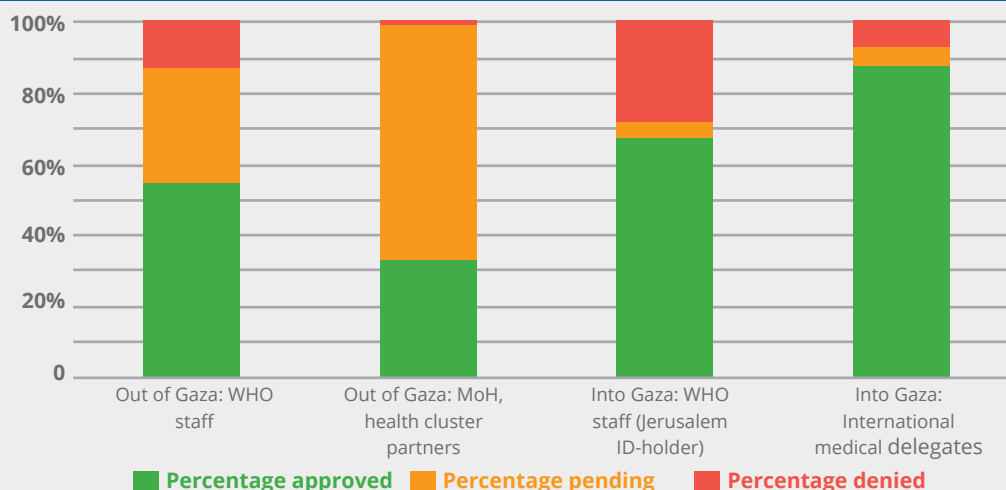


Humanitarian health staff applications

In theory, humanitarian health workers are exempted from the general travel ban placed on Palestinians in Gaza, allowing health staff to apply for permits to exit the Strip for continuing professional development, coordination meetings, workshops and conferences. In practice, however, preliminary data from the Palestinian Ministry of Civil Affairs show that more than four in every five humanitarian health workers (87%) are unsuccessful in obtaining a permit to exit Gaza, with a total of 3,448 humanitarian health staff applying for permits to exit Gaza in 2017.

Inability to exit the Gaza Strip limits the continuing professional development of health professionals in Gaza and poses a major barrier to the cohesiveness of the health system across the occupied Palestinian territory, including East Jerusalem. Table 2 shows data collected by WHO on access for 222 humanitarian health staff in 2017. Those applying to enter Gaza were substantially more likely to secure permits than those applying to exit (78% versus 44%). MoH and health cluster partners from Gaza were the least likely to secure permits to travel out of Gaza, with only a third being approved (33%), while international delegates traveling to Gaza were most likely to be approved for travel – with more than four in five delegates (88%) accepted to enter when applying through WHO.

Chart 25: Approvals for humanitarian health staff applying through WHO January - December 2017



Access across Rafah

6% of patient referrals by the Ministry of Health in Gaza were to health care facilities in Egypt, requiring exit via Rafah. Access out of Gaza via Rafah remained limited in 2017, restricted to humanitarian cases, including patients seeking health care in Egypt. The terminal was open for only 21 days in 2017, compared to 38 days in 2016 and 24 days in 2015. Of 16,795 people exiting via Rafah terminal in 2017, 1,405 were patients and 61 of these were transferred by ambulance. One medical shipment, a truckload of drugs and medical disposables purchased for the MoH in Gaza from Egypt, entered through the terminal. No medical delegates entered or exited through the terminal. Before the July 2013 closure, more than 4,000 Gaza residents crossed Rafah terminal to Egypt each month for health-related reasons.

At the beginning of November 2017, the terminal control and management was handed over to the Palestinian Authority by the de-facto authority in Gaza as part of the reconciliation process at that time.



21

days Rafah terminal open
for patient access





6 Barriers to health access in the West Bank

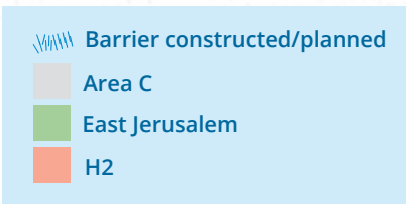
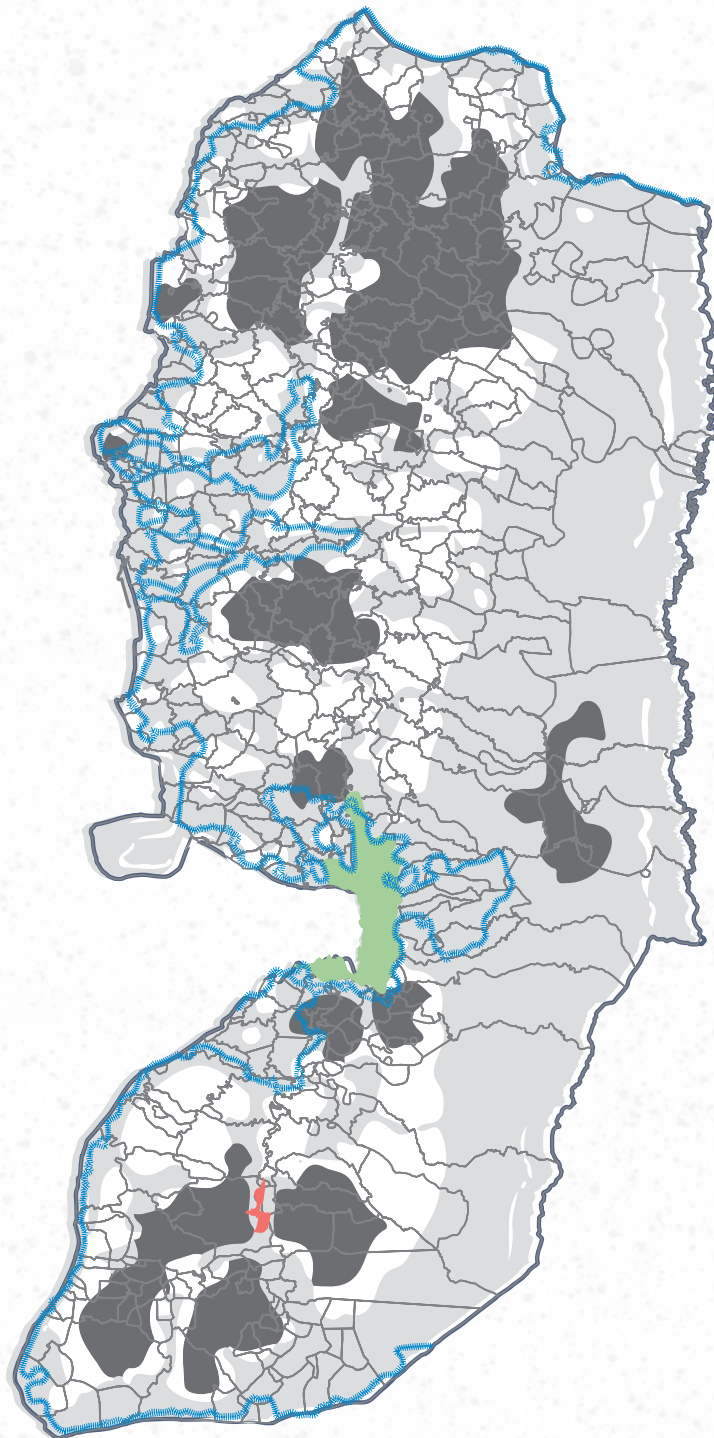
The geographical, legal and administrative fragmentation of the West Bank creates specific barriers to health access for Palestinians who live here. The West Bank is divided into Areas A, B and C, in addition to Israeli controlled Areas H2 in Hebron and East Jerusalem. Israel's building of its separation wall from the early 2000s additionally created an area called the Seam Zone between the wall and the 1949 Armistice Line, which presents particular access challenges for Palestinians who live or farm land in this area.

Israel's de facto annexation of East Jerusalem has separated it from the remainder of the West Bank. Palestinians who live in the rest of the West Bank outside of East Jerusalem must obtain permits to access this area. The vast majority of patients, patient companions and health staff from the West Bank outside of East Jerusalem must obtain specific permits to access health facilities in either East Jerusalem or Israel. The majority of women over 50 years of age and men over 55 are exempted from needing to apply for permits. This section examines the approval rates for these permits in more detail. Ambulances transporting patients to hospitals in East Jerusalem must undergo a 'back-to-back' procedure with a Jerusalem ambulance in order for the patient to reach the desired destination. In 2017, 90% of ambulances entering East Jerusalem were required to carry out this procedure, according to data collected by the Palestinian Red Crescent Society. Palestinians who live in East Jerusalem have differential access to health services compared to Palestinians from the West Bank. Palestinians in East Jerusalem are able to apply to Israeli authorities for a 'residency' status that entitles them to Israeli health services, on the condition that they continue to live or work in East Jerusalem or Israel. Qualitative research carried out by WHO in 2017 showed that vulnerable Palestinian patients in East Jerusalem often choose to live in overcrowded areas with poor delivery of municipality services in order to maintain their Jerusalem residency.

Area C of the West Bank is under direct Israeli civil and military control. In this area, Israel has significantly expanded its settlement infrastructure, while development efforts for the some 300,000 Palestinians who live here – including efforts to develop health services – are severely restricted. Additionally, communities like Khan al Ahmar are subjected to precarious circumstances, with demolition orders over many of the existing structures creating insecurity and anxiety. Many communities in Area C rely on mobile health clinics for primary health care, though coverage of these clinics is incomplete and checkpoints and barriers, as well as natural hazards such as floods in winter, can hamper access for clinics, particularly to more remote areas. There are specific barriers to health access in Area H2 of Hebron and the Seam Zone. In H2, there is a large military presence and a high concentration of checkpoints that restrict Palestinian access to areas of the town centre, including where health clinics are located. Similarly, parts of the Seam Zone are almost completely sealed off by Israel’s separation wall. Limited access to such communities results in convoluted journeys to nearby towns and health clinics, with access through checkpoints volatile and at times heavily restricted.



Figure 5: Barriers to health care access in the West Bank



Separation barrier¹
712km planned route



Checkpoints²
140 fixed checkpoints*
3,377 'flying checkpoints' in 2017



Permit system

To access health care in East Jerusalem and Israel

Restricted areas

Area C	Seam Zone**
East Jerusalem	H2

Settlement infrastructure

- No Palestinian access to 40km of roads³
- Fragmentation of Palestinian communities



Financial barriers to access

78% health insurance coverage⁴
45.5% out of pocket payments⁵

1. B'Tselem, 2017. 'The Separation Barrier.' Available at: https://www.btselem.org/separation_barrier

2. OCHA, 2018. Protection of Civilians Database

3. B'Tselem, 2017. 'Statistics on Settlements and Settler Population.' Available at: <https://www.btselem.org/settlements/statistics>

4. PCBS, 2017. Preliminary Results of the Population Housing and Establishments Census.

5. PCBS, 2017. Percentage of current health expenditure in Palestine distributed by financing schemes for the years 2014-2016. Available at: http://www.pcbs.gov.ps/Portals/_Rainbow/Documents/HF%20E%2014%2016.htm

* This number incorporates all checkpoints with permanent infrastructure, including 68 partial checkpoints, 20 checkpoints within H2 and 8 checkpoints on the 1949 Armistice Line.

** Area between the barrier and 1949 armistice line.

Patient permit applications

In the West Bank in 2017, 88% (68,017) of the 77,040 patient permit applications to access hospitals in East Jerusalem from the rest of the West Bank, or to access hospitals in Israel from the West Bank outside of East Jerusalem, were approved. In the West Bank, the Palestinian Coordination and Liaison Administration does not distinguish between delayed or denied applications, grouping these together as unsuccessful. Moreover, it has not been possible for previous years to disaggregate patient and patient companion applications. Chart 26 shows the trend in the annual approval rate for patient and companion applications since 2011, which has shown no significant fluctuation.



77,040

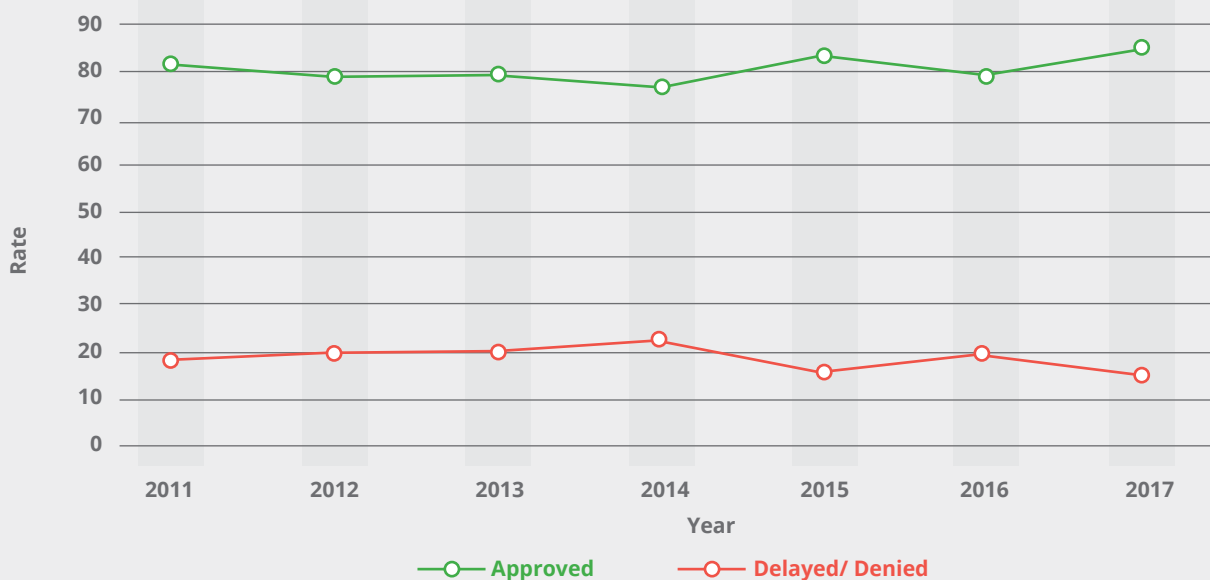
patient permit applications



88%

of West Bank patient permit applications approved

Chart 26: Israeli responses to West Bank patient and companion applications to access health care in East Jerusalem and Israel, 2011 to 2017



Patient companion permit applications

In 2017, 82% (68,858) of the 84,057 applications to accompany patients to access hospitals in East Jerusalem from the rest of the West Bank, or to access hospitals in Israel from the West Bank outside of East Jerusalem, were successful.



84,057

patient companion permit applications



82%

of patient companion permit applications approved

Health staff access

Health access to East Jerusalem hospitals for staff from the rest of the West Bank, and for a small number of health workers from Gaza, is dependent on securing a permit for access from Israeli authorities.

In 2017, approximately 94% of staff applications for permits to access hospitals in East Jerusalem were approved permits for six months. A further approximately 5% or one in 20 were approved permit applications for a three-month period. It is the norm for staff from Gaza to receive three-month permits, in addition to a minority of staff from the West Bank. 26 staff permit applications, comprising 1.5% of staff permit applications for 2017, were denied.



94%

of permit applications for health care staff to access hospitals in East Jerusalem were approved for 6 months

Table 2: Access for Palestinian health staff requiring permits to reach hospitals in East Jerusalem, 2017

Hospital	Total applied	Approved (6m)	Approved (3m)	Denied
St. Joseph Hospital	257	251	3	3
Augusta Victoria Hospital	413	397	11	5
St John's Ophthalmic Hospital	108	108	0	0
Makassed Hospital	743	660	69	14
Princess Basma Hospital	58	58	0	0
Palestinian Red Crescent Society	129	125	0	4
Total	1708	1599	83	26
Percentage		93.6%	4.9%	1.5%

Ambulance access

In 2017, as in previous years, the majority (90%) of ambulances carried out back-to-back transfer of patients at checkpoints into East Jerusalem to avoid long delays and searches. Ambulances from the West Bank will meet ambulances registered in Jerusalem and transfer patients who require transport to hospitals in East Jerusalem. The Palestinian Red Crescent Society monitors this systematic barrier to direct ambulance access. Table 4 details the number of ambulances required to undergo the back-to-back procedure by ambulance provider and district of origin in the West Bank outside of East Jerusalem. Ambulances from Tulkarem, Nablus and Tubas had the highest rates of direct access (100%), while ambulances from Bethlehem had the lowest rate (81%).



90%

of ambulances entering Jerusalem required to carry out back to back procedure

Table 3: Ambulance access from West Bank to East Jerusalem

District	Back to back - private ambulance	Back to back - PRCS ambulance	Direct access	Total	Percentage back-to-back
Hebron	14	255	18	287	94%
Bethlehem	8	116	29	153	81%
Jericho	1	27	4	32	88%
Qalqilia	0	13	1	14	93%
Tulkarem	0	32	0	32	100%
Jenin	0	29	2	31	94%
Nablus	0	62	0	62	100%
Al Bireh	339	1012	160	1511	89%
Tubas	1	2	0	3	100%
Total	363	1548	214	2125	90%

Mobile health clinic access

In 2017, seven mobile health clinics run by three health providers were denied permits to access communities in Area C of the West Bank. These seven included two clinics run by the Palestinian Medical Relief Society (PMRS), two clinics run by UNRWA and three clinics run by Humanity and Inclusion (HI). PMRS was denied access to two communities for two months from September to November 2017, while UNRWA was prevented from access to two catchment areas from March 2017 for the rest of the year. HI was prevented from access to three communities for more than four months from August 2017, with access not granted into 2018. In total, more than 1,370 people living in these communities were affected by denial of access to mobile health clinics delivering primary health care services.





7 Health attacks

Definition and monitoring in the occupied Palestinian territory

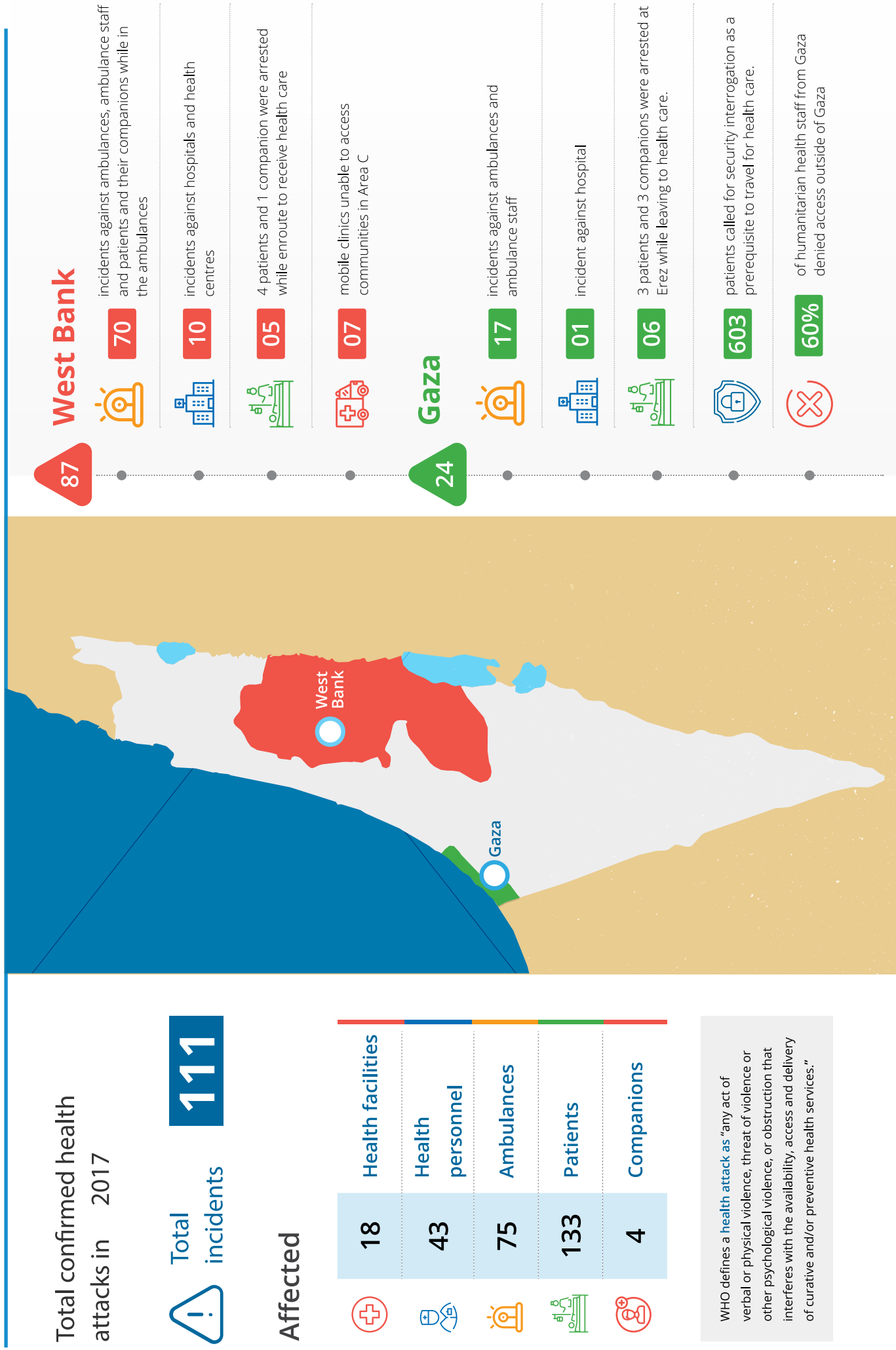
WHO defines a health attack as “any act of verbal or physical violence, threat of violence or other psychological violence, or obstruction that interferes with the availability, access and delivery of curative and/or preventive health services.”

Obstructions to access for patients, patient companions, health staff and services resulting from Israel’s permit regime and restrictions on the free movement of Palestinians – detailed in previous chapters – in some instances fall within WHO’s definition of attacks on health, but are reported separately in this publication owing to the systematic nature and scale of these barriers.

WHO monitoring of health attacks in the occupied Palestinian territory depends on the reporting of incidents by health partners, which WHO follows up to verify. In 2017, WHO received regular reporting on health attacks from the Palestinian Red Crescent Society (PRCS), and ad hoc reports on health attacks from the other health partners. While ambulance staff working for PRCS are vulnerable to health attacks, the absence of reporting from other partners – including other providers of ambulance services – indicates likely under-reporting, an observation backed up by qualitative feedback provided by partners during a workshop on health attacks in 2018. Health partners reported that certain types of attack that prevent the effective delivery of health services, such as severe injury from tear gas inhalation, were normalized by many health providers and under-reported. Health partners also commented on the difficulty of reporting on psychological attacks that result from regular harassment at checkpoints or the lack of respect for health personnel attending demonstrations.

A summary of incidents reported to WHO in 2017 and the number of those affected can be found on page 42.

Figure 5: Attacks on health care in 2017



Case study: incursion into Makassed Hospital in East Jerusalem

On Friday 21st July, Israeli policemen and border guards entered Makassed Hospital in East Jerusalem, reportedly to detain a patient who had been shot during Friday prayer protests against the placement of metal detectors at the entrance to the Al Aqsa compound in Jerusalem's Old City. Makassed Hospital houses the main Emergency Department in East Jerusalem and at the time of the incursion staff were attempting to treat around 120 casualties, including some who were critically injured, in the wake of demonstrations outside the gates of Jerusalem's Old City.

Dr Rafiq Hussein, at that time CEO of Makassed Hospital, reported that around 50 policemen and border guards entered the grounds of Makassed Hospital on Friday. According to Dr Hussein, Israeli forces fired weapons within the hospital grounds and forcibly delayed a critically injured patient from reaching life-saving surgery. WHO saw CCTV footage of the incursion, which backed up the claims of staff who witnessed the incident on the ground. WHO reiterated its calls for the protection of medical facilities and health personnel.

Security interrogation and arrest of patients and companions

In 2017, Israel continued its practice of calling patients and patient companions for security interrogation as a prerequisite to travel outside of Gaza for healthcare. During the year, 603 patients and 95 patient companions were called for security interrogation at Erez.

The Palestinian Center for Human Rights (PCHR) reported Israeli practices of using health access to gain security information from patients and patient relatives. Ahmed Shbair was 17-year-old patient who died on 14th January 2017 following repeated unsuccessful applications to exit Gaza for cardiac surgery. He had previously had operations to treat his congenital heart condition in 1999, 2001, 2007, 2011 and 2015. His father testified regarding the practices of Israeli security forces in preventing Ahmed's access to care:

"On 22nd February 2016, my son Ahmed travelled with his mother as a companion through Beit Hanoun (Erez) checkpoint to reach an ambulance from Tel Hashomer Hospital in Israel, when his mother was recalled for an intelligence interview and subjected to a humiliating inspection. She was then asked about neighbours and relatives, and my wife told them that she didn't know any information about them. The intelligence blackmailed her in that meeting, and bargained with her that if she wanted to preserve the life of her son she should cooperate with them, presenting the information they wanted from her. Later, an appointment date of 10th September 2016 was set for a heart valve replacement at Tel Hashomer Hospital. We put forward three applications to get permission to reach the hospital, but all the applications were denied. On 16th November 2016 we headed to the Palestinian Centre for Human Rights, for help getting a permit. We were then informed that the Occupation Authorities requested Ahmed for interview, and Ahmed and I went to Beit Hanoun (Erez) checkpoint [for him] to undergo the interview. Ahmed went into the interview at 6 o'clock in the morning, and the meeting lasted until 6 o'clock in the evening. After the end of the interview, Ahmed told me that the Occupation Authorities openly asked him for intelligence information in exchange for a permit for him to continue his treatment. When he replied to them that he could not collaborate with them, the interrogators told him: 'If you don't collaborate, let Gaza treat you.'"

In 2017, three patients and three patient companions were arrested at Erez terminal en route to accessing health care outside of Gaza. Of these six arrests, four (two patients and two companions) were subsequently released without charge, one patient was sentenced to four years and two months imprisonment and one companion was sentenced to two years imprisonment.

In the West Bank in 2017, four patients and one patient companion were arrested while being transported to receive health care in ambulances. No further details on the outcome of these arrests was made available to WHO by the time of publication.

WHO Surveillance System of Attacks on Healthcare (SSA)

In 2012, the 65th World Health Assembly passed Resolution 65.20, which called on the Director-General of WHO to:

"...provide leadership at the global level in developing methods for systematic collection and dissemination of data on attacks on health facilities, health workers, health transports, and patients in complex humanitarian emergencies, in coordination with other relevant United Nations bodies, other relevant actors, and intergovernmental and nongovernmental organizations, avoiding duplication of efforts."

To address this Resolution, and building on previous pilots for the systematic monitoring of health attacks, WHO launched its global Surveillance System of Attacks on Healthcare (SSA) towards the end of 2017. The occupied Palestinian territory is one of the first five countries and territories to implement the tool, which will be expanded to 27 priority countries by the end of 2019. The programme aims to provide and improve the availability of comprehensive data on attacks on healthcare across the world, to inform effective advocacy and to highlight and inform work to address information gaps and needs.

In 2018, WHO in the occupied Palestinian territory trained health partners in the use of the online reporting platform, which will serve as an important tool to strengthen the comprehensiveness of data at the country level, including information on the impact of attacks.





8 Conclusions and recommendations

Conclusions

In 2017, Palestinians continued to face substantial barriers to realizing their right to enjoyment of the highest attainable standard of physical and mental health. The situation of chronic occupation presents unique challenges to the Palestinian health sector, where patients, patient companions and health staff must all navigate a complex bureaucratic system that limits free movement and creates additional obstacles for the provision of health services and for access to care.

The approval of patient permits to exit Gaza shows a worrying continued decline, reaching a low in 2017 of 54% that represents a sustained reduction from 2012, when more than 90% of patient permits were approved. The cost of referrals for patients to non-Ministry of Health facilities is a major challenge to the sustainability of health care delivery for the Palestinian Ministry of Health, with its ability to deliver comprehensive, universal health coverage hampered by restricted income through lack of control over its territory and resources, as well as unpredictability resulting from donor dependence. In the West Bank, the fragmentation of territory and limited jurisdiction of the Palestinian Authority impedes access to care and impacts on the underlying determinants of health, especially for particularly vulnerable populations in Area C, the Seam Zone and H2 of Hebron.

WHO continues efforts with partners to accurately document barriers to the right to health for Palestinians, including through documentation of barriers to access and availability of health care, and through implementation of the global Surveillance System of Attacks on Healthcare. WHO calls on all duty bearers to respect, protect and fulfil the right to the highest attainable standard of physical and mental health for Palestinians in the occupied Palestinian territory. The recommendations below outline practical steps forward to improve the right to health for Palestinians.

Recommendations

The recommendations put forward by the Special Rapporteur on the situation of human rights in the Palestinian territories occupied since 1967 to the Government of Israel, as detailed in the report on the right to health to the thirty-seventh session of the Human Rights Council in 2018, remain valid. These include:

1. To ensure **regular and reliable access**, at all times, for all Palestinian patients who require specialized health care outside of their jurisdictions, consistent with genuine Israeli security concerns;
2. To **end the conditions which obstruct the free passage of Palestinian ambulances** to access and transport patients to health care facilities in an expeditious fashion;
3. To ensure the **respect and protection of medical personnel and medical facilities** as required by International Humanitarian Law;
4. To substantially **improve prison conditions** and the provision of adequate health care for Palestinian prisoners and detainees;
5. To remove the unnecessary barriers that prevent **Palestinian health care staff** from acquiring professional training and specialization elsewhere in the Occupied Palestinian Territory and abroad, and to receive training at their home institutions from international health professionals;
6. To ensure that no one is subjected to **torture or degrading treatment**;
7. To take meaningful steps to improve the many **social determinants that influence health** outcomes in the occupied Palestinian territory
8. To comply fully with its **obligations under international human rights and humanitarian law** with respect to fulfilling the health needs of the protected population.





 **World Health Organization**
occupied Palestinian territory

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