

Country Cooperation Strategy  
for WHO and  
the Occupied Palestinian Territory  
2009–2013

Occupied  
Palestinian  
Territory



World Health  
Organization

Regional Office for the Eastern Mediterranean



Country Cooperation Strategy  
for WHO and  
the Occupied Palestinian Territory  
2009–2013

# Occupied Palestinian Territory



**World Health  
Organization**

Regional Office for the Eastern Mediterranean

World Health Organization 2010 ©

All rights reserved.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Publications of the World Health Organization can be obtained from Health Publications, Production and Dissemination, World Health Organization, Regional Office for the Eastern Mediterranean, P.O. Box 7608, Nasr City, Cairo 11371, Egypt. tel: +202 2670 2535, fax: +202 2765 2492; email: PAM@emro.who.int. Requests for permission to reproduce, in part or in whole, or to translate publications of WHO Regional Office for the Eastern Mediterranean – whether for sale or for noncommercial distribution – should be addressed to WHO Regional Office for the Eastern Mediterranean, at the above address: email: WAP@emro.who.int.

Document WHO-EM/ARD/040/E

Design and layout by Pulp Pictures

Printed by WHO Regional Office for the Eastern Mediterranean, Cairo

## Contents

❖❖	<b>Acronyms and Abbreviations</b>	<b>5</b>
❖❖	<b>Section 1. Introduction</b>	<b>7</b>
❖❖	<b>Section 2. Country Health and Development Challenges and National Response</b>	<b>11</b>
	2.1 Macroeconomic, political and social context	13
	2.2 Health status of the population	15
	2.3 Health systems and services	22
	2.4 Thematic groups	29
	2.5 Health strategy	31
	2.6 Indicators	32
	2.7 Summary of key health and development challenges and major opportunities/strengths	32
❖❖	<b>Section 3. Development Cooperation and Partnerships</b>	<b>35</b>
	3.1 Aid environment in the country	37
	3.2 Aid coordination mechanisms	38
	3.3 Aid to the health sector	39
	3.4 Emergency versus development aid	40
	3.5 Specific assistance	41
	3.6 Implications for WHO	41
	3.7 Summary of key issues and challenges and opportunities for aid effectiveness and partnerships	42
❖❖	<b>Section 4. Past and Current WHO Cooperation</b>	<b>43</b>
	4.1 WHO cooperation overview	45
	4.2 WHO collaboration in oPt	46
	4.3 Lessons learnt: opportunities and challenges for WHO country programme	50
❖❖	<b>Section 5. Strategic Agenda for WHO Cooperation</b>	<b>53</b>
	5.1 Strategic agenda	55
	5.2 Strategic priorities	55
	5.3 Key objectives and strategic approaches	55

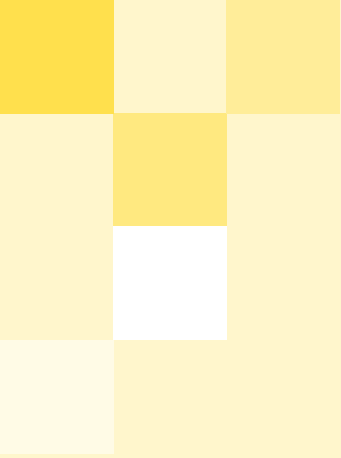
❖	<b>Section 6. Implementing the Strategic Agenda: Implications for WHO</b>	<b>61</b>
	6.1 Overview	63
	6.2 Implications for the country programme	63
	6.3 Implications for the Regional Office and headquarters	64

## ❖ Acronyms and Abbreviations

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
CAP	Consolidated Appeal Process
CCS	Country Cooperation Strategy
CEHA	Centre for Environmental Health Activities
CERF	Central Emergency Response Fund
DALYs	Disability-adjusted life years
ECHO	European Commission for Humanitarian Aid
GDP	Gross domestic product
GNP	Gross national product
HIV	Human immunodeficiency virus
HIO	Health Insurance Organization
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illness
JPRM	Government/WHO Joint Programme Planning and Review Mission
MoH	Ministry of Health
NIS	New Israeli Shekel
NGO	Nongovernmental organization
NHA	National health accounts
NUG	National Unity Government
oPt	Occupied Palestinian territory
OCHA	Office for the Coordination of Humanitarian Affairs
PNA	Palestinian National Authority
PHC	Primary health care
PCBS	Palestinian Central Bureau of Statistics
PFHS	Palestinian Family Health Survey
PRDP	Palestinian Reform and Development Plan
TB	Pulmonary tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS

UNDP	United Nations Development Programme
UNDP/PAPP	UNDP Programme of Assistance to the Palestinian People
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
USAID	United States Agency for International Development
WHO	World Health Organization





Section

1



Introduction





## Section 1. Introduction

The Country Cooperation Strategy (CCS) reflects a medium-term vision of WHO for technical cooperation with a given country and defines a strategic agenda for working in and with the country. The CCS is a key instrument for WHO in the context of improving aid effectiveness at country level through alignment and harmonization of the health and development agenda. The CCS clarifies the proposed roles of WHO and how its core functions are applied in supporting the national health and development plans and strategies. The CCS takes into account regional as well as Organization-wide strategic orientations, priorities and the broader international legal and policy framework of the United Nations (UN) system, such as the Millennium Development Goals, gender equity and the human rights-based approach to development.

The CCS examines the health situation in the country within a holistic approach that encompasses the health sector, socioeconomic determinants of health and national policies and strategies that have a major bearing on health. The exercise aims to identify the health priorities in the country and place WHO support within a framework of six years in order to strengthen the impact on health policy and health system development, as well as the linkages between health and cross-cutting issues at the country level. The CCS is the reference for WHO's work in the country, and guides planning, budgeting and resource

allocation. It is the basis for reviewing WHO country presence and for mobilizing human and financial resources for strengthening WHO's support to health development in the country.

The CCS process takes into consideration the work of all partners and stakeholders in health and health-related areas. The process is a strategic dialogue in the country and within the entire WHO secretariat: the country office, Regional Office and headquarters. It draws from, and contributes to, aid coordination and partnership platforms, in particular the Common Country Assessment/United Nations Development Assistance Framework (CCA/UNDAF). It seeks to complement the cooperation strategies of other major external actors in the country.

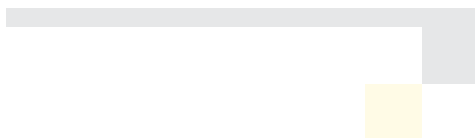
The health of the people of the occupied Palestinian territory (oPt) and health services have been uniquely affected by Israel's occupation of the Palestinian territory which has been ongoing since 1967. These effects have been documented in detail in a series on 'Health in the occupied Palestinian territory' recently published in *The Lancet*.<sup>1</sup> Health concerns relate not only to direct effects of the conflict and military action but to the wider impact of the occupation on human security and well-being. The political situation in oPt further compounds the health risks and constrains normal health development. There are also those health challenges, such as the rising

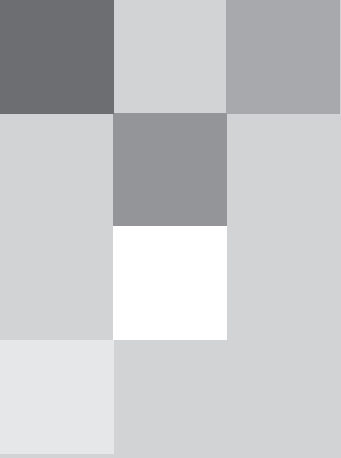
<sup>1</sup> Health in the occupied Palestinian territory. *The Lancet*, 373:788–790, March 2009.

burden of noncommunicable diseases, which are common to neighbouring and other countries that are living in peace. In formulating the CCS, due attention is given to these conditions as well as the presence of many UN, bilateral, multilateral international nongovernmental organizations and partners.

The CCS for the occupied Palestinian territory is the result of a preliminary analysis of the health and development situation, and of WHO's current programme of activities. A mission comprising five senior staff from the Regional Office and the United Nations Relief

and Works Agency for Palestine Refugees in the Near East (UNRWA) together with the country office staff carried out extensive consultations in December 2008. During the mission, the team consulted with key officials from the Ministry of Health, as well as officials from various other government authorities, United Nations agencies, nongovernmental organizations and private institutions. Critical challenges for health development were identified. Based on the health priorities of the country, a strategic agenda for WHO collaboration was developed for the period 2009–2013.





Section

# 2



**Country Health and Development  
Challenges and National Response**





## Section 2. Country Health and Development Challenges and National Response

### 2.1 Macroeconomic, political and social context

The territory of the Palestinian National Authority (PNA) includes two separated geographical areas, the West Bank and the Gaza Strip with a total population of 3.77 million (2.35 million in the West Bank, including East Jerusalem, and 1.42 million living in the Gaza Strip).<sup>2</sup> About half of the population is below 15 years of age and the average annual population growth rate is 2.6%; one of the highest in the Region.<sup>3</sup> The population is expected to increase by 50% by 2020. The population density in the Gaza Strip is one of the highest in the world.<sup>4</sup> The refugee population is 1.7 million, constituting 29% of the population in the West Bank and 69% in the Gaza Strip, living in 27 refugee camps.<sup>5</sup> In Jerusalem, there are 91 274 registered refugees and 18 719 non-registered refugees.<sup>2</sup>

The West Bank and the Gaza Strip have been under occupation by Israel since 1967. The PNA was established in 1994 following the Oslo agreement. However, there has been ongoing political turmoil and economic decline sparked, in particular, by the second *intifada* in September 2000 and

the resulting Israeli military intervention. Gross domestic product (GDP) per head fell by 40% between 2000 and 2004. In 2006, the international community withdrew direct financial support for the PNA following the election of Hamas. In February 2007, a National Unity Government (NUG) was formed but was not widely supported and was short-lived. Factional clashes continued and in June 2007 Hamas took over control of the Gaza Strip. An emergency government was established under President Mahmoud Abbas after dissolving the NUG. Israel and the international community subsequently ended the boycott of the PNA.<sup>6</sup>

The PNA presented the framework of a Palestinian Reform and Development Plan at the Paris conference in December 2007 outlining a comprehensive national plan for development, including a 3-year fiscal framework. US\$ 7.7 billion was pledged in funding support.<sup>7</sup>

2008 began with a renewed sense of hope for progress. Throughout 2008, the PNA proceeded with a series of significant and tangible reforms, reducing its fiscal deficit, containing its wage bill and improving security conditions in the West

<sup>2</sup> *Palestinian census*. Palestinian Central Bureau of Statistics, January 2008.

<sup>3</sup> Palestinian Central Bureau of Statistics. Census final results in the West Bank - Summary (population and housing 2007) from the World Bank Report: *Palestinian Economic prospects: aid, access and reform*. Economic monitoring report to the Ad Hoc liaison committee, September 2008.

<sup>4</sup> Abed Y. *Health sector review: a summary report*. Jerusalem, Italian Cooperation, 2007.

<sup>5</sup> *National Strategic Health Plan (2008–2010)*. Palestinian National Authority, Ministry of Health, 2008.

<sup>6</sup> *Consolidated Appeals Process. The 2008 Common Humanitarian Action Plan*. Office for the Commissioner of Humanitarian Affairs.

<sup>7</sup> *Statement by the Chair and the Co-chairs of the International Donors' Conference for the Palestinian State*. UNISPAL.

Bank. However, growth targets projected in the PNA's development plan were revised downwards, as economic productivity continued to decline.

This is in large part due to conditions in the Gaza Strip, where the ongoing Israeli blockade, imposed in June 2007 after the Hamas take-over, has crippled the private sector, driving unprecedented numbers of Palestinians into unemployment and poverty. However, it also reflects continued strife in large parts of the West Bank. The number of Israeli checkpoints continued to increase in 2008, causing further social and economic fragmentation.<sup>6</sup> Some checkpoints and obstacles were removed during the first half of 2009 which has eased movements in the West Bank but it is too early to assess the impact yet. Global rises in food prices and reduced domestic agricultural yields due to adverse weather conditions have placed further strain on Palestinian coping mechanisms, leading to further increases in household food insecurity in both the Gaza Strip and West Bank, despite ongoing large-scale food aid programmes.<sup>6</sup>

The situation in the Gaza Strip was further exacerbated as a result of the Israeli military action (Operation Cast Lead) between 27 December and 18 January 2008. 1366 people were killed, of whom 430 were children and 111 women. Vital infrastructure was damaged or destroyed, including manufacturing and commercial units, housing and other buildings, electricity, water and sanitation services. 14 of the 27 hospitals and 38 primary health care (PHC) clinics, as well as 29 ambulances in the Gaza

Strip were damaged by the strike, although all are now fully functional again (providing services from alternative premises in the case of two PHC centres). Access to health care for ordinary patients was severely restricted during the conflict. Referrals of patients out of the Gaza Strip for specialized treatment were limited to casualties during the conflict and all of them went out via the Rafah crossing with Egypt. Referrals have continued to be disrupted since the end of the conflict as a result of a dispute between the authorities in the Gaza Strip and Ramallah about referral procedures and decisions. It was only in June, following resolution of this dispute, that the number of referrals returned to anything like previous levels.

Despite sustained regional efforts at fostering internal Palestinian reconciliation, the two authorities in Ramallah and the Gaza Strip remain divided, with ordinary Palestinians, particularly in the Gaza Strip, paying the price. Internal divisions have compounded the disruption of basic services, including health, water and sanitation and community services for the most vulnerable.

Unemployment in the Gaza Strip is 48.6% of the active work force.<sup>8</sup> The percentage of Gazans who live under the national poverty line is 51.8% compared to 47.9% in 2006.<sup>9</sup> The percentage of Gazans in deep poverty has also continued to rise; increasing from 21.6% in 1998 to 35% in 2006. The deep poverty line is based only on household income, disregarding food aid and remittances. For a family of six the deep

<sup>8</sup> *Palestine in Figures 2007*. Ramallah, Palestinian Central Bureau of Statistics, 2008.

<sup>9</sup> *Annual report 2005*. Palestine, Ministry of Health, 2005.



poverty line in 2006 was New Israeli Shekel (NIS) 1837 or approximately US\$ 436 per month. With the continued economic decline and the implementation of even stricter closures on the Gaza Strip, the high poverty rate is expected to be higher in 2008.<sup>3</sup>

The unemployment rate in the West Bank is approximately 28.5%.<sup>8</sup> The poverty rate is 45.7% and the deep poverty rate 34.1%.<sup>3</sup> Settlement activity continues to take place across the West Bank and East Jerusalem. Construction is continuing in many of the approximately 120 settlements on both sides of the Separation Barrier. Barrier construction has also continued around East Jerusalem and within the West Bank. Road blocks and checkpoints together with random “flying” checkpoints<sup>10</sup> and other restrictions on movement for people and goods in the West Bank and the Gaza Strip have a negative impact on access to emergency care, preventive services and medicine supply.

Educational and literacy standards remain relatively good. In 2007, the adult literacy rate (aged over 15) was 93.9%, significantly better than neighbouring countries, other than Israel. The combined primary, secondary and tertiary enrolment rate is 82.4%, which is also higher than neighbouring countries, other than Israel and Lebanon.<sup>11</sup> 7.5% of the population attained a Bachelors degree or higher.

## 2.2 Health status of the population

### 2.2.1 Overview

The Palestinian population is going through a rapid epidemiological and demographic transition. The health status of the Palestinian population is comparable to that in other low-middle income countries with relatively good maternal and child health indicators. Due to a successful immunization programme, the communicable diseases of childhood are largely controlled. Some communicable diseases such as tuberculosis, diarrhoeal diseases and acute respiratory infections persist. But noncommunicable diseases are now the main challenge. A combination of factors, including urbanization, globalization and the longstanding stressful conflict situation is giving rise to an increase in the prevalence of risk factors (such as smoking, unhealthy diet and lack of physical activity) of noncommunicable diseases.

In 2007, life expectancy was estimated to be 71.7 years for men (71.9 in the West Bank and 71.4 in the Gaza Strip) and 73.2 years for women (73.6 in the West bank and 72.5 in the Gaza Strip).<sup>8</sup> The fertility rate for the entire territory was 4.6 per woman in 2006 (4.2 in the West Bank and 5.4 in the Gaza Strip). The difference between rural and urban areas is marginal.<sup>11</sup>

According to the 2006 Palestinian Family Health Survey, infant mortality is 25.3 per 1000 live births, and is higher in the Gaza Strip than the West Bank (28.8 and 22.9, respectively). Under-5 mortality is 28.2 per 1000 live births

<sup>10</sup> UN Security Council Briefing, 18 September 2008.

<sup>11</sup> *Women and men in Palestine – issues and statistics*, 2007. Ramallah, Palestinian Central Bureau of Statistics, 2007.

(31.8 in the Gaza Strip and 25.8 in the West Bank). Both rates are higher for males than for females. Both have fallen substantially over recent decades but levelled off since 2000 – a further indication of the decline in the socioeconomic environment and health care. In 2006 pre-maturity and low birth weight accounted for 16.7% of all reported infants deaths compared to 24.7% in 2005.

### 2.2.2 Child and maternal health

The Palestinian Family Health Survey shows that 96.5% of infants (up to 23 months) had completed their vaccination programme which consists of tuberculosis, polio, DPT and measles. Immunization coverage is higher in the Gaza Strip (99.4%) than the West Bank (94.4%). 97.5% of children under-5 years are breastfed with a mean duration of 13 months and 24.8% of children aged 0–5 months were exclusively breastfed.

In 1995, the estimated maternal mortality ratio was 70 per 100 000 live births. It has significantly decreased since then and currently the figure of 38 per 100 000 live births is reported. However, there may be some cases of under-reporting of deaths (mainly in the marginalized areas in the West Bank); omission from the data of deliveries in the other institutions and recording errors by medical staff, e.g. deaths during the pregnancy period are not included. The percentage of women between 15 and 49 years of age who reported currently using any family planning method was 50.2% (54.9% for the West Bank and 41.7% for the Gaza Strip). According to the survey, 98.8%

of pregnant women reported having received antenatal care for their last birth during the past five years. In addition to that, 99.7% of these mothers consulted skilled health personnel for this care. The mean of health care visits during pregnancy was 7.8 visits.<sup>12</sup>

### 2.2.3 Communicable diseases

In 2008, the reported incidence rate for pulmonary tuberculosis in oPt was low at 0.9 per 100 000 population (34 reported cases – 29 in the Gaza Strip and 11 in the West Bank).<sup>13</sup> The reported incidence rate of extra-pulmonary tuberculosis was 0.58 per 100 000 population in the Gaza Strip and 0.21 per 100 000 in the West Bank. OPt has been successful in the Global Fund Round 8 application. A grant will be awarded for the tuberculosis programme in order to expand and enhance directly observed treatment (DOTS), especially among vulnerable groups such as refugees and Bedouins.

Viral hepatitis A, B and C are endemic in oPt. In 2008, the reported incidence of hepatitis A was 50 per 100 000 population (59.79 in the Gaza Strip and 44.6 in the West Bank). 37 cases and 1481 carriers of hepatitis B were detected with an incidence of 0.98 per 100 000 and 39.37 per 100 000 population, respectively (0.0 for cases and 33.04 for carriers in the Gaza Strip and 1.32 for cases and 43.02 for carriers in the West Bank). 3 cases and 154 carriers of hepatitis C were also detected in the same year with an incidence of about 0.1 and 34.17 per 100 000 population (0.0 for cases and 4.09 for carriers in the Gaza Strip and 0.2 for cases and 3.03 for carriers in the West Bank).<sup>13</sup>

<sup>12</sup> *Palestinian Family Health Survey, 2006, preliminary report.* Palestine, Ministry of Health, 2006.

<sup>13</sup> *Health status in Palestine, Annual report 2008.* Palestine, Ministry of Health, 2008.

The cumulative total of HIV/AIDS cases reported since 1988 is 64, of which 45 are AIDS cases and 19 HIV carriers.<sup>13</sup> Although data and dynamics of HIV infection suggest a low prevalence in the oPt, it is assumed that many cases are undetected. The dynamics of transmission change from blood product-related transmission to heterosexual transmission and injecting drug use. OPt has been awarded a Global Fund grant for HIV/AIDS to halt the spread of the epidemic.

#### 2.2.4 Chronic and lifestyle-related diseases

##### Noncommunicable diseases

The family health survey showed that, for all ages, 10.1% of the surveyed population reported that they were suffering from at least one diagnosed chronic disease.<sup>12</sup> The burden of noncommunicable diseases is rising because of the effects of the political and socioeconomic situation, the rise in life expectancy and unhealthy behaviours, including tobacco use, physical inactivity and unhealthy diet. There was an increase of 31.1% in the prevalence of chronic diseases between 2004 and 2006.

Based on mortality data from the Ministry of Health, the leading causes of deaths are heart diseases (53.7 per 100 000), cerebrovascular diseases (30.2 per 100 000) and malignant neoplasms (24.1 per 100 000). Among women, breast cancer is the most prevalent cancer (7.5 per 100 000), while lung cancer is the most common cancer among males (5.2 per 100 000). Cancer of

the trachea, bronchus and lung contribute by 14.3% to the overall mortality rate for cancer.<sup>14</sup>

The lack of investment in prevention contributes to this rapid rise. Although comprehensive data are missing, there is some evidence of increasing prevalence of overweight, obesity, hypertension and raised levels of blood pressure and lipids.<sup>15</sup> According to the Palestinian Family Health Survey 2006, by the PCBS, 19.8% of surveyed persons were reported as smokers, 22.5% in the West Bank and 14.8% in the Gaza Strip.<sup>12</sup> Levels of smoking among adolescents are among the highest in the Region although relatively few women smoke.<sup>12</sup> 17.0% of youth (15–29 years) smoke; 28.1% for males and 1.0% for females; 21.0% in the West Bank compared with 9.8% in the Gaza Strip.<sup>12</sup>

Rates of blood pressure and diabetes were highest among older people. The prevalence of diabetes among people aged 60 years and above was 24.8%, while the prevalence of high blood pressure for the same age group was 35.2%.

WHO is assisting the Ministry of Health in noncommunicable diseases prevention and control with the objective of improving the health system's capacity to prevent and manage chronic diseases. To lay the foundation for a comprehensive noncommunicable disease strategy, a national committee for noncommunicable diseases was established, a department for noncommunicable diseases was set up

<sup>14</sup> *Health status in Palestine, Annual report 2006*. Palestine, Ministry of Health, 2006.

<sup>15</sup> A risk factor survey conducted in 2007 by UNRWA. A health programme among 9608 patients attending noncommunicable disease clinics showed that 62% were obese (BMI<30), half had raised blood sugar, one third had a blood cholesterol above 200 mg/dl and one fourth had raised blood pressure (>140/90).

under the General Directorate for Primary Health Care and another unit for ‘Research and Surveillance for Chronic Diseases’ was created under the General Directorate for policy and planning. WHO is technically supporting these entities. WHO has assisted in developing treatment protocols for key chronic conditions, diabetes mellitus, hypertension and bronchial asthma. Staff have been trained in utilization of these guidelines and in a specialized institute in Jordan on the management of diabetic patients. The main priority now is to develop a national strategy and action plan for prevention and control of noncommunicable diseases. The Ministry of Health, WHO and a noncommunicable disease thematic group are collaborating on development of a national strategy which will give special attention to prevention and control through PHC centres. A comprehensive data collection and situation analysis has been planned.

## Nutrition

Between 1996 and 2006 the prevalence of chronic malnutrition (stunting) among children under 5 rose from 7.2% up to 10.2%; this increase needs specific attention if Millennium Development Goals (MDG) targets are to be achieved. 2.9% suffer from underweight and 1.4% from wasting.<sup>12</sup> Micronutrient deficiencies continue to be the most prominent nutrition problem in the oPt with high levels of anaemia among women and children (anaemia prevalence among pregnant women visiting antenatal care (ANC) services was 29.1%,<sup>16</sup> as compared to 35.8% in 2006,<sup>14</sup> despite the implementation of large micronutrient supplementation programmes for children and women).

WHO has been technically supporting the Ministry of Health in the development of a nutrition policy and strategy and preparation of a document “State of nutrition”. WHO has also assisted in establishing nutrition surveillance and growth-monitoring standards and to build the capacity of central public health laboratories both in the West Bank and the Gaza Strip.

## Injuries and accidents

Injuries and accidents in oPt are the leading cause of death for males under age 59. These figures include casualties of conflict. For children (1–4 years) accidents caused 27.7% of total deaths (traffic road accidents accounted for 11.7 %). For 5–19 year olds, the main cause of death was also accidents, accounting for 46.6% of total deaths (5.6% of which were traffic road accidents). For 20–59 year olds, accidents caused 33.3% of all deaths, of which 2.1% were road traffic accidents.<sup>13</sup>

The Ministry of Health department “Safety on the Road” is responsible for conducting awareness activities on road safety to reduce traffic accidents and related deaths and injuries. The same department also conducts medical examination for drivers to ensure that they are eligible and able to drive.

### 2.2.5 Mental health

According to a 2006 survey, almost three quarters of Palestinians in oPt suffer from depression.<sup>13</sup> Children living in zones of war and political conflict are exposed to a variety of traumas. This has been found to affect their mental health and well-being, and can have long-lasting consequences, even after

<sup>16</sup> *Nutritional surveillance system report, 2007.*

termination of the conflict. Children reported high rates of post-traumatic and anxiety reactions. Trauma exposure was significantly associated with post-traumatic symptoms.<sup>13</sup>

A recent study on the “relationship between the siege of the Gaza Strip and its impact on the economic and social areas and the quality of life of Palestinian families” revealed that the negative effects of the siege reached all facets of life, affected the whole society and suspended people’s life. The results of the study showed that 47% of patients in the Gaza Strip are not able to get the medicine that they need, social visits were reduced by 79% due to worsening financial and social conditions, and sadness was affecting up to 96% of the citizens. 51% of children do not have a desire to participate in any activities; while 47% of them are no longer able to perform school and family duties; another 41% were complaining of aches and physical pains; signs of fear were apparent among 61% of them and 45.5% showed signs of anger. 43% of children complained of sleeping problems and about 63% of anxiety symptoms.<sup>17</sup> Surveys carried out since the conflict began indicate further psychological distress caused directly by it. Results of a household sample survey conducted in March showed that 1% of the population suffer from acute psychological distress as a result of the war. Another survey by WHO of patients attending PHCs found that 37% showed psychological distress as measured by the General Health Questionnaire-12.

In 2004, a strategic operational plan was signed with the Ministry of Health, WHO and French and Italian Cooperation to support

mental health. Implementation has been ongoing since 2007. The overall objective of the mental health policy is developing, reorganizing, improving and expanding current mental health services according to a community-based mental health approach. As a result of this joint collaboration, over the last 2 years two mental health units to lead the mental health reform in the West Bank and the Gaza Strip have been established, mental health postgraduate programmes with local universities have been established, staff are being trained, a nongovernmental organization for family associations has been established and a host of other activities have been carried out. The programme is continuing with a scheduled end date of 2010. In view of the high burden of mental health problems in oPt and the many challenges of implementing a radical reform of this nature, it is likely that the programme will need to be extended.

### 2.2.6 Disability

The Palestinian Central Bureau of Statistics 2006 data showed that the percentage of individuals with disabilities in the Palestinian territory was 2.7% (2.9% in the West Bank and 2.3% in the Gaza Strip).<sup>18</sup> Males have higher percentages of reported disabilities compared to females, 3.0% and 2.3%, respectively.<sup>18</sup> The most common types of disability are visual impairment totalling 60 041 persons (2.9% of the population) and physical disability, totalling 1.3% of the population (1.4% in the West Bank and 1.2% in the Gaza Strip). Persons suffering from difficulties of communicating with others represent the smallest category of disability

<sup>17</sup> *Palestinian reform and development plan (2008–2010)*.

<sup>18</sup> *MDG indicators data in Palestine, 1994–2007*. Ramallah, Palestinian Central Bureau of Statistics, 2007.

totalling 0.26% (0.25% in the West Bank and 0.28% in the Gaza Strip). Concerning type of locality, the data indicated that physical disability is higher in camps and rural areas than in urban areas (1.62%, 1.24%, and 1.18%, respectively), and higher than vision difficulties, which the data indicated is higher in camps and rural areas than in urban areas (0.84%, 0.83% and 0.70%, respectively). Disability is caused by armed conflict and genetic or congenital conditions representing 30.0% of disabilities in oPt (29.9% in the West Bank and 30.3% in the Gaza Strip). These causes are higher in rural areas than in urban areas. Diseases are the second leading cause of disability in the Palestinian territory representing 29.5% of disabilities, 29.9% in the West Bank and 28.6% in the Gaza Strip.<sup>18</sup> The recent war in the Gaza Strip has resulted in more individuals with permanent disabilities, including many amputees, but the numbers involved are not yet known.

Nongovernmental organizations are providing rehabilitation services to people with special needs. WHO could provide technical support to strengthen rehabilitation institutions, and coordination among the different providers.

### 2.2.7 Environmental determinants of health

Environmental health in oPt suffers from neglect and lack of sustainable development. The absence of clear environmental management policies aggravates the problem. Work on environmental issues is distributed between several government and nongovernment institutions.<sup>14</sup> The Ministry of Health environmental health department

and the Environment Authority are the key players. There are many environmental health challenges faced in oPt in the areas of drinking-water safety, food safety, solid and water waste management, and environmental hazards of industrial establishments.

The major concerns regarding water supplies are water shortages, lack of chemicals for water disinfection and limited access to safe water for the rural population. Most of the population has access to water from domestic wells or piped water networks. However, many rural communities rely on water catchment from roof-tops. Water supply and wastewater services in oPt, especially in the Gaza Strip, are seriously limited by damages and shortages of fuel, closures and restrictions of imports of essential consumables.<sup>6</sup> The current water supply in oPt has declined since 2006 and is estimated at 75 litres per capita per day (65 litre per capita per day in the West Bank and 80.5 litres per capita per day in the Gaza Strip), which is only half the international standard of 150 l percap per d.<sup>6</sup>

There are not adequate sewerage and wastewater management systems. The sanitary inspection of water-supply systems and the use of water safety plans are limited and corrective measures are not conducted promptly. Almost 66% of Palestinians in oPt are not connected to a sewerage network and 70%–80% of domestic wastewater produced is discharged into the environment without treatment.<sup>4</sup> In the West Bank wastewater from Israeli settlements is often discharged without treatment into streams and open channels that run either very close to, or sometimes inside, Palestinian

<sup>19</sup> *The effects of the siege on the quality of life of citizens in the Gaza Strip.* Psychology Department, Islamic University of the Gaza Strip, June 2008.

communities.<sup>19</sup> This practice results in contamination of groundwater aquifers and springs. Indicators of groundwater pollution, such as nitrites over 45 mg/l, show that the permissible levels are exceeded.<sup>13</sup> In addition, the release of wastewater increases the risk of diseases such as dysentery, watery diarrhoea and typhoid. Also, it attracts different types of insects and vectors (shadflies, mosquitoes, and rodents) that can cause water- and sanitation-related vector-borne diseases such as leishmaniasis.

As a result of shortages of fuel and electricity, the water authorities in the Gaza Strip have been dumping a daily 60 000 cubic metres of sewage into the Mediterranean Sea since January 2008 to avoid flooding residential areas. The results of the analysis of 26 sea water samples in 2008 showed that sea water in four out of 13 areas was polluted with faecal coliforms and faecal streptococcus and three areas were polluted with faecal coliforms only. A second round of analysis of sea water samples collected from 30 areas revealed that 13 areas constituting seven beaches were polluted.<sup>20</sup>

Solid waste disposal is practised through open dumping, due to limited areas available for proper sanitary landfills.<sup>6</sup> Moreover, most of the medical waste is disposed of without proper treatment and in uncontrolled disposal sites.

Finally, contaminated or poor quality food adversely affects health. There is an absence of clear policy related to food from production stage to consumption. A drafted country food safety strategy is still under

review. Moreover, there is a need to develop food legislation, capacity-building for human resources, strengthening laboratory infrastructure and upgrading of food control facilities.<sup>6</sup>

The WHO country office is providing support to build the capacity of the Environmental Health Department and support their activities. At the beginning of 2008, a rapid assessment was conducted of environmental health conditions and recommendations were made to the Ministry of Health. Following that assessment, and in order to strengthen the surveillance and monitoring role of the Ministry of Health in the area, WHO supported training for the environmental health staff of the Ministry of Health in areas including vector control, solid and waste water management, water and food safety and licensing of industries and handcrafts. Environmental health supplies and GPS devices were also provided to the Ministry of Health.

Several donors have worked on water and sanitation issues through various initiatives. The United Nations Development Programme (UNDP) provided support to the National Palestinian Water Sector Strategy and Investment Programme, the foundation of the national water database and the establishment of effective integrated water resources management tools within the Palestinian Water Authority (PWA). Over 200 water supply and sanitation projects have been initiated by UNDP Programme of Assistance to the Palestinian People (PAPP) in the West Bank and the Gaza Strip. These projects have included the construction

<sup>20</sup> WHO situation report on the sea water pollution. World Health Organization, June 2008.

<sup>21</sup> United Nations Development Programme/Programme of Assistance  
["http://www.undp.ps/en/focusareas/engenv/engenv.html"](http://www.undp.ps/en/focusareas/engenv/engenv.html).

of water supply and distribution networks, storage reservoirs and house connections.<sup>21</sup> United States Agency for International Development (USAID) continued to deliver small-scale water and sanitation improvements to towns and municipalities in the West Bank and Gaza Strip.

## 2.3 Health systems and services

### 2.3.1 Health system organization

The Ministry of Health has made encouraging progress in 2008–2009 in promoting the development of the health sector and in strengthening its own role in stewardship. The publication of the National Health Strategic Plan in March 2008, in line with the Palestinian Reconstruction and Development Plan represented an important step forwards in setting a clear framework for development. More details about these developments are given in Section 2.4 below.

However, the benefits have been limited so far solely to the West Bank. In the Gaza Strip, health services have continued to deteriorate as a result of both the siege and the political split with Ramallah. The closure of the Gaza Strip has resulted in fuel shortages and electricity cuts, shortages of medicines and medical equipment and malfunction of equipment because of a lack of spare parts and appropriate maintenance. Leadership and management of the health sector have been severely affected by politically-driven changes of senior personnel and training and professional development has been seriously neglected. Building works have been frozen because materials are not available. A strike

of health staff from 1 September to the end of December (brought to an end by the war) caused further damage to the provision of care. Inpatient admissions, elective operations and outpatients at clinics and primary health care (PHC) centres all fell substantially in the first month of the strike.

While the situation is significantly better in the West Bank, the fragmentation of the health system as a result of the occupation and the restrictions on the movement of people and goods seriously impedes the provision of efficient and effective care. There are more than 600 checkpoints, road blocks and other obstacles, as well as military zones and the Barrier. Freedom of movement for those who seek care and those who provide it is restricted within the West Bank and also for those in need of tertiary care services in East Jerusalem.

### 2.3.2 Health services delivery

Health services are delivered by the Ministry of Health, UNRWA, nongovernmental organizations and the private sector. The Police Medical Services provides medical care to the police forces and their families in the West Bank.<sup>14</sup>

The Ministry of Health of the PNA owns and operates the largest network of facilities, with 425 PHC centres (Table 1) and 24 hospitals with 2857 beds (Table 2) in the West Bank and Gaza Strip.<sup>22</sup>

The Ministry of Health provides preventive health services through four primary health care levels.

- Level 1: maternal and child health medical care and immunization; and

<sup>22</sup> Ministry of Health report and WHO mission reports.



curative services; first aid.

- ❖ Level 2: maternal and child health and immunization; and curative services: general practitioner medical care and laboratory in some centres.
- ❖ Level 3: maternal and child health, immunization, family planning and dental care; and curative services: general practitioner medical care, medical specialists, health education and laboratory.
- ❖ Level 4: maternal and child health, immunization, family planning and dental care; and curative services: general

practitioner medical care, medical specialists, gynaecology and obstetrics, laboratory, radiology, health education and emergency medical services.<sup>20</sup>

There are 76 hospitals in oPt, with 4878 bed capacity and about 13 beds per 1000 population (see Table 2).<sup>13</sup> While Ministry of Health hospitals are often crowded, nongovernmental hospitals, private hospitals and mental health hospitals are underutilized. The average occupancy rate of Ministry of Health hospitals was estimated at 70%,<sup>13</sup> while the overall average of occupancy rate of hospitals is 62%.<sup>12</sup>

**Table 1. Distribution of PHC centres\* by provider, 2008**

	Ministry of Health	Nongovernmental organizations	UNRWA	Total
West Bank	370	121	35	526
The Gaza Strip	55	57	18	130
Total	425	178	53	656

\*Regardless of the level of the PHC centre.

**Table 2. Distribution of hospitals\* and beds by sector, oPt, 2008**

Provider	West Bank **			The Gaza Strip			OPT		
	No. of hospitals	No. of beds	% of beds	No. of hospitals	No. of beds	% of beds	No. of hospitals	No. of beds	% of beds
Ministry of Health	12	1289	44.1	12	1568	80.1	24	2857	58.6
UNRWA	1	63	2.2	0	0	0	1	63	1.3
NGOs	20	1162	39.8	10	355	18.1	30	1517	31.1
Private	19	407	13.9	2	34	1.7	21	441	9.0
Total	52	2921	59.5	24	1957	40.1	76	4878	100
Bed per 10 000 population		12.2			13.6			12.8	

\* Including three emergency and two psychiatric hospitals.<sup>23</sup>

\*\* Including East Jerusalem hospitals.

<sup>23</sup> *Health status in Palestine, annual report 2007*. Palestine, Ministry of Health, 2007.

Important progress has been made in improving the hospital infrastructure of the Ministry of Health. Plans are being made to create a new medical complex in Ramallah consisting of two state-of-the-art hospitals, in addition to two existing hospitals. In addition, several projects to upgrade and rehabilitate hospitals and health facilities have been initiated such as Rafidia Hospital, Yatta Hospital and Hebron Hospital. A number of hospitals are also being upgraded as teaching facilities such as Ramallah Hospital, Rafidia Hospital and Hebron Hospital. In addition, an agreement was signed between the Faculty of Medicine of the An-Najah National University and the Ministry of Health to replace Al Watani Hospital in Nablus by a new hospital (An-Najah–Al Watani Hospital) that is expected to have 200 beds and serve as the main referral hospital for the north of the West Bank.

Private and nongovernmental organization hospitals make an important contribution to the provision of tertiary care services. Tertiary services are purchased by the Ministry of Health from the local private sector, East Jerusalem Hospitals, and from hospitals in Israel, Jordan and Egypt for insured patients with a varying level of co-payment. The majority of cases are referred by Ministry of Health medical committees to non-Ministry of Health facilities while others are referred by a humanitarian aid committee in the ministers' cabinet. The number and the cost of cases referred to non-Ministry of Health facilities increased significantly between 2003 and 2007.<sup>24</sup> In 2008, a total of 43 047 patients were referred for treatment

to non-Ministry of Health hospitals, of which 20 894 were referred to East Jerusalem hospitals and 10 184 were referred outside the country.<sup>13</sup> In 2008, however, the Ministry of Health took steps to reduce the number and cost of referrals from the West Bank, including more rigorous procedures for assessing the medical need for referrals and tighter contracts with referral hospitals. It has not been possible to make similar changes in the Gaza Strip in present circumstances and the need for referrals abroad from the Gaza Strip has continued to increase.<sup>25</sup>

UNRWA operates mainly PHC services and serves those Palestinians, and their descendents, who were displaced in the war of 1948. There are 1.7 million refugees in the West Bank and the Gaza Strip, representing 45% of the total population. 69% of the Gaza Strip and 29% of the West Bank population are refugees.<sup>3</sup> In July 2007, after the international boycott of the PNA, UNRWA included Palestinians who were married to non-refugees among their beneficiaries.

Nongovernmental organizations operate 26.5% of all PHC centres and 31.1% of hospital beds. They employ 28% of the human resources in the health sector. Nongovernmental organization support to the health sector varies from longstanding missionary hospitals, to facilities supported by international organizations, to community health centres organized by political factions or supported by Islamic charities. The sectors' PHC centres tend to be relatively small, and have been declining in number since 1994. Nongovernmental organizations are, however, the second largest hospital

<sup>24</sup> *Primary health care directorate annual report, 2004*. Palestine, Ministry of Health, 2007.

<sup>25</sup> *Strengthening aid management and planning practice in the Palestinian health sector*. Enrico Pavignani, 2008.

care provider.<sup>13</sup> Police Medical Services provide medical care to the police forces and their families in the West Bank. The provision of this service stopped in the Gaza Strip after the Hamas takeover in June 2007.<sup>24</sup>

As of 2008, the private sector operated 21 hospitals – about 9% of the available beds – many of which were specialized maternity beds and some private diagnostic units.<sup>13</sup> There are also many solo and group private practices. Although adequate data about the private health sector in oPt are missing.

### 2.3.3 Health policy and planning

The Ministry of Health is responsible for ensuring equitable and affordable access to quality essential health services for all Palestinians. The Ministry of Health is the steward of the health sector and is in charge of defining a vision and direction for the health sector and establishing a strategic policy framework.

With the formulation of a National Strategic Health Plan (NSHP) for 2008 to 2010, the Ministry of Health made an important step forward in developing a strategic framework for development of the health sector and identifying necessary institutional reforms. The National Strategic Health Plan outlines objectives and strategies to ensure an ‘integrated health system that contributes to promoting and sustaining the health status of the Palestinians (NHSP 2008). The production of the National Strategic Health Plan involved the creation and strengthening of a Health Policy and Planning Unit, the formation of the National Health Policy and Strategic Planning Council and the creation of a number of technical committees.

Support to the Health Policy and Planning Unit is provided by WHO through an agreement with Italian Cooperation. The Health Policy and Planning Unit was successful in preparing the 2008–2010 National Strategic Health Plan, which was issued and endorsed in early 2008. The Health Policy and Planning Unit also played a crucial role in finalizing project proposals from all Ministry of Health directorates, units and departments as a basis for allocating resources pledged at the Paris Conference.

While the formulation of the NHSP is a step in the right direction, it needs to be accompanied by a sound planning process across the health sector based on wide consultation with health providers and partners. Plans and priorities must also be more closely linked to budgets. National strategic directions still need to be translated into operational plans and systems need to be established to evaluate progress with implementation. Work on these issues has been proceeding in 2009 supported by the Health Policy and Planning Unit and WHO. The Health Policy and Planning Unit is focusing on improvement of the planning process, involving the Ministry of Health directorates, units and departments and health-related stakeholders and institutions in a more participatory planning cycle. Work is also proceeding on updating and revision of the national strategic health plan and on a monitoring and evaluation framework. The aim is to establish a clearer strategic direction and a limited number of key strategic priorities within the planning framework.

Major challenges also include strengthening governance and the

institutional capacity of the Ministry, and developing and carrying through a clear agenda for health sector reform. However, it is difficult to see how any of these developments can be extended to the Gaza Strip in present circumstances.

### 2.3.4 Health care financing

National health accounts are not available in oPt; therefore there are no reliable recent estimates of health spending. Total health spending is estimated at about 8% of GDP. GDP in 2007 was estimated to be US\$ 4165.4 million; about US\$ 1257 per capita.<sup>12</sup> Ministry of Health expenditures amounted to 10.5% of the total PNA budget for 2009.<sup>26</sup> Financing of the health sector derives from taxes, health insurance premiums, co-payments, out-of-pocket payments, international aid and grants as well as nongovernmental resources.

As far as public spending on health care is concerned, the budget of the Ministry of Health in 2005 was estimated at US\$ 157 million and per capita public spending on health was US\$ 41.5. Ministry of Health expenditure increased by 66% between 2000 and 2005 at a time when GDP has remained static. In 2007, Ministry of Health spending reached about US\$ 223 million<sup>22</sup> and US\$ 248 million in 2008. In the Palestinian Reform and Development Plan, US\$ 116 million in capital was allocated for the Health Quality Improvement Plan for 2008–2010 and US\$ 23 million for the Health Care Affordability Plan.<sup>14</sup>

Staff salaries constituted 55% and other operational spending (mainly referral

abroad and medicines and supplies) 45%. Investment spending accounted for only 0.2% of Ministry of Health spending in 2007.<sup>22</sup> Cost of treatment abroad (outside of Ministry of Health facilities) was about US\$ 74 million, of which US\$ 33 million was spent for patients referred to treatment in local health facilities.<sup>22</sup> According to the Ministry of Health, the number of referrals abroad from the West Bank has decreased substantially in 2008 as a result of efforts to tighten up the referral criteria and get more cases treated locally. Cases referred to Israeli hospitals were reportedly reduced by 50% and even more sharply in 2009 following a decision to refer cases to Israeli hospitals only as a last resort if there is no suitable treatment available elsewhere. Costs have also been reduced by better contracting. Pharmaceutical expenditures of the Ministry of Health increased from US\$ 20.8 million in 2005 to US\$ 26.8 million in 2007 – an estimated 29% increase.

The governmental health insurance system covers 60.4% of the total population (350 460 families). 29.9% of the insured population pay premiums and 30.5% benefit without contributing to the system.<sup>25</sup> However, those who are not insured can obtain treatment by paying a modest premium retrospectively when they require treatment. In effect therefore, Ministry of Health services are available to all under the governmental health insurance scheme and are free of charge apart from a small payment of user charges at the point of services utilization. The Ministry of Health has drafted legislation for a major reform of the health insurance scheme (see Section 2.4 below).

<sup>26</sup> Palestinian National Authority Budget 2009.

### 2.3.5 Pharmaceuticals

Following the 2006 election and withdrawal of budget support by the international community, most of the pharmaceuticals and consumables for the Ministry of Health were procured by WHO under projects funded by the European Commission Humanitarian Aid department (ECHO) and other donors and by the World Bank. WHO procured over US\$ 20 million of drugs and consumables in 2007 and 2008.

In early 2008, with the resumption of direct budget support for the PNA, the Ministry of Health took back responsibility for the purchase of drugs and medicines. A procurement unit was set up with responsibility for procuring all health and non-health commodities, works and services needed for the Ministry of Health. Standard procurement procedures for pharmaceuticals were developed.

The total costs of the purchase orders issued by the Ministry of Health in 2008 were approximately US\$ 43 million covering needs for one year of medicines, disposables and laboratory reagents.

Regulation of pharmaceutical suppliers has also been strengthened. Local and international pharmaceutical companies were asked to register their products with the Ministry of Health in order to participate in the tendering process and to be legally marketed in the Palestinian market. All imported drugs must be registered with the Ministry of Health in order to be licensed and assurance provided of compliance with national regulations. In addition, it was agreed with the Israeli manufacturing association to register all Israeli pharmaceutical products before being marketed in oPt.

There are significant challenges in the pharmaceutical sector. One issue is the high price paid for medicines, up to eight times the international price in some cases. There are several reasons for this, the main one being that, under the Paris agreement with Israel, medicines can only be procured from companies that are registered in Israel. This means a shortage of real competition and high market entry barriers for international companies per bidders.

Other issues to be addressed include inadequate storage facilities, weaknesses in stock management, distribution and control and poor prescribing practice. While some of these have been partly addressed as part of the WHO project, there is more to do to put in place an efficient pharmaceutical supply and management system. Meanwhile shortages of medicines and consumables continue to occur.

### 2.3.6 Human resources

According to Ministry of Health figures,<sup>14</sup> there are about 40 000 staff working in the health sector (Table 3). The Ministry of Health as main health care provider is the main employer. There are 966 specialists, 1455 general practitioners, 221 dentists, 391 pharmacist and 3647 nurse and midwives and 1344 paramedical staff working at Ministry of Health facilities. Approximately 59% of Ministry of Health staff are employed in the hospitals, 27% in primary health care and 14% in the other Ministry of Health directorates.<sup>22</sup>

OPt has fewer physicians per head compared with neighbouring countries and fewer dentists, nurses and midwives compared with Egypt and Jordan but falls within the overall regional average.<sup>23</sup>

**Table 3. Distribution of human resources for health by region, oPt, 2007**

Profession perRegion	West Bank		Gaza Strip		oPt	
	Number	Per 10 000 population	Number	Per 10 000 population	Number	Per 10 000 population
Physicians	4 551	19.4	3 842	27.1	8 393	22.3
Dentists	1 358	5.8	700	4.9	2 058	5.5
Pharmacists	2 261	9.6	1 595	11.3	3 856	10.3
Nurses	2 681	11.4	4 277	30.2	6 958	18.5
Midwives	487	2.1	234	1.7	721	1.9
Paramedicals	7 501	32.0	3 245	22.9	10 746	28.6
Total	18 839	80.3	13 893	98.1	32 732	87.0
Administration	4 492	19.2	3 505	24.7	7 997	21.3
Grand Total	23 331	99.5	17 398	122.8	40 729	108.3

Source: Ministry of Health report 2007.

**Table 4. Human resources in oPt and neighbouring countries per 1000 population, 2005–2007**

Category	Egypt	Jordan	Lebanon	oPt	Average for the Eastern Mediterranean Region
Physicians	2.5	2.5	2.84	2.23	1.07
Nurses and midwives	3.5	3.3	1.5	2.04	1.40
Pharmacists	0.34	1.20	0.93	1.03	0.32
Dentist	1.25	0.82	0.13	0.55	0.02

Source: WHO Regional Office Observatory on Human Resources for Health ([http://www.emro.who.int/hrh-obs/regional\\_profile.htm](http://www.emro.who.int/hrh-obs/regional_profile.htm)).

There are many challenges in developing and retaining the workforce that the health sector needs to provide high-quality care. These include strengthening medical nursing and midwifery education, including programmes for continuing education of existing professionals which are sorely lacking; ensuring the recruitment of sufficient number of high calibre candidates for the health sector; reducing the serious losses

to the private sector and abroad; improving remuneration in order to retain and motivate staff and reduce the levels of private practice through which the majority of doctors working in the public sector supplement their incomes. Policies need to be developed to address all these issues. At present, however, an adequate database for human resources for health is missing. Dual practice at both public and private sectors is a

problem for getting proper information about health personnel. The Ministry has, however, developed plans for strengthening the skills of its management and administration personnel for human resources.

### 2.3.7 Health information

The Palestinian Health Information Centre currently collects health-related data that includes vital statistics and clinic-based data, and publishes an annual report “Health status in Palestine”, while the Palestinian Central Bureau of Statistics collects and compiles demographic data and conducts health surveys.<sup>5</sup>

In spite of efforts made by Ministry of Health and several partners to strengthen health information management there is still much room for improvement, especially in terms of comprehensiveness and integration of the system. Quality of data collection has to be improved, data analysis capacity at central and district level remains insufficient. Many types of data that are essential for effective health system planning and management are not available for formulating long-term strategy or for addressing emergency health needs. Information on risk factors for noncommunicable diseases, human resources and health expenditures are not available. Many health care providers, nongovernmental organizations and international agencies collect and analyse data to monitor their own programmes and activities, resulting in a scattered and

sometimes inconsistent and contradictory flow of information. A framework for health system performance assessment operated by the Ministry of Health is also needed to measure progress towards the implementation of the National Strategic Health Plan.

Substantial technical input is required to support the Ministry of Health to address these deficiencies and to establish a comprehensive and integrated national health information system. This system should have surveillance of communicable and noncommunicable disease, financial, human, materials and data on other resources to support policy formulation, planning and decision-making at different levels of the health system.

## 2.4 Thematic groups

A number of thematic groups have also been established to develop policy and programmes on specific areas of the health sector, reporting to the Health Sector Working Group. Currently, these cover noncommunicable diseases, nutrition, mental health, maternal and child health, HIV/AIDS and tuberculosis, the health information system and health sector reform. Each thematic group developed its terms of reference and comprises a number of participants from different stakeholders that have a technical experience to provide guidance on achieving the objectives of the thematic group in each area.

**Table 5. Demographic, social and economic indicators for oPt, 2006–2007**

Demographic indicators
Population 3 761 646 (Gaza Strip 1 416 539 and West Bank 2 345 107) <sup>12</sup>
Total fertility rate 4.6 per woman (5.4 in Gaza Strip and 4.2 in West Bank) <sup>22</sup>
Contraceptive prevalence rate (condom use only) 3.9% <sup>12</sup>
Annual population growth rate 2.5% <sup>22</sup>
Refugee population out of total population in Gaza Strip 58.8%, West Bank 41.2%
Economy and human development
GDP US\$ 4165.4 million <sup>12</sup>
Per capita GDP US\$ 1272 <sup>12</sup>
Per capita national income US\$ 1374 <sup>12</sup>
UN human development index ranking
Poverty rate West Bank 45.7%, Gaza Strip 51.8% <sup>3</sup>
Life expectancy at birth male 71.8 years, female 73.3 years <sup>22</sup>
Social determinants of health and MDG-related indicators
Proportion of population below US\$ 1 (PPP) per day (51.8% in Gaza Strip and 19.1% in West Bank) <sup>8</sup>
Unemployment rate 35.3% (28.5% West Bank, 48.6% Gaza Strip) <sup>8</sup>
Prevalence of underweight children under-five years of age 2.9% (3.2% in the West Bank, 2.4% in Gaza Strip) <sup>8</sup>
Literacy rate of 15–24 year-olds 99.1% (99% West Bank, 99% Gaza Strip) <sup>8</sup>
Ratio of literate women to men 15–24 year olds 95.8% (95.6% West Bank, 96.1% Gaza Strip) <sup>8</sup>
Under-five mortality rate (per 1000 live births) 28.2 (25.8 West Bank, 31.2 Gaza Strip) <sup>8</sup>
Infant mortality rate (per 1000 live births) 25.3 (22.9 West Bank, 28.8 Gaza Strip) <sup>8</sup>
Reported maternal mortality rate (per 100 000 live births) 38.0
Reported 19 HIV and 45 AIDS cases since 1988 <sup>13</sup>
Prevalence and death rates associated with malaria 0.0
Prevalence of pulmonary tuberculosis 0.9 per 100 000 (0.63 West Bank, 2.04 Gaza Strip) <sup>13</sup>
Proportion of the population with sustainable access to an improved water source 93.8% (91.9% West Bank, 97.3% Gaza Strip) <sup>8</sup>
Proportion of the population with access to improved sanitation 99.3% (99.2% West Bank, 99.7% Gaza Strip) <sup>8</sup>



**Health financing**Ministry of Health expenditure as percentage of GDP 4%<sup>3</sup>Percentage of government spending allocated to health 10.5%<sup>26</sup>Total expenditure on health US\$ 220 million (2004)<sup>3</sup>

Total expenditure on health by Ministry of Health US\$ 157 million (2005)

Household spending on health as percentage of total health spending 40.5%

**Human resources**Health workforce per 10 000 by categories: physicians 22.3, dentists 5.5, nurses and midwives 20.4, pharmacists 10.3 and 28.6 paramedical<sup>23</sup>**Health facilities (public and private) by geographical distribution:**

Hospitals: 76 hospitals, total of 4878 beds and 12.8 beds per 10 000 populations.

52 hospital and 2921 in West Bank and 24 hospitals and 1957 beds in Gaza Strip<sup>13</sup>PHC: 672 centres: 542 in the West Bank and 130 centres in Gaza Strip<sup>13</sup>**Data on health service coverage**Immunization coverage (DPT3) 98.7% (97.8 West Bank, 100% Gaza Strip)<sup>12</sup>Pregnant women immunized with at least two or more doses of tetanus toxoid 37.4%<sup>13</sup>Percentage of deliveries in health institution 98.1%<sup>13</sup>Percentage of women attending Ministry of Health antenatal care out of total live births 27.6%<sup>13</sup>

## 2.5 Health strategy

The priorities of the Ministry of Health for 2008 to 2009, as outlined in the Palestinian Reform and Development Plan, are to build strategic management capacity and reform health financing in order to increase the quality, sustainability and affordability of public health care. The Health Quality Improvement programme aims to invest in the quality of individuals, organizations and physical facilities. It covers a wide range of infrastructure, equipment, training and other capacity-building needs. It is also planned that investment in tertiary health care facilities will progressively reduce the need for expensive medical referrals to private hospitals locally and overseas. There

will also be an emphasis on preventative care and primary health care to improve the general health of the population and reduce the cost of treatment. The Ministry of Health also aims to build its capacity to fulfil its role as regulator of the sector. The Health Care Affordability programme aims to improve the allocation of resources to improve health service delivery to citizens. The Health Care Affordability programme focuses on developing effective policies, systems and processes for ensuring more cost-effective procurement of medicines and medical equipment. It is also seeking to strengthen accountability for the allocation of resources through, for example, upgrading internal financial management systems and providing training on public financial management.<sup>13</sup>

Over the last 12 months the Ministry of Health has made significant progress in a number of these areas. It has strengthened its role as steward of the sector in terms of coordination and strategy formulation. The work of thematic groups that tackle technical challenges of the various areas has been reactivated. Progress and relevant matters raised in these groups are reported to the Health Sector Working Group.

The Ministry continues its commitment to reform of the health sector and has established a task force for health sector reform that will include national and international partners. Important technical inputs to reform were provided by the World Bank in the areas of health insurance, financial management, cost containment for pharmaceuticals and human resources management. The Ministry is currently undertaking a major reform of its health insurance system; draft legislation has been prepared and approved by the Cabinet; it is currently awaiting presidential approval. The ceiling on contributions is to be abolished so that everyone will pay the same percentage contribution on their income. Contributions will be mandatory for all with explicit procedures for hardship cases. An independent or semi-governmental health insurance entity will be established working in coordination with the Ministry of Health.

The Ministry of Health is also seeking to strengthen its role as regulator of the Palestinian health sector. The process of licensing and registration of health care facilities and health professionals has been reviewed and by-laws are being developed to support the process. Health care facilities were requested to register or renew their

registration at the Ministry of Health by August 2008. Steps are also being taken to tighten the regulation of the pharmaceutical sector as indicated above.

## 2.6 Indicators

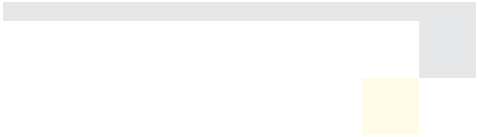
Table 5 provides demographic, social and economic indicators for oPt 2006–2007.

## 2.7 Summary of key health and development challenges and major opportunities/strengths

The challenges facing oPt include:

- ❖ occupation, access restrictions and related emergency conditions that seriously affect the operation of health services;
- ❖ health system fragmentation, between the West Bank and the Gaza Strip and between different providers;
- ❖ the rising burden of health expenditure, particularly from increased staffing, pharmaceuticals and referrals abroad raising questions about long-term affordability in the absence of strong economic growth;
- ❖ increasing poverty and high out-of-pocket expenditure on health;
- ❖ the lack of adequate health promotion programmes to combat lifestyle-related diseases and conditions;
- ❖ inadequate capacity in the Ministry of Health to monitor environmental health safety;
- ❖ lack of human resource development and motivation, including retention of qualified staff, medical, nursing and midwifery education and continuing education of existing professionals.

The opportunities include:

- ❖ health status (as measured by key health indicators) is still relatively good;
  - ❖ committed leadership for health development;
  - ❖ the active role of civil society organizations and academia;
  - ❖ a qualified health workforce;
  - ❖ the support and commitment of the international community;
  - ❖ awareness of the need for better donor coordination and alignment.
- 





Section

3



Development Cooperation  
and Partnerships





## Section 3. Development Cooperation and Partnerships

### 3.1 Aid environment in the country

#### 3.1.1 Palestinian Reform and Development Plan

The preparation of the Palestinian Reform and Development Plan turned a new page in the way external assistance is provided to the PNA. At the Paris pledging conference in December 2007, a draft Palestinian Reform and Development Plan was presented, including a 3-year fiscal framework. Following the conference, international donors have pledged US\$ 7.4 billion for budget and development support. Funds are either directly channelled to the Single Treasury Account or through the Palestinian Reform and Development Plan Trust Fund, created by the World Bank and the Palestinian European Aid Management Mechanism (PEGASE). According to the data in the Palestinian Assistance Monitoring System commitments worth over US\$ 3 billion for 2008 have been signed since September 2007 (when the draft Palestinian Reform and Development Plan was first circulated), including almost US\$ 800 million for development projects. A total of US\$ 2771.4 million was actually disbursed in 2008 of which US\$ 556.8 million was emergency and humanitarian, US\$ 685.9 million was development assistance and US\$ 1528.7 million was budgetary support (PNA: Interim Briefing on International Assistance to the oPt 2008).

The Palestinian Reform and Development Plan 2008–2010 is a national plan which sets out a medium-term agenda for Palestinian

reform and development. It represents a comprehensive framework of goals, objectives and performance targets, and the allocation of resources to achieve them.<sup>13</sup>

The PNA considers the Palestinian Reform and Development Plan to be an essential step towards the improvement of policy-making, planning and budgeting in compliance with the national policy priorities, service delivery and development results. It is envisioned that the Palestinian Reform and Development Plan will initiate a comprehensive process for estimating the current and future cost of public sector activities, and matching these to projections of available resources. This will lead to greater fiscal stability over the medium term and, in the longer run, to improvements in financial management, regulations, procedures and systems, which will provide a basis for effective performance management mechanisms.

The Palestinian Reform and Development Plan also provides the basis for the alignment and harmonization of aid from the international community. Currently, the PNA is developing an “Action Plan for Aid Effectiveness” that is linked to the Partnership Principles for Effective Aid, endorsed by the Cabinet and the Ad Hoc Liaison Committee. Both documents are meant to be in line with the principles of the Paris Declaration. The draft action plan document prepared by the Ministry of Planning has been shared with line ministries for elaborating on further details and is being reviewed by the Ministry of Health and the Health Sector Working Group.

The UN recognizes that the Palestinian Reform and Development Plan is the central document defining overall national strategies and priorities. The UN has developed a Medium Term Response Plan in order to align UN development interventions with national efforts, particularly the Palestinian Reform and Development Plan and sector strategies. The role of UN agencies, including WHO, in development of the health sector is reflected in the Medium Term Response Plan. There are some areas, such as food security, human rights and protection that are not fully part of the Palestinian Reform and Development Plan and institutional capacity-building is only partly addressed. The aim increasingly is to align and disburse aid through Palestinian systems but this will require further strengthening of systems and capacities before it can be fully realized.

### 3.2 Aid coordination mechanisms

Aid coordination mechanisms are well established having been put in place following the Oslo accords and remaining largely intact since. The Ad Hoc Liaison Committee is chaired by the Prime Minister and brings together key PNA ministers with senior representatives of the donor community. It provides a high-level forum for reviewing and discussing political and economic progress in the PNA and assessing the priorities for donor support. Sector working groups have been established below this level to ensure coordination of donor support in key sectors and they, in turn, are underpinned by working groups, such as the Health Sector Working Group, which focus on particular ministries or sectors.

In the health sector, the Health Sector Working Group, which is jointly chaired by the Ministry of Health and Italian Cooperation, with WHO as technical adviser, brings together the main donors to the health sector and key health partners. Its role is to ensure effective aid coordination in support of the strategic development of the health sector. A number of thematic groups have also been established to develop policy and programmes on specific areas of the health sector, reporting to the Health Sector Working Group. Currently these cover noncommunicable diseases, nutrition, mental health, maternal and child health, HIV/AIDS and tuberculosis, health information system and health sector. Each is chaired by the relevant Ministry of Health director or director-general and is supported by WHO or another donor. Discussions are currently ongoing within the Health Sector Working Group, led by Italian Cooperation with the support of WHO and the Ministry of Health, to make it a more effective mechanism for aligning donor support to the health sector with the priorities of the Ministry of Health as reflected in the Palestinian Reform and Development Plan and National Strategic Health Plan.

The Central Coordination Committee, which comprises the Ministry of Health and public and nongovernmental organization health care providers, is responsible for operational coordination within the health sector. It acts mainly as an information-sharing forum, identifying health needs and solutions that are shared with the Ministry of Health and Health Sector Working Group. Coordination committees at district level ensure coordination between partners at local level and feed back their recommendations into the Central Coordination Committee.



WHO supports these committees; it co-chairs the Central Committee and provides secretariat support to the district committee, preparing agendas and minutes, organizing meetings, etc. WHO also leads and supports the health cluster which was established early in 2009 to coordinate the international humanitarian health response to the crisis in the Gaza Strip. The health cluster is now the principal mechanism for coordinating the response of health partners to emergency health needs. Cluster meetings are held regularly in West Bank perEast Jerusalem and in the Gaza Strip.

### 3.3 Aid to the health sector

It is not possible to identify the total aid from donors to the health sector because much of the aid for the PNA is not earmarked, i.e. provided to the PNA to determine its own priorities and not allocated specifically for health. The PNA pools the various sources of funding and determines the allocations for each sector or Ministry.

Among the donors contributing to funding initiatives that support the development of the health sector are USAID and the World Bank. USAID is funding the Flagship Project which is a five-year initiative that started in 2009 with an estimated budget of US\$ 57 million. The Project's main objective is to support the Ministry of Health, selected nongovernmental organizations, and selected educational and professional institutions in strengthening their institutional capacities and performance to support a functional and democratic Palestinian health sector able to meet priority public health needs. The Project works to achieve this goal through three components: (1) supporting health sector reform and management; (2) strengthening clinical and community-based

health; and (3) supporting procurement of health and humanitarian assistance commodities. The project has developed an institutional development plan with the Ministry of Health, based on a needs assessment carried out towards the end of 2008. Table 6 shows the key areas for reform that have been identified and agreed by the Ministry of Health which the Flagship programme plans to support over a five-year period.

WHO and other partners and donors are currently providing technical support and assistance in some of the above areas, or are planning to do so (see Section 4). The flagship team are working closely with these partners to ensure support is coordinated and that overlap and duplication are avoided. Discussions are underway to map relevant partner activities and plans and to clarify who should do what.

The World Bank published a report in July 2009 (*Reforming prudently under pressure*) focusing on the drivers of the sharp recent increases in health expenditure by the Ministry of Health and the growing gap with health revenues. Key drivers were the increase in staff and in salaries and the impact on the overall wage bill of the PNA, the growth in Ministry of Health pharmaceutical expenditures and the increase in referrals for specialized hospital treatment to the private sector and neighbouring countries. The report outlines options for reform of the above areas and of the health insurance scheme and financial and human resource management. There are proposals for further support by the Bank to the Ministry of Health to support reform in these areas. WHO is liaising with the Bank to ensure coordination of common activities in these areas.

**Table 6. Key areas for reform to be supported by Flagship Programme**

Module	Priority area
1	Create a centre of excellence at the Palestine Medical Complex
2	Develop a health information system
3	Support implementation of the new health insurance programme
4	Design and implement a continuous education programme for health professionals
5	Create and implement a relicensing system for health professionals
6	Design and implement a health facility accreditation programme
7	Improve performance management
8	Strengthen service delivery and clinical guidelines
9	Improve coordination of stakeholders
10	Support passing and implementation of the health commodities procurement by-laws
11	Improve clinical Ministry of Health primary care system
12	Improve the quality of clinical services in the Palestinian Ministry of Health hospital system
13	Improve health communication services
14	Support Ministry of Health emergency department and emergency preparedness
15	Establish a training and fellowship programme in health administration and management for the public sector
16	Improve community-based health services
17	Improve medical waste management
18	Introduce and implement a comprehensive monitoring and evaluation approach and system

### 3.4 Emergency versus development aid

While the Palestinian Reform and Development Plan outlines the strategy for economic development, the need for humanitarian and emergency assistance has continued as living conditions for most Palestinians in oPt, especially in the Gaza

Strip, continued to deteriorate in 2008 and early 2009.

The Consolidated Appeal Process (CAP) for 2009 presented an overall budget requirement of US\$ 462 million of which US\$ 37.9 million was for health and nutrition. The flash appeal prepared during the Gaza Strip crisis in early 2009 amounted to US\$ 613 million, including health projects

for US\$ 46.2 million. The revised CAP total, including the flash appeal, amounted to US\$ 873 million. The mid-year review of the CAP resulted in a revised total of US\$ 803 million, including US\$ 82 million for the health sector. The reason for the increase in the mid-year revised requirements for the health sector is the inclusion of mental health and psychosocial projects in the health component. The overall funding rate for all projects at the mid-year review was 53%; funding for health projects amounted to 44%.

The preparation for the CAP 2010 is currently underway. It was agreed by UN agencies and international nongovernmental organizations that the CAP should focus explicitly on emergency needs and on vulnerable communities. There will be sector-specific consultations at local level to identify the most pressing needs as part of the CAP process. In the health sector, these will be led by WHO.

## 3.5 Specific assistance

### 3.5.1 Global Fund to Fight AIDS, Tuberculosis and Malaria

OPt has been awarded two Global Fund grants. The goal of the first grant from Round 7 is to halt the spread of HIV perAIDS and STIs among the most-at-risk populations and the general community and to improve the quality of life for people living with, and affected by, HIV perAIDS. The five-year programme is worth US\$ 10.8 million for the duration of 5 years. The Theme Group for HIV perAIDS had applied for this grant as a non-CCM applicant with UNDP as the primary recipient and WHO as one of the subrecipients. Similarly, oPt will receive, as a

non-CCM applicant through the UN Theme Group, the grant of the Global Fund Round 8 for quality DOTS implementation in the West Bank and the Gaza Strip. This grant is worth 2.2 million Euro (€) over five years.

## 3.6 Implications for WHO

WHO is working with partners to support the alignment and harmonization of aid within the health sector. Through the support it is providing to the Health Policy and Planning Unit in the Ministry of Health, it is also seeking to strengthen the planning processes within the health sector and to update the NHSP. The objective is to ensure full consistency between the NHSP and the health sections of Palestinian Reform and Development Plan and for the NHSP to provide a clearer set of strategic priorities which donors are committed to supporting.

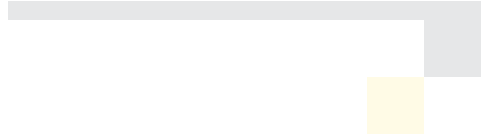
WHO's CCS as set out in this document is fully consistent with these aims and with the priorities of the NHSP. WHO's humanitarian work is funded through the CAP mechanisms. In the case of the development programme however, funding support, other than that provided through the Joint Programme Planning and Review Missions (JPRM), depends largely on bilateral discussions with and support from donors and on the recognition that WHO's technical advice and support to the Ministry of Health is critical to the achievement of the shared goals or development of the health system.

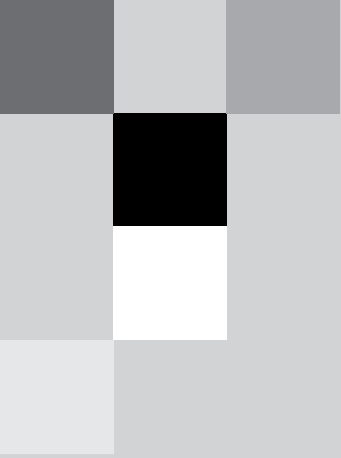
### 3.7 Summary of key issues and challenges and opportunities for aid effectiveness and partnerships

The opportunities include: commitment by, and willingness of, donors to support the health sector; good aid coordination mechanism for the health sector; existence of

health thematic groups to coordinate inputs on specific policy and strategic issues.

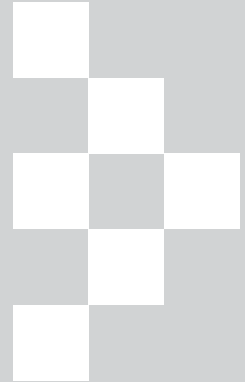
The challenges include: distinction between humanitarian, early recovery and development assistance not always fully understood or accepted; and coordinating support for the Gaza Strip with the Ministry of Health.





Section

# 4



**Past and Current  
WHO Cooperation**





## Section 4. Past and Current WHO Cooperation

### 4.1 WHO cooperation overview

WHO has been working with the Palestinian population for over 50 years since it first provided support to UNRWA to establish a health department to meet the health needs of the Palestinian refugees. With the formation of the PNA in 1994, the Palestinian Ministry of Health was established and took over responsibility for the health sector previously carried out by the Israeli Civil Administration. In 1994–1995, WHO worked with the two parties (Israel and the Palestinians) to facilitate the transition. WHO assisted in setting up the Ministry of Health and assumed the Secretariat role for donor coordination.

In 1994, WHO started the Special Technical Assistance Programme, and established the West Bank and the Gaza Strip office with the main office in Jerusalem and suboffice in the Gaza Strip. The Programme was initially dependent on the Department of Emergency and Humanitarian Action, now Health Action in Crisis, at WHO headquarters and relied on their extra-budgetary support. More recently, the responsibility for the WHO West Bank and the Gaza Strip office has transferred to the Regional Office for the Eastern Mediterranean. The Regional Office provides core funding for the office. Planning of activities for the biennium is undertaken, as for the other countries of the Region, through the biennial JPRM exercise. The total amount of funds for the biennium has been about US\$ 1 365 000 between 2008 and 2009.

The CCS for 2006 to 2008 set out WHO's strategic agenda for oPt. The mission statement was: "To promote the health of all Palestinian people by improving health sector performance based on equity, effectiveness and sustainability, as well as by addressing the broader social, economic, environmental and cultural health determinants, particularly those which are most affected by the Israeli–Palestinian conflict." Four main strategic directions were defined: health policy and systems development, coordination, technical support in particular areas, and advocacy. Emergency preparedness and response did not feature as a strategic area in its own right (although it did feature within these four areas).

The emergency situation following the Hamas election victory in June 2006 has dominated WHO's health agenda since 2006. Much of the work was of an emergency nature and was funded through CAP or other emergency funding. The pharmaceutical and health coordination projects were particularly large and operational compared with previous WHO activities in oPt and involved a significant expansion of staff.

In 2008, with the resumption of budget support for the PNA, the Ministry of Health has resumed responsibility for the procurement of pharmaceuticals and medical supplies for the health sector and WHO has closed the pharmaceutical project. While there has been some shift of emphasis back towards development activity, the situation in the Gaza Strip, the impact of the war and the ongoing effects of the military occupation of

the West Bank mean that the humanitarian agenda for WHO remains very significant both for its role as lead of the health cluster and in respect of individual projects.

## 4.2 WHO collaboration in oPt

WHO's recent collaboration in oPt has been in five main areas: emergencies, health sector partnership and coordination, health information, health programmes development and advocacy on the right to health.

### 4.2.1 Emergencies

*Pharmaceuticals.* WHO managed a major project to procure, store and deliver pharmaceuticals and consumables to the Ministry of Health in 2007 and 2008 with over US\$ 20 million in funding from ECHO, Central Emergency Response Fund (CERF) and Spanish Cooperation. The aim of the project was to ensure that quality assured essential medicines and consumables are available at Ministry of Health central and district level through effective selection, procurement and distribution. Various development activities were also undertaken to promote rational use of medicines. Stock management tools and standard operating procedures and manuals to facilitate the efficient management of drug registration and regulatory control were developed and Ministry of Health staff were trained to use and implement procedures and tools.

*Gaza Strip:* WHO's operation during and following the recent Israeli military attack on the Gaza Strip has been intensive and has had a wide scope. The collaboration included an assessment of the health situation and of immediate needs, supply of medicine,

disposables and equipment, logistic support to the central drug stores and support to departments in the main the Gaza Strip hospitals. WHO has also been a conduit for the delivery of donations and support from Member States of the Region.

*Emergency preparedness:* WHO has supported preliminary work on emergency preparedness, including the review of existing policy and systems and recommendations on a strategy for strengthening preparedness.

WHO's role in emergencies has been of growing importance in recent years, both as health cluster lead and coordinator of the humanitarian health response and in undertaking health assessments, providing information and filling gaps. The WHO assistance and capacity to response to emergencies should be maintained and expanded. It is vital to mobilize potential donors to ensure timely provision and support for emergency and humanitarian situations separately from development assistance.

### 4.2.2 Health sector partnership and coordination

WHO works in close partnership with the Ministry of Health, other UN agencies and other stakeholders in the health sector and plays an important role in health sector coordination in the West Bank and the Gaza Strip. WHO is technical adviser to the Health Sector Working Group (see Section 3.2 above) and also coordinates and facilitates the work of thematic health groups on various health topics.

WHO, with the Ministry of Health, organizes and supports regular central and district



health coordination meetings involving local and international nongovernmental organizations, UN organizations and local authorities to discuss needs and priorities and update key activities at both central and district levels.

As the designated lead of the health cluster, WHO organizes and chairs regular meetings of the health cluster in West Bank and the Gaza Strip and coordinates cluster activities, including the health sector response plan for the CAP, the contingency health response plan and the health sector input for the monthly humanitarian monitor produced by the Office for the Coordination of Humanitarian Affairs (OCHA).

WHO represents and speaks for the health sector at various UN and donor meetings, including the UN Country Team, the Humanitarian Country Team and the ECHO perdonor meeting ('Friday' meeting).

WHO collaboration and support of the Ministry of Health play a crucial role in coordination of the health sector and position the Ministry of Health/WHO collaboration in a unique position to help advance the development of the sector. Hence, both the Ministry of Health and WHO should maintain, and expand, efforts in this area.

### **Health information**

WHO has been active in collecting and sharing information concerning the humanitarian health situation and response, the status of health facilities and the availability of medical supplies in order to support decision-making, advocacy and emergency response. This has involved the following activities.

- ❖ Monitoring health status and services: visits to the hospitals, primary health clinics and other relevant departments in the West Bank and the Gaza Strip and collection and analysis of sentinel indicators for producing monthly or bi-monthly reports and monitoring emergencies, especially in the Gaza Strip.
- ❖ Health facilities database: WHO, jointly with the Palestinian Health Information Centre, is updating the Health Facilities Database containing comprehensive health status and management information to facilitate the planning activities of the Ministry and other stakeholders.
- ❖ Joint initiatives: WHO provides information on the health sector regarding status, needs and monitoring of humanitarian concerns, CAP and special initiatives.
- ❖ Other initiatives with the Ministry of Health: WHO facilitated the production of terms of reference for the Health Information Thematic Group and will support the Palestinian Health Information Centre in implementing its objectives. Also, WHO provided support for the completion of the Global status report on road safety and Global Youth Tobacco Survey.

The Ministry of Health and WHO collaboration on information and communication should be further expanded. There is a gap on environmental health which needs further attention.

### **Health programmes development**

The need for an effective Policy and Planning Unit at the Ministry of Health

has been widely recognized by donors, government authorities and health stakeholders. Support to the Health Policy and Planning Unit is provided by WHO through an agreement with Italian Cooperation. A WHO adviser provided full-time support to the Health Policy and Planning Unit under this agreement from August 2007 to July 2008. The project has been extended for a further year and support is now provided by means of full-time local consultant together with a part-time international consultant.

Key achievements through WHO support to the Health Policy and Planning Unit include: its success in preparing the 2008–2010 National Strategic Health Plan, and finalization of the 2009 annual work plan – an annual implementation plan of the 3-year national strategic health plan.

### **Mental health**

In view of the critical stressful conditions resulting from occupation, mental health care is one of the highest priorities in oPt. In recognition of this huge need, WHO collaboration on mental health has been scaled up since 2004 through a joint project between the Ministry of Health, WHO, French and Italian Cooperation. The overall objective of this project is to reform and modernize mental health services through a community-based mental health approach project implementation started in 2008 and achievements to date include establishing a mental health unit in Ministry of Health, training of large number of mental health care professionals, initiating the integration of mental health into PHC, developing

mental health postgraduate programmes with local universities, and establishing a nongovernmental organization for family associations for advocacy and mental health awareness-raising. It has been agreed with the Ministry of Health that there is a need to review the strategic operational plan and mental health legislation during 2009.

### **Noncommunicable diseases**

The burden of noncommunicable diseases is one of the highest health priorities to be addressed in oPt. WHO has helped in establishing a national committee for noncommunicable diseases, setting up a department for noncommunicable diseases under the General Directorate for Primary Health Care and a unit for ‘Research and Surveillance for Chronic Diseases’ under the General Directorate for Policy and Planning. WHO has also helped the development of noncommunicable diseases treatment protocols and training of staff in oPt and outside. Currently, WHO is providing technical assistance to support the development of a national strategy for prevention and control of noncommunicable diseases.

### **Nutrition**

WHO collaboration has supported the development of nutrition policy and strategy primarily as technical support to elaborate on the ‘State of nutrition’ document, and has helped to strengthen the nutrition surveillance system through the introduction of WHO growth-monitoring standards. Support has also been provided to build the capacity of public health laboratories to monitor levels of micronutrients in fortified foods and the micronutrient status of the population.

## East Jerusalem Hospitals Project

With grant assistance from the European Commission (2007–2008), East Jerusalem Hospitals (Makassed, Augusta Victoria, Red Crescent Maternity, St John Ophthalmology, St Joseph Hospital and Princess Bassma Rehabilitation Centre) have been going through a process of strategic reforms, including a review of internal governance and networking, policies, organizational structures, systems and procedures. At the end of 2006, the European Commission signed an agreement with WHO to launch a second phase of this project. Three components of the project are: quality improvement, direct financial support for the social cases that the hospital treats and strengthening East Jerusalem Hospitals network. A proposal for the next phase of the project was submitted to the European Commission and is expected to be funded by the Commission starting in 2010.

## Communicable diseases and environmental health

OPt has been awarded the Global Fund Grants for HIV perAIDS and tuberculosis. On tuberculosis, WHO has led the preparation of the proposal for the Global Fund Round 8 and is co-chair of, and technical adviser to, the UN thematic group. On HIV perAIDS, WHO is one of the subrecipients of the grant and will focus on technical support to the national HIV/AIDS committee, voluntary counselling and testing (VCT), blood safety and universal precautions, ART treatment and monitoring, as well as health information system and operational research.

Because of the volatile situation and abrupt interruption and damage to services,

Environmental health is a major public health concern in oPt, WHO support was provided to the Environmental Health Department in the Ministry of Health to assess environmental health conditions and needs, providing capacity-building for staff and supplies and materials for addressing environmental health hazards, e.g. water safety and vector control activities. Technical support has been channelled through the Regional Centre for Environmental Health Activities (CEHA). The level of support to environmental health needs to be increased.

Ministry of Health/WHO collaboration on strengthening health programmes has been effective in areas such as mental health, health policy and planning and communicable diseases. However, in other areas such as environmental health, nutrition, human resources development, and health care quality, there have been difficulties in mobilizing technical assistance from Regional Advisers and staff from WHO Regional Office because of Israel's visa restrictions. Further expansion and scaling-up may be needed in some of these areas.

## Advocacy on the right to health

WHO plays a wide ranging role on advocacy on health issues in oPt. This involves monitoring and reporting on the health situation, raising issues of concern and following up to mobilize action or resources. The work covers both the general health situation and advocacy on particular topics (e.g. access to health, health strikes, the right to health). Advocacy activities target specific geographic areas (such as the Gaza Strip, East Jerusalem and marginalized communities in the West Bank) and ad hoc

issues of concern. Much of the advocacy work is conducted through a dialogue with relevant stakeholders: the Ministry of Health, UN agencies, nongovernmental organizations, donors, Israeli authorities, etc. In some cases, there is a need for a higher profile, involving publication of information and the media. A health advocacy task force has been initiated and is chaired by WHO, which brings together all main health stakeholders.

The main advocacy products have been:

- ❖ two publications on access to health services for Palestinian patients, exposing the difficulties and hardships of Palestinian patients awaiting referral outside the Gaza Strip. The publications received wide media coverage.
- ❖ a report prepared on access to East Jerusalem hospitals. This has been discussed with the Government of Israel which has given an initial positive response about easing the access problems for staff and patients to East Jerusalem hospitals.
- ❖ the holding of conferences involving health stakeholders, including Palestinian and Israeli institutions and international organizations, to draw attention to the difficulties faced by Palestinian patients in accessing health services.
- ❖ workshops organized for the Ministry of Health on “Health and the law”, to mainstream a rights-based approach.

Since 2006, the WHO Advocacy Unit has also supported dialogue between Palestinian and Israeli health professionals by promoting the Bridges project and publishing Bridges, an Israeli Palestinian public health magazine.

Twenty editions of Bridges were published before the decision was taken to suspend the publication at the start of 2009. Three workshops were also organized and discussions are ongoing about arranging further joint workshops on issues of mutual interest and concern in 2009–2010.

Advocacy on the right to health in an important component of WHO’s role in oPt. It requires ongoing support including in the regional and global governing bodies meetings and related events.

### 4.3 Lessons learnt: opportunities and challenges for WHO country programme

The WHO country programme has played a vital and effective role in the following areas.

- ❖ Supporting development of a national health strategy.
- ❖ Assessing, monitoring and reporting on the health situation.
- ❖ Supporting the Ministry of Health in coordination of aid to the health sector.
- ❖ Facilitating and assisting in development of priority thematic health programmes.
- ❖ Coordinating the international health response to humanitarian and emergency crises.

Opportunities and areas in which to expand include:

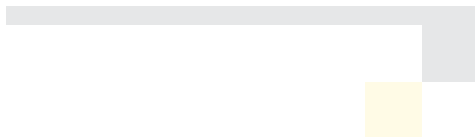
- ❖ human resources development.
- ❖ support for strengthening environmental health.
- ❖ technical support to expand tertiary care and reduce referrals abroad.
- ❖ developing more noncommunicable

disease programmes.

- ❖ implementing the healthy city programme with a focus on healthy lifestyles to prevent primary causes of noncommunicable diseases.
- ❖ supporting development of a comprehensive health information system.

Challenges include:

- ❖ brokering effective intersectoral perinterdisciplinary collaboration.
- ❖ collaboration with the Ministry of Health for operations in the Gaza Strip.
- ❖ recruiting and fielding consultants on time and overcoming visa restrictions.
- ❖ securing adequate funding from donors for early recovery and development assistance.







Section

# 5



Strategic Agenda  
for WHO Cooperation







## ❖❖ Section 5. Strategic Agenda for WHO Cooperation

### 5.1 Strategic agenda

The WHO cooperation strategic agenda at the country level is guided by the overall policy framework for the work of WHO as set out in the *Eleventh General Programme of Work*, *WHO Medium-Term Strategic Plan* and the regional priorities. Furthermore, WHO country cooperation is strongly influenced by *WHO Core Functions*.

In consideration of the above, the strategic agenda for WHO's cooperation with the PNA identifies the proposed role of WHO in supporting oPt's national health and development plans during the six years 2010–2015. The strategic agenda has been prepared based on:

- ❖❖ key health and development challenges confronting the country as analysed by WHO in full consultation with the government, national stakeholders and development partners recognizing the adverse affects of the occupation and the ongoing humanitarian crisis in the Gaza Strip;
- ❖❖ the PNA's policy orientation and priorities particularly, the Palestinian Reform and Development Plan (2008–2010); the National Strategic Health Plan (2008–2010);
- ❖❖ contributions to health development by other development partners and identified challenges and gaps in health sector cooperation;
- ❖❖ WHO's past and current cooperation;
- ❖❖ WHO's General Programme of Work, the strategic objectives in the UN

Medium Term Response Plan and regional orientations and priorities.

### 5.2 Strategic priorities

The strategic agenda for WHO cooperation includes six strategic priorities for WHO technical assistance to the PNA during the period 2009–2013. The order in which the priorities are listed does not indicate a relative weighting or the importance attributed to the individual priorities.

- ❖❖ Building institutional capacity in the Ministry of Health to strengthen health systems.
- ❖❖ Addressing the unfinished agenda for communicable diseases.
- ❖❖ Addressing noncommunicable diseases.
- ❖❖ Strengthening health sector cooperation and partnerships.
- ❖❖ Addressing humanitarian and emergency health needs.
- ❖❖ Advocacy for health as a human right.

### 5.3 Key objectives and strategic approaches

A set of “key objectives” and strategic approaches have been formulated for each of the strategic priorities. The key objectives outline the role of WHO in addressing that priority, reflecting WHO's comparative advantage and WHO's role as policy adviser and convener. The strategic approaches indicate key areas for action by WHO for each of the key objectives and are based on WHO's core functions.

### 5.3.1 Building institutional capacity in the Ministry of Health to strengthen health systems

Strengthening the main leadership and governance functions through institutional development, training and provision of technical assistance

Strategic approaches include:

- ❖ providing technical support for the Health Policy and Planning Unit of the Ministry of Health and building capacity in policy analysis and formulation, strategic planning and budgeting
- ❖ assisting the Ministry of Health to develop a long-term plan for secondary and tertiary care (a 'master plan' for hospitals)
- ❖ supporting development of the regulatory and enforcement responsibilities of Ministry of Health for health care services provided by the public, private and nongovernmental organization sectors
- ❖ supporting the development and strengthening of a national regulatory authority responsible for selecting, using and assessing health and biomedical technologies in health care
- ❖ building capacity to utilize analytical tools in assessing the health system performance including burden of disease analysis, national health account analysis and economic tools and principles in health system management
- ❖ supporting the Ministry of Health to convene a national forum on health sector reform bringing together major stakeholders to work with the

Ministry of Health in carrying through a programme of reform.

Key objective: Support the development of sustainable and equitable health care financing options

Strategic approaches include:

- ❖ generating evidence on health care expenditure and utilization of health care services
- ❖ implementing national health account analysis in order to assess the flow of finance in the system and to measure fairness of financial contribution
- ❖ developing expertise in costing and cost analysis in health systems.

Key objective: Support to human resource development strategies aimed at improving availability, distribution, skill mix and management of health workforce

Strategic approaches include:

- ❖ strengthening the human resources development department of the Ministry of Health
- ❖ supporting development of national policies and strategies for workforce planning and human resource development
- ❖ assisting in establishing and updating an human resource database to facilitate the implementation of national human resource observatory
- ❖ supporting, in close collaboration with key partners, development and implementation of continuing medical education.

Key objective: Strengthening national information system in order to support the

development of evidence-based policies and strategies

Strategic approaches include:

- ❖ assessing the present information system and identifying gaps and needs for improvement
- ❖ supporting implementation of the WHO household health expenditure and utilization survey and make use of other population-based surveys including DHS, MICS, etc.
- ❖ assisting improving vital registration (including for maternal mortality) through coordination with ministry of interior, local government and national bureau of statistics
- ❖ developing the capacity of government and nongovernmental organization on key technical areas.

### 5.3.2 Addressing the unfinished agenda for communicable diseases

Key objective: Accelerating the implementation of the Stop TB Strategy

Strategic approaches include:

- ❖ providing technical support for “DOTS expansion and enhancement”, as well as other components of the Stop TB Strategy, with particular focus on vulnerable populations
- ❖ providing technical assistance to strengthen and building capacity of the national tuberculosis programme and other partners in tuberculosis care
- ❖ strengthening capacity to assess the epidemiological situation of tuberculosis through improving surveillance and supporting operational and epidemiological research.

Key objective: Supporting the scaling up of the national response to HIV towards universal access to HIV prevention, care and treatment

Strategic approaches include:

- ❖ providing support for generating strategic information, including HIV prevalence and programme monitoring in the health sector, and ensuring effective use of data for decision-making
- ❖ providing technical support to develop perrevised guidelines for HIV prevention, treatment and care interventions in the health sector
- ❖ strengthening capacity for effective planning and implementation of quality HIV

Key objective: Update national preparedness plan for H1N1 and avian influenza

The strategic approach involves:

- ❖ engaging with the Ministry of Health, other relevant ministries, national and international partners, to update and implement the national action plan for influenza preparedness.

Key objective: Strengthening Ministry of Health capacity to assume responsibilities under the International Health Regulations

Strategic approaches include:

- ❖ providing technical support to meet the requirements of the International Health Regulations regarding national surveillance and response systems
- ❖ supporting development of the core capacities required by the International Health Regulations for

the establishment and strengthening of alert and response systems for use in epidemics and other public health emergencies

### 5.3.3 Addressing noncommunicable diseases

Key objective: Support the implementation of the “Global Plan of Action on noncommunicable diseases”

Strategic approaches include:

- ❖ continuing to collaborate with and assisting the Ministry of Health, other ministries, international development partners, nongovernmental organizations, civil society organizations, and academia in the development of a national strategy for the prevention and control of noncommunicable diseases, including cancer
- ❖ providing technical support to implement national noncommunicable diseases strategy and appropriate action plans.

Key objective: Support improvement in the quality, effectiveness and sustainability of community mental health services

Strategic approaches include:

- ❖ reviewing progress in implementing mental health reforms with partners
- ❖ advising and assisting in improving the knowledge, skills and competencies of mental health professionals
- ❖ providing technical support in the development of the Ministry of Health mental health directorates
- ❖ providing technical support for a public education campaign to reduce the stigma associated with mental illness.

Key objective: Support action to address malnutrition

Strategic approaches include:

- ❖ supporting Ministry of Health to finalize the “National Nutrition Strategy” and its operational plan of action
- ❖ providing technical support to the Ministry of Health on strengthening nutrition surveillance and the infant and young child feeding components of the “National Nutrition Strategy
- ❖ supporting Ministry of Health to implement agreed standards for the micro-nutrient content of foods.

### 5.3.4 Strengthening health sector cooperation and partnerships

Key objective: Support the Ministry of Health to fulfil its health sector leadership role in the health sector and promote active partnerships with other sectors and local communities in health development

Strategic approaches include:

- ❖ strengthening capacity of the Ministry of Health to support a community-based approach
- ❖ implementing the healthy city programmes with a focus on health promotion and healthy lifestyles to prevent primary causes of noncommunicable diseases
- ❖ strengthening Ministry of Health environmental health monitoring and surveillance and Ministry of Health advocacy for incorporation of environmental health in urban and rural development
- ❖ supporting Ministry of Health in developing partnerships with nongovernment institutions, academia

and international organizations and in advocacy for health.

Key objective: Harmonize development partners' programmes and procedures for a more coordinated response to country needs and increase alignment of development assistance with national priorities

- ❖ engaging with partners to strengthen aid coordination in the health sector, including movement towards a sector-wide approach
- ❖ participating actively in ensuring that health gets due prominence in the formulation of the United Nations Medium Response Plan and its implementation
- ❖ strengthening WHO advocacy role on health-related issues and promote multi-agency planning and cooperation
- ❖ ensuring that health-related data and analysis are included in relevant UN advocacy and information activities in the oPt.

### 5.3.5 Addressing humanitarian and emergency health needs

Key objective: Providing leadership to ensure adequate services are provided where the restrictions or limitations on services are most severe, especially to vulnerable groups

Strategic approaches include:

- ❖ providing leadership for the health cluster to identify emergency health needs and coordinate the health response

- ❖ ensuring that the health cluster carries out the functions expected of it in line with the global health cluster guidelines
- ❖ advocating and supporting the implementation of health cluster initiatives.

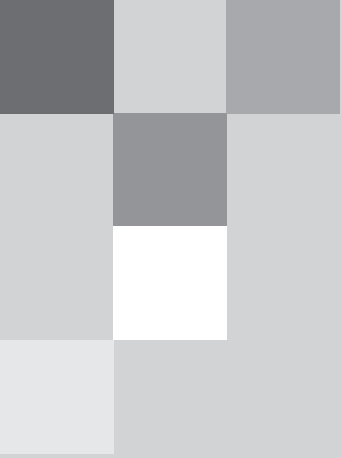
### 5.3.6 Advocacy for health as a human right

Key objective: Advocate for health as a human right with particular regard for the impact on access to health of the restrictions on movement created by the occupation

Strategic approaches include:

- ❖ working with the Ministry of Health and other international and local partners to collect relevant information and conduct and publish research on the impact on access to health of the restrictions on movement, both in West Bank, the Gaza Strip and East Jerusalem
- ❖ ensuring that all key issues relating to the right to health are monitored and, when appropriate, an advocacy strategy is developed
- ❖ engaging with the media and decision-makers to ensure that key health and human rights concerns are highlighted
- ❖ supporting mainstreaming human rights and a rights-based approach in the Palestinian public health system.





Section

# 6



**Implementing the Strategic Agenda:  
Implications for WHO**







## ❖ Section 6. Implementing the Strategic Agenda: Implications for WHO

### 6.1 Overview

The people of oPt face formidable health challenges. Their health is affected by adverse economic and social determinants and by the many other negative effects of the occupation including frequent outbreaks of violence, insecurity, emergencies, restrictions on movement and access to health facilities and poor environmental and other civil amenities. The main challenges have been identified in Sections 2, 3 and 4. These provide the basis for the formulation of critical priorities for support to the health sector and the articulation of the strategic agenda for WHO cooperation in Section 5.

The strategic agenda calls for WHO to provide assistance to respond to humanitarian health emergencies and to a large list of health development priorities. The following are the key priorities identified for 2009–2013.

- ❖ Building institutional capacity in the Ministry of Health to strengthen health systems.
- ❖ Addressing the unfinished agenda for communicable diseases.
- ❖ Addressing noncommunicable diseases.
- ❖ Strengthening health sector cooperation and partnerships.
- ❖ Addressing humanitarian and emergency health needs.
- ❖ Conducting advocacy for health as a human right.

Each one of these priorities entails a number of strategic objectives and related approaches. The tasks involved are substantial and will require a review and expansion of WHO's current operation in oPt in terms of staff, management methods and administrative arrangements and the implications for the country programme, the Regional Office and headquarters are indicated below.

### 6.2 Implications for the country programme

There is adequate administrative and national capacity to support an expanded and flexible programme. There will, however, be a need for additional specialist expertise, mostly on a short-term consultancy basis, to support the new proposed areas of collaboration and assistance. Identifying sources of funds for maintaining and backstopping the physical presence in several locations is a major challenge. A significant expansion of staffing has put pressure on office space, IT capacity, transport needs and cost of maintaining MOSS compliance. Securing resources for core funding to establish a fixed-term international public health post has become a major challenge. This issue should be seriously considered by the country office, Regional Office and headquarters and proper arrangements should be made to resolve it.

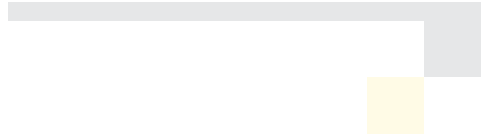
### 6.3 Implications for the Regional Office and headquarters

The strategic agenda in terms of technical content and scope calls for substantial technical support from the Regional Office. Unfortunately, Israel's visa restrictions do not allow most Regional Advisers and Directors of Divisions to travel to oPt to provide back-up support. Nonetheless, special arrangements can be adopted to allow for visits of consultants and staff who can easily travel to oPt. This entails long-term planning in each Division in the Regional Office to locate the required consultants who can support the required missions. Advanced planning and preparedness is needed.

In addition to this it will be necessary for each Division in the Regional Office to prepare a medium-term rolling plan of action

for collaboration with oPt on their respective health programmes. This medium-term plan of action, that may cover 2–3 biennia, will be designed around respective strategic objectives and approaches that are outlined in Section 5. This plan can be drawn in collaboration with the country office and headquarters.

At the Regional Office and headquarters, careful attention should be given specifically to strengthen the coordinating and leadership role of WHO collaboration in relation to the large number of international bilateral and multilateral donors. Also, the advocacy role of the office should receive adequate back-up from the Regional Office and headquarters. This includes technical, promotional and institutional support and input.





[www.emro.who.int](http://www.emro.who.int)