oPt HEALTH AND NUTRITION CLUSTER

CAP 2012-13 NEEDS ANALYSIS FRAMEWORK

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ACRONYMS AND ABBREVIATIONS

WB	– West Bank
GS	– Gaza Strip
NCD	– Non Communicable Diseases
MoH	– Palestinian Ministry of Health
HNC	– Health and Nutrition Cluster
MoH	– Ministry of Heath
NGO	– Non Governmental Organization
OCHA	– Office for the Coordination of Humanitarian Affairs
oPt	– Occupied Palestinian Territory
WHO	– World Health Organization
GCMHP	– Gaza Community Mental Health Program
PCBS	– Palestinian Central Bureau of Statistics
MICS	– Multiple Indicator Cluster Survey

BACKGROUND

Geography:

The territory of the occupied Palestinian territory includes two separated geographical areas, the West Bank (WB) and Gaza Strip (GS). The West Bank is an area of 5,800 sq km - roughly 130km long and 40-65km wide. It is hilly and for the most part rugged terrain, which changes from desert and scrub landscape in the south to more lush vegetation in the north. The West Bank has an average elevation of 750m, but it also comprises Jericho and the shores of the Dead Sea which, at 390m below sea level, forms the lowest point on earth.

The Gaza Strip is an area of 365 sq km – some 45km long and 5-12km wide. The region is mostly flat and the soil is sandy.

Population:

The total population of oPt is 4.17 million[1] , 2.58 million people in the West Bank (including East Jerusalem) and 1.59 million people in Gaza. Around half of the population is below 15 years and the average annual population growth rate is 2.9%[2]; one of the highest in the region[3]. The population is expected to increase by 50% by 2020. The population density in Gaza is one of the highest in the world[4]. The refugee population is 1.7 million, constituting 29.7 % of the population in the West Bank and 67.5% in Gaza, living in 27 refugee camps[5]. In Jerusalem, there are 91,274 registered refugees and 18,719 non- registered refugees[6].

In 2007 life expectancy was estimated to be 71.7 for men (71.9 in West Bank and 71.4 in Gaza) and 73.2 for women (73.6 in West bank and 72.5 in Gaza[7]). The fertility rate for the entire territory was 4.6 in 2006, 4.2 in West Bank and 5.4 in Gaza. The difference between rural and urban areas is marginal[8].

[1] Ministry of Health, Health Annual Report 2010, April 2011
[2] Ministry of Health, Health Annual Report 2010, April 2011
[3] PCBS - Census final results in the west bank - Summary (population & 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
[4] Abed Y. Health sector review: a summary report. Jerusalem: The Italian Cooperation, 2007.
[5] Ministry of Health, Health Annual Report 2010, April 2011
[6] PCBS - Census final results in the west bank - Summary (population & 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
[7] PCBS
[8] PCBS August 2007: Women and men in The oPt – Issues and Statistics, 2007

HEALTH PROFILE

Overview:

Despite serious constraints posed by the occupation on development of health systems in the West Bank and in the Gaza Strip the Palestinian MoH, with the support of donors, has continued to develop the scope and range of public health services in the West Bank over the past few years. The oPt has a relatively well-developed health care system that provides primary and specialized services to most of the oPt, although considerable problems with access to health care persist in Gaza and many locations in the West Bank, including East Jerusalem[9]. The main factors contributing to this are violence, restrictions on movement of health staff, patients and medical commodities, restrictions on construction and rehabilitation of health infrastructure in Area C and Gaza and financial constraints.

The health status of the Palestinian population is comparable to the neighbouring countries, with exception of Israel, 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. Against that background both occurrence and prevalence of chronic illnesses, mental health disorders and disability have been increasing with violence and other effects of the occupation contributing to this rise. There has been a slow but steady deterioration of the nutrition state among young children and pregnant women, particularly in Gaza with prevalence of anaemia being a particular source of concern.

Restricted access to health care and nutrition services not only poses health and safety risks for the populations living in the vulnerable communities in the West Bank and Gaza Strip; it violates the fundamental right of Palestinians to health care and has significant implications for their livelihoods as ill health reduces their economic opportunities and places an additional burden on the families forced to pay for transportation, medicines and other health related costs out of pocket.

Depleting resilience of the Palestinian communities, coupled with inadequate disaster preparedness of the health systems, particularly in Gaza, renders them vulnerable to future hazards and risks, high casualties and economic loss in case of new adverse events, Women and children, older people and people with disabilities are generally the most vulnerable groups when such events occur.

Access to essential Health and Nutrition Services

The access to health and nutrition services remains limited for the populations in Gaza, East Jerusalem, Area C, closed military areas, or “Seam Zones” and some localities in areas A and B in the West Bank. Continued restrictions on importation of medical supplies, equipment and spare parts, limitations on movement of patients, health staff and medical students, widespread insecurity in the West Bank and Gaza, restrictive planning and zoning policies in the West Bank hamper access of vulnerable Palestinian communities to quality essential health and nutrition services .In addition, an internal political divide within the oPt have seriously hampered performance and development of the health care systems in the Gaza Strip.

[9] HNC Internal Communication, OCHA reports on impact of Israeli occupation on access to services in the West Bank, Gaza Strip and East Jerusalem

GAZA

The blockade imposed on Gaza since the takeover of Hamas in 2007 has led to a gradual erosion of the public health system. Shortage of fuel, medical supplies, equipment, inadequate health infrastructure and flagging medical training programme has led to a situation where the health care network in Gaza performs at a fraction of its capacity[10].

FIGURE 1: GAZA FEB 8, DESTROYED CDS WAREHOUSE

There are now fewer obstacles to importation of medical commodities to Gaza; requests for the entry of most of these commodities have been processed by Israeli authorities relatively quickly (24 to 48 hours)[11]. However some commodities, such as equipment and spare parts can take several months to clear[12]. Supply of the essential drugs and other medical supplies, however, have deteriorated due budgetary restrictions faced by the PA as well as disputes and lack of coordination between the Palestinian Authority in Ramallah and the local authorities in Gaza[13]. Furthermore, the attacks from the Israeli forces on Gaza in February 2011 have resulted in the destruction of a warehouse used by the Central Drug Stores (CDS) that included 180 types of medical commodities, leading to a further deterioration of the supply of medical commodities.

In the beginning of 2011 shortages of essential drugs and disposables in Gaza reached the highest recorded levels. 38% (or 183 types) of essential drugs and 23% (or 160 types) of disposables were out of stock during that period[14].

At present, the shortages of drugs and disposables pose the biggest threat to the provision of health services in Gaza. As of August 2011, 156 types of drugs and 186 types of disposables were out of stock. Shortages of medical commodities in Gaza led to frequent interruptions of treatment of life threatening diseases such as renal failure, cancers, diabetes and others[15]. Unavailability of essential medications in government clinics, especially in the Gaza Strip where poverty is higher, will negatively affect personal and community health and wellbeing, despite people's coping mechanisms. Patients who cannot find their medication in the MoH may try to obtain it or an alternative from other sources such as UNRWA clinics or NGOs, and may hoard medicines when they do find them available…[11] A diabetic patient who requires insulin as their line of treatment must spend NIS 200 or more every month, while patients who depend on blood sugar lowering agents will pay from NIS 40 to 120

[10] HNC Internal communication, WHO Gaza
[11] Assessing the humanitarian impact on the population of the Gaza Strip; OCHA March 2011
[12] HNC partner reports
[13] Shortages of Drugs and Disposables in Gaza; World Health Organization July 2011
[14] DRUG SHORTAGES IN GAZA; Background Note to the HC; World Health Organization Feb 2011
[15] Shortages of Drugs and Disposables in Gaza; follow up reports World Health Organization February-July 2011

according to the type and the dose of drug. Patients who use lipid lowering agents, usually the elderly, will pay from NIS 50-70 monthly to buy their medications. Asthmatic patients will pay NIS 24 for a common inhaler [16].

The ability of the health system in Gaza to function properly has been seriously affected as a consequence of the destruction to the health infrastructure and the inability to repair or upgrade it[17]. An assessment carried out by WHO jointly with UNDP in 2011 showed that 63% of the primary health care and around 50% of hospital infrastructure is inadequate for the provision of quality health care. The waste disposal system was inadequate in all 13 Gaza hospitals, resulting in an estimated 1 ton or Hazardous Medical Waste and 6 tons of general Medical Waste dumped in the open every month. Warehousing facilities were found not suitable for storage of medical supplies in 10 out of 13 hospitals[18].

Proper maintenance of available equipment is still challenged by restrictions on the entry of technicians and manufacturers, as well as on the ability to send equipment for servicing outside Gaza[19]. Currently around 23% of all of the medical equipment in Gaza used in the public health system is not functional[20].

As a result of the political split between the West Bank and Gaza nearly 2,184 health sector staff went on strike leaving the public health sector in dire needs of health professionals. Gaza health authorities estimate that 800 additional doctors, 700 nurses and 900 administrative staff are needed for optimal functioning of the Gaza public health network[21].

Specialized medical knowledge requires months and years of training in medical units that are only available in the West Bank, particularly in East Jerusalem. However, travel restrictions make access to such training impossible for most medical staff. Significant capacity shortages exist in the area of cardiovascular diseases, oncology, ophthalmology, orthopaedics and neurosurgery, areas that accounted for the majority of referrals outside Gaza in the past five years. In the second half of 2010, a total of 44 medical staff members were issued permits to attend trainings outside Gaza, a significant increase compared to the previous six months (19 permits), but an insignificant fraction of the actual needs[22].

Gaps in the availability of key medical services, generated by decades of neglect and compounded since the imposition of the blockade, have created the need to refer patients to hospitals outside Gaza for specialized medical treatment. The process needed to obtain an exit permit adds anguish and stress to people already vulnerable due to illness. While the nature of this process has not changed since the relaxation announcement, the average rate of approval increased from 76 to 81 % between the first and second halves of 2010. In other words, during the latter, one out of five patients still missed their hospital appointment because their permits were denied or delayed[2324]. Since March 2008 66 people including 22 children died, while waiting referral outside Gaza[25].

[16] Shortages in Essential Medicines in The oPt World Health Organization September 2011
[17] Assessing the humanitarian impact on the population of the Gaza Strip; OCHA March 2011
[18] Assessment of Public Health Estate in Gaza; WHO/UNDP/UNSCO/MoH draft report
[19] Assessing the humanitarian impact on the population of the Gaza Strip; OCHA March 2011
[20] World Health Organization Gaza
[21] World Health Organization Gaza
[22] Assessing the humanitarian impact on the population of the Gaza Strip; OCHA March 2011
[23] Referral of Patients Abroad; Data and Commentary for 2010; WHO oPt 2011

WEST BANK (INCLUDING SEAM ZONE COMMUNITIES AND EAST JERUSALEM)

While due to more favourable political and economic conditions health care network in West Bank have seen significant developments in the last several years, an assessment carried out by the Palestinian MoH jointly with WHO revealed that nearly 65 or 24% of communities in the Area C and seam zones lack access to health care with the following being the main reasons for the above.

1. Insecurity due to the presence and actions of security forces and settler violence
2. Restrictions to the freedom of movement of patients, health staff and medical students due to closure regime and the expansion of settlements;
3. De facto and de jure discrimination (permits; zoning and planning);
4. Residency rights
5. Shortage of medicines and other medical supplies
6. Shortages of health staff

TABLE 1: PROBLEMS WITH ACCESS TO HEALTH AND NUTRITION SERVICES IN AREA C OF THE WEST BANK[26]

District	Access Problems	Affected Communities
Jericho	Problems caused by: Tayasir checkpoint (Road to Tubas), Al Hamra checkpoint (Nablus Road) Alloja checkpoint in Jericho. Lack of public transportation between villages (Zbeidat, Marj a, Fasayil Al Foqa, Frush Beit Daja, Marj Al Ghazal, Marj Naja)	Fasayel Al Foqa, Frush Beit Dajan, Jiftlik and Marj Ghazal (no clinic)
Tubas	1. Tayasir checkpoint restricts ability of staff to get to clinics in Area C. 2. Lack of transportation restricts ability of patients to reach services (for instance communities in ein al Beida find difficulty to access clinic in Bardla due to lack of public transportation) 3. No clinic in Atof	Northern Jordan Valley :Al Maleh, Bardla, Ein Al Beida, Kardala, Al Farisiya, Al Aqaba. Atof Valley: Khirbet Atof, Khirbet Yarza, Khirbet Himsa, Al Ras Al Ahmar. There are three clinics in Bardala, Ein Al Beida, Aqaba in addition to mobile clinic. Access restrictions are due to problems mentioned in Q1.A.
South Hebron	1. Closures and checkpoints; 2. Long distance to clinics; 3. Rocky roads and mountains 4. Scattered population and lack of public transportation 5- proximity to settlements;	1- Problems of access and delivery of services in: At Tuwaineh, Imneizal, Main, Jinba, Susya (access restrictions: Closed military areas, checkpoints, settlements, lack of public transportation, rocky roads) 2. Geographic areas that do not have service coverage are: Al Tabaqa (150), Sha'b Al Batm (149), Um Al Shaqhan (322), Al Mafqara (190), Khirbet Taweel Al Sheikh (198), Isfi Al Foqa (150), Asfi Altahta (150), Al Fakheit (851), Jinba (300), Al Mirkez (200), Susya (500).

[24] Assessing the humanitarian impact on the population of the Gaza Strip; OCHA March 2011
[25] WHO Gaza
[26] Area C Assessment of Health Needs; Palestinian MoH; WHO (draft report)

		3. communities that have only Level 1 such as: areas of Dura, areas of Yatta, areas of Western Al Dahiriya, Alsamoo' areas;
Jenin	1. Difficulty of seeking health services in PHCs especially when the gates are closed (Reikhan Barta and Tura) 2. Ambulances get checked at checkpoints; 3. Staff unable to get to those communities (below) without permits 1. 4- Drugs and vaccines cannot be distributed to these areas until there is coordination with the village council and these are inspected before entry;	Barta Al Sharqiya (4669 ppl); Um Al Rihan (422); Dahr Al Malih (207); Khirbet Abd Allah Al Yonis (138); Khirbet Masood (47); Khirbet Al Minthar Al Gharbiyeh (22)
Bethlehem	The most two difficult barriers are Masmoria & Alcontainer	Al Kas and Numan (625), Al Walaja (2248), Al Jaba (987), Wadi Rahhal (1521), Wadi Fukin (1287), Harmla (Janata)(5805), Arab ar Rashayida (1557), Wadi An Nis (827)
Salfit	1. Presence of large settlement blocs (Ariel); planned Barrier construction around that will force people wanting to access Salfit hospital to take detour of 1 to 1 1/2 hours; 2. Currently: Gate at Ariel already impeding staff and patients from using direct road to reach Salfit directly; Staff can only access if they obtain permits. When Gate is closed access to the neighboring villages (shown in following column) is completely forbidden.	Bidya, Haris, Al Zawiya, Sarta, Rafat and Masha (communities are located both in Area B and C)
Hebron	1. Presence of checkpoints; 2. Long distance to the closest facility; 3. Lack of transportation;	H2, Masafer Bani , Wadi Al Reem/Sair, Al Dowara/Sair, Kfan Khamis/Al Shyokh, Safa/Beit Ummar, Al Dir/Sorref, Al Jaba, Al Shyokh Al Aroob/Al Aroob, Al Baqa/Hebron
Qalqilia	Patients and staff are unable to reach the 3 Bedouin communities: 1. Northern Arab Ramadeen (100 ppl) at the entrance of Tsofim settlement 2. Southern Arab Ramadeen (300 ppl) close to Alfe Menashe settlement 3. Arab Abu Farda (200 ppl) close to Alfe Menashe.	The 3 Bedouin communities: 1. Northern Arab Ramadeen (100 ppl) at the entrance of Tsofim settlement 2. Southern Arab Ramadeen (300 ppl) close to Alfe Menashe settlement 3. Arab Abu Farda (200 ppl) close to Alfe Menashe.
Jerusalem	3 bedouin communities in Khan Al Ahmar; 1- access to East Jerusalem hospitals is difficult;	3 bedouin communities in Khan Al Ahmar; 1- access to East Jerusalem hospitals is difficult;

Health and Nutrition Cluster partner agencies believe that the number of communities in the West Bank that lack access to health and nutrition services is larger than revealed by the above assessment as

often existing public primary health care centres fall short of providing essential health and nutrition services up to the required standard[27].

TABLE 2: HNC ASSESSMENT OF VULNERABLE COMMUNITIES IN WEST BANK

Vulnerability Criteria	Communities
1. Communities whose members travel one hour or longer to reach fully functional PHC level 2 and above[22]. For the communities that cannot access transportation and for whom walking is the only way to reach health services the acceptable travel time to fully functional PHC level 2[22] and above is less than 40 minutes.	Al Jab'a, Al Khas, Marah Ma'alla, Al Ma'sara, Al Walaja, Arab ar Rashayida, Arab Faleh and Arab Nahar (Tajam'u Badawi ,south of Bethlehem), Dar Salah, Khallet an Numan, Khallet Saqkariya, Umm Salamuna, Wadi an Nis, Wadi, Fukin, Wadi Rahhal, Ad Deirat, Al 'Arrub Camp, Al Baqa, Al Buweib, Al Jalaje, Al 'uddeisa, Ar Rawa'in, An Najada, Al Qawawees, As Simiya, At Tuwani, Ar Zuweidin, Ar Ramadin, Ar Rawa'in, Arab al Fureijat, Hamrush, Imneizil, Khashem Adaraj (Al-Hathaleen), Beit ar Rush at Tahta, Deir al 'Asal at Tahta, Dura, Halhull, Khirbet ad Deir, Hitta, Idhna, Khirbet al Fakheit (part of Masfer Yata), Khirbet Bir al 'Idd, Khirbet Tawil ash Shih, Jala, Khirbet Zanuta, Khallet al 'Aqed, Khallet al Maiyya, Khallet Edar, Khallet Salih, Kharas, Ma'in, Rabud, Susia, Khirbet Asafi, Khirbet ash sheikh sa'eed(Qiqees), Um Al-Khair, Khirbet, Salama, Umm al Butm, Wadi Al Amayer, Kurza, Wadi al Ghrouz, Masafer, Yatta, Msafer al Samou, Msafer Bani Naem, Nuba, Wadi al Kilab, Sa'ir, Al Mafqra, Sikka, Al Mirkiz, Tarrama, Al 'Attara, Al Mentar, AnzaAr Rama, Arraba, Arrana, Asa'asa, Barta'a ash Sharqiya , Faqqu'a, Imreiha, Khirbet 'Abdallah al Yunis, Khirbet al Muntar al Gharbiya, Khirbet al Muntar ash Sharqiya, Al 'Auja, Al Jiftlik, An Nabi Musa, An Nuwei'ma, Az Zubeidat, Deir al Qilt, Deir Hajla, Ein ad Duyuk al Fauqa, Fasayil, Marj al Ghazal, Marj Na'ja, Anata, Aldahia, Althore, Alttor, Wad Qadom, Al khalayleh, Al Qubeiba, Anata, Arab al Jahalin, Ash Sheikh Sa'd, Beit Duqqu, Biddu, An Nabi Samwil, Sawahira ash Sharqiya, Al 'Aqrabaniya, Al Lubban ash Sharqiya, Ammuriya, An Naqura, Aqraba, Ar Rajman, Asawiya, Awarta, Beit Dajan, Beit Furik, Ein Shibli , Furush Beit Dajan, Iraq Burin, Jaloud, Jurish, Khirbet Tana, Jibiya, Madama, Ad Dab'a, Al, Funduq, Arab Abu Farda, Arab Al-Khouleh, Arab ar Ramadin al Janubi, Arab ar Ramadin ash Shamali, Azzun 'Atma, Beit Amin, Isla , Izbat al Ashqar, Izbat at Tabib, Izbat Alsalman, Izbat Jal'ud, Kafr Thulth, Khirbet Ras 'Atiya, Ras at Tira, Al Lubban al Gharbi, Al Mazra'a ash Sharqiya, Deir Abu Mashal , Kafr Ni'ma, Rantis, Ras Karkar, Deir Ballut, Deir Istiya, Al 'Aqaba , Al Farisiya, Al Malih , Aqqaba, Bardala, Ein el Beida, Ibziq, Kardala, Khirbet ar Ras al Ahmar , Khirbet 'Atuf , Khirbet Humsa , Khirbet Yarza, kafr Jammal, Kur, Umm ar Rihan , Sanniriya, Majdal bani Fadel, Osarin, Urif, Tel Rumaidah (H2), Al tabaqa, Isfi Al Fuqa, Isfi Al tahta, Salhab, Wadi ar Rasha, Iskaka, Kafr ad Dik, Khirbet Qeis, Kifl Haris, Marda, Masha , Qarawat Bani Hassan, Rafat, Sarta, Yanun , Umm Lasafa, Jinba, Shi'b Al Batin, Um Al Shoqhan, Wadi ash Shajina, Yata, Daher Al Malih, kafr Laqef, Al Badhan, Odala, Salim
2. Communities that can't access EMS services (both ambulances and inpatient) within 30 minutes after an	Al Jab'a, Al Khadr, Al Khas, Al Walaja, Arab ar Rashayida, Beit Fajjar, Khallet an Numan, Khallet Saqkariya, Nahhalin, Umm Salamuna , Wadi an Nis , Wadi Rahhal , Ad Deirat , Al Baqa , Al Buweib , Al Jalajel, Al 'uddeisa, Ar Rawa'in, An Najada, As Simiya, At Tuwani , Az Zuweidin, Ar Ramadin, Ar Rawa'in, Arab

[27] The primary health care system in oPt consists of four levels. Curative services for common illnesses (both chronic and acute) are provided at PHC level 2 and above. Therefore Access to Health Care is defined by the health and nutrition cluster as access to PHC Level 2 and above five days a week five hours a day

incidence of a critical event	al Fureijat, As Samu', Hamrush, Imneizil, Beit Kahil, Beit Ula, Beit Ummar, Khirbet ad Deir, Khirbet al Fakheit (part of Masfer Yata), Khirbet Bir al 'Idd, Khirbet Tawil ash Shih, Jala, Khirbet Zanuta, Khallet al 'Aqed, Khallet al Maiyya, Khallet Edar, Khallet Salih, Ma'in, Rabud, Susia, Khirbet Asafi, Khirbet ash sheikh sa'eed(Qiqees), Um Al-Khair, Khirbet Salama, Wadi Al Amayer, Wadi al Ghrouz, Masafer Yatta, Msafer al Samou, Msafer Bani Naem, Wadi al Kilab, Surif, Al 'Attara, AnzaAr Rama, Arraba, Arrana, Asa'asa, Barta'a ash Sharqiya , Faqqu'a, Imreiha, Khirbet 'Abdallah al Yunis , Khirbet al Muntar al Gharbiya , Khirbet al Muntar ash Sharqiya , Al 'Auja, Al Jiftlik, An Nabi Musa, An Nuwei'ma, Aqbat Jaber Camp, Az Zubeidat, Deir al Qilt, Deir Hajla, Fasayil, Marj al Ghazal, Marj Na'ja, Al khalayleh, Al Qubeiba, Arab al Jahalin, Ash Sheikh Sa'd, Biddu, Biddu, An Nabi Samwil, Al Lubban ash Sharqiya , Asawiya, Beit Dajan, Beit Furik, Burqa, Ein Shibli , Furush Beit Dajan , Iraq Burin, Jaloud, Jurish, Khirbet Tana, Madama, Ad Dab'a, Al Funduq, Beit Amin, Ras at Tira, Deir Abu Mashal , Bedia, Bruqin, Deir Ballut, Deir Istiya, Al 'Aqaba , Al Farisiya, Al Malih , Aqqaba, Bardala, Ein el Beida, Ibziq, Kardala, Khirbet ar Ras al Ahmar , Khirbet 'Atuf , Khirbet Humsa , Khirbet Yarza, Umm ar Rihan , Majdal bani Fadel, Osarin, Za'tara, Tel Rumaidah (H2), Salhab, Wadi ar Rasha, Iskaka, Kafr ad Dik, Marda, Qarawat Bani Hassan, Sarta, Yanun , Umm Lasafa, Wadi ash Shajina, Zif, Daher Al Malih, Jayoos, kafr Laqef, Tuqu
3. Camp based refugee communities and isolated refugee communities whose access to health and nutrition services was affects as a result of second intifada	Ad Duheisha Camp , Al 'Aza Camp, Ayda Camp, Adh Dhahiriya, Al 'Arrub Camp, Al Fawwar Camp, Ar Ramadin, Dura, Susia, Nuba, Tarqumiya, Jenin Camp, Qabatiya , Silat adh Dhahr, Silat al Harithiya , Aqbat Jaber Camp, Az Zubeidat, Az Za'ayyem, Beit Surik, Qalandiya Camp, Shu'fat Camp, Askar Camp, Balata Camp, Ein Beit el Ma Camp, Azzun 'Atma, Ein 'Arik, Al Amari Camp, Beit 'Ur al FauqA, Deir 'Ammar Camp, Qaddura Camp, El Far'a Camp, Kur, Nur Shams Camp, Tulkarm Camp, Ya'bad, Masha
4. Communities located within 2 km from settlements and IDF bases	Abu Nujeim, Al Jab'a, Al Khas, Jurat ash Sham'a, Khallet al Haddad, Kisan, Marah Ma'alla, Al Ma'sara, Al Walaja, Arab ar Rashayida, Ath Thabra, Battir, Hindaza, Husan, Khallet an Numan, Khallet Saqkariya, Nahhalin, Umm Salamuna , Wadi an Nis , Wadi Fukin, Wadi Rahhal , Ad Deirat , Al Baqa , Al Buweib , Al Jalajel, Al 'uddeisa, Beit Mirsim, An Najada, As Simiya, At Tuwani , Az Zuweidin, Ar Ramadin, Ar Rawa'in, Arab al Fureijat, Hamrush, Imneizil, Khashem Adaraj (Al-Hathaleen), Beit Ula, Khirbet ad Deir, Idhna, Khirbet al Fakheit (part of Masfer Yata), Khirbet Bir al 'Idd, Khirbet Tawil ash Shih, Jala, Khallet al 'Aqed, Khallet al Maiyya, Khallet Edar, Ma'in, Rabud, Susia, Khirbet Asafi, Khirbet ash sheikh sa'eed(Qiqees), Um Al-Khair, Khirbet Salama, Umm al Butm, Wadi Al Amayer, Masafer Yatta, Msafer al Samou, Msafer Bani Naem, Wadi al Kilab, Al 'Araqa, Al Jalama, Al Ka'abina (Tajammu' Badawi), Al Mutilla, Anin, Arraba, Arrana, At Tarem, At Tayba, Barta'a ash Sharqiya , Dhaher al 'Abed, Imreiha, Jalbun, Khirbet 'Abdallah al Yunis , Khirbet al Muntar al Gharbiya , Khirbet al Muntar ash Sharqiya , Tura al Gharbiya, Tura ash Sharqiya, Al 'Auja, Al Jiftlik, Fasayil, Marj Na'ja, Mikhmas, Al 'Eizariya, Al Jib, Al khalayleh, Al Qubeiba, AlJudeira, Anata, Arab al Jahalin, Ash Sheikh Sa'd, Beit 'Anan, Beit Duqqu, Beit Hanina al Balad, Beit Ijza, Beit Iksa, Beit Surik, Jaba, An Nabi Samwil, Qatanna, Sawahira ash Sharqiya, Al Lubban ash Sharqiya , An Nassariya, Asawiya, Awarta, Balata Camp, Beit Dajan, Beit Furik, Ein Shibli , Furush Beit Dajan , Ijnisinya, Iraq Burin, Jaloud, Jurish, Khirbet Tana, Madama, Ad Dab'a, Al Funduq, Al Mudawwar, Arab Abu Farda,

	Arab Al-Khouleh, Arab ar Ramadin al Janubi, Arab ar Ramadin ash Shamali, Azzun 'Atma, Beit Amin, Falamya, Far'ata, Habla, Hajja, Immatin, Izbat Salman, Kafr Qaddum, Khirbet Jbara, Khirbet Ras 'Atiya, Ras at Tira, Al Jalazun Camp, Umm Safa, Khirbet Qeis, Al Mazra'a ash Sharqiya, Badiw al Mu'arrajat, Beit Nuba, Beit Sira, Beit Sira, Beitin, Bil'in, Budrus, Kafr 'Ein, Ras Karkar, Bruqin, Deir Istiya, Al 'Aqaba , Al Farisiya, Al Malih , Aqqaba, Bardala, Ein el Beida, Ibziq, Kardala, Khirbet ar Ras al Ahmar , Khirbet 'Atuf , Khirbet Humsa , Khirbet Yarza, Umm ar Rihan , Sanniriya, Majdal bani Fadel, Osarin, Urif, Za'tara, Tel Rumaidah (H2), Salhab, Silwad Camp, Wadi ar Rasha, Iskaka, Kafr ad Dik, Marda, Masha , Qarawat Bani Hassan, Yanun , Umm Lasafa, Wadi ash Shajina, Daher Al Malih, Nazlet Isa, Kafr al Labad, Far'oun, Yasuf, kafr Laqef
5. Seam zone communities	Barta'a ash Sharqiya , Khirbet 'Abdallah al Yunis , Khirbet al Muntar al Gharbiya , Khirbet al Muntar ash Sharqiya , Tura ash Sharqiya, Al khalayleh, An Nabi Samwil, Arab Abu Farda, Arab ar Ramadin al Janubi, Arab ar Ramadin ash Shamali, Azzun 'Atma, Khirbet Jbara, Umm ar Rihan , Daher Al Malih
6. Communities whose dwellers need to cross one or more checkpoints to access PHC Level 2 and above	Al Khas, Al Walaja, Khallet an Numan, Umm Salamuna , Wadi an Nis , Wadi Rahhal , Al Baqa , Al Jalajel, Al 'uddeisa, As Simiya, At Tuwani , Ar Rawa'in, Imneizil, Khirbet al Fakheit (part of Masfer Yata), Rabud, Susia, Khirbet ash sheikh sa'eed(Qiqees), Wadi al Ghrouz, Masafer Yatta, Msafer al Samou, Al Mentar, Awarta, Furush Beit Dajan , Iraq Burin, Khirbet Tana, Madama, Arab ar Ramadin al Janubi, Arab ar Ramadin ash Shamali, Azzun 'Atma, Izbat Salman, Khirbet Jbara, Khirbet Ras 'Atiya, Ras at Tira, Majdal bani Fadel, Urif, Tel Rumaidah (H2), Wadi ar Rasha, Kafr ad Dik, Marda, Umm Lasafa, Daher Al Malih
7. Communities that were subjected to settler or IDF violence in the past 6 months	Al Khas, Al Walaja, Khallet an Numan, Khallet Saqkariya, Umm Salamuna , Wadi an Nis , Wadi Rahhal , Ad Deirat , Al Baqa , Al Buweib , Al Jalajel, Al 'uddeisa, An Najada, As Simiya, At Tuwani , Az Zuweidin, Ar Rawa'in, Arab al Fureijat, Imneizil, Khirbet al Fakheit (part of Masfer Yata), Ma'in, Rabud, Susia, Khirbet ash sheikh sa'eed(Qiqees), Um Al-Khair, Wadi al Ghrouz, Masafer Yatta, Msafer al Samou, Msafer Bani Naem, Barta'a ash Sharqiya , Imreiha, Khirbet 'Abdallah al Yunis , Khirbet al Muntar al Gharbiya , Khirbet al Muntar ash Sharqiya , Al Lubban ash Sharqiya , Awarta, Ein Shibli , Furush Beit Dajan , Iraq Burin, Jaloud, Khirbet Tana, Madama, Arab ar Ramadin al Janubi, Azzun 'Atma, Deir Istiya, Al Malih , Ibziq, Kardala, Khirbet ar Ras al Ahmar , Umm ar Rihan , Majdal bani Fadel, Osarin, Urif, Tel Rumaidah (H2), Salhab, Kafr ad Dik, Kifl Haris, Marda, Qarawat Bani Hassan, Yanun , Umm Lasafa, Wadi ash Shajina, Daher Al Malih, Qusra, Asira al Qibliya

East Jerusalem

Palestinian residents of East Jerusalem are entitled to the health services provided by the Israeli authorities, by virtue of their monthly payments to the Israeli National Health Insurance. However, in health as in other areas, there is a discrepancy in the number of facilities available to Palestinian as compared to Jewish residents of Jerusalem, especially with regard to specialized services such as

mother and child clinics. Jewish residents of West Jerusalem have 25 such clinics at their disposal – of which three also serve East Jerusalem – while East Jerusalem has only four mother and child clinics[28]

An estimated 57,500 Palestinians[29]; residents of West Bank who are separated by the barrier to Jerusalem side and residents of East Jerusalem separated to the West Bank face considerable challenges to accessing essential health care services, including emergency care as it requires undergoing tedious and often unpredictable process of crossing barrier checkpoints.

East Jerusalem, with its six hospitals, is the main provider of specialized care to the population of the oPt. The hospitals have 624 beds, 12.4 % of the total available in the oPt[30] and provide a range of specialized treatment unavailable elsewhere in the West Bank and the Gaza Strip: dialysis and oncology at Augusta Victoria hospital; open-heart surgery at Maqassed Hospital; neurosurgery at St. Joseph Hospital; neonatal intensive care at the Red Crescent and Maqassed Hospital, eye surgery at St. John Hospital and rehabilitation for handicapped children at Princess Basma Hospital[31].

Non Jerusalem Palestinian patients require permits for consultations and operations in East Jerusalem hospitals. The bureaucratic and physical difficulties, which these patients experience in accessing East Jerusalem is one of the major concerns in the provision of health care to Palestinians throughout the oPt[32].

The Palestinians from West Bank (and Gaza, see above) often endure arduous journeys to access healthcare in East Jerusalem. Patients with West Bank ID cards are required to cross checkpoints on foot (vehicles with Palestinian license plates are forbidden from entering Israel and East Jerusalem), which often implies waiting in crowded lines for long periods. Checkpoints are not well adapted to the needs of the people with disabilities that experience considerable problems waiting in line, crossing revolving gates, or passing through metal detectors[33]

Physical and bureaucratic obstacles also hamper the ability of medical staff to access their workplaces in East Jerusalem, to the detriment of both patients and hospitals. With the imposition of tightened restrictions in July 2008, West Bank hospital employees were only allowed to access East Jerusalem through the most crowded checkpoints of Qalandiya, Zaytoun and Gilo. An improvement ensued for a short period of time in 2009 but by early 2010 the situation had reverted so that, while doctors can still pass through all of the checkpoints, access for other hospital staff access is uncertain and usually restricted to the busy pedestrian crossing points.

There are over 500 obstacles to Palestinian movement in the West Bank, including over 60 staffed checkpoints. Citing security concerns for Israelis in the West Bank, including settlers, the Israeli military significantly increased the number of internal obstacles to Palestinian movement following the beginning of the second Intifada in September 2000. These obstacles considerably limit accessibility of health and nutrition services, including during emergencies; in 2009, the The oPt Red Crescent Society (PRCS) recorded 440 delays and denials of ambulances throughout the oPt.

[28] East Jerusalem; Key Humanitarian Concerns; OCHA March 2011
[29] Barrier Update; OCHA July 2011
[30] Annual Health Statistics; Palestinian MoH; 2011
[31] The Impact of the Barrier on Health; OCHA 2010
[32] East Jerusalem; Key Humanitarian Concerns; OCHA March 2011
[33] East Jerusalem; Key Humanitarian Concerns; OCHA March 2011

In addition, approximately 7,800 Palestinians reside in the closed area between the Barrier and the Green Line. Few health and education services are available in the closed area…[34]. As most services and livelihoods are located on the 'Palestinian' side of the Barrier, residents have to pass through Barrier checkpoints to reach hospitals and health centers, schools and workplaces. The impact on the residents' access to health is a particular source of concern[35]

The requirement for 'visitor permits' to enter the 'Seam Zone' generally prevents doctors from providing house calls, ambulances from collecting patients and mobile teams providing health services. As a precautionary measure, pregnant women often leave this community one month before delivery to avoid complications[36].

The Barrier gate opening times pose potential health risks for the thousands of farmers who enter their land in the 'Seam Zone' on a daily or seasonal basis. The majority of gates open for brief periods, two to three times daily: only two Barrier gates out of 13 open continuously throughout the day. As the gates are locked and unstaffed by soldiers between these short opening times, a widespread anxiety among farmers is that in the event of a work accident, snake bite or pesticide inhalation, they are unable to leave the 'Seam Zone.' Unless they succeed in attracting the attention of the military patrol which controls the gates (or communicate through the Humanitarian Hotline to the DCL - Israeli District Coordination Liaison Office) they are stuck until the next opening time, without access to first aid or emergency care[37].

Restrictive zoning and planning regime have had a strong impact on access to services and livelihoods of the Palestinians. Due to inability to upgrade and build health facilities in Area C and Seam Zones many communities in the West Bank are left to struggle with difficulties to access essential health and nutrition services, including emergency care.

ACCESS TO HEALTH AND NUTRITION SERVICES PROVIDED BY UNRWA AND OTHER HNC PARTNER AGENCIES

UNRWA and Non-Governmental Organizations operate a significant share of health and nutrition services in West Bank and Gaza. There has been an increasing demand for these services in both locations, particularly in the aftermath of second intifada as many Palestinians shifted from using public health services to the above providers. Thus daily consultation rate at UNRWA clinics in the West Bank and Gaza in 2011 fluctuated between 100 and 150 consultations per clinician per day[38] which is 2-3 times higher than internationally accepted standard for clinician's workload.

The reasons for this are numerous, and reflect demographic changes due to population growth, physical availability of services, their acceptability and affordability. Inability to pay health insurance premiums is the main reason for this shift in the West Bank, with a reduction of quality of services provided by the Gaza public health system being the main factor in Gaza.

While demand for HNC partner health and nutrition services is growing, its programme in the oPt remains severely underfunded. By June 2011 less than half of the required USD 22 million required to

[34] The Impact of the Barrier on Health; OCHA 2010
[35] Barrier Update; OCHA July 2011
[36] Barrier Update; OCHA July 2011
[37] The Impact of the Barrier on Health; OCHA 2010
[38] UNRWA

run health and nutrition services were secured by the cluster partners. UNRWA – the biggest health service provider in the oPt after MoH have secured only 21% and 41% of the funds for its health programme in Gaza and the West Bank respectively; most of it from its reserve funds. Deterioration of the sector funding will further limit accessibility and quality of health services in the West Bank and Gaza affecting the wellbeing and livelihoods of the most vulnerable Palestinian communities.

Health impact of violence

Violence and other human rights violations in West Bank and Gaza are major factors affecting fundamental right of the Palestinians to health. Furthermore violence is an important health determinant itself that has significant direct (increased mortality and disability) and indirect (increased incidence of acute and chronic illnesses) impact on the health of the Palestinians. Trauma (all types) is one of the major causes of death in the oPt[39].

During 2010, at least 58 Palestinian civilians, including nine children, were killed in Gaza, and another 257, including 46 children, were injured. Of these at least 15 Palestinian civilians, including four children, were killed in the access restricted areas on the land and at sea, and another 169 civilians, including 45 children, were injured[40]

Furthermore 15 Palestinian civilians of which three children were killed in West Bank and another 1,504 including 336 children were injured between August 2010 and July 2011. 170 or 11% of these incidents were due to settler violence and 1,349 or 89% due to IDF/ISF activity[41].

Incidence of violent deaths is highest in the age group of 5 to 19 years old where accidents cause 26.9% of all deaths in that age group followed by the age group of 20 to 59 years old. In both age groups accident related mortality is higher among males.

TABLE 3: ACCIDENT RELATED PROPORTIONATE MORTALITY

	Accident related proportionate mortality %	
Age group	Male	Female
5-19	32%	16%
20-59	12%	3%

According to the 2011 Palestinian Disability Report 7.6% of mental health disability, 4.6% of physical disability and 5.2% of learning disability in West Bank and Gaza were a direct consequence of settler/IDF violence. Considering the profound impact of the Israeli occupation on all aspects of the lives of the Palestinians its actual impact on the prevalence of ill health and disability in oPt is expected to be much higher.

Maternal and Child Health and Nutrition

Infant and child mortality indicators had some improvement in the oPt in the last decade however there is evidence that they have worsened in the poorest quintiles of the population[42]. Maternal (32/100,000

[39] Annual Health Statistics; MoH 2011; annex 20
[40] Assessing the humanitarian impact on the population of the Gaza Strip; OCHA March 2011
[41] OCHA oPt
[42] Palestinian Family Health survey

live births), infant (14/1,000 live births) and under five (17/1,000 live births) mortality indicators favourably compare with the regional averages[43], although some of these figures may have been underestimated[44]. According to the MoH leading causes of under-five mortality in West Bank in 2010 were: conditions originating in the perinatal period (prematurity, birth trauma etc.) 50.8%, congenital malformations (tumours) 18% and septicaemia (blood poisoning caused by bacteria and their toxins) 11%[45].

99.4% of deliveries in the West Bank and Gaza were attended by skilled health provider in 2010; Coverage of antenatal and postnatal care in the same period was 99.2% and 81%[46] respectively. Proportion of deliveries by caesarean section have increased almost twice in the oPt since the year 2000. In 2010 14% of women delivered by caesarean section in Gaza and 18.8% in the West Bank [47], with proportion of deliveries by caesarean section reaching 35% in Tubas. The rate in Gaza approaches the internationally agreed threshold according to which the proportion of deliveries by caesarean section shall not exceed 15%, while the proportion of deliveries by C-section in the West Bank exceeded the accepted threshold. This highlights the need of strengthening emergency obstetric care in oPt to improve it in the West Bank and prevent its deterioration in Gaza.

Coverage of vaccination in the oPt in 2010 is reported to be above 100% which to all appearances is a result of overestimation. Most likely the coverage of vaccination is close to the levels cited in the 2006 "Palestinian Family Health Survey" report according to which the vaccination coverage in the oPt was 98.7% with 97.8% in the West Bank and 100% in Gaza, although the coverage in Gaza may be lower due to the challenges faced by the health system in that locality.

Prevalence of anaemia remains at very high levels both among pregnant women and infants in the West Bank and Gaza, with the prevalence in Gaza showing strong upward trend in the past 3 years. The prevalence of anaemia among pregnant women and infants in Gaza increased by 14.1% and 5.3% respectively from 2007 to 2010[48]. Within the same period of time the prevalence of anaemia decreased in West Bank among infants by 5.9% and among pregnant women by 5.1%. High fertility, low levels of micronutrient supplementation and exclusive breastfeeding are among the reasons for deterioration of nutrition status in Gaza[49].

Prevalence of wasting and underweight among children under five, while currently being within the limits of a norm, have worsened in the past ten years both in West Bank and Gaza with the rates of wasting (acute malnutrition) increased twofold (see table 3). At the same time the prevalence of stunting (chronic malnutrition) worsened in West Bank, but improved in Gaza[50]. It is important to note that this analysis is made based on preliminary data which may be revised.

TABLE 4: PREVALENCE OF MALNUTRITION AMONG CHILDREN U5 IN WEST BANK AND GAZA[51]

	Gaza (%)	West Bank (%)

[43] World Health Report; WHO 2010; MoH Annual Health Statistics 2010
[44] Report on Maternal Mortality in The oPt; UNFPA 2011
[45] Annual Health Statistics; MoH 2011
[46] Annual Health Statistics; MoH 2011
[47] MICS 2000, 2006, 2010 (preliminary data)
[48] National Nutrition Surveillance Report MoH; 2010
[49] National Nutrition Surveillance Report MoH; 2010
[50] MICS 2010 preliminary data
[51] MICS 2000, 2006, 2010 (preliminary data)

	2010	2006	2000	2010	2006	2000
Stunting	9.9	13.2	8.3	11.3	7.9	7.0
Wasting	3.8	1.2	1.4	2.8	1.7	1.5
Under weight	3.5	2.4	2.4	3.8	3.2	2.6

Disability, Non Communicable Diseases, Mental Health

The recent years have been characterized by a substantial increase of 31.1% in both incidence and prevalence of chronic diseases[52] as well as disability and mental illness among the population of the oPt with posttraumatic stress disorder affecting up to 45% of families in Gaza[53].

According to the latest disability assessment about 6.9% or over 279 thousand people in the oPt suffer from disability[54]. Most common disability types are physical disability and problems with learning and communication.

TABLE 5: PROPORTION OF DISABILITIES BY TYPE[55]

Type of Disability	Proportion
Vision	13%
Hearing	9%
Communication	13%
Mobility	28%
Learning	28%
Mental Health	9%

As mentioned earlier 7.6% of mental health disability, 4.6% of physical disability and 5.2% of learning disability in West Bank and Gaza in oPt is estimated to be direct consequence of settler/IDF violence.

At the Primary Health Care level, there is limited expertise to address issues relating to disability, furthermore many health facilities in West Bank and Gaza are not well equipped to ensure access of people with disabilities to health and nutrition services. Persons with disabilities, and in particular children (CwD), elderly and their families still remain some of the most vulnerable and poverty stricken. Children with multiple disabilities exhibit impairments ranging from mild to severe impairments of speech, hearing, vision, and physical mobility, as well as difficulties with learning.

Proportion of people suffering from NCD-s both in the West Bank and Gaza has grown dramatically over the past decade; the burden of chronic illnesses in the oPt increased by nearly 37% since the year 2000[56]. Trauma (all types), perinatal illnesses, congenital disease and lung diseases are the major causes for mortality in children (0-19 years old) in the oPt while cardiovascular diseases (hearth attack, stroke), malignant neoplasms, lung diseases and trauma (all types) are the major causes of mortality in

[52] MICS 2000, 2006, 2010 (preliminary data)
[53] GCMHP.Effect of trauma on mental health, social support, and coping of Palestinian families after one year of Gaza War. July 2010
[54] Disability Survey 2011; Press Conference Report; PCBS 2011
[55] Disability Survey 2011; Press Conference Report; PCBS 2011
[56] MICS 2000, 2006, 2010 (preliminary data)

adults (20-59 years old). Cardiovascular diseases, tumours and diabetes are the major mortality causes for the older people (60+)[57].

Reliable information about prevalence of mental health disorders in West Bank and Gaza is lacking. However, without doubt, violence, restrictions on movement and access to services and other effects of the occupation have significant impact on mental health of the Palestinians.

Mental health and psychological disorders affect individuals, families and entire communities with children and people with disabilities being amongst the most vulnerable to the impact of the mental health disorders.

Research conducted over the past two years, have shown that on average 10.6% of children in Gaza exhibited severe reactions to traumatic experiences they have been exposed to, with no significant sex or age differences[58]. Emotional problems have been revealed among 14.2% of kindergarten children with 46% of them having peer relationship problems, 33.8% hyperactivity, and 15.1% multiple-social problems[59]. This is similar to prevalence of Post-Traumatic Stress Disorder (PTSD) in areas of recent or/and ongoing conflict like Iraq and Israel; 10.5% and 9.4% respectively. While it is significantly higher than politicaly stable countries in the Middle East, e.g, Yemen before the current uprising reported 0.2% as prevalence rate[60].

People with disabilities are another vulnerable group with 79.9% of disabled adults having psychiatric morbidity[61]. This considered significantly high compared countries like Northern Ireland; where percentage of people with disability experience great deal of stress is 52% [62]. Children with special needs are showing high prevalence of anxiety problems and they are more vulnerable to developing mental health problems than normal children[63].

Communicable Diseases

Communicable diseases are well controlled both in West Bank and Gaza. Due to well conducted immunization program there were no epidemics of communicable diseases in the oPt for the last several years. Although localized outbreaks of measles, H1N1 and food poisoning have been registered in 2010-11.

Communicable diseases now constitute a minor share of the overall morbidity and mortality in the oPt, with Pneumonia (and other respiratory illnesses) 8.4% (of the overall mortality) and Septicaemia (blood poisoning caused by bacteria and their toxins) 3.4% (of the overall mortality) being leading causes of death amongst infectious diseases in all age groups[64]. Difference of infectious disease mortality between males and females was insignificant.

[57] Annual Health Statistics; MoH 2011; annex 20
[58]GCMHP.Trauma, mental health, and coping of Palestinian children after one year of Gaza War. May 2010
[59]GCMHP.Evaluation report of project “Capacity Building of Kinder Garden Teachers in the Gaza Strip”. July 2010
[60] Neria, Y., Bravova, M., Helper J. (2010) Trauma and PTSD among Civilians in the Middle East. National Center for PTSD 21 (4)
[61] Psychiatric morbidity is also known as psychiatric or mental illnesses
[62] http://www.dhsspsni.gov.uk/disabilitymentalhealth.pdf
[63]GCMHP.Mental health and social support of disabled Palestinian adults in Gaza Strip. 2010
[64] Annual Health Statistics; MoH 2011; annex 20

According to UNRWA [65] there has been increase of incidence of watery diarrhoea in 2011 compared to 2009 and 2010. During the same period the incidence of other waterborne diseases, such as bloody diarrhoea, typhoid and hepatitis A, reduced.

The assessment of the environmental impact of operation Cast Lead carried out by UNEP at the request of the Palestinian Authority in 2009 revealed an alarming situation vis-a-vis environmental health in Gaza. While at the moment it did not lead to outbreaks of communicable disease or increase of mortality due to waterborne disease this situation poses an immediate and long term threat to the health and wellbeing of the dwellers of that area.

EMERGENCY PREPAREDNESS:

The oPt is highly vulnerable to a large variety of natural and manmade hazards: including war/large scale violence, earthquakes, floods, landslides, droughts and desertification.

Against the background of the on-going conflict in oPt and the response to immediate humanitarian needs, emergency risk reduction and preparedness have been given relatively less importance by both state and non-state actors in the area. While health sector actors in oPt have developed an impressive capacity to deal with the consequences of armed conflict and manage mass casualties, they are much less well prepared to anticipate, plan for and mitigate those events; nor is there sufficient standby capacity to respond should the current situation deteriorate. Furthermore the health systems in oPt are inadequately prepared to respond to other possible disasters; such as earthquakes, floods and epidemics of communicable diseases. The above, coupled with depleting resilience of the communities and systems particularly in Gaza, increases their vulnerability to future hazards and risks, high casualties and economic loss in case of new adverse events, Women and children, older people and people with disabilities are generally the most vulnerable groups when such events occur.

Recognizing this Palestinian Ministry of Health with support from the Palestinian Health Sector Reform and Development Project (Flagship) and other partners initiated the process of strengthening health sector emergency preparedness. HNC fully supports this process by involving in the development of the national health sector emergency preparedness plan, coordinating with the MoH its emergency response and preparedness actions and aligning them with the relevant national policies, strategies and norms.

[65] Epidemiological Bulleting for Gaza;