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THE RIGHT TO HEALTH IN PALESTINE

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This report is published as part of the Arab NGO Network for Development's Arab Watch Report on Economic and Social Rights (AWR) series. The AWR is a periodic publication by the Network and each edition focuses on a specific right and on the national, regional and international policies and factors that lead to its violation. The AWR is developed through a participatory process which brings together relevant stakeholders, including civil society, experts in the field, academics, and representatives from the government in each of the countries represented in the report, as a means of increasing ownership among them and ensuring its localization and relevance to the context.

This 6th edition of the AWR focuses on the Right to Health. The AWR 2023 on the Right to Health is a collaboration between the Arab NGO Network for Development and the Faculty of Health Sciences at the American University of Beirut. Through this report we aim to provide a comprehensive and critical analysis of the status of the Right to Health in the region and prospects in a post COVID-19 era. It is hoped that the information and analysis presented in this report will serve as a platform to advocate for the realization of the right to health for all.

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THE RIGHT TO HEALTH IN PALESTINE

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جوانبه المتابعة الصحية الشاملة لمريض السكر
MICROCLINIC
كيف تغسل يديك؟
من العنف ضد الأطفال
#احموا المستقبل

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INTRODUCTION

Historical Palestine is an Arab country on the eastern side of the Mediterranean Sea. It borders Jordan, Egypt, Lebanon, and Syria, with an area of 27,000 square kilometers. Since the 1948 Palestinian Nakba, Palestine has been under a military occupation that has displaced the vast majority of Palestinian citizens to neighboring Arab countries and refugee camps in the West Bank and Gaza Strip.

The 1967 Nakba was another stage in immigration, displacement, and occupation. It is the year when Israel occupied the West Bank, the Gaza Strip, the Egyptian Sinai desert, and the Syrian Golan Heights, displacing hundreds of thousands of Palestinians to neighboring Arab countries.

The 1993 peace agreement with Israel included the withdrawal of the occupying state from the West Bank, Gaza Strip, and East Jerusalem. However, the withdrawal never took place. The manner in which Israel implemented the agreement resulted in unilateral practices of land confiscation and settlement expansion. It established its own road network and more than 600 checkpoints that isolate and fragment Palestinian land and impede the possibility of establishing a Palestinian state in a geographically contiguous area.

According to 2022 statistics, Palestinians around the world numbered 14.3 million (**Table 1**).

Table 1. Palestinians' place of residence

Place of Residence	Number (in millions)
West Bank and East Jerusalem	3.19
Gaza Strip	2.17
Areas Occupied in 1948	1.7
Arab Countries*	6.4
Other Countries	0.8
Total	14.3

***Palestinian refugees and residents of Palestinian origin in these countries.**

Source: Palestinian Central Bureau of Statistics 2022.

Based on the peace agreements with the occupying state, the Palestinian territories were defined as areas occupied on June 5, 1967. According to UNSC Resolutions 242 and 338, the following constitute the lands on which the Palestinian state shall be established: the West Bank, East Jerusalem, and the Gaza Strip. These are the areas defined in the current report.

5.4 million Palestinians live in the West Bank, Gaza Strip, and East Jerusalem. Palestinian society's demographic composition is characterized by high fertility rates and, consequently, a high percentage of young people. Around 38% of the population is under 14. Those over sixty-five make up 3% of the population. 2.17 million people live in Gaza, which is a 360 square kilometers strip, making it one of the most densely populated regions in the world, with 6,027 people per square kilometer.

Unemployment and poverty are the most prominent features of Palestinian lives in the territories due to the deteriorating political and security reality resulting from the military occupation's policies, apartheid, and closures. Those living under the poverty line comprise 26.4% of the population (15% in the West Bank and 47% in the Gaza Strip).

The human rights situation of Palestinians in the West Bank, Gaza Strip, and East Jerusalem is an important entry point for the report. Legal violations include the continuous military occupation and its exclusionary, racist practices (See the box below for the advisory opinion presented to the International Court of Justice).

Advisory opinion presented to the International Court of Justice

The Committee recognizes that the continued Israeli occupation, settlement expansion, and blockade of the Gaza Strip, which are illegal under international law, pose severe challenges and impede the full implementation of its obligations under the Convention and lead to grave violations of the rights of Palestinians, such as arbitrary detention, torture, ill-treatment, and excessive use of force and ill-treatment by Israeli security forces, acts of violence by Israeli settlers, restrictions on freedom of movement, forced displacement and evictions, appropriation of private land, home demolitions, construction of illegal settlements, and

restrictions on access to healthcare services, and preventing access to humanitarian aid.

The Committee recalls the obligations of Israel as the occupying power under international humanitarian law and international human rights law. It also recognizes that the challenges above limit the State party's effective control over its jurisdiction over its territory and its ability to prevent and combat torture and ill-treatment effectively, but reminds the State party that the Convention applies throughout its territory and that the State party should take all possible measures to implement it throughout its territory.

In this regard, the Committee regrets that, although Fatah and Hamas signed an agreement to end the Palestinian division on October 12, 2017, the State party has made only limited progress in resolving internal political issues that negatively prevent Palestinians in the West Bank, including in East Jerusalem and the Gaza Strip from enjoying their rights under the Convention and contribute to the political and geographical fragmentation of the territory of the state party. It notes that, due to this fragmentation, Palestinians are still subject to multiple legal regimes that impede the full realization of their rights under the Convention.

PREAMBLE

Although the right to health is considered a fundamental human right, its implementation under occupation poses a significant challenge to the Palestinian health institution and society. Palestine suffers from multiple influences on the right to health and the determinants of this right in terms of comprehensiveness, the direct impact on health, and the association of these determinants with political, social, economic, and environmental factors. This report aims to study and demonstrate the extent to which rights bearers obtain their rights and the extent to which duty bearers are committed to developing legislation, enforcing laws, and establishing a service system that respects the right to health and delivers it to its bearers in a fair manner.

This report on the right to health in Palestine does not constitute an evaluative study of health system and facilities performance, nor does it aspire to blame any party. Instead, it tries to shed light on the successes and challenges faced by the system and its users and inform the extent to which the right to health is realized. In addition, the report aims to provide transparent observations to inform multisectoral national efforts to reach a better level of care.

The realization of the right to health in Palestine is affected by a complex set of public and private determinants. The COVID-19 pandemic and the pattern of global and local interventions carried challenges related to the unequal distribution of prevention and treatment resources. The confusion of health systems, the lack of coping even in developed countries, and the decline of an essential group of health services in favor of confronting the pandemic are factors that apply to many countries, including Palestine. Moreover, combating COVID-19 in Palestine faced several challenges and sometimes failure. Notably:

1. The health system focused on preventing the pandemic and dealing with infections. This has lead to shifting priorities away from other health and medical sectors, such as maternity care, kidney patients, people with mental illnesses, disabled and cancer patients. All of the latter faced difficulties in accessing services and medicines. For example, the maternal mortality rate sharply increased during and after the pandemic, indicating a decline in essential

maternal safety services.

2. There were many sources and varying types of messages to citizens during and after the first lockdown (March-June 2020), specifically regarding safety measures, the second lockdown, and the conflict between economic and health priorities. Unfortunately, this pluralism and lack of unification of the health message led to a decline in citizens' confidence in information and, consequently, to a significant decline in compliance with prevention instructions and uptake of vaccines, which led to successive waves of infections and deaths.

3. To overcome the unavailability of vaccines in the Palestinian territories, the Ministry of Health agreed to obtain a certain quantity from the Israeli side close to the expiration date. This led to severe confusion and a problem with public opinion at the time. Receiving Pfizer vaccines from Israel posed a serious challenge to promoting compliance with the vaccination campaign.

Furthermore, health and social systems in developing countries are influenced by neoliberal policies that deepen the class divide, redistribute resources in favor of the wealthiest groups, and restrict programs to address root causes of poverty and improve the lives of the poorest and most vulnerable societies or social groups. This report will not delve too much into the impact of neoliberalism on the right to health in Palestine due to urgent priorities. However, its impact on the local reality could be summarized in the following:

1. Development programs are influenced by the policies of international institutions and donors: Over the years of building the Palestinian state and its institutions, the number and size of aid, relief, and development institutions grew. However, developmental results and gains do not alighn with the extent of spending due to the fragmentation of donor mechanisms and policies and the political nature and conditions of a large segment of financing. As a result, programs targeting the health sector for relief and development are impacted. The report does not provide an in-depth look into the role of international institutions, including the United Nations (UN), but its observations point to the need for its review.

2. The occupation's pervasiveness in the economic reality and horizon through unfair agreements: The Paris Economic Agreement is one of the most critical examples of the lack

of justice for Palestinians in achieving balanced economic development. The occupation generates 41 billion USD annually in profits from the exploitation of natural resources that are supposed to be under the ownership and control of the Palestinian Authority. In addition, the Palestinian National Authority loses 3-4 billion USD annually due to confiscated funds, unfair taxes, and economic restrictions.

3. The impact of international pharmaceutical and medical equipment companies on the local market:

   Medicines:

   The list of drugs in Palestine is long and changes frequently due to rapid changes in medical and pharmaceutical sciences, the absence of strict treatment protocols for many emerging cases, and pressures on drug manufacturing and importing companies. Successive developments in medical products, strategies for promoting newly discovered and expensive products under trial, and pressure on patients and caregivers are significant contributors to the high cost of the drug bill for patients and the health system.

   The above point and the lack of clear and binding medical protocols for many diseases contribute to a similar pressure on patients and the health system to use expensive therapeutic alternatives outside the basic basket of medicines. In addition, the private procurement mechanism delays patients' access to medicines and forces them to make costly transfers or lose valuable time waiting.

   Legislations exempting from accountability:

   Article 4 of Decree-Law No. 11 of 2021 regarding the regulation of medical products to combat the COVID-19 virus states that "except for the death or severe injury caused by intentional misconduct or violation of the terms of the agreement signed with the Ministry, the responsibility does not rest on the producing company or supplier as a result of damage resulting from acts or activities related to the regulation of the medicinal product or from the results of such acts or activities."

This article aligned with international policies and instructions that granted legal cover, exempting vaccine production companies from accountability in case of harm from the newly produced vaccine used without going through the clinical trial processes. At the same time, this exemption gave companies a large margin to promote the vaccine's impact with the intent of

making profits.

FOCUS OF THE NATIONAL REPORT

The current report attempts to shed light on the right to health in Palestine in line with the effort to examine this right in the Arab region. Considering the complex and multiple nature of the determinants associated with the right to health, the Palestine report will focus on three most prominent reasons for deprivation in Palestinian society and various community groups:

1. The dominating military occupation is the primary determinant and greatest challenge to realizing the right to health in Palestine. The direct impact of its measures on the fundamental right to life and health is evident in the number of martyrs, wounded, and disabled as a direct result of military operations by the occupation army, its special forces, and settler mobs. According to al-Quds Center for Human Rights, in 2022, for example, the West Bank witnessed 154 Palestinian deaths and 10,000 injuries at the hands of the occupation forces and settlers (مركز القدس لحقوق الإنسان 2023). As of writing this report (March 2023, and numbers increase by the day), the number of prisoners in occupation prisons reached 4,700, including 150 children and 460 women. Added to the above figures is the indirect impact on the right to health, evident in the exposure to constant harassment and restrictions on freedom of movement, work, and access to resources and services. Consequently, the percentage of Palestinians suffering from mental disorders significantly increased with 51% and 70% of West Bank and Gaza people report at least one sympom of epression respectively (World Bank report on mental health in West Bank and Gaza, March 2023).

2. Added to the above factor, the division of authority in the regions and the blockade of the Gaza Strip are essential determinants in the deterioration of healthcare capabilities, the decline in access to specialized services, the flow of essential resources necessary for the operation of health services, thus leading to extremely high levels of deprivation.

3. Over 30 years, the process of establishing a Palestinian healthcare system as a component of the future state faced several challenges related to governance, efficiency, and quality of services in parallel to impediments resulting from occupation practices. These difficulties impede what Palestinian citizens aspire to in terms of universal and fair

access to high-quality services. It is important to stress that despite the multiplicity of health sectors, the responsibility for realizing the right to health for Palestinian citizens rests with the governmental body that bears the duty. It means drawing up national strategies, activating participation and complementarity in covering health services and controlling their quality.

The three determinants mentioned above are the lens through which the right to health and its implementation in Palestine shall be assessed, and will be the main focus of this report without neglecting other direct and indirect determinants.

METHODOLOGY

The report utilized an investigative research methodology of three elements:

1. Reviewing literature and local and international reports on the right to health: They included reports of the Palestinian Ministry of Health, the Central Bureau of Statistics, and the publications of legislative and executive bodies. The reviews also included reports from international organizations, particularly the World Health Organization (WHO), UN-OCHA, and UNDP. References also included reports of Palestinian human rights organizations such as the Independent Commission for Human Rights, the Jerusalem Legal Aid and Human Right Center, and the Palestinian Institute for Economic Studies (MAS).
2. Individual and group meetings with representatives of governmental and private bodies working in the health sector.
3. Meetings with the Palestinian NGO Network.

A preliminary meeting with the Palestinian NGO Network (PNGO) set the ground for a shared conceptualization of the Palestine report and the themes that should be covered. Accordingly, the literature was reviewed, consultations were held with representatives of a group of institutions, and an initial draft was developed. Comments by AWR's regional coordinator led to a second draft. Finally, the third and penultimate draft was developed based on ANND's comprehensive review.

LIMITATIONS

- International organizations were not involved in the research due to a lack of response to the request sent to the health cluster for a meeting.
- Many relief and development institutions and UN organizations are operating in Palestine. Unfortunately, the report could not cover their contributions to realizing the right to health. However, this aspect could warrant an in-depth study.

DEMOGRAPHIC AND HEALTH OVERVIEW

Palestinian society is young due to a persisting high fertility rate, reaching 4.1 according to the latest population census. Those under 15 comprise 56% of the population, and youth between 15 and 29 comprise 30%. Around 3% of the population is over 65 (الجهاز المركزي للإحصاء الفلسطيني a2022). The average life expectancy at birth is 74 years (76 for females and 72 for males) (الجهاز المركزي للإحصاء الفلسطيني 2022b).

From an epidemiological point of view, the high calorie intake and sedentary lifestyle, the spread of health services, and the decent economic situation have led to a significant transition in the morbidity pattern as follows:

1. Several infectious diseases that contribute to high child mortality rates have been eradicated due to 100% coverage of polio, mumps, and rubella vaccination (الجهاز المركزي للإحصاء الفلسطيني 2021), leading to a drop in child mortality rates and an increase in the life expectancy index at birth.
2. Environmental changes, a technology-dependent lifestyle, and decreased physical activity among Palestinians are pushing a wave of chronic diseases. Consequently, cardiovascular diseases, diabetes, and cancer are now the top three causes of adult death (الجهاز المركزي للإحصاء الفلسطيني 2021).

MAIN HEALTH INDICATORS

Table 2 presents the leading health indicators based on the latest surveys.

Table 2. Main health indicators

Indicator	2019/2020
Neonatal mortality rate per thousand live births[i]	9.4/1000
Infant mortality rate per thousand live births[i]	12.1/ 1000
Under-five mortality rate per 1000[i]	14.2/ 1000

Vaccine coverage[II]	99.8%
Maternal mortality rate per 100,000[III]	47/100000
Proportion of hospital births	99.6%
Healthcare during pregnancy (at least four visits)[IV]	94.8%
Total fertility rate[II]	4.1
Average life expectancy at birth (years)[V]	74
Number of hospital beds per 1000 inhabitants[II]	1.3
Average number of citizens per health center	5000
Number of doctors per thousand citizens	2.3
Number of nursing staff per thousand citizens	2.7

I الجهاز المركزي للإحصاء الفلسطيني 2021 a
II وزارة الصحة الفلسطينية 2019 a
III وزارة الصحة الفلسطينية 2022
IV الجهاز المركزي للإحصاء الفلسطيني 2021 b
V الجهاز المركزي للإحصاء الفلسطيني 2020

Based on the above table, health indicators in Palestine point to a relatively good situation due to the systematic and extensive effort of governmental, NGO, and private health teams. Following the Oslo Accords, the national health system was considered a crucial pillar in building the Palestinian state and national authority through national sectoral institutions.

When the Palestinian National Authority (PNA) was established, the Ministry of Health assumed responsibility for the health system. However, by that time, Palestinian CSOs already had in place a system of health services reaching particularly to the marginalized communities and contributed to primary care service provision reaching 28% of primary healthcare needs (البرغوثي 1991).

Following the PNA's establishment, social and economic developments contributed to improving nutrition, services, and information among citizens. The Ministry of Health exerted significant efforts in health education in close cooperation with health CSOs, promoting healthy behavior related to mother and child care, adherence to vaccinations, and access to preventive and curative healthcare. The cumulative improvement in the above matters led to a significant decrease in infant mortality and an increase in the average life expectancy at birth and health indicators such as coverage and

access to services.

In the past few years, investment in training and education, such as expanding the faculties of Medicine, Nursing, and Health Sciences, provided more qualified health personnel. The growth in numbers significantly improved the quantity and quality of health services in Palestine.

Healthcare in Palestine is provided through a complex network of primary, secondary, and tertiary facilities covering the West Bank, Gaza Strip, and East Jerusalem. The government sector is the largest provider of primary and secondary healthcare. UNRWA provides primary healthcare services to refugees, who comprise 40% of the population. In addition, NGOs contribute 8% of such services. The private sector provides primary healthcare in private clinics. However, its work focuses on the secondary and tertiary levels and is organically linked to the government system through the referral program or service purchase.

Table 3. Child mortality rates (comparison between 2014 and 2020)

		Premature Infant Mortality (after birth) Death per 1000 live birth		Premature infant mortality (first 28 days) death per 1000 live births	
	Year	2014	2020	2014	2020
Area	All Palestine	7.1	2.7	11.2	9.4
	West Bank	6.2	1.9	10.9	9.8
	Gaza Strip	8.1	3.9	11.5	8.8
Location	Urban Population	7.0	2.2	12.0	9.3
	Rural Population	9.7	3.4	8.0	9.5
	Camp Population	2.7	7.0	9.4	10.5
Education	Primary	19.9	3.6	11.8	9.6
	Secondary	7.3	2.3	14.7	10.8
	Higher	2.7	2.7	10.4	8.1

Economic Situation	Poorest	10.3	5.6	7.2	9.2
	Average	6.2	1.8	15.9	14.3
	Wealthiest	5.6	0.8	6.0	7.8

Source: Palestinian Central Bureau of Statistics (2021)

Several factors contributed to Palestine's significant progress in reducing infant mortality (**Table 3**). They include an improvement in the rate of births under medical supervision in hospitals, progress in medicine and premature infant resuscitation skills, and an almost 100% vaccination rate. For example, the mortality rate for children under one is 12 deaths per thousand live births (2021 وزارة الصحة الفلسطينية). However, the table above indicates that many infant deaths occur in the first days after birth. According to public health principles, these deaths are attributed to health conditions during pregnancy and quality of medical care during this critical period.

The apparent disparity in infant mortality rates in Palestine is linked to education, place of residence, and economic status. It is a clear indicator that vulnerability is related to access to resources, access to services, and sufficient awareness to provide optimal care for children. The low level of infant mortality among camp residents clearly indicates the quality of the primary healthcare programs used by service providers in the camps, namely UNRWA.

Table 4. Women's health: Access to essential reproductive health services

		Access to 4 visits during pregnancy (%)		Giving birth under professional supervision (%)		Cesarean birth (%)	
Year		2014	2020	2014	2020	2014	2020
Area	All Palestine	95.5	94.8	100	100	20.3	25.8
	West Bank	95.7	94.3	100	100	22.7	28.2
	Gaza Strip	95.3	95.4	100	100	17.4	22.4
Location	Urban Population	95.6	94.7	100	100	19.4	24.8
	Rural Population	94.7	95.2	100	100	24.1	30.5
	Camp Population	94.3	94.6	100	100	22.4	24.9

Education	Primary	93.8	91.3	100	100	22.3	25.8
	Secondary	95.9	94.6	100	100	18.9	22.5
	Higher	96.3	96.1	100	100	20.2	25.2
Economic Situation	Poorest	95.4	94.3	100	100	17.7	20.0
	Average	96.1	92.2	100	100	20.3	29.0
	Wealthiest	96.3	97.0	100	100	26.5	34.0

Source: Palestinian Central Bureau of Statistics (2021)

Table 5. Women's health: Access to family planning

		Unfulfilled need (%)		Use of modern method (%)		Use of any method (%)	
Year		2014	2020	2014	2020	2014	2020
Area	All Palestine	10.9	12.9	44.1	42.8	57.2	57.3
	West Bank	11.0	13.6	46.3	42.8	59.8	55.9
	Gaza Strip	10.7	11.9	40.8	42.8	53.4	59.4
Location	Urban Population	10.5	12.6	43.4	42.3	56.6	57
	Rural Population	10.8	14.8	45.2	43.5	59.9	56.9
	Camp Population	11.7	11.9	48.1	47.1	57.6	61.1
Education	Primary	14.3	10.9	48.7	48.6	61.1	62.0
	Secondary	10.9	12.6	43.7	42.5	56.7	56.5
	Higher	10.5	14.4	39.4	39.4	53.4	54.8
Economic Situation	Poorest	95.4	94.3	100	100	49.0	56.3
	Average	96.1	92.2	100	100	55.9	54.5
	Wealthiest	96.3	97.0	100	100	66.3	58.5

Source: Palestinian Central Bureau of Statistics (2021)

Although women's sexual and reproductive health services have wide coverage (**Table 4**), the maternal mortality rate recorded 47 deaths per 100,000 live births in 2021. This 3-fold increase from the rate in 2017 is worrisome. The 2021 maternal

mortality rates report shows that 80% of those deaths could have been prevented, which points to healthcare quality. Nevertheless, maternal mortality witnessed a significant increase between 2017 and 2022, increasing four times in the Gaza Strip. As a crucial indicator measuring the health system's performance, the reason behind the increase in maternal mortality warrants investigation. However, the report's scope does not cover the multiple causes associated with maternal mortality.

Table 5 indicates a deterioration in another indicator related to women's reproductive health. The unmet need for family planning rose from 10.9% to 12.9% between 2014 and 2021. The matter warrants study since the indicator is related to a human rights issue for women. It also relates to social issues such as decision-making in family planning, access to services, contraception methods, and the quality of services if available. Moreover, the unmet need for family planning increased significantly among rural and urban residents compared to camp residents, indicating the stability of these services through UNRWA and their decline through the Ministry of Health, the leading service provider in cities and villages.

RIGHT TO HEALTH IN PALESTINE: MAIN DETERMINANTS

DIRECT REPERCUSSIONS OF THE OCCUPATION

According to the Central Bureau of Statistics, the number of martyrs of the al-Aqsa Intifada between 2000 and 2008 reached 10,577, in addition to 35,099 wounded. In addition, occupation prisons hold around 5,000 detainees at any given time. Although the above statistics are not updated, daily life in Palestine gives a clear idea of the occupation's continued violation of the right to life and health. The following factors influence the situation in this context:

- Martyrdoms, injuries, and detentions do not occur during military clashes between two equal forces. Instead, they are due to the encroachment of occupying forces and armed settlers onto unarmed and civilian areas, considered under military occupation according to international law.
- The impact of killings, disabilities, and arrests does not stop at the victim's physical health. However, it extends to their future and those around them.
- The high number of injuries, especially from major invasions, weakens the health service system, which already suffers from challenged human and financial resources.
- The Palestinian territories are subjected to many military incursions, which are detrimental to the health system's infrastructure. For example, statistics from Gaza indicate that the military operation against the Gaza Strip in 2014 put 50% of medical equipment out of service. The attack destroyed six hospitals and 50 primary healthcare centers. Another 30 centers were closed as a result of extensive damage to the infrastructure (UNFPA, WHO, MOH, 2014).

MARTYRS

In terms of quantity, the question of martyrs describes the magnitude of the negative impact of the occupation on the most basic human right, the right to life. The social and psychological impact of martyrdom is escalating dramatically within Palestinian society. Along with disappearances, it has become the focus of social movements that aim to mitigate the

impact on martyrs' families, find sources of psychological and material support, and broaden the scope beyond numerical simplification. One of the practices involves the occupation refusing to hand over martyr's bodies, which is equal to the killings and executions, even exceeding them in brutality.

The bodies of 375 martyrs are currently being held by the occupation, which is a compound violation of International Humanitarian Law. It is an attack on the right to life. UN reports indicate that 62% of assassinations since the beginning of 2022 were not armed and did not fall during armed confrontations, including the assassination of a high percentage of children (مركز القدس للمساعدة القانونية والإرشاد 2022).

The occupation army has stopped conducting investigations, even formally. In December 2021, it changed its shooting instructions to allow armed response to stone-throwing, leading to a significant increase in murders targeting young people as a general rule. The year 2022 was the deadliest year in the last two decades, while in the first half of 2023 154 Palestinians were killed, including 28 children. The occupation authorities also refuse to issue death certificates for martyrs whose bodies are withheld, and their cases remain pending. The majority meet the definition of enforced disappearance in light of the uncertainty of their martyrdom.

In many cases, the occupation authorities handed over the bodies in ice blocks, stipulating that they be buried within two hours, before the ice melts. In other cases, they set conditions for burial, including preventing a forensic autopsy and obtaining guarantees from families not to violate the instructions under the penalty of a fine.

PRISONERS

The occupation authorities do not adhere to international standards and laws for the treatment of prisoners, especially concerning health.

> "Based on observing the health status of prisoners, it is clear that healthcare was inferior. Reports of local and international human rights and prisoner affairs institutions confirm that the treatment of prisoners has become a subject of bargaining, extortion, and pressure on detainees by Israeli prison administrations. This is a flagrant violation of the articles of the Third and Fourth Geneva Conventions (Articles 29, 30, and 31 of

> the Third Geneva Convention and Articles 91 and 92 of the Fourth Geneva Convention), which stipulate the right to medical treatment and care, the provision of appropriate medicines for sick prisoners, and the conduct of periodic medical examinations."

(Report of the Palestinian National Information Center 2022)

Around 5,000 Palestinians are detained in occupation prisons, including 150 children and 1,083 administrative detainees (detained for precautionary reasons without being charged or announcing the reasons for their arrest). Administrative detention is carried out as a practice of British law imposed on Palestine during the mandate days and continues today under Israeli occupation. Since 1967, the number of martyrs among prisoners due to diseases contracted during their imprisonment reached 233. In addition, 500 prisoners are in poor health. They suffer from incurable diseases such as cancer, nervous system diseases, kidney problems, and cardiovascular ailments.

Deprivation from healthcare and preventing minimum medical services is a clear policy practiced by the occupying prison authorities against Palestinian prisoners (See box below). The Palestinian National Information Center Report indicates that the occupation authorities tend to neglect the health status of prisoners, preventing access to timely diagnosis, treatment, and palliative care in most cases.

Case examples of the situation of prisoners in occupation prisons

Ahmad Manasra

Ahmad Manasra was born on January 22, 2002, in Beit Hanina, occupied Jerusalem. He was arrested on October 12, 2015, at the age of 13, on stabbing charges. On November 7, 2016, the Central Court sentenced Manasra to 12 years in prison for allegedly stabbing settlers and imposed two fines of one hundred and eighty thousand shekels (50,000 USD). The judge stated that "the child's young age does not give him immunity from punishment." Ahmed has been held in solitary confinement since the beginning of November 2021. On April 17, 2022, the Israeli Prison Service requested a renewal of solitary confinement for another six months.

In October 2022, an independent Israeli psychiatrist working with Physicians for Human Rights in Israel diagnosed Ahmed Manasra with severe psychological problems and stated that these problems had arisen since his imprisonment. In February 2022, Ahmed was diagnosed with schizophrenia. He has psychosis and severe depression accompanied by suicidal thoughts (Al-Jazeera 2016).

Nasser Abu Hamid

Prisoner Nasser Abu Hamid was killed in a hospital after the occupation authorities neglected his treatment for 12 consecutive years after his lung cancer diagnosis. Although his condition kept deteriorating in the past years to the point of near death, the military authorities refused to release him or grant him facilities to visit his relatives until hours before his death. The occupation authorities also refused to release the prisoner's body and insisted on imprisoning the body in the refrigerator until the end of his sentence.

Moreover, the Palestinian National Information Center Report indicates that the transfer of patients to specialized facilities or hospitals occurs only when there is a direct threat to life. However, these transfers occur under humiliating conditions and do not comply with international human rights conventions. For example, sick prisoners are transported using heavily sealed but standard transport vehicles. They remain in handcuffs in hospitals.

Palestinian female prisoners in Israeli prisons suffer from a humiliating health and humanitarian situation. They are deprived of special medical services, even during pregnancy or childbirth, and are treated by general physicians. Furthermore, female prisoners' medical and humanitarian needs during pregnancy or childbirth are not respected. They are forced to give birth while their hands are still tied.

OBSTRUCTION OF ACCESS TO SERVICES

The occupation's closures, movement restrictions, and the blockade of the Gaza Strip are serious impediments to realizing the right to health and access to health services in Palestine. Palestinian areas are divided into three completely isolated geographical sections. Movement between them is subject

to permits closely linked to the occupying state's security agencies.

The Gaza Strip has been under a complete blockade since 2007, making it the largest open prison in the world. The blockade has restricted any potential for economic, service, or humanitarian growth. In 2017, a UNDP report concluded that if the blockade and the living conditions in Gaza continue at the same pace, the Strip would not be suitable for living by 2020.

Following the outbreak of the second Intifada in September 2000, the Gaza Strip suffered from repeated Israeli attacks, a blockade, and isolation from the outside world. The consequences of such actions were felt by the health sector and the Ministry of Health, which could no longer cover its operational expenses and had to halt all development projects. Moreover, the bombing of health facilities has been a staple of the war on Gaza. For example, in 2014, such attacks destroyed six hospitals and fifty primary care centers, and severely damaged 30 centers, leading to their closure (UNFPA, 2014).

In terms of healthcare, the Ministry of Health facilities suffer from a 41% shortage of medicines and a 17% shortage of medical supplies. The interruption of supplies and spare parts has led to the failure of many medical devices.

Gaza's residents, especially those needing healthcare outside the Strip, suffer from a double blockade. Patients and accompanying persons must obtain special permits subject to a security check that may extend to family members (**Table 6**). Permits are denied in the event of a security reason. As a result, many people, including children, have lost their lives while waiting for a permit or because of its rejection by the occupation authorities. The occupation's permit policy impedes Palestinians' access to healthcare due to the security checks. Data from 2021 indicate that 40% of medical permits were delayed.

As reported by Amjad al-Shawwa (Gaza, September 21, 2023 (Petra)), "A human rights organization said that a patient from the Gaza Strip died after he was denied from traveling for treatment in Al-Matlaa Hospital in occupied Jerusalem. This brings the number of patients who died due to denial of travel for treatment outside to six, including three children, since the beginning of the year." (وكالة الانباء الأردنية 2023).

Table 6. Rate of acceptance of referral permits for patients in the Gaza Strip in August 2022

August 2022 2022 Age Group	Number of Applications Male	Number of Applications Female	Rate of Approval Male	Rate of Approval Female
0-3	92	59	60%	59%
4-17	276	218	51%	52%
18-40	271	273	44%	56%
41-60	218	270	56%	66%
Over 60	209	181	68%	77%
Total	1066	1001	54%	62%
Grand Total	2067		58%	

Source: WHO 2022

Similarly, the West Bank is divided into separate cantons patrolled by the occupation authorities, and includes 362 roadblocks and checkpoints between areas. The isolation and closures restrict the movement of citizens, including patients. According to the Central Bureau of Statistics, while the percentage of births in hospitals in Palestine has reached 99.6%, between 2000 and 2007, 1.4% of births occurred at checkpoints or on the way to the hospital (الجهاز المركزي للإحصاء الفلسطيني 2007), which is equivalent to 1400 births annually. These closures are impeding access to essential health services, leading to many deaths and disabilities, in clear violation of the right to health and the occupation authorities' duty towards civilians.

A permit system controls the movement of citizens through checkpoints to and from the PNA territories. In addition to Jerusalem's residents, around 140,000 Palestinian workers pass through the checkpoints to work in Israel. Patients from the West Bank and Gaza referred to hospitals in Jerusalem or the Palestinian interior must follow the same route. With some exceptions, patients are forced to enter through very crowded crossings, leading some to refrain from going for treatment even if the entry permit is approved.

The impact of the occupation on the residents of the West Bank and Gaza is far-reaching. According to the World Bank, more

than 50% of the West Bank's and 71% of Gaza's population suffer from symptoms related to depression. A third of the residents have post-traumatic stress disorder (PTSD) due to the impact of the political and social situation on mental health in the Strip and recurrent exposure to violence (البنك الدولي والجهاز المركزي للإحصاء الفلسطيني 2023).

DEPRIVATION OF NATURAL RESOURCES - WATER

Water in Palestine is a significant challenge due to climate change and, to a greater extent, the Israeli occupation's almost total control over water resources. On average, Israeli settlers consume 13 times the amount of water used by Palestinian citizens. The following list summarizes the impediments facing the right of access to water:

- Discrimination in distribution: The UN Committee on Economic, Social, and Cultural Rights has expressed concern about the "inequity" of Palestinian access to water sources. The committee noted that the wall "would limit or prevent access to land and water resources." The United Nations Committee on the Elimination of Racial Discrimination called on Israel to "ensure equal access to water resources for all without any discrimination."
- Denial of access to water: The quantities of water available to Palestinian communities in some areas are far below internationally accepted levels.
- Unsafe water: There are unacceptable levels of chlorine and nitrates in the drinking water resources in the Gaza Strip, which endangers public health, especially the health of children. Unlicensed water sellers in PNA areas often sell water of questionable quality at inflated prices.
- Destruction of infrastructure: The UN Fact-Finding Mission on the Gaza Conflict documented the Israeli army's widespread destruction of water and sanitation infrastructure during Operation Cast Lead. Amnesty International has documented the destruction of water cisterns and other infrastructure in West Bank communities by the Israeli army and settlers.
- Blockade of Gaza: The United Nations Humanitarian Coordinator for the Occupied Palestinian Territories called for an immediate end to the blockade, as "the deterioration and collapse of water and sanitation facilities in Gaza compound the continued denial of human dignity in the Strip."

- High cost: On average, Palestinian citizens spend 11% of their income on water, more than any other citizen in the Arab region, where the average is 2% of the income.

DIVISION OF AUTHORITY

In early 2006, disagreements between Fatah and Hamas following the results of the Legislative Council elections led to armed clashes. In mid-June 2007, Hamas took control over Gaza , creating a new reality that strengthened the geographical division between the West Bank and the Gaza Strip. As a result, the government in the West Bank has no authority in the Gaza Strip and has little supervision authority over the facilities of the Ministry of Health located in Gaza.

The division of the Palestinian authorities after 2007 created a distorted reality and multiple political and service references. This situation helped the occupation authorities tighten the embargo on Gaza, adding to their brutality through a series of wars on the Strip, resulting in many martyrs, injuries, and disabled people and the destruction of the basic healthcare infrastructure. In terms of the right to health, the tightening of the blockade led to a deterioration in the health system's ability to respond to health service needs in the Strip and its citizens' right to access health services on an equal basis with the West Bank.

Due to the division, the health sector in Gaza witnessed several setbacks, affecting its performance and threatening its existence:

- Most Ministry of Health employees in the Gaza Strip stopped working after the division, leading to the loss of expertise and competencies in the field.
- Challenged financial management of Gaza human resources in health: The PNA in Ramallah refused to pay the salaries of a significant number of Ministry of Health employees in Gaza. During the years of division extending from 2007, no employee of the Ministry of Health in Gaza was employed on the Ramallah government's salaries, while hundreds of its employees left their jobs due to retirement or death.
- The conflict over the management of the health sector between the governments of Gaza and Ramallah meant the absence of a unified plan, and health became an issue of political dispute.
- The number of referrals for outpatient treatment dropped,

and the quality of external services deteriorated. Under the objective of nationalization (توطين) "treatment abroad," Gaza Strip patients were sent to private health sector facilities in the West Bank, proliferating at the expense of the public health sector, especially in the Gaza Strip.

- Health employees in Gaza and Ramallah are treated differently. The Ramallah government pays the salaries of many Ministry of Health employees registered on the Ministry's records in both Gaza and Ramallah. Employees in Gaza are deprived of the allowance for the nature of the profession, resulting in the relative insignificance of their salaries compared to their peers in the West Bank, which impacts their motivation.
- The Ministry of Health in Ramallah spends on specialized treatment abroad for patients in the Gaza Strip and on the needs of its facilities in terms of medicines and medical supplies. However, despite the recent improvement in this situation, the Ministry's shipments of medicines and medical consumables to its facilities in the Gaza Strip has long been scarce and seasonal.

The impact of the division on the right to health can be summarized as follows:

- The multiple political and procedural authorities in the Ministry of Health lead to disarray in performance and resource management protocols.
- Work procedures related to development priorities, maintenance of facilities, provision of medicines and supplies, training, and referrals are complicated.
- Material and human resources are unstable and not always available.
- Practical capacities declined due to the lack of training and development.
- A new service sector has emerged to bridge the gap and provide as many services as possible that are unavailable within the government system (public service, private sector). However, this sector has placed a huge financial burden on citizens despite its importance, and access to care has been limited to those who can pay.

HEALTH SYSTEM GOVERNANCE

LEGISLATION

Although occupation is the root cause of the non-fulfillment of the right to health for Palestinians, this section of the report reviews the extent to which Palestinian legislation is committed to clarifying the right and enacting laws and policies that lead to its realization.

Palestinian Basic Law does not address the right to health directly. However, it stipulates in Article 10 the commitment to human rights and fundamental freedoms and that they are binding and must be respected. Furthermore, it obligates the national authority to join, without delay, regional and international declarations and covenants that protect human rights, including charters that affirm the right to enjoy the highest standard of health. The Basic Law also addresses several issues related to the right to health, such as medical, scientific experiments, maternal and child care, and occupational health.

Similarly, the Palestinian Public Health Law No. 20 of 2004 does not directly address the concept of the right to health. However, the concept can be deduced from several health topics covered by the law and the tasks entrusted to the Ministry of Health. These include maternity and childhood care, combating communicable diseases and epidemics, quarantine, health adversities, environmental health, occupational health, health culture, medical drugs, paramedical professions, food safety, hospitals, clinics, and health centers. Nevertheless, the various economic factors imposed by the Israeli occupation weaken the PNA's capacity to define the right to health. The thousands of martyrs and wounded and the separation wall are some factors.

Article 60 of the Public Health Law of 2004 describes patients' rights in health facilities regarding receiving care, being informed about treatment, enjoying privacy, and submitting complaints. However, PNA laws and legislation do not refer to them as rights, although the law describes the duty of public health authorities to provide essential services within their facilities, specifically those directed to children and women.

The right to access services was addressed through legal

decrees aimed at facilitating access to healthcare and benefiting from coverage through the various government health insurance schemes. The Palestinian President took the most prominent legal decision in this regard. He exempted the people of Gaza from health insurance fees while granting them comprehensive coverage.

Other enforced legal decisions contribute to clarifying the concept of the right to health in the Palestinian legal system. However, many issues mentioned in the health law remain absent due to the lack of implementing regulations. On the other hand, the law does not mention other critical issues, such as health insurance, mental health, geriatric health, and persons with disabilities (PwD). Furthermore, while it pays attention to women's reproductive roles, it does not extend attention to other stages of their lives.

A review of the health laws mentioned above indicates the extent to which the health system fulfills the right to health as guaranteed by international conventions. Following the enactment of the Basic Law of 2002 and the Public Health Law of 2004, advanced steps were taken in legislative regulations on several health issues to achieve the highest possible standards. However, they do not cover the entirety of the conventions, and the Health Law does not utilize a Human-Rights Based Approach (HRBA). Instead, it considers health a mere service to citizens that required regulation.

However, determining consistency with international human rights standards is not limited to harmonization. It requires a review of regulations, decisions, and policies implemented by the authorities. While some laws and decisions are adequate, they are poorly executed, leading to a deteriorating health situation despite the presence of legal text. The same applies to the health budget. The more efficient the financial administration is in managing the budget allocated to the health sector, the closer this budget is to realizing the right to health.

Based on interviews with experts, most rights-holders do not see health as a right. The legal understanding stops at the right to obtain services, the availability of facilities and medicines, and guaranteed coverage of all health ailments on the individual, family, and community levels. This type of understanding leads to seasonal practices, random enrollment in the government's health insurance, and multiple and duplicate use of health facilities.

There is still no clear description of the right to health and HRBA. Moreover, while accountability for failure to achieve the right is addressed by national human rights organizations, there is no committee specialized in monitoring and tracking the right to health in a holistic sense outside the scope of health or medical services.

When it first assumed management of daily life in PNA territories, the PLO established the Higher Council for Health, which developed a guide on patient rights emphasizing that access to healthcare must be safe and dignified. Despite the guide's pertinence, it remains the only document addressing the health rights of citizens.

COMMUNITY PLANNING AND PARTICIPATION

Since its establishment, the PNA has developed several strategic health plans [1]. They focused on building the health system and ensuring services to all Palestinians fairly and comprehensively. In 2019, the Council of Ministers mandated a National Health Committee to develop a health plan between 2019 and 2030. The plan addressed the right to health, the significance of social determinants of health, and the services that guarantee access to this right[2]. The strategic plan and health reports cover a broad range of issues, such as maternal and child health, sexual and reproductive health, mental health, and chronic and infectious diseases.

Sexual and reproductive health, equivalent to 40% of services, are addressed in detail in a national strategy covering the period between 2018 and 2022 (وزارة الصحة الفلسطينية 2018). Moreover, work is underway on a national strategic plan for children's mental health, and a national strategic plan has recently been issued to reduce suicide and self-harm attempts. The Strategic Health Plan in Palestine is developed through a participatory process that combines various health sectors covering primary, secondary, and tertiary services. These include:

- The government sector, including the Palestinian Ministry of Health, its facilities, and military medical services covering military and security institutions
- NGO sector
- UNRWA
- Private sector

[1] Strategic Health Plan (1994-1999, 1999-2004, 2004-2007, 2007-2010, 2018-2022)
[2] National Health Plan

All the above sectors participate in preparing the strategic plan. However, despite duplication and a high level of lack of coordination in service provision, there are various forms of integration between the public, NGO, and private sectors:

- Healthcare NGOs and CSOs coordinate with the Ministry of Health through joint facilities where the programs are harmonious and integrated. This mechanism was successful in several Palestinian areas and provided adequate services, particularly in marginalized areas.
- NGOs also work jointly with the Ministry of Health to provide healthcare services within a network of mobile clinics for remote communities. This network helps facilitate access to essential health services in areas threatened with removal and forced displacement, strengthening their steadfastness.
- The Ministry collaborates with the NGO and private sectors in secondary and tertiary healthcare by purchasing services, including through the referral system. This system allows access to health services unavailable in the Ministry's facilities. It acts as a service channel to fulfill the common interests between the two sectors and their users.

Nevertheless, beneficiaries and vulnerable groups are still absent in the planning process and in influencing policies and practices related to fulfilling the right to health. Although the various concerned groups are organized into representative and advocacy groups, their role is limited to the service provision stage, if any.

People with incurable and chronic diseases lack access to services, medicines, and special equipment. Despite several active CSOs advocating and defending their rights, reaching sufficiency remains a significant challenge for patients, institutions, and the health system alike. The coverage of persons with disabilities is a clear example of deprivation. Their representatives are still striving for the recognition of the right of persons with disabilities to obtain fair and comprehensive health insurance.

HEALTH SERVICES TO PERSONS WITH DISABILITIES

The Rights of Persons with Disabilities Law No. 4 of 1999 regulates the lives of persons with disabilities. The law filled a vacuum after years of neglect and the absence of local laws emphasizing their rights. Although the law mentions the right to education, work, and accommodation for persons with disabilities, it remains general and does not go into

detail. It also lacks precise mechanisms and unified standards between service providers and committees entrusted with determining the type and scope of coverage. However, coverage is contingent on a 40% disability rate, determined randomly and without uniformity between regions, leading to deprivation in access to services and privileges. The absence of punitive conditions in the law also lead to flexibility in its implementation, making the rights of persons with disabilities subject to the discretion of ministries, regional bodies, and individuals.

The deprivation faced by persons with disabilities with regard to the right to health is summarized as follows:

- **The right to obtain necessary medication:** Many types of medications needed by persons with disabilities are unavailable in the Ministry of Health's departments. Patients are forced to buy them from outside the Ministry's pharmacies, increasing their burdens and those of their families.
- **The right to obtain equipment:** The government occasionally provides some equipment as gifts or in response to individual appeals. However, community organizations supporting persons with disabilities bear the greatest burden in securing this equipment, including artificial limbs, electric chairs, wheelchairs, and walking devices for polio.
- **Diagnosing and determining disability levels by medical committees:** In determining disability levels, the committees rely on a book dating back to 1965, during the Israeli civil administration. Unfortunately, the book has not been amended to adopt the modified 1997 WHO classification as a basis for determining the type and percentage of disability, despite the significant shift in the concepts of disability and the inclusion of several disabilities that were not known before, such as autism, in addition to the long journey to obtain this classification in terms of costs and physical exhaustion.
- **Obtaining medical consumables:** The health insurance coverage basket does not include medical consumables for people with disabilities, although they are an essential element in rehabilitation, treatment, and engagement in everyday life.

UNIVERSAL HEALTH COVERAGE

Since 2012, Palestine has been committed to universal health coverage, whose methodology and mechanism are centered on the family medicine model. The Palestinian Ministry of Health and its partners use universal health coverage as a compass for planning health programs. As for the family medicine model, significant experience has been accumulated in the UNRWA system at the regional level and certainly in PNA areas. However, implementing the concept on the ground faces the following obstacles:

- Despite political and policy commitment to this principle, there is no precise programmatic analysis regarding its alignment with Palestinian society's demographic and epidemiological reality.
- Monitoring is absent, and there is no clear definition of the basket of services, the distribution of appropriate health facilities, and the mechanism for entitlement to services for the category under coverage.
- Efforts to develop a universal and unified health insurance system faltered.
- Harmony and integration in the provision of health services between the different sectors are absent.
- The scarcity of funding and the inefficient management of resources in the health sector leads to financial obstacles.

Table 7. Health insurance subscription

		Any Insurance (%)	Government Insurance (%)
Area	All Palestine	79.3	75.6
	West Bank	68.9	68.4
	Gaza Strip	94.8	83.4

Location	Urban Population	79.6	75.2
	Rural Population	68.3	84.0
	Camp Population	95.1	68.9
Education	Primary	78.5	76.3
	Secondary	78.7	76.0
	Higher	80.1	75.0
Economic Situation	Poorest	93.4	82.3
	Average	74.5	72.0
	Wealthiest	72.0	65.6

***Health insurance subscription (all forms: government, UNRWA, private)**

Source: Palestinian Central Bureau of Statistics (2021)

The health insurance system in Palestine includes several insurance schemes and segments, which vary according to the provider, the service financier, the basket of services, and the insurer's contribution. According to the Independent Commission for Human Rights, the following health schemes are available in Palestine:

- Governmental health insurance, administered by the Palestinian Ministry of Health
- UNRWA insurance, managed by the agency and benefits registered refugees
- Health insurance affiliated with the military medical services, covering workers in the Palestinian security and military establishment and their families and intersecting with government health insurance
- Private health insurance (2% of the coverage), managed by private insurance companies and adopts a coverage ceiling and a limited basket of services

These schemes cover 79% of Palestinians (Table 6). However, they can barely respond to service needs, suffer from financial inefficiency, and deprive some segments of the population of services. Governmental health insurance covers 64% of citizens, 68% in the West Bank, and 83% in the Gaza Strip. However, out-of-pocket expenditure on health is high at 39%, which is catastrophic and leads to impoverishment, according to WHO definitions. It also points to the need for a clear definition and

fair access to the appropriate basket of services included in government health insurance.

The Palestinian health system, government health insurance in particular, suffers from a low collection level in exchange for a high level of spending on health, amounting to 11% of the GDP. According to Ministry of Health reports, its revenues are a mere 10% of expenditure (وزارة الصحة الفلسطينية a2019). Since the government health coverage basket is open, it includes many high-cost interventions. In addition, the basic list of medicines includes open items that allow the use and purchase of medicines outside the basket based on the recommendations of service providers, leading to inflated spending and increased lack of justice and equality in access to health services. The low health insurance revenue is an obstacle to improving services and coverage. However, Palestinian citizens contribute to the national budget through taxes and fees, and they need to see that reflected in health services.

SPENDING ON HEALTH

The Ministry of Health's budget makes up 13% of the PNA's total budget. Per capita spending from this budget is 320 USD per person per year, the highest among countries with similar social and economic levels. However, health spending suffers from challenges related to output, efficacy, and quality of care, the most important of which will be addressed in this part of the report.

FINANCIAL EFFICIENCY (OUT-OF-POCKET SPENDING ON SERVICES)

A set of interrelated indicators provide a description of the right to access services in Palestine: the percentage of citizens enrolled in health insurance (79%), the gap between the revenues of the Ministry of Health (68 million USD) (وزارة الصحة الفلسطينية a2019) and its expenses (714 million USD), and out-of-pocket spending on healthcare (39.5%). The above numbers point to a significant challenge in covering expenditures through revenues. There is a high reliance on donors, and the health budget suffers from a chronic deficit. However, healthcare financing must also be through the various taxes and fees citizens pay.

The financial feasibility of the Palestinian health system requires a detailed study within the framework of its commitment to universal health coverage. This requires working systematically to determine needs based on the demographic reality and epidemiological characteristics. Furthermore, it must define the roles and contributions of the different sectors in providing services according to specialization and capacity. Finally, the use of financial resources must be rationed effectively and sustainably.

Spending on referrals is high, as is the number of referrals outside the Ministry of Health facilities. In 2019, the cost of health services from outside the Ministry of Health facilities was estimated at 264 million USD (وزارة الصحة الفلسطينية 2019b), equivalent to 35% of the Ministry's total budget. Although the Ministry succeeded in localizing health services to a large extent, spending on referrals has gone mainly to Palestinian health institutions outside the Ministry's facilities. Due to the high level of spending, this aspect requires consideration of

its sustainability, fairness, and adherence to the best care protocols. As in the above paragraph, spending on purchasing services from outside the Ministry's facilities must be in accordance with rights, eligibility, and financial efficiency. With regards to access to referrals for those in Gaza, although 40% of the population lives in Gaza, they only benefited from 13% of medical referrals in 2021.[3]

Table 8. Number of referrals to purchase services outside the Ministry of Health facilities between 2011 and 2021

Year	Number of Referrals
2011	56468
2012	56076
2013	61635
2014	74683
2015	87620
2016	91927
2017	94939
2018	109818
2019	104881
2020	80020
2021	99064

[3] International Cooperation & Projects General Directorate, Gaza, December 2022

QUALITY OF HEALTH SERVICES

The Palestinian health system achieved a qualitative leap under the PNA due to the sincere work of the national health staff in the harshest conditions. Several indicators are close to the levels in developed countries. However, the quality of services in Palestine remains an obstacle to achieving the right to health and well-being according to citizens' potential, expertise, and expectations. Deficiencies in the quality of healthcare can be summarized as follows:

- The rates of mortality and complications associated with healthcare are unreasonably high. In 2021, the Maternal Mortality Committee reported that the maternal mortality rate in Palestine was 47 deaths per 100,000 live births, a significant increase from 15 deaths in 2017. The latest report indicates that 80% of maternal deaths were preventable (وزارة الصحة الفلسطينية 2022). However, despite the tendency to attribute the rise to COVID-19, the steady increase began in 2017, three years before the pandemic. Thus, the actual reason for the rise could be associated with the deterioration of maternal mortality surveilance and response systems at the national level.
- Medical errors are prevalent due to the lack of standardized operations procedures and best practice protcocols adoption and the lack of learning processes to advance the quality of healthcare. Instead, medical errors and adverse incidents are largely addressed through a penal legal framework that does not foster the question of quality improvement and system strengthenning. The Ministry of Health, the Physician's Syndicate, and the private hospital network adopted a Decree-Law No. 31 of 2018 under the auspices of the Council of Ministers. The law addressed medical and health protection and safety from the medico-legal point of view, but was not implemented due to the absence of an insurance system for health worker practice.
- Multiple utilization of health services (or decribed as shopping for healthcare) is prevalent due to lack of harmony and coordination among health service providers and the country's health insurance schemes, without an added value to the quality of outputs. For example, the average number of pregnancy visits per pregnant woman per pregnancy

is 7.7, compared to the scientific recommendation of four visits. In addition, 60% of emergency visits could have been handled within healthcare facilities, indicating a clear gap for both facilities and users.

- Early detection, confirmation of diagnosis, treatment and post-treatment support for the most dangerous and burdensome diseases, such as cancer, are incomplete. For example, reports indicate that 70% of breast cancer cases are detected in the third or fourth stages of the disease leaving little space for cure or effective treatment.

The above points indicate the need to focus on healthcare quality as one of the pillars of realizing the right to health. However, its negative impact on people's confidence in the healthcare system causes a financial burden that affects the system and impedes its development.

MAIN CONCLUSIONS

The Israeli military occupation is the primary determinant impacting Palestinians' right to health. The occupation's policies and practices represent a threat to the right to life, first and foremost, and impact other determinants related to access to services, their quality, and adequacy. Therefore, ending the occupation is the priority for realizing Palestinians' right to health.

Several attempts were made to cover the social and economic determinants associated with the right to health in Palestine. However, the right to health at the legislative, institutional, and societal levels is defined as the right to access health services . Palestinian legislative documents and the Palestinian Basic Law lack clear articles and clauses regarding the right to health. Within the frame of service provision, there is a gap and an opportunity for wider definition of this right to include social, environmental and economic determinants. Within the frame of universal health coverage, there is an opportunity to both improve the definition and better articulate the right to health within the wider scope at the policy and practice levels.

Achieving the right to health in Palestine is a highly complicated endeavor. The elements of neoliberalism, political reality, and the multi-faceted emergency significantly obstruct access to this right. Although it was impossible to look into the role of international institutions, the decline in a set of health indicators related to some of their missions, mandates and programs indicates the need to review this role and put it in its proper framework and direction.

The division between the Gaza Strip and the West Bank poses a serious challenge to Palestine's political and institutional situation. However, despite its negative impact on the national health system's performance, it cannot be seen in isolation from the embargo imposed on Gaza.

The Palestinian health system is multisectoral and serves a relatively small population of 5 million people. However, the fragmentation of services and the multiplicity of policies and interests impede the realization of the right to health and thus lead to the loss of meaningful opportunities for justice and development.

Significant differences exist in the distribution of services between geographic regions and societal groups. Persons with disabilities suffer from an apparent deprivation in obtaining the right to health and the privileges that take into account their health and dignity.

Out-of-pocket spending on health, which amounts to around 40%, is a clear indicator of the state of inadequacy and deprivation with regard to coverage, justice, and universal access to health services. Although this indicator reaches higher levels in some Arab countries, the nature of Palestinian society, the multiplicity of healthcare sectors, and the distribution of utilities require out-of-pocket spending that is caused by system deficiencies or collateral expenses on transportation and medications outside the essential list. Here, the health sector's economic (actuarial) management efficiency requires a more in-depth study.

The maternal mortality rate is a comprehensive indicator that reflects the performance of health systems in different countries. The doubling of the maternal mortality rate in Palestine during the last five years is evidence of a systematic challenge. All relevant local and international players must be taken into consideration. While the current report did not look into the performance of international institutions, an in-depth study is necessary.

Governance of the health system requires a comprehensive and detailed discussion. Health services must be localized, maximizing integration and copmplementarity among care sectors, increasing the efficiency of health spending and coverage within a comprehensive and fair national health insurance system, and improving the quality of each health service. Within the current report, systemic governance is a prerequisite for realizing the right to health. However, efforts in this regard are still in the planning stage.

RECOMMENDATIONS

The Israeli occupation is responsible for the deterioration of health status and services in Palestine. As long as the occupation remains, the occupying power must respect international covenants and international humanitarian law in this context.

Bearing in mind the confines of the Israeli occupation, the Palestinian government, in general, and the Ministry of Health, in particular, are the duty-bearers concerning the right to health. Accordingly, the government and the Ministry must assume legal and moral responsibility for the lives of Palestinian citizens and ensure access to high-quality healthcare that guarantees their lives and dignified access to services.

In particular, the following recommendations would serve to realize the right to health in Palestine:

1. End the occupation and pressure the occupation government to stop its practices against Palestinian citizens and the Palestinian health system. In addition, the embargo on Gaza must be lifted to ensure access to health services.
2. Work on the adequate and faithful application of the national health system, which requires that executive authorities put in place decisions, bylaws, systems, instructions, and all other executive procedures for these texts.
3. Develop the public health legal system in line with global and national developments in this regard, particularly in relation to the 17 sustainable development goals (SDGs) and the State of Palestine's accession to the International Covenant on Economic, Social and Cultural Rights in 2014 and its obligations to reconcile the conditions of its health legislation according to the covenant.
4. Amend the Public Health Law to guarantee the right to access health services through a national plan based on localizing healthcare and strengthening partnerships between providers.
5. Implement a universal health insurance system based on citizens' rights to a basket of services that covers their needs and prevents the financial burden of out-of-pocket spending.

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