Country Cooperation Strategy for WHO and the Occupied Palestinian Territory 2006–2008

World Health Organization
Regional Office for the Eastern Mediterranean

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Contents

Abbreviations

AGFUND	Arab Gulf Programme for United Nations Development Organizations
AHLC	Ad Hoc Liaison Committee
CAP	Consolidated Appeal Process
CCS	Country Cooperation Strategy
CEHA	Centre for Environmental Health Activities
DFID	UK Department for International Development
DPT	Diphtheria, pertussis and tetanus
ECHO	Humanitarian Aid Office of the European Commission
GDP	Gross Domestic Product
GHI	Government Health Insurance
HAC	Health Action in Crisis
HI	Health Inforum
HSR	Health sector review
ICESCR	International Covenant on Economic, Social and Cultural Rights
IDF	Israeli Defence Forces
IDP	Internally Displaced Person
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant mortality rate
JPRM	Joint Programme Review and Planning Mission
LACC	Local Aid Coordination Committee
MCH	Maternal and Child Health
MMR	Measles, mumps and rubella
OCG	Operations Coordination Group
OCHA	Office for the Coordination of Humanitarian Affairs
OHCHR	Office of the High Commissioner for Human Rights
oPt	occupied Palestinian territory
PCBS	Palestinian Central Bureau of Statistics
PHC	Primary health care
PLO	Palestinian Liberation Organization
UN	United Nations
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief and Works Agency for Palestinian Refugees in the Near East
UNSCO	Office of the United Nations Special Coordinator in the Occupied Territories
UNSECOORD	United Nations Security Coordinator
UPMRC	Union of Palestinian Medical Relief Committees
USAID	United States Agency for International Development
WHA	World Health Assembly
WHO	World Health Organization

Executive Summary

The political momentum witnessed since the beginning of 2005 has provided a turning point in a previously static political environment. The election of President Abbas, the Sharm al Sheikh Summit (February 2005), a 'period of calm' announced by Palestinian militant groups combined with the decrease of military activity from Israel and the disengagement (although unilateral) opened a new window of opportunity for settlement of the Palestinian–Israeli conflict.

Running in parallel, the Palestinian Authority initiated its first three year Medium-Term Development Plan for 2006–2008 and the arrival of James Wolfensohn as Special Envoy of the Quartet on Gaza Disengagement resulted in the pledging by donors of up to three billion US dollars to the recovery effort over a period of three years. These developments appear to suggest that the occupied Palestinian territory (oPt) is at a new juncture.

The lack of contiguity between Gaza and West Bank and the lack of free movement within the West Bank have severely affected the socioeconomic conditions of the Palestinians since the eruption of the second *intifada* in 2000. GDP per capita declined by 40%, unemployment increased from 10% to 30% and the population living below the poverty line increased from 21% to 60%.

Palestinians currently have relatively stable health status indicators, but with worrying trends: life expectancy is 72 years, the fertility rate is 4.6, infant mortality rate is 24.2 per 1000 live births and iron deficiency anaemia affects one fourth of children under 5 years and one third of women of child-bearing age. Chronic malnutrition is slowly increasing as well as dietary-related chronic diseases, and mental health is an increasing concern due to everyday life stressors (movement restrictions, feeling of insecurity).

In the years following the Oslo Accord, the oPt received an enormous amount of donor assistance, reaching US$ 300 per capita in recent years. Until 2000, most donor support was in the form of development aid. Near the end of 2000, however, most donors shifted their development programmes into emergency aid. In 2004 international aid disbursed to the health sector was US$ 66.1 million, representing 6.3% of the total disbursed, an increase from 3.2% in 2002 and 4.3% in 2003.

WHO has operated in the oPt through two main bodies: the Regional Office for the Eastern Mediterranean and the WHO headquarters West Bank and Gaza office. In addition WHO has been also working in agreement with UNRWA for the Palestinian refugees. A process of integration between the WHO presences started a few years ago and during 2005 became really operational.

WHO's mission in oPt is to promote the health of all Palestinian people by improving health sector performance based on equity, effectiveness and sustainability, as well as by addressing the broader social, economic, environmental and cultural health determinants, particularly those which are most affected by the Israeli–Palestinian conflict. Four main strategic directions: coordination, health policy and information, technical support and

advocacy, are identified as leading towards a comprehensive public health approach based on the right to health, vulnerability and socioeconomic determinants, with a long-term perspective, while keeping ready to respond to the potential re-emergence of acute crisis.

Section 1. Introduction

The political momentum witnessed since the beginning of 2005 has provided a turning point in a previously static political environment. The election of President Abbas, the Sharm al Sheikh Summit (February 2005), a 'period of calm' announced by Palestinian militant groups and decrease of military activity and Israel's disengagement (although unilateral) of settlers and military infrastructure from within the Gaza Strip and parts of the northern West Bank opened a new window of opportunity for settlement of the Palestinian–Israeli conflict.

Running in parallel, efforts are under way to move towards a development approach. The Palestinian Authority initiated its first three year Medium-Term Development Plan for 2006–2008. The arrival of James Wolfensohn as Special Envoy of the Quartet on Gaza Disengagement resulted in the pledging by donors of up to three billion US dollars to the recovery effort over a period of three years. After five years during which a humanitarian style response was predominant, these developments appear to suggest that the occupied Palestinian territory (oPt) is at a new juncture.[1]

Historically WHO has operated in the oPt through two channels. One is through the WHO West Bank and Gaza office (main office in Jerusalem, sub-office in Gaza). This office was established in 1994 by a Special Technical Assistance Programme, and has been directly dependent on the Department of Health Action in Crisis (HAC) at WHO headquarters, and has been reliant on extrabudgetary support from donors. The other channel is through the support of the Regional Office for the Eastern Mediterranean to the Palestinian Ministry of Health, where planning of activities is undertaken, as for the other countries of the Region, through the exercise of a biennial Joint Programme Review and Planning Mission (JPRM). In addition WHO has been also working in agreement with United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNRWA).

A process of integration between the two channels started a few years ago but only during 2005 became really operational. The main goal of this process has been to work for one 2006–2007 WHO plan for oPt, with the two integrated components.

The Country Cooperation Strategy (CCS) exercise for oPt took place at a very appropriate time with regard to strengthening WHO commitment and presence, and took into consideration internal and external factors. The joint effort between WHO headquarters and the Regional and Country Offices in a changing context, enabled reflection, insight and suggestions into creating more solid, stable and far-sighted WHO presence. At the end of 2003 informal discussions within WHO West Bank and Gaza identified the main strategic directions for WHO in oPt and oriented its interventions during the past two years. That collective reflection represented an important starting point for the CCS exercise. Through

[1] However from a humanitarian perspective, while progress on the political front is understood as the only means to alleviate poverty and suffering, the above-mentioned steps do little in themselves to alter the root causes of the humanitarian situation and its symptoms. The structural constraints related to Israel's occupation of the oPt remain–Israel's permit and closure system regulating movement of people and goods, ongoing settlement and bypass road construction, and control over water and water resources. The humanitarian situation cannot improve unless Palestinians have significantly better access both to other areas within the oPt and to other countries on oPt's borders, particularly Israel. (UN OCHA CAP 2006).

analysis of past experience, difficulties and achievements, the WHO commitment and intervention should be revised and strengthened in order to better deal with the present and future challenges.

Section 2. Country health and development challenges

2.1 Socioeconomic and geopolitical profile

OPt comprises two areas–Gaza Strip and West Bank–with a total population of 3.7 million. Gaza Strip is a narrow zone of land along the Mediterranean Sea where 1.34 million people live in an area of 362 km^2. It has one of the highest population densities in the world. West Bank is a hilly area where 2.36 million people live in an area of 5634 km^2. Refugees number 1.5 million, comprising 32% of the total population of West Bank and 71% of the total population of Gaza Strip (see Annex 3).

The Palestinian Authority (PA) was established in 1994 after the signature of the Oslo Agreement. It is a parliamentary system with three distinctive powers: Legislative, Executive and Judiciary. The Legislative Council with elected members conducts legislative practices. The President is the head of the state and is directly elected from the oPt population. The President, with the agreement of the Legislative Council, nominates the Prime Minister. The territory is administratively divided into 15 provinces: 10 in West Bank and 5 in Gaza.

The eruption of the second *intifada* in September 2000 and the increase in Israeli military action had a dramatic effect. It resulted in weakening the capacity of the Palestinian Authority and the destruction of public infrastructure. From 2000 to 2004, the GDP per capita declined by almost 40%. The unemployment rate increased from 10% to 30% and living standards have been severely compromised. In 2000, 21% of the population were living below the poverty line of US$ 2.1 a day: today, more than 60% are living at that level. Taking into account population growth, this means that the number of poor has tripled, from 650 000 to 1 900 000.[2]

The unilateral 'disengagement' of Israel from Gaza has given both hope and uncertainty regarding the future of Gaza and of a Palestinian State. The lack of territorial contiguity between West Bank and Gaza, the continued construction of the Separation Barrier and the system of closures in West Bank will further limit socioeconomic recovery in the short term. In the medium and long term, a lot will depend on the progress in ensuring a secure environment and building a viable framework for socioeconomic recovery: this includes structures for export and the relaxation of restrictions on the movement of people and goods.

2.2 Health profile

Despite the overall difficulties that Palestinians have faced, their health status is still commendably reasonable. Life expectancy in 2003 was 72.3 years.[3] Maternal mortality ratio and infant mortality rate were respectively 2.1 per 10 000 live births and 24.0 per 1000 live births[4], better than in neighbouring countries of the Region (although insufficient and

[2] World Bank. *Four Years–Intifada, Closures and Palestinian Economic Crisis: an Assessment*, 2004.
[3] Ministry of Health. *Health Status in Palestine, Annual Report 2003*, July 2004

[4] PCBS. *Demographic and Health Survey*, 2004

controversial data on maternal mortality emphasize the need for vigilance on this issue). The outcomes reflect, in part, the efforts of the basic public health and primary care functions. Consequently, oPt has gone through the "epidemiological transition." Noncommunicable diseases are the main causes of death (heart diseases 20.1%; cerebrovascular conditions 11.1% cancer 9%; accidents 8.9%), together with perinatal conditions (9.7%).[3]

Mental health is an increasing concern in oPt. Recent studies have shown that stressors such as the severe restriction on movement and lack of access to education and health care are present in everyday life. One study[5] showed that 52% of those surveyed had thought of ending their life, 92% felt no hope for the future, 100% reported feeling stressed, and 84% expressed feelings of constant anger because of circumstances beyond their control. Feelings of insecurity have also increased in the areas directly affected by the Separation Barrier: 90% compared to 75% in other areas.

Noncommunicable diseases present important public health problems (Table 1). Of the eight leading causes of death, seven are noncommunicable diseases (Table 1). In 2003, 3893 persons died from cardiovascular diseases (2041 males and 1852 females), with a rate of 99.5 per 100 000 population. Accidents have sharply increased as a cause of death: from 9 per 100 000 in 1995 to 24 per 100 000 in 2003. Accident injuries are mainly caused by road accidents: 85% of all injuries in 2003. Other causes of injuries included poisoning, falling, drowning, fire, and intentional "accidents" like firearms, missiles, suicide and homicide.[3]

Iron-deficiency anaemia is the major nutritional problem: over one quarter of children under-five and a third of women of child-bearing age are anaemic.[4] Other micronutrient deficiencies of concern are sub-clinical vitamin A deficiency,[6] rickets and iodine deficiency.[7] Chronic malnutrition (stunting) levels among the under-five children appear to be slowly increasing.[4] Obesity and dietary-related chronic diseases appear to be increasing, particularly in the older age group, and present a major challenge in nutrition.[7]

Table 1. Leading causes of death in oPt

Cause of death	2003
Heart Diseases	20.1%
Carebrovascular diseases	11.1%
Perinatal conditions	9.7%
Cancer	9.0%

[5] Palestinian Counselling Centre. *A study on the psychological implications of Israel's Separation Wall on Palestinians*. 2004.

[6] The MARAM Project. *Prevalence of vitamin A deficiency among children 12 to 59 months of age in the West Bank and Gaza Strip*. 2004.

[7] Ministry of Health, WHO, UNICEF. *The state of nutrition*, *West Bank and Gaza Strip*, 2005.

Accidents	8.9%
Hypertension	4.9%
Diabetes mellitus	4.1%
Renal failure	3.4%

Source: Ministry of Health

The maternal mortality ratio is relatively low: 2.1 per 10 000 live births in 2003.[3] The fertility rate is almost at the same range with neighbouring countries: 3.9 in oPt[4] compared with 3.7 in Jordan and 3.2 in Egypt.[8] This could be due to early marriage and prevailing traditions. Anaemia is an important problem in women.[7] The recent situation has also affected women's health: from 2000 to 2003, 103 women delivered at checkpoints, according to the Ministry of Health.[3]

The infant mortality profile suggests a medium-income country, with the mortality rate among children less than 4 weeks old (neonatal mortality) comprising more than half of the under-5 mortality rate (U5MR).[3] The infant mortality rate (IMR) and U5MR are relatively low, 24.2 and 28.5 per 1000 live births in 2003.[4] In terms of trends, the IMR has been very slightly decreasing since 1996.[4,9] However, there is an important imbalance between West Bank and Gaza, IMR being 30% higher in Gaza (30.2 per 1000) than West Bank (20 per 1000). The situation in Gaza is actually deteriorating and mortality figures have increased by 15% in comparison with the pre-*intifada* level.[4,9]

With regard to causes of death, it is to be highlighted that prematurity and low birth-weight alone made up for 27% of all reported deaths among 0–19 year olds and 41% of all reported infant deaths in 2003.[3]

Communicable diseases in total account for 10% of all deaths only. Among them, pneumonia and other respiratory infections, particularly among children, represent the highest specific death rate. The immunization coverage is very high: more than 95% for DPT, HepB and MMR.[3]

Viral hepatitis A, B, C are endemic in oPt. Brucellosis, which was a serious problem a few years ago, is under control, falling from 32 per 100 000 in 1998 to 4 in 2004.[3] HIV/AIDS is not yet a significant problem. The reported incidence of tuberculosis is low. However, data on communicable diseases remain inaccurate as the surveillance system is still insufficient.

Table 2 indicates current trends.

[8] EMRO, WHO East Mediterranean Region, Country profiles, EMRO website: http://www.emro.who.int/emrinfo/

[9] PCBS. *Demographic and Health Survey*, 1996

Table 2. Selected health indicators and trends in oPt

Indicator	2000	2001	2002	2003
Total population size*	3 150 056	3 298 951	3 464 550	3 737 895
Gaza	36 %	36 %	36 %	37 %
West Bank	64 %	64 %	64 %	64 %
Refugee population*	1 428 891	1 483 394	1 532 589	1 592 189
Gaza	833 043	865 242	893 141	896 943
West Bank	595 848	618 152	63 948	695 246
Life expectancy at birth*	71.8 years	71.82 years	71.8 years	72.3 years
Total fertility rate **	5.9			4.6
Gaza	6.8			5.8
West Bank	5.5			4.1
Crude death rate* (per 1000 population)	3.2	2.8	3.1	2.7
Infant mortality rate** (per 1000 live births)	28.0 (1995–1999)			24.2 (1999–2003)
Gaza	35.1			30.2
West Bank	23.2			20.0
Under 5 mortality rate** (per 1000 live births)	31.0 (1995–1999)			28.3 (1999–2003)
Gaza	40.0			34.8
West Bank	27.6			23.7
Maternal mortality ratio* (per 100 000 live births)	37.3 (1997)	18.6	13.8	12.7
Gaza			21.6	21.3
West Bank			7.6	6.7
Low birth weight **	8.6%		12.2%	
Wasting (in children <5)**	1.4%			1.9%
Gaza	1.4%			1.4%
West Bank	1.5%			2.1%
Stunting (in children <5)**	7.5%			9.4%
Gaza	8.3%			11%
West Bank	7.0%			8.6%
HIV/AIDS cumulative prevalence * (per 100 000 population)		1.75	1.75	1.75

Sources:* Ministry of Health ** Palestinian Central Bureau of Statistics

2.3 Health system

2.3.1 Health system organization

The health care system in oPt is complex. There are five major health care providers: Ministry of Health, UNRWA, nongovernmental organizations, private sector, and hospitals outside oPt. The Ministry of Health is the main health care provider. It provides primary, secondary and tertiary care and purchases the unavailable tertiary health care domestically and providers from abroad. UNRWA provides mainly primary health care services to the refugee population, and purchases secondary and tertiary care services when needed. The nongovernmental organization sector is extensive: from missionary hospitals, to facilities

supported by international organizations, to community health centres. The private for-profit health sector also provides the three levels of care through a wide range of practices. Reliable data on the private health sector is however lacking. The fifth group of providers are hospitals outside the territory: in Jordan, Egypt and Israel. Referral abroad, particularly to Israeli health facilities, was seriously affected in recent years.

The health care system, in addition to the complexity described, is further fragmented by the lack of access, or right to health, in oPt. The continuously volatile situation has resulted in depriving the Palestinian people of access to essential services, including health services. The UN Commission on Human Rights issued a resolution in 2005 regarding Israel's violation of human rights in oPt and, among other things, requested the UN High Commissioner for Human Rights to address the issue of Palestinian pregnant women giving birth at checkpoints owing to denial of access by Israel to hospitals.

2.3.2 Governance

The Ministry of Health is the principal organization for ensuring a well-governed health system. Its main roles are: health care provision; regulation and legislation; human resource development; public health activities; surveillance; and financing through insurance.[10] The Ministry of Health has its headquarters in Gaza, and has parallel administrative structures in West Bank and Gaza. Together with international partners, it has been reviewing its role: from traditional care provider to care regulator and financer (or purchaser).

Although good progress has been observed, particularly in the expansion of public health services, there are certain shortcomings. The Ministry of Health's capacity in developing health policy is limited: a mid-term national health plan is not yet developed although the previous plan expired in 2003. The regulatory function is also limited: for instance there is virtually no regulation or licensing of the private health sector. Coordination capacity, particularly for international partners, is weak. Moreover, coordination and communication within the Ministry of Health, particularly between West Bank and Gaza is not always smooth.

2.3.3 Health care financing[11]

The per capita health expenditure in oPt was US$ 138 in 2003, which corresponded to 13% of the GDP.[12] This is lower than in some neighbouring countries, such as Jordan (US$ 163) and Lebanon (US$ 510), but higher than in Egypt (US$ 66).[13] In terms of source of funding, data from 2002 indicate that 15% of funds are from the Palestinian Authority, 37%

[10] Palestinian National Authority, Ministry of Health. National Strategic Health Plan 1999–2003.

[11] Note: Some inconsistencies among the reported data can be explained by differences in information sources and years of reference.

[12] PCBS. Press conference on the initial survey results: Health expenditure survey, 2004.

[13] WHO. *World health Report*, 2004

from direct patient payment (including premiums and fees), and 48% from external donors.[14] The total expenditure of the Ministry of Health in 2003 was US$ 98.4 millions.[3] The Ministry of Health budget has expanded rapidly in the last 10 years as its employees increased from 4700 to more than 9000. The very high degree of dependence on external donations (i.e. 48% of total health expenditure) raises obvious concern about long-term sustainability. A national health account study has yet to be undertaken in oPt.

The Government Health Insurance (GHI) covered 56% of all families (i.e. 75% of the total population) in 2004. This includes government employees, workers in Israel, and those covered by the Ministry of Social Welfare for economic support. GHI is however not a full-fledged social health insurance. Instead its collections are simply credited to the Ministry of Health budget, and its members are eligible for free care at the Ministry of Health facilities. The target is to have universal coverage. However in light of the economic hardships and the high degree of external aid, extensive review of the GHI system is needed.

2.3.4 Health care delivery

The network of PHC centres and hospitals has been considerably developed in oPt. The total number of PHC centres was 630 in 2004: 511 in West Bank and 119 in Gaza. This includes: 394 established by the Ministry of Health (62%), 54 by UNRWA (9%), and 182 by nongovernmental organizations (29%). There are 80 hospitals (57 in West Bank and 23 in Gaza). In total, 5654 hospital beds are available, with a ratio of 15.1 beds per 10 000 inhabitants. This rate is among the lowest in the region, if compared with Egypt (21 per 10 000), Jordan (18 per 10 000) and the Syrian Arab Republic (14 per 10 000). The Ministry of Health owns 51% of the beds, nongovernmental organizations 39%, private sector 9% and UNRWA 1%.[15]

Hospital utilization is reasonably high in the Ministry of Health hospitals (81%), but low in nongovernmental organization and private hospitals (38%) and maternity hospitals (36%) in West Bank. Data on utilization of PHC centres and clinics are incomplete: particularly, no data on the utilization of private clinics are available. For the Ministry of Health and UNRWA clinics, utilization of PHC health services significantly increased between 2000 and 2001 while between 2001 and 2003 it only increased at UNRWA facilities and remained stable at the Ministry of Health PHC centres.[3,16] The latest data show an almost 10% decrease in UNRWA utilization in 2004.[17] Health care delivery is carried out quite independently in West Bank and in Gaza, not in a unified standardized manner. Information on quality of care is limited. However, anecdotal evidence indicates the overall poor quality of care in oPt.

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[14] Health Sector Review, EC / HERA. October, 2003.

[15] WHO, MoH, Health Facilities Network Database, August 2004

[16] UNRWA, Annual Report of the Department of Health, 2002-3-4

2.3.5 Human resources

Accurate information on the health workforce, particularly those exclusively working in the private sector, is not available. Excluding the private sector, the total health sector workforce was estimated at 16 935 in 2003 (Table 3) and 19 198 in 2004. The Ministry of Health is the major employer: 54% of personnel in 2003 and 58% in 2004.[3,18] The ratios of health personnel to population increased significantly following the establishment of training programmes at Palestinian universities: physicians per 10 000 population increased from 8.3 in 2003 to 9.6 in 2004; nurses from 13.1 to 14.1.[3,18]

However, these ratios are still lower than neighbouring countries. Moreover, distribution of health personnel is not well balanced among provinces. There is also a serious shortage of medical specialists (e.g. cardiac surgery, oncology, etc.), qualified nurses and midwives, and public health sub-specialists. Moreover, the lack of incentives for health personnel, deficiencies in training opportunities and in licensing, and uneven accreditation undermine human resource management and development in oPt.

2.3.6 Health information

Two main parties collect health-related data: the Palestinian Central Bureau of Statistics (PCBS) and the Ministry of Health. PCBS maintains the vital statistics and conducts epidemiological monitoring surveys. The Ministry of Health collects population and clinic-based data, and publishes the annual report Health Status in Palestine. In collaboration with the World Bank and other partners, it has been developing the health management information system. Still, the area of health information has much room for improvement. The system is not fully comprehensive or integrated. Quality of data collection is questionable. Data analysis capacity at central level is still insufficient. The data have scarcely supported national planning efforts, policy development, research and evaluation.

Table 3. Health sector workforce by category of personnel and provider/employer in 2003

	Ministry of Health	Nongovernmental organizations	Police and General Security Medical Services	UNRWA	Total
Physician	1722	976	253	142	3093
Nurse/midwife	2917	1916	200	446	5479
Paramedical	910	1199	243	259	2611
Pharmacist	254	37	36	2	329
Dentist	134	81	51	27	293
Administration	3064	1385	276	257	4982
Others	68	38	18	24	124
Total (%)	9069 (54%)	5632 (33%)	1077 (6%)	1157 (7%)	16935 (100%)

[17] UNRWA. Annual Report of the Department of Health, 2005.

[18] Ministry of Health. Press release of the Health Status in Palestine, Ministry of Health Annual Report 2004, 2005.

Source: Ministry of Health, Annual Report, 2004.

Health Inforum (HI), an innovative tool to improve health information flow, was created in 2002 by WHO, Italian Cooperation and USAID (currently it is a WHO project co-funded by USAID) to function as an information clearinghouse, particularly for emergencies. HI has gradually included a wider perspective in health events, and organizes and supports coordination meetings and other activities. In addition to HI, there are several activities to strengthen the oPt health information system. Nevertheless, greater integration and coordination, as well as improvement of the quality of the information system, are much needed.

2.4 Health sector response

The Ministry of Health, in collaboration with national and international partners, is currently formulating the multi-year national strategic plan on health. The previous plan, developed for the period of 1999 to 2003, was only partially implemented due to the deteriorating general situation after the *intifada* started. The previous plan defined the national vision for health, roles of the Ministry of Health, and national strategic objectives. It was, in general, based on the traditional view of a Ministry of Health that provides and purchases health services, regulates and licenses activities, etc.

In the preparation of the new multi-year national strategic plan on health, there have been discussions about the role of the Ministry of Health: whether it should remain a service provider and purchaser, or become a service purchaser (mainly) and service regulator. The debate has not yet reached a conclusion, and this is one reason why the Ministry of Health has not developed a new strategic plan. The national policy on decentralization, recently developed, has further complicated the debate. Nevertheless, this delay in developing a new strategic plan on health clearly indicates the limited capacity of the Ministry of Health in health policy development.

Yet, the Ministry of Health has been working on a mid-term vision and strategy, particularly within the Health Sector Review process which has been developed during the past three years with the support of some international partners (European Commission, World Bank, Italian Cooperation, Department for International Development and WHO). The Ministry of Health recently discussed the creation of a unit for Health Policy and Planning, which is expected to focus on the development of the new multi-year strategic plan. The development of a mid-term plan that would define the strategic directions and identify priorities will remain critical for effective health sector response.

Section 3. External assistance and partnerships: aid flows, instruments and coordination

3.1 Development and humanitarian assistance for all sectors including health[19]

3.1.1 Aid disbursement

In the years following the Oslo Accord (1993), the oPt received an enormous amount of donor assistance, averaging over US$ 200 per capita per year during 1995–1999[20] and reaching US$ 300 in recent years.[21] This amount was many times the level of official assistance to lower and middle income countries or to other countries in the Region.

The three top donors, USAID, European Commission and the League of Arab States, accounted for 60% of total disbursements in 2003, excluding support to the UNRWA regular budget (Table 4).

Table 4. Donor disbursements to oPt in 2002–2003 (US$ million)

Country	2002	Country	2003
League of Arab States	316	USAID	224
European Commission	217	European Commission	187
USAID	194	League of Arab States	124
Norway	44	Norway	53
World Bank	37	World Bank	50
Italy	32	UK	43
Germany	21	Italy	40
Denmark	18	Sweden	32
Sweden	16	Germany	27
Canada	14	Spain	17
Others	117	others	94
Total	**1026**		**891**
Share of top 3 donors (%)	70	Share of top 3 donors (%)	60

Source: World Bank. *Four years–Intifada, closures and Palestinian economic crisis: an assessment*, 2004
Note: Figures do not include support to UNRWA regular budget and Islamic Development Bank contribution

[19] Reliable data on international aid in oPt are not available. The main sources of data on aid currently available are the World Bank and the Ministry of Planning, and are those used for this chapter. The data on general aid (paragraph 3.1.1) are mainly taken from the World Bank, while those on the health sector (paragraph 3.1.2) are mainly from the Ministry of Planning. Several major inconsistencies are evident between these two sources.

[20] World Bank, *West Bank and Gaza: An evaluation of Bank assistance*, 2002.

[21] World Bank, *Disengagement, the Palestinian economy and the settlements*, June 2004.

3.1.2 Emergency versus development aid in all sectors including health

The initial framework for assistance to oPt was articulated in the Emergency Assistance Programme for the Occupied Territories (EAP) in 1993. The EAP anticipated that for the first three years (1994–96) about 75% of assistance would be for investment projects; about 20%, or US$ 225 million, would be for start-up and recurrent expenditures, and the remainder for technical assistance and training. In fact, until 2000, most donor support was in the form of development aid, mainly in areas of institution-building and reconstruction (Figure 1). Towards the end of 2000, however, most donors shifted their development programmes to emergency support[2] with the acknowledgement that this shift could have a negative impact on the efforts devoted to institutional building and structural reform. This shift in funding direction clearly coincides with the first months of the second *intifada,* when casualties and fatalities mounted sharply and the system faced difficulties in coping with the situation. In 2002, donor disbursements reached US$ 1026 million, with over 89% of this as humanitarian assistance and budget support.[22]

In 2003, donors committed US$ 1404 million, of which US$ 323 million were for development support, with a sharp increase from 2002. The total disbursed was US$ 891 million, with a 14% decrease from the 2002 level.

Donor spending on budget support dropped from 45% of total disbursement in 2002 to 30% in 2003. In 2003, an amount of US$ 264 million was disbursed for humanitarian and emergency assistance, representing a drop of 28% compared with 2002.[2] The European Commission provided the largest contribution to humanitarian assistance, which accounted for 43% of total humanitarian assistance (US$ 130 million). USAID took the lead in development spending, contributing 40% of development disbursements in 2003 (US$ 130 million).

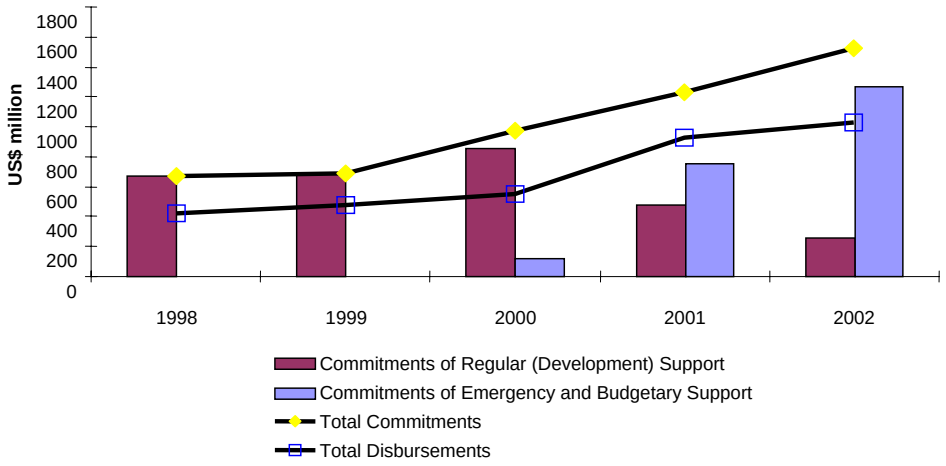

Figure 1. Donor commitments and disbursements, 1998–2002

[22] Palestinian National Authority, Ministry of Planning. *Donors assistance in the occupied Palestinian territory for year 2003 with projections for 2004 and update on funding status for the SESP*, June 2004.

3.1.3 Aid to the health sector

According to the Ministry of Planning database, in 2004 international aid disbursed to the health sector was US$ 66.1 million. Out of the total disbursed, the proportion of aid to the health sector has been increasing during the past three years, representing 3.2% of the total in 2002, 4.3% in 2003 and 6.3% in 2004. Among the financial support that UN agencies received or secured for 2005 (US$ 351 million), about 10% is for the health sector, while 28% is for food, and 35% for education.[23]

In recent years, the main donors for the health sector were USAID, European Commission, Islamic Development Bank, World Bank, Japan and Italy. According to the World Bank, donors doubled their contributions to Ministry of Health non-salary operating costs in 2002, meeting 87% of requirements.[24]

The need to integrate humanitarian and emergency aid into sound and constructive sectoral planning (e.g. through the Mid Term Development Plan produced by the Ministry of Planning with the collaboration of the other Ministries) is becoming a priority. As explained in 3.2 below, there are coordination mechanisms that would allow for such an integration if properly developed.

3.2 Aid coordination mechanisms

3.2.1 Donor coordination

Aid coordination in oPt represents a challenging task: over 40 official donors are active, aid flows are high, and the general situation is volatile. International assistance has been closely tied to the peace process and has been delivered in the absence of a sovereign state while critical political, economic and security issues have remained unresolved. The Palestinian Authority is highly dependent on foreign aid but has had limited capacity to manage it. Donors have strong (and often competing) strategic and/or economic interests and bilateralism is pervasive.

The aid coordination process started after the Oslo Accords with the development of a set of arrangements in oPt. The Steering Committee, Ad hoc Liaison Committee (AHLC) and Consultative Group were international bodies from which the Local Aid Coordination Committee (LACC) was formed (see Figure 2). It is a country-level body that deals with aid coordination matters on the ground. It comprises major donors, is chaired jointly by the World Bank, UNSCO and Norway, deals with high level political and economic matters, operates by consensus, provides regular coordination at the operational level to direct donor assistance towards Palestinian Authority priorities and fosters information exchange.

[23] UNSCO. Quartet Special Envoy matrices as at August 2005.

[24] World Bank. *Twenty-seven months–Intifada, closures and Palestinian economic crisis: an assessment*, 2003.

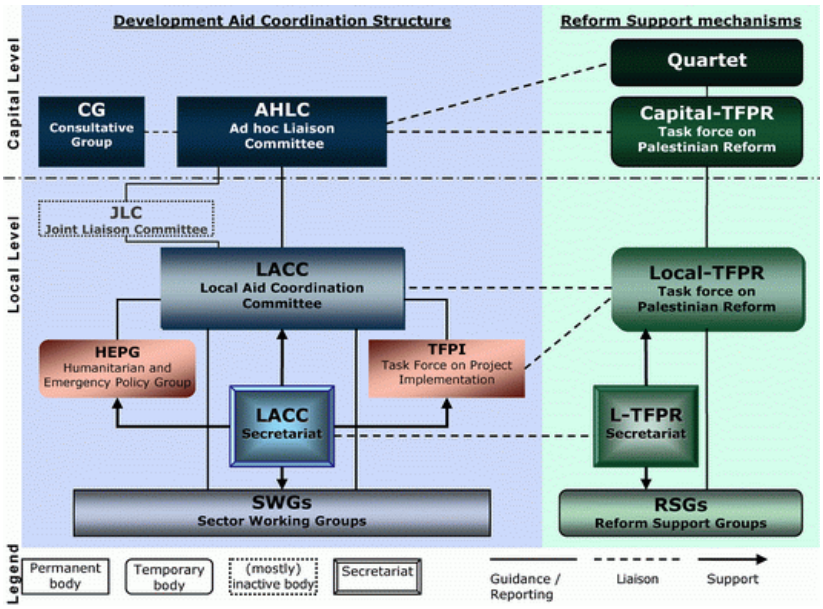

Figure 2. Donor coordination structure

Studies on aid coordination have stressed the fundamental importance of ownership[25]. This is particularly crucial in oPt where, due to the initial absence of the Palestinian Authority on the ground in the early years, coordination was entirely donor-led. Once the ministries were established, logistical problems (e.g. West Bank and Gaza separation and access) emerged for coordination. Donor/Palestinian Authority disagreements and inter-ministerial competition and rivalries within the Palestinian Authority complicate the task.

In addition, donors have supported numerous nongovernmental organizations active in service delivery and several quasi-autonomous implementing agencies. The Palestinian Authority has noted, with some frustration, its inability to set development priorities in the face of donor preferences and lack of coordination within the Palestinian Authority: both donors and agencies select projects that coincide with their own priorities, sometimes leaving the Palestinian Authority's "top of the list" unfunded.

In mid 2003, after the change in Cabinet, the Palestinian Authority promoted a debate concerning reform of the aid coordination mechanism. The Ministry of Planning, which has taken the lead role, identified the main obstacles in the aid coordination process as: lack of coordination between ministries, especially the Ministry of Planning and Ministry of Finance; lack of capacity in coordination and management of aid; unclear role of Ministry of Planning; inadequate database to facilitate coordination; and unclear development policies and priorities. A new format was adopted also taking into consideration specific critical analysis on the subject (see for instance the Mokoro study[26]). The main objectives of reshaping the coordination tools are to provide more ownership to the Palestinian Authority, improve intersectoral links and create a more effective and efficient structure.

[25]World Bank. *Review of aid coordination and the role of the World Bank*, November l999.

[26] Listers S and Le More A. *Aid management and coordination during the Intifada. Report to the LACC co-chairs*. Mokoro, July 2003.

During 2005, a shift towards a medium-term planning perspective emerged. The Palestinian Authority's Ministry of Planning issued a draft Medium Term Development Plan setting out multi-annual investment priorities under four broadly defined national programmes[27]. While the UN's annual Consolidated Appeal Process (CAP) has remained a mechanism for responding to immediate needs in the oPt, bilateral donors have increasingly begun to consider longer-term investment options. Several UN agencies took initial steps to return to a more normalized cycle of longer term programming in coordination with the Palestinian Authority. Increasingly, policy dialogue within the international community focused on the need to strengthen the role of the Palestinian Authority in managing and coordinating international aid investments, and to better integrate the Palestinian Authority's aid management and governance efforts.

In 2002, the **Humanitarian and Emergency Policy group** was established in which UN agencies and donors are involved, with the objective of developing and updating a coherent donor strategy for dealing with the current socioeconomic and humanitarian emergency and to consider relevant policy options that donors might want to pursue[28].

A European Union informal **Humanitarian Policy Dialogue Forum** ('Friday group') involving international agencies and organization as well as donors on humanitarian assistance is chaired twice a month by ECHO.

With regard to **UN coordination and CAP**, UNSCO chairs a monthly UN heads of agency meeting for West Bank and Gaza while OCHA and UNRWA co-chair the Operations Coordination Group (OCG) meetings twice a month both in West Bank and in Gaza. The Security Management Team, chaired by the Designated Official (UNRWA's Commissioner General) meets twice a month.

Since 2003, the Office for the Coordination of Humanitarian Aid (OCHA) has led the Common Humanitarian Action Plan and the subsequent CAP for oPt. In October 2005, 20 humanitarian agencies appealed through the CAP for US$ 215 million to provide humanitarian assistance to the Palestinians. WHO coordinates the health sector component of the appeal. A summary of requirements by sector is compiled by OCHA.

3.2.2 Health coordination

The **Health Sector Working Group** is chaired by the Ministry of Health, co-chaired by Italian Cooperation and WHO is the technical adviser. The other members of the Health Sector Working Group are the European Commission, World Bank, USAID, Japan, Belgium, Department for International Development and France. UNRWA and Union of Palestinian Medical Relief Committees are observers. Thematic Groups were established in mental health, nutrition, reproductive health and health information system. Currently only three Thematic Groups are operational. WHO acts as the technical agency for the Nutrition and

[27] The programmes outlined in the Medium Term Development Plan are social protection (including a humanitarian component), social and economic development, governance and institutional development and private sector development.

[28] www.lac.ps/donor_coordination

Mental Health Thematic Groups, and is the secretariat for the newly established Women and Child Health Thematic Group. The Health Sector Working Group has proved to be one of the most active sector working groups.

In **health emergency coordination**, *Health Inforum (HI)* provides regular reports on the current humanitarian situation and organizes monthly, or weekly if needed, emergency coordination meetings in West Bank and Gaza, co-chaired by WHO and the Ministry of Health. Several international and national nongovernmental organizations in addition to UN agencies involved in the emergency response participate in the meetings. HI concentrates on collecting and disseminating data concerning the health sector. It also contributes by gathering and analysing information on health status and health services from primary sources such as Ministry of Health and PCBS reports and ad hoc surveys. The HI website includes news, reports and a library archiving the most relevant documents produced locally on the health sector.[29]

With regard to **UN health coordination**, A UN health coordination group was established in 2004 with the participation of health-related UN agencies namely WHO, UNICEF, UNFPA, UNDP and UNRWA. OCHA and UNSCO are also involved for their coordinating role. WHO took the leadership role in establishing the group, and organizes, and chairs, monthly meetings. The group has been effective in debating critical issues, and developing consensus on situation analysis, needs, priorities and relevant strategies.

An informal meeting initiative for **donor meetings on health** among relevant donors of the health sector was undertaken recently by Italian Cooperation and WHO. The main goal is to promote harmonization and alignment among donors and improve health coordination.

[29] www.healthinforum.net

Section 4. Current WHO cooperation

4.1 Historical background and presence in oPt

WHO has been working with the Palestinian population for over 50 years since it came into agreement with the United Nations Relief and Works Agency (UNRWA) for Palestinian Refugees in the Near East regarding the health needs of the Palestinian refugees (see Annex 1).

With the establishment of the Palestinian Authority in 1994, the Ministry of Health was established and absorbed the health service previously managed by the Israeli Civil Administration. In 1994/1995, WHO worked with the two parties (Israel and the Palestinians) in easing the transfer of the health services. WHO assisted in setting up the Ministry of Health and assumed the Secretariat role for donor coordination like the Health Sector Working Group.

In 1994, WHO started the Special Technical Assistance Programme, and established the West Bank and Gaza office: main office in Jerusalem and sub-office in Gaza. The Programme has been dependent on the Department of Emergency and Humanitarian Action, now Health Action in Crisis (HAC), at WHO headquarters and relies on their extrabudgetary support. The support is mainly oriented to specific projects, like mental health, water and sanitation, and supplies, on a short-term basis. The average investment from 1994 to 1998 was around US$ 2 million a year, however, the funds have been diminishing as many donors channel their support directly to the Palestinian Authority. After 2000 the structure of WHO presence in oPt was expanded to promote capacity-building, deliver assessment, coordination, advocacy and humanitarian aid.

At the same time, WHO supports the Ministry of Health from the Regional Office for the Eastern Mediterranean. The support focuses on several health interventions. Planning of activities for the biennium is undertaken, as for the other countries of the Region, through the biennial Joint Programme Review and Planning Missions (JPRM) exercise. The total amount of funds for the biennium has been around US$ 900 000. In the biennium of 2004–2005, the support focused on health care delivery, nursing, mental health, nutrition and noncommunicable diseases. WHO headquarters Health Action in Crisis and WHO West Bank and Gaza office have participated in the JPRM exercise in the last two bienniums (2002–2003 and 2004–2005), and have provided administrative and logistic support for the implementation of the plans.

Concerning the link with Israeli authorities, besides the formally established relationship between the WHO Regional Office for Europe and Israel, the WHO West Bank and Gaza office has put into place an active line of communication and collaboration with the Israeli Ministry of Health.

The current WHO presence in oPt is organized in two offices (Jerusalem and Gaza). At present 21 staff members (5 internationals and 16 locals) plus 2 interns are working in the activities described below (see Annex 2).

The funds utilized during 2004–2005 have been approximately US$ 2 million–2.5 million each year, mainly extrabudgetary funds. The main donors have been Norway, USAID, ECHO and AGFUND.

4.2 Current programme of work

WHO supports the Palestinian Authority and national and international partners in oPt through various mechanisms. The main areas of work at the country level are as follows.

a) Maximizing health through up-to-date technical guidance

- WHO supports the Ministry of Health in formulating and implementing national health policy according to the principle of equity and sustainability, and advocates for health to be considered as a top national priority.

- More specific support has been given to the Ministry of Health, through extrabudgetary support as well as JPRM plans, in strengthening policies, strategies and local capacities in important health areas, such as mental health, noncommunicable diseases, nutrition, essential drugs, communicable diseases and food safety. In the field of mental health, the technical support has had a programme-based approach, focusing on policy as well as service delivery and training. Noncommunicable diseases have given priority as there is a considerable burden of noncommunicable diseases in oPt. Concerning nutrition, technical support has been provided to the Ministry of Health in order to elaborate a 'State of Nutrition' document, nutrition policy and strategy.

- The JPRM covers health care management and delivery, noncommunicable diseases, mental health, child health, nutrition, essential medicines, oral health and laboratory. Of the various activities, capacity development, in both public health and medical services, of the Ministry of Health staff is given special attention.

- WHO is involved in the ongoing implementation of the Health Sector Review, together with the European Commission, World Bank, DFID and Italian Cooperation.

b) Improving impact of health interventions through efficient and effective coordination

- Monthly (or weekly if needed) emergency support coordination meetings are co-chaired by WHO and the Ministry of Health in Ramallah for West Bank and Gaza for Gaza strip. International and national nongovernmental organizations and UN Agencies involved in the emergency response are participating. The meetings have been implemented also at district level.

- WHO is maintaining its technical advisory role in the Health Sector Working Group. Within the same framework, WHO is the technical agency to the Thematic Groups on Nutrition and Mental Health, and acts as the secretariat in the Women and Child Thematic Group.

- Ad hoc coordinating bodies have been recently created on specific issues (e.g. the separation barrier), where WHO coordinates the health-related component.

c) Obtaining, collecting and interpreting health information

- WHO keeps Health Inforum operational, collecting and sharing information concerning the humanitarian health situation and response. HI aims at supporting decision-making capacities of the coordinating mechanisms and focuses on the accumulation of data on health and the health sector activities, the status of health facilities and the availability of medical supplies. HI regularly reports on the current humanitarian situation and networks with local and international stakeholders.

A survey on quality of life is ongoing. The objective of the study is to assess the overall quality of life that Palestinian people are presently experiencing, especially during the past four years.

d) Improving access to humanitarian assistance

WHO has developed, together with other UN agencies, a joint advocacy strategy for health in the oPt, and recently made a special effort by involving Palestinian institutions, Israeli human rights organizations and international organizations. The main advocacy outcomes are two feature stories on Palestinian hardship (published by different media outlets) and three public events on health access. In addition several UN press statements focusing on women, children, poverty and human rights in oPt have been released.

e) Improving access to supplies

WHO has responded to the emergency by sending specific emergency medical supplies, health emergency kits and public health items.

f) Promoting a context for health and humanitarian action

WHO is committed to keeping lines of communication open, creating platforms for dialogue and taking advantage of all opportunities to advocate for open discussion and collaboration between Palestinian and Israeli health professionals, nongovernmental organizations and health institutions.

Six issues of *Bridges,* the Israeli–Palestinian public health magazine, have been published so far on issues related to poverty, disabilities, nutrition, quality of care, women's health and mental health. *Bridges* is a unique publication conceived, written, edited, produced and managed jointly by Palestinian and Israeli academics and health professionals under the sponsorship of the WHO.

A decentralized cooperation project -*European, Palestinian and Israeli Cities for Health and Social Partnership* (EPIC)- involves 8 European cities, 6 Palestinian cities and 6 Israeli cities which are entering into a triangle cooperation in the field of health and social action.

Section 5. WHO policy framework: global and regional directions

5.1 Operating framework

Health systems in developing countries are becoming more complex. The role of the state in provision of health care is diminishing rapidly, with the private sector and civil society becoming active and important players. Also, globally, a number of development organizations and financial institutions have become heavily involved with health development activities in developing countries. It was, therefore, timely for WHO to respond to this changing environment by calling for new ways of working with its Member States.

WHO has adopted a broad approach to health within the context of human development with a particular focus on the links between health and poverty reduction. It is assuming a greater role in establishing wider national and international consensus on health policies, strategies and standards, through managing the generation and application of research, knowledge and expertise. At the country level, through the CCS process, it is envisaged that:

- WHO collaboration will be more strategic and focused on fewer priority areas, which will be an amalgam of global, regional and national priorities;
- increased emphasis will be given to WHO's role as a policy adviser and broker;
- opportunities will be sought for increasing and strengthening partnerships with other international and national agencies, including nongovernmental organizations working in the field of health;
- innovative approaches will be sought to increase the effectiveness of WHO support;
- attempts will be made to ensure the utilization of the knowledge and skills present in the country for WHO's normative work.

5.2 Country level functions

To carry out WHO operations at the country level four WHO functions have been identified:

- catalysing the adoption and adaptation of technical strategies; seeding large-scale implementation;
- supporting research and development; monitoring health sector performance;
- information and knowledge sharing; providing generic policy options; standards; advocacy;
- providing specific policy advice; serving as broker; influencing policy, action and spending.

It should be noted that the sequence in which the above functions are listed is not an indication of their priority. In fact, the relative importance of these functions would vary from country to country depending on its state of development and strategic priorities identified for collaboration with WHO during the process of formulation of CCS.

5.3 WHO-wide strategic directions

WHO's current (2002–2005) General Programme of Work lists the following four inter-related strategic directions to provide a broad framework for focusing WHO's technical work.

- Strategic direction 1: reducing excess mortality, morbidity and disability, especially in the poor and marginalized populations.

- Strategic direction 2: promoting healthy lifestyles and reducing risk factors to human health that arise from environmental, economic, social and behavioural causes.

- Strategic direction 3: developing health systems that equitably improve health outcomes, respond to people's legitimate demands and are financially fair.

- Strategic direction 4: framing an enabling policy and creating an institutional environment for the health sector and promoting an effective health dimension to social, economic, environmental and developmental policy.

5.4 WHO global priorities

Based on the analysis of major challenges in international health, WHO has established a set of global priorities. The selected global priorities as stated in the General Programme of Work for 2002–2005 are as follows.

1. Malaria, tuberculosis and HIV/AIDS: these three major communicable diseases pose a serious threat to health and economic development and have a disproportionate impact on the lives of the poor.

2. Cancer, cardiovascular diseases and diabetes: there is a growing epidemic of these diseases in the poor and in transitional economies.

3. Tobacco: is a major killer in all societies and rapidly growing problem in developing countries.

4. Maternal health: the most marked difference in health outcomes between developed and developing countries show up in maternal mortality data and it is difficult to reduce maternal mortality without a well-functioning health system.

5. Food safety: poses a growing public health concern with potentially serious economic consequences.

6. Mental health: five of the ten leading causes of disability are mental health problems; major depression is the fifth contributor to the global burden of disease and may be second by 2020.

7. Safe blood: is both a potential source of infection and a major component of treatment, and crucial in the fight against hepatitis and HIV/AIDS.

8. Health systems: development of effective and sustainable health systems underpins all the other priorities; demand is substantial from Member States for support and advice on health sector reform.

9. Investing in change in WHO: is a prerequisite for WHO to become a more efficient and productive organization and one capable of response within an increasingly complex environment. The development of new skills, systems and process is central to the effective management of WHO's core functions.

5.5 WHO regional priorities

The Eastern Mediterranean Region has the demographic profile of a developing region. It is a low–middle income region. Poverty and unemployment affect a large number of people. Communicable diseases are still prevalent in the least developed countries and tuberculosis, malaria and HIV/AIDS are major killers. A number of countries in the Region are in a state of conflict and emergency. Malnutrition is still a significant problem in some countries. Water scarcity is a region-wide challenge. Also, the lack of adequate safe water supply and proper sanitation are major health hindrances in the least developed countries, which constitute a large percentage of the population in the Region. Similarly, rapid urbanization and increase in car ownership have resulted in severe air pollution in major cities of the Region. Solid waste management, particularly of hazardous and medical wastes, is particularly weak in a significant number of countries of the Region.

An epidemiological shift is being witnessed in the Region. Currently, due to changes in lifestyles, noncommunicable diseases constitute 40% of the disease burden. It is projected that by 2020 the share of the burden for noncommunicable diseases will increase to 60%. This is creating a double burden of both communicable and noncommunicable diseases. Maternal mortality is still unacceptably high in some countries. The average maternal mortality ratio for the Region in 2001 was as high as 330 per 100 000 live births, while over 60% of infant deaths occur in the neonatal period in most countries. Foodborne diseases are also on the rise and represent a major public health challenge. The rapid change in lifestyles in many countries is having a clear impact in terms of stress and mental health-related conditions.

The health system, including governance, quality assurance, service delivery, health regulation, and medical technologies and medicine, needs major strengthening in almost all countries. Health financing is a major emerging issue in the Region. In lower income countries most health expenses are borne by people. The middle-income countries have a mix of private and public sector. In these countries, in some instances, there is a surplus of trained human resources, such as physicians. In high-income countries the major share of health

expenditure is borne by governments. The health information system in almost all countries needs to be strengthened. The nursing picture is rather gloomy, both in terms of adequate numbers in poor countries and career structure.

In light of the above situation, the Regional Office has identified certain priority areas for its collaboration with Member States. These were spelled out in the programme budget for the period 2004–2005 which was endorsed by the Regional Committee for the Eastern Mediterranean at its Forty-ninth session held in October 2002 (EM/RC/49/R.2). The priorities include the following.

Health protection and promotion

- Promotion and development of healthy lifestyles through programmes such as the Tobacco Free Initiative, healthy communities, villages and cities, action-oriented school health activities, health of special groups and health education.

- Strengthening of national and regional initiatives to improve nutritional status through raising awareness of individuals and the community and control of micronutrient deficiencies.

- Integration of health promotion aspects with clinical approaches at all levels of the health care system, such as in the example of the regional initiatives to integrate at the primary health care level maternal, child and adolescent health, prevention and control of noncommunicable diseases and mental health activities.

- Promotion and strengthening of environmental health initiatives, particularly those relating to water safety and security, environmental health impact assessment, food safety and healthy environments for children and development of intersectoral activities in this respect.

Community development

- Addressing the underlying determinants of health and poverty as essential to ensuring sustainable development and sustained health improvements in the long term. Community-based initiatives such as basic development needs (BDN), healthy cities, healthy villages and women in health and development are among the priorities adopted by countries. In all these initiatives special emphasis is given to strengthening and enhancing the role of women as major stakeholders in achieving and sustaining the desired health and development goals.

- Efforts to facilitate achievement of the Millennium Development Goals, aiming to halve the number of people living in absolute poverty by the year 2015. This will include the development of various policies and plans such as Poverty Reduction Strategy Papers, to create supportive political, physical and economic conditions for all segments of the population to produce a positive impact on the overall quality of life. Concerted efforts are being made to make health systems better oriented to the needs of the poor by giving greater attention to promoting health throughout the life span, and reducing inequities in health status.

Disease control

- Improvement of epidemiological profiles using quantitative methods, such as burden of disease assessment and forecasting techniques. Efforts should be made to strengthen national and regional capabilities in epidemiology and national information systems through developing national and subnational registries for priority health problems. Efforts should also be made to benefit from epidemiological research studies in designing health policies and strategies. Priority diseases that are the main contributors to the disease burden and at the same time are amenable to intervention strategies will be identified.

- An integrated approach in communicable disease control programmes through ensuring political commitment, integrating cross-cutting control activities, scaling-up disease-specific control activities, and developing synergy of managerial processes.

  – Essential packages of services for prevention and control of priority diseases and indicators to monitor and evaluate these programmes will be developed.

  – Integration of cross-cutting control activities will cover at least communicable disease surveillance, epidemic preparedness and response including developing early warning and surveillance systems, infection control and containment of antimicrobial resistance, integrated human resource development, health education and advocacy, and operational research.

  – Scaling-up of disease-specific activities includes immunization programmes, tuberculosis control, malaria control, HIV/AIDS/STD prevention and control, elimination and eradication of specific diseases.

- Immunization programmes maintained and strengthened, with particular focus on countries that have lower immunization coverage and problems in certification of poliomyelitis eradication. The Regional Office will pursue its policy aimed at achieving self-sufficiency in vaccine production.

- Integrated management in control of noncommunicable diseases. Particularly attention will be paid to quality assurance programmes and to emerging needs, such as palliative care for cancer patients and health of the elderly.

Health systems and services development

- Promotion of a culture of strategic thinking in decision-making, using evidence-based policies and strategies, and development of important components of the stewardship function, such as regulation, public–private mix management, coordination, etc.

- Strengthening decentralization of health systems through capacity-building and technical expertise, and supporting district health systems through institutionalization of the district team problem-solving approach and development of sustainable management through national management effectiveness programmes.

- Improving quality in health service delivery through implementation of a programme of continuous quality improvement based on quality standards for individuals, departments and organizations against which performance will be measured.

- Support to accreditation initiatives, such as multidisciplinary assessments of health care functions, organizations and networks, as an important approach for improving the quality of health care structures.

- Enhancing national information systems in order to provide necessary data on spending on health, particularly on private services, making use of household expenditure and utilization surveys and national health accounts analysis.

- Testing of the WHO framework and tools for health system performance assessment and development of an observatory in the Regional Office to assess, manage and monitor health sector reforms.

- Development and decentralization of laboratory activities, health imaging technology, blood safety and blood transfusion.

- Strengthening of the essential drugs programme and ensuring use of essential drugs lists by most countries while promoting rational drug use and traditional medicine.

- Improvement of coordination for human resources development and promotion of continuing education for health personnel at the various levels of the system. Efforts will focus on developing innovative approaches for human resources development, including community-oriented health personnel education.

Section 6. WHO strategic agenda in and with oPt

6.1 Mission statement

To promote the health of all Palestinian people by improving health sector performance based on equity, effectiveness and sustainability, as well as by addressing the broader social, economic, environmental and cultural health determinants, particularly those which are most affected by the Israeli–Palestinian conflict.

The fact that, so far, no major disaster or catastrophic deterioration in terms of health indicators has taken place in the oPt is frequently a cause of debate. However, some trends are worrying and, together with the determinants already outlined in this document, deserve attention in order to prevent further deterioration or the surge of a disaster situation. WHO will work towards a comprehensive public health approach based on the right to health and taking into account the need to address factors that have a critical impact on health. The strategic directions will address both the long-term perspective of sustained capacity-building and the continued need for an emergency mode of operation in case of crisis

Right to health. The continuous suffering, constant fear, insecurity and feeling of neglect and lack of future brought about by the violent situation on the ground results not only in depriving Palestinian people from access to essential services, including health services[30] but also in deeply affects their psychological well-being, particularly in the case of children.[31] The above constitutes a deprivation of basic rights with an impact on the health status of the population. According to WHO, the most authoritative interpretation of the right to health is outlined in Article 12 of the ICESCR[32] (International Covenant on Economic Social and Cultural Rights) of which Israel is a signatory. In 2000, General Comments to the ICESCR, it was recognized that the right to health is closely related and dependent upon the realization of other human rights, including the right to food, housing, work, education, participation, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. Evidence collected concerning the systematic violation of many of these determinants[33] leads to the inference that the current situation is still preventing the fulfilment of the right to health in the oPt. The UN Commission on Human Rights issued a resolution in 2005 regarding Israel's violation of human rights in oPt and, among other things, requested the UN High Commissioner for Human Rights to address the issue of Palestinian pregnant women giving birth at checkpoints owing to denial of access by Israel to hospitals. The last two reports of Professor John Dugard (*John Dugard. Questions of the violation of human rights in the Occupied Arab territories, including oPt. Dec 2004, March 2005*), UN Secretary-General Special Rapporteur on the

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[30] Ziv H. *A legacy of injustice. A critique of Israeli approach to the right to health of Palestinians in the Occupied Territories*. Physicians for Human Rights, Israel, November 2002.

[31] Arafat C. *Psychological assessment of Palestinian children*. USAID/Save the Children, July 2003.

[32] WHO, *25 Questions and answers on health and human rights.* Health and Human Rights Publication Series, Issue No. 1, July 2002.

[33] A number of reports by Israeli human rights organizations document the extent of this situation. See, for example http://www.phr.org.il/Phr/Pages/PhrArticles_index.asp?Cat=13 and http://www.btselem.org

situation on human rights in the oPt, highlight the human rights violations incurred by Israel, namely the Separation Barrier, checkpoints and movement restrictions, Palestinian prisoners and the imposed change of normal life for Palestinians living in Jerusalem and Bethlehem, as well as the issue of Gaza. The report expresses the need for Israel to halt military activity against Palestinians as well as activities causing Palestinian militancy.

Vulnerability and socioeconomic determinants. A number of factors increasing vulnerability have become evident in the oPt[34], such as a high proportion of children under 15 years old, poor and unemployed; rising number of mental health disorders; the high proportion of refugees and increase of internally displaced persons (IDPs);[35] increase in the number of disabled persons and in social cases. Contextual factors (closure, economics, violence) as well as systemic factors (access to health services, West Bank/Gaza Strip separation, constraints to policy and planning, etc.) play an important role in this respect. Increased poverty and rising unemployment in oPt are the result of an economic crisis caused by closures and internal and external restriction of movements of goods and people. These socioeconomic factors are recognized worldwide as powerful health determinants.[36]

Adopting a long-term perspective, while keeping ready to respond to the potential re-emergence of acute crisis: the four strategic directions presented below will guide WHO's work in a very unpredictable future. While the goal is to participate in the building of a sustainable Palestinian State, the key functions of the Organization will remain valid in case of emergency, while activities will shift to a much more operational mode, as experienced in the past.

6.2 Main strategic directions

In order to support the Palestinian Authority and its partners in health to deal with a highly complex situation, WHO will work along four main strategic directions: Health policy and systems development, Coordination, Technical support in particular areas and Advocacy. These four directions have been identified in order to properly respond to the needs of the situation considering the WHO mandate, role experience, potential and comparative advantage. The main focus will always be put on the strengthening of national capacity, not only of the Ministry of Health but also other ministries and national partners, so that the Palestinian people can address all health issues with effective governance and coordination.

While coordination and health policy are interlinked areas which can provide a general framework absolutely essential for the future health development in oPt, technical support in key health sectors is a specific contribution that WHO can provide, allowing the Palestinians

[34] Pfeiffer M. *Vulnerability and the international health response in the West Bank and Gaza Strip*. WHO/Peacepath, November 2001.

[35] No systematic data on IDPs are available, but in: Arafat C. *Psychological assessment of Palestinian children*. USAID/Save the Children, July 2003, from a sample of children meant to be representative of West Bank and Gaza, 21% reported permanent or temporary relocation of residence for conflict-related reasons.

[36] WHO. *Social determinants of health. The solid facts.* Copenhagen, World Health Organization, Regional Office for Europe, 2nd edition, 2003.

to deal better with the health problems of a society in transition and under complex emergency. Advocacy is an atypical commitment required by the peculiar characteristics of the crisis in oPt, both humanitarian and political, related to basic needs and linked to human rights, involving Palestinians but also Israelis.

6.2.1 Health policy and systems development

Objective: to support the Ministry of Health in steering the whole health policy development process, guided by the values of Health-for-All and with due consideration of WHO-supported work on macroeconomics and health, and social determinants of health.

Strategic approaches: WHO will provide appropriate technical assistance to the Ministry of Health, nongovernmental organizations and other development partners including Palestinian civil society, in order to ensure a high level of participation in the process of reform. The involvement of UNRWA is essential. WHO will strive to help the Palestinian Authority in establishing a health policy framework with a vision of the future, building on the informative work done by the Health Sector Review. This will encourage the channelling of international assistance into activities that contribute to health development and reform of the health sector. Care should be taken not to jeopardize the short-term objectives of emergency relief.

In the oPt, the health policy and planning functions have been traditionally weak. This, together with political and economic instability, and cultural orientation towards western styles of practice and high tech medicine, has greatly limited a broad public health approach. The recent Health Sector Review has shown some of the limitations of local policy development and effective regulatory and stewardship functions by the Palestinian Authority. Furthermore, the Ministry of Health's attitude towards the recognition of the need for change was found to be rather lukewarm. Moreover, health policy and planning have been understandably dominated by an "emergency culture" characterized by a short-term outlook, the urgency to respond to the immediate, crisis-related medical needs, and a neglect of the long-term implications of resource allocation decisions, in terms of sustainability, both financial and institutional. The availability of reliable information is also limited. In spite of efforts made by the Ministry of Health and several partners to strengthen health information management, there is still much room for improvement, especially in terms of comprehensiveness and integration of the system.

Taking into account the difficulties mentioned above, WHO will support the setting up of a functional policy and planning unit within the Ministry of Health which should contribute to improved performance of the health sector. Technical support will aim at facilitating a participatory and dynamic process.

In order to support policy development in relation to critical elements of health systems, WHO will provide, in partnership with key stakeholders in the sector, advice on policy direction to be discussed and assessed in the Palestinian context in order to inform policy choices and get away from uncoordinated, ad hoc responses. Improving the structure, management, financing and regulation of the sector will require expertise on issues related to decentralization, packages of care, norms and standards for services and human resources,

national health accounts, health insurance, human resources development including training strategies and incentives, etc.

WHO will also support the Ministry of Health in addressing the health information management, enhancing harmonization between West Bank and Gaza, and ensuring consistency between the work of the PCBS and the health information centres of the Ministry of Health. This will entail centralization of data collection, standardization of health indicators and definitions, enhancing communication networks, development of an advanced medical information network, linking health management information system data with planning and policy-making processes. An issue of particular importance is to integrate the Ministry of Health and UNRWA health information systems into one coherent and efficient system. WHO will also, through enhancing *Health Inforum*, link relief with development-related information, thus promoting a synergy between short and longer term planning. Based on past experience, *Health Inforum* will maintain preparedness for any further critical changes in the situation, while maintaining key management data that should in the long run be part of the Ministry of Health system. It will cover information support by both geographic areas and themes.

6.2.2 Coordination

Objective: to ensure progress towards more harmonization and alignment of external aid and interventions in the health sector, by supporting the Palestinian Authority in dealing with agency coordination in relation to sector planning.

Strategic approaches: WHO will play a stronger role in facilitating coordination processes, through enhancing the effectiveness of existing mechanisms, including the provision and exchange of information. This work will contribute to, and be supported by, the cooperation related to health policy and planning (see paragraph 2 below).

Improving existing mechanisms

WHO will support the Ministry of Planning and the Ministry of Health in re-engineering the entire set-up relating to external aid coordination in the health sector. The support will be based on a situation analysis which is expected to take place at the end of 2005. The analysis will focus on the Health Sector Working Group and related thematic groups, and will deal with the structures (terms of reference, membership, "governance", etc), discussion topics, activities and tools to support them such as: information pooling and sharing, joint statements, project planning and review, ways of providing technical support, administrative and managerial issues. At present, although funding agencies have been strongly requesting the Palestinian Authority to provide them with clearer priorities, information and guidance, the Ministry of Health has yet to have such capacity to meet the request. This clearly shows that this line of work is directly linked to the WHO (and other partners) support to the Ministry of Health in policy, planning and systems development.

Emergency coordination

WHO will continue to take the leadership role in health-related emergency coordination through *Health Inforum*, which it jointly chairs with the Ministry of Health. This work involves assessing and monitoring the situation, disseminating and exchanging information through different platforms (Health Sector Working Group, Local Aid Coordination Committee, emergency coordination meetings, newsletter, and website), developing advocacy strategies, coordinating the emergency response and providing direct relief to address identified gaps. Since 2003, the need to integrate emergency coordination mechanisms into general aid coordination has become clear. WHO will have to identify the necessary mechanisms to make this possible, in such a way that donors and Palestinian Authority at the highest levels can share in the emergency response strategies fostered at the field level.

UN coordination

The UN system has enlarged its presence in the oPt over the last years and has a pivotal role in the provision of aid. Several agencies are involved in health-related issues, namely WHO, UNICEF, UNFPA and UNRWA, and the relationships between these are quite good. However, a common approach to needs and strategies in the health sector is still lacking. WHO will reinforce the coordination of health-related issues and try to overcome the limited communication that has been experienced so far. Additionally, WHO will help to improve the process of building up the requirements related to the CAP: it should be better coordinated, and be based on a coherent framework of intervention in the sector, involving the relevant agencies and avoiding pre-arranged and fragmented lists of projects.

6.2.3 Specific support to technical programmes

Objective: to build the capacity of the health sector to address the critical emergency and longer terms needs of the population in specific areas where WHO has a comparative advantage.

Strategic approaches: following up on previous commitments and responding to newly expressed requirements, WHO will work on key programmes, either through full fledged, sustained support, or through short-term high level expertise, looking always at enabling the Ministry of Health to take the lead in policy formulation, implementation, monitoring and follow-up.

Mental health

The Ministry of Health has placed emphasis on mental health as an urgent priority, given the historic insufficiency of appropriate mental health services combined with the sociopolitical crisis and the increased needs of the population. No significant support had been provided to the Ministry of Health when WHO started in 2003 (most was directed at nongovernmental organizations).

The specific objectives of the work are to reorganize, improve and expand the current mental health services, according to a community mental health approach, at the primary, secondary and tertiary levels of health care.

A mental health policy and plan and a national strategy for the reorganization of mental health services, have been elaborated by the Steering Committee for Mental Health established by the Ministry of Health and WHO. The Organization will pursue the work already started, in particular: the expansion and improvement of three existing mental health centres (run by the Ministry of Health) into pilot community mental health centres, based on internationally-recognized criteria for providing effective community-based care and support; a range of short-, medium- and long-term training activities for mental health professionals and primary health care staff; the establishment of family and patients' associations, in order to empower and improve the social support system available to the mentally ill and their families; and the implementation of a nationwide anti-stigma programme.

In addition, WHO will pursue its engagement in promoting coordination, in particular with Italian Cooperation, the French Foreign Ministry and other key partners in this area.

Noncommunicable diseases

Noncommunicable diseases are the leading causes of death, accounting in total for more than 50% of reported deaths in oPt. Out of 10 leading causes of death, five are noncommunicable diseases: heart disease (1st), cerebrovascular disease (4th), malignant neoplasm (5th), hypertension (6th) and diabetes mellitus (8th). WHO will therefore scale up its support on noncommunicable disease control particularly regarding these major causes of death, as a matter of priority.

The Ministry of Health has been trying to address this vast need through a public health approach, in addition to its traditional clinical approach. WHO will support the efforts of the Ministry of Health, particularly through the strengthening of the noncommunicable disease control unit of the Ministry of Health and development of relevant guidelines. Strengthening of surveillance is also an important area of work as noncommunicable disease is still under-reported, and available information is not accurate. For example, a cancer registry exists but it is not complete or accurate. WHO will also promote preventive measures and healthy lifestyles.

Nutrition

Given the multiplicity and diversity of providers in the oPt, the type, profile and quality of interventions related to nutrition are heterogeneous, and not necessarily according to the needs of the population. In relation to policies, food and nutrition issues have been fragmented among several ministries and disciplines.

WHO's strategy on nutrition since 2004 is to strengthen the capacity of the Ministry of Health in policy and planning, management and follow-up of nutrition-related issues, while other partners—in particular UNICEF—would concentrate on more operational work. This

involves, for WHO, providing technical support to the Ministry of Health, and strengthening the coordination of interventions.

Following its successful action related to situation assessment and consensus building on policy and strategies, WHO will pursue its assistance for strengthening the Ministry of Health Nutrition Department, developing policies and guidelines, supporting the Integrated Management of Childhood Illnesses (IMCI), strengthening nutritional surveillance and improving coordination through the thematic group and other mechanisms in place.

Emergency preparedness

Although, as already mentioned, emergency work is potentially present under all WHO strategic directions, specific support to the Ministry of Health in emergency preparedness is definitely required in light of the continuing volatile situation. This will involve advice, training, capacity-building and, in coordination with others, pre-positioned supplies.

Environmental health

Environmental health is an increasing concern in oPt, because of the volatile, insecure general situation. The Ministry of Health has an Environmental Health Department, which is responsible for three programmes: food and water control, vector control, solid waste and wastewater monitoring. WHO will assist the Ministry of Health, particularly through the Regional Centre for Environmental Health Activities (CEHA), in addressing environmental health effectively.

Pharmaceuticals

WHO will continue to support the area of pharmaceuticals. Training activities related to rational use of drugs will be enhanced, based on the proposed revision of the Essential Drug List and Drug Formulary. Good Manufacturing Practices, drug regulation and control are other aspects that might require specific technical support.

Other areas: food safety, child health, hospital care, supplies

Strengthening food safety activities, developing food legislation and covering gaps in health supplies have been supported over the past years and this will continue. Concerning child health, the Integrated Management of Childhood Illness strategy was adopted in oPt in 2001. IMCI guidelines and a training package have been developed and a number of a training activities have been implemented at PHC level. This will continue with the support of UNICEF, who will also sustain the community component of IMCI. WHO will focus on the following aspects: establishment of a training site at hospital level, follow-up and supervision, quality of care at the referral level and incorporating IMCI training into the existing teaching curricula, in national medical and nursing schools.

Other areas will be supported through specific expertise and training activities as opportunities and critical needs arise, and in coordination with others.

WHO will also be engaged to fill the gap in emergency health supplies according to contingent needs.

6.2.4 Advocacy and communication: 'health as a human right and as a bridge for peace'

Objective: to advocate for the right to health of Palestinians in the oPt and promote health as a bridge for peace.

Strategic approaches: WHO will promote, in collaboration with all relevant partners including those in the UN, lobby and monitor health and its main determinants in oPt, with a particular focus on access to health services. The Organization will keep lines of communication open and create platforms for dialogue and collaboration between Palestinian and Israeli health professionals, nongovernmental organizations and institutions.

The UN Secretary-General emphasized that, in order to bring peace and security within reach of both Israeli and Palestinians, it is essential to "address the core issues: occupation, violence including terrorism and the economic plight of the Palestinians".[37] WHO is committed to promoting advocacy for health and healthy behaviours.

Working in this direction, WHO engagement in the oPt will consider the need to reconcile epidemiological, technological, and economic pressures with ethical imperatives, such as advocating for the right to health, including equity of access to health care and other basic services. For WHO, advocacy work aims at effectively and proactively raising awareness on the health situation and its main determinants in the oPt, and communicating WHO's strategic priorities to key audiences.

Health as a Bridge for Peace fits into the larger picture of the UN system's interventions on peace-building. The UN General Assembly[38] has resolved "to make the United Nations more effective in maintaining peace and security by giving it the resources and tools it needs for conflict prevention, peaceful resolution of disputes, peacekeeping, post-conflict peace-building and reconstruction". Field experience shows that health-related goals may be shared among conflicting parties, giving them the basis needed for cooperation. This may create an opportunity to build a negotiating framework, to counter dehumanization of the enemy, or to demonstrate the possibility of promoting dialogue. It must be highlighted that the activities are generally small initiatives involving a limited number of people with little impact on the overall crucial variables that influence the processes of armed conflict. However, it has been proved by practice that such health initiatives can contribute to bringing divided populations closer together.

The Organization will focus on:

- Monitoring the impact of the crisis on the health conditions of the population.

[37] Statement to the Commission on Human Rights, 12 April 2002.

[38] UN General Assembly, Millenium Declaration quoted in the United Nations Plan of Action on Peace-building, 18th September 2000.

- Enhancing partnerships with the international community, in particular the UN, to promote respect for the right to health of the people in oPt and provision of unconditional and safe access to health services.

- Keeping lines of communication open and creating a platform for dialogue for health personnel belonging to different parties who can work jointly in the areas of health policy, training, service delivery and health information. WHO will promote partnership among cities (European, Palestinian and Israeli cities / EPIC); a bi-monthly newsletter (Bridges magazine) edited and distributed to health and social institutions and individuals; joint training and research activities in health. It will also promote the reactivation, within a WHO institutional umbrella, of Israeli–Palestinian joint committees in the following sectors: epidemiology, environmental health, pharmaceuticals, food control, referral to hospital and training.

- Interacting with Israeli authorities regarding access constraints. WHO has activated a line of communication with the Israeli Ministry of Health in an attempt to improve access problems related to Palestinian health workers and users as well as WHO employees. As the decision-making authority of the Israeli Ministry of Health sometimes has insufficient leverage to facilitate access, other resources within the Israeli government and Israeli Defence Forces (IDF) might be explored in coordination with the UN system.

Section 7. Implementing the strategic agenda: implications for WHO secretariat at all levels

With the strategic directions presented under section 6 above, WHO will increase its profile in the oPt. Although this is a challenge, it is coherent with the developments of the WHO office over the past few years. To consolidate this trend, and to fulfil the full potential of the Organization, its country presence will have to be consolidated and new resources will have to be mobilized.

7.1 WHO West Bank and Gaza office

The historical dichotomy between the headquarters and the Regional Office for the Eastern Mediterranean components and between regular budget and extrabudgetary-funded activities of the WHO programme in the oPt will be overcome. The WHO West Bank and Gaza office will be a single umbrella under which all WHO activities are coordinated under one plan and joint resources.

Human resources

The current practical split between Gaza and West Bank as well as the restrictions on staff movement, result in the need for WHO to have in the oPt more staff than the cooperation would generally call for in a complex country of this size. The strengths of the Organization clearly lie in its institutional identity, provision of brokering and coordinating functions in support of the Government, and in its technical expertise.

The current "office staff" needs to be maintained and provided with more secure contracts. In addition, with the growing and quite complex set of activities to be managed, the recruitment of additional administrative officer(s) needs to be considered (see Annex 2).

In order to implement its cooperation strategy, WHO will increase the number of programme or "project" staff. Improving support to aid coordination will require additional analytical and facilitation capacities within the country team. The work related to policy and systems development will require more resources, including a full time health policy adviser based in the Ministry of Health. In addition, high level, short-term technical expertise will be required on some of the critical issues presented in section 6.

Funding strategy

WHO should act as an independent broker between donors and the Palestinian Authority, ensuring that the direction chosen by the Palestinian Authority and its support as far as health is concerned is maintained and is not driven by individual institutional or donor agendas. Traditionally, WHO has relied on very few countries to support its rather modest infrastructure in oPt, through extrabudgetary contributions. However, sustaining a strategic vision and ensuring freedom of action require the development of a clear funding strategy in order to support both core WHO functions in oPt and involvement in particular projects and programmes.

Core funding, preferably under the WHO regular budget, will be ensured for a minimum, permanent presence, while other sources will be sought to support more time-limited commitments. "Time-limited" does not necessarily mean "short-term" and the Organization will seek to engage funding partners in a sustainable funding strategy for the agenda described in section 6 above. Mechanisms like Associate Professional Officers, United Nations Volunteers and other modalities of getting health personnel at reasonable cost will be explored. The Organization is faced with the ongoing challenge of making explicit and demonstrating its role to convince donors about the need to support WHO action. This approach requires persistence and a willingness to engage donors in ongoing dialogue and to invite them to see how WHO operates in a given environment. This can be done but requires consistency, good documentation, follow-up and reporting.

7.2 Regional Office for the Eastern Mediterranean (EMRO)

The Regional Office is now becoming the first level of managerial, administrative and technical support to the office in the oPt. The Regional Office will help strengthen the country presence through expertise and guidance while supporting the office in mobilizing the adequate level of resources. It will continue to involve oPt in regional activities relevant to the strategic agenda outlined in this cooperation strategy. Swift response to requests from the country office will be essential in such a complex, and crisis-prone, environment. The Regional Office will also explore possible fundraising (i.e. extrabudgetary funds) for work in oPt.

In order to provide support effectively, it is absolutely essential that all Regional Office staff have smooth and unconditional access to oPt as international civil servants. To date, the Israeli authorities have provided visas to a very limited number of Regional Office staff. This has seriously hampered the support from the Regional Office. The Organization at large needs to work to realize this essential need in collaboration with all relevant authorities.

7.3 WHO headquarters

WHO headquarters will support the Regional Office as needed in its response through global guidance, information, sharing of experiences with other countries in other regions as well as expertise in particular domains. Headquarters will play a key role in the mobilization of resources and will have to ensure those are provided in a flexible manner to the country office, for responding to the needs identified in the present cooperation strategy.

Annex 1

HISTORY OF WHO INVOLVEMENT IN OPT[39]

WHO involvement with the Palestinians is as old as the Organization. When the UN General Assembly voted Resolution 191, creating the United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNRWA), the agency turned to WHO to help it create the Health Department which now provides basic health services to Palestinian refugees in Lebanon, the Syrian Arab Republic, Jordan and the Occupied Territories. WHO has, since 1949, been responsible for appointing the handful of international staff that forms the nucleus of the UNRWA Health Department.

Parallel to WHO's early involvement with UNRWA, and due to the acceptance in early 1975, of the Palestinian Liberation Organization (PLO) as an observer in the UN, the PLO was invited to participate in the General Assemblies of various UN agencies, including WHO, in an observer capacity.

With the establishment of the Palestinian Authority in 1994, the newly-created Palestinian Ministry of Health absorbed the health service previously managed by the Israeli Civil Administration. The Palestinian leadership refuses the incorporation of the health services operated by UNRWA within the Palestinian Ministry of Health, since the overall policy of the Palestinian Authority retains the notion that the Palestinian refugees constitute an international responsibility. The issue of refugees is the subject of ongoing talks.

WHO assistance to the Palestinian people has gone through various stages. It evolved with the situation on the ground, before the first *intifada,* at the time of the *intifada*, and after the conclusion of the Oslo Agreement. In 1994–1995, WHO worked with the two parties (Israel and the Palestinians) in easing the transfer of the health services from the Israeli Civil Administration to the Palestinian Authority. WHO supported setting up the nascent Palestinian Ministry of Health (with funds from Japan) and assumed the Secretariat role of the Health Sector Working Group to the LACC established under the Co-chairmanship of the Palestinian Authority, Norway and the UN Special Coordinator in the Occupied Territories. The Director-General of WHO regularly reports to the World Health Assembly on the health conditions of, and assistance to, the Arab population in the Occupied Arab Territories, including oPt. Discussions are followed by the adoption of a resolution calling for renewed support.

At the regional level, in 1985, the Regional Office made special arrangements with the Palestinian Red Crescent Society and UNRWA, which it supported financially and with posts.

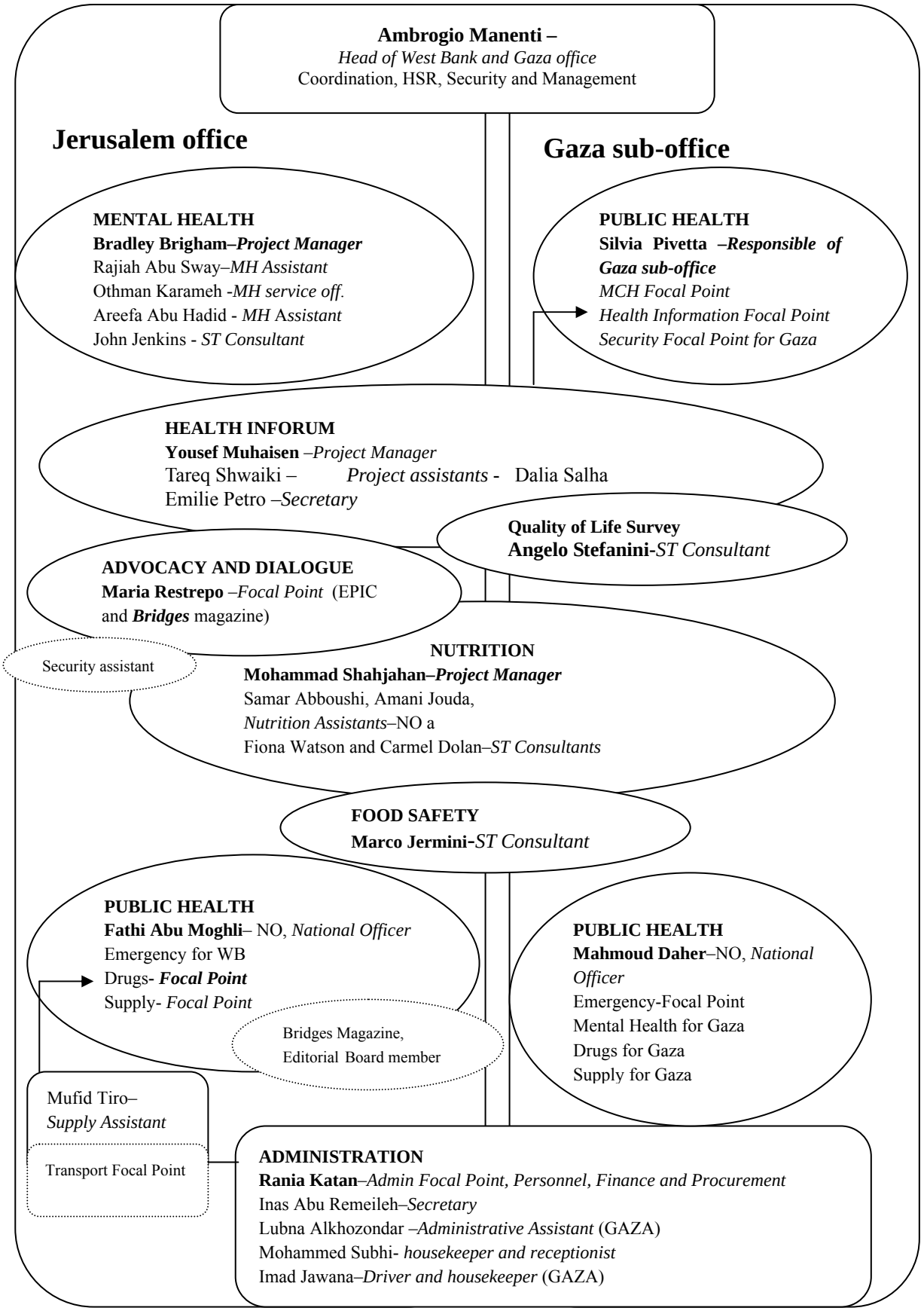
In 1993, the Regional Committee for the Eastern Mediterranean adopted a resolution welcoming Palestine as a member of the Regional Committee for the Eastern Mediterranean (EM/RC40/R.2) without voting rights. At the same time, the Member States agreed to deduct

[39] *Report of mission to EMRO and the Palestinian Territory, 9–16 October 1999.* Dr JP Menu and Mr J Hazbun, Department of Emergency and Humanitarian Action, WHO headquarters.

1% of the indicative planning figure from the WHO regular budget of the Region, to be used in providing assistance to the oPt. Following the Oslo Accords, the Regional Office invited various representatives of Palestinian groups and reached a consensus on a comprehensive framework for the national health sector.

Annex 2

ORGANIZATIONAL CHART OF THE WHO OFFICE WEST BANK AND GAZA



Annex 3

MAPS