

# Humanitarian-development- peace nexus for health profile

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## OCCUPIED PALESTINIAN TERRITORY



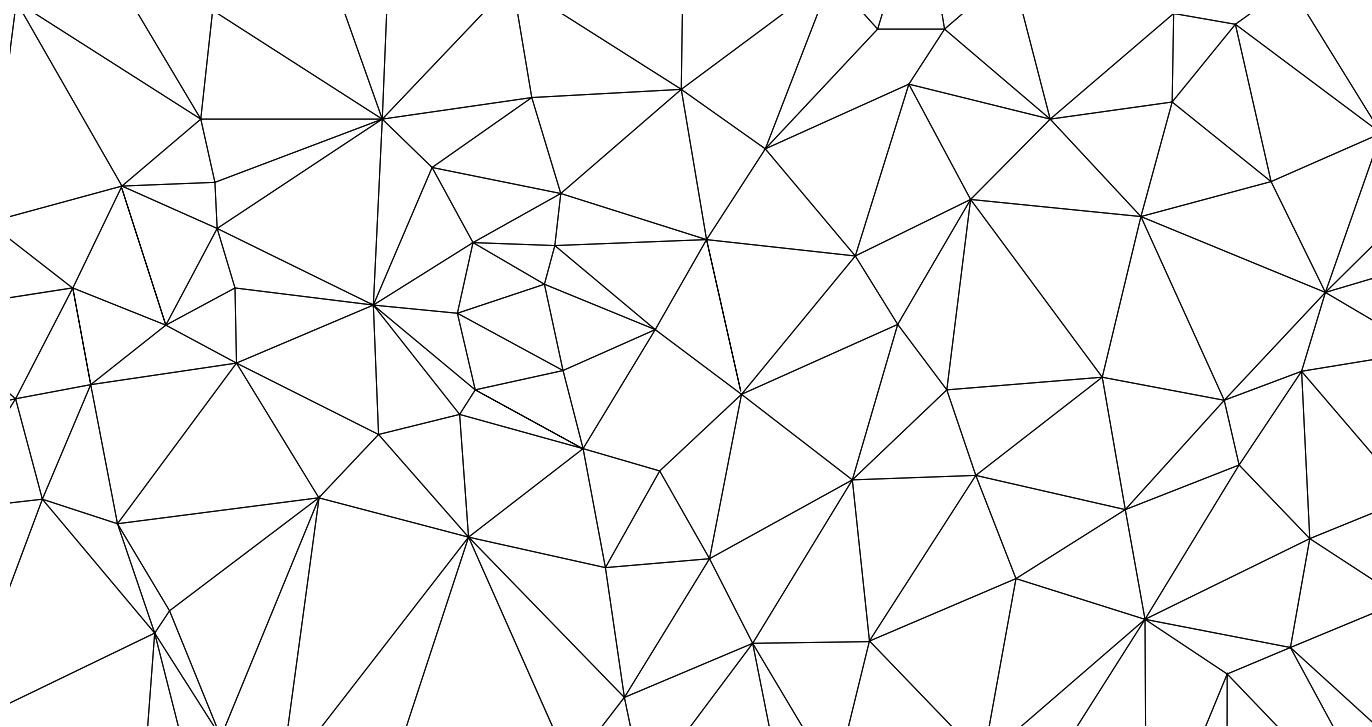
*February 2021*



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## WHO Library Cataloguing in Publication Data

**Names:** World Health Organization. Regional Office for the Eastern Mediterranean

**Title:** Humanitarian development peace nexus for health profile: Occupied Palestinian Territory, February 2021 / World Health Organization. Regional Office for the Eastern Mediterranean

**Description:** Cairo: World Health Organization. Regional Office for the Eastern Mediterranean, 2021 | Includes bibliographical references

**Identifier:** ISBN 978-92-9022-764-9 (pbk.) | ISBN 978-92-9022-766-3 (online)

**Subjects:** Emergencies | Relief Work | Delivery of Health Care | Warfare - prevention & control | COVID-19 | Betacoronavirus | Disease Outbreaks | Health Status | Palestine

**Classification:** NLM WA 295

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**Suggested citation.** Humanitarian-development-peace nexus for health profile: occupied Palestinian territory: February 2021. Geneva: World Health Organization; 2021. Licence: CC BY-NC-SA 3.0 IGO.

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# Acknowledgements

**THIS DOCUMENT WAS JOINTLY** produced by the World Health Organization (WHO) Office in the occupied Palestinian territory (oPt) and the Health Systems in Emergencies Lab in the Department of Universal Health Coverage/Health Systems, in collaboration with the Department of Health Emergencies and Department of Healthier Populations, at the WHO Regional Office for the Eastern Mediterranean.

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The team wish to acknowledge the contributions made by Dr Mohamed Ali Kamil (Programme Area Manager for Emergency Operations), Dr Alaa Abouzeid (Team Lead Partnership), Dr Wasiq Mehmood Khan (Regional Adviser), Dr Rayana Ahmad Bou Haka (Manager, Country Cooperation Unit), Dr Khed EL Tahir (Emergency Officer), Dr Vian Russel (Technical Officer, Department of Healthier Populations) of the WHO Regional Office for the Eastern Mediterranean, and Dr Andre Griekspoor (Senior Policy Adviser), Dr Rudi Conix (Senior Policy Adviser) and Dr Mathilde

Boddaert (Technical Officer) from WHO headquarters, and Clara Affun (Consultant).

The document was produced under the overall direction of Dr Gerard Rockenschaub (WHO Representative in oPt), Dr Awad Mataria (Director, Universal Health Coverage/Health Systems), Dr Richard Brennan (Regional Emergency Director) and Dr Maha El-Adawy (Director, Healthier Populations). The team gratefully acknowledge Dr Ahmed Al-Mandhari (WHO Regional Director for the Eastern Mediterranean) and Dr Rana Hajjeh (Director of Programme Management), for their support to the initiative.

We would like to thank the United Kingdom's Foreign, Commonwealth and Development Office, the European Union, Luxembourg, as well as the Governments of France, Ireland and Japan for their funding support through the Universal Health Coverage Partnership for health systems in emergencies work in the WHO Regional Office for the Eastern Mediterranean, including the development of this profile. The work was also partially funded by the Federal Ministry of Health of Germany.

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## **Abbreviations**

<b>CCA</b>	Common Country Assessment
<b>COVID-19</b>	Coronavirus disease 2019
<b>HCT</b>	Humanitarian Country Team
<b>HDPNx</b>	Health-development-peace nexus
<b>HeRAMS</b>	Health Resources and Services Availability Monitoring System
<b>HRP</b>	Humanitarian response plan
<b>MoH</b>	Ministry of Health
<b>NGO</b>	Nongovernmental organization
<b>NIS</b>	New Israeli Shekel
<b>NPA</b>	National Policy Agenda: Putting Citizens First
<b>OCHA</b>	United Nations Office for Coordination of Humanitarian Affairs
<b>oPt</b>	Occupied Palestinian territory, including east Jerusalem
<b>PHC</b>	Primary health care
<b>RC/HC</b>	Resident/Humanitarian Coordinator
<b>UHC</b>	Universal health coverage
<b>UN</b>	United Nations
<b>UNCT</b>	United Nations Country Team
<b>UNRWA</b>	United Nations Relief and Works Agency
<b>WHO</b>	World Health Organization





# 1. Introduction

**THE HUMANITARIAN-DEVELOPMENT-PEACE NEXUS (HDPNX)**, as part of the New Way of Working, is a framework for coherent, joined-up planning and implementation of shared priorities between humanitarian, development and peacebuilding actors in emergency settings. In any crisis-affected setting, the dynamic and non-linear nature of emergencies can mean different stages of the nexus process may be ongoing, leading to varying presence and levels of activity of humanitarian and/or development actors. Therefore, the HDPNX approach should be initiated from the earliest phases of the emergency and should remain in operation until a humanitarian response plan is no longer in place. To advance the HDPNX in a given country, a shared, foundational understanding of the current progress must be established. However, finding such a resource can be challenging, perpetuating poor understanding, planning and operationalization. To address this need through a health lens, the HDPNX for health profiles aim to provide an overview of health-related nexus efforts and of opportunities for advancing humanitarian and development collaboration and health as a bridge to peace in countries affected by protracted emergencies in the Eastern Mediterranean Region of WHO.

Although there is consensus as to the value of the HDPNX approach, the question of how to operationalize it remains. As HDPNX operationalization is at a nascent stage, many cross-cutting humanitarian, development and

peacebuilding activities have not been formally labelled or conceptualized as “HDPNX,” although the collaborations between the three groups of actors exist. Conceptual criteria were therefore needed in order to evaluate whether or not an activity should be considered “HDPNX” work. In this profile, HDPNX or nexus-style activities are defined as the following:

“Any health-related activity where at least two of the three groups of actors (humanitarian, development and peace), work together with the aim of fulfilling at least two of the following: providing immediate lifesaving and life-supporting assistance; strengthening or rebuilding national systems, institutions and capacities; strengthening emergency management capacities; and addressing the drivers of emergencies.”

The development of the *Health-development-peace nexus for health profile: occupied Palestinian territory* is a joint initiative by WHO Office in the oPt and the Health Systems in Emergencies Lab in the Department of Universal Health Coverage/Health Systems, in collaboration with the Department of Health Emergencies and Department of Healthier Populations, at WHO Regional Office for the Eastern Mediterranean, as well as relevant programmes at WHO headquarters.

## 2. Overview of crisis

### Political conflict

The humanitarian context of the occupied Palestinian territory, including east Jerusalem (oPt) follows more than 50 years of Israeli occupation, with cyclical escalations in conflict between Israeli Security Forces and Palestinian armed groups, violations of international humanitarian and human rights law and internal Palestinian political divisions. (1)

These factors are magnified in the Gaza Strip, by the continued blockade imposed by Israel, the increasing internal divide between the West Bank-based Palestinian Authority and Hamas, and the intensification of casualties during the Great March of Return – demonstrations calling for the Palestinian right of return and ending of the Israeli blockade. Although the Great March of Return was suspended at the end of 2019, thousands of wounded and/or traumatized people continue to suffer consequences of these demonstrations. Furthermore, Hamas' control over Gaza has continued to impede development, as land, sea and air closures have been imposed on the Gaza Strip. (2)

Although the situation in the West Bank, including East Jerusalem, is less acute, Israel has increasingly seized lands, exploited natural resources and established/expanded settlements, illegal under international humanitarian law. (1) Many Palestinians who reside in the occupied West Bank - particularly in Area C, East Jerusalem, and the settlement area of Hebron city (H2) - face the risk of forcible transfer due to certain Israeli policies and practices. (1)

The persisting humanitarian situation has been compounded by significant reductions in donor support for humanitarian actors, namely United Nations Relief and Works Agency (UNRWA) and other UN agencies, in addition to tighter restrictions on operational space, limiting the ability of the international community to implement an effective response. (1)

As a result of the protracted crisis in oPt, over two million people – nearly half of all Palestinians living in the oPt, including around 75% of all residents of Gaza – were projected to need some form of humanitarian assistance in 2020. (1, 2) The population of refugees living in the oPt is 2.2 million, with 70% (1.4 million) living in the Gaza Strip. (3)

### Impact of the COVID-19 pandemic

The impact of COVID-19 has exacerbated pre-existing humanitarian needs from the protracted crises in oPt. On 5 March 2020, the Palestinian Prime Minister declared a State of Emergency to contain the spread of COVID-19, after the first cases were confirmed in Bethlehem city. (4) Since then, the number of confirmed cases has risen to, as of 30 December 2020, 152 558 with 1479 associated deaths. (5)

The capacity of the Palestinian health system to cope with the spread of the pandemic is severely weakened, especially in Gaza, where the health system continues to decline as a result of ongoing conflict between Hamas and Israel, the Israeli blockade, the internal Palestinian political divide, a chronic power deficit and shortages in health workforce, drugs and equipment. (4) The Palestinian health system has very limited capacity to cope with the surge of patients due to the pandemic. This has made it challenging to maintain the provision of essential health services such as vaccination, non-communicable diseases management, and mother and child health care to the most vulnerable Palestinians. Across the oPt, movement restrictions, school closures and growing unemployment are taking a toll on the most vulnerable. Service providers report that domestic violence affecting women and children is on the rise. (4) In addition, COVID-19-related fear, anxiety, and social isolation has placed Palestinians under unprecedented physical, mental and social well-being pressures, exacerbating the condition of those with mental health disorders. (6)

At the same time, the Palestinian and Israeli authorities have maintained cooperation in some efforts to contain the pandemic. For example, Israel has enabled the entry of critical supplies and equipment into Gaza. But appeals to Israel for

allocation of vaccines to Palestinians have not yet led to the expected results. Among the Palestinian authorities, despite longstanding tensions, there has also been coordination between the Ramallah-based Palestinian Authority and the Gaza-based Hamas authorities. (4)

### 3. Public health status and health system

The protracted conflict has led to an overburdened health system suffering from damaged infrastructure, limited human resources, a partially functional referral system and chronically depleted medical supplies. (1) Currently, an estimated 1.3 million people are in need of humanitarian health interventions across the oPt, with two out of every three of these being in the Gaza Strip. Within the Gaza Strip, nearly 20% of the population requires humanitarian interventions for sexual, reproductive, maternal, neonatal and child health and nutrition services; one in six of Gaza's adult population requires treatment for non-communicable diseases; 10% suffer from severe mental health disorders; and 20% of pregnant women in the poorest communities are undernourished. The health system in the Gaza Strip has been undermined by ongoing conflicts, blockade and shortages in staff, drugs, and equipment.

In the West Bank, the capacity of vulnerable communities, particularly in Area C, to cope with the crisis continues to be undermined by the Israeli authorities' destruction of property lacking building permits, as well as by Israeli settler violence. (4)

The oPt faces many challenges that adversely affect the health of the population. The chronic exposure to trauma and violence related to the occupation has led to a crisis in mental health, with the oPt having the largest burden of mental health disorders in the Eastern Mediterranean Region. (1) The burden of disease attributable to communicable diseases is 15.1%, noncommunicable diseases 74.9% and injuries 5.5%. Cardiovascular disease is the number one cause of death in the oPt. (3) Similar to other health systems in the region and globally, the COVID-19 pandemic had grave implications for the oPt health systems. This was seen in the increased need for health workforce, supplies and equipment, hospitals and primary health care (PHC) capacities to respond to COVID-19 and at the same time maintain essential health services. More than ever, the importance of investment in common goods for health became apparent in the form of investments to strengthen prevention and communicable disease

programmes, as prioritized in the National Health Strategy. (7)

In addition, the Palestinian Authority's financial crisis in 2020 had an impact on the financial sustainability of the East Jerusalem Hospitals. The Palestinian Authority's debt to the East Jerusalem hospitals affected the hospitals' operational capacity at a time when the COVID-19 pandemic caused a decline in their revenues (30% reduction since July 2022) due to the reduction of referrals and reduced utilization of health services.

#### Service delivery

PHC is administered by various health service providers, including the Ministry of Health (MoH), nongovernmental organizations (NGOs), the UNRWA and Military Medical Services. In 2019, there were 591 PHC centres in the West Bank and 158 centres in Gaza Strip. The MoH centres comprise 63.4% of the total number of PHC centres. (8)

The MoH is also the main provider of secondary health services (hospital care) in the oPt, running 3531 hospital beds in 28 hospitals, out of a total of 85 hospitals with a total capacity of 6435 beds. Of the 85 hospitals, 53 are in the West Bank including East Jerusalem, with a capacity of 3950 beds, accounting for 61.3% of total hospital beds in the oPt, with the remainder located in Gaza. In addition to the MoH, NGOs run 38 hospitals with the capacity of 2096 beds. The private sector runs 16 hospitals with a capacity of 573 beds. (8)

MoH hospital beds cover the majority of medical specializations, including general surgery and specialized surgeries, internal medicine, pediatrics, mental illnesses and others. Rehabilitation and physiotherapy services are offered by NGOs. While dialysis services are mainly supported by MoH facilities. (7)

In instances where further specialist health care may be needed, the Palestinian MoH may refer Palestinian patients to non-MoH facilities inside or out of the oPt. However, referrals out of Gaza and out of the West

Bank to East Jerusalem hospitals require Israeli-issued permits to access health facilities. In Gaza, the approval rate for patient permits to pass through the Israeli-controlled Erez crossing was 61% in 2018, increasing to 67% in the first seven months of 2019. In the West Bank, the approval rate for patient permits to access hospitals in East Jerusalem from the rest of the West Bank or to access hospitals in Israel from the West Bank outside of East Jerusalem has remained similar over the last eight years. In the first seven months of 2019, the combined approval rate for patient and patient companion permit applications was 80%. (1)

## Health workforce

Health workers are employed by five major providers: the MoH, Military Medical Services, UNRWA, NGOs and the private sector. The majority of workers in the West Bank and Gaza Strip are employed by the public sector. Of the 36 809 health workers in the oPt, 56% work in the West Bank and 44% in the Gaza Strip. Additionally, 14% of the total workforce are doctors and 23% are nurses. (3)

Overall, the ratio of nurses to doctors is 1.7 and 1.4 in the West Bank and the Gaza Strip respectively. The ratio of nurses to doctors is highest (3.3) in private sector hospitals in the West Bank and lowest in the private sector for the Gaza Strip. Overall, the Gaza Strip has lower nurse-to-doctor ratios in the hospital setting across all sectors. (3)

On average, the health workforce in the oPt is relatively young, with 74% of all health workers under the age of 45, and 4% over the age of 60. More specifically, 65% of doctors and 79% of nurses are under the age of 45. The large young population in the oPt, as well as the introduction of new academic health programmes, have contributed to the increase in a younger workforce. (3)

## Health information systems

The establishment of a comprehensive national health information system has been prioritized in the National Health Strategy. The Ministry of Health, with the support of WHO, previously conducted a comprehensive national health information system assessment with the

participation of the main stakeholders, and a strategy has subsequently been developed.

In the West Bank, all governmental hospitals use electronic medical records in the hospital facility-based information system “Avicenna-Turkish System”. Data from the electronic medical records are transferred to a central relational database at the MoH; data is extracted, and managerial dashboards have been produced to support the Ministry in decision making. Ongoing efforts by the Palestinian National Institute of Public Health are underway to use the District Health Information System (Norwegian System - DHIS2) starting with the mother and child health clinics in the primary health care clinics.

Health information system strengthening is also a core function of the Public Health Institute, which emphasizes assessing the ability of the current systems to generate evidence-based data for decision-making. With the support of WHO, the Institute, developed a human resources observatory, conducted initiatives to strengthen surveillance systems, civil registration, and research and played an essential role during the current COVID-19 pandemic.

The Health Cluster aims to expand the Health Resources and Services Availability Monitoring System (HeRAMS) to NGO health care facilities, which is currently being implemented at MoH and UNRWA facilities in Gaza, targeting 14 public hospitals, 49 primary health care clinics and 22 UNRWA clinics. HeRAMS includes an integrated component on the monitoring of fifteen to twenty tracer medicines availability in health facilities on a monthly basis. It is also planned to be extended to mobile clinics in the West Bank.

## Essential medicines

The oPt health system has experienced persistent challenges, including the shortage of essential medicines and supplies. The lack of medicines is particularly severe in the Gaza Strip, where on average, in the first half of 2019, 42% of the items on the essential medicines list were recorded as out of stock. According to the MoH, the shortage in essential medical drugs exceeded 52% as of May 2019. This shortage is seriously threatening the quality

and availability of health care provided to thousands of patients seeking health care services. (1)

## Health financing

Government health expenditure as a share of general government expenditure exceeded 12% in 2019, indicating a high priority for health in the government budget. Despite this, out-of-pocket expenditures for health care as a percentage of current health expenditure in the oPt has increased to one of the highest in the region at 39.5%, disproportionately impacting the poorest. In 2018, the share of government health expenditure was 44.8% of the total health expenditure. (1)

Government health expenditure as a share of general government expenditure reached 14% in 2017, indicating a high priority for health in the government budget. In 2018, the share of governmental health expenditure was 44.8% of the total health expenditure. On the other hand, out-of-pocket expenditures for health care as a percentage of current health expenditure in the oPt remains high as compared to other countries in the region at 39.5%, disproportionally impacting the poorest. (9)

## Leadership and governance

The oPt health sector consists of four main partners: the MoH and Military Medical Services, the

UNRWA, NGOs and the private sector. These four partners participate in the delivery of health services at three levels: primary health care, secondary health care and tertiary health care. The MoH is the institution responsible for leading and regulating the health sector, ensuring the allocation of necessary resources for its sustainability and development in response to the dynamic needs of the population. The nongovernmental health sector works in tangent with the MoH in institutional development and health planning. Private and NGO hospitals, including East Jerusalem hospitals, play a major role in providing health services, particularly tertiary health care services. In addition, the Palestine Red Crescent Society (PRCS) is the prime provider of ambulance and pre-hospital emergency medical services in oPt. UNRWA offers health services in the West Bank and Gaza Strip to Palestinian refugees (42.8% of the population in the oPt are refugees, around 2.03 million refugees). International organizations, including UN agencies, donors and countries, play an important role in supporting the Palestinian health sector's sustainability and development by offering the required financial, logistical and technical support. Moreover, the international community plays an important role in raising awareness about the situation in oPt and the importance of international support to the Palestinian health sector. (7)

## 4. HDPNx operationalization

This section highlights the health activities pertinent to operationalization of the HDPNx for health in the oPt, while putting into perspective the wider scope of HDPNx conceptualization and operationalization in the country.

### Coordination architecture

The United Nations Development Assistance Framework (UNDAF) details the UN's cooperation framework with the Government of Palestine from 2018-2022. The UNDAF presents key shared objectives of the UN system in oPt, the issues on which the UN intends to support the Government of Palestine, as well as the expected outcomes. (2) The UN's objective is to “enhance development prospects for the people of Palestine, by advancing Palestinian statehood, transparent and effective institutions, and addressing key drivers of vulnerability.” (2) To do this, the UNDAF 2018-2022 outlines four strategic priorities:

1. Supporting Palestine's path to independence;
2. Supporting equal access to accountable, effective and responsive democratic governance for all Palestinians;
3. Supporting sustainable and inclusive economic development;
4. Supporting social development and protection.” (2)

Within oPt, the United Nations Country Team (UNCT) is an accumulation of 19 resident UN agencies, funds and programmes which have offices in oPt, in addition to five non-resident agencies. The 24 agencies, funds and programmes together provide a diverse range of expertise across humanitarian and development activities. (2) The UNCT's comparative advantage includes the ability to link humanitarian and development strategies given the dual role of the Resident/Humanitarian Coordinator (RC/HC) and the fact that many United Nations Development Group (UNDG) members are also working on humanitarian issues.

Since the onset of COVID-19, an Interagency COVID-19 Task Force has been established, meeting two to three times per week to set policy and to coordinate responses. Outside of the task force, the RC/HC has been convening a weekly general coordination meeting, including a wider group of partners and donors. The RC/HC and the UN Office for the Coordination of Humanitarian Affairs (OCHA) currently engage on a regular basis with relevant Palestinian authorities, including the Prime Minister's Office and Palestinian Civil Defense and Governors' offices throughout the West Bank. In addition, regular engagement with Israeli authorities, including the National Security Council of the Prime Minister's Office, Coordinator for Government Activities in the Territories and the National Emergency Management Agency, has also been taking place. (4) Between the West Bank and the Gaza Strip, the Inter-Cluster Coordination Groups is responsible for implementation of Task Force decisions and monitoring of movement restrictions on regular humanitarian programming. The Palestinian and Israeli authorities continue their cooperation in efforts to contain the pandemic.

### Joint analysis

Although humanitarian and development actors have conducted most assessments separately, there have been considerations of the needs of the other. On the humanitarian side, the Humanitarian Needs Overview (HNO) showcases analysis of the overall affected population, disaggregated by age and gender across key geographic areas of concern. Specific attention has been placed on the most vulnerable groups, which were identified by the Humanitarian Country Team (HCT). The analysis was drawn from a range of primary and secondary data sources. (1)

On the development side, the oPt Common Country Analysis (CCA), was conducted by the UN in 2016. The CCA investigated the structural obstacles to achieving the 2030 Agenda goal to ‘leave no one behind.’ This was done by analysing the situation of twenty

highly vulnerable groups, the main drivers of their vulnerability and the challenges they face under oPt's current development course. (2) The report seeks to address why some groups in society are systematically more disadvantaged in the ability to access the oPt's development gains. The CCA serves as the analytical basis for the UN's development strategy for oPt, reflected in the UNDAF 2018–2022. The CCA identifies seven key imperatives to translate the findings of the CCA into action. One of these imperatives is to “bridge the development-humanitarian divide.” (10)

A final example of a health-related analysis with a HDPNx approach can be seen in the Universal Health Coverage (UHC) High-Level Mission, conducted by WHO from 25 to 28 August 2019, to further support the oPt's road to UHC. The focus of the mission was on the following priority areas:

- I. The national health financing system, including the national health insurance strategy;
- II. Strengthening health service delivery through a family practice approach to primary care delivery,
- III. Ensuring frontline acute care, and implementing concrete quality improvement initiatives; and
- IV. Optimizing movement across the system via hospital master planning, strengthening emergency care system organization, setting standards for referrals, and improving health system planning at the national level. (11)

## Collective outcomes

The definition of collective outcomes can ensure that all health actors have a common vision that drives their planning and programming, bridging the spectrum between immediate assistance and long-term development.

In 2016, the Palestinian Government embarked on a consultative planning process to identify the national development priorities for 2017-2022. The result of this process was the National Policy Agenda: Putting Citizens First (NPA), which outlines three pillars that chart the strategic direction of the Government in the coming years. The three pillars include: 1) Path to independence; 2) Government reform; and 3) Sustainable development. Under each

pillar, national priorities and sector-based policies were outlined. (12) Specific to health is Pillar 3: Sustainable development, which contains the National Priority 9, “Quality health care for all.”

The National Health Strategy further expands on the pillars and priorities laid out in the NPA, linking the NPA and sectoral health strategic objectives. The National Health Strategy is centered around six national strategic objectives:

1. Ensure the provision of comprehensive health care services for all citizens towards nationalization of health services in Palestine;
2. Promote programmes for the management of noncommunicable diseases, preventive health care, community health awareness and gender issues;
3. Mainstream quality systems in all aspects of health service delivery;
4. Enhance and develop the human resource management system;
5. Enhance health governance, including effective management of the health sector, enforcement of laws and legislations, cross-sectoral coordination and integration among service providers;
6. Enhance health financing and improve financial protection of Palestinian citizens against health costs. (7)

The specific objectives for the health cluster under the oPt 2021 Humanitarian Response Plan (HRP) are to:

1. Ensure the availability of acceptable and quality essential health care services to vulnerable communities in oPt;
2. Strengthen the health care system's capacity to respond to emergencies and build community resilience to cope with the impact of current and future crises;
3. Advocate for unhindered and equitable access to health care and protection of the right to health for all, including the most vulnerable in oPt (13).

Although the HRP outlines humanitarian activity objectives, all three objectives can be considered HDPNx-style as they bridge humanitarian and development interventions.



## Joint planning and implementation

A primary example of HDPNx-style, multi-year planning can be seen in the discussions led by the UN Office for the Coordination of Humanitarian Affairs (OCHA) in 2017 to develop an HRP spanning a three-year period of 2018–2020. One objective for this extended time period was to encourage efforts that may address the drivers of vulnerability, even if these efforts may be outside the reach of traditional humanitarian action (1). In creating a three-year HRP, OCHA promoted the principles of the New Way of Working, particularly in framing the work of development and humanitarian actors, along with national and local counterparts, in support of collective outcomes. (14)

In addition to joint planning, the collaboration between the Italian Agency for Development Cooperation and WeWorld-GVC in designing a toolkit is an example of implementing the nexus in oPt. It was based on a joined-up, multi-sector analysis called the “Community Protection Approach”. (14) The methodology for this initiative was first piloted at the community level in Area C by WeWorld-GVC and later adopted by the West Bank Protection Consortium, a consortium funded by 11 actors, including European Union institutions and member states. The coordination system implemented in Area C of the West Bank included donors, international NGOs, local and national authorities, UN agencies and local communities. The West Bank Protection Consortium employed both humanitarian and development funds from various donors to implement its activities. The coordination system supported a common programmatic framework with direct outcomes in the targeted communities in Area C. (14)

The WeWorld-GVC Toolkit presented an approach to pave the way for integrating the HDPNx into the strategies and operations of implementing agencies. In addition to the Toolkit, the following three strategic lines of action were proposed:

1. Territorial approach: connect communities with territorial planning;
2. Main streaming of international human rights law, international humanitarian law and international refugee law; and

3. Strengthening of communities and governance mechanisms in oPt

## Joint monitoring and evaluation

Currently, oPt is making strides towards promoting the HDPNx in joint monitoring and evaluation. On the humanitarian side, monitoring and evaluation has traditionally been led by the Assessment Information Management Working Group (AIMWG). This group operates under the guidance of the Humanitarian Country Team (HCT), chaired by the RC/HC. On the other hand, the UNCT in oPt has formed a “Data Group” to simplify, streamline and improve UN development activities through better data sharing, improved collaboration, as well as common assessments and analyses. The work of the Data Group directly feeds into the UNCT monitoring and evaluation and other analytical materials and facilitates the process of drafting the next Common Country Assessment. One of the UNCT’s goals is that the data used by the humanitarian and development systems in oPt are aligned with each other and so work is not duplicated.

In preparation for joint strategic planning in 2021, the RC/HC decided in August 2020 to merge the UNCT Data Group and the HCT AIMWG. The two groups are set to work collaboratively on the 2021 Humanitarian Needs Overview process and to fully merge their operations by the end of 2020. This new entity, the “Nexus Data and Analysis Group,” will coordinate all common data work and analysis by the UNCT and HCT. The Group’s mandate includes, but is not limited to, coordinating:

- I. Nexus-related analyses;
- II. All common data work and analysis on COVID-19 impact assessment;
- III. All common data work and analysis on the impact of annexation and/or non-cooperation;
- IV. All common data work on needs and response analysis;
- V. Any requests by the Palestinian Government for common data work and analysis by the UNCT or HCT; and
- VI. National capacity building, for example on the use of evaluation.

Although the merge has been fully endorsed by the UNCT, the approach and discussion as to how best to achieve it is still ongoing.

In addition to the Nexus Data and Analysis Group, the HeRAMS Initiative is supported by WHO in the Gaza Strip for MoH hospitals, PHC facilities and UNRWA PHC centres. The HeRAMS Initiative aims to ensure that core information on essential health resources and services is readily available to decision makers. It looks into functionality of health facilities, availability of key services, medical equipment and pharmaceuticals. HeRAMS is also used to strengthen health information systems, particularly through the compilation, maintenance, regular updating and continuous dissemination of an authoritative master list of health facilities. Its modularity and scalability make it an essential component of emergency preparedness and response, health systems strengthening, UHC and the HDPNx.

## Harmonized resources and financing

In 2019, oPt received almost US\$ 17.4 million for health, amounting to roughly 5% of the total financial support to oPt (US\$ 351.4 million) that year. (15) According to the National Health Strategy 2017–2022, the budget allocation to the MoH for the same period is around 12 billion New Israeli Shekel (NIS), in addition to NIS 14 million allocated to the MoH developmental budget. A further breakdown of this budget shows the following: Programme 1 (Primary health care and public health programme) – 13% of the total budget; Programme 2 (Secondary and tertiary care programme) – 38%; and Programme 3 (Management and governance) – 49%. (7)

An example of a HDPNx-style approach to harmonizing financial resources can be seen in the WHO project, “Improving health systems in oPt towards UHC, Health for all by all.” (16) This project initially called for development funding, from the Italian Development Cooperation, to improve the quality of mental health and psychosocial services and to strengthen health information systems. However, at the same time, there was an identified need for humanitarian funding in the Gaza Strip, as the service delivery and information systems were lagging behind due to the acute

humanitarian situation. Therefore, after consultation with the Italian Development Cooperation, humanitarian funding was also allocated to improve early and essential new-born care in the Gaza Strip with a health systems strengthening approach to improve human resource capacity and quality of care.

Another example of a HDPNx-style approach is the trauma and emergency care project implemented by WHO and health partners in the Gaza Strip. Through this project, donors allocated funds to support the local health authorities in addressing the massive increase in the number of gun-shot injuries due to the acute, humanitarian situation, through a systematic approach. This approach resulted in the strengthening of key elements of the trauma pathway and contributed to building more sustainable health system to respond to future mass casualty events.

Similar consultative and participatory approaches to harmonizing humanitarian and development funding resources can be seen in the context of COVID-19. For example, the majority of humanitarian interventions in the COVID-19 response plan will significantly contribute to the strengthening of the oPt health system, specifically in event-based surveillance, laboratory testing for new and emerging pathogens, and building capacities for case management of patients in critical conditions. To ensure the long-lasting impact of these humanitarian interventions, the UNCT Development Plan for COVID-19 included recovery and development interventions essential to ensuring transition from the current COVID-19 emergency to recovery and longer-term development. This plan was discussed with the donor community and Prime Minister’s Office, to ensure the harmonization of humanitarian and development funding.

## Conflict prevention, peacemaking and peacebuilding

In fragile and conflict-affected countries, “peace building strategies are necessary to ensure lasting health gains.” (17) Conversely, “the health sector can play a significant role in promoting peace by using its competencies, credibility and networks.” (18) The neutrality of the health sector and health workers can be leveraged to mediate and promote dialogue.

The multilateral consultation meeting on the Health and Peace initiative, held on 1 November 2019 and co-sponsored by the Sultanate of Oman and Government of Switzerland in collaboration with WHO Regional Office for the Eastern Mediterranean and with participation from WHO headquarters, gave WHO the opportunity to share lessons learned from the field with the international community. The Health and Peace initiative is an established framework that supports health programmes to operate in conflict settings while contributing to peacebuilding. It calls for increased partnerships among Member States, UN and non-UN partners and academia to conduct diplomacy, build capacity on the ground and design and implement strategic initiatives linking health interventions with peacebuilding. (18, 19)

The Middle East Consortium on Infectious Disease Surveillance is a collaboration of public health experts and Ministry of Health officials from Israel, the Palestinian Authority, and Jordan who are working

together to respond to infectious disease outbreaks and other threats to public health. (20) The aim is to enhance disease surveillance, monitoring and mitigation. At the same time, the consortium has “a vision of promoting long term health, security, and stability across the Middle East” through fostering dialogue to address future challenges.

Another example is the Canada International Scientific Exchange Program, which is based on the “Health as a Bridge for Peace” framework. It was founded to promote cooperation and to facilitate training and patient care exchanges despite current political challenges. Projects from this initiative include the development of medical education in Israel and oPT, the creation of an Arab language health system navigator training programme at the Hadassah Medical Center in Jerusalem and the development of the Peace through Health Experiential Lecture Series aimed at physicians and public health professionals. (21)

## 5. Way forward and recommendations

Significant groundwork has been done in oPt to promote the HDPNx approach. The following are proposed recommendations for advancing the HDPNx for health in oPt:

- I. **Strengthen existing health coordination mechanisms:** The first priority is to fortify the existing health sector coordination structure at the national and sub-national levels, such as the Health Sector Working Group and the Health Cluster. The Health Cluster should feed into this national coordination structure to ensure better linkages between the humanitarian and development programmes. It is recommended that an HDPNx for health strategy be developed to guide the establishment of a nexus coordination mechanism to facilitate collaboration, effective information management, communication, and harmonization of processes and funding/financing resources and instruments among health actors. It should be updated as the situation evolves. It is important to note that health is part of a wider ecosystem as the success of HDPNx for health depends on the success of HDPNx coordination at large.
- II. **Build on ongoing and past health system initiatives towards a more joint humanitarian-development assessments:** Many assessments have been conducted from the humanitarian perspective, with consideration of development needs. A high level UHC health system mission in August 2019 identified developmental gaps in the health system and provided concrete recommendations for health financing and service delivery. However, a more comprehensive joint assessment may be needed in order to advance HDPNx. As with the nexus coordination mechanism, the joint assessment can take many different forms, but should ideally be conducted in an integrated manner by a coalition of nexus actors, using the same tools and common methodology. The joint assessment should follow a rights-based approach and include national and community perspectives, with the aim of strengthening communities and governance mechanisms in the oPt.
- III. **Define health sector development objectives and identify HDPNx for health collective outcomes:** To advance health-related HDPNx work in oPt, collective outcomes need to be jointly identified, to drive planning and programming while bridging the spectrum between immediate assistance and long-term development. The collective outcomes – such as focusing on the advancement of the UHC and Health Security – should be based on the results of the joint assessment. Key entry points for health should be leveraged, such as ensuring an essential package of health services is in place during emergencies and transition phases, strengthening supply chain management and ensuring a sustainable and qualified health workforce during emergencies. Implementation of these entry points has already been attempted, but was impeded by the prioritization of the response to the COVID-19 pandemic.

It is important that civil society and representatives of marginalized groups be included in the formulation of collective outcomes so that no Palestinians are left behind. In addition, it is vital to consider the implementation of other Sustainable Development Goals as progress towards achieving other targets will have an impact on overall health outcomes.
- IV. **Develop a multi-year strategic plan** building on experience of the multi-year HRP 2018-2020 and UNDAF, a multi-year strategic planning should be conducted with the aim of continuing efforts to align response to urgent needs with long-term development in the health sector of the oPt. For this purpose, in addition to the multi-year HRP after 2021, development of the United Nations

Sustainable Development Cooperation Framework (UNSDCF) should be prioritized.

In the midst of the COVID-19 pandemic, it may be challenging for HDPNx actors to come together to develop a shared cooperation framework in light of the ever-changing nature and unknowns of the pandemic. However, as the effects of COVID-19 will continue to impact vulnerable populations into the future, it is vital to have a sustainable strategy for response, recovery, and resilience-building. Cross-cutting issues such as gender equality and human rights should be integrated in HDPNx programme planning, implementation, and monitoring and evaluation.

V. **Bolster monitoring and evaluation mechanisms:**

Regular monitoring of progress should be undertaken to assess the impact of HDPNx for health activities against the collective outcomes. Currently, some monitoring and evaluation coordination exists, but more robust monitoring and evaluation mechanisms are needed. Simultaneously, HDPNx for health focal points should be assigned to facilitate communication and knowledge management. Systematic collection and archiving of HDPNx-related documents should be conducted. Additionally, due to the dynamic nature of the emergency, the HDPNx for health profile for oPt should be updated regularly.

VI. **Create HDPNx-related resource and financing records:**

At this time, there are no agreed upon HDPNx funding mechanisms and discussions surrounding an interagency framework are ongoing. One of the biggest obstacles to

coherent planning in oPt is the absence of a centralized health sector-wide resource tracking mechanism. More precise breakdown of finances is needed in order to understand the current level of resources allocated to HDPNx for health activities and in turn, to gauge the appropriate short, medium and long-term financing/resources required in order to further HDPNx efforts. For example, a possible starting point could be a map of financing strategies of the various health actors to show existing financing flows and to suggest opportunities for harmonizing resources to achieve collective outcomes. In the oPt, the United Nations Country Team and donors may wish to consider establishing a “Nexus Trust Fund,” analogous to the Humanitarian Pooled Fund.

VII. **Mainstream conflict analysis and peacebuilding prioritization:**

Closer coordination among humanitarian, development and peacebuilding actors can be achieved by ensuring that health-related activities are more inclusive of and informed by peacebuilding activities in oPt. The Health and Peace Initiative framework is a primary example of an initiative that can be used for defining interventions to advance the HDPNx agenda. (19) A potential starting point is thorough conflict analysis. Secondly, the development of a risk management strategy is needed to not only identify and assess risks, but also develop mitigating measures to address these risks. Once completed, the conflict analysis and risk management strategies can inform HDPNx programme design. (17, 19)

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**THE HUMANITARIAN-DEVELOPMENT-PEACE NEXUS (HDPNX)** is a new way of working that offers a framework for coherent, joined-up planning and implementation of shared priorities between humanitarian, development and peacebuilding actors in emergency settings. To advance the HDPNx in a given country, a shared foundational understanding of the current situation is needed. However, it can be challenging to find such a resource, perpetuating poor understanding, planning and operationalization. This is one of a series of country profiles that have been developed by WHO to address that need. Each profile provides an overview of health-related nexus efforts in the country and will be updated regularly.

