RESPONSIBILITY SHIRKED

ISRAEL AND THE RIGHT TO HEALTH IN THE OCCUPIED WEST BANK DURING COVID-19

PHYSICIANS FOR HUMAN RIGHTS ISRAEL
רופאים לזכויות אדם בישראל
أطباء لحقوق الإنسان في إسرائيل

The occupying power has the duty to ensure that the medical needs of the civilian population in occupied territory continue to be satisfied

Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts (Protocol I), 8 June 1977

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Executive Summary

- While the COVID-19 pandemic has caused substantial harm to the health, well-being and daily routines of all people around the world, the Palestinians have also had to contend with restrictions imposed by the Israeli occupation regime, which negatively their capacity to handle the pandemic.
- This report demonstrates how the Israeli policy applied to the occupied Palestinian territories (oPt) – characterized by apartheid and colonialism, while evading obligations under international law – has produced tremendous disparities between the Israeli and Palestinian health care systems. This was the case even before the COVID-19 crisis and has remained the situation during the pandemic.
- Throughout the crisis, Israel has eschewed its responsibility for the state of health in the oPt. It has offered very minor, limited humanitarian gestures, while leaving the Palestinians to contend with the crisis on their own. The disparities in preparedness between the Israeli and Palestinian health care systems are apparent in medical and sanitation and hygiene supplies, ventilators, gloves, etc. This disparity between the two populations has been most pronounced with regard to access to vaccines, with Israel explicitly refusing – contrary to recommendations by Israeli medical experts – to provide enough vaccines to the Palestinians. Even status-less Palestinians residing within Israel proper have been denied vaccination – even though Israel has provided vaccines to non-Palestinian status-less individuals living within it.
- Moreover, Israel has used medical assistance as a bargaining chip to achieve political ends, an action which is in breach of international law.

- This report also demonstrates major disparities between the health of the occupied Palestinian population and the population in Israel. These disparities may be seen in the allocation of budgets for health care, in medical personnel, number of hospital beds per capita, funding for public medicine, and so forth. The disparities in medical resources are reflected in other health indices: life expectancy, infant mortality rate, maternal mortality rate, morbidity rate and morbidity-related mortality rates.
- Even prior to the pandemic, the precarious situation of the Palestinian health care system and a lack of resources compelled the Palestinian Authority to significantly curtail all non-emergency medical services – a restriction which was kept in place for a long time. Moreover, in Israel, hospitals opened COVID-19 wards – whereas hospitals in the West Bank turned away COVID-19 patients, referring them to a limited number of specifically designated hospitals.
- The Oslo Accords that Israel and the Palestinian Authority signed between 1993 to 1995 have enabled Israel to shirk its responsibility over the health of the occupied Palestinian population, while carrying on with the occupation of Palestinian land through various practices of dispossession, demolition, and control. By doing so, Israel has kept Palestinians from obtaining a standard of health that is optimal or at least equal to that of the Israeli population.
- This decades-long fundamental violation obliges Israel to end the occupation. So long as Israeli occupation and control prevent Palestinians in the oPt. from independently securing their right to health, Israel is duty-bound to guarantee it. Consequently, Israel is obligated to take action to offset shortages by providing supplies, treatment, and equipment unavailable in the Palestinian Authority and the Gaza Strip. Above all, Israel must lift any and all obstructions and barriers it imposed that hinder the development of the Palestinian health care system and its ability to properly address the needs of the Palestinian population.

Abstract

The COVID-19 crisis has made it clear that although that entire world has had to cope with its fallout, not everyone has suffered equally. Countless studies and findings have demonstrated that the pandemic has inflicted disproportionate harm on populations suffering from poverty, discrimination, and institutionalized oppression - burdens which make it difficult for them to manage the pandemic properly.[1] On top of these disadvantages, Palestinians in the oPt must also contend with the results of years of military occupation and closures, which negatively impact their ability to handle the COVID-19 crisis. While Israel has no less of a responsibility towards the Gaza Strip, this report focuses on the West Bank because the separation between the two areas created disparate conditions which require a separate analysis.

For more than five decades, Israel has imposed a harsh military rule in the West Bank, controlling most aspects of the lives of the Palestinian population there. During all that time, Israel has refrained from investing in infrastructure that would benefit the Palestinian population, exploited natural resources, and expropriated West Bank land to benefit its own citizens. In the course of implementing these actions Israel has violated human rights, while severely restricting freedom of movement and the development of the Palestinian economy and society in the West Bank.[2]

The Oslo Accords signed between the PLO and the Israeli government in the 1990s, were designed to establish a temporary framework through which to facilitate the Palestinian leadership's shift to a sovereign state. Under the accords, responsibility for civilian matters – including health – was transferred to the

[1] David Mills, Bram Wispelwey, Rania Muhareb and Mads Gilbert, "Structural Violence in the Era of a New Pandemic: The Case of the Gaza Strip," The Lancet, March 2020.

[2] Human Rights Watch, Born without Civil Rights: Israel's Use of Draconian Military Orders to Repress Palestinians in the West Bank, December 17, 2019 [Hebrew].

Palestinian leadership. In practice, however, Israel retained the majority of the power. The promises held out by the Oslo Accords collapsed in the face of a reality of a diplomatic standstill, armed conflicts, closures, physical barriers and roadblocks which divided the oPt into enclaves, while construction in Israeli settlements continued unabated. The mechanisms of the occupation remained in place as tools of control and prevented sovereignty in the oPt. Under these circumstances, the Palestinian health care system remained poor in financial resources and personnel and lacking in various spheres of medicine and health. The Palestinian Authority was therefore obliged to spend a significant portion of its health care budget on purchasing external health services, including from Israel – a situation which merely compounded the existing budgetary hardship and, in turn, increased dependence on international aid and donations.[3]

The outbreak of the COVID-19 pandemic further exposed the weakness of the Palestinian health care system, with a severe shortage in COVID-19 tests, sanitation and hygiene supplies, ventilators and ICU beds. The West Bank was placed under both an external closure (by Israel) and an internal lockdown (by the Palestinian Authority), which caused severe harm to the economy and to social life in the West Bank. The Palestinian Authority has no budgetary reserves it can repurpose to provide relief to its citizens. Shutting down economic activity in the West Bank resulted in a swift and massive downturn: an upsurge in unemployment, massive cutbacks in salaries and a considerable rise in poverty.[4] Prolonged cuts in international aid to the health care services of the Palestinian Authority exacerbated the situation.[5]

Throughout the crisis, Israel continuously denied and evaded its responsibility for Palestinians' health, citing the transfer of responsibility for health to the Palestinian Authority under the Oslo Accords. However, as this report shows, the policy of the Israeli government and the practices it instituted undermined the ability of the Palestinian leadership and population in the West Bank to adopt appropriate measures during the pandemic. For example, Israel's demolition policy – the demolition of homes and other structures by the Israeli military, including buildings meant to provide medical services – was stepped up during the pandemic, contrary to a statement that demolitions would be postponed during the crisis.[6] Violence by Israeli settlers targeting Palestinians also intensified, resulting in bodily harm and property damage.[7] Moreover, during a crisis situation which

[3] The World Health Organization, "Health Conditions in the Occupied Palestinian Territory, Including East Jerusalem, and in the Occupied Syrian Golan," November 5, 2020.
[4] Yehia Abed, "COVID-19 in the Gaza Strip and the West Bank under the Political Conflict in Palestine," South Eastern European Journal of Public Health (SEEJPH) (2020).
[5] "U.S. Gives $5 Million to Palestinians amid Pandemic, After Years of Aid Cuts," Reuters, April 16, 2020.
[6] Maya Horodniceanu, "Despite Coronavirus Crisis: Record Number Of Home Demolitions In East Jerusalem This Year," Walla!, November 2, 2020 [Hebrew].
[7] Oxfam, "Violence and Impunity in the West Bank during the COVID-19 Pandemic: Briefing Note," May, 2020.

requires cooperation, the Israeli government's declarations regarding annexation of portions of the West Bank resulted in a breakdown of communication between the governments.[8]

Even had Israel acted differently during the crisis, its de facto continued control over the oPt eliminates the Palestinian Authority's sovereignty in most spheres of life, preventing the development of a robust health care system. Israeli control proves particularly detrimental during pandemics, which pose a tremendous challenge even to developed, sovereign states. This challenge is even greater for an entity which lacks autonomy and sovereignty and for a people under occupation. This difficulty is further compounded by the crowded conditions in some of the Palestinian cities and villages that make it difficult to adopt preventive measures such as social distancing. Israel's control of water resources in the West Bank hampers access to clean water, which is essential to maintaining hygiene.

Once again, the flaws of the Oslo Accords have been exposed, this time by the COVID-19 crisis. The Oslo Accords laid responsibility for addressing pandemics with the Palestinian Authority, and the Israeli government cites them in order to evade its duty under international covenants to provide health care services to an occupied population. Israel's role and responsibility must therefore be examined. In light of the state of the Palestinian health care system before the COVID-19 crisis, including the implications of Israeli control over the Palestinian territories, the methods of handling of the COVID-19 pandemic must be examined. This assessment must extend beyond the effects of the disease per se and address broader harm to overall health. For example: the Palestinian Authority, realizing that the health care system in the West Bank is inadequately equipped to handle the pandemic, adopted a policy of deferring non-urgent care as much as possible. Consequently, the true toll the pandemic has taken on the Palestinian population in terms of other health issues remains to be seen.

This report calls on the Israeli government and the international community to acknowledge the toll exacted from Palestinians by the prolonged occupation – with its distinct apartheid and colonialist traits – as well as by Israel's control over most of the areas indispensable to safeguarding and promoting the right to health in the oPt in general, and specifically in the West Bank. It is therefore our position that such a fundamental, decades-long violation of rights obliges Israel to end the occupation. This, though it is only a first step and not a complete answer in and of itself, is an essential prerequisite to enabling the Palestinians to act independently to secure their right to health. So long as the Israeli occupation

[8] Barak Ravid and Yifat Rosenberg, "The Palestinian Authority Announces Renewed Security and Civil Coordination with Israel," Walla!, November 17, 2020 [Hebrew].

prevents Palestinians from doing so, Israel is duty-bound to guarantee the right to health of Palestinians in the oPt. Accordingly, Israel is obligated to take action to offset shortages by providing supplies, treatment, and equipment unavailable in the oPt. Above all, Israel must lift any and all obstructions and barriers it has imposed that hinder the development of the Palestinian health care system and its ability to properly address the needs of the Palestinian population.

THE OSLO ACCORDS ENABLED ISRAEL TO DENY ITS OBLIGATION TO ENSURE PALESTINIANS' HEALTH UNDER THE CLAIM THAT ACCORDING TO THE AGREEMENT, THIS RESPONSIBILITY HAS BEEN HANDED OVER FROM ISRAEL TO THE PALESTINIAN MINISTRY OF HEALTH. AT THE SAME TIME, ISRAEL'S CONTINUED CONTROL OVER THE WEST BANK HARMS THE PALESTINIAN ECONOMY AND IMPAIRS THE ABILITY OF THE PALESTINIAN INSTITUTIONS TO MEET THE POPULATION'S NEEDS


Jeep

Introduction

The COVID-19 pandemic which began in China in late 2019 will go down in history as one of the most serious pandemics of the modern age and as a health crisis unparalleled in the past century. As of the writing of this report, about 100 million cases have been documented and over two million people have died.[9] The rapid spread of the disease and its severity led the World Health Organization (WHO) to declare a global state of emergency and to call upon governments and organizations to adopt serious measures in order to avert large-scale disaster.[10] WHO Director-General Dr. Tedros Adhanom Ghebreyesus stated that "**all countries can still change the course of this pandemic. If countries detect, test, treat, isolate, trace, and mobilize their people in the response, those with a handful of cases can prevent those cases becoming clusters, and those clusters becoming community transmission. Even those countries with community transmission or large clusters can turn the tide on this virus.**"[11]

Governments around the world, including Israel, instituted various emergency policies in order to safeguard their citizens. However, Israel maintains colonialist and apartheid practices in the oPt, the effect of which is an absence of effective Palestinian national institutions essential for formulating an action plan for the outbreak. The Palestinian health care and economic systems have had to endure years of severe Israeli-imposed restrictions, resulting in a shortage of doctors and medical equipment, an inability to develop, and difficulty in dealing with the COVID-19 pandemic and its waves.

[9] Marc Santora and Lauren Wolfe. "There have now been over two million virus-related deaths worldwide." The New York Times, January. 15, 2021.
[10] "Coronavirus Declared Global Health Emergency by WHO," BBC, January 31, 2020.
[11] WHO, "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19," March 11, 2020.

This report aims to examine the way in which Israeli control over the oPt resulted in harm to Palestinians' right to health, both before and during the COVID-19 pandemic. The occupation and the practices of apartheid and colonialism employed by Israeli governments have severely impaired the Palestinian health care system as well as other civil systems, intensifying the hardships Palestinians faced during the COVID-19 crisis and hampering Palestinian leadership in adequately addressing the people's needs. At the same time, Israel persisted in an injurious policy of violating Palestinian human rights in the West Bank. Throughout the crisis, Israel has refused to acknowledge it bears responsibility for the lives and health of the Palestinians in the oPt. It argues that the Oslo Accords release it of responsibility but neglects to take into account Israeli control over Palestinians' lives.

Israel and the Occupying Power's Obligation under International Law to Ensure the Right to Health

Since 1967 the Israeli military occupation of the West Bank and the Gaza Strip has controlled the lives of millions of Palestinians. Various international treatises, including the Geneva Convention, have established the duties of occupying powers. Under these covenants, Israel has a range of duties with regard to the Palestinian population as an occupying power, including providing adequate health care services.[12] However, the State of Israel has denied its obligations as an occupying power towards the civilian population for years and has refrained from providing the Palestinian residents of the oPt a standard of human and social rights, including the right to health, that equals what it provides its own people.[13]

In 1993 the PLO and the Israeli government signed a declaration of principles, followed by the signing of the Gaza-Jericho Agreement (also known as the Cairo Agreement) in 1994, which served as the cornerstone for the Palestinian Authority. This series of agreements (referred to in this paper as the Oslo Accords) led to the transfer of powers and authorities to the Palestinian Authority, including the responsibility to provide health care services. The Palestinian Ministry of Health was formed in 1994. Ever since, it has been the primary provider of Palestinian medical services. Other providers continue to work alongside the ministry including private facilities, health care services run by the Palestinian security forces, and facilities run by UNRWA (the UN Relief and Works Agency for Palestine Refugees in the Near East) and other NGOs.[14] The Oslo Accords enabled

[12] Maha Abdallah and Vito Todeschini, "The Right to Health in the Occupied Palestinian Territory during the COVID-19 Pandemic," Opinio Juris, May 19, 2020.
[13] Hadas Ziv, A Legacy of Injustice: A Critique of Israeli Approaches to the Right to Health of Palestinians in the Occupied Territories, Physicians for Human Rights Israel, November 2002.
[14] Ibid.

Israel to deny its obligation to ensure Palestinians' health under the claim that according to the agreement, this responsibility has been handed over from Israel to the Palestinian Ministry of Health.[15] At the same time, Israel's continued control over the West Bank harms the Palestinian economy and impairs the ability of the Palestinian institutions to meet the population's needs.[16] Therefore, the UN Committee on Economic, Social and Cultural Rights and the UN Human Rights Committee stated that because of the continued occupation, Israel still bears the duty for the health of the Palestinian population in the oPt.[17]

For decades, and particularly since the signing of the Oslo Accords, Israel has maintained and developed mechanisms of control over the Palestinian population and institutions that in effect prevent the Palestinian Authority from establishing sovereignty over the oPt. Israel employs practices which keep the socio-economic systems in the oPt weak and non-autonomous. In view of the prolonged occupation, with its implementation of colonialist and apartheid features including Israeli control over the economy, natural resources and the population, Israel bears a moral duty to provide the Palestinians in the oPt medical services equal to those it provides its own residents.[18]

[15] "Treating Applicants from the Palestinian Authority," Memo by the Ministry of Health Accountant, April 6, 2011 [Hebrew].
[16] "Economic Costs of the Israeli Occupation for the Palestinian People: The Gaza Strip under closure and Restrictions," United Nations, Note by the Secretary-General, August 13, 2020.
[17] "In Dialogue with Israel, Experts of Committee on Economic Social and Cultural Rights Say Human Rights Obligations Extend to Territories under the Country's Effective Control – Press Release," United Nations, October 3, 2019; "COVID-19: Israel Has 'Legal Duty' to Ensure that Palestinians in OPT Receive Essential Health Services – Special Rapporteur on the Situation of Human Rights in the oPt: Press Release," United Nations, March 19, 2020.
[18] Hadas Ziv, A Legacy of Injustice: A Critique of Israeli Approaches to the Right to Health of Palestinians in the Occupied Territories, Physicians for Human Rights Israel, November 2002.

Health services in the West Bank

Disparities in Health between the West Bank and Israel

For decades, the Israeli government has denied its moral and legal obligation to the health of the Palestinian population in the oPt. Not only has this impinged on the right to health in the oPt, but it has also left the Palestinian health care system in a state of chronic shortages – a situation which has grown even worse in recent years. The chapter below reviews the state of the health care system in the West Bank and explains how shortages have impacted the Palestinian population and the health care system in the West Bank during the coronavirus crisis.

There are 2.95 million Palestinians in the West Bank (including East Jerusalem), including 800,000 who are registered as refugees.[19] It is a relatively young population: The median age is 21.9; 35% of Palestinians are under 14 years old; and fewer than 5% of the population are over 65 years old.[20] In 2018, average life expectancy at birth was 75.9,[21] nearly seven years less than in Israel in the same year (82.8 years).[22] Infant mortality rate was 12.8 per 1,000 live births – more than four times higher than in Israel (3.1 deaths/1,000 live births).[23]

As for morbidity and morbidity-related mortality, while little data exists that applies exclusively to the Palestinian residents of the West Bank, a study published in *Global Public Health* indicates significant disparities between Israel's residents, including Israeli settlers in the oPt, and Palestinians in the West Bank and the Gaza Strip.[24] According to the figures, the mortality rate of children under age 5 in the

[19] "West Bank," CIA World Factbook (Accessed June 27, 2021)
[20] Index Mundi, West Bank Demographics, July 2020.
[21] "West Bank Life expectancy at birth." Index Mundi, November 27, 2020.
[22] "Israel Life Expectancy 1950-2021," Macrotrends, (accessed June 6, 2021).
[23] "Israel: Infant mortality rate from 2009 to 2019 (in deaths per 1,000 live births)," Statistica, (accessed June 6, 2021).
[24] Frank S. Rosenthal, "A Comparison of Health Indicators and Social Determinants of Health between Israel and the Occupied Palestinian Territories," Global Public Health (2020): 431-447.

oPt is 20.9 per 1,000, a number ten times the rate in Israel. In addition, there are vast disparities in the mortality rate of children aged 5-14 (0.9 per 1,000 in Israel versus 3.2 per 1,000 in the oPt) and maternal mortality rate (2 per 100,000 in Israel versus 47 per 100,000 in the oPt). As for death from morbidity, there are significant disparities in most diseases (with the exception of deaths from cancer). These disparities can be seen in mortality rates from stroke, ischemic heart disease, diabetes, hypertension and congenital defects, to name but a few (see Table 1).

Table 1: A Comparison of Morbidity-Related Mortality in Israel and the oPt

	Israeli Mortality Rates (including Israelis living in the oPt)	Palestinian Mortality Rates in the oPt (the West Bank and the Gaza Strip)
Child mortality – under age 5	2.9 per 1,000	20.9 per 1,000
Child mortality – ages 5 to 14	0.9 per 1,000	3.2 per 1,000
Maternal mortality	2.0 per 100,000	47 per 100,000
Ischemic heart disease	47.7 per 100,000	153.0 per 100,000
Stroke	23.9 per 100,000	81.6 per 100,000
Alzheimer's disease	34.0 per 100,000	43.3 per 100,000
Diabetes	17.4 per 100,000	37.9 per 100,000
Chronic kidney disease	17.7 per 100,000	28.5 per 100,000
Lower respiratory infection	17.4 per 100,000	22.6 per 100,000
Neonatal disorders	2.9 per 100,000	15.8 per 100,000
Lung cancer	47.7 per 100,000	14.9 per 100,000
Hypertension	1.7 per 100,000	13.0 per 100,000
Colorectal cancer	14.0 per 100,000	12.6 per 100,000
Chronic obstructive pulmonary disease (COPD)	12.3 per 100,000	12.1 per 100,000
Breast cancer	10.8 per 100,000	10.2 per 100,000
Cirrhosis	6.2 per 100,000	9.2 per 100,000
Congenital birth defects	2.7 per 100,000	7.6 per 100,000
Leukemia	6.1 per 100,000	6.1 per 100,000
Brain and nervous system cancer	4.6 per 100,000	6.0 per 100,000
Liver cancer	3.3 per 100,000	5.9 per 100,000
Stomach cancer	5.8 per 100,000	5.2 per 100,000

ISRAEL OFTEN ABUSES ITS CONTROL OVER THE CROSSINGS BY TAKING ADVANTAGE OF PALESTINIANS' NEED TO OBTAIN ISRAELI ENTRY PERMITS IN TO ACHIEVE THE MOST COMMONPLACE NEEDS OF THEIR DAILY LIVES, SUCH AS EMPLOYMENT, MEDICAL TREATMENT, EDUCATION AND VISITING FAMILY. ISRAEL HAS OFTEN DEMANDED COLLABORATION OR THE RETURN OF RELATIVES WHO ARE "ILLEGALLY" IN THE WEST BANK OR ISRAEL AS A CONDITION FOR GRANTING PERMIT APPLICATIONS

Disparities in Health Care Services

The disparities in morbidity and mortality rates between Israel and the oPt can be explained by disparities in health care services and in health indicators (including economic situation, access to water, residential density, etc.). The disparities in health status are one outcome of economic shortages, poor access to health services, and stress as a result of life under military occupation.[25] ***The review below demonstrates the differences between the health care services available to the Palestinian population in the West Bank and to the Israeli population, two populations who are ruled by the same entity.***

Insurance coverage. Approximately 78% of the Palestinian population in the West Bank and the Gaza Strip is covered by health insurance.[26] The major providers are the government health insurance plan and UNRWA, who together account for 90% of health insurance coverage. Government health insurance covers primary, secondary and tertiary (specialist) medical care, which is unavailable at government health facilities and is purchased from private facilities both in and outside the oPt. Out-of-pocket payments account for 45.5% of Palestinian health care financing,[27] in contrast to Israel, where all residents are covered under the National Health Insurance Law and only 6.5% of financing coming from out-of-pocket payments.[28]

Primary care. Primary care centers provide child health services, vaccinations and chronic disease management. There are approximately 590 primary care centers in the West Bank.[29] The Palestinian Ministry of Health is the main provider of primary care. Additional providers are UNRWA and non-state actors.[30] It should be noted that over 160,000 Palestinians in the West Bank have very limited access to health care and must rely on mobile clinics, most of which are operated by non-state actors.[31]

Secondary care. According to the WHO there are 52 hospitals in the West Bank.[32] Many of these hospitals offer a very limited array of services, have no more than a few dozen beds, and lack many types of wards, such as ICU, maternity, rehabilitation, surgery, labs etc. The Palestinian Ministry of Health is considered the

[25] Frank S. Rosenthal, "A comparison of health indicators and social determinants of health between Israel and the Occupied Palestinian Territories," Global Public Health (2020): 431–447.
[26] WHO, Right to Health in the Occupied Palestinian Territory: 2018.
[27] WHO, Report by the Director-General, Seventy-Second World Health Assembly: Provisional agenda item 14, "Health Conditions in the Occupied Palestinian Territory, Including East Jerusalem, and in the Occupied Syrian Golan," May 1, 2019.
[28] Rani Plotnik and Nir Kedar, "Twenty Years since the Enactment of the National Insurance Law: Compiled Figures and Statistics 1994–2014," The Israeli Ministry of Health, May 2015 [Hebrew].
[29] WHO, Right to Health in the Occupied Palestinian Territory: 2018.
[30] WHO, Report by the Director-General, Seventy-Second World Health Assembly: Provisional agenda item 14, "Health Conditions in the Occupied Palestinian Territory, Including East Jerusalem, and in the Occupied Syrian Golan," May 1, 2019.
[31] "WHO Supports Primary Health Care Targeting Vulnerable Communities in the West Bank – WHO Article," United Nations, June 9, 2019.
[32] WHO, "Health Conditions in the Occupied Palestinian Territory, Including East Jerusalem, and in the Occupied Syrian Golan," November 5, 2020, p. 8.

chief provider of secondary care in the oPt, with 16 non-governmental hospitals and over thirty private or independent hospitals run by churches and NGOs.[33]

Hospital beds. The per capita hospital bed ratio is 1.3 per 1,000 in both the West Bank and the Gaza Strip (as compared with an average of 2.2 per 1,000 in Israel and an average of 4.7 per 1,000 in the OECD).[34] The Palestinian Ministry of Health is responsible for 43% of hospital beds in the West Bank and 73% of hospital beds in the Gaza Strip. Non-state actors, including hospitals run by NGOs and churches, are responsible for 46% of hospital beds in the West Bank and 22% of hospital beds in the Gaza Strip. Private institutions in the West Bank provide 9% of the beds and UNRWA another 2%.

Medical personnel. As of early 2018, the Palestinian Ministry of Health has faced a dire shortage in its medical workforce. Consequently, the existing workforce struggles to meet the needs of the population. **The ratio of doctors per 1,000 people** is 1.45 in the West Bank,[35] as compared with 3.1 doctors per 1,000 people in Israel,[36] and 3.4 in the OECD.[37] The ratio for nurses in the oPt is 2.6 nurses per 1,000 people,[38] in contrast to 5 per 1,000 in Israel,[39] and 8.8 in the OECD average. [40]

Health Expenditure per capita. As of 2015, per capita expenditure in the oPt is about $300 per person.[41] In contrast, health expenditure per capita in Israel was 3,213 dollars in 2017,[42] and the OECD average is about $4,000 per capita.[43]

Table 2: A Comparison of Health Care System Figures in Israel and the oPt

	oPt	Israel	OECD
Expenditure on health per capita	282$ (2015)	3,213$ (2017)	4003$ (2017)
Physicians per 1,000 people	1.45 (2017)	3.1 (2018)	3.4 (2017)
Nursing staff per 1,000 people	2.6 (2017)	5 (2019)	8.8 (2019)
Hospital beds per 1,000 people	1.3 (2018)	2.2 (2017)	4.7 (2017)

[33] Danny Zaken, "The Palestinian Plan for Disengagement from the Israeli Health Care System," Globes, May 10, 2019 [Hebrew].
[34] For the Palestinian figures, see: Palestine Central Bureau of Statistics, "Number of Hospitals, Hospital Beds and Beds Per 1,000 Inhabitants in Palestine, By Region," 2019; for the Israeli figures see Emma Averbuch, Gidi Peretz, Shlomit Avni, "Health Inequity and Addressing It," The Israeli Ministry of Health, February 2020 [Hebrew]. For OECD figures see: "Hospital beds and discharge rates," OECD library.
[35] CIA World Factbook, " West Bank." June 09, 2021 (accessed June 30, 2021).
[36] Emma Averbuch, Gidi Peretz, Shlomit Avni, "Health Inequity and Addressing It," The Israeli Ministry of Health, February 2020 [Hebrew].
[37] "Health at a Glance, Health Workforce, Doctors." World Health Organization, 2017.
[38] "Health workforce snapshot PALESTINE," World Health Organization, 2020,
[39] OECD Data, "Nurses." Accessed: June 08, 2021.
[40] OECD Library, "Nurses." Accessed: June 08, 2021.
[41] PCBS. "Preliminary Results of Palestinian Health Accounts in Palestine for 2015." Palestinian Central Bureau of Statistics (PCBS) & Ministry of Health (MOH).
[42] "Israel - Current health expenditure per capita." Knoema, (Accessed June 06, 2021)
[43] OECD, "Health Expenditure Per Capita," Health at a Glance 2017 : OECD Indicators.

Economic Disparities

One of the major reasons for health care service disparities is economic impediments which are an outcome of the continued occupation. The Paris Protocol on Economic Relations made the Palestinians extremely dependent on the Israeli economy, as is evident in the matter of imports and exports as well as in the sphere of employment. It has become impossible for the Palestinian Authority to separate its economy from the Israeli economy. In fact, as the occupation has continued, the ties have grown more entrenched. The Palestinian economy depends on Israel for energy, water, fuel and the transportation of goods. Moreover, the Palestinian government has no administrative authority over collecting taxes on imports. The Israeli government collects the customs on Palestinian imports and then transfers the tax money to the Palestinian Authority after deducting the cost of payments for electricity, water and health care.[44]

The Palestinian Authority's lack of control over economic life significantly impinges on its ability to develop its economy. While the Palestinian economy in recent decades had been characterized by growth, this trend has virtually ground to a halt over the past few years.[45] According to the Palestinian Central Bureau of Statistics, the Palestinian population has had to contend with unstable economic growth, attributed in part to political instability.[46] In 2017 the gross domestic product per capita in the oPt was about $ 3000,[47] whereas in Israel the GDP was about $ 40,000.[48]

The economic recession is also reflected in unemployment rates. In early 2020 unemployment in the West Bank was 13.7%-15%,[49] while in Israel it was 4.2%.[50] Moreover, years of economic stagnation have led to increased poverty levels – poverty being defined as having an income of less than $4.6 a day, including government aid. 2020 saw poverty levels of 17.8% in the West Bank, a substantial increase from the 2011 figure of 13.9%. Some two-thirds of Palestinians who are below the poverty line are designated as being in **deep poverty,** which is defined as living on less than $3.6 a day (the minimum amount necessary to cover basic shelter, clothing, and food requirements).[51] This stands in contrast to a poverty rate of 22% in Israel, but poverty there is defined as living on less than $25 a day.[52]

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[44] Suleiman M. Abbadi, "Economic Development under Occupation: The Palestinian Case," Journal of International Business and Economics 4, no. 1 (2016): 49-60.
[45] Mohammed T. Abusharbeh, "The Impact of Banking Sector Development on Economic Growth: Empirical Analysis from Palestinian Economy," Journal of Emerging Issues in Economics, Finance, and Banking 6, no. 2 (2017): 2306-2316.
[46] Fadi Shihadeh, "Individual's Behavior and Access to Finance: Evidence from Palestine," The Singapore Economic Review? (2019).
[47] "Palestine GDP per capita." Trading Economics, (Accessed: June 08, 2021).
[48]" GDP per capita (current US$) – Israel." The World Bank.
[49] Gisha – Legal Center for Freedom of Movement, "Increase in Gaza's Unemployment Rate in 2019," March 5, 2020; "Official Survey Says Unemployment in West Bank, Gaza Rises 25%," Asharq Al-Awsat, February 14, 2020; "Unemployment Rate Stands at 24 Percent in Palestine," WAFA News Agency, February 14, 2020.
[50] Gad Lior. "Israel's unemployment soars beyond 20 percent." Ynet, February, 2020.
[51] "53 Percent Of Palestinians In Gaza Live In Poverty, Despite Humanitarian Assistance," OCHA oPt, June 5, 2018.
[52] "The Poverty Trap: The Crisis Will Last a Long Time, and Might Result in Another 1.5 Million Poor People in Israel," The Marker, January 24, 2021 [Hebrew].

This situation drastically impacts tax-collecting capacity of the Palestinian Authority, and consequently the budgeting of health care for Palestinians.[53] According to the Palestinian Central Bureau of Statistics, the annual expenditure on health in Palestine was approximately 1.33 billion dollars in 2016 and approximately 1.466 billion dollars in 2017.[54]

Due to the difficulty in tax collection, the survival of the health sector in the oPt is largely dependent on donations, including from state donors, private donors, NGOs and businesses. Over one-third of the healthcare expenditure is payment for services by private health care providers.[55] The Palestinian Authority has received billions of dollars in aid over the past few decades, a significant part of which has been allocated to government projects such as hospitals and schools.[56] Since the signing of the Oslo Accords, the U.S. government has been the most significant single contributor of aid to Palestinians, second only to the European Union as a whole. According to OECD figures, the U.S. alone spent some 7.3 billion dollars on Palestinian aid from 1993 to 2017.[57] Given this reality, one of the most significant developments in recent years has been the Trump Administration's decision to cut 200 million dollars of aid that funded food and health programs.[58]

Medical referrals from the oPt to providers outside of the public health system account for a substantial portion of the Palestinian health budget. From 2000 to 2013 the cost of referrals increased from 8 million to 52 million dollars, accounting for about 50% of non-salary related expenditure in the public medicine sector.[59] In 2019, East Jerusalem hospitals received the most referrals from the Palestinian Ministry of Health (45%). They were followed by hospitals in the West Bank (39%), Gaza (6%), Israel and Egypt (5% each) and Jordan (1%). At the same time, there was a substantial decrease in the number of referrals to Israeli hospitals, which dropped from 17% in 2018 to 5% in 2019. The lower figures are a result of the Palestinian Authority's policy decision to cut back on referrals to Israeli hospitals. This decision was based on various political reasons, including Israel's withholding transfer of Palestinian tax revenue.[60] In other words, the decrease in referrals does not reflect a decline in the need for treatment outside the Palestinian system. The effect of this is a heavy toll on the health of many patients, and it has even cost some their lives.

[53] At the same time, it should be noted that the economic situation in the West Bank is not as bad as that of the Gaza Strip.
[54] Palestinian Central Bureau of Statistics, "Percentage Distribution of Current Expenditure on Health in Palestine* by Health Care Functions, 2016-2017."
[55] WHO, Right to Health in the Occupied Palestinian Territory: 2018, (2019).
[56] Suleiman M. Abbadi, "Economic Development under Occupation: The Palestinian Case," Journal of International Business and Economics 4, no. 1 (2016): 49-60.
[57] Jeremy Wildeman and Alaa Tartir. "Why Cutting US Aid Will Help Palestinians - And Peace," Middle East Eye, February 6, 2019.
[58] "Trump's Palestinian Aid Cuts Means Thousands Lose Access to Food and Healthcare," Haaretz, January 22, 2019.
[59] The World Bank, "Public Expenditure Review of the Palestinian Authority," September 2016.
[60] WHO, "Health Conditions in the Occupied Palestinian Territory, Including East Jerusalem, and in the Occupied Syrian Golan," November 5, 2020.

Health Care Services in an Occupied and Fragmented Area

Since 1967, and increasingly in recent decades, Israel has restricted freedom of movement in Palestinian territory by imposing various mechanisms of control over the population, first and foremost through the permit regime. This policy inhibits access to health care, in the oPt itself and for Palestinians obtaining it in Israel. The Separation Barrier separates the West Bank from Israeli territory. It cuts through the heart of the occupied Palestinian territory, leaving an approximated10% of West Bank land is on the Israeli side of the Separation Barrier. This severely curtails freedom of movement of the Palestinian communities living in the area.[61]

Under the Oslo Accords, the West Bank was divided into areas A, B and C, and Hebron was divided into Areas H1 and H1. Under this division, Areas C and H2 (which constitute over 60% of the West Bank) have been placed under Israeli control in security and civil matters, breaking up the contiguity of Palestinian territories. Moreover, since September 2000, the freedom of movement of Palestinians living in the West Bank has been drastically curtailed due to Israeli-imposed restrictions in the form of physical obstacles (checkpoints, roadblocks, the Separation Barrier) and administrative and legal prohibitions (roads placed off-limits, permit requirements, etc.). These restrictions facilitate control over the Palestinian population and restrict Palestinian movement and access throughout the West Bank.[62] An OCHA (the UN Office for the Coordination of Humanitarian Affairs in the oPt) survey found 593 fixed, permanent obstacles that impede freedom of movement within the West Bank.[63] An equally serious impediment to free movement is accelerated construction in the Israeli settlements, including the construction of about 40 kilometers of roads that are off-limits to Palestinians, in addition to other military checkpoints and barriers.[64]

This multitude of physical and legal obstacles has brought about the fragmentation of Palestinian land in the West Bank. The land is partitioned into different districts that are cut off from one another by the network of obstacles imposed by Israel. This fragmentation is particularly significant in view of the unequal distribution of medical services in the various districts across the West Bank.

Since the pandemic began, PHRI has been approached many times to help with obtaining access to medical treatment in the West Bank and East Jerusalem. These requests indicate that over the past year the access of many patients to treatment has been obstructed. Unluckily for the residents of the West Bank, medical specialties such as oncology and cardiology are far more available in

[61] B'Tselem, "The Separation Barrier: Background," November 11, 2017.
[62] OCHA, "West Bank Movement and Access Update," May 2009
[63] OCHA, "Longstanding Access Restrictions Continue to Undermine the Living Conditions of West Bank Palestinians," June 2020.
[64] WHO, Right to Health in the Occupied Palestinian Territory: 2018 (2019).

East Jerusalem than in the West Bank. Consequently, in order to provide patients with treatments unavailable near their homes, the Palestinian Ministry of Health is compelled to refer them elsewhere, mostly to hospitals in East Jerusalem. As a result of pandemic-related restrictions on people's movement and the fact that obtaining treatment in East Jerusalem entails a "border crossing" for those in the West Bank, many patients had to wait for the lifting of restrictions in order to receive medical treatment.

The Permit Regime

Certain tests, screenings and treatments are unavailable in the West Bank – for example in the areas of oncology, geriatrics, radiology, mental health, and rehabilitation. Therefore, the DCOs (District Coordination and Liaison Offices), which are administered by Israel's COGAT (the Unit for Coordination of Government Activities in the Territories), issue thousands of permits to leave the oPt in order to travel to East Jerusalem and hospitals in Israel for treatment. These permits are in addition to the ones that must be obtained from Israel for the purpose of bringing in medical supplies and for the support of hospitals and clinics.

Israel's control of the checkpoints and crossings and the implementation of the permit regime greatly restrict passage between the West Bank and the Gaza Strip, as well as passage from the West Bank and Gaza into East Jerusalem and Israel. All Palestinian residents have restricted access to Israel, with the exception of the Palestinian residents of East Jerusalem. This restriction applies also to medical personnel, patients and their families. Gaza residents must obtain an Israeli entry permit from COGAT in order to travel via Israel for the purpose of reaching the West Bank or East Jerusalem, or to get treatment at an Israeli facility. Permits are issued only after applications are examined, including checking the availability of treatment in the oPt, security clearance, and are subject to the criteria defined in COGAT's "Status of Authorizations." According to the WHO, over 2,000 such applications are made every month by Gaza residents and another 9,000 by West Bank residents.[65] A considerable number of applications are denied or deferred pending further inquiry. In addition, many applications by relatives to accompany patients – including patients who are toddlers and infants – are denied or deferred, with major repercussions for the health and wellbeing of patients and their families.[66]

Israel often abuses its control over the crossings by taking advantage of Palestinians' need to obtain Israeli entry permits in to achieve the most commonplace needs of

[65] Danny Zaken, "The Palestinian Plan for Disengagement from the Israeli Health Care System," Globes, May 10, 2019 [Hebrew].
[66] WHO, "Health Access: Barriers for Patients in the Occupied Palestinian Territory, Monthly Report August 2018," 26 September 2018.

their daily lives, such as employment, medical treatment, education and visiting family. Israel has often demanded collaboration or the return of relatives who are "illegally" in the West Bank or Israel as a condition for granting permit applications. Israel has also used the permit regime as a form of collective punishment.[67]

The decentralization of the Palestinian health care system in the West Bank has far-reaching consequences. Instead of establishing a health care system that can take full advantage of its resources to maximize benefits to all residents, duplicate services must be created and scattered across as wide a geographical distribution as possible, due to restrictions on freedom of movement. Unfortunately, as was discovered during the coronavirus pandemic, the lack of centralized and effective planning harms the capacity of institutions to handle emergency situations.

[67] Mor Efrat, Between the Hammer and the Anvil: Women's Right to Health in the Gaza Strip, PHRI, March 2019.

The Palestinian Government's Response to the COVID-19 Crisis

As explained in the chapter above, the health care system in the West Bank was ailing and largely dependent on contributions, medical services, and equipment from international parties even before the pandemic began. As a result, in view of the shortages in skilled personnel and vital resources – including ICU beds, ventilators, surgical masks, and PPE (personal protective equipment) for medical personnel – the Palestinian authorities' level of preparedness for the outbreak of COVID-19 was considered to be low.[68]

As of early 2020, there were only 255 ICU beds in the West Bank.[69] On average, there were about 10 ventilators per 100,000 people in the West Bank. In Israel, at the beginning of the pandemic there were 50 ventilators per 100,000 people, but Israel then launched a major procurement effort and reached 150 ventilators per 100,000 in a matter of months.[70] While the Palestinian Authority did get donations of ventilators from various parties during the crisis, including from the WHO, they were insufficient to bridge the gap.[71] Moreover, conversations we held indicated that a serious shortage of medical teams trained in operating ventilators meant that the additional equipment did not do much to improve matters.

On March 5, 2020 the first cases of COVID-19 were discovered in the Palestinian Authority.[72] That very day the Palestinian Authority declared a state of emergency

[68] In the course of the pandemic, PHRI held 26 interviews with West Bank hospital executives (not CEOs). The interviews indicate inadequate preparedness of the health care system in the West Bank, both in terms of treating COVID-19 patients and patients in general.
[69] Yara Hawari, "COVID-19 in Palestine: A Pandemic in the Face of 'Settler Colonial Erasure'," IAI, September 15, 2020.
[70] Shaher Obaid, "Local Authorities in Palestine in Light of the Corona Pandemic (COVID-19)," International Journal of Management Excellence 15(2):2220-2224.
[71] WHO, "COVID-19 Emergency Situation Report 23 (18 November - 2 December 2020), December 2, 2020; "Germany Supports The Palestinian Health System With 50 Ventilators To Help It For The CORONA Response, Wafa, October 27, 2020.
[72] Suha Arra, "The Palestinian Authority Is Fighting COVID-19, Israel Is Fighting the Palestinian Authority," Siha Mekomit [Local Call], April 19, 2020 [Hebrew].

and adopted significant preventive measures, including imposing a lockdown in Bethlehem, where the cases were discovered. Later, extensive restrictions on movement were imposed throughout the West Bank, with the exception of leaving home to obtain essential supplies, including medical supplies.[73] Palestinian Prime Minister Mohammad Shtayyeh established an emergency command center to oversee and implement containment measures, allocate funds and ensure public outreach and communication.[74] In conversations held with representatives of 26 Palestinian medical institutions in the West Bank – including government-run, private and international facilities – regarding the handling of the COVID-19 pandemic, PHRI learned that these restrictions severely impacted the ability of the health care system to provide adequate medical services. PHRI learned that the *hospitals adopted a strict policy in order to prevent the spread of the within their facilities:*

1. The Palestinian Ministry of Health instructed hospitals not to accept COVID-19 patients. The majority of hospitals did not set aside wards for treating COVID-19 patients. Instead, they referred the patients to specially designated hospitals such as Hugo Chavez Hospital in Ramallah, al-Askari Hospital in Nablus, the Birth Center in Dhahiriya, Hebron District, or the government hospital in Bethlehem.

   This policy stands in stark contrast to Israel's mode of operation, in which every Israeli hospital opened a designated COVID-19 ward. The difference in policy is the result of the difference in available resources: a strong health care system with robust hospitals can afford to create COVID-19 wards in every hospital in order to provide treatment for patients living nearby. A weak health care system, which oversees small hospitals with meager resources, cannot. Instead, despite the restrictions on freedom of movement, it must refer COVID-19 patients to hospitals far from their homes.

2. The Ministry of Health gave instructions to reduce the number of patients (for example, by cutting back on the number of operations), and to stop providing treatment at the outpatient clinics. Most of the members of the medical staff received training by the Palestinian Ministry of Health on personal protection and the treatment of COVID-19 patients. From interviews PHRI held with medical staff both in Israel and the oPt, we learned that a significant proportion of ventilators were not utilized because of a shortage in suitably trained staff to operate them.

[73] Amit Waldman, "Strict Closure versus Minimal Restrictions: The Difference in Handling COVID-19 in the West Bank and Gaza," Mako, April 10, 2020 [Hebrew].
[74] Reuters Staff, "Palestinians Declare State of Emergency over Coronavirus," Reuters, March 5, 2020.

THE BUDGETARY SHORTFALLS CAUSED BY THE ONGOING ISRAELI OCCUPATION MEANT THAT THE PALESTINIAN GOVERNMENT FACED A SEVERE SHORTAGE OF MEDICAL RESOURCES – INCLUDING ICU BEDS, TESTS AND OTHER VITAL EQUIPMENT – AND WAS COMPELLED TO MINIMIZE AMBULATORY MEDICAL SERVICES.

In order to mitigate the pandemic's impact on the Palestinian economy, the Palestinian Ministry of Finance instructed banks and financial institutions in the West Bank to offer their customers four months of deferred payments (in the form of loans) and six months to tourism companies and the hotel industry. As part of its response to the crisis, the Palestinian Authority allocated 120 million dollars to pay for COVID-19-related medical needs, including the purchase of equipment and medication, and for the assignment of designated personnel. In addition, a 1.4-billion-dollar loan application by the banking sector was made to the Palestinian Ministry of Finance to help the banks contend with diminished income. The Palestinian government reached an agreement with representatives of the private sector that private businesses would pay 50% of their employees' March and April salaries.[75]

However, the Palestinian economy is not capable of providing adequate assistance of this type in the event of a pandemic that lasts for more than a year. The COVID-19 crisis has been devastating for the Palestinian economy. About a month after the pandemic broke out, revenues from sectors such as commerce and tourism dropped to a 20-year low. The harmful impact to the economy was exacerbated by the higher-than-normal expenditure on medical and welfare services as well as by support offered to businesses failing due to the crisis. The pandemic has had an economic impact estimated to be anywhere from a 7% to 35% decline in GDP.[76] In June 2020 there were reports that the Palestinian economy is expected to shrink by 7.6% to 11%, after several years of a disappointing growth of a mere one percentage point a year.[77] The World Bank projected that the pandemic would lead to a 30% rise in poverty in the West Bank.[78] The Palestinian Central Bureau of Statistics reported an increase of about 10% in unemployment due to the economic fallout of the pandemic. One reason for this figure is that the number of Palestinians employed in Israel in the second quarter of 2020 dropped from 120,000 to 94,000.[79]

The Palestinian government was forced to combat the COVID-19 crisis in the midst of an existing diplomatic crisis. On May 19, 2020 Palestinian President Mahmoud Abbas declared that the Palestinian Authority considers itself absolved of all agreements and understandings with Israel in view of the Israeli government's announcement that it plans to annex portions of the West Bank. The Palestinian Authority virtually halted all bilateral ties with Israel, including security coordination.

[75] "Ministry of Labor Reaches Agreement with Private Sector to Pay 50% of Wages for the Months of March and April," Aliqtisadi, March 16, 2020 [Arabic].
[76] Habib Hinn and Shams Hanieh, COVID-19 in Palestine: Economic Slump, Rising Vulnerability and Limited Policy Response, EuroMeSCo, June 2020.
[77] "West Bank Poverty May Double over Pandemic: World Bank," Al Jazeera, June 1, 2020; UNCTAD, "COVID-19 Devastates Palestine's Shattered Economy," September 08, 2020.
[78]"West Bank poverty may double over pandemic: World Bank," Al Jazeera, June 1, 2020
[79] "Report: Unemployment rises to 26.6% in Palestine," Middle East Monitor, September 11, 2020.

Due to this, the Palestinian Authority stopped receiving the taxes Israel collects on its behalf, causing a loss of nearly 80% of the Palestinian Authority's monthly revenue and affecting its capacity to pay salaries – adding to the existing insecurity and hardship wrought by the pandemic. Suspending coordination also adversely impacted humanitarian operations throughout the West Bank, including pandemic-related operations by international aid organizations such as the WHO and UNICEF (the UN Children's Fund) as well as by local NGOs.[80]

The Palestinian economy suffered further downturns in the second wave of the coronavirus, during which 121,000 Palestinian lost their jobs.[81] Moreover, it was found that 27% of salaried employees in the private sector were paid less than minimum wage (NIS 1,450) in the third quarter of 2020.[82] Another factor that impacted the Palestinian economy was the cessation of U.S. aid to the Palestinian Authority, including to hospitals in East Jerusalem (as well as to the Gaza Strip), an action taken as leverage against the political leadership of the Palestinian Authority.[83] In addition, U.S. funding to UNRWA was cut, and other countries were pressured to reduce the support they gave the agency.[84] UNRWA budget cuts have had serious repercussions on the lives of millions of Palestinian refugees, who were already struggling to meet their basic needs.[85]

Despite the budget cuts, international organizations have had a very significant role to play in the Palestinian handling of the pandemic. For example, the WHO prepared a major intervention plan which included raising tens of millions of dollars to deal with the crisis. In addition to funds, international aid included supplying ventilators, patient monitoring equipment, ICU beds, surgical masks (including N-95 respirators), hundreds of thousands of COVID-19 tests and other items.[86]

The bleak situation of the Palestinian health care system was revealed during the pandemic in the form of shortages. Hospitals reported shortages in personal protective equipment, gloves, surgical masks and alcohol. Several hospitals reported shortages in ventilators and staff. A universal shortage in COVID-19 test kits was also reported. Indeed, one of the worst shortages was in testing. The laboratory at Bethlehem's hospital was the only one in its district able to process COVID-19 tests (with an estimated capacity of approximately 500 tests per day). On April 21, the testing ratio was 3,397 tests per million Palestinian residents (a total

[80] "End of Palestinian Authority Coordination with Israel in Response to Annexation Threat: Decision Already Impacting Medical referrals," Relief Web, July 20, 2020.
[81] "Occupied Palestinian Territory (oPt): COVID-19 Emergency Situation Report 22 (3 - 17 November 2020)," ReliefWeb, November 19, 2020.
[82] Palestinian Central Bureau of Statistics, "Labour Force Survey (July- September 2020)," November 8, 2020.
[83] Yehia Abed, "COVID-19 in the Gaza Strip and the West Bank under the Political Conflict in Palestine," South Eastern European Journal of Public Health (SEEJPH) (2020).
[84] "UNRWA Faces Greatest Financial Crisis in Its History Following 2018 Funding Cuts," United Nations fourth committee seventy-third session, 24th meeting (pm), November 9, 2018.
[85] "UNRWA Funding Cut Spells 5 Million Victims," WILPF, October 5, 2018.
[86] "Occupied Palestinian Territory (oPt): COVID-19 Emergency: Situation Report No. 26." OCHA, 31 December 2020 - 13 January 2021.

of 17,329 tests);[87] that day the testing ratio in Israel was about 32,000 per million residents (nearly ten times greater).[88]

Despite shortages in medical equipment, tests, etc., the preventive measures instituted along with the rigorous restrictions on the liberties of the Palestinian residents of the West Bank proved successful in curbing the spread of COVID-19. From March to June the number of COVID-19 cases among Palestinians in the oPt remained relatively low. By mid-June, there were only 665 confirmed cases in the West Bank. In early June, the Palestinian Authority announced it would lift the lockdown it had imposed in early March when the first cases were discovered in Bethlehem.[89]

That situation changed dramatically during the second wave of the coronavirus that began in July, with the number of cases quickly rising to the thousands. In early June, when the lockdown was lifted, there were 62 cases in the oPt, and only five people had died of COVID-19. However, by early August there were over 15,000 cases and the death toll had risen to 85. On November 25, due to the outbreak, Director General of the Ministry of Health Ali Abed Rabbo said that **"the situation of the virus in Palestine is very worrying. We are working on preparing wards and opening new wards in public and private hospitals"**.[90] The worsening situation also led Palestinian Prime Minister Shtayyeh to announce a heightening of the restrictions in order to contain the spread of the disease. These measures included imposing a lockdown on areas under Palestinian Authority control for the first time since July, and a nighttime curfew.[91] On December 17 – after three weeks of tightened restrictions had been unsuccessful in containing the spread of the virus – the Palestinian Authority announced a two-week lockdown over the entire West Bank in the evenings.[92]

In conclusion, the severe economic shortages endured by the Palestinian government resulted in severe harm to Palestinian health care services and social services. The budgetary shortfalls caused by the ongoing Israeli occupation meant that the Palestinian government faced a severe shortage of medical resources – including ICU beds, tests and other vital equipment – and was compelled to minimize ambulatory medical services. The harm was further exacerbated by the significant cutback in the operation of humanitarian aid organizations which are essential to Palestinians in the West Bank.

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[87] Pascale Salameh, "COVID-19 in the Eastern Mediterranean Region: Testing Frequency, Cumulative Cases and Mortality Analysis," Eastern Mediterranean Health Journal 26, no. 9 (2020).
[88] "Total COVID -19 Tests per 1,000 people," Our world in Data, Accessed: November 25, 2020
[89] "West Bank Poverty May Double over Pandemic: World Bank," Al Jazeera, June 1, 2020.
[90] Barak Ravid, "Netanyahu Gives Instructions to Consider Closing Crossings with Palestinian Authority due to Spike in Cases," Walla!, November 25, 2020 [Hebrew].
[91] Aron Boxerman, "Palestinians In West Bank And Gaza Battered By Record Surge In Virus Cases," The Times of Israel, November 24, 2020.
[92] Aron Boxerman, "PA announces two-week closure throughout West Bank as virus surges," The Times of Israel, December 17, 2020.

COVID-19 and Israel's Obligation to Ensure the Health of Palestinians in the West Bank

As an occupying power, Israel bears overall responsibility for Palestinians' health. This chapter will examine Israel's specific responsibilities during a pandemic, as set out in international conventions and the Oslo Accords. As explained above in Chapter 1, the Oslo Accords officially transferred health-related matters to the Palestinian Authority. However, it is PHRI's contention that because Israel remains an occupying power which retains control of most of the essential conditions necessary to upholding and promoting the right to health, Israel bears responsibility for the health of the Palestinian population in the oPt. This is doubly true during a pandemic.

One of the international conventions that address the duties of an occupying power during a pandemic is the Fourth Geneva Convention, which discusses the protection of civilian populations during times of war (1949). Articles 55 and 56 of the convention address the supply of food and medical supplies to the local population: "The Occupying Power has the duty of ensuring the food and medical supplies of the population; it should, in particular, bring in the necessary foodstuffs, medical stores and other articles if the resources of the occupied territory are inadequate." (Article 55) "To the fullest extent of the means available to it, the Occupying Power has the duty of ensuring and maintaining, with the cooperation of national and local authorities, the medical and hospital establishments and services, public health and hygiene in the occupied territory, *with particular reference to the adoption and application of the prophylactic and preventive*

measures necessary to combat the spread of contagious diseases and epidemics (Article 56, emphasis added). Moreover, Article 59 obliges the occupying power to allow consignments of aid, including medical supplies, to reach the civilian population in need, and to enable the aid to reach them as speedily as possible and without hindrance.[93]

These articles demonstrate Israel's responsibility to adopt appropriate measures for managing the spread of epidemics, including the COVID-19 pandemic. Such measures include the distribution of medications and hygiene supplies, carrying out tests, sending medical staff to areas with high infection rates, providing quarantine and medical treatment in hospitals to people who have contracted an infectious disease, and helping to open new hospitals. In addition, Article 12 of the International Covenant on Economic, Social and Cultural Rights (1966) sets out the duty to uphold the right to health and the **"creation of conditions which would assure to all medical service and medical attention in the event of sickness."** Israel's duty in this case is even greater than that of an occupying power because of the colonialist and apartheid-like features of the measures it employs in the oPt. Under the covenant, Israel is duty-bound to ensure the highest attainable standard of health, including combating and eliminating epidemics and infectious diseases, and ensuring conditions that will guarantee adequate treatment in the case of an infectious disease or pandemic.[94]

Even the Oslo Accords themselves include articles pertaining to health, and particularly to infectious diseases. The basis for cooperation between Israel and the Palestinians is addressed in the 1995 Interim Agreement (Oslo II). In Article 17 of the Protocol Concerning Civil Affairs (Annex III, Appendix I) the parties agreed to **"exchange information regarding epidemics and contagious diseases, [...] cooperate in combating them and [...] develop methods for exchange of medical files and documents"** (Paragraph 6). The parties also agreed that **"the health systems of Israel and of the Palestinian side will maintain good working relations in all matters, including mutual assistance in providing first aid in cases of emergency, medical instruction, professional training and exchange of information"** (Paragraph 7).[95] The above demonstrates the commitment by both sides to coordinate efforts, which must also apply to combating the COVID-19 pandemic together. While the Oslo Accords do not take into account the disparity in capacity and resources available to each party, or that to a large extent Israel has remained the sovereign in the oPt, at the very least they compel and obligate cooperation and provision of aid.

[93] Yara Asi, "Occupation in the Time of COVID-19: Holding Israel Accountable for Palestinian Health," al-Shabaka, November 15, 2020.
[94] Articles 58-59 of the Concluding Observations on the Fourth Periodic Report of Israel by the UN Committee on Economic, Social and Cultural Rights: See Article 59(a), on the Knesset website.
[95] Alan Baker, "In the Covid-19 Pandemic, What Are the Reciprocal Israeli and Palestinian Obligations?," Jerusalem Center for Public Affairs, April 19, 2020; The Israeli-Palestinian Interim Agreement – Annex III, the Israel Ministry of Foreign Affairs website, September 28, 1995.

ISRAEL'S DECISION TO APPLY A DIFFERENT POLICY TOWARDS STATUS-LESS INDIVIDUALS LIVING IN ITS TERRITORY BASED ON WHERE THEY COME FROM – I.E., ENABLING THE VACCINATION OF ALL STATUS-LESS INDIVIDUALS WITH THE EXCEPTION OF PALESTINIANS – DEMONSTRATES THAT THE POLICY WAS PREMISED NOT SOLELY ON AN EFFORT TO ENSURE THE HEALTH OF ITS OWN RESIDENTS, BUT ON RACISM

In conclusion, international law explicitly establishes the responsibility of the occupying power vis-à-vis the right to health of the occupied population for good reason, and it is especially relevant in the event of an epidemic. The resources, powers and authority that are at the disposal of the occupying power grant it greater capacity than local agencies to handle a viral outbreak and protect the occupied population. The Oslo Accords, which were designed to serve as a temporary, interim agreement, ultimately gave rise to a weakened, impoverished and inadequate Palestinian health care system that does not have the capacity to provide a satisfactory response to an outbreak of disease. The system has been further weakened by radical measures that Israel employs in an effort to take over large portions of the West Bank, as it seizes and exploits natural resources while harassing the Palestinian population with colonialist and apartheid-like practices. It is therefore our contention that the Oslo Accords do not relieve Israel of its responsibility to ensure the right to health of the Palestinian population in the oPt.

Israel's Policy Regarding West Bank Residents during the COVID-19 Pandemic

In the spirit of the Oslo Accords, Israel has adopted a minimalist policy in terms of providing aid to the Palestinian population in the West Bank for the purpose of handling the COVID-19 pandemic. Israel's actions have been limited to transferring medical supplies to the West Bank sent by international bodies.[96] In March, the UN Director-General released a statement that *Israel and the Palestinian Authority are continuing to coordinate their responses constructively*.[97] However, Nickolay Mladenov, the UN Special Coordinator for the Middle East Peace Process, later warned that the suspension of relations between Israel and the Palestinians over Israel's annexation policy is injurious to the fight against the coronavirus (coordination was resumed in November).[98]

In a petition to the Israeli High Court of Justice, PHRI demanded that Israel provide aid to the Palestinian Authority and the Gaza Strip during the pandemic. The State responded that responsibility for handling the pandemic rests with the Palestinian Authority, not Israel.[99] Nevertheless, the State's response detailed additional steps Israel had undertaken for the purpose of coordination with the Palestinian Authority during the pandemic, including coordination with representatives of the Palestinian Ministry of Health in Ramallah, meetings and consultations, and sharing professional materials that were translated into Arabic. The State's

[96] Response from COGAT to a Freedom of Information Request by PHRI, March 31, 2020, Ref.: 289-01-3686.
[97] "COVID-19: UN Envoy Hails Strong Israel-Palestine Cooperation," UN News, March 28, 2020.
[98] "Envoy Welcomes Restart Of Israeli-Palestinian Coordination Amid COVID-19 Rise," UN News, November 18, 2020.
[99] See HCJ 2669/20 PHRI v Minister of Health and Minister of Defense, April 23, 2020 [Hebrew].

response further noted that Israel had held training sessions at Magen David Adom (the Israeli equivalent of the Red Cross) and Tel HaShomer Hospital for medical staff from the Palestinian Authority on personal protection and the treatment of COVID-19 patients.[100] According to the State's response, it had provided the Palestinian Authority with 1,950 testing kits and 2,400 sample-collection swabs from the stores of Israel Ministry of Health's Emergency Department. In addition, the State's response noted that Israel has allowed the transport of donations as part of its pandemic response. It stated that donations from the international community – including ICU beds, ventilators and auxiliary equipment, testing kits and sample-collection swabs, medications and protective gear – had been transferred. Israel also communicated with the Palestinian Authority regarding cases in which Palestinians in Israel had tested positive. In addition, Israel shared the names of Palestinian Authority residents who entered Israel via Ben Gurion Airport and Allenby Crossing, in order to coordinate their quarantine.[101]

In April, Israel authorized thousands of tests to be transported to the Palestinian Authority, as well as thousands of personal protective equipment kits for medical staff in Gaza. In addition to the transfer of supplies and medication, Israel sent medical personnel from the Israel Center for Disaster Medicine and Humanitarian Response to provide training to some one hundred Palestinian medical personnel.[102] Special coordination enabled Israeli doctors to provide instruction to their Palestinian colleagues on how to help the Palestinian population.[103]

Israel also divulged steps the government had taken to help the Palestinians manage the economic crisis during the pandemic. On March 19, the Israeli Ministry of Finance issued an order to transfer 33 million dollars of Palestinian tax revenue to the Palestinian government.[104] In May, Israel approved a loan of 230 million dollars to the Palestinian Authority for the purpose of combating the pandemic. This decision was made following a request by the Palestinian Minister of Finance to receive "sums above the standard amount" due to the COVID-19 outbreak and the heavy economic burden placed on the Palestinian Authority. That said, Israeli Finance Minister Moshe Kahlon stated in his response to the High Court that the loan would be deducted from future transfers to the Palestinians of the import taxes collected on their behalf.[105]

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[100] See Ruling in HCJ 2669/20, May 7, 2020.
[101] Noa Landau, "Because of the Coronavirus: Tonight, Israel Will Approve NIS 800 million in Aid to the Palestinian Authority," Haaretz, May 10, 2020 [Hebrew].
[102] Song Niu and Li Nianci, "Israel's Measures and Its Cooperation with Palestine to Fight COVID-19," Asian Journal of Middle Eastern and Islamic Studies 14, no. 3 (2020): 396-409.
[103] "Thousands of Coronavirus Testing Kits Transferred to the Palestinian Authority," Kipa News, April 16, 2020 [Hebrew].
[104] Song Niu and Li Nianci, "Israel's Measures and Its Cooperation with Palestine to Fight COVID-19," Asian Journal of Middle Eastern and Islamic Studies 14, no. 3 (2020): 396-409.
[105] Noa Landau, "Because of the Coronavirus: Tonight, Israel will Approve NIS 800 million in Aid to the Palestinian Authority," Haaretz, May 10, 2020 [Hebrew].

In its response to the High Court, Israel listed the instances that it had allowed the transfer to the Palestinian Authority of supplies and medication, as well as of contributions and aid by international bodies and foreign countries, including by Arab states. Israel described these actions as part of the aid and relief it was offering in response to the outbreak of the pandemic in the oPt. It is most peculiar that Israel considers its authorization of the transfer of necessary equipment as good will "aid" on its part, when this action derives from its legal and moral duties. This is especially odd considering that not transferring these supplies (which were not even purchased by Israel, but actually came from external donations) might have thwarted the capacity of the Palestinian authorities to combat the virus. Moreover, the quantity of medical supplies that Israel approved for transfer to the West Bank is nowhere near adequate for a population of nearly three million.[106] Yael Ravia-Zadok, Deputy Director of the Economy Division at the Foreign Ministry, made clear that **"the Palestinians' needs in this matter are greater than what the State of Israel is able to provide"**.[107] Yet no data were presented to support her statement. Therefore, based on past experience, Israel is neither prepared nor willing to supply the Palestinians' needs.

It is clear that the nominal response Israel has provided to the Palestinian authorities in Gaza and the West Bank since the crisis began falls far short of its moral and legal obligations for Palestinians' health, particularly in the case of a pandemic. Moreover, Israel described its actions purely as a gesture of good will on its part and certainly not as part of a duty it must uphold. Worse, while Israel provided token responses unequal to its moral and legal duties with one hand, its other hand was implementing an injurious policy that obstructed the Palestinian Authority's capacity to combat the spread of COVID-19 in the West Bank.

The escalation of the Israeli government's policy can be seen first and foremost in the dramatic increase in the demolition of homes and other structures during the COVID-19 crisis. Apart from dwellings, various other types of structures were demolished, including water and sanitation infrastructure and agricultural facilities.[108] The deteriorating situation may also be seen in the substantial increase in settler violence against Palestinian during the pandemic.[109] This violence has not been addressed by Israeli law enforcement or the judiciary. This enables and encourages settler violence while violating Palestinians' right to legal remedies for the victims of violence.[110]

[106] Yara Hawari, "COVID-19 in Palestine: A Pandemic in the Face of 'Settler Colonial Erasure'," IAI, September 15, 2020.
[107] "Briefing for Foreign Ambassadors on Coronavirus Management and Cooperation with the Palestinians," Israel Foreign Ministry, March 31, 2020.
[108] Maya Horodniceanu, "Despite Coronavirus Crisis: Record Number Of Home Demolitions In East Jerusalem This Year,"Walla!, November 2, 2020 [Hebrew].
[109] OCHA, "Unprotected: Settler Attacks against Palestinians on the Rise amidst the Outbreak of COVID-19," June 22, 2020.
[110] UN Human Rights. "Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law." Adopted and proclaimed by General

Discrimination in COVID-19 Vaccines

The Israeli policy with regard to vaccines for Palestinians is no different from the policy it has adopted since the onset of the coronavirus crisis in the oPt. Namely, Israel is shirking its responsibility as an occupying power to provide equal services to the Palestinians, commensurate with its control over Palestinian territories.

During the first few months after Israel announced its procurement of vaccines for its citizens and after the rollout of the vaccination program in Israel and for Israeli settlers in the oPt, Israel eschewed its duty to provide vaccines to the Palestinians. The official position Israel adopted was basically an objection to transferring vaccines to Palestinians, citing as grounds that it is the Palestinian Authority's responsibility under the Oslo Accords. This position was in stark contrast to the opinion of public health experts in Israel who called upon the government to vaccinate the Palestinian population as a preventive step that would contain the disease.[111] Moreover, the exclusion of Palestinians from vaccination extended also to those Palestinian individuals residing in Israel. This stands in contrast to Israel's decision to vaccinate all other status-less individuals currently in Israel.[112]

Israel's decision to apply a different policy towards status-less individuals living in its territory based on where they come from – i.e., enabling the vaccination of all status-less individuals with the exception of Palestinians – demonstrates that the policy was premised not solely on an effort to ensure the health of its own residents, but on racism. This decision was made even though it flies in the face of the logic of public health and jeopardizes all of Israel's citizens, proving just how deep-seated this racism is. Furthermore, Israel used as a political bargaining chip its statement of intent that, once it finishes vaccinating its own residents, including Israeli settlers in the oPt, it would grant the Palestinian Authority's demand for humanitarian aid. In one instance, Israel stipulated the return of the bodies of Israeli soldiers from the Gaza Strip as a condition for giving vaccines to the Gaza Strip.[113] This demand was even raised at a session of the Knesset's Foreign Affairs and Defense Committee.[114]

Assembly Resolution 60/147 of 16 December 2005.

[111] Ronni Gamzu, "Taking Responsibility for Vaccinating the Residents of the Palestinian Authority," Haaretz, 15 March 2021 [Hebrew].

[112] Oren Ziv, "It Is Shocking that the Simple Fact of Being Palestinian Prevents a Person from Being Vaccinated," Siha Mekomit [Local Call], February 18, 2021 [Hebrew].
An English version of this article was published as: Oren Ziv, "Israel Approves COVID Vaccines for Undocumented Persons, but Not for Palestinians," +972 Magazine, February 18, 2021.

[113] Tal Lev-Ram, "On Condition that Issue of Captives and MIAs Is Resolved, Israel Will Help Gaza with COVID-19," Ma'ariv, December 12, 2020 [Hebrew].

[114] "National Security Council Representative Could Not Say Who Decided to Transfer 5,000 Vaccines from Israel to the Palestinian Authority or Who Would Decide on Transferring Vaccines from the PA to Gaza," Knesset News, February 15, 2021 [Hebrew].
A condensed English version of the press release: "Subcommittee on Policy and Strategy discusses transfer of COVID-19 vaccines to the Palestinian Authority," Knesset News, February 16, 2021.

THE CRISIS EXPOSED THE EXTREME DISPARITIES BETWEEN THE ISRAELI AND PALESTINIAN HEALTH CARE SYSTEMS: TWO DIFFERENT HEALTH CARE SYSTEMS WHICH SERVE TWO POPULATIONS SUBJECT TO THE SAME RULE. THE COMBINED EFFECT OF THE LIMITED POWER AND RESOURCES OF THE PALESTINIAN AUTHORITY AND ISRAELI POLICY, CHARACTERIZED BY COLONIALIST FEATURES (SETTLEMENTS, LAND APPROPRIATION, CONTROL OF NATURAL RESOURCES, ETC.), HAVE LED TO UNDER-DEVELOPMENT OF THE PALESTINIAN HEALTH CARE SYSTEM. THE PALESTINIAN AUTHORITY HAS BEEN LEFT WITH LIMITED SPACE TO MANEUVER AND REMAINS HEAVILY RELIANT ON INTERNATIONAL BODIES. THE UPSHOT IS AN ABSENCE OF AN EFFECTIVE AND INDEPENDENT PALESTINIAN HEALTH CARE SYSTEM.

As of April 2021, about 153,000 vaccines had been brought into the West Bank all in all, most of which were the Chinese Sinopharm vaccine. In addition, in early March, Israel vaccinated about 100,000 Palestinian laborers employed in Israel and the settlements.[115] In other words, the total number of vaccines in the West Bank are sufficient only for about 2.5% of the population. At the same time, a mere half-hour ride away, Israel has the highest vaccination rate in the world, with 52% of its population already vaccinated, including settlers in the oPt. There have even been media reports of surplus vaccines being discarded, and reports of plans by Israel to purchase additional Pfizer vaccines to vaccinate teenagers and to use as booster shots.[116]

As of April 2021, it appears that Israel's involvement in the vaccine program in the West Bank has been minimal. It has basically been limited to vaccinating Palestinian laborers (as noted, about 100,000 people) who are employed in Israel and the settlements and travel on a daily basis between Israeli territory and the oPt. In addition, Israel supplied vaccines to about 1,000 medical personnel in the West Bank. It should be noted that the majority of vaccines that have thus far reached the Palestinians in the West Bank were sent thanks to the aid of countries such as the United Arab Emirates, and organizations such as the WHO. Israeli involvement, as far as has been made public to date, amounts to approximately 2,600 vaccines out of a total of 5,000 it had pledged (mostly Moderna vaccines), which were transferred in February 2021 and earmarked for medical staff in the West Bank.[117]

Although Israel has remained vague about plans to transfer vaccines to the Palestinians in the oPt, e.g. in the High Court petition by the Goldin family,[118] myriad evidence confirms that Israel has shirked its duty to supply vaccines to Palestinians on a scale equal to that provided to its own residents.[119] Israel has acted this way despite the recommendations of experts, including that of the expert panel of the Coronavirus Cabinet to vaccinate the Palestinians.[120] Israel continues to eschew its responsibility to vaccinate the Palestinians, be it in the Gaza Strip or the West Bank, in the hope that the imposition of external and internal lockdowns and closures or changing of the criteria for approving entry permits and passage permits, will relieve it of the economic burden and of its legal responsibility to the Palestinians.

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[115] OCHA,"COVID-19 Emergency Situation Report No. 29," March 2021; Nir Hasson, "Israel Begins Vaccinating Palestinian Workers against COVID," Haaretz, March 8, 2021.
[116] Josh Nathan-Kazis, "Pfizer Negotiating Deal to Sell More Covid-19 Vaccines to Israel," Barron's, April 5, 2021.
[117] Statement by the State of Israel in HCJ 9284/20.
[118] Avishai Grinzaig, "State to High Court: No Plan at Present to Transfer COVID-19 Vaccines to Gaza," Globes, January 6, 2021 [Hebrew].
[119]Amira Hass, "Israel's Vaccine Apartheid," Haaretz, March 1, 2021. [The original Hebrew article was published in Haaretz on February 28, 2021.]
[120] Adir Yanko, "Discouraging Meeting on Lockdown by Expert Cabinet: 'Spread of Illness Continues; Efficacy Doubtful'," Ynet, January 18, 2021 [Hebrew].

In conclusion, the COVID-19 vaccines are an unambiguous case in point demonstrating the reality in the oPt since the Oslo Accords. In practice, Israel continues to control many spheres of life, while leaving the Palestinian Authority to bear the economic onus without the benefit of authority. This is particularly true in the field of health care. Israel controls a large portion of the Palestinian Authority's budget and chooses when to transfer or delay its transfer, using this as a political bargaining chip. Even the vaccines the Palestinian Authority purchases independently require Israeli authorization in order to reach the oPt. At the same time, Israel shirks its obligation to uphold Palestinians' right to health. As things now stand, Israel controls the entire region between the Jordan River and the Mediterranean Sea and maintains two systems of law: one grants privileges to Israelis while the other deprives Palestinians of their rights and dispossesses them of many resources. Therefore, there is no choice but to view the case of the vaccines as one of discrimination between two groups living in the same region.

This is the basis of the demand that Israel supply vaccines to the Palestinians in the same amount, timing, and quality that it offers Israelis. Naturally, this demand in no way grants legitimacy to Israel's continued control over the Palestinians. Nor does it deny the right of the Palestinian Authority to also provide vaccines to the Palestinians, if it is within its power – although it is doubtful that the Palestinian Authority has the independent capacity to supply vaccines on the scale needed to meet the needs of the entire population. Our demand that Israel fulfill its duties is largely based on its obligations towards the Palestinians as a protected population and on the principle that control entails responsibility. Israel cannot be allowed to shirk its responsibility over and over again.

Conclusion

The COVID-19 pandemic hit the Palestinian population in the West Bank at a time when it was already in severe economic and political straits, after years of economic recession and political uncertainty. At the same time, the Palestinian Authority has also had to face diplomatic escalation on the part of the Israeli government, whose declarations of planned annexation were made at the height of a global emergency. Throughout the crisis the Israeli government has persevered in its longstanding policy of shirking its responsibility for the right to health of the Palestinian population in the oPt.

In a policy that violates international law regarding the obligation of an occupying power to uphold the rights of an occupied people, the Israeli government has refrained from fulfilling its obligation to transfer to the Palestinian population in the West Bank essential medical resources – tests, sanitation supplies, ventilators, etc. – adequate for the population's needs in both quality and quantity. Moreover, because of the closures imposed in the oPt, aid organizations – on whom the Palestinian population in Area C of the West Bank has relied for years – have been unable to provide the medical treatment they normally would.

The crisis exposed the extreme disparities between the Israeli and Palestinian health care systems: two different health care systems which serve two populations subject to the same rule. The combined effect of the limited power and resources of the Palestinian Authority and Israeli policy, characterized by colonialist features (settlements, land appropriation, control of natural resources, etc.), have led to under-development of the Palestinian health care system. The Palestinian Authority has been left with limited space to maneuver and remains heavily reliant on international bodies. The upshot is an absence of an effective and independent Palestinian health care system.

Israel's responsibility for the Palestinian population's human rights, including its right to health, is set out in international law. It is particularly clear in the Fourth Geneva Convention and the International Covenant on Economic, Social and Cultural Rights (1966) which establishes the responsibility to safeguard the right to health and the **"creation of conditions which would assure to all medical service and medical attention in the event of sickness."** As long as Israel maintains its position as an occupying power and controls most of the conditions essential to safeguarding and promoting the right to health, it bears responsibility for the health of the Palestinian population in the oPt. This is all the more true in the event of a pandemic. As the Oslo Accords were designed to serve as a short-lived interim agreement, they certainly did not address a scenario of the continuation and entrenchment of the occupation, which has also involved splitting up the land into disparate blocs and the expansion of settlements. These laws and conventions establish the responsibility of the occupying power – in this case, Israel – to adopt appropriate measures to combat the spread of epidemics, including the COVID-19 pandemic. Such measures include the distribution of medications and hygiene supplies, carrying out tests, sending medical staff to areas with high infection rates, providing quarantine and medical treatment in hospitals to people who have contracted an infectious disease, and helping to open new hospitals.

Not only has Israel's government refused to uphold its legal obligations, it has even been shown to undermine the Palestinian Authority's efforts to combat the disease. On top of decades of systematically and consistently hampering the development of an independent and viable health care system, Israel impeded the provision of medical care even during the coronavirus pandemic. It imposed travel restrictions between areas; set obstacles that hindered patient referrals; limited access to hospitals in East Jerusalem; and caused significant harm to health indicators, including water and sanitation, through demolitions carried out by its military.[121]

Perhaps the clearest example of Israel's attitude towards the Palestinian population during the pandemic is the matter of vaccines. Although Israel has remained vague about its vaccination policy for Palestinians, the fact is that while millions of Israeli residents – as well as Israeli settlers in the West Bank – have already been vaccinated, the vaccination campaign in the West Bank has only just gotten underway. This state of affairs demonstrates a reality of apartheid, whereby while two populations live under a single sovereignty, one will receive a high-quality vaccine early on, whereas the other will receive fewer vaccines, of another type and at a later time. The very fact that two populations living under the same

[121] Yara Hawari, "COVID-19 in the West Bank and Gaza: A Second Wave under Military Occupation and Siege," Middle East Institute, July 29, 2020.

regime are treated in such disparate ways is unparalleled confirmation of the existence of a reality of apartheid in the West Bank.

Apart from the obligations set out in international law and conventions, one cannot ignore the moral aspect of ruling over a population that has been bereft of rights for so many years. While the tragedy that unfolded during the COVID-19 pandemic is indeed exceptional in its scope and intensity, it cannot be separated from living under an occupation that has persisted for more than five decades.

After so many decades in which the right to health of millions of Palestinians in the oPt has been violated, PHRI demands – as an essential measure, though not sufficient in itself – that Israel ensure access to all medical treatments that are inadequate or entirely unavailable in the oPt, and that Israel foot the bill for referring those patients to hospitals outside the Palestinian system. However, full realization of the Palestinians' right to health in the oPt, like that of any other people, cannot exist without the realization of their civil and political rights as individuals and collectively as a nation.

Israel's duty to ensure Palestinians' right to health cannot go on indefinitely, as this duty stems from Israel's position as an occupying power. The need to end it is even more pressing in view of the very length of the colonialist and apartheid-like occupation and Israel's control over most of the conditions essential to safeguarding and promoting the right to health. As long as the Israeli occupation and control prevent the Palestinians from ensuring their right to health themselves, Israel must:

- Enable free and open passage between the West Bank – including East Jerusalem – and the Gaza Strip, thereby enabling the Palestinian health care system to operate as a single entity.
- Terminate the permit regime and end the blockade over the Gaza Strip.
- Provide and fund treatments that are unavailable in the oPt.
- Ensure consistent and reliable passage that will allow Palestinians access to medical services in Israel and allow medical and human rights organizations access to the Palestinian population in the oPt.
- Ensure that the Palestinian population will have full access to the same vaccines that Israeli residents receive and within the same time frame.
- Aid the Palestinian population in obtaining equipment and medical treatments that will help it overcome the COVID-19 pandemic as quickly as possible.

ISRAELI POLICY IN THE OPT COMBINES MILITARY OCCUPATION WITH ELEMENTS OF APARTHEID AND COLONIALISM. THESE HAVE WORKED TOGETHER TO UNDERMINE THE PALESTINIAN HEALTH CARE SYSTEM. THE DISPARITIES BETWEEN THE ISRAELI AND PALESTINIAN HEALTH CARE SYSTEMS ARE IMMENSE, WITH MATCHING GAPS IN HEALTH OUTCOMES.

THIS REPORT EXAMINES HOW THE RESTRICTIONS IMPOSED ON THE PALESTINIAN HEALTH CARE SYSTEM AND THE CHRONIC, SEVERE SHORTAGE IN PERSONNEL AND INFRASTRUCTURE HAVE UNDERMINED ITS ABILITY TO RESPOND TO THE CORONAVIRUS PANDEMIC. THE REPORT ALSO SHOWS HOW ISRAEL CONTINUED TO EVADE ITS RESPONSIBILITY FOR THE HEALTH OF PALESTINIANS EVEN DURING A GLOBAL HEALTH CRISIS.