Government and U.N. Healthcare Delivery in the Palestinian Territories:

History, Current Status, and Suggested Policy Improvements

Esa Rayyan

A Thesis Submitted to the

University of Arizona in Fulfillment of the Requirements

For the Honors Recognition for the Bachelors of Science in Health Sciences

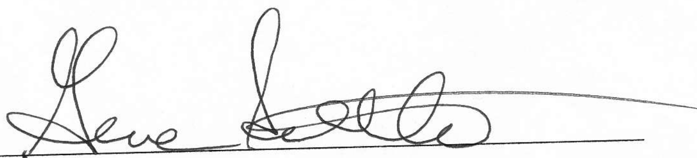
Department of Physiology

University of Arizona Honors College

2011

Approved by

Advisor



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Abstract

Under the current Israeli military rule, several aspects of Palestinian healthcare have proved to be problematic for the Palestinian people as the Palestinian Authority, the Israeli Defense Forces and the United Nations are constantly at odds with one another and with the civilian population in question. The deterioration of Palestinian healthcare continues to worsen as the political context of the region becomes increasing dire. Equally to blame as the political climate, however, is the lack of willingness on the part of the Palestinian governance to solidify the necessary organizations and institutions needed to implement effective reforms. This report will address the Palestinian Healthcare Delivery, governmental and United Nations-directed, with respect to its history, current status and suggested policy improvements.

Acknowledgements

This thesis is the culmination of a year of research, reading, interviewing, contemplating, reflecting and revising. Without the individual contributions outlined below this product would not have been possible.

I owe a particular debt to Dr. Carol Eugene Settle who has been my mentor and friend since the Spring of 2010 when he ignited my curiosity into the relationship between people and the scientific institutions and medical entities that govern and persuade them. I extend to him my sincere appreciation for serving on my thesis committee and for sharing with me his radiant energy and keen investigative insight and skills on this convoluted topic. I would also like to extend the utmost appreciation to the Department of Near Eastern Studies which has been instrumental, over the years, in solidifying and championing my dedication and my desire to focus my time and effort on the Middle East and on this endeavor. Specifically I would like to thank Dr. Maha Nassar for sharing her piercing passion and enthusiasm for the Palestinian cause and narrative, without which I would have not been inspired to embark on this research.

Introduction

Often times in the realm of modern society much focus is placed on the political and societal climate of Israel/Palestine. Standing as a historical and spiritual center for three of the world's largest religions, it has come to embody the plights, aspirations, hopes, and religious convictions of numerous groups throughout the ages. However, due to the political inclinations of the region and international foreign policy towards the Muslim world, the health and medical situation is often times overlooked. Despite the fact that the current conflict in the region has been going for quite some time, the heart of the conflict comes down to land; two nations believe that they are entitled to the land currently known as Israel and the Palestinian Territories. For the Jews, the land of Israel represents an entitlement bestowed upon them during the age of antiquity through the Prophet Abraham's covenant with God. The Palestinians, on the other hand, view Palestine as their national homeland as it is the land of their ancestors; the land that they have cultivated and occupied for thousands of years.

The conflict as we know of it today began after the resolutions of World War I. According to records of the Ottoman Empire, which ruled Palestine for several centuries, in the year 1900, the population of Palestine was 600,000, of which 94% were Arabs (Smith 2007). This proportion began to change, however, upon the defeat of the Ottoman Empire by the Allied powers. In accordance with the terms of the Treaty of Versailles, Britain seized control of then Palestine and Transjordan and governed it as a mandate region (Smith 2007). During this time period, paralleling European and African countries, there was an increased sense of nationalism unlike anything the world had ever seen. The 20th century marked the age of the nation-state in which various groups of individuals around the world wanted to define their own borders in

terms of ethno-national guidelines, characterizing themselves as a contrast to a subjective perceived "other"; Palestinians and Jews were not immune to this phenomenon. Under the British Mandate of Palestine there was a spark in Jewish Immigration to the region in part due to growing anti-Semitism in Europe and in part as a result of Zionistic initiatives to repopulate the sacred Jewish city of Jerusalem (Matthews 2007). In the 1930s, inspired by the Gandhian movement in India, Palestinians initiated a revolt in attempts at declaring their own personal nationalistic aspirations and yearning for self-governance (Matthews 2007). The British swiftly reacted and put down the revolt with the assistance of various Jewish militias, however it bred an even greater sense of hostility between these two groups.

Following World War II, the international community sought to end the era of the empire by granting several peoples the ability to rule and govern themselves in their own nation-states. In 1948, the British relinquished their power over the region allowing the Jews in Palestine to declare the independence of the new State of Israel on mandate Palestine. The neighboring Arab nations of Egypt, Saudi Arabia, Transjordan, Syria and Iraq invaded Israel to aid the Palestinian Arabs in their nationalistic endeavors (Smith 2007). The Arabs inevitably lost and Israel's campaign in the region caused the expulsion of over 400,000 Palestinian refugees according to some estimates. The animosity between the Israelis and the Palestinians escalated in the 1967 war as well, leading to the Israeli military occupation of the West Bank and the Gaza Strip.

The illegal military occupation of the Palestinian Territories remains very much at the forefront of international politics and is the main obstacle to substantial peace between the two peoples. However under the current Israeli military rule, several aspects of Palestinian

healthcare have proved to be problematic for the Palestinian people as the Palestinian Authority, the Israeli Defense Forces and the United Nations are constantly at odds with one another and with the civilian population in question (Barnea 2002). Despite the uniqueness of the health sector when compared to other social and industrial institutions, the technical aspects show a similar lack of respect for political boundaries as most other policies in this region. A potentially volatile confrontation between technical requirements has characterized relationships in the health sector between Israel and the Occupied Palestinian Territories visa vie the United Nations since for the past sixty years (Barnea). This report will address the Palestinian Healthcare Delivery, governmental and United Nations-directed, with respect to its history, current status and suggested policy improvements.

The geopolitical context of the Palestinian health care system

In order to understand the modern geography of the Occupied Palestinian Territories, one must look at the political history of the region itself. Currently, the Palestinian territories form a combined area of 6000 sq. km and are divided into two geographically distinct and divided territories: the West Bank and the Gaza Strip (Palestinian Central Bureau of Statistics 1999). In between these two pieces of land is the internationally recognized State of Israel. The West Bank and the Gaza strip are collectively inhabited by approximately 3.7 million people. Gaza in particular is one of the most densely populated areas in the world with 2100 inhabitants per square kilometer, 65% of which are refugees from the 1948 and 1967 wars (Khawaja 2000). Furthermore, of these 3.7 million inhabitants of this region, 47% of them are below the age of fifteen (Palestinian Central Bureau of Statistics 1999). Despite both of these land masses being intricate components of Palestine, each has significant disparities including total fertility rate, which is 5.44 in the West Bank as opposed to 7.41 in the Gaza Strip and infant mortality rate which is 25.5 and 30.2 per 1000 live births respectively (World Bank 2002). In 1998 Gaza and the West Bank had a combined GNP of $1800 U.S. dollars and were deemed as being a lower-middle income economy (World Bank 2002). Since that time, however, the per capita incomes have decreased as the Palestinian economy collapsed following the volatile political climate. By the beginning of 2002 it was estimated that 45-50% of the population was living below the poverty line (Khawaja 2000).

Due to the fact that there are major geographical divisions induced by the political conditions of the past decade, two separate and distinct de facto government health systems have formed for each the West Bank and the Gaza Strip. The day-to-day restrictions of movement

and the varying degrees of restrictions on the ground have led to the near impossibility of standardizing these isolated health sectors closing in on the gap between these two regions.

Healthcare under the British Mandate

The period of the British Mandate over Palestine between the years 1920 and 1947 marked a critical phase of political turmoil, economic evolution and colonial governance. This period ended with the 1948 Arab-Israeli war which led to a totally collapse of the geographically cohesive Palestinian population and led to the complete erosion of health services provided by the British mandatory government in Palestine (Smith 2007). Upon the creation of the British Mandate, Palestine had become a distinct political entity for the first time in several centuries. Palestinian Arabs and Zionists both came to the realization that the future of each of their respective nations relied on their role in the Mandate. Thus, the main concern throughout the Mandate period for both the Arabs and the Jews was how to respond to the British rule in a manner than ensured their survival and viability. Although these two groups were simultaneously vying for similar aspirations, the manner in which the British colonial powers dealt with the two groups differed a great deal (Khalidi 2007). Dating back to the inception of the British Mandate over the region, there had been blatant bias and animosity directed towards the Arab inhabitants of the land in comparison to their Jewish counterparts of the region (Khalidi 2007). The Mandate for Palestine, issued by the League of Nations in 1922, was an internationally recognized document representing the consensus of the great powers following WWI over the former Ottoman territory of Palestine. In the actual text of this mandate it becomes clear through the rhetoric that as early as the resolution of the war, the British had already marginalized the Arab populations of Palestine as an inferior people (Khalidi 2007). The actual written mandate, as drafter by the world powers, failed to mention neither the Palestinian people nor their national self-determination; rather, the text makes an occasional reference to ‘native inhabitants’ that occupy the land. Contrastingly, however, the Jewish

minority of the region was most definitely recognized under this document, clearly indicating that the British themselves entered the mandate period with less than impartial intentions. In regards to the framing of the mandate document itself, Rashid Khalidi goes so far as to argue that the very nature behind the organization of the original mandate document is to exclude any sense of self-determination for the Arab majority, while still at the same time aiding the Jewish minority in their endeavors (Khalidi 2007).

This blatant bias manifested itself in various political and social outlets, not excluding the health sector of society. As a means of wielding Britain's control over Palestine, they exercised what historians have often referred to as "colonial medicine" (Davidovitch 2007). Typically speaking, colonial efforts to deal with the health of developing regions were closely linked to the economic interests of the colonizers (Davidovitch 2007). The health of the colonized subjects was a topic only considered when their medical ailments threatened colonial economic enterprises or the health of the Europeans. Accordingly, the success or failure of health interventions was measured more in terms of the colonies' production than by measuring the levels of health and well being among the native population. Furthermore, colonial medicine tended to be narrow in both its design and utilization (Davidovitch 2007). Health as it was defined during the pre–World War II era was simply the absence of disease. What that entailed was that health could thus be achieved by understanding and developing methods for attacking specific diseases, mainly those that were infectious and posed the greatest threat to the colonizers, one at a time (Davidovitch 2007). This narrow approach to health and illness appeared to be cheaper and more manageable than efforts to improve the general health and well-being of colonial subjects through social and economic development. Colonial authorities construed both the concept of broad-based health care and efforts to deal with the underlying

social and economic determinants of illness as both impractical and unnecessary (Davidovitch 2007).

Following World War I, health services were provided by the Government Department of Health under the British Civil Administration. Though a few governmental hospitals and health clinics were provided for the Arab population of Palestine, British colonial policy aimed to limit investments of any sort in the social services of the region, and thus poor Palestinian population resided, had very limited access to medical services (Barghouthi 1990). Many city dwellers were able to utilize the Christian Mission hospitals and the government hospitals in the major Palestinian cities. The 1948 Arab–Israeli War brought about the creation of the State of Israel and the displacement of the Palestinian population, whereby approximately 750,000 Palestinians became refugees (Smith 2007). Immediately after the war, while Jordan ruled the West Bank and Egypt administered the Gaza Strip, two separate health systems began to emerge. Furthermore, the United Nations Relief and Works Agency for Palestine Refugees (UNRWA) was established by the United Nations General Assembly in 1949 and began operations in 1950, with the mandate to 'carry out direct relief and works programmes for Palestine refugees' (Barghouthi 1990). Thus, as of the late 1950s, modern medical services began to become available to refugees and to the rural areas, as basic health and education infrastructures reached the countryside. However, those health services were for the most part remedial and unreliable depending on the political context (Giacaman 2003).

Healthcare under the Israeli Military Occupation

On the eve of the 1967 occupation of the West Bank and Gaza by Israel, there were three systems for health service provision operating in the area. The governments of Jordan and Egypt supervised the public system in the West Bank and the Gaza Strip, respectively, while UNRWA provided health services for refugees; the private sector included charitable organizations operating major hospitals and diagnostic centers or primary care centers (Giacaman 1990). Following the military occupation, the Israeli Civil Administration (under the Ministry of Defense and *not* the Ministry of Health) took over the governmental health care system and proceeded to administer it in a manner that kept it stunted and frail with severe budget restrictions, referral to Israeli hospitals for tertiary care, and restrictions on licenses for new medical and health care projects (Giacaman 1990). What this, in turn, did was create a total dependence on the Israeli health system by the Palestinians. This was a political tactic initiated as a means of ensuring that the Palestinian people would be unable to create a sense of societal normality and prevent them from fully forming their own solidified ethno-national entity. In addition, health service delivery in that era was characterized by the disempowerment of the Palestinians in decision making and top level management (Giacaman 2003). Although the actual service providers were all Palestinians, institutions were not developed to meet the changing needs and growth of the Palestinian population and these Palestinians were not granted to effort and the means of learning how to serve themselves autonomously.

As for the private sector, operating small hospitals and basic medical clinics owned and run by individual physicians on a fee-for-service basis provided an alternative to the health care norms that had existed prior (Giacaman 2003). A major area of concern however, is that since the inception of the Israeli Occupation up until the present the private sector was subject to

Israeli military rules and licensing restrictions and was prohibited before any substantial developments could ever take root. As an act of defiance to established powers and as an attempt at responding to the needs of the Palestinian community, popular grassroots health committees branched out from the political movements and become prominent beginning in the 1970s (Giacaman 2003). These devoted activist NGOs based their approach on reaching out to underserved areas with volunteer health providers and promoting preventive care, health education activities, and popular participation in health related issues. This grassroots movement served a significant purpose in that it allowed the Palestinian community to begin to realize their ability to be in charge of their own health system and medical futures. Many of the lessons and inspirations they garnered as a result of these movements are still echoed today and are the basis by which Palestinian healthcare has managed to progress at all.

Healthcare and the UNRWA

At the same time as the Israeli government was attempting to create a culture of medical dependency amongst the Palestinians, the United Nations having similar results with their health care initiatives, though unintended. The United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) is a relief and human development agency that provides education, health care, social services and emergency aid to over 4.7 million Palestine refugees living in Jordan, Lebanon and Syria, as well as in the West Bank and the Gaza Strip (Barghouthi 1990). It is the only agency dedicated to helping refugees from a specific region or conflict. During these years the UNRWA was able to develop its own system of basic services, including health, education, relief and social services, for the refugees relatively independent from the Israeli bureaucracy (Barghouthi 1990). Though the UNRWA sought to provide the Palestinians with opportunity at acquiring adequate medical attention, what they did was prevent Palestinian capacity building and leadership which further curtailed their political and nationalistic endeavors. The UNRWA's assistance was provided to the Palestinian people in a manner that acknowledged the transient nature of the situation. As such, the UNRWA created a culture of dependence of sorts where Palestinians were rarely asked to be accountable for their own well being or to be active participants in the policy making. The problem with this, however, is that the situation and the conflict between Israel/Palestine has been gaining momentum for the past sixty years and the fact that the United Nations has yet to fully acknowledge the severity of the current situation under the occupation amounts to incompetence.

Oslo Peace Accords and its Significance on Palestinian Healthcare

The Oslo Accords, officially called the Declaration of Principles on Interim Self-Government Arrangements was a series of secret meetings attempting to resolve the ongoing Palestinian-Israeli conflict in 1993 (Smith 2007). It was intended to be the one framework for future negotiations and relations between the Israeli government and Palestinians, within which all outstanding final status issues between the two peoples could be discussed and finalized. Since the Oslo Peace agreement, the context of the Palestinian healthcare is characterized by political and economic destabilization (Giacaman 1994). The authority over the Palestinian health care system was transferred to the Palestinian in 1994. Since the transfer, fundamental changes in the system have taken place including what constitutes as governmental health services. Of the many reforms implemented, many included expanding the health care provision capacity, improving the management and oversight, developing human resources, and creating a financial framework for future public insurance options (Giacaman 2004).

Palestinian Health Care under the Palestinian Authority

During the Oslo accords, Israel and the Palestine Liberation Organization (representing the Palestinian people) signed the Declaration of Principles allowed for the creation of the Palestinian Authority, a Palestinian governing body, later that year. A subsequent series of negotiations and agreements resulted in further allocations of powers and responsibilities to the PA, including overall responsibility for health care. Upon the Palestinian Authority gaining the responsibility for healthcare, they created The Palestinian Ministry of Health in 1994 (Shu'aybi 2000). Currently, the Ministry of Health remains the primary provider of health services to the Palestinian population with about 40% of primary health care visits taking place at government facilities, 31% at UNRWA and 29% at private and NGO facilities (Policy Research Incorporated 1999).

The extensive task of rebuilding the ailing healthcare has been alleviated some by substantial donor assistance. Between 1994 and 1999 financial boosters committed nearly $353 million US dollars to assist in modernizing the health industry (World Bank 2000). With these investments on Palestinian social capital, the Ministry has made remarkable strides in increasing the number of government primary health care clinics are available and in integrating family planning services to the already-existing clinics. The ministry was able to create some semblance of a structure and managed to create a national health information system and health insurance scheme (Shu'aybi 2000). The Ministry of Health also made a commitment to further investigate and develop facets of medicine that are often times deemed socially taboo in Arab culture including women's health.

Another major priority for the Ministry of Health following the Oslo Accords was establish coverage under a governmental health insurance (Policy Research Incorporated 1999). Between the years 1994 and 1998, the PA Ministry of Health expanded the percentage of households utilizing this insurance from 25% initially to 48% (Policy Research Incorporated 1999). These achievements, however, were limited as government health services began to deteriorate upon the financial crisis of 1997. This has resulted in a far fewer percentage of households participating in the government insurance program and has caused direct out-of-pocket household expenditures on medical treatments to soar. This in turn resulted in a decline in public participation in the governmental health insurance program. With the ever so growing poverty within the West Bank and Gaza, many are beginning to raise concerns about equity in health care and the need by many (particularly those injured by the Israeli Defence Forces) for costly, long term care.

Conditions in the Gaza Strip

Whether it be politically or socially or, in this case, in terms of healthcare Gaza always seems to be the exception. Due to its geographical isolation from the West Bank and due to the unique political turmoil in undergoes distinct from the West Bank, the medical plights of the region vary a great deal and are more urgent. Studies on Gaza have shown that nervousness, tiredness, headaches, psychological distress and post-traumatic stress disorder (PTSD) as the main complaints of the population (World Bank 2007). Moreover, it has been argued that mental and psychological problems encountered in areas under turmoil are frequently 'translated' into psychosomatic symptoms such as muscle pain, tiredness, depression, fatigue, headaches and sleep disturbances in order to conform with acceptable cultural values and practices. Thus, previous findings from the Gaza Strip showing that primary health care professionals were able to detect only 11.6% of mental health problems, with the remaining 88.4% cases going undetected, are of particular concern (World Bank 2007).

Furthermore, in the years following the Israeli withdrawal from Gaza and the militant Hamas political group's claim over the land, Gaza has been inflicted with an Israeli-imposed blockade of goods and services. Though the Israel government has issued several policies at ensuring that medicine and health related items are exempt from the blockade, the policies are not being put into effect on the ground. Writer Mohammed Omer from the Inter Press Services detailed in an op-ed piece about Israeli infringements on human rights to medicine in Gaza. "The health ministry now lists 375 deaths due to shortage of life-saving medicines. The medicines sit just outside the borders of the territory until most pass their expiry dates. But there are no expiry dates on about 10,000 coffins that have been donated for Gaza. The coffins do make it to those that eventually need them. By the end of last month more than 70 percent of

medicines donated for Gaza had been dumped because they were past their expiry date, the health ministry says. They were worth many millions of dollars and were worth many, many lives". In order to ensure that the sanctity of life is maintained and that Gazans are given the opportunity to leave healthy lives, there must be a greater level of coordination between the United Nations and the Israeli IDF soldiers imposing the blockade on the ground.

Major Obstacles to Health Care Reform

There are several obstacles currently in existence that have made it nearly impossible for substantial medical reform to truly take effect. Those include a stable, peaceful political environment with an active economy, strong state institutions and structures, internal political and popular will to implement reform, and the presence of a policy dialogue on what types of reforms the country should invest in.

Ongoing Conflict with a Perceived, Peaceful Horizon:

Reform initiatives within the Palestinian Territories have taken a path similar to those in other post-conflict situations in the sense that they are based on the assumption that the country was entering a period of peace-building and political transition (Giacaman 1998). The trust of the matter is, however, that the Oslo period proved to settle with reality that consistently and continuously undermined and sense of health services overhaul. Palestinians have been conditioned by the international community to constantly cling to the notion that peace is waiting for them just beyond the horizon, making them ill-prepared to deal with the trials and tribulations they are experiencing at hand. This negotiation culture, the idea that mutual dialogue without concessions will lead to substantial changes, is something that both the Palestinians and the Israelis share, because they have co-created it. What has been created over the years is a shared, deep, abiding and mutually exclusive commitment to one's own victimhood, a sense of insecurity and a historical questioning of legitimacy of other. With that being the case, the status norm in regards to healthcare is rarely challenged because it is constantly painted as being nothing more than a transition until peace is achieved, at the expense of the Palestinian population.

Despite what was construed as progress in state building that began with the Oslo peace process, the situation on the ground remained highly problematic. By 1998, it had become clear that a final and peaceful solution to the long conflict between Israelis and Palestinians was not materializing (Giacaman 1998). Eventually the hopelessness that was permeating the West Bank turned into animosity, rendering itself in the form of the second Intifada in 2002. Overnight, these events drove the Palestinian Territories into an unprecedented economic crisis with at least half of the population living under the poverty line by the beginning of 2002 (Giacaman 1998). Moreover, the death of over a thousand Palestinians along with the injury of thousands more and the substantial destruction of property and infrastructure including roads and hospitals all contributed to the precipitation of a health system crisis (World Bank 2002). With the sudden need to meet the emergency situations that would constantly arise after the second Palestinian uprising, any initiatives to fortify the Ministry of Health with sound health institutions were foiled, leading to an overall abandonment of system and infrastructure building. Thus what we have been seeing in the past ten years is that the ongoing national liberation struggle and conflict with Israel is not only proving to be seemingly never-ending, but it is also frustrating any attempt at making substantial policy reforms in health care.

Non-Existent Palestinian State Institutions and Governance

Another substantial obstacle to peace that is mere incompetence of the Palestinian Authority to govern and make decisions required of a government; the lack of political involvement is manifesting itself in lack of medical reforms. The congressional cabinet hardly meets, leading to an absence of collective decision-making, integrated planning and the adoption of general policy lines (Giacaman 2003). In the health sector, the ramifications of such a sloppy system of rule can be far-reaching, as the need to coordinate with other ministries (i.e. education,

environment, agriculture, etc) is of the utmost importance. In addition, the limitations of the Oslo accords for a public health approach are evident in that the PA has no control over water, land, the environment and the movement of people and goods (Giacaman 2003).

Conclusion

Overall, it is apparent that the topic of Palestinian Healthcare is very convoluted and has embodied within it decades of political turmoil. Regardless of the current state of the healthcare, be it governmental or UNRWA allocated, the underlying cause is a lack of willingness to strive towards creating permanent institutes in what is perceived to be a transitional and temporary context. The main impediment to the Palestinian healthcare crisis is the unjust framework for peace from which they have been living from for the past 63 years. Until major strives are made by the international community in the political arena in terms of solidifying provisions between Palestine and Israel, Palestinians will lack the sense of normality necessary before reformation and reorganization of the health sector can be underway.

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