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## **A Legacy of Injustice**

# **A Critique of Israeli Approaches to the Right to Health of Palestinians in the Occupied Territories**

**Writing**

Hadas Ziv

**Legal Background**

Noam Lubell

**Research and Fieldwork**

Iman Aghbariyya, Na'ama El'ad, Hadas Ziv, Salah Haj-Yehya

**Translation**

Shaul Vardi, Miri Weingarten

**Editing**

Miri Weingarten

**Graphic Design**

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**Print**

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*“I learned I had the indirect hand in the deaths of thousands of people; that I’d even brought about their deaths by approving of acts and principles which could only end that way. Others did not seem embarrassed by such thoughts, or anyhow never voiced them of their own accord. But I was different; what I’d come to know stuck in my gorge. I was with them and yet I was alone.”*

**Albert Camus, *The Plague***

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## Introduction

Since the 1967 War, Palestinian residents of the Occupied Territories<sup>1</sup> have been subject to a military administration that has severely impacted the course of their lives. The purpose of the present report is to address the question of Israel's responsibility for implementing the right to health in the Occupied Territories following the Oslo Accords. These agreements, signed between Palestinian representatives and the State of Israel, transferred authorities in the field of health to the Palestinian Authority. However, Israel's continued control over basic conditions that are prerequisites for health (water, housing, freedom of movement, etc.) raises the question as to whether the Palestinian Authority is capable of managing an independent health system based on professional considerations. The Oslo Accords did not bring the Israeli occupation to an end and cannot release Israel of its responsibility for the security and welfare of the civilian population in the Occupied Territories.

This report begins with an introductory chapter examining of the protections afforded to the right to health in international law. In order to address the question whether the Palestinian residents of the Occupied Territories are able to realize their right to health, the report continues with a brief historical review of health services prior to the peace negotiations, as well as a review of the clauses in the Oslo Accords relating to health issues. The legal situation following the accords is then analysed, including a review of the Israeli position in light of the requirements of relevant conventions and international law.

The report then discusses the situation created in the Occupied Territories following the Oslo Accords, particularly in the context of Israel's continued control of factors that determine health, and its long-standing policy of restricting the movement of patients and medical personnel in the Occupied Territories. This section reviews High Court petitions filed by Physicians for Human Rights–Israel (PHR-Israel) on this issue during the period 1991-2002, and presents case histories illustrating the inability of Palestinian residents to realize their right to health due to Israel's control of every step of their life.<sup>2</sup> Israel's control of many aspects of the management of the Palestinian health system (e.g., import of medicines, patient referrals) will also be presented.

There can be no doubt that the violation of the health rights of Palestinians has reached new dimensions since the eruption of violence in September 2000. During the two years that have passed, dozens of roadblocks – many impassable – have been established in the West Bank, as well as a number of roadblocks in the Gaza Strip, which cut this region into three parts. Villages have been surrounded by physical barriers; medical personnel have been prevented free passage; ambulances have come under fire; hospitals have been surrounded by tanks and searched, and equipment has been destroyed; Hospitals have been left without medical supplies, and residents have been imprisoned in their homes

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<sup>1</sup> This report relates mainly to the West Bank and the Gaza Strip. East Jerusalem will be the subject of a separate chapter, emphasizing Israel's efforts to disconnect the city from the other parts of the Occupied Territories.

<sup>2</sup> The information in this report is based on various written sources, on PHR-Israel's petitions to the Israeli High Court of Justice, on PHR-Israel's work in the field, and on information accumulated in our office while addressing appeals from patients and physicians, and corresponding with Israeli authorities.

without basic food items or access to medicines for the sick. Such a grave exacerbation has been possible, in no small measure, because Israeli society no longer generates internal checks and balances on such behavior. Various elements that could have checked this deterioration, such as the Israeli Supreme Court, the Israel Medical Association (IMA), the media and oppositionist public opinion, have either failed to do so, or done too little, too late.

Operation “Determined Path” (initiated June 2002) and subsequent military operations have perpetuated Israel’s control over the Palestinians, and indeed increased this control to the point of total stranglehold. There can be absolutely no doubt that Israel bears responsibility for the health of the Palestinians in the Occupied Territories. Concern has been expressed in certain quarters that if Israel were to provide medical services, this would constitute the reinstatement of the occupation by the “back door.” Such concerns pale in the face of a reality in which the Israeli occupation has already reinstated its presence through the smashed walls of Palestinian homes. PHR-Israel does not, however, advocate the reinstatement of the Civil Administration (see glossary and explanations below), since we are well-acquainted with its aspects as a tool for occupation and for the violation of human rights. Accordingly, we urge Israel to remove all restrictions on freedom of movement in the Occupied Territories, in order to enable the civilian Palestinian system, with the assistance of foreign organizations, to at last implement an autonomous health policy.

## **Glossary**

The Israeli government and military have developed a lexicon denoting bureaucratic structures, procedures and activities, using terms that are far from transparent. As a result, Israelis are seldom led to think of their concrete content, and the convolutions of the system are often confusing for international audiences. Below is a brief outline of some basic terms relevant to our subject, which will be further elaborated upon in the report.

**Military Government in the Occupied Territories** - Israeli organ of control of Palestinians in the Occupied Territories from 1967-1980, during which time this government was responsible for both military activities and civilian affairs. From 1981 civilian affairs were taken over by the **Civil Administration** (see below) and military activities were conducted by IDF military commanders. The government was under the authority of the Israeli Minister of Defense.

**Civil Administration** - Israeli organ of administration and control of civil affairs of Palestinians in the Occupied Territories, from 1981 to the present. In 1994 its responsibilities in the realm of health were officially transferred to the Palestinian Authority, but its control of passage of patients, medical personnel and medical supplies remained in force. The Civil Administration is subject to the authority of the Minister of Defense, via the Coordinator of Operations in the Territories, who carries the rank of a Major-General.

**Chief Medical Officers (CMOs) and Medical Coordinators** - Officers subordinate to the **Civil Administration** and the COT, who administer the control of health affairs of Palestinian residents of the West Bank and the Gaza Strip (separately). Prior to the Oslo Accords this post (CMO) was staffed by doctors, and involved direct management of the Palestinian health system. Today the equivalent post (Medical Coordinator) is staffed by officials with no training in medicine or public health, whose role is to regulate the passage of Palestinian patients, medical personnel and supplies within the Occupied Territories and outside them.

**High Court of Justice** - The Israeli Supreme Court, when not handling appeals, is called the High Court of Justice (Hebrew acronym 'Bagatz'). In the absence of an Israeli Constitution, individuals and organizations may petition this Court on issues not relating to the enforcement of existing laws. Petitions submitted to the High Court are designated by its initials, a number, and the last two digits of the year, e.g., H CJ/2222/02.

**“The Area”** – Term used by Israeli authorities to denote the Occupied Territories, not including East Jerusalem (which was annexed in 1967). **‘The Areas’** is sometimes used to denote the West Bank and the Gaza Strip as two distinct regions.

**General Closure** – Invalidation of permission to enter Israel and East Jerusalem, to travel overseas, or to travel between the Gaza Strip and the West Bank. The closure relates solely to Palestinian residents of the West Bank and the Gaza Strip, and is enforced by manned military checkpoints. The first closure was imposed in 1991. Since 1993, written permits have been necessary by default for exit from the Occupied

Territories. Any regular entry/transit permits held by residents lose validity when closure is announced. The current closure has been in effect since September 2000.

**Internal Closure** – Denial of passage between regions or centers of population (towns, villages, zones) within the West Bank and Gaza Strip. The internal closure relates solely to Palestinian residents of the West Bank and the Gaza Strip, and is enforced by permanent or temporary manned army checkpoints and by physical barriers blocking routes. Since early 2002 passage within the West Bank and Gaza has only been permitted to bearers of written permits issued by the **Civil Administration**.

**‘Encirclement’ (Siege)** – Physical blocking of entry and transit from individual centers of population (towns, villages), by means of soil ramps, concrete blocks and destruction of routes. This policy has in effect stopped vehicular travel by Palestinians on all main roads and on most other routes. The physical blocks are usually added to manned military checkpoints in larger centers.

**Curfew** – Prohibition on the exit of individuals from the threshold of the houses they are residing in at the time of announcement of curfew. Curfews are usually declared in individual towns and villages, and are occasionally lifted for short periods (hours) to allow residents to purchase supplies.

## Legal Background

### The Right to Health in International Law

Since the Universal Declaration on Human Rights appeared in 1948, the right to health has been considered one of the most fundamental of human rights. The Declaration states that “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.”<sup>3</sup>

The accepted definition of this right is based on the formula adopted in the constitution of the World Health Organization in 1946: “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, political belief, economic or social condition.” Accordingly, the 1966 International Covenant on Economic, Social and Cultural Rights affirms that “The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”<sup>4</sup> Israel is a party to this Covenant and is bound to comply with its provisions.

The right to health also appears in the 1989 UN Convention on the Rights of the Child, which states: “States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.”<sup>5</sup> Israel is a party to this Convention and is bound to comply with its provisions.

The definition of health as a human right has several ramifications:

- ▶ “Conceptualizing something as a right emphasizes its exceptional importance as a social or public goal. (Rights as “trumps”).
- ▶ Rights concepts focus on the dignity of persons...Accordingly, utilitarian arguments relating to the maximum good of the greatest number of people cannot excuse the infringement of the inherent dignity of the individual.
- ▶ Equality or non-discrimination is a fundamental principle of human rights.
- ▶ Participation of individuals and groups in issues affecting them is an essential aspect of human rights.
- ▶ The concept of rights implies entitlement.
- ▶ Rights are interdependent.

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<sup>3</sup> Article 25(1).

<sup>4</sup> Article 12(1).

<sup>5</sup> Article 24(1).



- ▶ Rights are almost never absolute and may be limited, but such limitations should be subject to strict scrutiny.”<sup>6</sup>

The United Nations Committee on Economic, Social and Cultural Rights, which is responsible for supervising the implementation of the covenant by states committed thereto, has interpreted this right – and the clarifications regarding the duty of the state to realize this right – in a detailed manner.<sup>7</sup> The use of the term “the right to health” does not imply that every individual has the right to be healthy and should never fall ill, just as the right to life does not claim to offer complete protection against death. The content of the right to health is not restricted to the matter of securing medical treatment, but has a much broader meaning. This right includes a number of socioeconomic factors that impinge directly on the state of health of the individual, including nutrition, housing, water, working conditions and the environment.<sup>8</sup> The scope of this report does not permit us to address all these factors, and we shall confine our discussion primarily to the subject of access to medical treatment.

The accepted formula for examining the implementation of a right calls for consideration of three distinct levels in terms of the state’s obligation: respect, protect and fulfill.<sup>9</sup> The obligation to respect a right means that the state must not take actions that directly or indirectly infringe the right, such as preventing access to medical treatment for specific population groups. The obligation to protect relates to the provision of protection against third parties, for example in the context of supervision of activities in the pharmaceutical market. The obligation to fulfill relates to the state’s commitment to take pro-active steps – inter alia: to determine policy and legislation; to establish a framework for medical treatment; to regulate inoculations for babies; to promote public health; and to ensure the existence of medical institutions.

### **The Applicability of the Right to Health in the Occupied Territories**

Israel argues that the conventions relating to international human rights law do not apply to the Occupied Territories, since the situation in these areas belongs to the field of international humanitarian law, which relates specifically to armed conflicts and occupation.<sup>10</sup> This claim is rejected both by the Committee on Economic, Social and Cultural Rights and by the Human Rights Committee (which monitors implementation of the International Covenant on Civil and Political Rights). According to the expert committees, and according to parallel rulings by the European Court of Human Rights,

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<sup>6</sup> Taken from: Leary, V., “The Right to Health in International Human Rights Law,” *Health and Human Rights* 24 1 (1994). For detailed discussion of the right to health as a human right in the general context, see also: Toebes, B., *The Right to Health as a Human Right in International Law*, Hart Intersentia (1999); Tomasevski, K., “Health Rights” in: Eide et al. (eds.), *Economic, Social and Cultural Rights: A Textbook* (1995), pp. 125-142; Lacopino, V., “Human Rights Concerns for the Twenty-First Century” in: Majumdar et al. (eds.), *Medicine and Health Care into the Twenty-First Century*, Pennsylvania Academy of Science (1995), pp. 376-391.

<sup>7</sup> The Committee’s comments are published in documents entitled “General Comments.” Comment No. 14 relates to the right to health.

<sup>8</sup> Committee on Economic, Social and Cultural Rights, General Comment 14, The right to the highest attainable standard of health, U.N. Doc. E/C.12/2000/4 (2000). par.11.

<sup>9</sup> Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, Maastricht, January 22-26, 1997. par.6.

<sup>10</sup> See Israel’s report to the UN Committee on Economic, Social and Cultural Rights. UN Doc. E/1990/6/Add.32, 16/10/2001.

human rights conventions apply unequivocally to all territories under the control of the state, including occupied territories.<sup>11</sup> The applicability of humanitarian law and the presence of a state of emergency, or even of war, do not nullify the need to observe human rights: this is confirmed by the provisions in the human rights conventions relating to the presence of states of emergency.<sup>12</sup> Accordingly, PHR-Israel believes that the State of Israel cannot evade its responsibility to realize the right to health in the Occupied Territories.

As noted above, the state's obligations may be divided into several levels, the first of which is the obligation to respect. This obligation requires the State of Israel to refrain from taking any actions liable to infringe the right to health. As made clear below in this report, one of the gravest infringements of access to health services is caused by the restrictions imposed by Israel on the freedom of movement of Palestinian residents of the Occupied Territories. The issue of freedom of movement provides a compelling demonstration of human rights being indivisible and interrelated. The infringement of one right can cause a chain reaction leading to grave injury to many areas of life, including health, employment, education and family life.

### **The Obligation to Respect the Right to Health: Freedom of Movement in International Law**

Article 12 of the International Convention on Civil and Political Rights states: "Everyone lawfully within the territory of a State shall, within that territory, have the right to liberty of movement and freedom to choose his residence." However, paragraph 3 of this clause permits restrictions on grounds of national security and public order. In states of emergency, moreover, Article 4 of the Convention permits states to take steps derogating from their undertakings in accordance with the Convention, with the exception of a number of specific rights (such as the prohibition on torture) that may not be derogated from in any circumstances. The right to freedom of movement is not included in the category of rights that are to be observed in all circumstances.

Despite the authorization for steps derogating from the state's undertakings in states of emergency, the state does not have *carte blanche* to impose restrictions at will. Article 4(1) limits the possibility of derogating from the provisions, and determines that the infringement of rights must be "...to the extent strictly required by the exigencies of the situation, provided that such measures are not inconsistent with their other obligations under international law...". The sweeping imposition of restrictions infringing the

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<sup>11</sup> Concluding Observations of the Committee on Economic, Social and Cultural Rights : Israel. 31/08/2001. E/C.12/1/Add.69  
Concluding Observations of the Human Rights Committee: Israel. ; 18/08/98. CCPR/C/79/Add.93. See also ruling of the European Court of Human Rights relating to the applicability of human rights in all territories subject to the effective control of the state: *Loizidou v. Turkey* (Preliminary Objections) (40/1993/435/514), paragraphs 62-64.

<sup>12</sup> The preliminary deliberations prior to the adoption of the Covenant on Civil and Political rights show that the states, as reflected in the regional conventions, intended the term "state of emergency" to include states of war. Quigley, J. The Relation Between human Rights Law and the Law of Belligerent Occupation: Does an Occupied Population Have a Right to a Freedom of Assembly and Expression? 12 BC Intl. & Comp. Law Review 1 (1989), 3-4. See also the assertion "It is well-recognized that international human rights law applies at all times, in peacetime and in situations of armed conflict," in: Inter-American Commission on Human Rights, Communication from 13/3/02 on Detainees in Guantanamo Bay, Cuba, page 3. For further discussion of states of emergency, see the section on freedom of movement and on prolonged occupation in this report below.

freedom of movement of all the residents of the Occupied Territories, regardless of their involvement in any particular activity; the instances in which restrictions appear to have been imposed as revenge for Palestinian attacks on Israelis; and the fact that Israel occasionally decides to relax the restrictions as a gesture of goodwill toward the Palestinians, all suggest that the restrictions imposed by Israel cannot be construed as the minimum steps necessary in response to the circumstances.<sup>13</sup> Moreover, as will become clear below, Israel's policy on the question of freedom of movement is also incompatible with other obligations under international law.

In situations of occupation and armed conflict, it is also necessary to examine the specific provisions established in international humanitarian law. For our purposes, the provisions of the Hague Regulations (1907) and the Fourth Geneva Convention are particularly pertinent.<sup>14</sup>

**The Hague Regulations:** Israel is not a formal party to the regulations, but they have acquired the status of customary law, and are therefore binding regardless of whether or not a given country is signatory. In the Beit-El case,<sup>15</sup> the Israeli Supreme Court accepted the customary status of the regulations. While international treaty law requires legislation introducing the relevant provisions into domestic law for it to be justiciable in Israeli courts, customary laws do not require any special act of legislation and are justiciable.

**The Fourth Geneva Convention:** ratified by Israel in 1951. Israel argues that the Convention does not apply to the Occupied Territories, since there has been no agreement concerning the sovereignty of these areas since 1967. However, Israel notes that although the Convention does not apply to the Territories, Israel shall in practice observe the humanitarian provisions of the law.<sup>16</sup> Moreover, the Supreme Court has ruled that, since this is treaty law, it is not justiciable. Nevertheless, the Israeli position is implausible: the international community as a whole, and senior legal experts in the field (including Israelis) agree that the Fourth Geneva Convention applies to the Occupied Territories.<sup>17</sup> On the question of whether the Convention may be heard in Israeli courts, there exists the opinion that the Geneva Convention constitutes customary law; accordingly, Israeli courts would be able to discuss its provisions.<sup>18</sup> It should be noted

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<sup>13</sup> B'Tselem, *Civilians Under Siege*, January 2001.

<sup>14</sup> Regulations annexed to the Hague Convention IV Respecting the Laws and Customs of War on Land (The Hague, 18 October 1907); Geneva Convention Relative to the Protection of Civilian Persons in Time of War of August 12, 1949.

<sup>15</sup> HCJ 606,610/78, *Suleiman Tawfiq Ayub et al. v Minister of Defense et al.*, Piskei Din 33(2) 113, pp. 120-122.

<sup>16</sup> Meir Shamgar, "The Observance of International Law in the Administered Territories," 1 *Is. Yearbook of Human Rights* 262 (1971), esp. pp. 262-266.

<sup>17</sup> Adam Roberts, "Prolonged Military Occupation: The Israeli-Occupied Territories 1967-1988" 84 *American Journal of International Law* 44 pp. 61-70.

Eyal Benvenisti, *The International Law of Occupation*, Princeton: Princeton University Press, 1993.

Dinstein, "The International Law of Belligerent Occupation and Human Rights", 8 *Isr. Y.B. Human Rights* 105 (1978).

Annual reports of the International Red Cross, from 1968 onward.

B'Tselem, *The Settlements in the Territories as a Human Rights Violation: Legal and Principled Aspects*, March 1997.

See also a long series of resolutions by the UN General Assembly, eg: GA Res. 35/122A (December 11, 1980) (141-1-1).

See the position of the US Department of State: Country Reports on Human Rights Practices for 1997.

<sup>18</sup> Theodor Meron, *Human Rights and Humanitarian Norms as Customary Law*, Oxford: Clarendon, 1989, pp. 41-62; Roberts p.54.

that the question as to whether the Convention may be raised in a domestic court does not affect the fact that international law obliges the state to observe its provisions.

The denial of freedom of movement has been implemented in a sweeping manner in the Occupied Territories. No distinction has been made between innocent residents, who seek only to pursue their everyday life, and those who, Israel claims, are liable to constitute a security threat. This situation is in clear violation of the principle – enshrined both in the Hague Convention and the Geneva Convention – that collective punishment must not be imposed on an entire population due to the acts of individuals, and that no person should be penalized for an act for which he/she was not responsible.<sup>19</sup>

In addition, the restrictions on freedom of movement in the Occupied Territories imposed by Israel directly cause a number of violations of humanitarian law, including in the field of medical treatment. Even according to Israel's position, the articles relating to humanitarian provisions are supposed to be observed, and there can be no doubt that the subject of medical treatment should fall in this category.

**Key articles of the Fourth Geneva Convention relating to medical care for civilians in an occupied territory:**

**Article 16** states that the wounded and sick, as well as the infirm, and expectant mothers, shall be the object of particular protection and respect.

**Article 17** states that the parties to the conflict shall endeavor to conclude local agreements for the removal from besieged or encircled areas, of wounded, sick, infirm, and aged persons, children and maternity cases, and for the passage of ministers of all religions, medical personnel and medical equipment on their way to such areas.

**Article 18** states that civilian hospitals organized to give care to the wounded and sick, the infirm and maternity cases, may in no circumstances be the object of attack, but shall at all times be respected and protected by the Parties to the conflict.

**Article 20** states that persons regularly and solely engaged in the operation and administration of civilian hospitals, including the personnel engaged in the search for, removal and transporting of and caring for wounded and sick civilians, the infirm and maternity cases, shall be respected and protected.

**Article 23** states that each High Contracting Party shall allow the free passage of all consignments of medical and hospital stores and objects necessary for religious worship intended only for civilians of another High Contracting Party, even if the latter is its adversary. It shall likewise permit the free passage of all consignments of essential foodstuffs, clothing and tonics intended for children under fifteen, expectant mothers and maternity cases.

**Article 55** states that the occupying power has the obligation 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.

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<sup>19</sup> Geneva Convention, Article 33; Hague Regulations, Article 50.

**Article 56** states that the occupying power has the obligation of ensuring and maintaining [...] the medical and hospital establishments and services, public health and hygiene in the occupied territory. [...] Medical personnel of all categories shall be allowed to carry out their duties.

As will become apparent later, Israel's actions in the Occupied Territories, and particularly the restrictions imposed on freedom of movement, cause severe violations of all the above-mentioned clauses.

In response to complaints of human rights violations committed by Israel in the Occupied Territories, Israel often argues that these actions seek to strike a balance between security needs and humanitarian needs. In this context, it is important to stress that the law was structured and worded in such a manner as to take into account military needs. It is both unnecessary and unacceptable to violate humanitarian law under the guise of balancing this law with military necessity.<sup>20</sup>

### **The Obligation to Fulfill the Right to Health in the Occupied Territories**

Regarding the obligation to fulfill the right to health in the Occupied Territories, the legal situation is more complex. As is the case with other economic, social and cultural rights, the right to health includes an element of core obligations that states are obliged to fulfill, regardless of circumstances.<sup>21</sup> In the case of the right to health, these include the provision of drinking water, vital medicines (as defined by the World Health Organization), equal access to health services, pre- and post-natal medical treatment, and so on.<sup>22</sup> With regard to these core obligations there can be no extenuating circumstances. All states are obliged to realize these rights for all persons in the area under their control. As this report shows, Israel does not even observe the fundamental core obligations in the Occupied Territories.

As far as children are concerned, it should be noted that states are bound by the explicit obligations in the Convention on the Rights of the Child; these include the obligation to ensure the provision of vital medical assistance and health treatment for all children, with an emphasis on the development of primary medical care and the struggle against diseases and malnutrition.<sup>23</sup> Our discussion here on the fulfillment of the right to health relates to the population as a whole, and to matters that go beyond the explicit obligations that already exist for specific groups.

Beyond the core obligations, the fulfillment of the right to health depends, among other factors, on the resources available to the state. States are required to do everything in their capability (under the scrutiny of the Committee) to achieve progress in realizing the

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<sup>20</sup> A.P.V.Rogers, *Law on the Battlefield*, Manchester: Manchester University Press 1996, p.4; W. O'Brien, "The Meaning of Military Necessity in International Law" 1 *World Polity* 109 (1957) p.130,138.

<sup>21</sup> General Comment 14, par. 47.

<sup>22</sup> *Ibid.*, par. 43-44.

<sup>23</sup> Article 24(2).

right.<sup>24</sup> There can be no doubt that the State of Israel has the capability to provide a standard of health that goes far beyond the core obligations, as is indeed the case within the Green Line. Accordingly, the question is whether Israel is obliged to provide the same level of fulfillment of the right to health for residents of the Occupied Territories.

One of the main arguments raised by Israel is that, under the agreements signed with the Palestinian Authority, the responsibility for health was transferred from Israel to the Palestinian Authority. A detailed discussion of the question of the transfer of authority in the accords is offered later in the report. For the present, several points should be briefly noted:

- This argument cannot be used to explain the gross violations of the right to health over the twenty-five years of occupation preceding the Oslo Accords;
- Even after the signing of the accords, Israel has continued to control a number of vital factors in the management of the civilian system and health services, including control of water sources, the entrance and exit of merchandise, and, in particular, the ability of residents to move between areas ostensibly under the control of the Palestinian Authority;
- For as long as there is no sovereign state in the Occupied Territories, ultimate responsibility rests with the only state that holds effective control – Israel;
- Over the past two years, Israel has proved its effective control by entering any territory and area it wishes, imposing closures and curfews on residents, and destroying civilian infrastructures. Accordingly, it would be absurd to argue that any other entity has the practical capability to implement the right to health.

The Fourth Geneva Convention does not impose an obligation on the occupying power to provide the same standard of health services for the residents of the occupied territory as it does for its own citizens.<sup>25</sup> There is some logic in this provision, since, in theory, there could be a situation in which a state forced to engage in a defensive war then finds itself – for the duration of the war and for a short period until an agreement is reached – in control of areas of a neighboring country with a much lower standard of health services. In this case, it is understandable that the occupying power should not be expected to begin to provide expensive health services that were not previously available to the residents, and which will cease to be available once the conflict (and the occupation) end.

In the case of Israel's presence in the Occupied Territories, however, closer examination is required. The international laws relating to occupation, including the Fourth Geneva Convention, were not planned for prolonged occupations extending over several decades, and accordingly the provisions in the Convention are more appropriate for temporary acts of occupation.<sup>26</sup> Israel has held the Occupied Territories for over 35 years. An entire generation has been born into military occupation and knows no other reality. Israel's

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<sup>24</sup> General Comment 14, par. 47.

<sup>25</sup> Such an obligation does exist, however, with regard to persons of a party to the dispute within the territory of the other party to that dispute.

<sup>26</sup> Roberts, p. 47.

prolonged occupation has created a situation in which some three million people<sup>27</sup> are forced to cope with a permanent and grave shortage of vital health services, and do not enjoy the basic conditions for an adequate standard of health (for example, hundreds of thousands of Palestinian residents have no access to a decent water supply<sup>28</sup>). At the same time, for almost half the twentieth century, Israel denied the occupied society any real chance to advance, develop and improve its standard of health. This prolonged occupation emphasizes the need to define the state's obligations not only in terms of the minimalist provisions of the Fourth Geneva Convention (particularly in the field of economic, social and cultural rights), but also in terms of the standards established in international human rights law.<sup>29</sup>

Another prominent feature of the Israeli occupation, and one that has ramifications in terms of Israel's obligations toward the Palestinian population, is the presence of the settlements. The Geneva Convention explicitly prohibits the transfer of population from the occupying power to the occupied territory; Israel's establishment of such settlements is a violation of the Convention.<sup>30</sup> One of the reasons for this prohibition is the assumption, as noted above, that occupation is supposed to be a temporary situation, to be ended as soon as possible. Accordingly, new conditions must not be created that can only hamper efforts to end the occupation.<sup>31</sup>

The argument that the commitment to realize the right to health applies differently in an occupied territory than within the state's own borders is weakened once the state itself acts to blur the distinction between these areas. The presence of over 120 settlements in the West Bank alone,<sup>32</sup> and of hundreds of thousands of Israeli citizens,<sup>33</sup> means that the Occupied Territories can no longer be considered a distinct entity in which life continues unconnected to the situation inside Israel. Unlike their Palestinian neighbors, the Israeli settlers enjoy a range of vital services, such as pediatric chemotherapy and transplants. In reality, Israel already realizes the right to health in the Occupied Territories at the same standard as applies within Israel. However, this standard of health is enjoyed exclusively by the residents of the settlements.

Equality and non-discrimination are a fundamental principle of human rights. The two principle covenants require that human rights be realized without discrimination on grounds of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.<sup>34</sup> Specifically, this also applies with regard to the right to health: one of the core obligations of this right is that it must be realized in

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<sup>27</sup> According to statistics from Peace Now.

<sup>28</sup> B'Tselem, *Thirsty for a Solution: The Water Shortage in the Territories and its Solution in the Permanent Agreement*, July 2000.

<sup>29</sup> Roberts, p. 71.

<sup>30</sup> Article 49.

<sup>31</sup> Roberts, p. 83.

<sup>32</sup> B'Tselem, *Land Grab: Israel's Settlement Policy in the West Bank*, May 2002.

<sup>33</sup> According to statistics from Peace Now.

<sup>34</sup> Article 2.

a non-discriminatory manner.<sup>35</sup> While there is no prohibition against discrimination between an occupied area and the state itself, this is not the case regarding discrimination within the occupied area. Within the Occupied Territories, Israeli policy causes gross discrimination between Palestinian residents and Israeli settlers regarding the right to health.

On the basis of the above review, it may be difficult to reach the unequivocal conclusion that Israel is legally obliged to provide the same level of realization of the right to health for residents of the Occupied Territories as it does for its own citizens. However, the arguments raised above suggest that the State of Israel is obliged to realize the right to health in a manner that goes beyond the minimum core obligations. These arguments, together with Israel's moral responsibility for the situation it has created over a prolonged period of occupation, leads PHR-Israel to take the position that Israel must recognize its responsibility not merely to respect the right to health by refraining from active infringements, but also to take steps to secure a significant improvement in the health situation in the Occupied Territories and to provide vital services that are not currently available.

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<sup>35</sup> General Comment 14, par. 43.



## Health in the Occupied Territories Prior to the Oslo Accords

After Israel assumed control over the Occupied Territories, it considered itself responsible, albeit to a limited extent, for the continued functioning of health services in the occupied areas. However, this was achieved not through the adoption of the area by the Israeli Ministry of Health, but by the establishment of civilian functions under a military government responsible for Palestinian communities in the Occupied Territories, and later under the so-called Civil Administration (see below). The outbreak of the first Palestinian Uprising (*Intifada*) in December 1987 led to an ongoing exacerbation in human rights violations in the Occupied Territories, including the impairment of health services for the Palestinian population and harsh restrictions on the freedom of movement of both patients and medical personnel.

### Limited Responsibility: 1967 – December 1987

In broad terms, the period between 1967 and 1993 may be divided into two: prior to the uprising in December 1987 and thereafter. Throughout the entire period, the medical system for the Palestinian residents of the Occupied Territories was managed as a closed economic circuit or ‘closed market’, distinct from the Israeli health system. The residents of the West Bank and Gaza Strip were regarded as people temporarily living under Israeli control (unlike the residents of East Jerusalem, whose integration was seen as the “price” Israel must pay for the annexation of East Jerusalem). Initially, their affairs were managed by the military government, but from 1981 authority was transferred to a ‘Civil Administration’. This change obscured the fact that the Palestinians were under occupation; indeed the establishment of the Civil Administration is seen by some as an attempt to “normalize” and hence perpetuate the occupation. Moreover, the Civil Administration was under the authority of the Israeli Ministry of Defense – a fact that underlines Israel’s separatist approach toward the Palestinian community in the Occupied Territories and its reluctance to address this community within a genuinely civilian framework. The Israeli Ministry of Health holds no authority in the Occupied Territories, and confines its activities to supervising aspects liable to present a danger to public health in Israel. The separation between the services provided for the Palestinian residents of the Occupied Territories and those provided for Israeli citizens (on both sides of the 1967 borders) was so sharp that Dr. Yitzhak Peterburg, Israeli Chief Medical Officer for the Civil Administration in Gaza in 1988-1989, considered Israel to be “abroad.” Israel’s underlying interest in this respect was that as little money as possible should be spent on referring Palestinian patients to Israeli hospitals.

Israeli policy was based on its interest in maintaining public health. The development of any services beyond primary care was always a lower priority and dependent on budget: “It was clear that Israel had to care for the local populations in the territories and ensure high standards of public health and reasonable medical care... The overall goal was to keep the population satisfied and quiet, and to provide a stable, calm and reasonable background for future negotiations that would lead to a political solution.”<sup>36</sup>

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<sup>36</sup> Barnea Tamara, Hussein Rafiq (Eds.): *Separate and Cooperate, Cooperate and Separate: The Disengagement of the Palestine Health Care System from Israel and its Emergency as a Independent System*, Praeger, Westport, Connecticut; London, 2002, p.

The Israeli Ministry of Health, having no authority in the Occupied Territories, could not help finance the health system in these areas. As for care provided to Palestinians outside the Occupied Territories, some patients were referred to treatment in Israel, but the budget was never sufficient to meet the needs in this regard.<sup>37</sup>

In terms of everyday life, Palestinian residents' access to health services was impaired mainly by bureaucratic factors:

**Obscure information:** The Majority of Palestinian residents who were included in the health insurance program offered by the Israeli Civil Administration were the latter's own employees (for whom the program was compulsory). Very few Palestinians voluntarily joined this program. Others were either rich enough to purchase private services, or too poor to afford the Israeli health insurance. Palestinians with health insurance lacked information about the services it entitled them to: it was unclear to them in which cases they could be referred for treatment in Israel, and in which cases they would be forced to confine themselves to the very limited solutions available in the local health system – which was in itself administered by the Israeli Civil Administration.

It should be noted that when the responsibility for health was transferred to the Palestinian Authority, this insurance program was nullified overnight. People who had paid insurance fees for years, and had believed that they were acquiring rights and ensuring access to medical care, suddenly found that the Israeli system refused to recognize any responsibility toward them or the services it had promised.

**Non-development:** On the systemic level, the health system in the Occupied Territories suffered from budgetary constraints and the absence of any development policy. Via the Civil Administration, Israel managed the health budget in the Occupied Territories separately from the Israeli health budget. Emphasis was placed on public health and on mother and child healthcare, rather than on development or on closing the gap between the Palestinian and Israeli health systems. The health budget itself, which was increasingly based on taxation taxes collected from the Palestinian residents of the Occupied Territories, was not transparent and did not enable an examination of investments and policies.

Among those involved in the field, opinions are divided as to the extent to which the health services in the Occupied Territories were developed during this period. The answer depends on which level of development is used as a yardstick – a decision that is inevitably influenced by ideological motives. There can be no doubt, however, that development took place within strict budgetary constraints, and that Israel did not aspire to bring services up to the level applying inside the 1967 borders. It is also apparent that the development of health services was shaped not only by professional medical considerations, but also by the interests of the Israeli security services, who sought to employ medical services as a means for control of the population. Dr. Ephraim Sneh

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43. This book was also published in Israel (Am Oved, Tel Aviv 2002), under the Hebrew title: *The Virus Does Not Stop at the Checkpoint* (heb. 'Ha-Virus Lo Otzer Ba-Machsom').

<sup>37</sup> Ibid., p. 50.

(who headed the Civil Administration in 1985-1987 and is currently the Israeli Minister of Transport) states that on entering his position, he found an Israeli policy intended to pressure Palestinians into collaborating on various levels: “The motto was ‘If you behave, you will receive; if not, you won’t.’ the policy wasn’t explicit, but it was known to all the involved parties, and mentioned in internal discussions.”<sup>38</sup>

**Training:** The Civil Administration did not develop a plan for training a future cadre of Palestinian medical professionals, and confined itself to providing short courses and partial specialist training. In some cases, personnel who participated in courses abroad were obliged to cut short their studies and return to the region, due to the threat that otherwise they would lose their residency status. Others had no possibility of traveling abroad for professional studies, since the Israeli security services vetoed their departure from the Occupied Territories. Some non-governmental organizations received support from abroad, enabling them to implement training courses in specific fields. The lack of overall planning led to a situation where certain fields were not covered by the Palestinian health system, while in other fields a surplus of personnel developed.<sup>39</sup> Even personnel who completed specialization training inside Israel did not receive specialist certificates from the Israeli Ministry of Health, on the pretext that these were granted solely to Israeli residents. Palestinian residents were not included in this category, and their efforts to secure parallel certificates were unsuccessful.<sup>40</sup>

Allowing Palestinians to study medicine in Israel would have been the logical solution, given the geographical proximity. This possibility was completely denied. Decision makers within the Medical School in Ben Gurion University (Beersheba, Israel) prevented the acceptance of students from Gaza. Instead, they preferred to open an additional class for Israeli medical students.<sup>41</sup>

Accordingly, the impaired access of Palestinians to health services during the period up to December 1987 can be characterized as relating mainly to the gap between the medical system in the Occupied Territories and the system inside Israel. This gap created a desire among Palestinians to secure access to services within Israel – a desire which, as acknowledged by various sources, was used as a tool for applying pressure on Palestinians. Israel did nothing to narrow this gap, and in many respects its policies perpetuated it.

### **The Intifada from December 1987: Responsibilities Reduced**

The 1987 Uprising brought to the introduction of new violations in addition to those described above, in the form of increasing impediments to the access of Palestinian residents to health services. Until the outbreak of the Intifada, a medical committee of Palestinian physicians had managed the referral of Palestinian patients from the Occupied

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<sup>38</sup> Ibid., p. 125.

<sup>39</sup> Ibid., p. 193.

<sup>40</sup> Dr. Ron Lobel, Chief Medical Officer with the Civil Administration in Gaza, 1988-1994, and currently Deputy Director of Barzilai Medical Center in Ashkelon, Israel, in a discussion with PHR-Israel, Ashkelon, August 1, 2002.

<sup>41</sup> Ibid.

Territories to medical care in Israeli hospitals. All its decisions were subject to authorization by the Israeli Chief Medical Officers (CMOs). Following the Intifada, the budget for referrals was cut; referrals were almost completely halted, and now required authorization by the Israeli Chief Finance Officer for the Civil Administration – a change that clearly placed financial considerations above medical ones. The cutback was explained as reflecting a significant fall in income from taxation among the Palestinian residents of the Occupied Territories, so that no source of financing was available for referrals. Dr. Yitzhak Peterburg, CMO in Gaza at the time, declared: ‘There is a financial problem due to the fall in tax collection. Our operations here work as a closed economic circuit, and reflect the level of income of the [Civil] Administration.’ After a struggle by PHR-Israel and others, the number of referrals was restored to approximately 70% of the pre-Intifada level. However, decisions of the Palestinian medical committee were still subject to review by the Chief Finance Officer, who held the final say. Hospitals were ordered to honor undertakings by the CMO to pay for hospitalization only if these were authorized by the Chief Finance Officer.<sup>42</sup> Like in 2001, cases reached the headlines during this period when cancer and hemodialysis patients were denied access to care in Israel, despite the fact that this meant they were condemned to die.<sup>43</sup>

### Scanned newspaper article

*Israeli press cuttings from the time of the 1987 Intifada: The top left legend reads: “Cancer patients from Gaza, whose lives could and should have been saved had they been sent to receive care in Israel, are left to die in the [Gaza] Strip due to the selection policy of the Civil Administration. The case of Abu-Habel as an allegory...”*  
*Bottom: “A doctor at Tel Hashomer [Israeli hospital – PHR-Israel]: “the [workers of] Civil Administration play God. This man arrived [here] after undergoing primitive surgery, and he’s going to lose his life, when all it needed was a simple operative procedure.”*

“The policies that I encountered among Israelis in the field were those of ‘closed doors’ and ‘them versus us.’ In the days of the *Intifada*, the Civil Administration wanted the Palestinians to understand that we were unapproachable, that we were the rulers and they were the ruled. That whatever we offered them were acts of mercy on our part, not rights which they deserved. This attitude was applied without distinction to a woman in labor and to a director of a hospital in Gaza. In dealing with the Civil Administration, each and every Palestinian went through a process that was intended to be as difficult as possible. This policy was not expressed officially, but it was clearly enforced and understood.” (Dr. Ron Lobal,<sup>44</sup> *Separate and Cooperate, Cooperate and Separate*, p. 118).

Thus, during the twenty-six years preceding the Oslo Accords, Israel maintained two health systems: one for its own citizens inside the 1967 borders, and for Jewish settlers

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<sup>42</sup> Pinchas Inbari, “They Also Hurt the Sick,” *Shabbat Supplement*, July 15, 1988.

<sup>43</sup> *Ha’aretz*, January 12, 1989, reported that the director of Sha’arei Tzedek Hospital in West Jerusalem accepted a child for hemodialysis treatment despite the absence of financial authorisation.

<sup>44</sup> Dr. Ron Lobel served as Chief Medical Officer for the the Civil Administration in the Gaza Strip in 1988-1994. He currently serves as deputy director of Barzilai Medical Center in Ashkelon.

outside these borders, and the other for the Palestinian residents of the Occupied Territories. The gap between these two systems led to increasing dependence of Palestinian health consumers on medical services in Israel. The absence of a comprehensive development plan and of serious investment in infrastructure – both physical and human – created an unbalanced Palestinian health system lacking numerous medical fields. This system was then transferred to the Palestinians within the framework of the Oslo Accords.

## **Health During the Peace Negotiations: Approaches to Health in the Agreements**

The issue of health was among the first to be discussed with regard to transfer of civilian responsibilities. Both parties to the agreements were well aware of the high costs of the health system, which was, moreover, in chronic deficit. It is difficult to overlook Israel's eagerness to transfer responsibility for spheres that involved high expenditure. From the Israeli perspective, the price of this transfer – a certain loss of control over the population – was low in relation to the profit. Israel retained control over border crossings, foreign relations, water sources, lands and other spheres. Below is a short analysis of the transfer of responsibilities in the sphere of health, as reflected in the agreements. These agreements are in fact the background and the basis for current events, and for Israel's total rejection of its responsibilities regarding the Palestinian residents of the Occupied Territories.

### **Madrid Discussions, 1991**

Dr. Yitzhak Sever, who served as Chief Medical Officer for the West Bank from 1976 to 1994, suggested to policy-makers in the Israeli Ministry of Defense that health was the most appropriate area of authority to be transferred to the Palestinians, since it was “relatively apolitical and totally humanitarian”.<sup>45</sup> Sever believed that the Palestinian health system was mature and well-managed, and thus ready for self-administration. This proposal was presented to Dr. Khaidar Abd Al-Shafi, the head of the Palestinian delegation. However, Al-Shafi rejected the idea of autonomy in the field of health alone, receiving autonomy in all sectors and without solving the issues of land, refugees, human rights and the need to put an end to the Israeli occupation.<sup>46</sup>

PHR-Israel believes that it is indeed impossible to maintain a health system without controlling broader factors that define health, such as water, housing, sanitation, the economy, and many other factors.

### **Declaration of Principles (DoP), September 13, 1993**

This agreement declared the goal of establishing Palestinian self-government and reaching a permanent settlement on the basis of UN Resolutions 242 and 338 (territories for peace, and a just and agreed solution for the refugees). In the context of this report, it is important to note that both parties to the Declaration regarded the West Bank and Gaza Strip as **a single territorial entity** whose integrity was to be maintained during the interim period. Territorial integrity enables contiguous and unrestricted movement – a vital condition for the maintenance of a rational and balanced health system. As we shall see below, disrupting territorial contiguity and movement gravely impairs the ability of the health system to operate. The DoP stipulated that after the Israeli withdrawal, authority on a number of spheres (including health) would be transferred from the Israeli Civil Administration and military government to the Palestinian Authority:

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<sup>45</sup> Dr. Ron Lobel, in *Separate and Cooperate, Cooperate and Separate*, p. 74.

<sup>46</sup> Ibid.

Article VI2:

*“Immediately after the entry into force of this Declaration of Principles and the withdrawal from the Gaza Strip and Jericho area, with the view to promoting economic development in the West Bank and Gaza Strip, authority will be transferred to the Palestinians on the following spheres: education and culture, **health**, social welfare, direct taxation, and tourism. The Palestinian side will commence in building the Palestinian police force, as agreed upon. Pending the inauguration of the Council, the two parties may negotiate the transfer of additional powers and responsibilities, as agreed upon.”* (Our emphasis).

This unspecific agreement was implemented when authorities were transferred on the ground. In May 1994, the responsibility for health in Gaza and Jericho were transferred to the Palestinian Authority. The new agreement provided little more detail regarding the specific content of this transfer.

#### Gaza – Jericho Agreement, May 4, 1994

This agreement reflected the fact that, at least for the present, Israel intended to freeze (or indeed to perpetuate) the situation it had developed over the years of occupation: an Israeli Jewish population within the Occupied Territories, receiving services from the State of Israel at a level far above that received by the Palestinian residents of the Occupied Territories. The wording of the agreement makes it abundantly clear that Israel intended to protect the privileges enjoyed by the settlers, who would continue to receive services from the occupying power (Article VIc):

*“The personal jurisdiction extends to all persons within the territorial jurisdiction referred to above, except for Israelis, unless otherwise provided in this Agreement.”*

On May 18, 1994, following this agreement, the Israeli Civil Administration in Gaza informed Israeli hospitals of the cancellation of all contracts relating to the hospitalization of Palestinian patients from the Occupied Territories. This step was taken before the Palestinian Authority had signed hospitalization contracts with Israel. After protests from human rights organizations, and indeed from Israeli hospitals, the Civil Administration extended the contract with the hospitals to June 1, in order to give the Palestinian Authority time to prepare hospitalization contracts with the various Israeli hospitals. These contracts were particularly important for patients receiving services not available at hospitals in the Occupied Territories (such as hemodialysis and chemotherapy); in these cases, cessation of treatment could cause irrevocable damage and even death.

#### **Interim Agreement for the Transfer of Authorities, August 20, 1994**

Signed not long after the Gaza – Jericho agreement, the new agreement for the transfer of authorities in the remainder of the West Bank reflected some of the lessons learned during the few months that had passed. Nevertheless, the agreement did not substantially alter Israel’s total renunciation of responsibility.

One of the main problems in the relations between the Palestinian and Israeli health systems was the fact that the Palestinians were obliged to purchase medical services from

Israeli hospitals. Israel had no desire to collect payment from each individual patient, and preferred to anchor in the agreements a practice whereby the Palestinian Authority would be responsible for covering the costs for Palestinian residents hospitalized in Israel. This aspect was reflected in a clause stating that the Palestinian Authority would “reach agreements” with Israeli hospitals regarding the receipt of services by Palestinians; for its part, the State of Israel undertook to help reach such agreements.

This formula completely releases Israel from any individual responsibility toward Palestinian residents. There is no reference to the need to ensure contiguous treatment for those who had already begun to receive services, and no mention of Palestinians who had paid health insurance premiums to the Israeli Civil Administration over many years. In addition, Israel accepted no responsibility for provision of services that did not exist in the health system in the Occupied Territories, despite the fact that this situation was due, in no small measure, to Israeli policies over the years.

The Interim Agreement specifies for the first time that the transfer of authorities also applies in zones defined as “Area C” (see below for explanation). The Palestinian Authority enjoys no power in these areas (since both civilian and military powers are held by Israel), yet the agreement states that the PA is responsible for providing medical services. Once again, therefore, the agreements perpetuate a situation in which two populations (the Palestinians and the Jewish Settlers) with two distinct standards of health services exist alongside each other. It is obvious that this distinction is made on the basis of nationality, in violation of the provisions of the International Covenant for Economic, Social and Cultural Rights.

In the agreement, Israel continues to be concerned about the issue of public health and preventing epidemics, hence the great attention devoted to the subject of vaccination, as well as to the exchange of information on infectious diseases and epidemics. Israel retains powers to perform autopsies (the Palestinian Authority is obliged to forward corpses for *post mortem* in Israel), and to register births and deaths in medical institutions – functions that enable Israel to continue to monitor (and control) registration of the population.

For our purposes, it is particularly important to note Israel’s commitment (in Appendix 2 to the agreement) to respect Palestinian medical institutions. It is apparent, however, that the authors of the agreement from the Israeli side took pains to reserve Israel’s right to enter these institutions for military reasons:

*“In exercising its security authority, the military government will do its utmost to respect the dignity of patients and medical staff and will act with a view to prevent any damage to medical installations or equipment.”*

### **The Interim Agreements, September 28, 1995**

In this agreement, Israel maintained its position that it no longer bore any responsibility for the Palestinian residents of the Occupied Territories or for the state of the health system within them. A twenty-eight-year legacy of occupation was deleted in a stroke of the pen. However, this was the first agreement in which more than half a page was



devoted to health issues. As a result, the maladies that accompanied the transfer of health powers at the time, and which lie at the base of future problems may be read between the lines. The following is the article (retroactively) detailing the transfer of the health system to the Palestinian Authority:<sup>47</sup>

**Article 17: Health**

1. Powers and responsibilities in the sphere of Health in the West Bank and the Gaza Strip will be transferred to the Palestinian side, including the health insurance system.
2. The Palestinian side shall continue to apply the present standards of vaccination of Palestinians and shall improve them according to internationally accepted standards in the field, taking into account WHO recommendations. In this regard, the Palestinian side shall continue the vaccination of the population with the vaccines listed in Schedule 3.
3. The Palestinian side shall inform Israel of any Israeli hospitalized in a Palestinian medical institution upon his or her admission. Arrangements for moving such hospitalized Israelis shall be agreed upon in the joint committee.
4. The Palestinian side, on the one hand, and the Israeli Ministry of Health or other Israeli health institutions, on the other, shall agree on arrangements regarding treatment and hospitalization of Palestinians in Israeli hospitals.
5. The Israeli authorities shall endeavor to facilitate the passage of Palestinian ambulances within and between the West Bank and the Gaza Strip and Israel, subject to the provisions of Annex I.
6. Israel and the Palestinian side shall exchange information regarding epidemics and contagious diseases, shall cooperate in combating them and shall develop methods for exchange of medical files and documents.
7. 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.
8. a. The Palestinian side shall act as guarantor for all payments for Palestinian patients admitted to Israeli medical institutions, on condition that they receive prior approval from the Palestinian health authorities.  
b. Notwithstanding the above, in all cases of the emergency hospitalization in Israel of a sick or injured Palestinian not arranged in advance via the Ministry of Health of the Council, the Israeli hospital shall report to the Palestinian side directly and immediately, and in any case not more than 48 hours after the admission, the fact of the admission and the person's condition and diagnosis. The report shall be made by telephone and fax and the Israel Ministry of Health shall be informed at the same time.  
Within 24 hours of the receipt of the said report, the Palestinian side must either give an undertaking to cover all the costs of the hospitalization or remove the patient, by its own means, to a Palestinian hospital.  
Should the Palestinian side have done neither of these in the given time, the Israeli hospital shall remove the patient in an Israeli vehicle and charge all costs to the Palestinian side at the accepted Israeli rate.  
In all cases, the Palestinian side shall cover all hospitalization costs from admission to discharge to the territory of the Palestinian side.

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<sup>47</sup> Protocol on Civilian Affairs, Appendix 2, Article 17

*Should the Israeli hospital not report as required to the Palestinian side, the hospital itself shall bear all costs.*

*9. A committee established through the CAC shall facilitate coordination and cooperation on health and medical issues between the Palestinian side and Israel.*

*10. Imports of pharmaceutical products to the West Bank and the Gaza Strip shall be in accordance with general arrangements concerning imports and donations, as dealt with in Annex V (Protocol on Economic Relations).*

## **Analysis**

### **Israeli intervention in considerations of the Palestinian health system is perpetuated:**

The desire to regulate the transfer of Israeli residents injured in Palestinian areas (item 3) is legitimate, and does not constitute interference in the Palestinian health system. In its desire to protect public health in Israel, however, Israel also intervenes in inherently internal Palestinian decisions, such as the vaccination regime (item 2), and Palestinian import of pharmaceutical products – an intervention which serves economic considerations as well as public health concerns (item 10).

### **Israel is freed of responsibility for the hospitalization of Palestinian patients in**

**Israel:** Given the gap between the two health systems, and the fact that certain services are available only in Israel, Israel was careful to ensure that the Palestinian Authority bore exclusive responsibility for funding the hospitalization of Palestinian residents in Israeli hospitals (items 4 and 8). Item 8 seeks to resolve cases in which Palestinian residents require urgent hospitalization for various reasons while present in Israel (for work, visits, etc.) and are brought to Israeli hospitals. PHR-Israel notified the Israeli Ministry of Health that Israeli hospitals were demanding the companions of such patients (some of whom may be unconscious on arrival) to sign a guarantee covering the estimated cost of hospitalization as a precondition for admission. This policy was bound to lead people to be reluctant to accompany such patients, or to offer help to a Palestinian who collapsed in the street. Accordingly, we demanded that the Ministry of Health instruct Israeli hospitals not to require guarantees from persons accompanying such patients. By way of a solution, item 8 charges the Palestinian Authority with the responsibility for paying for these hospitalizations. In practical terms, the problem of funding the hospitalization of Palestinian patients in Israel was not resolved. The gap between the Palestinian and Israeli health systems has led large numbers of Palestinian patients to the doorsteps of Israeli hospitals. Today, even if they bring an undertaking from the Palestinian Authority to cover the costs, the current financial plight of the Palestinian Authority (particularly following Israeli attacks) leads to cases in which it cannot respect the undertakings. The Ministry of Health has continued to ignore the damage caused to Israeli hospitals due to lost debts, and has not taken steps to formulate a thorough and moral solution to this problem (see the story of Shams Ad-Din Tabia below).

The State of Israel promises to “endeavor to facilitate the passage of Palestinian ambulances within and between the West Bank and the Gaza Strip” (item 5), but it does not commit actually to do so. Implicit in this wording is the priority given to Israel’s own

security considerations. This item foreshadows the severe impairment of the freedom of movement of Palestinian ambulances in subsequent years – a phenomenon that reached an unprecedented scale during the incursions made by Israeli military forces into Palestinian cities (particularly, but not exclusively, during “Operation Defensive Shield” in March and April 2002).

### **Summary**

The agreements created three different types of control in the West Bank (leaving aside Hebron, where a special arrangement was formulated):

- Area A: Comprising mainly the Palestinian cities and towns. This area was declared to be under Palestinian civilian and security control.
- Area B (in the West Bank only): Includes the majority of the Palestinian rural sector. This area was declared to be under Palestinian civilian control alongside Israeli security control.
- Area C: Includes Palestinian villages, Jewish settlements and main roads. This area was declared to be under Israeli civilian and security control.

In practice, however, Israel holds effective control over all these areas, which therefore continue to constitute occupied territory. Israel controls all entries and departures from all areas. It controls passage between the different areas, as well as international crossings. Moreover, a particularly grave aspect is the disconnection of all these areas from East Jerusalem – their spiritual, cultural, economic and medical center. This last obliged the Palestinian community to transfer many of these functions to Ramallah in the West Bank.

The agreements also established a system of coordination and liaison that is almost a precise replica of the mechanisms applying in earlier years under the Civil Administration:

**Before Oslo:**

<b>Israeli Minister of Defense</b>
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<b>Coordinator of Operations in the Territories (COT)</b>
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<b>Civil Administration</b> (executive arm of COT policies), West Bank	<b>Civil Administration</b> , Gaza Strip
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<b>Chief Medical Officer (CMO)</b> , West Bank. The last was Dr. Yitzhak Sever.	<b>Chief Medical Officer (CMO)</b> , Gaza Strip. The last was Dr. David Levanon
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<b>Senior Medical Officer</b>	<b>Senior Medical Officer</b>	<b>Senior Medical Officer</b>	
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<b>Medical Committee with Palestinian representatives</b>	<b>Medical Committee with Palestinian representatives</b>	<b>Medical Committee with Palestinian representatives</b>	<b>Medical Committee with Palestinian representatives</b>
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**Following Oslo:**

<b>Israeli Minister of Defense</b>
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<b>Coordinator of Operations in the Territories (COT)</b>
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<b>Civil Administration</b> (executive arm of COT policies), West Bank	
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<b>Medical Coordinator, West Bank, Ms. Dalia Besa</b>	<b>Israeli District Coordinating Office (DCO), Gaza Strip</b>
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<b>Israeli District Coordinating Office (DCO)</b>	<b>Israeli District Coordinating Office (DCO)</b>	<b>Israeli District Coordinating Office (DCO)</b>	<b>Medical Coordinator, Gaza Strip, Mr. Menachem Weinberg</b>
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<b>Palestinian District Coordinating Offices (DCO)</b>	<b>Palestinian District Coordinating Offices (DCO)</b>	<b>Palestinian District Coordinating Offices (DCO)</b>	<b>Palestinian District Coordinating Office (DCO), Gaza Strip</b>
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### **Obstacles to Health in the Wake of Oslo**

Since the signing of the Oslo Accords, it has become dramatically more complicated for a Palestinian resident to secure medical treatment than it was before Israel imposed the regime of liaison and permits. Due to Israel's closures policy, each patient must secure a transit/entry permit before leaving their place of residence to travel to the place where they are to receive treatment. During the early days following the signing of the accords, this was necessary only for transit between the Gaza Strip and the West Bank, between these areas and East Jerusalem and Israel, or to cross certain international borders. Gradually, however, the permits policy was extended to include almost any movement between locales within the Occupied Territories. Moreover, the possibility of contacting Israeli representatives directly to request permits or to appeal against decisions was almost completely denied.

- In Area A, a Palestinian resident must contact the Palestinian District Coordination Office (DCO), which forwards the application to the Israeli DCO. The Israeli DCO then sends the reply to the Palestinian DCO, which forwards it to the resident. This convoluted procedure continues to cause delays in reaching medical care. No grounds are given for negative replies, thus impairing the ability of residents to appeal and/or to act in manner that might ensure that they could reach their destination in time.
- In Area B, residents may apply either to the Israeli or the Palestinian DCO.
- In Area C, residents apply directly to the Israeli DCO.

Today, many Palestinian DCOs are no longer functioning. Most Palestinian residents find it very difficult to reach the Israeli DCOs, due to curfews, closure or siege. Despite this, they are still obliged to request travel permits to commute between cities, and sometimes even between villages. The similarity between the mechanisms of occupation and the mechanisms established by the agreements is therefore apparent: both are bureaucratic and far from user-friendly. When combined with Israel's policy of roadblocks, the resulting situation means that it is almost impossible to realize the right to health.

As has been seen, the agreements for the transfer of authorities paid scant attention to social rights in general, and health rights in particular.<sup>48</sup> Both parties to the agreements had no desire to impose any responsibility on Israel in terms of the social rights of Palestinians. The Palestinian Authority was preoccupied with the process of preparing the foundation for a state, and with acquiring national characteristics. Accordingly, it sought to provide all services independently, rather than ask Israel for what might be construed as a “favor.” Israeli governments emphasized the aspect of Israeli security, in order to maintain Israel’s position as a victim, and refused to accept responsibility for the harsh results of the occupation. Palestinian and Israeli leaders alike refused to address the social-economic dimensions of the dispute, relying heavily on issues relating to nationhood.

Over the years, the defects in the agreements – and, in particular, the transfer of health powers without transferring responsibility for factors that are prerequisites for health (such as water, freedom of movement, housing, sanitation, land, the economy, and so on) – have become more apparent. These defects formed the foundation for the chronic maladies of the health system in the Occupied Territories. It is apparent that those responsible for drafting the agreements did not share a vision of implementing (or facilitating the implementation) of the health rights of Palestinian residents of the Occupied Territories. Such a vision is expected of signatories to peace agreements, which are intended to contribute to the welfare of humans on both sides of the conflict.

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<sup>48</sup> This violates the provision of General Note 14: International agreements shall not cause a deterioration in health services.

## Israeli Responsibility after the Agreements

### The Israeli Position

Israel argues categorically that it bears no responsibility for the healthcare of Palestinian residents in the Occupied Territories. This position was reflected in the State's response to a High Court petition in which PHR-Israel sought to oblige the State to cover the cost of treatments for Shams Ad-Din Tabia, a boy suffering from cancer<sup>49</sup>, on the grounds that no such treatments were available in the Palestinian Authority. The following are some of the principal arguments included in the State's response to the Court:

“As stated in the agreements between the State of Israel and the Palestinian Authority, powers and responsibility in the field of health were transferred from the military government and the Civil Administration to the Palestinian Authority. This principle was first established in the Agreement regarding the Preparatory Transfer of Authorities, the second appendix of which states that the powers and responsibility of the military government and the Civil Administration in the field of health shall be transferred to the Palestinian Authority; in the context thereof, responsibility for all the health institutions was transferred...

“The military government continued to hold authority regarding criminal matters (autopsy, investigations, narcotics offenses). The Palestinian Authority further undertook in this agreement to reach agreements with the Israeli medical institutions regarding arrangements relating to complementary medical services for Palestinians at these institutions, including hospitalization at Israeli hospitals.

“The Israeli-Palestinian Interim Agreement regarding the West Bank and Gaza Strip, dated September 28, 1995, also related, in Article 17, to the issue of the transfer of power and responsibility in the field of health from the Israeli side to the Palestinian side. As stated in the Interim Agreement, power and responsibility in the field of health in the West Bank and Gaza Strip shall be transferred to the Palestinian side, including the health insurance system. This transfer of authorities relates to Areas A, B and C.

“These sources show that the internal law in the Area [*Occupied Territories – PHR-Israel*] has adopted, de facto, the transfer of authorities in the Interim Agreement with the Palestinians. Therefore, and even in accordance with the law in the Area, authorities in the field of health have been transferred to the Palestinian Authority.”

It is worth noting that the State's response specifically notes that “regarding Israelis, authority in the field of health rests **with Israel**” [*emphasis in original*].

In this specific petition, the High Court judges ordered the sick boy Shams a-Din and PHR-Israel to obtain a financial undertaking from the Palestinian Authority to cover the

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<sup>49</sup> HCJ 270/02, submitted to the High Court of Justice in June 2002.

cost of treatment. The Israeli Ministry of Health guaranteed that, if this undertaking were not honored, it would cover the costs, rather than the hospital. Thus the High Court declined to rule on the core question of Israel's responsibility for the health of Palestinian residents in the Occupied Territories.

### **International Conventions**

The Israeli position is contrary to several conventions, from which one may deduce that, so long as no sovereign authority (state) has been established in the Occupied Territories, Israel continues to bear responsibility for the Palestinian residents, since the occupation has not ended (see **Legal Background** above). This position is expressed in the declaration of the International Committee of the Red Cross (ICRC):<sup>50</sup>

“In accordance with a number of resolutions adopted by the General Assembly and the Security Council of the United Nations, and by the International Committee of the Red Cross and Red Crescent, reflecting the position of the international community, the International Committee of the Red Cross has always affirmed the de jure applicability of the Fourth Geneva Convention to the territories occupied by the State of Israel since 1967, including East Jerusalem. This convention, ratified by Israel in 1951, continues to apply in full, and is also relevant in the context of the present violence. As an occupying power, Israel is also bound by other customary rules relating to occupation, as reflected in the annexed Regulations regarding the Laws and Customs of War, dated October 18, 1907.”

This statement becomes even more pertinent as Israel reimposes tight control over the Occupied Territories, to the point of suffocating and paralyzing Palestinian civilian authorities. The right to health of residents of the Occupied Territories is bound up with the right to freedom of movement, since this determines their access to healthcare.

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<sup>50</sup> Committee of Contracting Parties to the Fourth Geneva Convention, December 5, 2001.



## **Against All Odds: The Functioning of the Palestinian Health System under Israeli Occupation**

A key question is whether, following the Oslo Accords, Israel continues to bear responsibility for the functioning of Palestinian civilian systems in the Occupied Territories, and whether these systems are capable of operating under the policies of Israeli occupation. In moral terms, the legacy of Israel's protracted occupation, including the violations of health rights discussed above, obliges Israel to support the Palestinian system by providing services and by developing aspects of health care that are not currently available under the Palestinian Authority. Apart from this moral responsibility, however, it can be argued that, since the 1993 Oslo Accords left Israel in effective control of the Occupied Territories, the state of occupation has not ended. What is clear is that Israel's responsibility becomes greater the more its actions hinder the functioning of the Palestinian civilian systems, virtually to the point of paralysis. This chapter reviews the restrictions Israel has imposed on the Palestinian health system, preventing it from functioning.

### **Freedom of Movement or The History of the Closure**

Up to the signing of the Oslo Accords, the main restriction on the freedom of movement of Palestinian residents was in the form of curfew (a prohibition on residents' leaving their homes for fixed and limited periods). This is the gravest form of restriction; however, at the time it was used on a limited scale in comparison to the situation following September 2000. An exception to this was during the Gulf War. In 1991, Israel nullified the general permit for Palestinian residents to enter Israel; residents of the Occupied Territories now required an exit permit in order to enter Israel. This policy came to be known as the "general closure," which separates the Occupied Territories from Israel. In addition, on January 15, 1991, a general curfew was imposed in the Territories; in certain areas, the curfew continued for more than one month. This curfew was in fact an early version of the "internal closure" (see below), whereby movement is permitted within a village or town, but not between villages and towns. The "Soldiers' Sheet" published and distributed by the Civil Administration at the time, stated that medical evacuation was permitted in local ambulances, and that medical personnel were to be allowed to move freely.<sup>51</sup> In practice, however, medical personnel were obliged to procure permits from the Israeli District Governors in order to move within the Occupied Territories.<sup>52</sup> This policy severely impaired health services: physicians were unable to reach their work and patients could not reach hospital. Some patients paid with their lives for this policy.

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<sup>51</sup> The Soldiers' Sheet published by the Civil Administration states that, during curfew, "the continued operation of vital services is to be facilitated, including:

- A. Health services:  
(1) Medical personnel – free movement.  
(2) Hospitals and clinics – open to provide services.  
(3) Medical evacuation – via local ambulances."

<sup>52</sup> Verdict in HCJ 477/91, *Israeli-Palestinian Association of Physicians for Human Rights v Minister of Defense et al.*, p. 3. The name of the association (the appellant) was changed to Physicians for Human Rights-Israel in 1993.

The first High Court petition filed by PHR-Israel on this issue (HCJ 477/91) demanded that the authorities enable the passage of patients and medical personnel. At the hearing, the Court refused to discuss the substantive claims regarding the situation created during the Gulf War, on the grounds that the war had since ended, and the petition was therefore “theoretical.” However, the Court noted that the question of the movement of physicians and patients under curfew “should be reflected in the publication of a comprehensive and special order, to be drafted in Hebrew and Arabic... The said procedure shall serve as a standing order for soldiers positioned at checkpoints, and shall constitute an authoritative written briefing for the *mukhtars* and other residents.”

A marginal discussion in the context of this High Court petition reveals once again Israel’s policy regarding the referral of patients for treatment in Israeli hospitals. Responding to the claim by PHR-Israel that patients were not receiving oncology treatment, the High Court judges determined in the ruling: “Against the claim included in the petition, that the oncology treatment ostensibly available only at Hadassah ‘Ein Kerem Hospital has been halted, the officer [*Chief Medical Officer – PHR-Israel*] presents a different factual description. In his words: “The statement in the petition that Hadassah ‘Ein Kerem Hospital [*in West Jerusalem – PHR-Israel*] is supposedly the only hospital providing treatment for oncology patients from Judea and Samaria is completely erroneous.

“Oncology patients from Judea and Samaria receive chemotherapy treatment from Arab oncologists at Beit Jala Hospital and at Watani Hospital in Nablus, under the supervision of Professor Y. Horn, the Israeli oncology consultant.”

The High Court declined to examine the quality or character of the treatment these departments were capable of providing. PHR-Israel’s Annual Report in 1990 examined this subject and found that “Al-Watani Hospital has an oncology outpatients’ clinic staffed only on Wednesdays... There is no medical equipment for treating oncology patients, and the clinic is intended solely for general consultation; clearly, radiation therapy cannot be provided there. Not all the physicians providing chemotherapy treatment have been trained for this function.”

The Israeli Chief Medical Officer’s notification to the High Court implied that referrals to Israel were easily managed. According to the Annual Report, however, “oncology patients in the Territories require a special permit from the Civil Administration in order to receive the appropriate medical care. Even during normal periods, when there is no curfew, patients must come to the Civil Administration – regardless of their medical condition – and submit a special application for medical care in Israel.” The considerations applied by the Civil Administration were primarily budgetary.

### **1993**

From March 1993, Israel’s closure policy more or less reached its permanent format. At this point, a general closure was imposed on the Occupied Territories, following several knifing attacks inside Israel by Palestinians from the Occupied Territories. The closure imposed in March also severely impaired movement between the north and south of the

West Bank, the Gaza Strip and East Jerusalem. Those permitted to travel between these zones did so only with transit permits issued by the Civil Administration. Thus the occupation acquired an additional bureaucratic dimension, which was accompanied by control of the procedures by the Israeli military forces, including the General Security Services; their power was often used to apply pressure on residents. Over twenty-seven years of occupation, the Palestinian economy had become dependent on the Israeli economy. Accordingly, the closure had grave consequences for all areas of life: the economy, education, health and many other fields. Moreover, the closure completely disconnected East Jerusalem from the remainder of the West Bank, with serious ramifications in terms of the movement of patients and medical personnel to and from the most advanced Palestinian medical centers (such hospitals as Augusta Victoria, Muqassed, St. John, and St. Joseph – all located in East Jerusalem). Unlike the temporary closures that preceded it (1991-1992), this closure was much more protracted: indeed, it was never officially cancelled.

The closure was institutionalized as a formal policy within the context of the Oslo Accords. Since travel between the West Bank and Gaza Strip requires passage through Israel, transit between these two areas and East Jerusalem (which had been annexed to Israel in violation of international law) was defined by the Israeli authorities as requiring an entry permit to Israel. It must be emphasized that this separation is contrary to the Oslo Accords, which specifically state that the territorial integrity of the West Bank and the Gaza Strip is to be maintained,<sup>53</sup> and that, to this end, safe passage shall be established between these two areas.<sup>54</sup> In addition, this separation obliged the Palestinian health system to duplicate medical and administrative functions, once in the West Bank and once in the Gaza Strip, thus impairing economic efficiency. This trend to duplication would increase as Israel caused ever-increasing fragmentation within the Gaza Strip and West Bank.

## 1996

In 1996, the concept of the “internal closure” was introduced for the first time. This closure differs from the general closure in that, in addition to the prohibition on entering Israel, restrictions were also imposed on movement between villages and areas **within** the Occupied Territories themselves. During this period, the blocking of passage between towns and villages was achieved mainly through checkpoints staffed by the Israeli military forces. This closure was imposed following the events surrounding the opening of the “Hasmonean Tunnel” in Jerusalem, and led to severe restrictions on the freedom of movement of physicians and medical personnel. In a number of cases, medical personnel were shot while evacuating injured persons. Hospitals in East Jerusalem suffered particularly badly from these restrictions, since a significant proportion of their staff are residents of the West Bank.

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<sup>53</sup> “In order to maintain the territorial integrity of the West Bank and the Gaza Strip as a single territorial unit, and to promote their economic growth and the demographic and geographical links between them, both sides shall implement the provisions of this Annex, while respecting and preserving without obstacles, normal and smooth movement of people, vehicles, and goods within the West Bank, and between the West Bank and the Gaza Strip.” Israeli-Palestinian Interim Agreement on the West Bank and the Gaza Strip, Washington, D.C., September 28, 1995.

<sup>54</sup> Israeli-Palestinian Interim Agreement on the West Bank and the Gaza Strip, Washington, D.C., September 28, 1995, Annex I, Article X 1(a).

Muqassed Hospital in East Jerusalem and PHR-Israel jointly petitioned the High Court against the denial of permits enabling these employees to reach the hospital (HCJ 2054/96). An expert opinion from Professor Alexander Aviram, an expert in medical administration, was attached to the petition, describing the importance of enabling hospitals to function with a full staff: “Few operations can be performed without a nurse, technician, sanitarian, cleaning worker or even clerk... My position is that the functioning of any hospital, however well-established and skillful, will be significantly and gravely impaired if it is prevented from working in a full and contiguous manner. This impairment will increase geometrically over time, and, at a certain point, become irreversible.” Following the petition, the State agreed to allow some of the employees to enter East Jerusalem; the remainder also received permits over the course of time.

**The transfer of patients was also severely impaired by the closure, as shown by the case of Hanan Zayyed. Hanan, a pregnant woman expecting twins, left her home in Nahalin at 5:45 am in order to reach a hospital in Bethlehem. Her car was delayed at an army checkpoint, where Hanan gave birth to her children at 6:10 and 7:15. Since the soldiers at the checkpoint still refused to enable Hanan and her family to cross, they were obliged to break through the checkpoint in order to reach hospital. The delay proved fateful, however. Hanan reached hospital two hours after leaving home. Both her babies died shortly after arriving at hospital. Correspondence between PHR-Israel and military and government officials revealed that “the soldiers received unequivocal orders to show sensitivity in such cases,” but no commitment was made to ensure the passage of patients in the future.**

In response, PHR-Israel petitioned the High Court (HCJ 9109/96), asking that the Minister of Defense be obliged to publish procedures regulating the free movement of residents of the West Bank in order to obtain medical treatments during the imposition of “internal closure.” The petition also demanded clear regulations for processing applications for transit permits by residents of the Gaza Strip for the purpose of obtaining medical treatment.

Following the filing of this petition, it was agreed that the Minister of Defense would publish “a procedure for processing applications by residents of the Areas [*West Bank and Gaza Strip – PHR-Israel*] to receive medical treatment,’ as well as “a procedure for processing residents of Judea and Samaria who arrive at a checkpoint in an urgent medical emergency situation.” The Minister of Defense undertook to distribute these regulations and ensure their implementation by all IDF and Border Guard soldiers at the checkpoints.

Given the importance of these regulations, and the fact that they have since been grossly violated by the security forces over the years – despite the minister’s undertaking – we quote here the exact content of the “Procedure for Processing a Resident of the Judea and Samaria Area Who Arrives at a Checkpoint in an Urgent Medical Emergency Situation” (emphases ours):

1. This procedure regulates cases in which a person arrives at a checkpoint in the Judea and Samaria Area in an urgent medical emergency situation, and asks to pass the checkpoint in order to reach a medical institution at which he can receive medical treatment, in Israel or in the Area, during calm, closure or internal closure.
2. As a general rule, the checkpoint commander shall permit the passage of the person at the checkpoint (including entry into Israel) for the purpose of obtaining medical treatment, even if that person does not have the requisite permit, if the case is an urgent medical emergency situation. An urgent medical emergency situation shall be, for example: a situation in which a woman about to give birth arrives at the checkpoint; a situation in which a case of severe bleeding arrives at the checkpoint; a case in which a severe burns case arrives at the checkpoint, etc.
3. The discretion regarding the question as to whether the case is an urgent medical emergency situation rests with the commander of the checkpoint. As far as time limitations permit, the checkpoint commander shall consult a medical source.
4. In the event of doubt as to whether the case is an urgent medical emergency situation, **the balance of doubt shall be in the resident's favor** [our emphasis].
5. A soldier at the checkpoint who encounters an urgent medical case shall immediately forward processing of the case to the checkpoint commander.
6. The checkpoint commander shall consider the possibility of accompanying the resident who is in an urgent medical emergency situation using a vehicle in the possession of our forces, and shall consider the possibility of transferring the resident to a vehicle or ambulance of our forces to take him to his destination.
7. This procedure shall be repeated to all IDF and Border Guard soldiers at the checkpoints.

Given the State's undertaking to disseminate and inculcate these regulations among the soldiers at the checkpoints, PHR-Israel agreed to withdraw its petition. It reserved the right to petition the High Court again if a problem arose in a particular case relating to the implementation or violation of these procedures. Unfortunately, the "particular cases" in which the procedures were grossly violated occurred all too soon. Over time, the violation of these procedures became the norm.

### **1998;**

During August 1998, Israel decided to impose an internal closure on Hebron, preventing the passage of Palestinian residents between the two parts of the city: Zone H2, which is under Israeli control, and Zone H1, under the control of the Palestinian Authority. During the month of August, two tragic events occurred, each leading to the death of a baby born to Palestinian residents of Hebron. These events showed that the Israeli military system had reneged on the undertakings that formed the basis for the withdrawal of H CJ 9109/96 – to ensure the dissemination and inculcation of the procedures among IDF and Border Guard soldiers stationed at the checkpoints.

**During August, Shirin Bader Tawfiq Al-Hadad Sultan, a resident of Hebron, sought to cross the checkpoint with Kusai, her son, who was sick. Shirin and her husband, Hani, lived in area H2, under Israeli control. Kusai was one of three babies born in the seventh month of Shirin's pregnancy. Kusai became ill, and the physician told**

**the mother that if his condition deteriorated and he began to vomit, they must immediately take him to hospital. On Saturday, when his condition deteriorated, Shirin left home with the baby in her arms, in order to go to hospital. Soldiers stationed outside her home refused to let her reach the area of the city under Palestinian control, which lies just a few meters from her home. After being apprehended on the spot for a long time, she evaded the soldiers and ran toward the Palestinian area. However, she arrived at the hospital almost two hours after leaving home, and the physician in the emergency room could do no more than determine the death of Kusai, aged three months. The reason: exacerbation and complications resulting from pneumonia.**

Haim Israeli, Assistant to the Minister of Defense, responded as follows to the complaint filed by PHR-Israel: “The events... are very tragic and regrettable, but unfortunately they resulted from the fact that the IDF soldiers at the checkpoint were not updated that these were urgent medical cases.”<sup>55</sup>

**On August 25, 1998, Fadwa Abd As-Salam Aldam, a 24-year old woman from Beit Ula near Hebron, was about to give birth. The young woman arrived at the Beit Kahel checkpoint in Hebron already in labor, accompanied by a number of relatives, and asked to cross the checkpoint in order to reach the maternity ward at Al-Alia Hospital in the city. The IDF soldiers at the checkpoint refused to allow her to cross. As a result of their refusal, she was obliged to travel via an adjacent dirt track. The baby was born during the journey, but the physicians at hospital could do no more than determine her death.**

It should be emphasized that, according to item 2 of the procedure prepared following H CJ 9109/96, the case of a woman in labor who reaches a checkpoint is considered an urgent medical emergency **obliging** the soldiers at the checkpoint to permit her to cross.

These cases raised grave fears that the procedures had not been disseminated or inculcated among the soldiers. Accordingly, PHR-Israel petitioned the High Court (H CJ 7517/99), asking that the procedures be disseminated and implemented immediately by all soldiers at the checkpoints. The petition also called for the prosecution of the soldiers who had prevented the passage of patients, or of their commanders if the latter had failed to inform them of the procedure for the passage of patients. Following the petition, PHR-Israel received a report composed by the Investigative Military Police examining the reasons for the death of Fadwa Al-Aldam’s baby. The investigation shows that the soldiers engaged in a cursory consultation. “The witness stated that he did not notice any sign of the young woman’s alleged pregnancy... The witness asked Corporal Yirmiyahu for his opinion, and the latter commented that while the young woman seemed a little plump, she did not seem to be pregnant.” The soldiers did not ask the woman to step out of the car, and claimed that they had no sense of doubt that she was not pregnant, despite the pleadings of the relatives who accompanied her.

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<sup>55</sup> October 23, 1998.

It must be emphasized that this case did not involve entry into Israel, or even entry into the part of Hebron under Israeli control, but rather permission to leave that area and enter the area under Palestinian control. In a similar case in the past, the former General of the Central Command, of the Israeli army, Uzzi Dayan, commented: “I imagine that if the commander of the checkpoint had met his neighbor from Kfar Sava [*town in Israel – PHR-Israel*] in the same circumstances, he would have behaved differently.”<sup>56</sup>

The Central Command Attorney decided not to prosecute the soldiers, since, in his opinion, one could not negate the possibility that the commander of the checkpoint, and an additional soldier present with him, genuinely formed the impression that Fadwa Al-Aldam’s claim to be in labor was false. The judges ruled that this decision did not deviate from the limits of what is reasonable, and accordingly did not justify the Court’s intervention.

Regarding the dissemination of the procedure to soldiers, the petition led to the establishment of a committee of inquiry. According to the judges, this committee found that the procedure had not been disseminated, and, accordingly, the military forces undertook to disseminate the procedure and to ensure that all soldiers serving at the checkpoints were aware of it. As for the demand to prosecute those responsible, the Court did not issue an order nisi, since the investigation material had been forwarded to the Chief of Staff’s Attorney in order for her to prepare a legal opinion. This opinion was later completed, and determined that the person responsible for the “mishap” of failing to disseminate the procedure would receive an administrative reprimand. In order to prevent similar failures in the future, “a procedure will be introduced discussing the proper manner to undertake HQ work regarding the preparation and dissemination of procedures, including ensuring that these are forwarded to their targets, inculcated and implemented.”<sup>57</sup>

In 1996 and 1998, PHR-Israel believed that insisting that the procedures be observed would improve the ability of patients and medical personnel to move in the Occupied Territories. The ongoing policy of internal closure, with all the delays this causes, and the prevention of passage of ambulances, as seen in the years following, and above all in the conflict that erupted in 2000, have shattered this illusion. Today, it is quite apparent that the procedures have been completely and systematically disregarded. There is room to suspect that today this is a matter of policy.

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<sup>56</sup> *Yediot Acharonot*, May 13, 1996.

<sup>57</sup> Legal opinion for committee of inquiry re: dissemination of procedure for processing a resident of the Area who arrives at a checkpoint in an urgent medical emergency situation. HCJ 2515/99 a-Salam and the Physicians Association, August 30, 2000.

## **2000**

After the outbreak of hostilities in September 2000, the closure imposed on the Occupied Territories was intensified, including general closure, internal closure and relentless siege (see below). In addition, extensive and protracted curfews were imposed on villages and entire areas as decided by the Israeli military forces.

This closure included the denial of movement from the West Bank and Gaza Strip into Israel and East Jerusalem. The closure has also effectively prevented travel between the Gaza Strip and the West Bank, since such travel requires passage through Israel. The “safe passage,” which was supposed to connect the two areas, operated for no more than a few months prior to September 2000. In addition, an internal closure has been imposed in the West Bank, while the Gaza Strip has been dissected into several areas. During this period, the internal closure has been accompanied by siege (known by the euphemism “encirclement”). Israel has “encircled” districts and individual villages, cutting them off from the remaining parts of the West Bank. This has been achieved through the use of both manned checkpoints and unmanned roadblocks (soil ramps, piles of refuse, concrete blocks and the destruction of roads). Thus Israel controls entry and exit from all locales in the West Bank. The presence of a large number of unmanned physical roadblocks (and some villages, such as Bruqin, have been closed off exclusively by such roadblocks) prevents any possibility of selective passage: the village is **completely isolated**. In the Gaza Strip, checkpoints have been established dissecting the area into two or three parts (at different times), preventing the passage of residents from one area to another during most of the hours of the day. Israel’s current policy has effectively caused the paralysis of all the civilian systems in the Occupied Territories: economy, education and health. As far as health is concerned, it should be noted that this policy has caused an increase in disease.

PHR-Israel and the Palestine Red Crescent Society jointly petitioned the High Court (HCJ 9242/00), arguing that Israel is violating its undertaking to enable the passage of sick persons through the roadblocks that dissect the Occupied Territories. In the petition, PHR-Israel noted numerous examples of the deadly consequences of the policies imposed on the Occupied Territories by the Israeli military forces:

**On November 14, 2000, Jimal Ibrahim Balawal, a resident of the village of Sinjil near Ramallah, suffered a heart attack. An ambulance that was supposed to take him to hospital in Ramallah was delayed by IDF soldiers when attempting to leave the village. After waiting approximately thirty minutes, during which time the soldiers refused to respond to the pleas of the nurses accompanying the patient, the ambulance was forced to turn back. The patient later died in the medical center in the village, which naturally lacked the equipment and medical expertise that could have saved his life.**

**On October 10, 2000, I’tidal Ahmad Aber Kheir Allah, a resident of the village of Hares in the West Bank, was about to give birth. She made her way to the hospital in Nablus. During her journey, she was delayed several times at Israeli checkpoints. I’tidal attempted to reach the hospital by ambulance, but the ambulance was**



**delayed for approximately thirty minutes at the checkpoints. Since her bleeding was growing worse, I'tidal was obliged to abandon her wait for the ambulance and attempt to make her way to hospital in her brother's car. After setting out, I'tidal was delayed several times at checkpoints and by Israeli security patrols. The result was that it took her some seven hours to reach hospital: from 9:00 pm, when she felt the contractions and called the ambulance (which, as noted, was unable to reach her after being delayed at the checkpoint) and through 4:00 am the next morning, when she finally arrived at the Anglican Hospital in Nablus. I'tidal eventually gave birth to twins in the vehicle as it traveled. One of the babies required an operation due to the difficult circumstances of the birth.**

It should be emphasized that I'tidal's story is yet another example of the violation of item 2 of the procedure issued following H CJ 9109/96, which stated that the case of a woman in labor was to be considered an "urgent medical case" requiring free passage of the patient.

"The myth of the woman giving birth at the checkpoint is not always correct. The problem is that Palestinian woman come to hospital at the last minute – not like us, where the woman rushes off to hospital every time she has a contraction. At Hadassah [Hospital], they often give birth in the emergency room. The Palestinian ambulance drivers are very embarrassed, because the women give birth while the ambulance is traveling on its way."

(Dalia Bessa, Health Coordinator for the Civil Administration in the West Bank, in an interview to the weekly supplement of *Haaretz* newspaper, August 9<sup>th</sup>, 2002)

Three years after the State of Israel promised to implement the procedures to which it had committed itself in H CJ 9109/96, these cases demonstrate again that Israel has, in fact, failed to do so.

In addition, the petition addressed the issue of the erection of physical roadblocks and embankments at entry and exit points in numerous locales. The use of these "mute" roadblocks means that there is no possibility to permit the selective passage of patients. The result is that the procedure – which was already a dead letter – was now officially buried. The establishment of ditches or concrete blocks physically prevent sick people unable to cross these obstacles from reaching the staffed checkpoints, and through these, perhaps, to the medical centers.

The High Court rejected the petition on procedural grounds, without discussing the substance of the claims. As with other petitions filed by various organizations during this period, the Court determined that the petition was general in nature, and lacked sufficient factual infrastructure.<sup>58</sup>

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<sup>58</sup> From the verdict: "The Appellant presents the Court with a general picture, without factual infrastructure sufficient to form the foundation of an order as requested. Indeed, the Respondents do not deny that the army has established physical roadblocks (through soil ramps or concrete blocks) in the areas of Judea, Samaria and Gaza. According to the existing policy, they state, however, these areas do not include villages or areas (in the Respondent's terms, "geographical cells") access to which is completely blocked by the physical roadblocks. In each existing geographical cell, there is (or, at least, according to the policy

In this context, it should be noted that the Court refused to accept an affidavit from the Palestine Red Crescent Society detailing **121 cases** reflecting the delay or prevention of passage of patients or medical personnel at the checkpoints. The Court also refused to issue an order requiring the state to observe the procedures to which it had committed itself in HCJ 9109/96.

The High Court also accepted the State's claim that, despite the presence of the physical roadblocks, there were no villages or regions in the West Bank and Gaza Strip to which access was completely blocked by physical roadblocks. Accordingly, the Court rejected our application for an order prohibiting the establishment of physical roadblocks in the Territories. This argument has been repeatedly disproved, as we have found villages that have been placed under siege without any staffed checkpoint. Thus, for example, when PHR-Israel complained that the villages of A-Dik and Bruqin were blocked in a manner contrary to the state's notice to the Supreme Court, we received the following reply: "We have found that the access road to the villages of Bruqin and A-Dik is indeed blocked, as is the paved road between these two villages... However, it should be emphasized that these restrictions on movement were not made arbitrarily, but for clear security reasons."<sup>59</sup> Haim Israeli, Assistant to the Minister of Defense, advised the residents to use the dirt road between Bruqin and Salfit, along the route of the water pipe. An investigation PHR-Israel found that this road is accessible only to four-wheel drive vehicles. Two other routes suggested by Israeli were actually inaccessible to the residents of the villages. The results of our investigation were sent to the Prime Minister, but he chose not even to address the fact that the government was violating its own undertaking to the High Court. Unstaffed roadblocks are still used – indeed, more extensively than ever before. Complaints received by PHR-Israel since the petition emphasize that this policy continues to claim lives.

### **Deaf-Mute Roadblocks**

Unstaffed roadblocks – whether in the form of large concrete blocks, mounds of earth, or destroyed sections of road – have now been erected at numerous locations throughout the West Bank. This is the case, for example, along the main road leading from Ramallah to the villages to the west. The Israeli army justifies this policy by noting that, during the period in which they were erected, there were numerous attacks along this road. This is a flimsy argument, however. While the attacks may warrant some form of blockage, they

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there should be) one access road that is not closed by a physical roadblock, but is staffed by soldiers. Moreover, according to the existing procedures, which have been brought to the attention of the soldiers at the checkpoints, passage should be enabled at these checkpoints in any case of medical need, as determined in the procedures. In practice, as noted by the Respondents, numerous ambulances, patients and injured patients routinely pass through the checkpoints in order to obtain medical treatment, not only in the Territories themselves, but also, as necessary, inside Israel. The Respondents indeed admit that there is no absolute guarantee that all the soldiers at all the checkpoints and in all cases properly observe the procedures. However, if there is a case of violation of the procedure, the Respondents ask to be informed thereof, so that they can remove the defect, or take steps against those responsible for the defect, and prevent further violations. Moreover, if, as claimed by the Appellant, there is a geographical cell that is truly and absolutely isolated by physical roadblocks, contrary to policy, the Respondents are interested to know of this, and even asked the Appellant to inform them thereof during the course of the hearings, and they undertook to clarify and deal with the case as necessary.

"The Court believes that this is indeed the proper course the Appellant should take: to submit specific complaints about certain cases in which the procedures are not maintained, and to enable the Respondents to clarify and process such complaints."

<sup>59</sup> Correspondence from Haim Israeli, Assistant to the Minister of Defense, to PHR-Israel, dated October 30, 2001.

cannot justify a policy that prevents any use of a major traffic route on which the lives of so many residents depend. The same effect (or better) could have been secured through the installation of a staffed checkpoint. The use of roadblocks on such a major thoroughfare is in complete contradiction to the claim by the military forces, as raised repeatedly in its responses to our complaints, that the IDF attempts to balance security needs and humanitarian considerations. Moreover, the roadblocks have not been removed. At the time of writing, they continue to prevent the passage of residents, ambulances and other functions.

**PHR-Israel was asked to help coordinate the passage of an ambulance from the village of ‘Ein ‘Ariq to Ramallah. The ambulance was carrying a woman suffering from a heart complaint. The coordination was requested after her attempt to travel to hospital in a private car with a member of her family proved unsuccessful. The ambulance could not travel along the main road due to the presence of an impassible roadblock. Their attempt to travel via a side road was also foiled by a staffed checkpoint: the soldiers “did not notice” that this was a humanitarian case, and ordered the patient and her relative to return home. The Civil Administration asked why the ambulance did not travel along the main road, and we were obliged to point out to them that this road was blocked by a physical roadblock (specifically, the road had been dug up in order to make it impassible). The next recommendation was that the ambulance should travel along the northern Ramallah by-pass, through Beit Zayit – a journey of ninety minutes, in comparison to the fifteen minutes the journey should have taken along the main road. Despite the coordination, the ambulance was not permitted to use this route, and was sent back to ‘Ein ‘Ariq.**

**The military system’s reply to our complaint completely ignored the question of the unstaffed roadblock. Regarding the behavior of the soldiers at the checkpoint on the side road, we were informed that they did not notice that this was a humanitarian case. Further investigation revealed that the case had been forwarded to the chief justice general, who subsequently determined that the complaint was “too unspecific.” We have not yet received any explanation as to how a complaint can be “too unspecific” when the precise identity of the soldiers at the checkpoint has been confirmed.**

“We are taking a big risk here. Unlike the staffed checkpoints, where the commander’s discretion can allow Palestinians to pass for humanitarian reasons, the ditches blocking the roads are impassible. The practical ramification is that tens of thousands of people are cut off from hospital and clinics, not to mention work and the markets. The whole concept of “breathing encirclement”<sup>60</sup> collapses at this point. It is doubtful whether it is justified to punish tens of thousands of people because of a small number of groups that engage in shooting attacks.” (Military source, *Ha’aretz*, March 8, 2001).

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<sup>60</sup> Term used by the Israeli military to imply selective passage that blocks ‘unwanted parties’ but enables routine passage of humanitarian cases.

We must emphasize that PHR-Israel believes that the State of Israel has no authority to erect checkpoints or roadblocks as a form of total control of the movement of Palestinian residents within the West Bank and Gaza Strip, whereas Israel is, of course, entitled to do so along its international borders. However, if Israel nevertheless erects such obstacles, impairing the territorial integrity of the West Bank and Gaza Strip, it must ensure that they do not damage the fabric of civilian life: the ability of residents to go to work and make a living, to reach educational and medical institutions, to visit relatives, and to engage in all other aspects of normal life.

Regrettably, the security forces, with the support of the Supreme Court, has used the procedures formulated as a consequence of the 1996 High Court petition as a fig leaf. While its external and declarative policy is consonant with the procedures, the actual situation in the field proves that it is the “exceptions” that are the true policy. No action is taken against those who violate the procedures, with the exception of a tiny number of cases (mainly those that receive media attention). The very design of many roadblocks (physical obstacles, or the stationing of soldiers at a great distance from the residents who arrive at a checkpoint) prevents any possibility for selective passage or for discussion between the patient and the soldier blocking his progress. One must also note cases in which the soldiers stationed at the checkpoints have been too quick to resort to the use of live fire. A number of instances in which patients have been injured and even killed while attempting to secure treatment makes Palestinians even more reluctant to approach the checkpoints.

**Actions of soldiers at the checkpoints:** The checkpoints constitute a constant focus of friction between the soldiers and the civilian population. Soldiers stationed at the checkpoints are required to cope with humanitarian cases and to work with the representatives of international bodies. It was found that the checkpoints were staffed by casual forces allocated to work at the checkpoints as part of the operational actions of the IDF and the Border Guard. The high rate of turnover of the personnel at the checkpoints means that they do not acquire professional skills in the said fields.

In accordance with orders issued by the Chief of Staff from August 2001, Amatz [*acronym for Operations – PHR-Israel*] ordered the Central Command to station an Arabic-speaking officer or senior sergeant at every checkpoint within the “seam zone.” As of completing our audit, in March 2002, the Chief-of-Staff’s instruction has not yet been implemented.

In March 2002, Amatz presented the Chief-of-Staff with a report on the checkpoints. Among other aspects, the report stated that the checkpoints operate in a makeshift manner, rather than as part of an orderly crossing point; actions at the checkpoints do not observe the orders and specific procedures; there is no supervisory mechanism to monitor the activities of IDF soldiers at the checkpoints and ensure control; the absence of documentation of routine activities at the checkpoints prevents the possibility of investigating incidents and drawing conclusions. Amatz stated that “**As a result, IDF soldiers find it difficult to cope with special populations entitled to cross the**

**checkpoints (international organizations, media personnel and physicians), and humanitarian cases requiring special treatment do not meet a proper response.”**

State Comptroller, Audit Report on the “Seam Zone,” July 31, 2002 (our emphases).

The denial of freedom of movement, including travel between the Occupied Territories and abroad, also enables Israel to control other aspects of the Palestinian health system: participation in medical training programs in Israel and abroad; participation in international conferences; the importing of medicines and medical equipment donated or purchased abroad; and the decision to which medical center patients are to be referred. All these aspects are dependent on Israel’s good will. This control has severe ramifications for the Palestinian health system, and constitutes an exacerbation and extension of the methods of control employed in the Occupied Territories prior to the Oslo Accords.

### **Medical Referrals within a Fragmented System**

Despite the difficulties, the Palestinian Ministry of Health prepared a short-term and long-term plan for the development of specialist services at different hospitals. The plans were based on the assumption that patients, physicians and emergency crews would be permitted to move freely. The efficient organization of health services requires a division of functions between different units specializing in different fields. Modern models for the organization of health services seek to ensure that each unit specializes in certain fields. The alternative is that each medical center attempts to provide the full range of medical services available in that country – an illogical demand. It is generally accepted that certain medical services will be available at one medical center, while others are provided elsewhere. This is the case in Israel and in all other countries. Preventing the movement of civilians between one city and another, or between villages and cities, destroys the foundation on which this assumption is based. Today, in order to cope with this reality, the Palestinian system is obliged to rely on outside aid, and on its own limited resources, in order to replicate services endlessly, to the point at which each field unit can provide a full range of medical services.

While the decision to refer a patient to a particular medical center should be a purely professional one, Palestinian medical professionals constantly encounter Israeli military demands that prevent the referral of patients. Israel seems to believe that its military considerations completely overrule Palestinian medical considerations. This creates complex situations relating to movement within the West Bank and Gaza Strip, not to mention cases where patients need to cross an international boundary:

**Omar Kamal Dabur, aged 37, a resident of Jilazoun near Ramallah, was diagnosed as suffering from cancer and received treatment at Al-Amal Hospital, a medical center for cancer patients in Jordan. In January 2002, Dabur attempted to travel to Jordan for further treatment. The Israeli authorities at Allenby Crossing prevented him from leaving, and ordered him to return to Ramallah hospital. In response to PHR-Israel’s attempt to clarify the matter, the Office of the Coordinator of Operations in the Territories replied that “our examination revealed that Mr.**

Dabur is prevented from traveling abroad for security reasons.” According to the defense authorities, they even consulted an oncologist at the hospital in Beit Jala, who stated that the necessary treatment could be provided at that hospital, and accordingly “there is no need for him to travel to Jordan.” PHR-Israel refused to accept this statement, for several reasons. If Israel argues that the Palestinian Authority is responsible for health services following the Oslo Accords, it has no right to intervene in the medical considerations of the staff treating Omar Dabur. Moreover, the treatment provided at Beit Jala Hospital is extremely partial, and the hospital is not equipped to deal with the complications that may develop in his case. PHR-Israel also noted the importance of continuing treatment at a hospital familiar with the patient’s medical history, as well as the patient’s right to choose a physician in whom he or she has confidence. It should also be noted that even reaching Beit Jala (near Bethlehem) is far from simple in a period of internal closure, siege and curfew. However, only after PHR-Israel threatened legal action, and an article about the case appeared in *Ha’aretz* newspaper, the defense authorities reconsidered their position, and announced that “the relevant authorities have approved [...] travel abroad for the purpose of medical treatment.” This reversal suggests that the original decision was largely arbitrary. On a broader level, when Israel permits itself to intervene in such a manner, what “powers” have, in fact, been devolved to the Palestinian Authority?

### **Medicines**

The import of medicines into the Palestinian Authority via international borders is subject to the supervision and authorization of the Israeli authorities. This prevents an independent imports policy and creates absurd situations:

**Dr. Hassan Barghouti, a lecturer in literature at Al-Quds University in Jerusalem, was suffering from cancer, and his situation was deteriorating. A hospital in Jordan sent medicine at the recommendation of his physician at Sheikh Zayyed Hospital in Ramallah. A special courier from the Jordanian hospital came to Allenby Crossing with the medicine, but was not permitted to cross to Ramallah. Instead, he left the medicine at the Israeli desk at the Crossing. The Union of Palestinian Medical Relief Committees (UPMRC) contacted PHR-Israel and asked us to help release the medicine for this patient. At first, the Israeli Civil Administration demanded that we arrange for a vehicle to come to the Crossing to collect the medicine. They could not decide, however, whether the vehicle should be Israeli or Palestinian, and whether it should be a private vehicle or an ambulance.**

PHR-Israel insisted that there was no point arranging for a vehicle until authorization was received to release the medicine. The Civil Administration then asked whether the medicine was intended for one patient or more; whether it was donated or purchased; whether it was in a box or a bottle; what legend it bore; who sent it, and so on. The authorities then demanded medical documents proving that this specific medicine was indeed required for Dr. Barghouti, well as the precise name of the medicine. While we were attempting to collect all these details, the authorities informed us that the people who were to come from Ramallah to collect

**the medicine from the Crossing must leave in a Palestinian vehicle. In Jericho, they must board a bus that would take them to the Allenby terminal. There was no point in their doing so, however, since authorization had still not been granted for receipt of the medicine. Our contacts with the Medical Coordinator for the Civil Administration, Dalia Bessa, were also unsuccessful, since she also demanded medical documents before approving passage of the bottle – or box. Two days later, we telephoned our colleagues at UPMRC to update them, only to learn that Dr. Barghouti had died. At the same time, a telephone call arrived from the Civil Administration, asking for yet another medical document in order to issue the permit for the passage of the medicine. We informed them that the coordination was no longer required. Dr. Barghouti would probably have died in any case, but the medicine might have alleviated his suffering.**

The Israeli authorities were in no rush, and had every opportunity to ensure that the package did not contain an incendiary device or explosives. Thus they could have protected Israel's security needs and forwarded the medicine without any need for endless interrogations. Could it be that the real factor here was not Israel's security, but rather force of habit: the habit of controlling the life and death of Palestinians?<sup>61</sup>

While attempting to enable the passage of physicians or patients, or to obtain medicines or oxygen tanks, the Palestinian health system encounters grave human right violations obscured by mountains of bureaucracy. Israel claims to “help maintain” civilian life despite closure and curfew. But the inability of patients, physicians, suppliers of medicines and equipment and others to cope with this bureaucracy is not a sign of incompetence on their part. This inability is the end product of a bureaucracy that in itself constitutes a violation of human rights. Every ambulance that leaves to collect a patient, however urgent the case, now requires prior coordination. Every patient requires a transit permit, as does every physician. In order to get the permit, the sick patient must go to the DCO. He or she will have to walk there, because only Jews are allowed to travel along the road. On arrival, patients must wait at the gate, hoping that the soldier on guard will let them enter the office. If the permit is not ready, the whole story will be repeated the next day. In many cases, the permit will arrive after the scheduled date for the examination or operation, so that the patient will have to start from scratch. Hidden behind the language of procedures and form-filling, bureaucracy is less glaring than the checkpoint or the individual soldier who beats a civilian. Yet it is no less harmful, and it has a devastating impact on the ability of a health system to function.

In addition to these violations, which are the product of Israel's power to control the movement of patients, medical personnel and equipment, the protracted and severe conflict has also made Palestinian medical services a target for direct attack.

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<sup>61</sup> The case appeared in an article by Gideon Levy in *Ha'aretz*, May 5, 2002, under the title “A Bridge Too Far”.

### **Medical Services under Direct Attack**

As detailed above, the entire period of Israeli occupation has been characterized by severe restrictions on the Palestinian health system, and by Israeli interference in Palestinian efforts to manage an independent health policy. Within this period, however, some years stand out as particularly dire: not only did the health system suffer grave damage due to the general situation, but it was also the direct target of attacks. In many respects, the situation extant until September 2000 has since been exacerbated further. Until Israel invaded Area A and attacked the symbols of Palestinian governance (in the so-called “Operation Defensive Shield”), many countries and organizations found it convenient to accept the Israeli argument that the Palestinian Authority was responsible for civilian affairs, including health. The motive for this was to support the fledgling Palestinian Authority and support the effort to end the Israeli occupation. Once the civilian frameworks collapse, however, there can no longer be any justification for this argument.

As the conflict between the Israeli and the Palestinians worsened, the Israeli army entered Area A (Palestinian towns) several times, remaining there for longer periods each time. Israeli control thus became actual and direct in all areas, eliminating the distinctions between Areas A, B and C. Israel assumed exclusive authority for military activities, and the Palestinian security services were largely crushed. As for civilian control, Israel’s attitude was more ambivalent, and to date Israel continues to show a hesitant and inconsistent approach to this sphere. Further discussion of this question appears below; for the present, it will suffice to explain that Israel’s hesitance is due to the significant economic burden<sup>62</sup> that would accompany any decision to accept responsibility for the organization and management of Palestinian civilian life, including health services. Israel is also concerned that acceptance of responsibility for civilian life would expose the reality that the State of Israel has worked hard to conceal from the world and from its own citizens: that the old-style occupation has been reinstated.

After Israel invaded the Palestinian cities, PHR-Israel received dozens of complaints of serious damage to medical services: ambulances, hospitals, medical personnel, the evacuation of wounded persons, movement of the sick, and supply of medicines and food. Familiar violations grew worse (e.g. delaying and preventing the passage of patients and medical personnel), and new violations were added (medical personnel were shot at, and shells were fired at hospitals). This policy exacted a heavy toll in terms of the loss of life of medical personnel and patients.<sup>63</sup>

### **Attacks on Ambulances**

On March 4, 2002, a Palestine Red Crescent Society (PRCS) ambulance carrying three crew members and a physician set out for Jenin refugee camp with the goal of evacuating injured persons. The departure of the ambulance was coordinated with the Red Cross and

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<sup>62</sup> According to General Amos Gilad, Coordinator of Operations in the Territories, the cost involved is approximately NIS 12 billion a year (*Ha'aretz*, August 7, 2002, article by Gideon Levy).

<sup>63</sup> For a detailed review of attacks during Operation Defensive Shield, see: *Medicine Under Attack*, April 4, 2002, PHR-Israel.



the Israeli Civil Administration. Despite the coordination, the security forces opened fire on the ambulance, which exploded. Dr. Khalil Suleiman was trapped in the ambulance and burned to death. The other occupants of the vehicle were able to jump out, thus saving their lives. All three sustained serious burns. There was no-one in the ambulance other than the medical personnel. The announcement of the IDF Spokesperson that the explosion was caused by hidden explosives was contradicted by a later announcement by the IDF Spokesperson claiming that the explosion had been caused by an oxygen tank. Following this attack, PHR-Israel appealed to the High Court (HCJ 1985/02), demanding that the passage of rescue teams be ensured. As interim relief, PHR-Israel asked the Court to instruct the Commander of IDF Forces in the West Bank to halt the attack on Jenin refugee camp. Since the IDF withdrew from the camp, the petition was withdrawn.

A few days later, on March 8, 2002, the securities forces opened fire on an UNRWA ambulance in the Tulkarem area. As the result of the firing, the driver Kamal Muhammed Salem was killed and two crew members were injured. At the same time, a Red Crescent ambulance also came under fire; the driver Ibrahim Muhammed Sa'ada was killed and two crew members were injured. In these cases, too, the departure of the ambulances had been coordinated in advance. PHR-Israel again petitioned the High Court (HCJ 2117/02), asking that the IDF be ordered to explain why it shot at ambulances and why it was preventing the evacuation of injured persons in the West Bank and Gaza Strip. This time, the interim relief requested from the Court was to instruct the IDF to halt immediately all shooting at ambulances. During the hearing, the judges asked the parties to support their positions with affidavits. While PHR-Israel collected affidavits from people injured in Jenin and Tulkarem, the State failed to produce affidavits from the soldiers who had shot at ambulances in these locations.

“[I feel] betrayed by the behavior of the IDF, which has willfully and brutally trampled on the rules of the Geneva Convention... I was shocked by the fear I saw in the eyes of the ambulances drivers. It is sad.” The Head of the ICRC Delegation to the Occupied Territories and Israel, René Kosiernick (*Ha'aretz*, March 20, 2002), when asked to speak of what happened to the [Palestinian] crew members hit by the IDF, stated that they had been murdered.

In order to avoid attack, Palestinian ambulance crews must coordinate their departure to collect patients, deliver food, and treat injured persons. The coordination with the Israeli security forces is effected via the International Committee of the Red Cross (ICRC). This is a protracted process, and effectively prevents any possibility for urgent and efficient evacuation. During Operation Defensive Shield, however, not only did the coordination delay evacuation, but even after coordination ambulances were still shot at and detained, either at the checkpoints or by tanks, and were delayed for many hours and even days. Ambulance crews were subject to humiliating and violent treatment, and every time they left to undertake their work, they did so under the shadow of this threat.

The apologies offered by the security forces for their attacks on ambulances during this period were shameful, and placed the blame on the alleged use of Palestinian ambulances to carry wanted persons and ammunition. Israel has provided evidence of such abuse in

one single case (see below), which occurred after the killing of medical personnel in Jenin and Tulkarem. PHR-Israel believes that such offenses, insofar as they occurred, cannot justify deliberate attacks on an entire network of ambulances performing their medical function and enjoying legal protection. Complaints presented to the Israeli military forces following attacks on Palestinian ambulances were answered in a partial manner. The authorities did not see fit to take steps against those responsible for any of these attacks.<sup>64</sup> Attacks on ambulances were typical of the actions of the forces during the so-called “Operation Defensive Shield”, and were therefore among the issues raised in our general petition.

### **The Unlawful Use of Ambulances**

Two cases of the unlawful use of ambulances have been documented in the media. PHR-Israel stresses that all sides must act decisively to prevent such violations, which threaten to drag the conflict into areas that all must seek to avoid. We call for the dissemination of international humanitarian law among the combative forces.

A Palestine Red Crescent Society ambulance was examined at Rama checkpoint north of Jerusalem in the early morning of March 27, 2002. During the search, an explosive belt was found underneath a stretcher on which a sick child was being transported. The ambulance was also carrying medical personnel and additional patients, some in a serious condition. The driver was arrested and accused of receiving the explosive belt from a senior figure in the Al-Aqsa Brigades. The other occupants of the ambulance were released.

The ICRC and the Palestinian Red Crescent Society (PRCS) condemned the incident. The PRCS called for an independent investigation of the events. The IDF Spokesperson claimed that this was not the first time that a Red Crescent ambulance had been used to transport explosives and wanted persons, but despite requests from the ICRC and PHR-Israel, no proof was provided of any other cases of this kind.

During the detention of Marwan Barghouti in Ramallah on April 17, 2002, Israeli soldiers from the Duchifat infantry regiment took part in the operation. “The Duchifat soldiers were crammed into a bullet-proofed ambulance in order to get as quickly as possible to the house where Barghouti was hiding and to surround him on all sides.”<sup>65</sup> In acting in this manner, Israel used ambulances unlawfully, in a manner that is reminiscent of its own allegations regarding the use of ambulances to transport Palestinian armed personnel while exploiting the immunity afforded to the ambulances. Despite repeated requests, the Minister of Defense has not answered these claims.

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<sup>64</sup> The World Medical Association also discussed this issue, and clearly stated: “The members of medical and auxiliary professions must be granted the protection needed to carry out their professional activities freely. The assistance necessary should be given to them in fulfilling their responsibilities. Free passage should be granted whenever their assistance is required. They should be afforded complete professional independence.” (Regulation in Time of Armed Conflict, WMA 1956, 1957, 1983 “Rules governing the care of sick and wounded particularly in time of conflict”).

<sup>65</sup> *Ha'aretz*, April 25, 2002.

## Direct Attacks on the Medical System

PHR-Israel petitioned the Supreme Court in an effort to force the security forces to respect basic conventions and refrain from attacking ambulances. The two petitions described above sought to prevent such attacks, but the deteriorating situation led PHR-Israel to prepare a comprehensive petition (HCJ 2936/02) relating to the damage sustained by health services in the Occupied Territories. The petition was prepared in the context of the paralysis of the ambulance system, Israeli mortar attacks on Palestinian hospitals in the West Bank, the prevention of access to hospitals by patients and wounded persons (including hemodialysis and chemotherapy patients), and so on. The petition also addressed cases in which the IDF refused to permit the evacuation of corpses. The petition specified fourteen examples of such violations; following are some examples:

- March 30, 2002: Five members of a **Palestine Red Crescent Society ambulance crew were arrested by the IDF**. The five were arrested while on their way to evacuate a woman in labor from the old quarter of Ramallah (the lower town). The Red Crescent is unaware where the employees are being held. Three of the crew members were seen by a Red Cross representative on March 30, handcuffed and blindfolded in a Ramallah apartment. Since then, however, they have been transferred elsewhere. The ambulance itself was returned to the station by the Red Cross. According to eyewitnesses, this ambulance was stopped by a military convoy and **forced to serve as a human shield** as the convoy progressed through the streets of Ramallah. The same “use” was made of an ambulance belonging to the Palestinian Ministry of Health, whose crew was also arrested.
- March 31, 2002: At approximately 8 pm an ambulance from Sheikh Zayid Hospital in Ramallah left for the “Mukata’a” compound with food, medicines and water, after proper coordination. The driver, Sami Hamdan, transferred the supplies to the office of the President of the Palestinian Authority and left the site. While returning to the hospital the ambulance was stopped by tanks a few hundred meters from the building and was not permitted to proceed, despite the fact that the same roadblock had permitted the ambulance to enter the compound. In a conversation with the ambulance driver (at 8:50 pm on March 31), he told us that he had reached a distance of 20 meters from the tanks before they blocked his passage. He left the ambulance with his hands raised and said that he must return to the hospital. The soldiers shouted at him to return via a different route. His efforts to explain that all the other roads were blocked were to no avail. The soldiers fired warning shots in the air in order to force him to retreat. The ambulance was now 500 meters from the tanks and unable to return to the hospital. A further conversation with the driver (at 10:15 am on April 1) revealed that he was **still waiting for the ICRC (Red Cross) to coordinate his return to the hospital**. In the meantime, he had found shelter for the night with a local family. He was finally released at approximately 3:30 pm, after waiting for some 19 hours.
- On April 2, three Palestine Red Crescent Society ambulances departed to evacuate sick and injured persons. The ambulances were stopped by Israeli tanks at 9 am. The crews – including Mr. Younis Al-Khatib, president of the PRCS – were

ordered to leave the ambulances and to crawl in the rain toward the tanks, a distance of 50 meters. At 7:30 pm the crew was released. Four members of the crew required medical attention. This is not the only case where ambulances have been delayed and their crews “held for interrogation.” This behavior constitutes the use of threats against medical personnel by the security apparatus, which is supposed to provide protection in order that they can carry out their function without fear.

- **Prevention of evacuation of corpses:** For several days during the operation, the Israeli forces prevented the evacuation of corpses from streets and homes. Residents were forced to live in their homes with corpses during this period. For example, the body of Mahmud Ruhi Al-‘Uk, a 40-year old resident of Nablus, lay for two days (from April 3, 2002) in a room in his house since no ambulance could come to remove it. On April 5, 2002, a UPMRC ambulance managed to remove the corpse. When the ambulance arrived at Al-Watani Hospital, in order to transfer the corpse to the refrigeration room, Israeli fired at it in order to force it to stop. The ambulance was eventually permitted to enter the hospital, but it was held there for some ninety minutes, and was not permitted to continue the evacuation of the sick.
- **Attacks on hospitals:** On April 4 at approximately midday, the Israeli security forces entered the Red Crescent maternity hospital in El-Bireh. Some twenty five soldiers entered the building, and roughly the same number stood in the courtyard of the hospital. The soldiers gathered together all the workers and patients in the hospital, including women who had given birth and new-born babies aged between 3 and 10 hours. The soldiers subsequently demanded that the director of the hospital, Dr. Auda Abu Nahla and another staff member accompany them as they searched the hospital rooms. When unable to open doors, the soldiers broke them down with large metal bars. The soldiers also entered the surgical theaters, the treatment rooms for premature babies and the delivery rooms. At a later stage, all those present in the hospital were concentrated in the entrance area close to the information desk and a process of humiliation began. Some of the soldiers photographed themselves with the group, while they laughed among themselves. About seven of those present, including the director of the hospital, were asked to stand to one side. Their eyes were bound and the hands tied behind their backs, after the soldiers removed their robes and their Red Crescent emblems. Dr. Abu Nahla and a cleaning worker named Haled were then released. The remaining Palestinians were taken to an armored troop carrier and the soldiers left the hospital, after some two hours.

Despite the long list of attacks specified in the petition – against the fabric of civilian life, medical services and human life – the Israeli High Court of Justice accepted the State’s position that the IDF soldiers acted in accordance with humanitarian principles, as well as its claim that, given the fighting in the Territories, it was impossible to examine the specific cases noted in the petition. Accordingly, the Court ruling confined itself to a

generalized comment by the High Court regarding the IDF's commitment to humanitarian law.

## **Humanitarian Crisis: From Operation Defensive Shield to Operation Determined Path and Beyond**

Israel's invasion of the Palestinian cities in March-April 2002 in the so-called "Operation Defensive Shield" was followed by additional operations, such as Operation "Determined Path" and Operation "This Time, Perhaps". These operations were accompanied by extreme restrictions on freedom of movement, including general closure, internal closure, siege and curfew. Due largely to international attention and criticism of the damage caused to medical services during Operation Defensive Shield, Israeli political and military sources claimed that particular attention would be given to preventing damage to the civilian fabric of life of the residents of the Occupied Territories. In practice, however, damage continued to be done to the civilian fabric of life, including the lives of the sick and the functioning of hospitals.

Palestinian society is clearly facing a humanitarian crisis, and has become increasingly dependent on outside donations and assistance from humanitarian organizations. This situation is not the result of an natural forces, however. This damage has been caused by humans. Accordingly, only ending Israel's attacks on the Palestinian civic structures will enable the Palestinians to recover from the crisis. It is difficult to over-estimate the importance of this connection, and the devastating impact it has had.

*"You may be aware of the Director-General's statement of 13 March 2002..., in which she expressed serious WHO concern about the escalation in the Middle Eastern conflict, especially with regard to the consequences for the people's health, and the inability of health personnel and patients to access health facilities and appealed to all sides in the conflict to accept and respect the critical role of health personnel in its life saving efforts."*

(World Health Organization, April 19, 2002, in response to correspondence from PHR-Israel asking the WHO to declare a humanitarian state of emergency in the Occupied Territories.)

Israel's responses to the crisis have varied, though the general direction is consistent:

1. "Israel is trying to alleviate the situation of the civilian population."
2. "The Palestinian Authority (not Israel) is responsible for providing services to Palestinian residents."
3. "Things aren't all that bad."
4. Requests for international involvement through donations and humanitarian aid.

Let us examine these claims:

### **"Israel is trying to alleviate the situation of civilian population"**

The Israeli military attempts to defend itself by mentioning the Civil Administration and the DCOs, which are supposed to alleviate life for civilians, by providing transit permits for the sick and so on. However, the checkpoints and the permits to cross them are essentially the same: instruments of discrimination and control. The Israelis decide on

everyone's fate, thus emphasizing the dependence of each individual Palestinian, and of the Palestinian system as a whole, on Israel's goodwill. Israel's repeated declarations of its consideration for humanitarian cases must increasingly be seen as an unsuccessful attempt to mask the shameful picture of its occupation.

**In October 2001, Mazen Tayatneh, a 50-year old Palestinian man from the village of Abu Qash (north of Ramallah) was diagnosed as suffering from cancer. The only medical center in the West Bank capable of providing the chemotherapy he required was in Beit Jalla (near Bethlehem). The story of what Mazen had to go through in order to receive treatment epitomizes the reality of the past two years. In March, he made his way to Beit Jalla, moving from one taxi to the next, including sections where he had to walk around roadblocks and along dirt tracks. A journey that should take one hour took twice as long. During Operation Defensive Shield, he was unable to reach the hospital. In a telephone conversation with his physicians, he was warned that his condition would deteriorate, and that he should try to come. However, he was unable to leave his village. After the military operation ended, it was evident that he would require a permit from the Civil Administration in order to travel to Beit Jalla; even then, he could only hope that a curfew would not be imposed on the day of treatment and the day stipulated on the permit. After PHR-Israel intervened, the permit was prepared. Mazen walked on foot – in most parts of the West Bank, Palestinians are forbidden to travel in their own cars – to the DCO at Beit-El. He waited in the sun for two hours, but the soldier on guard refused to allow him to enter, so he returned home. When PHR-Israel attempted to clarify the matter, the Spokesperson and Head of the Organizations Desk in the Civil Administration, Mr. Peter Lerner, claimed that Mazen must have gone to the wrong place. The Civil Administration had acted properly – after all, the permit was ready and waiting. Again, PHR-Israel was informed that the permit was waiting – and this time it was not merely a one-day permit, but a long-term one, valid even during curfew. Mazen once again came to Beit-El, and again the soldier refused to allow him to enter. This time, however, the soldier agreed to speak to a representative of PHR-Israel over the phone, who explained that a permit was waiting. Mazen was allowed in, and the permit and its recipient finally met.**

#### **“The Palestinian Authority is responsible”**

For the Palestinian Authority to be responsible for its residents, it would require governmental mechanisms enabling it to develop policies and engage in long-term planning for the development of Palestinian society, education and economy. In reality, Palestinian society is currently involved entirely in coping with emergencies. In the few cases in which long-term planning has been possible, the Palestinians face active Israeli interference with a view to foiling such efforts. This was the case, for example, with the Medical School at Al-Quds University in East Jerusalem.

**Since the beginning of the conflict, Israel has refused to allow medical students from Gaza to travel to the Faculty of Medicine in Abu Dis (outside Jerusalem). This has gravely impaired the Palestinians' ability to develop a future cadre of well-trained**

**physicians – an essential condition if they are to develop an independent and efficient health system. On July 23, 2002, Israeli forces entered the university and arrested two Palestinian students from Gaza, who were subsequently deported back to Gaza.**

PHR-Israel contacted the Health Coordinators in Gaza and the West Bank, complaining about Israel's attacks on the education system in general, and medical studies in particular. We argued that these attacks denied Palestinian society any chance of planning or developing a professionally diverse Civil Society capable of meeting its future needs. It takes a remarkable measure of cynicism to argue, as the Israeli authorities do, that the Palestinian Authority is responsible for malnutrition and the state of the health services, while at the same time reserving the right to hamper development, education and health. We were informed by the Coordinator of Activities in the Territories that the matter is "under examination."

Israel has for many years prevented Palestinians from studying medicine if they happened to be residents of the Gaza Strip. Throughout the years of occupation, for example, Israel prevented students from attending Israeli universities. Those who wished to study medicine were forced to travel abroad – something that required a substantial investment on the part of their family. This policy has nothing to do with the security background of the students. The damage to their education, to their personal future and to the future of the society they wished to serve was undertaken in an arbitrary and disproportionate manner. Israel's refusal to allow students to travel between the West Bank and the Gaza Strip is in violation of the Oslo Accords, in which Israel undertook to maintain the territorial integrity of the two areas as a whole.

Even in short-term decisions, the Palestinian health authorities find it difficult to function independently. Referrals to hospitals outside the Occupied Territories require Israeli approval, even if the hospital involved is in Jordan or Egypt.

**Khaled Raja Abu Al-Hija, resident of Jenin, was injured in a shooting attack. Israel refused to allow him to travel to Jordan for treatment, on the grounds that he was on a security "blacklist." Khaled states that he has never been involved in any actions against the State of Israel or Israeli residents. He was recently arrested, interrogated and released. PHR-Israel contacted the Civil Administration and asked that he be allowed to leave the Occupied Territories for medical treatment. The Spokesperson and Head of the Organizations Desk in the Civil Administration, Mr. Peter Lerner, replied that an investigation had shown that "the operation can be performed at the hospital in Ramallah." It must be understood that not only has the Civil Administration thus acquired the authority to decide where a patient will be referred, and to refuse to respect a patient's wishes, but even travel from Jenin to Ramallah must now take place with its coordination: "Since he is a resident of Jenin," Lerner notes, "we will be pleased to help issue a travel permit for use during 'encirclement,' in order to enable him to reach the hospital." PHR-Israel has petitioned the High Supreme Court regarding this prohibition. The petition is pending.**



### **“Things aren’t all that bad.”**

The most prominent feature of recent months, following the so-called Operation Defensive Shield, is undoubtedly the humanitarian crisis. Israel’s attacks on Palestinian cities have paralyzed civilian life through the excessive use of military force. On entering a city, a complete curfew is imposed. The curfew and the paralysis of the civilian systems creates an emergency situation for the population: food shortages (including baby food), problems with fresh water and electricity, accumulation of garbage in the streets, and so on. In such conditions, weak populations such as children, pregnant women, the sick and the old are particularly vulnerable. The Palestinian economy is paralyzed. Increasing numbers of Palestinians are unemployed, or are unable to access their land. As a result, a growing number of families must resort to seeking donations from overseas organizations and governments. Although non-governmental organizations are working alongside Palestinian health organizations in an effort to meet the needs of these groups, they cannot meet the full range of needs.

A preliminary survey commissioned by USAID and conducted by physicians from Johns Hopkins University has showed that 9.3% of children in the Occupied Territories are suffering from acute malnutrition, and 13.2% of children are suffering from chronic malnutrition (mainly in the Gaza Strip). These nutrition figures are defined as “a humanitarian emergency.” The researchers also found that there is a lack in protein-rich food products. The main reason for this is the Israeli roadblocks, closures and curfews. Even when food is available in the shops, many Palestinian residents can purchase very little, due to financial hardship.

Israel’s response to these difficulties is astonishing. Dalia Basa, Israeli Health Coordinator – and someone who should be particularly sensitive to the Palestinians’ hardship in the medical field, states that “they are not in distress. Actually, in these conditions, the reserves of medicine and medical equipment are full, and the hospitals are not full.” Dalia Basa has problems understanding the connection between low occupancy rates in hospitals and the permit regime imposed by Israel. General Amos Gilad denies that there is hunger or malnutrition in the Territories: “Hunger is when there is a lack of basic products and people wander around with a pot belly, collapse and die. There is no hunger now.”<sup>66</sup> The same general prepared a plan that aimed to enable the Palestinians to “keep their head above the water.” According to his vision, “The education, health and municipal services will continue to operate even when the IDF is present... with funding from the international community.”<sup>67</sup>

### **Requests for international involvement**

The Israeli government and its agents on the ground – the military forces – refuse to accept responsibility for meeting needs, as required by international law. Moreover, they interfere with the efforts of Palestinian bodies to perform this function. Accordingly, it is convenient for Israel to transfer to the international community the financial burden of

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<sup>66</sup> *Ha’aretz* internet site, August 7, 2002, article by Gideon Levy.

<sup>67</sup> *Ha’aretz*, July 5, 2002, Uzzi Benziman.

financing a society whose economy has been paralyzed. At the same time, Israel refuses to hear criticism of its own policies from the international community, although these are the principal cause for the current situation, or even to provide help in cases when it does not approve of international presence (as was the case in Jenin refugee camp in April 2002). Thus, for example, whereas the Israeli government refuses to receive a UN delegation to investigate the actions committed during “Operation Defensive Shield”, it accepts, and even invites, humanitarian aid from international bodies. This help is useful from Israel’s perspective, since it enables Israel to continue its own harsh and destructive policies without having to bear responsibility for the economic and humanitarian distress that results from these policies.

PHR-Israel believes that this request for intervention in the form of assistance opens the door to external intervention in the form of influence on policy. The donor countries should make it clear that they will not continue to forward contributions for the construction of a civil society if the fruits of these investments are going to be shelled in the future by the Israeli military forces. If investments are to be more than charity; if they are to empower and strengthen Palestinian society and enable it to begin to act on its own again, they must be accompanied by an unequivocal demand that Israel cease to violate human rights in the Occupied Territories, act to find a political resolution, and immediately remove all restrictions on freedom of movement in the Occupied Territories: internal closure, siege and curfew.

## **East Jerusalem: Divorce by Force**

Unlike the residents of the remainder of the Occupied Territories, the residents of East Jerusalem were annexed to Israel along with the eastern part of the city in 1967, in violation of international law. Accordingly, they became Israeli residents, and as such entitled to health services. Thus, the Palestinians of East Jerusalem could register with one of the Israeli Health Maintenance Organizations (HMOs), and, after the National Health Insurance Law came into force, they were supposed to benefit from its provisions, though not without continuing difficulties that illustrate the discrimination they suffer relative to other Israeli residents.

After the annexation of East Jerusalem, the Palestinian hospitals in the city came under Israeli rule. These hospitals constitute the most advanced medical center providing care to the residents of the Occupied Territories. Most of the patients who received care at the hospitals were residents of the West Bank and Gaza Strip, as was a significant proportion of the staff. The status quo that applied during most of the years following annexation allowed the hospitals to function as an almost independent system. However, they were also damaged by the closure policies. Until the closure of February 1996, closures had serious results during the first few days, but the damage to the provision of medical services was limited in time. When the closure was imposed in 1996, this damage became severe and protracted. The hospitals were cut off almost completely from their community they served, since patients could not freely reach Jerusalem: as Israel regards entry into East Jerusalem as synonymous with entry into Israel. Moreover, transit permits for medical personnel were withdrawn, and the hospitals had to rely entirely on local Jerusalem staff – i.e. less than half their usual staff, and without many of their specialists. The arrangement reached after our petition (1996) did not provide solutions for employees coming from Gaza, and did not enable physicians to arrive in their own cars (essential in emergencies); nor was it clear when the hospitals would again be able to work at full capacity. These problems have continued ever since. As of today, a large proportion of hospital employees who are residents of the West Bank cannot obtain permits enabling them to commute between home and work.

Since the High Court ruling in 1996, the situation has grown steadily worse, excluding a lull of a few years. Hospitals, encountering financial difficulties, reached agreements with various Israeli HMOs so that they could also receive Palestinian patients from within East Jerusalem. This dependence on the HMOs (which is problematic, as will be explained below) as a source of income became more pronounced as it became harder for patients from the Occupied Territories to reach the hospitals. At the same time, the Palestinian system began to attempt to provide services in other cities that had hitherto been provided only in Jerusalem. This led to an unnecessary duplication of medical departments, and a waste of money that could and should have been invested in real medical needs.

These two developments – the loss of patients from the Occupied Territories and the growing dependence on the Israeli HMOs – have made the hospitals highly vulnerable,

particularly those that do not receive funding from donations, churches, etc. Since the HMOs function as a virtual monopoly, they provide humiliatingly low reimbursements for hospitalization – approximately forty percent of the rate at Israeli hospitals. This payment barely covers the costs, let alone providing any profit margin.

The State of Israel is aware that these hospitals constitute a symbol of Palestinian presence in East Jerusalem. A direct attack on the hospitals, such as forcing them to close, would meet with a serious response on the international level. Accordingly, Israel seems to prefer to “kill them gently” by divorcing them from the economic and social hinterland on which they rely.

### **“Checks and Balances”**

Several organizations could help halt the deteriorating attitude of the Israeli security forces toward international conventions and humanitarian law. Unfortunately, when the cannons roar, the muses are largely silent. Even when these organizations have made a stand, this has usually been too little and too late.

#### **The High Court of Justice**

“The Supreme Court is considered an innovative and activist legal body, particularly when it sits as a High Court of Justice. It has a reputation for being a judicial body that manages to ensure human rights even in the absence of a constitution or a bill of rights; that manages to listen to citizens’ distress in their conflict with the authorities, and to pose penetrating and trenchant questions to governmental powers. However, these qualities do not seem to be reflected when the Court addresses petitions filed by residents of the Territories. Though the doors to the Halls of Justice are wide open, these guests cannot satisfy their hunger at the Court’s abundant table in their need for concrete and tangible relief. They can, at best, gather crumbs from partial successes and procedural victories.”

(“The Border of Activism is the Green Line: In the Margins and Paths of the Rulings of the High Court of Justice in the Territories,” Leon Shelef, *Iyunei Mishpat* 17(2), 1993).

Between 1991 and 2000, PHR-Israel filed five petitions intended to secure the freedom of movement of patients and medical personnel in the Occupied Territories. These petitions encapsulate the lives of Palestinian residents – patients, physicians and nurses – who struggle every day for their right to get to hospital in order to give or provide medical treatment.

Certain successes have been achieved in this work, and the military forces have been obliged to permit the (limited) entry of medical personnel into East Jerusalem, to allow patients to travel to obtain medical care, and so on. From a long-term perspective, however, the High Court has not provided a genuine or comprehensive response to the severe restrictions imposed on the freedom of movement of patients and medical personnel. The fact that the High Court has declined to respond to the challenge with

which it has been presented has created a situation in which Palestinians are all the more vulnerable to closure, internal closure, siege and curfew, which have now become daily realities. In their recent rulings, the High Court judges have even refused to discuss the substance of the cases, and have rejected numerous petitions on procedural pretexts. Alternatively, they have confined themselves to issuing a declarative ruling that does not offer any practical relief, and refrains from imposing sanctions on those who violate human rights.

### **The Israel Medical Association (IMA)**

Since the hostilities erupted, PHR-Israel has forwarded dozens of copies of its correspondence to the Israel Medical Association, in the belief that its function obliges it to protect medical personnel performing their duties. As the representative of the medical establishment in Israel, we believed that IMA might be able to curb the appalling deterioration in the attitude of Israeli military forces toward Palestinian health and rescue services. Yet despite severe injury to medical personnel and to the ability of physicians to act in safety to advance their patients' interests; despite Israeli shells that have fallen on Palestinian hospitals; despite the killing of medical personnel on duty – IMA has chosen to remain silent. Only after extensive contacts between PHR-Israel and global medical bodies, and ahead of the convention of the World Health Organization, was a discussion forum called to discuss IMA's position given the damage to health services in the Occupied Territories.

“Following incidents involving IDF soldiers and staff from the International Committee of the Red Cross, including attacks on vehicles and offices, the International Red Cross is today obliged to reduce its operations in the West Bank to a minimum... This behavior is absolutely unacceptable, insofar as it endangers not only the rescue and assistance operations of the medical emergency personnel, but also the humanitarian mission of the International Red Cross.”  
(ICRC press release, April 5, 2002)..

The above-mentioned forum prepared a position paper presenting fourteen points, in what it sees as an effort to balance a commitment to provide health services during armed conflict with Israel's security needs. This belated declaration, drafted in order to avoid censure, and presented as an Israeli propaganda victory (which prompts one to ask whether the IMA is an executive arm of the Israeli establishment?) includes recognition of the supremacy of medical considerations. We hope that the IMA will continue to use its power not only to explain Israel's moral dilemma around the world, but also to oblige the IDF to act in accordance with international conventions, and to refrain from damaging health services in the Occupied Territories.

### **The Israel National Ambulance Company (Magen David Adom)**

Magen David Adom remained silent despite grave attacks on Palestinian ambulance personnel. It failed to show solidarity or to demand that the crews be afforded protection. After a protracted propaganda campaign against the Palestine Red Crescent Society by the Israeli security services, based on the claim that it was transporting weapons and

ammunition, Magen David Adom saw fit to issue a statement condemning the Red Crescent and tarnishing it with the claim of the illegal use of ambulances. Magen David Adom accepted all IDF allegations. The organization later apologized to the Red Crescent, but did not bother to make this apology public. Moreover, after the President of the Palestine Red Crescent Society was beaten and delayed for hours by Israeli forces, the President of Magen David Adom, Dr. Moshe Maloul, felt no need to express solidarity with his Palestinian counterpart.

PHR-Israel believes that Magen David Adom should have protested clearly and unequivocally against such grave violations of international humanitarian law, and against the distress suffered by patients and physicians in the Occupied Territories. PHR-Israel urges Magen David Adom to publicly retract its sweeping allegations against the Palestine Red Crescent Society – allegations that endanger the work and even the lives of ambulance crews in a very real way.

### **The Press**

The media could play an important role in informing the public about various aspects of the conflict in the Occupied Territories. Alongside its coverage of the high price paid by Israeli society in terms of human lives, the media could also present the price paid by the Palestinians in the Occupied Territories and the violation of human rights on both sides of the 1967 borders. Numerous studies have found a tendency by the media to “toe the line” and accept the consensus – this issue lies beyond the scope of the present report. We will note, however, that given the difficulties in reaching the public through the media, PHR-Israel has attempted to create direct contact with the public and to inform it of the severe damage caused in sphere of medicine. For example, an ambulance that had been shot at by the military forces was brought from Tul Karem in the West Bank and exhibited in the plaza outside Tel-Aviv Museum.

**Photo**

## Conclusion and Recommendations

In this report, we have attempted to describe the State of Israel's approaches regarding the Palestinian residents of the Occupied Territories, and especially regarding their right to health. In general, it may be said that the attitude of the State of Israel toward the Occupied Territories and the Palestinian residents living within them is clearly characterized by exploitation. While seeking to utilize the resources of the Palestinian economy (particularly cheap labor, water and land), Israel has evaded its obligation to ensure the fair implementation of social rights for the Palestinian community. Thus it has maximized its profit from the occupation, without taking responsibility (paying the price). Between 1994 and 2000, various powers were transferred to the Palestinian Authority. However, Israel retained such extensive authorities that, at least effectively, and often formally, it controlled the lives of the residents. Israel's policy of renouncing its responsibilities has reached a peak since September 2000. Israel has now resumed full control of the Occupied Territories, and exerts total authority over the everyday lives of Palestinian residents. It has moreover attacked and destroyed civilian infrastructures, while at the same time continuing to refuse to accept any responsibility for the fate of the population it has affected so deeply.

One of the most prominent manifestations of this control is the regime of severe restrictions imposed by the State of Israel on freedom of movement. This has led to the paralysis of civilian systems in the Occupied Territories, and has made Palestinian society in general, and the health system in particular, dependent on foreign donations and assistance. In these conditions, the Palestinian health system cannot implement routine work or engage in long-term development: it is almost totally preoccupied with crisis management. A measure of coordination takes place between the various international bodies in the field, so that assistance is provided in a systemic manner. However, this assistance is problematic, since it addresses a situation to which the solution can only be political.

By way of example: the oxygen for hospitals throughout the West Bank is provided by a single factory in Jenin. The factory's vehicles encounter problems in reaching all the hospitals, due to the numerous roadblocks and endless coordination procedures. During "Operation Defensive Shield", some hospitals ran out of oxygen balloons completely. Various organizations intervened, and donated concentrated oxygen. But is the solution really to donate oxygen to hospitals, so that they are not dependent on the Palestinian factory? We believe that the answer to this question is negative, for several reasons. First, the dependence on external bodies and foreign donations will ultimately destroy the few remnants of an independent Palestinian economy. Thus, for example, if all the hospitals sever their links with the oxygen factory, it will close. Second, it must be asked whether the response to Israel's dissection of the Occupied Territories is to be the endless replication of Palestinian health units, until every village can offer all services? Should not the solution, first and foremost, be to reverse this dissection?

**Accordingly, we believe that local responses to distress must always be accompanied by constant pressure to remove the roadblocks, closures and curfews that cause this distress.**

As detailed in this report, Israel's fragmentation of the Occupied Territories has been accompanied by steps suggesting that the old-style occupation is being reinstated: full control of the lives of Palestinians in the Occupied Territories, the difference being the refusal to assume even minimum responsibility for the civilian systems. The fear of accepting responsibility leads policy-makers in the army and other Israeli authorities to demand that the Palestinian Authority supply services to the residents, while at the same time working to destroy the same Authority. Israeli authorities then contact foreign organisations and ask them to provide humanitarian assistance for the residents of the Occupied Territories.

This situation cannot continue indefinitely. To prevent any misunderstanding, we must emphasize that we have no desire to see the return of the Civil Administration, which was – and can only be – a tool to implement a policy of occupation.

**Accordingly, Israel must remove all restrictions on movement in the Occupied Territories, and must enable Palestinian and international bodies to operate in the field, and – at last – to develop an independent health system that is both economically and professionally viable. As long as the occupation continues, the State of Israel is obliged to undertake in Israeli hospitals medical procedures that cannot be implemented in the Occupied Territories. Israel must also enable the free passage of Palestinian residents within the Occupied Territories, in order to enable the medical, economic and educational infrastructures to begin to function once more. Such travel must not be dependent on permits from the Civil Administration, which by its nature is characterized by an unpleasant mixture of control mechanisms, bureaucratic procedures and exterior considerations. If and when peace agreements are signed between Israel and the Palestinians bringing the occupation to a complete end, and establishing an independent Palestinian state, Israel will be required, for a transitional period, to continue receiving Palestinian patients for care, and at the same time to assist in developing foundations for an independent Palestinian health system, within the framework of existing Palestinian civil systems as well as international assistance. Given the legacy of occupation and the damage this has caused the Palestinian health system, as described in this report, Israel's commitment to provide such assistance is both moral and legal.**



**Response of the IDF Spokesperson [*translated from the Hebrew by PHR-Israel*]**

IDF Spokesperson

IDF  
IDF Spokesperson Unit  
Public Relations Department  
Army Zip 01000  
Tel: 03-6080340/1  
Fax: 03-6080343  
ZK 1557  
October 22<sup>nd</sup>, 2002  
Heshvan 16<sup>th</sup>, 5763

Attention  
Ms. Hadas Ziv  
Physicians for Human Rights-Israel

Re: Your Application to the IDF Spokesperson

Good Day,

The draft of your report regarding the right to health in the territories was received at our offices. Following is our response:

As is well-known, over the past two years IDF forces have been contending every day and every hour with combat events taking place in the area of Judea and Samaria and in the area of the Gaza region. Since the start of these events 14918 terrorist attacks have been recorded that have led to the death of 640 Israeli civilians and IDF soldiers.

These events feature shooting attacks on civilians and IDF soldiers, the laying of explosive devices near routes, shooting of mortar bombs toward settlements and military outposts, disruptions of public order and terrorist attacks of various kinds (in the Area and in Israel), all of which cause ongoing danger to the lives and safety of IDF forces and the civilian population in the Area.

This war was forced on the State of Israel and on the IDF.

The State of Israel in general, and the IDF in particular, have always afforded great importance to the issue of ensuring appropriate medical care to the residents of the Palestinian population [sic] in the Area of Judea and Samaria and the Area of the Gaza region. This has been observed with full awareness of the moral and legal importance of this subject. Accordingly, IDF soldiers are advised to abide by the spirit of the IDF and the principles of international law that apply to this subject.

In this context we note that the quality of hospitals in the Area of Judea and Samaria and the Area of the Gaza region has improved immeasurably since the IDF entered the Area. Moreover, over the years, Israel has permitted access of Palestinians in need of medical care to hospitals in neighboring countries, and even to Israeli hospitals. This has been done despite the fact the the Palestinian population has no recognized right to enter the State of Israel.

Even after the signing of the accords with the Palestinians and the transfer of powers in the sphere of health to their responsibility, the State of Israel enabled the entry of Palestinians into its territory for the purpose of receiving medical care, and an organized mechanism was set in relation to the Palestinian Authority, whereby such entry was permitted. Evidence for this can be found in the large debts, to the order of millions of NIS, accumulated by Israeli hospitals, due to medical care provided to Palestinian residents of the territories.

Within the framework of the agreements a joint medical committee was established and arrangements were reached for cooperation, stemming from a will to assist the Palestinian side to continue and develop this sphere which had been transferred to its responsibility. Unfortunately, the Palestinian side chose to abandon the way of peace and to transfer the scene to the arena of violence. Beyond this, the protagonists of Palestinian

terrorism that is aimed against Israeli civilians, do not distinguish themselves from innocent populations. On the contrary, they act from within the civilian population, using it as a shield for themselves. For examples, even ambulances were used for purposes of terrorism.

In light of the complex security situation created by violent activities coming from within civilian populations, the IDF is obliged to imposed limitations on the freedom of movement of the Palestinian population, in order to protect Israeli civilians and to prevent danger to the lives of soldiers. These limitations stem from situation assessments made by the IDF according to the circumstances on the ground. For example, movement of Palestinians is sometimes limited if there are grounds to suppose that suicide bombers will leave a certain area in order to carry out terrorist activities against Israelis or IDF forces.

Unfortunately, we have repeatedly been witness to the fact that in many cases the lifting of these limitations have been exploited almost immediately by terrorist elements for the execution of terrorist attacks against Israel, as we have seen yesterday, in the terrorist attack at Karkur.

Even when limitations are placed on freedom of movement, unequivocal instructions are given to enable movement to the population in humanitarian cases, and especially in cases of medical need. There is no basis for the claim that a policy of collective punishment is implemented against the Palestinian population. All steps that taken are based on security considerations and on assessment of the situation on the ground.

In the complex circumstances of life's reality, there are cases of deviations from orders. The IDF makes every effort to identify such cases, to investigate them and to take the necessary steps to prevent their repetition, including suitable legal steps.

Sincerely,

Enrietta Levy, Captain  
Assistance Department

**Preparation and publication of this report and the work it expresses was made possible through the support of the following organizations and individuals:**

The European Commission, the Swiss Agency for Development and Cooperation, Diakonia, EPER, Centrale Sanitaire Suisse, SIVMO, Department for Global Ministries of the Uniting Churches in the Netherlands, the Ford Foundation, the New Israel Fund, Entwicklungshilfe-Klub, Haella Stichting, the Naomi and Nehemiah Cohen Foundation, the Embassy of Finland, Vicop Stiftung, Art Exhibition 'Imagine', the Late Shifra and Alyakim Vos

## Captions for Photos

1. No Credit
2. Photograph: Palestine Red Crescent Society
3. Photograph: Palestine Red Crescent Society
4. Transport of medicines in the rural sector, December 2001. Photograph: PHR-Israel
5. Photograph: Palestine Red Crescent Society
6. PHR-Israel's Head Fieldworker, Salah Haj-Yehya, during a visit at the local branch of the PRCS in Tul Karm, after its ambulance crew had come under direct fire from IDF forces. Photograph: PHR-Israel
7. Evacuating a patient. Photographs courtesy of the Palestine Red Crescent Society. Submitted as evidence in PRCS and PHR-Israel joint petition against the policy of closure and checkpoints.
8. PHR-Israel supporters demonstrate for protection of medical neutrality, outside the High Court of Justice. Photograph: Avi Berg
9. Photograph: Palestine Red Crescent Society

Press cutting: caption (already in text):

*Israeli press cuttings from the time of the 1987 Intifada: The top left legend reads: "Cancer patients from Gaza, whose lives could and should have been saved had they been sent to receive care in Israel, are left to die in the [Gaza] Strip due to the selection policy of the Civil Administration. The case of Abu-Habel as an allegory..."*

*Bottom: "A doctor at Tel Hashomer [Israeli hospital – PHR-Israel]: "the [workers of] Civil Administration play God. This man arrived [here] after undergoing primitive surgery, and he's going to lose his life, when all it needed was a simple operative procedure."*