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Palestine and COVID-19: Global Standards, Local Constraints

Although the Palestinian authorities followed a set of global standards and procedures to tackle the pandemic, they had to manoeuvre within severe constraints: weak health infrastructure, a fragile financial situation for the Palestinian Authority (PA), and the political ramifications of the Israeli military occupation – particularly the imminent threat of annexation of major parts of the West Bank. The COVID-19 response yielded a strengthening in the perceived legitimacy and popularity of the Palestinian government, but this is very likely to be short-lived.

Brief Points

- The COVID-19 outbreak in the West Bank and Gaza Strip, observed in late June 2020, has been mild. A possible second wave may be stronger.
- The Palestinian Authority's strategic communication, with regular briefings to the population, was key to the relative success of the response.
- Despite the instrumentalization of COVID-19 by the Palestinian political and security leadership, deep legitimacy and trust gaps remain.

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Country Overview

The Palestinian West Bank (5,655km^2) has been under Israeli military occupation since 1967.[1] Following the 1993 Oslo Accords, the West Bank was divided into Areas A, B and C to delineate areas of Palestinian Authority (PA) control and areas of Israeli military control. Around 3 million Palestinians live in the West Bank, most of whom reside in Area A (18% of the territory). There are 671,007 Israeli settlers living in more than 150 illegal settlements in the West Bank.[2] The settlements are continuously expanding, causing further territorial fragmentation, and creating isolated Palestinian enclaves. The unemployment rate in the West Bank is around 18%, while the poverty rate is around 14% (in Jerusalem, 72% of Palestinian families live below the poverty line).[3]

The Gaza Strip (365km^2) has been occupied since 1967, and under Israeli military siege since 2007. It has a population of 2 million Palestinians, 600,000 of which live in refugee camps (some 1.3 million, in total, are refugees). Gaza is one of the most densely populated areas in the world (5,533/km2), and a 2018 UN report deemed it to be 'unliveable' within two years due to the destruction of its infrastructure by Israeli bombardments and the siege.[4] The unemployment rate is in the 45–52% range, 53% of the population live in poverty and 68% of households are food insecure. On top of that, 95% of the regional aquifer's water is unsafe for drinking and therefore requires treatment.[5]

In 2019, Palestine ranked 119 out of 189 countries and territories on the UNDP's Human Development Index, with a GDP per capita of USD 3,562. As a result of decades of military occupation, health care does not meet basic standards. Palestinians face many barriers to accessing treatment and care, and there are acute shortages of equipment and medications as a direct result of Israeli restrictions on imports. In Gaza, many essential medications are consistently at "zero stock", meaning that there is less than a month's supply.[6] Israeli restrictions on Palestinian freedom of movement also means that it is very difficult for Palestinians from the West Bank and Gaza to travel (even to East Jerusalem) to receive proper care. The West Bank and Gaza Strip combined have 375 adult intensive care unit beds in private and government hospitals (255 in the West Bank, 120 in Gaza Strip), and 295 ventilators (175 in the West Bank, 120 in Gaza Strip).[7] There are 82 hospitals in the West Bank and Gaza Strip, with 6,440 beds (1.33 beds per 1,000 inhabitants).[8]

The Israeli occupation of Palestinian territories – including control over the economy – in addition to a deep reliance on donor funding and aid has led to a process known as "de-development". This means, inter alia, that despite the massive inflow of aid, societal infrastructure is not keeping pace with the needs of the population. Donor funding has totalled around USD 40 billion since the Oslo Accords were signed (1993), making Palestinians one of the highest per capita recipients of non-military aid in the world.[9] In April 2020, the Palestinian Central Bureau of Statistics (PCBS) warned that the economy "will incur losses of about USD 2.5 billion in case the coronavirus pandemic lasts for three months". It predicted that the Palestinian GDP will decline by 14% compared to 2019.[10]

East Jerusalem, which has been illegally annexed by Israel, has a population of 370,000 Palestinians.[11] Israel forbids the PA from operating in East Jerusalem in any capacity, including in the health sector. This was aptly demonstrated when Israeli authorities raided a clinic in the East Jerusalem neighbourhood of Silwan and arrested health workers because they were using COVID-19 test kits donated by the PA. Simultaneously, the Israeli Jerusalem municipality neglects neighbourhoods of East Jerusalem and the hospitals and clinics that serve them.

Severity of COVID-19 Outbreak

As of 19 June 2020, The West Bank (including East Jerusalem) and Gaza Strip had 834 confirmed cases and 5 deaths (1 in the West Bank, 1 in Gaza Strip, 3 in East Jerusalem). Out of the 834 cases, 639 cases are registered with the PA's Ministry of Health (MoH) (567 cases in the West Bank and 72 cases in the Gaza Strip), and the remaining 195 cases are Palestinians living in East Jerusalem neighbourhoods. Between 5 March and 19 June, 69,730 tests were conducted, and the cumulative number of home quarantine cases totalled 97,078.[12] This means that the rate of infection was 16.6 per 100,000, and the death rate 0.1 per 100,000.

A closer look at the 639 cases registered with the PA's MoH reveals that an estimated 65% of the cases originated from Israel, 10% from Egypt, and 9% from Greece. Around 25% of the cases are Palestinians working in Israel and in the settlements, 40% are those who interacted with the workers, and 15% are Palestinians coming from abroad.[13]

Policies to Deal with the COVID-19 Crisis

The first measures against COVID-19 in the West Bank were taken on 5 March, when the PA declared a state of emergency and imposed a lockdown on the site of the first infections, Bethlehem, banning all entry and exit as well as enforcing a curfew. The PA also announced restrictions across the West Bank, including prohibitions on travel between governorates and the closing of public spaces and education facilities. On 22 March, following a steady increase in cases, the PA declared a curfew on Area A.

In the Gaza Strip, by mid-March, Hamas authorities and UNRWA began converting schools into quarantine centres and clinics, in preparation for a possible outbreak. On 21 March, two Gazans returning from Pakistan tested positive for the virus and were immediately hospitalised. 29 people were identified to have come into contact with them and were quarantined. A similar lockdown was imposed by the Hamas authorities in Gaza with public spaces and schools closing.

Whilst the official date for reopening of restaurants, cafes and other public spaces was 7 June, they unofficially began opening from the beginning of June. On 18 June, the MoH reported the beginning of the second wave and re-introduced restrictions on gatherings and travel in between governorates.

The Palestinian authorities were initially praised for their quick and effective actions. Indeed, on governmental and civilian levels, there was a general understanding that the Palestinian health care system was incapable of dealing with a serious outbreak, and that dramatic measures would be needed to avoid it. A poll undertaken by AWRAD in late March revealed that 82% of respondents evaluate the authorities' response positively.[14] This is an unprecedented positive evaluation of the Palestinian authorities.

The most ineffective set of policies concerned labourers who work in Israel. It is estimated that there are approximately 70,000 Palestinian workers in Israel whilst a further 30,000 work in illegal Israeli settlements.[15] The Israeli authorities

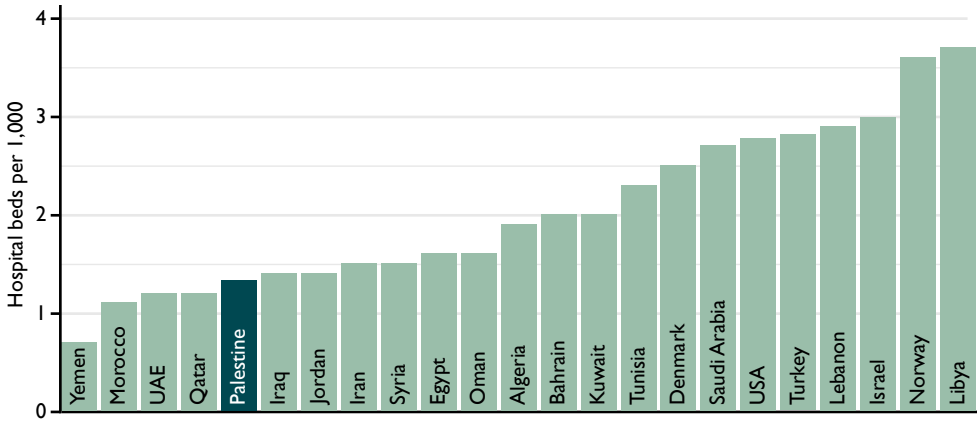

Figure 1: Hospital beds per 1,000 inhabitants. Source: Our World in Data, coronavirus statistics

and the PA reached an agreement that, as of 18 March, Palestinian labourers' continued employment was conditioned on them remaining in Israel for several months rather than returning to the West Bank. For those who chose to remain with their families in the West Bank, remuneration packages were not offered, leaving many families without their daily incomes.

For the labourers who chose to stay in Israel, they were more often than not deprived of proper protective equipment and satisfactory sanitary conditions. It was also reported that Israeli authorities dumped workers who they suspected of having the virus at checkpoint entrances to the West Bank without informing the PA. As a result, Palestinian Prime Minister Mohammad Shtayyeh reversed the agreement on 25 March, ordering the workers home. Israel had not offered them testing, and there was a lack of capacity to test them upon their return. Thus, much of the contagion came with those returning from Israel.

On 26 March, the PA released a COVID-19 Response Plan, a document aimed at donors, and outlined the COVID-19 strategy as one that focused on "preparation, containment and communication".[16] In response, the EU offered the PA a coronavirus assistance package of EUR 71 million. Other donors and UN institutions promised to follow suit. The PA's fragile financial situation and its inability to pay the salaries of its public sector employees pushed its leadership to request a USD 100 million loan per month from the member states of the Arab League. The Arab states' decision is still pending.

On 9 June, Shtayyeh stated that the PA had moved from the relief to the recovery phase, after having offered "relief assistance to 125,000 families, 40,000 workers who lost their work or income, and 30,000 families 'new poor' due to corona". The PM declared that the collection of USD 400 million – from donors, the Palestinian Monetary Authority, and Banks – would be devoted to non-commercial low-interest rate loans, especially for the most affected sectors. As part of the health sector plan, the Prime Minister highlighted that the PA went from having a testing capacity of 298 per day to 6,000 per day.[17]

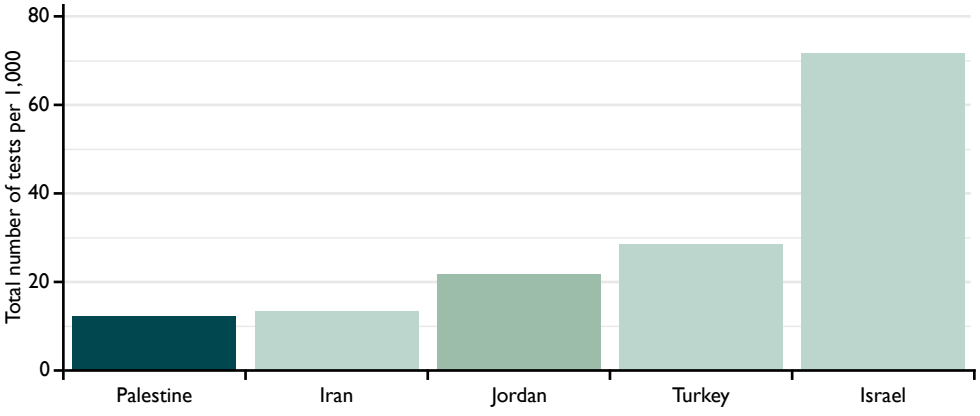

Figure 2: Total number of tests per 1,000 as of early June. Source: National government reports

Civil Society and Media

In the West Bank there were various civil society initiatives to help the PA deal with containing the spread of COVID-19. Checkpoints – colloquially called "checkpoints of love" to distinguish them from Israeli military checkpoints – were set up between villages, in particular in Areas B and C where the PA is not allowed to operate. These checkpoints limited the movement between villages and also monitored the movement of labourers returning from Israel. Another initiative was led by the General Federation of Trade Unions who sent volunteers to Israeli military checkpoints to give labourers who were returning to the Israeli labour market hand sanitisers and masks. Emergency committees and village councils were set up to liaise with the PA on preventative measures.

There was also considerable online activity and advocacy during the lockdown. For example, the Palestinian Human Rights Organisations Council sent letters to the international community regarding the situation of Palestinian prisoners and detainees during the pandemic.[18] Grassroots groups and activists mobilised on a local level to gather supplies and donations to distribute to vulnerable families. One such effort was a campaign called "Al nas le ba'ed" (The people for each other). An independent initiative by a journalist established a COVID-19 website (www.corona.ps) which gave official live statistics of infections, deaths and recoveries, as well as news updates.

In East Jerusalem, civil society and grassroots groups mobilised to try and make up for the neglect by the Israeli authorities. Groups organised food distribution to vulnerable families, in particular to those who lost wages as a result of the lockdown, as well as disinfection of neighbourhoods, particularly in the old city where the houses are densely packed. The Israeli authorities met these efforts with hostility, at times shutting them down and fining activists.

Finally, the private sector-led Wakfet Izz Fund was launched to face the economic consequences of the pandemic. By mid-May, Wakfet Izz

Fund had collected around USD 17 million. By mid-June, it started allocating the money as follows: 39% allocated to 40,000 workers who had lost their jobs (USD 200 per worker); 25% allocated to 30,000 families (USD 150 per family: 75% in the West Bank, 25% in Gaza Strip); 3% to Jerusalem; 10% to refugee camps and charities; and the remaining 23% allocated to the PA's Ministry of Health to meet urgent medical needs, including for Jerusalem.[19]

Concluding Remarks

The perceived success of the Palestinian authorities in dealing with the COVID-19 crisis yielded a significant increase in the approval for, and satisfaction with the performance of, the government. The PA's strategic communication and the near daily briefings offered by officials were a refreshing element in the crisis response. Yet, the deep legitimacy and trust gap remains far from being bridged. This rise in popularity and satisfaction level is likely to be short-lived. In fact, since the government announced its inability to pay the salaries of the public sector employees in mid-June, it has already diminished. The financial situation of the PA is fragile, the health infrastructure is weak, and the Palestinian economy is structurally dependent on aid and the Israeli economy. If there is a potentially stronger second wave, the consequences could be much more severe.

The Palestinian case demonstrates how pandemics can present political opportunities, including abuse of power by external forces, internal actors, and occupying powers. For example, COVID-19 did not stop, or even slow down, the US-sponsored Israeli plans for annexation of parts of the occupied West Bank. Neither did the pandemic halt the daily manifestations of the occupation, including Israeli army incursions, house demolitions and arbitrary arrests of Palestinians. Furthermore, despite some hopes, COVID-19 did not bring the two main political parties – Fatah and Hamas – any closer to national reconciliation.

As of late June 2020, the COVID-19 outbreak in Palestine has been mild, although the impacts of the second wave are yet to be seen. However, the reactions to the pandemic illustrate that inequality in Palestine-Israel is inherently political and directly reflects the overall power imbalances. As illustrated by the infections brought back by Palestinian workers from Israel and the settlements, Israel serves as a regime of comorbidity;[20] in other words, not only does it exacerbate the conditions that increase Palestinians' susceptibility to infection, it is also directly responsible for those conditions. ■

Notes

1. Due to the scope of this brief, Palestinian refugees in exile and Palestinian citizens of Israel, although an inseparable part of the Palestinian people, will not be discussed.
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THE CENTRE

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