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**Submission to the Committee on Economic, Social and Cultural Rights, 66th Session, 2019**

**Response to Israel’s Reply to the UN-CESCR`s List of Issues**

**Violations of the Right to Health in Israel and the Occupied Palestinian Territories**

**Submitted by:** Physicians for Human Rights Israel

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**Aims and Objectives of this Report:**

This submission illuminates Israel's insufficient protection and violation of the right to health, under international human rights law and international humanitarian law. Specifically, the right to health has been obstructed with respect to several groups: (1) Groups from the peripheral areas of Israel who experience disparities in health services 2) Soldiers, prisoners and others who undergo insufficiently regulated clinical trials 3) Undocumented migrant children 4) particularly vulnerable groups of patients from Gaza, including women and children.

**About Physicians for Human Rights Israel (PHRI):**

PHRI stands at the forefront of the struggle for human rights—the right to health in particular—in Israel and the occupied Palestinian territory. Founded in 1988 by a group of Israeli physicians, PHRI works to promote a just society where the right to health is granted equally to all people under Israel’s responsibility.

**Responses to List of Issues, listed under Article 12:**

**Question 28 (a) investment in public health system, (b) access to quality care for all, including disadvantaged communities**

1. A lack of government investment in Israel’s health system has resulted in an overall deterioration in the medical system and increased inequalities in the provision of care. Between 2000 and 2017, the percentage of current national expenditure on health out of Israel’s GDP increased only 0.4%, despite population growth, compared with an OECD average of 1.7% for the equivalent time period.The Israeli health tax is also very low, compared to the OECD, standing at 7.4 compared to 8.9%.[[1]](#footnote-0)

2. This stagnation in the healthcare budget is visible across the health sector, in e.g. the availability of critical medical equipment, such as MRI’s, which - at 4.9 per million - is one of the lowest in the OECD, which has a 15.8 average in the OECD. The number of hospital beds per 1000 people stands at 1.75, compared with the OECD average of 3.6 . A lack of medical personnel is reflected in waiting times, with, for example, a median waiting time of 31 days for an endocrinologist in 2010 and 90 days in 2018.[[2]](#footnote-1)

3. The overload on the medical system has a direct impact on the well-being of patients, with, e.g. hospital-acquired infections as the third most common cause of death as of 2015. The overload ultimately results in a mortality rate of over 40 per 100,000 and continuing disparities between different geographical areas and population groups in health outcomes.[[3]](#footnote-2) As a result of the quick rate of population growth in Israel, further deterioration will inevitably occur if the current expenditure on health remain.

4. Although Israel’s Response to the List of Issues notes that Israel has, e.g. invested 900 million in medical operations in the public sector, the impact of this investment has been unclear. In reality, more than 60% of these funds have gone to private institutions instead of public hospitals, due to a capping of the number of operations carried out in the public sector.[[4]](#footnote-3)

5. The health system requires a much more significant investment than has taken place thus far. An analysis by PHRI noted that an incremental investment of 14 billion NIS ($3.9 billion) is required over 8 years solely to prevent further deterioration and address the health needs of the population. Similar figures across other timelines were confirmed by reports of other civil society organizations.[[5]](#footnote-4) The Ministry of Health has echoed the call, with a May 2019 report by the Administration for Strategic and Economic Planning arguing that Israel’s Ministry of Health has not properly accounted for Israel’s increase in population and the concurrent need for additional investment.[[6]](#footnote-5)

**Question 28 (b) access to quality care for all in the context of privatization**

6. Israel has attempted to compensate for insufficient expenditure on health through placing the burden on the citizen to pay privately through additional health services. These, which are in the form of supplementary insurance policies provided by Israel’s Health Maintenance Organizations (HMO’s), have increased sharply in recent years. In 2005, 1.6 billion NIS were spent on supplementary insurance policies, rising to 4.6 billion in 2017.[[7]](#footnote-6) Certain treatments are only covered if you purchase the supplementary insurance policies.

7. This reliance on supplementary insurance policies enables quality medical care for those who can afford it, in contradiction to the intention of the 1994 National Health Insurance Law, which determined that health services will be based on the principle of equality. In 2016, 77% of the population had supplementary insurance coverage, yet only 58% of the population in the periphery of Israel, which are the poorer areas, where most of the Bedouin and Palestinian-Israeli populations live.[[8]](#footnote-7) Private citizens who cannot afford to pay supplementary insurance policies are required to use the public healthcare system, with long waiting time and implications for health outcomes.

8. Efforts to end this outsourcing to private care and ensure accessible and affordable healthcare for all have been minimal. Israel, for example, cites the Cooling Period Law in its Report— where a set time must pass before doctors can transition to the private sector—as one of the ways in which it has tried to minimize supplementary insurance policies, yet this law is insufficient in light of the extensive nature of the problem.[[9]](#footnote-8)

**Question 28(c) addressal of disparities in enjoyment of right to health**

9. The impact of the lack of government investment, combined with reliance on supplementary insurance, is seen most strongly in peripheral areas, namely the North and South where most of the Bedouin and Palestinian-Israeli populations live.

10. Data available demonstrates that investment in the health system in the center of Israel has been prioritized over the periphery. For example, the South of Israel, with 1.24 million residents, has 1,938 hospital beds, while the Tel Aviv district, with 1.39 million inhabitants, has 3,373 hospital beds.[[10]](#footnote-9) According to MOH figures, the South has 52 rehabilitation beds, compared to 267 in Tel Aviv.[[11]](#footnote-10) Lack of infrastructure causes delays in treatments and requires traveling significant distances for hospital admission, with inevitable separation from family members who can accompany patients, thereby impeding the recovery process. In 2014, the government committed to building another hospital in the South (specifically in Beer Sheva) by 2025, upon the recommendation of a governmental committee.

11. Recently, the State Comptroller’s report criticized the delay in the establishment of the hospital and noted that the “Ministry of Finance and Ministry of Health have not yet determined the operating model of the hospital nor the budgetary framework”.[[12]](#footnote-11) In April 2019, PHRI, together with municipalities, organizations and individuals presented a petition to the High Court of Justice, requesting that the aforementioned Ministries publish a tender, set a budget and establish a timeline for the building of the hospital.

12. Although the 1994 Health Insurance Law stipulates that health services must be given in a reasonable manner, no set standards have been established, enabling these massive gaps between the periphery and center of Israel. PHRI previously petitioned the Ministry of Health in 2008 to ensure set standards for hospital beds in rehabilitation units, and although this has been established, an overall standardization of health services - specifically in terms of waiting time and distance to travel - is yet to be established. Only following our High Court of Justice petition did the government establish the Standardization Committee in the last few months to set standards, but the Committee has not yet published its conclusions.

13. In response to pressure regarding disparities in investment in health services, in 2010 the MOH amended the formula that determines the budget that the HMO’s receive so that it will include an additional budget for those live away from population centers in order to better cover the investment and expenses of the HMOs. However, lack of transparency by the HMO means that it is unclear whether these funds were actually spent by the HMO’s in the periphery.

14. A request by PHRI and others in August 2017 for specific details on this budgetary expenditure has been ignored, with the MOH responding that they do not have these details and that we must appeal to the HMO’s. In response to Freedom of Information requests by PHRI, the MHO’s were unwilling to provide the necessary info, with 2 out of the 4 not responding and 1 refusing to provide the information requested due to claims of “trade secrets”.[[13]](#footnote-12)

*Recommendations:*

* *Prevent further deterioration of the health system through increasing budgetary allocation to the public healthcare sector.*
* *Provide a timeline for the cancellation of supplementary insurance policies and provision of treatments currently covered by them inside the public health basket.*
* *Enable quality, accessible medical care for all, including those in peripheral areas, through budget allocations and concrete timelines for establishment of the hospital in the South (Beer Sheva ), while placing parameters for transparency in the allocation of funds by the HMO’s to the peripheral areas.*

**Question 28 (e), implementation of recommendations MOH Committee on Racism**

15. Although the MOH’s Committee on the Elimination of Racism, Discrimination and Exclusion has been established and has acknowledged presence of racism in health system, it’s mandate—and therefore impact—has remained unclear. There are almost no mechanisms of enforcement by the MOH, making accountability by government institutions and health professionals extremely unlikely. Israel, in it’s Report in response to the List of Issues, has noted that an Ombudsman has been appointed, but the extent of their powers are undefined and not equivalent to an enforcement mechanisms, specific timetables and a clear means of holding hospitals and health professionals accountable.[[14]](#footnote-13)

*Recommendations:*

* *Ensure the MOH’s Committee on the Elimination of Racism, Discrimination and Exclusion has a clear mechanism and timetable for investigation and enforcement.*

**Question 28 (f) access of children to medical treatment, regardless of legal status**

16. There are currently approximately 10,000 non-resident children living in Israel, out of which approximately 7000 are children of African asylum seekers, mainly from Eritrea and Sudan, that are protected from expulsion to their country of origin despite not receiving refugee status. The remaining, approximately 3,000 children, are children of migrant workers and of undocumented migrants.[[15]](#footnote-14)

17. In 2001 the MOH devised a health insurance program available through an Agreement with the “Meuhedet” Health Fund to all non-resident children. Children covered under this Agreement (hereafter: the “Meuhedet Agreement”) could receive medical services that are almost identical to those provided under the National Health Insurance Law (NHIL) for a monthly fee. The Meuhedet Agreement, as noted in the MOH’s 2001 Circular regarding its establishment, had been intended to align Israel’s policy with the Convention of the Rights of the Child.[[16]](#footnote-15)

18. In September 2018, the MOH began excluding children of undocumented migrants from the Meuhedet Agreement, presumably using this withdrawl of government subdizied insurance as a political tool to pressure their parents to leave the country. Those affected include children of undocumented migrant workers, of tourists whose visa has ended and of asylum seekers whose request for asylum has been denied.[[17]](#footnote-16)

19. Undocumented migrant newborns and children who were previously enrolled but whose parents had paused payment on the insurance program available through Meuhedet will now, as a result of being excluded, not be able to secure medical treatment. Their only real option is to wait until their situation deteriorates to that of a medical emergency, at which point they are legally entitled to access emergency care, as per the Patient Rights Law. Since 2018 more than 20 families - including parents of newborns - have reached out to PHRI requesting assistance, after they could not register their children under the Meuhedet Agreement. This is not a reflection of the total number of children impacted, but represent the tip of the iceberg.

20. The MOH’s reversal of policy was explicitly ignored in Israel’s Fourth Periodic Report, which was submitted to the Committee in July 2018.This report only noted that “the MOH signed an agreement with the Meuhedet Health Fund for the provision of the full range of health services (with the exception of health services provided abroad) to minors resident in Israel without civil status….Since the renewal of the agreement, there has been a steady increase in the enrolment of previously uninsured minors.”[[18]](#footnote-17) Yet in correspondence with PHRI prior to Israel’s submission of the State Report, the MOH clearly admitted that certain undocumented migrant children would no longer be eligible under the Meuhedet Agreement.[[19]](#footnote-18)

21. No appropriate alternatives exist to the Meuhedet Agreement, as tourist insurance policies - the only alternative available for children who can no longer register under the Meuhedet Agreement - exclude child development services, as well as care of pre-existing conditions, rehabilitation or mental health. Tourist insurance policies are also subject to frequent renewals which posit risk for continuity of coverage, and care. Lastly, their cost renders them unaffordable and therefore inaccessible to many in the community.

22. The health consequences of denial of access to appropriate medical care are clear and in the case of newborns and young children, particularly dangerous. Moreover, this new policy compounds the other social determinants of health, such as poverty, fear of detention and deportation, and poor housing, all of which negatively affect health in multiple ways.

23. The Israeli Medical Association has expressed its intention to join PHRI’s petition to the High Court of Justice to challenge the denial of medical care to undocument migrant children.[[20]](#footnote-19)

Recommendations:

* Reverse the current policy and ensure that all children - regardless of their legal status - have access to appropriate medical care and services when needed.

**Question 28 (h) clinical trials on human beings**

24. No advancement has taken place in amending the legal loophole which exists regarding human trials that are not conducted in hospitals, a definition which excludes soldiers, prisons, private corporations and others.[[21]](#footnote-20) Clinical trials are not regulated in primary legislation but by the outdated Public Health Ordinance 1940 and the 1980 Public Health Regulations.[[22]](#footnote-21) As a result, trials take place despite a lack of monitoring and control mechanisms, and without any legislative protections. This situation enabled the unethical trial (1998-2006) on hundreds of soldiers for a vaccination for anthrax, which had serious implications for hundreds of soldiers.[[23]](#footnote-22)

25. Although proposals to rectify this dangerous situation have been discussed in the Knesset since 2007, the MOH has not yet given it’s input to these proposals, blocking any transformation of proposals into government-initiated legislation.[[24]](#footnote-23) Although the government noted that it wants to turn one proposal by a Member of Knesset into government-initiated legislation, the Ministry of Health (MOH) has yet to provide its input, thereby blocking any development. This footdragging has received intense criticism in Knesset discussions.

Recommendations:

● *Ensure the MOH supports and advances legislation governing all human trials, including through giving input on proposed legislation. Special attention must be given to the protection of vulnerable populations including soldiers, asylum seekers and prisoners.*

● *Ensure the authorities ban unregulated human trials until they are brought under the aforementioned legislation.*

**Question 29, access to medical treatment of patients from Gaza**

26. Although the 1995 Interim Agreement transferred responsibility for health services to the Palestinian Authority (PA) the fragmentation between Gaza, the West Bank and East Jerusalem and the control Israel imposes on freedom of movement of patients, medical equipment and medications and healthcare personnel prevents the PA from creating a well-functioning healthcare system. As many treatments are unavailable in Gaza and as specialist hospitals are found in East Jerusalem, patients must receive a medical exit permit from the Coordinator of Government Activities in the Territories (COGAT) and Israeli Security Agency (ISA) to cross checkpoints and access treatments that cannot be found locally.The majority of patients those seeking PHRI intervention with permit refusals or delays come from Gaza. PHRI collects data on trends regarding these requests for assistance.

27. PHRI observations from recent years highlight that Israeli authorities consistently and increasingly prevent patients from reaching their medical appointments, either through outright denials of medical exit permits, or lack of a timely response, which has the same impact as a denial in terms of blocking patients from accessing hospitals. In 2018, 265 patients appealed to PHRI after their request for a medical exit permit was denied or not given a final answer for a significant period of time, from several weeks and months and over a year. This is contrary to COGAT’s own directives, which as of October 2017 state that permit responses will be received within 23 days.[[25]](#footnote-24) In 2018, PHRI succeeded in ensuring 52% of the patients who requested our assistance for a medical exit permit received the permit, highlighting the arbitrary nature of Israel’s initial response to these patients’ requests.

28. These obstructions of access to treatment are confirmed by statistics collected by the World Health Organization (WHO). In 2012, 92% of patients from Gaza received a permit in time for their hospital appointment, a figure that went down to 54% in 2017, the lowest since 2006. 2018 and 2019 have seen only a small rise in the number of medical exit permits given.

29. These denials of access have an increasingly deleterious impact on patient health as Gaza’s healthcare system continues to deteriorate following the Great March of Return and patient overload. As per the WHO’s report for May 2019, the PA made 3,348 referrals for Gaza patients to leave the Strip for treatment which was not available locally, the highest number ever in one month.[[26]](#footnote-25)

30. Particularly vulnerable groupings are impacted by Israel’s medical exit permit policies. In the past 2 years, from 2017-2018, PHRI has assisted 251 female patients who received a negative response for their medical exit permit requests. A detailed analysis of their cases demonstrates that Israel does not take gender implications of medical exit permit policies into account, contrary to various UN Resolutions, thereby impacting women’s health.

 31. Of these women, 129 women were cancer patients. Delays in responding to their medical exit permit requests have potentially lethal consequences. In 2017, the WHO reported that 54 patients died while waiting to receive security permits, including 46 cancer patients. Only after media exposure, legal advocacy and outreach to COGAT from Israeli civil society organizations such as “1 out of 9” and the “Israel Cancer Association” were their permits reversed. PHRI ultimately succeeded to have every single one of the 129 permit decisions reversed, demonstrating the arbitrary reasons for the initial response and refusal of the Israeli authorities.

32. Women have also been disproportionately impacted by specific criteria according to which medical exit permit denials have been made. In mid 2018, 13 patients reached out to PHRI and al Mezan Center for Human Rights (In Gaza), including several women, after they were denied medical exit permits on the basis of “ family proximity to Hamas”. The specific meaning of this term is unclear, with some patients protesting that they did not have Hamas members in their family. Freedom of information requests by PHRI revealed not only that a dramatic increase occurred in the use of this criterion in 2018, but that it was used twice as often to deny women access to treatment. In 2017–18, 969 patients were denied on the basis of this criterion, of whom 608 were women. PHRI, together with other organisations, successfully appealed to the High Court of Justice to overturn the use of this criterion on behalf of five female patients with cancer. Since then, no female patients have reached out to PHRI after they were denied on the basis of “family proximity to Hamas”, although at least three patient denied on this criteria was later denied on the basis of other criteria.

33. Patients who need to leave Gaza for medical treatment are entitled to an accompanier, with, since 2018, a specific accompanier permit available for parents.[[27]](#footnote-26) The presence of an accompanier is especially important in the case of children, for whom parental presence can have an impact on medical recovery, while the reverse - needing to undertake a medical procedure without their parents - can have negative medical consequences on recovery speed and a lasting psychological impact. Since 2018, PHRI has received requests from 39 parents whose request to accompany their children for medical treatment were either refused or left unanswered. Their children therefore underwent critical medical procedures without their parents at their side. These children were aged from 4 months to 18 years, including breastfeeding babies.

34. The medical impact of separating children from their parents has been documented. During conversations with PHRI, staff at East Jerusalem hospitals noted that toddlers and young children separated from their parents refused to eat and interact with their environment, repeatedly asking for their parents. Indeed, childhood trauma created by separation from parents has been widely noted in medical literature. Separation threatens the attachment bond, which is critical to a child’s inherent sense of protection and security and drives the brain development foundational for subsequent physical, emotional, social and cognitive maturation. When parents are removed from a child’s life suddenly and without adequate support, childhood trauma can ensue through dramatically increased stress hormones, which risks becoming toxic, activating inflammatory and immune changes, considered to be a response to the increased risk of physical injury and healing required in situations of danger. Such processes drive the long term development of disease and disorder, while short-term impact includes chest pains, vomiting and significantly increased anxiety.[[28]](#footnote-27)

35. In 2018, from February - October, as per the Ministry of Defense’s response to a freedom of information request by PHRI, 60% of medical exit permits for children for Gaza were not accompanied by exit permits for their parents. That is, 1,859 permits were given to parents to children, while 4,581 medical exit permits were given to children, indicating that the majority left Gaza for medical treatment absent their primary caregivers.

36.These children were forced to undergo medical procedures - from diagnosis to surgery and chemotherapy - without their parents. Instead, other relatives attended instead of their parents, including grandparents and aunts or even strangers. For example, among those reaching out to PHRI were the parents of a 3.5 year old who was hospitalized for 43 days with only his grandmother present, due to accompanier exit permit refusals for his mother.

37. In several cases, as a result of lack of available replacement accompaniers or the parents’ need to accompany the children, the children missed important treatments, such as heart surgery, until PHRI interevened. Treatment in some cases was delayed up to several months as a result of lack of permits given to accompaniers.

38. PHRI’s success in overturning the permit decisions made by the army for parents accompanying children testifies to the arbitrariness of permit refusal. Out of the 39 cases that PHRI received since the beginning of 2018, PHRI succeeded in overturning at least 30 permit decisions, demonstrating the random, irrational and unjustified nature of these refusals

39. The List of Issues (LOI) published in 2019 *requested that Israel “provide information on the steps taken to ensure that patients seeking healthcare services outside the Gaza Strip get timely medical treatments, including data on the number of applications for an exit permit and of permits rejected during the reporting period as well as the main reasons for the rejections. “* Israel has not done so in it’s latest report. The Committee’s previous Concluding Observations, published in 2011, urged Israel “*to ensure unrestricted access to health facilities, goods and services, including urgency treatment, for Palestinians living in the Occupied Palestinian Territory”*.[[29]](#footnote-28) Since then, rates of medical exit permit denials have only increased, with a grave impact on patients.

*Recommendations :*

* Abolish the current medical exit permit mechanism and allow all Palestinian inhabitants in need of medical treatment and their accompaniers access and free passage to the best medical treatment available to them, without any delay. This should be the case for all patients, including cancer patients.
* Carry out a comprehensive study on the effects of the blockade on women in Gaza, including on medical exit permit denials.
* Ensure all children needing to exit Gaza for medical treatment will be accompanied by at least one of their parents, whose requests for an accompanier permit must be confirmed prior to the child’s hospital appointment, so as not to cause delay of treatment.

1. Central Bureau of Statistics, August 2018 (Hebrew).<https://goo.gl/R27HwP>, p.5 [↑](#footnote-ref-0)
2. Some, therefore, wait significantly longer times. [https://www.ynet.co.il/articles/0,7340,L-5254370,00.htm/](https://www.ynet.co.il/articles/0%2C7340%2CL-5254370%2C00.html) [↑](#footnote-ref-1)
3. In comparison, Greece, which has the second highest hospital-acquired infection rate in the OECD, has 24 deaths per 100,000, as per 2017 data of the Central Bureau of Statistics, (Hebrew) <https://goo.gl/XhWXpu>,p.9. [↑](#footnote-ref-2)
4. Hila Weissberg. Hospital Directors against Reform in Waiting List: A Disastrous Plan for the Public System – Prioritizes Private Centers. Globes. October 10, 2018. <https://www.globes.co.il/news/article.aspx?did=1001255743> [↑](#footnote-ref-3)
5. These organizations include “5 Billion for Health”, a grouping of civil society organizations, including PHRI, which request the injection of 5 billion NIS immediately into the health budget. [↑](#footnote-ref-4)
6. “Updating the Cost of the Health Basket – a Fixed Mechanism Proposal", Administration for Strategic and Economic Planning, Ministry of Health. [↑](#footnote-ref-5)
7. Central Bureau of Statistics, p. 2. [↑](#footnote-ref-6)
8. MOH Committee for Examination of the Supplementary Health Service Plans of the HMOs, Steering Committee No. 1 - Background on the activities of the Supplementary Health Service Plans, page 19. <https://goo.gl/SwxxHV> [↑](#footnote-ref-7)
9. UN Committee on Economic, Social and Cultural Rights (CESCR). *Responses to the list of issues in relation to the fourth periodic report of Israel, Addendum*, *paragraph 144*, 15 August 2019, CESCR, E/C.12/ISR/Q/4/Add.1, available at: https://tbinternet.ohchr.org/\_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT%2fCESCR%2fARL%2fISR%2f35805&Lang=en [accessed 20 August 2019]. [↑](#footnote-ref-8)
10. MOH publication, Hospital Beds and Licensing, January 2018 (Hebrew). <https://goo.gl/8WBNsY>, p.8 [↑](#footnote-ref-9)
11. Following a petition to the High Court of Justice by PHRI and other organizations in 2016, the MOH committed to increasing the overall number of beds across Israel, with priority for North and South. However, in their response, it was clear that these changes will still leave significant gaps between the periphery and the center. [↑](#footnote-ref-10)
12. Ido Efrati. Ministry of Health is not Sufficiently Prepared for Aging of Population. Haaretz. May 6, 2010. <https://www.haaretz.co.il/news/mevaker/.premium-1.7208999> [accessed 14 August 2019] [↑](#footnote-ref-11)
13. Letter from Maccabi to PHRI (13 May 2018), on file with PHRI. [↑](#footnote-ref-12)
14. Israel, in it’s Response to the LOI, noted that lectures have begun to take place in nursing schools. These, however, represent only a fraction of academic frameworks for health professionals. [↑](#footnote-ref-13)
15. Letter, Population and Immigration Authority letter, July 2019. On file with PHRI. [↑](#footnote-ref-14)
16. Circular of the Director General, Ministry of Health, March 15, 2016 <https://www.health.gov.il/hozer/mk05_2016.pdf> (accessed April 2019). [↑](#footnote-ref-15)
17. Eritrean and Sudanese children, who live in Israel have received a conditional release visa and are therefore currently not excluded from the Meuhedet Agreement. [↑](#footnote-ref-16)
18. Fourth Periodic Report submitted by Israel, E/C.12/ISR/4, 14 January 2019. [↑](#footnote-ref-17)
19. Letter, MOH, received 6th of January 2019, on file with PHRI [↑](#footnote-ref-18)
20. The petition will be heard on December 23rd 2019. [↑](#footnote-ref-19)
21. Under customary international law everyone has the right to health and integrity of their body, placing a severe prohibition of medical experiments, except in cases of informed consent. [↑](#footnote-ref-20)
22. In it’s Response to the List of Issues, Israel cites the 1999 Amendment to the Nation’s Health Regulations, yet this applied only to genetic experiments. General regulations regarding clinical trials have not been amended since 1980. [↑](#footnote-ref-21)
23. Sfard, Michael, 2016. Anthrax Experiment - Omer 2 - Failures in Legal Regulation.<https://goo.gl/uNA9iR> [↑](#footnote-ref-22)
24. This issue was raised in various Committees since 2007 and legislation was proposed in June 2016. [↑](#footnote-ref-23)
25. Processing permit applications by Palestinian residents of the Gaza Strip , Gaza Civil Liasion Administration, available at <https://www.gisha.org/UserFiles/File/LegalDocuments/procedures/general/200en.pdf>, accessed August 2019. [↑](#footnote-ref-24)
26. Health Access for Referral Patients from Gaza Strip. WHO Report, May 2019. <http://www.emro.who.int/images/stories/palestine/documents/May2019-Monthly_report.pdf?ua=1> [↑](#footnote-ref-25)
27. http://www.cogat.mod.gov.il/he/services/Procedure/%D7%A1%D7%98%D7%98%D7%95%D7%A1%20%D7%94%D7%A8%D7%A9%D7%90%D7%95%D7%AA.pdf [↑](#footnote-ref-26)
28. Wood LCN, Impact of punitive immigration policies, parent-child separation and child detention on the mental health and development of children. *BMJ Paediatr Open.* 2018; 2: e000338-e [↑](#footnote-ref-27)
29. UN Committee on Economic, Social and Cultural Rights (CESCR), *Consideration of reports submitted by States parties under articles 16 and 17 of the Covenant : concluding observations of the Committee on Economic, Social and Cultural Rights : Israel*, 16 December 2011, E/C.12/ISR/CO/3, available at: https://www.refworld.org/docid/52d65ec64.html [↑](#footnote-ref-28)