"Disturbing Distortions":

A Response to the Report of the Ministry of Health of Israel to the Thirty-Sixth World Health Assembly on Health and Health Services in the Occupied Territories, Geneva, May 1983

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1. Introduction

During the past fifteen years, numerous reports on the health conditions and health services in the Israeli-occupied West Bank and Gaza Strip have been published by the Israeli military government and the Ministry of Health of Israel. One main feature characterises nearly all these publications, and that is the attempt to present an apologia for health conditions and practices under military occupation. Recently, however, authors of such reports have gone a step further. Utilising World Health Organization jargon and referring to social, economic, educational, community, and environmental infrastructural conditions, they now attempt to create the impression that military occupation is beneficial for the "physical, mental and social well-being" of people (the definition of health).

It is the purpose of this report to examine some of these allegations and show that the data base utilised to construct such arguments is defective and represents a misinterpretation of reality. Ultimately, with a political motive in mind, the official Israeli authors intend to distort instead of increase our understanding of the reality of health and life under military occupation. It is also the purpose of this report to show that health conditions under occupation, in contradiction with the military government's allegations, are inadequate, and that military occupation represents a system of control that impedes the natural growth and development of health care services, as of almost every sphere of life, and is, therefore, actually harmful to people's health.

Table 1. Basic Health Indices: the West Bank

	1968	1974	1980	1981
Population (thousands)	581.7	661.6	703.1	723.8
Birth rate (per 1,000 population)	44.0	45.5	43.7	44.3
Crude death rate (per 1,000 population)	4.8	5.3	5.5	5.6
Infant mortality rate (per 1,000 live births)	33.6	30.7	28.3	29.1
Hospital deliveries (per cent of total)	13.5	30.0	44.8	43.6
Hospital beds (total general per 1,000 population)	1.51	1.41	1.45	1.44
Hospital utilisation discharges (per 1,000 population)	68.3	70.4	91.6	88.9
Days of care (per 1,000 population)	543.1	577.2	560.0	542.0
Community clinics (governmental) (MCH* and general medical)	113	149	211	223
Physicians in government services (per 10,000 population)	1.8	1.7	2.5	2.5
Physicians (government and non-government) (per 10,000 population)	N/A**	N/A	6.2	6.2
Nurses and paramedical staff in government services (per 10,000 population)	5.6	9.0	11.3	11.0

Source: State of Israel, Ministry of Health (1).
* Maternal and child health care
** Not available

2. Infant Mortality Rate

It should be stated at the onset that infant mortality figures which have been published by either Israeli or Palestinian sources represent only estimates of reality. The reason is simply that birth and death registration in the Occupied Territories is incomplete and defective. This fact is well-known and accepted even by those working within the military government's health apparatus and the Israeli Central Bureau of Statistics (2).

The military government places the infant mortality rate for the West Bank, for instance, for the period 1968 to 1982 within a range of 33.6 to 29.1 deaths per 1,000 live births (Table 1). Knowing fully well that these figures, derived from reported cases, represent a substantial underestimation of the problem, the author of the ministerial report proceeds to state:

> The reported Infant Mortality Rate of 29.1 per 1,000 live births in Judaea and Samaria in 1981 and 41.3 per 1,000 live births in Gaza in 1982 are now within the limits defined by WHO as "low infant mortality rate" (3).

Thus the author concludes that there is no problem with infant mortality and, therefore, seems to absolve himself and the military government from the responsibility of improving the situation.

If one examines Israeli sources of data, one is generally left with a feeling of surprise at how such sources contradict each other. What is also interesting is the fact that different sections within the same report seem to contradict each other. Contrast, for example, the paragraph just quoted and the following one:

> Inadequacies in the preexisting reporting system have necessitated a continuing process of development for the gathering of general and specific statistical and demographic data. This is an essential and still problematic requisite for monitoring changes in health status and for planning future program needs (4).

If the reporting system still poses a problem, it follows that the infant mortality figures quoted in the previous paragraph are also problematic. The latter paragraph then contradicts the conclusions of the former.

Other Israeli researchers have attempted to arrive at more realistic estimates. A group from the Israeli Central Bureau of Statistics conducted a survey of births and deaths in the

Occupied Territories in 1975, followed by a field check of the results of the survey. As a result of the survey, an infant mortality rate for the West Bank was estimated at 43-47 deaths per 1,000 live births. Their field check, however, revealed an infant mortality rate of 82, and the authors thus concluded that the results of the survey were impossibly low (5).

These conclusions seem to be compatible with the figures that Palestinian researchers and health professionals quote. Not being able to conduct total surveys for political and infrastructural reasons, Palestinian researchers have resorted to studying prototype populations in the various regions of the country. They estimate the infant mortality rate of the West Bank to be in the range of 50-100 deaths per 1,000 live births (6). The results of the Israeli Central Bureau of Statistics' study are significant for two reasons: First, they confirm the Palestinian point of view that health conditions under military occupation, as reflected by the high infant mortality rate, are inadequate; secondly, they demonstrate the great discrepancy between figures published by the military government and reality, and thus reveal the political motives that lie behind an apologia such as the one discussed in this presentation.

3. Health Services

The ministerial report on health in the Occupied Territories summarises the military government's health policy by stating that:

> ... efforts have been made to improve and strengthen a local health care system that is maintained and operated locally, thereby improving the health of the indigenous population (7).

Contrary to the statement above, Table 1 confirms the view that no significant change has occurred in health and health services since 1968. Both the crude death rate and the infant mortality rate reflect a more or less stable pattern of death. The number of hospital beds per 1,000 population has also remained essentially unchanged throughout the period, and so has hospital utilisation. The number of clinics and mother and child health centres has increased since 1968. Not present in Table 1, however, is the illuminating fact that the number of visits to such centres has actually declined dramatically since 1968 (from almost 120,000 to less than 70,000). In 1980, of all the notified births, only 16% occurred at government clinics (8). These figures are derived from data published by the military government and seem to be particularly significant because these trends are observed in spite of the increase in the number of clinics, and in spite of a 24% population growth (9). Thus we must ask why such a pattern of increasing service and decreasing utilisation would emerge.

The answer is clear to most Palestinian health professionals and patients alike. Despite the jargon, despite the apparent quantitative "improvements", health care provided by the military government's health services remains quite inadequate. Clinic physicians work on average 6 hours per week and treat about 4,000 patients per year, which means that they spend less than five minutes with each patient. Facilities are lacking for the treatment of many diagnosed diseases (10). Even simple diagnostic tools and medications are lacking much of the time (11). In short, health services provided by the military government fail to fulfil people's basic health needs.

A quick look at the military government's health budget indicates that improvements and strengthening of the health facilities that existed before 1967 are unlikely to have occurred because of, among other factors, budgetary restrictions. Budgetary appropriations for health are known to be insufficient to even maintain health facilities at a level that existed prior to military occupation. The West Bank medical services budget (both

hospital and public health) for 1975, for instance, was equivalent to about 60% of the budget of one Israeli hospital alone for the same year (12). Adding insult to injury, this already insufficient budget is being reduced yearly. The health budget for 1978 was 12% less than in 1977, that of 1979 8% less than that of 1978, and that of 1980 6% less than that of 1979. In addition, it is known that about 30% of the Occupied Territories' health budget is paid to Israeli hospitals (13), which would not be the case were it not for the lack of interest on the part of the military government in maintaining adequate health services.

Table 2. Estimated Monthly Salaries (Israeli Shekels) for Government Health Employees (1982) in Jordan and the West Bank

	West Bank	Jordan
Specialist	14,000	22,000
Generalist	12,000	22,000
Staff Nurse	9,000	16,000
General Nurse	6,000	9,000
Aids	5,000	7,500
Cleaners	4,500	6,000

Source: Ishaq, J. and Smith, C. (14).

Inadequate budgets also reflect negatively on the quality of medical staff employed by the military government's health services (Table 2). It is well-known by now that low pay in combination with the lack of proper equipment and facilities are major reasons that push qualified Palestinian health professionals to seek employment outside the Occupied Territories. This, in effect, leaves the less qualified, and sometimes the unqualified, in key positions at government health services, which thus further reduces the quality of care provided.

It should be born in mind that budgetary restrictions of the sort described for health services apply to virtually all other services in the Occupied Territories. Benvenisti (15) found that the military government's civilian budget in 1980 was 1.7% of the total civilian budget of the State of Israel, and 0.01% of the GNP of the West Bank. He concludes his report as follows:

> Available data show a very low level of services and almost no governmental investments in infrastructure and development, either by the central military government or through Arab local councils (16).

As for health insurance, the ministerial report on health claims:

> In Judaea, Samaria and Gaza voluntary health insurance plans have been established over the past several years with quite high participation rates. A health insurance premium is charged for each family (17).

The above statement is an example of the half-truths intended for the distortion of reality, namely for the following reason: prior to 1967, no system of health insurance existed under the Jordanian regime. Instead, a system of fee for service was used, with heavy subsidy. Thus, for instance, a one-night-stay at the hospital would cost the patient approximately US$ 0.3, generally affordable by the majority of people. This fee was normally waived by hospital directors in hardship cases. Today, following the institution of the health insurance scheme by the military government, only about 40% of the population are enrolled. Most of them are government employees or workers in Israeli companies for whom subscription is compulsory. As for the rest of the population, it is understood that the lack of trust combined with poor facilities and poor quality care are major causes for the unwillingness to voluntarily join the scheme. In addition, the cost of governmental hospital services has become prohibitively expensive; a single night stay, for instance, now costs about US$ 75 (18). Thus the health insurance scheme devised by the military government has in fact pushed governmental health care services beyond the reach of the majority of the population, and in particular beyond the reach of the poor and those who need health care services most. The scheme, in combination with low quality care, has also pushed the population into a behavioural pattern where people would only seek help late in the course of disease, and perhaps too late.

4. Incidence of Disease

Table. 3. Incidence of Selected Reported Infectious Diseases: the West Bank
(Number of cases per 100,000 population)

Disease	1970	1975	1977	1978	1979	1980	1981	1982
Diphtheria	0.3	0.8	0.4	0.4	0.9	2.7	0.1	0.1
Measles	56.3	51.6	26.2	33.5	45.9	10.2	73.2	137.8
Pertussis	4.0	12.2	1.6	1.3	2.3	1.6	0.7	0.8
Polio	3.3	3.2	2.5	1.9	0.3	3.4	0.1	0
Tetanus	2.3	3.5	2.8	2.0	4.1	2.3	3.2	1.5

Source: State of Israel, Ministry of Health (19).

If anything, Table 3 shows that there is no significant pattern of either increase or decrease in the incidence of diseases listed. It should be stressed, however, that the above figures represent only cases that have been reported. Because reporting is defective, these figures are not an accurate reflection of reality.

Other researchers, upon examination of the military government's health statistics, have concluded that most diseases have been reported at a fairly constant frequency between 1972 and 1980. They also conclude that the two most frequent diseases, respiratory and digestive, have not shown a decrease in the number of cases, and that the claim of improved nutritional levels is not supported by the data which show a constant reporting of deficiency diseases. They finally conclude that claims by the military government of improved reporting is not supported by the data which do not show an increase in the number of visits to clinics (20).

Indeed, field investigations of selected population groups support the argument that major causes of death and morbidity in the Occupied Territories today are malnutrition and infection, primarily respiratory and gastrointestinal, which are two preventable disease categories. It was found, for instance, that major causes of death among refugee populations in the West Bank

and Gaza during the 1975-1977 period were due to respiratory and gastrointestinal diseases (21). In another study of a Jordan Valley peasant community, it was found that over 50% of the children under the age of five were malnourished, with, again, major causes of death and morbidity being malnutrition and infection (22). Ramallah district villages, known for their relatively better socio-economic conditions, did not appear to have a significantly different health picture. An in-depth investigation there revealed that 30% of all children under three in three villages were infested with one or more parasites (an index of environmental contamination), 44% were malnourished, and 18% were anaemic (23). Though such results are not generalisable, they do indicate the presence and the persistence of major and simply preventable health problems, which the ministerial report seems to be oblivious to.

Regarding the relationship between nutrition and agriculture, the ministerial report declares:

> Increased agricultural production ... has been accompanied by increased purchasing power. This has resulted in a sufficient per capita energy availability and the increased ability of the population to purchase the available food (24).

Since 1968, a constant growth in the value of agricultural production has occurred as a result of, among other factors, increased mechanisation and the use of pesticides and fertilisers. There has also been a marked decrease of manpower employed in agriculture, with more and more of the workforce seeking employment in Israel. The point, however, is that today West Bank agriculture is dependent on Israel for agricultural techniques, machinery, fertilisers, and for the marketing of its produce. Moreover, land expropriation, Jewish settlement, and closure of areas for security purposes result in a shortage of vacant land for agricultural growth. This, coupled with Israeli control over water resources and its policy of rationing, makes further agricultural development impossible, and contributes to the abandonment of marginal agricultural land (25).

For several reasons, these changes can only be seen as ultimately having a negative impact on the nutritional status of the population: First, the increasing neglect of the land in conjunction with a growing proportion of the workforce seeking work in Israel as wage labourers is effecting a shift in the consumption pattern of food, from home-grown products to the coca cola, biscuit, and powdered milk variety (26). Secondly, further agricultural growth, which is necessary for improving the nutritional status of the population, is not possible as long as the State of Israel continues to be in control. Finally, the cost

paid for such changes, namely dependence, is deemed too high by Palestinians, particularly since such changes are subject to fluctuations dependent on the occupier's economy and its needs.

5. The Environment

The ministerial report states:

> In view of the preexisting problems of housing and sanitary conditions ... the continuous development of essential community sanitation infrastructure services are important factors in improved living and health conditions for the people based on rising expectations (27).

It also says:

> Environmental health program development has been a major commitment on the part of the authorities in the establishment of the necessary infrastructure of solid waste disposal systems, sewage systems, electrification, water purification systems ... (28).

Table 4. Home Services and Appliances: the West Bank
(Percentage of homes with services)

	1972	1974	1975	1978	1979	1981
Electricity	34.9	45.8	48.0	74.2	N/A	81.6
Electric fridge	13.8	22.6	27.5	35.8	41.3	51.5
Radio	74.9	79.9	84.6	79.2	79.4	80.2
Television	10.0	20.5	26.2	41.1	46.7	60.7
Bathtub or shower	28.2	40.7	N/A	N/A	N/A	92.3
Toilet	73.0	78.9	N/A	N/A	N/A	85.3
Electric or gas heater	N/A	8.3	10.8	16.0	17.0	N/A
Electric or gas range	23.9	32.7	43.0	65.5	72.8	75.3

Source: The State of Israel, Ministry of Health (29).

Table 5. Household Facilities by Selected Type of Localities: the West Bank
(Percentages)

	Total		Villages		Towns	
	1974	1981	1974	1981	1974	1981
Electric or gas range	N/A	74.6	N/A	69.0	N/A	87.4
Running water in dwelling	23.5	44.6	9.8	29.3	60.9	79.0
Tub or shower	17.0	28.6	7.8	20.3	44.0	49.2
Electricity around the clock	45.8	50.6	27.6	26.9	91.5	95.8

Source: Statistical Abstracts of Israel 1981 (30).

By comparing Tables 4 and 5, one can locate several discrepancies and omissions. For instance, the percentage of households with bathtub or shower is listed as 40.7 for 1974 and 92.3 for 1981 in Table 4. Table 5 lists ownership of tub or shower as 17 and 28.6 for 1974 and 1981 respectively. In Table 4, electricity (taken together for part of the day and around the clock) is listed as being present for 1981 in 81.6% of households, whereas Table 5 reveals that electricity around the clock (an important distinction to make) is available for only 50.6% of households. In villages (where 70% of the population live) electricity around the clock is available for only 26.9% of households. Similar discrepancies can be found by looking at electric or gas range figures.

But what is really significant, is that neither Table 4 nor any other section in the ministerial report provide us with figures on availability of potable water supply in households, so crucial for health. Those located in Table 5 indicate that only 44.6% of households in the West Bank are provided with running water in dwellings. The figure of 29.3% for villages is even more remarkable. Both sources, too, fail to state that none of the West Bank villages has a sewage system, while only two towns do.

Both Tables show a pattern of increasing ownership of household facilities important for health. These improvements, however, do not appear to be very significant, particularly given that they occurred over a period of fifteen years. Most Palestinians believe that such improvements have happened in spite of the military government, mainly through both the financial and technical assistance of local and international aid agencies. If anything, the military government is seen as a deterrent to progress, and as a system of manipulation and power that often utilises general and health services as an instrument of potential control. Ample evidence (testimonials) is available to support this statement, but it is beyond the scope of this presentation to provide a list of such allegations.

To illustrate the problem, however, the case of the village of Kobar shall be discussed. For about two years, the villagers of Kobar, in conjunction with Community Development Foundation (a US aid agency operating in the Occupied Territories) waited for military government approval to institute a piped water supply in the village. Neither a positive nor a negative response was given by the authorities throughout the period in spite of the fact that financial, technical and manpower resources for the project were to be provided by both the aid agency and the village community. That is, the project would not have cost the military government anything. Following a health status survey in the area, Birzeit University staff members attempted to obtain permission from the military government to at least connect the spring water (located at the end of a steep hill three miles down from the farthest house) through tubes and a pump to a tap to be installed within the village. This, it was thought, would at least facilitate the process of water collection and transport by women and children, and thus encourage women to upgrade their sanitation standards. The military government's response was:

> "You are not allowed to proceed with such a project because the spring water, even rain water, is the property of the State of Israel. But ... of course, you can seek help from the village league."

The military government then utilises basic services so as to impose on Palestinians a leadership that is totally rejected, deemed illegitimate and politically corrupt.

This example demonstrates the discrepancy between military government allegations and factual Israeli policy in the Occupied Territories. In the final analysis, Israeli policy calls for possessing the land without its people. And this, of course, is in contradiction with a policy allegedly aimed at improving services and infrastructure. Thus, any improvement should be placed in its political context and deemed only palliative, for

every other available evidence indicates that the military government aims at weakening Palestinian institutions and at paralysing the ability of Palestinians to maintain the infrastructure for the reconstruction of their society in the future.

6. Mental Health

The ministerial report states:

> Some people living in societies in the process of rapid change brought on by rapid economic growth, full employment and educational opportunities inevitably experience social stress and cultural conflict (31).

Thus the report places the blame for mental health problems in the Occupied Territories on rapid development, and it proceeds to look for solutions:

> The emphasis in the development of mental health services in Judaea, Samaria and Gaza has focussed on the establishment and expansion of improved outpatient and inpatient psychiatric services (32).

The military government opted for the "expansion" of services and for palliative treatment instead of eradicating one of the major causes of mental illness in the area today, namely military occupation itself.

Though no study has been conducted on the status of mental health of people under occupation (and we deem that negligence on the part of the military government's health apparatus), it is logical to assume that the incidence of anxiety and stress, among other diseases, may actually have risen dramatically since 1967. Land confiscation, control of water sources, demolition of houses, expulsions and deportations, imprisonment and torture, town and house arrest, restrictions on the freedom of movement, expression, and even thought, to name only a few precipitating factors, must be having their impact on the mental health of an occupied people. Indeed, testimonials from Palestinian health professionals do indicate that mental disease, particularly among prisoners and their families, constitutes a serious health problem in the area. The "schoolgirls' poisoning" in spring 1983 is a case in point. Though no firm proof has been obtained that the thousand or so cases were victims of toxicity, Palestinian health professionals who attended the cases believe that toxicity, at least at the onset, was responsible for the symptoms the schoolgirls suffered. They point to the fact that even Israeli soldiers who were patrolling areas in question at the time were affected by the same symptoms. Palestinian health professionals add, however, that a number of the cases were actually suffering symptoms due to psychological origins, within a background of anxiety and stress caused by the political reality. These conclusions are compatible with those reached by the team of experts from the Centers for Disease Control who were

invited by the State of Israel to investigate the episodes (33). A phenomenon such as this one demonstrates that military occupation with all its ramifications on daily life is a cause of mental disease. A real improvement in the mental health of Palestinians living under occupation entails the removal of the cause, and not the institution of curative services.

7. Socio-Economic Conditions

The ministerial report claims:

> Social and economic conditions, both major factors in the health of a population, have improved steadily in the past 16 years. Chronic unemployment and underemploymemt prior to 1967 in Judaea, Samaria and Gaza have been replaced by full employment (with about one percent of the labour force unemployed) and steadily increasing wage scales. This has resulted in the establishment of a cash economy which has increased local economic activity, employment potential, the standard of living and the gross national product. In addition, the free flow of labour and goods to and from Judaea and Samaria and Gaza into Israel, Jordan and other neighbouring countries has greatly increased the cash economy of these districts (34).

It appears that the employment situation has actually improved since 1967. In 1980, approximately 49% of the total active labour force of the West Bank worked in Israel. However, hourly wages of West Bank labourers employed in construction work, for instance, are 50-60% of the hourly wages of Jewish labourers of the same labour specifications. Benefits that Jewish workers are eligible for (pension, health insurance, and the like) are not granted to Palestinian Arab workers, who are not represented by labour unions, but by the government-run labour exchange officials who are indifferent to discrimination in work conditions for Palestinian Arabs. Most importantly, the opening-up of work opportunities for Palestinian Arabs in Israel has resulted in the transformation of Gaza, and to a lesser extent, the West Bank, into a labour camp completely dependent on Israel. In addition, the situation of full employment and relatively high income is only temporary in the sense that changes in the economic climate or political decisions may reverse the trend (35). Full employment also comes as a result of the emigration of particularly the young male population in search of work elsewhere. Surely, all of the above, including the resultant separation of families, cannot be beneficial to the "physical, social and mental well-being" of workers or their families.

As for the economy, Benvenisti summarises the situation in 1982 as follows:

> ... The economy of the West Bank may be characterized as underdevelopped, non-viable, stagnant and dependent. It is an auxiliary sector to both the Israeli and the Jordanian economies.

He adds:

> The benefits to Israel are substantial:
> a. It is a source of cheap unskilled labour.
> b. It is a protected market for industrial and consumer goods, which amount to 25 percent of all Israeli exports.
> c. It is used as a cheap subcontracting source of labour intensive products.

He further adds:

> ... The Israeli government has implemented deliberate policies to perpetuate the dependence of the West Bank economy ...

Benvenisti finally concludes:

> The West Bank economic situation is unbalanced, subservient and distorted. The total dependence on Israel (and on Jordan to a lesser degree), the lack of industrialization, credit and capital investment in production factors, prevent a balanced and viable growth (36).

Any improvements in socio-economic conditions of the Occupied Territories are seen as temporary, distorting, and ultimately harmful. Harmful, because today, due to a system of "internal colonialism", Palestinians have been turned into a pool of wage labourers, subject to continuous exploitation, and not in control of their own development and lives. Harmful, because Palestinians today have also been turned into a pool of consumers of Israeli and internationally manufactured goods. Harmful, because the deliberate policy of the Israeli government to weaken the Palestinian economy and institutions, including health services, and to reduce them to a situation of complete dependence on Israel, can only be seen in its most dangerous form, and that is as an attempt to stifle Palestinian efforts in resisting domination by other groups. And this attempt, we deem, is harmful to health.

8. Summary and Conclusions

To summarise, the claim that substantial improvemements in health and health services have been made in the Occupied Territories is not upheld either by data obtained from Palestinian or Israeli sources, or by information provided by the military government's health apparatus. At best, we can safely say that the health status of Palestinians living under Israeli military occupation has not changed significantly during the past 16 years. The infant mortality rate remains high, within a range of 50-100 deaths per 1,000 live births. Major causes of death and morbidity are still malnutrition and infection, services as reflected by budgets have remained at a standstill in spite of population growth and an increasing demand for health care services, and governmental health services are being slowly, but systematically, pushed beyond the reach of the majority of the population.

Available evidence also indicates that the efforts of the military government have been directed against self-reliant and natural growth, and development in health and health services. The military government policy is shown to create, perpetuate, and reinforce a situation of stagnation and dependence on Israel, not only in health services, but in all aspects of life.

It becomes clear then that any genuine attempts to improve health conditions and the quality of life of Palestinians in the West Bank and Gaza are linked with one precondition: the end of military occupation. The fact remains that in the absence of this clear and basic solution, very little can be done to control the disease called military occupation, a disease that is not only distorting and destroying Palestinian society, but perhaps Israeli society as well.

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(12) Katbeh, op. cit.

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(15) Benvenisti is an independent Israeli researcher and ex-deputy mayor of Jerusalem.

(16) Benvenisti, M., The West Bank and Gaza, Data Base Project, Unpublished Pilot Study Report, Jerusalem, 1982, pp. 16-17.

(17) State of Israel, Ministry of Health, op. cit., p. 26.

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(21) Puyet, op. cit., p. 3.

(22) Tamari and Giacaman, op. cit., pp. 12-20.

(23) Giacaman, op. cit., Note (6).

(24) State of Israel, Ministry of Health, op. cit., p. A94.

(25) Benvenisti, op. cit., pp. 11-13.

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(27) State of Israel, Ministry of Health, op. cit., p. 8.

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(29) Ibid., p. A99.

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