THE LABYRINTHS TO HEALTH IN GAZA

MÉDECINS DU MONDE PALESTINE

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**Methodology**
- A shattered economy
- Out of pocket health
- Episodic financing and chronic de-funding
- The economic burden of referrals

**Human resources**
- Human resources for oncology
- Oncology medicines
- Radiotherapy and palliative care
AHLC — Ad Hoc Liaison Committee

ENT — Ear, Nose and Throat

GMR — Great March of Return

IHL — International Humanitarian Law

IHRL — International Human Rights Law

MdM — Médecins du Monde

MHPSS — Mental Health and Psychosocial Support

MoH — Ministry of Health

OECD — Organisation for Economic Co-operation and Development

oPt — Occupied Palestinian territory

PET — Positron emission therapy

PHRI — Physicians for Human Rights Israel

SPU — Services Purchasing Unit

UNCTAD — United Nations Conference on Trade and Development

UNRWA — United Nations Relief and Works Agency for Palestine Refugees in the Near East

WHO — World Health Organization
When Palestinians in Gaza want to access health services, from the moment they are born until their last breath, their experience can be summarised as a perpetual maze full of obstacles. Both patients and public health experts agree that the blockade is the main obstacle to health, however some also recognise that important challenges exist beyond the blockade. When public health experts are asked what the main challenges are for improving access to health within Gaza, the answer contains the following elements: availability of drugs, equipment and qualified human resources.

The following work, addressed to the donor and advocacy community as well as the general public, does not intend to reiterate key statistics or simply describe some of the systemic challenges affecting the availability of tertiary-level care services. Rather, it provides a scope for understanding how intertwined these different factors are and illustrate them within a broader context. Simultaneously, it provides snapshots of the challenges the health system in general has to face, and offers some concrete recommendations on how to tackle them.
INTRODUCTION
Gaza: a 365-square-kilometre strip of land containing dozens of governmental, NGO and private institutions focused at providing health services to two million Palestinians. After several years of wars, political division and siege, the access to health for this population has witnessed almost a reversal. The availability of services is questionable. New departments open, but the essential components required to make them run are missing: drugs, equipment, and human resources. When these services are not available inside the Strip, patients have to seek them elsewhere. The ambition of attaining the essential right to health can take a Palestinian through an almost endless maze of obstacles imposed within and outside the Gaza strip.

Among the complex pathways to health, one of the most remarkable obstacles Palestinians from Gaza have to face is the Israeli controlled permit regime. In February 2018, Al Mezan Center for Human Rights, Amnesty International, Human Rights Watch, Medical Aid for Palestinians (MAP) and Physicians for Human Rights Israel (PHRI) published a joint statement highlighting the consequences of the permit restrictions Gaza patients regularly suffer. It made the case that the permit regime has negatively affected the life of thousands of people, even condemning some to death. Moreover, scientific research has shown that populations barred from travel for medical care are at increased risk of poor health in the long run, suffering the consequences up to 25 years later. The permit regime is an obvious expression of the implications of the blockade; but more importantly, it also implies that the structural cause for needing these exit permits is the lack of advanced medical services capable of responding to complex and specialised cases within Gaza.

Up until now, the health community has focused its advocacy on the permit regime for patients who seek services outside the Strip, but not enough interest has been given to understanding why these tertiary-level care services are not available inside Gaza. This study thus aims to bridge the current narrative with the concepts of sustainable access and proper development of the tertiary-level care services sector within the Strip.

Uncovering the multiple challenges of the specialised health services in Gaza and their nexus with the harsh reality of the exit permit regime is easier when it is seen through the eyes of Palestinians and from thereon explore the world that lies behind those experiences. Inspired from real life stories, MdM offers to accompany the Al-Gazaoui family on its journey seeking treatment for their different health problems. The report therefore does not follow a traditional structure deconstructing the technical components by thematic clusters, but aims to provide a more human experience for understanding the current challenges patients and the health system suffer in Gaza. The report focuses mostly on three medical specialisations: paediatrics, orthopaedics and oncology, as these represented almost 50% of all referrals between 2017 and 2018 and portray both general and specific challenges of Gaza’s health care system.
Introduction

This report is the combination of MdM’s 16 years of observation of the Gaza health system, and semi-structured interviews with 18 local and international experts. It intends to deconstruct the different structural components of the tertiary care services in Gaza and to shed light on the sombre ramifications of this endless maze and the obstacles that characterise the health system in the oPt. This work is also supported by Al-Haq’s legal assistance to dozens of individual cases. For this, Al-Haq provided MdM with 44 legal declarations describing what patients and their companions experienced during their referral permits, their journeys when crossing out of Gaza and when coming back. These declarations, covering the period from 2007 to 2018, where summarised in a matrix that allowed a quantitative analysis. While the sample can’t be considered a proportional representation of all cases during eleven years, it does illustrate the experiences patients have to endure.

Khaled is the father of the Al-Gazaoui family. As a refugee living in Gaza with his wife and three children, he has been making his life as a small-scale fisherman, selling his daily catch at the local market. The money he makes is barely enough to cover the basic needs of his family.

METHODOLOGY

This report is the combination of MdM’s 16 years of observation of the Gaza health system, and semi-structured interviews with 18 local and international experts. It intends to deconstruct the different structural components of the tertiary care services in Gaza and to shed light on the sombre ramifications of this endless maze and the obstacles that characterise the health system in the oPt. This work is also supported by Al-Haq’s legal assistance to dozens of individual cases. For this, Al-Haq provided MdM with 44 legal declarations describing what patients and their companions experienced during their referral permits, their journeys when crossing out of Gaza and when coming back. These declarations, covering the period from 2007 to 2018, where summarised in a matrix that allowed a quantitative analysis. While the sample can’t be considered a proportional representation of all cases during eleven years, it does illustrate the experiences patients have to endure.
THE LABYRINTHS TO HEALTH IN GAZA

Introduction
The health sector, like most other public services, finds itself at the crossroads of a context shaped by the ongoing Israeli occupation, dispossession, and colonisation; by the increasing territorial, demographic, socio-economic and political fragmentation of the Palestinians, and a persisting humanitarian crisis. In Gaza, public health services have experienced this through their own de-development, meaning not only the lack of further development but in some aspects its reversal.

In 2018, the GDP per capita in Gaza was of USD 1,507, the lowest in eight years, and since 2016 has decreased by 19%. This has been the result of an economic sector affected by more than a decade of isolation, lack of regular electricity, weak financial incentives, and a population and goods kept under strict surveillance and limited mobility. UNCTAD explains that “occupation has undermined the efficacy of ordinary, traditional development policies and set the Palestinian economy onto a uniquely distorted growth path, whereby donor-funded government spending plays a crucial role in maintaining a minimum level of aggregate demand.”

Unemployment rates continue to sky rocket and break historic records above 45%, forcing families to rely on borrowed money from relatives or friends. Independent workers such as fishermen, instead of looking at the weather to predict their chances of catching fish, have to inquire first on the fishing limits established by the Israeli authorities, avoid being shot at sea by the Israeli coast guard and do the best they can with the limited tools they have.
OUT-OF-POCKET HEALTH

The general impoverishment of the population in Gaza also affects the access to health. Between 2011 and 2017 poverty in Gaza increased by 14%, amounting to 53% of the population in 2017, and out of them, 33.7% are considered to be in deep poverty. In a context, where poverty is the main socio-economic trend, resulting from the increase of unemployment, reaching over 45% and decreasing salaries (from USD 18.2 per day in 2014 to USD 17 in October 2018), access to specialised healthcare services health in Gaza is a luxury, in particular when someone is referred outside Gaza.

Non-urgent patients and their companions often have to pay for private transportation from the Gaza strip to the city they are referred to. Considering that the round transportation cost for two persons from Gaza to Jerusalem is USD 200, this represents a one of many burdens for the average budget of a Palestinian family. However, the burden increases with the number of days that those companions have to dwell far from their homes, particularly in Jerusalem where, compared to Gaza, the average cost of living is four to six times higher. This burden has to be multiplied for each time the patient has to leave Gaza for treatment. Furthermore, when the required medicines are not available, which happens quite frequently, patients are forced to seek alternatives in the private sector.

The overall impact of out of pocket spending is daunting. Despite the fact that more than three quarters of Palestinians are covered by a form of prepayment for healthcare, in 2016, 44.5% of health financing came directly from out-of-pocket payments. Most of it is related to the need for pharmaceuticals, in particular for chronic diseases. In the case of tertiary-level care patients, these economic consequences are more severe due to the duration, the cost of specialised drugs, and the associated disabilities. In the case of oncology patients, one study found that 77% of patients had their income negatively affected after developing the disease and almost the totality imputed it to the treatment costs.
EPISODIC FINANCING AND CHRONIC DE-FUNDING

As mentioned previously, the lack of sovereignty and the blockade have shattered the economy, poverty continues to increase and the population further resorts to negative coping mechanisms such as child labour.\textsuperscript{15} In 2018, an estimated 4,840 children were working full-time in Gaza.\textsuperscript{14} Such context diminishes the possibility for domestic development. For decades Palestinians, and in particular the Palestinian Authority, have massively relied on external funding as a crucial component of their economy and development of key sectors. Meanwhile, donor countries have relied on providing this funding, instead of setting the road for sovereignty.

However, this external funding has hardly been sustainable. Throughout time it has followed a downward trend moving from development to emergency and then further to de-funding. The International Monetary Fund, in a 10 year retrospective analysis of international aid funding between 2007 and 2017, observed that around one quarter of all aid had been addressed to humanitarian assistance; they noted, however, that the protracted nature of the crisis has led to fewer funds directed at sustained growth and development, which ultimately risk developing into a vicious cycle of humanitarian needs.\textsuperscript{15} This analysis is actually in line with studies covering previous years. Development revenue from international aid, during the 1994 to 2001 period in the oPt, did not encourage further investments. Authors like Anne Le More argue that this was the consequence of the inefficiency of structures and institutions that had barely existed for few years, but most importantly because the coercive environment of the occupation represents an unsurmountable obstacle to development.\textsuperscript{16}

During the last decade, development and humanitarian funding has decreased systematically and only when emergencies surged, funding has poured down with limited impact beyond the immediate crisis: Following a peak in 2014, humanitarian funding to the oPt has declined year by year since 2016. Since 2017, the decline has been especially drastic when funding nearly halved from USD 679 million to USD 340.8 million and in 2018, the total funds received were the lowest in the last ten years. UNOCHA reported that their total required humanitarian funding for 2019 was USD 350.6 million, but until September 2019 only 46% of that funding had been met.\textsuperscript{17} In regards to development aid, the Organisation for Economic Cooperation and Development (OECD) has observed a similar trend. While in 2009 the official development aid amounted to USD 1,780 million, it has gradually decreased by 40% in a span of 10 years, reaching in 2019 only USD 1,062 million.

The allocated funding for health has not been spared from these trends. Despite that, access to some services continues to relatively increase, available resources have been halved in the last ten years. In this sense, the heavily donor-dependent and the occupation-hampered national Palestinian economy can hardly compensate the progressive financial needs required for responding to the regular technical and quality advancements of the health sector.
FIGURE 2
Comparison between total humanitarian funding for health and nutrition per year and direct foreign contributions to the Ministry of Health expenditures. The red line is a guide to the eye.
The reduction in external funding leads to a situation where health funding only responds to health emergencies. Figure 2 illustrates this, comparing the trends between humanitarian and development aid. In regards to humanitarian aid, the general downward trend is only interrupted by peaks addressing the 2008-2009 and 2014 Israel-Gaza conflicts, reaching then to nearly USD 100 million, and then in 2018 with a smaller peak, amounting to USD 33.52 million, as a result of the Great March of Return (GMR) demonstrations. The international contributions to the Ministry of Health expenses follow a very similar trend; they first decreased progressively between 2009 and 2013, and then increased to similar numbers to humanitarian assistance following the 2014 conflict, to later immediately fall by two thirds, down to USD 36 million.

In the case of the health system in Gaza, the almost exclusive re-direction of funding towards emergency response has been at the expense of bolstering primary healthcare, physical therapy services and tertiary level health services. Despite recent efforts by international aid organisations, such as the Qatar Red Crescent Society and the Palestinian Children Relief Fund on improving the quality of cardiology and paediatric services in the Gaza Strip, there are still several specialised treatments that the Ministry of Health cannot offer within the Strip. This situation leads to thousands of patients requesting transfer permits to hospitals elsewhere.

Even where funding is prioritised, such as the response to trauma injuries in the context of the GMR, the lack of funds is a clear obstacle to access for patients who require complex follow-up surgeries or rehabilitative care. Jamie McGoldrick, UN Humanitarian Coordinator for oPt, has recently spoken out about how the 1,700 people shot by Israeli security forces in the last year may need amputations in the next two years because they cannot access reconstruction surgery in Gaza. With around 10 international organisations, including UN agencies, working in the health sector, and donors agreeing with the need for multi-year funding to ensure predictable and adequate resourcing of collective outcomes in protracted situations, the responses have not yet reflected a humanitarian approach bridging towards a sustainable one. The current donor-led humanitarian approach was probably the best suited response at the beginning of the blockade in 2007, but 12 years later the problems have escalated to systemic challenges, where sticking plaster solutions are not sufficient. Long term development strategies and funding, hand in hand with concrete political measures aimed at tearing down the blockade, are the only solution to pull off the current trend of de-development.

Another factor that has played an important role in the chronic de-funding of the health sector was the US administration’s unilateral decision to withdraw its funding to all programs. In 2012, the US was investing almost USD 500 million, hitting an all-time low after the August 2018 White House decision to eliminate all fiscal year 2017 assistance to the West Bank and Gaza, amounting to some USD 231 million. One of the main development projects funded by USAID was the USD 50 million Gaza Health Matters 2020 project. The project was cut short by two years, affecting approximately 11% of the population in Gaza, which would no longer receive the humanitarian assistance they were eligible for. This project, implemented by International Medical Corps, Mercy Corps and CARE, provided prenatal care for Palestinian women, treatment for the injured in Gaza, and funding mammograms and biopsies for women. It included equipping the Dar Essalam Hospital in Khan Younis south of Gaza with a state-of-the-art Computerised Tomography (CT) scanner benefiting up to 400 patients per month. These cuts averted 3,000 children from receiving healthcare for anaemia and malnutrition and jeopardising the excellent vaccination rate. In addition, 16,000 women were prevented from receiving clinical breast cancer treatment. They were forced to look for other places. Unfortunately, even fall-back options, such as the East Jerusalem hospitals, where these treatments are available, were also affected by the funding cuts.
THE ECONOMIC BURDEN OF REFERRALS

When the Ministry of Health (MoH) encounters the lack of availability of specific treatments, human resources, equipment or medicines to deal with the health needs of a specific patient, the MoH then refers him or her to an external structure. This is a standard procedure all around the world. However, for Palestinian patients in Gaza, this represents a major challenge.

The number of referrals from the MoH out of the Gaza Strip continues to multiply incessantly year after year, and between 2017 and 2018 it has seen its steepest increase. In 2018, out of the 30,869 referrals the MoH registered, 52% were issued for patients that required to exit the Gaza Strip, the rest were for referrals within the Strip. This represents a 29.4% increase compared to the previous year.

Among the MoH expenses, after salaries, referrals represent by far the most important one. In 2018 they represented 34% of the total expenditures and their proportional weight continues to increase. Between 2017 and 2018, the total cost of referrals outside the MoH increased by 68%, amounting to more than USD 210 million. The significant financial weight this represents, should be of great concern to not only the MoH and the Palestinian Authority, but also to the international community, which as mentioned previously, subsidises in great measure the national budget.

These increasing numbers attest to the diminishing capacity of the MoH to deal with an ever-greater number of patients with complex medical cases. They also highlight some of the challenges that lie ahead for the implementation of the localisation of health services policy, which ultimately should reduce to the minimum the number of referrals. Already in 2016, the World Bank had expressed concern over the lack of clear strategic decision-making mechanism to prioritise investments for specific services and those that would further be referred. This should encourage decision makers to conceptualise new strategies aiming at curbing the costs and emphasise on the importance of sustainable investments for the whole population.
FIGURE 3
Total number of referrals and cost per year for Palestine from 2013 to 2018, disaggregated between West Bank and Gaza.
Source: Ministry of Health of Palestine annual reports
EMPTY SHELVES
Dima is a new born baby and is the last girl of the Al-Gazaoui family. She suffers from breast milk intolerance. The MoH is not capable of offering her the therapeutic milk substitute she needs. The family attempts to buy one in the private market but due to the high price and limited demand, there are insufficient quantities and they can’t even pay for what they need. After they run out of milk substitute, she slowly develops cardiac problems and her health deteriorates rapidly.

When medicines are not available, the right to health is compromised. At the end of July 2019, the MoH stated that 48% of the essential medicines in Gaza were in zero-stock, which included 71% for mother and child’s health and 56% for oncology and blood disorders. These figures follow a trend that has endured too long. During the second quarter of 2019, an average of 50% of drugs were reported at less than one month’s supply, and over 40% were completely depleted.

The lack of medicines not only has a direct impact on the quality of treatment, but it can also represent an increasing public health risk when dealing with communicable diseases, and the difference between life and death for some patients. In the case of tertiary-level care services in Gaza, the lack of medicines has become a critical issue for all specialisations.
In the case of neonatology services, a critical story occurs with babies suffering from metabolic problems. Therapeutic milk is essential for saving the lives of an average of 350 children per year who have problems digesting maternal milk. When the treatment is not available, the consequences range from growth problems to global developmental delays. The main problem arising from these milk formulas is the price per tin can, which ranges between USD 9 and USD 139. Each one has to be multiplied by the number of months these patients have to endure the treatment. The Palestinian MoH has listed eleven different therapeutic milks and estimated that, based on the demand, USD 508,293 are required per year to cover the needs. For Gaza alone, an average of 45% of that amount is required to cover the local needs. Some of those therapeutic milks have been missing from the central drug store (CDS) for one to six months.

Unfortunately, this empty shelf trend actually extends itself to several services. A major problem is that donations for mother and child drugs and similar products are rare and irregular, making it difficult for doctors to know when the products will be available. Major donors focus on providing medical drugs during emergencies, addressing mostly trauma and emergency equipment, while leaving behind thousands of patients, who require locally available medicines and disposables.

In Gaza, the estimated annual need for medicines is USD 10 million. There are several factors that challenge the availability of these medicines, including the capacity to produce them locally, political decisions and administrative obstacles.

When the local industry cannot produce some of these medicines due to the import restrictions imposed on raw materials by the blockade-related dual-use list, the ministry is forced to import more expensive drugs from outside. The dual-use list is a list of items and substances which are forbidden to import into Gaza, because the Israeli army considers that they could potentially be used for military purposes. As an example, local pharmaceutical companies in Gaza face regular challenges when importing aluminium foil for drug packaging or potassium-based chemicals. This hinders the local capacity to produce high-standard packaging and medicines such as nonsteroidal anti-inflammatory drugs.

Medicines represent the third most important expenditure of the MoH. Compared to international benchmark prices, the Palestinian MoH has been overpaying for medicines due to import restrictions from the customs union.

During the first six months of 2019, Gaza only received one shipment of medicines from Ramallah in mid-May, representing about 3% of their needs. This highlights the importance of the 2019 Humanitarian Needs Overview report calling for improving the monitoring systems as well as the UNSCO September 2019 report to the Ad Hoc Liaison Committee (AHLC) recommendation to facilitate the UN’s Project Management Unit to monitor the drug supply chain. Simultaneously, it is important that the supply of essential medicines is isolated as much as possible from the Palestinian Authority’s financial crisis.

In 2019, it is shameful if toddlers struggle to survive because a USD 9 tin of milk powder is not available. With sufficient and sustainable funding, combined with an enhanced management system, access to medicines could be solved.
Despite having a specialised paediatric hospital in Gaza, children represent the largest referral age group. Neonate and paediatric congenital heart diseases are a major cause of referral. These patients are systematically referred to Al-Makassed Hospital because the local surgery unit is simply not fit. The technical capacities in terms of diagnosis are present in Gaza, but there are no human resources specialised in this type of surgery.

When the referral for these patients has been approved, the physical transfer can be a critical step because paediatric stabilisation of critical and complex cases requires specialised paramedic human resources. In these cases, patients should be allowed to be accompanied by both their relative and a specialised medical staff, but referral policies only allow one companion per patient.

In other cases, the Israeli authorities do not even allow their parents to accompany them. In the lapse of 18 months, between January 2018 and June 2019, 56 babies were separated from their parents and six babies passed away alone in Al-Makassed Hospital because none of the mothers or fathers obtained the Israeli permit to exit the Gaza Strip. The emotional impact this has on children and parents can be disastrous; while some babies spend their last days alone, parents suffer the stress of only receiving rare and limited information on the status of their new-born babies. In case the baby does not survive, the permit regime does not even give the parents the right to go through the normal grieving process. In any of these cases both babies and parents require palliative care, and closeness is fundamental.

**HUMAN RESOURCES**

Human resources are a key challenge for the whole specialised health sector in Gaza. Not only highly skilled staff are rare, but those available express great frustration because they feel being constantly devalued. With an average of only 40% of salaries paid, it not only affects direct motivation, but the staff feels systematically stressed out about their capacity to cover their families’ essential needs.

Regarding other incentives, due to problems with exit permits, it is impossible for health staff to go outside of the Strip to get further training and staying up to date or to attend conferences and share their work. Specialised health staff in Gaza are left with no other incentives other than their passion for their work. Nevertheless, in 2018 an estimated 150 doctors left the Gaza Strip, hoping to find a brighter future in Turkey or Europe. Hospitals run with a large number of volunteer staff, who hope that one day they will get hired, but the financial situation makes it impossible to hire new staff, so as soon as they find a chance elsewhere they leave.
Empty Shelves
Dima is referred to the Al-Makassed Hospital in East Jerusalem, because in Gaza there is no staff capable of dealing with her kind of specialised cases. A paediatric specialist accompanies the little girl and her mother, but none of the adults is given permission to accompany Dima after Erez. During her transportation after Erez, she suffers from complications but makes it to Al-Makassed Hospital, where she stays for two weeks alone.
ENTERING THE MAZE: THE REFERRAL SYSTEM
To understand the referral pathway, it is necessary to enter the labyrinthic circuit of administrative procedures required to access treatment. First, we will describe the “normal” pathway, representing the experience of the vast majority of patients.

A physician determines that a patient requires to be referred outside Gaza because the necessary treatment or procedure is unavailable locally. He or she then fills the primary form (Form No. 1), that requires three key signatures from its medical structure. The form is sent to the medical committee, which should analyse the case. This can take up to two weeks. After this review, the patient’s file is sent to a peer committee in Ramallah, which meets on an ad-hoc basis. If this second committee approves it, the file is sent to the External Medical Treatment Department in Ramallah for ensuring the financial coverage, which is then sent back to Gaza. This is only the first stage.

Then comes the second stage out of three: obtaining an appointment at a specialised hospital outside of Gaza. For this, the External Medical Treatment Department in Gaza is responsible of contacting the hospitals, which often are overloaded and have established quotas for patients per region (West Bank and Gaza). Aware of the high risk of not making it to the appointment due to obstacles at the third stage, specialised hospitals can take between 14 to 42 days to schedule the appointment. With the appointment the patient usually gives its file to the Coordination and Liaison Service of the MoH, which will prepare a special form that ultimately is presented to the Israeli counterparts.

The third and last stage, also known as one of the silent tools of occupation, begins with the Israeli authorities receiving the file and conducting a first technical screening of the application. Here, the Israeli authorities, with total disregard and disrespect for the work of the Palestinian doctors and committees, check that the case does require referral outside Gaza based on their own criteria. If the file is not convincing enough, the whole application will be refused.

In case the patient’s file passes this first check, then other circumstantial factors come to play such as age, who the relatives and neighbours are (if they belong to a political faction, or have a security concern), etc. As concrete examples, in 2018, 28 applications were denied because they did not have a mobile phone, and 17 because they had a relative accused of overstaying in the West Bank or Jerusalem. Even the date of application can be a determinant for obtaining permission. If the case is not considered urgent and the appointment is in less than 26 working days, the refusal rate is very high. Similar security criteria are applicable to companions.

The population group with the highest percentage of refusals is male between 14 and 40 years old, reaching 30% in 2018. Meanwhile, children between 0 to 10 years old are also particularly vulnerable. Representing 25% of all applicants, children usually expect a family member to accompany them; however, the permits for the companions can be denied, thus potentially condemning the child to travel and endure treatment alone.

The companion permit rate has fallen systematically from 2012 to 2017, whereas at the beginning of the period 83% of them were granted exit permits, in 2017 it went down to 44%.

This third stage, that lies exclusively in the hands of Israeli authorities takes normally between 7 to 30 days. Within those days, patients have to wait for a last minute call from the Israeli side. Sixty percent of patients will experience the difficulty of not obtaining their permit straight away or get a clear negative response, but will undergo the consequences of delays. These delays, defined as inconclusive, can last between 30 and more than 150 days and prevent patients from attending their initial medical appointment. In those cases, a new appointment has to be organised, which is one of the longest steps. In 2018, the average number of applications per patient was 2.67. In the meantime, the general health situation of the patient continues to deteriorate.
Entering the maze

When intending to exit, the permit can be conditional to a security interrogation. Usually patients or their companions are informed about the interrogation at the very last minute, or can even be requested to be subject to it during their passage through the Erez terminal. If patients do not accept to be interrogated, due to the fear of being coerced to provide information, their permit has a high chance of being denied. In some occasions, these interrogations lead to an arrest. In 2018, 133 patients and 52 companions were called for interrogation; among them, one patient and four companions were arrested.41

For normal cases, it can take up to 94 days from the moment the patient’s physician establishes the need for referral to the time the patient finally is treated. For urgent cases, the whole process can take between 3 to 7 days. In these latter cases, the file bypasses the local technical committee and is sent directly to the Services Purchasing Unit (SPU) in Ramallah for technical and financial approval. A study developed by the WHO and the University of Eastern Piemont found that cancer patients applying for chemotherapy and/or radiotherapy, who were initially delayed or had their exit permits from Gaza denied between 2015 and 2017, were 1.45 times less likely to survive in the subsequent years.42

Sometimes, when patients have received a negative reply from the Israeli authorities, the option is to go to Egypt, through the southern Rafah crossing. In mid-May 2018, the Rafah crossing was opened in a regular basis after longstanding restrictions and became the primary exit point to the outside world. But for referral patients, this is an option very few dare. Even if the crossing is “open”, Palestinians can wait for days at the border expecting to cross. Only 8% of patients were referred through that crossing in 2018.43

Defaming the defenders

As a result of the interminable obstacles, loop-wise frustrations and in some occasions incomprehensible situations, patients from Gaza address themselves to human rights organisations such as Al-Haq, the Palestinian Center for Human Rights, Physicians for Human Rights Israel, Adalah, Gisha, Al Mezan, among others. These organisations accompany the patients in their individual quest for health through the labyrinth, submitting complaints with the concerned prosecution and in some occasions, they take the cases to court against the Israeli authorities. These organisations also advocate to dismantle piece by piece the walls of the labyrinth and the endless hidden traps. A remarkable advocacy success was the revocation of the decision by the Political-Security Cabinet to deny relatives of Hamas members exit permits to leave the Gaza Strip in order to receive medical treatment.44 However, several of these organisations have suffered from “targeted defamation and smear campaigns.”45 Simultaneously, the UN has expressed concern about “constraints on the invaluable work being done by human rights activists” imposed by the Government of Israel.46 These measures affect their capacity to work and to continue providing assistance and hope to hundreds of patients in need.
After going through the maze of the referral system, patients reach their referral destination. 40% of referrals from Gaza are made to East Jerusalem, where a large majority of Palestinian tertiary-level care services are provided by public and private institutions. Despite being a central pillar within the health system, these too have suffered serious blows challenging the whole system.

Historically all Palestinians had unrestricted access to specialised services in East Jerusalem. The main hospitals are the Al-Makassed Islamic Charitable Society Hospital, Augusta Victoria Hospital, Palestine Red Crescent Society Hospital, St John of Jerusalem Eye Hospital Group, Jerusalem Princess Basma Centre, and Saint Joseph Hospital. They are organised in a network known as the East Jerusalem hospitals and they represent the core tertiary-level care centres for all Palestinians. Together they cover a broad spectrum of services including eye and cardiac surgeries, to rehabilitation for handicap children, neonatal intensive care and advanced oncology and nephrology services.

Most of these institutions run thanks to the donations of several international donors and national funding. However, in the last few years, besides working beyond their capacity, these institutions have faced an ongoing financial crisis. This crisis has been the result of the Palestinian Authority’s difficulties in paying the referrals; by August 2018 the debt amounted to almost USD 80 million.47

In 2017, the crisis reached such a point that the Augusta Victoria Hospital in East Jerusalem was forced to temporarily turn some patients away in two different moments of the year simply because they no longer had the money to pay for the medicines required to treat the patients referred from the West Bank and Gaza.48 The crisis then deepened in September 2018, as a result of the funding cuts US, mentioned earlier in the Episodic financing and chronic de-funding section. The East Jerusalem hospitals had their annual budget reduced by USD 25 million of regular support funds. The core of the tertiary-level care was shaken.

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After a year of constant advocacy with the Palestinian Authority and international donors, none of these hospitals was compelled to close, but the debt problem remains. It is a critical issue that should be analysed and tackled as part of the overall challenge of the health system. Contrary to the boy who cried wolf, in the future there won’t be any more alarming declarations but rather devastating consequences for the whole Palestinian population.
VIOLENCE AGAINST HEALTHCARE
Beyond the structural challenges healthcare providers and patients suffer when intending to offer or access healthcare services respectively, and despite being protected by both International Humanitarian Law (IHL) and International Human Right Law (IHRL), Palestinian healthcare services and personnel are a recurrent target of violence. When comparing the number of attacks with the rest of the world, the oPt recorded in 2018 more incidents than any other country in emergency situation.49

Between March 31, 2018 and end of July 2019, the consequences have been staggering: three health workers have been killed and 803 injured in 519 recorded incidents against health staff and facilities in the Gaza Strip. Moreover, 112 ambulances and 7 health facilities have been damaged.50

Beyond the physical impact violent incidents can produce on a specific health worker, the same incident can have direct and indirect psychological consequences on the immediate environment, including fellow health workers and patients. The high number of health care workers targeted, together with the appalling number of people shot requiring urgent medical attention and complex surgeries has pushed the health system to its limits, or as the UN Humanitarian Coordinator Jamie McGoldrick would qualify it, “the number of wounded during the Great March of Return became an emergency on top of a crisis.”

After more than a year and half since the beginning of the Great March of Return, even if children continue to be shot and killed, the scale and regularity of the violence has sadly been normalised by most actors. In this context, it is important to recall that in March 2019, the UN Commission of Inquiry on the Protests in the oPt reminded the international community that “unless undertaken lawfully in self-defence, intentionally killing a civilian not directly participating in hostilities is a war crime.”51
Mahmoud is the first boy in the Al-Gazaoui family. At 17 he is finalising his high school studies and has applied as first aid volunteer at a local health NGO responding during the GMR. On his first day in the field, while trying to provide first aid to someone, he is shot on his right leg with live ammunition by the Israeli army, leaving him severely wounded.
THE LABYRINTHS TO HEALTH IN GAZA

Entering the maze
ORTHOPAEDICS
In Gaza, with an average waiting time of 16 months for elective surgeries, the patient surge flooding the hospitals and operation theatres resulting from the Great March of Return have challenged the limits of the health system. By the end of August 2019, the excessive use of force employed by the Israeli security forces had injured more than 7,500 Palestinians with live ammunition and out of them almost 6,000 were directed to the limbs. This represents an unprecedented number of severe and complex lower limb injuries, where the main challenge has been limb reconstruction and infection prevention.

The complexity of limb reconstruction is due to two major aspects: the first one is the shortage of treatments and required medical devices and supplies, such as external fixators and most kind of graft supplies; the second is the long period over which an important number of patients require numerous multidisciplinary surgeries plus individual rehabilitation therapy.

Two concrete examples illustrate the difficulties patients had when seeking access to equipment and devices: arthroscopic surgeries are no longer available in the Strip because the equipment is currently out of order; and during the first months of the GMR, it was impossible to have access to the carbon ring external fixators, because the Israeli authorities considered them as dual-use items.

Bone grafts, on the other hand, are used in reconstructive surgeries. Whenever the patient’s own bone is not sufficient to cover the bone gap, surgeons use allografts (donated bones) or synthetic grafts. The problem is that in Gaza there is no bone bank, forcing surgical teams to import organic and artificial supplies, which have to go through special import procedures and this can take several weeks. In addition, in a context void of vascular and plastic surgeons, the available human resources lack the experience of working in multidisciplinary cases, and those already operating evermore complex cases, require further specialised training.

In regards to infection prevention, the challenge originates in both the nature of the wound and the overuse of antibiotics. Gunshots are more prone to infections than other sort of wounds and there are very high rates of antibiotic resistant infections. Up to 73% of infected cases have shown indications of multi-drug resistant bacteria. Treating these cases requires rare and expensive drugs, which often are not available. After more than a year and half since the beginning of the GMR, approximately 1,000 patients are at risk of osteomyelitis, the infection of the bone.

In summary, a patient who had a large gunshot wound on one or both of his limbs will face the following challenges: he may require between three to five years of constant surgeries, which include prolonged hospital stay and temporary or permanent disability; he may face delays due to the long waiting list for accessing the operating theatre; he should hope not to suffer an infection by multidrug resistant bacteria; and he should also hope that analgesics and anaesthesia are available throughout those years.

In case there are any complications, contrary to most other health conditions, these patients face further challenges when the local authorities refer them outside of Gaza. They have to confront the Israeli bias against those who participated to the GMR. Up until March 2019, only 18% of the cases which had been filed for referral, meaning those that were considered to have a chance of obtaining a permit, finally obtained the Israeli permit. This means that a large number of patients, which in any other setting would have the chance for a second medical opinion or seek treatment beyond what is available locally, have had to abandon the simple idea to fight for their right. In some occasions, the consequence has been the amputation of the limb. Since the GMR demonstrations started and until August 2019, 149 amputations took place in Gaza and at least 172 Palestinians have been disabled for life.
After undertaking a couple of initial urgent surgeries, Mahmoud is told that he will need a bone graft for reconstructing his lower tibia. Unfortunately, the Israeli authorities have not allowed the importation of bone graft materials. After attempting several times to exit through Erez, Mahmoud’s infection has spread. Doctors inform him that the risk of amputation increases by the day, as long as the reconstructive surgery required is not available in Gaza.
ONCOLOGY
Oncology services in Gaza date back to 1984. At that time, the authorities gave a big initial push resulting in most medicines being available. With time passing by, medicines and treatments became more expensive. Nevertheless, in 2007 cancer services were still responding to most of local needs. But now in 2019, 6,000 cancer patients have their lives hanging by a thin string: the human resources are overwhelmed with cases, only 40-60% of the required drugs are available and one of the four main pillars for cancer treatment, radiotherapy, is not available.

Cancer patients represent by far the largest percentage of patients requiring referral (31%). Treating cancer requires a full spectrum of expensive services and highly qualified human resources working in sync. About 80% of all cancer patients have been referred outside of Gaza at least once for treatment and access to medicines; this includes diagnosis and the follow-up, which might require isotope scans.

To understand the tribulations which cancer patients in Gaza face, it is necessary to follow the whole medical pathway. After being screened, a key component is the diagnosis and the work done by the pathologists. With an average of 9,000 annual biopsies, the three public pathology centres in Gaza have to provide on-time diagnosis, with limited resources. Human resources are scarce because the universities do not have the specialisation, so those who approach this branch are trained in situ. In the meantime, new techniques and knowledge evolve very rapidly but the practitioners have not had the opportunity for a proper update since 2002. In the laboratory, even if the equipment does work, but the lack of consumables represents a major problem. For example, commonly used bio markers and dyes used for the paraffin technique, such as Xylene and Haematoxylin, are often unavailable. The pathologists, like much of the health system, rely on unpredictable donations and are incapable of ensuring their own regular supply. This situation results in patients waiting between three to eight weeks for their results.

For 5 to 10% of cancer cases, the scanning and diagnosis requires advanced equipment such as molecular and nuclear imaging. In the Strip there are fifteen Computerised Tomography (CT) and five Magnetic Resonance Imaging (MRI) scanners, but only 70% work and are overwhelmed. One of the reasons is that all departments seem to have troubles in their structure, design and essential supplies. For even more complex cases, a positron emission therapy with computerised tomography (PET/CT) scan is required to be able to follow with precision the evolution of cancerous metastasis, but this is only available in the Augusta Victoria Hospital in East Jerusalem.

Referrals for oncology services are also among the most expensive. In 2018, they represented 37% of the total costs of referrals. To make sure that scarce resources are best used for avoiding further erosion of the health system in Gaza, efforts on improving the performance of the health system is primordial while also investing in key specialised services. Recent studies have shown that Palestinian hospitals still have the capacity to improve their efficiency by 14.5%. At the same time, even if technology advances have been considered among the most important drivers of healthcare spending, not all technologies share that same premise. Investments on NICU and oncology technologies have shown to have a negative correlation between use and spending.
Some months later, Intisar, Khaled’s wife, notices that one of her breasts feels slightly different but does not go to the hospital for screening because she believes it will disappear just like it appeared. A year later, she is diagnosed with breast cancer.
After the doctor prescribed Intisar radiotherapy, the Israeli authorities delay her permit, not giving any reason. She misses her first appointment. She has to apply once again for an appointment at the Augusta Victoria Hospital. During this second application, the Israeli authorities inform Intisar that she has to present herself and her husband in Erez for an interview, which should determine if they get their permit.
HUMAN RESOURCES FOR ONCOLOGY

With only three oncologists available and two assistants, the Rantisi hospital in Gaza city treats 70% of the cases, and the European Gaza Hospital the remaining 30%. The waiting hall is constantly saturated and doctors have very limited minutes for each patient. In contrast, in the West Bank, there are more than 15 oncologists, including haematologists. The process of having new oncology specialised human resources is like a Gordian knot, solving it requires a combination of almost impossible features: the specialisation requires students to have access to all essential therapies, including radiotherapy, which, as mentioned previously, is not available in the Strip. The only relative solution is to obtain practical experience at the Augusta Victoria Hospital, the only place where the services are available; however, medium term mobility to East Jerusalem is not permitted to Gaza residents. This means that there is no respite for the available doctors, who have to do the best with the limited resources.

ONCOLOGY MEDICINES

In July 2019, only 25 out of 65 cancer drugs were available in the Gaza strip, meaning that doctors have had to suspend the treatment protocol for a large number of patients. Oncology chemotherapies follow specific protocols: the cocktail has to include all drugs and if one of them is not available, it is ill-advised to follow the treatment. Simultaneously, the available quantities rarely meet the demand, forcing medical doctors to take difficult decisions.

Oncology is a fast-paced sector of medicine, where new therapies and treatments are developed every day. New medicines do provide improved treatment, but this comes at a cost. For example, Herceptin, a drug that targets cancerous cells with great precision, has been a life saver for breast cancer patients globally, however a year-long treatment costs USD 76,700. The same goes for Avastin, a drug used for colon cancer, which costs USD 2,380 per month, and in addition, requires fluoropyrimidine-based chemotherapy. These drugs are simply out of reach for patients in Gaza and West Bank alike. Private institutions such as the Augusta Victoria Hospital in East Jerusalem are capable of covering on some occasions the cost of specialised drugs, but the in-service costs have to be covered by the MoH.

With an average of 120 new cancer patients in Gaza per month, due to the lack of regular chemotherapy, not to mention "new era" personalised therapies, a good number of patients will have to endure surgery as the only option left. But even among these patients, 15% will require to be referred outside of the Strip for specialised surgery because of the technical complexity, such as neurosurgery. Without any previous pharmacologic or radiologic treatment to reduce the size of the tumour, patients have less chance of finding a cure and are at risk of several disabilities.
The day of the appointment has arrived.
By this time, Intisar has lost a lot of weight and can hardly move by herself. She needs a wheelchair.
In Erez, despite her movement difficulties, she is requested to walk around, go back and forth through the scan machine twice and then is forced to wait while her husband is interrogated.
Two hours after entering the crossing, they are finally able to go to East Jerusalem.
**RADIOTherapy AND Palliative CARE**

Despite radiotherapy being one of the most cost-effective treatments for curative and palliative care of cancer patients, in the whole occupied Palestinian territory, there are only four linear accelerators. Cancer patients must surmount a good number of physical and administrative obstacles because the only three functioning machines are found in the Augusta Victoria Hospital, situated in East Jerusalem. This number is still below international standards. It is estimated that the need for radiation therapy equipment in the oPt, based on current mortality studies, is of 1 machine for every 400,000 persons.67

In Gaza, between 800 and 1,000 patients per year require referral outside of Gaza for radiotherapy. The treatment lasts between one to eight weeks, meaning that some have to stay for up to two months far from their families. The mental health as well as economic and social impacts on the patients and their families are felt for several months after the treatment.68

The reason that there are no linear accelerators outside East Jerusalem, some argue, is that the use of Cobalt-60, used for teletherapy, could allegedly be used for terrorist purposes. However, it is important to note that other radioactive isotopes such as the Fluorine-18 are used for medical purposes during positron emission therapy (PET), and are available and used within the Gaza strip. More importantly, nowadays it is possible to acquire linear accelerators (LINAC) capable of producing high-intensity X-rays without having to use radioactive isotopes. The only major downside is their higher training and maintenance cost compared to the older isotope dependent technologies.69

Those who do not obtain the exit permit for their radiotherapy or the vital chemotherapy often have to endure surgeries, hoping that there have been no metastases. Breast cancer patients not only have to bear the knowledge that they are affected by the “leading cancer-related cause of death,”70 but they are also at risk of mastectomy and only a few of them receive reconstructive surgeries, affecting their confidence and self-esteem.71 The side-effects of chemotherapy, such as hair loss, also entail similar emotional consequences. Signs of depression and thoughts about death are recurrent among these patients. Cancer patients in general, not only require appropriate biomedical treatments, but also require a more holistic approach to care, which should include psychosocial support.72 Palliative care, requiring multidisciplinary teams, has not only been found to be a generalised gap for oncology patients in Gaza, but also for patients suffering other chronic diseases.73
After a week of treatment, Intisar travels back to Gaza. In Erez, her husband is detained and imprisoned.
REAL STORIES OF OBSCURE JOURNEYS: AN 11-YEAR RETROSPECTIVE
With the intention of further illustrating the current challenges with concrete examples, the Palestinian human rights organisation Al-Haq provided MdM 44 legal declarations describing what patients and their companions experienced when trying to obtain their referral permits, as well as their journeys when crossing out of Gaza and back. These declarations span from 2007 to 2018. While the sample cannot be considered a proportional representation of all cases during eleven years, it does represent the experiences some patients have to endure.

**FIGURE 4**
Number of patients per medical treatment amongst Al-Haq followed cases between 2007 and 2018.
The sample’s main leading causes of referral were orthopaedic and oncology, which is not far off from WHO’s statistics, where in 2017 oncology represented the first cause of referrals, followed by cardiology, haematology, orthopaedic and paediatric cases. See Figure 5

Out of the 44 cases, 42 were related to referrals outside of Gaza. The other two were not related to referrals but obstacles to health such as the availability of constant electricity power to maintain a quadriplegic boy alive. Some of the 42 patients were referred in some occasions to more than one destination after their permit was refused recurrently. For instance, one case was first referred in January 2017 to the Augusta Victoria Hospital in East Jerusalem for treating her endometrial cancer, but her permit was denied three times. After an urgent surgery was carried out in Gaza in August, the cancer metastasised to the pelvic bone. In December, she was then referred again outside; this time to Nablus but the permit was also rejected.

In regard to the destination of the referrals, 43% requests were made to hospitals in East Jerusalem, 28% to Israel and 20% the West Bank. The rest were referrals to neighbouring countries such as Egypt and Jordan.

The most important information, however, regards the outcomes of patients’ or their companions’ experience. Out of 44, 21 cases ended in the arrest and imprisonment of the patient or the companion, 14 in the death of the patient and 8 were still awaiting their permit by the time of their deposition. See Figure 6.
**FIGURE 5**
Number of patients or companions per referral destination in Al-Haq reports

<table>
<thead>
<tr>
<th>Destination</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Jerusalem</td>
<td>20</td>
</tr>
<tr>
<td>Israel</td>
<td>13</td>
</tr>
<tr>
<td>West Bank</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
</tr>
</tbody>
</table>
One of the most frustrating and life endangering situations is when patients, who had previously benefited from treatment outside Gaza, are refused upon reapplying: 22 out of the 37 were refused upon reapplying to continue their treatment or access new treatment. In some of the cases, the referral outside was the only opportunity to stay alive; for 12 cases the different obstacles to health resulted in the death of the patient.

Behind the statistics, the analysis of these legal declarations not only reflects more than a decade of struggle between life and death to access health services, but also the human experiences of frustration and imprisonment of hundreds of Palestinians.

**FIGURE 6**
Consequences experienced by patients or companions before, during or after referral abroad for medical purposes. Al-Haq (2007 - 2018)
Here are some extracts from the affidavits deposited by the patients, their companions or family members:24

MAHMOUD, a 17-year-old boy requiring an urgent heart operation for congenital heart problems, reported being coerced by Israeli forces to cooperate in providing intelligence before his permit was refused on security grounds. He died a year later in January 2017.

OMAR, a 49-year-old man with kidney cancer who previously had undergone surgery in Egypt, was ordered to attend an interview with Israeli intelligence for a permit request, despite a severe deterioration in his health. He died at Erez checkpoint in June 2018 before reaching the Israeli side.

DAOUD, 75 years old, required urgent heart surgery in East Jerusalem. His permit was refused and the Israeli authorities asked him to return to the checkpoint the following day. He passed away at the Erez checkpoint waiting for the approval of the Israeli authorities in October 2007.

IBRAHIM, 24 years old, had suffered various types of cancer and needed treatment in Israel for the removal of a 9kg tumour. The permit was refused with no reasons provided and the patient subsequently died due to lack of access to treatment.

OSAMA, 11 years old, was denied access to East Jerusalem in 2008. Quadriplegic due to gunshot wounds to his shoulder, he depends continuously and permanently on a respiratory machine. His father was requesting a permit to exit as lack of electricity in Gaza meant that the machine was regularly cutting out, critically endangering his son’s life.

OTHMAN, 20 years old, had suffered from a hepatic artery blockage. Despite previous consultations in Al-Makassed, as a result of his deteriorating condition, he required further treatment at the same hospital. His request for a permit was refused in December 2010 because he had been unable to attend an interview due to being in a coma. He passed away 6 days after denial of permit.

MUNA, 68 years old, required treatment for arthritis at a hospital in Israel. She travelled together with her son to the Erez border crossing during Eid. There, he was arrested and Muna’s papers and medical file were confiscated by the Israeli authorities. She was then told that she could not travel until her son was released from prison.

ZARA, 53 years old, had suffered from breast cancer since 2008 and underwent several treatments in Egypt. Despite this, the cancer spread to the lungs, liver and bones, and was somehow controlled with chemotherapy. With her condition deteriorating, in 2016, she applied several times to hospitals in East Jerusalem and the West Bank, but each time the file was delayed by the Israeli authorities. Even with the support of several human rights organisations, she was never allowed to cross. She died in 2017.
CONCLUSIONS
The Gaza health sector is not fully underdeveloped, because basic services are available, but external and internal factors are pointing towards an ongoing de-development of the sector and patients are forced to suffer the consequences. In the context of a protracted crisis, the well-being of a population is not attained by maintaining the same availability of services, but in improving them through time. In the case of the oPt, Israel has to abide to its international law obligations, the Palestinian Authority has to ensure the health sector remains a priority and is void of political rifts and the international community has to reshape its aid strategy for health in Gaza. The current one is entrenching and deepening the current crisis.

Among the key aspects hindering the development of the health sector in Gaza, the geopolitical determinant of occupation has been a key driver undermining the general economy and establishing systematic obstacles to access to health. Under the pretext of a blockade, the occupying force has avoided fulfilling its duty of good governance under IHL, which in other words means to ensure the well-being of the population under occupation, and to respect and protect their rights as established by the Geneva Conventions and the Hague Regulations. In regards to the provision of medical care, third States have to remind the occupying force its duty to commit to this principle “to the fullest extent of the means available.” Recalling the Advisory Opinion on the Wall, the occupied territories have been under Israel’s territorial jurisdiction as occupying power, and bound by the provisions of the International Covenant on Economic, Social and Cultural Rights. In this sense, the occupying force must not create any obstacles to the enjoyment of such rights where the responsibility for their fulfilment has been transferred to the Palestinian Authority. Therefore, under both IHL and IHRL legal frameworks, the occupying power has to strive to attain a higher level of well-being of the protected population and not only seek to maintain the status quo. Based on this, the establishment of a permit regime determining the possibility for a person to access or not health services is in contravention of its obligations. In the same sense and in a larger scale, the continuation of the occupation for over 52 years has been the key determinant of a coercive environment contrary to the promotion of access to health. This includes a vast range of consequences: from blocking the essential principle of self-determination and hampering the economic development necessary for the proper function of public services, to the impossibility to import life-saving equipment.

Second, the Palestinian health authorities should make more efforts to ensure that all Palestinians have equal access to services and medicines and medical staff be supported at all times. Some key structural challenges remain such as the management of available equipment, questioning the sustainability of some of the investments made so far. Referrals keep representing a growing and unsustainable burden for the Palestinian national health budget. Not addressing the question of localisation and access to specialised healthcare services, through a comprehensive and sustainable approach, could have catastrophic consequences on the long run for the whole health system. Despite the volatility of the context, investments on key sectors such as oncology and paediatrics in Gaza would seem like viable options for reducing dependence and strengthen local capacities.

The third aspect hindering the development of the health sector is the lack of longer-term funds cementing sustainable humanitarian and developmental schemes together. This lack of sustainable funds is mostly caused by the irregular availability of governmental resources, topped by the dependency towards international donors, who respond to contextual and political factors. Therefore, in a protracted conflict such as this one, pure humanitarian assistance will continue failing at responding to the structural challenges and due to its lack of sustainability, it will further weaken the development of the health system.
Healthcare in Gaza is a system that should be assisted as such, from a systemic approach. The general approach to funding health in the oPt has to be transformed into a more comprehensive and sustainable response. It has to address urgent issues such as the lack of drugs, while adapting its strategies to accompany the health sector in its efforts to respond in a long-term approach to a growing demand of specialised services with adequate equipment and human resources. Sustainable funds, together with stronger coherence between humanitarian and developmental schemes, should allow better short, medium and long-term planning for health. In order to curb the fund-draining context and switch towards a return on funding scheme, the international community should be reminded that its development aid cannot be a substitute for its lack of real engagement addressing the root causes of de-development. Sustainable development only thrives where international human rights law and international humanitarian law violations are not constantly hampering it.

Finally, it should not be forgotten that the ones who are paying the consequences of the health sector’s current situation are babies, children, persons with disabilities, mothers, breadwinners, grandparents and all those attending them on the frontline every single day in the health structures. Therefore, those who aim at engaging more actively at supporting the ongoing work in the health sector in Gaza should visualise the sector as a system in crisis requiring systemic thinking and not as a hopeless maze with only dead ends. All actors should be working together on a common vision of sustainable development centred on one thing: responding to the current and future health needs of Palestinians, not more, not less.

One of the shortcomings of this report is that it portrays almost exclusively current challenges related to tertiary-level care services and their patients in Gaza; in this sense, it is recommended to pursue, similar studies covering the West Bank and the environmental determinants of health.
THE LABYRINTHS TO HEALTH IN GAZA

Conclusions

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RECOMMENDATIONS
GENERAL RECOMMENDATIONS:

1. All actors should be reminded that health should not be politicised or used as a lever to achieve non-health related objectives

2. Third States should ensure that Israel lifts the blockade and ends the occupation

3. Third parties to the Geneva Conventions should ensure that Israel, as the occupying power, abides to International Humanitarian and Human Rights Law guaranteeing that all the population under occupation has unrestricted access to health and that all obstacles within its control are eliminated; this includes for example:

   a. To ensure that all patients can be accompanied for the whole duration of the referral, giving priority to first degree relatives (parents, children, spouses)

4. The Palestinian Authority should ensure that proper health-funding is channelled equally to all Palestinians

5. The international community should review its aid strategy and aim towards more sustainable funding schemes, while simultaneously take all necessary measures to ensure that the occupying power is accountable within its IHRL and IHL obligations, including the access to health for all the population living under occupation
ON ENSURING THE AVAILABILITY OF MEDICINES AND EQUIPMENT:

1. All relevant actors should follow the recommendations UNSCO provided to the Ad-Hoc Liaison Committee (AHLC), in particular:
   a. To build a monitoring mechanism that would follow the availability of medicines and disposables and evaluate the conditions of available equipment and potential upgrades
   b. The establishment of an external mechanism that would have full oversight of the supply chain with a view to transfer this function to the local authorities over time

2. All relevant actors should review the possibility of taking concrete measures such as upgrading neonatal intensive care and oncology equipment in the Gaza Strip, including radiotherapy equipment, supported with trained staff

3. Third States should pressure Israel to avoid hindering the capacities of the domestic pharmaceutical industry to continue producing medicines adapted to the local market

4. The Ministry of Health, donors and civil society should further advocate international pharmaceutical companies to lower the prices of specialised medicines, in particular for oncology

HUMAN RESOURCES

Third States should urge the Government of Israel to:

1. Allow specialised doctors to accompany patients who require particular support during transfer, such as neonates under intensive care

2. Avoid establishing barriers to medical and technical staff to continue their education, improving their skills with professional training and to participate in conferences abroad

The Palestinian Ministry of Health should:

1. Invest in covering the gaps in key specialisations, such as cardiac and plastic surgery, including for children, as well as in oncology services

2. Ensure palliative treatment is provided to all oncology and chronic disease patients with multidisciplinary teams
GENERAL MANAGEMENT

The Ministry of Health of Palestine should:

1. Restore a unified nation-wide health information system that aims at improving the follow-up of patients across different institutions.

2. Share a common and comprehensive vision on the development of the health sector, based on the current and future financial challenges.

3. Reinforce the links with the Network of East Jerusalem Hospitals by developing a strategy together with the donor community to address the increasing referrals’ related arrears and find a more sustainable model for the provision of tertiary-level care services.

VIOLENCE AGAINST HEALTHCARE

MdM recommends third States to compel the Government of Israel:

1. To adhere to the obligations of international humanitarian and human rights law regarding the respect for and protection of health services and the wounded and sick and the ability of health workers to adhere to their ethical responsibilities of providing impartial care to all in need.

2. To follow the recommendations of the Commission of inquiry on the protests in the oPt, including:
   
   a – Refrain from using lethal force against civilians, including children, journalists, health workers and persons with disabilities, who pose no imminent threat to life.

   b – Ensure that all those injured at demonstrations are permitted prompt access to hospitals elsewhere in the Occupied Palestinian Territory, in Israel or abroad.

   c – Ensure timely access of medical and all other humanitarian workers to Gaza, including to provide treatment to those injured in the context of demonstrations.

   d – Ensure efficient coordination for entry of medical items and equipment into Gaza, and remove the prohibition of entry applied to items with legitimate protective and medical uses.

PROTECTION OF HUMAN RIGHTS DEFENDERS:

1. Thirds States should ensure that the Government of Israel and its associated organisations abide to international law on the protection of human rights defenders.

2. The international community should:

   a – Condemn the delegitimisation and smearing human right defenders and human rights organisations.

   b – Further protect and support human rights defenders against the increasing attacks.
ACKNOWLEDGEMENTS
MÉDECINS DU MONDE THANKS

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7 Palestinian Central Bureau of Statistics, Poverty Profile in Palestine, PCBS, 2017. The PCBS defines: individuals that live below the poverty line are unable to acquire the necessities of food, clothing and shelter.


10 The average public transportation cost is calculated based on the following: USD 8.5 (Gaza City - Erez) + USD 1 (Erez) + NIS 43 per person (Erez - Jerusalem).


19 OECD, “Multi-year humanitarian funding - World Humanitarian
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27 Compilation of MoH’s Central Drug Store monthly reports, April-June 2019.
38 Ibid.
39 Ibid.
41 Ibid.
42 Ibid.
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WHO, “Right to Health: Crossing barriers to access heath in the occupied Palestinian territory 2017”, Cairo: WHO Regional Office for the Eastern Mediterranean, 2018


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61 Reports of the Liaison and Coordination for referrals abroad. 2018.


68 See the out-of-pocket section, within the introduction to this report.


74 All names have been modified for their own protection. 

75 Geneva Convention IV, Art. 56.

76 ICJ, “Advisory Opinion on the Wall”, above note 18, para. 112.

