WORLD HEALTH ORGANIZATION

Disengagement - Healthcare during withdrawal operations in Gaza

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ABBREVIATIONS
1. INTRODUCTION

The Israeli pullout from the Gaza settlements will officially begin during the period of 15-17 August 2005. The evacuation will include the removal of civilian settlers and their goods, as well as the withdrawal of Israeli military forces from 17 settlements in the Gaza Strip. The disengagement will also include the dismantling of four West Bank settlements. It is announced that the withdrawal should be completed by September 22. However, this period relates only to the removal of settlers and their goods from Gaza. The withdrawal of military forces and their infrastructure from Gaza, and their redeployment around the outside of the Strip, could take until at least mid-October, and potentially longer.

During the withdrawal period, increased restrictions of movement will be imposed on the Palestinian population in Gaza. Internal closures, segmentation of the Strip and sealing of settlements will be in place. Palestinian enclave communities located inside the settlements will be completely hampered in their capacity to move. Israeli military cordons surrounding the settlements will create a ring of further enclaves of Palestinian communities. Restrictions on access in and out of Gaza for Palestinian people and goods are also planned. Access to Gaza will be restricted for Israelis but, according to Israeli military sources, international humanitarian staff will be allowed access, based upon prior coordination.

Preparedness measures will be put into place by the local service providers, with the support of international agencies. However, whilst some humanitarian needs such as food and water can be anticipated with a certain degree of confidence - and partially addressed by pre-positioning and distributing stocks to communities and families in areas at risk - healthcare needs are not as simple to predict or deal with. These healthcare needs, particularly related to emergency referral care, are at risk of not been addressed if access to adequate health facilities is not guaranteed and implemented by the occupying power.

2. CRITICAL ISSUES ON HEALTH

2.1 Access

The main issues to be addressed during the disengagement period are related to access, in terms of: a) patient capacity to reach the health facilities of the appropriate level of care; b) the access of health workers to their places of work; c) delivery of drugs and medical supplies to the health facilities.

What has been planned by the IDF during the withdrawal period is: a) closure of the Gaza perimeter and external cordonning of the Strip; b) internal segmentation in 4 sections of the Strip through internal closures; c) closure of the gates giving access to enclave communities inside the settlements, in addition to the cordonning of the settlements and of main roads connecting settlements with Israel.
a. **External closures.** Erez and Rafah checkpoints will be closed for Palestinians, according to the latest Israeli declarations. Patients in need of referral abroad in order to receive specialized care not locally available (e.g. cardiac surgery, radiotherapy for cancer; paediatric surgery for newborns with congenital malformations, treatment for advanced renal failure, neurosurgery, etc.) could be affected. Between 500 and 700 patients are expected to be in need of referral abroad during a period of one month.

External closures of terminals for goods may restrict the regular importation of drugs and medical supplies. Humanitarian staff could experience difficulty and delay in entering the Strip when needed. This will be exacerbated by the external cordonning of the Strip that has been planned by the IDF, which will require any humanitarian worker needing to enter Gaza (including, for example, truck drivers transporting humanitarian cargos) to pass through two additional checkpoints before reaching Erez, Karni or Sufa.

*Map (1): External closures*
b. **Internal closures.** Segmentation of the Strip with closures at Sufa-Morag junction (south), Abu Houli junction (central), and the coastal road close to the west of Nezarim settlement, has been planned by the IDF. These closures are likely to last throughout the disengagement period, although with hypothetical suspensions at night and on weekends (security permitting, as conditionality).

*Tertiary health care* available in the Gaza Strip is provided by Shifa Hospital and El Nasser Paediatric Hospitals, in Gaza city, and by the Gaza European Hospital in Kahn Younis. However, some specialized diagnostic and treatment services are only provided in Gaza city by Shifa and El Nasser hospitals. Therefore, patients in need of these services should reach Gaza city, despite the internal closures. The estimated number of residents from the areas south of the costal road checkpoint (Mid-Zone, Khan Younis and Rafah) in need of tertiary care that is only available in Shifa hospital is about 150 per month. Furthermore, some diagnostic laboratory tests (e.g., serology including HIV, immunology and tumor markers) are only provided by the MoH Al Rimal central laboratory, in Gaza city. Therefore, blood samples collected in the district health centers should be transported to Gaza city on regular basis.

*Secondary health services* have been decentralized by the MoH. Hospitals delivering referral and emergency care are now available in all districts. The MoH also has a plan for the reorganization of health care staff that, in case of internal closures, has proven to be effective through redeploying health workers to those facilities located near to where they reside.

However, in the Rafah area there are several gaps in secondary care. First of all, Al Najiar hospital has a limited capacity to respond to emergency needs – e.g., is able to provide only basic emergency care and to a limited number of patients - being a PHC center only partially upgraded to hospital. Therefore, patients from Rafah need to be guaranteed access to hospitals in Kahn Younis, in the cases of severe or complicated health problems (e.g. multiple traumas), and in the event of a high number of trauma cases. Also, 25 people with kidney failure are resident in Rafah and need haemodialysis 3 times a week, which is provided by the European hospital in Kahn Younis.

Furthermore, obstetric care is not provided by Al Najar hospital, and only one UNRWA clinic in Rafah camp provides obstetric care for normal deliveries to refugees. All at-risk deliveries in Rafah are referred to the hospitals in Kahn Younis, as no facilities for caesarean section are available in the district. The number of expected deliveries for the Rafah population is about 400 per month, of which 65 are in Tal al Sultan area. Almost one third of these deliveries will be classified as at-risk and should be referred to Kahn Younis (130 per month, 45 of which need a caesarean section).

*Primary Health Care (PHC)* access may, in theory, not be affected for the majority of people (with the exception of some enclave areas and the areas trapped inside the settlement cordons, see following paragraph), given that the PHC network covers most of the areas. However, curfews and military operations can disrupt the system's delivery
capacity, potentially hampering access to any level of health care, and especially endangering those in need of emergency care.

*Map (2): Internal closures*
c. Enclave areas. There are four enclave areas in the Strip: Al Mawassi, al Sayafa, Al Maani and Abu Alajin. Given that these communities are located within the Israeli settlements), - during disengagement it is likely that the enclave areas will suffer from stricter than usual, or even complete, movement restrictions, including prolonged curfews. Military cordons surrounding the settlements will create further enclaves of Palestinian communities, although it is not precisely known the extent of the areas that will be closed by the cordonning. It also must be taken into consideration that the risk of incidents - and therefore of casualties – will be higher in these areas than in the rest of the Strip during disengagement. Al Mawassi and those populated areas most probably included in the inner cordon of Gush Katif block have been assessed as the most at-risk areas in terms of access to health services and of the possibility of a higher number of casualties resulting from clashes. This is because of the high number of the Palestinian population involved (more than 90,000 people), and for the longer time the evacuation of the Gush Katif settlers will take (several weeks, according to IDF), as compared to the other settlements.

*Al Mawassi*, with a population of 8,500, is located within the Israeli Gush Katif block, in the southern Gaza Strip. Movement in and out of the enclave is only possible through two checkpoints. There are three primary healthcare facilities. The health staff working in the clinics are resident in the area. The clinics provide primary curative and preventive services, including immunization. The stocks of drugs and medical supplies currently pre-positioned cover the population's PHC needs for three months. There are no referral facilities in the area. Referral care, including emergency care, normal deliveries, cesarean sections/at-risk delivery care, is normally provided by the referral hospitals in Khan Younis (mainly Nasser hospital and Gaza European hospital) and in Rafah (Yousef El Najar hospital).

Emergency transportation to the hospitals is provided by the PRCS, who coordinates with the IDF through the ICRC or MoH, and carries out a “back-to-back” transport through the checkpoint. The process of coordination usually takes 1-2 hours, and the waiting time of ambulances at the Tufah Check point is 30-180 minutes. It is expected that, for a period of one week, the average number of residents in need of referral care (excluding conflict related traumas) to hospitals out of Al-Mawasi is 30. In May 2005, 6 cases were referred for delivery, and 25 children and 78 adults were referred for both emergency and chronic disease management.

As for the communities situated inside the cordonning around Gush Katif block, it appears very likely that two densely populated areas will be included and closed: *Kahn Younis camp*, with a population of 60,000 and *Tal El Sultan* in Rafah, with a population of 25,000. Among the residents of Kahn Younis camp, the expected number of people in need of referral care is about 300 per month, in addition to approximately 150 deliveries per month.
In Tal El Sultan, the expected number of people in need of referral care is about 140 per month, plus about 65 deliveries per month.
The other enclave communities, *al Sayafa, Al Maani and Abu Alajin* can be considered less at risk, as the estimated period of the evacuation of the settlers will be shorter (a few days). However, it must be noted that these communities have no access to any health care inside the enclave, and therefore access to any level of care must be guaranteed, without delay in case of emergency.\(^1\)

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1 *Al Sayafa* is located within Dugit settlement, in the northern Gaza Strip. About 250 residents live inside. Access in and out is only possible through a single gate, which is controlled by the IDF. Only residents and internationals, after coordination, can access the gate. In case of emergencies, crossing is usually allowed - after coordination – 24 hours per day, and it usually takes 30 minutes. No health clinics are available in the area. One resident has received basic health training by UNRWA and he is the first contact for the residents with health problems. He also receives from UNRWA some essential drugs for managing simple health problems. He is the person who coordinates with the IDF when there is a need for health care. For the transportation of patients, there are no ambulances or cars in the area, and no ambulances are allowed to come from outside and cross the gate. No transportation is usually guaranteed even outside the gate. No preventive health activities are provided to the residents. Therefore, the residents seek care only when acutely sick. There is the serious risk that some insidious health problems are present in the population, without having been detected. Cases of home delivery are sporadic.

*Al Ma'ani* is located inside the Kfar Darom settlement, in the middle part of the Gaza Strip. There are 27 Palestinian families (157 people, 80 of them are children) living there, mostly refugees. Movement in and out of the enclave is only possible on foot or by a licensed donkey cart through a gate that opens four times a day. Only residents can move in and out of the enclave, if they possess a magnetic card. People other than the residents can apply for coordination, which is not guaranteed. Several houses are occupied by the IDF. No health facilities are available in the area, and no health personnel resides there. Secondary care services, including emergency care, normal and at-risk delivery care and cesarean sections, are normally provided to the residents by the hospitals in Dair El Balah (Aqsa Martyres hospital). Eight chronic patients with cardiovascular disease live in the area. These patients receive their medical care from an UNRWA clinic in Dair El Balah, which provides them enough required medication to cover 2 weeks periods.

*Abu El-Ajin* is an area surrounding the portion of Salah Eldin road between north and south Abu Holi checkpoint. 120 families live in the area, which is divided into four enclaves. The Eastern and Western parts are separated by Abu El-Ajin road, and the Northern and Southern parts are separated by Kissufim road. No health clinics are available inside the areas. In case of health emergencies, people must wait to go to the hospital until the time when the gate opens. In the north-western enclave the community leader calls the IDF for coordination, an Israeli ambulance takes the patient to Abu Holi check point and a Palestinian ambulance takes the patients to Dair El Balah. Water and electricity are available in the four parts. People receive food aid from UNRWA, WFP and ICRC.
Map (3): Internal cordons, enclaves and access to hospitals
2.2 Extra burden of traumas resulting from clashes

It has been assessed that, during disengagement, there will only be a moderate number of traumas from clashes. The local system has demonstrated, in previous crises, to be able to cope with a moderate number of cases. However, access to the patients for first aid at the place of the incident has been often delayed for security reasons. Also, in areas under incursion, transportation to referral emergency care has been hampered on many occasions.

In a worst case scenario, in which there is a significant burden of traumas, it is likely that the local health system will not be able to cope. The quality of emergency/trauma care – which is already precarious – could be affected by an overload of injuries and the morbidity and mortality rates of these casualties could increase. Also, the capacity of the MoH to deliver medical supplies, oxygen, blood and blood products to the hospitals may well reach its limit and become insufficient to respond to the needs.

The above may be of particular concern for the Southern area, e.g. in Rafah, where the Al Najjar hospital is most likely to be impacted by the disengagement (higher number of casualties and most affected by internal closures) and lacks the proper infrastructure to meet the needs in case of closure (Najjar hospital has no oxygen production facility; the blood bank in the South has a limited capacity). Another problem in the South is that El Nasser Hospital, in Kahn Younis, is exposed to an area of high risk of clashes and has already been affected by exchange of fire and shell launches during recent incursions.

In this scenario, it is likely that the routine hospital activities would be neglected, as priority would be given to emergency care and health personnel would not be sufficient in case of mass trauma casualties. Therefore, stocks of all consumables supplies should be maintained at a level that allows for the normal functioning of the hospitals in case of the sudden influx of a high number of trauma patients.

There are specific concerns regarding the enclave areas and the areas within the inner cordon (particularly Tal El Sultan in Rafah, and Kahn Younis camp, as mentioned above). On one hand, there is an increased and prolonged risk of incidents and on the other, emergency first aid, advanced medical posts for stabilization of critical patients and referral care are not available, and access outside the areas will be restricted. Medical evacuation of patients will be crucial.
3. PREPAREDNESS AND RESPONSE

3.1 Service Delivery

The MoH runs 54 primary health care facilities and 11 hospitals in the Gaza Strip, while UNRWA has 17 PHC facilities. Three month emergency stocks are pre-positioned at all MoH facilities including two clinics in Al Mawasi, with two month stocks available at all primary health care centres and pharmacies operated by UNRWA. However, the central stocks of the MoH are low and need to be replenished before the disengagement – possibly before the external cordonning is in place - given the difficulty foreseen in
transporting goods, even humanitarian, into the Gaza Strip during that period. All but one UNRWA health centre have generators, in the event of a power failure.

The MoH currently operates 66 ambulances in Gaza. The fleet is distributed between the 5 districts and redeployed as required. Each district has 3 ICU ambulances. PRCS operates 40 ambulances located in six ambulance stations, one in each district and one sub-station in Al-Mawasi. PRCS can be directly reached through 101 telephone line and will coordinate with the MoH ambulance service. In times of acute crises generated by large scale IDF incursions, coordination on behalf of the PRCS will normally be required by the ICRC.

In those enclave communities where health services are very difficult to access (only existing outside the enclave), the most vulnerable populations (children under 5, pregnant women, and chronic patients) have been identified and screened by UNRWA health workers to identify possible undetected problems, to provide appropriate treatment and to prevent or anticipate any possible complications during disengagement. ICRC is also considering the deployment of an Advanced Medical Post in El Mawasi area, to address the possibility of a prolonged closure and mass casualty situation.

3.2 Information

a. Baseline information: WHO is completing an assessment on availability and pre-positioning of stocks of drugs and medical supplies, focusing on emergency care, the availability of health personnel in the local health facilities, and access to referral care (with special focus on enclave communities). Information is being collected through contact with the relevant MoH departments (Emergency Dept, Pharmaceutical Dept, PHC Dept, Hospital Dept), phone contact with PHC facilities, meeting with key residents, information exchange with other agencies (ICRC, UNICEF, OCHA, SCF, UNRWA) and field visits (all enclaves have been visited).

WHO has a database available, providing information by district and by health facility. This will be made accessible to all of the health community, providing updated and reliable information on the health facility network. Maps and database on the health facility network will be available soon through Healthinforum website (www.healthinforum.org).

b. Monitoring during withdrawal: Tight monitoring of health needs and response by local services is critical, in order to respond, from central level, and through the international community, to any unfolding gap -- and to prompt access to health care if not guaranteed. This is especially important in those communities that are at most risk of experiencing access problems, namely all enclave communities and families trapped inside the settlements and within the inner cordons (around settlements and roads).

A list of monitoring indicators is under preparation by ICRC and WHO. The agreed set of data should be utilized by all health agencies as the common monitoring tool. Therefore,
standardized and systematic data collection should guarantee a sufficiently reliable, efficient and effective monitoring coverage.

A network of contacts in the field has been developed, including health workers and key persons within the communities. Regular and frequent phone links will be the most relevant sources, and should provide necessary information included in the indicator list. Field visits will be done whenever deemed necessary and if security permits.

\[c. \text{Information management and reporting}: \text{OCHA will be the focal point for the dissemination of humanitarian information. WHO will produce health sector briefing notes to be included in UN reports on the humanitarian situation, in specific reports on baseline health information, and on monitoring during the withdrawal. These will be disseminated through the OCHA system; } Healthinfo\textit{rm}'s mail network, website and monthly newsletter; and through OCG and Health Emergency Coordination Meetings.\]

3.3 Coordination

\[a. \text{Health sector coordination. Given that the MoH is the main provider of emergency care, it is important to guarantee a strong coordination with its main central departments involved -- which are the Emergency Dept., the Pharmaceutical Dept., the PHC Dept., and the Hospital Dept. It has been agreed that WHO is the liaison agency between the MoH, international health agencies and the main local health agencies. In addition, WHO will be the focal agency for health within the UN interagency coordination structure/contingency plan.}\]

On the basis of any unfolding needs and gaps identified through the monitoring system, coordination should guarantee a prompt and effective response in terms of procurement of medical supply, enabling access for referral, redeployment of medical staff, and availability of emergency transportation for rapid patient evacuation.


\[b. \text{UN/Intersectoral coordination. An Interagency contingency plan was recently drafted by a group of UN agencies (OCHA, WFP, UNICEF, WHO, with inputs from UNSCO, UNDP and UNRWA). The plan lays out a set of agreed planning assumptions, objectives and responses, amongst the UN agencies, in response to the possible humanitarian consequences linked to the disengagement.}\]

In addition, a range of meetings and discussions have taken place with other organisations operational in Gaza, including the key NGOs and the ICRC. Further discussions have involved the PA, notably the Ministry of Civil Affairs and the Ministry of Health, to ensure a consistency of objectives and actions between the international agencies and the Palestinian Ministries, Governorates and Municipalities.

This exercise contributed to: a) a consensus on likely scenarios and the possible humanitarian impact to be addressed, b) a comprehensive analysis of needs, the response capacity of local providers and gaps c) a consensus within the UN system and among main service providers on response strategy and coordination mechanisms.
3.4 Advocacy for access

As mentioned above, the main concern of international agencies remains the ability of patients to access secondary health care in the event of a prolonged shut-down of the type expected in the enclaves inside and around Gush Katif block. Not only un-delayed access to emergency care for injured will be needed, but also access to care for the most common medical emergencies, such as acute cardiovascular crisis (e.g., heart attack), severe asthma attacks, and normal and complicated deliveries.

Assurances have been sought from the Israeli DCL that emergency access will be provided through Tel El Sultan checkpoint in the case of Al Mawasi and the northern settlement block, if emergencies arise in Siafa. The DCL has given assurances that the coordination of ambulances would be facilitated, upon request, to all closed areas. However, even assuming that this will be the policy adopted by the IDF, the capacity to implement this policy does not seem guaranteed.

Preventive actions through negotiating with the IDF concerning sufficient measures to guarantee access to health care, and a close monitoring during the pull-out phase, are vital.

ICRC is the main agency addressing access to healthcare and medical facilities. ICRC is already working on preventive access, through advocating that the Israeli authorities guarantee access to patients, incorporate humanitarian routes for medical evacuation into military plans, and facilitate the transfer of patients -- emphasising the highest level of importance and the legal obligation of allowing access to healthcare. For the UN, OCHA and the TFPI are responsible for advocating humanitarian access with the IA. Negotiation and preparatory activities have already begun, with the support of UN RFCO which provides security advice and analysis.
**Abbreviations**

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<th>Abbreviation</th>
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<tr>
<td>DCL</td>
<td>District Coordination Liaison</td>
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<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<td>ICU</td>
<td>Intensive Care Unit</td>
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<td>ICRS</td>
<td>International Committee of the Red Cross</td>
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<td>IDF</td>
<td>Israeli Defense Forces</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>OCG</td>
<td>Operations Coordination Group</td>
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<td>OCHA</td>
<td>United Nations Office for the Coordination of Humanitarian Affairs</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>PA</td>
<td>Palestinian Authority</td>
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<td>PRCS</td>
<td>Palestine Red Crescent Society</td>
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<td>SCF</td>
<td>Save the Children Foundation</td>
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<td>SHC</td>
<td>Secondary Health Care</td>
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<td>TFPI</td>
<td>Task Force on Project Implementation</td>
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<td>United Nations Children’s Fund</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNRWA</td>
<td>United Nations Relief and Works Agency for Palestine Refugees in the Near East</td>
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<tr>
<td>UN RFCO</td>
<td>United Nations Regional Field Security Coordination Officer</td>
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<td>UNSCO</td>
<td>United Nations Office of the Special Coordinator</td>
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<td>WFP</td>
<td>World Food Program</td>
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