

THE

MÉDECINS DU MONDE PALESTINE

LABYRINTHS TO HEALTH IN GAZA



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ACRONYMS

- 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

PREFACE

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.

Considering that these systemic challenges are mainly structured around institutions but experienced by the Palestinian population in the Gaza Strip, this report follows the fictional life of the Al-Gazaoui family and explains the internal and external factors that influence their journey.

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.¹ It made the case that the permit regime has negatively affected the lives 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.² 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.

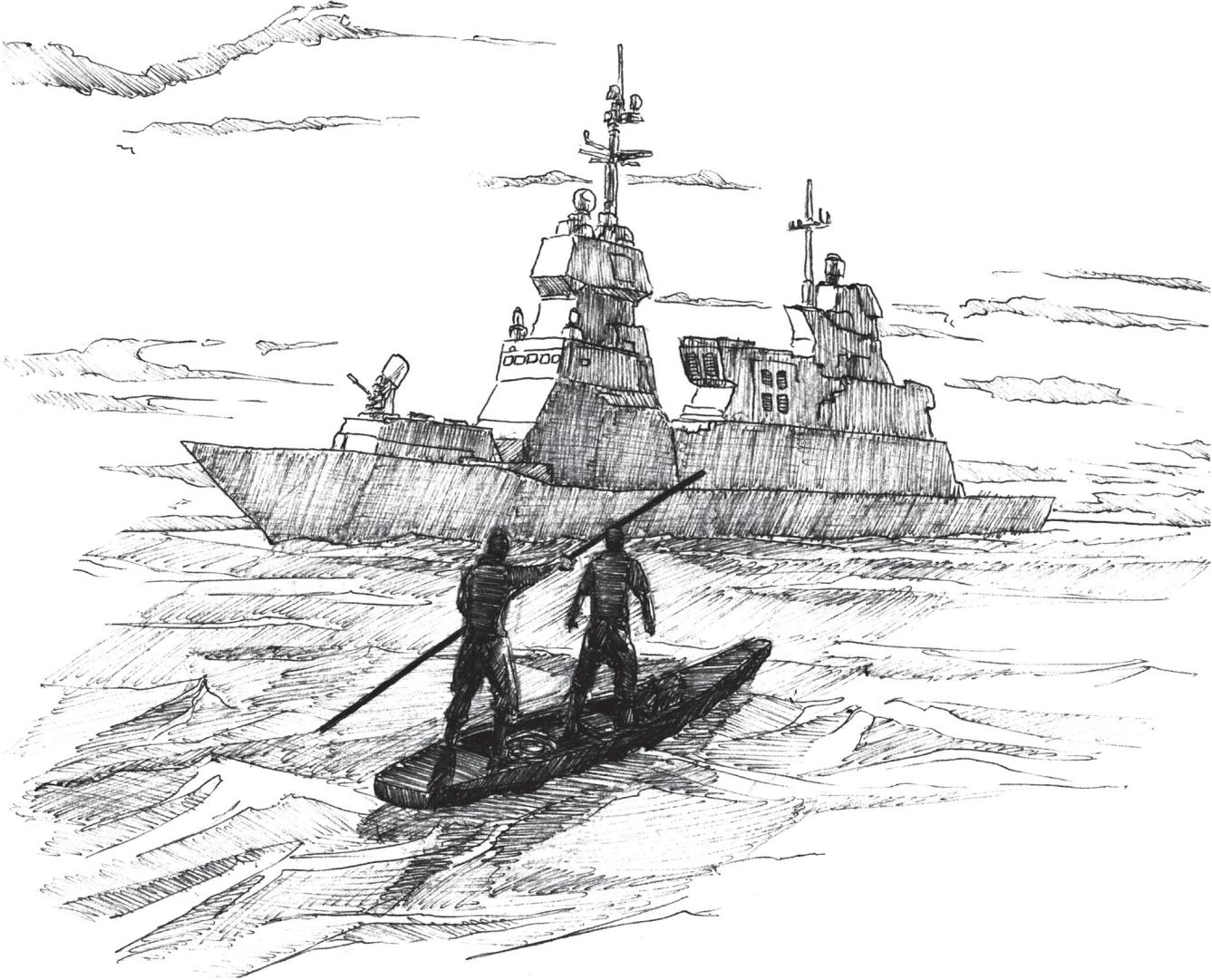
Uncovering the multiple challenges of the specialised health services in Gaza and their nexus with the harsh reality of the exit permit regime is easier when it is seen through the eyes of Palestinians and from thereon explore the world that lies behind those experiences. Inspired from real life stories, 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.

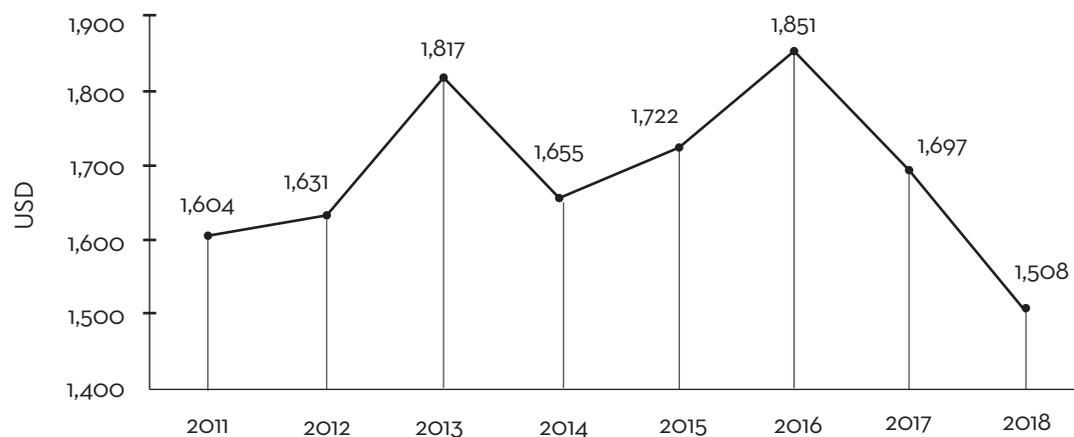
Khaled is the father of the Al-Gazaoui family. As a refugee living in Gaza with his wife and three children, he has been making a living as a small-scale fisherman, selling his daily catch at the local market. The money he makes is barely enough to cover the basic needs of his family.

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 clients. For this, Al-Haq provided MdM with 44 legal declarations describing what patients and their companions experienced while applying for permits, during their journeys when crossing out of Gaza and when coming back. These declarations, covering the period from 2007 to 2018, were 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.



CONTEXT

**FIGURE 1**

GDP per Capita in Gaza 2011 – 2018.

Source: PCBS, 2019.

A SHATTERED ECONOMY

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 Palestinian state, 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 USD 1,507, the lowest in eight years, and since 2016 has decreased by 19%.³ 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.”⁴

Unemployment rates continue to skyrocket to record-breaking rates as high as 45%. This forces families to rely on borrowed money from relatives or friends.⁵ 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.⁶

OUT-OF-POCKET HEALTH

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The general impoverishment of the population in Gaza also affects the access to health. Between 2011 and 2017, poverty in Gaza increased by 14%. By 2017, 53% of the population were living in poverty, of whom 33.7% were considered to be in deep poverty.⁷ In a context where poverty is the main socio-economic trend, resulting from the increase of unemployment, reaching over 45%⁸ and decreasing salaries (from USD 18.2 per day in 2014 to USD 17 in October 2018),⁹ access to specialised healthcare services in Gaza is a luxury, in particular when someone is referred outside of Gaza.

Patients with non-urgent conditions 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 people from Gaza to Jerusalem is USD 200,¹⁰ this represents 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 reside far from their homes, particularly in Jerusalem where, compared to Gaza, the average cost of living is four to six times higher. This burden multiplies 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.¹¹ 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 of their treatment, the cost of specialised drugs, and the associated disabilities. In the case of oncology patients, one study found that 77% of patients' incomes were negatively affected after contracting the disease. Almost all of them imputed this to the treatment costs they had incurred.¹²

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.¹³ In 2018, an estimated 4,840 children were working full-time in Gaza.¹⁴ Such a 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 not been sustainable. Over 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 directed at 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 risks creating a vicious cycle of humanitarian needs.¹⁵ This analysis is actually in line with studies covering previous years. Development revenue from international aid in the oPt from 1994 to 2001 did not encourage further investments. Authors like Anne Le More argue that this was the consequence of the inefficiency of structures that had only existed for a few years, but most importantly because the coercive environment of the occupation represents an unsurmountable obstacle to development.¹⁶

During the last decade, humanitarian funding has systematically decreased. It has only been when emergencies have escalated that funding has started pouring in. However, its impact beyond the immediate crisis has been limited. 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 with funding nearly halved from USD 679 million to USD 340.8 million. In 2018, the total funds received were the lowest they had been for 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.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 reaching oPt amounted to USD 1,780 million, it has gradually decreased by 40% over the last ten years, amounting to only USD 1,062 million in 2019.

The allocated funding for health has not been spared from these trends. Although access to some services has increased in relative terms, available resources over the last ten years have halved. In this sense, the heavily donor-dependent and occupation-hampered national Palestinian economy cannot begin to deliver the sustained financial investment required to advance the quality of the health sector.

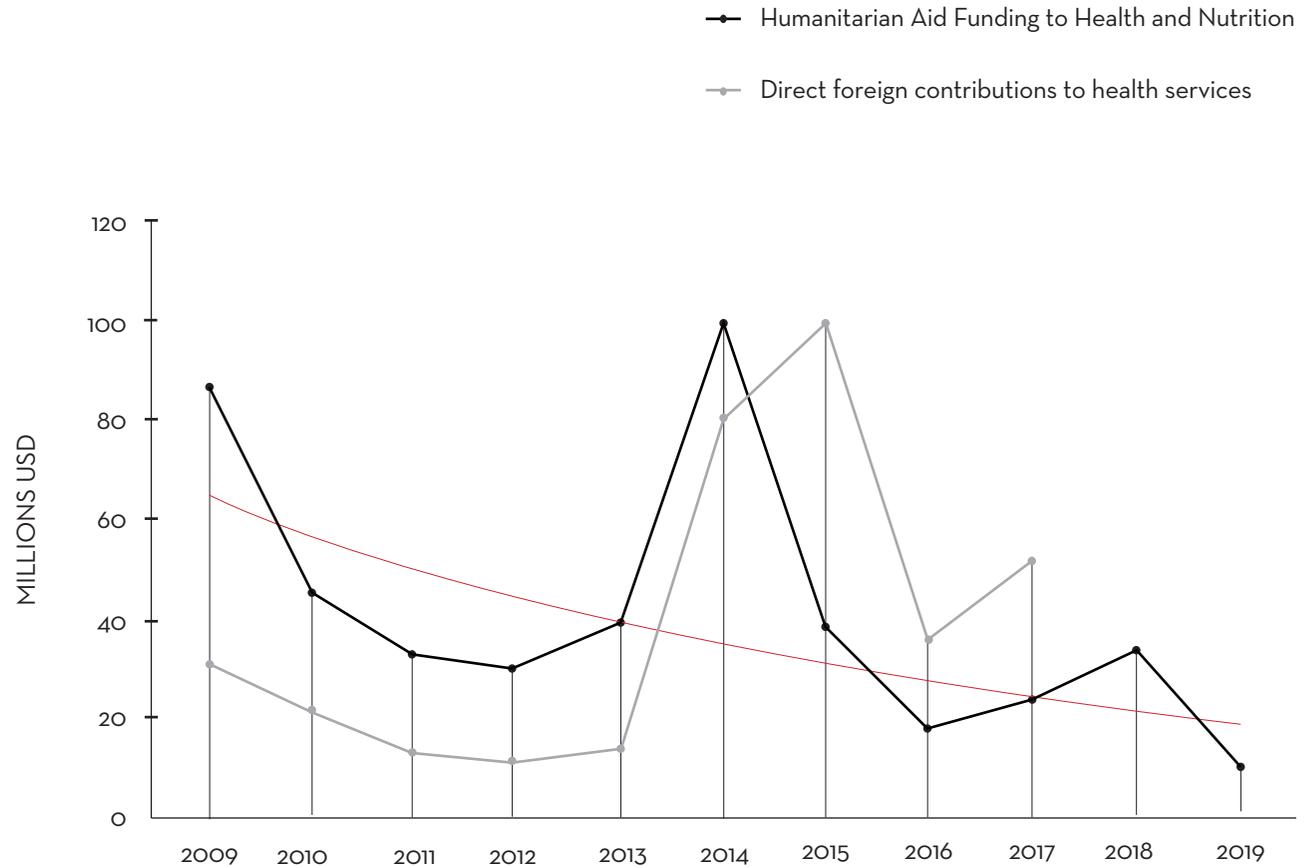


FIGURE 2

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 guideline.

Sources: UN OCHA Financial Tracking Service, oPt (2009-2019); PCBS, Annual National Health Accounts series between 2009 and 2017.

The reduction in external funding has led to a situation where health funding can only respond 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.¹⁸

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,¹⁹ 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. After the August 2018 White House decision to eliminate all assistance to the West Bank and Gaza for the 2017 fiscal year, US funding hit an all-time low of USD 231 million.²⁰ 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.²¹ This project, implemented by International Medical Corps, Mercy Corps and CARE, provided prenatal care for Palestinian women, treatment for the injured in Gaza and funded 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 prevented 3,000 children from receiving healthcare for anaemia and malnutrition and jeopardised the excellent vaccination rate. In addition, 16,000 women were prevented from receiving clinical breast cancer treatment.²² They were forced to look for fall-back options such as the East Jerusalem hospitals where these treatments were available, but they were also affected by the funding cuts.

THE ECONOMIC BURDEN OF REFERRALS

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When the Ministry of Health (MoH) is faced with insufficient treatments, human resources, equipment or medicines to respond to the health needs of a specific patient, the MoH then refers him or her to an external provider. 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, of the 30,869 referrals registered by the MoH, 52% were issued to patients that needed to exit the Gaza Strip, while the remainder were for referrals within the Strip.²³ This represents a 29.4% increase compared to the previous year.

After salaries, referrals costs represent by far the highest MoH expense. In 2018 they represented 34% of the total expenditures and their proportional burden 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.²⁴ The significant financial burden 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, substantially subsidises the national budget.

These growing expenses 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 implementing 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.²⁵ This should encourage decision-makers to conceptualise new strategies aimed at curbing costs and placing the emphasis on sustainable investments for the whole population.

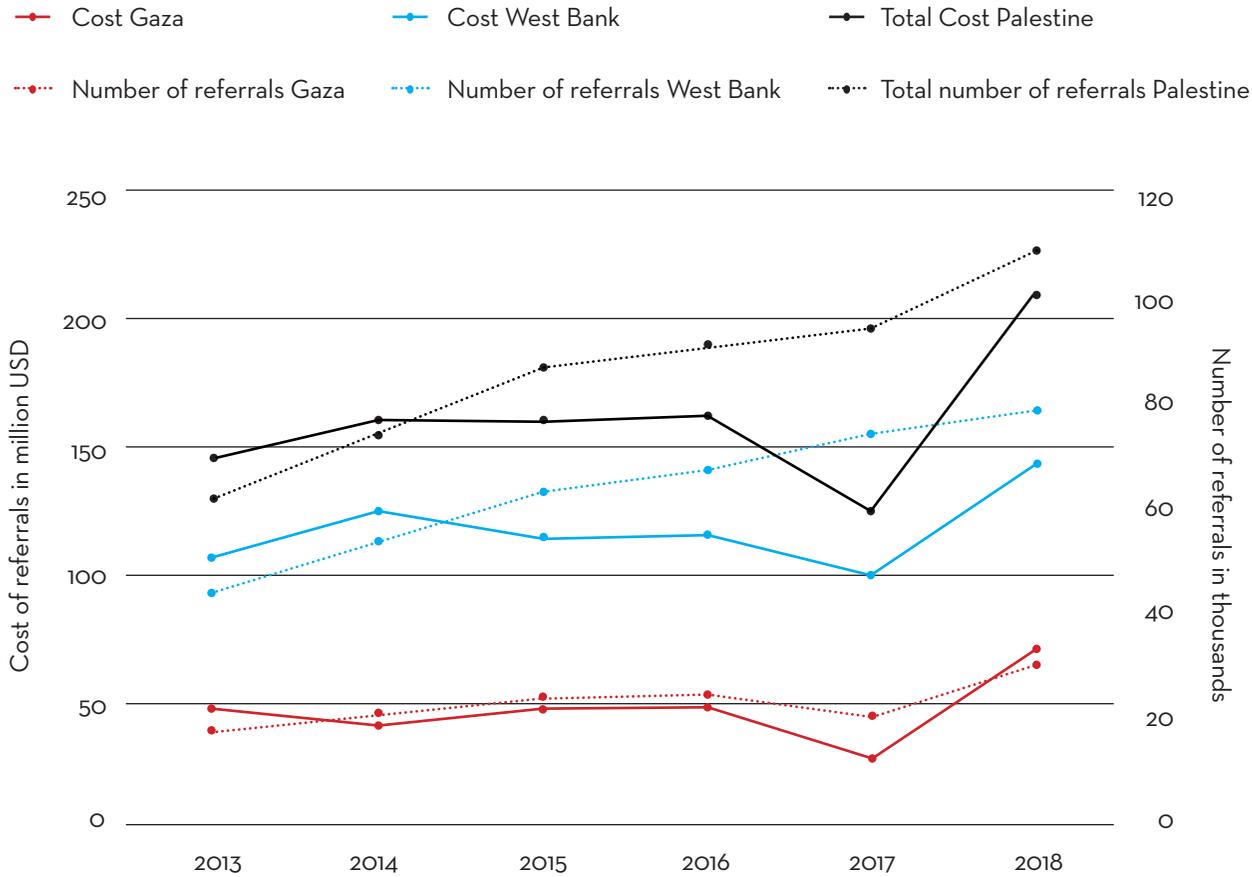


FIGURE 3

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



THE LABYRINTHS TO HEALTH IN GAZA

Dima is a newborn baby and is the last girl of the Al-Gazaoui family.

She has an intolerance to breast milk.

The MoH is not capable of offering her the therapeutic milk substitute she needs.

The family attempts to buy one on 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 the 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 maternal and child health and 56% for oncology and blood disorders.²⁶ These figures follow a trend that has endured far too long. During the second quarter of 2019, 50% of drugs on average were available with only one month's supply remaining, while over 40% were completely depleted.²⁷

The lack of medicines not only has a direct impact on the quality of treatment, but it can also represent a growing public health risk when dealing with communicable diseases. It can mean 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 medical disciplines.

In the case of neonatal services, a critical issue arises when babies suffer from metabolic problems. Therapeutic milk saves the lives of, on average, 350 children every year who have problems digesting maternal milk. When the treatment is not available, the consequences range from growth problems to 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 follow the treatment. The Palestinian MoH has listed eleven different therapeutic milks and estimated that, based on the demand, USD 508,293 is required per year to cover the needs.²⁸ 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 restrict the availability of these medicines, including the capacity to produce them locally, political decisions and administrative obstacles.

When local industry cannot produce some of these medicines due to the import restrictions imposed on raw materials by the blockade-related dual-use list,²⁹ the ministry is forced to import more expensive drugs externally. The dual-use list is a list of items and substances which it is 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.³⁰ This highlights the importance of the 2019 Humanitarian Needs Overview report calling for improvements to the monitoring

systems³¹ as well as the UNSCO September 2019 report to the Ad Hoc Liaison Committee (AHLIC) recommendation to facilitate the UN's Project Management Unit to monitor the drug supply chain.³² 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 that toddlers struggle to survive because they cannot access a USD 9 tin of milk powder. With sufficient and sustainable funding, combined with an enhanced management system, access to medicines could be solved.

PAEDIATRICS

Despite the presence of a specialised paediatric hospital in Gaza, children represent the single largest age group for external referrals. 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 for purpose. The technical capacities in terms of diagnosis are present in Gaza, but there are no staff who are 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 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 their mothers or fathers obtained the Israeli permit to exit the Gaza Strip.³³ 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. Where the baby or child does not survive, the permit regime does not even allow parents to go through the normal grieving process. In any of these cases both babies and parents require palliative care, and closeness is fundamental.³⁴

HUMAN RESOURCES

Human resources are a key challenge for the whole specialised health sector in Gaza. Not only are highly skilled staff rare, but those available express great frustration at being constantly devalued. Presently, only 40% of staff salaries are consistently paid out.³⁵ This leads them to feel demotivated and persistently stressed about their ability to cover their families' essential needs.

The permit system also makes it impossible for health staff to leave the Strip to obtain further training or attend conferences to share their work with colleagues and stay up to date with advances in their field. Specialised health staff in Gaza are left with no other incentives other than their passion for their work. In 2018 an estimated 150 doctors left the Gaza Strip, hoping to find a brighter future in Turkey or Europe.³⁶ Hospitals are operating 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.

THE LABYRINTHS TO HEALTH IN GAZA

Paediatrics

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Dima is referred to the Al-Makassed Hospital in East Jerusalem because in Gaza there are no staff capable of dealing with her specialised case.

A paediatric specialist accompanies the little girl and her mother, but none of the adults are given permission to accompany Dima after Erez. During her journey 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 labyrinthine 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 needs to be referred outside Gaza because the necessary treatment or procedure is unavailable locally. He or she then fills out the primary form (Form No. 1), that requires three key signatures from the medical institution. 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 to confirm 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 for contacting the hospitals, which are often 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.³⁷ Once the patient’s appointment is booked, the file is usually sent 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 the 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 into play such as age, who their relatives and neighbours are (if they belong to a political faction, or have a security concern, etc). For example, in 2018, 28 applications were denied because the patient 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 also apply to companions.

The population group with the highest percentage of refusals are males 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 start of the period 83% of them were granted exit permits, in 2017 it went down to 44%.³⁸

This third stage, which lies exclusively with the Israeli authorities, normally takes between 7 to 30 days. During this time, patients wait nervously for a last-minute call from the Israeli side. 60% of patients will not obtain their permit straight away or receive a negative response; they will experience delays while applying over and over again.³⁹ 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 2.67.⁴⁰ In the meantime, the patient’s health continues to deteriorate.

When intending to exit, the permit can be subject to a security interrogation. Usually patients or their companions are informed about the interrogation at the very last minute, or are subject to it during their passage through the Erez terminal. If patients refuse to go through the interrogation 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 is finally 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 Piedmont 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, another option is to go to Egypt through the southern Rafah crossing. In mid-May 2018, the Rafah crossing was opened on 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 frequently seek help from 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 to relevant authorities and on some occasions, they take the Israeli authorities to court. 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.

HOPE BEYOND THE WALL: THE EAST JERUSALEM HOSPITALS

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 ranging from eye and cardiac surgeries, to rehabilitation for handicapped children, neonatal intensive care and advanced oncology and nephrology services.

Most of these institutions can only operate thanks to 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 was such that the Augusta Victoria Hospital in East Jerusalem was forced to temporarily turn some patients away at two periods that 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 US funding cuts, 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.

After a year of constant advocacy with the Palestinian Authority and international donors, none of these hospitals were required to close, but the debt problems remain. 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. In 2018, health care staff in the oPt experienced more attacks than any other country in an emergency situation.⁴⁹

Between March 31st, 2018 and the 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 of violence on the health worker it directly affects, it also leads to direct and indirect harm on 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. As the UN Humanitarian Coordinator Jamie McGoldrick has set out, “the number of wounded during the Great March of Return became an emergency on top of a crisis.”

Over a year and a half since the start of the Great March of Return, even as children continue to be shot and killed, the scale and consistency of the violence has sadly been normalised by many humanitarian 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 finishing his high school studies
and has applied to be a 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 in his right leg with live ammunition
by the Israeli army,
leaving him severely wounded.

THE LABYRINTHS TO HEALTH IN GAZA



ORTHOPAEDICS

In Gaza, with an average waiting time of 16 months for elective surgeries, the number of patients flooding the hospitals and operation theatres resulting from the Great March of Return has 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 had injuries to their limbs.⁵² 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 factors: the first one is the shortage of treatments and required medical devices and supplies, such as external fixators and graft supplies; the second is the long period during which many patients require numerous multi-disciplinary surgeries and individual rehabilitation therapy.

Two specific examples illustrate the difficulties that patients had when seeking access to equipment and devices. First, arthroscopic surgeries are no longer available in the Strip because the equipment is currently in disrepair. Second, during the first months of the GMR, it was impossible to access carbon ring external fixators because the Israeli authorities considered them dual-use items.

Bone grafts are an alternative means of carrying out reconstructive surgery. 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 taking several weeks. In addition, given the absence of vascular and plastic surgeons, the available staff lack experience of working on multidisciplinary cases, while those already operating on ever more 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.⁵³ 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, an infection of the bone.⁵⁴

In summary, a patient who had a large gunshot wound on one or both of his limbs would face the following challenges: he may require between three to five years of constant surgeries, which include prolonged hospital stays and temporary or permanent disability; he may face delays due to the long waiting lists for accessing the operating theatre; and he risks suffering an infection due to multidrug resistant bacteria. All this within an environment where access to analgesics and anaesthesia are far from guaranteed.

Where there are complications and patients require further treatment outside of Gaza, patients face further challenges. One such challenge is confronting Israeli attitudes against those who participated in 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.⁵⁵

This means that a large number of patients, who in any other setting would have the chance to get a second medical opinion or seek treatment beyond what is available locally, have had to abandon the simple idea to fight for this right. On some occasions, the consequence has been a limb 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.⁵⁶

After undertaking a couple of initial urgent surgeries, Mahmoud is told that he will need a bone graft to reconstruct his lower tibia. Unfortunately, the Israeli authorities have not allowed the import 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 have been provided in Gaza since 1984. At that time, the authorities made a big initial push to make most medicines available. Since then, medicines and treatments have become 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: staff 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 referrals (31%).⁵⁷ Treating cancer requires a full spectrum of expensive services and highly qualified staff 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.⁵⁸

To understand the tribulations which cancer patients in Gaza face, it is necessary to follow the whole medical pathway. After being screened, the next component is diagnosis by 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. Staff specialised in this field are scarce because universities cannot teach it as part of their curriculum, so those who work within this branch of medicine are trained *in situ*. In the meantime, new techniques and knowledge evolve very rapidly but the practitioners have not had the opportunity to update their knowledge since 2002. In the laboratory, even if the equipment works, the lack of medical 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.⁵⁹

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 they

are in overwhelming demand. One reason for this is that all departments are experiencing struggles in their structure, design and essential supplies.⁶⁰ For even more complex cases, a positron emission therapy with computerised tomography (PET/CT) scan is required to follow precisely the evolution of cancerous metastasis, but this is only available in the Augusta Victoria Hospital in East Jerusalem.

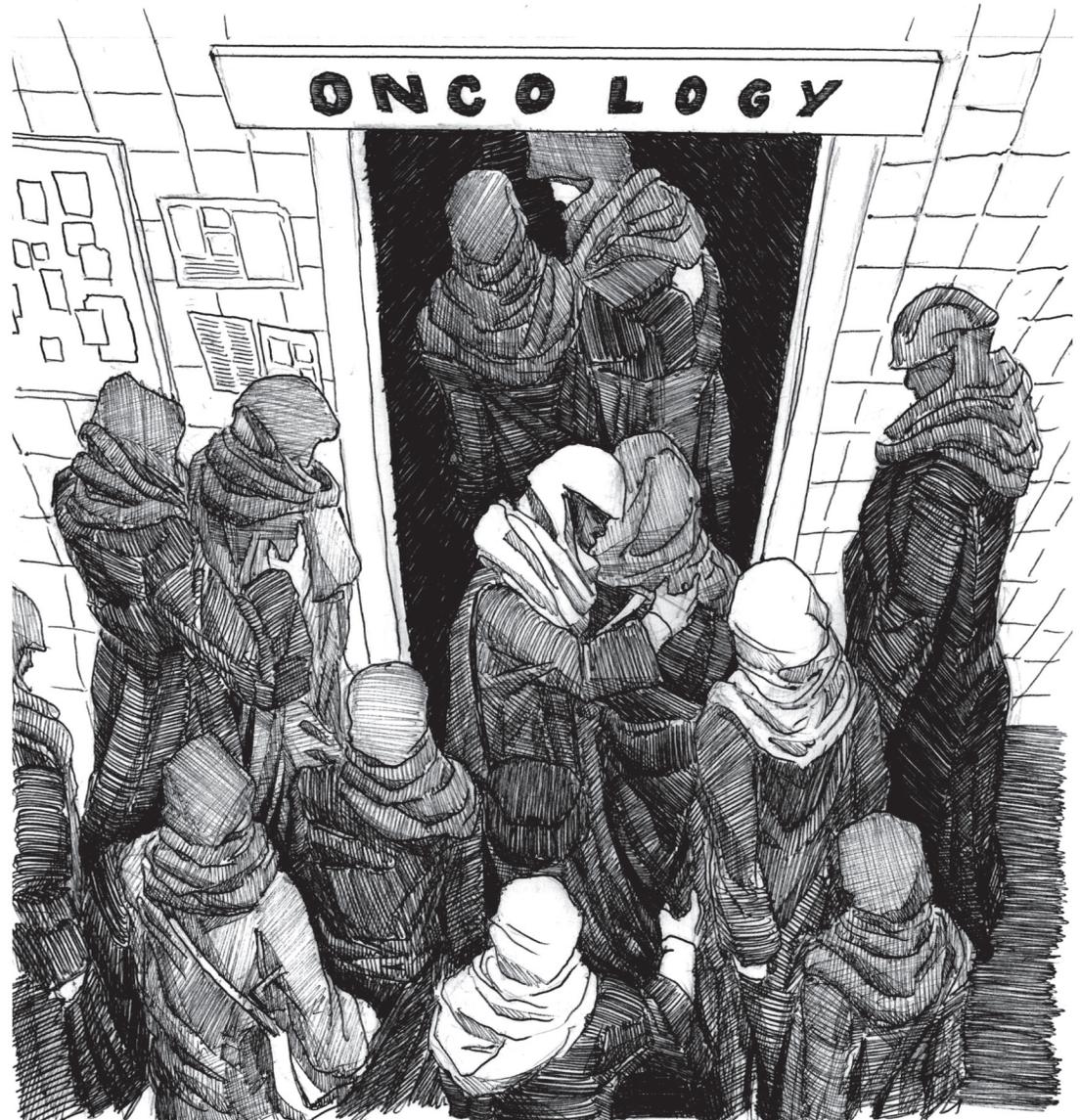
Referrals for oncology services are also among the most expensive. In 2018, they represented 37% of the total costs of referrals.⁶¹ To make sure that scarce resources are used efficiently and avoid further erosion of the health system in Gaza, it is necessary to improve the performance of the health system and also strategically invest in key specialised services. Recent studies have shown that Palestinian hospitals still have the capacity to improve their efficiency by 14.5%.⁶² At the same time, even if technology advances have been considered among the most important drivers of healthcare spending, not all technologies share the same potential. Investments on NICU and oncology technologies have been shown to have a negative correlation between use and spending.⁶³

THE LABYRINTHS TO HEALTH IN GAZA

Oncology

42

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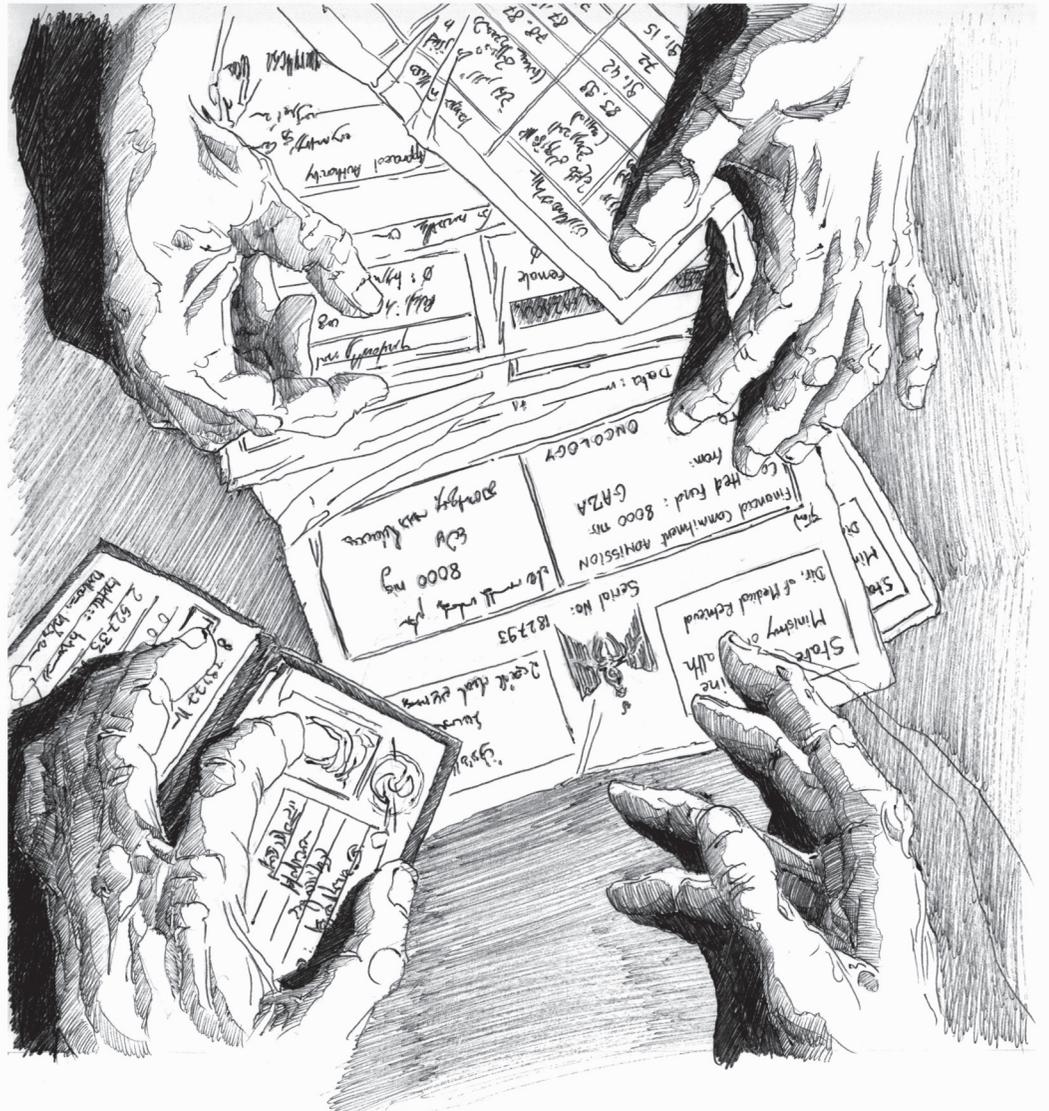


Some months later, Intisar, Khaled's wife, notices that one of her breasts feels slightly different but does not go to the hospital for screening because she believes it will disappear just like it appeared. A year later, she is diagnosed with breast cancer.

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 and her husband have to present themselves in Erez for an interview, which will determine whether 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 room is constantly full and doctors have very limited time to spend with each patient. In contrast, in the West Bank, there are more than 15 oncologists, including haematologists. The process of training new staff as oncologists is like a Gordian knot: solving it requires an almost impossible combination of features. Being a specialist in this field requires students to have access to all the essential therapies, including radiotherapy which, as mentioned previously, is not available in the Strip. The only potential solution is to obtain practical experience at the Augusta Victoria Hospital, the only medical facility where these services are all available in one place. However, in reality, for Gaza residents, travelling to East-Jerusalem for such reasons is not permitted. This means that there is no respite for the few specialised doctors; they do the best they can with very limited resources and help.

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.⁶⁴ Oncology chemotherapies follow specific protocols: the cocktail has to include all the drugs required 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 lifesaver for breast cancer patients globally. However, a year-long treatment using the drug costs USD 76,700.⁶⁵ The same goes for Avastin, a drug used to treat colon cancer, which costs USD 2,380 per month⁶⁶ and, in addition, requires fluoropyrimidine-based chemotherapy. These drugs are simply out of reach for patients in Gaza and the West Bank alike. Private institutions such as the Augusta Victoria Hospital in East Jerusalem are capable on some occasions of covering the costs 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 be left with surgery as their only option left. But even among these patients, 15% will need to be referred outside of the Strip for specialised surgery because of the technical complexity of the required treatment, 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 developing several disabilities.

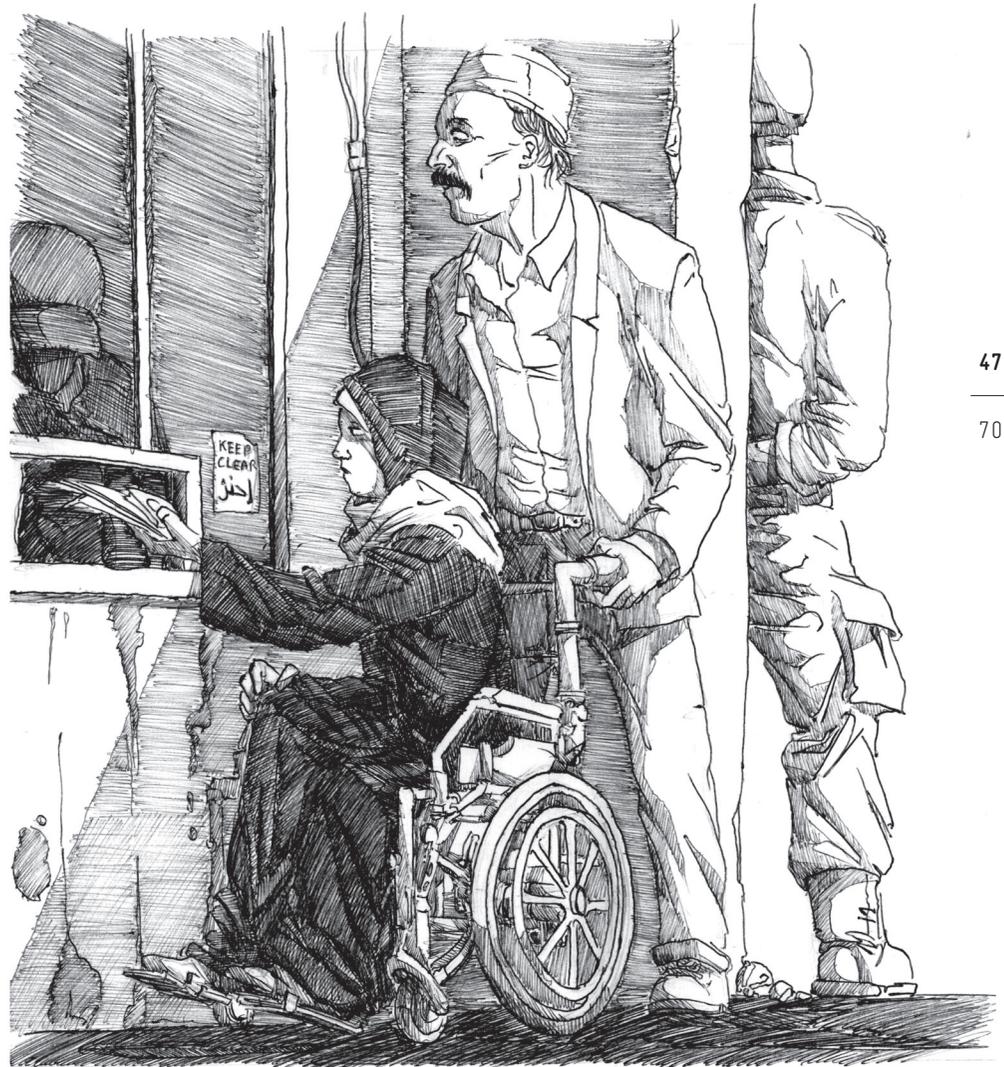
The day of the appointment
has arrived.

By this time, Intisar has lost
a lot of weight
and can hardly move
by herself.

She needs a wheelchair.

In Erez, despite her mobility
difficulties, she is requested
to walk around,
go back and forth
through the scanner
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.



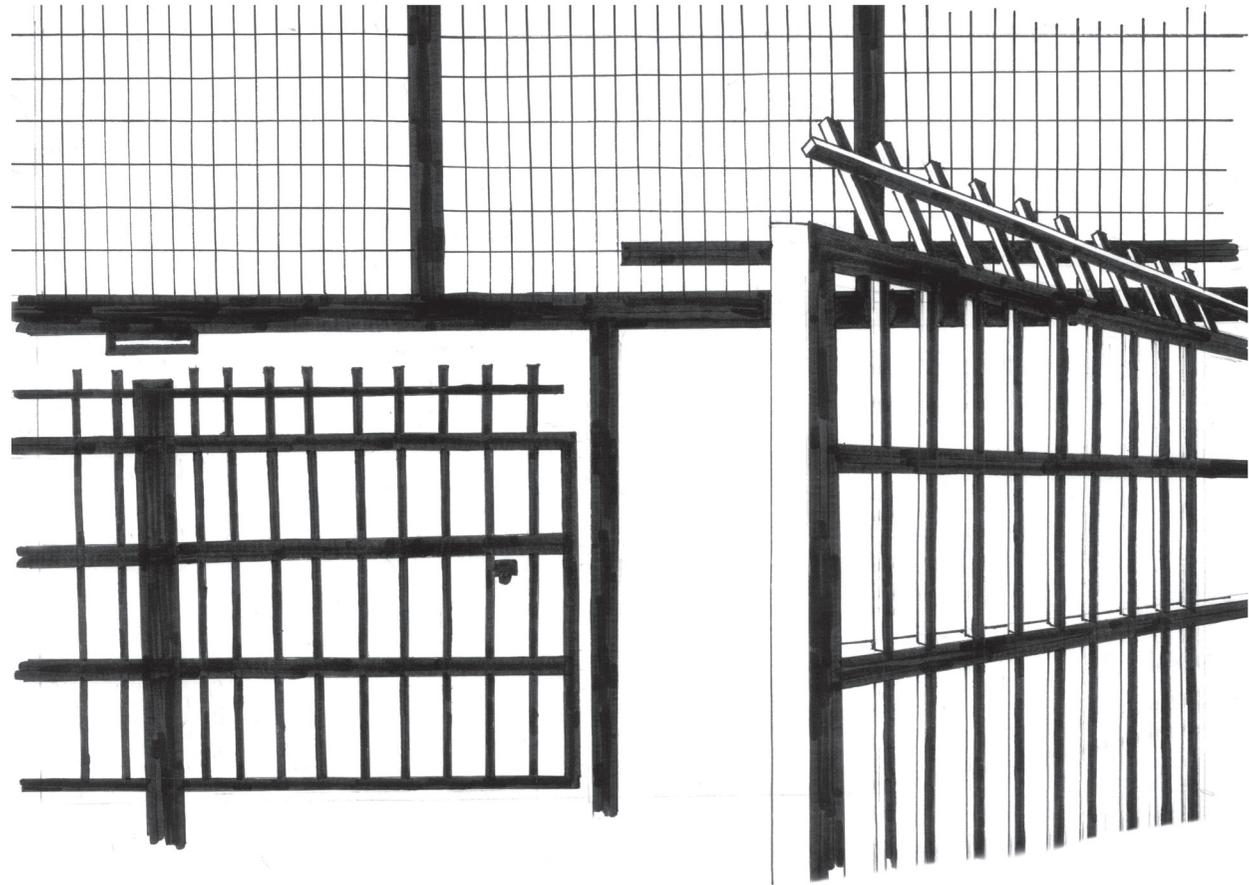
RADIOTHERAPY AND PALLIATIVE CARE

Despite radiotherapy being one of the most cost-effective treatments for curative and palliative care of cancer patients, there are only four linear accelerators to provide radiotherapy in the whole oPt. Cancer patients must surmount a substantial 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 1 machine for every 400,000 persons.⁶⁷

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

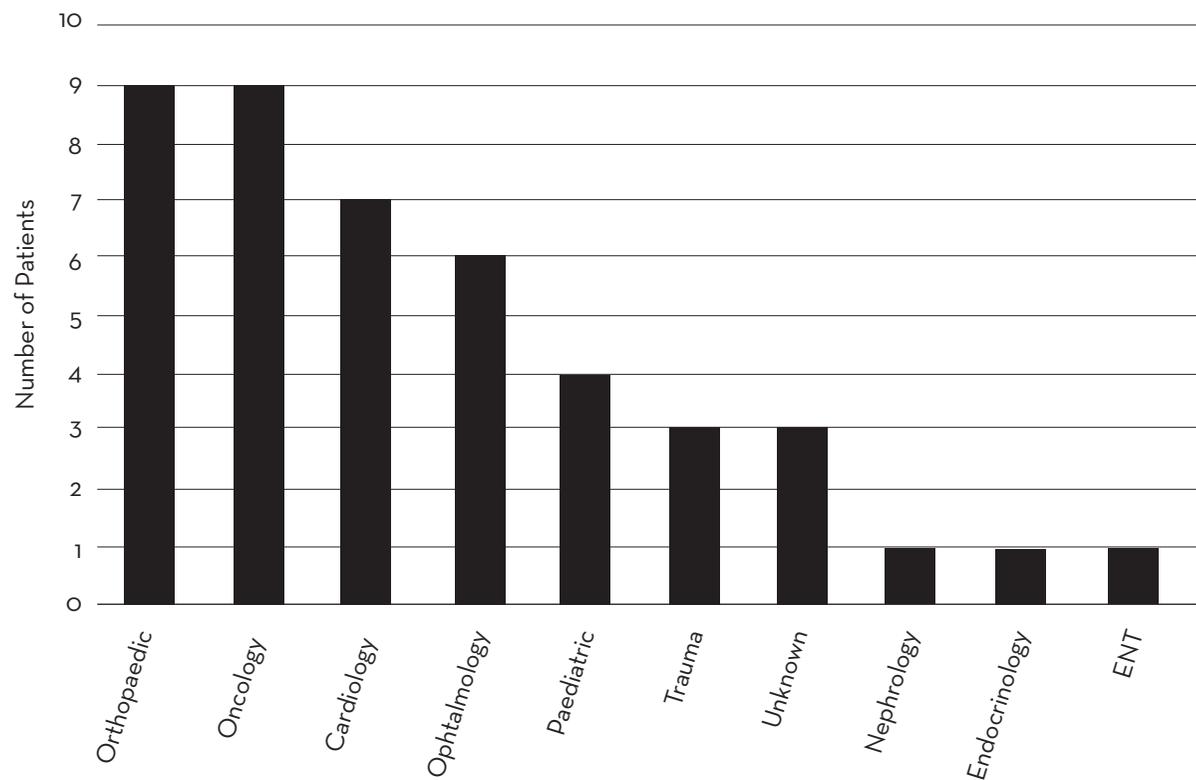
The reason that there are no linear accelerators outside East Jerusalem, some argue, is that the use of Cobalt-60, used for teletherapy, could allegedly be used for terrorist purposes. However, it is important to note that other radioactive isotopes such as Fluorine-18 are used for medical purposes during positron emission therapy (PET), 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 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 that they also risk needing a mastectomy. With few among them likely to be offered reconstructive surgeries, this affects 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 is not only lacking for oncology patients in Gaza, but also for patients suffering from 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



In order to illustrate the current challenges facing patients with specific examples, the Palestinian human rights organisation Al-Haq provided MdM with 44 legal declarations describing what patients and their companions experienced when trying to obtain their referral permits, as well as their journeys when crossing Gaza and back. These declarations span from 2007 to 2018. While the sample cannot be considered a proportional representation of all cases during this eleven-year period, it does convey many of the experiences patients in Gaza have to endure.

FIGURE 4
 Number of patients per medical treatment among the cases tracked by Al-Haq between 2007 and 2018.

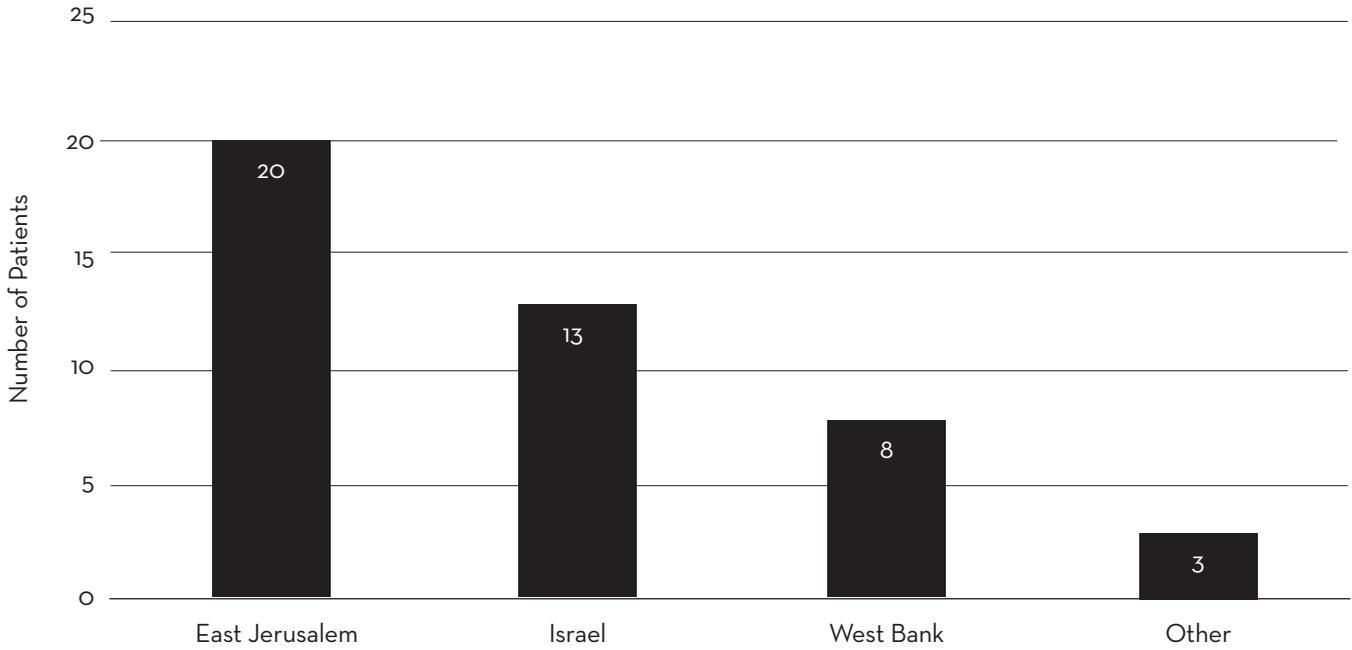
The leading grounds for referral in this sample were for orthopaedic and oncology conditions. This is similar to WHO's findings in 2017, which found that oncology represented the main referral need, followed by cardiology, haematology, orthopaedic conditions and paediatric cases. *See [Figure 5](#)*

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 keep a quadriplegic boy alive. Some of the 42 patients were referred on 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 to treat 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 of Gaza, this time to Nablus, but this permit was also rejected.

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

The most important information, however, regards patients' outcomes or their companions' experiences. 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](#)*

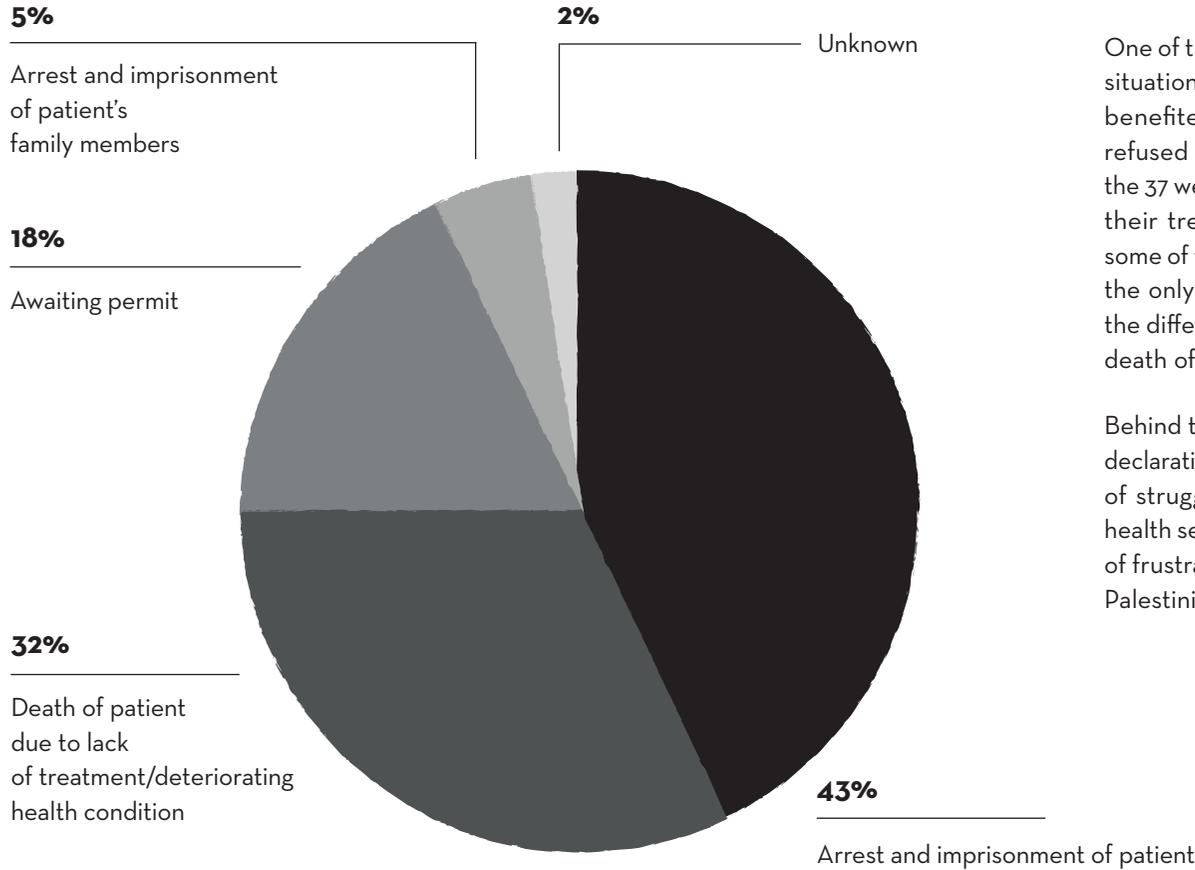
FIGURE 5
Number of patients or companions per referral destination in Al-Haq reports



THE LABYRINTHS TO HEALTH IN GAZA

Real stories

54
70



One of the most frustrating and life-threatening situations is when patients who had previously benefited from treatment outside Gaza are refused upon reapplying for a permit: 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 Gaza 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 for 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:⁷⁴

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 had previously 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 the permit was denied.

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 indicate an ongoing de-development of the sector, with patients 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 over 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 unaffected by political rifts and the international community has to reshape its aid strategy for health in Gaza. Current strategies are only entrenching and deepening the current crisis.

Among the key factors 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; in other words, ensuring the wellbeing of the population under occupation and respecting and protecting 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 of its duty to commit to this principle “to the fullest extent of the means available.”⁷⁵ Recalling the Advisory Opinion on the Wall, the occupied

territories have been under Israel’s territorial jurisdiction as an 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.⁷⁶ 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*.⁷⁷ Based on this, establishing a permit regime which determines whether or not a person can access health services contravenes its obligations. In the same sense, albeit on a larger scale, the continuing occupation for over 52 years has been the key determinant for a environment, which does promote equal access to health. This has led to a vast range of consequences, from blocking the essential principle of self-determination and hampering the economic development required for public services to function properly to making it impossible 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 that medical staff are supported at all times. Some key challenges remain, including how available equipment is managed, which raises questions regarding some of the investments

in health services made thus far. Referrals represent 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 in the long run for the whole health system. Despite the volatile context, investing in key sectors such as oncology and paediatrics in Gaza are viable options for reducing dependence and strengthening local capacities.

The third aspect hindering the development of the health sector is the lack of longer-term funds linking together sustainable humanitarian and developmental schemes. This lack of sustainable funds is mostly due to irregular availability of government resources, topped off by being dependent on international donors who respond in a reactive fashion to contextual and political events. Therefore, in a protracted conflict such as this, humanitarian assistance as it stands will continue failing to respond to structural challenges. Moreover, its lack of sustainability will further weaken the development of the health system.

Health care in Gaza requires a systemic response. 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 responding to the growing demand for specialized services with adequate equipment and staff. Sustainable funds, together with stronger coherence between humanitarian and developmental schemes, should allow for better short, medium and long-term planning for health. To ensure good returns on the funds invested, the international community must be reminded that its development aid cannot be a substitute for truly engaging with the root causes of de-development.⁷⁸ Sustainable development only thrives where international human rights law and international humanitarian law violations are not constantly hampering it.

One of the shortcomings of this report is that it focuses almost exclusively on current challenges related to services and patients at the tertiary level in Gaza. With this in mind, this report recommends that future studies are pursued, with the objective of exploring the environmental determinants of health across the West Bank too.

Finally, it should not be forgotten that the ones who are paying the consequences of the health sector's current paralysis are babies, children, people with disabilities, mothers, breadwinners, grandparents and all those attending them on the frontline every single day in medical institutions. Those who wish to support ongoing work in the health sector in Gaza must approach it as a system in crisis requiring systemic thinking, 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, no more, no less.



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 those under occupation have unrestricted access to health and that all obstacles within its control are eliminated; this includes ensuring that 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 health funding is channelled equally to all Palestinians
5. The international community should review its aid strategy and establish more sustainable funding schemes, while simultaneously taking all necessary measures to ensure that the occupying power is accountable within its IHRL and IHL obligations, including ensuring access to health for everyone 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 track the availability of medicines and disposables and assess 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 extra support during transfer, such as neonates under intensive care
2. Avoid creating barriers which prevent medical and technical staff from continuing their education, improving their skills through professional training and participating in conferences abroad

The Palestinian Ministry of Health should:

1. Invest in filling the gaps within key areas of medicine, including cardiology, plastic surgery, oncology services and paediatric care
2. Ensure palliative treatment is provided to all oncology and chronic disease patients through utilising multidisciplinary teams

GENERAL MANAGEMENT

The Ministry of Health of Palestine should:

1. Restore a unified nationwide health information system that aims to improve follow-up care for patients across different institutions
2. Share a common and comprehensive vision for the development of the health sector, based on current and future financial challenges
3. Reinforce links with the Network of East Jerusalem Hospitals by developing a strategy in collaboration with the donor community to address growing referral-related arrears and find a more sustainable model for providing tertiary-level care and services

VIOLENCE AGAINST HEALTHCARE STAFF

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 to provide 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 people 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. Third 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 of human right defenders and human rights organisations.
 - b – Further protect and support human rights defenders against increasing attacks

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