The Disengagement Plan
and its Repercussions on
the Right to Health in the
Gaza Strip

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Foreward
by Dr Iyad al Saraj
The Gaza Community Mental Health Program

It all began in 1988. Gaza was blanketed in smoke and fire. Palestinian youths threw stones as a response to the Israeli army. This was the Palestinian uprising. A moment which changed the course of history.

One day that year a group of Israeli doctors arrived in Gaza in order to see with their own eyes what was happening in the field. They went the rounds of Shifa Hospital and saw children with broken bones. In the afternoon of that same day we all assembled in the courtyard of my house in Gaza. The common pain we all felt made us want to get up and do something. And thus, within a few weeks, the Israeli-Palestinian organization of Physicians for Human Rights was born.

Setting up the organization was a noble reaction to the political struggle and the continuing violence. It showed that we were keeping to the principles of protecting human life and dignity and other basic rights. The activities of the organization were important in uncovering the serious infringements of rights by the Israeli army: torture, collective punishments, mass arrests and liquidations. The members of the organisation took on the Israeli medical establishment and revealed its collusion with the policy and practice of torture.

But more important was the fact that Israeli human rights activists, including the members of PHR, sharpened the awareness of and the need to defend human rights, and sent the Palestinians a clear message saying that there were Israelis who cared, and that they were brave enough to take on the authority of the State.

When the uprising gave way to processes of bargaining, which took the form of the Oslo Agreements and the setting up of the Palestinian Authority, we decided to split into two bodies: one Israeli and the other Palestinian, with the intention of keeping our finger on the pulse on both sides, and not allowing the euphoria which had taken over in the past to return. On the Palestinian side, we understood very quickly that a watchdog
on human rights was an essential element in our society. This conclusion was the result of a painful process during which we came to understand that the Palestinian Authority does not respect basic human rights. And indeed, evidence of illegal arrests, torture, and deaths during interrogation piled up and up.

These events happened during a period when I was appointed to be responsible for citizens’ rights. My efforts to uncover infringements of human rights by the Palestinian Authority led to my arrest and torture. The response of the local and international communities of those involved in human rights – including the Israeli Physicians for Human Rights – was amazing. The fight to free me from the prison bars of the Palestinian Authority led not only to my release, but also to a dramatic fall in the number of deaths during interrogation.

At the same time as we were fighting to make the Palestinian Authority take account of human rights, PHR in Israel was struggling with the medical establishment and in the courts to stop torture on Israeli territory. Their tenacity paid off in 1999, when the court ruled against torture. However, unfortunately the courts still allowed the use of torture when there is a suspicion that the prisoner under interrogation is a ‘time-bomb.’ As a result of the ruling, the Israeli Medical Association instructed its members not to take part in torture.

And then, suddenly, Ariel Sharon set light to a new uprising, which has ruled our lives for the past four years. The Palestinians wanted dignity, the Israelis wanted security. Palestinian extremists took part in acts of revenge which were expressed as suicide bombings aimed at civilians. So the stage was set for extremists from both sides and many other voices were silenced. But the voice of Physicians for Human Rights in Israel went on making itself heard against the infringements of human rights in Israel. They continued to insist on helping the victims across the border by giving drugs, treatment and food.

Thus I am proud to belong to those who are part of Physicians for Human Rights in Israel, Palestine and other parts of the world, people who stand shoulder to shoulder in the struggle for a world where there will be justice and dignity for all. It is our common struggle to respect human beings, their dignity and the rights that are common to all. It is our common goal to overcome tyranny, oppression and hatred. This is our common dream: to bring about the victory of life over the forces of death.

Gaza, 9th December 2004
Introduction

As Dr al-Saraj writes above, in 1988 an organization of Israeli and Palestinian doctors was set up during a visit to the Gaza Strip. This organization was eventually called by the name of Physicians for Human Rights. Among the founder members were Dr Ruchama Marton, Dr Ilan Gull, Dr Meir Liron, Dr Andre Dresnin and other doctors. Apart from the difficult conditions the doctors found in Shifa Hospital, the presence of the Israeli army in the Strip was most marked. The army had begun to dictate life for the local residents and was already involved in all aspects of their lives. At the entrance to the hospital was a military post which inspected everything which happened inside. A large part of the Palestinian residents had no health insurance. Receiving medical treatments which were not available in the Gaza Strip required permits from the Civil Administration, and these were given only in very small numbers. Palestinian doctors, who could have alleviated the situation to some extent, were not allowed to finish their medical specializations. And all this at a time when the occupying state had developed one of the most advanced medical systems in the world.

Today, about 17 years later, the inhabitants of the occupied territories in general, and the Gaza Strip in particular, are in a worse state than they have ever been. The Strip is divided into separate parts and movement within it is extremely restricted because of the Israeli military and civilian presence there. Poverty in the Gaza Strip has reached unprecedented levels and the medical system is in a parlous state.

The Gaza Strip in effect is the largest and most overcrowded prison in the world. The Strip is closed off on all sides by the State of Israel which has complete power over it, within and without. The Gaza Strip is managed, supposedly, by the Palestinian Authority, but in many respects this management is only symbolic. In actual fact, even the restricted powers of the Palestinian Authority are dwindling fast.

The Right to Health. For four years now the right of the residents of Gaza to receive medical treatment has been broadly denied them because
of the closure policy imposed by Israel. So too the right to life, for adults and children, the sick and the healthy, has been abandoned. In the context of the discussion of the one-sided disengagement plan not one word has been uttered about the human catastrophe taking place today in the Gaza Strip. Nor has there been any discussion of the implications of the policies of the State of Israel and the Palestinian Authority on the fate of its 1,400,000 inhabitants. The future of the inhabitants, hostages to the complex political and security interests of both sides, does not seem assured.

The goal of this report is to bring about a discussion of the implications of the one-sided Disengagement Plan for the lives of the inhabitants of Gaza, particularly from the point of view of their right to health.

Physicians for Human Rights has tried to draw an inclusive picture of what exists and what does not exist in the field of health in the Gaza Strip, and to present the possibility of realising the Right to Health in the widest meaning of the term. This includes an analysis of its different elements as they are defined in different declarations. The report concentrates in part on the Palestinian Health System and the difficulties which stand in its way in attempting to provide medical services for the residents of the Strip. A further part of this report surveys what is happening at Gaza’s two gateways to the outside world: the Rafah Crossing and the Erez Checkpoint, and the obstacle course which patients battling with serious illness must pass, when there is no treatment available in Gaza. Finally, the report presents the gist of the Disengagement Plan and its implications for the right to health of the residents of the Gaza Strip.
Part I:

History: The Gaza Strip before and after the Oslo Agreements

Demography

The Gaza Strip runs along the Mediterranean Coast. It is 45km. long and 5-12km. wide, 360 square km. in all. It has a coastline of 40km. in length. The land borders are 62km. long, 51km. of them bordering on Israel and 11km. on Egypt. All the borders, including the airspace, are completely under the control of the State of Israel.

The estimated number of inhabitants in the small area of the Gaza Strip is 1,451,689. The inhabitants live in very crowded conditions in 44 settlements, including three central cities: Gaza, Khan Yunis and Rafah. In Gaza, the biggest of the cities, there are 339,083 inhabitants, in Khan Yunis 122,484, and in Rafah 69,071 inhabitants.

The refugee population of the Gaza Strip is about 878,00, of whom 441,071 refugees still live in the refugee camps. There are eight refugee camps in the Gaza Strip. In the largest, Jabaliya, there are 103,646 inhabitants, in the second largest Rafah, there are 90,638, and in the rest of the refugee camps, A-Shati, Nusseirat, Al Burij, Deir al Balah, Megazi and Khan Yunis there are 246,787 inhabitants.

The refugees make up about a third of the whole population of the Gaza Strip and live in the most over-crowded conditions in the world. On average there are 55,000 inhabitants per square km. In the A-Shati camp (=the Beach camp, also called Rimal) there are 76,000 inhabitants in one square kilometre.

The population density in the Gaza Strip is rising all the time. From 1989, when the average density was about 1,857 inhabitants per square km., it has doubled, and stands today at 3,600 inhabitants per square

1. The statistics are mostly taken from the CIA fact book and UN-OCHA.
2. Figures from UNRWA.
km. And if this was not overcrowded enough, the territory available to the Palestinian inhabitants is also getting smaller because of the policies implemented by Israel, which include demolition of houses in urban areas, eviction of residents from their houses (when these are adjacent to Israeli settlements) and the taking over of large territories by these settlements.

The Gaza Strip is in real danger of a population explosion. This process is continuing apace.

In the Gaza Strip there are 17 Israeli settlements, which take up an area of 54 square km. The total area held by Israel, including army installations, is about 55-75 square km. In other words, about 15%-20% of the territory of the Gaza Strip is held by Israel and not accessible to the Palestinians at all. This fact is scandalous, especially in the light of the huge differences in the size of the populations: in 16 settlements there are altogether 7,781 Jewish Israeli settlers, and settlement number 17, Shalev, which is in Gush Katif, is not inhabited at all. The population density in the Israeli settlements is only 665 people per square km. The built-up area of these settlements is only 160,000 square metres, so that they can allow themselves to devote 32 square km. to agriculture.

The serious discrimination in the division of territorial reserves has produced a situation whereby the Israeli settlers, who form 0.6% of the population of Gaza, are in possession of at least 17% – i.e. one sixth – of the land of the Gaza Strip (see table).

<table>
<thead>
<tr>
<th>Population of Gaza strip</th>
<th>% of land</th>
<th>% of population</th>
<th>average population density per sq. km.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palestinians</td>
<td>80%-85%</td>
<td>99.4%</td>
<td>3,600 inhabitants</td>
</tr>
<tr>
<td>Israeli settlers</td>
<td>15%-20%</td>
<td>0.6%</td>
<td>665 inhabitants</td>
</tr>
</tbody>
</table>

3. The number of settlements is determined by the fact that some of them have extensions, e.g. Netzarim and New Netzarim (Netzarim B). Here they have been counted as one settlement.
4. Figures from UN-OCHA.
5. These figures relate to the situation in the year 2000. According to the Palestinian Development office, Israel today holds 38% of the territory of the Gaza Strip because of clearing of the territory around the settlements and their access roads.
Aerial photograph of the settlement of Nisanit and the settlement extension of New Nisanit.

On the right: The Erez Industrial Area and the Erez Checkpoint. On the left: The Beduin village and open sewage reservoir of Beit Lahiyah.
The A-Shati Refugee Camp
**Characteristics of the Population**

The average age of the Palestinian inhabitants of the Gaza Strip is 15.5 yrs, with 49% of the population between the ages of 0-14, and 48.3% aged 15-64. The majority of the population in Gaza is young, and the yearly rate of growth is 3.83%. (Other sources claim it is 6%). The average life expectancy is 71.59 years, as opposed to the life expectancy in Israel of 79.17 yrs. Women in Gaza give birth to an average of 6.04 children over their lifetime, as opposed to Israeli women who average 2.47 children.

One of the accepted yardsticks in the western world of fixing the socio-economic status of a society and its health status, is the yardstick of infant mortality in the first year of life:

<table>
<thead>
<tr>
<th>Infant mortality per 1,000 live births</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Israel:</strong></td>
</tr>
<tr>
<td>Whole population</td>
</tr>
<tr>
<td>Arab population</td>
</tr>
<tr>
<td>Jewish population</td>
</tr>
<tr>
<td><strong>Gaza Strip:</strong></td>
</tr>
</tbody>
</table>

**Ruling authority**

The inhabitants of the Gaza Strip have never had autonomy or fully independent self-rule. For hundreds of years they have lived under foreign rulers – Turkish, British, Egyptian and Israeli. Only for a very short time after the Cairo Agreement in 1994 and the transfer of the Gaza Strip to the Palestinian Authority did the residents of Gaza enjoy relative freedom.

In the United Nations’ decision on partition in 1947, Palestine was divided into two states: the State of Israel for the Jews, and a State for the Palestinians. With the ending of the British Mandate in Palestine, which had lasted about 30 years, the State of Israel was proclaimed. A Palestinian State was supposed to have been set up in parallel. However, the war which broke out between the Arab States and the State of Israel completely changed the situation. At the end of the war in February 1949, the ceasefire lines were fixed. A strip of land 45 km. long and about 7 km. wide was left under Egyptian control. This is the Gaza Strip.
At the end of the war in 1949, the population of the Gaza Strip included 80,000 previous residents, who lived in the town of Gaza and the surrounding towns and villages, and about 200,000 refugees who were evicted and who fled south in the war of 1948. Until 1967 they lived under Egyptian military rule, apart from a short period in 1956 when the Gaza Strip and Sinai were conquered by Israel. The Egyptians, who did not see Gaza as part of Egypt, never gave its inhabitants Egyptian citizenship. The Israelis, for their part, did not allow the refugees to return to their old homes. Thus the situation was created of a large population caught between two warring states.

In the 1967 war the Gaza Strip was taken by Israel and since then it has remained in Israeli hands. During all those years up to the signing of the Oslo Agreements in 1994, the inhabitants of Gaza have continued to live under a military government without rights, under the rule of the State of Israel.

The popular uprising, the ‘Intifada,’ in the occupied territories began on 9th December 1987, with popular demonstrations by many people in the Gaza Strip. The event which lit the fire was a road accident which had taken place a day earlier in Gaza, when an Israeli lorry hit a Palestinian car, killing the four people from Jabaliya who were in it. From Gaza the demonstrations spread to the West Bank.

The Oslo Accords

Following the first Intifada, talks were held between the two sides. In October 1991, under the auspices of the USA and Russia, Israel, Jordan, Syria, Lebanon, Egypt and the Palestinian inhabitants of the occupied territories met at the Madrid Conference. Following this, Israeli representatives met representatives from the Palestine Liberation Organization for direct talks, which led to the Oslo Accords and the setting up of the Palestinian Authority in 1994.

In the agreement on principles, which was signed in 1993 in Washington, an interim period of five years of independent Palestinian self-rule was agreed on, with some restrictive characteristics in Gaza and the West Bank. The agreements arranged for the transfer of municipal and security control

7. The Palestinian representatives came as part of the Jordanian delegation, because Israel had only agreed to come to the talks on condition that there should be no independent delegation from the PLO.
over the Gaza Strip to the Palestinian Authority, apart from the areas of the Israeli settlements, the areas along the sides of the roads leading to the latter, and the areas of the military camps. Among other things, this agreement ruled that the Gaza Strip and the West Bank would be one territorial unit, and that freedom of movement between them would be preserved, subject to some restrictions to be set down by the State of Israel. In the Cairo Agreement of 1994, Gaza and Jericho were the first places where the transfer of authority from Israel to the Palestinian Authority was to take place. In this agreement it was again stated that ‘the two sides view the West Bank and the Gaza Strip as a single territorial unit, the integrity of which will be preserved during the interim period.’ (Cairo Agreement, May 1994, subsection 6.)

Among the other powers which were transferred to the Palestinian Authority when it was set up as a result of this agreement, was the power and duty to provide medical services to the Palestinian population. However, the ability of the Palestinian Authority to carry out this responsibility met with difficulties, which arose from the precedence taken by Israel’s security considerations. This precedence was based on the agreements themselves: Israel retained the last word in everything related to security. The use of the security argument was defined from the outset as unlimited, with the potential at all times for total control of the lives of the Palestinians. The agreements even perpetuate further means of control by Israel over the lives of the inhabitants of the occupied territories, including economic means. The Gaza Strip was, and still is, directly dependent on Israel in everything, including travel within, to and from the area; its economy and the employment of the inhabitants; and the provision of electricity, water, fuel and communications.

In the Israeli-Palestinian Interim Agreement on the West Bank and the Gaza Strip, September 28th 1995, (Oslo B) which was drawn up in Washington, the Occupied Territories were defined as three areas of Israeli and Palestinian control: A, B and C. Most of the area of the Gaza Strip, i.e. Area A, was transferred to the control of the Palestinian Authority. However, the fact that Israel retained full control of the territory of the Israeli settlements and the roads leading to them, allowed her at different times to divide Gaza into three parts and to set up checkpoints at the crossings between the parts. In the context of the agreements Israel retained control over the land, sea and air borders of the Gaza Strip, including a belt along the border between Gaza and Egypt, known as the Philadelphi corridor. Israel also retained the exit from Gaza to Egypt via the Rafah crossing, the
entry to Israel from the Erez checkpoint, and the Karni and Sufa crossings for agricultural produce and goods. The Israeli means of control is still the decisive factor in the severance of the Gaza Strip from the outside world, and thus determines the future of its inhabitants in the fields of health, economics, education, and life in general.

Thus since the end of 2000, when the second uprising broke out, the Gaza Strip has been under siege.

**Safe Passage in the Agreements but Punitive Immobilization in Reality**

_’There will be a safe passage which will join the West Bank with the Gaza Strip for passage of people, vehicles and goods as detailed in this paragraph. Israel will ensure passage for people and for vehicles during daylight hours (from sunrise to sunset), or as will be agreed… and in any case for no less than 10 hours a day.’_ 8

The Oslo Accords defined the West Bank and the Gaza Strip as one territorial unit, with open passage between the two parts. However, already in the agreement, Israel’s right to restrict the passage of people in accordance with security considerations was established. ‘Israel will be allowed to prevent the use of its territory for the safe passage of people who have seriously or repeatedly violated the instructions for the safe passage… as required by the agreements.’ However, we should stress that Israel was not given the authority to cancel the safe passage for the population in general.

The feeling of being trapped is made more real by the fence around Gaza. This fence was the first to be put up between the territories of Palestine and the territory of the State of Israel, and was the inspiration for the initiators of the dividing Wall between the West Bank and Israel. The Israelis and the Palestinians already agreed to leave the Gaza fence in place in the Cairo agreement, where it was established that as long as the agreement was in force the fence around the Gaza Strip should stay in place, and the line along which it had been erected should be the border between the two entities signed on the agreement.

8. From the terms of the Interim agreement.
The Gaza Strip and the West Bank were thus divided from one another. Gaza was shut in by the security fence, which stopped any possibility of leaving or entering except with the permission of the State of Israel. This situation allowed Israel to relate to the Gaza Strip as to a prison, and to move people there from the West Bank whom she wanted to punish by distancing them from their homes. Thus the Gaza Strip was used for punitive immobilisation.

When someone who was expelled to Gaza needs medical treatment which is not available in Gaza, the situation is sometimes insoluble.

Y. a-H. was one of the group who were besieged in the Church of the Nativity in Bethlehem in 2002. In the evacuation agreement which was signed with the Palestinian Authority, he too was sent to Gaza. Y. suffers from a heart condition and was in need of an urgent catheterization. Catheterization, as will be described in this report, is one of the procedures which does not exist at all in the Gaza Strip. On 13th February 2004, after his requests to leave for a catheterization were answered by an Israeli refusal and his medical state did not allow the treatment to be postponed, Y. applied to PHR. Fortunately a delegation of German and Egyptian doctors arrived in Gaza with equipment and treated him. After a number of months Y. applied again to PHR. An examination had shown that the catheterization had not worked and he needed another urgently.

Dr Zvi Zusskind from Tel HaShomer hospital in Israel wrote that ‘Mr Y. a.-H. suffers from a total blockage of one of the three arteries which supply blood to the heart. There is significant narrowing of the other two arteries. He needs a catheterization or operation urgently, and if not, he is in danger of suffering a heart attack which could lead to heart failure or death.’ In spite of this, Y.’s applications to leave for treatment in Egypt were rejected again and again. At the time of writing this report it is not clear whether he will be allowed to leave or not.

9. Note: Chaim Sheba Hospital at Tel Hashomer is referred to here as Tel Hashomer Hospital, as it is commonly known.
Part 2: The Right to Health

The Conditions which define Health

In May 2000 the work of the United Nations Committee for Economic, Cultural and Social Rights ended when it published note 14, which clarifies the Right to Health which appears in paragraph 12. The note includes not only an unprecedented expansion of the right to health, with insistence on non-discrimination, but also the various factors which define health, such as the cycle of poverty, violence etc. This is all from the viewpoint that for a person to be able to live a healthy life there must be certain prior conditions, such as a safe and healthy environment. The document contests the approach which confines itself to formal equality, and calls for the establishment of universal values of social solidarity both within and without the geographical boundaries of a state.

Among the subjects of outstanding importance for the Israeli policies in Gaza are: the right to access to health services; the right to housing; the right to water fit to drink; the protection of vulnerable groups (children, women, the elderly and the disabled); and economic and social inequality. Thus the present report, even though it concentrates on access to health services, will also relate to some of these pre-conditions: unemployment, poverty, water, housing and electricity.

This chapter will survey the financial state of the residents of the Gaza Strip in the light of Israeli policy, and its influence of this state on their health. The Israeli policy of continued occupation, siege and the destruction of infrastructure and sources of income, is leading to severance from the traditional sources of income while not allowing the Palestinian residents to develop new sources of income. Thus, for example, many Palestinians who used to make their living outside the Gaza Strip, might have expected that they could continue to feed their families by returning to farming. However, even this branch of the economy has been damaged by the Israeli attacks. For example, from 2000, more than 50% of the agricultural lands
of Beit Hanoun have been destroyed, especially orange and olive trees. In July 2004 alone, the Israeli army uprooted 2,890 dunams of agricultural plantations in Beit Hanoun, during Operation Frontal Shield.

Palestinian workers at the Erez Checkpoint Photograph: Nir Kafri

10. Data from UN-OCHA.
Unemployment

The economy of the Gaza Strip is in a deep depression, among other things because it has been cut off from its major source of income: work in Israel. The high rates of unemployment in the Gaza Strip derive from the progressive ban on the entry of workers to the territory of Israel. In addition, every time there is any sort of tension between Israel and the Palestinians, entry to Israel is automatically stopped. After the attempt on the life of Sheikh Ahmad Yassin in March 2004, the entry of workers from Gaza to Israel was banned for three months. After this, Israel limited the number of workers allowed to enter to 500 a day only.11

In 2000 there were 147,000 Palestinian daily workers in Israel. In the first quarter of 2004, the daily average was 33,100 Palestinian workers, of whom only 13,200 were inhabitants of the Gaza Strip,12 and all of whom had permits.13 Israel’s explicit intention, as described in the Disengagement Plan, is to reduce the numbers of Palestinian workers entering Israel, slowly but surely. In 2005, only 25,000 workers are expected to enter Israel with a work permit, and in 2006, about 15,000.14 The expectation is that by 2007 there will be no more Palestinian workers entering Israel.15

The Erez Industrial Area, which includes 200 Israeli and Palestinian businesses, has been closed most of the time since January 2004, and is in danger of final closure. 4,900 Palestinian workers, who supported at least 3% of the inhabitants of the Gaza Strip, are today unemployed. 100 of the 200 businesses at Erez are owned by Palestinians. The Israeli Minister for trade, industry and employment, Ehud Olmert has declared that Israel intends to evacuate the Israeli factories from Erez.16 The president of

12. Different sources report that the real numbers of those entering Israel are smaller than the number of those receiving permits. The reason for this is that the process of leaving Gaza for Israel via the Erez checkpoint is so complex that it becomes unbearable. A worker who wants to get to his work in Israel by 7am leaves his house at midnight. The situation deteriorated in particular after the suicide bombing by Rim al-Riashi at the Erez checkpoint in 14th January 2004. In this attack four soldiers were killed. On 16th February 2004 Mohammed al-Sheikh was crushed to death at the checkpoint because of the excessive crowding there.
13. Some of them pay about 2000 NIS to permit dealers in order to receive the desired permit.
the Israeli Industrialists’ association, Oded Tira, told Yediot Achronot newspaper on 29.11.2004 that eight Israeli factories had already moved into Israel, and 30 factories had moved their production abroad.

**The Port of Gaza**

"The Israeli and the Palestinian sides recognize the great importance of the port of Gaza to the development of the Palestinian economy and the expansion of Palestinian trade. They undertake to act without delay in order to achieve an agreement which will allow the building and operation of the port in accordance with the earlier agreements. The Israeli-Palestinian committee will renew its work immediately in order to sum up the protocol within 60 days which will enable the beginning of the building of the port." ¹⁷

The building of the sea port in Gaza began in August 2000, with money from European donors. However, not long after the outbreak of the Al Aqsa Intifada in October of that year, work was stopped because of the political and military situation.

In spite of the fact that the Gaza Strip has a sea border stretching for 41 km., the use of economic resources based on the sea is severely restricted by the State of Israel. Goods which arrive in the territory of the Palestinian authority and are exported by her, pass through Israeli ports, particularly the port of Ashdod. Customs duties are taken by Israel and passed on to the Palestinians. However, Israel can stop the transfer of monies at any time, and does so. Confiscation of these taxes on the import and export of Palestinian goods to countries abroad via Israeli ports is used by Israel as a tool for punishing and controlling the Palestinians.

Moreover, Israel has an economic interest in not allowing the building of the port. The Israeli Ports Authority is not interested in giving up the profits made from goods intended for the Palestinian territories. In addition, the existence of a port in the territory of Gaza would be a competitor for the Israeli ports, and an alternative when they are on strike. ¹⁸

¹⁷. From the memorandum of the Wye Agreement, September 1995, paragraph 3.
¹⁸. During the last strike by the port workers in 2004, the Minister of Finance, Binyamin Netanyahu, threatened that Israel would use the ports of her neighbours, Egypt and Jordan. He did not hesitate to threaten the workers with a further possibility – the use of the port of Gaza. These threats were particularly entertaining in the light of the fact that there is no commercial port at Gaza and there has not been one since antiquity, for its infrastructure was destroyed by the attacks of the Israeli airforce. (From a report by Hannah Kim, Haaretz 3.10.2004.)
The importance of a port at Gaza to the Palestinian economy was agreed on by both sides, and it is necessary for the development of free foreign trade with other countries in the world. A port of this kind could also provide employment for hundreds of workers and support thousands in their families. It would allow the Palestinians to develop a kind of economic independence and gradually free themselves from dependence on Israel.

**Fishing**

Historically, fishing has been one of the most important economic resources of the inhabitants of the Gaza Strip. However, for a number of reasons it has become progressively more difficult to make a living from the sea – the resource which should be the most easily available in Gaza. In recent years there has been a decline in the number and quality of fish because of various processes occurring in the Mediterranean in general. In addition, in Gaza a considerable part of the sewage is released into the sea, pollutes the coast and increases the dangers of fishing near the beaches. Furthermore, Israel has imposed serious restrictions on Palestinians going out to fish in the open sea, so that fishing has changed from an important source of income to a dying industry.

In the Oslo agreements the coastline was divided into three parts, and only one of these, in the central part of Gaza, was open to Palestinian boats. The two ends of the Gaza Strip, the northern and the southern, were defined as buffer zones and forbidden for Palestinian fishing, in order to stop boats getting to Egypt, or to the area opposite the Israeli settlements of Gush Katif, or to Israel itself. The extent of the area of sea permitted to Palestinian boats was restricted to 20 sea miles out from the coast.\(^{19}\) As a result of these restrictions, deep water fishing was prohibited to the Palestinians, so that their ability to make a living from the sea was even more reduced. And if this was not enough, after 2000 all Palestinian vessels were forbidden to go further than six sea miles out, in contradiction to the agreements reached at Oslo.

Apart from all the restrictions described so far, sometimes a complete ban on going to sea\(^{20}\) is imposed on the Palestinians for long periods of

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19. One sea mile =1.853 km.
20. In November 2002, after a booby-trapped boat of the Islamic Jihad blew up next to a vessel of the Israeli navy, no fishing boats were allowed to put to sea for three months.
A restriction like this is a death blow to the fishing industry, which is a seasonal occupation. Any vessel which dares to disobey the restrictions is shot by the Israeli navy. Many boats have already been sunk like this, and the fishermen have lost their livelihood. Damage to fishing boats also occurs even when there is no contravention of the rules.

**Poverty in Gaza**

On June 23rd 2004, the World Bank published a report on the Palestinian economy, laying stress on the Disengagement Plan and evacuation of the Israeli settlements. The report gives a miserable picture of the state of the Palestinian economy. The recession in the Palestinian economy is one of the worst in modern history. In fact, the loss of income is worse than in the great depression in the USA in the thirties. Since September 2000, the average private income has gone down by about one third, and almost half the Palestinians live today below the poverty line. The deep economic crisis into which the Palestinian economy has declined since the breakout of the second Intifada is particularly acute in Gaza. The average salary in the Gaza Strip in the first quarter of 2004 was 55.6 NIS per day, and 1,556 NIS per month of 28 working days.

In 2003, the rate of poverty in Gaza stood at 64%, and the rate of unemployment at 29%. The rate of unemployment among men of 15-24 was 43%, in other words young men entering the work market were finding it hard to get work. The forecast for 2004 showed a growth in the general dimensions of poverty and unemployment in Gaza, with the rates growing to 68% and 32% respectively. The rate of absolute poverty in Gaza is 25% today. In other words, about a quarter of the inhabitants of the Gaza Strip, about 350,000 people, are unable to feed themselves properly, even after humanitarian donations of food. The World Bank estimates that without the help from outside donors the rate of absolute poverty would grow by 40%.

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21. Most of the material for this chapter is based on this report.
22. 2.1 dollars a day or 1800 NIS per month per family of six reflects what is calculated as a minimal budget for food, clothing, housing and household necessities, health, education and transport.
23. The absolute poverty line is $1.5 per person per day, or 1,235 NIS per family of six per month.
24. A food parcel from UNRWA includes: 50k. flour, 5 k. rice, 5k. sugar, 2lt. cooking oil, 1k. milk powder, 5k. pulses.
Most of the inhabitants of Gaza are insured with health insurance. However, from a survey conducted by the Palestinian Office of Statistics, it appears that 82.7% of the mothers in the Gaza Strip reported that the difficulty in getting medical care for their children derived from financial problems. In other words, even the existence of health insurance is no guarantee of receiving medical treatment when this is dependent on any payment, even the most minimal.

**Poverty in the Refugee Camps**

Poverty in the refugee camps is the worst in the Gaza Strip. After 1948 the demography of the Gaza Strip changed drastically. 200,000 penniless refugees were added to the original 80,000 inhabitants. The state of the refugees was so grave that the United Nations set up a U.N. agency to give aid to the Palestinian refugees: UNRWA. The refugee population of the Gaza Strip today is more than half of all the inhabitants. More than half of them still live in overcrowded refugee camps without basic facilities. These refugees are the poorest of the population of Gaza.

From the general Palestinian average, it appears that the children in the refugee camps suffer from a rate of anaemia of 41.6%. UNRWA runs a permanent programme of food aid to families without any income in the refugee camps. From September 2000, UNRWA reports that the number of those in need of basic food aid has risen from 11,000 families to almost 22,000 families, in other words a rise of 100%.

**The Palestinian Authority**

The Palestinian Authority is at present in budgetary deficit of 650 million dollars before external funding. Within two years the pension insurance system of the Authority in Gaza will become bankrupt, a situation which threatens to introduce yet more families to the cycle of poverty. Even members of the security forces in Gaza today have no pension plan. The financial situation of the Palestinian Authority is so unstable that, even if donations continue to come in at the present rate, the following scenario is liable to take place.

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25. In 2003 UNRWA asked for emergency financial aid of 93.7 million dollars for the first six months of the year but only managed to obtain a third of this sum.
The aid from the donor communities, which stands today at an average of about a thousand million dollars a year,\textsuperscript{27} will not be sufficient to prop up the Palestinian economy, if there is no substantive change in the conditions in which the Authority acts and in the manner in which it functions. The only way in which the Palestinian economy can rehabilitate itself gradually is by building a permanent and more efficient economic system. This economic system must be based on visibility, and on just distribution of resources, with continued massive support from donors, at least in the foreseeable future.

However, even if the Palestinian Authority makes its work methods more efficient, the main factor which will determine the future of the Palestinian economy is the policy of blockade. In the report of the World Bank, it was ascertained that the main reason for the serious economic situation in Gaza is the restriction on freedom of movement. Even the carrying out of the Disengagement Plan and removal of the restrictions on travel within the Gaza Strip will not be enough by themselves to resuscitate the economy. If the external blockade on the Gaza Strip is not lifted, and the way to markets abroad is still acutely restricted, the Gaza economy will not recover even after the Disengagement Plan. The report of the World Bank presents a depressing forecast even for the period after the Disengagement, if this does not lead to opening the borders: 72% poverty and 38% unemployment in 2006.

**Diet and Poverty in the Gaza Strip\textsuperscript{28}**

Note 14, the Right to Health, includes a wide spectrum of social and economic factors which provide the basis for healthy life. Among these are the right to food and diet. This appears as one of the factors which determine health and its importance is stressed by its being included in the core responsibilities of a state to its inhabitants. A particular stress is laid on suitable diet for children.

The states which are signed on this agreement have individual and collective responsibility for humanitarian aid at a time of emergency, when precedence should be given to the distribution and organisation of

\textsuperscript{27} When the sum is divided by the number of recipients, this is the largest amount of aid in history.
\textsuperscript{28} Most of this section was written with the help of Dr. Dorit Nitzan Kaluski, based on her paper: *Iron Deficiency Anaemia – the Importance of Prevention*, November 2001.
resources such as food (40). So too in the operations of international health organisations, national and non-state bodies, stress is laid on aid at times of catastrophes, when precedence it to be given to the supply of food (65).

Iron deficiency is the commonest dietary deficiency in the world. It is particularly common in young children and women of child-bearing age. The iron content of food is the most important measure of the status of iron. In babies it has been found that iron deficiency is connected to the use of cows’ milk, tea drinking, lack of breast-feeding, and a lack of available iron in the diet.

Anaemia is a sign of dietary shortages and demonstrates a shortage of iron. However, iron-deficiency anaemia appears at later stages of the shortage and is only the tip of the iceberg. The WHO published standards for defining iron-deficiency anaemia, which demonstrate situations where iron deficiency is serious and prevents the formation of haemoglobin.

The standard for iron-deficiency anaemia in children is haemoglobin lower than 11mg./dl.

The standard for iron-deficiency anaemia in women is haemoglobin lower than 12mg./dl.

Solid scientific evidence links the finding of iron-deficiency anaemia with a fall in cognitive functioning, some of which is irrevocable. In cases where iron deficiency in the early years of life is not treated, the learning ability and output of whole sub-populations can be damaged irrevocably. A reliable source of iron is needed to ensure correct growth and development, whereas iron deficiency causes hold-ups in development and behaviour disorders, particularly in young children from the age of two. Anaemia in the context of iron deficiency in pregnant women demonstrates shortage of added dietary iron and folic acid during pregnancy and after birth. Similarly, iron deficiency increases the danger of premature birth and of giving birth to babies with low iron reserves. One of the yardsticks for the normal development of children is their height in relation to their age. When this is too low it is called in technical language ‘stunting.’ This datum is an accepted yardstick for chronic undernourishment which derives from factors such as: lack of breastfeeding or partial breastfeeding, shortage of food or of a balanced diet, frequent diarrhoea or respiratory infections.

29. Drinking tea of any sort by babies leads to problems in absorbing iron.
Anaemia in Gaza

Undernourishment and anaemia are an inseparable part of growing up in the Gaza Strip. Research carried out over 20 years demonstrates that children in Gaza suffer from a high rate of anaemia for many reasons, the causes of which are poverty and all that this implies.

1984: A survey of women and children in Mother and Child Clinics in the West Bank and Gaza showed that in the Gaza Strip, 20.4% of children were underweight for their age, and 50% of children were anaemic. In addition, 50% of the pregnant women were anaemic.

1990: A survey carried out on refugee children from the UNRWA camps in Gaza, the West Bank, Jordan, Lebanon and Syria showed that 4.5% of the children in Gaza and 3.9% of the children in the West Bank were underweight for their age. The rate of anaemia among the children was 57.8% in the West Bank, and 70.3% in Gaza. As a comparison, anaemia among Arab children in Israel fell gradually from 70% in 1975 to 20% in 1996.

1997: A survey of anaemia among refugees, which included a sample of 1,990 children under the age of 3 in Gaza, the West Bank, Syria, Jordan and Lebanon showed that 67% of the children were anaemic.

2000: The organization Ard Al Insan runs four clinics which provide food for children in need in the Gaza Strip. In April 2002, a member of the organization stated that the number of anaemic children had risen from 2,528 in 2000, to 5,704 in April 2004. In addition, the medical manager of the organization stated that many of the children below the age of 2 did not have an adequate diet, as their diet consisted mainly of tea and bread.

2002: In this year the Palestinian Authority conducted a survey of anaemia in women aged 15-49. From the survey it appears that 36.4% of women in the Gaza Strip were suffering from anaemia. This high figure is a


32. From Project Appraisal Document on a Proposed Trust Fund Grant in the amount of USD 10.0 million equivalent to the West Bank and Gaza for a Social Safety Net Reform Project. World Bank April 26, 2004.
sign of inadequate nutrition, in particular in proteins from animal sources. Pregnant women clearly lack iron and folic acid supplements during pregnancy and after childbirth. Even though the standards in the Palestinian Authority for provision of dietary supplements during pregnancy are the same as the Israeli standards, there is a gradual decline in implementing them. This can be explained by the high cost of providing supplements to a whole population, and also by the difficulties of providing medical supervision of ante-natal care for pregnant women, owing to the closures and restrictions on freedom of movement. In a similar survey conducted on children aged 6-59 months, the rate of anaemia in children in Gaza was 41.6%.

2003: In a survey conducted by Johns Hopkins and Al Quds Universities, malnutrition in respect of proteins and calories was found in 13.3% of children aged 6-59 months in Gaza. The figures from Gaza are similar to parallel figures found in Eritrea in 1955, in Yemen in 1997, and in Nigeria in 1999. 45% of Palestinian children suffer from chronic malnutrition as shown by their height in relation to their age (stunting).

2004: The Food Relief Organization and the World Food Programme estimated at the beginning of 2004 that almost 40% of Palestinians suffer from dietary insecurity. In other words, they do not have sufficient food which is safe and nutritious for them to live a healthy life. Another quarter of the population is in danger of joining this group. 51.5% of the inhabitants of Gaza reported shortages of food. The highest figure in all the Palestinian territory for food shortages came from Rafah, where 71.2% of people reported shortages of food.33

Water

‘The two sides agree to establish an Israeli-Palestinian continuing Committee for Economic Cooperation focusing, among other things, on the following: Cooperation in the field of water, including a Water Development Program prepared by experts from both sides, which will also specify the mode of cooperation in the management of water resources in the West Bank and Gaza Strip, and will include proposals for studies and plans on water rights of each party, as well as on the equitable utilization of joint water resources for implementation in and beyond the interim period.’

In November 2003, the United Nations Committee for Economic, Social and Cultural Rights determined that access to sufficient clean water for personal and household use was one of the basic human rights: ‘the human right to water is essential to life with human dignity.’\textsuperscript{34} If there is no access to clean water, other basic rights, such as the right to health and life, are damaged.

Various different sources show that the use of water by the Palestinian and Jewish populations before 1948 was the same. Over the years, and because of the restrictions imposed on the Palestinians, both in use of water, and in drilling new wells and deepening the old wells, a gap opened in water-use between the two societies. The gap today is so large that the Israeli use of water is three times as large as the Palestinian. The difference between the use of water in the Israeli settlements and the use by the Palestinians is even greater, and is now five to six times as large.

The Cairo Agreement, which was signed in May 1994, deals with the subject of water in the Gaza Strip. According to this agreement, the water system in the Gaza Strip, which includes about 2,000 wells pumping underground water, would be run by the Palestinians themselves. In parallel, water for the Israeli settlements and army installations in Gaza would continue to be provided by Israel, pumping from about 40 wells in the Israeli area of Gaza. This is over and above the water supplied to these settlements from the Israeli Mekorot company. Any change in use of water from the moment the agreement was signed, needed the ratification of both sides, but the present allowance of water to the Israeli settlements was not be reduced.

The second Oslo Accord, signed in September 1995, and the Interim Agreement, laid down a limited potential for changing the Palestinian use of water and thus permanently set the unequal distribution. In the second Oslo Accord, it was laid down that all extra use of water by the Palestinians, over and above the present use, should come from new sources of water which had not been used up till now. It was further laid down that there would not be a new distribution of water sources so that there would be enough for both sides. In spite of the fact that Israel

\textsuperscript{34} General Comment No.15 “The Right to Water” on the implementation of Article 11 and 12 of the 1966 International Covenant on Economic, Social and Cultural Rights.
recognized the West Bank and the Gaza Strip as one territorial unit, she does not allow the Gaza Strip to receive any water from the West Bank. In the Interim agreement it was laid down that the Gaza Strip would be a separate economy in everything connected to water, and must supply its own needs only from the sources available to her, in other words, continue to over-use the Gaza aquifer. The main source of water in the Gaza Strip is the Gaza aquifer, which provides 96% of the water used. This aquifer stretches underground from the northern Negev into the territory of the Palestinian Authority, underneath Gush Katif. Thus excessive pumping of water in the Israeli settlements directly affects the amount of water available for the Palestinians.

The WHO has fixed a standard of 100 litres of water per person per day. This quantity includes water needed for normal day to day living, i.e. for drinking, cooking, cleaning and washing. The minimum for drinking for survival is between 2-5 litres of clean water a day. The use of water in the Israeli settlements in Gaza is estimated as 1.3 million cubic metres a year. The water distributed for household use is 584 litres per person per day. This use is almost seven times the parallel use among Palestinians in the Gaza strip. The Palestinian inhabitants of the Gaza Strip are allocated an inclusive water allowance of 134 litres of water per person per day. However, the real use of water per person per day is only 80 litres of water, because of the general water losses in the Gaza strip, which can reach as much as 45% of water drawn. 40% of these losses are due to water leaks, due to poor maintenance of the water system.

Apart from the fact that the quantity of water used by each Palestinian resident in the Gaza Strip is below the world standard, there is a far more serious problem: the quality of the water. Because of over-pumping and infiltration of pollutants into the underground reserves, from the 1950’s the aquifer has become more and more saline and polluted, so that its water is no longer fit to drink. The accepted standard yardstick for the quality of drinking water is the amount of chloride per litre. The WHO recommends a maximum of 250 mg of chloride per litre, and has laid down that more than 600 mg per litre constitutes a real danger to health. The level of chloride in about 90% of the wells in the Gaza Strip varies between 400-1,200 mg per litre. The situation is particularly grave in the centre of the Gaza Strip, in

35. From BeTselem: Thirsting for a Solution: the Water Shortage in the Occupied Territories and its Solution in the Context of a Permanent Agreement. (July 2000).
36. Loc. cit.
the towns of Gaza and Deir al-Balah, and in the wells of the refugee camp Nusseirat, and in the south-east of the Gaza Strip in Bani Suhilah, Absaan and Hirbet Ahzawiya.37

The second standard yardstick, which generally deals with pollutants from organic sources, is the level of nitrates. In high concentrations these are liable to damage babies and pregnant women. The recommended standard according to the WHO is a maximum of 50 mg per litre. The average level in most of the wells in Gaza varies between 100 and 200 mg per litre. In the refugee camps at Jabaliya and Khan Yunis the level varies between 300 and 600 mg per litre, 6-12 times the recommended highest standard.38

Because of the low quality of the water in Gaza pumping is often stopped. For these and other reasons, the daily life of the inhabitants of Gaza is punctuated by frequent water stoppages. In actuality, almost all of the inhabitants have water tanks on the roofs of their houses, which they fill when there is water in the pipes. In a survey conducted by the Palestinian Ministry of Health, Al Quds University and the WHO, it was noted that 64% of the population reported problems with the water supply. In other words, 64% experienced water stoppages of three days or more during March 2002.39

S.B., the mother of a family of 10, tells of the daily life of her family who live in Rimal, the most expensive suburb of Gaza. ‘In Rimal the situation is good. There is water every night. During the day the water in the pipes is stopped. In other parts of Gaza there is one day in three when there is running water. In any case it is impossible to drink the water from the tap and we buy filtered water for drinking in tubs, about 60 gallons40 a month [=273 litre, M.B.] which costs 60 NIS. I cook in tap water, because otherwise it is too expensive.’

According to the minimum set by the WHO this family should be using 600 litres of water a month just for drinking. But because of the high price of water, the family uses just one third of this quantity. The rest they make up from tap water, which is not fit for drinking or cooking.

37. Loc. cit.
38. Loc.cit.
40. 1 gallon=4.56 litres.
R.M. lives with his family in the suburb of Tel al-Hawah in the town of Gaza. ‘In the hot months of the summer’ he says ‘the water was often stopped for two days and started again for a few hours. No-one knew when the flow would stop or when it would start again.’ His parents’ family, who live in the refugee camp at Jabaliya, use water collected in various tubs. The quality of water at Jabaliya has deteriorated drastically in the last few years, because of infiltration of sewage from the open sewage reservoir north of the camp at Beit Lahiyah.41

Electricity

The Palestinian Authority buys its electricity from Israel. It is totally dependent on Israel in this respect, as there is at present no alternative source of electricity. Because of the expected shortage of electricity in Israel, and because of the high load of demand from the existing system, there is a fear that the first to suffer from a shortfall in supply of electricity will be the Palestinians. The discovery of natural gas opposite the coast of Gaza could have been a solution to the dependence on Israeli sources of energy, had it not been for the fact that Israel rules every decision about the use of this gas that belongs to the Palestinians.

The electricity voltage in the Gaza Strip is lower than 220 volts, which leads to frequent falls in voltage. In Nusseirat there is a power station which produces part of the electricity needs, with a capacity of 140 mega. But it actually produces only 60 mega, 30% of the total use in the Gaza Strip. The power station is dependent on oil from Israel, so because of oil shortages at different times it does not work to its full capacity. Thus, for example, during the recent military campaigns in the north of Gaza,

41. In spite of the fact that 64% of the sewage in Gaza is collected, there is a serious problem of sending out sewage to the sea, pollution of the beaches and infiltration into the Gaza aquifer. In Beit Lahiyah there is a large reservoir containing the sewage of the area which is run into it. At times the reservoir overflows and floods the houses of the residents of the surrounding area. From surveys conducted among the neighbouring population it appears that more than 50% of the children suffer from intestinal infections and skin diseases connected to infected insect bites. Furthermore, there is a higher rate of respiratory infections among the local inhabitants than the general average. The World Bank and different international organizations are financing a plan for solving the problem of environmental pollution caused by the sewage reservoir at Beit Lahiyah, which is planned to be carried out in 2005.
it stopped working for several days because of a shortage of oil. Further repeated incursions of Israeli military forces have also led to severance of the electricity supply and destruction of the infrastructure. Sometimes a particular area has stayed without electricity until the Israeli army agreed to allow the Palestinians to get to the place in question and repair the destruction they [the army] had caused. The cost of repairs falls on the Palestinians.

**Housing and Demolition**

The right to health includes a wide range of social and economic factors which form the basis for a healthy life. Among them is the right to housing. The importance of this right is underlined by its being included in the core of responsibilities of a state to its inhabitants. The state is obliged to have a policy, preferably enshrined in law, of ensuring equal access for everyone to all the factors which determine health, including suitable housing and living conditions (section 36).

During the last four years Israel has applied a violent policy of mass demolition of houses. 24,547 people became homeless during these four years. In 2004, Israel demolished an average of 120 houses per month. Calculating on the basis of an average of eight people per family, 960 people have become homeless every month.

**Summary: The Right to Health**

The right to health is based on the factors which promote health: water which is accessible and safe to drink, varied food, a roof over the head and a source of income. However, these are being gravely damaged in the Gaza Strip as a result of Israeli control over Palestinian freedom of passage inside and outside Gaza. The situation became even more serious following the Al Aqsah Intifada, when a consistent policy of destruction of infrastructure was added to Israeli control over movement. This situation has serious consequences for the Palestinian inhabitants.

- The rate of absolute poverty in Gaza today is 25%, i.e. a quarter of the population of the Gaza Strip. In other words, about 350,000 people are unable to feed themselves properly, even after receiving humanitarian food aid. As far back as the beginning of 2004, the

42. Figures from UNRWA.
organisations Food Aid and the World Food Plan established that almost 40% of Palestinians suffer from food uncertainty, i.e. they do not have food in sufficient quantity that is safe enough and nourishing enough to live a healthy life. Another quarter of the population is in danger of joining this group.

- Diet has a vital influence on the rate of anaemia. Iron deficiency anaemia in pregnant women demonstrates a lack of iron and folic acid additives before and after childbirth. Iron shortages of this kind increase the danger of premature births, and babies with low iron reserve
- Over the years there has been a trifling improvement in the rate of anaemia among the children in the Gaza Strip. Firm scientific evidence links iron deficiency anaemia with lowered cognitive functions, sometimes irreversibly. In cases where iron deficiency in early childhood is not treated, the learning powers and output of whole sub-populations are liable to be irreversibly damaged. A reliable source of iron is needed to ensure proper growth and development, while iron deficiency causes delay in development and disturbances in behaviour, especially in children from the age of two.
- In the Gaza Strip, the Palestinian inhabitants do not have enough water fit to drink by world standards. The fact that they drink substandard water is liable to cause severe health problems.
Part 3:
Access to Health

Health Services in the Gaza Strip

In Note 14 to the Right to Health, the compilers stress the importance of physical access to health services. This access is not only important for the patient. Efficient organization of health services in a state is also dependent on this accessibility, since on this is based the ability of the system to refer the patient to a specialist health centre, which is not necessarily the medical centre in the area where s/he lives. Stopping the movement of the civilian population between different towns cuts away the ground on which this is based.

Checkpoints

‘Less than three years ago I was the officer in charge at the Orhan checkpoint in the Gaza Strip, which overlooks Gush Katif. This is the checkpoint which divides the Gaza Strip in two. South of me were Rafah and Khan Yunis, and to the north, Dir al-Balah and Gaza. Over three weeks we carried out goals which simply had no connection whatsoever to the security of the State of Israel. You don’t have to be an expert on national security to understand that holding up thousands of local inhabitants for long hours every day in order to allow the Israeli settlers of Gush Katif free passage into Israel only produces frustration among the local residents.’

Along the Gaza Strip from north to south run two main traffic arteries, the sea road and the Salah a-Din road. [See map]. The Salah a-Din road traverses the Gaza Strip from Beit Hanun in the north of Gaza, to Rafah in the south. However, for the last two years, traffic has been permitted only on the southern section of the road leading to the town of Deir al-Balah, but has been banned on all the northern section. The permitted

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43. David Zonshein, head of the movement Ometz le-Sarev [Dare to Refuse], from Y-net, 09.09.04.
section of the Salah a-Din road is crossed twice by access roads to the Israeli settlements in Gaza: in the north there are two checkpoints on the access road to Netzarim, while in the remaining section there is the Abu Holi (al-Metahan) checkpoint which commands the Palestinian road traffic from north to south, and vice versa. Over the Abu Holi checkpoint there is a raised road, which serves as the main entrance to Gush Katif. This road is only used by the vehicles of the Israeli settlers. The Sea Road runs from the town of Gaza to the town of Deir al-Balah. For the last two years, travel from the town of Gaza to the south of the Gaza Strip has been allowed on this road only, as long as it is not closed by the army.

In addition to the two parts of the Abu Holi checkpoint, inside the Gaza Strip there are three permanent checkpoints, five checkpoints at the borders, 10 gates on the roads, 9 road closures, 12 earth barriers, 46 army posts and 67 lookout towers. These are the means by which the Israelis control the traffic in the Gaza Strip and divide it up – at any time – into three or more parts.

<table>
<thead>
<tr>
<th>Name of checkpoint</th>
<th>Site and purpose (from North to South)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Siafa</td>
<td>In Siafa enclave, between Alei Sinai and Dugit</td>
</tr>
<tr>
<td>Abu Holi (Al-Matahan) north</td>
<td>Stops traffic crossing Gush Katif access road from North</td>
</tr>
<tr>
<td>Abu Holi /Gush Katif (Al-Matahan) south</td>
<td>Stops traffic crossing Gush Katif access road from South</td>
</tr>
<tr>
<td>Tufah</td>
<td>Between Khan Yunis and Neveh Deqalim. Stops entry of pedestrians and vehicles to the area of al-Mawasi via the settlements of Gush Katif</td>
</tr>
<tr>
<td>Tell A-Sultan/Rafah</td>
<td>Stops entry of pedestrians to the area of al-Mawasi via the settlements of Rafiah Yam and Shalev</td>
</tr>
</tbody>
</table>

The checkpoints all over the Gaza Strip are the main routine points of contact between the inhabitants of Gaza and the Israeli army. In addition, during the frequent incursions of the Israeli army to the Gaza Strip in the last year, all crossing points within Gaza have been closed automatically even when the army activities were taking place in a distant part.

The Abu Holi checkpoint: This checkpoint is the main point of derangement of the routine of daily life in the Gaza Strip. The checkpoint is made up of two parts: Abu Holi North and Abu Holi South. Between the two parts of the checkpoint is an area of about 500m. which lies under an overhead bridge and is surrounded by watchtowers. For half a year now private cars have been forbidden to pass, and only taxis are allowed across. The two parts of the checkpoint are often closed, so that all the Palestinian vehicles are held up on either side. The traffic lights on either side of the checkpoint, which are supposed to regulate the movement of Palestinian vehicles, are controlled by Israeli soldiers. Anyone who does not comply with the traffic lights is shot. A wait of four hours at the checkpoint is routine. Anyone who gets out of a car, or even opens the window, is in danger of being shot by the soldiers in the watchtower.

Hours of opening of the checkpoint: For two years the checkpoint at Abu Holi has been completely closed from 8 pm. until 6 am., so that it is not possible to move from the north to the south of the Gaza Strip at night. Inhabitants of Khan Yunis working in Gaza, for example, have to return to their homes before evening, or they will be unable to get home. During the last closures imposed on the Gaza Strip, many workers were unable to reach their offices in the city of Gaza since the Abu Holi checkpoint was completely closed for several days. On the other side of the checkpoint, people were trapped in Gaza and could not return to their homes in the south.

On 7.9. 2004 the Abu Holi checkpoint was closed for two days. On 9.9.2004 Physicians for Human Rights received a call from A.H., a cancer patient, who had waited for two days at the Abu Holi checkpoint on her way to medical treatment in Egypt. The 44 year old patient and her elderly father had slept for two days on the ground, waiting for the checkpoint to open.

45. See the section on Access to Routine Medical Services in Gaza.
At the same time, a group of 67 blind children aged 4-13 from the Nur School, run by UNRWA, were trapped in Gaza City. The children were forced to sleep in the school for two days, because the closure of the Abu Holi checkpoint prevented them from going to their homes in the south of Gaza.

On 3.10.2004 the Abu Holi checkpoint was closed for the second day. R.S., a 21 year old cancer patient was on his way to medical treatment in Egypt, via the Rafah crossing, with a permit from the Gaza District Civil Liaison Centre [DCO]. He waited two days in a car with his parents at the Abu Holi checkpoint, expecting it to open. PHR applied to the Gaza DCO who confirmed that R.S. had a permit to leave. Two hours later, PHR were told by the Gaza DCO that the permit the patient had received was no longer valid since ‘today there is a closure, and the permit was given for passage on a normal day.’ The clerks in the DCO promised to try to arrange for passage the next day, according to the number of the car of the patient R.S. R.S. was told to return to the place he had come from, and he drove off to sleep with some relatives in nearby Deir al-Balah. Next day, at 8 am, RS and his parents returned to the checkpoint in the car agreed with the DCO. A member of PHR and the Gaza DCO stayed in constant telephone contact and instructed the car and its driver to proceed, having been assured by the DCO that the soldiers at the checkpoint could see them. The driver proceeded, and then the soldiers at the checkpoint shot at the car and damaged two of its wheels. The car, with its startled passengers, retreated fast. After an hour the checkpoint was opened and the patient and his parents were allowed to pass.

The hermetic closure of the Abu Holi checkpoint by the Israeli forces is routine. From 1.7.2004 to 15.10.2004, PHR collected exact daily statistics of the hours that the Abu Holi checkpoint was actively functioning. From the information collected, it appears that the Abu Holi checkpoint was completely closed for 18 days and partly closed for 81, in other words, open for only a number of hours every day. This means that during three and a half months the checkpoint hardly ever functioned in a way which allowed normal day to day life to carry on i.e. allowing freedom of movement between the north of the Gaza Strip and the south, with access to health services, education and trade.

Cutting off places in the Gaza Strip from each other for long periods of
time seriously interferes with the ability of the inhabitants to receive health services in general, and in particular emergency health services. Although there are medical centres in various parts of the Gaza Strip, they are only able to provide primary and secondary medical care at the most basic level. The most advanced medical services in the Gaza Strip, and in particular tertiary medicine, are to be found in the Shifa Hospital in the city of Gaza and in the European Hospital in Khan Yunis. In addition, since the main centre for emergency medicine is at Shifa Hospital, the most serious cases must get to this hospital with all possible speed. Thus the inhabitants of the Gaza Strip are extremely dependent on Shifa Hospital. Part of the cancer patients who live in the south of the Gaza Strip are forced to pass the Abu Holi checkpoint in order to receive medical care in Gaza. Because of the constant closure of the checkpoint, owing to the passage of the settlers’ cars above and some army manoeuvre or other, many patients, including cancer patients, are unable to get to the hospital.

On the days that the checkpoints are open, the journey from Rafah to Gaza, which is 35km in length, takes five hours and more. Dialysis patients can usually get treatment in Shifa Hospital or in Nasser Hospital in Khan Yunis. But when the Gaza Strip is divided into three parts, patients living in the villages between the two checkpoints Abu Holi and Netzarim cannot get treatment at either of these medical centres. Since closures and division of the Gaza Strip have become routine, the Palestinian Authority has had to find solutions for dialysis and cancer patients who have to have treatment regularly. Thus equipment for giving chemotherapy has been moved to the European Hospital in Khan Yunis, so that cancer patients from the area can receive treatment when the checkpoint at Abu Holi is closed. In parallel, dialysis equipment has been moved from the Nasser Hospital in Khan Yunis to the Shuhada al Aqtza hospital in Deir al-Balah. Dialysis patients trapped between the two checkpoints can thus get there if there is a closure and division of the Gaza Strip.46

46. Report on Access to Health Services for Palestinians through Border Crossings and Checkpoints in Gaza Strip, Health Inforum 20.7.04.
Aerial photograph of the Abu Holi checkpoint. From East to West: access road to the Gush Katif settlements. From North the South: the destroyed Salah a-Din road with the alternative road permitted to Palestinian traffic marked in white.
The centre of the Gaza Strip as seen from the air. From the West: the Sea road, which runs from Gaza to Deir al-Balah. A little to the left in the upper portion of the photograph are the lands of Israeli settlements of Netzarim A and Netzarim B. Access to the extensive empty areas around the settlements is forbidden to Palestinians.
Enclaves

In Gaza there are several areas which are closed in as enclaves, where access is permanently extremely restricted. Most of the enclaves are trapped between the Israeli settlements, or between the settlements and the sea. There are also other enclaves, such as the area of Johar a-Diq, which are not near settlements but very near the border with Israel. This area is an enclave because the army activity nearby, including frequent shooting of Palestinian vehicles, endangers those entering or leaving its gates.

Between the enclaves are tiny villages, such as Siafa, which is sited between the settlements Dugit and Alei Sinai, with 180 inhabitants. There are also enclaves with large areas, closed on all sides, like al-Mawasi. This area is the largest enclave, which stretches for 14 km. along the Mediterranean coast and is one kilometre wide. The area is bounded on one side by the sea and on another by the area of the Israeli settlements of Gush Katif. In the north it borders on the town of Dir al-Balah and in the south the town of Rafah. In al-Mawasi 8,000 people live in two large villages, al-Mawasi Khan Yunis and al-Mawasi Rafah.

In May 2002, the Commander of the Southern Forces declared al-Mawasi a closed area. The meaning of this was that everyone who was not a resident of the area could only enter it with a special permit, and entry in

Photograph: Nir Kafri
a vehicle was allowed only from the a-Tufah checkpoint. This checkpoint leads to the nearby town of Khan Yunis. It is built like an army camp, and passage through it is restricted to certain hours of the day, and to permit holders only. The second checkpoint, the Rafah checkpoint, allows entry to pedestrians only. Since 2002, the army has often shut these checkpoints completely for long periods of days or weeks.

During Operation ‘Defensive Shield’, the al-Tufah checkpoint was closed for fifty days (!) with no prior notice. Anyone outside the area could not get back to his or her home, and anyone inside was trapped.

The sources of income of the inhabitants of this area are traditionally farming and fishing, but from July 2000 there has been an almost total ban on fishing. The area of al-Mawasi is especially fertile and rich in water, but the restrictions on export of goods from the area have severely interfered with the income of the inhabitants from farming. Before 2000, there were regularly 50 lorries a day leaving the area of al-Mawasi, piled high with agricultural produce. Today, about five lorries a day leave the area, and that is after many hours of delays at the checkpoints. 47

The entrance to the enclave of Ma’aniya, next to Kfar Darom. Entry to the enclave is only permitted three times a day. Photograph: Nir Kafri.

Dr Haled Bardawil is a doctor in the clinic at al-Mawasi Rafah. In a telephone interview with PHR which took place on 17.11.2004, he described the situation of the medical services in the enclave as follows:

‘In the area of al-Mawasi there are two clinics. One in al-Mawasi Rafah, and the other in al-Mawasi Khan Yunis. The clinics are run by five doctors and three nurses. The number of patients varies between 50-80 a day, and they receive satisfactory primary care for problems such as coughs, colds, children’s ear infections and so on. We also carry out simple surgical procedures such as sewing up cuts.

The main medical problems arise when there is need of emergency transfer to receive secondary or tertiary care. We have an ambulance in al-Mawasi, but the checkpoint can only be crossed with prior agreement, and that sometimes takes an hour and a half, or more. For example, we usually deliver women ourselves in the clinics, but in cases where women have difficulties in labour, we have to transfer them to the European Hospital in Khan Yunis, and then it takes a long time to get through the Tufah checkpoint.

We have no electricity, and we have a problem with storing drugs. We received a fridge as a donation from the Save the Children Fund, and we have a generator which works on oil, but sometimes the oil runs out, and it takes time to bring more from outside. We always have problems because of the electricity. Insulin, for example, is a problem, because it has to be kept in the refrigerator.

A further problem is access to specialist doctors. Once every month or two months, a mobile clinic comes from the United Nations, and brings dermatologists, dentists, etc.

Injury to Medical Personnel

In Gaza there are a number of functioning organizations apart from the Palestinian Authority which provide the population with evacuation and emergency services. Among the larger of these are the Palestinian

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48. The Palestinian Authority is not allowed to provide electricity to the area of al-Mawasi, which is defined as a closed military area. In addition, it is forbidden to build in the area of al-Mawasi, and bringing building materials through the checkpoint is forbidden without prior agreement.
Red Crescent Society, Medical Relief Committee (UPMRC) and the Red Cross. The Office of Health of the Palestinian Authority has six intensive care ambulances, apart from its ordinary ambulances. The evacuation and treatment teams are exposed to the continual threat of the Israeli army forces spread over the Gaza Strip, who carry out massive operations along the major roads and at the checkpoints. This presence is a threat to evacuation vehicles, which need to move at all hours at maximum speeds. In every case of curfew or closure of a particular area, or the closure of major roads, prior coordination is demanded, even in a case of life and death.

In the afternoon of 31.8.2004, the ambulance of Medical Relief Committee (UPMRC) was fired on. The ambulance passed through the checkpoint of Abu Holi on its way from Khan Yunis to Deir al-Balah. As a result of the gunfire, two members of the team were injured: a doctor, who was moderately injured and the ambulance driver who was seriously injured.

The ambulance arrived at the Abu Holi checkpoint and found it closed from both sides. The vehicle, with its passengers, waited about two hours for the checkpoint to open, together with hundreds of people and three long lines of cars. Suddenly, without any apparent reason, one of the soldiers got down from an army jeep which stood at the watchpoint next to the checkpoint, and fired on the ambulance. Only after 40 minutes did they allow them to evacuate the two wounded.

The case described above is one of dozens of cases of injury to medical teams while they are fulfilling their function. From the statistics published by the Palestinian Red Crescent Society, it appears that damage to ambulances is a common phenomenon. From 29.9.2000 to 8.10.2004, 12 members of medical teams have been killed, and 202 medical team members injured. 361 episodes of firing on medical teams have been recorded. 327 ambulances have been damaged. 28 ambulances have been taken out of use. 1,540 times the passage of medical teams was forbidden.

**Medicine during Army Operations**

In addition to the fact that regular movement within the Gaza Strip is very restricted, during army operations the situation becomes intolerable. Even when fighting is happening in one part of the Gaza Strip, serious
restrictions on movement are imposed on all areas.

In the last year, the Gaza Strip experienced several lengthy incursions. The most serious incursion of all was into the town of Rafah in the south of Gaza, on 18.5.2004. It was called by the pastoral name of ‘Rainbow in the Clouds’ [Qeshet be-Anan]. During the incursion, PHR received dozens of emergency calls from medical teams who tried to evacuate the wounded under fire, and from sick and wounded people who needed help to get to medical centres.

The Yusuf a-Najar Hospital in the town of Rafah itself is not equipped to give complex treatments, complex surgical procedures or to carry out advanced tests. During the days of fighting, most of the injured suffered from gunshot or shell injuries and needed hospitalization in intensive care units for life-saving surgery, neuro-surgery and orthopaedics. The only hospital which could help, and that only partially, was the European Hospital in Khan Yunis. But the road to Khan Yunis was totally cut off from the first day of fighting.

During the army operation PHR received many complaints. These included live fire on rescue teams; stopping evacuation and rescue teams from getting to the wounded and dead to evacuate them; severe shortages of medicaments, disposable medical equipment, baby food and milk; shortages of drinking water; and electricity cuts which lasted for days on end.

An ambulance was covered with sand by Israeli army bulldozers and its team were trapped inside. • A patient who was shot in the head bled for 8 hours in the field until an ambulance was allowed to evacuate him to hospital. • An injured man died of his wounds after he bled in the field for five hours. • The brothers Ahmad and Mohamed a-Sha’ar, aged 17 and 18, were seriously injured. They were taken to hospital after four hours and died of their wounds. • Brother and sister Mohamed and Asmaa Mugheir, aged 14 and 16, were shot and died in their own home. Evacuation of their bodies was only made possible after 10 hours, and only then after the intervention of PHR.

The incursion began in the neighbourhood of a-Sultan. On the first day of fighting 24 civilians were killed, among them children and youth. During the day, PHR received reports of many injuries to the civilian population, destruction of infrastructure, and injury to medical teams. In the Bilal bin-Rabah mosque, a helicopter shot at a group of people, and the
mosque was set on fire. Attempts to organize entry for rescue teams and firemen were unsuccessful, evacuation was prevented for long hours, and the mosque was burned down.

On the next day, a procession of hundreds of civilians set off from the town of Rafah in the direction of a-Sultan, now besieged for the third day. They included women and children, who brought food and water for the besieged. During the march, several shells were fired from tanks towards the marchers. According to the Israeli army this was in order to warn them, and prevent them from reaching the neighbourhood. As a result of the fire, 8 civilians were killed, four of them children aged 10, 11, 13 and 14.

On 19.5.2004 the Yusuf a-Najar Hospital applied to PHR, with a request to provide them with emergency equipment, including drugs, bandages, disposable equipment and blood transfusions, in order to treat the hundreds of injured streaming in. PHR sent disposable equipment to them immediately, but it only reached them on 21.5.2004, after the intervention of the High Court.

During the first days of the operation, because of the chaos it created, PHR was forced to work through all hours of the day and night to try to coordinate with all the parties involved: the Palestinian evacuation forces in the field, the Yusuf a-Najar Hospital, and the humanitarian centre at the DCO in Gaza. The breakdown in communications between the Gaza DCO and the army forces in the field was so bad that members of PHR had to update the soldiers at the humanitarian centre about what was happening in the field.

Every request for evacuation of wounded from the hospital to medical centres in Khan Yunis met with a demand from the army for specific individual coordination, including names of the wounded, numbers of the ambulances and details of the drivers. The demand for identification of the wounded was impossible, since some of them arrived in the hospital seriously wounded with no-one accompanying them, and nothing to identify them.

In the light of what has been described above, on 21.5.2004, the fourth day of fighting in Rafah, PHR and other human rights organizations applied to the Israeli High Court. In their application, they demanded an immediate explanation for the Israeli army’s operations in Rafah, and

49. High Court File no 4764/04: PHR-Israel against the Commander of the IDF forces in Gaza.
the serious contravention of international humanitarian law and various agreements. In addition, PHR requested that a team of PHR-Israel doctors be allowed to get to the hospitals in Rafah, in order to see what was happening on the spot.

At the hearing in the High Court it was made clear to PHR that their request to enter Rafah would not be acceded to. In fact, the High Court judges accepted the claim of the commander of the IDF in Gaza, that the efforts they were making (which were in a large part the result of pressure from PHR and other human rights groups) to answer all the humanitarian demands were enough. However, in the ruling of the High Court, it was established for the first time that it was the duty of an army commander to assess and foresee humanitarian needs beforehand. Furthermore, he was obliged to provide a practical answer to the humanitarian demands which arise as the result of every army action, and not merely to allow the work of different sorts of humanitarian bodies to alleviate the situation. It is the duty of the army commander to ensure that in the area of fighting there should be enough medical equipment. This is his duty towards his soldiers, but also towards the civilian population in his charge.

In spite of this, in July 2004, when Israeli army forces invaded the north of the Gaza Strip and imposed a curfew on Beit Hanun, PHR were again forced to coordinate the entry of ambulances with mobile clinics belonging to Medical Relief, on at least five different occasions.

**Life during the Invasion of the Northern Gaza Strip**

On 28.9.2004, Israel invaded the north of the Gaza Strip in Operation Days of Repentance. By 10pm., there were already 54 Palestinians dead and about 223 injured. The Erez checkpoint had been closed for six days, as well as the Sea Road and the Abu Holi checkpoint. Even though the army

50. The Fourth Geneva Convention – protection of civilians, the principle of treating the wounded, immunity for ambulances. The First Geneva Convention – protection of wounded who belong to armed forces. Decision 2444 of the General Assembly of the UN – on the necessity of distinguishing between people taking part in enemy activity and civilians. The UN Committee for economic, social and cultural rights – the right to health and the right to receive medical treatment, etc. The duty to honour the instructions of the International Convention on the subject of economic social and cultural rights during war. The Convention for the Rights of the Child – the Right to Life.

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operation was only in the northern part of Gaza, a closure was imposed on
the whole of the Gaza Strip, and internal movement between the different
parts was not allowed.

The IDF announced to all the media that they were opening a
‘humanitarian corridor’ to be used for the transport of food and drugs, and
the evacuation of the sick. However, in the field things looked different.
The army operation concentrated on the area of the Jabaliya refugee camp
and north-east of it, in the direction of the Erez checkpoint and Beit Hanun.
On the same day, the army invaded the Jabaliya refugee camp. For a week
and a half the area was under siege, and none of the essential services were
provided for the inhabitants.

The neighbourhood of Klebo suffered the most. There was no
electricity or running water and there was a serious shortage of milk and
medicaments. A Red Cross worker informed PHR that his organization
could not get in to the area to provide essential medical services. On one
occasion only during these ten days did the Red Cross succeed in bringing
in 10 gallons (about 45 litres) of water to the adjacent neighbourhood of
al-Buhari, to supply thirty families. Only on 7.10.2004 was the local water
system mended. The next day, 8.10.2004, food, water and basic drugs were
permitted to be supplied to the neighbourhoods of al Buhari, Sha’ashaa, al
Idara al Madinia and Klebo.

In the only public clinic, in the town of Beit Hanun, there was a serious
shortage of blood transfusions and drugs. Sick people who needed
emergency evacuation were brought to the clinic, but it was not possible to
coordinate their transfer to a hospital. P.a-H., a seven month old baby with
a heart defect who needed urgent hospital treatment; A.B. a girl who had
been bitten by a snake and was in urgent need of evacuation to a hospital;
another small girl arrived having swallowed poison, and in need of
emergency evacuation. PHR received many requests from al-Mezan, our
partner in Gaza, asking for help in coordinating the entry of ambulances
bringing blood transfusions and oxygen balloons, and in transfer of patients
to hospitals. Coordinating the entry of one ambulance took a whole day,
and only at 8 pm was it allowed to enter the town.

H.T. is a six year old girl who lives in a Bedouin village next to
the Erez checkpoint. The village was under curfew. H. suffers from
brain cancer. She was in the middle of chemotherapy treatment in
Shifa Hospital.
On 13.10.2004 she had a high fever, after being prevented from going for her chemotherapy. The village doctor was unable to bring down her fever. Only after the intervention of PHR was an ambulance allowed to evacuate her to the hospital.

Abraj al Awda and Abraj al Nida are neighbourhoods near the Israeli settlement of Nitzanit, and together they are called al Abraj, 'the Towers'. The neighbourhood of Abraj al Awda includes eight buildings of 32 flats. The neighbourhood of Abraj al Nida has 15 buildings of 18 flats. Their population is about 8,000 people. When they turned to us for help, these neighbourhoods had already been closed and under curfew for five days. No-one was allowed in or out. They were being fired on incessantly from the direction of Nitzanit. At one stage, a committee was formed in the neighbourhood, which collected food from the residents. The committee calculated that the food which they had collected would only last for five days, and that there was also a shortage of baby food.

During the time of the incursion a tank was positioned in the courtyard of the Balsam Hospital, which is near the Towers and the neighbouring Bedouin village. No-one was allowed to go near it. Patients from the Bedouin village and the Towers were not allowed to get to the hospital. In the hospital itself, there was a shortage of water, food, and oil for the generators. On 4.10.2004, there was massive firing on the doctors’ room, and the tank in the courtyard shelled the engine room of the hospital.

In Abraj al Nida there was only one pharmacy, which was closed, and one clinic, belonging to Medical Relief Committee, which stayed locked. The team which ran it could not get in to the neighbourhood because of the curfew. For four days there was no electricity, and as this was needed to pump water from the well, there was no water either. Medicaments such as insulin, which need refrigeration, became unusable. At one point the inhabitants of the area called for help from the Palestinian Authority via the radio. In the neighbourhood there were patients who needed medical assessment and treatment. For example, a two year old girl with a metal implant in her hip who was in serious pain; four people with asthma, who needed inhalers; a woman suffering from severe pain in the head; a woman suffering from severe toothache; three cancer patients in the middle of chemotherapy; and five diabetics who had run out of insulin.

Only on 6.10.2004 were 500 food parcels, sent by the Palestinian...
Authority to the residents of the Towers, allowed in. At the same time, the inhabitants were allowed to burn the refuse which had accumulated. On that day, the first ambulance entered the place, bringing supplies for the clinic. The clinic was opened and received the cases which needed medical treatment. Two days later, on 8.10.2004, the supply of electricity and water was stopped again.

**Summary: Access to Health inside and outside the Gaza Strip**

From a survey conducted by the Palestinian Central Bureau of Statistics, it appears that one of the main reasons for non-access to health services in the Gaza Strip is the internal closures, such as that at the Abu Holi checkpoint. In fact, 51.8% of the inhabitants of the Gaza Strip reported that they had been obliged to get medical services from a place other than the one where they had been treated before March 2000. 88% of them reported that the reason for changing the place of treatment was the restriction on travel. 44% of mothers in the Gaza Strip reported that they had encountered difficulties in receiving treatment for their children during a curfew. Of those mothers reporting difficulties, 91.6% were from villages and 73% from refugee camps.

As already noted, there are considerable difficulties in accessing medical services within the Gaza Strip itself, difficulties which should be removed with the evacuation of the Israeli settlements and army from Gaza. However, the difficulty in leaving Gaza for medical treatment or professional training will continue after the Disengagement, and may well increase. The fact that the Gaza Strip is entirely dependent on external health services in the West Bank, East Jerusalem, Israel, and abroad makes open links with the outside world an essential element to be included in any plan which discusses the future of the Gaza Strip.

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Part 4:
Medical Institutions and Providers of Services

Hospitals

In Gaza there are 12 public hospitals, and another 12 hospitals which belong to various different bodies. All of them provide medical services to the inhabitants of the Gaza Strip. In the public hospitals there are 1,480 beds of all kinds, in other words a bed for every 614 people. In Israel, in comparison, there is one bed for every 145 people. In other words, the provision of hospital beds is one quarter of what is acceptable in the Israeli health system.

There are significant differences between the medical services in different areas. Most services are provided in the Shifa Hospital in the town of Gaza and in the European Hospital in Khan Yunis. Other hospitals are Nasser Hospital for Children in Khan Yunis, Yusuf a-Najar in Rafah, and Kamal Adwan in the north of the Gaza Strip. The most difficult problem is the area in the middle of the Gaza Strip, where there are 0.037 beds per person. On the scale of accessibility to medical services, this area is at the bottom of all the territories of the West Bank and Gaza Strip. The significance of this is that when the Israeli army divides Gaza into three parts, there is no solution for the medical needs of the residents of this part. There is also a difference in provision during emergencies. In spite of the fact that there are six intensive care ambulances in Gaza, their ability to provide for the needs of the inhabitants of the different areas is restricted.

53. The number of beds in private hospitals in Gaza is 455
54. According to the Palestinian Office of Health there is one bed per 715 people including mental health, in other words 1.399 beds per thousand people.
55. Israeli Ministry of Health.
M.G., an inhabitant of Nusseirat in the centre of the Gaza Strip, had an operation on his spine in the European Hospital in Khan Yunis. 10 days later, on 21.12.2004, a large amount of fluid began to flow from his operation scar. As a result of this, M. lost his ability to move. When his medical condition deteriorated, his doctors instructed him to go quickly to hospital. It was M.’s bad luck that on that day the Sea Road was closed, and special coordination was needed for the ambulance to travel along the Sea Road, and via the Abu Holi checkpoint. From the early hours of the morning, the representative of the Palestinian Health office tried to coordinate his journey, but in vain. At 11am., M.’s family turned to PHR-Israel with an urgent request for help. At 11:32 am the road was opened, without any explanation.

Blood bank

In the Gaza Strip there are seven public centres, which provide 80% of the blood transfusions used in Gaza. Another organization which does not belong to the Palestinian Authority, the Central Blood Bank, which has two branches in Gaza, provides the rest. The use of blood transfusions in Gaza and the West Bank rose sharply in the last five years, from 25,799 blood transfusions in 1999, to 74,809 transfusions of blood and blood products in 2003. This rise is explained by the huge number of wounded which resulted from the outbreak of the second Intifada, especially in the Gaza Strip where the fighting was continuous. In fact, in 2003, the number of blood transfusions given in the Gaza Strip was almost twice as great as in the West Bank.56

Because of the exceptionally large numbers of donations, there is no shortage of blood for transfusions in the Gaza Strip. However, when there is an army incursion into Gaza the problem arises of getting the blood to its destination. Thus during the army incursion into the city of Rafah in May 2004, an urgent request was made to PHR from the city hospital Yusuf a-Najar, to assist in coordinating the transfer of blood transfusions from Gaza city to Rafah city.


56. In spite of the fact that the population of Gaza is smaller than that of the West Bank: 11,752 blood transfusions were given in Gaza as compared with 6,539 in the West Bank.
Laboratories

There are about a million and a half inhabitants of the Gaza Strip, but there are only 39 laboratories serving them. In these laboratories there are 197 workers. The average annual workload of a technician stands at 12,726 tests. There is only one histology laboratory in the whole of Gaza, in the Shifa Hospital. This laboratory employs only two qualified technicians, who are supposed to provide a service for the whole population of Gaza. The workload of the laboratory is enormous, and people can sometimes wait two weeks for results. PHR-Israel knows of a number of cases when critical mistakes in diagnosis were made, as a result of mistakes in tests carried out by this laboratory.

Haemodialysis

In Gaza there are 209 reported patients who are permanently on haemot-dialysis. The patients are treated at four centres with a total of 41 beds, in other words a ratio of five patients to a bed. In Israel too, the ratio is five to six patients to a bed. However, in Israel the patients receive three treatments, which is the minimum accepted medical standard, because of the fact that the dialysis units work three full shifts. The average number of weekly treatments in Gaza is only two, less than the elementary minimum. The dialysis units in Gaza are not able to run a full service, both because of lack of personnel, and because of the high cost of treatment.

CAPD treatment, peritoneal dialysis, does not exist at all in Gaza. This treatment needs special equipment and training of supervisory staff, as well as follow up of patients. The advantage of peritoneal dialysis is that the patient can treat him or herself at home, and come to hospital for a check-up once a month. This treatment could have huge advantages, particularly for patients in Gaza where there are serious problems of access to medical centres.

Professional personnel

The Gaza Strip is characterized by the lack of a suitable physical basis which could supply the huge demand for health services. However, while this sort of lack is relatively simple to supply, (only money is needed), the more problematic shortage is that of human resources, and in particular, the lack of a cohort of experienced medical personnel. This shortage can only be supplied through long-term planning, and many years’ training of medical personnel.
Table comparing the numbers of the different medical and paramedical professions in Israel and in Gaza

<table>
<thead>
<tr>
<th>Profession</th>
<th>Number per 1,000 in Israel</th>
<th>Number per 1,000 in Gaza</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>4.61</td>
<td>0.75</td>
</tr>
<tr>
<td>Nurses</td>
<td>5.2</td>
<td>0.9</td>
</tr>
<tr>
<td>Dentists</td>
<td>1.33</td>
<td>0.85</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>0.86</td>
<td>0.31</td>
</tr>
</tbody>
</table>

Table comparing the numbers of the different medical professions in Gaza in 1998 and 2004

<table>
<thead>
<tr>
<th>Medical professionals per 1,000 in Gaza</th>
<th>In 1998</th>
<th>In 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>0.86</td>
<td>0.75</td>
</tr>
<tr>
<td>Nurses</td>
<td>1.4</td>
<td>0.9</td>
</tr>
</tbody>
</table>

The table shows clearly the fall in the number of professionals in the medical field over the years, so that today there is a fall of 13% in the number of physicians and 36% in the number of nurses relative to the increase in size of the population.

This fall can be explained as the result of two main causes:

1. Young people wanting to learn medicine are not able to travel abroad, or to the West Bank where there are medical schools which teach the various specialties. Israeli institutions have always been beyond the pale for Palestinian residents of the Occupied Territories.

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2. Because of the difficult situation and the bleakness of the future outlook, there is a ‘brain drain’ of people in the free professions from the better off parts of the population, including physicians. In parallel, those who have left Gaza to study medicine abroad, tend not to return at the end of their studies.

The significance of these figures is that the Palestinian population has grown but the number of physicians and nurses who provide medical services is slowly shrinking.

**Dependence on External Medical Services**

**The figures**

This section will survey the medical fields where the Palestinian Authority is obliged to buy services for the inhabitants of Gaza from different sources. This survey also demonstrates the level of services which are given by the Palestinian Authority’s health system. There are services which do not exist at all in Gaza: cardiac catheterisation and cardiac surgery, burns treatments, paediatric cardiology, neuro-cardiology, maxillo-facial surgery, radiotherapy, any sort of transplant surgery, eye surgery, tests such as MRI, bone scans, bone marrow testing, metabolic tests and more.\(^58\) These sorts of services are bought at full price by the Palestinian Authority from Egypt, Israel and Jordan. There are other fields where the services exist, but are on a relatively low level, which does not permit treatment of the more complex cases. In order to illustrate this we shall note a number of important services to which the Authority refers most of the patients.

In 2003 the budget of the Palestinian Office of Health stood at 98,421,543 dollars. From this, the Palestinian Authority spent 12,350,000 dollars on referrals of patients to receive medical services abroad, especially in Egypt and Israel. This outlay was 12.9% of the budget of the Palestinian Office of Health.

The number of referrals to treatment outside Gaza which the Palestinian Authority sent out added up to 7,805, of which 1,348 were to hospitals in Israel, 4,879 to Egypt, 685 to East Jerusalem and 562 to hospitals in the West Bank. In the first half of 2004 they sent 4,152 referrals to treatment

\(^{58}\) For full details see Appendix A p. 123.
outside Gaza, of them 707 to hospitals in Israel, 2,669 to Egypt, 314 to East Jerusalem and 255 to hospitals in the West Bank.

Table showing the major sorts of referrals which the Palestinian Authority sent outside the Gaza Strip in 2003 (in brackets: estimate for 2004)

<table>
<thead>
<tr>
<th>Type of referral</th>
<th>To Israel</th>
<th>To Egypt and Jordan</th>
<th>To the West Bank and East J’lem</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>31 (34)</td>
<td>116 (120)</td>
<td>27 (16)</td>
<td>174 (170)</td>
</tr>
<tr>
<td>Catheterisation</td>
<td>17 (42)</td>
<td>467 (560)</td>
<td>456 (364)</td>
<td>940 (966)</td>
</tr>
<tr>
<td>Cardiac surgery</td>
<td>67 (66)</td>
<td>120 (74)</td>
<td>24 (48)</td>
<td>211 (188)</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>95 (68)</td>
<td>682 (646)</td>
<td>10 (2)</td>
<td>787 (716)</td>
</tr>
<tr>
<td>Oncology</td>
<td>349 (360)</td>
<td>441 (378)</td>
<td>0 (4)</td>
<td>790 (742)</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>129 (92)</td>
<td>628 (766)</td>
<td>155 (240)</td>
<td>912 (1098)</td>
</tr>
<tr>
<td>Orthopaedic Surgery</td>
<td>58 (54)</td>
<td>624 (616)</td>
<td>71 (96)</td>
<td>753 (766)</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>15 (34)</td>
<td>184 (216)</td>
<td>1 (0)</td>
<td>200 (250)</td>
</tr>
<tr>
<td>Nuclear medicine</td>
<td>31 (28)</td>
<td>223 (320)</td>
<td>1 (0)</td>
<td>255 (348)</td>
</tr>
<tr>
<td>MRI</td>
<td>4 (2)</td>
<td>169 (250)</td>
<td>111 (134)</td>
<td>284 (386)</td>
</tr>
</tbody>
</table>

The figures in this table demonstrate the marked dependence on medical services bought from outside bodies, and explain the high outlay of the Palestinian Authority on patient referrals. It can be seen that most of the patients are referred to medical services in Egypt – the provider preferred by the Palestinian Authority, because of the low cost in comparison with Israel.
In spite of the fact that part of these services exist in the Gaza Strip, for example ophthalmology, the referrals demonstrate that in Gaza it is not possible to treat eye conditions other than at the most basic level. In fact, all the sub-specialties in the various fields, such as surgery, oncology, ophthalmology, urology etc. are non-existent.

Over the last four and a half years there has been a significant rise in the number of referrals of the inhabitants of Gaza for treatment abroad by the Palestinian Authority.

**Table showing the rise in number of referrals for treatment abroad by the Palestinian Authority from 2000**

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of referrals for treatment abroad</th>
<th>% increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>2,733</td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>4,481</td>
<td>64%</td>
</tr>
<tr>
<td>2002</td>
<td>5,603</td>
<td>25%</td>
</tr>
<tr>
<td>2003</td>
<td>7,805</td>
<td>39.3%</td>
</tr>
<tr>
<td>2004 (estimated)</td>
<td>8,304</td>
<td>6.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total increase = 204%</td>
</tr>
</tbody>
</table>

The figures in this table demonstrate a sharp rise of 64% in the number of referrals already in 2001. This rise can be explained by the outbreak of the second Intifada, at the end of 2000. Following the episodes of violence, the number of wounded rose sharply, and the health system in the Gaza Strip was not built to cope with such numbers of wounded or such complex cases. Thus, for example, complex surgical procedures, such as neurosurgery, vascular surgery, and orthopaedic surgery either do not exist in Gaza, or, if they do exist, it is only at the most basic level. Orthopaedic surgery, for example, does exist in Gaza, and in comparison with other fields has a considerable number of doctors, but their professional competence is not sufficient. Thus the Palestinian Authority refers 750 patients every year for orthopaedic treatment, mostly to Egypt.

59. Details of the source of this information are with PHR-Israel.
The number of referrals in the four years between 2000 and 2004 trebled, in spite of the fact that the population of the Gaza Strip did not treble. The sharp rise in referrals can only be explained by the rise in the number of sick or wounded people, and the concomitant fall in the ability of the health system to fulfil their needs.

As already noted, even when a treatment actually exists in Gaza, the number of referrals demonstrates that the local health system is not able to provide a proper answer to the needs. In the field of cancer treatment, for example, the Palestinian Authority refers patients to Israel and Egypt. In Shifa Hospital there is an oncology department, but the chemotherapy they provide is only basic, and they do not have the newest drugs. A patient in need of chemotherapy sometimes has to wait for about a month before s/he can get it, because of complex and centralist bureaucracy. In 2003 the Palestinian Authority referred 790 cancer patients for treatment in Israel and Egypt, which is over 50% of all the patients diagnosed with cancer in a year. In addition to this, the patients have to wait for months before receiving treatment.

M., whose sister suffers from cancer, told a member of PHR-Israel that when they diagnosed cancer in her sister they told her she would have to wait for a long time in order to get a referral to Egypt from the Palestinian Authority. As a result, the family took the patient to Egypt at their own expense. A large proportion of the patients are referred for radiotherapy, mostly to Israel. Among these are children, for whom the chemotherapy available to them at the Nasser Hospital in Gaza is so basic as to be of little use. Diagnostic tests, such as MRI, bone scans and bone marrow testing are not done at all. In addition, a large number of cancer patients are referred for radiotherapy to the private Assuta Hospital in Tel Aviv, with which the Palestinian Authority has a financial agreement.

Factors Holding up the Development of Medical Services

Throughout the years after the Oslo Agreements, Israel claimed that she had no further responsibilities towards the inhabitants of the Occupied

60. F.B., a cancer patient, had to wait about a month until the Chairman of the Palestinian Authority, Yasser Arafat, signed a permit to give her Taxol – a relatively expensive chemotherapy medication. Afterwards she waited another week for a permit from the Health Office in Gaza and after that several more days until the drugs were brought from the warehouse to the hospital. She missed two rounds of treatment because of these delays.
Territories in general, and in particular in the field of health:

‘We should stress that in the Interim Agreement the inclusive responsibility for the field of health passed… to the Palestinian Council… however Israel still helps the Palestinian Authority on a humanitarian basis as far as possible, taking into account the Israeli security considerations. But it should be stressed that this is aid ‘beyond the demands of the law’ and not from force of necessity.’

Given Israel’s total control of movement within and from the Gaza Strip, it is clear that Israel rules the lives of the inhabitants of Gaza, and is thus obliged to care for their safety and health. Furthermore, during all the years of the occupation, Israel had a policy of preventing the development of medical services, a fact which strengthens the claim that she is responsible for the state of the medical services.

The medical services in the Gaza Strip are not up to the standards of a developed medical system, and they are most certainly nowhere near the standards of the Israeli medical system. This is not the responsibility of the Palestinians alone. At least until 1994, Israel was responsible for the medical services in the Occupied Territories, so that it is reasonable to suppose that in 1994 – the date of the transfer of responsibility for the medical services to the Palestinian Authority – one should have expected to find a health system similar in standards to the Israeli system. However, it is clear that this was far from being the situation, and the State of Israel was happy to divest itself from the responsibility for a sickly health system, and from the financial burden involved in giving medical services to the Palestinian population.

The neglect of the Palestinian health system by Israel can be measured by many yardsticks. For example, we may look at the number of hospital beds in the Gaza Strip between 1970 and 1993, when Gaza was under full Israeli occupation. In 1970, there were 323,000 inhabitants in Gaza and 790 hospital beds. In 1993, there were 772,000 inhabitants and 900 beds. In other words, even though the population more than doubled, only 110 beds were added. If the ratio of beds to population had been preserved,

there should have been about 1,500 beds in Gaza in 1993, instead of the actual number of 900.

Table comparing health services and conditions in Israel and the Occupied Territories

<table>
<thead>
<tr>
<th>Medical/health element</th>
<th>Israel</th>
<th>Occupied Territories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Official expenditure on Health per capita (estimated in dollars)</td>
<td>500</td>
<td>18-23</td>
</tr>
<tr>
<td>Number of hospital beds per 1,000 population (approx)</td>
<td>6.1 in 1992</td>
<td>2.2 in 1975</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.1 in 1991</td>
</tr>
<tr>
<td>Number of ambulances per capita (approx)</td>
<td>1 per 5,000 population</td>
<td>1 per 16,000 population</td>
</tr>
<tr>
<td>Number of children’s respirators (approx)</td>
<td>1 per 18,000 population</td>
<td>1 per 160,000 population</td>
</tr>
</tbody>
</table>

As already noted, because of the fact that many services are not available in the territory of the Palestinian Authority, the latter is obliged to buy them outside, from Israel among others. The dependence of the Palestinian health system on bought medical services is a heavy burden on its budget. The same budget could be used to develop the local medical system, which would develop gradually, and provide a sufficient answer to the medical needs of the population. However, the ability of the Palestinian Authority to develop suitable medical services today, under occupation and curfew, is very limited. There is also the problem of pressure from the patients to continue to receive referrals to Israel. In fact it is quite amazing that the Palestinian Authority is managing to survive, and even develop, slowly but surely.

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64. Figures from *A Health System under Occupation* PHR annual report, 1992.
Part 5:
Prevention of the Development of Human Resources and Medical Industries

In the Gaza Strip there is no radiotherapy. Cancer patients needing this treatment receive it in Egypt and Israel. In Israel, radiotherapy for residents of Gaza is given mainly in Tel HaShomer, Ichilov and Assuta hospitals.

The Palestinian Office of Health has been trying for several years now to set up a radiotherapy unit in Shifa Hospital. Lately an X-Ray machine has been bought and a building built for the unit. The main problem is the lack of trained personnel to run the unit and maintain it. Because of this, the government of France has offered to finance the training of radiotherapists in the Gustav Rouassi Medical Centre in France. The Palestinian Office of Health chose five suitable candidates from among its workers. The preferred candidate of the Office of Health and the professionals in France was Anwar Salah Salamah Atallah, an engineer by training. Atallah, a father of three, asked for permission to leave for training in France via the Rafah crossing but his exit was denied on the grounds of security.

PHR-Israel and the Palestinian Centre for Human Rights applied to the High Court, asking to remove the ban on Atallah’s travelling abroad. As a result of the application, even before the court session began, the Israeli Security forces lifted the ban and Atallah left for France.

R. a-A. is a second year student of medicine in Romania. At the end of the academic year 2003, he arrived for a vacation at his parents’ home in Gaza. When he tried to return to his studies, his exit was barred at the Rafah crossing. PHR-Israel applied in his name to the Gaza DCO, and were told that his exit was denied for security reasons. After we appealed against the decision to the Legal

65. High Court file no. 3268/04: Atallah vs. the Commander of IDF Forces in the Gaza Strip.
Advisor of the Gaza Strip, the advisor agreed to allow R. to leave, on condition that he did not return to Gaza for four years, since he was a threat to security. After consultation with R., we refused to accept the offer. R. told us that his fellow students had managed to make a better deal: not to return home for only two years. As a result of the refusal, a new process of examination began with the Office of the Legal Advisor, which was mainly a process of bargaining about the length of time. At the end of the process, after seven months and when the academic year was well on its way, the final answer was received: R. was refused on security grounds and therefore was not allowed to leave Gaza at all.

Dr Y.M., a 42 year old dentist works for the Palestinian Office of Health, and in the past had left for a number of conferences and training courses in Germany. In July 2004, he was invited to a training course in Aachen University in Germany. Nine times he went to the border crossing at Rafah but was forced to return. However, the University of Aachen agreed to still accept him for participation in the course, even after his arrival was postponed again and again because he was not allowed to leave. In October 2004, PHR applied in his name to the Legal Advisor of the Gaza Strip with a request to allow him to leave. In reply, the Office of the Legal Advisor told us that ‘the exit of the above to Germany via the Rafah crossing will not be allowed for security reasons.’ The security reasons were not specified, and Dr Y.M. does not know what prevented his leaving.

**Bans on Leaving on the Basis of Sex Age and Occupation:**

**Men aged 16-35 are banned from leaving Gaza**

In April 2004, a new rule came into operation, a sweeping ban on men aged 16-35 from leaving the Gaza Strip to any destination. The only exceptions to this rule were, theoretically, humanitarian cases, i.e. the sick. All the rest were completely forbidden. The significance of this ruling in the context of the ability of the Palestinian health system to survive and develop, was catastrophic. Many Palestinian doctors attempting to improve their professional knowledge meet up with the problem of restrictions on their movements outside Gaza. PHR-Israel has received applications from
doctors invited to conferences and training abroad. Since many doctors fall inside the 16-35 age-group, they are totally banned from leaving. The very doctors who are of the age most suited to benefit from further professional knowledge in a certain field are unable to do so.

In May 2004, a group of seven physicians and a pharmacist asked to leave Gaza to attend a professional conference in Beirut which dealt with antenatal care. Since the Rafah crossing was closed at the time, they were unable to leave. When we asked to coordinate their exit via the Rafah crossing, it became clear that the Israeli authorities refused to allow them to leave because they were under 35 years old. PHR-Israel applied to the High Court, but withdrew their application when it became clear that the applicants would not be given a permit to leave, and the time which was left before the conference was too short to allow the legal process to take place. Furthermore, in her reply, the Government Attorney claimed that the Rafah crossing was closed because of ‘episodes of fighting,’ so that in any case the application was theoretical. The High Court accepted her claim. The group of doctors from Gaza did not go to the conference.

On 18.10.2004, Dr Iyad al Saraj, the Chairman of the Gaza Centre for Mental Health, applied to the general secretary of the United Nations, Kofi Anan. In his letter, Dr al Saraj asked for the support of the UN in allowing 2,700 students trapped in Gaza since April to leave via Egypt. He described the consequences of the ban: on the students who were unable to finish their studies, on visitors trapped in Gaza, and on the sick, who were losing all possibility of receiving medical treatment. Dr al Saraj added that this sort of collective punishment was against the Fourth Geneva Convention, and fed the feelings of degradation of the residents of Gaza, their hatred and their despair.

On 1.11.2004, one of the staff in the DCO in Gaza told PHR-Israel that ‘there is huge pressure’ on their offices because the Palestinians had made 2,000 requests at once for coordination over the exit of men between 16-35. In spite of the fact that until that moment the DCO had claimed that there was no need for coordination and the rule was cancelled, the DCO began to deal with the requests. According to the same staff member, the reason that the Palestinians had not put in requests for coordination was

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66. High Court file no. 4566/04 Abu Nada et al. vs. the Commander of the IDF Forces in the Gaza Strip.
due to their bitterness that the security checks at Rafah took so many hours – even when there was prior coordination. According to him, the agreement to accept the requests for coordination was ‘a result of all the fuss there had been.’

**Ban on Students’ Leaving to Study in West Bank Academic Institutions**

The Al Quds University in Abu Dis is the only place in the territory of the Palestinian Authority where medicine is taught. For many years, hundreds of doctors from the West Bank and Gaza studied there. With the outbreak of the second Intifada, a total ban was placed on students from Gaza leaving to study in institutions in the West Bank. Dozens of students, including medical students, were forced to freeze their studies for an unknown length of time. Once again, it was demonstrated that the lack of a safe passage from Gaza to the West Bank allows Israel to imprison the residents of Gaza in their homes, and prevent them from educating and bettering themselves.

A. a-H. is a sixth year medical student in Al Quds University. In spite of this, in November 2004, about a month after the beginning of the academic year, she was still not allowed to leave Gaza to get to her studies. Professor Rafi Walden, a member of the Board of Directors of PHR-Israel, and teacher of hundreds of medical students, applied on her behalf and on the behalf of eight of her fellow students, to the Coordinator of Activities in the Occupied Territories, General Yoseph Mishlav, with a request to allow them to leave to continue their studies. On 25th November, an answer was received from the office of the Coordinator of Activities in the Occupied Territories, saying that entry of students from Gaza to the West Bank was not allowed for security reasons.

(See full details on Appendix B p. 126)

A further problem faced by medical students who are residents of Gaza, is connected to their internship or specialization, which they have to do in a hospital outside the Gaza Strip. In Gaza there is no university hospital. As a result of preventing the exit of students to the West Bank or abroad, many doctors are forced to do their specialization in one of the Gaza hospitals, which are not able and not allowed to train specialists. As a result of this, the professional level of young doctors in the Gaza Strip does not stand up
against international standards, and many doctors who are not specialists work in many of the departments of the Gaza hospitals. In a conversation with someone who is intimately acquainted with the Gaza medical system, our informant claimed that his greatest fear as a resident of Gaza is that there will come a day when the older doctors will be replaced by the young doctors who simply do not know their medicine.

Prevention of the passage of students to their institutions of learning actively damages Palestinian society, especially the population trapped in the Gaza Strip. In this case too, the security claim serves as the excuse for sweeping bans of freedom of movement for whole populations. Individual cases are not examined on their merits, and it does not look as if any counterweight is given to the huge damage done to Palestinian society as a whole. This is collective punishment for acts which appear to be those of individuals.

**Preventing the Entry of Foreign and Israeli Medical Personnel**

If Palestinian students and physicians are not allowed to leave, it would be reasonable to suppose that they might try to bring in teaching and means of progress. And indeed there are professionals from abroad who are prepared to come to Gaza for different periods of time, in order to train the physical and mental health teams. But this movement too faces growing problems, because of Israeli policies. PHR has been working with the Gaza DCO for a long time in order to allow the entry of medical personnel into the Gaza Strip. In our work we are meeting more and more problems in entering Gaza, as part of the policy of cutting Gaza society off from the outside world.

Dr Ted Rynerson, a senior American physician, was invited to professional meetings at the Gaza Centre for Mental Health at the end of 2003. On 30.12.2003, after he landed in Israel, the International Organization Department [IOD] in the Gaza DCO received a notice that he had an entry permit for Gaza. However, on 8.1.2004 the IOD notified PHR-Israel that Dr Rynerson’s entry permit had been cancelled and he would have to apply again. This was because of new procedural rules which had just come into effect. The new procedural rules laid down that

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foreign nationals cannot apply for entry permits in advance: only when they arrive at the Erez crossing can they fill in forms on the spot. It is not possible to send anyone to fill them in their place, nor can they send the form by fax. PHR-Israel tried in vain to cancel this draconic ruling, at least for Dr Rynerson, who had already arrived in Israel. On 19.1.2004, Dr Rynerson returned to the USA, after 19 days of waiting for an entry permit to Gaza which never arrived.

PHR applied through their representative, lawyer Yossi Tsur, to cancel the requirement, which in effect means banning entry to Gaza, and the destruction of the links of the Gaza Health services with the outside world. It was unreasonable in the eyes of PHR-Israel that physicians should arrive here from all over the world, with all the financial outlay involved, and that they should have to drive to the Erez checkpoint to request an entry permit in writing, and then have to wait for an answer, which would take at least five working days. And all this without knowing if they would be able to enter or not.

In reply to this, PHR-Israel was allowed to submit applications by fax. The time set for giving a reply was five working days. However, our rich experience shows that replies are generally not received within this time framework. Very often the reply arrived the day before the planned visit, or even on the morning of the visit itself. In other words, guests from abroad continue to take a gamble on the chances of being allowed to enter Gaza.

If foreign medical personnel succeed here and there in passing the Israeli filter, Israeli medical personnel – like Israeli human rights workers – are not allowed entry at all. Thus there is no free exchange of knowledge, and no possibility of talking about joint development. The volunteer doctors who work with PHR-Israel are prevented from entering Gaza themselves. When PHR applied to coordinate entry permits for four of their workers, two Israeli Arabs and two Jewish women, the permits were given to the Israeli Arabs only. The next day, the day before the planned entry to Gaza, their permits were cancelled too.

PHR-Israel has applied twice to the High Court on this subject, but the applications were rejected. PHR-Israel continues to apply but is continually rejected. Furthermore, on 17.12.2004, PHR-Israel requested a permit for one of their workers with American citizenship. The workers of the IOD phoned several times to ascertain that this person did not have Israeli citizenship or residence, and finally all was revealed: the request was denied because the worker was Jewish.
Restrictions on the Import of Medicaments: Industry and Trade

The State of Israel lays restrictions and piles up difficulties also over the passage of goods from the Gaza Strip, including medicaments. In the Paris agreements, which were signed in 1994, Israel’s control over the entry of any sort of goods in to the territory of the Palestinian Authority was protected. This includes both medicaments and the raw materials for making them, both when the source is from abroad, or from the West Bank. Every consignment intended for entry into Gaza will be supervised, examined and given a permit by Israel.

All import of raw materials to the territory of the Palestinian Authority requires a special permit. In a case where this is raw material for a medical industry, a permit is needed from the Israeli Ministry of Health. The request is passed on via the Palestinian Authority to the Israeli Ministry of Health, and there it takes two weeks to be dealt with. Even raw materials, for which Israeli companies do not need special permits, have to go through this process of obtaining a permit.

In the town of Ramallah in the West Bank there is a thriving medicaments industry. Many medicines are sent from there to the Gaza Strip and they are allowed entry via the Karni Crossing. The lorries carrying the goods are sealed by Israeli officials before leaving the West Bank to ascertain that none of the goods should find their way into Israel. The lorries wait to be checked at the Karni checkpoint for between two to five days, depending on the pressure at the checkpoint. Sometimes the wait at the checkpoint lasts for whole weeks, during which time the drivers sleep in their lorries. The checks at the Karni checkpoint are extremely exacting, but in spite of this up till a few months ago there was only one x-ray machine for checking the lorries. Because of the large financial losses which were being incurred due to goods being delayed at the checkpoint, Palestinian business people from the private sector bought another x-ray machine with their own money, which came into use at the checkpoint in September 2004.

At periods when the Karni checkpoint was closed, medicaments and raw materials were prevented from entering Gaza. In May 2004, for example, the checkpoint was closed for a month and a half. When it returned to working the checks were slower than usual. Among the many who were

68. Itamar Yaar, deputy head of the The National Security Council, who is in charge of the subject of the Disengagement for the Council.
damaged by the period of closure of the checkpoint were industrialists in Israel, who lost millions of dollars. It is clear that more could be done in transferring goods into Gaza without affecting security.69

Israeli companies such as the Electricity Company, the telephone company Bezeq, the water company Mekorot as well as private Israeli businessmen, have an interest in preserving the present situation and continuing the restrictions on the ability of the Palestinian Authority to trade with the world outside. For example, the Israeli fruit growers export 20% of their produce to Gaza. As a result of the shutting of the Karni crossing they were left with excess produce which they were obliged to sell in Israel at a loss of 80% of its value. Because of these losses, which were estimated at 45 million NIS, the Israeli farmers threatened to sue the Israeli government for damages.

Israeli drug companies have priority in the entry of goods to Gaza. This is expressed, among other things, in quicker checks and the possibility of passing through the Erez checkpoint when the Karni checkpoint is closed. It is reasonable to suppose that these will be among the first to object to the opening of the Gaza Strip to unrestricted international trade.

Checking of goods in Israeli ports is exacting, and produces a further delay before their arrival at Gaza. For example, in May 2002, all goods, including medicaments, were held up on the ruling of the Ministry of Defence, which demanded of their manufacturers to prove that they could not be used in the manufacture of weapons. The process of freeing them took about a month. Even in normal times, according to the estimate of Palestinian industrialists, the average time it takes to free goods from the ports is three weeks longer than for Israeli industrialists. This situation adds 22% to the cost of distributing drugs.

PHR-Israel was involved on a few occasions in freeing goods intended for the Palestinian Authority, such as the case when the British Council donated two vehicles to the Palestinian Health Office, which were held up in the port for a long time without any apparent reason.

69. Disengagement, the Palestinian Economy & the Settlements, World Bank, June 23, 2004: “the paper argues…that major improvement can be made without compromising Israel’s security, particularly in relation to trade of goods across borders”.

71
Part 6:
The Gaza District Civil Liaison Office (DCO) and the Rafah Crossing – the Gateways to the World

The destroyed airport at Dahaniyya. On the left: The Rafah Crossing
Gaza as Prison

“On the same day, the day of the operation, I waited for a reply until 10:30 am, and then they told me my permit was ready. I hurried to the Erez checkpoint, arriving there at 11:20. I entered the crossing and presented my papers. After a wait of an hour and a half they told me I had not coordinated my entry. ‘Come back again’ they told me. I turned to the soldier who was inside the concrete cube, and tried to explain to him the urgency of the situation and that I was sure I had an entry permit through PHR-Israel. He refused to listen to me, left the place where he had been sitting (the concrete cube) and shouted at me: ‘Go back! Now! Now!’” (The Late Fatma Barghout, a cancer patient, was on her way to a mastectomy [removal of her breast] at Tel HaShomer Hospital.)

As has been noted, years of lack of development and financial distress have made the medical system dependent on outside services. The system of referrals from the Gaza Strip to the West Bank, to East Jerusalem, to Israel and abroad is totally dependent on the Israeli permit system. This system, as will be seen, works arbitrarily and bureaucratically, and always wraps itself in the excuse of ‘security,’ not balanced at all against medical needs. In the permits policy which will be described below, the way for patients and medical teams is blocked.

The District Civil Liaison Offices: the Background

In the second Oslo Accord, a joint system was established whose function was to coordinate between the Palestinian and Israeli bodies, and to organize cooperation in the organization of civilian affairs of the Palestinian inhabitants. The agreement established a system of twin offices of coordination and liaison in the West Bank and Gaza. These committees were to liaise on a regular basis and it was established that in Gaza the meetings were to be a minimum of once every two weeks.70

In Gaza, a system of coordination and liaison was established between the two parallel committees, the Israeli and the Palestinian, based on the Israeli DCO which worked with the Palestinian coordination committee. In the agreement the areas of work of the committees for area coordination and liaison were defined. Thus, for example, they are supposed to deal with

70. For details see PHR-Israel and Mahsomwatch: The Bureaucracy of Occupation (May, 2004.)
all the subjects connected to infrastructure, such as roads, water, electricity, sewage and communications. Everything to do with the free passage between Gaza and the West Bank, crossing points, and international border crossings were also under the aegis of these committees. The subject of permits for exit abroad and to Israel, and passage between Israel and the West Bank, were also within their jurisdiction.

In spite of the fact that stress was laid on continuous communication between the Palestinian committees and the Israeli DCO, in times of crisis and tension communication was cut off completely. Thus for example in 1996, following a number of serious attacks on Israel, a curfew was imposed on the West Bank and Gaza, and there was a complete severance of communications between the Israeli DCO and the Palestinian committee. Even in the case of medical emergencies, communication was not resumed, because of lack of response on the Israeli side.

On 25.2.1996, PHR received a request from the Palestinian office of health to help evacuate H., who was suffering from a growth in her abdomen, from Shifa hospital in Gaza to Israel. The requests from the Palestinians to the authorities at the Israeli DCO in Gaza had been answered by slamming down the telephone, after it became clear that the requests came from the Palestinian Authority. H. received a permit two days later, as a result of a request from PHR.

In addition, the import of medical equipment and drugs to Gaza was forbidden during the first days of the closure, and hospitals in Gaza were without sterile water and oxygen. Only after the intervention of PHR, and with the help of the then Member of Knesset, Yael Dayan, did they allow in vital medical equipment. After about ten days, new procedural rules were formulated, which allowed the import of medicaments at the request of the Palestinian Authority without the necessity for the intervention of a third party.

Sometimes it was the Palestinian side which cut off communication, for example, because of an internal decision of the Palestinian Authority in Gaza, for a long time no requests were made for coordination for exit from Rafah for patients with metal plates in their legs, or men below the age of 35. Whether it was the Israeli or the Palestinian side which caused the break in communications, the results were the same: the patients were hurt immediately.
The Process of Getting a Permit

The Israeli-Palestinian cooperation system was designed so that it should be the Palestinian DCO which was in direct contact with the Palestinian inhabitants, and was the mediator between them and the Israelis. The resident was to submit his request to the Palestinian DCO, which was usually sited within the towns themselves, and the staff of the DCO were to transfer the requests to the Israeli DCO. The answer, positive or negative, was sent from the Israeli to the Palestinian side, and from them to the resident. Sometimes the whole of this simple process took several weeks.

In the West Bank the Palestinian inhabitants very quickly began to apply directly to the Israeli DCO. From their experience, direct application to the Israeli DCO produced a quicker response, often within a few days or even on the same day. In addition, when some sort of documentation was missing from the application, the applicant was informed immediately when s/he submitted his or her request. The situation has thus developed in such a way that in the West Bank today, the vast majority of applications are submitted directly to the Israeli DCOs. The inhabitants understood what was clear from the agreements themselves: the real power is in the Israeli DCO, while the Palestinian DCO has the function of a messenger only.71

In Gaza things were different. Because it was surrounded by a fence, it was easier to prevent direct contact between the inhabitants and the Israeli DCO, so that the process of submitting the applications takes place via the Palestinian Civil Committee. Even after the outbreak of the second Intifada, the Israeli and the Palestinian DCO continued to work opposite each other. However, as will be shown below, the functioning of both sides is seriously at fault, and neither of them exhibit transparency as to the nature of the considerations which lead to the decisions which affect the lives of the Palestinian inhabitants of Gaza.

The Procedure for Submitting Applications

For the past few years, PHR-Israel has objected to the fact that there are no procedural rules which completely cover the treatment of applications

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71. Further details: PHR and Machsomwatch The Bureaucracy of Occupation (May, 2004.)
from patients, and that where procedural rules have been drawn up and agreed, they are not observed. This is even more true of the functioning of the Gaza DCO.

Our experience for many years of the treatment of requests for permits for the sick has revealed that there have been no written procedural rules for establishing criteria for the passage of patients and doctors. The non-publication of procedural rules in writing has created a situation of obtuseness, and a lack of transparency about the way decisions are made. Similarly, a negative answer to a patient’s request for an entry permit is not detailed in writing, and no Israeli agent signs the decision. PHR-Israel claimed that the fact that decisions are transmitted orally to the Palestinian representative at the DCO leads to a situation where it is impossible to ascertain if a request was examined properly, or to appeal against the way the decision was made. It is thus not clear whether a decision was made in consultation with a medically qualified person, weighing up the medical implications for the patient who applied. By behaving like this, PHR-Israel has claimed, Israel is divesting itself from all responsibility.

In cases of refusal on security grounds, the inhabitant has no way of knowing what the background to the refusal was. When the Israeli authorities answer our criticisms about security refusals, they use the term ‘balance,’ between the security threat involved in the entry of the sick person into Israel, and between his medical need. However, the large number of cases when entry has been refused to a terminal patient, or even an unconscious patient, demonstrate that in this the Israeli authorities are completely unbalanced, to the detriment of the patient.

The Present Procedural Rules

On the basis of this information, PHR-Israel applied to the High Court in 1996. In their application,PHR asked that the IDF be instructed to establish and publish binding principles for giving exit permits to the Palestinian inhabitants of the West Bank and Gaza Strip for the purpose of medical treatment abroad and in Israel. PHR-Israel gave as an example, the story of Bisam Tapash aged 16 from Gaza, who needed to go to Israel for an urgent heart operation. The refusal of her request was not explained, and only after pressure from PHR-Israel was her entry into Israel allowed. PHR-Israel also brought the request of Mahmoud Naemah aged 3, whose request was also refused, and who was brought to Israel for a heart operation

72. PHR-Israel vs. The Minister of Defence et al. High Court file no. 9109/06
only after the intervention of PHR-Israel. As a result of this case, there were established ‘Procedural rules for treatment of requests by inhabitants of the territories for receiving medical treatment.’ On the principles behind the procedural rules, it stated that ‘these procedural rules relate to the exit of the inhabitants of the territories to Israel and abroad for receiving regular medical treatment during closure, and when there is internal closure in the territories,’… ‘treatment in an urgent medical emergency as noted will be established in separate procedural rules.’ However, these separate procedural rules (for a patient arriving at a checkpoint) were only established for the West Bank. Patients in emergency situations in Gaza were, and continue to be, victims of a system which is unable to provide them with a solution.

**Important points to note:**

1) Requests must be submitted to the DCOs. While the inhabitants of the West Bank can also apply to the Israeli DCOs, the procedural rules for the Gaza Strip say that ‘requests must be submitted to the DCO via the Palestinian Committee.’

2) The validity of the request and the contents will be examined by the Health Coordinator in coordination with security staff, ‘in every case the Commanding Officer of the regional DCO in Judaea and Samaria or the head of the Coordination Team in Gaza will not refuse, according to the subject, to accede to a request unless he has before him an opinion from a physician provided by the state which relates to the request.’ In the case of a security refusal ‘a request, as noted, shall be refused for security considerations only after all the considerations (medical and security), relevant to the matter have been weighed up and balanced against other possible options. The applicant shall be given an answer in writing.’

3) ‘In the case of a refusal the applicant shall be informed of the reason for the refusal. As noted, the decision on the refusal shall be given in writing and shall be detailed.’

4) The requests and answers must be recorded.

5) An appeal should be submitted in writing, and so too the answer to it, which must be given based on a written medical opinion by a
doctor provided by the state, as well as on the position of the security forces. 73

Our activities in conjunction with the different DCOs since, including the DCO in Gaza, have shown that answers are never given in writing and the reason for the refusal is never detailed (except for the verbal comment: security refusal), so that there is no possibility of an effective appeal. Similarly, we have never been presented with a medical opinion from a doctor supplied by the state when a request for a permit was denied, not even in cases where we applied to the High Court against the refusal. It should be noted that in the overwhelming majority of cases, the case never came to court, as the security system withdrew its refusal. The fact of the withdrawal of the refusal one step outside the court, could well be evidence that the process of the examination of the request, and the decision about it, was not correct, or not balanced, and may well have been made against the procedural rules. The moment that the threat of a case in the High Court was laid at the door of the security system, the latter preferred to allow the applicant to enter for his or her treatment, rather than that the case should be debated in court, and that, as a result, there should be a ruling with consequences of a precedent.

The Coordination and Liaison System in Gaza – the Present Situation

“I might be new in this job, but I intend to bring some order into this mess… to sit on it with my superiors… It can’t go on like this.” (Officer in the Gaza DCO) 74

This section will deal with the process of getting an exit permit from Gaza to Israel for medical treatment, or to accompany a sick person, and will describe in detail what has been happening at the Gaza DCO in recent years.

In the Interim Agreements a number of entry points were defined via which Palestinians could enter Israel.

73. For further details see: PHR and Machsomwatch The Bureaucracy of Occupation (May, 2004.)
74. Details of the name of this officer have been kept by PHR. The telephone conversation with him took place on 19.9.2004.
‘Passage between the Gaza Strip and Israel will be via one or more of the following passage points:
1. The Erez checkpoint
2. The Nahal Oz crossing
3. The Sufa crossing, and
4. The Karni commercial crossing.’

However, de facto, entry to Israel was only allowed via the Erez checkpoint and all the traffic of Palestinian workers and patients was directed there. This situation created a heavy load at the checkpoint. In addition, the security checks of those passing through gradually became more exacting, and their number fell slowly as a result of Israeli policy.

The official DCO of the Gaza Strip is part of the Civilian Administration and subject to the Coordinator of Operations for the Territories. At the head of the DCO stands Colonel Yoav Mordechai. The DCO is sited next to the Erez checkpoint, and is responsible for examining the requests, and producing all sorts of permits, including permits for sick people. The Office for Administrative Coordination headed by an officer at the level of lieutenant is responsible for this process.

The application for a permit to leave for medical treatment is submitted by the Palestinian residents of Gaza via the Humanitarian Office of the Palestinian Civilian Committee. This office is headed by Mr Ahmad Abu Raza, who has held this position for about eight years, and is a member of the Palestinian Authority Office of Health. Mr Abu Raza is responsible for collecting the requests, filling in the forms and passing on the completed application to the Office for Administrative Coordination at the Gaza DCO. Mr Abu Raza submits the applications at the Erez checkpoint once a day, usually in the afternoon, but often later. Sometimes he sends the applications by fax, and very rarely by telephone. The applications which are submitted at the checkpoint are transferred to be dealt with by the Office for Administrative Coordination at the DCO, which is about a kilometre away from the checkpoint itself.

The Office for Administrative Coordination is manned by a staff of two: a soldier at the level of lieutenant and another soldier. All the requests to leave for medical treatment are supposed to go through this small office, and be processed by it. In addition, this office is responsible for the processing of requests for coordinating leaving via the Rafah crossing, when for some reason special coordination is required, for example for people with pieces of metal inside their bodies, patients who need evacuation by ambulance, and men below the age of 35.
Processing the Applications for Permits

After the application arrives in the Office for Administrative Coordination, the process of checking it begins, which takes a day or two, during which time the application is passed on to the Health Coordinator. The Health Coordinator has the responsibility of checking the medical justification for the application, and whether in fact the requested medical treatment is not available in Gaza – a necessary condition for a permit to leave Gaza. After this check, the application is passed on to be examined by the security services, in order to assess the level of security risk involved in allowing the patient to enter Israel. After the application has been accepted or refused, the relevant office of the Palestinian Civil Committee is informed, and they pass on the answer to the patient by telephone.

Documentation of Applications

One of the most serious failures in the treatment of applications for travel permits is the failure to comply with the procedural rule that all applications must be documented. This contravenes the procedural rules which the security system is obliged to observe. The transfer of the applications between the Palestinian Committee to the Office for Administrative Coordination at the Gaza DCO is not documented, and there are no records of the applications which have been submitted. Thus very often patients who submit applications to the office of Mr Abu Raza, but do not get any answer have no way of knowing what happened to their request. Our checks with the Israeli DCO show that in some cases there was no record of the application, and it was not dealt with at all. It can only be supposed that at some stage during this complex process the application went missing, or was forgotten. Thus it can happen that sick people can wait for weeks for a reply, and only after our intervention does it become clear that their wait was in vain, for nothing is known about the application in the DCO. In more extreme cases, the Palestinian side claims that the application has been submitted three times, while the Israeli side claims that this particular application was never submitted at all. However, as noted already, there is no way to find out the truth of the matter, because there is no documentation.

On 20.9.2004 F.B., a cancer patient, had an appointment for chemotherapy treatment at Tel HaShomer Hospital. Her request for a permit was sent in in time, about three days before the appointment, to the Palestinian Health Coordinator, Ahmad Abu Razah. On the
day before the appointment we were told by the Gaza DCO that the request, which had just been brought in the last few hours by the Palestinian side, was being dealt with. The next day at 1pm. The Palestinian Health Coordinator contacted us and admitted that he had lost the application and therefore never submitted it. He asked us to fax him the appointment for treatment again, together with the medical documentation. P.B. did not go for her treatment that day.

A.B. is the sister of a young cancer patient who was hospitalized in August in a critical state in the Oncology department of Tel HaShomer Hospital. When the state of the patient deteriorated, and there was a reasonable fear that she would not survive, she asked to see the members of her family once before she died. An urgent request to give a permit, first and foremost to her eldest sister, was sent via the Palestinian Civil Committee as was required, backed up by a letter from the doctor treating her, explaining the critical state of the patient. Two days after this, when no reply had been forthcoming from the Gaza DCO, PHR-Israel applied to the Office for Administrative Coordination, which is responsible for dealing with the applications. In response, it became clear that the soldier responsible for dealing with the applications had no knowledge of the application, or at what stage of the process it had reached. This was in spite of the fact that, according to her, the application had ‘gone via her.’ When it was explained to her that this was a case of a patient in a critical state, and that even a negative answer would be at least some kind of answer for the anxious family, she replied that ‘I am not responsible to anyone.’ PHR-Israel were forced to apply again in the name of the family, while valuable time had been lost.

H. a.-Z., a little girl of 6 and a half, suffers from serious breathing problems due to nasal polyps, and had an appointment for surgery at Tel HaShomer Hospital. She was given an appointment for the operation on 4.11. 2004, and before this an appointment for pre-operative checks on 19.10.2004 at 10 am. The child and her family waited for two days on end at the Erez checkpoint but the permit to leave Gaza for medical checks had never been dealt with, and the application to leave for the operation, as they claimed at the Israeli DCO, had not been transferred to them by the Palestinian Health Coordinator. The child did not arrive at the hospital on these two occasions, obviously through no fault of her own. On 9.12.2004 a staff member of PHR-Israel advised them to submit a new
application. Two days later, the DCO claimed that no application had been submitted, and a week later they submitted a new application. Thus for two months the family was lost in the bureaucratic maze until the child finally went for her operation.

V.V. is a patient who suffers from advanced kidney malfunction. His condition deteriorated and his doctors in Gaza could no longer help him. He submitted an application for the issue of an entry permit to Israel for medical treatment, and was refused on security grounds. On 8.2.2004, PHR-Israel applied on his behalf to the Gaza DCO in order to ask for the issue of an entry permit for an Israeli hospital. Two days later he was asked by the DCO in Gaza to submit a new request via the Palestinian Civilian Committee, and we were told that he had to provide a commitment from the hospital to which he was referred that they took responsibility that the patient would go to them, and not to any other place. After discussion, a further application was submitted, and the patient was again told that he was refused on security grounds.

When we applied to appeal against the refusal to the Legal Advisor to the Gaza Strip, a total closure was imposed on Gaza, and the Office of the Legal Advisor refused to deal with the request.

During the closure, the state of the patient worsened, and an urgent request was sent – this time for an entry permit for hospitalisation. During the processing of the request, a member of PHR-Israel was told by the Office of the Legal Advisor that there was no security refusal, but there was a police refusal. After 23 days, on the day before the appointment that had been made for the patient in hospital, the required answer came back, saying ‘from the check we have just made…it appears that there is no refusal to allow the patient to enter Israel.’ However, there was a catch: the patient’s brother was not allowed to accompany him because he was refused on security grounds In spite of his grave state, V.left for treatment alone. He was hospitalised in Ichilov Hospital in Tel Aviv for tests, received treatment by dialysis, and it was decided that he needed to have a kidney transplant at the earliest opportunity. His kidneys had almost ceased to function.

From the day that the first application was submitted, until the day when he left for treatment, three months had elapsed.
A.J. is a girl aged 16 who suffers from keratoconos, a medical problem which causes progressive blindness. She was in need of a corneal transplant, a process which is not available in Gaza. On six occasions, appointments were made for treatment at St John’s Eye Hospital in East Jerusalem, but she never managed to get to treatment. On 23.2.2004, a staff member of PHR was told that the girl herself was refused on security grounds. Amazingly, none of the rest of the family were security problems at all. After the intervention of PHR-Israel, and application to the Office of the Legal Advisor, she was told on 16.6.2004 that the refusal was lifted and she was able to leave for treatment.

From our first application until the day when A. left for treatment more than a year (!) elapsed.

Very often, after our intervention the security refusal is surprisingly removed and the patient is allowed to leave for medical treatment.

As we have said, the reason for the refusal on security grounds is secret, and is not given to the patient or to the Palestinian go-between. In spite of this, because patients referred to treatment outside Gaza have no alternative within the Gaza Strip, they try to submit their applications to leave for treatment again and again. There is no real possibility of appealing against a refusal, once again because the patient does not know the reason for the refusal.

There is no agency outside the system which can supervise or check the process of making decisions. When the case of the patient refused on security grounds comes to court, his or her lawyers, and the lawyers of anyone else involved, if there are any, are asked to leave the court, so that they will not be able to hear the reasons for the refusal. The experience of PHR-Israel has been

1) The judges tend in most cases to accept the position of the security forces

2) The policy of the security system is to impose sweeping refusals, such as, for example, all the inhabitants of a certain village, or all people of a certain age, or all the members of a certain family. Very often security refusals are imposed on someone the security forces have injured, even if this was done by mistake. The refusal includes all the members of a family.
On 20.10.2003 the Israeli Air Force fired two rockets at the Nusseirat refugee camp, with only a minute and a half between the first and the second. The target was a car with two passengers who were suspected of being members of the Hamas organisation. Many inhabitants who rushed to the spot after the first rocket fell were injured by the second rocket.

Among the many injured were Mahmoud Tabazah aged 14. Because of his serious state he was taken for treatment to Tel HaShomer Hospital. His brother, Abed Tabazah, aged 23, a student of economics and statistics, and his cousin Ibrahim, a schoolboy in class 12, were killed.

Mahmoud’s father Muhamad held a permit to work in Israel. He had worked as a tile-layer for 30 years. However, when he tried to enter Israel to visit his son in hospital, the soldiers at the Erez checkpoint took away his permit. Why? ‘Because of your children, because of what happened to your family,’ the soldiers explained to him.

Muhamad Tabazah had become ‘refused’ on security grounds. He could not visit his son nor could he support his family.

Mahmoud Tabazah underwent a serious operation. No-one from his family was by his side before the operation, and none of them waited by his bed for him to wake up from the anaesthetic.

Legal and media activity by PHR-Israel and the intervention of the Member of Knesset Yossi Sarid eventually allowed Muhamad, the father, to regain the permit he had held before.

A. D., a 28 year old man, fell from a building and received a serious head injury. He was hospitalized in the intensive care unit in Shifa Hospital in Gaza paralysed in all four limbs, unconscious, breathing through a tracheostomy and with pneumonia in both lungs. When his state deteriorated, his doctors coordinated his transfer to Assuta Hospital. He was sent by ambulance to the Erez checkpoint but when he got there he was prevented from leaving on the grounds of security.

We appealed against the decision at the Office of the Legal Advisor but the answer was firm: he could not enter Israel. On
the same day we appealed again against the decision, and on the following day he was allowed to enter Israel.

Very often, after a large number of times when patients have not arrived at hospital for their appointments, the hospital appointments system refuses to make new appointments for them.

**A.B.** is a 4 year old boy with kidney problems under treatment at Ichilov Hospital in Tel Aviv. Three years ago he had an operation and was now in need of a further operation, which was fixed for 22.2.2004. Every time the application to leave for treatment was submitted, it became clear that the child’s accompanying adult was refused for security reasons. This was the case for all the adults in his family – his father, mother, aunt, grandfather, grandmother and cousins.

On 8.3.2004, an appointment was made for the operation, but the child still could not leave Gaza.

On 25.7.2004 and only after the intervention of PHR, a new appointment was made after discussion with the surgeon, who had not wanted to make another appointment for the child because of previous cancellations. One of the child’s aunts received the desired permit to accompany him, five months after the original date.

**Refusal on Financial Grounds Dressed as a Security Refusal**

Sometimes the security reason is an excuse to interfere with the rights of workers from Gaza who are suing their employers. Even when the High Court intervenes, this is no guarantee that the rights of the Palestinian will be preserved.

**H. M.** worked in the Erez industrial area in a meat factory. On 3.8.1999, two of his fingers were cut off in a work accident. When H.M. brought a case against his Israeli employers for damages, the District Court in Nazareth, Israel asked him to bring a medical opinion by which the percentage of disability could be determined according to the procedural rules of the National Insurance institute, by an **Israeli doctor** from the National Insurance institute.
H.M. submitted a request to get an entry permit to Israel in order to be examined by a doctor, but his request was refused again and again on the grounds that he was a security risk. In response H. applied to the court and asked for an order to the authorities to allow him entry to Israel in order to obtain a medical opinion. The court accepted his plea and issued the order he had asked for.

However, the authorities ruled that he was refused on security grounds and made his entry to Israel dependent on security accompaniment. H.M. paid for a private security guard from Ashkelon, who undertook to accompany him from the Erez checkpoint to the National Insurance Institute in Ashkelon in a car, with two security guards armed with sub machine guns. In spite of this, his entry was not allowed.

Meanwhile H.M.’s house in Rafah city, was demolished by accident: the IDF demolished his neighbour’s house which fell and destroyed H.M.’s house. H.M. is now living with his wife and five children in a tent on the ruins of their house. Because of his injury, he is no longer able to work and support his family. H.M. turned to PHR-Israel in the hope that they could find him an Israeli physician who would agree to examine him at the Erez checkpoint, or in Palestinian territory. But this could not be done because of the restrictions on entry to the Gaza Strip.

The Process of Appeal

‘The procedure for dealing with requests for permits to leave for the purpose of medical treatment of the inhabitants of the territories’ was, as noted, established by the security system in response to PHR’s application to the High Court in 1996. The procedural rules establish that in every case of refusal on security or other grounds it is possible to appeal. The applicant must fill in a special form with details of the reasons for the need for medical treatment. In actuality this procedure does not exist. Patients who receive a negative answer to their requests do not know that they are entitled to appeal. The Coordinator for Health in the Gaza DCO, Mr Menahem Weinberger, told PHR that in all his years in the job he had not dealt with a single appeal.75 According to him, the Palestinians are not interested in appealing against a refusal, for their own reasons.

The consequences of a patient’s not knowing about his right to appeal against the refusal, are liable to be most serious for his or her health and life. The problem springs from the fact that between the patient and the DCO there is a further go-between, the Palestinian Civil Committee, which has its own agenda and its own restrictions, some procedural and some political.

The families of seriously ill patients who have been refused turn to PHR, and the organization represents the member of the family of the patient whose exit has been refused before the Gaza DCO. PHR presents an application to lift the security refusal temporarily to the Health Coordinator of the Gaza Strip in the name of the patient. In this way, the security services can enable even people subject to refusal on security grounds to leave for medical treatment.

A further grave failure in the process of appeal against security refusals is demonstrated by the relationship of the system to medical emergencies. In a medical emergency, the time taken to remove the security refusal is critical. In spite of the fact that the cases to be discussed below were emergency cases of patients in intensive care, the average time taken to deal with the cases was 12.6 days. The shortest time was six days, and the longest 43 days! Furthermore, at the end of the wearying process, in five out of eight cases, the answer to our request was negative. It should be noted that in all cases where a negative answer was received, no alternative treatment for the patient was offered as demanded by the procedural rules which the army itself created.

Colonel Avi Biton, the head of the Task Force in the Office of the Government Operations Coordinator in the Occupied Territories writes that: ‘With respect to your question about the alternatives suggested to residents of the Gaza Strip whose applications are refused, we should point out that residents of the Gaza Strip whose request to enter Israel in order to receive medical treatment is refused, and who cannot receive their treatment in Judaea and Samaria [i.e the West Bank], are offered an alternative in the form of leaving for abroad via the Rafah crossing.’ In the experience of PHR, this alternative is certainly not actively offered to patients, and de facto does not exist. Many patients are refused exit to Israel, the West Bank or to Egypt. And of course when the Rafah crossing is closed, no-one is able to leave or enter for medical treatment either to Israel or via Israel. Sometimes even when an alternative is suggested, it is not suitable given the state of the patient.

**A.a-R.** was hospitalized for 53 days in the intensive care unit of Shifa Hospital in Gaza suffering from tears in his intestines and stomach. He underwent a number of operations because of recurrent leaks. A fistula formed in his intestines, through which large amounts of intestinal contents were discharged. The patient was in a very poor general state, on a respirator, and his doctors gave up. When they asked to move him to Israel, his passage was blocked because of a security refusal. An application was submitted by PHR to lift the refusal so that he could enter Israel, but received a negative answer. However, there was an alternative suggested to PHR, of submitting a further application for a permit, this time to leave for Egypt.

Professor Yoel Donchin, from the Department of Anaesthetics and Intensive Care in Hadassah Ein Karem Hospital in Jerusalem stated that: ‘In my opinion … his state will deteriorate further and will be much worse. As to the Egyptian alternative, in his medical condition and from my knowledge of the public hospitals of our neighbours, there is no point in moving him there when we can treat him more quickly and better here. I do not understand why this patient, who is 10 minutes drive from Barzilai Hospital in Ashkelon city in Israel, which is willing to receive him, should have to be on the road for more than 6 hours in his present medical condition. In sum … it is beyond my capacity to understand how this patient in his serious medical state can endanger anything at all, apart from his own health.’
Part 7: The Health Coordinators and the Transfer of Patients

Background

Requests for permits from the sick submitted to the various DCOs are supposed to be examined by the Health Coordinators. Their function is to examine the medical urgency of every one of the applications, and only then to transfer them for the security check. Their function is defined as follows: Liaison and coordination between the medical systems of the Palestinian Authority and the Ministry of Health and the Medical Institutions in Israel. These functions derive from the Interim Agreement, paragraph 17 in the section on Health. 

In the West Bank and the Gaza Strip there are two functioning Health Coordinators, Menahem Weinberger and Dalia Bassa, who work in coordination. Neither of them are medical personnel. It is they who examine each application for medical treatment, and give their opinions as to its validity. The Health Coordinators are civil servants who work both according to the yardsticks accepted in the Israeli civil service, and according to the rules and procedures which apply to the Occupied Territories.

The Gaza Health Coordinator in the Gaza Strip

The Health Coordinator at the Gaza DCO is Mr Menahem Weinberger, who has held this position for a number of years. He replaced the previous Health Coordinator, Dr Levanon, who was himself a physician.

77. Letter from Colonel Sharon Biton, aide to the Coordinator of Operations in the Territories, to PHR 28th December, 2003.
When there are no restrictions on the number of patients leaving for treatment, Mr Weinberger suffers from an unrealistic workload. In spite of the fact that there are about 1,400,000 inhabitants in the Gaza Strip, only this one man, without any helpers, deals with all the requests to leave for medical treatment. Mr Weinberger himself has said a number of times to PHR that he cannot deal by himself with all the requests which come to him.

In a telephone conversation with him on 19.9.2004 a staff member of PHR related to him all the serious problems PHR had found in the working of the system. In reply, Mr Weinberger claimed that: ‘I can’t deal with everything. I am only one person, I have no helper or secretary, and I have many more things to deal with. I work alone and I am just one person, so it is not surprising that everything works like that.’

This conversation was around the fifth(!) application for issuing an entry permit for an urgent neurosurgical consultation for W. D., a Gazan woman, a request which had been refused again and again. When the PHR staff member claimed that he should have known this case by now, for the application had been submitted five times, the Health Coordinator replied: ‘How can I know all the cases?’

It should be noted that the Gaza Health Coordinator is not available during the night, and even said to a staff member from PHR that ‘It is policy that I am not available after working hours.’

The huge workload of the Gaza Health Coordinator springs from the fact that he is the only agent dealing with the examination of the medical reasons in the different requests for permits. Furthermore, in contradiction of the procedural rules, and in defiance of the agreements made with the High Court, there is no doctor at his side as a permanent advisor. Following the grave criticism of the treatment by the Israeli security system of the health needs of the Palestinian residents after the imposition of the various curfews, for a short time the West Bank Health Coordinator was provided with a medical advisor, Dr Adler. However, a few months later the latter left the job – which he has been doing as a volunteer. No new advisor was provided, either in the West Bank or Gaza.

Even though Mr Weinberger is not a doctor, he decides whether medical treatment is urgent or not. He himself describes the absurd situation which is created: ‘the [Palestinian] Civil Committee passes me the documents, and I go over the application like a doctor, even though I am not a doctor.’

S.a.-A. is a 23 year old cancer patient. He was operated on for the removal of a malignant growth in Tel HaShomer Hospital. The growth was diagnosed as a high-grade malignancy chondroblastic osteosarcoma. His doctors at Tel HaShomer, Professor Yoav Talmi and Dr Lev Badrin, instructed that he was to have radiotherapy. In the medical opinion which they sent to PHR, they wrote that ‘according to the treatment plan the patient is definitely in need of complementary treatment with post-operative radiotherapy at a period no later than two months after his operation.’ After two months, when the patient submitted a request for entry to Israel to the Gaza DCO, the answer was that the treatment is not urgent. Only two weeks after the first refusal, and after the intervention of PHR, did he receive an entry permit for Israel in order to receive treatment.

H.A., a child resident of Gaza, suffers from an active brain disease which includes epilepsy. In July 2004 he was given an appointment to Shaarei Zedeq hospital. The child was not allowed to enter. ‘his state is not urgent and only urgent humanitarian cases are allowed entry.’ 79 A staff member of PHR sent a letter after this with a specialist’s report from Dr Itai Berger, which stated that the child must come for examination and treatment. Three days later the permit for the child to leave arrived.

On 31.10.2004, during a 78 day curfew on Gaza, an appeal was lodged with the Gaza Legal Advisor against the refusal of entry to two patients, who were defined as security refusals. On the 2.11.2004 a member of the staff of PHR applied to the office of the Gaza Legal Advisor in order to see what had happened to the requests. It appeared that it was only after this telephone conversation that the medical documents were passed on to Mr Weinberger the Health Coordinator, who claimed that he was examining them for the first time. In spite of this, Mr Weinberger ruled that same day that they were not urgent:

M. a.-M. aged 18 was in the intensive care unit in Shifa Hospital with neurological damage and serious breathing problems. His physician at Hadassah Har HaZofim Hospital wrote explicitly after he had read the medical file that ‘his state is worsening’ and that

79. Statement made to the PHR staff member from the Administrative coordination office at the Gaza DCL on 7.7.2004.
‘he must be hospitalized urgently.’ In spite of this, his application for an entry permit to Israel was refused. Only three days after we applied to appeal against the refusal was the application passed on to the Health Coordinator. On the same day, we received the answer from the Health Coordinator, who ruled, in contradiction to the incontrovertible advice of the doctor, that the state of the patient was not good, but in spite of that ‘he does not need urgent hospitalization.’ When we requested evidence that a physician had examined the request and the decision had been made on the basis of his expert opinion, the PHR staff member was told by the office of the Legal Advisor that as far as they knew there was no such expert opinion, and the Health Coordinator did not need a physician.

Seven days after the first appeal the patient was allowed to leave for Egypt via the Rafah crossing.

It is clear, then, that even in emergency cases the treatment of applications by the Gaza DCO system is negligent. The DCO system does not deal with applications quickly, in contravention of the procedural rules which the security system itself established. The decisions to refuse requests for entry for treatment are dealt with without the involvement of qualified medical personnel, and no medical opinion is presented to the officer in charge of the DCO as required by the procedural rules. This true even when an appeal is lodged against the refusal.

In the West Bank too the procedural rules are contravened that lay down that a medical opinion from a doctor supplied by the State of Israel must be provided in every case of refusal. However, PHR is aware that the Health Coordinator there, Dalia Bassa, does at least consult Palestinian doctors when she examines applications from patients, and she is usually available 24 hours a day.

From the cases described, we can learn that in the decision as to whether to allow entry to Israel or refuse it, there are no medical considerations involved. In the light of what is described here, one wonders what happens to patients who do not manage to get the help of PHR.

**Leaving the Gaza Strip**

Patients in need of treatment outside the Gaza Strip are mostly referred to Egypt and Israel. Leaving to Israel is done via the Erez checkpoint
– after the permit is obtained. Leaving for Egypt is via the Rafah crossing, and according to the Oslo Accords, does not need previous coordination. However, in reality, large groups, including groups of patients, are required to seek prior coordination, because of different categories of refusals. Patients’ requests for coordination for exit to Egypt via Rafah are submitted through Ahmad abu Razah the Palestinian Health Coordinator.

As already described, once the desired permit has been obtained, the patients still have to undergo a difficult and degrading passage through the checkpoints, and sometimes they are refused passage in spite of a valid permit. In a conversation with Menahem Weinberger, the Health Coordinator, on 12.9.2004, he said about the mother of a baby with a life-threatening illness: ‘She has a permit. Will she be allowed through? I can’t be sure. Every five minutes they change their decisions round here. I’ve given up.’

**Passage through the Erez Checkpoint**

The Erez checkpoint is a closed army camp fenced in on all sides. It is controlled by regular soldiers and reservists. The passage through the Erez checkpoint is a process which is exhausting and degrading. At best it takes four hours, and at worst a whole day. Cancer patients who leave regularly for radiotherapy at Assuta Hospital arrive at the checkpoint at 6.30am three times a week. However, they manage to leave only between 11am and 1pm, after the workers have finished passing through.

Marwan Baker, the head of the Evacuation and Emergency services in Gaza, says that since 14.2.2004, after the suicide bombing carried out by Rim al Riashi at the Erez checkpoint, the conditions of passage for the sick at the checkpoint have got worse. In the past, the sick were first in the queue to enter Israel. However, for the last six months they begin the process of passing through the checkpoint last, after the traders and workers. Because of this, many patients only manage to get to the hospitals in the afternoon, when the Outpatients’ departments are already closed.

In spite of the prolonged stay at the checkpoint, there are no toilets, chairs, drinking water or anywhere to buy food. Sick or old people who pass through the checkpoint have to walk 200metres through the workers’ passage (called ‘the sleeve’) – the only entry for patients today. Before the bombing, sick people used to cross via a shorter way intended for VIPs and foreign visitors.
All in all the distance that a sick person is required to cross on foot is about one kilometre, with no place to rest. There is one wheelchair for disabled people. If someone is tired and wants to rest the only place is on the dirty floor. The conditions at the checkpoint are particularly outrageous given the fact that the second largest group of those entering Israel are the sick.80

Workers who arrive at the examination station are obliged to remove their shirts while still a distance away. Anyone who does not abide by these regulations is faced with the sanction of being refused entry to Israel.

But the soldiers at the checkpoint do not observe the explicit instruction not to undress women.

The late F.B., who had cancer of the breast, arrived at the checkpoint in a serious state, where she was scarcely able to stand upright. The soldiers instructed her to remove her upper garments because the examination machine showed she had ‘something’ in her chest. F. did as she was asked, but that did not help. She explained to the soldiers that she had a silicone breast prosthesis. Even then they would not allow her to pass, and she returned to Gaza.

Palestinian workers at the Erez checkpoint. Photograph: Nir Kafri

80. Itamar Ya’ar, deputy head of the The National Security Council, who deals with the subject of the Disengagement on behalf of this Council.
The Rafah Crossing

The Rafah crossing is the only exit from the Gaza Strip to countries abroad which is not via Israel (i.e. via the Erez checkpoint). The crossing is used by all those going abroad from Gaza, including patients on their way to medical treatment which is not available in the Palestinian medical system. The need to leave for treatment in Egypt has grown in the past few years because of the growing restriction on the entry of Palestinians to Israel for treatment in Israeli hospitals, or in passage to treatment in the West Bank and East Jerusalem.

Israel allows the passage of only 60 patients a day accompanied by a family member, in other words, 120 people, through the Rafah crossing.\textsuperscript{81}

In order to leave from the Rafah crossing for Egypt, and from there to anywhere else in the world, there is no need for a permit, but because of security refusals, or age restrictions, many people have to coordinate their passage. The process of coordination is as follows: Palestinian resident must arrive at the crossing, where a security check is done. If for any reason exit is blocked, the applicant must submit a request for coordination via the Gaza DCO at the Erez checkpoint through the Palestinian Civil Committee, as described above. In other words, there is no direct contact between the applicant and the Israeli DCO.

In the course of the coordination the reason for leaving is checked, and a general security assessment is made. The applicant is told that the coordination has been effected and that s/he must go to the Rafah crossing. However, even after the coordination, the resident may arrive at the crossing to discover that his or her exit is banned, for it is only at the crossing that the final security check is done.

For reasons that are not clear, the complete security check is not done at the Gaza DCO in parallel with the coordination of the request, so that the residents who arrive at the Rafah crossing must wait, often for hours, for the security examination, when in the end they may not be allowed to leave at all.

Even though there is not supposed to be any need for coordination for patients leaving from the Rafah crossing, PHR has collected a number of details of patients who were denied exit to Egypt.

\textsuperscript{81} Report on Access to Health Services for Palestinians through Border Crossings and Checkpoints in Gaza Strip, Health Inforum, 20.7.2004.
From 4.12.2004 until this report was written, 181 patients were not allowed to leave for treatment in Egypt. Some of these arrived at the Rafah crossing in an ambulance in a serious medical state, some of them were cancer patients and others suffered from other serious medical conditions.

There is no alternative medical treatment available to any of them in Gaza, and the result of stopping them from leaving is to deny them medical treatment – which could lead to their death.

**Passage of Wheelchair patients**

At both checkpoints there are further restrictions which are imposed on patients with physical disabilities.

**Erez:** Passage through the Erez checkpoint in the patient’s private wheelchair is forbidden because it is technically impossible to check the chair with metal detectors. A patient confined to a wheelchair is allowed to use the single ‘sterile’ wheelchair which never leaves the crossing. Obviously, once the patient passes through the checkpoint and enters Israel – he is left without a wheelchair.

**Rafah:** At the Rafah crossing there is no wheelchair at all. In spite of this patients are still not allowed to leave for Egypt with their own wheelchair. This leaves the disabled person two alternatives: to leave in an ambulance, or to be carried by his accompanying persons.

A.N. is an old woman confined to her wheelchair because of a cancer of the base of her spine and the lower pelvis. Every movement causes her exquisite pain. She is under treatment at Tel HaShomer hospital to reduce her pain. On 30.8.2004 she was given an appointment to see her doctor. The morning of the appointment, after she had received an entry permit, she arrived at the Erez checkpoint in her own wheelchair, but she was told she could not leave in it.

When we talked to the Health Coordinator at the Erez checkpoint, Mr Menahem Weinberger, the latter suggested that A. N. should transfer to the ‘sterile’ wheelchair at the crossing. After this, when she entered Israel she should go in the regular sterile ambulance (details below) which would take her to the hospital together with
other patients. In the hospital she could ask for a wheelchair. Going back, Mr Weinberger suggested, she could do the same.

We explained to him that every movement causes the patient excruciating pain. Mr Weinberger then suggested that she should take a private ambulance. Hiring a private ambulance costs thousands of sheqels. A.N. did not go to her appointment that day.

It was the definitive opinion of Professor Avi Ori, the Head of Rehabilitation at the Re’ut Medical Centre in Tel Aviv, and of Dr Shirit Ophir, a rehabilitation specialist at Beit Levinstein Hospital, that the patient should be allowed to pass in her own wheelchair.

We applied to the DCO asking them to solve the problem in a way that would not cause unnecessary suffering to the patient. To our surprise they coordinated for the patient to leave in her own wheelchair.

So on 30.8.2004 the patient and her accompanying person arrived at the checkpoint with a valid permit. At 12.15pm the soldier at the checkpoint ordered them to return to whence they had come.

A new appointment was made for this elderly cancer patient on 13.9.2004, but on that date the checkpoint was hermetically sealed and no-one was allowed to leave.

Passage for the disabled

The Erez checkpoint . Photograph: Miki Kratsman

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Taking a cancer patient through the Erez checkpoint: Photograph: Reuters

Taking a cancer patient through the Erez checkpoint: Photograph: Reuters
The Passage of Patients with Metal Inserts in their Bodies as the Result of Medical Treatment (Plates and Nails)

Patients with metal parts, such as plates and nails, in their bodies have to do a special coordination in order to pass through the Erez checkpoint or the Rafah crossing, because it is not possible to check them with metal detectors. For the purposes of the coordination they have to provide medical documentation which demonstrates hat they have metal parts inside their bodies.

These requests must be submitted via the Palestinian Civil Committee at the Erez DCO. From applications to PHR, it appears that the Palestinian Civil Committee advised some of these patients to remove the plates from their body and replace them if necessary after their return to Gaza, since coordination for someone who has plates in his or her body is an extraordinarily complicated process, and even after everything has been coordinated via the DCO, patients are often stopped from leaving at both Rafah crossings.

A. a.-A. is a young man who suffers from an orthopaedic problem. Several plates were set in his leg. He was referred for a complex orthopaedic operation in Egypt, which was not possible to do in the Gaza Strip. Both because of the plates, and because he was aged under 35, he needed special coordination. When he applied for this he was refused on the grounds that he was a security refusal. During the treatment of his application, the patient told PHR that he had undergone an elective operation to remove the plates from his leg. In spite of his doctors’ recommendation, A. refused to include nails in his leg to support the bone, for fear that he would not be able to pass through the Rafah crossing.

PHR appealed against the security refusal and this was lifted. In spite of this, two months afterwards A. still had not left because of the curfews on the Gaza Strip.

P.B. was injured in his legs and external plates were placed on his right leg. When he applied to leave for treatment in Egypt he was not allowed to leave. It was suggested to him to try to go to Israel for treatment via the Erez checkpoint. When P.B. applied to request permission to enter Israel, he was told that he was refused on security grounds. Six appointments in turn were made for P.B.
at the Maqassad Hospital in East Jerusalem, but he did not manage to get a permit for any of them. After a number of applications by PHR to the office of the Legal Advisor in Gaza, the patient was told he could leave for Egypt. When we asked why he was refused at the beginning, the spokesperson of the Gaza DCO replied ‘That was in August,’ but now people can leave with plates in.

As already noted, there are sometimes sweeping instructions which forbid whole groups of patients from leaving Gaza. It is clear that the DCO does not have any consistent policy which is clear to the patients or to the Palestinians. Instructions are liable to change at any time, and often nobody knows this has happened, not even the soldiers serving in the DCO. Often we came across different answers from different offices, and, as of today, there are still subjects where it is not clear what the policy is, if there is any.

Palestinian society also has a responsibility for putting the sick outside the conflict. It is important to note that it has been security considerations which have led to the closing of crossings for long periods of time, as a result of which the passage of patients to treatment was deleteriously affected. At least in one case, the hardening of policy towards patients was the result of the fact that a woman from the Gaza Strip, Ghaim al Riashi, blew herself up at the Erez checkpoint, after she had posed as a patient with metal plates in her leg. In spite of the fact that an all-inclusive hardening of procedural rules in respect of patients is a kind of collective punishment, it is important to note that taking advantage of the facilities which were granted in the past to patients is illegitimate. There should be no use of the sick for military objectives. Palestinian society must eradicate such misuse.

**Patients with Visiting Permits**

In the Gaza Strip today there are 24,000 people with visiting permits.82

These are Palestinians, who left for other countries or were not present in the Gaza strip during the occupation in 1967 or afterwards; and citizens of Arab states who are married to inhabitants of the Gaza Strip.

In all the cases described, when these people entered Gaza they received from the Israeli authorities a visiting permit for three months.

82. In the West Bank there are about 30,000 people.
After this expired, it was extended usually automatically by the month. These people have lived in the Gaza Strip continuously for many years. They have established families in Gaza, they work there, and for them it is the centre of their lives. However, these people are not entitled to receive Palestinian identity documents, for in the Interim Agreements Israel defined, with Palestinian agreement, who is a Palestinian: the inhabitants of the West Bank and the Gaza Strip are: ‘people who when this agreement comes into effect are registered as inhabitants of these areas in the population register run by the Military Government of the West Bank and the Gaza Strip, and by the Council, as well as people who later will receive permanent residence in these areas with the agreement of Israel’.(From the ‘Israeli-Palestinian Interim Agreement on the West Bank and Gaza Strip’, Appendix 3 – Protocol on Civilian Affairs).

This definition protects the right of Israel to decide who can receive an identity document and is thus entitled to live in the occupied territories. The intention of this clause is to prevent the return of the Palestinians from the Diaspora to their homeland, especially the 1948 refugees. However, even a Palestinian born in Gaza who left to work and live in another country and now wants to return to Gaza needs the agreement of Israel to do so.

In the years after the Oslo Accords, many Palestinians who had left the Gaza Strip after its occupation by Israel asked to return home. The hope that something new was being built between the two peoples, and the possibility for making a living in the new situation in their homeland drew many of them to return to the territories of the Palestinian Authority. In addition, the results of the Gulf War made the lives of many Palestinians who had moved to Saudi Arabia and Kuwait in particular too hard to bear. The many restrictions placed on their ability to become citizens, or to get an education like all refugees, moved many of them to return to their land of origin. They entered the territory of the Palestinian Authority on visitors’ permits issued by Israel and began the process of applying for Palestinian identity cards.

However, the Al-Aqsa Intifada put an end to all their hopes. Israel stopped the process of citizenship, and in the territories of the Palestinian authority there remained tens of thousands of people with no civil status. They were defined by Israel as illegal residents. Because they have no legal status they are unable to leave Gaza and return, and they are also not allowed to enter Israel, except with a special permit. As a result of this, serious problems arise when they need to leave Gaza for medical treatment. During the last year, a number of people with visitors’ permits
have applied to PHR because they needed urgent treatment, but could not obtain an exit permit. In fact when they applied for a permit no reply was received, positive or negative, and the patients waited long weeks in vain.

PHR applied to the High Court in a number of applications in order to oblige the State of Israel to allow patients to receive medical treatment. Following this, there was a change in the policy of the Civil Administration system towards sick people with visitors’ permits. In the past, every request of this sort had needed application to the court, but recently there has been flexibility of sorts and permits are usually granted. But the process today is still long drawn out, complex, and every request needs to be ratified personally by the head of the Gaza DCO.

Patients with visitors’ permits usually receive an answer about their permit on the same morning as the examination, and often in the late hours of the morning. As noted, normal passage through the Erez checkpoint often takes a number of hours. For a patient with a visitor’s permit the length of the wait can vary between 6 and 12 hours. This means that the patient usually misses the medical appointment.

**Fatma Barghout**, a 28 year old Palestinian woman, returned from Saudi Arabia in the Oslo years, and lived in Gaza. Her visitor’s permit expired ten years ago. Because of this, it was not possible to deal with her application to leave and be treated at an Israeli hospital when it was found she was suffering from advanced breast cancer. The Israeli authorities refused to deal with her request for an entry permit even though she herself was not a security refusal, and even though the Palestinian authority undertook to pay for the expenses of the treatment.

Only after PHR applied to the High Court was her request dealt with, and did she begin to receive vital treatment in Tel HaShomer Hospital.

**The Border Police**

Recently yet another agency was added to those who can prevent patients with visitors’ permits from leaving Gaza: the Border Police at the Erez checkpoint. These patients, since they are considered foreigners

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83. Application to the High Court through advocate Yossi Tsur, file no. 10642/03. Fatma Barghout et al. vs the Commander of the IDF Forces in Gaza, the General of the Southern Command et al.
and not Palestinians, pass via the Border Police and the latter refuse to allow them to enter the State of Israel. In their version they are staying illegally in the Gaza Strip. At one stage the Border Police even began to demand enormous monetary guarantees as a condition for allowing them to enter. In one case they demanded 90,000 NIS from the three members of a patient’s family, i.e. 30,000 NIS from each of them.

A member of the State attorney’s office told PHR-Israel that there is a fear that they might decide to stay in Israel illegally, and then it would not be possible to expel them to another state or to return them to Gaza. Alternatively, they are advised to leave for treatment in Egypt. In this case they will not be allowed to return to Gaza.

**H.A.** is an old woman who is in need of outpatient medical follow-up following a kidney transplant at Tel HaShomer Hospital. She had an appointment for 9.8.2004. Because she does not have a Palestinian identity document, but only a visitor’s permit which has expired, her application for a permit to enter Israel was not answered, without any explanation, on two occasions. After our intervention, we were informed by the Gaza DCO on the morning of the appointment that a permit had been issued allowing her to go for treatment.

H.A. arrived at the Erez checkpoint accompanied by her son. When she began the process of passing through the checkpoint she found that the border police would not allow her to enter Israel. The aged H.A. was kept at the checkpoint until 3pm without food or drink. Then she was returned to Gaza.

A new appointment was made for 19.8.2004. After this experience we asked to ascertain beforehand that she would be allowed to enter, in order to coordinate this with the border police. H.A. arrived at the checkpoint on the date of her appointment. When she arrived at the crossing, we were told that H.A. has passed through the checkpoint and was on her way to Israel.

Later it turned out that she was held for hours at the crossing and eventually returned to Gaza.

At the time of writing this report it is not clear whether H.A. will succeed in getting to her treatment at Tel HaShomer Hospital, or whether she will continue to spend her days in vain attempts to pass through the border police checkpoint.
PHR-Israel threatened to apply to the High Court in order to oblige the different agencies – the Civil Administration and the Border Police – to allow patients and their accompanying persons to get to medical treatment, even if they only had visitors’ permits which had expired. PHR claims that it is not reasonable that people to whom Israel has denied the possibility of becoming citizens in the Gaza Strip, should be further harmed by this very fact when they need medical treatment. Medical need should not be used as a card in order to help throw these people out of their homes.

Following our activities, patients with visitors’ permits are today allowed to enter Israel for treatment. In parallel to their application for an entry permit, special coordination is done for them with the Border Police at the Erez crossing. The demand of the Border Police for huge sums as guarantees has also been cancelled.

However, the process is still long and complicated, and passage through the checkpoint is long drawn out and exhausting.

**Men under the Age of 35**

As described above in this report, on 16.4.2004, a new ruling came into effect, with a sweeping ban on men aged 16-35 leaving the Gaza strip. The only exceptions to this rule are humanitarian cases, i.e. sick people.

In order to leave via the Rafah crossing to Egypt, they are required to coordinate their exit via the Gaza DCO. From our work it is clear that being in need of medical treatment in no way ensures that they will be allowed to leave.

The requirement to coordinate leaving via the Gaza DCO places exceptional and unreasonable pressure on the Civil Coordination system. In spite of this, no-one took the necessary steps to prevent the foreseeable catastrophe in the Gaza DCO. As a result, the treatment of the requests for coordination took many long weeks while some of these applications disappeared or were forgotten.

Only a month after the implementation of this ruling, many applications were piling up at PHR from patients who had submitted requests but had had no reply. In conversations with the Gaza DCO, we were told about a number of applications that they had never been submitted. In reply, in a conversation with a senior member of the Palestinian Civil Committee, PHR were told that: In the DCO they are ‘liars’ and they have dozens of
requests for coordination of exits via Rafah which have been ‘lying there’ for many weeks and have not been dealt with.

Only humanitarian cases are allowed to leave via the Rafah crossing and even then only after coordination with the Gaza DCO. In the cases which reach PHR, it appears that the need for medical treatment does not ensure that they will be allowed to leave. A considerable proportion of patients do not know anything about the need for prior coordination. Other patients submit applications and find themselves waiting long weeks for an answer, in spite of the fact that theirs is a case of clear medical need which is sometimes urgent.

On 9.8.2004 the officer in command of the Humanitarian Centre in the Gaza DCO, Major Grisha Yakobovitz who was at the end of his term of office, told PHR that the security refusal on the grounds of age had been cancelled. However, it became clear that this was not the case. Men under the age of 35 were sent back from the crossing after hours of waiting. It became clear that the Palestinian Civil Committee had stopped submitting applications for coordination for patients to leave. The Palestinians told us that they had made this decision because they had not been told officially about the cancellation of the need for coordination, and anyway, when they did coordinate as required by Israel, patients were still not allowed to leave.

In December 2004, a member of the staff of PHR was informed that in spite of all this all men aged less than 35 who were not sick needed coordination of their exit, and must apply to the Palestinian Liaison Committee at the Rafah crossing. When we tried to ascertain if a certain patient had been told to submit a request for coordination, we were told by the Humanitarian Centre that it was not possible to check this on their computer, because these were handwritten lists of about 3,000 people.

The ‘Sterile’ Ambulance and Emergency Evacuation

Erez checkpoint: The alternative way to leave the Gaza Strip when the patient is unable to walk is by ambulance. However, even an ambulance carrying sick people is not allowed to come from Gaza into the territory of the State of Israel. In order to allow the transfer of patients by ambulance to hospitals in Israel there is an arrangement with the Palestinian Authority
according to which a Palestinian ambulance which has been thoroughly checked should stand permanently on the Israeli side of the checkpoint. This is why it is described as ‘sterile.’ The patients arrive from Gaza in a Palestinian ambulance, cross the checkpoint on foot, and on the other side they are transferred to the sterile ambulance. The ambulance leaves as early as possible in the morning in order to take the patients to the various hospitals, so that patients held up at the checkpoint will miss it. It should be noted that a taxi – the only mode of transport from the Erez checkpoint – to central Israel costs 170 IS and 230 IS on the return journey, a huge sum for the average inhabitant of Gaza.

Many medical emergencies are taken for life-saving treatment to Israel, where there are the most advanced medical centres at a reasonable distance from the Gaza Strip. It would be unreasonable to send such cases to Egypt, because the journey from Gaza to Cairo takes six hours at least.

Up till about six months before the writing of this report, the Palestinian ambulance which bore the patient used to go straight in to Israel. Today, even in cases of emergency evacuation when the patient is in a critical state on a respirator, Palestinian ambulances are not allowed to enter Israel. An intensive care ambulance takes the patient from the hospital to the checkpoint, from where he is transferred straight to the intensive care ambulance of the Israeli Magen David Adom which has been previously coordinated.

Apart from the dangers of moving the patient, this process takes a lot of time (two to four hours) and holds up the arrival of the patient in hospital, which thus takes 3-4 hours.

**Closure of the Checkpoints**

As already described, during certain periods of security tensions the checkpoints are often closed and patients miss previously booked medical treatments.

**Erez checkpoint:** In spite of the considerable dependence of many patients on the Israeli health services, again and again the crossing is closed hermetically and few if any patients manage to get to treatment. This is what happened, for example during the curfew which was imposed on Gaza during Operation Days of Repentance, during the Jewish festivals, from 8.9.2004 until 18.11.2004 when the checkpoint was completely closed, and seriously ill patients cannot get to treatment. During this
curfew, from 8.9.2004 till 14.10.2004, even cancer patients did not enter Israel, including 28 radiotherapy patients who were in the middle of their treatment.

After more than a month of total curfew, it was decided in the Security services to allow the most serious cases to enter Israel. To the question of a staff member of PHR as to what constitutes a ‘patient in a serious state,’ the spokesperson of the Gaza DCO, Yaniv Alon (who of course is not a doctor), answered that only someone who ‘if he does not leave will die on the operating table’ is included in this definition.

On 27.9.2004 a delegation of Israeli women doctors arrived at the Gaza DCO in order to protest vigorously against refusal of life-saving medical treatment. They asked to meet the head of the Gaza DCO, Colonel Yoav Mordechai, but he absolutely refused to see them. Lieutenant Colonel Moshe Levi, the head of the Humanitarian Centre agreed to meet representatives of the delegation. At the meeting data was presented to him about the cancer patients trapped in Gaza, some of whom were in a state which was deteriorating during the curfew. At the meeting Lieutenant Colonel Levi agreed that the humanitarian situation in Gaza was ‘catastrophic,’ and claimed that the hands of the Civil Administration were tied, for it was the army which was in charge at the checkpoints and they would not allow anyone to enter Israel. The Civil Administration, Lt Colonel Levi claimed, were simply there to make suggestions. Lt Colonel Levi agreed to issue an entry permit to one cancer patient only, whose state was considered grave, but the permit was issued at 6pm. and did not include any permit for an accompanying person. The patient was in such a bad state that she could not stand up by himself, so she did not get to treatment.84 Only after one month were the rest of the cancer patients allowed into Israel.

However, the general curfew was not lifted. Even though they claimed at the Gaza DCO that urgent requests were still examined during a curfew, it became clear to PHR that this was not accurate. On 15.7.2004, the Rafah crossing had been closed for five days. That same day, a telephone conversation between a staff member of PHR and Lieutenant Racheli Siboni, the Administrative Coordination officer, was held in order to ascertain what had happened to two requests to coordinate the exit of patients who had submitted them two weeks earlier. During the conversation, Lt Siboni said she could not see the requests on the computer

84. Details of her experiences when she received an entry permit together with her mother can be found in the PHR report Breast Cancer in Gaza (January, 2005).
and it was possible that they were in the pile of 150 requests which had not been dealt with during the curfew. To my question when she intended to go over these requests, she replied that she would do this during the next 6 days, as she could not manage to examine them all on one day. To the question about the urgency of the requests, Lt Siboni answered that the Palestinian Health Coordinator submitted 100-150 requests every day in one hand, and 20 urgent requests in the other hand.

In a second conversation with another staff member of PHR, Lt Siboni said that, to tell the truth, Ahmad Abu Raza knows that there is a curfew, and understands that there is no point at all in submitting requests.

In a conversation between a member of PHR-Israel and Mr Abu Raza on 19.9.2004, relating to a different curfew, he claimed ‘These are the instructions. I can’t submit a request for an appointment. You know that we are in a very, very sensitive security situation and these are the instructions from the Israelis, because they don’t want them wandering around there. I am also careful. I don’t want, Heaven forbid, to let someone in and then something happen. They never look at appointments for outpatient clinics, only at requests for hospitalization.’

**Four Children with Cancer wait a Whole Day at the Erez Checkpoint**

As we have already noted, cancer patients do not receive their chemotherapy and radiotherapy treatments during periods of curfew.

On 8.9.2004, a total curfew was imposed on the Gaza Strip because of the Jewish festivals, as is done every year. The curfew continued and on 29th September army forces entered the north of the Gaza strip after a Kassam rocket fired on the Israeli town of Sderot killed two children, Yuval Abbaba and Dorit Inasu. By 14.10.2004 there were already 90 dead in Gaza, of whom 30 were children.

During the days of curfew on Gaza, patients did not leave for treatment in Israel. Among the patients were 28 cancer patients, some of them in the middle of courses of radiotherapy, a treatment where a continuous course is particularly important. During this period only 12 permits to leave were issued, when in actuality about 30 patients were supposed to leave for treatment each day. The passage of 25 patients injured by bullets and shells who needed urgent treatment was stopped.
This enforced gap in treatment interferes significantly with the efficacy of treatment of cancer and endangers the lives of the cancer patients. As for other patients in need of different examinations and treatment, there is nothing that can be said. Doctors from Tel HaShomer hospital, where many patients from Gaza are treated, told PHR that sometimes they hospitalise patients from Gaza, in particular cancer patients, even if there is no real medical need for this, because in their experience it is uncertain whether these patients will otherwise be able to carry on their treatment.

However, even when a permit is obtained, passage via Erez can be an almost impossible mission, when one department does not know what the other department is doing.

On 19.9.2004, during the general curfew imposed on all the territories, a group of children with cancer arrived at the Erez checkpoint. It was 6 am. They had been informed the previous evening that they had been issued permits. Two of them A.G. and A.Z. were aged 6 and 9. They were on their way to be hospitalized in Tel HaShomer hospital. A further boy was on his way to Ichilov hospital for complicated surgery to remove a cancer from his leg the next day. Another girl was on her way to hospitalization in Ramallah.

At 1pm the exhausted parents turned to us for help. They told us they had been waiting since 6 am on the Palestinian side of the checkpoint and were waiting for the permit from the Israeli side to proceed into the crossing.

We applied to the Humanitarian Centre at the Gaza DCO and they began to deal with this, but not before they had ascertained that the children and their parents has entry permits for Israel for that day.

At 2.18pm the group were at last asked to give in their identity papers for examination. This meant that some progress had been made on the Israeli side, and that the process of passage through the checkpoint had begun.

However the hours went by, and the children waited in the blazing sun, getting weaker and weaker.

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85. Their names are kept by PHR.
Professor Yitzhaq Meller, the head of the National Unit for Oncological Orthopaedics, waited at Ichilov Hospital for his young patient to come for his operation to remove the cancerous growth from his leg. When his patient did not arrive, he turned to PHR to request our help. He explained that in order to carry out the operation, three different medical teams had been coordinated, and that if the boy did not arrive, the operation was liable to be postponed for at least a month because of the difficulty in assembling the teams. In addition, the boy might have to undergo another round of chemotherapy if the operation were postponed.

The surgeon tried several times during the day to get hold of the Health Coordinator, Mr Menahem Weinberger, but the latter did not reply all day long.

After many efforts and involving journalists in the matter, at 7 pm the entry of the patients and their accompanying persons into Israel was allowed. The group had waited on the Palestinian side for 13 hours. The sick children were on their last legs. The evening of the next day, little A.Z. died in Tel HaShomer hospital.

The spokesperson of Gaza DCO claimed in response to our complaints that ‘No prior coordination was made for their exit.’

The Rafah crossing: The Rafah crossing was completely closed from 10.7.2004 to 6.8.2004 by Israel for security reasons. During this period it was opened for two days only. On 28.7.2004, PHR, together with Mazan for Human Rights and the Gaza Centre for Mental Health, applied to the High Court asking them to allow the return of Palestinian residents who were trapped in subhuman conditions on the Egyptian side of the crossing. In addition, the applicants stated that Israel was obliged to make provision for the humanitarian needs of these people, since it was Israel which had given rise to their plight by closing the crossing for many days without prior warning. This obligation had been stressed in High Court decision 4764/04:

‘In the context of the internalization of humanitarian laws it is proper to stress that the obligation of the army commander is not confined to preventing the army from harming the lives and dignity of the local population (the negative obligation: paragraph 11 of the above ruling). His obligation is also positive (loc. cit.)’
Thus there should be prior organization in order to ensure a sufficient quantity of water in a certain place... there should also be ensured a sufficient quantity of drugs, medical equipment and food. Harm to the civilian population can be expected, and with all the attempts to minimize it there will be at the end of a battle local residents who will be harmed, and there should be organization to deal with this beforehand. [The commander] must not rely in these cases only on help from international and Israeli organizations even though this help is important. The army commander must internalize the recognition that the basic obligation is his, and he must take steps beforehand so that he can fulfill this obligation on the day of battle.

In spite of the fact that discussion of this case was postponed sine die, the crossing was opened on 6.8.2004 for the entry of thousands of people who had been held up on the Egyptian side. Three days later, the crossing was also opened to people leaving Gaza and there was enormous pressure on both sides. From 9.8.2004, the thousands of people who had been waiting for the opening for three weeks arrived at the crossing. However, the exit of men under the age of 35 was stopped, in spite of the fact that contrary information had been received from the Erez DCO. On 11.8.2004 hundreds of people crowded the Palestinian side asking to leave for Egypt and there was a great commotion. Even patients for whom there had been coordination from the Erez checkpoint still were unable to leave and waited at the crossing. Among those waiting was a doctor with plates in his legs. The previous time he had tried to leave from the crossing he had been stopped in spite of prior coordination, on the grounds that coordination from the Erez DCO was ‘not valid at Rafah’.

Communication between the Rafah Crossing and the Erez DCO

And indeed, one of the most enigmatic things is the communication between the Gaza DCO and the Rafah crossing. Again and again, PHR is witness that the right hand does not know what the left hand is doing. Cases where PHR have been involved in coordinating the exit of patient via the Rafah crossing have demonstrated that even when coordination is done in the DCO this is no guarantee that the patient will indeed leave. Moreover, in a number of cases when we appealed to the Gaza Legal
Advisor against security refusals of patients, we received written replies stating explicitly that there was no reason for security refusals in those specific cases. One of these patients, supplied with a copy of this letter, arrived at the Rafah crossing, only to discover that the paper in his hand was not valid in Rafah.

In a number of cases, a staff member of PHR was indeed told in telephone conversation with people at the Gaza DCO that they have no control over what happens at Rafah, and that the security services do whatever they feel like.
Part 8:  
The One-Sided Disengagement Plan

About the Disengagement Plan

On 6.6.2004, the Israeli Knesset approved Prime Minister Ariel Sharon’s disengagement plan, which involved a one-sided process of evacuating the Israeli settlements in the Gaza Strip. In the revised version of the plan, which was published on 28.5.2004, it was established that by the end of 2005:

1. Israel would evacuate the Gaza Strip and organize anew outside the territory of Gaza. This is apart from the army line-up in the area of the border between the Gaza Strip and Egypt (the Philadelphi corridor). As a result of this – it says in the plan – there will be no grounds for the claim that the Gaza strip is an occupied territory.

2. Israel will aim at leaving some of the properties of the settlements evacuated, subject to an international body which will take possession of them.

3. The infrastructure of water, electricity and communications will stay. Israel will aim at continuing the supply of water, petrol, gas and electricity to the Palestinians subject to the existing agreements.

4. Israel will continue the economic agreements between herself and the Palestinians: entry of workers to Israel, movement of goods, taxes and customs, post and communications.

5. Israel will consider leaving the Erez industrial area as it is.

6. The Erez checkpoint will be moved to the territory of the State of Israel at a time which has not yet been fixed.

86. Israel would also evacuate territories in the North of Samaria.
However:

7. Israel will continue to inspect and guard the outer envelope of the Gaza Strip on land and in the air, and will carry out navy operations in the territorial waters of the Gaza Strip.

8. Israel reserves to herself the right to take preventive measures including the use of force against any threats which might occur from the Gaza Strip.

9. Israel will have a military presence on the border between the Gaza Strip and Egypt.

10. On this border it is possible that Israel will ask for further physical expansion (i.e. further demolition of houses, M.B.) of the area where army operations will be held.

11. In the future she will consider evacuating this area, but this is dependent on the security situation which will be created and on the degree of cooperation with Egypt.

12. The present agreements at the international border crossings between Gaza and Egypt will continue.

13. Israel insists that there will be no foreign presence in the Gaza Strip except in coordination with her, and with her agreement.

The world outlook behind this plan is first and foremost security-oriented. The only element of rule which will be removed is the open Israeli presence inside Gaza. The visible Israeli presence, that is the army and civilian presence, will disappear. However, Israel is not giving up all the rest of her tools of power over the lives of the residents of Gaza, either from the military or the economic point of view. The plan even details this openly – how Israel will continue to control what is done in the Gaza Strip, control by military means along the borders, and by economic means as defined in the existing agreements. The most significant change for the daily life of the residents will be the institution of freedom of movement within the Gaza Strip. This will be a significant change, especially as regards movement between the different parts of the Gaza Strip and the ending of living in enclaves suffocated by the occupation.

However, it is reasonable to suppose that the border areas will continue to be very dangerous. Israel even declares openly that she intends to
continue to demolish houses along the border with Egypt, and it can be presumed that this will also be done in other places. From the economic point of view, Israel will continue to control the money that goes to the Palestinian Authority from taxes and customs duties and can stop these at any time she chooses, as she has done in the past. She can prevent the entry of goods, medicaments and petrol, and at any time can freeze the life of the civilian population and the medical system. Israel will continue to control the border crossings and the present agreements will stay. This means that the friction between the residents of the Gaza Strip and the Israeli army presence will all be concentrated at these crossings. It is not unreasonable to expect bloody events at the border crossings and their automatic closure in consequence.

Even though Israel has proclaimed her intention to leave the Gaza Strip, she reserves to herself the right to operate within Gaza against any threats that might appear from there. In other words, in the same way as she operates today – without any balance between the gravity of the threat and the strength of the response. Moreover, it is most likely that the responses will be even more violent, for the supposed moral justification will be even greater and the ability to operate freely within Gaza will be greater, since there will be no more presence of Israeli citizens who they must be careful not to hurt.

And it is most important of all to note that Israel will continue to control the borders of the Gaza Strip, by sea, by land and by air: she will continue to control the border crossings and decide who will live and who will die. In the light of this, the strangest claim in the plan is that ‘there will be no grounds for the claim that the Gaza strip is an occupied territory.’ The international legal definition of effective occupation is among other things that there is effective control. Such control is defined as control of all the borders. Therefore Israel will continue in effective control of the territory of the Gaza Strip, and will continue to carry responsibility for Gaza even after the evacuation. Israel’s claim contains an implicit acknowledgement that today she is the occupier of the Gaza Strip. What has been clear to the whole world is now also clear to the State of Israel. The significance of the acknowledgement of the occupation of the Gaza Strip is that Israel must, at least now, acknowledge her responsibility for the lives of the inhabitants. And in spite of this, even now she does not do this, in open contravention of international law.

In the context of responsibility for the lives of the inhabitants of the Gaza Strip it is likely that what Israel wants more than anything is to hand
over the control of the Egyptian border of Gaza, the Philadelphi corridor, to Egypt. In doing this, she will be able to divest herself completely from any responsibility for the well-being of the inhabitants of Gaza, for she will then not be the only agent in control of the borders.

However, Israel’s interest in whitewashing her sins in front of the international community conflicts with the security interests. The fear that the Egyptians will not be able to prevent the entry of weapons to Gaza prevents her from taking this up. And the legacy of the occupation as presented in this report will leave Israel a heavy historical responsibility for the situation in the Gaza Strip for years after the occupation is ended. The international community must define the part which Israel must take in her responsibility for the rehabilitation of the Gaza Strip.

The question of the Israeli responsibility for the fate of the inhabitants of Gaza is not expressed at all in the plan. The plan explicitly relates to Palestinian workers, for Israel intends to prevent their entry into her borders. But in spite of the fact that, in 2003, 6,335 entry permits to Israel were issued to patients from Gaza, the plan does not relate at all to the sick. Will Israel allow patients to enter her borders to go to Israeli hospitals, or allow them passage to hospitals in the West Bank or East Jerusalem?

On 20.10.2004 two members of the management of PHR, Professor Zvi Bentwich and Professor Michah Aldar sent a letter to the Minister of Defence and the Minister of Health. In this letter the doctors asked for clarification about Israeli plans for patients in the Gaza Strip after the Disengagement plan. About a month later an answer was received from the aide to the Minister of Defence, Ms Ruth Bar, as follows:

> Even after the completion of the said process, Israel will weigh up humanitarian considerations for the Palestinian residents including the entry of patients to Israeli hospitals in exceptional cases which need this. (see Appendix C p. 127)

Israel, then, is not obliged in any way for the fate of patients in Gaza. Entry of patients to Israel will be allowed in exceptional cases only, but there is no mention of the nature of these cases. Our experience, as it has been described in this report, demonstrates that the definition of exceptional cases, urgent cases or urgent medical need do not match

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the definitions accepted among medical personnel, and in many cases do not match any humanitarian concepts. Behind the maltreatment that Palestinians experience at the Erez checkpoint there is a goal: to take away from them any desire to enter Israel. The DCO is a central part of the Israeli system of control, which has made its goal the one-sided disengagement from Gaza.

It can be predicted that the process of closing the gates in the face of Palestinian patients after the disengagement will continue gradually. As described in this report, this process is already happening. In a conversation on 9.12.2004 which a staff member of PHR held with the Legal Advisor to the Gaza Strip, he was told that the Commander of the Southern Forces, Dan Harel, had issued an instruction not to admit patients to Israel for treatment, but to insist on their going to Egypt. In the office of the Legal Advisor they claimed that we should only apply to them in the most urgent cases, and only after ‘weighing everything up.’

This change in policy is directly connected to the Disengagement plan, and to Israel’s claim that when it is implemented she will cease to be responsible for the inhabitants of the Gaza Strip. Accepting this claim will endanger the lives of the Palestinian inhabitants of the Gaza Strip.

At a conference on the subject of the disengagement plan and its implications, Itamar Ya’ar, deputy head of the National Security Council, who deals with the subject of the Disengagement on behalf of this Council, mentioned an idea which arose in connection with building a new and advanced medical centre in the city of Gaza. According to him, Israel suggested that the International Red Cross should be a partner in this enterprise, but was answered in the negative.

In a letter which he sent to PHR-Israel, Professor Avi Israeli, the director general of the Ministry of Health, writes on this subject: ‘In addition, I have been informed that there is some activity going on with the international community to encourage the setting up of a large hospital in the Gaza Strip (and in the territories evacuated in Judaea and Samaria) which will serve the Palestinians after the implementation of the Disengagement plan. This is on the understanding that the setting up of a hospital like this, as well as the development of medical services in the Gaza Strip in general, will allow the Palestinians to free themselves from the present dependence on passage via Israel in order to receive treatment, a passage which will always be influenced to some degree by the circumstances and the security threat.’ (see Appendix D p. 128)
The building of an advanced medical centre will not solve the problem which exists in the Gaza Strip, for every advanced centre needs experienced staff to run it, and such staff need to train and update themselves in medical developments. Patients, equipment, drugs need to be able to move to and from such a hospital. The European hospital in Khan Yunis, which was set up with money from the European Union was considered advanced and well-equipped in its time. Today it suffers from the same problems and shortages as the Shifa Hospital in Gaza – aging equipment, poor upkeep, shortages of trained staff and of drugs etc.

In order to set up an appropriate medical centre to serve the inhabitants of the Gaza Strip, the external factors which restrict and suffocate the present medical system must be removed.

The State of Israel is faced with a serious legal and moral responsibility, dating from the occupation of the Gaza Strip in 1967. Her neglect of, and failure to develop a medical system in Gaza have increased year by year throughout the years of occupation. Thus when it comes to the medical needs of the Gaza Strip, the Disengagement plan must be backed up by the development of an appropriate medical infrastructure within Gaza. Concomitantly, the medical system in Gaza must be able to have assured contacts with the world outside in all areas connected with medical training, specialisation, transfer of patients, and import of drugs and medical equipment.

**Summary of the Report and Recommendations**

The clear desire revealed in the Disengagement Plan is to forestall the increasing demands from the international community and human rights organisations that Israel should fulfil her responsibility towards the Palestinian residents of the Gaza Strip, a responsibility which derives from the fact that they are subject to Israeli occupation.

In the opinion of the State of Israel, ‘the process of disengagement will negate the validity of the claims against Israel on the subject of her responsibility for the Palestinians in the Gaza Strip.’

And indeed denial of responsibility for the Palestinian citizens living in the Occupied Territories has characterized, and still characterizes, Israeli policy, not least because of the heavy financial burden bound up in her
obligation to recognize responsibility.

However, in the absence of serious preparation of the Gazan health system for the Disengagement, and the ensuring of links with the health systems on which she is dependent, the Disengagement will bring about a human catastrophe.

Today, because of the lack of physical and professional infrastructure, the Gaza Strip is dependent on external agents to provide medical services: cancer treatments, heart operations and catheterizations for adults and children, ophthalmology, emergency medicine, etc. In addition, various tests are simply not available at all: MRI, bone scans, etc. These services must be bought at full price particularly from Egypt, Israel and Jordan.

Israel completely controls the passage of patients, medical teams and drugs to and from the Gaza Strip. This control has allowed Israel from the early 90’s to implement a policy of cutting Gaza off from the outside world. From this point of view, Disengagement will provide a certain death blow to patients in a grave state. Without guaranteed continuity of medical treatment carried out today in Israel or abroad, these patients will die.

Suggestion for a Solution

In order to prevent a catastrophe, professional bodies are needed to conduct a survey of the present situation in the Health System in the Gaza Strip, to define the future needs of this system in order to provide health services at a suitable level.88

88. Setting up an infrastructure like this is estimated at half a billion American dollars. (a rough estimate for the setting up of three hospitals, and training staff at the average level of hospital staff in Israel). This could – if planned properly – be spread out over three years. To this investment must be added running costs. In estimating the running costs it is clear that the Palestinian system will not be able to bear the expense per head that Israel bears, because this is directly dependent on the state finances, and the sources which are available in building a budget. In the foreseeable future, the Gaza Strip in particular, and the Occupied Territories in general, will not be able to close the financial gap between them and Israel. Even in comparison with the countries of the Accord, which are in a much better state than the Occupied Territories – Israel is exceptional in the much higher expenditure on health per capita. Thus for example Israel’s expenditure on health per capita is ten times that of Jordan, (1,641 as compared with 163 American dollars). Thus the running costs, at least for a few years, will need to come from sources other than the Palestinian economy. If we wish to bring the level of the system up to
In the Gaza Strip (as in the rest of the Occupied Territories) it is necessary to set up a physical and professional infrastructure which will be able to provide for most of the needs for health services in Gaza (including treatment of chronic patients, cancer patients and emergency medicine).

Every process which includes building infrastructures together with reliance on the health services which exist at present in the Gaza Strip, will involve dependence on outside agents to provide the health services which do not exist (either at all or at a reasonable level) in Gaza. It is estimated that at least in the next ten years, the Palestinian Health Service will have to buy part of these services abroad. Because of their propinquity it is reasonable to suppose that the suppliers of medical services will continue to be Egypt, Israel and Jordan.

Following this, the Palestinian health service will have to decide which medical services to develop inside Gaza and which services will have to continue to be bought abroad.

**What is needed from International Agencies**

- Survey of the present situation in order to define the future needs of a suitable Health Service.
- Exacting planning with follow up of the implementation of the building of a suitable Health Service in Gaza.
- Investments in the budget and in experienced personnel
- Preservation of the obligations of both sides – Israeli and Palestinian – and supervision of the process

that of the Israeli system, we would be talking about a process of decades, and heavy dependence on outside sources of income. The cost of such services to the population of Gaza alone would be an estimated 2.5 billion dollars a year. If this demand were to be placed before Israel it would be based on responsibility for the occupation which has lasted for a generation. To compare: if we want to bring the health system in Gaza to the level of the Jordanian, we would be talking about a process of about ten years and about an investment of about 250 million dollars a year. It should be noted that since the cost of medicine in Gaza is cheap (because of the cost of living, the level of prices and the salaries) these sums will be lower than those noted above, and in any case these are sums which are only a rough estimate and need more professional examination and estimation than we are able to provide.
What is needed from Israel

- Stopping the scorched earth policy in the Gaza Strip which has involved the demolition of infrastructure and the destruction of income sources.
- A considerable improvement in the functioning of the Erez checkpoint and the Rafah crossing
- An undertaking to allow the entry of patients from the Gaza Strip for medical treatment in Israel, for at least 10 years from the date of the Disengagement
- Provision of medical services which will be defined as needing support (free) for 10 years, during which time she will build an infrastructure to bring medical services at least to the level of those in Jordan; and an undertaking to provide services which do not exist in the Gaza Strip even after the 10 year period, at the same rate as Israeli residents.
- Permission for Palestinian medical personnel to train in Israel on a continuous basis with Israeli participation in the costs. (For Palestinian trainees, training in Israel is preferable, as this does not involve moving their living quarters from Gaza, which is only a few hours away from Israeli medical training centres.)
- Ensuring a positive environment for development by opening international borders to enable direct links between the Gaza Strip and countries abroad, and guaranteeing a safe passage to the West Bank and East Jerusalem, in order to enable what must eventually become a single Palestinian Health System.
- Undertaking to found a secure atmosphere and begin development in order to help attract Palestinians from the Diaspora home to the Gaza Strip. Among the many Palestinians who left Gaza are many qualified members of the free professions, including medical personnel. They could help develop, stabilize and build an independent Palestinian Health System.
What is needed from the Palestinian Authority

- Total openness to surveillance.
- A call to Palestinians in the Diaspora to come and help build a Health System for suitable remuneration.
- Readiness to nationalize a considerable part of the Health System so that necessary health services will be available in the public system, including prevention of interested parties who make money from private medicine from dictating the nature of the public system.
- Development of a uniform national health insurance.

End of the Report

PHR-Israel’s requirement that Israel should bear the costs of founding a Palestinian Health Service derives from the recognition that all the time that Israel is in control of the Gaza Strip, she is the only one responsible for the health services of the inhabitants. The legacy of decades of occupation obliges Israel to invest in building an infrastructure of an independent health service in the Occupied Territories in general, and in the Gaza Strip in particular, even after withdrawal.

All through the years of occupation Israel has tried to divest herself of this responsibility both by providing health services which were inferior to those provided for her own residents, and by not developing a physical and human independent infrastructure. Israel will not be relieved of this responsibility even when ‘with the completion of the process, there will not remain in the areas which will be evacuated of the land space of the Gaza Strip any permanent Israeli presence of security forces or Israeli citizens.’

There is no basis for the Israeli claim that ‘as a result of this there will be no grounds for the claim that the Gaza Strip is an occupied territory’ and this is because Israel will still effectively control Gaza. In her own words: ‘Israel will continue to inspect and guard the outer envelope of the Gaza Strip on land and will be the only one to control the Gaza airspace, and will continue to carry out navy operations in the territorial waters of the Gaza Strip. In other words, the occupation will remain the occupation.'
Part 9:
Appendices

Appendix A: Health Services which are Lacking in the Gaza Strip
by
Health Inforum

Summary by PHR-Israel

Cardiovascular treatment:
Catheterizations with or without balloons, insertion of stents by catheterization, repair of valves, cardiac bypass surgery, replacement of heart valves, heart surgery to repair congenital defects in children, insertion of pacemakers.

Ophthalmology:

Neurosurgery:
Removal of intracerebral tumours, total removal of tumours from the spine, repair of prolapsed lumbar disc, repair of prolapsed cervical disc, widening of spinal canal, correction of instability of spinal column, surgery to peripheral nerves.
Orthopaedics:
  Primary or secondary knee and hip replacements with prostheses, lengthening of bones

Ear, Nose and Throat:
  Radical laryngectomy, tympanoplasty, stapedectomy, maxillo-facial surgery, mastoid- and antrectomy.

Urology and Urosurgery:
  ESWL, endoscopic ureteral lithotripsy, cystectomy, urethral anastomosis, intravesical cystography, prosthetic bladder valve, kidney transplant and urethral dilatation and stenting.

Gastroenterology:
  Injection of oesophagal varices, ERCP with bileduct biopsy, oesophageal dilatation.

Plastic surgery
  Correction of squints, reconstructive surgery for entropion and ectropion, laser treatments and general and surgical rehabilitation of the eye

Diagnostic services and treatments which are not available:
  MRI, angiography, gastro-intestinal endoscopy, radio-isotope scanning, chorionic villi sampling, trans-oesophageal echo-cardiography, radiotheraphy, treatment with radioactive iodine, fluorescent angiography of the retina.
External Providers of Services

Medical Services Bought from Israel
Paediatric consultation, neurosurgical treatment, chemotherapy, radiotherapy, bone marrow transplants, intensive care, burns treatments, haematological investigations, oncological follow-up, paediatric cardiac surgery, vascular treatments.

Medical Services Bought from Egypt
Neurosurgery and follow up, lumbar disc surgery, correction of retinal detachments, vasectomy, orthopaedic surgery, plastic surgery, vascular surgery, stabilisation of vertebrae, catheterization, oncological surgery, oncology, urology, IVF, transplants.

Medical Services Bought from Jordan
Urology, neurology, ophthalmology, cochlear transplants, cardiology and especially catheterization, cardiac surgery for adults and children, cardiac bypass, orthopaedics, plastic surgery.

Referrals to the West Bank and East Jerusalem
Cardiology especially catheterization, ophthalmology especially cataracts surgery, lens implants and laser treatments, MRI, paediatric intensive care, rehabilitation and physiotherapy, gastroenterology and FRCP, endoscopic imaging of catheterization of the bile duct and pancreas, haemodialysis.
**Appendix B:** Entry of Medical Students from the Gaza Strip to Al Quds University in Abu Dis: The Reply of the Office of the Coordinator of Activities in the Occupied Territories.

**Note:** Appendices B, C and D contain translations of original documents in Hebrew

Unclassified

[1] The State of Israel

Ministry of Security

Coordination of Operations in the Territories
Task Force unit-Public relations Dept
Tel 03-6976848/7971
Fax 03-6975865
Physicians -108829
12 Kislev 5965
25.11.2004

To Prof. Rafi Waldi [sic]
Physicians for Human Rights

Re. **Entry of Medical Students from the Gaza Strip to Al-Quds University at Abu Dis**

Your ref: Your application to General Mishlav from 14.11.2004

1. I hereby acknowledge receipt of your application on this subject, and herewith our reply:

   a) Investigation [of this application] together with security agents shows that the entry of students who are residents of the Gaza Strip to study in Judaea and Samaria is not permitted for security reasons.

   b) In the light of the above, it is not within our power to reply positively to the request under discussion.

2. Yours sincerely.

   Col. Avi Biton, head of department.

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Appendix c: Entry of Patients from Gaza to Israel after the Implementation of the Disengagement: The Reply of the Aide to the Minister of Defence

Ministry of Security

Office of the Minister of Security

The Kiryah, 1 Kislev 5965
Date: 14.11.2004
K: Minister’s aide-9870-271004

To Prof Zvi Bentwich
Chair of the Board
Physicians for Human Rights
52 Golomb Street
Tel Aviv 66171

Re: Entry of patients from Gaza into Israel after the implementation of the Disengagement Plan
Your letter of 30.10.04

Even after the completion of the said process, Israel will weigh up humanitarian considerations for the Palestinian residents including the entry of patients to Israeli hospitals in exceptional cases which need this.

Yours truly

Ruth Bar
Aide to the Minister of Security

/ir

Office of the Minister of Security, the Kiryah, Israel Zip code: 61909
Tel 03-6975220 Fax 03-6962757
Appendix D: Clarifications about Israel’s Responsibility for the Entry of Patients into her Territory after the Implementation of the Disengagement Plan

The State of Israel

Director General

Ministry of Health

To: Prof Zvi Bentwich, Chair of Board
Prof Michah Aldar, member of the Board,
Physicians for Human Rights,
52 Golomb Street,
Tel Aviv, 66171

21 Tevet 5965
2.1.2005
reference no: 103/48895-13 (m)
In reply quote reference no.

Dear Sirs,

Re: Clarifications about Israel’s Obligations for the Entry of Patients from Gaza into her Territory after the Implementation of the Disengagement Plan
Your letter to the Minister of Health of 20.10.04

The Disengagement Plan will not interfere with existing arrangements which allow the Palestinians now also to receive medical treatment in Israel according to need, for cases which cannot be treated in Palestinian territory. The agency responsible for coordinating the treatment in these cases will continue to be the Office for Coordination of Activities in the Territories. The present arrangements – all those connected with prior coordination, including security and finance in non-urgent cases – will continue also after the evacuation of the Gaza Strip.

In addition, I have been informed that there is some activity going on with the international community to encourage the setting up of a large hospital in the Gaza Strip (and in the territories evacuated in Judaea and Samaria) which will serve the Palestinians after the implementation of the Disengagement plan. This is on the understanding that the setting up of a hospital like this, as well as the development of medical services in the Gaza Strip in general, will allow the Palestinians to free themselves from the present dependence on passage via Israel in order to receive treatment, a passage which will always be influenced to some degree by the circumstances and the security threat.

Yours truly

Prof Avi Yisraeli

cc. Office of the Minister of Health (current 23541)
Mr Amos Yaron, Director of the Ministry of Security
Dr Yitzhaq Berlowitz, Deputy Director and Head of Medical Administration, Ministry of Health

2 Ben-Tabbai Street, Jerusalem 93591 PO box 1176 Jerusalem 91010 TEL 02-6705706
FAX 02 6783266

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