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Glimpses of Hope? An Interview on Access to Health in Gaza

The outbreak of the COVID-19 pandemic has exposed the fragility of the global health system. The below interview focuses on access to health in the Gaza Strip as part of a fragmented and already fragile Palestinian health system. Due to the political reality of the Israeli occupation and the Palestinian national division, the responsibility of the Palestinian health system in Gaza falls under multiple actors: Israel as the occupying power, the Palestinian Authority (PA) and the de-facto authority, Hamas, in the Gaza Strip. Considering the impact of the military confrontations in May 2021 and the ongoing COVID-19 pandemic, it is important to look at access to health in the Gaza Strip and how the health sector managed to cope with military attacks and COVID-19.

Duha Almusaddar, programme manager at the RLS Regional Office for Palestine and Jordan in Gaza, spoke with Dr. Ayed Yaghi, the Director of the Gaza Branch at the Palestinian Medical Relief Society (PMRS) on issues related to access to health in Gaza Strip.

About the Interviewee:

Dr. Ayed Yaghi started working in the Palestinian Medical Relief Society (PMRS) in Gaza in 2003 and is now the Director of the Gaza Branch. Dr. Yaghi worked as a urologist from 1994-2003. In 2008, he received a master's in Public Health (Management) from Al-Quds University.

Image for Mohamed Reefi

Please share with us your general assessment of the health situation in the Gaza Strip.

I would first like to stress that health is an essential basic human right. Health is not just about being free from diseases; it also entails living in an environment that is safe, healthy and with good mental health. Without a doubt, basic rights for Palestinians living in the Gaza Strip are infringed due to the Israeli occupation. As per international laws and the Geneva Convention, the Gaza Strip – despite the withdrawal and re-distribution plan of 2005 – still under Israeli Occupation. Israeli authorities control all the main crossings (air, land, and sea space) of the Gaza Strip. Thus, the primary responsibility for ensuring access to good quality health lies with Israel.

Within the Gaza Strip, there are key providers that form the health system – the first and main of which lies within the Palestinian Authority (ministries of health and military medical services). The second provider is the UN Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), which in accordance with its mandate provides services to Palestinian refugees. Seeing that Gaza's population is estimated to be around 70% refugees, UNRWA only provides primary health services, while civil society organizations provide primary, secondary, and third-level healthcare services. There are few private sector services consisting of specialized centers, pharmacies, laboratories, and small hospitals that also provide

some basic operations, but the private sector is generally weak due to the economic situation shaped by poverty and unemployment.

By and large, the health services in the Gaza Strip are affected by three factors: The first is the Israeli occupation and siege imposed on the area. The second is the Palestinian political division since 2007, which negatively impacts the provision of health services due to the existence of two ministries/authorities, one in Ramallah and one in Gaza, whose relations often conflict. The third factor is the decline in funding (whether for public/government or civil facilities) due to the global economic crisis, the political division, and the presence of Hamas in Gaza.

How do socio-economic factors and the political split impact people's ability to access healthcare?

A key factor is the unemployment rate among graduates, especially those from health faculties. Many graduates have been unemployed for many years and cannot participate in the labor market. This increased the numbers of patient visits to health centers and clinics, as well as delays in operations or any medical interventions. The other factor is poverty, which is estimated to be around 52% in Gaza, and where almost 80% of families rely on aid. Poverty obviously impacts the health situation as it limits access to basic needs (such as hygiene and food), as well as to health services (conducting tests, getting medications, or carrying out operations on time). Poverty is also linked with diseases such as anemia and malnutrition. On another note, awareness and education levels are also critical for health, as poor communities with limited awareness and education are less likely to seek medical consultation despite being in greatest need for medical treatment. All this is especially challenging when estimates suggest that Palestinians contribute 40% of their income towards health; an extremely high percentage in comparison to other countries.

What about the health capacities in terms of hospitals, medical supplies, number of doctors and other indicators?

The hospitals' rate per 100,000 of the Gaza Strip population is 1.7, while the bed rate per 10,000 of the population is 12.4. Although these rate are sufficient, yet they are not invested correctly to ensure that there are enough beds for the population. There is also a shortage of medical staff. Health workers, especially within the health ministry, are heavily burdened. In 2007, all healthcare workers were receiving salaries from the government in Ramallah. Today, around 4000 medical staff receive salaries from the government in Ramallah (as the others have retired, emigrated, left the services, or passed away). It is worth noting that doctors' salaries in Ramallah are three times more than those in Gaza, while those appointed by the Hamas government do not receive salaries but only honorarium fees.

Not only is it essential for health workers to receive their basic right of pay, but they should also receive capacity development (whether nationally, regionally, or abroad). However, this is almost nonexistent due to the siege. Health workers in the Gaza Strip are likely to be over-worked, which is understandable since the area is prone to attacks, as witnessed through direct military escalations and during protests along the separation barrier and the Great March of Return (GMOR). In these circumstances, the medical staff were fully exhausted while they put their lives in danger without protection. Additionally, the insufficient number of staff to cover various departments has increased the burdens. This is one of the reasons that government facilities rely on volunteers or temporary contracts – all of which affects the quality of work.

Clearly, the siege and political division heavily impact health services in the Gaza Strip. This has forced health service providers like CSOs to widen their services, establish additional health centers and mobile clinics, as well as implement new programs to cover the deficit in services. They also had to increase their staff in response to the needs of the population. For example, the Palestinian Medical Relief Society (PMRS) increased its staff of 70 (in 2007) to 200 (today), and UNRWA has increased its services, developed its facilities, and absorbed a greater number of workers.

How does the division of labor work between the above-mentioned agencies operating in the health sector? Are there clear policies (with division and occupation) regarding the health sector in Gaza?

In essence, the health of Palestinians is mainly the responsibility of Israel (as the occupying power). As per the Palestinian basic law and public health law, the ministry of health (MOH) is the authorial and key health provider for Palestinians in the occupied territories. However, the law has not addressed the existence of two ministries, which is reflected adversely on the provision of services such as equipping health centers and hospitals with the needed medications and health staff. These circumstances, plus the increase of the population, create a need for hiring considerably more staff, from administrative to medical professionals.

Although the Hamas government has hired some of the needed staff, yet many of them lack the required expertise and skills. Moreover, being under siege

prevented most health professionals from participating in trainings and exchanges to get updated about developments in the field. The online option, although available, is not adequate to advance the health system, and while another alternative is to conduct surgeries and trainings via medical delegations from abroad, this still is not sufficient.

The lack of a centralized government has also negatively affected health policies. After all, due to the split between governments, major health-related decisions have been enforced in Ramallah and not in Gaza, or the other way around. This issue was observed in the COVID-19 strategy, seeing that the quarantine period in Ramallah lasted for 14 days and later 10 days, whereas in Gaza it lasted for 21 days.

Another key health policy affecting a wide range of the population is the Palestinian government insurance. Currently, the mandatory health insurance system (government insurance) deducts part of the salary of government employees (both PA and Hamas) to cover their health insurance. The government also covers the insurance of workers for a small fee. Those registered in the Ministry of Social Affairs and receive welfare support, are covered by the government health insurance for free. Specific cases, like those injured during the first and second intifadas, the GMOR, and other casualties due to Israeli aggressions, are also covered. Furthermore, special patients of thalassemia, cancer, and kidney dialysis are eligible for free healthcare – even if they do not have health insurance and regardless of class. These regulations have been in place since 2000, but it has become noticeable in Gaza that not all treatments were being granted due to lack of medications and tests, and because of the overall weakness in regulating the health sector. After pressure and advocacy of civil actors, the rights of patients (like with Thalassemia) were eventually restored and managed to access free healthcare services at government facilities. However, some of the required services (such as a CT or MRI) could be unavailable, broken, or put on a long waiting list, thus requiring patients to resort to civil society services.

Although patients should only pay a symbolic contribution for health insurance services, yet it has been noticed in the past few years that the amount of these contributions in the Gaza Strip has increased, largely affecting those relying on welfare or with limited income. The fact that not everyone can afford this amount, which should be covered by insurance, further violates the right to health access. Moreover, people with disabilities (PWD) being a significant part of the society, should – by law – receive free services from the MOH, yet they have not been receiving the required rehabilitation services in the last few years. A recent Memorandum of Understanding was brought forth between the ministry of social affairs and the ministry of health to ensure that PWD will receive the needed services, and we hope it is enforced.

In addition to the horrid impact of the Israeli siege, the political division also stands in the way of access to healthcare among Palestinians. Oftentimes, the MOH in Gaza refrains from spending on health services on the premise that this is the responsibility of the MOH in Ramallah, and vice versa. With each government laying the responsibility on the other and stating the lack of funding as another reason, there is a chronic shortage of medications that is between 30 to 50%.

Adding to this complexity is the Occupation, which is not only present in the military sense but also in its direct control. In this respect, the Paris Agreement authorizes Israel to collect and deduct taxes off of the PA. In withholding tax money as a way by which to pressure the PA, the Israeli policies create a deficit for the PA, which in turn uses this as another reason to justify not sending medications.

Essentially, health personnel are the first element for providing services, yet their rights are infringed for several reasons (such as lack of adequate compensation for their work, mental state, development capacity, not to mention injuries, arrests, and deaths by the Israeli army). The fact that health providers are not protected largely influences the provision of good quality health services. Another important issue is the absence of strong medical unions, which is also linked with the political division and laws that deter and undermine union work including doctors and nurses.

What are the impacts of the siege on Gaza concerning the provision of health services?

Israel has the dual use items system, whereby it lists thousands of items that are prevented from entry. Such items that are forbidden entry include thermometers (due to containing mercury), radiation devices, and oxygen cylinders. While, CT and MRI devices are delayed for six to nine months.

As for permits, Israel has specific criteria to be allowed to exit the Erez crossing. These permits are restricted to humanitarian cases for patients in need of urgent medical interventions that are not available in Gaza (i.e., cancer cases) or that require ambulance transport and special coordination. However, not all such cases are allowed to exit due to security rejection. Meanwhile, health workers are seemingly eligible to exit Gaza to participate in training or workshops, yet this is rarely applicable.

The Israeli military control over patients' movement and their prevention from receiving treatment on time denies the basic right to health access. Patients in need of examinations or operations have to wait for weeks to get security clearance, and many patients (or their companions) are denied to exit. They could also be returned from the crossing, detained/arrested, or blackmailed. It is worth noting that the approval rate for permits is low, while some approved cases still get prevented to exit. Out of the 1,136 patient applications submitted to cross Beit Hanoun/Erez in July, only 839 were approved.
Furthermore, medical supplies and materials are also delayed or banned from entering. On this note, cancer medication is usually unavailable in Gaza – not only due to the siege but also due to lack of funding, yet the military occupation's dual use policy is what prevents the creation of radiation centers and entry of PET scans for cancer detection.

Electricity has also had a great impact on medical services in the past years. The continuous power cuts are so burdensome that the average power supply in Gaza, today, is 8 hours per day (at some point it was 4 hours a day). This inconsistency of power supplies has clear repercussions on hospitals that have to dedicate heavy budgets for maintaining and supplying expensive generators that they reply on, as well as to preserve and replace medical equipment (like the CT and MRI).

Another critical issue is the water. 97% of the water in the Gaza Strip is unsuitable for drinking and human use. The fact that the sewage system also relies on the availability of power and gas supply would cause water contamination, and this evidently increases the risks to health.

What new challenges do COVID-19 and military aggression pose to health access?

COVID-19 impacted the global health system, and we saw advanced health systems struggling to cope with the pandemic. One of the ironic advantages of the Israeli siege is that it may have delayed the Coronavirus from reaching the Gaza Strip, thus giving health workers the chance to train the staff and learn from the experiences of others. To respond to COVID-19, additional personnel, protective gear, and services such as PCR tests were needed, all of which require increased financial capacities.

Eventually, COVID-19 arrived in Gaza in August 2020 to an already vulnerable health system amid occupation, siege, GMOR, and without resources. Despite the human and financial burden, the health system in Gaza was able to respond to these needs. We did not have a crisis as seen in other countries. This was possible due to learning from other's experiences, support, cooperation, and coordination of all health service providers. This was in addition to government measures taken – such as lockdowns, quarantines, and community awareness campaigns implemented from March 2020 to August 2020. We were concerned that the situation would be much worse, but all these measures and precautions contributed to contain the pandemic.

As for the vaccines, Israel is the one responsible for the health of Palestinians, especially during pandemics. Accordingly, it helped the PA with the testing, yet it had a negative role in the vaccination process. Israel began vaccinating a large number of its population (starting at the end of Dec 2020), but it did not consider vaccinating the Palestinians under its occupation, let alone the Palestinian prisoners – even though it is its responsibility under international law. After intensive campaigns, it finally allowed prisoners to receive vaccination, and we later heard about Palestinian/Israeli cooperation over the vaccination.

In our defense of the right to health for all, we believe that the PA should continue to uphold Israel its legal obligation and duty to provide vaccination for Palestinians, and not to resort to background contracts with companies. The disparity is evident in how 100% of the Israeli population has already been vaccinated, and the third vaccination shot vaccination commenced, whereas in Gaza only 26% are vaccinated (and not fully). This is not to mention the dubious vaccination agreements (as the one discovered in June 2021 wherein expired vaccinations were to be sent from the Israelis to the PA).

The Israeli military attack in May 2021 was an additional burden to the already-challenged health sector in Gaza (due to COVID-19, regular patients, previous injuries from the GMOR and Israeli aggressions, and the shortage of medications and staff). The military escalation in May caused around 2000 casualties , damaged 30 health facilities and roads leading to health centers. After the end of the aggression, the health system was severely affected as Israel closed the crossings for over two and half months, thus restricting patient movement and the entry of medications, medical supplies and some equipment. The PMRS, for example, has been waiting since May for the entry of an Echocardiogram, which is not available in Gaza.

What emerging action/recommendation is required to improve access to good quality health?

The main recommendations relate to the factors that affect the right to health in Gaza. First is ending the Israeli occupation over the Palestinian territories and lifting the siege so that Palestinians can enjoy their right to health. The second is ending the Palestinian division, introducing new laws, updating the public health law (introduced in 2004), and organizing health services. The PLC in Gaza had previously discussed some laws such as organ transplantation, smoking, and profession regulations – all of which are needed, but the political split affected the ability to issue such laws and regulations. It is vital to update and improve the health insurance system. Lastly, it is critical to increase funding for health services in the Gaza Strip.

*** Do you see glimpses of hope when you observe the health situation in Gaza?**

So far, no, because hope is conditioned upon political change. Our problem is political: It stems from the Israeli occupation. We welcome any intervention that will improve the Gaza Strip's health and humanitarian conditions, but not at the expense of the political issues. We find that all these solutions are temporary and will not end the main problem. Our problem will only be solved when we are freed from the Occupation; Only then can we enjoy good health.

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