VIOLENCE AGAINST HEALTHCARE IN GAZA

Violence against Palestinian NGOs Healthcare Personnel, Vehicles and Medical Structures during the 2018 "Great March of Return" Demonstrations

MÉDECINS DU MONDE

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ACRONYMS

AP	1977 Additional Protocols to the 1949 Geneva Conventions
BLS	Basic Life Support
CBO	Community-based Organizations
GCIV	1949 Fourth Geneva Convention
ICL	International Criminal Law
IHL	International Humanitarian Law
IHRL	International Human Rights Law
ISF	Israeli Security Forces
MDM	Médecins du Monde France
MoH	Ministry of Health
OHCHR	UN Office of the High Commissioner for Human Rights
PAS	Public Aid Society
PHCC	Primary Healthcare Centre
PMRS	Palestinian Medical Relief Society
PNGO	Palestinian NGO Network
TSP	Trauma stabilisation points
UHCC	Union of Health Care Committees
UHWC	Union of Health Workers Committee
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
UNSC	United Nations Security Council
WHO	World Health Organisation

INTRODUCTION

Concerned by the unprecedented large number of incidents affecting healthcare personnel, facilities and ambulances in Gaza since 30 March 2018, Médecins du Monde France (MDM) launched a project aimed at bringing light to the multifaceted consequences of violence in the health sector. The Palestinian NGO Network (PNGO) and the Palestinian Medical Relief Society (PMRS) also participated in providing valuable information for the realisation of this project.

On March 30th, an array of national factions and organisations from the occupied territory and the diaspora, named the Higher National Commission for the March of Return and Breaking the Siege,[1] organised civil demonstrations along the perimeter fence with Israel with the intention of commemorating Land Day. This was the first chapter in a series of demonstrations that would continue until May 15th, Nakba Day. Aware of the possible consequences of demonstrating in what the Israeli army has called the "No Go Zone", the Ministry of Health (MoH) and several Palestinian health organisations established stabilisation and first aid tents within the five camps spread along the perimeter fence.[2]

Healthcare staff and volunteers worked for more than 10 weeks, providing first aid, stabilisation and transportation to hospitals to thousands of injured demonstrators. However, while on duty, the healthcare staff, mobile units and structures were not spared from the violent response to the demonstrations. Up until June 11th, more than 328 health staff members were injured, of which two were killed and 45 ambulances were damaged.

This report intends thus to present an insight to the violence health staff have suffered during the seven weeks between 30 March and 15 May, based on the information provided by the Palestinian health NGOs and their staff. The intention is to offer a better understanding of the incidents occurred along the border area, to frame these incidents within the different applicable legal frameworks and to portray the consequences they have had on the overall provision of health services. Simultaneously, this report also stresses the importance of improving the safety protocols of healthcare personnel working in Gaza and the responsibilities each actor has.

This report is divided into two major sections: the first provides a general introduction on violence against healthcare and the second focuses on the results of the fieldwork carried out with the Palestinian NGOs in Gaza. The first section therefore describes what violence against healthcare is; it provides a description of the different legal bodies that ensure protection to health workers, ambulances and units; it focuses on the role of safety management in reducing the impact of violence; and then contextualises the recent incidents against healthcare in Gaza. The second part begins with a methodological description of the fieldwork and then develops the results found in terms of health access, the safety of personnel and safety incidents, giving especial attention to the consequences of these incidents. Finally, a series of recommendations are proposed to instigate action and change in favour of improving protection and safety of healthcare in Gaza.

[1] Thrall, Nathan, Gaza Protests Mark Shift in Palestinian National Consciousness, International Crisis Group, 2 April 2018. *https://www.crisisgroup.org/middle-east-north-africa/eastern-mediterranean/israelpalestine/gaza-protests-mark-shift-palestinian-national-consciousness*

[2] The MoH temporary structures, called Trauma Stabilisation Points (TSP), provided triage, treatment and discharge for minor injuries as well as triage, stabilisation and referral for the severe cases towards the closest hospital. The triage at this level allowed to unclog the saturated ambulatory services and emergency departments from the massive influx.

CONTEXT

VIOLENCE AGAINST HEALTHCARE

While violence is ubiquitous and affects millions of people in the world; physical violence against healthcare personnel, structures and ambulances is a major risk that represents almost a quarter of all physical violence at the workplace.[3] The effects of violence in this sector can range from temporary suspension of activities to the dispersion of healthcare givers due to fear, and even to long-lasting disruption of services.

> **THE IMPACT OF VIOLENCE AGAINST HEALTHCARE IS GREATER DURING ARMED CONFLICT AND LAW ENFORCEMENT OPERATIONS BECAUSE THAT IS WHEN THEIR SERVICES ARE OF GREATER NEED**

During special periods of violence, regardless of its nature, the consequences of violence against healthcare personnel go far beyond the immediate act. It spills over reducing or preventing access to the fundamental right to health. The 2009 attack in Mogadishu during the Benadir University medical school graduation ceremony illustrates the far-reaching consequences of a single incident. At that occasion, the university was celebrating the first generation of medical doctors since 2002 when a suicide attack targeting four members of the transitional government killed 25 people. Among the victims were two doctors and nine students.[4] Among those who survived, several students left the country. In a country where there are approximately only 3.5 doctors for every 100,000 people,[5] losing more than 10 doctors in a single incident meant that the state lost the capacity to cover the health needs of around 300,000 people.

While there are daily incidents affecting healthcare services around the world, in terms of frequency and intensity, armed conflicts and law enforcement operations are the most significant among several causes of violence against healthcare. It is during this kind of situations that their services are of greater need. With the intention of reducing the impact of overall violence on the most vulnerable, international human rights law and international humanitarian law define both the particular need to protect healthcare and ensure access to the right to health.[6]

Figure 1 - Damaged ambulance in the Iraqi city of Ramadi, January 16, 2016. REUTERS/Thaier Al-Sudani

[3] Nordin, H. Fakta om vaold och hot I arbetet, Solna, Occupational Injury Information System, Swedish Board of Occupational Safety and Health. 1995
[4] CNN, Blast kills 19 at graduation ceremony in Somalia, December 4, 2009, *http://edition.cnn.com/2009/WORLD/africa/12/03/somalia.attacks/*
[5] World Bank, Physicians (per 1,000 people) Database, based on the World Health Organizations Global Health Workforce Statistics: *https://data.worldbank.org/indicator/SH.MED.PHYS.ZS?locations=SO*
[6] Cf. ICRC, International legal framework for the protection of healthcare during armed conflicts, *http://www.icrc.org/en/download/file/19448/health-care-in-danger-workshop-legal-provisions.pdf*

INTERNATIONAL ACCOUNTABILITY: APPLICABLE LAW IN THE GAZA CONTEXT

International organisations and legal experts agree on the fact that there are the two different normative frameworks for the use of force: International Humanitarian Law (IHL) and International Human Rights Law (IHRL).[7] This section intends to cover the essential aspects of these two normative frameworks and sheds light on the existence of other frameworks related to or inspired by these.

INTERNATIONAL HUMANITARIAN LAW (IHL)

Applicable during armed conflict, I HL p rovides s pecific ru les an d expresses the obligation to protect the wounded and sick, as well as the healthcare personnel, its facilities and ambulances from any act of violence. In particular, it is important to recall the applicability of the 1949 Fourth Geneva Convention relative to the protection of the civilian population in time of war and occupation, as enshrined in its Article 2, which states that the Convention shall also apply to all cases of partial or total occupation of the territory of a High Contracting Party, even if the said occupation meets with no armed resistance. The broad international community, including the International Committee of the Red Cross (ICRC), the UN, the United States and the European Union, refers thus to this Convention as the main legal framework.

The fourth convention explicitly states that hospitals, clinics, ambulances and healthcare staff have to be protected at all times during conflict so that the wounded and sick can be safely and freely treated.[8] Article 18 actually specifies that civilian hospitals may in no circums-tances be the object of attack. Already the Common Article 3 to all four Geneva convention states that the rights of the wounded and sick must be respected in all circumstances; attempts upon their lives and violence against their person are strictly prohibited.

The 1977 Additional Protocols to the Geneva Conventions further detail the extent of the protection of victims of armed conflict, and as such provide more details and extends the provisions to all actors during armed conflict.

- Personnel engaging in medical tasks must always be respected and protected, including their right to access any place where their services are essential (Protocol I Articles 15 & 17);
- Medical units, transports, equipment and supplies, such as hospitals and ambulances must be respected and protected in all circumstances (Protocol I Article 12).

Customary law, understood as the general repeated practice of what states have integrated into national law or accepted as law but not necessarily translated in international treaties, also integrates important elements concerning the protection of healthcare. This international practice has been classified into rules of customary IHL, which are applicable to both international and non-international armed conflicts.[9] This set of rules reinforce the general custom that grants medical personnel special respect and protection in all circumstances (Rule 25); same goes for medical units (Rule 28) and medical transports (Rule 29) assigned to medical purposes. Rule 30 prohibits any attack against medical personnel and objects displaying the distinctive emblems of the Geneva Conventions. Further reinforcing this latter concept, Rule 35 prohibits directing an attack against a zone established to shelter the wounded, the sick and civilians from the effects of hostilities.

Figure 2 - Damaged Red Cross and Red Crescent medical supplies lie inside a warehouse after an airstrike on the rebel-held Urm al-Kubra town, western Aleppo city, Syria September 20, 2016. REUTERS/Ammar Abdullah

[7] Maltz, Judy, "Israel's Gaza Killings: War Crimes or Self-defense? Experts Weigh In", Haaretz, May 17, 2018. https://www.haaretz.com/israel-news/.premium-israel-s-gaza-killings-war-crimes-or-self-defense-experts-weigh-in-1.6095293
[8] ICRC, 1949 Geneva conventions. Fourth Convention, Articles 14, 18, 20, 56, plus in Annex 1, article 11.
[9] OHCHR, Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, UN Office of the High Commissioner for Human Rights (OHCHR). 1990.

INTERNATIONAL CRIMINAL LAW (ICL)

Enshrined in the Rome Statute of the International Criminal Court, ICL provides the legal framework defining the most serious of human rights and international humanitarian law violations to which individuals can be held accountable. Its Article 8 specifies that any attack on any of the above mentioned protected persons is a grave breach of the Geneva Conventions and as a war crime.

INTERNATIONAL HUMAN RIGHTS LAW (IHRL)

On the other hand, IHRL is applicable at all times, including law enforcement operations.[10] In these cases, even when the use of force is unavoidable, law enforcement officials must:

- Warrant medical assistance to those wounded and the sick in life-threatening circumstances as early as possible.
- Respect the rights and responsibilities of healthcare personnel.

International Human Rights Law affirms that States must therefore refrain from arbitrarily denying or limiting such medical access. Attacking, harming or damaging civilian or military healthcare personnel, mobiles or structures, represents a way of denying or limiting such access and it is a violation of the right to health. Beyond these international legal frameworks, there are other initiatives and frameworks that have further developed the rights and obligations of healthcare workers. The World Medical Association (WMA), an international organisation engaged at promoting the highest possible standards of medical ethics, adopted in 1959 the WMA Regulations in times of armed conflict and other situations of violence. These regulations also refer to the need of ensuring physicians access and entitling them to be clearly identified and protected.

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THE RIGHT TO HEALTH

The right to health is defined as "the enjoyment of the highest attainable standard of physical and mental health." [11] *However, in practical terms, the Committee on the Economic Social and Cultural Rights General Comment defines*[12] *this right as the "access to a series of individual freedoms and entitlements". These entitlements include a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health; access to essential medicines; equal and timely access to basic health services, among others.*[13] *All countries have ratified one or several international human rights treaties recognizing the right to health, and through these treaties, states are bonded to three key obligations: to respect, protect and fulfil this right.*[14]

These obligations call all States to refrain from interfering directly or indirectly with the right to health, to prevent third parties from intervening against it, and to adopt any appropriate measures whether legislative or administrative to fully realize the right to health.[15]

SAFETY MANAGEMENT

While the international legal bodies do express the essential protection provisions to which health workers are entitled, and through which accountability is expected to be exerted, it is also important to highlight that risk reduction and safety are a shared responsibility between the health workers, their organisations or institutions, the governments and the international community.

Healthcare workers are the first responsible for keeping themselves safe. This means that staff members of health organisations should follow the safety procedures given by their organisation or institution, participate in the safety trainings, report safety incidents and should be clearly identified as such and use available protective gear.

Their organisations are responsible for establishing minimum safety rules, ensuring their personnel abides by the procedures and regulations, providing the adequate training, offering appropriate equipment, having internal safety policies reducing work-related risks and regularly monitor their staff's safety.

Governments have the responsibility of establishing mechanisms preventing the attacks on healthcare such as legislation and ensure internal accountability, including the obligation to prevent third parties from violating their protection.

Finally, the international community has the responsibility of calling for accountability and ensuring the application of international law, as well as continuing the development of relevant international mechanisms that facilitate accountability.

[11] Art. 12, International Covenant on Economic, Social and Cultural Rights, 1976. See the 1946 Constitution of the World Health Organisation as well.
[12] OHCHR – Committee on Economic, Social and Cultural Rights, CESCR General Comment No. 14: The Right to the Highest *Attainable Standard of Health (Art. 12), OHCHR, Aug. 2000, www.ohchr.org/EN/HRBodies/CESCPages/CESCRIndex.aspx.*
[13] OHCHR, OMS, The Right to Health, Factsheet No. 31. UN Office of the High Commissioner for Human Rights (OHCHR). June 2008.
[14] These treaties are:
- The 1965 International Convention on the Elimination of All Forms of Racial Discrimination: art. 5 (e) (iv)
- The 1966 International Covenant on Economic, Social and Cultural Rights: art. 12
- The 1979 Convention on the Elimination of All Forms of Discrimination against Women: arts. 11 (1) (f), 12 and 14 (2) (b)
- The 1989 Convention on the Rights of the Child: art. 24
- The 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families: arts. 28, 43 (e) and 45 (c)
- The 2006 Convention on the Rights of Persons with Disabilities: art. 25.

[15] OHCHR, OMS, The Right to Health, 2008.

INCIDENT REPORTING

Among the main components of the standard safety management policies, incident reporting and analysis are the basic steps for further improving the health workers safety policies. As referred in UNSC Resolution 2286, incident reporting and general data collection are essential for recording, analysing, understanding, and campaigning to improve policy change and accountability.

UN SECURITY COUNCIL RESOLUTION 2286

In March 2016, six months after the attack on the MSF Hospital in Kunduz, Afghanistan, the United Nations Security Council (UNSC) adopted unanimously resolution 2286 condemning all attacks on medical personnel. It is the most comprehensive and specific resolution on violence against healthcare;[16] it demands an end to impunity for those responsible and also respect for international law, in particular the obligations found under the 1949 Geneva Conventions and their additional Protocols.

While emphasizing the gravity of impunity and the need for accountability, the resolution also gives concrete guidelines on how to reduce the risk of these incidents. It urges States to develop effective measures to prevent and address acts of violence through the development of domestic legal frameworks, the collection of data, and sharing challenges and good practices experienced on the ground. Civil society therefore has the moral obligation to remind the States of their responsibilities vis-à-vis International Law and to participate actively in the promotion of the implementation measures urged by this resolution.

In terms of applicability, article 25 of the United Nations Charter specifies that all Security Council Resolutions are legally binding; meaning that the content of the resolution 2286 is applicable to all UN member states whereas they are responsible to respect and follow its content.

The World Health Organisation (WHO) is among the actors responsible for reporting this kind of incidents; specifically, it has the task to develop systematic methods for incident reporting and dissemination of data when it comes to attacks on health workers, facilities, ambulances and patients as part of its mandate to support the state's health sectors. Based on World Health Assembly Resolution 65.20, the WHO has launched the Surveillance System for Attacks on Health Care (SSA), aiming at producing a standardised data collection system and regular reports identifying trends and patterns of violence.

Besides the WHO, States have the specific responsibility to develop reporting plans and facilitate investigations, including those established by the international bodies and those directed by the Office of the High Commissioner for Human Rights, as well as to prosecute those responsible in case of violations. However, as found on the field and despite the efforts, including those taken by organisations such as the ICRC and the International Federation of the Red Cross (IFRC), the measures taken in terms of improving safety management and incident reporting by the international community and individual states are still far from ensuring protection and accountability for these kinds of attacks.

Civil society therefore has the special role of being a catalyst for raising awareness, including highlighting the current challenges and providing an independent analysis. For instance, MDM has also strengthened its advocacy directed to the protection of healthcare through campaigns such as "Targets of the World", through which it has systematically condemned these kinds of attacks, raised awareness on the severity of the situation and called for action.

One of the great challenges the international system has in terms of reporting is that health workers don't always recognize violations when they occur, and when they do, they lack the proper resources to know where or how to report them.[17] General awareness of what constitutes a violation, plus the availability of reporting resources and procedures are key to improve the reporting and therefore the whole chain of actions related to the protection of health workers.

[16] Other relevant Security Council resolutions include: 2175 (2014) and 1502 (2003) on the protection of humanitarian personnel, resolutions 1265 (1999), 1296 (2000), 1674 (2006), 1738 (2006), 1894 (2009) and 2222 (2015) on the protection of civilians in armed conflict, resolutions 1539 (2004) and 1612 (2005) relating to the establishment of a monitoring and reporting mechanism on children and armed conflict, and resolution 1998 (2011) on attacks against schools and/or hospitals.

[17] This was also found during the Protection of Health Workers, Patients and Facilities in Times of Violence 2013 Conference, Convened by the Center for Public Health and Human Rights. Johns Hopkins Bloomberg School of Public Health Bellagio, Italy November 2013

Figure 3 - A Palestinian demonstrator is evacuated after inhaling tear gas fired during a protest marking al-Quds Day, (Jerusalem Day), June 8, 2018.

VIOLENCE IN PALESTINE

In general, Gaza is a complex and complicated environment for healthcare staff to work in. Structural challenges such as the lack of drugs, salaries and specialized training abroad challenge the capacity of the health system to respond to the standard needs of the populations. In times of emergency, this situation becomes more blatant. Mr. Michael Lynk, Special Rapporteur on the situation of human rights in the oPt and Mr. Dainius Pūras, Special Rapporteur on the right to health, in this sense stated in June 2018 that the Gaza health system was at a breaking point. When on top of this violence against this sector is also associated, the consequences are very severe.

> PALESTINE IS THE SECOND MOST DANGEROUS PLACE ON EARTH FOR HEALTHCARE

The occupied Palestinian territories come across as one of the most dangerous places in the world when comparing international trends of violence against healthcare structures, personnel and ambulances. Between 2014 and 2016, after Syria, Palestine had the second highest number of attacks on healthcare among countries in emergency situations, with 53 attacks, representing 9% of all the attacks the WHO registered.[18] In 2017 alone, 93 attacks were registered by the Safeguarding Health in Conflict Coalition, conferring Palestine the second most dangerous place on earth for healthcare.[19]

While there are clear statistics on the latest years, safety and right violations incidents against Palestinian health services has been an unfortunate trend that has lasted for decades. The health services in the West Bank are constantly suffering obstacles and attacks. In Gaza, the episodes are usually rare but whenever these episodes happen, they are of very high intensity. To illustrate this, in 2016, 43 separate attacks were registered in the West Bank and none in Gaza; the sort of incidents registered included rubber bullets hits, tear gas, pepper spray and clubs wounding about thirteen emergency and clinic personnel.[20] In the West Bank health services are also regularly affected by access prevention, delays, damaging facilities, the incursion of security forces into facilities and even arresting patients. On the other hand, during the 2014 summer conflict with Israel, 23 healthcare staff members lost their lives and 78 were injured, plus 45 ambulances were damaged or destroyed. Hospitals and other health structures were also damaged, including fatal incidents in which patients were killed.[21]

This year, in the context of the 'Great March of Return' demonstrations held in the Gaza strip, actors from all the international spectre have expressed their concern on the direct and indirect attacks against healthcare structures, personnel and ambulances. From joint UN agencies statements to the Secretary-General of the UN, international human right, health, humanitarian organisations, the international community has largely called for independent investigations on the incidents. The Human Rights Council even approved an independent, international Commission of Inquiry which should provide its report in March 2019.

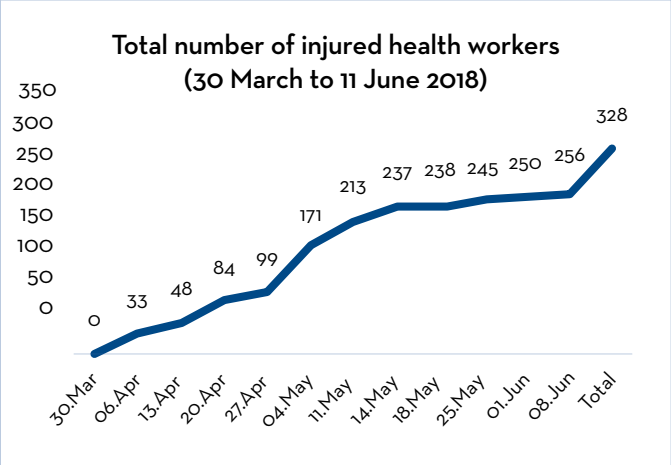

Figure 4 - The total number at the end differs from the last date (8 June) because not all organisations provided on-time reports. Source: WHO, Special Situation Reports oPt, Gaza. (from 20 March 2018 to 4th–11th June 2018) http://www.emro.who.int/pse/palestine-infocus/situation-reports.html

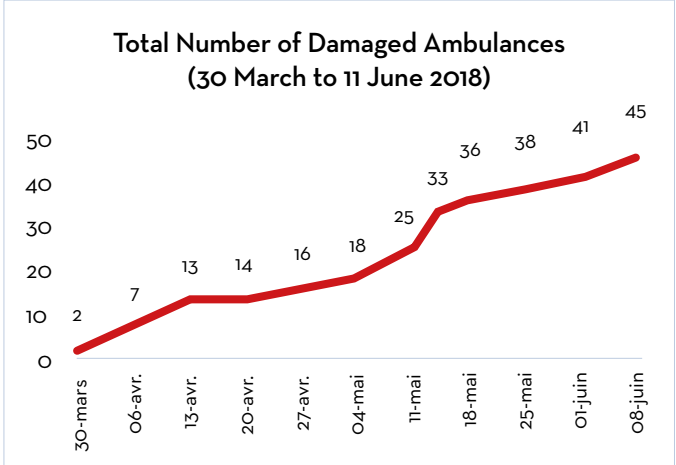

Figure 5 – The damaged ambulances belong to the Palestinian Red Crescent, the government, PMRS and UHWC. Source: WHO, Special Situation Reports oPt, Gaza. (from 20 March 2018 to 4th–11th June 2018) http://www.emro.who.int/pse/palestine-infocus/situation-reports.html

[18] World Health Organization (2016), Report on Attacks on Healthcare in Emergencies. Site: http://www.who.int/hac/techguidance/attacksreport.pdf, p.4
[19] Safeguarding health in conflict Coalition, Violence in the front line: Attacks on Health Care in 2017, IntraHealth International, Johns Hopkins Bloomberg School of Public Health, 2018.
[20] WHO (2016). Right to health: Crossing barriers to Access health in the occupied Palestinian territory 2014-2015: https://reliefweb.int/sites/reliefweb.int/files/resources/EMROPUB_2016_EN_19231.pdf
[21] Ibidem.

Figure 6 - MDM staff visits Al-Dorra Paediatrics Hospital in eastern Gaza, right after the 2014 war.

To date, there have been some efforts to report on the diverse incidents happening during these demonstrations. The WHO and MoH compiled weekly situation reports giving special attention to these incidents. During the first weeks, their reports included mostly information from the MoH and the Palestinian Red Crescent Society. Since then, these reports have progressively integrated different actors into their reporting. However, it is not possible to say that all incidents have been fully reported because not all Palestinian NGOs have systematically compiled and shared their concerned incident reports, and some actors have remained out of the spotlight such as the civil defence services, private hospitals and volunteers from community-based organisations (CBO).

Particularly in volatile contexts characterised by a massive number of casualties, it is difficult to ensure an exhaustive and highly detailed reporting. Nonetheless, the first reports show a staggering increase in the number of incidents throughout the weeks. After the first couple of weeks, reports state that a total of 48 healthcare staff plus five ambulances were affected by different incidents in the span of one week.[22] After 10 weeks, the number increased to 328 cases of healthcare injuries, two deaths and 45 ambulances damaged. The causes of the staggering increase of incidents are both the intensification of violence and the number of organisations participating to the reporting system.

[22] WHO, Special Situation Report oPt, Gaza – 6th-9th April 2018. WHO-Health Cluster http://www.emro.who.int/images/stories/palestine/documents/WHO-Special-Situation-Report-on-_Gaza-6th_April_2018.pdf?ua=1 http://www.emro.who.int/images/stories/palestine/documents/WHO-Special-Situation-Report-on-_Gaza-6th_April_2018.pdf?ua=1 ; Palestinian Ministry of Health, The Most important statistics of current events - 7:00 PM - 13.04.2018, MoH-PHIC.

VIOLENCE AGAINST PALESTINIAN NGOs DURING THE GREAT MARCH OF RETURN

With the intention of bringing a new layer of analysis in terms of the Palestinian health sector and the implications the recent violence had on the overall sector, MDM decided to approach the Palestinian NGOs working on health. The idea was to provide some initial analytical elements to cover the gap concerning the current reporting system in Palestine and to provide the spotlight to these actors who have played a key role in the response to the thousands of injured Palestinians. For this, MDM prepared three different surveys intending to cover three key questions: Did the NGOs suffer any problems in terms of access; what safety measures were available for the personnel working in the field and what kind of incidents affected the NGOs.

METHODOLOGY

The field research required for this report was undertaken by MDM together with PNGO in the Gaza strip in 2018, covering the weekly demonstrations between 30 March and 15 May. A total of 45 surveys were distributed in English and Arabic to senior staff, employees and volunteers of the main Palestinian NGOs actively working in the field, namely: Palestinian Medical Relief Society (PMRS), Union of Health Workers Committee (UHWC), Union of Health Care Committees (UHCC), Public Aid Society (PAS), and the El Wafa Medical Rehabilitation and Specialized Surgery Hospital. As stated previously, these surveys intended to collect information on three main issues: Humanitarian access, safety measures and incident reporting.

The first survey, distributed exclusively to a single senior staff per Palestinian health NGO in Gaza, allowed to map the sort of activities each of them undertook and assess the access constraints these organisations had throughout the period. This survey also allowed to obtain a preliminary number of the total number of attacks against NGO health workers during the surveyed period.

The second and third surveys were distributed simultaneously to 40 randomly-chosen NGO health workers, with the intention of covering the diversity of positions, age, work experience, location, and incidents among the NGO health workers.

The second survey focused on understanding the perception of safety from the field's perspective. It had the challenge to measure the subjective perception of safety, while also depicting the basic safety measures followed by healthcare workers and institutions. Safety is usually assessed and analysed using context-adapted risk assessment tools and risk management strategies; though, when surveying individuals' perception of safety, it is important to be aware of the subjective component of each answer. In other words, it is not possible to directly compare the perception answers between each responder because of the specific individual interpretation and analysis of risk during an individual specific context. Elements such as training and experience do play a role in modifying a person's safety perception. This challenge was therefore tackled by focusing the questions on standard healthcare safety measures such as identification and visibility as healthcare personnel, structure or ambulance and the availability of safety policies.

The third one was designed for collecting specific data on individual violent incidents and give the opportunity to provide analytical trend indicators. These indicators covered the date & location of the incidents, type of incident, classification of the victims of the incident, and the measures taken by the person following the incident. For this survey, the concept of "violent incident" was essential. To avoid any underreporting and reduce confusion as to what the participants should consider as a violent incident, a definition was given during the survey: "[Violent incidents] refer to all kind of events where the physical or emotional integrity of the healthcare staff was threatened or at risk as a result of violence. This includes cases where [the healthcare staff] has not necessarily been injured but was present when the attacks on health structures and ambulances occurred; near-miss situations; or any situation that made [the healthcare staff] feel particularly unsafe."

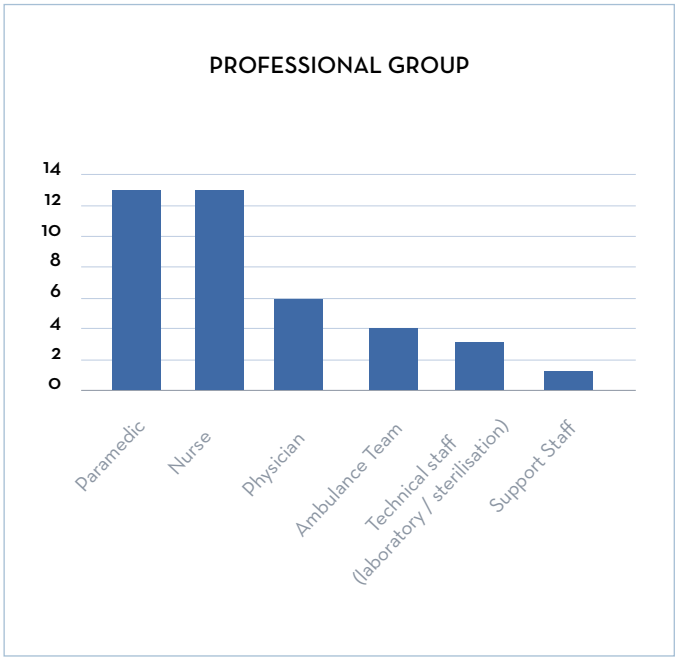

Figure 7 - Professional distribution of health workers who participated in the survey. It is not proportional to the total number of NGO health workers.

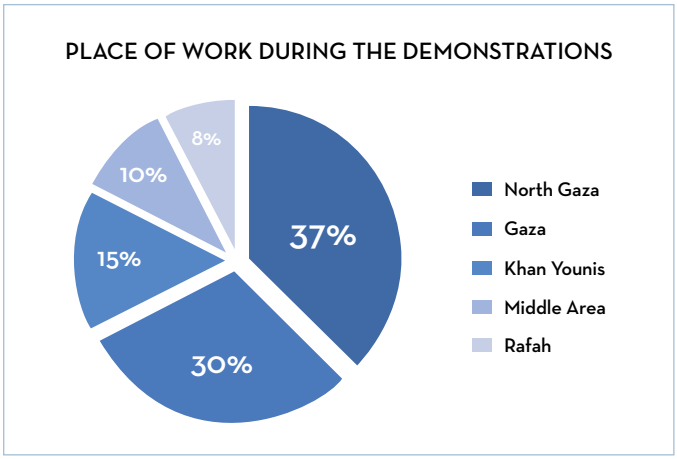

Figure 8 - This chart shows the geographical distribution of the health workers who participated in the survey. It is not proportional to the total number of NGO health workers.

The health workers who participated in the second and third surveys belonged to all staff levels and came from the five regions of the Gaza Strip. The majority of the participants were volunteers (47.5%) and regular staff (45%), only a minority were managers. The random distribution of the surveys also showed that men represented an important majority of the health staff working in the field (77.2%). The average age was 28 years old. In terms of profession, 33% percent of the respondents were paramedics, 33% nurses and 15% physicians. While they had an average experience of 8 years, 15% had only worked for about a year.

The surveys were mostly done face to face and some were done by phone. To ensure the identity protection of the surveyed population, names have been withheld or replaced by initials (which are not necessarily the interviewee's actual initials); and all testimonies have been validated by the interviewee.

UNDERSTANDING ACCESS, SAFETY AND SAFETY INCIDENTS WITHIN THE NGO HEALTH COMMUNITY IN GAZA

ACCESS

Between 30 March and 15 May health services were provided to the thousands of demonstrators protesting along the Gaza border. Among the health actors present directly at the campsites it was possible to identify a vast range of actors ranging from public institutions to private actors. The MoH organised the referral pathway and ensured most stabilisation cases in their five trauma stabilisation points (TSP); in terms of staff, it relocated a good number of its Primary Healthcare Centre (PHCC) emergency room's personnel to the TSP. The Palestinian Red Crescent Society of Gaza also had five tents for first aid and provided the largest number of ambulances, ensuring key referral services. Other actors such as the Military Medical Services, and the Civil Defence also operated through their health services. Palestinian NGOs were a key component of the response to the number of wounded; among them it was possible to find the Palestinian Medical Relief Services (PMRS), the Union of Health Workers Committees (UHWC), Public Aid Society (PAS), Union of Health Care Committees (UHCC), El Wafaa Hospital and the Central Blood Bank Society. Apart from these, the private sector hospitals and community-based organisations were also present. When surveyed NGO senior staff representatives were asked what other health actor was not present and would have been expected to be present, only one mentioned that UNRWA was not present; none of the other surveyed organisations mentioned or wondered about the absence of the international health organisations among the first respondents or in the tent areas.

Out of the 6 respondent organisations who stated having provided first aid with professional doctors and or nurses, two stated not having established a tent along the border area (between 800 and 1000 meters from the fence).

All the Palestinian NGOs participating to the survey have previous experience working in volatile and dangerous environments, as a result of the frequent and consecutive escalations with Israel. However, among them, only three stated they regularly work in the access restricted areas giving them extra knowledge on the kind of terrain, security threats and how to react directly to them. Despite their respective experience, all organisations had several safety incidents affecting their staff, except for Public Aid Society, which did not register any incident. Until the end of May, the above-mentioned organisations stated having a total of 96 incidents.

For instance, PMRS had 62 volunteers working during the demonstrations. They reported having 30 incidents between 30 March and 6 June, out of which 22 were in Khan Younis. Some staff members suffered from several different incidents, mainly from tear gas. Only two of these incidents were severe; both were live ammunition wounds and one of them proved to be fatal. Despite this incident, access was not challenged, limited or reduced for the organisation.

Beyond the survey, MDM also interviewed health volunteers trained in first aid working with some smaller community-based organisations. In terms of access, as individuals working quasi-independently, they stated having no impediments to go and work in the area. Some of them were organised by the Ministry of Health to fulfil standard basic first aid but with no obligation to respond to it or any other centralised structure. Some of these smaller local organisations had no means to provide supervision or the capabilities of ensuring proper training or safety measures, including incident reporting.

SAFETY

Despite the different levels of experience and training among the participants, the survey showed that 95% of the health workers felt that they were working in an environment which was not safe at all. This high number is also surprising considering that some minimum safety measures were available for the majority of the health personnel in the field. 75% stated that their visibility as a health worker was good or excellent, though 13% stated it was very poor; and 75% stated that the structures in which they were working had an excellent use of the distinctive protective emblem (Red Crescent). However, the distance to the danger area was between regular and good, indicating that it was far from ideal.

Figure 9 – A colleague of Palestinian nurse Razan Al-Najjar reacts at a hospital in the southern Gaza Strip.

Out of the 40 respondents, only three stated they had not been a direct/indirect victim or witness of a violent incident concerning healthcare during their 10 weeks of work. However, 50% of them did not have the means to report the incident as a result of the lack of a reporting system at their organisation level, or they were not trained on how to use it. Nevertheless, they all stated their organisations had specific policies (rules and procedures) concerning "health and safety", as well as "physical violence at the workplace". This means that there is an actual gap between policy and implementation.

When asked about the possible recommendations they would give to improve their safety, the participants asked for safety equipment such as bulletproof vests, adequate shoes, helmets, gas-proof masks, and even shields. Nevertheless, some others stated they required more medical supplies. Some of them also recommended to act on specific risks, such as the relocation of the tents to safer places; and fewer of them stated in a desperate manner that no matter what could have been done, they were being targeted.

Among the CBOs, several members had received Basic Life Support (BLS) training including safety measures to be taken during work. However, these CBOs did not always have the means and experience to ensure the minimum protection framework for their volunteers. In the words of one of those volunteers, Eman[23], a volunteer deployed by Afaq, a small CBO in Rafah governorate: "Our biggest challenge in the field was the lack of safety for myself and the demonstrators as well. I also suffered from the lack of guidance and supervision, we were left on our own after deployment."

Figure 10 - Palestinian paramedics evacuate an injured man on the Gaza side of the Israel-Gaza border, as seen from the Israeli side of the border, March 30, 2018. REUTERS/Amir Cohen

[23] Her name was changed to protect her identity.

INCIDENTS

As stated previously, the total number of attacks against healthcare usually underestimated. Nonetheless, the number of reported cases up to June 13 is staggering. There was a total of two health workers killed, 328 injured, out of which 25 with live ammunition, 11 with shrapnel, 18 directly by a gas canister, plus 45 ambulances damaged based on incident cases reported to the MoH and WHO.[24] Compared to global statistics, these figures are extremely high. To put the "Great March of Return in Gaza" attacks in perspective, the Palestinian healthcare personnel suffered more incidents in a single day (14 May) than war-torn countries suffering a humanitarian crisis during a whole year like South Sudan.[25]

The proportion of healthcare personnel affected during the demonstrations was very high. Out of 40 healthcare workers surveyed, 28 stated to have been direct victims and 9 had witnessed or been indirect victims of an attack. The large majority of casualties occurred within the most dangerous area. 35% of the cases registered occurred within the first 100 meters from the fence. Yet, what should be considered as safe areas proved to be also very risky. Five healthcare workers, in at least 4 independent cases, stated that the tent where they had been working was directly affected by tear gas (two health workers referred to the same incident).[26] In Khan Younis, two other health staff said that they had been present during an incident occurring within the larger area surrounding the medical tent, which was at least 700 meters away from the fence. A couple of other cases mentioned that the health staff was inside the ambulance and the tear gas grenades fell next to them.

In terms of kind of injuries, 97% of the cases surveyed were caused by tear gas and only one by live ammunition.[27] Though, in some cases, they were injured when running for safety: one health worker fell and broke his arms when running away from the gas. The health workers were working in teams making them more vulnerable to collective incidents. Quite often, a single gas grenade would fall close to them and at least 6 health workers would be injured.

As previously mentioned, reporting is an important challenge, particularly in terms of precision and exhaustivity. For example, considering that most gas bomb attacks affected several health workers, several reports could refer to the same incident; simultaneously not all witnesses or victims reported each incident, making thus very difficult the task of identifying each particular incident. This situation has consequently also limited the capacity of their organisations to further share with the WHO those incidents and analyse their impact. The incident reporting survey therefore also focused on understanding the reporting trends and challenges.

While in most cases (21 out of 37), the health workers told their line managers about the incident, only 6 filled up a written report. A few cases even acknowledged to have pretended the incident never happened or did absolutely nothing about it. Half of them stated not being aware of the availability of the reporting templates, hence demonstrating the urgent gap. Those that were aware of the need to report often said that they lacked the time to fill the reports or that the place was unsafe to do it. However, there was one answer which raises concerns: one health worker mentioned that he had not been authorized to do it. These latest comments reflect the lack of understanding of the procedures for filling up a report.

Figure 11 – Medical volunteers, equipped with a MDM's Basic Life Support Kit, provide first aid to a demonstrator in Khan Younis.

"Healthcare workers must be allowed to perform their duties without fear of death or injury. The killing of a clearly-identified medical staffer by security forces during a demonstration is particularly reprehensible. It is difficult to see how it squares with Israel's obligation as occupying power to ensure the welfare of the population of Gaza."

oPt Humanitarian Coordinator, Mr. Jamie McGoldrick

[24] WHO, "Situation report – occupied Palestinian territory, Gaza – 4-11 June 2018", June 2018. http://healthclusteropt.org/admin/file_manager/uploads/files/shares/Documents/5b1ecdb440bc9.pdf
[25] Safeguarding health in conflict Coalition. "Violence in the front line: Attacks on Health Care in 2017". IntraHealth International, Johns Hopkins Bloomberg School of Public Health, 2018.
[26] There is one incident which was not possible to confirm if it was the same or different as another previously reported.
[27] The NGOs for which the volunteers and staff work have registered more incidents, so these figures are indicative and not exhaustive.

To further illustrate some of these incidents, two NGO health workers were willing to share their stories:

On Friday, May 11th, M., a UHWC paramedic approached the border in the Middle Area Governorate of Gaza together with other medical teams to assist the injured. The Israeli security forces fired large amounts of tear gas towards the demonstrators and many of them suffered from suffocation.
"We retreated fearing for our lives. While running, I was trying to protect my head by covering it with my hand when suddenly a tear gas bomb hit my head and the hand. I continued to run but could not escape from the gas; I ended up inhaling large amounts of gas and consequently fainted falling to the ground. I only regained my consciousness in the tent, where the crew provided me with the needed medical care. After that, I went home due to extreme fatigue and after a few hours my hands started to hurt badly." He went to the health centre the following day and did an x-ray to his hand, which revealed that his thumb was broken. Despite the pain, he went back to the field the following Friday to provide medical aid."

While most cases were related to tear gas, more than 20 were caused by live ammunition causing in some cases severe long-term consequences:

On Friday, April 7, A., a 25 years old volunteer at the Palestinian Medical Relief Society in Gaza was working with his colleagues in Khuza' area in the Khan Younis governorate. He was assisting a big range of different injuries there when he became a target himself.
"After bringing the first injured to the medical tent run by the ministry of health, we went back to help other wounded people who were close to the fence, that is when we were surprised by heavy gunfire. I was shot in my legs. The bullet penetrated my right leg and came out through my left leg hitting and settling in someone else's leg." PMRS Medics rushed to provide him with aid and tied his legs to stop the bleeding, and then took him to the same medical tent he had been taking injured people to minutes earlier. His condition was very critical due to heavily dissected and damaged arteries. He was then transferred to the European Hospital in Southern Gaza, where he stayed for about 40 days and underwent several surgeries to reconstruct the shattered bones and tissue. Despite several interventions, doctors have stated that he requires to be treated abroad. "I have submitted the necessary paperwork to exit Gaza and get treated in Jordan, but since then I have been endlessly waiting."

THE CONSEQUENCES OF VIOLENCE

The consequences of these attacks ranged from delaying some staff members from working momentarily, as a result of suffocation, to deeply disrupting whole teams, with some of them fainting and having spasm attacks, reducing therefore their response capacity for the day. When the incidents targeted the health tents and tent area, the healthcare staff was asked to evacuate the structures, limiting the response capacity for stabilizing the more serious cases. Moreover, a great number of them expressed systematic psychological stress and fear.

Sometimes it is difficult to measure the consequences of this violence in terms of service interruption and impact on the general provision of health services. The case of Razan Al Najjar, however, allows to illustrate quite clearly the series of -sometimes interlinked- consequences. When Razan, the young PMRS volunteer, was shot and killed, the incident had vast consequences on PMRS activities on the ground. First, it is important to take into consideration the number of people Razan attended herself; PMRS estimates that during the days she volunteered, she helped hundreds of people, up to 900. When she was shot, some of her colleagues were also injured and had to be transported to the hospital. Moreover, the general shock of having one of their staff killed provoked psychological distress among her colleagues on the field and elsewhere. This led some of them to decide on leaving the field. A large number of them suspended their activities and headed to the hospital to mourn her death. Meanwhile, PMRS first responders' services were no longer available in the Khan Younis area for the rest of that day. Through this case, it is possible to observe that the impact of violence was felt punctually during the incident and at the incident area, but it also had greater repercussions at the organisation's level as well as long-term impact on the morale of the healthcare community.

The previous example reinforces the case that beyond the physical impact of a critical incident towards a specific health worker, the same incident can have direct and indirect psychological consequences. In terms of mass psychological consequences, severe incidents trespass the immediate environment; it can affect the whole organization where the health giver works and even the whole health sector. In the Gaza strip, there are projects such as the ICRC's "Helping the helpers", aiming at providing psychological assistance to medical and non-medical staff working in the emergency departments of the Ministry of Health in Gaza. Yet, this sort of projects is not always available for NGO staffs, despite the fact they have been working side-by-side in the field experiencing the same incidents. NGO staff and volunteers should also benefit from an aid package that allows them to ensure both their physical and mental wellbeing, particularly through critical periods. Only when the healthcare staff is physically and mentally supported that they can provide more efficient and safe aid to those who need it most.

CONCLUSIONS

Attacks on healthcare workers, structures and ambulances should never occur: neither in times of peace nor in times of war. They represent serious violations of IHL and IHRL.

Between 30 March and 16 June 2018 healthcare workers, volunteers, ambulances and structures of all health actors in Gaza were victims of intense attacks. These attacks occurred in a context where the health system was challenged to its limits in terms of casualty management while also dealing with a deep structural crisis characterised by the lack of drugs, disposables, salaries and equipment.

Despite the latest efforts, the international community has not been able to ensure proper accountability and protection of healthcare. Even after the reporting period, Israel continued failing its duty to respect and protect healthcare personnel, structures and ambulances, breaching international law.

During the 10 weeks of work covered by this report, between 30 March and end of May, MDM found that the Palestinian NGOs were able to access and work extensively providing essential aid to the injured; however, these NGOs have also been constant victims of the unprecedented levels of violence. This resulted in the unfortunate killing of one of their volunteers, plus dozens of injured health workers and damaged ambulances despite the systematic use of visible identification means. In general, violence hindered their work on the ground and affected the quality of the provided health services due to exhaustion, evacuation and direct injuries.

Beyond the evident physical marks of live ammunition on the bodies of healthcare staff, these attacks and the death of their colleagues have left strong psychological scars. The general consequences in terms of service provision are difficult to quantify or measure beyond the untold stories of the injured or killed because those who were supposed to help were also injured.

Understanding the impact these violent incidents have is key for promoting the protection of healthcare, implementing risk reduction strategies and providing complementary psychological assistance, which are all required for ensuring efficient and safe aid. Even if some Palestinian health NGOs have been progressively improving their reporting system and integrating it to the WHO / national reporting system, not all of them enjoy the same level of access to it or enjoy having standard reporting procedures. The same is applicable in terms of their safety policies, training and practical measures for all their employees and volunteers.

Beyond its medical activities, MDM France in Palestine is engaged in further raising awareness among Palestinian NGOs and CBOs on the importance of improving safety and reducing risks for healthcare personnel.

RECOMMENDATIONS

Considering the IHL and IHRL obligations to which the state of Israel is bound, MDM calls Israel to:

- **Ensure that the Israeli Security Forces (ISF) comply with international human rights standards for law enforcement;**
- **Hold all perpetrators accountable for the unlawful use of force;**
- **Guarantee that all healthcare services and personnel are protected;**
- **Incorporate IHL provisions in the national legal frameworks, including sanctions;**
- **Abide to UN Security Council resolutions calling for the protection and accountability of all attacks against healthcare.**

All actors are encouraged to condemn all attacks against healthcare personnel, structures and ambulances, and to promote awareness on the importance of their protection.

Third-States should ensure:

- They are not indirectly related to these kinds of violations, particularly when selling weapons which are then used to commit them;
- Proper accountability through international institutions such as the International Criminal Court.

Health actors and especially Palestinian health NGOs should:

- Invest themselves in improving safety measures, including:
  - Reviewing safety policies, in line with WHO guidelines and IHL and IHRL regulations
  - Providing safety training
  - Reviewing the incident reporting protocols and tools
  - Fostering impact and risk reduction analysis of incident
  - Providing protection gear for first-responders health workers
- Work together to develop a series of minimum standard policies on safety, which could include a standard incident report system and create a common space for trend analysis and share best practices;
- Continue strengthening their public awareness and advocacy activities through collaborative efforts.

Finally, the Palestinian authorities should:

- Continue enhancing the available national surveillance system, in line with international standards;
- Further integrate smaller organisations, such as the CBOs, to the surveillance system and provide them with the essential safety training, tools and protocols;
- Encourage research and impact analysis at national level.

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