Trapped in Gaza: Health of Palestinians under Israeli military occupation

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Background:

The Gaza Strip is a roughly rectangular coastal enclave on the eastern shores of the Mediterranean Sea, bordered by the State of Israel on the North and the East and Egypt in the South. It encompasses a total area of approximately 360 square kilometers, where some 1.7 million Palestinians live. This makes it one of the most densely populated areas in the world. The demography of the Gaza Strip is characterized by its young and rapidly growing population.

The Gaza Strip is an artificial geopolitical entity that came into existence only after the 1948 Arab-Israel war which brought about the establishment of the State of Israel and the forceful dispersal of more than three fourths of indigenous Palestinians from their villages and towns into the neighboring Arab countries, and in the parts of Palestine which were not captured by Israel during the war. The population of the Gaza Strip tripled as a result of the influx of 250,000 Palestinian refugees who were forcibly ejected into the costal enclave. After the 1948 war, Gaza was put under the Egyptian military administration, till the time when Israel occupied the strip in June 1967.

Population Health Status in Gaza

The population in Gaza, like Palestinians elsewhere, has been going through a rapid epidemiologic transition, whereby chronic Non-communicable diseases (NCDs) have surpassed infectious communicable diseases in terms of effects on mortality and morbidity.

While the Israeli 22 days military operation on the Gaza Strip - the Cast Lead Operation (CLO22) - has made accidents and firearms a leading cause of mortality with a proportion of 23.5% of total mortality in 2009, most causes of deaths are attributed to NCDs. 16.1% of the adult population in the Gaza strip, have reported having at least one of the NCDs in 2010 -- an increase from 9.3% in 2000.
Most vaccine-preventable diseases are well under control; however, other communicable diseases especially those associated with poor environmental health conditions are still endemic; and those diseases that are associated with overcrowding continue to cause a proportion of the reported morbidities. Conventional health indicators, such as life expectancy and Maternal and childhood mortality rates are comparable with regional indicators; but some indicators such as infant mortality rate has stagnated during the last few years (and reversed to some extent ) in contrast to improvements observed during the last decades. (See figures 1 and 2).

**Figure 1:** Average Percentage of Annual Reduction in IMR in the Gaza Strip (1970-2009)

![Average percentage of annual reduction of IMR in Gaza Strip](image)

**Figure 2:** Number of Infant deaths per 1000 live births between 1970 and 2009 in Gaza Strip

![Number of Infant deaths per 1000 live births between 1970 and 2009 in Gaza Strip](image)
Determinants of Health

One of the important determinants of population health in the Gaza Strip is the unprecedented increase in unemployment and poverty. This widespread social and economic deprivation is a direct result of the Israeli policies and practices of separating and isolating Gaza, especially since 2000. This situation has led to a relative increase in the incidence of diseases of poverty and poor nutrition, and has influenced the pattern of utilization of health care services (toward using free of charge health services regardless of quality of care in a situation where the local Palestinian Authority struggles to provide free of charge services). The prevalence of anemia is high – affecting more than half (57.5%) of children (6-36 months), and 44.9% of pregnant women. Stunting among under five children is also high -- increasing from 8.3% in 2000 to 9.9% in 2010.

Figure 3: Prevalence of Underweight among children in Palestine

![Figure 3: Prevalence of Underweight among children in Palestine](image)

* Preliminary, unpublished data

Source: Palestinian Central Bureau of Statistics, 2011

The other prominent aspect of the current health situation in the Gaza Strip is directly related to the proliferation of violence as a consequence of the continuing occupation of the region. As a result of this violence 3,003 were killed in the Gaza Strip by the Israeli army from 28th of September 2000 till 27th of December 2008 (the beginning of CLO22). The Closed Lead Operation in December 2008, over a period of 22 days,

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resulted in death of 1,390 people and injuries to 5,380 people. Its aftermath had diverse devastating effects – extensive resultant disabilities and health effects related to insecurity. Since then, Israeli attacks on Gaza have averaged 6 per week between mid-January 2009 and the end of October, 2012 and have resulted in the death of 283 Palestinians. The most recent 8-days onslaught on Gaza resulted in 182 Palestinian fatalities, 47 (26%) of whom were children. In addition 1399 more were injured, 37% (516) of whom were children.

The cycle of violence in the region is not entirely limited to those related to violence by Israeli forces. There are also occurrences of violence between different Palestinian groups. It is instructive to recall, in this context, Franz Fanon’s contention that chronic violation turns into internal violence².

**Post-traumatic stress disorders** (PTSD) and other psychological and behavioral problems are widespread among the population, especially among children and youth. This is a direct consequence of having to live entire lives in a situation of insecurity, exposed regularly to extreme violence. Children in Gaza, who are highly exposed to traumatic events, experience behavioral problems, negative emotions, speech and sleeping difficulty, nocturnal enuresis, and other behavioral problems at home and school. It is important, while studying the impacts of war and conflicts on the health and wellbeing of the population to be cognizant of the profound impact on health, of human insecurity. Self reported Quality of life in the occupied Palestinian territory is reported to be lower than that in almost all other countries. Furthermore, most responders report high levels of fear; threats to personal safety, safety of their families, and their ability to support their families; loss of incomes, homes, and land; and fear about their future and the future of their families³. Health related quality of life was severely impaired among pre-school children in the Gaza strip even before the CLO22. There is a significant associations between low health related quality of life and the occupation related violence in the entire population. 44.7% of Gazans reported a high level of human insecurity 6 months after the CLO22⁴.

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² Hospitals in Gaza struggling after factional fighting, The Lancet, **Volume 369, Issue 9580**, Pages 2147 - 2148, 30 June 2007
Another determinant of the population’s health in Gaza, which is usually overlooked, relates to conditions of housing and habitation — the patterns of settlement and extremely poor housing conditions.

The deterioration of water quality and poor sanitation also impact on the conditions of health in the region. The sea water around is polluted by raw sewage that is dumped into the Mediterranean Sea, as the import of materials to build sewage treatment plants has been restricted for years by the Israeli occupying forces. Salinity levels in fresh water is beyond the WHO’s standards for safe drinking water, and the availability of safe drinking water is limited for most Gazans, with an average consumption well below the global WHO standard of 100 liters per person per day. The principal underground source of fresh water in Gaza, could become unusable as early as 2016, with a possible irreversible damage by 2020.5

**Health System in Gaza**

Resources for the health system, mechanisms of interactions between different stakeholders in the overall health system, and the outcomes of the health care system have been shaped by the historical development in Palestine — in particular the unfolding of the occupation of Palestinian territories. The health care system in Gaza has acquired certain characteristics which developed in a response to the different (political, social, and demographic) developments, thus leaving little space for planned development.

Prior to the 1948 Nakba, there were one missionary hospital in the Gaza Strip — the Baptist hospital which is known now as Ahli Arab hospital - and one government hospital in addition to some government clinics. The 1948 Nakba led the United Nations ( UN) to establish the UN Relief and Work Agency for Palestine Refugees in the Near East (UNRWA) in November 1949. The health program of the UNRWA commenced its operations in May 1950, and since then, UNRWA has become one of the major components of the health care delivery system in the oPt (occupied Palestinian territory) and the most prominent provider of Primary Health Care (PHC) services in the Gaza Strip.

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From 1948 to 1967, the Gaza Strip was under the control of the Egyptian military. There were two distinct periods of the Egyptian administration of the Gaza Strip. The first was from 1948 till 1956, which was followed by a brief period of Israeli occupation of the Gaza strip (from October 1956 to March 1957) during the Suez Crisis. The second phase stretched between March 1957 and 1967. The second period was characterized by an increased Egyptian attention toward Gaza, which resulted in improvement of curative health services and increased number of Palestinian medical students in Egyptian universities.

Between 1967 and 1994, the health services in the Gaza Strip were neglected and starved of funds by the Israeli military administration, resulting in shortages of staff, hospital beds, and essential and specialized service. This resulted in the health care system in Gaza coming to depend heavily on health services provided in Israeli hospitals. The local Palestinian response to this neglect and dependency was the creation of some local (Palestinian) alternatives since the early seventies. Some of these alternatives were the Red Crescent Society in Gaza Strip which was led by Dr. Haider Abdel Shafi, the Central Blood Bank Society, and the popular health committee which were started on the eve of 1987 intifada and have now become the nucleus of the current Non-governmental Organizations (NGOs) sector in health care.

The Palestinian Ministry of Health (MoH), which was established after the Oslo Accords with the establishment of the Palestinian National Authority (PNA) in May 1994, inherited a debilitated health system from the Israeli. Supported by massive external assistance, the MoH was able to upgrade and expand its network of health services, increase the percentage of coverage in the Government Health Insurance scheme (GHI) administered by it from 20% of the households in 1993 to a peak of 52% in 1999, increase the health workforce in its facilities, and introduce technical improvements.

The second Intifada in September 2000 changed the entire orientation of the health system in the oPt into one that needed to address an emergency situation. The Ministry of Health converted 3 Primary Health Care (PHC) centers into emergency care hospitals, the health system was geared for the treatment of victims of the Intifada, and hospitals and health facilities were forced to deal with a sudden influx of patients who were victims of the violence. The Israeli administration responded to the Intifada
by severely restricting the movement of people in the Gaza strip, thus posing another layer of challenge to the health system, especially when required to deal with those who were severely injured or very sick. Action by the Israeli administration also severely restricted the access of the region to the rest of the world, thus compromising access to humanitarian medical aid.

The destabilization of the health system described above and the restrictions imposed upon it continue till today as abiding features of the health system in the region. It has continued to be so through periods that encompass the nominal Israeli disengagement from Gaza in 2005, Hamas’s electoral victory of 2006 and its military takeover in 2007.

**Fragmented Services**

The history of the development of the health system in Gaza explains the extreme fragmentation of health care services. Four different components of the health care delivery system can be identified which play a role in providing health care services. The government health care services are provided by the MoH and by the Police Medical Services – PMS (provides curative services to employees of the Police and their families). The Ministry of Health runs the largest network of facilities, accounting for about 71% of hospitals beds and 54 PHC centers. The NGOs sub-sector is composed of a smorgasbord of organizations and charities with different backgrounds, histories, styles, affiliations, volume of activities, sources of funding, size and interests. The UNRWA offers perhaps the most complete network of PHC services in Gaza, in terms of the range of services offered and the volume of utilization. In 2011 physicians working with the UNRWA recorded 104 consultations per day. Private for Profit Providers (PFPP) are inadequately regulated and account for a considerable proportion of out of pocket payments on health care in the region. In spite of multiple systems of providers, the quality of care is of a fairly high standard.
### Table 1. Health Resources availability by sector in Gaza Strip (PFPP sector is not included).

<table>
<thead>
<tr>
<th>Sector</th>
<th>PHC centers</th>
<th>Hospitals</th>
<th>Beds</th>
<th>Physicians</th>
<th>Dentist</th>
<th>Nurse-Midwife</th>
<th>Nurse/Physician Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>MoH</td>
<td>54</td>
<td>13</td>
<td>1968</td>
<td>1764</td>
<td>124</td>
<td>2508</td>
<td>1.42</td>
</tr>
<tr>
<td>PMS</td>
<td>-</td>
<td>3</td>
<td>177</td>
<td>144</td>
<td>24</td>
<td>141</td>
<td>0.98</td>
</tr>
<tr>
<td>UNRWA</td>
<td>22</td>
<td>-</td>
<td>-</td>
<td>172</td>
<td>31</td>
<td>351</td>
<td>2.04</td>
</tr>
<tr>
<td>NGOs</td>
<td>74</td>
<td>14</td>
<td>636</td>
<td>187</td>
<td>62</td>
<td>300</td>
<td>1.60</td>
</tr>
<tr>
<td>Total</td>
<td>150</td>
<td>30</td>
<td>2781</td>
<td>2267</td>
<td>241</td>
<td>3300</td>
<td>1.46</td>
</tr>
<tr>
<td>Proportion per 10000 of people</td>
<td>16.4</td>
<td>13.3</td>
<td>19.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Vaccination and antenatal care coverage is high, as is the rate of institutional deliveries. A remarkable feature of health services in the Gaza strip is its extensive reach and relatively high quality, given the conditions under which they operate. However, there are repeated disruptions that the system faces during periods of military operations by the occupying forces. Residents in the region face restrictions when they require to access specialized services from facilities outside the region. Moreover, access to health services is a challenge for 25% of households who are not enrolled in the MoH administered GHI scheme. Data on health care seeking behaviors shows considerable level of utilization of multiple providers, simultaneous utilization of more than one component of the health care delivery system for the same health condition, and overuse of health services in many instances. These are clearly functions of an extremely fragmented health care delivery system.

**Human resources**

The first medical college was set up within the occupied Palestine territories after 2000. As a result most physicians working in the region are graduates of foreign universities (from more than 120 countries around the world!). Thus, medical professionals in the Gaza Strip have variable clinical skills and expertise, with no real way in which these skills can be harmonized. The variability of skills and training poses a challenge for licensing procedures for physicians, which are followed in the region.

Overall, going just by numbers, doctor-patient ratio in the region is high and there is actually a surplus of pharmacists and laboratory technicians. There is, however, a shortage of specialists in some categories as well as a shortage of nurses and midwives. There are restriction on the movement of health personnel between Gaza
and West Bank, including East Jerusalem. This adversely affects training of medical students and other health personnel as the main teaching hospitals are located in East Jerusalem.

**Access to Medicines**

Gaza has only one small local pharmaceutical manufacturer. Consequently the pharmaceutical sector in Gaza is almost totally dependent on the global, Israeli, and Palestinian pharmaceutical industry in the West Bank. With Gaza converted into a ‘hermetic ghetto’ severe shortages of medicines were seen between 2007 and 2010. This situation has led to dependence on drugs procured from Egypt through underground tunnels. The uncertain and clandestine nature of such importation is associated with poor storage facilities during transportation, thus impacting on the quality of medicines imported.

The uncertain nature of supplies causes frequent shortages -- the Gaza MoH central pharmacy regularly reports that a number of medicines in its essential drugs list remain unavailable for extended periods. The chronic shortage of drugs and disposables, which has been reported in Gaza since 2007, are also caused by political divisions between the two rival health authorities (in Gaza and the West Bank) and by the blockade on Gaza.

**Health Information**

Health information systems of varying sophistication and methodologies are linked to different groups of providers. The official source of data in the oPt is the MoH and the Palestinian Central Bureau of Statistics (PCBS). The PCBS, which is based in Ramallah, faced serious difficulties and obstacles in carrying out the census in 2007 and other surveys during the first years of the internal rift (between Gaza and the West Bank). It is now operational in the Gaza strip. Similarly, the availability of the MoH data and its analysis were affected by the political split as the Gaza based MoH has been unable to produce and disseminate health data from 2007 till the end of 2011.
Financing of Health Care

The health care financing system in Gaza is highly fragmented. There are multiple sources of finance, including tax revenues of the PNA, external assistance to the health sector which are sourced by all providers, and out of pocket payments which are collected variably by all providers except those under the UNRWA.

The customer taxation revenues, which are collected by the Israeli authorities on behalf of the PNA on the point of entry of imported materials and commodities, have become a source of political and financial pressure on the PNA as delays and suspensions in the transfer of these funds have become very frequent after September 2000. Fund transfers are critically dependant on political developments in the oPt. Similarly, the health care system in general has become highly dependent on external donor assistance. UNRWA is totally dependent on international donor contributions. NGOs too receive substantial external donor assistance for their projects and programs. The MoH is dependant on budgetary support from the PNA. After Hamas’s electoral victory in 2006, and its subsequent military takeover of the region, international donors have suspended a large proportion of their assistance to the PNA.

The uncertainty in the flow financial resources and the fragmentation of health care delivery systems combine to create a situation where, on one hand, health services are often inadequately funded, and on the other hand, there are unnecessary wastages because of duplication of functions and inefficiencies built into the fragmented system.

The UNRWA has decreased its budget since 2010, further compounding the strain on health services in the region, as it is the only agency that provides services that are entirely free. The MoH in Gaza charges nominal fees for diagnostic tests and drugs obtained from its outpatient services. NGOs charge varying levels of user fees while PFPPs charge for all services. The proportion of households which experienced Catastrophic Health Expenditure in the oPt increased from 1.16% in 1998 to 2.15% in 2007. It is further reported that households in Gaza spent 2.9% of their total expenditure in 2010 on medical care.
**Governance of the health sector**

The region is characterized by an absence of sovereign control over borders, sea water and airspace, water resources and the environment. Movements of people and goods between the Gaza Strip and the West Bank and within the latter are restricted. The Israeli administration controls birth and death registries. They also have control over import taxation revenues. The absence of sovereign control over almost all aspects of governance and civic amenities and rights has created a situation where the governance of the health sector in the oPt is crucially influenced by the continuing Israeli military occupation. This continues to be the hallmark of the governance of health services even after the inception of the Palestinian National Authority (PNA) after the Oslo accord and the transfer of government health services and responsibilities to the Palestinian Ministry of Health in 1994.

The health sector in Gaza is under the direct control of Gaza MoH. Governance of the health sector in Gaza has become more complex and complicated in the aftermath of the internal rift in Palestine. Presently, the two rival Palestinian Ministries of Health (in Gaza and the West Bank), health providers, donors and UN agencies, and formal and informal decision making centers, form different parts of the process of governance with little accountability to the people of Palestine.

The Ramallah based PNA continues to finance the Gaza MoH for supply of drugs, salaries of about half of the health workforce, and the costs of outsourced services. However relations between the Ministries of Health based in Gaza and West Bank respectively are often marked with acrimony. Tensions between the two relate to issues such as sharing responsibility for inadequate supply of drugs to Gaza, appointments and administration actions, etc.

UNRWA is a prominent provider of health services, especially primary care. It is engaged in providing services linked to some national health programs of the MoH, such as immunization and maternal and child health. UNRWA recruit most of its personnel in line with the Ministry’s licensing procedures. However, its facilities, unlike the facilities run by NGOs are not monitored or licensed by the Ministry.
Historically, even before the political split in Palestine the oversight functions of the MoH was never fully realized given the urgent need for the health system to address the emergency situation associated with escalation of military conflict in the region. The lack of sovereign control over key areas critical to any health system, which we describe earlier, has also been a major impediment for the MoH. As a consequence the MoH has been able to make little progress in areas such as setting standards of care, implementation of regulations, and coherent expansion of the network of health care facilities in order to address major gaps in the health system inherited from the Israeli administration.

The freezing of the external budget support in 2006, the health sector strikes in 2007 and 2008, the extensive effects of the Israeli siege on Gaza, and the Israeli CLO22 have all destabilised government health services. As a result the MoH in Gaza has been engaged in running health services which are perpetually on the verge of collapse, without being able to regulate existing services and plan ahead for expansion. The MoH has been able to make some progress in establishing its oversight functions after the end of the CLO22 and the easing of the siege in June 2010. It has been able to overcome, also, the organisational slump that resulted from the strikes in the health sector strike. It has also started enforcing existing regulations, such as the licensing of pharmaceutical outlets and some professional practices.

While recruitment of health professionals to join the workforce of the MoH is not very linked neither to loyalty nor to patronage. But with multiple and multiplying directorates, departments and units over time in the Gaza MoH, managerial positions are subject to competence, performance, some patronage, and certainly political loyalty; however, the managerial positions seem to be in a permanent state of flux with a shift to a younger generation of managers and rotation among them.

The multiplicity of services providers had made coordination between them difficult. Issues of concern include the duplication of services by multiple providers and a lack of coherence in funding by external donors, where they can end up funding multiple care providers for similar functions. Participation of different stakeholders in the decision making process is arbitrarily decided upon and Palestinian NGOs continue to seek avenues by which they can be included in such processes. Coordination among
different stakeholders in the Palestinian health system in Gaza, is neither optimal nor a regular feature and there is no overarching framework for coordination.

**Conclusion: Into the Mediterranean Sea?**

We have seen how the current conditions of health and health care in Gaza have largely been shaped by the continuing economic deprivation in the region – which is a result of its occupation by Israel and the military violence that is periodically unleashed by the occupying forces. The current Palestinian health care system in Gaza has not emerged from a vacuum, but is shaped by the country’s history and politics. Over the years the health system has acquired resilient features that are constantly required to struggle against its decay.

The purported Israeli unilateral disengagement from Gaza Strip in 2005 did not put an end to Israeli occupation of Gaza. It was, in fact, the beginning of a new era in which the Israeli authorities have developed new strategies to deal with the people of Gaza. Israel is able to impose its will and can control Gaza by subjecting it to repeated military attacks and economic blockades without having its military forces on the ground. In a manner of speaking, the disengagement marks the beginning of a strategy designed to sink the Gaza strip – along with the hopes and aspirations of the people living in the region -- into the Mediterranean Sea, without finding a just solution to the Palestinian question.

During the past two decades the health sector was dependent on external aid, which provided support to build new health facilities, procure equipment and drugs, train the health workforce, and promote medical interventions. However, this aid did not result in a strengthening of the performance of the health system. Although the Israeli military occupation is mainly responsible for the deterioration of health and humanitarian conditions in Gaza, Palestinians too need to take some responsibility for the distortions of their health system. They too have contributed to its present state through internal rifts and mismanagement.

The main obstacle to the establishment of a robust and effective health system in Palestine continues to be the Israeli occupation of Palestinian territories and in the case of Gaza, its isolation from the rest of the world and even from other Palestinian
territories. Moreover, the occupation has a direct effect in displacing people from their homes, and 70% of the population in Gaza is refugees.

The health situation in the Gaza Strip cannot be improved without a political solution that guarantees the dismantling of the Israeli military occupation, the securing of geographic connectivity between Gaza Strip and the West Bank, and a just solution to the refugee question. While a political solution still appears a distant possibility, in the interim it is necessary that the international community support the Palestinian people in their efforts to strengthen the capacities of their health care system and improve all determinants of health including those linked to poverty, nutrition, housing, and access to natural resources.

Finally, it needs to be underlined that as long as Israel continues to be an occupying force in Palestine, it should be mandated to respect The Fourth Geneva Convention (1949) which contains specific provisions pertaining to the delivery of healthcare services in occupied territories. Clearly, Israel stands in complete violation of various Articles of the Convention, including the following:

Article 55 states: “To the fullest extent of the means available to it, the Occupying Power has the duty of ensuring the food and medical supplies of the population; it should, in particular, bring in the necessary foodstuffs, medical stores and other articles if the resources of the occupied territories are inadequate”.

Article 56 states: “To the fullest extent of the means available to it, the Occupying Power has the duty of ensuring and maintaining, with the cooperation of national and local authorities, the medical and hospital establishment and services, public health and hygiene in the occupied territory with particular reference to the adoption and application of the prophylactic and preventive measures necessary to combat the spread of contagious diseases and epidemics. Medical personnel of all categories shall be allowed to carry out their duties”
Testimonies:

“They can attack our bodies but not our strength”

Those who were injured during Israel’s offensive on the Gaza Strip between 27 December 2008 and 18 January 2009 are in need of long term rehabilitation. They continue to struggle in the face of medical shortages. Yahia Abu Saif is one of them. He was severely injured in an Israeli airstrike on 1 January 2009.

“I was praying in the mosque that afternoon. When I was on my way out, a bomb hit us. 20 days later I woke up from a coma in Shifa hospital, in Gaza City. My right leg was gone. After 10 days I was transferred to al Wafa rehabilitation center where I stayed for 6 months. I also received medical treatment in Egypt for a few days. I was supposed to be transferred to a hospital in the West Bank or Israel but I was too afraid to go there, having to pass by the army in the border.”

“I have a shrapnel in my head which has affected the left side of my body. It is very difficult for me to use my left hand, even after a lot of therapy, so I cannot move around in a normal wheelchair. I need an electric one.” Yahia’s normal wheelchair is broken beyond repair and the electric wheelchair doesn’t function either at the moment. Says a care provider: “We can’t find the required spare parts to fix the electric wheelchair. So then the only solution is to try and find another wheelchair, but there aren’t any.”

Until now Yahia receives physiotherapy from several medical NGOs in the Gaza Strip. One of these NGOs is the Palestinian Medical Relief Society (PMRS) which provides him with psychosocial support, physiotherapy, technical support and other follow up. Bassam Zaqout, PMRS’s Project Coordinator, underlines the problems caused by the blockade: “We face many difficulties in our work. For example, we lack spare parts for machines and devices because they cannot be imported. Usually there is a refusal or a delay in the approval for the supplies that we want to import. It is also difficult to bring wheelchairs into Gaza. Electric wheelchairs especially take a very long time to be imported.”
Because he has no functioning electric wheelchair Yahia is mostly bound to his family house in Jabaliya. He spends his days sitting and chatting with friends, going to the mosque, and doing his rehabilitation exercises.

Yahia had just started his first year as a student in Al Quds Open University when he got injured. He was studying in the Education Department, aspiring to become a teacher. His disability has not deterred Yahia in pursuing his dreams. “Life doesn’t stop because of a disability. In the new year I will go back to the university. I will join the Education Department again but I don’t know in which field, probably Sharia’ Law or Islamic religion. I am very happy to continue my education.”

Yahia has a clear idea of what he wants and hopes for in the future. “First I want to finish my studies, so that I have a basis for the future. After that I hope to get married and have a family. Just like everyone else, I want to live a normal life, just live my life.”

The destructive 2008-2009 offensive left permanent marks on the lives of people in the Gaza Strip. Despite his trauma, Yahia is confident that his spirit cannot be broken by war and violence. “In the war they tried to kill us and destroy our lives. They can attack our bodies but not our strength. We lost many things in our life but not our strength.”

The targeting and severe injuring or killing of a civilian, a protected person, is a war crime, as codified in Article 147 of the Fourth Geneva Convention and Articles 8(2)(a)(i) and (iii) Article 8 (2)(b)(i) of the Rome Statute of the International Criminal Court.

The ongoing blockade of the Gaza Strip constitutes a form of collective punishment meted out to the civilian population living under occupation, which is in contravention of Article 33 of the Fourth Geneva Convention.
The life of two years-old Leen Raed Hassan, a cancer patient from Al-Bureij refugee camp in central Gaza Strip, was endangered as her treatment in an Israeli hospital was suspended for financial and political reasons.

Suffering from kidney cancer, Leen comes from a low-income six-member family. Her father is an employee of the Palestinian Authority and her mother is a housewife. Leen's mother said her baby girl was diagnosed with the disease seven months ago. "Leen suffered high recurrent fever that kept getting worse. She was seen by a number of doctors but no one could tell what's wrong. Her situation got worse and she got abdominal swelling," said the mother.

A doctor in Bureij then recommended an ultrasound test, which showed the girl had a mass growing on her kidneys. Leen and a member of her family had to await an Israeli approval to seek treatment in an Israeli hospital. On May 15, 2012, Leen was transferred to Kaplan Hospital in the Israeli city of Rehovot for chemo and radiotherapy, which were not available in the Gaza Strip due to the six-year blockade Israel imposed on the territory. Palestinian medical officials complained that Gaza’s hospitals lacked medications and medical disposables because of the Israeli blockade as well as internal political and financial reasons.

Leen stayed in the hospital for six and a half months accompanied by her mother for some time, or by her father and grandmother. During this period, Leen received Chemotherapy and Radiotherapy but it was not successful. Doctors informed her mother that the only way was to remove the child’s kidney (nephrectomy). Leen’s mother said: "we agreed after doctors assured us that the operation would succeed and that it is necessary. At this point, doctors stopped the chemotherapy in preparation for the operation. This was around the period of holidays in Israel".

When the doctors came back, Leen’s mother noticed that the hospital administration was procrastinating and was not giving her a clear answer when she asked about the time and date of the operation.
Instead Leen’s mother got a surprising instruction from the hospital staff on a cold night. She was told to be prepared to take her daughter and leave the hospital.

She was terrified at the prospect of having to leave with her dying daughter on such a cold night and at such an odd hour. She did not know how she could secure transportation to the Erez crossing (Erez is the check point separating Gaza strip from Israel). Transportation from the Israeli city of Rohovot to Erez takes about an hour, and it is only open from 7:00 am to 7:00 pm.

She finally begged the hospital staff that she be allowed to spend the night in the hospital. A nurse who intervened to help had to pay 800 NIS (about 215 US dollars) for that extra night. When Leen’s mother asked about the reasons for this decision, she was told that there had been no financial coverage for Leen’s treatment from the Palestinian Ministry of Health. The hospital required 60,000 NIS (around 16,000 US dollars) for medical services they provided for Leen and another 100,000 (around 27,000 US dollars) shekels should the girl be re-admitted for surgery to remove the kidney.

After returning back to Gaza, Leen’s family was able to secure the 160,000 NIS (around 53,000 US dollars), through the Palestinian Authority, but they were shocked to learn that the hospital is now requesting for 500,000 NIS (around 135,000 US dollars) to secure expenses of Leen’s treatment after the operation.

Leen is now at her home, in Al-Bureij camp, receiving no treatment with no hope of recovery unless the operation is done.