BREAST CANCER IN THE GAZA STRIP:
THE IMPACT OF THE MEDICAL PERMIT REGIME ON PUBLIC HEALTH

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Abstract

For the last 14 years, the Gaza Strip has been subject to an illegal blockade imposed by the Israeli and Egyptian governments. This severe restriction on movement prevents Gazans from accessing critical resources and makes access to health care, even for the most severely ill patients, contingent on a convoluted permit system run by the Israeli military. Consequences of the permit system include major delays in treatment and adverse health outcomes. My thesis explores the impact of the permit system on health outcomes for breast cancer patients in Gaza and offers recommendations for improving public health via community-based and political initiatives.

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I would like to thank my thesis advisor, Dr. Norbert Goldfield, for his wisdom, guidance, and support throughout this challenging process. Dr. Goldfield is not affiliated with Georgetown and juggles an extremely demanding workload as a practicing internist and executive director of Healing Across the Divides, an organization which seeks to promote peace-building through health in the Israeli-Palestinian conflict. Nevertheless, he still took the time out of his busy schedule to help me shape my research plan and connect me with valuable resources.

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Introduction

Effective health care management is difficult to achieve for many of the most developed nations in the world. What, then, can be done for developing nations, many of which lack the infrastructure and funding to provide high-quality medical care to their citizens? What about territories in the throes of humanitarian conflict, systematically deprived of essential resources by their political adversaries, such as the Gaza Strip? In my thesis, I perform a qualitative analysis of the health care system in the Gaza Strip, focusing on the outsourcing of care for the most critically ill patients to providers in the State of Israel, the West Bank, and abroad through the Israeli Defense Force’s (IDF) medical permit system. Despite limited data availability, I also investigate the impact of COVID-19 on health outcomes in Gaza, tracking the drastic decrease in medical permits issued for urgent cases as a result of the pandemic.

This paper explores the major research question: What is the impact of the medical permit regime on health outcomes for patients with breast cancer in the Gaza Strip? Breast cancer is the leading cause of cancer deaths among Palestinian women, accounting for 36 percent of cancer cases in the Occupied Palestinian Territories (OPT) and 18 percent of cancer diagnoses in Gaza.\(^1\)

While lumpectomy and wide local excision have become the global standard for breast cancer treatment, up to 80 percent of women requiring surgery in Gaza receive total mastectomies due to the lack of locally available radiotherapy.\(^2\) Further, in 2016, 60 percent of deaths due to breast cancer in Gaza were found to be avoidable, typically the result of late diagnosis.\(^3\) In a recent report, the Israeli organization Gisha – Legal Center for Freedom of Movement found that the medical

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permit system disproportionately impacts women due to criteria which “overlook women’s needs, reinforce their exclusion from the job market, block opportunities for personal and professional development, and constantly disrupt, if not fracture, family life.” Not only is breast cancer a pressing public health issue in the Gaza Strip, but it also exemplifies the intersectional impact of armed conflict on women’s health. Through this analysis, I argue for community-driven solutions promoting peacebuilding through health in the absence of significant political will to put an end to this longstanding conflict.

**Background: The Israeli-Palestinian Conflict**

The Israeli-Palestinian conflict has dominated the Middle East since the early twentieth century. In 1922, the League of Nations granted Great Britain the mandate over Palestine, vesting the country with the authority to implement the Balfour Declaration which endorsed the establishment of a “national home for the Jewish people” in Palestine. Successive riots by the Palestinian population throughout the 1920s and the Great Palestinian Revolt of 1936-1939 prefaced the century’s major territorial schism: The First Israeli-Arab War (1948-1949). Following the declaration of an independent State of Israel on May 14, 1948, armies from the Arab League countries of Syria, Egypt, Lebanon, and Jordan invaded the former British Mandate in Palestine. Violent expulsions and bloodshed wreaked havoc on the land, resulting in the displacement of approximately 750,000 Palestinians and the expulsion or voluntary immigration

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of up to one million Jews from Arab countries over the following three decades. Over 6,000 Israelis and 10,000 Palestinians died in the First Israeli-Arab War.

Though a ceasefire was established in 1949, consequent wars and isolated acts of terrorism continued throughout the remainder of the twentieth century and into the twenty-first. The Six-Day War (1967), War of Attrition (1967-1970), Yom Kippur War (1973), First Lebanon War (1982), and First Intifada (1987-1993) further exacerbated the ethnic struggle over control of the land between the Mediterranean Sea and the Jordan River. Throughout this time, control over the Gaza Strip passed from Great Britain (1923-1948) to the Arab League (1948-1959) to Egypt (1959-1967) and then to Israel (1967-1994). During the period of Israeli control, the Israeli government introduced financial incentives and other measures to encourage Gazans to emigrate outside of the Strip and established settlements for Israeli citizens that would eventually cover over 15 percent of the territory. Quotas on goods exported from Gaza and prohibitions on agricultural development and direct exports to Western markets combined with tax breaks for Israeli producers contributed to the decline of Gaza’s agricultural sector and the increasing economic demobilization of the region.

The enforced military isolation of Gaza was initiated during the same period. In 1993, Israel and the Palestinian Liberation Organization (PLO), the “sole legitimate representative of the Palestinian people,” signed the Oslo Accords, which vested the Palestinian Authority with limited

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8 See UN General Assembly (1951) & Sachar (2007).
administrative control over the West Bank and Gaza Strip.\textsuperscript{14} The Accords allow Israel to retain control over the airspace, territorial waters, and land borders of the Gaza Strip, with the exception of Gaza’s border with Egypt.\textsuperscript{15} In 1994, Israel began construction on a security barrier to control the movement of people and goods exiting Gaza.\textsuperscript{16} This initial barrier was torn down during the Second Intifada (2000-2005) in which approximately 6,371 Palestinians and 1,083 Israelis lost their lives.\textsuperscript{17} After several months of fighting, the barrier was rebuilt with an additional one-kilometer buffer zone and technologically-advanced observation posts; soldiers were directed to fire at those attempting to cross the barrier by stealth.\textsuperscript{18}

The bloodshed of the Second Intifada was such that Israel decided to unilaterally withdraw from Gaza in 2004, forcing the evacuation of nearly 7,000 Israeli settlers living in the Strip.\textsuperscript{19} Less than a year after the disengagement plan was complete, the militant Palestinian nationalist organization Hamas won a surprise victory over Fatah, the PLO’s largest political faction, in the Palestinian legislative elections. However, Fatah decided not to honor the results and maintained control over the West Bank, while Hamas took over Gaza. Hamas’s ongoing sovereignty in Gaza spurred the governments of Israel and Egypt to impose land, sea, and air blockades on the Strip in 2007, which have been deemed “collective punishment” by organizations such as the United Nations and the International Committee of the Red Cross.\textsuperscript{20}


\textsuperscript{16} “Agreement on the Gaza Strip and the Jericho Area (Cairo Agreement) | UN Peacemaker.” Un.org, 2018.

\textsuperscript{17} “10 Years to the Second Intifada – Summary of Data.” B’Tselem, 27 Sept. 2010.


Figure 1: Map of the West Bank and Gaza Strip

From World Health Organization, Right to Health in the Occupied Palestinian Territory, 2018.
The evolution of the Palestinian health care system can be broken down into four main eras: the British Mandate Period (1920-1948), Egyptian Rule (1948-1967), the Israeli Administration (1967-1994), and the Palestinian Authority (1994-present). Under the British Mandate Period, government hospitals and health clinics, in addition to Christian Mission hospitals, were the main providers of health care for the Palestinian population. However, the majority of Palestinians in poor, rural areas of the country had very limited access to medical services; British colonial policy aimed to limit investments in social services. Thus, under British colonial rule, health care administration was taken out of the hands of the local Palestinian population and inadequately addressed the needs of its constituents.

In the aftermath of the First Israeli-Arab War (1948-1949), two separate health systems began to emerge between the divided Palestinian territories: Jordan administered the West Bank while Egypt ruled the Gaza Strip. Meanwhile, the United Nations Relief and Works Agency for Palestine Refugees (UNRWA) began operations in 1950 under the mandate to “provide assistance and protection to Palestine refugees pending a just and lasting solution to their plight,” supporting initiatives to deliver health care, education, relief and social services, camp infrastructure, microfinance, and emergency assistance to the ever-growing population of refugees. According to Rita Giacaman, founder of the Institute of Community and Public Health at Birzeit University in the West Bank, “as of the late 1950s, modern medical services began to become available to refugees and to the rural areas, as basic health and education infrastructures reached the

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21 Britain conquered Palestine at the end of 1917, establishing a civil administration there in July 1920. The mandate was approved by the League of Nations in July 1922 and officially came into effect in 1923. See United Nations (1947).
countryside. However, those health services were mainly curative and rudimentary.”

The replacement of the British colonial administration with services provided by Jordan, Egypt, and UNRWA, in addition to charitable organizations in the private sector, expanded access to health care for refugees and the general Palestinian population, but still failed to advance the quality of care beyond a basic standard.

In the Six Day War of 1967, Israel captured both Gaza and the West Bank, in addition to key territories in East Jerusalem, the Golan Heights, and the Sinai Peninsula. In the OPT, the Israeli Civil Administration—run out of the Ministry of Defense and not the Ministry of Health—“took over the governmental health care system and proceeded to administer it in a manner that kept it stunted and underdeveloped, with severe budget restrictions, referral to Israeli hospitals for tertiary care, and restrictions on licenses for new medical and health care projects.” The Israeli system disempowered the Palestinians in decision-making processes despite the fact that they made up the vast majority of service providers, creating a total dependence on the Israeli health system and discouraging the development of an independent Palestinian administration.

In the private sector, attempts to offer an alternative to government-provided care were hindered by licensing restrictions and Israeli military rules. In the late 1970s, grassroots health committees affiliated with popular Palestinian political movements emerged with the goal of filling the gaps left by the Israeli system through the promotion of “preventive care, health education activities, popular participation in addressing health issues and grassroots mobilization in addition to basic curative services.” These NGOs harnessed a network of volunteers to

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25 Ibid.
strengthen outreach to underserved areas, expanding access to care outside of the traditional government apparatus. Today, some NGOs remain the primary providers of essential services to various sectors of the population.\textsuperscript{28}

The current stage in the evolution of the Palestinian health care system began following the signing of the Oslo Accords and the subsequent creation of the Palestinian Authority (PA) in 1993. Tasked with the responsibility of providing health care for the Palestinian people, the PA established the Ministry of Health (MoH) in 1994, expanding coverage from 25 to 48 percent of households between 1994 and 1998.\textsuperscript{29} Today, approximately 40 percent of primary health care visits occur at government facilities, with 31 percent at UNRWA and 29 percent at private and NGO facilities.\textsuperscript{30} The MoH also succeeded in increasing the number of government primary health care clinics from 207 to 365, more than tripling the MoH staff from 2,000 to 7,000, developing a national health information system, promoting a government insurance plan, constructing a plan for human resource development, and developing policies and protocols in maternal and child health in conjunction with UNRWA, NGOs, and the private sector.\textsuperscript{31}

Despite these achievements, growth of the Palestinian health care system remains limited due to consecutive economic and political crises. According to Giacaman et al., “the financial crisis of the Ministry of Health beginning in the second half of 1997, when the Ministry of Finance failed to allocate it the expected budget, led to a deterioration of government services including a lack of essential drugs and supplies.”\textsuperscript{32} As a result, public participation in the government health insurance program declined, leading to an increase in direct out-of-pocket household costs of up

\textsuperscript{28} Giacaman, et al. (2003).
\textsuperscript{30} Ibid.
\textsuperscript{32} Giacaman, et al. (2003).
to 40 percent of total health expenditures in the West Bank and Gaza.\textsuperscript{33} This trend is troubling considering the increased burden on the health system resulting from staggering poverty rates, which rose as high as 56 percent in Gaza in 2020, and injuries inflicted by the Israeli army.\textsuperscript{34}

The Oslo Accords also exposed the weaknesses of the MoH and the PA in addressing the needs of the Palestinian population. In the international community, the Accords brought hope for a more peaceful future in a perpetually war-torn region. However, the majority of the Palestinian population considered the Accords to be unjust and detrimental to the national interests, as the agreement did not satisfy the legitimate demands of an occupied people for independent statehood, nor did it inhibit the continuing Israeli colonialist expansion in Palestinian areas, undermining even the meagre possibilities of creating peace. The Palestinian Authority came to be perceived as incapable of transforming itself into a democracy as long as it remained confined to the Oslo framework.\textsuperscript{35}

Therefore, the PA came to be seen as an increasingly authoritarian and corrupt political regime, unrepresentative of the will of the Palestinian people, only several years after its inception.\textsuperscript{36}

The newly established MoH confronted serious challenges in 2000 with the outbreak of the Second Intifada. In addition to exacerbating the territories’ economic troubles, causing “the death of over a thousand Palestinians, the injury of thousands more, and the substantial destruction of property and infrastructure…, as well as the shelling and occasional ramsacking [sic] of hospitals,” the violence “contributed further to the precipitation of a health system crisis, undoing to a considerable extent donor-led attempts at reform.”\textsuperscript{37} Crisis management replaced the push to build a sustainable and autonomous Palestinian health system. For example, the MoH began providing free services to both insured and un-insured citizens, as well as soliciting drug donations

\textsuperscript{34} See Giacaman et al. (2003) & UNCTAD (2020).
\textsuperscript{37} Giacaman, et al. (2003).
from the international community. While these decisions were astute in a time of national emergency, they undermined the development of the MoH’s essential drug list, “undoing its attempts at rehabilitating prescription patterns and along the way, further weakening the local drug industry.” The MoH’s approach to the catastrophe of the Second Intifada is indicative of the ways in which responsible crisis response can be antithetical to long-term plans for reform.

Additional barriers to health system reform in the OPT include Israeli control over important aspects of development such as licensing and permits and the need to meet the demands of external donors. Yezid Sayigh, Senior Fellow at the Carnegie Middle East Center in Beirut, and Khalil Shikaki, Director of the Palestinian Center for Policy and Survey Research, describe donor aid for the Palestinians as “one of the largest ever undertaken by the international community” in both absolute and per capita terms, totaling US$175 per person. Though donor assistance has been integral to the execution of health systems reform projects, “in some cases, donor preferences for funding rather than the actual needs determined in a perspective of sustainable development have defined the very nature of the projects themselves.”

Not only do donors lack familiarity with the culture and language of the population they aim to serve, but the varying reporting procedures for each donor create excessive paperwork for Palestinian health workers and exacerbate existing inefficiencies. In an environment of limited resources, physicians are obliged to perform extraneous human resources tasks despite already receiving low salaries in the government sector. Though in theory the PA gained exclusive control over the Palestinian health system in the Oslo Accords, much work still needs to be done.

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41 Ibid.
42 Ibid.
to bolster the existing health infrastructure and reduce dependence on Israel and the international community.

The Legal Status of Gaza

Today, Gaza’s status under international law remains controversial. Following disengagement from the Strip in 2005, the Israeli State Attorney’s Office has argued that “Israel has no obligation whatsoever under international law toward residents of Gaza, who should now direct all their claims and requests to the Palestinian Authority.” However, international human rights organizations and the United Nations (UN) generally regard Israel as an occupying power due to five main categories of violations of international human rights law: unlawful killings; forced displacement; abusive detention; the development of settlements (along with accompanying discriminatory policies that disadvantage Palestinians); and, most relevant to this analysis, the closure of the Gaza Strip and other unjustified restrictions on movement.

According to B’Tselem, the Israeli Information Center for Human Rights in the Occupied Territories, the Law of Occupation—derived from the Hague Convention (1907), the Fourth Geneva Convention (1949), and customary norms of international human rights law—imposes obligations on Israel toward residents of the Gaza Strip. The Law of Occupation applies if a state has “effective control” over a territory. The effective control test was elucidated by the Nuremberg Tribunal in the 1948 Hostages Trial, formally known as United States v. Wilhelm List et al.

In this case, the withdrawal of German troops from Greece and Yugoslavia was deemed an ineffective end to the German occupation “because the German military could have reentered the

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45 B’Tselem (2017).
territories and exercised effective control at will.”46 Israel not only retains the ability to exercise such power over Gaza, but does so on a regular basis and to a much greater extent than Germany over Yugoslavia and Greece in the Second World War. In addition to the blockades, the Israeli military reserves the right to enter Gaza at will and over 24 percent of the land within the Strip is unavailable to Gazans due to its use as a military “buffer zone.”47 Despite the IDF’s lack of a physical presence in Gaza, the extent of control exerted through Israel’s policy of closure serves as reasonable basis to pass the “effective control” test.48

Additionally, the Universal Declaration of Human Rights (1948), the founding document of international human rights law which has been adopted by the UN and ratified by over 150 countries including Israel, enshrines the responsibility of states to respect the human rights of populations under their control.49 These include the rights of every person “to freedom of movement, to work, to an adequate standard of living, to education, to adequate health care, and to family life.”50 Despite Israel’s disengagement from the Gaza Strip, the state remains legally accountable for the safety and welfare of individuals living in the occupied territory. According to George Bisharat, the Honorable Raymond L. Sullivan Professor of Law at University of California-Hastings, Israel has “consciously and assiduously tried to push the limits of the law in manners that serve its short-term, military benefit. This campaign at the margin, and sometimes beyond the margin, of international legality is dangerous, both for Israel, and for all nations.”51

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46 Bisharat (2009).
48 Ibid.
49 B’Tselem (2017).
50 Ibid.
51 Bisharat (2009).
blindly granted impunity by the international community, regardless of the actions taken by Hamas which push the IDF to take military action.

_Gaza Today_

From a political and public health perspective, the crisis in Gaza continues to grow ever more dire. With over 5,326 people per kilometer, the Gaza Strip is one of the world’s most densely populated areas.\(^{52}\) In comparison, Las Vegas, a city roughly the same size as Gaza, has a population density of 1,773 people per kilometer.\(^{53}\) Of Gaza’s population of two million, 70 percent are refugees from other parts of the OPT.\(^{54}\) Thus, a substantial percentage of the population receives health care through UNRWA, which is dependent on donor contributions and chronically underfunded, rather than the traditional government health care system. Since the closure of the Gaza Strip in 2007, there have been major conflicts between the OPT and Israel in 2009, 2012, and 2014, as well as border protests in Gaza from 2018-2019. As recently as late April 2021, a rocket exchange between Israel and Gaza led to the closure of Gaza’s already limited fishing zone, cutting off the livelihoods of thousands of fishermen and their families in a time of protracted economic crisis.\(^{55}\) According to Shaymaa AlWaheidi, a cancer epidemiology researcher at King’s College London, “the long-term conflict between the OPT and Israel…has created a fractured and…deeply unstable society. Gaza has not been able to make the transition to a post-conflict context, and the continuing insecurity means there has been no opportunity for the people of Gaza to live in or to experience a recovery phase.”\(^{56}\)


\(^{53}\) “U.S. Census Bureau QuickFacts: Las Vegas City, Nevada.” _Census Bureau QuickFacts_.

\(^{54}\) AlWaheidi (2019).


\(^{56}\) AlWaheidi (2019).
A 2012 UN report predicted that Gaza would be unlivable by 2020. In 2019, the UN’s special rapporteur on human rights in the Palestinian territories, Michael Lynk, stated: “The prediction of unliveability has already arrived. The common measuring stick used by the UN or any other international organization to be able to evaluate how people live is human dignity, and Gaza has been without human dignity for years now.” Over 90 percent of the water in Gaza has been deemed “unfit for human consumption.” Meanwhile, electricity is typically available for only half the day and widespread poverty and food insecurity threaten the livelihoods of Gazans young and old. The Gaza Strip “holds the world record for unemployment,” with 54 percent of the overall population and 70 percent of young people without jobs. For women, the unemployment rate is even higher, reaching a staggering 88.4 percent in the third quarter of 2020.

When it comes to medical care, the blockades and severe restrictions on movement in and out of Gaza have led to “a chronic shortage of hospital beds, medical equipment and specialist physicians.” Though the lack of data on health performance indicators complicates efforts to systematically assess and compare the status of Gaza’s health system to that of other countries, it is clear that territorial and political fragmentation have worsened despite increases in health expenditures on medical referrals, resulting in health outcomes worse than expected for the current spending levels. Although the system receives substantial amounts of funding from the UN and other international organizations, “at the end of July 2019, Gaza’s hospitals had run out of 516

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61 Gisha (2020.)
63 AlWaheidi (2019).
essential medicines, representing 49 percent of the stock of medications included in the basic Palestinian health supply.”

**Figure 2: Formal Unemployment Rate in Gaza, 1995-2018**

![Graph showing unemployment rate in Gaza from 1995 to 2018](image)


Gaza also faces unique challenges due to its status as a conflict zone. Many of the hospitals and clinics bombed in the 2012 and 2014 wars with Israel have yet to be rebuilt. Further, the environmental impact of modern warfare has created a pressing public health need to adequately treat populations that may have been exposed to increased levels of potentially toxic and carcinogenic materials. Not only do Gazans suffer from severe physical health conditions, but the psychological impact of decades of war and internal strife among opposing political factions has led to a high rate of mental health issues as well. A study conducted by the Norwegian Refugee

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65 Hatuqa (2021).
Council found clear signs of psychosocial distress in 68 percent of schoolchildren living close to the Israeli border fence, which has been deemed illegal under international law.\(^67\)

The infant mortality rate, generally accepted as an indicator of the overall physical health of a population, points to the severity of the crisis in Gaza. At 15.6 deaths per 1,000 live births, the infant mortality rate in Gaza is over four times that of Israel, and the numbers have remained stagnant for over a decade.\(^68\) Due to licensing and permit restrictions imposed by the Israeli government, attempts to reform Gaza’s health system to better meet the serious needs of its population are extremely limited. While many patients have no option but to seek care within Gaza, where “the unstable power supply, …deteriorating functionality of medical equipment, [and] …periodic shortages of essential drugs and medical consumables have had an impact on the quality of medical care,” a select few suffering from life-threatening diseases may choose to apply for permits to receive treatment in the West Bank, East Jerusalem, or Israel, which was ranked the sixth healthiest country in the world by Bloomberg in 2015.\(^69\) This thesis analyzes the impact of the medical permit regime on public health, capturing the ways in which this system is highly sensitive to changes in the political relationship between Gaza’s leaders and the Israeli authority.

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Weighing the physical and mental health needs of Gazans against changing dynamics between Israel and political actors such as Hamas and the PA will reveal the extent to which the medical permit system prioritizes security at the expense of human life. Finally, highlighting the denial of permits for patients a reasonable person would consider ‘exceptional humanitarian cases,’ such as “two children [who] passed away while waiting for a permit that would allow their parents to take them to open-heart surgery,” will reveal the areas in which meaningful health policy must be implemented in order to prevent ailing patients from slipping through the cracks. This research is essential to upholding the ideal of health care as a human right. In the words of Giacaman, “in its broader framework, the Palestinian experience may…assist in improving our understanding of reform efforts in other countries of the world that endure endemic conflict and instability.”

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Methodology

The aim of this paper is to review what is already known about the Israeli medical permit system and breast cancer in the Gaza Strip to identify which interventions are both relevant and feasible to help prevent patients from dying unnecessarily as a result of bureaucratic delay. A search of the Georgetown University Library database was conducted to identify potentially relevant published studies on breast cancer and health sector reform in the OPT. Keyword searches of breast cancer or medical permit combined with Gaza were used in the search process. Reports from international health and humanitarian organizations working in the OPT were reviewed to further identify relevant information. After determining which articles were pertinent to the analysis, common themes relevant to the research questions were delineated. The author is grateful to Dr. Norbert Goldfield, founder of Healing Across the Divides, and Dr. Michael Stoto, Georgetown University Professor of Health Systems Administration and Population Health, for providing literature crucial to this analysis.

Analysis

The objective of this thesis is to analyze the trends in medical permits granted to the chronically ill, specifically breast cancer patients, in the Gaza Strip. Cancer is the second leading cause of death in both the West Bank and Gaza, exceeded only by cardiovascular disease.\textsuperscript{72} Cancer care is the top medical reason for referral to facilities outside of Gaza, comprising nearly a quarter all referrals, and is most frequently delayed compared to other types of care.\textsuperscript{73} While breast cancer is already the leading cause of cancer deaths among Palestinian women, an expected decline in


fertility suggests that it will become an even more pressing issue in the near future. Considering the impact of late diagnosis on health outcomes, coupled with the major delays in access to care engendered by the permit system, a greater understanding of this issue has the potential to reduce the number of avoidable deaths among women in Gaza. Analyzing the fluctuations in medical permits and other barriers to care for breast cancer patients in Gaza, along with the impact of COVID-19, will provide a strong foundation for the reform recommendations proposed in the following section.

*The Israeli Medical Permit System*

Israeli security concerns are a major obstacle to health care access for patients in Gaza. On the surface, the IDF’s permit system is presented as a mechanism to eliminate the threat of terrorism posed by Hamas’ political sovereignty over Gaza. However, upon reviewing the criteria which determine whether or not civilians may seek passage for medical, commercial, or personal purposes (typically family-related, such as funerals), the Israeli organization Gisha - Legal Center for Freedom of Movement has labeled the permit system a bureaucratic regime designed to manage and control the Palestinian population living under Israeli sovereignty.

According to a December 2020 Gisha report entitled “Discrimination by Default: A Gender Analysis of Israel’s Criteria for Travel Through Erez Crossing,”

The labyrinthine bureaucracy involved in acquiring a permit (even in the narrow circumstances defined by Israel), as well as the lack of transparency surrounding the processing of permit applications, the inordinately long time Israeli authorities take to respond to applications, and the tendency to arbitrarily bar people from travel based on vague “security reasons,” means that even when people do meet Israeli criteria, they are often denied a permit in practice.

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75 Elshami (2021).
76 Gisha (2020).
77 Ibid.
Therefore, it is necessary to rely on testimonies from patients and advocacy organizations in addition to permit application statistics released by the IDF in order to gain a more comprehensive understanding of Israel’s policy toward permit-seekers. This analysis seeks to delve beneath the surface of the permit system in order to identify the ways in which its criteria limit the movement of Gazans beyond a degree reasonably warranted by the threat of attack posed by Hamas.

The permit regime arose in the early 1990s, growing to over 100 types of Israeli-issued permits for Palestinians by 2014. Though patients were previously able to receive treatment in nearby countries such as Egypt and Jordan, financial and political issues including terrorism in the Sinai Peninsula and the influx of Syrian refugees into Jordan have left Israel as the main provider of care for many Palestinians. The permit application process has proven to be heavily bureaucratized and even fatal for Palestinians in Gaza. The IDF limits travel through Erez Crossing, Gaza’s passenger crossing to Israel, the West Bank, and the outside world, to ‘exceptional humanitarian cases’—in other words, those with severe health conditions and prominent businesspeople. The authorization of these permits has rapidly declined over the past decade. With the WHO reporting 92 percent approval of applications in 2012 down to 54 percent in 2017, the data suggests that even ‘exceptional humanitarian cases’ are subject to restriction.

These permits apply to patients, their companions, and health staff exiting Gaza. In order to reach health facilities outside of the Strip, patients must navigate a lengthy and complex bureaucratic process:

Once the patient’s doctor identifies the need for referral, the patient must seek medical and financial approval for the referral from the Services Purchasing Unit (SPU) of the Ministry of Health. The SPU requests an appointment date from health facilities offering the required

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78 World Health Organization, Right to Health in the Occupied Palestinian Territory, 2018.
79 Halahleh (2018).
medical intervention. Following this, the patient must apply to Israeli authorities through the Palestinian Coordination and Liaison Office in the Gaza Strip. Israeli authorities require permit applications to be submitted a minimum of 23 working days prior to the patient’s hospital appointment. The patient’s application is then approved, denied or delayed; the latter meaning that patients receive no definitive response to their application by the date of their hospital appointment.\textsuperscript{82}

Applications must be submitted for every single medical appointment, even if a patient’s treatment requires frequent travel, and border crossings are closed to patients with permits on very short notice.\textsuperscript{83} As a result, Gazans missed at least 11,000 scheduled medical appointments and 54 patients, 46 of whom had cancer, died following denial or delay of their permits in 2017 alone.\textsuperscript{84} A study found that patients in Gaza initially delayed or denied permits from 2015 to 2017 were nearly 1.5 times less likely to survive than patients who were initially granted permits to exit.\textsuperscript{85}

\textit{Figure 4: Patients applying for permits to exit Gaza and number of applications, 2008-2018}

\hspace{1cm}

\textit{From World Health Organization, Right to Health in the Occupied Palestinian Territory, 2018.}

\textsuperscript{82} WHO (2018).
\textsuperscript{83} AlWaheidi (2019).
\textsuperscript{84} Ibid.
\textsuperscript{85} Ibid.
According to the Gisha report, Israel has restricted crossing since the onset of the coronavirus pandemic to only the most urgent medical cases.\textsuperscript{86} In January 2020, 2,973 patients and companions traveled through Erez Crossing, while that number dropped as low as 193 five months later.\textsuperscript{87} Passage through Erez is already limited to those seeking “life-saving or life-changing” medical treatment that is unavailable in Gaza.\textsuperscript{88} These criteria raise the questions: How are some cases deemed more urgent than others in a group composed entirely of the severely ill? What are the consequent health outcomes for these patients?

\textit{Figure 5: Israeli responses to Gaza permit applications, 2006-2018}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure5}
\caption{Israeli responses to Gaza permit applications, 2006-2018}
\end{figure}


Not only does the permit system routinely deny eligible candidates, but it has also been found to systematically favor male applicants. Though both men and women suffer tremendously

\textsuperscript{86} WHO (2018).
\textsuperscript{87} Gisha (2020).
\textsuperscript{88} al-Mughrabi (2017).
as a result of Israel’s 14-year closure policy, the role of Palestinian women in an overwhelmingly patriarchal society places them at an even greater disadvantage. A Physicians for Human Rights-Israel (PHRI) report found that some Israeli exit permit policies affect women twice as much as men.\(^8^9\) Permit application denials on the grounds that a patient had “family proximity to Hamas” occurred twice as often for women—criteria which was successfully overturned by the High Court of Justice through the efforts of PHRI, along with several other organizations, on behalf of a group of female cancer patients. Additionally, the Israeli army’s refusal to grant medical permits for patients until their relatives accused of illegally living in the West Bank or Israel return to Gaza has impacted women approximately 50 percent of the time, even though most of the relatives in question are men.\(^9^0\) This policy is representative of the recurring theme in conflicts in which women are unfairly punished for the actions of men.

*Figure 6: Applications per patient compared to trend in acceptance rate, 2008-2018*

![Graph showing applications per patient and trend in acceptance rate, 2008-2018.](image)

*From World Health Organization, Right to Health in the Occupied Palestinian Territory, 2018.*


\(^9^0\) Ibid.
International development practitioners generally agree on the profound consequences of armed conflict and occupation on women and girls. The Beijing Declaration and Platform for Action, adopted in 1995 by 189 UN Member States, called upon governments, the international community, and civil society to take strategic action in critical areas of concern including “the effects of armed or other kinds of conflict on women, including those living under foreign occupation” as well as “inequalities and inadequacies in and unequal access to health care and related services.” Gisha has similarly recognized the disproportionate impact of the Status of Authorizations, the principal document listing criteria for obtaining permits to travel to and from Gaza, on women. For this reason, focusing on the impacts of the permit regime on patients suffering from breast cancer, a disease which predominantly affects women, allows for an intersectional understanding of the crisis in Gaza.

*Breast Cancer in the Gaza Strip*

Like many lower- and middle-income countries (LMICs), Gaza lacks routine data reporting procedures that would allow researchers to estimate the incidence and trends in mortality for breast cancer. The available data suggests that, as of 2018, the incidence of breast cancer in Gaza was 33 per 100,000—lower than in neighboring countries. However, this number is expected to rise over the next few decades, related to a predicted decrease in the fertility rate among Palestinian women and an accompanying rise in the number of women aged 60 and older. In addition to a more than 135 percent rise in breast cancer cases by 2040, “breast cancer mortality is…expected to increase, and the rising cancer burden will increase demands for infrastructure for pathology and drug

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92 Gisha (2020).
93 AlWaheidi (2019).
delivery, and trained health staff accordingly.″ These demographic trends emphasize the need for meaningful policy action around an already dire health issue.

The main factors contributing to the delay in diagnosis of breast cancer in the Gaza Strip are political, structural, and sociocultural. In addition to Gaza’s lagging health infrastructure, social stigma prevents women from seeking early diagnoses. According to a study conducted by the MoH in conjunction with the UN Population Fund (UNFPA),

In Palestine, it is widely understood that vulnerability to breast cancer can be hereditary. As a result, some women avoid getting screened because they fear a breast cancer diagnosis could affect their daughters’ marriage prospects. Women with breast cancer have also faced gender-based violence and abandonment. Another factor leading women to defer screening is a lack of female health professionals. Culturally, it is seen as embarrassing and even religiously unacceptable for women to talk to male doctors about their private problems. Because women delay screening, breast cancer cases are identified later. A 2011 study found that 42 percent of breast cancer cases were reported at stage III and 18 percent at stage IV, for a total of 60 percent non-early cancer cases. In this way, stigma has a substantial impact on health outcomes. In 2016, 60 percent of deaths due to breast cancer in Gaza were found to be avoidable.

Further, the Palestinian healthcare system’s three linear accelerators—the devices used for radiation therapy—are all located in East Jerusalem because “Israel considers radioactive isotopes, which are used in these devices, to be dual-use materials and therefore bans them from entering

94 AlWaheidi (2019).
96 AlWaheidi (2019).
98 Elshami (2021).
the Gaza Strip.” As a result, access to radiation therapy is contingent on receiving a permit to travel outside of Gaza. Due to the lack of locally available radiotherapy, up to 80 percent of women requiring surgery in Gaza receive total mastectomies, even though lumpectomy and wide local excision have become the global standard for breast cancer treatment.

**Figure 7: Projection of age structure by large age-groups (2015-2050)**

![Graph showing age structure projection](image)


**Figure 8: Estimated number of incident cases and deaths among females of all ages with breast cancer in Gaza and the West Bank (2018-2040)**

![Graph showing cases and deaths](image)


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100 AlWaheidi (2019).
As such, the stigma surrounding breast cancer in Gaza becomes a self-fulfilling prophecy, as women who receive later diagnoses are more likely to require more serious treatment resulting in “the loss of one or both breasts, hair loss caused by chemotherapy and major...changes resulting from exposure to radiotherapy” that leave both physical and psychological scars. 101 Women with breast cancer are also occasionally forced to travel alone when the IDF refuses to approve exit permits for their companions, impacting their mental health and treatment outcomes while away from their families for weeks at a time. 102 In addition to increasing the availability of and access to care for breast cancer patients in Gaza, social and psychological support programs are urgently needed to ameliorate their coping, survival, and quality of life. 103

Due to the lack of resources and oncological specialists caused by the blockades, Gaza’s health infrastructure is in need of serious reform. There are only two oncology departments in the Strip, primarily in urban areas, at which delays and shortages of critical chemotherapy drugs like Trastuzumab (Herceptin) remain common. 104 The waiting time for breast cancer surgery at Al-Shifa Hospital, the largest hospital in Gaza, currently stands at up to 9 months. 105 Overburdened oncologists have “little time to provide women with psychological support, or explain comprehensively the whole process of treatment, pros and cons of the different options, and potential effects, or provide information on nutritional and lifestyle changes that women need to follow, etc.” 106 Case management is severely limited, with the patients themselves tasked with reaching out to their providers to arrange follow-up appointments. 107 The lack of communication

101 Jubran (2019).
102 Ibid.
103 Ibid.
105 Jubran (2019).
106 Ibid.
107 Ibid.
between MoH and non-MoH providers, in a territory where over 30,000 referrals were made to non-MoH hospitals in 2018 alone, further limits patient follow-up.\footnote{WHO (2018).}

\textit{Figure 9: Breast cancer service providers mapped by type of organization}

![Service providers mapped by type of organization](image)


Finally, poor health care coverage in the government health system increases out-of-pocket costs for patients in a territory where over half the population lives in poverty. The MoH health insurance program covers basic chemotherapy and radiotherapy for patients in public hospitals in Gaza as well as for referrals outside of Gaza, with funding support from UNRWA.\footnote{AlWaheidi (2019).} However, key services such as breast reconstruction and prosthesis, psychological support for patients and their families, survivor support groups, and physiotherapy are not covered by government health insurance.\footnote{Jubran (2019).} Patients must purchase hormonal drugs out-of-pocket during shortages, incurring an
average of 1,200 to 2,500 NIS (US$369-768) in outside costs even when covered by government insurance.\textsuperscript{111} Many are unaware that services are available free of charge in public hospitals or choose to seek care in the private sector despite its higher costs due to an increased perception of privacy and quality of care.\textsuperscript{112} Likewise, referrals to facilities outside of the MoH can cost up to twice as much as those at government facilities, with the average breast cancer case costing the MoH up to US$98,210.\textsuperscript{113} In sum, the poor health infrastructure in Gaza and resulting dependence on referrals for services outside the local MoH is neither cost-effective nor medically beneficial.

\textit{COVID-19 in Gaza}

The plight of Palestinians in Gaza has only been exacerbated by the coronavirus pandemic. Before COVID lockdowns, an average of 2,200 to 2,500 patients were granted permission to leave Gaza monthly for treatment.\textsuperscript{114} In April 2020, this number decreased to a mere 159 and in June of the same year, reports emerged of “around just five people a day who are in a very serious condition...being permitted to leave.”\textsuperscript{115} This calls to mind the notion of ‘excess mortality’: not only do limited testing and the politicized nature of data reporting obscure the true toll of the coronavirus worldwide, but the deaths caused by the disproportionate strain on the health care system are also difficult to quantify and represent an even greater number of lives lost.

Due to increased restrictions on movement, common cancer treatments and tests such as radiotherapy, chemotherapy, and PET/CT scans remain inaccessible to patients in Gaza. In April 2020, the MoH signed an agreement with a private health center to provide chemotherapy to cancer

\textsuperscript{111} Jubran (2019).
\textsuperscript{112} Ibid.
\textsuperscript{113} AlWaheidi (2019).
\textsuperscript{115} Ibid.
patients so they would not have to travel to hospitals outside of Gaza. However, shortly after the agreement was signed, the hospital reported it was experiencing shortages of medicine and could not meet the needs of its new patients. 116 This story demonstrates how, even when the MoH attempts to find creative solutions to work around the blockade, Israel’s policy of closure still manages to pose a risk to patient health outcomes.

The story of S., a 54-year-old resident of the Jabalia Refugee Camp, further demonstrates the gravity of the COVID-19 crisis in Gaza. 117 S. was diagnosed with breast cancer in early 2020 and quickly underwent a double mastectomy followed by chemotherapy. However, these treatments failed to stop her cancer from metastasizing, so S. was urgently referred for radiation therapy at the Augusta Victoria Hospital in East Jerusalem, which houses all of the Palestinian healthcare system’s linear accelerators. In May 2020, Israel announced its plans to formally annex large swaths of land in the West Bank, leading the PA to cut off bilateral ties with Israel. 118 As a result, “security coordination” in the form of communication between the Israeli authorities and the PA-run liaison offices—which apply for travel permits on behalf of Palestinian patients—ceased, eliminating the main avenue to care for many patients. According to reports from the UN and human rights groups, two babies and a 22-year-old man died while waiting for permits to leave Gaza for treatment during this period. 119

After the dispute between Israel and the PA erupted in May 2020, S.’s attempts to secure a travel permit with the assistance of PHRI were thwarted by bureaucratic hurdles put in place by the Israeli Coordination and Liaison Administration (CLA), the office which processes permit applications. The CLA required S. to attend a “humiliating” security interview and submit copies

116 Khoury (2020).
118 Hatuqa (2021).
119 Ibid.
of her imaging and biopsy results. While S. waited for the CLA to process her application, the date of her appointment passed. Since applications must be submitted for every single medical appointment, even if a patient’s treatment requires regular travel, S. had to file a new application and endure the same labyrinthine process all over again. Only two months after her original appointment date was S. finally issued a medical travel permit.

Due to the ongoing dispute between Israel and the PA, the UN assumed temporary responsibility for the permit system in September 2020. Since then, the number of permit applications has seen a slight but meaningful uptick relative to pre-COVID numbers. The number of patients and companions leaving Gaza more than quadrupled from September 2020 to March 2021.\(^\text{120}\) However, it is difficult to isolate a specific factor or set of factors responsible for this change.

**Figure 10: Exits by Palestinians via Erez Crossing (January 2020 - March 2021)**

![Exits by Palestinians via Erez Crossing](image.png)

*From Gisha – Legal Center for Freedom of Movement. “Exits by Palestinians via Erez Crossing to Israel, the West Bank, and Abroad.” Gisha, Nov. 2020.*

\(^{120}\) Gisha (2020).
In recent weeks, Gaza has reached an all-time high of coronavirus infections. Hospitals are filled to the brim, with patients packed three to a room and rapidly dwindling oxygen supplies.\textsuperscript{121} According to the MoH, nearly the entire territory has been declared a “red zone” due to high levels of community transmission.\textsuperscript{122} In mid-April, the daily death toll regularly exceeded 20, compared to a one-time daily high of 15 during the first outbreak in the fall of 2020.\textsuperscript{123}

Though the blockade initially worked in Gaza’s favor by lowering the risk of transmission from Israel and the surrounding territories, it is now effectively assuring rapid spread of the virus within Gaza’s densely-packed borders, facilitated by the crowded markets and late-night prayer sessions of Ramadan. When the number of infections decreased in February, Gaza’s Hamas leaders decided to lift the lockdown in order to deliver a desperately-needed boost to the economy and attempt to win political support ahead of Palestinian parliament elections in May.\textsuperscript{124} The emergence of more aggressive virus variants as well as a shortage of vaccines and widespread apathy toward safety precautions are accelerating community spread and placing an even greater burden on Gaza’s chronically overworked health care system.

As an occupying power, Israel is bound by international law to uphold “the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.”\textsuperscript{125} This includes “the prevention, treatment and control of epidemic … diseases [and] the creation of conditions which would assure to all medical service and medical attention in the event of sickness,” as well as “the creation of a system of urgent medical care in cases of … epidemics” and “the provision of disaster relief and humanitarian assistance in

\textsuperscript{122} Ibid.
\textsuperscript{123} Ibid.
\textsuperscript{124} Ibid.
As the world leader in coronavirus vaccinations, Israel has been criticized by the UN and other human rights groups for refusing to accept responsibility for vaccinating Palestinians in the West Bank and Gaza.\textsuperscript{127} As of late April 2021, Gaza had received enough doses from international donors such as the UAE and the UN’s COVAX program to fully vaccinate just 55,000 people out of its population of two million.\textsuperscript{128} Israel is at greater risk as the virus continues to spread and mutate on its borders, so it would benefit from sharing its vaccine surplus and supporting COVID safety education in the OPT before sending surplus vaccines to countries in Africa and South America, as it has announced plans to do.\textsuperscript{129}

In a time of extreme hardship in the OPT, one of the few positive developments to come out of the past year is the renewal of U.S. funding for aid to the Palestinian people. The Trump administration cut funding for UNRWA by approximately $300 million in 2018, sending the organization into a dire financial crisis. On April 7, 2021, the U.S. State Department announced an aid package including $150 million for UNRWA, $75 million for the West Bank and Gaza, and $10 million for peacebuilding programs delivered via the U.S. Agency for International Development.\textsuperscript{130} UNRWA Commissioner Philippe Lazzarini has also touched on the ways in which COVID revolutionized the agency’s operations. In addition to rapidly switching to telemedicine, UNRWA developed a mobile app to support pregnant women and people suffering from diabetes and hypertension and established an IT hub in Gaza.\textsuperscript{131} Though Gaza still lacks

\textsuperscript{127} BBC News (2021).
\textsuperscript{128} Akram (2021).
\textsuperscript{131} Ibid.
consistent internet access and electricity, these initiatives promise new jobs and channels for improving the quality and accessibility of health care in the Strip.

Policy Implications and Suggestions for Future Research, Policy, and Practice

There is no “one size fits all” solution to the crisis in Gaza. Due to the rapidly changing political situation, it is necessary to consider a range of short-, medium-, and long-term solutions that may be applied both in times of conflict and in times of peace. Further, different solutions address the territory’s different needs, from internal mechanisms to boost Gaza’s health infrastructure to negotiations with Israel and other foreign countries to smooth the passage of patients out of the Strip. Before highlighting these policy solutions, it is necessary to evaluate past reform attempts in order to understand how to avoid repeating prior mistakes and build a better future for breast cancer patients and the wider community in Gaza.

Policy Implications

First and foremost, Giacaman et al. emphasize how a lack of understanding of the situation in Gaza among donors and international development workers hinders reform initiatives. Specifically, attempts to unify the geographically disparate government health systems of the West Bank and Gaza fail to address the vastly different needs of patients in the two territories.¹³² Further, models for genuine and effective reform thought to be applicable to a wide range of LMICs assume the existence of certain pre-conditions that are either lacking or non-existent in Gaza. These include: “a stable, peaceful political environment with an active economy, strong state institutions and structures, internal political and popular will to implement reform, and the presence of a policy dialogue on what types of reforms the country should invest in.”¹³³ Generally, Giacaman et al.

¹³² Giacaman et al. (2003).
¹³³ Ibid.
advocate for a modification of assumptions about reform in the OPT to better suit the reality of the ongoing conflict: “Policies need to be guided by the principle of mixing selected possible and realizable reform measures with relief and emergency operations, rehabilitation and reconstruction. Otherwise, reform operations are likely to be frustrated by events.”\textsuperscript{134} In this way, health sector reform in the OPT should be seen as highly context-dependent.

This principle is demonstrated by the “contrary reality” set in motion by the Oslo Accords. Though many in the international community saw the Accords as a bright flicker of hope for peace in a long-troubled region, the situation on the ground was antithetical to effective health systems reform. Old problems including “severe economic deprivation, a seemingly permanent bantustanization and isolation of villages and towns..., restrictions on the movement of the Palestinian population, and increasing expropriation of land and natural resources for settlement expansion or bypass roads” drove an even greater wedge between the Israeli and Palestinian populations, and the massive outpouring of international aid donated following the signing of the Accords essentially went to waste in the destruction of the Second Intifada.\textsuperscript{135}

Moreover, a ‘microcosmic’ rather than ‘systemic’ focus has led to investments in impractical strategies. Giacaman et al. describe a concentration by decision-makers on achieving narrow biological, medical, and economic goals, as opposed to working toward building a more resilient, health-promoting environment.\textsuperscript{136} Organizations invested in the development of Gaza such as the World Bank consistently define reform in purely economic terms, “where access and equity appear to be conflated, and where access is elaborated in terms of ‘affordability of premiums’, ‘ability to pay’ and focusing on physical/distance access.”\textsuperscript{137} Despite acknowledging

\textsuperscript{134} Giacaman et al. (2003).
\textsuperscript{135} Ibid.
\textsuperscript{136} Ibid.
political and economic trends such as high unemployment and declining wages, valuable goals including equity in quality and social access are often left out.

Even more strikingly, through the lens of Western development agencies, aid can become ‘a fundamentally political process.’ For one, free market capitalism and the development of the private sector are seen as instrumental to bolstering the economies of LMICs, which is indeed a possible outcome, as is the widening of socioeconomic and class inequities in currently dedeveloped economies like that of Gaza.\textsuperscript{138} In the OPT, aid is also often contingent on acceptance of the peace process. In the words of Giacaman et al.,

\begin{quote}
Time has shown that it is difficult to sell a basically unjust peace process with aid money, not only because the ‘peace dividends’ have never materialized, but also because freedom is still an issue for people who are struggling for self-determination. Serious attempts at health sector reform require a just resolution to the Palestinian-Israeli conflict that the population, and not only the PA, is willing to accept.\textsuperscript{139}
\end{quote}

In the meantime, aid should work toward accomplishing the real, long-term needs of populations rather than merely focusing on short-term achievements that show shallow if tangible improvements to everyday life.

The shortcomings of development efforts in the OPT demonstrate the need for donors to cede ownership to the Palestinians. The relationship of donor and beneficiary is inherently unequal, and while international funding has been critical to Palestinian survival under the occupation, greater progress may be realized by building a strong foundation for an autonomous, self-sufficient Palestinian health system.\textsuperscript{140} Though the economic focus on reform is perhaps the most rewarding from a quantitative perspective, it distracts from the real issues that need to be addressed in reform.

\textsuperscript{138} Hilal (1998).
\textsuperscript{139} Giacaman et al. (2003).
\textsuperscript{140} Ibid.
that are grounded in the social determinants of health and less tangible markers of quality and equity.  

**Recommendations for Reform**

Following the structure of a 2018 MoH-UNFPA report entitled “Pathway to Survival: The Story of Breast Cancer in Palestine,” the following recommendations will be organized by immediate, short-term actions; medium-term actions; and long-term actions. In the report, the MoH identifies five priority areas: 1) developing a common breast cancer care strategy amongst all health care providers; 2) enhancing promotion of breast awareness through targeted promotion of self-breast exams, selective and effective screening programs, and addressing stigma, misconceptions, and myths; 3) enhancing coordination of care, referral networks, and women’s navigation pathways and experiences; 4) enhancing knowledge production and sharing about the epidemiology of breast cancer and women’s experiences; and 5) strengthening psychological support to women and their families, as well as responding to unmet needs of women with breast cancer and their families. The following recommendations will incorporate these priorities while looking beyond to evaluate the feasibility of political solutions to Gaza’s health crisis.

**Short-Term**

In the short-term, the MoH should focus on strengthening the availability of screening and confirmation services, raising awareness about the importance of early diagnosis, supporting cancer registration, ensuring the availability of skilled practitioners in primary and secondary care facilities, endorsing and operationalizing a national screening protocol, and

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141 Giacaman et al. (2003).
142 Jubran (2019).
enhancing the availability of treatment and post-treatment programs. For the sake of brevity, I will focus on the first three goals.

Currently, the only active screening program in the OPT is for breast cancer.\textsuperscript{143} The Palestinian Breast Cancer Program was established in the West Bank in 2008, expanding to the Gaza Strip in 2010. Via a mobile mammography unit, the program provides free mammograms for women ages 40-50 and younger women considered to be at high risk of developing breast cancer.\textsuperscript{144} Although the program has increased early detection of breast cancer in the OPT, more work needs to be done in order to address major barriers to care such as social stigma and poor coordination between providers.

The MoH plans to overcome some of these hurdles by establishing “one-stop” centers for breast cancer care starting in the city of Ramallah in the West Bank. Each center will incorporate screening, diagnosis, and treatment and include mammography, fine needle aspiration, tru cut biopsy, and ultrasound services.\textsuperscript{145} The centers will take a multidisciplinary approach to treatment, maintaining a staff of general practitioners, surgeons, and radiology specialists. Even if radiotherapy remains unavailable due to the IDF’s “dual-use” rule, the enhanced communication among referral pathways engendered by the “one-stop” centers is desperately needed in Gaza, where the MoH intends to duplicate the program if it proves successful in the West Bank. In addition to enhancing the availability of screening and confirmation services, the “one-stop” centers would support the medium-term goal of establishing treatment centers capable of providing care for all affected women through the nationalization of care.\textsuperscript{146}

\textsuperscript{143} Halahleh (2018).
\textsuperscript{144} Ibid.
\textsuperscript{145} Jubran (2019).
\textsuperscript{146} Ibid.
Another strategy to prevent adverse health outcomes for breast cancer patients is informing the population about the benefits of early diagnosis through awareness campaigns. Campaigns should be directed at husbands and family members as well as those at direct risk of developing breast cancer so that women receive encouragement from their support systems to seek care.\(^\text{147}\) In Gaza, UNFPA works with the Culture and Free Thought Association (CFTA), a humanitarian NGO, to raise awareness about breast cancer in the general population.\(^\text{148}\) According to Firyal Thabet, director of the Women’s Health Center at the CFTA, “the aim is to increase awareness on the importance of early diagnosis for breast cancer for both women and men. We do this by online campaigns, radio coverage, and by involving mosques, hair salons and taxi companies. Now we see more and more women and men coming to our centre for screening.”\(^\text{149}\) The MoH and donor organizations, in addition to UNFPA, should consider funding awareness campaigns such as the one coordinated by the CFTA—run for Gazans, by Gazans.

Importantly, awareness campaigns are most successful and, arguably, ethical in conjunction with screening and referral to treatment and confirmation services.\(^\text{150}\) According to the MoH, incorporating awareness campaigns within the mobile outreach clinics is a successful approach that should be strengthened and maintained.\(^\text{151}\) Running the mobile outreach clinics out of the “one-stop” centers, and incorporating psychological care, would improve the quality, standardization, and coordination of breast cancer care in Gaza. Decision-makers should defer to groups like the CFTA, which already provides psychosocial support, recreational activities, and

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\(^{147}\) Jubran (2019).
\(^{148}\) UNFPA (2020).
\(^{149}\) Ibid.
\(^{150}\) Ibid.
\(^{151}\) Ibid.
group outings for breast cancer patients, to determine an appropriate suite of services for the “one-stop” centers.  

Lastly, AlWaheidi stresses the need for “a population-based cancer registry for Gaza that will allow policy-makers to properly plan cancer care services based on empirical evidence of burden.” Though the MoH established a cancer registry covering the West Bank and Gaza in 1996, there remains a lack of accurate population-based data and robust health information systems to process and store this information. Further, the geographical separation of the OPT makes it difficult to effectively capture the cancer burden in Palestine. In order to build an effective registry, the MoH will need to invest in hiring health and administrative staff who have the time, training, and resources to support the implementation of this ambitious and much-needed project.

Medium-Term

In the medium-term, the MoH should concentrate on supporting infrastructure for pathology services and regular drug delivery, improving research capacity, implementing a provider capacity-building program, developing a national strategy for the early detection and treatment of breast cancer, updating evidence-based protocols for comprehensive treatment, and establishing national treatment centers. For the sake of brevity, I will focus on the first three goals.

Facilitating regular drug delivery and pathology services would reduce delays in care and decrease excess costs for the MoH. According to Halahleh, “the cost of the many recently approved cancer drugs, cell therapies, advanced radiotherapy, and surgical techniques will create substantial challenges because of the insufficient resources of the government’s insurance

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152 Jubran (2019).
153 AlWaheidi (2019).
155 AlWaheidi (2019).
156 Ibid.
Despite these challenges, enhanced focus on this issue by international donors, and the creation of a drug-sharing program with Israel, could be mutually beneficial by reducing the number of patients reliant on exit permits to access chemotherapy and other services.\(^{158}\)

Building on the short-term goal of strengthening Gaza’s cancer registry, improving research capacity would allow for a more evidence-based approach to reform. According to AlWaheidi,

> An audit of current internationally accepted treatment of women with breast cancer is needed to identify deficiencies and...investigate adherence to treatment and surgical guidelines by surgeons and oncologists. Further assessment of the quality, cost-effectiveness and accuracy of pathological services in Gaza is still required to inform the most appropriate management of treatment for women with breast cancer. This might help to inform an economic assessment of actual need of treatment facilities which could influence how the government-funded treatment budget could be spent in the most cost-effective manner.\(^{159}\)

Currently, many studies conducted on breast cancer in Gaza are unpublished master’s theses, making them less accessible to policy-makers and the general public and preventing them from influencing reform.\(^{160}\) Further, as in many Middle Eastern countries, the evidence on breast cancer in Gaza is not translated into the language that breast cancer patients themselves speak.\(^{161}\) As a result, patients cannot benefit from research conducted in their specific contexts. Thus, building research capacity and increasing knowledge production on breast cancer in Gaza could improve efficiency in the health care system and create a sense of self-understanding among patients.

Lastly, implementing a provider capacity-building program could facilitate the other two medium-term goals highlighted above. Specifically, the creation of a Gaza Medical Reserve Corps, “an organization of public health and preventive medicine (PHPM) specialists (reservists) who

\(^{157}\) Halahleh (2018).
\(^{158}\) AlWaheidi (2019).
\(^{159}\) Ibid.
\(^{160}\) Ibid.
\(^{161}\) Ibid.
would be trained in emergency and crisis care to provide aid during turmoil, war, and epidemics/pandemics,” could bolster the provision of primary care services that are currently lacking in Gaza.162 The idea for the Reserve Corps is drawn from the successes of PHPM specialists and community health workers in locales such as the Philippines during the COVID-19 pandemic and sub-Saharan Africa during the Ebola epidemic, respectively. In these instances, the PHPM approach was proven to be low-cost, cost-effective, and rapidly scalable.163

In addition to providing primary care services in their clinical practice, reservists would complete three additional rotations in education and outreach, research and development, and public health policy and advocacy. The education and outreach division would utilize social media to raise awareness about public health issues like breast cancer among the general population.164 The research and development division would adopt open science principles such as data transparency and sharing to maximize the impact of health research in Gaza.165 Finally, the policy and advocacy wing would contribute to funding development and “create advocacy campaigns, write critical papers..., lobby for policy change, and empower the public to advocate for data-driven services and health equity.”166 The pandemic has exposed the need for governments to invest in the health sector, so decision-makers should take advantage of this policy window and advocate for the formation of a multifaceted Reserve Corps.

A Reserve Corps could be particularly effective in Gaza due to the high rate of people who are educated but unemployed. By hiring recent health science graduates, the Reserve Corps would counter the 70 percent youth unemployment rate and help foster a more “culturally aware,

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163 Ibid.
164 Ibid.
165 Ibid.
166 Ibid.
language-appropriate, and socially acceptable experience between providers and patients.”

Reservists could be hired to meet different needs, such as the shortage of female providers, and focus recruitment in the most underserved neighborhoods and refugee camps in order to reflect the health system’s most pressing needs. The Reserve Corps would also be housed under a Gaza Public Health Advisory Network—composed of stakeholders such as the MoH, aid organizations, hospitals, medical schools, the private sector, and community leaders—in order to “transition Gaza away from the need for short-term aid...by creating a self-sustaining, financially sound, long-term health system that has the capacity to coordinate care effectively and efficiently.” In this way, the Reserve Corps could be used as a transferable model for other areas experiencing health care crises such as the West Bank and Syria.

**Long-Term**

In the long-term, stakeholders in Gaza’s development must **advocate for the free movement of breast cancer and other critically ill patients towards treatment services**, support community action towards prevention and early detection, and enhance efforts addressing peer support in an effort to improve quality of life for those affected by the disease. Since easing restrictions on movement would have the greatest impact on public health and be the most challenging to implement, this analysis will focus on the pros and cons of that strategy.

First, it is necessary to define Israel’s policy of closure, and the permit system by association, as a government failure. Despite its small population, Israel surpasses all other countries in military spending per capita and is second only to the United States in military spending by percentage of GDP. While Gaza’s militant Hamas leaders pose a risk to Israel’s

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167 Mahayosnand (2020).
168 Ibid.
safety and security, perpetuating the conflict in Gaza distracts Israel from threats in Lebanon, Syria, and Iran, countries with much stronger militaries than Gaza.\textsuperscript{170} Israel’s use of excessive force also results in the deaths of many more Palestinians than Israelis, subjecting the state to increasingly heightened criticism from the international community.\textsuperscript{171}

Moreover, the late political scientist Ted Robert Gurr found that states are more likely to rebel when they lack nonviolent means to express their grievances.\textsuperscript{172} Writes American political commentator Peter Beinart,

> When Palestinians in Gaza want to protest Israeli policies, they have few options other than to cheer Hamas rocket fire or march toward the fence that encloses them, and risk being shot. By contrast, when Palestinian citizens [of Israel] want to protest Israeli policies—including the policies that discriminate against them—they can vote.\textsuperscript{173}

Especially considering Israel’s obligations to Gaza under international law, restoring fundamental rights such as freedom of movement could deescalate the conflict, improve Israel’s image in the international community, and allow the IDF to reallocate its budget to more cost-effective endeavors.

In Gaza, the cumulative economic cost of the Israeli occupation was estimated at $16.7 billion for the period between 2007-2018, six times the value of Gaza’s GDP.\textsuperscript{174} Without closure, Gaza’s poverty rate in 2017 could have been 15 percent instead of the current 56 percent.\textsuperscript{175} In contrast, a study found that normalizing the operations of Gaza’s crossings through Israel would triple Gaza’s exports and increase its imports by 30 percent, with the impact enhanced if combined

\textsuperscript{171} Fisher, Max. “This Chart Shows Every Person Killed in the Israel-Palestine Conflict since 2000.” Vox, Vox, 14 July 2014.
\textsuperscript{173} Beinart, Peter. “Yavne: A Jewish Case for Equality in Israel-Palestine.” Jewish Currents, 8 July 2020.
\textsuperscript{175} Ibid.
with other easing measures such as humanitarian payments and increasing the electricity supply. Stimulating Gaza’s economy by reopening its border crossings to Israel would also allow the MoH to invest in a stronger health infrastructure and reduce its dependence on referrals for care outside of Gaza. In sum, ending the closure policy would eliminate the excessive costs to both Israel and Gaza’s economies, as well as the enormous toll it takes on human life.

**Figure 11: Short-term impact of easing measures on GDP**

![Graph showing the impact of easing measures on GDP](image)


The U.S. has a direct stake in the crisis in Gaza. $3.8 billion in taxpayer dollars is given in foreign military financing to Israel every year, more than the U.S. gives to the rest of the world combined. President Biden and the Democratic establishment, in addition to many conservative leaders, remain staunch in their commitment to uphold the terms of the U.S. and Israel’s longstanding alliance. Recently, however, prominent progressive Democrats such as Bernie

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Sanders and Elizabeth Warren have expressed support for conditioning aid to Israel in response to Israeli proposals to annex parts of the West Bank and other violations of international law.\footnote{Magid, Jacob. “Sens. Sanders, Warren Call for 'Restricting' US Aid to Israel at J Street Confab.” \textit{The Times of Israel}, 20 Apr. 2021.} During his campaign for the 2020 Democratic presidential nomination, Senator Sanders said: “My solution is to say to Israel: ‘You get $3.8 billion every year. If you want military aid, you’re going to have to fundamentally change your relationship to the people of Gaza.’”\footnote{Barrow (2019).}

\textit{Figure 12: Short-term economic impact for Gaza of facilitating access through Israel}

<table>
<thead>
<tr>
<th>Economic Indicator</th>
<th>Individual Impact</th>
<th>Combined Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Increase</td>
<td>Change %</td>
</tr>
<tr>
<td>GDP</td>
<td>$396 million</td>
<td>12.0%</td>
</tr>
<tr>
<td>Employment</td>
<td>24,000 people</td>
<td>10.0%</td>
</tr>
<tr>
<td>Purchasing power</td>
<td>$68 million</td>
<td>5.9%</td>
</tr>
<tr>
<td>Exports</td>
<td>$8 million</td>
<td>200.0%</td>
</tr>
<tr>
<td>Imports</td>
<td>$180 million</td>
<td>30.0%</td>
</tr>
</tbody>
</table>


Given the changing attitude towards military aid in Congress, pressure from U.S. policymakers could force Israel to comply with international law and uphold the right to health for its Palestinian neighbors. Legislation seeking to achieve this goal was recently announced, though not yet formally introduced, in the House of Representatives. On April 16, 2021, Representative Betty McCollum (D-MN-4) introduced the \textit{Promoting the Human Rights of Palestinian Children}
and Families Living Under Israeli Military Occupation Act (H.R. 2407). This legislation would amend a provision of the Foreign Assistance Act of 1961 known as the “Leahy Law” to prohibit funding for the military detention of children in any country, including Israel. Specifically, this legislation would bar Israel from using U.S. taxpayer dollars in the West Bank and East Jerusalem for “the military detention, abuse, or ill-treatment of Palestinian children in Israeli military detention; to support the seizure and destruction of Palestinian property and homes in violation of international humanitarian law; or, to extend any assistance or support for Israel’s unilateral annexation of Palestinian territory in violation of international humanitarian law.”

While this legislation does not include provisions for Gaza, it represents a monumental shift in the U.S.-Israel relationship. According to Alex Kane, a journalist specializing in U.S. foreign policy in the Middle East, “by targeting Israel’s detention of Palestinian children—just one aspect of Israel’s military occupation, but one that involved a highly vulnerable population—McCollum was attempting to make her [bill] appeal to the widest swath of Democrats possible.” In the coming weeks, McCollum plans to introduce legislation that would prohibit U.S. aid from subsidizing a wider array of Israeli occupation offenses. Given the contentious nature of criticizing Israel in American political discourse, it may be some time before McCollum’s bill garners adequate support to substantially impact life in the occupied Palestinian territories.

Conditioning aid on lifting the blockade of Gaza will prove even more contentious. Hamas’ violent form of rebellion expressed through rocket launches on Israeli civilians—demonstrated as recently as May 2021, in response to attacks by Israeli police on Palestinian worshippers during

184 Ibid.
Ramadan—masks the disproportionate impact of Israel’s closure policy on civilians in Gaza.\textsuperscript{185} Hamas, which has experienced a decline in popularity in recent years due to the deplorable living conditions in Gaza, does not represent the majority of Gazans.\textsuperscript{186} The vast majority of the population struggles to acquire the most basic means for survival and lacks the resources to dedicate energy towards plotting against Israel.\textsuperscript{187} Regardless of Gazans’ political beliefs, Israel is obligated to protect civilians under its control and uphold their right to health. Should current tensions between Israel and Hamas subside, lifting the blockade is the key to improving public health in Gaza. It is time for U.S. policymakers to recognize their critical role in improving public health through peacebuilding endeavors and support Representative McCollum’s bill along with other similar initiatives.


Action-oriented recommendations:

1- Immediate, short-term actions
   a- support national capacity to provide holistic screening and confirmation services within the continuum of care frame in both West Bank and Gaza;
   b- ensure availability of skilled practitioners within primary and secondary care facilities;
   c- formally endorse and operationalize a national screening protocol and guidelines that both respond to needs and capacity of health care providing institutions;
   d- support treatment and post treatment programs in terms of availability and quality at the national level.

2- Mid-term actions:
   a. develop a national strategy on breast cancer early detection and treatment involving public and private actors;
   b. update evidence-based protocols for comprehensive treatment of cases including post-treatment care;
   c. implement comprehensive capacity building program targeting national care providers;
   d. establish treatment centers capable of providing care for all affected women through nationalization of care.

3- Long-term actions:
   a. advocate for free movement of breast cancer patients towards treatment services;
   b. support community action towards prevention and early detection;
   c. enhance efforts addressing peer support in an effort to improve quality of life of those affected by the disease.

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