Contingency Plan Health Cluster

occupied Palestinian territory

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HEALTH CLUSTER
OCCUPIED PALESTINIAN TERRITORY

World Health Organization

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Hereby the Health Cluster Coordination Team would like to thank all the Strategic Advisory Group (SAG) members and Health Cluster members for their contribution to the Health Cluster Contingency Plan and commitment to helping Palestinian communities become better prepared to prevent and respond to the consequences of new disasters.

FOREWORD

The process of revising the Health Cluster emergency preparedness plan has been led by the Health Cluster Team and the Strategic Advisory Group, where Health Cluster partners have been asked to review and comment on the document considering changes in the situation and lessons learned from the last crisis which took place in May 2021 and the prolonged COVID-19 pandemic.

It will be reviewed and revised on a regular basis following any significant change of humanitarian situation, or once a year if no changes of humanitarian situation occur, to ensure its technical soundness and context appropriateness.

It should be stressed that this Plan does not replace individual agency contingency plans. Health Cluster partners are encouraged to consult this plan to develop their own agency specific and locally adapted contingency plans.

Finally, it must be noted that emergency preparedness does not exist in a vacuum; the Health Cluster will engage as much as possible with various sectors to ensure that the health contingency plan suits the context and is encompassing all relevant sectors. Platforms such as the national inter-cluster coordination group, will help reinforce the necessary interoperability.

DEFINITIONS

	Understanding key definitions
Disaster risk reduction	The practice of reducing disaster risks through systematic efforts to analyse and manage the causal factors of disasters, including through reduced exposure to hazards.
Hazard	A dangerous phenomenon, substance, human activity, or condition that may cause loss of life, injury or other health impacts, property damage, loss of livelihoods and services, social and economic disruption, or environmental damage.
Risk	Probability of an event (x) negative consequences.
Resilience	The ability of a system, community or society exposed to a hazard to resist, absorb, accommodate to and recover from the effects of a hazard in a timely and efficient manner, including through the preservation and restoration of its essential basic structures and functions.
Preparedness	Effectively anticipate, respond to, and recover from, the impacts of likely, imminent, or current hazard events or conditions.
Mitigation	Reducing the negative effects caused by the hazard.
Prevention	Outright avoidance of the negative effects related to the hazard.
Vulnerability	Vulnerability is the result of several factors that increase the chances of a community being unable to cope with an emergency. Not all sections of a community are vulnerable to hazards, but most are vulnerable to some degree. Vulnerability consists of two aspects - susceptibility and resilience. Susceptibility concerns the factors of a community which allow a hazard to cause an emergency, e.g., living in an earthquake-prone area or the level of development of the community.

Acronyms and Abbreviations

CEmOC	Comprehensive Emergency Obstetric Care
CSO	Civil Society Organizations
HC	Humanitarian Coordinator
HCT	Humanitarian Country Team
HeRAMS	Health Resources and services Availability Monitoring System
ICCG	Inter-cluster coordination group
MIRA	Multi-Cluster Initial Rapid Assessment
MoH	Ministry of Health
NGO	Non-Governmental Organization
OCHA	Office for the Coordination of Humanitarian Affairs
oPt	Occupied Palestinian Territory
PCBS	Palestinian Central Bureau of Statistics
PFA	Psychological first aid
PHC	Primary Health Care
SAG	Strategic Advisory Group
UNICEF	United Nations International Children's Emergency Fund
UNFPA	United Nations Population Fund
WHO	World Health Organization

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INTRODUCTION

Purpose of document: The purpose of this document is to lay the **foundation** of the emergency preparedness approach for the Health Cluster in the occupied Palestinian territory. The primary aim of the emergency preparedness approach is to optimize the speed and volume of critical assistance delivery immediately after the onset of a humanitarian emergency.

Integrated preparedness means that all interventions, including response programming, are to be risk informed. Analysis and design should be based on a sound assessment of risk and all interventions designed by the Health Cluster should seek to reduce immediate and future risks. In practice, all preparedness actions listed in this plan must be part of the response strategy of the Health Cluster. Preparedness and response activities should go hand in hand. Furthermore, the Health Cluster must be able to reach vulnerable populations at community level, while at the same time looking at gaps at regional or national levels and addressing those when necessary. This is recognized as a major contribution to the current approach to disaster risk reduction.

Putting preparedness into context: The Health Cluster intends to work closely with the Humanitarian Coordinator (HC), the Humanitarian Country Team (HCT), and the Inter-Cluster Coordination Group in preparing and responding to potential emergencies with the appropriate humanitarian assistance and protection. As part of this broader response, the role of the Health Cluster is to reduce the loss of lives and morbidity in emergencies. Therefore, the Health Cluster partners' ability to respond within 24 hours is most important if lives are to be saved.

Finally, the international procedures for surveillance, preparedness, assessment, and management of public health emergencies of international concern are set out in the International Health Regulations (2005) and led by WHO. This plan will guide the preparedness for the management of potential humanitarian relief requirements arising with these crises.

GUIDING PRINCIPLES

Accountability to Affected Population - people are at the core of the plan. That means including that in the entire planning, implementation process, those receiving the services are involved, listening to their feedback, and addressing concerns.

Investing in risk assessments - it is key that collectively, the Health Cluster partners invest in risk assessments to identify at-risk groups. This is crucial if we are to better understand what their needs and their capacity are.

The impact of disasters is not gender neutral - abuse and violence is often heightened during disasters, recognizing this, and responding accordingly is fundamental.

Protection - Protection of the most vulnerable is a priority in humanitarian action. The most vulnerable include children, women, persons with disability, the elderly and the economically disempowered.

Information - collecting and analysing data and ensuring that it is disaggregated allows it to be universally accessible. Therefore, establishing real time monitoring system and inclusive early warning systems is fundamental.

Meaningful partnerships - the role of civil society must not be underestimated when planning. Civil Society Organizations (CSOs) may not be a key player in the Health Cluster; however, it is the duty of each partner to proactively engage with CSOs and establish linkages that can be mobilized during a disaster.

Building back better – Preparedness, response, and recovery[1] are strategies implemented during and after emergencies that have specific humanitarian and social objectives. Effective emergency preparedness programs ensure that response and recovery strategies lead to enhanced development. Emergencies may be viewed as a 'springboard' for development, in that they may create a situation where resources can be applied to improve the conditions of communities.

1 'Relief' and 'rehabilitation' are subsets of response and recovery.

BACKGROUND INFORMATION

Demographics and health outcomes

The estimated population living in the occupied Palestinian territory (oPt) by mid-2020 is 5.1 million, with 3.05 million in the West Bank and 2.05 million in the Gaza Strip.[2] Over 380,000 Palestinian residents live in East Jerusalem.[3] More than 2.34 million registered refugees reside in the oPt, with 1.47 million refugees living in Gaza alone (comprising almost 70% of Gaza's population). One quarter of the refugees in the West Bank live in the 19 camps located there and over half a million refugees in Gaza live in the eight camps in the Gaza Strip.[4] The overall Palestinian population is young: nearly 38% of Palestinians are aged 0–14 years, while 3.4% are aged 65 years or older.[5]

Total fertility rate in in the occupied Palestinian territory is 3.8 with marked differences between Gaza (3.9) and the West Bank (3.8). Life expectancy at birth for Palestinians was 74.1 years in 2020.[6] In 2020, the maternal mortality ratio was 28.5 / 100,000 livebirths (24.3 in Gaza and 31.4 in West Bank), infant mortality for Palestinians in the West Bank and Gaza was reported to be 6.9 per 1,000 live births and under-5 mortality was 8.2 per 1,000.[7] Health inequalities exist, with, for example, health indicators for populations in Area C of the West Bank and in the Gaza Strip worse than compared to the Palestinian average.

Non-communicable diseases remain the leading cause of mortality in oPt, accounting for more than three-fourths of all Palestinian deaths in 2020.[8]

Palestinians living under occupation are exposed to various forms of violence. In 2021, a total of 355 Palestinians, including 87 children were killed and more than 19,200 were injured because of military conflicts and confrontations with Israeli security forces and settlers. The WHO analysis of the trauma caseload reveals that of the total hospitalized casualties, more than 90% were male and 22% were children under the age of 18.

West Bank				
	Male	**Female**	**Children**	**Total**
Deaths	84	6	18	90
Injured	No data	No data	No data	16,858
Hospitalized	889	39	195	964

Gaza				
	Male	**Female**	**Children**	**Total**
Deaths	200	65	37	265
Injured	1,459	752	685	2,367
Hospitalized	No data	No data	No data	2,131

Source: https://www.ochaopt.org/data/casualties

A recent violence survey conducted by PCBS (2019) shows that 29% of married women have been exposed to some sort of violence; 38% in Gaza and 24% in the West Bank. These women experience difficulties in

2 PCBS annual report 2020

3 OCHA, HNO 2022 oPt

4 https://www.unrwa.org/where-we-work (accessed 01.02.2019)

5 https://www.pcbs.gov.ps/Downloads/book2595.pdf (accessed 03.02.2022)

6 PHIC, Health Annual Report: Palestine 2020

7 PHIC, Health Annual Report: Palestine 2020

8 PHIC, Health Annual Report: Palestine 2017, p116

receiving support, medical care, and counselling. During 2021, there has also been escalation of hostilities between Israel and oPt.

The mental health of Palestinians is affected by the exposure to violence and the context of chronic occupation, with mental distress representing one of the most significant public health challenges. Furthermore, an estimated 300,000 or over 1 in 10 people suffer from severe or moderate mental health disorders in oPt.[9] Overall, the occupied Palestinian territory has one of the highest burdens of adolescent mental disorders in the Eastern Mediterranean Region. About 54% of Palestinian boys and 47% of Palestinian girls aged 6 to 12 years reportedly have emotional and/or behavioural disorders, and the overall disease burden for mental illness is estimated to account for about 3% of disability-adjusted life years.[10]

Health resources availability, health access and attacks on health care

There are several providers of health care services in the West Bank: Ministry of Health, UNRWA, Nongovernmental organizations, Palestinian Military Medical Services, and the private sector, each with its own respective network of primary health care centres and hospitals.

In the Gaza Strip, the Ministry of Health accounts for about one third (32%) of the 52 primary health clinics, with a larger role played by UNRWA and nongovernmental organizations. Currently, there are 22 UNRWA primary healthcare clinics. In the West Bank, there are 424 MoH PHC facilities and 43 UNRWA clinics.

There are 89 hospitals in total in the occupied Palestinian territory, with 53 in the West Bank and 36 in the Gaza Strip. Bed capacity is approximately 12.8 beds per 10,000 of the population, which is 13.2 per 10,000 in the West Bank and 16.1 per 10,000 in Gaza Strip. The Ministry of Health accounts for 43.8% of bed capacity in the West Bank and 78.4% of bed capacity in the Gaza Strip. Comprehensive emergency obstetric care (CEmOC) is provided at 5 MOH and 8 non-governmental hospitals in Gaza, while Family planning is provided at all UNRWA 22 clinics, and 16 MOH clinics only.

Nongovernmental organizations account for 39% of bed capacity in the West Bank and 15% in the Gaza Strip, while private institutions provide 15.7% of bed capacity in the West Bank and 1.3% in the Gaza Strip[11].

For further information on the mapping of health resources availability in Gaza, refer to the HeRAMS on www.healthclusteroPt.org.

Further information on the needs and gaps can be found in the 'Humanitarian Needs Overview 2022'.

Barriers to accessing health services represent a serious challenge to ensuring adequate health care provision for Palestinians. Israeli-issued permits are required to reach health consultations in different parts of the occupied Palestinian territory, as well as for referrals to Israel or abroad. In 2021, nearly two-fifths (37%) of patient permit applications from the Gaza Strip were not approved, while in the West Bank 10% of patient permit applications were denied. Most permit applications were for services within the occupied Palestinian territory.

The protracted protection crisis in the occupied Palestinian territory means that health care is frequently exposed to attacks. In 2021, there were 235 health attacks, with 106 injuries of health care workers and affecting 105 health vehicles and 130 health care facilities.

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[9] OCHA, 2018. Humanitarian Needs Overview 2019. Available at: https://www.ochaopt.org/content/humanitarian-needs-overview-2019 (accessed 07.02.19)

[10] Charara R, Forouzanfar M, Naghavi M, Moradi-Lakeh M, Afshin A, et al. The burden of mental disorders in the Eastern Mediterranean Region, 1990–2013. PLOS One, 2017 Available at: http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0169575 (accessed 07.02.19).

[11] Palestine Health Information Centre, Health Annual Report: Palestine; 2020.

RISK ANALYSIS AND MONITORING

'Risk Analysis and Monitoring' identifies the hazards that could trigger a crisis and ranks them by impact and likelihood. In this plan, the Health Cluster partners have decided to use all-hazard scenarios.

The risk ranking determines whether thresholds are low, medium, or high. The monitoring provides an early warning of emerging risks, which in turn allows for early action such as tailoring the advanced preparedness action and where possible taking action that could mitigate the impact of the emerging risk. A clear and common understanding of the risks which may trigger a crisis significant enough to require a coordinated humanitarian response is fundamental to the entire emergency preparedness plan including advanced preparedness actions as part of a hazard and risk threshold specific contingency plan.

Analysis informs the planning, while monitoring ensures that the process is responsive to emerging risks. Development of a contingency plan is then undertaken when triggered. Table below indicates the outcome of the agreed Health Cluster description of impact and likelihood description.

Table 1. Description of impact and likelihood

IMPACT	LIKELIHOOD
Negligible (1) Minor additional humanitarian impact. Government capacity is sufficient to deal with the situation.	**Very unlikely (1)** A remote chance of an event occurring in the current year, from 0-5%. e.g. Seasonal hazards that have happened once or less in the last twenty years.
Minor (2) Minor additional humanitarian impact. Current country level inter-agency resources sufficient to cover needs beyond government capability.	**Unlikely (2)** The event has a low chance of arising in the current year, from 5 to 15%. e.g. Seasonal hazards that have happened one to three times in the last twenty years.
Moderate (3) Moderate additional humanitarian impact. New resources up to 30% of current operations needed to cover needs beyond government capacity. Regional support not required.	**Moderately likely (3)** The event has a viable chance of arising in the current year, from 15-30%. e.g. Seasonal hazards that have happened two or three times in the last ten years, or once or twice in the last few years.
Severe (4) Substantive additional humanitarian impact. New resources up to 50% of current operations needed to cover needs beyond government capacity. Regional support required.	**Likely (4)** the event has a significant chance of arising in the current year, from 30-50%. e.g. Seasonal hazards that happen every second or third year, e.g. two times in the last year.
Critical (5) Massive additional humanitarian impact. New resources over 80% of current operations needed to cover needs beyond government capacity. l3- scale emergency.	**Very Likely (5)** The event has a positive chance of arising, over 50%. e.g. Seasonal hazards that have happened three or more times in the last five years, or five or more times in the last ten years.
RISK = IMPACT x LIKELIHOOD **LOW: 1–7 MEDIUM: 8-14 HIGH: 15-25**	

Table 2. Health Cluster Risk Analysis - Gaza

HAZARD	IMPACT	LIKELIHOOD	CALCULATED RISK	RISK RATING
War/ conflict	5	4	20	HIGH
Communicable Diseases Outbreak	5	4	20	HIGH
Floods	2	2	4	LOW
Earthquake	5	2	8	MEDIUM

Table 3. Health Cluster Risk Analysis – West Bank

HAZARD	IMPACT	LIKELIHOOD	CALCULATED RISK	RISK RATING
Violence and unrest	5	4	20	HIGH
Communicable Diseases Outbreak	5	4	20	HIGH
Increasing restrictions on access and coercive environment	5	5	25	HIGH
Earthquake	5	3	10	MEDIUM

War/conflict in Gaza: Within this complex emergency, the hazard of 'war/conflict' can result from several different hazards, or more often, to a complex combination of both natural and man-made causes and difference causes of vulnerability. For example, the triggering of increased war or conflict can result in displaced population and therefore increased risk of an outbreak. When planning the preparedness measures, it is important to consider all these factors and establish risk mitigation measures as part of the emergency preparedness plan. Moreover, in the recent May 2021 escalation of hostilities, it was recorded that access to major Hospitals had been obstructed by roads destroyed from debris and shelling.

Violence and unrest in the West Bank including East Jerusalem:
Continued Israeli settlement expansion, dispossession, and displacement of Palestinians, and use of excessive force in the West Bank mean high risk of exposure to violence and its consequences for health and health care provision. For contingency planning purposes, a combination of the worst-case outcomes will be considered. Below are the areas that may be affected.

- The West Bank experiences mass protests, increased settler violence, demonstrations met with violence by Israeli forces, with high risk of further excessive use of force as observed in 2021.
- In East Jerusalem, demonstrations and confrontations with Israeli forces and settlers continue. Approximately 126k Palestinians live adjacent to settler communities or in areas vulnerable to confrontations and attacks.

Area C: In Area C of the West Bank, where approximately 300K Palestinians and some 427K Israeli settlers live, an increase in confrontations with the Israeli army and settlers will occur alongside additional restrictions on access as well as a continued comprehensive freeze of any Palestinian activity in the area (e.g. construction agriculture, grazing etc). 90 separate locations in Area C are identified as areas of settlement expansion creating friction and demonstrations, including communities adjacent to settlements and settlement infrastructure, such as roads restricted for use by settlers. In addition to direct attacks against Palestinians, settler violence also takes the form of damage to Palestinian properties. Up to one third of the communities in Area C will be affected at any one time.

Increasing restrictions on access and coercive environment: Further tightening of existing severe restrictions on access could occur across the occupied Palestinian territory. This includes limitations on movement into East Jerusalem from the rest of the West Bank, restrictions on access to and for communities in the Seam Zone, Area C and H2, and the ongoing blockade and closure of the Gaza Strip. The main entry points to major Palestinian towns in the West Bank can be completely shut down by Israeli forces with prevention of exit and entry, as has occurred in the past, while the proportion of

permits approved for patients and companions varies substantially each year, particularly for the Gaza Strip. Access for ambulances and health care workers, similarly, may be further restricted relative to policies and approvals in 2021.
In Area C, there already exist severe restrictions on planning and development accompanied by many communities with demolition orders at high risk of displacement. The number and the severity of demolitions and confiscation incidents as well as settler violence is expected to continue and may rise in different areas, particularly with lack of effective measures for accountability or redress. This would result in further degradation of communities' basic services and assets and the forcible transfer of some communities. New regulations are applied and enforced by the Israeli authorities and movement and access will be highly affected in specific areas, particularly in E1, H2, the Jordan Valley and the firing zones.
With the enforcement of new regulations from the Israeli authorities, indicatively 140,000 people are estimated to be potentially affected, an average of 10,000 people will be displaced every month and 100,000 people will lose their livelihood. Public services are expected to be impeded and a growing number of cases requiring legal support due to the implementation of new regulations will be registered. Many people will require assistance in other areas such as MHPSS, in addition to the basic needs and services such as WASH and temporary shelters.
In recent years there is progressively shrinking space for local and international NGOs, due to restrictive counter-terrorism laws, Israeli authorities' procedures, etc. This is relevant considering the important role of NGOs and INGOs as health services providers, among other roles.

Parameters and triggers for a response to war/ conflict/ violence/ unrest/ coercive environment
*Please refer to Scenario1 and 2 for specific triggers (page 22 and 23)
Monitor political situation and temperature within the population. Increase in confrontation in West Bank and East Jerusalem usually precedes war, violence, and civil unrest. In addition, increase in number of confiscations or demolitions, number of security incidents in the areas affected or nearby, number of temporally or permanently displaced people and increase in the number of attacks on health, access to health services and other sectors such as education, WASH, shelter.

Trigger(s) suggested: Reports of attacks in oPt. Introduction of a new relevant Israeli regulation. Disproportionate Israeli response to Palestinian protests. Unauthorised entrance of settlers to Al Aqsa Mosque esplanade. Access and movements in the affected areas restricted/permit regime.

Communicable disease outbreak: The COVID-19 pandemic has further exposed how an outbreak of a communicable disease can take place any time and infect a significant number of people throughout the oPt at a rapid rate.

Post an emergency such as war, the risk of communicable diseases is influenced by six factors, including:

- Pre-existent levels of disease;
- Ecological changes which are the results of the emergency;
- Population displacement;
- Changes in population density;
- Disruption of public utilities; and
- Interruption of basic health services.

According to the communicable disease characteristics, climate, people behaviour and other environmental and social factors, oPt may experience many people infected upon declaration of the first confirmed case. If not properly contained, the disease may spread in an uncontrollable manner very quickly, exposing and impacting people at an exponential rate. In response, lockdown measures will be declared by the authorities depending on the level of the infection, and people will be ordered to apply social distancing and other preventive measures to contain the outbreak as much as possible. Quarantine centres may be established for suspected cases as well as facilities appointed for the treatment of the confirmed cases with clear symptoms. If the infection cannot be contained to certain areas, the state of emergency will be declared at the national level. Various services will be disrupted

or heavily affected, with an expected impact especially on vulnerable groups. Israel may apply similar measures – thus also to East Jerusalem – and strongly regulate the circulation of people with the rest of the West Bank and Gaza.

An increase in population density caused by population displacement provides the opportunity for an increase in person-to-person transmission of communicable disease, this is particularly the case in Gaza, which is already classified as one of the highly populated areas in the world. Therefore, emergencies may create opportunities for increase in the numbers of disease vectors. Fleas and lice may increase in crowded living conditions, such as designated emergency shelters. The failure of water supplies and sewage systems can also result in increased disease transmission.

Parameters and triggers for a response

* Threshold for trigger will be determined by the disease guided by WHO

Monitor the number of confirmed cases (mild, moderate, and severe cases), number of people in quarantine or isolation facilities and home-quarantine or home-isolation (if applicable), number of people treated or in need of ICU treatment or specialized treatment, number of children separated due to quarantine measures, due to abandonment or due to loss of both parents/caregivers.

Trigger(s) suggested: Report of outbreak prone disease, declaration of the national state of emergency, lockdown, and other movement restriction measures.

Earthquake: An earthquake of 6 or more on the Richter scale will bring down hundreds of buildings throughout the oPt. One of the worst affected areas will be the edge of the Jordan Valley (from Lake Tiberias to the Dead Sea), which includes the cities of Jenin, Tubas, Nablus, Ramallah, and Jerusalem. The Jordan Valley is an active seismic region; eight significant earthquakes have happened in the last 1,000 years ranging from 6 to 7 on a magnitude scale. Time intervals for earthquakes ranging from 6 to 7 Richter is from 10 years to 213 years, with the latest one in 1927, measuring 6.3 Richter scale. This level of seismicity calls for a constant high level of mitigation and preparedness.

An earthquake of 6 to 6.5 on Richter scale will result in approximately 1,000 fatalities, 10,000 casualties and 100,000 displaced. Some sources estimate that 6% of all buildings in the main cities of the West Bank will totally collapse at that magnitude. Tens of thousands of homeless and displaced people will seek refuge in tent camps as well as in UNRWA, municipal and government buildings and newly established collective centres; female-headed households and persons with disability will be particularly affected. Children will be separated from their families and/or protective environment. Deterioration in psycho-social wellbeing, including among children, women, persons with disabilities and the elderly will be evident.

Sewage and water, communication and electricity networks will be severely damaged throughout the affected areas, leading to concerns over the spread of communicable diseases.

An earthquake with a magnitude of more than 7.5 Richter scale will affect neighbouring countries, hindering their capacity to help. Casualties could reach hundreds of thousands.

Parameters and triggers for a response

Monitor seismic reports

Trigger(s) suggested: Report of potential earthquake, declaration of the national state of emergency, lockdown, and other movement restriction measures.

MONITORING & IDENTIFYING RISK THRESHOLDS

The table below summarises some of the hazards and a key set of indicators that should be routinely monitored. This should be updated on a quarterly basis by the Health Cluster to remain relevant.

Hazard	Indicators	Trigger (intensity and duration variables)	Sources	Time period
Gaza Strip				
War/ conflict	Number of conflict related injuries segregated by age, gender and disability Destruction of critical medical infrastructure Number of internally displaced people segregated by age, gender and disability Number of health facilities/ staff/ vehicles attacked	An incident which generates more patients at one time than locally available resources can manage using routine procedures. Activation of the emergency department mass casualty management plan *Attacks on 1 or more hospitals* *Destruction of the medicine warehouse*	WHO dashboard MoH, HeRAMS	Daily/hourly
Communicable diseases/ outbreak	Number of cases of notifiable disease identified (A cases) B cases C cases	*>1 with a notifiable disease A* *Any 'unusual' increase in diseases that results in a declared national outbreak with the WHO IHR*	Gaza Surveillance System	Within 24 hours of confirmation
Earthquake, flooding and other natural disaster	-Number of households/people displaced segregated by age, gender and disability -Number of houses and facilities declared at risk - Number of destroyed health facilities. - Infrastructure damage which will delay the access to health care. - Any potential of communicable diseases	Declaration of the state of emergency.	Government	Within 24 hours of confirmation

Hazard	Indicators	Trigger (intensity and duration variables)	Sources	Time period
West Bank				
Increasing restrictions on access and coercive environment	Number of security incidents. No of health attacks, number of injuries & fatalities Damage of critical medical infrastructure	Introduction of a new relevant Israeli regulation. Access and movements in the affected areas restricted/permit regime. Settlers' violence Popular protest Confrontations with the Israeli soldiers Health attacks	OCHA updates MoH/WHO MoH/ WHO	Daily/hourly

Communicable diseases/ outbreak	Number of confirmed cases, mild and moderate cases, number of sever cases who needs ICU treatment or ventilators.	Declaration of the national state of emergency, lockdown, and other movement restriction measures.	Government	Within 24 hours of confirmation
Increasing restrictions on access and coercive environment	- Severe increase of number of confiscations or demolitions - Number of security incidents in the areas affected - number of forced displacements	-Changes in the Political context -Any unilateral Israeli action in oPt -Settlers' violence	OCHA/UNSCO updates MoH/ WHO dashboard	Within 24 hours of confirmation
Earthquake, flooding and other natural disaster	-Number of households/people displaced segregated by age, gender and disability -Number of houses and facilities declared at risk, number - Number of destroyed health facilities. - Infrastructure damage which will delay the access to health care. - Any potential of communicable diseases	Declaration of the state of emergency.	Government	Within 24 hours of confirmation

The oPt is particularly challenging to monitor as the high rated hazard "war/conflict/civil unrest" is classified as an "evolving hazard". In other words, it does not emerge from a single, distinct event but rather a manifestation of various political, economic, and social factors (drivers) and it is often unpredictable during times throughout the year. The risk that it poses is irregular over time. The Health Cluster sees this as an opportunity for disaster risk reduction, early response and implement procedures to avoid a catastrophic outcome. Early response should be encouraged: It is better to activate the contingency plan and upon re-evaluation freeze the implementation, than to respond in a delayed manner.

LESSONS LEARNT FROM PREVIOUS EVENTS

The following lessons have been captures from previous emergencies in the Gaza Strip:

Service delivery:

- Most of the primary healthcare centres are closed during conflict periods, hindering treatment for non-communicable diseases patients, pregnant women, children, the elderly, and persons with disability who often rely most on primary healthcare services[12]. However, in May 2021 escalation, the PHCCs resumed activities on day 5 of the 11 days war, and this proved beneficial not only for NCD needs, but for minor physical Trauma patients, as well. [13]
- Hospitals remain open but are unable to cope with the increased influx and are often lacking in proper organization (including crowd control, cleanliness, and hygiene standards). In May 2021 escalation though, the application of Mass casualty Management principles improved the outcome compared to previous events[14]
- Substantial damage to health care facilities may affect major hospitals and health care centres required for the emergency response.
- Medical supplies across all levels significantly deplete, even basic supplies can be exhausted within the first few days, depending on the severity. Pre-positioning equipment and supplies within the facilities to ensure speed in response.
- Medical attention and resources are diverted to cope with the huge influx of injuries, at the expense of other groups/services i.e. obstetric care, non-communicable diseases etc. For example, during the 2014 military operations, operation theatres in Shifa maternity were dedicated to cope with surgery[15]. NGO and private hospitals in Gaza have addressed the needs for acute, non-conflict, surgical interventions in May 2021
- Although PHCs might be closed, primary healthcare staff could be better utilized during emergencies. Emergency teams (incl. health professionals, community volunteers, CBR workers, etc) distributed geographically might be helpful to ensure linkage and coordination between the affected population and the health facilities.
- All health facilities should be taking into consideration that in times of need they may be having to operate only with personnel that lives within walking distance from the health facility
- Mobile clinics have a role in emergencies.
- Designated emergency shelters should have basic treatment facilities such as medical/ nursing station with capacity to screen, detect, and refer cases for urgent treatment.
- Designated emergency shelters must be accessible by outreach teams from the closest emergency primary healthcare unit and should be physically, informationally and geographically accessible for affected population especially for persons with disability and other vulnerable groups.
- Bureaucracy of the large agencies leads to delays in response.
- Health workers after emergencies get burnt out and in need of self-care and MHPSS support.
- People with severe mental health disorders have no access to the specialised services during an emergency and do not receive their psychotropics in time which leads to being more agitation and relapses occur.
- Displaced people in shelters need of MHPSS support.
- Persons with disability who rely on carers are often neglected during emergencies.

[12] HeRAMS

[13] WHO https://healthclusteropt.org/admin/file_manager/uploads/files/shares/Documents/60bc871f8dc5e.pdf page 8

[14] WHO https://healthclusteropt.org/admin/file_manager/uploads/files/shares/Documents/60bc871f8dc5e.pdf page 9

[15] WHO

- Provision of multi-disciplinary rehabilitation (MDR) services are suspended and not prioritized in emergency situation leaving people in need behind and worsen their functional and psychological situation.

Access and attacks against health care:

- Health workers found it difficult to reach injured persons or operate in a safe space due to the increased frequency of attacks against healthcare staff and facilities[16][17].
- Patient and companion permits to reach essential health care outside the Gaza Strip are suspended[Error! Bookmark not defined.].
- Governorates and certain localities can be cut-off, hindering access of patients to hospitals, including pregnant women in labour, and increasing the risk of maternal mortality and morbidity due to increased home deliveries, and others in need such as patients suffering from a trauma injury or persons with chronic disability in need for medical care.
- Emergency medical teams / ambulance movements can be restricted due to damage to buildings and infrastructure, as well as attacks on health facilities or roads reaching health facilities.
- Patient injured because of the conflict face additional barriers in obtaining a permit for treatment, especially outside of Gaza.
- International shipments face severe delays from the Israeli authorities, making availability of essential supplies unpredictable and unreliable during times of crisis.
- People with NCD and mental health problems will have difficult access to essential health services

Coordination and information

- Accurate, complete, and timely information is a major obstacle in the emergencies. Pre-hospital and hospital data (especially the emergency departments) have no system of obtaining the information necessary in a timely manner.
- Coordination between partners can be cut off, and distance conference modules (like Teams and Zoom) should be ready to be used, to achieve some level of coordination.
- Partners can be direct and indirect targets during conflict.
- Movement of cluster partner staff within the West Bank, including East Jerusalem and the Gaza strip during incursions, lockdowns, bombardment, escalation of conflicts is restricted.

[16] WHO

[17] WHO https://healthclusteropt.org/admin/file_manager/uploads/files/shares/Documents/60bc871f8dc5e.pdf page 6

PREPAREDNESS ACTIVITIES & CONTINGENCY

It is the responsibility of the Health Cluster to decide which phase should be activated, when it is activated, and when to return to the recovery phase. **It is also of cardinal importance for the local authorities to be providing continuous feedback to the Health cluster, so that partners are all aware of the current state.**

The different phases include:

- **Phase 1 (preparedness activities)** - This is where ongoing preparedness happens alongside with and the continuous daily work of the Health Cluster. This is in-line with the IASC minimum actions for preparedness. It is not scenario specific.

- **Phase 2 (heightened readiness / response within 72 hours)** –This phase encompasses event-based preparedness and response, such as the preparation for a scheduled event or during a conflict situation with ongoing hostilities, whilst ensuring business continuity and minimum disruption of the chronic emergency needs. Phase 2 is scenario specific.

- **Phase 3 (beyond 72 hours)** – The event has been going on for more than 72 hours and requires a continuous response. The likely impact of routine services is detrimental and even some non-communicable diseases patients are severely impacted. Stocks must be replenished, and plans adjusted. Staffing requirements need to be considered to reduce burn out. Phase 3 is scenario specific. Increased frequency of monitoring for health care functioning, access and attacks on health care is required to support coordination of the humanitarian health response.

- **Phase 4 (recovery)** – The event is declared over. Medicines and consumables need to be replenished, kits and assistive devices need to be re-stocked, damaged equipment should be replaced, partner debriefing should occur, and the Health Cluster should return to phase 1. Phase 4 is not scenario specific. Strong advocacy is required to reinstate access to essential health care, throughout the occupied Palestinian territory and abroad.

PHASE 1 – PREPAREDNESS ACTIVITIES

	Activity	Indicator	Responsible	Area of intervention	Current Capacity
Coordination and information					
1	Establish contact with the Director of International Cooperation at the MoH level	Contact with MoH agreed	Health Cluster coordination team	oPt	
2	Ensure that most health projects submitted to the HRP have a component of 'preparedness'' and disaster risk reduction.	% projects in HRP with a preparedness component.	Health Cluster	oPt	
3	Map partner's capacity to response in emergencies	Up to date 4Ws	Health Cluster	oPt	
4	Establish a mechanism of improved, timely communication	Public Health Emergency Operational Centre (PHEOC) with the Cluster representative present	WHO and MoH	oPt	
5	Initiate the Early Warning and Response mechanisms with agreed frequency during acute and chronic situations	Early warning system	Health Cluster / ICCG	oPt	
6	Inventory of the pre-positioned and in pipeline medicines and supplies, including trauma kits and IAHK (Inter-Agency Health) Kits (MoH, national and international partners)	Up-to-date inventory of stocks	Health Cluster	oPt	
Fundraising and advocacy					
7	Develop a funding request for the preparedness plan	Preparedness plan (phase 1) has a budget tag shared and uploaded on the Cluster website	Health Cluster coordination team	Gaza and West Bank	
8	Undertake coordinated advocacy to strengthen protection of health and health care of populations during major events	Frequency of coordination meetings and advocacy outputs	Health Cluster Advocacy Taskforce	Gaza and West Bank	
9	Implement protection strategy for health care and ensure that health care staff are trained on protection issues	Protection strategy in place and training conducted at least once per year, in line with WHO Surveillance System for Attacks on Health Care	WHO	Gaza and West Bank	
10	Ensure effective reporting and monitoring of violations against health care, including restrictions on access and health attacks	Maintain database available to all partners on health care access and attacks on health care, in line with WHO Surveillance System for Attacks on Health Care	WHO	Gaza and West Bank	
Logistics capacity					
11	Expand number of warehouses in high-risk areas	Potential warehouses identified in each governorate are activated	WHO, other partners as appropriate	As appropriate for access	
12	Agreed LTAs with suppliers for timely delivery of supplies	LTA established and shared amongst the UN agencies	WHO, UNFPA, UNICEF, UNRWA	As appropriate	
13	Identify a back-up TSP location for safety and protection	Back-up location/alternative location for each TSP in each governorate identified	PRCS, MoH and WHO	oPt	
Prepositioning essential supplies and kits					
14	Preposition Trauma Stabilisation Points / Emergency Medical teams / Advanced Medical Point across each governorate (including infrastructure)	Each governorate has the capacity to set-up a TSP/EMT/AMP to absorb minor and some moderate cases and stabilise, treat, and refer critical cases to hospitals	PRCS, MoH, WHO, MSF Spain	oPt	MSF Spain: Training on BLS and FA to community volunteers, donation and regular replenishment of TSC kits in the following Hebron pre-identified hotspot communities (Al Arroub Pheonix Society, Al Fawwar Community Center, Beit Ummar Community Center, Beit Ummar Charity, H2/Mutaseb Community, H2 Triq Bin Ziad Center, H2 Tariq Bin Ziad School. Community volunteers lists and contact details submitted to general registry of MoH

					General Directorate of Emergency roster for quick mobilization when needed.
15	Pre-position 5 trauma care supplies (1,000 beneficiaries per kit), 5 Trauma Stabilisation Kits (500 beneficiaries per kit), 5 weapon wounded kits (500 beneficiaries per kits) and 5 surgical supply kits (1,500 surgical interventions per kits), 1000 community first aid kits.	4,000 injured people have access to essential and adequate medical supplies, including medicines and disposables	Cluster partners PRCS, MoH, WHO, MSF Spain	As appropriate for access	MSF SPAIN: Trauma Stabilization Kits, Ambulance Kits prepositioned in Hebron; 1 MCP kit donated and prepositioned in Alia Hospital in Hebron; 1 ER Trauma + 1 ambulance kit donated and prepositioned in Yatta, Mohtaseb and Halhul Hospitals in Hebron WHO: 6 PHCC distributed all along the Gaza Strip have their Emergency Rooms upgraded with equipment, and prepositioned supplies and medications capacitating them to support the Gaza Health system against any sudden onset disaster. These are: Al Darj clinic, Old Nuseirat clinic, and Tal Al Sultan clinic For ICRC Al Rahma PHC (Shejaiya), Jabalia PHCC, Al Qarara PHCC HI: able to contribute with wound dressing and mobility aids for burning wounds)
16	Pre-position medicine and supplies for non-trauma care	4,000 people have access to acute care (non-trauma) through the provision of NCD kits or supplies 500,000 women of reproductive age (WRA) have access to lifesaving SRH (sexual and reproductive health) care through the provision of RH kits 2000 people have access to dignity kits (coordinated with protection cluster)	Cluster partners	As appropriate for access	MSF Spain – 1 IEHK (2018) with supplementary modules for NCD and PEP prepositioned in Hebron WHO: planning to be having set of TESK kits, prepositioned within Gaza, for any sudden onset disaster, will keep Health Cluster updated on developments
17	Preposition assistive devices	6,400 people have access to assistive devices	Cluster partners	Gaza	
18	Pre-position Diarrheal Diseases Kits in case of diarrheal disease (e.g. Cholera) outbreak	700 DDK across five governorates in Gaza	Cluster partners	As appropriate for access	
19	Prepositioning of nutrition supplies for children 6-23 months in high-risk areas	1,000 children 6-23 months have access to nutrition supplies for treatment of various forms of malnutrition	UNICEF and Nutrition Working Group partners	As appropriate for access	
20	Expand Safe Delivery Network, and procure safe delivery kits to ensure women can safely give birth in the case they cannot reach a health facility in an emergency	200 members across all of Gaza included in Safe Delivery Network	UNFPA, MoH, Cluster partners, PRCS	Gaza	UNFPA: The established network might need update, kits need replacement/refilling etc.
21	Preposition emergency reproductive health kits	List of kits and quantities, enough for 500,000 WRA, including 45,000 pregnant women at any time for 3 months	UNFPA, MDM France	Gaza	
22	Preposition 37 medicine items and 35 disposable items	Available 24 hours, 7 days a week. Always kept up to date and constantly replenished if released.	MAP-UK	Gaza	
23	3 IEHK (Inter-agency Emergency Health Kit) to serve 10,000 primary health care patients. Each kit includes 65 medicines, 52 disposables and 42 equipment.	Available 24 hours, 7 days a week. Always kept up to date and constantly replenished if released.	Cluster partners	Gaza	

24	150 external fixators	Available 24 hours, 7 days a week. Always kept up to date and constantly replenished if released.	Cluster partners	Gaza	
25	Preposition of psychotropic drugs	Patients in need for medicine as a part of their psychotherapy plan will benefit from medicines as per their need and as available in the GCMHP stocks.	Cluster partners	oPt	GCMHP has prepositioned supplies for Gaza
Infrastructure					
26	Ensure that 24-hour MHPSS hotline that can be upscaled during emergencies	Hotline is established and can be activated upon trigger	MoH, Sawa, GCMHP , MSF Spain	oPt	
27	Ensure centralised ambulance dispatch centres in Gaza and Ramallah for primary providers of pre-hospital care are operational	There is a centralised dispatch centre in Gaza able to coordinate the key providers of ambulance care	PRCS with support from WHO	oPt	
Training activities					
28	Conduct mass casualty management training for all pre-hospital and emergency unit hospital staff (simulation and clinical coaching) + surge support staff	250 prehospital staff trained and 250 emergency unit staff trained on MCM (mass casualty management) + surge staff	MoH, WHO, MAP-UK, MDM France, ICRC	oPt	
29	Conduct mass casualty management training for all emergency unit staff working in the back-up hospitals (including upgrading minor structure)	250 emergency unit staff trained on MCM (mass casualty management)	MoH, WHO, MAP-UK, MDM France, ICRC	oPt	
30	Conduct first aid training for vulnerable communities, targeting key vulnerable groups such as farmers and fishermen	TBC	Cluster partners	oPt	
31	Design and development of training materials and Training of local authorities in nutrition interventions for children delivery in high-risk areas	100 health staff trained	UNICEF and Nutrition Working Group partners	Affected areas	
32	Training of primary health care workers in high-risk areas on IYCF-E	100 health staff trained	UNICEF and Nutrition Working Group partners	Affected areas	
33	Training of community volunteers in high-risk areas on IYCF-E counselling	100 health staff trained	UNICEF and Nutrition Working Group partners	Affected areas	
34	Development of counselling cards and information materials on IYCF (breastfeeding and age-specific complementary feeding)	100 health staff trained	UNICEF and Nutrition Working Group partners	Affected areas	
35	Conduct ToT and further training on MISP (the Minimal Initial Service Package for Reproductive Health) in emergencies	100 new trainees in 2020, including 30 master trainers	UNFPA, MoH	oPt	UNFPA: 25 TOT people trained in 2021, more to be targeted in 2022/2023
36	Build the capacity of MHPSS professionals on psychological interventions such as PM+	50 MHPSS professionals trained	WHO, MoH, GCMHP	oPt	GCMHP: can provide the training for additional 50 MHPSS professionals
37	Build the capacity of PHC health workers and emergency department at hospitals on MHPSS by implementing mhGAP program	100 health staff trained	Cluster partners	oPt	
38	Train healthcare providers in the clinical management of rape (CMR) – In coordination with GBV sub-cluster	15 healthcare providers trained in training of trainers for CMR and 50 providers trained by trainers on CMR	MoH, UNFPA, and GBV Sub-Cluster partners	oPt	UNFPA/WHO: Around 20 providers are planned to be trained "TOT" in May 2022
39	Train healthcare providers in detection and referral of gender-based violence (GBV), with a focus on the referral pathways during an acute emergency - In coordination with GBV sub-cluster	200 healthcare providers are trained in detection and referral of GBV in an acute emergency	MoH, UNFPA and GBV-Sub cluster partners	oPt	Training is planned in 2022 targeting 250 health service providers on GBV identification and referral
40	Conduct education awareness campaigns so that communities know where to go to for access to healthcare including rehabilitation services	Vulnerable communities receive key messaging	Cluster partners	oPt	

41	Train the health workers/ community volunteers o minimum standards on rehabilitation in disasters and conflict	At least 100 trained	HI/RTF	oPt	
42	Development of guidelines and minimum standards for the provision of health services including rehabilitation	Guidelines produced	WHO, MoH and HI	oPt	
43	Provide caring sessions of supervision and stress management to MHPSS and health professionals	GCMHP can provide caring for 50 professionals from different specialities	GCMHP	Gaza	
Deployment of emergency medical team's (EMT) preparedness activities					
44	Ensure a functioning EMT-CC with fully functioning components (EMT roster, EMT agreed standards etc)	EMT-CC is functional EMT roster is established	WHO, MoH	oPt	
45	Emergency Psychological First Aid (PFA) satellite teams are functioning and provide PFA services to affected people.	Lists of affected population are provided from the MoH and other field working partners	GCMHP	Gaza	

PHASE 2: RESPONSE ACTIVITIES < 72 HOURS

Phase 2 is in response to a scenario/ activation of the plan. As mentioned before, the plan can be activated at any point by the Health Cluster, in close coordination with the MoH. If Phase 2 is activated, the ICCG and the HC must be informed, especially as it may trigger the need for a full ICCG response.

Scenario 1: Gaza War/ conflict

Considering the Health Cluster Risk Analysis for Gaza (refer to table 2), war/conflict was identified as a high priority scenario. Phase 2 and 3, therefore outlines the response measures to this scenario.

The immediate effects of this scenario may include deaths, injuries, and disease, requiring emergency and trauma care and rehabilitation. However, the impact on the overall system and lifestyle may lead to an increased risk of infectious diseases, such as water-borne or respiratory infections, psychosocial effects, and the disruption of regular health services such as, for instance, provision of basic and/or emergency comprehensive obstetric and neonatal care. Epidemics following a disaster are frequent, and mostly they result from an insidious break-up of community infrastructure, basic health services including vaccination and from overcrowding. Food security emergencies can also lead to undernutrition, requiring supplementary and therapeutic feeding.

Main needs identified

- 15,000 injuries. Over 20% of these will require emergency care at the hospital level.
- Number of inaccessible or damaged hospitals and primary health facilities:
    - Hospitals: Southern governorate (Rafah) is cut off. Governorates can become isolated and cut off from the rest of the Gaza Strip.
    - PHC: approximately 38 closed. Leaving only 11 MoH primary healthcare clinics (PHCs) functioning and some UNRWA PHCs
- Electricity cuts: **highly likely + high impact**
- Lack of or limited access: **highly likely + high impact**
- Access restrictions: **highly likely + high impact**
- Insufficient access to trauma and emergency care: **highly likely + high impact**
- Reduced access to essential health services in hospitals and PHC facilities:
    - MHPSS services- low impact as MHPSS should be up-scaled and is critical **after** the event: **highly likely + high impact**
    - NCD management services: **highly likely + high impact**
- Poor water quality and spread of water-borne diseases: **unlikely + high impact**
- Imposition of additional restriction on accessing health facilities outside of Gaza: **likely + low impact**
- Communication channels are interrupted or cut. Contact may be reduced

Main response actions:

- Provision of first aid and primary trauma care at the pre-hospital and hospital level.
- Establish trauma stabilization points / Emergency Medical Teams / Advanced Medical Points at safe distance from the confrontation spots.
- Emergency referral services/ambulance.
- Provision of Psychological First Aid (PFA) services for populations in the affected areas and especially for at-risk people such as PwD and patients with mental illness and in need for medicines.
- Maintain lifesaving primary health services for the populations in the affected areas, including nutrition care, reproductive and MH services, as well as services for chronic patients (MoH, UNRWA or mobile clinics by NGOs).
- MHPSS and care/services in coordination with other clusters and in compliance to the Inter-Agency Standing Committee (IASC) standards.
- Procurement of medical supplies, including essential drugs and disposables reagents, in accordance with the MoH protocols and approved lists and in compliance to international standards
- Information dissemination and advocacy about the availability of services, restrictions on access and attacks against health care.

Scenario 2: Violence and Unrest in the West Bank

Main needs identified:

- Confrontations between Palestinians, Israeli authorities, and settlers at various hotspots across West Bank and East Jerusalem resulting in 1,000 injuries/ week.
- Use of live ammunition
- Limited access to lifesaving primary health care, emergency care and ambulance services for Area C, Seam Zone.
- Referrals of Palestinians to health services in East Jerusalem.
- Stockpiles and procurement of medical supplies.

Main response actions:

- Maintain lifesaving primary health services for the populations in the affected areas, including nutrition care, reproductive and MH services, as well as services for chronic patients (MoH, UNRWA or mobile clinics by NGO).
- Provision of first aid and primary trauma care at the pre-hospital and hospital level.
- Establish Advanced Medical Points at safe distance from the confrontation spots. Make known the position of these facilities to all actors involved and reassure that ICRC communicates their position with the Israeli Authorities
- Emergency referral services/ambulance.
- MHPSS and care/services in coordination with other clusters and in compliance to the Inter-Agency Standing Committee (IASC) standards.
- Procurement of medical supplies, including essential drugs and disposables reagents, in accordance with the MoH protocols and approved lists and in compliance to international standards
- Information dissemination and advocacy about the availability of services, restrictions on access and attacks against health care.

Scenario 3: Communicable Disease Outbreak:

Main needs identified:

- Large number of people to test, quarantine and treat while keeping other services running.
- Early detection (surveillance, contact tracing), large need for supply.
- The need of PPEs, test kits and swabs.

Main response actions

- Stopping further transmission of the disease across the oPt and reducing the demand for hospital critical care services and to avoid any overload of hospital care capacity.
- Providing adequate care for patients affected by the disease and to support their families and close contacts.
- Minimizing the impact of the epidemic on the functional capability of the health system.
- Establishment of the coordination centre and early detection of cases and surveillance.
- Scale-up of IPC protocols, (6) dedicated, use of stockpile and dedicated procurement.
- Activate RCCE and dedicated communication and information sharing system.
- MHPSS and care/services in coordination with other clusters and in compliance to the Inter-Agency Standing Committee (IASC) standards.

Scenario 4: Increasing restrictions on access and coercive environment

Main needs identified:

- Sustainability of access to the healthcare services.
- Guarantee the movement of ambulances and health workers.

- Safe and protected environment for both patients and medical staff.
- Supply chain, maintenance and operating capacity ensured.

Main response actions:

- Maintain healthcare services, including nutrition care, sexual, reproductive and mental health services, trauma and emergency care and services for chronic patients (MoH, UNRWA or mobile clinics by NGO).
- Information dissemination and advocacy about the availability of services, restrictions on access and attacks against health care.
- Trauma care at the community level, including first aid.
- Establish trauma stabilization points at safe distance from the confrontation spot.
- Strengthen the emergency department at major hospitals to enable the management of mass casualties.
- Procurement of medical supplies including drugs, and disposables reagents in accordance with the MoH protocols and approved lists as well as in compliance with the international standards.
- Dedicated information circulation and culturally sensitive MHPSS.

Scenario 5: Earthquake or Other Major Natural Disasters

Main needs identified:

- Damages to health facilities could be massive and could lead to an interruption in basic healthcare services. Therefore, there will be need to:
- Maintain the availability of the hospital healthcare, especially the surgical needs (injuries, fractures, etc).
- Maintain access to basic health services (PHC).
- Stockpiles and procurement of medical supplies.

Main response actions

- First aid / primary level trauma care.
- Triage at all levels of healthcare.
- Emergency referral services (consider possible damage of health infrastructure and roads).
- Emergency care services, including surgical care and emergency obstetric care.
- PHC services level 2 and above for the populations in the affected areas, including nutrition care, reproductive and mental health services through stationary (where health and crucial roads infrastructure is preserved) or mobile/temporary clinics.
- MHPSS and care integrated within or closely coordinated with PHC services, emergency response
- Regular monitoring of potential outbreaks of diseases through physical examination and lab tests and monitor the risk of water pollution

PHASE 2 RESPONSE ACTIVITIES <72 HOURS					
	Activity	**Indicator**	**Responsible**	**Area of intervention**	**Notes**
	Coordination				
1	Enhance/strengthen the -National operational representation of Health Cluster in most affected regions – conduct a Health Cluster meeting, activate information exchange and information systems upscaling using the early warning indicators tracking system	Information on Health Status and Resources Availability is collected and shared daily.	Cluster Lead Agency and Coordinators	oPt	
2	Health Custer coordination meeting with the MoH to update the response plan (Who, will do What and Where)	Meeting with the Director of the PHEOC is conducted within the timeframe of the phase.	Cluster Lead Agency and Coordinators	oPt	
3	Initiate emergency Health Cluster coordination meeting: ● Context update ● Activation of the HC contingency plan (make modifications if needed based on the context information)/ development of HC provisional response plan	Health Cluster meeting has been conducted within the timeframe of the phase.	Cluster Lead Agency and Coordinators	oPt	
4	Activate the WHO-led Incident management System (IMS) and establish task force groups, if necessary	IMS is activated and the Incident Manager is named by WHO.	WHO and Coordinators	oPt	
5	Update the 4Ws (or the equivalent) and increase frequency of the early warning alert response system by deploying surge data collectors, if applicable	The PARP system is updated by relevant active partners.	Cluster Partners	Gaza	
6	Increase the frequency of the early warning alert response system to every 24 hours	Information from key informants is collected in a daily basis.	Cluster Partners	Gaza	
7	Prepare and disseminate regular humanitarian health situation report/bulletin	At least one Health Cluster SitRep is issued within the first 72 hours.	Health Cluster team	oPt	
8	Ensure participation in the EOC, inter-cluster/inter-sectoral coordination meetings; contribution to inter- cluster/sectoral analysis and planning	The Health Cluster focal person in the EOC is named	Cluster Lead Agency and Coordinators	oPt	
9	EMT call based on needs through the global alert system	EMT needs are issued by the MoH and shared with the Health Cluster	MoH supported by WHO	oPt	
10	Activate GBV emergency referral system – In coordination with GBV Sub-Cluster	GBV emergency referral system has been activated and shared with Cluster Partners	MoH supported by UNFPA	oPt	UNFPA: GBV sub cluster will update the GBV referral pathways including during emergencies
	Response Actions				
11	Activate) trauma- hospitals and non-trauma hospitals (moving all elective cases to non-trauma hospitals)	The non-trauma hospitals are named and shared with partners.	MoH, Trauma Working Group	Affected areas	Includes move-up and fill-in of trauma supplies (kits) and training MSF-Belgium: working at Al Awda Hospital and can conduct orthoplastic surgeries
12	Begin the process of deployment of national and international Emergency Medical Teams and emergency community volunteers communicate any barriers to HCT	A schedule and timetable illustrating the type and location of deployed International teams is shared with partners.	MoH	Affected areas	Includes all preparation for EMTs, placement and coordination
13	Provision of essential primary and secondary health care for IDPs at the DES' (designated emergency shelter), including maternal and child health and Mental Health and Psychosocial Support and MD rehabilitation services	The PHC and health facility serving the IDPs are identified and shared with partners.	MoH, WHO, cluster partners as well as non-health cluster stakeholders	Affected areas	
14	Relocate Medical Emergency Primary care Units (MEPUs) (outreach teams) to the areas with highest density of IDPs and with important population movements	Existing Mobile clinics that serve IDPs are identified, located and shared with partners.	Cluster partners, MoH	Affected areas	
15	Provision of sexual and reproductive health, including maternal health services, such as emergency obstetric and SGBV (sexual gender-based	The health facilities providing maternal services are identified, located and shared.	MoH, UNFPA and partners	Affected areas	UNFPA: through our support to MOH and relevant implementing partners

	violence) care. This should be done through the activation of the MISP – Minimum Initial Service Package for Reproductive Health in Emergencies				
16	Activate the Diseases Outbreak response system and treatment for communicable disease (e.g. Measles, Cholera and Polio)	Development of Operational Plan for Disease Outbreak and Response is initiated.	MoH, WHO, with support of health stakeholders	Affected areas	Technical and operational support to the management of the outbreak
17	Ensure Blood safety and availability (for e.g. trauma and obstetrics)	Blood Banks are identified and shared.	Blood banks	Affected area	
17	Distribute pre-positioned medicine and supplies (trauma, IEHK, IARH Kit – Inter-Agency Reproductive Health Kit, DDKs) to the affected areas	Release of pre-positioned items is shared by partners.	MoH, cluster partners	Affected areas	Will require support from Logistics Cluster
18	Conduct joint Initial Rapid Health and Nutrition Assessment for identifying the needs and prioritising the immediate health and nutrition activities	Initial Rapid Health and Nutrition Assessment is initiated.	MoH, WHO, cluster partners	Affected areas	Conducted concurrently with the multi-sector assessment
19	Preparation and submission of proposals for CERF and the Flash Appeal. See box 1/2 below.	Proposals for CERF and Flash Appeals are prepared.	Health Cluster		CERF and Flash appeal submitted
20	Activate communication with community (in coordination with ICCG)	Input from health key informants is collected and analysed.	ICCG	Affected areas	
21	Upscale monitoring of health attacks and access restrictions	The health attacks are identified and shared on a daily basis.	WHO	oPt	
22	Upscale MHPSS hotline	The MHPSS hotline numbers are shared.	Cluster partners	oPt	
	Fundraising and advocacy				
23	Participate in a flash appeal, if agreed by HCT	Flash Appeals are prepared	Health Cluster team	oPt	
24	Kick-off a CERF appeal, if agreed by HCT	Proposals for CERF are prepared	UN agencies	oPt	
25	Ensure that protection issues, access concerns, or other human rights violations are being adequately recorded and communicated	Protection issues are included in the SitRep and shared.	UN agencies	oPt	

PHASE 3: RESPONSE ACTIVITIES BEYOND 72 HOURS					
	Activity	**Indicator**	**Responsible**	**Area of intervention**	**Notes**
	Coordination				
1	Update and maintain the early warning alert system, 4Ws, and information system	PARP system is updated by 90% of active members	Cluster partners	oPt	
2	Conduct an evaluation of the MIRA results, disseminate and update programming as necessary	MIRA results are disseminated to partners	Health Cluster, MoH etc	Affected area	
3	Conduct health cluster meetings – national and subnational	National and/or subnational Health Cluster Meetings are conducted in a weekly basis.	Health Cluster team	oPt	
4	Establishment/ Convening of technical working groups, as/when needed and organization of joint training (HC Support Group)	Technical working groups are established and trained.	Cluster lead agency and coordinator	oPt	
5	Continuing participation in EOC, inter-cluster/inter-sectoral coordination meetings; contribution to inter- cluster/sectoral analysis and planning and effective integration of cross-cutting issues, such as GBV and MHPSS	Active participation in the ICCG activities is well demonstrated.	MoH, Cluster lead agency and coordinator	oPt	
6	Continuous support to trauma care and early rehabilitation (including prosthesis support and assistive devices) in conflict affected areas	Trauma and Rehabilitation working groups are activated and trained.	MoH, WHO, HI/RTF, ICRC, MSF	oPt	
7	Support the creation of referral pathways or strengthen the existing ones to ensure access of affected population to health and other services	Improved access of affected population to other services based on their needs	WHO, HI partners	oPt	
8	Continue to support the DES'- take stock of impact and effectiveness and revise approach accordingly	Health needs of the people at DES are identified and shared for response.	MoH, Cluster partners	Affected area	
9	Deployment of international EMTs for emergency and acute care	Needs for International EMTs are identified and shared.	MoH, Cluster partners	oPt	
10	Release primary health care supplies (IEHK and ERHK) and non-communicable disease kits to ensure uninterrupted health access	primary health care supplies (IEHK and ERHK) and non-communicable disease kits are released.	MoH, Cluster partners	Affected area	
11	Maintain the upscaled MHPSS hotline	MHPSS hotlines are maintained.	Cluster partners	oPt	
12	Provide PFA services to affected people in addition to PFA kits.	Emergency satellite teams are mobilized.	Cluster partners	oPt	GCMHP: has capacity to provide for Gaza
13	Ensure continued operation of the MISP (Minimum Initial Service Package for RH in Emergencies), including access to maternal health care, family planning services, and the clinical management of rape. Continued operation of the Safe Delivery Network, if deemed necessary	Access to MISP and Maternal services are ensured and maintained.	UNFPA, MoH	oPt	UNFPA: everything is in place, confirmed after revisiting Gaza safe delivery network
14	Child and maternal care activities to maintain a minimum service based on the needs identified	Child and maternal care activities are maintained	UNICEF, UNFPA	oPt	UNFPA: pending availability of resources
15	Activate restocking of any supplies released and consider increasing stocks	Restocking of supplies is identified and located.	WHO and partners	oPt	
16	Consider surge staff needs and act accordingly	Surge Staff needs are identified and shared.	Cluster partners, WHO	oPt	
17	Sustain reporting on access restrictions and attacks against health care, with continued advocacy to improve protection of health care, including patients, companions, health care staff, ambulances, and health facilities.	Report on access and attacks on health care	WHO	oPt	

PHASE 4: RECOVERY					
	Activity	**Indicator**	**Responsible**	**Area of intervention**	**Notes**
1	Continuation of regular health coordination meetings (e.g. biweekly)	Health Coordination meetings are conducted biweekly.	Health Cluster team	oPt	
2	Information exchange and coordination of response with the Ministry of Health and MoH of the affected district(s)	Information exchange between MoH and partners is facilitated.	Health Cluster team	oPt	
3	Organization of in-depth assessment to identify health impact of the emergency and needs	In-depth Health Assessment report is shared with partners.	ICCG	oPt	Conduct post-emergency assessment to identify gaps and impact health
4	Periodic updating of the HC response strategy and action plan	Health Cluster Response Strategy and Action Plan is updated twice a year.	ICCG/HCT	oPt	
5	Suspension of technical working groups, as needed	Suspension of non-needed working groups in agreement with relevant partners.	Health Cluster team	oPt	
6	Contingency planning (CP) for possible changes in the situation	Health Cluster CP is updated and shared.	Health Cluster team		
7	Preparation and dissemination of regular health-sector bulletins	Health Cluster bulletin is maintained and disseminated quarterly	Health Cluster team	oPt	
8	Update 4Ws database	PARP database is updated in agreement with partners when needed.	Health Cluster IM and OCHA IM	Affected areas	
9	Continue the deployment of EMTs for specialised services and non-acute care	The need for specialized EMTs is identified and shared.	Health Cluster team	Affected areas	
10	Release of surge staff and return to normal staffing levels	Non-needed Surge Staff are released.	Health Cluster team	Affected areas	
12	Health Cluster debriefing for lessons learnt	Lessons learnt are agreed upon by the Cluster Partners and shared	Health Cluster	Affected areas	
13	Prepare for phasing out / handover of projects to local providers	Phasing out plan is prepared and shared with local partners	MoH, Cluster partners and development partners	Affected areas	
14	Restock all supplies and return to “Phase 1 Advanced Preparedness Actions” Support MoH and NGO and private hospitals to replenish the depleted medication, supplies and consumables, and apply Lessons Learned and Best Practices to their contingency plans.	Information on restocking of supplies is shared.	Health Cluster partners	oPt	
15	Sustain reporting on access restrictions and attacks against health care, with continued advocacy to improve protection of health care, including patients, companions, health care staff, ambulances, and health facilities.	Report on access and attacks on health care	WHO	oPt	
16	Construction of destructed accessible health facilities and procurement of equipment and vehicles	Health facilities constructed/ rehabilitated	WHO.MOH and HC partners	oPt	
17	Review of the existing minimum standards and guidelines based on the LL from the crisis/ emergency		Cluster partners	oPt	

DO NOTS

DO NOT DO:

- Blanket distribution of milk formula / distribution of formula to caregivers of children that can be fed with breast milk e.g. Whose mother is alive and does not have medical indications for cessation of breastfeeding
- Procurement of drugs with shelf life shorter than 1 year, procurement of drugs not included in the oPt MoH essential drugs list
- Vertical interventions that can be provided in the scope of PHC package (vaccination, except supplementary immunisation activities (SIA) mandated by the epidemiological situation) or interventions that are not relevant to the context
- Design standalone psycho-social interventions that are not culturally appropriate
- There is enough health staff in oPt to provide primary and most of hospital / specialist services, do not bring in international medical teams unless specific skills have been identified and coordinated with the MoH and the cluster coordination team
- Unilateral decision on resource allocation: Do not take it without evidence of needs and coordination with the MoH and the Cluster
- Field hospitals, modular medical units: Do not send them! Considering that this type of equipment is justified only when it meets medium-term needs, it should not be accepted unless it is donated
- Import of blood or blood derivatives