Victims in the Shadows

Gaza Post-crisis Reproductive Health Assessment

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Forward

The Palestinian Ministry of Health is proud to make available this study that reflects the impact of crisis on our people in Gaza. While the war had devastating effects on the lives of all families and resulted in major destruction of civil infrastructure, the impact on health in general and on reproductive health in particular has been significant, with pregnant women killed and thousands denied access to essential services. This assessment has been a collaborative exercise between the Ministry of Health and national and international partners. Together with the health system assessment conducted by the World Health Organization, the reproductive health assessment forms a key resource to guide our relief and recovery efforts and the development of the health system in Gaza. The Palestinian Ministry of Health extends its thanks to the United Nations Population Fund for financing and undertaking this study, and looks forward to a fruitful partnership toward implementing the recommendations stemming from this study.

Dr. Jawad Awwad,
Minister of Health,
State of Palestine

On behalf of the UNFPA Palestine Country Office, it is an honor for me to witness the release of this assessment on the impact of the Gaza Crisis on reproductive health. The report is the result of a joint effort of the Palestinian Ministry of Health and local and international agencies working tirelessly to identify the effects that this crisis has had on the most vulnerable Palestinians in Gaza. The title “Victims in the Shadows” reflects the unfortunate fact that reproductive health needs are often forgotten in the midst of crisis situations, with devastating consequences—particularly for women and girls. I would like to congratulate the authors of the report, who have done a remarkable job drawing out this important reality. I hope that the findings and recommendations of the report will enable partners to formulate the humanitarian response and recovery efforts urgently needed to improve health care, particularly in the area of reproductive health, to safeguard the dignity and rights of families, women and girls in Gaza and in Palestine as a whole.

Anders Thomsen,
Representative,
UNFPA, Palestine

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UNFPA would also like to extend its thanks and deep appreciation to the data collection teams, who demonstrated an unprecedented level of dedication, commitment and professionalism in conducting this important assessment at a high level of quality.

UNFPA also extends its appreciation to the United Nations Relief and Work Agency/Health Department, Union of Health Work Committees, Palestinian Medical Relief Society, Near East Church Council, Red Crescent Society for the Gaza Strip for cooperating and facilitating access their health facilities for data collection.

Many thanks go to UNRWA for technical input, cooperation and facilitation of data collection in the field and for enabling smooth access to health facilities and shelters throughout the Gaza Strip.

Many thanks go to UNICEF for cooperation, dedication and technical input to this assessment.

The constructive partnership and support provided by the World Health Organization office in Jerusalem and Gaza have been instrumental in conducting this assessment, which we hope will contribute to the health cluster efforts in addressing gaps in the humanitarian response and recovery.

It is our honor to extend thanks to national and international members of the reproductive health sub-cluster, who enriched the development of the assessment`s concepts and tools and were instrumental in reviewing and finalizing this report.

Last but not least, we would like to acknowledge the academic and professional guidance offered by Professor Bassam Abu Hamad in designing and finalizing the assessment.

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List of Acronyms

ANC	Antenatal Care
BL	Baseline
GP	General Practitioner
IDPs	Internally Displaced Persons
IUFD	Intrauterine Fetal Death
MISP	Minimal Initial Services Package
MOH	Ministry of Health
NECC	Near East Church Council
NICU	Neonatal Intensive Care Unit
NGO	Nongovernmental Organizations
OCHA	Office of Coordination of Humanitarian Affairs
PMRS	Palestinian Medical Relief Society
PHC	Primary Health Care
PNC	Postnatal Care
RCS	Red Crescent Society
SB	Stillbirth
STI	Sexually Transmitted Infection
UNFPA	United Nations Population Fund
UNICEF	United Nations Child Fund
UNRWA	United Nations Relief and Works Agency
WHO	World Health Organization

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1. Executive summary

The recent violent crisis in Gaza was the third major military operation during the last six years. For the past seven years, the Gaza Strip has been subject to strict closure and siege, resulting in a massive deterioration in living conditions, increased unemployment and poverty, impaired development and a significant decline in the standard of health care.

Prior to the start of the recent escalation, a World Health Organization (WHO) report on Gaza exposed major shortages in the capacity of the health system to cope with routine health care services due to a severe lack of resources (1).

The extremely high number and severe nature of casualties during the recent military assaults on Gaza have further stretched an already overburdened health care system and challenged its coping capacity. Three weeks after the start of military operations, the Ministry of Health declared that 50 percent of all medical equipment was not functioning, and the rest was likely to break down if the current demand continued (2).

The impact of the crisis on women was significant: More than 250 women were killed, including at least 16 pregnant women. Due to damage to six hospitals and extremely unsafe operations in some Gaza Strip locations, six maternities were closed (3). Furthermore, the high number of wounded patients overloaded hospitals and made it necessary to transform part or all of maternity wards into surgical care units. This resulted in reduced care for women in need for emergency obstetric care, including surgical interventions, and reduced post-operative care, as women were immediately discharged after giving birth.

As part of the overall assessment of health system, UNFPA undertook this post-crisis assessment to review the magnitude, scope and impact of the recent hostilities on reproductive health. The assessment took place under the health cluster approach led by WHO and the Palestinian Ministry of Health, in coordination with relevant national and international partners.

Recognizing the importance of continuity of care between the communities and primary and secondary levels of health care, and because such continuity has been disrupted during past crises, the assessment collected evidence on responsiveness, functionality and outcomes related to reproductive health at all three levels of care.

To ensure the quality of information and validity of conclusions and recommendations, the assessment team used a triangulated research methodology, combining quantitative and qualitative methods. While the bulk of data collection in the field was devoted to qualitative research—interviewing groups of stakeholders and key informants—the team obtained quantitative data from facility registries, checklists and published literature.

The quantitative data-collection tools were consistent with WHO standards and verified by the research team. For the qualitative research, UNFPA developed an interview guide and questions to capture different stakeholders' perspectives on the crisis and to identify issues that arose related to reproductive health and rights.

All hospitals, including maternities, entered the crisis with severe shortages in resources and materials, as indicated by stock-outs in medications and disposable supplies. Due to the extremely high number of serious injuries, maternity ward space and facilities, including operating theatres, were designated for treatment and hospitalization of the injured. Wounded women were hospitalized in the maternity departments, and obstetricians on duty had to provide general surgery for wounded patients. Hospital staff suffered additional stress as they helped and witnessed the death of their own family members.

Major hospitals in the Gaza Strip were used as displacement shelters by fleeing families, creating an additional logistical burden on the facilities. At the peak of military operations, around 20,000 people inhabited the garden of Shifa Hospital and used its facilities and resources such as toilets, corridors, hygiene supplies and food.

Difficult transportation during the crisis also resulted in significant shortages of staff and severe shortages of life-saving medications, such as antibiotics and surfactant (a medication used to enhance the maturity of the lungs). Shortages of surfactant resulted in extended hospitalization of newborns under ventilation, and hence increased the risk for infection and other complications, leading to increased fatality rates.

Neonatal units usually support breastfeeding by ensuring direct contact and early attachment between the mother and child. When direct contact is not possible, the hospital policy is to encourage bringing the mothers' expressed breast milk to the hospital. This practice almost came to a halt because of limited access to the hospital during the attacks. As a result, milk formula had to be introduced for hospitalized infants.

Only 50 percent of primary health care facilities were operational during the war. In addition, many health workers were not able to reach their duty stations because of security, and therefore more than half of the facilities surveyed operated with significantly reduced staffing. At facilities with staffing levels at 100 percent, health care professionals reported to the nearest facility regardless of the provider or their original duty station. Furthermore, to cope with staff shortages, primary health care centers benefited from private sector practitioners available within the geographic area.

Military operations continued for a period of 51 days, and heavy bombardment occurred during the months of July and August. The intensity of military operations declined after a ceasefire was declared on August 1st, which led to 13 ceasefire days during the month. This explains the rise in reproductive health service utilization during August at all of the facilities surveyed.

Family planning services suffered during the crisis, with Ministry of Health clinics in Gaza showing a 60–90 percent decline in the number of beneficiaries in July. While the uptake of family planning services improved in August, it did not reach the pre-crisis level. Also, while injectables would have been a good medium-term method of choice during emergency conditions, Depo-Provera injections were not given during the 51 days of war.

Due to the extremely high number of internally displaced persons (IDPs) fleeing their homes in a short time, existing aid organizations did not have the capacity to respond to their needs. According to a report by the Office of Coordination of Humanitarian Affairs (OCHA), the number of IDPs exceeded

500,000, representing 28 percent of Gaza's population and 10 times the worst-case scenario anticipated in the contingency planning prior to the crisis. As a result, the adequacy and appropriateness of aid during the crisis period fell far short of needs.

This assessment was conducted after most of the displaced people returned to their homes; only about 53,000 displaced people remained in the 12 United Nations Relief and Works Agency (UNWRA) schools. Therefore, understanding the actual conditions during the crisis would require more analysis; they were likely to be far more severe.

Because of the short notice given prior to the bombardment of houses, people fleeing to shelters left their personal belongings and assets behind, and therefore came to UNWRA schools with almost no clothing, money or even identification documents. At the time of assessment, the organization of services and resources available within UNRWA and aid organizations had begun to improve.

After the ceasefire, UNRWA assigned health practitioners to each school to provide basic medical services and health education. During the crisis period, however, medical care was only available through mobile teams visiting the shelters or at Ministry of Health, UNRWA and NGO centers. Shelter residents reported that these options were not feasible because of the need to leave the shelter during hostilities, the need to pay for medications and/or transportation and, for women in particular, the fear of leaving children alone in the shelter while seeking services.

According to the data collected during this assessment, health services at UNRWA shelters did not include the reproductive health package, and women who needed such services were referred to outside facilities. The Deir Balah shelter employed a midwife as part of the health team, but even in this shelter, reproductive health services were not provided. Only the Tuffah shelter in Gaza provided reproductive health services.

Many women from the shelters and host communities reported gender-based violence. Because of the sensitivity of this issue, UNFPA conducted a special assessment on this topic, which will be presented in a separate report.

The poor living conditions of host families experiencing high unemployment were further aggravated by the influx of fleeing families coming without any resources. The situation was made worse by the fact that the displaced families were not registered for entitlement to aid, increasing their dependency on host families. This resulted in significant discomfort and reduced living standards for both the hosting and hosted families, along with other economic and psychological problems.

الضحايا في ظل الازمة، دراسة اثر الحرب على غزة على صحة المرأة والصحة الانجابية

صندوق الامم المتحدة للسكان بالتعاون مع وزارة الصحة الفلسطينية ومنظمة الصحة العالمية

تشرين اول- 2014

ملخص تنفيذي:

شكل العدوان الاخيروهو الثالث على قطاع غزة خلال السنوات الست الماضية محصلة لحصار واغلاق استمر لفترة تزيد عن السبع سنوات. ولقد تسبب الاغلاق المفروض على قطاع غزة لفترة طويلة في تدهور كبير في ظروف حياة المواطنين من حيث ارتفاع نسبة البطالة والفقر، تعطيل التنمية وتدهور مستوى الخدمات الصحية.

في المرحلة التي سبقت التصعيد الاخير على القطاع، اظهرت تقارير منظمة الصحة العالمية التحديات الكبيرة التي تواجه النظام الصحي الفلسطيني وقدرته على تقديم الخدمات الصحية الروتينية بسبب النقص الحاد في الادوية والمستهلكات الطبية. لقد ادى العدد الكبير للضحايا والجرحى الذين كانوا في حالة حرجة الى زيادة العبئ على الخدمات الصحية بشكل غير مسبوق وادى الى ارهاق نظام الخدمات بما في ذلك قدرته على التعامل مع الوضع الطارئ. بعد ثلاثة اسابيع من بدء الحرب، اعلنت وزارة الصحة الفلسطينية ان 50% من الاجهزة الطبية في مستشفيات غزة غير قابلة للاستخدام نتيجة للاستهلاك.

قام صندوق الامم المتحدة للسكان وبالتعاون مع وزارة الصحة الفلسطينية ومنظمة الصحة العالمية في اطار تجمع الصحة بتقييم اثر الازمة على الصحة الانجابية. وبالاخذ بعين الاعتبار مستويات الخدمات الصحية، والتجارب السابقة في الازمات التي ادت الى انعدام امكانية الوصول الى الخدمات على مستوى الرعاية الصحية الاولية والثانوية، فان الدراسة سعت الى جمع الدلائل والبيانات حول تاثر الخدمات كنتيجة للازمة على كلا المستويين.

اظهرت نتائج الدراسة ان جميع مستشفيات قطاع غزة قد دخلت الازمة مثقلة بنقص شديد في الامدادات الطبية واللوجستية. ونتيجة للعدد الهائل من الاصابات ذات المستوى العالي من الخطورة، فان اقسام الولادة بما فيها غرف العمليات التابعة لها قد استخدمت كاقسام جراحة لاستقبال الجرحى من النساء. ونتيجة لتعذر وصول العاملين الصحيين لاماكن عملهم، فقد عملت مستشفيات قطاع غزة ضمن نظام فترات عمل طويلة ادت الى زيادة الضغط على العاملين. وفي الوقت الذي استخدمت فيه مجموعة من المستشفيات كملاذ لعائلات النازحين، فقد زاد ذلك من الاعباء على المستشفيات وخاصة من خلال استخدام الاقسام واللوازم المتوفرة.

لقد كان تاثير الازمة على النساء كبيرا حيث قتل اكثر من 250 امرأة بما فيه 16 امرأة حامل. وبسبب الدمار الذي لحق بستة مستشفيات، خطورة تنقلالعاملين الصحيين الى اماكن عملهم، فان ستة اقسام ولادة توقفت عن العمل وبالنظر الى تدفق اعداد كبيرة من الجرحى فان اقسام الولادة استخدمت للتعامل مع حالات جراحية. نتج عن ذلك كله تراجع الخدمات المقدمة للسيدات الحوامل بما في ذلك الخروج المبكر من المشافي بعد الولادة او العمليات القيصرية. تم تسجيل 4 حالات وفيات امهات خلال فترة العدوان على القطاع ومن خلال بحث الظروف المصاحبة للوفاة تبين ان التاخير لتلقي الرعاية بسبب العمليات العسكرية كان عاملا مهما.اضافة الى ما ذكر، ارتفعت نسبة المضاعفات المصاحبة للحمل حيث تم رصد ارتفاع كبير في حالات الولادة المبكرة، الولادات الميتة، الولادات لاطفال دون الوزن الطبيعي وحالات الاجهاض في المستشفيات.

اثر انخفاض عدد العاملين في اقسام رعاية الاطفال الخدج، نقص الادوية والمستلزمات وارتفاع عدد الولادات المبكرة الى ازدحام كبير في اقسام انعاش حديثي الولادة، تدني مستوى الخدمات وادى ذلك ايضا الى ارتفاع حاد في وفيات الاطفال حديثي الولادة كما هو موثق في سجلات مستشفى الشفاء ومستشفى ناصر. في اطار اخر، فان القدرة على ممارسة ومتابعة الرضاعة الطبيعية قد تراجعت بشكل كبير نتيجة لتعذر حضور الام او نقل حليبها الى المستشفى لارضاع الوليد.

تراجعت خدمات الرعاية الصحية الاولية بشكل كبير حيث ان 50% فقط من مراكز الرعاية الصحية عملت ايام الحرب بسبب التدمير او عدم وصول العاملين لاماكن عملهم اضافة الى تعذر حركة المراجعين بسبب الوضع الامني. على الرغم من ذلك، فان كوادر الرعاية الصحية الاولية قد عملوا على تعويض النقص من خلال تشغيل متطوعين وعاملين صحيين من مقدمي خدمات اخرين متواجدين في المنطقة.

تراجعت خدمات رعاية الحوامل بنسبة تزيد عن 70% في شهر تموز بالتزامن مع نشاط العمليات العسكرية وتصاحب ذلك بانخفاض 60-90% لخدمات تنظيم الاسرة لنفس الفترة.

نزح ما مجموعه 500,000 نسمة والذي يشكل 28% من عدد سكان قطاع غزة بسبب العمليات العسكرية وقد شكلت هذه الاعداد عشرة اضعاف التقديرات التي قدمتها مؤسسات الاغاثة مما اثر بشكل سلبي على امكانات وبرامج الاغاثة. بعد توقف اطلاق النار، بقي ما مجموعه 108,000 نسمة مشردين في 31 مركزا للايواء ومنتشرين لدى العائلات المضيفة. وعلى الرغم من توفي بعض الخدمات الصحية المتنقلة في المراكز، فقد واجه النازحون صعوبات كبيرة في الحصول على الخدمات الصحية اثناء العدوان بسبب تعذر الحركة وعدم توفر النقود اللازمة للمواصلات او ثمن الادوية. قامت وكالة غوث وتشغيل اللاجئين بعد وقف اطلاق النار بتوظيف عاملين صحيين في مراكز الايواء وعلى الرغم من ذلك، فان خدمات الصحة الانجابية لا زالت غير متوفرة داخل مراكز الايواء.

ان ظروف المعيشة المتردية لدى العائلات في غزة قد زادت بعد الحرب ونزوح عائلات للاقامة لدى اقاربهم. وفي الوقت الذي تسبب الازدحام في انخفاض مستوى المعيشة بيئيا واقتصاديا لدى العائلات المضيفة والنازحة، فان هذا القطاع من النازحين ايضا قد حرم من المساعدات بسبب ان معونات الاغاثة قد تركزت على القاطنين في مراكز الايواء. كل ذلك اضافة الى شح الخدمات عامة ادى الى وضع بيئي، صحئ ونفسي صعب على هذا المستوى.

2. Introduction

The recent crisis in Gaza was the third major military operation during the last six years. For seven years, the Gaza Strip has been subject to strict closure and siege, resulting in a massive deterioration of living conditions, increased unemployment and poverty, impaired development and a significant decline in the standard of health care.

Prior to the start of the recent escalation, a WHO report on Gaza exposed major weaknesses in the capacity of the health system to deliver routine health care services due to severe shortages in resources (1).

Due to the strictly imposed closure, importing medical equipment and spare parts has become extremely difficult, leading to an inability to operate much of the medical equipment needed for intensive care units and surgical departments, including maternities and radiology.

The extremely high number and severe nature of casualties during the recent military assault on Gaza further stretched an already overburdened health care system and challenged its coping capacity. Three weeks after the start of military operations, the health ministry declared that 50 percent of all medical equipment was not functioning and the rest was likely to break down if the current demand continued (2).

The impact of the crisis on women was significant: More than 250 women were killed, including at least 16 pregnant women. Due to the damage to six hospitals and extremely unsafe operations in some Gaza locations, six maternities were closed (3). Furthermore, the high number of wounded patients overloaded hospitals and made it necessary to transform part or all of maternity wards into surgical care units. This resulted in reduced care for women in need of emergency obstetric care, including surgical interventions, and reduced post-operative care because women were discharged immediately after giving birth.

Other impacts included an increase in pregnancy complications such as miscarriage, bleeding and premature labor. The increase in these complications was further compounded by the severe shortage of human and material resources available in the hospitals. Consequently, newborn care units were overloaded, the quality of care for newborns was compromised and the case fatality rate among newborns at Shifa Hospital reportedly doubled, from 7 percent to 14.5 percent.

According to Ministry of Health reports, 50 primary health care centers were damaged and 30 were closed as of August 28 due to physical damage and their proximity to active military operations (4). Because these primary health care centers included 11 emergency response hubs, the ability to offer essential reproductive health services and emergency obstetric care to women in remote areas was compromised.

Reproductive health and maternal health services at the primary and secondary levels were affected by reduced capacity and the shift in attention and assets toward direct victims of the crisis. Health facilities reported an increase in life-threatening complications among pregnant women and newborns and higher mortality rates, due to the crisis and the compromised capacity to provide quality care in primary health care centers, maternities and newborn care units.

At the peak of the crisis, more than 500,000 people fled their homes and took refuge in UNRWA schools, government schools and other community spaces including mosques, churches and hospital gardens. Around 170,000 displaced people sought refuge in extended family homes (5). Destruction of homes, devastation, poor living conditions, extreme poverty and lack of essential resources in Gaza, and in shelters in particular, created a fertile environment for health and social problems among displaced families, especially related to sanitation and hygiene and psychological and reproductive health.

The displaced communities faced increasing health, psychological and social problems along with a lack of essential services, including reproductive health and psychosocial aid to womenand children. Increased levels of violence and the spread of infectious diseases became serious public health threats at close to disaster levels (2).

3. Reproductive Health Assessment

As part of the overall assessment of health system in the aftermath of the crisis in Gaza, UNFPA was asked to undertake this post-crisis assessment to review the magnitude, scope and impact of the recent hostilities on reproductive health. The assessment took place under the health cluster approach led by WHO and the Palestinian Ministry of Health, in coordination with relevant national and international partners.

UNFPA and partners agreed to include the areas of maternal and newborn health along the continuum of care (from conception to antenatal, delivery and postnatal care), in addition to the critical reproductive health areas included in the internationally recognized Minimal Initial Service Package (MISP). These include emergency obstetric care, sexual and gender-based violence, sexually transmitted infections, and family planning.

Recognizing the importance of continuity of care between the communities and primary and secondary health care and the major disruptions in continuity that occurred on previous occasions, the assessment focused on these three levels of care, collecting evidence about responsiveness, functionality and outcomes related to reproductive health.

3.1 Context

Several major contextual issues shaped this assessment:

- Due to the fragile security situation, the assessment was conducted rapidly and in the shortest possible time, while ensuring the validity and quality of the data and findings.
- To avoid repeated assessments by different partner agencies and major stakeholders with overlapping mandates, members of the Reproductive Health Sub-cluster were involved in planning and developing the assessment framework, methodology and tools, so that their areas of interest were incorporated in this assessment.
- The Palestinian Ministry of Health, UNRWA and NGOs supported the assessment teams by contributing to the methodology and tools.
- The assessment report is an integral part of the national assessment, carried out by Ministry of Health data collection staff.

3.2 Methodology

To ensure the quality of information and validity of conclusions and recommendations, the assessment team used a triangulated research methodology that combined quantitative and qualitative methods. While the bulk of data collection in the field was devoted to qualitative research with stakeholders and key informants, quantitative data were obtained from facility registries, checklists and published literature.

The sample was drawn from health care facilities (hospitals and primary health care centers), shelters and communities. To ensure the sample was representative of the geographic areas in the Gaza Strip, the research team selected different health care providers functions during the crisis, as illustrated in the map and Table 1.

Reproductive Health Assessment Map

Table 1: Sample of Health Care Sites

GOVERNORATE	MATERNITY HOSPITAL AND NEONATAL ICU	PRIMARY HEALTH CARE CENTER	SHELTER	HOST COMMUNITY
NORTH GAZA	AWDA MAT	JABALIA MARTYR PHC "MOH" JABALIA PHC "UNRWA"	BEIT HANOON PRP BOYS QLEBO SCHOOL	BEIT LAHIA JABALIA
GAZA CITY	SHIFA MAT. HARAZEEN MAT. SHIFA NICU AL NASR PEDIATRIC NICU	ZAITOON PHC "MOH" NECC PHC "NGO"	MAMLKAT EL-BAHREEN GAZA PREP SCHOOL GIRLS A	GAZA CITY
DEIR BALAH	AQSA MAT	DEIR BALAH MARTYR "MOH"	DEIR BALAH SCHOOL	DEIR BALAH
KHANYOUNIS	NASER MAT. EGH NICU	BANDAR PHC "MOH" ABASAN "RCS" ABU TAIMA "PMRS"	AHMED ABDELAZIZ PREP BOYS A	MAGHAZI AND KHANYOUNIS
RAFAH	HILAL EMARATI MAT.	TAL SULTAN PHC "MOH" TAL SULTAN PHC "UNRWA"	RAFAH PREP BOYS A	RAFAH
TOTAL	9	10	7	7

The quantitative data collection tools were consistent with WHO international standards and were verified by the research team. The team used two versions of the tool, one for maternities and the other for primary health care centers. A third tool was designed for shelters (see Annex 1).

For the qualitative research, a comprehensive tool was developed to capture different stakeholders' perspectives on the crisis and to identify issues arising concerning reproductive health and rights (see Annex 2).

UNFPA developed the qualitative data collection tools in English and translated them into Arabic for the team to use in the field. After the qualitative data was collected, it was professionally translated and verified prior to data entry, analysis and report writing. Quantitative data collection tools were developed and used in English, relying on highly educated members of the team with backgrounds in nursing and midwifery. All data entry was done in English.

Secondary data collection consisted of a review of situation reports produced by the Ministry of Health, OCHA, WHO, UNICEF and UNFPA. In addition, the research team reviewed the facilities' services records and data for July and August 2014 and compared them with data from 2013. The monthly average in 2013 was used as the baseline to assess the fluctuation in access, uptake and outcomes of health care during the crisis.

The team used both quantitative and qualitative methods to collect primary data from facilities and community. Table 2 shows the qualitative methods used in each location.

Table 2: Qualitative Data Collection Methods Used by Type and Location

DATA COLLECTION METHOD	NORTH	GAZA AND MIDDLE AREA	KHANYOUNIS AND RAFAH	TOTAL
INDIVIDUAL INTERVIEW WITH MATERNITY DIRECTOR	2	4	3	9
FGD WITH STAFF IN MATERNITIES	1			1
INDIVIDUAL INTERVIEW WITH PHC DIRECTOR	2	3	5	10
FGD WITH PHC STAFF	1			1
FGD WITH WOMEN IN SHELTERS	2	3	2	7
FGD WITH WOMEN IN HOST COMMUNITY	2	3	2	7
INTERVIEW WITH INDIVIDUALS WOMEN IN SHELTERS	2	3	2	7
INTERVIEW WITH INDIVIDUALS WOMEN IN PHC	2	3	5	10
INTERVIEW WITH INDIVIDUALS WOMEN IN MATERNITY	1	2	1	4
FGD WITH MEN IN SHELTER	2	3	2	7
FGD WITH MEN IN HOSTING COMMUNITY	3	2	1	6
TOTAL	18	28	23	69

Note: FGD=focus group discussion.

To ensure proper triangulation of information and to increase the validity of findings, the team conducted the following research activities:

1- Focus group discussions:

   a. Women of reproductive age living in shelters
   b. Pregnant women from hard-hit communities
   c. Pregnant women hosted by relatives
   d. Lactating women
   e. Men living in shelters
   f. Men living with host families
   g. Health professionals at maternities, primary health care centers and neonatal intensive care units (NICUs)

2- Key informant interviews with stakeholders:

   a. Key health officials (MOH, UNRWA, PMRS, UHWCs, RC and NECC)
   b. Heads of maternities and NICUs
   c. Site managers at shelters

3- Field observations of security standards, environmental context, social interaction and general atmosphere:

a. Maternity
b. Primary health care center
c. Shelter
d. Host family for displaced persons

4- In-depth case studies of families and women experiencing difficult situations during the crisis

3.3 Data collection

A group of qualified professionals from UNFPA, UNICEF, WHO, Ministry of Health and NGOs participated in a two-day orientation on the objective and scope of the assessment, framework and assessment tools. The training involved role play, a detailed review of each question and incorporation of feedback. Special emphasis was put on awareness of unexploded ordinates, "UXOs": The data collection teams were trained on how to detect, avoid and report on any suspicious items during their field work. These precautions were taken to ensure the safety and security of field workers, especially because data collection started immediately after the long ceasefire. For proper organization of field work, especially in such an unpredictable environment, the team was divided into three groups with designated team leaders and well-articulated tasks. To ensure high quality data and to provide an opportunity for prompt verification in the field, the data were collected and verified by the field supervisor at the end of each day and immediately transferred to the central office for translation and data entry. As a quality control procedure, each data collection activity was given a unique identifier to enable cross-checking and further validation if needed. (See Annex 3 for information about the organization of field work and team member assignments.*)*

3.4 Main findings

Hostilities in Gaza resulted in 2,133 fatalities, of which 500 were children (187 girls and 313 boys) and 257 were women. Among the women killed, at least 16 were pregnant. According to the Ministry of Health, 11,100 Palestinians were injured, including 3,374 children and 2,088 women. Up to 1,000 children were expected to sustain permanent disability (5), and there were 500 amputees of various ages.

During the hostilities, people living in the eastern part of the Gaza Strip had to evacuate their homes under active bombardment, leaving their belongings behind. More than 500,000 people, representing 28 percent of the total population of Gaza, fled their homes and sought shelter at 89 UNRWA schools (293,000 people), 17 Governmental schools (49,000 people), and other locations (170,000 people), which included host families and community spaces such as mosques, churches and hospital compounds. The number of both casualties and displaced people exceeded many times the maximum scenario anticipated in the UN contingency plan, which was developed after the Cast Lead operation in 2008-2009.

According to the OCHA report after the war, an estimated 18,000 houses were completely or severely damaged, leaving 5 percent of Gaza housing stock uninhabitable. Even after the ceasefire, an estimated 108,000 people will remain homeless because their houses were destroyed; they will remain in UNRWA shelters and with host families in the local community.

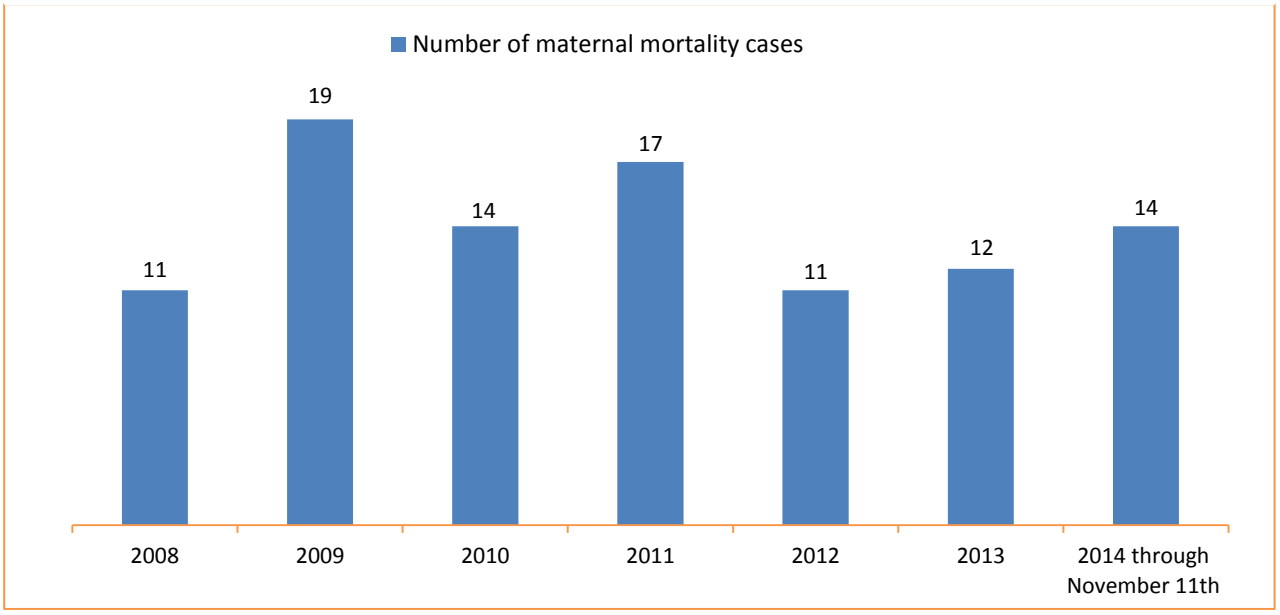
3.4.1 Impact on maternal health

In Gaza, with a population of 1.8 million people, there are approximately 45,000 pregnant women at any point of time. Around 160 deliveries take place every day. During the crisis and due to the destruction of civilian infrastructure, including residential houses, 91 families were killed and wiped out of civil records; all members of these families died, including many pregnant women.

3.4.1.1 Maternal mortality

For the last seven years, UNFPA has worked closely with the Ministry of Health to develop the maternal mortality surveillance system and has invested significant resources and technical efforts to prevent maternal mortality under the slogan, "no woman should die while giving life." Thanks to the comprehensive national effort of health care providers led by the Ministry of Health, maternal mortality in the Gaza Strip declined markedly during the period 2009 - 2013. Factors that are thought to have contributed to the decline include significant investments to improve the quality of obstetric care, a strengthening of referrals and continuity of care among the health care levels, and widespread education about danger signs during pregnancy.

Figure 1: Maternal Deaths from 2008 to 2014



During the first six months of 2014, the Ministry of Health reported six maternal deaths due to cardiac arrest, septic shock or cancer—an average of one death per month. During the 51 days of the military offensive, the ministry reported four maternal deaths, bringing the average to 2.7 deaths per month. A review of maternal mortality cases during the offensive shows that delays in accessing care due to ongoing military operations occurred at three levels: at home, on the way to the hospital and at the hospital.

A total of 20 pregnant women died during the war. Four cases were due to obstetric causes, and an additional 16 were killed as a direct result of hostilities. In accordance with the WHO definition of

maternal mortality as a death from any cause related to or aggravated by pregnancy or its management, four cases of maternal deaths were recorded during the time of the offensive on Gaza.

3.4.1.2 Impact on reproductive health service delivery

Military operations in civilian areas resulted in an extremely high number of deaths and injuries, with the severe nature of wounds requiring major resources and causing permanent disabilities. Such a rapid and high load on critical care facilities further stretched an already overstretched health care system, and challenged its already exhausted coping capacity.

Even with some preparedness and contingency planning at hospitals and health facilities, the level of destruction and number of casualties far exceeded any planning scenarios anticipated before the start of military operations. On July 28, the Israeli army attacked a market place in Shajaeye, killing 17 people and seriously injuring 210 others, who were transferred to Shifa Hospital. Due to the influx of such a large number of severely injured people, Shifa Hospital consumed a 15-day stock of medical disposables and medications in one day. Such a volume is very difficult to replenish in a short period, and therefore it affected the overall capacity of the hospital to function.

Three weeks after the start of military operations, the Ministry of Health declared that 50 percent of all medical equipment was out of order, and the rest were likely to break down if the current load continued.

The Shuhada Aqsa and Harazine maternities reported an increase in home deliveries, with no registration of cases. Hilal Emirati, Tahreer, Shifa and Awda hospitals, on the other hand, reported and documented 29 cases of home deliveries due to difficult access to maternities during the military operations.

This study assessed six maternities according to their geographic distribution in Gaza and affiliations. A review of data from these maternities shows significant changes from the baseline in key indicators of morbidity and service outcomes. All hospitals studied were functional during the crisis and faced major material and human resources challenges (see Table 3).

Table 3: Highlights of Conditions in Assessed Maternity Hospitals

Maternity	Damage sustained	Snapshot of services during the crisis period
Hilal Imarati-Rafah Date of assessment visit Sept. 3, 2014 Key informant: Dr. Abdul-Razzaq El-Kurd	No infrastructure damage	Worked long shifts with reduced staffing capacity. All hospital departments were transformed into surgery from August 1-5 and were overwhelmed with casualties. Mobilized volunteer doctors to help cope with high number of wounded. Increased load (33%) due to closure of private facilities. Noted increase in complications related to pre-term delivery, abortion and intrauterine fetal death (IUFD). Few cases of home deliveries were reported. One hospital staff was killed. Due to the high number of deaths, food refrigerators were

Maternity	Damage sustained	Snapshot of services during the crisis period
		used to store human bodies.
Tahrir- Khan younis Date of assessment visit Sept. 3, 2014 Key informant: Dr. Mohamed Khalil Zaqout, Director	No infrastructure damage	Worked in emergency mode with sufficient human capacity, but increased load. No reported shortages in supplies, but noted increase in pregnancy and delivery-related complications, especially vaginal bleeding and reported cases of home deliveries (5 cases reported after home delivery because of failure to access hospital due to shelling). Some hospital staff suffered from the death of family members and demolition of houses, resulting in bringing their children to work. 24-hour shifts were adopted due to difficult travel to work. Hospital admitted cases transferred from Aqsa hospital after being shelled.
Shahada` Aqsa – middle area Date of assessment visit Sept. 2, 2014 Key informant Dr. Kamal Asad, Director	Surgery department was shelled and Slight damage in infrastructure with no impact on working capacity	Hospital was hit by bombs and was evacuated to Tahreer hospital for a short period. Worked in emergency mode with reduced human capacity (50% of doctors). Nurses were replaced by nursing students to fill gaps in nurses on duty. 24-hour shifts were adopted to cope with staff shortages. The hospital was evacuated totally for one day after being bombarded. 5 pregnant women were reported among the people killed. On the day of bombardment, 3 women stayed only one hour after Caesarean-section deliveries. Outpatient clinics were totally closed. Noted increases in preterm delivery, miscarriage and home delivery during the crisis.
Harazine Date of assessment visit Sept. 1, 2014 Key informant Dr. Naeem Ayoub	Partial, but significant damage	Maternity remained functional until July 22, 2014, on a one-shift basis. Then, due to land incursion, sustained severe damage and was closed until August 5. As of August 5, working on two-shift basis until 7pm, and recently reopened on a full-scale basis. Closure of Harazine maternity during the crisis resulted in shifting of clients to Shifa hospital, increasing the load on Shifa. Severe damage in infrastructure and non-medical equipment was sustained in Harazine due to strikes in the nearby neighborhood. Repair work was supported by UNFPA and the maternity is now back to full function.
Shifa hospital Date of assessment visit Aug. 8, 2014	No direct damage to infrastructure except of damaged	Change in work modality to longer shifts and 70% of staff capacity. Maternity department received load of wounded women. 15 cases of deliveries at home or in the car on the way to hospital.

Maternity	Damage sustained	Snapshot of services during the crisis period
Key informant Dr. Hasan Louh, Director Dr. Allam Abu Hamda Director, NICU	infrastructure due to misuse by displaced people	2 cases of maternal deaths and increased infections due to declined capacity to maintain adequate infection control practices. 40% increase in case load due to closure of private hospitals and 30% increase in number of births. Increase in complications. Severe lack of equipment and supplies that has been aggravated by the war. Interrupted working environment and depletion of resources due to massive number of IDPs next door in the garden. Shortage of supplies was mitigated through direct support from UNFPA during the attack. Neonatal care was affected by increased preterm deliveries, increased case load and shortages of human resources and drugs such as surfactant used to support lung maturity in preterm infants.
Awda hospital Date of assessment visit Sept. 3, 2014 Key informant Dr. Jameel Abu Fanouneh Mr. Mohamed Shrafi Dr. Jamil	Slight damage due to indirect exposure	Worked on full capacity with longer shifts. 100% increased load. Stopped elective surgery and outpatient clinics. The only hospital working in the northern part of Gaza receiving maternal cases and wounded from this area. Shortage of oxygen, IV fluids and hospital linen was overcome through contact with MoH and international organizations. Noted increase in complications such as miscarriage, preterm delivery, bleeding and caesarean section. 6 cases of home deliveries and 2 cases of delivery outdoors. Home deliveries were assisted though the hotline 151. A case of postpartum hemorrhage after delivery at home was referred to and managed at the hospital. Severe psychological distress affected workers and hindered their ability to help mothers and families. Some staff and their families were offered shelter at the hospital.

Staff capacity during the war

Table 4 demonstrates the extent to which staff capacity was affected by the security situation during the war. The majority of assessed maternities worked under significant staff shortages due to the inability of staff to report to their duty stations during times of increased hostilities. The maternities that were able to maintain their pre-crisis levels of staff were those benefiting from volunteer health practitioners living nearby and/or using intern physicians and nursing students.

Table 4: Percent of Available Staff During the Crisis Compared to the Pre-crisis Situation

Staff	Harazeen	Emirate	Aqsa	Naser – Tahreer	Shifa	Awda
Doctors	100%	115%	40%	40%	65%	50%
Nurses	100%	110%		30%	80%	120%
Midwives	100%	107%	85%		60%	80%
Technicians	0%	120%	80%	30%	40%	100%
Pharmacists	0%	50%	55%	15%	50%	30%
Others	100%	95%		40%	100%	110%

Data from the maternity hospitals reveal the increased case load resulting from the closure of private facilities, which usually absorb around 30 percent of maternity services in Gaza. Table 5 shows the number of cases of normal delivery and Caesarean sections in all maternities surveyed except for Harazine, which is located in the Shejayya area. This facility was severely damaged due to bombardment nearby. Furthermore, all residents of Shajaiyeh were displaced, leading to the complete closure of the maternity for two weeks.

Table 5: Services and Case Load Pattern in Assessed Maternities (Number of Cases)

	Hilal Emirati			Aqsa MRTYRS			Nasser			Shifa			Awda		
	BL	July	Aug	BL	July	Aug	BL	July	Aug	BL	July	Aug	BL	July	Aug
Normal delivery	427	504	565	396	523	607	672	791	736	1,025	1,242	1,319	201	307	359
Caesarian section	103	NA	NA	98	103	113	173	168	171	310	400	372	37	63	109
Low birth weight	26	23	20	18	27	33	24	76	71	48	54	47	7	13	11
Pre-term delivery	40	23	22	50	154	106	45	122	117	60	51	61	5	10	12
IUFD/ SB	4	55	60	3	2	3	7	7	6	11	36	17	1	4	1
Miscarriage	51	39	68	103	109	131	116	124	152	285	290	316	39	42	58

Notes: BL=baseline (monthly average in 2013); IUFD/SB= intrauterine fetal death/stillbirth.

In this assessment, the indicators selected to describe maternal morbidity included low birth weight (indicating preterm delivery or poor maternal conditions), intrauterine fetal death or still birth, and miscarriages. Although there was some variation among individual maternity hospitals, in general, all indicators of morbidity increased compared with the baseline, calculated as the monthly average from

2013. In particular, and as would be expected during times of crisis, the maternity hospitals surveyed showed an increase in miscarriages and intrauterine fetal deaths and stillbirths. Al-Awda hospital in northern Gaza consistently reported increases in pregnancy-related complications, such as miscarriages, pre-term deliveries, bleeding and Cesarean section deliveries, related to increased stress on women during the war.

Although not recorded due to the immediate referral of cases for hospital care, 80 percent of health personnel interviewed in the primary health care centers in Gaza reported an increase in complications related to pregnancy such as hypertension, ante-partum bleeding and post-partum anxiety.

Women interviewed in hospitals, primary health care centers and shelters reported severe impacts of the crisis on their physical and mental wellbeing. A special section in the report is devoted to the reproductive health conditions of displaced women.

3.4.1.3 Impact on hospitals and maternities

The impact of the attack on Gaza hospitals was evident from physical damage and the severe disruption of work in the hospitals receiving extremely high numbers of casualties. Seventeen out of 32 hospitals operating in Gaza sustained physical damage, and 58 out of 97 primary health care clinics were damaged (3). Nineteen physicians, health staff and paramedics were killed during the offensive and 47 ambulances were damaged, of which 14 were completely destroyed.

This assessment looked at maternity and newborn care departments to examine the extent to which the six selected facilities were able to continue providing life-saving obstetric and newborn care. The selected maternity hospitals represented governmental and NGO sectors and worked collaboratively to respond to the needs of people affected by the attack and those isolated in remote locations due to military operations.

As shown in Figure 2 and Table 5, due to the closure of private maternities during the war, Ministry of Health and NGO maternities experienced around a 30 percent increase in demand for obstetric and newborn care. Three out of the six selected hospitals in this assessment incurred physical damage. Overall, according to the WHO situation report of 23-28 August, 17 hospitals were damaged, of which six were closed at the time this situation report was prepared.

Figure 2: Number of Normal Births, Six Gaza Hospitals

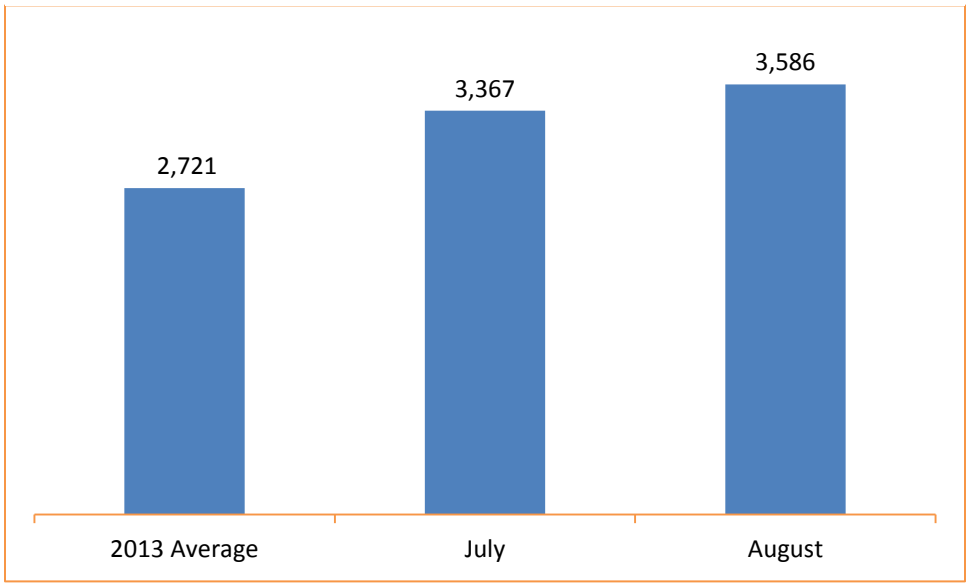


Figure 3: Normal Deliveries by Hospital

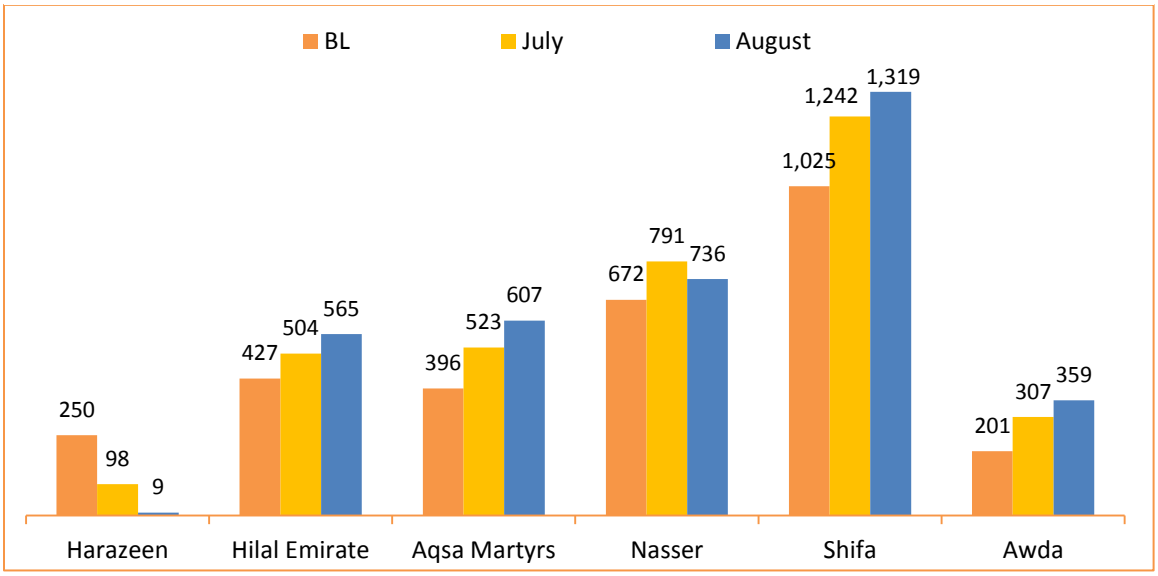


Figure 3 shows an increase in case loads in all assessed maternities except Harazine, which was closed in July due to bombardment in its proximity.

Figure 4: Number of Caesarean Sections

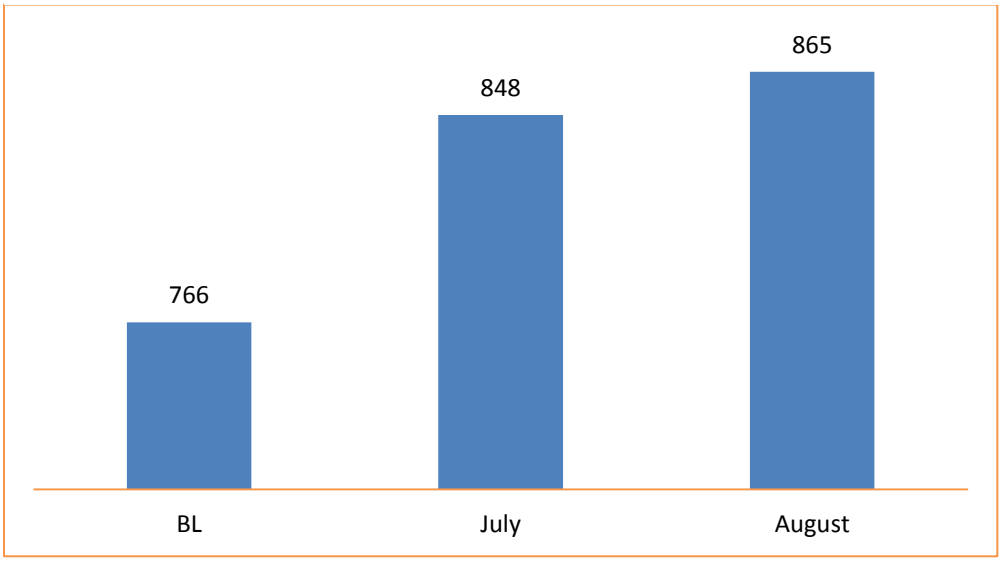
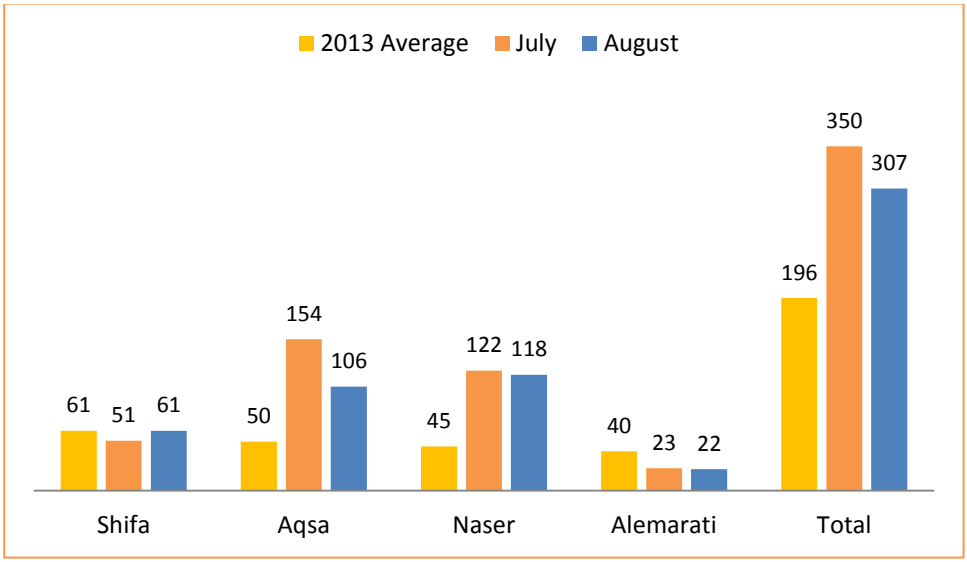


Figure 4 shows a significant increase in the number of Caesarean sections performed during the war. This finding is remarkable given the increased load on already stretched human and material resources in the hospitals during the war. Even more significant is the increased proportion of deliveries performed by Caesarean section compared with the national baseline of 15.6 percent. The surveyed hospitals showed a 25 percent increase compred with pre-crisis conditions, when the Caesarean-section rate was 20 percent. The increased number and proportion of Caesarean-section deliveries is consistent with the reported increase in at-risk pregnancies.

Figure 5: Preterm Deliveries at MOH hospitals



An increase in preterm delivery is generally expected and documented in times of crisis. In four major maternities, the rate of preterm deliveries increased dramatically, resulting in an increased burden on

neonatal care services. The rate is also believed to have contributed to the rising fatalities among newborns admitted to neonatal intensive care units.

The team made the following general conclusions with regard to the working conditions in hospital maternity wards:

1- All hospitals, including maternities, entered the crisis with severe shortages in resources and materials, as indicated by stock-outs in medications and disposable supplies.

2- Due to the high number of serious injuries, maternity ward space and facilities, including operating theatres, were designated for treatment and hospitalization of the injured. Wounded women were hospitalized in the maternity departments, and obstetricians on duty had to provide general surgery for the wounded.

3- As movement of staff was extremely difficult during military operations, significant staff shortages were witnessed in major maternities. This led the hospitals to adopt long shift regimes, and staff routinely worked on shifts for several days.

4- Health staff working in hospitals underwent an additional burden when they helped and saw the death of their own family members. The story of medical staff being killed and the physician from Shifa Hospital receiving the dead body of his own son while on duty are only examples of cases where health staff were also direct victims of the crisis.

5- Health staff were under stress thinking of their families and homes while on duty. Nineteen medical and rescue team members were killed and 83 were injured while on duty. A number of incidents were reported in which health staff lost their homes and family members.

6- The morale of workers was further compromised by not receiving salaries for a long time.

7- Major hospitals in the Gaza Strip were used as displacement shelters by fleeing families, adding a logistical burden on the hospital facilities. At the peak of military operations, around 20,000 people inhabited the garden of Shifa Hospital and used its facilities and resources such as toilets, corridors, hygiene supplies and food.

8- The huge number of casualties overstretched the capacity of housekeeping and sterilization services, both in operating rooms and departments. This increased the occurrence of hospital-acquired infections reported after discharge from hospitals and primary health care facilities.

9- During the attack, hospitals were granted six hours of electricity supply from the network, and the remaining needs were ensured through local generators. The shortage of fuel and severe overuse of generators created a serious problem in the short term, but will also have long-term consequences.

These observations highlight the extremely difficult conditions under which maternity staff had to work. Moreover, with the 30 percent increase in case loads, concerns about the quality of care provided to mothers and newborn appear to be legitimate.

3.4.1.4 Neonatal care

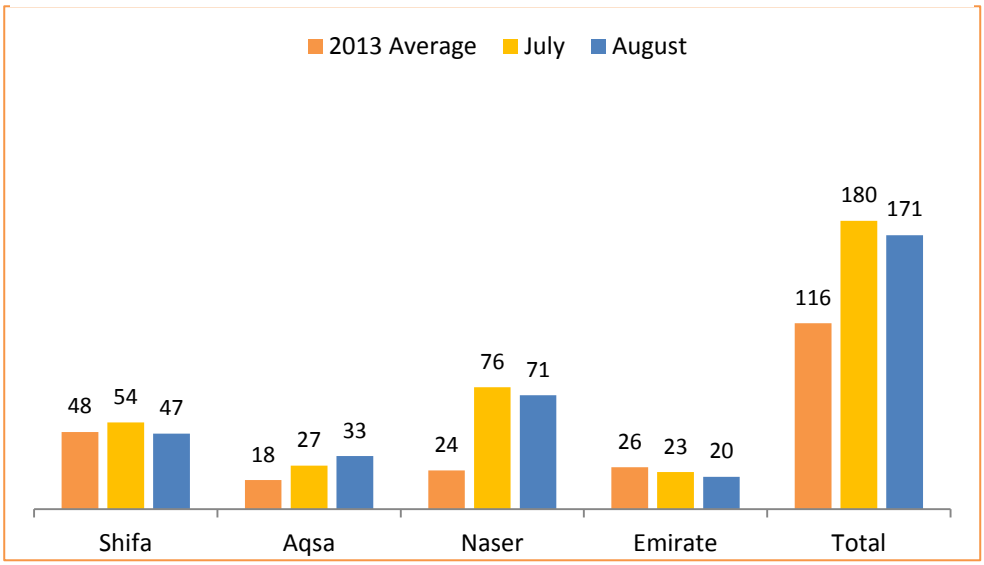
Five neonatal intensive care units (NICU) were assessed to determine the impact of the crisis on the functioning of the units and survival of newborns.

According to service delivery records in the five assessed units, Shifa Hospital (the hospital with the highest number of deliveries) had the highest number of admissions to the NICU. According to workers in the Shifa and European hospitals, the increase in the number of premature newborns resulted in such a crowded unit that at any point in time, they had two newborn babies in the same incubator.

Photo source: Shifa Hospital

In many cases, the discharge of newborns was postponed, especially when the parents were living in shelters, to avoid endangering the life of the newborn in an unsafe shelter environment.

Figure 6: Low Birth Weight Deliveries



Although the occurrence of low birth weight is largely attributed to the general condition of mothers during pregnancy and not limited to short-term factors such as an acute crisis or war, a rise in low birth weight would be expected given the large increase in preterm deliveries observed during this crisis.

Figure 7: Intrauterine Fetal Deaths/ Stillbirths (IUFD/SB)

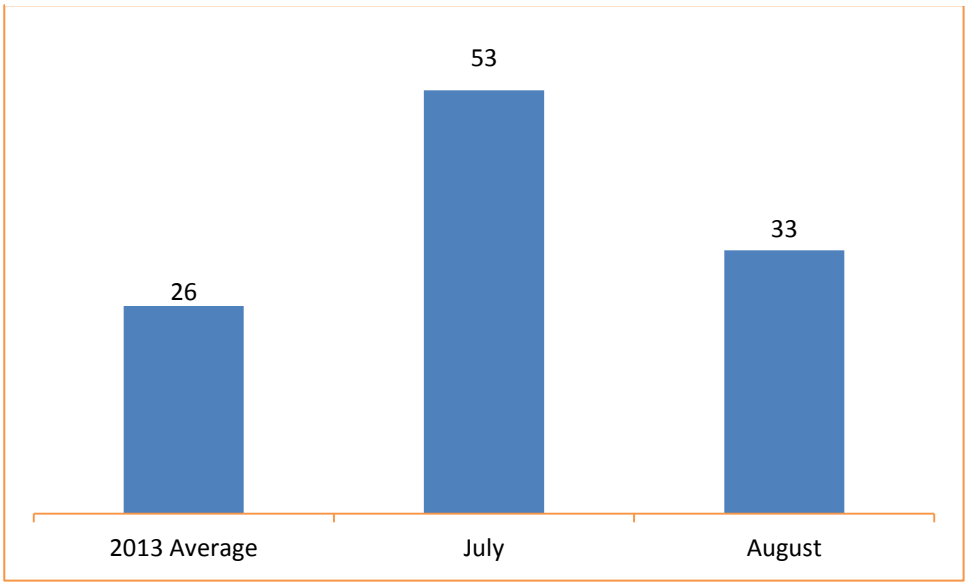


Figure 7 shows a doubling of intrauterine fetal deaths and stillbirths in the five neonatal units in July. Such an increase was thought to be caused by extreme stress and/or the reluctance to promptly seek care when changes in fetal movement were observed.

Difficult transportation during the crisis also resulted in significant shortages of staff and life-saving medications, such as surfactant and antibiotics. Shortages in surfactant (a medication that is used to enhance the maturity of the lungs) resulted in extended hospitalization of infants under ventilation, and hence an increased risk for infections and other complications, leading to increased fatality rates.

Figure 8: Case Fatality Rates in Newborn Intensive Care Units (%)

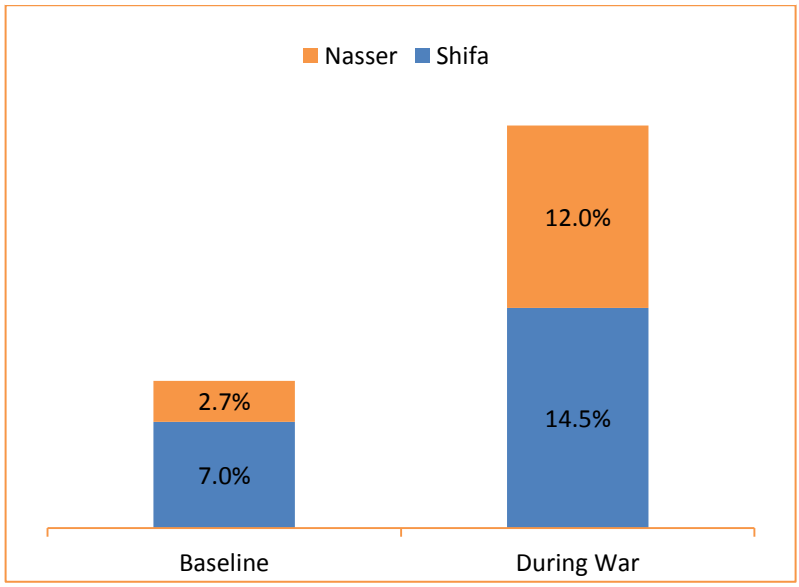


Figure 8 shows data on newborn fatalities from Nasser Pediatric Hospital and Shifa Hospital. Systemic and logistical challenges during the attack were associated with a significant increase in neonatal case fatality, which climbed from 7 percent to 14.5 percent of newborns admitted to the NICU in Shifa Hospital alone. Most of the deaths were due to prematurity. At Al Nasser specialized pediatric hospital, the mortality rate increased from the baseline of 2.7 percent to 12 percent. Data from the European hospital show that there were 28 admissions to the newborn care unit and 10 neonatal deaths during the month of July. While there are no baseline values from the European hospital, these figures indicate that the neonatal mortality rate reached 35 percent.

Neonatal units usually support breastfeeding by promoting early attachment between mother and child, enhancing the early initiation of breastfeeding. When direct contact was not possible, the hospital policy was to encourage bringing expressed breast milk to the hospital. This practice almost halted due to limited access during the attacks and transportation difficulties for the mother or the expressed milk. Hence, milk formula had to be introduced for hospitalized infants.

3.4.1.5 Impact on primary health care

The Ministry of Health, UNRWA and NGOs tried to maintain full operation of primary health care facilities even during active military operations. When movement was not possible or extremely risky, staff were instructed to report to their closest possible facility. Nevertheless, during the attacks, 50 percent of primary health care facilities were closed due to direct damage or proximity to military operations and consequent unsafe travel. Those that remained open operated under difficult conditions (see Table 6).

According to the WHO situation report of 23-28 August, 50 out of 97 primary health care facilities sustained some damage. As of 27 August, 30 primary health care centers were closed.

Table 6: Primary Health Care Centers

Primary health care center	Damage sustained	Snapshot of services during the crisis
Hilal Abasan Red Crescent Society Key informant Fairooz Assar	Partially damaged due to unexploded shell in the waiting area.	Facility was functional during the crises, but with low attendance of clients during active military operation. Medications were available and were distributed free of charge during the war. After the war, nominal fees were charged for medications and services.
Abu Teima Palestinian Medical Relief Society Key informant Halima Abu Teima	Partially damaged area surrounding the center is full of ruble due to shelling in the proximity of center. Broken doors and windows, holes in the walls and cracks affecting most of the clinic walls. Loss and damage of computers and furniture.	The facility was functional during the period July 7-22, and then shifted to mobile health services and to shelters in the area. Increased occurrence of vaginal bleeding among women in shelters. These women were transferred by ambulance for hospital treatment. Ambulance services were delayed during the crisis.
NECC- Shajaeya NGO Key informant Dr. Widad Kana`an	Partially damaged.	Partially functioning only during ceasefire. Reduced case load compared with baseline. Services were provided free of charge during the crisis.
Jabalia Ministry of Health Key informant Amer Ramlawi	Partially damaged due to shelling of the nearby structures.	Fully functioning center with reduced staff and increased load due to displacement of people to Jabalia from other areas. Most workers in this facility were employees from other locations, but residing near the center and reporting to it. Work under stress and with medication shortages, especially for chronic patients. Pregnancy-related complications were noted and referred to the hospital, especially preterm delivery, bleeding and hypertension. Special services for psychosocial support are needed.
Tal Sultan Ministry of Health	Partially damaged due to shelling of the surrounding area. Broken windows and	Continued to provide services; staff had difficulty reaching center during attacks. One nurse lost her husband. Medication shortages were noted and electricity cuts

Primary health care center	Damage sustained	Snapshot of services during the crisis
Key informant Wafa Khaleefa	cracked walls.	resulted in damage of vaccines. Noted increased pregnancy complications such as miscarriage due to stress.
Khan Younis Ministry of Health Key informant Najwa Sulaiman	No damage	Due to security situation in the proximity of the center, all services were moved to a nearby shelter, except for laboratory and x-ray services. Antenatal care services were stopped during July and resumed in August. Severe shortage of medications was experienced during the attack, especially antibiotics, anti-fever, chronic disease medications and anti-inflammatory drugs. Family planning services were available and provided to clients, except for IUD insertion. Complications associated with pregnancy increased, such as bleeding, miscarriage and hypertension, due to stress. Increase in violence.
Jabalia UNRWA Key informant Dr. Kifah Najjar	No damage (minor with broken windows and doors)	Fully functioning center with shortage of staff due to difficult transportation and increased case load, up to double, due to movement of people to nearby shelters. Home visit program halted due to security. Workers worked under high stress due to overload and worries about their own families. Vaccination and care for pregnant women were given priority attention. Registration of new cases for antenatal care was postponed except for high-risk cases. While no sexual violence was registered, the center registered 3-5 cases of physical, verbal and psychological violence.
Zeitoon Ministry of Health Key informant Iman Natat	No damage	Due to movement of people to Zeitoon from areas affected by the crisis, the load on this center increased.
Tal Sultan UNRWA	No damage (minor with broken windows)	Center operated under difficult conditions, with a staff shortage. Family planning services continued; postnatal home visits were stopped. Radiology and laboratory were closed for 10 days because the technician lost his whole family. Increased complications such as bleeding during pregnancy were noted, but cases were referred to the hospital.

Table 7: Percentage of Staff Reporting to Work During Crisis Compared to Pre-crisis Period

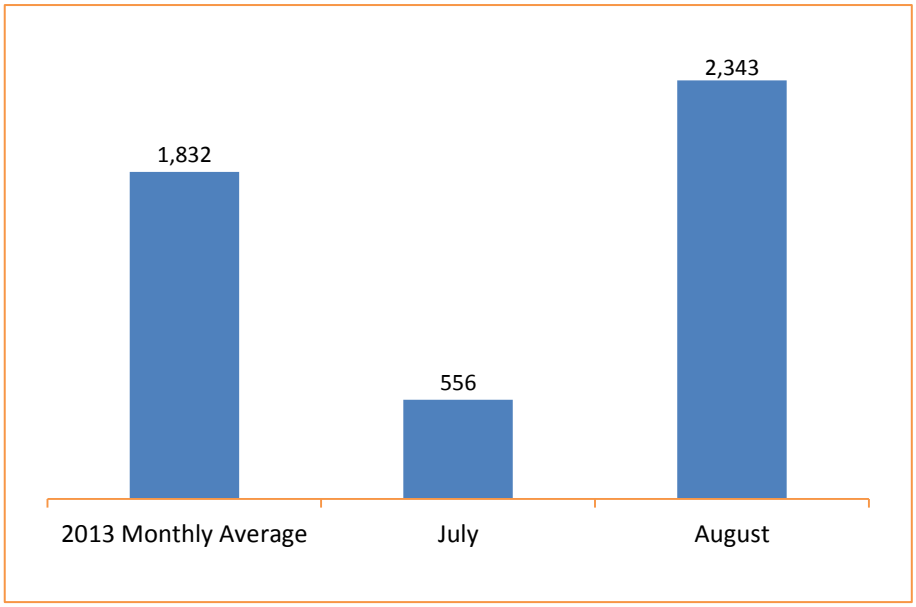
	Hilal Abasan	Abu teima	Jabalia	Tal sultan	Khan Younis ***	NECC	Jabalia	Zaitoon	Tal sultan
	NGO	NGO	MOH	MOH	MOH	NGO	UNRWA	MOH	UNRWA
Doctors	100%	130%	40%	70%	NA	100%	60%	40%	90%
Nurses	100%	100%	90%	60%	65%	100%	40%	35%	90%
Midwives	NA		100%	60%	60%	100%	40%	NA	0
Technicians	100%	100%	40$	50%**	0%	100%	90%	30%	66%
Pharmacists	100%		60%	50%	100%	100%	50%	40%	70%
Other	100%	*	40%	60%	30%	100%	30%	100%	90%

* 3 psychotherapists added to staff in the clinic.
** Radiology technician lost his entire family and the service was closed for 10 days; lab technician also lost members of his family.
*** Services were moved to a shelter; lab and x-ray were not moved.

Only 50 percent of primary health care facilities were operational during the war. In addition, staff were not able to reach their duty stations because of security, and therefore about half of the reviewed facilities operated with significantly reduced human resources (Table 7). The facilities with 100% of staff attending benefited from health care professionals who reported to the nearest facility regardless of the provider or their original duty station. Furthermore, to cope with staff shortages, primary health care centers benefited from private sector practitioners available within the geographic area.

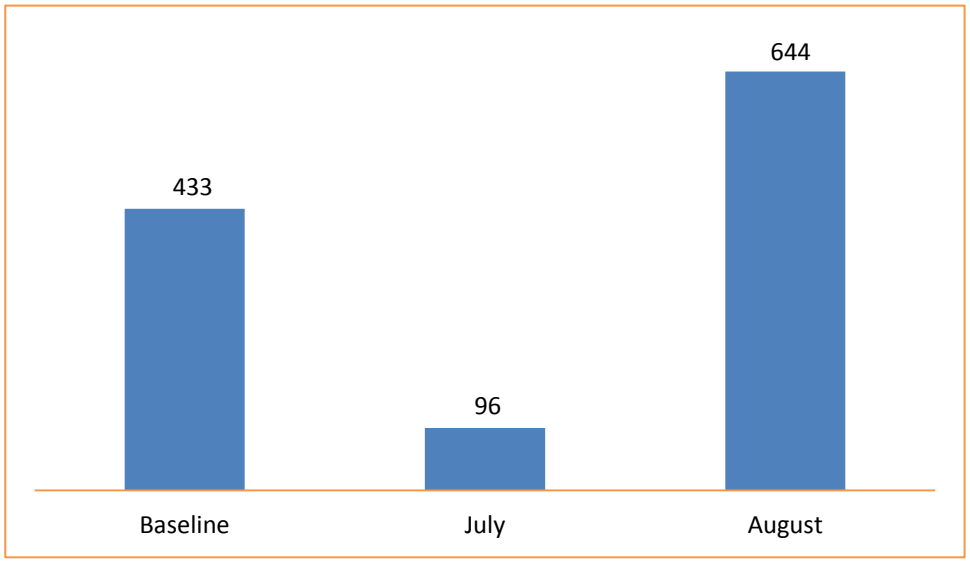
Military operations continued for 51 days, with heavy bombardment during July and August. In August, the scope and intensity of military operations declined because of the ceasefire declared on August 1, which led to 18 ceasefire days. This explains the observed rise in the use of reproductive health services in August at all facilities.

Figure9: Antenatal Care Visits at Surveyed Facilities



Data from the primary health care centers surveyed show that all providers recorded a sharp decline in the utilization of reproductive health services in July. Figure 9 demonstrates the decline in antenatal care visits in July caused either by the closure of facilities, the limited ability of women to reach the facilities, or both. The decline in new case registrations was even greater, with July records showing only 22 percent of cases compared with the baseline. Follow-up antenatal care visits were higher than new cases, but still lower than the baseline. For both new and follow-up cases, August utilization rates returned to normal because there were significantly fewer days of military assaults.

Figure10: New Registrations at Antenatal Care Clinics



The Near East Church Council (NECC) clinic in Jabalia showed a 62 percent and 83 percent decline in antenatal and postnatal care visits, respectively. Although the uptake of these services improved in

August, it did not reach the pre-crisis level. This was possibly due to the fact that a significant proportion of the north Gaza population was displaced, and some people did not return home.

Figure11: Follow-up Visits to Antenatal Care Clinics

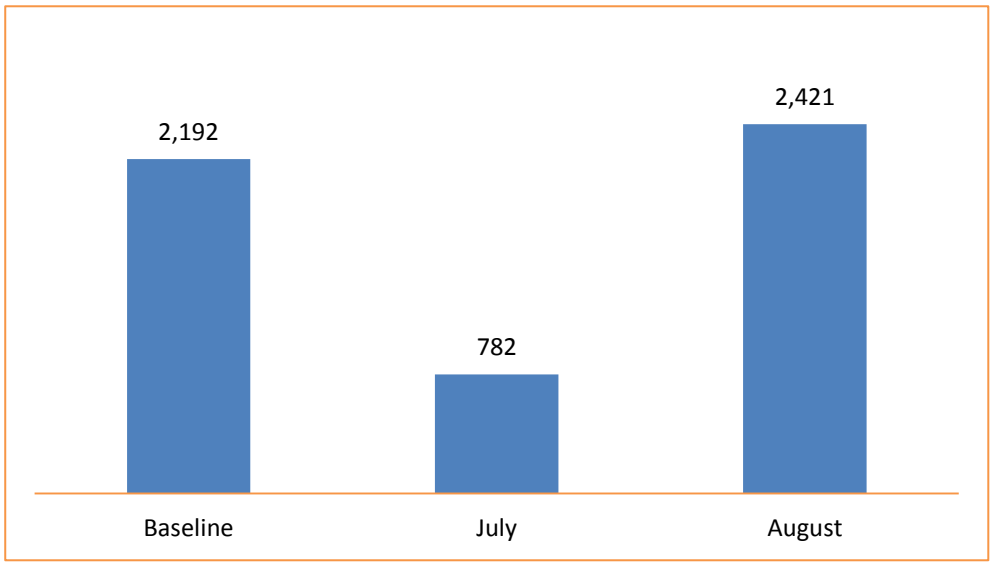


Figure12: Family Planning Uptake at Ministry of Health clinics (New Cases)

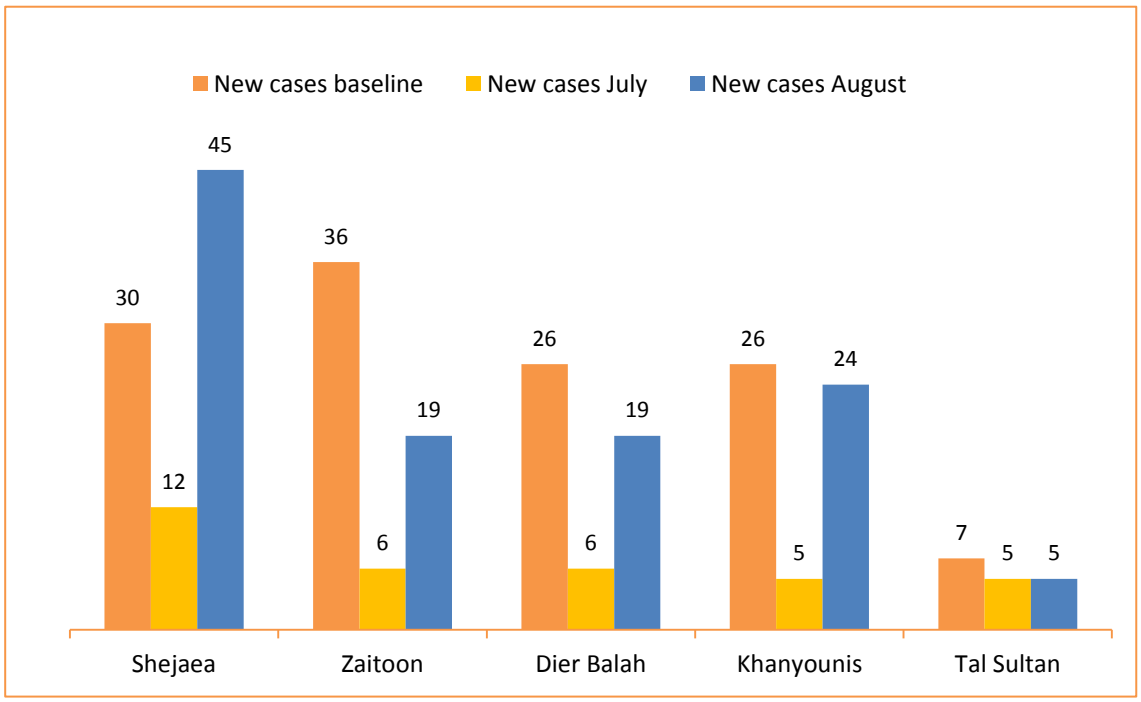
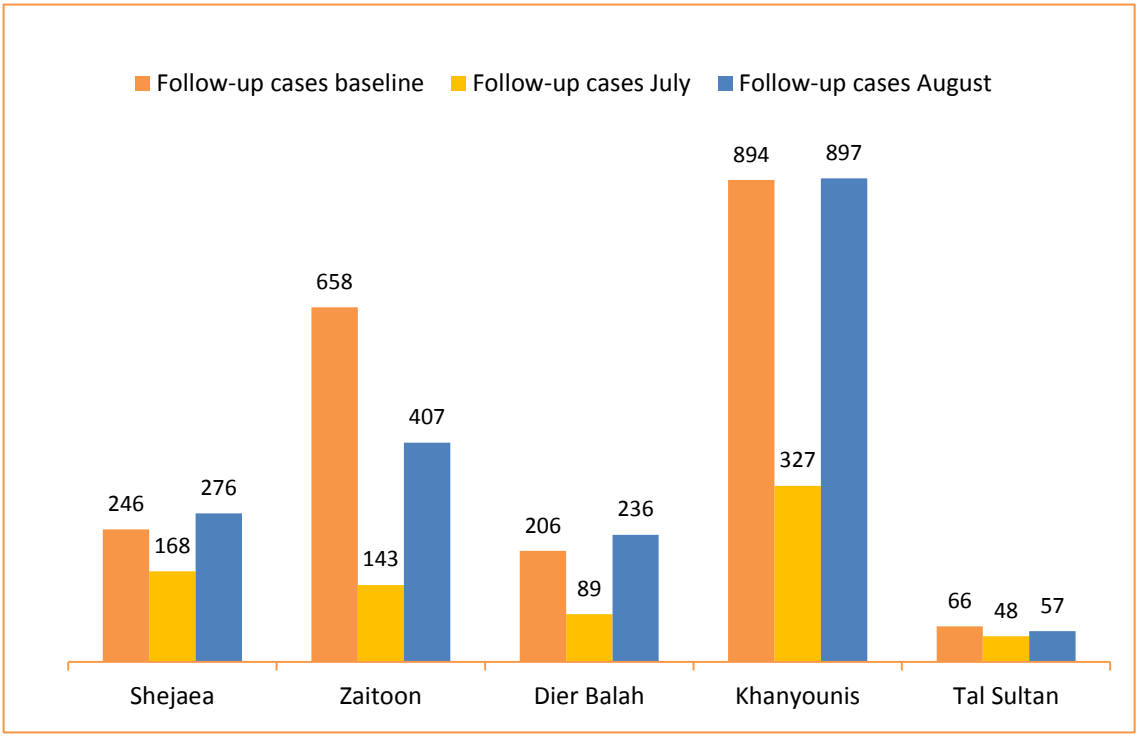


Figure13: Family Planning Uptake at Ministry of Health Clinics (Follow-up Cases)



Family planning services were negatively affected during the crisis, with Ministry of Health clinics in Gaza showing a 60 percent to 90 percent decline in the number of beneficiaries in July (see Figures 12 and 13). While the uptake of family planning services improved during August, it did not reach the pre-crisis level. Analysis of service data from the ministry shows an almost complete halt of IUD insertion and removal during the war, which is explained by the shortage of providers, lack of time and inability to sterilize equipment properly during emergencies and electricity cuts. While the injectable method would have been a good medium-term method of choice during emergency conditions, Depo-Provera injections were not given during the 51 days of the crisis.

While condom use declined in July, it slightly exceeded its pre-crisis level in August. The use of pills showed the least variation during the months of crisis. In July, the decline in use reached 30%, but pre-crisis levels were restored in August.

Primary health care services continued to a certain degree depending on the security situation. Interviews with both staff and clients indicated a significant decline in services during July, when the military operation was at its peak. During this period, various complications associated with pregnancy were reported, with an emphasis on hypertension, ante-partum bleeding and premature labor pains. Women suffering from such complications were referred directly to hospitals to avoid deterioration. UNRWA reported an increase in its case loads, especially in centers close to shelters where there was an influx of internally displaced people. During the crisis period, services were offered free of charge to all displaced people, regardless of their refugee status. NGO providers also reported adopting a free-of-charge policy during the crisis for all service users.

Some services, such as health education, counseling and outreach home visits were stopped due to a lack of transportation and security concerns. Due to severe shortages in medications and resources, some services continued, but on a lower scale. Due to a lack of time and means for sterilization, IUD insertion, checking and removal services were interrupted in all of the centers surveyed. Depending on the availability of staff and resources, vaccination and antenatal care continued. Shortages of iron supplementation, vitamins and medications for chronic diseases resulted in a significant decline in these services. Primary health care clients reported severe problems related to unsanitary conditions and supplies. The lack of medications at the centers combined with the need to buy medications from outside created financial burdens for families. In some cases, the families bought only a portion of the prescribed medications, or none at all. Some clients reported selling food aid in order to get medications when they were not available at the health care centers.

The disruption of the outreach home visit programs resulted in a significant decline in care for people discharged from the hospital. This affected women in the postpartum period, chronically ill people and wounded people.

Clients reported low satisfaction with services due to the lack of medications and the need to purchase medications from private pharmacies.

3.4.2 Shelters

More than 500,000 people fled their homes during the war. The number of displaced people fluctuated depending on the security situation; there were 489,000 displaced people just before the ceasefire that began on August 26. According to OCHA, 108,000 people will remain homeless and will need shelters. As of September 1, there were 58,000 people hosted in 31 UNRWA schools, and the rest were living in host communities and with relatives.

Due to the extremely high number of IDPs fleeing their homes in a short time, existing aid organizations in Gaza did not have the capacity to respond adequately to their needs. According to the OCHA report, the number of IDPs was 10 times the worst-case scenario, and therefore aid fell far short of need during the crisis. The current assessment was conducted after most of the displaced people had returned to their homes, and only about 58,000 displaced people remained in the 31 UNRWA schools. Therefore, understanding the actual situation during the period of active hostilities would require further analysis.

Due to the short notice given before the bombardment of houses, people fleeing to shelters did not have the chance to collect personal items. They left their savings and assets behind and came to UNRWA schools with almost no personal assets, clothing, money or even identification documents. At the time of the assessment, the organization of services, environment and resources available within UNRWA and aid organizations had improved, which was expected to improve the living conditions for displaced families.

Table 8 illustrates the conditions and services available in the surveyed shelters.

Table 8: General Conditions in Shelters

		Tufah Gaza	Amal Khan Younis	Beit Hanoun	North Gaza	Der Balah	Rafah	Gaza East *
Operation		UNRWA	UNRWA	UNRWA	UNRWA	UNRWA	UNRWA	UNRWA
Population		1071	3061	664	2373	1083	1000	
Population/toilet ratio		45	123	37	170	36	125	
Hand washing facility		No	Yes	No	Yes	Yes	Yes	No
Shower/ bathing facility		Yes	No	No	No	Yes	No	No
Qty of water per person per day		5 liters	5 liters	3 liter	1.5 liter	5 liter	3 liter	3 liter
Proximity to PHC on foot		10 minutes	10	10	More than 30	45	20	10
Proximity to hospital		20 minutes	10	10	60	45	45	20
Health services on site		Yes	Yes	Yes	Yes	Yes	Yes	Yes
Package	ANC	Yes	No	No	Yes	No	No	No
	MNCH	Yes	No	No	No	No	No	No
	PNC	Yes	No	No	No	No	No	No
	EPI	No	No	No	No	No	No	No
	GP	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	dressing	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Early warning system		No	No	No	No	No	No	NA
3 top priorities	1	Meningitis	Enteritis	Skin	Fever	Skin	Enteritis	Meningitis
	2	Enteritis	Skin	Enteritis	Skin	Lice	Skin	Enteritis
	3	Skin	Food poisoning	Fever	Food poisoning	Enteritis	Scabies	Skin
Health promotion		Yes	Yes	Yes	Yes	Yes	Yes	NA
Health professionals	Doctor	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Nurse	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Midwife	No	No	No	No	Yes	No	No
	Promoter	No	Yes	No	Yes	Yes	Yes	No
	cleaners	20		4		9		

* Responses were taken from residents due to the shelter manager's refusal to cooperate.

The table shows the diversity in living conditions in the shelters studied. The ratio of individuals to toilets varied widely, with some shelters having more than one hundred individuals assigned to only one facility. This, in addition to the absence of bathing facilities in most of shelters (all but two) and the extremely small amounts of water made available to the shelter population, highlights the devastating hygiene conditions. Combined with the absence of financial resources to purchase hygiene supplies, low morale and depression, these conditions resulted in a significant spread of skin diseases and gastroenteritis among children.

After the ceasefire, UNRWA assigned health practitioners to each school to provide general medical services and health education. Information gathered from the shelters indicated that these services had just become available. In contrast, during the crisis, shelter residents could only receive medical care through mobile teams visiting the shelters or at Ministry of Health, UNRWA and NGO centers

outside. This option was reported as unaffordable due to the need to leave the shelter during the crisis and to pay for medications and/or transportation. Women in particular were afraid to leave their children alone in the shelter in order to travel to seek health care.

According to the data collected during this assessment, health services at UNRWA shelters lacked the reproductive health package, and women who needed such services were referred to outside facilities. Only Deir Balah shelter employed a midwife on the shelter health team. Even in this shelter, reproductive health services were not provided, and except for Tuffah shelter in Gaza, these services were unavailable.

At all of the shelters surveyed, health problems resulting from the lack of hygiene and poor environment ranked first among the concerns of shelter respondents. People who fled to shelters and remained there after the ceasefire were among the poorest, who had little opportunity to rent or repair their destroyed homes and/or lacked family support to rely on. In focus group discussions and individual interviews with men and women, shelter residents said that they were poor and could not afford to pay for services or other needs.

> When a service is needed outside the shelter, we would not go because we need money for transportation, and if the medication is not available, we cannot buy it from the pharmacy.
>
> We sell food aid to buy baby formula, medications or other needs that are not made available.
>
> Even if distribution of hygiene kits happened once, we consumed the material in it within one week and after that no one replenished these items.
>
> —*Women and men in shelters*

3.4.2.1 Availability of reproductive health services

While all participants in the focus group discussions and individual interviews reported the existence of some medical services, 100% of women in the focus groups reported the absence of reproductive health services such as antenatal care, family planning and treatment of sexually transmitted infections (STIs). For such services, women were referred to facilities outside of the shelter. This finding is consistent with the team's observations of the shelters, shown in Table 8, which also showed a lack of reproductive health services. Noting that women and girls comprise a significant proportion of the shelter population and the fact that the reproductive health needs of both groups are a major concern for public health and psychological health, the failure to incorporate these services in the essential package of services represents a serious shortcoming in the humanitarian response.

Furthermore, all respondents reported that they left all of their assets behind, including money, while fleeing the bombardment. Women who were referred to outside medical services did not use them for security and financial reasons.

3.4.2.2 Reproductive Health Problems

- **Pregnancy**

Eighty percent of respondents in the focus group discussions with women reported experiencing or observing other women's increased complications during pregnancy. Participants reported stories about bleeding, preterm delivery and infant death, and related it to the stress and fear caused by the crisis and associated hostilities, and the losses of family members, homes and belongings.

- **Childbirth**

Pregnancy and childbirth became a horror for women during the crisis. Women in the focus group discussions across Gaza were worried about where to give birth, and what would happen to the child living in such an unsafe environment.

> I fled my home on August 8 in east Deir Balah and walked to the shelter, when my water broke even though it was not my date. I was taken to the hospital and stayed for two days before I came back to the shelter.
>
> I breast fed my infant and due to the lack of hygiene, my nipples cracked and I had to stop breast feeding.
>
> The baby is not feeling well, she always has colic, distention and is always surrounded by flies.

> I gave birth at Shifa and returned home. We had to flee and when I ran under fire, the stitches broke, and here in the shelter I cannot get any care.
>
> *—A woman from Shajaeyeh*

- **Sexually transmitted infections**

Primary health care services reported a significant reduction in clients seeking STI services. Women in the shelter reported symptoms suggestive of STIs or vaginitis. STI symptoms were exacerbated by the lack of water and sanitation facilities and the absence of reproductive health services in the shelters.

- **Family planning**

Ninety percent of women responded that family planning is needed; the rest thought that to compensate for those who were killed, family planning is not needed. Family planning services were lacking at the shelters, and the women who wanted the service were referred to outside facilities.

In focus group discussions in the shelters, eight out of 10 women believed that family planning services are important to have, even during crisis, because the prospect of having children is not positive. Women reported being upset about the idea of bringing children to the reality of Gaza. Other women thought that bringing children should continue and increase in the current situation, to compensate for those lost in the crisis.

Menstruation created a horror for women in shelters. Because of the lack of hygiene and inadequate facilities, young women were prevented from going to the bathroom. The lack of hygiene pads compelled women to use cloth as pads, causing a lot of discomfort. Some women reported using contraceptive pills to benefit from the effect of stopping menstruation.

Living conditions in shelters were extremely difficult. Classrooms hosted 50 to 80 people from six to 11 families. This severely limited normal life, eliminated privacy and interrupted natural communication among family members, including the opportunity to privately meet with husbands. This was considered a natural family planning-supporting condition.

In the shelters visited after the crisis, the practice was that women and children were hosted in the classrooms while men were kept in the corridors or on the playground. In addition to being humiliating, the practice became a means of separation that severely affected communication.

- **Breastfeeding**

Displaced women tried to maintain breastfeeding; however, stress, poor nutrition and lack of privacy in the shelter prevented continuation of breastfeeding. Some women reported that they had to sell food allowances to buy baby formula. The attitude toward breastfeeding was very positive, acknowledging the benefits of mother milk for the baby and the continuous availability under normal conditions. The crisis and displacement, however, was considered as the breaking point preventing the practice from continuing.

> I delivered at home and when we fled, I could not take my babies` clothing. My milk (breast milk) dried up and I could not initiate breastfeeding. The baby got an ear infection and then had diarrhea, for which he took intra-venous fluid at the hospital, and they referred me to the clinic to continue treatment. This treatment needs money and I do not have money.
>
> *—A woman from Rafah Shelter*

- **Violence**

People living in the shelters came from diverse social, economic and geographic backgrounds. Furthermore, some families reported moving from one shelter to another, and from shelter to host families and then again to a shelter. This happened under extremely insecure and dangerous conditions, which led to the loss of family members and increased stress on families. Normal life was interrupted in the shelter environment, with both women and men reporting a loss of privacy, increased feelings of anger, unfairness and vulnerability to violence.

Women in the focus groups reported disrupted breastfeeding, compromised hygiene and comfort, poor communication with family members and frequent disputes with other families.

One hundred percent of interviewed professionals and displaced family members reported the existence of violence. While they did not report sexual violence, women commonly reported physical, verbal and psychological violence, referring basically to the violence practiced by the male members of the family and by the service providers in the shelters.

On many occasions, residents reported unfair treatment and favoritism in shelters. They perceived the distribution of food rations and hygiene needs to benefit those with a better relationship with the shelter manager.

"If I experience another war, I would never go to a shelter"
- A woman in a shelter

Case of complicated pregnancy due to war

Cinderella

Cinderella Mohamed Ali Husain, a 34 year-old woman from Gaza, was married at age 14 and is now pregnant with her ninth baby. Cinderella never experienced menstruation, as she got married before menstruation started and has been pregnant or lactating ever since.

Cinderella tells her story during the crisis in Gaza:

"*I live in Beit Hanun, north of Gaza, now I am 23 weeks into my ninth pregnancy. I visited antenatal care only once during this pregnancy, in Jabalia UNRWA clinic. My house was shelled and my water broke, so I went to Awda hospital by ambulance, also with a wound in my right leg. After this incident, I started to have low blood pressure, difficult breathing and blurred vision. I am terrified of the situation and especially in the shelter after a nearby house was also shelled. I have no idea about where and if I will live to give birth, but most probably will need a C-section as my last delivery was through operation.*

I used to be a calm person, usually; now I am so nervous, and for no reason, I start crying and keep away from others. In the shelter, I became careless even when my little boy became sick, I did not take him for treatment, because I was afraid that something will happen if I leave my seven children in the shelter unattended.

Here in the shelter, I fight with my children, husband and even with others because I no longer tolerate anything, and once my husband beat me here in the school."

3.4.3 Host communities

The host communities were characterized by overcrowded houses lacking resources and falling outside the scope of aid agencies. The team conducted 12 field visits to host families in Gaza (4), Beit Lahia (2), Jabalia (2), Rafah (1), Maghazi (1), Khanyounis (1) and Deir Balah (1).

Access to health care could only be ensured by private means or by traveling to a public health center. Due to a lack of money, neither was feasible. In 10 out of the 12 meetings with host families, access to care was not ensured, and services were perceived as insufficient. Reproductive health services, in particular, were not accessible for displaced people staying with host families. They would have had to purchase services from private practitioners, which was not possible for financial reasons.

Due to crowding, long-lasting electricity cuts and a lack of water and hygiene supplies, displaced people and host families reported skin diseases, urinary tract infections and diarrheal diseases among children.

Displaced people in host communities needed to show a displacement identification card from a shelter in order to be allowed to use health services or receive food and non-food items. Such a card was not usually granted to those not living in the shelter, which caused additional stress to people displaced within the community.

The poor living conditions already affecting host families with high unemployment were further aggravated by the influx of fleeing families coming without any resources. The situation was made worse by the fact that these families were not registered for entitlement to aid, consequently deepening their dependency on host families. This resulted in significant discomfort and reduced living standards for hosting and hosted families.

All respondents in the focus group discussions and individual interviews reported violence. The stress of the crisis, displacement and loss of homes, lack of personal belongings and the limited ability of host families to cope with the financial burden of hosting additional families contributed to violence within this mini-shelter environment. The violence described by women in the focus group discussions followed the patriarchal structure of Palestinian family; it was directed from the head of family to the sons, who in turn harassed their wives, who took out their anger and frustration on their children.

Tensions between displaced and host families were reported in three of the visited locations, and this resulted in the misuse of host family facilities (one woman reported that breaking the sink in the house resulted in a major dispute between her family and the hosting family).

While children in the shelters could go out to play in the playground, children living with host families (usually in an apartment) did not have the chance to go out to play. These children were closed in the house, which irritated both the children and the adults. This added to the stress of hostilities, creating a tense environment and contributing to increased domestic violence.

4. Conclusions

The crisis in Gaza came on top of seven years of continuous deterioration of the health system. Already at the start of the hostilities, some medical items had complete stock-outs, while others were at a very low level. The availability of medications and disposables items was around 50 percent.

The replenishment and repair of medical equipment also lagged behind. With the high load during the recent offensive, the situation deteriorated further and at the time of this assessment, 50 percent of medical equipment in the health facilities was not working.

The assessment recorded significant destruction of hospitals, clinics and ambulances, as well as shortages of medical staff, which further compromised the capacity of the health system to cope.

Health care practitioners demonstrated unprecedented resilience, which reduced the impact of the crisis. Realigning systems of work, redistributing work loads and the high motivation to help formed strong coping mechanisms.

Reproductive health status and services were severely affected during the 51 days of the offensive. Victims in the shadow of hostilities gave testimonies of pregnant women killed and increased maternal and newborn mortality.

The increased incidence of complications during pregnancy was clear, which not only affected women but also contributed to increased case loads in already overstretched health care services.

Access to reproductive health services was disrupted during the hostilities, compromising the right of women to access essential services such as antenatal care and family planning. Such impaired access to key services will have short- and long-term effects on women and their babies.

Displaced families lived under dire conditions of lost dignity, resources and access to basic care. Access to basic services was very limited during hostilities, and people were not able to purchase the services they needed. In spite of significant efforts to make health services available through fixed and mobile health teams, reproductive health services were largely not available in shelters, even after the ceasefire.

The psychological wellbeing of families and women in particular is a major concern. The accumulation of stress caused by losing family members and homes, extreme poverty and displacement have been associated with increased violence and devastating impacts on women`s mental health.

5. Recommendations

There is an urgent need to rehabilitate the health care system in Gaza. Physical rehabilitation of both infrastructure and functions is needed, not only as an emergency preparedness measure, but also to enable the system to cope with and respond effectively to the growing daily needs of the population in Gaza.

The team recommends that the rehabilitation effort be built around the transformational idea of "building back better," taking into consideration the infrastructure, equipment and material resources needed to fulfill the functions of health care facilities.

The rehabilitation of health care services should take into account the logical and appropriate continuity of care from the community to primary health care centers, and ultimately to the hospital level, in a manner that allows a smooth transition of users among the three levels at all times.

Consistent with the national health strategy and its intention to improve quality of care, it is vital to for recovery efforts to combine "hardware" interventions such as rehabilitation and equipment with "software" activities such as training, capacity building and information management to improve the performance of health care services at all levels.

Immediate action must be taken to reach displaced populations with a full package of services, as physical and economic barriers to care are substantial. Options include expanding existing services in displacement centers and continuing mobile health services to remote areas.

Reproductive health services, psychological support and providing help and services to survivors of gender-based violence are critically needed services at this point of time.

There is an immediate, critical need to improve living conditions in shelters in terms of safety, hygiene, supplies for daily living and psychological support. Providing adequate food and non-food aid is an urgent need that falls beyond the health sector mandate, but is leading to physical and psychological harm.

Further assessment of and outreach to displaced people in the communities are needed immediately, as these people often fall below the radar of services and aid.

6. References

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6. Ministry of Health, Report on pharmaceuticals and consumables published by the directorate general of pharmacy at the Ministry of Health, July 2014

7. Annexes

Annex 1: WHO Quantitative Data Collection Tools

Annex 2: UNFPA Qualitative Data Collection Tools, Arabic and English Versions

Annex 3: Organization of Field Work and Distribution of Team Members to Assigned Geographic Locations

Annex 4: List of Key Informants

Annex 5: Photo Gallery

Annex 1: WHO Quantitative Data Collection Tools

1.1 Joint Cluster Partner Rapid Health Sector Assessment RH Questionnaire – Health Facilities

Name and signature of the team leader of the assessment team: Date:

A	GENERAL INFORMATION					
1	Name and Position of the Key Informant					
2	Contact phone and mail					
3	District					
4	Health Facility Name					
7	Ownership	☐ MOH ☐ UNWRA ☐ NGO ☐ other (describe)				
B	INFRASTRUCTURE					
1	Health Facility damaged	☐ Fully Damaged ☐ Partially Damaged ☐ Not Damaged				
2	Service still in original place?	☐ Yes ☐ No				
3	Health facility status	☐ Fully Functioning ☐ Partially Functioning ☐ Non-functioning				
Fully functioning = 100% of previous services functioning | partially functioning = when one or more of the usual services provided are not functioning (please describe the situation in the comment section (e.g. only 3 basic services are functioning – or there is only minor change to the usual services)						
4	Reason for closure of HF	☐ Damaged ☐ Security ☐ Staffing				
5	If no – where did the facility relocate to	Alternative fixed building ☐ tent ☐ facility closed with no replacement ☐ replaced by mobile clinic ☐ other pls. describe Distance to old structure < 10 min. on foot ☐ > 20 min on foot ☐ > 30 min. on foot ☐				
C	HEALTH SERVICES Please provide appropriate answer (Yes or No) & provide numbers where applicable		Functioning prior to the conflict 0=No 1 = Yes	Functioning Now 0=No 1 = Yes	Number of cases in July 2014	Number of cases in August 2014
1	C3. Neonatal Health	Counsel activities about breast feeding (exclusive BF up to complete 6 months and continue BF with adding supplementary feeding				
2		Presence or distributing breast milk substitute (artificial formula) inside PHC centers or shelters				
3		Number of neonates seen at neonatal emergency section				
4		Number of neonatal admitted cases				
5		Number of neonatal deaths				
6		Number of Premature cases out of admission number in the neonatal department				
7		Neonatal feeding inside the unit - (milk formula)				
8		Neonatal feeding inside the unit - (expressed breast milk)				
1	C4.	Expanded Programme of				

C	HEALTH SERVICES Please provide appropriate answer (Yes or No) & provide numbers where applicable		Functioning prior to the conflict 0=No 1 = Yes	Functioning Now 0=No 1 = Yes	Number of cases in July 2014	Number of cases in August 2014
	Child Health	Immunization: routine immunization against all national target diseases				
2		Vaccination coverage: how many children were vaccinated				
3		Cold chain functioning				
4		Screening of malnutrition (growth monitoring by anthropometric measurement W/A, H/A, W/H)				
5		Diarrhea and other (RTI, meningitis….) acute illness diseases management				
6		Continue active PKU and TSH screening programme				
1	C5. Nutrition	Screening of malnutrition or anemia for pregnant & lactating women				
2		Screening of malnutrition or anemia for children at 12 months old				
3		Screening of malnutrition (growth monitoring by anthropometric measurement W/A, H/A, W/H)				
4		Provision of supplementary micronutrients for children				
1	C6. Antenatal care	assess pregnancy				
2		birth and emergency plan				
3		advise/counsel on nutrition of the mother				
5		self-care and family planning				
6		preventive treatment(s) as appropriate				
7		tetanus toxoid				
1	C7. Essential newborn care	Skilled care during childbirth for clean and safe normal delivery				
2		basic newborn resuscitation + warmth,				
3		vit K supplementation				
4		clean cord care				
1	C8. Basic Emergency Obstetric Care (BEmOC)	manual removal of placenta				
2		removal of retained products with manual vacuum aspiration (MVA) if needed				
3		assisted vaginal delivery				

C	HEALTH SERVICES Please provide appropriate answer (Yes or No) & provide numbers where applicable		Functioning prior to the conflict 0=No 1 = Yes	Functioning Now 0=No 1 = Yes	Number of cases in July 2014	Number of cases in August 2014
1	C9. Comprehensive Emergency Obstetric Care (CEmOC)	Basic Emergency Obstetric Care plus caesarian section plus safe blood transfusion				
2		safe abortion care including antibiotic prophylaxis, uterine evacuation using MVA or medical methods if needed, treatment of abortion complications				
1	C10. Post Natal Care	Examination of mother and newborn in the health facility for minimum 6 hours				
2		Examination of mother and newborn in the health facility for minimum 6 days				
3		Examination of mother and newborn up to 6 weeks				
4		Number of post natal home visits				
1	C11. Key Indicators for Reproductive Health	Maternal mortality				
2		Number of CSs				
3		Number of Antenatal visits				
4		Number of Normal Deliveries				
5		Number of preterm deliveries				
6		Number of newborn < 2500 gram				
7		Number of induced deliveries				
8		Number of IUFD/SB				
9		Number of abortion				
10		Number of bleeding before delivery				
11		Number of bleeding after delivery				
12		Number of early neonatal deaths within 1st week				
13		Number of newborn admission to the ICU				
14		Number of referral cases due to pregnancy complications				
15		Syndromic management of sexually transmitted infections				
COMMENTS/REMARKS: please comment on issues that have been discussed using the number of the question you'd like to comment on e.g.= C11.9 Key informant thinks the low number of bleeding after delivery is due to women having to leave the health facility early after the delivery for security reasons and therefore if they bleed they will not report this to the facility						

C	HEALTH SERVICES Please provide appropriate answer (Yes or No) & provide numbers where applicable	Functioning prior to the conflict 0=No 1 = Yes	Functioning Now 0=No 1 = Yes	Number of cases in July 2014	Number of cases in August 2014

D	HUMAN RESOURCES (please specify the number of the available core staff ON AVERAGE during 24 hours)	
1	Doctors	Before the conflict(#: ____) During the conflict (#:_____)After the conflict (#:_____)
2	Nurse	Before the conflict(#: ____) During the conflict (#:_____)After the conflict (#:_____)
3	Midwife	Before the conflict(#: ____) During the conflict (#:_____)After the conflict (#:_____)
4	Technicians	Before the conflict(#: ____) During the conflict (#:_____)After the conflict (#:_____)
5	Pharmacists	Before the conflict(#: ____) During the conflict (#:_____)After the conflict (#:_____)
7	Others (specify)	Before the conflict(#: ____) During the conflict (#:_____)After the conflict (#:_____)

D COMMENTS/REMARKS: please comment on issues that have been discussed using the number of the question you'd like to comment on	
Further space for comments and remarks please use same numbering as before	

1.2 Joint Cluster Partner Rapid Health Sector Assessment —SHELTER COMPONENT

Name and signature of the team leader of the assessment team: Date:

H	GENERAL INFORMATION				
1	Name & role of the KI				
2	Contact Phone/mail				
3	District				
4	Name of Shelter site				
5	Shelter manager:	UNWRA	Government	other (pls. Specify)	
6	Shelter Population (Number of….)	Female < 5 female < 18 female > 18 female > 60 female total	male < 5 male < 18 male > 18 male > 60 male total		
7	Shelter space in meter square (observation!)				
K	INFRASTRUCTURE				
1	Nr of Toilets already in place				
2	Nr of Toilets currently being constructed				
3	Availability of hand washing facilities	Yes	No		
4	Availability of showers/bathing areas	Yes	No		
5	Availability of soap and water in toilets?	100%	more than 50%	less than 50%	
6	Quantity of water for drinking & washing/person/day	< 3 l/person	> 5 l/person	> 10 l/person	> 15 l/person
	Quality of water	Good for consumption Good for washing but not for consumption	yes yes	no no	
8	Proximity to closest functioning health center	< 10 min. on foot ☐	> 20 min on foot	☐ > 30 min. on foot	
9	Proximity to closest functioning general hospital	< 10 min. on foot ☐	> 20 min on foot	☐ > 30 min. on foot	
L	SERVICES				
1	Health services available on site	Yes	No		
2	If yes please circle appropriate	Health post	mobile clinic	(indicate frequency)	other (please describe)
3	Which of the following services are provided	ANC	MNCH	PNC	EPI general clinical services dressing of injuries
4	Early Warning System in place	Yes	no	please inspect documentation for completeness, request to have the system of reporting explained	
	What are the top 3 morbidities (in order of highest numbers)	1 2 3			
	Are health promotion activities in place, if yes please inquire which topics are being addressed and frequency and type of sessions				
M	HUMAN RESOURCES				
1	Doctor	Yes	No	> than 50% of the time	< than 50% of the time
2	Nurse	Yes	No	> than 50% of the time	< than 50% of the time
3	Midwife	Yes	No	> than 50% of the time	< than 50% of the time
4	Health Promoter	Yes	No	> than 50% of the time	< than 50% of the time
5	Other (describe)	Yes	No	> than 50% of the time	< than 50% of the time

COMMENTS/REMARKS: please comment on issues that have been discussed using the number of the question you'd like to comment on e.g.= C11.9 Key informant thinks the low number of bleeding after delivery is due to women having to leave the health facility early after the delivery for security reasons and therefore if they bleed they will not report this to the facility	

Annex 2: UNFPA Qualitative Data Collection Tools

2.1 Guiding questions for qualitative data collection – English version

2.1.1 Guiding notes for researchers

- Explain briefly the purpose of the meeting.
- Give the full freedom to participants to participate, refrain or stop at any point they feel like it.
- Introduce yourself to the group and show a lot of empathy by greeting them and starting by listing to brief stories they want to tell about themselves.
- Explain that this assessment is meant to be a work to try to explore their suffering and develop interventions matching their needs without raising expectations about immediate magic solutions (you may want to explain the process briefly).
- Make sure you work in a team of two (one asking the questions and the other making notes). It is important to write exactly what people say in their language).
- Probing is very important. Give people space to talk and express themselves.

2.1.2 Women of reproductive age: In Health facility/ shelter - Focus Group discussion/ individual interview

- What are the health problems you face as a result of the attack?
- What you do to overcome/cope with these problems?
- What are your health needs? Mention 3-5 priority needs?
- To what extent are you satisfied with the health services provided to you? Explain
- What services do you feel are needed here?
- Do you think family planning services are needed here? Explain
- Do you think there is violent behavior arising during this period? Explain
- What else would you add?

2.1.3 Pregnant Women: in Health facility/ shelter - Focus Group discussion/ individual interview

- How is your pregnancy going? If problems reported, what?
- Do you feel you got sufficient care for your pregnancy during the last month? Explain
- Were you able to access ANC according to your schedule? Explain
- Where do you plan to give birth, especially for women in 3rd trimester? Explain
- Is there a need for psychosocial support and counseling services? Explain
- Do you think there is violent behavior arising this period? Explain
- What else would you add?

2.1.4 Lactating Women: in Health facility/ shelter - individual interview

- Did you face any problems in breast feeding your baby, particularly during the attack? what?
- Do you use any milk formula for your baby? Why?, from where you get the formula?
- Till what age you intend to continue breast feeding?
- Were you able to access child services according to your schedule? Explain
- Were you able to get child immunization according to schedule? Explain?
- Did your baby face any health problems during the attack? Enlist these problems?
- What else would you add?

2.1.5 Men: In shelter - focus group discussion/ individual interview

- Do you think that the health service provided here are enough for you and your family? Explain?
- What are your family's health needs, especially for women, whether pregnant or not? Explain
- Do you think violence is present? Is this a concern for your family or only for others? Explain
- Do you think the following services are needed?
    a. ANC
    b. Postnatal care
    c. Newborn care
    d. Vaccination
    e. Family planning?
- What are you recommending your family to do to protect their health in these circumstances? Particularly mother and child health?
- What do you do to maintain your family health in such hard circumstances?
- What else would you add?

2.1.6 Health workers at PHC

Observation

- Observe the physical structure and describe any damage and loss of integrity of the center (briefly)
- Assess the damage or loss of functionality of reproductive health equipment?
- Review facility record for utilization of (ANC, family planning, Postnatal care) and register if birth occurred at this facility*

KI interview with PHC managers and FG with senior nurses/midwives

- How was your facility affected by the attack?
- Were you able to continue providing services, which services? And how did you manage?
- Did you have interrupted supplies "drugs and consumables"? Which supplies? And what did you do?
- Did you notice complications related to pregnancy?
- Did you notice increase in complications related to other reproductive health issues? And how did you deal with them?
    - PNC
    - Sexual violence and GBV
    - STI's
    - Unmet need for family planning
- Did you notice increase in-home deliveries? Why? What were women doing if delivery service were needed?
- What else would you add?

2.1.7 Health workers at Maternity

Observation and interview with the head of maternity

- Observe the physical structure and describe any damage and loss of integrity of the maternity (briefly and inform that a detailed assessment of infrastructure will take place)
- Assess the damage or loss of functionality of reproductive health equipment?
- Describe how this maternity was affected by the war in details

- Review facility record for births, complications by type, Caesarean sections, any different trends in utilization or results (for mothers and infants)

KI interview with maternity heads and FG with senior nurses/midwives

- How was your maternity affected by the war?
- Were you able to continue providing services, which services? and how did you manage?
- Did you have interrupted supplies "drugs and consumables"? Which supplies? And what did you do?
- Did you notice increase of pregnancy-associated complications? What?
- Did you notice increase in-home deliveries? Why? What women were doing if delivery service was needed?
- Are women now (during the ceasefire) back to seeking the service as they did before?
- What are your key challenges in providing reproductive health services now?
- What else would you add?

2.1.8 Health workers at NICU

Observation and interview with the head of NICU

- Observe the physical structure and describe any damage and loss of integrity of the maternity (briefly and inform that a detailed assessment of infrastructure will take place)
- Assess the damage or loss of functionality of NICU equipment?
- Describe how this maternity was affected by the war in details
- Review NICU records by type, complications of neonates, early neonate deaths and any different trends in utilization or results

KI interview with heads of NICUs/Focus group discussion

- How was your NICU affected by the war?
- Were you able to continue providing services, which services? And how you managed?
- Did you have interrupted supplies "drugs and consumables"? Which supplies? And what did you do?
- Did you notice increase of neonate's complications? Please explain in details?
    - Low birth weight < 2500 grams
    - Premature neonates
    - Neonate complications
- Were mothers been able to visit their babies and breastfeed them? How you did during the war?
- What are your key challenges in providing NICU services now?
- What else would you add?

2.1.9 Shelters

Observation

- Observe the physical structure and describe any damage and loss of integrity of the place.
- Describe the shelter in general in terms of space, capacity, cleanness etc.
- Request a copy of the shelter records by type, ,i.e. number and nature of registered IDPs, age and genders distribution, special groups, children, women who recently gave birth, and handicapped etc.

Interview with shelters heads

- How is the overall situation in this shelter??
- What kinds of services are offered, whether from shelter sponsoring agency or others?
- Is there a medical unit/clinic in the shelter? For how many days?
- Have you registered, heard of or encountered deliveries at the shelter?
- What are your key challenges in providing services, especially health services in this shelter?
- What else would you add?

2.2 Guiding questions for qualitative data collection – Arabic version

أسئلة إرشادية لجمع المعلومات الكيفية

2.2.1 تعليمات لجامع البيانات:

- يجب مراعاة تنويع الفئة المستهدفة لتشمل: والدات حديثا, فتيات عازبات, متزوجات بأعمار مختلفة
- اشرح بإختصار الغاية من اللقاء
- امنح الحرية الكاملة للمشاركين للمشاركة, الإنسحاب و التوقف فى أى لحظة يشاءون
- قدم نفسك للمجموعة و اظهر تفهمك و تعاطفك معهم عن طريق تحيتهم و البدء بالإستماع بشكل موجز عن قصصهم التى يريدون اخبارها
- اشرح ان دراسة الإحتياجات هذه تهدف لإستكشاف معاناتهم و تطوير تدخلات تناسب احتياجاتهم, مع عدم رفع سقف التوقعات بحلول سحرية و سريعة, ممكن توضيح الهدف من الدراسة و العملية برمتها بشكل موجز.
- تأكد من العمل كفريق من شخصين: الأول لادارة النقاش و التواصل و الثانى لتسجيل الإجابات. من المهم تسجيل ما يقوله الناس حرفيا و بلغتهم
- التدخل للتوضيح مهم و مطلوب, مع اعطاء الناس المساحة للحديث و التعبير عن أنفسهم

2.2.2 النساء فى سن الأنجاب فى "الملجأ أو المرفق الصحى" - نقاش المجموعات البؤرية/المقابلات الفردية

- ماهى المشاكل الصحية التى تواجيهنها نتيجة لهذا العدوان؟
- ماذا تفعلين للتغلب على هذه المشاكل فى ظل هذا العدوان؟
- ماهى احتياجاتك الصحية؟ , اذكرى من 3 – 5 حسب الأولوية
- ما مدى رضاكى عن الخدمات الصحية المقدمة لك؟ الرجاء الشرح و التفصيل؟
- ما هى الخدمات التى تنقصكم فى هذا المكان؟
- هل تعتقدين ان هناك حاجة لخدمات تنظيم الأسرة هنا؟ الرجاء الشرح؟
- هل تعتقدين ان هناك زيادة فى السلوكيات العنيفة فى هذه الفترة ؟ الرجاء الشرح؟
- ماذا تودين الإضافة؟ سؤال مفتوح

2.2.3 النساء الحوامل فى "الملجأ أو المرفق الصحى" - نقاش المجموعات البؤرية/المقابلات الفردية

- كيف حملك؟ لو تم الحديث عن مشاكل.. ما هى؟؟
- هل تلقيت رعاية كافية لحملك خلال الشهر الماضى؟ الرجاء الشرح
- هل استطعت الوصول لخدمات متابعة الحمل فى العيادة حسب مواعيدك؟ الرجاء الشرح
- اين تخططين للولادة "خصوصا للسيدات فى الثلث الأخير من الحمل" ؟ الرجاء الشرح
- هل هناك حاجة للدعم النفسى و خدمات المشورة النفسية؟ الرجاء الشرح
- هل تعتقدين ان هناك زيادة فى السلوكيات العنيفة فى هذه الفترة ؟ الرجاء الشرح
- ماذا تودين الإضافة؟ سؤال مفتوح

2.2.4 النساء المرضعات فى "الملجأ أو المرفق الصحى" - المقابلات الفردية

- هل واجهتى اى مشاكل فى ارضاع طفلك؟ و خصوصا اثناء العدوان؟
- هل تعطين طفلك اى حليب صناعى حاليا؟ و لماذا ؟ و من اين تحصلن عليه؟
- حتى اى سن تنوين الإستمرار فى الرضاعة الطبيعية لطفلك ؟
- هل استطعت الوصول لخدمات متابعة الطفل " الميزان " حسب مواعيدك؟ الرجاء الشرح
- هل تمكنتى من تطعيم طفلك حسب جدول التطعيمات؟ الرجاء الشرح
- هل واجه طفلك اى مشاكل صحية اثناء العدوان؟ اذكرى تلك المشاكل؟
- ماذا تودين الإضافة؟ سؤال مفتوح

2.2.5 الرجال فى الملآجىء - نقاش المجموعات البؤرية

- هل تعتقد ان الخدمات الصحية المتوفرة هنا كافية لعائلتك؟ الرجاء الشرح
- ما هى الأحتياجات الصحية لعائلتك و خصوصا النساء؟ سواء حوامل او غير حوامل
- هل تعتقد ان العنف موجود؟ هل هذه امر يقلقك بالنسبة لعائلتك ام فقط للآخرين؟ الرجاء الشرح
- هل تعتقد ان هناك حاجة للخدمات التالية:
  - خدمات الرعاية ما بعد الولادة
  - خدمات رعاية المواليد
  - خدمات التطعيم
  - خدمات تنظيم الأسرة
- بماذا توصى عائلتك للحفاظ على صحتهم فى هذه الظروف و خصوصا رعاية الأمومة و الطفولة؟
- ماذا تفعل للحفاظ على صحة عائلتك فى هذه الظروف الصعبة؟
- ماذا تود الإضافة؟ سؤال مفتوح

2.2.6 العاملون الصحيون فى الرعاية الأولية

<u>المشاهدات</u>

- لاحظ التركيب البنيوى للعيادة و سجل بإختصار اى ضرر او خلل فى المكان
- قدر الضرر او تعطل عمل الأجهزة و المعدات الخاصة بخدمات الصحة الإنجابية
- اطلب سجلات الخدمات للعيادة (رعاية الحوامل, تنظيم الأسرة, رعاية ما بعد الولادة) و استعلم ان كان هناك ولادة حدثت فى المكان؟

<u>لقاء مدير العيادة / مجموعات بؤرية مع مسئولى التمريض/ القابلات</u>

- كيف تأثرت عيادتكم بالعدوان؟
- هل تمكنتم من الإستمرار فى تقديم الخدمات؟ أى خدمات؟ وكيف تعاملتم؟
- هل كان هناك تقطع فى امداد الأدوية و المهمات؟ أى نوع؟ و ماذا فعلتم ازاء ذلك؟
- هل لاحظتم زيادة فى مضاعفات الحمل؟
- هل لاحظتم زيادة مضاعفات فى مناحى الصحة الإنجابية الأخرى؟ و ماذا فعلتم للتعامل معها؟
  - رعاية ما بعد الولادة
  - العنف الجنسى و العنف القائم على النوع الإجتماعى
  - العدوى المنقولة بالجنس
  - الحاجة الغير ملباة لتنظيم الأسرة
- هل لاحظتم زيادة فى الولادات فى البيوت؟ لماذا؟ ماذا كانت تفعل النساء لو احتاجت خدمة الولادة؟
- ماذا تود الإضافة؟ سؤال مفتوح

2.2.7 العاملون الصحيون فى أقسام الولادة

<u>المشاهدات و المقابلة مع مدير الولادة</u>

- لاحظ التركيب البنيوى للمكان/القسم و سجل بإختصار اى ضرر او خلل فى المكان " بين انه سيكون هناك تقييم مفصل للأضرار من مهندسين"
- قدر الضرر او تعطل عمل الأجهزة و المعدات الخاصة بخدمات الصحة الإنجابية
- اوصف بالتفصيل كيف تأثرت هذه المستشفى/قسم الولادة بالعدوان
- راجع سجلات المستشفى/القسم ل الولادات, المضاعفات و حسب النوع, القيصريات, اى نمط مختلف فى استعمال الخدمات او النتائج (للأم و الطفل)

<u>مجموعات بؤرية مع مسئولى التمريض/ القابلات</u>

- كيف تأثر قسمكم بالعدوان؟

- هل تمكنتم من الإستمرار فى تقديم الخدمات؟ أى خدمات؟ كيف تمكنتم من الإستمرار؟
- هل كان هناك تقطع فى امداد الأدوية و المهمات؟ أى نوع؟ و ماذا فعلتم ازاء ذلك؟
- هل لاحظتم زيادة فى مضاعفات الحمل و الولادة ؟ ماذا؟
- هل لاحظتم زيادة فى الولادات فى البيوت؟ لماذا؟ ماذا كانت تفعل النساء لو احتاجت خدمة الولادة؟
- هل عادت النساء الأن "فى وقت وقف اطلاق النار" لطلب الخدمات كما بالسابق؟
- ماهى التحديات الرئيسة التى تواجهونها فى تقديم خدمات الصحة الإنجابية؟
- ماذا تود الإضافة؟ سؤال مفتوح

2.2.8 العاملون الصحيون فى أقسام الحضانة

المشاهدات و المقابلة مع مدير الحضانة/المركزة

- لاحظ التركيب البنيوى للمكان/القسم و سجل بإختصار اى ضرر او خلل فى المكان " بين انه سيكون هناك تقييم مفصل للأضرار من مهندسين"
- قدر الضرر او تعطل عمل الأجهزة و المعدات الخاصة بخدمات الحضانة المركزة
- اوصف بالتفصيل كيف تأثرت هذه المستشفى/قسم الحضانة المركزة بالعدوان
- راجع سجلات الحضانة المركزة ل مضاعفات الخدج و حسب النوع, وفيات الأسبوع الأول ,أى نمط مختلف فى استعمال الخدمات او النتائج

لقاء مع مدير الحضانة/مجموعات بؤرية مع مسئولى التمريض

- كيف تأثر قسمكم بالعدوان؟
- هل تمكنتم من الإستمرار فى تقديم الخدمات؟ أى خدمات؟ و لماذا؟
- هل كان هناك تقطع فى امداد الأدوية و المهمات؟ أى نوع؟ و ماذا فعلتم ازاء ذلك؟
- هل لاحظتم زيادة فى هذه الحالات؟ وضح بالتفصيل؟
  - النقص الحاد فى وزن المواليد
  - المواليد الخدج
  - مضاعفات الخدج
- هل تمكنت الامهات من زيارة اطفاهن الخدج و ارضاعهم؟ كيف تم التعامل اثناء العدوان؟
- ماهى التحديات الرئيسة التى تواجهونها فى تقديم خدماتكم الصحة فى الحضانات المركزة؟
- ماذا تود الإضافة؟ سؤال مفتوح

2.2.9 مراكز الإيواء/الملاجىء

المشاهدات

- لاحظ التركيب البنيوى للمكان و سجل بإختصار اى ضرر او خلل فى المكان
- صف المكات بشكل عام من حيث السعة, النظافة الخ
- اطلب ما يتوفر من سجلات الملجأ من حيث عدد و طبيع النازحين المجلين و نوعهم: عدد الأطفال , الرجال, النساء و خصوصا الحوامل و الوالدات, ذوو الإحتياجات)

المقابلة مع مدير المركز/الملجأ

- كيف الوضع العام فى هذا المركز؟
- ما هى الخدمات التى يتم تقديمها؟ سواء من الجهة المسئولة او من اى جهات اخرى؟
- هل هناك عيادة او نقطة طبية فى المكان؟ عدد الأيام التى تتوفر فيها العيادة؟
- هل سجلتم او سمعتم عن ولادات فى هذه الملاجىء؟
- ماهى التحديات الرئيسة التى تواجهونها فى تقديم الخدمات و خصوصا الصحية منها؟
- ماذا تود الإضافة؟ سؤال مفتوح

Annex 3: Organization of Field Work and Distribution of Team Members to Assigned Geographic Locations

Team #	Governorate	Team Members	7 FG/W Shelters	Interview With individual women/ shelter	7 FG/M Shelters	6 FG/M HC	7 FG/W HC	Interview with individual women/ facility	Quantitative data collection PHC	Quantitative data collection Hosp.	Quantitative data collection Shelters
Team1	North Gaza	**REEM QATTAWI** MAYSARA KAFARNEH HANAN ZAQOUT WAFA NAJELY SAMA SAHHAR	SHADIA ABUGHAZAL	SHADIA ABUGHAZAL	SHADIA ABUGHAZAL	BIET HANOON & JABALIA	BIET HANOON & JABALIA	AWDA MATERNITY	JABALIA MARTYR PHC	AWDA	SHADIA ABUGHAZAL
								JABALIA MARTYR PHC			
			ABU HUSSAIN SCHOOL	ABU HUSSAIN SCHOOL	ABU HUSSAIN SCHOOL			JABALIA UNRWA	JABALIA UNRWA		ABU HUSSAIN SCHOOL
Team2	Gaza & Middle area	**SABREEN NASHABAT** FATMA DERBALLY SAMAH ZRAIE JEHAD ABU OWAMER AZZA RIZIQ RASHA ALMOGHANY	DARAJ SCHOOL	DARAJ SCHOOL	DARAJ SCHOOL	TAL HAWA	TAL HAWA	SHIFA & HARAZEEN		SHIFA MAT	DARAJ SCHOOL
								NECC	NECC	SHIFA NICU	
			HOLLY FAMILY	HOLLY FAMILY	HOLLY FAMILY	GAZA CITY	GAZA CITY	ZAITON	ZAITON	AL NASR PED. NICU	HOLLY FAMILY
										HARAZEEN	
			DEIR BALAH	DEIR BALAH	DEIR BALAH	DEIR BALAH	DEIR BALAH	DEIR BALAH	DEIR BALAH	AQSA	DEIR BALAH
Team 3	Khanyounis & Rafah	**SANA ABU SAMRA** WAFA KHALEEFAH KAREEMA ALASHQAR	AHMED AZZIZ PREP BOY "A" KH	AHMED AZZIZ PREP BOY "A" KH	AHMED AZZIZ PREP BOY "A" KH	KHANYONIS	KHANYOUNIS	EMARATI MATERNITY		NASER MAT	AHMED AZZIZ PREP BOY "A" KH
								BANDAR	BANDAR		
								ABASSAN/RCS	ABASSAN/RCS	EGH NICU	
		SAMEERA DAWOOD NAILA MASSRI WAFA ABU HASHEESH	RAFAH UNRWA SCHOOL	RAFAH UNRWA SCHOOL	RAFAH UNRWA SCHOOL	RAFAH	RAFAH	TAL SULTAN MOH	TAL SULTAN MOH		RAFAH UNRWA SCHOOL
								TAL SULTAN UNRWA	TAL SULTAN UNRWA	EMARATI	
								ABU TAIMA/PMRS	ABU TAIMA/ PMRS		
Team 4	All Gaza	**DR. SAWSAN HAMAD** MONEER AQEELY ABDALLAH SALEM									

Team 5	ITIMAD	1 FG - 6 MATERNITIES
	DR. YOUNIS	1 FG - 3 NICU
	DR. SAWSAN	KI INTERVIEWS - 6 MATERNITIES
	Dr. Younis	KI Interviews - 3 NICUS

Annex 4: List of Key Informants

FACILITY	PLACE	AREA	NAME	JOB TITLE
MATERNITY	ALAWDA HOSPITAL	NORTH	DR. ABDULSAMAD YOUNIS	HEAD OF OBSTETRICS DEPARTMENT
			DR. JAMIL ABU-FANOUNA	OBSTETRICS & GYNECOLOGY CONSULTANT
			N. MOHAMMED ALSHRAFI	MATRON
			DR. YOUSEF ALSWEITI	MEDICAL DIRECTOR
			ASMAA KUTKUT	HEAD OF POST NATAL DEPARTMENT
	ALSHIFA HOSPITAL	GAZA	DR. HASAN ALLOUH	DIRECTOR OF THE HOSPITAL
			LAILA ALMASHARFA	HEAD OF NURSE DEPARTMENT
	ALHARAZIN HOSPITAL		DR. NAIM AYOUB	DIRECTOR OF THE HOSPITAL
			WARD ABU-GHURAB	HEAD OF NURSE DEPARTMENT
	SHOHADAA ALAQSA HOSPITAL	MIDDLE GAZA	DR. KAMAL KHATTAB	DIRECTOR OF THE HOSPITAL
	ALTAHREER HOSPITAL (NASER)	KHANYOUNIS	DR. MOHAMMED ZAQOUT	DIRECTOR OF THE HOSPITAL
			WAEL ABDULHADI	NURSING DIRECTOR
			NAWAL ALGHALBAN	HEAD OF LABOR DEPARTMENT
			KHAWLA ALMADHON	SUPERVISOR OF LABOR DEPARTMENT
	ALHELAL ALEMARATI HOSPITAL	RAFAH	DR. ABDILRAZEQ ALKURD	ACTING DIRECTOR OF THE HOSPITAL
			GHAZI ASHOR	STAFF NURSE
			ZAINAB SIAM	STAFF NURSE
			RUHAIFA ALFARRA	STAFF NURSE
NICU	ALSHIFA HOSPITAL	GAZA	DR. ALLAM ABUHAMDA	DIRECTOR OF NICU
			ALIAA SHAQOURA	CHIEF NURSE
	ALNASER HOSPITAL		AMER FROUKH	NICU DOCTOR
			SHIREEN ABED	DIRECTOR OF NICU
			JAMILA SLEEM	STAFF NURSE
			MOHAMMED HAMDAN	STAFF NURSE
	GAZA EUROPEAN HOSPITAL	RAFAH	EZZELDAIN OBAID	STAFF NURSE
			DR. AHMED JEBARAH	DIRECTOR OF GAZA EUROPEAN NEONATES UNIT
			DR. MAJED HASSANEEN	HEAD NURSE AT NEONATES UNIT
PHC	JABALIA (UNRWA)	NORTH	DR. KIFAH ALNAJAR	HEAD OF THE CLINIC
			SABAH ALDADAH	STAFF NURSE
			AHLAM SHAQOURA	STAFF NURSE
	SHOHADAA JABALIA (MOH)		AMER ALRAMLAWI	HEAD NURSE
			N. HIND NIJIM	HEAD OF MIDWIVES
	SHOHADAA ALZAITOUN	GAZA	IMAN NATTAT	STAFF NURSE

	(MOH)			
	SHUJAEA (NECC)		DR. WAFAA KANAAN	MEDICAL COORDINATOR
			LUBNA SABBAH	SUPERVISOR OF ALSHUJAEA FAMILY CENTER
	SHOHADAA DERALBALAH (MOH)	MIDDLE GAZA	DR. KHALIL QASMEYA	MEDICAL DIRECTOR
			AZMI ALJAMAL	HEAD NURSE
	SHOHADAA KHANYOUNIS	KHANYOUNIS	NAJWA ABU-MUSTAFA	STAFF NURSE
			DR. HUDA ALASSOULY	FAMILY PLANNING DOCTOR
			KAMAL ALDAHOUDI	NURSING SUPERVISOR
	ABASAN (RC FOR GAZA STRIP)		FAYROUZ ALASSAR	DIRECTOR OF THE CLINIC
			DR. ZOHAIR BARZAQ	ACTING MEDICAL DIRECTOR OF RC FOR GAZA STRIP
			AMNA HAMDAN	HEALTH COUNCELOR
			DR. MARIAM ALFARRA	GENERALIST DOCTOR AND COUNSELOR
	ABUTEAMA (PMRS)		HALEEMA ABU-TEAMA	STAFF NURSE
			DR. DINA ALSHAWA	HEAD OF PMRSCENTRAL PHARMACY
			SAMAHER ABUSHAHLA	PSYCHOLOGICAL SPECIALIST
	TALALSULTAN (MOH)	RAFAH	ABDULAAZIZ ABU-AMRA	HEAD OF NURSE
	TALALSULTAN (UNRWA)		SAMEER ARAFAT	STAFF NURSE
			LAILA ABU-ZOBAYDA	STAFF NURSE
			DR. MAHFOUZ OTHMAN	SENIOR MEDICAL OFFICER
SHELTERS	QELAIPO PREP BOYS	NORTH	MONZER ALNAJJAR	DEPUTY DIRECTOR
	BEIT HANOUN CO-ED		BASEL ALZAANEAN	DIRECTOR
	GAZA PREP GIRLS A	GAZA	SOUZAN ALDABBA	DIRECTOR
	DARAJ ELEM CO-ED		JAMAL MUSALLAM	DIRECTOR
	DAR EL BALAH PREP GIRLS C	MIDDLE GAZA	NOAMAN ABU-SHAMLA	DIRECTOR
	KHAN YOUNIS PREP BOYS C	KHANYOUNIS	RAWYA HILLIS	DIRECTOR
	RAFAH PREP BOYS C	RAFAH	AHMED ABU-ELEASH	DIRECTOR

Annex 5: Photo Gallery

Source: Osama Kahlout and Mohamed Khaledi


AMBULANCE


ROSY