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A Strategic Framework for Rebuilding Gaza's Health System

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Building Forward Better:

A Strategic Framework for Rebuilding Gaza's Health System

Prof. Dorit Nitzan[1*]

A Policy Publication for Mitvim and SID[2]

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2 Writing about the reconstruction of Gaza's health system from within Israeli civil society carries an ethical responsibility. This paper was prepared in that spirit: not as a substitute for Palestinian ownership, decision-making, and leadership over Gaza's future, but as a professional contribution offered in partnership. It draws on public health, humanitarian, and peacebuilding experience, and on dialogue with Palestinian and international colleagues who contributed insights, knowledge, recommendations, and feedback, including those who, for legitimate reasons of safety and context, are not named here. Precisely because Israeli society is part of the regional reality that has contributed to the scale of harm, Israeli public health and peace professionals have a duty to speak, to listen, and to help build conditions for a shared future rooted in dignity, equity, accountability, and mutual security.

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Executive Summary

The near-total collapse of Gaza's health system represents a catastrophic institutional breakdown that simultaneously offers a historic, post-conflict window of opportunity to leapfrog from a fragmented, donor-dependent system toward a resilient, integrated, and equitable future. By early 2026, the human toll surpassed 72,000 fatalities and 171,000 injuries, occurring against a landscape where 84% of health facilities are damaged or destroyed and the remaining 1,400-bed capacity is critically insufficient for a population of 2.2 million. This strategic framework for Mitvim and SID advocates for a radical shift toward a "Building Forward Better" framework that transcends traditional relief to address the deep-seated political, structural, and environmental determinants of health. Findings reveal a precarious health-risk landscape defined by 61 million tons of contaminated debris and the daily discharge of 130,000 cubic meters of raw sewage, which threatens regional desalination plants and has triggered the re-emergence of variant poliovirus type 2 and West Nile Fever.

Strategic success calls for the establishment of a unified stewardship architecture under a semi-autonomous National Health Council, mirroring successful radical reforms in Kosovo that detached policy-setting from direct service implementation to ensure merit-based leadership and professional ethics through independent Medical Chambers.

Service delivery should be rooted in primary health care services where family medicine teams treat 90% of care needs as well as preventive services. It should be supported by the training of non-medical personnel, including teachers and community leaders, as well as for mental health monitoring and the establishment of dedicated community centers for trauma victims.

To bridge the specialized skill gap, it is recommended that the reconstruction will prioritize clinical fellowships for Palestinian

physicians and health workforce in trauma, rehabilitation, mental health, oncology, preventive services, while reintegrating experienced health workers through civil society organizations and vocational partnerships.

Immediate stability requires the capitalization of a Financial Intermediary Fund (FIF) to pool the estimated $7 billion needed for recovery and the facilitation of "white-listed" supply chains to bypass dual-use restrictions on life-saving technologies. Infrastructure must shift from a reliance on the fragile centralized grid toward the deployment of off-grid, solar-powered medical points and mobile desalination units to ensure service continuity in unstable security environments. Beyond the clinical, environmental security is paramount; we recommend the rapid reconstruction of cross-boundary sewage infrastructure to protect regional water sources and the implementation of the six dimensions of food security, prioritizing local "seeds for health" agriculture and empowering local civil society to lead aid coordination.

The need to ensure a high-quality health system in Gaza presents a historic opportunity to create a system that is more equitable, resilient, and sustainably financed than the one that existed before. The evidence from Kosovo, Rwanda, Germany, and Bosnia and Herzegovina provides a clear roadmap: invest in primary health care and public health services, deploy community health workers, establish universal coverage mechanisms, unify governance, and ensure local ownership of the recovery process. The community's needs and voice should be heard and used to steer concrete actions, utilizing "good-neighborhood" modalities that treat health as a common denominator and a bridge for peace.

For Israel, the choice is not ideological but pragmatic. Decades of health cooperation demonstrate that cross-border collaboration in public health is not only possible but essential for regional security. The shared environmental ecosystem, the cross-boundary disease surveillance imperative, and the direct threats to Israeli infrastructure from Gaza's collapsed sanitation system make disengagement a self-defeating strategy.

For the international community, the Gaza Reconstruction and Development Fund provide the necessary financing architecture. What is needed now is political will, sustained commitment, and the application of lessons from evidence-based post-conflict reconstruction efforts over the past eight decades. Building forward better is not merely a slogan; it is a strategic imperative for the health, security, and dignity of every person, Palestinian and Israeli, as well as others who share this small, interconnected region.

1. Introduction and Context

The destruction of Gaza's health system since October 2023 calls for urgent action that would lead to a sustainable, people-centered health system with universal coverage. As of early 2026, 94% of all hospitals have been damaged or destroyed, over 1,722 healthcare workers have been killed, and the World Health Organization (WHO) has recorded 697 attacks on healthcare facilities.[3] The overall reconstruction costs are estimated at $53 billion, according to the Gaza and West Bank Interim Rapid Damage and Needs Assessment (IRDNA).[4] Yet history demonstrates that post-conflict recovery can serve as a "window of opportunity" to leapfrog from fragmented, under-resourced systems to resilient, equitable models. Kosovo's family medicine revolution, Rwanda's community health insurance achieving 97.3% coverage, and Germany's Marshall Plan-driven economic miracle each offer actionable lessons.

This framework, commissioned jointly by the Mitvim Institute and SID-Israel, deploys the WHO Building Blocks model and the Humanitarian–Development–Peace (HDP) Nexus to chart a phased roadmap for Gaza's health recovery. It explicitly addresses the Israeli role, both historical contributions and future obligations, as integral to regional health security. The shared environmental ecosystem, cross-border epidemiological threats, and decades of institutionalized cooperation make disengagement impossible and collaboration imperative.

3 World Health Organization (WHO), "Health system at breaking point as hostilities further intensify, WHO warns," 22 May 2025;

4 World Bank, European Union and United Nations, Gaza and West Bank Interim Rapid Damage and Needs Assessment, February 2025.

1.1 The Magnitude of the Crisis

The scale of destruction in Gaza is unprecedented in the modern history of conflict and health. As of mid-2025, only 19 of 36 hospitals remained operational, with 12 providing a variety of services and the remainder limited to basic emergency care. WHO documented 697 attacks on healthcare facilities since October 2023. Over 1,722 healthcare workers had been killed by September 2025, representing a devastating loss of human capital that took decades to build. Physical damage to the health sector alone exceeds $554 million, while total reconstruction needs across all sectors are estimated at $53–70 billion.[5]

Gaza: Demographic and Socioeconomic Context

Gaza's pre-war population of approximately 2.2 million was among the youngest and most densely settled globally. The blockades that took place since 2007 have constrained economic activity, with GDP per capita in Gaza declining to $1,508 by 2022, 36 times lower than Israel's $54,931. The conflict since October 2023 has erased decades of development: the World Bank reports an 83% contraction in GDP and poverty rates approaching 100%.[6]

Burden of Disease and Priority Health Needs

The collapse of water and sewage infrastructure has led to a 20-fold increase in diarrheal disease and the re-emergence of the circulating vaccine-derived poliovirus type 2.[7] Women in Gaza are three times more likely to die in childbirth and three times more likely to miscarry

5 WHO, "Health system at breaking point as hostilities further intensify, WHO warns," 22 May 2025; OCHA oPt, "Reported impact snapshot: Gaza Strip," 17 September 2025;

6 World Bank, "New Report Assesses Damages, Losses and Needs in Gaza and the West Bank," 18 February 2025; World Bank, European Union and United Nations, Gaza and West Bank Interim Rapid Damage and Needs Assessment, February 2025.

7 Grotto, I., Agha, H., Abu Al-Halaweh, A., Davidovitch, N., McKee, M., & Nitzan, D. (2025). "Public health, war and cross-border challenges: The recent cVDPV2 polio outbreak in Gaza." EClinicalMedicine, 81, 103136. https://doi.org/10.1016/j.eclinm.2025.103136

compared to pre-war levels.[8] Over 320,000 children under five face the risk of acute malnutrition.[9] Non-communicable disease management has collapsed due to the loss of primary care facilities, medicines, laboratory services, and imaging capacity.[10] Mental health needs are catastrophic, over one million children require psychosocial support.[11]

8 Palestinian Central Bureau of Statistics, "World Health Day, April 7th, 2026," 7 April 2026; https://www.pcbs.gov.ps/media/2zslosog/worldhealthday2026e.pdf

9 UNICEF State of Palestine, "Gaza's Malnourished Children Can't Afford to Wait," 28 July 2025; Integrated Food Security Phase Classification (IPC), Acute Malnutrition Situation for April 2025–March 2026: Gaza Strip.

10 Aldabbour, B., Barakat, Y., Elamassie, S. et al. War and chronic illness: a health center-based study of Palestinians with non-communicable diseases in Gaza. Confl Health 19, 36 (2025). https://doi.org/10.1186/s13031-025-00679-9

11 UNICEF, State of Palestine Humanitarian Situation Report No. 45, 30 November 2025; UNICEF, State of Palestine Appeal, 2026. https://www.unicef.org/media/177756/file/SOP-Humanitarian-SitRep-30-November-2025.pdf

Strategic Gaps

Domain	Pre-War Status	Current Status (2026)	Gap
Hospitals	36 operational	10–19 partially functional	47–72% loss
Hospital Beds	About 3,500	About 1,400	60% deficit
Healthcare Workers	About 10,000+	1,722 killed; mass displacement	Critical shortage
Water/ Sanitation	Degraded but functional	Near-total collapse	20 times increase in diarrheal disease
GDP	About $6.2B (West Bank + Gaza)	83% contraction	Near-total collapse
Poverty Rate	About 53%	Close to 100%	Total dependence on aid

1.2 Rationale and Scope

This publication responds to the urgent need for an evidence-based, forward-looking strategic framework for rebuilding Gaza's health system. It is premised on the concept of "Building Forward Better", not merely restoring what existed, but creating a health system that is more equitable, resilient, and sustainably financed than the pre-war status quo. The framework is anchored in three interconnected paradigms: (a) the WHO Health System Function Building Blocks, (b) the HDP Nexus or "Triple Nexus", and (c) the Health-for-Peace approach, which positions health cooperation as a bridge to broader political reconciliation.[12]

The HDP Nexus recognizes that humanitarian relief, long-term development, and peacebuilding cannot operate in isolation. In protracted crises like Gaza, short-term emergency responses must be designed to feed into medium-term recovery and long-term system strengthening. WHO's strategic positioning within this nexus emphasizes that expanding universal health coverage (development), responding to emergencies (humanitarian), and building social cohesion (peace) must occur simultaneously.[13]

12 World Health Organization, Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action, Geneva, 2007. https://iris.who.int/server/api/core/bitstreams/809f813f-5b90-4187-861b-3953bb54e244/content; WHO Regional Office for the Eastern Mediterranean, "Humanitarian-development-peace nexus"; World Health Organization, Bridging the Divide: A Guide to Implementing the Humanitarian-Development-Peace Nexus for Health, Cairo, 2021. https://applications.emro.who.int/docs/9789290227502-eng.pdf?_gl=1*18lsnzq*_ga*OTAwMjI5OTQzL-jE3NzM4Njg5OTg.*_ga_610FGB0GNK*czE3ODE0NDk4NTAkbzEkZzAkdDE3ODE0ND-k4NTAkajYwJGwwJGgw; World Health Organization, "The Health and Peace Approach to programming," Global Health and Peace Initiative; WHO Executive Board, Global Health for Peace Initiative, EB150/20, 2 December 2021.

13 WHO Regional Office for the Eastern Mediterranean, "Humanitarian-development-peace nexus"; World Health Organization, Bridging the Divide: A Guide to Implementing the Humanitarian-Development-Peace Nexus for Health, Cairo, 2021. https://www.who.int/initiatives/who-health-and-peace-initiative/an-innovative-approach---the-health-for-peace-approach-to-programming

1.3 Methods and Sources

This framework synthesizes evidence from multiple authoritative sources: the World Bank's Interim Rapid Damage and Needs Assessment (IRDNA),[14] WHO operational reports and health system frameworks,[15] peer-reviewed case studies from post-conflict Kosovo,[16] Bosnia and Herzegovina,[17] and Rwanda,[18] as well as the Palestine Emerging Blueprint and Mitvim institutional publications.[19] Primary and gray literature were reviewed.

14 World Bank, European Union and United Nations, Gaza and West Bank Interim Rapid Damage and Needs Assessment, February 2025. https://palestine.un.org/en/download/178604/289429

15 WHO, Everybody's Business: Strengthening Health Systems to Improve Health Outcomes, 2007.

16 Buwa, D., & Vuori, H. (2007). Rebuilding a health care system: war, reconstruction and health care reforms in Kosovo. European journal of public health, 17(2), 226–230. https://doi.org/10.1093/eurpub/ckl114
Percival, V., Sondorp, E., & Maclean, A. (2010). "A case study of health sector reform in Kosovo." Conflict and Health, 4, 7.

17 The Portland Trust, Economics in Peacemaking: Lessons from Bosnia and Herzegovina, London, 2009.

18 Hezagira, E. et al. (2025). "Three decades of community health workers in primary health care in Rwanda"; Rwanda Social Security Board, "Community Based Health Insurance (Mutuelle de Santé)."

19 Palestine Emerging, Economic Reconstruction & Development Blueprint, April 2024; Mitvim Institute, Recommendations for Essential Infrastructure and Healthcare in the Gaza Strip, Tel Aviv, 2024.

1.4 Paper outline

The paper opens by presenting relevant lessons from historical cases of post-conflict health system reconstruction, focusing on examples from Kosovo, Rwanda, the Marshall Plan, and Bosnia and Herzegovina. It then translates the insights from these cases into guiding principles and concrete steps to be adopted and advanced in the context of Gaza's reconstruction. Particular attention is given to the areas of governance, financing, professional workforce, physical infrastructure, information systems, service delivery, the health–environment nexus, food and nutrition, accessibility and equity, and more.

The paper further discusses Israel's roles and the need to examine the reconstruction of Gaza's health system as an integral part of a single, unified health system encompassing Israel, Gaza, and the West Bank, and accordingly, the necessity of promoting cooperation. Finally, the paper emphasizes the need to adopt a gradual, three-phase process to implement the World Health Organization's building blocks in Gaza, as well as the urgency of taking action already at this stage.

The paper has two important annexes. The first one introduces operative proposals for improving immediate medical care for Gaza Strip residents, and the second one introduces short-term interventions aimed at improving the humanitarian response in the Gaza.

2. Historical Success Stories in Post-War Health Reconstruction

2.1 Kosovo (1999): PHC as the Fulcrum for Change

Kosovo's post-war health reform is widely regarded as the most instructive case for Gaza. After the 1999 conflict, over 90% of parallel health clinics were destroyed, and public facilities had been looted. Rather than simply restoring the pre-war specialist-dominated model, Kosovo's Department of Health chose comprehensive reform.

Key reforms included:

- Adoption of Primary Health Care (PHC) as the cornerstone of the system, with family medicine teams treating 80–90% of presenting problems and acting as gatekeepers to tertiary care, the so-called "Blue Book" model.
- Launch of a postgraduate Family Medicine specialization through which 400 Kosovar doctors graduated, affiliated with the Royal College of General Practitioners (UK).
- A 2-year Master's program in Health Care Management to train a cadre of reform-oriented leaders for decentralized health management.
- Detachment of the Ministry from direct program implementation, allowing it to focus on policy-setting, quality assurance, and human resource planning.

Between 1999 and 2002, donors spent approximately €80 million on Kosovo's health sector, the second-largest portion of the consolidated budget after education. The favorable implementation environment, high donor engagement, a supportive population, and concentrated human capital in a small geographic area offer both encouragement and caution, given Gaza's far more constrained conditions.

2.2 Rwanda (1994): From Ruins to Universal Coverage

Rwanda's post-genocide health transformation stands as perhaps the most dramatic success story in modern public health. In 1994, the health system was devastated: hospitals were destroyed, fewer than 100 doctors remained in the country, and essential supplies were depleted.

Rwanda's strategic pillars:

- **Community Health Workers (CHWs):** Introduced in 1995, CHWs became the backbone of primary care delivery, providing antimalarials, tuberculosis treatment, malnutrition screening, contraceptives, and maternal care at the community level.
- **Mutuelle de Santé (Community-Based Health Insurance):** Piloted in 1999, scaled nationally from 2004, and made mandatory by law. By 2024, 97.3% of the population was covered. Premiums were set at approximately US$2 per family member per year, with state subsidies for the poorest.
- **Constitutional Right to Health:** The 2003 Constitution formalized the inalienable right to health, signaling long-term political commitment.
- **Performance-Based Financing:** Health facilities received supplementary funding linked to measurable outputs, driving quality improvement.

Rwanda grew from fewer than 100 doctors post-genocide to over 2,000, and now operates 2,067 public and private health facilities, including eight national referral hospitals. The Lancet credited Rwanda's success to government leadership, a national development plan that champions health equity, community-based insurance, CHW training, and successful collaboration with international development partners.

2.3 Germany and Japan (1945): The Marshall Plan Model

Post-World War II reconstruction in Germany and Japan set the standard for post-conflict recovery. The Marshall Plan (1948–1952) disbursed approximately $13.3 billion (equivalent to over $150 billion today), prioritizing food security, disease prevention, and the restoration of economic infrastructure.

Key parallels to Gaza include:

- **Immediate priorities:** Half of all first-year Marshall aid was devoted to food, with systematic efforts to prevent epidemics of tuberculosis and other diseases.
- **Local ownership:** Participating nations were required to assist in developing recovery plans, ensuring «a cure rather than a mere palliative» for economic distress.
- Aggregate production capacity in Germany at end of 1947 stood at just 33% of pre-war levels (comparable to Gaza›s 83% GDP contraction), yet recovery generated the «economic miracle» of the 1950s–1960s.

2.4 Bosnia and Herzegovina (1995): Cautionary Lessons

Bosnia and Herzegovina offers critical lessons in failure. The Dayton Peace Accords ended the conflict but created a fragmented state with two entities, a tripartite presidency, and multiple layers of administration. This structure proved catastrophic for economic recovery and governance:

- **$5.1 billion** was pledged at the first donor conference; 82% went to infrastructure reconstruction and only 18% to business development.
- Thirteen years later, GDP remained 20% below pre-war levels, unemployment hovered at 40%, and social trust was virtually non-existent (7.2% lowest among comparator nations).

- Ethnic fragmentation entrenched corruption, prevented labor mobility, and created a dysfunctional economy where "everyone openly speaks about the possibility of a new war".
- The promotion of free market reforms in a weak state, with little local input, aggravated rather than ameliorated ethnic tensions.

The overarching lesson: The structure of the political settlement controls the nature of the post-conflict economy. For Gaza, this means avoiding fragmented governance arrangements and ensuring health system leadership is unified, technically competent, and Palestinian-led.

Case Study	Key Success Factor	Key Lesson for Gaza
Kosovo (1999)	PHC-centered reform; family medicine	Shift from hospital-centric to PHC-oriented model
Rwanda (1994)	CHWs + Mutuelles; right to health	Community insurance + workforce for universal coverage
Germany (1945)	Marshall Plan; local ownership	Large-scale financing with local planning authority
Bosnia and Herzegovina (1995)	Fragmented governance	Avoid political fragmentation in health governance

3. Employing the Lessons

from historical success stories for Building Gaza's Health System Forward and Better: Leading Efforts, Guiding Principles and Concrete Steps

Governance, Leadership, and Stewardship

The Fragmentation Challenge

Gaza's health governance has historically suffered from fragmentation between the Ministry of Health (MoH) in Ramallah, local administration in Gaza, UNRWA, and international NGOs. The most successful post-conflict reforms, notably in Kosovo, involved detaching the Ministry from direct program implementation, allowing it to focus on policy-setting, human resource planning, and quality assurance. In contrast, Bosnia's multi-layered, ethnically divided authority structure led to uncoordinated aid and systemic inefficiencies that persisted for over a decade.

Strategic Recommendations

- **Unified Health Authority:** Establish a single, technically empowered health authority for Gaza aligned with the Palestinian Ministry of Health in Ramallah, with operational autonomy for day-to-day management and regulatory oversight. The alternative is to set an administration that would operate in cooperation with the international Board of Peace (BoP) and the Palestinian Authority. This organization should place all active healthcare workers in Gaza under an autonomous, transitional, and professionally led administrative vehicle: the Gaza Health Board (GHB).

- **Legal and Regulatory Alignment:** Draft a unified Palestinian regulatory framework aligned with the International Health Regulations (IHR) and international humanitarian law (IHL), drawing on Israeli health policy expertise for technical consulting.
- **Coordination Architecture:** Formalize coordination across humanitarian, development, and peace actors through a dedicated recovery coordination mechanism within the MoH, following WHO guidelines for health system recovery.
- **Accountability Mechanisms:** Implement community engagement and social accountability platforms modeled on the Palestine Emerging framework›s Citizen Assembly Platforms and Women›s Clubs.[20]

Regional Security-Health Committees

Establish joint committees as formal liaison bodies to ensure medical facilities maintain “protected spaces” status. These committees are essential to operationalize the International Humanitarian Law (IHL), a set of global rules that grants healthcare facilities and personnel “protected status” to ensure they remain neutral safe zones during hostilities. Furthermore, they facilitate adherence to the International Health Regulations (IHR), the legally binding framework that mandates how states coordinate cross-border responses, share data, and manage health threats to prevent local crises from becoming regional or global public health events.[21]

20 Palestine Emerging (April 2024). PALESTINE EMERGING is an initiative of the Palestinian Reconstruction and Economic Partnership (PREP). https://palestine-emerging.org/2024/04/08/1-prologue/

21 World Health Organization, International Health Regulations (2005), 4th ed., 2024. https://www.who.int/health-topics/international-health-regulations/#tab=tab_1

Health System Financing and Financial Protection

Pre-War Financing Structure

Gaza's pre-war health financing was structurally fragile and regressive, with low-income groups bearing a disproportionate burden through out-of-pocket (OOP) payments for chronic medications and tertiary care. While the suspension of clearance revenue transfers has created a critical liquidity crisis, the system's financial instability is rooted in deep-seated structural challenges that predate the current conflict. These include a catastrophic decline in international aid, which dropped from $2 billion in 2008 to $358 million in 2025, and an overreliance on a poorly managed medical referral system that consumes one-third of the health budget. The high unit costs of external care, coupled with a lack of internal capacity and the absence of a unified social health insurance model, have created a chronic fiscal drain that requires radical reform beyond the restoration of previous funding levels.

Reconstruction Financing

The World Bank's IRDNA estimates total reconstruction needs at $53–70 billion, with $20 billion required in the first three years. Health-sector-specific reconstruction needs are estimated at $1.2 billion for medium- to long-term facility rebuilding and digital infrastructure. The Gaza Reconstruction and Development Fund, established as a Financial Intermediary Fund (FIF), was announced operationally in February 2026 with $5 billion in initial pledges. The World Bank serves as a limited trustee, managing inflows and outflows under the direction of the Board of Peace, with strict financial transparency and oversight standards.[22]

22 World Bank, "Financial Intermediary Fund for Gaza Reconstruction and Development," 25 November 2025; https://www.worldbank.org/en/country/westbankandgaza/brief/financial-intermediary-fund-for-gaza-reconstruction-and-development

Transition to Sustainable Financing[23]

Drawing on Rwanda's successful Mutuelle de Santé model, Gaza should progressively transition from humanitarian financing to sustainable health coverage through:

- **Social Health Insurance (SHI):** Develop a contribution-based SHI model where payments reflect ability to pay, with state subsidies covering the most vulnerable, mirroring Rwanda's approach that achieved 97.3% coverage.
- **Performance-Based Financing:** Link facility funding to measurable health outputs, as successfully implemented in Rwanda and recommended by WHO.
- **Donor Coordination:** Pool donor resources through the FIF mechanism to avoid the fragmented, uncoordinated aid flows that undermined Bosnia›s recovery.

Health Workforce: Resilience and Retention

The Human Capital Crisis

Gaza's healthcare workers are operating under extreme conditions and face mass "burnout." Research indicates that 56% have lost a coworker, and 37% report high secondary traumatic stress. The killing of 1,722 health workers represents an incalculable loss which is equivalent to decades of training, mentorship, and institutional knowledge. Moreover, some report on "moral injury" among Gaza's healthcare workers. It arises from the systemic impossibility of fulfilling their professional oaths under extreme resource scarcity. Clinicians are forced into "crisis standards of care," where they must perform procedures like amputations without anesthesia. Such acts directly transgress their core ethical codes and induce a profound sense of professional failure.

23 Ghanem, H., & Maghen, L. (2026). Financing Sustainable Reconstruction of Gaza. Mitvim / Policy Center for the New South, April 2026. English-Financing-Reconstruction-in-Gaza-Liel-Maghen-and-Hafez-Ghanem-April-2026-final_Designed.pdf

Comparative Lessons

Kosovo addressed its acute physician shortage through "re-professionalization", utilizing a 2-year master's program in Health Care Management to train change agents for decentralized leadership. Rwanda deployed Community Health Workers at scale beginning in 1995, creating a cadre that expanded primary care to every community.

Strategic Recommendations

- **Human-Centered Recovery:** Transitioning to the Gaza Health Board (GHB) Framework. Prioritize the immediate, regularized payment of standardized salaries to healthcare personnel as the baseline for civil stabilization and the prevention of professional "brain drain". Crucially, this financial stabilization provides the necessary pathway to move forward from humanitarian-rooted medical aid to a sustainable, well-governed, and managed health workforce
- **Clinical Fellowships:** Medical institutions, in Israel and beyond, should offer advanced surgical, oncological, rehabilitation, and critical care fellowships for Gazan clinicians to address the specialized skill gap.
- **Vocational Training:** Partner with Israeli and international medical and public health schools for advanced fellowships in preventive services, trauma surgery, rehabilitation, oncology, mental health, and more. These programs allow Gazan specialists to gain high-level skills in complex care that were degraded during the conflict.
- **Professional Self-Governance:** Medical associations from different countries, including the Israeli Medical Association, can support the establishment of an independent Palestinian Medical Chamber for professional licensing and ethics.
- **Task-Sharing and CHWs:** Train non-medical community leaders and teachers to provide basic mental health, and nutritional screenings. This allows the community to support health needs at the neighborhood level when specialized doctors are in short supply.

- **Mental Health Support for Workers:** Institutionalize psychological support services for healthcare workers, including peer support programs, structured debriefing, and access to specialized mental health professionals.
- **Innovation Diffusion and International Surge Capacity (RAND Model):** Accelerate the spread of life-saving medical practices using RAND strategies, such as creating real-time digital dashboards to track disease outbreaks and forming "guidance teams" that distill complex research into simple instructions for health workers. In the immediate recovery phase, international volunteers and Emergency Medical Teams (EMTs) will be vital to provide "surge capacity", filling the gap left by the 1,722 health workers lost, before gradually phasing out as local staff are reintegrated. This involvement will transition into long-term "training-the-trainers" programs, where foreign experts mentor local clinicians to achieve full medical self-sufficiency.[24]

Physical Infrastructure and Essential Medical Products

The Infrastructure Deficit

The systematic damage to 84% of health infrastructure amounts to $554 million in health-sector losses alone. Of 36 hospitals, only 10–19 remain partially operational, providing approximately 1,400 beds, a critical deficit for 2.2 million people. Essential items, including incubators, ultrasounds, and prosthetics, have been restricted as "dual-use" despite 24,000 people requiring major life-changing injury care.

To move forward from emergency, humanitarian-rooted medical aid toward a sustainable and well-governed healthcare system, physical reconstruction must target localized, semi-permanent community clinics rather than relying on temporary or mobile health services. Given

24 O'Hanlon, C. E., Berdahl, C. T., Sousa, J. L., et al. (2026). Improving Diffusion of Clinical Care Innovations in Public Health Emergencies. RAND Corporation, RR-A4441-1; https://www.rand.org/pubs/research_reports/RRA4441-6.html

the severe spatial constraints and resource limitations on the ground, the reconstruction plan should prioritize the development of multi-use community spaces.

These adaptive facilities can serve as primary school classrooms in the morning and transition into fully operational community health clinics in the afternoon-evenings, maximizing utility and restoring civilian routines. To ease and accelerate the physical recovery, the administration can employ also modular construction methods. This approach bypasses Israeli concrete import restrictions while establishing rapid, resilient health infrastructure. Critically, these multi-use centers must be prioritized for immediate connection to localized electricity networks (utilizing micro-solar arrays) and clean, restored water infrastructure to ensure basic clinical sanitation and operational continuity.

To prevent this infrastructure rollout from stalling or falling into administrative chaos, it is suggested that this spatial strategy will be coordinated on the ground by the National Committee for the Administration of Gaza (NCAG) providing the newly formed technocratic committee with operational "hands and feet" in the health sector. Working through its dedicated technical agency, the Gaza Health Board (GHB), the NCAG can act as the single planning and coordinating authority. It is recommended that the GHB will 1. Conduct localized spatial needs assessments in coordination with the UN and World Bank; 2. Allocate capital directly from the World Bank-hosted Gaza Reconstruction and Development Fund; 3. Enforce compliance with unified Palestinian clinical and construction standards; and 4. Directly recruit, and deploy the medical and administrative staff needed also to run these community centers.

Strategic Recommendations

- **Off-Grid Innovation:** Deploy Israeli-developed solar-powered mobile clinics and micro-desalination plants providing «plug-and-play» healthcare independent of centralized grid infrastructure.
- **White-Listed Supply Chains:** Israeli NGOs should coordinate with the Ministry of Defense to create designated supply chains for temperature-controlled drugs and diagnostic hardware.
- **Climate-Resilient Design:** All rebuilt health facilities should incorporate solar power, rainwater harvesting, and disaster-resistant construction standards, following the Palestine Emerging blueprint›s emphasis on sustainable networks.
- **Debris Management:** The 60 million tons of debris, 15% contaminated with asbestos and heavy metals, must be systematically decontaminated before reconstruction begins, following UNEP environmental assessment recommendations. Crucially, this process must prioritize a comprehensive safety protocol for the detection and disposal of unexploded ordnance (UXO) and explosive remnants of war (ERW), which saturate the rubble and pose a lethal risk to workers and returning civilians. Clearing these remnants is a mandatory first step, as buried explosives can be triggered during decontamination, leading to catastrophic loss of life and further damage to local environments[25].

25 For a more detailed discussion of construction waste management, see: Adi Magar (2026), *Resource Management and Waste Treatment in the Gaza Strip: An Innovative Model for Environmental and Diplomatic Recovery.* Mitvim Institute and Brody Institute.

Health Information Systems and Digital Transformation

The Data Crisis

The destruction of Gaza's health information has crippled decision-making and epidemiological tracking. Without functional surveillance, outbreak detection, disease monitoring, and evidence-based resource allocation are severely compromised.

Strategic Recommendations

- **Digital Health Tools:** Deploy telemedicine, remote decision support, and mobile health applications to extend specialist reach beyond physical facility constraints. This calls for **Cloud-Based Architecture:** Rebuild Gaza's health information system, including a novel approach through the "Health in My Hand" (HIMA) initiative (e.g., people-centered, people-owned health records that can be shared with health providers). This requires decentralized cloud architecture and mobile applications to ensure data survival in the event of physical facility damage.
- **Epidemic Intelligence:** Integrate WHO›s «Epidemic Intelligence from Open Sources» (EIOS) platform for real-time detection of cross-boundary threats, including West Nile Fever, Polio, and emerging pathogens.
- **Interoperability Standards:** Adopt the Health Level Seven Fast Healthcare Interoperability Resources (HL7 FHIR) standard to ensure Gaza's digital records are compatible with regional and global systems, building on the MECIDS framework. HL7 FHIR is an international "common language" framework for medical computers that uses modern web technologies to allow different health applications to exchange data seamlessly, regardless of which software they use. By using this standard, Gaza can ensure that a patient's medical history can be transmitted instantly and accurately to hospitals in Israel, Jordan, or the West Bank during referrals, and

that disease outbreak data can be shared automatically with the WHO to prevent regional pandemics.

Service Delivery: The Primary Health Care Fulcrum

The Kosovo Model for Gaza

The evidence from post-conflict Kosovo is unequivocal: rebuilding must prioritize the transition from a hospital-centric model to a primary health care (PHC)-oriented system to ensure cost-efficiency, equity, and population coverage. Kosovo's "Blue Book" reform established family medicine teams that treat 80–90% of presenting problems and serve as gatekeepers to secondary and tertiary care.

Comprehensive Service Delivery Framework

- **PHC:** Re-establish PHC clinics as the foundation of the continuum of care, integrating maternal and child health, chronic disease management, immunization, and mental health/psychosocial support (MHPSS) into every consultation.
- **Referral Systems:** Develop structured patient pathways and referral protocols connecting PHC to hospital services, with particular attention to emergency medical systems (ambulances, MEDEVAC, Emergency Medical Teams).
- **Mental Health Integration:** Over one million children in Gaza require mental health support. MHPSS must be integrated into PHC as a core component, not siloed as a specialty.
- **Palliative and Long-Term Care:** The large population with conflict-related injuries and disabilities requires expanded rehabilitation and palliative care services.

One Health and Environmental Peacebuilding

Cross-Boundary Environmental Risks

The accumulation of 60 million tons of debris, 15% contaminated with asbestos and heavy metals,[26] creates a generational environmental and health crisis. The daily discharge of 130,000 cubic meters of raw sewage into the Mediterranean poses direct risks to Israeli desalination plants, fisheries, and coastal communities. EcoPeace Middle East's 2019 Health Risk Assessment documented that defects in Gaza's sewage treatment had already interfered with the Ashkelon desalination plant and contaminated Israeli groundwater reserves.[27]

Shared Risks, Shared Solutions

Environmental degradation in Gaza constitutes a direct security threat to Israel. Israeli institutions have repeatedly acknowledged that public health collapse in Gaza cannot be contained and poses severe risks to Israeli civilian areas. This dynamic creates a pragmatic basis for cooperation even in the absence of political resolution.

Strategic Recommendations

- **Joint Environmental and Climate Resilience Commission:** Build on existing or establish a bilateral Israeli Palestinian environmental monitoring and response systems to manage shared physical and biological threats. This commission will track hazards like microbial antibiotic-resistance, vector-borne diseases, and more, while coordinating on transboundary flood prevention and stormwater management. This involves a shared group of experts from both

26 United Nations Environment Program (UNEP), "Environmental damage in Gaza Strip harming human health, threatening long-term food and water security," 23 September 2025. Environmental damage in Gaza Strip harming human health, threatening long-term food and water security - new UNEP report

27 Hermesh, B., Maya, M., & Davidovitch, N. (2019). Health Risk Assessment for the Israeli Population Following the Sanitary Crisis in Gaza. EcoPeace Middle East. https://ecopeaceme.org/wp-content/uploads/2024/04/Gaza-Health-Report-Eng.-Mar.-2019.pdf

sides who watch out for environmental hazards that do not stop at the borders. They should also work together to prevent winter floods by ensuring storm drains and drainage infrastructure on both sides are synchronized. This prevents the rain from washing trash and sewage into the groundwater and the Mediterranean Sea, used by both populations, protecting regional water security and human health.

- **Cross-Boundary WASH Rehabilitation:** Prioritize repair of shared water infrastructure, with EcoPeace facilitating collaboration on cross-boundary pipeline repair and sewage treatment.
- **One Health Governance:** Institutionalize bilateral Israeli-Palestinian cross-sectoral collaboration between human, animal, plant and environmental health. This "One Health" paradigm is the scientific recognition that human health is linked to the health of animals and our shared environment. In an interlinked ecosystem where pathogens, pollutants and people do not respect borders, a hazard in one Israel or one of its neighbors, will be shared by all in the region. By integrating this approach into recovery planning, regional experts can coordinate on joint zoonotic disease and other hazards' surveillance and shared environmental sanitary codes, reviving the historic success of regional prevention programs like the 1970s Rift Valley Fever mass animal immunizations.
- **Food and Nutrition Security:** Following the framework proposed by Berry et al., food security planning for Gaza requires action along six dimensions:[28]

28 Berry, E. M., Nitzan, D., & Kussmann, M. (2025). "Providing food security in Gaza for the 'day after'." Israel Journal of Health Policy Research, 14, 34. https://doi.org/10.1186/s13584-025-00700-9

Dimension	Strategic Priority
Availability	Restore multiple entry routes (land, air, sea); promote local "seeds for health" agriculture
Accessibility	Re-establish market functionality; social safety nets for 132,000 children at malnutrition risk
Utilization	Ensure safe water (WASH); nutritional prescriptions for patients with diabetes, celiac disease
Stability	Develop community-based coping strategies for short-term shocks
Sustainability	Recycle debris for reconstruction materials; rebuild local food industries
Agency	Empower Palestinian civil society and NGOs to lead food aid coordination

Universal Health Coverage, Equity, and Access

UHC in a Protracted Crisis

Achieving Universal Health Coverage (UHC) in Gaza requires simultaneous progress on three dimensions: service coverage, financial coverage, and quality. Pre-war barriers, including movement restrictions, referral limitations, gender-based access gaps, and high Out-of-pocket (OOP) payments, were severe. The current situation has made these barriers exponentially worse. UHC in Gaza means a protected entitlement to an agreed package of essential services, with no household pushed into poverty because of illness.

A pragmatic proposal would be to establish a Gaza Health Protection Scheme: a publicly governed, Palestinian-led health coverage mechanism that progressively enrolls every resident of Gaza into a

basic health insurance package. In the first emergency phase, services should remain free at the point of care for lifesaving, maternal, child, vaccination, trauma, rehabilitation, infectious disease, mental health and chronic disease prevention and care, and palliative services. It is recommended to build them outside of an open-ended, unstable and unsustainable humanitarian model. From the outset, every resident should be registered, linked to a primary care team, and covered by a defined benefits package.

One of the finance options is to have a dedicated Health Coverage Window within the Gaza Reconstruction and Development Fund/ Financial Intermediary Fund, complemented over time by Palestinian public financing, donor contributions, and income-adjusted symbolic household or payroll contributions once livelihoods begin to recover. The poorest households, children, pregnant women, persons with disabilities, and older people, should be fully subsidized. Contributions should never be a barrier to care. Their purpose is not to finance the system alone, but to create a structured, predictable, responsive, people-centered and rights-based insurance mechanism that can gradually replace fragmented emergency aid.

It is advised to prepare an explicit and realistic essential package, and to include PHC, maternal and child health, immunization, nutrition services, mental health and psychosocial support, chronic disease treatment, essential medicines, acute dental care, emergency care, basic diagnostics, rehabilitation, palliative care, disability support, and referral pathways for services not available in Gaza. More advanced tertiary care could be covered through a transparent referral fund, with pre-agreed pathways to facilities in the West Bank, Egypt, Emirates Jordan, Israel, Cyprus and other willing partners.

Such social health protection model creates a defined entitlement, pools risk across the population, protects households from catastrophic out-of-pocket expenditure, gives providers predictable financing, allows strategic purchasing of services, and creates accountability for quality

and access. In short, emergency care should be free now, but Gaza needs an insurance-based UHC system for the very near future.

Equity-Centered Strategies

- **Progressive Realization:** Develop a phased UHC strategy that prioritizes the most vulnerable populations, including women, children, the elderly, persons with disabilities, and internally displaced persons, consistent with the «leaving no one behind» principle.
- **Movement and Access:** Negotiate systematic frameworks for medical referrals outside Gaza, including to Israeli, Cypriot, Egyptian, Emirates, Jordanian, and West Bank facilities, building on the pre-existing tertiary care referral pathways.
- **Rights-Based Approach:** Embed the right to health in any future governance framework, following Rwanda›s constitutional model.

Cross-Cutting Themes and Enablers

Gender, Age, Disability, and Intersectionality

Women in Gaza face compounded vulnerabilities: three times higher maternal mortality, gender-based violence in displacement settings, and disproportionate caregiving burdens. The pre-war young women's unemployment rate of 87% signals the need for economic empowerment as a health determinant. The Palestine Emerging framework's proposed Women's Club and global mentorship programs offer actionable models for enfranchising women in the governance of reconstruction.[29]

29 United Nations Palestine, "Amid violence and displacement: a reproductive health crisis in Gaza," 12 December 2025. https://palestine.un.org/en/307014-amid-violence-and-displacement-reproductive-health-crisis-gaza

Climate Change and Disaster Risk Reduction

All health infrastructure rebuilding must incorporate climate resilience—such as solar energy, water recycling, and heat-resistant construction materials—given the Eastern Mediterranean's vulnerability to extreme heat events, water scarcity, and sea-level rise. The Palestine Emerging blueprint emphasizes that short-term investments will influence Gaza for generations; without climate-smart design, rebuilt facilities risk premature obsolescence.

Ethics and Protection of Healthcare

The systematic targeting of health facilities during the conflict demands robust enforcement mechanisms. Joint Israeli Palestinian security-health committees, mandated under IHL, should ensure that rebuilt medical facilities are recognized and protected as neutral spaces. The RAND Corporation's framework for communication networks in public health emergencies provides an operational model for how clinical innovation diffusion and coordination can be maintained even under constrained conditions.[30]

30 O'Hanlon, C. E., Berdahl, C. T., Sousa, J. L., et al. (2026). Improving Diffusion of Clinical Care Innovations in Public Health Emergencies. RAND Corporation, RR-A4441-1; https://www.rand.org/pubs/research_reports/RRA4441-6.html

4. The Israeli Role: Past, Present, and Future

4.1 Historical Contributions

Israel's role in Gaza's health development is substantial and documented. The 1967–1994 period produced measurable public health gains through systematic investment in maternal and child health, disease eradication, and professional training. The MECIDS consortium demonstrated that health cooperation can be sustained "even during times of political dispute and outbreaks of violence".[31]

The Civil Administration Era (1967–1994)

The rebuilding of Gaza's health system cannot be untangled from its deep historical links with the Israeli health establishment. From 1967 to the mid-1990s, civilian healthcare in Gaza was administered under the guidance of the Israeli Ministry of Health, producing dramatic public health gains through partnerships between Palestinian staff, Israeli experts, and UNRWA.[32]

- **Maternal and Child Health:** Mother–child health centers in Gaza grew from 3 in 1976 to 29 by 1994, contributing to a decline in infant mortality from 76 per 1,000 live births in 1978 to 40 by 1991.[33]
- **Polio Eradication:** In the late 1970s, a joint Palestinian Israeli team, assisted by WHO, implemented a combined oral Sabin and

31 Tulchinsky, T. H., Troen, A. M., Nitzan, D., Lobel, R., & DeFriese, G. (2025). "Israel and Gaza: Keeping room for hope based on past cooperation in public health." American Journal of Public Health, 115(7), 1046–1049. https://doi.org/10.2105/AJPH.2025.308190

32 Tulchinsky, T. H., Troen, A. M., Nitzan, D., Lobel, R., & DeFriese, G. (2025). "Israel and Gaza: Keeping room for hope based on past cooperation in public health." American Journal of Public Health, 115(7), 1046–1049. https://doi.org/10.2105/AJPH.2025.308190.

33 Hermesh, B., Maya, M., & Davidovitch, N. (2019). Health Risk Assessment for the Israeli Population Following the Sanitary Crisis in Gaza. EcoPeace Middle East.

inactivated Salk vaccine strategy that eliminated polio in Gaza for over 25 years—a model later adopted internationally.[34]

- **Vaccination Leadership:** In 1983, Gaza introduced a two-dose measles program achieving over 90% coverage, a model Israel itself adopted nearly a decade later.[35]

Professional Training and Clinical Exchanges

The professional development of Gaza's medical workforce was historically anchored in the Israeli hospital system. In the 1970s, 25 physicians from Gaza and the West Bank completed intensive 30-month residencies in Israeli hospitals. Until 2005, Palestinian physicians, nurses, and laboratory technicians regularly participated in professional training programs within Israel, fostering shared clinical standards and a common technical language.[36]

Institutionalized Cooperation (1994–2023)

The establishment of the Palestinian Authority in 1994 shifted administrative control, but technical interdependencies persisted, see for example:

- **MECIDS:** The Middle East Consortium on Infectious Disease Surveillance, established in 2003, created formal mechanisms for Israeli, Palestinian, and Jordanian laboratories to share surveillance data and develop joint response strategies. MECIDS proved vital during avian influenza outbreaks (2006), H1N1 pandemic planning (2009), and the early COVID-19 response.[37]
- **NGO-Led Initiatives:** The Peres Center for Peace›s «Saving Children» program facilitated over 6,560 referrals for Palestinian infants receiving life-saving surgeries in Israeli hospitals.[38]

34 Ibid.

35 Ibid.

36 Ibid.

37 Ibid.

38 Ibid.

- **Tertiary Care Dependence:** Barzilai Medical Center in Ashkelon served as a tertiary backstop for Gaza, treating thousands of complex cases annually.

Examples for Israel-Gaza Health Cooperation Benefits

Period	Key Achievement	Israeli Palestinian Interface
1967–1994	MCH centers: 3 to 29; IMR: 76 to 40/1,000	Civil Administration with MoH guidance
Late 1970s	Global polio eradication model	Joint team with WHO assistance
1983	Two-dose measles, >90% coverage	Gaza pioneered, Israel later adopted
1970s–2005	Physician training (30-month residencies)	Israeli hospital system as training hub
2003–2023	MECIDS disease surveillance	Tri-national consortium (IL-PA-JO)
1994–2023	6,560 pediatric cardiac referrals	Peres Center to Israeli hospitals

4.2 Israel's Self-Interest in Gaza's Recovery

EcoPeace's research establishes that the health crisis in Gaza constitutes a direct threat to Israeli public health and environmental security:[39]

- Untreated sewage from Gaza has contaminated Israeli coastal waters and threatened desalination infrastructure.
- Antibiotic-resistant pathogens from Gaza's collapsed health system pose cross-border transmission risks.

39 Ibid.

- Communicable disease outbreaks (polio, measles, hepatitis) in Gaza's unvaccinated population directly threaten Israeli border communities.

4.3 Recommended Israeli Action Items

Domain	Action	Mechanism
Governance	Technical consulting on regulatory framework	Israeli health policy experts + IHR alignment
Workforce	Clinical fellowships for Gazan physicians	Israeli medical institutions
Professional governance	Support the Palestinian Medical Chamber	Israeli Medical Chambers
Infrastructure	Solar-powered mobile clinics	Israeli cleantech innovation
Supply chains	White-listed medical supply corridors	Israeli NGOs and MoD coordination

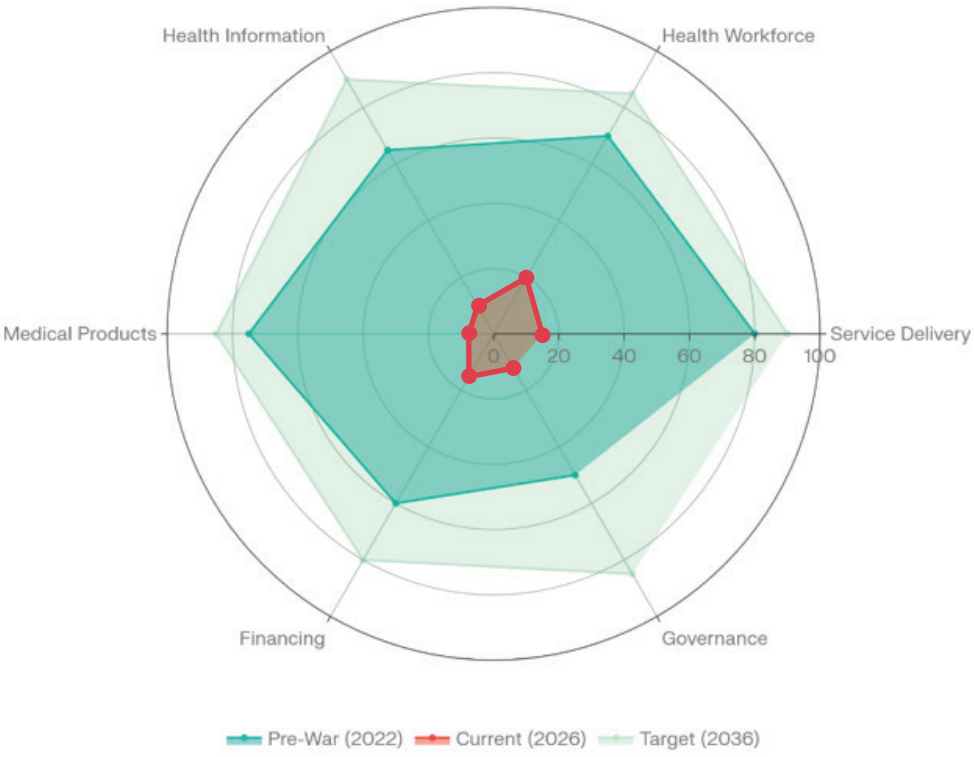
5. Conclusions and Call to Action

5.1 Strategic Roadmap for Recovery

The radar chart below illustrates the collapse across all six WHO health system functions and the aspirational target for 2036. Every dimension requires simultaneous investment; no single building block can be rebuilt in isolation.

WHO Building Blocks: Gaza Health System

Pre-war vs. current vs. target capacity (indexed)



To Build Forward Better, Gaza's health recovery should proceed through a phased strategic roadmap.

The first phase (0–6 months) must stabilize lives and restore minimum public health functions: trauma care, vaccination, urgent WASH repair, and hazard mapping. The second phase (6–24 months) should move from emergency substitution to early recovery: re-establishing PHC, chronic disease care, rehabilitation and palliative care, workforce retraining, and environmental decontamination. The third phase (2–10 years) should consolidate a resilient system through sustainable financing, professional self-governance, climate-resilient infrastructure, and universal health coverage. The ability to realize these phases depends on parallel progress in a credible political process that creates sufficient stability, access, and professional space for Palestinian and international health actors to implement their tasks.

5.2 Three-Phase Framework

Phase	Timeline	Strategic Objectives
I. Relief & Stabilization	0–6 months	Life-saving trauma care; mass Polio/Measles vaccination; urgent WASH repair; debris hazard assessment
II. Early Recovery	6–24 months	Re-establish PHC clinics; restore chronic disease outpatient care; systematic soil decontamination; health workforce retraining
III. Long-Term Resilience	2–10 years	Institutionalize SHI; establish independent Medical Chambers; finalize "Green Blue Deal"; achieve UHC

5.3 Monitoring, Evaluation, and Learning

A robust monitoring framework should track progress against the WHO UHC Service Coverage Index indicators, disaggregated by gender, age, displacement status, and geographic location. Real-time dashboards, following the RAND Corporation's recommended model for operating condition monitoring, should provide transparency to donors, implementing partners, and the Palestinian public.[40]

5.4 Risks and Contingencies

Risk	Likelihood	Mitigation Strategy
Resumed hostilities	High	Decentralized, off-grid health infrastructure; cloud-based data systems
Governance fragmentation	High	Unified health authority mandate; international technical support
Donor fatigue	Medium	FIF mechanism for pooled, transparent financing
Brain-drain of health workers	High	Competitive compensation, fellowship programs, and professional development pathways
Environmental contamination delay	High	Prioritized hazard mapping; phased decontamination per UNEP guidelines

40 O'Hanlon, C. E., Berdahl, C. T., Sousa, J. L., et al. (2026). Improving Diffusion of Clinical Care Innovations in Public Health Emergencies. RAND Corporation.

5.5 Call to Action

The need to ensure a high-quality health system in Gaza presents a historic opportunity to create a system that is more equitable, resilient, and sustainably financed than the one that existed before. The evidence from Kosovo, Rwanda, Germany, and Bosnia and Herzegovina provides a clear roadmap: invest in primary health care and public health services, deploy community health workers, establish universal coverage mechanisms, unify governance, and ensure local ownership of the recovery process. The community's needs and voice should be heard and used to steer concrete actions. The good-neighborhood modalities should be part of the process, using health as a common denominator, using health-for-peace.

For Israel, the choice is not ideological but pragmatic. Decades of health cooperation demonstrate that cross-border collaboration in public health is not only possible but essential for regional security. The shared environmental ecosystem, the cross-boundary disease surveillance imperative, and the direct threats to Israeli infrastructure from Gaza's collapsed sanitation system make disengagement a self-defeating strategy.

For the international community, the Gaza Reconstruction and Development Fund provide the financing architecture. What is needed now is political will, sustained commitment, and the application of lessons from evidence-based post-conflict reconstruction efforts over the past eight decades.

Health-system reconstruction cannot be sustainable in a political vacuum. A comprehensive political peace process is necessary to provide a credible long-term horizon for stability, access, governance, and investment. Without such a framework, even the best technical plan will remain fragile: health workers will not be able to operate safely, donors and investors will hesitate, and early recovery resources will be repeatedly diverted back to crisis response. The reconstruction

of Gaza's health system should therefore be treated as both a technical public health project and a peacebuilding imperative.

Building forward better is not merely a slogan. It is a strategic imperative for the health, security, and dignity of every person, Palestinian and Israeli, who shares this small, interconnected region.

Annex A: Operative Proposals for Improving Immediate Medical Care for Gaza's Residents

A.1 Background

The fighting in the Gaza Strip has created a severe imbalance between the medical needs of the local population and the treatment capabilities available to them, due to:

- A large number of wounded
- Destruction of medical infrastructure
- Paralysis of the routine healthcare system
- Cessation of transfer of complex patients for treatment in Israel
- Overcrowded living conditions in refugee camps without water and sewage infrastructure
- Disruption of food supply and consequent malnutrition

A partial response to these needs is provided by the limited operations of local hospitals, supplemented by shipments of medications and medical supplies from aid organizations, as well as limited deployment of international medical delegations within the Strip. These solutions address only a small fraction of the actual needs.

In the subsequent phases of the conflict, as combat intensity decreases (Phase 3) and the need arises to provide for the civilian population under Israeli control — and in light of the international pressure that will be exerted on Israel in this regard — the need will arise to establish a medical facility capable of providing treatment to a large number of wounded and sick individuals. Beyond the humanitarian necessity, there is a significant public diplomacy element in establishing such a hospital, which is urgently needed given the ongoing humanitarian crisis in the

Strip following the fighting. It is of paramount importance to initiate and lead such a response rather than be led by external forces.

A.2 Proposal 1: Humanitarian Field Hospital for Gaza Strip Residents

Core Concept

- Establishment of a civilian field hospital on Israeli territory, near the Gaza Strip border. The exact location will be determined based on considerations of need (population concentrations), security (ability to screen patients and accompanying persons), logistics (preference for a military or civilian facility with connection to electricity, water, and sewage systems), and considerations of distance from the border and patient transport.
- The field hospital will be established in full coordination with the security establishment.
- The hospital's capabilities will include: an emergency room, outpatient clinics (approximately 100 patients per day), inpatient ward (up to approximately 50 patients), obstetrics, and surgical capacity (5–7 minor to medium surgeries).
- Priority should be given to beginning operations with treatment of women and children. This has advantages in terms of gradual entry into the operation, the humanitarian aspect, security risk mitigation, and willingness of domestic authorities to approve the mission.
- Logistical operation of the field hospital by KLP, a company specializing in operating field hospitals in Israel and around the world.
- Medical personnel will be based on teams recruited domestically and abroad.

International Collaboration

- Cooperation with additional international medical organizations — both governmental and non-governmental. This cooperation can be expressed in reinforcing the field hospital staff with international teams, establishing additional medical facilities adjacent to the field hospital (clinics or field hospitals), and establishing a forward clinic by an international team on the Gaza side of the border. This forward clinic would perform initial triage, treat minor cases, and refer more complex cases to the field hospital for treatment.
- Cases more complex than the field hospital's capacity will be transferred for treatment abroad, following the model that has already transferred patients to additional countries. As the domestic atmosphere changes, consideration may be given to transferring patients for treatment in Israeli hospitals.

Funding

Since this is a mission with significant public diplomacy value to the State of Israel, funding should ideally come from the State of Israel. Additionally, efforts should be made to obtain funding from international bodies involved in Gaza Strip rehabilitation assistance.

A.3 Proposal 2: Establishing a Telemedicine System as a Partial Solution for Routine Healthcare in the Gaza Strip

In addition to the acute medical problems resulting from the war, there is a collapse of the healthcare system in the Strip at both the hospital and community medicine levels. Rehabilitation of hospitals is an enormous long-term project, but a partial solution for routine healthcare can be provided by establishing a telemedicine system that serves as an advisory resource for local teams. The components required for establishing such a system include:

- Local medical teams on the Gaza end

- A multidisciplinary team of medical consultants on the Israeli side
- Dedicated examination equipment
- A communications system

Local teams can be identified based on existing connections between medical professionals in Israel and medical professionals in the Strip. The consultant system can be based on organizations such as Physicians for Human Rights, hospitals in East Jerusalem or the West Bank, and private volunteers who can work under the organizational umbrella of these entities.

For the technical solution of examination equipment, existing systems in Israel such as Sheba Beyond can be utilized. The communications solution must be obtained from the security establishment.

Of course, beyond remote consultation, a parallel system providing actual treatment solutions must develop simultaneously.

Annex B: Short-term Interventions aimed at Improving the Humanitarian Response in the Gaza

B.1 Introduction

The humanitarian crisis in Gaza manifests in hunger, the spread of infectious diseases, exacerbation of chronic diseases, trauma and its complications, and lack of access to adequate medical care. Providing a humanitarian response to this crisis is our fundamental duty as human beings and as medical professionals. The guiding principle is "First, do no harm," alongside ensuring the delivery of humanitarian aid in a safe and professional manner. Furthermore, improving the humanitarian situation in the Strip will serve the objectives of the State of Israel at both the tactical and strategic levels. It should be noted that this principles document is based on our expertise in providing medical responses during humanitarian crises resulting from natural disasters and wars.

B.2 Needs Assessment

B.2.1 Food and Nutrition

- General nutrition – needs versus international standards (SPHERE): fresh food items and cooked meals.
- Nutritional needs for vulnerable populations (children, women, the elderly, the disabled, and the sick).
- Protocols and measures to prevent refeeding syndrome (protocol adapted for low-technology settings), dedicated formulas, nutritional supplements, and mobile laboratories.

B.2.2 Water, Sanitation, and Hygiene (WASH)

- Water needs according to international standards (SPHERE).
- Medical implications of water shortages at the above-mentioned standards.

B.2.3 Medical Response

The following outlines total needs. A model will be constructed for the needs of 1,000,000 displaced persons, and once what currently exists is known, more precise needs for establishment and allocation will be derived, categorized by facility types and mobilization capacity:

- **Preventive Medicine:** Vaccinations, early detection and monitoring of outbreaks, additional public health aspects — detailed needs including vaccination stations, cold chain maintenance, required personnel, etc., according to the model.
- **Ambulatory Routine Medicine:** Number of equipped and staffed clinics according to the model and population size, from which required personnel will be derived.
- **Hospital-Level Routine Medicine:** Hospital beds needed according to population size (1.5–2 beds per 1,000, yielding a need for 1,500–2,000 beds), plus calculations for delivery rooms, operating rooms, imaging, laboratory, etc. Required personnel based on size metrics — physicians, nurses, and health professionals.
- **War-Related Medical Needs:** Trauma, interruption of complex treatments. Required capabilities (dedicated facilities, surgical equipment, personnel, blood, and blood products).
- **Pharmaceutical Supply:** Including cold chain management.
- **Rehabilitation:** Rehabilitation capabilities, including prosthetics, rehabilitation facilities, and rehabilitation personnel.
- **Psychosocial Support:** Including the number of centers and required personnel.

B.3 Treatment Settings and Medical Facilities

The following details the capabilities, advantages, and disadvantages of each facility type. After what currently exists is known, the needs for establishment can be derived:

B.3.1 Local Health System

Ultimately, this will be the main system providing healthcare to the population, both in terms of its size and its long-term permanence. Therefore, substantial resources should be directed toward the rehabilitation of hospitals and clinics.

B.3.2 International Organization Facilities

Field hospitals, clinics, and mobile teams can reinforce local medical facilities. Each facility is admittedly small, with capabilities limited to primary and secondary care and no capacity for complex treatments, and its size is relatively small compared to permanent facilities. However, their advantage lies in the ability to deploy across multiple locations and a certain degree of mobility in case of population displacement.

Additional advantages include:

- Most of these organizations have developed logistics systems for the procurement and transport of medical supplies and medications, adding to the quantities entering the Strip.
- Some organizations have direct or indirect connections with hospitals in their home countries and can arrange the evacuation of complex cases to these hospitals.

For all these reasons, in the current situation, international aid organizations constitute a significant component of the total medical response, and therefore, barriers to the entry of personnel and equipment should be removed to allow them to maximize their capabilities.

B.3.3 Israeli Facilities on the Border

Field hospitals and clinics on the border/lines can provide primary and secondary medical care and can serve as screening and preparation facilities for evacuating patients out of Gaza.

B.3.4 Hospitals in Israel

Establishing a mechanism for treating complex patients and wounded, like the Syrian mechanism. Ensuring access to hospitals in East Jerusalem and the West Bank should be a priority and providing financial and technical support to these hospitals.

B.3.5 Hospitals Abroad

Expanding the number of receiving countries to include neighboring countries, including Gulf states and Turkey; distant Muslim countries (Pakistan, Bangladesh, Indonesia); South Africa; and additional countries worldwide. The evacuation mechanism to these countries should be refined, while simultaneously creating a mechanism for the return of patients after completion of treatment.

B.4 Active and Potential Actors

- Local medical teams
- International organizations
- The Israeli medical system
- Arab-Israeli health professionals/ East Jerusalem /West Bank
- Health forces from neighboring countries

B.5 Operational Models

- **Dedicated Israeli Coordination HQ:** Establishment of a dedicated Israeli headquarters in partnership with international bodies for approving and coordinating missions and shortages of equipment and medications (inviting the Health Cluster to coordination meetings).
- **Direct Communication Channels:** Establishing direct communication channels between professional medical forces at various facilities inside the Strip and the coordination center or border hospitals outside the Strip and in Israel, to coordinate transfer of patients requiring advanced treatment and return of patients for continued treatment and follow-up in the Strip.

Support for the local medical system through:

- Filling gaps in permanent and consumable equipment + medications
- Filling personnel gaps through international organizations and bringing additional teams from abroad
- Establishing a telemedicine system for support from hospitals in Israel and abroad
- Operating aid corridors (land, air, sea) while keeping strict security and oversight
- Involvement of the Palestinian Authority / “third” countries for field coordination

B.6 Health System Needs for One Million Displaced Persons

Based on UNHCR, WHO, and SPHERE standards:[41]

B.6.1 Hospitals, Inpatient Beds, and Clinics

- One hospital per 250,000 people (i.e., 4 hospitals per million displaced persons). Their locations should be distributed so that the entire population has access to at least one hospital.
- At least 18 inpatient beds (excluding maternity) per 10,000 people.
- Community clinics: one clinic per 10,000 people (i.e., approximately 100 primary clinics, fixed or mobile, per million displaced persons).
- In areas with low population density, one clinic per 50,000 people may suffice (i.e., 20 fixed and mobile clinics).

B.6.2 Personnel

- Hospital physicians: 1 per 25,000 (i.e., 40 physicians per million people)
- Community physicians: 1 per 10,000
- Hospital nurses: 4 nurses per standard department, on round-the-clock shifts
- Clinic nurses: 1 nurse per 10,000 people (100 nurses, without shift work)
- Community health workers: 1–2 per 1,000 people (volunteers and employees)

41 Sphere Association, The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response, 2018. The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response - 2018 edition [EN/AR] - World | ReliefWeb; WHO, Emergency Handbook: Health; WHO, Classification and Minimum Standards for Emergency Medical Teams, 2021. https://iris.who.int/server/api/core/bitstreams/f1a9750a-f68b-401c-87ea-c5157a3af6d9/content

B.6.3 Vaccination Stations and Mental Health

- Every primary community clinic, whether fixed or mobile, should include a unit trained in administering vaccinations.
- At least 1 mental health specialist (possibly also social workers) per 25,000 people.
- Nutrition: One station recommended per clinic and per reception center — for conducting nutritional surveys, nutritional treatment, prevention and treatment of refeeding syndrome.

B.6.4 Mobile Clinics (MEPUs)

Based on experience from Ukraine, Syria, and other settings:

- **Staffing:** Physician, nurse (also qualified as midwife), sometimes only 2 paramedics, and sometimes also with social workers, dietitians, and a medical registrar. They provide primary care including preventive treatment, medications, perform growth and nutritional status assessments, administer vaccinations, and more.
- **Basic Equipment:** Stethoscopes, blood pressure monitors, thermometers, blood glucose meters, otoscope, ophthalmoscope, first aid and bandaging materials, essential medications (analgesics, basic antibiotics, chronic disease medications including insulin, etc.), infectious disease treatment kits. Monitoring equipment such as ECG, portable ultrasound, glucometer, saturation monitor. Vaccines and refrigerators, basic delivery kit, basic prenatal care, scales, height meter, MUAC meter. Sometimes a portable X-ray machine. Staff protective equipment.
- **Digital Equipment:** Laptops with telemedicine software, data storage and processing. The HIMA (Health In My Hand) application is also recommended.
- Equipment for management and treatment of medical waste.

B.7 Accessibility

- At least 80% of the population should be able to reach a clinic within less than one hour's walk.
- A system of visits to displaced persons' camps — essential for identifying non-mobile patients.
- A network of MEPUs (mobile clinics) — covering all camps at least twice weekly.
- An organized system of referrals and transportation for urgent cases to hospitals.

B.8 Monitoring and Oversight

To be carried out by Israeli experts and international partners.

Creating a monitoring mechanism for determining compliance with standards, transparency of distribution, reporting of failures, and continuous improvement.

B.8.1 Monitoring and Oversight Objectives

- Ensuring compliance with professional standards (SPHERE and others) in the delivery of humanitarian aid.
- Preventing diversion of resources (water, food, medical equipment) to irrelevant or hostile actors.
- Ongoing measurement of aid effectiveness and its actual impact on the population's health and nutrition status.
- Identifying failures and rapid response to challenges during implementation.

B.8.2 Monitoring Mechanisms

a. Real-Time Mapping and Monitoring:

- Operating a daily data collection system from the field (including through applications, sensors, and sample tracking).
- Real-time updates of quantities, routes, and distribution points for food, water, and medications.

b. Full Documentation of Resource Flows:

- Use of digital documents, barcodes, and ERP systems for tracking every shipment.
- Digital signatures of recognized representatives (Israeli and international) upon receipt/transfer of equipment.

c. Health Surveys and Population Indicators:

- Deployment of international and local monitoring teams for periodic inspections (nutrition indicators, morbidity, mortality, access to services).
- Data collection also through community centers, clinics, and aid organizations.

B.8.3 Oversight Mechanisms

a. Independent External Supervision:

- Integration of a neutral international organization — e.g., Red Cross, WFP, WHO — for conducting frequent audits and issuing public reports.
- Operating according to regulated procedures and documents accessible to all stakeholders.

b. Israeli-International Quality Control Team:

- Synchronized operation of a field and border quality control team, in partnership with Arab-Israeli representatives, to ensure transparency and reliability.

c. Complaints Hotline:

- Operating a telephone call center and digital communication channels for receiving reports, complaints, and direct feedback from the population and field workers.

B.8.4 Evaluation Processes

a. Ongoing Evaluation:

- Weekly/monthly data analysis to examine trends (e.g., decrease in morbidity, increase in access to services).
- Adapting aid processes based on findings: "learning while moving."

b. Summative Evaluation:

- Processing periodic reports (quarterly/annual) and comparing to pre-defined targets such as malnutrition rates, per capita water supply, availability of medical services.
- Publishing summary reports for the public, donor nations, and the Government of Israel.

c. Population Feedback:

- Conducting structured feedback through interviews, focus groups, and questionnaires administered by an independent third party.

B.8.5 Response, Correction, and Transparency

- Formulating an immediate response protocol for any malfunction or violation found in audits/inspections.
- Public presentation of reports (subject to security constraints) and implementation of a tracking mechanism for completion of corrections.
- Holding periodic discussions of a steering committee, with the participation of all stakeholders, for updates, review, and decision-making.

B.9 Technology for Monitoring and Oversight

- Remote sensing
- Implementation of a Geographic Information System (GIS) for tracking shipments in the field
- Deployment of health measurement applications (HIMA — Health In My Hand)
- Integration of cameras and visual monitoring at critical points

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