oPt Health and Nutrition Cluster

8/20/2011

Contingency Plan; final

Table of Contents

ACRONYMS AND ABBREVIATIONS:

CPWG – Contingency Planning Working Group
DCCD – District / Local Committee of Civil Defense
GDCD – General Directorate of Civil Defense
HC – Humanitarian Coordinator
HCCD – Higher Council for Civil Defense
HCT – Humanitarian Coordination Team
HNC – Health and Nutrition Cluster
IRA – Initial Rapid Assessment
MoH – Ministry of Heath
NGO – Non Governmental Organization
OCHA – Office for the Coordination of Humanitarian Affairs
oPt – Occupied Palestinian Territory
PFA – Psychological first aid
WHO – World Health Organization

ACKNOWLEDGEMENTS:

Hereby I would like to thank all HNC partner agency teams for their support to the cluster contingency planning and their commitment to helping Palestinian communities become better prepared to prevent and respond to the consequences of new disasters.

In particular I would like make a special mention of the input if the **HNC Contingency Planning Working Groups (CPWG)** into the above process. It is due the hard work and dedication of the CPWG members in West Bank and Gaza led by **WHO** and **MDM Spain** that it became possible to collect data on health hazards and risks in the occupied Palestinian territory, conduct analysis of Health and Nutrition Cluster preparedness to new disasters, prepare for and carry out Contingency Planning Workshops in West bank and Gaza. Through this they have made an invaluable contribution to strengthening awareness of the cluster partners of disaster preparedness and building consensus between humanitarian agencies on the preparedness and response arrangements and actions to be carried out by the cluster collectively to be better prepared to face consequences of new disasters.

V. Harutyunyan M.D.
HNC Coordinator

CPWG-s Members

1. **Care International:** Ayman Shuaibi; Mohammad Lafi
2. **International Medical Corps:** Wael Fteaha
3. **Map UK:** Kathy Al Ju'beh; Fikr Shaltoot
4. **MDM France:** Federico Dessi; Maria Chavez
5. **MDM Spain:** Boris Aristin; Asma Shalayel; Caroline Bedos
6. **PMRS:** Dr. Iskafi Mohammad; Dr. Ghassan Zaqqut
7. **Save the Children UK:** Jamal El Hawajri; Salwa El Tibi
8. **UNFPA:** Dr. Ali Shaar; Osama Abueita
9. **UNRWA:** Faiza El Sharif
10. **World Health Organization:** Yousef Muhaisen; Abdelnaser Soboh
11. **NHC:** Dr. Vachagan Harutyunyan

FOREWORD:

In early March 2011 Health and Nutrition Cluster embarked on the sector contingency planning process that aimed at strengthening the cluster collective capacity to predict, prevent and address the consequences of disasters affecting oPt by means of implementing the following measures:

- Analysis of potential emergencies;
- Analysis of the potential humanitarian health impact and consequences of identified emergencies;
- Establishing clear objectives, strategies, policies and procedures and articulating critical health and nutrition actions that must be taken to respond to an emergency, and;
- Ensuring that agreements are recorded and necessary actions are taken in order to enhance preparedness.

The process was led by a group of health professionals from HNC partners agencies (see above) led by MDM Spain and WHO that carried out analysis of data, national policies and plans relevant to the HNC contingency planning as well as developed and facilitated Health and Nutrition Cluster Contingency Planning Workshops held in West Bank and Gaza in May 2011.

These workshops brought together HNC partners from UN, local and International NGO-s and the Palestinian Ministry of Health to discuss and agree on the principles and processes guiding cluster planning and response to emergencies in oPt and to ensure their alignment with the relevant national policies and standards. In the scope of this exercise the cluster partners have built consensus on the most critical hazards, planning assumptions, appropriate response options, cluster capacity, preparedness priorities and coordination and information management actions during emergencies.

This report was developed to document the consensus reached by the cluster partners during the workshop and to guide the cluster partners emergency preparedness and response actions. It will be reviewed and revised by the cluster partners on a regular basis following any significant change of humanitarian situation, or once a year if no changes of humanitarian situation occur, to ensure its technical soundness and context appropriateness.

It should be stressed that this Contingency Plan does not replace individual agency contingency plans. Health and Nutrition Cluster partner agencies and other agencies providing health and nutrition services in oPt are encouraged to consult this plan to develop their own agency specific and locally adapted contingency plans.

INTRODUCTION:

Geography:

The territory of the occupied Palestinian territory includes two separated geographical areas, the West Bank (WB) and Gaza Strip (GS). The West Bank is an area of 5,800 sq km - roughly 130km long and 40-65km wide. It is hilly and for the most part rugged terrain, which changes from desert and scrub landscape in the south to more lush vegetation in the north. The West Bank has an average elevation of 750m, but it also comprises Jericho and the shores of the Dead Sea which, at 390m below sea level, forms the lowest point on earth.

The Gaza Strip is an area of 365 sq km – some 45km long and 5-12km wide. The region is mostly flat and the soil is sandy.

Population:

The total population of oPt is 3.77 million, 2.35 million in the West Bank (including East Jerusalem) and 1.42 million living in Gaza[1]. Around half of the population is below 15 years and the average annual population growth rate is 2.6%; one of the highest in the region[2]. The population is expected to increase by 50% by 2020. The population density in Gaza is one of the highest in the world[3]. The refugee population is 1.7 million, constituting 29 % of the population in the West Bank and 69% in Gaza, living in 27 refugee camps[4]. In Jerusalem, there are 91,274 registered refugees and 18,719 non- registered refugees[5].

Recent history[6]

In 1947, the United Nations adopted a proposal to divide Palestine into an Arab and a Jewish State and recommended the internationalization of Jerusalem. The modern State of Israel was proclaimed in 1948, but the Arab State of Palestine never came into existence. During 1948-49 the territory was conquered in part by Israel, Transjordan and Egypt. During the 1967 Six Day War Israel captured East Jerusalem, the West Bank and Gaza Strip (and the Sinai and the Golan mountains outside the former British Mandate of Palestine). By the end of the war, Israel had increased by 40% the size of the area originally afforded by the United Nations.

As a result of the 1948 Arab-Israeli war, the Gaza Strip came under Egyptian administration, which ended in 1967 when the Gaza Strip was captured by Israel in the Six Day War. In 1979 Egypt and Israel signed a peace agreement, but it was not until the early 1990s, after years of an uprising known as the Intifada, that a peace process began with the Palestinians. Despite the handover of Gaza and parts of the West Bank to Palestinian control in 1994, a "final status" agreement has yet to be reached.

Health Profile

The access to health and nutrition services remains limited for the populations in Gaza, area C and some localities in areas A and B in West Bank. Continued restrictions on importation of medical supplies and equipment, including spare parts and on movement of health staff between West Bank and Gaza as well as intra-Palestinian tensions hamper access of quality essential health services of the most vulnerable Palestinian communities[7].

The above caused gradual erosion of public health system in Gaza. Shortages of essential drugs reached highest registered level of 38% at the beginning of 2011 and continue up to this point. Assessment carried out by WHO jointly with UNDP in 2011 showed that 63% of the primary health care and around 50% of hospital infrastructure is inadequate for provision of quality health care. Furthermore around 23% of all of the medical equipment in Gaza is not functional. Stringent travel restrictions imposed by the IDF further restrict access to health of the Gazans in need of treatment in West Banks and Israel. In 2010, almost one out of five

[1] Palestinian Central Bureau of Statistics (PCBS): *Palestinian census*, January 2008
[2] Palestinian Central Bureau of Statistics- Census final results in the west bank - Summary (population & housing 2007)- from the World Bank Report: *Palestinian Economic prospects: Aid, Access and Reform*. Economic monitoring report to the Ad Hoc liaison committee: September 2008
[3] Abed Y. Health sector review: a summary report. Jerusalem: The Italian Cooperation, 2007.
[4] Palestinian National Authority Ministry of Health, National Strategic Health Plan (2008-2010), 2008.
[5] Palestinian Central Bureau of Statistics- Census final results in the west bank - Summary (population & housing 2007)- from the World Bank Report: *Palestinian Economic prospects: Aid, Access and Reform*. Economic monitoring report to the Ad Hoc liaison committee : September 2008
[6] Save the Children
[7] Refugees, Women (particularly pregnant women), Children, People with NCD-s , People with disabilities, Older people , People with mental illnesses, Bedouins in isolated communities

patients missed their hospital appointment because the Israeli authorities either denied or delayed their permit. Since March 2008 66 people including 22 children died, while waiting referral outside Gaza.

While due to more favourable political and economic conditions health care network in West Bank have seen significant developments, an assessment carried out by the Palestinian MoH jointly with WHO revealed that nearly 22% of populations in the Area C and seam zones lack access to treatment of most common illness with shortages of staff, long distances to health facilities, poor conditions of roads and settler activity and Israeli military being the main reasons for the above.

Infant and child mortality indicators had some improvement in Palestine in the last decade however there is evidence that they have worsened in the poorest quintiles of the population[8].

Prevalence of anaemia remains at very high levels both among pregnant women and infants in West Bank and Gaza, with prevalence in Gaza showing strong upward trend in the past 3 years. The prevalence of anaemia among pregnant women and infants in Gaza increased by 14.1% and 5.3% respectively from 2007 to 2010[9]. Prevalence of wasting, stunting and underweight among children under five, while currently being within the limits of a norm, have worsened in the past ten years both in West Bank and Gaza with the rates of wasting (acute malnutrition) increased more than twofold[10]

The assessment of the environmental impact of operation Cast Lead carried out by UNEP at the request of the Palestinian Authority in 2009 revealed alarming situation with environmental health in Gaza. While at the moment it did not lead to outbreaks of communicable disease or increase of mortality due to waterborne disease this situation poses an immediate and long term threat to the health and wellbeing of the dwellers of that area. The HCT initiated Strategic Response to the UNEP Report further highlights the needs and actions to mitigate the identified threats.

The recent years have been characterized by a substantial increase of 31.1% in both incidence and prevalence of chronic diseases[11] as well as disability and mental illness among the population of the oPt with posttraumatic stress disorder affecting up to 45% of families in Gaza[12].

Emergency Preparedness:

The occupied Palestinian Territory is highly vulnerable to a large variety of natural and manmade hazards: including war/large scale violence, earthquakes, floods, landslides, droughts and desertification.

Against the background of the on-going conflict in oPt and the response to immediate humanitarian needs, emergency risk reduction and preparedness have been given relatively less importance by both state and non-state actors in the area. While health sector actors in oPt have developed an impressive capacity to deal with the consequences of armed conflict and manage mass casualties, they are much less well prepared to anticipate, plan for and mitigate those events; nor is there sufficient standby capacity to respond should the current situation deteriorate. Furthermore the health systems in oPt are inadequately prepared to respond to other possible disasters; such as earthquakes, floods and epidemics of communicable diseases. The above, coupled with depleting resilience of the communities and systems particularly in Gaza, increases their vulnerability to future hazards and risks, high casualties and economic loss in case of new adverse events,

[8] Palestinian Family Health survey
[9] MoH; Nutrition surveillance report 2010
[10] MICS 2010 preliminary data
[11] Palestinian Health Survey – 2006 – Preliminary Report
[12] GCMHP.Effect of trauma on mental health, social support, and coping of Palestinian families after one year of Gaza War. July 2010

Women and children, older people and people with disabilities are generally the most vulnerable groups when such events occur.

Recognizing this the Palestinian Ministry of Health with support from the Palestinian Health Sector Reform and Development Project (Flagship) and other partners initiated the process of strengthening health sector emergency preparedness. HNC fully supports this process by involving in the development of the national health sector emergency preparedness plan, coordinating with the MoH its emergency response and preparedness actions and aligning them with the relevant national policies, strategies and norms.

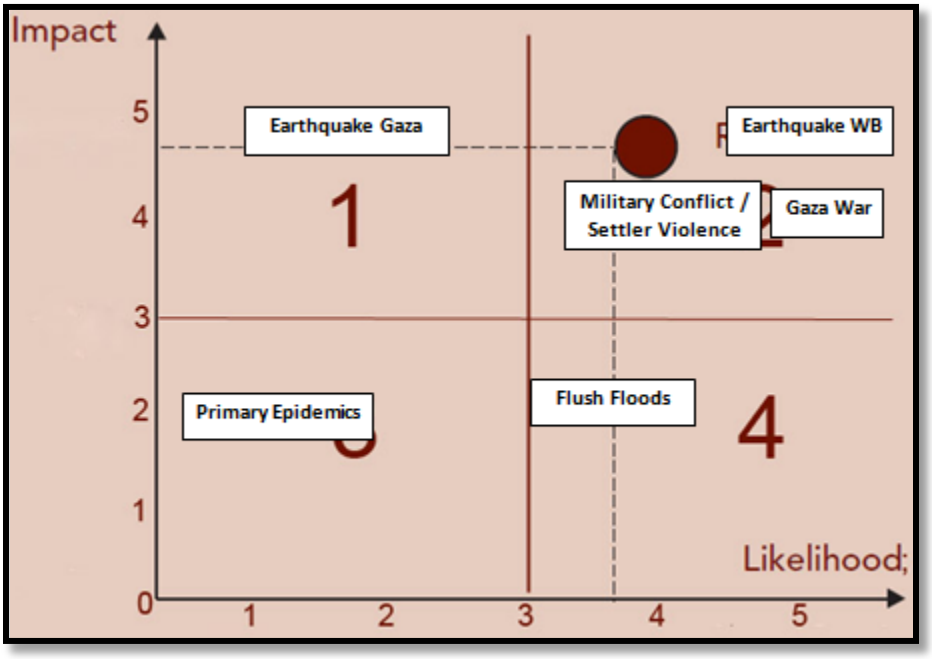
HAZARD AND RISK ANALYSIS

oPt is vulnerable to a wide plethora of natural and manmade hazards. These hazards will vary in their frequency and scale and will have different impact on health and wellbeing of the Palestinians. To optimize HNC preparedness process and to focus their resources on the most critical hazards the cluster partners conducted analysis of common hazards and their risks that consisted of two phases.

In the first phase a broad analysis of hazards potentially affecting oPt was carried out by studying historical data and analysis conducted by the Palestinian Ministry of Health, OCHA and PRCS. This resulted in selection of hazards for further risk analysis:

1. Gaza War
2. Flush Floods (Gaza)
3. Earthquake (Gaza)
4. Earthquake (West Bank)
5. Military Conflict / Settler Violence (West Bank)
6. Primary Epidemics (West Bank and Gaza)

Following the identification of the hazards their risk analysis was carried out using the risk assessment framework whereby likelihood and impact of all the above hazards was appraised on the scale from one to five. The following matrix shows the results of the risk analysis conducted by the cluster:



Based on this analysis a) Earthquake WB b) Earthquake Gaza c) Gaza War and d) Military Conflict / Settler Violence were selected as priority hazards for HNC contingency planning.

Due to low impact of the flush flooding observed so far this hazard currently will not be considered in the cluster contingency planning, however its incidence and impact will be monitored by the cluster. Should it be assessed appropriate the cluster will include this scenario in the future revisions of the HNC contingency plan.

It was decided by the cluster partners that no preparedness planning will be conducted for the primary epidemics scenario (H1N1 etc). The implications of this scenario will be addressed through the cluster partners' regular programming.

SCENARIOS AND PLANNING ASSUMPTIONS:

To explore the implications of each hazard selected and support HNC contingency planning; scenarios and planning assumptions were developed for each hazard based on the analysis carried out by the Palestinian MoH, PRCS, OCHA and HNC.

The scenarios and HNC contingency planning assumptions agreed on between the cluster partners are as follows:

1. Gaza War

An escalation of hostilities between different parties leading to internal clashes and or wide Israeli attacks on Gaza causing restrictions of movement and flow of goods

Planning Assumptions:

1. Based on past experience from Gaza War in 2009, casualties would reach up to 5,000 people at their highest in the first 10 days of the military operations (1500 dead, 2000 wounded in need of inpatient care of which 500 in the first week)
2. Displacement of more than 70,000 persons as a result of mass displacement from one occupied part to the other especially near Philadelphi Corridor.
3. Damage in water, waste water, and power and communications systems in areas targeted by Israeli fire, resulting in public health hazards potentially affected population reaches up to 400,000 people.
4. As a result of possible internal and external access difficulty; shortages of food supplies potentially affecting 250,000 people in addition to the existing humanitarian caseload
5. Clashes hinder the delivery of health services especially between districts.
6. Disruption of health services due to continued disruption in the access and provision of utilities and internal movement restrictions affecting vulnerable groups (access to emergency care, referrals to secondary and tertiary care)
7. Restricted humanitarian access to people in isolated areas controlled by armed groups.
8. Closure of some local NGOs and CBOs affecting health service delivery

3. Earthquake (West Bank and Gaza)

A scenario of earthquake which has tremors in excess of 6 on the Richter scale brings down hundreds of buildings throughout the oPt. One of the worst affected areas would be the edge of the Jordan Valley (From Lake Tiberias to the Dead Sea) which includes the cities of Jenin, Tubas, Nablus, Ramallah and Jerusalem, in different scales.

The area has historically seen 2 cycles of Earthquakes; the first occurs every 80 – 100 years with a magnitude of 6.5 Richter. The last one was seen in 1927, which hit the northern Palestine with 6.2 Richter. This cycle is due since 2007, 80 years after the last one.

The other cycle is every 200-250 years with a magnitude of over 7 on Richter scale. The last one was recorded in 1759, 7 Richter, in northern Palestine and caused thousands of casualties. This cycle is due since 2009 after 250 years of the last major one.

An earthquake of 6 to 6.5 on Richter scale might result in 1000 fatalities and 10,000 casualties. Some sources estimate 6% of all buildings in the main cities of the West Bank might totally collapse at that magnitude (vulnerable areas are Jordan Valley, Nablus, Jerusalem and Hebron). At 7 Richter, in addition to more damages in the inner land, the coastal sandy area might have some strong reaction waves specially in is western Gaza City due to the number of high rise buildings. And if the magnitude is more than 7.5 the effect might exceed oPt and effect neighboring countries hindering their capacity to help, the damages might affect most of the building in different scales and casualties might reach 100s of thousands.

Planning Assumptions:

1. Tens of thousands of homeless and displaced people seek refuge in tent camps established in the former settlements as well as UNRWA, municipal and government buildings.
2. Earthquakes cause high mortality (from several thousands to tens of thousands depending on the magnitude) resulting from trauma, asphyxia, dust inhalation (acute respiratory distress), or exposure to the environment (i.e. hypothermia).
3. Surgical needs are important the first weeks. (injuries, fractures, crush syndrome, etc)
4. Several thousand people will be in need of surgical care and tens of thousands will require access to basic health services (PHC)
5. Damages to health facilities are massive and can lead to an interruption in basic health care services.
6. Massive damages to lifelines such as water and sewage systems, energy lines, roads, and telecom.
7. Sewage and water networks are ruptured and severely damaged throughout the Gaza Strip leading to concerns over the spread of communicable diseases.

5. Military Conflict / Settler Violence (West Bank)

IDF and a large number of settlers embark on a campaign of retribution on the nearest Palestinian villages, towns and neighborhoods and disrupt movement on main roads in the West Bank.

Planning Assumptions:

1. Increased settler / military violence to large-scale attacks on civilians in different/multiple areas of the West Bank affecting provision of health care to nearly 1,129,090 Palestinians in in 132 locations of the West Bank including 93,675 in East Jerusalem
2. A large number of casualties and fatalities (depends on scale).
3. Displacement of large number of persons as a result of massive attacks mainly in isolated areas/military zones, area C
4. Strict closure and isolation of affected communities (this could be limited to:
    - some areas of West Bank like Khirbet Tana, north Jordan Valley, Iraq burin, etc
    - or affecting large areas within the West Bank like Qalqilya, Nablus, etc
    - at worst case scenario total internal West bank closure with no access to Jerusalem.
5. Psycho-social problems and trauma especially among children and other vulnerable groups.

6. Disruption of health services due to continued restrictions on access to health care and provision of utilities and internal movement restrictions affecting vulnerable groups.
7. Restricted humanitarian access to people in isolated areas controlled by IDF

RESPONSE OBJECTIVES AND STRATEGIES

Establishing common objectives and strategies helps to ensure that all sectors/ clusters and agencies/organizations are working towards the same overall goal.

1. Gaza War

Objective: To reduce mortality and morbidity by sustaining the provision and accessibility to emergency and basic health services.

Response Strategies:
DO:

- PHC services level 2 and above for the populations in the affected areas including nutrition care (IYCF, micronutrients) and, reproductive and mental health services, and services for chronic patients
    - In areas where PHC services can be covered by previously established MoH, UNRWA or NGO clinics: provide logistic and HR support operation of these clinics
    - In areas not covered by MOH: directly provide PHC services via stationary and mobile clinics
- First aid (including PFA) / trauma care at the community level (24 hours a day 7 days a week)
- Triage at all levels of health care
- Emergency referral services / ambulance (24 hours a day 7 days a week)
- Emergency care services, including emergency obstetric care at PHC-s and Hospitals (24 hours a day 7 days a week)
- Psychosocial support and care integrated within or closely coordinated with PHC services
- Information dissemination about the availability of health and nutrition services
- Advocacy to ensure access of vulnerable population groups to life saving basic and specialist care
- Protections mechanisms integrated within health responses (to be discussed with protection cluster)

DON'T DO

- Blanket distribution of milk formula / distribution of formula to caregivers of children that can be fed with breast milk e.g. Whose mother is alive and does not have medical indications for cessation of breastfeeding
- Procurement of drugs and medical disposables/receiving medical donations with shelf life shorter than 1 year, and not included in the oPt MoH essential drugs list
- Vertical interventions that can be provided in the scope of PHC package (vaccination, nutrition, mental health) or interventions that are not relevant to the context (supplementary and therapeutic feeding centers)
- Import blood or blood derivatives
- There is enough health staff in oPt to provide primary and most of hospital / specialist services, do not bring in international medical teams unless coordinated with the MoH and the cluster
- **Unilateral decision on resource allocation: Do not take it without evidence of needs and coordination with the MoH and the Cluster**

2. Earthquake (West Bank and Gaza)

Objective: Reduce preventable morbidity and mortality through provision of life saving trauma care / essential surgical care, ensuring access to basic health care services and communicable disease control.

Response Strategies:
DO:

- First aid (including PFA) / primary trauma care including management of "Crush" syndrome at the community level available 24 hours a day 7 days a week.
- Triage at all levels of health care
- Emergency referral services (consider possible damage of health infrastructure and roads)
- Emergency care services including surgical care and emergency obstetric care 24 hours a day 7 days a week
- PHC services level 2 and above for the populations in the affected areas including nutrition care (IYCF, micronutrients) and, reproductive and mental health services through stationary (where health and crucial roads infrastructure is preserved) or mobile / temporary clinics
    - Organization of care to displaced populations
- Psychosocial support and care integrated within or closely coordinated with PHC services
- Protections mechanisms integrated within health responses (to be discussed with protection cluster)
- Information dissemination about the availability of services and prevention of communicable diseases of epidemic potential (context specific)
- Measures to control spread of communicable diseases (surveillance, early case detection and management, planning locations of isolation centers, health education)
- Regular Monitoring of potential outbreaks of diseases through physical examination and lab tests, and monitor the risk of water pollution. Distribution of hygiene / dignity kits and coordinate with other clusters to deliver clean water and food packages to the isolated communities

DON'T DO

- Blanket distribution of milk formula / distribution of formula to caregivers of children that can be fed with breast milk e.g. Whose mother is alive and does not have medical indications for cessation of breastfeeding
- Procurement of drugs with shelf life shorter than 1 year, procurement of drugs not included in the oPt MoH essential drugs list
- Vertical interventions that can be provided in the scope of PHC package (vaccination, nutrition, mental health) or interventions that are not relevant to the context (supplementary and therapeutic feeding centers)
- Field hospitals, modular medical units: **Do not send them! Considering that this type of equipment is justified only when it meets medium-term needs**, it should not be accepted unless it is donated
- Medical or paramedical personnel or teams: **Do not send them! They would arrive too late**. Local and neighboring health services are best placed to handle emergency medical care to disaster victims.
- Import of blood or blood derivatives
- **Unilateral decision on resource allocation: Do not take it without evidence of needs and coordination with the MoH and the Cluster**

3. Military Conflict / Settler Violence (West Bank)

Objective: To prevent high mortality and morbidity by ensuring the provision and accessibility of Primary and Hospital care and protection of civilians through health service provision and advocacy.

Response Strategies:
DO:

- PHC services level 2 and above for the populations in the affected areas including nutrition care (IYCF, micronutrients) and, reproductive and mental health services, and services for chronic patients
    - In areas where PHC services can be covered by previously established MoH, UNRWA or NGO clinics: provide logistic and HR support operation of these clinics
    - In areas not covered by MOH: directly provide PHC services via stationary and mobile clinics
- First aid (including PFA) / trauma care at the community level (24 hours a day 7 days a week)
- Triage at all levels of health care
- Emergency referral services / ambulance (24 hours a day 7 days a week
- Emergency care services, including emergency obstetric care at PHC-s and Hospitals (24 hours a day 7 days a week)
- Culturally sensitive psychosocial support and care / services in coordination with other clusters and in compliance to IASC standards
- Procurement of medical supplies including drugs, disposables reagents etc is according to MOH protocols and approved lists and in compliance to international standards
- Information dissemination about the availability of services
- Distribution of hygiene & dignity kits and coordination with other clusters to deliver clean water and food packages to isolated communities
- Advocacy to ensure access of vulnerable population groups to life saving basic and specialist care
- Protections mechanisms integrated within health responses (to be discussed with protection cluster)

DON'T DO

- Blanket distribution of milk formula / distribution of formula to caregivers of children that can be fed with breast milk e.g. Whose mother is alive and does not have medical indications for cessation of breastfeeding
- Procurement of drugs with shelf life shorter than 1 year, procurement of drugs not included in the oPt MoH essential drugs list
- Vertical interventions that can be provided in the scope of PHC package (vaccination) or interventions that are not relevant to the context (supplementary and therapeutic feeding centers)
- Design standalone psycho-social interventions that are not culturally appropriate
- There is enough health staff in oPt to provide primary and most of hospital / specialist services, do not bring in international medical teams unless coordinated with the MoH and the cluster
- **Unilateral decision on resource allocation: Do not take it without evidence of needs and coordination with the MoH and the Cluster**

COORDINATION AND INFORMATION MANAGEMENT DURING DISATSTERS

Coordination:

Well planned and executed coordination is critical to effective and efficient humanitarian response; it facilitates forming operational partnerships, development of commonly shared technical policies and information sharing to support decision making and advocacy.

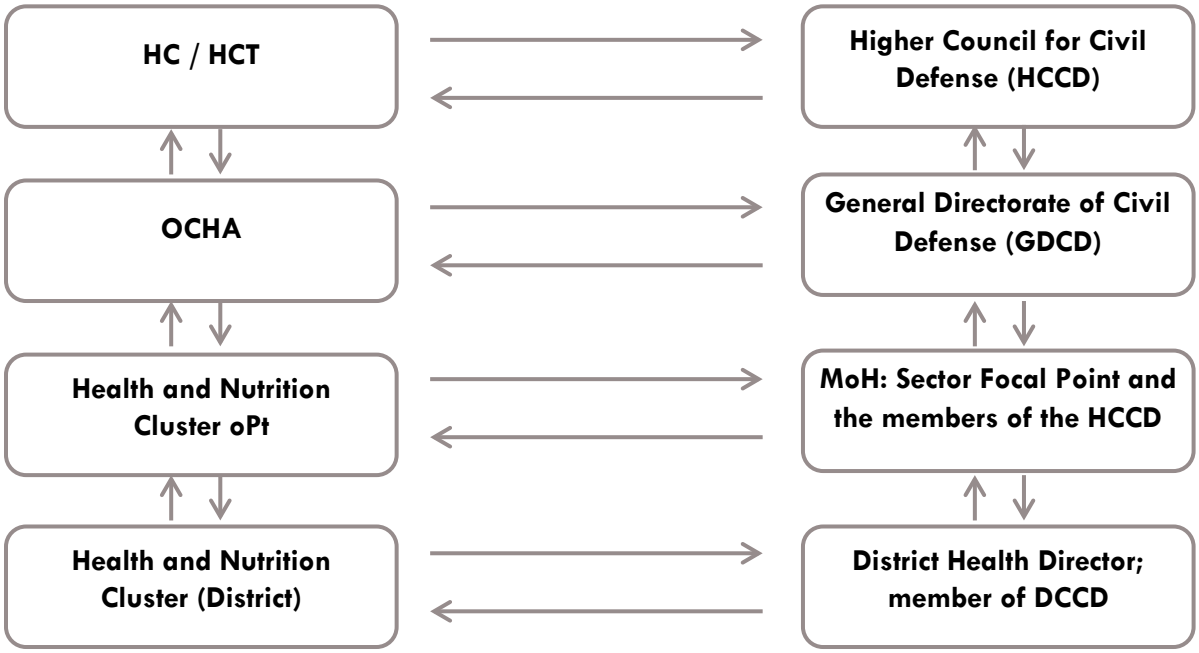
Emergency Coordination Structure in oPt

There are two principal coordination mechanisms that will govern the disaster response in oPt; that of the National Authority (NA) and the International Community represented by the Humanitarian Country Team (HCT) (figure 1).

The NA has a principal role and responsibility for the safety and wellbeing of the Palestinians. In most of the cases it is the NA disaster management structures that will assess situation on the ground, trigger and lead the response following an emergency. It will request an international assistance should the internal capacity be considered inadequate to deal with a disaster. The international community's response will, as a rule, be organized by request and in support of the NA disaster response.

The HCT is a consultative body that includes representatives from UN, NGO-s and International Organizations that provides strategic leadership to international humanitarian response. The HCT is chaired by the UN Humanitarian Coordinator. The international humanitarian community has thus a distinct coordination mechanism that ensures its impartiality and neutrality as well as operational efficiency of the humanitarian response. NA and the International Community will closely cooperate and exchange information at each coordination level (Figure 1).

Figure 1: Humanitarian Coordination Structure in oPt (simplified)



Information management

Information management that includes data collection, analysis and dissemination is critical for health and nutrition sector coordination and resource mobilization. Following are the information management tools that oPt Health and Nutrition Cluster has at its disposal:

- Initial Rapid Assessment (IRA)
- Health Facilities Database
- 3Ws
- Mobile Clinics Database

- Situation reports/ Bulletin
- MoH/UNRWA surveillance

Principal cluster activities during the different phases of disaster response (to be modified to include column indicating agencies responsible for implementation of the activities)

Every disaster response has several phases. Every phase is characterized by a set of factors that determine response priorities and thus coordination and information requirements. The principal activities of the health and nutrition cluster during the disaster response are as follows

Phase 1: 0-72 Hours:

- Preliminary contacts with OCHA and the Director of International Cooperation Department at the MoH *(Health and Nutrition Cluster Team)*
- Preliminary enquiries and consolidation of information on the extent of emergency from OCHA, MoH and Health Authorities of the affected district(s) *(Health and Nutrition Cluster Team)*
- First health cluster coordination meeting *(Health and Nutrition Cluster Team, all HNC Partner Agencies)*
    - Context update
    - Activation of the HNC contingency plan (make modifications if needed based on the context information)[13] / development of HNC provisional response plan
    - Designate district level HNC lead agency (ies) if needed
- Update of 3W *(All HNC Partner Agencies)*
- Initiate update of health facility and mobile clinic databases *(Health and Nutrition Cluster Team; WHO with inputs from HNC Partner Agencies)*
- Preparation and dissemination of first health cluster/sector bulletin *(Health and Nutrition Cluster Team with inputs from HNC Partner Agencies)*
- Participation in initial inter-cluster/inter-sectoral coordination meetings; contribution to initial inter-cluster/sectoral analysis and planning *(Health and Nutrition Cluster Team)*
- Planning the initial rapid assessment (IRA) in coordination with MoH / Launch IRA if IRA team had been formed pre crisis *(Rapid Assessment Team composed of HNC Partner Agencies)*
- Initiate Early Warning and Response mechanisms *(Health and Nutrition Cluster Team with inputs from HNC Partner Agencies)*

Phase 2: 4 days – 4 weeks

- Update and maintain health facility and mobile clinic databases *(Health and Nutrition Cluster Team with inputs from HNC Partner Agencies)*
- Information exchange and coordination of response with the Ministry of Health and Health Authorities of the affected district(s) *(HNC Partner Agencies with support from Health and Nutrition Cluster Team)*
- Launching the initial rapid assessment (IRA) / Disseminate IRA results (Rapid Assessment Team; HNC team)
- Establishment of emergency health information system / monitor HNC response *(Health and Nutrition Cluster Team with inputs from HNC Partner Agencies)*
- Regular health and nutrition cluster meetings – national and district (if applicable) disseminate context updates, update resource inventory and carry out gap analyses. *(Health and Nutrition Cluster Team, all HNC Partner Agencies)*
    - Update HNC response plan in accordance with the updated contextual information

[13] The HNC contingency plan will lay basis for development of the HNC disaster response plan

- Formulation of initial health sector strategic plan (based on the HNC Contingency Plan and the results if IRA) *(HNC Partner Agencies with support from Health and Nutrition Cluster Team)*
- Preparation of health component of the UN-OCHA Flash appeal (if any) (see Box 1) *(Health and Nutrition Cluster Team with inputs from HNC Partner Agencies)*
- Preparation of proposals for CERF funding (if any) (see Box 2) *(HNC Partner Agencies)*
- Preparation and dissemination of regular health-sector bulletins *(Health and Nutrition Cluster Team)*
- Continuing participation in inter-cluster/inter-sectoral coordination meetings; contribution to inter-cluster/sectoral analysis and planning and effective integration of cross-cutting issues ensuring equity of vulnerable groups. *(Health and Nutrition Cluster Team)*
- Maintain Early Warning and Response mechanisms *(HNC Partner Agencies with support from Health and Nutrition Cluster Team)*
- Update 3W database *(HNC Partner Agencies)*

Phase 3: 4-6 weeks (disaster), Up to 3 months (conflict)

- Update and maintain of health facility and mobile clinic databases *(Health and Nutrition Cluster Team with inputs from HNC Partner Agencies)*
- Information exchange and coordination of response with the Ministry of Health and Health Authorities of the affected district(s) *(HNC Partner Agencies with support from Health and Nutrition Cluster Team)*
- Continuation of regular health coordination meetings *(e.g. weekly, depending on the needs) (Health and Nutrition Cluster Team, all HNC Partner Agencies)*
- Continuing participation in inter-cluster/inter-sectoral coordination meetings; contribution to inter-cluster/sectoral analysis and planning *(Health and Nutrition Cluster Team)*
- Update health sector response plan as needed and the cluster response plan *(HNC Partner Agencies with support from Health and Nutrition Cluster Team)*
- Implementation and monitoring of initial response *(with gender, age and disability-sensitive indicators) (Health and Nutrition Cluster Team with inputs from HNC Partner Agencies)*
- Preparation of health section of CHAP and consolidated appeal (if applicable) *(Health and Nutrition Cluster Team with inputs from HNC Partner Agencies)*
- Resource mobilization frequent up-dating of resource inventory and gap analyses *(HNC Partner Agencies with support from Health and Nutrition Cluster Team)*
- Establishment of technical working groups, as/when needed organization of joint training *(HNC Support Group)*
- Monitoring implementation of the health crisis response strategy & cluster action plan *(Health and Nutrition Cluster Team with inputs from HNC Partner Agencies)*
- Preparation and dissemination of regular health-sector bulletins *(Health and Nutrition Cluster Team)*
- Maintain Early Warning and Response mechanisms *(HNC Partner Agencies with support from Health and Nutrition Cluster Team)*
- Update 3W database *(HNC Partner Agencies)*

Phase 4: Continuing humanitarian response / phase out

- Continuation of regular health coordination meetings (e.g. biweekly) *(Health and Nutrition Cluster Team, all HNC Partner Agencies)*
- Information exchange and coordination of response with the Ministry of Health and Health Authorities of the affected district(s) *(HNC Partner Agencies with support from Health and Nutrition Cluster Team)*
- Organization of in depth assessment to identify health impact of the emergency and needs *(HNC Partner Agencies with support from Health and Nutrition Cluster Team)*

- Periodic up-dating of the planning scenario, health facilities and mobile clinic databases, and gap analyses *(HNC Partner Agencies with support from Health and Nutrition Cluster Team)*
- Periodic updating of the HNC response strategy and action plan *(Health and Nutrition Cluster Team with inputs from HNC Partner Agencies)*
- Establishment/suspension of technical working groups, as needed *(HNC Support Group)*
- Real-time or interim/mid-term evaluation of sector response *(OCHA; Health and Nutrition Cluster Team with inputs from HNC Partner Agencies)*
- Contingency planning for possible changes in the situation *(HNC Partner Agencies with support from Health and Nutrition Cluster Team)*
- Preparation and dissemination of regular health-sector bulletins *(Health and Nutrition Cluster Team)*
- Update 3W database *(HNC Partner Agencies)*
- Prepare for phasing out / handover of projects to local providers *(HNC Partner Agencies)*
    - Coordinate departure and replacement of international teams *(Health and Nutrition Cluster Team)*

Box 1: The Central Emergency Response Fund (CERF) is a stand-by fund established by the United Nations to enable more timely, reliable and equitable humanitarian assistance to victims of natural disasters and other types of emergency. It is intended to complement – not substitute for – Flash and CAP. There are two CERF funding windows:

- Rapid response – CERF may provide seed funds to jump-start critical operations.
- Under-funded emergencies – CERF can fund life-saving projects in an ongoing emergency situation that is under-funded (priority projects that are not yet covered by other donors).

The Fund is intended to support emergency response in general but NGOs are not eligible to access CERF funds directly. Only UN agencies can submit requests for CERF funding.

Box 2: The Flash appeal is a tool for structuring a coordinated humanitarian response for the first three to six months of an emergency and mobilizing the necessary resources from donors. The Humanitarian Coordinator (HC) triggers a Flash appeal in consultation with all stakeholders and defines the time frame for preparation. Normally, the HC and humanitarian country team should complete a draft within 5 to 7 days of the onset of a crisis. The appeal is then issued by OCHA-Geneva about 48 hours later. Usually, there is a scheduled revision about a month later based on additional information and including more early recovery projects. (The flash appeal may be developed into a CAP if an inter-agency response is needed beyond six months.)

HEALTH AND NUTRITION CLUSTER PREPAREDNESS ACTIONS

The main objective of the Contingency Planning carried out by the HNC is to ensure that partner agencies/organizations develop a level of preparedness that is sufficient to respond to an anticipated emergency. Analyzing gaps in preparedness and prioritizing and implementing preparedness actions and convert this objective into action.

The following preparedness actions were identified by the cluster partners during the contingency planning process conducted in March – May 2011. These actions will be evaluated on regular basis during the following reviews of the HNC Contingency Plan

Preparedness Action	Responsible Agency (TBD)
Category: Systems and Processes	
Carry out organization specific Contingency Planning aligned with HNC Contingency Plan. Revise agency specific Contingency Plans every year or after every significant change of the humanitarian context	HNC partners
Adapt procurement, human resources, and administration systems for use in emergencies	HNC partners
Strengthen operational capacity of WHO as a provider of last resort	WHO
Scale up first aid / trauma care service provider network through training and providing necessary logistic and admin support	HNC partners
Category: M&E, Information Management, Advocacy	
Develop HNC IRA tools; questionnaires, data management guidelines and database	HNC SG
Train HNC IRA stand by team from among health and nutrition cluster partners	HNC team
Commit to sharing timely and accurate data on health needs and progress of health and nutrition projects	HNC partners
Develop set of core HNC response monitoring and evaluation indicators	HNC SG
Advocate with MoH, UNRWA and NGO-s to harmonize their disease surveillance systems	HNC team / WHO
Establish HNC bulletin / Web site	HNC Team / WHO
Regularly update health facility and mobile clinic database	HNC partners / WHO (technical support)
Category: Staffing and Core Capacity	
Build staff capacity in M&E and data management, including HNC core indicators	HNC partners / HNC team /WHO
Designate dedicated HNC information management officer	WHO
Scale up first aid / trauma care service provider network through training and providing necessary logistic and admin support	HNC partners
Conduct training on contingency planning for the health and nutrition cluster partners	HNC team / WHO
Category: Material & financial resources	
Preposition 3 month stocks of essential drugs and supplies to ensure continuity of service provision in the context of tightened blockade, movement restrictions	HNC partners – service providers (UNRWA, PMRS, HWC, UHWC etc)
Advocate with donors to fund prepositioning of essential drugs and supplies	HNC partners

ANNEX 1: HNC EMERGENCY CONTACTS (TO BE DEVELOPED)

Location		Name	Number	Email	Title
Ard El Atfal					
Hebron		Hazem Maraqa	0599678011	hmaraqa@aeapal.org	Financial and Admin officer
Hebron		Abdel kareem Shreiteh	0599111966	kareem066@aeapal.org	Board Chair
Jerusalem		Khalil Marouf	0597934498	kmarouf@aeapal.org	Executive Director
Care International					
Gaza		Mohammad Lafi	0598935498	mlafi@carewbg.org	Health Program Representative Gaza
Gaza		Yazdan El Amawi	0599258124	yamawi@carewbg.org	Gaza Office Manager
Bethlehem		Anees Mahareeq	059925-123	mahareeq@carewbg.org	Health Program Representative Hebron / Bethlehem
Hebron		Anees Mahareeq	0599258123	mahareeq@carewbg.org	Health Program Representative Hebron / Bethlehem
Jenin		Jamal Rashed	0599677461	jrashed@carewbg.org	Health Program Representative Jenin
Jerusalem		Ayman Shuaibi	0599210517	shuaibi@carewbg.org	Health Sector Coordinator
Nablus		Jamal Rashed	0599677461	jrashed@carewbg.org	Health Program Representative Jenin
Ramallah		Ayman Shuaibi	0599210517	shuaibi@carewbg.org	Health Sector Coordinator
Tubas		Jamal Rashed	0599677461	jrashed@carewbg.org	Health Program Representative Jenin
Dier al Balah		Mohammad Lafi	0598935498	mlafi@carewbg.org	Health Program Representative Gaza
Dier al Balah		Yazdan El Amawi	0599258124	yamawi@carewbg.org	Gaza Office Manager
Khan Yunis		Mohammad Lafi	0598935498	mlafi@carewbg.org	Health Program Representative Gaza
Khan Yunis		Yazdan El Amawi	0599258124	yamawi@carewbg.org	Gaza Office Manager
North Gaza		Mohammad Lafi	0598935498	mlafi@carewbg.org	Health Program Representative Gaza
North Gaza		Yazdan El Amawi	0599258124	yamawi@carewbg.org	Gaza Office Manager
Rafah		Mohammad Lafi	0598935498	mlafi@carewbg.org	Health Program Representative Gaza
Rafah		Yazdan El Amawi	0599258124	yamawi@carewbg.org	Gaza Office Manager
Help Age					
Jerusalem		sonja van Osch	0524332717	svanosch@helpageinternational.org	oPt Programme Director
Gaza		sonja van Osch	0524332717	svanosch@helpageinternational.org	oPt Programme Director
Handicap International					
Jerusalem		Ligneau david	545270704	dligneau@hi-me.org	Head of mission

Gaza		Samah Abu Lamzy	598995859	sabulamthy@hi-me.org	Gaza Project Manager
Gaza		Sharaf Faqawi	598851130	sfaqawi@hi-me.org	Physical Rehabilitation Officer
Gaza		Osama Hamdan	599244073	ohamdan@hi-me.org	Disability Mainstream Officer
North Gaza		Focal point Partner 1 (PMRS NG) Mr. Mustafa Abed	599607076	cbr5555@hotmail.com	CBR program manager for PMRS
Gaza		Focal point Partner 2 (NSR GC) Mr. Kamal Abu Qamar	599540146	k.abuqamar54@hotmail.com	NSR dircetor
Dier al Balah		Focal point Partner 3 (NSR MG) Mr. Abdel Hakim Ismael	599462404	nsr-midzone@hotmail.com	NSR Mid zone coordinator
Khan Yunis		Focal point Partner 4 (PRCS KH. Y.)	599751774	nassar_center@hotmail.com	PRCS rehabilitation Manager
Rafah		Focal point Partner 5 (SPHP R.) Mr. Haider Abu Shawish		sphpgaza@yahoo.com	SPHP branch director
Health Work Committees					
Bethlehem		DR. Ramze Abo Yosef	599203030		
Bethlehem		DR. Rauf Azar	598948185		
Hebron		DR. Ramze Abo Yosef	599203030		
Jerusalem		Miassar abo tair	549227571		
Nablus		DR. Abed Alazez	599383657		
Qalqiliya		DR. Basem Hashem	599294253		
Ramallah		DR.Hussam Alremawe	598948118		
Salfit		DR. Abed Alazez	599383657		
Tubas		DR. Basam Shaban	598948175		
International Medical Corps					
Gaza		Ted Tuthill	0595220254	ttuthill@internationalmedicalcorps.org	Mission Director
Gaza		Dr Munira Olia	0595878779	muni.e.olia@gmail.com	Mental Health Specialist
Islamic Relief					
Hebron		Mahmod Amro		mamro@yahoo.com	Yatta Coordinator

Ramallah		Abdelrahim Alasa'd		a.shawahna@irpal.org.ps	Head of Missio
Jenin		Nur Alkhaldi		N.Khaldi@irpal.org.ps	Projects Coordinator
Juzoor					
Ramallah		Rihab Sandouka	022414488	info@juzoor.org; rsandouka@juzoor.org	
MAP UK					
Jerusalem		Kathy Al Jubeh	0599313414	kathy@map-uk.org	Director of Programmes oPt
Gaza		Fikr Shalltoot	0599884459	fikr@map-uk.org	Programme Coordinator Gaza Strip
Gaza		Nawraz Abu Libdeh	0599651452	nawraz@map-uk.org	Finance & Logistics Coordinator Gaza Strip
Ramallah		Esperanza Shanan	0599204667	esperanza@map-uk.org	Programme Officer oPt / Emergency Officer oPt
Ramallah		Nuriya Oswald	0599677585	programme.support@map-uk.org	Programme suppor officer oPt (for all access issues)
MDM France					
Nablus		Salah Daraghmeh	598928424	fieldco.nablus.mdmpalestine@gmail.com	Field coordinator Nablus
Jerusalem		TBD	598914260	genco.mdmpalestine@gmail.com	General coordinator (must be always copied)
Gaza		Federico Dessi	598929164	fieldco.gaza.mdmpalestine@gmail.com	Field coordinator Gaza
MDM Spain					
Jerusalem		Boris Aristin	598312009	palestina@medicosdelmundo.org	Head of mission
Gaza		Caroline Bedos	598993008	emergencypreparedness.gaza@medicosdelmundo.org	Project Coordinator
Medico International					
WB		Luke McBain	546539790	ho-jlem@medico.de	Representative
Norwegian Aid Committee (NORWAC)					
Gaza		Ann-Cathrin Pedersen	597800909	pal@norwac.no	Project Coordinator
		John Eivind Jensen	4792891390	jensen@norwac.no	Country Director (based in Oslo)
Palestinian Medical Relief Society					
Gaza		Mohamed Shomer	970599867223	dr_mohammed69@hotmail.com	Doctor
Hebron		Dr Othman Abu Sabha	599204902	othman_abusabha@yahoo.com	
Bethlehem		Amal Banoura	599094599		
Jenin		Mohammad Abu Heija	599201771		
Jericho		Dr Mohammad Tmaizi	2322148		
Jerusalem		Dr Iskafi Mohammad	599561599	driskafi@yahoo.com	
Nablus		Dr Ghassan Hamdan	599877793		

Qalqiliya		Dr Aboushi Mohammad	599658608		
Ramallah		Dr Iskafi Mohammad	599561599	driskafi@yahoo.com	
Qatar Red Crescent Society - Gaza					
North Gaza		Mohammed Abu Haloub	0598 055552	mabuhaloub@qrc.ps	QRC - Gaza office director
Gaza		Akram Nassar	0595 699386	anassar@qrc.ps	Health officer
St. John Eye Hospital					
Jerusalem		David Dahdal	549400729	david@sjeh.org	Fundraising Manager
Save the Children UK					
Gaza		Jamal El Hawajri	598705802	jhawajri@scuk.org.ps	health consultant
Gaza		Salwa ElTibi	597911083	stibi@scuk.org.ps	program manager
Terre des Homme Italy					
Gaza		Michele Crimella	595518153	m.crimella@tdhitaly.org	Project manager
UNFPA					
North Gaza		Osama Abueita	0599 12 11 91	abueita@unfpa.org	National Programme Office, Gaza Sub-Office Coordinator
Jerusalem		Dr. Ali Shaar	054-817 4151	shaar@unfpa.org	RH Programme Officer, OPT
Jerusalem		Elke Mayrhofer	054-9201341	mayrhofer@unfpa.org	Deputy Representative, Humanitarian Focal Point
UNICEF					
Gaza		Younis Awdallah	598935375	yawadallah@unicef.org	Health Specialist
Jerusalem		Najwa Rizkallah	547787616	nrizkallah@unicef.org	Nutrition Specialist
Jerusalem		Kamel Benabdallah	547787611	kbenabdallah@unicef.org	Chief Health and Nutrition
Gaza		Diane Araki	547787692	daraki@unicef.org	Chief of Field Office
UNRWA					
Gaza		Dr. Amna Shurbasi	2887228	a.shurbasi@unrwa.org	Deputy chief field health programme
Gaza		Dr. Isa Saleh	599609525	I.SALEH1@UNRWA.ORG	Epidemiology Officer
Gaza		Mrs Fayza Al Sharif	599609461	F.el-sharif@unrwa.org	Director of Nursing
WB		Dr Al-Titi Mahmoud	542168675	M.AL-TITI@UNRWA.ORG	Project Manager (mobile clinics)
WB		Nuria Branders	542168429	n.branders@unrwa.org	Progr. Support (Health & Psychosocial)
WB		Dr Umaiyeh Khammash	542168435	u.khammash@unrwa.org	Chief Field Health Programme
WHO					
Gaza		Mahmoud Daher	599675641	mda@who-health.org	Head of Office
Gaza		Abdelnaser Soboh	599671088	aso@who-health.org	Information Management Officer

oPt		Jenny Oskarsson	547179018	jos@who-health.org	Advocacy Officer
WB		Yousef Muhaisen	547179019	ymu@who-health.org	Coordination Officer
oPt		Anita Vitullo	547179023	avk@who-health.org	Advocacy Project Manager

ANNEX 2: EMERGENCY STOCKS MAINTAINED BY THE HNC PARTNERS (TO BE UPDATED)

Stock Item Category	Item Details	Unit	Quantity	Location
Handicap International				
DRESSING MATERIALS	wound dressing kits	Unit	1367	Gaza
MEDICAL EQUIPMENT / DRESSING	assistive devices(wheel chairs, crutches , walkers)	Unit	146	Gaza
International Medical Corps				
IA Emergency Health Kit (Basic unit 1,000*3m)		Unit	1	Gaza
MDM France				
Disposables	58 types of disposables used in provision of emergency care, including trauma care. Quantities are sufficient to sustain services to approximately 10,000 people for 3 months	Months / Supply	3	Gaza
PMRS				
Dressing Materials	Sufficient to sustain organizations own operations for 12 month at the current level of caseload	Months / Supply	12	Gaza
Essential Medicines	Sufficient to sustain organizations own operations for 3 month at the current level of caseload	Months / Supply	3	Gaza
UNICEF				
IEHK 2006 Kit; Supplementary Unit (medicines and renewables)	A supplementary unit contains medicines, medical devices renewables for a population of	Unit	4	Gaza

	10,000 people for 3 months. It is designed to be used by physicians and senior health care workers			
Midwifery Kit 3; Renewable	This kit represents the basic requirements of renewable medical supplies (consumables) to facilitate around 50 normal deliveries	Unit	2	Gaza
Resuscitation kit; Basic	Part of Midwifery kit. This kit consists of basic resuscitation equipment to facilitate resuscitation in all types of environment, including emergency situations	Unit	75	Gaza
ICRC				
Trauma Kit	Each kit is designed to treat 100 trauma cases of which 20% are severe	Unit	4 (3 Gaza 1 WB)	