



15th August 2024 The establishment of a clear and efficient mechanism for safe medical evacuations from Gaza: evidence for consideration by the International Community.

Background

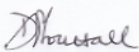
Currently, it is estimated that at least 50,000 civilians in Gaza are living with major medical problems or major injuries that are causing immense suffering and a high risk of death within a few days likely without urgent and effective treatment. Pregnant women, babies and children comprise the major proportion of these patients. The health systems, staff, drugs, equipment and facilities, such as operating theatres, available to treat most of these patients is not available in Gaza. The absence of a clear and universally understood system of medical evacuation, is leading to confusion, inefficiencies, and prolonged processes. A sustainable and effective evacuation system is urgently needed for many thousands of critically ill or injured patients.

Appendix 1 summarises for pregnant women, babies and children the kind of medical emergencies that require stabilisation and evacuation.

Possible actions to achieve an efficient medical stabilisation and evacuation centred (ESEC) system in Gaza.

1. Given the huge numbers of vulnerable patients, provisions to medically stabilise and evacuate many thousands of patients and their dependent relatives requires an effective new system.
2. A Cease Fire is urgently needed to achieve the sustainable system described below.
3. Our hope is that a number of countries will each offer a large number of hospital beds (perhaps 1000 initially) together with accommodation for dependent relatives (see below). Currently MCAI has been calling on the British authorities to support the implementation of this kind of medical evacuation scheme from Gaza. We are currently awaiting their response.
4. To achieve a medically urgent timeframe, it is essential that the need for evacuation is rapidly identified by urgency level at triage and that for those in a life-threatening condition a few hours only must pass before the patient arrives in an effective healthcare facility where stabilisation through effective emergency care and then urgent transport to a well-equipped hospital is achieved.
5. Our suggestion regarding this plan involves the border between Gaza and the Mediterranean Sea. We are advocating for hospital ships from different countries to become anchored just outside the international 12-mile limit and provide definitive medical and surgical care before patients and their dependents are flown to those donor countries willing to provide hospital beds and "leave to remain" accommodation for the families.
6. Next to the beach, set aside for triage, stabilisation and evacuations, each donor country will provide, along with the Israeli Defence Force (IDF) and the donor's own security forces, a set of safe buildings within which this emergency evacuation system can function (Emergency Stabilisation and Evacuation (ESEC) centres). These centres will operate like a hospital where a gentle, patient, and family orientated, support system by both healthcare staff and security staff will be in operation so that patients and relatives can feel relatively safe ([link here to a reference](#) on the ethical management of patients by doctors working in zones of armed conflict or other emergencies).

7. Again, in partnership with the IDF, donor countries would rapidly transfer patients to the anchored hospital ship linked to that country. Transfer from the shorefront to the anchored hospital ships could be undertaken using helicopters or military landing craft whichever was considered the most effective for the medical condition of each patient and weather conditions.
8. Each ESEC would process identification and security arrangements concerning the patient and his/her family. We suggest that the IDF, alongside special international forces provided by the donor country, provide the necessary security services, including screening for any possible persons who may create a security risk. It is likely that only female patients or pre-pubertal children would be able to be screened within the time scale needed to ensure rapid evacuation of the patient to the donor hospital ships. Because of the existing security problems, when a pregnant woman is being evacuated, some of her dependent relatives (husbands, and post pubertal sons) may need to be processed over a longer timescale before being able later, subject to having no security issues, to be re-united with their initially medically evacuated family members.
9. All patients and their dependents will need to be given secure identity cards containing photographs. All must be documented by an internationally secure data system which will include their origins and destination and must include contact details for both surviving patients and their families left behind. Data protection processes must be in place so that patients and their relatives retain absolute privacy on arrival in the donor countries.
10. The media must only receive private information, including medical information on a highly selected basis and always with the support of the patients and their families. Patient confidentiality is paramount.
11. All patients, if well-enough to do so, must consent to being evacuated to a donor country (see Appendix 1). If they are too ill to consent, a close relative if available must do so on their behalf. Otherwise, a consensus of the healthcare staff must make a decision with the best interests of the patient in mind.
12. We suggest that the World Health Organization supervise the collection of patients and their dependents from the communities living within Gaza and transfer them as safely as possible (supported by the IDF) to the Emergency Stabilisation and Evacuation (ESEC) centres.
13. It is essential that healthcare workers volunteering from the donor countries to work in the ESEC centres are kept safe.



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DRAFT 3 Patients In need of urgent life-saving medical evacuation and temporary medical stabilisation before and during transfer.

Name Date of birth // // Age.....

Primary medical/surgical reason(s) for transfer

Details of accompanying dependent relatives:

FORM CONTAINING CONSENT TO THIS MEDICAL EVACUATION

Detailed summary

SIGNATURE OF MEDICAL PERSON RESPONSIBLE FOR SELECTION: DATE

NAME..... MEDICAL QUALIFICATIONS.....

ORGANISATION RESPONSIBLE FOR MEDICAL EVACUATION:

.....

SIGNATURE OF PATIENT OR FAMILY MEMBER RESPONSIBLE: DATE.....

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APPENDIX 1 TRIAGE CATEGORY

RED= 1 Needs to reach hospital care (national or international) with surgical availability, including CS, within 24 hours.

ORANGE = 2 Needs to reach hospital care (national or international) with surgical availability, including CS, within 4 days.

GREEN = 3 Needs review at an appropriate time depending on condition.

The lists in the Table below may not be complete and any patient with a condition not listed who is at danger of dying can be considered for stabilisation and evacuation.

- 1) Main problems in **pregnant women** likely to need transfer: decisions to be made by clinicians based on individual needs and possible medication to be given whilst awaiting and during transfer (click [here](#) to see link to MCAI handbook on obstetric emergency care)

Medical reason for evacuation	Triage category	Stabilisation including treatment needed before and during transfer
<i>Previous Caesarean section(s) with one or more scars in the uterus.</i>		
Previous CS for obstructed labour	1	Consider short acting tocolysis until safe CS possible
More 2 or more previous CS for whatever reason	1	
1 or 2 previous CS for parental choice	3	Try Vaginal Birth After Caesarean section (VBAC)
Known to have accreta or percreta	1	
Previous CS via vertical incision in uterus	1	
Previous CS x1 for malposition	3	Try VBAC if presentation now cephalic
Previous CS for macrosomia	3	Try VBAC if scan no evidence macrosomia and pelvic size adequate
Multiple pregnancy	2	VBAC with safe CS immediately available
<i>Vaginal bleeding after 28 weeks' gestation * Ideally with portable US scan to exclude</i>		

Medical reason for evacuation	Triage category	Stabilisation including treatment needed before and during transfer
<i>placenta praevia and to identify early abruption.</i>		
Placenta praevia suspected (painless bleeding +/- transverse lie)or proven by scan	1	Blood for transfusion if available. Tranexamic acid. Consider short acting tocolysis. CS, EZIO if venous access not possible
Abruption with shock	1	Blood transfusion if possible. VBAC with safe CS immediately available EZIO if venous access not possible, Oxygen if available.
Known to have vasa praevia	1	
<i>Post partum haemorrhage</i>	2 3 1	Blood transfusion and oxygen if possible, Misoprostol or ideally oxytocin IV, Tranexamic acid, Elavi balloon tamponade if still bleeding, Intravenous antibiotics if septic: Ceftriaxone, ampicillin and metronidazole, Evacuation of products including placenta if appropriate and possible. EZIO if shock and if venous access not possible. If safely stopped If bleeding continues and laparotomy needed for repair of ruptured uterus or emergency hysterectomy. EZIO if venous access not possible. Blood transfusion, Tranexamic acid, oxygen if available.
History of previous massive PPH >1.5 litres or more than one delivery where PPH >500 ml	2	
<i>Miscarriage</i>		
If bleeding continues, retained products, infection	1	Blood transfusion, misoprostol, evacuation of products (ideally by manual vacuum aspiration), triple intravenous antibiotics
If bleeding and infection continue despite management above	1	Blood transfusion, misoprostol, triple intravenous antibiotics, if shock EZIO if venous access not possible and oxygen if available.

Medical reason for evacuation	Triage category	Stabilisation including treatment needed before and during transfer
Ruptured ectopic pregnancy	1	Blood transfusion, autotransfusion IV if possible (ideally Haemafuse device), intraosseous needle into humerus (EZIO) if venous access not possible, oxygen if available.
<i>Severe growth restriction of the fetus and in the 3rd trimester</i>	2	
<i>Life threatening sepsis</i>		
Intrauterine fetal death present for more than 48 hours *Ideally confirmed with portable US scan	2 or 1 if vaginal delivery not possible	Misoprostol to induce labour if possible. IV antibiotics, destructive procedure if needed for vaginal delivery.
Prolonged rupture of membranes greater than 24 hours because of the risk of life-threatening infection to mother and unborn baby.	2	Misoprostol, oxytocin Intravenous antibiotics: Ceftriaxone, ampicillin and metronidazole
Intrauterine sepsis following premature rupture of membranes, intrauterine fetal death or severe sepsis post-delivery at any gestation.	1	Intravenous antibiotics: Ceftriaxone, ampicillin and metronidazole. If shock give oxygen if available. May need emptying products from the uterus.
<i>Pregnancy after 28 weeks' gestation in a child <17 years of age.</i>	2	
<i>Persistent transverse fetal lie after 36 weeks' gestation</i>	1	Consider short-acting tocolysis if available.
<i>Severe hypertension with a risk of cerebral haemorrhage. BP>160/110 mm Hg. and/or severe preeclampsia with risk of eclampsia and death. BP</i>	1	Intravenous hydralazine, oral methyldopa, Magnesium sulphate Misoprostol, IV oxytocin

Medical reason for evacuation	Triage category	Stabilisation including treatment needed before and during transfer
elevated >140/90 and > ++proteinuria and symptoms including, headaches and/or visual disturbance and/or epigastric pain.		
<i>Severe anaemia (Hb <7g/dl but >5g/dl).</i>	2	Intravenous iron infusion
<i>Very severe anaemia (Hb < 5g/dl) and in 3rd trimester</i>	1	Blood transfusion and Oxygen if available.
<i>Severe/extreme malnutrition (BMI < 16m/kg2).</i>	2	Enteral or oral tube feeding with high energy food. Blood transfusion if severe anaemia or if shocked. Oxygen if available.
<i>Burns</i>		
Severe burns (>20% full or partial thickness). Also depends on site of burns	1	Intravenous antibiotics: Ceftriaxone, ampicillin and metronidazole Intravenous and oral paracetamol. Ketamine for dressing changes Cling film for dressings plus appropriate sterile dressing materials/gauze
Burns of the face or neck threatening the upper airway	1	Airway management, oxygen if available,
<i>Severe trauma that could have a good outcome if advanced treatment only available outside Gaza is undertaken.</i>	1	Blood transfusion, airway management, EZIO if venous access not possible, Oxygen if available. IV paracetamol or opiate or ketamine if available, Tranexamic acid if bleeding

Medical reason for evacuation	Triage category	Stabilisation including treatment needed before and during transfer
Penetrating abdominal wounds and/or severe chest trauma.	1	Blood transfusion, Intravenous antibiotics: Ceftriaxone, ampicillin and metronidazole, Tranexamic acid, Intravenous paracetamol, opiate or ketamine as appropriate EZIO if venous access not possible
<i>Life threatening medical conditions</i>		
Malignancies (cancers) that could have a good outcome if diagnosed correctly and managed in a specialist hospital in another country.	2	Depends on severity and potential for treatment in an international setting.
<i>Chronic medical conditions</i> such as heart disease, diabetes mellitus, renal impairment, chronic liver disease.	1 or 2	Depends on severity and potential for treatment in an international setting.

- 2) **Main problems in *newborn infants* (< 4 weeks of age) likely to need transfer: decisions to be made by clinicians based on individual needs and possible medication to be given whilst awaiting and during transfer (click [here](#) to see link to MCAI handbook on neonatal emergency care)**

Medical reason for evacuation	Triage category	Treatment needed before and during transfer
<i>Premature birth and/or low birth weight infants</i> needing medical care to survive without long-term handicap . Above 28 weeks gestation, not needing intubation and ventilation, but with respiratory failure needing oxygen and possible nasal CPAP if breathing deteriorates.	1	Intravenous antibiotics; Ceftriaxone, ampicillin and metronidazole Additional inspired oxygen via nasal cannulae Nasogastric tube feeding with breast milk or appropriate formula milk Skin to skin care by mother or close relative to prevent hypothermia.
<i>Congenital abnormalities</i> that have a good long-term outcome following appropriate medical and/or surgical attention in a specialist international hospital. Includes some congenital heart disorders.	2	

Cyanotic congenital heart disorder	1	<p>If there is a possibility of transferring the baby to a facility with specialist cardiology care, the baby needs the arterial duct to be kept open while you arrange transfer.</p> <ul style="list-style-type: none"> • Do not give oxygen after a hyperoxia test, as it may precipitate ductal closure. • Start IV prostaglandin E (PGE) (if available) to maintain ductal patency. <p>Commence either prostaglandin E1 (PGE1) or prostaglandin E2 (PGE2) at 5 nanograms/kg/minute and increase in steps of 5 nanograms/kg/minute to a maintenance dose of 10 or 20 nanograms/kg/minute. Higher doses than this have been used but cause apnoea.</p> <ul style="list-style-type: none"> • PGE2 can be given orally as a maintenance dose of 40-50 micrograms per kg every 2 hours.
<i>Close monitoring and treatment for hypoglycaemia</i>	2	Blood testing for blood glucose levels whenever hypoglycaemia is suspected, for example when a baby has a fit.
<i>Close monitoring and treatment for severe jaundice</i>	2	Blood testing for blood glucose levels whenever severe jaundice is suspected and provision of sunlight to the uncovered baby.

- 3) **Main problems in children likely to need transfer: decisions to be made by clinicians based on individual needs and possible medication to be given whilst awaiting and during transfer (click here [\(book1\)](#) and here [\(book 2\)](#) to see links to two MCAI handbooks on paediatric emergency care)**

Medical reason for evacuation	Triage category	Medication needed before and during transfer
<i>Severe malnutrition (MUAC <115mm, oedema and weight for height < 3SD).</i>	1	<p>Enteral or tube feeding of high energy food appropriate for degree of malnutrition present (click here to see Handbook 1 pages 320-356 for details).</p> <p>Blood transfusion if severe anaemia (Hb < 5g/dl) or if shocked.</p> <p>Oxygen if available.</p>

		Intravenous antibiotics: Ceftriaxone, ampicillin and metronidazole
<i>Severe trauma that could have a good outcome if advanced treatment only available outside Gaza is undertaken.</i>	1	Blood transfusion, airway management, EZIO if venous access not possible, Oxygen if available. IV paracetamol or opiate or ketamine if available, Tranexamic acid if bleeding
Penetrating abdominal wounds and/or severe chest trauma.	1	Blood transfusion, airway management, EZIO if venous access not possible, Oxygen if available. IV paracetamol or opiate or ketamine if available, Tranexamic acid if bleeding. Intravenous antibiotics: Ceftriaxone, ampicillin and metronidazole
<i>Severe burns (>15% full or partial thickness).</i> Depends on site of burns Click here to Paediatric Handbook 1 pages 532-542	1	Intravenous antibiotics: Ceftriaxone, ampicillin and metronidazole Intravenous and oral paracetamol. Ketamine for dressing changes Cling film for dressings plus appropriate sterile dressing materials/gauze
Burns of the face or neck threatening the upper airway	1	Airway management, oxygen if available,
<i>Malignancies</i> that could have a good outcome if diagnosed correctly and managed in a specialist hospital in another country.	2	
<i>Chronic severe diarrhoea with dehydration not responding to local treatment.</i> (click here to see Paediatric Handbook One pages 381-385)	1 or 2	Resomal oral rehydration solution Oral or nasogastric tube feeding. IV fluids when safe and appropriate. If shocked EZIO if venous access not possible, Oxygen if available.
<i>Upper airway obstruction due to congenital abnormality.</i>	1	
<i>Severe anaemia (Hb <7g/dl).</i>	2	Intravenous iron infusion
<i>Very severe anaemia (Hb < 5g/dl)</i>	1	Blood transfusion and Oxygen if available. Appropriate nutrition by oral or tube feeding.
<i>Severe pneumonia, especially with empyema, not responding to local treatment.</i>	1	Intravenous antibiotics: Ceftriaxone, ampicillin, flucloxacillin. Oxygen if available
<i>Severe asthma</i>	1-2	Metered dose inhalers of salbutamol. Nebulisers for salbutamol or adrenaline. Oxygen if available

<i>Severe acute renal impairment</i> (Acute Glomerulonephritis and Nephrotic syndrome)	1-2	Steroids. Fluid management
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