

International Development Committee

Oral evidence: Humanitarian situation in Gaza, HC 110

Tuesday 27 February 2024

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Members present: Sarah Champion (Chair); Dr Rosena Allin-Khan; Mr Richard Bacon; Chris Law; Nigel Mills; David Mundell; Mr Virendra Sharma.

Questions 90 - 115

Witnesses

I: Dr Richard Brennan, Regional Emergency Director for Eastern Mediterranean Region, World Health Organization; Matthew Hollingworth, Country Director Palestine, World Food Programme.

Examination of witnesses

Witnesses: Dr Richard Brennan and Matthew Hollingworth.

Q90 Chair: I would like to start this evidence session of the International Development Select Committee on the humanitarian situation in Gaza. We are joined by two witnesses today, Dr Richard Brennan, who is the regional emergency director of the World Health Organization, and Matthew Hollingworth, who is the country director for the World Food Programme for Palestine. We were fortunate enough to meet both of you last week, when the Committee came out to Egypt and El-Arish to get firsthand testimony of exactly what the situation is in Gaza right now. Thank you so much.

Matt, I know that you drove 12 hours to get to see and speak to us, so we are very grateful for that. Richard, we have been seeing today that the World Health Organization has been putting footage out via the BBC inside hospitals. Can I say to both of you that we always had the deepest admiration for your organisations and your staff? The conditions that they are working in right now in Gaza are simply beyond—I do not have a polite enough word. They are just horrendous. Thank you to them for all that they do to try to support the people of Gaza right now. Could I ask you both to introduce yourselves and your organisations, and then tell us what you are actually doing in Gaza and when?

Matthew Hollingworth: My name is Matthew Hollingworth. I am the country director for the World Food Programme in the state of Palestine. I came out of Gaza last Monday late afternoon or early evening. I was there for a week prior to me going out to Egypt. Before that, because I am based in Jerusalem, I was here. Then I had been in Gaza before for 10 days a week earlier.

The World Food Programme in Gaza today is providing emergency food assistance and nutrition assistance to approximately 1.3 million to 1.4 million people each month. With the United Nations Relief and Works Agency for Palestine Refugees, we are the two largest organisations providing food assistance, in particular in the strip. We have an agreement in terms of our division of labour on whom we provide assistance to.

Dr Brennan: My name is Dr Rick Brennan. I am the regional emergency director for the World Health Organization in the eastern Mediterranean, based in Cairo. Our region covers 22 countries. We have some of the largest and most complex humanitarian emergencies in the world, from Gaza of course to Sudan currently, Somalia, Syria, Lebanon, Afghanistan, Yemen and so on. We always have our hands full and no more than today, with the two truly catastrophic crises in Gaza and Sudan. I am actually here in Doha for a two-day meeting on Afghanistan, which is another story altogether.



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My role with respect to Gaza is that I oversee what we call the WHO's technical and operational support for our response inside Gaza. I bring together the resources from right across the organisation to support our operation. I have spent only 48 hours inside Gaza since the start of the war and that was two weeks ago, but I am in daily contact with our team there. What I saw in my two days on the ground confirmed everything you have seen, thought and heard about the desperate situation in Gaza.

Like you, Madam Chair, we find it hard to come up with the appropriate adjectives. Like Matthew, I am a humanitarian veteran. I have been in this field for 31 years. I rarely use the term "catastrophic". We have been using it with respect to Gaza since November. I do not know what is after catastrophic. Ambassador Satterfield, at a meeting with us three weeks ago, described the situation as beyond catastrophic. We are all pushed to come up with words and descriptions that can really convey the gravity of the situation from the humanitarian, public health and other perspectives.

Chair: I do not want to know what comes beyond catastrophic, because I do not want us to get there.

Q91 **Chris Law:** I wanted to explore that a bit more. There will be many people watching this from outside this room as well as giving evidence here. When you say "catastrophic"—I know that both of you have been to many locations in different parts of the world—can you give some examples of what that looks like?

Matthew Hollingworth: I have worked for the World Food Programme now for 23 years. I have served in many of the countries that Rick mentioned: Afghanistan, Yemen, Syria, Sudan, South Sudan et cetera. I have seen firsthand what famine looks like. I have seen firsthand what starvation really means and what it does to communities.

The key issue today in Gaza is that it is 100% manmade. It is something that has happened in four months. I do not think that I have ever seen the speed at which the situation has deteriorated in the Gaza Strip. I worked in Gaza City 25 years ago. I was in Gaza City a week last Sunday and it looks nothing like it once did. 75% of it is destroyed. If it is not entirely destroyed, it is extraordinarily badly damaged. The roads, the tarmac, the water pipes and the sewage pipes are torn up.

There is rubbish rotting everywhere. There is a smell of death in buildings and from buildings. There is a stench of excrement in the air. It is dusty. It stinks and it is overpowering. It is where 300,000 people live, and are trapped and can hardly move. It is under bombardment every day. You wake up to the sound of drones and you go to sleep listening to the sound of drones. It is hell on earth, to be honest with you.

I have seen horrible situations around the world because of natural disasters. I have seen the terrible things that man can do to man and the impact of war, but what you see in Gaza is something that has happened so quickly and is so devastating. To most of the Gazans I have met, it is



so bewildering because it has been so destructive. One in 100 have died in this war. It is almost getting to the point of reports that 30,000 have been killed during this war, notwithstanding the 1,200 or more Israelis who were killed on 7 October.

With the sheer number of deaths and the toll on both communities, but in Gaza in particular, people are shattered. You meet walking zombies in Gaza because people just cannot believe the situation they are living in. We use the word "catastrophic" in the food security world to describe famine, where people not only miss meals but go days without eating. Their health deteriorates and, in relation to that hunger, the merest of illnesses can be fatal. That is the level of catastrophic hunger you are starting to see in places such as Gaza City.

This was forewarned in December when we completed the integrated phase classification survey. The experts from around the world made the case that, if we did not do something in terms of significant volumes consistently provided to people in that area, some 500,000 million people were at risk of starvation. We have not been able to respond consistently and with the volumes that it would take to ensure that food is there. "Catastrophic" is a difficult word to understand, but when you break it down scientifically it is very clear. People will die and have already started to die of hunger-related illnesses, including children, old people and the most vulnerable people who are already compromised with chronic illness. It is happening.

Q92 Chair: "Famine" is a technical term. I wonder whether you can describe what that looks like and when that definition comes in. I think that there are four stages before you get to famine. Can you talk us through that a little bit?

Matthew Hollingworth: We talk about levels of food insecurity in terms of stages, yes. By the time you are at famine-like conditions, risk of famine and famine itself, you are at catastrophic levels of food insecurity. I will send to you the last integrated phase classification survey, which explains where we were in December in terms of the understanding from the analysis at that time. We are starting, with august organisations such as the World Health Organization, the Food and Agriculture Organization, UNICEF and many more, to collect the data right now to update that survey, which will be out again in March.

Essentially, as I said, you start to talk about catastrophic food insecurity when people are missing days of food, where they are ill and sickness is caused because of that lack of nutrition. It is beyond the slow decline of health because of the slow decline in the amount of food available. It is when it is acute and beyond crisis levels. It is beyond emergency levels. That is indeed the situation that the 300,000 people living in Gaza City and the north, and around 200,000 more in the middle area and heading into the north, face today.

Q93 Chris Law: You have talked about the intensity and the fact that people



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are trapped and cannot get out, and you have never seen anything like this before. Often we hear that the operations in Gaza are precise and targeted towards Hamas. What is your experience from what you see on the ground? If I could follow up on that, have you seen acts that you would describe as clearly in breach of international humanitarian law?

Matthew Hollingworth: There is no question that there is 21st century weaponry in use that is extraordinarily precise, but there is also weaponry that has been in use for the last 200 years at least. That includes shellfire, mortars, bullets and grenades, which are anything but precise. There is no question that they are having an impact on the general citizenry of the Gaza Strip. While indeed there are precise weapons used, it is predominantly a blunt-force battlefield. That is the reality.

I have seen large numbers of civilians hit. One could argue, or it would be argued, that people are collateral and in the wrong place at the wrong time, but the bottom line is that the violence is everywhere. There is nowhere safe across the entirety of the Gaza Strip. It is a total war and that is what we are seeing. The entire population is frightened, jaded, scared and bewildered because of the level.

In terms of international humanitarian law, there is no question that it is being tested as much as it has ever been tested anywhere in the world in terms of what we can and cannot negotiate and how long it takes us to have access to people. It is not just the timeliness but also the ability for us to go and deliver where we must and demand to go and deliver. We are constantly frustrated because of a lack of co-ordination, i.e. a lack of approval to move into areas. We are frustrated because we frequently do not get the approvals when we need to get them.

I have talked to you face to face about the sheer crisis in terms of the law and order epidemic across the strip. If we do not receive clearances to go outside of hours when roads are congested and people are around, criminals opportunistically will take aid. It is Hobbesian in the Gaza Strip right now. It is a survival of the fittest situation because people are so desperate and the criminal gangs are starting to take over. We are approaching a point where it is almost at the level of anarchy in parts of the Gaza Strip. If you marry that with the fact that we do not get clearances when we need them and we are forced to wait with our convoys in areas without getting into places that are the most vulnerable, there is no question that international humanitarian law, as I said, is being tested to breaking point.

Q94 **Chris Law:** Rick, do you want to add to that, particularly on the issue of clearances? Has that become worse over the last four or five months in your experience as well?

Dr Brennan: By clearances, do you mean facilitation of missions?

Chris Law: Yes, exactly.



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Dr Brennan: We have had facilitated missions over the last week and a half to Al-Nasr Hospital and Al-Amal Hospital. In terms of access to the north, I have some data here on the 77 missions requested by the UN to the north between 1 January and 12 February. Of those, 12 were facilitated, three were partially facilitated, 39 were denied, 14 were impeded and nine were postponed.

If I may, you asked us to elaborate. Perhaps I can throw some figures and data behind our more qualitative description of the situation. As you are aware, 1.9 million have been forcibly displaced in a very small geographic area. Having been in this business for 31 years, I have never seen that level of displacement. The only thing that could come even remotely close in such a short period would be the Rohingya crisis and it was less than half that number.

Matthew mentioned that there have been almost 30,000 traumatic deaths since the start of the conflict. We estimate that 65% of those deaths are among women and children. That is the inverse of what you would expect in a normal war. It is indeed the inverse of what we saw in the conflicts in 2008 and 2014, where you would expect the majority of deaths to be of men of fighting age. Here, we have the majority of deaths among women and children. There are also close to 70,000 injuries, and these are not just broken bones. These are complex war injuries, such as penetrating injuries to the head and chest, spinal injuries, burns, amputations and multiple injuries.

That data has been questioned in several quarters because it comes from the Ministry of Health. It is important to point out that three different academic institutions have looked at the data and think that they are reasonable estimates. It has been validated.

Associated with that massive level of displacement of course comes the terrible overcrowding and lack of access to water and sanitation. We have established disease outbreaks of diarrhoea and hepatitis, and terrible soaring rates of skin infections and childhood infections such as chickenpox and so on. That situation could certainly worsen and we expect it to worsen.

Matt has talked about the food crisis. In northern Gaza, over 15.5% of kids under the age of two now are acutely malnourished. Prior to the conflict, less than 1% of kids under the age of five across Gaza were malnourished. We are starting to see the rates of acute malnutrition skyrocket.

In that context, with these soaring needs, we have seen this massive and acute degradation of the health system. Prior to the conflict, there were 36 public hospitals functional in Gaza. Today, there are 12 hospitals functioning, and they are only partially functioning. They are only minimally functioning. You can take Nasser Hospital, the second-biggest hospital, off the table right now, because its functioning has been



massively degraded following the siege of the last couple of weeks. Only seven of 23 UNRWA clinics are functioning.

In addition, two leading professors from the London School of Hygiene and Tropical Medicine and from Johns Hopkins University have just done some modelling and projections about potential death rates, based on scenarios of whether there is an escalation in the conflict, whether we have status quo or whether we have a ceasefire, and whether there are epidemics or not. In the worst-case scenario, they are talking about another 85,000 to 86,000 excess deaths due to trauma, untreated infectious diseases, untreated chronic diseases and so on over the next six months. That would be an issue that is unimaginable. That is something that we can prevent. All of those deaths would be preventable if the right political action was taken.

Q95 Chris Law: On that point on the data, you have talked about a worst-case scenario. Under an immediate ceasefire, what is the best-case scenario?

Dr Brennan: If there is an immediate ceasefire and no disease outbreaks, there would be about 6,500 excess deaths. If there is an immediate ceasefire and outbreaks, there would probably be around 11,500 excess deaths. If it is status quo, it is around 58,000 to 65,000 deaths.

Chair: That is pretty stark. Thank you.

Q96 Mr Sharma: Matt, is it safe for your organisation to operate in Gaza?

Matthew Hollingworth: As you know, we are currently trying to work through a temporary pause of deliveries into northern Gaza and Gaza City since my team last was able to get a convoy in, which was not this Monday but the Monday before, so a little bit more than a week ago. The reason we paused after those deliveries was twofold. First, on two consecutive days we took a convoy of 10 trucks of food to Gaza City. When we crossed into Gaza City, tens of thousands of people swarmed forward, desperately trying to get their hands on the assistance that we were bringing.

Because they came too close to the checkpoint, the tank opened fire on them, killing some and hitting my vehicle on the Sunday. That was because, again, they were just too close. Even with that situation, with a light machinegun firing in their direction, people still continued to run forward. I cannot imagine how hungry you must be, or how hungry or sick your family must be, for you to be willing to continue running in waves into machinegun fire for a box of food.

When you see the risks that people are willing to take just to get a bag of flour or a box of food, it behoves us to continue to try to support. We also have to take tough decisions to try to make sure that the people we serve are not put into further danger than they are already living in when



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we are providing them aid. That is the primary reason why we stopped deliveries to Gaza City.

The secondary reason why we stopped is that, on the second day, our teams came under at least five, if not six, waves of attempting violent looting by criminal gangs. They were tipped off that we were going to be trying to get assistance again into Gaza City. They beat up our drivers, threatened our people, smashed our trucks and indeed ended up stealing about 40% of what we desperately needed to get into Gaza City.

In answer to your question, it is not safe. It is a warzone. Frontlines are constantly changing. Battlefields are changing. There is use of rockets, missiles, mortars and shellfire. You add to that, as I said, an approaching anarchy-like situation. The state that existed has been degraded. There are no police on the streets to bring civil order. The ones who are on the street are the bullies who are opportunistically filling that space.

It is a concern. We do everything in our power to mitigate those concerns. We use armoured vehicles to move around. We negotiate and notify everywhere we are going, and we maintain communication internally, although that is frequently difficult because a lot of communication equipment is not allowed into the strip. It is not the safest place to be, but we are fully aware of that and put every measure in place to operate safely. Like I have said already, there is nowhere completely safe inside the Gaza Strip today.

Dr Brennan: Matthew has described it extremely well. I will maybe, again, put some data to it. There have been over 150 UN staff killed since the start of the conflict, including a WHO staff member, a 27-year-old national staff member who was running our limb reconstruction project. She was killed together with her six-month-old son, her husband and around 50 members of her family. They were taking shelter in her father's house and had been displaced. In addition, there have been over 120 journalists killed. Philippe Lazzarini from UNRWA has come out saying that there have been more UN staff, journalists and medical personnel killed in this conflict in the last four or five months than any other since the UN was founded.

Q97 **Dr Allin-Khan:** Hi, Rick. Hi, Matt. It is lovely to see you again. I wanted to come in on Virendra's question. Rick, can you describe how the WHO member, her six-month-old and her family died please?

Dr Brennan: She and her husband and infant were displaced from northern Gaza. She took refuge in the home of her father, together with around 50 members of the extended family. As I understand it, that home was struck in an aerial attack and 51 members of one family were killed.

There are numerous examples that are similar. When I was in Gaza the other day, one of our drivers told me of three of his siblings who had been killed together with their entire families, including their spouses and



kids. That was 19 killed from his family in separate attacks. He has established a tented facility next to the main WHO house in southern Gaza, where he is now accommodating 47 of his extended family. As I understand it, he is one of only one or two in the entire family who have gainful employment right now, so he is providing that type of accommodation. There are numerous examples of entire families being killed during the conflict.

Q98 Mr Sharma: Matt, you mentioned the food situation in Gaza and that it is very close already to the stage of famine in that area. You also said that you were there about 25 years ago. How would you compare then, the situation of people's own food and vegetables growing, and now? In addition to this, is there any food being produced in Gaza at this stage?

Matthew Hollingworth: Prior to this crisis, Gaza was a very significant producer of its own food, including fresh vegetables, fresh fruit, chicken meat and eggs. There were issues in Gaza that were poverty-related in terms of food insecurity, but in production and food availability it was doing well. You have seen a very significant deterioration in the amount of land that is available and safe to farm. There is a harvest that has been lost, animals that have been killed and fodder that is no longer available to animals, which either are being killed because they cannot be fed or have already perished.

The food-producing capacity of the Gaza Strip has been decimated. When it comes to cattle, sheep, goats and chicken, replacing them and rebuilding that stock will take many years. When you look at their ability now to produce the food they need, it is absolutely severely curtailed. They are, to a greater extent, entirely dependent on aid in kind because of the lack of significant amounts of local production.

In areas where there has not been such active ground fighting, you see areas where the greenhouses still stand and the fresh vegetables—tomatoes and cucumbers—are still grown and are available, but it is in those areas that have yet to be included in the ground warfare, so that can change. We hope that it does not. We hope, for example, that the Rafah incursion does not take place. For example, in Rafah, a lot of the fresh vegetables that are available are still grown in those greenhouses. It is not the same elsewhere.

At the time I was in Gaza City, spices were for sale because they still had them in stock. People were not buying those. Some dried nuts were for sale. Citrus fruit was for sale because some of the citrus farms were still accessible. There was very little else and certainly no mainstays of diet. There was no wheat flour, bread, lentils or rice. There was very little. It is shocking when you refer back to what markets looked like five months ago.

Q99 Chair: Matt, to try to give some context to this, the Committee went up to El-Arish and met the amazing volunteers of the Egyptian Red Crescent who are co-ordinating all the aid getting in. They were phenomenal. On



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17 February, only four truckloads of aid got in. From what we can understand, that was because of all the red tape that the Israeli Government are putting around goods getting in and out. Where the World Food Programme has worked in hunger situations around the world, thinking of, for example, a refugee camp—I know trucks are not an ideal metric, but they are the only one I have—what numbers of trucks would you see in a similar food shortage situation going into a refugee camp in the past? That is just for us to get an idea of whether four is adequate or not.

Matthew Hollingworth: We need to be seeing 500 trucks going into Gaza at the moment to make a difference.

Q100 **Chair:** Is that per day?

Matthew Hollingworth: Yes. You are talking about food needs, water, sanitation and hygiene needs, shelter needs, medicine needs and other health materials. Those are the four critical areas that we know must be switched on in terms of the delivery if we are going to make a big difference to people's lives right now. We need to be seeing 60 trucks going into Gaza City alone every single day.

The original plans called for UNRWA and WFP to be sending 30 trucks each per day over a month in order to, essentially, make a change to the food situation, and that is just Gaza City. We are seeing a drop in the ocean. A lot of that is down to the violence in the corridor between Nitzana and Kerem Shalom and the Rafah gate. It is down to some protests we have seen. Today the gates are not open because there is an election in Israel and everything is off for the day.

We need a vast increase in the amount of assistance going in. To do that, we also need to see other corridors. It is crazy at this moment that we only have a southern corridor to bring humanitarian materials and commercial materials into Gaza Strip. We need other entry points for both aid and trade to enter Gaza if we are going to see markets improve. If you look at the price of flour today in Rafah, it is 979% higher than it was pre-crisis. Vegetable oil is 198% higher. Salt is 467% higher. Rafah, in comparison to Deir Al-Balah, Nuseirat, Khan Yunis and certainly Gaza City, at least is next to the crossing where assistance and trade comes through. It is far worse in Gaza City.

We need a much greater number of trucks coming in, but I would challenge and say that we need a much greater number coming in of both aid and trade. We need them coming in from multiple directions because, again, to get to Gaza City in the north from Rafah is extraordinarily difficult. It can be made easier. It is all about a political decision to enable it.

Q101 **Chair:** Why is it difficult?

Matthew Hollingworth: At the moment, the politics in Israel post 7 October are such that there is a strong view from the population that aid



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should not go directly from Israel into the Gaza Strip. Hence all aid is going from Egypt, either to Kerem Shalom or through Nitzana, in order to then end up in the Rafah crossing and enter the Gaza Strip.

Q102 **Dr Allin-Khan:** A lot of what I was going to ask has been covered, so I will tailor my questions slightly to get some further information. Matt, would it be fair to say that Israel is prohibiting food getting into Gaza?

Matthew Hollingworth: We need to see more food getting in. If it is a question of Israel stopping all food going in, it is not. Are we seeing enough going in? Are we seeing every opportunity used for assistance to go in, including food? Are we seeing every corridor and entry point being open to enable food to go in? The answer is no to all those questions. We need to see more. We need to see it consistently going in and at every single possible entry point if we are going to turn this crisis around. That is a political decision. It is for Israel to assist in allowing us to have that access.

Q103 **Dr Allin-Khan:** As you stated to us in Egypt and have said already today, if I may paraphrase—please feel free to correct me—you have made that case to Israel and it has not been forthcoming to allow the proportion of food in that is required to feed people in the Gaza Strip.

Matthew Hollingworth: We need a lot more to get in, particularly to the north, if we are going to stop a famine in its tracks. Right now, we are not able to do that.

Q104 **Dr Allin-Khan:** You have made that case.

Matthew Hollingworth: Yes, absolutely, and I continue to make it publicly every day.

Q105 **Dr Allin-Khan:** You do it very well. Thank you. Rick, I know that in Egypt we spoke about—and you have again today very articulately spoken about—the impact of the ongoing crisis and the number of excess deaths. For the benefit of those who did not have three hours of your company, can you talk a bit more about those with chronic or ongoing conditions, such as cancer or diabetes, or those who require dialysis, things that would ordinarily be quite easy to come by when Gaza was operating, even though not in the full capacity that we would enjoy? Can you talk a little bit about that?

Dr Brennan: It is important to note that, prior to the conflict, Gaza, with all the constraints that it existed under with, essentially, the blockade, actually had a pretty good health system and pretty good health outcomes. If you look at the 22 countries across our region, when you look at the main health indicators it was probably pretty middle range. Given the circumstances, it did quite well and had a solid response to the Covid pandemic, for example. The major cause of death in Gaza prior to the conflict was exactly what you were saying, the chronic diseases: heart disease, strokes, diabetes, cancer and so on.



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This major disruption to the functioning of the health system puts people who have been treated for chronic diseases at enormous risk of complications and death from those diseases, particularly the dialysis and cancer patients. We have not been able to put together a comprehensive enough strategy to target those people, because they are on the move. Clinics are working one day and then they are not the next day. Hospitals are not functioning and so on. It absolutely vital, as you say, that we keep those truly life-saving interventions for chronic disease going.

Dialysis is an example. I was in Al-Najjar Hospital the other day, where it has a dialysis unit. That dialysis unit was working 24 hours a day. Unfortunately, most patients could only get a two-hour session twice a week. To put that into perspective, my brother-in-law, who has had four kidney transplants and is back on kidney dialysis, gets very sick if he does not get his three treatments for four hours a week. We went into that dialysis centre. It is absolutely heroic what those doctors are doing, but we know that people are dying. We do not have good data. We know that people are dying because they do not have adequate access to the dialysis, insulin or their cancer treatment.

Up in Al-Shifa Hospital, which has been in the news a lot, in northern Gaza, one of the main departments of the hospital that somehow they have been able to keep going is dialysis, but we have not been able to get supplies up there recently. This modelling that Johns Hopkins University and the London School of Hygiene and Tropical Medicine are doing is trying to work out how many people will die from untreated diabetes, high blood pressure and a lack of cancer care.

With a number of partners—WHO has not taken a lead on this, but we have been able to facilitate it—we have evacuated several hundred cancer patients. They have gone to countries such as Türkiye, Egypt and Emirates. It is a very difficult situation to get those types of treatments to people with chronic diseases at this stage. We know that people are dying because of the lack of that treatment.

Q106 Dr Allin-Khan: As well as hearing from and meeting with you, we met with many others in Egypt who are working as heads of other NGOs. They spoke of the fact that there are now a tiny fraction of hospitals and medical centres working in comparison to previously. Rick, can I ask you, very honestly, whether you have seen and heard accounts of hospitals and healthcare facilities being targeted?

Dr Brennan: We have heard numerous report of military action that has impacted hospitals and clinics, absolutely. For example, our team was in Al-Amal Hospital just a couple of days ago. Over the few days before they entered, the hospital was hit approximately eight times by military fire. When they went to Al-Nasr Hospital—you may have seen some of the videos—there was extensive destruction. There are other examples online of hospitals and other health facilities being struck.



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WHO has documented over 380 attacks on hospitals, clinics and healthcare more generally in Gaza. For example, when the team visited Al-Amal Hospital the other day, none of the ambulances was functioning due to a combination of damage, lack of fuel and maintenance, and so on. There is this massive degradation of the health system.

If you look at the number of hospitals functioning, most of the main hospitals prior to the war were in northern Gaza and the middle region of Gaza. In southern Gaza, in Rafah, there were only three public hospitals functioning. Together, they had about 200 beds. This is where we know now that over a million people have been displaced and where the next military offensive by the IDF is being planned. You have three hospitals with around 200 beds together.

There have been two field hospitals established, one by the Emiratis, with about 200 beds, and one by International Medical Corps, with about 100 beds. Prior to the war, Al-Najjar Hospital had 65 beds. Right now, it has 300 beds. It is completely overwhelmed. I really do not think that I have seen a situation like that and I know that it is not the worst hospital.

When we visited Al-Najjar Hospital in Rafah and the IMC hospital in Rafah, they were preparing for the expected military offensive into Rafah. They were doing two things. One was that they were planning to refer their patients out to other facilities. I have just told you that, prior to the conflict, there were only three hospitals in Rafah. They have to find other places for these patients to go and there are only 12 hospitals partially functioning across the whole area. They are just going to try. They will probably discharge patients too early. They will end up overloading other hospitals because they are going to be in the firing line if this offensive starts.

Secondly, they are also looking at relocating to other areas of Rafah, further west in Muwasi or perhaps a little bit north of that. If they have to discharge patients and transfer them, those patients will clearly suffer. Whatever existing hospitals continue to function will be even further overwhelmed. If they then try to relocate, they will be out of action for another three or four days in the middle of a military offensive where we know that trauma cases will soar. It is absolutely a desperate situation.

I would add another point that I think is important for this Committee to be aware of. I am conscious that time is almost up. UNRWA was the largest provider of healthcare across Gaza and, I know, also an important partner with WFP. Matt knows UNRWA well. Every humanitarian agency is gravely concerned about the defunding of UNRWA. We have to be honest. We are the second biggest actor in health in Gaza. There is no chance that we will be able to compensate for gaps left by the defunding of UNRWA. We have already grappled to find the right words to describe the humanitarian situation in Gaza. If UNRWA is taken out of action, God help us all.



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Perhaps the final point I might make is that, like Matt, I want to acknowledge the suffering that the Israeli people went through on 7 October. Nothing that we have said today diminishes that suffering, but it is very important that you understand the gravity of the situation right now and how we are in a downward spiral that, if we make the right choices, we can avert.

Q107 Dr Allin-Khan: I absolutely note your point about 7 October. That is a sentiment that we all absolutely share. That is always on the record and thank you for re-establishing that fact again today for the second time. I know that Matt said it already.

I have a couple more questions. I will try to be brief. We have heard about journalists who have been killed. It is a disproportionate number of journalists compared to any other conflict. We have heard about the over 150 UN staff who have been killed. We have heard about the disproportionate number of medical staff who have been killed. You have lost some of your own. I know that, Rick. Are either of you aware of targeted attacks on healthcare workers?

Dr Brennan: At WHO we have our surveillance system for attacks on healthcare. We have documented over 380 attacks on healthcare. It is not within our mandate or our level of expertise to say whether a specific attack is targeted or to determine who the perpetrator is. What we can tell you is that the attacks occur. It is not our mandate to apportion blame or to determine whether it is a deliberate event.

Q108 Dr Allin-Khan: That is absolutely understood. How does it compare to other areas that you, as WHO, have worked in?

Dr Brennan: It is largely out of proportion. In the early stages of the Ukraine crisis, there were a lot of attacks on healthcare as well, but nothing in my direct experiences compares with this in terms of the scale of attacks in the period of time. I can get you that data to share with you the proportion of attacks that WHO has documented. Of the 15 or 16 countries in which we have this system operating, I know that a significantly disproportionate percentage is occurring in the Occupied Palestinian Territories. I might add that, over the last few months, we have also documented over 300 attacks on healthcare in the West Bank. Again, during the attacks on 7 October, there were attacks on healthcare inside Israel by Hamas, as well as deaths during that assault.

Q109 Dr Allin-Khan: Matt, when we were in Egypt, you described something that I have not been able to stop thinking about. Though difficult, would you mind telling us again about your experience in Gaza of watching people die in front of you and what that looked like?

Matthew Hollingworth: The events that I described are the events of the first convoy that I was on and that managed to succeed in getting into Gaza, which was on Sunday 18 February. That is when tens of thousands of people just swarmed our trucks. I was in the last vehicle. People were jumping on to trucks and throwing boxes down. People were



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catching them and running. They were weak and people were falling over. They could not carry the boxes of food, each of which weighed 26 kilos. It is astonishing to see. It is astonishing when it is literally tens of thousands of people who are suddenly appearing out of ruined buildings and rubble.

Because they were so close—they were coming right into the area around the Israeli frontlines and their checkpoint—the tank fired at them. One man was cut down right in front of me, with a bullet wound to the abdomen, and one suffered a chest wound and died immediately. They were within arm's reach. What was frightening is that people stepped over them, picked up the boxes that they had held and took them. At this stage, death and desperation are so normal in so many places, which is a frightening thought for anybody in the world. It is not normal. It is abnormal. It is horrifying. Those poor people will be mourned by their families, but, in the hurry to get aid to family members, to friends and for themselves, people just carried on. What I find strange is just that carrying on and that normalcy around something that is so horrifying and abnormal.

I hasten to add that it is very important that we now have systems in place. We have spent a lot of time talking with the Israeli Defence Forces and with the people in that area to establish a means to deliver, so that people do not panic, do not think that the trucks are going away and do not run forward into a frontline area to get aid. They know that there is a safe area where we will drop the assistance and that they can go to safely. We have now spent a week putting that into place and, as soon as we are absolutely confident that that will work, we will start delivering again to Gaza City.

I am very sorry, but I have to go. It has been a real pleasure and honour to give evidence before you today.

Chair: We are incredibly grateful that you made this time for us and that you met with us last week as well. Please express our huge gratitude to all of your staff and all of your volunteers, who are doing an amazing job in, quite simply, untenable circumstances. You have paid tribute to them, and you have also given us the testimony that, hopefully, we can use to try to get this awful situation to stop and to keep them safe, as well as the people of Gaza. Thank you very much, Matt. We really appreciate it.

Matthew Hollingworth: Thank you. God bless. Goodbye.

Dr Brennan: Since 7 October, WHO has this surveillance system on attacks on healthcare functioning in around 16 countries. I do not have the exact number in front of me. Since 7 October, we have documented 977 attacks on healthcare, of which 780, or 80%, have occurred in the Occupied Palestinian Territories. That includes Gaza and the West Bank.

A lot is said about the use of hospitals and medical facilities by Hamas for military purposes, and WHO has documented militarisation of health



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facilitates. Our big concern is the way in which that finding is being managed. If a health facility is being used for military purposes and is still maintaining its lifesaving functions, there are very clear principles guiding military engagement with that facility under international humanitarian law. Those principles are proportionality, precaution and distinction.

We have very significant concerns that those principles are not being consistently applied when health facilities that have allegedly been militarised are being addressed. If a medical facility is being used for military purposes, for whatever reason, it does not mean that it is open to direct attack. There are principles that guide engagement in that context, and we have very serious concerns about how that engagement has been managed in a number of instances.

Q110 David Mundell: Rick, you set out the tragic circumstances in which one of your employees was killed. Matt described a horrific situation that he was involved in. What is the wider day-to-day impact on people and on your staff of the situation that they find themselves in?

Dr Brennan: Staff have been devastated. Their losses are enormous. They have lost their homes. They have lost their livelihoods. They have lost their loved ones. They have lost their incomes. When I was in Gaza a couple of weeks ago, I met with our national staff. As you could well imagine, it was incredibly emotional. One of the staff broke down crying. Out of all those losses, what she highlighted was the loss of dignity. Gazans feel that they have been dehumanised and forgotten. They feel that international humanitarian law is not being applied to them. They feel that the world is dealing with them with double standards.

Because of those losses, I would have to say that a significant proportion of our staff are certainly not nearly as functional in their day-to-day work as they might be. All of them have been displaced more than once. I do not think that any of them have their homes to go back to. Their day-to-day existence is about sometimes being on the move, trying to find food, trying to find shelter, and trying to find safety for their staff.

As WHO and other UN agencies, we have found shelter for them. We have found some accommodation. Because they have an income, they have broader responsibilities for their extended families. I mentioned earlier the driver who is accommodating 47 of his family. There is no doubt that some of them have such mental health problems, with reactive depression and anxiety, that they are not as functional. They are not able to care for their families as much.

In addition to all of those losses, there is the constant bombardment. There is the constant fear. While I was there, I spent most of the time in central and western Rafah. Most of the attacks were in eastern Rafah and Khan Yunis. I heard frequent shelling, and everyone was saying, "It is a quiet day". None of the shells was near us. People are living in that fear, day in and day out. The accumulated stresses are hard for us to describe.



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I have not spoken to one staff member who would not leave Gaza if they were given the opportunity.

Q111 David Mundell: In terms of the structure of how you can operate in those circumstances, how are instructions given out? How does it work on a day-to-day basis? Do people follow their own initiative in terms of, "What will I do in these circumstances?" or are they reporting to a central point? How does it operate in the midst of such a chaotic environment?

Dr Brennan: The UN and NGO partners have set up what is called a joint operations centre in Rafah. All of the UN and most NGO partners gather there in the morning and get a joint update. WHO, like other partners, has a clear plan. We know what our objectives are. We have four main objectives in that plan. Each day, staff within our organisation have specific tasks to deliver on that plan: to ensure the delivery of health services, to ensure that we have a supply line working for the drugs, to set up surveillance to detect and prevent the spread of infectious diseases. We also play a vital co-ordination role within the sector.

The team is structured. We use a best practice for emergency management called the incident management system. We have structured our team around that, so that everyone has a particular function and is working on various elements of the plan. We have the trauma experts working on that. We have the infectious disease experts working on that. We have the co-ordination experts working on that.

It sounds a lot crisper and better organised than it is. Of course, it is a chaotic environment. Our international staff are leading and co-ordinating this, and are being very understanding when the national staff are not able to deliver on a given day, for example. It is as structured and as co-ordinated as it can be, but, as you can imagine, it is an incredibly difficult operating environment.

David Mundell: As other Committee members have said, we are very grateful for and respectful of what people on the ground are doing. If there is any opportunity to convey that, please do so.

Dr Brennan: Thank you very much.

Q112 Mr Bacon: You mentioned a littler earlier the wider situation, including in the West Bank. To what extent has this crisis impacted your ability to deliver in the wider area? We were in the West Bank 15 months ago and met UNRWA, which has now been defunded. Could you say a bit more about the wider area and particularly the West Bank?

Dr Brennan: We have operations in the West Bank. We still try to maintain our support there for similar types of activities: the delivery of health services, the delivery of supplies, disease surveillance and control, as well as that important co-ordination function. We have limited resources. We have multiple crises to which we are responding across our region. There are gaps in what we are able to do in the West Bank right now. In fact, as soon as I get off this call, I have a call with our country



representative in Lebanon. The situation is now escalating there, as you might know, with the first aerial attacks north of Beirut.

We are very concerned about the wider fallout. There are political and security implications, not only for Lebanon but certainly for Syria, for Yemen, as we have all seen with the attacks on commercial shipping in the Red Sea, and in Jordan and Iraq. When we do our weekly update, we get updates from all those countries calling in to give us information about the implications of what is happening in Gaza for their countries. We are watching this very closely. We are doing contingency planning right across the region for all of those countries. It is an increasingly tense situation across the region, particularly for those countries.

Q113 Mr Bacon: To what extent does what has happened to UNRWA make things more difficult for you? We heard, both in Egypt last week and also in the West Bank 15 months ago, from some of your UN colleagues that UNRWA does things that other agencies do not do and, in fact, it is, in some ways, more akin to a Government. It collects the rubbish. It provides schools as well as hospitals. If you defund—for reasons that are widely talked about and understood—what is, in effect, a Government of the area, in some ways, how does that affect you as WHO in delivering your services?

Dr Brennan: UNRWA has 13,000 staff in Gaza. WHO has 30. Of course, those 13,000 UNRWA staff are not just health staff, but, as you rightly say, they run multiple clinics; they run education and schools. They are running shelters and setting up health posts right now for people who have been displaced. They are the biggest healthcare provider in Gaza.

If all of their clinics closed tomorrow—and we know that over two-thirds of them are not functioning right now—we do not have the capacity to step in and compensate for those gaps. Even after the war, if there is no UNRWA to run those vital social services, it is hard to imagine WHO or other agencies being able to step up and fill the gap. Therefore, there would be substantial and sustained gaps in healthcare, education, garbage removal—as you say—and so on for the foreseeable future. It would be a long-term crisis.

Q114 Chair: Thank you for explaining what UNRWA does. This Committee has seen its operations in many countries. We have always been incredibly impressed with the services that it provides, and it pains me very deeply that we have also seen it, for many years, being used as a political football. It concerns me that, of the nine principal donors and the EU, two, including the UK, have paused their funding. I do not know if the allegations against the UNRWA staff have been proven one way or the other, but has WHO seen an impact on the ground from that pause in funding, or is it the conflict and destruction that has caused the main impact on the services that you are describing?



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Dr Brennan: It is really the conflict, the disruption of supply lines and so on. At this stage, I cannot say that we have seen an impact. We will start to see that at the end of March, until when UNRWA has funding.

Just to pick up on a point made earlier about the impact on staff, we have about 14 UNRWA staff who have been displaced from Gaza working in our office in Cairo. The chief of health there is in daily contact with her UNRWA colleagues on the ground who are delivering these vital health services. She said that it is extremely difficult to ask them each day about their activities and what they have been able to achieve, because they are fighting for the survival of their own families, let alone taking responsibility for the delivery of health services to others.

Like you, I have been to UNRWA facilities. It really does heroic work. As I mentioned before, the health outcomes in Gaza prior to the war were very impressive, given the circumstances. UNRWA can take a lot of credit for that. In any large organisation, you are always going to have people who do the wrong things and maybe do very bad things, but the whole UNRWA organisation should not be tainted because of that. It pains all of us to see the way in which it is used as a political football and to see these threats of defunding. It will have disastrous effects for all of us.

Q115 **Chair:** I share your picture of a future without UNRWA, and we just have to try to hope that that does not happen. I know that we are eating into your time, but could I ask you one more question? You have touched on it, but, very early on, we heard the concerns about the lack of water in Gaza, which has only got a lot worse. Matt was describing open sewage, but also just the lack of water and the consequences of that on health. Could you describe the situation in relation to water, what that does to a human and what the bare minimums are that we ought to be advocating for in order to keep people alive? One wishes that we could advocate for them to have dignity, but I do not think that that is coming in the very near future.

Dr Brennan: A minimum standard of clean water would be three litres per person per day. We estimate that, right now in Gaza, it is 1.8 litres per person per day. People are probably getting six to seven litres in total, including unclean water. The minimum standard is 15 litres of water per person per day, not only for drinking but for cooking and for personal hygiene, and so we are well below international standards.

To paint a picture of what it is like in the settlements where people are, water, sanitation and living space are absolutely vital. There are established international minimum standards for all of these things: food, water, shelter, sanitation and healthcare. We are nowhere close to meeting international standards for any of those.

An important example is sanitation, where, in some UNRWA shelters, they estimate that there is one latrine per 400 to 500 people. The minimum standard is one per 20 people. Imagine if you had to share one latrine with 20 people, let alone with 400 to 500 people. It is a huge



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health risk. There is open defecation in a lot of these places. Matt mentioned earlier the smell of excrement. There is a huge public health risk. There was an article in the *New York Times* in the last couple of days about this. It is the indignity of it all: the indignity of having to defecate in an open space, of trying to find somewhere, or of going at night.

That puts young girls at risk in the darkly lit collective centre, with so much overcrowding. If a young girl is menstruating or wants to defecate, where does she go? That puts her at greater risk of sexual abuse and gender based violence, which is an issue that we have hardly touched on. It always happens. It has to be happening. If you are a father or a mother trying to protect your young daughter in these kinds of circumstances, you have to be so vigilant in this sort of situation. It is these practical, day-to-day things—going out to collect water or to go to the bathroom—that are now at-risk activities for young girls and, indeed, for the whole population.

Chair: Rick, thank you. We have heard you. We are intensely grateful that you have come and shared this with us today. I hope that the Israeli politicians also hear this and hear what life is like for civilians. If it is a war, it is meant to be against soldiers or against terrorists, not against civilians. I cannot speak about the utter inhumanity of what is happening to civilians and stay civil. Thank you for sharing with us. We aim to get a report out on all of this by the end of the week, because the UK Government can and must do more, and the Israeli Government can and absolutely must do more to protect civilians in this situation. Thank you so much for your time.