MCAI Maternal & Childhealth Advocacy International

Address:
1 Columba Court,
Laide, Scotland, UK IV222NL
Email: director@mcai.org.uk
Website: https://www.mcai.org.uk/

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Re: Call for urgent scheme for donor countries to provide large scale medical evacuations from Gaza

To the following Foreign Ministries:

We act on behalf of Maternal & Child health Advocacy International (‘**MCAI**’), an international medical charity based in Scotland. We have been trying since November 2023 to support the establishment of a large-scale medical evacuation scheme for vulnerable and at-risk patients in Gaza in need of critical care. This is all the more important now, as the situation in Gaza for civilians has significantly worsened since we began this campaign. The country is currently (and will continue to be) uninhabitable, especially for babies and children who are injured or suffering from injuries and complex medical conditions, and for women or adolescent girls who are pregnant with dangerous complications that, during labour or delivery, could be fatal for them and/or their unborn babies.

MCAI has engaged with key stakeholders to assess how to aid the most vulnerable patients in Gaza. There is already a process in place to identify patients for evacuations and approve them with both the West Bank and the Israeli authorities. Unfortunately, this process operates on an ad-hoc basis, involves small numbers compared with the vast need, and is far too slow to be fit for purpose, taking weeks to obtain agreement to transfer patients who – due to the critical nature of their illness or injuries - require treatment within days.

In the first year of this terrible and worsening conflict, we encountered resistance to medical evacuation from some humanitarian organisations which considered that evacuations could be seen as assisting an agenda of ethnic cleansing.

However, for the following reasons we cannot see any alternative to large scale medical evacuations as the only effective way to address the vast numbers of patients existing in Gaza who continue to be terrorised, damaged for life, or killed.

Firstly, while MCAI acknowledges that, ordinarily as recommended by the WHO, patients during emergencies, including armed conflict, should be treated as close to home as possible, it is clear that in the prevailing circumstances there is nothing in the WHO’s policy or practice arguing against international medical evacuations from Gaza. To the contrary, given the unprecedented humanitarian situation in Gaza, the WHO has itself appropriately supported medical evacuations beyond the region. For example, the WHO facilitated the evacuation of patients to countries including 15 to Spain (in July 2024), >100 to Romania (in November 2024), 29 children to Jordan and 8 children to Ireland in 2025. Additionally, the WHO - following medical evacuation of 85 patients to Abu Dhabi - has repeatedly called on the international community *‘to intensify efforts to ensure safe, sustained, timely, and organized medical evacuations.’* In July 2024, following the medical evacuation (reported above) of 15 children to Spain, Dr Tedros Adhanom Ghebreyesus, WHO Director General, stated ‘*[w]e encourage other countries who have the capacity and medical facilities to welcome people who, through no fault of their own, are caught in the grips of **this** war.”*

Secondly, a widely held view that *‘countries in the region have the capacity to provide the specialist care that is required for these complex cases’* is unfounded. In relation to Egypt, for example, in May and November 2024, Human Rights Watch (‘HRW’) warned of the *‘strain’* on that country’s healthcare system caused by the (limited) number of evacuations from Gaza, stating that the wider international community must step-up. On

that basis, HRW has also repeatedly called on third countries, including countries outside the region such as Sweden, to accept patients from Gaza. Similarly, the European Union ('**EU**') has urged Member States to evacuate patients from Gaza and called for *'a coordinated effort involving the international community, including European countries, to provide the necessary logistic, medical and financial support'*. If countries in the region had the capacity and expertise to care for the tens of thousands in need of medical evacuation, such calls for international evacuations (which, as outlined above, have also been issued by the WHO) would be unnecessary.

Thirdly, the concept that humanitarian efforts located within Gaza can better assist pregnant mothers and injured or ill children in Gaza through development of appropriate medical facilities, drugs, supplies and equipment continues to be opposed by the Israeli Government. It is abundantly clear that foreign aid to provide essential healthcare on the ground in this particular armed conflict is not the answer.

Conditions for the provision of medical aid are intolerable as indiscriminate violence continues. There are, in the words of the United Nations Population Fund ('**UNFPA**') '*repeated, egregious attacks on healthcare facilities'* which '*cause death and injury and deprive women of their essential right to access reproductive healthcare.'* Women in particular '*have lost access to essential health services, including emergency obstetric care, prenatal check-ups, and safe delivery facilities, contributing to a drastic increase in pregnancy-related complications and maternal deaths.'*

As one of many examples of the above, the WHO and the United Nations Office for the Coordination of Humanitarian Affairs ('**UNOCHA**') raised serious concerns about the raid on Kamal Adwan Hospital in northern Gaza, already *'overflowing with close to 200 patients – a constant stream of horrific trauma cases'.* The staff reported to be *'completely overwhelmed'* and '*also very much under-equipped to deal with that*.'

The above is one of the many illustrations of the scale of the crisis. As UNOCHA warned *'the humanitarian crisis in North Gaza is rapidly worsening, with humanitarian essentials in extremely short supply. Moreover, the vast majority of attempts to deliver critical assistance continue to be denied or impeded by the Israeli Government*.'

These immense challenges, making sustained provision of essential care impossible, are acknowledged by those brave humanitarian agencies that are trying to treat within Gaza the massive numbers of ill and injured patients. For example, the UK humanitarian organisation UK Med confirmed prior to the winter beginning in 2024 that '*The few remaining hospitals in Gaza can only offer limited maternity, trauma and emergency care services and the humanitarian need is catastrophic*.' The humanitarian crisis is '*set to worsen'* during the winter. As UK-Med's CEO and team lead in Gaza, David Wightwick, stated:
'The situation is increasingly dire; simply put, we are running out of hospitals. Many thousands of people are living in terrible, cramped conditions. As the medical capacity continues to reduce – the need for vital, lifesaving medical support continues to rise. We are doing everything we can to increase our ability to help in any way we can. We are seeing many trauma cases and increased levels of malnutrition. We desperately need more medicine and other supplies like food and fuel.'
and
'The demand on these field hospitals is immense as they transition from relieving main hospitals to becoming the primary care providers themselves. Medicine stocks, food, and fuel are critically low.'

It is clear from UK Med that provision of treatment on the ground cannot meet the needs of the Gazan population, including the most vulnerable women and children.

Fourthly, the reliance on the possibility that residents of Gaza can simply apply for visas to get medical treatment within, for example the UK, is misplaced. There is no route under the UK Immigration Rules specifically designed for potential medical evacuees, nor is there any provision for applications under routes that might otherwise be available to be suitably expedited. Furthermore, this option does not ensure continued

access to medical assistance and care for patients upon arrival in the UK, nor does it address the logistical and practical considerations involved in securely transporting patients. In short, it cannot and does not replace the urgent need for a large-scale global, donor Government-led medical evacuation scheme.

Fifthly, calls upon Israel to '*to urgently establish sustained, organized, safe and timely passage for critically ill patients out of Gaza via all possible routes*' is insufficient and any such calls have been futile. The Israeli authorities have not only failed to de-escalate the conflict and open-up safe evacuation routes, but also have passed a law banning the United Nations Relief and Works Agency ('**UNRWA'**) from operating inside Israel, this decision by Israel described as the *'criminalization of humanitarian aid'.*

The dire humanitarian situation in Gaza continues to be well documented despite the deaths of huge numbers of international and national journalists (173 by March 2025).

According to The United Nations and other humanitarian agencies such as ICRC, the conditions of life in Gaza continue to deteriorate rapidly with catastrophic levels of hunger, serious shortages of safe water and electrical power and other essential utilities, a collapsing medical and health system, and outbreaks of contagious diseases.

Women and children are most at risk (see UNFPA report). There are estimated to be at least 50,000 pregnant women currently trying to survive in Gaza, cut off from any safe birthing and neonatal services. An International Rescue Committee IRC report describes Pregnant women are at risk of starvation and dehydration, with many experiencing premature labour, often resulting in the death of their babies. The IRC reported that 37 mothers have been killed each day since the Hamas attack on Israel on October 7th 2023, a rate of 1 mother every 2 hours. Also, they report that approximately 60,000 pregnant women in Gaza have little-to-no access to adequate prenatal health services and at least 183 women are giving birth in Gaza every day. Most do not have access to midwives, doctors, or healthcare facilities during or after delivery.

Save the Children reported that some women in Gaza are self-inducing labour to avoid giving birth on the move, while others are scared to seek vital prenatal care because of fears of bombing. Some have lost their lives due to a lack of access to a doctor. As reported by UN agencies since the start of the conflict, the lives of newborns '*hang by a thread'*. The situation is significantly worsening every day.

Severe malnutrition among children is rampant. In March 2024, UNICEF reported that 1 in 3 children under 2 years of age were '*acutely malnourished*' in the north of Gaza. By June 2024, the WHO reported that 8,000 children under five in Gaza had been diagnosed with acute malnutrition, including 1,600 with severe acute malnutrition. The WHO reported being unable to provide health services safely.

Clearly the consequences of this urgent public health catastrophe and the needs of vulnerable pregnant women and children cannot be fully and adequately addressed by the agencies and medical staff who operate on the ground, in extremely dangerous conditions. Resources are limited. Hospitals have been destroyed and large numbers of health workers killed and seriously injured. By January 2025, more than 1,000 healthcare workers have been killed since October 2023 and a senior Palestinian doctor (Dr Hussam Abu Safia, Director of Kamal Adwan Hospital Hospital) has been imprisoned in Israel.

Since November 2023, MCAI has been engaging with key stakeholders to assess how to provide enough hospital places in donor countries. MCAI understands that medical evacuations from Gaza since the outbreak of the conflict have occurred (see earlier in this report). There is thus already a process in place to identify patients for evacuations and approve them both with the Palestinian authorities in the West Bank and the Israeli authorities. Albeit MCAI understands that it operates on an ad-hoc basis, involves small numbers, and requires weeks to obtain agreement to transfer in clinical situations where patients with critical illnesses or injures require treatment within days if they are to survive or prevent permanent damage.

The number of medical evacuations to date has been grossly insufficient to manage the urgent and acute needs of critically ill or injured patients and prevent further loss of life and intense suffering. The procedures for evacuations are far too slow and inefficient, and the selection criteria unclear. Greater international assistance and cooperation is required.

MCAI is therefore calling on the selected Foreign Offices of potential donor Governments to lead international efforts to set up an urgent medical evacuations scheme for the massive numbers of those most vulnerable patients from Gaza. MCAI is prepared to assist donor Governments in any way it can in setting up and implementing the scheme, including the provision of safe logistic assistance on the ground.

MCAI considers that any effective evacuation scheme would have to involve, at a minimum:

1. Urgent determination of clear and transparent initial screening criteria for most vulnerable pregnant women and children to form each tranche of evacuees. MCAI's proposed criteria for the first tranche of 500 patients for each donor country are set out in Annex 1.

2. Provision of essential screening equipment to include blood pressure and oxygen saturation monitoring, haemoglobin measurement for detecting anaemia, urine testing for protein, blood and infection, weighing scales and measurements of mid upper arm circumference and portable (laptop based) abdominal ultrasound scanners.

3. Provision of facilities for the most urgent needs of the patients, including access to life-saving medication such as intravenous (IV) fluids and blood products, IV antibiotics, uterotonic drugs and tranexamic acid for post-partum haemorrhage, adequate intravenous and oral pain controlling medication prior to their transfer to donor countries, including neighbouring countries, or at sea in hospital ship(s) based close to the Western coast of Gaza.

4. Coordination with organisations on the ground, including screening and triage by local medical staff and provision of urgent medical facilities for interim treatment, set up in coordination with agents including the World Health Organisation, UNRWA, UK Med, MSF, Project Hope, UNFPA, UNICEF, UNHCR, IOM, ICRC, Children not Numbers, Save the Children, Physicians for Human Rights and Human Rights Watch and any other international organisations providing hospital care in Gaza.

5. Speedy and efficient coordination by the authorities in the West Bank and the Israeli Government, and the donor country to ensure a safe, streamlined and rapid evacuation approach for the very large numbers of critically ill patients who need urgent transfer to safe and effective hospital care. This needs to include (i) efficient and fair screening procedures to allow dependents and other close family members to accompany the most vulnerable patients out of Gaza, (ii) provision of international security for those medical personnel undertaking screening and emergency treatment when needed for medical evacuees and (iii) provision for transport facilities to enable safe travel of the most vulnerable patients and their close relatives within, out of Gaza, and internationally.

6. Provision of an efficient system for keeping up to date evacuation lists.

7. Operational capacity for significant numbers.

8. Appropriate grant of *"temporary leave to remain"* for patients and their families within the donor countries.

If your country is willing to donate hospital beds and family accommodation, MCAI staff are keen to meet with you to discuss the proposals for the scheme and relay the discussions which MCAI has conducted with NGOs, international organisations and professionals working with the field. As set out above, MCAI is willing to lend its expertise and support to any extent necessary to put it in place and implement it. As described below MCAI would be willing to provide its practical and clinical expertise in the screening process, including setting up screening procedures and questionnaires, liaison with local doctors and medical staff and, if access is possible, direct assistance on the ground.

Based on the foregoing, MCAI continues to call on all Governments to set up a medical evacuations scheme for the most vulnerable patients in Gaza, including pregnant women and children. Details of the proposed screening system are set out below.

We look forward to your response to this request which we understand requires considerable resources, but a positive response would indicate the international community's commitment to preventing further deaths and trauma in Gaza.

Annex 1: Proposed criteria for inclusion in first group of 500 medical evacuees plus their close family members to a donor country

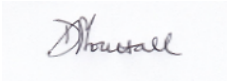
This draft summarises for pregnant women, babies and children the kind of medical emergencies that require stabilisation and evacuation.

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 500 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.



Professor David Southall OBE, MD, FRCPCH
Consultant Obstetrician Liberia and Professor of Paediatrics UK
Honorary Medical Director MCAI, 1 Columba Court, Laide IV22 2NL, UK
Mobile numbers and WhatsApp +44 (0) 7710 674003 and +44 (0)7944 632011
https://www.mcai.org.uk/

Catherine Ferrari (Stowell) BA, MSc
Trustee MCAI

DRAFT: 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
Previous Caesarean section(s) with one or more scars in the uterus.		
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
*Vaginal bleeding after 28 weeks' gestation * Ideally with portable US scan to exclude placenta praevia and to identify early abruption.*		
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	
Post partum haemorrhage	2	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.

Medical reason for evacuation	Triage category	Stabilisation including treatment needed before and during transfer
	3 1	 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	
Miscarriage		
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.
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.
Severe growth restriction of the fetus and in the 3rd trimester	2	
Life threatening sepsis		
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.
Pregnancy after 28 weeks' gestation in a child <17 years of age.	2	
Persistent transverse fetal lie after 36 weeks' gestation	1	Consider short-acting tocolysis if available.

Medical reason for evacuation	Triage category	Stabilisation including treatment needed before and during transfer
Severe hypertension with a risk of cerebral haemorrhage. BP>160/110 mm Hg. and/or severe preeclampsia with risk of eclampsia and death. BP elevated >140/90 and > ++proteinuria and symptoms including, headaches and/or visual disturbance and/or epigastric pain.	1	Intravenous hydralazine, oral methyldopa, Magnesium sulphate Misoprostol, IV oxytocin
Severe anaemia (Hb <7g/dl but >5g/dl).	2	Intravenous iron infusion
Very severe anaemia (Hb < 5g/dl) and in 3rd trimester	1	Blood transfusion and Oxygen if available.
Severe/extreme malnutrition (BMI < 16m/kg2).	2	Enteral oralor tube feeding with high energy food. Blood transfusion if severe anaemia or if shocked. Oxygen if available.
Burns		
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,
Severe trauma that could have a good outcome if advanced treatment only available outside Gaza is undertaken.	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, Intravenous antibiotics: Ceftriaxone, ampicillin and metronidazole, Tranexamic acid, Intravenous paracetamol, opiate or ketamine as appropriate EZIO if venous access not possible
Life threatening medical conditions		
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.
Chronic medical conditions such as heart disease,	1 or 2	Depends on severity and potential for treatment in an international setting.

Medical reason for evacuation	Triage category	Stabilisation including treatment needed before and during transfer
diabetes mellitus, renal impairment, chronic liver disease.		

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
Premature birth and/or low birth weight infants 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.
Congenital abnormalities 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	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. • 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. 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. • PGE2 can be given orally as a maintenance dose of 40-50 micrograms per kg every 2 hours.
Close monitoring and treatment for hypoglycaemia	2	Blood testing for blood glucose levels whenever hypoglycaemia is suspected, for example when a baby has a fit.
Close monitoring and treatment for severe jaundice	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
Severe malnutrition (MUAC <115mm, oedema and weight for height < 3SD).	1	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). Blood transfusion if severe anaemia (Hb < 5g/dl) or if shocked. Oxygen if available. Intravenous antibiotics: Ceftriaxone, ampicillin and metronidazole
Severe trauma that could have a good outcome if advanced treatment only available outside Gaza is undertaken.	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
Severe burns (>15% full or partial thickness). 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,
Malignancies that could have a good outcome if diagnosed correctly and managed in a specialist hospital in another country.	2	
Chronic severe diarrhoea with dehydration not responding to local treatment. (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.
Upper airway obstruction due to congenital abnormality.	1	
Severe anaemia (Hb <7g/dl).	2	Intravenous iron infusion
Very severe anaemia (Hb < 5g/dl)	1	Blood transfusion and Oxygen if available. Appropriate nutrition by oral or tube feeding.

Severe pneumonia, especially with empyema, not responding to local treatment.	1	Intravenous antibiotics: Ceftriaxone, ampicillin, flucloxacillin. Oxygen if available
Severe asthma	1-2	Metered dose inhalers of salbutamol. Nebulisers for salbutamol or adrenaline. Oxygen if available
Severe acute renal impairment (Acute Glomerulonephritis and Nephrotic syndrome)	1-2	Steroids. Fluid management

Drugs, equipment and supplies for Gaza medivac program

Manual Vacuum Aspiration MVA kit for managing incomplete miscarriage
Misoprostol 200 microgram tablets
Intravenous iron infusion for managing severe anaemia without blood transfusion
Tranexamic acid 0.5 grammes per 5ML pack of 10 for reducing postpartum haemorrhage and other internal bleeding
Intravenous paracetamol 10 milligram per 1ML 100 ML ampules
Cool therm gel dressings for burns. 10 by 40 centimetres
Magnesium sulphate 50 percent 10ML ampoules for eclampsia and severe preeclampsia
Hydralazine 20MG per 2ML ampoules
Gentamicin 80MG per 2ML ampoules
Intravenous cannulae 18 G+ wing plus injection port: pack of 50
10 parameter urine analysis stick tests including protein 100
Lubricant Jelly for ultrasound scanning
Fetal Doppler Sonicaid
Caesarean section kit
Laparotomy kit
2% lidocaine 20ML vials
Digital thermometers 32 to 42°C
Spinal anaesthetic needles 25 G
Bupivacaine for spinal anaesthesia 0.5% in 8% glucose
Kiwi vacuum device
Sutures silk for skin closure
Sutures Vicryl absorbable for internal closures
Chlorhexidine 1% obstetric cream for infection prevention
Blood for transfusion collecting bag 450 ML plus 16G needle plus CPDA anticoagulant
Blood glucose test sticks for code free glucometer
Code free glucometer
Urinary catheter Foley 16FG with 30ML balloon
Micropore tape 5 centimetres x 9.1 metres
Adrenaline one milligram per 1ML for subcutaneous injection
Frusemide 20 milligram per 2ML ampoules
Atropine one milligram per 1ML ampoules
Dextrose 50 percent 50ML ampules
Nasogastric tubes 6CH
Pregnancy testing strips
Wrigley forceps
Neville Barnes forceps

Manual suction pump