HEALTH CLUSTER

GAZA STRIP

The Minimum Initial Service Package for Sexual and Reproductive Health

IMPLEMENTATION EVALUATION

SEPTEMBER 2025

This report was written in and reflects the situation as of September 2025, prior to the 10 October 2025 ceasefire agreement.

Summary

This assessment evaluates the implementation of the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) in Crisis Situations in the Gaza Strip in the context of an ongoing war, the collapse of health infrastructure, and mass displacement. The analysis draws on primary and secondary data, along with service mapping, to evaluate the extent of MISP integration, identify gaps, and provide actionable recommendations for scaling up lifesaving interventions.

MISP Framework

The **Minimum Initial Service Package (MISP) for SRH in Crisis Situations** is a set of essential lifesaving interventions, developed by the Inter-Agency Working Group on Reproductive Health in Crisis (IAWG) and designed to be launched at the outset of any humanitarian emergency (within 48 hours wherever possible). It includes six key objectives: 1) coordination, 2) preventing sexual violence, 3) reducing HIV/STI transmission, 4) preventing unintended pregnancies, 5) ensuring safe childbirth, and 6) planning for integrated SRH services. These initial services should be maintained and expanded as soon as possible (ideally within 3 to 6 months) into comprehensive SRH services and supplies, continuing through prolonged crises and recovery phases.[1]

Priority Actions

- Institutionalize cross-sector coordination between SRH, GBV, MHPSS, nutrition, HIV, disability, and community protection mechanisms.
- Expand community participation in response planning, using local leaders and camp focal points to adapt SRH/GBV services to cultural norms.
- Re-establish and expand Women and Girls Safe Spaces, integrating health, psychosocial, and legal support within them.
- Expand syndromic management training for front-line providers and negotiate the re-inclusion of STI indicators into the SRH dashboard.
- Scale up midwifery-led care – which proved resilient and effective during the war – through community awareness, capacity building, and supplies provision.
- Promote culturally sensitive FP awareness through community-based channels while avoiding reputational risks.
- Strengthen referral systems by designating select PHCs for high-risk pregnancies and ensuring referral pathways are updated every 2 weeks.
- Integrate additional critical services into the SRH package for Gaza's context, including nutrition, ANC and prenatal care follow-up, as well as psychosocial and community-based support, to ensure that the essential SRH services address the evolving needs of affected populations.
- Develop tailored services for adolescent and youth groups through capacity building for front-line staff, awareness programs for the community, and a clear reporting system for their indicators.

This work was conducted on behalf of the Global Health Cluster Sexual and Reproductive Health Task Team (GHC SRH TT). The authors extend their gratitude to the task team members, national SRH Working Group members, and additional reviewers for their valuable contributions.

Background & Context

The Gaza Strip is a 365 km² region with nearly 2.3 million individuals, half of whom are children. It is one of the most densely populated regions in the world. Even before the escalation in October 2023, Gaza faced chronic humanitarian challenges due to a 17-year blockade, high unemployment, widespread poverty, and heavy reliance on humanitarian assistance. Health services operated under severe strain, with recurrent shortages of medicines, electricity, and medical equipment, and previous escalations of violence had already damaged infrastructure and undermined food security.[2,3]

The war that began in October 2023 precipitated a near-total collapse of Gaza's already fragile health system. By mid-2025, over 70% of health facilities had been damaged or destroyed, with only half of the hospitals partially functional, leaving entire governorates, such as North Gaza, without any operational hospital.[4,5] Massive displacement compounded these pressures: up to 2 million people (nearly 90% of the population) were displaced, many repeatedly, into overcrowded and insecure conditions where access to water, food, and healthcare was severely disrupted.[6,7]

This collapse has had particularly devastating consequences for SRH. UNFPA's July 2025 situation analysis estimated there were 55,000 pregnant women in Gaza, of whom 20% were malnourished and nearly 30% faced high-risk pregnancies. Daily births averaged 130, yet increasing numbers of women were forced to deliver outside formal facilities due to the destruction of maternity wards and the lack of medical supplies.[8] Miscarriages surged, with humanitarian actors reporting a 300% rise in spontaneous abortions, largely linked to stress, malnutrition, and unsafe conditions.[9]

The war dynamics have created what humanitarian agencies describe as an unprecedented public health and protection crisis. Moreover, the breakdown of referral pathways, shortages of SRH supplies, recurrent displacements, destruction of women and girls' safe spaces (WGSS), and cultural and logistical/security barriers to services have left women, girls, and other marginalized groups acutely vulnerable.[10,11,12] It has led to severe consequences for SRH, leaving tens of thousands of pregnant women without safe delivery options, contributing to an increase in spontaneous abortions, and disrupting access to lifesaving maternal, newborn, and gender-based violence (GBV) services. These vulnerabilities underscore the urgent need for systematic implementation of the MISP to ensure continuity of essential SRH services and protect the rights and health of affected populations, contextualized to the Gaza situation.

Objectives of the Assessment

This assessment aimed to evaluate the implementation of MISP objectives and essential SRH services in Gaza, including maternal and newborn health (MNH), family planning (FP), GBV prevention, awareness and response, and prevention and management of sexually transmitted infections (STIs). It examined barriers and enablers, such as the collapse of health infrastructure, displacement, cultural restrictions, and funding shortages. The study mapped key actors and their roles in reaching affected and marginalized populations. Special focus was given to adolescents and people with disabilities (PWDs) to identify service gaps. The assessment also reviewed financing sources and concluded with recommendations to strengthen coordination, improve service delivery, and plan for a transition toward comprehensive services.

Methodology

Ethical approval was secured from the International Cooperation Committee (ICD) of the Ministry of Health (MoH) as well as the International Rescue Committee's (IRC) internal ethics review board. Conducted from June to September 2025, the study employed mixed methods, leveraging secondary data and primary qualitative interviews.

To assess policy frameworks, coordination mechanisms, service delivery and gaps, and health system resilience, the **Desk Review** synthesized evidence from grey literature, UN agency reports (UNFPA, WHO, OCHA, UNRWA), MoH protocols and annual reports, humanitarian needs assessments, pertinent documents from partners of the SRH Working Group (WG), and SRH service mapping datasets.

The review showed that despite the collapse of Gaza's health system due to widespread destruction and displacement, the SRH WG (co-led by UNFPA, MoH and UNRWA) and the GBV Sub-Cluster (co-chaired by UNFPA and UNRWA) sustained critical services through continuous coordination, regular meetings, and updated service mapping. Although many safe spaces for women and girls were damaged, efforts were made to re-establish them whenever possible. Referral pathways for services were also adjusted to accommodate the realities of displacement. Basic Emergency Obstetric and Newborn Care (BEmONC), Comprehensive Emergency Obstetric and Newborn Care (CEmONC), and mobile clinics were maintained by partners, such as the MoH, International Medical Corps, UK-med, Médecins Sans Frontières, the International Committee of the Red Cross, and local NGOs. Other essential SRH services were maintained during multiple disruptions due to the adaptability and commitment of partners in addressing the significant needs. GBV actors, including UNFPA, UNICEF, Culture and Free Thoughts Association, Abed Al Shafi Community Health Association, Women's Affairs Center and others, provided case management, psychosocial and legal support, alongside awareness campaigns to reduce stigma. Although HIV and STI services were deprioritized and marginalized groups such as adolescents and people with disabilities (PWDs) were often excluded, the coordinated efforts of SRH and GBV actors demonstrated resilience in maintaining essential services under extreme constraints.

To further inform the findings from the desk review, **qualitative interviews** were conducted with 11 individuals selected from the SRH WG (n=7), GBV Sub-cluster (n=3), and MoH-HIV Unit (n=1), representing a range of experiences with MISP components during the ongoing war. Most participants were national staff, along with one expatriate, representing UN agencies (n=3), non-UN organizations (n=6), and the MoH (n=2), covering both hospital and primary healthcare levels. Participants included eight women and three men, all SRH/GBV service providers or project leads working in Gaza during the war, with up to 30 years of relevant experience.

Results

MISP awareness and infrastructure

Stakeholder awareness of the MISP varied. Respondents from UN agencies, such as UNFPA, UNRWA, and WHO, described a strong familiarity with MISP, noting that it is central to their mandates and cluster coordination, supported by multiple training sessions. In contrast, other participants admitted to limited or no training, with some providing relevant services without knowing they fell under MISP. Several requests were made for broader awareness and training to ensure that all partners, especially local NGOs and front-line staff, adopt a shared understanding. A few respondents critiqued parts of the package, such as the HIV objectives, as less relevant for Gaza and therefore advocated for contextually adapting the MISP to prioritize interventions for reducing maternal and neonatal mortality and morbidity. Overall, the MISP was found to be well understood at the higher or leadership levels of an agency, but less familiar among local actors and providers, with some respondents calling for greater localization and customization. This highlights the need for systematic training, inclusive dissemination, and adaptation to Gaza's context.

Preparedness plan

Preparedness planning for essential SRH services in Gaza has long been discussed but remains fragmented and incomplete. Although WHO and the MoH developed a preparedness plan in 2023 and other efforts, such as the AFD-supported emergency preparedness plan initiative with UNFPA, WHO, and UNICEF, were underway, none were operationalized before the war.[13] As a result, Gaza entered the escalation without a comprehensive SRH emergency plan. Stakeholders contrasted this with the West Bank, where SRH emergency response teams had been piloted, noting that Gaza never established such locally based teams, despite their critical importance given access restrictions.

> *...we never [envisioned an escalation] destroying hospitals, destroying the infrastructure, destroying the water, destroying the environment. So I think we need to redo the emergency preparedness strategy."*
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> **SRHWG MEMBER 5**

Key informants reported that at the cluster level, SRH partners have contributed to broader contingency planning exercises, including scenarios for Rafah invasions, ceasefires, or floods. However, they repeatedly stressed that SRH is often the first component to disappear from national or cluster-level strategic documents, requiring constant advocacy to remain visible. While specific discussions occurred when a timely need arose, such as winterization measures for floods, hypothermia risk in infants, or contingency shelter arrangements, these rarely translated into structured, system-wide protocols. This aligns with desk review findings that describe Gaza's preparedness planning as largely programmatic and partner-driven, rather than a nationally MoH-led and -endorsed policy framework integrated into disaster risk management.

Preparedness at the facility and organizational levels was equally inconsistent. Some partners described contingency plans for evacuation triggers, pre-positioning of supplies, or stock management (e.g., maintaining three months' worth of essential SRH commodities). Other actors described practical improvisations: during the early months of the war, with hospitals inaccessible, midwives were trained and equipped for urgent deliveries, many of which occurred in displacement shelters or communities. Some organizations rapidly established emergency medical points in schools or shelters, following population movements from Khan Younis to Rafah, and later to Al Mawasi and Deir al-Balah. NGOs like Médecins du Monde (MdM) admitted that before the war, they had no direct service delivery preparedness plans, having focused on capacity building; their entry into service provision during the war was reactive and shaped by "learning while doing." This highlights the emergence of new service providers in the field as they respond to the growing needs and collapse of the healthcare system during the ongoing war.

Some respondents have described the current situation in Gaza as a "shock," explaining that the preparedness was never designed to handle such intense destruction and health system collapse. Pre-war scenarios had been prepared for the displacement of up to 150,000 people but did not anticipate the mass displacement of nearly two million. Similarly, contingency plans did not account for the destruction of UNRWA's infrastructure, prolonged

border closures, or the blockade's impact on humanitarian supply chains. This perspective highlights both the limits of conventional preparedness models and the urgent need for adaptive, locally driven planning that reflects Gaza's realities.

Furthermore, it was noted that while emergency reproductive health (RH) kits from UNFPA, UNICEF, and WHO were useful, several kitted supplies that were procured early in the conflict – likely due to prepositioning, their ease of ordering and shipping, and the familiarity of the responders – were not contextually appropriate. For example, several INGOs initially procured emergency kits that prioritized care for AIDS, malaria, and rape, which were not in demand for the response. These kits were instead missing essential and needed supplies such as micronutrients, iron, or context-appropriate delivery kits. Respondents requested that implementing partners be more intentional about revising systems and processes (supplies, procurement, monitoring, etc.) and investing in the local system so as to ensure the right support, rather than relying on traditional approaches that are intended for other settings.

MISP OBJECTIVE 1

Coordination and Leadership

Coordination was identified as both a major strength and a complex challenge in the response. Interview participants consistently named UNFPA as the lead agency for sexual and reproductive health and gender-based violence coordination, acting as co-lead of the SRH Working Group with the Ministry of Health (MoH), and leading the GBV Steering Committee's Area of Responsibility. This is notable because, during the war, UNFPA expanded its usual level of engagement to frequently act as a gap-filler, mobilizing supplies, deploying midwives, and ensuring continuity of essential services when no other actors could intervene.

> *...we have dozens of partners implementing health. We have over 200 facilities - 13 CEmONC, about 200 PHCs or mobile teams. So ... you have a MOH, you have UNWRA, you have big actors that have many facilities and then you have smaller, smaller actors [with] one or two ...service points. So we come together and we discuss together on types of action, triggers, needs for support from the coordination level"*
>
> **SRHWG MEMBER 1**

The SRH WG was established in November 2023. It brings together 30–40 partners and has been the primary SRH coordination mechanism since its establishment. Through weekly meetings and technical reviews, the group facilitated information sharing, joint planning, and resource allocation by directly funding SRH WG activities, providing SRH supplies to SRH WG members, and covering the travel costs of medical staff and equipment evacuation. Although engagement was not always consistent, some actors attended irregularly due to security and connectivity issues. At the same time, smaller private clinics or military hospitals were sometimes unaware of the coordination processes, requiring outreach from both parties to bring them into the loop. Despite these challenges, the working group was widely credited with creating space for dialogue, technical exchange, and rapid learning, particularly once it became more active in the months following the escalation.

There are other relevant coordination bodies, such as the protection group and case management task force, led mainly by the WHO, UNFPA and UNICEF. These were primarily mentioned by the GBV members, as they are more involved in such coordination and regularly update the available services to create a service mapping for all governorates. Coordination also extended beyond health to cross-sectoral linkages. The SRH WG worked closely with the GBV sub-cluster, the Disability Working Group, MHPSS actors, and nutrition partners (e.g., TSFP, Targeted Supplementary Feeding Programmes). Mapping and inclusion efforts have also begun to engage women-led organizations, though their participation remains limited. Some participants acknowledged that coordination with logistics, shelter, and winterization actors was weaker, reducing the ability to anticipate cross-cutting needs such as heating, safe shelter for survivors, or cold-chain continuity for maternal and child health supplies.

Importantly, coordination has been especially crucial for supply chain management. Early in the war, UNFPA pre-positioned large quantities of RH kits, delivery kits, and FP supplies, which helped buffer the initial shock of the blockade. A system of program distribution agreements enabled UNFPA to channel supplies to non-formal implementing partners based on need, providing critical flexibility in a constantly shifting landscape where partners expanded, downsized, or shifted their mandates. The support was not limited to medical supplies; it also included staffing, capacity building, and the identification and coordination of referral pathways. Yet, access restrictions, destruction of warehouses, and the classification of items

as “dual use,” (i.e., some supplies, including sterilization chemicals and solar equipment, were classified as having potentially dangerous uses by Hamas, and therefore were restricted, even if a second use case was lifesaving for health services), severely hampered the flow of commodities, underscoring the limits of even well-coordinated supply pipelines. On the operational side, coordination also enabled rapid, pragmatic problem-solving. Examples included covering transport costs to evacuate staff and equipment from destroyed facilities like Jabalia Hospital, deploying midwives into UNRWA shelters, and pre-positioning supplies to sustain service continuity during blockades.

> *The barriers that we face [include] the fuel shortage and ambulance services, especially for the GBV cases, for the woman in labor, and for the electricity of the hospitals. And for the transportation of the stuff, either for SRH or for GBV”*
>
> **GBV MEMBER 2**

Despite these efforts, duplication of services was a recurring issue, particularly in “humanitarian zones” where many partners clustered, leaving some hard-to-reach areas underserved. Participants recommended stronger mapping, clearer definition of partner roles, and geographic allocation to prevent overlap and ensure equitable coverage. A related concern was that some coordination was experienced as directive or controlling, rather than facilitating collaboration and transparency. Respondents emphasized that coordination should involve information sharing, mutual support, and avoiding duplication, rather than imposing activities on partners.

> *You feel that the work [is] disconnected somehow, and sometimes there’s duplication of some services – [it would be better if] some providers can take one thing and the others can focus on something else.”*
>
> **SRH WG MEMBER 4**

Data and information management were another area of struggle. Some informants described lengthy negotiations to agree on a minimum set of SRH indicators, as agencies initially insisted on retaining overly large indicator lists (up to 130). Ultimately, partners agreed to a simplified dataset, but the delays in harmonization slowed early response. Participants emphasized the urgent need to improve data flow, data cleaning, data validation, and data visualization. A joint six-month report between UNFPA and MoH was cited as a step forward, though gaps remain in consistency and timeliness of reporting.

Overall, coordination around MISP in Gaza has been adaptable and inclusive in intent, but often constrained by external blockades, fragmented participation, and competing institutional interests. The system has demonstrated clear strengths in convening actors, mobilizing resources, and ensuring continuity of services under extraordinary circumstances. Yet it continues to grapple with duplication, data quality issues, underrepresentation of local actors, and the over-reliance on UNFPA’s leadership, raising questions about long-term sustainability and national ownership.

> *They did a great job and to be honest, the clusters did a great job. OK, they were rapid responders. We all know the reality [is] that they are limited because the Israeli are not allowing anyone to intervene.”*
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> **SRG WG MEMBER 2**

MISP OBJECTIVE 2

Prevent and Manage the Consequences of Sexual Violence

The assessment’s results revealed that prevention and response to sexual violence were recognized as essential components of the response, yet both strong coordination efforts and persistent barriers have shaped delivery. Regarding the coordination and availability of services, clinical management of rape (CMR) and broader GBV response were integrated into SRH interventions from the early days of the war. UNFPA and WHO played central roles in training providers on CMR protocols, often adapting WHO protocols to the specific context of Gaza. There were several discussions about convincing the MoH to train the healthcare staff in response, and ultimately, the MoH acknowledged the significance of the topic in such circumstances.

Coordination took place primarily through the GBV Steering Committee and the SRH WG, with regular meetings, joint referral pathways, and service mappings across the governorates. Additional actors were involved in preventive measures through interagency efforts, such as Sanad, a UNICEF-led interagency mechanism focused on Protection from Sexual Exploitation and Abuse (PSEA).

These efforts strengthened accountability systems by raising awareness, providing staff training, and establishing safe and confidential reporting mechanisms, which helped the population overcome stigma in disclosing incidents.

Moreover, the GBV response was integrated with SRH and protection services to reduce stigma and enhance accessibility. To offer discretion, survivors could seek support at medical points without being identified as "GBV cases," since health, nutrition, and psychosocial services were co-located. Available services extended beyond health care to include psychological first aid, group and individual therapy, legal counselling, shelter provision, and emergency cash assistance, particularly crucial during displacement. WGSS were established in fixed buildings rather than tents whenever possible, ensuring privacy, dignity, and continuity of care.

> *"The most important point about [my organization is that] we provided SRH and GBV services in the same place in the same medical point. They were not separated."*
>
> **GBV MEMBER 3**

Training and sensitization for front-line staff were widely implemented. Mandatory safeguarding and PSEA training were reported across all the included agencies, and referral protocols were updated for the war context. However, challenges emerged with applying protocols due to security constraints, resource shortages, or restrictive laws imposed by health authorities. And similar to GBV, the widespread destruction of health facilities and safe spaces forced services into tents and makeshift shelters, severely compromising privacy and confidentiality.

Continuous displacement, overcrowding, and the collapse of formal protection systems have further heightened women's and girls' vulnerability, while restricting their ability to access lifesaving care. It was found that chronic shortages of supplies such as emergency contraception, PEP kits, and sterilization materials, compounded by fuel and electricity constraints, further weakened service delivery. Importantly, there was a delay at the start of the war in the availability of the safety shelter for survivors of sexual violence, as it wasn't established until nearly 6 months into the war. But even if safety shelters exist, those are only exclusive to female survivors, leaving male groups without safe spaces despite the increase in reported cases seeking health facilities. These barriers often led to late or incomplete care, with survivors presenting only after serious complications.

> *"We are facing a lot of numbers of males who we explore for exposure for sexual violence."*
>
> **GBV MEMBER 3**

Stigma, cultural taboos, and an unsupportive legal environment exacerbate underreporting, while practices such as mandatory reporting and virginity testing undermine survivor-centered approaches. Coordination among actors, although improved since the war, remains fragmented, with duplication in some areas and gaps in others. Vulnerable groups, including adolescents, PWDs, and male survivors, remain largely excluded, despite heightened risks.

MISP OBJECTIVE 3

Prevent and Manage HIV and STI Transmission

This objective is complicated by factors such as unintentional neglect, cultural sensitivities, and the constraints imposed by the ongoing war. HIV is not considered a pressing public health concern: only around 36 cases are reported in Gaza (four were newly discovered during the war).[14] While antiretroviral therapy (ARVT) is provided exclusively by the MoH, the specific needs of people living with HIV beyond treatment, including psychosocial support, stigma reduction, and linkage with SRH and GBV services, are ignored. Coordination between the SRH WG and the GBV Steering Committee does not extend to HIV, leaving it isolated from broader response.

> *"Despite [that HIV cases] are limited, they are ignored."*
>
> **HIV FOCAL POINT**

Records show regular access to supplies for managing sexually transmitted infections (STIs) using Kit 5, although there were few documented cases of STIs, likely due to the use of different terminology (for example, "reproductive tract infections"), under-reporting, or under-diagnosis. The collapse of laboratory capacity has forced providers to rely on the WHO syndromic approach, which is pragmatic in emergencies but undermines surveillance and case confirmation. This has been compounded by gaps in provider training, inconsistent classification, and the stigma associated with sexual health. Conservative attitudes have also limited condom distribution, and donor sensitivities have made STI/HIV programming harder to fund. Meanwhile, this evaluation found that displacement, overcrowding, and the collapse of WASH services have heightened other reproductive tract infection risks, particularly for adolescent girls lacking access to hygiene kits and safe sanitary products.

Despite these challenges, successful lessons exist. Syndromic management of STIs has been rolled out across SRH services, with health workers trained to deliver care even without laboratory diagnostics. HIV/STI kits remain pre-positioned for emergencies, ensuring at least minimal readiness. With the exception of December 2024 to January 2025, there was consistent stock of ARVT, due not only to the limited number of diagnosed cases but also continued funding from the International Organization for Migration (IOM) specifically for HIV, allowing for strategic distribution of ARVT to patients every three months. Integration of STI prevention and management into antenatal, postnatal, and FP care provides women with discreet entry points to access services, reducing stigma barriers. The SRH WG has also pushed to reinstate STI indicators into health dashboards, ensuring the issue remains visible in coordination despite resistance.

Overall, as HIV cases in Gaza are few and STIs are mainly diagnosed only within married couples, their deprioritization highlights the need for stronger coordination across SRH, GBV, MHPSS and HIV programs. Without improved surveillance, full services integration, and destigmatized service delivery, the full intent of MISP Objective 3 cannot be realized. Considering the higher priorities of other essential SRH services in Gaza, this may take longer to be recognized as an essential MISP component compared to other emergency and fragile contexts.

MISP OBJECTIVE 4

Prevent Maternal and Newborn Morbidity and Mortality

Data from the desk review showed that the maternal mortality ratio in Gaza was estimated at 164.2, and the maternal mortality rate was 11 per 100,000 live births. Before the war in 2022, these figures were much lower: the maternal mortality ratio was 17.4, and the maternal mortality rate was 1.86 per 100,000 live births. This stark increase reflects the severe impact of the war on maternal health.[15] Similarly, neonatal mortality and morbidity have been reported to have increased, with field observations and analysis from a recent UNFPA study supporting that.[16]

Respondents in this study reported that women who previously attended 6+ antenatal care (ANC) visits before the war often now access care only in late pregnancy, contributing to rising complications. Some key informants reported having midwives follow up with ANC cases, especially low-risk cases, while others mentioned having an obstetrician for high-risk cases. Nonetheless, the rate of skilled birth attendants remains high, reflecting both community trust and good health-seeking behavior among women. This was also confirmed by some participants who reported that deliveries outside health facilities remain limited.

Challenges persist, however, due to the uneven distribution of Comprehensive Emergency Obstetric and Newborn Care (CEmONC) facilities and the destruction of Al Awda Hospital, leaving North Gaza without such services. Referral pathways are frequently disrupted by insecurity, displacement, or ambulance refusals. There have been some promising advances - emergency delivery clinics and mortality reviews help mitigate risks, and referral guidance was developed with support from the SRH WG and distributed to facilities across the governorates.[17] Respondents reported that the monthly mortality review investigates causes of maternal death and engages partners and some hospitals. But gaps in EmONC remain acute - service mappings have revealed a varied distribution of services and partners across governorates. While areas like Khan Younis and the Middle Area have high service coverage and partner presence, with over 60 outpatient facilities each and

strong support from numerous organizations, Rafah is critically underserved, with only a few functioning facilities and limited partner involvement. Gaza governorate and Gaza North also have moderate service coverage.[18] The general exclusion of the "red zones", due to partners deeming these areas too high-risk coupled with Israeli security clearance restrictions, leaves some populations underserved, which was confirmed by participants.

In an effort to address challenges in safe delivery, UNFPA introduced a midwifery-led delivery model at the primary health care (PHC) level, including an on-call midwife system for daytime coverage (and ideally 24-hour coverage) for low-risk cases and under strict criteria defined by SRH WG (delivery at PHC level with a midwife is allowable if during second stage of labor, the nearest hospital is inaccessible or more than 30 minutes away by car, and a midwifery kit is available). However, some key informants questioned its effectiveness due to several barriers: the strong cultural preference for hospital-based deliveries among women in Gaza, limited midwife training in community-based care, weak referral systems, low community awareness of the service, and even a lack of knowledge among ambulance services about its availability. Despite the extreme destruction to the health system, informants described that the population (and many responders) still view institutional deliveries as the best choice. One key informant reported having emergency delivery clinics that are open 24/7 with skilled doctors and nurses to facilitate normal vagina delivery, but described it as not the first option, and rather only a good option for women who live in camps and are many kilometers away from the hospitals.

Nutrition

There is a high percentage of malnourished pregnant and lactating women, with one key informant reporting that around 40% of pregnant and lactating women are malnourished, and responders finding it very challenging to talk to these women about any other important services while they are hungry. Sometimes people reach out to health facilities to prioritize a nutrition consultation and possibly some food supplies over being seen for other medical conditions, as the medical condition is not necessarily seen as fatal compared with hunger.

One key informant reported that they are providing nutrition supplies for pregnant and lactating women, such as lipid-based nutrient supplements in small quantities and high-energy biscuits, but the supply remains limited. This is closely related to what has been said in the last IPC report regarding the famine in Gaza and how it is now negatively affecting the entire Gaza population.[19] One respondent said they believe clients will die from the famine, so if MISP services aren't considering or including nutrition services, the response is more "missed than MISP."

Abortion

In the Gaza context, there are no voluntary safe abortion practices, as abortion is prohibited by law and only permitted in medically eligible cases following specialized consultations and approval. The MoH protocol permits safe abortion services under the CMR only within the first 40 days of pregnancy, and exclusively in hospital settings by specialized physicians. Cultural stigma and mandatory reporting requirements further discourage women and girls from seeking abortion-related care. This is especially acute in cases of sexual violence, where survivors face structural and societal barriers to disclosure and timely treatment. Due to legal and cultural restrictions, safe abortion services—as defined by global sexual and reproductive health and rights frameworks—are not available in Gaza. As a result, abortion care was not widely discussed during the interviews. However, key informants noted that decisions regarding abortion are made solely by a committee within the Ministry of Health, and only within the bounds of existing law.

Humanitarian actors, including CARE International, have reported a 300% increase in spontaneous abortion cases.[20] Another key informant mentioned that they thought about allowing one of their gynecologists to prescribe Misoprostol for managing miscarriage cases, such as "missed abortion" at the PHC facility, as this provider worked at a MoH hospital as well and could follow up cases. Still, they decided not to proceed because of the interrupted referral system and lack of transportation to the hospital, especially at night, if the women start bleeding. However, post-abortion care is integrated within the spectrum of SRH services and has become increasingly critical in recent months.

MISP OBJECTIVE 5

Prevent unintended pregnancies

Efforts to prevent unintended pregnancies during the war have faced complex challenges shaped by both the prolonged duration of the war and contextual sensitivities. Unlike shorter crises, this war's extended nature led to shifts in reproductive behavior (despite the decrease in fertility rate, from 3.3 to 2.8),[21] with some families actively seeking to exercise reproductive rights. A range of FP methods (including IUDs, pills, implants, injectables, and condoms) were reported available through SRH actors, though female condoms remained absent.[22] Supplies were available through RH kits, but some organizations also succeeded in maintaining their own stock.

Since October 2023, there were fluctuation in the availability of FP commodities, especially since the closure of boarders, the long term shortage significantly undermined service continuity, one example was critical gaps included IUD kits, which are the most widely used method in Gaza (almost 50% of the used methods), but one respondent mentioned that insertions were halted for at least six months due to sterilization challenges. Stockouts of oral contraceptives and reliance on donations further weakened service reliability, as they were the most commonly used methods for the new users (42%).[23] In response, some providers offered emergency contraception beyond post-rape care contexts, framing it as a way to preserve women's autonomy during displacement. Service quality issues also emerged. Biased counseling against certain methods, such as injectables due to side effects (irregular bleeding), risked limiting choice, even as providers emphasized women's right to make final decisions. Meanwhile, some actors resisted distributing male condoms outside health facilities, citing cultural appropriateness and reputational risks.

Overall, while FP remained a priority for several SRH providers, its delivery was constrained mainly by supply shortages, service interruptions, and sociocultural barriers to some methods. The findings highlight the need for context-sensitive programming that safeguards women's reproductive rights while aligning with humanitarian realities and community acceptance.

MISP OBJECTIVE 6

Plan for comprehensive SRH services

1. Service delivery and Referral

Planning for comprehensive SRH services during the war reflects both commendable resilience and deep systemic fragility. While several actors were somewhat successful in maintaining comprehensive service delivery — including antenatal and emergency obstetric care, congenital malformation screening, nutrition support, and specialist consultations — continuity was severely disrupted by bombardments and forced evacuations. In May 2025, the loss of Al Awda Hospital, the only facility providing secondary care and CEmONC services in North Gaza, left the entire governorate without critical referral capacity. This highlighted the stark inequities across the Strip. Whereas central and southern areas retained a concentration of functional facilities and partner engagement, North Gaza and Rafah became increasingly fragile and underserved.

UNRWA's expansion into rehabilitation and psychosocial services, alongside NGO-supported outreach and mobile clinics, demonstrated innovation in bridging gaps. GBV and SRH actors further adapted by updating referral pathways regularly and embedding GBV support into health facilities, ensuring clients access integrated packages of medical, psychosocial, legal, and cash services despite ongoing displacement. Overall, the war has underscored both the adaptability of service providers and the fragility of Gaza's SRH infrastructure.

2. Health Workforce

During this war, many health providers left Gaza, were displaced inside Gaza, or were killed, and the needs of the population have been constantly changing, all greatly impeding agencies' ability to maintain service delivery and requiring a focus on constant capacity building of new, unfamiliar, or under-skilled staff. Replacing specialists was rarely possible, as emphasized by one UNRWA respondent who noted that when their specialists were killed, they were hampered by policies restricting UNRWA movements inside Gaza. Unsurprisingly, capacity building was a common recommendation from key informants on how to improve SRH services, but this is not always easy; one key informant explained the challenges of moving the *MamaNatalie* training aid, as this item was not allowed to enter

Gaza because it is classified as “dual use”. On a positive note, the SRHWG has developed a training list where all the SRH WG members share information about current or future training related to SRH, and any capacity to include other members outside their organization. This information is shared with all members and is updated regularly.

3. Health Information System

Because data systems have been disrupted, most sexual and reproductive health (SRH) indicators are based on estimates. As a result, health statistics are often incomplete and may underrepresent the true situation. While the SRH WG has worked to improve reporting, the war has reversed key gains and caused dramatic shifts in maternal mortality, neonatal outcomes, and contraceptive coverage. Data collection dropped sharply in the first months of the war, but starting in January 2024, the SRH WG began manually gathering indicators from field hospitals and partner organizations.

Compared to other crisis settings, the health information system for SRH in Gaza is well-established, but this also means there is an ongoing struggle to balance capturing the bare minimum encouraged by MISP with aiming for a more comprehensive system. Despite good relationships between MoH and the SRH WG, reporting practices are fragmented across partners. Some partners insist on documenting up to 130 indicators, while UNFPA has streamlined reporting through a three-tier system prioritizing essential MISP data. Persistent challenges include over-reporting, duplication of forms, and under-reporting of sensitive issues such as STIs, which are under-reported due to sensitivity, lack of diagnostics, and inconsistent classification. Methods for documenting health data range from tally sheets and paper records to electronic systems. However, these processes are frequently disrupted by electricity shortages, internet outages, displacement, and ongoing attacks. To compensate, some organizations rely on phone calls or WhatsApp groups to track patients. Despite these adaptive strategies, concerns remain about data quality, with indicators often reflecting quantity rather than service quality or patient satisfaction. Stakeholders agree that qualitative insights are essential to complement numerical reporting and to capture the lived realities of service delivery in the war context.

4. Medical Commodities

Planning for comprehensive SRH services in Gaza is critically undermined by structural supply chain and political barriers. Key informants reported extreme delays (sometimes up to nine months) for essential commodities and kits to enter, compounded by looting, warehouse destruction, and repeated border closures. UNRWA, historically a main SRH provider, has faced additional constraints as political decisions (including US policy shifts and Israeli Knesset legislation) restricted its ability to import supplies, deploy staff, or receive external support. At the service level, even basic equipment maintenance has become nearly impossible; for instance, the inability to repair or replace an ultrasound machine led one facility to refer women unnecessarily to hospitals, placing further strain on an already fragile health system.

5. Financing

Before the current war, SRH funding in Gaza was poorly defined, with no clear allocation shared by the MoH or health cluster. With the collapse of the health system, financing for SRH has become almost entirely dependent on external humanitarian aid, primarily through pooled funds and the inter-agency Flash Appeal. For 2025, UNFPA requested $99.2 million to sustain essential SRH interventions, yet as of July, only $28.2 million had been secured, leaving a $71 million shortfall.[24,25]
Moreover, many providers integrate SRH within broader PHC projects without dedicated budgets, while others, such as MSF Spain and Juzoor, shifted their services during the war to fill gaps. UNRWA has been particularly affected by political and financial constraints, with project renewals now occurring every month rather than annually. UNFPA provides some stopgap support through pooled funds and supply agreements, but these are also short-term and insufficient to meet needs. Key informants consistently identified chronic underfunding as a major barrier to sustaining and scaling SRH services.

6. Governance and Leadership

The MoH has played a central role in Gaza's SRH response, closely monitoring INGOs, aligning services with national guidelines, and directly providing much of the SRH care alongside UNRWA. However, the incorporation of MISP into Gaza's health system has been partial and uneven. While elements such as maternal and newborn care, family planning, and GBV response are reflected in MoH guidelines and SRH WG activities, MISP-related activities or objectives are embedded within broader reproductive health strategies rather than articulated as a standalone humanitarian SRH protocol. One key informant reported concerns that, while emergency coordination has been effective during the war, local authorities may deprioritize integrating MISP objectives into comprehensive, ongoing SRH services once a ceasefire and recovery phase begin, posing risks to sustainability.

Community engagement

Key informants consistently highlighted the crucial role of community engagement in sustaining GBV and SRH services during the war. They reported that organizations actively involved community members in project design, implementation, and feedback processes, often through health promoters, community leaders, and dedicated committees. According to informants, this engagement enhanced service awareness via recreational activities, social media, podcasts, mobile messaging, flyers, and WhatsApp groups. Several key informants described how communities contributed directly to service continuity — for example, by providing power and water to primary health care sites, or by supporting mapping of displaced populations and food distribution through youth and women's "friendship committees." In some cases, informants noted that communities served as informal protection networks in the absence of formal policing.

Informants felt that structured coordination mechanisms were a big facilitator to enabling community engagement, such as having community engagement groups and the SRH WG to facilitate direct feedback on and the dissemination of health messages. However, they also noted barriers or challenges, such as the need to validate updated health messages with the MoH and concerns that not all community representatives truly reflected wider community needs due to potential power imbalances. Overall, key informants observed that health education on SRH services is not receiving as much community attention as other health issues, such as vaccination, and more efforts are needed in this area.

> *...once we decide that we will provide [services in a particular] location, we have a meeting with the community leaders informing them about available services, what we can support, and what support we need from the community"*
>
> **SRHWG MEMBER 2**

Additional concerns

Contextualization for Gaza

The findings from this evaluation in Gaza demonstrated both the value of the MISP as a global framework and the urgent need for contextual adaptation. It was consistently emphasized that while MISP provides essential guidance, its objectives cannot be applied wholesale to Gaza without tailoring to local realities. Unlike regions where HIV, malaria, or epidemic diseases may drive SRH priorities, Gaza's public health burden is shaped by protracted occupation, repeated displacement, and systemic collapse of WASH and healthcare systems. For example, while HIV remains a central objective in the global MISP framework, with only around 35 cases in Gaza, it was argued that scarce resources should instead prioritize maternal and neonatal mortality, antenatal care for high-risk pregnancies, and emergency obstetric care.

> *How can how can we talk about the STI is while we don't have hospitals that are working? How can we talk about HIV while in Gaza, it's not common... So I suggest that to make MISP, as much as we can, tailored to the Gaza context. Maybe the context of Gaza has been totally changed from prior to the war, but we can start from here."*
>
> **SRHWG MEMBER 3**

The war has dramatically shifted needs and required reprioritization of objectives over time. Early during the war, the destruction of hospitals and lack of functioning facilities meant that discussions around STI and HIV care seemed disconnected from realities on the ground. However, as the war continued and sanitation deteriorated, participants reported rising reproductive tract infections and syndromic STI presentations, highlighting how priorities evolve over different stages of the emergency. This underscores the need for a phased or staged approach to MISP in Gaza, responsive to shifting risks as the crisis context changes.

Another major critique was that the MISP does not explicitly account for antenatal care or CEmONC care for high-risk pregnancies, despite these being the most vulnerable cases in Gaza. Providers highlighted that conditions such as pregnancy-induced hypertension and postpartum hemorrhage, previously well-controlled in Gaza's health system, are now frequently observed due to the collapse of continuity of care. This gap illustrates the limitations of a strictly global template, which may overlook locally relevant morbidity drivers.

Cultural and political sensitivities further constrain adaptation. Participants noted that donor priorities often favor "neutral" objectives such as maternity care, while HIV/STI interventions face resistance due to stigma and conservatism, limiting condom distribution and data collection. Additionally, some INGOs initially deployed emergency kits designed for African or Asian contexts, including drugs for malaria and large HIV allocations, which had little applicability in Gaza, where those burdens are negligible. Such mismatches waste scarce entry points for supplies and highlight the importance of locally informed emergency planning.

Overall, the experience in Gaza shows that MISP is a vital but mistaken tool: it offers a lifesaving framework, yet must be contextualized to local epidemiology, cultural realities, and the dynamic stages of crisis. A Gaza-adapted MISP would prioritize maternal and newborn survival, integrate antenatal and high-risk pregnancy management, GBV response, incorporate syndromic STI care within broader reproductive health, and maintain flexibility to re-rank objectives as humanitarian conditions evolve.

Specialized groups

During the war, marginalized groups such as adolescents, PWDs, men and boys, and individuals living with HIV were largely overlooked in the implementation of essential SRH services. Adolescents faced stigma, lack of targeted programming, and severe menstrual hygiene challenges, while people with disabilities encountered inaccessible facilities, inadequately trained staff, and heightened risks of GBV. Men and boys, including survivors of sexual violence, were rarely recognized within service provision, and people living with HIV remained absent from integrated SRH and GBV responses, relying solely on the MoH and IOM for treatment. Despite isolated initiatives, such as awareness sessions, assistive devices, and some disability-focused collaborations, the response was overwhelmingly centered on women, leaving these groups "missed" and their specific needs unaddressed. This gap highlights the urgent need for a more inclusive, contextualised application of the MISP in Gaza.

Limitations of the Assessment

- **Data Fragmentation and Underreporting:** SRH data remain incomplete due to health facility disruptions, staff displacement, recurrent attacks, and cultural sensitivities. Sensitive issues such as sexual violence and STIs are particularly underreported due to stigma and weak documentation systems.
- **Restricted Access and Escalations:** Ongoing conflict and movement restrictions limited primary data collection, reducing the breadth of insights.
- **Technical and Logistical Constraints:** Unstable internet disrupted online recording, resulting in partial data loss for some interviews.
- **Limited Sample Representation:** Time constraints prevented inclusion of additional key informant interviews from other SRHWG organizations or multiple representatives per organization, potentially missing diverse perspectives on SRH service provision. Gaps also exist in perspectives from related sectors, including disability, nutrition, and other clusters.

Conclusion

The implementation of the MISP in Gaza has proven both possible and, to a degree, embedded in existing health practices despite immense challenges posed by the destruction of health infrastructure, displacement, supply shortages, and sociocultural sensitivities. Enablers such as the strong commitment of healthcare workers, community trust in institutional deliveries, and the continuous coordination of the SRH Working Group and partners have sustained essential maternal, newborn, and GBV-related services even under siege conditions. The prolonged duration of the war highlights the need to move beyond emergency stopgap measures toward adapting and contextualizing the MISP for Gaza. Its flexibility provides an opportunity to re-prioritize objectives in line with the evolving context, particularly by addressing inequities in service access, strengthening referral systems, and expanding support for marginalized groups. The commitment and adaptability demonstrated by front-line health providers offer a critical foundation for scaling toward comprehensive SRH service packages. Ultimately, Gaza's experience underscores that while the MISP remains a vital entry point for humanitarian SRH, its effectiveness depends on context-driven adaptation, sustained funding, and stronger integration into local systems to ensure continuity, quality, and equity of care.

New Evidence and Insights on MISP Implementation in Gaza

1. Access and Supply Chain Constraints

- Severe restrictions on essential RH supplies: Access to emergency reproductive health (RH) kits, training materials (e.g., *MamaNatalie* training aid), and other critical commodities has been systematically denied or delayed.
- "Dual-use" classification barriers: Items such as solar energy systems, sterilisation solutions and certain medical devices have been blocked at borders, impeding facility operations and training efforts.
- Funding–access paradox: Even when funding was available, border closures prevented utilization—supplies could not enter Gaza, delaying or halting implementation.
- UNRWA and policy restrictions: UNRWA facilities face limitations on staff recruitment and procurement, undermining their ability to deliver comprehensive SRH services independently.

2. Health System Capacity and Human Resources

- Loss of specialists: The targeting and killing of health professionals created severe capacity gaps, with replacement nearly impossible under movement restrictions.
- Training barriers: Capacity-building initiatives were frequently obstructed—for instance, the *MamaNatalie* training aid was classified as dual-use and barred from entry.
- Resilience of health workers: Despite these constraints, the dedication and commitment of MoH and UNRWA health staff emerged as a key enabler for maintaining essential SRH services.

3. Coordination, Leadership, and Institutional Support

- MoH dependency on international partners: Key informants emphasized that MISP cannot be implemented by the MoH alone; effective implementation requires international technical and logistical support under MoH coordination.
- Adaptive coordination and innovation:
  - UNRWA's expansion into rehabilitation and psychosocial support, alongside NGO-supported mobile and outreach clinics, demonstrated innovative approaches to bridging service gaps.
  - GBV and SRH actors strengthened referral pathways and embedded GBV response within health facilities, ensuring integrated access to medical, psychosocial, legal, and cash support services even amid displacement.

4. Community Contributions and Local Resilience

- Community as service enabler: Communities played a direct operational role, providing electricity, water, and protection for health facilities when systems collapsed.
- Grassroots protection networks: Youth and women's friendship committees supported population mapping, food
  - The distribution and local security effectively substitute for formal policing.
  - These findings highlight that community solidarity and participation are defining features of Gaza's health resilience.

5. Social and Cultural Considerations

- Persistent stigma and sensitivity:
- Male condom distribution remains socially unacceptable.
- STI care is often confined to discussions within marriage, limiting early diagnosis and prevention.
- Emergency contraception is increasingly understood as a means to preserve dignity during prolonged displacement—an emerging, context-specific framing.
- Missed populations: SRH services remain overwhelmingly focused on women, leaving men and persons with disabilities underserved.

6. Infrastructure, Shelter, and Protection Gaps

- Slow establishment of safe shelters: Efforts to create protective shelters took over six months, with limited accessibility for men and persons with disabilities.
- Dependency on community resources: Facilities often relied on local contributions of power and water, underscoring the erosion of formal systems and the need for sustainable infrastructure investment.

7. Strategic and Programmatic Adaptations

- Localization of MISP: Translating the MISP into Arabic represents a critical step toward local ownership and operationalization.
- Gaza-adapted MISP priorities: A tailored MISP for Gaza should:
  - Prioritize maternal and newborn survival
  - Integrate antenatal and high-risk pregnancy management
  - Strengthen GBV response and syndromic STI care within broader SRH services
  - Maintain flexibility to re-rank objectives based on the evolving humanitarian context
  - Include antenatal care for high-risk cases as a specific sub-objective

8. Funding Outlook

- Critical funding gap: As of July 2025, UNFPA had secured only $28.2 million of the $99.2 million requested in the Flash Appeal for SRH interventions—leaving a $71 million shortfall.
- UNRWA's financial instability: UNRWA's funding is now being managed on a month-by-month basis, which significantly undermines the sustainability and predictability of service delivery by one of Gaza's main SRH providers.
- The combination of unreliable funding flows, access restrictions, and chronic under-resourcing poses a direct threat to the continuity of lifesaving SRH and GBV services, and highlights the urgency of sustained, flexible, and multi-year donor commitments.

9. Recommendations

- As key players, the ministries, particularly the MoH, play a central role in implementing the recommendations in the Gaza Strip, alongside the main actors in the field. Here are the per-objective recommendations, and then additional general ones.

Additional specific recommendations provided by respondents per objective

Recommendations	Responsible body
Objective 1: Coordination and Leadership	
Establish a Gaza-specific SRH Emergency Preparedness and Response Plan, building on lessons learned from this war.	MoH, along with the SRHWG partners
Strengthen the SRHWG role in service mapping, regular referral updates (every 2–4 weeks), and inter-agency coordination.	Health cluster
Enhance the SRH referral pathways between inter-agencies based on the referral guidance note with practical solutions, such as cash and voucher assistance, specific free transportation and focal points.	SRHWG partners
Improve communication at the organizational and interagency levels to keep information about essential SRH services updated for both frontliners and the community.	MoH and SRHWG partners
Institutionalize cross-sector coordination between SRH, GBV, MHPSS, nutrition, HIV, Disability, and community protection mechanisms.	MoH, Inter-cluster (Health cluster, nutrition cluster, protection cluster, and shelter) disability working group
Expand community participation in planning, using local leaders and camp focal points to adapt SRH/GBV services to cultural norms.	SRHWG and GBVsc partners
Objective 2: Prevent and respond to sexual violence, including GBV	
Re-establish and expand Women and Girls Safe Spaces, integrating health, psychosocial, and legal support within them.	Women's Affairs Ministry, GBVsc partners
Ensure integrated GBV and SRH services within health facilities to reduce referral barriers.	SRHWG and GBVsc partners
Involvement of male survivors and PWDs in the culturally sensitive interventions through capacity building of frontliners, community awareness, safe shelters, and funding for such programs.	MoH, health cluster, protection cluster, Disability task force
Guarantee confidentiality and survivor-centered approaches, especially in displacement sites where privacy is at risk.	MoH, protection cluster, frontliners
Scale up awareness campaigns (multi-channel: posters, community focal points, social media) to address stigma and inform survivors about services.	The health cluster and protection cluster are working in coordination with the Ministry of Telecommunication
Objective 3: Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs	
Secure continuous supplies of condoms, STI treatment drugs, and CMR kits.	Health cluster "WHO, UNFPA"
Expand syndromic management training for front-line providers and negotiate the re-inclusion of STI indicators into the SRH dashboard.	MoH, Health cluster
Advocate for MoH-supported laboratory testing for STI confirmation, while maintaining syndromic approaches in low-resource areas.	Health cluster
Ensure comprehensive support for HIV-positive individuals beyond ARVT (psychosocial care, reproductive health, nutrition, stigma reduction),	MoH, SRHWG, and GBV actors

Objective 4: Prevent excess maternal and newborn morbidity and mortality	
Scale up midwifery-led care, which proved resilient and effective impact during the war, through community awareness, capacity building, and supplies provision.	MoH, UNRWA, SRHWG partners
Guarantee a minimum 3-month stock of key EmONC supplies in secure warehouses across governorates.	MoH, WHO, UNFPA
Invest in local sterilization and repair capacity (ultrasound, surgical kits) to reduce delays in emergency care.	SRHWG partners with skilled community workers
Maintain mobile outreach clinics with safe passage coordination and dedicated funding to reach underserved areas.	Health cluster with MoH and SRHWG)
Integration of nutritional services along with the essential SRH services, ensuring the continuous provision of supplies.	UNICEF (nutritional cluster), SRHWG partners
Ensure the full package of PAC services at the PHC and secondary levels	MoH, SRHWG
Objective 5: Prevent unintended pregnancies	
Ensure a continuous supply of FP commodities (IUDs, pills, implants, injectables, emergency contraception) through tracking tools and update this closely with the SRHWG.	MoH, UNFPA, WHO
Ensure the availability of the IUD services through privacy settings, sterilization services, and refreshment training sessions.	MoH, SRHWG
Introduce emergency contraception beyond post-rape care, including for displaced women at risk of losing access to regular FP methods.	MoH, SRHWG
Promote culturally sensitive FP awareness through community-based channels while avoiding reputational risks (e.g., inappropriate condom distribution during mass displacement).	MoH, Health cluster, along with the Ministry of Telecommunication
Objective 6: Plan for comprehensive SRH services integrated into PHC	
Strengthen referral systems by designating select PHCs for high-risk pregnancies and ensuring referral pathways are updated every 2 weeks.	MoH, UNFPA, WHO
Integrate MISP services into the existing health system by mapping against the health system building blocks, and directing funding to identified gaps. For those who are still delivering minimum services, encourage them to move to comprehensive services within a limited timeframe.	MoH, UNRWA, Health Cluster
Invest in disability-inclusive SRH services, ensuring accessibility of facilities and training staff in disability-sensitive care.	SRHWG, Disability Task Force
Integrate additional critical services into the SRH package for Gaza's context, including nutrition, ANC and prenatal care follow-up, as well as psychosocial and community-based support, to ensure that the essential SRH services address the evolving needs of affected populations.	MoH, Inter-cluster collective efforts
Inclusion of the Health Information System into the national preparedness response plans by taking the existing tiered reporting system (3-T model) into consideration and minimizing reporting burdens.	MoH, SRHWG
Secure multi-year, flexible donor funding to sustain comprehensive SRH services beyond short-term humanitarian cycles	Donors, Global SRH Task Team, IAWG
Diversify communication and awareness channels to go beyond verbal sessions or mobile/online messaging. Local community focal points, including within displacement camps, should be engaged as trusted messengers to ensure sustained awareness of essential SRH services.	MoH, Implementing partners, Community groups

Additional Recommendations	
Enhance understanding of the MISP components among service providers through TOT trainings and cascaded models, translating tools into Arabic, and establishing feedback mechanisms for capacity building.	MoH, UNFPA, SRHWG
Develop tailored services for adolescent and youth groups through capacity building for front-line staff, awareness programs for the community, and a clear reporting system for their indicators.	MoH, Inter-cluster collective efforts
Triangulate findings and recommendations from this evaluation into any ongoing or future MISP readiness evaluation in the West Bank or Gaza to inform the future preparedness plans.	SRHWG, Global SRH Task Team

References

1. IAWG. *Quick Reference for the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH).* 2025; Available from: https://iawg.net/resources/misp-reference.
2. OCHA, *Humanitarian Needs Overview 2022.* 2022.
3. OCHA, *Gaza Strip | The humanitarian impact of 15 years of the blockade - June 2022.* 2022.
4. WHO, *Health system at breaking point as hostilities further intensify in Gaza, WHO warns.* 2025.
5. OCHA, *Reported impact snapshot | Gaza Strip,* 25 February 2025 at 15:00. 2025.
6. UNRWA, *UNRWA SITUATION REPORT #68 ON THE SITUATION IN THE GAZA STRIP AND THE WEST BANK, INCLUDING EAST JERUSALEM.* 2025.
7. OCHA, *Humanitarian Situation Update #300 | Gaza Strip.* 2025.
8. UNFPA, *Situation Report on the Crisis in the Occupied Palestinian Territory -May/June 2025.* 2025.
9. Human Rights Watch, *Gaza: No Safe Pregnancies During Israeli Assault.* 2025.
10. UNFPA, *Situation Report on the Crisis in the Occupied Palestinian Territory -May/June 2025.* 2025.
11. OCHA, *Humanitarian Situation Update #311 | Gaza Strip* [EN/AR/HE]. 2025.
12. Acaps, *Impact of the war in Gaza on the sexual and reproductive health and health rights of women and girls.* 2024.
13. WHO and MoH, *Sexual, Reproductive, Maternal, Newborn and Child Health Emergency Preparedness and Response Strategic Plan.* 2023.
14. MoH, *Health Annual Report Palestine 2024.* 2024.
15. MoH, *Annual report.* 2022.
16. MoH, U.a., *Qualitative Analysis 2022 – 2024 Maternal and Newborn Health Gaza.* 2025.
17. Cluster, U.a.H., *Referral Pathway for Sexual and Reproductive Health and Rights Guidance Note (April 2025).* 2025.
18. UNFPA, *SRHR service mapping for Gaza Strip 2025.* 2025.
19. IPC, *IPC ALERT: Worst-case scenario of Famine unfolding in the Gaza Strip.* 2025.
20. Human Rights Watch, *Gaza: No Safe Pregnancies During Israeli Assault.* 2025.
21. MoH, *Annual report.* 2022.
22. WHO, *Health system at breaking point as hostilities further intensify in Gaza, WHO warns.* 2025.
23. MoH, *Annual report.* 2022.
24. UNFPA, *Situation Report on the Crisis in the Occupied Palestinian Territory -May/June 2025.* 2025.
25. OCHA, *Flash Appeal for the Occupied Palestinian Territory 2025.* 2024.

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