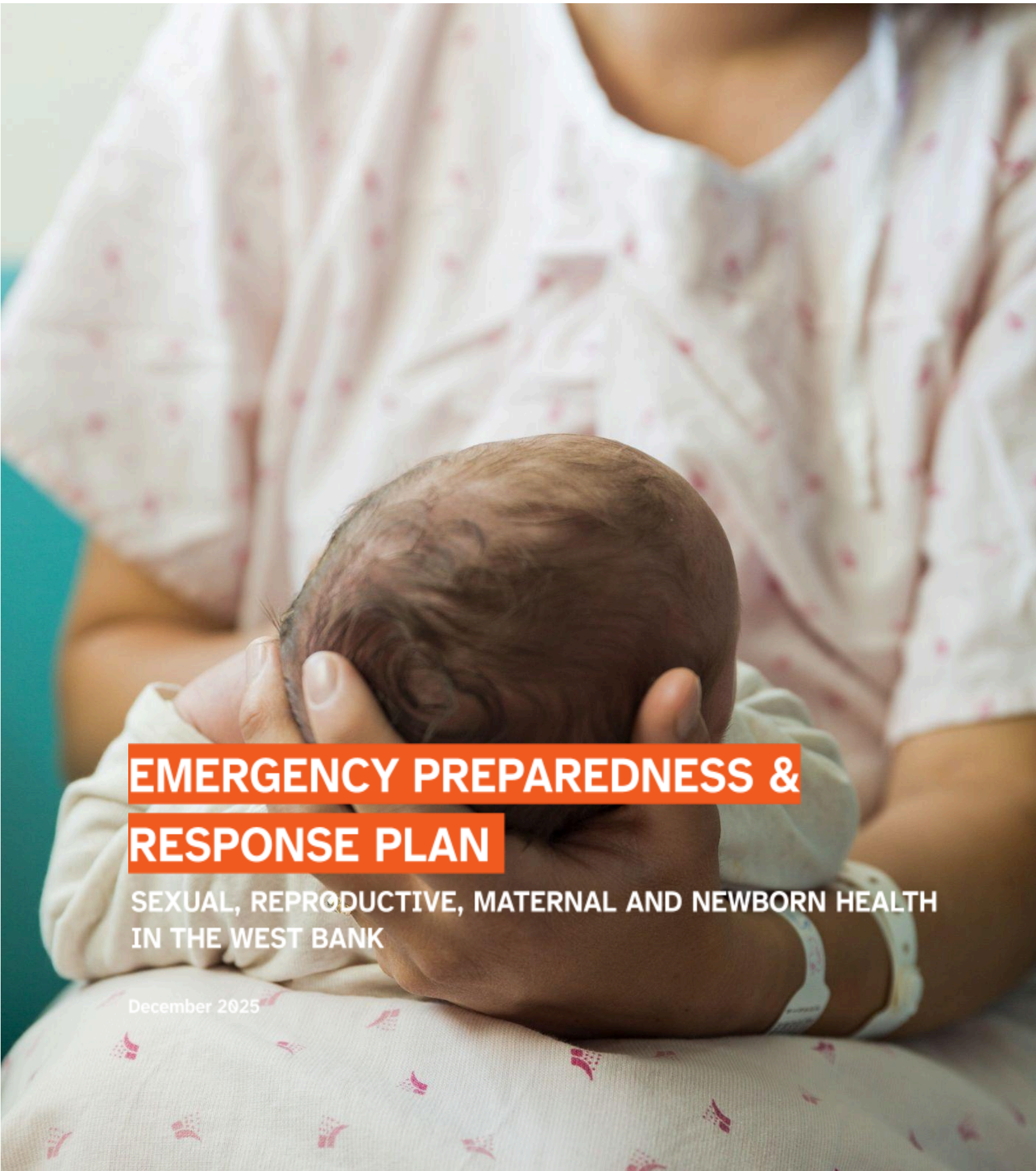


EMERGENCY PREPAREDNESS & RESPONSE PLAN

SEXUAL, REPRODUCTIVE, MATERNAL AND NEWBORN HEALTH IN THE WEST BANK

December 2025

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ABBREVIATIONS

CBOs	Community Based Organizations
EC	Emergency Contraception
ED	Emergency Directorate
EmFP	Emergency Focal Points
EmONC	Emergency obstetric and newborn care
GBV	Gender-Based Violence
HCP	Health Care Providers
HCM	Health Care Managers
HED	Health Education Department
IEC	Information, Education, and Communications
IPPF	International planned parenthood federation
SDPs	Service Delivery Points
SGBV	Sexual and gender-based violence
SRHW Group	Sexual and Reproductive Health Working Group
MOH	Ministry of Health
MISP	Minimum Initial Service Package
MOWA	Ministry of Women Affairs
NGOs	Non-Governmental Organizations
PEP	Post-exposure prophylaxis (PEP)
PHC	Primary Health Care
PHCP	Potential Health care providers
SRHTG	Sexual and Reproductive Health Thematic Group
UNFPA	United Nation Fund Population Fund
UNRWA	United Nation Relief and Work Agency
WHDU	Women Health & Development Unit
WHO	World Health Organization

DEFINITIONS OF TERMS

Emergency Focal Points (EmFP): An SRH emergency team is a multidisciplinary team formed of a number of obstetricians and gynecologists, GP doctors, midwifes, nurses, blood banks & laboratory technicians working at MoH hospitals, primary health care centers, UNRWA, PMRS,PRCS and all other SRH service providers, GBV focal points, who have been trained on MISP and who showed the scientific, technical, administrative and communication capabilities. Each member of the team will be allocated as a focal point in his/ her area, and will be responsible for effective coordination during emergency situations and crises to ensure the access of women and girls to essential SRH, maternity including responding to GBV.

Gender-Based Violence: UNFPA defines Gender-Based Violence (GBV) as any harmful act perpetrated against a person's will based on socially ascribed gender differences, resulting in physical, sexual, or psychological harm, and including threats, coercion, and deprivation of liberty. GBV encompasses a range of acts, such as physical, sexual, emotional, or economic abuse, as well as harmful practices like child marriage and female genital mutilation (FGM). While GBV disproportionately affects women and girls, it can also impact men, boys, and sexual minorities.

The Minimum Initial Service Package (MISP) for SRH in emergencies is the standard of care for SRH interventions in humanitarian settings. It is a coordinated set of priority activities aimed at preventing sexual violence and responding to the needs of survivors; preventing the transmission of and reducing morbidity and mortality due to HIV and other sexually transmitted infections (STIs); preventing excess maternal and newborn morbidity and mortality; preventing unintended pregnancies; and planning for comprehensive SRH services that are integrated into primary health care. The standard also calls for safe abortion care to be available to the full extent of the law, in health centers and hospitals (3).

Preparedness: The knowledge and capacities developed by governments, response and recovery organizations, communities and individuals to effectively anticipate, respond to, and recover from the impacts of likely, imminent or current disasters (25).

Sexual and Reproductive Health Thematic Group (SRHTG) in Palestine: The Sexual Reproductive Health Thematic Group (SRHTG) is a sectoral sub-group under the Health Sector Working Group, chaired by the Women's Health and Development Unit in the

Ministry of Health and formed based on the Decision of the Palestinian Minister of Health. RHTG advocates for a coordinated and harmonized planning, development and implementation of SRH programs among different stakeholders including donors, services providers and academic institutions. For further information please refer to Annex 1.

Emergency Obstetric Centers (EOCs): These facilities primarily provide general emergency medical services, with some operating 24 hours. A number of these centers already provide a limited range of SRH services (such as ANC) usually during daytime hours, and within this plan these services are to be further scaled up toward basic emergency obstetric care during emergencies and crisis. Specifically, the centers are equipped to manage complications during pregnancy, delivery, or the postpartum period until referral or transfer to hospital care is possible. Emergency obstetric care includes basic functions such as assisting spontaneous vaginal delivery, administering antibiotics, magnesium sulfate, or oxytocin.

Women Health and Development Unit (WHDU): WHDU is the strategic unit at the Ministry of Health, which generally aims at improving women's and girls' sexual and reproductive health and well-being. WHDU plays a key role in the formulation of the SRH and GBV strategic national plans, development of national protocols and technical guidelines and regularly reviewing programs, activities, results, and alternatives with different partners inside and outside the MoH to improve performance and workflow, including at times of emergencies. Another important responsibility of the WHDU is to determine and allocate resources to cover the needs for improving the quality of SRH and GBV services such as policies, action plans, guidelines, necessary equipment and training gaps. The WHDU also largely contributes to the capacity building of healthcare providers through coordinating and undertaking training workshops at various levels and for different professions that are involved in SRH and GBV care.

BACKGROUND AND RATIONALE

Sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce and the freedom to decide if, when, and how often to do so. To maintain one's sexual and reproductive health, people need access to accurate information and safe, effective, affordable and acceptable contraception methods of their choice, and when they decide to have children. Women must have access to skilled health care providers and services that can help them have a fit pregnancy, safe birth and healthy baby. Every individual has the right to make their own choices about their sexual and reproductive health, and must be informed and empowered to protect themselves from sexually transmitted infections (4).

An emergency is a situation that poses an immediate risk to life, health, property, or the environment that requires a coordinated response. Sexual and reproductive health rights in emergencies refers to the protection and fulfillment of SRH needs when normal systems are disrupted, and ensuring integration of SRH care in humanitarian responses. In these settings, women, girls, and other vulnerable groups face increased risks of unintended pregnancy, unsafe abortion, maternal mortality and morbidity, HIV and other STIs, and sexual and gender-based violence. Access to antenatal care, skilled birth attendants, contraception, and protection services is often interrupted when it is most needed. Ensuring the availability of essential sexual, reproductive, maternal, newborn, and child health (SRMNCH) services in crises is therefore critical to safeguarding health, dignity, and rights, and to preventing avoidable illness and mortality (2).

The International Conference on Population and Development (ICPD) Program of Action and multiple global frameworks and guidelines enshrine the right to SRH information and services in humanitarian settings. The accessibility to and provision of SRHR services, including maternal health care and gender-based violence (GBV) related services, are central to health, rights and well-being of women and girls. The diversion of attention and critical resources away from these provisions may result in exacerbated maternal and neonatal mortality and morbidity. In general, pregnant women are more vulnerable to experience serious complications during emergencies and must be treated with utmost priority (23).

Preparing to provide comprehensive, high-quality SRH services in an emergent humanitarian setting requires a multi-sectoral and integrated approach to reach women and girls, particularly survivors of sexual and gender-based violence (SGBV) (4). FP2030 Strategy considers governments engagement in emergency preparedness for SRH to strengthen the health systems and improve the delivery of the lifesaving priority services of the MISP for SRH (2). The Ministry of Health upon coordination and cooperation with a wide range of partners and service providers should ensure overcoming any SRH barriers during emergencies and work toward the goal of universal access to SRHR, including family planning. The MISP for SRH in crises outlines the life-saving SRH care to be provided and maintained at the outset of a crisis. It is a set of priority activities to be implemented from the onset of a humanitarian crisis (conflict or natural disaster or any other type of emergency), and further scaled up and sustained to ensure equitable coverage throughout protracted crisis and recovery (2) while planning is undertaken to implement comprehensive SRH as soon as possible (for details of MISP, please refer to the definition of terms at page 5).

The SRMNHH action plan; emergency preparedness and response (EPR) will build on the experiences of preparing for, building resilience to, responding to and recovering from a range of hazards that Palestinians endure and face from the ongoing Israeli conflict, the arbitrary practices imposed such as the separation wall and military check points and natural disasters including pandemics and lockdowns that hinder access to health care services.

This Plan is initiated by the MoH, updated and costed by an external consultant, supported and funded by the United Nations Population Fund (UNFPA) through the AFD joint project in partnership with WHO and UNICEF.

WEST BANK SITUATION ANALYSIS

Since the outbreak of the 2023 war on Gaza, the West Bank has experienced a sharp escalation in violence, movement restrictions, and instability, all of which have directly impacted access to SRMNH services. Frequent military incursions, intensified checkpoints, and road closures have severely limited the mobility of patients and ambulances and the delivery of humanitarian assistance. Since the 7th of October, 909 attacks on health and 1056 fatalities were documented in the West Bank, with 212 children and 20 women. In light of these circumstances, women's access to antenatal care, delivery, or emergency obstetric services has been critically delayed or entirely prevented. In the West Bank, more than 230,000 women and girls, including 14,800 pregnant women, have limited or no access to reproductive health services amid increased violence, movement restrictions, and attacks on health facilities (22).
These access constraints sit atop substantial underlying need: the West Bank has 820,000+ women of reproductive age and an estimated 73,000 pregnant women, with around 8,000 expected births each month, all requiring continuity of care, medical commodities, and referral pathways that are frequently disrupted by closures and insecurity. Additionally, the MoH 2024 Annual Health Report notes that 22.2% of pregnant women registered at MoH facilities are referred to high-risk pregnancy centers, meaning any disruption to screening, referral, transport, or supplies can quickly translate into preventable maternal and perinatal complications. This underscores the need for a robust, well-coordinated SRH emergency preparedness and response plan that sustains essential services, preserves timely access and referral pathways, and reduces preventable morbidity and mortality while upholding health, dignity, and rights (23).

Humanitarian and Emergency Risks: The West Bank faces various humanitarian and emergency risks that warrant careful consideration.

- **Population Displacement:** Although the West Bank experiences fewer instances of large-scale displacement to formal shelters than Gaza, localized displacements do occur. In early 2025, Israeli military operations led to the displacement of over 40,000 Palestinians from northern West Bank camps, including Jenin, Tulkarm, Nur Shams, and El Far'a. This displacement has exacerbated the vulnerability of mothers and children in these areas. These circumstances put a strain on the provision of health services to mothers and neonates. The health system must be

prepared to deploy mobile clinics and outreach teams to any shelters or host communities.

- **Isolation of Communities**: Curfews, military sieges have the potential to isolate towns or villages. In these situations, local primary healthcare centers, if functional, along with community health workers, serve as essential resources for urgent maternal and neonatal care. Remote communities located behind the Barrier or in the Jordan Valley frequently experience persistent isolation, necessitating the development of contingency plans for the delivery of vaccines, referrals, and supplies, along with the implementation of telemedicine services.
- **Public Health Emergencies and Disasters**: **Public Health Emergencies and Disasters:** The COVID-19 pandemic (2020) exposed the health system's vulnerability to global crises, leading to temporary disruptions in routine RMNCH services. There remains a risk of future disease outbreaks particularly if immunization coverage or WASH systems are compromised.

Emergency Scenarios and Delivery Strategies

The plan identifies the following scenarios representing potential emergencies that could disrupt SRMNH services in the West Bank. They are based on patterns and risks outlined in recent OCHA Humanitarian Situation Updates (2024–2025), as well as past assessments and contingency exercises by UNFPA, WHO and partners. By drawing on these documented developments, the scenarios anticipate how an increase in access limitations, displacement, settler violence, and system fragmentation could impact SRMNH service delivery and guide preparedness and response interventions.

Scenario 1: System disruption & movement restrictions with limited accessibility to health facilities due to widespread movement restrictions in the West Bank (All districts are affected)

Definition:

A scenario characterized by a convergence of large-scale military operations, intensified movement restrictions, widespread facility damage, increased closures, and stockouts of essential medicines and fuel lead to health system disruption. Escalated conflict or safety measures that result in extensive movement limitations throughout the West Bank, restricting access to healthcare services. This situation may result from military

operations, prolonged curfews, the closure of metallic doors at the entrances of districts and villages, or checkpoints that impede patients and healthcare workers from reaching hospitals and clinics. It may happen on a local scale, such as a city-wide lockdown, or potentially extend across an entire territory in the event of a significant escalation. Checkpoints and road closures increase, further restricting movement, including ambulance access, while some health facilities face damage or access denial.

The impact on health services: Communities may experience partial or complete challenges in accessing their regular health care providers. Health facilities may be functioning with limited staff or encountering shortages in supplies due to interrupted supply routes. Routine services, such as outreach and well-baby clinics, may be temporarily suspended. Pregnant women at high risk and newborns with health issues may find themselves in a difficult situation. It is likely that main hospitals and primary health care centers will maintain emergency operations, although with a reduced capacity.

Delivery Strategies: In this scenario, the goal is to bring services **closer to the population** and provide remote support:

- **Use of Telemedicine and Hotlines:** Implement and initiate emergency telephone hotlines through telemedicine. Telemedicine consultations can be organized when possible—such as a physician in a hospital instructing a nurse in a rural clinic over the phone on the procedures for newborn resuscitation.

- **Decentralized Service Points:** Identify operational health facilities that are accessible within each locality, which may include small clinics or private doctor's offices that are open. It is necessary to maintain a stock of essential medicines and communication tools for effective coordination with primary hospitals.

- **Emergency Transport Coordination**: In situations where general movement is limited, it is essential to communicate with authorities to facilitate the movement of ambulances for critical cases.

- **Continuity of Critical Services**: Certain life-saving services must remain functional, even if routine care experiences delays. For neonates, it is essential that all operational hospitals maintain the provision of emergency obstetric and neonatal care, including deliveries, C-sections, and newborn resuscitation. In situations where a mother is unable to access the referral hospital, the closest

facility, regardless of its usual designation as a delivery center, should make an effort to manage the delivery with the assistance of phone guidance. This indicates the importance of distributing clean delivery kits and providing training for general staff in emergency delivery procedures.

- **Mobile Medical Teams**: Implement mobile health teams to reach communities that have not received care. These teams, consisting of midwives, pediatric nurses and potentially a physician, are equipped to:
    - conduct immunizations, monitor growth, and manage ill neonates on-site. They transport essential supplies such as vaccines (in temperature-controlled containers) and essential medications.
    - Antenatal and postnatal monitoring, including taking maternal vital signs, rapid test screening for anemia, PET, and DM, and auscultation of fetal heart.
    - GBV detection, management and referral services
- **Triage and Task Shifting**: At the operational facilities, follow strict triage protocols: prioritize emergency cases (injuries, deliveries, neonatal emergencies) and delay elective or non-urgent visits.
- **Community Support Systems**: Communities should mobilize their own support by identifying individuals with medical expertise in the area, such as a retired nurse, doctor, or midwife, who can assist with immediate needs.

Scenario 2: Expansion of closures & Mass Displacement to Shelters (Population Influx in Specific Areas)

Definition: A scenario in which, as a result of conflict or disaster, a significant number of families, including newborns and children, are forced to leave their homes and seek refuge in temporary shelters. Building on Scenario 1, the situation worsens with the addition of new checkpoints across the West Bank, further limiting access to hospitals and referral systems. Settler violence persists in key areas, exacerbating insecurity and displacement. Families seek refuge in temporary shelters, often with inadequate health services. This results in heightened demand for SRH and EmONC services in settings with limited capacity, while overcrowding and poor living conditions increase GBV risks and raise the likelihood of diseases spreading. Hospitals face access restrictions or

direct damage, while mobile units and other health facilities are placed under significant strain as referral times grow longer.

Impact on Health Services: The sudden increase of population in shelters results in overcrowding, inadequate sanitation, and a greater risk of communicable diseases, significantly impacting health services. Routine health services for the displaced will be disrupted. The level of psychosocial stress is elevated. Newborns in shelters are at risk of hypothermia during winter, dehydration, diarrhea, and insufficient access to appropriate feeding.

Delivery Strategies: The focus here is to establish healthcare provision within or near shelters and address the special needs of displaced children:

- **Deploy Mobile Clinics and Medical Teams to Shelters:** Promptly mobilize clinic teams to establish operations at each major shelter location. It is essential for each team to include at least one medical doctor or a nurse/midwife, along with support staff. These clinics are expected to provide acute care for illnesses, first aid, and limited preventive services, including vaccinations.
- **Establish Newborn Friendly Spaces:** In shelters, establish a designated area for newborn care, providing support for mothers with infants. This area may serve as a specific space within a classroom for breastfeeding and neonatal check-ups. A health worker or trained volunteer should conduct daily rounds to monitor newborns for any potential danger signs, as displacement may result in issues such as umbilical cord infection or jaundice being missed. Establish a space suitable for psychosocial activities for children, as this environment facilitates the monitoring of their well-being and serves as a place for health education, including hygiene promotion and nutrition screening.
- **Adapt service delivery:** Standard hospital-based care may not meet all requirements. In the situation of neonatal care, if local NICUs are full or located at a long distance, it may be helpful to establish a stabilization unit at a designated shelter or nearby clinic. This unit would provide to newborns who are ill but do not require immediate NICU intervention or who are in the process of being transferred. In certain situations, stable neonates are cared for outside the NICU during periods of hospital overload. Only critical cases should be referred externally.

- **Water, Sanitation, and Nutrition in Shelters:** Collaborate effectively with WASH and relief organizations to guarantee that shelters are equipped with clean water, latrines, and waste management systems to mitigate the risk of illness. Coordinate on-site nutrition support: Monitor infants' milk intake. If mothers are unable to breastfeed due to stress or other challenges, it is advisable to engage lactation counselors to provide encouragement and support for lactation when feasible. If formula must be provided, do it in a controlled manner with clean preparation to avoid diarrheal outbreaks (following the Operational Guidance on Infant Feeding in Emergencies standards).
- **Referral from Shelters: Ensure that a minimum of one ambulance or mobile team is on standby for each large shelter cluster.** In the event that a newborn experiences a severe illness, such as the development of severe pneumonia in a newborn, it is important that they are transported quickly to the nearest functioning hospital. The leader of the shelter's medical team will maintain direct communication with the focal points at the referral hospital to inform them of incoming patients. In situations where specific specialized services, such as incubator care for a preterm infant, are required, it is necessary to facilitate the transfer of the infant to an appropriate medical facility, even if that requires relocation to another city, potentially with the assistance of UN agencies for effective coordination.
- **Engagement with the community in shelters**: Within the displaced population, it is essential to identify individuals with health-related training, such as nurses, midwives, and similar professionals, who may be present among the population. Involve them as volunteers; they can assist with crowd management at the clinic, provide health education within their community, or help identify individuals in need.

Scenario 3: Health Service Disruption at Facility Level

Definition: A scenario where one or multiple health facilities are non-functional due to an emergency. This could be from direct impacts of conflict (e.g., a hospital damaged by military action) or loss of critical utilities (power, water) for extended periods.

Impact on Health Services: For neonatal health, if a pediatric hospital or NICU is damaged, the vulnerable inpatients are at high risk. Even partial infrastructure problems (like loss of water) can force a hospital to relocate patients.

Delivery Strategies: Emphasize **relocation and rapid recovery** of services.

- **Evacuate and Redistribute Patients**: In the event that a hospital with a NICU or pediatric ward becomes non-operational, the foremost priority is the secure evacuation of admitted neonates and pediatric patients. Identify alternative facilities that are capable of accommodating these patients in advance. Utilize ambulances or civil defense vehicles as necessary to facilitate the transportation of incubators equipped with manual ventilation support. Upon evacuation, notify the public that the facility is temporarily closed and provide guidance to alternative options.
- **Continuity of Operations in Alternate Facilities:** Implement emergency measures in receiving hospitals: establish additional beds or convert recovery rooms into temporary NICU facilities. Utilize portable equipment, such as transport incubators and portable monitors, from the evacuated facility. Staff may need to be reallocated as well; for example, pediatricians from the damaged hospital move with their patients to help at the receiving hospital. It is essential to transfer the medical records of evacuated patients, even if this is done through a handwritten note in an emergency situation.
- **Field Hospitals or Temporary Units:** In situations where nearby facilities are unable to accommodate the patient load, such as during a large-scale disaster with multiple hospitals unable to function, it is essential to establish a **field hospital or temporary clinic** dedicated to maternal and newborn health. These can be utilized until the infrastructure is restored. To address primary care requirements, deploy **mobile clinics** to fill service gaps in the event of local clinic destruction—position them at the location of the affected clinic to guarantee the community can easily access necessary services.
- **Rapid Repair and Rehabilitation**: Collaborate with relevant authorities to accelerate the repair of healthcare facilities. It is essential to engage infrastructure support, such as emergency engineering teams, to evaluate and establish safe areas while implementing prompt repairs.

- **Healthcare Provider Outreach:** If a primary clinic is down, community health workers and remaining staff can do outreach in that community so that the population still receives basic care until the facility is restored or they can travel elsewhere. This scenario might also require health workers to work out of unusual locations—e.g., a nurse might run a vaccination session from a mosque if the clinic building is unsafe. Flexibility and communication are key.
- **Records and Supplies**: Following an incident at the facility, make an effort to relocate the medical supplies, vaccines, and equipment, provided that the environment is considered safe. If a clinic's pharmacy remains intact, transfer those medications to the nearest functioning clinic for utilization.
- **Public Communication:** Notify the community regarding service re-routing; for example, "Clinic X is currently closed due to damage; a temporary clinic has been established at the municipality hall" or "For pediatric emergencies, please visit Hospital Y instead of Hospital Z for the time being." This provides families with clear guidance on where to seek care for their ill children.

Scenario 4: Isolation of a Geographic Area (Siege/Quarantine)

Definition: A scenario where a specific area (village, neighborhood, or entire town) becomes **isolated** from outside assistance. This could be due to a strict military siege (no one can enter or leave the area for a period of time) or a quarantine in case of a severe disease outbreak. The isolation can last days or even weeks. Essentially, the area must rely on whatever resources are inside it, as external support is delayed or prevented.

Impact on Health Services: Local health facilities and community resources are the only crucial. If the area has a clinic or small hospital, it might soon run low on supplies or capacity if the isolation is prolonged. Patients cannot be referred out easily. This is a worst-case scenario for those requiring advanced care, like a newborn needing NICU or a child needing surgery—they might not be able to reach it. Morbidity and mortality risk rises each day of isolation.

Delivery Strategies: Focus on **self-sufficiency and bridging until access is restored**.

- **Preparedness and Stockpiling in High-Risk Areas:** As preparedness, identify the high-risk communities (history of sieges or remote areas). **Preposition stocks**

of essential medicines, water sterilization tablets, and food in those communities. For example, clinics in Area C villages that have a single access road should have an extra month's worth of essential drugs and supplies at any given time.

- **Local Empowerment**: Train community healthcare professionals in essential skills. Enhance the community's capacity to operate independently for a period of time.
- **Telemedicine and Remote Support**: During a siege, communication channels such as phone lines or the internet may remain functioning, even when physical access is restricted. Offer remote healthcare consultation. Healthcare professionals working externally can provide guidance to those inside on managing complex cases. In the event that a particular medication is unavailable, such as an anticonvulsant for a pediatric patient experiencing seizures, remote consultation may involve the consideration of an alternative medication that is accessible.
- **Community-Based Referral Alternatives:** If ambulances cannot come in, consider **local transport** solutions; e.g., if someone critical must leave, perhaps via coordination a walking patient transfer at a front line could be done (rare and dangerous but has occurred under Red Cross escort in some sieges). If not, within the area, move patients to the location with the best available care. Use what's there—if there's a midwife in that isolated area, all pregnant women should go to her if in labor since they can't reach a hospital.
- **Psychosocial support and messaging:** Isolation can cause panic. Provide calming but honest communication to the community: instruct them on hygiene to avoid illness and encourage mutual help. Psychosocial support networks (like religious leaders or teachers) can keep motivation and interaction, which indirectly helps protect health (people share scarce food or help take care of each other's kids).
- **Breaking the Isolation (Advocacy):** Meanwhile, outside actors (MoH, UN) should be advocating to lift the siege or get humanitarian corridors.

These four scenarios guide specific response adaptations, but the main principle is **flexibility and rapid response**. The health system should be ready to shift depending on which scenario (or combination) happens.

VISION

To ensure that in an emergency, all people in the occupied Palestinian territory (oPt), regardless of sex, age, gender, gender identity, socioeconomic condition, ethnicity, cultural background and legal status, have timely, safe, and equitable access to essential SRH, maternal, newborn and GBV services, their rights, dignity, and safety are respected, protected, and fulfilled, and that national and international partners coordinate effectively to reduce inequities by strengthening preparedness, activating MISP, sustaining continuity of care, and supporting early recovery.

METHODOLOGY

The methodology used for developing this action plan was participatory approach where stakeholders and some partners (MOH-WHDU, WHO, Unicef, NGOs, MOH-Emergency Directorate Personnel and UNFPA representatives) have their discussion and exploration of ways and methods have guided the development of the plan. The goal and operational objectives, the SRH guiding principles and the MISP framework for the core issues of emergency preparedness and response strategies were the building blocks of this action plan. The plan was initiated in line with the previous national and international plans and commitments.

In 2025, the plan was revised and amended to account for the most recent developments in the West Bank, particularly in relation to the complexities of the political situation and the resulting impact. Following a discussion with the MoH, a list of key stakeholders was compiled for potential interviews. This list includes UN agencies and NGO SRH service providers.

The costing of interventions in this plan was conducted using a combination of humanitarian costing tools and Palestine-specific adaptations. The MISP Calculator was used to calculate affected population size to feed into the Inter-Agency Reproductive Health (IARH) Kit Calculator (Annex 3), which calculated quantities of medicines, devices, and reproductive health commodities. This provided the necessary forecasting of supplies, including contraceptives, clean delivery kits, and others. To ensure feasibility of implementation, logistical costs were estimated through the Logistics Cost Calculator (Annex 4), covering the transport, storage, and distribution of caravans and mobile units where relevant.

The MISP Costing Tool and framework (Annex 2) was applied to structure activities under each objective and to generate cost estimates. While the original tool allows calculations for a limited set of countries, it was adapted with Palestine-specific cost inputs and interventions, ensuring contextual accuracy.

GOAL AND OBJECTIVES

The goal of this action plan is to strengthen SRMNH emergency preparedness and response (EPR), to be integrated within the MoH emergency plan for the affected governorates. The plan seeks to ensure provision of the MISP during emergencies in order to reduce maternal morbidity and mortality, unsafe abortions, and responding to GBV cases identified by the health service provider particularly women and girls in underserved areas, shelters, and hard-to-reach locations.

To achieve this goal, the following operational objectives and resultant activities were carried out:

1. Revision of studies and statistics on the status of Palestinian demography,
2. Revision of studies and statistics on SRH/GBV indicators and coverage issues
3. Highlighting the health resources and services provided for SRH/GBV
4. Identifying the Role of MOH and its Partners including NGOs and International NGOs and private sector (Annex)
5. Following the guiding principles for SRH services
6. Identification of the target audiences of the plan
7. Utilization of the MISP preparedness and response in emergencies guided by its six objectives to form the core issues of this annual action plan

PALESTINIAN DEMOGRAPHY

Based on population estimates published by PCBS, there are about 14.9 million Palestinians in the world at the end of 2024, of whom about 5.5 million are in the State of Palestine; 2.8 million males and 2.7 million females. The estimated population of the West Bank (WB) is 3.4 million, comprised of 1.71 million males and 1.65 million females. The estimated population of Gaza Strip (GS) is 2.13 million for the same year; of whom 1.07 million males and 1.06 million females (18). By the end of 2024, the percentage of individuals less than 15 years of age constituted 37% of the total population; 35% in WB and 40% in GS; and 65% under 30 years of age. The percentage of elderly population aged (65 years and above) reached 4% of the total population (15).

There is also a steady decline in the average household size in Palestine, declining to 5.0 individuals in 2022 compared to 5.8 in 2007. In the West Bank, the average household size declined to 4.7 in 2022, compared to 5.5 in 2007 (13). Additionally, 11.8% of households were headed by females in Palestine as of 2024. The 4th quarter of 2024 also saw the unemployment rate for females in the West Bank reach 29.1%, compared to 27.7% for males (16).

The number of females of reproductive age in the West Bank is 847,505 females, representing 25.2% of the total West Bank population. The crude birth rate in the West Bank in 2024 was 27.0 births/1,000 of the population, compared to 28.1/1000 in 2023. In 2024, the total number of reported live births in the West Bank was 81,151, 99.9% of which took place at health facilities (5). The adolescent birth rate in the West Bank in 2024 numbered 0.02/1,000 for the age group of 10-14 years, while it numbered 24.9/1,000 for the age group 15-19 years. Additionally, in 2024, the total number of maternal deaths in the West Bank was 18 cases, with a maternal mortality rate of 22.22/100,000 live births. Five of these deaths were during pregnancy, four during delivery, and nine deaths 42 days after delivery (5). Infant Mortality rate (IMR) 8.5 per 1000 and under-five mortality rate 26 per 1000 livebirth. A constant decline in the fertility rate reached 3.8 births in 2017-2019, compared to 4.6 births during 1999-2003; 3.8 births in the West Bank and 3.9 births in Gaza Strip. On the other hand, the fertility rate was 3.8 births in urban areas compared to 4.4 births in rural areas and 3.5 births in the Palestinian refugee camps (5).

SRH INDICATORS AND SRH COVERAGE IN PALESTINE

The Palestinian population has seen a steady improvement in SRH indicators in recent years. About 99% of women in Palestine received antenatal care from skilled health personnel in 2020, with women who received antenatal care at least 4 times about 95%, and those who received at least 8 times approximately 73%. The use of any contraceptive methods for married women aged 15-49 reached 57% in 2020, rising 4% from 2010. The percentage of caesarean deliveries reached 35% in 2024, rising from 17% in 2010. The percentage of exclusive breastfeeding reached approximately 43% in 2020, compared to 27% in 2024 (14).

Yet, discrepancies in the data of SRH indicators is noticed when the Palestinian Multiple Indicator Cluster Survey 2019-2020 (12) reported that 13% of women in Palestine have unmet need for family planning and do not use any means of family planning methods (FP). Unmet need in the country has been linked to availability and quality of services, particularly weak counseling, and limited availability of female providers, and in some cases negative providers' attitude towards FP. This rate, as well the other aforementioned indicators, have likely worsened since the war on Gaza, due to increased barriers to access of services. According to a 2025 UNFPA advocacy brief on the northern West Bank, intensified military operations, mass displacement, and movement restrictions have left over 160,000 women of reproductive age and more than 70,000 adolescent girls without access to SRH services, with thousands of pregnant women facing unsafe delivery conditions and heightened maternal morbidity risks. 20 births occurred outside a hospital in the Northern West Bank in 2024 and until March 2025, 12 being home deliveries, one without assistance, and the remaining assisted by midwives or retired midwives.

GENDER-BASED VIOLENCE

Prevailing evidence and research dictate that GBV occurs in all emergencies worldwide, so we do not wait to prove GBV is occurring before taking action (1). The prevalence and risks of GBV increase as existing gender inequalities are exacerbated by the chaos and tensions within households, communities, and society. GBV is among the greatest protection challenges for individuals, families, and communities face during humanitarian emergencies.

SGBV is too often the norm in humanitarian settings. Survivors can be women, men, adolescents, people with disabilities, young children, and people with diverse sexual orientations, gender identities, or sex characteristics, ethnic and religious minorities, and sex workers, among others. GBV restricts choices and decision making of those who experience it, curtailing their rights across their life cycle to access critical SRH information and services.

SRH is a human right and an essential component of the overall health and protection package in a humanitarian response. Providing comprehensive, high-quality SRH services in humanitarian settings requires a multi-sectoral and integrated approach to reach women and girls, particularly survivors of sexual and gender-based violence (SGBV).

The Violence Survey in the Palestinian Society (2019) indicated that 52% of women in the West Bank were exposed to psychological violence, 12.4% physical violence, 7.6% sexual violence, 24.3% social violence and 32.4% economic violence. In the West bank, the intimate partners were the aggressors; 52.3% husbands, and 19.8 by others (brother or father). There is a large number of females who were abused do not report that because of the social norms and practices. This same survey reported that 53% of female youth 18-29 who have never been married kept silent and 47% avoided talking to the aggressor and only 18% talked to the aggressor to stop their aggression (11).

As previously mentioned, these indicators have likely worsened since the war on Gaza and increased aggression on the West Bank. A UNFPA Gender-Based Violence Safety Audit Report of the West Bank in 2024 found that not only are women subject to increased violence from Israeli forces, but many women reported an increase in intimate partner violence due to the ongoing war, where increased financial strains and psychological pressure led to a rise in domestic violence (20).

These groups are often undeserved in an emergency. There is a need to support these groups specifically, by incorporating inclusive measures into SRH practice focusing on building capacities of agencies and care providers particularly in crisis situations as emphasized in objective 2 of the MISP where this needs to be sustained and institutionalized throughout all health and social protection agencies and programs.

HEALTH SYSTEM

According to the Palestinian Ministry of Health, there are four main providers of health care services in Palestine; 1) Ministry of Health, 2) UNRWA, 3) Nongovernmental organizations, and 4) the private sector. Each provides primary health services at the 4 levels of care and with its own respective network of primary health care centers and hospitals to ensure a quality of care given to the Palestinian citizens (5).The Ministry of Health report (2024) also noted the number of primary health care (PHC) centers/clinics according to each health care provider in the West Bank as such; MOH 447, UNRWA 43, NGOs 88, and Palestine Medical Military Services 12 with a total of 590 PHCs in the West Bank. The MoH provides family planning services in 270 centers, and high-risk pregnant services in 77 clinics.

As of 2024, there are 60 hospitals in the West Bank, with a bed capacity of 13.4 per 10,000 of the population. The MoH accounts for 42.7% of total bed capacity in the West Bank. Nongovernmental organizations account for 37.3% of bed capacity, UNRWA for 1.3%, while private institutions make up 18.7% (5).

In the 2025 rapid assessment of EMONC facilities in the West Bank, 29 MoH facilities were assessed for emergency obstetric and newborn care (EmONC). Only 4 MoH hospitals (Hebron, Ramallah, Nablus, Jenin) had full BEmONC and CEmONC functionality. The rest were missing critical signal functions, while all 15 emergency centers lacked more than two, especially in assisted delivery and blood transfusion. Gaps in staff, equipment, and referral systems create serious delays, particularly in underserved areas like Tubas and South Hebron (24).

For more information, Please refer to the link below, “full rapid assessment report on EmONC services in the West Bank”.

https://palestine.unfpa.org/en/publications/rapid-assessment-emergency-obstetric-and-newborn-care-west-bank-occupied-palestinian

THE ROLE OF THE MINISTRY OF HEALTH AND ITS PARTNERS

The leadership role of national and local authorities, communities and beneficiaries in ensuring access to SRH services should be recognized and supported by MOH from policy formulation, through the development of action plans and in the design and delivery of services. This action plan is formulated and will be guided and led by MOH-WHDU, and integrated within MOH-Emergency Department Plan.

Partnerships at global, regional and country levels have a fundamental responsibility to support and strengthen the capacity of national and local actors and ensure ownership and acceptability of programs by communities and individuals. Primary health care provider for SRH services (MOH, NGOs and UNRWA) in each town and district in WB and GS have been identified from previous plans (Annex 2)

Formulation of major bodies in SRH/GBV services at national level guided by MOH is another strength, these are; the Emergency Obstetric Centers (EOCs), the Reproductive Health Thematic Group (RHTG), the Emergency Focal Points (EmFP) roles have been (identified in the definition page), SRH working group and GBV sub-cluster are the core SRH/GBV service providers in emergencies and the aftermath of emergency.

An integrated approach to the planning and delivery of SRH services (e.g. strengthening the linkages between SRH, GBV and other services) optimizes resources and maximizes opportunities for improving access to SRH in communities, including during emergencies.

In emergency situations where demands on health services are high and time and resources are limited, SRH services are prioritized on the basis of saving lives, optimizing scarce resources and responding to the needs of the affected community. The Minimum Initial Services Package (MISP) describes the key SRH priorities that are expected in emergencies.

GUIDING PRINCIPLES

This national plan has been drafted with a focus on the following guiding principles:

- Sexual and Reproductive health (SRH) is a human right.
- Sexual and reproductive health is a significant public health issue, including in emergencies.
- Timely provision of SRH services before, during and after emergencies can prevent a range of adverse outcomes
- Sufficient numbers of trained health-care workers and adequate facilities and supplies are essential for SRH service delivery.
- SRH should be promoted as a fundamental component of primary health care at all times.
- The Minimum Initial Service Package (MISP) for Reproductive Health is standard for essential health services in crises.
- In emergencies, communities are the first responders and can identify pregnant women and adolescents and survivors of sexual violence and support them in getting the care they need.

TARGETED AUDIENCES

- This national plan is addressed to the policy-makers responsible for setting policies and developing national or sub national plans of action and associated budgets on sexual and reproductive health and rights.
- National and international partners (managers and providers of care) are important audiences, since they are expected to play a key role in the implementation of national policies as stakeholders working in partnership with, or alongside, public health programs and services. These partners include the international and national, governmental and non-governmental organizations, and the private sector.
- Beneficiaries include; the general public, all family members particularly women and girls and survivors of GBV, all family members in isolation or in underserved areas
- Health service providers in primary health care centers, MCH centers, emergency centers and hospitals

THE CORE ACTION PLAN

OBJECTIVE 1: MoH supports WHDU efforts in leading the SRHTG and partners in Emergencies				
Intervention	**Preparedness Activity**	**Response Activity**	**Responsible Stakeholders**	**Cost**
1.1 Coordinate actions to have this plan in place as first step for system approach in SRH preparedness for all areas of intervention	Plan signed off on by WHDU and RHTG partners and disseminated	Used as guiding framework in for Emergency preparedness and Response	MoH-WHDU and RHTG	No cost envisaged, part of regular MoH spending and coordination
1.2 Host regular monthly meetings and based on needs of WHDU with all relevant partners and stakeholders on a monthly basis and as relevant in emergencies to ensure consistency in emergency	Monthly WHDU coordination meetings with partners and stakeholders for SRH emergency preparedness	Emergency meetings convened as relevant during crises	MoH-WHDU, RHTG, EmFPs, HCMs	No cost envisaged, part of regular MoH spending and coordination

preparedness activities				
1.3 Ensure each MOH-WHDU partner organization has an emergency focal point in place	Designation of SRH GBV emergency focal points within MoH-WHDU partner organizations and training where necessary Identify and designate trained adolescent / youth focal within MoH-WHDU partner organizations to ensure youth perspectives are included in planning and preparedness efforts	Focal points activated for direct coordination during emergencies	MoH-WHDU, RHTG, and EmFPs	No cost envisaged, part of regular MoH spending and coordination
1.4 Develop a centralized digital platform / live	Platform developed, functional, and tested for readiness	Updated in real time by EmFPs during emergencies	MoH-WHDU and partners, RHTG, EmFPs, MoH	$10,000

document / Excel sheet for real-time reporting by EmFPs of SRH/GBV services during emergencies			Emergency Directorate (ED)	
1.5 Train PHC health care providers, and selected referral hospital staff (ob/gyn doctors, midwives, emergency nurses), in the MISP curriculum; and conduct a refresher Training of Trainers (TOT) for previously certified EMFP trainers	Train 40 healthcare providers per governorate) MISP curriculum; refresher TOT for 16 EmFP trainers	Application of MISP protocols by trained staff during emergencies	MoH-WHDU, RHTG, HCPs	$12,808
1.6 Pilot SRH telemedicine initiative to provide remote medical services in case of	SRH telemedicine service developed and piloted under MoH-UNFPA plan	Telemedicine activated to deliver SRH services when access to centers is blocked	MOH-WHDU, UNFPA, MoH ED	Costing ongoing within MOH-UNFPA telemedicine plan

inability to reach centers				
1.7 Creating SRH supplies tracking mechanisms to track supplies availability, consumption and any stockouts	Connect with supply chain relevant departments at MoH and agree on tracking mechanism	Rapid mobilization of FP/drugs/devices	MoH-WHDU, UNFPA, WHO, MoH Procurement and Storage	Cost for provision of supplies will be updated on annual basis and based on availability of funds

OBJECTIVE 2: Prevent gender-based violence/sexual violence and respond to the needs of survivor				
Intervention	**Preparedness Activity**	**Response Activity**	**Responsible Stakeholders**	**Cost**
2.1 Strengthen multi-sectoral coordination, accountability, and community-based prevention mechanisms to address and respond to GBV	• Collaboration and coordination within GBV subcluster in enacting preventative measures at community level for all partners • Referral system	• GBV subcluster activates community-level coordination and prevention mechanisms during emergencies • Referral pathways for prevention and response to GBV fully activated and used in crisis settings • WHDU leads and oversees implementation during emergencies	MoH-WHDU, GBV Subcluster, MOWA.	No cost envisaged, part of regular MoH spending and coordination

in emergencies to protect affected populations, particularly women and girls, from sexual violence	documents for “multi-sectoral, interagency coordination and action to prevent and respond to GBV” in use and integrated in preparedness strategies of all • WHDU responsibility and accountability established for all activities in this regard				
Capacity building on GBV/CMR	WHDU, MOH	WHO and UNFPA , health cluster , GBV sub cluster and SRH organized ToT for health providers in	UNFPA, WHO Health cluster, GBV sub cluster and SRH		

		north of Gaza and the south WHO / UNFPA/ Juzoor/ health cluster / GBV sub cluster and SRH will organize 5 cycles of training will to train health workers on GBV and CMR and referral pathways in Gaza		
Ensure quality reporting of GBV cases identified by health frontliners, treated or referred based on the survivor's			MoH,UNICEF,UNFPA	

centered approach					
2.2 Ensure detection and referral to other supportive services available for survivors of sexual violence by capacity-building of health care providers on detection and referral of GBV, including adolescents, with age-appropriate referral based on the developed protocol	Train PHC doctors, nurses, and midwives; referral hospital emergency and obstetric staff across governorates in the detection and referral of GBV survivors (40 trained, 3–4 per governorate)	Detection protocols and referral systems activated for GBV survivors in emergencies		MoH-WHDU, GBV Sub-cluster, MOWA.	$9,421.62

Provision of dignity kits for women and girls at risk, IDPs treated by health frontliners		WHO has procured 77,500 DK and distributed to MOH/ UNRWA/ GBV sub cluster partners in Gaza	UNFPA, WHDU, GBV SC, WHO,unicef		
2.3 Ensure that confidential and safe spaces within health facilities can adequately receive and provide survivors of sexual violence with appropriate clinical care and referral, , including adolescents, with age-appropriate	Consultant hired to conduct functionality and privacy rapid assessment of existing GBV safe spaces; adequacy, confidentiality, and usability assessed; gaps identified	Gaps in safe spaces addressed and made functional, and used during emergencies for provision of clinical care and referrals		MoH- WHDU, UNFPA, GBV subcluster, MOWA.	$3,500

clinical care and referral.				
2.4 Ensure community awareness about availability of GBV services for women and girls	Conduct community awareness in camps/shelters and/or vulnerable areas to increase knowledge of available GBV services, referral pathways, and protection mechanisms (10 sessions in most vulnerable governorates (est. 5), each workshop includes 20 participants; total outreach 1,000	Further awareness sessions scaled up in emergencies to ensure affected communities are informed of available GBV services and referral pathways	MOH-HE Department, MOH-WHDU, GBV Subcluster.	$10,569

	people; scalable based on need)			

OBJECTIVE 3: Prevent the transmission of and reduce morbidity and mortality due to STIs				
Intervention	**Preparedness Activity**	**Response Activity**	**Responsible Stakeholders**	**Cost**
3.1 Capacity building in National STI Protocols for MoH PHC staff (doctors, nurses, midwives) and selected referral hospitals across governorates	Capacity building refresher sessions held for health care providers across governorates on National STI Protocols (approx. 60? providers, spread across governorates)	Trained providers apply National STI Protocols in emergencies	MoH-WHDU	$23,586.8
3.2 Ensure the availability in supplies for treatment of sexually transmitted infections (STIs)	Procure and pre-position STI treatment kits at PHC facilities and referral hospitals	X number of Kits/items mobilized and distributed to ensure uninterrupted STI management during emergencies	MoH Procurement Department, MoH-WHDU, UNFPA	$421,667.26

3.3 Ensure application of standard precautions of infection prevention and control at all levels of care	Protocols for infection prevention developed and maintained for service providers	Protocols applied by service providers during emergencies	MoH Quality Control Department	$ 5500
3.4 Guarantee the availability of free lubricated male condoms where applicable (e.g., already used by the population) in hospitals and PHC clinics	Procure and pre-position male condoms in hospitals and PHC facilities	X number of Condoms distributed to hospitals and PHC clinics for public use during emergencies	MoH Procurement Department, MoH-WHDU, UNFPA	$192,171
3.5 Provide clinical management of rape kits/items or to health care facilities (hospital and primary health care centers) as well as post exposure	Procure PEP/ CMR kits/items and pre-position them at hospitals and PHC facilities.	X number of CME/ PEP are distributed to PHCs and hospitals in emergencies for survivors of sexual violence and	MoH Procurement Department, MoH-WHDU, UNFPA	$160,950.52

prophylaxis (PEP) kits for occupational exposure		occupational exposure		
3.6 Emergency provision of blood transfusion kits and supplies for treatment of STIs	Procure and maintain stock of blood transfusion kits at hospitals	Blood transfusion kits distributed and used in hospitals during emergencies.	MoH Procurement Department, MoH-WHDU, UNFPA	$12,094.5

OBJECTIVE 4: Prevent excess maternal and newborn morbidity and mortality				
Intervention	**Preparedness Activity**	**Response Activity**	**Responsible Stakeholders**	**Cost**

4.1 Ensure availability and accessibility of clean and safe delivery, essential newborn care, and lifesaving emergency obstetric and newborn care (EmONC) services	• Protocols for safe delivery and newborn care maintained • Accessible SDPs and referral hospitals identified • EmONC kits pre-positioned at SDPs - Develop protocols for the management of preterm or low-birth-weight infants in emergency situations.	• EmONC services activated during emergencies to ensure safe delivery and newborn care -Maintain high routine immunization coverage by quickly restoring immunization activities after any disruption. -Implement an early warning alert and response system (EWARS) for communicable diseases in emergency shelters or camps. -Ensure the functionality of NICUs and enhance	MoH hospital management dept, MoH Procurement, MoH-WHDU, UNFPA WHO	10,000

		capacity during mass casualty events -Promote exclusive breastfeeding and establish Mother-Baby Safe Spaces to provide lactation support and counseling -Perform nutritional assessments in displaced populations to detect malnutrition at early stages.		
4.1.1 At referral hospital level: Skilled medical staff and supplies for provision of CEmONC	CEmONC supplies procured and pre-positioned at referral hospitals, EOCs, and PHCs	CEmONC supplies distributed and used, and services provided by trained staff during emergencies	MOH- hospital management department MOH Procurement department MOH-WHDU	$136,600

			UNFPA WHO	
4.1.2 At health facility level: Skilled birth attendants and supplies for BEmONC	BeMONC supplies procured and pre-positioned at EOCs, hospitals and PHC clinics	BEmONC supplies distributed and used, and services provided by trained staff during emergencies	MOH- hospital management department MOH Procurement department MOH-WHDU UNFPA	$419,325.31
4.1.3 At community level: Clean delivery kits provided to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible	Clean delivery kits procured and stockpiled	Clean delivery kits distributed to visibly pregnant women and birth attendants during emergencies; EmFPs involved in identification and distribution	MOH- WHDU UNFPA MOH- Procurement department Emergency Focal points (EmFP)	$665,214

4.2 Expand MoH referral system of transport and communication from the community to the health center and hospitals to include private hospitals and NGOs to minimize delays and maintain access to BEmONC/CEmONC during movement restrictions	Referral system protocols in place; communication guidelines set; MOUs signed with private hospitals and NGOs	Referral system activated during emergencies to maintain access to EmONC	MoH-WHDU, MoH hospital management dept, RHTG	No cost envisaged, similar MOUs signed did not incur a cost
4.3 Ensure availability of essential supplies and clinical management kits for post-abortion care and miscarriage management, pre-positioned at	Kits and supplies for management of post-abortion care and miscarriage procured and pre-positioned at referral hospitals	Kits and supplies distributed and used at hospitals for post-abortion and miscarriage care during emergencies	MoH- Procurement department MoH- WHDU	$35,461

priority referral points and hospitals			MoH- hospital management department UNFPA	
4.4 Expand MoH referral system of transport and communication from the community to health centers and hospitals to include private hospitals and NGOs, to ensure timely access to life-saving post-abortion and miscarriage care	Referral system protocols in place; communication guidelines set; MOUs signed with private hospitals and NGOs	Referral system activated during emergencies to ensure timely post-abortion and miscarriage care	MoH-WHDU, MoH hospital management dept, RHTG	No cost envisaged, similar MOUs signed did not incur a cost
4.5 Coordinate with designated adolescent / youth focal points and EmFPs to identify	Coordinate with adolescent/youth focal points and EmFPs to map and engage pregnant	Coordinate with focal points to actively reach out to pregnant adolescents, provide	Moh-WHDU, EmFPs	No cost envisaged, part of regular spending and coordination

pregnant adolescents in the community and link them to health services	adolescents in their communities, promote awareness of available SRH services, and encourage early contact with health facilities.	information on where and how to access urgent care, and facilitate their safe engagement with health providers.		

OBJECTIVE 5: Prevent unintended pregnancies				
Intervention	**Preparedness Activity**	**Response Activity**	**Responsible Stakeholders**	**Cost**
5.1 Ensure availability of a full range of long-acting reversible and short-acting contraceptives (including male condoms and emergency contraception) at	Contraceptive methods, including EC, procured and available at PHCs	Contraceptive methods distributed and used at PHCs during emergencies	MoH Procurement dept, MoH-WHDU, UNFPA	$155,485

PHCs and through mobile clinics				
5.2 Provide information, including existing information, education, and communications (IEC) family planning materials that emphasize informed choice and consent, effectiveness, client privacy, equity, and non-discrimination, ensuring content is adolescent-friendly	IEC materials on family planning and contraception developed, printed (10,000 copies), and distributed across SDPs based on need	IEC materials disseminated during emergencies to ensure informed choice and accessibility, and scaled where needed	MoH-HE department	$3,000
5.3 Ensure the community is aware of where and how to seek access to contraception, including adolescent community	a. Produce informative video on contraceptive methods and availability, ensuring content is adolescent-friendly,	a. Disseminate informative video on social media during emergencies b. Broadcast radio advert during emergencies	MoH-HE department	$6,950

members. Information should be communicated in multiple formats to ensure accessibility	and prepare for dissemination b. Produce informative radio advert c. Produce informative radio podcast	c. Disseminate radio podcast during emergencies		
5.4 Ensure provision of preconception care services, full implementation of the protocol and capacitated health cadre				
Train healthcare providers on family planning counseling and provision of services				
Strengthen the supply chain for commodity security and ensure	Support MoH to preposition family planning supplies considering	Provide supplies to hotspot areas as needed	MoH,UNFPA	

prepositioning of FP supplies	warehouses capacity and conditions			

OBJECTIVE 6: Comprehensive SRH Integration into Primary Health Care				
Intervention	**Preparedness Activity**	**Response Activity**	**Responsible Stakeholders**	**Cost**
6.1 Health Workforce 6.1.1 Mapping of SRH workforce and employment/deploy ment strategies	Consultant hired to map SRH workforce, identify gaps, and recommend employment/deployment strategies	Recommendations applied to guide rapid workforce deployment during emergencies	MoH-WHDU, UNFPA,WHO	$8,000
6.1.2 Capacity-building for PHC providers on comprehensive SRH care	National training sessions for 120 PHC (national coverage across governorates, can be scaled) providers on FP, postnatal care, and GBV referral	Trained PHC providers deliver comprehensive SRH care during emergencies (ANC,PNC,STIs)	MoH-WHDU, UNFPA, SDPs,WHO	$29,254.86
6.2 Service Delivery	Mapping of SRH SDPs across governorates to identify service gaps, under-served areas, and opportunities for	Mapped data used to redeploy services	MoH-WHDU, UNFPA	$9,500

6.2.1 Mapping of SRH services and SDPs across governorates	integration into primary healthcare	and fill critical gaps during emergencies		
6.2.2 Budget for purchase of BEmONC and CEmONC field hospitals	Pre-positioned budget for mobile BEmONC/CEmONC clinics developed	Mobile clinics deployed if facilities destroyed, access restricted, or IDPs increase	MoH-WHDU, MoH ED, UNFPA, MoH Procurement	$9,387,028
6.3 Health Information System: (baseline for SRH needs, mapping of services, populations as # of WRA, pregnant women) Minimum data set identified and collected (EmONC services, F, referrals..) 6.3.1 Develop protocol for SRH patient data sharing between hospitals	Committee formed; consultant hired; protocol disseminated across MoH hospitals, NGOs, PHCs	Protocol activated for real-time SRH data sharing during emergencies	MoH-WHDU, NGOs, MoH hospitals WHO	$16,413.50

and NGOs and MoH (data collection & data analysis)				
6.3.2 Develop live dashboard for SRH indicators	Dashboard platform designed and tested with MoH-WHDU and partners	Dashboard activated to share real-time SRH indicators with MoH and partners	MoH-WHDU, NGO, UNFPA, PCBS	Cost will be ongoing, $21,000 for initial 6-month assignment
6.4 Medical Commodities 6.4.1 Implement tracking system for SRH commodity stock-outs	Information management consultant develops tracking system for critical SRH commodities	Tracking system activated to monitor and address stock-outs during emergencies	MoH-WHDU, MoH Procurement	Cost will be ongoing, $21,000 for initial 6-month assignment
6.5 Financing 6.5.1 Integrate SRH service continuity in national emergency budget planning	WHDU inputs integrated into MoH emergency budget and planning	Emergency budget lines mobilized for SRH continuity during crises	MoH-WHDU, MoH ED	No cost envisaged, part of regular MoH coordination

6.6 Governance and leadership 6.6.1 Ensure WHDU input in national emergency plans	WHDU technical inputs integrated into MoH emergency department planning	WHDU leads coordination of SRH in MoH emergency plan implementation	MoH-WHDU, MoH ED	No cost envisaged, part of regular MoH coordination

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ANNEXES

(ANNEX 1)

Terms of Reference

Sexual and Reproductive Health Thematic Group (SRHTG) in Palestine

2017

1. Scope of the Group

The Sexual and Reproductive Health Thematic Group (SRHTG) is a sectoral sub-group under the Health Sector Working Group, chaired by the Women's Health Directorate in the Ministry of Health and formed based on the Decision of the Palestinian Minister of Health.

2. The mission of the SRHTG is to:

Advocate for a coordinated and harmonized planning, development and implementation of RH programs among different stakeholders including donors, services providers and academic institutions

3. The objectives of the SRHTG are:

- To support and strengthen coordination among members and stakeholders (government, non-government, national and international agencies, including donors)

- To assist stakeholders making policies develop, implement, monitor and evaluate strategy, activities and work plan
- offer an advisory role in realization of the national strategic health plan and the sexual and reproductive strategy, in particular.

4. Responsibilities and Tasks of the SRHTG:

Strategically, the SRHTG will support and complement the implementation of the national Sexual and Reproductive health program. More specifically, the group will:

1. *Maintain regular exchange of information among member organizations, including information on best practices and factors constraining or facilitating RH programs' delivery, to ensure complementarily of work and avoid duplication of activities.*
2. *Use a formal system for SRHTG to regularly monitor of RH activities for future planning and developing policy agenda on reproductive health and rights, advocacy and policy dialogue to articulating the rationale for raising attention to reproductive health and rights particularly in the context of health system reform;*
3. *Facilitate broadening of stakeholders' involvement into the dialog on the issues of RH and rights using evidence-based practice as a foundation of RH inquiries.*
4. *Provide a platform for members to arrive at a common understanding on key SRH issues, ensure coherent messages on SRH policies and programs and make evidence-based public statements as necessary;*
5. *Maintain the existing and develop new partnerships to promote reproductive health and rights, including partnerships with non-governmental, community and faith-based organizations;*

6. *Review and discuss the current needs for strategic, programmatic, and technical operational coordination and support in the areas of family planning, prevention of unsafe abortions, maternal health, HIV/STI prevention, young people's health, safe behavior promotion;*

7. *Explore opportunities to undertake common and joint monitoring and evaluation of programs and projects of member organizations, as well as advocacy activities such as donor visits to the regions;*

8. *Develop common mechanism of support to the Ministry of Health to develop common and unified frameworks and tools, including indicators, data collection methodologies, monitoring, clinical audits, evaluation of guidelines, and research to ensure regular and consistent tracking and measurement of impacts of sexual and reproductive health policies and programs, based on the international standards.*

9. *Jointly explore opportunities and engage into dialogue with potential donors to seek additional resources for sexual and reproductive health programs*

10. *Monitor and assess availability and accessibility of reproductive health commodities to service providers and their clients as a prerequisite of quality and scope of services; This will also include the private sector;*

5. The chair (WHDU) has the following tasks:

- Formally calls for thematic group meeting, prepares the agenda and disseminate to the group members, provides facilities as appropriate for the thematic group meetings.
- Ensures that minutes are prepared and distributed to all members
- Maintain coordination and communication with thematic group members and other thematic groups.
- Follows up as appropriate on all decisions taken by the group.

- Prepare progress reports as appropriate and submit to His Excellency the Minister and through him to the health sector working group.

6. Composition of the Group

The Women's Health and Development Directorate (WHDU) will be the chair of the group, United Nations Population Fund (UNFPA) will be the co-chair.

Members:

1. Ministry of Health through relevant departments such as (GD of Primary health care,WHDD, GD of computer and information technologies, GD of Education in Health, GD of nursing and midwifery, GD of Hospitals, GD of planning and policy, GD of Public Health..etc)
2. UNRWA
3. NGO sector (Palestinian Medical Relief Society, *Palestinian Family Planning* and Protection *Association* (PFPPA), Red Crescent Society, Juzoor, UHWC... etc.)
4. OB/GYN society
5. UNFPA
6. WHO
7. UNICEF

8. JICA
9. USAID
10. NORWAC
11. MAP-UK
12. UN-WOMEN
13. UNODC
14. Academic institution hosting reproductive health related programs (AnNajah University, BirZait University, Al-Quds University, Hebron University, Ibn Sina College for Health Sciences, Bethlehem University)

7. Subcommittees of the SRHTG will be formed according to the national needs that are consistent with the national RH strategy as required, who will regularly report to the chair and to member organizations in the SRHTG.

8. Meetings of the Group

- The Group will conduct meetings every 4 months at a location agreed upon by all members and according to needs.
- Non-members may be invited to meetings in pertinent discussions, especially when addressing multi-spectral themes
- Recommendations of the Group will be submitted to the Minister of Health and stakeholders.

(ANNEX 2)

MISP Costing Tool and Framework

MISP Objectives										
a. Objective	b. Sub-Objective	d. Tasks	**	e. Cost Category	f. Type of Cost	g. Frequency (No. of Meetings/ Training)	h. Quantity (Pax, Pieces, Units, Set, etc.)	i. Duration (No.of Days)	k. Cost per Unit	l. Total Costs (USD)
Objective 1										
1. Ensure the Health Sector/Cluster Identifies an Organization to Lead Implementation of the MISP	1.1. Coordinate actions to have this plan in place as first step for system approach in SRH preparedness for all areas of intervention	a. No cost envisaged, part of regular MoH spending and coordination								
	1.2. Host regular meetings of WHDU with all	a. No cost envisaged, part of regular MoH								

	relevant partners and stakeholders on a monthly basis and as relevant in emergencies to ensure consistency in emergency preparedness activities	spending and coordination										
	1.3.Ensure each MOH-WHDU partner organization has an emergency focal point in place	a. No cost envisaged, no extra cost on regular organizational spending										
	1.4. Develop a centralized digital platform / live document / Excel sheet for real-time reporting by EmFPs of SRH/GBV	a. No cost envisaged, part of MoH spending and activities										

	services during emergencies								
	1.5.2.Train PHC health care providers, and selected referral hospital staff (ob/gyn doctors, midwives, emergency nurses), in the MISP curriculum; and conduct a refresher Training of Trainers (TOT) for previously certified EMFP trainers	a. Train 40 healthcare providers (3–4 per governorate) in MISP curriculum	Consultancies	MISP trainer daily rate	3	1	3	400	3,600.00
			Accommodation	Room for trainees	1	40	3	39.55	4,746.00
			Refreshments	Lunch and coffee break	1	40	3	10.38	1,245.60
			Venue	Small training room	3	1	3	211.67	1,905.03
		b. Conduct refresher TOT for 16 EmFP trainers to strengthen capacity for future cascading.	Consultancies	TOT trainer daily rate	1	1	1	600	600.00
			Refreshments	Lunch and coffee break	1	16	1	10.38	166.08
			Venue	Small training room	1	1	1	211.67	211.67
	1.6. Pilot SRH telemedicine	a. Pilot development is							

	initiative to provide remote medical services in case of inability to reach centers	ongoing cost in UNFPA-MoH telemedicine plan									
	1.7.Improve coordination and communication between WHDU and MOH storage and procurement office to lead efforts for securing SRH needed stocks of drugs/FP/Devices	a. No cost envisaged, part of regular MoH spending and coordination									
	1.8 Ensure each MOH-WHDU partner organization has an adolescent / youth focal point	No cost envisaged, part of regular MoH spending and coordination									

Objective 1	***Sub Total***	***12,474.38***

Objective 2										
2. Prevent gender-based violence and sexual violence and respond to the needs of survivors	2.1.Strengthen multi-sectoral coordination, accountability, and community-based prevention mechanisms to address and respond to GBV in emergencies facilities to protect affected populations, particularly women and girls, from sexual violence	a. No cost envisaged, part of regular MoH spending and coordination								
		a. No cost envisaged, part of regular MoH spending and coordination								
	2.2. Ensure detection and referral to other supportive services available for survivors of	a. Train 40 healthcare providers (3-4 per governorate) in		Consultancies	GBV Trainer daily rate	2	1	3	360	2,160.00
				Accommodation	Room for trainees	1	40	3	39.55	4,746.00

	sexual violence by capacity-building of health care providers on detection and referral of GBV, including adolescents with age-appropriate referral	GBV detection and referral		Refreshments	Lunch and coffee break	1	40	3	10.38	1,245.60
				Venue	Small training room	6	1	1	211.67	1,270.02
	2.3. Ensure that confidential and safe spaces within health facilities can adequately receive and provide survivors of sexual violence with appropriate clinical care and referral, including adolescents with age-appropriate clinical care and referral	a. Consultant hired to assess safe spaces, 3 month consultancy		Consultancies	Assessment consultant			3-month		3,500.00

	2.4 Ensure community awareness about GBV services	a. Organize 10 sessions in most vulnerable governorates (est. 5), each workshop includes 20 participants, total awareness outreach 1,000 people. (can be scaled based on need)	Consultancies	GBV community session facilitator	50	1	1	111	5,550.00
			Venue	Small training room	50	1	1	10.38	519.00
			Refreshments	Coffee and light snack	50	20	1	2.5	2,500.00
			IEC	Leaflet (GBV)	50	20	1	2	2,000.00

Objective 2	***Sub Total***	***23,490.62***

Objective 3									
3. Prevent the transmission of and reduce	3.1.Capacity building in National STI Protocols for MoH PHC staff	a. Conduct refresher training session for 20 providers in North	Consultancies	STI Protocol trainer fee	1	1	2	0	0

morbidity and mortality due to HIV and other STIs	(doctors, nurses, midwives) and selected referral hospitals across governorates.	governorates (no cost envisaged for trainer fee, part of MoH spending)	Accommodation	Room for trainees (North)	1	20	2	75.57	3,022.80
			Refreshments	Lunch and coffee break (North)	1	20	2	45.38	1,815.20
			Refreshments	Dinner (North)	1	20	2	24.2	968.00
		b. Conduct refresher training session for 20 providers in South governorates (no cost envisaged for trainer fee, part of MoH spending)	Consultancies	STI Protocol trainer fee	1	1	2	0	0
			Accommodation	Room for trainees with dinner included (South)	1	20	2	166.3	6,652.00
			Refreshments	Lunch and coffee break (South)	1	20	1	45.38	1,815.20
		c. Conduct refresher training session for 20 providers	Consultancies	STI Protocol trainer fee	1	1	2	0	0

		in Middle governorates (no cost envisaged for trainer fee, part of MoH spending)	Accommodation	Room for trainees (Middle)	1	20	2	151.175	6,047.00
			Refreshments	Lunch and coffee break (Middle)	1	20	2	45.38	1,815.20
			Refreshments	Dinner (Middle)	1	20	2	36.3	1,452.00
	3.2 Ensure the availability in health facilities of supplies for treatment of sexually transmitted infections (STIs).	a. Cost outlined in Annex 3, in IARH kits calculation	IARH kit	Kit 5		340			421,667.26
	3.3.Ensure application of standard precautions	a. No cost envisaged, part of regular MoH coordination							

	3.4.Guarantee the availability of free lubricated male condoms where applicable (e.g., already used by the population) in hospitals and PHC clinics	a. Cost outlined in Annex 3, in IARH kits calculation	IARH kit	Kit 1A		340			192,171
	3.5.Provide rape kits to survivors of sexual violence as appropriate and for occupational exposure	a. Cost outlined in Annex 3, in IARH kits calculation	IARH kit	Kit 3		340			155,119.82
			IARH kit	Kit 9		10			5,830.72
	3.6. Ensure availability of blood transfusion kits and supplies for treatment of STIs	a. Costs outlined in Annex 3, in IARH kits calculation	IARH kit	Kit 12		12			12,094.50

								Objective 3 Sub Total 810,470.70
Objective 4								
4. Prevent excess maternal and newborn morbidity and mortality	4.1.Ensure availability and accessibility of clean and safe delivery, essential newborn care, and lifesaving emergency obstetric and newborn care (EmONC) services including:	a. Costs outlined in Annex 3, in IARH kits calculation		IARH kit	Kits 11A and 11B		48			60,540.80
				IARH kit	Oxytocin		46			76,059.21
		b. Costs outlined in Annex 3, in IARH kits calculation		IARH kit	Kit 6A		44			60,843.84
				IARH kit	Kit 6B		68			115,645.65
				IARH kit	Hand Held Vacuum Assisted Delivery System		68			112,323.78
				IARH kit	Kit 9		10			5,830.72
				IARH kit	Misoprostol		270			26,449.30
				IARH Kit	Kit 10		20			22,172.81

				IARH kit	Oxytocin		46			76,059.21
		c. Costs outlined in Annex 3, in IARH kits calculator		IARH kit	Kit 2A		340			517,530.94
				IARH kit	Kit 2B		340			87,504.02
				IARH kit	Chlorhexidine gel		340			33,729.24
				IARH kit	Misoprostol		270			26,449.30
	4.2. Expand MoH referral system of transport and communication from the community to the health center and hospital to include private hospitals and NGOs to minimize delays and maintain access to BEmONC/CEmONC during movement restrictions.	a. No cost envisaged, similar MOUs signed did not incur a cost								
		a. No cost envisaged, similar MOUs signed did not incur a cost								

	4.3.Ensure minimum availability of essential supplies and clinical management kits for post-abortion care and miscarriage management, pre-positioned at priority referral points to sustain life-saving services when supply chains are disrupted.	a. Costs outlined in Annex 3, in IARH kits calculator		IARH kit	Kit 8		20			35,461
	4.4.Expand MoH referral system of transport and communication from the community to health centers and hospitals to include private hospitals and	a. No cost envisaged, similar MOUs signed did not incur a cost								

	NGOs, to ensure timely access to life-saving post-abortion and miscarriage care during movement restrictions.									
	4.5 Coordinate with designated adolescent / youth focal points and EmFPs to identify pregnant adolescents in the community and link them to health services	No cost envisaged, part of regular spending and coordination								
								Objective 4	***Sub Total***	***1,256,599.82***
Objective 5										
5. Prevent unintended pregnancies	5.1.Ensure availability of a full range of long-acting reversible and short-acting	a. Costs outlined in Annex 3, in IARH kits calculator		IARH kit	Kit 4		340			150,830.13
				IARH kit	Kit 7A		20			2,144.55

	contraceptives (including male condoms and emergency contraception) at PHCs by pre-positioning supplies to maintain continuity of family planning services during movement restrictions and supply chain disruptions.		IARH kit	Depot-Medroxyprogesterone Acetate Sub-Cutaneous		20			2,511.26
	5.2. Provide information, including existing information, education, and communications (IEC) family planning materials that emphasize informed choice and consent,	a. Print and disseminate 10,000 leaflets on family planning and emergency contraception, to be disseminated at SDPs, can be scaled based on need	IEC	Leaflet (family planning)	1	5,000	1	0.3	1,500.00
			IEC	Leaflet (emergency contraception)	1	5,000	1	0.3	1,500.00

	effectiveness, client privacy, equity, and non-discriminati on, ensuring content is adolescent-frien dly								
	5.3.Ensure the community is aware of the availability of contraceptives for women, adolescents, and men	a. Produce informative video on contraceptive methods and availability and disseminate on social media	IEC	Informative video	1	1	1	650	650.00
			IEC	Social media advertiseme nt	1	1	7	42.86	300.02
		b. Produce informative radio advert	IEC	Month-long radio advert, 6 times a day	1	1	1 month	3000	3,000.00
		c. Produce radio podcast	IEC	Radio podcast	1	1	1	3000	3,000.00

									Objective 5	***Sub Total*** ***165,435.96***
Objective 6										
6. Plan for comprehensive SRH services, integrated into primary health care as soon as possible. Work with the Health Sector/Cluster partners to address the six health system building blocks.	6.1.Health workforce	6.1.1 Consultant hired to map SRH workforce, with gaps in employment identified, and employment and deployment strategies recommended		Consultancies	Workforce mapping consultant	1	1	4 month consultancy		8,000
		6.1.2 Organize training workshops for PHC providers on comprehensive SRH service delivery (family planning,		Consultancies	Comprehensive SRH care trainer fee	6	1	3	400	7,200.00
				Accommodation	Room for trainees	1	120	3	39.55	14,238.00

		postnatal care, and GBV referral) across governorates.	Refreshments	Lunch and coffee break	1	120	3	10.38	3,736.80
			Venue	Small training room	6	1	3	211.67	3,810.06
	6.2. Service delivery	6.2.1 Mapping conducted of SRH SDPs and services, assessing their accessibility, availability, and scope.	Consultancies	Service mapping consultant	1	1	5 month consultancy		9,500
		6.2.2 Costing outlined in Annex 3, costing of BeMONC and CeMONC caravans.	BeMONC and CeMONC caravans						9,387,028
	6.3.Health information system	6.3.1.a Committee formed to	Accommodation	Rooms for committee members	1	15	1	118.50	1,777.50

		develop protocol		Refreshments	Committee lunch and coffee	2	15	2	30.7	921.00
				Venue	Committee meeting room	1	1	2	207.5	415.00
		6.3.1.b Consultant hired to review protocol		Consultancies	Protocol consultant			8-week		3,300
				Printing	Protocol printing and dissemination					10,000
		6.3.2 Information management consultant develops a dashboard tracking system and platform available and used by MOH		Consultancies	Information management consultant			6 month initial assignment		21,000

		and HCPs (cost will be on-going)								
	6.4.Medical commodities	a. Information management consultant develops a live commodity tracking system, and platform available and used by SDPs, MOH Procurement and Storage		Consultancies	Information management consultant			6 month initial assignment		21,000
	6.5.Financing	6.5.1 Regular WHDU integration and input in ED budget and planning, no								

		cost envisaged, part of regular MoH spending and coordination									
	6.6.Governance and leadership	6.6.1 Regular WHDU integration and input in development of ED national plans no cost envisaged, part of regular MoH spending and coordination									

Objective 6	***Sub Total***	***9,491,926.36***

Grand Total	**11,760,397.84**

(ANNEX 3)

Cost of IARH Kits

Item	Qty	Total supplies cost USD	Weight per kit (Kg)	Total Weight	Estimated Pallet #	Estimated Truck #	Estimated Containers #	Customs Clearance Cost per Container	Possible standby/ demerge	Est Cost of standby/ demerge	Transport from Port to WB	Risk 2%	Total Cost Upstream	Full Total cost
Kit 1A	**340**	$187,680.00	16.1	5,474	22	1	1	$2,729.89	5	$995.27	$ 710.91	$54.60	$4,490.67	$192,170.67
Kit 2A	**340**	$510,000.00	27.0	9,180	37	2	2	$4,578.08	5	$1,669.09	$1,192.21	$91.56	$7,530.94	$517,530.94
Kit 2B	**340**	$ 85,384.20	19.5	6,630	27	1	1	$3,306.39	5	$1,205.45	$ 861.04	$66.13	$5,439.01	$ 87,504.02
Kit 3	**340**	$153,000.00	7.6	2,584	10	0	0	$1,288.64	5	$469.82	$ 335.58	$25.77	$2,119.82	$155,119.82
Kit 4	**340**	$146,200.00	16.6	5,644	23	1	1	$2,814.67	5	$1,026.18	$ 732.99	$56.29	$4,630.13	$150,830.13
Kit 5	**340**	$408,000.00	49.0	16,660	67	3	3	$8,308.36	5	$3,029.09	$2,163.64	$ 166.17	$13,667.26	$421,667.26
Kit 6A	**44**	$59,400.00	40.0	1,760	7	0	0	$877.71	5	$320.00	$ 228.57	$17.55	$1,443.84	$60,843.84

Kit 6B	**68**	$107,780.00	141.0	9,588	38	2	2	$4,781.55	5	$1,743.27	$1,245.19	$95.63	$7,865.65	$115,645.65
Kit 8	**20**	$7,600.00	86.0	1,720	7	0	0	$857.77	5	$312.73	$ 223.38	$17.16	$1,411.03	$9,011.03
Kit 9	**20**	$11,120.00	33.0	660	3	0	0	$329.14	5	$120.00	$85.71	$ 6.58	$ 541.44	$11,661.44
Kit 10	**20**	$22,140.00	2.0	40	0	0	0	$19.95	5	$7.27	$5.19	$ 0.40	$32.81	$22,172.81
Kit 11A	**24**	$10,344.00	10.5	252	1	0	0	$125.71	5	$45.83	$32.74	$ 2.51	$ 206.79	$10,550.79
Kit 11B	**24**	$21,672.00	824.0	19,776	79	4	4	$9,862.32	5	$3,595.64	$2,568.31	$ 197.25	$16,223.51	$37,895.51
Kit 12	**24**	$23,520.00	34.0	816	3	0	0	$406.94	5	$148.36	$105.97	$ 8.14	$669.42	$24,189.42
CHXIARH	**340**	$30,940.00	10	3,400	14	1	1	$1,695.58	5	$618.18	$441.56	$33.91	$2,789.24	$33,729.24
MISOIARH	**808**	$72,720.00	10	8,080	32	1	1	$4,029.51	5	$1,469.09	$1,049.35	$80.59	$6,628.54	$79,348.54
DMPA-SCIARH	**20**	$2,380.00	8	160	1	0	0	$79.79	5	$29.09	$20.78	$ 1.60	$131.26	$2,511.26
Kit 7A	**20**	$1,800.00	21	420	2	0	0	$209.45	5	$76.36	$54.55	$ 4.19	$344.55	$2,144.55
OXYIARH	**92**	$151,892.00	3	276	1	0	0	$137.64	5	$50.18	$35.84	$ 2.75	$226.42	$152,118.42
VADIARH	**68**	$112,268.00	1	68	0	0	0	$33.91	5	$12.36	$8.83	$ 0.68	$55.78	$112,323.78

(ANNEX 4)

Logistics Calculator

Items	Location	UoM	Qty	Unit Cost	Total Cost
BeMONC Chassic (on wheels)	West Bank	Each	24	$219,702.98	$5,272,871.52
CeMONC Cassi (On wheels)	West Bank	Each	12	$300,000.00	$3,600,000.00
Total Est Cost for IARH kits allocated	WB	L.S	1	$288,000.00	$288,000.00
Total Logisitcs Cost	WB	L.S	1	$291,840.18	$291,840.18
Total Last mile Logisics cost	WB	L.S	1	$35,020.82	$35,020.82
TOTAL					**$9,487,732.52**