Destroyed houses in the al-Rimal neighborhood of Gaza City, October 10, 2023

There is an increasing recognition that conflict is not gender neutral; in fact, protracted conflicts such as in Gaza create a landscape of multidimensional and intersectional vulnerabilities for diverse groups compounding over time (specifically around access to food, mobility, poverty, education, protection and employment) and disproportionately affect women and girls across all categories. The escalation of violence in Gaza and the surrounding region has led to an unfathomable level of death, deprivation and destruction for the most vulnerable populations and further compromises their ability to respond, adapt and build resilience to continued shock. Thus, the humanitarian response must account for these pre-existing vulnerabilities while integrating and adapting to the complexity of this unprecedented crisis through a gender and inclusive programming lens. This Rapid Gender Analysis (RGA) aims to highlight existing gender, age and disability data and provide operational recommendations for the humanitarian response in Gaza, while centering 'Do No Harm' principles. Given the rapidly evolving context of this crisis, this RGA brief draws from secondary data to inform immediate programming and will be updated as more information becomes available and more in-depth information is needed to support the humanitarian response.

Overview

On October 7, 2023, armed groups launched an attack on Israeli towns near Gaza, leading to an escalation of the on-going, protracted crisis in Gaza Strip. Civilians are paying the price of the current conflict. Thousands of people have been killed, injured, and nearly two hundred remain held hostage, including children and elderly. As of October 22, the confirmed figures of Palestinian civilians killed is about 4,385 (with 1,756 children and 967 women),[1] 29 UNRWA staff members,[2] 19 journalists,[3] and a growing number of medical staff as well as those reported missing buried under the rubble.[4]Over one million have been displaced, including more than half a million sheltering in UNRWA-designated emergency shelters, and the basic supply of humanitarian goods and services, including water, food, fuel and medicines, into Gaza cut off. United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) that acts as the primary service provider for essential social services such as education, health and emergency assistance (outside of Palestinian refugee camps) has reported that "Gaza is being strangled" and all facilities are fully overwhelmed without basic supplies and "on the verge of collapse."[5]

On October 9, Israel announced a "complete siege" on Gaza ceasing all supplies and movement across the border, including food, water, fuel, medicine and humanitarian aid. This severity of the humanitarian crisis is also being compounded by electricity deficits that had become increasingly stretched over the last decade and, prior to the current escalation, was already less than half of the estimated requirement for the population (including Israeli contributions).[6] Without fuel, the sole power plant in Gaza shut down on October 11 leaving essential lifesaving health services for the most vulnerable and critical sanitation and water services relying on generators operating on limited fuel and exacerbating already fragile living conditions in Gaza.[7] On October 21, the only available border crossing into Gaza via Rafah, Egypt was temporarily opened to allow 20 convoys of crucial humanitarian aid (including food, water and medical aid, but no fuel) into Gaza; however this represents 0.002% of aid required and the humanitarian conditions remain dire for a majority of the population.[8]

The humanitarian crisis has heightened as the security situation remains volatile and uncertain, with intense airstrikes and shelling continuing, schools and hospitals destroyed, and all utilities cut. Negative coping strategies are increasing as resources further deplete, creating increased risk of sexual exploitation and abuse (SEA) especially for women and separated children. Since the order from Israeli forces on October 13 for civilians to evacuate northern Gaza, about half the total population of Gaza has been displaced (as of October 18), while an unknown population of displaced families (including the most vulnerable with limited mobility) remain in Gaza City and North Gaza (zones of active conflict).[9] The humanitarian implications are catastrophic and widespread across all sectors. Deaths and injury of civilians are expected to continue to rise as a result of active conflict and by the wide scale destruction of critical infrastructure, such as schools and healthcare facilities, drinking water installations as well as agricultural lands and livestock essential for food security.

Demographics Profile

As of 2022, the population of Palestine was estimated to be about 5.35 million between the West Bank holding about 3.19 million (1.62 million males and 1.57 million females) and Gaza Strip holding 2.17 million (1.10 million males and 1.07 million females)[10] with the household size averaging 5.5 people.[11] Female-headed households, widows, refugees, youth, those living with disability and the elderly experience multidimensional and intersectional vulnerabilities (specifically around access to food, mobility, poverty, education, protection and employment) and are disproportionately impacted by displacement and shocks.[12] While updated sex-age-disability disaggregated data (SADDD) is limited, it is estimated that people living with disability represent about 7%[13] of the Gazan population and one out of every five households is headed by someone 65 years and older.[14] Children under 18 years of age represent 47.3% and youth (18-29 years of age) represent about 21.8%.[15] According to OCHA, prior to the recent escalation, 53% of the population were living below the poverty line and 34% below the deep poverty line, disproportionately affecting female headed households (10% of total households in Gaza[16]) and refugee populations (68% of the Gazan population[17]).[18] Prior to the conflict, it was estimated that 1.3 million people (63% of Gaza residents) are in extreme and severe need of humanitarian assistance, including 224,000 people in North Gaza and 389,000 people in Gaza[19]. Although 73% of households in Gaza Strip received humanitarian assistance for survival (including 68.3% citing NGO or charity assistance as their primary income source), 50% of the Gaza population are categorized as food insecure and 40.7% experiencing severe food insecurity.[20] Food insecurity disproportionately affects women (especially widows, refugees and those living with disability) in Gaza who are twice as likely to experience unemployment given social and cultural norms related to their caregiving roles in the private sphere and discrimination.[21] UN Women estimates that, as a result of the ongoing violence, about 900 new households will be headed by women and widows, amplifying their vulnerabilities.[22]

Shelter

Gaza Strip represents one of the most densely populated areas in the world at 5,900 residents/square kilometre;[23] thus the call to evacuate the entire population north of Wadi Gaza (representing 1.1 million people, including those living with disability, pregnant and lactating women, elderly and sick patients in hospital facilities) has been characterized by the UN to have “devastating humanitarian consequences”.[24] The total number of IDPs (as of October 21) is estimated to be 1.4 million people with numbers expected to increase as the conflict continues to escalate.[25] About 700,000 IDPs are seeking shelter with host families, and 566,000 people have been sheltering in 148 UNRWA designated emergency shelters (DES), including 367,500 in central and southern Gaza.[26] An unconfirmed number of people remain taking shelter in Gaza City and the North formerly supported UNRWA facilities that are no longer equipped with essential supplies of clean water or basic health services.[27] About 15% of IDPs are reported to be living with one or more disability and in conditions not appropriately equipped to meet their needs.[28]

Amidst growing anxiety and mass displacement, alternative shelters are being created in university buildings, mosques, refugee camps, hospitals and churches to accommodate the massive influx. However, overcrowding has also led to makeshift shelters built adjacent or some families forced to sleep outdoors. UNRWA reports that many of their shelters are between 2.51 times to 11 times over capacity.[29] Overcrowding and the lack of privacy present significant safety and protection risks, particularly for women and girls, and heighten risks of GBV.[30] Additionally, unaccompanied women, the elderly, people with disabilities, and children have unique and urgent needs and vulnerabilities, both relating to the current conflict and due to structural gender discrimination, including laws in Palestine placing women under the protection and guardianship of men. Such structures increase women’s and vulnerable populations' risks to GBV and make them more likely than men to be living in sub-standard temporary shelters when displaced. The electricity blackout conditions and the absence of public and private partitions within the shelters also heighten already amplified levels of fear and insecurity and hinder the mobility of IDPs, especially women, children, elderly and those with disability.

Under the conditions of the current blockade, key emergency services and supplies (including tents, bedding, hygiene kits or construction materials) are unable to be substantially restocked and existing supplies are insufficient to meet the growing needs. IDPs south of Wadi Gaza also lack basic humanitarian provisions of safe shelter, access to water, medical care, and protection provisions.[31] The continued escalation of violence has led to at least 35% (about 15,100) of all housing units (HU) destroyed, uninhabitable (about 10,656 HU), or moderately/lightly damaged (about HU139,000) in the Gaza Strip since the start of the hostilities, according to the Ministry of Housing (as of October 21),[32] as well as alternative shelters destroyed or damaged (such as schools/emergency shelters or hospitals[33]) perpetuating a sense of insecurity, distress and grief.

Water, Sanitation and Hygiene (WASH)

The fragile WASH system in Gaza has historically faced chronic shortcomings to meet the needs of the dense population. Prior to the escalation of violence, the population of Gaza was not reaching WHO's recommended minimum level of water consumption of 50-100 litres per person/day,[34] and more than 96% of households received network water that didn't meet drinking water quality standards.[35] Thus the population developed a heavy dependence on desalination plants and purchased trucked and bottled water from private vendors (now depleted and cost prohibitive). Currently, almost all core water production, treatment and distribution infrastructure as well as waste management systems (as of October 21) has been heavily impacted, damaged or shut down due to the violence and severe levels of insecurity, power shortages and lack of fuel.[36,37] All water needs (including drinking, cooking and hygiene) in Gaza has been reduced to an estimated three litres per person per day[38], significantly under the minimum emergency threshold of 15 litres per person per day[39], which creates disproportionate stressors on women and girls who are typically responsible for managing the domestic sphere given patriarchal social and cultural norms in Gaza. That said, in light of the increased water scarcity and heightened insecurities, the responsibility of seeking and securing water for the household has increasingly fallen to men rather than women who traditionally hold the role.

Without access to clean water, people have been resorting to extracting water from agricultural wells, which presents high risks of exposures to pesticides, chemicals and animal waste.[40] While the water crisis severely impacts the entire population across all spheres of life, those with compromised/fragile immune systems (such as elderly), bottle-fed infants, pregnant women, and children under five are particularly vulnerable to an increased risk of contracting infections and waterborne diseases. Additionally, those with mobility limitations, women and girls, unaccompanied children and people living with disability may experience disproportionate challenges accessing already scarce water sources, especially if longer queues start to form.

The overcrowding at official and makeshift shelters and the absence of safe and hygienic WASH facilities (including lit, private, lockable and gender segregated toilets and bathing facilities) that meet international guidelines, increase risks of open defecation and infection, as well as pose protection risks for women, adolescent girls of reproductive age, and pregnant and lactating women.[41] Many women and adolescent girls reported traveling in groups to the toilet to mitigate safety concerns; however, they report fears of violence remain strong. Many also reported that they tended to use menstrual products for longer than recommended due to inadequate washing facilities and limited availability of menstruation products further exacerbating vulnerabilities to diseases and infections. The extensive breakdown of the WASH system across Gaza presents severe current and long-term challenges that exceed pre-existing contingency plans for the most extreme circumstances;[42] the UNICEF-led WASH Cluster declared that the population could be facing dehydration and be "at imminent risk of death or infectious disease outbreak if water and fuel are not immediately allowed to enter the Strip."[43,44]

Health (including sexual and reproductive health)

Since Israel imposed a tight blockade on supplies and movement restrictions on Palestine in 2007, combined with recurrent escalations, all of Gaza's socio-economic and health indicators and overall humanitarian condition has severely deteriorated.[45] Increased periods of conflict across Gaza have also been historically correlated with increased cases of gender-based violence (GBV), including early and forced marriage, sexual harassment and intimate partner violence, rape, incest, denial of resources, and psychological abuse and trauma.[46] In the current crisis, the medical system is experiencing an electricity blackout (since October 11 relying on available generators) and on the brink of collapse, which is further impeding the delivery of essential services such as GBV case management and reproductive health services.[47] Women of reproductive age (15-49 years) represent about 24% of the Gazan population.[48] Pregnant women, estimated to be about 50,000 in Gaza with 5,500 of these women expected to give birth in the coming month,[49] face heightened fears and

limited resources to access facilities to ensure safe delivery. Micronutrient deficiencies (especially anemia experienced by over half of pregnant women in Gaza) due to poor dietary intake is a severe public health concern in Gaza associated with increased morbidity and mortality.[50] With the reduction of critical health services due to the ongoing blockade, access to essential prenatal and maternity care services (including nutritional analysis and supplementation) are no longer available and maternal care services across the continuum of care (including postpartum recovery and lactation) are insufficient to meet immediate needs of birthing women, thus heightening the already disproportionately high likelihood for birth complications and increased risks for maternal and newborn mortality.

Confronted with a fuel crisis, hospitals are unable to provide clean water or sanitation conditions (even in operation rooms or emergency departments) amidst the overflow of needs beyond capacity[51] and the critically low supply of essential medical supplies (such as antiseptics, anesthetics and blood reserves).[52] This has been exacerbated by the shutdown of over 65% of primary health care facilities run by the Ministry of Health and UNRWA (as of October 16).[53] Given increasingly desperate conditions, the risk of outbreak of waterborne diseases or the spread of infectious disease is significant, especially as wastewater systems are unfunctional and corpses accumulate**.** While the deteriorating conditions within the health system has devastating impacts for the entire population seeking urgent medical care, children under five face heightened risk of death from diarrheal disease due to unhygienic conditions or consuming contaminated water, which is globally the leading cause of child mortality for those under five years old.[54] Additionally, the further reduction of essential services (including dialysis chemotherapy treatment[55]) has serious implications for GBV survivors seeking to receive critical physical and phycological support services (even through remote helplines that are dependent on electricity). This is also compounded by existing gender norms. stigma, service providers' attitudes, national policies and protocols and limited awareness of safe clinical care and referral of GBV, which risk further preventing survivors from accessing scarce health services.

Insecurity, fear and uncertainty are dominant across Gaza as casualties and damages mount. WHO has documented 62 attacks on health care in Gaza,[56] amplifying severe psychological stress.[57,58] Frontline healthcare workers are working through exhaustion and significant phycological distress without reprieve. The psychosocial and mental health toll and trauma, especially to children and youth, are severe and compounding. Prior to the escalation of the conflict, nearly half of all Palestine children (54% boys; 47% girls) aged 6 to 12 years were diagnosed with emotional and/or behavioral disorders.[59] About 38% of youth consider suicide (though predominately carried out by men suffering from depression and hopelessness)[60] and increased numbers of women and girls were experiencing post-traumatic stress or anxiety disorders due to witnessing acts of violence from the conflict[61] experiences of GBV and/or intimate partner violence.[62] As of 2020, almost 200,[63] who are currently unable to access essential mental health services (including medications) exacerbating their vulnerabilities to violence and abuse and/or going missing during continued evacuation or migration.[64] Given current limitations of hospital facilities, there is a lack of trained staff, poor quality of services and under-resourcing to the mental health impacts of this crisis.

Recommendations: A Humanitarian Call to Action

Against this backdrop of a growing humanitarian crisis in Gaza and potential spillover effects in the region, the current situation is marked by a disregard for international human rights and humanitarian law that has caused severe barriers to ensuring basic services. Parties to conflict, Heads of State, and the UN Security Council should prioritize the preservation of human life above all else and urgently agree to a ceasefire.[65]

Humanitarians have demonstrated their unwavering commitment to deliver essential assistance and relief in near impossible conditions. **Below highlights recommendations to humanitarian actors for immediate to medium term priorities:**

Overarching:

- **Humanitarian Access**: Safe, unconditional and unimpeded humanitarian access into Gaza for the transport of essential life-saving supplies (including fuel specifically for hospitals and WASH services)
- **Funding:** Adequate and quality funding for the humanitarian response in Gaza and across the region, including resources for sexual and reproductive health services, protection and GBV programming.
- **Gender Responsive Approaches:** Require the collection and use of sex-age disability-disaggregated data (SADDD) across all assessments and apply an iterative approach to intersectional gender analysis to strengthen effectiveness, inclusivity and timeliness of gender responsive approaches

- **Protection from Sexual Exploitation and Abuse**: Ensure that all actors in all sectors of the humanitarian response (including their partners' staff, consultants and contractors) are aware of their responsibility and obligations to mitigate sexual harassment, exploitation, and abuse, including ensuring accessible and safe reporting mechanisms to affected communities and collaborating with the PSEA Network (operational in Gaza/Palestine)
- **Localization:** Consider the centrality of protection, do no harm principles and mental health sensitivities in both the design of the response and engaging with local partners (especially front-line staff and emergency respondents).
- **Participatory Approaches:** Foster common platforms to promote the meaningful and safe coordination and participation of local groups (formal and informal) in all stages of humanitarian action, especially in program design, once it becomes feasible. Invest in local capacities to respond and protect the spaces in which they can operate.
- **Accountability:** Ensure regular women and girls' friendly feedback and accountability mechanisms are in place for early program initiatives and throughout all stages of emergency response and recovery.
- **Access to Information:** Strengthen information networks to ensure that women and other vulnerable groups know where to go and how to access humanitarian assistance (eg. food distribution sites, phone recharging stations, means to top up mobiles, shelter support, etc.) as well as essential GBV services such as health, psychosocial support and safe spaces.
- **Gender-Based Violence:** Prioritize GBV service mapping (including gap analysis and referral pathways), conduct GBV risk mitigation assessments and ensure GBV risk mitigation measures are integrated into sectoral response plans (including the training of front-line responders on safe and ethical disclosure management and referrals); While national helplines and psychosocial support hotlines remain operational, access is limited due to lack of power to charge phones, connectivity, and resources to top up mobiles. It's essential that all programming accounts for and addresses existing barriers to access.

Shelter:

- **Provide urgent basic shelter and non-food items (NFI) to IDPs and identified host families**, in line with IASC guidance on gender inclusion in shelter[66] and Global Shelter Cluster guidance on shelter programming,[67] including bedding (mattresses/mats, blankets, or sleeping bags), tents, tarpaulins and solar lights and solar recharging stations for phones. Ensure safe access and input from most vulnerable groups: female-headed households, unaccompanied children, widows, those with disability and elderly.
- **Establish mother and child safe spaces in collective centres** to increase privacy and specialized services for pregnant women, adolescent girls and children (including counselling services for GBV referrals and children facing psychological distress and trauma)
- **Post culturally sensitive information and resources for GBV reporting and/or support resources** (including to sector focal points across the response) visibly in each official and unofficial shelter site, including for those with varying levels of literacy

WASH:

- **Immediate provisions of bottled water and critical hygiene kits** (including culturally appropriate menstrual hygiene management supplies and private dignified disposal, newborns care supply kits and incontinence products) targeting the most vulnerable populations (such as adolescent girls, elderly, pregnant and breastfeeding women, those living with disability and children under 5 years old)
- **Strengthen partnerships with local humanitarian actors to widen water distribution and treatment networks**, especially to reach the most vulnerable populations once it becomes feasible
- **Work with humanitarian actors to meet minimum SPHERE standards for WASH facilities[68]** in shelters including lights, locks and gender segregation, and the accessibility of facilities with those with more limited mobility (such as the elderly or those living with disability)

Health:

- **Support the urgent restock of hospitals and health clinics with essential medications, medical supplies and electricity/fuel**, especially targeting the needs of women and girls (including nutritional supplements for pregnant women and children under 5 years old and resources for birthing mothers)
- **Coordinate with local health actors to ensure access to lifesaving sexual and reproductive health services including 24/7 access** to emergency obstetric, postpartum new-born care and lactation as well as the clinical management of rape, in line with the Minimum Initial Service Package (MISP).
- **Prioritize mental health and psychosocial support services** for IDPs, especially children, and also for humanitarian responders and health workers--- including through accessible helplines and improved access to up-to-date GBV referral information across sectors.

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