**Call for submissions**

***Women’s and girls’ sexual and reproductive health and rights in situations of crisis***

The Working Group on discrimination against women and girls will present a thematic report on women’s and girls’ sexual and reproductive health and rights[[1]](#footnote-1) (SRHR) in situations of crisis to the 47th session of the Human Rights Council in June 2021. The report will examine women’s and girls’ SRHR within an overarching framework of reasserting gender equality and countering roll-backs.

The Working Group will take a broad approach to crisis. In doing so, it intends not only to look at humanitarian crises, typically understood as encompassing international and non-international conflicts and occupied territories, natural disasters, man-made disasters, famine and pandemics, but it will also examine long-standing situations of crisis resulting from structural discrimination deeply embedded in histories of patriarchy, colonization, conquest and marginalization (such as in the case, for example, of indigenous women, Roma women and women of African descent), as well as other types of crisis based on the lived experiences of women, such as those induced by environmental factors, including the toxification of the planet, land grabbing, political, social and economic crises, including the impact of austerity measures, refugee and migrant crises, displacement crises, and gang-related violence, among others. The Working Group will examine how existing laws, policies, and practices can contribute to negative reproductive health outcomes for women and girls in situations of crisis and restrictions on their autonomy during their life-cycle, using an intersectional approach.

In order to inform the preparation of this report and in line with its mandate to maintain a constructive dialogue with States and other stakeholders to address discrimination against women and girls, the Working Group would like to seek inputs from all stakeholders. Submissions should be sent **by 31 August 2020** to [wgdiscriminationwomen@ohchr.org](mailto:wgdiscriminationwomen@ohchr.org) and will be made public on the Working Group's web page, unless otherwise requested. The Working Groupd is particularly interested in receiving information about challenges faced in ensuring that women’s and girls’ sexual and reproductive rights are respected, protected and fulfilled in times of crisIs, and are adequately prioritized, as well as examples of good practices.

**Questionnaire**

Concept/definition of crisis

1. Please provide information on the legal and policy framework used by your State to manage situations of crisis and on how the concept of “crisis” has been defined or framed.

The state of emergency is defined in Article (110) of the Amended Basic Law of 2003, as an exceptional system defined in time and place, which may be declared by the President of the State of Palestine when there is a threat to the national security caused by war, invasion, armed insurrection or in times of natural disaster. The decree declaring a state of emergency shall state its purpose, the region to which it applies and its duration. The Parliament shall have the right to review all or some of the procedures and measures adopted during the state of emergency, at the first session convened after the declaration of the state of emergency or in the extension session, whichever comes earlier, and to conduct the necessary interpellation in this regard.

Moreover, the State of Palestine is preparing a system at the national level that organizes disaster risk management, reduction processes, and clarifies the responsibilities between law enforcement agencies and other relevant authorities. The Palestinian Government is working on a proactive approach towards disaster risk management, in line with policies related to climate change and sustainable development. In addition, the Palestinian Government is working to include disaster risk management in development policies, plans, sectoral and non-sectoral programs, and budgets, and to enhance the role of marginalized groups in disaster risk management.

According to the applicable legislations the disaster is defined as: disruption in the functioning of society or gatherings as a result of an event or phenomenon arising from natural factors or human action, or both. This includes great losses and negative effects on lives, material and economic aspects, and the environment that exceeds the ability of the affected community or urban community to confront it using their own resources.

1. Please list the type of situations that would fit the concept of “crisis” in your State and indicate what situations are excluded.

* Israeli occupation and its systematic violations of Human Rights, as Palestinian women and girls suffer from the daily systematic and widespread violations of their fundamental rights, including the right to life and survival, the right to health, the right to education, the right to self-determination and the right of return, in violation of international law, including international human rights law, international humanitarian law, and relevant United Nations resolutions.

Palestinian women and girls are exposed to and the target of illegal policies such as extrajudicial killings and injury, home demolitions, confiscation of land, destruction of property, forced displacement, arrest and arbitrary detention, harassment and settlers’ terrorism.

* The recent COVID-19 Pandemic.

1. What institutional mechanisms are in place for managing a crisis and how are priorities determined?

During the Coronavirus crisis, the President of the State of Palestine has declared the state of emergency as explained above. A National Health Emergency Committee, headed by the Ministry of Health (MoH) including a platform for the private sector, was established to confront the Coronavirus crisis. A confrontation plan has been drawn up, including emergency plans at the level of public administrations, hospitals and primary health care centers. Regular committee sessions are held to continuously assess the existing situation and modify the executive plans as needed.

In addition, the Palestinian government has taken the following measures:

* Health Care measures:
  + Reopening of the productive health clinics and finding alternatives to monitor them.
  + Providing psychological and social counselling and support for 1410 persons through “Tawasol centers” and psychological health committees.
  + Providing sex disaggregated data via the online platform that tracks COVID-19 reported cases.
  + Preparing special rooms for abused women and girls in the governorates.
* Social protection measures:
  + In cooperation with the Ministry of Women’s Affairs, the Ministry of Social Development, the Ministry of Health, the Police, the Governorates, the Protection Centers and the civil society organisations, 14 procedures were approved, adopted, and followed to transform women victims of violence during the state of emergency.
  + Providing counseling and psychological assistance to 887 cases from the different governorates through innovative technologies.
  + Proposing a plan to enhance the role of protection centers and the centers for dangerous cases, and to improve the services provided by them.
* Establishing Emergency Committees:
* In cooperation with the Ministry of Women’s Affairs and the Governmental institutions, the security forces and the civil society organisations, an emergency plan has been developed to confront the Coronavirus crisis.
* Involving the security forces advisory committee in the emergency operations.
* Involving “Tawasol Centers” of the different governorates in the emergency groups (17 centers in the Northern & Southern Governorates) .
* Creating groups on WhatsApp for the families in need, in order to provide them with the necessary services.
* Media :
* Organizing campaigns to strengthen the physical and phycological immunity, such as the campaign “an Information every day”.
* Systems:
* Launching the National Observatory on Violence against Women.
* Creating an electronic tool titled “Palestinian diaries documenting the role of women in confronting the pandemic.”

Challenges and good practices

1. Please highlight any challenges faced in the provision of SRH services and good practices in ensuring women’s and girls’ SRHR in situations of crisis, including, for example, measures concerning timely access to the the following types of services and aspects of care:
2. Access to non-biased and scientifically accurate information about sexual and reproductive health matters and services;

The National Health Strategy of the Ministry of Health states that all Palestinians should have equal access to health, services and information without discrimination regardless of their age, residency, sex or disability. Community awareness is achieved by dissemination of information on SRH, breast feeding, nutrition of children, pregnant and lactating women, in addition to GBV with particular emphasis on crisis situations, currently the coronavirus pandemic, using social media, internet ads, national TV and announcements made by worship and community centers (e.g. mosques).

Sexual and reproductive health education in Palestine is a debatable issue constrained by political, economic, cultural, and religious factors. Societal taboos are major obstacles to holding informative discussions on sexual and reproductive health issues, especially with regard to young women. This represents constitutes a constraint on efforts to raise women’s and girls’ awareness of their SRHR, which enable them to make decisions in this regard.

1. Access to medical professionals and health service providers, including traditional birth attendants, with adequate provision for their training and safety including personal protective equipment;

In order to ensure access to medical professionals and health services, including traditional birth attendants, an emergency strategy has been developed to provide face-to-face and remote services using internet technologies. A coordination of SRH services among different providers is taking place under the leadership of the Ministry of Health. Roles are distributed between different partners to establish a service directory, activate mobile clinics and/or home visits, improve the referral mechanisms for women who are not able to enjoy these services. Moreover, health professionals are trained to provide services during crisis, and to protect themselves from COVID-19 infection. A plan has been put in place to support at least 5,000 health workers with infection prevention and control measures, including providing them with personal protective equipment (PPE).

1. Access to essential medicines as prescribed by the WHO, equipment and technologies essential for the quality provision of sexual and reproductive health services;

The essential medicines prescribed by the WHO are kept available. There is a plan to give women double the amount of medication, nutritional supplements and contraception needed, especially during times of lockdown. The deficit in essential equipment needs is widened by crisis situations. During the coronavirus pandemic, a fund was relocated out of the budget of the MOH, along with national, civilian and international donations to purchase essential equipment for SRH services. The purchase and distribution of this equipment was based on needs assessment.

1. Prevention of HIV transmission, post-exposure prophylaxis and treatment for HIV/AIDS as well as the prevention and treatment of sexually transmissible infections;

In Palestine the prevalence of HIV/AIDS is very low. HIV case reporting began in 1988, while HIV prevention Strategy was developed in 2019. During the crisis, particularly the recent pandemic, responsive healthcare services take priority over preventive healthcare services, such as testing for sexually transmitted infections, including HIV. More cases are expected to go undetected during the emergency.

1. Pregnancy-related health services, including pre- and post-natal care, assistance during child-birth, and emergency obstetric care;

In response to the emergency situation due to the coronavirus pandemic, a national protocol has been developed to guide health professionals in the care of women infected with the virus, during pregnancy, labor and after delivery. Delivery in hospitals, access to emergency obstetric care has remained the same, if not increased during the pandemic. Antenatal and postnatal care for high-risk pregnancies has been shifted from primary healthcare to hospitals or to private sector clinics. Antenatal and postnatal care for low-risk pregnancies has been noticeably reduced due to the restriction of movement during the lockdown measures, and the fear of catching the infection, which has limited the access to health facilities for both health care providers and women.

1. The full range of modern contraceptive information and services, including emergency contraception, as well as family planning information and services related to the number, timing and spacing of pregnancies and infertility treatments;

The MOH ensures access to a full range of family planning information and services and modern contraceptives, which have also been included in the list of essential medicines to increase their availability, and ensure that women and men have access to them. Emergency contraceptive methods are mainly provided to victims of rape. According to the Health Information Center at the MOH, unmet need for family planning has increased due to the decline in the number of women seeking contraceptive advice due to the crisis. The main concerns are the expiration of contraceptive methods before use, the increase in the number of unwanted pregnancies and the short intervals between pregnancies which are associated with increased maternal and perinatal morbidity and mortality. Therefore, the MoH has included face-to-face and remote family planning services in the aforementioned national protocol. In the event of a lockdown, the distribution of contraceptive services in childbirth or delivery facilities will be considered through mobile clinics.

1. Safe abortion services including surgical and non-surgical methods of termination of pregnancy and humane post-abortion care, regardless of the legal status of abortion;

A monitoring system for abortion cases has been established at the MoH facilities to obtain relevant data. The majority of women and girls have access to institutionalized and safe abortion methods, regardless of the legal status of abortion.

According to the applicable laws, abortion is criminalized unless there is a medical reason for it. Article (8) of the Public Health Law stipulates that abortion is medically acceptable only if there is a threat to the woman’s life, and if it is certified by two doctors. In this case, abortion can be performed with the consent of the woman, or the consent of her guardian. In cases of sexual violence and rape, an official committee reviews each case before making a decision about abortion.

1. Treatment for pregnancy-related morbidities such as obstetric fistula and uterine prolapse, among others;

Obstetric fistulae is rare in Palestine. After giving birth, all women should undergo a thorough evaluation of their perineum to rule out obstetric injuries. Intrapartum and immediate postpartum services are not affected by the crisis. In contrast, treatment of uterine prolapse is not considered as a priority during emergency situations, but screening for prolapse is part of the postnatal services provided by the MoH.

1. Screenings and treatment for reproductive cancers;

The MoH has developed a National Strategy on Cancer Prevention and Control. Early detection of cancer is one of the main components of the strategy, through the implementation of effective screening programs, and the expansion and promotion of national screening programs, including breast cancer mammography program, and Pap smear test for early detection of cervical cancer. However, mammography program and pap smears were halted during the pandemic. Treatment for reproductive cancer was not interrupted, but some patients were transferred to different treatment centers when the hospitals, where they were being treated, were temporarily closed due to COVID-19 infection. However, the situation in the Gaza Strip is much worse, as cancer patients are not allowed to seek treatment outside the Gaza Strip. The blockade of the Gaza Strip has put many women at the risk of losing their lives due to the delayed treatment.

1. Menstrual hygiene products, menstrual pain management and menstrual regulation;

Women and girls have easy access to menstrual hygiene products and pain killers, even during lockdowns, as pharmacies have been consistently excluded from the closure. Women and girls infected with COVID-19, and who were kept in quarantine centers, were provided with all necessary menstrual products and pain killers through the MoH and the municipality in charge.

1. Prevention, investigation and punishment of all forms of gender-based violence, and access to timely and comprehensive medical interventions, mental health care, and psychosocial support for victims and survivors;

Several actions have been taken to put in place a legal framework regulating women’s rights. For instance, the draft law concerning protection of the family from violence includes provisions for the protection of women from violence that are consistent with the CEDAW Convention. Those measures make it easier for women victims to access justice and ensuring that anyone who commits such crimes against them is prosecuted. Work is being done to amend certain articles of the applicable Penal Code. For example, article 99 on mitigating circumstances is being amended to ensure that it does not apply to crimes against women and girls, article 308, which provides for prosecution and the enforcement of judgments to be suspended if the perpetrator marries the victim, has been repealed. Numerous other amendments have recently been made to certain provisions of the penal laws.

However, Palestinian women and girls are subjected to all forms of violence by Israeli occupation forces and settlers. In addition to restrictions on movement and access to certain services due to restrictive measures imposed by the government during the pandemic. Nevertheless, the MoH is cooperating with all relevant ministries, partners and authorities to provide all necessary services for women and girls infected with the coronavirus, including preventive and responsive activities and psychosocial support. The MoH also ensures the protection of all women and girls, including those infected with the coronavirus, by setting up isolation rooms for victims of gender-based violence infected with the virus in hospitals and quarantine centers. The MoH will also make a decision to exempt victims of GBV from the costs of emergency medical interventions.

1. Measures to prevent and prohibit practices such as female genital mutilation and child, early and forced marriage;

Genital mutilation is not practiced in Palestine. The State of Palestine has committed to eliminate child, early and forced marriage by 2030 in line with target 5.3 of the Sustainable Development Goals. The minimum age of marriage has been raised to 18 years old for both males and females, in line with the recommendations of Human Rights Treaty Bodies, including the CEDAW Committee. Medical education emphasizes the negative impact of early marriage on the health of women and girls.

1. Legal and policy safeguards against abuses and delays in the provision of SRH services for example in relation to confidentiality, referrals, informed consent, conscientious objection, and third party consent requirements;

The Amended Basic Law and the Charter of Women’s Rights, published in 2008, guarantee equality and a number of economic, political and social rights without discrimination. They ensure the right of women to equal health care and services, they also affirm women’s access to information about their health status and eliminate all forms of violence against them. The MoH conducted several trainings, for all relevant personnel working in the health sector, on the implementation of the National Referral System for women and girls victims of violence, in addition to allocating the necessary resources to ensure its effective and comprehensive implementation. Palestinian Basic Law and the abovementioned Charter prohibit torture and other cruel, inhuman, or degrading treatment or punishment, they also guarantee access to emergency contraception, especially in cases of rape, and the right to terminate pregnancy when a woman’s life or health is in danger, in cases of rape and fatal impairment.

The right to privacy includes the right to bodily autonomy and decision-making in matters of sexual and reproductive health, and confidential health information, in addition to the prohibition of consent from third parties, such as spouse and/or parents, to sexual and reproductive health services.

1. The affordability of SRH services especially for those in situations of vulnerability;

The vision of the MoH, as stated in the National Health Strategy, is to ensure health care for all Palestinians, by providing them with high quality health services, which are accessible to all Palestinians regardless of their age, residency, sex or disability. The MoH’s vision for reproductive health is ‘to promote optimal and equitable reproductive and sexual health and rights of all people in Palestine, through the development of an effective reproductive health system, population policies, the implementation of quality reproductive health care, public health surveillance, research, leadership, strategic partnerships, capacity building, preparedness, and access to information.’

1. Other pertinent information that may affect the availability accessibility, affordability, acceptability and quality of SRH services and information.
2. Strategic plans related to SHR services, post-abortion, gender-based violence, postpartum and mothers of abnormal babies are available, but their implementation is delayed.
3. Several draft laws relevant to SHR services have not yet been adopted.
4. The lack of comprehensive and age-appropriate education on sexual and reproductive health rights in schools. However, several manuals have been developed to train teachers on SHR services.
5. Information on family planning methods is not consistently provided to women before or after abortion. While family planning services are widely offered by the public health system, their full use is limited, especially for vulnerable women from marginalized communities, due to limited physical access to these services, lack of awareness , in addition to the socio-economic conditions.
6. Cultural, economic and social factors are the main reasons for the high rates of early marriage in Palestine, especially in the Gaza Strip and the so called “Area C”.
7. The limited participation of women, youth and vulnerable groups living in the so called “Area C”, Jerusalem and the Gaza Strip, in public life and in decision-making.
8. In relation to ensuring the Right to Life by preventing maternal mortality and morbidity, WHO has identified delays in delivery care as one of the main causes of maternal death, including delays in reaching a health facility and in receiving care at a health facility. Palestinian women are subjected to degrading treatment and discrimination based on their nationality at Israeli checkpoints. In addition to the large number of women physically and psychologically traumatized because of these illegal practices.
9. Economic barriers and the lack of resources among women are the main obstacles to health care in both the West Bank and the Gaza Strip.

Experiences of crisis

1. Please list the situations of crisis experienced by your State in the last five years.

* Israeli occupation and the systematic human rights violations for more than 70 years.
* Division between the West Bank and the Gaza Strip.
* The illegal Israeli blockade of the Gaza Strip since 2007, and the ongoing Israeli wars on Gaza.
* The coronavirus pandemic and its economic and psychosocial impact.

1. What was the impact of those crises on women and girls? Please provide information in particular on the following aspects:
2. Which groups of women and girls were most affected and how, taking into account different factors, such as age, geographic location (including urban and rural areas), ethnic and social origin, disability, marital status, migratory status, citizenship status or other status?
   1. Pregnant and lactating women and children who may not be able to receive essential health care due to reshuffling of health service priorities.
   2. Palestinian refugees living in the overcrowded refugee camps, as well as Bedouin communities with inadequate living conditions, especially access to water and sanitation.
   3. Palestinians living in the Gaza Strip.
   4. Palestinians living in the so-called “Area C” and in East Jerulalem.
3. What was the impact on their SRHR? Were any specific risk factors and needs identified? Do you have data and/or qualitative information disaggregated by the factors listed under question 6(a)? If not, please explain why.
   1. Maternal Mortality in the Gaza Strip witnessed a sharp increase during and after the war in July 2014. The MoH reported 4 cases of maternal mortality during the 51-day war. The MoH reported a total of 17 maternal deaths in 2014. Furthermore, 20 pregnant women died during the war; four cases due to obstetric causes, and the other 16 cases were killed as a result of the hostilities. From July 2014 to June 2015, cumulative deaths amounted to 1.859, compared to 2013 where 12 cases of maternal mortality were reported.
   2. The restrictions on movement, the closure of schools and the growing unemployment rate due to the coronavirus pandemic, is affecting the most vulnerable people. Domestic violence against women and children has increased, and according to the Ministry of Social Development at least 53,000 families have fallen into poverty in the recent weeks.
   3. The pandemic has disrupted the delivery of essential health care services across Palestine. All major providers have scaled down sexual reproductive services, putting women, girls and their neonates at higher risk of death and disability. The impact on family planning and pre-conception care services, may lead to an increase in unplanned pregnancies, which can be life-threatening. In the Gaza Strip, 44% of all essential medicines were in stock within a month and 35% were completely depleted.
   4. Potential increase in obstetric complications and/or home deliveries due to lack of access to transportation.
   5. Severe impact on the mental health and well-being of women, particularly pregnant women, who fear for themselves and their children.
   6. The economic impact of COVID-19 on families, which can lead to further deterioration of nutrition for many pregnant and lactating women. Household financial pressures may lead to a de-prioritization of women’s health care.
   7. The lockdown and movement restrictions have disrupted rehabilitation and support programs for women and girls with disabilities, which can potentially worsen their conditions.
4. What were the main obstacles encountered by the State, if any, in identifying and addressing the impact of the crisis on women’s and girls’ SRHR?
   1. The ongoing Israeli occupation and its illegal practices and violations of human rights, including SRHR, are the most dangerous challenges for the Palestinian health sector.
   2. The health system has been undermined by the ongoing political conflict, the Israeli blockade of the Gaza Strip, the internal division, and the shortages of specialized personnel, drugs and equipment. In addition to capacity shortages, in the West Bank, vulnerable communities, particularly in the so-called “Area C”, due to the destruction of property by Israeli forces, as well as settlers’ violence, which undermine the capacity of the Palestinian government to cope with the crisis.
   3. The illegal Israeli blockade of the Gaza Strip imposes severe restrictions on movement and undermines the Government’s ability to uphold human rights in general and SRHR in particular. Many communities have become marginalized due to the closure of borders and restrictions on movement. Israeli checkpoints between cities and villages impede access to health services and violate the right to health.
   4. Cultural challenges and traditions.
   5. Shortage of healthcare providers and psychosocial workers.
   6. Limited data and analysis difficulties.
5. What measures were adopted during and after the crisis to ensure women and girls’ access to sexual and reproductive health services? Please indicate which SRHR services are recognized as essential services in the health policy or laws of your State and are funded through the health system. What steps were taken to ensure the continuity of services and access during the crisis?

The MoH considers SRH services to be essential services. This includes surveillance for maternal mortality, near misses, pre-conception care, antenatal and postnatal services, screening for breast cancer, cervical cancer, STIs, including HIV, and family planning. The coronavirus pandemic has caused a disruption in the provision of SRH services, but the MoH has put in place an emergency plan to ensure the provision of these services in cooperation with relevant partners. A policy framework has been established to guide health care providers and beneficiaries during the crisis, as explained above.

1. What other protocols or systems were put in place to prevent adverse reproductive and sexual health outcomes due to the common risks triggered by crisis including, for example, gender-based violence and child marriage? Were any special measures adopted for specific groups of women and girls?

cross-sectorial support was provided to vulnerable communities, particularly those living in Bedouin communities, in the Gaza Strip and in the so-called “Area C”, through awareness campaigns. In addition to taking all necessary measures to combat domestic violence against women and children. Please see the previous section (items b, e, k, I).

1. Were women’s rights organizations[[2]](#footnote-2) involved in the needs and impact assessments and the recovery policies? If not, please indicate why.

Women's rights organizations participate in the assessment of needs and implications of the current crisis and health disaster. They aslo participate in the assessment of the consequences of political disasters due to the Israeli occupation. Moreover, they are members of the national committees concerned with women's health and rights.

1. Which actors or institutions played a role in the provision of emergency responses? Please describe their role and explain what roles were played, if any, by national women’s rights or human rights mechanisms, or other similar bodies as well as civil society organisations.

Besides the MoH, other members of the SRH National Committee were involved in formulating the policy framework and emergency plan, including the URWA, the WHO, the UNFPA, the UNICEF, and relevant civil society organizations. Different roles were assigned to different partners in a complementary manner. For example, Civil society organizations provided SRH services to rural, remote and marginalized areas through mobile clinics and/or home visits. The WHO and the UNFPA provided technical and financial support to the MoH. In addition, SRH service providers were trained by different partners on infection control measures and ICU interventions.

Morover, the civil defense, the Red Crescent, the security services, the municipalities and governorates played a role in providing emergency responses.

1. How were the emergency responses funded and to what extent did they rely on foreign aid or assistance, if any? Please also indicate how in your State adequate financing of women’s sexual and reproductive health is ensured more generally on an ongoing basis.

The SRH strategic plan and programs are generally funded by the UNFPA and the MoH. However, emergency responses to the crisis relied on external funds. During the current pandemic, funding for SRH services and gender-based violence programs relied on the relocation of the existing budget to meet the urgent needs.

1. What obstacles have civil society organisations encountered in their efforts to deliver sexual and reproductive services?

The challenges and obstacles that civil society organizations encounter in their efforts to deliver sexual and reproductive services, whether due to the coronavirus pandemic or due to the Israeli occupation, are similar to those encountered by the government as follows:

* 1. The current situation is affecting the use of SRH services due to the:
* Fear of being infected with the coronavirus.
* Lockdown measures and movement restrictions
* Lack of public transportation.
* Economic reasons.
  1. Healthcare providers are not always capable of providing services, due to the lack of access to appropriate PPE. This issue was raised during the sessions of the SRH Working Group, where all members stressed out the importance of making PPE available to SRH health workers.
  2. Doctors are not well prepared to provide online/virtual SRH support.

Almost all service providers have activated a hotline/phone consultation to follow up with the cases, others have started raising awareness campaigns through social media.

1. Could you identify any lessons learned? Please indicate if and how these lessons have been applied in preparedness strategies or in subsequent situations of crisis.
   * + The coherent response to essential services, and the recognition of SRH as one of these services.
     + The formulation of a comprehensive emergency plan that can be easily replicated in situations of crisis.
     + The importance of providing PPE to SRH health workers, to enable them to provide appropriate services. The provision of PPE should be in coordination with the MOH and the health cluster, due to high global demand and limited supplies.
     + The development of clear guidelines for SRH service providers, in line with WHO recommendations.
     + A review of the information and services that should or could be provided through the hotline, in coordination with the MoH and the UNFPA and relevant civil society organisations.
     + Activate the role of the working group on SRH and strengthen coordination between all partners concerning the activities of the health cluster.
     + The development of monitoring mechanisms.
     + Activation of phone counselling to deal with urgent cases.
     + The importance of conducting home visits (taking all necessary precautions into account) to provide counseling to midwives working in PHC centers.
     + Designation of focal points (Doctors) for each area to follow up online consultations with ANC, PNC, and provide guidance and advice.
     + The integration of SRH services in PHC mobile clinics.
2. If your State has humanitarian aid programmes, please indicate whether SRHR are explicitly covered in the humanitarian aid strategy and how priorities on SRHR are set.

The State of Palestine has different humanitarian aid programs, including cash assistance to poor families, health insurance, distribution of food and health packages for poor families and HIV patients. However, the SRHR are not explicitly included in these programs.

1. Please indicate the main challenges, if any, encountered by women and girls to access justice and obtain reparations for violations of their SRHR, including any procedural barriers, and the types of assistance available to access legal and other remedies. Please also indicate the groups of women and girls most affected. Where applicable, please indicate the role played by a national truth and reconciliation commission (or a similar body) in ensuring the recognition of human rights violations in relation to women’s and girls’ SRHR and reparations.

The Basic Law and the applicable legisltions ensure women’s access to justice and remedies. Moreover, the applicable Penal Code criminalizes violence against women, and the draft Family Protection Law includes provisions to prevent GBV and hold the perpetrators accountable. However, there are several challenges encountered by women and girls to access justice and obtain reparations for violations of their SRHR, such as:

* + - Fear of family and social stigma.
    - Fear of being hurt or killed by the perpetrator of violence.
    - Cultural barriers related to the prevailing traditions.
    - Lockdown measures and restrictions of movement.

Preparedness, recovery and resilience

1. Is there any preparedness or risk management strategy/plan/policy in your State? If so, please provide information on the following aspects:
2. To what crisis does it apply? What situations are excluded?

There is an available risk management strategy in Palestine which applies to different contextual crisis, such as natural disasters, political conflicts, wars, pandemics, food poisoning and refugee crisis.

1. Does it contain a definition of crisis? If so, please indicate the definition used.

Please see the first section “definition of Crisis”.

1. Does it include measures concerning women and girls’ SRHR? If so, please describe the measures included and any special measures envisaged and/or adopted for specific groups of women and girls concerning both preparadeness and recovery.

SRHR for women and girls have not been included in the risk/emergency management strategy. However, the strategy will soon be updated to ensure the inclusion of minimum essential services for SRH.

1. How were the risks related to women and girls’ sexual and reproductive health and rights, in urban and rural areas, identified and assessed?

Not applicable.

1. Were women’s rights organizations involved in: i) the development of the strategy/plan/policy; ii) assessment of the risks concerning SRHR; iii) the design of the measures implemented; and iv) the monitoring of the strategy/plan/policy? Please indicate the steps taken to ensure their participation and to include a gender-perspective in crisis preparedness, management and recovery.

Not applicable.

1. Please indicate if the strategy/plan/policy has undergone any assessments to date. If so, what were the main findings and recommendations concerning women’s and girls’ SRHR?

Please see item a.

1. If your State does not have a plan that can immediately go into effect in a time of crisis, please explain why it is so.
2. Are there specific ways in which international human rights mechanisms can support States in their efforts to address a crisis?

The State of Palestine participates in all activities organized by the UNDRR. Moreover, Palestine is a member of the Sendai Framework which identifies the appropriate international mechanisms to deal with any crisis.

1. SRHR include women’s right to make free and responsible decisions and choices, free of violence, coercion and discrimination, regarding matters concerning one’s body and sexual and reproductive health, as well as entitlements to unhindered access to a whole range of health facilities, goods, services and information on sexual and reproductive health, such as maternal health, contraceptives, family planning, sexually transmitted infections, HIV prevention, safe abortion and post-abortion care, infertility and fertility options, and reproductive cancer. Women’s right to sexual and reproductive health further encompasses the “underlying determinants” of sexual and reproductive health, including access to safe and potable water, adequate sanitation, adequate food and nutrition, and adequate housing, among others, and effective protection from all forms of violence, torture and discrimination and other human rights violations that have a negative impact on the right to sexual and reproductive health. Moreover, it covers social determinants, notably social inequalities in society, poverty, unequal distribution of power based on gender, ethnic origin, age, disability and other factors, systemic discrimination, and marginalisation, which affect people’s patterns of sexual and reproductive health. [↑](#footnote-ref-1)
2. The expression women’s rights organizations should be understood as encompassing organizations of women of different ages, backgrounds and identities. [↑](#footnote-ref-2)