Steadfastness in Service

2025 PMRS EMERGENCY REPORT

Contents

Acronyms and Abbreviations

- **ANC** – Antenatal Care
- **AWD** – Acute Watery Diarrhoea
- **GBV** – Gender-Based Violence
- **H2** – Hebron City Restricted Area
- **INGO** – International Non-Governmental Organisation
- **MHPSS** – Mental Health and Psychosocial Support
- **MUAC** – Mid-Upper Arm Circumference
- **NCDs** – Non-Communicable Diseases
- **NGO** – Non-Governmental Organisation
- **OCHA** – United Nations Office for the Coordination of Humanitarian Affairs
- **PHC** – Primary Health Care
- **PMRS** – Palestinian Medical Relief Society
- **PFA** – Psychological First Aid
- **PNC** – Postnatal Care
- **SRHR** – Sexual and Reproductive Health and Rights
- **STI** – Sexually Transmitted Infection
- **WHO** – World Health Organization
- **5Ws** – Who does What, Where, When, for Whom

1. Executive Summary

Overview

In 2025, the Palestinian Medical Relief Society (PMRS) delivered a large-scale, life-saving health response across the Gaza Strip and the West Bank amid unprecedented humanitarian conditions. The year was marked by near-total health system collapse in Gaza, escalating access restrictions in the West Bank, repeated mass displacement, and shrinking humanitarian space. Within this context, PMRS sustained essential healthcare delivery through a decentralised, locally led, and rights-based approach, ensuring continued access to care for communities otherwise excluded from routine health services.

PMRS's response spanned primary healthcare, sexual and reproductive health, trauma and emergency care, non-communicable disease management, nutrition screening, mental health and psychosocial support, rehabilitation, disease surveillance, and preventive health, delivered through mobile clinics, temporary medical points, outreach teams, and digital health systems.

Scale and Reach of the 2025 Response

Across Gaza and the West Bank, PMRS delivered hundreds of thousands of health consultations and services in 2025, responding to both acute humanitarian needs and chronic access barriers.

In the Gaza Strip, PMRS operated across all five governorates—North Gaza, Gaza City, Deir al-Balah, Khan Younis, and Rafah—maintaining service delivery despite widespread destruction of health infrastructure, repeated forced evacuation orders, and severe disruption to referral pathways. Services were delivered in conditions of mass displacement, overcrowded shelters, unsafe water and sanitation, and intermittent access to fuel and medical supplies.

In the West Bank, PMRS focused on Area C, seam zones, and other access-restricted communities across Hebron, Bethlehem, Nablus, Jenin, Tubas, Salfit, Qalqilya, and the Jordan Valley, where movement restrictions, settler violence, and territorial fragmentation severely constrained access to healthcare.

Impact Highlights by thematic area

- **Primary Health Care (PHC):**
  PMRS delivered more than half a million acute illness consultations in Gaza, addressing respiratory infections, diarrhoeal disease, skin conditions, urinary tract infections, parasitic infections, and other preventable conditions. In the West Bank, mobile clinics reached tens of thousands of people who would otherwise face delayed or foregone care.

- **Sexual and Reproductive Health (SRHR):**
  PMRS provided comprehensive SRHR services across Gaza and the West Bank, including antenatal and postnatal care, gynaecological consultations, family planning, and STI services, mitigating heightened maternal and reproductive health risks amid disrupted maternity care.

- **Trauma and Emergency Care:**
  In Gaza, PMRS treated over 140,000 trauma patients, providing emergency stabilisation and wound care under conditions of mass casualties and constrained hospital capacity. In the West Bank, community-based first aid and emergency preparedness reduced harm during delayed ambulance access.

- **Non-Communicable Diseases (NCDs):**
  PMRS supported continuity of care for more than 67,000 people living with chronic disease in Gaza, preventing deterioration and excess mortality caused by treatment interruption. Mobile delivery in the West Bank addressed structural barriers to chronic care.

- **Nutrition:**
  Nearly 50,000 nutrition screenings were conducted in Gaza, identifying rising levels of acute malnutrition, particularly among children and pregnant and lactating women, and enabling early intervention amid deepening food insecurity.

- **Mental Health and Psychosocial Support (MHPSS):**
  PMRS delivered more than 74,000 MHPSS consultations across Gaza and the West Bank, prioritising direct psychosocial support, counselling, and psychological first aid for populations exposed to sustained trauma, displacement, and loss.

- **Rehabilitation:**
  Over 24,000 rehabilitation consultations supported functional recovery for people living with injury, disability, and chronic impairment, mitigating long-term disability in contexts where specialised services were severely limited.

Operating Constraints and Adaptive Capacity

PMRS's response in 2025 was delivered under extreme and evolving constraints. In Gaza, three PMRS-supported clinics were damaged or destroyed in late October 2025, further reducing fixed-site capacity. Ongoing forced evacuation notices and the progressive shrinking of civilian space created intense competition for viable service locations, complicating efforts to re-establish fixed or semi-fixed health points and disrupting continuity of care.

In the West Bank, access restrictions intensified throughout the year. According to humanitarian monitoring, at least 849 movement obstacles, rising to approximately 898 checkpoints, gates, and barriers by early 2025, fragmented the territory and delayed or prevented access to health facilities. These constraints disproportionately affected women, children, older persons, people with disabilities, and individuals requiring ongoing care.

During this period, in Gaza PMRS health infrastructure was heavily affected by direct and indirect attacks. Overall, three PMRS health centers were completely destroyed: Umm Al-Nasser Health Center, Al-Samer Health Center, and Khan Younis Health Center. In addition, severe damage was inflicted on key facilities, including Tel Al-Hawa Chronic Diseases Center and Haider Abdel Shafi Health Center, significantly disrupting service delivery and forcing the relocation or suspension of critical health services. Numerous medical points were also damaged or rendered non-functional due to insecurity and repeated displacement. Since the beginning of the aggression, a total of 11 PMRS health centers and more than 30 medical points have been destroyed or rendered non-operational across the Gaza Strip, further undermining access to care for vulnerable populations and placing immense pressure on remaining functional facilities.

PMRS however, continued to respond through adaptive, decentralised delivery, service integration, flexible redeployment of teams, and the use of digital health and telemedicine to maintain continuity of care under conditions of ongoing violence and increasing instability across Palestine.

Local Leadership, Coordination, and Accountability

As a Palestinian-led organisation, PMRS operated at the core of the humanitarian health response, consistently reporting through the WHO-led Health Cluster and aligning interventions with identified gaps and priorities. PMRS's embedded presence, community trust, and local leadership enabled sustained delivery amid increasingly constrained international access, in particular in Gaza, but also across the West Bank.

Accountability to affected populations and donors was maintained through transparent reporting, community engagement, and adherence to humanitarian principles, even under conditions of severe operational pressure.

Why Local Health Organisations Matter Now

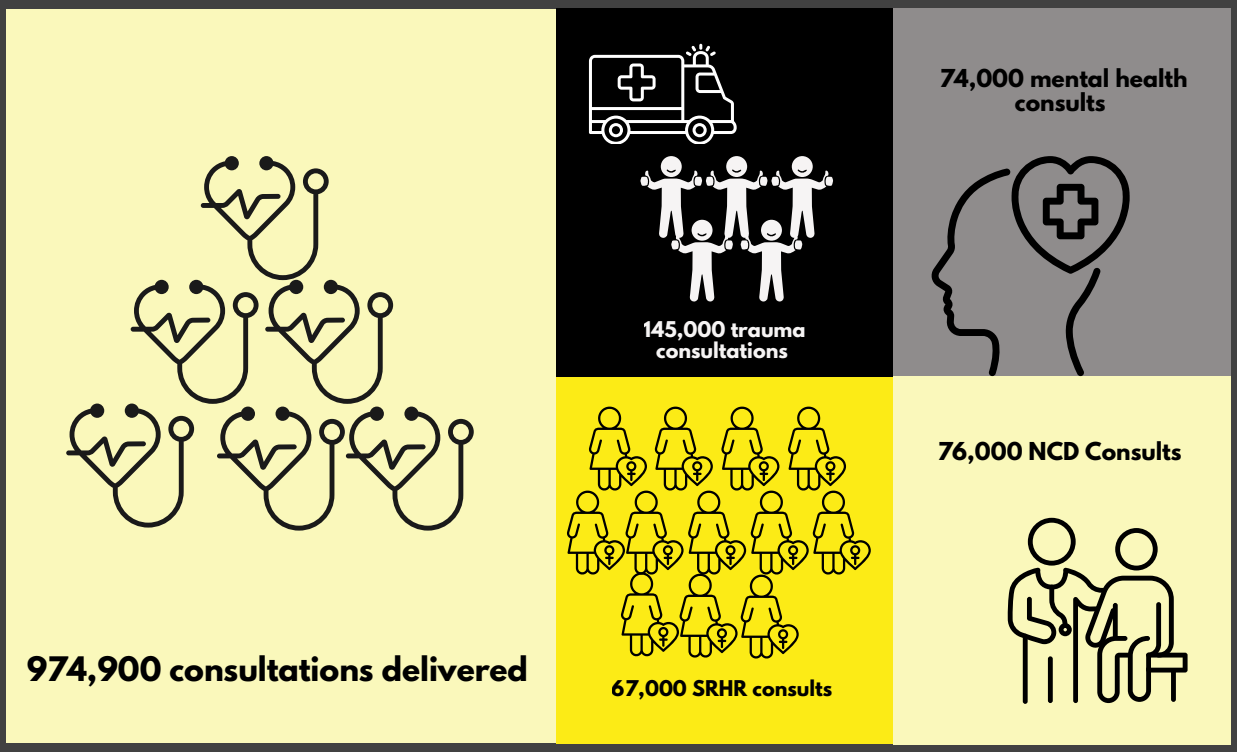
The experience of 2025 underscored the growing fragility of Palestinian local health organisations, particularly in Gaza, as pressures on the international humanitarian sector intensified. Local organisations are increasingly bearing responsibility for frontline service delivery while operating with fewer buffers against insecurity, infrastructure loss, and political pressure. Additionally, our teams are continuing their work diligently, whilst

Spotlight on: Continuing Attacks on Healthcare- West Bank

Spotlight on: Continuing Attacks on Healthcare- Gaza Strip

PMRS ACHIEVMENTS

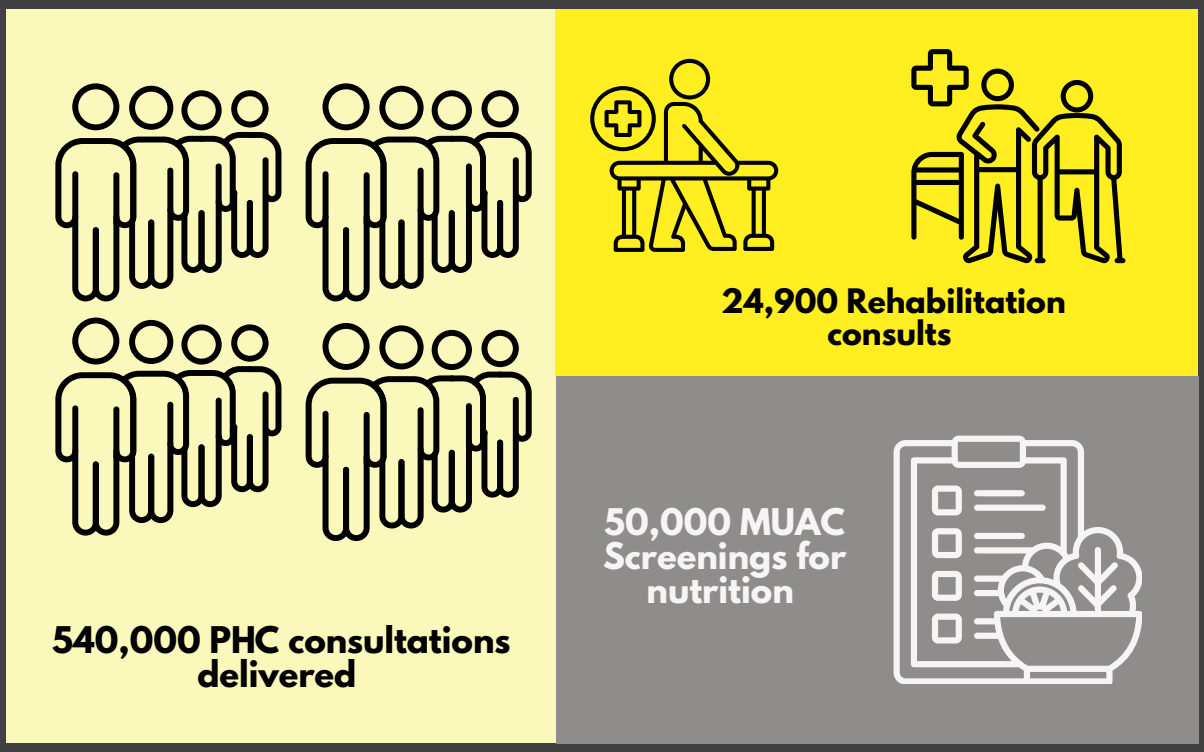
Medical Health Services



Overall, as part of the emergency health services program, in 2025, PMRS delivered 974,900 health consultations and services across the Gaza Strip and the West Bank.

PMRS ACHIEVMENTS

Medical Health Services



Primary healthcare is not only a frontline service but a critical safeguard of the right to health. In environments where access to secondary care is limited or denied, PHC plays a vital role in preserving life, dignity, and health system continuity. PMRS contined to provide high quality care for the most vulnerable.

facing occupation, genocide and contineous attempts to prevent them from reaching their patients.

Further, the rights of health workers and the protection of healthcare face mounting threats. Safeguarding healthcare from political interference and defending the neutrality of health services requires sustained, creative, and principled advocacy alongside operational support as we move forwards in 2026 as a collective committed to the same principles, driven by the desire to ensure all Palestinians have access to quality healthcare.

Looking Forward

PMRS teams demonstrated ongoing resilience and commitment throughout 2025, continuing to serve their communities under extraordinary strain. This resilience, however, must not be assumed. Sustained financial support, principled partnership, and active advocacy are essential to ensure that Palestinian-led health organisations can continue delivering care, protecting health workers, and upholding the right to health in an increasingly constrained humanitarian environment.

The impact achieved in 2025 reflects what is possible when local leadership, community trust, and sustained donor solidarity converge. Preserving and expanding this impact in the year ahead will depend on continued investment in locally led, rights-based healthcare delivery at a time when it is needed more than ever.

1. At-a-Glance Impact Summary

Sector	Gaza Strip	West Bank	Total (PMRS)	Notes on Scope & Impact
Primary Health Care (PHC)	**~500,000+ consultations**	**~40,000+ consultations**	**~540,000+**	**Acute illness diagnosis and early intervention**
Sexual & Reproductive Health (SRHR)	**~55,000+ consultations**	**~12,000+ consultations**	**~67,000+**	**ANC, PNC, family planning, STI services**
Trauma & Emergency Care	**~140,000+ trauma cases**	**~3,000+ emergency cases**	**~143,000+**	**Emergency stabilisation and wound care**
Non-Communicable Diseases (NCDs)	**~67,000+ patients supported**	**~9,000+ consultations**	**~76,000+**	**Continuity of chronic disease care**
Nutrition (MUAC & Screening)	**~50,000 screenings**	**—**	**~50,000**	**Early detection of malnutrition**

Mental Health & Psychosocial Support (MHPSS)	**~60,000+ consultations**	**~14,000+ consultations**	**~74,000+**	**Direct counselling and PFA**
Rehabilitation Services	**~18,700+ consultations**	**~6,200+ consultations**	**~24,900+**	**Functional recovery and disability support**
Health Education & Disease Prevention	**Integrated across services**	**Integrated across services**	**—**	**Surveillance-informed prevention**
Digital Health & Telemedicine	**System-wide use**	**Targeted West Bank use**	**—**	**Continuity and access support**

3. Operating Context and Humanitarian Environment

3.1 Gaza Strip

Throughout 2025, the Gaza Strip experienced an unprecedented humanitarian and public health crisis characterised by near-total health system collapse, repeated mass displacement, and severe disruption to civilian infrastructure. Large-scale damage to hospitals, clinics, laboratories, water and sanitation systems, and transport networks critically reduced the availability and functionality of health services. Health facilities that remained operational faced extreme overcrowding, shortages of essential medicines and medical consumables, unreliable fuel supplies, and constrained referral pathways.

The scale and frequency of forced evacuation notices throughout the year resulted in repeated displacement of large segments of the population, often with little warning. As designated “safe” areas were repeatedly redefined, the geographic space available for civilian presence progressively shrank, leading to severe overcrowding in remaining accessible areas. This dynamic created intense pressure on health services and significantly complicated the ability of humanitarian actors to establish and maintain fixed or semi-fixed service delivery points.

Environmental health conditions deteriorated sharply. Limited access to safe water, inadequate sanitation, and constrained waste management increased the risk of communicable disease transmission, particularly acute respiratory infections, diarrhoeal disease, and skin infections. These risks were compounded by overcrowded living conditions in shelters and informal displacement sites.

Referral pathways to secondary and tertiary care were repeatedly disrupted due to insecurity, damaged infrastructure, and restrictions on movement. As a result, primary healthcare and community-based services became a critical substitute for unavailable hospital care. Early diagnosis, treatment, and prevention were essential to reducing

Spotlight on: Continuing PHC-Gaza Strip

avoidable morbidity and mortality in a context where delayed care could rapidly become life-threatening.

Within this operating environment, healthcare delivery required constant adaptation. Service locations were frequently relocated, delivery modalities shifted from fixed facilities to mobile and temporary points, and health teams operated under sustained physical and psychological strain. Despite these constraints, locally led service delivery remained a cornerstone of access to care for displaced and highly vulnerable populations.

3.2 West Bank

In the West Bank, the humanitarian and healthcare environment in 2025 was shaped by entrenched structural barriers linked to territorial fragmentation, movement restrictions, and insecurity. Communities living in Area C, seam zones, and access-restricted localities faced persistent obstacles to reaching fixed health facilities, often requiring lengthy detours, prolonged waiting times at checkpoints, or complete inability to travel.

Movement restrictions intensified during the year. Humanitarian monitoring documented a sharp increase in physical barriers, including checkpoints, roadblocks, and gates, further fragmenting the territory and isolating communities. These constraints disproportionately affected rural villages, herding communities, and populations living far from urban centres, where alternative health services are limited or unavailable.

Access barriers had a direct impact on health-seeking behaviour. Delays in reaching care contributed to the progression of preventable illness, interruptions in chronic disease management, and reduced uptake of routine services such as antenatal care and follow-up consultations. For women, children, older persons, people with disabilities, and individuals living with non-communicable diseases, these delays increased the risk of avoidable complications and long-term health deterioration.

Insecurity and exposure to violence further constrained humanitarian operations, affecting both communities and health workers. These conditions limited the feasibility of fixed service delivery in many locations and necessitated flexible, mobile, and outreach-based approaches to care.

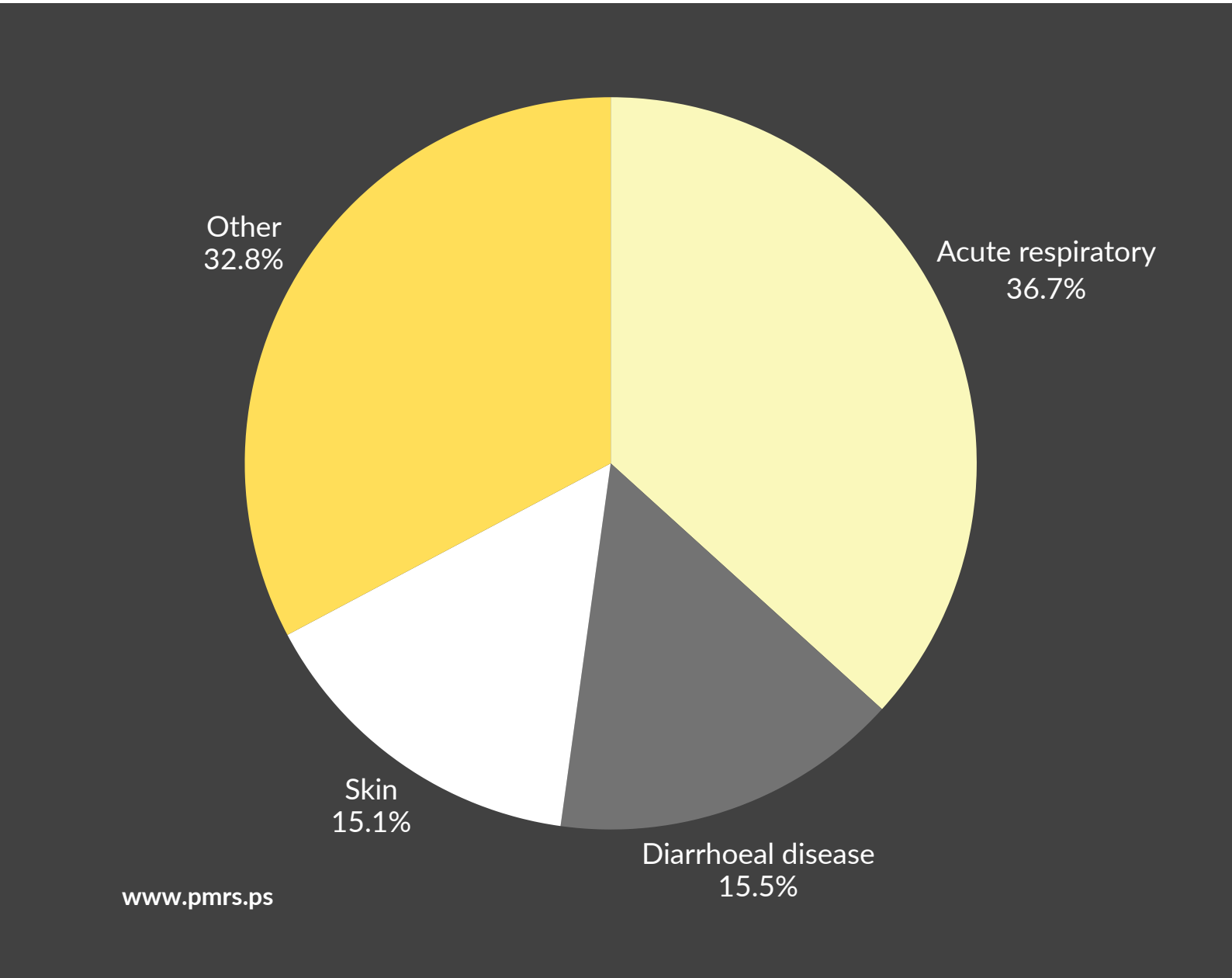
Despite these challenges, community-based and mobile health services played a vital role in mitigating access barriers, maintaining continuity of care, and reaching populations otherwise excluded from routine healthcare provision.

3.3 Implications for Humanitarian Health Response

Across both Gaza and the West Bank, the operating environment in 2025 underscored the necessity of decentralised, adaptable, and locally led health service delivery models. Traditional facility-based care alone was insufficient to meet needs under conditions of displacement, access restrictions, and infrastructure damage.

NON-COMMUNICABLE DISEASE SERVICES - GAZA

The morbidity profile of PHC consultations reflects the severe public health consequences of displacement, overcrowding, and environmental exposure. Acute respiratory infections alone accounted for nearly one-third of all consultations (36.7%), followed by diarrhoeal disease (15.5%) and skin infections (15.1%), underscoring the impact of deteriorating living conditions and inadequate water and sanitation.



The context demanded:

- Rapid adaptation of service locations and delivery modalities
- Integration of preventive, curative, and rehabilitative services
- Strong coordination and data-driven prioritisation
- Sustained investment in the local health workforce capacity

Within this environment, PMRS's ability to operate at the community level, adapt in real time, and maintain trust with affected populations was central to preserving access to essential healthcare and mitigating the most severe public health impacts of the crisis.

4. Primary Health Care (PHC)

4.1 Gaza Strip: Acute Illness Consultations and Morbidity Profile

Primary Health Care services constituted the backbone of PMRS's emergency health response in the Gaza Strip throughout 2025. In a context marked by widespread destruction of fixed health facilities, repeated displacement, overcrowded shelters, and severe disruption to water, sanitation, and hygiene systems, decentralised PHC delivery was essential to preventing avoidable morbidity and mortality.

Between January and December 2025, PMRS delivered a total of 544,783 acute illness consultations across the Gaza Strip. Service delivery was maintained through a network of mobile clinics, temporary medical points, and redeployed health teams, often operating under extreme access constraints and fluctuating security conditions.

The morbidity profile of PHC consultations reflected the public health consequences of prolonged displacement, overcrowding, environmental exposure, and food insecurity. The most frequently treated conditions included:

- Acute respiratory infections: 159,214 cases
- Diarrhoeal disease and gastroenteritis: 67,127 cases
- Skin infections (including impetigo): 65,272 cases
- Urinary tract infections: 40,598 cases
- Scabies: 23,086 cases
- Parasitic infections: 20,849 cases

- Pediculosis (lice infestation): 16,784 cases
- Varicella (chickenpox): 7,459 cases
- Acute hepatitis: 2,320 cases
- Other acute and chronic complaints: 142,074 cases

These disease patterns are consistent with sustained exposure to overcrowded living conditions, inadequate shelter, unsafe water, and reduced access to hygiene supplies. Without decentralised PHC interventions, a significant proportion of these conditions would likely have progressed to severe illness requiring hospital-level care, at a time when hospital functionality and referral pathways were severely constrained.

Monthly service delivery data demonstrate persistent demand for PHC services throughout the year, with fluctuations corresponding to displacement patterns, access restrictions, and episodic escalations in hostilities. Despite these constraints, PMRS maintained continuity of care, mitigating pressure on secondary and tertiary health facilities and reducing the risk of large-scale disease outbreaks.

4.2 West Bank: Mobile Clinics and Curative Services in Area C and Marginalised Communities

In the West Bank, PMRS delivered primary healthcare services primarily through mobile clinic modalities, responding to chronic access barriers faced by communities in Area C and other marginalised locations. These barriers include movement restrictions, checkpoint regimes, settler violence, and the absence or inaccessibility of fixed health facilities.

During 2025, PMRS operated 21 mobile clinics serving 126 communities, reaching a total of 49,987 people with curative PHC services. Services focused on the diagnosis and treatment of acute illnesses, basic clinical assessments, and referral for more complex conditions where feasible.

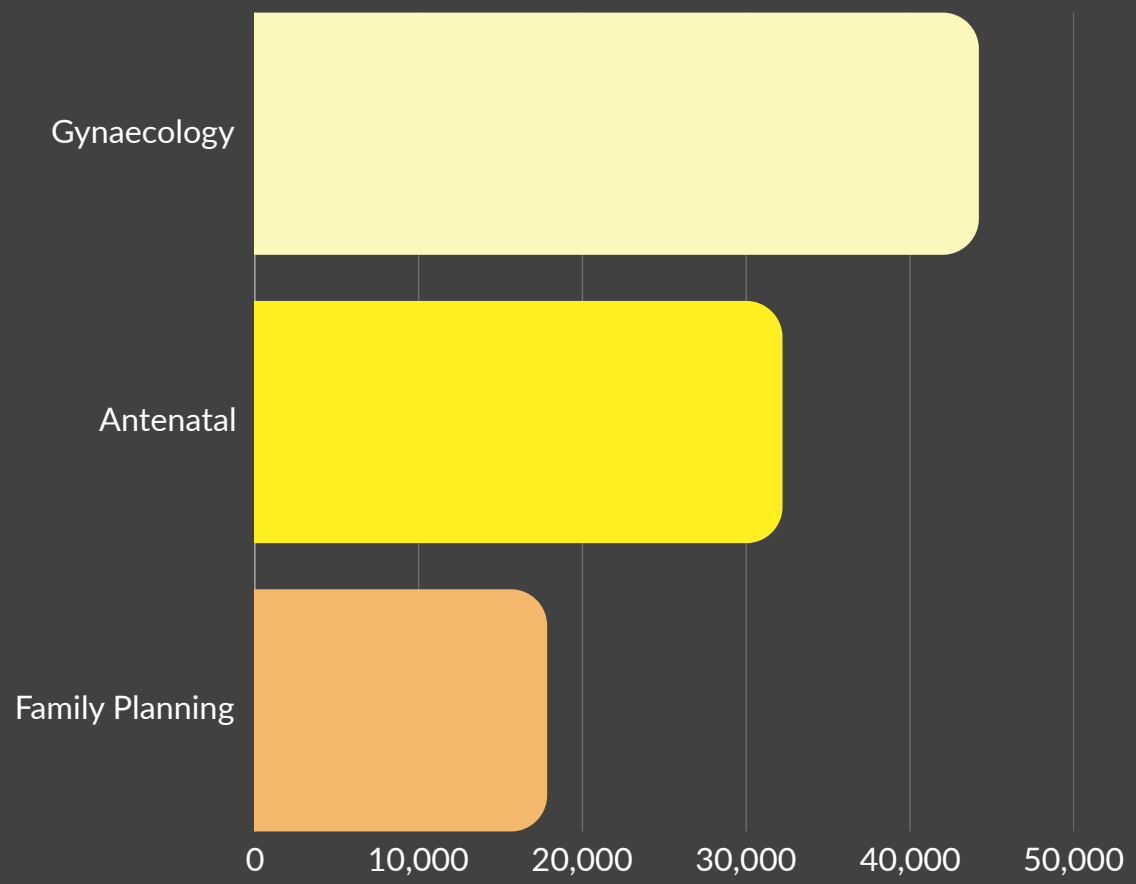
Mobile clinics functioned as a critical access mechanism for populations who would otherwise face significant delays or complete inability to reach healthcare facilities. In many communities, PMRS mobile clinics represented the only regular source of primary healthcare, particularly for women, children, older persons, and individuals with mobility limitations.

4.3 Cluster Context and System-Wide Implications

PMRS PHC service delivery during 2025 was formally captured and reported through the WHO-led Health Cluster information management system. According to Health Cluster 5Ws reporting (Power BI dashboard, 2025), PMRS reached an average of approximately 34,800 people per week through direct health service provision in Gaza.

SRHR

Gynaecological consultations, antenatal care, and family planning services accounted for the majority of SRHR service delivery, reflecting the sustained demand for essential reproductive healthcare under crisis conditions. The remaining services—including postnatal care, STI management, and midwifery counselling and education—played a critical role in ensuring continuity of care and supporting women's health across the full reproductive continuum.



Health Cluster thematic analysis indicates that PMRS-reported activity was concentrated in general clinical services, with substantial contributions to sexual and reproductive health and mental health and psychosocial support, closely mirroring cluster-wide morbidity trends and priority needs. PMRS-reported PHC consultations constituted a significant share of decentralised service delivery at a time when a large proportion of fixed health facilities across Gaza were partially or fully non-functional.

The inclusion of PMRS data within the Health Cluster reporting system provides external validation of both the scale and relevance of PMRS interventions. It demonstrates alignment with cluster-identified priorities and confirms PMRS's role as a key provider of essential primary healthcare services amid systemic health system disruption and severe access constraints.

4.4 Health Impact Analysis

The scale and morbidity profile of PHC services delivered by PMRS in 2025 underscore the role of primary healthcare as a life-saving intervention, rather than a routine service, in protracted humanitarian emergencies. By treating acute conditions early and at scale, PMRS reduced the risk of complications, secondary infections, and avoidable hospital admissions at a time when referral capacity was severely limited.

In Gaza, PHC services mitigated the public health consequences of displacement, overcrowding, and deteriorating environmental conditions, while in the West Bank, mobile clinics addressed structural inequities in access to care driven by geographic fragmentation and movement restrictions. Across both contexts, PMRS PHC interventions directly contributed to preserving health system functionality, protecting vulnerable populations, and reducing excess morbidity under conditions of sustained crisis.

5. Sexual and Reproductive Health (SRHR)

5.1 Gaza Strip: SRHR Service Delivery Across Governorates

Sexual and reproductive health services were delivered by PMRS across all five Gaza governorates—North Gaza, Gaza City, Deir al-Balah, Khan Younis, and Rafah—in a context of repeated displacement, disrupted referral pathways, and widespread damage to maternity and hospital-based services.

Throughout 2025, women and girls in Gaza faced heightened risks of maternal morbidity, untreated gynaecological conditions, interrupted family planning, and limited access to skilled birth-related care. Food insecurity, overcrowded living conditions, and the collapse of routine health services further compounded SRHR vulnerabilities, particularly among pregnant and lactating women.

Spotlight on: Women and Children Activities- Gaza Strip

During the reporting period, PMRS delivered a total of 116,349 SRHR-related services through mobile clinics, temporary medical points, and redeployed health teams. Services included:

- Antenatal care (ANC): 32,215 consultations
- Gynaecological consultations: 44,205
- Family planning services: 17,844
- Sexually transmitted infection (STI) services: 5,629
- Postnatal care (PNC): 5,275
- Midwifery counselling and SRHR health education: 11,181

Service delivery was maintained despite repeated interruptions linked to insecurity, displacement of both communities and health staff, and shortages of essential medicines and supplies. In many locations, PMRS teams were required to adapt service delivery modalities on a weekly basis in response to access constraints and population movements.

The high volume of gynaecological and antenatal consultations reflects both accumulated unmet need and the erosion of routine SRHR services elsewhere in the health system. Continuity of SRHR care provided by PMRS played a critical role in mitigating preventable complications during pregnancy and the postnatal period, particularly in settings where referral to secondary or tertiary care was delayed or impossible.

5.2 West Bank: Women's Health and SRHR Services in Area C and Marginalised Localities

In the West Bank, PMRS SRHR services were delivered primarily through mobile clinics operating in Area C and other marginalised localities, including communities across Hebron, Bethlehem, Nablus, Jenin, Tubas, Salfit, and the Jordan Valley.

Movement restrictions, checkpoint regimes, settler violence, and the absence of nearby fixed health facilities continue to limit access to SRHR services for women and girls in these areas. Mobile clinics, therefore, represent a critical access mechanism, particularly for pregnant women, older women, and those with limited mobility.

During 2025, 28,774 women and girls accessed SRHR services through PMRS mobile clinics in the West Bank. Services included antenatal and postnatal care, family planning, gynaecological consultations, and referral for higher-level care where feasible. SRHR delivery in these contexts was closely linked to broader protection concerns, including delayed care-seeking due to insecurity and fear of harassment during travel.

PMRS mobile clinics enabled earlier detection of pregnancy-related complications, supported continuity of care, and reduced the need for unsafe or delayed journeys to distant health facilities.

5.3 System-Wide Implications

Health Cluster reporting for 2025 highlights sustained demand for SRHR services across the Gaza Strip, particularly in governorates experiencing repeated displacement and high population density. The WHO Health Cluster thematic analysis indicates that SRHR remained a priority area throughout the year, with elevated needs linked to disrupted maternity services, food insecurity, and limited access to referral care.

PMRS-reported SRHR activity, as captured through the WHO Health Cluster information management system, aligns closely with these system-wide trends. The volume and geographic spread of PMRS SRHR services underscore the organisation's role in maintaining continuity of essential women's health services during periods when fixed facilities were partially or fully non-functional.

5.4 Health and Protection Impact Analysis

The scale and distribution of SRHR services delivered by PMRS in 2025 reflect both acute humanitarian need and long-standing structural barriers to care. In Gaza, SRHR interventions mitigated risks associated with disrupted maternity services, malnutrition, and delayed referrals, while in the West Bank, mobile clinics addressed geographic and political barriers that disproportionately affect women's access to healthcare.

By sustaining SRHR services across multiple governorates and hard-to-reach communities, PMRS reduced the likelihood of preventable maternal and neonatal complications and supported women's bodily autonomy and dignity under conditions of sustained crisis. The integration of SRHR into broader primary healthcare delivery further strengthened early identification of risk and continuity of care across the life course.

6. Trauma and Emergency Care

6.1 Gaza Strip: Trauma Caseloads and Emergency Interventions Across Governorates

Trauma and emergency care constituted a core life-saving component of PMRS's health response in the Gaza Strip throughout 2025. Services were delivered across North Gaza, Gaza City, Deir al-Balah, Khan Younis, and Rafah, in a context characterised by mass casualty incidents, repeated displacement, destruction of civilian infrastructure, and severe restrictions on ambulance movement and referral pathways.

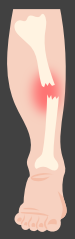
Trauma Care- Gaza

141,307 Trauma Patients Treated in Gaza

Psychosocial services were provided to 147,705 people including 39,897 children, 22,174 women and 4,393 men. Services included Psychological first aid Individual and group psychosocial sessions for affected people and prevention, Awareness and response to violence against vulnerable group.

TRAUMA SERVICES

Bleeding control & stabilisation



Fracture management

Emergency Referrals

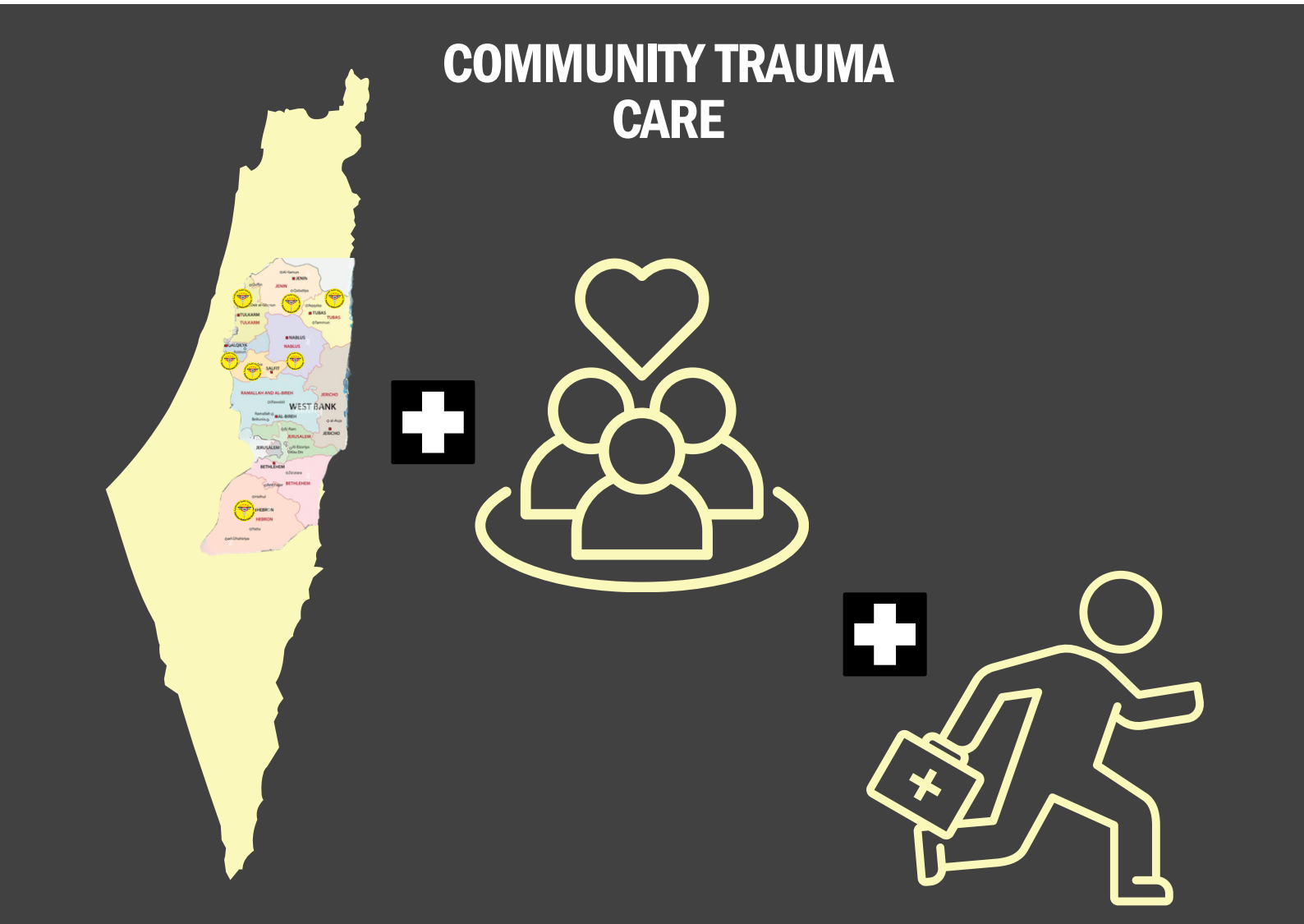
Wound management, shrapnel and blast

Burn wounds

Trauma Care- West Bank

Spotlight on 641 community volunteers trained

In a context where access to emergency care is frequently delayed or obstructed, PMRS's training of community emergency care trainees represents a critical, locally led response to protect life. These trained community members act as first responders, delivering immediate care in high-risk environments and ensuring that injured individuals are not left without assistance. This approach not only strengthens community resilience but also highlights the essential role of locally embedded health capacity in contexts of restricted access and insecurity.



During the reporting period, PMRS treated a total of 141,307 trauma patients through mobile medical teams, emergency medical points, and redeployed health facilities. Trauma care was provided in both acute emergency contexts and protracted displacement settings, often under conditions of insecurity and limited medical supplies.

Trauma interventions included:

- Emergency wound care and management of blast and shrapnel injuries
- Bleeding control and stabilisation
- Burns management
- Fracture stabilisation and musculoskeletal trauma care
- Initial emergency assessment and referral, where feasible

The geographic distribution of trauma caseloads reflected shifting frontlines, population movements, and episodic escalations in hostilities. Khan Younis, Gaza City, and Rafah experienced particularly high trauma caseloads during periods of intensified displacement and attacks, while North Gaza and Deir al-Balah saw recurrent surges linked to repeated evacuations and overcrowding of shelters.

Decentralised trauma care delivered by PMRS played a critical role in bridging gaps created by damaged or overwhelmed hospital emergency departments. In many cases, PMRS teams provided the first and only point of emergency medical care, stabilising patients who would otherwise face life-threatening delays in accessing hospital services.

6.2 West Bank: Community First Aid and Emergency Preparedness

In the West Bank, PMRS trauma and emergency response focused on community-based first aid and emergency preparedness, addressing the realities of movement restrictions, delayed ambulance access, and violence affecting civilians in marginalised areas.

Emergency and trauma support was delivered across communities in Hebron, Nablus, Jenin, Qalqilya, Salfit, Tubas, and the Jordan Valley, with particular attention to Area C localities where emergency response times are frequently prolonged.

During 2025, PMRS supported 5,340 injured individuals through community-based first aid interventions. In parallel, PMRS trained 641 community volunteers in bleeding control, basic trauma management, and emergency response, strengthening local capacity to respond during critical delays before formal medical assistance can arrive.

Community first responders played a vital role in:

Spotlight on: Emergency Response Teams- Tulkarem

- Immediate bleeding control and stabilisation
- Safe transfer coordination where ambulance access was delayed
- Reducing preventable complications arising from delayed care

This approach reflects a deliberate strategy to mitigate structural barriers to emergency care and reduce the risk of preventable injury-related morbidity and mortality.

6.3 Health System-Wide Implications

WHO Health Cluster reporting for 2025 indicates sustained and elevated trauma-related health needs across the Gaza Strip, driven by mass casualty incidents, repeated displacement, and damage to emergency and surgical services. Health Cluster analyses consistently highlighted trauma care as a priority gap, particularly in areas experiencing repeated access disruptions.

PMRS trauma activity, as captured through Health Cluster 5Ws reporting (Power BI dashboard, 2025), aligns with these system-wide trends and reflects the organisation's role as a key provider of decentralised emergency care. PMRS-reported trauma interventions contributed to maintaining emergency response capacity at the community level during periods when hospital-based services were partially or fully inaccessible.

6.4 Life-Saving Impact Analysis

The trauma caseloads managed by PMRS in 2025 underscore the central role of decentralised emergency care in reducing preventable mortality during armed conflict. In Gaza, early stabilisation and emergency interventions delivered by PMRS mitigated the consequences of delayed referrals, overwhelmed hospitals, and damaged transport infrastructure. In the West Bank, community-based first aid reduced the risk of severe complications arising from prolonged response times.

Across both contexts, PMRS trauma interventions functioned as a life-saving bridge between injury and definitive care, preserving lives under conditions where formal emergency systems were frequently compromised. The scale and geographic spread of trauma services highlight the necessity of sustained investment in decentralised emergency response and community-level preparedness.

7. Non-Communicable Diseases (NCDs)

7.1 Gaza Strip: Continuity of Care for Chronic Disease Across Governorates

Continuity of care for people living with non-communicable diseases emerged as a critical life-preserving intervention in the Gaza Strip throughout 2025. NCD services were delivered across North Gaza, Gaza City, Deir al-Balah, Khan Younis, and Rafah, in

a context marked by repeated displacement, destruction of health infrastructure, medication shortages, and disrupted referral pathways.

Individuals living with chronic conditions faced acute risks as interruptions in treatment rapidly led to decompensation, avoidable complications, and increased mortality. Access to regular follow-up, medication refills, and clinical monitoring was therefore essential to sustaining life and preventing emergency admissions.

During the reporting period, PMRS supported a total of 67,026 patients living with non-communicable diseases in Gaza. The NCD caseload included:

- Cardiovascular diseases: 29,614 patients
- Diabetes: 24,258 patients
- Musculoskeletal and rheumatologic conditions: 4,259 patients
- Endocrine disorders (non-diabetic): 2,957 patients
- Neurological conditions: 2,644 patients
- Chronic respiratory diseases: 2,140 patients
- Chronic kidney disease: 1,154 patients

NCD services were delivered through mobile clinics, temporary medical points, and integrated PHC consultations, often in parallel with treatment for acute illness. Medication continuity was prioritised despite supply constraints, with PMRS teams adapting prescribing practices in response to fluctuating availability.

Geographic patterns of NCD service delivery mirrored displacement dynamics, with particularly high caseloads recorded in Gaza City, Khan Younis, and Deir al-Balah, where large displaced populations and overcrowded shelters amplified chronic disease risk.

7.2 Clinical Implications of Interrupted NCD Care

Interruptions to NCD treatment in Gaza have immediate and severe clinical consequences. Uncontrolled hypertension and cardiovascular disease increase the risk of stroke and acute cardiac events; untreated diabetes leads to hyperglycaemic crises and accelerated complications; and unmanaged chronic respiratory disease heightens vulnerability to respiratory infections in overcrowded environments.

By maintaining continuity of NCD care at scale, PMRS mitigated these risks and reduced the burden on emergency and inpatient services at a time when hospital capacity was critically constrained. NCD consultations frequently intersected with

nutrition and mental health needs, underscoring the compounding nature of chronic disease in protracted emergencies.

7.3 Cluster Context and System-Wide Implications

WHO Health Cluster reporting for 2025 consistently identified continuity of NCD care as a critical gap in Gaza, particularly amid medication shortages, facility damage, and displacement-driven service interruptions. Health Cluster analyses highlighted elevated risks of excess mortality among people living with chronic illness when routine services were disrupted.

PMRS-reported NCD activity, as captured through the WHO Health Cluster information management system, aligns with these system-wide concerns. The volume and geographic spread of PMRS NCD consultations demonstrate the organisation's role in sustaining life-preserving chronic disease care under conditions of severe system stress.

7.4 Health Impact Analysis

The scale of NCD services delivered by PMRS in 2025 underscores the centrality of chronic disease management in humanitarian health responses. In Gaza, NCD care functioned not as a secondary service, but as a core life-saving intervention, preventing avoidable deterioration and deaths among a population already exposed to extreme stressors.

By sustaining continuity of care across multiple governorates, PMRS reduced the risk of acute decompensation, preserved functional health, and mitigated cascading impacts on emergency and inpatient services. These interventions contributed to stabilising health outcomes for individuals living with chronic illness under conditions where interruption of care would have had rapid and irreversible consequences.

8. Nutrition and MUAC Screening

8.1 Gaza Strip: Nutrition Screening and Detection of Acute Malnutrition Across Governorates

Nutrition screening emerged as a critical public health intervention in the Gaza Strip throughout 2025, as prolonged access restrictions, disruption of food systems, and widespread displacement drove escalating levels of food insecurity and malnutrition. PMRS nutrition services were delivered across North Gaza, Gaza City, Deir al-Balah, Khan Younis, and Rafah, with a focus on early detection of acute malnutrition among children and vulnerable adults.

During the reporting period, PMRS conducted 49,432 nutrition screenings using Mid-Upper Arm Circumference (MUAC) measurements, integrated into primary healthcare, maternal and child health, and outreach services. Screening activities

targeted children under five, as well as pregnant and lactating women, populations at the highest risk of adverse health outcomes linked to undernutrition.

Monthly screening data demonstrate a progressive deterioration in nutritional status over the course of the year, corresponding with deepening food insecurity, repeated displacement, and reduced access to diverse and adequate diets. Peak rates of acute malnutrition reached 12.9% in August 2025, representing a significant public health alarm and indicating elevated risk of morbidity and mortality, particularly among young children.

Geographic variation in malnutrition detection reflected patterns of displacement and access constraints, with particularly high screening volumes and detection rates in Gaza City, Khan Younis, and Rafah, where large numbers of internally displaced persons were concentrated in overcrowded shelters with limited food availability.

8.2 Linkages Between Malnutrition and Disease Burden

Malnutrition in Gaza during 2025 did not occur in isolation but intersected directly with the disease burden observed across PMRS primary healthcare services. Undernutrition increased susceptibility to acute respiratory infections, diarrhoeal disease, and skin infections, conditions that were among the most frequently treated through PMRS PHC consultations.

For children and pregnant women, even moderate levels of acute malnutrition significantly heightened the risk of complications, delayed recovery from illness, and long-term developmental harm. In adults living with chronic diseases, food insecurity and inadequate nutrition exacerbated disease progression and undermined treatment effectiveness.

By integrating MUAC screening into routine healthcare delivery, PMRS enabled early identification of nutritional risk, timely referral where feasible, and prioritisation of follow-up care for individuals most at risk of deterioration.

8.3 Health System-Wide Implications

WHO Health Cluster and inter-agency analyses throughout 2025 consistently highlighted escalating nutrition risks across the Gaza Strip, driven by disruption of food supply chains, loss of livelihoods, and access constraints. Health Cluster reporting underscored the convergence of malnutrition with communicable disease outbreaks and chronic illness as a key driver of excess morbidity.

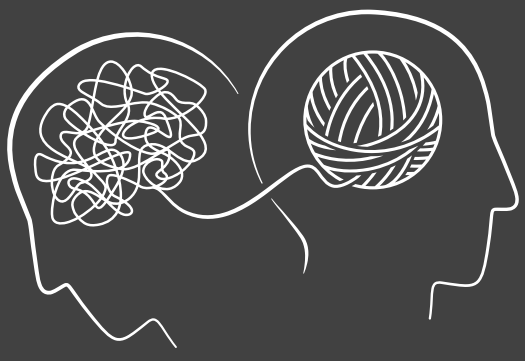
PMRS nutrition screening activity, as reported through the WHO Health Cluster information management system, aligns with these system-wide findings. The scale and timing of malnutrition detection by PMRS mirror broader humanitarian assessments, indicating worsening food security conditions during mid-2025.

Mental Health Conditions

Over 80,000 MHPSS consults across Palestine

Mental health and psychosocial support (MHPSS) services were a critical component of PMRS's response in 2025, addressing the widespread psychological distress associated with displacement, insecurity, and prolonged exposure to violence. Through individual counselling, psychological first aid, and community-based support, PMRS delivered services to tens of thousands of individuals across Gaza and the West Bank. The scale and nature of needs reflected high levels of trauma, anxiety, and emotional distress, often compounded by loss, instability, and limited access to specialised care. In this context, MHPSS services played a vital role not only in alleviating immediate psychological suffering, but also in supporting coping mechanisms, functional recovery, and overall well-being in communities facing sustained crisis conditions.

MHPPS SERVICES
PSYCHOLOGICAL FIRST AID
COUNSELLING FAMILY AND GROUPS
ONE ON ONE COUNSELLING
YOUTH AND CHILD FRIENDLY MHPSS
REFERRALS AND SPECIALISED CARE FOR COMPLEX CASES



8.4 Public Health Impact Analysis

The findings from PMRS nutrition screening activities in 2025 point to a rapidly deteriorating nutritional environment with significant implications for population health. Detection of acute malnutrition at scale enabled earlier identification of at-risk individuals at a time when referral pathways and specialised nutrition services were severely constrained.

By embedding nutrition screening within primary healthcare and outreach services, PMRS mitigated the risk of undetected deterioration among vulnerable populations and contributed to preventing more severe forms of malnutrition and associated mortality. The convergence of malnutrition, infectious disease, and chronic illness underscores the necessity of sustained investment in integrated health and nutrition interventions under protracted crisis conditions.

9. Mental Health and Psychosocial Support (MHPSS)

9.1 Gaza Strip: MHPSS Service Delivery Across Governorates

Mental health and psychosocial support needs intensified across the Gaza Strip throughout 2025 as a result of prolonged exposure to violence, repeated displacement, bereavement, destruction of homes, and severe deprivation. PMRS delivered MHPSS services across North Gaza, Gaza City, Deir al-Balah, Khan Younis, and Rafah, integrating psychosocial care into primary healthcare, trauma response, and community-based service delivery.

During 2025, PMRS delivered a total of 63,842 MHPSS consultations in Gaza. These consultations addressed acute stress reactions, anxiety, depression, trauma-related symptoms, grief, and psychosocial distress linked to displacement and loss. Services were provided through mobile clinics, temporary medical points, and integrated health teams operating under severe access and security constraints.

MHPSS delivery in Gaza prioritised direct, clinical and psychosocial consultations, reflecting the acute nature of needs and the limited availability of specialised mental health services. The majority of MHPSS interventions consisted of psychological first aid and counselling, delivered either as stand-alone consultations or embedded within other health services.

9.2 West Bank: Psychosocial Support Services in Area C and Marginalised Communities

In the West Bank, PMRS delivered MHPSS services primarily through mobile clinics and community-based health interventions operating in Hebron, Bethlehem, Nablus, Jenin, Tubas, Salfit, Qalqilya, and the Jordan Valley.

Communities in these areas experience chronic psychosocial stressors linked to movement restrictions, settler violence, home demolitions, and prolonged uncertainty. These conditions contribute to sustained levels of anxiety, depression, and trauma-related symptoms, often compounded by barriers to accessing specialised mental health care.

During 2025, PMRS delivered 10,350 MHPSS consultations in the West Bank, focusing on early identification of psychosocial distress, basic counselling, integration of mental health support into routine health services, and referral to specialised care where feasible. Mobile delivery modalities were essential in mitigating access barriers and enabling continuity of psychosocial care.

9.3 Composition of MHPSS Services

Based on PMRS and Health Cluster MHPSS indicator categories, PMRS MHPSS consultations in 2025 primarily comprised:

- Psychological First Aid (PFA) delivered within health emergency and trauma-related services
- Basic counselling provided to individuals, families, and groups
- Structured psychological counselling using evidence-informed approaches
- MHPSS services for adolescents and children, including age-appropriate psychosocial support
- Specialised mental health care referrals where higher-level services were accessible

In addition to consultations, PMRS MHPSS programming incorporated awareness-raising activities aimed at reducing stigma and promoting psychosocial well-being, as well as targeted capacity-building for health workers and community volunteers. These activities complemented, but did not replace, PMRS's focus on direct service provision.

9.4 Health and Protection Impact Analysis

The scale and nature of MHPSS services delivered by PMRS in 2025 highlight the role of mental health care as a core health and protection intervention, rather than an ancillary service. In Gaza, integrated MHPSS mitigated acute psychological distress, supported coping mechanisms, and reduced the risk of longer-term mental health deterioration under conditions of sustained trauma and deprivation. In the West Bank, psychosocial support addressed chronic stressors associated with violence, insecurity, and restricted mobility.

Spotlight on: Emergency Injury Point-Gaza Strip

REHABILITATION

REHABILITATION SERVICES OPT

Our integrated approach to care enabled earlier initiation of functional recovery following injury, reducing the risk of long-term disability in a context where access to specialised services is limited. By combining rehabilitation with emergency and psychosocial support, PMRS improved pain management, restored mobility, and supported patients in regaining functional independence. It also strengthened referral pathways between emergency, rehabilitative, and mental health services, ensuring more coordinated and continuous care for individuals affected by injury and trauma.

By prioritising direct consultations and embedding MHPSS within health services, PMRS reduced stigma, improved access to care, and strengthened early identification of individuals at risk of severe mental health outcomes. These interventions contributed to preserving functional capacity, supporting recovery, and reinforcing community resilience across both acute and protracted crisis settings.

10. Rehabilitation Services

10.1 Gaza Strip: Rehabilitation Services Across Governorates

Rehabilitation services formed a critical component of PMRS's health response in the Gaza Strip throughout 2025, addressing the long-term consequences of injury, trauma, and chronic illness in a context of mass casualties, repeated displacement, and severe disruption to hospital-based rehabilitative care. PMRS delivered rehabilitation services across North Gaza, Gaza City, Deir al-Balah, Khan Younis, and Rafah, primarily through mobile and decentralised service delivery modalities.

During the reporting period, PMRS provided 18,742 rehabilitation consultations in Gaza. Services focused on restoring functional capacity, preventing secondary complications, and supporting recovery for individuals whose access to specialised rehabilitation facilities was limited or entirely unavailable.

The rehabilitation caseload included individuals with:

- Musculoskeletal injuries, including fractures, soft tissue injuries, and mobility impairments
- Neurological conditions, including post-traumatic neurological deficits and stroke-related impairments
- Burn injuries, requiring ongoing functional management
- Amputations and severe limb injuries, often linked to blast trauma
- Chronic pain and functional limitations associated with prolonged injury and delayed care

Rehabilitation services were frequently delivered alongside trauma, primary healthcare, and mental health interventions, reflecting the complex and multi-dimensional needs of patients recovering from injury in emergency settings. Geographic concentrations of rehabilitation needs were observed in Gaza City, Khan Younis, and Rafah, corresponding with areas that experienced high levels of displacement and injury.

Spotlight on: Trauma and Rehabilitation Care-Gaza Strip

10.2 West Bank: Rehabilitation and Disability Support in Area C and Marginalised Communities

In the West Bank, PMRS delivered rehabilitation services primarily through mobile clinics and community-based health interventions operating in Hebron, Bethlehem, Nablus, Jenin, Tubas, Salfit, Qalqilya, and the Jordan Valley.

Movement restrictions, limited availability of specialised rehabilitation services, and delayed referral pathways pose significant barriers to recovery for individuals living with injury or disability in these areas. PMRS rehabilitation interventions focused on functional assessment, basic physiotherapy, pain management, and referral to specialised services where feasible.

During 2025, PMRS delivered 6,214 rehabilitation consultations in the West Bank. Services were particularly important for individuals with mobility impairments, older persons, and those recovering from injury who would otherwise face prolonged disability due to delayed or interrupted care.

10.3 Integration with Trauma, MHPSS, and Chronic Care

Rehabilitation services delivered by PMRS were closely integrated with trauma care, mental health and psychosocial support, and chronic disease management. Many patients receiving rehabilitation support also presented with psychological distress, chronic pain, or co-morbid conditions requiring coordinated care.

This integrated approach enabled:

- Earlier initiation of functional recovery following injury
- Reduction in long-term disability risk
- Improved pain management and mobility
- Strengthened referral pathways between emergency, rehabilitative, and psychosocial services

Integration was particularly critical in Gaza, where delayed access to specialised surgical and rehabilitative care increased the risk of permanent impairment.

10.4 Health Impact Analysis

The rehabilitation services delivered by PMRS in 2025 played a vital role in mitigating the long-term health and socioeconomic consequences of injury and disability. In Gaza, decentralised rehabilitation enabled individuals to regain functional capacity in a context where hospital-based rehabilitation services were severely constrained or destroyed. In

the West Bank, mobile rehabilitation services addressed structural barriers to care faced by populations living under movement restrictions and geographic fragmentation.

By prioritising functional recovery and disability prevention, PMRS rehabilitation interventions contributed to preserving independence, reducing caregiver burden, and supporting dignity and quality of life for individuals affected by injury and chronic impairment. These services represent an essential, yet often under-resourced, component of humanitarian health responses in protracted crisis settings.

11. Health Education, Disease Surveillance, and Prevention

11.1 Gaza Strip: Disease Surveillance and Outbreak Prevention Across Governorates

Preventive health interventions and disease surveillance were central to PMRS's response in the Gaza Strip throughout 2025, operating as life-saving measures in a context of extreme overcrowding, unsafe water, disrupted sanitation systems, and repeated mass displacement. PMRS implemented surveillance and prevention activities across North Gaza, Gaza City, Deir al-Balah, Khan Younis, and Rafah, integrating these functions within primary healthcare, nutrition, and outreach services.

PMRS health teams systematically monitored trends in acute respiratory infections, diarrhoeal disease, gastroenteritis, skin infections, parasitic infections, varicella, and acute hepatitis—conditions with a high potential for rapid transmission and escalation to severe illness in displaced populations. Surveillance data were reviewed continuously and used to guide clinical prioritisation, outreach targeting, and health education messaging.

This surveillance-informed approach enabled early identification of rising caseloads, allowing PMRS to intervene before isolated increases evolved into large-scale outbreaks. In a setting where hospital surge capacity was severely limited, preventing escalation from mild or moderate illness to severe disease was critical to reducing avoidable morbidity and mortality.

11.2 Prevention as a Mortality-Reduction Strategy in Gaza

In Gaza's collapsed health system context, the distinction between prevention and treatment became blurred: preventive action directly reduced deaths. Early detection and management of diarrhoeal disease, respiratory infections, and skin conditions prevented progression to dehydration, pneumonia, sepsis, and other life-threatening complications—particularly among children under five, pregnant women, older persons, and individuals with chronic disease.

By integrating disease surveillance with:

- Early clinical management
- Targeted health education
- Nutrition screening and referral
- Prompt follow-up of high-risk cases

PMRS reduced the likelihood that common, preventable illnesses would progress to severe disease requiring hospitalisation. This was especially significant at a time when referral pathways were disrupted, transport was restricted, and hospital functionality was inconsistent.

While precise counterfactual mortality figures cannot be calculated, the scale of acute illness treated early through PMRS primary healthcare—combined with surveillance-driven prevention—represents a substantial reduction in the number of cases likely to have deteriorated into life-threatening conditions.

11.3 West Bank: Preventive Health and Surveillance in Area C and Marginalised Communities

In the West Bank, PMRS implemented preventive health and disease surveillance activities primarily through mobile clinics and community-based outreach in Hebron, Bethlehem, Nablus, Jenin, Tubas, Salfit, Qalqilya, and the Jordan Valley.

Communities in these areas face chronic exposure to environmental health risks, delayed access to care due to movement restrictions, and limited public health infrastructure. PMRS surveillance focused on identifying recurring patterns of preventable illness linked to delayed care-seeking, poor living conditions, and interrupted chronic disease management.

Preventive interventions in the West Bank reduced morbidity by:

- Promoting earlier presentation for care, before complications develop
- Reducing avoidable exacerbations of chronic illness
- Preventing escalation of minor infections into conditions requiring hospital referral

In contexts where access delays can turn minor illness into severe disease, prevention functioned as a critical risk-reduction strategy.

11.4 Health Education as a Preventive and Protective Intervention

Health education was delivered by PMRS as a clinical prevention tool, not merely an awareness activity. Education was tailored to the immediate risks faced by communities and delivered primarily during consultations and outreach encounters.

Key focus areas included:

- Prevention of diarrhoeal and respiratory disease in overcrowded settings
- Hygiene practices adapted to severe water scarcity
- Recognition of danger signs in childhood illness and pregnancy
- Nutrition awareness and infant and young child feeding practices
- Self-management of chronic disease when access to routine care was disrupted

These interventions directly supported earlier care-seeking and reduced delays that are strongly associated with increased morbidity and mortality in humanitarian emergencies.

11.5 Surveillance-Informed Programming and Risk Mitigation

Disease surveillance data collected by PMRS informed real-time adaptation of service delivery throughout 2025. Identified trends were used to:

- Reposition mobile clinics toward emerging disease hotspots
- Intensify outreach and follow-up among displaced populations
- Integrate nutrition and MHPSS support in areas of compounded risk
- Support coordination with local health authorities and humanitarian partners

In Gaza, this adaptive approach reduced the likelihood of uncontrolled disease transmission in a severely compromised public health environment. In the West Bank, it mitigated the health impacts of delayed access and environmental exposure.

11.6 Public Health Impact Analysis

Preventive health and surveillance activities delivered by PMRS in 2025 played a decisive role in reducing avoidable morbidity and mortality across both Gaza and the West Bank. By identifying risks early, treating illness promptly, and addressing upstream determinants of disease, PMRS prevented thousands of cases from escalating into severe or life-threatening conditions.

In contexts where hospital care was limited, prevention functioned as a life-saving substitute for unavailable tertiary services. PMRS's integrated approach—linking surveillance, prevention, and early treatment—protected population health, preserved health system capacity, and reduced excess mortality under conditions of sustained crisis.

12. Digital Health and Systems Strengthening

12.1 Strengthening Health System Continuity Through Digital Solutions

Digital health interventions formed a critical component of PMRS's approach to sustaining health service delivery and system functionality throughout 2025. In a context of widespread infrastructure damage, movement restrictions, disrupted referral pathways, and fragmented health information flows, digital tools enabled PMRS to preserve continuity of care, strengthen coordination, and support evidence-informed decision-making across both the Gaza Strip and the West Bank.

PMRS's digital health approach prioritised practical, context-appropriate solutions designed to function under conditions of instability, intermittent connectivity, and constrained resources. Digital tools were embedded within routine service delivery rather than treated as parallel or standalone initiatives.

In the West Bank, access to healthcare in 2025 was significantly constrained by an expansion in physical movement barriers. According to monitoring by the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), there were at least 849 movement obstacles across the West Bank, including checkpoints, roadblocks, earth mounds, and gates, restricting Palestinian movement between communities and access to essential services. Other monitoring sources documented the total number of checkpoints, iron gates, and military barriers at approximately 898 by early 2025, reflecting a substantial increase compared to previous years and indicating a continued expansion of access-restricted areas. These barriers fragmented the territory into isolated enclaves, forcing prolonged detours, delays at checkpoints, and, in many cases, preventing timely access to health facilities for both routine and emergency care. The impact was most acute for pregnant women, children, older persons, people with disabilities, and individuals with chronic illness, for whom delayed or interrupted access to care is directly associated with increased morbidity and risk of complications. Within this context, PMRS's mobile service delivery, telemedicine, and digital health systems were critical to mitigating access barriers and maintaining continuity of care for communities otherwise excluded from regular healthcare provision.

Source: United Nations Office for the Coordination of Humanitarian Affairs (OCHA), West Bank movement and access monitoring, 2025.

12.2 Gaza Strip: Data-Driven Service Delivery Under System Collapse

In the Gaza Strip, where fixed health facilities were repeatedly damaged or rendered non-functional, digital health systems enabled PMRS to maintain operational oversight and continuity of care across North Gaza, Gaza City, Deir al-Balah, Khan Younis, and Rafah.

Digital data collection supported:

- Real-time tracking of service delivery across mobile clinics and temporary medical points
- Monitoring of morbidity trends, including communicable diseases, trauma, NCDs, and MHPSS needs
- Rapid adaptation of service delivery locations in response to displacement and access constraints
- Timely reporting to the WHO Health Cluster, ensuring PMRS activity was visible within coordinated humanitarian response mechanisms

These systems enabled PMRS to sustain high-volume service delivery despite repeated disruptions to physical infrastructure and shifting population movements.

12.3 West Bank: Telemedicine and Digital Health Integration

In the West Bank, PMRS leveraged digital health tools to address chronic access barriers and strengthen continuity of care in Hebron, Jenin, Nablus, Bethlehem, and surrounding marginalised communities, particularly in Area C.

Telemedicine services were used to:

- Provide remote specialist consultations for patients unable to travel safely or legally
- Support clinical decision-making by frontline health workers
- Reduce delays in diagnosis and treatment
- Minimise the need for unsafe or prolonged travel to referral facilities

Telemedicine complemented mobile clinic delivery, extending the reach of PMRS healthcare provision and improving access to specialised care for populations living under severe movement constraints.

12.4 Data Management, Protection, and Accountability

PMRS digital health systems were designed to uphold principles of data protection, confidentiality, and ethical information management, even under emergency conditions. Patient data were collected and managed in line with organisational protocols and humanitarian standards, ensuring respect for privacy and safeguarding sensitive information.

Digital reporting strengthened:

- Internal accountability and service quality assurance
- Evidence-based programme adaptation
- Transparency in reporting to donors and coordination mechanisms

Integration with Health Cluster reporting frameworks further reinforced PMRS's role as a reliable and accountable health actor within the wider humanitarian response.

12.5 Systems Strengthening and Local Leadership

Beyond immediate service delivery, PMRS's digital health interventions contributed to longer-term health system resilience. By strengthening data literacy, reporting capacity, and digital workflows among Palestinian health professionals, PMRS invested in locally led systems capable of adapting to prolonged crisis conditions.

Digital tools supported:

- Preservation of institutional memory despite staff displacement
- Continuity of service records under repeated disruption
- Strengthening of Palestinian-led coordination and planning

This approach reflects PMRS's commitment to reinforcing local health system sovereignty, ensuring emergency interventions contribute to sustainable capacity rather than temporary workarounds.

12.6 Systems-Level Impact Analysis

Digital health and systems strengthening interventions enabled PMRS to sustain essential health service delivery under conditions of severe system stress. In Gaza, digital tools functioned as an operational backbone, supporting adaptive response amid infrastructure collapse. In the West Bank, telemedicine and digital integration reduced access barriers and mitigated the health consequences of movement restrictions.

By embedding digital solutions within locally led health services, PMRS strengthened resilience, improved accountability, and preserved health system functionality in both acute and protracted crisis settings. These interventions contributed not only to immediate health outcomes but also to the long-term capacity of Palestinian health systems to withstand ongoing instability.

13. Coordination, Partnerships, and Accountability

13.1 Health Cluster Coordination and Strategic Alignment

Throughout 2025, PMRS operated as an active and consistently reporting member of the WHO-led Health Cluster in the occupied Palestinian territory. PMRS aligned its service delivery with cluster-identified priorities, geographic gaps, and evolving needs, ensuring that interventions complemented rather than duplicated the efforts of other humanitarian actors.

PMRS regularly contributed data to Health Cluster information management systems, including the 5Ws reporting framework, enabling visibility of service coverage, identification of unmet needs, and evidence-informed coordination across partners. This continuous reporting reinforced PMRS’s role as a reliable implementing partner and supported collective efforts to maximise coverage and efficiency under severe access and resource constraints.

In Gaza, PMRS coordination with the Health Cluster was particularly critical during periods of mass displacement and episodic escalations, when rapid adaptation of service delivery locations was required. In the West Bank, cluster engagement supported prioritisation of mobile clinic deployment to access-restricted and underserved communities.

13.2 Partnerships with Local Institutions and Communities

PMRS's operational model is grounded in local leadership and community-based partnerships, enabling sustained service delivery under conditions where international access is often constrained. Throughout 2025, PMRS worked in close coordination with local health authorities, community leaders, and grassroots organisations to ensure that services were responsive to local needs and contextually appropriate.

Community engagement informed:

- Selection of service delivery locations
- Identification of vulnerable households and individuals
- Adaptation of outreach and health education activities
- Feedback on service quality and accessibility

These partnerships strengthened trust, facilitated access to hard-to-reach populations, and supported continuity of care amid ongoing instability.

13.3 Inter-Agency Collaboration and Referral Pathways

PMRS maintained referral relationships with hospitals, specialised service providers, and other humanitarian organisations where referral pathways were accessible. Coordination focused on maximising the use of limited secondary and tertiary care capacity, particularly for trauma, high-risk pregnancies, severe malnutrition, and complex chronic conditions.

Where formal referral pathways were disrupted, PMRS worked with partners to identify alternative mechanisms for follow-up care and to prioritise cases at highest risk. This collaborative approach helped mitigate the health impacts of fragmented service availability.

13.4 Accountability to Affected Populations

Accountability to affected populations was a core principle underpinning PMRS's work in 2025. PMRS implemented mechanisms to ensure that services were delivered in a manner that was respectful, responsive, and aligned with community needs.

Accountability measures included:

- Direct feedback gathered during service delivery
- Engagement with community representatives and leaders
- Adaptation of services based on reported access barriers and needs
- Clear communication with patients regarding available services and referral options

These mechanisms supported the continuous improvement of service quality and reinforced community trust in PMRS as a locally rooted health provider.

13.5 Accountability to Donors and Coordination Mechanisms

PMRS maintained accountability to donors and coordination bodies through regular reporting, transparent data sharing, and participation in coordination fora. Digital reporting systems supported the timely and accurate submission of service delivery data, while internal review processes ensured consistency and quality of information.

Through sustained engagement with the Health Cluster and other coordination mechanisms, PMRS demonstrated compliance with humanitarian standards, strengthened collective accountability, and contributed to system-wide analysis and planning.

13.6 Coordination and Accountability Impact Analysis

Effective coordination and accountability mechanisms were essential to sustaining PMRS's health response in 2025. By aligning with Health Cluster priorities, partnering with local institutions, and maintaining transparent reporting and feedback systems, PMRS maximised the reach and relevance of its interventions under extreme constraints.

These coordination efforts reduced duplication, enhanced coverage of underserved areas, and strengthened trust among communities and partners. In a context of protracted crisis and constrained access, PMRS's coordinated and accountable approach contributed to preserving health system functionality and improving health outcomes for vulnerable populations.

14. Key Challenges and Constraints

Healthcare delivery across the occupied Palestinian territory in 2025 took place in an environment where the protection of healthcare, health workers, and medical infrastructure was increasingly eroded, and where humanitarian operations were shaped not only by access constraints and system collapse, but also by direct interference with medical services. Under the Geneva Conventions and their Additional Protocols, medical personnel, ambulances, and medical facilities are afforded special protected status, and all parties to a conflict are obligated to respect and protect medical services at all times. However, the challenges documented in this section—including attacks on health infrastructure, obstruction and delay of emergency medical access, arbitrary detention and degrading treatment of health workers, forced displacement, and denial of care to wounded civilians—reflect systematic breaches of these obligations across both Gaza and the West Bank. Several documented incidents reach the threshold of grave breaches, including direct attacks on medical transport, wilful endangerment of protected medical personnel, and deliberate prevention of life-saving medical assistance.

Within this environment, the role of local Palestinian medical organisations is not only humanitarian, but also protective and evidentiary. In many affected communities—particularly in Gaza under conditions of mass displacement and infrastructure destruction, and in the West Bank in refugee camps, rural villages, and Area C locations—local organisations such as the Palestinian Medical Relief Society (PMRS) constitute the only consistent medical presence. These communities are frequently cut off from mainstream health services due to evacuation orders, closures, checkpoints, militarised zones, or active violence. Without locally embedded medical teams, injured civilians would often receive no care at all, and many violations affecting civilians and protected medical personnel would occur without witnesses or documentation.

Local medical crews continue to operate despite extreme risk precisely because their proximity, community trust, and geographic reach allow them to respond when external or international actors cannot. Their presence ensures not only the provision of emergency, primary, and preventive healthcare, but also the documentation of violations contributing to accountability efforts and international awareness. The challenges outlined in this section therefore reflect not only operational and logistical constraints, but also the systematic erosion of medical neutrality, and underscore the indispensable role of locally led health organisations in sustaining life, dignity, and truth in contexts of protracted crisis, occupation, and fragmentation.

14.1 Gaza Strip: System-Wide Challenges Affecting Healthcare and Humanitarian Response

Healthcare delivery in the Gaza Strip throughout 2025 took place amid a near-total health system collapse. Repeated attacks on civilian infrastructure, mass displacement, and prolonged restrictions on movement and supplies created an operating environment in which routine healthcare delivery was continuously disrupted.

Key system-wide challenges included:

- Destruction and damage of health facilities, resulting in reduced functionality of hospitals, clinics, laboratories, and maternity services

- Severe overcrowding in shelters and informal displacement sites, increasing disease transmission and complicating service delivery

- Disrupted referral pathways, with inconsistent ambulance movement and limited access to secondary and tertiary care

- Critical shortages of medicines, medical supplies, and fuel, affecting continuity and quality of care

- Health workforce strain, including staff displacement, insecurity, and cumulative psychological stress

- Environmental health degradation, including unsafe water, inadequate sanitation, and limited waste management

Towards the end of October 2025, three PMRS-supported clinics in Gaza were damaged or destroyed, further constraining service availability at a critical stage of the response. The loss of these facilities reduced fixed-site service capacity, required the rapid redeployment of health teams, and increased reliance on mobile and temporary service delivery modalities. This incident underscores the ongoing vulnerability of health infrastructure and the operational risks faced by local health providers delivering care under conditions of active hostilities.

Ongoing forced evacuation notices and repeated re-designation of “safe” and “unsafe” areas throughout 2025 further compounded these challenges. As evacuation orders expanded and the geographic space available for civilian presence progressively shrank, humanitarian and health actors faced increasing competition for limited physical space in which to operate. For PMRS teams, this translated into growing difficulty in identifying viable locations to re-establish fixed or semi-fixed service points that met minimum requirements for safety, accessibility, and patient privacy.

The concentration of displaced populations into increasingly confined areas placed additional pressure on already overstretched services and infrastructure. Health teams were required to relocate repeatedly, often with little notice, disrupting continuity of care and necessitating constant reassessment of service locations. The shrinking humanitarian space also limited options for co-location with other services and reduced the feasibility of maintaining stable referral points, significantly increasing the logistical, operational, and psychological burden on health teams while elevating health risks for affected populations.

14.2 West Bank: Structural Barriers and Direct Violations Affecting Healthcare Delivery

ATTACKS ON HEALTHCARE

Unfortunately, attacks on healthcare continued throughout 2025, across Gaza and the West Bank. Towards the end of 2025, 3 PMRS clinics in Gaza were damaged due to bombardments. In the West Bank, direct attacks on facilities and staff continued.

Across these incidents, **all four core humanitarian principles—humanity, neutrality, impartiality, and independence—were repeatedly undermined.** Several incidents meet the threshold of grave breaches of IHL, including direct attacks on ambulances and deliberate obstruction of life-saving care.

Between 8 April 2025 and 30 January 2026, there were **22 Distinct Attacks on PMRS staff and services in the West Bank.**

Type	No.
Live Ammunition	6
Arbitrary Detention	5
Obstruction and Access Denial	12
Direct Attacks on Facilities	2
Physical Assault	7
Tear Gas Attacls	10

14.2.1 Structural Barriers to Healthcare and Humanitarian Access

In the West Bank, healthcare and humanitarian operations in 2025 were shaped by entrenched structural barriers linked to territorial fragmentation, movement restrictions, and insecurity. Communities in Area C, seam zones, and access-restricted localities faced persistent obstacles to reaching health facilities and humanitarian services.

Key challenges included:

- Extensive movement restrictions, including checkpoints, gates, and road closures, resulting in delayed or foregone care
- Fragmentation of territory, isolating communities and limiting continuity of service provision
- Exposure to violence and insecurity, affecting both communities and health workers
- Limited availability of fixed health facilities in rural and marginalised areas
- Administrative and access barriers affecting humanitarian operations and referral pathways

These constraints disproportionately affected women, children, older persons, people with disabilities, and individuals requiring regular follow-up for chronic conditions, increasing the risk of preventable complications and deterioration.

14.2.2 Violations Against PMRS Medical Crews and Services (West Bank)

Overview and Context

Between 8 April 2025 and 30 January 2026, Palestinian medical crews—particularly those affiliated with the Palestinian Medical Relief Society (PMRS)—were subjected to systematic, repeated, and escalating violations across the West Bank, including Nablus, Hebron Governorate (Al-Fawwar Camp, Masafer Yatta), Ramallah Governorate, Salfit, and Jericho.

These violations occurred in the context of military incursions, settler violence, home demolitions, forced displacement, and the militarisation of civilian areas. They directly interfered with the ability of medical personnel to provide life-saving, impartial healthcare, demonstrating a pattern of conduct rather than isolated incidents.

Nature and Patterns of Violations

1. Direct Attacks on Medical Personnel and Transport
Medical crews were repeatedly fired upon with live ammunition, including:

- Targeting of ambulances transporting injured civilians
- Live fire directed at senior medical leadership, including the PMRS Director in Nablus
- Shooting at paramedics during active duty and rescue operations

2. Obstruction and Delay of Medical Access
Medical teams were:

- Prevented from entering affected areas declared military zones
- Delayed for prolonged periods at checkpoints and roadblocks
- Subjected to searches, confiscation of protective equipment, and tampering with medical supplies

In one documented case, ambulance access was delayed 47 minutes, a period sufficient to result in preventable death or permanent disability.

3. Physical Assault, Arbitrary Detention, and Degrading Treatment
Medical personnel were beaten, threatened, arbitrarily detained, stripped, bound, filmed, and verbally abused while on duty, including the detention of a uniformed female paramedic for eight hours. These actions amount to inhuman and degrading treatment of protected medical personnel.

4. Exposure to Tear Gas and Militarised Environments
Medical crews were repeatedly exposed to tear gas fired directly at them while treating civilians, resulting in mass suffocation incidents and cumulative physical and psychological harm.

5. Attacks on Medical Facilities
Medical centres were vandalised, broken into, surrounded, or rendered unsafe, further undermining continuity of care and staff safety.

Incident Typology, Geographic Reach, and Quantified Impact

Between 8 April 2025 and 30 January 2026:

- 22 distinct violations against Palestinian medical personnel and services were documented

Breakdown by type (non-exclusive):

- 6 incidents involving live ammunition
- 5 incidents of arbitrary detention
- 12 incidents of obstruction or denial of medical access
- 7 incidents of physical assault
- 10 incidents involving tear gas exposure
- 2 incidents involving direct attacks on medical facilities

Geographic distribution:

- Nablus Governorate: 11 incidents
- Hebron Governorate: 6 incidents
- Ramallah Governorate: 3 incidents
- Salfit Governorate: 1 incident
- Jericho Governorate: 1 incident

Implications for Medical Neutrality and Health System Resilience

Across these incidents, all four core humanitarian principles—humanity, neutrality, impartiality, and independence—were repeatedly undermined. Several incidents meet the threshold of grave breaches of IHL, including direct attacks on ambulances and deliberate obstruction of life-saving care.

Beyond individual harm, these violations have resulted in:

- Chronic fear and psychological distress among medical staff
- Moral injury from being prevented from saving lives
- Burnout and emotional exhaustion
- Erosion of the perceived safety of medical work, threatening staff retention and long-term health system resilience

In many of the affected communities, local organisations such as PMRS represent the only consistent medical presence. Their role is therefore not only humanitarian but also protective and evidentiary, ensuring both care delivery and documentation of violations.

14.3 PMRS-Specific Operational Challenges

Operating within these compounded constraints, PMRS faced a set of specific operational challenges across both Gaza and the West Bank:

14.3.1 Access and Mobility Constraints

- Continual relocation of mobile clinics due to changing access conditions
- Delays affecting staff movement, supply transport, and referrals

14.3.2 Supply Chain Disruptions

- Inconsistent availability of essential medicines and consumables
- Adaptation of treatment protocols in response to shortages

14.3.3 Human Resources and Staff Protection

- Exposure to insecurity, displacement, and cumulative trauma
- Balancing staff safety with the imperative to sustain services

14.3.4 Infrastructure and Service Delivery Constraints

- Operation from temporary or non-standard facilities
- Reduced availability of spaces suitable for privacy-sensitive services

14.3.5 Data and Communication Challenges

- Intermittent connectivity affecting reporting and supervision
- Maintaining data protection and accountability under emergency conditions

14.4 Programmatic Implications and Adaptive Strategies

In response, PMRS adopted adaptive strategies including:

- Decentralised service delivery through mobile clinics and outreach
- Integrated care models (PHC, SRHR, MHPSS, nutrition, rehabilitation)
- Flexible programming to respond to displacement and access changes
- Strengthened coordination and digital reporting
- Investment in local health workforce capacity

These strategies enabled sustained, life-saving service delivery despite extreme and evolving constraints.

14.5 Impact of Constraints on Health Outcomes

The challenges faced in 2025 directly shaped health outcomes. In Gaza, system collapse and shrinking humanitarian space increased reliance on early intervention, prevention, and decentralised care to reduce excess morbidity and mortality. In the West Bank, structural barriers and direct violations prolonged delays in care and increased the burden of untreated illness.

Despite these conditions, PMRS's adaptive approaches mitigated the most severe impacts on population health, preserving access to essential services and sustaining health system functionality under sustained crisis.

15. Conclusion and Forward Look

15.1 Sustaining Health Care Under Protracted Crisis

The scale and scope of PMRS's health response in 2025 reflect the organisation's continued commitment to delivering essential healthcare under conditions of sustained crisis. Across Gaza and the West Bank, PMRS teams provided life-saving and life-preserving services amid health system collapse, access restrictions, displacement, and escalating humanitarian needs. These interventions were not delivered in isolation but as part of an integrated, locally led response rooted in community trust and adaptive capacity.

At the same time, the operating environment in 2025 underscored the increasing fragility of Palestinian local health organisations, particularly in Gaza. As international humanitarian access became more constrained and operational pressures on international NGOs intensified, local organisations carried a growing share of service delivery responsibility—often with fewer buffers, greater exposure to risk, and heightened operational strain. This reality reinforces the urgent need for sustained financial support and principled advocacy for locally led health actors.

15.2 The need to advocate for the protection of Health Workers and the Right to Health Care

The experiences of 2025 reaffirm that healthcare delivery in crisis settings is inseparable from the protection of health workers and the safeguarding of healthcare itself. PMRS health teams operated under conditions of insecurity, repeated displacement, infrastructure loss, and psychological strain. Their ability to continue delivering care depended not only on technical capacity but on the preservation of humanitarian principles and respect for the neutrality of healthcare.

The rights of health workers and the right of communities to access healthcare must be actively defended. This requires ongoing and creative advocacy, engagement across multiple platforms, and collective action to ensure that political pressures do not encroach upon healthcare delivery. The erosion of humanitarian space and the normalisation of constraints on healthcare pose long-term risks to population health and to the integrity of humanitarian action.

15.3 Ongoing Health Resilience

Throughout 2025, PMRS teams demonstrated extraordinary commitment, adaptability, and professionalism. They remained steadfast in serving their communities despite personal risk, displacement, and cumulative stress. However, this resilience must not be taken for granted. The capacity of local health workers to continue under such extreme conditions is finite, and sustained pressure without adequate support risks long-term harm to both individuals and institutions.

Recognising resilience must go hand in hand with concrete action to protect staff well-being, ensure organisational sustainability, and uphold the principles that enable healthcare to function even in the most constrained environments.

15.4 Thank you to Donors and Partners

The continued support of donors and partners throughout 2025 was instrumental in enabling PMRS to sustain its response. Financial support, flexible funding, and principled partnership provided the organisation with the stability and confidence needed to adapt operations, retain staff, and continue serving communities under extraordinary pressure.

Equally important, donor solidarity and advocacy have sent a powerful message to health workers on the ground—that their work is seen, valued, and supported. In a context marked by uncertainty and constraint, this support has strengthened morale and reinforced PMRS’s ability to continue delivering care where it is needed most.

15.5 Looking Ahead

As the crisis continues, the need for locally led, rights-based healthcare delivery remains acute. PMRS will continue to prioritise decentralised service delivery, integration of care, and adaptive programming in response to evolving needs. Sustained investment in Palestinian health organisations, protection of healthcare and health workers, and collective advocacy to safeguard humanitarian space will be essential to preserving health outcomes and system functionality in the period ahead.

The impact achieved in 2025 demonstrates what is possible when local expertise, community trust, and principled support converge. Maintaining this impact will require continued partnership, shared responsibility, and a commitment to ensuring that healthcare remains accessible, protected, and upheld as a fundamental right—even in the most challenging circumstances.