



GAZA SMART SURVEY 2026

Executive Summary



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The Gaza SMART Survey 2026 provides a population-based assessment of the nutritional status of children aged 0–59 months and women and girls aged 15–49 years living within accessible areas of the Gaza Strip between 31 May and 15 June 2026. Around 17 per cent of Gaza's population, some 358,000 people, was excluded from the sampling frame before cluster selection because of access and security constraints. The survey assessed important factors related to maternal and child nutrition, including childhood illness, infant and young child feeding practices, maternal nutrition, measles vaccination, vitamin A supplementation, deworming and care-seeking behavior. The findings provide a snapshot of the latest nutrition situation based on the data collected during the survey period and cannot be used to confirm, disprove, or reinterpret assessments describing nutritional conditions in the past.

The survey used internationally recognized SMART methodology and a cross-sectional, two-stage cluster sampling design across three survey domains: Gaza and North Gaza, Deir Al-Balah, and Khan Younis and Rafah. A total of 2,089 households participated, and 1,335 children completed anthropometric assessment. Weighted estimates were generated for the accessible survey population. Approximately 83 per cent of the Gaza Strip's estimated population was covered by the survey, while the remaining 17 per cent could not be included due to security and access limitations. The nutritional situation of populations living in these excluded areas cannot be inferred from this survey and may differ from the estimates presented here. Humanitarian assistance, food availability, disease patterns, population displacement, access to services and the broader operating environment are important contextual factors for interpreting the survey findings.

The survey shows a complex nutritional picture: relatively low acute malnutrition among children in the accessible population, concerning rates of chronic malnutrition (stunting), maternal malnutrition, very poor dietary quality, suboptimal infant and young child feeding practices, and a substantial burden of childhood illness.

Combined Global Acute Malnutrition, based on weight-for-height, MUAC where applicable, and/or bilateral pitting edema, was estimated at 1.3 per cent. Severe acute malnutrition was uncommon across the three survey domains. Stunting affected 12.2 per cent (95% CI: 10.4–14.2) of children under five years, indicating that approximately one in eight children had impaired linear growth relative to international child growth standards. Stunting can cause life-long and irreversible cognitive and developmental impairments if not identified and treated early. Underweight affected 3.9 per cent (95% CI: 3.0–5.1) of children under five, while overweight affected 4.0 per cent (95% CI: 3.0–5.4) of children under five. Among children aged 0–59 months, Global Acute Malnutrition (GAM) based on weight-for-height Z-score was estimated at 0.5 per cent. The coexistence of stunting and acute malnutrition reflects a dual burden of malnutrition, underscoring the importance of diet quality rather than food quantity alone. Among children aged 6–23 months, only one in three children achieved minimum dietary diversity (consumption of food from five or more food groups) and 22.4 per cent received a minimum acceptable diet (frequency of eating depending on age combined with diversity). The findings also revealed a high consumption of unhealthy foods.

It's important to note that different nutrition indicators capture distinct aspects of nutritional well-being during specific periods of time. Acute malnutrition, measured through weight-for-height and mid-upper arm circumference MUAC, reflects current nutritional status and can change relatively quickly in response to shifts in food intake, disease and other conditions.

Stunting, by contrast, reflects cumulative nutritional and health deprivation over a longer period beginning before birth and continuing throughout infancy and early childhood. Maternal malnutrition, poor dietary diversity, suboptimal breastfeeding and complementary feeding, and recurrent childhood illness similarly identify vulnerabilities that are not captured by acute malnutrition prevalence alone. The coexistence of relatively low acute malnutrition with these other concerns is not contradictory. The survey findings should therefore be considered together rather than using any single indicator to characterise the overall nutritional situation.

Maternal malnutrition was also a concern, with 9.4 per cent of non-pregnant, non-lactating women and 7.2 per cent of pregnant and lactating women affected by acute malnutrition, based on MUAC below 230 mm. Infant and young child feeding findings showed important gaps. Breastfeeding was widely practiced, with 96.5 per cent of children aged 0–23 months having ever been breastfed. However, exclusive breastfeeding among infants younger than six months was only 20.4 per cent. Among children aged 6–23 months, 30.3 per cent achieved minimum dietary diversity (consumption of food from five or more food groups) and 22.4 per cent received a minimum acceptable diet (frequency of eating depending on age combined with diversity). High consumption of unhealthy foods and limited intake of fruits and vegetables suggest that many children are not receiving the nutrients necessary for healthy growth and development.

Childhood illness was common. During the two weeks preceding the survey, 37.1 per cent of children had experienced diarrhea, 31.9 per cent had experienced fever, and 6.0 per cent had symptoms of acute respiratory infection. Care-seeking was relatively high for fever and respiratory symptoms, but appropriate treatment of diarrhea remained limited: 25.6 per cent of children with diarrhea received oral rehydration salts, 18.9 per cent received zinc and only 12.3 per cent received both.

The coverage of selected preventive health interventions showed a mixed picture. Among children aged 9–23 months, 75.9 per cent were reported to have received at least one measles vaccination based on a vaccination card or caregiver recall. This measure does not represent verified age-appropriate two-dose coverage. Vitamin A supplementation among eligible children was 71.0 per cent, while deworming coverage remained considerably low.

The survey followed a substantial expansion of humanitarian assistance after the October 2025 ceasefire. In the months before, including August 2025, when the IPC confirmed Famine in Gaza Governorate, severe access constraints and supply disruptions meant that blanket supplementary feeding - a principal means of preventing acute malnutrition - had largely ceased across Gaza. Some programmes to detect and treat malnutrition continued to operate, but the supplies and access needed to prevent children becoming malnourished in the first place were not reaching them. Admissions for treatment of acute malnutrition peaked at nearly 17,000 children in August 2025 and had fallen to under 3,000 by March 2026.

The survey findings support continued attention to both acute nutritional risk and the wider determinants of maternal and child nutrition. Maintaining strong capacity for early identification, referral, and treatment of acute malnutrition remains important, particularly in a humanitarian context where conditions can change rapidly. Routine screening, treatment services, and availability of essential nutrition commodities must be sustained.

The findings highlight the importance of strengthening preventive action. Priorities include maternal nutrition, protection and support of breastfeeding, improved complementary feeding and child diet quality, prevention and treatment of childhood illness, vaccination and micronutrient interventions, safe water and adequate sanitation, food security and social protection.

The high prevalence of diarrhea particularly highlights the need for stronger integration between nutrition, health, and WASH interventions. The findings on dietary diversity and minimum acceptable diet similarly underline the importance of ensuring that young children have access not only to sufficient food but to diverse, safe and nutrient-rich diets, in addition to timely access to health, WASH, and nutrition supplies.

Continued nutrition surveillance is also essential. SMART surveys should be used alongside routine nutrition information systems, community MUAC screening, sentinel surveillance, program monitoring, and other humanitarian evidence to identify changes in nutritional conditions and inform timely decision-making. The survey provides an important evidence base for humanitarian decision-making and highlights the need to maintain capacity to prevent and treat acute malnutrition while simultaneously addressing the broader nutritional, health, dietary and environmental vulnerabilities affecting women and children.

