



A MUCH NEGLECTED SERVICE

**ASSESSMENT OF FAMILY PLANNING SERVICES IN PALESTINE
CHALLENGES AND OPPORTUNITIES**

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CHALLENGES AND OPPORTUNITIES**

By

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BPA	Beijing Platform for Action
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CFTA	Cultural and Free Thought Association
CS	Commodity security
FP	Family Planning
GBV	Gender Based Violence
GPI	Gender Parity Index
GS	Gaza Strip
HHs	Households
HIMS	Health Information Management System
ICPD	International Conference on Population and Development ('The Cairo conference')
IUDs	Intra-Uterine Contraceptive Devices
LAM	Lactational Amenorrhea Method
MCH	Mother and Child Health services
MENA	Middle East and North Africa
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
MOSA	Ministry of Social Affairs
NECC	Near East Council of Churches
NGO	Non-Governmental Organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OPTs	Occupied Palestinian Territories
PA	Palestinian Authority
PCBS	Palestinian Central Bureau of Statistics
PD	Population Development
PFPPA	Palestinian Family Planning and Protection Association
PHC	Primary Health Care
PMRS	Palestinian Medical Relief Society
RCS-GS	Red Crescent Society-Gaza Strip
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
SDGs	Sustainable Development Goals
SDPs	Service Delivery Points
SOP	State of Palestine
SRH	Sexual and Reproductive Health
TFR	Total Fertility Rate
TOR	Terms of Reference
UN	United Nations
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNRWA	United Nations Relief and Works agency for Palestine Refugees in the Near East
WB	West Bank
WHDD	Women`s Health and Development Directorate
WHO	World Health Organization

EXECUTIVE SUMMARY

Background

The use of Family Planning (FP) is not only associated with better health outcomes, higher quality of life and a reduction in mortality and morbidity. It also accelerates a country's progress toward poverty reduction, economic growth, better education and women's empowerment. The right to access Sexual and Reproductive Health Services (SRHS) and information, including FP is a critical human rights issue. Nevertheless, in Palestine many barriers exist, which limit the ability to fulfil rights and enjoy quality FP services. FP is widely perceived as a medical issue that mainly concerns women; men are largely not involved in this issue.

Since the year 2008, in response to the high demand and the unmet need for FP services, the United Nations Population Fund (UNFPA) committed a significant proportion of its resources to secure modern FP commodities at the national level, providing these commodities to the SRHS providers including Ministry of Health (MOH), United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) and Non-Governmental Organizations (NGOs). This strategy contributed to a significant reduction in the unmet needs from 19% in 2006 to 11% according to what was reported by the Multiple Indicator Cluster Survey (MICS) (2014). However, despite UNFPA's efforts to secure a consistent and sufficient supply of FP methods in Palestine, there were tedious challenges with frequent shortages, stock-outs and sometimes over supply and expiry of methods. This exacerbates the issue of chronic protracted humanitarian crisis, especially in the Gaza Strip (GS), political division between the West Bank (WB) and the GS, and the deterioration of socioeconomic status in Palestine. Other important challenges to be considered include duplication of services, access to services, shortage of supplies, poor coordination due to political and administrative issues, and restricted movement of goods and people.

UNFPA, in its continuous efforts to promote FP services in Palestine and to improve the overall management of FP supplies, commissioned two consultants to conduct an external assessment of FP services. Particular focus was given to commodity security as an important step to ensure a sustainable and reliable supply of high-quality FP commodities.

Methodology

This endeavor is not intended to be an evaluation exercise, rather an assessment of FP services. To reflect the reality from its different perspectives, a triangulated approach was followed utilizing different data collection methods and diverse verification means. This assessment utilized a mixed-methods approach involving a literature review and analysis, quantitative data collection from medical records and databases of organizations providing FP services and qualitative data collection. The qualitative data which included conducting around 45 key informant interviews, sought to explore in greater depth, methods of forecasting of FP commodities, supply chain system, storage status, management, stock level and distribution of commodities. Interviews were carried out to collect information using a semi-structured set of questions. Field visits were conducted in a sample of facilities providing FP services. During the field visits the physical status of service delivery points, status of FP storage sites and the methods and tools used for FP were assessed. The data collected were triangulated to produce a layered analysis, enabling the researchers to more fully explore the supply chain management processes. The assessment was conducted first in the WB in October and November 2016 and was followed by another round of data collection in the GS in late 2017.

Overwhelmingly constraining context

FP services are highly influenced by the prevailing context in Palestine. The protracted occupation by Israel, which is punctuated by repeated conflicts and coupled with severe restrictions on the movement of both people and goods, especially in the GS. This situation, combined with a lack of sovereignty and control over resources, has resulted in highly fragmented and distorted local economies, which are overwhelmingly dependent on external aid, including in the provision of FP commodities. The complex and unpredictable context, has further hindered Palestinians' ability to set long term policies and plans, including population policies, provision of reliable services and securing the needed commodities. Participation of women in the labor force is limited, due to socio-cultural factors, particularly having many children and political factors. Women in the work force is a strong determinant of fertility, as women working or searching for jobs tend to be less interested in having many children. On the positive side, according to the Palestinian Central Bureaus of Statistics (PCBS), the literacy rate among Palestinians, especially among women is very high, which is a positive indication for higher utilization of FP services. Although it is less strong than before, the Arabic culture reflects a strong hierarchy of people, with women perceived more as dependent housewives, a reproductive instrument, and the primary caregivers and nurturers. Young Palestinian girls are also vulnerable to child marriage and pregnancy. They are not only poorly protected by national law — which permits the marriage of girls as young as 14.5 years — but they face considerable pressure from their families to marry early in order to uphold honor and also because of economic hardship. Due to several factors, the Palestinian population has one of highest fertility rates in the region. High fertility rates could also be related to many factors including, cultural, educational, political, tribal and religious factors. For instance, religious and cultural beliefs dominating the society encourage high fertility and having many children. Although decreasing, fertility remains high in Palestine, primarily due to early marriage mainly among females and a low frequency of divorce. However, it is also attributable to a relatively low rate of contraception use and high unmet need for FP.

Our analysis underscores the complexity and interlinked nature of the factors affecting fertility and FP utilization in the Palestinian context, and the critical role that context-specific gendered norms and practices play in shaping women and family's decisions and choices. These complexities need to be understood and considered by policy makers, stakeholders and service providers. Through inter-sectoral initiatives, it is important to address key determinants affecting fertility and the use of FP methods, such as combating poverty, women's empowerment, supportive legislation and targeting vulnerable groups. Moreover, investment in girls' secondary and post-secondary education and development of health promotion programs, including the use of media, are critical to induce a real change in fertility and use of contraception.

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Stagnant use of contraceptives

Contraceptive prevalence rate is used as a proxy indicator that reflects the interplay of many factors in both supply and demand. It is the most widely reported measure of outcome for FP programs at the population level. Influenced by the context described above, trends of using modern FP methods between 2000 and 2014, show a slow increase in the contraceptive prevalence rate from 51% in 2000 to 53% in 2010 and 57% in 2014. The annual increase of contraception use of all methods in the past 15 years is 0.78%. It is higher in the GS (1.2% annual increase) than in the WB (0.74% annual increase). As a proxy indicator for the supply and demand of FP services, the contraceptive prevalence should be monitored and analyzed with better use of findings for policy recommendations and actions. The finding that the contraceptive prevalence is stagnant, indicates that measures should be taken to enhance the use of FP services, working on two fronts; supply through strengthening FP services and demand, through increasing awareness, demand and utilization by the community.

According to the 2014 MICS survey, among the current FP users, around one out of eight use less effective “traditional” methods (13% of all the surveyed married women at the reproductive age). 43% of all married women reported not using any method at all. The contraceptive prevalence rate of 57% is low according to international and regional rates standards (Turkey at 74% and Iran at 82%). The use of contraception is higher in the WB (60%) than in GS (53%) and it also increases with age, wealth, education and the number of live births. Household level surveys show that the most commonly used modern contraceptive method is the IUD, which has been used by 26% of all married women. IUD use is significantly higher in the WB (31%) than GS (19%). Unlike the GS, the use of IUDs in the WB is constantly increasing, particularly among older women (35 years and over), and those who are less educated and live in rural areas, who tend to use IUD more than others. Contraceptive pills, which were the second most commonly used modern method, were more used in the GS (10%) than the WB (6.5%) and their use has increased in 2014 in comparison to 2010. Male condoms were also more used as a modern contraceptive method in GS (7.4%) than in the WB (4.3%). Male condom use in GS is increasing. Male condom use was reported more among couples with higher educations. Nevertheless, other methods such as female sterilization (1.9%), injections (Medroxyprogesterone) (0.9%), implants and female condoms were less popular.

The types of FP methods used, as reported by organization providing FP services, shows great inconsistencies in comparison with the PCBS data (2016). In the WB, the analysis found that pills are the most commonly used method, while the number reported by PCBS is much lower in all years. The same disparity was found in the reports produced by NGOs and MOH in Gaza. It is clear that different organizations use different methodologies for calculating contraceptive type and there is an absence of clear standardized case definitions and indicators. The method of documenting FP services is also not consistent.

Unmet need for family planning is often portrayed as a problem of access, leaving the perception that women do not use contraceptives because they cannot find or afford them. However, unmet need is at least partially attributed to poor quality of service, weak counselling and negative providers' attitudes towards FP, which combined discourage women from using FP. In 2014, unmet need was 11% (5% for limiting and for 6% for spacing) and is similar in the WB and the GS. From 2006 to 2014, there was a reduction of unmet need by around 42%, which is regarded as a good achievement. The achievement could be attributed to improvement of service delivery and commodity security.

Contraceptive prevalence is the percentage of women who are currently using, or whose sexual partner is currently using, at least one method of contraception, regardless of the method used. It is usually reported for married or in-union women aged 15 to 49. (WHO Contraceptive prevalence 2016. http://www.who.int/reproductivehealth/topics/family_planning/contraceptive_prevalence/en/)

Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior (WHO https://www.who.int/reproductivehealth/topics/family_planning/unmet_need_fp/en/).

Landscape of FP services

Recent reports show that there are 306 MOH centers providing FP services in the WB, which served 36,877 new beneficiaries in 2016. In the GS, out of the 56 MOH centers, only 17 provide FP services which had served 5,659 women. At MOH facilities, FP services are provided regardless of whether the client has medical insurance or not, for only a minimal co-payment charge. At UNRWA, all the 65 agencies centers in the WB and the GS provide free FP services (22 in the GS). In 2016, 12,185 new users and 72,225 continuing users in the GS and 2,721 new users and 23,556 continuing users in the WB were served at UNRWA clinics. In addition, there are a large number of NGOs that provide FP services but not necessary regularly. Most of these NGOs rely on receiving commodities from MOH and provide FP services with minimal fees. Few of these NGOs have procurement plans for FP methods from their core resources.

Despite the large number of public and non-for-profit providers, at the national level, the main service provider for FP services is private doctors who serve 29% of the users. The rate of private sector use in the WB (40.6%) is much higher than the GS (5.7%). In addition, 13.5% of FP users reported receiving services from community pharmacies or private institutions. This makes the total FP contribution of the private sector in Palestine up to 42.6%. This is worrying, as it raises equity issues on the ability of poor families to seek services in the expensive private sector. Moreover, buying FP commodities from community pharmacies without appropriate counseling or appropriate medical checkup might be risky for users. Seeking private sector services could be attributed to better confidentiality, trust, respect and privacy at private centers. Although the private sector is the biggest service provider for FP in Palestine, it is typically not targeted by programs aiming to improve the quality of FP services, such as supervision and training.

UNRWA is the second biggest provider (27%) after the private sector and is the main provider in the GS (61%), much more than in the WB (11.4%). This is possibly due to the higher proportion of refugees in Gaza. Despite running the largest number of clinics, the government ranked third as it provides FP services to only 18.7% of the FP users, with the rate being higher in the WB (21.5%) than the GS (12.9%). The role of NGOs was limited in both the WB and the GS (3.5%) despite the fact that they had received large amounts of commodities during the period 2008 to 2014. This raises important questions about where the efforts and resources aiming to promote FP services should be directed. It was noted that the amount of methods dispensed to NGOs doesn't correspond to the number of beneficiaries they serve. During a focus group discussion (FGD) with the members of the FP steering committee in Gaza, a key informant at one NGO said, "We receive condoms from MOH but we use them for something else other than family planning. We use them to cover the head of the ultrasound probe during doing vaginal ultrasound".

Disparities in service provision

Different modalities were applied in providing FP services. For example, midwives are allowed to insert IUD at UNRWA and some NGO facilities, but not at the MOH. At UNRWA, technical guidelines, which are specific to the agency are used, while at NGOs, each has its own policies and protocols or work without any of these. There are nationally endorsed guidelines as a part of the reproductive health protocols, but very few service providers knew about them and very few, if any, are applying them. Moreover, organizations have different systems for estimating needs, reporting and even for determining the medical indications for the method to be used. Furthermore, even within the same organization, sometimes there were variations among providers' perspectives and practices related to FP. Structurally, at UNRWA clinics, FP services are integrated into the primary health centers and are provided by the family health team, which provides the entire primary health care service package. At MOH, 30% of the centers provided FP services, and when they were available, they were provided as an independent service by specifically designated teams. Evidence shows that FP services are more effective when they are provided integrated with other SRH services like antenatal care. At NGOs, FP is less perceived as an essential service and is usually skipped if the commodities are not provided for free by the MOH, except in certain NGOs, which procure these items when they are not available at the MOH stores.

Another important point is the lack of a standardized reporting format and national FP database. Strangely, the MOH reports about FP don't incorporate the services provided by NGOs at all. Monitoring is also very weak, and service providers are rarely being supervised, with the absence of agreed performance indicators. While FP commodities are part of the pharmaceuticals, it is neither managed nor inspected by pharmacists, it is left to the technical staff like midwives or physicians who are usually not adequately trained on commodity management. Coordination among FP service providers is generally limited, therefore there is duplication of services and waste of resources. It is essential that MOH invests more efforts in regulating FP services with clearer accountability mechanisms. Empirically collected data confirm that weaknesses in FP also include limited access to information on FP methods and poor counselling which negatively affected utilization. It was also noticed that training and capacity building in FP is limited, as it is less popular now than it was previously. Therefore, FP should be re-categorized as a priority topic in capacity building and training for all service providers working in FP, focusing not only on the technical aspects, but also on staff perceptions and attitudes, which are perceived as not adequately gender and human rights sensitive.

Commodity security: a mixed equation

Regarding commodity security, the assessment revealed inconsistencies. The supply chain management at MOH and UNRWA is generally working efficiently with adequate storage capacity, appropriate storing conditions, and a good distribution system to service delivery points. However, monitoring and follow up of the stock level at both central and peripheral levels is working less effectively, with many items reaching expiry date. Due to political turbulence, change in donors' policy, political division, insufficient coordination at policy level between suppliers and providers and among the service providers themselves, the supply of FP commodities is irregular with great variations across the years and frequent periods of interruption, particularly during the past three years. The GS is facing more shortages than the WB. The MOH, in its capacity as a regulator of the healthcare services in Palestine, distributed FP supplies to the other service providers, yet the process was irregular and inconsistent. While it was a good idea to centralize the supply chain of FP commodities through the MOH, this should be associated with better regulatory and coordination mechanisms and also more commitment to procure the needed commodities from domestic financial resources. In 2015, when UNFPA decided to reduce the reliance of the health sector on the support provided by UNFPA for procuring FP commodities, shortages become more prominent. Unfortunately, the process of transition wasn't smoothly implemented and created discomfort and frequent stock breaks. One senior person at MOH said 'It was shocking to hear that UNFPA will not provide commodities anymore, it's a disaster, it was a big surprise, no one is going to provide these commodities. This came on top of financial constraints facing the health care system, in addition to lack of consensus among policy makers that securing FP commodities is a priority. It is preferable that UNFPA develops an exit strategy and coordinates better with the different sectors to ensure continuity of the services. However, UNFPA continued to secure FP methods through emergency funds, which helped in meeting the needs on one hand, while on the other hand has created more uncertainties and oversupply for the organizations which decided to buy commodities from their own resources like UNRWA. Some providers coped through buying commodities from the local market, although it was very expensive (sometimes 70 times higher than UNFPA). Others decided to skip the service with or without telling anyone. Positively, UNRWA decided to allocate part of its core budget to procure FP methods benefiting from UNFPA's international bidding system, which is highly efficient. Ideally, MOH and NGOs need to do the same and to regard FP methods as a priority area.

The data at the stores of the main providers reveals serious gaps in commodity security. Variation across the years is mainly due to the irregular supply, gaps in commodity management and other confounders such as receiving unexpected amounts of commodities. It is unlikely that this variation is due to a decrease or an increase in demand for the commodities. Apparently, there is no clear consumption standard that can be used as a reference point. For example, during the period 2010-2015, a total of 60,462 units of IUDs were dispensed from the central stores of the MOH in Nablus with a yearly dispensing average of 10,077 loops, ranging from 6,400 the lowest in 2011 to 13,050 (double the amount), the highest was in 2014. The supply trend of the IUD to Gaza shows severe differences, ranging from 14,750 to zero in certain years and subsequently zero dispensing to service delivery points who reported frequent stock rupture at the service delivery points. Only in two years (out of seven), what has been dispensed is sufficient according to the standard consumption average. The picture with other commodities is similar, as is detailed in the full report. In addition, the dispensing pattern of the combined pills is not consistent with the utilization pattern at the organizations which received these commodities. What has been dispensed to MOH Primary Health Care (PHC) centers show that in certain years there was an oversupply (in 2013 and 2014), while in others there were severe shortages, especially in 2015. Progesterone only pills supply and dispensing showed the same irregularity. With regard to male condom, in 2014 and 2017, no supplies were provided to the GS at all by anyone. The same applies to dispensing from MOH stores in Gaza which also showed severe variances. For instance, in 2011 and 2017, nothing was dispensed to NGOs although they rely mainly on MOH. The monthly consumption at PHC centers in the GS has never been reached. Contrarily, in 2016, due to failure in commodity management, thousands of condoms were discarded at MOH stores in Gaza. The supply and dispensing of injectable Medroxyprogesterone (also known as Depo-Provera) wasn't much better, the same scenario was noticed as detailed in the report.

A worrying stock levels

The stock level status is an important indicator that reflects the commodity security status. Figures reported by the MOH central store in the GS indicate that there was a great variance of the annual average stock level. The store hasn't been adequately maintained at a strategic safe level with sufficient buffer stock, which is especially important during an emergency. The median gives even gloomier picture, where in certain years the median of stock was zero as in 2015 and 2016 in combined oral pills and Medroxyprogesterone, which means for six months in the year the stock at the central store was zero. The monthly stock level analysis shows serious gaps at the MOH main store in Gaza, as it was at the zero level for almost all the commodities in certain years. The IUD shortage was reported in many months with zero stock in May, August and November in 2015, and also in February 2016 and November 2017. The status of Medroxyprogesterone was even worse, with many months out of stock (22 months in five years). Combined pills were at zero stock at least for 15 continuous months and at a low stock level in many other months.

Separate from the data collected from the central stores, the records at the service delivery points indicate that the stock outs at the central stores have negatively affected the service provision. Reports at MOH clinics indicate that in 2015, shortage of combined pills and Medroxyprogesterone were recorded during the period March through December (for 10 continuous months). In 2016, a shortage of combined pills and Medroxyprogesterone were recorded during the period January through August (for nine continuous months) and in 2017, a shortage of combined pills and progesterone were recorded during the period May through November (for eight continuous months).

The stock level status at UNRWA in Gaza was somewhat better than at the MOH. However, due to irregularity of supply, many items showed great variations with some items reaching zero stock level at the UNRWA central stores in Gaza. For instance, male condom stock level was so dispersed ranging from 2,139 units in 2012 to 12 in 2010 and 291 in 2017. The combined oral contraceptives stock level was even more problematic, with great variability across the years ranging from 6,759 in 2012 to 51 in 2010. Variations were also noted in the progesterone oral contraceptive pills, ranging from 1,499,000 to zero in some years. Moreover, the stock level of Medroxyprogesterone was at zero stock in certain years (in the last quarter of the year 2015 and 2016) and with overstock in other years.

Improving commodity security requires stakeholders' collaboration to enhance regulation, ensure political commitment to procure commodities from domestic resources, improve monitoring strategies, and train on commodity management. All FP service providers should budget for the procurement of FP commodities and it should be included in their respective general procurement plans with the objective of achieving sustainability. Another recommended option is to establish a national fund from all stakeholders that is dedicated to securing commodities and to use more efficient mechanisms for procurement, delivery and distribution. It is important to support the overall supervisory and regulatory role of the MOH in order to ensure that FP commodities are secured at peripheries and service delivery points. It is important to ensure that the commodities are delivered directly from the suppliers to Gaza central stores to avoid bureaucracies and delays which sometimes happen. UNFPA needs to develop a written strategy for its support to FP services and to communicate that strategy with stakeholders. The focus of the UNFPA should be more on advocacy to increase commitment to FP, software interventions, knowledge generation, monitoring and capacity building, in addition to contributing to filling gaps in securing the national needs for commodities.

INTRODUCTION

Health, including Sexual and Reproductive Health (SRH) and rights, is critical for human and sustainable development, with the enjoyment of the highest attainable standard of physical and mental health as a recognized basic human right (United Nations-UN, 2015, 2014). Family Planning (FP) is critical for the health of women and their families and it can accelerate a country's progress toward reducing poverty, economic growth, enhancing education, reducing sexually transmitted diseases, reinforcing women's empowerment and contributing to achieving developmental goals (World Health Organization-WHO, 2018). There is consistency in the literature that FP promotes gender equality and accelerates educational and economic empowerment for women. The use of FP has proven to reduce maternal and child mortality, prevent unwanted pregnancies and unsafe abortions and can protect individuals from sexually transmitted infections (Mutomb and Bakibinga, 2013; Mutomb, et al 2017).

FP is a cost-effective public health intervention, with multiple societal and individual benefits. Effective use of FP methods helps couples achieve desired number of children, may contribute to improve maternal and child health which is a proxy indicator for the health status of the entire community. Globally, it has been well-documented that FP is associated with better health outcomes, higher quality of life and a reduction in mortality and morbidity (WHO, 2017). Effective use of FP methods is important to the health of women and children by preventing pregnancies that are too early, too late, too close or too many.

FP refers to use of modern or natural methods for either limiting or spacing pregnancies. Intrauterine Devices (IUDs), pills (combined estrogen and progesterone and progesterone only), male and female sterilization, Medroxyprogesterone (also known as Depo-Provera injections), implants, male and female condoms, spermicide pessaries, diaphragm and emergency contraception are examples of modern methods of contraception. On the other hand, traditional methods include periodic abstinence, withdrawal and folk methods (WHO, 2007, 2017).

Although, the right to access and use FP methods is considered a critical human right adopted and endorsed by a number of human rights declarations, still in Palestine many barriers exist which limit people's ability to fulfil their rights to access quality FP services. The rights-based approach to FP services is not well-conceptualized or endorsed, and focus is more on the narrow medical aspect of the issue rather than, the wider conceptualization of family planning as a health and social right. Globally, the importance of having access to FP services is now well-recognized to not only improve women's chances of surviving pregnancy and childbirth, but also to contribute to the larger related issues such as gender equality, better child health, greater education outcomes, economic development and poverty reduction. Because of its crucial effects on individual and community health and development perspectives, FP has been both implicitly and explicitly stated in the Sustainable Development Goal (SDG). Almost all the SDG are relevant in a way or another to FP, Box 1 shows the FP related SDG-related commitments with at least two FP related international indicators.

BOX 1: SDG' FP RELATED GOALS AND INDICATOR

Goal 1. End poverty in all its forms everywhere

1.1 By 2030, eradicate extreme poverty for all people everywhere, currently measured as people living on less than \$1.25 a day

Goal 2. End hunger, achieve food security and improved nutrition and promote sustainable agriculture

2.1 By 2030, end hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including access of infants, to safe, nutritious and sufficient food all year round

Goal 3. Ensure healthy lives and promote well-being for all at all ages

3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births

3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for FP, information and education, and the integration of reproductive health into national strategies and programs. Indicator: 3.7.1 Proportion of women of reproductive age (aged 15–49 years) who have their need for FP satisfied with modern methods



Goal 5. Achieve gender equality and empower all women and girls

5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Program of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences. Indicator: 5.6.1 Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care



Empirical research reveals that spacing of at least 36 months and at most 59 months (optimal birth spacing) will reduce the risks of under-five mortality (Rutstein, 2005). Shorter intervals, such as less than 18 months, increase the risk of maternal and child health problems such as preeclampsia, eclampsia, low birth weight, prematurity, small-for-date, and even mortality. The rate of preterm birth (before 37 weeks' gestation) was higher in women who conceived after a short interval of less than 12 months. They were around triple as likely to give birth before 37 weeks compared to pregnancies following an optimal interval (20.1% vs. 7.7% respectively) (Rutstein, 2005).

UNFPA AND FAMILY PLANNING

The United Nations Population Fund (UNFPA) is an international development agency that promotes the right of women, men and children to enjoy quality healthy life and equal opportunity. UNFPA is the Sexual and Reproductive Health agency of the United Nations. Globally, UNFPA supports countries to use population data for policies and programs to promote development, reduce poverty, enhance maternal and neonatal health and ensure that women and youth are treated with dignity and respect. The UNFPA was established as a trust fund in 1967 and began funding population programs in 1969. In 1987, it was officially renamed, reflecting its lead role in the UN system in the area of population. Since then, UNFPA has worked in many countries, including Palestine. Through more than thirty years of its work in Palestine, UNFPA has contributed to the development of SRH strategies, promoted SRH services, including FP, reduced inequalities in health, promoted maternal and neonatal health, ensured that women are treated with dignity and respect, provided drugs, equipment and

consumables, reinforced capacity building, combated Gender Based Violence (GBV), increased youth participation and supported the Palestinian community. Moreover, UNFPA contributed to the improvement of related services through provision of drugs, equipment and consumables, capacity building of staff and helped to build the capacity of Palestinian Authority (PA) institutions and civil society.

UNFPA programs in Palestine are implemented in partnership with local organizations (to ensure sustainability) to safeguard SRHR including FP, gender equality and Population Development (PD) with focus on women, neonates, youth, social and population protection. UNFPA programs are closely coordinated with the Palestinian Ministries including the Ministry of Health (MOH), United Nations Relief and Works Agency (UNRWA), WHO, other UN agencies, international development actors, and local Non-Governmental Organizations (NGOs) to maintain the integrity of the local systems and support sustainability and complementarity.

As a key player in the women`s health domain, UNFPA and partner agencies emphasizes FP, birth spacing, and the importance of informed choice, as a crucial area of intervention to address availability, access to and quality of services within the health sector. From 2008 to 2018, in response to high unmet need for FP, UNFPA secured FP commodities at the national level. UNFPA slowly phased out procurement of FP commodities in the years leading to 2018 for sustainability purposes. Under the umbrella of the MOH in Palestine, FP commodities were distributed to an expanding net of health facilities in the MOH, UNRWA and main NGOs in Palestine. At least partially, UNFPA`s identity in Palestine is linked to its support to FP program, which doesn`t receive much support from other development donors. UNFPA support to FP services contributed to a reduction in the unmet need for FP (Less than 11% in 2014) as revealed by the Multiple Indicator Cluster Survey (MICS) conducted in 2010 and 2014.

STUDY QUESTION/PROBLEM

Although the prevalence of contraceptive use is well-known in Palestine and regularly assessed during the MICS surveys conducted every four years, what we know less is why the prevalence is almost constant and not improving as expected. Furthermore, despite the high spending on health, the high availability of health facilities, and a reasonable health provider population density, it is unclear why unmet FP needs are still reported at this rate. As commodity availability at the service delivery points (SDPs) is one of the most important factors influencing meeting FP needs and the utilization of FP methods, it has been given particular attention in this assessment. For several years, commodity security in Palestine has been problematic. This adds to the challenges of the protracted humanitarian crisis in the Gaza Strip (GS), political division between the West Bank (WB) and the GS and the deterioration of socioeconomic status which results in a wide range of challenges, from duplication of services to shortage of equipment and supplies, delays due to political and administrative issues

and restricted movement of goods and people. Health reports and service providers indicate that the current processes of forecasting of needs, supply chain management and logistic challenges have resulted repeatedly in stock rupture and disruptions at the SDPs and the central drug stores. In spite of the active policy and program dialogue, significant capacity building and other efforts aimed at ensuring availability of commodities at the national level, stock outs and or excess amounts of commodities were reported by various service providers. Therefore, UNFPA is keen to explore how the FP commodity security processes can be more reliable, sustainable, and efficient so that FP methods are adequately available to beneficiaries. The organization is interested to learn how the management processes of FP commodities can be enhanced.

To have an independent judgment about this issue, UNFPA commissioned consultants to conduct an external assessment of FP with particular focus on commodity security (Annex 1 TOR). The assessment considered the processes associated with commodity security and management, such as ordering, forecasting, procurements, distribution and monitoring and the outcomes of the FP program, such as the prevalence of contraceptive use and the rate of unmet needs.

UNFPA envisages conducting a review of the FP services and commodity security policies, procedures and practices as a step towards ensuring a sustainable and reliable supply of commodities. The study aimed to do the following:

- Appraise FP service provision and utilization, including how much the structure and processes at the health system are conducive to FP.
- Ascertain FP commodity security practices including forecasting, procurement, delivery and the flow of commodities from central level, to district and to service delivery level.
- Assess the stock level and number of beneficiaries served by organizations.
- Assess the health information system, including recording and reporting in terms of adequacy, relevance and quality.

METHODOLOGY

To reflect the reality from different perspectives, a triangulated approach was followed utilizing different data collection methods and diverse verification means. This assessment used a mixed-methods approach involving a literature review, quantitative data collection from medical records and databases of organizations providing FP services, and qualitative data collection. The literature review involved reviewing and analyzing reports about FP. The quantitative component aimed to obtain more generalizable findings about beneficiaries served, beneficiaries' characteristics, type of methods and the stock status across the different organizations. Dummy tables were developed, and organizations were asked to fill in these tables.

The qualitative analysis sought to explore, in greater depth, methods of forecasting of FP commodities, supply chain system, storage, management, and distribution of commodities. Information was collected related to stock availability, periods of stock out, average monthly consumption (AMC), recording and reporting systems, inventory control,

condition of storage and capacity building of relevant staff. Interviews were carried out to collect information using a semi-structured set of questions. Annex 2 shows a list of sample questions for the interviews. 45 key informant interviews were conducted (19 in the WB and 26 in the GS) with the following categories of people:

- Policy makers from MOH, UNRWA and NGOs
- Staff from UNFPA
- Service providers from different sectors
- Middle management
- Health care providers engaged directly in service provision
- Staff from UNRWA
- Staff from central stores management
- International donors

Field visits were conducted to a sample of facilities providing FP services. During the field visits the physical status of SDPs, status of FP storage sites and the methods and tools used for FP were assessed. Also, the assessors talked to beneficiaries and explored their perspectives.

The data collected was triangulated to produce a layered analysis, enabling the researchers to fully explore the strength and weaknesses in service provision, including supply chain management.

The assessment was conducted first in the WB only, as it was initially planned that the consultant would conduct a field visit to the GS, however, this was not possible within the timeframe of this mission. Therefore, UNFPA contracted another consultant based in GS to complete the assignment. Data collection took place in two rounds, October through November 2016 in the WB and followed by another round in December 2017 in GS. All interviews, with appropriate consent were recorded, translated and transcribed. An open coding thematic technique was used in data analysis, with the team unpacking each transcript to extract key issues.

Study limitations

- Lack of national standardized indicators for FP services affected the ability of the consultants to draw solid conclusions. For example, lack of standards for stock level, lack of standards for ordering FP commodities, methods of calculations contraceptive prevalence etc.
- Lack of effective documentation and recording systems somewhat complicated the task. For example, there was no database for stock supply, dispensing, waste disposal, and different work modalities at many organizations. Data collected from service providers were different in terms of the time intervals. For example, some organizations with a well-functioning electronic health information system were able to provide retrospective data for several years (from 2010), others just recently developed their computerized system and provided data for only the past few years. In all the scenarios, data was inconsistent and not standardized.
- In a politically and economically uncertain context, such as in Palestine, the situation can change rapidly, which means that the degree of uncertainty is extremely high and significantly affects service provision and commodity security.
- This study didn't have the resources to adequately assess beneficiaries' perspectives and therefore focused mainly on the supply side, it is important to consider the demand side and explore beneficiaries' perspectives in further studies.
- Due to the contextual related limitations, it was difficult to have one consultant or one team to conduct the study due to travel restrictions. The two consultants worked almost independently using different approaches and methods. Efforts were made to integrate the findings from the two consultants into one document at the national level, still there was long time gap in reference to the period at which the data collection took place.

CONTEXT

Difficult livelihood conditions

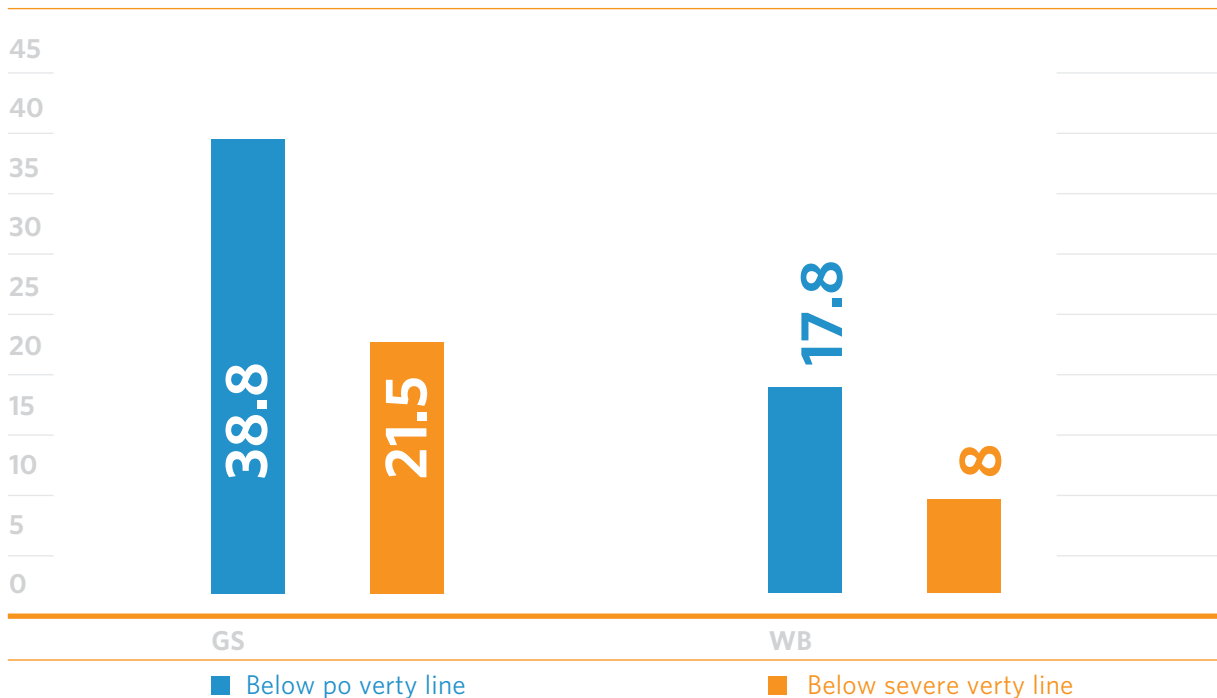
Any situation is best understood within a frame of reference; therefore, the authors present some contextual information related to FP service provision and utilization. While considered by the United Nations Development Program (UNDP) to be in the medium human development category, the Palestinian people remain highly vulnerable. The protracted occupation by Israel, which is punctuated by repeated conflicts and coupled with severe restrictions on the movement of both people and goods, especially in GS, has resulted in highly fragmented and distorted local economies, which are overwhelmingly dependent on external aid including in the provision of FP commodities (World Food Program, 2015; World Bank 2012). Set against this 'human dignity crisis', which the UN considers a 'collective punishment' in clear violation of international humanitarian law, such a complicated uncertain context, has affected the Palestinians' ability to set long term policies and plans, including population policies, provision of reliable services and securing the needed commodities. The cycles of

political instability, combined with continued Israeli occupation, control of its borders and the building of the separation wall and the settlements, which drastically restricts freedom of movement and trade, exposes people to violence and cycles of international sanctions against Palestinian militancy (particularly the GS blockade instituted in 2006), continue to negatively affect the lives of Palestinians, including community and population dynamics. For instance, the role of political fertility (increased fertility for the purpose of affecting the demographic dimension of the conflict) resulting from the ongoing conflict with Israel can't be excluded. Additionally, conflict and the war like context have affected priorities and plans towards emergency services and injuries and away from other critical services like SRH, including maternal health and FP.

The Palestinian Central Bureau of Statistics (PCBS, 2015) report indicates that 38.8% of the Households (HHs) in the GS and 17.8% in the WB live below the poverty line and an additional 21.5% and 8% (respectively) of the HHs in the GS and WB live below the severe poverty line with women and children mostly affected.



FIGURE 1: DISTRIBUTION OF HHS LIVING BELOW POVERTY AND SEVERE POVERTY LINE (PCBS, 2015)

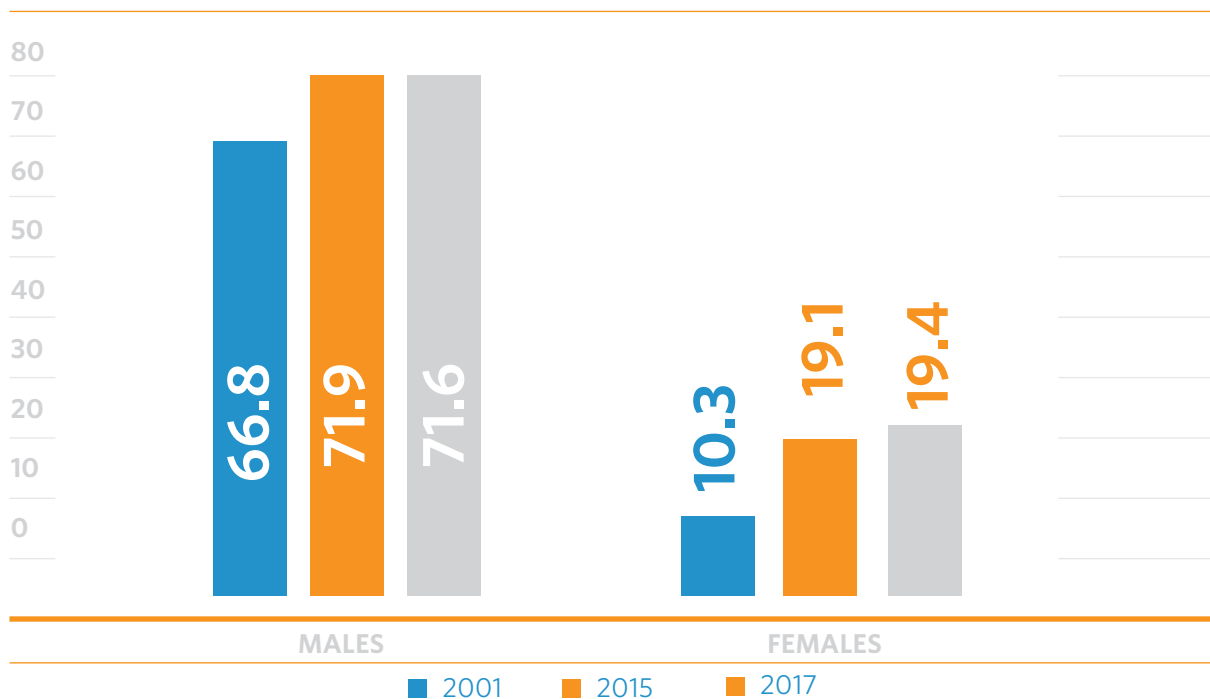


The main drivers of poverty in Palestine are the severe impacts of macro-structural, sociocultural and political influences on household-level (political economy), such as unemployment, over-population, high fertility rates, political uncertainty, lack of sovereignty, the ongoing blockade, recurrent conflict, displacement, destruction of livelihood sources and assets, lack of national development policy and also gender norms, which inhibit many women from work and transformative participation (Abu Hamad, et al 2016; Jones & Abu Hamad, 2016). The most vulnerable households are those where the household head is unemployed; those with many children; those with a family member with disability or chronic illness; female headed household and those with limited access to informal social support (Hamad and Panvello, 2012). According to the Ministry of Social Affairs (MOSA), the incidence of poverty among Palestinian families with ten or more children is 58.5%, compared to only 18% for families with two to three children (MOSA, 2011). The main sources of livelihoods in the SOP are employment at the services sector (mainly at government, UNRWA and NGOs), trade, working in Israel, rain-fed agriculture, construction, livestock rearing, and fishing. Recent statistics (PCBS, 2015) show that the unemployment rate reaches more than 40% in the GS (among females 55.2%; males 37.9%) and 17.3% in the WB.

Due to socio-cultural factors particularly having many children and political factors, women participation in labor force, including informal labor, constitutes only 19.7% in the GS and 18.3% in the WB while it reaches 70.7% among males in GS and 72.2% among males in the WB (PCBS, 2018). Women participation in the labor force, which is slightly increasing despite the significantly high educational level, is a strong determinant for fertility, as women working or searching for jobs tend to be less interested in having many children.



FIGURE 2: DISTRIBUTION (%) OF LABOR FORCE PARTICIPATION RATES IN PALESTINE (WB AND GS), BY SEX, OVER TIME, FOR THOSE AGED 15+



Education is highly valuable

According to PCBS (2014), the literacy rate among Palestinians (15 years old and above) is very high (above 96.4%). The rate is slightly higher among males (98.4%) than females (94.4%). This reflects the high value Palestinian people have traditionally placed on education, regarding it as a durable and movable asset, 'contrary to land and houses that can be and were lost'; therefore, they have instilled this value in their children (Hamad and Shalabi, 2013). Recent findings showed that 37.9% of youth (15-29 years) are currently enrolled in education; with 36.3% in the WB and 37.9% in the GS. There is a gender difference in favor of females (32.1% among males compared to 42.0% among females). Almost all surveys indicated that the proportion of females who completed university education (14.3%) is higher than their male counterparts (11.2% males), both in the WB and the GS (PCBS, 2016). Females invest more time on education and hence have higher levels of enrolment and attainment than males. Even though more females than male's complete university education, with scarce resources, families often prefer to invest in sending their sons to university. Early marriage (which is more prominent in rural areas) restricts girls' access to university education.

While girl's uptake of schooling is good, with girls more likely than boys to transition to both secondary school (Gender parity index- GPI of 1.2) and higher education (GPI of 1.3) (PCBS 2015), Palestinian culture largely values girls' education not only for the way it fosters girls' agency and voice, but more noticeably, for the way in which it prepares them to be economically better off and prepare them to be better wives and mothers. The idea that higher education can open up job opportunities and be an important insurance for women in the event of divorce or widowhood was also documented (Perezniето et al. 2014).

Restrictive social and cultural norms

Cultural norms highly determine how we react, interact, behave and have a strong influence on family dynamics. Cultural norms are not static, and are influenced by economic, educational and social factors in the local and international context. Traditionally, Arabic culture reflects a strong hierarchy of people with a sacred obedience for the figurehead, people of older age, especially males. This narrows the space given for younger people, and young women in particular. The same applies to household decision making processes where the male and older authorities, like parents in law, are typically unchallengeable. The traditional and still prevalent Palestinian family model sees men as the household's main breadwinner, decision maker and source of protection, and women as dependent housewives, a reproductive instrument, and the primary care-givers and nurturers. A number of studies have documented the gender obstacles and ingrained expectations of women's role in Palestinian society that hinder autonomy, fertility decisions, employment opportunities and participation in the labor force (UN-Women, 2011; World Bank, 2011; 2010).

Palestinians are a highly passionate community, with a strong commitment to the institution of marriage, which contributes to the increase in fertility. The median age of marriage among females is 20.3 years (24 years among males). Of the entire population 15 years and above, 35% of the females were never married before, and 44% among males. The prevalence of the currently married females (15 years and above) is 56% (54% among males). However, being divorced (1.6% of females and 0.3% of males) or widowed (5.1% among females and 1% among males) was significantly higher among females (PCBS, 2017). The majority of households of the Palestinian population are nuclear families (84.5%) and is lower in GS (79%) than the WB (87.4%) (PCBS, 2015). The percentage of households that are extended families is declining, as the figure reported 15 years ago was 35%.

The socio-political environment in Palestine means that women and girls' ability to autonomously take decisions and to access the public sphere is limited, and it is often difficult for women to secure income, access services and secure their rights, including independent decision making about fertility and reproduction. Women's involvement in the formal economy is marked by highly segmented labor markets, with more than 80% of women employed by only two sectors—services (primarily education, health and social work) and agriculture—mostly as wage employees (World Bank, 2010).

The rapid escalation of urbanization, together with a shift away from an agricultural society, is associated with shifts in norms and traditions. There is less reliance on family and informal support and more of a tendency to seek support from formal services. This was associated with reduction in fertility level, but was less than the expected. The urbanization trend hasn't been associated with major changes in social norms, therefore, fertility trends remained high, especially in GS.

Palestinian girls are also vulnerable to child marriage and pregnancy. They are not only poorly protected by national law—which in the case of the WB permits the marriage of girls as young as 14.5 (16.5 in GS)—but they face considerable pressure from their families to marry early in order to uphold honor and because of economic hardship. Of all the women married in 2010, nearly 23% were girls younger than 18 (PCBS 2013). The median age of marriage is 19 years, which means that half of girls are married before reaching 19 years (PCBS, 2018). The end result of this high rate of child marriage is that Palestine's adolescent pregnancy rate is also very high. Nearly 30% of girls in GS and 25% of girls in the WB are pregnant before they turn 18 and about half are mothers before the age of 20 (Miftah et al. 2015). Notably, despite their early exposure to sex, less than 10% of adolescent girls had adequate knowledge about HIV according to the UN knowledge indicators providers (PCBS, 2015). Furthermore, nearly one-third of marriages are between first degree relatives, which drives up the country's high rate of birth defects (Miftah et al. 2015).

This context has significant policy implications for fertility and family planning. Box 2 highlights some of these implications.

BOX 2: POLICY IMPLICATIONS OF CONTEXTUAL ISSUES ON FERTILITY AND FP

Overall, the analysis underscored the complexity and interlinked nature of the factors affecting fertility and FP utilization in the Palestinian context and the critical role that context-specific gendered norms and practices play in shaping women's decisions and choices. These complexities need to be understood and considered by policy makers, stakeholders and service providers. FP is not simply another type of medical or health service, rather it is a multi-faceted issue that is underpinned by many political, cultural and social factors.

Inter-sectoral collaboration initiatives address key determinants affecting fertility and the use of FP methods like combating poverty, women empowerment and supporting particularly vulnerable groups. Community mobilization efforts need to combat early marriage, increase awareness and educate the community about the importance of birth spacing and risks associated with having many children. The school health program and media (mass media and social media) represent a missed opportunity to educate the community about FP. Re-classification of this topic in the social context is needed through community mobilization, legal and social systems. For instance, more attention should be paid to FP during designing and implementing health promotion, school health, media programs. More efforts are needed to keep the concept of FP on the agenda of stakeholders with further investment in educating and increasing awareness about it. It is noted that the attention to FP in general has declined in Palestine with a prevailing misperception that all people know about it and services providers have integrated it into the system. FP should be part of school health, youth initiatives, premarital counselling, preconception and natal care. Also, community organizations, such as mosques and churches, can play an important role in changing perceptions about fertility and FP.

Increased coordination among stakeholders including legal forums, schools, community entities, and services providers is important to induce social change towards empowering women's ability to make reproductive decisions. More efforts are needed to support women's tertiary education and engage them more in economically productive opportunities.



FERTILITY IN PALESTINE

The most striking aspect of population growth in Palestine is that, since the middle of the last century until 2015, the population has multiplied five times, from 0.9 to 4.75 million at an average annual growth rate of 2.5% (UNFPA, 2016). This is despite a particularly troubled history and significant streams of migration outwards, including forced migration and puts Palestine among the fastest growing countries of the Arab world. Following the demographic transition, the effects of modernization should cause countries to have increasingly lower death and birth rates, with the birth rate falling faster than the death rate. According to the model, Palestine should have experienced this transition already. However, in spite of a particularly low and decreasing death rate, falling from 4.9 per 1,000, to 3.6 per 1,000 between 1997 and 2015, the birth rate - although falling - remained quite high from 42.7 per 1,000 to 31.9 per 1,000. Thus, the present rate of natural increase of 2.83% remains high enough that a further doubling of the population in a matter of 25 years is possible. One of the major characteristics of the Palestinian population is the disparity between the GS and the

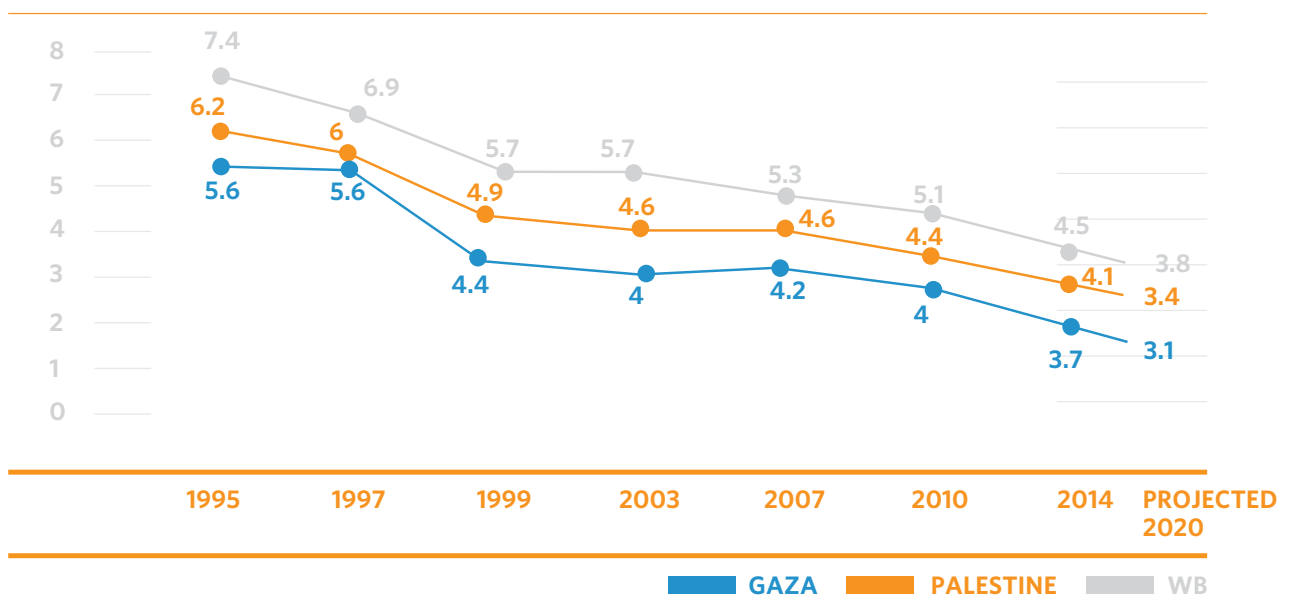
rest of Palestine. The growth rate for the GS is one-third higher than in the rest of the country.

High fertility rates could be related to many factors, including culture, education, politics, tribal characteristics and religion. Religious and cultural beliefs dominate the society encourage fertility and having many children. Furthermore, polygamy is not an uncommon phenomenon in the area especially in rural areas. However, according to the Palestinian community having many children provides a type of social security and protection to the family and to the tribe against others. In other words, children provide social security and financial support to their family that is unlikely to be provided regularly and adequately by the government. Additionally, having a large family is a necessity for agricultural work, the continued main source of livelihoods for some households. Another significant factor affecting the high fertility rate is the political situation. Most Palestinian families lost family members in the consecutive wars and most Palestinians are aware of the demographic dimension of the Arab-Israeli conflict. Therefore, they are committed to the principle of having many children to preserve the national identity. Some Palestinians perceived high fertility and having many children as prestigious (E'zwa) and it is among the few available opportunities for them to prove themselves and to prove that they exist. With unemployment and a lack of opportunities, men represent a symbol of failure, therefore the only thing they can do to protect their ego, is to have more children.

The rapid escalation of urbanization, together with a shift away from an agricultural society, is associated with shifts in norms and traditions. There is less reliance on family and informal support and more of a tendency to seek support from formal services. This was associated with reduction in fertility level, but was less than the expected. The urbanization trend hasn't been associated with major changes in social norms, therefore, fertility trends remained high, especially in GS.

The Palestinian Total Fertility Rate (TFR) was high with more than six children per woman in 1996 (higher in GS than in the WB) (see figure3). High fertility in the GS persists, although the difference between it and that in the WB is narrowing. Fertility still remains high in Palestine, primarily due to early marriage, mainly among females and a low frequency of divorce. But it is also attributable to a relatively low rate of contraception use.

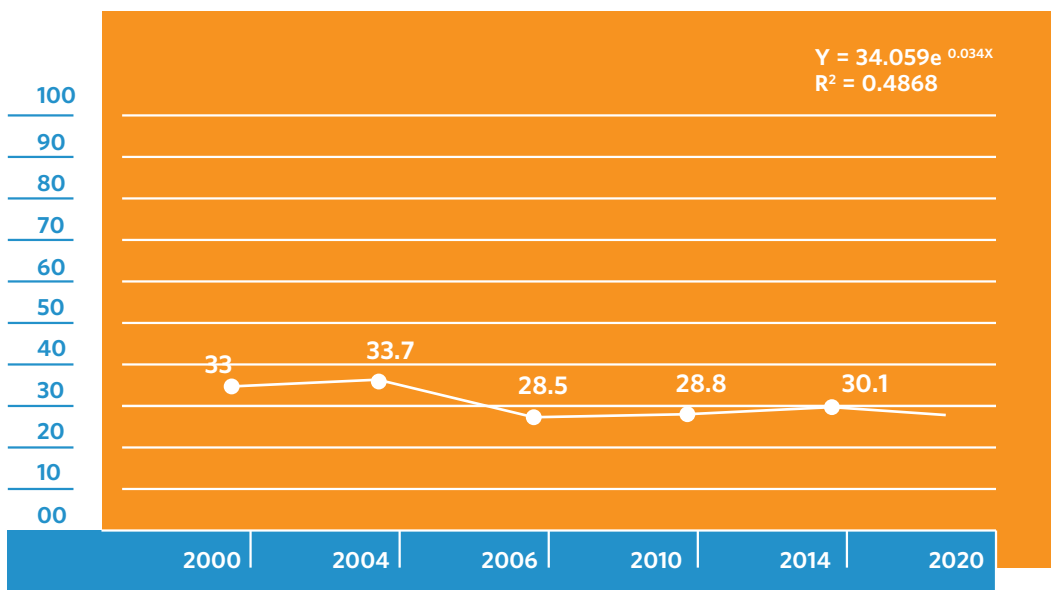
FIGURE 3: TOTAL FERTILITY RATE (TFR) PER WOMAN



In Palestine, as described, several socioeconomic factors affect fertility, particularly very high universal marriage, early marriage, limited opportunities for decision making and a low contraceptive prevalence rate, especially for modern methods of contraception (used by 44%). These are the main proximate determinants of the present high level of fertility. Household wealth also plays a significant role. But it is mainly education, particularly female education that determines the fertility rate. The dramatic decrease in fertility that follows when education levels improve from primary to secondary and then to higher education is a common pattern in Palestine. Hence, population growth and structure for the next 35 years will mainly be influenced by educational progress in Palestine. Other socioeconomic factors play a minor role, for example, female employment is still limited for economic and sociocultural reasons. Hence the paradox is that more highly educated women – often with more education than their male counterparts – are kept outside the labor market, where their contribution is needed. Urbanization and internal migration also play a minor role since the country has been almost completely urbanized and what might have been considered a “village” in the past, now benefits from all the attributes of life in towns and cities.

Birth interval (spacing) is a major determinant of fertility and measures paternal investment in a child. Therefore, analyzing birth intervals provides useful information for guiding the formulation of effective FP programs. Spouses manage the interval for personal, cultural, psychological and economic reasons. Also, longer birth intervals of over three to five years are becoming a necessity for parents who plan to send their children to higher education. Although this period (3659- months) is the recommendation, it was widely internationally believed that a 24-month birth interval is the minimum needed to ensure good health outcome for the mother and the child.

Figure 4: Average birth interval in Palestine by year (in months) - UNFPA 2017



The average birth interval in Palestine in 2000 was 33 months. It was longer in the WB (34.1) than the GS (31.2) and dropped to 28.5 months (29.3 in the WB and 17.2 in GS) in 2006. Birth intervals of WB women are longer than those of the GS. A slight change occurred between 2010 (28.8) and 2014 (30.1) in both WB and the GS. Birth intervals increased with the increase of a woman's age, which shows that women did not have a clear understanding of the importance of birth interval to mother's and baby's health especially in the first age groups. The authors believe that mothers tend to have the number of children they prefer and to have them all within a limited period of time. Despite improvement, birth intervals remain much lower than the internationally recommended period (three to five years). Differences in birth intervals between WB and the GS could be attributed to cultural factors and higher utilization of FP in the WB than GS. Also, possible socio-economic and political factors might play a role. Differences related to place of residence were minimal, which could be attributed to the strong deeply rooted beliefs about fertility. Also, poorer women tended to have shorter birth intervals than rich women. This was consistent throughout the years studied (see Annex 3). Addressing social, economic and development determinants to the prevailing high fertility is essential, particularly education and employment.

BOX 3: POLICY RECOMMENDATIONS FOR BIRTH SPACING

Invest more in education especially for female university education, which is instrumental in community development and ensuring that women and families have access to quality family planning information and services to make informed decisions on their fertility. Ensure that social protection programs support access for vulnerable groups to university education, including protecting girls from early marriage.

Invest more in economic empowerment and designing programs to increase women participation in labor force.

Set policies to ensure equity, equal opportunity, preventing early marriage and gender-based violence and increase women's participation in decision making and public sphere.

Through collaborative, multidisciplinary efforts, induce change in social norms, address gender norms, gender equity and promote women's empowerment.

Invest more in increasing community awareness about birth spacing and having safe intervals between births, through educating women, engaging fathers and the community leaders. Schools, mosques, community organizations and mass media could play a vital role.

FP and birth spacing should be an integral part of community-oriented programs. Attention to FP has faded and is rarely a topic of discussion in the media or in the health education programs.

To set evidence-based policies, it is important to invest research about drivers, perspectives, norms and challenges related to fertility and contraceptive use, not only from a medical perspective, but rather from a holistic perspective including political, socioeconomic and cultural factors.

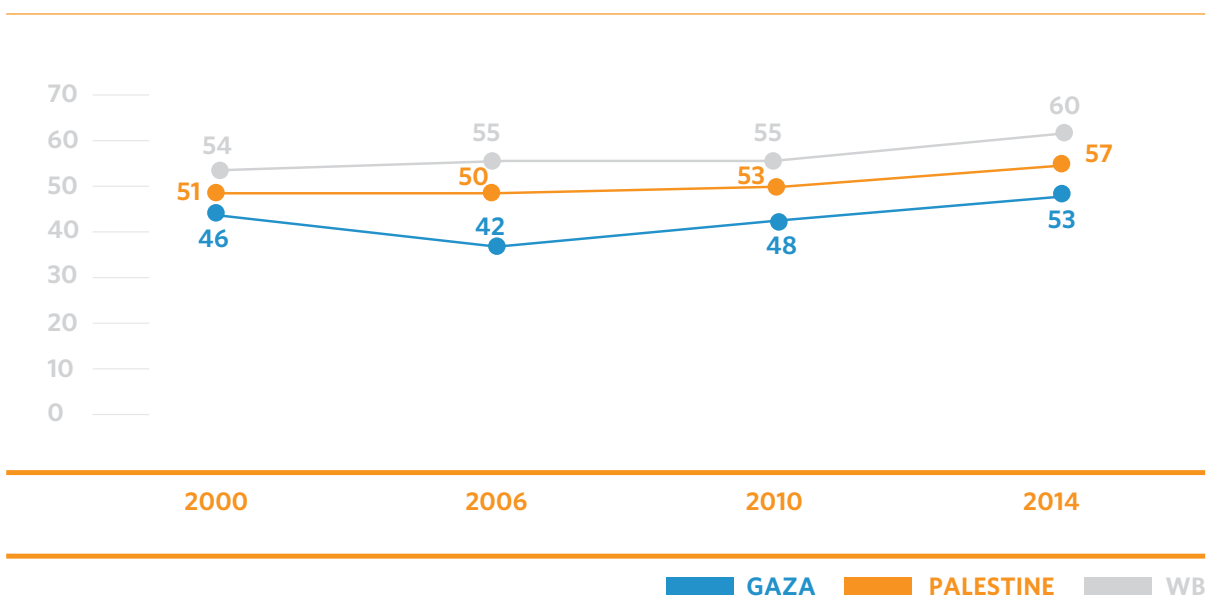
Use of contraception

Contraceptive prevalence rate is defined as the percent of women of reproductive age who are using (or whose partner is using) a contraceptive method at a particular point in time. It is almost always reported for women married or in sexual union. It is used as an indicator that reflects the interplay of many factors at both the demand and supply sides, as it provides a measure of population coverage of contraceptive use, taking into account all sources of supply and all contraceptive methods. It is the most widely reported outcome measure for FP programs at the population level. Influenced by the context described above, trends of FP method use between 2000 and 2014 show a slow increase in the contraceptive prevalence rate; 51% in 2000 to 53% in 2010 to 57% in 2014 (UNFPA, 2016). The annual increase rate of contraceptive use of all methods in the past 15 years is 0.78%, being higher in the GS (1.2% annual increase) than the WB (0.74%). This is possibly because the prevalence was lower in Gaza before 2000 (marginal effect). The annual increase in the use of modern methods was 1.4% in Palestine (1% in the WB and 2.2% in GS). The use of traditional methods was higher in the WB than GS (see Graph 5).

According to the MICS survey of 2014, among current FP users, almost one quarter use less effective, "traditional" methods (13% of all the surveyed married women in reproductive age), while 43% of all women reported not using any method at all (PCBS, 2015). These rates of contraceptive use are low according to international rates standards, 75% in Northern America (UN, 2015) and also low in comparison with those of the Middle East and North Africa (MENA) countries (Turkey at 74% and Iran at 82%). The use of contraception is higher in the WB (60%) than in GS (53%). The contraceptive prevalence rate increases with age, from 38% at 20-24 years to 72% at 40-44 years and with the number of live births, from 25% for married women with one

live birth to 74% for those with four children or more. It is well-documented that FP is typically initiated late, and first contraceptive use (ever-use) tends to begin only after the fourth or fifth child and after having a satisfactory number of children/boys (UNFPA, 2016). As aforementioned, authors believe that mothers and their families reach a satisfactory number of children. As the mother's age increases, the birth interval increases. Almost no changes were noticed between the years 2004 through 2014 in this regard. Wealth also positively affects the contraceptive rate, from 49% for the poorest to 66% for the richest. But some counterintuitive correlations are also observed, which require further in-depth investigation. Contraceptive use is higher in rural than in urban areas and camps. Also, according to PCBS reports, governorates' variations were noticed with the prevalence being the highest in Bethlehem governorate (65%) and the lowest in Rafah governorate (43%) (PCBS, 2013). Astonishingly, the contraceptive rate decreases with higher level of education, from 61% among those women with less than secondary education to 57% among those with secondary education to 53% for those with higher education. More highly educated females' lower fertility is correlated to their marriage patterns, with prolonged celibacy and higher age at marriage. More in-depth analysis is needed with control of other confounders, including age, number of live births and age of marriage (PCBS, 2015).

FIGURE 5: PREVALENCE OF CONTRACEPTIVE USE OF ALL FP METHODS (MODERN AND TRADITIONAL) (% OF MARRIED WOMEN IN REPRODUCTIVE AGE) AS REPORTED BY PCBS REPORTS



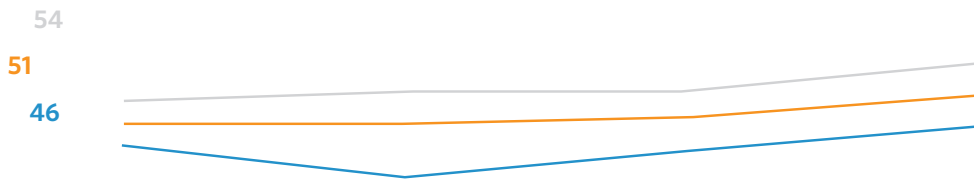


Figure 6: Prevalence of the use of modern contraception methods (% of married women in reproductive age) as reported by PCBS reports

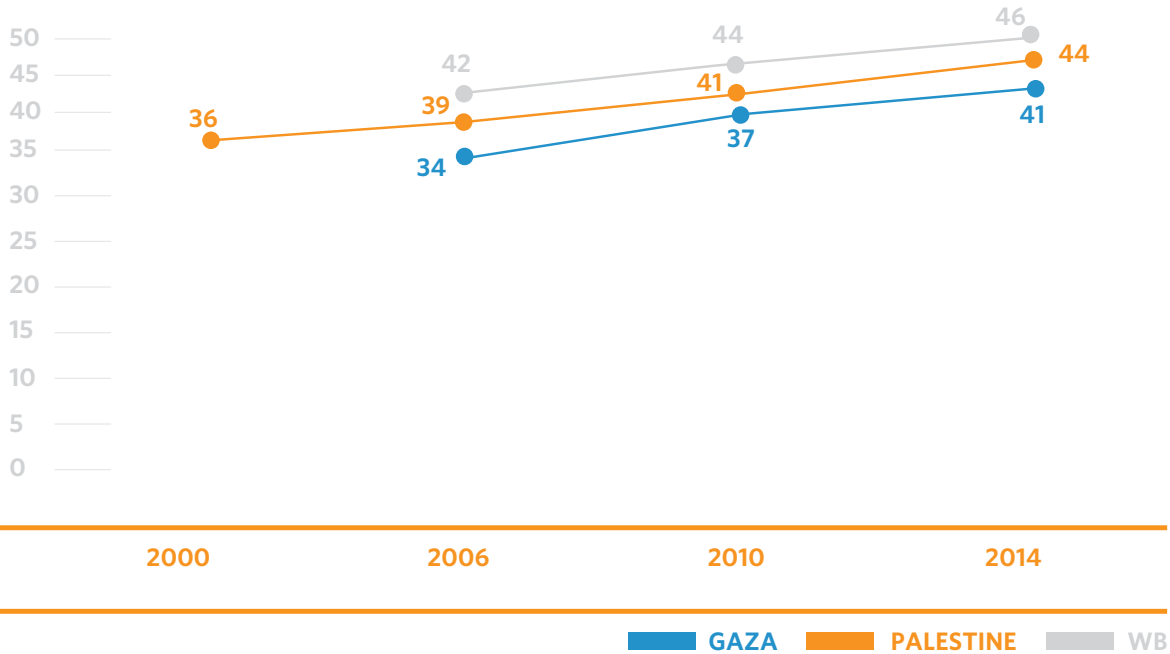
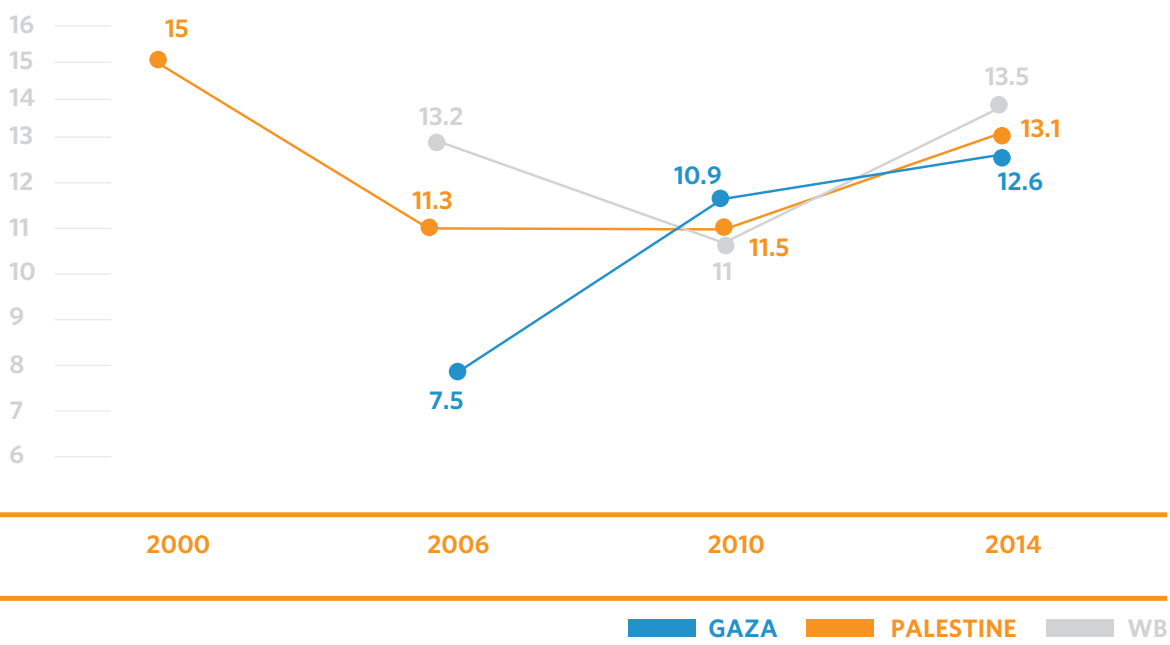


Figure 7: Prevalence of the use of traditional contraception methods (% of married women in reproductive age) as reported by PCBS reports



Data from the PCBS survey in 2010 showed that 11% of married women in reproductive age who don't use FP, have concerns about side effects, indicating weak counseling and provision of quality information. About 7% of those who don't use FP, reported inconvenience of the available FP methods, while in 5% of cases, their husbands disagree to using FP.

FP methods

The type of FP method used by Palestinian women hasn't changed significantly in the past 10 years. In 2014, traditional methods were used more in the WB than the GS and the trend of using traditional methods is gradually increasing in comparison to the year 2010, with significant variations among governorates. The prevalence of using traditional methods, such as withdrawal or periodic abstinence, was the highest in Deir Al Balah (18.7%), Ramallah and Tulkarem (17%) and the lowest was in Jericho (2%) and north Gaza (7%). Older couples, higher economic status and more educated people tend to use traditional methods more than their counterparts in other groups. One cause of the high rate of traditional methods among highly educated women may be fear of side effects, which motivates them to use traditional methods. Other reasons behind women's selection of methods need to be further investigated.

As reported by the PCBS (2015), the most commonly used modern contraceptive method among married women was the IUD which has been used by 26% of all married women in reproductive age, being significantly higher in the WB (31%) than GS (19%). The difference in the use of IUDs didn't change across the years studied. Significant regional variations were noticed as Jerusalem had the highest rates of IUD use (35%) and Khan Younis having the lowest (15%). Older women (35 years and above), especially those living in rural areas and less educated women, tended to use IUDs more than others. For instance, with basic education the use of IUDs was 29%, 27% with secondary education, and 22% with higher education. Some international studies attribute the differences in use of IUDs to cultural characteristics, as it was preferred by young and low parity women (Shrestha, et al 2014; Glenn, 2007). Other studies suggest that using IUD increases with age (Shrestha, et al 2014,). Globally, the use of IUDs is higher in low income countries, especially for women post-delivery, and when relatives recommend using it (ibid). Other studies suggest that the level of education, religion and occupation of the respondent did not have any significant association with using IUDs as a FP method (Mbutia, 2015).

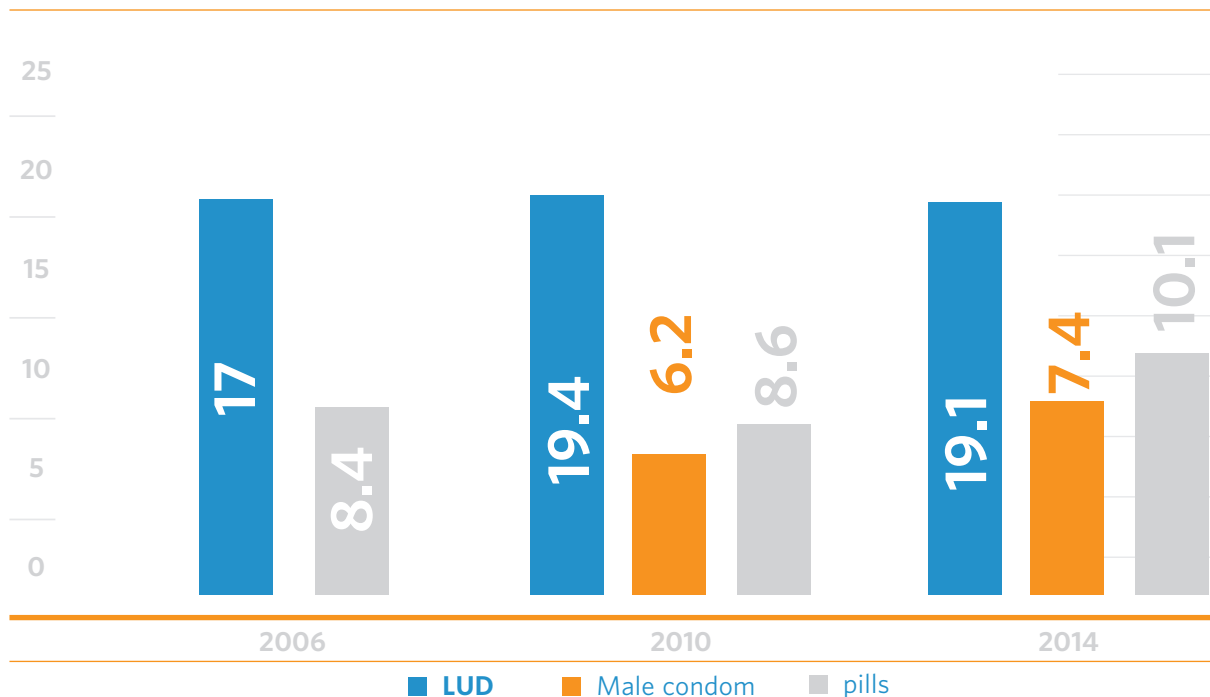
Pills, which represented the second most commonly used modern method, were more used in the GS (10%) than the WB (6.5%). In all of Palestine, pill use increased from 2010 to 2014, although in the WB their use is nearly constant (PCBS, 2015). The highest reported use of pills was among women aged 30-34 years, the less economically privileged, and women living in refugee camps. International literature indicates that the duration of pill use is positively associated with age and cigarette smoking, and among women who are knowledgeable about oral contraceptives and having hormonal irregularity (Shrestha, et al 2014).

Male condoms were also more used as a modern contraceptive method in GS (7.4% of all women surveyed) than in the WB (4.3%), especially in GS and north GS governorates (8%), while Jericho had the lowest prevalence (2.5%) (PCBS, 2015). Living in camps and higher education was more associated with male condom use. Nevertheless, other methods, such as female sterilization (1.9%), Medroxyprogesterone injections (0.9%), implants and female condoms were used by less than 1% of all women surveyed. According to data from the Household Health Survey 2006, pills scored the highest rate of knowledge of FP methods among the youth (90.5%), followed by the IUD (79.2%), condoms (23.7%), withdrawal (20.9%), Medroxyprogesterone (18.9%), and natural breastfeeding (17.6%) (PCBS, 2007). Data show that women are more aware of these methods than men in all cases except for withdrawal and male and female condoms. The literature indicates that internationally the use of male condoms was more associated with younger age groups, higher education, employment and women with higher self-esteem and better opportunities to make decisions. It is also used as a temporary method for a short period of time and for couples with sexually transmitted infections (Glenn, 2007).

There is great inconsistency between PCBS data at HH level and data collected at health facility level on the types of FP methods used. For instance, the MOH report in the WB shows that pills are the most commonly used method; while it is much lower as reported by PCBS. The same applies to the reports produced by NGOs and MOH. It is clear that different organizations use different methods for calculation with the absence of clear standardized definitions and indicators. The method of documentation of data about FP services is also not consistent.



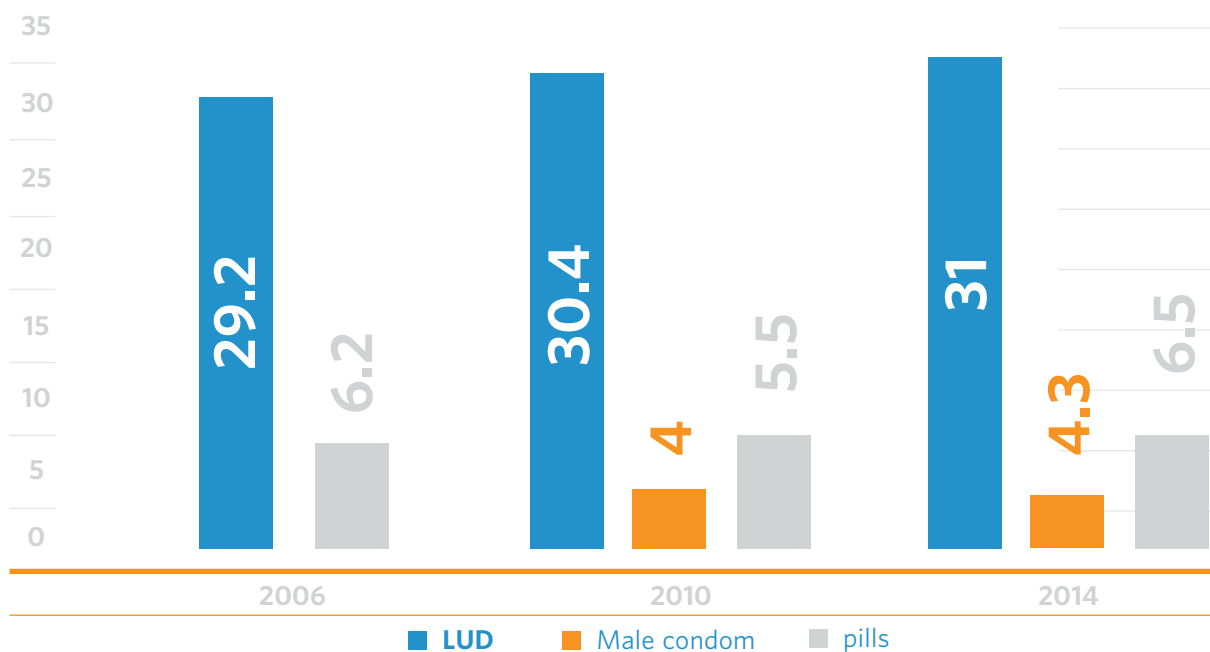
FIGURE 8: MOST COMMON FP METHODS USED IN GS BY YEARS (% OF ALL WOMEN SURVEYED) AS REPORTED BY PCBS REPORTS



DATA ABOUT CONDOM USE IN 2006 IS NOT AVAILABLE



FIGURE 9: MOST COMMON FP METHODS USED IN THE WB BY YEARS (% OF ALL WOMEN SURVEYED) AS REPORTED BY THE PCBS



Unmet need for FP

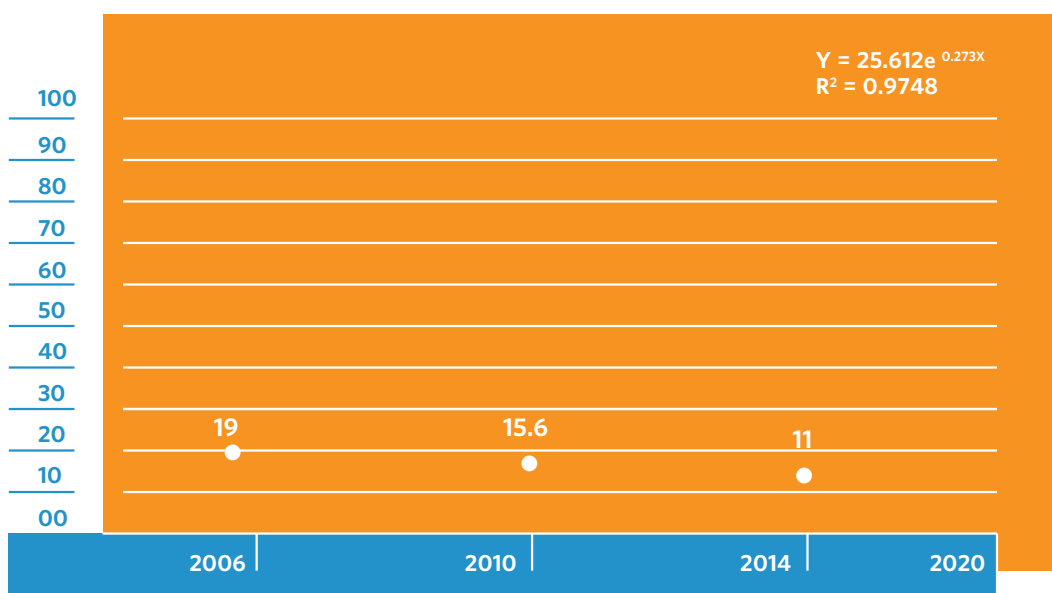
Women with unmet need for FP are those who want to stop or delay childbearing but are not using any method of contraception (UN, 2014). Total unmet need for contraception is the sum of unmet need for spacing and unmet need for limiting (PCBS, 2015). The concept of unmet need has influenced the development of FP programs for decades, and unmet need was an indicator for Millennium Development Goal 5, improving maternal health. In developing countries about half of sexually active women of reproductive age, want to avoid pregnancy, meaning that they do not want to become pregnant for at least two years or want to stop childbearing altogether (UN, 2014). About 17% of the women who do not want to get pregnant, are not using any method of FP, while 9% are using less-effective traditional methods (UN, 2014).

Unmet need for FP is often portrayed as a problem of access, leaving the perception that women do not use contraceptives because they cannot find or afford them. In countries in transition to smaller families, like Palestine, unmet need will probably continue to be a problem until information, supplies, legislation and services meet the increasing demand for contraception. Having said that, it is worth pointing out that, while access is an important issue, women have many other reasons for not using FP, including personal, cultural, or religious objections, fear of side effects, health concerns and lack of knowledge. For this reason, simply making contraceptives available at healthcare facilities does not ensure that women will use them. In countries where many women prefer large families, unmet need, as well as contraceptive use, will be low-as the case of Palestine. Therefore, high levels of unmet need are not necessarily solely due to the failure of a FP program, but may reflect growing demand for contraception. Having said that, unmet need is contributed to poor quality of service, weak counselling and negative providers' attitude towards FP, which discourage women from using FP.

Review of PCBS reports indicates that while the contraceptive prevalence rate increased slightly during the period 2006-2010- (figure 10), it didn't improve significantly. There was a slight decrease in unmet need for FP to 15.6% in 2010; 10% of married women 15-49- were not using contraceptives but want to stop having children (limit) or postpone the next pregnancy for at least two years (space) and 5% wished to stop pregnancy. In 2010, unmet need was higher in the GS 17% than the WB 14.9%. Unmet need in the region is lower than in Palestine (Egypt 11.5%, Israel 9.1% and Jordan 14%). In 2014, unmet need was 11% (5% for limiting and for 6% for spacing) and is similar between the WB and the GS. During the period 2006 through 2014, there was a reduction of unmet needs by around 42%, which is a good achievement.

Variations across governorates exist, but the differences were not consistent. In 2010, the highest rates were reported in Deir Albalah 20%, while in 2014, the unmet needs were the highest in Jericho 14% and Rafah 13%. Women living in poverty reported much higher unmet needs than their counterparts who are economically better off (in 2010, 20.6% versus 10%; in 2014, 11.8% versus 9%). The recent decline in the unmet need could be attributed to the significant improvement in commodity availability noticed during the period between 2010 and 2014 which has contributed to the increase in the uptake of FP services in general and reduced system related barriers to FP services.

Figure 8: Most common FP methods used in GS by years (% of all women surveyed) as reported by PCBS reports



In a 2011 study in Gaza, Hamad (2011) found that 64% of pregnancies were wanted, 12.3% unwanted and 23.7% mistimed, indicating unmet need for FP. In the same study, TFR was 5.8 per woman, higher than the ideal number of children-based on their preferences (4.5-); which implies 31% and 13.8% were unwanted. Findings also indicated that about half of the contraceptive non-users indicated they did not want to become pregnant, but were not using contraceptives “I prefer to leave it to fate,” and “I do not know how I got this child.” Some of the 22% of the traditional methods users in that study would be classified as having unmet needs.

A study conducted by Al-Quds University in 2013 indicates that different factors are associated with unmet need for modern FP methods in Palestine. Fear of side effects, stemming from contraceptive experiences of others and rumors were found to be a major obstacle to use of modern contraceptives. There is a lot of misinformation and misconceptions about modern FP methods. The influence of others, including peers, relatives, and particularly husbands and mothers in law, is a key factor for unmet need. Cultural beliefs, social pressure and preference of male children deter women from using contraceptives. Religious beliefs are an important factor for some of the women. The current political and economic situation in Palestine influenced couple's decisions regarding FP. Moreover, poor communication, and unpleasant and unresponsive attitude of some healthcare providers discourage women from seeking FP services. Lack of convenience and privacy in public healthcare facilities contributed to low FP use or using FP services in the private sector. Shortage of staff and limited knowledge affected the health care capacity to address the unmet need of FP. Data also revealed clearly that the perceived limited quality and efficacy of some of the provided contraceptives at the governmental centers reinforced underuse of FP methods.

TABLE 1: PROPORTION OF WOMEN WHO GAVE THE LAST BIRTH AGAINST THEIR PREFERENCE BY AGE (2010 AND 2014)

AGE	PALESTINE		WB		GS	
	2010	2014	2010	2014	2010	2014
15 - 19	13.2	7.6	19.7	8.8	7.1	6.7
20 - 24	22.6	16.9	26.8	15.5	16.6	18.7
25 - 29	26.9	27.8	30.9	26.9	21.3	29.1
30 - 34	30.9	30.8	34.1	30.2	26.7	31.7
35 - 39	42.3	36.1	42.6	34.3	41.9	38.8
40 - 44	49.8	50.5	48.3	47.5	51.6	54.8
45- 49	40.9	70.0	58.3	85.7	20.0	33.3
TOTAL	29.4	26.1	32.8	25.6	24.9	26.7

Proportion of women who become pregnant or give birth to a child against their desire are proxy indicators reflecting the effectiveness of FP programs. 29.4% of women in 2010, higher in the WB (32.8%) than in the GS (24.9%), gave birth against their preference of how many children they would like (PCBS, 2013). It could be inferred that there is a significant failure in FP program as at least a quarter of women gave birth against their preferences. It didn't differ between 2014 and 2010, especially in the GS. It has decreased, especially in the WB, indicating better utilization of FP. As women age, unwanted pregnancies also increase, since women would have already reached the ideal number of children. Women have various reasons for not wanting to become pregnant. Some want to delay births, meaning that they want to have a child at some point in their lives, but not yet. Some women already have one or more children and want another child, but they want to wait at least a few more years because they prefer to space their births (PCBS, 2015). Other women either do not want to have any children or have had all the children they want. Certain contraceptive methods may better suit the needs of women who want to delay or space births, while others are better for women who want to stop childbearing altogether.

In 2010, the rate of unwanted pregnancy in rural areas was significantly higher (34.6%), compared to urban or camp areas (28.4%). That decreased slightly in 2014 in the three localities with camps having the highest proportions of unwanted pregnancies (PCBS, 2013, 2015). Wealth index and education are not correlated to the percentage of unwanted pregnancy. The same applies to women's education. Around 60% of women wanted to have more children later on. Nearly 40% of women don't want any more children. This should be judged while considering the number of children already women had.

TABLE 2: PROPORTION OF WOMEN WHO GAVE THE LAST BIRTH AGAINST THEIR DESIRE BY LOCALITY, WEALTH INDEX AND LEVEL OF EDUCATION (2010 AND 2014)

VARIABLES	2010	2014
LOCALITY TYPE	%	%
URBAN	28.4	26.2
RURAL	34.6	25.0
CAMP	28.4	27.2
WEALTH INDEX		
POOREST	33.5	24.6
SECOND	29.2	26.6
MIDDLE	26.1	26.8
FORTH	29.7	24.9
RICHEST	28.1	28.8
EDUCATION OF WOMEN		
NONE	34.6	11.1
BASIC	33.0	30.8
SECONDARY	25.0	24.0
HIGHER	25.0	24.8
EDUCATION OF WOMEN		
WANTED TO HAVE BABY LATER ON	59.7	62.5
DID NOT WANT ANY MORE CHILDREN	40.3	37.5

Box 4: Policy implications for the use of contraception

As a proxy indicator for the supply and demand of FP services, the prevalence of contraceptive use should be monitored, analyzed with better uptake of findings for policy recommendations and actions.

The prevalence of modern FP use is stagnant. Measures should be taken to enhance the use of FP services, working on two fronts; supply through strengthening FP services and demand, through increasing awareness, demand and use by the community.



At the service delivery and policy front

- Ensure that FP is incorporated as an essential component of SRH in health plans and strategies.
- Enhance commitment of service providers and policy makers to FP services, including securing financial resources, better monitoring, marketing of services, and advocacy.
- Fill gaps in services provision particularly weak counseling; providers' attitudes; utilization of midwives, such as allowing midwives to insert and remove IUD; and consistently securing needed commodities.
- Improve documentation and reporting about FP, including standardization of definitions, calculations formulas and methods of forecasting needs.
- Address unmet need, which requires political and financial commitments that begins with understanding reasons behind the unmet need for FP and then respond accordingly through expanding and improving FP information and services and initiating a national supply system of contraceptives at central, district and peripheral levels.
- Set national level performance indicators for FP services and continuously monitor them.

At the community front (demand)

- Ensure that FP services are incorporated in women empowerment programs, not only in the reproductive health programs, but also, in gender, education, youth, awareness and health promotion programs.
- Engage men, members of the extended family and the community as a whole, in programs aiming to increase utilization of FP information and services.
- Incorporate FP as part of community mobilization and gendered social norms to enhance the demand and support the utilization of FP.
- Use mass media, social media and influential community entities like mosques/churches to encourage spacing and FP use.
- Invest in counseling for women to understand the reasons for unmet need and respond accordingly.
- Women's peer to peer education is essential to influence behavior change since women's decision for FP use is influenced by other women.

Issues that require further investigation

- Variations in FP use and factors affecting it, including how to turn unmet need into demand.
- Drivers for using or not using FP among women, men, families and the community.
- Underlying cultural and sociodemographic reasons for selecting the methods used by Palestinian women and men.
- Reasons behind taboos and misconceptions about modern FP services.
- Policy makers and providers' attitudes and perspectives about FP remain as an ambiguous area which requires in-depth investigations.



Palestinian health system: a mixed equation

The four major healthcare providers in Palestine are the government, UNRWA, NGOs, and private for-profit operators. The MOH is responsible for a significant portion of health care delivery, including SRH (MOH, 2017), in addition to performing the role of regulator and supervisor of all health services. There are 80 hospitals in Palestine; 30 of them are in the GS. In addition, there are 739 centers, of which, 587 are in the WB and 152 in the GS. Around two thirds (63.1%) of the total number of Primary Health Care (PHC) centers in Palestine (466) belong to MOH. There are 189 PHC centers managed by NGOs (25.6% of all the PHC facilities), 64 UNRWA centers (22 in GS), and 20 military medical centers. UNRWA plays an important role in providing SRH services through its centers and buys secondary and tertiary services for registered Palestinian refugees (UNRWA, 2017). NGOs play a complementing role in supporting vulnerable groups. The private sector is largely unregulated and tends to focus on obstetrics and surgical intervention (MOH, 2017).

Compared to other countries at a similar level of economic development, the Palestinian population's overall health outcomes are relatively good, partly due to strong performance of most basic public health and PHC functions (MOH, 2014). Also, the very high female literacy rates, strong family commitment and cultural values are also positive factors.

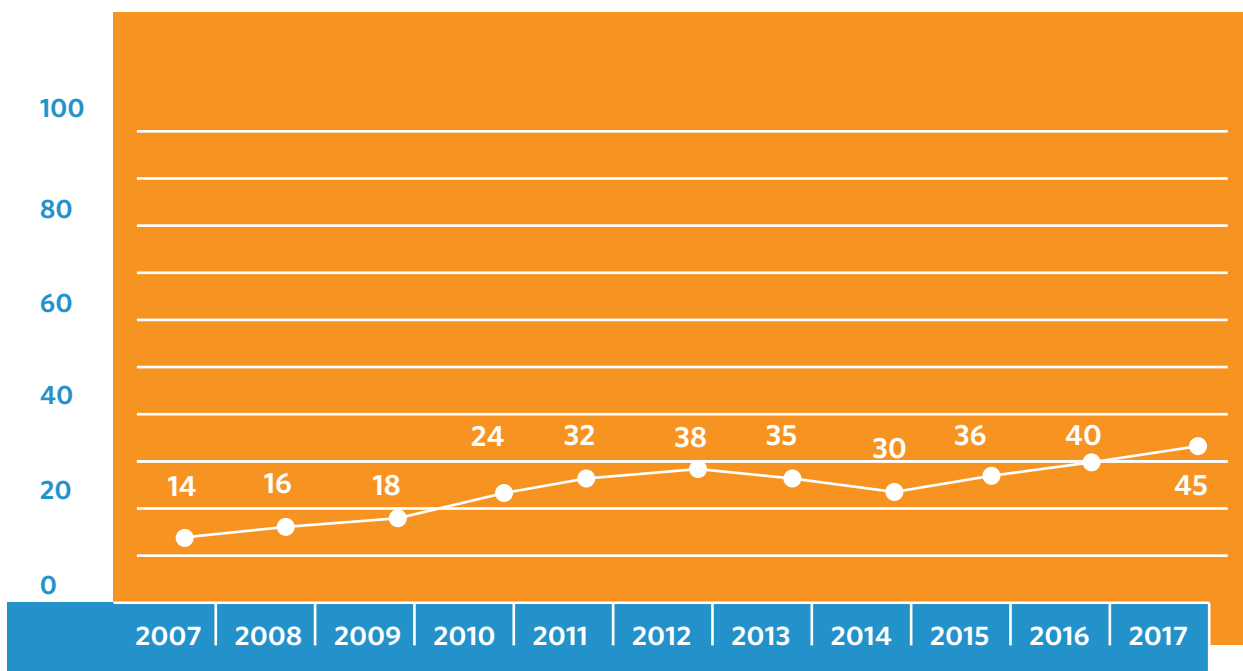
Palestine is experiencing an 'epidemiological transition', due to the chronic stress that people in Palestine face, coincided with sedentary life style, and the change in population structure (demographic transition). In this transition, non-communicable diseases (NCDs) linked to lifestyle and stress (including heart disease, cancer, hypertension and cardiovascular diseases, and diabetes) are gradually replacing infectious diseases as the leading cause of death (MOH 2017). During the transition to NCDs countries face a 'double burden of disease', where the population suffers from high rates of both infectious diseases and non-communicable diseases.

Generally, the hospital bed distribution per population is reasonable at around 1.4 bed per 1,000 population. The health personnel density per population in Palestine is fair and higher than most Arab countries with 17 doctors and 29 nurses per 10,000 population (UNFPA, 2016), while there is a higher density in the GS than the WB (almost double). However, specialty and subspecialty areas, including in midwifery, are greatly under-represented. For instance, in the GS in 2010, there were only around 130 midwives, at a rate of 1.23 per 10,000 (UNRWA employees 93 of the midwives in GS). However, with the recent establishment of many midwifery programs, the number of trained midwives is much higher (around 400), however, many are unemployed. In 2016, the GS succeeded in having two midwives for each 10,000 population, but this is still not the case in the WB. Also, the utilization of midwives in providing RH services is limited, as the system is hyper-medicalized. For instance, while in UNRWA facilities, midwives provide FP services, including insertion and removal of IUDs, at the governmental sector it is the physician's role to insert IUDs. The policy at some NGOs (like the Palestinian Medical Relief Society-PMRS and Cultural and Free Thought Association-CFTA) allows midwives to insert IUDs, and at others, like the Near East Council of Churches-NECC, it is not allowed. This might partially explain the low coverage of FP in the governmental sector.

There is a reasonable gender balance among health personnel in certain professions, such as nursing and pharmacy; but less in others, such as medicine. In medicine, only 16.3% are female (20% in the WB and 12.4% in GS) (UNFPA, 2016). Health insurance is mostly available (more than 90% of HHs are medically insured, but it doesn't fulfil peoples' demands, as few medicines covered or available, there are limited specialized services, and long waiting lists for surgeries (Jones, et al 2016).

While people are generally able to access basic health services under ordinary conditions, access becomes very challenging during conflicts and emergencies. However, access to specialized services outside the GS, such as oncology, radiotherapy, advanced cardiac and neurosurgery, remains a real challenge for the health care system in the GS. In 2016, there was a noticeable decrease in the number of patients permitted by Israel to cross Erez into Israel and the West Bank, and in the approval rates for patients' companions which decreased from 83% in 2015 to 35% in December 2016 (United Nations Office for the Coordination of Humanitarian Affairs-OCHA 2017). In the WB, getting a permit to reach hospitals in Jerusalem, the separation wall, and checkpoints constitute barriers to access. The repetitive wars, blockade, political division and lack of resources, particularly drug shortages (see figure 11) negatively affect access to health services (UNFPA, 2017; MOH, 2017), especially in GS.

Figure 11: % of drug shortage in GS from the essential drug list by years (481 items)-MOH Data 2017

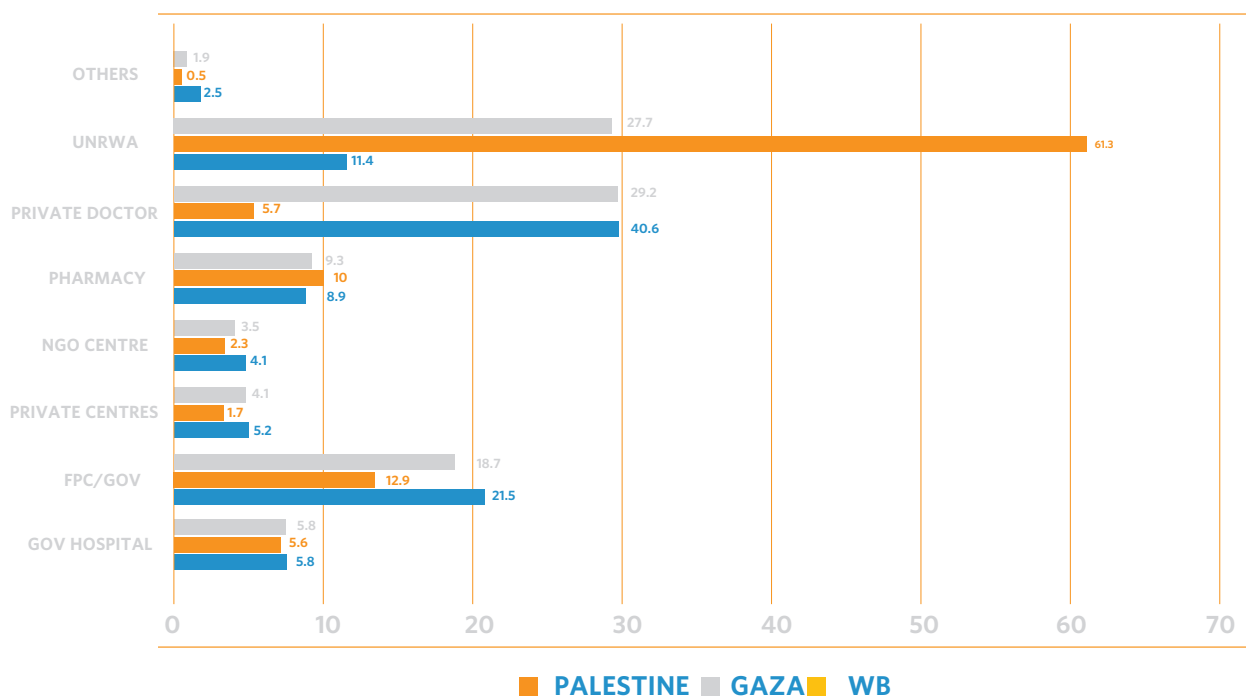


FP services

In 2016, 306 MOH centers provided FP services in the WB, and there were 36,877 new beneficiaries registered in those clinics (MOH, 2017). In the GS, out of the 56 MOH centers, only 17 provided FP services, which served 5,659 women. FP services are provided with only a small copayment charge to all women and it is not required to have health insurance to receive services. At UNRWA, all of the 64 centers operating in Palestine provide FP services. In 2016, there were 12,185 new users and 72,225 continuing users in the GS and 2,721 new users and 23,556 continuing users in the WB served at UNRWA clinics. The Mifath study (2015) indicates that despite the availability of a large number of PHC centers that provide reproductive services, there are many barriers that prevent women from accessing health, including reproductive health and FP, services. The lack of resources among women, especially lack of access to money is the most commonly reported barrier to health care in the WB and GS (48%). Furthermore, depending on the region there are challenges for women in not knowing where to go (10%), having to travel long distances (15%), transportation (15%), not being willing to go alone, and no availability of female providers (25%). About 10% of women indicated that they faced obstacles in seeking health care since they need a permission to get out of the house to seek medical care.



FIGURE 12: DISTRIBUTION OF FP USERS (%) BY SERVICE PROVIDERS IN PALESTINE IN 2016



Surprisingly, at the national level, the main service provider for FP services is the private doctors who provides 29% of the services in Palestine with being much higher in the WB (40.6%) than the GS (5.7%). In addition, 13.4% of FP users reported receiving the FP services from community pharmacies or private institutions. This makes the contribution of the private sector up to 42.6%. This is concerning and raises equity issues about the ability of poor families to secure the needed resources from the private sector. Also, despite having a large number of clinics in the public sector, the private sector is more approached for FP. This might reflect a critical gap in the quality of services in the public sector and other non for profit providers. It is expected that of the level of confidentiality, trust, respect and privacy at the private centers can't be always maintained. On the other hand, buying FP commodities from pharmacies without appropriate counseling or medical checking might be risky. Although the private sector is the main service provider in Palestine, it is usually not targeted by programs implemented by development agencies.

UNRWA is the second main provider after the private sector (27%) and is the main actor in the GS (61%), much more than in the WB (11.4%) due to the higher proportion of refugees in Gaza. Despite running the largest number of clinics, the government ranked third as it provides FP services to 18.7% of users, and is higher in the WB (21.5) than the GS (12.9%). The role of NGOs was limited in both the WB and the GS (3.5%), despite the fact that they receive a large number of commodities. This raises questions about where the efforts and resources aimed at promoting FP services should be directed. Interestingly, it was noticed that the number of methods dispensed to organizations doesn't match with the number of beneficiaries served at these organizations, as they often get significantly more commodities than the number of people they serve. During a focus group discussion with the members of the FP steering committee in Gaza, a key informant said, "We receive condoms but we use them for something else other than family planning. We use them to cover the head of the probe during conducting vaginal ultrasound".

As stated earlier, more midwives are available at UNRWA clinic than at MOH. UNRWA started FP services as an integral part of the Maternal and Child Health care program in 1993, while the MOH started the FP program in 1997. The effect has been reflected in the high coverage of FP services at UNRWA, where the organization covers 61.3% of FP services in the GS (PCBS, 2015). At UNRWA clinics, FP services are integrated into PHC and reproductive health services. This is a strength by itself, as evidence shows that FP is more effective when it is provided integrated with other reproductive health services (Hamad, 2013), as detailed later. Also, at UNRWA, there is strong commitment to FP services which are regarded as essential part of the package of services provided to refugees. UNRWA has rigorous systems for commodity management and relatively stable and reliable financial resources. Also, technical instructions are available for both service delivery and commodity management including using standardized forecasting formula for estimating needs. FP commodities are included in UNRWA's drug list. Since the introduction of comprehensive care through the Family Health Team approach, FP services are provided by the multidisciplinary health team with other services like antenatal, postnatal, child, NCD, and outpatient care.

At MOH, when the FP department was established, it operated as independent, even isolated program with few interactions with other departments including MCH services. There were overlapping responsibilities between the community health department, maternal health department and women's health department. FP service providers at clinics rarely coordinated with other departments such as antenatal or postnatal care. Recently, there is better integration but still, FP services are a vertical program, provided by teams who are specifically designated for this purpose. A structural defect still exists, as FP services are only available at around 30% of the MOH clinics which provide Mother Child Health services (MCH). At MOH, MCH services are only provided at clinics which only have immunization services. Therefore, if the clinic doesn't provide immunization, then it doesn't provide MCH and definitely doesn't provide FP services. Even worse is that FP is only provided at around half of clinics that provide MCH. The centers that do not offer FP services refer women to the closest center offering these services. Hamad (2011) conducted a study about determinants of FP and concluded that integration of MCH and FP in all MOH-PHC centers is essential to increase the possibility that women receive FP services. Availability of MCH and FP services at the same health center was associated with a higher rate of contraceptive use. The first Palestinian National drug list developed in 2002, and the updated list in 2013, incorporated modern FP commodities including IUD, pills, Medroxyprogesterone, male and female condoms and many others. Despite this, until now, policy makers at the MOH

didn't conceptualize FP as essential services and don't regard it as a priority, like the other lifesaving drugs and is therefore often neglected. This was evident during the shortage of FP commodities which continued for several months and no actions were taken by the MOH to fill the stock shortage.

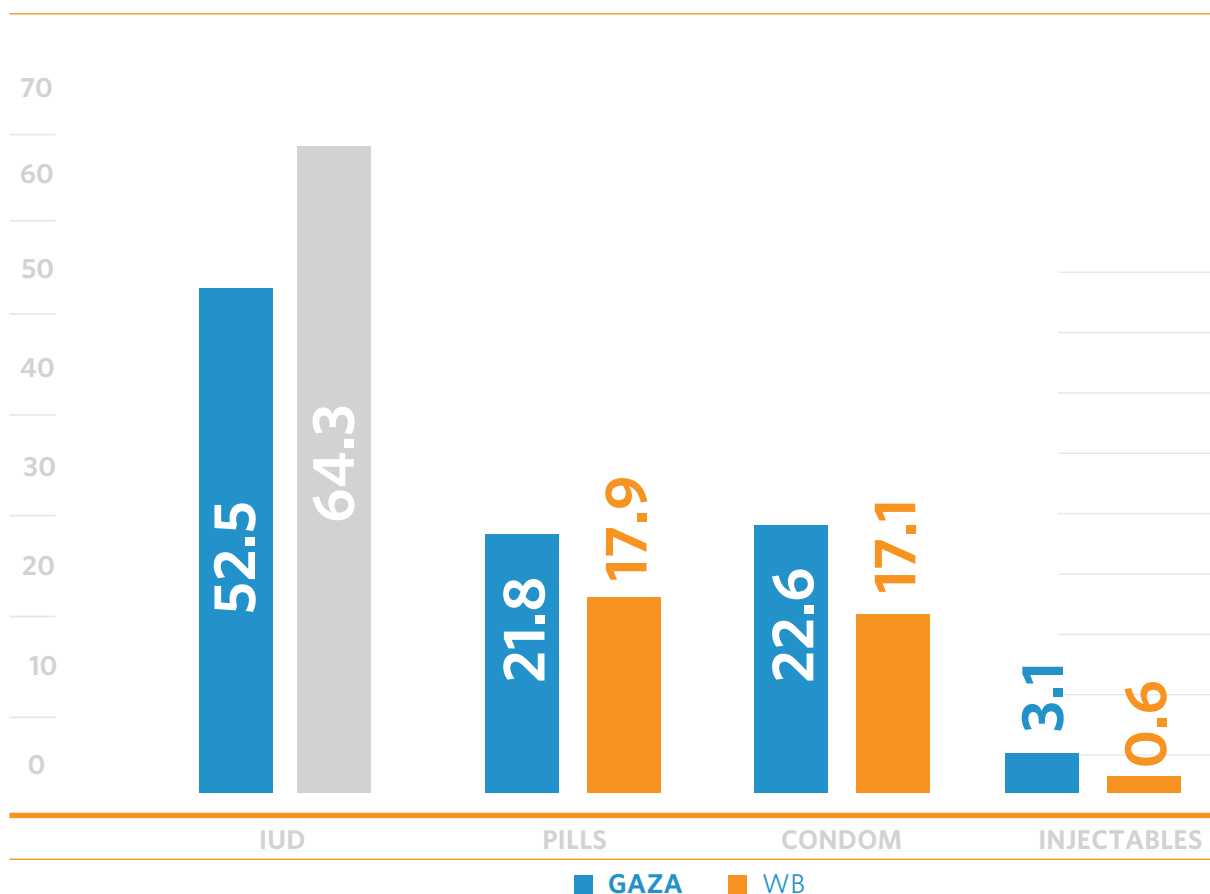
Another important point is the lack of a standardized reporting format, as each organization uses its own system. Surprisingly, the MOH FP report doesn't include NGOs at all. It only includes MOH and UNRWA statistics. Monitoring is also very weak and usually service providers are not adequately followed with clear performance indicators. While FP commodities are part of the pharmaceuticals, it is not usually inspected by pharmacists, it is left to the technical staff (mostly nurses) who are usually not adequately trained on commodity management.

Coordination among FP service providers is generally limited. Therefore, there is duplication of services and waste of resources. Moreover, standardization of FP services doesn't exist, as each organization behaves according to its own regulation in forecasting needs, ordering mechanisms and in service delivery and reporting. For instance, UNRWA follows its own technical instructions that are applicable in the five areas of UNRWA operations. At MOH there is a guideline for FP, but many staff within the MOH are not aware about its existence. Furthermore, many of those who know about the guidelines don't apply it. At the NGOs, either there is no clearly defined protocol, or each organization works on its own policies. For instance, the PMRS uses its own policies. There was an attempt to establish a FP steering committee in Gaza to regulate the work but it didn't function as anticipated. Examples of fragmentation include that at UNRWA, SDPs make orders of FP commodities every two months, while at MOH it is done every month. UNRWA uses a written formula for estimating needed quantities, while at MOH it is more based on the judgement of the nurse or the physician who estimates the amount based on the historical consumption pattern or based on his/her best judgement. A physician said "I should order an amount that is sufficient for 4 weeks, but I make the order for 10 weeks, I afraid from running out of commodities". When health providers were asked when it is possible to insert an IUD for a woman with C-section, some said two months, others said four or even six months. Variations were noticed not only across organizations, but also within the same organization.

There were great differences in methods used, as the MOH report indicates that in 2016 contraceptive pills accounted for 69.6% of the total means used in the WB, condoms ranked second (17.3%), followed by IUDs (12.5%), Medroxyprogesterone (0.5%), and suppositories (0.05%). The MOH report in GS shows that IUDs are used by 44.5% of users, followed by pills (33.3%), and condoms (21.5%). The PCBS data provides a different picture, where pills ranked much lower and the IUD use was much higher in both the WB and Gaza (PCBS, 2015). UNRWA data on refugees has a different method mix (see figure below).



FIGURE 13: DISTRIBUTION OF FP METHODS (%) USED BY REFUGEES SERVED AT UNRWA CLINICS IN THE WB AND GS IN 2016



In UNRWA's five areas of operation (Gaza, West Bank, Jordan, Syria and Lebanon) IUD prevalence was 49%. It was more prominently used in Palestine, especially in the WB, and was higher than the other areas (23.7% in Syria, 42% in Jordan, and 45% in Lebanon). Interestingly, there was a more noticeable change in IUD prevalence in the WB than GS, especially as there was an increase in IUD use and a reduction in the use of pills. There was a slight increase in condom use in GS. These figures contradict what has been reported by the MOH as referred above. The difference could be attributed to discrepancies in documentation and methods of calculating, rather than actual differences in the method mix. If there is an actual difference, it could be attributed to providers' attitudes, perspectives and influence on service provision, which may be regarded as a violation of the human rights approach. Service provider statistics revealed that many of them double count cases and confuse cases with visits. Figures below show the change in the method used by refugees as reported by UNRWA.



FIGURE 14: TRENDS OF FP METHODS USED (IN %) BY REFUGEES SERVED BY UNRWA IN THE WB - AS REPORTED BY UNRWA HEALTH REPORTS

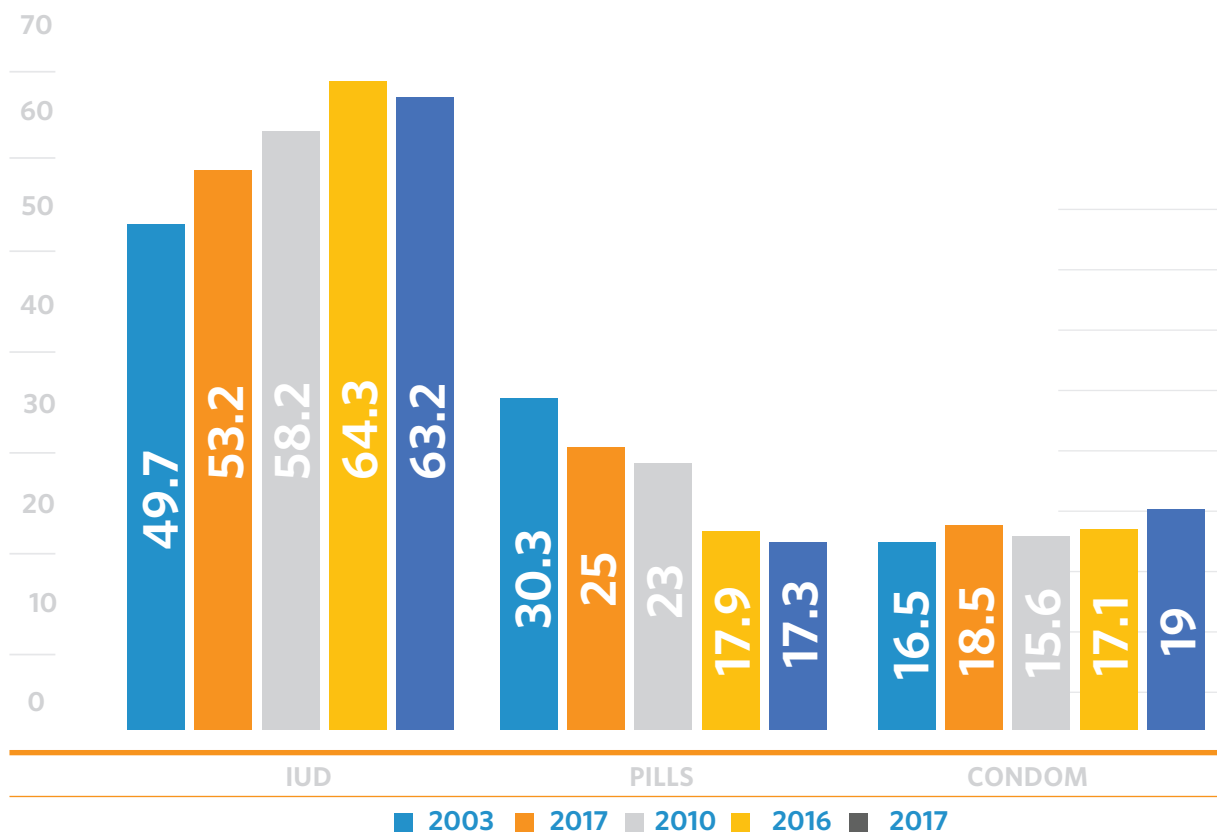
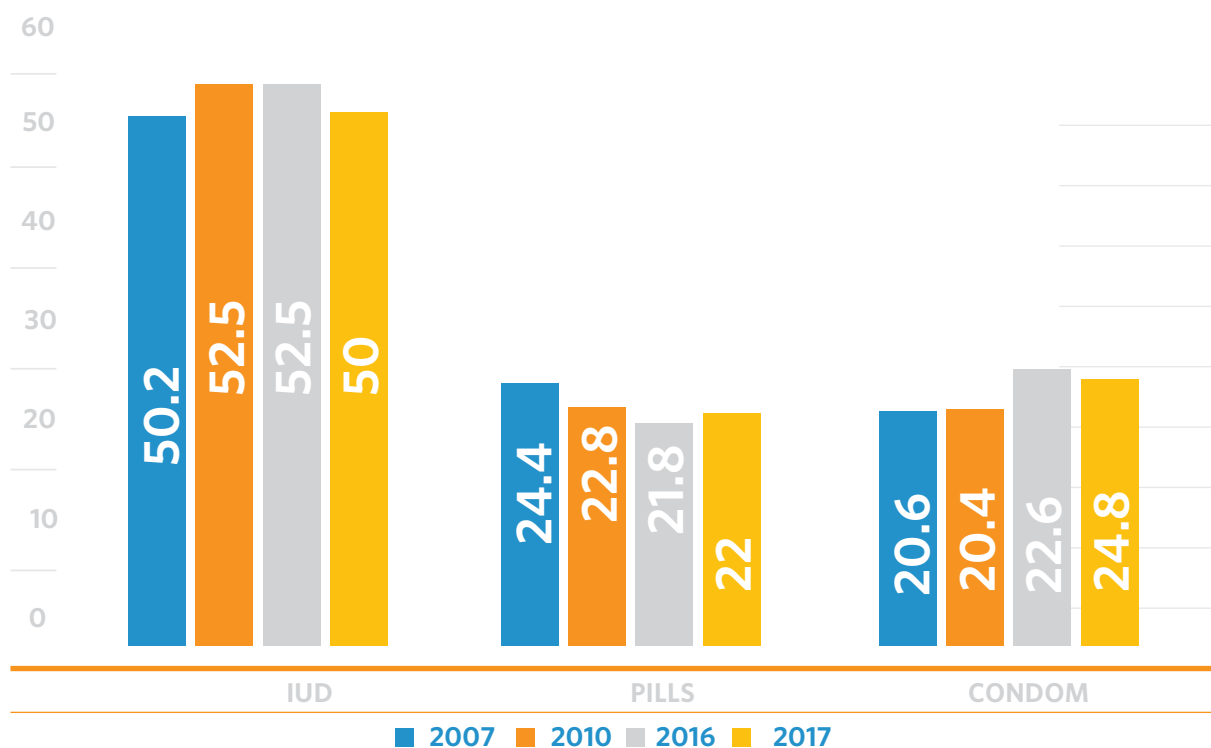




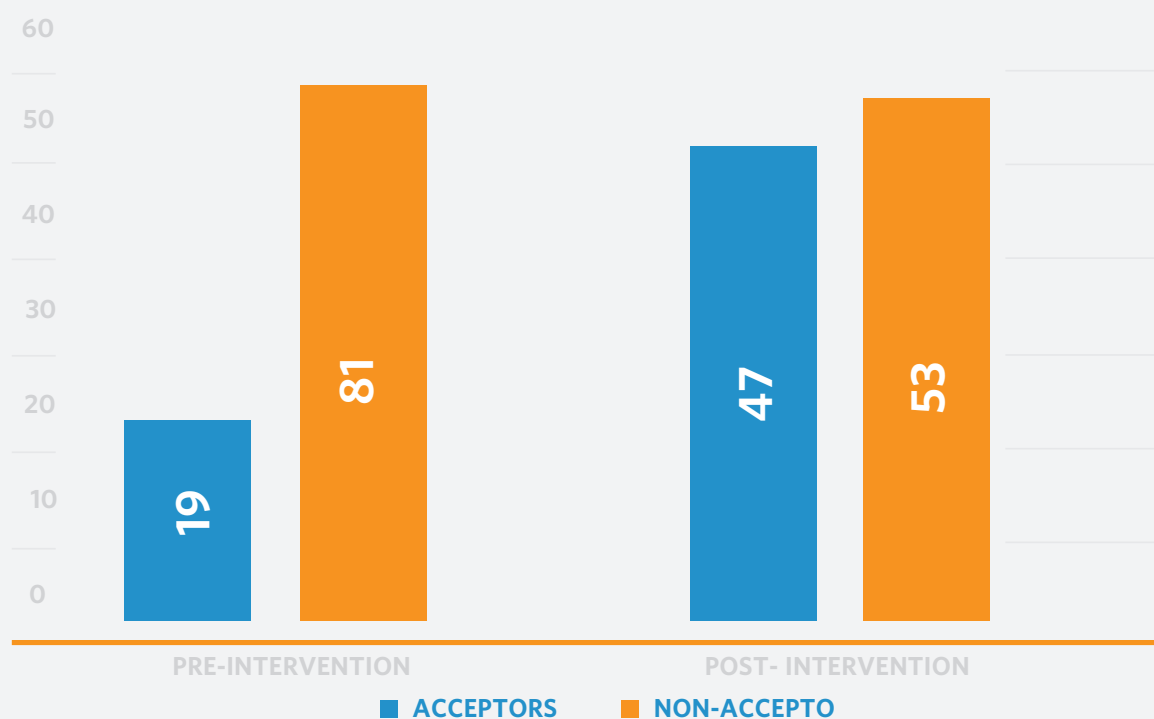
FIGURE 15: TRENDS OF FP METHODS USED (IN %) BY REFUGEES SERVED BY UNRWA IN GS-AS REPORTED BY UNRWA HEALTH REPORTS



Empirically collected data confirms that caveats in FP include limited access to information on FP methods and weak counselling, which negatively affected utilization. As a result of social, cultural, political, economic and legal pitfalls, women and girls often face particular challenges to their enjoyment of their full SRHR which includes autonomous access and utilization of FP. For instance, traditionally, the consent of the partner on using the FP by women is a prerequisite for receiving services. This is regarded as a violation of SRHR; however, partner consent is required less now than in the past. Counseling plays an important role in enhancing the utilization of family planning as illustrated in box 5 below.

The Director of UNRWA Nusirat Clinic in Gaza noticed that the number of new FP acceptors during the post-partum period is limited. Therefore, in coordination with Al-Quds University, a quality improvement initiative was launched to enhance counseling practices during the post-partum period, including FP counseling.

Pre-intervention measurements indicated that the percentage of new acceptors of FP was 18%. A change in the patient flow was introduced so that non-acceptors were referred by the midwife to the senior staff nurse for more in-depth counseling. Through counseling alone, in 4 weeks, there was a significant increase in the percentage of new acceptors (47%). This gives an example how field initiatives, which cost little or no money, can have a large impact (see graph below).



It is also noted that training and capacity building in FP is limited. Previously, many training courses were provided, but these are less common now. FP should be re-categorized as a priority topic in capacity building and training. Training needs to focus not only on technical standards, but also on staff perceptions and attitudes, proper recording and reporting, supervision and management of services, administration of commodities and most importantly, the rights based approach to quality FP services.

STATISTICS ABOUT FP SERVICE PROVISION

MOH

According to the 2015 MOH annual report, FP services were provided in a total of 306 centers of these 289 in the WB and 17 centers in the GS. The total number of users of FP services was 82,115 of these 41,554 were new acceptors (38,556 in the WB and 2,998 in the GS). Among the new users, contraceptive pills was the most commonly used method with 68.3% of users (70.1% in the WB and 44.5% in the GS), followed by male condoms with 18.7 % (17.8 % in the WB and 29.8% in the GS), IUDs with 12.6 % (11.7 % in WB and 24.7 % in GS) and Medroxyprogesterone with 0.4% (0.1% in WB and 1.0% in GS). During the period 2010-2015- the number of new acceptors

increased by 117% from 19,094 in 2010 to 41,554 in 2015, while the total number of visits from continuous users increased by 18.3% from 69,436 in 2010 to 82,115 in 2015.

The data from the GS revealed that the number of users has significantly increased, especially in 2016. The increase could be attributed to the increase in the size of the population and also an increase in the number of beneficiaries attending the MOH facilities, possibly due to inability to seek private services. The type of method used is another story were according to our calculation (which is different from what is reported by MOH) pills were more reported as the most commonly used method followed by IUD and then condom. The variation between what is reported by MOH and PCBS is a result of variation in the calculation more than actual variations in the use. The use of FP increases with age (table 5), which didn't change significantly between 2010-2017-.

TABLE 3: NUMBER OF BENEFICIARIES OF FP SERVICES AT MOH CLINICS IN GS

YEAR	NEW	FOLLOW UP	TOTAL
2010	1920	17019	18939
2011	3475	33787	37262
2012	3842	41376	45218
2013	3683	48117	51800
2014	3258	46868	50126
2015	3087	41347	44434
2016	4444	28849	33293
2017	4001	37926	41927
TOTAL	27710	295289	322999

TABLE 4: DISTRIBUTION OF BENEFICIARIES BY TYPE OF METHOD USED AT MOH CLINICS IN GS

YEAR	IUD	PILLS	CONDOM	MEDROXYPROGESTERONE
2010	23%	51%	22%	4%
2011	22%	47%	29%	2%
2012	20%	51%	28%	1%
2013	21%	49%	29%	1%
2014	21%	47%	31%	1%
2015	26%	43%	30%	1%
2016	29%	42%	27%	1%
2017	28%	46%	25%	2%

TABLE 5: DISTRIBUTION OF BENEFICIARIES AT MOH CLINICS IN GS BY AGE

AGE GROUP	2014	2015	2016	2017	AVERAGE
< 20	3%	3%	3%	3%	3%
20 - 30	51%	50%	49%	49%	50%
>30	47%	47%	48%	48%	47%

UNRWA

FP services are provided as an integral part of the maternal health package of services through the Family Health Team model. In 2015, FP services were provided in 43 health centers in WB and 22 health centers in GS. The total number of new FP acceptors was 12,772 (10,198 in GS and 2,574 in WB), while the total number of continuing users receiving regular supplies and services was 91,331 (66,567 in the GS and 24,764 in the WB). Among the continuous users, IUDs were the most common (51.8% in the GS and 61.1% in the WB), followed by pills (25.7% in the GS and 20% in WB), male condoms (19.1% in GS and 17.6% in WB) and Medroxyprogesterone (3.3% in the GS and 1.3% in the WB). From 2010-2015- the number of new acceptors increased by 9%, while the total number of continuous users increased by 29.3%.

UNRWA data in GS shows more consistency than other service providers and a gradual increase in the number of beneficiaries. In the past eight years, there was an increase by 31% in the number of new beneficiaries and 52% in the number of follow up cases. Consistent to what was reported by the PCBS and UNRWA health report, IUDs (around 50%), pills (around 22%) and condoms (around 20%) were the most commonly used methods in Gaza. No differences were noticed regarding the age of users from what was reported by MOH, at both MOH and UNRWA facilities. Older women tend to use FP much more than the younger ones. The peak use was among women 20-34 years.

TABLE 6: NUMBER OF BENEFICIARIES OF FP SERVICES AT UNRWA CLINICS IN THE GS

YEAR	NEW ACCEPTORS	FOLLOW UP
2010	9256	40541
2011	10841	43857
2012	11058	47943
2013	10639	52009
2014	9705	51969
2015	10198	56369
2016	12185	60040
2017	12188	63759
TOTAL	86070	

New: used FP method for the first time

Follow up: continued users who receive their FP supplies regularly from an UNRWA clinic

TABLE 7: DISTRIBUTION OF METHODS USED BY BENEFICIARIES AT UNRWA CLINICS IN GS

YEAR	IUD	PILLS	CONDOM (MALE AND FEMALE)	MEDROXYPROGESTERONE	SPERMICIDE
2010	52.5%	22.8%	20.4%	3.6%	0.7%
2011	51.6%	25.8%	16.0%	2.4%	0.6%
2012	55.8%	21.5%	18.9%	3.3%	0.5%
2013	55.9%	21.2%	19.5%	3.0%	0.3%
2014	56.3%	21.1%	19.1%	3.2%	0.1%
2015	56.1%	21.4%	19.1%	3.5%	0.1%
2016	52.5%	21.8%	22.6%	3.1%	0.0%
2017	50.5%	22.0%	24.3%	3.2%	0.0%

TABLE 8: DISTRIBUTION OF BENEFICIARIES AT UNRWA CLINICS IN GS BY AGE

	2014	2015	2016	2017	AVERAGE
< 20	2%	1%	2%	2%	2%
20 - 34	60%	61%	60%	59%	60%
>34	38%	38%	39%	39%	39%

NGOs

Many NGOs in Palestine provide FP services, however, their overall contribution to service coverage is less than 5%, indicating underutilization. As NGOs are smaller and less bureaucratic than UNRWA or MOH, they represent a missed opportunity to test new models and approaches for FP services, such as providing FP services within a human rights framework and trying community mobilization models. As grassroots organizations focus on vulnerable people, it is also an opportunity to reach particularly marginalized groups. However, it was found that many NGOs receive FP supplies from MOH and theoretically provide FP services, but in reality, FP services are not regarded as essential, as they don't generate income for the organization. Provision of services is limited, seasonal and often only provided when MOH provides commodities. In addition, NGOs are often selective in FP methods they provide, as they usually only provide cheaper commodities and methods that have high potential for cost recovery from clients' payments or reduced fees. For example, NECC doesn't provide Medroxyprogesterone and RCS-GS doesn't provide progesterone only oral contraceptives. This raises questions about the organization and regulation of services, respecting client's choices, and hindering continuity of services. Moreover, not all the NGOs who receive FP commodities from MOH provide services, as commodities received are sometimes used for other purposes. More details are available later in the report. In the coming paragraphs we provide a description of the FP services provided at the main NGOs working in Palestine.

Palestinian Medical Relief Society (PMRS)

PMRS is one of the largest health NGOs hosting a number of health, rehabilitation and community-based services in the WB and the GS. In addition to PHC services provided through a network of centers and mobile teams, PMRS has a well-established youth, women's health and community-based rehabilitation program. A center for chronic diseases in Ramallah provides diabetes and cardio-vascular care in a holistic approach. A network of trained volunteers provides first aid in times of crises, especially in hot spots.

PMRS runs 26 PHC centers in the WB and GS. Most of these clinics are located in rural or marginalized areas. These PHC centers offer services in general medicine, child health, management of chronic disease, emergency care, and provision of medications. 23 of these centers provide women's health services, nine provide dental and oral health services, and 19 are equipped with laboratories.

They provide five modern contraceptive methods including IUDs, the two types of pills, condoms and Medroxyprogesterone. They used to receive regular supplies from the MOH central stores. During the last three years the supply became irregular, which affected the continuity of care at service delivery level. The average monthly consumption (AMC) of IUDs at the organization is 100 pieces, however, in 2015 they received 800 and only 300 pieces in 2016. The other methods were also out of stock for long periods in 2016 and 2017. They submit regular reports to the MOH and they receive supplies every three months. The organization doesn't have alternative procurement plan, however, when funds are available, they buy from the local market at a high price. They charge minimal fees for FP services based on the method that is used. They have sufficient and adequate storage capacity and prefer to receive their needs on annual basis. This will help them to plan their needs and ensure continuity of care.

Data on PMRS services in GS shows that the number of new beneficiaries and the number of follow up cases is not increasing, despite the increase in the population size. Similar to most NGOs, there is a lack of standardization on how the method mix is being calculated. Pills are the most commonly used method as reported.

TABLE 9: NUMBER OF BENEFICIARIES OF FP SERVICES AT PMRS CLINICS IN THE GS AS REPORTED BY THE ORGANIZATION

YEAR	NEW	FOLLOW UP	TOTAL
2011	300	908	1,208
2012	239	728	967
2013	311	549	860
2014	238	837	1,075
2015	289	380	669
2016	239	285	524
2017	215	370	585
TOTAL	1,831	-	-

TABLE 10: DISTRIBUTION OF METHOD MIX USED BY BENEFICIARIES AT PMRS CLINICS IN THE GS

YEAR	IUD	PILLS	CONDOM	MEDROXYPROGESTERONE
2011	14.0%	51.9%	19.6%	14.5%
2012	11.4%	57.8%	18.6%	12.2%
2013	13.8%	58.5%	7.9%	19.8%
2014	11.2%	65.8%	8.4%	14.7%
2015	17.2%	64.6%	9.6%	8.7%
2016	23.3%	53.6%	15.1%	8.0%
2017	16.8%	68.7%	8.2%	6.3%

TABLE 11: DISTRIBUTION OF BENEFICIARIES AT PMRS CLINICS IN THE GS BY AGE

AGE GROUP	2011	2012	2013	2014	2015	2016	2017	AVERAGE
< 20	0%	24%	1%	2%	0%	2%	0%	4%
20 - 30	30%	50%	28%	44%	46%	41%	61%	43%
>30	70%	25%	71%	55%	54%	57%	39%	53%

Near East Council of Churches (NECC)

NECC is part of the Department of Service to the Palestine Refugees (DSPR). The DSPR is a department of the Middle East Council of Churches. NECC Gaza Committee was founded in 1952, launching a humanitarian program to assist Palestinians who took refuge in the GS following the establishment of Israel in 1948. Since then, NECC has focused on the provision of humanitarian aid and contributing to an overall improvement in living conditions and poverty alleviation. Its work has rested on respecting the humanity and dignity of those whom it helps and on adherence to clear transparency and accountability standards. The NECC's health program offers a comprehensive package of health services, with a particular focus on PHC services. The bundle of services includes essential MCH services such as preconception care, antenatal care, postnatal care, health education, family planning, well-baby care, psychosocial services, home visits, treatment for malnourished children, and dental services. The number of new beneficiaries hasn't significantly changed, however, the number of follow up cases has doubled. NECC used to provide basic FP services, including the five methods and had a thorough follow up system. However, recently, because Medroxyprogesterone is not provided by MOH and is expensive, it hasn't been available since 2012. Beneficiaries pay minimal fees to get FP services (10 NIS for the IUD). Again, the method of calculating the method mix is not standardized and isn't totally reliable.

TABLE 12: NUMBER OF BENEFICIARIES OF FP SERVICES AT NECC CLINICS AS REPORTED BY THE ORGANIZATION

YEAR	NEW	FOLLOW UP	TOTAL
2010	455	435	890
2011	270	488	758
2012	308	559	867
2013	322	669	991
2014	280	628	908
2015	375	807	1,182
2016	491	895	1,386
2017	437	926	1,363
TOTAL	2,938	-	-

TABLE 13: DISTRIBUTION OF METHOD MIX USED BY BENEFICIARIES AT NECC CLINICS IN THE GS

YEAR	IUD	PILLS	CONDOM	MEDROXYPROGESTERONE
2010	11%	26%	62%	1%
2011	9%	21%	69%	1%
2012	7%	30%	63%	0%
2013	6%	30%	63%	0%
2014	7%	31%	62%	0%
2015	8%	35%	57%	0%
2016	9%	34%	57%	0%
2017	8%	32%	61%	0%
AVERAGE	8.1%	29.9%	61.7%	0.4%

TABLE 14: DISTRIBUTION OF BENEFICIARIES AT NECC CLINICS BY AGE

AGE GROUP	2010	2011	2012	2013	2014	2015	2016	2017	AVERAGE
< 20	2%	4%	4%	5%	4%	3%	4%	6%	4%
20 - 30	78%	65%	67%	66%	72%	71%	71%	71%	70%
>30	20%	31%	29%	29%	25%	26%	25%	23%	26%

CULTURE AND FREE THOUGHT ASSOCIATION (CFTA) AND RED CRESCENT SOCIETY (RCS-GS)

The CFTA and the RCS-GS are Palestinian institutions that aim to strengthen the capacities of civil society in the GS through integrated programs for children, youth, and women. For many years, CFTA has been running Bureij center in the mid-zone which provides comprehensive reproductive and women health services. Also, RCS provides health and social services in Jabalia center, GS and also in the south. In GS, UNFPA supported two women health centers, Jabalia center in the north of GS and Bureij center. The two centers were established with the vision of providing comprehensive services for women, going far beyond the dominant medical model at PHC centers implemented at UNRWA and MOH clinics at that time. The two centers provide comprehensive services for women including ANC, PNC, vitamin and mineral supplementations, FP services, physiotherapy and sport services, psychosocial and legal counseling, breast cancer related services, and others. Health education and awareness services are also provided including providing sessions about RH, right-based approach, GBV, capacity building and civic participation. CFTA provides FP services using a human rights framework, including controlling GBV. In 2014 UNFPA supported a pilot trial to introduce implants as a new FP method and results were encouraging. The following paragraphs show the number of beneficiaries served by these two centers.

Data shows that the number of beneficiaries served by CFTA is increasing for both new and follow up cases. Data before 2013 is not electronically available. The distribution of methods used is not reliable, as it hasn't been calculated appropriately. The organization receives FP commodities from MOH but is based on availability at the central store. In addition, when the main store has shortages, the organization procures them separately, as the management is committed to securing the needed items.

TABLE 15: NUMBER OF BENEFICIARIES OF FP SERVICES AT CFTA CLINICS IN GS AS REPORTED BY THE ORGANIZATION

YEAR	NEW	FOLLOW UP	TOTAL
2013	165	0	165
2014	92	116	208
2015	318	164	482
2016	391	302	693
2017	486	353	839
TOTAL	1,452	-	-

TABLE 16: DISTRIBUTION BY METHOD USED BY BENEFICIARIES AT CFTA CLINICS IN GS AS REPORTED BY THE ORGANIZATION

YEAR	IUD	PILLS	CONDOM	MEDROXYPROGESTERONE
2013	1%	71%	24%	5%
2014	1%	63%	30%	6%
2015	18%	44%	34%	5%
2016	25%	40%	29%	6%
2017	26%	37%	31%	7%

TABLE 17: DISTRIBUTION OF BENEFICIARIES AT CFTA CENTERS IN GS BY AGE AS REPORTED BY THE ORGANIZATION

AGE GROUP	2013	2014	2015	2016	2017	AVERAGE
< 20	0%	0%	1%	0%	2%	1%
20 - 30	60%	47%	62%	54%	60%	56%
>30	40%	53%	37%	46%	39%	43%

TABLE 18: NUMBER OF BENEFICIARIES OF FP SERVICES AT RCS-GS CLINICS AS REPORTED BY THE ORGANIZATION

YEAR	NEW	FOLLOW UP	TOTAL
2013	199	0	199
2014	150	100	250
2015	161	100	261
2016	99	84	183
2017	68	107	175
TOTAL	677	-	-

TABLE 19: DISTRIBUTION OF METHOD USED BY BENEFICIARIES AT RCS-GS

YEAR	IUD	PILLS	CONDOM	MEDROXYPROGESTERONE
2013	34%	46%	11%	9%
2014	36%	40%	16%	9%
2015	20%	50%	20%	10%
2016	39%	38%	23%	0%
2017	47%	26%	22%	5%

TABLE 20: DISTRIBUTION OF BENEFICIARIES AT RCS-GS CENTERS BY AGE

AGE GROUP	2013	2014	2015	2016	2017	AVERAGE
< 20	4%	1%	1%	0%	1%	1%
20 - 30	64%	56%	59%	62%	55%	59%
>30	32%	44%	41%	38%	45%	40%

The Palestinian FP and Protection Association (PFPPA)

The PFPPA established in Jerusalem in 1963, is an independent non-profit association with full membership of the International Planned Parenthood Federation (IPPF). Its executive office is based in Jerusalem and it has six branches and youth centers scattered throughout the WB and the GS. PFPPA primarily provides various services in sexual and reproductive health (SRH), where it offers training for young leaders and staff from other governmental and non-governmental organizations. Moreover, it provides, inter alia, medical services in women's health, laboratory tests, counseling, awareness raising, advocating for women rights, conducting applied research, and organizing lobbying and advocacy campaigns to influence national policies. In 2015 the PFPPA provided FP services to 4,615 clients, of which 1,065 were follow up users. IUDs were the most common method among new acceptors, at 70% of all new users. Despite the irregular supplies from the MOH central stores from 2015-2017, PFPPA did not experience stock outs of any method in their clinics, due to their efficient procurement system. The system ensures a minimum level of three months and a maximum of six months stock at health facility level and 18 months of supply at central level. If the stock level in the clinic reaches three months consumption level, they ask for a new order to replenish their stock to six months. In GS, the activities of PFPPA has sharply decreased in the past several years. For several years, the organization played an important role in initiating and supporting FP services in Gaza, but unfortunately not anymore.

TABLE 21: METHOD MIX AND FP SERVICES PROVIDED IN 2015 BY THE PFPPA IN THE WB AS REPORTED BY THE ORGANIZATION

MEDROXYPROGESTERONE	NEW	RETURNING	TOTAL
COMBINED PILLS	125	1,863	1,988
PROGESTERONE ONLY	85	311	396
MEDROXYPROGESTERONE	16	90	106
IUD	748	748	1,496
CONDOM	82	527	609
EMERGENCY CONTRACEPTION	9	11	20
TOTAL	1,065	3,550	4,615

The Union of Health Work Committees (HWC)

HWC was established in 1985 as NGO by a group of volunteers and now provides medical care through a network of 13 centers and clinics across the geography of the WB, in addition to six centers in GS. Mobile health teams in south and north WB respond to the needs of isolated communities. They have a special program on breast cancer in Ramallah, offering comprehensive diagnostic services in addition to community-based and outreach programs providing health education. During 2014 a total of 2,782 FP services were provided.

Box 6: Policy implications for the governance of FP services

- FP services are not adequately framed, poorly regulated and poorly governed with no clear catchment areas and clear roles and responsibilities for the different providers. It is essential that MOH invest more efforts in regulating FP services with clearer accountability mechanisms. There is a need to streamline/standardize concepts, definitions, criteria, service delivery, human resources and processes related to FP.
- Political commitment to FP should be enhanced. FP should be conceptualized more as an essential right based service, not a luxury service. There is a need to set a legal framework to protect and regulate reproductive rights, including FP.
- Given that the MOH is mandated not only to provide basic health services, but also to regulate service provision, MOH should be more engaged in regulation and coordination. MOH should do better in term of coordination at policy level including at the supply and service provision aspects. This includes, better standardized service delivery processes, better standardized reporting and setting measures to ensure quality and increase the rational use.
- FP services lack clear standards and protocols that are applied by service providers. Although there is a guideline for FP developed with support from UNFPA, most organizations are not aware of it. The study shows that different organizations use different standards and sometimes within the same organization there are variations in practice. It is important to reactivate the guideline, train providers on its use and adequately monitor the compliance of the protocol.
- FP services lack adequate monitoring and supervision. It is important to set performance indicators and to track these indicators. The role of MOH should not only be restricted to provide NGOs with commodities when they are available, but also to follow up the adequate utilization within an acceptable quality standard of service.
- Activating and expanding the role of the FP steering committee to set standards and monitoring systems for the service provision, regulation, and financing is essential.
- It is important to strategically integrate FP services within the reproductive health

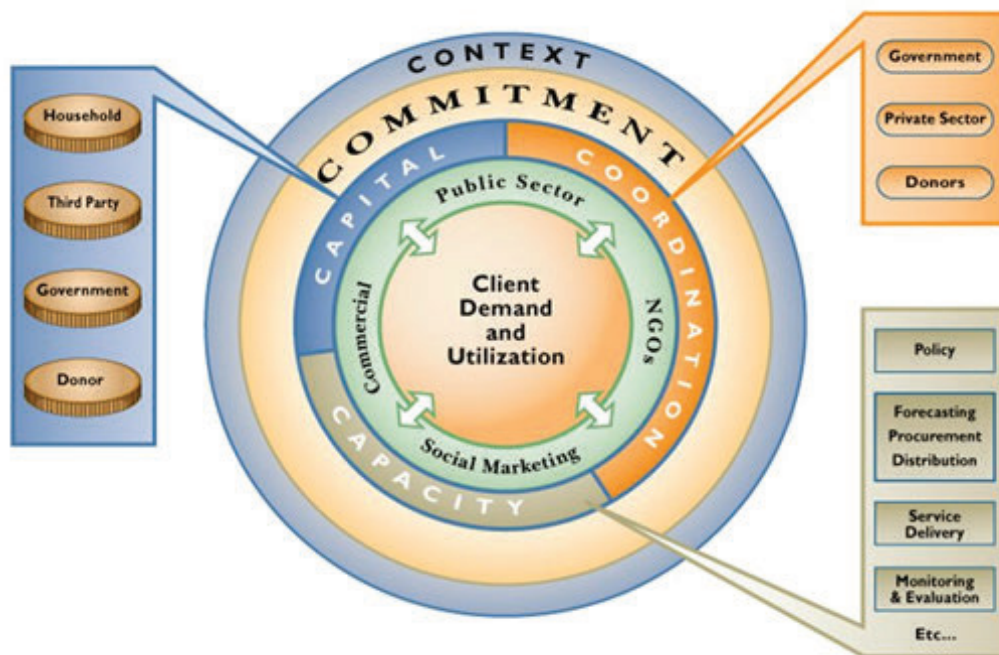
services at PHC centers, as this increases access and utilization. The fact that only 30% of PHC centers at the MOH provide FP, constitutes a major barrier for service utilization.

- The analysis of the available data flags that the main provider of FP services in Palestine is the private sector (more than 40%), followed by UNRWA, then MOH and lastly the NGOs. This has significant implications in terms of understanding drivers for selecting providers, equity and quality of services at different providers, and most importantly, the target of programs aiming to promote the quality of the service provision. The ability of women from poor families to access private and expensive FP services raises concern (out of pocket health expenditure should be not more than 20%). Also, the utilization of services in the private sector, especially community pharmacies, might jeopardize safety and expose users to risks. UNFPA and MOH should engage the private sector in efforts aimed at improving quality of services.
- Issues that require urgent corrective measures include improving quality of services, promoting counselling and informed choices, and changing providers' attitude towards FP, which discourages women from seeking FP services.
- Training for healthcare providers in FP is limited. Due to uncertainty, conflict, and many competing issues on the agenda of policy makers, not enough attention is being paid to training in FP. Further investment in training of staff and on-the-job supervision is highly needed. There is a need to further support the capacity of managers to coach and supervise employees. Training should not only focus on technical issues, such as protocols and commodity management, but also on the rights-based approach for SRH. Ensuring the provision of age and gender appropriate services is a must. With their "caring" more than "curing" orientation, utilization of midwives in providing FP services is essential.
- Documentation practices are fragmented. Each organization uses their own forms and calculation formulas, which are not necessarily appropriate and results in incorrect information. Therefore, standardizing documentation practices, using nationally endorsed forms, and developing a national electronic database is essential for tracking performance indicators and informing policies.

Commodity security

Many countries face the challenge of meeting the rising demand for contraceptives, which results not only in financial constraints but often also in disruptions and vulnerabilities in the systems that need to work well, work together and have the resiliency to adapt to changes to ensure that reproductive health supplies are available to people at all times (Hare, et al 2004). Therefore, FP commodity security (CS) is not only a problem of increasing financing for supplies, but also of improving the systems needed to make the supplies available to users. FP CS exists when every person is able to choose, obtain, and use quality contraceptives whenever they need them. CS came from a growing realization that, alone, strong supply chains cannot ensure availability of, and access to, FP commodities. CS requires strong national leadership, sufficient financing, supportive policies and regulations, active coordination among partners, and adequate service delivery (Rao, 2008).

Policy makers and providers' commitment to FP is very important to ensure that the different service channels have resources and capacity, and are coordinated to respond effectively to clients' needs. There needs to be a clearly articulated policy commitment to making and keeping contraceptives and other essential supplies available to people as a public health priority. Number, qualification and capacity of service providers can limit or promote FP CS. For example, the number and skills of providers are important. For instance, their capacity to provide counselling services and their awareness about gender norms play an important part. Service providers cannot do their jobs without reliable supply chains delivering the "six rights": the right product, to the right place, at the right time, in the right quantity, in the right condition, for the right price. A pre-requisite is having a clear forecasting mechanism, which doesn't exist in Palestine. In order to ensure that service providers and logistics systems have adequate quantities of supplies, timely and coordinated forecasting and procurement must take place, using financing from a variety of sources. Also, FP CS is based upon collaboration and joint action planning. Coordination is required at multiple levels and among different stakeholders including among government, UNRWA, NGOs and other providers. The graph below provides a framework for CS.



Effective coordination helps avoid duplication of efforts and promotes information sharing across and between programs. Strengthening CS requires routine monitoring of information. International experience suggests FP CS requires a number of prerequisites as outline in box 7.

Box 7: Pre-requisites to FP commodity security

- Reinforcement of commitment and leadership to regard FP CS as a priority.
- The ability to accurately forecast and quantify of commodities needed to provide FP services.
- Coordination between all the major stakeholders, including different departments within the MOH, UNRWA, international donors, NGOs and the private sector.
- Finances mobilized to meet forecast needs for FP commodities.
- The capacity to procure commodities at the best possible prices and quality.
- Well-functioning logistics systems to ensure the delivery of commodities in the right time, at the right place, and to the right person in the supply chain.
- Partnership with the private sector to work on service delivery and product availability at competitive prices.
- Rational use by competent service providers to ensure the most cost-effective methods are used to meet client's needs.

From 2008 to 2018, UNFPA supported the provision of the five main FP commodities (IUDs, condoms, pills -combined and progesterone, and Medroxyprogesterone) as an area of harmonized service provision within the public sector. The MOH in its capacity as the umbrella of the healthcare services in Palestine, distributed these supplies to the other service providers. FP service providers in the MOH, UNRWA and NGOs used to receive regular supplies from the central stores of the MOH in Nablus. While it was a good idea to centralize the supply chain of FP commodities, it hasn't been associated with appropriate regulation for coordinating service provision. As with other services, FP services are largely unregulated, fragmented, and poorly documented and monitored. For instance, many providers receive commodities from MOH but don't seriously engage in service provision. Some organizations only provide services seasonally when they receive supplies from MOH. Also, coverage, catchment areas, roles and responsibilities are poorly defined. Moreover, MOH doesn't have a strategic plan about who should receive what and which amounts and doesn't perform any follow up after dispensing commodities to organizations.

In 2015, UNFPA decided to reduce the dependence of the health sector on the support provided by UNFPA for procuring FP commodities. The aim was to increase ownership and commitment of the local health system to FP services. Although UNFPA is still committed to support FP, the organization doesn't want to be the first choice for financing these commodities. The national health care system should do that, especially as FP commodities are listed in the Palestinian Essential Drug List since 2002. The cost of FP commodities is not high, less than 2% of the overall pharmaceuticals procured in the different sectors. Unfortunately, the process of transition wasn't smoothly implemented and created distress for the system and frequent stock rupture. One senior person at MOH said 'It was shocking to hear that UNFPA will not provide commodities, it's a disaster, no one is going to provide these commodities. This came on top of financial constrains facing the health care system and lack of consensus among policy makers that securing FP commodities is a priority. It is preferable that UNFPA develops an exit strategy and coordinates better with the different sectors to ensure continuity of the services. After discontinuation of regular funding for FP commodities, for a short period of time, UNFPA continued to secure FP methods through emergency funds. UNRWA decided to allocate part of its core budget to procure FP methods, benefiting from UNFPA international bidding system. The procurement of commodities by UNRWA is cost effective and UNFPA takes commission for performing that. All NGOs were surprised when the MOH in GS stopped supplying them with commodities they need. Some NGOs started to procure their needed FP commodities, while others stopped service provision. Sometimes the MOH provided supplies to some NGOs, at the same time that they receive donations from other parties, especially during emergencies.

Another complexity reported by UNRWA is that they are not sure whether the UNFPA will procure commodities or not in the future. This confuses the organization and causes uncertainties, as they are not sure about UNFPA plans. In certain years, they didn't allocate resources because they were promised to receive commodities from UNFPA. Then they didn't receive them or received them with a lot of delay. In other years, they procured from the organizations own resources and then UNFPA provided them with large quantities of some commodities. In the two scenarios, there are limitations which affected the smooth-running of UNRWA's FP program. Therefore, UNFPA needs to have a clear strategy and to communicate that to partners.

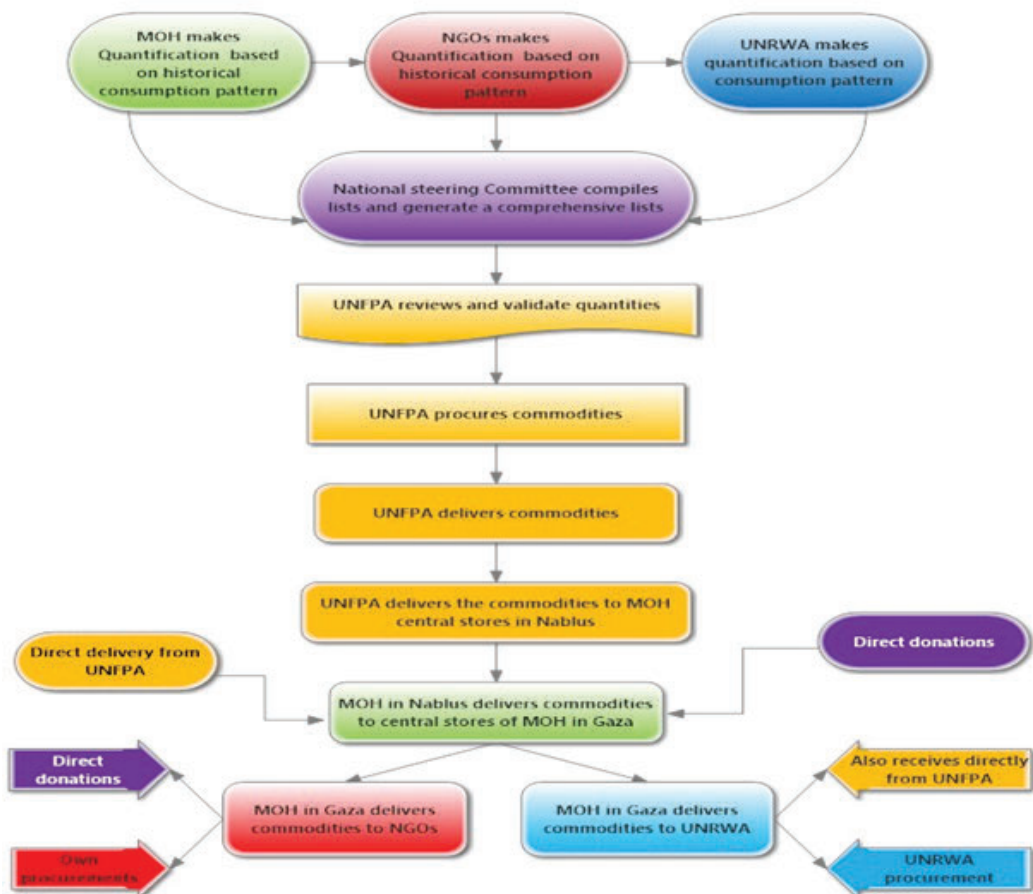
At the national level, requests and supplies were coordinated by the Women`s Health Directorate at the MOH, which chairs the national steering committee for FP. Before 2013, the regular meetings of the national committee provided a platform and guidance for the continuous improvement of the system, including expansion of method mix. It should be noted that while the Women`s Health and Development Directorate continued to perform its coordination role for supply of commodities, the overall coordination and guidance role of the national committee has been limited since 2013. In Gaza, three years ago, a FP committee was established, which is unlike the committee in the WB (pharmacists dominated) as it contains more technical and mid management level staff. In both the WB and Gaza, the committees constitute a good forum, not only in CS, but also for promoting the quality of FP services as a whole including for governance.

Hamad (2011) conducted a study about determinants of FP in GS and concluded that integration of MCH and FP in all MOH-PHC centers is essential to increase access to FP services from integrated clinics. The availability of MCH and FP services at the same health center was associated with a higher rate of contraceptive use. Maintaining the sustainability of supply is essential, as 30% of women do not have regular access to contraceptives (Hamad 2011). Communication strategies that target the entire community is essential. Social and economic development to reduce the demand for children (political fertility) is essential particularly education and employment.

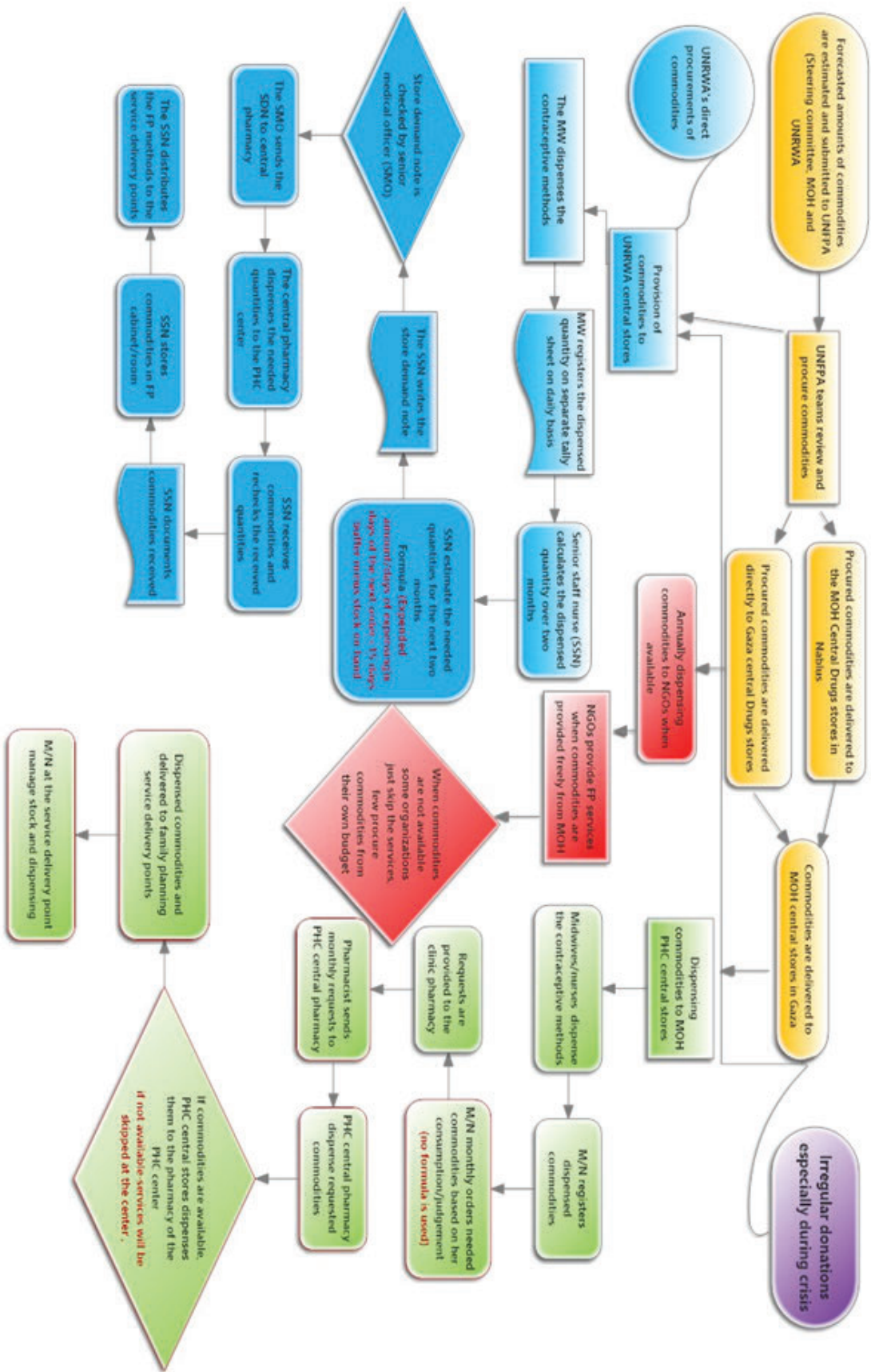
Supplying and dispensing of FP commodities

The flow charts below show the flow of commodities at both the MOH and UNRWA, as drawn by service providers. The flow chart reveals that the process is not adequately streamlined and there is overlapping in the supply of commodities. Supply flow comes from several sources which leads to surplus in certain years and deficits in others. This was more noticeable when organizations were unaware or even surprised by the amount of FP methods donated to them and/or they didn't receive a routinely pledged amount of FP methods without prior notification. Also, with the absence of a standardized national approach, each provider acted on his own for estimating needs or even providing or skipping the FP services entirely.

High Level flow chart



NB: The flowcharts above were drawn by the authors based on the description provided by the respondents in 2017.



The coming sections illustrate the analysis conducted based on data obtained from the records of the central stores of the MOH in Nablus. The results display the main service providers who received FP supplies from the MOH and the quantities dispensed to each service provider between 2010 and 2017. This was complemented with data obtained from the central stores of the MOH and UNRWA in the GS on the supply received and dispensed. As most organizations have shifted to electronic documentation, there are some inconsistencies in data in some years, as some of the organizations have just started computerization of their systems. Also, there are variations in years attributed to the timing of data collection, as the first round of data collection was done in October 2016 in the WB, while the second round was conducted in December 2017 in the GS.

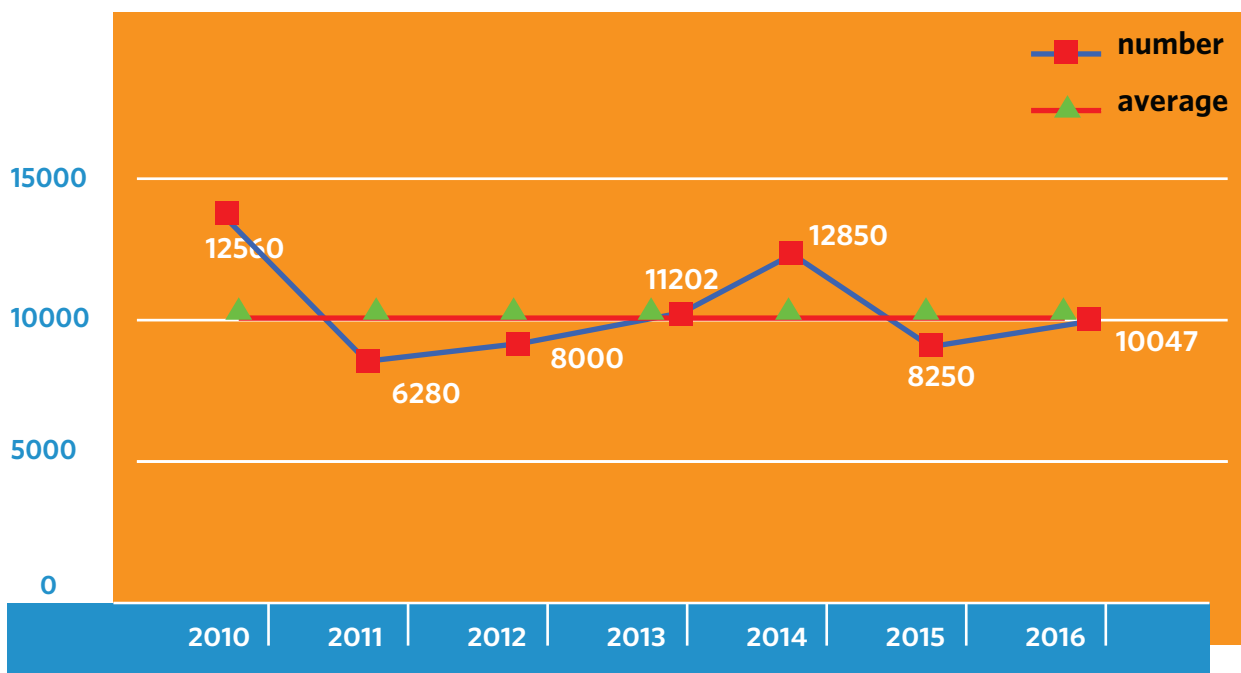
IUD

IUDs are the most widely used method in Palestine by married women in reproductive age, as reported by the MICS HH surveys. The IUD is inserted by doctors at MOH and some NGOs, while in UNRWA and other NGOs this is also done by trained nurses and midwives. From 2010 to 2016, a total of 69,189 units of copper IUDs were dispensed from the central stores of the MOH in Nablus, with a yearly dispensing average of 9,884 loops, ranging from 6,400 in 2011 to 12,850 in 2014. The annual dispensing average in the WB is 8,333 IUDs. In Gaza from 2010 to 2017 (table 23), 26,099 IUDs were supplied to Gaza from all sources with an annual average of 3,728 IUDs. There is a noticeable irregularity of IUDs supplied to Gaza with an oversupply in certain years and zero supply in others due to several reasons including gaps in commodity management, delay in procurements and political division. The shelf life of commodities of some items, like IUDs, should be considered to ensure use long before expiry.

TABLE 22: IUDS DISPENSED BY THE MOH MAIN STORE IN NABLUS FROM 2010 - 2016

YEAR/ PROVIDER	2010	2011	2012	2013	2014	2015	2016	TOTAL
MOH (WB)	4,110	3,450	5,300	3,400	5,400	2,950	3,497	28,107
MOH (GS)	0	500	500	3,852	0	2,000	4,000	10,852
UNRWA	7,000	0	0	0	3,000	0	1,000	11,000
PFPPA	200	1,350	1,200	1,500	3,500	1,500	1,150	10,400
PRCS	1,200	300	0	500	0	400	0	2,400
HWC	0	600	600	1,000	0	500	0	2,700
PMRC	0	0	200	800	800	900	300	3,000
DAHRIEH CENTRE	50	80	200	150	150	0	100	730
TOTAL	12,560	6,280	8,000	11,202	12,850	8,250	10,047	69,189

Figure 17: Distribution of IUDs dispensed from 2010-2016- from the MOH central store in Nablus to service providers



Variations across the years is mainly due to the irregular supplies, gaps in commodity management and other confounders, such as receiving unexpected amounts. It is unlikely that this variation is due to an increase or decrease in demand for IUDs. Apparently, there is no clear consumption standard calculation that can be used as a reference point for comparison. In GS, data shows that supplies are very skewed and range from zero to 14,750 IUDs in certain years. Subsequently, sometimes there is zero dispensing to service delivery points, which resulted in denying people FP services (detailed later). This reflects serious gaps in commodity planning and management, creates uncertainty among providers, and affects continuity of services at these organizations. Organizations reported that they are not aware of when they will receive and when they will not receive the method. The table shows that in the past UNFPA sometimes provided supplies directly to GS stores, and sometimes through the MOH central stores in Nablus. Also, UNRWA provided 1,000 IUDs in 2016, which were taken previously from MOH as a loan.

TABLE 23: DISTRIBUTION OF IUDS DELIVERED TO THE MOH CENTRAL STORE IN THE GS

SOURCE	UNFPA-DIRECTLY	MOH NABLUS STORE	UNRWA	TOTAL
2011	14,750	0	0	14,750
2012	0	500	0	500
2013	0	3,850	0	3,850
2014	0	0	0	0
2015	0	2,000	0	2,000
2016	0	3,999	1,000	4,999
2017	0	0	0	0
TOTAL	14,750	10,349	1,000	26,099

Figure 18: Trend of the IUD supply (delivered) to MOH central store in the GS

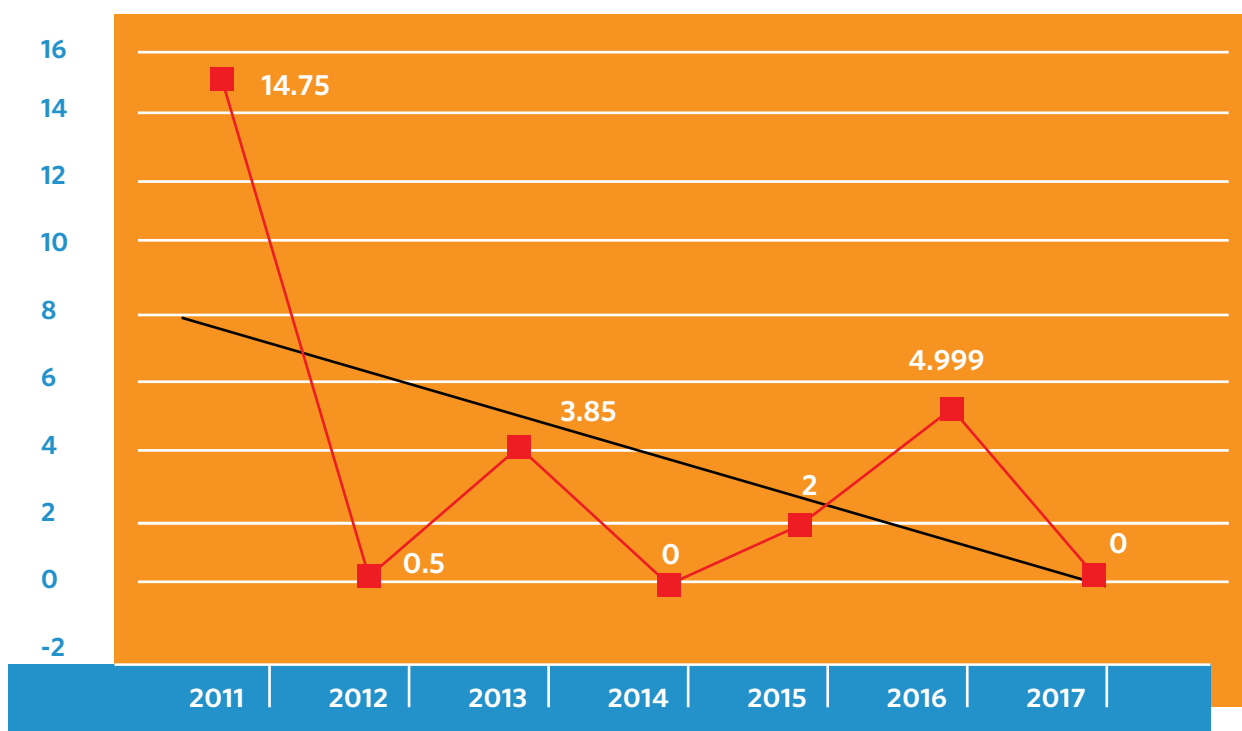


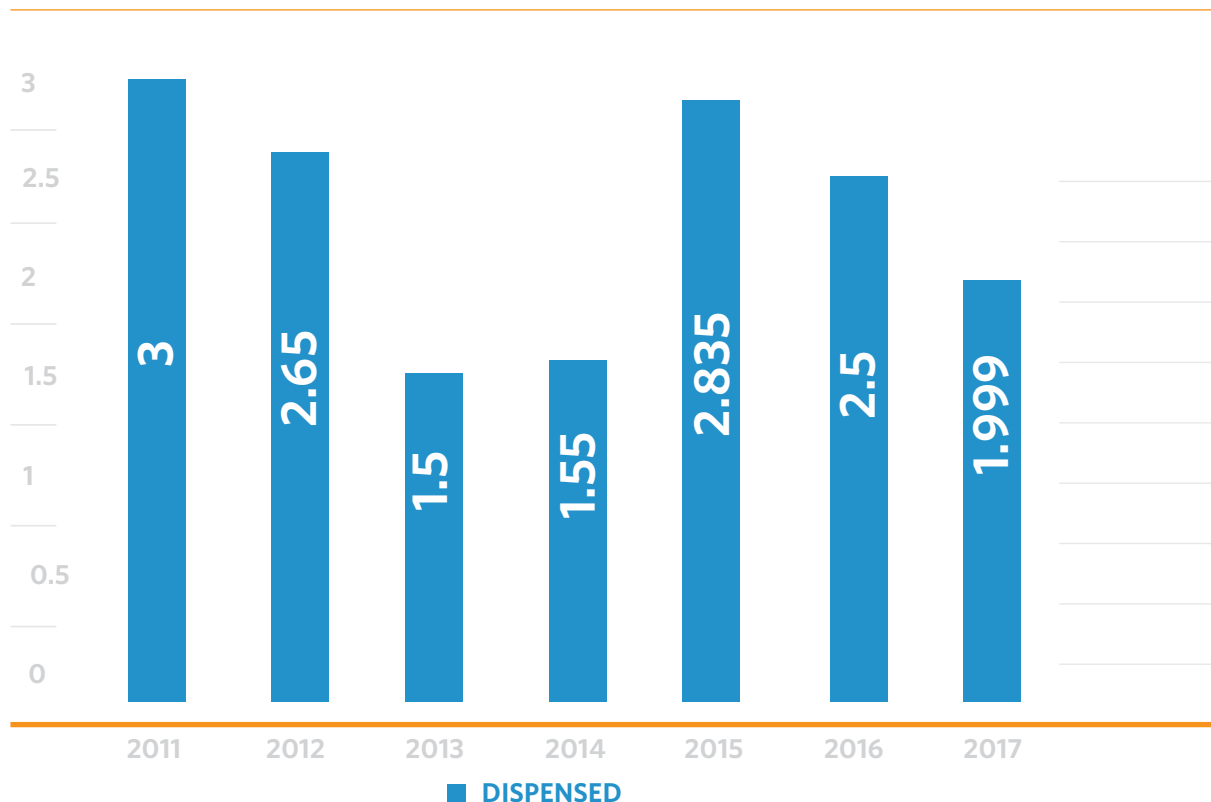
TABLE 24: DISTRIBUTION OF IUDS DISPENSED FROM THE MOH CENTRAL STORE IN GS TO SERVICE PROVIDERS

YEARS	GOVERNMENTAL	NGO'S	UNRWA	TOTAL
2011	3,000	2,200	0	5,200
2012	2,650	1,600	0	4,250
2013	1,500	3,375	500	5,375
2014	1,550	1,290	0	2,840
2015	2,835	0	0	2,835
2016	2,500	0	1,000	3,500
2017	1,999	0	0	1,999
TOTAL	16,034	8,465	1,500	25,999

With regard to dispensing in the GS, it also varied by year with the highest being 2011 where 3,000 IUDs were dispensed to governmental PHC centers (they needed 2,640 according to FP department at the MOH/Gaza). Therefore, what was dispensed was higher than the need. Only three years (2011, 2012, and 2015) out of seven (see table 24), had the number dispensed as sufficient according to the standard consumption average. While UNRWA procures commodities through its own systems, NGOs are mostly deprived when the MOH doesn't provide them with the needed commodities. From 2015-2017, NGOs in the GS didn't receive any IUDs from MOH. Some reported buying them from local markets or asking clients to buy it at private pharmacies. The cost from the private market could reach up to 70 times higher than the prices, if procured by UNFPA.



FIGURE 19: IUDS DISPENSED TO MOH PHC CLINICS IN GAZA (MONTHLY NEEDED 220, YEARLY 2,640)



Combined pills

Pills are the second most popular FP method nationwide. A total of 13,729,940 tablets of combined pills were dispensed from the central stores of the MOH in Nablus with an annual average of 2,288,323 tablets ranging from 1,161,664 in 2015 to 3,464,328 in 2013. This huge variation is a sign of inappropriate commodity management of supplies. In three years (2010, 2013, and 2014) out of the seven years in this study, the GS received zero combined pills from MOH in Nablus. In the other years, it received much less than the needed. For example, in 2015, Gaza received 15% of the total dispensed combined pills it needed. Only in 2016, Gaza received more than 50% of the total dispensed amount needed.

TABLE 25: COMBINED PILLS DISPENSED FROM THE MOH CENTRAL STORES (NABLUS) FROM 2010-2016- (IN THOUSANDS)

YEAR/ PROVIDER	2010	2011	2012	2013	2014	2015	2016	TOTAL
MOH-WB	902.748	811.44	816.48	1119.888	848.4	516.152	528.444	5543.552
MOH-GS	0	604.8	403.2	0	0	181.44	1399.972	2589.412
UNRWA	2047.36	302.4	403.2	2157.12	1330.56	366.24	226.968	6833.848
PFPPA	20.16	141.12	40.32	60.48	161.28	21.056	21.056	465.472
PRCS	69.72	60.48	0	60.48	0	20.16	0	210.84
HWC	0	40.32	28.56	40.32	0	25.2	0	134.4
PMRC	0	7.56	20.16	20.16	32.76	31.416	28.056	140.112
DAHRIEH	1.68	1.68	7.56	5.88	0	0	0.7	17.5
TOTAL	3041.668	1969.8	1719.48	3464.328	2373	1161.664	2205.196	15935.136

Figure 20: Distribution of combined pills dispensed during the period 2010-2016- from the MOH central store in Nablus to service providers (in thousands)

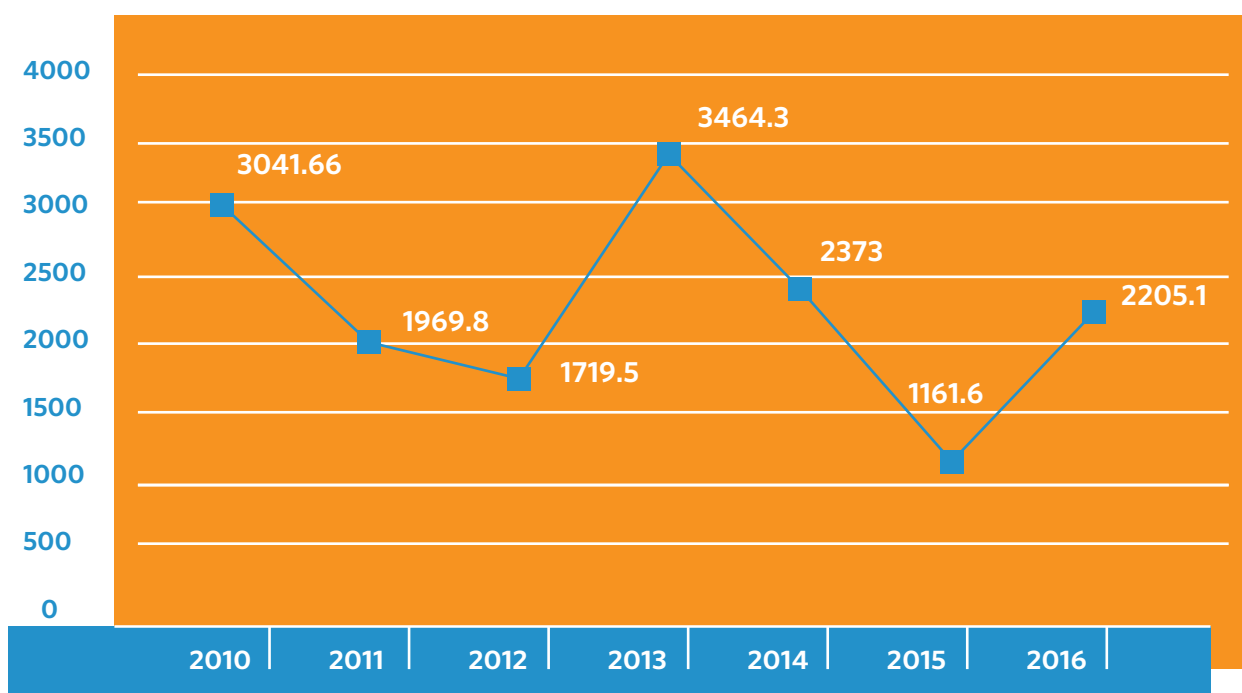


TABLE 26: DISTRIBUTION OF COMBINED ORAL CONTRACEPTIVES PILLS DELIVERED TO THE MOH CENTRAL STORE IN GS BY SOURCE (IN THOUSAND)

YEARS	UNFPA	CENTRAL STORE/WB	UNRWA	TOTAL
2011	3539.200	604.800	0	4144.000
2012	0	403.200	0	403.200
2013	0	0	0	0
2014	0	141.120	0	141.120
2015	0	181.437	0	181.437
2016	0	1401.820	262.080	1663.900
2017	0	0	0	0
TOTAL	3539.2	2732.377	262.08	6533.657

Table 26 shows that the amount of combined oral contraceptive pills delivered to the central stores in GS wasn't consistent. There was a huge variation across the years, with zero delivery in certain years. In 2013 and 2017, there was no delivery, possibly due to the large amount of procurement in 2016 which is almost ten times higher than what was procured in 2014 and 2015. The item shelf time is an important factor to be considered when assessing the commodity status. In addition, inconsistencies were reported between the information provided by MOH in Nablus and MOH in Gaza. The supply was zero in certain years, however, there was dispensing in these particular years possibly due to availability of an adequate stock given the long shelf time of some items like IUD.

Figure 21 Trend of the combined oral contraceptive tab supply to MOH central store in GS (in thousands)

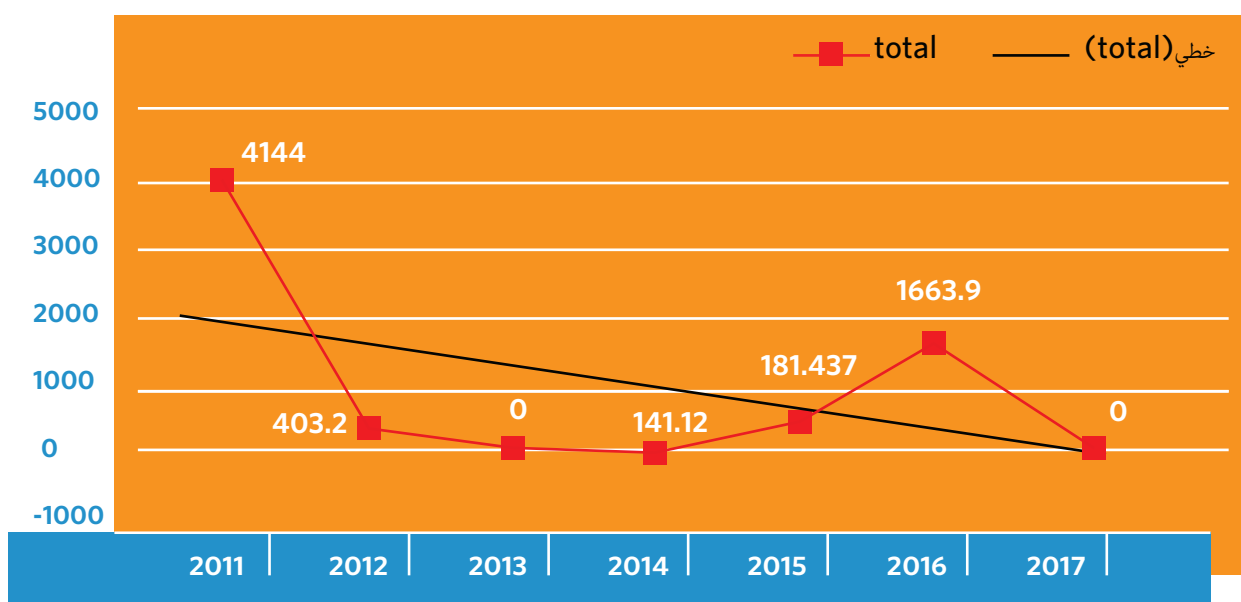
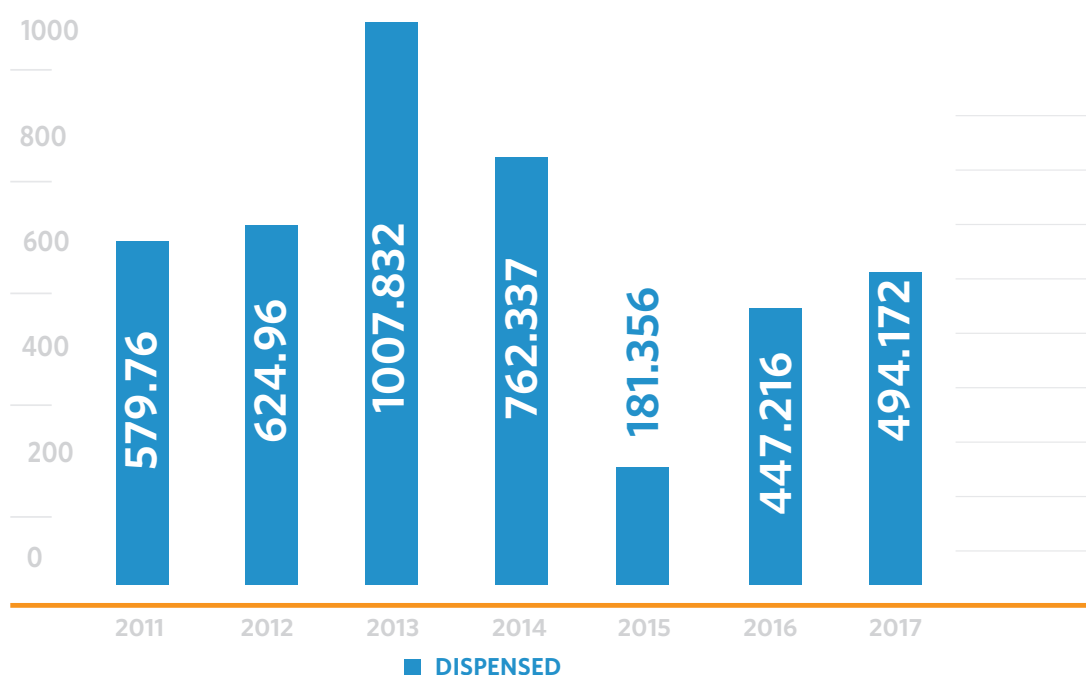


TABLE 27: DISTRIBUTION OF COMBINED ORAL CONTRACEPTIVES PILLS DISPENSED FROM THE MOH CENTRAL STORES IN GS TO SERVICE PROVIDERS (IN THOUSANDS)

YEARS	GOVERNMENTAL	NGO'S	UNRWA	TOTAL
2011	579.760	144.256	313.600	1037.616
2012	651.859	89.628	0	741.487
2013	1007.832	220.584	0	1228.416
2014	762.337	201.880	700.000	1664.217
2015	181.356	0	0	181.356
2016	447.216	22.680	0	469.896
2017	494.172	40.320	0	534.492
TOTAL	4124.532	719.348	1013.6	5857.48



FIGURE 22: COMBINED ORAL CONTRACEPTIVE PILLS DISPENSED TO MOH PHC CLINICS IN GAZA (MONTHLY NEEDED 60.000 YEARLY 720.000)



Again, the dispensing pattern shows variations per year and across providers. The dispensing pattern is not consistent with the utilization pattern at organizations (annual consumption at MOH PHC is around 720,000 tablets). The amount dispensed to MOH indicates that in certain years over supply was provided (in 2013 and 2014), while in others there was shortage. Especially in 2015, as the monthly consumption at MOH centers was 60,000 tablets. In most of the years, what was dispensed was much less than the needed.

Progesterone only oral contraceptive pills

As shown in the Table 28, progesterone dispensing at the MOH Nablus store was also skewed across the years and ranged from 311.22 thousand in 2014 to 2921.1 in 2013, almost ten times higher. Dispensing to the GS and NGOs was also not consistent and varied across the years with zero dispensing during 2010 and 2014. The amount received in the GS was not sufficient. This may jeopardize the CS and increase unmet needs.

TABLE 28: PROGESTERONE DISPENSED BY THE MOH CENTRAL STORES IN NABLUS DURING THE PERIOD 2010-2016- (IN THOUSANDS)

YEAR/ PROVIDER	2010	2011	2012	2013	2014	2015	2016	TOTAL
MOH-WB	366.065	379.05	478.8	149.1	265.16	257.635	205.485	2101.295
MOH-GS	0	756	504	252	0	806.4	355.53	2673.93
UNRWA	1008	378	1310.4	2419.2	4.06	504	0	5623.66
PFPPA	25.2	102.9	0	0	39.9	56.42	21.28	245.7
PRCS	55.65	37.8	0	75.6	0	77.7	15.75	262.5
HWC	0	50.4	35.7	25.2	0	8.4	0	119.7
PMRC	0	5.25	10.5	0	2.1	3.57	3.57	24.99
DAHRIEH	2.1	0	4.2	0	0	0	0	6.3
TOTAL	1457.015	1709.4	2343.6	2921.1	311.22	1714.125	601.615	11058.075

FIGURE 23: DISTRIBUTION OF PROGESTERONE ONLY PILLS DISPENSED DURING THE PERIOD 2010-2016- FROM THE MOH CENTRAL STORE IN NABLUS TO SERVICE PROVIDERS (IN THOUSANDS)

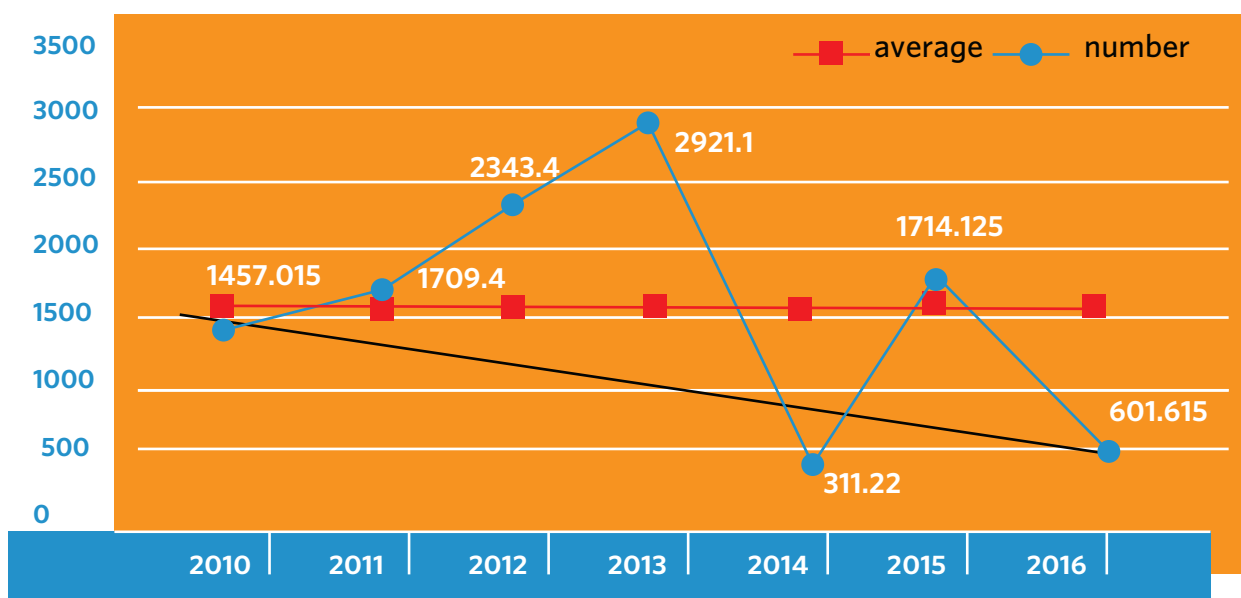


TABLE 29: DISTRIBUTION OF PROGESTERONE ONLY ORAL CONTRACEPTIVES PILLS DELIVERED TO THE CENTRAL STORES IN GS (IN THOUSANDS)

YEAR	UNFPA-DIRECTLY	MOH NABLUS STORE	UNRWA	TOTAL
2011	756.000	756.000	0	1512.000
2012	0	503.685	0	503.685
2013	252.000	0	105.000	357.000
2014	0	252.000	0	252.000
2015	0	806.400	0	806.400
2016	0	352.800	0	352.800
2017	0	0	70.000	70.000
TOTAL	1008	2670.885	175	3853.885

As Table 29 depicts, similar to the combined pills, there were inconsistencies in the supply of progesterone pills to the main stores in Gaza, with zero supplies in certain years. In 2011 and 2013, UNFPA provided supplies to central stores directly, while in the subsequent three years, it was only provided through MOH. UNRWA also provided progesterone supplies to MOH stores in 2017, mostly as surplus or returning loans.

Figure 24: Trend of progesterone only oral contraceptive tablet supply to the MOH central store in Gaza

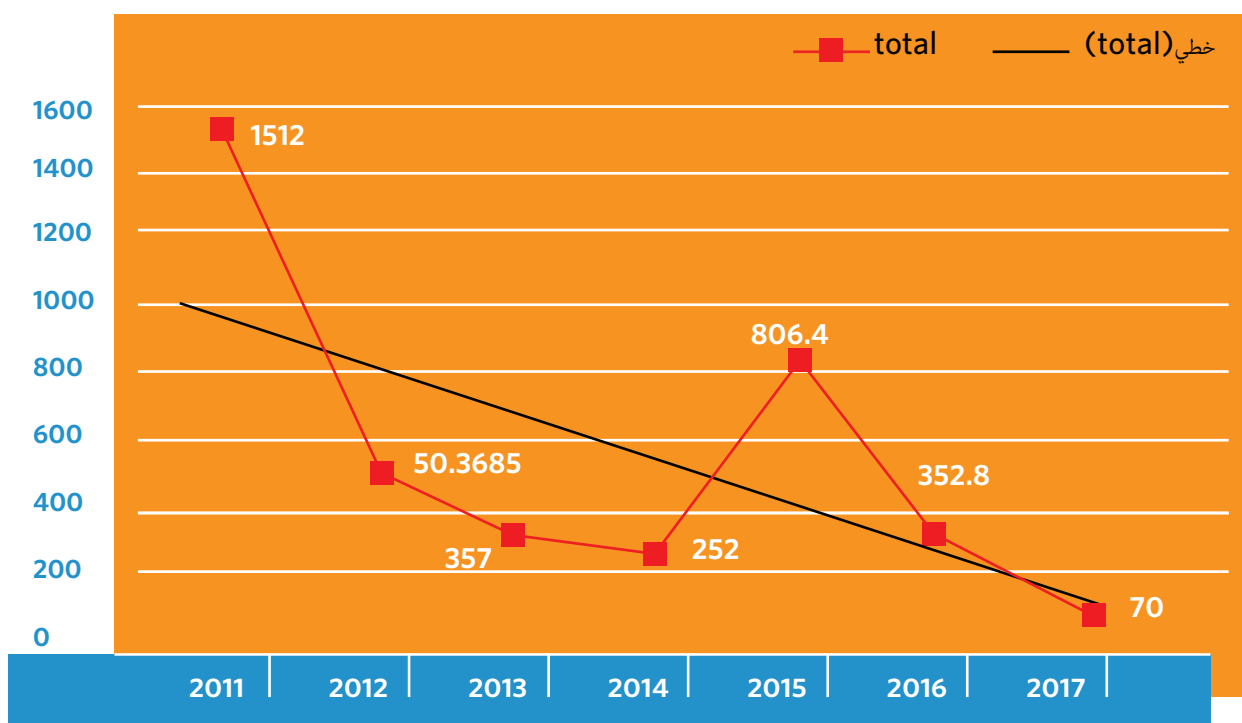


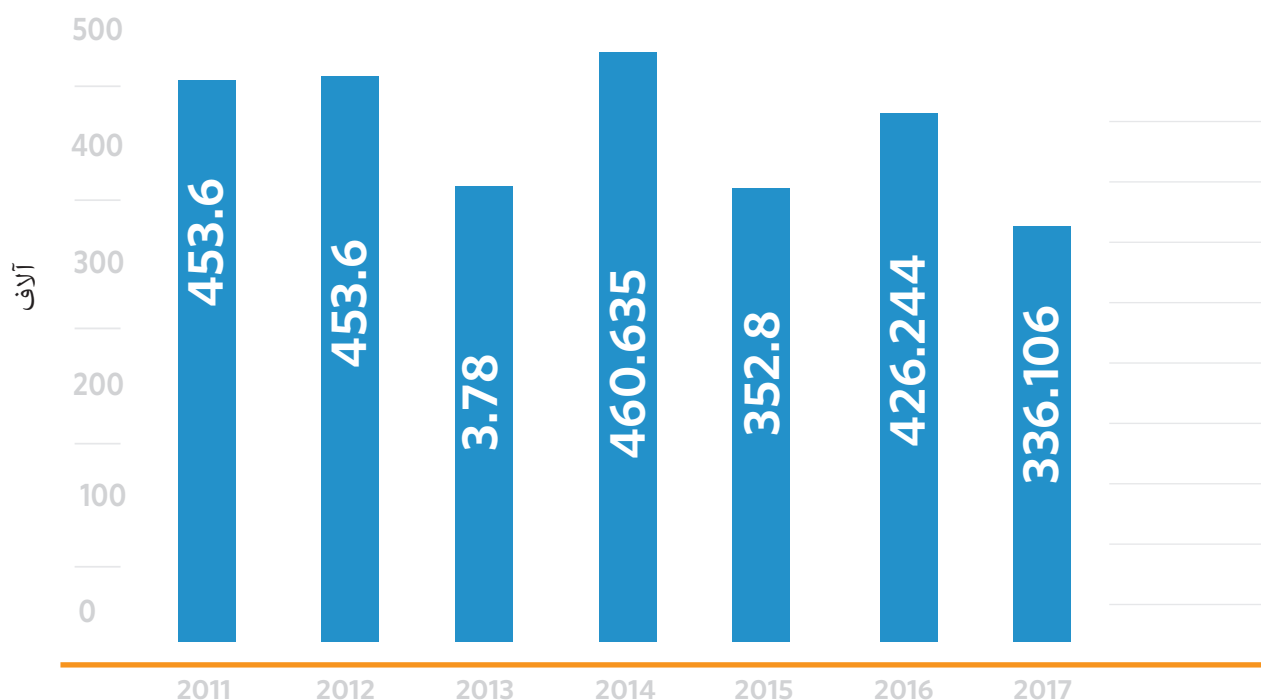
TABLE 30: DISTRIBUTION OF PROGESTERONE ONLY ORAL CONTRACEPTIVES PILLS DISPENSED FROM THE MOH CENTRAL STORES IN THE GS TO SERVICE PROVIDERS

YEARS	GOVERNMENTAL	NGO'S	UNRWA	TOTAL
2011	453.600	0	378.000	831600
2012	453.600	69.720	0	523320
2013	378.000	198.975	105.000	681975
2014	460.635	127.155	0	587790
2015	352.800	78.350	0	431150
2016	426.244	19.950	0	446194
2017	336.106	1.5750	0	351856
TOTAL	2860.985	509.9	483	3853885

The usual needed amount for MOH clinics in GS is 30,000 tablets monthly (360,000 annually). The dispensing pattern at MOH shows that the annual average amount is less than the estimated amount needed for the MOH clinics in GS.



FIGURE 25: PROGESTERONE DELIVERED TO MAIN STORES AND DISPENSED TO MOH PHC CLINICS IN GAZA (MONTHLY NEEDED 30,000, YEARLY 360,000)



Male condoms

Male condoms were the third most widely used method. From 2010-2017, a total of 6,672,528 condoms were dispensed from the MOH stores. Of them, the largest amount was dispensed to UNRWA with 3,616,704 (54%), followed by the MOH-WB with 1,985,040 (30%), and MOH - GS with 986,400 (15%). Other providers received 84,384 (1%). The average annual distribution of male condoms was 953,218 with large variability between years, ranging from 189,504 in 2011 to 1,890,864 in 2015. The GS received almost 50% of the condoms dispensed to WB, however, the supply to Gaza was irregular with zero dispensing during the years 2010, 2011 and 2014.

TABLE 31: MALE CONDOMS DISPENSED BY THE MOH STORES IN NABLUS FROM 2010-2016- (IN PIECES)

YEAR/ PROVIDER	2010	2011	2012	2013	2014	2015	2016	TOTAL
MOH-WB	424,656	120,240	309,600	636,480	79,920	155,664	258,480	1,985,040
MOH-GS	0	0	72,000	396,000	0	345,600	172,800	986,400
UNRWA	633,600	64,800	468,000	520,704	172,800	1,382,400	374,400	3,616,704
PFPPA	0	4,320	14,400	7,200	21,600	7,200	21,600	76,320
PRCS	0	0	0	7,200	0	0	0	7,200
DAHRIEH	720	144	0	0	0	0	0	864
TOTAL	1,058,976	189,504	864,000	1,567,584	274,320	1,890,864	827,280	6,672,528

Figure 26: Distribution of male condom dispensed from the MOH central store in Nablus to servi

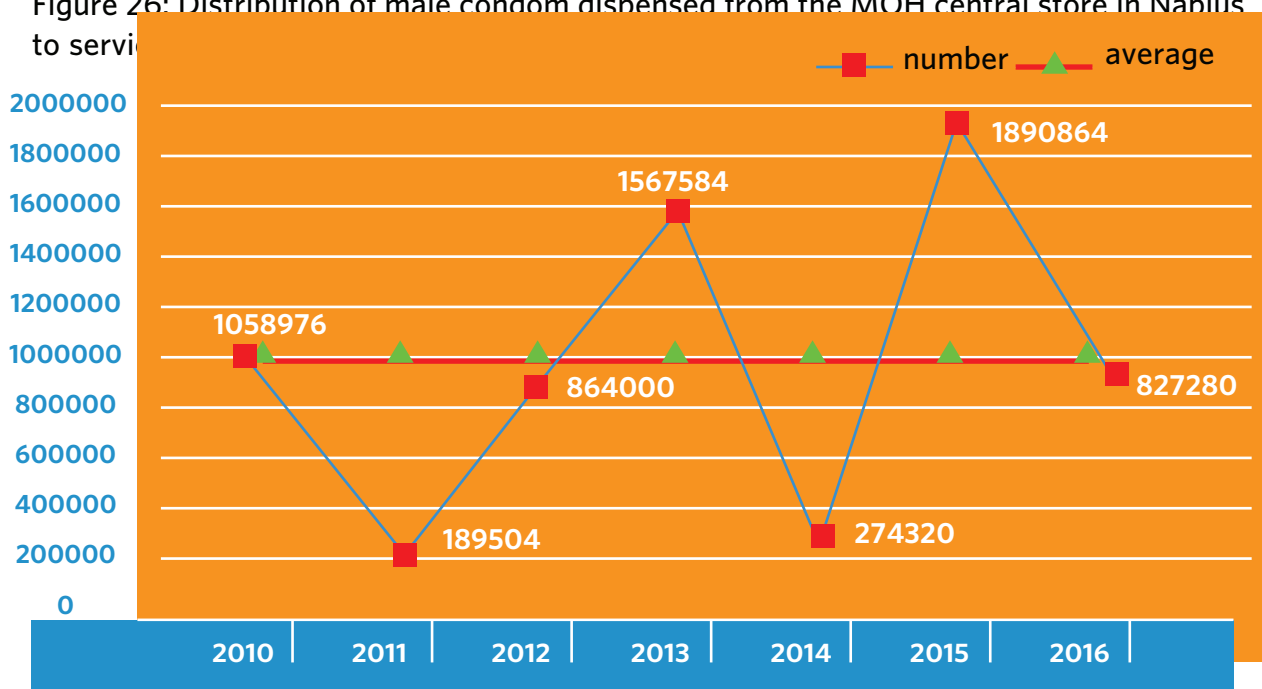


TABLE 32: DISTRIBUTION OF MALE CONDOMS DELIVERED TO THE MOH CENTRAL STORES IN THE GS

INPUT	UNFPA	NABLUS STORE	DONATION	UNRWA	TOTAL
2011	453.600	0	378.000	0	353,624
2012	453.600	69.720	0	0	180,000
2013	378.000	198.975	105.000	0	394,400
2014	460.635	127.155	0	0	0
2015	352.800	78.350	0	0	259,200
2016	426.244	19.950	0	0	262,800
2017	336.106	1.5750	0	0	0
TOTAL	2860.985	509.9	483	0	1450,024

The number of condoms delivered is not reliable and greatly varied from year to year. In 2014 and 2017, no supplies were provided to Gaza. The same applies to dispensing from stores which also showed severe skewness, for instance in 2017 and 2011, nothing has been dispensed to NGOs although they rely mainly on MOH. This could be explained by the large quantities received during previous year. The MOH monthly consumption is around 14,000. The estimated amount annually is 168,000, which was not delivered to MOH PHC centers between 2010 and 2017 (130,000 annual average dispensing at MOH clinics). In 2016, due to failure in commodity management, thousands of condoms were discarded.

From Table 31 and 32 we can observe the discrepancy in the reported dispensed amount from the central stores in Nablus and MOH-GS stores. This is an example of poor coordination and inadequate stock management.

Figure 27: Trend of male condom supply to MOH central store in GS 2011-2017-

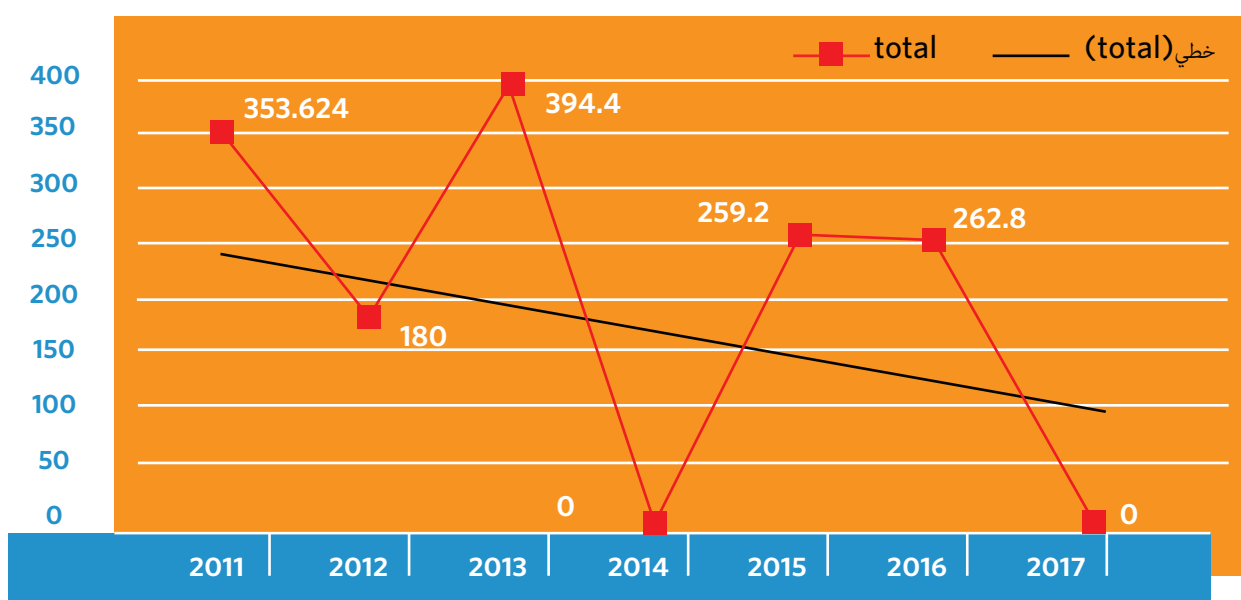
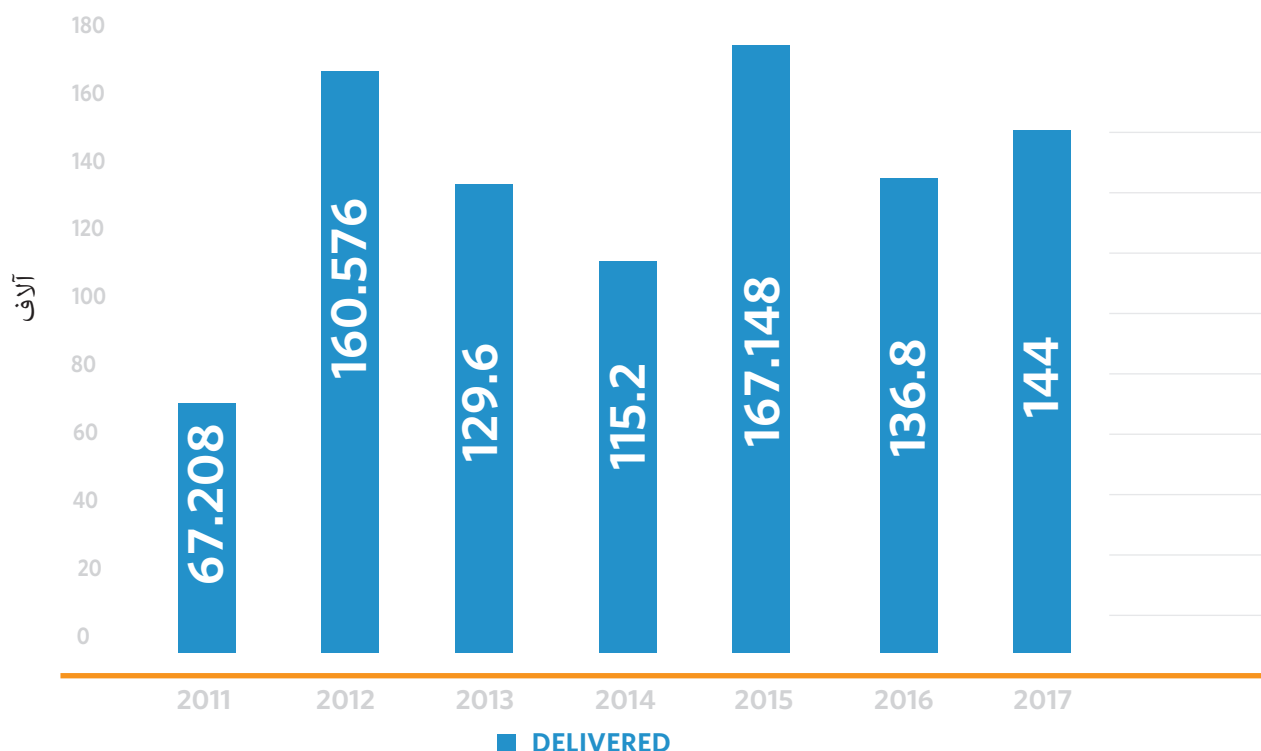


TABLE 33: DISTRIBUTION OF MALE CONDOMS DISPENSED FROM THE MOH CENTRAL STORE IN GS TO SERVICE PROVIDERS IN THE GS

DISPENSED	GOVERNMENTAL	NGO'S	UNRWA	DISCARDED	TOTAL
2011	67,208	0	0	0	67,208
2012	160,576	48,224	0	0	208,800
2013	129,600	67,392	250,560	0	447,552
2014	115,200	43,344	0	0	158,544
2015	167,148	25,632	0	0	192,780
2016	136,800	8,208	0	66,300	211,308
2017	144,000	0	0	0	144,000
TOTAL	920,532	192,800	250,560	66,300	1,430,192



FIGURE 28: MALE CONDOMS DISPENSED TO MOH PHC CLINICS IN GAZA (MONTHLY NEEDED 14000, YEARLY 168000)



Medroxyprogesterone

This method is only used by about 2% of clients, with an average annual distribution of 5,726 vials with great variability between years from 12,050 vial in 2011 to 235 vials in 2014, to zero in 2015. Similar to the other methods, the variability is related to irregular supplies in the central stores. Irregularities in both in supplying and/or dispensing resulted in discarding large amounts in some years. While the FP department stated that the monthly consumption at MOH clinics is 90 vials, the central store gave another figure (150). Only in one year (2011), was the amount dispensed sufficient to meet the estimated needs. Due to its high cost, this method is not offered regularly within the available package of services of the NGOs.

TABLE 34: DISTRIBUTION OF MEDROXYPROGESTERONE DISPENSED BY THE MOH CENTRAL STORE IN NABLUS DURING THE PERIOD 2010 -2016

YEAR/ PROVIDER	2010	2011	2012	2013	2014	2015	2016	TOTAL
MOH-WB	1,400	850	2,000	1,443	135	0	600	6,428
MOH -GS	0	11,200	2,000	800	0	0	1,500	15,500
UNRWA	8,225	0	0	0	0	0	0	8,225
PFPPA	0	0	125	50	100	0	0	275
PRCS	0	0	300	0	0	0	0	300
DAHRIEH CENTRE	0	0	0	0	0	0	0	0
TOTAL	9,625	12,050	4,425	2,293	235	0	2,100	30,728

Figure 29: Distribution of Medroxyprogesterone dispensed during the period 2010-2016- from the MOH central store in Nablus to service providers

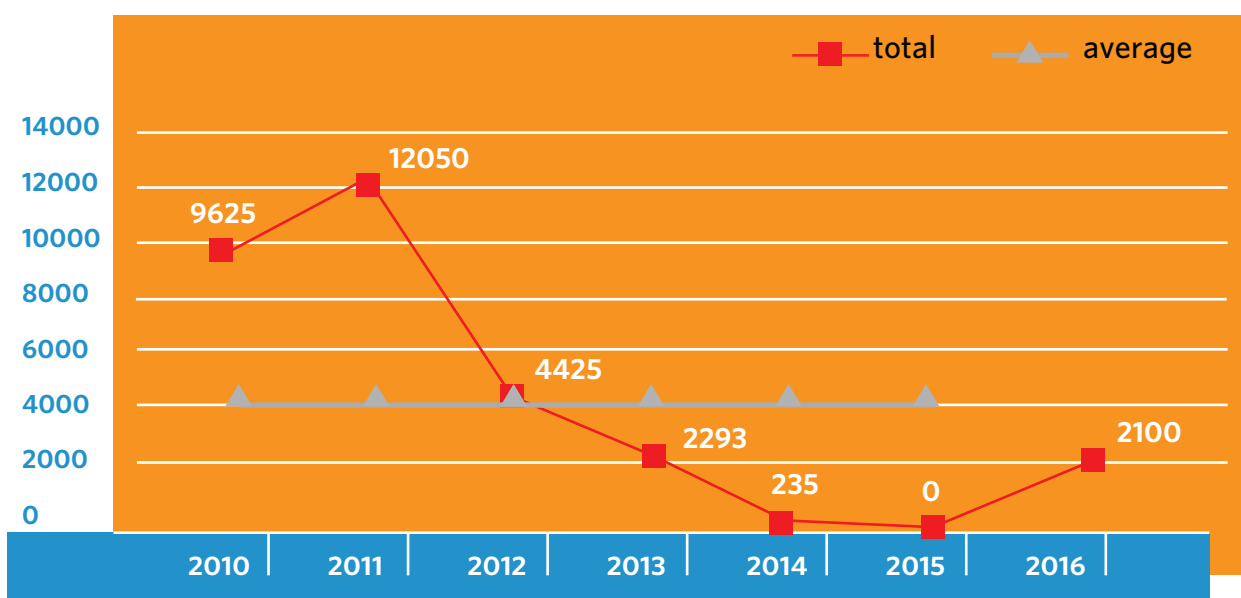


TABLE 35: DISTRIBUTION OF MEDROXYPROGESTERONE DELIVERED TO THE MOH CENTRAL STORE IN GS

INPUT	UNFPA	NABLUS STORE	DONATION	UNRWA	TOTAL
2011	2,600	11,180	11,200	0	24,980
2012	0	2,000	0	0	2,000
2013	0	0	0	0	0
2014	0	800	0	0	800
2015	0	0	0	0	0
2016	0	1,500	65	0	1,565
2017	0	0	75	0	75
TOTAL	2,600	15,480	11,340	0	29,420

Table 35: Distribution of Medroxyprogesterone delivered to the MOH central store in GS

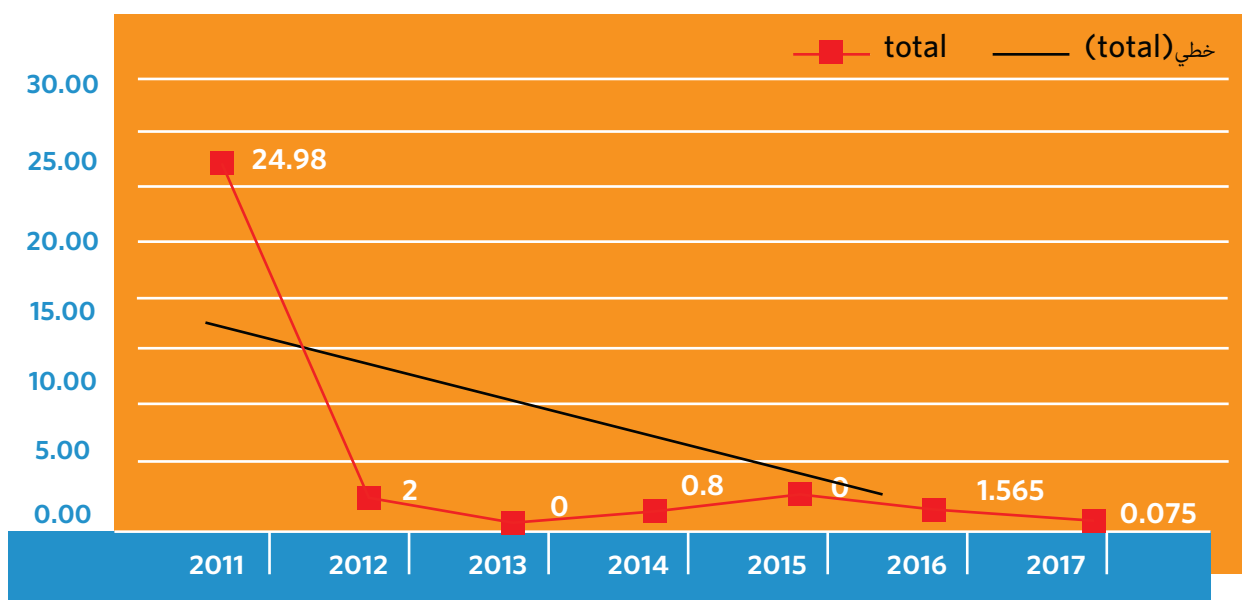
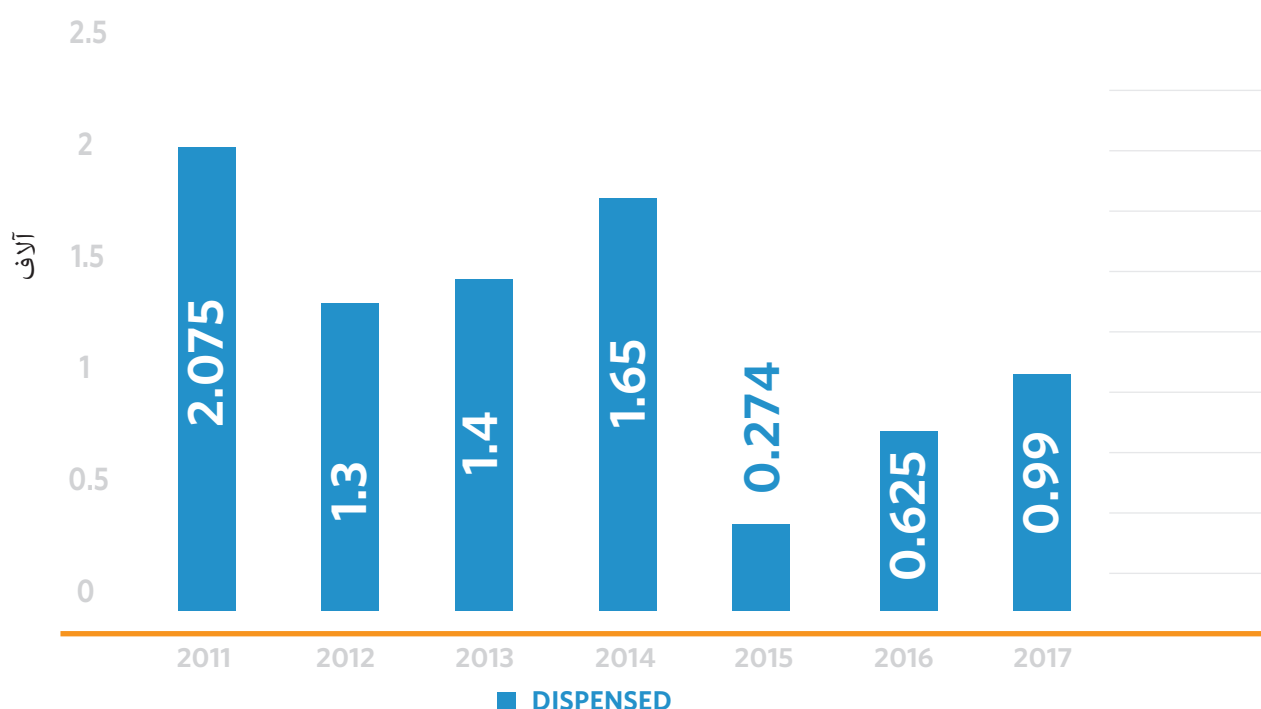


TABLE 36: MEDROXYPROGESTERONE DISPENSED FROM THE CENTRAL STORE IN GS TO SERVICE PROVIDERS IN GS

DISPENSED	GOVERNMENTAL	NGO'S	UNRWA	DISCARDED	TOTAL
2011	2,075	1,115	9,100	0	12,290
2012	1,300	360	0	0	1,660
2013	1,400	905	2,000	0	4,305
2014	1,650	430	3,974	1,146	7,200
2015	274	25	0	2,501	2,800
2016	625	0	0	0	625
2017	990	0	0	0	990
TOTAL	8,314	2,835	15,074	3,647	29,870



FIGURE 31: MEDROXYPROGESTERONE DISPENSED TO MOH PHC CLINICS IN GS (MONTHLY NEEDED 150, YEARLY NEEDED 1,800)



The MOH in both the WB and the GS is the main channel through which most FP methods are provided to service providers. Central drug stores inventory in GS shows that the MOH provides FP methods to many organizations providing any sort of FP services. The main FP service providers who receive methods from MOH are UNRWA, PHC directorate, NECC, PMRS, UHWC, RCS-GS, CFTA. In addition to that, many NGO hospitals received FP methods from MOH when they were available. It was noticed that many organizations provide irregular FP services and they receive commodities without adequate monitoring and supervision. Distribution of supplies is irregular with frequent cuts, and under and over supply. This jeopardized the sustainability and continuity of services. The dispensing pattern at the organization was not always consistent with the workload, which might indicate misuse or at least inefficiency. At least in Gaza, MOH provides supplies to organizations based on availability on the shelf. There is no clear regulation that determines who should do what and for whom. While UNRWA and some NGOs are politically willing and financially capable to secure their needs, until 2018, MOH solely relied on UNFPA to provide these commodities. When UNFPA doesn't provide the FP commodities, service providers often skip the services despite the great need.

Stock level status at MOH stores - GS

The stock level status is an important indicator that reflects the CS status. Table 37 shows the stock level at MOH central store in the GS. The figures illustrate that the stock level hasn't been adequately maintained at a strategic safe level with adequate buffer stock. This is especially important during emergencies. The annual average of FP stock varied greatly. The median is worse, as in certain years the median stock was zero (2015 and 2016 in combined oral pills and Medroxyprogesterone).

Table 37: Annual average of stock level of FP methods at the MOH main stores in GS

YEAR	PROGESTERONE ONLY*		COMBINED PILLS		CONDOM		IUD		MEDROXYPROGESTERONE	
	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN	MEAN	MEDIAN
2013	597	386	2025	1915	300781	242640	3355	4175	11075	10200
2014	280	225	466	302	120322	89200	2879	2860	5814	5230
2015	460	555	17	0	158458	168385	814	917	681	0
2016	383	362	712	850	68413	56750	1792	1999	453	0
2017	138	145	581	570	75884	70700	721	690	325	247

The stock level monthly analysis shows serious gaps at the MOH main store in Gaza, as it was at zero for almost all the commodities in some years (Annex 5). IUD shortage was reported in many months with a zero stock in May, August and November 2015, Feb 2016, and Nov 2017. The status of Medroxyprogesterone was even worse with many months out of stock (18 months in five years). Combined pills were at zero stock at least for 14 continuous months and at a low stock level in many other months.

During a key informant interview with the nursing supervisor of MCH department at the MOH, she reported the following shortages at the service delivery points.

Box 8: Reported shortages in contraceptives at the service delivery points at MOH PHC centers in the GS

- 2014: shortage in combined pills in November and December
- 2015: shortage of combined pills and Medroxyprogesterone during the period March through December (10 continuous months),
- 2016: shortage of combined pills and Medroxyprogesterone during the period January through August (9 continuous months)
- 2017: shortage of combined pills and progesterone during the period May through November (8 continuous months)

Figures presented in the coming pages show the monthly stock level at the MOH central stores in Gaza for the five most common contraceptive methods used in Palestine.

Figure 32: IUD monthly stock level at the MOH central stores in the GS (needed monthly = 220)

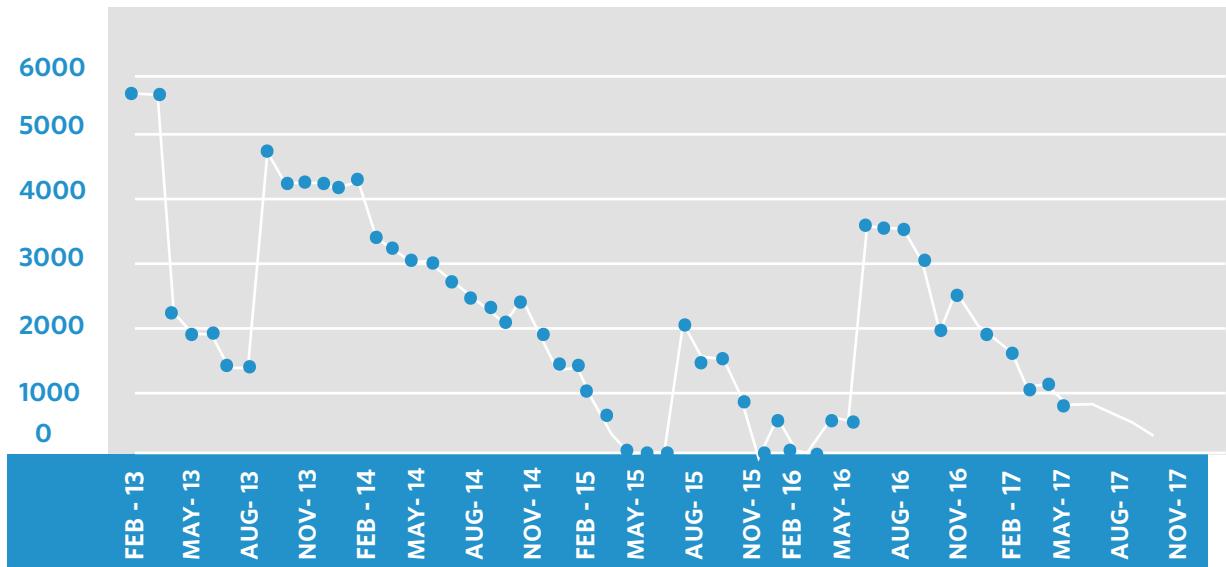


Figure 33: Monthly stock level of Medroxyprogesterone at the MOH central stores in the GS (needed monthly = 150)

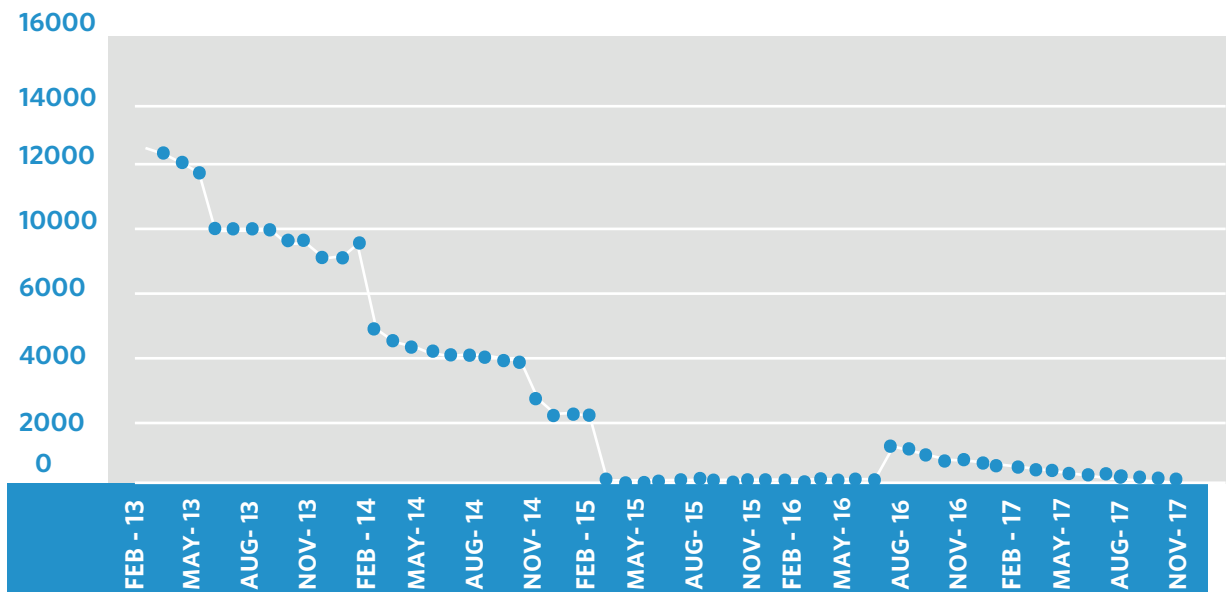


Figure 34: Progesterone only monthly stock level at the MOH central stores in the GS (needed monthly = 30,000)

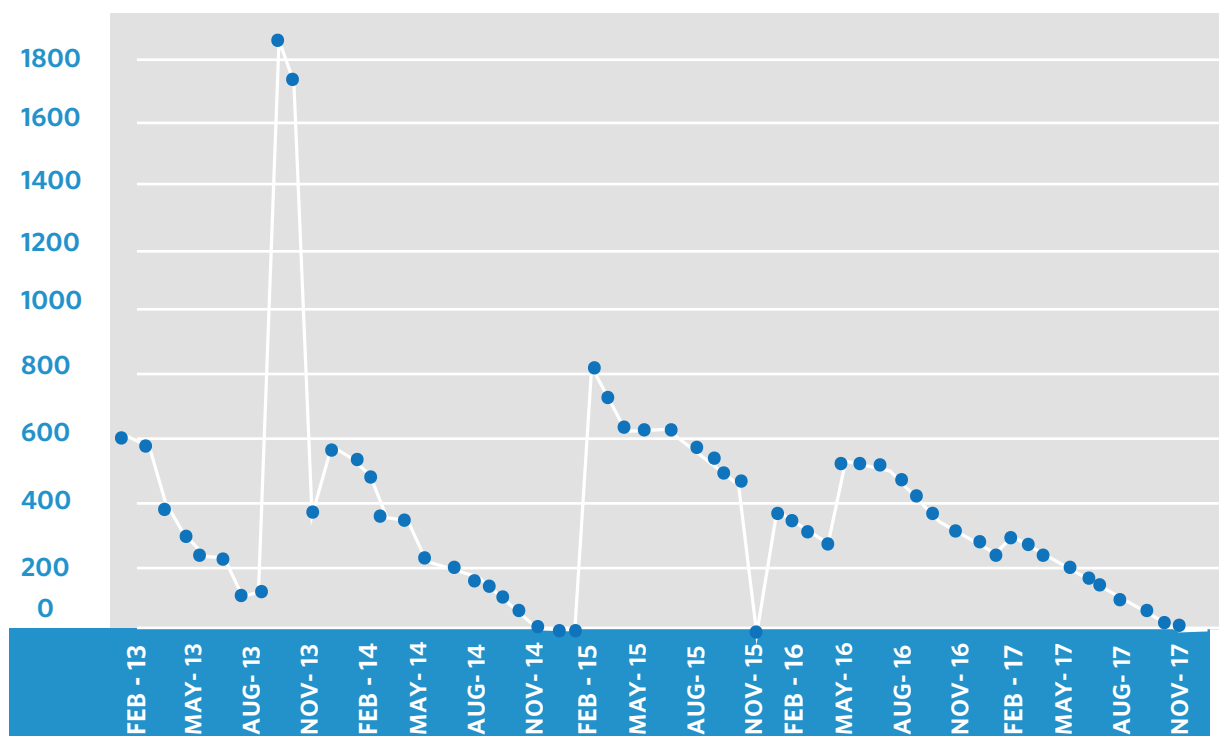


Figure 35: Contraceptive Combined Oral pills monthly stock level at MOH central stores in the GS (needed monthly = 60,000)

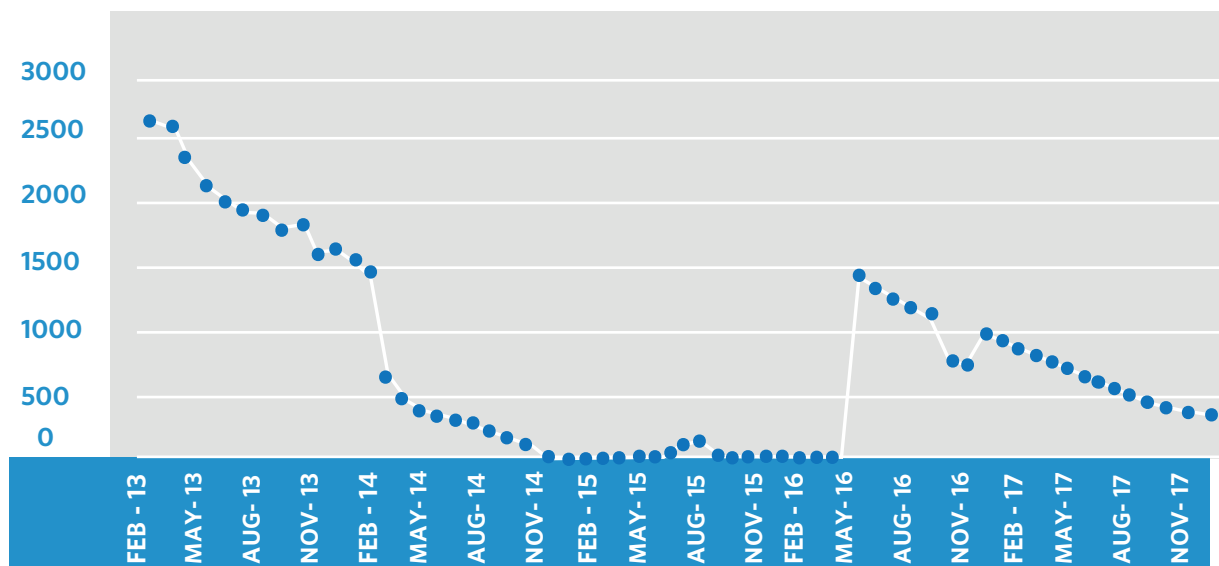
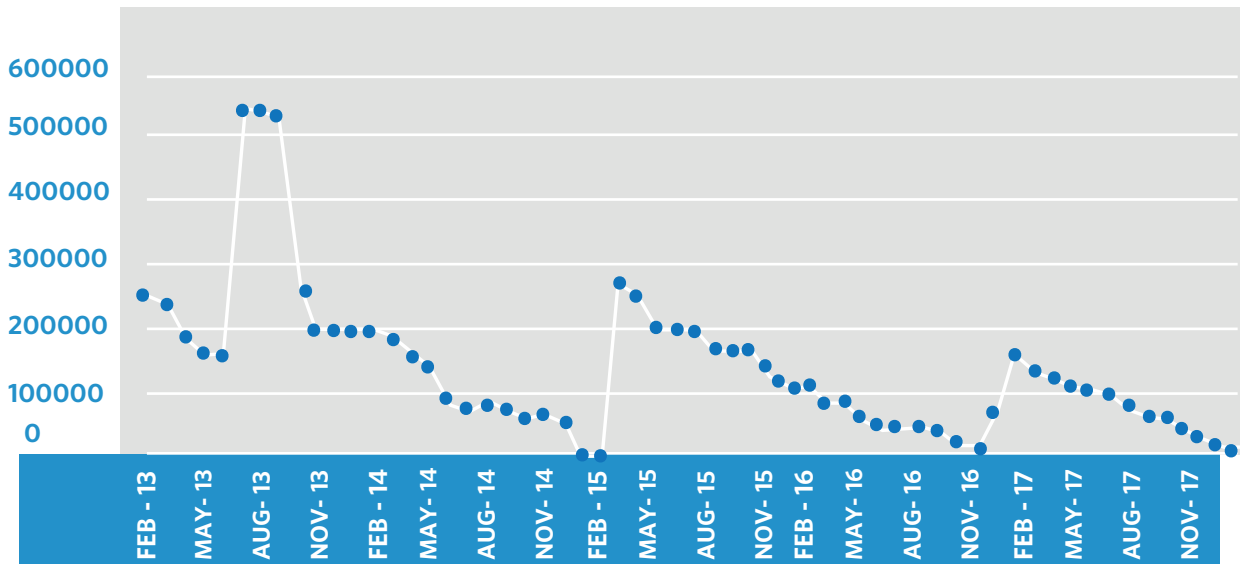


Figure 36: Male Condom monthly stock level at MOH central stores in GS (needed monthly = 14,000)



Stock level status at UNRWA-GS

The stock level status at UNRWA was somewhat better than at the MOH. However, due to irregularity of supply from the MOH, many items had large variations, with some items reaching zero stock level. For instance, male condom stock level had a very wide range, from 2,139 in 2012 to 12 in 2010 and 291 in 2017. Figure 38 shows that the combined oral contraceptives stock level was even more problematic, with great variability across the years, ranging from 6,759 in 2012 to 51 in 2010. Variations were also noticed in the progesterone oral contraceptive pills ranging from 1,499 thousand to zero (figure 39). As figure 40 depicts, stock level of Medroxyprogesterone was at zero stock in some years with overstock in others. Data about IUDs was not available at UNRWA for all of the concerned years, but still from the available data, the assessment concluded that the stock level of IUDs at UNRWA declined over time.

At UNRWA, zero stock level of Medroxyprogesterone was reported in the last quarter of 2015 and 2016. There were less frequently recorded severe shortages in condoms, IUDs and combined pills as showed in the figures 42 through 46.

Figure 37: Male condom stock level at UNRWA central stores in GS

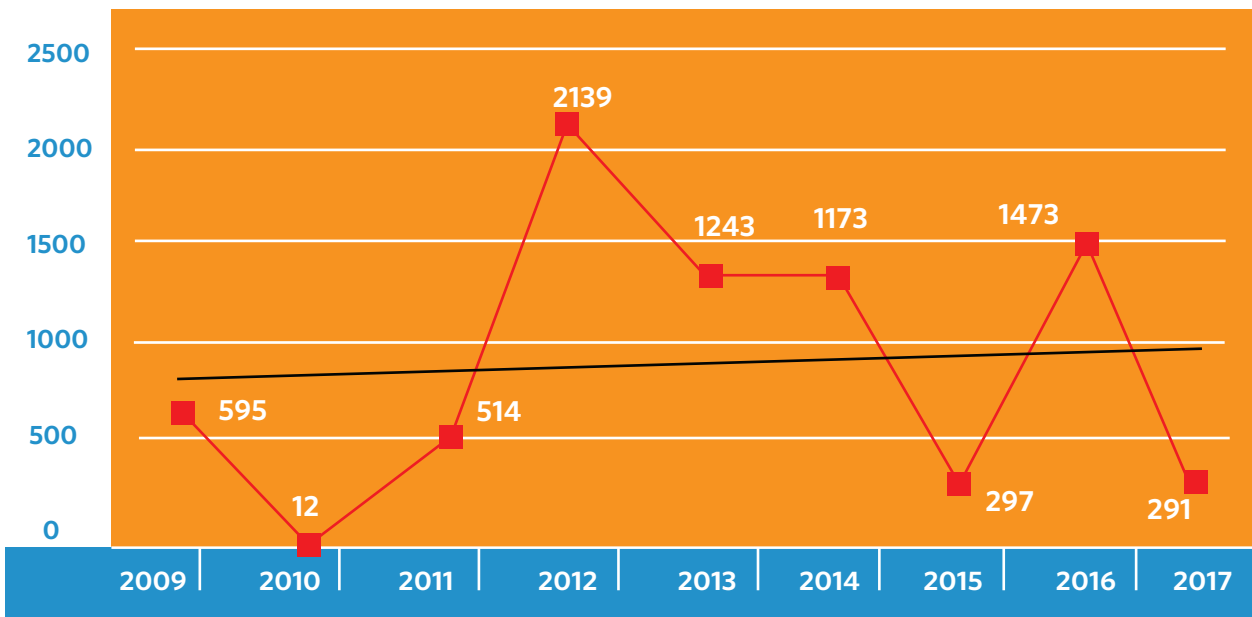


Figure 38: Stock level of oral combined contraceptive pills at UNRWA central stores in GS

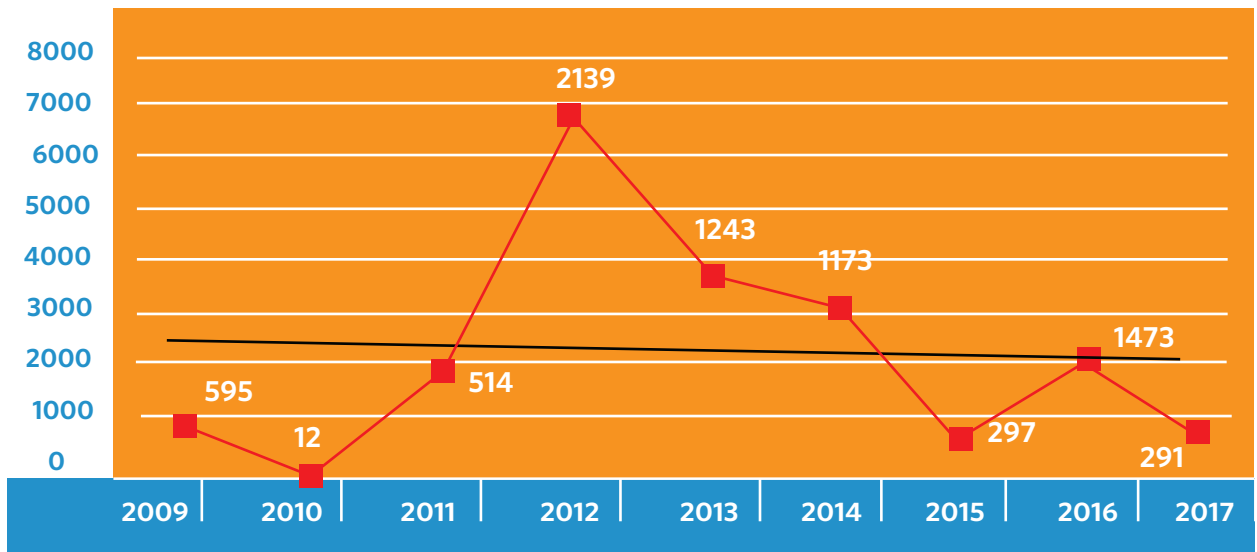


Figure 39: Stock level of progesterone contraceptive pills at UNRWA central stores in GS

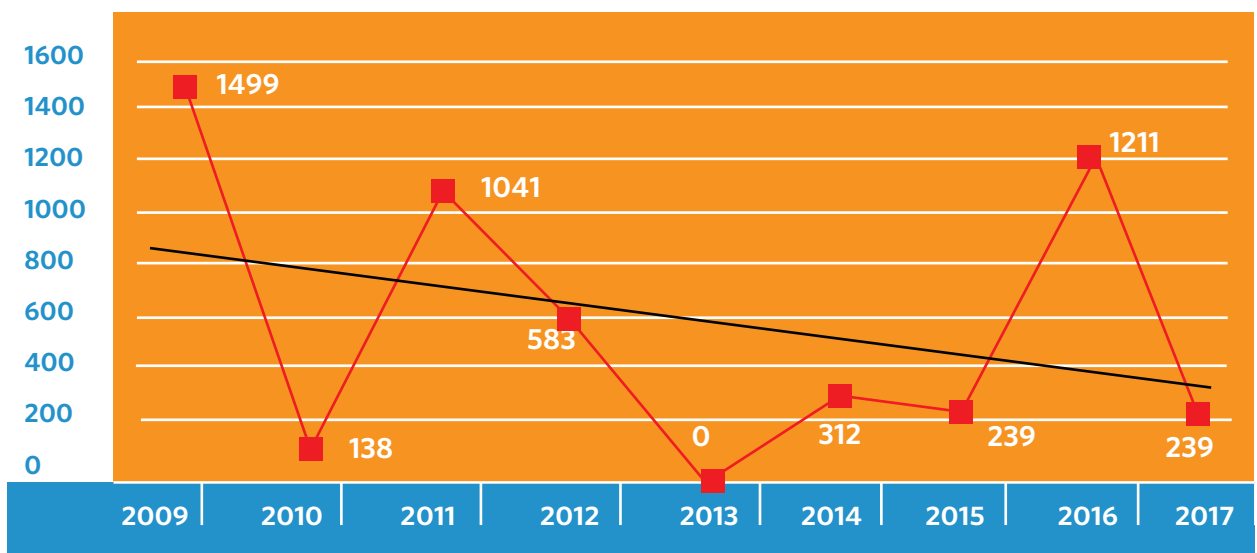


Figure 40: Stock level of Medroxyprogesterone at UNRWA central stores in GS

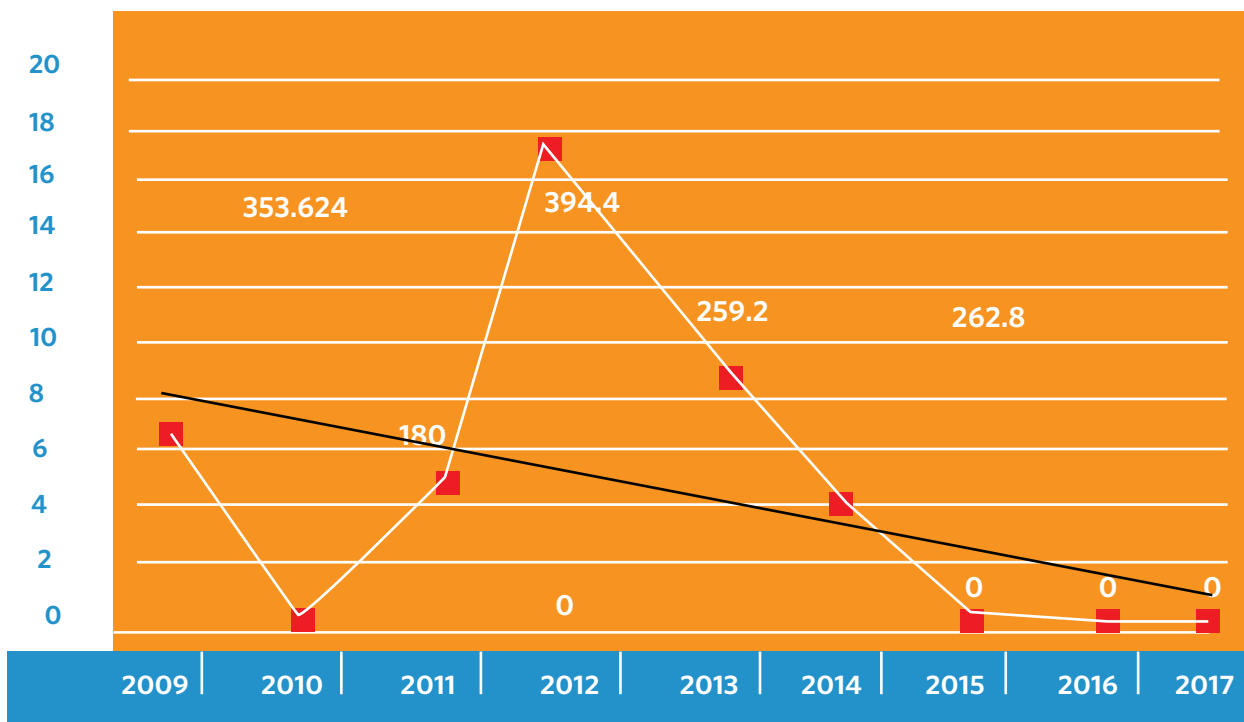


Figure 41: Stock level of IUD at UNRWA central stores in GS

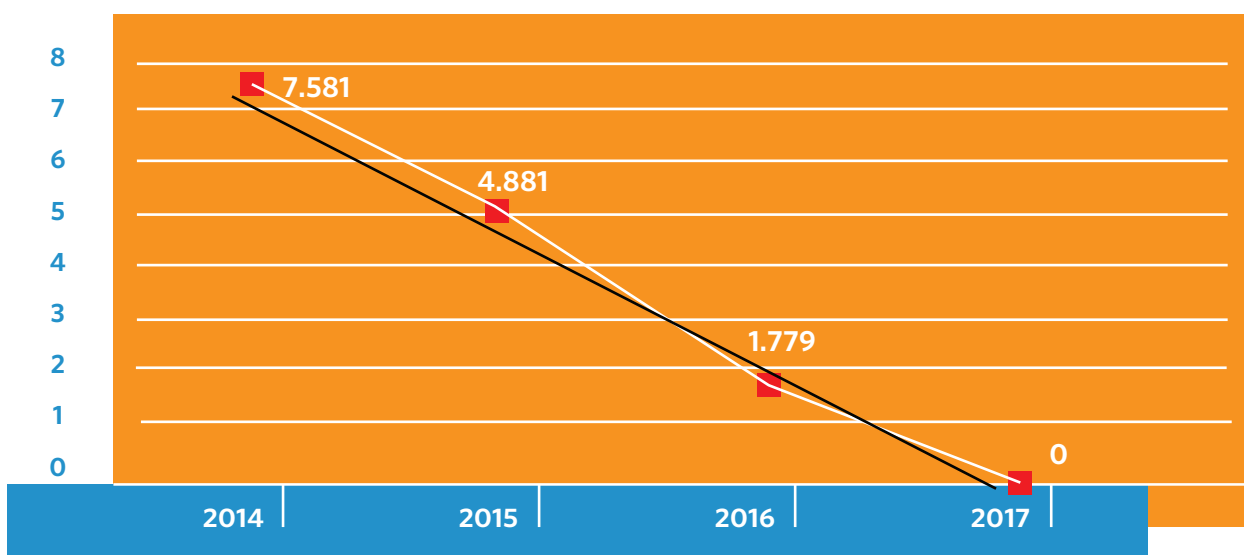


Figure 42: Contraceptive Combined Oral pills monthly stock level at UNRWA central stores in the GS (average monthly consumption = 190,000)

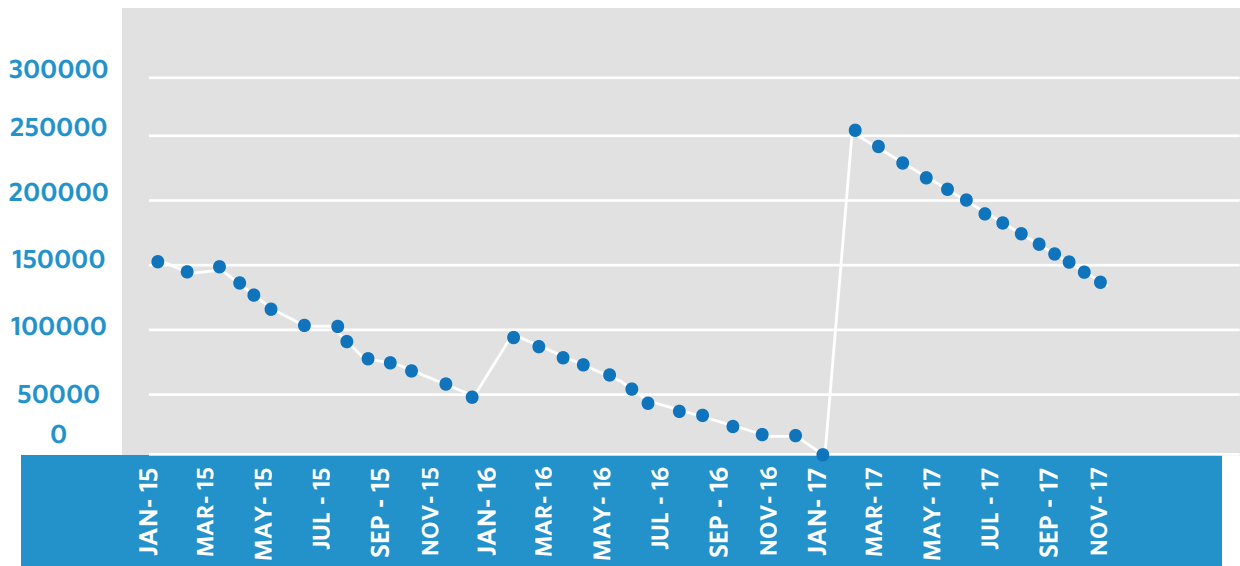


Figure 43: Progesterone only monthly stock level at UNRWA central stores in the GS (average monthly consumption = 84,000)

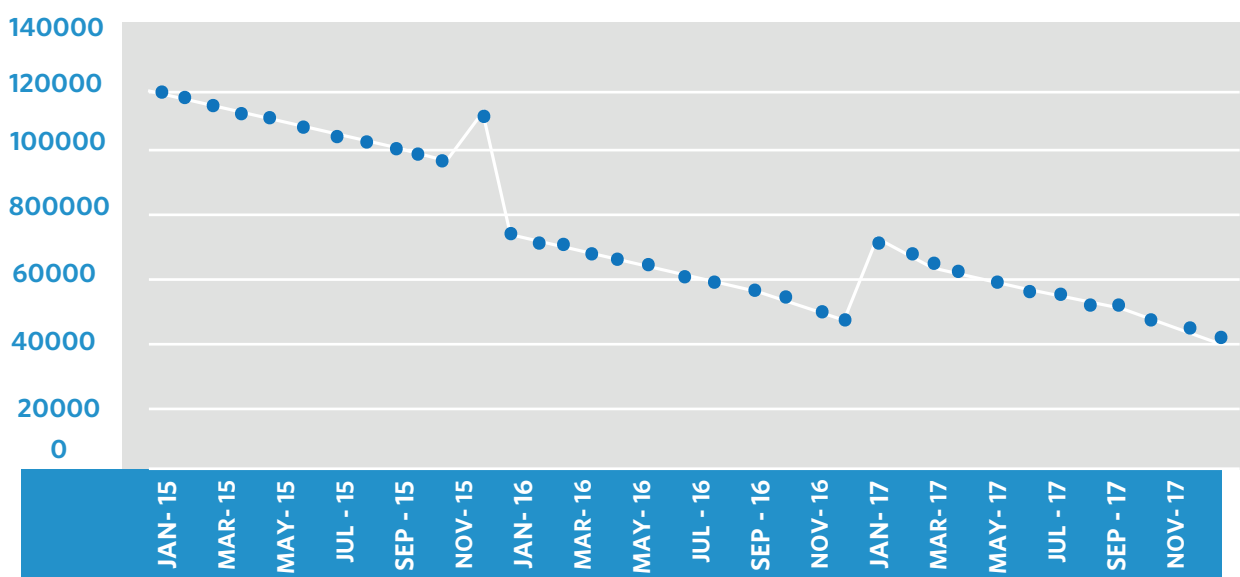


Figure 44: Monthly stock level of Medroxyprogesterone at the UNRWA central stores in the GS (average monthly consumption = 700)

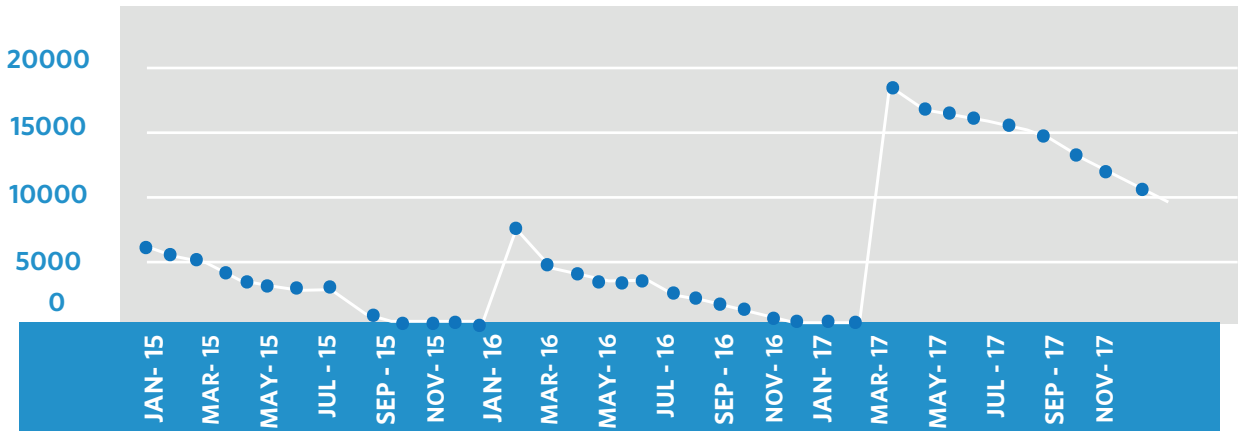


Figure 45: Male Condom monthly stock level at UNRWA central stores in GS (average monthly consumption = 82,000)

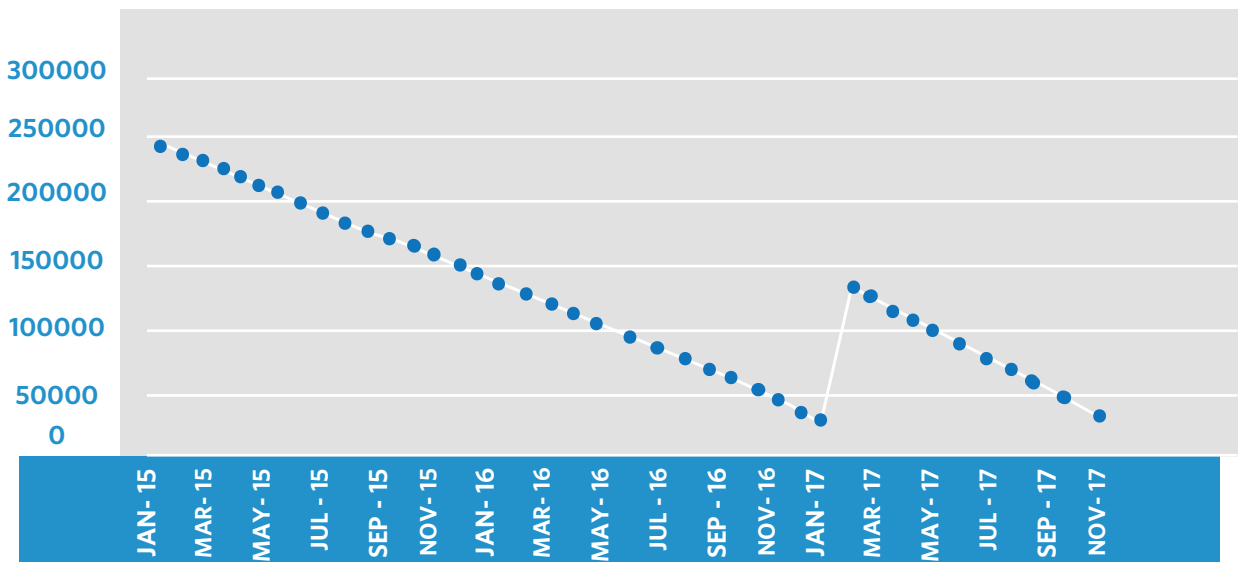
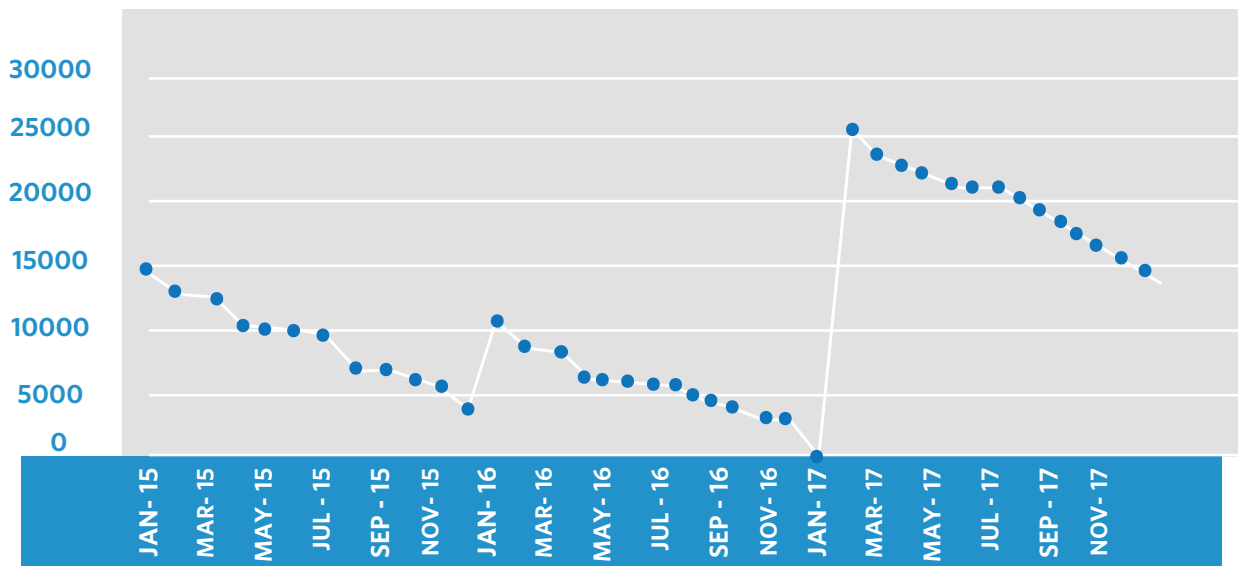


Figure 46: IUD monthly stock level at UNRWA stores in the GS (average monthly consumption = 1000)



Box 9: Policy recommendations for FP commodity security

- Advocacy and lobbying by all stakeholders to ensure more commitment from the policy makers to secure the resources needed to procure FP commodities, especially those listed in the essential drug list of the MOH. FP commodities are as essential as other drugs like vaccines, supplements and other preventive drugs. This requires further policy dialogue to convince decision makers at NGOs and MOH about the importance of FP, setting and implementing policies for securing FP methods and services, and the need to better integrate these services in the reproductive health services and among providers.
- The quality of care and the process of service delivery, including the supply cycle and stock management, are deficient and need to be revisited and strengthened. We can build on the achievements made in computerizing the central store operations, however, this system needs to be complemented by a good system of distribution, monitoring, supervision and feedback at the middle level of management and at service delivery levels.

- There is a need to streamline concepts, definitions and approaches related to commodity management including methods for estimating needs, amount of buffer stock, interval of ordering commodities, reporting and documentation and using the same units of measurement across providers, which currently is not the case, as UNRWA and some NGOs use cycle as a unit of measurement for contraceptive pills, while the MOH uses tablets as a unit of measurement.
- Better coordination to avoid duplication and fragmentation which leads to waste of resources on one hand, and unmet needs on the other hand. The national steering committee could play an important strategic role in leading FP services starting from raising demand, determining national needs, distribution of work load among actors and ensuring commitment and accountability. Ideally, there should be mapping for FP service providers, their roles are clear and agreed, national forecasting for the amounts of methods needed, standardized national documentation forms, and a central national database and national monitoring system.
- Regulation of the works and services of NGOs and private sector providing FP services is essential. Although the NGOs/private sector should be committed to the national reproductive health strategy, the reality grim and reflects a lack of commitment and very poor coordination. Some NGOs, especially in GS, receive FP commodities from MOH, but are not committed to the sustainability and continuity of service provision. Some provide FP services seasonally, others skip providing certain methods because they are expensive with little cost recovery, so they select methods that are not costly to the organization. Even when they receive FP supplies freely from MOH stores, most NGOs ask beneficiaries to pay fees. MOH should invest further in monitoring the utilization of services through supervision, regulations and better coordination.
- Some organizations receive supplies and commodities from MOH disproportionate to their contribution to the service provision. It is important to track and monitor the utilization of FP from service providers.
- As a result of several limitations in commodity management, shortages and sometimes overstock were consistently present. Urgent measures, including developing written policies, are needed to improve all the processes associated with commodity security including appropriate estimating needs, tendering, delivery, storage, dispensing and utilization and developing performance monitoring indicators for each of these steps. Although there were shortages in many years, some FP commodities were discarded due to expiry. Activating monitoring and supervision at the organizational level and national level is essential.

- The study flags serious delays and inefficiencies in the delivery which could be mitigated by better planning and having adequate buffer and emergency stock to cope with unexpected delays resulting from unpredictable Israeli clearance procedures.
 - It was reported that FP commodities were pushed from the central store to the lower levels in amounts greater than requested and sometimes for organizations that are not seriously interested in providing FP services. Some clinics commented that they had received quantities larger than requested. Efforts to better regulate and standardize services is essential.
-
- Gaps in FP commodity security are not only related to lack of resources and or the political commitment to procure FP methods, but also due to structural defects. Unlike other drugs or disposables, FP commodities are usually requested, managed and dispensed by nurses/midwives who are not trained to do that. This means that training should be provided to nurses on commodity management. Pharmacists at the service delivery points should also be involved in managing commodities. Currently, the department in charge of drug inspection and supervision at MOH doesn't perform any checking on commodities, stock and registration. Stock management at service delivery level should be the responsibility of the pharmacists. The role of nurses is to dispense these commodities to clients while the role of the pharmacist is to secure enough stock at the level of his facility.
 - Sustainability of supplies is the cornerstone of FP services. In order to enhance sustainability, the PA should consider how to ensure consistent supply. More resources should be secured from the PA budget (similar to vaccines) to procure FP methods. It is important to support MOH efforts by creating a national fund for FP with contribution from different service providers, international donors, and private sectors. Until that occurs, organizations need to demonstrate commitment to the national reproductive health strategy including the procurement of FP methods to avoid any interruption of provision of services.
 - UNRWA's approach of procuring commodities through UNFPA is highly efficient and results in high savings. The same approach can be used for buying all FP commodities on a national level. The steering committees would determine the national needs, UNPFA would support the procurement process, UNRWA would help in

logistics, and MOH would have the role of oversight supervision.

- Unintentionally and with the best intentions, UNFPA contributed to some irregularity in commodity security. Although, UNFPA encourages the health care system to show more commitment to FP and to procure the commodities from the core budget which is positive, still it provides some commodities through projects or emergency funds. Organizations are confused whether they will receive commodities from UNFPA in the future or not.

Box 10: Policy implications for the UNFPA

UNFPA aims to invest more in raising commitment to FP and to encourage the local service providers to procure FP commodities from their own budgets, similar to other drugs listed on the essential drug list. UNFPA is keen to decrease dependence on the organization as the first provider of the commodities. However, shortages were noticed with frequent stock outs especially from 2015-2017. Nevertheless, when possible, UNFPA is still committed to secure FP commodities through emergency funds and projects' money. In the past decade UNFPA supported the procurement of FP supplies, which unintentionally created dependence. Now service providers are concerned and they are not sure whether UNFPA will continue to provide commodities to them or not. UNRWA, as one of the main FP service providers, is especially keen to develop a coordinated national strategy to ensure regular supplies of FP commodities. This will avoid interruption of service provision and decrease waste of resources. It is advised that UNFPA develops a clear RLS including exit strategy in coordination with service providers.

It is preferable if UNFPA invest more on;

- o Developing a written strategy for the UNFPA support to FP with clear negotiated plan for a gradual phasing out.
- o Communicating the strategy to the stakeholders. Also, it is important to engage stakeholders in the processes so they are aware about who will provide what and where in order to avoid surprises and to align UNFPA's support with the service providers' plans.
- o Helping organizations to develop an efficient and effective procurement system to sustain the provision of FP services with clear roles and responsibilities.

- o The momentum for FP services has somewhat faded and little attention is paid to it now. It is important that UNFPA keeps FP on the agenda of policy makers, service providers and social and health promotion programs and acts as a safety to advocate that FP is critical to achieve the SDGs.
- o Supporting the sustainability and effectiveness of the national FP services, UNFPA should advocate for the integration of the FP services within the reproductive health services in a people-centered and holistic approach to care.
- o Advocating for the procurement of commodities from organizational core budgets, similar to other organizations.
- o Possibly helping in creating a national core fund for procurement of commodities. UNFPA can help through its efficient procurement processes, UNRWA can support the logistics and delivery and MOH can provide regulatory frame and strategic leadership.
- o Upgrading, disseminating and training on FP guidelines/protocols and monitoring its implementation.
- o Focusing on supporting community mobilization efforts to induce change in social norms, particularly through addressing adolescents and youth, monitoring performance in reference to SDGs, and leading knowledge generation about issues relevant to FP.
- o Ensuring that FP is incorporated into capacity building programs and fostering training in FP services.
- o Advocate for using the FP program as an entry point and catalyzer for other programs and services such as youth services, mental health and psychosocial support, gender based violence and vice versa, using these programs to change social norms about FP.



References

- Abu Hamad, B and Panvello, S. (2012), Transforming Cash Transfers: Beneficiary and community perspectives on the Palestinian National Cash Transfer Programme. London: Overseas Development Institute.
- Abu Hamad, B. Gercama, I., Jones, N. and Presler-Marshall, E. (2016), Participatory Research with Adolescents. London: GAGE/Overseas Development Institute.
- Al Quds University (2013), Unmet Needs for Modern Family Planning in State of Palestine. Jerusalem: UNFPA.
- Glenn, R., (2007), Demographic Factors Associated with Condom Use in 1824- Year Olds For Two States, 1998 and 20002001/. Thesis, Georgia State University, USA.
- Hamad, B. and Shalabi, A., (2013), Applicability of the Learning Organization Concept, (Saarbrucken, LAP Lambert Academic Publishing, 2013)
- Hamad, K. (2011), Socio-Economic Determinants of Family Planning Services in the Gaza Strip, Doctoral Thesis, Brandeis University, USA.
- Hare, L., Hart, C., Scribner, S., Shepherd, C., Pandit, T., and Bornbusch, A. (2004), SPARHCS: Strategic Pathway to Reproductive Health Commodity Security. A Tool for Assessment, Planning, and Implementation. Baltimore, MD: Information and Knowledge for Optimal Health (INFO) Project/Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health.
- Jones, N and Abu-Hamad, B with Plank, G (2016), Women and Power: How Women Leaders Negotiate Gaza's Political Reality. London: Overseas Development Institute.
- Jones, N, Abu Hamad, B, Odeh, K, Perezniето, P Abu Al Ghaib, O. Plank, G, Presler-Marshall, E and Shaheen, M. (2016), Every Child Counts: Understanding the Needs and Perspectives of Children with Disabilities in the State of Palestine. Palestine/UNICEF.
- Mbuthia, F. (2015), Intrauterine Device Uptake among Women Seeking Family Planning Services at Mbagathi and Mama Lucy Kibaki Hospitals. Master of Science in Public Reproductive Health in the School of Public Health of Kenyatta University. Nairobi-Kenya
- MIFTAH, Independent Commission for Human Rights and UNFPA (2015), Country Assessment towards Monitoring and Reporting Sexual and Reproductive Health and Rights [SRHR] in Palestine. Available: http://www.miftah.org/Publications/Books/Country_Assessment_Book2015.pdf
- Ministry of Health (2014), Health Sector Strategy Plan: Gaza Governorates 20142018-. Gaza: MOH
- Ministry of Health (2017), Health Annual Report Palestine 2016. Ramallah MOH
- MoSA (2011), Ministry of Social Affairs: Business Strategy. Ramallah, May 2011. Ramallah, Palestine: Ministry of Social Affairs.
- Mutombo, N. Bakibinga, P. Mukiira, C. and Kamande, E. (2017), Benefits of family planning: an assessment of women's knowledge in rural Western Kenya. Open BMJ, 4, 3 Publishing Group Limited ISSN 20446055-.

Mutombo, N. and Bakibinga, P. (2013), The Effect of Joint Contraceptive Decisions on the Use of Long-acting and Permanent Methods among Married Female (15-49) Contraceptive Users in Zambia: a Cross-sectional Study. *Reproductive Health* (Under review).

Palestine Central Bureau of Statistics (2015), *Palestinian Multiple Indicator Cluster Survey 2014, Final Report*. Ramallah: Palestine.

Palestine Central Bureau of Statistics (2016) *Palestinian Youth Survey, 2015: Main Findings*. Ramallah Palestine: PCBS

Palestinian Central Bureau of Statistics (2007), *Palestinian Family Health Survey, 2006: Final Report*. Ramallah-Palestine: PCBS.

Palestinian Central Bureau of Statistics (2013), *United Nations Population Fund & United Nations Children’s Fund Palestinian Family Survey 2010*. Ramallah Palestine: PCBS.

Palestinian Central Bureau of Statistics (2018), *A Press Release on the Eve of the International Women’s Day on Tuesday, 08201/03/*. Ramallah: Palestine PCBS

Palestinian Central Bureau of Statistics (2018), *Preliminary Results of the Population, Housing and Establishments Census, 2017*. Ramallah Palestine: PCBS

PCBS (2015), *The Status of the Palestinian Population Living in Palestine*. Ramallah Palestine: PCBS

PCBS (2017) *Statistical Yearbook of Palestine 2017*. Ramallah Palestine: PCBS

Rao, R. (2008), *Commodity Security for Essential Medicines: Challenges and Opportunities*. Arlington, Va. USAID: DELIVER PROJECT, Task Order 1.

Rutstein, S. (2005), “Effects of preceding birth intervals on neonatal, infant and under-five years mortality and nutritional status in developing countries: evidence from the demographic and health surveys”. *International Journal of Gynaecology & Obstetrics* 89 (Supplement 1), 2005. pp. S7-S24.

Shrestha, T. Gauchan, S, and Parsad, R. (2014), *Socio-Demographic Factors Affecting Family Planning Decisions among the Married Women in Rural District of Nepal*. *Journal of General Practice and Emergency Medicine of Nepal*, 5, Jul-Dec, 2529-.

UN Women (2011), ‘*Cross-Sectoral National Gender Strategy: Promoting Gender Equality and Equity 2011-2013*’. Ramallah- Palestine: Palestinian National Authority, Ministry of Women’s Affairs/UN Women (http://www.unwomen.org/wp-content/uploads/201105//UN-Women_oPt_Full-Palestinian-Gender-Strategy_2011_en.pdf).

UNFPA (2016), *PALESTINE 2030: Demographic Transition in Palestine and What it Means for Development*. Palestine: UNFPA.

UNFPA (2017), *Youth in Palestine: Policy and Program Recommendations to Address Demographic Risks and Opportunities*. Palestine. palestine.unfpa.org/en/publications/youth-palestine-2017

United Nations (2014), Health in the Framework of Sustainable Development: Technical Report for the Post-2015 Development Agenda. Thematic Group on Health for All of the Sustainable Development Solutions. Retrieved unsdsn.org/wp-content/uploads/201402//Health-For-All-Report.pdf.

United Nations Office for the Coordination of Humanitarian Affairs-OCHA (2017), Overview of Access of Palestinians from Gaza in 2016. Posted on 10 February 2017 as part of The Monthly Humanitarian Bulletin | January 2017. <https://www.ochaopt.org/content/overview-access-palestinians-gaza-2016>.

United Nations, Department of Economic and Social Affairs, Population Division (2015), Trends in Contraceptive Use Worldwide (ST/ESA/SER.A/349).

United Nations, Department of Economic and Social Affairs, Population Division (2014), World Contraceptive Use (POP/DB/CP/Rev2014).

UNRWA (2017), Annual Report Health Department. Amman: UNRWA

WHO (2018), Family planning/Contraception? Fact Sheet. [UNFPA%20group/family%20planning/WHO%20_%20Family%20planning_Contraception.htm](https://www.unfpa.org/group/family%20planning/WHO%20_%20Family%20planning_Contraception.htm)

World Bank (2010), 'Checkpoints and Barriers: Searching for Livelihoods in the West Bank and Gaza. Gender Dimensions of Economic Collapse'. Washington, DC: The World Bank.

World Bank (2011), 'West Bank and Gaza: Coping with Conflict? Poverty and Inclusion in the West Bank and Gaza'. Report 61293. Washington, DC: World Bank, Social and Economic Development Group, Middle East and North African Region.

World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/ Center for Communication Programs (CCP), INFO Project (2007), Family Planning: A Global Handbook for Providers. Baltimore and Geneva: CCP and WHO.

Annex 1
Terms of Reference



UNITED NATIONS POPULATION FUND
Study family planning commodity security system (WB)

I. Background:

UNFPA works with the Palestinian Ministry of Health and other partners on improving family planning services uptake at public sector facilities. Unmet need for family planning in Palestine reached 15.6% in 2010 and declined to 10% in 2014. While declining unmet need has marked significant improvement in commodity availability and increased uptake of family planning services in general, significant variation among districts have been associated with the quality of care and social determinants affecting women`s ability to decide and seek care.

Forecasting of needs, supply chain management and logistic challenges have resulted repeatedly in stock disruption at service delivery points and central drug stores. In spite of active involvement in policy and program level dialogue aiming at ensuring availability of commodities at the service delivery points, and continuous supply with commodities at the national level, stock outs and excess amounts of commodities were reported few times by various service providers.

UNFPA envisages conducting a system review of family planning commodity security policy, procedures and practice as a step towards ensuring sustainable and reliable supply with commodities across the country and providers.

To undertake this task, UNFPA country office is recruiting a national health system development expert/s to conduct the review using a range of quantitative and qualitative methods.

II. Purpose of the Study:

The review aims at identifying system gaps leading to frequent disruption of supply with family planning commodities at central and peripheral levels. In particular, the review will shed light on modern contraceptive use, social barriers to women`s choice, forecasting policies and procedures within the public health sector, identify delays and gaps in goods transportation, storage and distribution within selected areas of West Bank and Gaza.

The review is also expected to highlight major bottlenecks in requesting, transporting and delivery of goods timely to relevant destination.

Upon review of current contraceptive prevalence rates and service utilization patterns, the researcher needs to develop an estimate about annual needs in contraceptives in line with the method mix present in the country.

This exercise needs also to offer a costing estimate on inputs related to commodity security, logistics and system operation aligned to service providing agency and geographic location. In particular, the review will highlight the interaction and complementary nature of service delivery and cost sharing between Government, UNRWA and NGO service providers. Options for procurement of commodities need to be identified including drawing price comparisons among different options.

III. Scope of Work:

Through working with UNRWA, which has a well-developed system for needs forecast, distribution and monitoring of uptake, UNFPA will try to come up with a clear definition and unified approach to assessment of needs in family planning commodities across all public providers.

If agreed, UNFPA Palestine country office will host Dr. Ali Khader from UNRWA HQ to undertake a one week visit to Palestine and work with UNFPA and partners on defining needed quantities reflective of current patterns.

Together with selected counterpart at UNFPA, Dr. Khader will produce a comprehensive and informative report describing population pattern in use of contraceptives, in-use policies and practices in service delivery and distribution of service delivery points and methods available to calculate, predict or project needed amounts for each provider and or province.

IV. Envisaged work plan:

One week visit to Palestine will focus on conducting the following activities. A detailed schedule will be prepared upon agreement on scope and dates:

1. Conduct literature review of available documents. Once agreed, a package of literature will be shared prior to visit
2. Conduct interviews with key stakeholders at the policy and program levels. Individual and group meetings will be arranged once dates are clear
3. Review available policies and practices in forecasting, supply and distribution of goods to district and service delivery points
4. Develop and use a costing methodology addressing inputs, operation and outcomes

TERMS OF REFERENCE FOR INDIVIDUAL CONSULTANT (GS)

TERMS OF REFERENCE (to be completed by Hiring Office)	
Hiring Office:	UNFPA Arab States Regional Office
Purpose of consultancy:	Finalize report on family planning commodity management and security in Palestine
Scope of work: (Description of services, activities, or outputs)	Review draft report produced by Dr. Ali Khader and introduce changes wherever needed Validate and complement information and evidence on situation in Gaza Interview, if needed relevant policy makers and program staff Produce a final report encompassing changes and updates to the formal one.
Duration and working schedule:	November 25th - December 30 2017
Place where services are to be delivered:	Gaza
Delivery dates and how work will be delivered (e.g. electronic, hard copy etc.):	<ul style="list-style-type: none"> - 30th November 2017- Methodology - December 2nd - December 15th - Desk review, data collection and meetings - December 20th - Draft report - December 30th - Final report
Monitoring and progress control, including reporting requirements, periodicity format and deadline:	Working with program specialist in Jerusalem and program officer in Gaza
Supervisory arrangements:	NA
Expected travel:	Internally in Gaza
Required expertise, qualifications and competencies, including language requirements:	<ul style="list-style-type: none"> - PhD health management - Expertise in health system research - Advances analytical skills and computer literacy
Inputs / services to be provided by UNFPA or implementing partner (e.g support services, office space, equipment), if applicable:	NA
Other relevant information or special conditions, if any:	NA
Signature of Requesting Officer in Hiring Office: Date:	

Annex 2 Example of questions for the KII interviews

- How you describe family planning services at your organization? When you have started this service, how it has been introduced, how essential it is in the delivered package of services? How the context is supportive/restrictive to family planning services and policies? (National policies, regulations, social, political and economic factors, and other competing health priorities)? How the context is affecting FP supplies. How you judge the level of national and local commitment to FP?
- Reflect on the quality of family planning services at your organization, what works well-what doesn't work well (reflect on counselling, respecting choice, privacy, rights dimension, regularity of supply, adequacy and variety of methods). How often are clients turned away or referred to other facilities because services or methods are not available at your facility?
- Where does family planning services fit within the services structure, how vital it is being regraded, staff working on family planning (number, category, qualifications, training). How much family planning are gaining attention and focus, is it part of the strategic plan, part of organization priorities, how much policy makers regard it as a priority-give examples?
- How much you contribute to the coverage of family planning, with whom you coordinate and on what? Reflect on the entitlement for family planning, right, conditions for service provision (health insurance, husband approval), who are typically the users, who denied from services, males' participation).
- Do you have any written policies and protocols to standardize the family planning services (generating demand, selection of tools, forecasting needs, procurement, supply chain, storage, inventory, distribution, utilization)?
- How you describe the demand for services, what strategies you use to generate demand? (Health education, policies). Unmet needs of family planning, causes, how addressed?
- To what extent, your organization culture and polices are supportive to family planning services, allocation of resources, infrastructure, supervision system, monitoring, staff capacity, structure? How developed are the human and systems capacities for FP, in service delivery, logistics management, forecasting and procurement, monitoring and evaluation, etc.? How do, actors, donors, and the private sector collaborate and act jointly for FP?
- Which family planning methods you provide? Have you seen any change in the method used by women? Any trends when, how, where and Why? Finally, who determines the method to be used by women? What is the profile of beneficiaries using different methods? Who uses what more?

- Who determines the types of methods to be procured? Do you conduct any assessments? Do you consider clients preferences? Looking to other providers, is there a difference between method used at your organization and other organization? For example, at UNRWA, more use of IUD, at MOH more use of pills and condoms? Why that difference is noticed?
- What kind of information you register about family planning use? Can we have data in the last 10 years?
- Which FP tools you currently provide? Modalities, how it is being decided, is it part of your essential list, specifications?
- Tell me about the processes currently in use in managing family planning services, having a written flow chart, how family planning services and commodities are managed, focus on supply, procurement, delivery, distribution to center?
- How quantities are determined for each type-which method you use? Who determines it, how? How effective that method is, what do you suggest to change in that method? What about the stock adequacy in the past 10 years, can you show us stock level and shortages trends in the past 10 years? How reliable is the supply? Monthly Stock and Storage for each method in the past 10 years? Why shortages occur, how can be prevented at central store and clinic level) How often are orders placed for FP methods? How are order quantities determined? What data items are used? How long does it take to calculate order quantities and place the order? Are order amounts validated by comparing previous estimated consumption with actual consumption? What is the average length of time between request and receipt of orders? Do you have order track system? Describe the process for receiving FP items.
- How much the FP services and methods cost? Who provided the resources, how much it constitutes from the total budget? How much the organization is committed to secure these resources? How much clients contribute to the costs?
- Do you have performance indicators for family planning, which are, who monitors them (ordering, procurement, delivery, distribution, utilizations)? How often you release reports? Can I have copies? What transaction records are kept for tracking receipts of FH services
- What does your information report show? Inventory balance (stock on hand)? Quantity Losses and adjustments? dispensed or issued during a specified reporting period? Quantities received?
- How you describe stock inventory management system for FP? Is periodic stock reconciliation performed by comparing actual quantities of stock on hand with inventory records? How far the supply logistic management is automated?

- Barriers and gaps in the processes of estimating needs, procurement process, storage, distribution and utilization
- Role of UNFPA, what does the organization do? How it does it? Main achievements/contributions made by UNFPA, How UNFPA role can be different? How you plan to cope with the UNFPA phasing out,
- In the coming period, what are prospects for financing of family planning supplies by governments and others (donors, household, third parties)?
- How the management of family planning services can be improved in the country?
- Any other comments

Annex 3: Birth intervals (in months) and selected variables

Variable	2010		2014			
Region						
State of Palestine	28.8		30.1			
GS	27.7		28.3			
WB	29.6		31.5			
Locality type						
Urban	29.1		30.0			
Rural	28.1		30.7			
Camp	28.0		30.4			
Wealth index						
Poorest	26.7		27.7			
Second	27.9		28.3			
Middle	28.4		29.6			
Forth	29.4		31.4			
Richest	31.9		33.8			
Women's age group						
19-15	20.5		19.9			
24-20	21.5		21.6			
29-25	25.6		25.3			
34-30	28.8		29.2			
39-35	30.7		32.2			
44-40	30.4		32.4			
49-45	29.1		30.7			
Women' education level						
None			28.2			
Basic			29.3			
Secondary			30.7			
Higher			30.1			
Preschool	25.2					
Elementary	28.3					
Preparatory	29.1					
Secondary	29.1					
Higher	28.9					
Number of children- parities						
1	33.2		0			
23-	24.5		25.4			
46-	31.9		34.4			
7+	32.7		35.7			
Sex of the last birth						
Female	28.9		30.2			
Male	28.7		30.1			
Table Birth intervals by age and region 2010						
Age group	Palestine		WB		GS	
	2010	2014	2010	2014	2010	2014
1519-	20.5	19.9	19.8	18.8	21.4	20.3
2024-	21.5	21.6	21.7	22.1	21.2	21.1
2529-	25.6	25.3	26.4	26.6	24.6	23.9
3034-	28.8	29.2	29.3	30.8	28.0	27.3
3539-	30.7	32.2	31.4	33.4	29.7	30.5
4044-	30.4	32.4	31.1	33.4	29.2	30.8
4549-	29.1	30.7	29.8	31.8	27.9	29.0
5054-	28.1	30.1	29.2	31.5	26.3	28.3
Total	28.8	19.9	29.6	18.8	27.7	20.3

Annex 4: FP methods dispensed from MOH central stores in Gaza to other organizations

Method	Combined	Progestin only	Condom	IUD	Medroxyprogesterone
UNRWA in Gaza					
2011	313600	378000	0	0	9100
2012	0	0	0	0	0
2013	0	105000	250560	500	2000
2014	700000	0	0	0	3974
2015	0	0	0	0	0
2016	262080	0	0	1000	0
2017	0	0	0	0	0
Total	1275680	483000	250560	1500	15074
PHC/MOH					
2011	579760	453600	67208	3000	2075
2012	624960	453600	160576	2200	1300
2013	1007832	378000	129600	1400	1100
2014	762337	460635	115200	1550	1650
2015	181356	352800	167148	2835	274
2016	447216	426244	136800	2500	625
2017	494172	336106	144000	1999	990
Total	4097633	2860985	920532	15484	8014
NECC					
2011	70000	0	0	100	35
2012	14028	14070	21600	100	20
2013	0	94500	14976	25	20
2014	22400	17500	24912	40	0
2015	0	21000	14400	0	0
2016	0	10500	7200	0	0
2017	40320	15750	0	0	0
Total	146748	173320	83088	265	75
PMRS					
2011	5600	0	0	0	150
2012	22400	10500	0	300	0
2013	25200	13650	4464	200	60
2014	5600	14000	4500	200	60
2015	0	3150	4320	0	25
2016	22680	9450	0	0	0
2017	0	0	0	0	0
Total	81480	50750	13284	700	295
UHCW					
2011	0	0	0	0	0
2012	22400	21000	21600	500	0
2013	53256	24570	6480	1800	50
2014	14000	7000	1008	100	0
2015	0	0	0	0	0
2016	0	0	0	0	0
2017	0	0	0	0	0
Total	89656	52570	29088	2400	50

RCS-GS					
2011	42000	0	0	400	200
2012	0	10500	0	0	100
2013	80640	50400	4032	500	200
2014	98280	50505	3996	500	200
2015	0	50000	4032	0	0
2016	0	0	0	0	0
2017	0	0	0	0	0
Total	220920	161405	12060	1400	700
Patient friends					
2011	0	0	0	0	0
2012	0	2100	0	0	60
2013	0	0	0	0	0
2014	0	0	0	0	0
2015	0	0	1008	0	0
2016	0	0	0	0	0
2017	0	0	0	0	0
Total	0	2100	1008	0	60
Kawuiti Hospital					
2011	14000	0	0	1500	500
2012	0	0	1000	0	0
2013	0	0	0	0	0
2014	28000	31500	7488	200	150
2015	0	0	0	0	0
2016	0	0	0	0	0
2017	0	0	0	0	0
Total	42000	31500	8488	1700	650
Karama					
2011	2800	0	0	50	50
2012	4200	2100	432	300	0
2013	0	0	0	0	0
2014	0	0	0	0	0
2015	0	0	0	0	0
2016	0	0	0	0	0
2017	0	0	0	0	0
Total	7000	2100	432	350	50
Sahaba					
2011	0	0	0	0	0
2012	7000	5950	1000	150	70
2013	40488	12705	36000	800	550
2014	0	0	0	0	0
2015	0	0	0	0	0
2016	0	0	0	0	0
2017	0	0	0	0	0
Total	47488	18655	37000	950	620

Military medical services					
2011	0	0	0	0	0
2012	26899	0	0	450	0
2013	0	0	0	100	300
2014	0	0	0	0	0
2015	0	0	0	0	0
2016	0	0	0	0	0
2017	0	0	0	0	75
Total	26899	0	0	550	375
Women Health-CFTA					
2011	0	0	0	0	30
2012	0	0	1440	50	0
2013	21000	3150	1440	50	25
2014	19600	3150	1440	50	20
2015	0	4200	1872	0	0
2016	0	0	0	0	0
2017	0	0	0	0	0
Total	40600	10500	6192	150	75
FPS					
2011	2856	0	0	100	150
2012	2800	3500	432	200	0
2013	0	0	0	0	0
2014	14000	17500	4752	200	0
2015	0	0	0	0	0
2016	0	0	0	0	0
2017	0	0	0	0	0
Total	19656	21000	5184	500	150
Al-Quds H					
2011	7000	0	0	50	0
2012	0	0	720	0	0
2013	0	0	0	0	0
2014	0	0	0	0	0
2015	0	0	0	0	0
2016	0	0	0	0	0
2017	0	0	0	0	0
Total	7000	0	720	50	0

Annex 5: Monthly average of stock level of FP methods at the MOH main stores

Month	Contraceptive Progesterone Only	Contraceptive Combined Oral	Condom	Multi-load	Medroxyprogesterone 150 mg
Feb-13	610	2599	257616	5600	13505
Mar-13	580	2539	242640	5575	13355
Apr-13	414	2318	190224	2225	12960
May-13	310	2117	161424	1825	12600
Jun-13	234.9	2016	161424	1825	10200
Jul-13	234	1915	541424	1325	10200
Aug-13	129	1915	541424	1325	10200
Sep-13	137.19	1814	527024	4675	10200
Oct-13	1814	1814	276464	4175	9700
Nov-13	1713.2	1613	204464	4175	9700
Dec-13	386	1613	204464	4175	9200
Jan-14	587	1511	204460	4100	9200
Feb-14	537	1411	204000	4175	9600
Mar-14	487	640	192000	3380	6113
Apr-14	370	436	162000	3180	5630
May-14	340	376	150000	2960	5480
Jun-14	240	332	89400	2980	5230
Jul-14	210	272	77400	2760	5080
Aug-14	190	232	89000	2490	5230
Sep-14	160	172	77000	2270	5080
Oct-14	130	112	65000	2050	4930
Nov-14	78	94	74000	2400	4930
Dec-14	28	0	59600	1800	3270
Jan-15	0	0	9200	1330	2800
Feb-15	0	0	9200	1300	2800
Mar-15	806	0	268000	835	2575
Apr-15	756	0	253500	300	0
May-15	630	0	206000	0	0
Jun-15	630	0	206000	0	0
Jul-15	630	80	206000	0	0
Aug-15	580	100.8	170370	2000	0
Sep-15	530	20	166400	1500	0
Oct-15	504	0	162020	1500	0
Nov-15	450	0	133200	1000	0
Dec-15	0	0	111600	0	0
Jan-16	375	0	111620	500	0
Feb-16	324	0	90000	0	0
Mar-16	287	0	82800	0	0
Apr-16	274	0	61000	500	0

May-16	500	1380.12	47000	500	0
Jun-16	526	1279	46800	3500	0
Jul-16	501	1239	52500	3500	0
Aug-16	455	1156	45300	3500	1350
Sep-16	405	1093	23700	3000	1300
Oct-16	350	770	23000	2000	1000
Nov-16	320	690	74120	2500	850
Dec-16	281.8	931.92	163112	1999	940
Jan-17	224	870	134000	1700	770
Feb-17	289	811	127100	1550	700
Mar-17	260	730	112700	1050	625
Apr-17	233	710	112700	1050	550
May-17	208	650	98300	800	400
Jun-17	160	600	76700	800	325
Jul-17	130	540	64700	580	155
Aug-17	84	498	62300	500	170
Sep-17	46	437	48000	350	100
Oct-17	21	417	33500	50	100
Nov-17	0	357	21500	220	0
Dec-17	0	357	19112	0	0

معايمة خدمات تنظيم الأسرة في فلسطين: تحديات وفرص

إعداد
د. علي خضر & د. بسام أبو حمد

ديسمبر 2018

النتائج، والتفسيرات والاستنتاجات الواردة في هذا التقرير هي تفسيرات واستنتاجات المؤلف/ المؤلفين ولا تعكس بالضرورة سياسات أو وجهات نظر صندوق الأمم المتحدة للسكان. لا تتضمن التسميات الواردة في هذا التقرير أي رأي بشأن الوضع القانوني لأي دولة أو إقليم أو سلطانه أو ترسيم الحدود.

مُلخَص تنفيذي

مُلخَص تنفيذي

لتنظيم الأسرة فوائد متعددة لا تقتصر فقط على الجانب الصحي و انخفاض معدلات الوفيات والمراضة، ولكنها تشمل أيضا تحسين الوضع الاقتصادي والحد من الفقر إضافة إلى تعزيز دور المرأة في المجتمع وتحسين المستوى التعليمي. وعلى الرغم من أن خدمات تنظيم الأسرة تعتبر قضية مهمة تتعلق بحقوق الإنسان، إلا أنه يوجد في فلسطين العديد من المعوقات التي تحد من القدرة على تلبية تلك الحقوق والحصول على خدمات تنظيم الأسرة عالية الجودة، كما يُنظر إلى تنظيم الأسرة على أنها قضية طيبة تتعلق أساساً بالمرأة، ولا يتم إشراك الرّجل إلى حد كبير في هذه المسألة.

منذ عام 2008، واستجابة للطلب العالي والحاجة الكبيرة لخدمات تنظيم الأسرة، خصص صندوق الأمم المتحدة للسكان نسبة كبيرة من موارده لتوفير وسائل تنظيم الأسرة لمزودي خدمات الصحة الإنجابية والجنسية بما في ذلك وزارة الصحة، ووكالة الأمم المتحدة لغوث وتشغيل اللاجئين في الشرق الأوسط و المنظمات غير الحكومية. حيث ساهمت هذه الاستراتيجية في تقليل الاحتياجات غير الملباة بشكل كبير ما أدى إلى انخفاضها من 19% في 2006 إلى 11% في عام 2014. وعلى الرغم من جهود صندوق الأمم المتحدة للسكان لتأمين مخزون مستقر وكاف لوسائل تنظيم الأسرة في فلسطين، إلا أنه لا يزال هناك تحديات متعددة مثل النقص المتكرر، نفاذ المخزون، وأحيانا فائض في المخزون وانتهاء صلاحية الوسائل قبل استخدامها. حيث يؤدي هذا إلى تفاقم مشكلة الأزمات الإنسانية المزمّنة -لا سيما في قطاع غزة- تعزيز الانقسام السياسي بين الضفة الغربية وقطاع غزة، وتدهور الوضع الاجتماعي الاقتصادي في فلسطين. ومن التحديات المهمة الأخرى التي يجب أخذها في الاعتبار: ازدواجية تقديم الخدمات، نقص الإمدادات، سوء التنسيق بسبب التحديات السياسية والإدارية، والحد من حركة البضائع والأشخاص.

وقد قام صندوق الأمم المتحدة للسكان، في إطار جهوده المتواصلة لتعزيز خدمات تنظيم الأسرة في فلسطين وتحسين الإدارة العامة لإمدادات تنظيم الأسرة، بالتعاقد مع خبيرين استشاريين لإجراء دراسة مستقلة لخدمات تنظيم الأسرة. حيث تم التركيز بشكل خاص على تأمين وتوفير الوسائل كخطوة مهمة لضمان إمدادات مستدامة وموثوقة من وسائل تنظيم أسرة عالية الجودة.

منهجية الدراسة

استخدمت هذه الدراسة نهجاً مختلطاً يتضمن مراجعة وتحليل الأدبيات، وجمع البيانات الكمية من السجلات الطبية وقواعد البيانات للمؤسسات التي تقدم خدمات تنظيم الأسرة وجمع البيانات النوعية. وليس مقصوداً من هذه الدراسة أن تكون بحثاً تقييمياً، بل يمكن اعتبارها معاينة لخدمات تنظيم الأسرة لإظهار الواقع من زواياه المختلفة، كما تم إتباع نهج مختلط باستخدام طرق جمع البيانات المختلفة ووسائل التحقق المتنوعة.

وقد سعت البيانات النوعية، التي شملت إجراء 45 مقابلة مع المسؤولين إلى استكشاف عميق لكل من: (طرق تقدير احتياجات وسائل تنظيم الأسرة، نظام سلسلة التوريد، حالة التخزين، الإدارة، مستوى المخزون، وطرق توزيع الوسائل). ولهذا الغرض أجريت المقابلات لجمع المعلومات باستخدام أسئلة شبه مفتوحة. وقد أجريت زيارات ميدانية لعينة من المرافق التي تقدم خدمات تنظيم الأسرة. وخلال الزيارات الميدانية، تم فحص الحالة البنيوية لنقاط تقديم الخدمات، و حالة مواقع تخزين تنظيم الأسرة والطرق والأدوات المستخدمة في تنظيم الأسرة. كما تم فحص وربط البيانات التي جمعت بطرق متعددة لإنتاج تحليل متعدد الطبقات، مما مكن الباحثين من استكشاف عمليات إدارة سلسلة التوريد بشكل كامل.

لقد تم إجراء التقييم أولاً في الضفة الغربية في شهري أكتوبر ونوفمبر 2016 وتبعها جولة أخرى من جمع البيانات في قطاع غزة في أواخر عام 2017.

سياق مُقيد جداً

ينعكس الوضع السياسي السائد في فلسطين على خدمات تنظيم الأسرة. كما أثر عليها وجود الاحتلال الإسرائيلي الذي طال أمده، والذي تتخلله صراعات متكررة، إلى جانب القيود الشديدة على حركة كل من الناس والبضائع، وخاصة في قطاع غزة. وقد أدت هذه الحالة المقترنة بانعدام السيادة والسيطرة على الموارد، إلى وضع اقتصادي هش للغاية يعتمد إلى حد كبير على المعونة الخارجية، بما في ذلك توفير وسائل تنظيم الأسرة. إن الوضع المعقد والذي يصعب قراءته واستكشافه، قد أعاق قدرة الفلسطينيين على وضع سياسات وخطط طويلة الأجل، بما في ذلك السياسات السكانية، وتوفير خدمات مستمرة وتأمين الوسائل المطلوبة.

أثبتت الدراسات أن معدلات الخصوبة في انخفاض بشكل عام إلا أن معدل الخصوبة لا يزال مرتفعاً في فلسطين بل من أعلى معدلات الخصوبة، ويرجع ذلك في المقام الأول إلى الزواج المبكر خاصة بين الإناث حيث يسمح القانون الوطني بزواج فتيات لا تتراوح أعمارهن 14.5 سنة، كما أنهن يواجهن ضغطاً كبيراً من عائلاتهن

للزواج في وقت مبكر من أجل الحفاظ على سمعة وشرف العائلة والمصاعب الاقتصادية وكذلك العوامل الثقافية والتعليمية والسياسة العشائرية والدينية. فالمعتقدات الدينية والثقافية التي تهيمن على المجتمع تشجع على الخصوبة العالية وإنجاب العديد من الأطفال وانخفاض معدل الطلاق واستخدام وسائل منع الحمل وارتفاع معدلات الحاجة غير المستجابة لتنظيم الأسرة.

كما وينظر إلى النساء باعتبارهن ربات بيوت غير مستقلات وأداة للإنجاب ومقدمات للرعاية والمربيّات الأساسيات للأطفال، ان مشاركة المرأة في القوى العاملة تعتبر محدد قوي للخصوبة حيث تبدي النساء العاملات أو الباحثات عن وظائف اهتماماً أقل بإنجاب عدد كبير للأطفال ولكن مشاركتها في القوى العاملة محدودة بسبب العوامل الاجتماعية والثقافية والسياسية. ولكن الجانب الإيجابي وفقاً للإحصاءات الفلسطينية أن معدل القراءة والكتابة بين الفلسطينيين خاصة النساء مرتفع جداً وهو يعتبر مؤشراً إيجابياً لاستخدام خدمات تنظيم الأسرة.

يؤكد بحثنا على التعقيدات والطبيعة المتداخلة للعوامل التي تؤثر على الخصوبة واستخدام خدمات تنظيم الأسرة في السياق الفلسطيني، والدور الحاسم الذي تلعبه معايير وممارسات النوع الاجتماعي في تشكيل قرارات وخيارات النساء والعائلات. ومن الضروري فهم هذه التعقيدات والنظر فيها من قبل صانعي السياسات والمسؤولين ومقدمي الخدمات. كذلك من المهم مراعاة المحددات الرئيسية التي تؤثر على الخصوبة واستخدام أساليب تنظيم الأسرة من خلال المبادرات المشتركة بين القطاعات مثل مكافحة الفقر، تمكين المرأة، التشريعات الداعمة واستهداف الفئات الهشة. وعلاوة على ذلك، فإن الاستثمار في تعليم الفتيات في المرحلة الثانوية وما بعد المرحلة الثانوية وتطوير برامج تعزيز الصحة، بما في ذلك استخدام وسائل الإعلام، أمر حاسم لإحداث تغيير حقيقي في معدل الخصوبة واستخدام وسائل منع الحمل.

ركود معدلات استخدام وسائل منع الحمل

يستخدم معدل انتشار وسائل منع الحمل كمؤشر دال يعكس تفاعل العديد من العوامل في كل من التوريد والحاجة، وهو الأكثر استخداماً لقياس النتائج على نطاق واسع لبرامج تنظيم الأسرة على مستوى السكان. يتضح من السياق الموصوف سابقاً، أن اتجاهات استخدام وسائل تنظيم الأسرة الحديثة بين عامي 2000 إلى 2014 تظهر زيادة بطيئة في معدل انتشار وسائل منع الحمل من 51% في عام 2000 إلى 53% في عام 2010 و 57% في عام 2014. الزيادة السنوية لاستخدام وسائل منع الحمل لجميع الأساليب في الـ 15 سنة الماضية هي 0.78%. وهو أعلى في قطاع غزة (زيادة سنوية بنسبة 1.2%) مقارنة بالزيادة في الضفة الغربية (زيادة سنوية بنسبة 0.74%). وكمؤشر دال لطلب وتزويد خدمات تنظيم الأسرة، ينبغي مراقبة وتحليل مدى انتشار وسائل منع الحمل مع الاستخدام الأفضل للنتائج للحصول على توصيات للسياسات والإجراءات.

يعتبر انتشار وسائل منع الحمل في حالة ركود، لذلك ينبغي اتخاذ تدابير لتعزيز استخدام خدمات تنظيم الأسرة، والعمل على جبهتين؛ أولاً: الإمداد عن طريق دعم خدمات تنظيم الأسرة، ثانياً: الطلب عن طريق التوعية والطلب والاستخدام في المجتمع.

ووفقاً لدراسة المسح العنقودي متعدد المؤشرات للإحصاء الفلسطيني لعام 2014، فمن بين مستخدمي خدمات تنظيم الأسرة الحاليين، يستخدم واحد من كل ثمانيه أساليب "تقليدية" أقل فعالية (13% من جميع النساء المتزوجات اللاتي شملتهن الدراسة في سن الإنجاب). وذكرت الدراسة أن 43% من النساء المتزوجات لا يستخدمن أي وسيلة على الإطلاق. يعتبر معدل انتشار استخدام وسائل منع الحمل والذي يمثل حوالي 57% منخفضاً وفقاً للمعايير الدولية والإقليمية (تركيا بنسبة 74% وإيران عند 82%). كما أكدت الدراسة أن استخدام وسائل منع الحمل أعلى في الضفة الغربية (60%) منه في قطاع غزة (53%)، حيث يزداد استخدامها مع العمر، والوضع الاقتصادي، والتعليم وعدد الولادات الحية. كما تُظهر الدراسات الإحصائية أن أكثر وسائل منع الحمل الحديثة استخداماً هي اللولب، حيث تم استخدامه بنسبة 26% من جميع النساء المتزوجات. وعلى عكس قطاع غزة، فإن استخدام اللولب أعلى بشكل ملحوظ في الضفة الغربية (31%) من قطاع غزة (19%) وخاصة بين النساء الأكبر سناً (35 سنة وأكثر). كما تميل النساء الأقل تعليماً واللاتي يَعِشْنَ في المناطق الريفية الى استخدام اللولب أكثر من غيرهن.

أما حبوب منع الحمل، التي تعتبر ثاني أكثر الوسائل الحديثة استخداماً، كانت أكثر استخداماً في قطاع غزة (10%) من الضفة الغربية (6.5%)، كما ازداد استخدامها في 2014 مقارنةً بعام 2010. وتم استخدام الواقي الذكري على اعتباره أكثر وسيلة حديثة لمنع الحمل في قطاع غزة بنسبة (7.4%) مما كانت عليه في الضفة الغربية (4.3%). إن استخدام الواقي الذكري في قطاع غزة يتزايد. وقد ذكرت الدراسة أن استخدام الواقي الذكري أكثر انتشاراً بين الأزواج ذوي التعليم العالي. ومع ذلك، كان هناك طرق أخرى كالتعقيم بنسبة (1.9%)، حقن الميذروكسي بروجسترون (0.9%)، كما كانت الأدوات الطبية التي يتم زراعتها داخل جسم المرأة والواقيات الأنثوية أقل شعبية.

كان هناك تضارب في البيانات الواردة من المؤسسات التي تقدم خدمات تنظيم الأسرة، مع بيانات الجهاز المركزي للإحصاء (2016). ففي حين وجد التحليل أن الحبوب هي الطريقة الأكثر استخداماً في الضفة الغربية، تبين أن النسبة التي ذكرها الجهاز المركزي للإحصاء أقل بكثير في جميع السنوات. كما تم ملاحظة نفس الاختلاف في التقارير الصادرة عن المنظمات غير الحكومية ووزارة الصحة في غزة. ومن الواضح أن المؤسسات المختلفة تستخدم طرق مختلفة لتحديد نوع وسائل منع الحمل، كما أن هناك غياب تعريفات ومؤشرات موحدة وواضحة للحالة. إضافة إلى أن طرق توثيق خدمات تنظيم الأسرة غير ثابتة.

عادة ما يتم اعتبار عدم تلبية الحاجة لتنظيم الأسرة على أنها مشكلة في الوصول إلي هذه الخدمات، مما يترك انطباعاً بأن النساء لا يستخدمن وسائل منع الحمل لأنهن لا يستطعن العثور عليها أو تحمل تكاليفها. ومع ذلك، فإن عدم تلبية الحاجة لتنظيم الأسرة تُعزى بشكل جزئي على الأقل إلى سوء جودة الخدمة، تقديم المشورة بشكل ضعيف، وتوجهات مقدمي الخدمات السلبية تجاه تنظيم الأسرة، التي لا تشجع النساء على استخدام خدمة تنظيم الأسرة. في عام 2014، كان عدم تلبية الحاجة يتمثل بنسبة 11% (5% للحد و 6% للمباعدة) وهي مماثلة في الضفة الغربية وقطاع غزة. منذ عام 2006 إلى عام 2014، حدث انخفاض في الاحتياجات غير الملباة بحوالي 42%، وهو ما يعتبر إنجازاً جيداً. ويمكن أن يعزى هذا الإنجاز إلى تحسن تقديم الخدمات وتأمين الوسائل.

مسطح خدمات تنظيم الأسرة

تُظهر التقارير الأخيرة أن هناك 306 مركزاً يقدم خدمات تنظيم الأسرة في الضفة الغربية، خدمت هذه المراكز 36,877 مستفيداً جديداً في عام 2016. بينما في قطاع غزة، يقدم هذه الخدمات 17 مركزاً فقط من بين 56 مركزاً من مراكز الرعاية الأولية بوزارة الصحة بما يشمل 5,659 أسرة. حيث يتم تقديم خدمات تنظيم الأسرة في مرافق وزارة الصحة بغض النظر عما إذا كان المستفيد لديه تأمين صحي أم لا، وبمقابل رسوم بسيطة فقط (مشاركة المستفيد). توفر الأونروا هذه الخدمات مجاناً في جميع مراكزها البالغ عددها 65 مركزاً في الضفة الغربية وقطاع غزة (منهم 22 مركزاً في قطاع غزة). في عام 2016، تم تقديم خدمات لـ 18,185 مستفيداً جديداً و 72,225 مستفيداً متابعاً في قطاع غزة، و 2,271 مستفيداً جديداً و 23,556 مستفيداً متابعاً في الضفة الغربية. بالإضافة إلى ذلك، هناك عدد كبير من المؤسسات غير الحكومية تقدم خدمات تنظيم الأسرة ولكن ليس بانتظام. تعتمد معظم هذه المؤسسات الغير الحكومية على استلام وسائل تنظيم الأسرة من وزارة الصحة وتقدم هذه الخدمات برسوم رمزية. هناك عدد قليل من هذه المؤسسات غير الحكومية لديه خطط شراء لوسائل تنظيم الأسرة من مواردها الأساسية.

أما على المستوى الوطني فعلى الرغم من أن هناك عددٌ كبيرٌ من مقدمي الخدمات العمومية وغير الربحية، إلا أن أطباء القطاع الخاص يُعتبرون من مقدمي الخدمة الرئيسيين في مجال تنظيم الأسرة حيث يقدمون الخدمة لـ 29% من المستفيدين. ويبلغ معدل الاستفادة من القطاع الخاص في الضفة الغربية 40.6٪، وهو أعلى بكثير من قطاع غزة (5.7٪). بالإضافة إلى ذلك، أبلغ 13.5٪ من مستفيدي وسائل تنظيم الأسرة عن تلقيهم خدمات من الصيدليات المجتمعية أو المؤسسات الخاصة، وهذا يجعل إجمالي مساهمة القطاع الخاص لتنظيم الأسرة في فلسطين 42.6٪، وهذا أمر مثير للقلق، لأنه يثير قضايا خاصة بالعدالة بشأن قدرة الأسر الفقيرة على طلب الخدمات من القطاع الخاص الباهظ الثمن. علاوة على ذلك، فإن شراء وسائل منع الحمل من صيدليات المجتمع دون تقديم المشورة المناسبة أو الفحص الطبي المناسب قد يسبب خطراً على المستفيدين. ويمكن أن يعزى سبب البحث عن هذه الخدمات في القطاع الخاص إلى ضمان السرية، الثقة، الاحترام والخصوصية. وعلى الرغم من أن القطاع الخاص هو أكبر مقدم لخدمات تنظيم الأسرة في فلسطين، إلا أنه لا يتم استهدافه عادة ببرامج كالإشراف والتدريب، والتي تهدف إلى تحسين جودة خدمات تنظيم الأسرة المقدمة.

تعتبر الأونروا ثاني أكبر مزود للخدمة بعد القطاع الخاص 27٪، وهي المزود الرئيسي في قطاع غزة بنسبة 61٪، وهو أكثر بكثير من الضفة الغربية (11.4٪)، وهذا ربما يرجع إلى تواجد نسبة أعلى من اللاجئين في غزة. تحتل الحكومة المركز الثالث على الرغم من أنها تشغل أكبر عدد من العيادات، حيث أنها تقدم خدمات تنظيم الأسرة إلى 18.7٪ فقط من مستفيدي وسائل تنظيم الأسرة، مع ارتفاع المعدل في الضفة الغربية (21.5٪) عن قطاع غزة (12.9٪). أما المؤسسات غير الحكومية فقد كان دورها محدوداً في كل من الضفة الغربية وقطاع غزة (3.5٪)، على الرغم من حقيقة أنها تلقت كميات كبيرة من وسائل تنظيم الأسرة خلال الفترة من 2008 إلى 2014، وهذا يثير أسئلة مهمة حول أين يجب توجيه الجهود والموارد التي تهدف إلى تعزيز خدمات تنظيم الأسرة؟ كما لوحظ أن كمية الوسائل الموزعة على المؤسسات غير الحكومية لا تتوافق مع عدد المستفيدين الذين تخدمهم. فخلال مناقشة إحدى المجموعات البؤرية مع أعضاء اللجنة التوجيهية لتنظيم الأسرة في غزة، قال أحد المسؤولين في إحدى المنظمات غير الحكومية: "ننقل الواقى الذكري من وزارة الصحة ولكننا نستخدمها لشيء آخر غير تنظيم الأسرة. نحن نستخدمها لتغطية رأس مسبار جهاز الألتراساوند (جهاز الموجات فوق الصوتية) أثناء استخدامه لفحص المهبل".

تباينات في تقديم خدمات تنظم الأسرة

تم استخدام طرق مختلفة خلال تقديم خدمات تنظيم الأسرة، ففي حين يُسمح للقبالات بإدخال ونزع اللوالب في عيادات الأونروا وبعض المؤسسات غير الحكومية، بينما لا يسمح بذلك في العيادات التابعة لوزارة الصحة الفلسطينية. كما يوجد لدى الأونروا بعض الدلائل الإرشادية التقنية الخاصة بها، بينما لدى المؤسسات غير الحكومية سياسات وبروتوكولات خاصة بها والتي قد تعمل بدونها. كما يوجد هناك دلائل توجيهية وطنية معتمدة كجزء من بروتوكولات الصحة الإنجابية ولكن قليل من مقدمي الخدمة يعلمون بها، وقليل منهم ان وجد يقوم بتطبيقها. علاوة على ذلك، لدى هذه المؤسسات أنظمة مختلفة لتقدير الاحتياجات والإبلاغ وحتى لتحديد دواعي الاستعمال الطبية للوسيلة المستخدمة. حتى داخل المؤسسة نفسها، كان هناك أحياناً اختلافاً في وجهات النظر عن الممارسات التي يقوم بها مقدمي الخدمة المتعلقة بتنظيم الأسرة. أما من الناحية الهيكلية، في عيادات الأونروا، يتم دمج خدمات تنظيم الأسرة ضمن مجموعة الخدمات الصحية الأخرى المقدمة من فريق صحة العائلة في مراكز الرعاية الأولية التابعة لها. أما في وزارة الصحة، فقد قدمت 30% من المراكز خدمات تنظيم الأسرة في حال توفرها، ويتم تقديمها كخدمة مستقلة قائمة بذاتها. حيث تظهر الأدلة البحثية أن خدمات تنظيم الأسرة تكون أكثر فعالية عندما يتم توفيرها مع خدمات الصحة الإنجابية والجنسية الأخرى مثل رعاية ما قبل الولادة. بينما لا تتعامل المؤسسات غير الحكومية مع خدمات تنظيم الأسرة كخدمات أساسية ويتم إهمالها عادة إذا لم يتم توفيرها مجاناً من قبل وزارة الصحة، باستثناء بعض المؤسسات غير الحكومية والتي تقوم بشراء هذه الوسائل عندما لا يتم توفيرها من قبل مخازن وزارة الصحة الفلسطينية.

كما لوحظ أن هناك اختلاف فيما يتعلق بالالتزام على المستوى السياساتي ببرامج تنظيم الأسرة بين مقدمي الخدمات، ففي حين تلتزم الأونروا التزاماً قوياً بتقديم خدمات تنظيم الأسرة، والتي تعتبر جزءاً أساسياً من مجموعة الخدمات المقدمة إلى اللاجئين، فإن القصة مختلفة تماماً في وزارة الصحة، حيث أنه على الرغم من أن صانعي السياسات في وزارة الصحة يعلنون عن التزامهم ببرامج تنظيم الأسرة، إلا أنهم ما زالوا يميلون إلى إعطاء أولوية أقل لتلك الخدمات ويميلون إلى إعطاء الأولوية لخدمات الطوارئ، حيث كان هذا واضحاً خلال الفترات التي شهدت نقصاً في وسائل تنظيم الأسرة لعدة أشهر أو حتى سنوات، ولم تتخذ وزارة الصحة أية إجراءات لشراءها. إن من الجدير ذكره أن القائمة الوطنية للأدوية الفلسطينية تشتمل على وسائل تنظيم الأسرة، حيث تم تطوير القائمة الأولى في عام 2002، وتم إصدار أحدث نسخة منها في عام 2013. وهذا يدل على فرصة ضائعة للالتزام بشراء وسائل تنظيم الأسرة- والتي تُعتبر جزءاً من قائمة الأدوية الأساسية من قبل وزارة الصحة.

فعليا تعتبر تكلفة هذه الوسائل ضئيلة وأقل من 2٪ من ميزانية الأونروا للمستحضرات الصيدلانية، وأقل من ذلك في وزارة الصحة، حيث تقوم وزارة الصحة بشراء أدوية باهظة الثمن لخدمات المستشفيات. وبالتالي يجب بذل المزيد من الجهود لزيادة التزام واضعي السياسات الصحية بخدمات تنظيم الأسرة. وترجمتها إلى سياسات تكفل دمج هذه الخدمات في الخدمات الصحية وخطط المشتريات الخاصة بهذه المنظمات. ويمكن للصندوق الأمم المتحدة للسكان والوكالات الإنمائية الأخرى أداء دور محفز لوضع تنظيم الأسرة على جدول أعمال صانعي السياسات.

هناك نقطة مهمة أيضا وهي عدم توفر نماذج للتوثيق الموحد وقاعدة بيانات وطنية لتنظيم الأسرة. كما أنه من المستغرب، أن تقارير وزارة الصحة حول تنظيم الأسرة لا تتضمن الخدمات التي تقدمها المؤسسات غير الحكومية على الإطلاق. ونادراً ما يتم تقييم خدمات تنظيم الأسرة أو الإشراف على مقدمي الخدمات، مع عدم توفر مؤشرات أداء متفق عليها. وفي حين تعتبر وسائل تنظيم الأسرة جزء من المستحضرات الصيدلانية، إلا أنه لا يتم مراقبتها أو الإشراف عليها من قبل الصيدلة، بل تُترك للفنيين الآخرين مثل القابلات أو الأطباء الذين عادة لا يكونون مدربين تدريباً كافياً على إدارة تلك الوسائل.

عادة ما يكون التنسيق بين مقدمي الخدمة محدودا وبالتالي يتسبب هذا بازواجية الخدمة المقدمة وهدر الموارد. وعليه أصبح من الضروري أن تستثمر وزارة الصحة المزيد من الجهود في تنظيم خدمات تنظيم الأسرة المقدمة من خلال آليات مساءلة أوضح. حيث تؤكد البيانات التي تم جمعها أن نقاط الضعف في خدمات تنظيم الأسرة تشمل أيضا الوصول المحدود إلى المعلومات والمشورة حول أساليب تنظيم الأسرة مما يؤثر سلباً على الاستخدام. كما لوحظ أن التدريب وبناء القدرات في مجال تنظيم الأسرة محدود، لأنه أقل انتشاراً وجاذبية الآن مما كان عليه في السابق وبناء على ذلك يجب إعادة تصنيف تنظيم الأسرة كأحد الموضوعات ذات الأولوية لبناء القدرات والتدريب لجميع مقدمي الخدمات العاملين في تنظيم الأسرة، مع التركيز على جميع الجوانب وليس فقط التركيز على الجوانب الفنية، ولكن أيضاً يجب التركيز على توجهات الموظفين ومواقفهم، والتي يُنظر إليها على أنها ليست حساسة بشكل كافٍ للنوع الاجتماعي وحقوق الإنسان.

تأمين وسائل تنظيم الأسرة : المعادلة المختلطة

فيما يتعلق بتأمين الوسائل الأساسية، أظهرت الدراسة وجود تناقض واضح في الأداء حيث تعمل إدارة سلسلة التوريد في وزارة الصحة والأونروا بشكل عام بكفاءة مع وجود سعة تخزين كافية، وظروف تخزين مناسبة، ونظام توزيع جيد لنقاط تزويد الخدمات ومع ذلك، فإن المراقبة والمتابعة على مستوى التخزين المركزي والفرعي تعمل بشكل أقل فعالية، مع وصول العديد من الوسائل

إلى تاريخ انتهاء الصلاحية. وقد أدى الاضطراب السياسي، التغيير في سياسة المانحين، الانقسام السياسي والتنسيق غير الكافي على مستوى سياسات الموردين والمزودين وبين مقدمي الخدمات أنفسهم، إلى توريد غير منتظم لوسائل تنظيم الأسرة مع وجود تباينات كبيرة عبر السنوات ووجود فترات من التوقف المتكرر، لا سيما خلال السنوات الثلاث الماضية، حيث يواجه قطاع غزة نقصاً في تلك الوسائل أكثر من الضفة الغربية. كما تقوم وزارة الصحة، بصفتها الجهة المنظمة لخدمات الرعاية الصحية في فلسطين بتوزيع مستلزمات تنظيم الأسرة على مقدمي الخدمات الآخرين، ومع ذلك كانت عملية التوزيع غير منتظمة وغير منسقة. في حين تعتبر فكرة أن تتمركز سلسلة إمداد وسائل تنظيم الأسرة من خلال وزارة الصحة فكرة جيدة إلا أنه ينبغي أن يرتبط ذلك بأليات تنظيم وتنسيق أفضل مع التزام أكبر بشراء الوسائل الضرورية من الموارد المالية المحلية.

في عام 2015، عندما قرر صندوق الأمم المتحدة للسكان الحد من اعتماد القطاع الصحي على الدعم الذي يقدمه لشراء وسائل تنظيم الأسرة، أصبح النقص أكثر بروزاً، ولسوء الحظ لم يتم تنفيذ هذه العملية الانتقالية بسلاسة وتدرج مما تسبب في حدوث إرباك ونفاذ المخزون عدة مرات.

أحد كبار المسؤولين في وزارة الصحة قال "كان من الصادم أن نسمع أن صندوق الأمم المتحدة للسكان لن يوفر الوسائل بعد الآن، إنها كارثة، كانت مفاجأة كبيرة، ولا أحد سيوفر هذه الوسائل". جاء هذا في فترة شح الموارد المالية المتاحة لنظام الرعاية الصحية، بالإضافة إلى عدم وجود توافق بين صانعي السياسات على أولوية تأمين وسائل تنظيم الأسرة، ومن الأفضل أن يضع صندوق الأمم المتحدة للسكان إستراتيجية خروج ملائمة، وأن ينسق بشكل أفضل مع مختلف القطاعات لضمان استمرارية تقديم هذه الخدمات. وبالرغم من ذلك لقد استمر الصندوق في تأمين وسائل تنظيم الأسرة عن طريق موارد الطوارئ، مما ساعد على تلبية الاحتياجات من جهة، بينما أدى من جهة أخرى إلى المزيد من عدم الوضوح وفائض أحياناً في الإمداد للمؤسسات التي قررت شراء وسائل من مواردها الخاصة مثل الأونروا. في حين سلك بعض مقدمي الخدمات عن طريق شراء الوسائل من السوق المحلية رغم أنها كانت باهظة التكلفة (في بعض الأحيان أعلى 70 مرة من صندوق الأمم المتحدة للسكان)، وقرر آخرون إهمال الخدمة مع أو بدون إعلام أي شخص. وبصورة إيجابية، قررت الأونروا تخصيص جزء من ميزانيتها الأساسية لشراء وسائل تنظيم الأسرة مستفيدة من نظام العطاءات الدولي التابع لصندوق الأمم المتحدة للسكان، وهو نظام ذو كفاءة عالية، ومن الناحية المثالية يتعين على وزارة الصحة والمنظمات غير الحكومية أن تفعل الشيء نفسه وأن تعتبر توفير وسائل تنظيم الأسرة مجالاً ذا أولوية.

و لقد كشفت الدراسة أيضا وجود فجوات خطيرة في تأمين الوسائل في المخازن الرئيسية، ويعزى التغيير على مر السنين بشكل رئيسي إلى التزويد غير المنتظم والثغرات في إدارة الوسائل ووجود مشاكل أخرى مثل تلقي كميات غير متوقعة من الوسائل. حيث أنه من المستحيل أن يكون هذا التغيير بسبب انخفاض أو زيادة في الطلب على الوسائل. على ما يبدو، لا يوجد معيار استهلاك واضح يمكن استخدامه كنقطة مرجعية، على سبيل المثال، خلال الفترة 2010-2015 تم صرف مجموعه 60,462 وحدة من اللوالب من المخازن المركزية لوزارة الصحة في نابلس بمتوسط صرف سنوي قدره 10,077 وحدة، تراوح بين 6,400 وحدة وهي الأقل في عام 2011 إلى 13,050 (أي ضعف العدد) وهي الأعلى والتي كانت في عام 2014.

يظهر اتجاه توريد اللوالب إلى غزة اختلافات حادة تتراوح بين 14,750 إلى الصفر في سنوات معينة، وبالتالي لا يتم صرفها إلى نقاط تقديم الخدمات التي أبلغت عن حدوث انقطاعات متكررة للمخزون لديها. فقط في غضون عامين (من أصل سبعة)، ما تم صرفه كان كاف وفقا لمتوسط الاستهلاك القياسي. وتتشابه الصورة مع الوسائل الأخرى لتنظيم الأسرة، كما هو مفصل في التقرير الكامل. بالإضافة إلى ذلك، فإن نمط صرف حبوب منع الحمل المركبة لا يتماشى مع معدل استخدامه من قبل المنظمات الأهلية التي حصلت على هذه الوسائل. وبالنسبة لما تم صرفه لمراكز الرعاية الصحية الأولية في وزارة الصحة، كان هناك فائض في التوريد في بعض السنوات (في 2013 و 2014)، بينما كان هناك نقص حاد في الأوقات الأخرى وخاصة في عام 2015. واطافة إلى ذلك، كانت عملية توريد وتوزيع حبوب منع الحمل المحتوية على البروجسترون فقط غير منتظمة أيضاً. وفيما يتعلق بالواقى الذكري، في الفترة ما بين 2014 و 2017، لم يتم توفير أي إمدادات إلى قطاع غزة على الإطلاق من قبل أي جهة حيث ينطبق الشيء نفسه على الصرف من مخازن وزارة الصحة في غزة والذي أظهر أيضاً تباينات شديدة. على سبيل المثال، في عامي 2011 و 2017، لم يتم صرف أي وسيلة للمؤسسات غير الحكومية رغم أنها تعتمد بشكل أساسي على وزارة الصحة. كما لم يتم الوصول إلى الاستهلاك الشهري في مراكز الرعاية الصحية الأولية في قطاع غزة. على النقيض من ذلك، في عام 2016، بسبب عدم إدارة الموارد بشكل جيد، حيث تم التخلص من آلاف الواقيات الذكرية في مخازن وزارة الصحة في غزة. إضافة إلى ذلك، لم يكن التوريد والتوزيع لحقن الميذروكسي بروجستون (المعروف أيضا باسم ديبو بروفيرا) أفضل بكثير، حيث لوحظ نفس السيناريو كما هو مفصل في التقرير.

معدل مخزون مقلق

يعتبر مستوى المخزون مؤشراً هاماً لتأمين الوسائل، حيث تشير الأرقام الصادرة من مستودع وزارة الصحة المركزي في قطاع غزة إلى وجود تباين كبير في المعدل السنوي للمخزون، فلم يتم الحفاظ على كمية كافية من المخزون بما يضمن وجود المخزون الاستراتيجي والذي يعتبر مهماً في أوقات الطوارئ. يعطي المتوسط صورة أكثر قتامة، حيث كان وسيط المخزون في سنوات معينة صفرًا كما في 2015 و 2016 في الحبوب المركبة والميدروكسي بروجستون، مما يعني أنه ولمدة ستة أشهر في السنة كان المخزون في المستودع المركزي يساوي صفرًا. يظهر تحليل معدل المخزون الشهري وجود فجوات خطيرة في مستودع وزارة الصحة الرئيسي في غزة، حيث كان عند الصفر بالنسبة لجميع الوسائل تقريباً في سنوات معينة. لقد تم الإبلاغ عن نقص اللولب في عدة أشهر مع عدم وجود مخزون في مايو وأغسطس ونوفمبر عام 2015، وكذلك في فبراير 2016 ونوفمبر 2017. كان وضع الميدروكسي بروجستون أسوأ من ذلك، بعد أن نفذ المخزون منه خلال العديد من الشهور (22 شهراً خلال خمس سنوات). علاوة على ذلك، لقد كان معدل الحبوب المركبة في المخزن صفر على الأقل لمدة 15 شهراً متواصلة وبمعدل تخزين منخفض في عدة شهور أخرى. بعيداً عن البيانات التي تم جمعها من المخازن المركزية. وإضافة إلى ذلك، تشير السجلات في نقاط تقديم الخدمات إلى أن نفاذ المخزون في المستودع المركزي قد أثر سلباً على توفير الخدمة. حيث تشير التقارير في عيادات وزارة الصحة أنه في عام 2015، تم تسجيل نقص في الحبوب المركبة والميدروكسي بروجستون خلال الفترة من مارس حتى ديسمبر (لمدة 10 أشهر متواصلة). أما في عام 2016، تم تسجيل نقص في الحبوب المركبة والميدروكسي بروجستون خلال الفترة من يناير حتى أغسطس (لمدة تسعة أشهر متواصلة).

وبالنسبة لعام 2017، تم تسجيل نقص في الحبوب المركبة والبروجستون خلال الفترة من مايو حتى نوفمبر (لمدة ثمانية أشهر متواصلة).

كان وضع معدل المخزون في الأونروا في غزة أفضل نوعاً ما من وزارة الصحة ومع ذلك وبسبب عدم انتظام التوريد، أظهرت العديد من الأصناف تباينات كبيرة مع وصول بعض الأصناف إلى معدل المخزون الصفري في مخازن الأونروا المركزية في غزة، فعلى سبيل المثال، كان معدل المخزون من الواقي الذكري مختلفاً للغاية من 2139 وحدة في عام 2012 إلى 12 وحدة في عام 2010 و 291 وحدة في عام 2017. وكان معدل مخزون موانع الحمل الفموية المركبة أكثر إشكالية، مع تباين كبير على مر السنين تتراوح بين 6759 وحدة في عام 2012 إلى 51 وحدة في عام 2010. كما لوحظت أيضاً اختلافات في معدلات حبوب منع الحمل الفموية المحتوية على البروجستون، حيث تراوحت بين 1,499,000 إلى الصفر في بعض السنوات. علاوة على ذلك، كان معدل المخزون من الميدروكسي بروجستون صفر في سنوات معينة (في الربع الأخير من عام 2015 و 2016) مع وجود تكديس في السنوات الأخرى.

يتطلب تحسين تأمين الوسائل الأساسية تعاون الجهات المعنية لتعزيز اللوائح التنظيمية، ضمان الالتزام السياسي بشراء الوسائل من الموارد المحلية و تحسين استراتيجيات الرصد والتدريب على إدارة الوسائل. يجب على جميع موفري خدمات تنظيم الأسرة وضع ميزانية لتوفير وسائل تنظيم الأسرة وأن يتم إدراجها في خطط المشتريات العامة الخاصة بها بهدف تحقيق الاستدامة. وثمة خيار آخر موصى به، هو إنشاء صندوق وطني بهدف تأمين الوسائل واستخدام آليات أكثر كفاءة في الشراء، والتوصيل والتوزيع. ومن المهم أيضا دعم الدور الإشرافي والتنظيمي الشامل لوزارة الصحة من أجل ضمان تأمين وسائل منع الحمل في المراكز النائية ونقاط تقديم الخدمات. كما أنه من المهم التأكد من تسليم الوسائل مباشرة من الموردين إلى مخازن غزة المركزية لتجنب الروتين والتأخير الذي يحدث في بعض الأحيان.

يحتاج صندوق الأمم المتحدة للسكان إلى وضع استراتيجية مكتوبة لدعمه لخدمات تنظيم الأسرة وإشراف تلك الاستراتيجية مع المسؤولين المحليين. ينبغي أيضا أن يكون تركيز صندوق الأمم المتحدة للسكان موجهاً أكثر نحو الحث والمناصرة لزيادة الالتزام بخطط التنفيذ، التدخلات البرمجية، خلق المعرفة، الرصد وبناء القدرات، بالإضافة إلى المساهمة في سد الثغرات في تأمين الاحتياجات الوطنية للوسائل الأساسية.