FAMILY PLANNING METHOD MIX IN PALESTINE – CHALLENGES AND OPPORTUNITIES

QUALITATIVE STUDY

MAY 2023

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United Nations Population Fund
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PUBLICATION AND RESEARCH TEAM INFORMATION:

This publication was supported by UNFPA (copy right holder) and developed by Amina Savridis, Independent SRHR and FP Consultant and Principal Researcher of this study; Dr. Suha Baloushah, SRHR Consultant and Qualitative Research Expert; Nidal Abu-Hamad, SRHR Specialist and Researcher.

DISCLAIMER

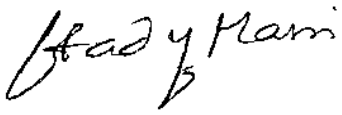
FOREWORD

The Ministry of Health of Palestine is determined to achieve the highest level of sexual and reproductive health and their rights for the entire population without discrimination. Universal coverage of high-quality, affordable sexual and reproductive health services and information, including family planning services, is fundamental to realizing the rights, empowerment, and well-being of women, which can also have positive economic, and social benefits for families and communities. We believe that improved access to a full range of contraception methods is a national responsibility, that ensures the ability of couples to decide the number of their children and the timing of their birth, whilst avoiding the adverse health and socioeconomic consequences of unintended and closely spaced pregnancies. Palestine has achieved a remarkable increase in the contraceptive prevalence rate from 51% in 2000 to 57% in 2014. This increase can be attributed to the cumulative efforts of national and international organizations that developed health system responses to reduce high levels of unmet need for family planning. However, there has been a plateau in the rate of contraception utilization since 2014 where almost the same figure (57.2%) has been reported in 2019, which is likely to be due to a complex bundle of unattended gaps and challenges. The Ministry of Health is aware that the prolonged humanitarian crisis and the recent COVID-19 pandemic have compromised the family planning services, including a limited choice and availability of contraceptive methods. Nevertheless, there is an emerging need to uncover specific barriers to the access to family planning services and their potential solutions.

We are therefore delighted to be part of this national study which aims at exploring the limiting and promoting factors for up-taking and introducing long-term reversible hormonal contraceptive methods from the perspectives of beneficiaries, healthcare providers, and policymakers. We believe that the delivered set of the study recommendations will help guide actions to combat the persistent unmet needs for family planning and enhance positive sexual health outcomes.

We are exceedingly grateful for the UNFPA for taking the initiative to conduct this important study as part of their continuous technical and financial support in Palestine. We also extend our thanks to the research team in the West Bank and Gaza; Amina Stavridis, Dr. Suha Baloushah, and Nidal Abu-Hamad, for their hard work, dedication, and the great accomplishment.

We trust that we will find this publication as an excellent resource for the planning and implementation of interventions for improving the access and quality of family planning services in Palestine.



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LIST OF ABBREVIATIONS:

COVID-19	Coronavirus Disease in 2019
CPR	Contraceptive Prevalence Rate
FGDs	Focus Group Discussions
FP	Family Planning
FPM	Family Planning Methods
GDP	Gross Domestic Product
GS	Gaza Strip
IDI	In-Depth Interview
IUD	Intra Uterine Device
LARCMs	Long-Acting Reversible Contraceptive Methods
LMIC	Low and Middle-Income Countries
MD	Medical Doctor
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Rate
MoH	Ministry of Health
NGOs	Non-Governmental Organizations
Ob/Gynae	Obstetrics and Gynaecologist
oPt	occupied Palestinian territory
PCBS	Palestinian Central Bureau of Statistics
PHC	Primary Health Care
SRHNSP	Sexual and Reproductive Health National Strategic Plan
UNCTAD	United Nations Conference on Trade and Development
UNFPA	United Nations Population Fund
UNRWA	United Nations Relief and Work Agency
WB	West Bank
WHO	World Health Organization

ABSTRACT IN ARABIC

هدفت هذه الدراسة بشكل رئيسي إلى استكشاف معرفة،ومواقف،وتصور النساء الفلسطينيات في سن الإنجاب تجاه استخدام وسائل منع الحمل الطويلة الامد(اللولب الهرموني ، Medroxyprogesterone Acetate Injection I.P، Implant) بالإضافة إلى فهم آراء ومواقف مزودي الخدمات الصحية وصانعي السياسات فيما يتعلق بالمعيقات والمحفزات لإدخال طرق قابلة للعكس طويلة المفعول.

استخدمت الدراسة منهجيات نوعية: تم عقد سبعة مجموعات بؤرية مركزة أجريت مع 49 امرأة تتراوح أعمارهن بين 18 و 49 عامًا ، و مجموعة اخرى مكونة من 22 من مزودي خدمات تنظيم الأسرة يمثلون وزارة الصحة والأونروا والمنظمات غير الحكومية ، بالإضافة إلى 10 مقابلات معمقة مع صانعي السياسات من قطاع غزة والضفة الغربية.

تم تصنيف النتائج إلى خمسة محاور رئيسية: 1) المعرفة والمواقف فيما يتعلق بتنظيم الأسرة ، 2) وجهات نظر صانعي السياسات ومقدمي الخدمات تجاه المستفيدات الراغبات في استخدام LARCMs، 3) تجربة المستفيدات حول طلب المشورة بشأن تنظيم الأسرة ، 4) ديناميكية صنع القرار في مجال تنظيم الأسرة لدى العائلات الفلسطينية 5) تحديات ادخال وسائل منع الحمل طويلة الأمد والقابلة للانعكاس (اللولب الهرموني ، Medroxyprogesterone Acetate Injection I.P، Implant).

جاءت نتائج الدراسة منسجمة مع نتائج الدراسات السابقة فيما يتعلق بالعوامل المعيقة والمحفزة تجاه استخدام موانع الحمل ، ولا سيما LARCMs. بينت النتائج أن المستفيدات يفتقرن إلى المعرفة العامة بموانع الحمل ، وديناميكية القوى داخل الأسرة فيما يتعلق باتخاذ قرارات تنظيم الأسرة، يعتبر النقص وارتفاع تكلفة الوسائل الهرمونية طويلة المفعول (LARCMs) من التحديات التي تمنع استخدام LARCMs. بالإضافة إلى ذلك ، فإن مواقف ومهارات مقدمي خدمات تنظيم الأسرة ونظام الرعاية الصحية هي قضايا محورية ويمكن أن تؤثر على قرار المرأة فيما يتعلق بأساليب تنظيم الأسرة. كما ذكر مقدمو الرعاية الصحية افتقارهم إلى التدريب الكافي ، ونقص الخبرة في تقديم المشورة للوسائل الهرمونية طويلة المفعول.

سوف تساعد هذه الدراسة النوعية كافة الاطراف المعنية على فهم المعيقات والمحفزات لتعزيز وتوسيع استخدام نطاق وسائل تنظيم الأسرة في فلسطين مما يساهم في تلبية الاحتياجات غير الملباة لتنظيم الأسرة.

EXECUTIVE SUMMARY

UNFPA's global mission statement is "to deliver a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled". Family planning is at the heart of this mission, so much so that ending the unmet need for family planning by 2030 is one of the three transformative results in the UNFPA Strategic Plan. As a step forward in adhering to this mission, the UNFPA Country Office in Palestine, in partnership with the Palestinian Ministry of Health through the Women Health and Development Unit (WHDU), is working hard towards expanding the existing family planning method mix by introducing new methods and increasing under-utilized methods.

The main aim of this study is to explore the knowledge, attitude, and perception of Palestinian women at reproductive age toward up-taking long reversible contraceptive methods (Hormonal IUD, Medroxyprogesterone Acetate Injection I.P, and Implant) in addition to exploring healthcare providers and policymakers' perception regarding barriers and enabling factors of introducing long-acting reversible methods.

The study uses qualitative methodologies: seven focus group discussions conducted with 49 women aged 18-49 years, 22 family planning healthcare providers representing MoH, UNRWA, and NGOs, as well as 10 in-depth interviews with policymakers from GS and WB.

The findings were categorized into five key themes: 1) Knowledge and perception regarding family planning, 2) Policymakers and service providers' perspectives toward beneficiaries willing to use LARCMs, 3) Experience in seeking family planning counselling, 4) Family planning decision-making dynamic in Palestinian families, and 5) Challenges to uptake long-term reversible contraceptive methods (Hormonal IUD, Medroxyprogesterone Acetate Injection I.P, and Implant).

In conclusion, the findings of the study were consistent with the results of previous studies regarding the hindering and enabling factors toward the use of contraceptives, particularly the LARCMs. The result reveals that beneficiaries' lack of contraception knowledge, the power dynamic within the family regarding FP decision-making, the shortages, and the high cost of the long-acting hormonal methods (LARCMs) are all challenges that deter the use of LARCMs. Additionally, healthcare providers' perception and skills and the healthcare system are pivotal issues and can influence the women decision regarding the family planning methods. The health care providers mentioned their lack of adequate training, and lack of experience in counseling of long-acting hormonal methods.

THE RECOMMENDATIONS OF THE CURRENT STUDY ARE:

Policymakers and health system:

1. Emphasize the top priority of FP services within the national SRHR strategic plan to meet women's needs and demands.
2. Collaborate with interested stakeholders to develop a phased scaling expansion plan for the introduction of new approaches to ensure that demand creation is appropriately met.
3. Policymakers through service providers should sensitize the community to the benefits and drawbacks of modern contraception, especially LARCMs.
4. Increase method choice: a wide range of modern methods must be available at an affordable price, subsidized price, or even for free through all distribution channels like public health facilities, social marketing, and the private sector.
5. Engage FP stakeholders, the private sector and private gynecologist doctors in introducing new FP methods or increasing underutilized methods. The private sector is a core pillar in improving the FP program contraceptive supply.
6. Improve the counseling capacity and skills of the service providers as they need refresher training on effective counseling.

Healthcare providers:

1. Provide comprehensive contraceptive counselling to women seeking the use of LARCMs by involving family members how to have the power of decision within the family
2. Consider that conduction of individualized counselling rather than structured counselling may render more efficient and better results.
3. Increase the dissemination of educational health information resources on contraceptives. Ensure accuracy of information available online and via social media using innovative technology by MoH and partners.
4. Increase knowledge and awareness campaigns to encourage contraceptive use by combating the prevalent misconceptions, stereotypes, and medically incorrect ideas about contraception.
5. Modify family planning program messaging to encourage couples' joint decisions about SRH, generally, and the contraceptives use, to increase the utilization and commitment of LARCMs.

CONTEXT

Palestine is a country in Western Asia that includes the West Bank (WB), East Jerusalem, and the Gaza Strip (GS), all of which Israel occupied in the 1967 Six-Day War. The WB shares the east borders with Jordan and Israel to the north, south, and west. The GS shares borders with Israel to the north and east, Egypt to the south, and the Mediterranean Sea to the west. Due to Israel's separation of the two enclaves, WB, and GS, making up Palestine, do not share a physical boundary. According to the Palestinian Central Bureau of Statistics (PCBS) in 2021(1), about 5.3 million people were living in the State of Palestine: 3.2 million in the WB and 2.1 million in the GS. There are around 878 persons per square kilometer in a land of 6,025 square kilometers in size. Compared with its neighbors, Palestine is extremely densely populated, especially in the GS where the average density is 5,855 inhabitants/km2 versus just 557 inhabitants/km2 in the WB. The percentage of Palestine's population below 15 years of age by the end of year 2021 is 38% and the median age is 21 years. Average household size is 5.1 with 80.0% of the population (4,083,476 persons in 2020) living in urban areas.

The WB and the GS have been under military occupation by Israel for more than 50 years, suffering from prohibited access to land, water, borders, or freedom of movement of people and goods from one area to another or even within the same part of the country. According to the United Nations Conference on Trade and Development (UNCTAD), the occupied Palestinian Territory's (oPT) Gross Domestic Product (GDP) increased by 7.1% in 2021 after declining by 11.3% in 2020 as a result of the COVID-19 pandemic and ongoing occupation-related restrictions.

The UNCTAD (2021) also reported that over one-third of households fall below the poverty line, food insecurity has increased, unemployment has remained high, and socioeconomic conditions worsened. The military assault that targeted Gaza in May 2021 seriously damaged the already-shattered infrastructure. More than 50% of the GS workers are unemployed compared to 17 % of unemployed workers in the WB, and 83% of the GS workers made less than the minimum wage versus 7% of the WB workforce paid below the minimum wage. Currently, 80% of the people of Gaza depend on international assistance (2).

HEALTHCARE PROVIDERS:

The Palestinian Ministry of Health (MoH) is the main provider of healthcare services in the oPt, followed by United Nations Relief and Works Agency (UNRWA), which caters to the needs of Palestinian refugees of the 1948 and 1967 wars, and a range of non-governmental organizations. The percentage of primary health care (PHC) centers in the Palestinian health sectors is as follows: the government health sector is at 66.4% (64.2% of which is the Palestinian Ministry of Health and 2.2% Military Medical Services), 8.5% the United Nations Relief and Works Agency and 25.1% non-governmental organizations. The number of MoH primary healthcare centers in

Palestine increased from 203 at the end of 1994 to 491 in 2021, an increase of 142% (3). The different health sectors are involved in providing health care services to citizens in all levels: primary health care, secondary and tertiary health care. The Palestinian Ministry of Health pays special and great attention in maintaining the continuity of the Palestinian health system and providing comprehensive health services of high quality to all citizens, including the family planning services provided by MoH PHC, particularly level 3 and 4. Through 65 centers (22 GS and 43 WB), UNRWA provides health-care services to the vast majority of Palestine refugees as follows: 70% of the total population of Gaza and 53% of WB population including members from 49 Bedouin communities in Area C. All UNRWA PHC provide family planning services (4).

MAIN SRH HEALTH INDICATORS

According to PCBS, the total fertility rate during (2017– 2019) has declined to reach 3.8 births per woman (3.9 in GS, and 3.8 in the WB) compared to 4.6 births in 1999-2003 (1). The 2019 Palestinian Multiple Indicator Cluster Survey (MICS) indicated that the percentage of unmet need for family planning increased from 10.9% in 2014 to 12.9% in 2019. Further reported indicators were as follows: Adolescent birth rate 34%, Early childbearing 5.9% and Contraceptive prevalence rate 57.3%, and need for family planning satisfied with modern contraception 61% (5).

The number of females of reproductive age (15 - 49 years) in Palestine in 2021 was about 1.3 million, which represents 24.8% of the total population. In the West Bank, females represent 25.1% of the total population, and they are 24.3% of the total population in Gaza Strip according to the MoH annual report 2021.

Furthermore, the report illustrated that the total number of maternal deaths in Palestine was 66 cases (32 deaths in the West Bank and 34 deaths in Gaza Strip), with maternal mortality rate (MMR) 47.7 per 100,000 live births. From the total 32 maternal mortality cases in 2021, there were 25 deaths due to COVID-19. In Gaza Strip, the MMR was 60 deaths per 100,000 live births, in which 68% of maternal mortality was due to COVID-19 in 2021. The findings of maternal deaths analysis revealed that most cases were preventable had the women received more support at home, community, and health facilities, particularly in ensuring adequate birth spacing (6).

FAMILY PLANNING HEALTH SERVICES

According to the MoH annual report, 2021, the total number of new registered family planning beneficiaries in MoH health centers was 16,759 women (12,129 in the WB and 4,630 women in the GS). Contraceptive pills were the most common used method by the new users in the GS, which was 47.3% of all used methods, even though there was an increase of using Intra Uterine Devices (IUDs), 37.9% and 50.6% at MoH and URWA clinics respectively.

Similarly, the highest percentage of used methods in the West Bank was contraceptive pills, representing 55.9% of the total used methods. Condoms were the second in consumption at 22.8%, while the IUDs recorded 19.7% of the total number of methods obtained by the new beneficiaries. In the WB, the number of PHC providing FP services is 263 out of 439 centers, whilst in GS, 27 out of 52 MoH PHC clinics provide maternal and child health services including FP services. A study conducted in 2018 underscored the shortage of contraceptive stock among other issues that lack standard quality provision of family planning services (7).

The availability of quality contraceptives is essential to ensure that every pregnancy is wanted, every childbirth is safe, and every young person's potential is fulfilled. Currently in Palestine, the FP contraceptives are enlisted within the MoH essential drug list, however, there is still shortage of the allocated budget to purchase contraceptives and for several times the contraceptives reported zero stock for some items.

INTRODUCTION

Almost all countries worldwide offer family planning clients a range of contraceptive methods. "Method mix" refers to the percentage distribution of total contraceptive use across various family planning methods (FPM) reflecting the availability of affordable FPM (supply) and client preferences (demand). The choices of the FP users are crucial because the worldwide community did not recognize an "ideal" method mix (8). Improving the contraceptive method choice is associated with a higher quality of life. Additionally, it expedites the progress of nations toward eradicating poverty, fostering economic development, improving education, and empowering women (7). Modern family planning methods, particularly long-acting reversible contraceptive methods (LARCMs), are highly effective in reducing maternal mortality by preventing unintended and closely spaced pregnancies (9). Women aged 15–24 in low and middle-income countries (LMIC) are at particular risk and are more likely to have an unmet need for contraception compared to older women (10). Women with an unmet need for modern contraception are those who want to prevent pregnancy but currently do not use any method or use a traditional method. (11). It is estimated that meeting adolescents' unmet need for modern contraception would reduce unintended pregnancies globally by 6 million each year (11). LARCMs require administering less than once per cycle or month (12). The trend in contraceptive usage has changed from user-dependent to user-independent methods of contraception, and LARCMs are very efficient in this regard (13). LARCMs offer women the option of using highly effective and convenient methods with the added advantage of being long-lasting and improved compliance rates (14, 15). The Palestinian Multiple Indicator Cluster Survey (MICS) findings report, 2019-2020 showed that the Percentage of women aged 15-49 years currently married who are using (or

whose partner is using) a contraceptive method was 57.3, while percentage of women aged 15-49 years who are currently married with unmet need for family planning was 12.9. Fear of side effects, stemming from the contraceptive experiences of others and rumors were found to be major obstacles to the use of modern contraceptives (16).

United Nations Population Fund (UNFPA) reported the unmet need for family planning is related to the unavailability of contraceptives, the poor quality of family planning services, and sociocultural factors (17). Previous studies indicated that the addition of one method would increase total contraceptive use by about 12%.(18). In a study carried out to assess the healthcare professionals' perceptions of family planning service provision and examine potential barriers to providing effective patient-centered care, the providers experienced a high prevalence of beliefs that modern contraceptives cause infertility and cancer (19). The main barriers to effective family planning services were misconceptions of potential harm, poor availability, and limited choice of contraceptive methods (19). Family planning providers need to understand the motivations, perceptions, and knowledge of women about contraceptive methods in their contextual situation, which illustrates their mode of interaction in the arenas of family planning decision-making (20). A study covered the experience of Implant in the West Bank (WB) and Gaza Strip (GS); the findings indicated that satisfaction and advantages were great for Norplant as contraceptive method. However, the study findings revealed that Norplant as "**a long-term contraceptive for women, usually effective for 5 years, consisting of several small slow-release capsules of progestin implanted under the skin"**, is not available on United Nations Relief and Works Agency (UNRWA) or the Palestinian Ministry of Health (MoH) agenda (21).

STUDY METHODOLOGY

OBJECTIVES

1. To explore the knowledge, attitude, and perception of Palestinian women of reproductive age toward the currently used contraceptive methods.
2. To identify the knowledge, attitude, and perception toward up-taking long reversible contraceptive methods (Hormonal IUD, Medroxyprogesterone Acetate Injection I.P, and Implant) among Palestinian women of reproductive age.
3. To understand factors that affect the decision-making process on contraceptives among Palestinian women of reproductive age.
4. To explore the perceptions and views of the family planning healthcare providers and policymakers regarding enabling and barrier factors of introducing long-acting reversible methods (Hormonal IUD, Medroxyprogesterone Acetate Injection I.P, and Implant) in the family planning program.
5. To provide suggestions and recommendations to the policymakers to effectively improve the family planning program.

STUDY DESIGN

The current study adopted the qualitative approach. It is the best fit model to meet the study's objectives in a short time and also to capture different dimensions of the same phenomenon (22).

The researcher gained more deep information about the phenomena under investigation by conducting seven focus groups (FGDs) with beneficiaries and family planning healthcare providers. In addition to ten In-Depth Interviews (IDIs) with the policymakers to generate evidence-based decisions making on challenges and opportunities adding new methods, increase the use of contraceptives and improve the quality of the family planning program.

STUDY SETTING

For comparative purposes, three sites were selected in the WB, and two sites in the GS as follows: Nablus, Ramallah, Hebron, the Middle of Gaza, and North of Gaza. The estimated number of Palestinians at the end of 2021 was about 5.3 million in the State of Palestine (3.2 million reside in 5,660 square kilometers of the West Bank and 2.1 million reside in 365 square kilometers of the Gaza Strip) as reported by the Palestinian Central Bureau of Statistics (PCBS). The estimated population of the WB and the GS represent 59.6% and 40.4% of the State of Palestine population respectively (23). The study sample were taken from the MoH, UNRWA, and NGOs health facilities that provide family planning services. The healthcare facilities were purposively selected considering the geographical areas distribution from both the GS and the WB governorates.

TARGET POPULATION:

The target population for this study is categorized into three groups: the first group includes married women of reproductive age who are currently utilizing contraceptive methods; the second group involves family planning healthcare providers such as midwives, nurses, Ob/Gynae., and family health doctors, the third group are policymakers who play a vital role in shaping the family planning services' policies from different health sectors. The women who participated in the current study aged more than 18 years old who are currently using both modern or traditional contraceptive methods. To maintain the maximum variation, the target population represents the following groups: employed, unemployed, educated, not educated, rural, urban, and seeking family planning services from MoH, UNRWA, and NGOs.

ETHICAL CONSIDERATION:

The research project was approved by the Helsinki committee for ethical approval in the Palestinian health research council (Number: PHRC/HC/1184/22). The researcher scheduled the interviews after the sample targets who met the research selection criteria indicated an interest in taking part in the study. Before starting the interviews (FGDs and IDIs), the research team

presented a detailed description of the study, the risks, and benefits and emphasized on the confidentiality. Consent was obtained for each respondent participating, and all respondents were informed of the voluntary nature of participation and the confidentiality and anonymity of information. “Sample of the consent in the annex 1”. Additionally, participants were informed of their right to refuse answering all questions, as well as to stop the interview at any time. Participants were also informed that they can withdraw from the interview without negative consequences and to decline to answer any questions posed by the researcher at any time. FGDs and IDIs were only audio-taped after receiving verbal consent to record, each interview was double-recorded. To avoid the possible risk of loss of confidentiality, the researcher used codes to protect the confidentiality. A code was assigned to each participant, and it was recorded. During the transcription of interviews, the names of all participants were replaced by codes to ensure anonymity. Moreover, the recorded interviews and transcriptions were kept with the principal researcher. All data collected is kept confidential, and transcripts were anonymized. Records were kept on secured device and destroyed after the researcher developed and checked the transcripts; the transcripts will be destroyed upon completion of the study.

ELEIGABILITY AND SAMPLING:

The researchers utilized a non-probability purposive sample using (IDIs) and (FGDs) methodologies. The targets were policymakers, family planning beneficiaries, and family planning healthcare providers who agreed to participate in the study to generate in-depth information on the issue of concern. The researcher team, 3 specialized researchers in the field of SRHR, invited women who are currently married, aged more than 18 years, and utilizing family planning services from the selected health facilities. The researcher asked the healthcare provider to invite beneficiaries who show a willingness to participate in the study which reflected high response rate among all participants that ranges from 98% to 110%. The researchers utilized a non-probability purposive sample using IDIs and FGDs methodologies. The targets were policymakers, family planning beneficiaries, and healthcare providers who agreed to participate in the study to generate in-depth information on the issue of concern. The research investigator carried out an IDIs with ten policymakers from GS and WB proportionally.

TIMEFRAME:

The study was carried during the period 1st September to 31st December 2022. The research team launched the study activities in September and completed the data collection process in October. Data analysis and the 1st draft finding report agreed to deliver by late November and the beginning of December. The deadline date to submit the final study report is 31st December 2022.

STUDY INSTRUMENT:

The researcher developed three unstructured questionnaires with open-ended questions and probing questions. A joint committee composed of the UNFPA and MoH representatives revised the study instruments. The researchers conducted the FGDs with beneficiaries and family planning healthcare providers separately, and IDIs with policymakers from the various health sectors: MoH, UNRWA and NGOs. Furthermore, the research team used a roster to collect demographic data and further information related to the phenomena. This approach allowed the participants to share their experiences towards utilizing and introducing new contraceptive methods within the family planning service package. "Study instruments are in the annex 2,3,4".

DATA COLLECTION METHODS:

This study applied qualitative research methods mainly FGDs and IDIs. Both methods were employed to describe the participant's knowledge and perceptions regarding family planning methods with a special focus on the long term reversible contraceptive method (Hormonal IUD, Medroxyprogesterone Acetate Injection I.P, and Implant). Besides identifying barriers, and challenges that encounter the inclusion of long-term reversible contraceptive methods in Palestine family planning service package. All the FGDs and IDIs were led by experienced facilitators and were double recorded. Transcription was provided for the interviews. Then, transcripts were analyzed in the Arabic language to protect the meaning, and then the quotation and categories were translated into English.

DATA ANALYSIS:

The qualitative research expert adopted the thematic analysis method to analyze the transcripts of the collected data from the IDIs and FGDs (24). Each interview transcript was coded and analyzed along with the key themes in the Arabic language to prevent the loss of meaning. Categories were created inductively and generated from reading the transcripts. Close reading and re-reading through text data identified many times, recurrent specific segments of information that relate to the objectives of the study were organized. Through refining and condensing initial codes, five main thematic categories and fourteen subcategories were created. Table 4 provides a summary of categories and subcategories. The researcher used SPSS 24 to analyze the quantitative part of the study data.

LIMITATION OF THE STUDY:

This qualitative study is the first experience to examine issues of the potential family planning method mix in Palestine. All qualitative investigations have several constraints, including a lengthy data analysis and interpretation process, subjectivity, and results that cannot be broadly generalized. The selection of the target population by socioeconomic status, age, and location was also challenging given budgetary limitations and the tight deadline of the study. Furthermore, the unstable political situation in the WB during the implementation of the study

threatened the completion of the data collection on the due timetable and put the research teams' lives at risk. Additionally, this had a negative financial implication on the allocated budget, as the cost of transportation leapt due to areas and road closure.

GENERAL CHARACTERISTICS:

The characteristics of the policymakers and length of interviews are presented in Table 1.

Serial	Participants' Workplace	Interview duration in minutes
1.	MoH-GS	50
2.	MoH-WB	45
3.	MoH-WB	30
4.	UNRWA-GS	55
5. ,	UNRWA-WB	35
6.	NGO-GS	70
7.	NGO-GS	65
8.	NGO-WB	60
9.	NGO-WB	48
10.	NGO-WB	45

Table 1: Characteristics of (10) policymakers

The research team also conducted seven FGDs with the beneficiaries and healthcare providers:

- Five FGDs with beneficiaries (three in the WB and two in the GS);
- Two FGDs for healthcare providers (one in the GS and one in the WB); each focus group consisted of ten to eleven participants.

The researcher contacted the selected participants and appointed a date, time, and a place for each FGD. The study researchers considered the Maximum variant in recruiting the participants to provide the research study with in-depth information about the phenomena under investigation.

As for the beneficiaries, they were (49) participants with mean age of (33.76) years. More than two thirds of them (67.3%) are married for more than 10 years and (63.7 %) have higher education.

The characteristics of the beneficiaries are presented in table 2 below.

Variables	Categories	Frequency	Percentage
Age	35 or less	32	65.3 %
	More than 35	17	34.7 %
Income	1000 or less	15	34 %
	More than 1000	34	66 %
Marital years	10 years or less	16	32.7 %
	more than 10 years	33	67.3 %
Children number	More than 5	30	61.2 %
	Less than 5	19	38.8 %
Job status	Have a job	7	14.3 %
	jobless	42	85.7 %
Care provider	MoH	20	40.8 %
	UNRWA	18	36.7 %
	NGOs	11	22.4 %
Education	High school or less	31	63.3 %
	University and postgraduate	18	36.7 %
Age at first-time contraceptive use	25 years or less	27	55.1
	More than 25	22	44.9

Table 2: Beneficiaries' characteristics

Twenty-two FP healthcare providers from doctors, nurses and midwives participated in two focus group discussions. Most of the providers who participated in the study work at the MoH health facilities, and about 40% of them are midwives. The characteristics of the service providers are presented in table 3.

Variables	Categories	Frequency	Percentage
Sex	Female	21	95.46%
	Male	1	4.54%
Age	35 or less	3	16.3 %
	More than 35	19	86.4 %
Job place	MOH	10	45.5%
	UNRWA	6	27.3%
	NGOs	6	27.3%
Working experience	10 yrs. or less	9	49.9%
	More than 10 yrs.	13	50.1%
Specialty	MD	3	13.6%
	Ob/Gynae.	4	18.2%
	Midwife	9	40.9%
	Nurse	6	27.3%

Table 3: Service providers' personal characteristics

RESEARCH FINDINGS

The graph below demonstrates that Copper IUD is the most currently and previously used contraceptive method at 46.9%, details are presented in figure no. 1.

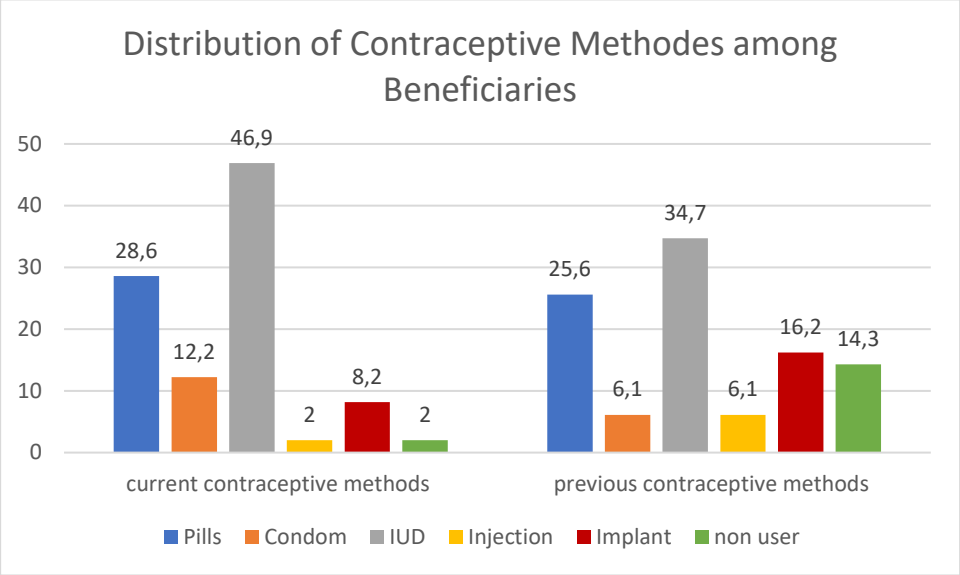

Figure 1: distribution of contraceptive methods used among beneficiaries.

THE QUALITATIVE ANALYSIS:

The study shows a range of findings related to contraception knowledge, perception, awareness, decision-making, and challenges and limitation to beneficiaries, service providers, and the health system. Information about contraceptive methods is a very important issue in decision-making and seeking behavior among beneficiaries. The source of information among beneficiaries is presented in figure 2 below:

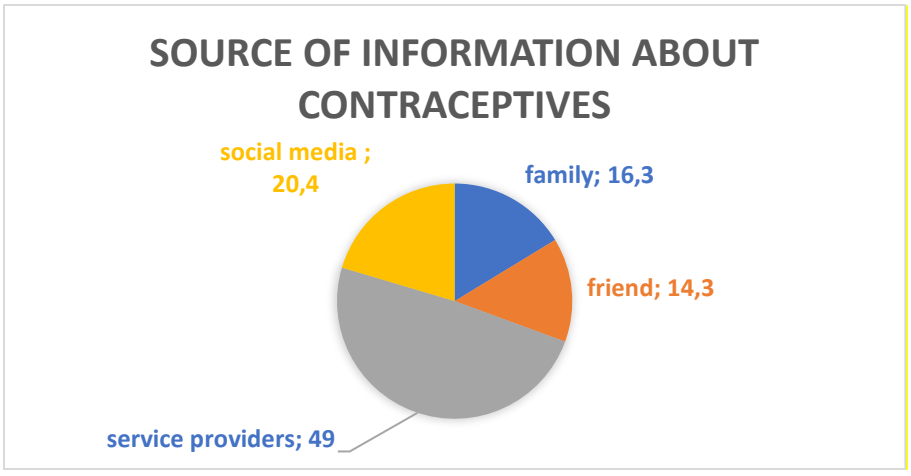

Figure 2: source of information about contraceptive among beneficiaries.

Based on the specific objectives and focus of the study, we placed the findings into five Key thematic categories: (1) Knowledge and perception regarding family planning, (2) Policy maker and healthcare provider perspective toward beneficiaries willing to use LARCMs, (3) Experience in seeking family planning counselling, (4) Family planning decision-making dynamic in Palestinian families, (5) Challenges to include Long term reversible contraceptive method (Hormonal IUD, Medroxyprogesterone Acetate Injection I.P, and Implant). In this part of the research project, we presented descriptive and analytical findings of the previously mentioned results. The current study presents five main categories and fourteen subcategories as presented in table 4.

CATEGORY 1	**KNOWLEDGE AND PERCEPTION REGARDING FAMILY PLANNING**
Subcategory 1.1	Knowledge of family planning benefits related to women's health
Subcategory 1.2	Knowledge of family planning benefits related to family health
Subcategory 1.3	Knowledge of family planning benefits related to community health
Subcategory 1.4	Modern contraceptive knowledge and perception through the lens of beneficiaries
Subcategory 1.5	LARCMs knowledge and perception through the lens of various study participants.
CATEGORY 2	**POLICYMAKERS AND SERVICE PROVIDERS' PERSPECTIVES TOWARD BENEFICIARIES WILLING TO USE LARCMS**
Subcategory 2.1	Eager to try
Subcategory 2.2	Fear of complications and side effects
CATEGORY 3	**EXPERIENCE IN SEEKING FAMILY PLANNING COUNSELLING.**
Subcategory 3.1	Experience of counseling by beneficiaries.
Subcategory 3.2	Experience of counseling by the care provider.
CATEGORY 4	**FAMILY PLANNING DECISION-MAKING DYNAMIC IN PALESTINIAN FAMILIES**
Subcategory 4.1	Beneficiaries power in decision making
Subcategory 4.2	Mother-in-law and husband power in decision making
CATEGORY 5	**CHALLENGES TO UPTAKE LONG-TERM REVERSIBLE CONTRACEPTIVE METHOD (HORMONAL IUD, MEDROXYPROGESTERONE ACETATE INJECTION I.P, AND IMPLANT)**
Subcategory 5.1	Challenges related to the system
Subcategory 5.2	Challenges related to care providers
Subcategory 5.3	Challenges related to beneficiaries

Table 4: Categories and subcategories identified based on the data findings

1. KNOWLEDGE AND PERCEPTION REGARDING FAMILY PLANNING:

KNOWLEDGE OF FAMILY PLANNING BENEFITS RELATED TO WOMEN'S HEALTH

All study participants, including beneficiaries, service providers and policymakers, revealed their awareness and knowledge regarding the importance of family planning in empowering women and rendering them opportunities to participate in the community by joining the labor force and completing their education. They mentioned the value of family planning in promoting women's health by limiting the risk of mortality and morbidity and reducing the risk of maternal complications and high-risk pregnancies. They recognize that seeking family planning services is a human right concept.

Beneficiaries, for instance, indicated their existing knowledge about the benefits of family planning related to women's health as showed below:

"Family planning promotes women's health through spacing that promotes her physical and mental health" [Unemployed, using IUD, GS]. Another participant stated, "*family planning and birth spacing reduce the risk of high-risk pregnancy*" [Employed, using Pills, WB].

A midwife from MoH in WB stated: "*family planning services protect mothers who have a postnatal complication from resurrecting pregnancy in a health condition that put her at higher risks*". Ob/Gynae. from MoH from the GS stated: "*family planning services help in promoting women's health and decrease the risk of morbidity and mortality by preventing unwanted pregnancy*".

"*Family planning services enhance women empowerment through the spacing of childbearing which provides a space of education and engaging in the labor force*" as stated by [Policymaker, UNRWA, GS]. Another participant stated that family planning services provide women with a chance to complete their education. They mentioned the vital effect of family planning on women's health as they stated:

A further participant stated that "women *benefit from the family planning methods through providing them the chance to restore their health and what they lost from their nutrients stored during pregnancy*" [Policymaker, MOH, GS].

Another policymaker from an NGO in the WB stated, "utilization of contraceptive helps mothers to prevent unintended pregnancy, as we are a Muslim community where abortion is not accepted for a non-medical reason". Another participant stated: "*family planning helps all women to restore their wellness and be ready for the next pregnancy, it protects mothers from the health risk of recurrent pregnancy*". [Policy maker, NGOs, WB].

KNOWLEDGE OF FAMILY PLANNING BENEFITS RELATED TO FAMILY HEALTH:

The study participants continued to express their knowledge about the reflection of utilizing family planning on the economy of community and families.

Participants from beneficiaries expressed their knowledge about the effect of family planning on family health as quoted below:

"In families where women are seeking family planning have higher chance to rear their children in better socioeconomic life's". She continues to state "birth spacing provides families with enough time to give the children enough care" [Employed, using IUD, GS].

A policy maker from UNRWA in WB *stated "family planning services help families in reducing the economic burden of having many children*"

Another policymaker from NGOs in WB "family planning services provide a mother a chance to provide her baby the requirement from her care". She continued to state: "family *planning does not help the mother only, but also her child through having a healthy baby through birth spacing, when a mother uses family planning her risk of high-risk pregnancy will be reduced and so, her risk of having a sick baby as premature or a low birth baby will be reduced*". A further policy maker from UNRWA in GS said: "*in communities that encourage utilization of family planning, they have a better economic situation, better education, and better health services*"

KNOWLEDGE OF FAMILY PLANNING BENEFITS RELATED TO COMMUNITY HEALTH

Overall, the data showed good general knowledge regarding the importance of family planning on women's health, family health, and the community.

"*The practice of family planning reduces the large population growth rate, which limits the development, the economic and living standards of many families in our country*" [Employed, using IUD, GS].

Health providers also expressed their knowledge and awareness, as one doctor stated: "The mothers' and children's health status in societies in which the contraceptive prevalence rate is high is better than in other communities in which the contraceptive prevalence rate is low". [Doctor from UNRWA-WB]. An Ob/Gynae. from MoH from the GS stated: "*family planning services help in promoting women's health and decrease the risk of morbidity and mortality by preventing unwanted pregnancy*".

One more health provider focused on the effect of family planning on providing women a chance to improve and *develop economically and educationally as she stated: "women who plan their pregnancy and utilize contraceptive can participate in the labor force and improve their own career"* [Midwife, MoH, GS].

A midwife from MoH in WB stated: "*family planning services protect mothers who have a postnatal complication from resurrecting pregnancy in a health condition that put her at higher risks*".

A policymaker from UNRWA in WB stated that "*family planning helps to strengthen community through providing women a power to be a decision maker in her fertility*". Another policy maker from NGOs in GS: "*utilization of family planning services is a cost-effectiveness issue, as we are living in the economical siege, the financial burden of complicated childbirth can be limited though family planning services*"

Participants mentioned the effect of family planning services on the strengthening of the women's role in the community through birth spacing which provides women the chance to complete their education and join work labor as they stated.
"*Family planning services enhance women empowerment through the spacing the of childbearing which provides a space of education and engaging in the labor force*" as stated by [Policymaker, UNRWA, GS].
Other participants stated that "women *benefit from the family planning methods through providing them the chance to restore their health and what they lost from their nutrients stored during pregnancy*" [Policymaker, MoH, GS].
A policymaker from NGOs in the WB stated, "utilization of contraceptive helps mothers to prevent unintended pregnancy, as we are a Muslim community where abortion is not accepted for a non-medical reason". Another participant articulated: "*family planning helps all women to restore their wellness and be ready for the next pregnancy, it protects mothers from the health risk of recurrent pregnancy*". [Policy maker, NGOs, WB].

MODERN CONTRACEPTIVE KNOWLEDGE AND PERCEPTION THROUGH THE LENS OF BENEFICIARIES:

The study participants were able to identify the short- and long-term modern contraceptives, and they revealed a good general knowledge regarding the beneficial outcome of using the contraceptive methods on women's health in general and newborns and families.

One participant stated: "*I know that using contraceptives will provide a woman a time of rest for the next pregnancy*" [Unemployed woman, using pills, From GS]. Other participants stated, "*the use of contraceptives will provide women an opportunity to space between pregnancies*" [Unemployed woman, using copper IUD, from GS].

Participants continued to say that "*contraceptive methods help the mother to provide the baby with his/her right of rearing and help the mother to restore her health after 9 months of pregnancy*". [Unemployed woman, using copper IUD, from WB]. One more study participant declared that" contraceptive *methods help the families who want to space birth for a health-related reason, as when the mother has a health serious condition that is exaggerated in pregnancy*" [Employed woman, using Pills, from GS]. She continued to state that "all of that, all

of the contraceptive methods have an advantage and disadvantage, every woman has to choose the method which suits her condition".

Another participant stated, "copper IUD is a contraceptive method that prevents ovum and sperm from meeting and prevents pregnancy". [Employed woman, using IUD, from GS]. A participant using IUD mentioned that she knows that IUD works by closing the cervical canal, it does not affect the body's hormones. [Employed woman, using IUD, from GS]. She continued by saying: "I know that IUD is very effective in the prevention of pregnancy, but in my case, it failed, and I got pregnancy".

The participants get their knowledge about the contraceptive from different resources: they stated that they know about it from their family as a mother, sister, and mother-in-law: [Employed woman, using IUD, from GS] declared that:" I knew about the IUD from my sister".
Another participant mentioned that she knew about the contraceptive from her sister-in-law as she said: "I heard about the implant from my sister-in-law, she works as a midwife". Knowing about the contraceptive methods from health care providers was also revealed by the study participants as it was stated by two participants [Employed woman, using IUD, from WB] and [Unemployed woman, using Condom, from GS].
Study participants stated that the internet was a source of information that helped them to know more details about the methods "*I used the internet frequently, I consider it as a source of information when I decided to use injection, I searched about its side effect and mechanism of action*" [Un employed woman, using Injection, from GS]. Other participants stated that they heard about the pills from their friends, social media, and the service providers such as a midwife or doctor are considered other sources of knowledge "*In our days, we can get information about contraceptives more easily and it is available via the internet, or we can seek for the information from the healthcare providers directly* "[Employed woman, using Pills, from WB]

LARCMS KNOWLEDGE AND PERCEPTION THROUGH THE LENS OF THE VARIOUS STUDY PARTICIPANTS.

All of the study beneficiaries did not hear about the injections (Medroxyprogesterone Acetate Injection I.P), they expressed their knowledge about the hormonal IUD. One participant stated: "it *provides a long-term prevention; it extends to 5 years*" [Employed, Using Pills, GS]. Another participant stated that: "*LARCMs contain a high level of hormone and it is very effective in pregnancy prevention*". [Employed, using Implant, WB].
The beneficiaries who expressed their awareness about the hormonal IUD expressed their knowledge about its high cost as one woman stated: "*I heard about it from my sister, she utilized it, and it costs about 800 NIS*". [Unemployed, using Pills, WB].
Many of the beneficiaries have concerns about implants and IUDs. They had a concern about negative effects because of hormonal content, and concern about insertion and removal

procedures. Beliefs about the higher level of hormonal methods' side effects were expressed by study participants, as one of the beneficiaries stated: "I *do not recommend women over 40 to use such these methods, her reaction and body response is not good and many complications may develop*" [Unemployed, using Condom, WB]. One more participant stated: "I *did not hear about hormonal IUD, but I heard about the implant from the service providers, they told me it is not easy to remove, it is difficult"*. [Unemployed, using IUD, WB].

Furthermore, the service providers expressed their awareness of the advantages, disadvantages, and mechanisms of action of the long-acting reversible contraceptive methods (LARCMs). Two midwives from MoH in Gaza stated, "*despite of lack of availability of this implant or hormonal IUD, we need it a lot, because the available methods are not effective to many women, and they experience higher failure rates*".

One participant expressed that she heard about the implant availability since 2013 at some private clinics. She continued to state that it is highly expensive as she said: "*we heard about Norplant since 2013, the UNFPA provided the MoH with implant and we got training on counseling and insert it*". [Midwife, MoH, WB].

A nurse from MoH in WB said that Norplant is very effective in the prevention of pregnancy as stated: "*it is very effective, is the success rate is 99.8%*". She continued to state: "*implant contains progesterone; it is inserted intradermal*".

Participants from the service providers showed the unavailability of hormonal IUDs in governmental or UN clinics. Other participants stated, "we *heard about the hormonal IUD, I know it can work for more than 5 years, and it is recommended for cases who have a problem with hormonal pills and IUD*". [Midwife, MoH, WB].

In brief, all the service providers showed acceptance to include LARCs method in the family planning services. However, the participants articulated their lack of experience with Hormonal IUD or Implant insertion as they expressed during the FGD:

"*The problem for me with the hormonal IUD is the insertion technique, it is a little bit different from copper IUD which needs training*". [MD, MoH, WB].

"*The implant or IUD needs training for insertion, it is not a big matter, but we need training*. *Hormonal IUD is suitable for women with dysfunctional uterine bleeding*" [Ob/Gynae., MoH, GS].

Additionally, the policymakers recognize the importance of the availability of various methods in family planning services, MD from MoH in WB stated: "*We always say there is no single-family planning method considered the best because each one is suitable for some women but not for others*". A policy maker from an NGO in the GS stated: *"Safety, cost, and effectiveness are essential for women before choosing any FP methods; if the methods are safe and effective, women can afford them".* A Policymaker from NGOs in GS stated, "the availability of this method provides a woman more options to choose what is better for her health". Another policymaker from NGOs in WB stated that: *"this method can be a good choice for women who want to limit the number of visits to the clinic, she stated".*

A policy maker from NGOs in WB also stated, *"I do not say the long-term hormonal reversible methods are better, she is the only one who can determine what is better for her and her body*". A second policymaker from NGOs in WB stated that "*lack of training and knowledge about these methods made care provider not competent in proving information about it to the mothers. So, the governmental and private sector do not introduce this method in the services*".

2. POLICYMAKERS AND SERVICE PROVIDER'S PERSPECTIVES TOWARD BENEFICIARIES' POTENTIALITY TO USE LARCMS

EAGERNESS TO TRY

Policymakers express that women who seek family planning services seem to have gone through a change due to increasing awareness and knowledge about contraceptive methods and that many women come and ask about the availability of new methods such as implants. A policymaker from MoH in GS stated: "*When coming for services, women ask about the availability of implants and questions why we do not have an implant or hormonal IUD that do not cause infection or bleeding*". Also, a policymaker from MoH in GS stated the same as a policymaker from UNRWA in WB who said: "*women come and ask about hormonal IUD, they heard about it before, and they want to use it because of its minimal disadvantages compared to copper IUD*".

A policymaker from an NGO in GS mentioned that women want to try new methods which are available in the private sector and not common in the public sector because they think high-cost methods are better and more effective than other methods.

A doctor from an NGO in WB thinks women may prefer the long-term method because they do not like recurrent visits to the family planning service settings to uptake the contraceptive methods and it will be easier than other short-term ones, which need a daily reminder as she stated: "*Any woman who wants to take any medicine will ask you about its side effects, and what it does, and it is her right as a patient to know all the details about any medicine she wants to take. I see that the new generation would like to use the new means, especially out of a concern for side effect or needs for reminders, when saying "I do not want to take a pill every day, I forget it, the IUD will cause bleeding"*.

A policymaker from UNRWA in WB said that women nowadays are willing to try new methods because of social media access which gives women a wide range of knowledge about different methods. She stated: "*Some women have information about the LARCMs and seek to take this method from another sector*".

FEAR FROM COMPLICATIONS AND SIDE EFFECTS:

Women with pre-existing knowledge expressed concerns about the side effects of the hormonal method and its possible health risk. A beneficiary stated that *"We heard that all of the methods which contain hormones can lead to cancer, so I'm afraid of any hormonal method*". [Unemployed woman, using IUD, from GS]

One more participant declared that concerns of adverse effects is a very crucial factor that affects her decision regarding utilizing the methods as she said, "*I'm thinking about the effect of methods on my body and my general health, all of the methods have a different side effect, but hormonal methods have a lot of side effects*". [Unemployed woman, using IUD, from WB]

Similarly, this was stated by a midwife from WB when she said: "*most of the women come with pre-existing knowledge, fear from complications of hormonal methods*". A policymaker from MoH in WB believes that many women may refuse the use of LARCMs due to the existing risk of many diseases as she stated: "*some women do not prefer hormonal methods because of its effects, and they said it could cause amenorrhea and breast cancer*". The same expression was stated by a further policymaker from UNRWA in WB.

3. EXPERIENCE IN SEEKING FAMILY PLANNING COUNSELLING

EXPERIENCE OF COUNSELING BY SERVICE PROVIDERS:

The focus group discussions showed different experiences in counseling. A service provider said that *"a woman with pre-existing knowledge regarding some methods, forced to use specific method because of her husband's decision as she declared".* [Midwife, MoH, WB]. A second service provider stated *"in many cases, women come to the clinic with own decisions and do not respond to my counseling and insist on their decisions"* [Midwife, MoH, GS]. Another participant stated, *"some women refused to take some methods because her husband and mother-in-law pushed her to utilize certain methods, they believe it could suit their family situation"* [Midwife, UNRWA, WB].

EXPERIENCE OF COUNSELLING BY BENEFICIARIES

Most of the participants highlighted the lack of handouts and written instructions which could help them in raising their awareness regarding family planning methods as they mentioned "*at the end of the counseling session, they did not give me any printed material to remind me of the method, how to use or side effect*". [Employed woman, using pills, from GS]. Other participants stated that most of the time they do not receive any counselling sessions, the healthcare provider asks them about the option they come with it and then provides them with an already chosen method that has been decided before at their home. "*They asked me which method I prefer, and then they provided me with it without giving me any other option*" [Unemployed woman, using pills, from GS]

4. FAMILY PLANNING DECISION-MAKING DYNAMIC IN PALESTINIAN FAMILIES

The findings of our study revealed different decision-making power in Palestinian families. Most of the beneficiaries indicated their independency in making decisions about seeking family planning services and choosing the method of contraceptive, whilst others disclosed the role of their husband or mother-in-law in the choice of method.

BENEFICIARIES' POWER IN DECISION MAKING

The majority of the beneficiaries revealed that they have the power to decide to utilize family planning methods and they can choose the method independently with their service providers without any forcing from their husbands. One participant stated, “my husband and I agreed to utilize family planning services, but I chose the pills”. [Employed woman, using Pills, from WB]

“*I chose the copper IUD, my husband wants me to use the pill, but I do not want a pill, I think IUD is better for me*” She continued to state, “*I’m the one who decide to use the IUD, I do to want to use pills, it will increase my body weight*”. [Unemployed woman, using IUD, from GS]
A woman from GS also stated that she is the one who takes the decision to utilize contraceptive methods and her husband supports her decision as she stated, “*I told my husband I want to use a contraceptive, and he accept my decision*”. [Employed woman, using IUD, from GS]; the same is revealed by two more participants who said, “*I discussed this with my husband, and we agreed that I have to take a rest from the previous pregnancy*”. [Employed woman, using a condom, from WB], and [Unemployed woman, using IUD, from WB].

MOTHER-IN-LAW AND HUSBAND POWER IN DECISION MAKING

The lack of women's control over the birth spacing decision could be a vital reason for not choosing LARCMs. It is well-known in the Palestinian community the social value of children in the family provides stability to marital life.

" *I have very bad varicose veins even reached the genital area, I have 7 children (4 male 3 female) and my husband wants me to get pregnant and if I don’t have more children ،he will marry another woman. I told him, go and get married; the same sheikh will get me the divorce from you. My health is the most important to me, now am using pills without his knowledge”.* [Unemployed women using Pills, from WB]
“*My husband may not let me utilize such long-term methods because he needs more children, if I utilized this method, he may divorce me*”. [Employed woman, using Condom, from WB]
One more participant revealed her desire to use IUD, but her husband refused her decision as he wants more children: "*I wanted to use IUD, but my husband refused, he was afraid from the side effect of copper IUD, he forced me to use pills*". [Employed woman, using Pills, from GS]
Study participants showed their concern about their mother-in-law's pressure if they utilize such long-term methods. A study participant reported that her mother-in-law asked her to have more

children as she said: "*My mother-in-law said to me that her son wants more children, this makes me utilize short-term contraceptive methods*". [Employed woman, using Pills, from WB]
One more woman declared that she was not allowed to use contraceptive methods as she stated: "*my mother-in-law does not accept using contraceptives after my first child, she said it is not good to use contraceptives after the first child, you have to have more than one child, then you can utilize contraceptive*". [Unemployed woman, using Injection, from GS]**.**
A further women said, "*My mother-in-law in front of me used to say every year to my husband let your wife get pregnant, I will not forgive you if she did not". [Employed woman, using IUD, from WB].*
It is hard to ignore the power of the Palestinian mothers-in-law that is rooted in the culture and supported by the region that called for old mothers' respect and obedience; the following narrative indicates and emphasizes the role that mothers-in-law play in decision-making within their families.
"*When I got married, I did not finish my university education yet, we agreed to take pills until I graduated, but my mother in- law kept insisting every day to stop using the pills and said it will lead to infertility and we need to have children for my son soon. Her debate every day makes my husband changed his mind and forced me to stop taking the pill and I had my first baby before finishing my degree, now am unemployed, and it is difficult for me to look for because of the children responsibility* "[Unemployed woman, using Pills, from WB].

5. CHALLENGES TO INCLUDING LARCMS (HORMONAL IUD, MEDROXYPROGESTERONE ACETATE INJECTION I.P, AND IMPLANT) WITHIN THE FAMILY PLANNING METHODS PACKAGE

CHALLENGES RELATED TO THE SYSTEM:
Interviews with the policymakers showed the challenges that limit the possibility of including LARCMs such Hormonal IUD, Medroxyprogesterone Acetate Injection I.P, and Implant to the health systems as a financial barrier. The current situation of Israeli occupation and limited resources and siege put the MoH at daily challenges in the provision and sustainability of the methods as a policymaker from MoH in GS: "*the cost of new methods and high prize limit the ability of MoH to provide this method*". Policymaker from NGOs in GS state similar concerns about the effect of cost on the sustainability of the provision of the new methods as she said: "*we are facing difficulties in seeking financial support to provide the current methods*"**.**

Adding a new method to the family planning system needs an awareness campaign from the organization that is planning to expand its services. People need the information to know more about the new methods which can be done through an awareness campaign. A policymaker from

UNRWA in WB stated: "*any new methods require awareness campaign among women and men in the community to increase the acceptability of using these methods*". Policymakers from UNRWA and MoH in WB stated the same about the advantage and disadvantages of these methods: *"we have to run an advertising campaign, marketing your product to encourage people to use it".*

Introducing any new methods requires to have a skillful care provider that plays an important role in increasing the trust among beneficiaries as a policymaker from UNRWA in GS stated: *"the provision of hormonal IUD or implant requires special training should be provided to the service providers to be more competent"*. A further policymaker from NGOs in WB articulated: "*beneficiaries' acceptance of new methods affected by the provider skill of counseling. So, we must improve the skills of our staff in providing the new method*".

CHALLENGES RELATED TO HEALTHCARE PROVIDERS

The service providers encountered many challenges in the process of counselling. They mentioned several issues, such as women's pre-existing knowledge, previous experience in contraceptive methods uptake, lack of education and inadequate training, and lack of experience in counselling on long-acting hormonal contraceptives, as they expressed in the focus group discussion:

"*Most women have already knowledge about the contraceptive benefits and disadvantages. So, that is why they come up with the decision on a method to choose*". [Midwife, MoH, WB].

[Midwife, UNRWA, GS] agreed on this also and stated: "*Women with pre-existing knowledge about some methods are difficult to change and convince them with a new one*"

One midwife stated that many women have already experienced some types of contraceptives which made them already have the decision to choose the method they want as she said "MD, UNRWA, WB].

"*We do not have enough experience in providing counseling for this method*". [Midwife, NGOs, GS]. They also stated: "*I think I'm not skillful enough in counseling of this new methods, I need enough training*". [Nurse, MoH, GS].

In short, all the healthcare providers articulated their need to receive a training course to enhance their knowledge and clinical skills that assist them to provide counseling on the new methods.

A policymaker from MoH in GS stated, "*We introduced training on the implant for midwives and doctors, but midwives refused to take this responsibility and said, it is a doctor job*". A one more policymaker from NGOs in GS highlighted the resistance to change in case of adding new methods and the effect of pre-existing ideas on introducing new methods to women as she mentioned: "*the care provider is resistant to change by nature and prefers to introduce the already existing method, invading their pre-existing beliefs and attitude about the method reflected during counseling with the woman*". A policymaker from MoH in WB mentioned that older service

providers who have a long experience and not follows the updates in family planning issues may also not prefer introducing these methods as she stated*" the service providers from doctors and midwives divided into old school and modern one, the new graduates prefer to introduce a new method and believe on the need to new choices*".
One more policymaker from MoH in WB expressed her fears about introducing new methods as she said "*It will not be going to be easy at the beginning for all of the service providers and they need training courses till they can become competent in providing these methods*".

CHALLENGES RELATED TO BENEFICIARIES:

The focus group discussion with the beneficiaries revealed that health-related factors, awareness, health service providers leading, and peer pressure can affect the women's decision regarding choosing contraceptive methods. To illustrate, a study beneficiary stated that awareness about the methods is a very important factor as she stated: "*If we know about the availability of the implant, we will search about the providers and look for the possibility of utilizing this method"*. [Employed woman, using Pills, from WB]

Another participant expressed that if she knows where she can receive an implant, she will think about this choice. "*How we will think about other choices if we do not know it is available and suit our condition*". [Employed woman, using Condom, from GS].
Service provider leading is one important factor that affects women's decisions as stated by: one woman "*The midwife advised me to use copper IUD, and I listen to her advice*". [Unemployed woman, using IUD, from WB]
Another participant showed that her health-related condition affected her choice as she said, "*I was complaining of anemia and that is why I have to choose a condom*". A second participant stated the same experience. She also highlighted the role of the services provider leading her to choose the contraceptive method. [Unemployed woman, using Condom, from WB]
The study showed that women in our community share their experiences regarding using contraceptive methods, a participant from the WB stated that she utilizes hormonal pills because her friend recommends them to her and convinced her to use them.
Some participants highlighted that the desire for birth spacing is vital in determining the method of choice. Furthermore, the availability of various contraceptive methods is an essential factor to be considered while making a choice, as two women stated: "*in my area, the implant is not available freely in our health care center, we cannot afford it*" [Employed woman, using Pills, from GS]. "*The option of LARCMs is not available in my health center*" [Unemployed woman, using copper IUD, from WB].
Furthermore, the policy makers stated that providing these methods with a cost that is not affordable for Palestinian women will limit their ability to choose one of them a policy maker from an NGO stated: "*if the methods are available free or with a cost that can be affordable, women can change their preference and choices because the price of methods is very important*

for the women" .A policy maker from UNRWA in GS stated the same issue and said, "*if the method is available within the accepted price, it will encourage women to use it but if it is not affordable, women will not be going to use it*". A policymaker from the NGOs in GS also stated if the method is freely available, women will accept it more easily.

DISCUSSION

To our best knowledge, this qualitative study project is the first one carried out to collate the data to inform on perceptions and experiences of women about LARCMs on the national level in Palestine. In response to the study question regarding their knowledge on the effect of family planning on women, families, and the community, the study participants from different groups as beneficiaries, healthcare providers, and policymakers demonstrated their full awareness of the wide range of benefits of family planning; most participants reported the perception that family planning is a health need in the Palestinian community, and it means spacing between children. More importantly, it protects the mother from pregnancy related complications, and decreases maternal morbidity and mortality. All study participants were in consensus about the positive meaning of the family planning term, to the degree that some of them perceive it as reproductive health (25, 26). The majority of the beneficiaries reported that healthcare providers are the main source of information for them to know about contraceptives. Similar findings were reported in the previous study (27). The friends and family members of the study beneficiaries with previous experience with contraceptive use were another source of information. These experiences mainly played a vital role in sensitizing the women and encouraging them to choose contraceptive methods (28). Around 50% of the study beneficiaries used copper IUD as a contraceptive method, which reflects their positive perception and good knowledge regarding LRCMs. Similar findings are presented in previous research (28).

The majority of the study participants in FGDs were able to identify short-term (Depo-Provera injection, pills, and condoms) and long-acting contraceptive methods (Implants, hormonal IUD) which is similarly reported in the previous study (29). Effectiveness, duration, side effects, cost, and access were the characteristics most commonly reported as important factors for choosing a method, which is reported previously in a similar study (30). Policymakers and healthcare providers showed acceptance of the inclusion of LRCMs due to their effectiveness despite the cost of some methods and the training required for expansion. It is worth mentioning that previous studies proved the cost-effectiveness of LRCMs by calculating the 5-year saving for the different contraceptive methods; moreover, they argued that using any contraception method is less expensive than having an unintended pregnancy. British National Health Service reported that LARC methods are economical; it is essential to identify and promote practices that increase user satisfaction and LARC use (31-33). Currently, across the world contraceptive practices are

more targeted towards modern family planning methods. As an important component of reproductive health, Modern family planning poses a major public health challenge in individuals of reproductive age when not adopted (34). Participants of our study indicated the presence of fears and rumors raised by their clients regarding each method, as well as mistrust towards the providers as pertains to removal, particularly implants. The fear came from the hormonal effect of contraceptives (29). Misconception and fear of modern contraceptives are proved in different published research. This fear poses a negative impact on the utilization and continuation of contraception (34, 35). Our study shows the willingness or desire of Palestinian women to accept new/different contraceptive methods, the policymakers and healthcare providers indicated the preference of women to try new methods that promote their health such as implants and other methods if available in the market. A similar finding is reported in a study carried out by White, K, et al. 2013 (36).

Counselling is an essential part of family planning training. In service delivery, good quality counselling leads to client satisfaction, allowing clients to make their own decisions regarding family planning use. The choice of methods is based on correct and accurate information; health care providers help the beneficiaries to attain the informed choice (37).

The study participants from healthcare providers shared their experiences in family planning counselling through the FGD and articulated that the counselling service they were providing was not inclusive of all modern contraceptives. Women visiting the clinic preferred a specific type of contraception and that is what they would provide for them. A similar finding is presented in previous research (38). Some women expressed their dissatisfaction with the counselling process, they reported inadequate information about different methods which might affect the women's ability to make informed choices and lead to discontinuity of methods.

A published study showed that structured counselling had little impact on contraceptive method choice, initiation, or continuation. Therefore, individualized counseling might be very effective in a practice setting (39).

The decision-making process related to fertility and various factors has been proposed as predictors of family planning decision-making. Women’s characteristics such as age, parity, level of education, level of income, occupation, and work status are the most frequently cited factors (40). Additionally, previous studies have analyzed diverse factors that influence family planning decision-making within the family, such as power relations and the dominance of male partners (41).

Results indicate that family planning decision-making- the decision on whether to avoid a pregnancy or not -is largely considered a women's issue, which is presented in different research results (42), whereas in some situations, this decision is affected by the husband or mother-in-law.

Similar qualitative research findings showed that there were obstacles to using modern contraceptives on a personal, cultural, and health system level. The mother-in-law influenced the

daughter-in-law through her ignorance and anxiety over the potential adverse effects of contraceptives (43).

The results of FGDs and IDIs are concurrent with findings from different qualitative and quantitative studies that demonstrated some challenges potentially limiting the utilization of LARCMs in the Palestinian community by different levels (44, 45). Availability of commodities, the cost price of the methods, staff training on the methods counselling, and provision are challenging issues that affect the beneficiary's utilization of such methods.

FP commodities availability assists every person to be able to choose, obtain, and use quality contraceptives whenever they need them. Utilization of contraception may be increased by making existing methods more accessible, enhancing existing methods' attributes, or introducing new ones. Having more options also makes it easier to cater to the unique demands of women and couples (46). The capacity of service providers can limit or promote family planning. For instance, their capacity to provide counselling services plays an important part. The lack of training capacity and cultural concerns were key reasons behind not introducing Norplant by MoH and removing it from the Al-Bureij Center in GS. Governments and decision-makers should pledge to ensure a national FP strategy is effective. To satisfy women's needs, FP providers should offer modern contraceptives like Norplant and ECPs (21).

Misconceptions about contraceptives and erroneous beliefs about modern contraceptives are considered important barriers to the use of contraceptives. Main misconception is the fear of them causing infertility and cancer. Such misconceptions were also found in other studies (19, 47). It has been determined that access to information on family planning is crucial in this regard. Data analysis indicated the role of the service provider in the provision of counseling which may affect the beneficiaries' decision-making in choosing the method (48).

CONCLUSION

Notably, widespread misconceptions and worries, ongoing shortages of family planning methods and the limited options for contraception in the West Bank and the Gaza Strip harm fertility control. Men have a big say in the decision-making regarding the contraceptive method choice; thus, it is essential to share information about contraception requirements with male community members to expand women's options. Additionally, the expansion of and availability of long-acting reversible contraceptives, such as hormonal IUDs and implants, may be essential in prompting contraceptive uptake in Palestine to reduce the incidence of unintended pregnancies and maternal deaths. Improved access to a full range of contraceptives is a fundamental element of the quality of care in family planning and is vital to achieving universal access to rights-based voluntary family planning. Moreover, Contraceptive method mix can be an indication of gender balance in any country. Globally, irreversible methods for males are much less widely available and used than female sterilization. The condom, rhythm, and withdrawal also require male participation or responsibility. Family planning programs have historically been poor at involving men in programs, interventions, and discussions. Encouraging greater gender equity in contraceptive practice is one goal of the efforts to involve men as partners in family planning and reproductive health. Overall, demand for family planning is high. Method-related dissatisfactions, flaws in family planning services, false views, and attitudes, in addition to a lack of support from male partners are major barriers that can cause or contribute to choosing short methods. The findings of this qualitative study will assist concerned parties to understand the barriers and motivators of promoting and expanding the use of LARCMs in Palestine.

RECOMMENDATIONS

The following interventions are recommendations to address this issue in the upcoming family planning programs and strategies in Palestine:

1. POLICYMAKERS AND HEALTH SYSTEM

1.1 Emphasize within the national SRHR strategic plan the top priority of FP services in meeting women's needs and demands and should be monitored by well-defined indicators to measure the progress.

1.2 Collaborate with interested stakeholders to develop a phased scaling expansion plan for the introduction of new approaches to ensure that demand creation is appropriately met. Consider the options and requirements for vertical and horizontal expansion approaches.

1.3 Policymakers should sensitize the community to the benefits and drawbacks of modern contraception and LARCs through smart marketing of the LARCs products.

1.4 Identify specific criteria to use in determining the proposed method mix by specialists. Method effectiveness, customer perception, acceptance of a similar type, availability, and the status of its registration are essential criteria to consider. A group of stakeholders from government, non-government, the private sector, and donors can then evaluate and prioritize the approaches to expand the method mix in Palestine.

1.5 Pilot the new methods to be introduced and promote the under- utilized one. During that phase, it is important to assess the new method acceptance from both service providers and beneficiary point views. Then, evaluate the impact of introducing the new method through contraceptive prevalence rate CPR and other related indicators.

1.6 Increase method choice: a wide range of modern methods must be available at an affordable price, subsidized price, or even for free through all distribution channels including public health facilities, social marketing, and the private sector. Furthermore, promoting family planning uptake through offering information about LARCs and the supplier in the area is an essential factor that may affect the demand on the LARC methods.

1.7 Involve all family planning stakeholders in the field, such as private sector and private Gynecologist doctors, in the process of expanding the existing method mix by introducing new methods or increasing underutilized methods as an important pillar to enhance program contraceptive supply. Services must reduce unmet needs and increase utilization of the available methods.

1.8 Improve the counseling capacity and skills of the service providers as they need refresher training on effective counseling.

2. HEALTH SERVICE PROVIDERS

2.1 Provide comprehensive contraceptive counselling to women seeking the use of LARC methods as previous studies revealed that those who receive counselling prior to using a method show higher rates of after-use satisfaction, continuance, and acceptance than those who do not.

2.2 Consider that conduction of individualized counselling rather than structured counselling may render more efficient and better results.

2.3 Increase availability of the scarce informational resources on contraceptives. Sufficient copies of Client information pamphlets for each method should be printed and distributed to healthcare facilities, pharmacies, and non-profit organizations that offer family planning services.

2.4 Ensure accuracy of information available online and via social media using innovative technology, employ media influencers and utilize peer-to-peer approach by MoH and partners. It's also essential to improve the accuracy of information disseminated via media away from censorship.

2.5 Increase knowledge and awareness campaigns to encourage contraceptive use. Raise awareness of prevalent misconceptions, stereotypes, and medically incorrect ideas about contraception.

2.6 Modify family planning program messaging to encourage couples' joint decisions about SRH in general and the contraceptives use to increase the utilization and commitment of LARCMs.

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ANNEXES

ANNEX 1. CONSENT FORM IN ARABIC LANGUAGE

نموذج موافقة على المشاركة في مجموعة بؤرية

1- أنا اسمي أمينة عويضات تم التعاقد معي بصفتي استشارية محلية لعمل دراسة تتضمن جمع بيانات نوعية حول وسائل تنظيم الاسرة طويلة المدى.

2- هذا التقييم اقوم به لصالح وزارة الصحة الفلسطينية وبدعم من صندوق الامم المتحدة للسكان ضمن برنامجهم لدعم احتياجات الشعب الفلسطيني وخصوصا النساء فيما يتعلق بوسائل تنظيم الاسرة.

3- قد تستغرق المقابلة حوالي 120 دقيقة يمكنك المشاركة فيها كاملة أو انهاء المشاركة في أي وقت تريده.

4- المشاركة طوعية ولك الحق في عدم الرد على أي سؤال أو تجاهله والقفز عنه كما يحق لك انهاء أو تعليق المشاركة بأي وقت بدون ابداء الأسباب.

5- لا يوجد إجابة صحيحة وإجابة خاطئة. فقط أخبرنا/أخبرينا بما يخطر ببالك. لن يتم الحكم على أو تقييم وجهة نظرك وليس ذلك من حق أي شخص لذلك نرجو ان تعبر/ي عن وجهة نظرك كما هي وكما تخطر ببالك تماماً.

6- بإمكانك طلب اعادة السؤال أو توضيحه بأي وقت تريد/ين.

7- نود التأكيد على خصوصية المعلومات الشخصية حيث أنه لن يتم الاشارة في أي مرحلة من مراحل التقييم أو بعدها لاسمك أو بياناتك الشخصية ولن يتم مشاركة شيء منها سوى لأغراض التقييم وسيكون ذلك من خلال تمويه البيانات الشخصية وحذف الأسماء.

8- يرجى العلم انه لن يترتب على مشاركتك في هذا التقييم أي منفعة مباشرة مادية أو غير مادية. وأن هذه المشاركة عمل تطوعي سوف تفيد مساهمتك في تحسين برنامج مشورة ما قبل الزواج.

9- نحن ننظر ببالغ التقدير لمشاركتك إذا رغبت في المساهمة بأفكارك ووجهة نظرك.

10- نرجو منكم احترام خصوصية بعضكم البعض والحفاظ عليها وعدم قول من قال ماذا عند مغادرة هذه القاعة.

11- لأغراض ضمان الجودة ولضمان تسجيل كل النقاط بدقة أرجو السماح لنا بتدوين الملاحظات وتسجيل المقابلة/النقاش صوتياً وربما يتم معاودة الاتصال بك بخصوص هذا النقاش من قبل الاستشاري المحلي.

12- السماح لنا بالاستمرار في الحديث معك يفيد بموافقتك على المشاركة في الدراسة من خلال هذه المقابلة وأنك لا تمانع/ين في تسجيلها لأغراض التقييم.

13- رغم هذه الموافقة يهمني اعادة التأكيد على حقك في تخطي أي جزء من الأسئلة أو المقابلة برمتها في أي وقت بدون أسباب ويمكنك السماح أو رفض استخدام المعلومات أو وجهات النظر التي أبديتها سابقاً.

14- هل لديك استفسارات أو أسئلة؟

15- هل توافق على المشاركة في هذه المقابلة؟

ANNEX 2. STUDY QUESTIONNAIRE QUID IN ARABIC LANGUAGE

اسئلة المجموعة البؤرية للمنتفعات

البنود	الأسئلة المقترحة
المقدمة	• تقديم نفسك والترحيب / الشكر للمشاركين. • قدم لمحة عامة عن أهداف الدراسة للمشاركين في المجموعة البؤرية. • وضح أهمية إشراك أكبر عدد ممكن من المشاركين، وعدم إصدار أحكام أثناء مرحلة الجلسة من اجل خلق بيئة مشجعة وآمنة. • الحصول على إذن للتسجيل وتدوين الملاحظات
البينات الشخصية	أخبرني بداية عن: 1. العمر .... 2. مستوى التعليم ..... 3. مكان السكن.....مخيم .....قرية.....مدينة 4. عدد سنوات الزواج..... 5. دخل الأسرة..... 6. المهنة: □ تعمل □ لا تعمل 7. عدد الاولاد..... 8. نوع جنس الأولاد عدد الاناث: ..... عدد الذكور: ..... 9. نوع الوسيلة المستخدمة حاليا ..... 10. الوسائل المستخدمة سابقا..... 11. العمر عند استخدام الوسيلة لأول مرة .....
المعرفة و التوجهات حول وسائل تنظيم الاسرة	1. أخبريني ماذا تعرفين عن وسائل تنظيم الاسرة (موانع الحمل)؟ وما هي مصدر معلوماتك؟ 2. ماهي الوسيلة التي تستخدمينها الان؟ أخبريني ماذا تعرفين عنها؟ 3. كم من الوقت تم تخصيصه للشرح واعطاء المشورة حول وسائل تنظيم الأسرة؟ ما الذي تم تضمينه في الشرح؟ (العيوب / المزايا/الآثار الجانبية المحتملة) 4. هل تلقيت أي معلومات مكتوبة؟ إذا كانت الاجابة نعم، كم كانت مفيدة؟ 5. هل قمتي سابقا باستخدام أي وسيلة تنظيم اسرة وتوقفت عن استخدامها ؟، ما هو السبب؟ 6. من اين تحصلين على وسيلة تنظيم الاسرة التي تستخدمينها الان او التي قد تودين استخدامها مستقبلا؟ 7. ماذا تفعلين في حال عدم توفر الوسيلة/الخدمة في العيادة التي تتابعين فيها؟ 8. لماذا تلجا السيدات لاستخدام وسائل تنظيم الأسرة؟ 9. لما قمتي باختيار تلك الوسيلة (المقصود الوسيلة السابقة)؟ 10. لماذا تفضلين الوسيلة الحالية؟ 11. هل تعتقدين ان هذه الوسيلة التي تتبعينها حاليا فعالة لتحقيق الهدف الذي اخترتها من اجلها؟
المعرفة و المفاهيم و الأدراك حول وسائل الحمل (الابر الهرمونية- اللولب الهرموني-الغرسات)	1. هل سمعتي من قبل عن الابر الهرمونية- اللولب الهرموني- الغرسات؟ ما هو مصدر معلوماتك؟ 2. إلى أي درجة ساعدتك المعلومات الصحية المكتوبة (منشورات، مطويات) وكيف أثر ذلك على اختياراتك وقراراتك لوسيلة تنظيم الأسرة؟ 3. ماذا تعرفين عن الابر الهرمونية- اللولب الهرموني-الغرسات؟ أخبريني أكثر.. 4. ما هو منظورك/ رايك اتجاه وسائل تنظيم الاسرة الهرمونية ذات المدى البعيد (الابر الهرمونية- اللولب الهرموني- الغرسات) ؟ هل تعتقدين أن هذه الوسائل قد تسبب أعراض جانبية أو اثار سلبية مقارنة بالوسائل الأخرى؟ يرجى التوضيح. 5. هل ترغبين في استخدام احدى هذه الوسائل؟ ماهي العوامل التي قد تدفعك/ تحفزك لاستخدام احدى هذه الوسائل؟

	6. هل تعتقدين ان هذه الوسائل أكثر كفاءه في منع الحمل؟ لماذا؟

اتخاذ القرار	1. كيف اتخذت قرارك باستخدام وسائل تنظيم الاسرة؟ 2. ما هي أهم العوامل التي تؤثر في صنع قرارك اتجاه اختيار وسيلة تنظيم الاسرة التي تتبعينها؟ 3. ما هو العامل الأكثر أهمية في اتخاذ هذا الاختيار؟ ولماذا؟ 4. ما الذي قد يدفعك/يحفزك في اتجاه اتخاذ وسيله ذات مدى بعيد مثل الابر الهرمونية- اللولب الهرموني- الغرسات؟ 5. ما الذي قد يمنعك من استخدام وسائل تنظيم الاسرة ذات المدى البعيد مثل الابر الهرمونية- اللولب الهرموني-الغرسات؟ 6. هل هناك اشخاص أو ثقافات او معتقدات معينه تؤثر في قرارك باستخدام وسيله معينه من وسائل تنظيم الاسرة؟ 7. من هو الشخص الأكثر أهمية الذي أثر في هذا الاختيار ولماذا؟

اسئلة المجموعة البؤرية لمقدمي الخدمات الصحية

البنود	الاسئلة المقترحة
المقدمة	▪ تقديم نفسك والترحيب / الشكر للمشاركين. قدم لمحة عامة عن أهداف مجموعة التركيز. ▪ وضح أهمية إشراك أكبر عدد ممكن من المشاركين، وعدم إصدار أحكام أثناء مرحلة الجلسة من اجل خلق بيئة مشجعة وآمنة. ▪ الحصول على إذن للتسجيل وتدوين الملاحظات
البينات الشخصية	أخبريني/ أخبرني بداية عن: 1. العمر..... 2. مكان العمل: حكومة/ وكالة/ مؤسسات غير ربحية..... 3. الاختصاص (طبيب/ة عام/ة، طبيب/ة أخصائي/ة، ممرض/ة، قابلة) ..... 4. سنوات الخبرة في مجال تقديم خدمات وسائل تنظيم الأسرة..... 5. عدد الدورات والتدريبات التي تلقيتها في مجال تنظيم الاسرة .....
المعرفة والمفاهيم و الإدراك حول وسائل الحمل (الابر الهرمونية- اللولب الهرموني-الغرسات)	1. ماهي برأيك فوائد تنظيم الأسرة على المستوى الفردي؟ وعلى مستوى الاسرة؟ 2. ماهي برأيك الآثار الصحية لعدم استخدام وسائل تنظيم الأسرة؟ 3. هل سمعت/ي من قبل عن الابر الهرمونية- اللولب الهرموني-الغرسات؟ ارجو التوضيح؟ 4. ماذا تعرف/ين عن الابر الهرمونية- اللولب الهرموني-الغرسات؟ 5. هل سبق وانت تعاملت معها او تلقيت تدريب عليها؟ ما هو مصدر هذه التدريب؟ هل كان تدريب وطني موحد؟ أخبريني أكثر.. 6. ما هو رأيك حول اضافة الابر الهرمونية- اللولب الهرموني-الغرسات في خيارات وسائل تنظيم الأسرة للمنتفعات؟ 7. هل تتوفر وسائل تنظيم الاسرة بأنواعها المختلفة طوال الوقت؟؟ وما هي اجراءاتكم في حال نقص وسيلة معينة أو كل الوسائل (كيف يتم التعامل مع السيدات الراغبات في الخدمة في هذه الحالة؟)
صنع القرار لدى المنتفعات والاسباب المتعلقة بالنظام الصحي	1. كيف تجدين رغبة المشاركين/المنتفعات في التعرف على تنظيم الأسرة وطرقه من وجه نظرك، 2. لماذا تلجأ المنتفعات لاستخدام وسائل تنظيم اسرة قصيرة المدى؟ ما الذي يمنع السيدات من استخدام وسائل طويلة المدى ماذا تعتقد/ين حول نظرة المنتفعات اتجاه وسائل تنظيم الاسرة الهرمونية ذات المدى الطويل؟ 3. ماهي العوامل التي تساعد في تغير اتجاهات السيدات في اختيار وسائل تنظيم الاسرة عموما؟ 4. ماهي الصعوبات (التحديات) التي تواجهك في تقديم المشورة مع المنتفعات حول استخدام وسائل تنظيم الاسرة الهرمونية ذات المدى البعيد؟ كيف تتغلب/ين على هذه المعيقات؟ 5. ما الذي توصي به لتحسين خدمات تنظيم الأسرة في المراكز الصحية؟

اسئلة اللقاءات مع صانعي القرار

البنود	الاسئلة المقترحة
المقدمة	▪ تقديم نفسك والترحيب / الشكر للمشاركين. قدم لمحة عامة عن أهداف الدراسة. ▪ الحصول على إذن للتسجيل وتدوين الملاحظات
المعرفة والمفاهيم والإدراك حول وسائل الحمل (الابر الهرمونية- اللولب الهرموني-الغرسات)	1. من وجهة نظرك ما هي آثار تنظيم الاسرة على مستوى الفرد، الاسرة والمجتمع؟ 2. من وجه نظرك ما هو أثار او انعكاس برنامج تنظيم الأسرة على المنظومة الصحي ؟؟ما رأيك بالوسائل الهرمونية ذات المدى البعيد مثل الابر الهرمونية- اللولب الهرموني-الغرسات؟ وما مدى توفرها؟ أخبريني /أخبرني أكثر.. 3. ماذا تعتقد/ين حول نظرة المنتفعات اتجاه وسائل تنظيم الاسرة الهرمونية ذات المدى البعيد؟ 4. ماذا تعتقد/ين حول نظرة مقدمي الخدمات اتجاه وسائل تنظيم الاسرة الهرمونية ذات المدى البعيد؟
صنع القرار لدى المنتفعات والاسباب المتعلقة بالنظام الصحي	1. هل يوجد استراتيجية وطنية لخدمات تنظم الاسرة؟ في حال كانت الدابة نعم؟ ما هي السياسات الاستراتيجيات المتبعة من اجل دعم وتطوير برنامج تنظيم الأسرة؟ وإذا كانت الإجابة بلا، لماذا برائيك لا يوجد إستراتيجية وطنية لخدمات تنظيم الأسرة؟ 2. ماهي رؤية المؤسسة الصحية المستقبلية اتجاه تطوير خدمات تنظيم الاسرة؟ 3. ماهي رؤية المؤسسة الصحية المستقبلية اتجاه اضافة حزمة جديدة من وسائل تنظيم الاسرة؟ 4. برأيك ماهي العوامل التي تدفع المنتفعات في اختيار الوسائل ذات المدى البعيد؟ ولماذا في رأيك قد لا تلجأ المنتفعات لاختيار وسائل هرمونية بعيدة المدى؟ 5. ما هي العوامل التي تزيد من اقبال المنتفعات على استخدام وسائل تنظيم اسرة هرمونية طويلة المدى؟ 6. ما هي العوامل التي تثبط من اقبال المنتفعات على استخدام وسائل حمل هرمونية طويلة المدى؟ 7. ماهي الفوائد المتوقعة من اضافه هذه الوسائل (وسائل هرمونية بعيدة المدى) الى حزمة وسائل تنظيم الاسرة على المستوى الوطني؟ 8. ماهي الصعوبات/التحديات التي قد تواجه النظام الصحي في اضافة هذه الوسائل للوسائل المعتمدة؟ كيف يمكن تجاوز هذه الصعوبات؟

ANNEX 3: ROASTER FOR BENEFICIARIES

FGD

Fieldwork Activity	Focus Group Discussion		
Group: **Beneficiaries**			
Date, start time, and duration of Interview -	_ _ / _ _ /2022	_ _ : _ _ (am/pm)	_ _ _ min
Place of FGD -			
Area -			

Please fill in the below roster for all participants in the above fieldwork activity.

10	9	8	7	6	5	4	3	2	1	البيانات الشخصية
										رمز المشارك
[__ __]	[__ __]	[__ __]	[__ __]	[__ __]	[__ __]	[__ __]	[__ __]	[__ __]	[__ __]	العمر
										رقم التلفون
قرية مدينة مخيم	قرية مدينة مخيم	قرية مدينة مخيم	قرية مدينة مخيم	قرية مدينة مخيم	قرية مدينة مخيم	قرية مدينة مخيم	قرية مدينة مخيم	قرية مدينة مخيم	قرية مدينة مخيم	مكان السكن
[__ __]	[__ __]	[__ __]	[__ __]	[__ __]	[__ __]	[__ __]	[__ __]	[__ __]	[__ __]	عدد سنوات الزواج
اعمل □ لا اعمل □	اعمل □ لا اعمل □	اعمل □ لا اعمل □	اعمل □ لا اعمل □	اعمل □ لا اعمل □	اعمل □ لا اعمل □	اعمل □ لا اعمل □	اعمل □ لا اعمل □	اعمل □ لا اعمل □	اعمل □ لا اعمل □	طبيعة الحالة المهنية
										الدخل الشهري للأسرة بالشيكل

رمز المشارك	1	2	3	4	5	6	7	8	9	10
اخر درجة علمية حصلت عليها										
عدد الأبناء										
جنس الابناء	... عدد الإناث ... عدد الذكور	... عدد الاناث ... عدد الذكور	... عدد الاناث ... عدد الذكور	... عدد الاناث ... عدد الذكور	... عدد الاناث ... عدد الذكور	... عدد الاناث ... عدد الذكور	... عدد الاناث ... عدد الذكور	... عدد الاناث ... عدد الذكور	... عدد الاناث ... عدد الذكور	... عدد الاناث ... عدد الذكور
ما هو نوع الوسيلة المستخدمة سابقا										
ما هو نوع الوسيلة المستخدمة حاليا										
كم كان عمرك عندما استخدمت وسائل تنظيم الاسرة اول مره										

ANNEX 4: ROSTER FOR THE HEALTH SERVICES PROVIDERS:

FGD

Fieldwork Activity	Focus Group Discussion		
Group : **health care Providers**			
Date, start time, and duration of Interview -	_ _ / _ _ /2022	_ _ : _ _ (am/pm)	_ _ _ min
Place of FGD -			
Area -			

Please fill in the below roster for all participants in the above fieldwork activity.

Respondent ID	**01**	**02**	**03**	**04**	**05**	**06**	**07**	**08**	**09**	**10**
Participant initial										
Age in years	[__ __]	[__ __]	[__ __]	[__ __]	[__ __]	[__ __]	[__ __]	[__ __]	[__ __]	[__ __]
Telephone Number										
Place of Current work status	□GOV □ UNRWA □ NGOs	□GOV □ UNRWA □ NGOs	□GOV □ UNRWA □ NGOs	□GOV □ UNRWA □ NGOs	□GOV □ UNRWA □ NGOs	□GOV □ UNRWA □ NGOs	□GOV □ UNRWA □ NGOs	□GOV □ UNRWA □ NGOs	□GOV □ UNRWA □ NGOs	□GOV □ UNRWA □ NGOs
Current job specialty	□MD □OG/Gyn □Midwife □Nurse	□MD □OG/Gyn □Midwife □Nurse	□MD □OG/Gyn □Midwife □Nurse	□MD □OG/Gyn □Midwife □Nurse	□MD □OG/Gyn □Midwife □Nurse	□MD □OG/Gyn □Midwife □Nurse	□MD □OG/Gyn □Midwife □Nurse	□MD □OG/Gyn □Midwife □Nurse	□MD □OG/Gyn □Midwife □Nurse	□MD □OG/Gyn □Midwife □Nurse

Respondent ID	01	02	03	04	05	06	07	08	09	10
No. of Working years' experience in family planning										
No. of workshop training in family planning services										

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