Sexual and reproductive health and reproductive rights regulatory frameworks across the Arab states region:

Current status and future outlook

Policy guidelines document

Palestine

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CONTENTS

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A. Acronyms

AIDS	Acquired Immunity Deficiency Syndrome
ANC	Antenatal Care
ASRO	Arab States Regional Office
AUB	American University of Beirut
CEFMU	Child, Early and Forced Marriages and Unions
CMR	Clinical Management of Rape
CO	Country Office
CPHP	Center for Public Health Practice
CSE	Comprehensive Sexuality Education
EC	Emergency Contraception
ESCWA	United Nations Economic and Social Commission for Western Asia
FGM/C	Female Genital Mutilation/Cutting
FHS	Faculty of Health Sciences
FP	Family Planning
GBV	Gender-based Violence
GCC	Gulf Cooperation Council
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
ICPD	International Conference on Population and Development
IPV	Intimate Partner Violence
LGBTQI+	Lesbian, Gay, Bisexual, Pansexual, Transgender, Genderqueer, Queer, Intersexed, Agender, Asexual, and Ally community
MCM	Modern Contraceptive Methods
MENA	Middle East and North Africa

MoH	Ministry of Health
NGOs	Non-Governmental Organizations
NHRIs	National Human Rights Institutions
PHCC	Primary Healthcare Center
PNC	Postnatal Care
PWDs	Persons With Disabilities
RH	Reproductive Health
SDG	Sustainable Development Goals
SGBV	Sexual and Gender-based Violence
SIGI	Social Institutions and Gender Index
SRH	Sexual and Reproductive Health
SRHRR	Sexual and Reproductive Health and Reproductive Rights
STIs	Sexually Transmitted Infections
SV	Sexual Violence
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
VAW	Violence Against Women
VCT	Voluntary Counselling Testing
WHO	World Health Organization

B. Introduction

This document is annexed to the regional sexual and reproductive health and reproductive rights (SRHRR) policy guidelines report that defines its scope and the context of its development.

The proposed policy guidelines are classified by SRHRR priorities of interventions as deduced from the conducted prioritisation exercise noted in the regional report and, based on the different elements of the socio-ecological model, as appropriate and relevant (Refer to the regional report).

Some of the proposed policy guidelines relevant to all the 15 countries and covered by the noted regional report are also relevant to Palestine. Accordingly, they are also proposed within this report to ensure a comprehensive and holistic coverage of all necessary SRHRR policies essential for promoting SRHRR in Palestine and also to ensure the inclusiveness of this report if consulted independently from the regional report.

C. Palestine country overview

Palestine's total population, as reported in 2020, is 5,100,000 with a total population density of 847 persons per square kilometre (Worldometer, 2020). The life expectancy in Palestine for both sexes is 74.62 years and the infant mortality rate is 15.8 infant deaths per 1,000 live births (Worldometer, 2020).

Palestinian refugees make up 42.8% of the Palestinian population, with 27.1% of them residing in the West Bank and 67.3% residing in the Gaza Strip (UNFPA, 2019a). The Gaza Strip is home to approximately 1.9 million people, including some 1.4 million Palestinian refugees, with a population density of more than 4500 inhabitants per one square kilometre — one of the highest in the world (UNFPA, 2019a).

Palestine is considered a lower-middle income country with a GDP of 16.3 billion US dollars for the year 2018 and a GDP per capita of 6,481 (ppp in USD) for the year 2019 (World Bank, 2020a; World Bank, 2020b; World Bank, 2020c). Blockades, occupation, local conflicts, high rates of unemployment and environmental breakdown act as significant impediments to its socio-economic development (UNCTAD, 2020).

The Palestinian population is young, with a median age of 20.8 and 38% of the population being under 15 years of age. The majority of Palestinians live in urban cities with only 20% living in rural areas (Worldometer, 2020). In 2020, the unemployment rate was estimated at 46% in the Gaza Strip and at 14% in the West Bank, and it was estimated at 21% among males and at 40% among females in all Palestine (PCBS, 2020).

The total fertility rate of Palestine fell gradually from 7.8 births per woman in 1971 to 3.5 births per woman in 2020 (Knoema, 2020). Literacy among the population has increased significantly along the years to reach 99.3% in 2018 (World Bank, 2020d).

Rapid population growth and changes in the age structure in Palestine is expected to affect the social and economic sectors and to increase demand for public services, including health care, education and employment, among others. The demographic transformation is also expected to affect the health needs of the population, with specific implications for health priorities of the different population groups, mainly children, youth, women in childbearing age and the elderly (Palestinian Ministry of Health, 2017).

The Palestinian health system is a fragmented sector governed by the following four main stakeholders: the Ministry of Health (MoH) and its affiliated Military Medical Services, the UN Relief and Work Agency for Palestine Refugees

(UNRWA), non-governmental organizations (NGOs) and the private sector. They all participate in the delivery of different health services at the three levels of primary health care, secondary health care and tertiary health care (MoH, 2017).

Many Palestinians live in difficult conditions, particularly so for those in Gaza, in view of the Israeli occupation. The protracted humanitarian crisis in the Gaza Strip is principally the combined result of the Israeli-imposed closure and blockade on one hand and its systematic destruction of public and private infrastructures on the other. The deterioration of Gaza's health sector is rooted in these practices and is maintained through the severe restrictions on movement of people and goods (Al Mezan Center for Human Rights, 2018). In consequence, the difficult conditions in which many Palestinians live exacerbate the shortcomings of the health care system and make it more challenging for Palestinians to access quality health care when they need it, and they also equally impede the ability of the Palestinian Authority PA to respond to the increasing health needs of Palestinian residents (Anera, 2020).

For example, in Area C of the West Bank — an area under full Israeli control — Palestinian residents considerably suffer unequal access to health care largely due to the restrictions imposed on the Palestinian Authority in being allowed permission to build any kind of health facilities and due to the communities themselves being denied consent to construct any buildings in the area. With restrictions on the freedom of movement and little access to their basic needs, such as running water, electricity, sewerage systems and health care services, Palestinians residing in Area C are amongst the most vulnerable populations in the West Bank (Dahmash, 2021).

As a whole, the Palestinian public health system lacks the sufficient infrastructure, such as water and electricity, which is needed to serve the enormous population in need of medical care. Years of restrictions on imports, particularly the Israeli and Egyptian blockades on Gaza, have left the Palestinian hospital system with critical shortages in supplies, such as medical equipment, prescription drugs, over-the-counter medications and protective gear. Ongoing conflict has also left many hospitals and clinics in disrepair, and restrictions on goods make it difficult to procure supplies for rebuilding. Lastly, the personnel infrastructure is limited as well. Palestine suffers from a shortage in family medicine and specialty doctors, especially those practicing in child health (Anera, 2020).

When it comes to SRHRR, we see that underage marriages represent 15% of all marriages in Palestine and that gender disparities have led to Palestine having one of the lowest rankings in the region on the Gender Development Index, recorded as 0.870 (UNDP, 2020). Furthermore, results of the 2019 Violence Survey conducted by the Palestinian Central Bureau of Statistics (PCBS) showed that one out of three women in Palestine is subjected to violence by her husband and 57%

of women suffer from psychological violence, the most common type of violence, followed directly by economic violence (41%). Among the marginalised groups, results showed that 37% of women with disabilities suffered from domestic violence (PCBS, 2019; UNFPA, 2019b).

Finally, in view of the increasing proportion of population groups in reproductive age, the high fertility rates, the population growth and the challenges surrounding gender-based violence (GBV), improving access to high quality reproductive health services and achieving gender equality remain main priorities in Palestine as expressed in the National Health Strategy as well as in the Vision for Palestine 2030 (MoH, 2017; UNFPA 2016).

D. SRHRR prioritized themes

D.1 Theme 1: maternal health care to ensure safe pregnancy and childbirth

The following methods were adopted to develop the regional youth SRHRR overview report.

D.1.1 Maternal health in Palestine: indicators, problem areas and opportunities

The historical trends in maternal mortality ratio (MMR) in Palestine showed that the ratio continued to decline over time. The World Health Organization (WHO) estimated MMR in Palestine at 55 maternal deaths per 100,000 live births in 1999 and 38 deaths per 100,000 live births in 2009 and reaching 23 deaths per 100,000 live births in 2010–2014. However, in view of the emergence of war in Gaza in 2014, an increase in maternal mortality ratio was observed. This was mainly due to the capacity and quality of care having been disturbed (MoH, 2017). In 2019, the MMR in Palestine was estimated at 19.1 maternal deaths per 100,000 live births (WHO, 2019).

The infant mortality rate (IMR) in Palestine is estimated at 12 infant deaths per 1,000 live births, with 12 deaths per 1,000 live births in the West Bank compared to 13 deaths per 1,000 live births in the Gaza Strip. The under-five mortality rate in Palestine is estimated at 14 deaths per 1,000 live births, with 15 deaths per 1,000 live births in the West Bank compared to 14 deaths per 1,000 live births in the Gaza Strip (MICS, 2021).

Nearly all births (99%) which occurred in the two years that preceded the Multiple Indicator Cluster Survey (MICS) in 2019 were delivered by skilled personnel. Approximately one in every four births in the two years preceding the MICS survey were delivered with the assistance of a midwife or nurse. Doctors assisted with the delivery of 93% of births (MICS, 2021).

Nearly 93% of women who gave birth to their last child during the last two years preceding the study have received antenatal care (ANC) from skilled medical personnel. Almost all mothers (99%) received ANC more than once with 95% receiving ANC at least four times, reflecting a high level of awareness of the importance of the consistency of care during the progress of pregnancy (MICS, 2021).

With regards to postnatal care (PNC) visits, the majority are noted to take place after the first week or after 3–6 days after delivery (41.6% and 26%, respectively). As a result, a total of 91.4% of all mothers receive a postnatal health check. This percentage varies from 95% in the West Bank to 86.5% in the Gaza Strip (MICS, 2021).

While the above indicators place Palestine among advanced countries in terms of coverage and outcomes, there is still much to do with regards to improving the quality and, more importantly, the sustainability of these results, especially while facing pressures with funding in a highly fragmented and donor-dependent health care system.

In fact, while it is noted that ANC coverage is high in Palestine, there are open questions on the rate of 'effective coverage' which assesses whether ANC interventions are completely and appropriately delivered in a timely manner. This type of assessment can identify critical gaps in health care service delivery. A 2019 study on effective ANC in public primary health care clinics in the West Bank reported that only 13% of women attended ANC visits according to the recommended national schedule, which drives effective coverage down particularly since the effective coverage of two-step ANC interventions (screening for gestational diabetes mellitus, repeated screening tests for anaemia and hypertension, symphysial fundal height measurement and antenatal ultrasound) were significantly limited. Clinics with a laboratory and ultrasound machines generally performed better in terms of effective coverage (Venkateswaran et al., 2019). Women also attend ANC in either public or private sector clinics, which may lead to an inconsistency in the care received (Palestinian Ministry of Health, 2020).

When it comes to PNC, a recent study on the perception of women in Gaza receiving PNC services revealed that while they rated their overall experience as positive, they expressed a lower level of satisfaction in the domains of 'postnatal health education' and 'communication and psychological support.' These include items related to providing education on family planning, postnatal exercise, breast care and baby vaccination programmes as well as providing emotional and psychological care (Alkasseh et al., 2020).

Last but not least, maternal health care in Palestine cannot be addressed without a closer look at the experience of the 'midwife-led continuity model' adopted in recent years. The Palestinian Ministry of Health adopted the midwifery-led model in 2012, and, in cooperation with the Norwegian Aid Committee (NORWAC), they facilitated the implementation of the model in a few Palestinian regions. As of 2016, and with only 2 midwives for each 10,000 individuals in the population, Palestine had a deficit of 3000 midwives to reach the international standard. The system started out as a physician-dominated health care system with no space for positioning midwives as the key practitioner and care provider in sexual and reproductive health (SRH) (UNFPA, 2020).

Through actively promoting midwifery as a health profession in partnership with national midwifery education institutes and midwifery associations, the UNFPA and Palestinian partners succeeded in standardising and increasing enrollment

in midwifery education. In 2016, however, the Norwegian aid policy shifted their interest in supporting similar programmes, and their funding stopped. By then, the model was successfully implemented in six out of twelve governmental hospitals, and engaged midwives succeeded to serve 37 rural villages (Mortensen et al., 2019). Recently, two studies assessing the impact of the midwife-led continuity model in Palestine reported a positive influence on women's utilisation of maternity services and/or any other quality indicators such as referral mechanisms and postnatal care, and they also noted an increase in women's satisfaction with care through the continuum of antenatal, intrapartum and postpartum periods besides other significant improvements in maternal health indicators (Abu El Nour et al., 2018; Mortensen et al., 2019). In addition to that, evidence shows that midwife-led models of care would be a cost-efficient way to improve maternal services in low- and middle-income countries (Friedman et al., 2015). Therefore, the need to grow this effective and efficient model in Palestine is ever more pressing considering the pressures on funding the costs of care. This opportunity, however, remains largely untapped due to several obstacles.

Today, and while midwives have the capability to safely provide 80% to 90% of SRH functions, the scope and autonomy of their work in Palestine is still restricted in a doctor-led environment (Mortensen et al., 2019).

Another SRHRR barrier is the disconnection between the educational system's and the health sector's needs. The issue of accreditation and licensing of colleges and their curricula is managed by the Ministry of Education with little or no involvement from the health sector, therefore the match between demand and supply is missing in terms of the numbers and qualities of midwives. There are also structural gaps in licensing midwives and nurses and there is no one standardised licensing procedure that is applied to all those who want to practice (UNFPA, 2015).

In summary, while Palestine has made significant progress in terms of maternal health care indicators, there are important challenges with regards to the preparedness, quality and effectiveness of ANC and PNC. On the other hand, the growing pressures on health care spending and funding could present an opportunity to scale the midwife-led continuity models through addressing key structural and behavioural barriers.

D.1.2 Access to contraception

In 2010, the rate of unwanted pregnancies in rural areas was significantly higher (34.6%) compared to urban areas or camps (28.4%). These percentages decreased slightly in 2014 in the three localities, with camps having the highest proportions of unwanted pregnancies. Wealth and education are noted not to be

correlated to the percentage of unwanted pregnancies (PCBS, 2016; PCBS, 2014).

In 2014, the unmet need for contraceptive information and services was estimated at 11% in total (5% for limiting and 6% for spacing births) and was quite similar in the West Bank and in the Gaza Strip. From 2006 to 2014, there was a reduction of this unmet need by around 42%, which could be attributed to the improvement of service delivery and commodity security (Khader, A., and Abu Hamad, B., 2015). The figures for unmet needs have remained relatively constant since 2014 (PCBS, 2021; UNFPA, 2018).

On the other hand, the MICS study showed that contraceptive prevalence ranges from 56% in the West Bank to 59% in the Gaza Strip. About 57% of married women in urban and rural areas and 61% in camps use a method of contraception. Adolescents are far less likely to use contraception than older women. Only about 32% of women aged 15–19 and married use a method of contraception compared to 39% of those aged 20–24 years, while the use of contraception among older women ranges from 54% to 70% (MICS, 2021).

Women's contraceptive choices in Palestine are limited by prevalent misconceptions and fears, by the poor quality of service, by weak counselling and negative providers' attitudes towards family planning and by recurrent commodity shortages, all leading to a negative impact on fertility control. In fact, the influence of others, including peers, relatives and particularly husbands and mothers-in-law, is a key factor affecting unmet needs. Men, who are a major factor in choosing a contraceptive method, have limited access to information. Cultural beliefs, social pressures and the preference of male children also deter women from using contraceptives. In addition, the lack of convenience and privacy in public health care facilities as well as the shortage of staff and their limited knowledge affect the health care system's capacity to address the unmet needs for family planning (Böttcher, B., Abu-El-Noor, M., and Abu-El-Noor, N., 2019; Khader, A., and Abu Hamad, B., 2015).

D.1.3 Policy guidelines associated with theme 1: maternal health

I. Overarching elements

These are classified by intervention priorities as deduced from the conducted prioritisation exercise noted in the regional report and, based on the different elements of the socio-ecological model, are deemed appropriate and relevant.

As noted in the regional report, this model consists of the following elements that need to be ensured and to work in synergy in order to create a system that is better able to address the SRHRR needs in the country. These elements relate to ensuring the following:

1. **Enabling environment:** to be achieved through appropriate regulations, guidance and sufficient resources allocated
2. **Quality and supply of services:** to be achieved through well-defined services and adequate capacities
3. **Demand for services:** to be achieved through supportive social norms and effective promotion, prevention and response actions
4. **Data availability and knowledge:** to be achieved through high-quality evidence and data for decision-making

First priority area of intervention

Policy strategic objective 1: to increase access and utilisation of maternal health care services

Policy statements

To achieve a comprehensive access to and utilisation of maternal health care including antenatal care (ANC), emergency obstetric care (EOC) and postnatal care (PNC) services, key actors shall commit to the following:

1. Enabling environment

a. Regulatory framework

- Review and amend regulatory frameworks including laws, policies and strategies to ensure the rights of individuals to accessing and utilising SRHRR, including maternal health services, without any discrimination.
- Develop and activate regulations and processes allowing to guarantee legislated access to a comprehensive package of essential SRHRR including maternal health interventions and services.
- Strengthen health systems at the national, district and community levels to expand coverage with particular emphasis on the Gaza Strip. This will contribute to sustainable improvements in health at the population level and in underserved regions. Accordingly, ensuring the sound functioning of primary health care centres (PHCCs) and hospitals within districts is essential to improving maternal and newborn health. Particular attention should be provided to strengthening public health entities as well as public–private partnerships.
- Ensure that SRHRR-related programming and interventions, including maternal health and HIV and AIDS prevention, treatment and care, are fully integrated into and in line with national health strategies, plans and budgets. This is important to avoid fragmentation of services.
- Integrate psychosocial mental health into the comprehensive package of reproductive health.
- Build on the achievements of the adopted 'midwife-led models of care' to improve maternal health.

b. Resources

- Ensure the availability of the needed human resources within public and private health entities, including family, physicians, nurses and midwives, particularly in remote and rural areas, within PHCCs and in the Gaza Strip.
- Increase financial support to SRHRR programmes as part of the national budget.
- Explore alternative financing mechanisms for SRHRR services to alleviate the financial burden from individual households.
- Establish support programmes favouring the affordability of needed maternal health services.
- Guarantee the availability of adequate SRHRR-related supplies, equipment and infrastructure.

c. Communication, collaboration and coordination

- Ensure that SRHRR national initiatives and interventions support country-led processes that bring together key stakeholders to develop, budget and implement national plans and strategies for improving maternal health services within a broader health systems framework.
- Ensure the availability of an efficient and effective system of communication, referral and transport that are essential to preventing the risks of maternal and infant mortality and morbidity.
- Ensure more regular interactions with the health system, including prenatal and postnatal visits, to allow women to access consistent support related to family planning, preventing unwanted pregnancies, optimising maternal health before pregnancy and decreasing the unmet need for contraception.

2. Awareness and social and behavioural change

- Develop and conduct awareness and social and behavioural change (SBC) public campaigns and interventions compounded with the development and distribution of information, education and communication (IEC) material to communities, mainly women, men, young people and adolescents, in order to empower populations and to create a demand for and increase the utilisation of SRHRR including maternal health services. Particular attention should be provided to influencing social norms and behaviours that influence men's and women's attitudes and behaviours in seeking SRHRR including maternal health services.

- Ensure the proper and adequate provision of SRHRR-related information to women, with particular attention to the poorest and least educated and with particular emphasis on postnatal health education and communication and psychological support.
- Conduct a continuous dialogue with and ensure a proactive engagement of community and religious entities. This is important in order to guarantee that cultural and religious practices are in line with the government's commitment to achieving SRHRR goals.

Policy strategic objective 2: To ensure the provision of essential SRHRR services including maternal health at all levels of the health care system

Policy statements

To ensure an effective SRHRR service provision including maternal health, key actors shall commit to the following:

1. Supply of maternal health services

- Integrate reproductive health services within family health services while aiming to achieve a universal SRH coverage.
- Promote the role of midwives in the provision of SRHRR services based on the achievements of the adopted midwife-led models of care.
- Expand SRHRR including maternal health quality services within public and private facilities with an emphasis on public facilities and community-based entities including PHCCs. Particular attention is to be given to the West Bank for antenatal care.
- Promote an equal and even distribution of skilled staff in urban, suburban and rural areas as well as at the community level while ensuring the availability of female health care providers.
- Strengthen communication and referrals between the different levels of care.
- Promote the provision of adequate basic SRHRR equipment and supplies to all concerned facilities with an emphasis on public and primary health care entities.
- Ensure the availability of comprehensive and integrated SRHRR services including maternal health and preconception care for all people, including vulnerable and marginalised persons, with no discrimination and with particular attention to displaced populations and to the Gaza Strip.

Second priority area of intervention

Policy strategic objective 1: to improve the quality of maternal health services

Policy statements

To achieve delivering effective SRHRR interventions, including maternal health, of the highest quality, key actors shall commit to the following:

1. **Quality of maternal health care**
   - Develop and implement a human resource capacity development strategy to orient and train, as well as to deploy and retain, health system workers, particularly SRHRR health workers.
   - Increase the capacity of service providers at different levels to meet the increasing demand for SRHRR services including maternal health by providing quality pre- and in-service education and training. Particular emphasis is to be given on safe abortion, basic emergency obstetric and newborn care, emotional and psychological care and interpersonal communication skills that allow for the proper provision of reproductive health counselling.
   - Upgrade the performance of service providers to meet national and international standards through regular monitoring, on-the-job supportive supervision and performance appraisals.
   - Equip and periodically supplement all SRHRR facilities continuously with adequate drugs, commodities and other essential supplies.
   - Maintain compliance with the national accreditation system (if available) for the delivery of SRHRR services including maternal health.
   - Establish quality assurance programmes to continuously monitor and guide further improvements in the quality of SRHRR services including maternal health.
   - Invest in training, recruiting and retaining skilled birth attendants including midwives to keep on reducing MMR.

Policy strategic objective 2: To ensure the availability of maternal health-related guidelines and operating procedures and evidence-based data

Policy statements

Compounded to the above, to achieve delivering effective and quality SRHRR services including maternal health, key actors shall commit to the following:

1. Quality of maternal health care

- Develop and roll out operational guidelines and service standards for managers at central and district levels, including hospitals, primary health care centres and other public and private entities. These guidelines and standards shall specify who is responsible for reproductive health-related activities at the different levels, how these should be planned, implemented and monitored, and what human, logistic and financial resources are required.
- Develop and roll out clinical protocols for staff training and quality improvement aiming to standardise clinical diagnosis and treatment procedures for a rapid and quality response. These protocols shall reflect contemporary international practices adapted for the region in general and for Palestine in particular.
- Develop separate protocols and operational guidelines for each of the concerned staff teams. These include medical officers, nurses/ midwives, health assistants, staff nurses, auxiliary health workers, maternal and child health workers and community health workers.

2. Evidence-based data andinformation on maternal health

- Strengthen applied and policy research in SRHRR that would inform policy makers.
- Develop mechanisms for the compilation of accurate and routine data and information about maternal health in general and about the causes of maternal, infant and under-five deaths in particular in the West Bank and the Gaza Strip.
- Develop, coordinate and implement a multi-sectoral research agenda for SRHRR including maternal health, with particular emphasis on social behaviour and health systems research.
- Strengthen the coordination between national and regional research institutions, and establish a national data bank on SRHRR including maternal health.
- Strengthen the national capacity for multi-disciplinary research in SRHRR including maternal health.
- Encourage the dissemination and utilisation of relevant findings of SRHRR research including maternal health.
- Conduct research on the special needs of adolescents, youth, displaced individuals and other marginalised groups in order to improve the design and execution of SRHRR interventions including maternal health.

II. Particular maternal health-related subject areas

Policy strategic objective: to decrease maternal mortality and morbidity

To decrease maternal and newborn mortality and morbidity, key actors shall commit to the following, as classified below by particular maternal health subject areas:

1. Safe motherhood

- Ensure the provision of quality antenatal care for the prevention, early detection and management of pregnancy complications leading to maternal mortality. Particular emphasis should be on screening for gestational diabetes mellitus, repeated screening tests for anaemia and hypertension, symphysial fundal height (SFH) measurement and antenatal ultrasound.
- Ensure the provision of proper support to ensure that antenatal care and safe delivery are attended to by skilled health personnel.
- Establish and maintain appropriate structures and infrastructures within the health care system in order to provide integrated safe motherhood services.
- Ensure the availability of a range of basic equipment that is necessary to deliver quality safe motherhood services.
- Encourage postnatal care attendance for the early detection of risks of maternal death after delivery.
- Ensure the provision of postnatal health education.

2. Maternal nutrition

- Promote public information on pregnant women's nutritional needs.
- Advocate for the integration of nutrition education, essential nutrition actions and food supplementation programmes within SRHRR services and training.
- Inform pregnant women and lactating mothers about breastfeeding through the Baby-Friendly Hospitals Initiative (BFHI) and the Baby-Friendly Clinics Initiative (BFCI).

3. Family planning

- Provide a full range of contraceptive methods, including long-term and emergency contraceptive methods, in accordance with national requirements and with an emphasis on people living in the camps.
- Consider alternatives to address logistic management and chain supply challenges that are associated with different contraceptive methods.

- Endorse the principle of informed choice for individual women and men and for couples to determine their method of contraception, including long-term methods.
- Provide emergency contraceptives for the prevention of unintended pregnancies, particularly for rape survivors as part of post-exposure prophylaxis (PEP) as per the national directives.
- Increase access to family planning services by strengthening community-based family planning provision.
- Advocate for public support of family planning programmes.
- Increase public awareness about family planning, including contraceptive methods.

4. Reproductive tract diseases (STIs/HIV/AIDS)

- Promote research on the prevalence and cures of STIs/HIV/AIDS.
- Develop protocols and guidelines for the management of reproductive tract diseases.
- Plan and conduct programmes aiming at reducing the spread of STIs/HIV/AIDS. This includes the promotion and dissemination of appropriate information, education and communication (IEC) and of behavioural change communication (BCC) on reproductive tract infections at all levels of care.
- Advocate for a continuous supply of affordable drugs and of alternative therapies for reproductive tract diseases.
- Promote the testing of HIV and syphilis for pregnant women during antenatal care.
- Provide STI services and integrate them in all types of care services including primary, HIV, reproductive health, family planning, antenatal and postnatal care services.
- Develop research on the prevalence of HPV and deliver HPV vaccines through the National Immunisation Programme.

5. Infertility

- Provide appropriate services for overcoming infertility barriers hindering the achievement of SRHRR.
- Carry out research to explore modifiable and non-modifiable factors associated with infertility.
- Integrate services for the prevention and management of infertility.
- Conduct in-depth assessments of the main challenges associated with in vitro fertilisation services and how to mitigate those challenges.

6. Other reproductive health issues

- Promote services associated with safe abortions, including prevention and proper management primarily through the capacity building of concerned service providers.
- Strengthen awareness campaigns for the screening and early management of reproductive health-related cancers.
- Plan and conduct programmes for preventing, screening and treating cervical and breast cancer in females and prostate cancer in males.
- Plan and conduct awareness programmes for women on menopause.
- Provide information and management services for women going through menopausal problems.

D.2 Theme 2: Gender-based violence including harmful practices

D.2.1. Gender-based violence in Palestine: indicators, problem areas and barriers

Gender-based Violence (GBV) continues to be a key concern when it comes to protection and health in Palestine. The protracted crisis, with its impact on gender and family dynamics, has exacerbated GBV in all its forms including sexual violence, intimate partner violence and child marriage.

Domestic violence in Palestine

Although domestic violence in Palestine has seen a decline in recent years, this form of GBV remains prevalent. The 2019 violence survey conducted by the PCBS revealed that the prevalence of domestic violence in Palestine decreased from 37% in 2011 to 27.2% in 2019. The Gaza Strip maintains a higher prevalence in comparison with the West Bank, reaching 35.2% in 2019. Psychological violence and economic violence are the most common forms of domestic violence, reaching 52.2% and 36.2%, respectively, in 2019. Psychological violence takes various forms including forced marriage, denying emotional needs and controlling resources even if these resources were earned by another family member, among others. Sexual violence constituted 6.9% of all forms of GBV in 2019 (PCBS, 2019).

It is important to note that six out of ten women experiencing violence preferred to keep silent about it. 40% of married women subjected to domestic violence reported being aware of the existence of centres or institutions for protection against violence in the West Bank, and this percentage drops to 28% in the Gaza Strip (PCBS, 2019).

Minimum Age of Marriage in Palestine

According to the Population, Housing and Establishments Census of 2017, nearly 11% of women aged 20–24 were married under the age of 18 years (8.5% in the West Bank and 13.8% in the Gaza Strip). Most cases of child marriage concern girls between the ages of 15 and 17; nevertheless, numerous cases of girls being married at the age of 14 persist. In 2017, 761 cases of such marriages were registered (PCBS, 2018). The MICS of 2021 reported that the percentage of women aged 20–49 years who got married before the age of 18 was similar among women who reside in rural areas and those who reside in urban areas and camps (22% and 20%, respectively).

The prevalence of child marriage, however, might be even higher as some girls who marry below the legal age may not register or may delay formal registration until they reach the legal age.

Child marriage is a violation of human rights, compromising the development of girls and often resulting in early pregnancy, social isolation and little education as many child brides drop out of school (child marriage is responsible for around 5% of school dropouts in UNRWA schools in the West Bank). Women who are married before the age of 18 tend to have more children than those who marry later in life. In the West Bank, 4.2% of women aged 20–24 had a live birth before the age of 18, whereas this number increases to 8.4% in the Gaza Strip (MICS, 2021).

In November 2019, the Palestinian Authority passed a law raising the minimum age for marriage to 18 for both women and men. Previously, the minimum age for marriage in the West Bank was 15 for girls and 16 for boys, and in Gaza it was 17 for girls and 18 for boys (Girls Not Brides, 2021).

However, it is still possible to get married before the age of 18 by receiving an exemption from a religious court and from the Palestinian Authority's Sharia judge (Girls Not Brides, 2021).

Honour crimes in Palestine

In the Palestinian society, as in many Arab countries, femicide may occur in response to 'crimes of honour'; actual or perceived behaviour of girls and women, one which typically involves their sexuality, is considered a social and cultural taboo. As such, 'immoral' behaviour is believed to tarnish the honour of the woman's family. Femicide in reaction to 'crimes of honour' is usually committed by a relative. The sociocultural roots of this phenomenon are so deep that the Palestinian legal system fails to deter it, blaming, until recently, the victim rather than the perpetrator (Shalhoub-Kevorkian, 2002).

Though there are no clear statistics on honour crimes in Palestine, the UN Special Rapporteur on Violence against Women reported in 2017 that the number of Palestinian women killed under the pretext of protecting 'honour' has dramatically increased in recent years. It was observed that they constitute a manifestation of culturally inherited values of inequality that impose upon women socially expected behaviours deriving from patriarchal norms and standards. Women's transgressions of these social norms are considered a violation of the honour of the family and men, and these norms legitimise violence against women as a disciplinary measure to maintain or restore the family honour. Women are, therefore, discouraged from reporting abuse by social norms and by fearing the reaction of family members who want to protect their reputation (Human Rights Council, 2017).

The penal laws reaffirm social norms by providing reduced punishments and pardons for male perpetrators of honour crimes. Attempts to reform these laws and advances were made, especially in the West Bank where the article legalising honour crimes was repealed following a presidential decree. However, other provisions in the law still allow for reduced penalties based on extenuating excuses. The government in Gaza had not applied the presidential decree (UNDP, 2018).

Female genital mutilation

There are no reported cases of female genital mutilation in Palestine.

Problem areas and barriers

As noted, GBV in Palestine is exacerbated by the context, social norms and stigmas as well as by structural and behavioural barriers to accessing GBV services and care.

Research has shown that a prolonged exposure to violence increases the accumulation of daily stressors, which risks triggering or aggravating GBV in general and intimate partner violence against women in particular (Müller and Tranchant, 2017; Wirtz et al., 2013; Llosa et al., 2012; HSR, 2012).

Forced displacement of populations, separation of families, disruption of community and institutional protection structures and challenged access to justice for survivors due to conflict put refugees and internally displaced persons at particular risk of GBV (Müller and Tranchant, 2017). A number of studies have suggested a link between the political violence of the Israeli occupation and changes in gender roles that have led to frustration and tension in households (UN Women, 2009; World Bank, 2010; Dana, K., and Walker, H., 2015), and there

are perceptions about the link between the second Intifada and the increased psychological, emotional, physical and sexual violence against women including sexual harassment (Müller and Tranchant, 2017).

In 2017, the UN Special Rapporteur on Violence against Women highlighted the increased pressure on Palestinian girls to get married in the context of the occupation. Following the 2014 hostilities in Gaza, women and girls suffered large scale displacement and moved to overcrowded camps, increasing the numbers of young girls getting married early as a coping mechanism towards financial and physical insecurity. This is particularly common among families with multiple daughters whereby their perceived burden can be higher (Girls Not Brides, 2021).

A mapping of GBV services in Palestine done by the UNFPA in 2016 revealed that distance, mobility restrictions, fragmentation of areas and services and the reluctance to report GBV due to fear of stigma, social exclusion, honour killings or reprisal, all limit survivors' access to and utilisation of critical services (UNFPA, 2016).

A limited role of the government in coordinating and providing humanitarian services and restrictions in budget for gender-related programmes are also noted. In addition to that, there is a lack of a GBV strategy as well as a limited technical, human and financial capacity in general and for GBV in particular as far as governmental partners are concerned (UNFPA, 2016). The functioning of the national GBV referral should be strengthened.

Palestine also suffers, as most Arab countries, from the lack of reliable systematic and coherent statistics on GBV, including information about the basic needs of women in need of urgent intervention. There is also limited documentation and evaluation of the effectiveness of complex multi-sectoral programmes and coordination functions (UNFPA, 2016).

On the other hand, a low level of community awareness on available GBV services as deduced from the PCBS violence report of 2019 and the UNFPA mapping of 2016 is highlighted (PCBS, 2019, UNFPA, 2016). In addition, discriminatory attitudes of people working in the justice and security systems were reported, and these factors reduce women's trust in the justice and security systems and impede their access to the needed services (UNDP, 2018).

In 2019, Palestine affirmed its commitment to eliminating GBV during the Nairobi Summit (Saadeh, 2020). This is expected to be achieved by providing high-quality, multisectoral services to prevent GBV by 2030, by issuing the family protection law and raising the age of marriage to 18 years and by updating the national strategy to combat violence. However, many challenges that hinder the elimination of GBV in Palestine remain. Some of these challenges include the inactivity of the Legislative Council for more than 11 years which puts the process of legislation and

law adoption to a halt, the internal division between the Gaza Strip and the West Bank which acts as a barrier to unifying legislation between the two regions, the cultural and religious rejection of possible amendments to the Family Protection Law, the tribal customs that limit the interference of official bodies, the lack of funds and the lack of awareness on women and gender issues (Saadeh. 2020).

In summary, preventing, mitigating and managing GBV is a complex challenge for any country, especially a country like Palestine where years of conflict, occupation and blockades coupled with established gender norms, GBV-associated stigmas and structural barriers constitute major impediments against progress. It is therefore important to focus efforts on coordination and standardisation in a highly fragmented GBV service environment, on building capacities and addressing the negative attitudes of service providers in the different sectors as well as the social and economic determinants of GBV, and, last but not least, on making GBV a clear national priority across all sectors. Special attention needs to be given to the Gaza Strip where conflict exacerbates the problem and where the social and legal environment is less conducive for progress on mitigating and managing GBV.

D.2.2. Policy guidelines associated with theme 2

Priority area of intervention

Policy strategic objective 1: to promote GBV essential prevention, protection and response services

Policy statements

To promote GBV prevention, protection, response and coordination, key actors shall commit to the following:

1. Enabling environment

a. Regulatory framework

- Review and amend regulatory frameworks that provide protection to sexual violence perpetrators in general and to rape and honour crimes perpetuators in particular. Particular emphasis is to be placed on the Gaza Strip.
- Eliminate child marriages and ensure the commitment of religious courts and of the Palestinian Authority's Sharia judges to abide by the legal requirements of the minimum age for marriage specified at 18 years for both men and women.
- Develop strategies to help reduce school dropouts among girls in order to increase their educational attainment which acts as a key factor towards their empowerment and towards the elimination of child marriage.

- Develop policies and strategies which ensure the availability and accessibility of comprehensive services for survivors of GBV/SGBV, including the collection of medico-legal evidence, post-exposure prophylaxis, emergency contraception and psychosocial support.
- Develop policies and strategies which ensure that the most excluded women and girls have equal access to GBV prevention and response, with particular emphasis on internally displaced persons and refugees, women in remote and rural areas, women and girls with disabilities and women with addiction disorders.
- Ensure that community-based protection systems are effective in protecting women and girls from GBV including early and forced marriage, rape, intimate partner violence, honour crimes and domestic violence.

b. Communication, collaboration and coordination

- Ensure the engagement of concerned government entities in GBV prevention and management.
- Promote and maintain coordination with relevant gender and GBV national and regional coordination bodies and agencies.
- Strengthen collaboration and coordination among the health, social and legal sectors for early reporting and treatment of GBV and for long-term legal, medical and psychosocial support of survivors and prosecution of perpetrators. Collaboration shall also be ensured between the public and private sectors.
- Provide technical support to integrate GBV risk mitigation into all aspects of SRHRR national and community-based interventions.

2. Quality of GBV services

- Sensitise health workers to GBV in order to eliminate any disrespect or discriminatory attitudes towards GBV survivors.
- Ensure that health workers have the necessary knowledge, skills and resources to (i) properly deal with sensitive GBV-related information, (ii) act with respect, sympathy and confidentiality with GBV survivors and (iii) adopt a survivor-centred approach for the provision of services.
- Upgrade health services and providers' capacities to provide a comprehensive response to sexual violence and its consequences, including counselling, shelters, women's and girls' safe spaces (WGSS), hotlines, prevention and treatment of STIs and HIV, collection of medico-legal evidence, post-exposure prophylaxis, emergency contraception, treatment and care for women with traumatic fistulas and pregnancy-related care.

- Increase the capacities of police, prosecutors and judiciary actors regarding GBV. Emphasis shall be made on decreasing their discriminatory attitude towards GBV survivors.

3. Supply of GBV services

- Review the modalities of key-actor programming to provide services for GBV survivors and those at high risk ensuring that the do-no-harm principle is respected.
- Consider adapting standard UNFPA interventions, such as WGSS and safe shelters, to decrease the risk of GBV and to protect the survivors.
- Review and scale up approaches adopted for GBV service delivery, including the ones for case management and psychosocial support in remote and rural areas. This shall be compounded with training, staff support and quality of care.
- Provide technical support to ensure that GBV prevention, clinical management care and referral systems are functioning according to the national guidelines.
- Prioritise reinforcing the response capability of national hotlines, if available.
- Increase remote access to mental health and psychosocial support as well as safety planning opportunities through trained service providers.
- Ensure an effective access to justice, legal aid and remedies for survivors of GBV, including compensation and rehabilitation.
- Ensure the availability of GBV clinical management tools such as forensic kits, sutural kits for cervical and vaginal tears, post-rape treatment kits and dignity kits.
- Ensure that GBV referral pathways and information are updated and disseminated regularly to all GBV actors in order to facilitate access to GBV services.
- Develop and strengthen a system for reporting sexual violence in order to facilitate the appropriate management of GBV/SGBV cases.

4. Awareness and social and behavioural change

- Promote the awareness of all women and girls, especially those at risk, about their rights to protection from GBV and to seeking related services from credible service providers.
- Encourage schools to incorporate information on SGBV and domestic violence prevention into health education curricula.
- Ensure concerned service providers are aware of the measures and requirements related to protection from sexual exploitation and abuse.

- Engage men and boys in mitigating GBV and in fostering positive masculinity, and promote gender equality to prevent GBV.
- Engage religious actors to influence the change of existing gender social norms and habits that reinforce GBV practices in general and honour crimes in particular.
- Promote advocacy and social mobilisation aimed at reducing GBV/SGBV. Emphasis should be placed on psychological and economic types of violence.

5. Evidence-based and documented data and information

- Support ongoing research on the causes and possible preventions of GBV for decision-making.
- Promote and protect the ethical and safe collection and use of gender- and GBV-related data throughout any GBV response.
- Promote confidential reporting for GBV cases.

D.3. Theme 3: Comprehensive sexuality education

D.3.1. Theme overview (UNESCO, 2018)

Comprehensive sexuality education (CSE) is defined as a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality.

It aims to equip children and young people with the knowledge, skills, attitudes and values that will empower them to realise their health, wellbeing and dignity, to develop respectful social and sexual relationships, to consider how their choices affect their own wellbeing and that of others and to understand and ensure the protection of their rights throughout their lives.

'Comprehensive education' implies that youth and adolescents acquire education about sexual and reproductive health and reproductive rights issues including, but not limited to, sexual and reproductive anatomy and physiology, puberty and menstruation, reproduction, pregnancy and childbirth, modern contraception and STIs including HIV and AIDS. CSE covers the full range of topics that are important for all learners to know, including those that may be challenging in some social and cultural contexts. Moreover, CSE supports learners' empowerment by improving their analytical, communication and other life skills for health and wellbeing in relation to sexuality, human rights, healthy and respectful family life and interpersonal relationships, personal and shared values, cultural and social norms, gender equality, non-discrimination, sexual behaviour, violence and gender-based violence, consent and bodily integrity, sexual abuse and harmful practices such as child early and forced marriage and female genital mutilation/cutting.

'Comprehensive education' also refers to the breadth and depth of topics and to content that is consistently delivered to learners over time throughout their education rather than a one-off lesson or intervention.

CSE often faces traditional and conservative social barriers and a high degree of misconception around the subject. CSE is sometimes perceived as encouraging promiscuous or immoral behaviour and as an early sexual-debut among youth and adolescents; therefore, abstinence-only programmes are often preferred although research continuously highlights that abstinence-only education is not effective.

CSE does not promote early sexual debut or unsafe sexual activity; on the contrary, two-thirds of CSE programmes lead to delayed initiation of sex, decreased frequency of sex, fewer sexual partners and increased use of condoms and/or other forms of contraception. Moreover, there is more to CSE than reproduction and sexuality because when it is well delivered, it promotes health, wellbeing, dignity, youth empowerment and gender equality. It discusses relationships, consent, bodily autonomy and boundaries, and it thus offers the opportunity to also address gender-based violence in all its forms.

Comprehensive sexuality education in Palestine: indicators, problem areas and opportunities

As stated by the Palestinian Central Bureau of Statistics, youth aged 18–29 years of age comprise 22% (1.14 million) of the total population (PCBS, 2020). If we follow the United Nations definition of youth as the individuals in the age group of 15–24 years, then this faction constitutes about 30% of the population in Palestine (UNFPA, 2021).

Youth in Palestine are sexually active even within a society that upholds strict social norms and values regarding sexual experiences before marriage (UNFPA, 2020). A report published by the UNFPA in 2017 and entitled "Youth in Palestine" indicates that "25% of older (19–24) unmarried male youth and 22% of younger (17–18) male youth report having had any sexual experience. Rates for females were generally similar. Rates for sexual intercourse remain lower (9.5% for older unmarried males and 7% for females)" (UNFPA, 2017; UNFPA, 2020).

Youth in Palestine are subject to GBV and are ill-equipped to seek the needed services and care. Nearly 45% of the female youth who have never been married experienced psychological violence by a household member; 1 in 2 female youth who has experienced violence remained silent; 36% of them are aware of the existence of centres or institutions providing protection against violence in the region, locality or governorate in which they live. Nearly 4% of male youth reported that they experienced sexual violence or sexual harassment when they were below the age of 18 (PCBS, 2019). Child marriage is still prevalent in

Palestine. According to the Population, Housing and Establishments Census of 2017, nearly 11% of women aged 20–24 were married under the age of 18 (8.5% in the West Bank and 13.8% in the Gaza Strip) (PCBS, 2018).

Societal taboos constitute major obstacles to informed discussions about SRHRR issues, particularly in relation to young people. The absence of sexual and reproductive health in school curricula represents a constraint to the efforts to raise children's awareness of their rights to protect their bodies and break the existing silence around sexual harassment and rape (DeJong et al, 2007).

Youth in Palestine lack the knowledge and skills related to their SRHRR and feel the need for CSE strongly. A recent study in Al Quds University showed that students were moderately knowledgeable of sexual education, where females had a lower knowledge of sexual education than males. Students also reported that any information that family members provide is infrequent and of poor quality. It was also noted that students from private schools had better sexual education knowledge, suggesting a subcultural difference in education in the Palestinian society, and that deeply religious students reported less sexual education perceptions and had a more conservative attitude towards sexuality in general (Ibrahim Banat and Dayyeh, 2019).

Another study conducted by UNFPA Palestine reported that 73.3% of a group of 300 girls and women surveyed indicated embarrassment as the main reason why they do not discuss SRH issues with others; 42% said they do not know from where to start, and 20.3% reported not having adequate information about what to ask (UNFPA, 2020).

Several studies emphasised the need for sex education among Palestinian youth in the West Bank for both males and females. This is due to the high risks Palestinian youth take by engaging in sexual behaviours in addition to the lack of available comprehensive sexuality education in schools or at home. It is thus evident that there is a necessity to strengthen youth-friendly services to provide counselling and sex education (Glick et al., 2018a; Glick et al., 2018b; Glick et al., 2016; Massad et al., 2014)

While the demand for CSE is high, the supply is suboptimal. In fact, sexual and reproductive health education in Palestine is a controversial issue circumscribed by political, economic, cultural and religious factors (DeJong et al., 2007). As a result, youth, who are a substantial part of the population in Palestine, are often left in the dark when it comes to SRH information and education.

Sexual and reproductive health curricula at schools are basic, are often limited to a biology lesson and are not sufficient for meeting the needs and questions youth might have at this critical time of their lives. Schools and educators are often hesitant or not cooperative when it comes to covering SRH lessons in their

classrooms. Also, most parents prefer not to address these topics with their children either for social or religious reasons or simply because they lack the tools and knowledge of how to address these topics. As a result, young people receive little or no information from these channels and must rely on external sources, such as peers or the media, for information (UNFPA, 2020).

To date, CSE is not included in the curricula taught in Palestine. There is no data collected in relation to relevant indicators such as the following: percentage of students who have received comprehensive education on SRHRR in schools, percentage of adolescents who understand how to prevent unwanted pregnancies and STIs, percentage of teachers trained on education in SRHRR and percentage of health providers trained in SRH counselling.

Despite this gap, it is important to mention some of the initiatives that are undertaken at this level, which includes fragmented education on SRHRR taking place in schools and for out-of-school children. Extracurricular activities including workshops for students around issues of SRH, teacher training manuals addressing issues of HIV/AIDS and health issues during adolescence as well as several other initiatives have also been implemented in recent years by the Ministry of Education in collaboration with international organizations (UNFPA, 2020). UNFPA also supported community initiatives led by youth and promoted a peer-to-peer approach by strengthening peer educators inside and outside of schools to deliver messages to their peers on life skills, GBV, HIV prevention and healthy lifestyles. School campaigns against child marriage and youth-friendly health service centres in universities were put in place. Important progress was also made in terms of making adolescents and youth a priority across sectors, with the inception of the National Adolescent Health Coalition in 2019 which aims at advocating for policies to support adolescent health at the national level (UNFPA, 2020). Moreover, Palestine announced its commitment to the principles adopted in the 2019 Nairobi Summit, one of which is incorporating CSE programmes into all schools by 2030 through distributing manuals, training teachers, running adolescent health centres and GBV programmes in schools and developing adolescent health modules (Saadeh, 2020). However, there are two main challenges that might impact achieving this principle. The first relates to the low number of schools that integrate health education activities in their curricula (8.6% of the total number of schools) and the second is the lack of educational counsellors in schools.

CSE is not an end on its own. In fact, CSE is a means to address several issues, from unintended pregnancies, to maternal mortality, to GBV, to youth empowerment, among other things. Therefore, it is important to determine the most pressing needs of youth in Palestine and to analyse what the contribution of CSE can be to this particular issue as this would constitute the entry point for a positive change.

Youth and women empowerment were noted as strategic imperatives translated in sectoral and cross-sectoral strategies and policies in Palestine (MoH, 2017). As such, reducing GBV and increasing youth empowerment could be further explored as objectives of CSE. The contribution of parents, teachers and faith leaders in advancing this agenda should not be overlooked as they can be strong allies.

In summary, Palestine has made progress on CSE through collaboration between international organizations, ministries and local communities and through expanding peer-to-peer sexual education programmes. The needs remain high and challenges need to be overcome as youth constitute a strategic segment of the nation. More knowledge around the needs of youth in relation to GBV as well as youth empowerment can contribute to developing a better strategy towards achieving CSE in support of broader SHHRR and youth development agendas and priorities.

D.3.2. Policy guidelines associated with theme 3

Priority area of intervention

Policy strategic objective 1: to ensure the right of youth in Palestine to comprehensive sexuality education

Policy statements

To ensure the right of youth in Palestine to comprehensive sexuality education, key actors shall commit to the following:

1. Enabling environment

a. Regulatory framework

- Repeal policies, laws and regulations restricting access to comprehensive sexuality education and information on SRHRR.
- Support the implementation of the National Adolescent Strategy that sets CSE as a priority area in order to ensure access to comprehensive and accurate sexuality education both in and out of schools.
- Ensure that the proper measures are in place for CSE to be integrated into school-based curricula and to be provided throughout schooling in an age-appropriate manner.
- Assess existing limitations or restrictions associated with CSE, such as existing social norms and beliefs as well as parental or guardian authorisation for participation in CSE programmes, and develop related mitigation plans.

b. Collaboration and coordination

- Engage the Ministry of Education and concerned key actors in reviewing/developing/upgrading SRHRR curricula and related teacher-training material.
- Support UNFPA recent initiatives associated with the promotion of CSE in Palestine, including the promotion and adoption of the peer-to-peer approach.

2. Quality of services

- Ensure that the content of existing CSE programmes follows international human rights norms and guidelines developed by the UNESCO.
- Include CSE into academic and non-academic training of teachers and students of pedagogy and other related disciplines.
- Sensitise concerned health promotion staff to the various SRHRR needs of students and to the importance of scientific accuracy free from myths and stereotypes.

3. Supply of services

- Review the existing and the needed structures, processes, training and resources that will support CSE programmes.
- Identify and develop the needed mechanisms and procedures to ensure the participation of children, parents and educators in the design, implementation and monitoring of CSE programmes both in and out of schools.
- Ensure the active and meaningful participation of children belonging to marginalised groups, including those not attending school and those who are married.
- Integrate CSE in schools with a particular emphasis on public schools.
- Integrate CSE into SRHRR programmes provided at the community level and within PHCCs.
- Ensure the availability of youth-friendly programmes integrating CSE within their services and providing services to youth from different socio-economic backgrounds.
- Ensure that adolescents are not deprived of any CSE due to service providers' or teachers' objections.
- Ensure the availability of CSE programmes to children with disabilities in a manner that is accessible to them.

4. Awareness and social and behavioural change

- Assess existing religious or social factors and other beliefs, practices and institutions that hinder individuals' access to CSE, and develop related mitigation programmes.
- Increase the awareness of parents, families, teachers, faith leaders and other social actors about the rights of adolescents to CSE.

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UNFPA
Arab States Regional Office
70 A Al Nahda street,
Maadi Sarayat,Cairo, Egypt
Phone: +202 25223900
Web: arabstates.unfpa.org

UNFPAArabic
@UNFPA_Arabic
unfpa arabic
UNFPA Arab States
UNFPA Arabic