

UNFPA
Third Cycle Country Programme Evaluation
(2006-2010)

Occupied Palestinian Territory

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Executive Summary	11
1. Introduction.....	17
1.1 Occupied Palestinian Territory Context	17
1.2 UNFPA: The United Nations Population Fund in occupied Palestinian territory- Country office	18
1.3 UNFPA Current Programme: Third Country Programme Cycle.....	19
1.4 Major Implementing Partners	20
2. Trajectory and Methodology.....	21
2.1 Purpose and objectives	21
2.2 Ethical Considerations	21
2.3 Encountered Limitations	23
2.4 Structure of the Evaluation Report	24
2.5 Methodology	24
2.5.1. Conceptual Foundations.....	24
2.5.2 Framework for Analysis.....	28
2.5.3 Stakeholders Involvement.....	16
2.5.4 Evaluation Approach	16
2.5.5 Design	16
2.5.6 Sample Selection and Size	17
2.5.7 Data Collection Methods and Instruments	20
2.5.8 Methods of Data analysis	23
3. Relevance of the Country Programme	24
3.1 Relevance of RH programme component	24
3.2 Relevance of PD programme component	25
3.3 Relevance of Gender programme component.....	27
4. Effectiveness of the Country Program	28
4.1 Findings on the Outcomes of the Reproductive Health Component	28
4.1.1 Findings on RH output 1.1: Improved accessibility to integrated, comprehensive, high-quality reproductive health services	28
4.1.2 Findings on RH Output 1.2 on Youth: Increased accessibility of reproductive and sexual health information and counseling services for young people, with a special focus on the prevention of HIV/AIDS and STIs.....	73

4.1.3	Humanitarian Response to RH.....	79
4.2	Findings on the Outcomes of the Population and development Program Component	81
4.2.1	Findings on Output 2.1: To have increased the national capacity to integrate population, gender and reproductive health into development and emergency planning processes	81
4.2.2	Findings on output 2.2: To have enhanced the national capacity to generate and utilize disaggregated data.	83
4.3	Findings on the Outcomes of the Gender Program component.....	88
4.3.1	Findings on output 3.1: To have enhanced the capacities of the Government and civil society organizations to empower women in community- building in six localities	88
4.3.2	Findings on output 3.2: To have built the technical and organizational capacities of the Ministry of Women's Affairs and civil society organizations to institutionalize gender principles and human rights.	90
4.3.3	Humanitarian Response to GBV including Resolution 1325	94
4.4	Cross Cutting Issues	95
4.4.1	Human Rights Based Approach (HRBA).....	95
4.4.2	Capacity Development.....	96
4.4.3	Partnership Strategy including Joint Programming	98
4.4.4	Programme Management, Monitoring and Evaluation	99
5.	Efficiency.....	101
5.1	Efficiency of RH Component.....	102
5.2	Efficiency of PD Component	103
5.3	Efficiency of Gender Component	103
6.	Impact.....	105
6.1	Impact of RH Component	105
6.2	Impact of PD Component	106
6.3	Impact of Gender Component.....	106
7.	Sustainability	107
7.1	Sustainability of RH Component.....	107
7.2	Sustainability of PD Component.....	107
7.3	Sustainability of Gender Component	108
8	Conclusions & Major Recommendations.....	109

8.1 On RH component	109
8.2 On Youth/RH sub-component	113
8.3 On Population and Development	114
8.4 On Gender	115
Appendix I- Terms of Reference	119
Appendix II: List of Documents reviewed	127
Appendix III: List of People interviewed	128
Appendix IV: Data Collection sources/methods by CP output indicators	129
Appendix V: Facility Audits	132
Appendix VI: Reproductive Health Evaluation Tools	140
Annex i: Focus Group Discussion Guide for Adolescents/Youth	140
Annex ii: Client Provider Interaction (CPI)- Observation Checklist for Antenatal Care	140
Annex iii: Focus Group Discussion For Care Users of RH Services	140
Annex iv: Focus Group Discussion Guide for Service Providers	140
Annex v: Client Provider Interaction (CPI)- Observation Checklist for Family Planning	140
Annex vi: Provider Interview	140
Annex vii: Facility Data Collection Instrument	140

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
BCC	Behavior Change Communication
CPI	Client Provider Interaction
CHW	Community Health Workers
DHS	Demographic Health Survey
EOC	Emergency Obstetric Care
CFTA	Culture and Free Thought Association
FP	Family Planning
GS	Gaza Strip
GO	Governmental Organization
GRI	Gender Regional Initiative
HEP	Health Education and Promotion
HEPD	Health Education and Promotion Directorate
HIV	Human Immunodeficiency Virus
HRBA	Human Rights based Approach
HS	Health Services
HSR	Health Services Reform
ICPD	International Conference on Population and Development
IEC	Information Education and Communication
IMCAW	Inter-Ministerial Committee for Advancement of Women
IUD	Intra Uterine Device
IV	Intravenous Infusion
MCH	Mother and Child Health
MDGs	Millennium Development Goals
MoEHE	Ministry of Education and Higher Education
MoSA	Ministry of Social Affairs
MoE	Ministry of Economics
MoPAD	Ministry of Planning and Administrative Development
MoWA	Ministry of Women's Affairs
NSHP	National Strategic Health Plan
NA	Not Available
NGO	Non Governmental Organization
OECD/DAC	Organization for Economic Cooperation & Development/ Development Assistance Committee
oPt	Occupied Palestinian Territory
PA	Palestinian Authority
PCBS	Palestinian Central Bureau of Statistics
PFPPA	Palestinian family Planning and Protection Association
PHC	Primary Health Care
PRDP	Palestinian Reform and Development Plan
PoA	Plan of Action
PRB	Population Reference Bureau

RH	Reproductive Health
SRH	Sexual Reproductive Health
SH	Sexual Health
STDs	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
UNRWA	United Nations for Relief and Works Agency
UNICEF	United Nations Children's Fund
WCLAC	Women Center for Legal Aid and Counseling
WB	West Bank
WBGS	West Bank and Gaza Strip
WHDD	Women's Health & Development Directorate
WHO	World Health Organization

List of Figures

- Figure 1: Visual presentation of the causal pathway
Figure 2: Framework for Analysis

List of Tables

Table 1:	Distribution of the sampled facilities by name, type and region
Table 2:	Distribution of FGDs by, region, location, target group and sub program/crosscutting issues addressed for discussion.
Table 3:	General information about the health centers/clinics by selected parameter
Table 4:	Staff employed at the PHC level health facilities by post category.
Table 5:	Providers' reported availability and use of protocols in practice by region
Table 6:	Providers' reporting on received supervision by region (%)
Table 7:	Performance appraisal of RH providers in the clinic by region
Table 8:	Reported BCC-IEC materials selected aspects by region.
Table 9:	Observed BBC/ IEC materials Usage in FP and ANC CPIs by region
Table 10:	Priority areas and topics as recognized by the interviewed providers (%)
Table 11:	Cognitive access as communicated in ANC CPIs observations by Region
Table 12:	RH services provided in the sampled PHC facilities supported by UNFPA
Table 13:	ANC Services in the sample of PHC facilities supported by UNFPA
Table 14:	FP Services in the sample of PHC facilities supported by UNFPA
Table 15:	STDs treatment Services as available in the sample of PHC facilities supported by UNFPA
Table 16:	Counseling Services offered in the PHC facilities supported by UNFPA
Table 17 :	Interpersonal Relations in ANC observed encounters by Region
Table 18 :	Routine procedures in follow up visits by Region
Table 19 :	Interpersonal Relations in FP observed encounters by Region
Table 20 :	Aspects of history assessment as observed in ANC CPIs by Region
Table 21:	Risk assessment information as elicited in the ANC CPIs
Table 22:	Aspects of history assessment as observed in FP CPIs by Region
Table 23:	Aspects of informed choice of method as observed in FP CPIs by Region
Table 24 :	Physical assessment of women's well-being in the ANC visit by region
Table 25:	Aspects of fetal well-being assessment as observed in ANC CPIs by Region
Table 26:	Universal precautions as observed in ANC CPIs by Region
Table 27:	Aspects of technical competence as observed in FP CPIs by Region
Table 28:	universal precautions as observed in FP CPIs by Region
Table 29 :	Continuity encouragement as observed in ANC CPIs by Region
Table 30:	UNFPA oPt Country Programme Resources 3 rd Cycle (2006-2010) Reported Financial Resources as of 12 May 2010 (USD)

Executive Summary

This is an evaluation of the UNFPA third cycle country programme in the occupied Palestinian Territory covering the period (2006-2010). This program was implemented in a challenging context characterized by mobility restrictions, political split between Gaza Strip and West Bank, separation wall in West Bank and the expansion of settlements, which all contributed to the deterioration in the socioeconomic conditions and to a chronic crisis situation.

UNFPA's support during the 3rd cycle was focused on improving the quality of reproductive health services, strengthening the national information system and help building the capacity of Palestinian authority institutions and civil society; in addition to humanitarian interventions.

The purpose of the evaluation was to assess the achievements and quality of the country programme in terms of its relevance, effectiveness, efficiency, impact, and sustainability. Also, to draw lessons learned and make recommendations which will feed into the 4th country programme action plan (2011-2013).

Quantitative and qualitative methods were used, including client provider interaction, facility audit and manager surveys to assess quality of care in RH Care facilities. Focus groups were conducted with beneficiaries including youth and women and with RH providers. Face to face interviews were done with implementing partners and other key stakeholders and decision makers. A workshop was conducted with UNFPA partners, to discuss the evaluation findings and recommendations for further feedback; the comments received were integrated in this report.

Major Conclusions:

I. Relevance:

The UNFPA program's relevance in the Palestinian context and the holistic approach, in both content and levels of intervention, contributed to making the program appropriate, comprehensive, and in line with the essential needs of the country.

II. Effectiveness of Results Achieved:

Improved accessibility to high quality RH services

Improved quality of care; The quality of reproductive health services still is a major challenge for Palestinian health policymakers, more in Gaza Strip than in the West Bank. Deficiencies in staffing, infrastructure, supervision, following protocols, training opportunities, clinical staff role definition, scope of practice, and performance appraisal all fall within MoH domain and control. These same deficiencies were also findings from the previous programme cycle.

Almost all service delivery points offer at least three family planning methods; however, there are substantial quality gaps regarding education and counseling about method mix and support to clients in making informed choice of available method. Adherence to basic hygiene and safety measures in FP was insufficient. Moreover, most providers in the two regions of the West Bank

and Gaza Strip overlooked danger signs during pregnancy; history taking skills were unsatisfactory.

UNFPA's work with villages/communities with restricted mobility was one of the key achievements for improved accessibility to high quality RH services. Community support teams enhanced awareness and a sense of ownership for services.

RH policy & Planning; although UNFPA thrived in most aspects to advance RH agenda in the context of health planning process, yet RH ideology including its gender and women empowerment components are weakly integrated in the recent National Health Strategy .

Maternal Mortality; UNFPA supported a national surveillance system via a National Committee on Maternal Mortality in the West Bank. This has resulted in the most accurate estimate of maternal mortality in the West Bank in 2009.

Reproductive Health Commodity Security; UNFPA is now the sole contraceptives provider to MOH, to UNRWA and to some NGOs. Management of supply chain remains however a challenge that needs to be addressed in order to maintain a reliable supply of contraceptives and commodities.

Community Midwifery; UNFPA supported the community midwifery academic program at Ibn Sina Nursing College, which has grown into a strategic partnership having an impact on the quality of midwifery education in the country at large.

Obstetric care protocol was developed, and all providers in West Bank as well as a number in Gaza were trained; however, evidence about compliance and outcomes of protocol implementation is lacking and monitoring system on case management is completely absent.

Humanitarian Response; The program successfully tied humanitarian assistance to development assistance. UNFPA was able to attract huge extra funds towards emergency RH care. Support of continuum of care was initiated both within the humanitarian response and as quality of care improvement frameworks. Provision of delivery care more than tripled in this cycle with particular emphasis on provision of RH commodities.

Increased Access to reproductive health and sexual health information and counseling services for young people

The programme contributed largely to increasing the number of young people accessing information on RH and HIV/AIDS prevention. Integration of RH information into the school curricula is the strategic achievement in this cycle. However, UNRWA and private schools were not covered. Peer to Peer education contributed to increasing the number of young people accessing information on RH and HIV/AIDS prevention. However, attempts to access out-of-school and vulnerable youth including those institutionalized in MoSA youth rehabilitation centers were not adequately addressed. East Jerusalem was little addressed in the third cycle, East Jerusalem youth are wrongly perceived as doing relatively well while in reality are being systematically weakened and traumatized. Attention must be paid to the needs of such marginalized youth sub-populations.

Enhanced national capacity to generate and utilize disaggregated data

UNFPA's role in supporting the 2007 census and other vital national surveys substantially enhanced the data system, ensuring data availability and utilization. This was a consensually communicated finding, as a remarkable achievement in the 3rd cycle.

Increased national capacity to integrate population issues into planning processes

The Population Unit in MoPAD needs to be further empowered to achieve progress in this regard. UNFPA should continue partnership with MoPAD and support systems development within the Ministry. In addition, UNFPA mobilized a population forum as an advisory body for MoPAD, comprising of academics, researchers and experts from the NGOs, PCBS and selected ministries and as a supportive network to keep discussions over population issues alive and vibrant.

Integration of a population course in the MPH program at BirZeit University proved attractive and successful.

Enhanced national capacity to empower women

UNFPA's work at the community level, building coalitions between grassroots organizations and formal structures that target poor women, was remarkable and rewarding. UNFPA supported the building of five coalitions in Hebron, Jenin, Nablus, Jericho and Gaza. The coalition-building model was an innovative idea, which brought together women's NGOs and community based organizations to work collaboratively and better develop their capacity. Member organizations felt positive about effectiveness on the level of interaction and coordination; capacity building is needed on the level of self-organization and pro-activeness.

Another successful strategy was the capacity improvement in MoSA rehabilitation centers, in support of vulnerable girls who received vocational training courses to improve their access to employment and economic empowerment.

.Enhanced technical and organizational capacity of the Ministry of Women's Affairs and civil society organization, to institutionalize gender principles and human rights.

UNFPA managed to lead innovative work on GBV, employing the UNSCR 1325 as implementation vehicle/instrument. UNFPA was a catalyst for the articulation of the national strategy for GBV, by supporting the first national conference and the establishment of the national committee for combating GBV. This strategy should be kept on track.

UNFPA invested huge efforts in three women's centers in Hebron (West Bank), Jabalia and Bureij (Gaza) which were able to reach women, including GBV survivors, with necessary clinical, psychosocial and legal services. Such successful efforts should be replicated in other marginalized and vulnerable areas as South Gaza.

III. Efficiency of the programme:

While the third program cycle started with a budget of 5 million \$US, the CP office was able to raise additional funds – mostly emergency-related - bringing it up to more than \$ 16 million.

Efficiency in the RH program component is not at best, given the large investments the programme had made. At the same time, this is the area where the programme had least control, especially with the internal political split and the blockade of Gaza.

The population and development component made tangible achievements, primarily in the enhancement of the national data system. This indicates efficiency in this component. The gender component also appears to have achieved high efficiency.

IV. Impact:

The impact UNFPA made was perhaps most pervasive in the successful integration of RH in the Palestinian school curriculum, with active engagement of Islamic religion supervisors. Under the RH component, UNFPA also made a positive impact on pregnancy and postnatal outcomes for many women, by enhancing early detection of danger signs and recognition of proper/available referral channels, through strengthening community support groups.

A long term positive impact is expected from the qualified cadres of neonatal nurses and midwives, graduates of the professional degree courses at Ibn Sina.

The PD component impacted on mainstreaming population issues into the planning processes , through persistent policy dialogue and advocacy activities, and through the establishment of a population unit at MoPAD as well as the Population Forum.

As for the Gender component, the coalition building model had a positive impact on the capacity and sustainability of women's organizations. The limited investment UNFPA had made with MoWA had a negative impact.

V. Sustainability:

Capacity development in RH, in the form of training and degree courses offered to staff from MoH and partner NGOs, are most likely sustainable. The RH protocols and guidelines developed under the programme are now reference documents for standard clinical practices. The integration of SRH into the school curriculum is believed to be highly sustainable, since it was achieved strenuous policy dialogue, public debate, and policy decision on the side of MoEHE.

Population data including in gender, youth and RH are all sustainable investments, being used nationally in various capacities, settings and levels in education, planning or policy.

The training UNFPA has given the community organization coalition on such key issues as SCR 1325 and life skills, the training of the community-based centers' staff in support of the girls in MoSA rehabilitation centers, in addition to the vocational training given to the girls, are all sustainable contributions to the beneficiary institutions and women. However, Coalition building, and follow-up mechanisms for most-in-need women, need more support to become sustainable.

Major Recommendations:

- UNFPA must make strategic investments in diversified partnerships - community support organizations, NGOs and the private sector - for building continuum of care, particularly at the second and third level of care.
- UNFPA should continue its work on quality of RH care with special focus on its human rights perspectives. It should support MoH to develop and implement quality indicators; to strengthen follow up, monitoring and supervision; on people management issues including proper distribution of training courses, fair incentives schemes, supportive supervision, and better definition of scope of work and roles.
- UNFPA should continue to support the surveillance system and scale up on preventing maternal deaths and expand reach towards the private sector.
- UNFPA should continue with the training in Gaza and continue to support MOH in setting quality assurance and monitoring system to follow up and monitor the implementation of the obstetric care protocol.
- UNFPA should strengthen its advocacy and policy dialogue towards restoring political commitment to the RH ideology , and mainstreaming reproductive health in the health reform agenda, in light of the ICPD PoA and its human rights principles including empowerment and participation.
- UNFPA must continue its support to ensure full contraceptive coverage, through strengthening the logistics and supply chain management at MoH to ensure timely availability to beneficiaries. It needs to ensure proper management of its own supply chain in order to maintain a reliable supply of contraceptives and commodities.
- UNFPA should target youth in MOSA institutions. It is recommended to increase human resources for MoSA for capacity building, coordination, supervision and monitoring.
- UNFPA should expand its partnerships with grassroots large organizations such as PRCS, which are credible sources of information for youth both in the West Bank and Gaza, and which usually serve disadvantaged and out-of-school youth.
- Men, who have an influential role on women's and youth's SRH and rights, need to be more involved. Community support teams for youth should include fathers, male opinion leaders, members of municipal offices and local associations, to engage them in support of RH.
- UNFPA should further support MOPAD's Population Unit, and encourage MOPAD to review the Unit's terms of reference, redefining its role within the Ministry and its coordination role among other ministries.
- UNFPA should continue to strengthen the utilization of population data in national planning and monitoring. Also, UNFPA should improve the synergy and alignment MoH data with those of the census and family health survey, for national surveillance and for monitoring purposes.
- UNFPA should strengthen the Population Forum through specialized training and joint regional research as trainers for young experts.
- It is recommended that the Bir Zeit partnership model is replicated to other universities in Gaza Strip and West Bank. UNFPA needs to diversify its academic partners, bearing in mind that universities are platforms for addressing youth.
- UNFPA should invest more in its partnership with MoWA and in capacity development, particularly for the implementation of the national GBV strategy.
- GBV is not only a human rights issue, but also a public health issue that needs to be brought to the forefront of the health care field. It is recommended that UNFPA continue to strengthen the capacity of health providers on GBV; to support its integration in the comprehensive package of reproductive health; to support the national initiative to create an effective referral system in oPt.

- The Fund needs to expand its human resources in line of its rapidly growing scope of operations. It is strongly recommended to aim for experts and resourceful technical people in this expansion process, especially in RH and youth, including in the Gaza office.
- UNFPA should set a more coherent monitoring and evaluation system to improve quality of program results.

1. Introduction

1.1 Occupied Palestinian Territory Context

The turbulent situation in oPt (West Bank, Gaza Strip and East Jerusalem) and its long term socioeconomic repercussions generated a condition of de-development, impoverishment of the population, and continuous decline in their quality of life and mental and physical well being. This can be testified from the existing socioeconomic statistics from the Office of the United Nations Special Coordinator (UNSCO), Palestine Central Bureau of Statistics (PCBS) and the World Bank among many other sources (United Nations, 2003). Moreover, the observed trend is towards a tightening of restrictions with increased isolation of Gaza Strip, and a growing lack of geographic continuity and therefore socioeconomic and family life disintegration in the West Bank. A majority of Palestinians, 58%, lives below the income poverty line, and about half of them, 30%, live in extreme poverty. In the Gaza Strip, 70% of households live below the poverty line, while 56% of West Bank households and 19% of East Jerusalem households live below the poverty line (UNDP, 2007). This means that even if the conflict is to terminate soon, a high growth rate is required to stop the exacerbation of poverty and heal its consequences.

The development experiences of States living in peace indicate a correlation between governance and the achievement of the MDGs, and the Palestinian experience in the years 1994-2000 agrees with this correlation (PCBS, 2008). It shows that the existence of a stable political system is a precondition for the ability to pursue the MDGs. Health as a key development indicator on the MDGs international agenda has been tremendously weakened by the later political upheaval and its adverse repercussions, particularly on women and children.

According to the latest PCBS Health Survey carried out in the year 2006, TFR stands at 4.6 per woman, 4.2 in the West Bank and 5.4 in Gaza. Percentage of currently married women aged 15-49 years who are using (or whose partner is using) any contraceptive method by 2006 was 50.2, 54.9 in the West Bank and 41.7 in Gaza Strip. Around all deliveries, take place in health facilities indicating that skilled health personnel are attending the vast majority of births. Nevertheless, of these 15% took the form of cesarean section.

Data on maternal mortality and morbidity in the oPt are insufficient. Although the number of cases of maternal deaths is limited, major causes of maternal mortality are due to hemorrhage, complications of unsafe abortion, pregnancy induced hypertension, sepsis and obstructed delivery. Thus, indicators of major causes of maternal mortality seem to be indicative of shortcomings in quality of care since causes listed are avoidable with good risk assessment during pregnancy, and quality care during delivery and postpartum period. While the coverage of prenatal services remains at a high level, postpartum care coverage appears to have increased over time in the oPt from 19.7% in 1996 to 26.3% in 2000 and 30% in 2006, but remains very deficient with two-thirds of women in the oPt not receiving any postpartum care (3CPAP, para 9).

Neonatal mortality (20 per 1000 live births) showed an abrupt rise in the period 2002-2006 two years after the eruption of the second *Intifada*.

Despite this intricate context, the oPt is entering a new era of politics characterized by a renewed commitment to strengthening and consolidating the peace process. The need to build strong national institutions and the human capital within them is a major challenge. Moving from emergency to development is another important challenge for the different institutions of the PA as well as to the aid agencies.

1.2 UNFPA: The United Nations Population Fund in occupied Palestinian territory- Country office

Since its inception in the oPt in 1986 on project by project basis, the UNFPA Programme of Assistance to the Palestinian People commenced its first programme cycle in 1996 in three main themes: reproductive health, advocacy, and population and development strategies. Currently, UNFPA around closing the implementation of its third programme cycle 2006 – 2009 extended to 2010 with three main themes: Reproductive Health, Gender, and Population and Development. For more than twenty years of its work in the oPt, UNFPA contributed to the development of reproductive health strategies, upgraded the provision of services, contributed to building a national information system, and helped build the capacity of Palestinian Authority institutions and civil society. Another cornerstone of UNFPA's work in oPt centers on better targeting its programmes to meet the emergency needs, while not overlooking congruence with the developmental plans (Palestinian Reform and Development Plan/PRDP) and frameworks (the Millennium Development Goals, the International Conference on Population and Development – Plan of Action ICPD/ PoA) to ensure sustainability.

In its undertaking, UNFPA's guiding philosophy is that national ownership of development strategies, alignment of development assistance with national priorities, harmonization of development efforts, results-based management and mutual accountability all contribute to better, more sustainable development outcomes as called for at the Paris Declaration on Aid Effectiveness in the year 2005 and reaffirmed at the 2008 Accra High Level Forum on Aid Effectiveness. In this later Forum using aid as one of the instruments for achieving the MDGs and securing development results stressing the importance of capacity development and the use of country systems were all strongly advocated (UNDG, 2010). Hence, national development plans and poverty reduction strategies developed and implemented under programme country leadership are seen as anchors for measures to meet these goals.

To this end, in line with its scope of action, UNFPA defined three impact areas for its work in Palestine. These are:

- *Improving women's legal status and the quality of services* in order to reduce the risk of maternal mortality and provide women and young people access to high quality, integrated reproductive health services
- *Increasing women's participation in decision-making*, ensure access to poverty-reduction programmes and reduce exposure to vulnerability, risk and insecurity.
- Developing policies that integrate population and gender concerns.

In its walk, UNFPA is equipped with a strong position of comparative advantage it had earned over more than twenty years of work in oPt. The Fund has a significant experience in implementing programmes and specifically, enjoys significant capacity in the following areas:

- UNFPA has a consolidated team of professionals working in programming (medicine, public health, advocacy, and gender), administration and finance.
- In addition to its main office in Jerusalem, the Fund has also two sub-offices in Ramallah/West Bank and the Gaza Strip.
- Long-standing and positive relationship with Palestinian governmental and non-governmental institutions has enabled UNFPA to efficiently implement programmes and have built UNFPA credibility in managing programmes and projects.
- UNFPA has a worldwide tested procurement system including long-term agreements for commodities and equipment that allows a quick and efficient procurement of supplies, drugs and equipment for women's and infant's health.
- A long programmatic experience in oPt, including emergency and humanitarian work, that is linked to the community level including emergency response mechanisms for safe motherhood, delivery and postpartum care.
- Extensive outreach and experience in reaching out to communities in rural and urban areas using innovative behavior-change- communications.
- As part of the UN family, UNFPA is closely coordinating and continues to coordinate its efforts with other UN sister agencies for effective use of available resources.

1.3 UNFPA Current Programme: Third Country Programme Cycle

UNFPA third programme cycle 2006-2009 extended to 2010, was designed to achieve the following outputs:

- Improving accessibility to integrated, comprehensive, high-quality reproductive health services in 10 service delivery points in villages with restricted mobility; 39 Ministry of Health primary health care service delivery points; three women's centers; and six hospitals;
- Increasing accessibility of reproductive and sexual health information and counseling services for young people, with a special focus on the prevention of HIV/AIDS and STIs;
- Increasing the national capacity of integrated population, gender and reproductive health into development and emergency planning processes;
- Enhancing the national capacity to generate and utilize disaggregated data;
- Enhancing the capacities of the Government and civil society organizations to empower women in community-building in six localities;
- Building the technical and organizational capacities of the Ministry of Women's Affairs and civil society organizations to institutionalize gender principles and human rights.

Initially, regular resources planned for achieving the above stated outputs were **7,800,000 USD**. Final expenditure, however, mounted up to **16,276,167 USD** indicating the acquisition of more

than double the planned financial resources with the increase centering most in reproductive health humanitarian response.

1.4 Major Implementing Partners

Implementation of the UNFPA country programme require the coordination with line ministries in charge of the execution of the UNFPA programme. These are MoH, MoPAD, MoWA, MoEHE and MoSA. Alongside, partnerships with local NGOs at the community level for community mobilization on RH rights, adolescent SRH, early marriage and gender inequalities included PMRS, the PFPPA, MIFTAH, WCLAC, and the CFTA. As such, UNFPA adopted multisectoral partnership development for positioning the ICPD agenda upon which the Fund's strategic plan is laid.

2. Trajectory and Methodology

2.1 Purpose and objectives

This evaluation is meant to serve as a systematic and objective assessment of the complete UNFPA program at the adjournment of its third programmatic cycle. The purpose is to assess the achievements and quality of the Country Programme (CP) by outcome thematic area and in terms of the five OECD/DAC evaluation criteria including relevance, effectiveness, efficiency, sustainability, and impact. It generates useful information that contributes to improved performance and accountability through examining the concluded program, its components and their effects/impacts. It also highlights; strengths, weaknesses, gaps, good practices, draws out lessons learned and make recommendations that can inform decisions for the forthcoming programming cycle.

To this end, the evaluation intends to meet the following objectives guided by the above stated criteria:

- To assess and analyze the achievement and shortfalls in outputs and the extent and means by which they have contributed to or hindered the outcomes.
- To assess the programme relevance in terms of the design alignment with the national needs and priorities, as well as the UNFPA's policies and priorities and the ICPD Programme of Action as it links to the MGDs achievement.
- To assess program effectiveness by examining the extent to which the results achieved contributed (or not) to the programme objectives.
- To assess the efficiency of the CP in terms of the quality of outputs achieved in relation to inputs and expenditures incurred.
- To assess the results sustainability as to their likelihood to last beyond the program support.
- To assess the program impact by examining the extent to which the achieved results contributed to long-term effects such as the socio-cultural or institutional ones and the external factors that could have influenced the occurring effects.
- To assess the UNFPA partnership, evidence based policy dialogue and capacity development strategies and the extent to which they have contributed to the achievement of the intended outcomes for each thematic area of intervention.

2.2 Ethical Considerations

The following ethical considerations guided this evaluation process;

- Approvals. Before beginning the evaluation, the needed permissions were obtained for ethical and logistical considerations. Permissions were obtained from all partner organizations including government, NGOs and international agencies. Permission to work

with facility staff was also secured. With prior approval of the administration, it was arranged to carry out spontaneous visits to observe the facilities on an average work day.

- Informed consent attainment.
The principle is that everyone who participates in the evaluation should do so willingly. Therefore, all participants were guaranteed the following rights;
 - Choose whether or not to participate without penalties.
 - Withdraw from the evaluation at any time, even if they previously gave consent.
 - Refuse to complete any part of the data collection instruments.

Participants' right to understand implications of their decision whether or not to participate was ascertained. To ensure that potential participants can make an informed decision UNFPA evaluation officer initially contacted all partner organizations and ministries informing them about the forthcoming evaluation, its purpose, time and duration, names of team members and answered all questions that were asked. Upon implementation, the evaluators provided partners with more detailed information about the evaluation as needed and sought. This included information on what will they be asked, how long it will take, and how will the results be used. In addition, answers to any other questions they had about the evaluation were pleasantly provided.

- Privacy and Confidentiality.

It is not always possible to conduct evaluations without identifying information, such as names as was the case in part of this evaluation. However, first, all evaluation information was kept confidential. Second, the evaluators made sure not to allow particular respondent's identification, which is to say who said what, through data presentation and discussion in the report.

To ensure confidentiality:

- Data was collected with maximum privacy and convenience for the respondent/s in places where conversations/discussions/interviews cannot be overheard.
 - Information sharing about individual participants with other people, including other agency staff was proscribed.
 - Completed surveys and interviews were kept in a secure location where they cannot be seen by other people.
 - Completed material will be securely disposed when it is no longer needed.
- Ethical issues related to the evaluators' Role.
Throughout this evaluation process the evaluation team watched over the following principles;
 - Utility: Evaluation addresses important questions, provide clear and understandable results, and include meaningful recommendations
 - Feasibility: Evaluation is maintained realistic and practical, so that it is completed in a time- and cost-efficient manner
 - Propriety: Evaluation is legal and ethical.
 - Accuracy: Information is collected, analyzed, reported, and interpreted correctly, truly and impartially.

Given the nature of this evaluation, research ethics approval was not deemed relevant. Alternatively, institutional review (UNFPA) was employed to reflect on data collection instruments completeness, relevance, soundness, aptness, and propriety.

2.3 Encountered Limitations

This evaluation encountered a number of limitations presenting it with additional load the team had to diligently tackle. These are recognized hereunder.

- *Challenge of attribution:* Where the internal validity of a given intervention is well established, e.g. use of family planning counseling and services, attribution of outcomes to an intervention, e.g. beneficiaries protected from unwanted pregnancy because they utilize a family planning method, will be fairly straightforward. However, in the case of many other programme interventions, internal validity is not well established and attribution is problematic. For example, attributing genuinely a positive change in the Palestinian women legal status to an intervention or set of interventions within this programme might be difficult especially in the presence of multiple national and international interveners in this area meaning that control for confounders is not possible here. In conclusion then the reality of methodological and resource constraints in carrying out this practical evaluation means that often attribution will be expressed in terms of likelihood rather than proof, and that ultimately the test of validity is credibility. This is the guiding professional premise here.
- *No baseline evaluation data* was available except for some data on the quality of RH services program component where the adopted methodology did not incorporate or define an evaluation criteria framework as a reference measure. Therefore, in this evaluation the evaluators could not precisely measure the changes, which could confidently be attributed to the interventions in any program component.

Evaluation culture: Some stakeholders were skeptical as to the purpose of the evaluation and the extent to which its findings will be incorporated into or shape the program in the coming cycle. As a result, their perception of the evaluation process altogether was poor. This manifested itself in the frequent postponements and rescheduling of some sites visits and experts interviews, and the brief answers some of them gave to key questions. In turn, this impacted gaining access to the needed information and imposed extra probing work in interviews in addition to extending the fieldwork period.

- *The extent of stakeholders' engagement* was one limitation in this evaluation in the sense that it was not possible to be systematic but rather periodic as feasible. Except for the programme operations staff at UNFPA representative office, the rest of stakeholders were engaged primarily in obtaining stakeholders' input in describing and learning about the program outcomes. This is ascribed to feasibility issues related to unavailability and structural complexity of the official stakeholders and the resultant difficulties in soliciting their input. The prevalent evaluation culture mentioned above is also another dimension to this.

- The above stated limitations alongside the Israeli imposed regional segregation and closure policies against GS in particular but also the WB, overburdened the *logistical, coordination and fieldwork management necessities* in this evaluation exercise. These limitations having exceeded our expectations compelled introducing occasional adjustments to the initially set plan including time allotted for the accomplishment of this mission.

2.4 Structure of the Evaluation Report

This evaluation report consists of eight main chapters. The first introduces the evaluation and briefly talks about the oPt context, UNFPA in oPt, UNFP CP 3rd country programme cycle and major implementing partners. Chapter two is on trajectory and methodology including; purpose and objectives, ethical considerations, limitation of the evaluation and structure of the evaluation report. Under the methodology part of chapter two the conceptual foundations are laid followed by framework for analysis, stakeholders involvement, evaluation approach, design, sample selection and size, data sources and data collection instruments, and methods for data analysis. Chapter three is on relevance of the Country Programme by the three programme component of; reproductive health with a sub-component on youth, population and development and gender.

Chapter four comprises the main body of the report on program effectiveness with special focus on achievements of results subdivided by program components in addition to a section on crosscutting issues being; human rights-based approach, capacity development and partnership strategy including joint programming. This is followed by a section on programme management, monitoring and evaluation. Efficiency, impact and sustainability sequentially follow in chapters five, six and seven by each programme component. Chapter eight includes the conclusions and major recommendations also by each programme component. Lastly, annexes are attached to the report as deemed necessary including; terms of reference, lists of people interviewed, list of documents reviewed, qualitative and quantitative data collection instruments and others.

2.5 Methodology

2.5.1. Conceptual Foundations

The causal pathway framework and the evaluation criteria of the Organization for Economic Cooperation & Development/ Development Assistance Committee (OECD/DAC) are put in synergy to generate the conceptual foundations of this evaluation.

The “Causal Pathway Framework” is based on the premise that the carried out activities should logically cause desirable results to occur; and that the causal links follow a technically and programmatically sound logical sequence.

It is divided into five main components: *Impact, Effects, Outputs, Activities and Inputs*. The ultimate purpose of any program is its desired *Impact*. In a visual display of the causal pathway, the program's *Impact* is placed at the very end of the pathway, since that is where we are ultimately heading.

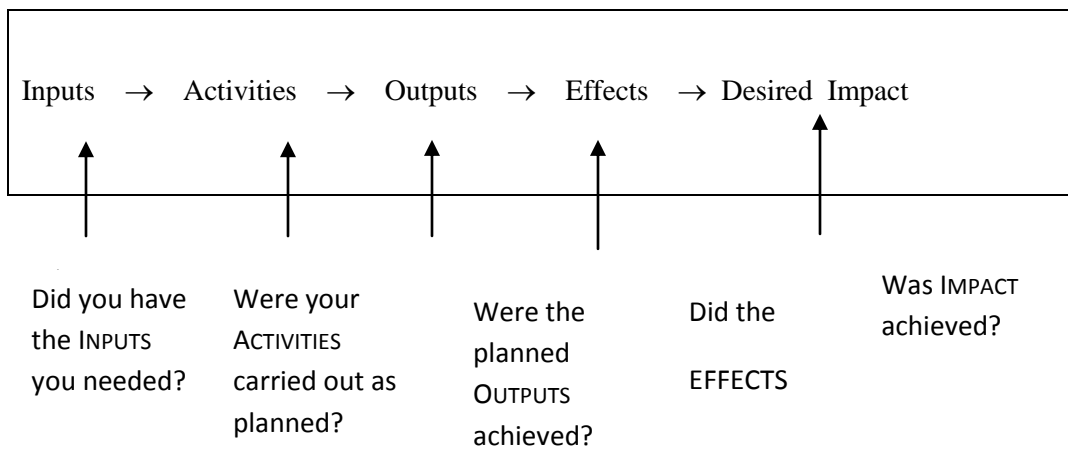
In order for a program to result in the desired *Impact*, people must choose to change things about themselves, typically their knowledge, attitudes, skills, intentions and/or behaviors. In the language of the causal pathway, such changes are the effects.

What must be in place to enable people make the changes described in the Effects? In service delivery programmes, a set of products and services must be available if we expect people to use them. Products and services that must be in place for the Effects to be achieved are the program outputs.

What the programme has to do to produce the outputs are the activities, which are the technical and support tasks required to produce the Outputs.

Before Activities are begun, the necessary resources must be available in adequate amounts. These resources are typically funds, staff, sites and community good will. In the Causal Pathway, these are program Inputs

Figure 1: Visual presentation of the causal pathway



In summary, the Causal Hypothesis can be summarized thus:

“This set of inputs and activities will result in these products and services [Outputs], which will facilitate these changes in the population [Effects], which will contribute to the desired Impact.”

Implementing the causal pathway the links along the pathway are examined. This is with reference to the UNFPA-CP predetermined outputs and indicators as benchmarks. In this evaluation, focus will be placed on these outputs; effects they have made on the targeted

population; and the impact they have made on people's lives in light of the inputs UNFPA committed to the program and the activities carried out to this purpose.

Throughout this process the OECD/DAC five evaluation criteria are incorporated into the adopted conceptualization in this investigation. These are: relevance, efficiency, effectiveness, impact and sustainability. These general criteria were used as a basis for developing the questions in this evaluation.

Taken together, these five criteria present the policy maker at UNFPA being the donor agency and PA being the key partner with the essential information and clues to understand the situation and determine what should be done next and how should it be done.

1. Relevance: is a measure of the extent to which programme interventions meet population needs and country priorities, and are at the same time consistent with donor policies.

A change in the PA policies or priorities, for example, could imply that the previously agreed interventions are now accorded lower priority, or lose some of their grounds. Relevance is basically a question of usefulness; in turn, the assessment of relevance leads to higher level decisions as to whether the activities in question ought to be terminated or allowed to continue, and, if the latter is the case, what changes ought to be made, and in what direction? Are the agreed objectives still valid, and do they represent sufficient rationale for continuing the activities?

Under this criterion, these questions are addressed at various levels with reference to the partner country being the PA in this case. At the higher level it concerns the relationship between the UNFPA Country Programme activities and the development policy and agenda of the PA. At the middle level it is a question of how activities are contextualized. That is to say are fit into the larger country context, e.g. in relation to other development interventions and development efforts within a larger programme or sector supported by other donor agency/body. At the lower level it is a question of whether the UNFPA programme activities are directed towards areas accorded high priority by the affected parties/stakeholders.

2. Efficiency: is a measure of the relationship between outputs, i.e. the products or services of an intervention, and inputs, i.e. the resources that it uses.

An output is a measure of effort; it is the immediate observable result of intervention processes over which the managers of the intervention, i.e. the implementers, have some means of control. An intervention can be thought of as efficient if it uses the least costly resources that are appropriate and available to achieve the desired outputs, i.e. deliverables, in terms of quantity and quality.

Efficiency measurement addresses waste in the process, either at the level of inputs, i.e. economy – obtaining appropriate resources at least cost or fair market value, or at the level of process, i.e. duplication-triplication of activities, conflicting processes, throughputs that do not link to outputs. Furthermore, good practices, i.e. pertinent lessons learned from previous programme cycles or midterm reviews are used as benchmarks for assessing efficiency.

3. Effectiveness: is a measure of the extent to which the intervention's intended outcomes, i.e. its specific objectives have been achieved.

Explicitly, effectiveness is the relationship between the intervention's outputs, i.e. its products or services – its immediate results – and its outcomes, meaning the intended benefits for a particular target group of beneficiaries.

As such, an intervention is considered effective when its outputs produce the desired outcomes; it is efficient when it uses resources appropriately and economically to produce the desired outputs.

In this effectiveness measure the key challenge of attribution is one limitation this evaluation process encounter as explained earlier.

4. Impact: is a measure of all significant effects of the programme interventions, positive or negative, expected or unforeseen, on its beneficiaries and other affected parties.

Whereas effectiveness focuses on the intended outcomes of the programme interventions, impact is much broader measure. It considers all consequences of the interventions such as economic, social, political, technical or environmental effects; locally, regionally, or at the national level; on the target groups and other directly or indirectly affected parties.

For example STIs prevention, diagnosis and treatment targeting adolescents groups could be having broader effects both positive, such as an increase in the demand and utilization of reproductive health counseling and service , and negative, such as a reduction or deferment of funding to infertility treatment to subsequent programme cycles. Effects may also be economic in nature, e.g. size of the workforce, political, e.g. PA budget allocation and relocation, and so on and so forth.

An assessment of impact is carried out in this evaluation. However, because such effects can be numerous and varied and are typically the result of complex interactions certainly in the Palestinian case assessing impact is particularly intricate.

5. Sustainability: is a measure of whether the benefits of the programme are likely to continue after external support has been completed.

While the four former criteria concern specific programme interventions, the assessment of sustainability addresses the effects of the programme implementation process itself over the long term.

Assessing sustainability, questions will address the extent to which partners' capacity has been successfully developed and by which means be it participation, empowerment, ownership, resources expansion and/or fostered political support.

Also assessing sustainability it is investigated whether the positive impacts of the programme justify the required investments being made and whether the community values the benefits sufficiently to devote them the needed resources afterwards.

2.5.2 Framework for Analysis

The adopted MEASURE Evaluation (2002) framework for analysis illustrated in Figure 2 below is adapted from a former similar model developed for family planning also under the same EVALUATION Project. This framework illustrates the pathways by which reproductive health programs achieve their objectives. The column on the far left defines the context in which the program operates: the social, cultural, economic, political, and legal systems in a given society, including that society's reproductive health programs. So in a way it addresses issues of program relevance.

The top left-hand side of the figure, lightly shaded, outlines the role of demand in the effectiveness of a given program. Demand is largely based on societal norms and preferences manifested in attitudes, perceptions and expectations about a given service. The lower left-hand side of the framework lists factors in the supply environment, shaded in a darker tone. Normally in cases of self governance strong social and economic development programs provide a more conducive environment in which to promote reproductive health.

The policy environment is both extrinsic and intrinsic to RH program operations; that is to say to the service delivery process : it forms part of the socio-political context in which programs must operate, and influences the scope of program actions, the resources allocated, and the organizational structure of the program itself. Strong political support (political will) for a program facilitates implementation. Because of that, whereas donor agencies and program managers once treated policy as a contextual variable that would influence program implementation, today they actively design interventions including advocacy packages with the aim of shaping the policy environment.

The service delivery environment is the situation prospective clients find when they seek services, both in terms of tangible factors (e.g., the physical stand, personnel, equipment, and supplies) and the intangibles (e.g., treatment received from the staff). The stronger the input from each of these functional areas, the better will be the services available to clients. Whereas the term service environment implies clinical services, the concept equally applies to behaviour change

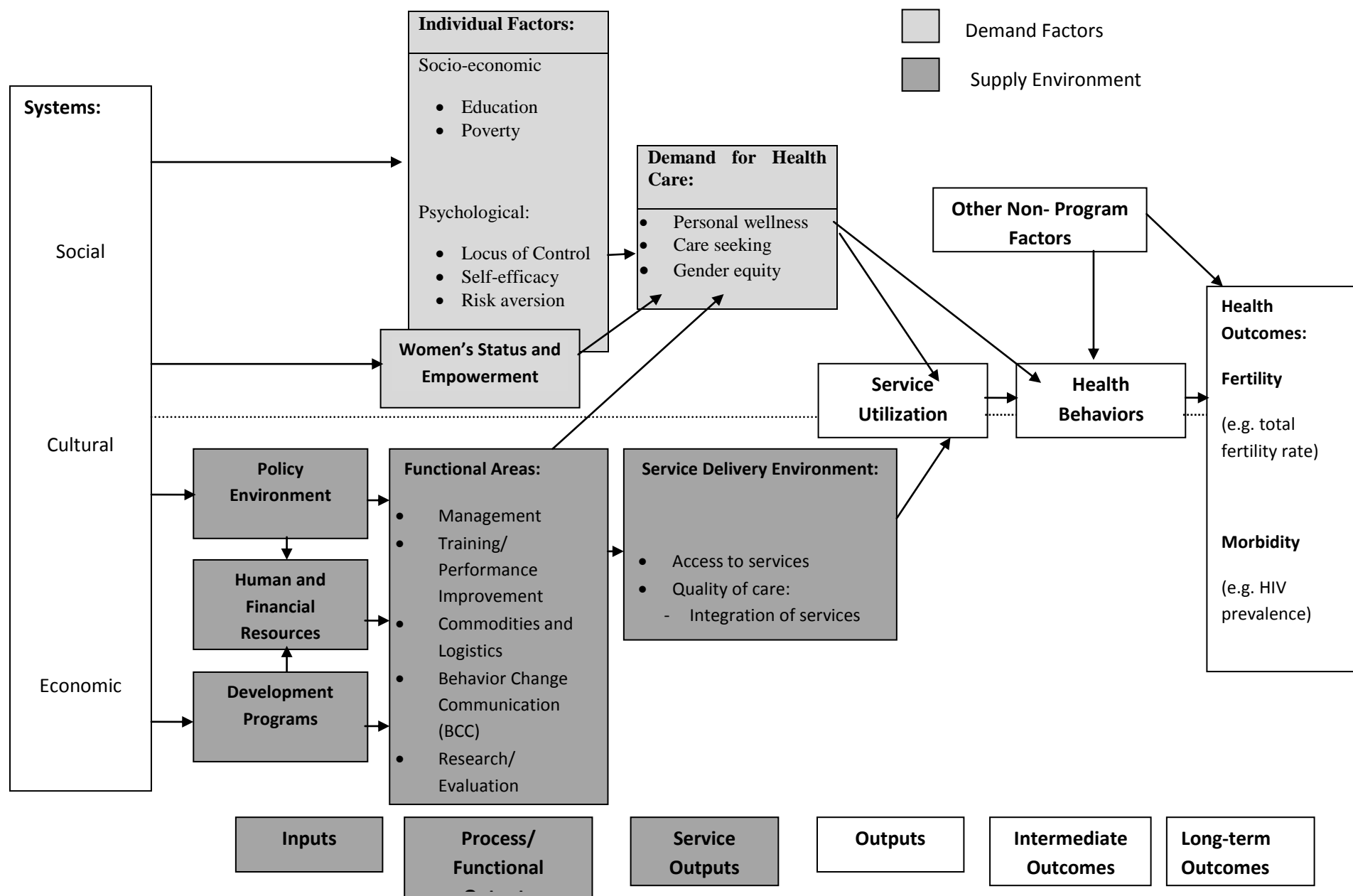
communication (BCC) components that are educational in nature. Focus is placed on the two defining characteristics of the service delivery environment: access to services and quality of care with integration of services and gender equity/sensitivity being sub-elements of quality. In so doing, the well known Bruce/Jain framework is employed, which defines the six elements of quality of care: appropriate constellation of services, choice of methods, information given to clients, technical competence, interpersonal relations, follow-up and continuity mechanisms (Bruce, 1990).

The rationale for evaluating access and quality is twofold. First, evaluation of these topics serves to focus attention on the need to strive for improvements in these areas. Second, this type of evaluation measures synergy between the different functional areas- management, training, commodities and logistics, BCC-IEC, and research/evaluation and the extent to which they are working to achieve: better outcomes.

These two sets of factors - supply and demand- jointly determine the level of service utilization. Although service utilization is not essential to the practice of certain behaviours (e.g., exclusive breastfeeding), it generally plays a key role in helping a client adopt healthy behaviours, through information and counselling, provision of supplies (e.g., condoms for STIs & AIDS prevention), or clinical procedures (e.g., insertion of an Intra-uterine device - IUD).

The box labelled “health behaviours” represents the objective of most RH programs: that is, the behaviours that members of the intended audience are encouraged to adopt. Examples include use of contraception for family planning, use of condoms for STIs prevention, delivery with a skilled birth attendant, and breastfeeding. Also, it should be born in mind that non-program factors may also play a role at this level in influencing both health behaviours and outcomes. For example, fertility is determined not only by contraceptive use, but also age at marriage, extent of induced abortion, and pathological sterility. The entire chain of causal events, outlined in Figure 2, leading to specific health behaviours directly affects the ultimate objective of reproductive health programs: improved health outcomes in terms of fertility, mortality, and morbidity.

Figure 2: Framework of Analysis



2.5.3 Stakeholders Involvement

Although a limitation was acknowledged to have existed as regards this aspect, to the extent possible, stakeholders' involvement was ascertained by addressing three major groups:

- Those involved in *program operations*: Management and technical program staff at the UNFPA representative office and key partners including those at Ministry of Health (MoH).
- Those *served or affected* by the program: Patients or clients at the service recipient end and projects/activities implementers/ service providers at the provider end such as RH care providers, PCBS selected staff, population course lecturers at BierZait University, women organizations staff, MoH, Ministry of Education (MoEHE) and Ministry of Planning (MoPAD) project staff amongst many. This is in addition to advocacy and youth groups primarily at the NGO and civil society organizations.
- Those who are intended *users* of the evaluation findings: Persons in a position to make decisions about the program, such as partners and funding agencies in sister organizations including UNICEF, UNIFEM, WHO and others.

Clearly, these categories are not mutually exclusive; in particular, the primary users of evaluation findings are often members of the other two groups, i.e., the program management or advocacy organizations or NGOs coalitions.

2.5.4 Evaluation Approach

This evaluation adopts an eclectic participatory non-conventional approach in its implementation. Methods were meant to test counterfactuals and triangulate among data sources. Several sources, research techniques and data collection methods and tools were employed to help pinpoint issues of interest and construct the most comprehensive and solid depiction of the program in order to enable planners and policy makers both at the UNFPA and PA correct pitfalls and capitalize on achievements. In evaluation literature, this specific approach is noted for being widely used in identifying problems in the delivery of reproductive health services, particularly that its methodologies integrate a client-oriented focus on quality of care.

2.5.5 Design

Quasi-Experimental namely ex-post design was employed in this evaluation. In this design, measurement is carried out only after exposure to the program, eliminating testing threats. As noted in research literature, quasi-experimental designs although demand substantial creativity and skills to design and

implement they can give highly accurate findings. Predetermined country program indicators pertaining to its three thematic areas of intervention; reproductive health, population and development and gender were utilized to measure the program's successes and achievements/failures.

Relevance, efficiency, effectiveness, impact and sustainability are the five evaluation criteria used as a basis for developing evaluative questions through the full range of the evaluation topics i.e. from single areas of intervention through to all crosscutting themes.

2.5.6 Sample Selection and Size

Sampling in this evaluation is done by use of **purposive sampling strategies** whereby specific types and numbers of settings/cases/respondents appropriate to the evaluation's purposes and resources are selected. Particular selection methods by area of intervention vary according to the objective/s to be met within each given area.

With regards to reproductive health and rights thematic area, the selected UNFPA-supported health facilities providing RH services including primary health care centers (PHC) and hospitals are considered the sampling units. Primary Health Centers (PHC) are further classified into Comprehensive Health Centers (CHC) and Service Delivery Points (SDP) ¹. Operationally, CHC provide comprehensive RH services that include; antenatal care (ANC), including care for high risk pregnancies, postnatal care (PNC), family planning (FP) services (including counseling), cervical smear tests, manual breast examinations (MBE), management of sexually transmitted infections (STIs), and health education. In contrast, SDPs are meant to provide a more limited package of essential RH services, including ANC, PNC, FP (including counseling), MBE, and health education.

With reproductive health and rights being UNFPA's prime area of intervention for comparison purposes this summative evaluation targets a sub sample from the reproductive health care facilities included in the RH sub program quality assessment completed in 2005 around the conclusion of the former program cycle. Table 1 below comprises an illustration of the health facilities in the West Bank and Gaza Strip (WBGS) sampled for the purpose of this evaluation.

Facilities are stratified by region (West Bank & Gaza Strip), type (service delivery point vs. comprehensive clinic vs. Hospital), location (north, center, and south), and client volume. In total, 2 comprehensive clinics and 2 SDPs are selected. Two out of the three non-governmental comprehensive

¹ In the Palestinian context, Comprehensive Health Centers (CHC) and Service Delivery Points (SDP) are service package based classifications that apply only to the Primary Health Care (PHC) settings at the first level of care. At the subsequent second (secondary) and third (tertiary) levels, these classifications do not apply.

women's health centers and two out of the six governmental hospitals are selected (1 in the West Bank and 1 in the Gaza Strip) for inclusion in the sample. Thus, in total, 9 facilities were visited (5 in the West Bank and 4 in the Gaza Strip), and their distribution by name, type and region is shown in table 1 below.

Table 1: Distribution of the sampled facilities by name, type and region

Region	CHC	SDP	Comprehensive WHC	Hospital
West Bank 5	Jenin	Ni'leen	PFPPA (Hebron)	Rafidia
	Yatta			
Gaza Strip 4	Jabalia	Al Qarara	Al Bureij Women's Health Center	Shifa
Total WBGS 9	3	2	2	2

Intensity sampling connoting information-rich cases is employed in selecting focus group participants. Meanwhile, criterion sampling is used to pick cases that meet certain criterion such as service providers/recipients or experts and planners in specific areas of interest for individual interviews.

Sample size within each targeted health facility varied by purpose and type of instrument employed in data collection. Breadth considerations, time limitations, and fieldwork circumstances have all played a role in determining this. In total, **9** Facility Audit and Manager Surveys were completed, 1 per service site. As regards client provider interaction (CPI), a total of **70 CPIs** were completed in all sites but hospitals using two types of observation checklists recording two different types of interactions one on FP and another on ANC interactions; 35 of each. Ten observations were completed in each facility.

The provider questionnaire was completed by the fieldworkers in a face to face interview with **25 care providers** from various health backgrounds, averaging 3 per facility; a nurse, a doctor and a midwife, as applicable.

From the wider community and institutional settings, a total of **97 people** participated in **8 different focus groups** carried out with different population groups as indicated in table 2 below. With an average of 12 participants each, focus groups discussions covered a wide range of youth, gender and population and development issues in addition to selected RSH service and awareness aspects according to the involved population group.

Face to face interviews was another qualitative method employed in this evaluation. **Thirty-one experts** were interviewed; 24 from the WB and 7 from GS; 14 from the Government, 8 from NGOs and 9 from International agencies, predominantly UN agencies. A detailed list of names and institutional affiliations are included in appendix 3.

Table 2: Distribution of FGDs by, region, location, target group and sub-program/crosscutting issues addressed for discussion.

Region	Location	Target Group	sub-program/ crosscutting issue
West Bank	Ramallah	Youth (both sexes from rural & urban areas in southern and middle governorates)	Youth: RH knowledge / Gender issues
	Ramallah	Youth (both sexes from rural & urban areas in northern governorates)	
	PFPPA WHC Hebron City (urban)	Women as WHC clients	RH services Quality, access/ gender (user perspective)
	Hebron city	RH male & female service providers from Bani Naim, and Tarqumia (rural)-UNFPA supported health facilities	* RH services Quality, access/ gender (provider perspective)
Gaza Strip	Al Rimal (urban)	Youth (both sexes)	Youth: RH knowledge / Gender issues
	Jabalia (rural/camp)	Youth (both sexes)	

	Al Bureij Women's Health Center (semi-urban/camp)	Women as WHC clients	RH services Quality, access/ gender (user perspective)
	Gaza city	RH male & female service providers from Khan Younis, Al Shija'ieh (urban and rural)- UNFPA supported health facilities	* RH services Quality, access/ gender (provider perspective)

2.5.7 Data Collection Methods and Instruments

It is to bear in mind that the unit of analysis varies for the different employed data collection instruments. Hence, while it is the client-provider interaction processes for the observation checklists it is the clinic/center for the facility audit/assessment and the identified provider or expert in interviews.

In this evaluation, quantitative and qualitative data were collected as follows:

- 1) Facility-based instruments: These were primary data sources whereby quantitative data were collected.
- **Facility Audit and Manager Survey** comprised of 7 sections that cover functional areas of the service including; Equipment and Commodities Inventory, Conditions of Facility, Behavior change communications (BCC), Supervision, Protocols and Guidelines, Use of Information in Clinic Management and Service Statistics. In this evaluation, facility audits were conducted in all 9 sampled facilities, using the *Facilities Data Collection Form*. The form contains an audit of clinical staff, support staff, equipment, and emergency transport vehicles. In addition, it collects data on the reported number of clients, visits per client, drugs and supplies, laboratory tests, and clinical staff time for the following components of the Mother-Baby package: antenatal care, severe anemia, abortion complications, eclampsia, family planning, neonatal complications, normal delivery, obstructed labor, postpartum care, sepsis, and sexually transmitted diseases (STDs). For the purpose of this evaluation, two amendments were introduced to the instrument. First, questions were added about preventive services including manual breast cancer and cervical smear examinations, high risk pregnancies, and home visits, being part of the UNFPA-supported RH package provided at the service delivery points (SDPs) and/or comprehensive health centers (CHCs). Second, the list of equipments inventoried was expanded beyond what was available in the form to produce a true reflection of items available in the facilities (*Appendix V*).

The facility audit was conducted in all sampled SDPs, CHCs, non-governmental comprehensive women's health centers, and hospitals. Naturally, for the first three types of facilities, the irrelevant sections of the data collection form were excluded, namely the sections on delivery, obstructed labor, and neonatal complications, as these services are available only at the hospitals. The information on reported practices was obtained from the nurse or midwife in the facility and/or from the doctor, based on their familiarity and involvement with the service and on their scope of practice. Thus, for example, nurses were asked about practices pertaining to home visits and manual breast exams, while doctors were asked about their management of high-risk pregnancies and sexually transmitted diseases. Whenever the nurse and the doctor both participated in providing a given service both were asked about their practices. To the extent possible, every attempt was made to square any differences in reported practices between the different providers by re-checking the responses with them and referring to available clinic records.

- **Observation checklists on client-provider interaction (CPIs).** Observational data describe various program facets, the individuals who participate in the activities and the meaning of these activities to the involved individuals.

Observing client-provider interactions during counseling and clinical sessions allows the evaluation of the provider's counseling and clinical skills and the extent to which the encounter is an interactive one that incorporates a conversational component whereby the client is a participant in her care more than just a mere recipient. In this evaluation, a public health nurse in the West Bank and a midwife in the Gaza Strip conducted CPIs. Thus, in total, **CPIs were conducted in 7 facilities**. Physicians, nurses, and midwives were observed providing family planning and antenatal services. Permission was first obtained from the provider to attend the clinical sessions, after explaining the procedure and assuring the provider that the observer would not interfere with the clinical encounter in any way. Oral consent was also obtained from women before the onset of the encounter during the waiting time.

On average, 10 observations were conducted in each facility as described above. Two sets of observation checklists were used: one on antenatal care visits, and the other on family planning and gynecology visits (*Appendices 4 and 5*). Verbal and non-verbal communications were observed, and qualitative observation notes were also recorded.

- **Provider Interviews.**

In this evaluation, from each targeted facility an average of 3 health care personnel who were involved in the provision of RH were interviewed. In general, assisted by a nurse and/or a midwife, a physician provides reproductive health services on offer. The system is such that nurses and midwives are permanently assigned to the clinics, whereas doctors may rotate among different clinics, especially in the rural areas.

In total, **25 providers were interviewed in the WBGs; 14 in the WB and 11 in GS**; 13 midwives and nurse/midwives, 9 physicians, 2 nurses and 1 health worker.

The health provider questionnaire covered the following areas: background information on the provider's education and work experience; the use of protocols and guidelines in clinical practice; roles and responsibilities at the facility; clinic management; supervision; evaluation; use of BCC materials; challenges for practice and suggestions for improvement and training needs(*Appendix VI*).

It is to mention that the above mentioned data collection instruments were developed in 2004 as a Monitoring and Evaluation Toolkit by the Reproductive Health Response in Conflict (RHRC) Consortium, which embraces seven highly credible member organizations all engaged heavily in various technical, academic, and service provision aspects of RH care. Since its development, the toolkit has been frequently used and proven useful in many program evaluations in many countries including in Palestine's UNFPA RH sub-program evaluation completed in the previous programmatic cycle in the year 2006. For the purpose of this evaluation, some modifications were introduced to the instruments as needed for contextualization purposes.

- 2) Non-facility based instruments: These were primary data sources too, but where qualitative data were collected.
- **Focus group discussions totaling 8** altogether were carried out with selected **service providers, service users and youth groups**. Focus group discussions were intended to facilitate gaining deeper insights and viewing RH service and needs from a broader outlook. They were also meant to test for counterfactual messages. The assumption is that different subgroups would bring a different perspective to the expressed RH needs, the extent to which they perceive the health facility as fulfilling those needs, and suggestions for improvements. In each region, four focus group discussions were conducted as illustrated in table 2 above. The group discussions were arranged through youth organizations for the youth groups, local NGOs for service users and MoH for the service providers. Two research assistants conducted the group discussions, one male in GS and another female in the WB. The Gazan research assistant is known to have had many previous experiences with male and female discussion groups and so no problems were anticipated in this regard.

In all groups, the discussion commenced with a brief introduction of the purpose of the discussion, followed by an explanation of its basic rules. In summary, it was clarified that responses to any particular question were voluntary, and there was no pressure to respond or comment if the participant did not wish to; there were no right and wrong answers; all opinions were welcome; differences would be respected, and confidentiality of the discussion was assured. Responses would be documented anonymously in the transcripts. Group discussions lasted generally between 1.5-2.5 hours. A structured focus group discussion guide was prepared to assist in initiating and focusing the discussions for each target group category.

- **Experts and policy makers' interviews.** In addition to the interviews carried out with the clinical staff providing RH services in the health facilities, a total of **31 interviews** was conducted with key stakeholders and decision makers in relation to the program three areas of intervention; successes and failures within each; and future priorities and forms of partnerships as expressed by partner Ministries. These included; Ministry of health, Ministry of Women Affairs, Ministry of Social Affairs, Ministry of Education and Higher Education. Representatives from partner NGOs experts such as Palestinian Family Planning and Protection Association (PFPPA) and Palestinian Medical Relief Society (PMRS) were also targeted with this in addition to partner international organizations and UN sister organizations such as UNICEF, UNESCO, WHO, and UNIFEM . For a listing of the interviewed stakeholders, please refer to appendix 3.

Primarily, Interviews with this target group were carried out towards the middle and end of the evaluation process, to clear up certain findings and develop a portrayal of the bigger policy, development and planning panorama in the respective areas of intervention.

- 3) Office-based instrument: **Desk review** where reference to secondary sources incorporating quantitative and qualitative data on youth, gender, population and development, and RH issues, was made. For the purpose of this evaluation, these sources were subject to revision, examination and assessment. Reviewed government documents included ministerial strategic plans and policy documents, PRDP 2008- 2010, gender inter-sectoral strategic plan 2011-2013, National Strategic Health Plan 2011-2013, and health Sector Reform report. While the UN ones included; the ICPD-PoA, MDGs achievement reports, Paris Declaration on Aid effectiveness, UNFPA CPAP, Strategic plan 2008-2011 and situation analyses reports. These documents were consulted as needed starting from the onset of the evaluation throughout its implementation up until its closure.

2.5.8 Methods of Data analysis

Upon completing each evaluation component, the team met to debrief, in person within each region and through video or call conference, nationally for all members working in the two regions of WBGS. Quantitative data were compiled and analyzed using the statistical package for social sciences (SPSS). Findings from the analysis were compared to standards for the delivery of quality services to identify deficiencies in the program being studied. Analysis of qualitative data from interview transcripts, observation field notes or open-ended questions identified similarities and differences across several accounts, as well as directions, trends and tendencies. For interpretive content analysis, data were then categorized into recurrent themes and topics that seemed relevant to answer the evaluation questions.

3. Relevance of the Country Programme

Program relevance is measured against its alignment with key national development policies and strategic documents while being consistent with the UNFPA policies, and strategic plans. In the case of this evaluation, the key Palestinian document of concern is mainly the Palestinian Reform and Development Plan (PRDP) 2008- 2010. Meanwhile the UNFPA ones are primarily the ICPD and the 2008-2011 UNFPA strategic plan.

The conceptual framework of the UNFPA program as delineated in its Country Program Action Plan addresses individual, interpersonal, organizational, community and health policy factors,² with the aim of supporting interventions at different levels that will be synergistic and contribute to enhancing overall outcomes. Thus the relevance of the UNFPA program in the Palestinian context and the holistic approach in both program content and the levels of intervention contribute to making up a program that is appropriate, comprehensive, and in line with the essential needs of the country. The log frame matrix for the program components lays out clear goals, objectives, means of verification, risks and assumptions. Specific activities are listed along with how they will lead to the accomplishment of objectives and program goals.

Evidence based programming approach holds strong indications on the relevance of the Fund's initiatives and projects that are largely based on research carried out locally by local NGOs and independent consultants with UNFPA funding. During this cycle, UNFPA alongside its invaluable support for PCBS to generate national disaggregated data carried out many pieces of research and studies to ensure relevance of its program to the actual population needs and priorities. A case in the point was the utilization of the findings from a study it funded to investigate the information needs in SRH among youth, psychosocial counseling within the school setting, and staff at social care and rehabilitation centers affiliated to MoSA. Guided by findings from this later study, girls in the Girls Rehabilitation Centers were supported by targeting the service providers (instructors/supervisors) for capacity building by providing them with training on; GBV, counseling, hygiene, RH and reproductive rights and life skills as the study recommended. Later on technical training in some selected vocational subjects were planned to be carried out to promote the delivery of improved quality training for these girls at the recipient end. A similar study offered evidence to working with in-schools youth while a third one assessed the psychosocial support needs of women living in seam zone villages and so on and so forth.

3.1 Relevance of RH programme component

Implementation in this programme presupposes, inter alia, the mainstreaming of gender concepts in the RH programme.

² Brownson R. *Evidence-based Public Health*. Oxford: Oxford University Press, 2003, p. 172.

UNFPA has been very active in promoting RH framework for service provision throughout the last three programmatic cycles with particular emphasis on quality of care and services integration into PHC settings. It particularly supported Women's Health Development Directorate (WHDD) especially in the first and second cycle. Target groups were the general population but with special attention to women within their reproductive age and role. Although the services are women oriented, there was no explicit focus on women leaving the door open for the integration of youth and the unmarried. Projects in all program components generated RH materials, services and information that are widely utilized in the Palestinian relevant establishments and service systems particularly MoH and MoEHE .

Although the service provision framework espoused in the Palestinian National Health Strategy 2011-2013 reflects the biomedical model of health care in general including RH as conceptualized by the vast majority of the medical doctors and clinicians who are the prime power holders in the MoH, UNFPA works with the Ministry to ensure integration of the broader RH framework recommended by the ICPD as depicted in Fund's strategic plan. To this end, UNFPA is working concomitantly on a number of levels and directions. Currently on the agenda is working aggressively on the empowerment of midwifery profession and promoting its professional practice by supporting the midwifery programme at Ibn Sina College for Allied Health professions to build the needed professional cadres and develop the existing ones. Working on the service quality deficits the previous and this evaluation diagnosed including management and professional scope of practice definition, supervision and performance appraisal, staffing and infrastructural issues UNFPA's intervention is most relevant being guided by evidence from the field to enhance the bio-psychosocial model in RH care provision as adopted in the ICPD.

Moreover, the situation analysis conducted in 2005 and the subsequent implementation of emergency and humanitarian response projects were tangible examples on the responsiveness of UNFPA to the rapidly shifting situation on the ground, and its attempt to understand and react to emerging needs in a timely manner.

3.2 Relevance of PD programme component

The first goal in Palestinian national policy as stated in the PRDP and illustrated in box 3 below, is safety and security of which the pillars are people's ability to pursue and freedom of violence, where the first implies access and the second implies violence combating. In comparison access to quality RH is core to the UNFPA PoA while materializing UNSCR 1325 the Fund continues to invest heavily in combating GBV on the one hand and support and solidarity initiatives to people living in isolated communities in seam zone by the community based coalitions the Fund had created are still on the go.

Under the second goal of good governance protection of human rights is a key theme that intersects with UNFPA agenda in terms of strengthening public institutions by intervening in the policy areas of integrity, accountability and transparency in addition to institutional capacity building.

Under the third goal of increased national prosperity poverty reduction and equitable distribution of resources crosscut the UNFPA agenda as it applies to gender and women most in need in particular by intervening in developing human capital, health development and education as it applies to RH in the Fund's case.

The fourth national goal is where the Palestinian and UNFPA development agendas as translated in the UNFPA strategic plan and development results framework, ICPD PoA and the PA PRDP are most in alignment. In both cases and reference documents, the interest is in enhanced quality of life with equitable access to services and assistance for vulnerable groups and those with special needs. Crosscutting policy areas under this goal include; emergency relief, unemployment (only among poor women in the case of UNFPA), gender and youth and children.

For a detailed diagram of the Palestinian national policy agenda framework with the goals, objectives and policy areas of each please refer to annex 3.

Box 3: Palestinian national policy goals

*** *Safety and security*:** a society subject to law and order, which provides a safe and secure environment in which the people of Palestine can raise their families and pursue their livelihoods and businesses, free from crime, disorder and the fear of violence.

*** *Good governance*:** a system of democratic governance characterized by participation by citizens, respect for the rule of law and separation of powers, capable of administering natural resources and delivering public services efficiently, effectively and responsively, and supported by a stable legal framework, a robust legislative process and accountable, honest and transparent institutions which protect the rights of all citizens.

*** *Increased national prosperity*:** economic security, stability, viability and self-reliance, achieved through an increase in sustainable employment and an equitable distribution of resources, leading to the reduction and eventual eradication of poverty and the growth of individual and national

Source: Palestinian Reform and Development Plan 2008-2010.

3.3 Relevance of Gender programme component

The MDGs and ICPD goals provide the overall context for identifying the results in the development results framework (UNFPA strategic plan, para 29). Gender equality is one of three defined focus areas in the Funds work. In parallel, PNHS 2011-2013 setting the strategic direction toward getting results identified gender equity within national policies and practices as the second crosscutting issue on its agenda committing to promote gender roles and relations that protect health and provide information and policy advice to policy makers on the influence of gender on health and health care (PNHS, P 19). Additionally, the above stated PRDP clearly have health and gender as two policy areas under its third and fourth goals as discussed above. This is on top of the Cross-Sectoral Strategic Gender Plan, and the MoSA Strategic Plan for Social Protection.

4. Effectiveness of the Country Program

4.1 Findings on the Outcomes of the Reproductive Health Component

Findings under the RH outcomes are presented and interpreted using the service delivery environment component of the espoused framework for achieving in RH program explicated under the section on methods. The said findings address service delivery environment being the situation prospective clients find when they seek services, both in terms of tangible features (e.g., the physical stand, personnel, equipment, and supplies) and the intangibles (e.g., treatment received from the staff). In the causal pathway, these are program inputs. The stronger the input from each of these functional areas, the better will be the services available to clients.

4.1.1 Findings on RH output 1.1: Improved accessibility to integrated, comprehensive, high-quality reproductive health services in 10 service delivery points in villages with restricted mobility; 39 Ministry of Health primary health-care service delivery points; three women's centers; and six hospitals. They are organized in such a way as to describe and assess the service delivery functional areas, access to services and quality of service with particular attention to the integration of services component.

Key achievements in this output area were:

- **Improved RH service availability and access especially in the communities with restricted mobility in seam zone:** UNFPA work with villages/communities with restricted mobility for improved accessibility to high quality RH services was undoubtedly a prime achievement in its own right in this programmatic cycle. Despite the quality issues this evaluation diagnosed and suggested for improvement, yet, most importantly, the Fund brought close to the clients RH services in an integrated manner where the woman could come for and receive more than one service at a time in a health facility that is proximal to or within her place of living. Within its service package it improved supply of high quality equipments and commodities including contraceptives and promoted linkages with the local community and higher level care for high risk pregnancy, and district maternities through better referral system. Distance to the nearest reproductive health facility as reported in this evaluation reflects the commitment of the UNFPA and PA-MoH to provide universal access to health care, translated into resources allocation, particularly to such disadvantaged population areas. Nevertheless, the challenge that remains is that UNFPA continues to work with the same facilities to strengthen and monitor services integration and improved quality before expanding coverage by program scaling up.
- The national surveillance system UNFPA established and effectuated via a national committee it had created and lead during this programmatic cycle in the second half of the year 2008 to work on the critical issue of Maternal Mortality is one of its prime achievements. The fruit of the extensive and

methodical work of the said committee yielded the most accurate measurement of Maternal mortality among Palestinian women in the West Bank being 38/100,000 women for the year 2009 the closest to the PCBS estimate of the same rate being 40/100,000 women in the year 2006 National Health Survey. UNFPA is strongly encouraged to keep track of this vital achievement and maintain its patronage.

- UNFPA made significant investments in the **enhancement of the contraceptives commodity security**. This made it the shepherd of FP services for being the sole contraceptives provider to such key agency as UNRWA securing access to at least three types of contraceptives and meeting the FP needs of the wide WBGS refugee population UNRWA serves. This is alongside similar provisions UNFPA makes to MoH and some NGOs. The Fund must continue with this and expand it to ensure full contraceptives coverage overseeing good supply chain management to ensure contraceptives timely arrival to the users end.
- **Early detection of breast cancer was an area where UNFPA excelled in the evaluated cycle.** The Fund was able to draw and systematically implement a comprehensive action plan for establishing early detection of breast cancer program building the capacity of professionals as a pillar, integrating all key components and working synergistically with other donors under MoH for a nationally sustainable program.
- UNFPA is the Chair UN agency in the UN team group. The Fund made a key contribution in advancing national ownership of HIV/AIDS response by playing an active role in the national AIDS committee. This was by supporting various relevant projects contributing to **reduce stigma around AIDS through awareness raising and knowledge sharing activism**.
- The investment the Fund made in the community linkages it created in the communities with restricted mobility in **reviving RH education and awareness** by use of the Community Support Teams was remarkable. As such contributing to the first objective on RH and rights in the ICPD PoA to ensure that “comprehensive and factual information and.....are accessible, affordable, acceptable and convenient to all users” (para 7.5 a).

A. Service Delivery Functional Areas:

A.1 Facilities Physical Stand

It is to mention that facilities chosen in this evaluation are a subsample of those included in the RH sub-program evaluation completed at the end of the preceding programmatic cycle (2001-2005). This was meant to allow for comparing the changes that might have occurred on the facilities in the interim, with our full awareness of the methodological limitations. In five years time, the overall picture of the visited clinics appeared somewhat better in the West Bank and deteriorating in the Gaza Strip. **The majority of the interviewed RH providers in both regions of the WBGS frequented problems in space and overcrowdedness as key impediments to quality care with particular emphasis on privacy issues.**

In the West Bank, infrastructure in some facilities such as Yatta, although classified as a comprehensive health Center (CHC), appear to be still suffering as was also reported in the above said evaluation five years ago. The facility that serves a large population area was rather **tight and overcrowded with old and poor infrastructure. It has an outdoor toilet with no clean water supply or functioning sink often days including in the day of the site visit, which brings hygiene and infection control practices** in that facility to the spotlight. In addition, except for one mobile phone, other means of communication that could enhance service access and quality including a fax, a care, or a computer are all nonexistent in Yatta CHC. In transporting women with complicated pregnancies, rental cars are used. Addressing a senior MoH official with this it was confirmed that construction of new upgraded clinic is underway and shall replace this one soon upon completion.

As from before, issues to do with privacy and client comfort vis-à-vis infrastructure still exist in that facility. A field note observation describes the situation thus:

“The nurse sits in a room for offering family planning services. The room is very small; around 2X2.5 square meters in size. When the door opens, it bangs against her office. Behind the door, there are piles of accumulating files topping one another annoyingly with chaos. Next to the nurse’s office, the doctor’s office is located; bigger than the first, it occupies the rest of the room leaving no space for even one single chair for the client’s use during the care provision encounter. The client remains standing throughout the care giving process. The fact that two clients are entered into the room simultaneously to receive the service one from the doctor and the other from the nurse makes the whole situation the furthest from quality”.

In Gaza except for Al Bureij women health center, which is an NGO run facility- Culture and Free Thought Association-CFTA, **all visited facilities are in a bad shape in terms of infrastructure and space. Privacy and client-provider information exchange are major issues of concern.** Jabalia CHC in specific was exceptionally overcrowded. **Equipment and furniture are worn out and in dire need of repair, renovation and replacement.** These were reported key challenges providers are confronted with in their daily practice.

A.2 Commodities and Logistics

Appendix V illustrates detailed view of the available supplies and equipment, as observed, being general, essential as defined by the national unified RH protocol, and consumable in addition to BCC-IEC materials with the later discussed under section 4.1.4. For around a quarter (24%) of the responding providers - 28.6% of the West Bank and 18.2% of Gaza Strip, clinics are poorly equipped and many of the equipments are used up. **Requesting renovation/ replacement of such equipments reiterated throughout our visits to most of the studied Gazan facilities.**

This aligned with our findings in the facility observation part of this evaluation. In terms of the general equipments, all visited facilities had a laboratory, refrigerator, means of communication (fax, telephone, or mobile), couches and gynaecological beds. Portable refrigerators were lacking from Yatta CHC, the PFPPA Hebron WHC, both Rafidia and AlShifa hospitals. **The three CHCs of Yatta, Jenin and Jabalia fared least of all lacking four identified items at minimum.** Jabalia for example had no window curtains. In Yatta there was not even one functioning sink or towels. Jenin had no towels, too, but also any soap. Al Bureij fared best with no missing item under this equipments category. **Key missing items hold basic hygiene and infection control implications and trigger privacy concerns** in relation to the no curtains facility where women may need to undress for a particular RSH service they seek at the said CHC.

The essential equipment section demonstrates the availability of equipment necessary for the health care provider to complete physical assessments and procedures required for RSH services in the studied clinics in light of the unified national guidelines. Here Ni'leen SDP and Hebron WHC did reasonably well followed by Jabalia and Yatta while Jenin CHC and Al Bureij WHC did not reflect a decent extent of preparedness in this regard. The later two facilities in addition to Rafidai hospital maternity outpatient clinic were short in no less than 9 such essential equipments as; speculum, glucometer, portable oxygen mask, airway, and suction. The ECG machine was absent in the three facilities of Hebron and Al Bureij WHCs and Al Qarara SDP. So was the Pap smear kits from Jenin, Jabalia, Al Qarara and Rafidia hospital, too, while plentiful (in surplus) in AlShifa. These essential equipments with some being life saving in many RH conditions cannot be accepted to remain missing from such health facilities, not to mention the quality of care a facility would offer with such significant items nonexistent. Work logistics seem to be suffering including in Ni'leen, despite faring best in most other aspects. The ultrasound machine has been out of order since 6 months by the day of the site visit. So was the infant scale in Jabalia.

A reoccurring observation refers to mal-distribution of logistics within MoH facilities. While such main CHC as the central Jenin one was found under or unequipped with vital equipments including gynaecological beds, couches, ophthalmoscopes, and dressing sets these were in surplus in places like Ni'leen SDP that serves a much smaller population in Ramallah peripheries. This is suggestive of the need for better coordination and logistical work within MoH.

The investigation five years ago and this current one appear to be in analogy with respect to consumables/disposables availability in the studied facilities including in hospitals. While some items were in place across all visited facilities such as disinfectant solutions, ultrasound jelly and disposable gloves many were distinctly lacking including items as simple as tongue depressors found missing from AlShifa hospital for example. **Jenin CHC and Rafidia hospital , both in northern West Bank fared worst of all with no less than 8 consumable items missing in each. In terms of regions, Jenin CHC and Al Qarara were most disadvantaged.**

Furthermore, **almost always missing items were central to core RH functions.** For example, urinary albumin dipstick strips and litmus papers, which are both cheap and fundamental component of focused antenatal care, were missing from Yatta CHC . Vaginal crème crucial for performing vaginal exam was

missing from four PHC facilities in addition to the two investigated hospitals. These were; Jenin central, Hebron, Jabalia , Al Qarara, Rafidia and AlShifa hospitals' maternity outpatient clinics. So were IV solutions in Jenin Central , Yatta, and Al Bureij. This is despite the centrality of these solutions to case management in emergencies. **Valid family planning methods were completely absent from Al Qarara and partially available in Jenin central (pills only) and Jablaia (pills and condoms only).** While this could contribute to increasing the unmet needs of FP it could also contribute to abortion complications resulting from unwanted pregnancies and present poor indication on the realization of RH integration of services. Lastly, despite the alarming prevalence rates of anaemia among women and children **valid iron and folic acid tablets and infant syrup were lacking at the time of Jenin central CHC visit.** This was reported to have been happening since one month for the first item and two months for the second. Moreover, the same tablets and syrup were also missing in the two hospitals of Rafidia and AlShifa, which could reflect badly on the said rates in case these deficiencies last longer.

Alongside the above stated commodity shortages, other such equipment as ambulances, cauterization devices, and boilers missing from most investigated facilities are major obstacles to universal access to reproductive health including in emergency situations. It also bring to question the extent to which the facilities as they currently stand reflect the institutionalization of the continuum of care and feasibly speak to the national health needs and priorities.

A.3 Management functions

Mainly physicians, assisted by nurses and/or midwives, provide reproductive health services at the PHC level in clinics. The clinics are open from 8:00am-2:00 pm or 2:30 pm 6 days a week, but doctors employed on rotating basis may not be available at the clinic every day. Clients contact time is shorter than the operating hours because of the limited time of the doctor's availability and the time spared for administrative tasks. On average, it was observed in the visited clinics that the **doctor sees 20-25 women by 12 noon where the service provision typically ends: four women in a quarter of an hour averaging four minutes of client/doctor contact time per woman.**

Clinics' presumed RH staffs reported and were observed handling all types of clients regardless of the sought service being it RH related or otherwise. In some MoH clinics doctors stated that **priority always goes to the general practice (GP) clinic.** Often times, RH doctors are pulled out of their clinics to do GP- when it gets too crowded- and RH service seeking women are requested to go home and return some other day! Hence, as illustrated in tables three and four below, it can well be argued that **staffing in the studied clinics are inconsistent with the caseload and facility catchment area especially in such clinics as Yatta and Jenin Central.** There were no significant differences between the MoH and NGOs facilities in this regard with the exception of Ni'leen SDP where 2 extra midwives were temporarily deployed in a five years project reflecting staffing level that is higher than the norm.

In addition, **understaffing and work overload were reiteratively reported to be a problem** for 44% of the RH providers interviewed; more so for the Gaza Strip (54.5%) than for the West Bank (35.7). The number of nurses and/or midwives responsible for reproductive health services per clinic ranged between

1-6 in the West Bank and 1-15 in Gaza Strip. Similarly, the number of physicians per clinic was much higher in Gaza than in the West Bank. Yet still in terms of provider client ratios in both regions understaffing is common. In the West Bank, physicians were more likely to rotate among clinics, while nurses and midwives were stationed in a single location. In both regions, physicians' work in the clinic is mostly curative clinical with minimal or almost no administrative responsibilities compared to more preventive tasks for nurses and/or midwives on top of considerable administrative responsibilities in both jobs.

Nurses and midwives typically provide clients with services that include; pregnant women care, child care; primarily vaccinations and growth monitoring, home visits for post partum women in some locations, manual breast examinations (MBE) for new ANC and FP clients, supplying family planning methods in repeat visits (except for IUDs), provision of health education and counseling, and assisting the doctor in clinically examining the women in his/her clinic. The administrative work includes taking appointments for the doctor's visit, filling out records and forms, dispensing iron, and procuring supplies in addition to other such similar duties. Together these work conditions brought about low staff morale and high burn out among them as reported in interviews and focus groups discussions.

Such broad scope of practice, roles and responsibilities are supposed to be clearly and precisely delineated in written job descriptions which was reported not to have been the case for most. Of the total providers interviewed, midwives (diploma holders) or qualified midwives (B,Sc. holders) constituted a little more than the half . Of the same total, **a little more than a third (36%) reported having a job description with only 28% reporting having it in written.**

In the second programmatic cycle UNFPA invested tremendously in RH protocols development with active involvement of key players and stakeholders. On following these RH protocols in daily practice, 60% reported protocols and guidelines guided practice versus 32% who reported no such manner of practice and 8% who were completely unaware of the existence of such protocols in the first place, let alone employing them in practice. Table 5 below shows the regional variations. Most alarmingly, **only a third of the Gaza compared to more than 90% of the West Bank providers reported actually following the protocols in daily practice.** This is regardless of their participation in writing these protocols up or being trained on their implementation. When asked about impediments to following protocols in daily practice, the followings were stated; no space and over-crowdedness, overly detailed protocols for overcrowded clinics, and understaffed, undersupplied and underequipped clinics including in provision with FP methods. Therefore, some respondents argued that **conditions for adherence to or following the protocols do not exist at the first place**, which together with its disconnectedness to performance measurement act as de-motivating factors in this matter.

Table 3: General information about the health centers/clinics by selected parameter

Selected parameter	Ni'leen	Hebron PFPPA	Yatta	Jenin Central	Jabalia	Al Qarara	Al Bureij CFTA
Type of Facility							

	SDP	WHC	CHC	CHC	CHC	SDP	WHC
Average Number of Clients at this Facility per/m	750	600	4500	370	11770	4000	600
Average Number of Maternal Health Contacts at this Facility per/m	80	550	200	280	1900	700	400
Name and Location of Nearest Health Centre	Qibia 5min.	Red crescent 5 min.	Yatta association 50 min. walk	West & east clinic 5 min.	Jabalia UNRWA clinic 10 min	Bandar KhanYounis polyclinic-MoH 5 min. walk	Al Bureij UNRWA Health Center- 2 min. walk
Name & location of Nearest Hospital	Ramallah Hosp. 45 min drive	Alia hosp. 5 min. drive	AlMinthar hosp. 3 min. walk.	Jinin hosp. 5 min drive	Kamal Idwan 10 min. walk	Shouhada Al Aqsa 10 min drive	Shouhada Al Aqsa 5 min. drive

Table 4: Staff employed at the PHC level health facilities by post category

Staff member title	Ni'leen	Hebron PFPPA	Yatta	Jenin Central	Jabalia	Al Qarara	Al Bureij CFTA
Nurse	3	-	2	-	12	10	1
Midwife	3	1	3	4	3	1	1
General Physician	1 female Dr.	1	2	-	10	6	1
Obstetrician	-	-	-	3	-	-	1
Paediatrician	1	1	-	1	-	-	1

Lab Tech.	1	1	2	1	3	2	1
Clerk	1	1	2	2	5	5	1
Cleaner and/or handy person	1	1	1	1	5	3	1
Driver	-	-	-	5	-	-	-
Others	Pharm. & x-ray tech.	Social worker	Pharm. 2	Health worker 2 days / week	-		Pharm. & Psychosocial counselor

Table 5: Providers' reported availability and use of protocols in practice by region

Provider reporting aspect	West Bank %	Gaza Strip %
Have written protocols that guide daily practice	78.6	36.4
Was trained on protocols' implementation	54.5	75
Follow the protocols in daily practice	90.9	33.3

* Total N= 25.

Almost all respondents reported having a say in the decision making process regarding the care provided to the clinic beneficiaries including via formal and informal meetings held in the clinic. Around 70% and 15%, consecutively, hold regular unofficial and official meetings to discuss clients clinical affairs compared to 61% and around 28% who hold unofficial and official regular meetings, consecutively, to address clinic management issues.

About supervision, **28% reported not receiving any form of supervision** compared to 44% who reported having been supervised through field visits the direct supervisor pays to the clinic. The received supervision is of administrative nature for 72% and of technical one for 28% of the supervised interviewees. For 40% these supervisory visits are inadequate or do not fulfill needs. Moreover, for more than 30% the said visits are either not beneficial at all or only of limited benefit lacking constructive feedback and support. One respondent labeled it as "*fault hunting missions*". As such, **80% reported their desperate need for other forms of support. Primarily, morale support (recognition and appreciation) came first, responding to training needs and addressing clinic understaffing, sequentially followed.** Table 6 below shows the regional differences in this. Although it could be said

that Gaza Strip is doing better than the West Bank in the actual occurrence of the supervision function yet adequacy, usefulness and subsistence remain a concern in both regions.

Table 6: Providers' reporting on received supervision by region (%)

Supervision aspect addressed	West Bank	Gaza Strip
Providers report being supervised	64.3	81.9
Supervision is adequate (in frequency)	71.4	63.6
Supervisor is useful (in feedback or support)	50	72.7
Providers report need for other forms of support	85.7	72.7

* Please note that figures in the later three rows rest on those on the first as their totals (100%)

On another level, 80% of the interviewed RH providers have their performance appraised while the remainder 20% either do not or do not know if it gets appraised or not. Means of such appraisal were fair for only 40% of whom 78% receive constructive feedback. For the remaining 60% the used confidential appraisal allows for abuse of authority on the side of the appraising person. More importantly, it does not promote accountability or improve quality because people never know how well or bad they do in practice. Be region this finding is rather interesting. While 100% of the WB interviewed providers reported having a performance appraisal yet only around 29% consider this appraisal as being fair and acknowledge receiving a feedback from their senior in light of the completed appraisal. For Gaza, the picture is reversed. While only around 55% of the interviewed have their work appraised around 67% consider this appraisal fair. This goes along with the finding on the use of confidential appraisal much more in the West Bank than in Gaza.

Table 7: Performance appraisal of RH providers in the clinic by region

Appraisal aspect addressed	West Bank %	Gaza Strip %
Work is appraised	100	54.5
Appraisal mechanism is fair	28.6	66.7
Feedback from the appraising senior is received	28.6	33.3

* Please note that figures in the later three rows rest on those on the first as their totals (100%)

A.4 Behavior Change Communication BCC- IEC Materials

The BCC-IEC audit indicates that facilities were similar in terms of items availability and deficiency. Almost all were found having; advertisement boards, updated, printed health education material to distribute to clients such as pamphlets for example, TVs, videos and video cassettes. Likewise, almost all clinics did not have female pelvic skeleton, childbirth simulator and neonate/infant doll. Ni'leen was in the worst shape in this along with Jabalai and Yatta compared to the better off Jenin central, Hebron and Al Bureij WHCs with the later faring best of all missing only the childbirth simulator.

Findings from the providers' interview in table 8 below line up with the audit finding above. They also show the regional differences in the BCC-IEC materials reported availability, use, usefulness and providers' role in generating them, which were all on behalf of the West Bank compared to Gaza with the exclusion of the materials use as part of the counselling sessions where the Gazan providers fared better than their West Bank counterparts.

Table 8: Reported BCC-IEC materials selected aspects by region.

BCC-IEC aspect addressed	West Bank %	Gaza Strip %
BCC-IEC materials are available <i>on a regular basis</i>	71.4	45.5
BCC-IEC materials are used <i>on a regular basis (when available)</i>	71.4	72.7
BCC-IEC materials are useful /very useful	78. 6	63.7
Ways of using IEC materials:		
• Used <i>as part of the counseling sessions</i>	75	88.9
• Give material to women <i>by hand</i>	25	11.1
Provider role in generating BCC-IEC material is by		
• Have a role in setting topics for materials	78.6	27.3
• Have a role in writing the content of the material	14.3	9.1

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* Please note that figures in the later four rows rest on those on the first as their totals (100%)

Taking this a step further both in our FP and ANC -CPI observations we verified the actual use of BBC-IEC materials in client provider information exchange processes. Table 9 below illustrates our finding classified by region where the same picture reiterated. **West Bank providers were very much ahead of their Gaza counterparts in using appropriate IEC materials in interacting with their clients both in FP (92.3%: 7.7%) and ANC (100%: 0%) information exchange processes.** They were also ahead, but with a narrower regional gap, in giving client IEC reading material when available.

Investing in behavioural change messages and IEC materials is believed to facilitate the desired changes in the population by introducing effects to relevant attitudes being the normative facet of the strategic social change. This aligns well with our adopted causal pathway hypothesis introduced earlier in chapter two.

Table 9: Observed BBC/ IEC materials Usage in FP and ANC CPIs by region

FP CPI observation of BBC / IEC materials by region				
Did the provider:	West Bank %	Gaza Strip %	Positive N per item	
Use appropriate IEC materials	92.3	7.7	N=13	37.1%
Give client IEC reading material (if available and appropriate)	54.5	45.5	N= 22	62.9%
ANC CPI observation of BBC/ IEC materials by region				
Did the provider:	West Bank	Gaza Strip	Positive N per item	
Use appropriate IEC materials	100.0	0.0	N= 17	48.6%
Give client IEC reading material (if available and appropriate)	56.0	44.0	N= 25	71.4%

* Total N=35 (20 in WB & 15 in GS)

A.5 Training and Performance Improvement

Training and performance improvement are key quality instruments MoH and Palestinian NGOs invested in for years toward capacity building and performance improvement with substantial support from UN and other donor agencies. To this end, an interviewed policy maker from UNRWA speaks of training as a cornerstone in UN joint programming and partnership building. He reports that along with other UN agencies including UNIFEM and UNICEF, UNRWA UNFPA partnership on AIDS awareness is a sign of successful joint programming and harmonization among UN sister organizations in response to the United Nations Reform strategic objective to leverage the internationally agreed MDGs. In turn, such work environment is expected to augment the momentum for implementation of the ICPD programme of action in Palestine. Within the framework of this partnership, UNRWA health department trainers delivered AIDS training using target group tailored training packages to college staff and students, schools, various health professionals' categories such as dentists, GPs, midwives and nurses in addition to media actors. The partnership still has three years to go whereby AIDS training will be delivered to various other audiences. On the longer run, UNRWA intends to capitalize on this joint programming venture and proceed with it further investing in the would have been achieved capacity building amongst its AIDS trainers.

Asked about participation in training, the majority of the interviewed RH service **providers reported having received training on high-risk pregnancy protocol, emergency delivery and obstetric care, breast examination, and infection control.** However, tremendous training needs still exist and were recognized as key challenges in enhancing staff technical competence and quality of care especially in Gaza Strip. This indicates that providers value and are aware of the significance of training toward their professional growth and improvement of the quality of the services they can offer their beneficiaries. Nevertheless, **they were skeptical about the system tolerance of training substance integration into the clinical operations on site given the unfavorable work conditions including over-crowdedness and understaffing where most providers find themselves obliged to operate.** Moreover, providers were particularly critical of a number of relevant practices in this regard of which the prime ones were; **non-professional based nominations for training, no dissemination of training substance to other colleagues, and de-contextualized training of limited applicability, that is to say lacking mechanisms and structures needed for implementation in the service settings.**

This means that **attending to the staffing and space issues within the facilities is a pre-requisite to other core professional aspects of institutional building.** To this end, it draws attention to read the Independent Commission for human Rights report on the “the Right to Health Status in the OPT”(2008) whereby it clearly expresses concern over the fact that 40.9% of the MoH cadres are administrative staff at the time when this percentage should not exceed 20% by international standards.

Where the Palestinian health service suffers understaffing of technical staff especially in nursing and midwifery this becomes an area in need of corrective measures.

Table 10: Priority areas and topics as recognized by the interviewed providers (%)

Management Skills	
Giving feedback to employees	84.0
Setting priorities at work	80.0
How to support / motivate your staff	80.0
Supervision skills	76.0
Time management	72.0
Team dynamics	72.0
Management by participation	72.0
STIs & STDs	
Candidiasis	72.0
Bacterial Vaginosis	72.0
Pelvic Inflammatory Diseases	72.0
Cervical cancer	
Early detection of cervical cancer	80.0
Pap smear	76.0
Interpretation of pap smear results	74.0
Maternal Health	
Prevention of anemia during the reproductive cycle	76.0
Proper diet during pregnancy, lactation & postpartum.	70.0
Neonate Care	
Danger signs	80.0
Infection prevention	74.0

* Other topics where the total percentages were less than 70% were not included in the table above.

Requested to **identify their training needs priorities, out of 14 different areas, providers gave highest priority to topics falling within the five areas of; management skills, STIs and STDs, cervical cancer, maternal health and neonate care.** In fact, it can be claimed that the identified priority areas are a true reflection of the Palestinian RH training profile. Areas such as antenatal care, breast feeding, and family planning where considerable training has been already delivered were not selected as training needs priorities by the interviewed or focus groups participants . On the other hand, to some extent the identified needs validate earlier findings and discussion on management issues such as usefulness, adequacy and support provided (or not) through the supervision function. In the same line, as can be seen in table 10 above between **72- 84% of the interviewed providers reported being in need of seven different management skills with highest priority going to giving feedback to employees.** STIs and STDs were recognized by 72% as another training priority area. Cervical cancer, maternal health and neonate care followed with rank one priorities being; early detection of cervical cancer (80%), prevention of anemia during the reproductive cycle (76%) and danger signs (80%) in each, consecutively.

Training if well planned, executed, geared and capitalized on have the strong power of agency in an organization. For it changes the knowledgebase and expands the capacity and perspectives of actors within it. For training schemes to harvest better crops, the design must be context based and strategically oriented. Of great importance is the need for it to incorporate monitoring and follow up mechanisms and dissemination plan components. There can be no doubt that selection of participants must be professionally based where nominations are made in light of predefined criteria for it to make an impact.

B. Access to Services

A primary strategy of health programs is to increase access to services. Different approaches to increasing access include establishing additional facilities, training more health workers, increasing outreach activities, and so forth. Despite the widely acknowledged importance of access as a key feature of the supply environment, this factor is often not assessed in RH program evaluation. Typically, however, some of the previous research in this area has focused on one aspect /dimension of accessibility: geographic (or physical) access. In this context, access refers to the degree of difficulty in reaching or obtaining reproductive health services. A variety of measures in relation to the distance to service points/ clinics, the time required to reach these points, and the density of service/supply points within a specified geographic area have been suggested in literature (Tsui and Ochoa, 1992). Access is a reflection of the degree of difficulty (or ease) in admittance to services that involves the dimensions: geographic or physical, economic, administrative, and cognitive (Foreit et al., 1978).

Geographical/physical access signifies the time required to reach the nearest service delivery site offering a specific type of reproductive health service. In this evaluation, data from facility audit and service users' focus groups discussions provided us with estimates of travel time between the clients' residence town/village/neighborhood and the nearest two types of service delivery sites: a clinic/health center and a hospital. Except for Ni'leen, which is 45 minutes away from Ramallah Hospital (by car), **all other centers and hospitals were inside towns/villages within only 5-10 minutes walk or drive, that is to say proximal/within the communities of the service users.** Thanks to the huge investments UNFPA and

other donor agencies made in supporting the MoH and local NGOs in these facilities for bringing the service close to its potential users instead of them having to go for it crossing the Israeli checkpoints and paying the opportunity costs these checkpoints have got to inflict upon them.

Overall, economic access in the form of cost of travel to the facility does not appear to be a significant access issue, which is believed to be connected to service physical proximity as discussed above. In terms of the cost of the sought RH service both in the MoH and NGOs facilities **clients contribution with out-of pocket expenses remain symbolic and therefore do not impose significant economic burden on the side of service users** as confirmed by women in focus groups discussions. Furthermore, as regards contraceptives costs in specific, UNRWA interviewed official confirmed that within the framework of a long-term sister organizations partnership **UNRWA currently receives its contraceptives needs in full from UNFPA securing clients access to contraceptives and meeting the FP needs of the wide WBGS refugee population UNRWA serves**. In addition, the same official underscores that UNFPA should be recognized as the gatekeeper and the spearhead agency in provision with contraceptives to fulfill due needs nationwide similar to UNICEF as regards immunizations. While this puts UNFPA in full responsibility and accountability in this it boosts its capacity and control over addressing and responding to the unmet needs in FP; item 5.6 of target 5.B concerned with achieving, by 2015, universal access to reproductive health under the fifth MDG “Improve Maternal Health”.

Administrative access refers to the existence of barriers to services in the form of unnecessary formal program policies, regulations, and procedures; such restrictions, mandated at the policy/program level, exceed those justified on medical grounds.

On administrative access related to supply chain management, a field anecdote from Yatta CHC points to **the deficient FP service and women’s limited right to choice of method and free access to services evidence their unmet needs in FP**.

The note says; a woman was seen leaving the clinic grumbling and rather bothered. The nurse asked about why was that so said that she sent the woman home and told her to return some other day for her sought IUD insertion. She explains, *“I only have 12 IUD sets which I already used today. Nothing sterile is left to use for her. Three other women were sent home for the same reason today. I hate having to do this but I have no time to sterilize the used sets and re-use same day for it is a two-hour long process- a time I can’t spare for doing this and leave other tasks pile up”*.

Even worse, in Al Qarara SDP no family planning method is available to clients since June 2009. Prior to that, the same SDP used to attend to an average of 120-150 FP clients per month and now it attends to a very limited number of clients who purchase the IUD from the market (pharmacy) and brings it in to the clinic for insertion. This **evident poor administrative access to FP services raises concerns over service integration, contraceptive prevalence, fertility rates and the program impact altogether**.

Clinics over-crowdedness frequently noted under the service delivery functional areas above is another vital dimension to administrative access. **Uncomfortable waiting spaces and conditions and poor visual and auditory privacy standards indicate the urgency for investing in the clinics infrastructure for more and better-suited spaces and correcting the staffing deficit as two crucial interventions for system development from an access perspective. Not to forget that from the human rights standpoint, clients' rights for privacy and confidentiality are systematically being violated here!**

Home visits conducted only by Ni'leen SDP and Hebron and Al Bureij WHCs staff are both administrative and psychosocial (cognitive) access bonus to these three facilities. Administrative for it denotes flexible procedures and policies within the service and psycho-social because it attends to such barriers as discomfort or social restrictions including fear of blame/criticism for going out of the house before the 40th postpartum day as in the tradition of most rural communities. This is not to forget that home visits indicate adoption of the service integration approach to RH service delivery.

Cognitive access refers to knowledge about services availability and ability to reach and use them. This type of access was assessed in ANC CPI observations. As it can be seen in table 11 below, providers seem not to be that concerned about this part of the women cognitive access. Only in a limited number of encounters not exceeding 25.7% at best were they keen to find out about the clients knowledge of this. Knowledge about service availability and the intention to use them are instrumental to clients' health seeking behavior, service utilization and subsequently maternal and newborn health outcomes. **Providers need to invest more in ensuring women's cognitive access to RH services.**

Table 11: Cognitive access as communicated in ANC CPIs observations by Region				
Did the provider do the followings?	West Bank	Gaza Strip	Positive N per item	
	#	#	#	%
Ask client where she plans to deliver	7	0	7	20.6
Ask client how far to closest health facility or to get TBA	6	0	6	17.1
Ask client where she plans to go if she has an obstetric problem	8	1	9	25.7
Ask how far to the closest health facility or to get TBA if obstetric problem	6	0	6	17.1

C. *Quality of Care*

Quality of care has been a central focus of the international RH programs for the past decade. Consistent with the major theme of the 1994 ICPD Conference for more client-focused services, many governments and NGOs worldwide designed and implemented initiatives to improve quality of care within their service delivery environment.

The paradigm behind much of this work is the Bruce/Jain framework as explained earlier in chapter 2 under methods. For feasibility reasons, in subsequent sections, the two most widely sought aspects of RH care being ANC and FP services, which were particularly observed in this evaluation are emphasized henceforth as models for quality of care examination.

C.1 *Appropriate constellation of services: Indicative of Service integration?*

Facility audits provided detailed information on the range of RH services provided at the different facilities, to establish whether the service package being provided complies with the original program design. As set, the design suggests that SDPs offer ANC (without high risk), FP, PNC, health education including counseling, and MBE. CHCs on the other hand, were meant to offer wider-range services adding STDs and Pap smear to the ones offered at the SDPs but also incorporating the high-risk pregnancies into the ANC service component. Psychosocial counseling is the comparative advantage of the WHCs.

Table 12 below shows a compilation of all RH services that were available and offered (or not) in the visited clinics at the time this investigation was completed regardless of their categorization as in the above-described facility type being SDP, CHC or WHC. This is because going over the service data collected in the clinics audit and illustrated in the table **we detected nonconformity with the defined service package**.

Table 12: RH services provided in the sampled PHC facilities supported by UNFPA

Provided here	Ni'leen SDP	Hebron PFPPA WHC	Yatta CHC	Jenin Central CHC	Jabalia CHC	Al Qarara SDP	AlBureij CFTA WHC
Antenatal care	✓	✓	✓	✓	✓	✓	✓
Family Planning	✓	✓	✓	✓	✓	X (NA)	✓

Postpartum care	✓	✓	✓	✓	X	X	✓
STDs	✓	✓	✓	X	✓	✓	✓
Home visit	✓	✓	X	X	X	X	✓
counselling	✓	✓	✓	✓	✓	✓	✓
Early detection of Cancers*	✓	✓	✓	✓	X	X	✓
Antenatal Care for High Risk Pregnancy	X Referred to MCH Ramallah	X	X		✓	✓	✓

* This includes manual breast examination (MBE) and Pap smear.

Service availability and offer are clearly inconsistent with the specific facility categorization as in the said package with significant omissions especially from the CHCs that are meant to provide a wider range of RH services, including antenatal care for high-risk pregnancies, screening for STIs, and cervical smear examinations, in addition to the basic package provided at SDPs. Meanwhile, services that are not meant to be available in the SDPs, according to program design such as STDs treatment and pap smear for example were on offer. An incongruity MoH needs to address be it an issue of planning or need.

In the West Bank, Jenin Central-CHC was not offering STDs treatments, home visiting and antenatal care for high-risk pregnancy, while in Gaza strip, AlQarara SDP was found lacking four RH services including; family planning, postnatal care, home visits and early detection of female cancers (both breast and cervical). Then Jabalia CHC followed missing three fundamental RH services. Jabalia shared home visits and early detection of cancers with AlQarara noting that both clinics serve the Gazan women population. Alongside Yatta CHC, home visits are notably missing from 4 different facilities: 2 in each region.

The situation in Ni'leen SDP where a small RH package is supposed to be offered is an ambitious model of quality RH services. During the field visits, the situation in this facility was rather advanced compared with its counterparts and its own history. All RH services were offered to all seekers in an integrated and organized manner. All service components and activities were offered according to protocols. The facility was well equipped with appropriate space and infrastructure. Privacy considerations were maintained as needed in all client provider interactions. Nevertheless, in the previous sub-program evaluation, five years ago, this clinic was reported to have been offering poor quality services. Hence, finding out about the reasons of such change was deemed worthwhile. In our search, we learnt that the Norwegian government supports this facility among few others including by hiring two rotating midwives who work three days a week in Ni'leen whereby they provide ANC, FP and PNC with a home visit component. It was observed

that the RH clients seeking care in this SDP receive quality RH services implemented by the assigned midwives. Nevertheless, with the third year of the project life nearing closure, the fact that only two more years are left rings the bell as to what would become of the service quality when the project ends especially as regards the midwives it hires. Even though a female doctor is part of the permanent SDP team, clearly, three such care providers can provide better quality service than only one! In fact, Ni'leen SDP provides evidence on the difference proper and adequate staffing could make on the care provision process and the overall quality of care.

When asked about problems most challenging to the carry out of daily practice in clinics, for the interviewed providers from **Gaza most critical challenges were of service constellation nature such as; out of stock medications and shortages in equipments and consumable supplies** most importantly in respect with RH services was the near finish supply of FP methods resulting from the Israeli imposed blockade on Gaza. Whereas for the **West Bank, the most confronted challenges was lack of adequate technical professional cadre and limited physical space both resulting in clinics' crowdedness**. To this end, 64% of the interviewed believe these shortcomings bear heavily on the quality of care they are able to offer their beneficiaries in addition to the overall health status of the population.

This is by different means including very short duration of client provider encounter and clients growing dropout rate due to their awareness of the lacking FP methods, treatments and medications (particularly in Gaza). This coupled with the growing poverty levels indicate that those who do not seek health care in the public health facilities cannot afford to seek it in the private ones and therefore they are likely not to seek it at all leaving their health status deteriorating and health care needs unmet.

C.1.1 Antenatal Care

Antenatal care is one of the most widely sought services in the RH health care facilities. Looking into the facility audit data presented in table 13 below, **it can be seen that an exaggerated service utilization was noticed in the average number of ANC visits a low risk pregnant woman pays the RH clinic in Yatta and Jenin Central CHCs: 15 and 13, sequentially**. This is more than double the average number of ANC visits recommended in normal pregnancies. On the other hand, these two facilities do not offer ANC for high-risk pregnancies, which they should by their RH package definition. Moreover, in Yatta, the team was told that rental cars are used to transport women who come to the facility and are found to be high risk.

Alongside, our ANC-CPI observations indicate only a quarter of the ANC visits are first visits while the other four quarters are follow-up ones which suggests that most of the made visits are routine ones only. **Numerous, routine ANC visits overburden women and healthcare system**. In fact, clinics' crowdedness was a reiterating remark in this evaluation. Then it would be worthwhile to **encourage rational use of resources and consider WHO recommendations on reducing the number of visits without affecting outcome for mother or baby; a minimum of four visits per normal pregnancy can suffice if focused ANC approach is adopted** (Carroli et al., 2001). This approach emphasizes; evidence-based, goal-directed actions, individualized, woman-centered care, content and quality versus number of visits i.e. quantity and care provided by skilled providers.

About Tetanus Toxoid administration in government clinics, all interviewed and focus groups participating **providers were familiar and in conformity with the disseminated MoH protocol**. As in the said protocol, pregnant women seeking ANC are asked about if they took the 9th grade TT dose at school. If the answer is positive and the woman is at more than 30 years of age, she is given one booster dose anytime in pregnancy. The recall effect here is potentially high implying significant maternal health risks. Nevertheless, the fact that the percentage of home deliveries does not exceed 2.8% nationally: 4% for the West Bank and 0.9% for Gaza Strip (PCBS, 2008) indicates that the vast majority of births are being attended by skilled health personnel having been taking place in a health facility where sterility and hygiene measures are expectedly maintained. The negligible number of reported Tetanus cases, which are all of home delivery, supports this analysis.

As for iron supplementation, **universal supplementation regardless of the woman's iron status still is the policy** as was found out five years ago. In all West Bank facilities, percent of ANC clients receiving iron supplements was 100% except occasionally when they run out of stock, which rarely happens, we were told. For Gaza, in clinics where the coverage is less than universal we learnt that women get the supplements from UNRWA facilities free of charge.

Table 13: ANC Services in the sample of PHC facilities supported by UNFPA

Element of care	Ni'leen	Hebron PFPPA	Yatta	Jenin Central	Jabalia	Al Qarara	AlBureij CFTA
Provided here	✓	✓	✓	✓	✓	✓	✓
Average # of ANC clients/ month	80	120	123	250	750	160	150
Average # of ANC visits a woman has	7-8	12	15	14	8-9	8	10
% of ANC clients receiving TT vaccine	2% as in Protoc.	NO	100%	4% as in protoc.	12%	60%	NO
% of ANC clients receiving Ferrous sulf+ folic acid, tabs	100%	100%	100%	100%	100% folic acid	90%	70%

60mg+0.25mg					is NA)		
% undergoes a physical exam	100%	100%	100% 1 st visit only	100%	100%	100%	100%
% of ANC clients receiving HB test	100%	99%	100%	100%	100%	100%	50%, the rest come with their results from UNRWA or Gov. clinics for cost savings
Frequency/ pregnancy	2-3	5	3-4	3	3-4	3-4	
% of ANC clients receiving Blood grouping	100%	99%	100%	100%	100%	100%	
% of ANC clients receiving Urine protein test	100%	100%	100%	100%	100%	100%	
Frequency/ pregnancy	2-3	8	3-4	3-4	9-12	9-12	

In addition, more than 85% of our ANC-CPI observations show that **providers ask women about the availability of iron and provide them with the supplementation when needed, but nothing on how to take them and on possible discomforts or side effects, or on what foods augment/diminish iron absorption.**

More critically, no single attempt to check compliance was observed in any of the studied facilities. These quality of care deficits manifesting in the prevalence of anemia among pregnant women standing at 31.1%: 31.4 for the West Bank and 36.4 (PCBS, 2002) despite all the efforts bring to question the received estimates of the monthly number of women counseled in/on pregnancy in the studied facilities as illustrated in table 16, which in turn raises concerns about the providers' definition of what constitutes counseling really.

Anecdotal observations indicate that the national family health survey PCBS intends to carry out this year (2010) will reveal a rise in the prevalence of anemia among pregnant women in light of the progressively rising unemployment and poverty levels in Palestine. If this turns out to be the case, sever MCH outcomes will be new added burden both the Palestinian health system and humanitarian aid agencies including UNFPA will urgently need to deal with.

As for laboratory tests, providers in all studied RH offering PHC settings reported that all women have their hemoglobin tested at least three times in pregnancy, and possibly more frequently for anemic

women. Blood group was also established for new pregnancies. All facilities conducted urinary albumin at least once, with a range of 2-4 times during the pregnancy in the West Bank Government facilities and a higher frequency in Gaza and NGO settings (8-12). Thus, in conclusion, **all facilities conducted the basic tests of hemoglobin, urinary albumin, and blood typing at least once, with slight variations in frequency.**

C.1.2 Family planning Services

National data from the PCBS (2006) health survey indicate that there is a slight regress in utilization of FP services with a considerable gap between the two regions of the West Bank and Gaza Strip: 54.9% and 41.7%, sequentially with the overall percentage being 50.2% compared to 50.6% in the year 2004. So is it a matter of deteriorating availability or utilization of FP services?

As illustrated in table 14 below **apart from AlQarara all of the sampled clinics provide at least three family planning methods and therefore secure women a reasonable choice of method as such.** Oral Contraceptives are the most widely used method followed by condoms and IUDs sequentially. Compared to the five years ago RH evaluation where low condom availability and demand were reported, a notable **progress appear to have occurred on condom utilization making of it a success area. Thanks to the improved supply chain management plan adopted for condom distribution and promotional strategies obligated by the PHCD at MoH.** The director of PHCD as a key policy maker at MoH talked about a new formula of partnership between the MoH and private sector whereby **condom utilization is promoted passing through the marketable concept of STDs prevention.** PHCD-MoH provides the private obstetrics practitioners with the condoms free of charge and the later reports all STD cases that come to their private clinics to PHCD where designated staff feeds it into the appropriate databases and surveillance system. He reports that in March alone, 45,000 condoms were distributed followed by 180,000 in April and May 2010. This formula, he confirms, is multi purpose: **condom use in FP is promoted, STDs are prevented and monitored, STDs surveillance system is constructed, and local partnerships are usefully built.**

Nevertheless, the Ni'leen figures on condom use tell us that still **more awareness and sensitization efforts need to be invested in condom promotional activities/campaigns, on the supply side perhaps as well as the demand one. Skilled providers must be more resourceful, informative and persuasive to people in condom counseling, awareness and sensitization emphasizing its role in STIs/STDs including HIV-AIDS besides being a family planning method.**

On the other hand, the situation at AlQarara SDP remains worrying and requires prompt action, especially given the considerable number of its FP clients stated in table 14 to underscore **the unmet FP needs resulting from the non-availability of FP methods** in the said clinic.

Findings on abortion complications cases at AlShifa and Rafidia hospitals estimated to be rather high in them both hold further indications on FP methods utilization. While it can be argued that the reason to this could be the unmet FP needs in the Gaza Strip, the West Bank parallel draws attention to convoluted socio-economic and political factors that are in fact external to both the UNFPA program and the MoH and other service providers. At the socio-cultural front there lie the prevalent marriage patters including the long reproductive and pregnancy exposure of women involved in early marriage alongside the customary consanguineous marriage (45.4%) power relations and family dynamics that put women under heavy extended family/tribal pressure and obligations to preserve the status and power of the extended family by bearing more children and keeping it “well sized” in the social standards. Furthermore, right after the political turmoil beginning late 2000, the sweeping sense of human insecurity and child survival deterioration started to gear reproductive choices and the numbers of children Palestinian women choose to have towards child quantity to compensate for potential losses in quality³. In the same line, parents fearing the ever growing potential of their children migration in future if the current political and economic situation persist, have only little faith in the value of making small families, for they would rather remain with some of their children if some others choose to emigrate.

Individually and collectively, these factors are central to the choices Palestinian women make with regards to use of FP methods or not which could markedly expose them to more abortion complications risks compared to their counterparts elsewhere. To this end, some interviewed experts and focus groups discussions participants **expressed concern over the noted reversion in FP services nationwide. Therefore, within the scope of the Fund’s mission and mandate RH concept must be re-emphasized and alternative strategies in FP services provision must be considered hand in hand with relevant human security interventions.**

Table 14: FP Services in the sample of PHC facilities supported by UNFPA

Element of care	Ni’leen	Hebron PFPPA	Yatta	Jenin Central	Jabalia	Al Qarara	AlBureij CFTA
Offered here	✓	✓	✓	✓	✓	✓	✓
Average number of clients receiving FP	100	200	180	165	200	120-150	200

³ Currently, Palestinian households are not being able to purchase/attain significant improvements in child survival regardless of income. Access to food and health care services and technologies are particularly jeopardized. Becker's theory of quality quantity tradeoff emphasizes the central role of making child survival more affordable materially and otherwise before expecting to see fertility declines in a population. When child quality (i.e. survival) is more expensive and risky, households resort to child quantity.

services each month							
Approximate number of women who receive a contraceptive method in any given month							
Condoms	1	40-50	40	29	22	NA	125
Pills (Oral Contraceptives)	30	100-120	80	9	102	NA	150
Depo Provera-inject.	-	3-4	5	-	22	NA	-
IUD	10	100	55	11	-	NA	12
Others: supp.	2	-	-	-	6	-	-
Condoms							
# of condoms a woman receives per visit	No cases *	10-40	15	10	15	15	12
Average frequency/year a women returns for refills	between pills rounds	2-4	12 once/month	15	4-9	5-10	24 : 2 rounds /m

* Couples are reluctant to use condoms.

C.1.3 Postnatal Care

Postnatal care is typically the service women utilize least. Progress made across time starting from 1996 shows that, nationally, 50% increase was made over ten-year period with only 30% of all delivering women reporting having received postnatal care at 2006. The percentages for Gaza Strip registered a steady increase arriving at the doubling point by the said year. Whereas, the West Bank witnessed a steady increase until 2004 after which time an alarming regress was registered with 7.3% relapse denoting the tightened Israeli mobility restrictive measures in the said period as a highly potential underlying reason (PCBS, 2008).

Reasons for nonuse of postnatal care were investigated in one study. Out of 264 postpartum women surveyed, the most frequent reason for not obtaining postnatal care was that women did not feel sick and therefore felt that they did not need postnatal care (85%), followed by **not having been told by the doctor to come back for postnatal care (15.5%)**. Fewer women were not aware of the service availability, had no one to take care of the children, did not want to go out before 6 weeks after delivery

conforming with the traditional norms, or stated having experience with previous deliveries and therefore not in need of additional information (Dhaher et al,2008). **Stated non-use reason denoting client-provider information exchange and cognitive access deficits suggest strengthening and institutionalization of outreach programs in the form of home visits as an integral component of RH care services.**

Our facility audit implies that in Gaza, only AlBureij WHC offers the counseling element of the postnatal care compared to the service being totally absent from Jabalia and AlQarara. In the West Bank, Yatta clients receive postnatal care only when they come for vaccinating the newborn. Hebron CHC and Ni'leen SDP, however, offer more systematic postnatal care where women pay an average of 2-3 visits to the facility particularly for this purpose, and receive counseling and micronutrients supplements (iron and folic acid) in addition to complete CBC one week after delivery.

Home visits are reported to be done only in two locations; Ni'leen SDP and Hebron WHC. On average, the visit lasts between 20-30 minutes where the woman is counseled about herself and her baby well being, given her iron and folic acid supplements as well as her infant Vitamin A & D drops. In the Hebron WHC all home visited women are referred to the clinic for a follow up clinical encounter. In conclusion, **integration of postnatal care into RH care services did not receive the needed attention of health planners or care providers for it to reflect on clients' health seeking behavior, service utilization and maternal and child health outcomes as upheld in the continuum of care notion.**

C.1.4 Other RH Services

Table 15 below shows the facilities where STDs symptomatic treatment with antibiotics and antifungal medications prescriptions is offered. This includes in three sites in the West Bank of which one is SDP (Ni'leen), another is an NGO and only one is an CHC (Yatta). One NGO facility in Gaza Strip provides similar services. The service being against payment puts service affordability in doubt given the economic hardship in Gaza, in particular. It draws attention to see **STDs treatment sought most in Yatta and Hebron both in southern West Bank. While this could indicate users' awareness and cognitive access to the service being offered it could also be an indicator on higher exposure to STDs due to a wider range of risk factors such as multiple sex partners as in polygamous marriage for example.**

Looking into the **documented number of STD cases the gender dimension surfaced.** Interviewed providers both in focus groups discussion and in individual interviews explained that many of the documented cases are chronic, especially in Yatta, because of husbands' reluctance to take treatment, which renews the woman's infection with every sexual encounter. Reporting this information, involved providers agree that **solutions to such serious RH risks need to be made at the higher level of RH policy such as strictly monitored surveillance system with a home visiting component executed by male health workers/educators.**

Table 15: STDs treatment Services as available in the sample of PHC facilities supported by UNFPA

Addressed aspects of care	Ni'leen	Hebron PFPPA	Yatta	Al Bureij CFTA
treated here	✓	✓	✓	✓
Average number of STD/STIs clients each month	2	25-30	90	10
Average number of visits required for STDs treatment	2	3-4 if husband does not take Rx, 2 visits if he takes Rx	2	2
Partner is notified and receive treatment at the facility	Yes give condom	yes	yes	yes

Counseling is an integral element of RH services on offer at all studied facilities, according to the reporting care providers. Table 16 below illustrates how the service is being employed and in what RH areas. It is worth mentioning that the numbers are senior providers' estimates rather than actual counts of documented counseling reports on case-by-case basis. The evaluation team argues that the given estimates are overstatements for they are incongruent with most facilities' caseload that evidently does not leave time for counseling sessions as implied in the table below, particularly in Yatta, Jenin central, Jablia and AlQarara (please refer to table 3 to link) .

On the other hand, this points to some sort of ambiguity among providers as to what counts as counseling, what contents in a client –provider interaction makes of it integrative of counseling and what quality of counseling is there in the above described facilities. The apparent contradiction between the data reported below and the national FP utilization rate legitimizes these queries. According to this data, family planning is the most counseled for service yet national FP utilization rate is on the decline. Therefore, **it is recommended to develop counseling protocols incorporating clear guidelines by service type counseling to be monitored against realistic measurable indicators.**

Table 16: Counseling Services offered in the PHC facilities supported by UNFPA

Counselling services/ month	Ni'leen	Hebron PFPPA	Yatta	Jenin Central	Jabalia	Al Qarara	AlBureij CFTA
Provided here	✓	✓	✓	✓	✓	✓	✓

Average number of clients who receive counselling on FP	50	200	180	All cases	180	150	80
Average number of clients who receive counselling related pregnancy	30	120	0	All cases	380	200	400
Average number of clients who receive counselling on breastfeeding	40	100	0	All cases	300	100	100
Average number of clients who receive counselling on high risk pregnancy	10	3	150	All cases	10-20	20	60
Average time spent in a counselling session (in minutes)	10	20	10-15	5-10	20	15	10

Early detection of breast cancer was an area where UNFPA excelled in the evaluated cycle. The grounds for a national level program was laid out and forwarded by means of well coordinated efforts of a number of key donor agencies alongside the lead role of UNFPA in this. Primarily these included the Italian cooperation, ANERA, and USAID-Flagship project with WHDD- MOH being the national umbrella of this collective effort. UNFPA work on this issue was all encompassing in the northerner, middle and southern parts of the country. Key components integrated in the Fund's work included; specialized training of 3 medical doctors on mammography interpretations, training of trainers package for clinical staff, community sensitization and education on manual breast examination as well as securing mammography films in relevant facilities and therefore enhancing the effectuation of the free of charge use of mammography service by ministerial decree. As such, it can be said that this was an achievement area for the Fund in its third program cycle.

Early detection of breast cancer using manual breast examination (MBE) and cervical cancer using Pap smear testing are variably integrated into the RH service package offered in all visited facilities except for Jabalia CHC and AlQarara SDP in Gaza. This leaves it for AlBureij WHC only to respond to the women needs in such a fundamental RH service that can severely impact women health and well being. **Compared to the 2006 RH evaluation findings, this area has considerably improved.** On breast cancer detection, Yatta CHC had the highest number of clients who; received breast examination, were suspected breast cancer cases and were referred for further evaluation. Performing Pap smear testing was less pronounced, nevertheless, better integrated than before.

As per hospital based RH services, information was difficult to attain due to poor documentation, lack of MIS and for some other logistical reasons. UNFPA invested substantially in developing detailed and

comprehensive protocols for case management in the area of RH. It also delivered specialized training for involved clinical staffs to promote adherence to the said protocols. Protocol-based case management was reported to be the practice by the interviewed care provider in Rafidia hospital. Nevertheless, **case management of women admitted with severe anemia was questionable in both Rafedia and AlShifa hospitals. These are admitted, administered two units of blood and sent home same day within few hours only.** The number of eclamptic women referred to Rafedia was documented as 2-3 per month compared to 30 referred to AlShifa hospital. Five women were admitted with sepsis and were hospitalized for 7 days whereas no registry was found on this at Rafedia hospital. The team in this evaluation believes it did not manage to adequately look into the quality of these services and therefore suggest further hospital based quality investigation especially that UNFPA invested substantially particularly in Rafedia hospital.

C.2 Interpersonal relations

C.2.1 In Antenatal care

Interpersonal relations were assessed by observing the ANC providers for: providing privacy, greeting the client, assuring confidentiality, giving the client a sense of concern and empathy, encouraging the client to ask questions, and generally treating the client with respect.

Of the 35 observed encounters only in 27 (77.1%) were women seen in private. Privacy appeared to be inadequate more in Gaza (in 9 out of 15 encounters) than in the West Bank (in 18 out of 20 encounters). Clients were greeted in near half of the observed ANC encounters in Gaza compared to around all West Bank corresponding encounters.

During the ANC session, the door was usually closed. Most of the time, bed screens were used to protect privacy inside the examination room. In Gaza Strip clinics, providers did not always assure clients of confidentiality when taking their medical and reproductive history (53%). Overall, giving the client a sense of concern and empathy appear to be a missing aspect of care, more so in Gaza than in the West Bank.

Table 17 : Interpersonal Relations in ANC observed encounters by Region

Did the provider:	West Bank	Gaza Strip	Positive N per item	
	#	#	#	%
See client in private	18	9	27	77.1
Greet client	19	7	26	74.3
Assure client of confidentiality	20	8	28	80

Ask open-ended questions	11	10	21	60
Encourage client to ask questions	10	5	15	42.9
Treat client with respect	19	15	34	97.1

* Total N=35 (20 in WB & 15 in GS)

Akin to the finding in the RH services evaluation five years ago, there was still a **substantial deficiency in encouraging women to ask questions** during the session. Only in 42.9% of the observed encounters were clients allowed to express their concerns freely and in their own words by encouraging them to ask questions; in 5 Gazan versus 10 West Bank encounters. In the same line, providers asked open-ended questions in only 60% of the observed encounters. While this could be attributed to time constraints and the heavy caseload in the studied facilities, the opportunity cost in terms of awareness raising, health education, and behavioral change communication in this is certainly very high. In spite of these insufficiencies, women participants in focus groups discussions uttered their sense of being **treated with respect by all providers in the clinic**, which is largely a matter of perceptions, expectations and social definitions. What is more was that they empathized with the clinic staff for having to respond to the needs of the huge numbers of care seekers in the facilities.

Table 18 : Routine procedures in follow up visits by Region

Did the provider:	West Bank	Gaza Strip	Positive N per item	
	#	#	#	%
Review client's previous records	20	12	32	91.4
Ask number of previous visits	18	2	20	57.1

According to the Unified RH guidelines and protocols, record review and learning about the client's previous visits are fundamental measures through which the provider follows up on any documented complaints and needs to establish his/her subsequent care giving plan/strategy. Observing these vital care components, we found out that almost always (91.4%) providers reviewed their client's previous records while in more than half of the made observations they missed asking them about the number of previous visits (57.1%); more so in Gaza Strip than in the West Bank, as can be seen in table 18 above.

C.2.2 In Family Planning Services.

Overall, **providers did better in FP encounters than in ANC encounters in terms of interpersonal relations. Still, it was noticed that providers did not ask or encourage women to ask questions, more so in Gaza than in the West Bank.** The dominant rhetoric remains highly instructional whereby

providers giving minimum details tell clients what to do and how to do it. As such, women are discouraged to ask questions and so no real interaction takes place. **Sessions are therefore run in a typically one-way communication process instead of an interactive one.**

Table 19 : Interpersonal Relations in FP observed encounters by Region				
Did the provider:	West Bank	Gaza Strip	Positive N per item	
	#	#	#	%
See client in private	19	15	34	97.1
Greet client	19	15	34	97.1
Assure client of confidentiality	19	13	32	91.4
Review client's previous records	19	9	28	80
Ask number of previous visits	19	3	22	62.9
Ask open-ended questions	14	14	28	80
Encourage client to ask questions	14	11	25	71.4
Treat client with respect	18	15	33	94.3

** Total N=35 (20 in WB & 15 in GS)*

Table 19 above indicates that providers did well in seeing clients in private, greeting them, assuring them confidentiality and treating them with respect. Meanwhile, as discussed above, some **deficits were seen in the interactive components of the interpersonal relations element** of the quality of care.

C.3 Information Exchange.

C.3.1 In Antenatal care

This was examined in history taking during first and follow up antenatal care visits as well as in the risk assessment being carried out as part of the care giving process. The first antenatal care visit is the time when the provider is expected to carry out a detailed history assessment, physical exam, and essential laboratory exams to establish baseline data for the pregnant woman profile.

Table 20 : Aspects of history assessment as observed in ANC CPIs by Region				
History assessment aspects as conversed about:	West Bank	Gaza Strip	Positive N per item	
	#	#	#	%
Current age	20	11	31	88.6
Marital status	20	2	22	62.9
Parity	20	6	26	74.3
Number of living children	20	5	25	71.4
Date of last normal menstrual period	19	13	32	91.4
Regularity of menstrual cycle	12	5	17	48.6
Family planning history	7	0	7	20.6
Interest in FP after this pregnancy	6	0	6	17.6
Breastfeeding history	8	1	9	26.5

* Total N=35 (20 in WB & 15 in GS)

In both regions, **providers did best in finding out about the date of last normal menstrual period (91.4%) and clients current age (88.6%)**. However, as shown in table 20 above, **for all other aspects of care concerning the client history assessment Gaza providers' in particular did either fair or poor lagging behind their West Bank counterparts in this**. Variably, providers in both regions were especially inadequate in learning about the women's history of family planning use (20.6%), Interest in FP after the current pregnancy (17.6%) and breastfeeding history (26.5%). No significant differences were noticed between first and follow up visits in this. This could be attributed to the providers' conviction that the ANC session is not the right situation for addressing family planning or too early for addressing breastfeeding.

As for the risk assessment component of history assessment in the ANC CPIs, it was observed whether the providers obtained information on the following risks and dangers during pregnancy: minor illness,

antepartum / postpartum hemorrhage, multiple gestation, eclampsia, sepsis, operative delivery, prolonged labor and presence of stillbirth, neonatal death, premature or low birth weight baby.

Table 21 shows that **assessing danger signs during pregnancy was overlooked by providers in the two regions, but more dramatically in Gaza Strip than in the West Bank.** Serious underestimation of the significance of this appears to be the case in Gaza in particular. This was also a finding in the 2005 RH evaluation indicating poor progress in this matter.

Table 21: Risk assessment information as elicited in the ANC CPIs				
Did the provider elicit information about?	West Bank	Gaza Strip	Positive N per item	
	#	#	#	%
Minor illness	17	1	18	51.4
Antepartum/postpartum hemorrhage	10	0	10	29.4
Multiple gestation	12	1	13	38.2
Eclampsia	12	1	13	38.2
Sepsis	9	1	10	29.4
Operative delivery (surgical, forceps, or vacuum)	11	0	11	32.4
Prolonged labor	9	0	9	25.7
Stillbirth or neonatal death	10	1	11	31.4
Premature/low birth weight baby	12	0	12	34.3
Social history	8	1	9	25.7
Symptoms of current STI/HIV	1	0	1	2.9
Medical problems (e.g., TB)	12	0	12	34.3

* Total N=35 (20 in WB & 15 in GS)

This could be due to the fact that the continuum of care is interrupted in the Palestinian health care system; particularly in this case between PHC settings at the first level of care and hospitals where women deliver at the second. Different MoH directorates do not share relevant information as was stated by some interviewed government officials. Women were instructed to go immediately to the hospital

when labor starts and antenatal care files are kept in the PHC clinic. This means that the home-based card women hand in upon admissions in hospitals when they go for delivery remains invalid in cases of high-risk pregnancies, simply because they have not been diagnosed as such at the PHC level at the first place as the observations above suggest.

C.3.2 In Family Planning Services.

Complete and skilful history taking is key to quality FP services. We observed providers during the FP visits for history taking skills. The following components of history taking were observed and documented: age, marital status, number of living children, age of youngest child, total number of pregnancies, desire for more children, timing of next child, current pregnancy status, pregnancy complications, partner attitude about FP, multiplicity of sexual partners, previous symptoms / signs of STI, partner previous symptoms / signs of STI, client breastfeeding history, past FP use, date of menstrual period and regularity of menstrual cycle.

Overall and regional percentages in table 22 hold clear indications on the weakness of FP service provision process as observed in the visited sites. **History taking skills according to the stated criteria were far less than desirable. Aspects dealing with STIs and pregnancy status and complications issues were noted to particularly be overlooked** being addressed in 14.3-25.7% of the completed observations.

Table 22: Aspects of history assessment as observed in FP CPIs by Region				
Did the provider elicit information about?	West Bank	Gaza Strip	Positive N per item	
	#	#	#	%
Current age	16	13	29	82.9
Marital status	14	5	19	54.3
Number of living children	9	7	16	47.1
Age of youngest child	9	6	15	44.1
Total number of pregnancies	8	7	15	44.1
Desire for more children (Want more?)	5	2	7	20.6
Timing of next child (When?)	4	1	5	14.7
Current pregnancy status	5	0	5	14.7

History of pregnancy complications	5	2	7	20.6
Partner attitude about family planning	6	5	11	32.4
Multiple sexual partners (as in polygamy)	5	0	5	14.3
Partner multiple sexual partners	5	0	5	14.3
Previous symptoms/signs of STI	5	4	9	25.7
Partner previous symptom/sign of STI	5	0	5	14.3
Client breastfeeding history	5	8	13	41.9
Past family planning use	12	12	24	72.7
Date of last menstrual period	16	15	31	88.6
Regularity of menstrual cycle	15	15	30	85.7

* Total N=35 (20 in WB & 15 in GS)

This implies that the service integration mindset and approach to service provision still does not exist and therefore is not practiced by providers as they address their clients in a given sought service. Such sort of coverage of the clients FP history can hamper availability of vital information needed for understanding population reproductive intentions and profile, and push health planners into unrealistic agenda setting and strategizing.

C.4 Choice of Method.

Choice of method was partly addressed under our appropriate constellation of services section whereby a list of methods available in every visited facility was provided. Referring to table 12, it can be seen that **apart from AlQarara all of the sampled sites offer at least three family planning methods** and therefore it can be said that women are secured a reasonable choice of method. Safeguarding the clients' right to an informed choice in FP is evidence on human rights integration into RH services. This is on top of being an integral quality element as in Bruce/Jain framework for quality where it is a cornerstone in assessing service delivery environment for achieving in RH programs. Looking into this component, however, it can be seen that **substantial quality gaps exist in making clients adequately informed about available methods in order for them to make an informed choice of method.**

Table 23: Aspects of informed choice of method as observed in FP CPIs by Region				
Did the provider do the followings?	West Bank	Gaza Strip	Positive N per item	
	#	#	#	%
Discuss available range of methods	8	12	20	60.6
Help client to choose appropriate method (short/ long term, or permanent)	6	9	15	45.5
Discuss client method preference	4	9	13	39.4
Discuss effectiveness of method	5	7	12	36.4
Discuss how to use method	4	2	6	18.2
Discuss side effects of method	5	8	13	39.4
Discuss advantages of method	4	3	7	21.2
Discuss disadvantages of method	4	4	8	25
Tell client what to do if experiences problems with method	9	5	14	42.4
Give method of choice or refer client for method of choice	6	9	15	45.5
Discuss HIV/STI prevention	5	0	5	15.2
Obtain informed consent	8	0	8	24.2

As illustrated in table 23 above, at the very best, only in 60.6% of the observed encounters did the providers discuss available range of methods with the clients. Helping the client to choose the appropriate method in terms of being short/ long term, or permanent and giving her method of choice or refer her for method of choice followed (45.5%), then came telling the client what to do in case of experiencing problems with the method (42.4%). As for the rest, positive observations were rather limited especially in Gaza and concerning discussing advantages and disadvantages of the selected method/s, which were observed only in no more than 25% of the cases. Discussing how to use method was done only in 18.2% compared to 15.2% for discussing pertinent HIV/STI prevention. This placed these two aspects of care in the lowest rank amongst all and revealed poor human right integration in this regard as mirrored in the providers' observed practices.

C.5 Technical Competence

Technical competence is examined by observing what technical aspects of care providers attend to in their care giving process vis-à-vis the unified RH guidelines and protocols and the extent to which they adhere to universal precautions in doing so.

C.5.1 In Antenatal care

Physical Assessment during the ANC visits is a requirement by the unified RH guidelines and protocols, particularly in the first visits but also the follow up ones.

We assessed whether providers performed the most crucial elements of the client's physical assessment, including checking the general appearance, signs of anemia, edema, height, weight, blood pressure, and previous Cesarean Section scar.

Table 24 : Physical assessment of women's well-being in the ANC visit by region				
Did the provider do the following according to protocol?	West Bank	Gaza Strip	Positive N per item	
	#	#	#	%
Check general appearance	18	6	24	68.6
Check signs of anemia	12	11	23	65.7
Check for edema	6	2	8	25
Check height	10	0	10	28.6
Check weight	20	9	29	82.9
Check blood pressure	20	11	31	88.6
Check previous caesarean section scar	5	6	11	34.4
Note assessment of complaints in history	14	4	18	54.5

Providers from the West Bank clinics did relatively well in the physical assessment component for women during the ANC visit. Gaza providers faring less than their West Bank counterparts almost in all aspects, however, paid attention most to checking signs of anemia and blood pressure measurement.

Due to the high prevalence rate of anemia among Palestinian women in reproductive age, anemia prevention and control is incorporated into the ANC guidelines and protocols as a key component of the ANC services. In more than 85% of the observed encounters, women were provided with iron and folic acid supplements and in 74% they received nutritional counseling concerning anemia. Nevertheless, the still high prevalence of anemia among women rings the bell as to the quality of such counseling.

Table 25: Aspects of fetal well-being assessment as observed in ANC CPIs by Region				
Did the provider do the followings?	West Bank	Gaza Strip	Positive N per item	
	#	#	#	%
Check fundal height	15	9	24	72.7
Check fetal movements	17	10	27	77.1
Check for fetal heart sound in 2 nd trimester	14	10	24	75
Check lie and presentation in 3 rd trimester	7	7	14	46.7
Listen to heart rate/heart sound	13	0	13	38.2

At best, providers did well in no more than 77.1% of the overall completed observations concerning the fetal well being. Assessments relied on observing if the provider checked fundal height, fetal movements, fetal heart sound in 2nd trimester, lie and presentation in 3rd trimester and if he/she listened to fetal heart rate/heart sound. **Most often fetal heart sound was checked using the ultrasound machine. Unlike the finding from RH evaluation five years ago providers were keen on ascertaining the status of fetal movement.** In 77% of the observed FP encounters in the two regions, they have asked clients about and checked fetal movements. Listening to the heart rate using the Doppler was the fetal well-being measure practiced least followed by checking fetal lie and presentation. Nonetheless, both are verifiable by means of ultrasound; the preferred fetal well-being examination method. By region, West Bank providers fared better than their counterparts in Gaza in this aspect of the RH care giving process.

Table 26: Universal precautions as observed in ANC CPIs by Region				
Did the provider do the followings?	West Bank	Gaza Strip	Positive N per item	
	#	#	#	%
Wash hands with soap and water:				
Before each patient contact	1	0	1	2.9

After each patient contact	1	2	3	8.6
After removing gloves	1	4	5	14.3
Gloves:				
Wear when drawing blood sample	8	0	8	22.9
Handle sharps safely:				
Dispose of needle without recapping or use “one-hand” technique to recap needle	8	0	8	22.9
Dispose of needles and other sharps in puncture proof container	7	8	15	42.9
Clean, disinfect, and sterilize appropriately:				
Tabletops cleaned with disinfectant solution between patients	1	1	2	5.7

As indicated in the table above, **universal precautions as observed in ANC CPIs were alarmingly poor in both regions.** By no means can the extent to which hand washing as practiced in ANC clinics contribute to infection control, clinical standers and quality of RH care. Nor can the inappropriate and insufficient use of disinfectant solutions and sterilization of tabletops between patients. Handling of sharps safely also is an area of poor technical competence we observed. The only explanation we could think of regarding this finding pertains to the providers’ perception of pregnancy as a state of wellness rather than illness. Therefore, they appear to think of ANC as being offered in healthy environment whereby contact does not warrant all these “unnecessary” precautions!

C.5.2 In Family Planning Services

Overall, clinics crowdedness and understaffing reflected negatively on the duration of clinical sessions of all types including the FP ones, which in turn reflected on the completeness and quality of the care being provides. **In the observed FP encounters in most cases, providers omitted crucial technical aspects of the care.** Only in around a third of the observed encounters did the provider check/ask client about pregnancy or last delivery date (29.4%, each). In less than one fifth, providers asked about smoking or about previous pregnancy complications, 14.3 and 15.6%, sequentially. At best, in less than half of the observed encounters he/she checked blood pressure or asked about chronic health problems (42.9%, each).

Table 27: Aspects of technical competence as observed in FP CPIs by Region

Did the provider do the followings?	West Bank	Gaza Strip	Positive N per item	
	#	#	#	%
Check blood pressure	12	3	15	42.9
Check/ask about pregnancy	6	4	10	29.4
Ask about smoking	5	0	5	14.3
Ask about current breastfeeding	4	8	12	35.3
Ask about chronic health problems	10	5	15	42.9
Ask about last delivery date	4	6	10	29.4
Ask about previous pregnancy complications	4	1	5	15.6
Check body weight	11	1	12	36.4

Except in asking about current breastfeeding and last delivery date West Bank observations registered better outcomes compared to their Gazan corresponding ones.

About **universal precautions adherence was found extremely poor and insufficient. In a limited number of encounters were providers seen watching out for basic hygiene and safety measures** as illustrated in table 28 below. Generally, in both regions, providers do not wash hands before patient contact but, to a limited extent, they do so after such contact or after removing gloves. In a little more than a fifth of the observed encounters did providers wear gloves when drawing blood sample. A similar number handled sharps safely. Noticeably, in both cases the positive observations were sole to the West Bank sites only. Tabletops were seldom cleaned with disinfectant solution between patients and sheets were not changed between clients unless they get terribly dirty. As they stand, these **poor hygiene and safety practices in clinics are far less than acceptable in terms of the infection control standards and the serious health and cost implications they hold for the well-being of care providers and recipients alike. Clearly the situation is worse in Gaza than in the West Bank sites in this regard.**

Table 28: universal precautions as observed in FP CPIs by Region				
Did the provider do the followings?	West Bank	Gaza Strip	Positive N per item	
	#	#	#	%
Wash hands with soap and water:				
Before each patient contact	4	0	4	11.4
After each patient contact	8	10	18	51.4

After removing gloves	8	10	18	51.4
Gloves:				
Wear when drawing blood sample	8	0	8	23.5
Handle sharps safely:				
Dispose of needle without recapping or use one-hand technique to recap needle	7	0	7	20
Dispose of needles and other sharps in puncture proof container	9	3	12	34.3
Clean, disinfect, and sterilize appropriately:				
Table tops cleaned with disinfectant solution between patients	0	1	1	2.9

C.6 Mechanisms to encourage Continuity

Overall, providers did well in this quality of care element. Least well however, concerning encouraging women in the first visit to do at least 2 ANC in pregnancy as a crucial element of care during the first antenatal care visit. In both regions, more than two thirds (65.7%) of the providers were observed to remind or ask women to attend the clinic at least twice during pregnancy. Compared to the previous evaluation, this registering a significant improvement as per the West Bank where it was reported that none of the providers did that it registers a regress in Gaza where 93% of the providers did that then compared to 53.3% who were observed doing it this time. Referring client if necessary, discussing return visit and date of next prenatal visit were all areas observed to be satisfactorily addressed in the ANC CPIs.

Promoting continuity of care also reflected in inquiring about clients' readiness with a plan for emergency situations in case of rising and for a place for delivery. Given the cognitive access dimension to this, we have discussed this under the section on access in this report. As mentioned earlier, only in a limited number of encounters not exceeding 25.7% at best were providers keen to encourage continuity. Be it by asking client where she plans to deliver, how far she is to the closest health facility or to get TBA, where she plans to go if she has an obstetric problem or how far she is to the closest health facility or to get TBA in such occurrence.

Table 29 : Continuity encouragement as observed in ANC CPIs by Region

Did the provider do the followings?	West Bank	Gaza Strip	Positive N per item	
	#	#	#	%
Encourage at least 2 ANC visits	15	8	23	65.7
Refer client if necessary	18	15	33	94.3
Discuss return visit	20	14	34	97.1
Date of next prenatal visit	18	15	33	97.1

Continuity of family planning services is sometimes interrupted due to logistic or administrative reasons that are controllable and fixable. In Yatta, for example, women were turned back home without the service for unavailability of sterile IUD insertion sets. AlQarara SDP in Gaza was found lacking four RH services including family planning denying women and men their reproductive rights with no intervention whatsoever by any agency operating on the ground.

In both regions, follow-up visits were more frequent than first visits, and while counseling and information were parts of all the clinical encounters, only two visits were conducted solely for that reason. **For both new and continuing family planning users, the most frequent** method of contraception was the **IUD** in both regions followed by **combined oral contraceptives (COC)** and **condoms**, sequentially.

Recommendations and Lessons learnt

- On RH policy and planning:** In its CP3 the Fund undertakes to advance the reproductive health agenda in the context of health planning processes as the preparation of sectoral health plans, health review and health reform through advocating for RH concerns and their link to poverty reduction programmes and impact on women empowerment. It also commits to support policy dialogue and advocacy activities aimed at mainstreaming RH issues into the health-reform agenda (CPAP, para 22). Although the Fund thrived in most aspects of these commitments, the later part on mainstreaming RH into the health-reform agenda needs more concrete work, particularly in terms of the ideology rather than the components. PNHS for the years 2011-2013 reflects fragmented manner of institutionalizing the ICPD RH philosophy. The espoused model for SRH care delivery might be comprehensive yet remains scattered and limited in integrating reproductive health and rights and gender sensitive approaches in addressing sexual and reproductive health issues. It can be argued that the adopted conceptualization and presentation is analogous to the stereotypical pre-ICPD era where MCH, FP, Infection diseases, noninfectious diseases etc were the proposed tenets for addressing what has become to be RH dogma. Additionally, managerial orientation and contents dominate the whole document with too many monitoring and evaluation indicators and no prioritization. It is **recommended that in the coming programmatic cycle UNFPA redresses this in light of the ICPD PoA liberating,**

empowerment, participation and inclusion principles, in order to refurbish national political commitment to RH and monitor its translation on the grounds. Reasonable approaches should consider engaging more actively in RH advocacy and policy formulation whereby civil society organizations, media and community participation and inclusion are instrumental elements. Furthering a wider-scope UNFPA partnership with the WHO- MoH's main health planning and policy partner will put efforts of both international UN agencies in synergy in this direction. Therefore, such cooperation could reflect positively on the work of them both. UNFPA in its CP addresses establishing active linkages between the formulation of population policies and the process of health reform. Meanwhile, strengthening the policy & planning Unit at the MoH is a fundamental component of the WHO intervention area. With WHO support, three key strategic planning frameworks were produced; the National Health Strategy 2011-2013, the National Plan on the Organization of Mental Health Services in the oPt 2010-2013, and National Policy and Strategy for the Prevention and Management of Non-Communicable Diseases. Close examination of these three documents clearly points to the huge number of issues that intersect with the UNFPA RH program component. It also brings to question the noted regression in RH approach/ ideology integration into the said policy documents. In fact, some interviewed experts expressed concern over this deterioration matter. This indicates the Fund's utter need to engage more systematically and closely in health policy development processes to contribute to their shaping and promote the integration of RH ideology. Broadening its scope of partnership with WHO as a key player in the health sector policy reform could be one step in the right direction.

- **On MoH management style and structures.** This evaluation has clearly shown that current management styles and structures within MoH hinder quality actualization and this cannot be overlooked.

The overly-centralized, physician-driven top down decision-making prevalent at the MOH along with lack of clear management structures, multiple directors and administrators, insufficient supervision and monitoring had all contributed to poor quality of RH services. The gap between the central Ministry and the field contributes to low staff morale reported in the providers' interviews and observed in the site visits. A more critical gap exists between physicians and the other health co-workers, primarily midwives and nurses, resulting in an encompassing sense of disempowerment and lack of appreciation on the side of the later two professions.

Viewing the healthcare system as a sub-culture of the overall culture within which it operates, this can be understood within the context of the gendered division of labor in the production of healthcare in the oPt with particular reference to the MoH systems including within the clinical settings. Due to the predominant patriarchy in terms of locus of power and control and womanliness of the two professions of nursing and midwifery they are confined in few positions with no real power, carrying out the vast majority of key clinical and managerial tasks including in the PHC settings with limited decision making space, authority, status, and financial rewards that does not correspond to the size, scope and value of work they shoulder within the said healthcare facilities. This strongly hits their morale, motivation, loyalty and faith in the justice of the system they serve. The evaluation team believes that definition of the scope of work and role alongside an appropriately matching decision making space, recognition and incentives scheme of

each of the three professional categories with most interconnectedness; nursing, midwifery and medicine is a key significant step to correct this situation that would certainly feed into quality of the services they offer. Evidence-based practice elsewhere in the world indicated that nurse/midwife lead RH services in PHC settings function with utter sensitivity to the human element of quality and yield high satisfaction level to both care providers and recipient alike. It also indicates efficient use of human resources especially as it applies to proper utilization of medical human resources at the second and third level health care service. It is believed that UNFPA in cooperation with WHO are in the best position to assist MoH review its management style and structures including correcting its inflated administrative staff currently filling employment spots that could be used to correct the much needed technical staff as indicated earlier.

- **Building a Continuum of Care⁴ through diversification of Partnerships and Government Leadership is a key challenge in the Fund's RH work.** In addition to the NGOs and UNRWA, partnership with the private sector cannot be overlooked, especially at the second and third level health services where private sector institutions with the good money, are key investors in Palestine. UNFPA must make strategic investments in diversified partnerships for building the highly-costive continuum of care particularly at the second and third level of care. In turn, mothers and children's quality of life are improved by combating mother, newborns and child preventable morbidities and mortalities. In addition, tremendous savings will be made from the outside referrals currently overburdening the budget of Palestinian Healthcare system. While such a view would promote collective ownership, it corresponds to the Palestinian National Health Strategy (PNHS) 2011-2013 whereby the seventh goal is: facilitation and reinforcement of private and public sector partnership in support of harmonization and coordination of the national efforts for securing access to high quality healthcare for all (PNHS, 2010).
- Emergency obstetric care protocol was developed in 2008-2009. This process was lead and run by WHDD yet implementation is carried out at PHC facilities and in hospitals where WHDD has no access to data and records nor does it receive any feedback on implementation, we were informed. What happens is that either a woman goes to the clinic of her access as a normal case of ANC and is found out to be a high-risk one upon examination or as an emergency with say placenta previa for example. In both cases, she is referred to hospital for emergency obstetric care where the PHCD is no more involved and has no tracking system whatsoever. Practically, only verbally from the client herself, if after she gives birth goes for FP or child vaccination that the clinic knows about what could have happened to her after being referred . Therefore, follow up, monitoring or evaluation of the manner and extent of emergency obstetric care protocol implementation or if it is being implemented at the first place is not possible to pursue by WHDD.

⁴ Continuum of care is a phrase that expresses the recognition that maternal, newborn, and child health are all intricately linked to each other; that linking health services for mothers, newborns, and children can be very effective and very efficient. It stresses that services offered vertically to these population groups without any integration must be rethought (Blanc,2010) accessed online at: <http://www.medscape.com/viewarticle/714330>

- **Developing capacity and promoting commitment** of the government, nongovernment and civil society actors in **monitoring, evaluating and reporting on program progress towards the MDGs** by using and tracking development indicators. Program monitoring and evaluation was recognized as one weakness point in this program cycle. This reflected itself in some deliverables to have been completely left out. For example, training of providers on obstetric care manual was done in WB but not in GS. **Review of RH protocols** was completely omitted because these protocols were believed not to have been fully implemented by the health care providers while no monitoring measures were put in operation. **The challenge of implementation and monitoring is a critical next step. However, this cannot be considered in isolation of the overall facility and systems management contexts;** particularly attending to issues of understaffing; deficiencies in supplies, infrastructure, and definition of providers' scope of work; role ambiguity; staff training, morale and motivation are all conditions for service implementation and monitoring including as regards protocols. As the findings in this evaluation clearly showed, these are all quality indicators that are still in need of good attention on the side of MoH supported by the Fund and others. Lush in her analysis of reproductive health policy development considers these deficiencies as barriers to service integration stating that: *"integrated service delivery is inhibited by problems in health facilities, particularly the low pay, poor morale and lack of motivation among providers"* (Lush, 2002).
- **Quality of reproductive health services:** Obviously, the question of quality of reproductive health services still is a major challenge for Palestinian health policymakers, more so for those in Gaza Strip than in the West Bank. The seriousness conferred to the quality issues as a whole was well presented in the PNHS in two of its identified areas for development; access to quality health services and quality assurance. This reflects the strong commitment of policymakers themselves to health quality matters and concerns. In terms of reproductive health in particular, the human and reproductive rights remain central especially to women who are the prime if not the sole RH service users. Bringing to light the gender and rights dimensions of quality, this evaluation indicated that some human rights violations were noted to accompany the care provision process where the woman's privacy and respect were not given much regard implying a need for strengthening the providers' skills in respecting the rights of the clients. For that while this leads to the women's dissatisfaction with the service it subsequently impacts the quality of care they receive at the service facilities. On the other hand, so far remarkable effort has been invested in creating "a culture of quality" as yet though, emphasis has been placed on the technical dimension of quality wherein the human element was overlooked or at least marginalized. A man who works in a donor agency puts this across along these lines: *"Despite sincere efforts to create a culture of quality in health you can still see the interpersonal defect in the client-provider interactive processes at most health service points. While this denotes the lacking human element in the quality training packages being offered, it could also be an indicator of the providers' dissatisfaction with their work conditions and status."* (AlRifai, 2009). Despite the five years gap between this evaluation and the above-cited source, this depiction still applies to quality in the currently evaluated healthcare settings, too. Therefore, UNFPA should continue its work on quality of care in the studied facilities with special focus on its human elements as explained above.

To this end, the technical capacity of the Fund's Gaza Office needs to be strengthened by adding technical people to its existing staff. Due to the particularly high dominance of the medical model

there, this new technical staff must include a medical doctor who is acceptable to the Gazan health policy makers for them to be able to relate to and cooperate with. This is crucial if quality of RH services is to be improved in the Strip also.

4.1.2 Findings on RH Output 1.2 on Youth: Increased accessibility of reproductive and sexual health information and counseling services for young people, with a special focus on the prevention of HIV/AIDS and STIs.

Three indicators were identified to measure achievements in this output area. These are

- Proportion of youth that recognize three methods of HIV/AIDS transmission and prevention, at least one of which is condom use
- Proportion of youth that recognize at least three STIs
- Proportion of students in grades 9-12 in selected schools who reflect positive attitudes on gender equity, equality and empowerment.

Although as stated this output focuses on behavioral change communication/ information, education and communication BCC-IEC/advocacy in addition to the counseling services, the Fund CP has gone far beyond that by exploring an expanded service package addressing the RH service needs of the young people.

Nevertheless, integration of RH information into the school curricula remains the strategic achievement in this cycle. This is because it was finally completed after years of challenging and exhaustive debates and policy arguments. Not to forget, the high cost, and background work including the tremendous revisions and approvals the process entailed. Also, teachers and school counselors training were indispensable assets in this

In the CP office, only one UNFPA core staff was working on youth issues. Alongside, most of those working with youth have rather limited experience with youth-oriented projects in both the service and to a lesser extent BCC-IEC and advocacy. However, generally, the capacity and experience to deal with youth programmes, particularly in such NGOs as the Palestinian Red Crescent Society and the MoEHE, is rapidly growing especially with the growing number of the youth civil society organizations were youth are present in various organizational levels and capacities. In addition, the public institutions awareness of the need to focus on youth affairs is also growing.

Like other organizations in Palestine, UNFPA as an organization has had limited experience in designing programmes for different sub-segments of youth, especially the out-of-school and institutionalized youth in MoSA rehabilitation centers for example. Hence, the competence or the capability to deliver technically sound youth programmes is drawn from lessons learned from other, more general projects the Fund implemented. Progressively, experience was gained by learning-by-doing, for example in integrating reproductive health into the formal education system highlighting youth RH and rights where it can now be confidently argued that Palestine has set a model for many Arab countries in the region in this regard.

Alongside the CP high awareness of the socio-cultural context of SRH issues for Palestinian youth, UNFPA staff working on youth issues are knowledgeable of available data sources including the National data on youth PCBS produces, in support of their arguments, especially in managing the critical influence of gatekeepers such as decision makers, religious leaders, parents, teachers and opinion leaders. To this end, it is strongly recommended that PCBS repeats youth national survey in the coming programmatic

cycle as one independent component for an updated picture on youth profile as a step toward youth surveillance system development to facilitate data driven planning regarding this ever growing population group.

Despite the existing awareness and understanding of the role of the said gatekeepers, so far there has been insufficient targeting of these groups with messages that are tailored to their different concerns. Men, as gatekeepers of traditions and traditional gender roles, have been neglected in youth UNFPA program. Their influential role on women's and youth's SRH and rights cannot be allowed to continue be underestimated as such. Similar to the work done under the gender and RH components, community support teams for youth are suggested to be formulated mainly from fathers, opinion leaders, member of municipal offices and local clubs and associations to engage them in relevant activities to solicit their participation, approval, commitment and support.

The programme contributed largely to increasing the number of young people accessing information on RH and HIV/AIDS prevention by targeting different youth groups in different entities and settings. *Namaa's* youth affiliated to rural associations, clubs and centers and youth volunteers strongly integrated into the PFPPA structures were key youth groups the program targeted in partnering with these two lead community based NGOs . Peer-to-peer education was the predominant approach here. Within the framework of these partnerships, 260 youth from both sexes in the two regions of the WB and GS were engaged in a peer-to-peer education network using a training of trainer like approach all referring to one same manual. Attempts to access out-of- school and vulnerable youth including those institutionalized in MoSA youth rehabilitation centers, with active involvement from Namaa' youth leaders as trainers is still in its initial stages and needs to be taken up further . The findings from the information needs assessment in SRH among youth and staff at social care and rehabilitation centers affiliated to MoSA and completed in 2006 for MoSA with UNFPA funds should continue to be used as a baseline for tailoring needs-based youth training and sensitization projects in the area of SRH.

In the same line, young people frequently stated Palestinian Red Crescent Society (PRCS) as a credible source of information the youth use both in the West Bank and Gaza. This goes along with the broad net of youth community centers the Crescent established and operates quite successfully since many years now. Those centers usually serve the disadvantaged including the out-of-schools in addition to the in-schools youth. It is believed that expanding its partnerships body to such a grassroots large organization will offer the Fund a huge platform to access a significantly large base of the youth.

Despite all such efforts youth participants in FGDs call upon service providers to reach out for service non-users youth. One female youth from Gaza puts it thus:

“Workshops should never stop. Youth issues must always be on the table. We the ones who participate in PFPPA activities are not the standers. We represent the exception to the rule. Youth organizations should reach out to those who do not look for information who are a majority. Organizations should find ways to include and motivate them”.

In the same line, another West Bank male youth confirms the view above as he says:

“ Centers addressing youth needs are existent, however, young people do not use them. They need to be reached out. Those in charge of the centers do not exert enough effort in this

pretending as if there is no social barriers to utilizing their services. So far silence is the master of the game when it comes to such problems as in STDs, contraceptives and sexual health”

In-schools youth, however, are the group the program targeted first and most in cooperation with the MoEHE. In the evaluated program cycle five hundred school counselors were trained (two thirds of the total) to provide SRH information with reference to the manual. Of these, distinguished ones served as the trainers in a UNFPA funded WCLAC implemented emergency response project carried out in 2006-2007 in the two regions of the West Bank and Gaza Strip for capacity building of 89 new university graduates with psychology, sociology or social work backgrounds. The one-year training was meant to broaden employability prospects and economic development opportunities of the trainees by making of these new graduates competent school counselors, as a step ahead for improving school counseling and promoting its effectiveness for children and youth at the MoEHE schools system. In the same line within the framework of the same project, twenty school counselors working in the field were targeted in debriefing sessions to help them air their feelings and release their stresses to improve the counseling processes outcomes.

By the end of the year 2007, the project was evaluated where the participating trainees expressed great satisfaction and appreciation of the gained knowledge and acquired skills. They however recognized a need for further expansion in the theoretical course components in the areas of sex education, behavioral problems of children, lobbying and advocacy and individual counseling techniques.

Evaluation of the project's managerial aspects showed clear deficits and role confusion between the MoEHE and WCLAC in terms of; supervision, follow up, and monitoring of the training process and outcomes. In this current evaluation, the evaluation team could not find out about if and how the involved parties including the Fund took these findings forward and acted upon them, which remains crucial for advancing the government school counseling system and replicate it in the private schools in future.

Mainstreaming gender, teachers and counselors from both sexes were targeted using special teachers' manual on SRH. Curriculum integration (unification) of the home economy and health and environment courses of the 7th, 8th, 9th and 10 graders was completed to gender sensitize students as both sexes would have to study both subjects while each used to stereotypically be assigned by sex, with home economy to girls and health and environment to boys.

On the other hand, Youth Friendly Services (YFS) information part has already achieved significant cultural appropriateness, approval and relevance after 5 full years of implementation accompanied by many revisions for cultural adaptation subsequent to intensive policy dialogue and civil society debates. National ownership is the outcome. MoEHE is currently undertaking an evaluation of the training offered to teachers and counselors mainly addressing the BCC-IEC /advocacy components of the RH, the findings of which will enlighten the coming programmatic cycle.

Some of the preliminary findings from the said evaluation indicate that the extent of school health Heads participation in the adolescents RH training plan was much better in Gaza than in the West Bank. The multipurpose training main objective was to improve performance of the involved school counselors and teachers and enhance their ability to address youth with sensitive SRH issues professionally and scientifically without any embarrassment or discomfort. To this end, in 2006 the link between Islamic texts and instructions with the proposed SRH subjects was made by engaging the Islamic religion school supervisors in the training. This was an excellent opportunity for presenting the trainees who are school counselors and teachers in this case with supportive evidence they can confidently employ in conducting

respective sessions with the students at schools minimizing risks of rejection or attacks from traditions gatekeepers in the communities. In fact, this has produced significant attitudinal progress on the side of trainers allowing for new development in the training agenda where focus was placed on STDs and physical bodily changes in puberty: two strongly tabooed areas in previous endeavors. The identified missing area in the adolescents' health training material was "dealing with peer influence", which trainees believe is very important to address youth with.

Another key issue this evaluation came out with was the shortage of the number of the training manual copies sent out to Gaza Strip where only a copy per trainer was delivered but no copies to schools. The MoEHE in Ramallah delivered only around 30 copies to Gaza although the initial plan was to deliver at least a copy per school in both regions. There was also shortage in the West Bank copies but to a much lesser extent. Eventually, the training manual was implemented in around 50% of schools in Gaza Strip and Ramallah, equally each, compared to around 78% of the Nablus area schools. Implementation monitoring was a deficit area the evaluation clearly pointed out (MoEHE, 2010). Securing the lacking copies of the training manual to the schools where it is missing is a sustainability issue UNFPA needs to address MoEHE with, while putting an implementation monitoring system in place is another area for future attention in the coming cycle.

As per YFS healthcare services part, work is much more difficult primarily due to the socio- cultural sensitivity when it comes to the unmarried youth. This, having prolonged the policy dialogue on youth services, could be argued crucial in the current context. Speeding its pace could be by involving parents especially fathers in the dialogue in the form of regional councils or community support groups not to forget youth themselves who should be active players in this process. Thus far, protocols and guidelines were developed for a referral system initiated by MoEHE in cooperation with the national committee formulated from selected NGOs, MoH, MoSA and others. Pushing this ahead, PHCD at MoH created and is stimulating a policy dialogue where UNFPA submitted a concept note that is being reviewed by MOH PHCD and will be piloted in Bethlehem clinics as an initial step. However, distinguishing between the needs of sub-groups within the youth population based on their circumstances, access to facilities and so forth should be critical to the provision of relevant and effective RH services to each group of potential clients. In addition, it should be kept in mind that risks lie in the misconceptions associated with perceived cultural inappropriateness, which could lead to resistance from stakeholders such as parents and community opinion and religious leaders. It is suggested that progress in this is cautious and thoroughly worked out conceptually, structurally and programmatically.

A double-pronged trilateral partnership model that includes UNFPA, MoH and MoEHE is proposed to serve the RH needs of the youth. Diversity in the needs of the female and male youth, married and unmarried will be a core matter of attention. Services should target those 15-25 years. Services should be provided at schools and in the form of youth-friendly clinics, to be called "Youth Health Clubs", for example, where young people can come for services and information without stigma because of the general scope of activities implied by the center's name. Issues that may be addressed could include menarche, early and relative marriage, pre-marital examinations, reproductive tract infections and incest. Theater and drama work can be an integrated means of learning for behavioral change.

Alongside, a feasible model that proved successful in other countries in the region is targeting the 18 and above youth by working with university clinics. These clinics are usual service provision sites in

Palestinian universities. Integrating youth RH components can be an appropriate and feasible entry point in this.

Addressing the young people with youth service issues one young man interestingly stated it thus: *“you know we take the system as serious as it takes us!”*.

Dwelling into this statement, many other issues surfaced both concerning information/counseling and service provision. Youth groups in Gaza were rather critical of the service system in terms of its poor infrastructure and qualification/ fitness of service providers especially doctors. They were most dissatisfied about lack of space and time for the service sessions. Additionally they agreed that doctors are rigid, and do not take youth seriously in terms of listening to their complaints, especially male doctors who, according to one young woman:

“...address us paternalistically with lots of authoritative tone and spirit, let alone judgment”.

This indicates that a deeper understanding of provider attitudes towards youth would be useful. Also additional research is needed to better understand the attitudes of parents and community leaders to young people's utilization of RH services including the unmarried. Besides, youth reporting on clinics/centers reflects their perception of “youth-friendly” services which to them do not exist. They frequented that the said centers are unwelcoming, unclean and smelly on top of being extremely boring including the colors used in painting the rooms. One said:

“First of all, young people want to see youth-friendly facilities where the atmosphere is pleasant and welcoming and where staff is positive, supportive, professional and competent. Only then, they would believe in the system and target the services on offer”.

One young woman in Gaza puts through the human dimension about which youth care as she says:

“All I want is for the service provider/counselor to treat me with respect to my humanity...is that I see values and consideration in his/her interaction with me...”

These youth voices from the field hold implications for the quality of service available to youth, if any, and call out for the need to make services youth-friendly including its outreach component. Despite the broader range of RH services now provided, practically, the only service that is provided for young unmarried people is the premarital examination with special emphasis on Thalassemia. However, these are medically oriented, and focus on exclusion of disease. Those consulted during the FGDs are strong believers of the need to do this examination and asserted their support of making such examinations compelling by law. They consider them quite useful especially with the prevalent consanguineous marriage in Palestine, but they expressed concern over possible negative outcomes affecting the reputation of partners (especially girls) when privacy is not well maintained the occurrence of which is not strange in some service facilities.

Recommendations and lessons learnt

- Working with youth, especially girls, proved to be a fertile area with very high potential for pushing ahead ICPD PoA and MDGs. However, in the previous and evaluated cycle the Fund primary **focus was on one key link, setting and geographical area in working on this matter; MoEHE schools and West Bank excluding East Jerusalem as well as other line ministries including MoYS.** Given the population youth bulge that will shape the Palestinian society for the next two and a half decades indicates that wise investments in today's youth will yield large profits for future development (Urban Population, 2007). Attention must be paid to the needs of these marginalized youth sub-populations; especially the East Jerusalem ones who are wrongly perceived as doing relatively well while in reality are being systematically weakened, isolated, and traumatized in the most critical ways; not to forget the severe circumstances for the Gaza youth as well. To this end, UNFPA might want to re-consider the size and competence of its Gaza office staff.
- Attempting to **expand coverage and responsiveness to the youth needs**, UNFPA made initial contacts with the Health Work Committees, but failed for institutional sustainability reasons on the Committees side. However, proceeding with this effort remains crucial for a wider impact. The PFPPA seems to potentially be in a good partner position to address youth needs in East Jerusalem while the PRCS is the one in the West Bank and Gaza. Considering new evolving NGOs could also be considered to serve the growing needs of the exceptionally troubled youth in East Jerusalem and Gaza.
- Assessing the risks and opportunities that exist in relation to offering YFS, no risk could be detected concerning the information part. On the contrary, it built specialized cadres within MoEHE that did not exist from before. These cadres could be utilized in a snowball fashion to train and build the capacity of new staffs in local NGOs and rural youth establishments in the youth empowerment arena, to expand coverage and ensure sustainability.
- The need for expanding the YFS information and counseling part of the package is still paramount. **The imperative of reaching vulnerable and most- at-risk youth** groups including the out-of-school ones cannot be ignored and is the big challenge in the youth component for the next programmatic cycle. MoSA runs a total of 13 social care centers and 3 juvenile rehabilitation homes serving a minimum of 1000 male and female vulnerable youth. This holds clear indications on the significant potential in targeting youth and staff in these centers and homes with well-developed strategically oriented projects that would particularly serve this critical segment of the youth population. MoSA remains inadequate in terms of financial and human resources but must be supported and empowered to be able to get engaged in this. Therefore it is highly recommended that one UNFPA staff be assigned at MoSA for capacity building, coordination, supervision and monitoring roles throughout the execution of the said projects. In addition, investments should be made in targeting new NGOs such as youth centers and clubs of all types and other relevant ministries such as the Youth and Sports Ministry alongside the existing ones. Partnerships in the youth component need to be expanded and more diversified for wider sustainable impact.
- **Prior to marriage youth do not have clear entry point to the health service, in particular. The YFS model** still lacks a lot on identification of service package, referral and organization. Both conceptual and programmatic level challenges are for serious considerations, including

consulting and communicating them with the youth themselves. **University clinics** were suggested by MoEHE interviewees as a potentially proper entry point where selected RH service components could be integrated and progressively expanded. UNFPA might need to explore this option more and pilot it in one of the universities in the coming program cycle.

- **Recentness of the concept of “Youth Participation” and YFS model** in the whole region, lack of expertise in youth program work areas and traditional views and tackling of youth issues are all barriers to the much needed creativity and innovation in this specific area. The challenge is how to support and motivate youth themselves to come out with ideas that suite them best and fulfill their needs while remain culturally appropriate. If a HRBA is adopted in working with youth where their participation is encouraged and their empowerment is optimized they can be the best advisors on how to make best use of YFS.

4.1.3 Humanitarian Response to RH

Program implementation has largely been influenced by various contextual factors. Of these, political escalation and subsequent repercussions including the internal political split were of paramount influence while at the same time being beyond the program control. The Fund needed to redirect a considerable portion of its focus towards the deteriorating humanitarian situation. To this end, it was able to attract huge extra funds towards emergency RH care where it excelled as testified by a number of the interviewed policy makers. Although this was not done on the account of the allocated resources and development agenda, yet it had to naturally consume considerable staff time and necessitate substantial management functions. Eventually, it imposed program extension one year beyond the intended duration bringing it to end in the year 2010 instead of 2009 as initially planned.

However, this tremendous contribution did not receive due recognition from some MoH officials who believe that UNFPA did not excel in this. Comparatively, UNRWA representative reported UNFPA as being highly responsive and perfectly prepared in emergency situations and gives the War on Gaza as an example in support of his statement. Source of such disagreements here could be owed to the internal logistical and bureaucratic discrepancies in the respective institution of each reporting rather than being a UNFPA affair.

At another level, in progression of its humanitarian response in previous programmatic cycle addressing the human right to health and education simultaneously, the Fund continues its humanitarian response work through supporting a community midwifery academic program whereby Diploma holding nurses are offered entry into B.Sc. in Community Midwifery bridging program at Ibn Sina College affiliated to the MoH. In addition, the Fund lately approved supporting a professional diploma course in neonatal nursing introduced at Ibn Sina College commencing in the coming academic year in September 2010. This is to attend to the sever need for professional neonatal care especially in the marginalized communities including those isolated in seam zone or trapped into checkpoints and besiegement. The deteriorating neonatal mortality rate of 20.0 per 1000 live births in the five-year period 2002-2006 compared with 16 in the years 1997-2001 present evidence on such need (PCBS, 2008).

At a more hands on level, village health workers (VHW) were targeted with professional diploma training on normal birthing and basic midwifery skills in support of safe home delivery, alongside identification and definition of referral channels as available and appropriate for each community. This is believed to strengthen and build on the Fund's work in 2002 and 2003 where sieges and segregation measures peaked blocking health care services off its seekers. UNFPA work then proved to rescue women's and infants' lives tremendously especially that it went hand in hand with the Birthing Homes established by Maram-USAID project at the time.

In another related matter, support of continuum of care was initiated both within the humanitarian response and as quality of care improvement frameworks. This continuum includes the community, clinic and hospital level care. In some districts, this was done by linking obstetric care offering hospitals with district clinics such as in Nablus, Khan Younes and Gaza. SDP services at some remote areas were improved and services in those areas were made more attractive and accessible to women. To this purpose, tertiary care in the two hospitals of Rafidai and AlShifa was improved by investing in infrastructure upgrading and betterment of flow of supplies, commodities and consumables. As a result, provision of delivery care more than tripled in this programmatic cycle with particular emphasis on provision with RH commodities including 40% of the essential drugs list. Nevertheless, building a continuum of care is an incremental process that can be best achieved through multilateral partnerships with active engagement of the NGOs, private sector and community participation and empowerment.

On the same line, recent research and reports have overwhelmingly supported a shift in health care strategies toward incorporating a continuum of care approach to maternal, newborn and child health. The 2005 World Health Report stressed the need to include the newborn in maternal and child health initiatives and to create an integrated continuum. Also in 2005, the United Nation's Millennium Project taskforce on child and maternal health called for a new focus on the rights of mothers and children, investment in newborn health, and for integrated systems (PRB, 2006).

In light of such guiding notion, a similar model was taken up to address newborn mortality and improve overall health care. Home visits targeted at newborns to complement the existing facility-based interventions must be put in place. Health workers / educators/nurses will visit newborns at home three times within the first critical 10 days. They will promote exclusive breastfeeding, early recognition of illness, and management of complications. What would make such an initiative a feasible endeavor is the UNFPA funded neonatal nursing professional diploma program at Ibn Sina College as it would train and qualify the needed human resources.

Moreover, UNFPA is recommended to support systematic access to services in marginalized, difficult to reach communities. This is especially important as MOH has limited logistical and human capacity to cover the RH needs of a large number of isolated communities in a sustainable and systematic manner. A practical way could be to support the establishment of a system for mobile RH services providing basic package of services and ensuring acceptable level of referral

4.2 Findings on the Outcomes of the Population and development Program Component

Findings in this chapter cater for the country program output 2.1: To have increased the national capacity to integrate population, gender and reproductive health into development and emergency planning processes and output 2.2: To have enhanced the national capacity to generate and utilize disaggregated data.

National sectoral policies take into account gender and population in the context of development and emergencies. The two outputs revolve around national and sectoral policies focusing on capacity-building measures that will assist the Government in developing population policies and plans as well as in monitoring gender (CPAP, para 24). In its third programmatic cycle, UNFPA assisted mainly the Ministry of Planning and Administrative Development, the Palestinian Central Bureau of Statistics and BierZait University in achieving this output. This is at the time when it had to cope with the departure of two key CP staffs whose contributions were exceptionally relevant to this particular program component. This included the Rep. Assistant who was also the CP officer for the population and development and gender components whose departure with too many concurrent tasks and responsibilities at the time, subsequently overwhelmed working on this program component but without hindering the shining successes achieved in this program component thereafter. In addition, the Rep. himself with his solid educational and professional base as a demographer, hands-on approach and exceptional sensitivity to the Palestinian context and needs was an indispensable asset to the UNFPA work in Palestine. This was widely testified by all. At the time, these significant human elements reflected in high positivity in the work relationship and environment between the Fund office and local institutions, and paved the way for significant achievements in the CP work during the evaluated cycle, despite the obvious complexities.

4.2.1 Findings on Output 2.1: To have increased the national capacity to integrate population, gender and reproductive health into development and emergency planning processes

Four indicators were identified to measure achievements in this output area. These are

- National mechanisms to elaborate and monitor population policy functioning
- Draft population policy document elaborated in line with the ICPD and MDGs
- At least two supportive networks for gender, population and development (journalists and parliamentarians) established
- Gender strategy developed and implemented in five line ministries

The programme key achievement in this output relates most of all to the first indicator above, in the form of the aggressive and persistent policy dialogue and advocacy activities the program initiated, stimulated and geared to ensure that population and gender concerns are mainstreamed into the

planning processes. This was by creating mechanisms and platforms for promoting such dialogue most notably perhaps within MoPAD. UNFPA continued to nurture and activate the population Unit it created within MoPAD. Within the framework of this vitalization process, the Fund instituted the Population Forum comprising academics, researchers and experts from the NGOs, PCBS and selected ministries as an advisory body for the MoPAD population unit with the long term purpose of developing a draft population policy. Materialized as such, the Fund was able to mobilize this forum as a supportive network to keep discussions over population issues alive and vibrant. This support manifested itself in the distinguished role the Forum had played in the accomplishment of the first national conference on population and development in October 2009. In fact, this was seen as an important step ahead in population policy and dialogue linking it to development. The Population Unit needs to follow this achievement through and build on it. Population policy papers, a series of discussion groups, and newspaper supplements are few examples of what can be done in light of the conference recommendations. The Unit is accountable to keep the population arena as alive and dynamic as it could in order to produce the sought effects in the area of population and development. In order for this to take place, the Unit's capacity must be built by various means including by subjecting staff to specialize training, study tours and other such empowering relevant interactive experiences, as requested by the staff itself upon being interviewed.

The Fund must attentively follow the institutionalization of this Forum through. The existing Inter-Ministerial Decree on the establishment of the population Forum needs to be taken further, especially that guidelines for its functioning were also developed. MoPAD must be encouraged to make use of the comparative advantage a powerful Population Forum presents it with in coming along as a strong player in the population field. Supported by the Fund, jointly with the PCBS, MoPAD should lead founding a national population experts network. PCBS involvement as a co-leader given the population data treasure it produces and possesses would be a valuable asset and excellent model of partnership building towards program effectiveness, impact and sustainability. Without such endeavors, it is believed, materializing an authentic population dialogue and formulating a viable population policy remain difficult in Palestine.

Despite these significant achievements, there was an agreement among the interviewed that the peculiarity and high sensitivity of population matters intertwined with the conflict and demographic national concerns makes of the population arena especially challenging for all. The Fund lacks the needed technical support staff in population, some believe. Currently, the Fund's role in this is mainly one of facilitation evaluators were told. Respondents requested the presence of population experts among the CP team in addition to the current officers, especially in such areas as demographic analysis and integration of population policies into planning. It also needs to invest more in its relationship with MoPAD, as its key partner in population and development. It was especially pointed out that investments the Fund made in the presence of population aware and supportive MoPAD Ministers at a number of successive ministerial cycles were inadequate. Given that, the evaluation team believes that UNFPA strategic work on population and development with MoPAD needs to be given more visibility and presence alongside expanded civil society participation and media coverage. Inter alia, this requires accountability fastened aggressive work plans of clearly defined role of population unit that is adequately staffed, equipped and empowered within MoPAD. Sensitization projects on population issues of the Fund's interest must be integrated in the coming program cycle more broadly and extensively. Bi or tri-annual national population conference should become a fundamental component of the UNFPA program. Planning, implementation

and supervision, however, should be carried out in a close hands-on approach on the Fund's side. Replication of the model of the 2007 GBV national conference including hiring an expert consultant to support the Population Unit in this specific task is recommended here for improved conference outcomes.

Additionally, the fact that Palestinian population experts with MDG and ICPD orientation are very few makes of the inclusion of a population expert among the Fund staff to serve as a resource person an imperative need. However, it was upheld that such resource person be stationed at MoPAD offices to contribute to capacity development within the Ministry. To this end, it was emphasized that the Fund should consider investing in specialized training and higher education at the Masters and PhD levels in the area of population studies/issues as a priority area for intervention in the coming cycle. This is believed to promote national leadership and capacity development by boosting the qualified specialized Palestinian cadres in the area of population in accordance with the UNFPA population agenda.

As per the academic community, population issues in local Palestinian universities were found to be addressed under a number of different titles and colleges; primarily geography and public health programs, and are often taught by non-demographers.

In the 3CP, the Fund collaborated with the Institute of Community and Public Health- BirZeit University in various aspects of population issues including, inter alia, the integration of population issues into different subjects' courses totaling 12 credit hour courses taught in the Masters of Public Health program (MPH)- thesis track. After three years of implementation within the MPH program, the course curriculum was reviewed by an interdisciplinary team of faculty to suite Masters Programs across disciplines and programs in the University. Introduced as an elective, the course proved and continues to be attractive and successful.

Within the framework of this same partnership, the said institute produced a number of policy briefs, which were useful to those who could access them. Nevertheless, those were limited in number, individually and institutionally, because the briefs were not shared widely enough among interested institutions and audiences as understood from most of the interviewed experts. This means that utilization of the produced policy briefs for advocacy purposes was largely hindered. Therefore, there is need for the Fund to be more closely involved in the production and dissemination of these policy briefs as valuable advocacy instruments including through organizing a series of seminars and panel discussions for example.

4.2.2 Findings on output 2.2: To have enhanced the national capacity to generate and utilize disaggregated data.

Four indicators were identified to measure achievements in this output area. These are

- Advocacy fund-raising plan for the 2007 census operationalized.
- International standards-based framework of national data systems operationalized.

- Set of indicators for the follow-up of the MDGs and ICPD, including gender equity and equality, the empowerment of women and human rights indicators institutionalized.
- Increased utilization of census and other population data.

Recognition of the Fund's role in data system enhancement by insuring data availability and utilization to the broadest extent possible was a consensually communicated finding in this evaluation making it one remarkable achievement in the Fund's work in its third programmatic cycle. The Fund's prime achievement here remains in its systematic and strategic engagement with the PCBS. Its footprints on the census, PAPFam (2006), GBV survey (2005) and user file availability are remarkable. The Fund invested extensively in data production & availability during this cycle, it was agreed. One PCBS interviewee confirms that the generated data continually on request proved to be widely utilized in bridging significant information gaps intra and inter-sectorally. A prominent example on this was the census data where the UNFPA was the main funding agency. Moreover, he adds, the Fund's consultative approach facilitates the making of this joint effort highly responsive to the national needs and development agenda.

Various data users including the Masters of Public Health students in their UNFPA funded theses and other researchers in international journals publications variably utilized the data produced in these surveys. The Palestinian Family Health Survey data 2006 was particularly utilized in the follow-up of the MDGs and ICPD, including gender equity and equality as in the third indicator above with the pertinent reports being widely used and referred to in planning and agenda setting by various parties. While this builds the capacity of involved students and researchers it also promotes institutionalization of such research capacity within the respective institutions and ministries.

The PCBS contemporary data is made available to individual professionals and researchers as well as institutions against payment despite having been produced in funded projects at the first place, which could weaken data access by some of its potential users especially students and young researchers. Therefore, it is recommended that PCBS make data available free of charge to secure access and promote utilization especially among such potential users replacing this with nonfinancial control measures, as needed.

In the same line, views on data systems enhancement reflected discrepancies among experts with regards to what constitutes good population data and how should it be enhanced. Few expressed their dissatisfaction with the quality of available research and population data utilization manner reporting under utilization and poor utilization as two overall observations. They suggested that for strategic data enhancement the Fund should consider specialized coverage by population subject area per cycle. For example, throughout the next cycle one academician proposed working collaboratively on the question of immigration tackling it from all perspectives in line with MDGs and ICPD priorities up until it is fully covered and a complete population profile on this is constructed, and so on and so forth in each programmatic cycle. The team however, believes that taking such direction would compartmentalize data

management and utilization, weaken integrative approaches to interpretation and analysis, and obliterate the needed recognition of interconnectedness between various areas of the data.

What is more important is that the Fund brings the census and specialized survey of the family health data and the like in synergy and alignment with the MoH data for surveillance and monitoring purposes, nationally.

To this end, as two key players in the health Information arena, particularly in relation to SRH, it is crucial that UNFPA strengthens and expands its partnership with WHO, especially in light of the intensive investment of the later in the MoH management health information system (MHIS). Lately, WHO worked on creating a local partnership between the PCBS and MoH where the first provides the later with the technical support needed for unifying, standardizing and verifying the statistical quality of the routine health data MoH produces in its various health operations and levels. To this end, it supported the participation of two MoH and PCBS officers in a regional relevant workshop in Egypt, one each. This way, WHO seem to be investing in the progress toward more harmonization and alignment of external aid and interventions in the health sector.

Technocrats' training was a component of three in the UNFPA- BirZeit University collaboration that was believed to have been carried out without adequate preparation, planning and monitoring. This training was meant to build the technical capacity in data utilization of targeted middle upper level staff who are potential data users and producers in selected ministries. Two 5-day courses of capacity building for 25 participants were completed every year since 2006. Nevertheless, training follow up and evaluation was not easy because the ministries seem not to have taken the training serious enough. Different people attended different sessions. Hence, the training program continuity was disturbed adversely influencing the training objectives and outcomes. Reasons behind such manner in dealing with the training could be related to lack of training sensitization efforts on the side of the trainers producing poor perception of the training with the targeted ministries who probably thought of it as being "similar to all other usual trainings" as one respondent put it. On the other hand, feedback given by a couple of training participants reflected their dissatisfaction with the quality and standards of the conducted training. Both respondents agreed that most of the times the trainers appear to have underestimated the caliber of their audience and so mediocrity and lack of preparedness were rather predominant in the delivered training. "It did not add much really" one of them said. This means that there is a need for more thorough pre-training planning and groundwork with particular emphasis on careful selection of high caliber resourceful trainers in order to fulfill the needs and meet the expectations of the trainees. This, in turn, would promote their commitment and interest and feed into the national plans they serve in their respective ministries.

Recommendations and Lessons Learnt

- It was found out that the Population Unit in the MoPAD is not as empowered as it needs to be, which could weaken progress in the area of population and development. To this end, the needed human and material resources should be recruited to promote the productive functioning of the established population unit and strengthen it. Carefully designed study tours should expose the respective staff to population experiences in similar countries in the region, deepen their understanding, broaden their horizon and enable them to think of creative contextualized means for addressing population issues in Palestine.

- In complement, in the coming cycle, toward strengthening its role, it is recommended that terms of reference of the Population Unit are re-dressed and reviewed to redefine the role of the unit within the current structure of the Ministry. More generally, the Fund should keep on investing in the relationship with MoPAD as the national gatekeeper of population affairs and support systems development within the Ministry.
- Experts' interviews indicated lack of common goal and understanding and diverse conceptualization of "population" within the established population Forum whose members were among this evaluation interviewees who expressed this sort of view. In addition, respondents articulated their concern over lack of clarity regarding the role of the forum as created under the MoPAD Population Unit. As such, its impact will always remain limited, some said. Hence, to deepen its effect and ingrain its impact the Fund needs to invest in this forum and strengthen it by subjecting interested members each by area of interest and expertise to specialized training activities and joint regional researches on population areas of joint interests. This will build their capacity and transfer the know how to Palestine through refining the experience of existing local experts who should themselves serve as TOTs later on to build the capacity of younger population experts. This must be completed within the framework of the Forum position as affiliated to the MoPAD Population Unit rather than each individual respective institution for it to reflect on the Unit's and national capacity and potential.
- Confined to BirZeit University as the sole UNFPA academic partner with no involvement from other academic entities knowledge production and sharing across the academic establishments and therefore regions is the opportunity cost in this. In fact, this was a concern interviewees frequented especially as it applies to Gaza Strip but also the West Bank. At Annajah University a rather strong population program is run under the geography department but lacks publicity and marketing, one women activist heading women NGO, said. It is recommended therefore that the BierZeit partnership model is replicated to other Gaza Strip and West Bank universities and taken down to the level of the first university degree for an expanded influence. For this to take effect, UNFPA surely needs to diversify its academic partners bearing in mind that universities are platforms for addressing youth with various RH issues including training them on data utilization. Strategically, this is one way for building the new young cadres and contributing to the shaping of their knowledge and attitudes concerning SRH and population issues in preparing them to eventually take seats in policy and decision making venues in future.
- Output 2.2 of the UNFPA CP is concerned with enhancing the national capacity to generate and utilize disaggregated data. Working on this, the Fund is an important actor in gender aggregated data production given its notable support to the PCBS demographic health surveys. Therefore, UNFPA is in a good position to contribute to putting the data produced by the PCBS –UNFPA supported surveys and the routine health data produced by MoH facilities in synergy and improve their quality. To this end, attention must be paid to updating the computer and health facilities networks to facilitate surveillance data submissions, which could be an area UNFPA may want to assume hand in hand with WHO in order to speak to its above stated output in its coming programmatic cycle.

4.3 Findings on the Outcomes of the Gender Program component

Findings below address the two country program output 3.1: To have enhanced the capacities of the Government and civil society organizations to empower women in community- building in six localities and output 3.2: To have built the technical and organizational capacities of the Ministry of Women's Affairs and civil society organizations to institutionalize gender principles and human rights.

In these output areas in particular, activities were implemented with utmost synergy to the extent that they were hard to view in isolation of one another. Often times the same activity meant to serve one output was invested also to the benefit of the other promulgating impact and making of the Fund's work in combating GBV including where the UNSCR 1325 was employed as an implementation vehicle/instrument a key achievement in the third program cycle.

4.3.1 Findings on output 3.1: To have enhanced the capacities of the Government and civil society organizations to empower women in community- building in six localities

This is based on the supposition that the lack of women's access to opportunities, whether educational, political or economic increases their vulnerability to poverty. This output, therefore, seeks to improve institutional capacity, particularly at the governmental level, and to create a linkage between grassroots organizations and formal structures that target women, especially the poor. Networking with the NGOs at the community level and strengthening bridges with local authorities were key strategies for this output. The improvement of the community-based centers' staff capabilities was considered as a prerequisite to the achievement of this output.

With MoSA this issue was addressed by supporting the girls in the Girls Rehabilitation Centers who are out of school and come from abject poor vulnerable families entitled for MoSA social services. This is by targeting the service providers (instructors/supervisors) where staff were targeted for capacity building by providing them with training on; GBV , counseling, hygiene, RH and reproductive rights and life skills. Later on technical training in some selected vocational subjects were planned to be carried out to promote the delivery of improved quality training for vulnerable girls at the recipient end.

Toward the improvement of the young women access to training and employment opportunities the Fund designed and implemented an action plan to encourage disadvantaged young women access vocational training and economic empowerment opportunities. In cooperation with the Rural Women Development Association vocational training courses were completed for 40 rural women in seam zone villages. Of these, 20 received small grants to start agricultural projects of their own in Hebron and Nablus. In addition, vocational training for girls was considered as an instrument of poverty alleviation, protection against GBV and overall women empowerment . From five community-based centers located in Qalqilya, Tulkarem, Jenin, Nablus, and Beit Jala, ten girls in each, received work kits to start their own businesses after having completed their respective training in the center. Hairdressing course graduates received a full package of hairdressing tools; dressmaking graduates received sewing tools package; photography graduates received high-resolution cameras and computer course graduates were linked each with a

selected NGO for internship with pocket money received from UNFPA. Of these, some was employed in their training institution while others started their home based micro-enterprises as in sewing for example. These measures, linked to market opportunities, served as affirmative actions directed at the engaged young women for increasing women's economic empowerment.

Networking with other women institutions is a point of success that manifested in working with a wide range of women NGOs and community based organizations interested in empowering women. Focus in this program cycle was on building and strengthening women networks and coalitions. One of the built coalitions comprised 20 community-based organizations operating in Hebron, under the umbrella of MIFTAH as a focal NGO. Through MIFTAH the Fund trained the said coalition on such issues as SCR 1325, priorities identification and communication to respective parties, team building, drafting joint action plans capitalizing on the strength of each individual organization, and joint commemoration of event such as in the GBV campaign for example.

According to MIFTAH, this endeavor came as an investment in the already successful partnership with the Fund since 2003, where focus on GBV has been already made in advocacy, research, and training of service providers. Starting 2006 a shift had occurred whereby focus of the cooperation moved to be on the SCR 1325 as a framework to combat GBV employing instruments of advocacy, mass media, research, and community mobilization. As for the later, MIFTAH believes that the experience of engaging grassroots organizations in dealing with GBV was very challenging, largely influenced by the lack of experience and resources at the targeted organizations in addition to the Israeli imposed mobility restrictions. Regardless, however, community mobilization cannot in any case be viewed as a onetime intervention, but rather a process that is to be built progressively and necessitates close monitoring, follow up and evaluation.

In MIFTAH's experience, as they stand now the 20 involved organizations are better equipped with the needed information and skills to work collaboratively and collectively. More importantly, they are more mindful of GBV and their need to contribute to pertinent national efforts and assume responsibility for acting against GBV at the community level.

About the coalition effectiveness, interviewees believe that on the level of interaction and coordination, member organizations respond positively and actively, but on the level of self-organization and taking own initiatives they still need more capacity building to be able to see things out of the usual historical competition between them. This could be owed to the reality they operate within in terms of lack of space for all, lack of adequate resources, in addition to the lack of division of tasks and specialization among them. Hence, coalitions building as an innovative project for social and health development in Palestine needs to be reviewed and evaluated for maximum efficiency and effectiveness.

This program component can be considered an area of sensible success in the Fund's work during the evaluated cycle despite major challenges. Enhancing the capacities of the government and civil society organizations to empower women in community-building in particular remain a relatively new intervention modality where these organizations' experience, caliber and expertise are still humble. This signifies making more thorough capacity building investments in this regard in the coming program cycle.

4.3.2 Findings on output 3.2: To have built the technical and organizational capacities of the Ministry of Women's Affairs and civil society organizations to institutionalize gender principles and human rights.

This Output focused on combating gender-based violence (GBV) through work mainly with civil society organizations and MoWA. Networking, knowledge sharing and coalition building, particularly around the issue of gender-based violence were UNFPA strategies to achieve this output.

The key modality the Fund employed in support of institutionalizing gender and human rights principles cored around coherent partnerships whereby each tackled GBV from one perspective or another targeting various women population sub- groups both in the government as well as NGOs. It is believed that the systematic and thorough UNFPA work on this issue contributed largely to most mobilization and policy dialogue efforts in the direction of combating GBV as a means for acting on the UNSCR 1325 for women protection in wars and conflicts.

In the evaluated program cycle, the Fund managed to lead innovative work on GBV employing the UNSCR 1325 as an implementation vehicle/instrument with utter global momentum. UNFPA worked with MoWA on combating GBV by enabling and engaging fully in holding the first national conference on GBV, after which time it invigorated the existing but completely inactive National Committee for Combating GBV (AlMuntada) aiming at building the National strategy on this. These two activities were believed to be significant steps ahead.

In the Fund's work, the SCR 1325 thematic area of protection seem to be superseding in addressing GBV. The formula was expanded even more in UNRWA "family protection" initiative embracing all those in need of protection; primarily women, children and the elderly. The concept incorporates issues such like all forms of GBV, child and/or elderly neglect and abuse as well as mental health issues for the three population groups. This stems from the understanding that while the lobbying, advocacy and networking to influence policies, laws and legislations remain as crucial as ever, time has come to attend to the link this has with the health care system. Here an effective referral system is an imperative need, because after all there are health consequences to GBV being it physical or mental or both. As such, GBV is a public health issue that needs to be brought to the forefront of the health care field. A child who is neglected including through inadequate feeding can develop anemia that can cause him low IQ or mental retardation if prolonged and severe. A pregnant that is beaten up is subject to preterm delivery, abortion, and/or any form of emotional and/or physical trauma/injury. An abused elderly can easily get into depression that can stop him/her from eating and so develop anemia in addition to the worsening of any health condition he/she may have and so and so forth. These are all conditions that compel protection of potential victims. To this purpose, Social protection networks are vital to invest in for active community involvement and mobilization to collaboratively address GBV and child neglect and abuse as captured in clinic-based encounters. These networks may include community leaders such as camp officers and school head teachers together with health center officers such as social workers, midwives, nurses and medical officers.

Guided by this notion, in 2009-2010 UNFPA started to work with MoH on building the capacity of health providers to deal with GBV survivors. Earlier before, however,

Since 2006 huge efforts have been invested in three women's centers in Hebron (West Bank), Jabalia and Bureij (Gaza) to provide the necessary clinical, psychosocial and legal counseling and support to women targeting the said centers and beyond in the communities through various outreach activities. The centre in Hebron in particular caters for a large collection of rural communities in remote areas lacking fundamental health services.

Similarly in the same line, the NGOs WCLC and Juzur are leading an attempt for creating an effective referral system in the oPt, in partnership with the police, medical and psycho-social providers, MoSA, MoWA, MoH, UNRWA, and other relevant organizations. The initiative is still in the stage of mapping available resources. It would warrant, therefore, if UNFPA capitalizes on this developing structure in the coming cycle to advance such MDG and ICPD incorporated issues, investing in its valuable work with the grassroots inside the communities, policy makers and legislators. To this purpose, more emphasis should be placed on community participation and capacity development as articulated in the UNFPA strategic plan 2008-2011 and implicated in the SCR 1325 thematic areas.

On the SCR 1325 thematic areas of protection and, relief and recovery a women network affiliated to Nablus municipality was recruited to implement a project of psychosocial support for women in Nablus governorate with particular emphasis on women living in seam zone areas. The project was implemented with Norwegian money and UNFPA support in partnership between 26 community organizations operating in the Nablus directorate. As such, this project created linkages between grassroots organizations and formal structures that target women. Primarily, the project was meant to support women by raising their awareness about GBV including about protection mechanisms and available referral channels. It served to build the capacity of the partner organizations by training 60 field workers on conducting successful workshops. These in turn carried out a total of 1000 workshops reaching a total of 12500 women throughout the project life cycle. The project managed to build a simple referral mechanism and actually referred 67 cases to 16 service providing organizations offering various types of services. Such a project provides clear evidence on the broad effect the Fund makes on the women's quality of life as empowered.

MoWA was not addressed with the gender program component at the time when Hamas came to office in 2007. Subsequent political repercussions caused freezing of the MoWA gender component work with the Fund. Subsequently, UNFPA work on the UNSCR 1325 for women protection in war and conflict was integrated into its work agenda with the NGOs. After Fateh resumed command UNFPA has already had developed its action plan and started working on these issues with civil society organizations in light of the resultant situation of internal political unrest manifesting most in the government systems instability, including in ministries. Furthermore as designed, the 3CP action plan does not spell out working on UNSCR 1325 which, although was adopted on October 2000 did not gain drive before 2006. This was after the office of the special Advisor on Gender Issues and Advancement of Women review of the implementation of UN system-wide action plan showed that beyond 2007, the said plan would need to be reconceptualized in order to transform it into a results-based programming, monitoring and reporting tool. Thereafter, a planning tool for further programming by the UN system in the areas related to SCR 1325 was developed and streamlined information available on activities undertaken by the UN system. Progress in this is assessed in light of five defined thematic areas under which seven impact areas were also

defined. While thematic areas were; participation, prevention, protection, relief and recovery and normative initiatives, impact areas included;

- 1) *Provision of goods and services*
- 2) *Partnership/Networking*
- 3) *Capacity Building: Guidelines (protocols)*
- 4) *Capacity Building: Training*
- 5) *Other Capacity Building*
- 6) *Advocacy*
- 7) *Policy Development.*

UN-wide assessment of SCR 1325 programming indicate that of the UN entities, UNFPA works most on initiatives concerned with the thematic area of participation followed by protection and prevention (UN, 2009).

In the Palestinian case, it can firmly be argued that in all projects and initiatives the Fund's work relates to the SCR 1325 one way or another, but perhaps most directly in addressing GBV given the inalienable connection between political violence and domestic GBV with them both bearing heavily on the mental and physical well being of all Palestinians.

Addressing GBV from different complementary perspectives, a broad-based approach to ensure all encompassing community participation was utilized. UNFPA established a number of policy dialogue circles and intervention channels for combating GBV. These included; creation of the National Committee for Combating GBV within MoWA with members representing and therefore engaging 11 different ministries and Violence FORUM- representing 15 NGOs working on GBV. This is in addition to continuous support, engagement and coordination with the Judge of the Judges office. Policy dialogue initiation whereby the discussion was maintained alive and active through meetings, discussion sessions, and conferences were all initiatives that contributed to strengthening the capacity of grassroots organizations.

As a modality for improving a system of knowledge sharing and fostering women's expertise, reproductive rights glossary was produced by MIFTAH in cooperation and full involvement of the National Committee for Combating GBV with UNFPA funds. The glossary was primarily and widely used as an advocacy instrument in lobbying and planning on the one hand and in community based organizations capacity building on the other. It promoted a unified conceptualization of the terms used in this field by different stakeholders. The very high demand it enjoyed compelled several re-prints. The later request for reprint, however, was postponed until after the glossary revision and update are conducted, significantly in the coming cycle.

Additionally, within the same partnership, on the publication: SCR 1325 and the Palestinian women being the first advocacy effort to link this international UN resolution to the Palestinian context, MIFTAH reported having received a great feedback from various stakeholder categories.

To disseminate success stories and support the production of gender development indicators UNFPA contracted the Palestinian Women's Research and Documentation Center to carry out an in-depth investigation of life experiences of selected women activists as real models of success in the Palestinian women movement. The stories as presented in the women own words and language offer strong indicative articulations of the gender roles definitions and the many taboos imbedded within them as regards women's rights and rites. The stories were published in a book that is used in gender roles analysis and

training but needs to incorporate a wider diversity of such insightful stories that should be disseminated and used more broadly as a women empowerment tool be it in training, networking, lobbying or else.

Recommendations and lessons learnt

- **Work with MoWA:** Employing the technical and organizational capacity building the Fund has offered MoWA to institutionalize gender using the human rights based approach was particularly cumbersome for the Ministry in the evaluated programmatic cycle. After 2007 UNFPA worked with MoWA at a low profile mainly on the GBV first national conference and the subsequent establishment of the national committee for combating GBV which were both essential achievements that were capitalized on nationally in addressing GBV issues. Doing so, UNFPA was a catalyst for pushing the articulation of the national strategy for GBV, first by holding the said conference and then by supporting MoWA and other stakeholders, through financing a coordinator in the MoWA to follow up on the formation of a national committee to proceed with this strategy. It remains crucial, nevertheless, that this strategy is kept on track, pushed ahead and guaranteed the financial and technical support it needs for implementation. In spite of this, in the UNFPA's experience and since its inception working with MoWA was not very rewarding compared to the made investments. The Ministry intended to serve as a high policy and advisory body is still severely hampered by the limited human and financial resources. The share of MoWA in the national budget remains the smallest among all ministries largely impacting its capacity to function up to the role expectations and potential, akin to UNIFEM being the smallest in the UN system!

This has pushed the Ministry from its originally advisory and policy role down to the technical level functions to the extent that no clear distinction can now be made between the role of MoWA and that of any other women NGOs especially given the historic power amongst the later. This triggered questioning its very existence at the first place and called for redressing the current structure and look into the extent to which it serves the women interests and strategic needs, at the second. Consequently, to the forefront, the old-new discussion on the viability and value of having MoWA as an independent entity versus merging it into women units in various ministries returns. The prevalent argument is that the Ministry as it currently stands is not gaining the political support and momentum it needs to serve the purpose of its being but rather it got marginalized and excluded from many significant initiatives that are not perceived as "women issues" as per se but however impact women interests in every way. This led to its weakening and deprivation of many growth opportunities while being obliged to function in line with policy decisions that do not necessarily support its agenda and therefore minimize its agency nationally.

- Institutionalizing gender issues through focal points in selected ministries and establishment of a coordination mechanism between the line ministries and the MoWA was largely hampered by the repercussions of the internal political divide where institutional stability at the PA structures including ministries was disturbed. Although the Fund invested in working with MoWA in addressing GBV issues particularly in the first national conference, this, however, needs to be driven forward and expanded within MoWA itself as well as in other line ministries.

- Women with particular reference to those in female-headed households (FHH) are less integrated in poverty eradication policies, especially those that do not fit definition of a FHH and those whose households include an unemployed male of working age. In the evaluated program cycle, to some extent, the Fund addressed women in FHHs through MoSA. Nevertheless, functional mechanism to follow up these women's accessibility to poverty alleviation schemes need to be firmly set to ensure the linkages between the community-based centres and the different programs of poverty alleviation already being instituted at the national level by other agencies such as at UNRWA, UNDP and World Bank. Partnership with such lead agencies in addressing poverty among women especially such most in need group must be reinforced.
- Enhancing the capacities of the government and civil society organizations to empower women in community building is a relatively new intervention modality where these organizations' experience, caliber and expertise are still humble. This signifies making more systematic capacity building investments in order to employ the elevated capacities in the coming program cycle in various empowerment projects.

4.3.3 Humanitarian Response to GBV including Resolution 1325

Humanitarian response to GBV in the Fund's program was meant to institutionalize UNSCR 1325 by strengthening small community based organizations through putting them together in a coalition and affiliating them to one larger institution which could be either an NGO or a municipality . So far five coalitions were built in Hebron, Jenin, Nablus, Jericho and Gaza. One is lead by MIFTAH in the West Bank while another is lead by the Culture and Free Thought Society in Gaza. The remaining three are lead by respective municipalities. In the year 2009, Nablus and Hebron coalitions organized a solidarity march with seam zone villages/ Neighborhoods such as Tal AlRoumaida in Hebron ad Salem village in Nablus; both known to be frequently attacked by settlers. The year before, in 2008, the Nablus coalition organized one day Conference on Women empowerment and unmet needs.

This needs to be taken up further and expanded to include lobbying for the realization of the long sought changes in the family and criminal law to optimize their responsiveness to women's reproductive and other human rights.

4.4 Cross Cutting Issues

4.4.1 Human Rights Based Approach (HRBA)

Human rights based approach (HRBA) is a process, which applies a number of core principles aimed at ensuring the full enjoyment of human rights by all (UN, 2003).

The Fund integrates and enshrines a human rights based approach (HRBA) by incorporating its core principles into its Palestine CP3:

1. Expressively apply the international human rights framework.
2. Empowerment.
3. Participation.
4. Non-discrimination and prioritization of vulnerable groups.
5. Accountability.

According to the UN Human Rights Strengthening Programme, Review 2001, applying a HRBA is a matter of changing the way business is done rather than simply introducing new “human rights” projects or infusing human rights language, or adding human rights components. HRBA entails more than formal commitment to respect the human rights norms and standards. It requires the integration of those minimum standards into all plans, policies, budgets, processes and institutions. By definition HRBA is as concerned with the process as well as the outcome. This in fact was the UNFPA - CP3 guiding notion upon integrating a HRBA in programming, according to one CP3 officer. But then how did it go about it?

In this program, one way the Fund employed the HRBA in the RH program component was by promoting community participation and empowering people to play an active role in their RH care especially in marginalized hard-to-reach communities as in behind the Wall or in besiegement. This inclusive model called community support teams, an interviewee from one prominent Palestinian NGO- UNFPA partner says, is based on creating linkages with local women who are known to be influential and credible to their local fellows such as women engaged in local women centers, clubs, associations and others. Then these were exposed to carefully studied RH training packages on a consistent and systematic manner. Equipped and empowered with the knowledge they gained and skills they acquired their relationship with the organization flourished. This was then built on by involving these teams as active participants in promoting RH in their local communities as educators and guides to women concerning critical RH and neonatal health issues. These include pregnancy and neonatal danger signs, MBE, within-reach health facilities and recourses, what to do in emergencies, where to go for what, when to resort to self help measures versus when to seek professional assistance and so on and so forth. Progressively, these teams became significant advocates and supporters of the respective organizations.

In fact, the same decision maker says:

“We barely see any resistance from the community about the activities we do including on critical issues such as STIs including HIV/AIDS for example. They now feel they are our partners who belong to the organization, defend and trust it...”

Community Participation & Inclusion was a means for a HRBA to achieve an expanded coverage of RH/FP services where the Fund outshined. In the CPAP the Fund clearly states its aim for community mobilization in order to secure the right of all sectors of the population to access RH quality services (para 20, CPAP). Participation and Inclusion both as a means and a goal was one fundamental human rights principle that was well integrated in almost every component of the program. This took place in three corresponding forms:

- ✓ Training of local personnel (e.g. school teachers, leaders of women’s groups) to improve their skills and knowledge in the concerned RH/FP practices and knowledge so that they can support best practices in service delivery and utilization in these areas to the community.
- ✓ Use of local associations and community groups to implement projects activities.
- ✓ Integration and implementation of project activities through broad development programmes, with community members taking a more active role in planning and structuring the programmes as in the community support teams for example.

4.4.2 Capacity Development

The findings and discussion below cater for **output 2.1: To have increased the national capacity to integrate population, gender and reproductive health into development and emergency planning processes**. Starting from the onset of this program cycle, program objectives were hit by Gaza separation and subsequent political divide between the WB and GS, especially that the program was designed to cater for one government and one country.

There was an overall agreement about the UNFPA hands-on participatory approach in program management including its needs driven planning, situation analysis and high interactivity with partners and stakeholders being valuable instruments to the success of the Fund’s-lead partnerships. The synergy UNFPA maintains in influencing policies, providing services, empowering women, mobilizing communities for collection actions and reforming laws was viewed as the key in the Fund’s work in the oPt.

With Ministries in general, partnership management was relatively difficult. Technical and managerial competence was issue of concern most of the time. Lack of respect to the set agenda and deadlines compelled intensive UNFPA follow up and monitoring to ensure tasks completion in due time. Consequently, the resultant UNFPA staff role shifting made it more technical than it was originally meant to be.

Bureaucracy and structural deficits at the MoH as well as UNFPA itself adversely influenced progress and caused serious delays at times. Within MoH, **WHDD appear to be somewhat isolated and disempowered. Despite the fact that it was set up by ministerial decree as the coordinating body for RH services and projects within the Ministry,** MoH did not build robust operational capacity within WHDD in terms of quality and quantity of human and material resources to enable its tasks accomplishment. The establishment of WHDD and its position in the Ministry's hierarchy is a mechanism for strengthening the Ministry's commitment to reproductive health ideology and gender integration particularly that women in decision making positions at the Ministry structures are very few. However, the overlapping roles of the different departments in relation to the provision of RH care creates some role ambiguity and a complex mechanism for management and coordination which alongside the structural disparity for services provision between Gaza and the West Bank makes implementation rather problematic.

Bureaucracy and such structural deficits within the MoH generally and within/between departments remain a key capacity development issue. Frameworks for scaling up essential health interventions to reach the health related MDGs need to be developed by inter-directorates/departments teams to ensure work is done in an integrated approach, which is mandatory to their institutionalization.

As an NGO partnership model, UNFPA support largely enhanced MIFTAH's capacity to empower women in community building. First, it gained more visibility on the community level and was engaged in active/strategic partnerships with some local institutions such as Al-Najah university, MoWA and PCBS. It enhanced its capacity in coordination with stakeholders giving it wider access to decision and policy makers. Most uniquely perhaps, it equipped MIFTAH with distinguished skills in defined critical fields such as advocacy, policy analysis, and policy papers preparation. MIFTAH's work on policy papers and briefs, in turn, was first effective in qualifying a group of trainees, researchers and activists to produce the contents in a professional manner. Second, it enhanced networking and coordination among stakeholders to agree on common understandings and standardizations in certain matters. Recently, adoption of unified Indicators that measure the "Quality of Services Provided to Pregnant Women in Palestine" to be conducted by PCBS was one example of such collaborative work. In the same line, a consensus was built regarding the need to assess the Palestinian curriculum for it to incorporate GBV and gender concepts. This consensus was taken up lately by Juzur Foundation for Health and Social Development to carry out the said assessment engaging active players from the health and women movement arena assuming that a unified women agenda would promote better responsiveness on the side of planners and policy makers.

Interviewed stakeholders recognized development of staff and institutional knowledge base in their respective institutions as being valuable point of success in their partnership with the Fund. They reported that UNFPA supported staff develop their knowledge and skills in networking effectively with stakeholders at the governmental and nongovernmental entities in advocacy, research and training activities. They received training on how to review and assess the prepared training materials, policy papers, fact sheets and researches conducted by the contracted experts. One interviewee asserts that the strengths of such trainings materialized in the form of Hebron field coordinator herself becoming a trainer in GBV, for example. It also opened doors for partner organizations to develop new projects with other donors in light of the findings, ideas and insights emerging from their partnerships with UNFPA.

Work environment between the MoH and NGOs remains critical. When the UNFPA intends to allocate some funds for NGOs work especially in the outreach, community mobilization and awareness work MoH is not sure of the added value, worries about duplication and competence, and their- MoH's- extent of control over the deliverables and effects linking that to the fitness of the NGOs completed work to the policy dialogue. Within the framework of different partnership structures, UNFPA attempts to build bridges between the government and NGO institutions in charge of different program components toward promoting interactive dialogue among different shareholders.

UNFPA needs to mobilize technocrats at the MoH, NGOs and other line ministries and support them in order to work more collaboratively to put RH, adolescents RH and RH Commodity Security on the national agenda. UNFPA local staff is knowledgeable of the political dynamics and possess adequate information on the national health needs as they emerge. As such, they are perceived and act as integral constituents to the Palestinian Healthcare system not external to it, which could widen their margin for RH advocacy and policy dialogue.

This is primarily by focusing on supporting systems and institutional development for governmental and civil society organizations. Building the capacity of Government to strengthen its health system is essential. This includes technical assistance to programme country for nationally agreed priorities (UNFPA strategic plan, 2007). The key area of addressing maternal mortality and morbidity necessitates a functioning health system. Strengthening health systems is usually complex and demanding, more so in political instability and war-like situations. While the Fund invested significantly in upgrading and expanding MoH and some NGOs facilities, it still needs to insure proper management of supply chain in order to maintain a reliable supply of commodities, which appears to still be suffering despite some progress.

UNFPA needs to consider and raise issues of adequate human resource planning and policies for correcting the understaffing problem including in nurses and midwives as the frontline RH care providers. Without such achievement-sustaining measures, it cannot be seen how clinics will ever be able to improve quality of care, integrate a HRBA in the care provision process or preserve privacy and informed choice as the minimum acceptable to human rights integration.

4.4.3 Partnership Strategy including Joint Programming

- **Diversification of partners including with non-PA actors:** The Paris declaration principles set forth accountability not only to governments and donors but also to national stakeholders including the civil society organizations. With the agreement and consent of the host country, the United Nations development system should assist national governments in creating an enabling environment with strengthened links and cooperation among all entities involved in the development process – national governments, the United Nations development system, civil society, national nongovernmental organizations and the private sector. This process would incorporate a view to seeking new and innovative solutions to development problems in accordance with national policies and priorities. UNFPA realized this in various ways including in coalitions building in working on UNSCR 1325 and community support teams in working on RH in seam zone areas.
- **Joint programming:** In the Fund's 2006-2009 CPAP, UNFPA states that in order to avoid duplication and to maximize the benefit of international donors, UNFPA, in agreement with its

counterparts, will coordinate with the different donors in the health. In the multilateral Global Fund supported partnership, for example, UNFPA chairs the UNAIDS thematic group. According to officials from WHO and other UN partner agencies, the Fund showed excellent partnership building skills in this. It did especially good in designating every partner agency a task and followed it through to full completion. However, it failed to translate the partnership at the level of knowledge sharing and dissemination. There was also lack of clarity in the role of partners; some partners exclusion from selected activities such as HIV training, for example, was observed and work was rather fragmented, according to at least three partner UN organizations. UNFPA appear to be in a bit of a competing position with its fellow sister organizations, as agreed by a number of the interviewed international agencies representatives. There are personal, attitudinal, transparency, control, and ownership elements to this according to the interviewed in one UN agency. UNFPA staffs maintain that joint programs development was put on hold due to unclear roles and responsibilities in implementation. The role of the “lead agency within the UN” is not clear nor defined creating a sizable grey area that hampered joint programming and held it back from progressing.

Overall, however, there was some recognition among the international donor agencies interviewees that, across the international agencies there still are no systematic means or common tools to ensure that the decisions made internally based on each process are compatible with those of other development actors operating in the same area. This contributes to incoherent and inconsistent processes among donors and probably facilitates playing them off against one another.

Development practitioners have identified some of the reasons behind this incoherence as agency-specific mandates and agendas. Sometimes, Isolated sectoral approaches continue to be applied where more holistic integrated approaches are needed, challenging national level harmonization by development actors, especially in joint or multi-sectoral programming. For UNFPA CP3 the challenge here is that **it needs to maintain UN reform momentum recognizing its strengths as well as limitations including the limited staff size and expertise of new staff relative to the program growing size and scope of operations. While there are overlapping areas of operations within the UN system, those of UNFPA comparative advantage are clear. It is in the later where UNFPA new CP should focus its investment in order to excel in joint programming leadership and minimize competition potential.** The expectations are that with time and experience joint programming will gradually develop and flourish with less grey areas, inconveniences and sensitivities.

4.4.4. Programme Management, Monitoring and Evaluation

- 4.5.1 Advance and promote management by results models for mutual accountability.** Closely linked to the question of managing for results is the issue of mutual accountability. The principle is that both donor and programme countries are accountable for the commitments made to one another, acknowledging the need for transparency and accountability on both parts.

As part of the United Nations, UNFPA is committed to help the PA in reviewing implementation of the Paris declaration at the country level in order to ensure their own accountability. **The challenge for UNFPA Country Team in Palestine is to employ its set up country-specific**

monitoring matrix, based on the Paris declaration “aid effectiveness action plan”, to assess national performance. Through its broad-based partnerships, which include government and NGOs but could be extended to the private sector as well, UNFPA CP3 should support the PA and others in making this monitoring a transparent and inclusive process, thereby promoting the principle of mutual accountability among all actors at the country level.

4.4.3 Growth in the UNFPA scope of work is not in line with growth in human resources.

The Fund needs to expand its human resources in line of its rapidly growing scope of operations. Currently the country program is moving to a higher level category within the UNFPA system which will entitle the office for more staff. It is strongly recommended to aim for experts and resourceful technical people in this expansion process, especially in RH and youth. More program associates by program component are important assets, not to forget the need for assistants by program component as well. In addition, it would be worthwhile to separate the two program areas of gender and population and development, in terms of senior officer handling them both, simultaneously, because each is a substantial piece of work in its own right. However, if the current structure is preferred for any reason, it will still be valid to add two more staffs with at least one of them being senior but on a different seniority level compared to the current one for managerial stability. Upgrading the youth from subprogram to a fully-fledged program component will better speak to the immense needs of such difficult and continually growing population group. The Gaza Office structure certainly needs to be expanded and strengthened especially as per the RH program component given the significant weakness and poor quality of the RH services there as this evaluation has clearly shown. This would allow staff to excel even more and feeds into improved program outcomes. It will also present the program with an opportunity to review, re-structure and promulgate its newly developed organogram.

4.4.4 Work with the NGOs: With MIFTAH as an example, for this NGO partnership with UNFPA proved particularly useful on the organizational level especially as compared with other partners/donors. This is because it enjoys continuity, similar vision between both organizations, and participatory approach to partnership management and follow up on the Fund’s side, incorporation of human and financial resources support and finally responsiveness and flexibility.

4.4.5 Annual Program Review, quarterly monitoring tool submitted by the partners to the UNFPA on what has been implemented, field visits reporting and program summative or formative evaluations were used by UNFPA CP3 to monitor program progress. However, the Fund found out that these instruments did not suffice for the said purpose. Therefore, **a more coherent monitoring system needs to be put in place to improve program outcomes.**

4.4.6 One program function is the disbursement of funds with no carryover, lapses, and/or deficits, evidence of program monitoring and improvement activities to ensure that the funds are being expended responsibly and in accordance with the program’s terms of reference and objectives is an essential accountability reinforcement instrument. Often times MoH felt short of expending project’s allocated budget. In such case, UNFPA involvement is meant to push the flow of resources to the relevant operational units providing the service. **Recognizing poor expenditure performance here, the lesson learnt is to establish a close monitoring system of which**

regular financial management training of programs management staff is a pillar. This is for all partners with most emphasis placed on government.

- 4.4.7** Along the five years program life cycle, four formative evaluations were completed on various aspects of different program components, primarily in the areas of youth and gender. No evaluations were done on any aspect of the population program area while one summative evaluation was carried out only on the RH services component at the end of the second program cycle. The lesson is that **criteria based evaluation instruments both formative and summative should be more systematically integrated into each program component and cycle to allow timely tracking of program performance and appropriate implementation.**

5. Efficiency

Efficiency is a measure of the relationship between outputs, i.e. the products or services of an intervention, and inputs, i.e. the resources that it uses including the financial and human ones.

An output is the immediate observable result of intervention processes over which the implementers have some means of control. An intervention can be thought of as efficient if it uses the least costly resources that are appropriate and available to achieve the desired outputs, i.e. deliverables, in terms of quantity and quality. In this evaluation, financial and human resources broken down by intervention area and pertinent lessons learned from previous programme cycles or projects evaluations were used as benchmarks for assessing efficiency.

One evident success indicator on programme efficiency in the evaluated cycle is the negligible percentage of expenditure on programme coordination being only 2.1% of the total and the number of human resources available for the CP to work on each programme component/ intervention area. As yet, in the country programme office there is only one or less staff by each intervention area. Only one officer shoulders the two programme components of PD and gender averaging half for each. The major program component of RH services is being handled by one staff too. The youth sub-component which is considerable in size is being handled by an average of half staff that also functions as the assistant representative. On this matter, one policy maker commented wondering how could such small size office manage such a big chunk of work, as she puts it!

UNFPA humanitarian response is in full harmony within the complex donors' environment. One way this harmony materialized was in the UNFPA acquirement of substantial extra funds for its humanitarian response to the War on Gaza in 2008. While the third program cycle commenced with a budget of 5 million \$US, acting upon its humanitarian mission, the CP office was able to bring it up to more than 16 Million through intensive fundraising efforts with the Donor agencies including Australian Government, Norwegian governments, Japan and CIDA-Canada. This demonstrates the extent of the CP efficiency in the Fund's human resources utilization and ability to work in harmony within its area of operations; an efficiency without which such a huge funds could not have been obtained.

5.1 Efficiency of RH Component

In terms of financial efficiency, the table below clearly shows that the highest percentage (58.2%) of the country programme expenditure goes to the RH programme component which obviously has especially increased after the emergency situation post the War on Gaza and subsequent repercussions. At the same time, this is the area where the programme have least control especially with the internal political split and the much diminished access to/in Gaza health facilities caused by the Israeli imposed prohibited mobility of medical supplies, equipments and staffs. This evaluation showed that efficiency in this program component is not at best especially compared to the huge investments the programme had made. Let alone this external factor, Palestinian-wise diagnosed deficiencies in staffing, infrastructure, supervision, adherence to protocols, training opportunities, clinical staff role definition, scope of practice, and performance appraisal all fall within MoH domain and control. These same deficiencies were also findings from the previous programme cycle RH evaluation that could have been used as benchmarks for quality improvement in the subsequent third cycle. To make an effect on the efficiency aspect of the RH program component, on the side of the programme, more staffs are needed to operate with closer hands on approach in monitoring and evaluation so as to better attend to more technical support requirements which would facilitate quality improvement.

Table 30UNFPA oPt Country Programme Resources 3rd Cycle (2006-2010)						
Reported Financial Resources as of 12 May 2010 (USD)						
Intervention area	Regular Resource		Others		Total	
	(Planned and Final Expenditure)		(Planned and Final Expenditure)		(Planned and Final Expenditure)	
Reproductive health and rights	3,300,000	3,371,171.33	1,800,000	6,109,807.80	5,100,000	9,480,979.13
Population and development	800,000	2,339,068.10	500,000	2,444,326.95	1,300,000	4,783,395.05
Gender equality	500,000	608,081.94	500,000	1,067,865.33	1,000,000	1,675,947.27
Programme Coordination	400,000	335,845.59	0	0	400,000	335,845.59
Total	5,000,000	6,654,167	2,800,000	9,622,000.08	7,800,000	16,276,167.04

As for the youth sub-component, the legendary change the UNFPA managed to make in integrating SRH information into the Palestinian curriculum which has become a lead model to be adopted in many Arab

countries in the region is an efficiency indicator that calls for making further investments in this program element, indeed, because here is where the enduring change is made.

5.2 Efficiency of PD Component (29.4%)

This program component consumed around a third of the programme expenditure but for a good reason. It had made tangible and sizable achievements, primarily, in the enhancement of the national data system through the support UNFPA had provided the PCBS with to carry out the census and some other vital national surveys. Some stakeholders articulated their held believe about the UNFPA being the twin godfather along with PCBS to the nationally credible data including in RH, youth and gender. This holds clear indications on the extent of the programme's efficiency in this component. The subsequent dissemination and utilization of the produced data made some of the much needed contribution to the development of the national capacity in this area, however does not seem to be as efficient as the production of the data was. Technocrats' training for example was not valued by the trainees and seems to lack adequate preparation on the side of the training provider. So were the produced policy briefs in terms of production and dissemination. This was an efficiency weakness in the program component the Fund needs to watch out for in the coming cycle.

5.3 Efficiency of Gender Component (10.3%)

There is evidence from evaluations and from comments of stakeholders that UNFPA was successful in stimulating and facilitating public debates and policy dialogue within important key groups including male opinion leaders and religious figures, on such sensitive issues as integration of previously tabooed sexual health information into the school curriculum, or GBV including sexual violence. On the one hand, UNFPA is credited for having effectively challenged such deeply embedded, cultural and religious traditions and beliefs in an acceptable and non-confrontational manner, indicating this effort to have been an efficient use of recourses. On the other one, the intricacy and interconnectedness of the completed activities makes it difficult to say exactly how much of the programme has been allocated to policy interventions as policies have been addressed within different components and the structure of the budget as available does not allow their demarcation.

The one tenth of the programme expenditure used for the gender component is believed to have been used with utmost efficiency. The national campaign for combating GBV where the Fund was a key driver including the first national conference on GBV, UNFPA awareness raising, community organizations mobilization and coalition building work and interventions especially as regards to the UNSCR 1325 had all produced great awareness and sensitization among women concerning their human rights in the war

like situations such as those prevalent currently in the oPt. Messages of such sort reiterated throughout the focus groups discussions and experts interviewees completed in this evaluation.

6. Impact

Impact is a measure of all significant effects of the programme interventions, positive or negative, expected or unforeseen, on the beneficiaries or others.

6.1 Impact of RH Component

According to Ex Minister of MoWA it was the UNFPA work that had placed reproductive health on the Palestinian map as a human rights, gender and population concept where quality of life is at the core. Therefore, its role had the most positive impact on changing the RH traditional procreation image to a more progressive one. UNFPA work in the area of RH services in terms of the community support groups it created in rural communities and seam zone areas in cooperation with partner NGOs made a positive impact on pregnancy and postnatal outcomes for many women by enhancing early detection of danger signs and recognition of proper/available referral channels.

MBE and Pap smear testing is another area where the programme made both positive and negative impact on women's lives. The fact that service providers were trained on doing Pap smear testing is the positive impact of the RH component while unavailability of trained professionals who can read the results (slides) is the negative part.

Family planning methods commodity security in the West Bank is another positive impact of the RH component. So is the availability of training opportunities to the clinical staff while lack of monitoring on criteria for nominations and training outcomes are negative impact. It is believed, however, that most of the negative impact in this programme component has to do with lack of adequate technical staff working on this component in the CP office on the one hand and the emergency situation external to the programme control forcing new priorities and reprioritizing existing ones on the other.

A longer term positive impact lies in equipping the first and second level health facilities with the qualified professional cadres of the neonatal nurses and midwives graduates of the professional degree courses. The Fund supported Ibn Sina College to making available to women and infants the qualified female professionals who can better serve them with the bio-psychosocial orientation and gender sensitivity to their needs toward the improvement of childbearing and rearing outcomes that feeds into the overall quality of care.

In terms of youth sub-component, interviewees agreed that the impact UNFPA made was perhaps most pervasive by working with MoEHE in the RH integration in the Palestinian school curriculum with active engagement of Islamic religion supervisors.

6.2 Impact of PD Component

Population mainstreaming into the planning processes was an impact the PD component made as a result of the aggressive and persistent policy dialogue and advocacy activities the program initiated, stimulated and geared. Establishment of a population unit as well as the Population Forum with an advisory capacity under MoPAD contributed to the population integration into planning processes were also two areas with positive impact of the PD component.

Wide production, availability and to a lesser extent utilization of the census and national demographic and health and other surveys data is a key achievement of this programme component. This contributed to strengthening the national information system and made data and information relating to population concerns widely available.

6.3 Impact of Gender Component

Stakeholders variably expressed considerable extent of agreement about the positive impact the programme had made in the gender front. Focus groups participants in particular but also some interviewed experts believe that the coalition building model is a revolutionary idea that impacted women's organizations positively by bringing them to work collectively making best use of their caliber and resources and most of all develop their capacity which is also another sustainable impact area.

Merging the two gendered school curriculum subjects of home economy and health and environment into one unified curriculum for both sexes was a great impact made in this component.

For some of the interviewed experts, UNFPA was the driving force behind many key national initiatives such as the later GBV campaign; another impact this program component had made.

The gender programme component made a positive impact on the system of knowledge sharing among individual and women organizations and in fostering women's expertise toward the collective production of reproductive rights glossary with UNFPA funds. Another positive impact it made was the development and adoption of a unified conceptualization of the terms used in this field by different stakeholders.

A negative impact, however, reflected in the limited investment UNFPA had made with MoWA as the key formal government body on and for women.

7. Sustainability

Sustainability is a measure of whether the benefits of the programme are likely to continue after external support has been completed. While the four former criteria concern specific programme interventions, the assessment of sustainability addresses the effects of the programme implementation process itself over the long term.

7.1 Sustainability of RH Component

Capacity development in the form of knowledge and skills gained in RH training and degree courses the program had offered various staff, mainly from MoH and partner NGOs, are most likely sustainable because people who join such courses and training opportunities are employees and staffs working in these institutions and are usually confirmed to their posts. Therefore they are inclined to remain especially with the lack of job opportunities. This means that, given no barriers to implementation newly gained knowledge and developed capacity is sustainable.

Integrated SRH information into the school curriculum is the net result of the collective work of various stakeholders. This integration is believed to be highly sustainable because its introduction in the first place was a painstaking task that was accompanied with strenuous policy dialogue, public debate, and policy decision on the side of MoEHE. The slightest change in the curriculum requires such laborious work and strong valid arguments to make. With regards to the SRH information it can confidently be said that the introduced change is sustainable and might not be changed for a good deal of time!

RH protocols and guideless developed under the programme are reference documents for standard clinical practices in health settings. They are to be used in daily practice with negligible addition costs regardless of the Fund's further involvement. As such they too are sustainable.

7.2 Sustainability of PD Component

Printed materials and produced population data including in gender, youth and RH are all sustainable investments UNFPA had made and are being used nationally in various capacities, settings and levels being in education, planning or policy. Documented and disseminated as they are the potential for their loss is very low. Tested history regarding utilization of the produced data and printed materials hold strong indications on their sustainability.

At another level, the establishment of Population Unit at MoPAD alongside the population Forum as an advisory body comprising representatives and experts from key ministries, civil society organizations and international institutions was gives it impetus and promotes institutionalization of population issues into the planning processes of the Ministry.

7.3 Sustainability of Gender Component

Gender sensitization of selected school curriculum is subject to the same interpretation of the SRH information integration into the curriculum.

The training the Fund has given the community organization coalition on such key issues as SCR 1325 and life skills, the training of the community-based centers' staff in support of the girls in MoSA rehabilitation centers in addition to the vocational training courses the girls themselves have received to improve their access to employment and economic empowerment opportunities are all sustainable contribution the Fund had made in the targeted institutions and women.

Coalition building and putting in place functional mechanism to follow up most-in-need women including those in FHH still have a good way to go until sustainability is ensured.

8 Conclusions & Major Recommendations

Clearly, guided by its Strategic Plan 2008-2011, the UNFPA adopted multisectoral partnership development for positioning the agenda of the International Conference on Population and Development.

8.1 On RH component

The Fund remains to be recognized as the most prominent institution in reproductive health and rights. It played a lead role in increasing contraceptive commodity security; a role the Fund is strongly encouraged to keep up. Not only that but also, some policy makers believe that the Fund needs to invigorate and restore the political leadership commitment to the reproductive health ideology and human rights principles embedded into it including those of empowerment and participation. According to them, strong advocacy and policy dialogue is needed due to the weak presence of the RH concept in the later PNHS document.

The programme successfully tied humanitarian assistance to development assistance. The programme's work on advocacy, policy dialogue, data system enhancement, gender, reproductive health and reproductive rights reflected this integration.

Nobody was outwardly negative toward the program. Some, however, had their reservations regarding the adequacy of staffs in the country program office. Those who voiced their reservations often raised the growing UN institutions recruitments of Junior Internationals, as an issue of concern. One key government official puts it thus:

"We need to see experts and resourceful people in the Fund's office and other UN agencies to maximize the Agencies' added value".

This program cycle evaluation demonstrated a dire need for more rigorous hands on technical support at MoH, especially at the primary healthcare level including at WHDD and PHCD, as was the practice in the previous program cycle, especially with the tremendous expansion in the CP scope of operations, as articulated by more than one government interviewee.

After the passage of five years since the previous evaluation of the RH program component was done, some of the conclusions made then are still valid despite the substantial investments made in this cycle program implementation. Universal access to quality RH health care integrated at the PHC level, including adequate and qualified staff in well-equipped facilities as set out in the CPAP is not yet fully in place.

The remarkable inputs UNFPA invested in equipment and facilities in order to expand the coverage of RH services, including RH-related education and counseling cannot be recognized enough. However, the ever-growing RH needs and demands especially in the context of the concomitant emergency RH and child health needs have surpassed the capacity of the recruited material and human resources compelling

a need to upgrade, including putting in operation some mechanism for monitoring and evaluation and find ways for removing potential limitations. Founding an MIS network would be a major strategic asset and achievement in this regard.

RH providers in both regions of the WBGS frequented problems in space, over-crowdedness, old and poor infrastructure and worn out equipments and furniture as key impediments to quality care with particular emphasis on privacy barriers. Uncomfortable waiting spaces and conditions and poor visual and auditory privacy standards indicate the urgency for investing in the clinics infrastructure for more and better-suited spaces and correcting the staffing deficit as two crucial interventions for system development from an access perspective. Not to forget that from the human rights standpoint, clients' rights for privacy and confidentiality are not being protected, on a systematic bases. Providers are, therefore, urged to invest more in ensuring women's cognitive access to RH services.

The three CHCs of Yatta, Jenin and Jabalia fared least of all in terms of logistics and commodities. Key missing items hold basic hygiene and infection control implications and trigger privacy concerns. In terms of consumables, Jenin CHC and Rafidia hospital, both in northern West Bank fared worst of all with no less than 8 consumable items missing in each. In terms of regions, Jenin CHC and Al Qarara were most disadvantaged. Almost always missing items were central to core RH functions.

On management functions, client/doctor contact time per woman per session was very short not exceeding 4 minutes in most instances. Staffing in the studied clinics is inconsistent with the caseload and facility catchment area especially in such clinics as Yatta and Jenin Central. Availability of Job descriptions, following the protocols in daily practice and conditions for adherence to or following the protocols, and supervision are all areas that came out to be quite weak in all studied facilities.

Providers reported having received training on high-risk pregnancy protocol, emergency delivery and obstetric care, breast examination, and infection control. Nevertheless, they had some reservations about the system tolerance of training substance integration into the clinical operations on site given the unfavorable work conditions including over-crowdedness and understaffing where most providers find themselves obliged to operate. Attending to staffing and space issues within the facilities must be viewed as a pre-requisite to other core professional aspects of institutional building.

Requested to identify their training needs priorities, out of 14 different areas, providers gave highest priority to topics falling within the five areas of; management skills, STIs and STDs, cervical cancer, maternal health and neonate care. A majority of the interviewed providers reported being in need of seven different management skills with highest priority given to supervision and performance appraisal.

Constellation of services indicates that service availability and offer are clearly inconsistent with the defined service package by facility type, with significant omissions especially from the comprehensive health centers. Gaza most critical challenges were of service constellation nature such as; out of stock

medications and shortages in equipments and consumable supplies most importantly in respect with the near finish supply of FP methods resulting from the Israeli imposed blockade on Gaza. Whereas for the West Bank, the most confronted challenges were lack of adequate technical professional cadre and limited physical space both resulting in clinics' crowdedness.

Service over-utilization was noticed in the average number of ANC visits a low risk pregnant woman pays the RH clinic in Yatta and Jenin Central CHCs. Numerous, routine ANC visits overburden women and healthcare system. Therefore, it is recommended to encourage rational use of resources and consider WHO recommendations on reducing the number of visits without affecting outcome for mother or baby; a minimum of four visits per normal pregnancy can suffice if focused ANC approach is adopted.

About Tetanus Toxioid administration in government clinics, providers were familiar and in conformity with the disseminated MoH protocol. Universal supplementation regardless of the woman's iron status still is the policy.

Women are asked about the availability of iron and are provided with the supplementation when needed, but nothing on; how to take them, possible discomforts or side effects, what foods augment/diminish iron absorption or on compliance.

Apart from AlQarara all of the sampled clinics provide at least three family planning methods and therefore secure women a reasonable choice of method. Nevertheless, an overall reversion in FP services is observed nationally. Therefore, RH concept must be re-emphasized and strategies employed in FP services provision must be re-visited.

Exceptionally though, condom utilization has improved as a result of the improved supply chain management plan adopted for condom distribution and promotional strategies. Condom utilization is promoted passing through the marketable concept of STDs prevention. Nevertheless, more awareness and sensitization efforts still need to be invested in condom promotional activities/campaigns. Skilled providers must be more resourceful, informative and persuasive to people in condom counseling, awareness and sensitization emphasizing its role in STIs/STDs including HIV-AIDS besides being a family planning method.

Postnatal care is typically still the service women utilize least. Stated non-use reasons denoting client-provider information exchange and cognitive access deficits indicate that integration of postnatal care into RH care services did not receive the needed attention of health planners or care providers for it to reflect on clients' health seeking behavior, service utilization and maternal and child health outcomes as upheld in the continuum of care notion. Therefore, it is suggested to strengthen and institutionalize outreach programs more systematically in the form of home visits as an integral component of RH care services.

Documented women cases of STIs/STDs in clinics were reported to have become chronic due to the husbands' reluctance to treatment. Therefore, addressing such serious SRH risks RH policies must include strictly monitored surveillance system with a home visiting component executed by male health workers/nurses/educators to target men investing in the exceptionally sizable male nursing population in Palestine. This could be thought of as the seeds for a program aimed at "involving men in RH" strategically on the longer run: an area that had been and still is largely marginalized in RH service programmes.

Counseling is an integral element of RH services on offer at all studied facilities. However, ambiguity among providers as to what counts as counseling, what contents in a client-provider interaction makes of it integrative of counseling and what quality of counseling suggest the development of counseling protocols that incorporate clear guidelines by service type counseling to be monitored against realistic measurable indicators for each.

Early detection of breast cancer using manual breast examination (MBE) and cervical cancer using Pap smear testing are progressively and variably integrated into the RH service package. The fact that breast cancer still is the leading cause of death among all reproductive cancers for Palestinian women must be re-emphasized in campaigning, outreach programs and health facilities.

Providers in the two regions of the West Bank and Gaza Strip alarmingly overlooked assessing danger signs during pregnancy. History taking skills according to the stated criteria were far less than satisfactory. Aspects related to STIs and pregnancy status and complications issues were noted to particularly be ignored.

Almost all sampled clinics offer at least three family planning methods, however, substantial quality gaps exist in making clients adequately informed about available methods in order to make an informed choice of method.

About universal precautions adherence was found extremely poor and insufficient although providers reported having received special training on this. Poor hygiene and safety practices in clinics are far less than acceptable in terms of the infection control standards and the serious health and cost implications they hold for the well-being of care providers and recipients alike.

These are all indicators on the extent of appropriateness and adequacy of inputs, which the health care system makes available for people/staff to use in their activities to achieve the intended outcomes as well as on the investments made in sustaining achievements. Technical competence and quality of care are the net result of individual, managerial, systems and institutional elements. Significant relevant initiatives that began in the previous cycle must be revitalized, built on and sustained. Future investments must focus on people management issues including justly and rightly distributed training courses for staff development

and empowerment, incentives schemes that incorporate principles of fairness and recognition, supportive supervisions for performance improvement, and scope of work and roles definition for better accountability and improved quality.

8.2 On Youth/RH sub-component

Policy dialogue and professional debates the Fund has lead enhanced the integration of RH information into the school curricula within the MoEHE system. This was an excellent entry point into the formal governmental body that would facilitate conveyance of this information to line ministries serving other youth population groups out of the school system including the vulnerable targeted by MoSA social services and those affiliated to MoYS youth clubs in rural communities in particular. To this purpose, capacity development at both ministries is a must, perhaps starting with MoSA. MoEHE teachers and counselors who are already trained on delivering RH messages essentially are potential assets that could be invested in as ToT in the newly targeted settings. Capacity at MoEHE needs to be developed to enable it expand its work to cover East Jerusalem and Gaza Schools.

Currently, UNFPA lacks the needed staffs to allow expanding and responding to the ever growing youth population and needs, while at the same time, most of those working with youth have rather limited experience with youth-oriented projects. Therefore, it is recommended to develop the youth sub-program into a more staffed program component with special considerations to the needs of the Gazan and Jerusalemite youth. In Gaza particularly, a special staff needs to be appointed to address youth needs only.

National data on youth PCBS produces was especially useful to UNFPA in managing the critical influence of gatekeepers such as decision makers, religious leaders, parents, teachers and opinion leaders. To this end, it is strongly recommended that the Fund in cooperation with others supports PCBS to repeat youth national survey in the coming programmatic cycle as one independent component for an updated youth profile as a step toward youth surveillance system development to facilitate data driven planning regarding youth issues on the one hand and contribute to the enhancement of the national capacity to generate and utilize disaggregated data on the other.

Men, as gatekeepers of traditions and traditional gender roles, have been neglected in youth UNFPA program. Their influential role on women's and youth's SRH and rights necessitates such strategies as community support teams for youth to be formulated mainly from fathers, male opinion leaders, member of municipal offices and local clubs and associations to engage them in relevant activities to solicit their participation, approval, commitment and support of youth RH related interventions and initiatives.

In-schools youth are the group the program targeted first and best through the MoEHE system. This is where the youth peer-to-peer education was initiated and followed by qualifying cadres of school counselors to provide SRH information to the youth in the school settings. Replicating this model in the private schools should be a priority in the coming program cycle because youth in these schools are wrongly assumed to be more advantaged in this regard while they could be experiencing more open life style that may expose them to more risks.

The concept of "Youth participation" remains vague and subject to various interpretations. It is not defined and therefore not institutionalized yet. New options need to be explored too, one of which is targeting youth in universities and students unions within them. In addition, re-approaching the youth groups who participated in the psychosocial support and debriefing sessions done in Gaza during this ending cycle could be another possibility. On another dimension, involving the Palestinian youth peer educators network, created by UNFPA, in global and regional networks will promote and empower the network and provide it with a platform for a more viable role in YFS. Youth participation at the institutional levels of planning, implementation and policy must materialize which remains a challenge for the Fund's work in this area in the coming programmatic cycle.

8.3 On Population and Development

The Fund instituted the Population Forum comprised of representatives from key stakeholders as an advisory body for the MoPAD population unit with the long term purpose of developing a draft population policy. Materialized as such, the Fund mobilized this forum as a supportive network to keep discussions over population issues alive and vibrant and therefore must follow the institutionalization of this Forum.

It is strongly recommended to strengthen this forum keeping it as active and engaged as possible toward the development of common understanding and conceptualization of population issues, priorities identification, and building its capacity as a national resource body by involving interested members in such activities as specialized training and joint regional researches and population conferences.

In addition, linking this program component to that of youth, it is proposed that the population forum is employed to create young population cadres from the youth. Preferably, this is to be done under MoPAD population unit in partnership with PCBS whereby UNFPA funds it to carry out a series of training programs for youth on population data utilization lead by the Population Forum members.

At an advanced stage this may include the production and dissemination of population policy briefs as valuable advocacy instruments including through organizing a series of seminars and panel discussions as well as investing in media.

In this formula, the capacities of the population unit staff, the forum and youth are built and the PCBS produced data is more widely utilized and disseminated enhancing the data system nationally. Strategically, discussion and dialogue on population issues remain alive and vibrant and passed on to the coming generation of the population policy leaders.

Universities could be brought in here to facilitate the selection of interested youth with good potential. Importantly, this should not be restricted to one university but rather open to wider addressees.

Currently, there are two major health data providers in the oPt; the PCBS and the MoH. So far, each produces its own data without adequate attention to the need for data consistency between them both which leaves the door open to various interpretations and views and indicates improper utilization of the limited available resources. In the coming cycle, the Fund should consider bringing the census and specialized survey of the family health data the production of which it supports in synergy and alignment with the MoH data for surveillance and monitoring purposes and improved use of national resources.

To this end, as two key players in the health Information arena, particularly in relation to SRH, it is crucial that UNFPA strengthens and expands its partnership with WHO, especially in light of the intensive investment of the latter in the MoH management health information system (MHIS).

8.4 On Gender

UNFPA work on networking with the NGOs at the community level and strengthening bridges with local authorities for creating linkages between grassroots organizations and formal structures that target women, especially the poor, was remarkable and rewarding, particularly in terms of coalitions building. One of the built coalitions comprised 20 community-based organizations operating in Hebron, under the umbrella of MIFTAH as a focal NGO. Through MIFTAH the Fund trained the said coalition on such issues as SCR 1325, priorities identification and communication to respective parties, team building, drafting joint action plans capitalizing on the strength of each individual organization, and joint commemoration of events. Adopting this modality in community mobilization and engagement the Fund chose and succeeded to act synergistically and innovatively in this area. Furthering this experience and replicating it is strongly recommended to institutionalize effect and produce impact at the community and organizational level.

Another successful strategy was the improvement of the community-based centers' staff capacities in support of the girls in MoSA rehabilitation centers who themselves received vocational training courses to improve their access to employment and economic empowerment opportunities toward poverty alleviation. Beneficiaries, however, remain very limited particularly women in FHHs who were targeted through MoSA. Nevertheless, functional mechanism to follow up most-in-need women's accessibility to poverty alleviation schemes need to be firmly set to ensure the linkages between the community-based centres and the different programs of poverty alleviation already being instituted at the national level by other agencies such as at UNRWA, UNDP and World Bank. Partnership with such lead agencies in addressing poverty among women must be considered.

On another level, the Fund must make the strategic decision of working with MoWA where it needs to make substantial short and long term investments. For as a matter of fact the existence of this Ministry was the outcome of the strenuous work of the Palestinian women movement at the first place. It cannot be allowed to fall off the map or remain with trifling presence. Within the framework of the ICPD and MDGs the Fund is accountable to contribute to strengthening entities with gender and women empowerment agenda such as MoWA and find appropriate formula/s for collaboration and partnerships. In the short term, a staff needs to be positioned within MoWA for capacity development and monitoring purposes.

A key area where good work was done and should be capitalized on is combating GBV including the first national conference with more emphasis on the UNSCR 1325. MoWA's role in this must be central and the Fund has done quite a lot in this area with the NGOs. This work can be adapted to suit the MoWA agenda, available human resources and strategic objectives. In fact, as interviewed MoWA expressed interest in more strategic partnership with UNFPA.

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Appendix I- Terms of Reference

Evaluation of the Third UNFPA Country Programme Cycle in the oPt. 2006-2010

I. Background:

The third UNFPA country program (CP) was endorsed by the UNFPA/UNDP Executive Board and agreed on by the Palestinian Authority for a four year period 2006-2009 with a one year extension till 2010. This program was supposed to contribute to the national development plan in addressing poverty, reducing unemployment and building social capital and functioning national institutions through focusing on **three areas of intervention, Reproductive Health, Population and Development and Gender Equality**. More specifically, this program was meant to contribute to three outcomes: 1) improving women's legal status and the quality of services in order to reduce the risk of maternal mortality and provide women and young people access to high quality, integrated reproductive health services; 2) increasing women's participation in decision-making, ensure access to poverty-reduction programmes and reduce exposure to vulnerability, risk and insecurity; and 3) developing policies that integrate population and gender concerns.

UNFPA is planning to conduct an end-term evaluation of the country programme. This programme intended to achieve the following outputs which should contribute to the outcomes identified under the three main areas of intervention.

Although UNFPA intend to evaluate the three areas of intervention, however, the evaluation will have a major focus on the Reproductive Health area.

Country Programme Outcomes & Outputs:

1. **Reproductive Health (RH) Outcome:** increased utilization of comprehensive, high-quality reproductive health services, with special focus to remote and deprived areas as well as those with restricted mobility.
 - a. Output 1: Improved accessibility to integrated, comprehensive, high-quality reproductive health services in 10 service delivery points in villages with restricted mobility; 39 Ministry of Health primary health-care service delivery points; three women's centers; and six hospitals
 - b. Output 2: Increased accessibility of reproductive and sexual health information and counselling services for young people, with a special focus on the prevention of HIV/AIDS and STIs.
2. **Population and Development Outcome:** National and sectoral policies take into account gender and population in the context of development and emergencies.
 - a. Output 1: To have increased the national capacity to integrate population, gender and reproductive health into development and emergency planning processes
 - b. Output 2: To have enhanced the national capacity to generate and utilize disaggregated data.

3. **Gender Outcome:** Institutional mechanisms for improving the legal status of women, eliminating gender-based violence, promoting women and girls' rights, and increasing gender equity in decision-making, including political and economic decision-making.
 - a. Output 1: To have enhanced the capacities of the Government and civil society organizations to empower women in community-building in six localities.
 - b. Output 2: To have built the technical and organizational capacities of the Ministry of Women's Affairs and civil society organizations to institutionalize gender principles and human rights.

Due to the deterioration of the humanitarian situation in oPt, particularly in Gaza, UNFPA has responded to the humanitarian crises through the following key interventions linking humanitarian assistance to the developmental objectives and results of the country programme.

- UNFPA has been working on improving access to adequate reproductive health services during emergency situations and crisis. Also, mitigating the impact of closure on access to obstetric care.
- Support and strengthen the delivery of psychosocial counseling and services to women and young people, to protect themselves from GBV as well as access services to deal with crisis in the humanitarian situations.
- UNFPA worked with community based organizations where a number of forums were established to institutionalize UNSCR 1325 and to provide a number of services for health, counseling, microcredit, and health education.

II. Evaluation Purpose:

The purpose of the evaluation is to assess the achievements and quality of the CP in terms of its relevance, effectiveness, efficiency, sustainability, and impact. The evaluation should highlight strengths, weaknesses, gaps, good practices and it should draw out lessons learned and make recommendations, which will be used in the design of the next country program action plan.

The evaluation findings and recommendations will be utilized by UNFPA country office oPt, UNFPA regional office for Arab States, UNFPA Headquarters, donors, partner agencies and relevant stakeholders.

III. Scope of Evaluation:

The evaluation will cover West Bank area and Gaza. The evaluation will generate lessons learned, findings, conclusions and recommendations through:

- Measuring the CP effectiveness, more specifically analyzing and assessing the achievements of outputs and to what extent these outputs have contributed to the outcomes. This would entail measuring the outputs and outcomes indicators and achievement of targets. Furthermore, the evaluation will identify any shortfalls in the achievements, the reasons for such shortfalls and whether any unexpected results or outcomes have occurred;

- Assessing the CP relevance, in particular, whether the programme design is in line with the national needs and priorities, mainly the PRDP, are programme results relevant to stakeholders and is the programme in line with UNFPA's policies and priorities and the 1994 ICPD PoA;
- Measuring the efficiency of the CP and assess the quality of outputs achieved in relation to inputs and expenditures incurred; Are resources used efficiently? Is the cost reasonable in magnitude of the benefit? Would alternative approaches yield equivalent benefits at less cost?
- Exploring whether UNFPA's approach in programme implementation contributed to sustainability;
- Assessing the impact of the CP, to what extent the achieved results contributed to a long term benefits and change;
- analysing factors within and beyond UNFPA's control that influenced performance and success of CP outputs (including strengths, weaknesses, opportunities and threats) in contributing to the realization of the Outcome;
- Assessing the identified cross cutting issues; Gender Mainstreaming, human rights-based programming and humanitarian and emergency context, if they have been adequately addressed in the interventions;
- Assessing the UNFPA partnership, policy dialogue and capacity development strategies and whether these strategies contributed to the achievement of the planned results.

Specific key questions have been identified in the attached list (ANNEX I), which is an integral part of the Terms of Reference

IV. Methodology:

- The consultants will design the evaluation methodology that will respond to the evaluation objectives in collaboration with the country office. The methodology should highlight the following:
 1. Information sources for data collection
 2. Data collection methods
 3. Data analysis methods
- UNFPA Country Office shall provide the relevant documentation required for the evaluation, the documents include:
 1. Country Programme Action Plan 2006-2009
 2. Country Programme Document
 3. UNFPA Situation Analysis
 4. Evaluation reports during the programme cycle
 5. Surveys and Assessments
 6. Progress reports
 7. Other documents as required

V. Research Work Plan and Time Frame

The consultants will accomplish the task through achieving the following milestones within the specified time frame:

- a. Methodological Approach paper, 1st week
- b. Briefing of stakeholders, 2nd week
- c. Evaluation process, 3rd - 5th week
- d. Draft Report, 5th – 7th week
- e. Final report, 8th week
- f. Present findings to stakeholders, 8th week

VI. Evaluation Team:

The evaluation team should be composed of consultants who are competent in the evaluation of similar type of programmes and who have background mainly in area of Reproductive Health, in addition to knowledge in population and Gender equality. They should also possess analytical skills, process management skills, data management and facilitation skills. A team leader will be responsible for the overall co-ordination of the evaluation and for the final report. The team leader should have extensive experience in leading evaluations and report writing.

VII. Expected Outputs:

The expected product of the evaluation is an evaluation report written in English. This report should mainly include executive summary written in English and Arabic as well, findings, conclusions, lessons learned and recommendations.

VIII. Duration:

The expected duration of the evaluation is 2 months⁵. The evaluation team is expected to commence on 01 January and to complete the task on 28 February 2010.

⁵ This was extended to six months.

ANNEX I

Evaluation of the 3rd Cycle Country Programme in oPt Key Questions

Relevant evaluation criteria	Key Questions
Relevance: Identified problems and real needs have been addressed	The relevance of a project relates to its design and concerns. The extent to which the original design: <ol style="list-style-type: none"> 1. Is in line with the PRDP, national needs, policies and priorities? 2. Is in line with UNFPA's policies priorities and 1994 ICPD PoA? 3. Reflect the beneficiaries' needs and addresses the identified problems? 4. Reflects development priorities and policies of local partners?
Efficiency: From inputs (materials, personnel, financial resources) through activities to results	<ol style="list-style-type: none"> 1. Foreseen activities were carried out in the most appropriate manner giving the available resources and time. 2. Assess the quality of outputs achieved in relation to the expenditures incurred and resources used. 3. Are resources used efficiently? 4. Is the cost reasonable in magnitude of the benefit? 5. Would alternative approaches yield equivalent benefits at less cost?
Effectiveness: From Results to purpose; to what extent service and products were used to eliminate the problems (confirmed planned deliverables)	The extent to which: <ol style="list-style-type: none"> 1. The programme produced the expected results? 2. The results achieved contributed to the programme objectives. 3. The factors influencing the achievement of the purpose, including unforeseen external factors. 4. The management capacity to ensure that the results achieved allow reaching the purpose. 5. The reaction of beneficiaries and the use of programme results and benefits. 6. The unplanned results that are likely to affect benefits.
Sustainability: Durability of the change	<ol style="list-style-type: none"> 1. To what extent the programme results have had or are likely to have lasting results after programme termination and the withdrawal of external resources? 2. Availability of local management, financial and human resources needed to maintain programme results over the long term.
Impact: Contribution to the long term benefit	<ol style="list-style-type: none"> 1. The extent to which the achieved results contributed to long-term effects (economic, socio-cultural, institutional, environmental, technological, etc.) 2. The external factors that influenced the overall impact and the capacity of the programme to respond to these factors. 3. The possible longer-term effects of the programme.

Area of Measurement	Key Questions
<u>Reproductive Health</u>	<ul style="list-style-type: none"> ◆ What is your definition of “comprehensive reproductive health services”? ◆ Are reproductive health services offered at the health service sites supported by the programme comprehensive? If yes, in what way? If not, why not and what are the deficiencies? And how can this be re-addressed? ◆ Where are the offered reproductive health services in terms of quality, accessibility and reproductive rights integration? How do these services respond to the unmet family planning needs for example? ◆ In what ways have the facilities and services delivery points targeted in the program become different from their non-targeted counterparts? ◆ To what extent is the current programs structure at the MoH (women health, health promotion and education and primary health care) enhancing/ encumbering efficient and effective Comprehensive reproductive health information and service delivery to the Palestinians and how is it impacting people (including the young, males and unmarried) at the user end? ◆ To what extent are stakeholders including from the civil society organizations involved in reproductive health policy dialogue? And what gaps are there in this process? How can this be corrected? ◆ Do the resources (material and human) available to UNFPA office staff go with the magnitude and scope of work they actually carry out in the program across the OPT? What is their officially defined role and should their role be more of a technical or policy level intervention or both? Is there a need to re-visit and re-define that role? ◆ What monitoring tools were used throughout the program implementation and to what extent they have actually guided program implementation throughout its different phases? ◆ What contextual factors influenced program implementation and in what way? ◆ How effective the comprehensive reproductive health package was in meeting women’s needs? <p><u>Youth Component:</u></p> <ul style="list-style-type: none"> ◆ To what extent the programme contributed to increasing the number of young people accessing RH and HIV/AIDS prevention program? ◆ To what extent the programme contributed to increasing the number of young people using the produced information material and utilizing counseling services? ◆ How successful was the integration of SRH in school curriculum? ◆ To what extent was the training offered to MoEHE teachers and counselors effective? ◆ To what extent is UNFPA on the right track in establishing YFS? ◆ Sensitivity and relevance of material and counseling services to the local culture. What package of services should be offered within the YFS that are culturally appropriate and relevant? ◆ What are the main risks and opportunities that exist in relation to offering YFS? ◆ To what extent was the programme successful in reaching out-of-school youth, especially in rural and marginalized areas? ◆ To what extent was the programme successful in reaching vulnerable and most- at-risk youth groups? ◆ Assess the peer- to-peer approach in terms of effectiveness, appropriateness and

	<p>relevance in reaching youth?</p> <ul style="list-style-type: none"> ◆ What other innovative approaches should be applied to reach youth? ◆ Has the programme been successful in networking with other youth institutions? ◆ To what extent the programme coordinated with other youth programmes, especially the ones that are executed by other UN sister agencies?
<u>Population and Development</u>	<ul style="list-style-type: none"> ◆ To what extent and in what ways are PD issues being Incorporated into national development and emergency planning processes? ◆ To what extent did the PD program succeed in filling the data gaps on ICPD related issues? ◆ What is the magnitude of the national resources mobilized for population related activities and who initiates and leads activities and in what way (i.e.; saliently or inaudibly)? ◆ Are the young people's multisectoral needs clearly addressed in poverty reduction strategies and in what way and extent? ◆ How far does the PD program contribute to the enhancement of the national capacity to generate and utilize disaggregated data? ◆ Are disaggregated data and databases made available and accessible for utilization in national development plans and other development uses (including education and academia)? By what means and extent? ◆ How effective was it to train master's students on data utilization? ◆ To what extent do you think producing policy briefs was an effective way of data utilization? ◆ How successful the program was in coordinating with stakeholders, sisters UN agencies? ◆ What additional human and financial resources UNFPA needs, if any, in order to strengthen its PD programme? ◆ Does the PD program contribute to the needed functioning of the Population National Committee? ◆ How far did the PD program succeed in integrating population issues in Palestinian Reform Development Plan 2008-2011 (PRDP)?
<u>Gender:</u>	<ul style="list-style-type: none"> ◆ What is the magnitude of the national resources mobilized for gender related activities and who initiates and leads activities and in what way (i.e.; saliently or inaudibly)? ◆ Are the women's multisectoral needs clearly addressed in poverty reduction strategies and in what way and extent? ◆ To what extent and how have the capacities of the Government and civil society organizations to empower women in community building been enhanced, if any? ◆ Did the Ministry of Women's Affairs and civil society organizations manage to institutionalize gender and human rights based on the technical and organizational capacity building offered to them by the program? If yes, to what extent and in what ways? If not why not? ◆ To what extent does UNFPA contribute to drafting national strategy for combating violence against women? ◆ How effective were producing policy documents and running policy dialogue in improving the legal status of women?

	<ul style="list-style-type: none"> ◆ How effective the district coalitions were? ◆ To what extent the program succeed to strengthen the capacity of grass root org. to deal with GBV? ◆ How effective was producing Reproductive Rights Lexicon (in planning, capacity building)? ◆ How successful the programme was in networking with other women institutions?
Humanitarian Response	<ul style="list-style-type: none"> a. To which extent the humanitarian programme contributed to: <ul style="list-style-type: none"> 2. Improved access to safe delivery in times of crisis? 3. Strengthened the delivery of psychosocial counseling and services to protect from GBV (women & young people) 4. Strengthened community based organizations to institutionalize UNSCR 1325 b. To which extent were in harmony within the complex donor's environment? c. How this affected the development objectives of the country programme and to what extent humanitarian intervention was linked with development.
Cross cutting issues	To what extent the cross cutting issues; Gender Mainstreaming, human rights-based programming and humanitarian and emergency context, have been adequately addressed in the interventions
Capacity Development Strategies	<ul style="list-style-type: none"> 1. Developed knowledge base and promoted its use? 2. Supported systems development including monitoring & evaluation systems, and institutional development for governmental and civil society organizations? 3. How effective was the partnership and networking strategies, supported by UNFPA during the implementation process of the country programme? 4. Relevant training (training materials and its relevance to the national needs, selection of trainers, effectiveness of training)? 5. To what extent policy dialogue and advocacy efforts contributed to the development of a common vision of internationally approved objectives of Reproductive Health and Population & Development? 6. To what extent the above-mentioned strategies contributed to creating sustainable capacities and improved performance?

Appendix II: List of Documents reviewed

- Country Programme Action Plan (CPAP)- 3rd Cycle
- Country Programme Document (CP)
- UNFPA Strategic Plan 2008-2011
- Youth Indicators
- Gender Indicators
- RH Indicators
- Population & Development Indicators
- RH Evaluation Report 2nd Cycle
- Evaluation of “Psychosocial counseling for Women in Nablus” 2008
- Evaluation of “Psychosocial counseling for Women in Nablus” 2009
- Evaluation of “Psychosocial counseling for Women in Jenin” 2009
- WCLAC UNFPA project evaluation- midterm evaluation 2007
- Youth baseline survey 2007
- PRDP 2008- 2010, gender strategy
- Ministry of Health latest strategic plan
- Health Sector Reform plan
- UNFPA later situation analysis

Appendix III: List of People interviewed

A: Government officials (14 people)

Dr. Muhammad El Najar	Pharmaceuticals Warehouse / MoH	Gaza Strip
Dr. Akram Sheikh Khalil	Shifa Hospital/ MoH	
Dr. Dina Abu Sha'ban	Women's Health and Development Directorate/ MoH	
Dr. Moein Kariri	Health Education and Promotion Department/ MoH	
Dr. Asad Ramlawi	Primary Health Care Directorate/ MoH	West Bank
Ms. Kholoud Hardan	Ibn Sina College for Health Profession/ MoH	
Dr. Suzanne Abdo	Women's Health and Development Directorate/MoH	
Dr. Na'eem Sabra	Hospital Administration Directorate/MoH	
Ms. Faten Wathaifi	Ministry of Women Affairs	
Mr. Mahmoud Ataya	Ministry of Planning	
Ms. Maysoun Whaidi	Ministry of Social Affairs	
Mr. Khaled Abu Khaled	Palestine Central Bureau of statistics	
Dr. Muhamad Al Rimawi	Ministry of Education and Higher Education	
Ms. Rima Kilani	Ministry of Education and Higher Education	

B: NGOs Representatives (8 people)

Ms. Myassar Abu Maileq	Palestinian Family Planning and Protection Association	Gaza Strip
Ms. Firyal Thabet	Al Bureij Women's Health Center	
Ms. Abla Abu Joummaiza	Free Thought Forum	
Dr. Khadejeh Jarrar	Union of Palestinian Medical Society	West Bank
Ms. Bisan Abu Rouqti	MIFTAH	
Ms. Ameneh Stafredes	Palestinian Family Planning and Protection Association	
Dr. Niveen Abu Rmaileh	BeirZait University	
Mr. Mousa Abu Zaid	Nama' Youth Center	

C. International Agencies (9 people)

Ms. Barbara Piazza-Georgi	UNFPA	West Bank
Mr. Ziad Yaesh	UNFPA	
Dr. Ali El Sha'ar	UNFPA	
Ms. Sana Asi	UNFPA	
Ms. Linda Sall	UNCEF	
Ms. Alia El Yassir	UNFEM	
Dr. Omayya Khammash	UNRWA	
Ms. Katia Schemionek	WHO	
Ms. Zahirah Kamal	UNESCO	

Appendix IV: Data Collection sources/methods by CP output indicators

Country program outputs,	Indicators	Data collection sources/methods
<p>Output 1.1</p> <p>Improved accessibility to integrated, comprehensive, high-quality reproductive health services in 10 service delivery points in villages with restricted mobility; 39 Ministry of Health primary health-care service delivery points; three women's centres; and six hospitals</p>	<p>100% of selected service delivery points offering at least three reproductive health services complying with protocols and guidelines</p> <p>Proportion of women having obstetric complications correctly identified or referred</p> <p>Existence of a RHCS strategy and coasted action plan</p> <p>RH commodities included in the Minimum service package and in the essential drugs list.</p>	<p>Service statistics</p> <p>Facility Audit and Manager Survey</p> <p>Observation checklist</p> <p>FGDs</p> <p>Expert interviews</p>
<p>Output 1.2</p> <p>Increased accessibility of reproductive and sexual health information and counselling services for young people, with a special focus on the prevention of HIV/AIDS and STIs</p>	<p>Proportion of youth that recognize three methods of HIV/AIDS transmission and prevention, at least one of which is condom use</p> <p>Proportion of youth that recognize at least three STIs</p> <p>Proportion of students in grades 9-12 in selected schools who reflect positive attitudes on gender equity, equality and empowerment</p>	<p>Expert Interview with 2 Ministry of Education officials (school health department)</p> <p>- Statistical data review (Youth survey)</p> <p>FGDs</p>
<p>Output 2.1</p> <p>To have increased the national capacity to integrate population, gender and</p>	<p>National mechanisms to elaborate and monitor population policy functioning</p> <p>Draft population policy document elaborated in line with the ICPD and</p>	<p>Policy documents review (secondary analysis)</p> <p>Policy environment assessment in individual</p>

reproductive health into development and emergency planning processes	MDGs	interview with key decision makers
	At least two supportive networks for gender, population and development (journalists and parliamentarians) established	Gender strategy review
	Gender strategy developed and implemented in five line ministries	Expert interview including members from the established networks and key involved ministries
Output2.2 To have enhanced the national capacity to generate and utilize disaggregated data	Advocacy fund-raising plan for the 2007 census operationalized	Systems strategic Analysis with the UNFPA representative office staff
	International standards-based framework of national data systems operationalized	Expert interview (PCBS)
	Set of indicators for the follow-up of the MDGs and ICPD, including gender equity and equality, the empowerment of women and human rights indicators institutionalized	Review of the DHS report completed in 2008 to examine PA response to the MDG
	Increased utilization of census and other population data	Expert interview (women organizations and Ministry) Expert interview (PCBS and BZU population studies program)

<p>Output 3.1:</p> <p>To have enhanced the capacities of the Government and civil society organizations to empower women in community-building in six localities</p>	<p>Functional mechanism to follow-up on women's accessibility to poverty-alleviation schemes in place.</p> <p>Number of NGO work plans addressing gender equity and equality and the empowerment of women components in six localities</p> <p>Six community-based centres offering skills to young women to access vocational training.</p>	<p>Systems strategic Analysis with the UNFPA representative office staff</p> <p>Review of relevant official documents such as the Gender strategy</p>
<p>Output 3.2</p> <p>To have built the technical and organizational capacities of the Ministry of Women's Affairs and civil society organizations to institutionalize gender principles and human rights</p>	<p>Functioning coordination of gender focal points in concerned line ministries and institutions</p> <p>Functioning observatory mechanism to monitor gender equity and equality and empowerment of women established</p> <p>Results-based plan of action and campaign elaborated with coalition combating violence against women</p> <p>Number of community organizations and leaders endorsing the plan of action and campaign</p>	<p>Expert interview (women organizations, Ministry of women Affairs, UNIFEM)</p> <p>Systems strategic Analysis with the UNFPA representative office staff</p>

Appendix V: Facility Audits

a) Equipments Audits

a.1) General Equipment

Item	West Bank clinics				Gaza Strip clinics		
	Ni'leen	Jenin Central	Yatta	Hebron PFPPA	Jabalia	Al Qarara	Al Bureij CFTA
Laboratory	1	1	1	1	1	1	1
* Refrigerators	3	1	3	1	6	4	1
* Portable refrigerators/ cooling boxes	2	1	X	X	3	5	3
* Communication equipment (Telephone, Fax)	1 mobile	2 Faxes	1 mobile	Tel.& fax	1	1	2
Computer	X	X	X	X	X	X	✓
Printer	X	X	X	X	X	X	✓
* Functioning Sink	12	4	X	5	23	10	1
* Towels	✓	X	X	5	X	30	1
* Soap	✓	X	✓	✓	✓	✓	1
* Window curtains	✓	5	✓	5	X	11	3
* Bed screen	2	2	✓	2	3	X	1
* Bed sheets	✓	8	✓	✓	100	40	10
* Gyn-exam bed	2	1	1	2	1	2	1
Couch	7	2	7	1	7	3	1

a.2) Essential Equipment

This section shows availability of equipment necessary for the health care provider to complete physical assessments

and procedures required for RH services in the studied clinics, bearing in mind that essential equipment are being assessed as per the unified national guidelines.

Item	<i>West Bank Clinics</i>				Gaza Strip Clinics		
	Ni'leen	Jenin Central	Yatta	Hebron PFPPA	Jabalia	Al Qarara	Al Bureij CFTA
Autoclave	3	1 old	1	2	2	2	4
Sonicaid / Doppler	2	1	X	1	X	X	X
Adult Scale	2	2	2	1	4	2	4
Infant scale	3	2	2	1	2 not working	2	1
Ultrasound	1 not working Since 6 months	1	1	1	1	1	2
Portable light	3	2	1	1	5	5	1
X-ray viewer	2	X	1	1	1	5	X
Fetoscope	2	X	X	1	X	1	2
Metric scale for height	2	2	1	2	1	X	X
Manual torch with batteries	2	1	1	1	2	3	1
Sphygmomanometer	5	3	5	3	10	8	4

Stethoscope	4	4	10	2	10	12	4
Thermometer	1	2	Many	Many	Many	2	Many
Ophthalmoscope	6	X	1	1	3	X	1
Hammer	1	X	1	1	1	1	1
Glucometer	1	X	X	1	3	1	2
Speculums	10	10	Many	Many	4	X	X
Dressing set (forceps, scissor, iodine cup & basin)	8	X	Many	✓	10	10	1
IUD insertion set (Speculum, Artery forceps, curved long successor, uterine sound, iodine cup & basin, sponge forceps).	10	4	13	Many	10	5	5
IUD removal set (Speculum, artery forceps, sponge forceps, iodine cup & basin)	10	4	7	Many	10	5	5
Pap smear kit	✓	X	✓	Many	X	X	1BOX
ECG machine	2	1	1	X	1	X	X
Portable Oxygen bottle and mask	3	2	3	2	6	3	X
IV stand	2	X	X	1	5	2	X
Airway	5	X	5	1	5	X	X
Suction	2	X	2	1	2	1	X

Item	West Bank Clinics				Gaza Strip Clinics		
	Ni'leen	Jenin Central	Yatta	Hebron PFPPA	Jabalia	Al Qarara	Al Bureij CFTA
Disposable gloves (sterile & clean)	Few	20 box	Many	Many	100	100	5000
Syringes	✓	1500 monthly	✓	✓	100	300	5000
Needles	✓	1500 monthly	✓	✓	300	300	5000
Gauze, cotton, pads	✓	✓	✓	✓	✓	20	500
Adhesive tape	✓	✓	✓	✓	5	2	50
Dipstick strips	✓	✓	X	✓	40	X	20
Litmus paper	✓	X	X	✓	X	X	20
Culture swabs	X	X	✓	✓	10	X	20
Tongue depressor	✓	✓	✓	✓	100	100	3000
Autoclave tape	✓	✓	X	✓	20	X	10
Autoclave paper roll	✓	✓	X	✓	100	5	X
IV solutions	✓	X	X	✓	60	14L	X
Disinfectant solutions	✓	✓	✓	✓	✓	1L	15L
Valid family planning methods -Condoms, IUD etc	✓	Pills only X	✓	✓	Condoms & pills only	X	12 each
Valid Vaccines	✓	X	✓	X	✓	500dose	X
Vaginal crème	✓	X	✓	X	X	X	170

Ultrasound jelly	✓	✓	✓	✓	✓	✓	30
Valid Iron & Folic Acid tablets	✓	X since one month	✓	✓	✓	9000	530
Valid Iron syrup for infants	✓	X since 2 months	✓	X	✓	500	X
Valid Vitamin "A & D" drops	✓	✓	✓	✓	X	500	90

a.3) Disposable/Consumable Items

This section shows Disposable/Consumable Items needed to conduct various procedures in the studied clinics

Item	West Bank Clinics				Gaza Strip Clinics		
	Ni'leen	Jenin Central	Yatta	Hebron PFPPA	Jabalia	Al Qarara	Al Bureij CFTA
Disposable gloves (sterile & clean)	Few	20 box	Many	Many	100	100	5000
Syringes	✓	1500 monthly	✓	✓	100	300	5000
Needles	✓	1500 monthly	✓	✓	300	300	5000
Gauze, cotton, pads	✓	✓	✓	✓	✓	20	500
Adhesive tape	✓	✓	✓	✓	5	2	50
Dipstick strips	✓	✓	X	✓	40	X	20
Litmus paper	✓	X	X	✓	X	X	20
Culture swabs	X	X	✓	✓	10	X	20
Tongue depressor	✓	✓	✓	✓	100	100	3000
Autoclave tape	✓	✓	X	✓	20	X	10
Autoclave paper roll	✓	✓	X	✓	100	5	X

IV solutions	✓	X	X	✓	60	14L	X
Disinfectant solutions	✓	✓	✓	✓	✓	1L	15L
Valid family planning methods -Condoms, IUD etc	✓	Pills only X	✓	✓	Condoms & pills only	X	12 each
Valid Vaccines	✓	X	✓	X	✓	500dose	X
Vaginal crème	✓	X	✓	X	X	X	170
Ultrasound jelly	✓	✓	✓	✓	✓	✓	30
Valid Iron & Folic Acid tablets	✓	X since one month	✓	✓	✓	9000	530
Valid Iron syrup for infants	✓	X since 2 months	✓	X	✓	500	X
Valid Vitamin "A & D" drops	✓	✓	✓	✓	X	500	90

a. 4) Other logistical Equipment

Item	West Bank clinics				Gaza Strip Clinics		
	Ni'leen	Jenin Central	Yatta	Hebron PFPPA	Jabalia	Al Qarara	Al Bureij CFTA
Boiler	✓	X	X	✓	X	X	✓
Electric fan	✓	✓	5	X	19	7	10
Chairs in the waiting Area	✓	✓	✓	✓	23	33	30
Binding Machine	X	X	X	X	X	4	20
Mobile office chair	✓	6	✓	6	X	16	18

Stapler	✓	X	X	7	3	7	20
File Cabinets to keep medical records	✓	7	✓	✓	11	8	20
Heaters	✓	✓	✓	✓	x	x	✓
Cauterization Device	x	x	x	x	x	x	✓
Ambulance	x	x	x	x	x	x	x
Governmental cars	x	✓	x	x	x	x	x

B) Behaviour Change Communication (BCC) Materials Audit

Item	<i>West Bank Clinics</i>				<i>Gaza Strip Clinics</i>		
	Ni'leen	Jenin Central	Yatta	Hebron PFPPA	Jabalia	Al Qarara	Al Bureij CFTA
Overhead Projector	X	✓	X	✓	X	✓	✓
Flip Chart	X	✓	X	✓	X	x	✓
Slide Projector	X	✓	X	✓	X	✓	✓
Photo Camera	X	X	X	✓	X	X	✓
Projection Screen	X	✓	X	✓	X	✓	✓
Female Pelvic Skeleton	X	✓	X	X	X	X	✓

Childbirth Simulator	X	X	X	X	X	X	X
Neonate/Infant Doll	X	X	X	X	X	X	✓
* TV	✓	✓	✓	✓	✓	✓	✓
* Video	✓	✓	<i>1not working</i>	✓	✓	X	✓
Lecture Chair	✓	X	X	✓	X	X	✓
Bookcase	X	✓	X	✓	X	X	✓
* Advertisement Board	✓	✓	✓	✓	✓	✓	✓
* Updated, Printed Health Education Material to distribute to clients. i.e. pamphlets	✓	✓	✓	✓	✓	X	✓
* Updated, Printed Health Educations Posters holding specific health messages Advertised in the clinic.	✓	✓	✓	✓	X	X	✓
Video Cassettes	✓	✓	✓	✓	✓	✓	✓

Appendix VI: Reproductive Health Evaluation Tools

Attached in a separate folder

Annex i: Focus Group Discussion Guide for Adolescents/Youth

Annex ii: Client Provider Interaction (CPI)- Observation Checklist for Antenatal Care

Annex iii: Focus Group Discussion For Care Users of RH Services

Annex iv: Focus Group Discussion Guide for Service Providers

Annex v: Client Provider Interaction (CPI)- Observation Checklist for Family Planning

Annex vi: Provider Interview

Annex vii: Facility Data Collection Instrument