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Needs Assessments "Increasing Access of the Underserved Areas in Palestine"

Dr. Sumaya Y. Sayej, RN, MSN, PhD, Mohammad Qtait, RN, MSN
Nursing Department, Faculty of Health Professions, Al-Quds University, Palestine

Abstract:

The socio-demographic profile of the surveyed population and the living conditions are very significant which indicate the availability and persistence of early and interfamily marriage, coupled with large and low income families in overcrowded houses. The living conditions of the surveyed population indicates the harsh circumstances they go through and how really they are underserved in basic living circumstances, health care facilities, services and professionals to meet their needs, because of restriction in movement, being in a remote area and under served for living in area C.

The study results were concluded from the quantitative data and qualitative analysis. The quantitative data results showed the need for comprehensive health care services because of poverty, lack of medical insurances, and difficulty in accessibility to these services, meanwhile 70.2% of the participants asked for ambulance services where it deemed necessary particularly in emergency cases. Also, the participants pinpointed that 0.3% is the service of the mobile clinic which mainly comes to the remote areas for child vaccination only. This indicates the need of well-equipped mobile clinics to provide a wide range of health services that are in need in the remote underserved areas.

The qualitative data results showed the urgent need for MCH services to meet the needs of the target population. Comprehensive services around the clock especially for maternity care and in case of emergencies should be ensured. The qualitative data also indicated that pediatric and child health services are greatly required. Adolescents need health education/promotion programs to help them develop their knowledge and attitude towards SRH matters. Also they asked for units within the SDP clinics which meet their needs and have free access for them.

All interviewees reiterated on the reasons why these services are needed; difficulties in accessing health care facilities outside their areas of residence because of military presence check points, and the separation wall. They further commented on PFPPA-SDPs being located in the cities, long distances require lot of expenses for public transportation and lack of ambulances with all these circumstances makes it very difficult to reach.

Keyword: ***Increasing Access of the Underserved Areas in Palestine***

Executive Summary

The Palestinian Family Planning & Protection Association (PFPPA) conducted a needs assessment for the underserved population living in area C, and the clients attending PFPPA Service delivery Points (SDPs) to provide the PFPPA administrators with specific information on the level of unmet needs for comprehensive SRH services including Family Planning. Areas C is known to be underserved from quantity and quality of health services because the provision of public health services is a challenge to Palestinians and health providers due to restrictions in access imposed by the conflict in the country. As a result, the Palestinian Ministry of Health cannot build any health facility within that Area. The future plans of the PFPPA are to improve and integrate comprehensive SRH services to these underserved areas. The information collected from this assessment will be used to identify the needs and plan for future scaling up of SRH services in these areas.

Study design

The study used quantitative and qualitative research methods. The quantitative data addressed the study participants' socio-demographics characteristics and their households' (HH) environment, the availability of and accessibility to health services and PFPPA- SDPs. The needs of women aged 15-49 were covered and the satisfaction of the clients by the service providers were assessed. There are two target groups' of study participants; people living in the underserved areas referred to as "community group" and clients attending PFPPA-SDPs referred to as "clients' group".

The qualitative research was based upon in-depth interviews to explore the needs and recommendations of the stakeholders and the SDP health providers. Focus groups for male and female teens and reproductive aged women were steered to also access their views, needs and recommendations for the PFPPA.

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Study results

To achieve our understanding of the needs' assessment we have answered the research objectives and research questions which were formulated at the beginning of the assessment study.

Socio-demographic characteristics and living conditions of target groups

The study recruited 264 for the sample from "community group"from 14 remote and underserved communities in Area C, 95.5% were females and 94% of them were married women. Of those married, 54% were married at an age of (14-18) years. The "client group"random sample recruited 334 participants attending SDPs (clinics), all females and 90% of them were married women of those married 45.5% were married at an age of 14-18 years. The 45.5% early marriage of client's group vs. 54% early marriage of the community group indicates the prevalence of early marriage in all areas, despite that the age at marriage for the "client group" was less than thatfor "community group". Yet, this rate is double "21.8%" for national statistics in 2010 " those who got married at the age of 18 years and less". Living closer to the cities has shown indication of better education opportunities and later age at marriage.

The average HHs member for both groups was over 6 members vs. 5.4 members for the national statistics. With more than two third of houses consisting of (1-3) rooms for both groupsindicating a high level of populated households and a likelihood of disruption of family dynamics as the study shows that 2.7% of clients group reported seeking gender based violence services from SDPs. Coupled with high unemployment rate where only 16% of client group and 11% of the community group "are currently working" knowing the two groups include women, and the average workforce for Palestinian women is 19%. In addition, it was found that more than 51% of both groupsHHs income ranged (300-2000 NIS) and 4.2% of the client group income was around 4000NIS vs.1.9% for community group indicating a high level of poverty. Another burden that the study shows is that 10% of the client group and 12.5% of the community group reported on persons with special needs (disabilities) in the house, more than the 7% for national statistics. The disabilities has varied and included but not limited to physical/mobility problems, mental disabilities, autism, cerebral palsy and those were mostly children as well as preventable disabilities (if quality and consistent provision of awareness and health care were provided).

Regarding HHs resources, 64% for community group vs. 70.5% for clients group had access to water network, 84% for community group vs.90% for clients group had access to electricity, and19% for community group vs. 24% for clients group have "own car" which means there is a problem in transportation for the majority to access health care facility when needed.

The socio-demographic profile, economic and social status reflect the need for PFPPA to coordinate efforts with Ministry of Health (MoH), Ministry of Education, Religious Leadersand others to work on contributing to reducing early age at marriage and promoting girls' education and help in finding financial resources through other NGOs for example micro grants business for women. In addition, it was evident that there was a need to coordinate with other health services and health providers to cover the needs of the general population and communicate with MoH for health insurance in order to help the target population seek health services without hesitation whilst alleviating cost related barriers.

Availability of and Accessibility to Health Services within the Target Communities

Regarding the availability of health facilities; 18.6% of the clients' group vs. 47% of the community groups reported NOT having access to a health facility. The client group reported; 53.9% have access to Health centers, 23.1% to PHC, 9% to both health center & PHC and 17.7% to hospitals.

Access of community group to health facilities were; 18.2% to Health centers, 23.1% to PHC, and 9% to both health center & PHC and 0.7 to hospitals. Noting the responses on the availability of health facilities include participants living in the same area –village who know about or have used the same health facility. The lack of health facilities was emphasized by UNDP (2013) indicating that more than 20% of communities in Area C have limited access to health services.Most of these services are provided by the government and very few by private sectors and NGOs.

The community group reported on the duration of service (working hours) for the health facilities; 13.6% all the week, 2.6% three days a week, 10.9% twice a week, 19.3% once a week, 3.4% once every two weeks, 2.2% once a month and 1.5 reported on Mobile governmental clinic once a week. The duration for providing these services is considered very minimal, inconsistent and scattered as for example, a sick person or a women with antenatal problems cannot have the follow up if she is living in an area where health services are provided once a week or twice a week. This notion was emphasized when 56% of community group who said NO, and 36% who said to some extent on the question "Are these services covering your reproductive health and family planning needs?"

This status shows the great need for health centers which provide services around the clock especially maternal health services that are badly needed as mentioned by the women in the focus group and the stakeholders residing in these

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areas. The PFPPA can scale up these services through opening a maternity clinic or setting up a mobile clinic to provide care to all women especially in emergency cases and employ midwives backed up by an obstetrician. Such projects will not only provide quality RH services to women but also a consistent sustainable health care provision.

The community group reported on the availability of health professional within their area of residence as follows; 50% said yes vs. 50% said no. The health professionals were; 21.2% a Doctor and a Nurse, 8.7% a Doctor only, 13.4% Nurse only, 1.9% mentioned Midwife and Daya. Noting these percentages also do NOT necessarily reflect such large numbers of health professionals BUT it could be explained that participants living in the same area reiterated on the same health professional. Midwife and Daya are the least among health professionals and this depicts the urgent need for these health professional i.e. midwives to cover maternal and child health requirements especially in emergencies.

Tounderstand the health professional roles within their communities, the participants were asked "do you think the health professional can meet the needs in your community?" only 3.8% said yes, 30% said No, and 47.3% said to some extent. Given these findings, the quality and consistency of care given by the local health professionals are questionable which means cooperation and coordination with available health professionals is required by PFPPA, MoH and other stakeholders in order to improve the health services delivered to the people living in these underserved areas.

Transportation system for underserved areas is an essential component for the delivery of quality health. Around 35% of participants said that they do not have any transportation means to access health facilities vs. 65% who said yes. Of those having transportation; 50% use public transportation and 9.1% also their own car. Under others category in the questionnaire; 2 participants needed security coordination (for people living in severe conflict ridden areas) and the worse transportation "in case of emergency"was indicated when 6 participants reported walking in cases of emergencies. Such lack of access is highlighted in terms of safety and appropriateness for people who are in urgent need for saving their lives and handled by unskilled personnel,using unequipped vehicles and to very distant areas. Yet, only 5.7% of the participants mentioned that" ambulances were available when needed" where such situations urge PFPPA and other stakeholders to ensure ambulance services within these areas.

Married woman in reproductive (15-49) SRH matters and seeking health services

For community group; around 82% of community participants have been pregnant. Of those, 55.4% mentioned thattheir pregnancy was not planned, again of those; 25.8% said "it is not my choice", this issue should be addressed knowing the cultural and traditional factors that affect women's choices regarding pregnancy and ultimately affects their health status and social role. Also these women reportedthat their unplanned pregnancy was due to; 7.3% contraceptives were not available, 2.3% emergency contraceptives were not available, 1.3% pregnancy happened using the IUCD, and 1.3% when breastfeeding and unaware of the pregnancy.

The community participants were asked "is there a PFPPA clinic in your community"?

66.3% said No vs. 34% said yes. This status needs to be addressed by the PFPPA in marketing their services and making their services accessible to all women especially the ones who are living in distant areas. Of those who said yes, only 2.7% said that condoms are offered for free, 4.5% said that pills are offered for free, 4.9% reported on IUCD with partial payments, 1.5% said that emergency contraception are offered for free and 20.1% said that none of the items are offered for free. This emphasizes the PCBS-FHS findings indicating that 19.3% of married women reported unmet needs for family planning. Also very minimal numbers reported on having folic acid, iron and other treatments for free. For women seeking antenatal care; around 34% go to private Dr., 12.1% goes to Government PH and the frequency for their antenatal care visits was; 13.6% went once during pregnancy, 11.7% went twice and11.7% went four times to get antenatal services.

The pregnancy complications described were mainly due to bleeding, hypertension and diabetes. This highlights the need for quality antenatal services in these areas since early diagnosis of these complications prevent lots of pregnancy/motherhood morbidities. This also necessitates the establishment of a system within the SDPs where an obstetrician can assess and provide care to the clients according to their needs. Regarding abortion, 12% said that they had an abortion and 7.6%of these abortions took place in hospitals. Also 1.3% only came to the SDPs for postnatal services which indicates very low rate for seeking postnatal care.

The above figures on RH indicates that the PFPPA must address the need for RH services starting from preconception, through antenatal period, postnatal checkups and family planning services. This requires cooperation with national and NGOS stakeholders in reaching and supplying this underserved population for the provision of comprehensive RH services.

For the SDPs- client's group, 94% were pregnant, and 40% reported unwanted pregnancy which is much less than the community group, again of those mentioning unwanted pregnancy; 32.3% reported "It was not my choice". Around 4% reported that contraceptives were not available and 0.9% reported emergency contraceptives were not available much

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less than the community group being SDPs clients. Around 3% reported that pregnancy happened over the IUCD and few with the use of oral contraceptives, during lactation, and one case reported "Forced by husband's mother".

Regarding antenatal care, despite the availability of SDPs for this group yet, the majority 43.4% goes to private doctor, 13.8% goes to Government PH clinic and 13.8% to PFPPA clinic noting that the number of participants seeking RH care is more for the private Doctors among both groups.

The pregnancy complications among the client group are described mainly due to bleeding, hypertension and diabetes and anemia counted the most frequent health problems among all. Yet a very indicative positive RH care provided by SDPs is that health complications among client group is much less 17.7% vs. 25.4% for the community group. This highlights the need of quality antenatal services in these areas since early diagnosis of these complications result in healthy mothers. Yet, FP offered by SDP for free was still minimal yet more available the clients' group than for the community group indicating the importance of having the SDPs. Only 3% reported on the following items to be offered for free; folic acid, iron and treatment.

PFPPA-SDPs accessibility and use by clients within their areas of residence

Regarding PFPPA-SDPs; the sample included 30% participants from Bethlehem, 27.8%Hebron, 22.2% Halhul and 20%Ramallah. Their knowledge about the SDPs was from different sources including family member, neighbors, PFPPA outreach service and the least 7.5% was through media. Therefore, the PFPPA needs to utilize media consistently and to establish a media center if possible to advertise for its services and launch health awareness programs in the study targeted areas. This was also mentioned by the SDP health providers a key mechanism to promote the SDPs' SRH services.

The clients chose PFPPA-SDPs services; 32.6% reported because of its quality services, 31% because of its convenience and accessibility and 36.2% because it meets their needs, good reputation, excellent services and availability of a female physicians. Furthermore, the participants reported their current use (time of data collection)of PFPPA-SDPs was; 40% seeking family planning services, 32% gynecology problems, 26% maternity care, 2.7% for GBV services and 2.7% for emergency contraception. 12% for Lab. Investigation, 2.4% for follow up care and very few responses for breast cancer screening, infertility treatment, and counseling. Such figures were complemented with all stakeholders acknowledging PFPPA work through its clinics and outreach activities as well as the need for further supporting of the association's services.

To understand utilization of SDPs services, interviewees were asked about the frequency of their visits in last 12 months, 79% visited and; 23% once, 40.7% two times, 9% three times, and 8% more than 3 times. And the reasons for visits during this period were given by 61.5% of the participants as;30% for gynecological problems, 22% for antenatal care, 19.2% for family planning, 8% for postnatal care and 2.4% for counseling. PFPPA activities were reported as numerous, but PFPPA can serve more clients by using media or any other more awareness activities to benefit the people living in the areas of SDPs.

Also to identify the clients use of treatment and medical consumables provided "for free or for minimal cost at SDPs"; 24.2% said yes, 14.4% said sometimes, 8.9% who did not agree to that, and 23.2% of the clients said that not all of their needs are available. 12.5% for condoms, 9.6% for pills, 5.1% for IUCD, and 4.5% for emergency contraceptives. Such findings are important to highlight for PFPPA so they can work on more provision of these FP methods which ultimately will be reflected on women's RH.

To complement the understanding of the PFPPA-SDPs services, the participants were asked "Do laboratory services in the PFPPA clinic meet your needs?" around 23% said yes, 16.1% said no, 19.6% said sometimes and 6% said that not all investigations are available in the SDPs' laboratory. For those who are not satisfied, they were asked to indicate their needs; 4.0% reiterated on the need for different types of tests that are not available and 1% asked for thyroid and hormones tests while only 2 asked for pap smear and mammography

Furthermore, the participants were asked "what other services in your area are not available and needed from the PFPPA; 70.2% emphasized that ambulance has to be available for service by the PFPPA, 49.3% emphasized that X-Ray machine has to be available for service by the PFPPA, 43.8% emphasized advanced lab services need to be provided for PFPPA and 37.6% emphasized that a pharmacy should be available by the PFPPA.

The PFPPA can cooperate with MoH or the private doctors to market and provide such services in their clinics. Establishment of pharmacies by PFPPA to provide medications at minimal cost will help the clients especially the 65% who are not insured.

Satisfaction of clients attending PFPPA- SDP clinics

Space, timing and communication with clients; on this the satisfaction with the physical structure and space, timing of service was reported as excellent compared to the numbers served daily in these clinics, and staff were assessed as very well communicating with and educating their clients

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When asked on the benefit from the IEC materials 28.4% said that they did not benefit from the IEC materials published by the PFPPA while 28.4% said the information contained is unattractive. This shows that there is a need to reassess the material of the IEC pamphlets. A professional graphic designer together with up to date information will make the IEC materials much more useful to the clients. This shows the need for specialized personnel to redesign the current IEC materials to meet the needs of the clients.

Out of the SDP clinics clientele 90.4% were served within 30minutes.This shows that timing of service is excellent compared to the numbers served daily in these clinics. When they were asked if the doctor greets you 47.6% only said excellently.

Male and female adolescents and women in reproductive aged SRH and health needs

The adolescents asked for units to be established in the SDP clinics in order to address their needs rendering these services available and accessible to them. They asked also for recreational centers in their residential areas which can provide health education and counseling services. The PFPPA future strategic plan must take into consideration the needs of adolescents in the targeted areas where the males and females in the focus groups emphasized these needs during their discussions.

"Women of Reproductive Age" focused on the need for ambulance services and SRH centers near their residential areas. They also asked for health education to increase their understanding of health issues. The PFPPA in cooperation with MOH must work to address these needs.

The stakeholders' perception needs and constraints

Ramallah area stakeholders focused on the need to open health centers to provide general health hand SRH services. Provide counseling sessions on SRH issues for the engaged and newly married couples.

Halhul area stakeholders asked for mobile clinic services to meet the health needs of the local population. Suggested creating small businesses for women to make them financially independent and the provision of pediatric services in the SDPs besides SRH and family planning services

Hebron area stakeholders asked for ambulances to provide services especially in emergencies, mobile clinics to reach remote areas, MCH services and a maternity unit which provides round the clockservices. Health education and awareness campaigns to the adolescents

Bethlehem area stakeholders asked PFPPA to provide them with clinics that include MCH and SRH services that are accessible and affordable. Ambulance services well equipped for all types of emergencies especially for women and children. Awareness campaigns to all sectors of the population.

Conclusion and Recommendations

The socio-demographic profile of the surveyed population and the living conditions are very much significant to indicate the availability and persistence of early-marriage, coupled with large and low income families in overcrowded houses. Their living conditions indicates harsh circumstances they go through and shows how really they are underserved for general living circumstances and for very basic health care facilities, services and professionals resulting from the conflict in the area, being in remote location and not served well being in area C for the majority of the surveyed. Therefore, it is hoped this report will help the PFPPA to undertake measures and to address these issues and most importantly ensure provision of health services in general and SRH in specific

General recommendation

1. PFPPA as a stakeholder interested in these underserved areas have to coordinate their efforts among many institutions including civil society and the Palestinian Authority institutions, to have long term and comprehensive intervention strategies regarding societal, traditional and financial issues mentioned within their socio-demographic profile. For example; PFPPA needs to coordinate efforts with the Ministry of Education, religious leaders and others to address early marriage and promote girls' education and help in finding financial resources through other NGOs as for example business micro grants for women.
2. To report the results of this study for MoH officials and coordinate efforts to cover the health services needed for the general population including MCH centers, services for people with disabilities as well as to ensure more health providers are available within those areas
3. Call on MoH to provide health insurance for all residents of these areas in order to help them seek health services within their areas of residence and without the burden of unaffordable treatment costs.
4. Health centers with comprehensive services around the clock especially during emergencies are needed badly and must be established.
5. Expand the male integrated services in all of PFPPA SDPs and in the community as there is a lack of such services in general.
6. Setting up mobile clinics with a mobile team which can reach remote areas and provide care

For PFPPA administrators

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1. Cooperate with available health professionals in the targeted areas like doctors, nurses and midwives to cover maternal and child health requirements especially during emergencies.
2. Continue to conduct training programs that include not only PFPPA health providers but also the available health professional to have a continuous and consistent care for those in need particularly in area C.
3. PFPPA needs to utilize media consistently to announce its services and launch health awareness programs that cover the health needs of the target population.
4. PFPPA to continue to visit women and provide the care needed in their homes especially for those living in areas distant from all types of services since the figures given for the number of visits and utilization of services by the target population is considered insufficient.
5. Expand services provided within SDPs to include for example, pre-conception care (i.e. SRH other than MCH)and new specialties such as urology, pediatric, infertility services and advanced laboratory tests.
6. Develop advocacy strategies through partnerships with other institutions and community based organizations to help advocate for the importance of SRH matters including social issues that affects women's health and to promote male involvement particularly for the issues of family planning, marriage and education.
7. Continue and expand awareness campaigns for the adolescents' woman and men concerning their health to reach remote and underserved areas.

Introduction

1.1 Introduction

In many parts of the world even in countries with well-functioning health care systems, there are unmet needs when it comes to the health of a targeted population since there are certain elements that can hinder services on the ground. Palestinians are not only suffering from political, social and economic issues, but the basic health needs of parts of its population are also not totally covered due to the current political status.

The PFPPA is planning to double its services by 2015 and triple them by 2020 in the West Bank and Gaza Strip with special emphasis on Area C which covers 60%of the land. According to the United Nations report (OCHA report 2013) the most vulnerable Palestinian communities live in Area C where it is classified as an area which needs humanitarian assistance at all levels. The PFPPA strategic plan is to cover the health needs in general and reproductive, gender, sexual and family planning issues in particularly in these areas.

The PFPPA conducted an in-depth baseline survey to discover the unmet needs of adolescents, men and women living in targeted underserved areas in Palestine (Bethlehem, Hebron, Halhul, and Ramallah). The survey's strategic objective is to establish a comprehensive database of information needed about the targeted population. This information will cover demographic data, contextual elements influencing their lives and identify their unmet needs concerning family planning and reproductive health defined by their perspectives. The study utilized different methods; two types of questionnaires designed to collect quantitative information about the targeted population conditions, and the second questionnaire to collect quantitative information about the clients' satisfaction of the services received from PFPPA-SDPs in same study areas. Interviews with the stakeholders of these communities were interviewed to give their opinion concerning the unmet needs also from their perspective. Focus groups were created for adolescents of both sexes and for women in their reproductive age where family planning and reproductive health issues were discussed with the moderator. These discussions highlighted upon different aspects off unmet needs where the PFPPA will take into consideration in their future plans.

1.2 Significance of study

A study conducted by the United Nations Office of the Coordinator of Humanitarian Affairs (OCHA Jan, 2013) concerning the humanitarian needs of Area C in the West Bank showed that 150,000 Palestinians live in these areas within 542 communities.70% of Area C is within the boundaries of conflict areas which are a main cause of hindering any development of these areas.

The Palestinian communities living in Area Care the most venerable among the nation because of the current conflict. These is limited their access for health, education, water and sanitation services.

Medical services provided by the Palestinian National Authority do not reach Area C and at the. As a result of being captivated under this status there is a complete lack of basic and essential services provided in these areas. The Palestinian ministry of health cannot build any health facility within Area C.

Within this context, the inhabitants have limited access to all health care facilities in their areas, especially when it comes to female adolescents and women because of the conservative culture and mindset. Conservative ideas and thinking not only impact women's health, but their education also since schools are located outside their communities or within a distance from their homes which unwillingly leads

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young adolescents to drop off their school. The inevitable consequence of dropping school off is early marriage for such young females living in a conservative community.

The results of the study will be an informative tool for PFPPA concerning the poor, marginalized, underserved and socially deprived population living in Area C. The results of the study will guide also the PFPPA on how to devise and adopt a strategic plan in the future for the provision of comprehensive SRHS services.

1.3Goal of the study

The goal of the needs assessment is to explore in-depth the holistic health needs of the population living in Area C and clients attending PFPPA-SDPs and their satisfaction of the services provided to them as well. Based on the quantitative and qualitative results of the study, the information will be used to identify the appropriate interventions for up scaling the service provision and address the unmet needs of reproductive health services of the target population. To achieve the goal of this study, the following objectives are set:

1.4 Objectives of the study

1. Identify the socio-demographic characteristics and health conditions of the two target groups
2. Identify the availability of and accessibilityto RH health services within the two target groups communities
3. Assess clients attending PFPPA-SDPs for accessibility and utilization of its services
4. Explore barriers to access reproductive health including family planning
5. Identify areas of improvement for the PFPPA clinics toward providing integrated comprehensive SRH services
6. Explore the needs and views of the male and female adolescents concerning health in general and reproductive health in particular
7. Highlight the views and perceptions of reproductive aged-women concerning reproductive health issues and family planning.
8. Identify the stakeholders' perception of the needs and constraints to provide quality services in the targeted areas.

Research questions

1. What are the socio-demographic characteristics and living conditions of the population living in the underserved areas in Palestine?
2. Are health services including SRH available and accessible to the population in the targeted areas
3. Does the target population know about PFPPA-SDPs within their areas of residence and use its services
4. Do adolescents identify their health needs including SRH explicitly and clearly
5. How do reproductive aged women living in area C perceive SRH and what are their needs and recommendations?
6. What are the stake holders' perceptions of needs and constraints to provide quality services in the targeted areas?
7. What are the views of the SDP health providers concerning the future plans to promote SRH services and the satisfaction of their clients

1.5 This report is expected to:

- A comprehensive reference for reproductive health needs in Palestine particularly Area C
- A reference for future up-scaling services in Area C.
- Use the results of the survey in the future for advocacy purposes locally and internationally.
- Put strategic action plans in order to change current status in these areas.
- Identify the essential items required to provide quality services in Area C.
- Highlight on the satisfaction level of the clients attending the SDP clinics.

Literature review

This chapter describes the current situation of the Palestinian Territories in general and Area C in particular. The literature review will identify also the current health status in general and reproductive health needs in particular.

2.1 History of the Palestinian Territory and the creation of Area C.

The term West Bank is given to this territory because it is situated to the West of the Jordan River. After the First World War Palestine was allocated to the British mandate by the Allied forces.In1947during this turbulent period the area was divided by the United Nations. In 1948 war broke up where the West Bank and East Jerusalem were captured by Transjordan at that time. This status quo was kept until 1967. In 1993 the Palestinian territories were divided to Area A, Area B, and Area C.

Area C encircles nearly all the land in the Eastern part of the West Bank as it spreads from the Eastern slopes of Nablus Mountains to the Jordan River. 61% of the West Bank is considered Area C which is considered mostly a conflict area. The Palestinian population living in Area C is estimated to be 300,000 inhabitants. 60,000 Palestinians live in 180 villages which are entirely in Area C and the rest reside in 290 villages and towns (B'Tselem-publications, 2013).

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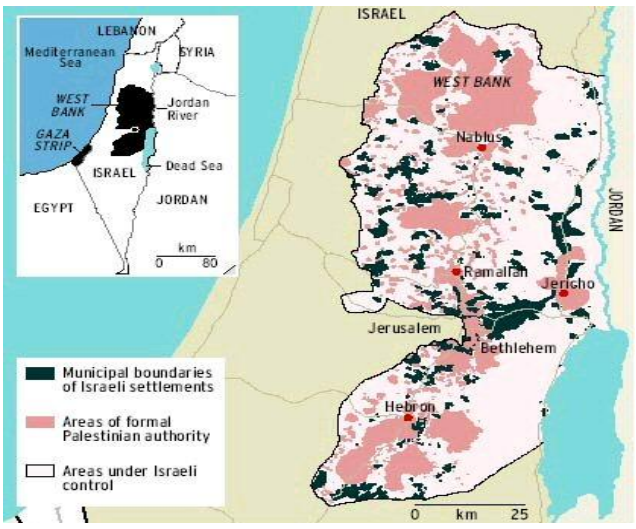
The Palestinian needs like construction or development projects are banned while the civil administration doesn't see the settlers building violations. An EU report in 2011 stated that before 1967 between 200,000 and 320,000 Palestinians used to live in Jordan valley which is an agricultural area. After Oslo accord 90% of its land is considered Area C (Halper, 2012) the demolitions of houses and prevention of building in the area its population number dropped to 56,000 where 70% of them now live in Area A. Although the international law of Geneva Convention prohibits transfers of population of an occupying power to occupied territories the Jewish population in Area C has grown from 1,200 to 310,000. They are not more than 6% of the Palestinian population of the West Bank. The region of South Hebron hills is considered Area C. It is under full Israeli control there are 30 villages and 4000 residents living from herding and farming. The region is known as greater Yatta where construction is prohibited and house demolitions of the locals are usual in this area (Halper, 2012)

Bethlehem stretches from the Green line in the West to the Dead Sea in the East and from the separation wall in the North to Hebron in the South. According to the UN in 2009 Bethlehem area had 19 settlements and 16 outposts with a total population of 86,000.The villagers living in Area C lost agricultural land vital for their livelihood and sustainability(9).



In some communities, families are being forced to move as a result of Israeli policies applied in Area C. Ten out of 13 communities recently visited by OCHA reported that families are leaving because policies and practices implemented by the Israelis make it difficult for residents to meet basic needs or maintain their presence on the land (OCHA Fact sheet, 2011).

According to EU report (2013), Israeli policies in the area have undermined the Palestinian presence there, with deterioration in basic services such as water supplies, education and shelter. Nearly 70% of the Palestinian villages are not connected to the water network that serves settlers, which accounts for the fact that Palestinians in the zone use only a quarter to a third of the pro capita consumption of settlers. UNDP (2013) further commented on the general situation of area C; the provision of public health services in Area C is a challenge to Palestinians and other health providers due to access and construction restrictions imposed by the Israeli- Palestinian conflict.

2.1.1 Socio demographic trends of OPT

According to PHIC in2010 the total estimated Palestinian population is 4,048,403 of which 50.8% are males and 49.2% are females. The fertility rate is 4.2 (3.8 in the West Bank while in Gaza Strip is 4.9) and the average population growth is one of the highest in the Palestinian territories. According to the PCBS figures of 2010 the natural increase of the population was 2.9% in the West Bank and 3.3% in Gaza Strip. While the yearly average growth worldwide is 1.4%.The crude birth rate is 26\1000 in the West Bank and 39.2\1000 in Gaza Strip. An important indicator is 41.1% of the population is under 15 years.

Theinfant mortality rate is 14\1000 in the West Bank and maternal mortality rate is 38\100,000. According to PCBS (2009), themedian age for first marriage is 19.9 years among women. Area C is facing poverty which is increasing gradually because of land confiscation causing unemployment for a large sector of its population because they are farmers or cultivate their land. Same report indicated that poverty in the west Bank is 21.3% and in Gaza is 37.6% while 32.3% of Area C are under the poverty line.

2.1.2 Reproductive Health and Family Planning Indicators

The World Health Organization (WHO) systemic analysis between (2003 -2009) indicated the global causes of maternal deaths are due to hemorrhage, hypertensive disorders and sepsis. These causes were the main factors responsible for more than half of maternal deaths worldwide. Horton in Lancet (2009) mentions that the health of pregnant women, mothers, new born babies and children are of special concern because they represent two thirds of the Palestinian population.Like any third world nations Palestinians too want to reach Millennium Development goals four and five but, besides the known reasons Palestinians have other hindering issues like restriction of movement, the separation wall and the military check posts which all effect the health of women and children.

Glassier et al. (2006) reported that the reduction of maternal mortality and morbidity in developing countries depends on finding skilled attendants to conduct deliveries, provide emergency care and improve antenatal and postnatal care.

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The Palestinian adolescent birth rate is 67/1000 and firstmarriage less than 18 years is 35.5%, these two indicators shows the importance and the need of reproductive health facilities that provide services, education and counseling for the Palestinians of all ages. The contraceptive prevalence rate is 52.5% using a form of FP reproductive aged women and19.3% of married women reported unmet needs for family planning (PCBS-FHS, 2010). These numbers emphasize on the need to promote family planning and SRH services which not only provide information, family planning supplies to control population growth but also minimize the incidence of STIs and HIV/AIDS.

According to UNFPA Dispatch last August 46,000 women in Gaza Strip are pregnant while 10,000 of them are displaced. MoH statistics shows that there is 160 deliveries each day in Gaza mainly in Shifa hospital which is the main hospital in Gaza 15-20% ofthese deliveries are premature or are complicated. UNRWA describes health in Gaza as challenging. Socioeconomic decline, conflicts and closures left the health sector lacking adequate physical infrastructure. This Status directly affects the health of its population and needs urgent action to promote the health of its people.

In an interview last July with a health officer in Palestine for UNFPA the United Nations population fund said, women in Gaza are suffering from preterm labor miscarriages and stillbirth due to stress of the war and at the same time the privilege of the care is given for the wounded and the maternity care is left with fewer resources and staff. This status will put pregnant women at risk because of lack of care and services. This status highlights the urgent need for maternal services to be implemented in Gaza to serve women in need.

The Palestinian representative in the United Nations economic and social council stressed on his commitment to the Cairo action program which consist of access to sexual and reproductive health, protection of women and girls from violence, proper health care, education and training for the young including family planning services. These challenging steps if implemented by the policy makers will help in solving our hindering development problems.

A Knowledge, attitudes and practice (KAP) study concerning reproductive health and women's human rights done by Dhaler (2008) showed when planning for any women's health programs and projects it should emphasize on the policies and regulations that protect women against violence and organize public education programs which will change women's perceptions towards intimate partner violence. Empowering women by education and employment helps them to take decisions regarding their fertility which will improve their living standards and her status.

Study Methodology

This chapter will discuss the description of the study methods, construction of the study tools, sample selection, data collection and data analysis techniques, ethical consideration and study limitation

3.1 Study design

The study design was exploratory, descriptive, utilized, quantitative and qualitative data to comprehensively cover all the aspects of the study. Quantitative data was collectedfrom two populations; 1) the population living in underserved areas particularly Area C and 2) clients attending PFPPA-SDPS clients. The qualitative data was obtained fromthe stakeholders of the communities living in Area C, PFPPA- SDPs providers and managers. Focus groups were conducted with male and female youth and with women in reproductive to assess their SRH health matters and needs.

3.2 Development of the study tools

The study tools are basedon Andersen's behavioral model which views access to services as a result of decisions made by the individual and constrained by their position in the society and the availability of the health care services (Anderson, 1995). In addition, the objectives of the study and the literature review guided development of the questionnaire.

The quantitative data were two sets of questionnaire; the first assessed the community participants for their socio-demographic characteristics, household environment, availability of and accessibility to health services, and reproductive age women (15-49) years for their SRH practices and seeking behaviors. The second set of the questionnaire assessed PFPPA-SDP clients' for socio-demographic characteristics, household environment, availability of and accessibility to health services, SRH practices and seeking behaviors for women in reproductive age (15-49) years. Inaddition, clients use and accessibility to PFPPA-SDPs within their areas of residence and their satisfaction of these services (please refer to annex 1 for the two sets of the questionnaires).

Pilot testing was done for both questionnaires. The researcher took into consideration the views of the participants and made changes accordingly. Thetool was developed in English first, translated into Arabic and the consent of the stakeholders was granted prior its administration into the field.

The qualitative datawas many sets of open–ended questions for both in-depth interviews and focus groups. In-depth

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interviews question for community stakeholders, SDP health providers and PFPPA administrative staff. Focusgroups questions for women in reproductive age (15-49) years, and young male and female adolescents to obtain detailed information about the study concepts, difficulties they encounter and recommendations they have particularly for PFPPA services and the future needs of the population living in Area C. Validity for the study tools was established when experts in research and social sciences revised the content of the questionnaire and gave their comments please refer to annex 2 for open-ended questions).

3.3 Participant's selection and accessibility for the quantitative data

Three villages or scattered population in villages, Bedouins andenclave areas particularly in Area C who are living under harsh circumstances because of military presence, Israeli settlements and the separation wall were selected by PFPPA office and the researcher. The questioners were distributed based on this criteria and it was filled by one member of the households whether male or female after explaining the purpose of the study. It is noteworthy that only 1.8% (11 males) who filled the questionnaire, so the results indicate females needs within the study targeted areas.

3.4 Ethical considerations

The data collectors explained to the participants the purpose of the study and ensured that their given information is confidential and their identity is anonymous. The PFPPA office provided their employees who did the field work with a formal letter describing the purpose of the study and the importance of their participation.

3.5 Data collection procedures and analysis

3.5.1 The quantitative data collection and analysis

The quantitative data collection from study participants was obtained by PFPPA service providers and under the supervision of PFPPA programsdirector. The purpose of this approach was to ensure PFPPA ownership of this assessment, buy-in to its recommendations and serves as an update plan to IPPF-PFPPA health provision in the target areas. The principle researcher of the study coordinated with programsdirector and field datacollectors and intervened when was needed. 264 questioners were collected from households in 20the targeted areas and 344 questionnaires were collected from clients attended all West Bank SDPs.

The two questionnaires were analyzed by using SPSS program (statistical package for social science version No. 17) after it's been categorized and cleaned. Dataresults were set into tables and their interpretation discussed by narrative style.

3.5.2 The qualitative data collection and analysis

The principle researcher conducted in depth interviews with SDPs providers and PFPPA administrative staff. While the field researcherconducted the focus groups and stakeholders interviews

All data collected was thoroughly read by the main researcher where she excavated themes by clustering and coding the statements of the respondents. This process guided the researcher to describe, analyze the results and write recommendations based upon the purpose of the study.

3.6 Study limitation

- Data collection was not an easy task and time consuming because Hebron and Halhulsurrounding villages were at the peak of instability and was very difficult to reach the very far villages
- Gaza Strip was under fire for nearly two months therefore the field work was impossible.

Quantitative Data Analysis and Findings

Introduction

This chapter will present two sets of quantitative data analysis and findings; the first one is for population characteristics living in Area C referred to the community group, and the second one is for the characteristics and satisfaction of clients attending PFPPA-SDPs referred to as clients group. The data of the two groups will be presented into tables and discussed into narrative style

Based on the quantitative and qualitative results of the survey, the information will be used by PFPPA to identify the appropriate interventions for up scaling the service provision and address the unmet needs of reproductive health services of the target populations.

4.1 The Community Assessment from Underserved Areas

To achieve the research objectives for the community assessment from Area C, a household survey was conducted and the data have identified their; socio-demographic characteristics and living conditions, availability of and accessibility to health services and focused on SRH matters for married women in Reproductive Age (15-49).

4.1.1 Socio-demographic Data

Sample distribution and social status of participants (Table 1): the community sample was 264 participants aged from (18 to 63) years with a mean of 33.3 years old. The participants represented males and the rest were women of all ages residing. The participants were; 35.4% from Hebron, 18.3% from Halhul, 32% from Bethlehem and 14.3% from Ramallah. The participants'social status was; around 94% married, 5% single, 0.8% divorced and0.4% Widower.

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Table 1: Place of residence and social status of participants

Place of residence			Participants		
	No.	%		No.	%
Hebron	93	35.4	Single	14	5.3
Halhul	48	18.3	Married	247	93.6
Bethlehem	85	32	Divorced	2	.8
Ramallah	38	14.3	Widowed	1	.4
Total	264	100.0	Total	264	100

The age at marriageas indicated in (Table 2); 30% were married at age of (19– 22) years and 4.5% were married at 22 years and more. There was 54% who got married between the ages of (14-18) years indicating that early marriage is much more dominant in these areas when compared to national statistics in 2010 with 21.8% who got married at the age of 18 years and less.

Table 2: Age at marriage

Age at marriage		
	No.	%
14-18	142	53.8
19-22	80	30.3
Older than 22	12	4.5
Missing	30	11.3
Total	264	100

The level of education (table 3); 7.6% are illiterate and 26.2% are educated at elementary/primary level, 44.3% at the secondary level, and22% at university level. To have around 34% illiterate and poorly educated is something worth paying attention by stakeholders in the target areas since education is a main reason for development. Such notion was approved by the PCBS-Family Survey (2010) which found marriage among those who have a bachelor or higher degree was 23.7 years for females compared to 16.9 years for those who have a preparatory certificate reflecting the role of education in reducing early marriage.

Table 3: Years of education

Years of education	Frequency	Percentage
Illiterate	20	7.6
Primary /elementary	69	26.2
Secondary	117	44.3
University	58	22.0
Total	264	100.0

Work status, work type, and household Income (table 4); Only 11% of the participants were working, 6% with full time job, 5.4% working sometimes, and 88.6% not employed where the same percentage counted for the housewives taking into consideration that 95.5% of the sample was women. Of those working; 7.2% were professionals, 2.7% were self-employed (family business like shops, farms etc...) and 1.5% work as laborer.

The households' income in Shekel has ranged from 300 - 5000 NIS with an average of 2094 and a standard deviation of 839.2 indicating high dispersion among families. More than half 53.3% of the HH income have ranged from 300-2000 NIS, followed by 34.1% income ranged 2001-4000 NISand very few 1.9% was 4000 and more. According to UNICEF Monthly Update (April, 2010); average monthly incomes among the herding communities in Area C have shrunk to 1024 NIS, less than half the average West Bank monthly income of 2,554NIS. The PCBS Expenditure and consumption survey report on poverty rate in (2010) indicated that the rate of the total distribution of poverty amongPalestinian households was 21.4%. A recent statistics on poverty, OCHA office (2013) indicated that 24% of the Palestinian population in Area C are food insecure compared to 17% in the remainder of the West Bank.

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Table 4: Work status, Type of work and Household Income

Work status			Type of Work			Range of HH income		
	No.	%		No.	%		No.	%
Full time	16	6	Self employed	7	2.7	300-2000	141	**53.3**
Sometimes	14	5.4	Laborer	4	1.5	2001-4000	90	**34.1**
Unemployed	234	88.6	Professional	19	7.2	4000 and more	5	**1.9**
Missing			Housewife	234	88.6	Missing	28	**10.6**
Total	**264**	**100**	**Total**	**264**	**100**	**Total**	**264**	**100**

4.1.2 Household Environment

This part will discuss the households' structure and occupancy by family members including people with handicaps, environmental facilities including accessibility to electricity, water, communication devices, owning a car and health insurance as well

Number of households members and number of rooms within each HH (table 5); the households members has ranged from (2-16) with an average of 6.3 members per family much more than the national statistics compared to 5.6 persons in 2012. Around 39% of the households have (2-5) members, 57.2% have (6-10) members, and 4.5% have (11-20) members.

Number of rooms in the households has ranged from (1-8) rooms with an average of 3.2 rooms per each household. 68.5% of houses consist of (1-3) rooms; of those, 20.8% consists of 2 rooms and 47% consist of 3rooms indicating a high level of populated households and a likelihood of disruption of family dynamics and poverty. Most of Area C has been designated as military zones and for expansion of Israeli settlements, severely constraining the living space and development opportunities of Palestinian communities by enacting laws prohibiting them to have licenses for construction and their homes land confiscation causing unemployment for a large sector of its population because they are farmers or cultivate their land

Table 5: Number of household's members and number of rooms within each HH

No. of HH members			No. of rooms perHH		
Range	No.	%	Range	No.	%
2-5	102	38.7	1-3	181	68.5
6-10	151	57.2	4-6	77	29.2
10 members and more	12	4.5	7-8	6	2.3
Total	**264**	**99.6**	**Total**	**264**	**100**

The PCBS-Palestinian Expenditure and consumption survey (2010) indicated the incidence of poverty increases consistently by the additional number of children among households as referred to in table (6)

Table 6: Likelihood of being poor among households according to households monthly Consumption by number of children in the household

No. of Children	Poverty	
	Value	Contribution
0	15.8	14.6
1.2	16.4	19.4
3-4	20.6	29.2
5-6	28.2	23.8
7+	43.0	13.0
Total	21.4	100

Source: PCBS, 2011. Data base of Palestinian Expenditure and consumption survey, (unpublished data)-Ramallah- Palestine.

Further data on the ***Household resources*** indicated; 84% of the households (221 out of 264) supplied with electricity, 64% (168 out of 264) supplied with water network vs. 36% are not. Almost half of what OCHA reported (2013) that 70% of communities located entirely or mostly in Area C are not connected to the water network. This study participants were selected from both areas C (entirely or mostly) to the extent possible. Given the study limitation in

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terms of time and resources, the study investigator assumes that the very distant and enclave areas need to be more explored and presented.

There are 94% with *communication* devices and only19% (50 out of 264) are having their own car which means there is a problem in transportation for 81% the majority to access health care facility when needed

Regarding ***health insurance***, 67.5% are not insured vs. 32.5% reported having health insurances. For those insured, their insurance was covered by; governmental 58%, Intifada Al-Aqsa 3%, Social Affairs 2%, UNRWA 1% and many few ones covered by other sources. Compared to national statistics, in 2009, the health insurance covered 60.4 % of the Palestinian population as reported in MOH-Palestinian National Health Strategy (2011–2013). According to same source, the Palestinian current health insurance system includes a compulsory component covering civil servants and retirees where this equals 45.3% of the total participants in the system, and 56.9% of the total income generated. Here the number of civil servants and retirees living in target areas are questionable to benefit from this system

Prevalence of persons with special needs (handicaps) within the households; this question has identified other salient health problems among the target population for the attention of the stakeholders. It was found that 12.5% of participants (33 out of 264) agreed to the availability of persons with special needs within their households compared to 7% prevalence for the national statistics (PCBS- Disabled Individuals Survey, 2011). These disabilities has varied between physical, mental/emotional and sensory; of those, 3.5% reported physical problems and motor dysfunction, followed by 1.7% mental health problems where they justified this notion by "lack of oxygen during delivery". Sensory problems were identified for the hearing 3.4% and sight 1.2%. To less extent there was autism, cerebral palsy, down syndromes and epilepsy with 1-2 cases of each. Noting some of these problems are very much attributed to reproductive health where proper screening and follow up care can play a role in reducing such problems

4.1.3 Availability of and Accessibility to Health Services within the Target Communities

This section will identify the availability of health facilities in terms of their types, who provide them, and for how many hours/days they are provided. The availability, types and roles of health professionals within the target communities and lastly transportation system and ambulance services will be identified.

Available health facilities and type of health providers within the targeted communities (table 7); around 47%of participants reported NOT having health vs. 53%having health facilities within their communities. These facilities are as such; 18.2% Health centers, 23.1% PHC, and 9% having both health center & PHC and 0.7 are hospitals. It is noteworthy, these numbers does not necessarily reflect such large number of health facilities, BUT it could be explained that participants living in the samearea–cluster knows or have used the same health facility. The lack of health facilities was emphasized by UNDP (2013) when reported that more than 20% of communities in Area C have limited access to health services.

The health facilities were provided by; 35.2% government (MoH) alone, 11% government and private, 4.9% Government and NGOs and 1.9% Private. The NGOs and private services are very minimal where this need to be emphasized for future planning to encourage both sectors invests in these areas and establish healthy services beside the MoH services to cover this widespread and scattered population.

Table 7: Available health facilities and type of health providers

Available health facilities	No.	%	Type of health providers	No.	%
Hospital		0.7	Government	92	35
Health center	48	18.2	Private	5	1.9
PHC	66	24.9	Government and Private	29	11
Health Center & PHC	24	9.1	Government and NGOs	13	4.8
			Mobile governmental clinic	4	1.5
NO	124	46.9	Missing	120	46
Total	264	100	Total	264	100

Duration of services offered by available health facilities (Table 8); 37.1% said "I do not know"and 63% reported on duration of health provision by these facilities as such; 13.6% all the week, 2.6% three days a week, 10.9% twice a week, 19.3% once a week, 3.4% once every two weeks, 2.2% once a month and 1.5 reported on Mobile governmental clinic one a week. It is noteworthy that the mobile health clinic as a pilot intervention was inaugurated in 2013 by the Prime Minister and MoH minister to answer emergency health needs of the Area C population.

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The duration for opening these services to the people is considered very minimal, inconsistent and scattered as for example, a sick person or a women with antenatal problems cannot have the follow up if she is living in an area having health services once a week or twice a week.

For the 53% who reported on the availability of health facilities within their communities were asked "Are these services covering you reproductive health and family planning needs?" 56% said No vs.30%said to some extent and 14%said yes. Forthose said yes were asked to clarify; the responses were very minimal (4 participants) and as such; it's nearby my house, the availability of a female physician, seek medical advice when necessary and FP methods not available all times.

Table 8: Duration of services offered by health facilities per week/month

Duration of services	Frequency	Percentage
Once a week	27	19.3
Twice a week	15	10.9
Three days a week	4	2.6
All week	19	13.6
Once a month	6	2.2
Once every two weeks	5	3.4
Mobile governmental clinic 1 day per week	15	10.6
Do not know	98	37.1
Total	264	100

Availability of Health professional living the targeted communities (table 9); 50% who reported not having any health professional living within their area of residence vs. 50% reported to have. The health professionals were; 21.2% a Doctor and a Nurse, 8.7% a Doctor only, are having a 13.4 Nurse only, 5.6% a Doctor, Nurse and midwife, 1.5% are having a Midwife and Daya, 1.9%are having a Dentists and 1.5%are having a Pharmacists. Noting these percentages does NOT necessarily reflect such large number of health professionals BUT it could be explained that participants living in the same area reiterated on the same health professional.

Table 9: Health professional living the targeted communities

Duration of services	Frequency	Percentage
Doctor & Nurse	56	21.2
Doctor	23	8.7
Nurse	33	13.4
Doctor, Nurse and Midwife	15	5.6
Midwife and Daya	4	1.5
Dentist	5	1.9
Pharmacist	4	1.5
No	124	46.9
Total	264	100

Furthermore; to understand the health professional roles within their communities, the participants were asked "do you think the health professional can meet the needs in your community?" only 3.8% (10 out of 264) said Yes, 30.3% (80 out of 264) said No, and47.3% (125 out of 264)said to some extent.Given these findings, the quality and consistency of care given by local health professionals is questionable and need to be discussed with stakeholders for the possibility to be partners when launching new strategy in that area in order to meet the peoples' needs.

Transportation system to access health facilities outside participants residence/communities(table 10); around 35% of participants do not have transportation system to access health facilities said no vs. 65% said yes. Of those with yes answer was; 50% for public transportation and 9.1% for own car. Under others category in the questionnaire; 2participants needed security coordination (for people living in enclave areas around the separation wall) and the worse transportation in case of emergency is to find 6 participants reported walking on foot. Only 5.7% of the participants agreed on the availability on ambulance when needed. No transportation is a major problem and Public transportation is not the appropriate vehicle to transfer people with health problems and jeopardizes their lives knowing the far distances hurdles they go through. The study highly recommends for stakeholders to take actions to try to be part of the solution to this problem

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Table 10: Type of transportations available to access health facilities in emergency

Type of transportations	Frequency	Percentage
Ambulance	15	5.7
Your own car	24	9.1
Public transportation	132	50
No transportations available	93	35.2
Total	**264**	**100**

4.1.4 Married woman in Reproductive Age (15-49)
This section will identify women in reproductive age (15-49) SRH matters and seeking health services within their areas of residence. It will start by asking about pregnancy and its problems, FP methods, abortion, antenatal and postnatal care and utilization of PFPPA-SDPs

Starting with pregnancy; around 82% (217 out of 264) of study participants have been pregnant. Of those, around 44.6% were planned pregnancy as they said "yes" vs. 55.4% not planned. Planned pregnancy is more than community, indicating the effectiveness of being with SDPs

Reasons why pregnancy was not planned (Table 11); women were asked "If not planned indicate the reason why?" of those not planned 40.3 responded as such; 25.8% (56 women) reported "It was not my choice" and this an issue that should be emphasized knowing the cultural and traditional factors that affects women choices regarding pregnancy which ultimately affects their health status and social role. Around 7.3% reported that contraceptives are not available, 1.3% reported that pregnancy happened over the IUCD, 2.3% reported unavailable emergency contraceptives and 1.3% reported on breastfeeding and unawareness of the pregnancy

Table 11: Reasons for unplanned pregnancies

Reasons for unplanned pregnancies	Frequency	Percentage
It was not my choice	56	25.8
No available contraceptives	16	7.3
Pregnancy happened over the IUCD	3	1.3
No available Emergency Contraceptives	5	2.3
Breastfeeding and unaware of pregnancy	3	1.3

Knowledge of participants on the availability of PFPPA - SDP and items offered for free by SDPs (table 12); the participants were asked "do you have a PFPPA clinic in your communities"? 66.3% said No vs. 34% (89) said yes. Of those said yes, only 2.7% said that condoms are offered for free, 4.5% said that pills are offered for free, 4.9% reported on IUCD with partial payments, 1.5% said that emergency contraception are offered for free and 20.1% said that none of the items are offered for free. This emphasizes the PCBS-FHS indicating that 19.3% of married women reported unmet needs for family planning. Under the category for others; only 3.1% (8) participants reported on the followings to be offered for free; 1.1% for folic acid, 1.1% to have injections, 0.8% for iron and0.8% for treatment.

Table 12: FP Items and other items offered for free at PFPPA-SDPs

Family planning items-SDPs	No.	%	Other items offered at SDPs	No.	%
Condoms	7	2.7	Iron	2	.8
Pills	12	4.5	For treatment	2	.8
IUCD insertion	13	4.9%	Folic acid	3	1.1
Emergency contraception	4	1.5%	Vitamins	1	.4
None of the items are offered for free	53	20.1%	Tohave injections	3	1.1
Missing	175	66.3	Missing	253	95.9
Total	264	100	Total	264	100

For abortion issue, women were asked "Did you ever have an abortion?" 11.7% (31 out of 264) reported that they had an abortion, and the number of abortions has varied from 1-5 times as indicated in table (13). Around 8% had abortion one time, 2% had abortion two times, 0.8% had abortion 3times, 4 times and 5 times and the providers for abortions were; 7.6% have had the abortion in Hospitals, 2.7% have had the abortion in Private Dr. Clinic and1.1% in PFPPA clinic-

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Table 13: Number of abortions and health provider for abortion

No. of abortions	No.	%	Health provider for abortion	No.	%
1	20	7.6	PFPPA clinic	4	1.1
2	5	1.9	Private Dr.	7	2.7
3	2	.8	Hospitals	20	7.6
4	2	.8			
5	2	.8			
Missing	233	88.3	Missing	233	88.3
Total	**264**	**100**	**Total**	**264**	**100**

For antenatal care, women were asked "Where do you usually go for your antenatal care?"(Table 14) indicates; around 34% goes to private Dr.,12.1% goes to Government PH clinic, 11.7% to PFPPA clinic, 10.6% to Private Dr. and Government PH clinic, 4.5% to PFPPA clinic and Government PH clinic and 3.8% to PFPPA clinic and Private doctor. Under the others category; 3% goes to UNRWA clinics and very minimal numbers 0.4% to high risk pregnancy clinic and 0.1% to Daya. Noting that the number of participants seeking RH care is more for the private Drs

Table 14: Provision of antenatal care by type of health facilities

Provision of antenatal care by type of health facilities	No.	%
PFPPA clinic	31	11.7
Private Dr.	89	33.7
Government PH clinic	32	12.1
PFPPA clinic and Private Dr.	10	3.8
PFPPA clinic and Government PH clinic	12	4.5
Private Dr. and Government PH clinic	28	10.6
Missing	62	23.5
Total	264	100

The number of antenatal visits during last pregnancy as indicated in (table 15);11.7% reported their visits was 4 times, 16.7% three times, 35% two times, and 13.6% once, and 3% more than more than 4 times. Further,to identify the use of the MCH booklet by health providers; 58% of those visited antenatal care said yes when asked "Have you ever been given the MCH booklet from your antenatal care providers?"

Table 15: Number of antenatal visits during last pregnancy

Number of antenatal visits	No.	%
Once	36	13.6
Twice	93	35.2
Three times	44	16.7
Four times	31	11.7
More than four	8	3
Missing	52	19.7
Total	264	100.0

Health complications during pregnancy (table 20); 25.4% of the pregnant women (67 out of 264) reported long list health complications during pregnancy. The complications mentioned within this table are for the more frequently mentioned among the participants making 13.3% (34 out of 67); these were as such; 1.1% complained of low blood pressure, 2.5% complained of bleeding, 3.4% complained of anemia, 2.3% preeclampsia, 1.1% of Gestational diabetes and 0.8% complained of Varicose veins and 1.9% of albumin in urine. The other 11.2% of the complications were distributed for one case or two maximum and these included for example; low back pain, bowel irritability, general aches, cough, nausea, exhaustion etc… Anemia counted the most among others 3.4% and this very much coincide with national statistics when FHS in 2010 indicated that 26.7% of pregnant women aged 15-49 in the Palestinian Territory were anemic

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Table 16: Health complications during pregnancy

Health complications during pregnancy		
	No.	**%**
Bleeding	7	2.7
Preeclampsia	6	2.3
Low blood pressure	3	1.1
Anemia	9	3.4
Gestational diabetes	3	1.1
Varicose veins	2	.8
Albumin	5	1.9
Total	264	100

Furthermore, women with complications were asked "where you were referred in case you have health complications?" and 20% (53 womenout of 67) were referred to as such; 13.6% were referred to the hospital and 6.4% to obstetrician.

The participants were asked about follow up care by the SDP providers (table 21); 41% (108 out of 264) said yes and the reasons were; 31.8% for follow up treatment, 6.1% for counseling and 3% for Medication.

Table 17: Follow up care by the SDP providers

Follow up care by the SDP providers		
	No.	**%**
Counseling	16	6.1
Medication	8	3.0
Follow up treatment	84	31.8
Missing	156	59.1
Total	264	100.0

To have a clear picture of the RH care, the participants were asked "During the six weeks after birth did you have any problems or complications?" 12.5% (33 out of 264) said yes, and 19 out of 33of visited the PFPPA clinic for treatment.

The results show the unavailability of SDPs in the underserved areas and the lack of FP services as well. Seeking access by participants to these facilities is minimal considering the target population remote residence. This insufficient services identified need to be known by all stakeholders for intervention strategies and plans to cover this poorly served population.

4.2CLIENT'S QUESTIONNAIRE ATTENDING PFPPA SDPs

To achieve the research objectives for client group attending PFPPA-SDPs in terms of accessibility, utilization and barriers to comprehensive SRH services. The data have identified their; socio-demographic characteristics and living conditions, availability of and accessibility to health services within their communities, PFPPA-SDPs clients satisfaction accessibility and use by clients and their satisfaction within with the services provided

4.2.1 Socio-demographic Data

Sample distribution and social status of participants (Table 1): the clients sample was 334 female participants aged from (16 to 70) with a mean of 35.29. The participants represented 15 areas including cities and villages from four districts in middle and south West Bank. The participants were; 41% from Hebron, 27.2% from Halhul, 22.5% from Bethlehem and 9.3% from Ramallah. The participants' social status was; around 90% married, 4.2% single, 2.1% divorced and 2.7% Widower.

Table 1: Place of residence and social status of participants

Place of residence			Participants		
	No.	%		No.	%
Hebron	137	41	**Single**	15	4.5
Halhul	91	27.2	**Married**	300	89.8
Bethlehem	75	22.5	**Divorced**	7	2.1
Ramallah	31	9.3	**Widowed**	9	2.7
Total	334	100	**Total**	334	100

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The age at marriage as indicated in (Table 2); 28% were married at age of (19– 22) years and 12% were married at 22 years and more. There was 45.5% who got married between the ages of (14-18) years indicating the prevalence of early marriage which is much less than 54% for the community group indicting those closer to the cities may have better education opportunities. Yet, the rate is double the 21.8% for national statistics in 2010 who got married at the age of 18 years and less. 54vs. 45.5 marriage age

Table 2: Age at marriage

Age at marriage		
	No.	%
14-18	152	45.5
19-22	94	28.1
Older than 22	40	12.0
Missing	48	14.4
Total	334	100

The level of education (table 3); 3.6% were illiterate and 28.2% are educated at elementary/primary level, 43.1% at the secondary level, and 25% at university level. Again the illiteracy rate 7.6% among community participants is double 3.6% for the clients' participants

Table 3: Years of education

Years of education	Frequency	Percentage
Illiterate	12	3.6
Primary /elementary	94	28.2
Secondary	144	43.1
University	84	25.1
Total	**334**	**100.0**

Work status, work type, and household Income (table 4); Only 16.3% (54 out of 334) of the participants were working, 10.3% with full time job, 6% working sometimes, and 82.6% not employed where the same percentage counted for the housewives taking into consideration that 100% of the sample was women. Of those working; 9.6% were professionals, 6% were self-employed (family business like shops, farms etc...) and 0.7% worked as cleaner

The households' income in Shekel has ranged from 500 to 8000 NIS with an average of 2280 and a standard deviation of 839.2 indicating high dispersion among families. More than half 51.2% of the HH income have ranged from 500-2000 NIS, followed by 32.6% income ranged 2001-4000 NIS and very few 4.2% was 4000 and more. Noting that clients' income in general is slightly better than the community group particularly for those with 4000 where it 4.2% for clients vs.1.9% for community group

Table 4: Work status, Type of work and Household Income

Work status			Type of Work			Range of HH income		
	No.	%		No.	%		No.	%
Full time	34	10.3	Self employed	20	6	300-2000	171	51.2
Sometimes	20	6	Cleaner/ maid	2	.7	2001-4000	109	32.6
Unemployed	276	82.6	Professional	32	9.6	4000 and more	14	4.2
Missing			Housewife	276	82.6	Missing	50	12
Total	**334**	**100**	**Total**	**334**	**100**	**Total**	**334**	**100**

4.2.2 Household Environment

This part will discuss the households' structure and occupancy by family members including people with handicaps, environmental facilities including accessibility to electricity, water, communication devices, owning a car and health insurance as well.

Number of households members and number of rooms within each HH (table 5); the households members has

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ranged from (2-20) with an average of 6.5 members per family. Around 40.7% of the households have (2-5) members, 51.8% have (6-10) members, and 7.5% have (11-20) members. Family's members in both sides are higher than the national Palestinian statistics

Number of rooms in the households has ranged from (1-8) rooms with an average of 3.2 rooms per each household. 68% of houses consists of (1-3) rooms; of those, 22.8% consists of 2 rooms and 44.3% consist of 3rooms indicating a high level of populated households. Yet there is 30.6% living in HH with 6-8 rooms

Table 5: Number of household's members and number of rooms within each HH

No. of HH members			No. of rooms per HH		
Range	**No.**	**%**	**Range**	**No.**	**%**
2-5	136	40.7	1-3	227	68
6-10	173	51.8	4-6	102	30.5
10 members and more	25	7.5	7-8	5	1.5
Total	334	100	Total	334	100

Further data on the **Household resources** indicated; around 90.5% of the households (300 out of 334) supplied with electricity, 70.5% (233 out of 334) supplied with running water, and 97.6% are having communication devices. Only 24.0% (80 out of 334) are having their own car which means there is a problem in transportation for 76% the majority to access health care facility when needed

Regarding **health insurance**, 30.8% are not insured vs. 67.5% (231 out of 334) reported having health insurances. For those insured, their insurance was covered by; governmental 66.8%, Intifada Al-Aqsa 4.2%, Social Affairs 3%, UNRWA 1.2% and many few ones covered by other sources. Very proximal to national statistics on health insurance that covered 60.4 % of the Palestinian population in 2009 as reported in MOH-Palestinian National Health Strategy (2011–2013). According to same source, the Palestinian current health insurance system includes a compulsory component covering civil servants and retirees where this equals 45.3% of the total participants in the system, and 56.9% of the total income generated. Here the number of civil servants and retirees living in target areas are benefiting from this system knowing that most of the clients come from cities and surrounding that are subjected to such laws.

Prevalence of persons with special needs (handicaps) within the households; this question has identified other salient health problems among the target population for the attention of the stakeholders. It was found that 10.8% of participants (36 out of 334) agreed to the availability of persons with special needs within their households compared to 7% prevalence for the national statistics (PCBS- Disabled Individuals Survey, 2011). The 10.8% disabilities varied between physical, mental/emotional and sensory; of those, 2.7% reported physical problems and motor dysfunction, followed by 1.7% mental health problems where they justified this notion by "lack of oxygen during delivery". Sensory problems were identified for the hearing 0.9% and sight 1.8%. To less extent there was autism, cerebral palsy, down syndromes and congenital abnormalities with 1-2 cases of each. Noting some of these problems are very much attributed to reproductive health where proper screening and follow up care can play a role in reducing such problems (both assessments are having similar diseases)

4.2.3 Availability of and Accessibility to Health Services within the Target Communities

Available health facilities and type of health providers within the targeted communities (table 6); around 18.6 % of participants reported NOT having health facility vs. 81.4% having health facilities within their communities. These facilities are as such; 53.9% Health centers, 23.1% PHC, 9% having both health center & PHC and 17.7% (57) having hospitals. Noting the client responses on the availability of health facilities found to be much more than for the community group 81% vs. 53% where this could be explained that clients group is living nearby the SDPs which are located within cities and the surrounding villages that contain many health facilities. Also numbers does not necessarily reflect such large number of health facilities, BUT it could be explained that participants living in the same area –cluster knows or have used the same health facility..

The health facilities were provided by; 56.0% government (MoH) alone, 5.7% government and private, 10.5% Government and NGO, 8.4 Government, Private & NGO and 1.2% Private. Very few responses (1-2) indicated the availability of pharmacy

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Table 6: Available health facilities and type of health providers

Available health facilities	No.	%	Type of health providers	No.	%
Hospital	58	17.7	Government	187	56.0
Health center	125	37.4	Private	4	1.2
PHC	21	6.4	Government + Private	19	5.7
Health Center & PHC	55	16.5	Government, Private & NGO	28	8.4
			Government and NGO	35	10.5
NO	73	21.9	Missing	61	18.3
Total	334	100	Total	334	100

Duration (timing) of services offered by available health facilities (Table 7);29.3% said "I do not know" and 70.7% reported on duration of health provision by these facilities as such; 27.5% all the week, 0.9% three days a week, 38.9% twice a week, 3.3% once a week.

Table 7: Duration of services offered by health facilities per week/month

Duration of services	Frequency	Percentage
Once a week	11	3.3
Twice a week	130	38.9
Three days a week	3	.9
All week	92	27.5
Do not know	98	29.3
Total	334	100.0

Transportation system to access health facilities outside participants residence/communities (table 8); around 31.4% of participants do said no vs. 68.6% said yes. Of those with yes answer; 31.1% for public transportation and 22.2% for own car. Under others category in the questionnaire; 7 participants reported walking on foot, 3 participants used friends cars. Only 4.8% of the participants agreed on the availability of ambulance when needed. The problem of transportation that it is not a system, where this should be emphasized in this report to make this need available for stakeholders to take actions on trying to be part of the solution to this problem

Table 8: Type of transportations available to access health facilities in emergency

Type of transportations	Frequency	Percentage
Ambulance	16	4.8
Public transportation	104	31.1
No transportations available	140	41.9
Total	264	100

4.2.4 PFPPA-SDPs accessibility and use by clients within their areas of residence

This section will identify the clients' knowledge of and accessibility to PFPPA-SDPs within their areas of residence and the utilization of its services.

Participant's attendance to and source of knowledge about PFPPA-SDP (Table 9); the PFPPA-SDPs attendees were from; **30**% Bethlehem, **27.8**% Hebron, **22.2**% Halhul and **20%**Ramallah. Their knowledge about SDPs was from different sources; 24.3% Family member, 20.4% neighbors, 13.2% PFPPA outreach services, 5.4% Neighbors and Family members and the least was7.2% from media. When asked about other sources, 1.3% heard from friends and from 0.2- 0.3% from beneficiary, PFPPA employee etc.... noting that PFPPA need to utilize media for its services since it received the least responses.

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Table 9: Participant's attendance to and source of knowledge about PFPPA-SDP

Name of SDP/AREA			Source of knowledge		
	No.	%		No.	%
Hebron	90	27.8	Neighbors	68	20.4
Halhul	73	22.2	Family member	81	24.3
Bethlehem	99	30	Media	24	7.2
Ramallah	72	20	PFPPA outreach services	44	13.2
			Neighbors and Family member	18	5.4
			Missing	99	29.6
Total	334	100	Total	598	100

The participants were asked "If you are coming for the first time did you easily find the clinic?" About 33.8% said no vs. 66.2% said yes while only 1% commented on the lack of a sign that guide to the clinic and 0.7% commented that the clinic is far from the parking lot

Why participants choose PFPPA-SDPs (table 10); the participants were asked to answer more than one choice if appropriate; 32.6% of the client's chose the PFPPA clinic for its quality of service, 31.2% for convenience and accessibility and 36.2% because their needs are met. Under the others category, 5.4% of the participants chose the PFPPA clinic for low prices and for Good reputation, 2.7% for excellent services and 2% for availability of a female doctor and availability of a Gynecologist

Table 10: why participants choose PFPPA-SDPs

Reasons for choosing SDPs	**Frequency**	**Percentage**
Quality of service	109	32.6
convenience and accessibility	104	31.2
Needs met	121	36.2
For Others category		
Excellent services	9	2.7
Lower price	18	5.4
Good reputation	18	5.4
Availability of a female doctor	7	2`
Availability of a Gynecologist	7	2

Current use of PFPPA-SDPs by participant clients (table 11); at the time of data collection, the participants were asked "Why did you choose to seek services from PFPPA – SDP?" and were asked to answer more than one choice if appropriate. The results found that; around 40% of participants seeking family planning services, 32% Gyn. Care, 26% maternity care, 2.4% for GBV services, 12% for Lab. Investigation, 1.5% for emergency contraception, 2.4% for follow up care. For others category, the responses were very minimal (1-3) for breast cancer screening, infertility treatment, and counseling. Such figures are encouraging

Table 11: Current use of SDPs by participants

Current participants SDPs use	**Frequency**	**Percentage**
Family planning services	133	39.8
Gyn. Care	107	32
Maternity care	87	26
GBV services	8	4.8
Lab. Investigation	40	12
Emergency contraception	1.5	1.5
Follow up care	8	2.4
Others		
Breast Cancer screening	6	1.9
Counseling	4	1.3
Infertility treatment	2	.7

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Number of visits made by the clients to SDP in past 12 months (Table 12); 79% responded to this question; of those around 23% visited once, 40.7% visited 2 times, 9% three times, and 6.6% more than 3 times.

Table 12: Number of visits clients made to the SDP clinic in the past 12 months

number of visits	Frequency	Percentage
Once	76	22.8
Twice	136	40.7
Three Times	30	9.0
More than three	22	6.6
Missing	70	21.0
Total	334	100.0

Reasons to visit SDP (Table 15); 61.5% responded to this question with a variety of responses regarding the reasons for their visits. Around 30% for gynecological problems, followed by 22.8% for antenatal care, 19.2% for family planning, 8% for postnatal care and 2.4% for counseling. There are minimal responses between 1-3 cases were seeking infertility and STIs services, children care and treatment, 2 participated in awareness sessions. PFPPA activities are numerous, but very much of the clients need to be involved through media or any other activity to benefit the people living in the area of SDPs.

Table 13: Reason to visit SDP

Reason for **visit**	**Frequency**	**Percentage**
Antenatal care	75	22.5
Post natal care	10	3
Gynecological problems	98	29.5
Family planning needs	64	19.2
Counseling	8	2.4
Missing	78	23.7
Total	334	100

The participants were asked "Are treatment and medical consumables provided for clients for free or for minimal cost at SDPs"; 24.2% said yes, 14.4% said sometimes, 8.9% who did not agree to that, and 23.2% of the clients said that not all of their needs are available. Those who answered yes and sometimes for free items are indicated in (Table 14); 12.5% for condoms, 9.6% for pills, 5.1% for IUCD, and 4.5% for emergency contraceptives. Such findings are important to highlight for PFPPA so they can work on more provision of these FP methods which ultimately will be reflected on women's RH

Table 14: Treatment and medical consumables for free from SDP's

Treatment and medical consumables	**Frequency**	**Percentage**
Condoms	43	12.5
Pills	32	9.6
IUCD	17	5.1
Emergency contraceptives	15	4.5
None of the items	167	50
Missing	51	18.3
Total	334	100

To understand the clients' needs from SDP please refer to table (15); 11.4% reported that some test are not available, 8.4% reported that some tests and medications are not available and to less extent, 2.5% some tests and family planning methods are not available. Some others reported the need for X-Ray, Pharmacy, Laboratory Ambulance, and clinic branch within their area of residence.

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Table 15: illustrates the frequencies and percentage of services that clients' needs are not met

Clients' needs from SDP	Frequency	Percentage
Some test are not available	68	11.4
Some test and medications are not available	50	8.4
Some test and family planning are not available	15	2.5
Provision of free medications	59	9.9
OTHERS		
Clinic	10	1.7
X-Ray	4	.6
Gynecologist	2	.3
Ambulance/Clinic branch	3	.5
Pharmacy/Laboratory	8	1.3

To complement the understanding of the PFPPA-SDPs services, the participants were asked "Do laboratory services in the PFPPA clinic meet your needs?" around 23% said that the laboratory services meet their needs, 16.1% said did not meet their needs, 19.6% of the clients said sometimes it meet their needs and 6% said that not all investigations are available in the SDPs laboratory. For those who are not satisfied were asked to indicate their needs; 4.0% reiterated on the need for different types of tests that is not available and 1% asked for thyroid and hormones tests while only 2 asked for pap smear and mammography

Furthermore, the participant were asked "what other services in your area are not available and needed from the PFPPA; 70.2% emphasized that ambulance has to be available for service by the PFPPA, 49.3% emphasized that X-Ray machine has to be available for service by the PFPPA, 43.8% emphasized advanced lab services has to be provided for service by the PFPPA and 37.6% emphasized that pharmacy should be available by the PFPPA

4.2.5 Married woman in Reproductive Age (15-49) attending PFPPA-SDPs

This section will identify women SRH matters and seeking health services attending PFPPA-SDPs. It will start by asking about pregnancy and its problems, FP methods, abortion, antenatal and postnatal care and utilization of PFPPA-SDPs

Starting with pregnancy; around 94% (314 out of 334) of client participants have been pregnant. Of those, around 60% were planned pregnancy as they said "yes" vs. 40% not planned.

Reasons why pregnancy was not planned (Table 15); of those not planned 40% responded as such; 32.3% reported "It was not my choice", around 4% reported that contraceptives are not available, 3.3% reported that pregnancy happened over the IUCD and 0.9% reported unavailable emergency contraceptives. For the others category, few different responses such as Pregnancy happened with the use of oral contraceptives, during lactation, and one case reported "Forced by husband's mother". These results indicted social issues affecting women's health including their choices in pregnancy, exposure to violence and incest and lack of awareness on utilization of oral contraceptives and IUCD check that needs to be discussed among *stakeholders* for a future planning on this matter.

Table 16: Reasons for unplanned pregnancies

Reasons for unplanned pregnancies	Frequency	Percentage
It was not my choice	108	32.3
No available contraceptives	13	3.9
Pregnancy happened over the IUCD	11	3.3
No available Emergency Contraceptives	3	.9

What family planning items are offered for free in the PFPPA clinic?

The participants reported on the **offered for free** FP items in **PFPPA-SDPs were;** only 5.1% for condoms, 9.6% for pills, around 13% for IUCD, 4.5% said that emergency contraception are offered for free and 50% said that none of the items are offered for free. Under the category for others; only 3.1% (36) participants reported on the following items to be offered for free; 4% for folic acid, 2.4% to have injections, 2.8% for iron and4.8% for treatment. All FP items and other consumables are minimal compared to the needs

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Table 17: FP Items and other items offered for free at PFPPA-SDPs

Family planning items-SDPs	No.	%	Other items offered at SDPs	No.	%
Condoms	17	5.1	Iron	7	2.8
Pills	32	9.6	for treatment	12	4.8
IUCD insertion	43	12.9	Folic acid	10	4.0
Emergency contraception	15	4.5	Vitamins	1	.4
None of the items are offered for free	167	50	To have injections	6	2.4
Missing	60	17.5	Missing	253	85.6
Total	334	100	Total	334	100

For abortion issue (table 18), women were asked "Did you ever have an abortion?" 12% (42 out of 334) responded to this question, of those, 8.1% reported that they had one abortion, 3.6% had 2 abortions, 0.3% had 3 abortions and 0.6% had 4 abortions. The providers for abortions were; 10.2% have had the abortion in Hospitals, 2.1% have had the abortion in Private Dr. Clinic and 0.3% has had the abortion with a Daya (the community group 11.7% vs. 8.1% for client group)

Table 18: Number of abortions and health providers for abortion

No. of abortions	No.	%	Health provider for abortion	No.	%
1	27	8.1	Private Dr.	7	2.1
2	12	3.6	Hospitals	34	10.2
3	1	.3	Daya	1	.3
4	2	.6			
Total	42	12.6	Total	42	12.6

For antenatal care, women were asked "Where do you usually go for your antenatal care?" (Table 19) indicates; around 43.4% goes to private Dr., 13.8% goes to Government PH clinic, 13.8% to PFPPA clinic, 10.5% to Private Dr. and Government PH clinic, 4.5% to PFPPA clinic and Government PH clinic and 6.6% to PFPPA clinic and Private doctor. Under the others category; 3% goes to UNRWA clinics and very minimal numbers 0.4% to high risk pregnancy clinic and 0.1% to Daya. Noting that the number of participants seeking RH care is more for the private Drs among both groups

Table 19: Provision of antenatal care by type of health facilities

Provision of antenatal care by type of health facilities	No.	%
PFPPA clinic	46	13.8
Private Dr.	145	43.4
Government PH clinic	46	13.8
PFPPA clinic and Private Dr.	22	6.6
PFPPA clinic and Government PH clinic	8	2.4
Private Dr. and Government PH clinic	35	10.5
Total	334	100

The number of antenatal visits during last pregnancy as indicated in (table 20); 5.7% reported their visits was 4 times, 9.6% three times, 39.5% two times, and 7.2% once, and 30.8% more than more than 4 times. Further, to identify the use of the MCH booklet by health providers; 77.5% of these visited antenatal care said yes when asked "Have you ever been given the MCH booklet from your antenatal care providers?" compared to community group, the frequency of antenatal clinics is much higher

Table 20: Number of antenatal visits during last pregnancy

Number of antenatal visits	No.	%
Once	24	7.2
Twice	32	9.6
Three times	132	39.5
Four times	19	5.7
More than four	103	30.8
Total	334	1000

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Health complications during pregnancy (table 21); 17.7% % of the pregnant women (59 out of 334) reported long list of health complications during pregnancy. The complications mentioned within this table are for the more frequently mentioned among the participants making 12.6% (38 out of 59); these were as such; 1.1% complained of low blood pressure, 1.5% complained of bleeding, 4.2% complained of anemia, 1.5% preeclampsia, .9% of Gestational diabetes and 0.8% complained of Varicose veins and 1.9% of albumin in urine. The other 5.1% of the complications were distributed for one case or two maximum and these included for example; low back pain, bowel irritability, general aches, cough, nausea, exhaustion etc… Complications in community group is double the clients group and Anemia counted the most frequent health complications among others (4.3 and 3.4%)

Table 21: Health complications during pregnancy

Health complications	No.	%
Bleeding	5	1.5
Preeclampsia	5	1.5
Low blood pressure	3	1.1
Anemia	14	4.2
Gestational diabetes	3	.9
Infections	6	1.8
Varicose veins	2	.6
Total	334	100

Furthermore, women with complications were asked "where you were referred in case you have health complications?" 14% (48 women out of 59) were referred; 10.5% to the hospital and 3.9% to obstetrician.

The participants were asked about follow up care by the SDP providers **(table 22);** 70.7% (236 out of 334) said yes and the reasons were for; 56.6% follow up treatment, 6.9% counseling and 4.2% for Medication. The follow up treatment is obvious with the large percentage 70.7 vs. 41% for community care for the clients; yet, counseling and medication beneficiaries are at low rate in both groups and this need to be worked on by PFPPA

Table 22 Follow up care by the SDP providers

Follow up care	No.	%
Counseling	23	6.9
Medication	14	4.2
Follow up treatment	189	56.6
Missing	23	6.9
Total	334	100

Furthermore on RH, participants were asked about postnatal care "During the six weeks after birth did you have any problems or complications?" 9.3% (31 out of 334) said yes, and 19 out of 33of visited the PFPPA clinic for treatment

4.2.6 Clients' Satisfaction questionnaire attending PFPPA Clinic

This part of the questionnaire aimed at assessing the clients' satisfaction when attending the SDPs within their area of residence to seek care. The clients were 334 females utilizing the 4 SDPs.

To do this, it started with questioning them about the time consumed to access the SDP; the majority of participants 90.4% have arrived to SDP in his locality in less than 30 minutes, 3.3% needed half to one hour and very few 0.9% needed more than one hour from arrival until the clients finished booking at the reception desk within time intervals (table 23). Around 98% (327 out of 334) of the clients felt at ease while giving their private information to the receptionist.

Table 23: Time needed for arrival to SDP (Minutes)

Time needed from arrival to SDP	No.	%
1-30	302	90.4
31-60	11	3.3
More than 60	3	0.9
Total:	316	94.6

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The waiting time to see the nurse or the Dr. (table, 24); participants experience in waiting to see the nurse or the Dr. is encouraging and indicates their satisfaction when 94% agreed their waiting time for nurses and 85% waiting time for the Drs. was less than 30 minutes. But there was a difference among participants in waiting time from 30-60 minutes was 3.5% for the Drs. vs. 2.4% for nurses.

Table 24: the time the clients waited to see their nurse and Dr. in SDP

Waiting Time for the nurse	No.	%	Waiting Time for the Dr	No.	%
Less than 30 minutes	314	94.0	**Less than 30 minutes**	285	85.3
30-60 minutes	8	2.4	**30-60 minutes**	45	13.5
1-2hours	1	.3	**1-2hours**	3	.9
Total	334	100	**Total**	334	100.0

Also the clients were asked "is the waiting room comfortable" 89.8% (300 out of 334) reported that the waiting room comfortable vs. 9.0% reported uncomfortable. The reasons given for those not comfortable (table 25) were minimal; around 4% reported that the place is tight, 1.2% reported that the place is dark and 0.6 uncomfortable room and seats etc…

Table 25: Why the waiting room not comfortable

Why the waiting room not comfortable	No.	%
Cold in the winter	1	.3
Dark	4	1.2
In need of accessories and décor	2	.6
Not what's expected	1	.3
Place is tight	13	3.9
Uncomfortable waiting room and seats	2	.6
Missing	311	93.1
Total	334	100.0

Furthermore, to understand the effectiveness of the IEC material, 70.7% of the participants said yes vs. 28.4% said no. The reasons for those said no; 28.4% said that the information provided in the IEC material is old, 4.2% said that they didn't find what they need in the IEC material, 42.1% of the participants didn't have time to read the IEC material and 5.2% couldn't read the IEC material.

4.2.7 Clients' satisfaction scale for health services provided by PFPPA-SDPs

This part of the questionnaire was designed in Lickert format scale ranging from excellent to poor on satisfaction elements (table 26). The results for the clients satisfaction was evident for rating on frequencies, percentages and means on the satisfaction elements of how clients evaluated the different health services provided by PFPPA and upon the values shown in the significant 2-tailed column(which has the value of .000 that is less than .05).

The scores of excellent and good are combined in this discussion because they represent a similar value. The satisfaction scale was highly significant to indicate that PFPPA-SDPs health providers are very well communicated with their clients, care for greeting them and respecting their dignity, listening to them, giving them more information regarding their health, explaining and sharing with their health concerns have scored highly. Yet, the least scores were for the physicians to greet their clients as indicated in item (1). The stakeholders should be familiar with these results in order to further empower and promote their employees through financial and educational incentives where many of these health providers complained about these two issues

Table 26: Frequencies and percentage for clients' satisfaction regarding health services

Service/Value	Excellent		Good		Fair		Poor		Sig.(2-tailed)	Mean
	No.	%	No.	%	No.	%	No.	%	.000	1.28
1. Did the doctor greet you	159	47.6	57	17.1	2	0.6	0	0.0	.000	1.13
2. How well you think the Dr. listened to you	292	87.4	40	12.0	2	0.6	0	0.0	.000	1.19
3. Did the Dr. give you information that was needed	281	84.1	42	12.6	9	2.7	1	0.3	.000	1.38

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4. Did you share the decisions of your care provider	224	67.1	92	27.5	17	5.1	0	0.0	.000	1.18
5. How satisfied you were from your Dr.	284	85.0	40	12.0	8	2.4	1	0.3	.000	1.39
6. Did the nurse introduce herself	234	70.1	62	18.6	29	8.7	2	0.6	.000	1.24
7. Did the nurse give you information that was needed	263	78.7	51	15.3	13	3.9	0	0.0	.000	1.56
8. Did she teach you about your RH needs	198	59.3	78	23.4	49	14.7	2	0.6	.000	1.19
9. Did she/he treat you with dignity	268	80.2	55	16.5	4	1.2	0	0.0	.000	1.11
10. You think you can talk freely with the nurse	280	83.8	29	8.7	3	0.9	0	0.0	.000	1.10
11. How satisfied you felt after your visit	286	85.6	21	6.3	5	1.5	0	0.0	.000	1.28

Discussion of the qualitative analysis

Introduction

This chapter presents the views of the PFPPA administrative staff, the health care providers and the social workers of the four regional SDP clinics of Bethlehem, Halhul, Hebron and Ramallah. The views of the stake holders, the focus groups of reproductive aged women and the teenagers of both sexes are also covered. The aim of these interviews is to highlight the needs, the difficulties encountered, the recommendations of the PFPPA administrative staff, SDP health providers, the stakeholders and the focus groups for the promotion of services provided in Area C. An in-depth interview was done with each health provider, social worker, PFPPA administrative staff and the stakeholders in private where they, expressed their views freely. In Gaza Strip only focus groups were conducted and their views are integrated in the study.

5.1 Interviews with SDPs' Health Providers

5.1.1 General impression concluded from the SDPs Health providers

There are 4 SDPS in the West Bank and one in Gaza with 19 employees as set in table (27); all health providers are females except for two males providing youth friendly services. This means that RH services are only provided by women. The clinics included a female physician except for Gaza, a nurse except for Ramallah, a social worker except for Bethlehem, secretary/administrative assistant except Ramallah and Gaza. Noting that not all health providers are on full time employment basis, for example; the social worker in Ramallah is working for four days, the nurse in Bethlehem is working for 3 days only. Gaza clinic offers health and social services including youth friendly services. Concluding on the health providers needed for the 5 SDPs as suggested by the health providers are set in table (27) to clarify the picture of what is available and what is needed regarding this matter

Table 27: PFPPA- SDPs and Health providers

	Doctors		**Nurses**		**Lab. tech**		**Social worker**		**Youth friendly**		**Secretary**	
SDPs	Available	Needed	Available	Needed	Available	Needed	Available	Needed	Available	Needed	Available	Needed
Hebron	1	1 M	1	1 M	1		1		1		1	
Halhul	1		1				1				1	
Bethlehem	1	1 M	1	1	1			1			1	
Ramallah	1					1	1					1
Gaza			1				1		1			

5.1.2 Health providers detailed responses toward each SDP

The Health providers responses on location, providers, documentations & IEC materials, C. Treatment and medical consumables, Access of SDPs to Area C population, Advocacy strategies, Difficulties and challenges, Improvement and strengthening of the provision of services and Needs of the clinic

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Bethlehem clinic

This clinic is located on the main road going to Bet Jala town. It is easily accessed by all clients BUT its name board which is put on the side of the building has to be changed to the front so that the clinic will be easily located.

A. Health providers

This clinic is run by two part time female doctors. According to the Dr. interviewed she doesn't see a need to a male Dr. or nurse because clients who are mainly females prefer a female health care provider for cultural and religious reasons. But she elaborated on the need of a male Dr. If in future the PFPPA plans to provide specialty services like in infertility, urology or reproductive issues concerning the men also.

There is one female nurse in the clinic that comes for three days per week. She gives health education sessions to the public in the field that's why she is not found at all times in the clinic. The Dr. said that "there is a need for another female nurse to run the clinic". The Dr. insisted on the need of a permanent counselor or a social worker to deal with the cases that they meet every day in the clinic because these women don't know where to go for help especially women who were sexually abused, raped or cases of incest.The lab technicians are enough in number they do routine lab exams and cultures. The service providers are trained in different fields concerning family planning or reproductive health issues.

B. Documentation & IEC materials

The files are kept in the clinic for seven years then they are shredded because there is no electronic filing system to keep the data. All the health care team asked for implementation of centralized electronic system because data will be available at all times it will be less time consuming and there will be no need to keep all the files which are taking space its extra work load on the health team and less stationary expenses. There are special standardized forms used by all clinics for referrals to other health care facilities like mammography or detailed ultra sound.

C. Treatment and medical consumables

All family planning gynecological and STIs are medically assessed and treatment is given accordingly. The lab can do routine exams. There are no drugs available except for folic acid and iron which is provided to the clients for free.

D. Access of SDPs to Area C population

Because of the current political situation in the West Bank all the health care team and administrative staff interviewed insisted on the need of ambulances to bring back to the regional hospitals or the clinics clients who need advanced care and a foundation of mobile team or mobile clinics which can serve the local population living in Area C not only for RH and FP issues, also for general population.

E. Advocacy strategies

When the health care team and the social worker were asked about advocacy strategies their answers were condensed as follows.

- A unit should be developed at PFPPA Jerusalem office which will join hands with the local media to address family planning and reproductive health issues all the year round to all segments of the society.
- Develop health education programs tailored to the Palestinian families and broadcasted via the
- TV and local radio channels
- Work with the youth to discover their views and needs because they are the future change advocates of our society.
- Start a new strategy in all family planning clinics where single women, menopausal and old aged women are encouraged to visit and take services.
- Due to difficult economic status create free medical campaigns in Area C to help the local people.
- Women who suffer from all types of violence should find a counselor or a social worker at all times in the clinic.
- Create a transportation system for women who live in Area C and cannot reach family planning clinic because they are either besieged by the wall or the military.

F. Difficulties and challenges

The major problem which is encountered by the providers is the transportation because they use public transportation which is tiring and time consuming. Their point of view is to have private car provided by PFPPA for them so that they can reach the targeted population easily and safely.

G. Improvement and strengthen the provision of services

- Training programs including sexual health courses to be given by an expert for all the staff.
- Provision of other medical services which can generate income like urology and infertility clinic.
- Centralized computer system to be connected to PFPPA Jerusalem office.
- Change in the facilities and system so that males will get reproductive services also.
- A dietitian to provide services on certain days to help women with medical or weight problems.
- Creation of an infertility clinic which cover south of the West Bank.

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Ramallah clinic

This clinic is located in Ramallah center. It is easily reached and newly renovated which opens four days per week.

A. Health providers

This clinic is run by two females the Dr. and the social worker who also acts as front desk clerk she does the admissions and the filing and meets all non-medical needs of the clients.The clinic has no nurses and according to the Dr. the social worker is taking the role of the nurse because their client's number is small compared to other clinics.This clinic has no private laboratory facilities but they have access to a local lab with special prices for their clients.

Concerning continuing educational programs the Dr. said that it is very limited and she thinks there should be exchange expertise programs at the regional level to develop the knowledge and skills she refers to the references sent to her from the HQ received from the IPPF and other national resources.

B. Documentation and IEC materials

There is no electronic filing system in this clinic and this causes an over load on the social worker because she has to do the paper work and the role of the nurse. The files are kept for seven years then they are shredded. Because the clinic is small keeping these files, they are an extra burden. There is a standardized protocol like the rest of the clinics where there are special forms for referrals for mammography or ultra sound.

There is stand for the IEC materials located in the waiting room where all clients can pick what they want. They are refilled every three months by the team in Jerusalem office. The social worker uses the IEC materials when she goes to the field and distributes them to the local population.

C. Treatment and medical consumables

The doctor said that she treats all conditions related to RHAND gynecology, but infertility cases are very limited. This clinic has no pharmacy facility all medications are purchased by the clients except folic acid and iron is given for free.

D. Accessibility and outreach activities

This clinic has no access to ambulances of its own or any private transportation facilities. The social worker uses public transportation which is time consuming and as she said" we cannot bring any client who needs advanced care from Area C because we don't have our own car"

E. Community strategies

- According to the Dr. and the social worker advocacy can be achieved through women's centers, nurseries and kinder gardens because, women can be easily targeted in these institutions.
- Development of links with women at the grass root level where if they are positively motivated they will become change advocates and promote our strategies.
- There should be continuous communication and links between the stake holders and the health providers because this helps in smoothing future collaboration.
- The mass media like the TV local radio and newspapers must discuss reproductive health issues which concerns the local population. This should be created by PFPPA in Jerusalem office.
- Ask teen age males and men about their health needs and develop strategies which address these needs. This also needs the involvement of Jerusalem office.

D. Needs to improve services

The clinic is newly renovated its area is small but their client's number is limited too.The waiting room acts as a space for filing, history taking and discussions with the clients with social problems that's why the social worker says there is no privacy and there is a need for a special room for such interviews or discussions.

Hebron clinic

This clinic is located in the center of Hebron city. It is easily located although its physical structure is relatively large but when compared with its client's number it is considered small. The registration clerk has no private room.

A. Health providers

This clinic is run by one female doctor who is on full time basis. There is one female nurse also who has other responsibilities too. The social worker is employed as a part time that's why she has no enough time to see all clients because of their number. There is one lab technician and the other one works on part time basis.During the interview the doctor mentioned that they have limited training programs but the nurses and the other staff attend workshops or seminars more often.

B. Documentation and IEC materials

There is no centralized electronic filing system files are kept for seven years then they are shredded. There are standardized protocols for all referrals for other health facilities. The IEC materials are provided by PFPPA Jerusalem office they are exhibited in the waiting room and available to all clients.

C. Treatment and medical consumables

The Dr. interviewed mentioned that they don't have any medications except folic acid and iron which is distributed

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for free to their clients. They don't have any vaccination all family planning methods are available and are given to their clients at a limited cost. The Dr. mentioned that all types of reproductive health problems and gynecological issues are treated besides family planning methods which are provided to all clients.

D. Accessibility and SDPs outreach activities

The nurse mentioned that there is no private car which can take them to the field this causes a lot of difficulties because, she has to use public transport carry all health education materials this status causes time consumption especially when they go to Area C which is not a safe area in Hebron district because of the settlers and the military concentration areas that's why there is an urgent need for private transportation provided by PFPPA.

E. Advocacy strategies

- Use of the local media for awareness programs concerning gender based violence, rape and incest where to go for help and counseling.
- What are women's rights and its importance?
- Focus on the elderly woman and her health needs.
- Be involved in teaching the science teachers of how to approach reproductive health issues in class.
- Pre marriage counseling for the couple concerning reproductive health issues which will be broadcasted via the local media.
- Use of the Facebook by adding spots concerning reproductive health issues.

F. Needs and recommendations

- Creation of new lab protocols where before prescribing combined contraceptive pills check the cholesterol and the triglycerides of all clients.
- TORCH exam and Australian antigen tests
- Three dimensional U/S services
- Establishment of mobile clinic to reach all scattered population living in Area C.
- Foundation of morning and evening shifts in the clinic. This helps the working women to excess services.
- Introduce new methods of family planning like Norplant, patches, suppositories and sprays.
- Development of centralized compute system.
- Open a pediatric clinic which provides general and specialized services to generate an income.

Halhul clinic

This clinic is founded in Halhul town it is part of a newly established building but it is not on a main street and public transportation doesn't reach it. The clinic is spacey and newly furnished.

A. Health providers

The clinic is run by one female physician and a midwife. There are no male health providers in this clinic. The midwife does all the nursing care and teaching in his clinic. She is also responsible for all outreach programs. The social worker works on part time basis although the doctor and the midwife insisted on the need of a full time social worker because their clients are increasing in number. The clinic has no lab of its own they sent their specimens to Halhul women's union and the pap smears are sent to MoH clinic.

B. Documentation and IEC materials

There is no electronic filing system for this clinic documentation is done manually. They have standardized protocols for referring clients to other health facilities. Files are kept for seven years and then shredded this status causes double work as the midwife said women come to the clinic at different intervals of their reproductive years this will cause loss of informative data but if it was electronically saved it will become qualitative information which can be used for research.

The IEC materials are provided for them from the PFPPA Jerusalem office they are exhibited in the waiting room where all clients can reach them. The midwife takes the IEC materials to the field to be distributed for the local population there.

C. Treatment and consumables

This clinic has no pharmacy but folic acid and iron pills are given for free to their clients. All available family planning methods are dealt with in this clinic. Infertility cases of male and female are seen also. There are no services for any kind of vaccination, antenatal clients are sent to MOH clinic in the town.

D. Accessibility of SDPs

There are no ambulances or mobile clinics to reach Area C the midwife uses public transportation to reach these areas which is time consuming and is not a safe area.

E. Advocacy strategies

- Involve men in advocacy and planning in all our activities because they are the decision makers in our society.
- Work with the political or religious personalities who are at the decision makers in our society.
- Use the local TV station to promote reproductive health issues.
- Coordinate with other health care facilities like Augusta Victoria Hospital which provide breast health services.

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- Provide awareness for gender based violence in our society.
- Coordinate with the local MoH clinic which also provide family planning services to send their clients for certain services because they don't provide the quality needed as the family planning association.
- Coordinate with the local MoH clinic to give health education services to their population because they don't have this service.

F. Needs and recommendations

- Expand the working days of the doctor on Saturdays because a lot of working women are free on this day they can come to get services
- Free medical campaigns including pediatric services for Area C population this act will introduce the family planning association and its services.
- Expand services in SDP to include services such as: men integrated services, Pediatric, urologist, nutrition
- Introduce new family planning methods like Norplant, female condoms and patches to expand and diversify choices available.

5.2 Interviews with PFPPA administrative staff

5.2.1 PFPPA administrative staff plans to promote reproductive rights for adolescents, men and women in their reproductive age

When PFPPA administrators were asked about the health providers; the PFPPA president described the health providers of the clinics as the "mirror for our work" and "they should be distinguished in their work and provision of care to their clients". While the PFPPA director said "We need health providers who are very well skilled and have good knowledge in reproductive health and are committed and flexible in their work".

The president also said "nurses at all times develop their competencies because they play a major role in our work they are the ones who reach the communities". The director reiterated on this "There is a need to increase the number of female nurses because they work in the clinic and the field,causing a lack in the provision of services and a burden on the staff. If funds were available staff would be segregated between those specialized for outreach from those working in the SDP, to ensure higher quality of services being provided with less burden of the staff".

The social workers are the referring bodies where clients are referred to regarding social and psychological problems. The PFPPA president further said "we need to have them on full time basis in all our clinics but for now it is difficult due to financial restrictions". Also this notion was emphasized by the director when said "The social workers and the counselors must be on full time basis to cover the needs of all women"

When asked about electronic documentation system which all clinic providers mentioned it needs to be studied. While the director said "Although it is extremely significant to have an electronic system for documentation between all our SPs and the HQ, currently with the infrastructure and difficulties faced electronically in Palestine this would be very difficult and costly to obtain and be utilized in an efficient and effective manner. Such a system, although would facilitate our work, will require training and staff to be conducted correctly. She also clarified that the PFPPA is electronically linked with the IPPF Regional Office and Central Office through an e-IMS system where all programmatic, financial and service statistic reports are updated periodically.

When asked about what are his views concerning accessibility of the SDPs and outreach activities? The director further commented as such "Our clinics are founded in the towns or cities and our health teams provide services in the clinics and go to the field to the country side and areas which part of Area C. These areas are known that they are deprived areas from all services including health because of political reasons. Yes these areas need our services BUT we need health team mobile clinics, medical equipment, labs and social workers."

Advocacy strategies

- Increase the number of key personnel in the local communities who back up our strategies and Awareness of the local population
- Networking with all female sectors of the population to strengthen the service provision for Palestinian women particularly in the remote underserved areas
- Advocate for the change of laws concerning women
- Increase our services by updating and upgrading them

Difficulties and challenges

- Work upon GBV and honor killing.
- Work upon strategies to empower women especially in remote and underserved areas.
- Establishment of small businesses to generate an income for the family.
- No public transportation to the areas where we provide our service when working in remote areas.

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- Safety of the staff because of settlers and military check points

Recommendations

The population in Area C is small in number and scattered reaching them is time consuming but there should be continuation to provide the area with essential services.

- Find new ideas to broaden our services.
- Work with the family because they are the core of any society.
- Find new strategies for continuation and renewal of our work in the clinics and the society.
- Develop our employees to be distinguished in their knowledge and performance.
- An infrastructure for their service must be planned which will be able to provide all their needs. Therefore a health team with different specialties and medical equipment must be prepared to reach our goal which is service to all categories of the target population.
- Capacity development of the provider by training him/her and providing updated information.
- Private transportation of the staff going to Area C to be provided by PFPPA.
- Increase working hours of SDPs to include 2 shifts, in order to provide a greater number of services for the local community and being able to expand the package of services provided

5.3Stakeholdersperception of status of the health services within their communities

There was a consensus by all representatives that the services are limited and doesn't meet the needs of the local population especially when it comes to reproductive health and family planning services. Asking about cooperation with other health providers in their areas the majority answered that MoH provides some services mainly child vaccination or antenatal care. There are few NGOs which provide general health services also. But all interviewed emphasized on the quality of services is not to the standards to meet the needs of the population residing in Area C.

Needs encountered by the stakeholders

- Professionals who can promote awareness campaigns concerning social, legal, psychological and reproductive health needs.
- Establishment of Women's centers which can provide social, recreational and health needs tailored according to the women's needs in that area.
- Provision of affordable reproductive health and family planning services by the PFPPA especially to the neglected clusters who live far away from all health services.
- Provision of PFPPA services based on the needs of adolescents living in these areas.
- No pharmacies or laboratory services in some areas of Area C.
- Health campaigns for the marginalized areas especially for chronic diseases.
- Networking between existing health providers and institutions which provide reproductive health and family planning services.
- Establishment of health centers in the remote areas to provide health, social and recreational services to the local population.
- Lack of human resources who can provide reproductive health information to all sectors of the population.
- Lack of ambulance services especially in emergencies and closures.
- Counseling and preconception care for the newly married couples.
- Mobile clinics which can cover all health needs of the population.
- Collaboration between the NGOs which provide health services and the local municipalities.
- Urgent need for regional clinics open around the clock which can provide health services in general and maternal services in particular.
- Urgent need for mother and child health services.
- Need for OB/GYN doctors to cover the needs of women.

Recommendations by the representatives

- Coordinate with the MoH and the private sector to provide care for the local population
- Foundation of a mobile team or mobile clinic which can provide all health services besides the reproductive and the family planning.
- Coordination of PFPPA with all municipalities so that their services reach all sectors of the population
- Health campaigns to promote reproductive health and family planning
- Focus on school children and their reproductive health needs
- Opening of centers by the PFPPA which provide reproductive health, family planning, health education and counseling to all sectors of the society
- The PFPPA must focus on the youth because they are the largest sector of the population
- Empowerment of women by providing them with small businesses to generate an income

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- Summer camps for the children especially the poor and the marginalized
- Special care of the children who are deprived from medical care and socialization
- Add pediatric services besides reproductive and family planning services provided by the PFPPA.
- Plan for small investments which can generate an income for the deprived families.
- Assess mental health needs especially for children

5.4 Focus group for male and female adolescents

Separate groups for the males & females adolescents were formulated in Area C.When they were asked how do they spend their free time? They mainly answered; doing voluntary work in their community, watching TV, Internet and Facebook, practicing sports or reading. This picture shows that adolescents are limited in their activities. When they were asked from where and when they got the information concerning sexual and reproductive health issues? Some of the females because of "culture of shame" did not answer. While others said the school, reading about the subject, the internet and magazines no one mentioned the family planning clinics.

During the discussions theywere asked "what reproductive health means to you", Most of the males and female participants said "I don't know" others kept silent and did not answer because of "culture of shame". When asked about problems or questions concerning reproductive health issues whom do they ask? Mainly the males answered their peers while the females said female family members mainly the mother who gave them limited information. Others kept silent because of the "culture of silence and shame" This shows the need for counselors or health providers who can answer their questions. Adolescent health needs to be part of PFPPA strategies in future.

When they were asked what information they have about STIs and HIV/AIDS? The majority said that we have limited information. Others mentioned that is contacted by contaminated blood or sex outside marriage. They were asked about domestic or gender based violence if they know about it? Their answer was yes especially physical and sexual violence in our communities where the female adolescents said because of fear from the family and the culture of silence and shame women keep silent.

When asked about the participation and the problems concerning SRH issues; the adolescents mentioned that they do not participate in any SRH activities within their communities because they are not allowed to discuss SRH issues. They collectively described their non-participation is due to the local traditions, ignorance, fear, social upbringing, early marriage and lack of information. Female adolescents said it is an embarrassing issue "one said it is due to culture of shame" while others said we are afraid to ask and we don't know who should we ask. Also the local traditions and the views of the family hinder the adolescents from asking for help. These problems need to be addressed to promote change within these communities.

When asked what the PFPPA needs to do to access reproductive health services of adolescents they mentioned

- Counseling of adolescents for SRH issues in their schools
- Marketing the PFPPA services in the local communities
- Open a unit for adolescents in SDP clinics
- Recreational services for the adolescents within their communities
- Health education campaigns addressing the needs of the adolescents
- Use of the local media and the face book to teach the local population about the needs of adolescent

5.5 Focus group discussions with reproductive aged women; perceptions and needs

Women's focus groups were held in Area C and Gaza Strip highlighted the views, needs and recommendations concerning reproductive health issues and family planning.

When they were asked about their major concerns concerning sexual and reproductive health issues the majority of women's concern evolved around their needs concerning ante natal care, post natal care, complications of pregnancy, abortion, gynecological issues like STIs and infertility. The women focused upon the need of health centers in their residential areas because, they are unable to access any health services located outside their boundaries due to imposed military closures and check points. The discussions with them revealed the lack of right information concerning maternal and reproductive health matters. This status indicates the need for health education and awareness campaigns. When referring to the MOH clinics in their areas some women indicated that they are open once a week whilst others indicated that these are open for part of the day. This status highlights upon the need for health centers which provide services around the clock. When they were asked what are the challenges that hinder their attendance for SRH services? The women indicated that they are unable to reach SRH services because of the "culture of shame" especially if she is divorced or a widow.

They also mentioned that they are not allowed to go to the health centers or clinics by their family because of fear from military stops or closures. Local traditions and the authority of the mother in laws don't allow women to access health facilities. Poverty or limited income inhibits women to reach health facilities." Money is spent on basic needs in the

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household" rather than my health needs as woman expressed herself. This indicates the need for services near their residential areas which are accessible and affordable to all. When the women were asked about their knowledge concerning STIs

The majority answered "I don't know" some said there will be vaginal discharge or itching bad smell and fever. Some women said "these infections are due to sexual relationships out of marriage "This indicates the need for education concerning STIs for the population at large and these communities in particular. When they were asked about HIV/AIDs the majority said "I don't know "It or they expressed their fear without knowing anything about the disease. Others said "It is the disease of the homosexuals and prostitutes" we don't have to know about it. During the discussions it was obvious that women have lack of knowledge and a discriminative approach towards this disease. When the women were asked about the reasons of miscarriages and what treatment they got some mentioned they aborted themselves because of unwanted pregnancy or they were married when they were between 13-15 years and aborted spontaneously. When they were asked about complications of abortions and their needs in their communities women emphasized on the need of ambulance services and OB/GYN doctors in their areas because of economic difficulties women cannot afford to go for these services in the cities they mentioned that six women died due to abortions and bleeding last year because of lack of services. When they were asked about the emergency pill for abortion, limited women knew about it and that it is available in the PFPPA clinics. When asked did you hear about violence in your community Most of the women said yes especially oral abuse or insults from their husbands, dictatorship of their mother in laws caused psychological abuse. Refusal of having sex caused the husband to be violent with his wife. Other reasons which were mentioned by women is related to poverty, relative or matched marriage without any thing in common between the couple, illiteracy, Ignorance and the "culture of silence"

When they were asked about gender based violence women mentioned a common example of being deprived from the right of inheritance from her family, forbid her from continuing her studies, or abide according to family traditions for matched marriage.

When asked how can tackle these issues they said there should be civil laws that protect the rights of women. Counseling centers in our communities which will help abused women and her family.

Conclusions and Recommendations

The socio-demographic profile of the surveyed population and the living conditions are very significant which indicate the availability and persistence of early and interfamily marriage, coupled with large and low income families in overcrowded houses. The living conditions of the surveyed population indicates the harsh circumstances they go through and how really they are underserved in basic living circumstances, health care facilities, services and professionals to meet their needs, because of restriction in movement, being in a remote area and under served for living in area C.

The study results were concluded from the quantitative data and qualitative analysis. The quantitative data results showed the need for comprehensive health care services because of poverty, lack of medical insurances, and difficulty in accessibility to these services, meanwhile 70.2% of the participants asked for ambulance services where it deemed necessary particularly in emergency cases. Also, the participants pinpointed that 0.3% is the service of the mobile clinic which mainly comes to the remote areas for child vaccination only. This indicates the need of well-equipped mobile clinics to provide a wide range of health services that are in need in the remote underserved areas.

The qualitative data results showed the urgent need for MCH services to meet the needs of the target population. Comprehensive services around the clock especially for maternity care and in case of emergencies should be ensured. The qualitative data also indicated that pediatric and child health services are greatly required. Adolescents need health education/promotion programs to help them develop their knowledge and attitude towards SRH matters. Also they asked for units within the SDP clinics which meet their needs and have free access for them.

All interviewees reiterated on the reasons why these services are needed; difficulties in accessing health care facilities outside their areas of residence because of military presence check points, and the separation wall. They further commented on PFPPA-SDPs being located in the cities, long distances require lot of expenses for public transportation and lack of ambulances with all these circumstances makes it very difficult to reach.

Recommended intervention strategies derived from the qualitative analysis

- Promote the living conditions of adolescents residing in Area C by opening recreational centers which meet their social and psychological needs.
- Empower adolescents specially the females to be involved in voluntary work within their communities and help them to be exposed to their social and health needs.
- Design plans by PFPPA for adolescent health education strategies where adolescents are directly involved in its preparation.

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- Collaborate with health, psycho-social, legal and security sectors to form a fully integrated cycle for the intervention and prevention of gender based violence and "honor killing" against women.

References

[1] Anderson (1995). Revisiting the behavioral model and access to medical care: does it matter? Journal of Health and social behavior 95;36: 1-10
[2] Ohman et. Al (2013) Inequalities facing women living in Area C of the Occupied Palestinian Territories; U.N OCHA area C of the West Bank Key Humanitarian concerns
[3] Humanitarian Factsheet on Area C of the West Bank (2011, OCHA) United Nations Office for the Coordination of Humanitarian Affairs; Occupied Palestinian territory.
[4] B Tselem-publications –Land Grab: Israel's Settlement policy in the West Bank May 2002 retrieved Oct. 2008.
[5] B'Tselem-publications – The Israeli information Center for Human Rights in the Occupied Territories 2013 retrieved May 2014.
[6] Geneva Convention Protection of Civilian Persons In the time of War to the Occupied Palestine Aug.1949.
[7] Israel and the Occupied TerritoriesState.gov 2002 retrieved Oct. 2010.
[8] Halper J. (July 2012) Is Israel Preparing To Annex Most of the West Bank, The Electronic Intifada Nazareh.
[9] Taylor R. Post Card from Palestine 10- leaving Bethlehem Jan 2013
[10] B'Tselem (Jan 2013) Background on the South Hebron Hills
[11] Palestinian Central Bureau of Statistics (2011). Palestinian Family Survey 2010, Main Report. Ramallah - Palestine.
[12] Ministry of Health; Palestinian National Health Strategy (2011 – 2013). Palestinian National Authority. Ramallah–Palestine.
[13] Ministry of Health Annual Report Palestine 2010.
[14] Population of Palestine at Mid. 2013 is 4.42 Million, Says Statistics Bureau
[15] PCBS- press release to mark the Labor Day - Published Tuesday 01/05/2012
[16] Atlas of Poverty in the State of Palestine July 2013
[17] Global Causes of Maternal Death WHO Systemic analysis The Lancet Global Health Vol.2 Issue 6 page 323-333 June 2014.
[18] Horton R. Palestinians the crisis in medical care New York Review of books march2007
[19] Glassier et.al Sexual and Reproductive Health a matter of Life and Death WHO 2006
[20] Palestinian Central Bureau of Statistics, (2011). Data base of Palestinian Expenditure and consumption survey, 2010 (unpublished data)- Ramallah- Palestine
[21] Dhaler E. (2008) Reproductive Health human rights women's Knowledge attitude& practices towards reproductive health in Palestine
[22] Palestinian Central Bureau of Statistics (2011). Palestinian Family Survey 2010, MainReport. Ramallah - Palestine.

List of abbreviations

FP	Family Planning
GBV	Gender Based Violence
HIV/AIDS	Human immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HH	Household
IEC	Information, Education Communication materials
KAP	Knowledge, Attitudes and Practices
MCH	Maternal and Child Health
MOH	Ministry of Health
NGOs	Non-Governmental Organization
OCHA	United Nations Office of the Coordinator of Humanitarian Affairs
OPT	Occupied Palestinian Territory
PA	Palestinian Authority
PCBS	Palestinian Central Bureau of Statistics
PFPPA	Palestinian Family Planning and Protection Association
PNHS	Palestinian National Health Strategy
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
SDPs	Service Delivery Points
ToR	Terms of Reference
WB	West Bank
WHO	World Health Organization

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