Palestinian Medical Relief Society(PMRS)

Mapping Adolescent and Youth Sexual and Reproductive Health Services in Palestine

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Contents

List of abbreviations

AWCSW: The Association of Women Committees for Social Work

CBOs: Community Based Organizations

CFTA: Culture and Free Thought Association

HIV: Human immunodeficiency virus

HWC: Health Work Committees

Juzoor: Juzoor for Health and Social Development

MIFTAH: The Palestinian Initiative for the Promotion of Global Dialogue and Democracy

MoH: Ministry of Health

NECC: Near East Council of Churches

PCC: Palestinian Counseling Center

PFPPA: Palestinian Family Planning & Protection Association

PMRS: Palestinian Medical Relief Society

PRCS: Palestinian Red Crescent Society

PRSG: Red Crescent Society for Gaza

PWWSD: The Palestinian Working Woman Society for Development

RGRCA: Rural Girl Renaissance Charity Association

RWDS: Rural Women's Development Society

SAWA: SAWA

SRH: Sexual and Reproductive Health Services

STIs: Sexually Transmitted Infections

UHCC: Union of Health Care Committees

UNFPA: United Nations Population Fund

UNRWA: United Nations Relief and Work Agency

UPWS: Union of Palestinian Women Society

WB: West Bank

WHO: World Health Organization

WSC: Women's Study Center

WVI: World Vision International

1. Background

Adolescent sexual and reproductive health refers to the physical and emotional wellbeing of adolescents and includes their ability to remain free from unwanted pregnancy, unsafe abortion, Sexually Transmitted Infection (STI) (including HIV/AIDS), and all forms of sexual violence and coercion (WHO, 2006). Adolescence is a period of transition from childhood to adulthood during which adolescents develop biologically and psychologically and move towards independence. The World Health Organization (WHO) defines an adolescent as an individual in the 10-19-year age group and usually uses the term, young person to denote those between 10 and 24 years. In this study, we use the term adolescent and youth reproductive health services to refer to early adolescence (10-14), late adolescence (15-19) and post-adolescence (20-24). Young people under the age of 29 comprise more than50% of the Palestinian population. Hence, their needs should be addressed to ensure safe transition to adulthood for healthy productive citizens.

2. Aim and Scope of the Study

This study has been conducted to complement a study that have been conducted by the Palestinian Medical Relief Society (PMRS) on "The Social Norms Related to Sexual and Reproductive Health and Rights (SRH/SRHR) of Young Girls in 2018". The aim is to map sexual and reproductive health (SRH) service providers, type of services provided, human resource capacity, facilities and program/services operating and management, as well as the challenges for provision of SRH services for the adolescents in the West Bank (WB) and Gaza Strip. This study can help in understanding the problems and designing appropriate interventions for young people of different ages.

3. Methodology

All sexual and reproductive health service providers were identified based on the researcher's academic experiences, available reports, documents and contacts with health service agencies. Additional providers of SRH services were identified using snowball sampling methodology. Interviewed agencies were asked to suggest additional providers of these services to interview.

A total of 18 have been identified in the youth SRH field, in both the WB and Gaza. In addition, the United Nations Relief Works Agency for Palestine refugees (UNRWA) is a key provider in

the region, however they were not able to participate in this study because it was not approved by the health department due to the instruction from the D/ CG for the Moratorium pertaining to research requests by third party individuals and institutions involving refugee data, therefore we have no data from UNRWA included in this assessment. Furthermore, institutions that provide only advocacy or deals with youth health right were excluded from the study. It is worth noting that five of the agencies are functional in both WB and Gaza (MoH, UHCC, HWC, PMRS, PRCS), but due to the differences in the services, capacities and conditions, the data collected from both offices were analyzed.

Data was collected by trained field workers in the WB and Gaza using a checklist (Annex 1). Permissions and approval from organization administrations were obtained prior to data collection. The survey was completed in a face to face, semi-structured interview with the reproductive health services program managers of the identified institutions.

Quantitative data was analyzed using frequencies and percentages and the comments (qualitative data) on each item of the checklist were aggregated and analyzed to give more insight and understanding.

4. Findings

4.1. Sexual and Reproductive Health Services providers

The results are summarized in Annex 1 and Annex 2. A total of 17 facilities were mapped, 53% (n=9) of which are located in WB and 47 %(n=8) in Gaza. The majority of institutions have services not solely for adolescents. The Ministry of Health (MoH) had one youth friendly service center in Doura–Hebron, however this center is currently not functioning.

In the 2019MoHplan, the MoH are planning to activate the center in Doura

And to establish a further center in the Northern region of the WB. The UNRWA family health and women's department in partnership with Juzoor, implemented and supervised RH programs in several community-based organizations(CBOs), like the Rural Girl Renaissance Charity Association(RGRCA) in Doura.

Al-Quds and Al-Azhar Universities in collaboration with PMRS established in 2018 a "Youth Friendly Health Center" funded by Italy and technically supported by UNFPA to provide comprehensive health services including SRH, counseling, disease or acute illness treatment.

4.2. Sexual and Reproductive Health Services

4.2.1. Health prevention and protection services

Awareness campaigns' activities and distribution of SRH educational materials are provided by all institutions through specific departments, clinics, centers or programs. The provided SRH services depend on the target group, to include information on the biological, psychological and behavioral changes during adolescence, protection from sexual harassment and abuse, the negative impact of early marriage, STIs, HIV, sexuality, breast feeding, counseling and family planning.

The results show a lack of adequate **SRH educational materials for adolescents**. Only 59% indicated the availability of posters on site, which are specifically designed for adolescents, 77.8% in WB compared to 37.5% in Gaza. Generally, these materials are not specifically designed for young people but for all age groups including mothers, raising awareness on pregnant care, breast-feeding and violence against women in general.

Family planning for married people is provided by 76% (n=13) of the interviewed organizations according to the MoH family planning protocol. The remaining organizations refer cases to the MoH or UNRWA.

Another important aspect of SRH services, is the availability of contraceptives and condoms to both young men and young women. The results indicated that 70% of service providers are providing different types of family planning methods such as pills, spiral, and condoms based on availability (mainly from UNFPA) and free of charge or for minimal fees of certain methods. However, many organizations mentioned that these services are mostly provided for married women and men. The blockade on Gaza and internal political division has been a barrier for the availability of materials and supplies within the Gaza Strip.

Eight agencies (47%), the majority in Gaza, reported doing STI testing, however two of them stated that the provision of testing, was limited. STI testing and treatment is free of charge at public health services. Those organizations are not providing the services directly; they refer their clients to MoH laboratories and clinics based on the MoH protocol and according to the national health referral system.

According to the MoH, voluntary testing and counseling services have been introduced primary health care centers in various districts. In addition, there are well-trained health providers that are responsible for all aspects of treatment and counseling of patients with HIV at MoH facilities.

Psychosocial counseling is provided by 94% (n=16) of the interviewed organizations. It is conducted by social workers, psychologists or nurses. When necessary patients are referred for specialist treatment with a psychiatrist.

Antenatal and postnatal services are provided by 82.4% (n=14) of SRH service providers, and preconception care (provision of biomedical, behavioral and social health interventions to women and couples before conception occurs) is provided by 70.5% (n=12). Some organizations in the WB expressed the challenge of the shortage of services. However, in Gaza, preconception care is highly demanded and accessed by engaged and married women.

The MoH indicated that breast cancer screening is provided free of charge as part of their reproductive health services strategy.

4.2.2. Specialized Services

The availability of specialized SRH services was assessed within the interviewed organizations (see Annexes 1 and 2). Disease treatment including STIs is provided by 47% (n=8) of the organizations, however, 35% (n=6) of those organizations refer cases to the MoH facilities as indicated above in section 4.2.1.STI testing is mainly done by the MoH and services provided for all age groups. HIV testing and treatment are mainly offered by MoH and according to the national protocol for HIV.

Although psychological treatment is provided by 23.5% (n=4), most agencies indicated that complicated cases are referred to the MoH community mental health centers or psychiatrist treatment. Three organizations: MoH, PRCS, HWC provide obstetrics services in their hospitals.

4.3. Nature and conditions of services' provision

The results (Annexes 1,2) indicate that 64.7% of the **facilities are located near a place where adolescents gather**. Since Gaza is high populated area, 87.5% of health faculties are located near schools, markets, homes, and youth clubs.

Although all interviewed organizations indicated that they **open during hours that are convenient for adolescents** at least from 8:00-14:00 hrs, but none of them indicated working during evening or weekends. This is a consideration that needs to be assessed as it might decrease the utilization of SRH services by young people.

With respect to **the cost of services**, all organizations indicated that they provide SRH services free of charge, however; at least six of them have requested to find a system of cost sharing or minimal charging fees for testing and medications.

When assessing the **privacy and confidentiality measures** taken by providers of SRH for adolescents; all organizations indicated that the adults and adolescents are treated in the same facility apart from one organization who indicated that they have a separate, discreet entrance for adolescents to ensure their privacy. One agency in Gaza and 2 in the WB assign certain days for adolescents to access services. Therefore, based on these results, it can be deduced that the majority of facilities have no specific convenient hours and services' setting for young people. This concludes that service providers do not have services designed and tailored to young people.

With respect to privacy and confidentiality within SRH facilities, 65% of the organizations (n=11) indicated that they maintain privacy and confidentiality. Three of them (17.6%) indicated their adherence to a protocol and social protection policy for children and adolescents. Furthermore, approximately half of them (58%) indicated having a Code of Conduct in place for staff at the health facility, and it is more in Gaza (87.5%) compared to the WB (33%).

Majority of the organizations 'staff (85%; n=15) have been trained to provide confidential adolescent services, 100% (n= 8) in Gaza compared to 77.7% in the WB. Some service providers indicated that the training includes communication skills and tools with young people in a respectful and non-judgmental manner and to include other topics of youth interest like leadership, and psychological support.

Majority of the providers (82.3%; n=14) indicated that there is **a transparent, confidential mechanism for adolescents to report complaints and feedback about SRH services provided** in the centers and the management team of the service providers, review/ analyze the complaints and take actions to amend them. Most facilities used a complaints box for all types of beneficiaries, however in Gaza as reported by organizations; the results indicated that management team were better at following up on the complaints. However, some

organizations in the WB are working on developing a referral for complaints and a management system and process.

Lastly, with regard to the **waiting time for receiving services**, there is no specific average estimation. Depending on the type of service, the average waiting time vary between providers. However, on average the waiting time range from a minimum of 15 to a maximum of 20 minutes, once a client has entered a service provider center for routine services.

4.4. Human resources for services

Table 1 shows the types of **human resources available for providing SRH** for young people. Most of the providers of SRH (88.2%) indicated that they have general practitioners in their clinics, 88.2% have gynecology and obstetrics specialists, 88.2% have other types of specialized physicians including internal medicine, dermatology, urology, 82.4% have midwives, 94.1% have nurses, 64.7% have health promotional/ educational workers, 94.1% have psychologists, and 88.2% social workers.

It was noted that in many organizations, patients are referred to central clinics or a specialized center if they need psychologist or counselor care. Furthermore, two organizations indicated having nutritionists, two organizations have physiotherapists, and one organization has a legal counselor for reproductive health issues. Despite of the fact that most of the organizations indicated that they have health educational/ promotional workers, however, SRH education is provided by nurses and midwives who are trained as educators.

Less than half of the organizations (47.1%) utilizes **peer educators or peer counselors** in SRH raising awareness. It is worth mentioning that this method was used in many health projects usually funded by international agencies. Many organizations in the WB and Gaza trained groups of peer educators (leaders) for raising awareness of youth on SRH issues. Volunteers from local communities and school students have been trained to conduct SRH awareness raising sessions.

In addition, university students were trained and engaged in providing educational prevention sessions for school students on SRH issues including early marriage in Gaza. Peer counselors/ educators were utilized in many community awareness programs in remote areas. The ‘Peer Educator’ concept was used in two organizations and mainly via social media platforms. In addition, messages through radio broadcasting, distribution of brochures in centers, schools and during workshops are utilized as means of raising awareness.

Only 59% of the agencies said that providers have been **trained to provide adolescent-friendly services**, however, there is lack of continuous training programs for them. Especially in Gaza, only 25% indicated that their staff are trained to provide adolescent-friendly services. Some training activities are reported by those organizations on the physical and health needs, communication skills, violence, stigma and cultural factors, physiological and behavioral issues of adolescence. Lack of qualified trainers in the field was indicated as a challenge.

Table 1: Human resources for SRH services

Category of human resource	Gaza (n=8)		West Bank (n=9)		Total	
	F	%	F	%	F	%
Physicians/General Practitioner	7	87.5	8	88.9	15	88.2
Gynecology/ obstetrician specialist	8	100.0	7	77.8	15	88.2
Specialized physician	7	87.5	8	88.9	15	88.2
Midwife	7	87.5	7	77.8	14	82.4
Nurse	8	100.0	8	88.9	16	94.1
Health education/ promotion	6	75.0	5	55.6	11	64.7
Counselor / psychologist	8	100.0	8	88.9	16	94.1
Social services	7	87.5	8	88.9	15	88.2

4.5. Programs management

This section addresses the SRH services administration issues (see Annexes 1 and 2). One of the key issues is the lack of **participation of the youth in program planning and management**. Participation is essential to ensure that programs and services are relevant and respond to the needs and expectations of the young people.

Moreover, participation in the planning and management of programs creates ownership and a sense of belonging among the youth. The survey showed low participation of the young beneficiaries; about 55% of the organizations indicated that young people (female and male) play a role in the planning, implementing and evaluating the organization's services. There is no significant difference between Gaza and the WB in this regard.

Those organizations who involved young people, indicated that they have achieved this by meeting with adolescents mainly in schools, community organizations and through focus groups discussions. Only two organizations indicated that they involved youth in their strategic planning process.

About 82% of the health providers are **using quality standard checklists** or any other type of assessment/review. The situation in Gaza is better than the WB (100% to 66.7%). Mainly

checklists are used in the evaluation process and completed by the program managers and reviewed by the RH staff afterwards. Very few organizations especially in Gaza indicated using systematic processes for conducting the review process and providing recommendations for improvement. Organizations using computerized health information system includes the MoH's system for quality assurance.

Moreover, only 41.2% of organizations indicated the **involvement of young people in monitoring the quality of SRH services** provision, 55% in Gaza to 33% in the WB. Two organizations indicated that they regularly undertake post assessments among the young beneficiaries, one organization indicated using focus groups to assess and obtain feedback about the quality of services.

Consent of the family and spouses was noted to be a barrier for young people accessibility to SRH services. In Gaza adolescents cannot be seen in any of the SRH facilities without the consent of their parents or spouses. In the WB only three organizations (33%) provide SRH services to young people without the consent of families. For unmarried young people, parents are usually accompanying them. Married young women usually attend the clinic with their mothers or mothers' in-law.

About 40% of the identified organizations have **written guidelines for providing young people services**. There was no significant difference between Gaza and the WB. However, few organizations indicated that the type of guidelines being used is mainly on the rights of patients or staff's management. It is recommended that proper guidelines on SRH is not available at least in the hands of the interviewed providers.

All organizations in Gaza and WB have **referral mechanisms or guidelines** in place for medical emergencies, mental health and psychosocial support. Most of them follow the national referral system. Referral to hospitals or specialized health services are provided by the organizations. Referral is also available in some organizations for social and legal support.

In total 70.6% of the organizations indicated that **young people-specific data are documented and monitored** on a regular basis including the number of young beneficiaries, disaggregated by age and sex. The percentage is much higher in Gaza (87.5%) than in the WB (55%). Many of the organizations, especially in Gaza, have computerized information systems which

generate regular reports on the number of beneficiaries (visits) and their information: age groups, gender, and geographical distribution.

4.6. Challenges for sexual and reproductive health services providers

Table 2 shows the frequency of challenges for SRH services provision reported by the interviewed organizations. Similar challenges were grouped together and then ranked according to their frequency. The key challenge is **the social norms and traditions and the perceptions of sexual and reproductive health** in the Palestinian Society. SRH is still a perceived as a sensitive issue to address. Young people feel confused of how to access such services without being stigmatized. This is considered one of the top challenges and barriers to the utilization of SRH services among young people in particular.

This is linked to the **lack of community awareness about young people SRH needs. Findings** show that this is more prevalent in Gaza where Families' members interfere in what, where and by whom SRH services are provided, for example mothers in-law have the power to decide and make choices on family planning methods on behalf of their daughters' in-law.

Another challenge is finding the right approach and methodologies to increase the demand of young people to SRH services. The package of services should be planned and tailored to young people's needs and interests, looking at the comprehensive well-being of young people. The difficulty of following up and keeping up with the adolescent and youth's expectations is a challenge. The **lack of qualified health providers** trained to deliver youth friendly health services is another challenge.

Although most organizations indicated that they have the staff, however, these human resources **lack the adequate training on the SRH needs for adolescents and youth**, and to the necessary communications skills. In addition, the accompany of parents with their children in the center is also preventing adolescents to open up to the provider and ask those sensitive questions. There are also challenges in regard to targeting adolescent girls out of school and in remote areas, as well as adolescent boys in conservative communities.

Moreover, the lack of a**dequate and accurate SRH information sources for young people is a challenge as expressed by the interviewed organizations.** The high reliance of adolescents and youth on internet for information on SRH is a challenge.

Finally, a challenge lies in lack of financial resources to maintain services and the crisis in Gaza shifts the attention to emergency needs rather than the SRH services.

Table 2: Frequency of challenges for SRH reported by the organizations

Challenges	West Bank	Gaza	Total
The culture, sexuality is still a sensitive subject to talk about and the fear of stigma.	5	7	12
Lack of community awareness about adolescent RH needs, society rejection of dealing with the subject. Family interference prevent adolescents continue or receive care.	7	3	10
Lack of family planning materials and drugs. Closure/ siege challenge impact on entrance of materials to Gaza.	2	7	9
We faced difficulties in targeting adolescent girls out of school, adolescent in remote areas, and adolescent men.	6	2	8
Difficulties of communication with adolescents, youth use internet as source of information.	3	2	5
Lack of human resources and adequate training on SRH services.	2	2	4
Lack of financial support/ financial resources of providers.	1	2	3
Lack of educational/ awareness SRH materials.	1	1	2

5. Recommendations

- There is a need to increase the amount and types of SRH provided to adolescent and ensure adequate geographic distribution of services.
- There is a need for SRH that are specially designed for adolescents and youth as per their expectations and needs.
- All key stakeholders (young people, community leaders, health providers, parents and others) should be in planning, implementation and evaluation of these services.
- There is an urgent need to raise the awareness of the community on SRH needs and services for young people. Cultural barriers to accessibility to services need to be addressed in a culturally sensitive manner to ensure engagement from the community and sustainability of programs and services.
- Health care organizations should involve the youth in the planning and management of health services to ensure that services respond to their needs, priorities, expectations and ownership.
- There is a need for better coordination among health care providers. Collaboration through partnerships in services provision can reduce inefficiencies and redundant services. In addition, it ensures adequate geographical distribution of services, especially in remote and underserved areas. Outreach programs should also be planned to target adolescent girls including the out of school.
- Actions should be taken to improve adolescent-health communication skills.
- There is a need to mobilize and train human resources, develop materials and mobilize financial resources to maintain adolescent and youth health services. Special focus should be on prevention and promotional methods.
- There is a need to improve the monitoring and evaluation of young people health services and programs.
- Organizations need to take measures ensuring privacy and confidentiality.
- Sustainability of friendly youth services is another issue that needs to be further discussed with the provider organizations and the funders.

6. References

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7. Annexes

Annex 1: Mapping of youth sexual and reproductive health services - West Bank

1. Services provision	**UHCC**	**PMRS**	**HWC**	**PRCS**	**Juzoor**	**PFPPA**	**PCC**	**SAWA**	**MoH**
a) Prevention and promotion									
- RH awareness campaigns	✓	✓	✓	✓	✓	✓	✓	✓	✓
- Educational material distribution	✓	✓	✓	✓	✓	✓	✓	✓	✓
- There are RH educational materials, posters on site, which are designed for adolescents.	✓	X	✓	✓	✓	✓	✓	X	✓
- Family planning (contraceptives)	✓	✓	✓	✓	X	✓	✓	X	✓
- STIs tests	X	✓	X	✓	X	X	X	X	✓
- Psychosocial counseling	✓	✓	✓	✓	X	✓	✓	✓	✓
- Ante-natal care	✓	✓	✓	✓	X	✓	X	✓	✓
- Post-natal care	✓	✓	✓	✓	X	✓	X	✓	✓
- Preconception care	✓	X	✓	✓	X	✓	X	✓	✓
- Contraceptives and condoms are available to both young men and women.	✓	✓	✓	✓	X	✓	X	X	✓
- Other indicate	-	-	-	-	-	-	-	-	-
b) Specialized services									
- Disease treatment (include STIs)	✓	X	X	X	X	X	X	X	✓
- Psychological treatment	X	X	X	X	X	X	X	X	✓
- HIV-testing treatment	X	X	X	X	X	X	X	X	✓
- Delivery/ obstetrics care	X	X	✓	✓	X	X	X	X	✓
- Other indicate	-	-	-	-	-	-	-	-	-
2. Facilities	**UHCC**	**PMRS**	**HWC**	**PRCS**	**Juzoor**	**PFPPA**	**PCC**	**SAWA**	**MoH**
a. The facilities are located near a place where adolescents gather (youth center, school, market, etc.)	✓	X	X	X	X	✓	✓	✓	✓
b. The facilities are open during hours that are convenient for adolescents (at least 8:00-14:00)	✓	✓	✓	✓	✓	✓	✓	✓	✓

c. RH services are offered for free, or at rates affordable to adolescents.	✓	✓	✓	✓	✓	✓	✓	✓	
d. There is a separate entrance for adolescents to ensure their privacy.	X	X	X	X	X	X	X	X	X
e. Adolescent privacy is ensured during service provision.	✓	X	X	X	✓	✓	✓	X	✓
f. There is a Code of Conduct in place for staff at the health facility.	✓	X	✓	✓	X	X	✓	✓	✓
g. There are specific clinic times or spaces set aside for adolescents.	X	X	X	X	X	✓	X	✓	X
h. All staff have been oriented to providing confidential adolescent services	✓	X	✓	✓	✓	✓	✓	✓	X
i. There is a transparent, confidential mechanism for adolescents to submit complaints or feedback about SRH services at the facility.	✓	X	✓	X	✓	✓	✓	✓	✓
j. Does the management review/ analyze the complaints and take actions to amend them	✓	✓	✓	X	✓	✓	X	✓	✓
k. Approximately waiting time for receive services in minutes	10	15	NA	NA	NA	25	1-2 months	call line (121)	30
3. Human resources	**UHCC**	**PMRS**	**HWC**	**PRCS**	**Juzoor**	**PFPPA**	**PCC**	**SAWA**	**MoH**
a. Availability, type of personnel to provide RH services:									
- Physicians/General Practitioner	✓	✓	✓	✓	✓	✓	X	✓	✓
- Gynecology/ obstetrician	✓	✓	✓	✓	✓	✓	X	X	✓
- Specialized physician	✓	✓	✓	✓	✓	✓	X	✓	✓
- Midwife	✓	✓	✓	X	✓	✓	X	✓	✓
- Nurse	✓	✓	✓	✓	✓	✓	X	✓	✓
- Health education/promotion mainly nurse play this role	X	✓	X	X	✓	✓	X	✓	✓
- Counselor / psychologist	X	✓	✓	✓	✓	✓	✓	✓	✓

- Social services	X	✓	✓	✓	✓	✓	✓	✓	✓
- Other indicate									
b. Providers have been trained to provide adolescent-friendly services, and there is continuous training program for them.	✓	✓	X	✓	✓	✓	✓	✓	✓
c. To what extent peer educators or peer counselors are available and utilized.	X	✓	X	X	✓	✓	✓	X	X
4. Program operation	**UHCC**	**PMRS**	**HWC**	**PRCS**	**Juzoor**	**PFPPA**	**PCC**	**SAWA**	**MoH**
a. Adolescents (female and male) play a role in the planning, implementing and evaluating the organization 's services	X	✓	X	X	✓	✓	✓	✓	X
d. Health providers are assessed using quality standard checklists or any other type of assessment/review, indicate.	✓	✓	✓	X	X	✓	X	✓	✓
b. Adolescents are involved in monitoring the quality of RH service provision. Is there is a satisfaction survey for youth?	X	X	X	X	✓	✓	✓	X	X
c. Adolescents can be seen in the facility without the consent of their parents or spouses.	✓	X	X	X	✓	✓	X	X	X
d. There are written guidelines for providing adolescent services.	X	X	X	X	✓	✓	✓	✓	X
e. Referral mechanisms/guide lines are in place, (for medical emergencies, for mental health and psychosocial support, etc.)	✓	✓	✓	✓	✓	✓	✓	✓	✓
f. Adolescent-specific indicators are monitored on a regular basis, (e.g. number of adolescent beneficiaries, disaggregated by age and sex etc.)	X	✓	X	X	✓	✓	✓	X	✓

MoH: Ministry of Health, **PMRS:** Palestinian Medical Relief Society, **UHCC:** Union of Health Care Committees, **UNRWA:** United Nations Relief and Work Agency, **HWC:** Health Work Committees, **PRCS:** Palestinian Red Crescent Society, **PFPPA:** Palestinian Family Planning & Protection Association, **Juzoor**: Juzoor for Health and Social Development, **SAWA:** SAWA, **NECC**: Near East Council of Churches, **RGRCA:** Rural Girl Renaissance Charity Association.

Annex 2: Mapping of youth sexual and reproductive health services - Gaza Strip

3. Services provision/ providers	**MoH**	**UHCC**	**PMRS**	**HWC**	**RCSG**	**CFTA**	**PRCS**	**NECC**
c) Prevention and promotion								
- RH awareness campaigns	✓	✓	✓	✓	✓	✓	✓	✓
- Educational material distribution	✓	✓	✓	✓	✓	✓	✓	✓
- There are SRH educational materials, posters on site, which are designed for adolescents.	X	X	X	✓	x	✓	✓	x
- Family planning (contraceptives)	✓	✓	X	✓	✓	✓	X	✓
- STIs tests	✓	X	✓	X	✓	✓	✓	X
- Psychosocial counseling	✓	✓	✓	✓	✓	✓	✓	✓
- Ante-natal care	✓	✓	✓	✓	✓	✓	✓	✓
- Post-natal care	✓	✓	✓	✓	✓	✓	✓	✓
- Preconception care	✓	✓	X	✓	✓	✓	✓	✓
- Other indicate	-	-	-	-	-	-	-	-
d) Specialized services								
- Disease treatment (include STIs)	✓	✓	✓	X	✓	✓	✓	X
- Psychological treatment	✓	X	X	X	✓	✓	X	X
- HIV-testing treatment	✓	X	X	X	✓	X	✓	X
- Delivery/ obstetrics care	✓	X	X	✓	x	X	✓	X
- Contraceptives and condoms are available to both young men and women.	✓	✓	✓	✓	✓	✓	X	x
- Other indicate	Breast screening	Physio-therapy	-	-	Physio-therapy			-
2. Facilities	**MoH**	**UHCC**	**PMRS**	**HWC**	**RCSG**	**CFTA**	**PRCS**	**NECC**

a. The facilities are located near a place where adolescents gather (youth center, school, market, etc.)	✓	✓	✓	X	✓	✓	✓	✓
b. The facilities are open during hours that are convenient for adolescents— (at least 8:00-14:00)	✓	✓	✓	✓	✓	✓	✓	✓
c. RH services are offered for free, or at rates affordable to adolescents.	✓	✓	✓	✓	✓	✓	✓	✓
d. There is a separate entrance for adolescents to ensure their privacy.	X	✓	X	X	X	X	**x**	x
e. Adolescent privacy is ensured during service provision.	✓	✓	✓	X	✓	✓	✓	✓
f. There is a Code of Conduct in place for staff at the health facility.	X	✓	✓	✓	✓	✓	✓	✓
g. There are specific clinic times or spaces set aside for adolescents.	X	X	X	X	x	✓	x	X
h. All staff have been oriented to providing confidential adolescent services	✓	✓	✓	✓	✓	✓	✓	✓
i. There is a transparent, confidential mechanism for adolescents to submit complaints or feedback about SRH services at the facility.	✓	✓	✓	✓	✓	✓	x	✓
j. Does the management review/ analyze the complaints and take actions to amend them	✓	✓	✓	✓	✓	✓	✓	✓
k. Approximately waiting time for receive services in minutes	15	10	10-15	NA	15-20	15-20	15-20	30-40
4. Human resources	**MoH**	**UHCC**	**PMRS**	**HWC**	**RCSG**	**CFTA**	**PRCS**	**NECC**
e. Availability, type of personnel to provide RH services:								
- Physicians/General Practitioner	✓	✓	✓	✓	✓	X	✓	✓
- Gynecology/ obstetrician specialist	✓	✓	✓	✓	✓	✓	✓	✓

- Specialized physician	✓	✓	✓	✓	✓	X	✓	✓
- Midwife	✓	✓	✓	✓	x	✓	✓	✓
- Nurse	✓	✓	✓	✓	✓	✓	✓	✓
- Health education/promotion	X	✓	✓	X	✓	✓	✓	✓
- Counselor / psychologist	✓	✓	✓	✓	✓	✓	✓	✓
- Social services	✓	✓	X	✓	✓	✓	✓	✓
- Other indicate	Nutritionist					Legal counselor		
f. Providers have been trained to provide adolescent-friendly services, and there is continuous training program for them.	X	X	✓	X	x	✓	x	x
g. To what extent peer educators or peer counselors are available and utilized.	X	✓	✓	X	x	✓	✓	x
5. Program operation	**MoH**	**UHCC**	**PMRS**	**HWC**	**RCSG**	**CFTA**	**PRCS**	**NECC**
a. Adolescents (female and male) play a role in the planning, implementing and evaluating the organization's services.	X	✓	✓	X	x	✓	✓	✓
b. Health providers are assessed using quality standard checklists or any other type of assessment/review, indicate.	✓	✓	✓	✓	✓	✓	✓	✓
c. Adolescents are involved in monitoring the quality of RH service provision. Is there is a satisfaction survey for youth?	X	✓	X	X	✓	✓	✓	x
d. Adolescents can be seen in the facility without the consent of their parents or spouses.	X	X	X	X	x	X	X	x
e. There are written guidelines for providing adolescent services.	✓	X	X	X	x	✓	✓	x

f. Referral mechanisms/guide lines are in place (for medical emergencies, for mental health and psychosocial support, etc.)	✓	✓	✓	✓	✓	✓	✓	✓
g. Adolescent-specific indicators are monitored on a regular basis, (e.g. number of adolescent beneficiaries, disaggregated by age and sex etc.).	✓	✓	✓	X	✓	✓	✓	✓

MoH: Ministry of Health, **PMRS:** Palestinian Medical Relief Society, **UHCC:** Union of Health Care Committees, **HWC:** Health Work Committees, **PRCS:** Palestinian Red Crescent Society, **NECC**: Near East Council of Churches. **RCSG**: Red Crescent Society for Gaza. **CFTA:** Culture and Free Thought Association.