Palestine's Commitment to the Nairobi Summit:

Prepared by: Luna Saadeh

ACRONYMS AND ABBREVIATIONS

APDA: The Asian Population and Development Association

FAPPD: Forum of Arab Parliamentarians on Population& Development

CEDAW: The Convention on the Elimination of All Forms of Discrimination against Women

GBV: Gender-based violence

GP: Global Priorities

HIV: Human immunodeficiency virus

ICPD: International Conference on Population Development

MDGs: Millennium Development Goals

MFP: Ministry of Finance and Planning

MICS: Multiple Indicator Cluster Survey

MM: Maternal Mortality

MOE: Ministry of Education

MOH: Ministry of Health

NRHS: National Reproductive Health Strategy

OCHA: United Nations Office for the Coordination of Humanitarian Affairs

PA: Palestinian Authority

PCBS: Palestinian Central Bureau of Statistics

PHC: Primary Health Centers

SDGs: Sustainable Development Goals

SRH: Sexual and Reproductive Health

SRHR: Sexual and Reproductive Health and Rights

UNDP: United Nations Development Programme

UNFPA: United Nations Population Fund

UNRWA: United Nations Relief and Works agency for Palestine refugees in the near east

WHO: World Health Organization

TABLE OF CONTENTS

Executive Summary

Since its establishment in 1993, the Palestinian Authority has focused its efforts on state-building and sustainable development. These endeavors were expressed, for example, through Palestine's commitment to the 1994 International Conferences on Population and Development (ICPD) and 2019 ICPD25 Nairobi Summit. But Palestine's journey has been arduous due to the dire socio-economic and political realities caused by the Israeli occupation, the associated harsh and unfair policies and practices, and Israel's continuous violations of its commitments towards the Palestinians.

The State of Palestine announced its commitment to the principles adopted in the 2019 Nairobi Summit—also known as ICPD+25, celebrating the 25th anniversary of the Cairo Conference—as the world makes efforts to meet the 2030 Sustainable Development Goals. With this pledge, Palestine seeks to enhance the achievements it has realized so far in line with the priorities established in the 1994 ICPD by committing to implement the following principles:

1. Secure access to sexual and reproductive health (SRH) as a part of universal health coverage;
2. Reduce the rates of maternal mortality, diseases, and imminent complications;
3. Decrease the proportion of unmet family planning needs to 10 percent by 2022;
4. Incorporate comprehensive sexuality education programs into all schools by 2030;
5. Draw on demographic diversity to drive economic growth and achieve sustainable development;
6. Eliminate gender-based violence.

The State of Palestine has issued a report that identifies the actions the government has taken to realize the commitments that were adopted by the international community in the Nairobi Summit and presents the challenges that impede the State's efforts to move forward. For example, while the ICPD asserts that SRH is a core element of population change that affects human development, the question remains of how Palestine can distribute available resources in line with ongoing changes.

Based on the 2017 Census, carried out by the Palestinian Central Bureau of Statistics (PCBS), Palestine will witness a change in the population pyramid over the upcoming two decades that will affect its efforts to meet the Sustainable Development Goals (SDGs). The survey indicates a population increase in the age group of 15 to 49 years, which means an increase in the group engaged in the labor force. It furthermore highlights a decrease in the numbers of children under the age of 15 years and a slight increase in the numbers of dependent older persons. Such a demographic change offers both

opportunities and challenges. Therefore, Palestine must invest in the growing young and working-age population, provide better education, improve health services, ensure women's empowerment, and offer the foundation for growth, among other policies (UNFPA, 2016). Gender inequality in Palestinian society is the main impediment to an investment process that targets this population segment and, in turn, will reflect on the efforts towards achieving development commitments according to international standards.

The report identifies several significant challenges that hamper the State of Palestine's efforts towards achieving its international obligations, as outlined in the Nairobi Summit. These challenges include the following: First and foremost, the Israeli occupation and ensuing arbitrary measures, including the separation and annexation of areas within the occupied territories that impede citizens' access to services, especially in remote areas, including to health services. These conditions hinder the State of Palestine's control of its natural resources and economic development, hamper its ability to serve its citizens, and make impossible the building of an independent state. Moreover, they lead to continuous daily violations of rights through measures such as arbitrary arrests, house demolitions, land confiscation, and repeated military invasions of the Gaza Strip.

A second challenge is the effective freeze of the Legislative Council since 2006, due to the Israeli occupation and the internal division, that obstructs the unification of the prevailing legislative systems in Palestine. Third, following the outbreak of the COVID-19 pandemic, the Palestinian government declared a state of emergency and announced an emergency budget. While these decisions and subsequent government actions focused entirely on preventing the spread of the virus, the policies of lockdown and quarantine have negatively impacted the economic and social life of the Palestinians. For example, Palestinian women's organizations (CEDAW Coalition, 2020) have stated that gender-based violence (GBV) increased during the lockdown. Fourth, the occupation and traditional patriarchy intersect to create a uniquely complex situation for women and girls, often termed as a 'double oppression' for women. Women are oppressed by the occupation-associated violent apparatus and the resulting loss of freedoms, which simultaneously perpetuates the existing patriarchal conservatism within Palestinian society. This situation prevents women and girls from reaching the pillars of justice and reporting violence against them, making it particularly difficult to advance or achieve gender equality.

The actions of the Palestinian government towards achieving its international obligations as outlined in the Nairobi Summit can be summarized as follows:

State Commitment (1): Secure access to sexual and reproductive health (SRH) as a part of universal health coverage, and

State Commitment (2): Reduce rates of maternal mortality, diseases, and imminent complications:

- At the level of strategic plans and national policies, the Ministry of Health (MOH) has adopted a Strategic Plan on Promoting Sexual and Reproductive Health (SRH) in Palestine. It outlines the approach and interventions of the Ministry to ensure citizens' rights in SRH. Whereas previous SRH plans focused on women only, the 2018–22 plan introduces policies that aim at integrating men.
- Quality and access to health services: The national indicators from 2014–18 for SRH indicate a significant improvement in the health of citizens, affecting women and girls in particular. Palestine is witnessing an increase in life expectancy, a slight decrease in the fertility rate, a decrease in infant and newborn deaths, and a reduction of maternal mortality. But whereas a decrease is reported in the maternal mortality rate (MMR), a 2019 MOH report indicates a gap between estimation and surveillance rates, which could point to underreporting in surveillance efforts.
- MOH provides primary care in primary health centers that are distributed throughout all governorates in the West Bank and the Gaza Strip. Most of these centers provide family planning and maternal and child care services, but their efforts to support family planning face many challenges, including shortages and stock-outs.
- The government makes available health insurance, enabling the majority of citizens to obtain low-cost health services, including SRH.

State Commitment (3): Decrease the proportion of unmet family planning needs to 10% by 2022:

- The State of Palestine faces many problems in facilitating family planning, mainly due to two factors: First, the government does not prioritize the purchase of contraceptives, and second, the MOH faces a budget deficit. Although unmet needs have reached 10.9%, which is in line with the commitment made by the State of Palestine at the Nairobi Summit, the adoption of family planning methods and the use of modern contraceptives among Palestinians remains low.

State Commitment (4): Incorporate comprehensive sexuality education programs into all schools by 2030:

- The Ministry of Education (MOE), in coordination with the MOH and civil society institutions, implements two programs in Palestinian public schools. First, the School Health in Schools program provides public health to students at all education levels (including vaccines for children, eye examinations, and more).
- Second, the Adolescent Health program provides adolescent health education by distributing manuals and running adolescent health centers and GBV programs in schools. Discussing sexuality education in schools remains a taboo in Palestinian society. But health and education counselors are available in many schools, even though there is a shortage of staff, compared to the number of schools and students, and some counselors must serve more than one school. Numerous training sessions on SRH have been held, but there exists a lack of information regarding the number and quality of these sessions.

State Commitment (5): Draw on demographic diversity to drive economic growth and achieve sustainable development:

- The MOH has established a database that covers health indicators and data.
- Since 2011, an electronic network has been implemented that aims to connect all government hospitals via a comprehensive digital system. Currently, according to the MOH, this system is available in the 27 government hospitals.
- No data is available, however, on demographic diversity to support the national plans and policies to drive economic growth.
- Statistical data related to public health indicators and other sectors are made available continuously by the Central Bureau of Statistics (PCBS), and most of these data are disaggregated based on gender and geographical distribution. This information is essential for planning processes.

State Commitment (6): Eliminating gender-based violence:

- The State of Palestine has taken many measures to reduce GBV, using strategies and interventions such as adopting the National Strategy to Combat Violence Against Women for the years 2012–19, the 2013 National Referral System for Victims of

Violence, and the Protocol for Case Management. Further measures include the formation of Family Protection from Violence Units in the Ministry of the Interior, the establishment of a Gender Unit in the Public Prosecution office, and the running of three shelters/safety houses. However, as the government of the State of Palestine has taken limited interventions in terms of legal protection from GBV, there is a lack of inclusiveness in interventions to combat violence.

Key Recommendations (for the full list of recommendations refer to page 53):

- Adopt the Family Protection Law
- Activate the decision to raise the marriageable age—with no exceptions—through procedures and monitoring tools in Shari'a Courts, and amend the Penal Code to criminalize early marriage.
- Adopt a cross-sectoral approach towards sexual and reproductive health and rights (SRHR) in the national strategic planning, and apply a universal approach to SRH in the social, health, education, and labor sectors.
- Develop a protocol system and adopt mechanisms to improve the monitoring of maternal mortality.
- Provide capacity building and training for medical staff in primary health care centers on GBV to ensure SRHR for all.
- Integrate the detection, treatment, and referral of GBV cases into the job descriptions of front-line health providers and family protection police officers.
- Ensure the rights of youth to participate in the shaping of policies and programs related to SRH and GBV; promote youth-friendly health services.
- Ensure the active involvement of men, young men, and boys in combating GBV.
- Include SRHR in emergency plans during political, humanitarian, and environmental crises
- Support the political commitment to SRHR by strengthening the monitoring system to ensure the provision of quality, accessible, and acceptable SRH services that ensure adherence to the associated rights.

1. Introduction

This report was prepared at the request of the United Nations Population Fund (UNFPA), the Asian Population and Development Association (APDA) and the Forum of Arab Parliamentarians on Population and Development (FAPPD), which are carrying out a mapping process in the Arab region, including the State of Palestine, on the Nairobi Summit commitments. The report aims to map and assess legal and policy issues which shape (limit or guarantee) the implementation of the Nairobi Commitments at the national level through the following objectives: 1) Determine the limitations and ways of support (challenges/opportunities) to the implementation of the Nairobi Commitments at the national level. 2) Examine the implementation and enforcement mechanisms as well as identify best practices. 3) Propose recommendations on measures to take for implementing the Nairobi commitments on ICPD25.

The Nairobi Summit marked the twenty-five years of the International Conference on Population Development (ICPD) in 1994, and was highly appraised for its commitment to building on the foundation that was laid in the ICPD's Programme of Action. ICPD's Programme of Action was a turning point in the global orientation towards SRH, as it paved the way for promoting SRHR to become a core element in achieving sustainable development. Since 1994, Governments, activists, civil society organizations and international organizations such as UNFPA have mobilized their efforts towards the realization of the ICPD's Programme of Action. Moreover, they have pledged to work on reducing the challenges that hinder women's and girls' access to health rights in general and to human rights in particular, and denies them their right of self-determination.

Palestine's participation in the Nairobi Summit on Population and Development in 2019 consisted of representatives from the Government, non-governmental organizations, and youth delegates. The delegation team was led by the Permanent Representative of the State of Palestine to the United Nations in New York, Dr. Riad Mansour, and included representatives of the Ministry of Planning, of the Palestinian Central Bureau of Statistics (PCBS), the Ministry of Foreign Affairs and Expatriates, and representatives of the civil society. This cross-sectoral involvement highlights the orientation of the Government towards making a genuine change that would enhance the wellbeing of the citizens reflected in the "Putting Citizens First" National Plan that was developed in line with the SDG pledge to "Leaving No One Behind". This participation resulted in the commitment of the State of Palestine to global priorities that would enhance Palestine's efforts towards reaching sustainable development. It has committed itself to:

1. Secure access to SRH as a part of universal health coverage;
2. Reduce the rates of maternal mortality, diseases, and imminent complications;
3. Decrease the proportion of unmet family planning needs to 10 percent by 2022;
4. Incorporate comprehensive sexuality education programs into all schools by 2030;

5. Draw on demographic diversity to drive economic growth and achieve sustainable development;
6. Eliminate gender-based violence

Palestine, as a state living under occupation, faces many challenges that would further impede its success in realizing its international commitments including the Nairobi Summit commitments. The political, socio-economic realities in Palestine are not only shaped by the developmental hindrances but also by practices and policies of Israeli authorities that target the essential components of sustainable development, including but not limited to: land, people, authority, infrastructure, agriculture, movement and borders. Absence or destruction of these components would mean delay or halt in the development process. Thus, the commitment of the State of Palestine to the Nairobi Summit is a pivotal part of its international commitment to achieving the SDGs, and to take necessary measures and interventions to ensure the realization of its commitments despite of all the Israeli obstacles that aim at aborting and derailing all Palestinian efforts and successes.

Further, challenges related to the prevailing patriarchal culture promotes gender inequality and traditional gender roles and beliefs. Thus, women and girls are marginalized not only at the community level but also on the National Agenda. Their voices and needs are marginalized and sidelined when it comes to the national priorities due to the dire political reality, which is worsened with the continuance of the Israeli occupation and its violations of human rights. This in turn was reflected in the national priorities, where women's rights remain at the bottom of the pyramid. The Government's efforts to make change through legislation and laws on one hand, and the implementation of socio-economic interventions on the other hand were slowed down by the prevailing traditions and customs of the society. Nevertheless, the State of Palestine made commitments to global priorities that would enhance Palestine's efforts towards reaching sustainable development.

Despite the political reality and the prevailing patriarchal culture, the State of Palestine has taken steps to improve the reality of SRHR in Palestine. Palestine has reduced its maternal and child mortality rate and a slight decrease in fertility rate, although when compared with some of the Arab countries, the percentages are still high. For example, in 2018, Jordan reached 2.8, Bahrain 2, Qatar 1.9 and Syrian Arab Republic 2.8.[1] Additionally, it has increased the number of individuals using modern family planning methods, and increased the number of primary health care centers; nevertheless, it is still important to make efforts to increase access of all citizens to these services. In terms of improving the rights of women and girls in other sectors, the governmental and non-governmental approaches to bridging the gender gap in the Palestinian society have been

[1] See in: https://data.worldbank.org/indicator/SP.DYN.TFRT.IN?display=graph--%3E&locations=JO-SY

successful, although the response varied from one sector to another. For example, in the education sector, the enrollment rate of girls in primary and university education is higher than that of males, but the gender gap in the labor sector and political participation widens in favor of males and this is due to many reasons. First, the Israeli occupation pursues to impose a fait accompli status in the Palestinian Territories, which laid tremendous burden on the Palestinian economy leading to a slow in growth necessary to achieve sustainability and to state building, and second, the patriarchal culture limits women participation in the labor force. The State of Palestine introduced some interventions to integrate gender and youth issues into its National Agenda 2017-2022 "Putting Citizens First", but as long as gender inequality exists, many will be "left behind".

2. Methodology

In order to map the process of achievements and limitations, the report was based on literary and statistical reviews of the national and international reports, studies on SRHR in Palestine and the national statistics that are relevant to the global priorities. Additionally, five individual interviews were conducted with members of the National Population Committee, who were nominated by the General Director of the Policy and Reform Unit - the coordinating body of the committee. Interviews were held with the Ministry of Planning and Policy, the Ministry of Health, the Ministry of Education, Ministry of Women's Affairs and the Palestinian Central Bureau of Statistics. Five human rights and health institutions have also been contacted to collect data and information on the matter, particularly the reality of SRH during the outbreak of the Covid-19 pandemic.

The compilation and classification of data was adopted in 2014 as the base year for the analysis of the first Global Priority. It was determined based on the content of the Global Priority and the national interventions to which Palestine had committed itself and due to the adoption of the 2014 in cluster Health Survey, which includes all developed indicators on universal SRH. As for the second priority, which aims at realizing economic, social and health empowerment, 2015 was adopted as the base year due to the availability of the basic indicators of measurement and to its proximity in time, thus ensuring accuracy of measurement and analysis. Regarding the third priority on combating violence, indicators were not available because of the non-implementation of the adopted interventions. Finally, the fourth priority concerning the mobilization of funding also adopted 2014 as a base year.

All indicators of interventions identified within each Global Priority have been developed and compared to 2018, because the national statistical data and indicators are available up to 2018.[2]

3. The Context of Palestine

The State of Palestine strives to become an active member of the international community that seeks justice and world peace and despite of the fact that the State of Palestine is under the Israeli Occupation, yet it has been able to make its presence felt in the international arena through declaring its commitment to international obligations. The Palestinian Declaration of Independence (1988), which is a fundamental reference point in the Palestinian State, affirms the Palestinian State's commitment to the rules of the International Law and the State's adherence with the Charter of the United Nations and the principles of the Universal Declaration of Human Rights. Further, in 2007, the State of Palestine ratified the Arab Charter on Human Rights, which entered into force in 2008, and in 2012, the UN General Assembly raised the status of Palestine to a non-UN observer state.

The State of Palestine's efforts to achieve development comes hand in hand with its efforts to promote human rights. Thus, in 2014, Palestine acceded to more than 20 treaties.[3] In the same year, Palestine became a party to the 1949 Geneva Conventions and the 1977 additional Protocol. In 2015, it signed the Convention on the Political Rights of Women and the Rome Statute of the International Criminal Court. In 2019, it declared its commitment to the International Conference on Population and Development Commitments at the Nairobi Summit.

Any state's accession to international treaties and obligations requires political, economic and legal commitment in order to be able to fulfill these obligations. This highlights the hardships facing the State of Palestine which would hinder its efforts. Palestine strives to become a full member and an independent State through the promotion and realization of such obligations despite all the impediments imposed by Israel, which seizes sovereignty and control over the political borders and the economic resources, and that in turn constitutes a major obstacle in the Palestinian State's achievement of its international commitments.

[2] All reports issued in 2019, used the statistics developed of 2018.

[3] the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT). Additionally, it acceded to the Convention on the Rights of the Child and its Optional Protocol on the involvement of Children in Armed conflict, Convention on the Rights of Persons with Disabilities, International Convention on the Elimination of All Forms of Racial Discrimination, International Covenant on Civil and Political Rights, and International Covenant on Economic, Social and Cultural Rights. Palestine has not expressed any reservations about these treaties.

The Oslo Accords, led to a complexity in administrative rule, security and access to justice in the West Bank. Area A falls under the administration of the Palestinian Authority, which manages most internal civilian affairs and internal security, whereas Area B is jointly administered by the Palestinian Authority and Israel, and Area C, which contains the Israeli settlements, is under Israeli administrative and military control. The agreements became the key constrain that limits the development of all aspects of life, and the main obstacle to achieving sustainability in Palestine.[4] The Palestinian economy became fully dependent on the Israeli economy and the Palestinian trade and movement became constrained by the Paris Protocol[5] of 1994 which determines and regulates the trade and economic Palestinian- Israeli relations. The Israeli occupation has erected checkpoints to separate between the Palestinian cities and communities. Further, the Gaza Strip is completely separated from the West Bank and the world. The permanent checkpoints erected in the West Bank are estimated at 700 (OCHA, 2018). Thus, the Palestinian villages were turned into ghettoes with gates that control the movement from and to the villages. In fact, the checkpoints are used as tools to enforce collective punishment against the Palestinians (OCHA, 2018). Accordingly, the Palestinians are deprived of their right to movement for any reason including education, trading, medical treatment, or pleasure. Adding to that, the Israeli separation between the Gaza Strip and the West Bank, in addition to the internal political division and the establishment of two different Palestinian governments resulted in an effective freeze of the Palestinian Legislative Council (PLC). This led to an absence of the Legislative Council's role in developing democratic culture in the Palestinian society and to a deepening of the loss of the most important official tool for monitoring and accountability. With the PA legislative and oversight process effectively frozen, Mahmoud Abbas has increasingly ruled through presidential decrees. According to the PA's Basic Law, the president "shall have the right, in cases of necessity that cannot be delayed, and when the Legislative Council is not in session, to issue decrees that have the power of law" (ECFR, 2020).

Israel as an occupying power continuously pursues to impose a fait accompli status in the Palestinian Territories. This policy laid tremendous burden on the Palestinian economy leading to a slow in growth necessary to achieve sustainability and to state building. The Palestinian Authority's (PA) budget depends on foreign aid and funds, which decreased in recent years despite of the urgent Palestinian needs. The PA has not been able to collect the tax revenues held by Israel (PCBS, 2019) causing a budget deficit. This has resulted in a financial crisis that has affected the economic growth and the investment rate in

[4] See in: Twenty years since the Oslo Accords ... an assessment of the economic dimensions ... a group of researchers published in Alhayaat aljadedah newspaper. Also, in MAS, 2013. Twenty years since the Oslo Accords. Final report for round table discussion.

[5]The agreements gave the Israelis the authority and control over the borders and the domestic and international movement of trade and individuals.

Palestine, which reflected badly on the socio-economic context, leading to an increase in the overall unemployment rate reaching at 33% in 2019 (PCBS, 2020), and a rise in the poverty rate especially among females. In 2018, male participation rate in the labor force was (72%), compared to (21%) among females (PCBS, 2019). Youth are the most detrimentally affected with unemployment rates reaching 39% in the West Bank, close to 60% in Gaza, and 51% of university graduates are unemployed (UNFPA, 2017). The UNFPA report Palestine 2030 has shown that the active-age population, "would grow from 2.9 million in 2015 to 7.2 million in 2050, thus a multiplication of 2.5. By 2030, labour force size will increase by one million."(UNFPA, 2017) Although this increase in the proportion of young people in the workforce constitutes an opportunity for economic revival, but in light of the continued Israeli occupation and its control over the Palestinian economy, it will contribute to creating a major problem leading to an increase in unemployment rates and a decline in the standards of living of the Palestinian population.

With the outbreak of COVID-19 pandemic and the subsequent measures at the international and local levels in terms of closures between countries, quarantine and closure of public utilities all led to a global economic crisis that will have last long-term consequences. According to the World Bank report (2020), the PA has been introducing measures since early March 2020 in efforts to halt the spread of the COVID-19 outbreak. While effective in limiting the spread of the virus, they seem to have resulted in disruptions in economic activity, especially in the West Bank. As a result, the economy is expected to contract by 2.5% in 2020. This reality has a multiplier effect on the State of Palestine due to the already deteriorating and dependent economic situation (World Bank, 2020) and with the restrictions and violations imposed by the Israeli occupation, thus the State of Palestine faces difficulties that would challenge its efforts towards the fulfillment of its international obligations.

4. Background on ICPD and Nairobi Summit:

The International Conference on Population and Development (ICPD) was held in Cairo, Egypt, from 5-13 September 1994, under the coordination of the United Nations and with the participation of about 20,000 delegates from various Governments, United Nations agencies, NGOs and the media. This conference was considered a turning point in international discussions on population, in terms of expanding the scope of development policy discussions from a focus on controlling population growth, mainly through family planning, to a comprehensive human rights perspective focusing on economic, social, environmental and legal policies that contribute to improving the lives of individuals, especially women. The Governments have agreed that population policies should address social development beyond family planning, it should be provided as part of a broader set of reproductive health care. This new assertion was the belief that promoting health and

individual rights would reduce fertility and ultimately slow population growth in order to reach to a real development.

The ICPD adopted a Programme of Action (PoA) that paves the way towards the betterment of the societies. It is an important document that addresses many of the basic challenges related to population, health, education, gender and development facing the entire human community. It does so by addressing the provision of comprehensive reproductive health care, which includes family planning, safe pregnancy and childbirth services, abortion where it is legal, prevention and treatment of sexually transmitted diseases (including HIV/AIDS), information and advice on sexual activity and elimination of harmful practices against women (such as circumcision and forced marriage). The PoA, defined reproductive health for the first time in an international policy document, which states, "reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or disability, in all matters related to the reproductive system."

Certainly, the ICPD was explicitly granted a broader mandate on development issues than previous population conferences, reflecting the growing awareness that population, poverty, patterns of production, consumption, and the environment are so closely interlinked that none of them can be considered separately. For this reason, it is considered a milestone in the development processes.

At this Conference, States have given broader commitments to sustainable development issues than the previous population conferences.[6] This approach has contributed to the promotion of a human rights perspective in SRH care that is not only related to health care services, but also to the demographic diversity and its impact on how needs and capacities are monitored based on gender, and its impact on the distribution and utilization of resources for sustainable development.

The ICPD's Programme of Action helped in promoting the implementations of the MDGs in addition to enhancing the efforts in realizing poverty reduction, health and education development and gender equality. Despite of the improvements, many obstacles still hinder the achievement of real sustainable development. The UN General Assembly R65/234 acknowledged that the ICPD's agenda had not been completed, and the Program of Action has been extended indefinitely. States also requested an operational reviewing to determine the extent to which the Program of Action was being implemented on grounds of data quality and analysis of population and development, taking into account the new challenges and the changing development landscape. Further, it highlighted the need to employ a coherent, comprehensive and integrated approach to responding to population and development issues.

[6] Previous population conferences, the 1974 World Population Conference in Bucharest and the 1984 International Conference on Population in Mexico City.

The Nairobi Summit was held 25 years after the International Conference on Population in order to advance the implementation of its PoA aiming at reaching "Three Transformative Results - Three Zeros" by 2030, "zero maternal deaths, zero unmet need for family planning, and zero gender-based violence and harmful practices" (UNFPA, 2019). These sought-after results represent the core of the SDGs 2030 pledge "Leave No One Behind".

The Nairobi Summit, attended by more than 9,500 delegates from more than 170 countries, released the Nairobi Statement-a non-binding declaration- that express recommitment to the goals adopted at the ICPD's Program of Action, the UN commitment came as follows (UN News, 2019):

- Uphold the human rights of all people, including their right to SRH.
- Intensify system-wide efforts to eliminate all preventable maternal and child mortality, to eradicate gender-based violence against women, girls and youth, and to eliminate the unmet need for family planning that constrains the rights and wellbeing of millions of women and young people,
- Support investments in adolescents and youth that uphold their rights,
- Support governments in the full and accelerated implementation of the ICPD agenda, in line with implementation of the SDGs,
- Ensure that no one is left behind, and that we reach the furthest behind first,
- Incorporate the outcomes of the Nairobi Summit as an integral component in the Decade of Action to deliver on the SDGs.

To realize the Nairobi Summit Goals (Three Zeros), donor countries pledged around $1 billion in support to SRH and gender equality programs, Private sector firms agreed to mobilize a combined $8 billion[7], to implementing the necessary programs and reaching SDGs.

5. State of Palestine's Commitments to the Nairobi Summit: Achievements, Gaps and Challenges

The State of Palestine's participation in the Nairobi Summit on ICPD25, which took place on 12-14 November 2019, came as a declaration of belief in the importance of the ICPD's Agenda and as part of its commitment to accelerating the process of achieving and realizing the priorities raised in the Cairo Declaration on Population and Development

[7] https://www.unfpa.org/news/nairobi-summit-ends-time-focus-accountability

1994. The State of Palestine affirmed its commitments to the following Global Priorities (GP):[8]

1. **Secure access to SRH as a part of universal health coverage:**
    - Adopting a comprehensive digital patient file system that brings together government health facilities, non-governmental and private hospitals to improve referral systems and quality of care by 2022.
    - Ensuring a universal coverage of comprehensive and high-quality health care by integrating the full range of primary health care services into the National Health System, including the provision of pre-pregnancy care, in 80% of primary health care facilities by 2021.
    - Establishing of a unit dedicated to adolescent health in the Ministry of Health by 2023
2. **Reduce the rates of maternal mortality, diseases, and imminent complications:**
    - Improving the timing of provided care to pregnant women and recent mothers to ensure that 85% of women receive the required care in accordance with recommended timelines by 2022.
    - Reducing rate of C-section deliveries in the government sector institutions by 20%, by the year 2030.
3. **Decrease the proportion of unmet family planning needs to 10 percent by 2022.**
    - Raising the financial commitment to $500,000 depending on resources availability, aiming at increasing the provided supply to family planning services, among which to include contraceptives.
    - Improving supply chain management, including requirements and supply forecasting, logistics management and distribution of family planning services and supplies to reach the poorest and most marginalized populations
4. **Incorporate comprehensive sexuality education programs into all schools by 2030.**
    - Reviewing the reproductive health concept and sexuality education included in the Palestinian curriculum
    - Training of teachers
    - Developing the health adolescence module

[8] https://www.nairobisummiticpd.org/content/icpd25-commitments

5. **Draw on demographic diversity to drive economic growth and achieve sustainable development.**

    - Collecting, analyzing and classifying data for planning and developing programs through censuses every 10 years.
    - Developing the statistical system

6. **Eliminate gender-based violence.**

    - Providing high-quality, multisectoral services to prevent gender-based violence by 2030.
    - Issuing the Family protection law and raise the age of marriage to 18 years by 2020.
    - Updating the national strategy to combat violence

In the same context, the Asian and Arab members of Parliament, including Palestinians, met in order to access and review to what extent the ICPD Programme of Action was implemented, to discuss the adopted mechanisms and to affirm the international commitments to accelerating the efforts toward realizing the ICPD25 Nairobi Commitments. The meeting was concluded with issuing a Declaration of Commitment in which the Parliamentarians pledged to provide support and assistance and to mobilize efforts to achieve the international commitments.

The commitments of the Nairobi Summit emphasized by the parliament members, are complementary and in line with other global commitments that the State of Palestine has ratified. As previously highlighted, the year 2014 witnessed the accession of Palestine to fundamental human rights treaties. By joining these treaties and adopting the slogan "Leave No One Behind" and the 2030 Agenda for Sustainable Development, Palestine renews its obligations to achieving equality and ending all forms of discrimination.

To fulfill its international obligations, the state of Palestine took preliminary action to implement its commitment to the Agenda 2030, which will consequently contribute to the realization of the global priorities of the Nairobi Summit. To achieve that, Palestine has introduced policies and adopted national strategies and goals that intersect with the ICPD global priorities. Thus, at the national level, a national team consisting of government representatives, civil society organizations and the private sector was put together and small-specialized planning groups were also formed, all came in efforts to put plans in line with the various SDGs 2030 goals, and in line with their interrelations with the relevant ministries.

In the same context, the PCBS selected 125 global indicators related to the Palestinian reality, and in view of the specificity of the Palestinian situation, an integrated set of 150

additional indicators have been adopted. On that basis, the Palestinian Government developed its National Agenda 2017-2022 under the slogan "Putting Citizens First" corresponding with the SDGs. The National Agenda is the compass and the framework for all government institutions within which they develop plans and operate to achieve adopted goals. The table below highlights the correlation between the Commitments of the State of Palestine to the Nairobi Summit Program of Action, the National Agenda 2017-2022 and the Sustainable Development Agenda 2030.

Table 7: Correlation between Nairobi Commitments and National Agenda

Palestine's Commitments to Nairobi Commitments	National Agenda 2017-2022	SDGs
Commitment no.1: Secure access to sexual and reproductive health (SRH) as a part of universal health coverage.	National Policy 24: Provide universal health care services. National Policy 25: Improve the health and well-being of citizens. National Policy 8: Promote accountability and transparency	Goal 3: Ensure healthy lives and promote well-being for all at all ages Goal 4: Ensure inclusive and equitable quality education and promote lifelong learning Goal 5: Achieve gender equality and empower all women and girls
Commitment no .2: reduce the rates of maternal mortality, diseases and imminent complications	National Policy 25: Improve the health and well-being of citizens.[9]	Goal 3: Ensure healthy lives and promote well-being for all at all ages
Commitment no .3: decrease the proportion of the unmet family planning needs to 10 percent by 2022.	-	Goal 3: Ensure healthy lives and promote well-being for all at all ages
Commitment no.4: incorporate comprehensive sexuality education programs into all schools by 2030	-	Goal 3: Ensure healthy lives and promote well-being for all at all ages Goal 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.

[9] The national agenda did not specifically address maternal mortality, but was addressed in the strategic plan for reproductive and sexual health, which depended on the general goals mentioned in the national agenda.

Commitment no.5: **Draw on demographic diversity to drive economic growth and achieve sustainable development**	National Policy 7: -Strengthen the response of local bodies to citizens by decentralizing the provision of services at the local level, where local authorities have the capacity to do so -Enhance the local economy	Goal 1: End poverty in all its forms everywhere Goal 8: Promote inclusive and sustainable economic growth, employment and decent work for all
	National Policy 8: Promote accountability and transparency	Goal 10: Reduce inequality within and among countries
	National Policy 12: Provide decent employment for all	
	National Policy 15: Eradicate poverty	
	National Policy 19: Our youth, Our Future	
Commitment no.6: **Eliminate gender-based violence**	National Policy 3: Modernization and unification of the legal and legislative system in accordance with the international obligations of the State of Palestine to the international commitments.	Goal 5: Achieve gender equality and empower all women and girls Goal 3: Ensure healthy lives and promote well-being for all at all ages
	National Policy 8: Promote accountability and transparency	
	National Policy 15: Eradicate poverty	
	National Policy 17: Promoting citizens' access to justice and national politics	
	National Policy 18: Promoting gender equality and women's empowerment	

In view of the importance of the global orientation of population and development, the Council of Ministers formed a National Population Committee in 2006, chaired by the Prime Minister.[10] Based on the decision no.22 of 2006, the tasks of the Committee included establishing a national and official favorable climate to set the population concerns on the National Agenda and to determine and adopt national population policies with general objectives that are translated into quantitative and qualitative goals. Further, the Committee is to adopt necessary policy instruments and to ensure that population policies are integrated into the national planning process and in coordination with partners.

Despite the Palestinian commitment to the Nairobi Summit and other treaties, the Palestinian efforts are at stake due to the political reality that derails the efforts aimed at realizing sustainability in all sectors. The Palestinian efforts are threatened due to several factors: the Israeli Occupation, the internal division between the West Bank and the Gaza Strip, the Palestinian economic dependency on the Israeli economy enforced by the Israeli control over the Palestinian financial and natural resources, and lastly the outbreak of COVID-19 and its impact on the social, economic and health rights (See page, 50).

Israel openly violates international humanitarian law and human rights law and breaches both International Covenants on Economic, Social and Cultural Rights and Civil and Political Rights. Its oppressive practices destroy all potentials in areas such as infrastructure, economy and culture needed to achieve sustainable development. This was raised at the Nairobi Summit by Dr. Riyad Mansour the permanent observer of the State of Palestine to the United Nations, indicating that the difficulties and challenges facing the State of Palestine in order to implement its obligations, as he said:

> *"represented in the Israeli occupation of the Palestinian Territory, including East Jerusalem, and its systematic and widespread racist practices, the latest of which was the Israeli aggression on the Gaza Strip, which claimed its victims are many Palestinian citizens, including women and children, as it is not possible to advance the social, economic and demographic reality of the Palestinian people and achieve the goals of sustainable development and access to basic services and access to natural resources in light of the continuation of this occupation".* [11]

[10]The Committee consists of: Minister of Planning, Minister of Health, Minister of Social Affairs (Ministry of Social Development), Higher Council of Youth and Sports, Minister of Women's Affairs, Minister of Education and higher Education, Minister of Finance and planning, Minister of Local Government, Chief Justice, two academic persons appointed by the Prime Minister, two representatives from the NGO network and two representatives from Palestine's General Union for Charitable Societies.

[11] http://www.mofa.pna.ps/ar-jo/mediaoffice/politicalstatement

In view of this reality, realizing sustainable development is almost impossible, as achieving the SDGs requires maintaining the interconnected nature of all goals at all levels, including the Nairobi Summit Commitments, to enable Palestine to take practical actions at all levels. Thus, the international community, States, international civil society and the United Nations have a responsibility to hold the Occupying Power accountable for the violation of the international conventions, and the hindrance of the Palestinian efforts: emphasizing that "planet and people" are two main components of sustainable development.

Despite these fundamental obstacles to achieving the international obligations, this report aims to address and examine the legal framework and procedural measures that the State of Palestine has taken in order to fulfill its international obligations at the Nairobi Summit. The following sections set forth the legal framework and its relationship to SRH and will present the national indicators in health in general and SRH in particular, to address the national achievements and challenges for each commitment.

5.1 The legal framework in Palestine and its role in achieving State commitment towards Sexual and reproductive health rights for all

The legal system in Palestine is affected by the general political situation. The legal system of the state of Palestine applies a group of British, Jordanians, Egyptians, Ottomans and Palestinian laws as well as Israeli military orders. Some of these laws have not been modified since 1948, while others have been slightly modified in some articles. The legal system faces several challenges, including:1) the administrative and security divisions that arose in the West Bank as a result of political friction after the Oslo Agreement, in addition to Israeli policy to impose the separation between the West Bank and Gaza Strip adding to the internal division that resulted in the establishment of two governments. This situation led to an increase in the legal dispersion, and contributed to the difficulty of unifying legislations and laws. The amendments that occur in the legal system in the West Bank do not apply in the Gaza Strip. Add to this, the Palestine Legislative Council (PLC) has not met in regular sessions since the 2007 West Bank-Gaza split, and has since been effectively frozen.

The PLC was created, as part of the Oslo Accords, as the legislative branch of the Palestinian Authority (PA) and is meant to represent Palestinians residing in oPt (i.e. Gaza, the West Bank, and East Jerusalem). The PLC as well as the prime minister and his Government approve the PA's budget. Articles (2&5) of the Palestinian Basic Law state clearly that the PLC as a representative body of the Palestinian people is the main source for the adoption and approval of the laws and its amendments and assert its responsibility in the monitoring and accountability on the Government and the President. With the PA legislative and oversight process effectively frozen, President Mahmoud Abbas has since been leading through presidential decrees.

Most of the prevailing laws, starting with the Palestinian Basic Law, deal with citizens' issues in general, and guarantee their rights, noting that the Palestinian laws that were drafted and adopted after the establishment of the PA, are more updated and formulated in line with human rights. For example, the adoption of the Palestinian Child Law (2004) and its amendments in 2012, the Labor Law in 2000 and the Civil Service Law 2005 come as a huge step towards the enhancement of human rights in the Palestinian Territories. However, when analyzing these laws from a gender perspective, many local studies[12] have highlighted the gender gap that contradicts with the international obligations of the State of Palestine, which was ratified in 2014, in addition to the obligations to the Nairobi Summit 2019.

5.2 Legal gaps modifications to pave the way for implementing the Country's commitments

Sexual and reproductive health is an issue that interrelates and crosscuts with other human rights. Therefore, the laws dealt with in this part of the report are those that have direct impact on the right to SRH.

With the establishment of the Palestinian Authority in 1993, and the approach of "state-building", a social movement endorsed by feminists, women and human rights institutions for legal reforms started calling for the importance of adopting laws based on human rights, women rights and full equality.

The integration of Women's Rights in Palestinian laws creates societal and political controversy especially in regards to the Penal Code and the Personal Status Laws, which determine the social relations within the family unit. The legislative reality in Palestine cannot be examined apart from the political context, where social and family relations are leverage points used in decision-making negotiations held at national level. Consequently, women and girls' rights in general, and their reproductive and sexual rights in specific, are the most affected by this interconnected relationship, as they not only pose a social dilemma, but a political one too.

There have been attempts by the Palestinian Government to amend and develop the current Palestinian Laws in order to promote the rights of women and girls in Palestine, but within the customary societal limits that the local culture permits. Thus far, the adopted laws promoted limited gender equality and were mostly insensitive to women's and girls' rights in the private space (family life). That is, although women were granted limited rights that provide them with limited legal protection, it should be highlighted that

[12] See in: Al-Botmeh, Reem, 2012. A review of Palestinian legislation from a Women's Rights perspective, UNDP. Also, in: Shalhoub-Kevorkian, Nadera, 2002. Femicide and the Palestinian Criminal Justice System: Seeds of Change in the Context of State Building?

they are unable to enjoy such opportunities due to the ongoing implementation of the old local laws, which endorse the dominance of patriarchal traditions in the society.

The Palestinian Basic Law stipulates equality and freedom in order to achieve justice and equality for all without discrimination; however, this contradicts the provisions of the applicable laws, especially the Personal Status Laws and the Penal Code. Even though the Basic Law clearly stipulates in Article (9) that "Palestinians shall be equal before the law and the judiciary, without distinction based upon race, sex, color, religion, political views or disability",[13] little change was witnessed in regards to achieving equality following the principles of the Basic Law.

Examining the Articles of the Basic Law, the source of local laws, reflects contradiction with the principle of equality despite of the fact that the Basic Law guarantees the rights of all citizens without discrimination. For example, in Article 4/2, which clearly expresses that "[t]he principles of Islamic *Shari'a* shall be a principal source of legislation",[14] is a keystone in the process of law-making. With regard to the right to health, it was not directly addressed in the Basic Law. However, Article 10 expresses that the obligation to human rights and fundamental freedoms is binding, and stressed that the "Palestinian National Authority shall work without delay to become a party to regional and international declarations and covenants that protect human rights".[15] Further, the Law guarantees compulsory education for all, the right to health and social insurance, and the right to work for every citizen, providing that labor relations are to be regulated in order to ensure justice for all and to provide care, security, health and social care.[16] (Al-muqtafi, 2003)

Labor Law:

The Palestinian labor law (No.7) 2000, is considered one of the most harmonized Palestinian laws with human rights. All sectors from women's and human rights organizations, Community based associations and Labor union have participated in the process of discussing the law. The law guaranteed many rights for women working in the formal and informal sectors. However, the following existing gaps should be addressed:

1. Domestic Workers: labor law does not apply to domestic workers. The President's Decree No.2 of 2003 provides some protections for domestic workers relating to the number of working hours, the right to rest, remuneration, post-contract rights and compensation.

[13] https://www.palestinianbasiclaw.org/basic-law/2003-amended-basic-law
[14] https://www.palestinianbasiclaw.org/basic-law/2003-amended-basic-law
[15] https://www.palestinianbasiclaw.org/basic-law/2003-amended-basic-law
[16] http://muqtafi.birzeit.edu/pg/getleg.asp?id=14138

2. Paid Maternity leave: labor law allows for maternity leave of 12 weeks, which is less than the ILO standard of 14 weeks.
3. Legal restrictions on women's work: some legal restrictions exist on women's employment in certain industries that apply to men such as mining.
4. Absence of articles that protect women against violence in the workplace.

Concerning the Personal Status Law and the Penal Code, the debate remains, "what law do we want to guarantee the rights of women and girls?" The debate was met by opposition because it was initiated from a gender rights perspective. The situation gave opportunities for some to use the debate to practice political pressure on decision-makers. This in turn, put pressure on the Government that led to the postponement of the debate for the sake of preserving the political national interests. Since 1993 to date, there was numerous work done by women organizations to draft a unified personal status law and penal code, but minor changes have been achieved.

Personal Status Law:

In matters relating to marriage and family relations, the provisions of the Jordanian Personal Status Law of 1976 apply in the West Bank, and the Egyptian Family Rights Law of 1954 apply in the common law culture. The Islamic Family Laws applied in the West Bank and the Gaza Strip discriminate against women in the matters of marriage, divorce and child custody and inheritance decisions.

With regard to the age of marriage, the decision was referred to President Mahmoud Abbas to issue a decree to amend Article 5 of the Personal Status Law of 76 to set the age of marriage at 18 for both sexes, with exceptions decided by the Chief Justice. Yet in light of the political division between the West Bank and the Gaza Strip, the amendment was not adopted by the latter. Further, despite of the importance of the decision, the exception grants the judge the authority to rule on the marriage of minors, which might be influenced by the judge's whims and convictions, and thus putting the issue of determining the age of marriage within a prevailing patriarchal culture under question. However, no amendments to the Penal Code have been made to criminalize those who marry his/her daughter under the age of 18, which requires a complementarity and homogeneous relationship between the laws to establish a unified legislative framework.

In the same context, the laws reflect gender-based inequality by granting men the permission to marry up to four wives, bound by the "condition" of ensuring justice and equality among wives, while women are prohibited from marrying without the permission of her guardian (Saadeh, Barghouti and Mo'aqat, 2019). The laws express that women who have previously married or women who have obtained the court's consent may marry without the permission of a guardian (Personal Status Law 16, Articles 6and 13 and

Egyptian Law No. 303 Article 9). Further, the laws allow men to annul their marriage by wording (you are hereby divorced) without the consent of the wife, and in her absence. Yet, women can only ask for a divorce on basis of "conflict and disagreement" as expressed by the Personal Status Law applied in the West Bank, or on basis of "harm" as expressed by the Egyptian Law applied in the Gaza Strip. In this reality, where men have the right to terminate the marriage without the consent of their wives, women feel emotionally, politically and economically insecure (Saadeh, Barghouti and Mo'aqat, 2019).

The aspect of gender inequality is also highlighted in women's right to ownership. Although the legislations and the Shari'a Law give women the right to own and manage property independently, yet in reality, women face legal, cultural and societal barriers that deny them such rights. For instance, male relatives coerce women into giving up their right to inheritance under the pretext of preserving the family fortune and heirloom (Saadeh, Barghouti and Mo'aqat, 2019). The two laws also address the issue of women's obedience to their husbands in exchange for the maintenance, which women are threatened to lose in case of disobedience.

Penal Code

Concerning the Penal Code, the Palestinian Government's efforts to provide women with security were highlighted in the amendment made to the Penal Code. For example, Article 98 states "[P]erpetrators may take advantage of the extenuating excuse, in cases of having committed crimes in a fit of rage that were the result of an unlawful and dangerous act by the victim". The Government made the amendment by law decree: "The perpetrator who commits a crime while he is in fit of fury resulting from an unlawful and dangerous act on the part of the victim shall benefit from a mitigating excuse. The perpetrator shall not benefit from such mitigating excuse in the event the crime is committed against a female under the pretext of honour". [17] Additionally, the Government repealed Article 308 of the Penal Code, which allowed the rapists to escape punishment if they married the victim. As for Article 99, work is still needed to end the violation of women's and girls' rights stated in the article, it states a reduction in penalty in honor crime cases, up to half of the sentencing, if the family of the deceased waive their personal rights. Unfortunately, these amendments are only enforced in the West Bank and do not apply in the Gaza Strip, thus women lives are still threatened in the absence of a unified body of legislation in Palestine, as reported femicide cases reached 24 cases in 2019. Further, the Penal Code still legalizes beatings as a disciplinary tool for children and criminalizes abortion without a legally based medical reason, binding for both the woman and the doctor. Moreover, the Penal Code lacks articles that criminalize sexual violence in marriage and marital rape. In addition, it does not address economic

[17] https://security-legislation.ps/node/100092/compare

violence as a violation of women's and girls' rights. In many cases, husbands deprived their wives of receiving daily expenses necessary for the survival of the family.

Adding to the previous issues in the penal code, there are some that are not covered:

1. Female Genital Mutilation/Cutting: there is no legal prohibition since it is not reported in Palestine.
2. Marital Rape is not criminalized.
3. Abortion for rape survivors is prohibited.
4. Emotional/ Psychological violence: there is no legal prohibition

In order to fulfill the commitment to the Nairobi Summit and the SDGs 2030, the Palestinian Government needs to prioritize the legal reform of the Personal Status Law and Penal Code in conformity with CEDAW and other international agreements on gender discrimination, which was ratified by Palestine in 2014. The efforts of the Palestinian Government and women rights organizations are threatened to be hindered or derailed due to the social pressure practiced by the hardline Islamic movements calling to cancel the commitment to CEDAW. They claim that it opposes in its provisions the Islamic Sharia, particularly Article 17, on the personal status, and Article 7 on health rights and in particular the right to abortion. Thus, the issue of women's and girls' rights became a political tool utilized to accomplish political goals at the expense of women's and girls' health and security.

Women's rights institutions have also worked on the drafting of the Family Protection against Violence law since 2004. The law was proposed by the Ministry of Social Development to the Ministry of Cabinet in 2020, after several amendments to the provisions of the law to keep it in line with the local culture. The philosophy of the law is based on the importance of protecting women and girls victims of violence, keeping the aggressor from living in the house and to foster the awareness concerning the individual's right to report violence. The law faces an anti-campaign aiming at stopping it from being passed under the pretext of its opposition to the Islamic Shari'a.

The national studies (Barghouti and Saadeh, 2014; Islah, 2008) shed light on the complex and troubling issue of violence against women that is deeply rooted in the patriarchal society, resonating in the male supreme authority, and its ownership and control of resources. The Palestinian society is dominated by a hierarchical culture and a community and family structure that promotes gender inequality; it marginalizes the role of women and the underprivileged, and strengthens men's hold to power and over resources. The prevailing social norms, traditions and expectations act as incubators for domestic violence, where males exercise dominance and women are expected to be submissive (Saadeh, Barghouti and Mo'aqat, 2019). On that basis, the Family Protection against Violence Law was faced with strong opposition as it deprives those in power and authority

within the family of their control, particularly over women and girls. Thus, it is vital to enhance the legal frameworks and institutions in order to build a safe environment to ensure women's and girls' security. It is acknowledged that a weak legal system generally fails to criminalize domestic violence, creates an environment that accepts gender-based violence and consequently hinders women access to equality. In Palestine, the penal code laws do not punish acts of domestic violence because they stem from the traditional belief that family issues must be managed within family boundaries.

In conclusion, the Palestinian Government needs to step up its efforts to integrate women rights in the Palestinian legal framework in order to bridge the gender gap at all levels, socially, economically and politically. The first step towards this goal is to amend the Personal Status Law and the Penal Code and to adopt the Family Protection against Violence law. Such measures will help develop women's self-awareness, reduce the marginalization of women and the domestic violence rates, promote women's political and socio-economic participation and enhance their access to SRH care. Women should become individuals with full rights, able to keep their inheritance, to use family planning methods, to choose their life partners and to make life decisions.

5.3 Health at glance in the Palestinian Context

- According to the PCBS, Palestine is experiencing population growth. The Population, Housing and Establishment Census 2017 highlighted, that the total population of Palestine in the year 2017 was 4.780.978 comparing to 3,767,549 in 2007 with an increase of 26%. The estimated annual population growth rate is 2.8%. At 77.1%, the majority of the population lived in urban areas, 14.6%in rural areas, and 8.3% in refugee camps (PCBS, 2019, p. 40).

- Based on PCBS, population pyramid shows that the Palestinian society is a young one. It shows that, the age group within (0-17) forms 47% of the population, and the age group within (18-29) forms 24% of the population, whereas the age group (60 and over) forms only 5.2% of the population (PCBS, 2017). A report prepared by the UNFPA under the title "Palestine 2030 - Demographic Change: Opportunities for Development" projects that the Palestinian population will reach 6.9 million in the year 2030, and goes further to project that in 2050 it will be expected to double, reaching 9.5 million (UNFPA, 2016, p.8). The UNFPA report also pinpointed that the population growth is caused by the change in the population momentum happening due to the change in the population pyramid. It suggests two contributing factors that would lead to the suggested increase in population: the young age structure of the society and the large percentage of women in reproductive age. This means that the Government of Palestine will need to respond appropriately and to double the efforts in order to meet the needs of the growing population in areas such as, education, health, housing and workforce.

- In regards to the composition of population by gender, the 2017 Census prepared by PCBS shows that the percentage of males in Palestine was 50.9%, whereas the percentage of females was 49.1%, in a ratio male to female 103.3: 100.

- Palestine has been witnessing an improvement in life expectancy since the beginning of the last two decades (PCBS, 2017). Life expectancy has increased about 5-8 years during the last two decades (PCBS, 2017). It increased for both males and females from 67.0 years in 1992 to 72.3 years for males and 75.4 years for females by the midst of 2017. Life expectancy is expected to increase during the coming years to reach 72.8 years for males and 75.7 years for females in 2020. The governmental and non-governmental interventions enhanced the health sector, leading to a rise in the life expectancy average for both males and females. However, due to the Israeli occupation prejudiced practices and restrictions, and due to the reliance on the foreign funding, Palestine still faces many challenges that would limit its success.

- The average family size is 5.1 people per household (4.8 in the West Bank and 5.6 in Gaza). Around 78.3% of the population (excluding residents of East Jerusalem) has health insurance, 98.1% is educated, 27.2% is unemployed, and 5.8% is disabled (PNIPH, 2017).

- The Palestinian Ministry of Health (MOH), UNRWA, Military Health Services, NGOs, and the private sector cover primary, secondary, and tertiary health care services. There are 743 primary health care centers in Palestine (583 in the West Bank and 160 in Gaza), 468 PHC centers out of the total number are followed to MOH, and 82 hospitals (52 in the West Bank, including East Jerusalem, and 30 in Gaza) (MOH, 2018).

- According to the Palestinian Ministry of Health (2017), the burden of non-communicable diseases in Palestine is high. The leading causes of death are cardiovascular diseases, cancer, cerebrovascular diseases, conditions in perinatal period, and diabetes. Related risk-factors such as smoking, unhealthy diet, and sedentary lifestyle are widespread (MOH, 2017).

- Due to political instability and worsening living conditions in Palestine but especially in Gaza, disabilities, traumatic injuries, and amputations are increasing. The burden of mental and psychological disorders is prevalent due to the occupation's continuous use of violence, lack of personal security, human rights violations, and restrictions on movement (PNIPH, 2017).

- Access to health services in the West Bank is restricted by the Israeli checkpoints and separation wall. Palestinians, especially in remote areas C, face difficulty in accessing health services, including SRH. They also face difficulty in accessing specialized hospitals in East Jerusalem, such as Augusta Victoria Hospital, which specializes in cancer. The situation is becoming increasingly difficult for patients from the Gaza Strip to access health services, both in the West Bank and outside Palestine. Medical

staff are also facing difficulty in reaching their workplaces in the Palestinian areas that yield to Israeli control, such as areas C and Jerusalem.

- Water, Sanitation, Hygiene and energy is facing a major problem due to the Israeli violations which undermined fragile living conditions. In the Gaza strip, only 10% of households have access to clean and safe drinking water, 97% of the water drawn from coastal aquifer is unfit for human consumption and shoreline is polluted. In the West Bank, the majority of population has direct access to clean water but in insufficient quantities (UNICEF, 2018), because of its conversion to the use of settlements by the Israeli occupation authority. Families living in Area C often spend more than 50% of their income buying water brought in by truck (Institute of Women's Studies& OXFAM, 2019). In Gaza Strip inly 38% of the population is connected to sewage lines comparing to 82% in the West Bank (UNICEF, 2018). In 2017, there was only 4-5 hours of electricity per day in the Gaza Strip (UNICEF, 2018). The ongoing power shortage has severely impacted the availability of essential services, particularly health (OCHA, no date, p.11).
- A World Bank report (2018) shows that around 29% of Palestinians live in poverty, while 2.5 million are in need of humanitarian assistance. According to the World Food Programme (2018), 22.5 million are food insecure.
- Based on MOH annual report (2019) shows an increase in the number of medical staff of doctors and nurses between 2014 and 2018. The increase of nurses and midwives by approximately 353, as for numbers of doctors, the increase of approximately 213.
- According to the Palestinian Central Bureau of Statistics (2018), total current expenditure on health reached 1.571 million USD (9.8% of GDP). Expenditure is covered by the Government (around 44.8%), private insurance companies (around 2.3%), households/out-of-pocket (around 39.5%), non-profit organizations (around 13.4%). According to MOH, budget deficit reached 414,134 in 2019 (2017-2022, p.38).

5.4. The National Indicators on Sexual and Reproductive Health Rights in Palestine

The Palestinian Ministry of Health (MOH) set a national strategy that recognizes the SRH as a vital and necessary element in the process of development and state building. The MOH and its partners from the non-governmental, civil and private institutions work together in order to promote the SRH system and services, yet they focus their efforts on women, thus minimizing the importance of providing same services to other community groups e.g. adolescents and youth.

Addressing SRH in Palestine mainly covers two aspects: childbirth and motherhood. It is a perspective driven by the prevailing societal concept of women's traditional reproductive roles and adopted by the MOH. The Ministry consequently shaped its policy

and built its strategy and interventions in accordance with that vision. Therefore, tackling the topic of SRH came as an issue related to marriage and women's role of childbearing rather than the comprehensive SRH needs of all people. In addition, reproductive health focused on physical health only, excluding attention to mental health.

The MOH took the initiative recently of addressing SRH in a more comprehensive view. The MOH reflected this vision toward the SRH in the National Reproductive and Sexual Health Strategy (NRSHS) (2018-2022). The strategy set its vision "to attain the highest possible level of SRHR towards a better and a healthier future in Palestine" to all groups of society, and not only women. The NRHS (2018-2022) stresses on three main objectives that intersect with the Nairobi Commitments as follows:

1. Upholding the right to have access to high quality SRH care.
2. Raising societal awareness, promoting preventive care and adopting better health behavior in order to improve the SRH care services provided to different age groups.
3. Promoting the sustainability and the governance of the SRH care sector.

The following sections will present the national indicators on SRH based on NRHS 2018-2022 and its feasibility to the state commitment to the Nairobi Summit's PoA. Each indicator will start with a description of the current situation, it will be followed by a presentation of the Government's actions and the challenges set for each commitment, as well as the related policies that the State of Palestine is obliged to implement by the end of 2030.

National Indicator: Age of Marriage

State commitment (2): reduce the rates of maternal mortality, diseases and imminent complications.

State commitment (6): eliminate gender-based violence.

Palestine has witnessed a decrease in early marriages; nevertheless, the decline has not reached the stage of eradicating early marriages. The PCBS statistical data of 2018 on men and women indicated that the proportion of women in the age group (20-24) who got married under the age of 18 is on the decline in the Palestinian society. It dropped from 30.3% in 1997 to 10.8% in 2017 (PCBS, 2018, p.26). Despite the low rate of early marriage, there is a discrepancy between the governorates. In the governorates of the West Bank, the highest rate of early marriage for females was in the Hebron governorate 38% of the total number of married females, and in the governorates of the Gaza Strip, the highest rate of early marriage for females was in the Gaza Governorate at 42%, out of the total number of females who married (PCBS, 2019).

The decree of raising the age of marriage[18] at 18 years is still not enforcement, and the implementation and the follow-up mechanism has not been monitored. Early marriage has legal, social-economic and health implications. The legal issue is related to the confusion between the judicial systems. There is a contradiction between a young woman's ability to appear before the Sharia court and not before civil judiciary and public prosecution. That is, a young female under the age of 18 has the legal capacity to appear before a Sharia court, but at the same time, she cannot move a criminal complaint. In addition, a young woman's guardian has the right to waive cases, and thus waive a complaint, without her consent, which means that she may be deprived of her rights. This contradiction allows her to be a plaintiff in an alimony suit, but at the same time, she cannot spend a check related to the alimony. This complex and contradictory issue where young females are seen on one hand as adults, grown women, wives, and foster mother, and on the other hand are considered children who cannot be responsible for themselves, exposes young females to great harm, and deprives them of their basic rights. Concerning the health issue, young females are more exposed to recurrent infections, anemia, premature births, preeclampsia, childbirth complications, and cases of postpartum hemorrhage. For example, preeclampsia occurs more often among minors, which can also lead to death. Eventually, this would put the health and the lives of the young mothers and the health of their babies at risk. With regard to social and economic impacts, it deprives them of their right to education and work and the right to self-determination. This will make them more vulnerable to poverty.

Regarding the decision of marriage**,** the proportion of male (15-29 years) who are the decision-makers in the matter of to whom they get married was 63%, compared with 33% for females (PCBS, 2015). This is attributed to the patriarchal culture which increase in unstable political situation, that prevents girls from self-determination as the Personal Status Law conditions male guardianship over women and girls marriage-related matters.

National Indicator: Fertility

State commitment (1): Secure access to sexual and reproductive health (SRH) as a part of universal health coverage.

State commitment (2): reduce the rates of maternal mortality, diseases and imminent complications.

State commitment (3): decrease the proportion of the unmet family planning needs to 10% by 2022.

[18] Despite the fact the Palestinian Cabinet approved to raise the age of marriage to 18, there is no evidence that it has been enforced.

Early motherhood remains a common phenomenon in the West Bank and Gaza Strip, as according to MICS survey, the adolescent birth rate is 48 per 1000 (PCBS, 2014) and this is reflected in the fertility rate. According to data from the PCBS, the total fertility rate among women of childbearing age (15-49) reached 4.1 in 2018, with a higher rate in Gaza Strip reaching 4.5.

The statistical data prepared in 2018 by PCBS on women and men in Palestine highlighted that factors related to the geographical region, mother's education level and wealth index affected the proportion of childbirth among married women within the age group (20-24). The report indicated that 22.0% of women in that age group had a child before the age of 18. The percentage is three times higher among women with primary education compared to women with higher education level. Further, it was noticed that the percentage of women having a child under the age of 18 increases among impoverished women (PCBS, 2018, p37).

National Indicator: Maternal Health Care to Ensure Safe Pregnancy and Childbirth

State commitment (2): reduce the rates of maternal mortality, diseases and imminent complications.

State commitment (5): draw on demographic diversity to drive economic growth and achieve sustainable development.

Health Care for pregnant Women: based on MOH report (2018), in 2018, the total number of pregnant women visits to PHC was 155,603. The total number of pregnant women registered (first time) in the MOH PHC centers was 34,605, with coverage of 46.5% of pregnant women. The average visit rate for pregnant women to the centers during pregnancy was 4.5 visits.

In regards to high- risk pregnancies, the MOH reports reflected an increase in the number pregnant women who received services for high-risk pregnancies between the years 2016 and 2018. In 2016, 5.067 women out of 26.341 total number of pregnancies were referred to high-risk pregnancy clinics, the number of cases formed 15.5% of total cases registered at the MOH's maternity and childcare unit (PCBS, 2017, p.43). In comparison, in the year 2018, the total number of visits was 32.249. The number of high-risk pregnancies referred to the high-risk pregnancy centers reached 6028, about 17.4% of the total number registered in the primary care centers (MOH, 2018. P.29).

The MOH report (2018) highlighted that the high- risk cases referred to the high-risk pregnancy centers were related to clotting and tubal implantation. Other cases were referred due to complications related to previous pregnancies: recurrent miscarriages forming 30.5% and C-section deliveries forming 34.8% of cases (MOH, 2018. P.29). Further,

in an interview conducted with an official in the Public Health Care Department shed light on the increase of C-section deliverers among women as an urgent and serious issue. The lack of monitoring and follow-up tools in the private sector encouraged the unnecessary but lucrative C-section deliveries.

- As for maternal mortality, prior to 2009, Palestine lacked a monitoring tool to screen and monitor maternal mortality. Later, the MOH set a system to register and observe maternal deaths (MOH, 2017, p.30). According to MOH report (2019), the year 2017 witnessed a decline in the number of maternal deaths, it reached 6 and it rise to 19.5 in 2019 (MOH, 2019). An official in the MOH[19] suggested that the gap between 2017 and 2019, was more likely due to the monitoring mechanisms set by the MOH, which he stressed need to be further developed. The MOH monitors and registers the cases reported to the Ministry, it does not conduct field visits to the centers for monitoring purposes. Based on MOH report 2019, a gap in MMR can be seen between estimation and surveillance rates, despite the decrease in maternal mortality rate. This could indicate an underreporting issue in surveillance. Based on the same report, results for the year 2019 revealed that MMR was higher in Gaza strip than West Bank (9 in the West Bank and 17 in the Gaza Strip). All West Bank maternal deaths were among women aged 20 to 37 years; this age group also has the most pregnancies. Pregnancies at early ages were noticeable[20] (MOH, 2019, p.9).

National Indicator: Live Births and Child Mortality

State commitment (1): Secure access to sexual and reproductive health (SRH) as a part of universal health coverage.

State commitment (2): reduce the rates of maternal mortality, diseases and imminent complications.

Palestine is one of the countries that have good childbirth care system. In 2016, the data showed that only 0.1% of childbirths were deliveries conducted at home, and 99.9% of childbirths took place in qualified health care facilities. Trained and specialized medical personnel assisted them. As the MOH provides the Palestinian people with state health insurance, for an annual nominal fee that fully covers childbirth, consequently 53.6% of the total deliveries took place at one of the Ministry's hospitals (MOH, 2017).

In 2016, the number of live births in Palestine was 130.497, of which 72.327 children were born in the West Bank (55.4% of total births), 58.150 of the births took place in government hospitals (forming 44.6% of the total registered births in 2016). As for child

[19] Interview conducted with Dr. Jawad Bitar, Director General of the Information Center of the Ministry of Health, June 2020.

[20] The report did not obtain sociodemographic profile for maternal deaths in the Gaza Strip.

mortality numbers for the same year, it was estimated at 10940 deaths of which 7.177 were registered in the West Bank forming 65.5% of the reported deaths in Palestine. As for the Gaza Strip, 763.3 child deaths were reported (34.4%) (MOH, 2017. P.30). Infant mortality rate in Palestine witnessed a decline. Based on PCBS, infant rate was 18 deaths per 1,000 live births under one year of age, and 22 deaths per 1,000 live births for children under-five (PCBS, 2015) compared to 28 deaths per 1,000 live in 2009.

As for child healthcare and nutrition, the MOH statistics reflected fluctuation in the proportion of child nutrition among children under the age of five between the years 2000 and 2014. In 2000, child nutrition was 7.5%, rising to 10.3% in 2010, and declining to 7.4% in 2014. The proportion of children with fragile health reached 1.4% in 2000, rising to 3.2% in 2010, and then declining to 1.2% in 2014. Further, children under the age of five suffered from weight loss reaching at 2.5% in 2000 and decreasing to 1.4% in 2014 (MOH, 2014. P.38). In the West Bank, 38.7% of infants aged 12 months suffered from anemia as shown in the 2017 statistics; 94.2% of the registered cases suffered from mild anemia (MOH, 2017. P.38). In addition, the percentage of children within the age group (0-17) with health insurance reached 80.0% in 2016, of which 67.2% lived in the West bank, and 95.6% received public services (MOH, 2017, p.39). The MOH PHC centers provide supplements for children under the age of three who receive PHC services at their clinics and provide PKU and TSH tests. The coverage rate was 98.2% of the total number of reported live births (MOH, 2018).

National Indicator: Access to abortion services and post- abortion care

State commitment (1): Secure access to sexual and reproductive health (SRH) as a part of universal health coverage.

State commitment (2): reduce the rates of maternal mortality, diseases and imminent complications.

Women in Palestine face many challenges that would hinder their safe access to abortion care services, as abortion in Palestine is illegal by law. The social and religious contexts in Palestine reject and prohibit abortion and hamper women's safe access to abortion care. Further, the legal system in Palestine incriminates abortion or termination of pregnancies as stated in Article 8 of the Palestinian Public Health Law No. 20 (2004) "it is forbidden to abort any pregnant woman by any means, unless there was an urgent reason to save her life and under the condition of having two specialized physicians as witnesses and a written approval from the pregnant woman".[21] It also states that a record of the pregnant woman's name and the date and cause of the abortion is to be kept by the medical institution where the procedure was performed. By Law, the records are to be kept for a

[21] http://www.hdip.org/public%20health%20law%20English.pdf

minimum period of ten years. Further, abortion and termination of pregnancy is criminalized under both the Jordanian Penal Code Law (1966) applied in the West Bank, and the Egyptian Law applied in the Gaza Strip. Both Laws incriminate and punish women who seek abortion along with any medical personnel who performed the procedure.

Consequently, a woman's physical and mental health is at risk as she is denied safe access to abortion services. In cases where women would seek an abortion, perhaps in the case of rape, they find themselves obliged to seek unsafe termination of pregnancies at private clinics or at home using primitive tools. This would put their lives at risk.

Moreover, the NRHS strategy avoids addressing the issue of abortion as it criminalized by Law. This reality made it difficult for institutions to gather information about abortion services and about abortion-related deaths and complications. The national statistics lack vital data on the topic needed to monitor unsafe abortions, and hence the local studies covering this area of reproductive health care services lacked information and data necessary to tackle the issue or to raise awareness.

National Indicator: use of contraceptives, access to information, guidance and contraceptive services

State Commitment (3): decrease the proportion of the unmet family planning needs to 10% by 2022.

Primary health care centers in Palestine are the key providers of family planning services. According to PCBS (2014), between 2000 and 2014, there has been a slow increase in acceptance of use of contraceptives as a method of family planning reaching to 51% in 2000, rising to 53% in 2010, and rising to 57% in 2014. The annual increase for the last 15 years was estimated at 0.78%, with a higher increase in Gaza (1.2%) than in the West Bank (0.74%). This slow growth in acceptance of contraceptives reflect the need for monitoring and awareness campaigns as well as for efforts aiming at providing safe, quick and affordable access to contraceptives to all women (Khader and Abu Hamad, 2018). Reproductive health care and rights promote safe and affordable access to contraceptives, and in the case of Palestine, impoverished and underprivileged families have limited access to such services. The study "Family Planning Services in Palestine: Challenges and Opportunities" (Khader and Abu Hamad, 2018) highlighted that 42.6% of the family planning services in Palestine are provided by the private sector, followed by the services provided by the UNRWA in the refugee camps reaching to 27%. This worrying reality of the limited access of women from all groups of the society to family planning methods need to be tackled and changed.

According to the 2014 MICS, among users of family planning methods, about one in eight use less effective "traditional" methods (13% of all married women surveyed at childbearing age) and 43% of married women highlighted that they refrain from using any.

The unmet need, in the West Bank and Gaza Strip, for contraception in 2014 was 11%, (5% for reduction and 6% for spacing). It was indicated that between 2006 and 2014, there was a reduction in the unmet needs by about 42%, an achievement that can be attributed to the improvement of provided services and the enhanced accessibility to family planning methods.

National Indicator: Prevention and Treatment of HIV and AIDS

State commitment (4): incorporate comprehensive sexuality education programs into all schools by 2030.

State commitment (1): Secure access to sexual and reproductive health (SRH) as a part of universal health coverage.

The Palestinian society does not tolerate out of wedlock relationships, despite of the fact they do exist, with regards to sexual activity, 25% of older (19-24) unmarried male youth and 22% of younger (17-18) male youth report having had any sexual experience. Rates for females were generally similar" (Youth in Palestine, 2017 referring to Glick et al, P.3.), and has a strict opinion towards AIDS and HIV as it is perceived as a disease related to extramarital relations or to homosexuality. Patients of AIDS or carriers of HIV (and their families) are ostracized and stigmatized in the society, thus they avoid being tested and often diagnosed in late stages. The public health sector needs to play an active role regarding this issue in order to be able to monitor the cases and to make change in the society's behavior towards the disease. There is a need to address this issue through stigma reducing activities and improved accessibility of prevention and treatment of HIV/AIDS.

According to the SDG statistical report issued by the PCBS, only four new HIV infections were reported in 2018. Palestine is one of the countries with low rates of HIV infections and HIV cases. A total number of 102 cases have been registered since 1998, including 81 AIDS patients and 21 HIV-positive cases (PCBS, 2019, p.38). Many of the people with the disease may refrain from disclosing their sickness because of the social stigmatization that accompanies individuals with HIV. On the other hand, many Palestinians who live in Jerusalem are registered in centers affiliated with the Israeli side, including Palestinian workers working in 1948; therefore, the number of cases may be higher than registered.

National Indicator: Breast and Cervical Screening

State commitment (1): Secure access to sexual and reproductive health (SRH) as a part of universal health coverage.

Mammography and Ultrasound Mammography are provided through PHC in MOH. Women attending the government medical facilities enjoy access to high cost services at a fair cost due to the health coverage they receive, compared to the high-priced tests conducted in the private sector (MOH, 2018). Taking into account that breast cancer is considered the highest of the diseases prevalent in Palestine (MOH, 2018). In 2014, 11 centers were designated to provide this service, and the number increased to 12 in 2018. As for the cervical swab, three centers specializing in offering the service were allocated to Palestinian women from all areas, the number remained unchanged in 2014 and 2018. Despite the fact that the number of centers is insufficient to ensure the universal health coverage of women, but it is an achievement that MOH is starting to provide this important service.

National Indicator: Adolescent Health

State commitment (4): incorporate comprehensive sexuality education programs into all schools by 2030.

MOH strategy 2017-2022 includes youth-friendly health services as an objective, but there is no mention of SRHR in particular. The MOH announced the move to establish the adolescent health unit; this comes as a step toward realizing the commitment of enhancing the health of adolescents. The SRH Strategic Plan does not address any indicators of measurements and fails pinpoint needed interventions in this area. The lack of youth friendly health services (YFHS) is also a challenge, noting that the MOH adopted a national protocol on YFHS in 2015 and was updated and used in 2018, which is an opportunity towards youth health and well-being. Adolescent and Youth Friendly Centers provide one of the only healthy and secure recreational activities for youth, with over 350 centers in Palestine (UNFPA, 2017). The first YFHS model in Doura, south of Hebron Directorate of health and in three universities (Al Quds, Birzeit and Al Azhar). However, these centers are characterized by extremely low female participation. This is due to both societal constraints in allowing young women to participate in activities with men, and also often due to access issues, where young women are not able to access these centers (due to checkpoints or poor infrastructure) or at certain times (such as late at night) (UNFPA, 2017, p.11).

Based on PCBS report (2016, p.26) young people (15-29 years) reported that the most important health issues to which they are exposed are diseases resulting from unhealthy

behaviors such as smoking and drug use which consist 50% and then psychological problems estimated at 27.4%.

Adolescents and young people face different challenges in accessing their right in reproductive and sexual rights, which can be addressed as follows:

- 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 (Imam, 2019). Generally, these materials are not specifically designed for young people but for all age groups including mothers, raising awareness on pregnancy care, breast-feeding and violence against women in general (Imam, 2019).
- 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 (Imam, 2019).
- The key challenge is the social norms and traditions and the perceptions of SRH in the Palestinian Society. SRH is still 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 (Imam, 2019).
- The lack of qualified health providers trained to deliver youth friendly health services is another challenge (Imam, 2019).
- There are also challenges concerning targeting adolescent girls out of school and in remote areas, as well as adolescent boys in conservative communities (Imam, 2019).
- Lack of psychosocial support or integrated health services means that young people do not know where to turn for this information, and fear of speaking to their families due to social stigmas. This is further worsened by recent drug-related arrests by the PA, where youth are imprisoned, and sometimes tortured, by the intelligence services. This punitive rather than rehabilitative response to drug use will likely lead to re-offense once released from prison (UNFPA, 2017).

School Health Program is one of the important programs institutionalized in the MOH and the Ministry of Education (MOE). The extent to which the terminologies in the Adolescence Health Manual has changed cannot be measured because the Manual has not been published yet. It is expected to be released in August 2020. Introducing health education to the school system is part of the education process and is an important achievement. Yet, work is needed to increase the number of schools that endorse the intervention, as only 8.6% of schools integrated health education activities. Health

education programs varied between SRH, childhood, non-communicable diseases and healthy lifestyle (MOH, 2018).

National Indicator: Gender-based Violence

State commitment (6): eliminate gender-based violence

GBV is one of the crucial issues prevailing in the Palestinian society that is ignited by the prevalent traditions and the political reality. The majority of the victims of violence, whether in domestic or public sphere, are women and girls due to the dominant culture of gender inequality in legal, economic, political or social spheres.

Gender inequality is deeply rooted in the society. Women and girls are looked at as dependents and as the most vulnerable component of the family, and thus they are in need to family and society protection. This social attitude gives men privilege and power over women's and girls' lives and independence. It deprives them of their right to self-determination and the right to life based on equality and social justice. Further, the division of roles based on gender led to a culture that accepts the femicide in the name of "honor-killing"; 24 femicide cases were reported in 2019, and in the first term of 2020, the number of reported cases was 17 (GUPW, Civil Society Coalition. 2020).

The PCBS conducted three surveys[22] on gender-based violence in Palestine in the years (2005, 2019, 2011), all of which indicated that domestic violence is the most prevalent in Palestine and that women and girls are the most affected groups, and that the aggressor is the husband or the brother. According to the 2019 PCBS survey, a slight decline was witnessed in the rate of violence directed against women compared to previous years. The proportion of married women within the age group of (18-64) who experienced psychological violence in 2019 was 56.6%, compared to 58.6% in 2011 and 61.7% in 2005, and 18% of married women experienced physical violence in 2019 compared to 23.5% in 2011 and 2005. The proportion of women who experienced sexual violence was estimated at 9% in 2019, compared with 12% in 2011 and 11% in 2005. Further, social violence against women decreased significantly in 2019 to 32.5% compared to 55% in 2011. The same applies to the proportion of economic violence, as it witnessed a decline reaching to 41% in 2019 compared to 55% in 2011. In 2019, the Palestinian women's institutions requested the addition of the variable of cyber violence to the Violence Survey. This came out of necessity after the prevalence of cyber violence due to the technological advancement and the wide use of social media, especially among young women and men. The data showed that many women and girls are threatened, blackmailed and harassed through social media. According to Violence in the Palestinian Society survey of 2019, 8% of ever-married women within the age group age (18-64) have

[22]Some indicators were not measured and were added to in later surveys.

experienced one form of online violence by other social media users. Further, the proportion of cyber violence against girls reached 10% compared to 8% against boys.

In conclusion, by reviewing the indicators presented in the MOH reports and strategic plans, it can be noted that reproductive and sexual health right is not comprehensive and does not cover all population groups. The SRH Strategic Plan fails to explicitly address the rights of persons with disabilities to SRH, as they are seen as a marginalized and vulnerable group in no need to such services or awareness on the matter. This is due to relating the concept of SRH to the issue of marriage and reproduction in the society, which this community group is deprived of. Therefore, the National Agenda marginalizes these rights. As well, the plan neglects to address any interventions to develop SRH services targeting this group, they are considered outside the age group of marriage.

Further, the SRH Strategic Plan failed to address the importance of access to mental health right and services to both women and men of various age groups. The mental health program has largely been confined to schools and mental illnesses. Furthermore, the psychological well-being of adolescents or of women during pregnancy, post-pregnancy, menopause and its symptoms, is also considered unimportant.

the same regard, the trend of integrating reproductive health remains limited to the integration of women of childbearing age, so the majority of the available national indicators are limited to women in the reproductive period. This vision contributed to further marginalization of other groups in the society and their right to SRH services. The Ministry of Health's vision of SRH is addresses as two separate axes. First, reproductive health is considered to be specific to women because of their reproductive role, and second, considering sexual health limited to young women and men, especially in the middle school years (eighth, ninth, tenth), as it is seen as a preparatory stage for marriage. Consequently, the developed indicators were limited to the middle school years, targeting the age group within (14-16years). This comes from the traditional notion that sexual health is "shameful" because it violates personal and family life, which contradicts with the prevailing societal culture. Community awareness therefore needs to be developed. This requires a development of mechanisms to facilitate the integration process of the interrelated axes of SRH, and to expand it to include the right to knowledge for all groups.

5.5. Government Actions: Achievements and Challenges

State Commitment (1): Secure access to sexual and reproductive health (SRH) as a part of universal health coverage	1.1. Adopting a comprehensive digital patient file system that brings together government health facilities, non-governmental and private hospitals to improve referral systems and quality of care by 2022. 1.2. Ensuring a universal coverage of comprehensive and high-quality health care by integrating the full range of primary health care services into the National Health System, including the provision of pre-pregnancy care, in 80% of primary health care facilities by 2021**.** 1.3. Establishing of a unit dedicated to adolescent health in the Ministry of Health by 2023.

1.1. Adopting a comprehensive digital patient file system that brings together government health facilities, non-governmental and private hospitals to improve referral systems and quality of care by 2022.

Achievements*:*

- Since 2011, MOH established an electronic network to connect all government hospitals to a digital system. Currently, according to the Ministry of Healt[23], a comprehensive digital system is available in the 27 government hospitals.

1.2. Ensuring a universal coverage of comprehensive and high-quality health care by integrating the full range of primary health care services into the National Health System, including the provision of pre-pregnancy care, in 80% of primary health care facilities by 2021.

Achievements*:*

- Strong and effective primary and secondary health care systems that provide high coverage through a wide network of governmental and non-governmental service providers and the private sector. There is an increase in the number of primary health care centers and the number of hospitals and their distribution in the regions. The majority of PHC provide family planning services, and maternity centers have reached 62, distributed over 15 geographical regions in the West Bank (Ministry of Health, 2017, p. 33).

[23] Interview conducted with Dr. Jawad Bitar, Director General of the Information Center of the Ministry of Health, June2020.

- Efficient human resources are available at the three levels, although there is a gap between the proportion of the population and the number of medical staff[24], but health institutions, whether governmental, private or non-governmental, have been able to make an improvement in the quality of the health services provided.[25]
- Based on the indicators previously presented, an improvement in the quality of provided health care services contributed to the enhancement of the wellbeing of individuals. Life expectancy in Palestine has risen to 73.8, and a slight decline in fertility rate was witnessed, which can be contributed to the decline in the rate of early marriage (PCBS, 2018). It is expected to witness further decline in the fertility rate with the new decree issued by the Government of Palestine raising the legal age of marriage to 18 years. A drop in Infant mortality and the under-five years was also witnessed in Palestine.
- Women's Pre-pregnancy Health Care: the SRH Strategic Plan indicates that the Ministry is working on developing and instituting such programs, and that is milestone towards achieving inclusive coverage.
- Breast and Cervical Screening Programs are provided by MOH centers with low cost.
- The government health insurance provides a uniform set of health services to registered individuals, regardless of the premiums paid by the insurers. Under this system, the MOH is obliged to provide health services that are not available in its institutions to insurers, which ensures universal access to health services. MOH is the body responsible for supervision over the implementation of the government health insurance under the health insurance and treatment system abroad (no. 11 of 2006).
- The presence of an organized system of national health information routinely and a computerized health information system in government hospitals (MOH, 2017).
- The presence of effective national health accounts system (MOH, 2017).
- The presence of the National Institute of Public Health to enhance evidence-based decision-making and to contribute to the development of some health monitoring systems.

[24] a comparison between 2014 and 2018 shows an increase in the number of nurses and midwives by approximately 353 nurses and midwives. As for numbers of doctors, there was an increase of approximately 213 doctors between 2014 and 2018.

[25] Interview conducted with Dr. Jawad Bitar, Director General of the Information Center of the Ministry of Health, June2020.

1.3. Establishing a unit dedicated to adolescent health in the Ministry of Health by 2023

***Achievements**:*

- In August 9, 2019, the Minister of Health announced that work is underway to establish a specialized section for adolescent health services within the Ministry of Health.
- The NSRSR stated in its first strategic goal to enhance and promote the quality of the SRH services targeting young people and adolescents by 2022 through: 1) adopting the approach of youth friendly clinics (YFHS) to enhance SRH attitude among young people, 2) intensifying awareness campaigns targeting young people towards healthy, reproductive and sexual behaviors.
- The MOH adopted a national protocol on YFHS in 2015, which is an opportunity towards enhancing youth health and well-being.

Challenges: **Based on the MOH reports (2017, 2018), challenges are as follows:**

1. The ongoing Israeli occupation and its policy of isolation between the territories, in addition to its daily repressive policies and practices against the Palestinian people and towards the Government of the State of Palestine, constitute a major obstacle towards achieving comprehensive health, the development of health services and access to health services by all. The Israeli control over all aspects of life and the separation policy imposed by the Israeli occupation in Area C, in addition to the military incursions into the Gaza Strip, led to the destruction of many medical facilities, such as clinics and hospitals, and to a shortage and to a deteriorating in the quality of services provided in these areas. Further, the isolation imposed between WB and GS in addition to the internal division led to the separation of government services between the two regions.
2. A shortage in the allocated public budget to the health sector in general hinders the development of the quality of the services provided and the expansion of its scope to include sexual and reproductive health for all groups and ages.
3. The disparity in the distribution of health services between geographical regions.
4. The absence of a neutral body for accrediting health institutions and ensuring their quality.
5. Lack of alternative plans for emergencies or disasters, including suspension of financial support.
6. Weak monitoring, evaluation and accountability systems
7. A continuous increase in patients with noncommunicable diseases, which contributes to increasing the demand for health services and thus increasing health care costs.
8. Shortage of specialized medical staff and increase in specialized doctors.

9. The absence of a comprehensive health insurance system that guarantees access to services for all and guarantees the continuity of financing and the development of services.

State Commitment (2): Reduce the rates of maternal mortality, diseases, and imminent complications	2.1. Improving the timing of provided care to pregnant women and recent mothers to ensure that 85% of women receive the required care in accordance with recommended timelines by 2022. 2.2. Reducing rate of C-section deliveries in the government sector institutions by 20%, by the year 2030.

2.1. Improving the timing of provided care to pregnant women and recent mothers to ensure that 85% of women receive the required care in accordance with recommended timelines by 2022.

Achievements:

- Women's health during pregnancy: Palestine succeeded in providing health care services to women during pregnancies as it reached 95.8%. Further, the proportion of women receiving health care during pregnancy from a qualified medical cadre was 99%. This is highlighted as an achievement fulfilled by the MOH, where primary health care played a vital role in providing the services in all areas including the marginalized ones, as the MOH has allocated its mobile clinics, which is estimated at 1%, to providing health services including health care for pregnant women in the marginalized areas.
- Health of postnatal and post-delivery care: the proportion of childbirths taking place in medical institutions reached 99.3% in 2014, with no change registered in 2018.
- Improve the detection process of all life-threatening complications for mothers: an improvement in diagnosis of complications and care services was witnessed which played a role in decreasing risks that threatens the lives of mothers. This was indicated in the reduction in maternal mortality rate, which dropped from 24 in 2014 to 19 in 2019. The data indicated that the actions taken by the Ministry of Health to prevent risks associated with pregnancy included the development and dissemination of a reproductive health protocol and the allocation of service centers to provide care in cases of risky pregnancies, which increased from 69 center in 2014 to 76 in 2018. Further, the proportion of registered pregnant women transferred from health care centers to high-risk pregnancy clinics reached 14% in 2014, and rose to 17.4% in 2018, indicating an improvement in staff and health system performance in the detection and treatment of high-risk cases.

- Maternal Mortality (MM)**:** based on MOH reports, there is a decline in the number of maternal deaths in 2019 compared to previous years. In 2019, it reached 19.5 per 100,000 live births compared to 38 in 2009.

Challenges:

1. An increase in the proportion of women within age group (15-49) who had their last baby in a C-section operation in government health center from 20% in 2014, to 25% in 2018. As for the private sector, it reached to 35%. It is worth noting that this percentage is the highest among rich women on wealth index at 26.5% (PCBS, 2018).
2. Monitoring of Maternal Mortality: based on MOH[26], in spite of the success achieved in monitoring the rate of maternal deaths through adopting a system that registers all deaths reaching hospitals, yet the MOH stated that they need to develop a system and a protocol as well as adopting mechanisms to expand the extent of the monitoring. Additionally, the MOH highlighted the need to increase the number on medical specialized workers, provided by a permit issued by the Ministry, to conduct regular visits to the primary health care centers for a further monitoring and registration of maternal deaths.
3. Based on MOH report, in 2019, four factors contributed to maternal deaths:1) poor quality of services (including clinical management, communication and documentation, adherence to protocols and guidelines, availability of equipment and drugs, and referral management), 2) Inadequate numbers of skilled doctors, midwives, and nurses at health facilities, Lack of critical specialized health care providers and Lack of specialists in high-risk pregnancy clinics(MOH, 2019,p.38); 3) delays in reaching an appropriate obstetric/medical facility most often due to geographical and financial barriers, such as transport, distance and cost (MOH, 2019,p.34).; 4) delays in deciding to seek medical care, due to lack of awareness by pregnant women and families related to seriousness of the health condition and to cultural barriers that limit woman's autonomy in making decisions regarding her health and Cultural demand for childbearing (males) as noticed in many cases of grand multiparity, especially in the GS (MOH, 2019,p.35).
4. Poor coordination between the Ministry of Health, the private sector, and non-governmental institutions contributed to the lack of comprehensive monitoring mechanisms of the quality of SRH services provision and maternal mortality.[27]

[26] Interview conducted with Dr. Jawad Bitar, Director General of the Information Center of the Ministry of Health.
[27] Ibid.

State Commitment (3): Decrease the proportion of unmet family planning needs to 10 percent by 2022	3.1. Raising the financial commitment to $500,000 depending on resources availability, aiming at increasing the provided supply to family planning services, among which to include contraceptives. 3.2. Improving supply chain management, including requirements and supply forecasting, logistics management and distribution of family planning services and supplies to reach the poorest and most marginalized populations.

3.1. Raising the financial commitment to $500,000 depending on resources availability, aiming at increasing the provided supply to family planning services, among which to include contraceptives.

Achievements:

- The proportion of the unmet family planning needs reached 11% according to the 2014 MICS Survey, since then no new statistics have been published. Based on State commitment 3, it has been achieved.

Challenges:

1. **Use of Family Planning Methods**: according to the 2014 MICS, the proportion of women using family planning methods remains low by international and regional standards. The Survey indicated that of family planning methods users, nearly one in eight uses less effective "traditional" methods, which represents 13% of all married women surveyed at childbearing age. Further, 43% of married women reported no use at all, compared to 44% of women using modern family planning methods.
2. **Proportion of unmet family planning needs**: multiple disparities were monitored in the **interventions** implemented to achieve this goal in line with Palestine's commitment to the Nairobi Summit. First, regarding the budget, there are no indicators in the budget of the MOH or the General Budget on the percentage of spending on the provision of family planning methods, as medical goods, based on the national definition of the PCBS, do not include family planning methods. Thus, the extent of the spending cannot be measured. Second, concerning the distribution, enhancing the supply chain management, including needs and supply forecasting, logistics management and distribution of family planning services and goods to reach the poorest and most marginalized populations. The indicators on health spending do not meet the goal of realizing the unmet family planning needs, although it reached a proportion of 10%, as the largest proportion of expenditure is allocated for health care services and administrative services in the health sector, which fail to include family planning methods

State Commitment (4): Incorporate comprehensive sexuality education programs into all schools by 2030.	4.1. Reviewing the reproductive health concept and sexuality education included in the Palestinian curriculum 4.2. Training of teachers 4.3. Developing the health adolescence module

4.1. Reviewing the reproductive health concept and sexuality education included in the Palestinian curriculum.

Achievements:

- The adolescent health manual for teachers and counselors was issued in 2008 and updated in 2020, adopting the SRH definition as stated in ICPD. It includes the main units which are adolescence, life skills (self-strengthening skills), healthy lifestyle, sexual orientation, family and family relations and social relations in adolescence for the seventh, eighth and ninth grades, with the inclusion of the AIDS and transmitted diseases units for the ninth grade, and touching on different topics depending on class discussions and needs. The guide is used for informational meetings conducted once a week, for a period of 90 minutes. It will rely mainly on the teachers and counselors who will need training on the topics, and in other cases on hosting external experts including NGOs. The guide was reviewed by the MOH and Juzoor, a non-governmental organization, to develop and monitor the process**.** The manual is expected to be finalized in September 2020 to be piloted in selected schools by trained counselors and teachers.

4.2. Training of teachers

Achievements:

- The Teacher's Guide to Reproductive Health (2009) was prepared for grades seventh to twelfth in order to provide a scientific material for teachers that would enable them answer students' questions related to SRH topics, regardless the teacher's specialization. In particular, the guide aims at providing the teachers with skills and information on how to tackle situations related to students' inquiries regarding reproductive health issues in an educational manner and at enhancing their role as a source of information. The end result sought is to show students how to deal with reproductive health issues consciously and knowledgeably and to provide reliable accurate sources of info on SRH to students and equip them with life skills.

-The School Staff Manual 2008 was prepared to deal with students' health problems (Conversion System) and with support from UNFPA with the aim of providing a reference material for the use of educational, health and guidance teams in schools to deal with

common problems faced by students. The guide aims in particular at providing teachers, health committee coordinators and educational counselors with basic information on common problems that hinder students' growth and development psychologically and physically, socially and emotionally, which in turn hinder their academic accomplishments. Further, the guide provides needed interventions to help schools deal with such issues and to identify cases and levels of intervention required, if and when, students need to be referred to centers outside the schools' scope to seek help.

4.3. Developing the health adolescence module

***Achievements**:*

- The health adolescence module is being finalized and is expected to be released in September 2020.

Challenges:

1. The number of schools that integrated health education activities in its curricula is only 8.6% of the total number of schools.
2. Shortage of counselors in schools in addition to the transfer from one school to another, led to the lack of adequate and complete application of the guide in all schools. Every school has a school health coordinator, but not every school has an educational counselor.

State Commitment (5): Draw on demographic diversity to drive economic growth and achieve sustainable development	5.1. Collecting, analyzing and classifying data for planning and developing programs through censuses every 10 years. 5.2. Developing the statistical system

Achievements:

- National Statistics: the Palestinian Central Bureau of Statistics (PCBS) is the main body responsible for providing the national statistics and data that help decision makers in the process of developing national policies. The National Strategy for Development of Statistics (2018-2022) was prepared based on the Palestinian National Policy Agenda "Putting Citizens First" and in line with the SDGs-2030. The Strategy aimed at strengthening and promoting the statistical infrastructure needed for accurate monitoring of the Sustainable Development Goals. The PCBS has developed national

indicators based on the Sustainable Development Goal indicators and in full coordination with all Ministries, based on the individual needs of each Ministry.[28]

Challenges:

1. Lack of awareness towards the importance of the statistical figure in planning and decision-making in many statistical units in institutions (PCBS, 2018).
2. Difference in the use of the normative guide, concepts, and classifications adopted in the statistical process between partners in the national statistical system (PCBS, 2018).
3. Data quality varies among the partners in the national statistical system (PCBS, 2018).
4. Weakness in the statistical planning in the Ministries and government institutions (PCBS, 2018).
5. Lack of financial sustainability for the statistical programs (PCBS, 2018).
6. Weakness of material and human capabilities in most of the existing statistical units in the GOs and NGOs (PCBS, 2018)

State Commitment (6): Eliminate gender-based violence	6.1. Providing high-quality, multisectoral services to prevent gender-based violence by 2030: 6.2. Issuing the Family protection law and raise the age of marriage to 18 years by 2020. 6.3. Updating the national strategy to combat violence

6.1. Provide high-quality multisectoral services to prevent gender-based violence by 2030:

Achievements:

- The National Committee to Combat Violence against Women (NCCVAW) was established by the Council of Ministers in 2008, and is led by MOWA. The NCCVAW is the official body responsible for monitoring the implementation of the National Strategy on Combating Violence against Women. The Committee consist of 13 governmental institutions and Al Muntada Coalition – NGO Forum to Combat Violence against Women.
- Palestine's National Policy Agenda: Putting Citizens First 2017–2022, endorsed by the Council of Ministers asserts the importance of integrating gender

[28] An interview with Mohamad Duradi. PCBS. June 2020.

mainstreaming tools to ensure that the principles of gender equality are integrated into public policy, legislation, planning, and budgeting processes.

- Integration of GBV in the National Health Policy 2017-2022 as well as in the MOHE policy 2017-2022.
- Palestine launched a National Action Plan in 2016 for the implementation of Security Council Resolution 1325 for the period 2017– 2019. The Plan sought to increase the participation of women in peacekeeping and conflict resolution, integrate the perspectives of women into peace agreements, address the impact of conflict on women, and protect women from sexual violation while criminalizing sexual violence. It has been incorporated into the Public Budget of 2018 (UN Women, 2018).
- Establishing a registry system for GBV cases within the National Health System.
- The establishment of the Family Protection and Juvenile Unit of the Palestinian Civil (FPJU) in police departments. The FPJUs adopt a human rights-based approach and focus on domestic and family violence, including cases involving children, the elderly, and women. They deal with GBV cases such as femicide, incest and sexual harassment. A Juvenile Unit focuses on child protection has also been established (UN Women, 2018).
- The Attorney General established the Gender Unit in the Public Prosecution Service (PPS), which aims at integrating gender standards and developing specialized services on violence against women in the PPS. In 2016, a Chief Specialized Public Prosecutor on violence against women was appointed and two units specializing in protecting family members against violence were established.
- The National Referral System was established in 2013 by a decision issued from the Palestinian Council of Ministers. It became an effective and binding document for all institutions (GOs and NGOs) working on GBV. The MOH, FPJUs and MOSD approved it, but no data are available on the effectiveness of implemented procedures. Further, many training sessions targeting both the government health sector and the police departments on the Referral System were conducted by government, civil society and women organizations. MOH equipped and specified a counselling room in PHC directorates and per hospital in all West bank hospitals and one hospital in Gaza to deal with VAW cases.
- A national system for shelters was approved in 2011 by the Council of Ministers. Shelters were recognized as official institutions under the State's responsibility. MOSD is the ministry responsible for the monitoring of the shelters to ensure their commitments to the requirements.

- SOPs developed in order to set a unified instruction to help workers working on GBV in the Ministry of Social Development (MOSD), Ministry of health (MOH) and Ministry of Interior (MOI).
- GBV indicators were developed and integrated into the National Health HIS, the Annual Health Status Report, and in the MOI reports.
- Case management protocol developed and is implemented in MOSD and MOI-Family Protection Units
- In January 2017, the Minister of Health issued a decree to exempt female survivors of GBV from any medical fee to obtain a medical certificate.
- Two specialized committees have been formed at the Ministry of Justice, the Legal Harmonization Committee and the Gender Legislative Committee, as branches of the National Committee on Combating Violence against Women. The committees shape policies, laws, and regulations concerning women and human rights in Palestine. Their legislative harmonization plan for 2018 included reviewing and amending the Penal Procedures Law, Penal Code, Personal Status Law, and Elections Law to ensure their compatibility with international standards.[29]

6.2. Issuing the Law to protect the family against violence and raise the age of marriage to 18 years by 2020.

Achievements:

- Family Protection against Violence law: The law was adopted by both the Ministry of Social Development and the Ministry of Women's Affairs and was put on the agenda of the Meeting of the Palestinian Cabinet for approval.

6.3. Updating the National Strategy to combat violence

The Strategic Plan on Violence against Women in the Palestinian Society: the National Strategic Plan on Violence against Women for 2012-2019 was approved by the Council of Ministers in 2012. The strategy was developed under the leadership of the MOWA and in partnership with all Ministries represented in the National Committee on Violence against Women in addition to the civil society institutions. So far, no development or change has been made to the plan, although the above commitment indicates that the intervention will be completed by the end of 2020.

[29] Interview with Amin Asi. MOWA. 2020.

Challenges:

1. The Legislative Council has been inactive for more than 11 years, which had a direct effect on the process of legislation and law adoption that would enhance gender equality and thus protect women.
2. The internal division between The Gaza Strip and the West Bank is one of the prominent obstacles that hinder the unification of legislation between the two regions.
3. The diverse sources of legislation in force in the West Bank and Gaza Strip as they are based or adopted from Jordanian, Egyptian, Ottoman, English, French, Israeli military and Palestinian.
4. The Patriarchal Culture is deeply rooted into the political, social, and legal structures. The Family Protection law is facing rejection and anger from religiously committed groups, arguing that the Family Protection Bill 30 affects societal customs and traditions that are built on obedience and respect for the family, especially by women.
5. Shortage in the allocated budget designated to combating GBV.
6. The prevailing tribal custom limits the interference of the official bodies and thus hampering the efforts and the application of the interventions that aim at finding solutions to women's issues.
7. Lack of societal awareness towards women issues in general and gender issues in particular.
8. The insignificant role of the policies developed and adopted by the media towards changing the stereotyped image of women as dependent individuals rather than an effective member of the society that would help in the development process.
9. The Referral system is still facing many challenges. The system provides some details about the nature of institutions specialized in dealing with different forms of violence, such as cases of pregnant women victim of violence, rape, the tendency to commit suicide, and life threating situations. Furthermore, this system dealt with cases of violence in general and did not provide sufficient details regarding the matter (depending on the situation and type of assault) (Chemonics, 2016). There isn't a consistent systemic line to adopt the responsibility to follow

[30] The opposing parties have described the law as a tool to incite moral corruption, arouse social degradation and encourage women and girls to rebel against family dependence and obedience. This attack came during an urgent political situation, represented by the Israeli Government's announcement of the Annexation Plan, which aims to annex vital parts of the Palestinian Territories. This will shed its darkness on the prioritization of the Palestinian Government, and will be at the expense of the adoption of the Family Protection Bill paving the way for further gender-based violent practices against women and girls in the upcoming dire political and socio-economic situation in light of the Annexation Plan and its consequences.

up on cases, nor a central body that oversees the process, until the case files are closed. Training sessions on referral system that were conducted in general by different institutions face many challenges, and most of the training and capacity-development efforts are still driven by the donors. These training sessions are mostly seasonal, partial and non-integrated, which means that the accumulation of experience is weak and building on the above (Chemonics, 2016).

5. Sexual and Reproductive Health during the COVID-19 Pandemic

With the outbreak of Covid-19 pandemic, the Palestinian Government declared a state of emergency for 30 days on March 4, 2020 and affirmed its extension twice for a period of 90 days so far. Due to the seriousness of the situation, the Government announced measures that focused on preventing the spread of the virus in line with the WHO recommendations, among which are lockdown and staying- at home orders to protect the population against COVID- 19. According to the world Bank report 2020, the pandemic causes more challenges to the Palestinian economy. An abrupt decline in economic activities and pressure on the Palestinian Authority (PA)'s finances have placed Palestinian livelihoods at high risks, as the impact of the Coronavirus (COVID-19) continues to hit the economy hard (World Bank, 2020) in line with Israeli hold to the Palestinian revenues.

Under this novel reality, women, girls and youth have become more vulnerable, further subjected to violence and denied access to health rights in general, SRHR in particular, and due to the increasing unemployment, which is already very high especially in Gaza

Based on the reports from women's organizations[31], home quarantine policy has led to an increase in the rate of domestic violence. This was highlighted by the data collected by women's institutions working on the matter[32], which showed an increase in the number and frequency of violence directed at women and girls and resulting from the perpetrator's continuous presence at home. The Covid-19 crisis has also inflicted further suffering upon women and girls with disabilities who have experienced a double increase in the violence directed at them, due to the increased restrictions during the pandemic, the community stigmatization, and because they are seen as dependent citizens rather than self-determining individuals (Palestinian CEDAW Coalition, 2020). Moreover, the economic crisis, which was exacerbated by the restriction of movement and the closure of industrial and commercial facilities, leading to a halt in the wheel of the economy. Many male and female workers were made redundant, others lost their wages and salaries, and the majority of the population lost job and livelihood security. This places

[31] Reports from WCLAC, GUPW, PWWsd, WAC and CWLRC.
[32] Women's Center for Legal Aid and Counseling, Palestinian Maintenance Fund, Health Work Committee and General Union for Palestinian Women -West Bank and Gaza Strip.

huge psychological burdens on the people, who became frustrated and consequently this frustration was projected on women and girls in the form of violence especially verbal violence. In the light of this crisis, many women have lost their jobs, which have doubled their dependence on men, thus losing their financial independence making them more vulnerable to violence.

With regard to the right to access to health care, within the State of Emergency procedures, and under the decision of the MOH, the Ministry's work was directed to survey the virus and provide diagnostic and treatment services. The MOH has not taken into account the special needs of women and girls in general or the battered women in specific. With the onset of the emergency measures, all primary health care centers, including those providing care to pregnant women, were closed, without taking into account the health effects that women at all ages may have due to the lack of health care, especially abused women and girls. Further, women's access to necessary health services was also affected, especially those suffering from chronic diseases or who needed to travel for treatment including women who leave the Gaza Strip for medical purposes, such as cancer patients (Palestinian CEDW Coalition, 2020).

As for areas C[33], which is under full occupation control, the problems facing the Palestinian inhabitants have increased in terms of the provision of health and education services, especially women, girls, the elderly and persons with disabilities, due to the enforced lockdown by the Palestinian government. Under the State of Emergency measures, the government care centers have been suspended and the Ministry has not taken any alternative measures in dealing with primary health care centers and reproductive health services, thus depriving women of receiving reproductive services during the period of the pandemic. This will have a significant post-pandemic impact in terms of increasing anemia among pregnant women, child malnutrition, sexual diseases, and unsafe abortion. In addition, women and girls are subjected to rape or sexual abuse within the family and the health consequences that may need to be addressed by health-care centers would be mounting, because those centers are the first doors to knock for help by the victims of violence, especially women and girls (Health Work Committees, 2020).

In the same context, access to health services for persons with disabilities has become more difficult during the period of the pandemic and the Government has not taken the necessary measures to facilitate their access to health services. After the suspension of

[33]The Israeli-Palestinian Interim Agreement on the West Bank and the Gaza Strip (Oslo II), signed on 28 September 1995, created - as an interim, five-year measure - three distinct zones in the West Bank: Areas A, B, and C - each with different security and administrative arrangements: • Area A: full Palestinian control; mainly urban areas, PA police patrol the streets. • Area B: Palestinian civil and Israeli security control; mainly villages on the outskirts of Area A cities. • Area C: full Israeli military and civil control; includes settlements, roads, strategic areas, areas adjacent to Israel proper.

field medical services, reaching villages and the outskirts of the cities during the period of the pandemic, in addition to the lack of access to many areas by medical cadres, this has contributed to the deprivation of persons with disabilities, especially women and girls with disabilities, of the SRH services and rights. As for the rehabilitation services for persons with disabilities, they have been completely interrupted (Qader for Community and Development, 2020).

Older people, based on the 2019 survey of violence, were the group that was subjected to health neglect the most, and older women were more likely to be neglected than males. Thus, in the period of the pandemic, it is expected to be the most marginalized group in access to health care under the closure of primary health-care centers.

The situation is worsening in area C, which lack mainly health centers to meet the needs of all individuals and all ages, as well as in the Gaza Strip, which is already suffering from a total blockade, separating it from the world by the Israeli occupation. The Gaza Strip is the target of destruction; Israel devastated the infrastructure, demolished several hospitals and clinics, and targeted the medical staff in the repeated incursions into the Strip. This led to a severe shortage in human resources and medical supplies, which increased the challenges facing the Palestinians during the pandemic, especially women and girls who are the group subjected to violence and marginalization the most.

It can be argued that despite the efforts made by women and international institutions to integrate gender into the orientations of the Palestinian Government, the period of the pandemic has shown that the commitment to integration remains at the formal rather than the operational level. The emergency plans have not taken into account gender, which is an indication of the importance of mobilizing efforts to develop working mechanisms to ensure real change in the patriarchal culture, which continues to control the orientation of the Government leading to further marginalization of the rights of women and girls.

7. Moving forward to achieve Nairobi Summit commitments:

In general, the achievements and the challenges in the fulfillment of the commitments of the State of Palestine towards the Nairobi Summit, the State of Palestine is striving to improve the health sector to ensure that all citizens have access to the services provided. A commitment hindered by the political situation in the Palestinian Territories due to the Israeli occupation and its repressive and exploitive policies that aim at destroying the components of sustainable development, and widening regional inequality because of the policy of segregation Israel imposes in efforts to separate between the West Bank and the Gaza Strip.

Palestine has been successful in its obligation towards the implementation of SRH services and rights reducing the rates of maternal and child mortality, in achieving a slight

decrease in fertility rates and unmet need for family planning Reached 10% as stated in the Nairobi Commitment no.3. Yet, much work is still needed to reach development in many other areas, especially combating gender-based violence against women and girls, which contributes to further female marginalization in the right to actively participate in the public life and in politics. Moreover, Palestine has to address the challenge that poses grave limitations to its efforts, which is the patriarchal culture that is deep rooted in the political, economic and social frameworks. Therefore, it hinders and limits the advancement of women and girls and denies them the privileges of active citizenship.

In order to move forward and ensure effective implementation of interventions, it is necessary to reduce gender-based inequality in all spheres of life. The State of Palestine needs to focus its efforts on the comprehensiveness of SRH as one of the key inputs to reducing the inequality prevailing in Palestinian society. Succeeding in eradicating inequality and closing the gender gaps is a major step towards realizing the much-anticipated goals developed in line with both the Nairobi Summit commitments and the 2030 Agenda, under the slogan, “Leave No One Behind”.

Recommendations to achieve the Nairobi Summit Commitments:

1. **Laws, procedures and regulations:** The Government of the State of Palestine should work on:
    1. Adopting the Family Protection against Violence law and its harmonization with the rest of the laws and legislations, particularly the Penal Code, with the CEDAW, and develop procedures and regulations for the Family Protection law.
    2. Implementing follow-up and monitoring on the enforcement of the presidential decree raising the age of marriage to 18 years without exceptions.
    3. Update the National Referral System to ensure the inclusion of persons of disabilities and to promote the adopted procedures implemented during the periods of crises.
    4. strengthen clinical management of rape services

2. **Cross-sectoral SRH in the National Strategic Plan:** The Government of Palestine in partnership with specialists from women’s, human rights and health institutions, at both local and international levels, should focus the efforts on:
    1. The provision of integrated SRH services through the primary health care system within the comprehensive, integrated approach originally envisioned in the ICPD

Programme of Action by creating a one stop access for all to basic information and health needs,

2. Raising awareness for strategic planners and public budgets about SRHR as a pre-stage of the planning process to ensure the integration of the SRHR in the Government's National Strategic Plan,
3. Empowering the National Population Committee on assessing the cost and monitoring progress against Nairobi Commitments,
4. Identifying the demographic, social and cultural factors of each governorate that might affect SRHR of all groups, focusing on young people and persons with disabilities and elderly, and to recognize and take into account the diversity of needs based on gender and age group.

3. To include SRHR in emergency plans during the political, humanitarian and environmental crises, through:

1. Developing a contingency plan with different scenarios (conflict, pandemic, natural disaster),
2. Developing procedures and referrals during crisis,
3. Developing guides based on gender, SRH for times of crisis,
4. Capacity building on dealing with SRH during crisis,
5. Promoting youth leadership during crisis with focus on vulnerable areas.

4. Eliminate Gender-based inequality and gender-based violence: prioritize SRHR in the context of public health and gender equality, through:

1. strengthen integration of combating GBV in the health, education, social development, protection national sectoral plans with clear monitoring system,
2. ensuring the activation and implementation of the quota to ensure political participation and public life of women, girls and persons with disabilities in all decision-making positions, including political negotiation committees, local committees and political parties,
3. establishing procedures and regulations protecting women from violence in the workplace (informal and formal sector),
4. the Government of the State of Palestine, UN agencies, multilateral institutions and civil society should integrate SRHR in their plans and programs, in order to address the adverse effects of gender-based inequality,

5. Update indicators to measure the implementation and effectiveness of the National Strategic Plan to combating VAW,
6. unifying methods in collecting data on cases of gender-based violence among government institutions as well as with civil society service providers institutions dealing with cases of gender-based violence, in order to activate and ensure the quality of the National Electronic Observatory of Gender- based Violence,
7. Activate the National registry for GBV cases (AlMarsad) at MOWA to ensure effective monitoring of cases of GBV in the government and the non- government sectors which would support the process of effective planning and set a tool for advocacy.

5. Promote the integration of SRH in the health sector in general by:

1. modifying and developing responses based on specific needs and requirements based on circumstances instead of standardized and rigorous interventions, taking into account different groups such as persons with disabilities and the elderly, as citizens, who have the full right to health rights and not sick or helpless citizens,
2. focusing in policy orientation on prevention, rather than just clinical care,
3. promoting psychological health as part of full and comprehensive services in SRH,
4. increase the number of the mobile clinics in order to ensure provision of health services in suburban areas,
5. strategize and develop a program to increase the number of midwives and enhance their capacities,
6. counseling and services related to family planning and a to ensure full range of modern contraceptive methods especially for engaged and newly married couples,
7. to develop a system and a protocol as well as adopting mechanisms to expand the extent of the monitoring of MM,
8. instituting the adolescent health unit in the Ministry of Health in terms of developing policies, procedures, strategy, programs and monitoring,
9. strengthening the youth friendly health services based on the 2015 MOH protocol.

6. **- Ensure Youth's rights to participation and promotion of youth leadership in SRH policies and programs**.

    1. To ensure youth Participation as a component of the program planning process, including needs assessment, design, implementation, monitoring, and evaluation,
    2. Capacity building to the Adolescent Health Coalition in lobby and advocacy tools and methods to push ahead the CSE and YFHS with the government,
    3. Develop an international network with between the Adolescent Health Coalition and international youth coalitions as a way to gain and exchange knowledge and skills on SRHR.

7. **Involvement of men and boys as partners in the gender transformative change** by ensuring that SRHR are a reality for all, through:

    1. engaging men and boys through civil society organizations, youth networks, donors and multilateral institutions as partners in programs related to health, SRHR, gender equality, and the empowerment of women and girls,
    2. challenging traditional gender roles and attitudes regarding concepts of masculinity and social gender, and promote fatherhood and motherhood roles and responsibilities as a way to improve gender equality and participation in the household level,
    3. promoting men's awareness of SRH from a human rights perspective,
    4. promoting men's access to SRH services and increase their use of family planning methods,
    5. mobilizing men, journalists and religious leaders for social transformation and in promoting gender equality and take a stand against gender-based violence.

8. **Capacity building at different levels and in various specializations to enhance the rights of women and girls in general, and SRH rights in specific, by:**

    1. conducting a review from gender approach of the guides on training and capacity building, both governmental and non-governmental levels, on SRH, ensuring that the universal concept is integrated and that the mechanisms are clarified,
    2. increasing the coordination and effective networking between the Ministry of Health, the Ministry of Education, the Ministry of Women's Affairs and the

Ministry of Social Development in developing SRH plans for staff working on SRH,

3. building the capacity of the police force, especially family protection units, against violence over SRHR from a human rights perspective,
4. developing a training plan, for at least three years, on the national referral system and associate it with SRHR.

9. **Continue and increase financial and political commitment to SRHR** to maintain the success of health interventions, and to expand and increase the potential for gender equality and empowerment of girls and women, through:
    1. Donors, multilateral institutions and the Government of the State of Palestine should continue to invest in SRHR and services in full scale, including rights-based family planning,
    2. emphasizing on investment in maternal health, prevention and reduction of gender-based violence,
    3. continuing and increasing investment by the Palestinian Government, civil society, private sector and grassroots donor institutions to build youth and women's individual and collective capacity through increased funding for youth and women's associations, especially in marginalized areas,
    4. allocating the budget required for the development of the primary health care and guaranteeing its geographical distribution due to its vital role as the primary provider of SRH services,
    5. developing monitoring and evaluation systems in government institutions and within donor countries' projects, particularly the UNFPA program for its role as the prime supporter for SRH services.

References:

Abdullah. Samir, 2018. Skills shortage and gaps in the health sector in the oPt. Palestinian Economic Policy Research Institute (MAS)

Albed, Dr. George Tawfiq, 2016. The Palestinian Economy: The Path to a Better Future. Palestinian Economic Policy Research Institute (MAS).

ALFA International, (No date). An evaluation study: The Adolescent Health and Teacher Guide Project in Reproductive Health. Palestinian Ministry of Education and Higher Education. From https://pal-tahrir.info/audio/files/AlMorahaqa.pdf

Al-Botmeh, S., 2013. Barriers to Female labour Market Participation and Entrepreneurship in the Occupied Palestinian Territory. Christianaid. Birzeit University, YWCA. From https://pfesp.ps/uploads/Barriers-to-Female-Participation-in-Labour-Market-2013.pdf

https://www.btselem.org/arabic/topic/jordan_valley

https://www.btselem.org/arabic/planning_and_building/east_jerusalem_statistics

Cross-Sectoral Strategy for Promoting Gender Equality and Equity in the National Development Plan 2017–2022 From: http://www.mowa.pna.ps/#34

Egyptian Family Law No. 303 (1954)

Egyptian Penal Code No. 74 (1936)

General Union of Palestinian Women, 2017. *Report on the status of women and girls in the State of Palestine (CEDAW Shadow Report)*. The Non-Governmental Women Coalition for the Implementation of CEDAW in the Occupied State of Palestine. Retrieved on 03 Dec. 2019 from https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/PSE/INT_CEDAW_NGO_PSE_29031_E.pdf

General Union of Palestinian Women, 2020. Report on violence against women During COVID-19 in the State of Palestine. The Non-Governmental Women Coalition for the Implementation of CEDAW in the Occupied State of Palestine

Hamdan, Dr. Motaem & Imam, Dr. Asma, 2019.MappingAdolescent and Youth Sexual and Reproductive Health Services in Palestine.

Health Cluster Occupied Palestinian Territory, 2020. The impact of COVID-19 on sexual and reproductive, Including maternal health in Palestine.

Independent Commission for Human Rights "Board of Grievances", 2008. The reality of the right to health in the territories of the Palestinian National Authority. Special Reports Series No. (63). Ramallah

Institute of Women's Studies & OXFAM, 2019. Addressing the needs of Palestinian Households in Area C of the West Bank. Findings of the Frist Comprehensive Household Survey. In: http://healthclusteropt.org/admin/file_manager/uploads/files/1/5c91e3b44a3c7.pdf

Jordanian Penal Code of 1960

Jordanian Personal Status Law No. 61 (1976)

Juzoor for Health & Social Development, May2020. Report on Gender Based Violence during COVID-19 Pandemic. Palestine.

Khader. Dr. Ali & Abu. Hamad. Dr. Bassam, 2018. Family-Planning Services in Palestine: Challenges and Opportunities.

https://www.maan-ctr.org/magazine/article/2606/

MIFTAH&ICHR&UNFPA, 2015.Country Assessment towards Monitoring and Reporting Sexual and Reproductive Health and Rights (SRHR) in Palestine

Ministry of Finance and Planning, General Administration of the General Budget, 2018. Citizen Budget, Fiscal Year 2018. Ramallah

Ministry of Health& The Palestinian National Institute of Public health& World health Organization, 2019.Maternal Death Review (MDR) Report Palestine.

Ministry of Health, 2018. National Strategy for Sexual and reproductive health in Palestine 2018-2022. General Department for Women's Health and Development. With support from the United Nations Population Fund. Ramallah

Ministry of Health, 2019. Annual Health Report Palestine 2018. Office of the Assistant Undersecretary for Planning Affairs, General Administration for Health Policy and Planning, and Palestinian Health Information Center. Ramallah

Ministry of Health, 2016. Maternal Mortality Report 2014. Palestine

OECD, 2019.Health at a Glance 2019.OECD Indicators, OECD Publishing,

OCHA, 2018, https://www.ochaopt.org/ar/content/over-700-road-obstacles-control-palestinian-movement-within-west-bank-0

https://www.ochaopt.org/sites/default/files/ocha_opt_area_c_factsheet_August_2014_english.pdf https:/doi.org/10.1787/4dd50c09-en

OCHA, 2019, https://www.ochaopt.org/ar/content/over-700-road-obstacles-control-palestinian-movement-within-west-bank-0. P.5

Palestinian Central Bureau of Statistics-PCBS, Ministry of Health, 2020. *Palestinian Health Accounts 2000- 2018:* Ramallah - Palestine

Palestinian Central Bureau of Statistics–PCBS (2019a). *Census Final Results: Detailed Report–Palestine Population, Housing and Establishments Census*. State of Palestine. Retrieved on 5 Dec. 2019 from https://www.pcbs.gov.ps/pcbs_2012/Publications.aspx

Palestinian Central Bureau of Statistics–PCBS (2006a). *Domestic Violence Survey in Palestine, 2005*. State of Palestine.

http://www.pcbs.gov.ps/Portals/_Rainbow/Documents/vio_e.htm

Palestinian Central Bureau of Statistics–PCBS (2011b). *Domestic Violence Survey in Palestine, 2011*. State of Palestine. Retrieved on 03 December 2019 from http://www.pcbs.gov.ps/Portals/_Rainbow/Documents/vio_e.htm

Palestinian Central Bureau of Statistics–PCBS (2018b, December). *Women and men in Palestine: Issues and Statistics*. State of Palestine. Retrieved on 26 Nov. 2019 from https://www.pcbs.gov.ps/pcbs_2012/Publications.aspx

PCBS, 2019, http://www.pcbs.gov.ps/postar.aspx?lang=ar&ItemID=3635#

PCBS, 2020, http://www.pcbs.gov.ps/postar.aspx?lang=ar&ItemID=3665#

Palestinian Central Bureau of Statistics–PCBS (2019). *Palestinian Labour Force Survey: Annual Report, 2018*. State of Palestine

https://reliefweb.int/sites/reliefweb.int/files/resources/Press_En_13-2-2019-LF-e.pdf

Palestinian Central Bureau of Statistics-PCBS, Ministry of Health, 2017*. Palestinian Health Accounts 2015:* Ramallah - Palestine.

Palestinian Central Bureau of Statistics–PCBS (July 2019b). "The Status of Gender in Palestine within the Implementation of the 2030 Agenda [in Arabic]". State of Palestine. Retrieved on 5 Dec. 2019 from

Palestinian Central Bureau of Statistics–PCBS, 2020.Sustainable Development Goals Statistical Report, 2019.Ramallah-Palestine.

Palestinian Central Bureau of Statistics-PCBS, 2018. Palestinians at the end of 2018. Ramallah – Palestine

Palestinian Central Bureau of Statistics–PCBS (2018a, July). *On the International Women's Day* (8/3/2019). State of Palestine. Retrieved on 12 June. 2020 from http://www.pcbs.gov.ps/postar.aspx?lang=ar&ItemID=3405#

Palestinian Central Bureau of Statistics–PCBS (2018a, July). *On the International Labor's Day* (2019). State of Palestine. Retrieved on 12 June. 2020 from http://www.pcbs.gov.ps/postar.aspx?lang=ar&ItemID=3594

Palestinian Central Bureau of Statistics, 2018. *Population, Housing and Establishments Census 2017*: *Census Final Results - Summary. 2017.* Ramallah - Palestine

Palestinian Central Bureau of Statistics-PCBS, 2016. Palestinian Youth Survey, 2015. Main Findings. Ramallah-Palestine

Palestinian Central Bureau of Statistics, 2019. The situation of youth in Palestinian society on International Youth Day. Press conference on 12/ 8/ 2019. http://www.pcbs.gov.ps/postar.aspx?lang=en&ItemID=3529#

Palestinian Central Bureau of Statistics-PCBS, 2019**.** Preliminary Results of the Violence Survey in the Palestinian Society, 2019*.* Ramallah - Palestine

Palestinian Central Bureau of Statistics-PCBS, 2017. Leaflet on population and education from a gender perspective. Ramallah – Palestine

Palestinian Central Bureau of Statistics-PCBS, 2015. The Palestinian Multiple Indicator Cluster Survey, 2014

Palestinian Central Bureau of Statistics-PCBS, 2017. Disability from Gender Lens. Ramallah

Palestinian Central Bureau of Statistics-PCBS, 2017.population and education from a gender perspective

Palestinian Central Bureau of Statistics–PCBS (2018a, July). *On the Occasion of the International Population Day* (11/7/2018). State of Palestine. Retrieved on 5 Dec. 2019 from https://www.pcbs.gov.ps/portals/_pcbs/PressRelease/Press_En_IntPopDay2018E.pdf

Palestine Monetary Authority-PMA, 2018. Economic Forecasts Report 2019

Saadeh, L., Barghouthi, F., & Muaqqet, F, 2019. "Country Case Study: Palestine." Chapter in: Afkhamai, M., Ertürk, Y. & Mayer, A.E, eds. Feminist A*dvocacy, Family Law and Violence against Women: International Perspectives*. London and New York: Routledge Studies in Development and Society

State of Palestine, 2016. National Policy Agenda 2017-2022. Citizen first.

Transparency Palestine-AMAN, 2019. General Budget Performance Report - 2019. Ramallah - Palestine.

Tohme. Ayssar and Massad. Nafir, 2019. A working paper on monitoring the reality of sustainable development indicators in Palestine. Faculty of Law and Public Administration. Conference on sustainable development in light of conflicts and crises. Birzeit University.

United Nations Population Fund-UNFPA, 2016. Palestine 2030. Demographic Change: Opportunities for Development. Summary Report

United Nations Office for the Coordination of Humanitarian Affairs (OCHA), 2020.COVID-19 Emergency Situation Report 10 (May-2 Jumne 2020). In: https://www.ochaopt.org/content/covid-19-emergency-situation-report-10

UNDP, 2019. Human Development Report, 2019.Beyond income, beyond averages, beyond today: Inequalities in human development in the 21st century.

UNWOMEN, 2020.Rapid Assessment on COVID-19 And Domestic and Family Violence Services Across Palestine.

UNFPA, 2017. Engaging Men in Sexual and Reproductive Health and Rights, Including Family Planning. Why using Gender Lens Matters. In:

https://www.engenderhealth.org/pubs/gender/gender-toolkit/.

UNICEF, 2018. Children in The State of Palestine. In: https://www.unicef.org/sop/media/341/file/Children%20in%20the%20State%20of%20Palestine.pdf

UNDP - Human Development Report, 2019. Inequalities in Human Development in the 21st Century Briefing note for countries on the 2019 Human Development Report

https://unctad.org/en/PublicationsLibrary/gdsapp2015d1_en.pdf. P.i

https://arabstates.unfpa.org/en/news/nairobi-summit-icpd25-ends-clear-path-forward-transform-world-women-and-girls

https://arabstates.unfpa.org/en/news/nairobi-summit-icpd25-ends-clear-path-forward-transform-world-women-and-girls

UN NEWS, https://news.un.org/en/story/2019/11/1051181

World Bank, 2018. Economic Monitoring report to the Ad Hoc Liaison Committee. In:

http://documents1.worldbank.org/curated/en/413851537281565349/pdf/129986-REVISED-World-Bank-Sept-2018-AHLC-Report-final.pdf